

Continuity of Care

Referral Core Information Components Questionnaire - Generic

August 2009

Background

The Referral Core Information Components are the **minimum set** of data items that are recommended for implementation in any GP system that creates and transfers referral information for GP referrers in Australia.

The Referral Core Information Components are defined as the minimum set of data items that are considered important to support the delivery of quality collaborative care. The inclusion of data in this minimal set is determined by two criteria: (a) the clinical relevancy of the data; and (b) the need of the data to ensure clinical safety in the collaborative care environment.

As the Core Information Components define the core information for exchange, it is anticipated that some referral templates will contain additional types of data to satisfy specific local requirements, or healthcare specialty requirements.

Note that the information included in these Core Information Components is defined at the logical level, and is therefore independent of specific exchange or presentation formats.

Purpose

To validate that the core data items included in the NEHTA Referral Core Information Components will not result in any clinical risk issues.

Please email responses to referrals@nehta.gov.au by 11 September 2009

Questionnaire

	Question	Yes/No	If YES, please justify
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1	<p>Are there any data items that are missing from the list that follows? That is, any items that you consider crucial to be included as part of a Core specification.</p>	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<p>Assumptions:</p> <ul style="list-style-type: none"> - wherever possible, the data will be autopopulated in the GP software when preparing the referral - wherever possible the length of the referral will be minimised (ie; if data items not relevant then they will not be present??). Both GPs & receivers of referrals want the shortest possible referrals. <p>GPV has worked extensively with the Victorian Department of Human Services in supporting and developing the Victorian Statewide Referral Form (VSRF) which has been developed in consultation with GPs and Victorian Divisions of General Practice. The VSRF has the following components that are not included in this core specification that we consider important:</p> <ul style="list-style-type: none"> - Preferred language of patient - Interpreter required - Feedback requested - Social History - Consent to share information - Preferred Name(s) - Other notes (eg current services) <p>Benefits Card Details</p> <ul style="list-style-type: none"> - include validity date and expiry date - include private insurance status (but ensure optional) <p>Referrer</p> <ul style="list-style-type: none"> - organisation identifier should be mandatory (this should be able to uniquely identify a GP at a specific location) <p>Referred to</p> <ul style="list-style-type: none"> - Person identifier & Person name - to be made mandatory - specialty to be 'service type'
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2	Are there any items in the list that you consider to not belong in a list of core items?	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Participation Type - unclear about what participation type is for? Current medications - current medications indicator - why is this in here? unnecessary Referral details - referral validity duration - not mandatory default is 12 months Allergies/Adverse reactions - reaction description should not be mandatory Diagnostic investigations - result status should be optional Document control - all items important provided they are autopopulated
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Name	Position	Organisation
Bill Newton / Ross Nable	CEO / Team Manager Population Health and E-health team	General Practice Victoria

The table below provides a general description of each data item in the Core Referral. Please note that formal definitions will be provided in the Referral Structured Document Template. Note that, component sections are shaded in yellow and component/items that require values in all referrals are formatted in bold.

Component	Item	Notes
Patient		The patient is the person about whom the healthcare event has been captured – that is, the subject of the information.
	Participation Type	The kind of Participation or involvement the person is playing with regard to making the referral. Value of this data element is default to “patient” and is used by the receiving system to properly group/display the information
	Identifier	The unique identifier of the patient. This must include the patient’s Individual Healthcare Identifier (IHI) when available. In the absence of an IHI, this may contain the patient’s local identifier.
	Name	The patient’s name, in a structured format. (E.g. family name and first name). Multiples allow for addition of ‘preferred name’ as required.
	Date of Birth	The patient’s date of birth. If necessary, this may be an approximation, which includes only the year, or the month and year. An estimation flag may be used to indicate whether or not the date is an estimation.
	Sex	The sex of the patient. Sex is the biological distinction between male and female. Where there is an inconsistency between anatomical and chromosomal characteristics, sex is based on anatomical characteristics.
	Address	The address of the patient, recorded in a structured format. Allows for multiple addresses such as ‘temporary’ or ‘postal’. May include “No fixed address” if appropriate.
	Communication Details	The patient’s preferred means of contact should be included to facilitate clinical follow-up. Each Communication Details data item includes the medium (e.g. telephone), usage (e.g. home) and details.
	Indigenous Status	A description of the patient’s indigenous origin.
Benefits Card Details		Details pertaining to the identification of patient held benefits cards, where applicable.
	Medicare Number	A national identification number, issued by Medicare Australia used for identifying individuals or family members for correct allocation of medical benefits through the Medical Benefits Scheme. A Medicare Number must be recorded if the patient has one.
	Government Benefit Type	A description of the type of government pension or benefit scheme provided to the patient.
	Government Benefit Access Card Number	An identification number indicating membership of government pension or benefit scheme/program.
	DVA Card Type	A description of the DVA Card that the patient was issued.
	DVA Card Number	An identification number identifying a patient's membership with Department of Veterans Affairs.

Component	Item	Notes
Patient's Contact		Details pertaining to the organisation or individual(s) nominated to act as the contact to receive and/or obtain information about the patient. The patient themselves may not be the primary point of contact (e.g. dementia or paediatrics).
	Name	The contact person's or organisation name, in a structured format. (E.g. family name and first name).
	Address	The address of the contact person, recorded in a structured format.
	Communication Details	The contact person's preferred means of contact. Each Communication Details data item includes the medium (e.g. telephone), usage (e.g. home) and details.
	Relationship to Patient	The relationship of the contact person to the patient.
	Contact Type	Descriptor that specifies the role of the contact person whom the health care provider or agency may contact about the subject of care. For example, 'Preferred contact'.
Referrer		The healthcare provider who is doing the referring.
	Participation Type	The kind of Participation or involvement the Referrer is playing with regard to making the referral. This allows the medical practitioner who authored the referral to be identified.
	Person Identifier	Must contain the referrer's Provider Number and the HPI-I (Healthcare Provider Identifier – Individual) when relevant (and when available). The "Identifier Type" subcomponent of the "Person Identifier" allows the Medicare Provider Number to be clearly identified and differentiated from other identifiers included in the referral.
	Person Name	The name of the referring individual, in a structured format.
	Healthcare Role	The role the referrer is playing in the course of initiating the referral. For example, 'Usual GP' or 'Locum GP'.
	Organisation Identifier	The identifier of the referring organisation. When an Organisation Name is provided, the Organisation Identifier should be included.
	Organisation Name	The name of the referring organisation. When an Organisation Identifier is provided, the Organisation Name should be included.
	Address	The structured address of the referrer.
	Communication Details	The contact details for the referrer. The Referrer's preferred means of contact should be included and should include at least one method of communication. Each Communication Details data item includes the medium (e.g. telephone), usage (e.g. home) and details.
	Digital Signature	A Medicare compliant digital signature, based on PKI.
Referred To		The healthcare provider and/or organisation to which the patient is being referred.
	Participation Type	The kind of Participation or involvement the person is playing with regard to making the referral. Value of this data element is defaulted to "Referred to provider" and is used by the receiving system to properly group/display the information.
	Organisation Identifier	The identifier of the organisational to which the patient is being referred. When an Organisation Name is

Component	Item	Notes
		provided, the Organisation Identifier should be included.
	Organisation Name	The name of the organisation to which the patient is being referred. When an Organisation Identifier is provided, the Organisation Name should be included
	Person Identifier	Must contain the HPI-I (Healthcare Provider Identifier – Individual) when relevant (and when available) of the individual to which the patient is being referred. This must contain a Person Identifier exactly when there is a Person Name.
	Person Name	The name of the individual to which the patient is being referred (if available), in a structured format. This must contain a Person Name exactly when there is a Person Identifier. An individual's name must be provided for Medicare reimbursable referrals.
	Specialty	The clinical specialty of the clinician being referred to. For example, 'Orthopaedic Surgery'.
	Address	The structured address of the party to which the patient is being referred.
	Communication Details	The contact details for the party to which the patient is being referred. The preferred means of contact should be included and should include at least one method of communication. Each Communication Details data item includes the medium (e.g. telephone), usage (e.g. home) and details.
Referral Details		This section captures detailed information about the clinical referral.
	Reason For Referral	This free text data element is intended to summarise the reasons for referral in a single text field. It is the narrative of the presenting problems, clinical presentation etc.
	Referral Validity Duration	The length of time the referral is valid from the date of the first client/referred to provider encounter. Captures the valid duration of the referral which may be constrained by, e.g. Medicare funding policy.
Current and Past Medical History		Describes all relevant diagnoses and health/medical problems pertaining to the patient, as well as any relevant clinical interventions that have been performed on or for the patient.
	Medical History Description	A description of the problem, diagnosis or intervention, which may or may not be coded.
	Medical History comments	Free text comments providing additional information relevant to the problem, diagnosis or intervention in question.
	Medical History DateTime Range	The date range (start date and/or end date) during which a patient's problem/diagnosis was active, or that the clinical intervention was performed. If necessary, this may be an estimate (such as April 2005, or 1998 - 2007).
Current medications		Medications that the patient is currently taking.
	Current Medications Indicator	Indicates whether or not the patient has any known current medications. For example 'Known', 'None known'.
		IF Known THEN. The Number of Values Allowed below are only applicable if Current Medications Indicator is set to 'Known'.
	Item Description	The name of the medication, as described by the referrer. This description should include the active ingredient names, brand name, strength and dose form of the medication, where appropriate.

Component	Item	Notes
	Dose Instruction	A description of how a particular product is being taken by the patient. This must include the route, dose quantity, frequency and any additional instructions required to safely describe the appropriate dosage. This should also include the administration schedule. In Referral systems, which support atomic dosage instructions, this item only needs to be populated when the atomic dosage items are not.
Allergies / Adverse reactions		Describes the known allergies and adverse reactions for the patient, and any relevant reaction details.
	Allergies / Adverse Reactions Indicator	Indicates the status of knowledge about the patient's Allergies / Adverse Reactions For example 'Known', 'None known', 'Unknown', 'Not asked'.
		IF Known THEN. The 'Number of Values Allowed' below are only applicable if Allergies / Adverse Reactions Indicator is set to 'Known'.
	Agent Description	The agent / substance causing the allergy / adverse reaction experienced by the patient.
	Reaction Description	The signs and/or symptoms experienced or exhibited by the patient as a consequence of the allergies / adverse reaction to the specific agent/substance.
Usual GP		The medical practitioner nominated by the patient as his/her "usual GP." Note that where the 'Referrer' is not the Usual GP, this component must be completed.
	Person Identifier	This must include the Healthcare Provider Identifier for the individual (HPI-I) when available. Person Identifier has a value exactly when Person Name has a value.
	Person Name	The name of the usual GP. Person Name has a value exactly when Person Identifier has a value.
	Healthcare Role	Defaulted to 'Usual GP'.
	Organisation Identifier	This must include the Healthcare Provider Identifier for the organisation (HPI-O) when available. Organisation Identifier has a value exactly when Organisation Name has a value.
	Organisation Name	The name of the GP Practice. Organisation Name has a value exactly when Organisation Identifier has a value.
	Communication Details	The GP's preferred means of contact. Each Communication Details data item includes the medium (e.g. telephone), usage (e.g. work) and details.
Diagnostic Investigations		Describes the diagnostic investigations performed on the patient during the healthcare event, that are considered to be relevant to the patient's ongoing care This allows the results to be included as an attached report, or as a reference (ie. link) to where the results are located. Pending results can be indicated using a Result Status of 'pending'.
	Investigation Type	The type or category of investigation performed on the patient – e.g. 'Pathology', 'Diagnostic Imaging'.
	Investigation Name	The name of the investigation performed on the patient – e.g. 'INR'.

Component	Item	Notes
	Investigation Date	The date and/or datetime that the diagnostic investigation was performed (in the case of diagnostic imaging investigations), or the specimen was taken (in the case of pathology investigations).
	Result Status	The status of the investigation result – e.g. 'pending', 'interim', 'final'.
	Document Control	Information about the attached results or pending result (such as the version number, identifiers, document type, status and date attested) that will assist in the processing and document management of the attachment.
	EITHER	
	Link	A reference to an external repository where the investigation results are stored.
	OR	
	Data	The actual content of the investigation report. The report may use one of a variety of formats (as indicated in the Document Control details), including PDF, structured text, or XML using a NEHTA-defined template.
Attachments		Documents that have been attached to the Referral (either as a link or as data), because they are relevant to the ongoing care of the patient. For example, relevant pathology reports, relevant diagnostic imaging reports, referral letters, a care plan, and assessments.
	Document Name	The name of the attached document, to be used when referencing the attachment (e.g. "Full Blood Count")
	Document Control	Information about the attachment (such as the version number, identifiers, document type and date attested) that will assist in the processing and document management of the attachment.
	Document Section	The category or type of attachment – e.g. Pathology, Physical Assessment. This information may be used to organise references to the attachments into appropriate groups.
	Link	A reference to where the contents of the attachment can be found. This may either be an internal link that references a document within the same message, or a reference to an external repository where the attachment is stored.
	Data	The actual content of the attachment. The attachment may use one of a variety of formats (as indicated in the Document Control details), including PDF, structured text or XML structured using a NEHTA-defined template.
Document Control		Versioning and other document control information associated with the Referral document. These details are required for the technical exchange of the document and do not necessarily need to be displayed to the user. However, there may be value in displaying some items, e.g. date of referral.
	DateTime of Referral	The date/time when the Referral document was sent.
	Document Instance Identifier	The unique identifier of this instance of the Referral document.
	Document Set Identifier	The unique identifier of the set of documents related to the same admitted event, of which the Referral document is a versioned instance.
	Version Number	The version number of the Referral document instance.

Component	Item	Notes
	Document Originating System Identifier	A unique identifier of the system used to create the Referral document.
	Document Type	The name of the Referral document type used – e.g. "Core Referral"
	Document Type Version Number	The version number of the Referral document type used to create the Referral.
	Confidentiality Indicator	The degree to how sensitive information might be and the extent to which the information can be shared. This is currently reserved for future application and values have not been assigned to this indicator.
	Document Status	The status of the document (e.g. interim, final, corrected)
	Language	The language primarily used within the document (e.g. "en-AU")