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General Practitioner Clinical Information System Standards Recommended minimum software requirements

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1 Introduction

1.1 Purpose

The purpose of this document is to describe the minimum requirements recommended for implementation within Clinical Information System (CIS) in primary care where the primary care healthcare provider is providing clinical care to an older person in a Residential Aged Care Home (RACH). These requirements are an extension of the Aged Care CIS standards recommended minimum requirements previously published [AGENCY2024a].

The minimum requirements are a selection of standards applicable to clinical information systems used by General Practitioners (GP), that will collate existing standards into one document for the primary care software sector. This will allow for interoperability, addressing barriers to GPs providing clinical support to residential aged care homes.

The Agency understands the term “patient management system” is used frequently. This document uses the more generic term of “clinical information system” to remain consistent with previous publications. In most cases, the terms are interchangeable.

The recommended minimum requirements reference technical standards, which collectively describe the recommended technical specifications a GP CIS needs to satisfy to move towards interoperability. The Australian Digital Health Agency (the Agency) will continue to work with software developers to enhance these requirements in future iterations to become more encompassing and further improve interoperability between clinical information systems.

1.2 Intended audience

The intended audience for this document is:

- GPs in the primary care and aged care sector.
- Clinical information system developers.
- Managers of GP clinics and clinicians.
- Peak bodies.
- Accrediting bodies (Australian Council on Health Standards, Australian General Practice Accreditation Limited).
- Standards developing organisations (SDO).
- Commonwealth bodies, especially the Department of Health, Disability and Ageing.

1.3 Scope

This document contains software requirements pertaining to clinical information systems for primary health care providers that provide clinical care to older persons in a RACH. The requirements in this document could also be applied to GP clinical information systems more broadly (not just those servicing older people) but that is not the focus of this document.

1.3.1 Out of scope

This document does not include:

- Requirements relating to clinical practices and workflows.
- Business practices and workflows relating to the operation of GP clinics.

- Requirements unrelated to the aged care sector.
- All matters relating to compliance or policy.
- Resident/relative/carer-facing information channels.

1.4 Overview

The development of the GP clinical information system requirements aligns with interoperability as a strategic priority in the Australian National Digital Health Strategy, as outlined in the National Healthcare Interoperability Plan 2023-2028, which states that interoperability of clinical information is essential to high-quality, sustainable health care in which clinical information is collected in a prescribed manner and can be shared in real time with patients and their providers.

GP clinical information system requirement development will support the level of software maturity and standardisation across Australia. The development of the requirements will support aged care sector interoperability and address barriers to GPs providing clinical support to residential aged care homes.

Standards create consistency and compatibility, support a single source of truth, and enable interoperability. This document describes the business requirements for the GP clinical information system, leveraging existing standards and infrastructure.

Efforts to standardise software systems aligns to the interoperability principles stated in the National Healthcare Interoperability Plan [AGENCY2023]. The sections in this document align to the following interoperability principles:

- health information is discoverable and accessible,
- national healthcare identifiers are used across the healthcare sector,
- national digital health standards and specifications are agreed and adopted,
- core national healthcare digital infrastructure is used across the sector, and
- collaboration and stakeholder engagement underpin interoperability.

The standardising of software systems needs to reflect the above interoperability principles.

2 Connections to national systems

This section describes the business requirements for implementation of clinical information systems in primary care when connecting to national systems. In a primary care setting a GP may use a clinical information system to prescribe, whereas in a RACH the GP would likely use Electronic Medication Management (EMM) systems and medication charts.

Agency design documents have traditionally used terms such as “consumer”, “patient”, “individual”, “healthcare recipient”, “resident”, and “healthcare individual” to refer to the person receiving healthcare. For simplicity, this document uses the generic term “patient”, while acknowledging in some circumstances other terms like “older person” are more appropriate, especially in a residential aged care home setting.

See the glossary for the meaning of the term “recommended” in the context of this document.

GPCS-005	**Uploading documents to My Health Record**
	The software must have the capability to author, upload, download and render the shared health summary to My Health Record.
Applicable to:	GP clinical information system
Notes:	The software will need to be conformant to the HI service conformance assessment scheme prior to gaining production access to the My Health Record system. Onboarding processes to the My Health Record system are publicly available. This requirement supports the Royal Australian College of General Practitioners (RACGP) publication “Minimum requirements for general practice clinical information systems to improve usability” [RACGP2022]. Also see the My Health Record System – Conformance Assessment Scheme [AGENCY2024c].

GPCS-010	**Download and render documents in My Health Record**
	The software should have the capability to download and render the following My Health Record document types: • Discharge Summary, • Advance Care Planning Information, • Goals of Care, and • Pharmacist Shared Medicines List.
Applicable to:	GP clinical information system
Notes:	The clinical information system should be able to download and render clinical documents to enable quality continuity of care. The Australian Digital Health Agency has technical specifications that describe these clinical documents [AGENCY2022]. Onboarding processes to the My Health Record system is publicly available.

This requirement supports the Royal Australian College of General Practitioners (RACGP) publication “Minimum requirements for general practice clinical information systems to improve usability” [RACGP2022].

GPCS-020	**Australian Immunisation Register**
	The software must integrate to the Australian Immunisation Register (AIR) via B2B web services so that a patient’s immunisation history can be uploaded, downloaded, and displayed.
Applicable to:	GP clinical information system
Notes:	Incorporating immunisation data into the local health record will assist with preventive health planning, improve quality of care, and is especially relevant during transfers of care for older people living in RACHs. Medicare Online and PBS software developers are required to integrate AIR functionality into their software product to obtain a Notice of Integration (NOI), where users of their product include health professionals who are eligible to administer vaccinations or administrators required to submit vaccination information to the AIR. Connecting to the AIR API also allows for a better user experience as it reduces reliance on web portals.

GPCS-025	**Send prescriptions to the National Prescription Delivery Service**
	The software should have the capability to send prescriptions to the National Prescription Delivery Service.
Applicable to:	GP clinical information system
Notes:	Software supporting chart-based electronic prescriptions simplifies the dispensing workflow and contributes to positive clinical outcomes. See the Electronic Prescribing - Technical Framework Documents v3.7 [AGENCY2025] for more information.

GPCS-030	**National Real Time Prescription Monitoring**
	The software should allow seamless integration with the Real Time Prescription Monitoring (RTPM) system.
Applicable to:	GP clinical information system
Notes:	Prescribers have a legal obligation (in some States and Territories) to view the RTPM system before prescribing a monitored medicine during prescribing events (including when creating charts). Understanding recent prescribing and dispensing events, including events that may not be detailed on the current RACH chart, contributes to positive clinical outcomes. Some State/Territory RTPM systems are web portals so seamless integration might be a link to the RTPM portal for the relevant State/Territory or other mechanism to facilitate the viewing of the RTPM system.

3 Standards for local software controls

This section describes the minimum requirements for the implementation of standards for local software controls such as privacy, clinical safety, and cyber security standards.

GPCS-040	**Cyber security**
	The software should implement cyber security controls described in the My Health Record Cyber security conformance profile [AGENCY2024b].
Applicable to:	GP clinical information system
Notes:	The Australian Cyber Security Centre security conformance profile provides detailed guidance on how careful software design can meet and exceed the "Essential 8" mitigation strategies [CYBER2023] that help organisations protect themselves against various cyber threats.

4 Standards for terminology code sets

This section describes the recommended requirements to implement terminology code set standards that reflect important health concepts.

GPCS-045	**Native support for SNOMED-CT AU**
	The software should implement native support for SNOMED-CT AU.
Applicable to:	GP clinical information system
Notes:	Native implementation of SNOMED-CT AU prevents complications caused by mapping data between reference sets. Due to some health information not having SNOMED-CT AU codes, it is important for software to not enforce a SNOMED-CT AU code for all health information. This requirement supports the Royal Australian College of General Practitioners (RACGP) publication “Minimum requirements for general practice clinical information systems to improve usability” [RACGP2022].

GPCS-050	**Authoring with SNOMED-CT AU**
	When authoring clinical information, the software should be able to author that clinical information using SNOMED-CT AU terms where clinically and technically appropriate.
Applicable to:	GP clinical information system
Notes:	Ensuring clinical information is expressed in SNOMED-CT AU terms at the point of information transfer increases the chance of data interoperability. In some contexts, the use of SNOMED-CT AU is not clinically advisable or technically possible. This requirement supports the Royal Australian College of General Practitioners (RACGP) publication “Minimum requirements for general practice clinical information systems to improve usability” [RACGP2022].

GPCS-055	**Australian Medicines Terminology (AMT)**
	The software should implement native support for AMT.
Applicable to:	GP clinical information system
Notes:	Native adoption of AMT prevents complications caused by mapping data between reference sets. Due to some medicines not having AMT codes, it is important for software to not enforce an AMT code for every medicine. This requirement supports the Royal Australian College of General Practitioners (RACGP) publication “Minimum requirements for general practice clinical information systems to improve usability” [RACGP2022].

GPCS-060	**Australian Medicines Terminology (AMT)**
	When authoring clinical information for transfer to other healthcare organisations, the software should be able to author that clinical information using AMT terms where clinically and technically appropriate.
Applicable to:	GP clinical information system
Notes:	Ensuring clinical information is expressed in AMT terms at the point of information transfer increases the chance of data interoperability. In some contexts, the use of AMT is not clinically advisable or technically possible. This requirement supports the Royal Australian College of General Practitioners (RACGP) publication “Minimum requirements for general practice clinical information systems to improve usability” [RACGP2022].

5 Standards for the point-to-point exchange of information

This section describes the recommended requirements for the implementation of the clinical note document. The clinical note document provides a record of clinical information relevant to the care of a patient. In the context of aged care, a clinical note document is a record of clinical information relevant to the care of an aged care patient or resident. The clinical note document can be safely and securely exchanged between healthcare organisations using existing point-to-point transfer mechanisms.

GPCS-065	**Author and send clinical note document**
	The software should author the clinical note document in the GP clinical information system and send the clinical note document to another healthcare organisation.
Applicable to:	GP clinical information system
Notes:	Ensuring healthcare providers can author the clinical note document using information from the patient record and send to the desired healthcare organisation. This requirement supports the Royal Australian College of General Practitioners (RACGP) Proposition statement, Seamless exchange of information between aged care and general practice. [RACGP2023]

GPCS-070	**Receive and render clinical note document**
	The software should receive and render the clinical note document in the GP clinical information system.
Applicable to:	GP clinical information system
Notes:	Ensuring healthcare providers can receive and render the information included in the clinical note document. This requirement supports the Royal Australian College of General Practitioners (RACGP) Proposition statement, Seamless exchange of information between aged care and general practice. [RACGP2023]

Acronyms

Acronym	Description
ACCIS	Aged Care Clinical Information System
AMT	Australian Medicines Terminology
CIS	Clinical Information System
EMM	Electronic Medication Management
GP	General Practitioner
HI Service	Healthcare Identifier Service
RACGP	Royal Australian College of General Practitioners
RACH	Residential Aged Care Home
SDO	Standards developing organisations
SNOMED-CT AU	Systematized Nomenclature of Medicine – Clinical Terms Australian edition

Glossary

Term	Meaning
Clinical Information System	A system that deals with the collection, storage, retrieval, communication and optimal use of health-related data, information, and knowledge. A clinical information system may provide access to information contained in an electronic health record, but it may also provide other functions such as workflow, order entry, and results reporting. A CIS may also serve the role, or have similar features to, an electronic medicines management system.
Discharge Summary	A record of a patient's hospital visit.
Electronic Medicines Management System	The utilisation of electronic systems to facilitate and enhance the communication of a prescription or medicine order, aiding the choice, administration and supply of a medicine through knowledge and decision support and providing a robust audit trail for the entire medicines use process. Also see Clinical Information System.
Mandatory	The solution design is expected to enable, support or make the stated requirement technically possible.
Recommended	It is desirable for the solution design to enable, support or make the stated requirement technically possible.
Shared health summary	A clinical document summarising an individual’s health status and includes important information such as allergies/adverse reactions, medicines, medical history and immunisations. Only a nominated provider can create or update the shared health summary.
Standard	Standards are voluntary documents that set out specifications, procedures and guidelines that aim to ensure products, services, and systems are safe, consistent and reliable.

References

AGENCY2022	*Discharge Summary*, v1.6, Australian Digital Health Agency, 2022.
AGENCY2023	*National Healthcare Interoperability Plan 2023 – 2028,* Australian Digital Health Agency, 2023
AGENCY2024a	*Aged Care Clinical Information System Standards v1.0*, Australian Digital Health Agency, 2024
AGENCY2024b	*My Health Record Connecting Systems - Security Conformance Profile*, v1.0, Australian Digital Health Agency, 2024.
AGENCY2024c	*My Health Record System – Conformance Assessment Scheme*, v2.0, Australian Digital Health Agency, 2024
AGENCY2025	*Electronic Prescribing - Technical Framework Documents*, v3.7, Australian Digital Health Agency, 2025
CYBER2023	*2023-2030 Australian Cyber Security Strategy*, Department of Home Affairs, 2023
RACGP2022	*Summary Minimum requirements for general practice clinical information systems to improve usability*, Royal Australian College of General Practitioners, 2022
RACGP2023	*RACGP - Seamless exchange of information between aged care and general practice*, Royal Australian College of General Practitioners, 2023