Minutes – AU Patient Summary Clinical Focus Group Online Meeting 4

Meeting Details	
Date	5/2/2025
Time	12:00pm – 2:00pm AEST (Brisbane time)
Location	Virtual

Meeting Overview	
Agenda Items	1. Welcome 2. Update to 'Purpose of AU Patient Summary' summary definition & characteristics 3. Patient Summary Consumer Journeys updates 4. Referral to Specialist & Allied Health: PS FHIR IG Project Questions 5. Test data development 6. Upcoming events and next PS CFG meeting

Discussion Summary	

Purpose of AU Summary	*Purpose of Patient Summary*
	• The updated purpose of a patient summary (V3) was presented. See slide pack for full definition.
	• Group discussion
	  ○ Update the wording to still specify the patient summary can be used internationally and link to the IPS however, make it clear that is for use both nationally and internationally
	  ○ "It allows individuals to share their health care information when travelling, including internationally"
	  ○ Consider changing the wording from 'facilitates' to 'supports the facilitation' or just 'supports' to better reflect the capabilities and purpose of the patient summary
	• Characteristics of AU Patient Summary v0.4
	  ○ Definitions
	  ▪ Asserted information refers to information that has received clinical sign-off and non-asserted information refers to information that has not received clinical sign-off.
	  ▪ An asserted patient summary contains both asserted and non-asserted information with

	clinical sign off/verification and a non-asserted patient summary contains both asserted and non-asserted information with no clinical sign off/verification
	• Group Discussion
	  ○ Change language from 'sign-off' as this can be ambiguous – clinical verification, clinical certification, clinical approval may be better suited
	  ▪ Need further definition when the clinical assertion will occur and if it's pulling previously verified information or if it will be verified at the generation of the patient summary
	  ○ Asserted/non-asserted may hold strong connotations about the information included in the patient summary – 'clinical oversight' may be more appropriate
	  ○ In an asserted patient summary, containing both asserted and non-asserted information, does the non-asserted information become asserted at the time the patient summary is asserted?
	  ○ Assertion of the information within the patient summary and clinical responsibility for the creation/preparation of the patient summary are different things and should use different terminology
	  ○ We may be able to leverage some of the existing HL7 reconciliation language to more clearly communicate the contents and status of the patient summary
	  ○ In the non-asserted patient summary, if there is asserted information, the data element could include "asserted date", "verification date" fields
	  ○ Will the patient summary include provenance of information – outlining whether it is pulled from a single source or generated and compiling information from multiple places
	  ○ Include previous medical history with the date in which this was recorded easily accessible to see – a 'hover' feature to see the date/provenance over the clinical entry was suggested
	  ○ Avoid words with existing associations – e.g. curated and its association within My Health Record
	  ○ Information included in the patient summary should have its time of verification easily visible – whether it was verified at the time of creation and validated later, or verified upon compilation in the patient summary should be made clear

Patient Summary Consumer	*Interstate GP Visit* • Wording modified in step 7 to update the patient summary, if required

Journeys Update	*Emergency Hospital Attendance* • A latex allergy was added to this scenario • Step 3 was updated to include that the multidisciplinary team is alerted to both an opioid and latex allergy and that they request the patient's most recent collated patient summary data • Step 6 wording is updated with the addition of the ED MDT • Step 4 wording is updated to specify the patient summary is from Charlotte's GP *Referral to Specialist and Allied Health* • Wording updated in step 2 from 'accesses via link' to 'allows access' • Wording updated in step 3 from 'using the information in the electronic referral and the current patient summary…" to "using the information in the electronic referral and the most recent patient summary…" • Wording updated in step 7 from "updates the patient summary…" to "updates a patient summary…" *Hospital Aged Care Interstate Transfer* • There were no specific updates to this journey, only to align language around most recent if used *Pre-operative Surgical Journey* • Language updated to align with other changes - e.g. 'allows access' instead of 'clicks link' • Removed 'snapshot patient summary' to avoid confusion • Wording updated from 'surgical date is set for removal of cataracts' to 'surgical date is set to remove Tristan's cataracts' for clarity *Group discussion* • Language for 'current patient summary' and 'recent patient summary' will be clarified with the TDG to determine what is most appropriate based on how it will be generated/compiled. It is currently referred to as 'most recent' to allow for the most flexibility, depending on the implementation or how the system may function • Defining who can create a patient summary is currently a 'hairy question' and will require further discussion, both within and outside of the CFG. Currently, if there is a clinical system with patient information, a patient summary can be created from that system
Referral to Specialist & Allied Health: PS FHIR IG Project Questions	*PS FHIR IG Project Questions* • The PS FHIR IG Project have nominated the 'Interstate GP Visit', 'Emergency Hospital Attendance' and the 'Referral to Specialists and Allied Health' consumer journeys for the use cases they are working through • The key considerations the PS FHIR IG Project have identified include whether a patient summary should be curated by a

clinician or automatically generated at certain points, and what are the implications

- Referral to Specialists and Allied Health
    - CFG discussion to determine whether this should be curated from the GP's own clinical system, machine generated from the GP's system, or machine generated from multiple sources using a collated compiled model
        - It's preferential to have patient information compiled and checked by a clinician in routine care, however this may not always be possible (e.g. 3am urgent situation)
        - Currently in practice, it differs, with information being collated within one or multiple systems which is then compiled into one patient summary.
        - The referring clinician has the most relevant information around why the patient is being referred, making it preferential that they sign off on the patient summary
        - A hybrid approach was proposed, which machine generates a baseline patient summary which a clinician can add to and check over. This may help to prevent incomplete information from one source of information to allow for the most up-to-date information from multiple sources, however, does require clinician time and funding
        - Where a patient summary is compiled from multiple sources, the provenance and source of truth needs to be identifiable
        - Provide feedback to the TDG that all scenarios need to be supported as there may be clinical requirements for each
        - Further determination is needed around how to manage and display potential changes in patient status if a referral has a long lead time (e.g. patient summary generated and approved at the time of the referral and the referred appointment occurring months in the future)
    - Step 3 references the most recent patient summary – does this refer to the patient summary created by Dr Burrows at the time of referral?
        - This is dependent on the time taken to do the triage and if anything occurs during the triage period, so the ability to pull an additional patient summary, should one be made, would be valuable

- Provide feedback to the TDG that it's assumed the patient summary is the same as at the time of referral unless there has been an emergent event or another healthcare provider interaction prior to the referred appointment
- Step 4 references the endocrinologist accessing the patient summary – assuming the patient summary is the one created by Dr Burrows at the time of referral?
  - Update wording to say 'the endocrinologist accesses the patient summary created at the time of referral to view and confirm the most recent patient summary'
  - In this scenario, is it possible there are two patient summaries – one which has been created and shared by Dr Burrows and another that has been generated by My Health Record in the instance that the patient has seen other clinicians during the waiting period.
  - Alternatively, there is one patient summary linked to the clinician's system which is updated with clinical entries
  - As the patient moves through the patient journey, multiple versions of a patient summary may emerge – 'verified' snapshot at the time of referral, a summary which reflects the latest updates in the referring practitioners clinical records, a summary which may have clinical encounters since the referral included, a summary which compiles the latest information from multiple sources to produce an unverified generated summary, or a combination of these
  - Provenance for data compiled into a generated summary is important to include and understand
  - It's important that the endocrinologist sees the original referral and patient summary as this information informed the referral made by the GP
  - Current and future state considerations need to be made when developing these processes. The long-term ability to generate an on-demand patient summary need to be provided, which may include a direct request to the requesting provider system vs broader spread summary
- Step 5 references the endocrinologist updating a patient summary, assuming they are making a new patient summary, is this machine generated or curated?

	▪ Does the endocrinologist need to generate a patient summary, or can these updates be shared with the GP for them to update? The patient summaries between these clinicians may be quite different due to their different focuses and they may instead update the existing summary with relevant information ▪ Critical data elements like dosage changes (e.g. insulin) should be contributed back to the GP system or added to My Health Record/patient record so it is accessible between systems and can be updated appropriately between the clinicians and is visible to the care team ○ Step 6 may reference two patient summaries – the summary embedded within their referral and the most recent patient summary (assuming this is the PS created in step 5) ▪ There are two summaries, as the endocrinologist updated the patient summary with the insulin dose ○ Step 7 references the dietitian creating a patient summary – should this patient summary be machine generated or curated? ▪ It's assumed the dietitian will send a letter back to the GP however, this process may look different to creating an entirely new PS ▪ It was noted that this step may include a letter to the midwife with the updated information which is then fed into the PS
Patient Summary Test Data	*Test data* • In reference to the 'referral to specialist and allied health' consumer journey, the test personas have been identified as the patient, Joyce Johnson; GP doctor, Dr Ginger Burrows; specialist endocrinologist, Dr Bryce Cruickshank; endocrinologist practice nurse, Abby Fraser; and dietitian, Nelson Henderson • The dietitian has been nominated from the test data, as there is not currently a dietitian within the test data within NSW • There are hopes to expand the data pool and requests for additional data have been made • The TDG have questioned what test data should be implemented, and what is reasonable to include within the original PS created by Dr Ginger Burrow ○ It's preferred to include as much information as possible in the patient summary however, there may be information that the patient does not want included or that is not possible to include

	○ The patient needs to express information they don't want in the summary or will need to review their summary before use, especially in the instance of a machine generated summary ○ When including as much information as possible in the patient summary, including the ability to filter/group/view the most important/relevant information would be beneficial ○ There are elements in FHIR that support surfacing care provision events. For example, the patient's health summary from the GP can be surfaced in the patient summary or if the patient summary contained aggregated information to the endocrinologist following an acute diabetes episode requiring a hospital visit, the patient summary can have multiple instances of a data element called 'care provisioning event' which covers the inpatient encounter in the GP health summary • Clinical scenario for test data – see slide pack for full detail ○ This includes information for the clinical scenario, test personas, a high-level timeline, and starting data for patient information in the PS data elements ▪ Please share any further anonymised test data to use within these test scenarios ○ With this clinical scenario, should a current medication and/or a prescription list be provided? If a prescription list is provided, how far back should this go? ▪ Understanding medication a patient was previously on can be important to their treatment (e.g. medication caused an adverse effect, cost reason, ineffective) however, there is not currently an easy way to provide this ▪ There is currently poor documentation (this may be due to having to manually enter this information) of over-the-counter medication and any supplements a patient may be taking ▪ The main information needed is the current medication the patient is taking, potentially prescribed by multiple clinicians
Future Meetings	*Upcoming meetings* • Wednesday 5th March • Wednesday 2nd April • Wednesday 7th May • Wednesday 4th June *Upcoming events* • February ○ 12th – Sparked Webinar ○ 18th – Sparked Leadership Evening (Adelaide)

	○ 19th – Sparked CDG F2F (Adelaide) ○ 20th – Sparked TDG F2F (Adelaide) • March ○ 18th – 20th – Trans-Tasman Symposium and HL7 Au FHIR Connectathon (Sydney) – This is also available as a virtual event ○ 27th – Sparked Webinar • April ○ 16th – Sparked online CDG

Actions

ID	Description	Responsible	Due	Status
20240205-1	Share test data with Sparked if available and willing	CFG Members		Open
20240205-2	Share word document of clinical scenario	Sparked Team		New
20240205-3	Provide feedback, markup, question the clinical scenario document	CFG Members		New

Attendees

1. Madison Black	2. Kylynn Loi
3. Tor Bendle	4. Olivia Carter
5. Shelley Behen	6. Kate Ebrill
7. Steph Ong	8. Christy Sieler
9. Nyree Taylor	10. Adrian Gilliland
11. Averil Tam	12. Charlotte Howard
13. Chris Moy	14. Jai Dacey
15. Danielle Bancroft	16. Darrell Duncan
17. Jacqui Rhodes	18. Janney Wale
19. Liz Keen	20. Paris Majot
21. Todd Miller	

Apologies

1. Shawn Francis	2. Belinda Hammond
3. Alvin Marcelo	4. Talat Uppal
5. Srinivasa Murthy	