

NZHUG Education Series 2-day Workshop on LOINC, HL7 and eOrdering



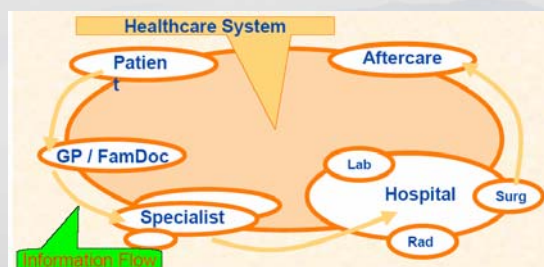
CDA and Referral, Discharge Summary, Shared EHR



*Dr Stephen Chu, NZHUG
12 November 2005*

Integrated Care

- Healthcare service focus now shifted from episodic acute care to managing chronically ill on an integrated care continuum

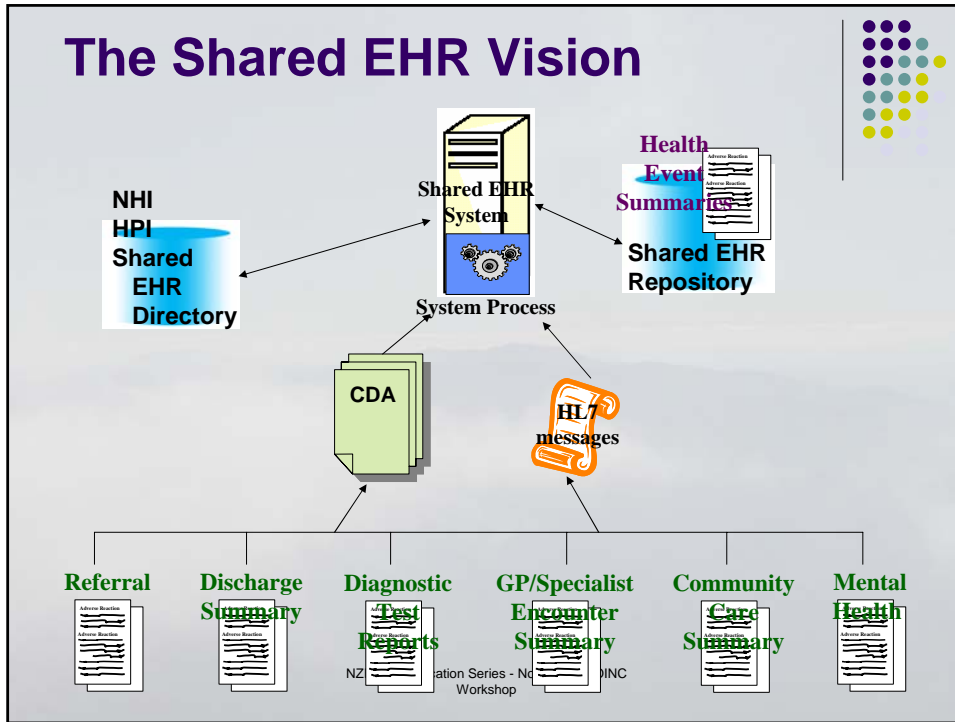


Information sharing:
critical to effective
integrated care
delivery

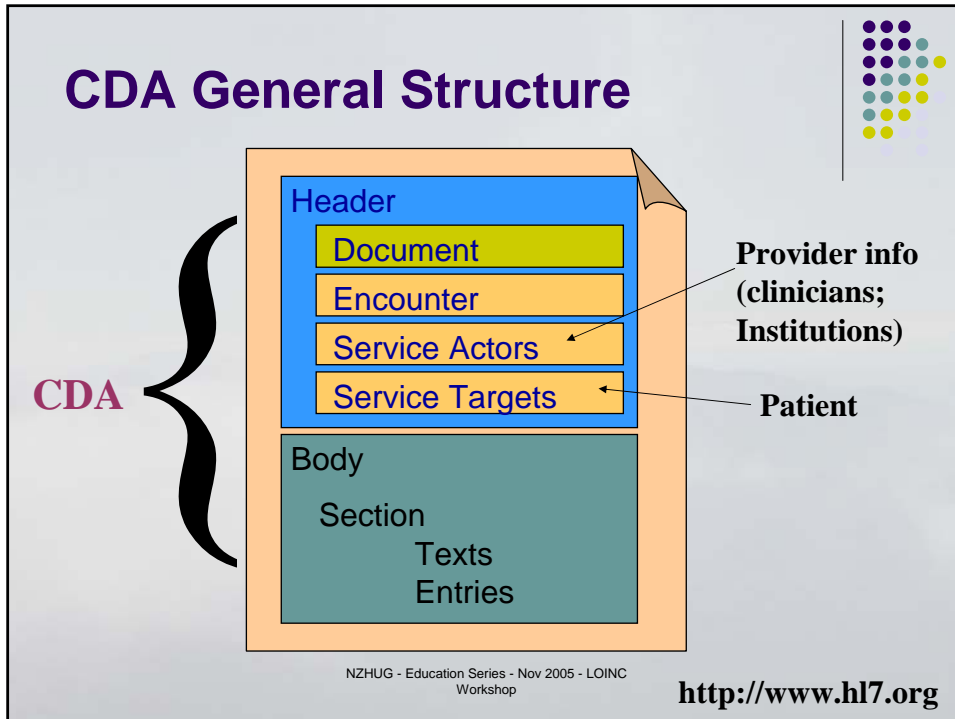
The Integrated Care Continuum

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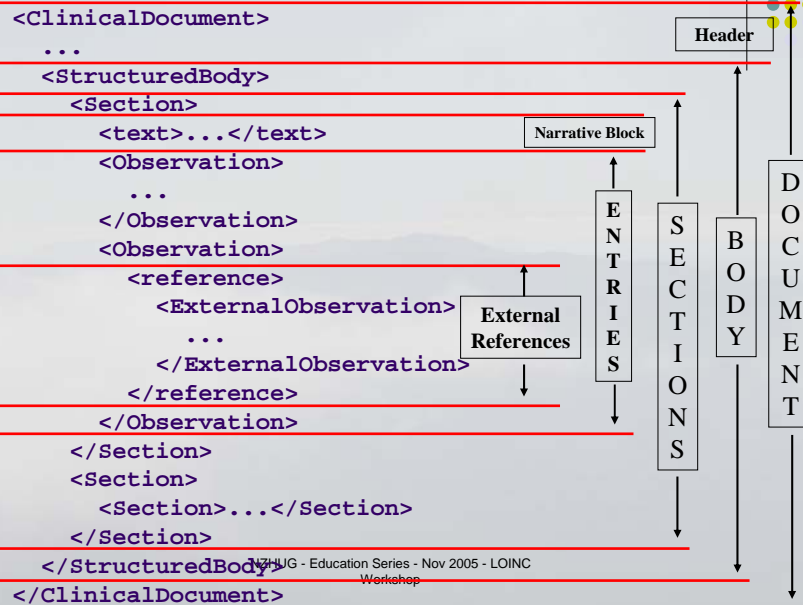
The Shared EHR Vision



CDA General Structure



CDA: Major components of Body



CDA: attractiveness

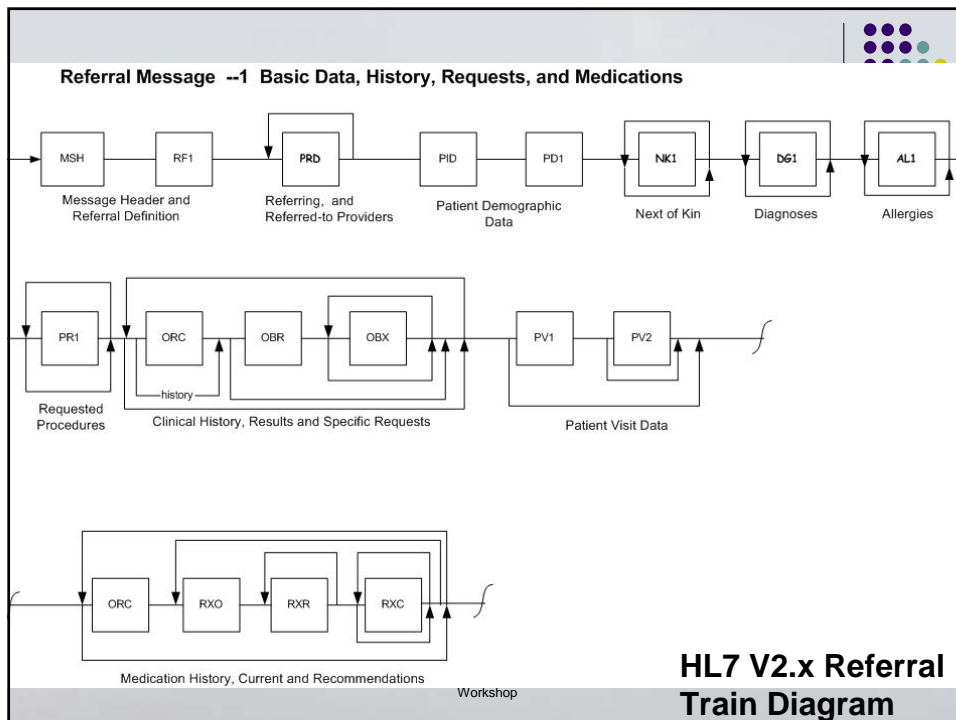
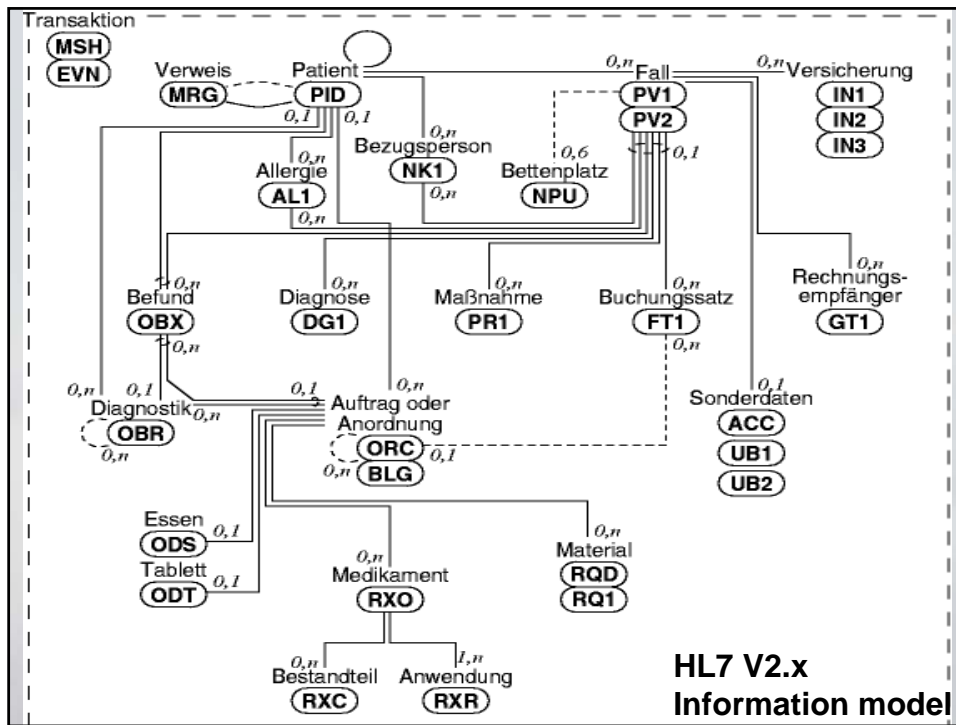
The screenshot shows a web browser displaying a "Good Health Clinic Consultation note". The page content includes fields for Consultant, Date, Patient, Birthdate, History of Present Illness, Past Medical History, Medications, Allergies, Social History, and Physical Examination. The "Medications" section lists: Theobor 200mg BID, Preventil inhaler 2puffs QID PRN, Prednisone 20mg qd, and HCTZ 25mg qd.

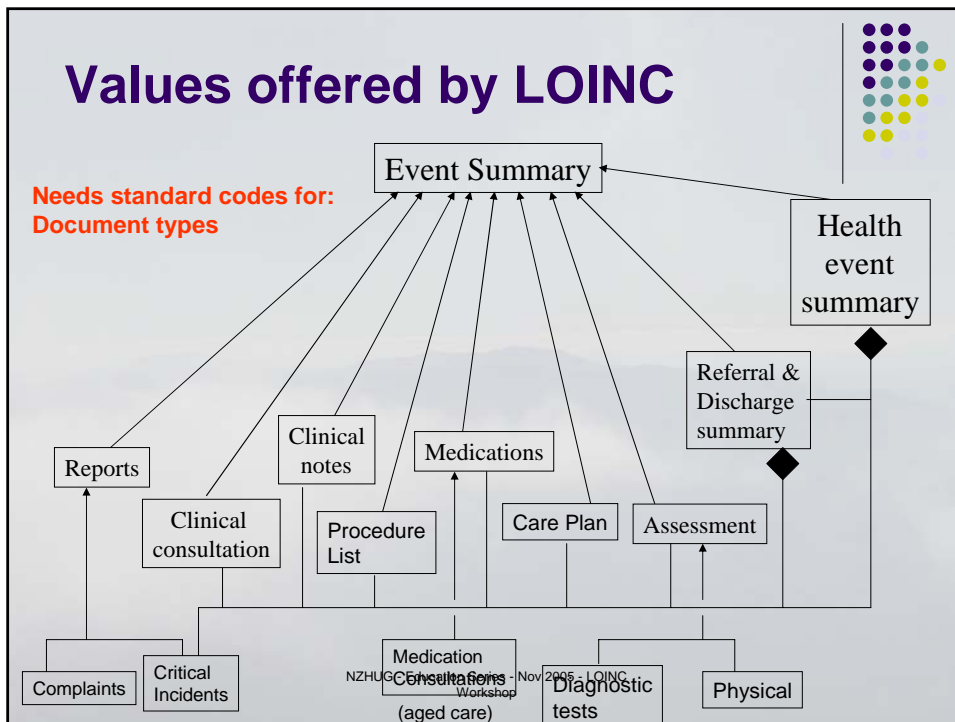
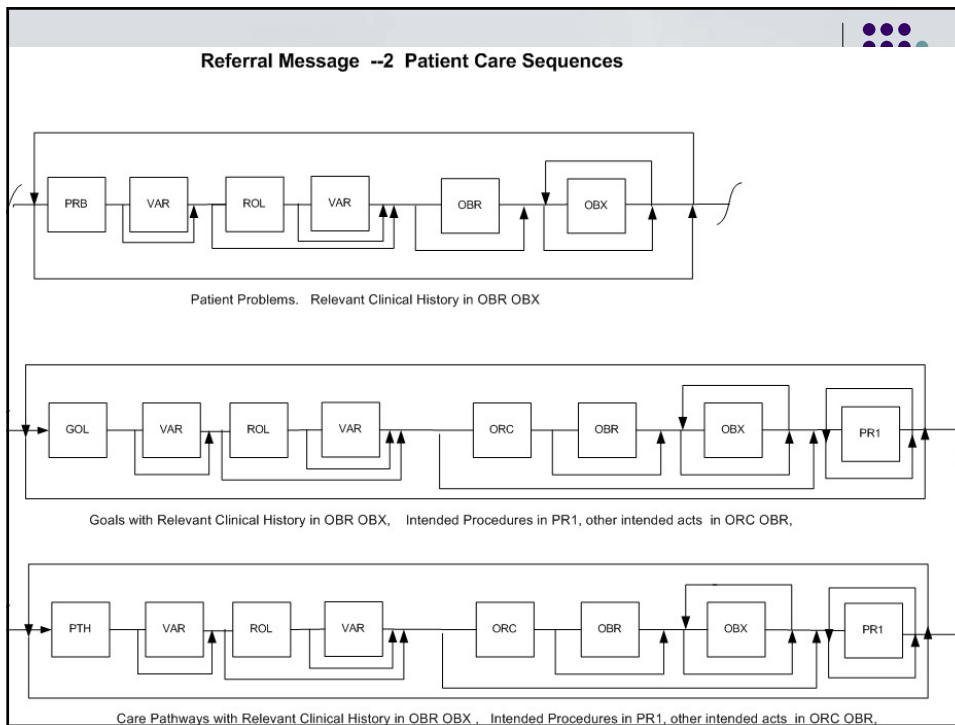
Annotations on the screenshot include:

- A box labeled "processable by applications" pointing to the top of the page.
- A box labeled "mandatory:" containing the XML snippet:

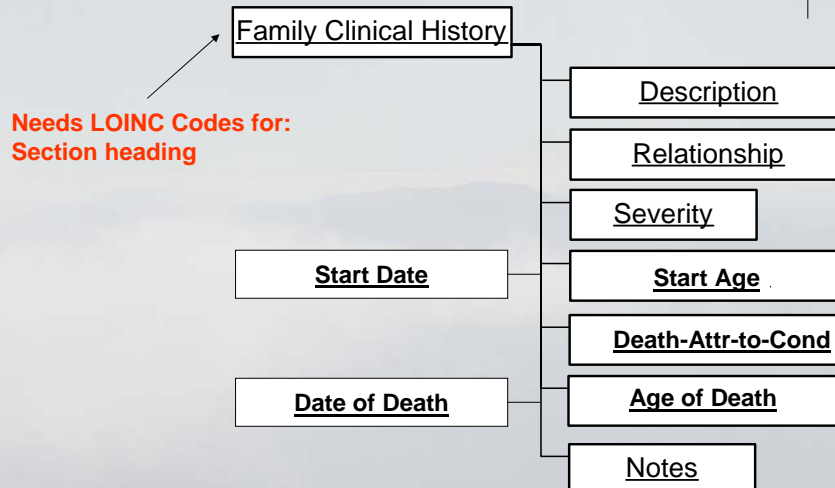

```
<caption>
            Medications
            </caption>
```
- A box labeled "optional:" containing the XML snippet:


```
<caption_cd V="10160-0"
            S="2.16.840.1.113883.6.1"/>
            Medications
            </caption>
```





Values offered by LOINC



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Values offered by LOINC



- Structured Document Technical Committee working with Templates SIG and LOINC
 - LOINC codes for Document Type
 - LOINC codes for Section Heading
- Advantages:
 - Standard naming conventions for document types and sections within documents
 - Improves searchability and processability on documents and sections

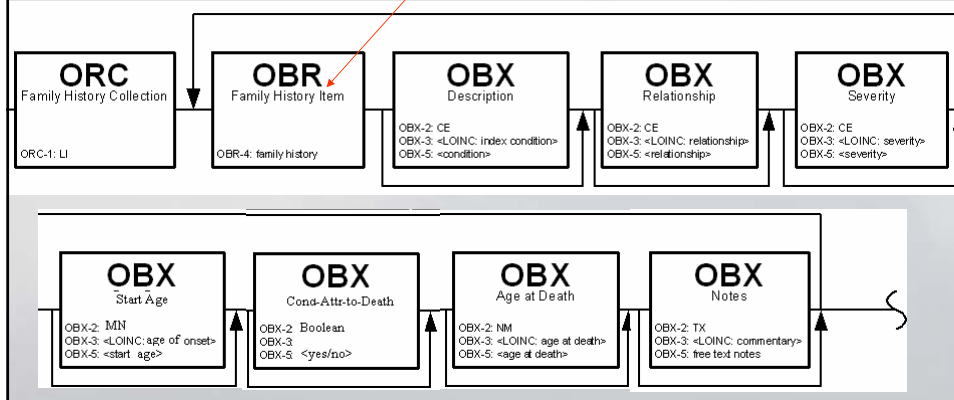
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Values offered by LOINC



- What about Version 2.x?

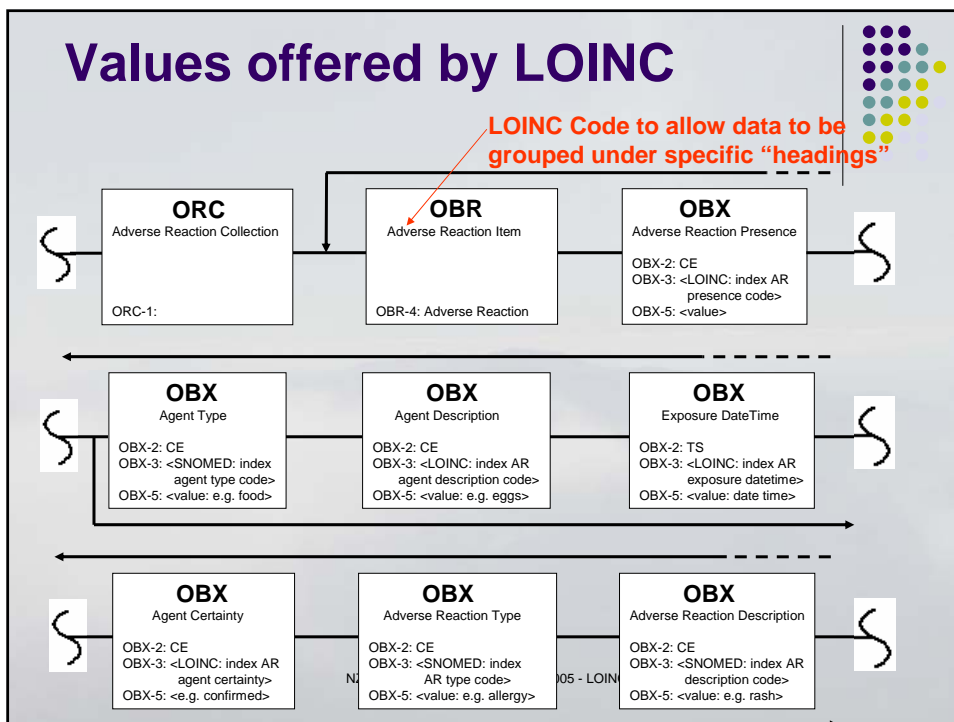
LOINC Code to allow data to be grouped under specific "headings"



Values offered by LOINC




LOINC Code to allow data to be grouped under specific "headings"

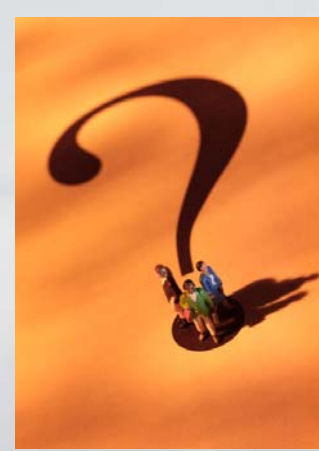


<p>Hospital Details Patient ID Patient Name Patient Address Patient DOB Patient Sex Patient's main contact (name, relationship, role & tel no.) Language (including if interpreter required)</p> <p>INTERIM/FINAL DISCHARGE Summary - (Summary Purpose) Admission Date Discharge Date Reason for Discharge Destination on Discharge</p> <p>Presenting problem(s) - Problems on admission Description</p> <p>Principal diagnoses Dx Status Description</p> <p>Other conditions/diagnoses Description</p> <p>Complications Description</p> <p>Problems on discharge Description</p> <p>Family Clinical History Description Relationship Age at onset Age at death Year of death</p> <p>Relevant Clinical History Problems/Diagnoses Description Date/Age at Onset Date/Age at Resolution</p> <p>Procedures Description Date</p> <p>Treatment Description Start Date Duration</p> <p>Investigations/Observations Description Date Findings</p> <p>Social Issues Description Start Date End Date</p> <p>Lifestyle Description Start Date Quantity End Date</p> <p>Risk Factors Description Start Date Quantity End Date</p> <p>Functional Status Description Score Assessed By/Date Swallowing Impairment Y/N</p> <p>CLINICAL SYNOPSIS (Comments on stay and management) Discipline Synopsis Author/Signatory (Name/Role) Date</p> <p>PROCEDURES Description Date</p> <p>INVESTIGATIONS - SUMMARY Service Provided Summary Result</p>	<p>MEDICATIONS Written Medication Instructions given to patient Y/N/U</p> <p>Preadmission Drug Details (Generic Name/ Strength/Form/ Brand Name) Dose/ Frequency/ Route</p> <p>Status</p> <p>During admission Drug Details (Generic Name/ Strength/Form/ Brand Name) Dose/ Frequency/ Route Treatment Duration Reason for new drug/ altered dose Administration details over 24 hrs prior to discharge Dose Time</p> <p>Status</p> <p>On discharge Drug Details (Generic Name/ Strength/Form/ Brand Name) Dose/ Frequency/ Route Supplied Amount/ Reason for new drug/ altered dose Administration details over 24 hrs prior to discharge Dose Time</p> <p>Status</p> <p>ADVERSE REACTIONS Identification Date Description Reaction Severity Certainty Evidenced By/Date</p> <p>ALERTS Type Description Date/Age at Onset End Date</p> <p>ADVANCE DIRECTIVES Description Start Date End Date</p> <p>CARE PLAN/FOLLOW-UP Follow-up care plan Start Date Title Pathway (for this patient) Providers</p> <p>Services arranged on discharge Start Date Type Providers</p> <p>Patient Instructions/Information Future appointments (including external referrals) Date Type Provider Name Location Reason</p> <p>CARE TEAMS Hospital Care Team Provider Name Provider Role Unit/Ward Contact Details</p> <p>Extra-Hospital Care Team Provider Name Provider Role Address Contact Details</p> <p>INTENDED RECIPIENT(S) Name Role</p> <p>AUTHOR/SIGNATORY Name Role Date</p>
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Standard codes for sections allow related data to be meaningfully grouped and rendered



Thank You



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