Australian Government
Australian Digital Health Agency

Common – Clinical Document
FAQ Qualifiers for Clinical Information

21 December 2017 v1.0
Approved for external use
Document ID: DH-2594:2017

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Acknowledgements
The Australian Digital Health Agency is jointly funded by the Australian Government and all state and territory governments.

Document information

Key information

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Technical Guidance for Qualifiers

The Australian Digital Health Agency's (the Agency) digital health specifications are based on international specifications such as the Data Types Abstract Specification published by Health Level Seven International. According to these specifications, a qualifier defines a property of an element of clinical information and constrains the meaning of the clinical information.

Examples of qualifiers are:

1. A medical condition's laterality (also known as side) such as 'left', 'right' or 'bilateral'.
2. Acuity, i.e. whether the condition is acute or chronic.
3. The severity of a medical condition.

A qualifier is not a new element of clinical information. If an element of clinical information is included in a clinical document then any qualifying information must also be included. This ensures that the narrative of a clinical document meets the Health Level Seven (HL7) Clinical Document Architecture Release 2.0 requirement for clinical information in a narrative to be attested content. Attested content is healthcare information entered into a clinical information system (CIS). If information in the narrative of a clinical document differs from the information entered into the CIS then the clinical document does not meet the requirement for the narrative to be attested content.

If the user interface of a CIS allows a healthcare provider to select a medical concept through the selection of pull down menus, radio buttons and checkboxes then for the clinical document narrative to be the attested content the information corresponding to the pull down menus, radio buttons and checkboxes is to be included in the narrative.

Some CISs allow the healthcare provider to describe a medical condition, procedure, diagnostic investigation, a problem or diagnosis by selecting a condition from a menu and then selecting qualifiers through the use of radio buttons or checkboxes. For example, the procedure 'right glaucoma' may be entered by selecting 'Glaucoma' and the qualifier 'right'. It is important that the qualifying information 'right' is included in the clinical document rather than solely 'Glaucoma' as the combined information is the information entered by the healthcare provider.

How the qualifying information is included is at the discretion of the software developer, and examples are:

1. Right Glaucoma
2. Glaucoma, right
3. Glaucoma [Right]
4. Glaucoma - right

As well as recording this information in the narrative of a clinical document, the corresponding <entry> element is expected to include an `<originalText>`[1] element whose value is the information entered or selected by a healthcare provider and its value must include any qualifiers, for example:

```
<code>
      <originalText>Glaucoma, right</originalText>
</code>
```

[1] The Agency's publication "Representing Coding in CDA Documents" explains that originalText is generally needed except for the scenario when the term selected by a healthcare provider has an exact correspondence to a code.

This also applies when there is a code for the concept that was qualified but no qualifier codes, e.g.

```
<code code = "23986001" displayName = "Glaucoma" codeSystem =
"2.16.840.1.113883.6.96" codeSystemName = "SNOMED CT-AU" >
      <originalText>Glaucoma, right</originalText>
</code>
```

Described below is a procedure to determine if your CIS includes qualifiers as expected. There are different scenarios depending on the how the CIS supports the entry of information.

Scenario 1

The CIS allows a healthcare provider to enter text to describe a medical condition, procedure, a problem or diagnosis, or other types of information.

1. Enter sample text into the CIS and create a clinical document;
2. View the clinical document XML file and
   a) Determine if the text is present in a narrative of the document; and
   b) If the document contains an <entry> element corresponding to the narrative with an <originalText> and then determine if the <originalText> element contains the same text that was recorded in the narrative.

In this scenario qualifying information may be present in the textual description of a medical condition or may be present as a separate comment if the qualifiers were entered into the clinical information as a comment.

Scenario 2a

The CIS allows a healthcare provider to select radio buttons or checkboxes to add qualifying information, and, depending on the user interface design, the information being qualified may be either entered as text or selected from a list of items. The CIS creates documents with <entry> elements without a code for the clinical information that will be qualified.

1. Enter or select the clinical information that will be qualified;
2. Enter the qualifying information by selecting the radio buttons or checkboxes, and create a clinical document;
3. View the clinical document XML file and
   a. Determine if the document's narrative includes the clinical information with the qualifiers; and
   b. Determine that the <entry> element corresponding to the narrative contains an <originalText> element with the same text that was recorded in the narrative (i.e. the clinical information with the qualifiers).

In this scenario the qualifiers must not be included as a comment in the clinical document as they were not entered into the CIS as a comment.

Scenario 2b

This is similar to scenario 2a except that the CIS creates documents with <entry> elements with a code (e.g. a SNOMED CT-AU code) for the clinical information that will be qualified, but does not include codes for the qualifiers.

1. Enter or select the clinical information that will be qualified;
2. Enter the qualifying information by selecting the radio buttons or checkboxes, and create a clinical document;
3. View the clinical document XML file and
    a. Determine if the document's narrative includes the clinical information with the qualifiers; and
    b. Determine that the <entry> element corresponding to the narrative contains an

Scenario 2c

This is similar to scenario 2b except that the CIS creates documents with <entry> elements with codes (e.g. SNOMED CT-AU codes) for the clinical information and qualifiers. Please contact the Agency if this scenario applies to your software.

Scenario 3

The CIS imports information from another source, such as test reports from a pathology laboratory.

1. Simulate the receipt from another source of clinical information with qualifiers; and create a clinical document;
2. View the clinical document XML file and
    a. Determine if the document's narrative includes the clinical information with the qualifiers; and
    b. If the document contains an <entry> element corresponding to the narrative with an <originalText> element then determine if the <originalText> element contains the same text that was recorded in the narrative.

A comment is a separate data element so if the qualifying information was received from the other source in a comment then determine that the comment has been included in the clinical document XML file.

References

NEHTA-1097:2011 National E-Health Transition Authority, 10 October 2011, *Representing Coding in Clinical Documents – Implementation Guidance v1.0*.