Consultation Paper

Pathology

and the

PCEHR System

25th June 2014
Table of Contents

1. THE PURPOSE & AUDIENCE OF THIS DOCUMENT .................................................................................................................... 3

2. BACKGROUND ............................................................................................................................................................................. 3
   2.1. The PCEHR System in 2014 .............................................................................................................................................. 3
   2.2 Pathology within Australia ................................................................................................................................................... 3
   2.3 Consultation to date ............................................................................................................................................................... 4

3. OBJECTIVES & BENEFITS OF PATHOLOGY REPORTS IN THE PCEHR .............................................................................. 4

4. THE UPCOMING FEEDBACK PROCESS ................................................................................................................................. 5

5. PROPOSED MODEL ...................................................................................................................................................................... 6
   5.1. What has been agreed so far ............................................................................................................................................... 6
   5.2. High level process flow ....................................................................................................................................................... 7

6. ISSUES FOR FURTHER DISCUSSION ..................................................................................................................................... 8
   6.1. Authority-to-Post Process – clinical issues ......................................................................................................................... 8
   6.2. Authority-to-Post process – technical issues ..................................................................................................................... 9
   6.3. Viewing pathology reports in the PCEHR .......................................................................................................................... 10

APPENDIX A: Viewing pathology reports in the PCEHR – proposed key design principles .................................................. 11
APPENDIX B: Sample pathology report views .......................................................................................................................... 12
APPENDIX C: Proposed metadata for PCEHR pathology reports & ATP Messages ............................................................... 13
1. The purpose & audience of this document

The purpose of this paper is to present a model for including community based pathology reports in the Personally Controlled Electronic Health Record (PCEHR) system. The model’s development is based on requirements for the health community, combined with feedback received from health stakeholders in a consultation process that took place in the second half of 2013. It seeks to gain further input from stakeholders on the appropriate way forward for solution design and build.

The paper provides:

- A background to the PCEHR and the consultation process to date;
- Objectives and benefits sought by all parties (from Government, the health sector and the community);
- A starting point for further consultation; and
- Issues for further discussion.

The information you supply in response to this document will be used to refine the model further (as described below in section 4).

2. Background

The PCEHR connects individuals and healthcare providers, to streamline services and provide ready availability of important health information such as diagnoses and medications. It facilitates more accessible, efficient and effective healthcare in a system that utilises healthcare identifiers, authentication services, standards (and information exchange) and secure messaging.

On 19 May 2014, the Government released the report from the Review of the PCEHR. The report found strong support for continued development and implementation of the electronic health record system and recommends, among other things, to proceed with the integration of diagnostic imaging and pathology reports into the PCEHR.

2.1. The PCEHR System in 2014

The PCEHR system currently provides access to the following types of health care documentation:

- Shared health summaries – a clinically reviewed summary prepared by an individual’s key healthcare provider;
- Event summaries – to capture key information about a key healthcare event relevant to ongoing care;
- Discharge summaries – to capture information about an acute healthcare event relevant to ongoing care;
- Specialist letters – to capture key information about specialist visits;
- Referrals – currently from GPs to specialists; and
- Prescription and dispense records.

The system also enables individuals to add Medicare information, and to create their own personal health summary and health notes. It provides access for participating individuals (people to whom the record relates, including authorised or nominated representatives) and healthcare providers via the following services:

- **Individual (including nominated & authorised representatives):** Accessed via the National Consumer Portal and viewed through a compatible web browser; and
- **Healthcare Provider:** Accessed via the National Provider Portal, an integrated Clinical Information System, or a Patient Administration System, with specialist clinical software in use to create these.

Information in the PCEHR system can be accessed as individual documents or through views which bring together clinical documents (such as prescription and dispense records) and displays them in a predictable way.

2.2 Pathology within Australia

Pathology services in Australia are provided across a variety of settings.

For community based pathology, requests are initiated by the GP or specialist and are fulfilled by a pathology provider of the individual’s choice (although GP/specialist may select a provider and transmit an electronic request). The majority
of requests are fulfilled by private pathology providers. According to Pathology Australia, private pathology laboratories distribute in excess of 40 million reports electronically each year. In general practice, at least 93%\(^1\) receive reports electronically while for specialist clinicians approximately 62%\(^2\) receive reports electronically.

In the fiscal year 2012/13 there were 83,801,556\(^3\) Medicare items claimed for referred pathology services.

2.3 Consultation to date

Consultation on the inclusion of pathology information in the PCEHR has been undertaken during 2009-2011. Further consultation was undertaken as part of developing the PCEHR Concept of Operations.

A series of three stakeholder workshops (as well as technical and clinical sessions) were held between July and December 2013. This work was paused following the announcement of the PCEHR Review in late 2013. Further feedback on the value of pathology information in the PCEHR was received and the Review Report recommended proceeding with the inclusion of pathology reports into the PCEHR.

3. Objectives & Benefits of Pathology reports in the PCEHR

Objectives and benefits of Pathology reports in the PCEHR are supported by the following high level objectives, identified by NEHTA's Diagnostic Services Reference Group (DSRG) in 2011, in consultation with key stakeholders. These objectives continue to guide the design and implementation of pathology functions in the PCEHR system.

1. Improving access to information for providers who do not currently have access.
   Providers involved with an individual's care may not currently get access to pathology reports unless they are the requester. Giving all providers greater access to pathology reports may reduce time spent on collection of information and result in better continuity of care for the individual.

2. Improving timeliness of information.
   Sharing pathology information via the PCEHR will be more time-efficient in many cases, as it will provide a single endpoint to which documents can be sent.

3. Maintaining individual control over access to information.
   As with other areas within the PCEHR, it is important that control over pathology information remains with the individual concerned, and that an adequate set of controls are provided for this purpose.

4. Reducing unnecessary duplicate testing.
   Better availability of information about pathology tests that have been completed has the potential to reduce the occurrence of unnecessary duplicate tests.

5. Better engagement of individuals with their own healthcare.
   Giving individuals' visibility of their own pathology information will have the potential to yield improved safety, and will also assist with increasing the ability for individuals to manage their own healthcare.

   Quality and integrity of pathology information will be critical to ensuring safety when sharing pathology information via the PCEHR.

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\(^1\) General Practice Activity in Australia, BEACH 2011-12
\(^2\) The eHealth readiness of Australia's medical specialists. Department of Health and Ageing May 2011
4. The upcoming feedback process

The Department will be engaging with a broad range of stakeholders in the healthcare sector to progress the design for the inclusion of pathology reports in the PCEHR. A series of workshops with key stakeholders are planned, commencing in July 2014, at which agreements reached in the previous rounds of consultation held in 2013 will be confirmed and outstanding issues progressed. A further workshop is planned for early August with a third workshop to occur in early September if required.

A written submission process is also being undertaken with responses due by 18 July 2014. Feedback should be provided via email to ehealth.consultations@health.gov.au. The outcomes of the written submission process will be summarised and brought to the August consultation workshop for further discussion.

To enable detailed technical discussion to occur on issues and design options identified, a co-design technical working group is being established through a nomination process. They will be tasked with reviewing and providing input to the design of the integration solution that supports the inclusion of pathology and diagnostic imaging reports in the PCEHR system. The groups will consider the following aspects within their remit:

- Clinical and technical workflows;
- Design, appearance and functions of screens involved (portal and desktop);
- Implementation, education and communication issues for both end users and software vendors;
- Processes to assure that the solution is usable and appropriate, complementing existing clinical functional testing and usability programmes; and
- Processes to support the evaluation and assessment of outcomes following implementation.

The co-design technical working groups will also be a key input to resolving technical issues identified through broader consultation. Nominations for the co-design technical working group have already been sought. The working group is anticipated to have short regular meetings, the outcomes of which will inform the design process and will be discussed at consultation workshops. The first meeting of the working group will be held in mid July 2014.

The information you supply in response to this document will be used to refine the model further for exposure and testing in the feedback process outlined above.
5. Proposed model

The proposed model presented within this section was established during consultation in 2013 and is broadly aligned with the model developed by DSRG in 2009/11. The key premise behind it is that an ‘Authority-to-Post’ (ATP) message must be provided by a reviewing healthcare provider prior to the Pathology Provider making a pathology report available in the PCEHR. The review process lessens the likelihood that sensitive reports are made available on an individual's PCEHR. It also provides assurance to a healthcare provider that a report has already been clinically reviewed.

During consultation broad agreement on the proposed model was reached however there are several outstanding issues which remain for resolution. This feedback process seeks confirmation that high level principles outlined in the following section are aligned with your understanding. We also require your input on outstanding issues (described in section 5.3) including detail on any further concerns that you have in relation to the proposed model.

5.1. What has been agreed so far

The following provides a summary of the high level solution principles agreed during consultation that underpin the proposed model.

1. The design should leverage existing technical infrastructure wherever possible.
2. The design should aim to integrate with existing clinical workflow and be aligned with medico legal responsibilities wherever possible.
3. The decision on what pathology reports should be made available in the PCEHR rests with the treating clinician and the individual.
4. When reviewing a report a healthcare provider may choose to authorise that a report is made available in the PCEHR, by sending an Authority-to-Post (ATP) message to the pathology provider. The healthcare provider can choose whether or not they need to consult with the individual prior to sending the ATP message.
5. The ATP message can be provided by any healthcare provider reviewing a report, including copy-to healthcare providers.
6. The authoring pathology provider is responsible for ensuring that:
   - All reports (that they make available) in the PCEHR have been authorised by a healthcare provider.
   - Outdated (and potentially inaccurate reports) are not available in the PCEHR.
   - Only one copy of a report is available in the PCEHR regardless of the number of ATP messages received.
7. A mechanism for uniquely identifying a specific version of a report is required across the integrated solution, i.e. preliminary, final or corrected.
8. Healthcare Identifiers (for individuals and healthcare providers) to be used across the integrated solution wherever possible, to ensure that only the right people have access to patient information and to ensure that newly acquired patient information is matched correctly with existing patient records.
9. The report will be made available in the PCEHR in immutable format (PDF). Information that supports the searching, viewing and auditing of reports will also be provided (detailed at Appendix C).
10. A new national technical specification to support the electronic transfer of ATP messages between healthcare providers and pathology providers will be required.
11. The development and implementation of standards, including terminology is required before pathology reports that include atomic data can be made available through the PCEHR.
12. The PCEHR will only use standard terms for filtering, grouping or searching of pathology reports in the National Provider or Consumer Portals. Guidance and conformance requirements will be provided to software vendors on how pathology report views should be displayed and managed in their systems.
13. Healthcare providers will be able to view a history of an individual’s pathology reports using the National Provider Portal and Clinical Information Systems.
14. Individuals will be able to view and remove pathology report(s) from their PCEHR using the National Consumer Portal.
5.2. High level process flow

This section describes the high level process flow for the proposed model.

### Proposed Model - Pathology Provider Uploads - Authority-To-Post (ATP)

```
1. Patient Attends Consultation
2. Pathology Request
3. Distribute Report
4. Clinical Curation
5. Authority-To-Post
6. ATP Message: Validation
7. Upload Report
8. Remove Report

Assumptions:
- Individual has registered for a PCEHR – therefore has provided 'standing consent' for healthcare providers to upload health information to their PCEHR.
- Healthcare provider is an Australian healthcare provider registered with the PCEHR system.

Legend
- Internal Process
- External Flow

Note: The ATP Message provides instruction as to whether a pathology report should be made available on an individual’s PCEHR.

Note: The Pathology Provider will remove a previously uploaded report when a new version is made available or when a healthcare provider revokes a previously provided ATP.
```

### Key steps:

1. Consultation between healthcare provider and individual occurs.
2. Healthcare provider determines that a pathology test is required. The pathology request is printed and provided to individual and may also be sent to the pathology provider electronically.
3. Pathology report is generated by the pathology provider (with PDF version attached). The report is then sent to the requesting healthcare provider and any other copy-to healthcare providers.
4. Pathology report is reviewed by a healthcare provider and communicated to the patient as per current practice, e.g. results as expected so no follow up consultation with patient required, or abnormal result so follow up phone call or consultation with patient required.
6. The healthcare provider sends an ATP message to the pathology provider to authorise the report’s upload to the PCEHR.
7. The pathology provider validates the ATP message.
8. The pathology provider ensures that the report (specified in the ATP) is made available in the PCEHR.
9. Upon receipt of an ATP message revoking a previously provided ATP, the pathology provider will remove the specified report from the PCEHR. When a report is superseded the pathology provider will also be responsible for removing the outdated (and potentially inaccurate report) from the PCEHR.
6. Issues for further discussion

In relation to the proposed model the following issues have been raised and require resolution. As part of the formal feedback process we seek your advice regarding these issues and associated open questions.

The Department appreciates that you may have further issues regarding the proposed model and would encourage you to provide details so that they may also be considered.

6.1. Authority-to-Post Process – clinical issues

1. Impact on clinical workflow

Concerns were raised about potential impact of the ATP process on clinical workflow, in particular:

- How the ATP process would fit with existing clinical workflows associated with reviewing reports;
- The processes for authorising or removing reports from the PCEHR; and
- How healthcare providers will inform other healthcare providers when consent is withdrawn by an individual for a report to be made available in the PCEHR.

It is recognised that more work needs to be done with clinicians and software vendors to ensure that design of the ATP workflow in clinical systems integrates well with existing practices. It is proposed that the co-design technical working group (clinical and technical representatives) will review the proposed workflow and provide input to design of clinical information systems.

Open Questions:

Do you have any other specific concerns in relation to the potential impact on clinical workflow?
Do you have any recommendations on how the clinical workflow issues could be addressed?

2. Medico legal concerns

During consultation concerns were raised about potential additional medico legal responsibilities implied under the proposed ATP model, in particular, where clinical curation of a report has not been provided by a healthcare provider and the ATP decision remains outstanding.

As well as seeking your feedback on this issue, advice will be sought from the Medical Defence Organisations (MDO) regarding the medico legal responsibilities associated with the proposed solution.

Open Questions:

Do you have any other specific concerns in relation to medico legal responsibilities?
Do you have any recommendations on the proposed model that may help to alleviate medico legal concerns?

3. Requirement for clinical review and ATP may impact on the number of reports available in the PCEHR

Concern was raised during consultation that reports may not be uploaded in a timely manner (or at all) due to the dependency on healthcare providers having to provide an ATP prior to a report being made available in the PCEHR. In particular many specialists and allied health professionals do not have the IT infrastructure to provide an ATP message.

This is considered to be a broader eHealth issue which probably cannot be addressed within the scope of this project.
6.2. Authority-to-Post process – technical issues

1. **Capability of software vendors to make the required modifications to their products**

During consultation the following technical issues were raised on the proposed ATP based solution:

- The model requires a two-way messaging capability between healthcare provider and the pathology provider. During consultation pathology providers advised that the majority of pathology providers only support outbound messaging and that implementation of an inbound messaging capability (clinical information system \(\rightarrow\) pathology provider) would come at significant cost and impact on time to market. It is also understood (to be confirmed) that the majority of clinical information system software products do not support an outbound messaging capability required for ATP (message from clinical information system \(\rightarrow\) pathology provider); and
- Pathology provider software vendors also advised that they may need technical or other support to assist them to integrate with the PCEHR owing to limited capability and knowledge of PCEHR compatible messaging specifications and formats (particularly CDA) within their organisations. NEHTA have advised that they are able to provide technical assistance and guidance to software vendors to assist them integrate with the PCEHR and implement the ATP model.

**Open Questions:**

Do you have any feedback on the type of technical support that software vendors might require?

Do you have any other concerns in relation to software vendor capabilities?

Do you have any recommendations on the proposed model that may help to alleviate any technical implementation issues?

If you are a clinical information system (CIS) software vendor do you support an outbound HL7 messaging capability (CIS \(\rightarrow\) pathology provider)?

If you are a pathology provider software vendor do you support an outbound HL7 messaging capability (CIS \(\rightarrow\) pathology provider)?

2. **Authority-to-Post - new national technical specification**

During the first round of consultation, broad agreement was received from a technical perspective that the ATP model was feasible and the new messaging requirements related to ATP should be based on the existing HL7 messaging framework.

It was also agreed that a new national technical specification to support the electronic transfer of ATP messages between healthcare providers and pathology providers would be required. It is proposed that NEHTA will draft the new ATP messaging specification based on input received during consultation. It is also proposed that NEHTA and the Department will seek detailed feedback on the draft specification via the co-design technical working group. At the time broad agreement was also reached on the type of metadata accompanying a pathology report and an ATP message (Appendix C).

**Open Questions:**

Do you have any technical feedback on the following:

- Proposed metadata for pathology reports and ATP messages (Appendix C)?
- Proposal to use the PCEHR Document ID as the unique report identifier across the integrated solution (described in Appendix C).
- Proposal that a pathology report may include details of one or more tests.
- Proposal that the IHI is verified by the healthcare provider and passed onto the pathology provider in the ATP message.
- Currently the maximum file size for clinical documents in the PCEHR is 10 MB – is this adequate?
- Proposed process for developing the new national ATP specification?
6.3. Viewing pathology reports in the PCEHR

1. *The absence of underpinning standards and terminology may make it difficult to locate pathology reports in the PCEHR.*

In terms of the development of underpinning standards and terminology, the Pathology Information Terminology Units and Standardisation (PITUS) project is currently working on the development of standards for information in pathology requests and reports and to facilitate their uptake by pathology practices and their customers to allow safer and better quality use of pathology. During consultation, software vendors advised that they would be reluctant to make changes to their products in terms of incorporating new standards and terminologies if they had not been developed through the PITUS project.

Given the lack of underpinning standards, careful consideration was given during the previous round of consultation in regard to the type of metadata that should accompany an ATP message and a pathology report. Through clinical and technical working groups, significant progress was made in terms of reaching agreement on the type of metadata that could accompany a pathology report and an ATP message (Appendix C).

Taking into account clinical safety, usability and the lack of underpinning standards the Department has drafted key design principles for PCEHR Pathology Report Views for your consideration (Appendix A). Sample Pathology Report views based on the proposed key design principles are also provided at Appendix B.

**Open Questions:**
- Do you have any feedback on the proposed design principles for viewing pathology reports in the PCEHR as detailed in Appendix A?
- Do you have any feedback on the sample Pathology Report Views as provided in Appendix B?
- Do you have any feedback from a clinical perspective on the proposed metadata for pathology reports and ATP messages (Appendix C)?
APPENDIX A: Viewing pathology reports in the PCEHR – proposed key design principles

Taking into account clinical safety, usability and the lack of underpinning pathology terminology standards the Department has drafted the following key design principles for PCEHR Pathology Report Views for your review and feedback.

Refer to Appendix B for sample Pathology Report views based on the proposed key design principles.

1. **Pathology Report List – Proposed Column Headings**
   - Specimen Collected Date (should always be displayed first);
   - Pathology Organisation;
   - Requesting Organisation;
   - Pathology Discipline;
   - Test Name;
   - Test Status: preliminary, final or corrected; and
   - Local Report ID – Identifier assigned to a pathology report by the pathology provider. It is used today in communications between healthcare providers and pathology providers. It is usually printed on the pathology report and can be used as a reference for follow up communications between a healthcare provider and the pathology provider.

   **Note:**
   - Standard terminologies are not currently available for ‘Pathology Discipline’ and ‘Test Name’.
   - Other metadata included in the clinical document will be available when the report is opened for viewing. Refer to Appendix C for a full list of proposed metadata for pathology reports.

2. **‘Group-By’ Options**
   - Pathology Report (Default View) - in this grouping the view will show all pathology tests belonging to the same Pathology Report grouped together;
   - No Grouping – in this grouping the view will show a list of all pathology tests ordered by reverse chronological Specimen Collected Date;
   - Pathology Organisation Name; and
   - Requesting Organisation Name.

   **Note:** Grouping by ‘Pathology Discipline’ and ‘Test Name’ is not supported due to lack of standard code sets for these terms.

3. **Filters for Pathology Report Views**
   - Due to lack of standard code sets it is proposed that the only filter that could be safely applied is one based on the ‘Specimen Collected Date’; and
   - The default date range for the filter is proposed to be 24 months.

4. **Ordering of Pathology Reports in Views**
   It is proposed that ordering within views should only be provided on the following fields:
   - Pathology Organisation Name;
   - Requesting Organisation Name; and
   - Specimen Collected Date Time.

   **Note:** Ordering by ‘Pathology Discipline’ and ‘Test Name’ is not supported due to lack of standard code sets for these terms.
APPENDIX B: Sample pathology report views

The following sample PCEHR Pathology Report Views have been drafted based on the proposed key design principles for Pathology Report Views (detailed at Appendix A).

Group by Pathology Report

No Grouping

Pathology Report View

This view is not a complete record of your pathology information. 
Note: Your search could return information created up to 2 hours before the start date and up to 5 hours after the end date you select. This is to cater for the different time zones in Australia. At times this may mean the search will return information about healthcare events on the day before or after the date selected.

Group by: Pathology Report

Specimen Collected Date Pathology Organisation Requesting Organisation Pathology Discipline Test Name Test Status Report ID

20 Nov 2012 North Ryde Labs 2 Tests (Specimen Collected Date from 20 Nov 2012 to 27 Nov 2012) 12-5566946-HIE-1
25 Nov 2012 North Ryde Labs Big Health Clinic Haematology FBC Final 12-3566943-HIE-1
27 Nov 2012 North Ryde Labs Big Health Clinic Immunology SLE Final 12-3566943-HIE-1

15 Nov 2012 North Ryde Labs 2 Tests (Specimen Collected Date from 15 Nov 2012 to 16 Nov 2012) 12-5566940-BBE-2
15 Nov 2012 North Ryde Labs Sam’s Clinic Biochemistry Electrolytes Final 12-3566940-BBE-2
16 Nov 2012 North Ryde Labs Sam’s Clinic Immunology SLE Final 12-3566940-BBE-2

13 Nov 2012 North Ryde Labs 2 Tests (Specimen Collected Date from 13 Nov 2012 to 17 Nov 2012) 12-1310-MG22

Specimen Collected Date Pathology Organisation Requesting Organisation Pathology Discipline Test Name Test Status Report ID

25 Nov 2011 South Sydney Labs Big Health Clinic Haematology FBC Final 12-4566-GDPL
21 Nov 2012 North Ryde Labs John’s Health Clinic Haematology FBC Final 12-254234-YTF-1
20 Nov 2012 North Ryde Labs Healthy People Clinic Biochemistry Electrolytes Final 12-554081-FRT-2
19 Nov 2012 North Ryde Labs Healthy People Clinic Microbiology Electrolytes Final 12-554081-FRT-2
18 Nov 2012 North Ryde Labs John’s Health Clinic Forensic SLE Final 12-25234-YFT-1
17 Nov 2012 South Sydney Labs Lasting Health Clinic Immunology SLE Final 12-4218-HNLT
16 Nov 2012 North Ryde Labs John’s Health Clinic Genetics Cystic Fibrosis Final 12-25234-YFT-1
APPENDIX C: Proposed metadata for PCEHR pathology reports & ATP Messages

PCEHR Pathology Reports

Broad consensus was reach during consultation on the type of metadata that should be associated with a pathology report. The list below includes a new field ‘PCEHR Document ID’ - not previously discussed during consultation. It is proposed that the PCEHR Document ID is used as the unique identifier for a specific version of a report across the integrated solution.

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Details</td>
<td>IHI, First Name (if available), Last Name, DOB, Gender.</td>
</tr>
<tr>
<td>Local Report ID</td>
<td>Identifier assigned to a pathology report by the Authoring Pathology Organisation. It is used in communications between healthcare providers and the pathology provider.</td>
</tr>
</tbody>
</table>
| PCEHR Document ID           | In previous consultation it was proposed that the NATA ID, Local Report ID and Request ID could be combined to constitute a unique identifier for a report. However further advice received has indicated that this approach may not be feasible for the following reasons:  
  - Request ID will probably only be available for electronic requests;  
  - The Local Report ID may not always be globally unique; and  
  - Some pathology providers may use the same Local Report ID for the initial and subsequent versions of a report, i.e. Interim, Final, Corrected.  
  When a clinical document is made available in the PCEHR the author is responsible for assigning a globally unique document ID (PCEHR Document ID). It is proposed that the PCEHR Document ID is assigned at the same time that the report is generated so that it can be used as the key identifier for the document across the integrated solution. |
| Lab ID                      | The NATA ID of the Pathology lab that ran the test.                                                                                                                                                         |
| Report Name                 | The Report Name provides a short description for the tests in a report (if available).                                                                                                                     |
| Report Status               | For the report as a whole, a value for Report Status (if available).                                                                                                                                       |
| Report Date Time            | The date and time the report was generated as a PDF by the pathology provider.                                                                                                                             |
| Test Name                   | For each test result within the report the Test Name provides a short description of the test. It differs from the Pathology Discipline by providing a more clinical description of the testing such as Full Blood Count, rather than Haematology. |
| Pathology Discipline        | For each test result within a report - Pathology Discipline will be provided, e.g. Haematology.                                                                                                              |
| Test Status                 | For each test result within a report - a value for Test Status will be provided.                                                                                                                            |
| Specimen Collected Date Time| For each test result within a report - the date and time (time if available) the specimen was collected.                                                                                                  |
| Authoring Pathology Organisation | The Healthcare Identifier (HPI-O) and name of Authoring Pathology Provider Organisation.                                                                                                               |
| Authoring Pathologist       | The Healthcare Identifier (HPI-I) and name of the Authoring Pathologist.                                                                                                                                    |
| Uploading Healthcare Organisation | The Healthcare Identifier (HPI-O) and name of the organisation that made the report available in the PCEHR.                                                                                          |
| Uploading Healthcare Professional | The Healthcare Identifier (HPI-I) and name of the Uploading Healthcare Professional.                                                                                                                      |
| Request ID                  | Identifier assigned to the request by a Requester (if available).                                                                                                                                           |
| Requesting Healthcare Provider Organisation | The Healthcare Identifier (HPI-O – if available) and name of the Requesting Healthcare Provider Organisation.                                                                                       |
| Requesting Healthcare Professional | The Healthcare Identifier (HPI-I – if available) and name of the Requesting Healthcare Professional (where available).                                                                                   |
| Requested DateTime          | The date and time (time if available) the pathology service was requested.                                                                                                                                   |
| Reviewing Healthcare Provider Organisation | The Healthcare Identifier (HPI-O) and name of the Reviewing Healthcare Provider Organisation.                                                                                                           |
### ATP messages

Broad consensus was reached during consultation on the type of metadata that should be associated with an ATP message. Note that the list below includes two new fields that were not previously discussed during consultation:

- **PCEHR Document ID**: It is proposed that this identifier is used as the unique identifier for a report across the integrated solution; and
- **Report status change date time**: Advice received post consultation indicated that this information could be used by the Pathology Provider in combination with other information in the message to uniquely identify a specific version of a report.

Depending on advice received from industry in regards to the mechanism for uniquely identifying reports these new fields may or may not be required.

<table>
<thead>
<tr>
<th>Field Name</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Details</td>
<td>Information about the individual for whom the pathology report is generated: IHI, First Name (if available), Last Name, DOB, Gender.</td>
</tr>
<tr>
<td>Request ID</td>
<td>Identifier assigned to the request by a Requester (if available).</td>
</tr>
<tr>
<td>Local Report ID</td>
<td>Identifier assigned to a pathology report by the Authoring Pathology Organisation. It is used locally and in communications between healthcare providers and the pathology provider.</td>
</tr>
<tr>
<td>PCEHR Document ID</td>
<td>When a clinical document is made available in the PCEHR the document author is responsible for assigning a globally unique document ID (PCEHR Document ID). It is proposed that the PCEHR Document ID is assigned at the same time that the pathology report is generated so that it can be used as the key identifier for the document across the integrated solution.</td>
</tr>
<tr>
<td>Lab ID</td>
<td>The NATA ID of the Pathology lab that ran the test.</td>
</tr>
<tr>
<td>Reviewing Healthcare Provider Organisation</td>
<td>The Healthcare Identifier (HPI-O) and name of the Reviewing Healthcare Provider Organisation.</td>
</tr>
<tr>
<td>Reviewing Healthcare Professional</td>
<td>The Healthcare Identifier (HPI-I) and name of the Reviewing Healthcare Professional.</td>
</tr>
<tr>
<td>Reviewing Healthcare Professional - Local System Identifier</td>
<td>The Local System Identifier of the Reviewing/Authorising Healthcare Professional providing the ATP, if available.</td>
</tr>
<tr>
<td>Authorisation instruction</td>
<td>Used to indicate whether the ATP is authorising a specific report to be uploaded or revoking a previously provided ATP.</td>
</tr>
<tr>
<td>ATP message - unique ID</td>
<td>The unique identifier (UUID) assigned to the ATP message.</td>
</tr>
<tr>
<td>ATP message - date and time generated</td>
<td>The date and time when the ATP message was sent from the Reviewing Healthcare Provider to the Pathology Provider.</td>
</tr>
</tbody>
</table>