Sparked CDG Brisbane Face to Face

11 – 12 September 2024

Workshop Aggregated Transcript

Sparked

HL7 FHIR

Agenda – Day 1

Time	Topic	Facilitator / Speaker
8.30am	Registration	
9:00am	Welcome and introductions	Kate Ebrill
9.10am	Objectives	Kate Ebrill
	Patient Summary	
9.20am	Department of Health and Aged Care	DoHAC
9.35am	Australian Digital Health Agency	Ryan Mavin
9.50am	International Patient Summary	Vince McCauley
10.00am	New Zealand Perspective	Alastair Kenworthy
10.10am	Consumer Perspective	Harry Iles-Mann & Mehmet Kavlakoglu
10.30am	**Morning Tea**	
11.00am	GP Perspective	Chris Moy & Shaun Francis
11.20am	Queensland Health Perspective – Transitions of Care	Andrew Blanch
11.30am	Australian Commission on Safety and Quality in Health Care – Transitions of Care and Discharge Summary	Rodney Ecclestone & Andrew Hugman
11.40am	Patient journey	Danielle Bancroft
11.50am	Workshop 1: Patient Summary Use Cases – exploring detailed use case requirements and priority workflows	Kate Ebrill & Kylynn Loi
12.45pm	**Lunch**	
1.30pm	Workshop 2: Patient Summary Data Group development	Kate Ebrill & Kylynn Loi
3.00pm	**Afternoon Tea**	
	Reason for Encounter	
3.30pm	Reason for Encounter Introduction	DoHAC
3.40pm	GP Perspectives	Averil Tam
3.50pm	Acute Care Perspective	Andrew Blanch
4.00pm	Australian Institute of Health and Welfare Perspective	Michael Frost
4.10pm	Workshop 3: Reason for Encounter Use Cases	Kate Ebrill & Kylynn Loi
5.00pm	Day 1 conclude	
5.30pm	Post event hang out	

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Agenda – Day 2

Time	Topic	Facilitator / Speaker
8.30am	Registration	
	eRequesting in Action	
9.00am	eRequesting in Action Introduction and Recap	Michael Hosking
9.15am	eRequesting in Action Requester Perspectives Provider Perspectives Intro to RCPA and RANZCR catalogues Industry perspectives DoHAC perspective	Rob Hosking Ken Sikaris Carmen Wong David Willock Jess White Angus Millar Jeremy Sullivan
10.30am	**Morning Tea**	
11.00am	Workshop 4: eRequesting terminology in Action Identifying opportunities for standardisation of national catalogues	Liam Barnes & Michael Hosking
12.15pm	AUeReqDI Release 1 update	Kylynn Loi
12.30pm	**Lunch**	
	Chronic Disease Management	
1.30pm	Chronic Disease Management Introduction	DoHAC
1.40pm	Chronic Disease Management Perspectives	Jackie O'Connor Steven Kaye Nyree Taylor Tim Blake
2.10pm	Workshop 5: Chronic Disease Management Use Cases – Exploring workflows and scoping	Kylynn Loi & Kate Ebrill
3.00pm	**Afternoon Tea**	
3.30pm	Workshop 5: Chronic Disease Management Continued - Data Group development	Kylynn Loi, Heather Leslie, & Kate Ebrill
4.15pm	Closing remarks and next steps	Kate Ebrill

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Patient Summary

Workshop 1

Patient summary workflows

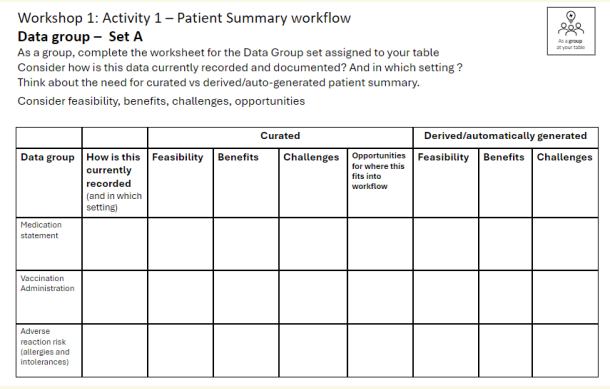
Objectives - Workshop 1: Patient Summary Workflows

To understand the opportunities and challenges with different Patient Summary workflow models – curated vs machine generated

Understanding data requirements in the Patient Summary workflow

Overview – Workshop 1: Activity 1

Attendees were asked, as a group at their table, to respond to the questions detailed on the worksheet (see inset below) to understand the opportunities, challenges, and data requirements of curated versus machine-generated Patient Summary workflows.

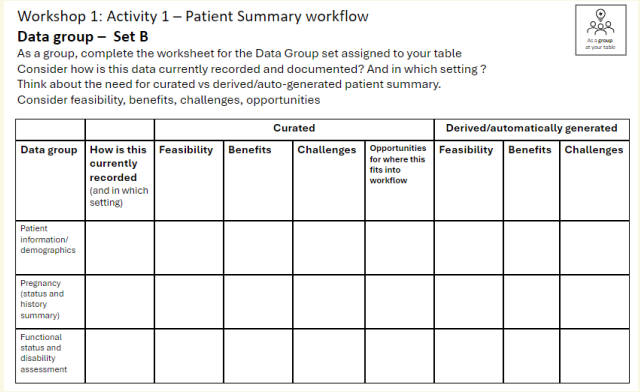


Workshop 1: Activity 1 – Patient Summary workflow

Data group – Set A

As a group, complete the worksheet for the Data Group set assigned to your table
Consider how is this data currently recorded and documented? And in which setting ?
Think about the need for curated vs derived/auto-generated patient summary.
Consider feasibility, benefits, challenges, opportunities

		Curated				Derived/automatically generated		
Data group	**How is this currently recorded** (and in which setting)	**Feasibility**	**Benefits**	**Challenges**	**Opportunities for where this fits into workflow**	**Feasibility**	**Benefits**	**Challenges**
Medication statement								
Vaccination Administration								
Adverse reaction risk (allergies and intolerances)								

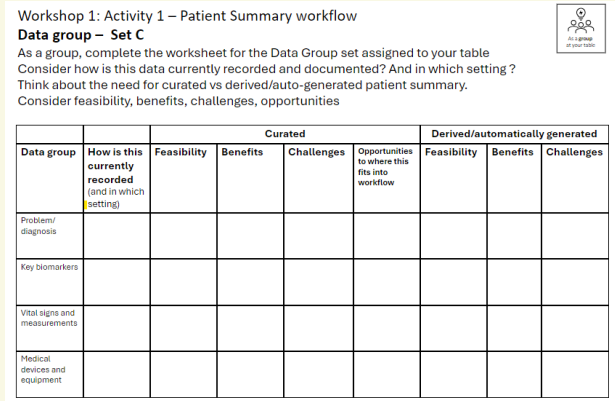


Workshop 1: Activity 1 – Patient Summary workflow

Data group – Set B

As a group, complete the worksheet for the Data Group set assigned to your table
Consider how is this data currently recorded and documented? And in which setting ?
Think about the need for curated vs derived/auto-generated patient summary.
Consider feasibility, benefits, challenges, opportunities

		Curated				Derived/automatically generated		
Data group	**How is this currently recorded** (and in which setting)	**Feasibility**	**Benefits**	**Challenges**	**Opportunities for where this fits into workflow**	**Feasibility**	**Benefits**	**Challenges**
Patient information/ demographics								
Pregnancy (status and history summary)								
Functional status and disability assessment								

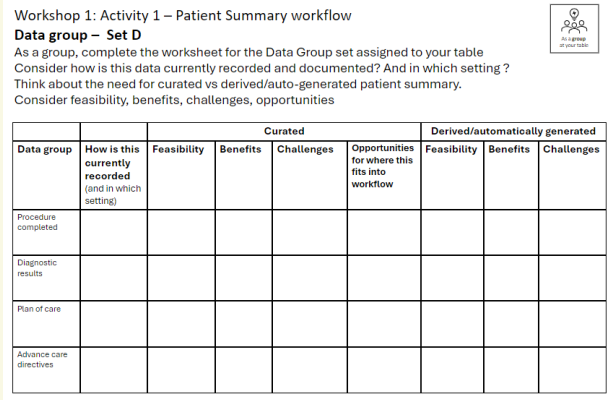


Workshop 1: Activity 1 – Patient Summary workflow

Data group – Set C

As a group, complete the worksheet for the Data Group set assigned to your table
Consider how is this data currently recorded and documented? And in which setting ?
Think about the need for curated vs derived/auto-generated patient summary.
Consider feasibility, benefits, challenges, opportunities

		Curated				Derived/automatically generated		
Data group	**How is this currently recorded** (and in which setting)	**Feasibility**	**Benefits**	**Challenges**	**Opportunities to where this fits into workflow**	**Feasibility**	**Benefits**	**Challenges**
Problem/ diagnosis								
Key biomarkers								
Vital signs and measurements								
Medical devices and equipment								



Workshop 1: Activity 1 – Patient Summary workflow

Data group – Set D

As a group, complete the worksheet for the Data Group set assigned to your table
Consider how is this data currently recorded and documented? And in which setting ?
Think about the need for curated vs derived/auto-generated patient summary.
Consider feasibility, benefits, challenges, opportunities

		Curated				Derived/automatically generated		
Data group	**How is this currently recorded** (and in which setting)	**Feasibility**	**Benefits**	**Challenges**	**Opportunities for where this fits into workflow**	**Feasibility**	**Benefits**	**Challenges**
Procedure completed								
Diagnostic results								
Plan of care								
Advance care directives								

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Data Group – Medication Statement

How is this currently recorded (and in which setting)	Curated				Derived/Automatically Generated		
	Feasibility	Benefits	Challenges	Opportunities for where this fits into workflow	Feasibility	Benefits	Challenges
• Can be structured or free text • Recorded by Doctor in primary care • Medication management and discharge summary recorded by Clinical Pharmacist in Pharmacy • Patient reported over the counter in Pharmacy • Uploaded automatically to MyHR	• Yes, coded -> updating and relevance • Depends on system • Structured vs free text • Epic (inbound) ✓ • Low • Large workload • Incomplete • Meds view of MyHR	• Holistic view • Clean exchange of data • Less mistakes • Good transition of care	• Items that don't exist -> time allocation • Recency of prescription • Confirming dispensing and administration Medication reconciliation • Complimentary medicines • Workflows • Consistency • Incomplete data	• Transition of care • Pharmacist presentation • Need confidence rating in data source • When with the patient • Handover of care, but not used	• Easier & more comprehensive • Yes, if medicines management system in use (structured data) • Hybrid model, some nominated, some derived - Epic autogenerate • PBS -> MyHR good • Non-PBS -> patchy, could be fixed	• More feasible and likely to be used. • Save time • Good picture	• Misinformation • Concerns with trusting quality, completeness and provenance of data • Need to confirm dispensing and administration of medication • What to include (rules) • Publish the standard!

Data Group – Vaccination Administration

How is this currently recorded (and in which setting)	Curated				Derived/Automatically Generated		
	Feasibility	Benefits	Challenges	Opportunities for where this fits into workflow	Feasibility	Benefits	Challenges
• Can be structured or free text • Australian immunisation register (AIR) - becoming very useful • Patient chart • MyHR • Patient reported • GP systems • Red book (personal health record)	• Yes • Coded • Can use serology to verify effectiveness	• Holistic view • Clean exchange of data • AIR good	• Overseas vaccination data • Vaccination history • Covid vaccine certificate • Pre-digital records	• Community or alternative providers • WHO "yellow card" immunisation record	• Already exists in AIR • Close already	• Good history • Population benefits	• Pre-digital record of vaccinations not currently included

Data Group – Adverse reaction risk (allergies and intolerances)

How is this currently recorded (and in which setting)	Curated				Derived/Automatically Generated		
	Feasibility	Benefits	Challenges	Opportunities for where this fits into workflow	Feasibility	Benefits	Challenges
• Can be structured or free text • Coded in system • EPIC structured • PAS coded • Patient reported • GP systems • MyHR • Discharge summaries	• Yes • Requires good data capture • Clinical agreement	• Holistic view • Clean exchange of data	• Categorised in SNOMED • Patients' self-diagnosed ID of allergies • Definition of allergy vs adverse reaction • System to system • State to state variation • Definitions	• Clinician verified vs self-diagnosed	• Good	• Less harm	• Poor source of truth • Motivation for clinician to upload/share data • Data capture quality • Definitions

Data Group – Patient Information/Demographics

How is this currently recorded (and in which setting)	Curated				Derived/Automatically Generated		
	Feasibility	Benefits	Challenges	Opportunities for where this fits into workflow	Feasibility	Benefits	Challenges
• Structured, coded and uncoded • Primary care • Acute • Aged care • Medicare • IHI – Individual Healthcare Identifier • Minimum data set varies across settings	• Yes • Use IHI? • Yes, but who?	• There is some structure and standards • Demographics follow the patient • Common element in Patient Summary	• People from overseas • Newborns • Patient identifiers • People with only one name • Estimated DOB • Preferred name • Gender • Duplicate matching/handling • Lack of consistency • Need for detailed curation	• Registration and sharing • Single digital identity • Simplified interface • Preventative health care personalised to your demographic • Current practice to check details for each visit • Common header element in Patient Summary	• Yes • Some information will be quite static	• Don't have to re-enter everything • Better visibility • Flag conflicting data • Real time up to date • Common element in Patient Summary	• Which is the source of truth • Resolving data mismatches between systems • Consistent ID's

Data Group – Pregnancy (status and history summary)

How is this currently recorded (and in which setting)	Curated				Derived/Automatically Generated		
	Feasibility	Benefits	Challenges	Opportunities for where this fits into workflow	Feasibility	Benefits	Challenges
• Structured and unstructured • Primary care • Acute - there is some codified tracking in acute • Specialist • Recorded in practice software, lab results, ultrasounds, scans • Not standardised across settings	• Majority • Yes, but mainly in acute setting	• CDS • Pathology requests • Young, digital natives, mobile population • Important for eRequesting and other use cases	• People from overseas • Newborns • Patient identifiers • People with only one name • Estimated DOB • Preferred name • Gender • Variability across the country • Capturing across all settings • Lack of consistency • Need for detailed curation	• May influence treatment options	• Pretty good • Difficult	• Different coding can be consolidated • eRequesting • Referrals • Up to date view	• Variability across the country • Comes from multiple sources collected in different ways (e.g. Rad, PAS, Notes) • Quality of recording

Data Group – Functional Status & Disability Assessment

How is this currently recorded (and in which setting)	Curated				Derived/Automatically Generated		
	Feasibility	Benefits	Challenges	Opportunities for where this fits into workflow	Feasibility	Benefits	Challenges
• Limited - tends to be unstructured • NDIS • Notes • Care plans • Some recording to support compensation or insurance (NDIS) • Not consistent	• Variable • Difficult to capture, but curators required due to inconsistent data formats	• Relevant to many care settings	• Can change based on patient presentation • Lack of consistency • Need for detailed curation	• Can inform how to engage, treat patient	• Possible from NDIS • Not possible currently		• Point in time assessment. Current data • Consult relevance

Data Group – Problem/Diagnosis

How is this currently recorded (and in which setting)	Curated				Derived/Automatically Generated		
	Feasibility	Benefits	Challenges	Opportunities for where this fits into workflow	Feasibility	Benefits	Challenges
• Can be structured/coded or free-text dependent on document/system • Structured in new EMRs • Semi-structured in other systems	• Feasible - already a core component of diagnosis being recorded • Needs to be curated	• More trust in information/ data quality • Holistic	• Past medical treatment - depends on source • Could be low quality	• Already exists in workflow • Assessing frequency - chronic, acute, repeating	• Yes • Do-able, provides bonus information	• Good for overarching diagnosis • No need for background • Automation/roles to adopt	• Over proliferation of data • When additional background information (e.g. complicated diabetes) needs to be included • Adopting the same standards

Data Group – Key Biomarkers

How is this currently recorded (and in which setting)	Curated				Derived/Automatically Generated		
	Feasibility	Benefits	Challenges	Opportunities for where this fits into workflow	Feasibility	Benefits	Challenges
• Structured	• Yes	• Consistency • Comparative	• Data is not necessarily linked to diagnosis	• Already integrated	• Possible	• May better match results to diagnosis	• Volume of data - managing currency of data

Data Group – Vital Signs and Measurements

How is this currently recorded (and in which setting)	Curated				Derived/Automatically Generated		
	Feasibility	Benefits	Challenges	Opportunities for where this fits into workflow	Feasibility	Benefits	Challenges
• Variable • Structured		• Better context		• Indicating the most relevant	• Yes	• Cheap, easy	• Amount of data to filter

Data Group – Medical Devices and Equipment

How is this currently recorded (and in which setting)	Curated				Derived/Automatically Generated		
	Feasibility	Benefits	Challenges	Opportunities for where this fits into workflow	Feasibility	Benefits	Challenges
• Can be structured or free text • Hospital			• No governance or standards all different				

Data Group – Procedure Completed

How is this currently recorded (and in which setting)	Curated				Derived/Automatically Generated		
	Feasibility	Benefits	Challenges	Opportunities for where this fits into workflow	Feasibility	Benefits	Challenges
• RIS - Private coded list • Primary care - usually structured list/coded and can free text • Acute - EMR and tailored list (determined by site) and can free text • Any setting EMR, PMS, paper • Free text/coded on claiming code systems • EMR - GP, Hospital, Specialist • MyHR	• Yes (if coded) • Hard • Depends on curated purpose - for who? • Not feasible to manually curate (time and workforce) in most settings	• Human clinical review to ensure accuracy and codified where possible • Data clean/QA • Efficient, prioritised, standardisation, consistency • Distil important • Remove unimportant	• Source of info to verify and curate • Knowing what to ask for and where to look • No data exchange standard • Reconciliation of information • Specs might not allow coding • No value set defined • Focused on funding not health • Time and cost • Change mgmt	• Done by healthcare provider • Set coding at PMS/EMR stage • Dedicated time • Funded/ rewarded • Change management	• Yes (if coded) • Easier	• Efficient, prioritised, standardisation, consistency • Quicker • Cheaper • Eliminates human error	• Specs might not allow coding • No value set defined • Focused on funding not health • Duplication • Conflicted information • Context • Quality and relevance

Data Group – Diagnostic Results

How is this currently recorded (and in which setting)	Curated				Derived/Automatically Generated		
	Feasibility	Benefits	Challenges	Opportunities for where this fits into workflow	Feasibility	Benefits	Challenges
• Free text • PDF docs • HL7 messages • Coded data • Labs, community • LMS, PMS, EMR • MyHR • Pathology Lab (LIS) • Imaging Centre (RIS)	• Some systems already curate but fragmented and inconsistent across systems/settings • High if coded at point of 'test'	• Relevance • Explanation for patients	• Need defined purpose • Safe re-use/ re-purposing of data • Time • Expensive • Change management		• Easier	• Quicker • Cheaper • Eliminates human error	• Context • Quality and relevance

Data Group – Plan of Care

How is this currently recorded (and in which setting)	Curated				Derived/Automatically Generated		
	Feasibility	Benefits	Challenges	Opportunities for where this fits into workflow	Feasibility	Benefits	Challenges
• Free text forms • EMR - GP, Hospital, Specialist	• Difficult		• Time • Expensive • Change management		• Not yet • Harder	• No human input • Extract from other document(s)	• Context

Data Group – Advance Care Directives

How is this currently recorded (and in which setting)	Curated				Derived/Automatically Generated		
	Feasibility	Benefits	Challenges	Opportunities for where this fits into workflow	Feasibility	Benefits	Challenges
• MyHR - GP • Paper - home • EMR - Hospital, GP's, MyHR, Aged Care	• Curated prior to upload	• Nuanced, individualised	• Time • Expensive • Change management	• At transitions of care	• Very, very difficult and inappropriate	• None	• Getting acceptance from community

Workshop 2

Patient summary

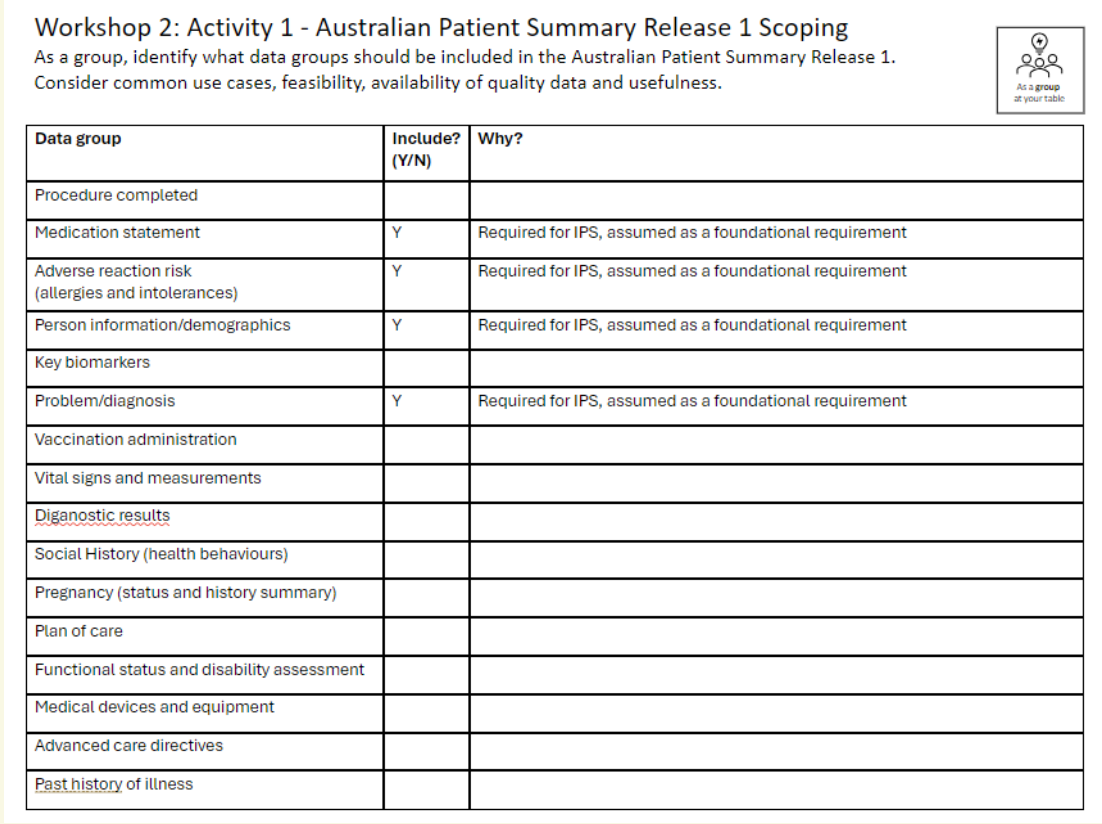
Objectives - Workshop 2: Patient Summary Use Cases

Identifying the data scope of the first release of an AU Patient Summary

Identifying what additional work on AUCDI is needed to support the identified data scope of release 1 for AU Patient Summary

Overview – Workshop 2: Activity 1

Attendees were asked, as a group at their table, to identify on the worksheet (see inset below) which other data groups should be prioritised for inclusion in the first release of AU Patient Summary and why.



Workshop 2: Activity 1 - Australian Patient Summary Release 1 Scoping

As a group, identify what data groups should be included in the Australian Patient Summary Release 1.
Consider common use cases, feasibility, availability of quality data and usefulness.

As a group at your table

Data group	Include? (Y/N)	Why?
Procedure completed		
Medication statement	Y	Required for IPS, assumed as a foundational requirement
Adverse reaction risk (allergies and intolerances)	Y	Required for IPS, assumed as a foundational requirement
Person information/demographics	Y	Required for IPS, assumed as a foundational requirement
Key biomarkers		
Problem/diagnosis	Y	Required for IPS, assumed as a foundational requirement
Vaccination administration		
Vital signs and measurements		
Diganostic results		
Social History (health behaviours)		
Pregnancy (status and history summary)		
Plan of care		
Functional status and disability assessment		
Medical devices and equipment		
Advanced care directives		
Past history of illness		

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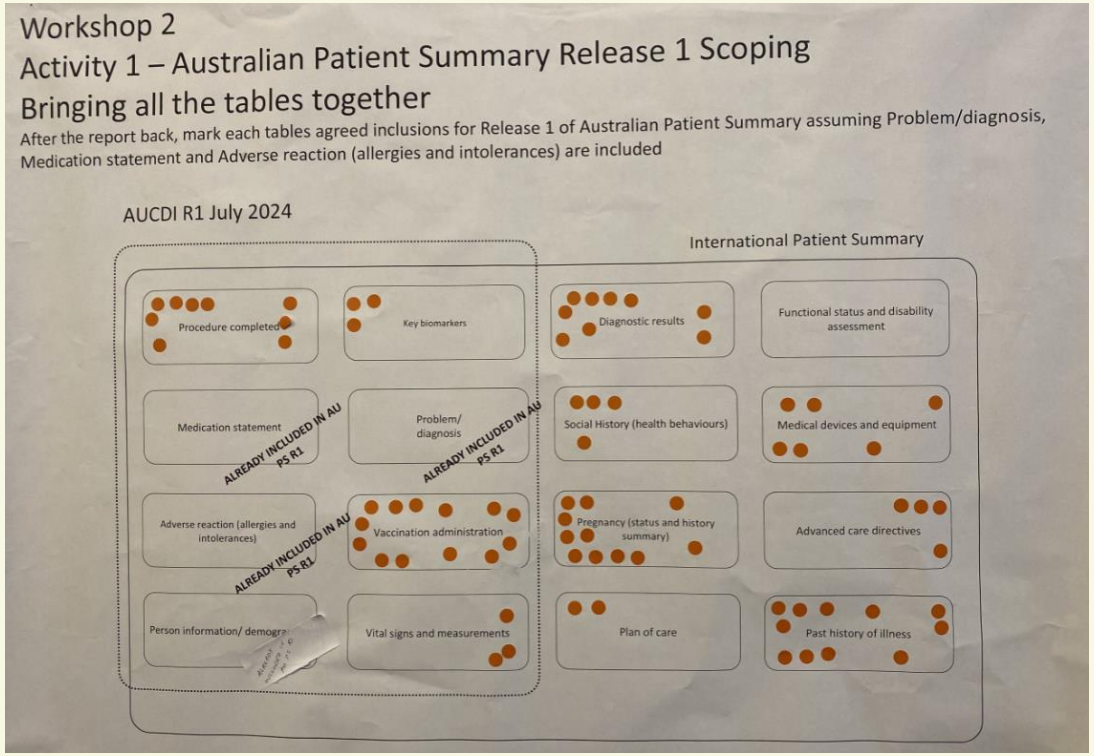
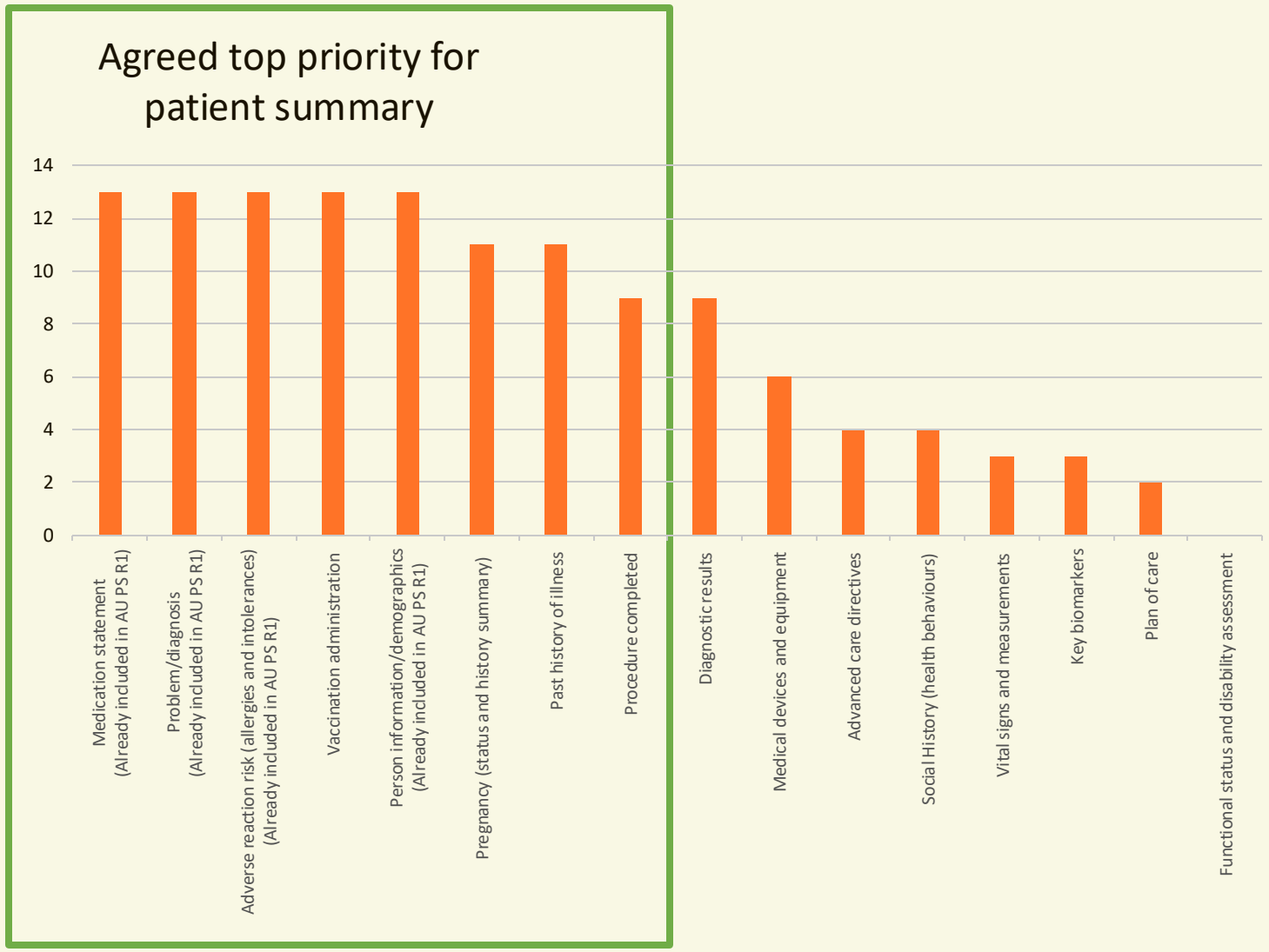
Overview – Workshop 2: Activity 1
AU Patient Summary Data Group Prioritisation

After the initial Patient Summary workshops, each table was asked to vote, as a group, on their inclusions for Release 1 of Australian Patient Summary assuming Problem/diagnosis, Medication statement and Adverse reaction (allergies and intolerances) are included



Patient Summary Data Group Prioritisation



	Data group	AU PS reqd	AUCDI R1
1	Medication statement	✓	✓
2	Problem/diagnosis	✓	✓
3	Adverse reaction risk (allergies and intolerances)	✓	✓
4	Vaccination administration		✓
5	Person information/demographics	✓	✓
6	Pregnancy (status and history summary)		
7	Past history of illness		?
8	Procedure completed		✓
9	Diagnostic results		
10	Medical devices and equipment		?
11	Advance care directives		
12	Social History (health behaviours)		?
13	Vital signs and measurements		
14	Key biomarkers		✓
15	Plan of care		
16	Functional status and disability assessment		

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Data Groups to Include in R1 AU PS and why

Data Group	Why Include in R1 AU PS?	Why Leave out of R1 AU PS?
Procedure completed	• Rule out issues and minimise wrong pathways • Easier implementation (already in AUCDI R1) • Important for clinicians during patient transfers between care settings • May be relevant to current problem • Can complement past medical history • How is this defined? How to differentiate from Past History • Useful but not applicable to all procedures	• Context-specific relevance • Focus on essential data ("Core of the Core“) • Information overload and feasibility • Need for definition and standardisation • Complexity and data span
Medication statement	• How does this include OTC/non-prescription meds?	
Adverse reaction risk (allergies and intolerances)		
Person information/demographics	• Individual Healthcare Identifier (IHI)	
Key biomarkers	• Holistic view of the patient • Cancer screening e.g. PSA, breast cancer • Relevant/related key diagnostic results • Diagnostics are challenging: - Not all results are included, consider filtering for relevance - Could include latest results by date	• Included as part of diagnostic results, focus on diagnostic results for R1 • Easy enough to capture but needs to be updated routinely (e.g. lipids, GFR, liver function) • Potential overlap with other diagnostic results
Problem/diagnosis	• Current	

Data Groups to Include in R1 AU PS and why

Data Group	Why Include in R1 AU PS?	Why Leave out of R1 AU PS?
Vaccination administration	• If not in history, can be easily done • Not all vaccinations are available in AIR • Achievable now, useful for patients (e.g. travel medications) • International records transferable/contraindications for repeat vaccinations • Easy to capture and data available • Good data source, beneficial	• Already in AIR - easily integrated or unnecessary because available
Vital signs and measurements	• Which ones and date • Needs date of observation • Informs the assessment • Subset focussed on AUCDI • Easy and useful (e.g. height and weight)	• Focus on latest measurements • Too contextualised and variable over time • Some cases are useful (e.g., BMI, O2 saturation) • Observations are dynamic and not necessary for summary • Encounter-based data • Easy to capture but question the value add
Diagnostic results	• Supports ongoing care and minimises retesting • Focus on most recent results • Abnormal results aid clinical decisions • Time-limited value, important for short-term use (e.g. disease progress/surveillance) • Standardised medical notes would be useful • History informs treatment approach and need for further testing • Coded results are possible in pathology	• Not considered "summary data" • Past history of illness is proxy for interpreted diagnostic results

Data Groups to Include in R1 AU PS and why

Data Group	Why Include in R1 AU PS?	Why Leave out of R1 AU PS?
Social History (health behaviours)	• Highlights issues which affect ability to access health care, follow up care or need which will affect ability to recover • Accuracy and privacy • Status in AUCDI	• Not in a standard format across settings • Too broad, low confidence in data • Requires further consideration for subsequent releases
Pregnancy (status and history summary)	• Risks of inappropriate treatment, imaging or procedure • Important for emergency • Distinction between pregnancy status/history and problems (e.g. gestational diabetes) • Status only	• Not a good coding system • Pregnancy status informs care, but history may be problematic • Needs agreed data structure • Status and history may not need to go together (consider for R2) • Patient should be asked directly as they know best • Data may not be reliable
Plan of care	• Ensure follow-up to minimise re-admission • Focus on outcomes: how to measure and record • Plan of care needs to be current and active	• Not a good coding system • Plan of care is dynamic and changes over time • Care team needs to be clearly defined • Too complex with many aspects, varies across settings • Requires further definition and investigation
Functional status and disability assessment	• Carer? • Relevant for consent • Complex but useful to know (e.g., wheelchair dependency)	• Dynamic and changes over time • Should apply to chronic conditions only • Needs clear definition • Inconsistent data origin and usage • Too complex and data not ready yet

Data Groups to Include in R1 AU PS and why

Data Group	Why Include in R1 AU PS?	Why Leave out of R1 AU PS?
Medical devices and equipment	• Feasibility of tracking implants • Important for imaging and other areas of care • Device status (e.g. pacemaker) may impact treatment and lead to adverse outcomes	• Likely linked to procedure completed • Needs clear definition, difficult to capture • Requires more work on tracking and terminology • Data is not ready or available, complex (consider for R2) • Uncertainty about data sources
Advance care directives	• A national standard is needed to ensure consistency across state borders • Highly nuanced, should indicate if a directive exists • Focus on presence and content, and its impact on care	• Low uptake • Needed in emergency situations but difficult due to current data issues • Only need to confirm if one exists and where it is, not include content
Past history of illness	• Question on whether it should be a curated and reviewed problem/diagnosis set • Relevance perhaps to current presenting issue • Important information to capture • Potential impact on care, but might be duplicated by the problem list • Concerns about privacy and insurance	• Linked sufficiently to procedure/problem and diagnosis • Complex, not in a position to add.

Additional Data Groups added to the worksheet

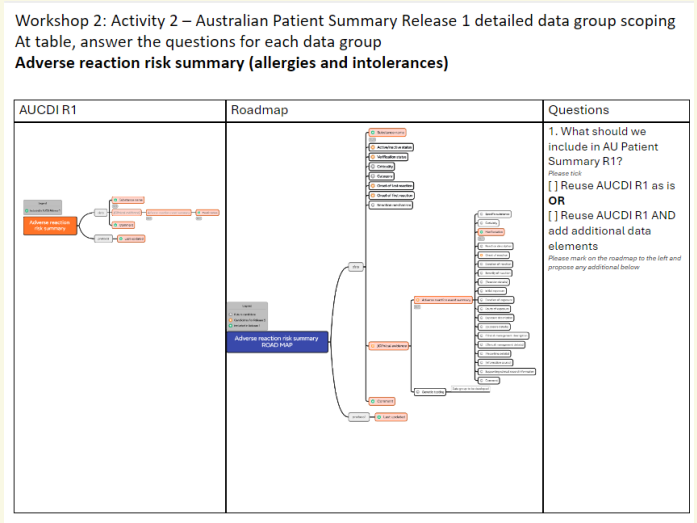
- Clinical trial history

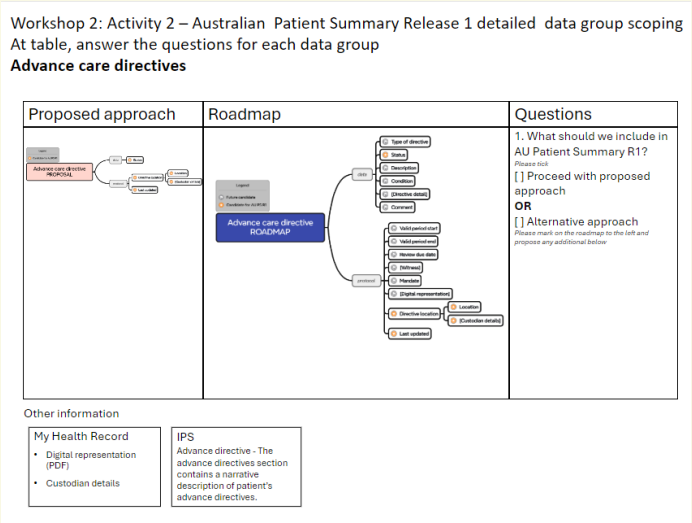
Additional comments on the worksheet

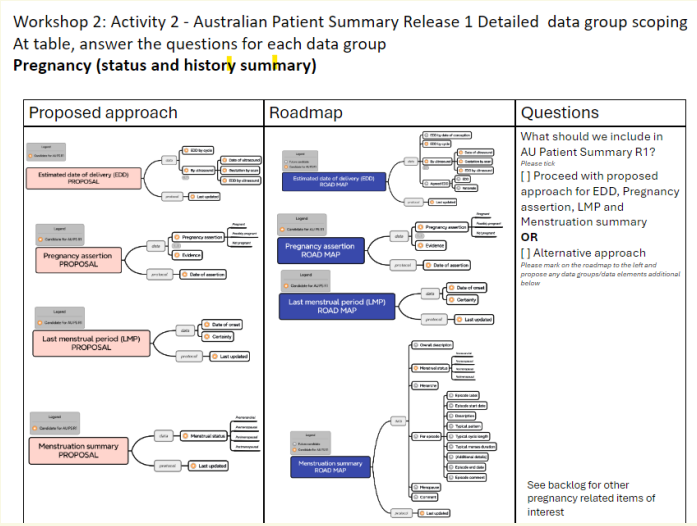
- Active problem + past history diagnostics/diagnosis + chronic
- Aged care setting context
- Key biomarkers, Problem/diagnosis, Vaccination administration, Vital signs and measurements, Diagnostic results - deal together

Overview – Workshop 2: Activity 2

Attendees were asked, as a group at their table if we should use the AUCDI R1 as is for AU PS R1 or if AUCDI R1 should be expanded to include additional data groups/elements. Additionally, groups were asked if we should proceed with the proposed approach for EDD, Pregnancy assertion, LMP and Menstruation summary, or to suggest an alternative approach.







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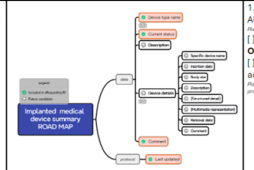
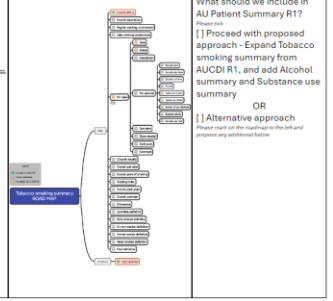
Workshop 2: Activity 2 – Australian Patient Summary Release 1 detailed data group scoping
At table, answer the questions for each data group
Medical devices and equipment

AUeReqDI R1	Roadmap	Questions
		1. What should we include in AU Patient Summary R1? Please tick [ ] Reuse AUeReqDI R1 as is **OR** [ ] Reuse AUeReqDI R1 AND add additional data elements *Please mark on the roadmap to the left and propose any additional below*

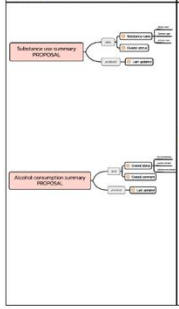
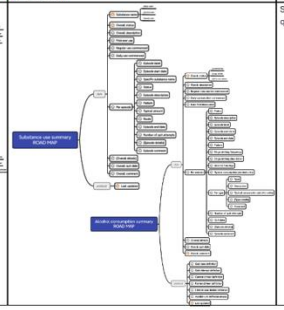
Other information

Medical Device regulations for 'Unique Device Identification' (UDI) are currently under development at the Therapeutic Goods Administration (TGA) and these include specific mandatory requirements regarding the identification of the specific device (UDI) and categorisation using the Global Medical Device Nomenclature (GMDN)

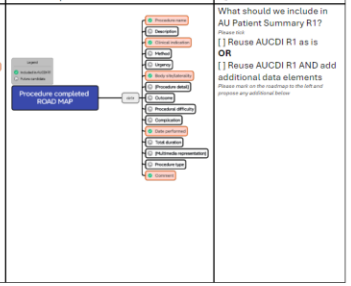
Workshop 2: Activity 2 - Australian Patient Summary Release 1 Detailed data group scoping
At table, answer the questions for each data group
Wellbeing concepts/Social History – health behaviours (part 1/2)

Proposed approach	Roadmap	Questions
Expand existing Tobacco smoking summary  Add new - Substance use summary - Alcohol consumption summary (see part 2/2 for details on approach and roadmap)		What should we include in AU Patient Summary R1? Please tick [ ] Proceed with proposed approach - Expand Tobacco smoking summary from AUCDI R1, and add Alcohol summary and Substance use summary OR [ ] Alternative approach *Please mark on the roadmap to the left and propose any additional below*

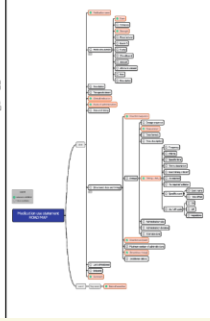
Workshop 2: Activity 2 - Australian Patient Summary Release 1 Detailed data group scoping
At table, answer the questions for each data group
Wellbeing concepts/Social History – health behaviours (part 2/2)

Proposed approach	Roadmap	Questions
		See part 1 for questions

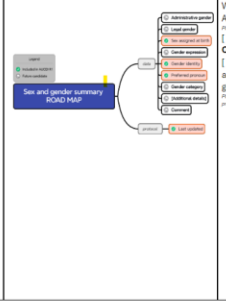
Workshop 2: Activity 2 - Australian Patient Summary Release 1 Detailed data group scoping
At table, answer the questions for each data group
Procedure completed

AUCDI R1	Roadmap	Questions
		What should we include in AU Patient Summary R1? Please tick [ ] Reuse AUCDI R1 as is **OR** [ ] Reuse AUCDI R1 AND add additional data elements *Please mark on the roadmap to the left and propose any additional below*

Workshop 2: Activity 2 - Australian Patient Summary Release 1 Detailed data group scoping
At table, answer the questions for each data group
Medication statement

AUCDI R1	Roadmap	Questions
		What should we include in AU Patient Summary R1? Please tick [ ] Reuse AUCDI R1 as is **OR** [ ] Reuse AUCDI R1 as is AND add additional data elements *Please mark on the roadmap to the left and propose any additional below*

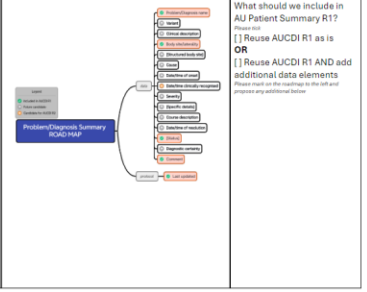
Workshop 2: Activity 2 - Australian Patient Summary Release 1 Detailed data group scoping
At table, answer the questions for each data group
Person information/demographics

AUCDI R1	Roadmap	Questions
		What should we include in AU Patient Summary R1? Please tick [ ] Reuse AUCDI R1 as is **OR** [ ] Reuse AUCDI R1 as is AND add additional data groups/elements *Please mark on the roadmap to the left and propose any additional below*

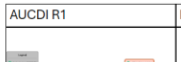
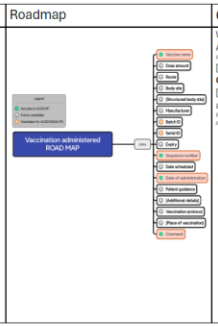
Workshop 2: Activity 2 - Australian Patient Summary Release 1 Detailed data group scoping
At table, answer the questions for each data group
Key biomarkers

AUCDI R1	Questions
	What should we include in AU Patient Summary R1? Please tick [ ] Reuse AUCDI R1 as is **OR** [ ] Reuse AUCDI R1 as is AND add additional data groups/ elements *Please propose any additional below (from backlog or other)* See backlog for identified biomarkers of interest

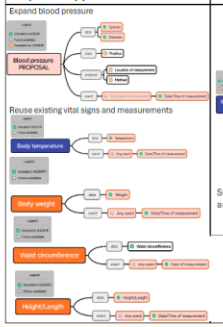
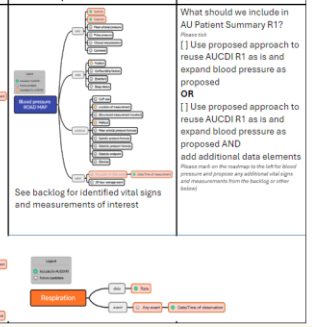
Workshop 2: Activity 2 - Australian Patient Summary Release 1 Detailed data group scoping
At table, answer the questions for each data group
Problem/diagnosis

AUCDI R1	Roadmap	Questions
		What should we include in AU Patient Summary R1? Please tick [ ] Reuse AUCDI R1 as is **OR** [ ] Reuse AUCDI R1 AND add additional data elements *Please mark on the roadmap to the left and propose any additional below*

Workshop 2: Activity 2 - Australian Patient Summary Release 1 Detailed data group scoping
At table, answer the questions for each data group
Vaccination administration

AUCDI R1	Roadmap	Questions
		What should we include in AU Patient Summary R1? Please tick [ ] Reuse AUCDI R1 as is **OR** [ ] Reuse AUCDI R1 AND add additional data elements *Please mark on the roadmap to the left and propose any additional below*

Workshop 2: Activity 2 - Australian Patient Summary Release 1 Detailed data group scoping
At table, answer the questions for each data group
Vital signs and measurements

Proposed approach	Roadmap	Questions
Expand blood pressure  Reuse existing vital signs and measurements	 See backlog for identified vital signs and measurements of interest	What should we include in AU Patient Summary R1? Please tick [ ] Use proposed approach to reuse AUCDI R1 as is and expand blood pressure as proposed **OR** [ ] Use proposed approach to reuse AUCDI R1 as is and expand blood pressure as proposed AND add additional data elements *Please mark on the roadmap to the left for blood pressure and propose any additional vital signs and measurements from the backlog or other below)*

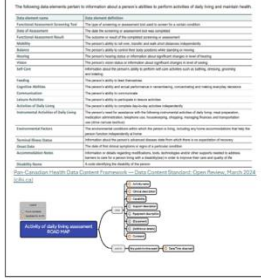
Workshop 2: Activity 2 - Australian Patient Summary Release 1 Detailed data group scoping
At table, answer the questions for each data group
Plan of care

Proposed approach	Questions
A description narrative for plan of care only Other data groups for care planning will be picked up for AUCDI R2 in the Chronic Disease Management topic e.g. goal, intervention, care team member, etc	1. What should we include in AU Patient Summary R1? Please tick [ ] Proceed with proposed approach OR [ ] Alternative approach *Please propose below*

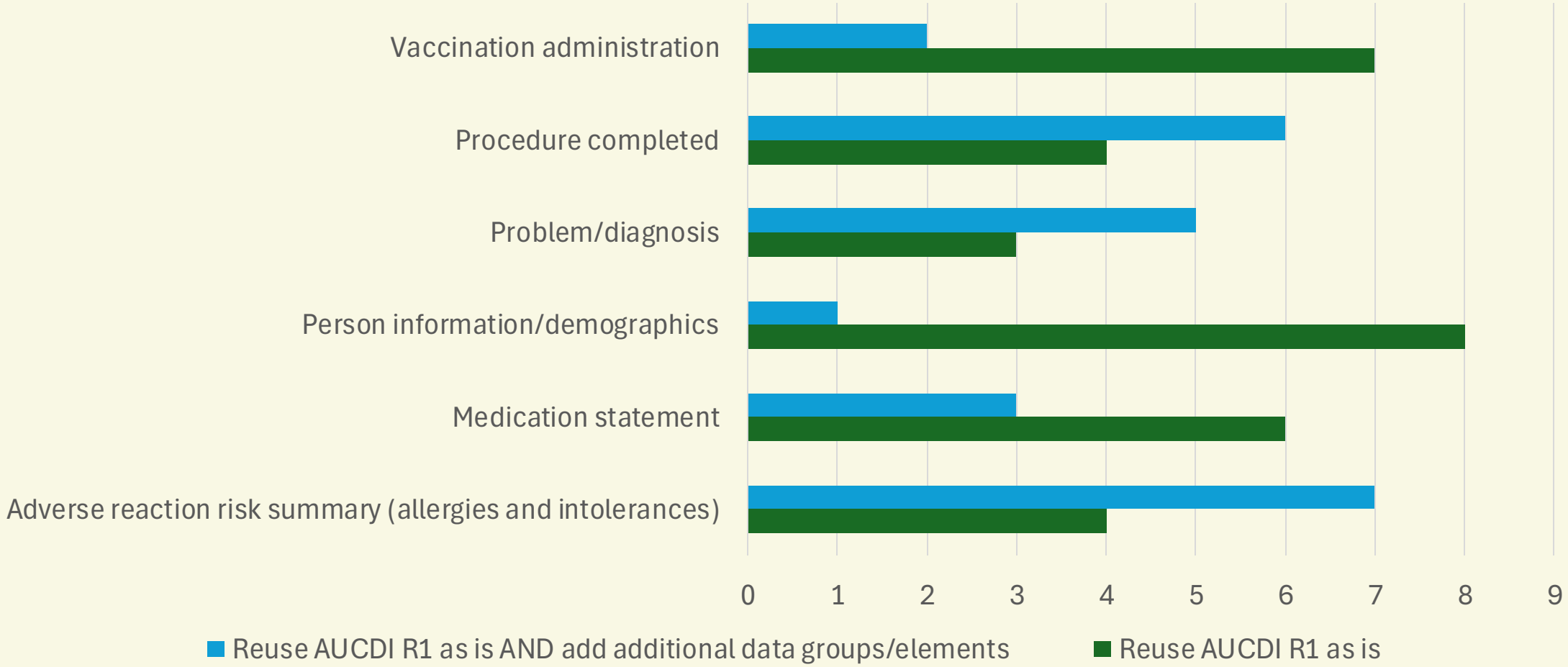
Other information

IPS
Plan of care - The plan of care section contains a narrative description of the expectations for care including proposals, goals, and order requests for monitoring, tracking, or improving the condition of the patient.

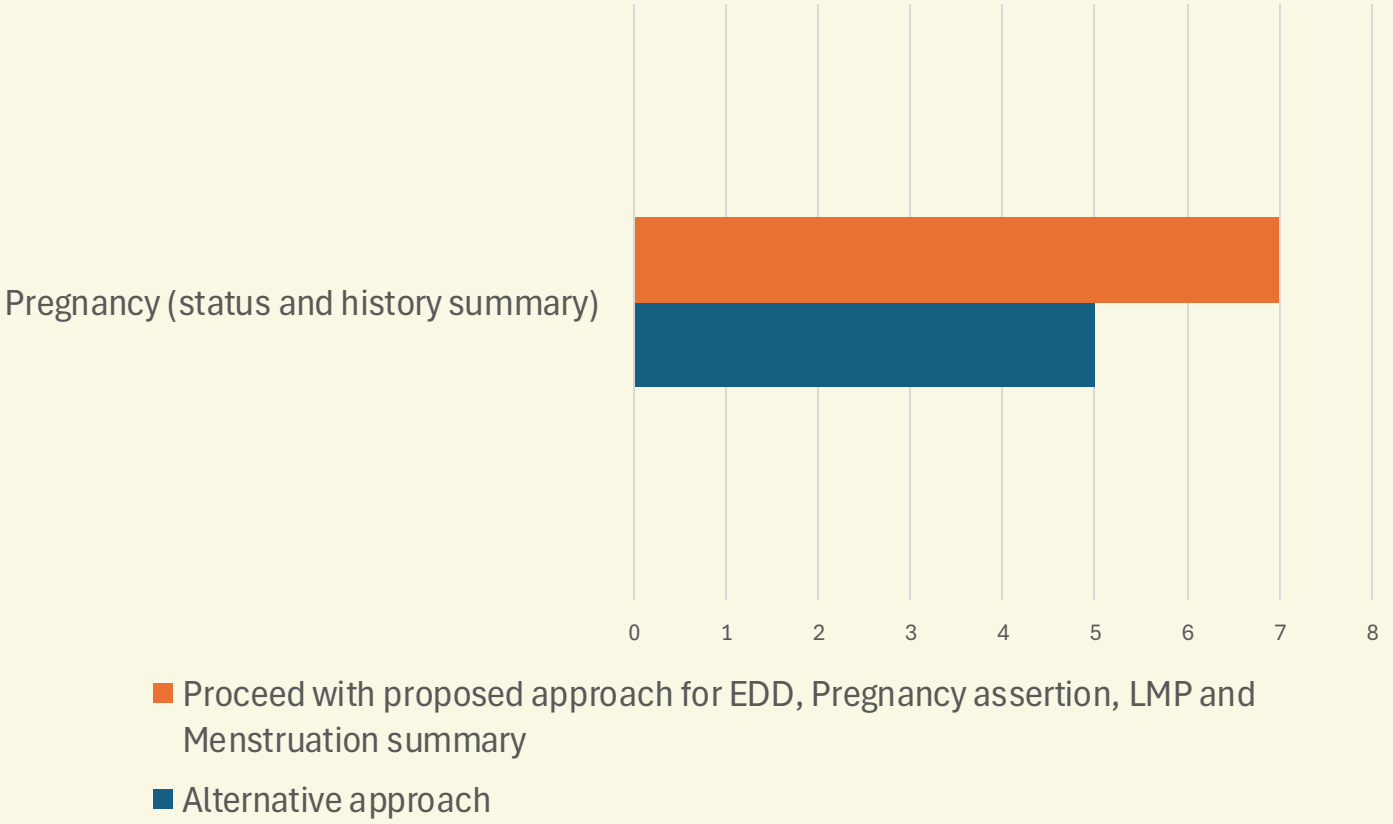
Workshop 2: Activity 2 - Australian Patient Summary Release 1 Detailed data group scoping
At table, answer the questions for each data group
Functional status and disability assessment

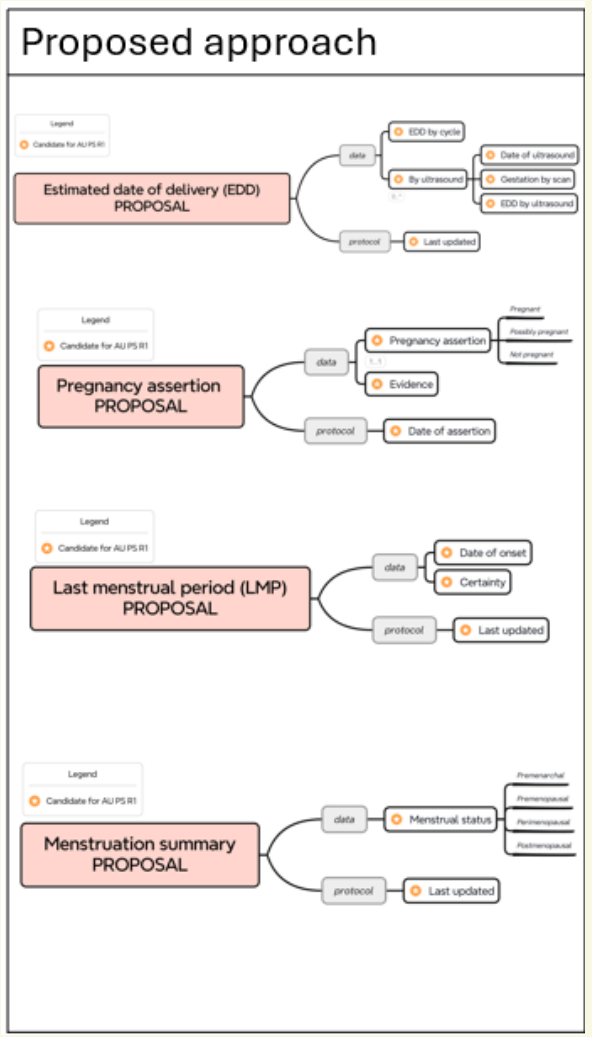
Supporting information	Questions
Pan-Canadian Health Data Content Framework 	1. What functional status and disability assessment information should we include in AUCDI R2 to support chronic disease management? 2. How should the information be collected? Please tick [ ] Codeable concept (coded where possible, otherwise free text) **OR** [ ] Free text 3. What do we need to consider when modelling this? Please specify below

Patient summary– Detailed Data Group Scoping



Patient summary – Detailed Data Group Scoping





Additional Elements That Should be Added

Data Group	Elements
Problem/diagnosis	• Goals of care • Date/time of onset • Date/time clinically recognised • Date/time of resolution • Cause • Course description
Vaccination administration	• Expiry • Route • Body site • Batch ID
Procedure completed	• Procedure name, Clinical indication, Body site/laterality, Date performed and Procedure type • Comment • Complication if known, significant and not covered by becoming its own element elsewhere in summary • Outcome • Linked procedures - how will you know this? i.e. surgery + anaesthetic activity

Additional Elements That Should be Added

Data Group	Elements
Medication statement	• Category - ingredients, class and excipients • Trade name - valuable for patients • Timing e.g. daily
Pregnancy (status and history summary)	• Number of viable births • Pregnancy history e.g. gestational diabetes, hypertensive disorders of pregnancy
Adverse reaction risk summary (allergies and intolerances)	• Active/Inactive status • Category • Reaction description, mechanism and severity • Split allergy and intolerance? • Acknowledge needing allergist to 'diagnose' • Verification status • Onset of first and last reaction • Specific substance

Additional Elements That Should be Added

Data Group	Elements
Person information/demographics	• Age/estimated age/DOB • Geography • Identifiers - IHI • ATSI status, CALD - country of birth, main language spoken other than English, proficiency in spoken English (ABS data items). • Sex and gender is just one part of person information/demographics - without strong identification of patient, it won't be used.

Reason for Encounter

Workshop 3

Reason for Encounter

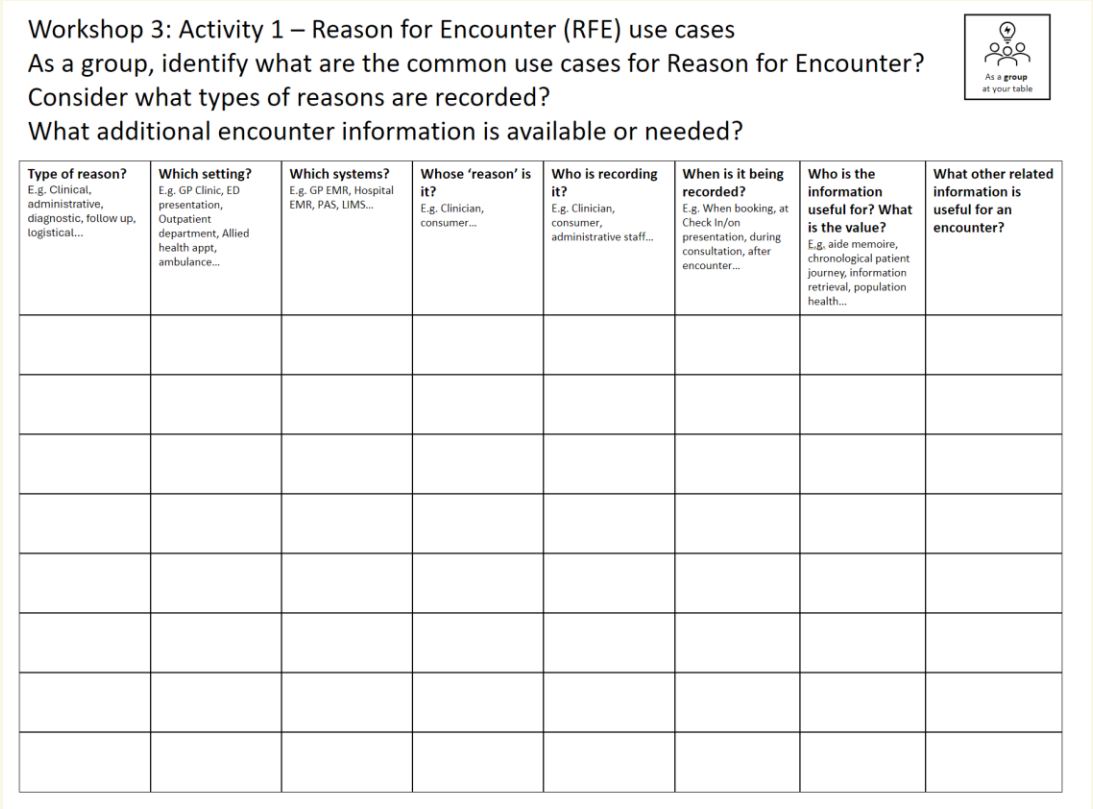
Objectives - Workshop 3: Reason for Encounter Use Cases

- Discussing the use cases of Reason For Encounter information
- Identifying who this information useful for and what value it adds

Overview – Workshop 3: Activity 1

Attendees were asked, as a group at their table, to respond to the questions detailed on the worksheet (see inset) to identify what are the common use cases for Reason for Encounter?

Including what types of reasons are recorded, and what other encounter information is available or needed?



Workshop 3: Activity 1 – Reason for Encounter (RFE) use cases

As a group, identify what are the common use cases for Reason for Encounter?

Consider what types of reasons are recorded?

What additional encounter information is available or needed?

As a **group** at your table

Type of reason? E.g. Clinical, administrative, diagnostic, follow up, logistical...	**Which setting?** E.g. GP Clinic, ED presentation, Outpatient department, Allied health appt, ambulance...	**Which systems?** E.g. GP EMR, Hospital EMR, PAS, LIMS...	**Whose 'reason' is it?** E.g. Clinician, consumer...	**Who is recording it?** E.g. Clinician, consumer, administrative staff...	**When is it being recorded?** E.g. When booking, at Check In/on presentation, during consultation, after encounter...	**Who is the information useful for? What is the value?** E.g. aide memoire, chronological patient journey, information retrieval, population health...	**What other related information is useful for an encounter?**

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Clinical Reason for Encounter Use Cases

Type of reason?	Which setting?	Which systems?	Whose 'reason' is it?	Who is recording it?	When is it being recorded?	Who is the information useful for? What is the value?	What other related information is useful for an encounter?
Record patient symptoms and diagnoses	GP, ED, Aged Care, radiology	GP, Hospital EMR, RACF EMR, PAS, LIMS	Patient, carer, doctor/clinician	Clinician, administration staff	At time of appointment (just before or after), admission, discharge	Aide memoire, population health, research/funders, patient journey, quality improvement, CDS, can be predictive of diagnosis	How many reasons for encounter?, reason for activity, modality
Referral from elsewhere	Imaging, pathology, other specialists	RIS, LIS, CIS and from referrer	Referrer	Clinician	At or after encounter	Interpretation at pathology imaging centre	
Ongoing management - follow up	GP, ED, outpatient clinics, specialist, allied health, transfers (in acute care), transfers (between system)	Practice management, CIS, EMR	Patient, clinician, hospital/claiming	Clinician, administration staff	At encounter, for next appointment	Patient, provider of care, funders, research, accountability, billing	

Clinical Reason for Encounter Use Cases

Type of reason?	Which setting?	Which systems?	Whose 'reason' is it?	Who is recording it?	When is it being recorded?	Who is the information useful for? What is the value?	What other related information is useful for an encounter?
Research/Service Advocacy	Clinic	Air Medical vs Primary Health	Clinician	Clinician		Clinicians, funders, donors	
Reason for transport	Clinic	Air Medical vs Primary Health	Clinician	Flight nurse		Clinicians, funders, donors	
Discharge/ encounter diagnosis, discharge summary, event summary	ED, inpatients, outpatients	EMR	Clinician/HIM/ surgeon	Clinician/HIM/hospital administration	During encounter, after encounter, near discharge	Clinical transfer of care, reporting, funding, referring party, patient	SNOMED, ICD-10, free text, PS (discharge including procedure details)
Clinical history, chief complaint	Inpatients	EMR	Clinician	Clinician	Day to day handover	Teams - clinical	Free text

Clinical Reason for Encounter Use Cases

Type of reason?	Which setting?	Which systems?	Whose 'reason' is it?	Who is recording it?	When is it being recorded?	Who is the information useful for? What is the value?	What other related information is useful for an encounter?
Provision of Equipment Order e.g. Wheelchair	Outpatient Clinic	Hospital, private					
Medical Assessment	GP, Hospitals, Allied Health		Resource Planning	Admitting RN	Check in	Management	Needs other fields - Presenting problem - Principal Diagnosis - Diagnosis in Discharge
Medication Review	GP, Hospital	GP, EMR					Needs other fields - Presenting problem - Principal Diagnosis - Diagnosis in Discharge

Clinical Reason for Encounter Use Cases

Type of reason?	Which setting?	Which systems?	Whose 'reason' is it?	Who is recording it?	When is it being recorded?	Who is the information useful for? What is the value?	What other related information is useful for an encounter?
Care plans							
Prescription being dispensed	Pharmacy	Dispensing system	Patient/pharmacist	Pharmacist	Pharmacist	All	
Screening							
Treatment procedures						Respectful to record patient	
Vaccination							
Counselling							
ED Triage Reason	ED Presentation	EMR	ED Triage Nurse	ED Triage Nurse	At ED presentation	ED prioritisation	Coded (not SNOMED/ICD-10)

Clinical Reason for Encounter Use Cases

Type of reason?	Which setting?	Which systems?	Whose 'reason' is it?	Who is recording it?	When is it being recorded?	Who is the information useful for? What is the value?	What other related information is useful for an encounter?
Pregnancy assessment							Needs other fields - Presenting problem - Principal Diagnosis - Diagnosis in Discharge
Chronic disease management							Needs other fields - Presenting problem - Principal Diagnosis - Diagnosis in Discharge

Consumer Reason for Encounter Use Cases

Type of reason?	Which setting?	Which systems?	Whose 'reason' is it?	Who is recording it?	When is it being recorded?	Who is the information useful for? What is the value?	What other related information is useful for an encounter?
Routine check up	GP	GP EMR	Consumer	Clinician/Nurse	At time of encounter	Consumer to monitor health, clinician, admin	Medical History
Reason for appointment	GP -> online booking	GP	Consumer	Consumer	When booking	GP practice and GP	Base symptoms
Mental health advice	Telehealth	Telehealth	Consumer/ patient	Consumer	Engagement (in real time)	Provider telehealth, consumer, third party provider	Past history/ medications
Online script/repeat script request	Telehealth	Telehealth	Consumer	Consumer	Engagement (in real time)	System/clinician	Medication/ past history
Problem	Patient registration	Booking	Patient	Patient/Registrar	Prior to encounter	Patient, reception staff - triage	

Consumer Reason for Encounter Use Cases

Type of reason?	Which setting?	Which systems?	Whose 'reason' is it?	Who is recording it?	When is it being recorded?	Who is the information useful for? What is the value?	What other related information is useful for an encounter?
Online medical certificate/ pharmacy	Telehealth/ pharmacy	Telehealth/ pharmacy administration	Consumer	Consumer/ pharmacist	Engagement (in real time)	System/clinician, pharmacist, employer	Not applicable?
Adverse event	Everywhere	GP, Hospital EMR, RACF EMR, PAS, LIMS	Patient	Patient	Anytime	Admin, clinician, patient	
Medical examinations (work)	GP	GP	Patient	GP	Engagement (in real time)	Clinician, patient	

Administrative Reason for Encounter Use Cases

Type of reason?	Which setting?	Which systems?	Whose 'reason' is it?	Who is recording it?	When is it being recorded?	Who is the information useful for? What is the value?	What other related information is useful for an encounter?
Administrative - Forms	GP, some specialists	GP CIS, specialist CIS	Patient, third party (insurers?)	Administrative staff, clinician, patient	At encounter, some in advance	Patient, third party, population health	
Activity	Acute	Hospital EMR	Clinician	Coder	After encounter	Funders	
Routine	GP, specialist	PAS/Scheduling/ EMR	Admin	Scheduler	Scheduling	Clinician, patient, registrars	
Test results						Service use/misuse	
Administrative procedure							
Financial	Clinic	Air Medical vs Primary Health	Clinician	Clinician		Clinicians, funders, donors	

Sparked
HL7 FHIR

Administrative Reason for Encounter Use Cases

Type of reason?	Which setting?	Which systems?	Whose 'reason' is it?	Who is recording it?	When is it being recorded?	Who is the information useful for? What is the value?	What other related information is useful for an encounter?
PAS Reason for Encounter	Hospital PAS	PAS	PAS Clerk	Admin Clerk	Initial registration	?	Free text

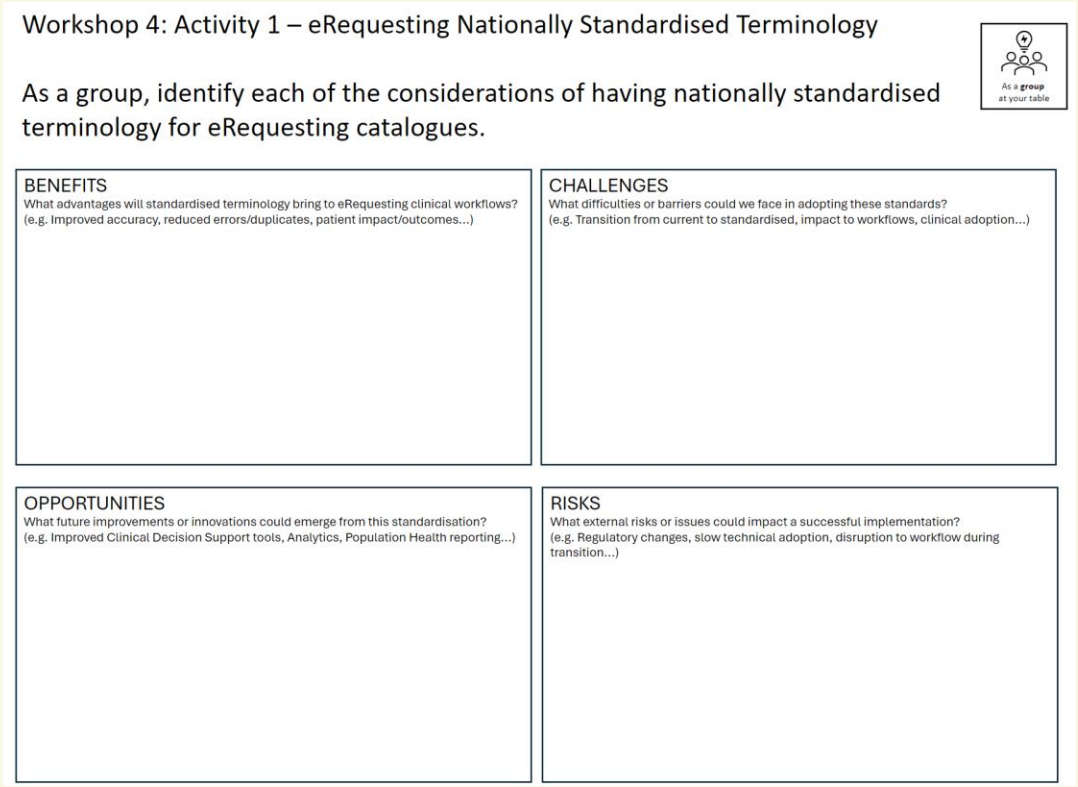
eRequesting in Action

Objectives

- Revisit our progress on eRequesting
- Discuss the benefits and opportunities of nationally standardised terminology catalogues
- Show how national terminology catalogues can work
- Identify considerations for nationally standardised terminology catalogues

Overview – Workshop 4: Activity 1

Attendees were asked, as a group at their table, to document on the worksheet (see inset) what are the benefits, challenges, opportunities and risks of having nationally standardised terminology for eRequesting?



Workshop 4: Activity 1 – eRequesting Nationally Standardised Terminology

As a group, identify each of the considerations of having nationally standardised terminology for eRequesting catalogues.

As a group at your table

BENEFITS
What advantages will standardised terminology bring to eRequesting clinical workflows?
(e.g. Improved accuracy, reduced errors/duplicates, patient impact/outcomes...)

CHALLENGES
What difficulties or barriers could we face in adopting these standards?
(e.g. Transition from current to standardised, impact to workflows, clinical adoption...)

OPPORTUNITIES
What future improvements or innovations could emerge from this standardisation?
(e.g. Improved Clinical Decision Support tools, Analytics, Population Health reporting...)

RISKS
What external risks or issues could impact a successful implementation?
(e.g. Regulatory changes, slow technical adoption, disruption to workflow during transition...)

Benefits of a Nationally Standardised Terminology for eRequesting

Research	Quality	Efficiency	Clinical Decision Making	Interoperability	Patient
Access of data for research	Improved data quality and safety	Reduction in duplicate tests	Improved clinical context to support result interpretation	Ability to marry result with request	Improving patient understanding of orders/procedures
Public health to analyse	Reduction in transcription and translation errors	Test performed with accuracy for faster review of patient outcome	Clinical is still making choice	Standard language across the country, decrease barriers to adoption	Improved patient care & experience
Trending lab results across IT systems	Right tests irrelevant of provider the consumer takes the request to	Simple data entry (real time search of services that are selected [referring to SMART form demo])	Consistency of understanding	Automate data flow between systems	
Easier reporting/analysis /research of requests	Consistency between labs on test type	Faster: digitally better than getting patient to phone up	Clinical Decision Support	Data readily available for local systems as well as national	

Benefits of a Nationally Standardised Terminology for eRequesting

Research	Quality	Efficiency	Clinical Decision Making	Interoperability	Patient
	Receiving the result into the system. Closing the loop. Acknowledgements	Ability to see previous tests = decreased duplication. Key = in real time	Upskilled clinicians	Obvious standardisation & benefits already articulated in presentations - Long overdue globally	
	Reduced ambiguity - speaking same language	Reduced time & resources in clarification of orders	Clinical clarity/safety	Readability	
	Ability to implement new testing consistently	Billing and reimbursement		Well supported, constantly updated, tools to build & test implementations	

Opportunities of a Nationally Standardised Terminology for eRequesting

Research	Quality	Efficiency	Clinical Decision Making	Interoperability	Patient
Opportunity to report	Governance/ ownership	Financial opportunities	Patient history of tests	Maturity. Readiness of systems for implementation	Consumer choice
Better analytics	Improved quality of patient identification and universal identification (IHI)	Innovation	Clinical Decision Support to guide improved utilisation	Compelling providers to update standards to bring about broad stream changes	Education for service providers to better meet needs of customers
Data mining	Build in sets of tests based on best practice guidelines and then able additional tests to be added to standard sets	Artificial intelligence	Increasing understanding and literacy of testing	Atomic data in MyHR and HIE	Translate in layman's terms so consumers can understand therefore [increased] health literacy
	Benchmarking (vendors, personnel, service providers)	Reduction in duplication of testing		Develop translators between systems/providers	

Opportunities of a Nationally Standardised Terminology for eRequesting

Research	Quality	Efficiency	Clinical Decision Making	Interoperability	Patient
	Move to value outcomes	Centralised repository		National infrastructure to send & receive eRequests	
	Sovereign Australia standards-based systems	Reduction of procurement costs		Local tooling - map terminology, mapping tool by central body	
	Global leadership opportunity	Acknowledge any failed requests --> not received by lab so can action		Standard terms --> eCDS standard enabled	
				Same test between systems & jurisdictions	
				Mandated and funding to implement across all sectors	

Challenges of a Nationally Standardised Terminology for eRequesting

Change Management	Technical and System Complexity	Governance, Policy and Funding	Social Considerations
Change management in terms of moving to new standardised nomenclature/workflow	Timeframe to transition	Patient identification, getting support and implementation of IHI	Widening gap for socially disadvantaged
Clinical adoption and resistance to adoption	Complexity and capability of current technical systems	Pathways effectively connected between radiology and pathology standards	Patient choice
Removing templates of free-text requests used by medical teams	Moving from Hl7 V2 to FHIR	Funding - cost of implementation across all sections including not for profit	
Education and training	All providers need to receive & use codes	Who is going to standardise it?	
Definition easily assessable to confirm harm	Must have free-text option for "add occasions"	Lag time in creation of new codes -> delays	
Testing workflow between orders to performers	Unassigned, assigned, redirect	Cost	

Challenges of a Nationally Standardised Terminology for eRequesting

Change Management	Technical and System Complexity	Governance, Policy and Funding	Social Considerations
UI and UX changes	Extra field that enables request for specimen required	Governance and ownership of ref sets in perpetuity	
Capturing the requirements	Volume of codes	New tests/Retirement of terms	
Displaying preferred terms for pathology & radiology for clinicians	Mapping from legacy codes	Politics - need to transcend elections	
	PDF recording of docs - not display who ordered	Need careful management or free-text will continue	
	HL7 V2 - lost for specimens is not complete. Needs to be expanded and assist with authorisation	Vendor engagement	
		Getting existing sites to invest in moving from HL7 v2 to FHIR (New sites OK)	

Risks of a Nationally Standardised Terminology for eRequesting

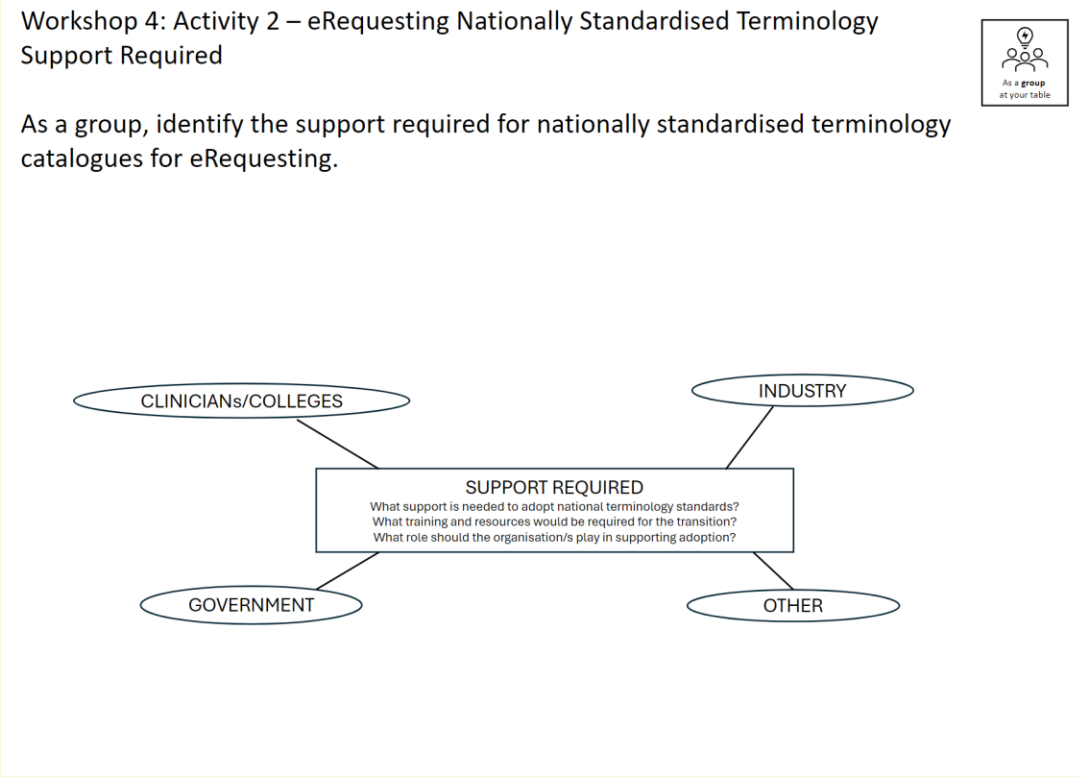
Change Management	Technical and System	Governance and Compliance	Operational and Resource
Risks vs current process	Cyber risk/privacy	Political influences, e.g. gov changes, change of policy/direction	Cost of technical uplift
Utilisation difficulties leading to poor implementation with lack of advantages of standardised terms, which leads to duplication of tests or missed/delayed patient management	Systems need to be able to accept IHI technically not feasible in many legacy systems [leading to] impact on adoption	Poor maintenance of data and funding continued	Cottage industry
Variability in timeframes to transition, inconsistent application	How test is SNOMED coded is not mapped to traditional request fields	Which is the standard set of terms to be used & how ensure all updated at same time as needed	National assets
All clinicians	Data quality over time	Needs to remain current and be maintained	Ongoing funding for maintenance
Identity of patient is consistent and integrated effectively	Slow technical adoption	Who holds the truth of test definition	

Risks of a Nationally Standardised Terminology for eRequesting

Change Management	Technical and System	Governance and Compliance	Operational and Resource
Clinical engagement not fulfilled if UI/UX not good	Systems dependent on 3rd-party systems, e.g. catalogue is externally hosted --> 3rd-party failure causes local failure	Cross border communications	
New tool has to be at least as good as current or won't uptake	Systems must be technically capable to use the catalogue (internally hosted or externally hosted)	Different parts of vocab might be used independently - needs certification process?	
May create lazy decision making by clinician	AI hallucinations	Jurisdiction's doing their own thing	
Appropriateness of codes (if gap use another one)	Free text errors	Risk of widening the gaps for some cohorts	
Time waste perception	Slow technical adoption in AH [?Allied Health]	Vendor engagement/compliance	
Systemic adoption			

Overview – Workshop 4: Activity 2

Attendees were asked, as a group at their table, to identify on the worksheet (see inset) what support is needed to adopt nationally standardised terminology for eRequesting by the different stakeholder groups?



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Nationally Standardised Terminology for eRequesting Support Requirements – Clinicians/Colleges

Engagement and Collaboration	Funding	Standards, Guidelines & Terminology	Education	Outcomes
Clinical colleges need to bring their cohorts on the journey	Funding needed for clinical decision support development and maintenance	Support to drive standards across colleges	Change management integrated into training (medical, nursing, pharmacy)	Evidence-based outcomes
Broader involvement of Allied Health, ACM, NACCHO	Funding required to support ongoing engagement efforts	Map guidelines to standardised terminology	Involve universities and study support needs	Value articulation (not solely financial)
Identify and engage change champions	Articulate benefits and business cases to support adoption and implementation	Maintain dynamic standards and guidelines	Address digital health literacy gaps	Support to enable interoperability, move away from bespoke systems
Coordination and oversight of change management		Value sets and catalogues to be completed; ensure all contexts are accommodated	Ongoing education and support	

Nationally Standardised Terminology for eRequesting Support Requirements – Government

Support and Governance	Coordination and Oversight	Funding	Standards, Guidelines & Terminology	Education	Outcomes
Policy and legislation to support compliance	Monitor compliance through accreditation (no compliance = no access)	Funding for interoperability standards and software capability - for all sectors (public, private, aged care)	Support for open terminology (e.g., AMT, SNOMED, ICD10, ICPC, ATC)	Educate on the importance of standards and interoperability	Focus on improving patient health, not just evaluating costs and outcomes
Promote compliance through regulation	Ensure continuity and national assistance	Incentives for clinicians, colleges, and industry to adopt standards	Align with international open standards (not proprietary)	Promote benefits of adopting standards	
Prioritise the use of interoperability standards and frameworks across sectors	Foster adoption across all staff levels	Develop ongoing funding models, e.g. Transaction-based funding model (similar to e-prescription)			
Establish governance for ongoing maintenance of standards and systems					

Nationally Standardised Terminology for eRequesting Support Requirements – Industry

Software Development and Technology	Implementation and Change Management	Funding	Standards, Guidelines & Terminology	Education
Building the software	Implementation support	Need for government mandates	Unified standards for public and private health providers	Engaging with consumers
Demand for solutions that meet defined standards	Ensure robust transmission processes and consumer access	Need for funding for initiatives to adopt/implement	Conformance, compliance, and certification	Educating staff
System designs are within the framework	Change management for users	Privilege of participating in market versus funded approach	Adopt/implement value sets and standards	Training for health providers
Support versioning and backward compatibility in systems	Notification and support for implementation		Develop processes to update or add codes/reference sets	Education on the rationale behind changes
Technology support				Move away from ambiguous terms (e.g., "test" in digital health)

Nationally Standardised Terminology for eRequesting Support Requirements – Other

Challenges	Consumer Engagement and Education	Stakeholder Involvement	Governance and Leadership
Demand for solutions that meet defined standards	Consumer education and engagement	Call out to PHNs	Standards maturity
	Media campaigns (e.g., cartoons/ads for e-scripts)	Inclusion of standards in university courses	Decision-making on mandates and clinical leadership across political gaps
	Broader consumer representation (age diversity, disability perspective, women)	Insurance companies' support for implementing standards	
	Education on the rationale behind changes		

Chronic Disease Management – real time, integrated shared care planning

Objectives

- Identifying and prioritising the scope of a AUCDI R2 to support Chronic Disease Management (real-time, shared care planning)

Workshop 5

Chronic disease management

Objectives - Workshop 5: Chronic Disease Management

- Identifying the data groups required to support real-time shared care planning and chronic disease management
- Understanding data requirements in the chronic disease management workflow

Workshop 5: Activity 1 – Chronic Disease Management (CDM) workflow

In your group, complete the worksheet for the Data Groups

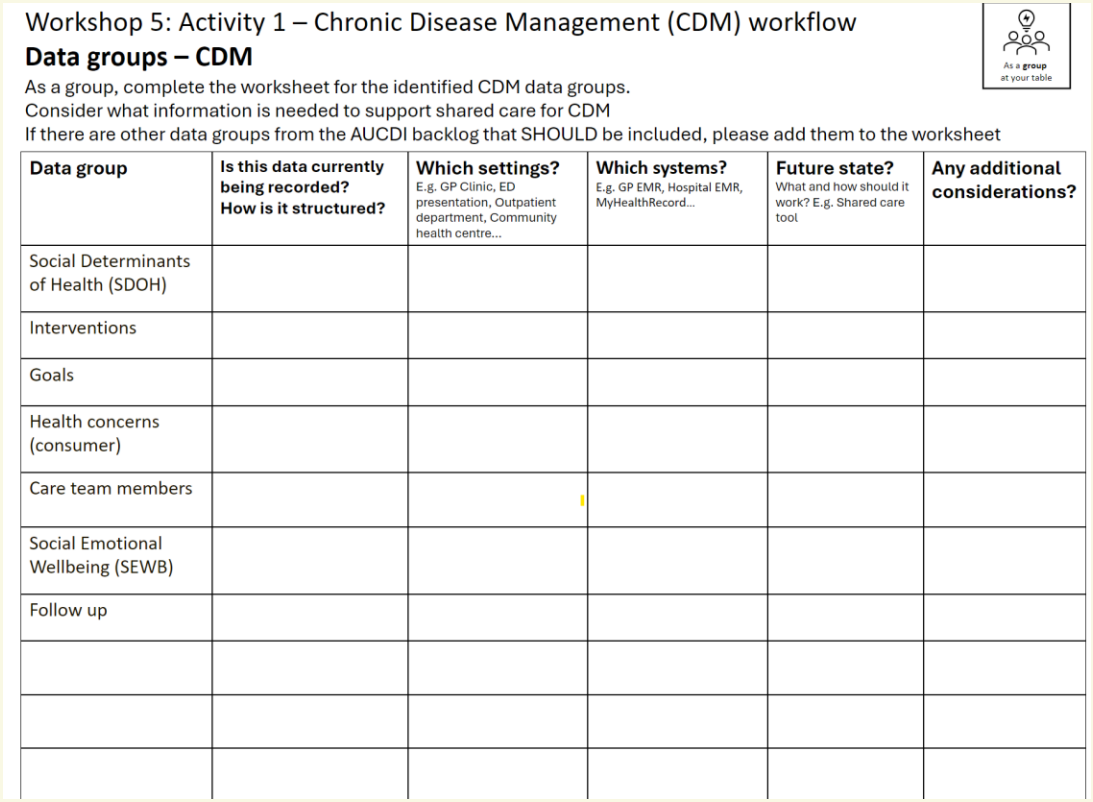
CDM Data groups

- Social Determinants of Health (SDOH)
- Interventions
- Goals
- Health concerns (consumer)
- Care team members
- Social Emotional Wellbeing (SEWB)
- Follow up

As a **group**
at your table

Overview – Workshop 5: Activity 1

Attendees were asked, as a group to respond to the questions on the worksheet (see inset below) to understand what information is needed to support shared care for Chronic Disease Management.



Workshop 5: Activity 1 – Chronic Disease Management (CDM) workflow

Data groups – CDM

As a group, complete the worksheet for the identified CDM data groups.
Consider what information is needed to support shared care for CDM
If there are other data groups from the AUCDI backlog that SHOULD be included, please add them to the worksheet

Data group	**Is this data currently being recorded? How is it structured?**	**Which settings?** E.g. GP Clinic, ED presentation, Outpatient department, Community health centre...	**Which systems?** E.g. GP EMR, Hospital EMR, MyHealthRecord...	**Future state?** What and how should it work? E.g. Shared care tool	**Any additional considerations?**
Social Determinants of Health (SDOH)					
Interventions					
Goals					
Health concerns (consumer)					
Care team members					
Social Emotional Wellbeing (SEWB)					
Follow up					

Data group – Social Determinants of Health (SDOH)

Is this data currently being recorded? How is it structured?	Which settings?	Which systems?	Future state? What and how should it work?	Any additional considerations?

• Mix of data being recorded
• Mostly unstructured or partially structured, can be free text
• Incomplete or inconsistent capture of information
• No standardisation
• Verbal, handwritten, multiple forms
• Varies across systems
• Includes Occupation, Ethnicity, Smoking/Alcohol, Drug use, Childhood trauma
	• All
	• Complex care coordination (e.g. transplants & cancer)
	• Varies by provider and setting
	• GPs
	• Aged care
	• Home care
	• Pharmacy
	• Emergency departments
	• Allied health documents
	• Acute care
	• Community health care
		• EMRs/CISs, including;
		  ○ Hospital
		  ○ GP
		  ○ PMS
		  ○ PAS
		  ○ AHP
		• Limited information in MyHR
		• Patchy GP data
		• Aged care data is good
			• Consistent data capture is essential, even if unstructured.
			• Patient-facing and clinician-to-clinician data.
			• Based on defined clinical standards.
			• Includes family, community care environments & extended care teams.
			• Respite care for caregivers.
			• EHIR bundle
			• Semantic interoperability
			• Patient visibility.
			• Should reflect current status.
			• Mechanism to update and validate information as situations change.
				• Onto server
				• Circumstances of carer
				• Privacy
				• Connection between health care & social care

Data group – Interventions

Is this data currently being recorded? How is it structured?	Which settings?	Which systems?	Future state? What and how should it work?	Any additional considerations?

• Mix of data being recorded
• Largely unstructured, not standardised, can be free text
• Includes past history
• Variable formats used;
  ○ Consultation/clinical notes
  ○ Referrals
  ○ Tables
  ○ Care pathways
  ○ Narrative documentation
  ○ Free text
	• All
	• Complex care coordination (e.g. transplants & cancer)
	• Varies by provider and setting
	• GPs
	• Multidisciplinary teams (MDTs)
	• Acute care
	• Community health care
	• Aged care
	• NDIS
		• EMRs/CISs, including;
		  ○ Hospital
		  ○ GP
		  ○ AHP
		  ○ PMS
		• Recorded in PMS or not at all
		• Not much in MyHR
		• Patchy GP data
		• Aged care data is good
		• Dynamic document
			• Data should be structured, consistent, and tied to goals
			• IPS supports this
			• Active documents, should be dynamic and regularly reviewed for success
			• EHIR bundle
			• Semantic interoperability
			• Recorded information should be granular
			• Automation & codifying of narrative content
				• Could be one-to-many or many-to-many
				• Multimorbidity
				• Patient different summary.
				• Procedural / non-procedural
				• Referrals
				• Broad
				• Privacy

Data group – Goals

Is this data currently being recorded? How is it structured?	Which settings?	Which systems?	Future state? What and how should it work?	Any additional considerations?

• Mix of data being recorded
• Largely unstructured; not standardised, can be free text
• Requires definition, e.g. who's goals?
• Significant variation in how data is captured
• Variable formats used;
  ○ Conversations
  ○ Tables
  ○ Care pathways/plans
  ○ GP management plans
  ○ Narrative documentation
  ○ Free text
• Used to document clinical and lifestyle information
	• All
	• Complex care coordination (e.g. transplants & cancer)
	• Varies by provider and setting
	• GPs
	• Allied health
	• Acute care
	• Community health care
	• Aged care
	• NDIS
	• Short/long term dependency on setting
		• EMRs/CISs, including;
		  ○ Hospital
		  ○ GP
		  ○ AHP
		  ○ PMS
		• Not much in MyHR
		• Patchy GP data
		• Aged care data is good
		• Multidisciplinary interfaces: patient, nursing, clinician
		• Paper notes
		• Consumer documents
		• Patient portals
		• Personal devices
			• Data should be structured, Unstructured data is a challenge
			• Multidisciplinary care plans
			• Approaches will differ by disease
			• Monitoring compliance for conditions, e.g. asthma, CF, diabetes, etc
			• Patient MyHR
			• Semantic interoperability
			• Required across all care aspects
			• Automation & codifying of narrative content
			• Shared documents among patient and care teams
				• Place to start
				• Captured on training & nursing documents
				• PREMs/PROMs

Data group – Health concerns (consumer)

Is this data currently being recorded? How is it structured?	Which settings?	Which systems?	Future state? What and how should it work?	Any additional considerations?

• Mix of data being recorded
• Some coded, mostly unstructured, not standardised, can be free text
• Significant variation in how data is captured
• Requires definition
• Variable formats used, i.e.
  ○ Conversations
  ○ Tables
  ○ Care pathways/plans
  ○ Narrative documentation
  ○ Free text/unstructured clinical notes
• Privacy concerns, including small communities' control over data sharing
	• All
	• Often recorded, less in ED/acute settings
	• Not in MyHR
	• Management plans as problem lists
	• GPs
	• Allied health
	• Acute care
	• Community health care
	• Aged care
		• EMRs/CISs, including;
		  ○ Hospital
		  ○ GP
		  ○ AHP
		  ○ PMS
		• Not much in MyHR
		• If no internet, unable to access care plans/MyHR
		• Paper notes
			• Consistent data capture is essential, even if unstructured
			• IPS supports this
			• Well defined care plans required
			• Patient MyHR
			• Semantic interoperability
			• Required across all care aspects
			• Automation & codifying of narrative content
			• Consumer questionnaires
				• Reason for encounter could result from discussion
				• PREMs/PROMs
				• Clinician versus consumer template
				• Too much information
				• Consent

Data group – Health concerns (consumer)

Is this data currently being recorded? How is it structured?	Which settings?	Which systems?	Future state? What and how should it work?	Any additional considerations?

• Mix of data being recorded
• Some coded, mostly unstructured, not standardised, can be free text
• Significant variation in how data is captured
• Requires definition
• Variable formats used, i.e.
  ○ Conversations
  ○ Tables
  ○ Care pathways/plans
  ○ Narrative documentation
  ○ Free text/unstructured clinical notes
• Privacy concerns, including small communities' control over data sharing
	• All
	• Often recorded, less in ED/acute settings
	• Not in MyHR
	• Management plans as problem lists
	• GPs
	• Allied health
	• Acute care
	• Community health care
	• Aged care
		• EMRs/CISs, including;
		  ○ Hospital
		  ○ GP
		  ○ AHP
		  ○ PMS
		• Not much in MyHR
		• If no internet, unable to access care plans/MyHR
		• Paper notes
			• Consistent data capture is essential, even if unstructured
			• IPS supports this
			• Well defined care plans required
			• Patient MyHR
			• Semantic interoperability
			• Required across all care aspects
			• Automation & codifying of narrative content
			• Consumer questionnaires
				• Reason for encounter could result from discussion
				• PREMs/PROMs
				• Clinician versus consumer template
				• Too much information
				• Consent

Data group – Care team members

Is this data currently being recorded? How is it structured?	Which settings?	Which systems?	Future state? What and how should it work?	Any additional considerations?

• Mostly structured, not standardised
• Not always available
• Depends on setting
• Transactional between care providers
• Commonly captured in EMRs, e.g. Sunrise EMR, Epic, etc
• Address book
	• All
	• Often recorded, less in ED/acute settings
	• Not in MyHR
	• GPs
	• PHNs
	• Allied health
	• Oncology
	• Acute care (ED/OPD)
	• NDIS
	• Community health care
	• Aged care
		• EMRs/CISs, including;
		  ○ Hospital
		  ○ GP
		  ○ AHP
		  ○ PMS
		• GP data great
		• Aged care are leaders
		• Multiple & unconnected
		• Health pathways
			• Captured structured in all systems
			• Ability to 'Copy to' required
			• Semantic interoperability
			• Single source
			• Coordinated care
			• National directory interfaced with EMR's
			• Live document
			• MyHR
			• Information exchange
				• Power of attorney
				• Provider directory

Data group – Social Emotional Wellbeing (SEWB)

Is this data currently being recorded? How is it structured?	Which settings?	Which systems?	Future state? What and how should it work?	Any additional considerations?

• Mostly not recorded
• Unstructured, not standardised
• Varies across systems
• Some coverage by Problem/Diagnosis list
• Assessments
	• All
	• Often recorded, less in
	• ED/Acute setting
	• Not in MyHR
	• Partially captured in care plan
	• Rural and remote practice inputs
	• GPs
	• Hospitals
		• EMRs/CISs, including;
		  ○ Hospital
		  ○ GP
		  ○ AHP
		• GP data great
		• Aged care are leaders
		• HIE exchange
		• Paper notes
			• Captured consistently, doesn't need structure
			• IPS supports this
			• Patient preferences captured
			• Needs to align with goal
			• Relates to SDOH
			• Needs to support compliance
			• Ability to 'Copy to' required
			• Semantic interoperability
			• Value based care
			• Effective Multidisciplinary teams
				• Patient non-compliance

Data group – Follow up

Is this data currently being recorded? How is it structured?	Which settings?	Which systems?	Future state? What and how should it work?	Any additional considerations?

• Structured, not standardised, can be free text
• Variable formats used, i.e.
  ○ Consultation/clinical notes
  ○ Appointment/admin tasks
  ○ Discharge summary
  ○ Care plans
  ○ Free text
	• All
	• GPs
	• Often recorded, less in ED/Acute settings
	• Not in MyHR
	• In-person follow-ups (not outcomes)
	• GPs and allied health
	• Acute care
		• EMRs/CISs, including;
		  ○ Hospital
		  ○ GP
		• GP data great
		• Aged care are leaders
		• Patient's pocket
		• Paper notes
		• Apps, e.g. pharmacy
			• Centralised
			• MyHR
			• Care plans
			• Needs to readily update to support standards
			• Automated
			• Required across all care aspects
			• Should reflect current status
				• Follow up related to interventions
				• Re-use of care plans
				• Follow up by patient or care providers?
				• PREMs/PROMs
				• Care plan that auto populates across the health system according to needs of practitioner (AHP, GP , Specialist, Nurse); includes consumer view

Additional data groups for CDM

Additional data groups suggested	Is this data currently being recorded? How is it structured?	Which settings?	Which systems?	Future state? What and how should it work?	Any additional considerations?
PREMs & PROMs	• Yes, structured but not by all sectors • Can measure • Including outcomes • Reconciliation during	• Often recorded, less in ED/Acute setting • Not in MyHR	• Less in Aged care		
Children in care/Court directions for children	• Court directions for children - pending which parent • Who is legal guardian? • Who needs to be notified? • Is the child emancipated and responsible for own care?				
Advance care information					
Mental health					
CDOH [Cultural Determinants of Health]					
Transition & continuity of care					
Vitals/Remote Monitoring					
Education	• For patient to self-manage • What has the patient received?				
Compliance					
Health literacy					
Patient portal	• How much can the patient do? • Partnership approach				

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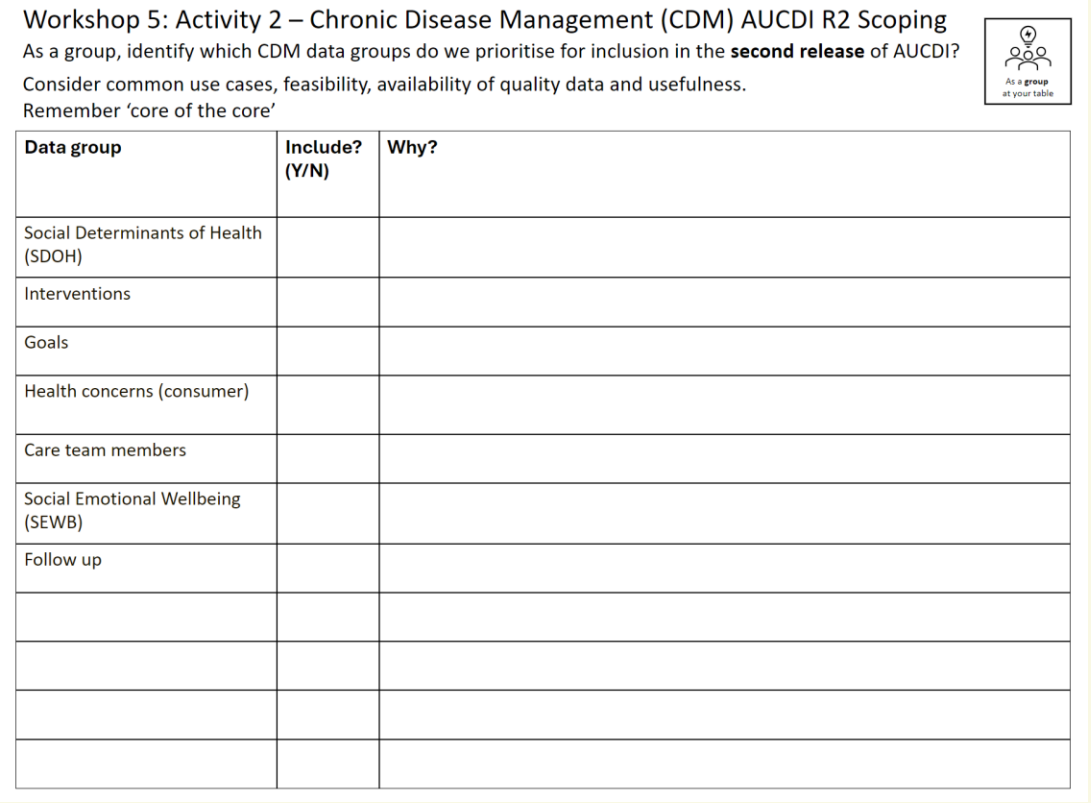
Overview – Workshop 5: Activity 2

Attendees were asked, as a group at their table, to identify on the worksheet (see inset) which data groups should be prioritised to support Chronic Disease Management for AUCDI R2.

Including any data groups from the backlog that should be considered for inclusion.



Workshop 5: Activity 2 – Chronic Disease Management (CDM) AUCDI R2 Scoping

As a group, identify which CDM data groups do we prioritise for inclusion in the **second release** of AUCDI?

Consider common use cases, feasibility, availability of quality data and usefulness.

Remember 'core of the core'

As a **group** at your table

Data group	Include? (Y/N)	Why?
Social Determinants of Health (SDOH)		
Interventions		
Goals		
Health concerns (consumer)		
Care team members		
Social Emotional Wellbeing (SEWB)		
Follow up		

Data Groups to include for Chronic Disease Management in AUCDI R2 and why

Data Group	Why Include in R1 AU PS?	Why Leave out of R1 AU PS?
Social Determinants of Health (SDOH)	• Strong influence on care outcomes. • Care plans - appropriate staff. • Define from an existing standard/framework • Gives a wider/holistic understanding of person. • Gives a wider/holistic understanding of person's unique circumstances. • Impacts care decisions • Identifies significant factors, risk factors & causes of diagnoses. • Give fuller picture of health and influencers of health. • Supports improved rapport/engagement • Supports personalised/tailored management plans & care • Feasibility; focus on key achievable areas, e.g. smoking status. • Data sets available to inform development, e.g. Gravity Project, OpenEHR • Inform population health policy	• Potential to blow out, not clearly defined. • What is the end-product? • Overlap with Gravity Project • Hard to capture/interpret • Free text • Feasibility
Interventions	• Broad Categories: therapeutic, prevention. • Procedural versus non-procedural, multidisciplinary interventions (MDI) major/minor, active/inactive qualification • Define from an existing standard/framework • Crucial to know along with medications • Need to measure against outcomes/goals • Use sections from FHIR IGs or AU Core that are already defined, e.g. Plans & Interventions, Procedures • Planned actitivities to achieve goals	• Linked to Goals data group. • Future release. • Requires further definition; ICHI/ACHI codes not granular enough, more detail required

Data Groups to include for Chronic Disease Management in AUCDI R2 and why

Data Group	Why Include in R1 AU PS?	Why Leave out of R1 AU PS?
Goals	• Goals can be patient or clinical • Care plans require synthesis of agreed patient & clinical goals • Goals are individual to the person/consumer • Contextualises the approach to care • Most fields are codeable; can be free-text immediately • Need to measure against outcomes	• Need to identify who's goals. • Linked to Interventions data group • Future release
Health concerns (consumer)	• Relates to Goals • Relates to Problems • Multidisciplinary • Achievable. • Patient centric; placing consumer first • Supports understanding of consumer drivers • Improved consumer compliance • Support communication.	• Should be entered by the consumer; how to capture? • Could be captured via Reason for Encounter
Care team members	• Supports care coordination; information sharing & transfer of care • Supports communication • Easy to pull from directives • Name and role documented • Feasible • Need to know key players involved; dependent on good quality provider directory, should include carers	• Future release; after Follow Up
Social Emotional Wellbeing (SEWB)	• Identifies significant factors/risk factors/causes of diagnoses • Supports improved rapport/engagement • Supports personalised/tailored management plans & care • Feasibility considerations • Could be collected via pre-appointment/pre-admission mechanisms	• Hard to capture & interpret • Future release; hard to define • Content captured via SMART forms. • Complex.

Data Groups to include for Chronic Disease Management in AUCDI R2 and why

Data Group	Why Include in R1 AU PS?	Why Leave out of R1 AU PS?
Follow up	• Needs to be clearly communicated, part of care plan • Already structured, low hanging fruit • Concrete next steps • Ensures outcomes align with goals • Required to review intervention outcomes & change of plans • Required to monitor health outcomes; access, data, funding/spend	• What does it mean?

Additional Data Groups suggested to include for AUCDI R2 and why

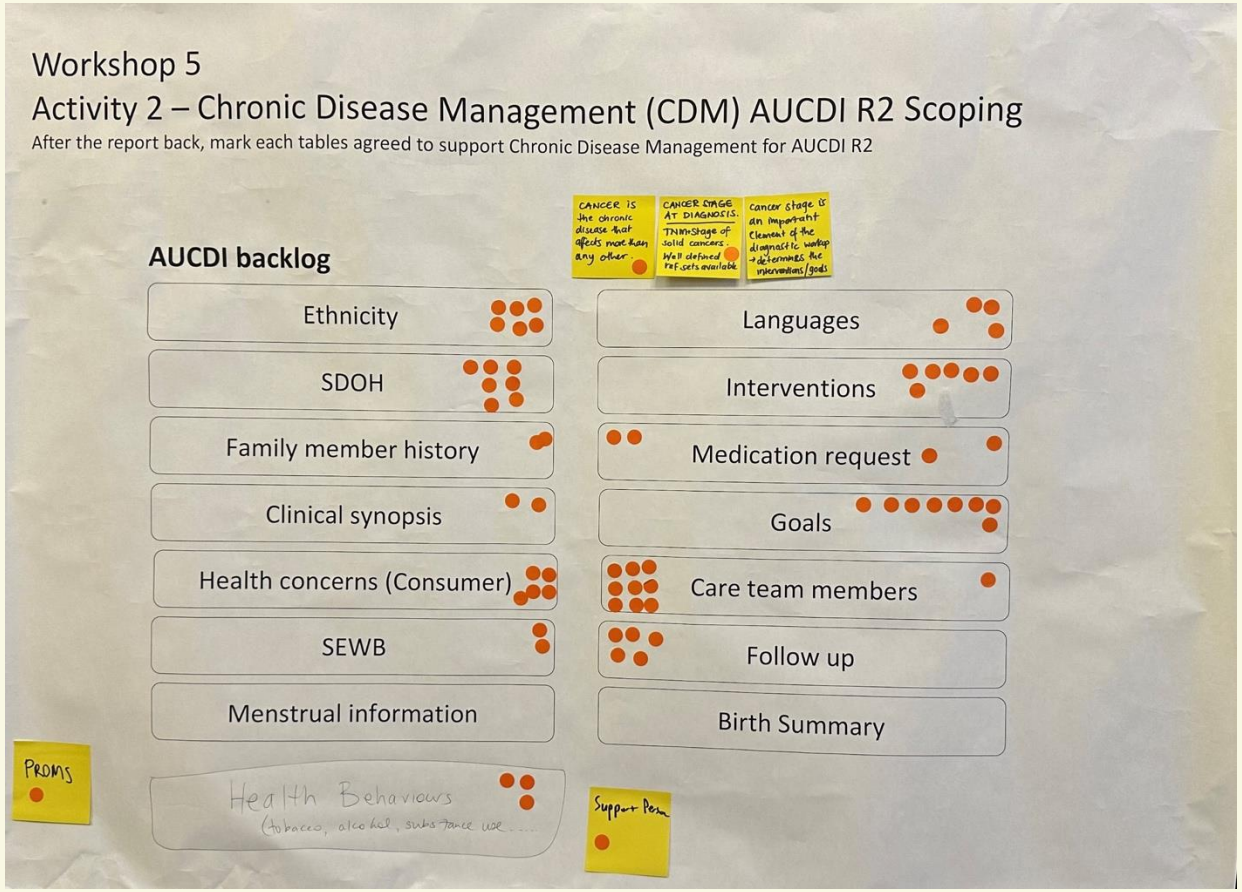
Data Group	Why Include in R1 AU PS?	Why Leave out of R1 AU PS?
Language	• Somewhat interdependent with Ethnicity; requires interpreter/translator	
Ethnicity	• Somewhat interdependent with Language; requires interpreter/translator	
Support Person	• Family, carers, guardianship etc.	
Medication Request	• Prescribed • Dispensed • What's actually been taken	
Health behaviours	• Consideration of complexity of data availability; data quality • Identifies significant factors/risk factors/causes of diagnoses • Supports improved rapport/engagement • Supports personalised/tailored management plans & care • Feasibility; focus on key achievable areas, e.g. smoking, alcohol, other drugs	

Additional comments on worksheet

- Concerns, Goals, Instructions, Outcomes

Overview – Workshop 5: Activity 2
Chronic Disease Management Data Group Prioritisation

After the initial Chronic Disease Management (CDM) workshop activities, each table was asked to vote, as a group, on their agreed data groups for inclusion in AUCDI Release 2 to support CDM



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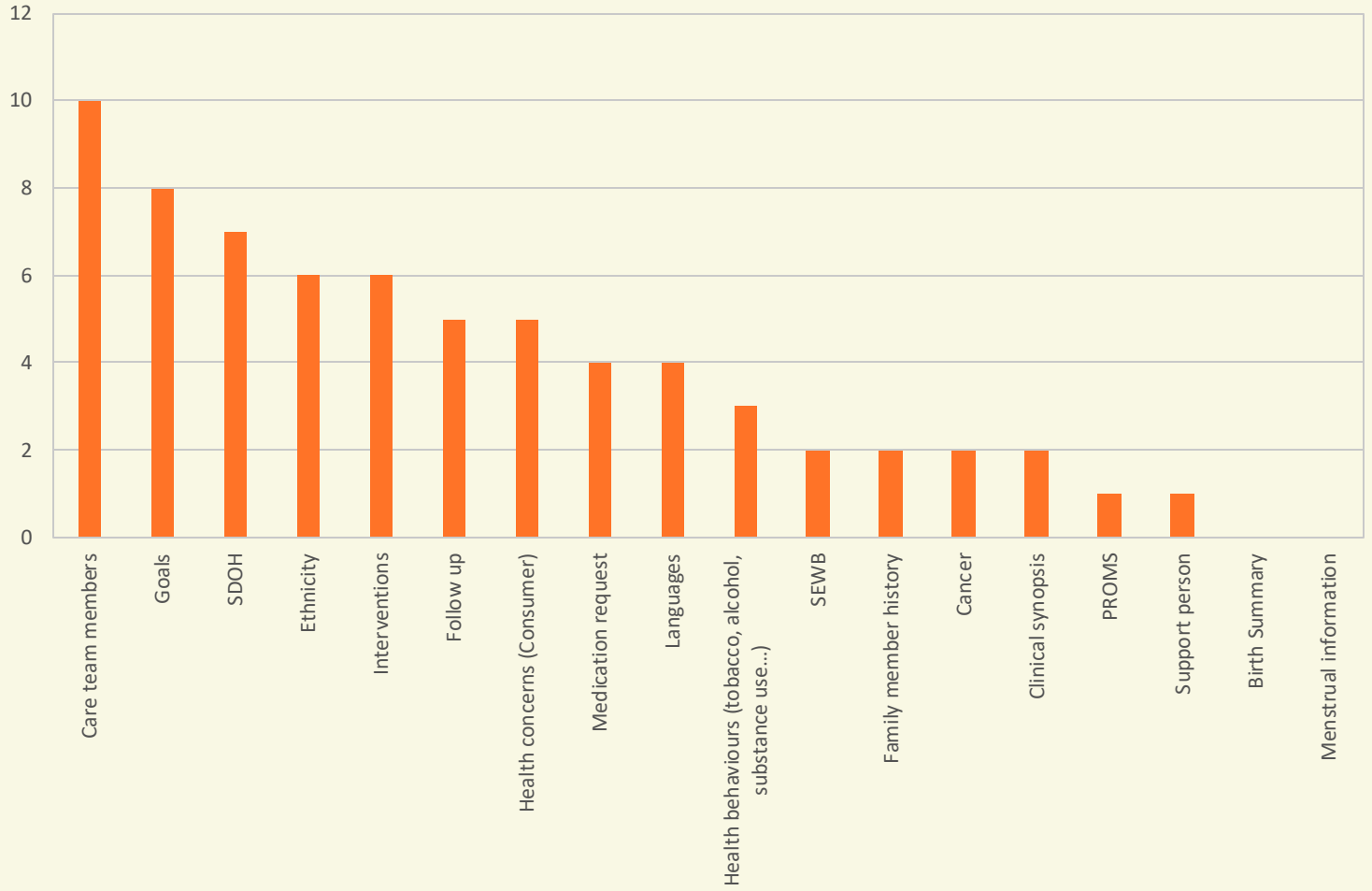
Chronic Disease Management Data Group Prioritisation



1	Care team members
2	Goals
3	SDOH
4	Ethnicity
5	Interventions
6	Follow up
7	Health concerns (Consumer)
8	Medication request
9	Languages
10	Health behaviours (tobacco, alcohol, substance use…)
11	SEWB
12	Family member history
13	Cancer
14	Clinical synopsis
15	PROMS
16	Support person
17	Birth Summary
18	Menstrual information

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