Continuity of Care

Vendor advice regarding e-Referral questions

Position Statement

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National E-Health Transition Authority

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1 Administration

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2 Problem Domain

2.1 Introduction

GP Desktop Vendors have raised several issues with regard to the e-Referral specification specifically:

The concern is that GPs are likely to be reluctant to use the e-Referral and Specialist Letter specifications because of the workflow implications – i.e.:

- It would impose unnecessary structure and restrictions in the way clinicians compose referral letters.
- Clinicians will lose their ability to include graphs, images and formatting that is supported by existing solutions (word processor)
- Clinicians will be forced to regenerate a letter every time they wish to make a change to the narrative, which adds additional steps to their business process
- Users will also lose the ability to be specific about which coded information to include
- Imposing structure over the referral narrative does not improve semantic interoperability (i.e. the structured entries could co-exist with an attached letter/document)

This document provides responses with regards to these matters and guidance on the most effective way to implement the specification.

3 Implementation Guidance

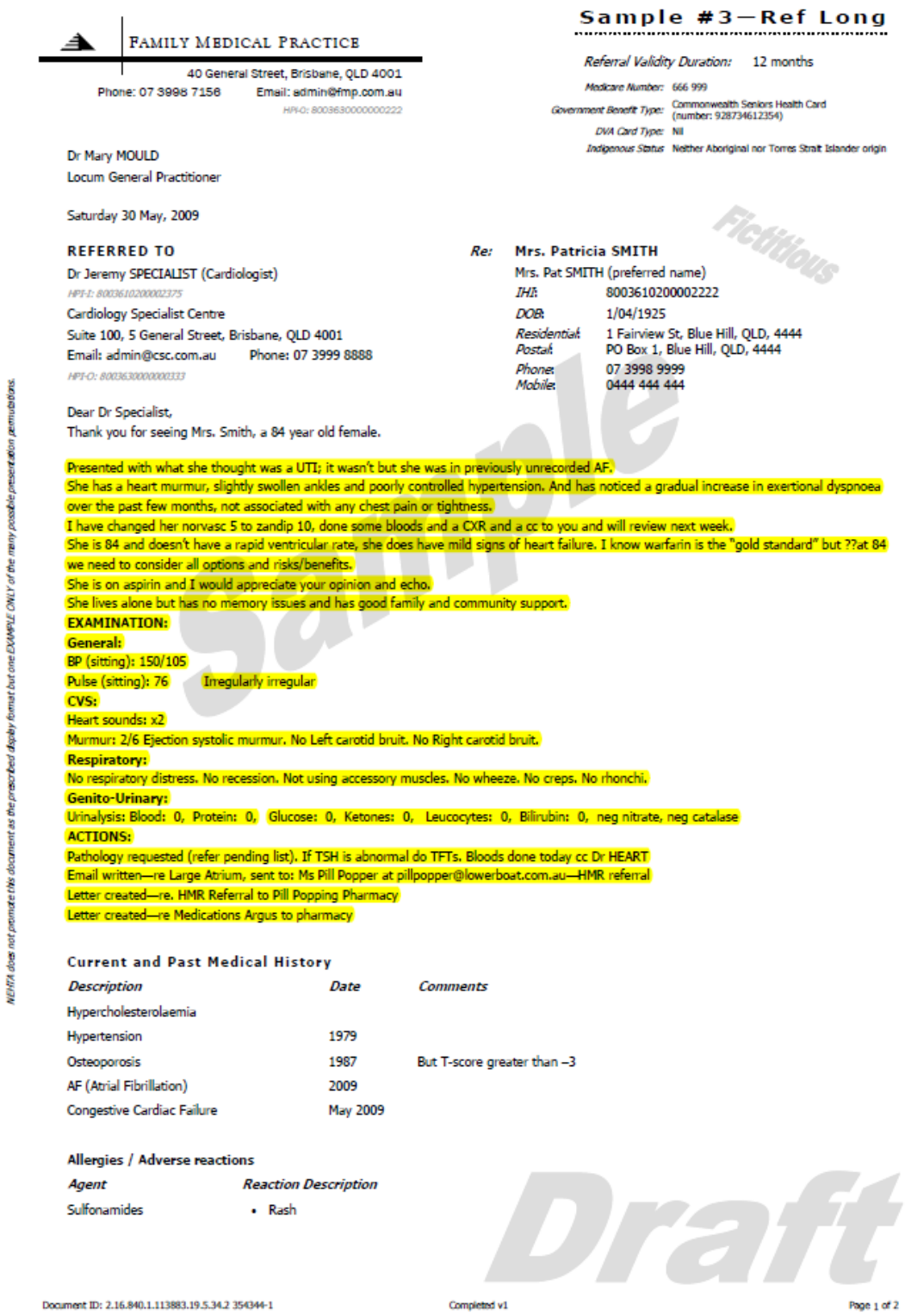
3.1 Structure of e-Referral Letters

Much of the confusion relates to the meaning of the "reason for referral" field. The definition of this is the reasons for the referral and the narrative of the presenting problems, clinical presentation, etc.

The field is mapped to a CDA type "ST" or plain string. The definition and the mapping together are not sufficiently clear with regard to how the referral letter is structured. To clarify this, the definition of "Reason for Referral" will be changed as a technical correction to:

> *In the creation of a referral, relevant information about the patient's Current and Past Medical History, Current Medications, Allergies / Adverse reactions and optionally Diagnostic Investigations will be included as structured data, according to the information components that follow.*
>
> *To complement this structured data, the data item "Reason for Referral" is a free text narrative for the referrer to include content regarding the patient's clinical story. This may include any details at the discretion of the referrer, such as a synopsis of the case, presenting problems, the service that is requested, pertinent history or key physical findings etc.*
>
> *The content in this data item may vary from a single line in simple cases to many paragraphs for more complex circumstances.*

To further clarify what this means for the structure of an e-Referral, consider this sample:



FAMILY MEDICAL PRACTICE
40 General Street, Brisbane, QLD 4001
Phone: 07 3998 7156 Email: admin@fmp.com.au
HPI-O: 8003630000000222

Sample #3—Ref Long

Referral Validity Duration: 12 months
Medicare Number: 666 999
Government Benefit Type: Commonwealth Seniors Health Card (number: 928734612354)
DVA Card Type: Nil
Indigenous Status Neither Aboriginal nor Torres Strait Islander origin

Dr Mary MOULD
Locum General Practitioner

Saturday 30 May, 2009

REFERRED TO
Dr Jeremy SPECIALIST (Cardiologist)
HPI-I: 8003610200002375
Cardiology Specialist Centre
Suite 100, 5 General Street, Brisbane, QLD 4001
Email: admin@csc.com.au Phone: 07 3999 8888
HPI-O: 8003630000000333

Re: **Mrs. Patricia SMITH**
Mrs. Pat SMITH (preferred name)
IHI: 8003610200002222
DOB: 1/04/1925
Residential: 1 Fairview St, Blue Hill, QLD, 4444
Postal: PO Box 1, Blue Hill, QLD, 4444
Phone: 07 3998 9999
Mobile: 0444 444 444

Dear Dr Specialist,
Thank you for seeing Mrs. Smith, a 84 year old female.

Presented with what she thought was a UTI; it wasn't but she was in previously unrecorded AF.
She has a heart murmur, slightly swollen ankles and poorly controlled hypertension. And has noticed a gradual increase in exertional dyspnoea over the past few months, not associated with any chest pain or tightness.
I have changed her norvasc 5 to zandip 10, done some bloods and a CXR and a cc to you and will review next week.
She is 84 and doesn't have a rapid ventricular rate, she does have mild signs of heart failure. I know warfarin is the "gold standard" but ??at 84 we need to consider all options and risks/benefits.
She is on aspirin and I would appreciate your opinion and echo.
She lives alone but has no memory issues and has good family and community support.
EXAMINATION:
General:
BP (sitting): 150/105
Pulse (sitting): 76 Irregularly irregular
CVS:
Heart sounds: x2
Murmur: 2/6 Ejection systolic murmur. No Left carotid bruit. No Right carotid bruit.
Respiratory:
No respiratory distress. No recession. Not using accessory muscles. No wheeze. No creps. No rhonchi.
Genito-Urinary:
Urinalysis: Blood: 0, Protein: 0, Glucose: 0, Ketones: 0, Leucocytes: 0, Bilirubin: 0, neg nitrate, neg catalase
ACTIONS:
Pathology requested (refer pending list). If TSH is abnormal do TFTs. Bloods done today cc Dr HEART
Email written—re Large Atrium, sent to: Ms Pill Popper at pillpopper@lowerboat.com.au—HMR referral
Letter created—re. HMR Referral to Pill Popping Pharmacy
Letter created—re Medications Argus to pharmacy

Current and Past Medical History

Description	*Date*	*Comments*
Hypercholesterolaemia		
Hypertension	1979	
Osteoporosis	1987	But T-score greater than –3
AF (Atrial Fibrillation)	2009	
Congestive Cardiac Failure	May 2009	

Allergies / Adverse reactions

Agent	*Reaction Description*
Sulfonamides	• Rash

Document ID: 2.16.840.1.113883.19.5.34.2 354344-1 Completed v1 Page 1 of 2

In this example, the portion marked in yellow is the "reason for referral".
This revised definition, along with the clarifying explanation, will be carried forward into future revisions of the e-Referral specification. Note that the same applies to Clinical Synopsis in Specialist Letter.

3.2 Selection of Coded Data

The CIC says that the referrer's discretion is exercised in allowing information relevant to the ongoing care of the patient to be included in the referral. This is the correct position and it is at the discretion of the user to decide which information is to be sent. This document clarifies that it is always at the referrer's discretion as to which information to include in a referral. One particular source of confusion is in the details of those sections where users may pick either:

☐ None known
☐ Not asked

Or the user may supply one or more items (e.g. medications). As a technical correction, the following additional item will be added to the choice:

☐ None Supplied.

The definition of none supplied is "no items have been supplied in this document". This is an exclusion statement code. The actual code is "03" in the code system "1.2.36.1.2001.1001.101.104.16299". A related question that arose during the consideration of this issue is what data must appear in CDA narrative? (Or, whether it is acceptable for the CDA document to contain data that is not explicitly represented in the Narrative). The base CDA specification leaves this open and it's up to the implementation guide to specify. The NEHTA specifications have not made any ruling about this. It has been agreed that the following rules apply:

For wave #1, the following items must be shown in the narrative:

- Medical History: An exclusion statement or each Problem or Diagnosis (name, dates and comment)
- Clinical Synopsis and Date
- Medications: an exclusion statement or each medicine (TGI identification and directions)
- Adverse substance reactions: an exclusion statement or each reaction (Agent, and each reaction event manifestation)
- Diagnostic Investigations: each pathology or radiology report (at least test name, report status, and a test result representation)

Each item should be shown in the narrative of the section in which the entry is contained.

Note that this does not specify that the narrative must be automatically generated from the data. Future versions may be more specific about the relationship between the data and the narrative.

3.3 Document Format

The CDA narrative is able to convey paragraphs, lists, tables, and images. Using the current NEHTA style guide, Bold, Italic, Underline, Font colour and fixed width font are also possible. Other formats such as PDF or RTF offer more extensive control over the formatting, but at the cost of loss of semantics and/or interoperability issues. Some clinical users care greatly about the appearance of the reports, and the lack of format control will concern them.

In order to smooth the introduction of the CDA based e-Referrals (and other documents); the implementation guide will be extended to allow the inclusion of a PDF and/or RTF representation of the content of the document as well. The following rules will apply:

- Senders must populate the CDA narrative correctly.
- Senders should format the CDA document as well as possible
- Senders may choose to provide the a PDF or RTF rendition in addition to the CDA narrative
- If PDF or RTF documents are attached, the contents must be equivalent in meaning
- Senders may only provide these additional format if they can be confident that the contents are equivalent in meaning.
- Receivers must be able to accept and display CDA narrative
- If either RTF or PDF are provided, receivers may choose to display these instead
- The decision which to display is made on technical/platform grounds, not because of the content of the documents

Technically, the PDF / RTF documents are carried as attachments in the same way as image attachments (see separate CDA packaging advice). In the document, the PDF and RTF attachments are represented as observation media in the administrative observations section. In CDA, this looks like:

```
<section>
 <code code="102.16080" codeSystem="1.2.36.1.2001.1001.101"/>
 <!-- other administrative section content -->
 <entry typeCode="DRIV">
  <observationMedia classCode="OBS" moodCode="EVN">
   <value mediaType="[mt]">
     <reference value=”[url]”/>
   </value>
  </observationMedia>
 </entry>
</section
```

Where [mt] is either “application/pdf” or “text/rtf”, and the [url] is a reference into the package following the packaging specification.

End of Document