

## Medtech32 GP2GP Patient Record Transfer Business Process Guidelines

### Limitations of Use

The GP2GP Patient Record Transfer functionality has been solely developed for the Transfer of Care between Providers (only within New Zealand) on a permanent or casual basis. It must not be used for other purposes.

Provision of patient information to the Patient should utilise existing functionality via the Report ▶ Patient ▶ Medical History menu option currently existing in the Medtech32 application.

The GP2GP functionality will be distributed to Practices as part of the Version 20.0 upgrade; therefore the Practice you are requesting a Patient Record from may not yet have the option to provide you an electronic patient record via the GP2GP Patient Record Transfer functionality if they have not upgraded. Over time this will be rolled out to all practices within New Zealand.

**Patient Consent is normally required for the GP2GP Patient Record Transfer to occur. In the absence of specific consent, GPs will need to consider the requirements of the Health Information Privacy Code before authorising Patient Record Transfer.**

Patient information must be formally requested by the Requesting Provider.

**The sole purpose of the GP2GP Patient Record Transfer is the “Transfer of Care/Responsibility as the ‘Primary’ Health Care Provider”**, however it recognised two or more Providers may be involved in a shared care situation, which may require the GP2GP functionality to be used. In this situation care must be taken to ensure other Providers are aware of any new Patient information that is relevant to their care. GP2GP functionality has not been devised to pass information to other Allied Healthcare Providers such as Specialists or Physiotherapists. In this instance existing referral functionality must continue to be used.

For detailed understanding of the GP2GP functionality please refer to the GP2GP Patient Record Transfer Walkthrough & Release Documentation.

### New Patient Arrives at Practice

Existing process will continue for casual or permanent Patients that arrive for a Primary Care Encounter. A decision is made whether to request Patient Records from the previous Provider.

### Create Patient Record Request

The existing manual process will continue as currently implemented when requesting a Patient record. This will be replaced by an electronic patient record request in a future release of the GP2GP Patient Record Transfer functionality.

The Patient Record Request must contain the following information:

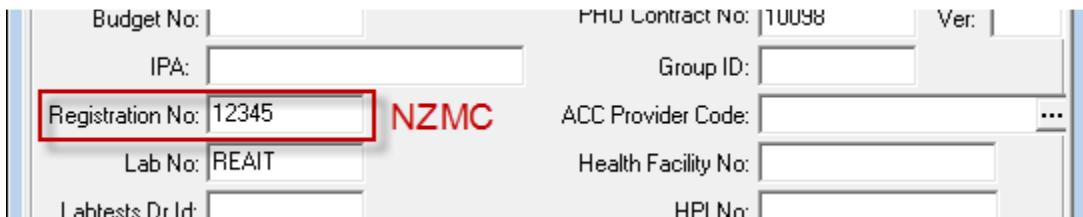
- NZMC number of the Requesting Provider
- Healthlink Mailbox ID of the Requesting Practice
- Whether it is a Permanent or Casual Patient Transfer
- Date Required By
- And the following Patient Information:
  - NHI
  - First Name & Surname
  - Date of Birth
  - Gender
  - Ethnicity
- It should also highlight that you have GP2GP Patient Record Transfer functionality.

At this point the Patient should be registered within your system, in preparation of receiving the electronic patient record. This process is necessary before a GP2GP Patient Record can be imported.

**A patient MUST be pre-registered in your system BEFORE opening the Patient Record Inbox item.**

**NZMC**, which will be replaced by the HPI following roll-out, is a critical piece of information to ensure the Patient Record arrives in the correct Medtech32 Provider Inbox. Your NZMC is used to determine this, therefore it is imperative this field is populated within your Medtech32 system AND is accurately contained within the Patient Record Request.

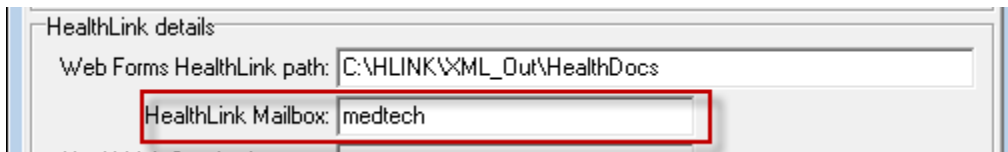
The NZMC can be found via Setup ▶ Staff ▶ Members ▶ Select Staff ▶ Provider Tab and the following field highlighted below:



The screenshot shows a form with several fields. The 'Registration No:' field contains the value '12345' and is highlighted with a red border. To the right of this field, the text 'NZMC' is displayed in red. Other fields include 'Budget No:', 'IPA:', 'Lab No:' (with value 'REAIT'), 'Labtests Dr Id:', 'PHU Contract No:' (with value '10098'), 'Ver:', 'Group ID:', 'ACC Provider Code:', 'Health Facility No:', and 'HPI No:'.

The **HealthLink Mailbox** is also a critical piece of information that must be accurately contained within the Patient Record Request. This value is required to ensure the Patient record is sent to the correct Practice mailbox.

This field is located within via Setup ▶ Location ▶ Location Settings ▶ Select Location ▶ Web Forms tab.



The screenshot shows a form titled 'HealthLink details'. The 'Web Forms HealthLink path:' field contains the value 'C:\HLINK\XML\_Out\HealthDocs'. The 'HealthLink Mailbox:' field contains the value 'medtech' and is highlighted with a red border.

### Patient Record Request Received

The existing Practice manual process will continue as currently implemented, but must be amended to include all fields highlighted in Create Patient Record Request section above.

Firstly you should validate whether it is a legitimate request by attempting to find the Patient in your Medtech32 database using the standard search routines.

This request for the Patients Clinical Records should then be processed by the Patients Provider via the Tools ▶ Patient ▶ GP2GP Patient Record Export menu option.

If the requesting practice does not have the GP2GP functionality implemented please use existing procedures to provide paper copies as they will not be able to Import the electronic GP2GP Patient Record file.

## Patient Record Export

This will be initiated via the Tools ▶ Patient ▶ GP2GP Patient Record Export menu option and is active only when a Patient is selected on the Palette. If this function is performed by Practice Support staff they should be aware entries marked 'Confidential' will not be sent by default. It should be the Provider who decides if the Confidential entries should be sent.

To re-export a Patient Record (if extra records need to be sent or there was a problem with the initial export process or transmission process) simply repeat the Export process via the menu option.

If an Export file is generated by mistake it can be manually deleted from the \\HLINK\HL7\_out\GP2GP directory. The file can be identified via the patient NHI and the time of the Export process. For example if an Export file was created for patient **BAB2345** on **1/7/2011** at **9.05.00am** the file name will be **BAB2345\_20110701090500**.

There is no mechanism to include a note as part of the Export record. It is recommended that a Consultation Note is created BEFORE the Export process if Patient details need to be passed on to the new Provider. For example No Recalls are exported; these must be manually established by the new Provider. In addition only standard Screening Terms are extracted. If your practice uses non-standard screening codes these will not be exported. Advance Forms are also not exported and it is expected these must be manually populated depending on their use within the Practice.

## Information NOT Exported

In the initial release of GP2GP patient record transfer the following information is NOT exported:

- Advanced Forms

Advanced Forms will need to be re-established with the patient, if applicable.

- Recalls
- Immunisation Schedule

Recalls & Immunisation Schedule will need to be created/selected manually, if applicable. Vaccination records are exported however not the relative schedule record

- **All Screening Terms are Exported but only the following Vital Signs are Imported:**  
**WE** – Body Weight, **HE** – Body Height, **BMI** – Body Mass Index, **PF** – Peak Flow Rate, **FEV1** – Forced Expiratory Volume in 1 Second, **FVC** – Forced Vital Capacity, **CVD** – Cardio Vascular Disease Risk, **HCIR** – Head Circumference, **BP** – Blood Pressure, **W** – Waist Circumference, **PUL** - Pulse.

The other screenings will be viewable via the Patient Record within the Inbox.

## Patient Record Import

The Patient Record that was requested will either arrive in paper form (if the Former Provider does not have electronic records for the patient) **and/or** the Patient Clinical Record will appear in the Requesters Inbox ready for Importing.

If the patient record is greater than 5MB in size it will be received via an external media device eg. CD, where the GP2GP Patient Record Manual Import menu option must be used to import this file into the Provider Inbox.

Once the file arrives into the Provider Inbox it can be imported into your system, provided the Patient has been pre-registered.

Upon opening the Inbox item the entire Patient record can be viewed in its original form and will remain within the Patient Inbox following a successful Import for future reference.

By default ALL records are selected for Import, however the Provider can choose to unselect specific records for import if deemed necessary.

Once the receiver is happy with their selection they would click the IMPORT button. Following the successful import an electronic acknowledgement will be sent automatically to the sender/originator.

A message will ONLY occur if the import process fails. If this occurs check the Audit Log and review the error condition.

To re-import a record into Medtech32 open the record within the Provider or Patient Inbox and click the Import button.

If the source of the Information is not a Medtech32 system, extra information may be passed which is NOT imported into Medtech32. These include:

- Advance Directives
- Functional Status
- Medical Equipment
- Care Plans & Maternity
- Other categories may also contain extra information which has no place within Medtech32 eg. Further Accident information may be provided but NOT Imported.

If these sections exist within the Patient Record, care must be taken to determine if relevant information exist in these sections.

In addition other GP systems use different coding systems which do not allow these to be imported and mapped to an appropriate code Medtech32 codes. This mapping process must occur manually. Please refer to next section for further details.

Minimal patient demographic details are transferred. Existing demographic information will not be overwritten during the Import process.

### Importing from Non-Medtech32 PMS

All attempts are made to allow information from a non-Medtech32 system to be imported into Medtech32. There are two key areas where this may not be the case:

**Medications** imported from a foreign system are imported as information purposes only and are identified by displaying in italics. This information should be used to prescribe new medications and make it a valid medication for prescribing. Once this is performed the corresponding italic entry could then be marked as Inactive. If Dates are not provided these are defaulted to maintain system integrity.

**For example:**

(Patient Manager view of foreign medication following Import)

Rep Date	Drug Name	Qty	Directions	Amount	Prov	Classification
1 Apr 2011	Green Script WALK	60	Take one walk twice daily for	0.00	SFE	
4 May 2011	Voltaren 100mg Supp [10]	99	99 sup, As Required	117.22	SFE	
4 May 2011	Diclax Sr Tablets 100mg Sustained Releas	98	98 tabs, Immediately	70.71	SFE	
12 Apr 2011	<i>Aspirin Tab Ec 75 Mg Aspirin Tab EC 75 m</i>	<i>90</i>	<i>Daily</i>			<i>#EX/T</i>

**Medications Profile** (provider Inbox view of medical record)

Drug	Qty/Freq	Route	Instructions	Status	Date(s)	Supply/Admin	Notes		+
Aspirin Tab EC 75 mg	90 every 0 hours		Daily	continued			<ul style="list-style-type: none"> <li>• Long Term Indicator: No</li> <li>• Reason: Regular Drug</li> </ul>		

**Classifications** imported from a foreign system are imported as Unclassified Z READ codes, unless the foreign system passes a valid READ code. All unclassified classifications must be manually classified using the appropriate READ code. The classification description is displayed to assist this process.

**For Example:**

Rep	Date	Read Code Term	Note	On Set	Prov	Severity
<input type="checkbox"/>	11 Apr 2011	Dog bite (TE60.00)	Left		SFE	
<input type="checkbox"/>	1 Apr 2011	Unspecified condition (Z.00)			SFE	
<input type="checkbox"/>	31 Mar 2011	Diabetes mellitus (C10.00)	diabetes		SFE	
<input type="checkbox"/>	25 Mar 2011	Light smoker - 1-9 cigs/day			SFE	
<input type="checkbox"/>	10 Dec 2008	(Pain in limb)	Un-Classified		#EXT	
<input type="checkbox"/>	1 Oct 2008	(Shooting pain)	Un-Classified		#EXT	
<input type="checkbox"/>	5 Sep 2008	([D])mpaired glucose tolerance	Un-Classified		#EXT	

**Medical Warnings** imported from a foreign system are imported as a NOTE Only warning. It is imperative these must be manually classified as a legitimate Medtech32 Medical Warning to ensure these are utilised during the Prescribing Medications process.

**Immunisation Vaccines** imported from a foreign system which are not recognised are NOT Imported. These must be manually populated with correct Medtech32 vaccines.

**IMPORTANT: To avoid the creation of non-standard data within Medtech32, as highlighted above, you do not have to use the Medtech32 Import functionality. The alternative is to use the content contained within the Inbox message and manually import the information. Care should be taken in accurately transcribing the Patient information if this approach is taken.**

**Casual Patients**

A Patient’s ‘full’ Patient Record may still be transferred if the Patient is attending another General Practitioner on a casual basis. Under these circumstances the patient record in your system should remain active as the Patient is likely to return.

**Health Information Privacy Code – Rule 2 – Source of Information**

In accordance with Rule 2 the New\_GP must obtain consent to obtain information from another source (Former\_GP). If consent is not given the New\_GP must obtain relevant information from the Patient. Please Note: There are exceptions to this as defined within Rule 2 sub clause (2).

**Health Information Privacy Code – Rule 8 – Accuracy of Information**

The New\_GP remains responsible to ensure any information it obtains from a Former\_GP is accurate BEFORE acting upon it.

The Rule states:

A health agency that holds health information must not use that information without taking such steps (if any) as are, in the circumstances, reasonable to ensure that, having regard to the purpose for which the information is proposed to be used, the information is accurate, up to date, complete, relevant, and not misleading.

Accordingly it is imperative the information is validated with the Patient, prior to acting on it.

## Health (Retention of Health Information) Regulations 1996

If a Former\_GP passes on information to a New\_GP they do not pass on responsibility of retention. ie. The Former\_GP retains responsibility of retention (at least 10 years) of identifiable health information they may have collected and accordingly retains a custodian role for the information.

### Processing Times

The time it takes to Export or Import a GP2GP Patient Record is dependent on the size of the Patient record and your available system resources, in particular RAM (Memory).

The following table provides a guideline: Operating System: Windows XP with 2GB of RAM

No. of Attachments	Attachment Size	Approximate Export Time	Exported HL7 File Size	Approximate Import Time
6	743 KB	Less than 10 secs	1.57 MB	Less than 1 minute
2	5.0 MB	Less than 30 secs	7.35 MB	Less than 1 minute
2	7.5 MB	Less than 1 minutes	11.3 MB	Less than 1 minute
7	8.07 MB	Less than 1 minutes	12.2 MB	Less than 2 minutes
3	12.4 MB	Less than 1 minutes	18.0 MB	Less than 4 minutes

### Data Mapping

To allow interoperability between different systems the GP2GP project has adopted an International standard called CDA (Clinical Document Architecture). The sections contained in this standard do not always match the Medtech32 definitions. For your reference please refer to the mapping table below:

GP2GP CDA Message Classifications	Medtech32 Data Classifications
Demographics	Demographics
Extra Demographics	Demographics
Encounters	Consultations
Medications Profile (Current Meds)	Medications (Long Term & Current)
Allergies	Medical Warnings
Problems	Classifications
Immunisations	Immunisations
Diagnostic Reports	Patient Inbox
Vitals	Screenings
Payers	Accidents
<i>Advance Directives</i>	<i>Not IMPORTED</i>
<i>Functional Status</i>	<i>Not IMPORTED</i>
Warnings	Alerts
Family History	History – Family History
Social History	History – Social History
Medication History	Medications (History)
<i>Medical Equipment</i>	<i>Not IMPORTED</i>
Procedures	History – Past Medical/Surgery History
<i>(Care) Plan</i>	<i>Not IMPORTED</i>
Correspondences	Patient Outbox
<i>Treatment Plan</i>	<i>Not IMPORTED</i>
<i>Obstetric History</i>	<i>Not IMPORTED</i>
<i>Maternity</i>	<i>Not IMPORTED</i>