Health & Care Information Model:

nl.zorg.Encounter-v3.1

Status:Final
Release:2017
Release status: Published

Managed by:

Content

1. nl.zorg.Encounter-v3.1

DCM::CoderList	Kerngroep Registratie aan de Bron
DCM::ContactInformation.Address	*
DCM::ContactInformation.Name	*
DCM::ContactInformation.Telecom	*
DCM::ContentAuthorList	Projectgroep Generieke Overdrachtsgegevens & Kerngroep Registratie aan de Bron
DCM::CreationDate	19-4-2012
DCM::DeprecatedDate	
DCM::DescriptionLanguage	nl
DCM::EndorsingAuthority.Address	
DCM::EndorsingAuthority.Name	PM
DCM::EndorsingAuthority.Telecom	
DCM::Id	2.16.840.1.113883.2.4.3.11.60.40.3.15.1
DCM::KeywordList	Contacten, contact, patiëntcontact
DCM::LifecycleStatus	Final
DCM::ModelerList	Kerngroep Registratie aan de Bron
DCM::Name	nl.zorg.Contact
DCM::PublicationDate	31-12-2017
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DCM::ReviewerList	Projectgroep Generieke Overdrachtsgegevens & Kerngroep Registratie aan de Bron
DCM::RevisionDate	31-12-2017
DCM::Superseeds	nl.zorg.Contact-v3.0
DCM::Version	3.1
HCIM::PublicationLanguage	EN

1.1 Revision History

Publicatieversie 1.0 (15-02-2013)

Publicatieversie 1.1 (01-07-2013)

Publicatieversie 1.2 (01-04-2015)
Bevat: ZIB-163, ZIB-164, ZIB-165, ZIB-306, ZIB-308.

Incl. algemene wijzigingsverzoeken:
ZIB-94, ZIB-154, ZIB-200, ZIB-201, ZIB-309, ZIB-324, ZIB-326.

Publicatieversie 3.0 (01-05-2016)
Bevat: ZIB-453.

Publicatieversie 3.1 (04-09-2017)
Bevat: ZIB-463, ZIB-465, ZIB-553, ZIB-563, ZIB-564, ZIB-565, ZIB-574.

1.2 Concept

A contact is any interaction, regardless of the situation, between a patient and the healthcare provider, in which the healthcare provider has primary responsibility for diagnosing, evaluating and treating the patient's condition and informing the patient. These can be visits, appointments or non face-to-face interactions.

Contacts can be visits to the general practitioner or other practices, home visits, admissions (in hospitals, nursing homes or care homes, psychiatric institutions or convalescent homes) or other relevant contacts.

This only includes *past* contacts. Future contacts can be documented in the PlannedCareActivity information model.

1.3 Mindmap

1.4 Purpose

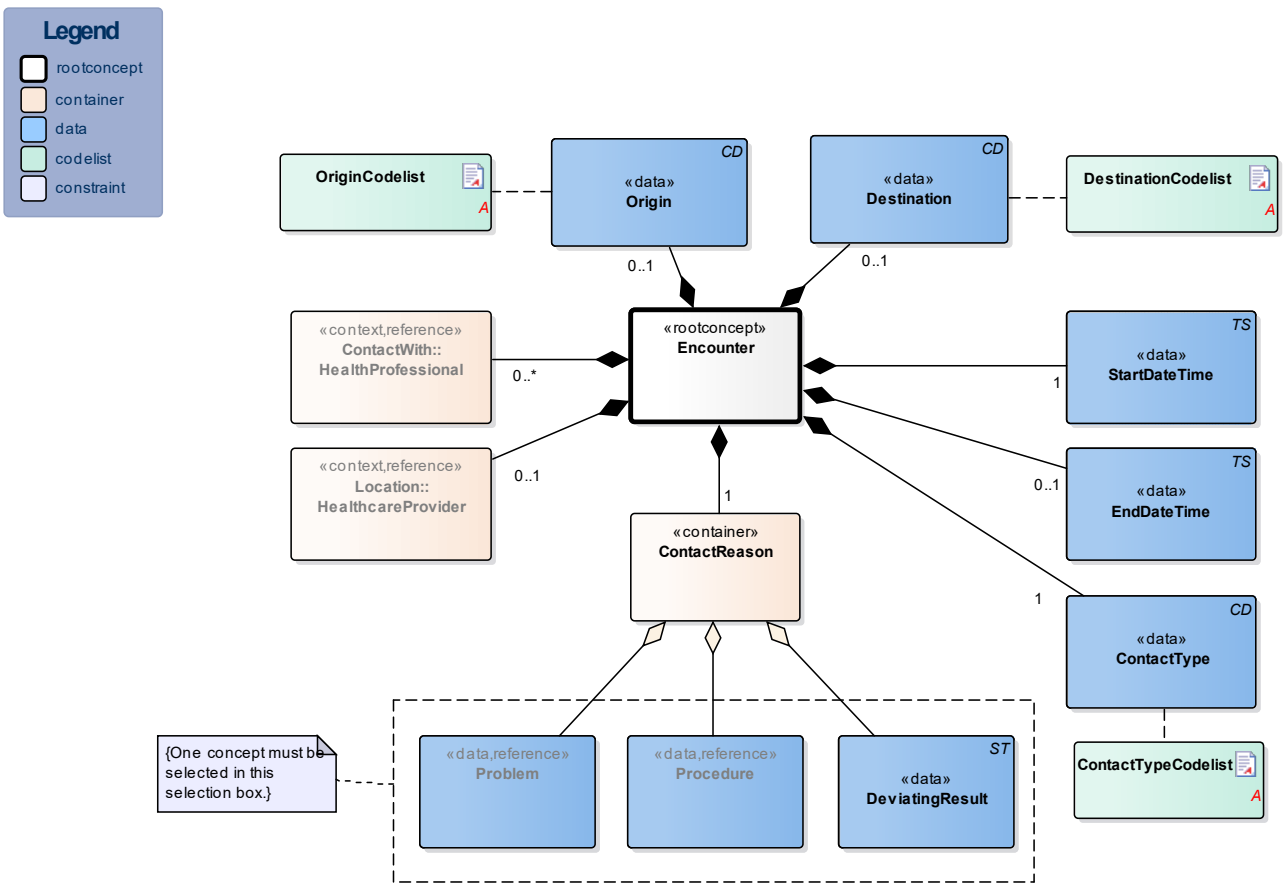
Contacts can be recorded to provide insight on the interactions that have taken place between the patient and healthcare professional and in which context these took place.

1.5 Patient Population

1.6 Evidence Base

The codelists for Origin and Destination generally correspond to the 'Landelijke Basisregistratie Ziekenhuiszorg' (National Basic Registration Hospital Care)

1.7 Information Model



«rootconcept»	Encounter
Definitie	Root concept of the Contact information model. This concept contains all data elements of the Contact information model.

Datatype		
DCM::ConceptId	NL-CM:15.1.1	
Opties		

«data»	ContactType	
Definitie	The type of contact.	
Datatype	CD	
DCM::ConceptId	NL-CM:15.1.2	
DCM::ValueSet	ContactTypeCodelist	OID: 2.16.840.1.113883.2.4.3.11.60.40.2.15.1.1
Opties		

«context»	ContactWith::HealthProfessional	
Definitie	The health professional with whom the contact took place. The specialty and role of the health professional can be entered in the HealthProfessional information model.	
Datatype		
DCM::ConceptId	NL-CM:15.1.7	
DCM::ReferencedConceptId	NL-CM:17.1.1	This is a reference to the rootconcept of information model HealthProfessional.
Opties		

«context»	Location::HealthcareProvider	
Definitie	The physical location at which the contact took place.	
Datatype		
DCM::ConceptId	NL-CM:15.1.8	
DCM::ReferencedConceptId	NL-CM:17.2.1	This is a reference to the rootconcept of information model Healthcare Provider
Opties		

«data»	StartDateTime	
Definitie	The date and time at which the contact took place.	
Datatype	TS	
DCM::ConceptId	NL-CM:15.1.3	
Opties		

«data»	EndDateTime	
Definitie	The date and time at which the contact ended. If the contact takes place over a period of time, this indicates the end of the period, in the case of an admission, for example.	
Datatype	TS	
DCM::ConceptId	NL-CM:15.1.4	
Opties		

«container»	ContactReason
Definitie	Container of the ContactReason concept. This container contains all data elements of the ContactReason concept.
Datatype	

DCM::ConceptId	NL-CM:15.1.13	
Opties		

«data»	Problem	
Definitie	The problem that led to the contact.	
Datatype		
DCM::ConceptId	NL-CM:15.1.6	
DCM::ReferencedConceptId	NL-CM:5.1.1	This is a reference to the rootconcept of information model Problem.
Opties		

«data»	Procedure	
Definitie	The procedure carried out during the contact.	
Datatype		
DCM::ConceptId	NL-CM:15.1.11	
DCM::ReferencedConceptId	NL-CM:14.1.1	This is a reference to the rootconcept of information model Procedure.
Opties		

«data»	DeviatingResult	
Definitie	A deviating result which serves as the reason for the contact.	
Datatype	ST	
DCM::ConceptId	NL-CM:15.1.12	
Opties		

«data»	Origin	
Definitie	Location from which the patient came before the encounter. In most cases this will only be used when the patient is admitted.	
Datatype	CD	
DCM::ConceptId	NL-CM:15.1.14	
DCM::ValueSet	OriginCodelist	OID: 2.16.840.1.113883.2.4.3.11.60.40.2.15.1.2
Opties		

«data»	Destination	
Definitie	Location to which the patient will go after the encounter. In most cases this will only be used when the patient is discharged.	
Datatype	CD	
DCM::ConceptId	NL-CM:15.1.16	
DCM::ValueSet	DestinationCodelist	OID: 2.16.840.1.113883.2.4.3.11.60.40.2.15.1.3
Opties		

«document»	OriginCodelist	
Definitie		
Datatype		
DCM::ValueSetId	2.16.840.1.113883.2.4.3.11.60.40.2.15.1.2	
Opties		

HerkomstCodelijst		OID: 2.16.840.1.113883.2.4.3.11.60.40.2.15.1.2		
Concept Name	**Concept Code**	**CodeSys. Name**	**CodeSystem OID**	**Description**
Home	264362003	SNOMED CT	2.16.840.1.113883.6.96	Eigen woonomgeving
Rehabilitation hospital	80522000	SNOMED CT	2.16.840.1.113883.6.96	Instelling voor revalidatie
Nursing home	42665001	SNOMED CT	2.16.840.1.113883.6.96	Instelling voor verpleging/verzorging
Psychiatric hospital	62480006	SNOMED CT	2.16.840.1.113883.6.96	GGZ instelling
Hospital	22232009	SNOMED CT	2.16.840.1.113883.6.96	Ander ziekenhuis
Liveborn born in hospital	442311008	SNOMED CT	2.16.840.1.113883.6.96	In dit ziekenhuis geboren
Hospice	284546000	SNOMED CT	2.16.840.1.113883.6.96	Hospice
Other	OTH	NullFlavor	2.16.840.1.113883.5.1008	Overig

«document»	DestinationCodelist	
Definitie		
Datatype		
DCM::ValueSetId	2.16.840.1.113883.2.4.3.11.60.40.2.15.1.3	
Opties		

BestemmingCodelijst		OID: 2.16.840.1.113883.2.4.3.11.60.40.2.15.1.3		
Concept Name	**Concept Code**	**CodeSys. Name**	**CodeSystem OID**	**Description**
Home	264362003	SNOMED CT	2.16.840.1.113883.6.96	Eigen woonomgeving
Left against medical advice	445060000	SNOMED CT	2.16.840.1.113883.6.96	Tegen advies in vertrokken
Rehabilitation hospital	80522000	SNOMED CT	2.16.840.1.113883.6.96	Instelling voor revalidatie
Nursing home	42665001	SNOMED CT	2.16.840.1.113883.6.96	Instelling voor verpleging/verzorging
Psychiatric hospital	62480006	SNOMED CT	2.16.840.1.113883.6.96	GGZ instelling
Hospital	22232009	SNOMED CT	2.16.840.1.113883.6.96	Ander ziekenhuis
Died in hospital	183676005	SNOMED CT	2.16.840.1.113883.6.96	Overleden
Hospice	284546000	SNOMED CT	2.16.840.1.113883.6.96	Hospice
Other	OTH	NullFlavor	2.16.840.1.113883.5.1008	Overig

«document»	ContactTypeCodelist	
Definitie		
Datatype		
DCM::ValueSetId	2.16.840.1.113883.2.4.3.11.60.40.2.15.1.1	
Opties		

ContactTypeCodelijst			OID: 2.16.840.1.113883.2.4.3.11.60.40.2.15.1.1	
Concept Name	Concept Code	Coding Syst. Name	Coding System OID	Description
Ambulatory	AMB	ActCode	2.16.840.1.113883.5.4	Poliklinisch
Emergency	EMER	ActCode	2.16.840.1.113883.5.4	SEH
Field	FLD	ActCode	2.16.840.1.113883.5.4	Op lokatie
Home	HH	ActCode	2.16.840.1.113883.5.4	Thuis

Inpatient	IMP	ActCode	2.16.840.1.113883.5.4	Klinisch
Short Stay	SS	ActCode	2.16.840.1.113883.5.4	Dagopname
Virtual	VR	ActCode	2.16.840.1.113883.5.4	Virtueel
Other	OTH	NullFlavor	2.16.840.1.113883.5.1008	Anders

1.8 Example Instances

Contact Type	BeginDatum Tijd	RedenContact	ContactMet	Locatie	
		ProbleemNaam	Zorgverlener Naam	Organisatie Type	Organisatie Naam
SEH	16-08-2012	Gebroken been	J.H.R. Peters	Ziekenhuis	Universitair Medisch Centrum Groningen

Contact Type	Begin Datum Tijd	Eind Datum Tijd	RedenContact	ContactMet	Locatie	
			VerrichtingType	Zorgverlener Naam	Organisatie Type	Organisatie Naam
Klinisch	16-08-2012	19-08-2012	Operatie been	G.Z.M. de Wit	Ziekenhuis	St. Lucas Andreas Ziekenhuis

1.9 Instructions

Explanation ‘Eigen woonomgeving’ (Home) from the ‘Landelijke Basisregistratie Ziekenhuiszorg’ (National Basic Registration Hospital Care) (concepts Origin and Destination)
The home environment is the environment where the patient stays regular. This distinguishes between living in a private home and living in an institution for nursing and care. This distinction is the difference between "independent living with any additional care" and "being taken care of including living". Thus, residential homes are counted as the first and stay in a nursing home to the second.

1.10 Interpretation

1.11 Care Process

1.12 Example of the Instrument

1.13 Constraints

1.14 Issues

1.15 References

1. Landelijke Basisregistratie Ziekenhuiszorg [Online] Beschikbaar op: https://www.dhd.nl/klanten/klantenservice/handleidingen_formulieren/Documents/Handleiding%20LBZ.pdf [Geraadpleegd: 29 juni2017].

1.16 Functional Model

1.17 Traceability to other Standards

1.18 Disclaimer

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