Referralrequest Fhir Resource Proposal
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Referral and Transfer of Care Request

This resource defines the information structure and related components to support the initiation of a request for referral and transfer of a patient to the care of another carer/provider.

Owning committee name

Patient Care

Contributing or Reviewing Work Groups

- Workgroup: Patient Care
- Project wiki link: Referral and Transition/Transfer of Care

FHIR Resource Development Project Insight ID

Pending

Scope of coverage

- In scope:
  - Patients (especially those with complex health conditions) are care for by multi-disciplinary health care teams. They may also be transitioned between different health care settings (e.g. from acute care to rehabilitation or long term care/skilled nursing facilities). The referral and transition of care processes with appropriate supporting documents are required to initiate and complete these processes.
  - The referral and transfer of care request resources will be designed to enable exchange of crucial administrative and clinical information to request the initiation of the referral process.
  - Administrative data are likely to include: Patient details, provider and provider organisation details (and others to be identified).
  - It is not uncommon for "care plan" or components of care plan to be included in a referral or transition of care information package.

- Out of scope:
  - While pathology and imaging studies requests are increasingly considered as a specialization of referral, until there is industry wide agreement on this thinking, such requests should use the Diagnostic Order resources [http://www.hl7.org/implement/standards/fhir/diagnosticorder.html]

RIM scope

- Patient Care D-MIM and R-MIMs
- Others???
Resource appropriateness

- Referral or Transfer of Care request is one of the two critical processes and information requirements in continuity of care, collaborative care and transition of care for patients among different health care settings and facilities
- The other critical resource is Referral or Transfer of Care fulfillment resource(s)

Expected implementations

- As referral and transition of care request messages
- As Referral Request or Transfer of Care request CDA documents and CCD

Content sources

- Patient Care - Care Provision/Care Transfer Models
- C-CDA Referral Note and CCD templates
- IHE PCC
- Other international sources: e.g. NHS, Australia (NEHTA)

Example Scenarios

- **Referral** type scenarios:
  - Referral for second opinion (aka "consult"/"consultation")
    - There is **partial transfer of care responsibility** from the referring provider to the referred to provider on the health issue/problem for which the referral is made
  - Referral for specific procedure(s) (e.g. bronchoscopy, gastroscopy, +/- biopsy; endodontic procedures)
    - There is also **partial transfer of care responsibility** from the referring provider to the referred to provider for the duration of the procedure and any follow-up management considered necessary/appropriate by the referred to provider
    - Referral for management of specific issues/problems
      - There is a **complete transfer of care responsibility** from the referring provider to the referred to provider with regard to the health issue/problem for which the referral is made.
      - The referring provider retains complete care responsibility of all other health issues/problems that this patient may have
      - The referred to provider may need to manage those other health issues/problems as co-morbidities during the duration the patient is under his/her care (e.g. when the patient requires hospital care away from the referring provider)

- **Transfer of Care** Scenarios:
  - Short term transfer
    - The transfer of care responsibility is temporary
    - When the care responsibility is returned to the original carer/provider/organization, another transfer of care activity is initiated
    - This may also be referred to "handover"
    - Examples:
      - A patient is transferred from an aged care/skilled nursing facility to an acute care hospital to manage a complex short term health problem, e.g. an episode of acute urinary tract infection, bronchopneumonia
      - A patient is transferred from a carer/family to respite care to give weekend relief to the carer/family
      - A clinician provides after hours/overnight or weekend coverage
      - (A referral may result in short term transfer of care)

  - Long term/Permanent transfer:
    - A carer/family/provider/organisation agrees to and takes over the care responsibility of a patient permanently or for an extended period of time
    - Examples:
- A provider (e.g., GP, PCP or specialist) takes over the care responsibility of a patient permanently because the patient wants to be cared for by a different provider; or when the primary/specialist provider retires
- A rehabilitation facility/aged care or skilled nursing facility takes over the care responsibility of a patient when discharged from acute care hospital

Resource Relationships

- Patient Resource as the "subject of Care"
- Provider and Organization Resources as the "author" and "recipient(s)"
- Clinical Resources include:
  - Condition/Concern
  - Family History
  - Observation
  - Allergy/Intolerance, Adverse Reaction
  - Medication (including Medication, Prescription, Dispense, Medication Statement, Immunization, Immunization Recommendation)
  - Procedure
  - Diagnostic Order, Diagnostic Report, Imaging Report
  - Care Plan

Timelines

- Referral/Care Transition resources development - Aug/Sept 2014
- Referral/Care Transition resources ready for QA - Prior to Sept 2014 WGM for QA process
- Content ready for inclusion in FHIR DSTU ballot - January 2015
- Ballot content published as part of next DSTU - March 2015
- PCWG FHIR Clinical Resources to align with/inform use of relevant C-CDA templates - May 2015

gForge Users

- Stephen Chu
- David Hay