



Australian Government

Australian Digital Health Agency



Medical History

Detailed Clinical Model Specification

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Australian Digital Health Agency

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Product version	Date	Release comments
1.0	18 Dec 2015	Initial public release. This specification is published to support the Structured Content Specifications published (in the first half of 2015) that use the versions of DCMs included in this specification. These DCMs used to be published as separate specifications but due to their nature have been combined into one.
1.1	5 Aug 2016	This version of the specification is published to support the Service Referral structured content specification. It includes rebranding for the Australian Digital Health Agency.

Related Documents

Name	Version/Release Date
Participation Data Specification	Version 3.2, Issued 20 July 2011

Included Detailed Clinical Models

This specification contains the following detailed clinical models:

- Problem/Diagnosis, version 5.3
- Exclusion Statement - Problems and Diagnoses, version 1.4
- Procedure (Action), version 4.3
- Exclusion Statement - Procedures, version 1.3
- Uncategorised Medical History Item, version 2.1

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1 Introduction

1.1 Purpose and Scope

This detailed clinical model (DCM) specification forms part of a suite of data specifications that the Australian Digital Health Agency (the Agency) is developing for the Australian health informatics community. The suite comprises specifications for a range of health topics (represented as data groups), which are considered to be the most critical to support the work programme given to the Agency and to realise the benefits derived from Level 4 (semantic) interoperability¹ in the Australian healthcare setting.

We value your questions and comments about this document. Please direct your questions or feedback to help@digitalhealth.gov.au.

1.2 Intended Audience

This document is intended to be read by jurisdictional information and communication technology (ICT) managers, clinicians involved in clinical information system specifications, software architects and developers, and implementers of clinical information systems in various healthcare settings.

This is a technical document; the audience should be familiar with the language of health data specification and also have some familiarity with health information standards and specifications. Definitions and examples are provided to clarify relevant terminology, usage, and intent.

1.3 Background

One area of priority for us is the identification of digital health data to be communicated and its structure. We are addressing this through data specifications, which detail the data elements (logically grouped) and their associated value domains.

Data specifications need to be independent of messaging formats. They are concerned with providing an information framework in which to achieve semantic interoperability.

Data specifications have been developed based on priorities identified by jurisdictions and clinicians, incorporating clinical examples of use to enhance utility and adoption. These specifications are intended to:

- suit the Australian model for a shared electronic health record;
- define collections of related information, e.g. event summaries, data groups, data elements;
- be human readable (with information enhanced by the hierarchical structure);
- provide a set of clinical terminologies specific to the requirements of the Australian healthcare system; and
- allow for expansion and extension as electronic systems mature.

While the My Health Record system is referred to in these documents, implementation within the system is not dealt with here.

1.4 Terminology

Our National Clinical Terminology Service (NCTS) is defining a national approach to clinical terminology. Consistent and accurate articulation and interpretation of clinical terms is critical to the process of safe exchange.

¹Level 4 interoperability is described in [The Value Of Health Care Information Exchange And Interoperability \[WALJ2005a\]](#).

We recommend the SNOMED CT as the preferred clinical terminology for Australia and this has been endorsed by the Australian, state and territory governments. SNOMED CT is considered to be the most comprehensive multilingual health terminology in the world. It is owned, maintained and distributed by the International Health Terminology Standards Development Organisation (IHTSDO).

Our NCTS is the Australian National Release Centre for SNOMED CT and is also responsible for managing, developing and distributing national clinical terminologies, such as SNOMED CT Australian Release (SNOMED CT-AU), the Australian Medicines Terminology (AMT), and related tools and services.

SNOMED CT-AU provides local variations and customisation of terms relevant to the Australian healthcare community. It includes the international resources, along with all Australian-developed terminology for implementation in Australian clinical information technology systems. The AMT provides a consistent approach to the identification and naming of medicines, and supports medicines management and activity across the Australian healthcare domain. The AMT is now included within SNOMED CT-AU, with even closer integration planned for the future.

Reference sets listed as value domains within this document have been developed taking into account data element and data group definitions, as well as how they align with and complement the SNOMED CT concept model.

SNOMED CT-AU has been available for software developers to use in their Australian products since 1 July 2006. It is updated monthly and is freely available under a dual licensing arrangement – namely the SNOMED CT Affiliate License and Australian National Terminology License.

For further information regarding terminology and the development of reference sets, please visit <http://www.healthterminologies.gov.au>. Email help@digitalhealth.gov.au with questions or feedback.

2 Problem/Diagnosis Detailed Clinical Model

This chapter describes version 5.3 of the *Problem/Diagnosis* Detailed Clinical Model.

2.1 Purpose

To record details about a problem or diagnosis by a clinician.

2.2 Use

Use to record detailed information about problems or diagnoses recognised by a clinician. There are many uses including: recording a diagnosis during an encounter; populating a problem list or a summary statement, such as a discharge summary.

Use to record all problems or diagnoses, including those with context-specific qualifiers such as past or present, primary or secondary, active or inactive etc. These qualifiers can be documented separately and included in the *Status* data component, because their use varies in different settings.

2.3 Misuse

Not to be used to record differential diagnoses - use the *Differential Diagnosis* DCM (to be published).

Not to be used to record reason for encounter - use the *Reason for Encounter* DCM.

Not to be used to record presenting complaint - which is information captured early in the encounter, usually prior to full assessment and will be represented using a separate DCM.

Not to be used to record procedures - use the *Procedure* DCM.

Not to be used to record symptoms or signs - these should be recorded as part of a patient story or history. A problem such as chest pain may masquerade as a symptom, however in this context we are recording it as a problem the person has.

2.4 UML Class Diagrams

The following figure represents the data hierarchy using a UML 2.0 class diagram. The diagram displays data groups and data elements, together with their names, data types and multiplicities. Data elements are displayed as attributes; data groups are displayed as classes; their label names are represented as association role names. Association role names are only displayed if they differ from the associated class name. When a data element has a choice of data types, the data type of the attribute that represents it is an abstract interface class generalised from the individual data types. The diagram shows the data hierarchy excluding the details of participation. The default multiplicity is 1..1.

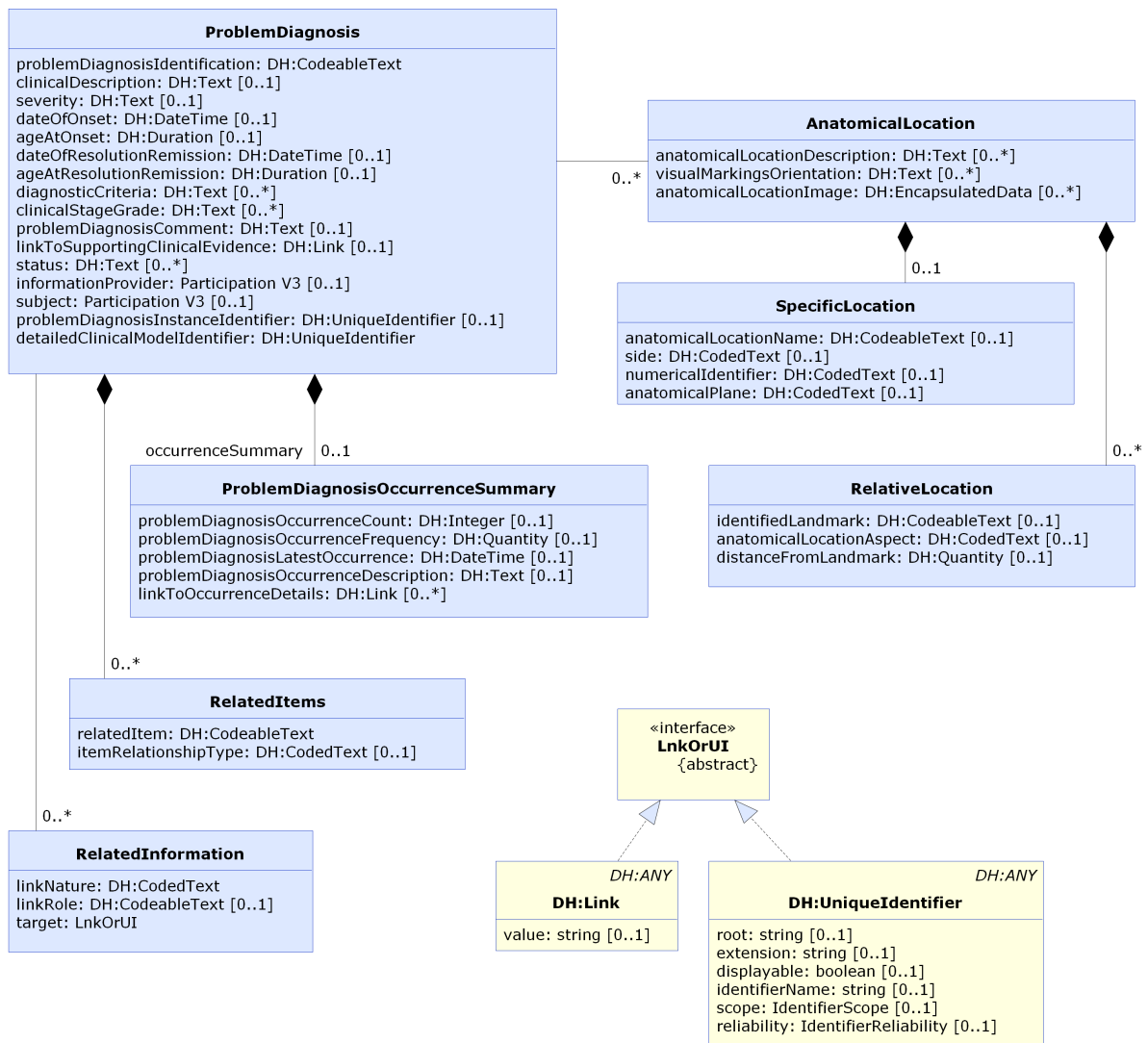


Figure 2.1. Problem Diagnosis

2.5 PROBLEM/DIAGNOSIS

Identification

Label	PROBLEM/DIAGNOSIS
Metadata Type	Data Group
Identifier	DG-15530
OID	1.2.36.1.2001.1001.101.102.15530

Definition









Definition	A health condition that, as determined by a clinician, may have impact on the physical, mental or social wellbeing of a person. A diagnosis is determined by scientific evaluation of pathological and pathophysiological findings identified from the patient's clinical history, family history, physical examination and diagnostic investigations.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	An account of relevant identified health-related problems as reported by a healthcare provider. This can include a disease, condition, injury, poisoning, sign, symptom, abnormal finding, complaint, or other factor influencing health status as assessed by a healthcare provider.


























Data Hierarchy













Note

Items below whose text is lighter (mid-blue and mid-grey) are technical identifiers whose purpose is to facilitate interoperability, sharing of data and secondary use. Typically, such identifiers will be generated internally by systems and not displayed to users since they rarely have clinical significance.

 PROBLEM/DIAGNOSIS			
		Problem/Diagnosis Identification	1..1
		Clinical Description	0..1
		Severity	0..1
		Date of Onset	0..1
		Age at Onset	0..1
		ANATOMICAL LOCATION	0..*
		SPECIFIC LOCATION	0..1

			Anatomical Location Name	0..1
			Side	0..1
			Numerical Identifier	0..1
			Anatomical Plane	0..1
		RELATIVE LOCATION		0..*
			Identified Landmark	0..1
			Anatomical Location Aspect	0..1
			Distance From Landmark	0..1
			Anatomical Location Description	0..*
			Visual Markings/Orientation	0..*
			Anatomical Location Image	0..*
	Occurrence Summary (PROBLEM/DIAGNOSIS OCCURRENCE SUMMARY)			0..1
			Problem/Diagnosis Occurrence Count	0..1
			Problem/Diagnosis Occurrence Frequency	0..1
			Problem/Diagnosis Latest Occurrence	0..1
			Problem/Diagnosis Occurrence Description	0..1
			Link to Occurrence Details	0..*
	RELATED ITEMS			0..*
			Related Item	1..1
			Item Relationship Type	0..1
			Date of Resolution/Remission	0..1
			Age at Resolution/Remission	0..1
			Diagnostic Criteria	0..*
			Clinical Stage/Grade	0..*
			Problem/Diagnosis Comment	0..1

		Link to Supporting Clinical Evidence	0..1
		Status	0..*
		INFORMATION PROVIDER	0..1
		SUBJECT	0..1
		Problem/Diagnosis Instance Identifier	0..1
		RELATED INFORMATION	0..*
		Link Nature	1..1
		Link Role	0..1
		Target	1..1
		Detailed Clinical Model Identifier	1..1

2.6 Problem/Diagnosis Identification

Identification

Label	Problem/Diagnosis Identification
Metadata Type	Data Element
Identifier	DE-15514
OID	1.2.36.1.2001.1001.101.103.15514

Definition


Definition	Identification of the problem or diagnosis.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	This item denotes the name of the condition used by the healthcare provider, after assessment, to describe the health problem or diagnosis experienced by the subject of care.
Data Type	CodeableText
Value Domain	Problem/Diagnosis Reference Set

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for CodeableText .
Exceptional Values	Absent values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PROBLEM/DIAGNOSIS	1..1

2.7 Problem/Diagnosis Reference Set

Identification

Label	Problem/Diagnosis Reference Set
Metadata Type	Value Domain
Identifier	VD-16617
OID	1.2.36.1.2001.1001.101.104.16617
External Identifier	SNOMED CT-AU Concept Id: 32570581000036105 <i>Problem/Diagnosis reference set</i>

Definition


Definition	The <i>Problem/Diagnosis reference set</i> provides terminology to support the recording of health problems or diagnoses experienced by a subject of care for medical records within Australia.
Definition Source	Australian Digital Health Agency

Value Domain

Source	SNOMED CT-AU
---------------	--------------

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Problem/Diagnosis Identification	1..1

2.8 Clinical Description

Identification

Label	Clinical Description
Metadata Type	Data Element
Identifier	DE-15597
OID	1.2.36.1.2001.1001.101.103.15597

Definition


Definition	Narrative description or comments about clinical aspects of the problem/diagnosis.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	Used to provide additional narrative information in relation to a problem/diagnosis.
Data Type	Text

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for Text .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PROBLEM/DIAGNOSIS	0..1

2.9 Severity

Identification

Label	Severity
Metadata Type	Data Element
Identifier	DE-15531
OID	1.2.36.1.2001.1001.101.103.15531

Definition


Definition	A subjective assessment of the severity of the problem/diagnosis as evaluated by the clinician.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	Text

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for Text .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PROBLEM/DIAGNOSIS	0..1

2.10 Date of Onset

Identification

Label	Date of Onset
Metadata Type	Data Element
Identifier	DE-15507
OID	1.2.36.1.2001.1001.101.103.15507

Definition


Definition	Estimated or actual date the problem or diagnosis began, as indicated or identified by the clinician.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	DateTime

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for DateTime .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PROBLEM/DIAGNOSIS	0..1

2.11 Age at Onset

Identification

Label	Age at Onset
Metadata Type	Data Element
Identifier	DE-16535
OID	1.2.36.1.2001.1001.101.103.16535

Definition


Definition	The estimated or actual age of the individual when the clinician assesses that the problem/diagnosis began.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	<p>May be important in situations where approximations of age based on calculations are not accurate enough, e.g. in infants under one year.</p> <p>It may also be important for assessing clinical implications such as prognosis of condition, e.g. early-onset Alzheimer's, multiple sclerosis, certain cancers, etc.</p>
Data Type	Duration

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for Duration .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PROBLEM/DIAGNOSIS	0..1

2.12 ANATOMICAL LOCATION

Identification


Label	ANATOMICAL LOCATION
Metadata Type	Data Group
Identifier	DG-16150
OID	1.2.36.1.2001.1001.101.102.16150

Definition






Definition	Slot to contain detailed and structured anatomical location details.
Definition Source	Australian Digital Health Agency
Synonymous Names	

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PROBLEM/DIAGNOSIS	0..*

Children

Data Type	Name	Occurrences
	SPECIFIC LOCATION	0..1
	RELATIVE LOCATION	0..*
	Anatomical Location Description	0..*
	Visual Markings/Orientation	0..*
	Anatomical Location Image	0..*

2.13 SPECIFIC LOCATION

Identification


Label	SPECIFIC LOCATION
Metadata Type	Data Group
Identifier	DG-16151
OID	1.2.36.1.2001.1001.101.102.16151

Definition





Definition	Specific and identified anatomical location.
Definition Source	Australian Digital Health Agency
Synonymous Names	

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	ANATOMICAL LOCATION	0..1

Children

Data Type	Name	Occurrences
	Anatomical Location Name	0..1
	Side	0..1
	Numerical Identifier	0..1
	Anatomical Plane	0..1

2.14 Anatomical Location Name

Identification

Label	Anatomical Location Name
Metadata Type	Data Element
Identifier	DE-16153
OID	1.2.36.1.2001.1001.101.103.16153

Definition


Definition	The name of the anatomical location.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	CodeableText
Value Domain	Body Structure Foundation Reference Set

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for CodeableText .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	SPECIFIC LOCATION	0..1

2.15 Body Structure Foundation Reference Set

Identification

Label	Body Structure Foundation Reference Set
Metadata Type	Value Domain
Identifier	VD-16152
OID	1.2.36.1.2001.1001.101.104.16152
External Identifier	SNOMED CT-AU Concept Id: 32570061000036105

Definition


Definition	The set of values for named anatomical locations.
Definition Source	Australian Digital Health Agency

Value Domain

Source	SNOMED CT-AU
---------------	--------------

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
 001011001	Anatomical Location Name	1..1

2.16 Side

Identification

Label	Side
Metadata Type	Data Element
Identifier	DE-16336
OID	1.2.36.1.2001.1001.101.103.16336

Definition


Definition	Laterality of the anatomical location.
Definition Source	Australian Digital Health Agency
Synonymous Names	Laterality
Data Type	CodedText
Value Domain	Laterality Reference Set

Usage

Examples	<ol style="list-style-type: none"> 1) Right 2) Left 3) Bilateral
Exceptional Values	<p>Absent values are PROHIBITED.</p> <p>Abnormal values are PROHIBITED.</p>

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	SPECIFIC LOCATION	0..1

2.17 Laterality Reference Set

Identification

Label	Laterality Reference Set
Metadata Type	Value Domain
Identifier	VD-16312
OID	1.2.36.1.2001.1001.101.104.16312
External Identifier	SNOMED CT-AU Concept Id: 32570611000036103

Definition


Definition	The set of values for identifying the laterality of an anatomical location.
Definition Source	Australian Digital Health Agency

Value Domain

Source	SNOMED CT-AU
---------------	--------------

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Side	1..1

2.18 Numerical Identifier

Identification

Label	Numerical Identifier
Metadata Type	Data Element
Identifier	DE-16338
OID	1.2.36.1.2001.1001.101.103.16338

Definition

Definition	Ordinal value used with anatomical site or part name to identify a specific anatomical site in a collection of enumerable sites, such as vertebrae or ribs.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	CodedText
Value Domain	<i>Not specified.</i>
	In the absence of national standard code sets, the code sets used SHALL be registered code sets, i.e. registered through the HL7 code set registration procedure ¹ with an appropriate object identifier (OID), and SHALL be publicly available.
	When national standard code sets become available, they SHALL be used and the non-standard code sets SHALL be deprecated.


Usage

Conditions of Use	This SHALL be an ordinal number between first and eighteenth.
Conditions of Use Source	Australian Digital Health Agency
Examples	<ol style="list-style-type: none"> 1) First, as in 'first rib'. 2) Second, as in 'second toe'. 3) Third, as in 'third lumbar vertebra'.
Exceptional Values	<p>Absent values are PROHIBITED.</p> <p>Abnormal values are PROHIBITED.</p>

¹ <http://www.hl7.org/oid/index.cfm>

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	SPECIFIC LOCATION	0..1

2.19 Anatomical Plane

Identification

Label	Anatomical Plane
Metadata Type	Data Element
Identifier	DE-16340
OID	1.2.36.1.2001.1001.101.103.16340

Definition


Definition	Line describing the position of a vertical anatomical plane in the body.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	CodedText
Value Domain	<i>Not specified.</i>
	In the absence of national standard code sets, the code sets used SHALL be registered code sets, i.e. registered through the HL7 code set registration procedure ² with an appropriate object identifier (OID), and SHALL be publicly available.
	When national standard code sets become available, they SHALL be used and the non-standard code sets SHALL be deprecated.

Usage

Examples	<ol style="list-style-type: none"> 1) Midline 2) Midclavicular 3) Midaxillary 4) Midscapular
Exceptional Values	<p>Absent values are PROHIBITED.</p> <p>Abnormal values are PROHIBITED.</p>

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	SPECIFIC LOCATION	0..1

² <http://www.hl7.org/oid/index.cfm>

2.20 RELATIVE LOCATION

Identification


Label	RELATIVE LOCATION
Metadata Type	Data Group
Identifier	DG-16341
OID	1.2.36.1.2001.1001.101.102.16341

Definition




Definition	Qualifier(s) to identify a non-specific location.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	An example is: 5cm (distance) inferior (aspect) to the tibial tuberosity (landmark). More than one relative location may be required to provide a cross-reference.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	ANATOMICAL LOCATION	0..*

Children

Data Type	Name	Occurrences
	Identified Landmark	0..1
	Anatomical Location Aspect	0..1
	Distance From Landmark	0..1

2.21 Identified Landmark

Identification

Label	Identified Landmark
Metadata Type	Data Element
Identifier	DE-16343
OID	1.2.36.1.2001.1001.101.103.16343

Definition


Definition	Identified anatomical landmark from which to specify the relative anatomical location.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	CodeableText
Value Domain	<i>Not specified.</i>
	In the absence of national standard code sets, the code sets used SHALL be registered code sets, i.e. registered through the HL7 code set registration procedure ³ with an appropriate object identifier (OID), and SHALL be publicly available.
	When national standard code sets become available, they SHALL be used and the non-standard code sets SHALL be deprecated.

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for CodeableText .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	RELATIVE LOCATION	0..1

³ <http://www.hl7.org/oid/index.cfm>

2.22 Anatomical Location Aspect

Identification

Label	Anatomical Location Aspect
Metadata Type	Data Element
Identifier	DE-16345
OID	1.2.36.1.2001.1001.101.103.16345

Definition


Definition	Qualifier to identify which direction the anatomical location is in relation to the identified landmark.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	CodedText
Value Domain	<i>Not specified.</i>
	In the absence of national standard code sets, the code sets used SHALL be registered code sets, i.e. registered through the HL7 code set registration procedure ⁴ with an appropriate object identifier (OID), and SHALL be publicly available.
	When national standard code sets become available, they SHALL be used and the non-standard code sets SHALL be deprecated.

Usage

Examples	<ol style="list-style-type: none"> 1) Medial to 2) Lateral to 3) Anterior to 4) Above
Exceptional Values	<p>Absent values are PROHIBITED.</p> <p>Abnormal values are PROHIBITED.</p>

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	RELATIVE LOCATION	0..1

⁴ <http://www.hl7.org/oid/index.cfm>

2.23 Distance From Landmark

Identification

Label	Distance From Landmark
Metadata Type	Data Element
Identifier	DE-16346
OID	1.2.36.1.2001.1001.101.103.16346

Definition


Definition	Distance of location from the identified landmark.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	Quantity

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for Quantity .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	RELATIVE LOCATION	0..1

2.24 Anatomical Location Description

Identification

Label	Anatomical Location Description
Metadata Type	Data Element
Identifier	DE-16319
OID	1.2.36.1.2001.1001.101.103.16319

Definition


Definition	Description of the anatomical location.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	Text

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for Text .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	ANATOMICAL LOCATION	0..*

2.25 Visual Markings/Orientation

Identification

Label	Visual Markings/Orientation
Metadata Type	Data Element
Identifier	DE-16407
OID	1.2.36.1.2001.1001.101.103.16407

Definition


Definition	Description of any visual markings used to orient the viewer.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	Text

Usage

Examples	<ol style="list-style-type: none"> 1) External reference points 2) Special sutures 3) Ink markings
-----------------	---

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	ANATOMICAL LOCATION	0..*

2.26 Anatomical Location Image

Identification

Label	Anatomical Location Image
Metadata Type	Data Element
Identifier	DE-16199
OID	1.2.36.1.2001.1001.101.103.16199

Definition


Definition	An image or images used to identify a location.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Context	This element is intended to be an image, e.g. a photo of the anatomical site such as a wound on the leg.
Context Source	Australian Digital Health Agency
Data Type	EncapsulatedData

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for EncapsulatedData .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	ANATOMICAL LOCATION	0..*

2.27 PROBLEM/DIAGNOSIS OCCURRENCE SUMMARY

Identification


Label	Occurrence Summary
Metadata Type	Data Group
Identifier	DG-16554
OID	1.2.36.1.2001.1001.101.102.16554

Definition






Definition	Summary information about occurrences or exacerbations.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	Detailed information about each occurrence or exacerbation is likely to be held in other parts of the health record.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PROBLEM/DIAGNOSIS	0..1

Children

Data Type	Name	Occurrences
	Problem/Diagnosis Occurrence Count	0..1
	Problem/Diagnosis Occurrence Frequency	0..1
	Problem/Diagnosis Latest Occurrence	0..1
	Problem/Diagnosis Occurrence Description	0..1
	Link to Occurrence Details	0..*

2.28 Problem/Diagnosis Occurrence Count

Identification

Label	Problem/Diagnosis Occurrence Count
Metadata Type	Data Element
Identifier	DE-16555
OID	1.2.36.1.2001.1001.101.103.16555

Definition


Definition	Cumulative number of occurrences or exacerbations of the problem/diagnosis.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	Integer

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for Integer .
-----------------	---

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Occurrence Summary (PROBLEM/DIAGNOSIS OCCURRENCE SUMMARY)	0..1

2.29 Problem/Diagnosis Occurrence Frequency

Identification

Label	Problem/Diagnosis Occurrence Frequency
Metadata Type	Data Element
Identifier	DE-16556
OID	1.2.36.1.2001.1001.101.103.16556

Definition


Definition	The frequency or estimated frequency of occurrences or exacerbations of the problem/diagnosis.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	Quantity

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for Quantity .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Occurrence Summary (PROBLEM/DIAGNOSIS OCCURRENCE SUMMARY)	0..1

2.30 Problem/Diagnosis Latest Occurrence

Identification

Label	Problem/Diagnosis Latest Occurrence
Metadata Type	Data Element
Identifier	DE-16557
OID	1.2.36.1.2001.1001.101.103.16557

Definition


Definition	The date of the last occurrence or exacerbation of the problem/diagnosis.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	DateTime

Usage

Conditions of Use	Record only date, time SHALL NOT be recorded.
Conditions of Use Source	Australian Digital Health Agency
Examples	Please see DateTime in Appendix B, Specification Guide for Use for examples and usage information on specifying a date.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Occurrence Summary (PROBLEM/DIAGNOSIS OCCURRENCE SUMMARY)	0..1

2.31 Problem/Diagnosis Occurrence Description

Identification

Label	Problem/Diagnosis Occurrence Description
Metadata Type	Data Element
Identifier	DE-16558
OID	1.2.36.1.2001.1001.101.103.16558

Definition


Definition	A narrative description, including outcomes and other key details, about occurrences or exacerbations of the problem/diagnosis.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	Text

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for Text .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Occurrence Summary (PROBLEM/DIAGNOSIS OCCURRENCE SUMMARY)	0..1

2.32 Link to Occurrence Details

Identification

Label	Link to Occurrence Details
Metadata Type	Data Element
Identifier	DE-10124
OID	1.2.36.1.2001.1001.101.103.10124

Definition


Definition	Link to further information about past occurrences or exacerbations of the problem/diagnosis that exist elsewhere in the health record.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	Link

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for Link .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Occurrence Summary (PROBLEM/DIAGNOSIS OCCURRENCE SUMMARY)	0..*

2.33 RELATED ITEMS

Identification


Label	RELATED ITEMS
Metadata Type	Data Group
Identifier	DG-16541
OID	1.2.36.1.2001.1001.101.102.16541

Definition



Definition	Further problems, diagnoses, procedures, substances or events that are related in some way to this problem/diagnosis.
Definition Source	Australian Digital Health Agency
Synonymous Names	

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PROBLEM/DIAGNOSIS	0..*

Children

Data Type	Name	Occurrences
	Related Item	1..1
	Item Relationship Type	0..1

2.34 Related Item

Identification

Label	Related Item
Metadata Type	Data Element
Identifier	DE-15562
OID	1.2.36.1.2001.1001.101.103.15562

Definition


Definition	Identification of a related problem, diagnosis, procedure, substance or event as text, coded text or link within the health record.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	This item identifies the relevant health problem experienced by the subject of care, as assessed by the healthcare provider. This element provides a link to one or more established problem(s) or diagnoses.
Data Type	CodeableText
Value Domain	Related Item Values

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for CodeableText .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	RELATED ITEMS	1..1

2.35 Related Item Values

Identification

Label	Related Item Values
Metadata Type	Value Domain
Identifier	VD-15562
OID	1.2.36.1.2001.1001.101.104.15562

Definition


Definition	The set of values for related items.
Definition Source	Australian Digital Health Agency
Notes	An explanation of AMT concepts can be found in Australian Medicines Terminology v3 Model - Editorial Rules v2.0 [NEHT2014ag] .

Value Domain

Source	Australian Digital Health Agency
Permissible Values	<p>The permissible values are the members of the following reference sets:</p> <p>SNOMED CT-AU:</p> <ul style="list-style-type: none"> • 32570071000036102 <i>Clinical finding foundation reference set</i> • 32570141000036105 <i>Procedure foundation reference set</i> • 32570091000036103 <i>Event foundation reference set</i> • 32570111000036109 <i>Organism foundation reference set</i> • 32570211000036100 <i>Substance foundation reference set</i> • 32570131000036100 <i>Physical object foundation reference set</i> • 32570121000036102 <i>Physical force foundation reference set</i> <p>AMT:</p> <ul style="list-style-type: none"> • 929360061000036106 <i>Medicinal product reference set</i> • 929360081000036101 <i>Medicinal product pack reference set</i> • 929360071000036103 <i>Medicinal product unit of use reference set</i> • 929360021000036102 <i>Trade product reference set</i> • 929360041000036105 <i>Trade product pack reference set</i> • 929360031000036100 <i>Trade product unit of use reference set</i> • 929360051000036108 <i>Containerized trade product pack reference set</i>

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Related Item	1..1

2.36 Item Relationship Type

Identification

Label	Item Relationship Type
Metadata Type	Data Element
Identifier	DE-16560
OID	1.2.36.1.2001.1001.101.103.16560

Definition

Definition	The type of relationship that this problem/diagnosis has to the related item.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	CodedText
Value Domain	<i>Not specified.</i>
	In the absence of national standard code sets, the code sets used SHALL be registered code sets, i.e. registered through the HL7 code set registration procedure ⁵ with an appropriate object identifier (OID), and SHALL be publicly available.
	When national standard code sets become available, they SHALL be used and the non-standard code sets SHALL be deprecated.


Usage

Examples	<ol style="list-style-type: none"> 1) Caused by: This concept identifies the direct cause or causative agent of a problem/diagnosis. The concept includes the idea of complications, causative agent and due to. Note: Where no causality or sequence of events is known, this relationship type should be left blank. 2) Following: This value identifies the sequence of events between the related items, but does not assert causality. This can be used for sequelae or late effects. Note: Where no causality or sequence of events is known, this relationship type should be left blank.
Exceptional Values	<p>Absent values are PROHIBITED.</p> <p>Abnormal values are PROHIBITED.</p>

⁵ <http://www.hl7.org/oid/index.cfm>

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	RELATED ITEMS	0..1

2.37 Date of Resolution/Remission

Identification

Label	Date of Resolution/Remission
Metadata Type	Data Element
Identifier	DE-15510
OID	1.2.36.1.2001.1001.101.103.15510

Definition


Definition	Estimated or actual date the problem or diagnosis resolved or went into remission, as indicated or identified by the clinician.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	DateTime

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for DateTime .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PROBLEM/DIAGNOSIS	0..1

2.38 Age at Resolution/Remission

Identification

Label	Age at Resolution/Remission
Metadata Type	Data Element
Identifier	DE-16544
OID	1.2.36.1.2001.1001.101.103.16544

Definition


Definition	The age of the person at the time of resolution or remission of the problem/diagnosis.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	May be important in situations where approximations of age based on calculations are not accurate enough, e.g. in infants under one year.
Data Type	Duration

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for Duration .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PROBLEM/DIAGNOSIS	0..1

2.39 Diagnostic Criteria

Identification

Label	Diagnostic Criteria
Metadata Type	Data Element
Identifier	DE-16623
OID	1.2.36.1.2001.1001.101.105.16623

Definition


Definition	The criteria on which the problem/diagnosis is based.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	This free text data element is currently a placeholder for further structured data that is as yet undefined. See Appendix A, Known Issues for further information.
Data Type	Text

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for Text .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PROBLEM/DIAGNOSIS	0..*

2.40 Clinical Stage/Grade

Identification

Label	Clinical Stage/Grade
Metadata Type	Data Element
Identifier	DE-16624
OID	1.2.36.1.2001.1001.101.105.16624

Definition


Definition	Clinical stage or grade of a problem/diagnosis.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	This free text data element is currently a placeholder for further structured data that is as yet undefined. See Appendix A, Known Issues for further information.
Data Type	Text

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for Text .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PROBLEM/DIAGNOSIS	0..*

2.41 Problem/Diagnosis Comment

Identification

Label	Problem/Diagnosis Comment
Metadata Type	Data Element
Identifier	DE-16545
OID	1.2.36.1.2001.1001.101.103.16545

Definition


Definition	Additional narrative about the problem or diagnosis not captured in other fields.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	Text

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for Text .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PROBLEM/DIAGNOSIS	0..1

2.42 Link to Supporting Clinical Evidence

Identification

Label	Link to Supporting Clinical Evidence
Metadata Type	Data Element
Identifier	DE-16546
OID	1.2.36.1.2001.1001.101.103.16546

Definition


Definition	Links to other relevant information, including pathology reports.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	Link

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for Link .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PROBLEM/DIAGNOSIS	0..1

2.43 Status

Identification

Label	Status
Metadata Type	Data Element
Identifier	DE-16625
OID	1.2.36.1.2001.1001.101.105.16625

Definition


Definition	Descriptor for context- or use-case specific label or workflow-related aspect of the diagnostic process.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	<p>It is important to note that the value captured by this data element is not safe to be used or persisted outside the context under which the data value is created and intended to be used, for example, in discharge summary or referral.</p> <p>This free text data element is currently a placeholder for further structured data that is as yet undefined. See Appendix A, <i>Known Issues</i> for further information.</p>
Data Type	Text

Usage

Examples	Please see Appendix B, <i>Specification Guide for Use</i> for examples and usage information for Text .
-----------------	---

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PROBLEM/DIAGNOSIS	0..*

2.44 INFORMATION PROVIDER

Identification

Label	INFORMATION PROVIDER
Metadata Type	Data Group
Identifier	DG-10296
OID	1.2.36.1.2001.1001.101.102.10296

Definition


Definition	Source of the information.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Scope	Only used when the recorder needs to make it explicit. Otherwise, it is assumed to be the subject of care of the enclosing structured document.
Scope Source	Australian Digital Health Agency
Notes	<p>This does not have to be a person and, in particular, does not have to be a healthcare provider. Types of sources include:</p> <ul style="list-style-type: none"> • an agent of a subject of care, e.g. parent, guardian; • a clinician; • a device or software; and • the subject of the DCM, when not the subject of care of the enclosing structured document.

Usage

Conditions of Use	<p>This SHALL NOT be used if the source of the information is the <i>SUBJECT OF CARE</i> of the enclosing structured document.</p> <p>This is a reuse of the <i>PARTICIPATION</i> data group, which is described in Participation Data Specification [NEHT2011v]. Further constraints on this data group that apply to this reuse of it are listed below.</p> <ul style="list-style-type: none"> • Participation Type SHALL have an implementation-specific value equivalent to "Information Provider". • PERSON OR ORGANISATION OR DEVICE SHALL be instantiated as a PERSON or as a DEVICE. <p>Terms used in obligation and occurrence constraints are explained in Appendix B, Specification Guide for Use.</p>
Conditions of Use Source	Australian Digital Health Agency

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PROBLEM/DIAGNOSIS	0..1

2.45 SUBJECT

Identification

Label	SUBJECT
Metadata Type	Data Group
Identifier	DG-10296
OID	1.2.36.1.2001.1001.101.102.10296

Definition


Definition	The individual about whom the problem/diagnosis information is being recorded.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Scope	Only used when the recorder needs to make it explicit. Otherwise, it is assumed to be the subject of care of the enclosing structured document.
Scope Source	Australian Digital Health Agency

Usage

Conditions of Use	<p>This SHALL NOT be used if the subject of the information is the <i>SUBJECT OF CARE</i> of the enclosing structured document.</p> <p>This is a reuse of the <i>PARTICIPATION</i> data group, which is described in Participation Data Specification [NEHT2011v]. Further constraints on this data group that apply to this reuse of it are listed below.</p> <ul style="list-style-type: none"> Participation Type SHALL have an implementation-specific value equivalent to "Subject". PERSON OR ORGANISATION OR DEVICE SHALL be instantiated as a PERSON. <p>Terms used in obligation and occurrence constraints are explained in Appendix B, Specification Guide for Use.</p>
Conditions of Use Source	Australian Digital Health Agency

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PROBLEM/DIAGNOSIS	0..1

2.46 Problem/Diagnosis Instance Identifier

Identification

Label	Problem/Diagnosis Instance Identifier
Metadata Type	Data Element
Identifier	DE-16702
OID	1.2.36.1.2001.1001.101.103.16702

Definition


Definition	A globally unique identifier for each instance of a <i>Problem/Diagnosis</i> evaluation.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Exceptional Values	Absent values are PROHIBITED . Abnormal values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PROBLEM/DIAGNOSIS	0..1

2.47 RELATED INFORMATION

Identification


Label	RELATED INFORMATION
Metadata Type	Data Group
Identifier	DG-16692
OID	1.2.36.1.2001.1001.101.102.16692

Definition


Definition	Information held elsewhere that is relevant to this instance of <i>Problem/Diagnosis</i> .
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	<p>Items of related information include, but are not limited to, documents, parts of documents, images and web pages.</p> <p>“Elsewhere” includes elsewhere in the same document.</p> <p>1:1 and 1:N relationships between instances of DCMs can be expressed by using one, or more than one, respectively, links. Chains of links can be used to see problem threads or other logical groupings of items.</p> <p>Links are only to be used between instances of DCMs or documents, i.e. between objects representing complete domain concepts. This is because relationships between sub-elements of whole concepts are not necessarily meaningful and may be confusing.</p> <p>When the item of related information is a complete document (including images) or a web page (or part thereof) an appropriate specialisation of the <i>Related Information</i> data group should be used.</p> <p>The document or other data component instance containing the <i>Related Information</i> data group is called the <i>source</i>. The related information is called the <i>target</i>.</p>



Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PROBLEM/DIAGNOSIS	0..*

Children

Data Type	Name	Occurrences
	Link Nature	1..1

Data Type	Name	Occurrences
	Link Role	0..1
	Target	1..1

2.48 Link Nature

Identification

Label	Link Nature
Metadata Type	Data Element
Identifier	DE-16698
OID	1.2.36.1.2001.1001.101.103.16698

Definition


Definition	The general semantic category of the relationship between this instance of this detailed clinical model (DCM), i.e. the source, and the target DCM instance or target document.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	This is one of two attributes that together communicate the semantics of the relationship between the source and target DCMs or document. This attribute is intended to be a coarse-grained category that can be used to enable interoperability between sender and receiver.
Data Type	CodedText
Value Domain	Link Nature Values

Usage

Examples	<ol style="list-style-type: none"> 1) is related to 2) is confirmed by or authorised by 3) is related to the same problem or health issue
Exceptional Values	<p>Absent values are PROHIBITED.</p> <p>Abnormal values are PROHIBITED.</p>

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	RELATED INFORMATION	1..1

2.49 Link Nature Values

Identification

Label	Link Nature Values
Metadata Type	Value Domain
Identifier	VD-16698
OID	1.2.36.1.2001.1001.101.104.16698
External Identifier	LINK_NATURE

Definition


Definition	Set of values for the general semantic category of the relationship between this instance of this DCM, i.e. the source, and the target DCM instance or target document.
Definition Source	Australian Digital Health Agency

Value Domain

Source	ISO 13606-3:2009	
Permissible Values	The permissible values are those specified in Termlist LINK_NATURE in ISO 13606-3:2009 Health informatics - Electronic health record communication - Part 3: Reference archetypes and term lists [ISO2009a] . The values are listed here with brief descriptions.	
	LINK-A0, is related to	The most general category of Link.
	LINK-B0, is confirmed by or authorised by	The link target contains an instance of a DCM or document that is either a legal or authoritative basis for what is documented in the source DCM instance, or is a declaration of intent to provide (or not provide) requested care.
	LINK-C0, is related to the same problem or health issue	The target instance of a DCM or document describes health or healthcare that concerns the same clinical situation as the source DCM instance.
	LINK-D0, is related to the same care plan, act or episode	The source and the target instances of DCMs or documents both describe parts of the same care plan, act or episode.
	LINK-E0, is a related documentation	The target instance of a DCM or document is an alternative documentary form of the source DCM instance. For example, a re-expression of the same clinical information or supplementary explanatory information.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
 001011001	Link Nature	1..1

2.50 Link Role

Identification

Label	Link Role
Metadata Type	Data Element
Identifier	DE-16699
OID	1.2.36.1.2001.1001.101.103.16699

Definition


Definition	The detailed semantic description of the relationship between this instance of this detailed clinical model (DCM), i.e. the source, and the target DCM instance or target document.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	<p>This is one of two attributes that together communicate the semantics of the relationship between the source and target DCMs. This attribute provides for a specific description of the actual role played by the target in relation to the source.</p> <p>This attribute may be populated from any suitable terminology and therefore might support human readership better than interoperable automated processing.</p>
Data Type	CodeableText
Value Domain	Link Role Values

Usage

Examples	<ol style="list-style-type: none"> 1) unspecified link 2) suggests 3) endorses 4) evidence for 5) outcome 6) is documented by 7) excerpts
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	RELATED INFORMATION	0..1

2.51 Link Role Values

Identification

Label	Link Role Values
Metadata Type	Value Domain
Identifier	VD-16699
OID	1.2.36.1.2001.1001.101.104.16699
External Identifier	LINK_ROLE

Definition

Definition	Set of values for the detailed semantic description of the relationship between this instance of this DCM, i.e. the source, and the target DCM instance or target document.
Definition Source	Australian Digital Health Agency
Context	These values are used within the context of the value of the <i>Link Nature</i> data element. They provide greater specificity and may be selected more for human readership than for interoperable automated processing.
Context Source	Australian Digital Health Agency

Value Domain


Source	ISO 13606-3:2009														
Permissible Values	<p>Values SHOULD be from Termlist LINK_ROLE in ISO 13606-3:2009 [ISO2009a].</p> <p>Values MAY be from any suitable terminology.</p> <p>Some values from Termlist LINK_ROLE in ISO 13606-3:2009 Health informatics - Electronic health record communication - Part 3: Reference archetypes and term lists [ISO2009a], together with brief descriptions, are:</p> <table border="0"> <tr> <td>LINK-A1, unspecified link</td> <td>This can be used to say explicitly “there is no semantic information available for this Link”.</td> </tr> <tr> <td>LINK-B1, endorses</td> <td>The source endorses (agrees with, confirms or verifies) the situation (or interpretation) described in the target.</td> </tr> <tr> <td>LINK-C3, evidence for</td> <td>The source describes evidence for the situation (or interpretation) described in the target.</td> </tr> <tr> <td>LINK-D1, outcome</td> <td>The source describes an outcome of the situation (or interpretation) that the target describes.</td> </tr> <tr> <td>LINK-E1, documented by</td> <td>The source is a less formal description of the situation (or interpretation) documented by the target.</td> </tr> <tr> <td>LINK-E4, excerpts</td> <td>The source is an extract (copy) of part or all of the information contained within the target.</td> </tr> <tr> <td>LINK-E5, derived from</td> <td>The source contains information that has been derived (e.g. calculated) from information in the target.</td> </tr> </table>	LINK-A1, unspecified link	This can be used to say explicitly “there is no semantic information available for this Link”.	LINK-B1, endorses	The source endorses (agrees with, confirms or verifies) the situation (or interpretation) described in the target.	LINK-C3, evidence for	The source describes evidence for the situation (or interpretation) described in the target.	LINK-D1, outcome	The source describes an outcome of the situation (or interpretation) that the target describes.	LINK-E1, documented by	The source is a less formal description of the situation (or interpretation) documented by the target.	LINK-E4, excerpts	The source is an extract (copy) of part or all of the information contained within the target.	LINK-E5, derived from	The source contains information that has been derived (e.g. calculated) from information in the target.
LINK-A1, unspecified link	This can be used to say explicitly “there is no semantic information available for this Link”.														
LINK-B1, endorses	The source endorses (agrees with, confirms or verifies) the situation (or interpretation) described in the target.														
LINK-C3, evidence for	The source describes evidence for the situation (or interpretation) described in the target.														
LINK-D1, outcome	The source describes an outcome of the situation (or interpretation) that the target describes.														
LINK-E1, documented by	The source is a less formal description of the situation (or interpretation) documented by the target.														
LINK-E4, excerpts	The source is an extract (copy) of part or all of the information contained within the target.														
LINK-E5, derived from	The source contains information that has been derived (e.g. calculated) from information in the target.														

Usage

Conditions of Use	Each of the values in LINK_ROLE from ISO 13606-3:2009 identifies a subcategory of a corresponding value in <i>Link Nature Values</i> . That correspondence is indicated by the first letter after the code string "LINK-". For example, the term LINK-A1 is a subcategory of term LINK-A0. If a term in this list is used for the <i>Link Role</i> data element, the appropriate corresponding value SHALL be used for <i>Link Nature Values</i> .
Conditions of Use Source	ISO 13606-3:2009

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Link Role	1..1

2.52 Target

Identification

Label	Target
Metadata Type	Data Element
Identifier	DE-16700
OID	1.2.36.1.2001.1001.101.103.16700

Definition


Definition	The “linked to” or identified information.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	Link UniquelIdentifier

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for Link , and UniquelIdentifier .
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Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	RELATED INFORMATION	1..1

2.53 Detailed Clinical Model Identifier

Identification

Label	Detailed Clinical Model Identifier
Metadata Type	Data Element
Identifier	DE-16693
OID	1.2.36.1.2001.1001.101.103.16693

Definition


Definition	A globally unique identifier for this detailed clinical model.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Conditions of Use	The value of this item SHALL be either the default value or a semantically equivalent value from an appropriate code system.
Conditions of Use Source	Australian Digital Health Agency
Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Default Value	1.2.36.1.2001.1001.101.102.15530
Exceptional Values	Absent values are PROHIBITED . Abnormal values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PROBLEM/DIAGNOSIS	1..1

3 Exclusion Statement - Problems and Diagnoses Detailed Clinical Model

This chapter describes version 1.4 of the *Exclusion Statement - Problems and Diagnoses Detailed Clinical Model*.

3.1 Purpose

To positively record the absence or exclusion of any problems or diagnoses within the health record.

3.2 Use

Use to record the positive exclusion or absence of problems or diagnoses within the health record. This Detailed Clinical Model (DCM) avoids the need to use terminology to express negation about any problem or diagnoses within the health record. This DCM is only to be used to record 'point in time' information. It is not to be used for a persistent storage of information as the patient should always be questioned about past or existing problems and diagnoses; diagnosis should always be undertaken prior to initiation of any treatment or management plan.

3.3 UML Class Diagrams

The following figure represents the data hierarchy using a UML 2.0 class diagram. The diagram displays data groups and data elements, together with their names, data types and multiplicities. Data elements are displayed as attributes; data groups are displayed as classes; their label names are represented as association role names. Association role names are only displayed if they differ from the associated class name. When a data element has a choice of data types, the data type of the attribute that represents it is an abstract interface class generalised from the individual data types. The diagram shows the data hierarchy excluding the details of participation. The default multiplicity is 1..1.

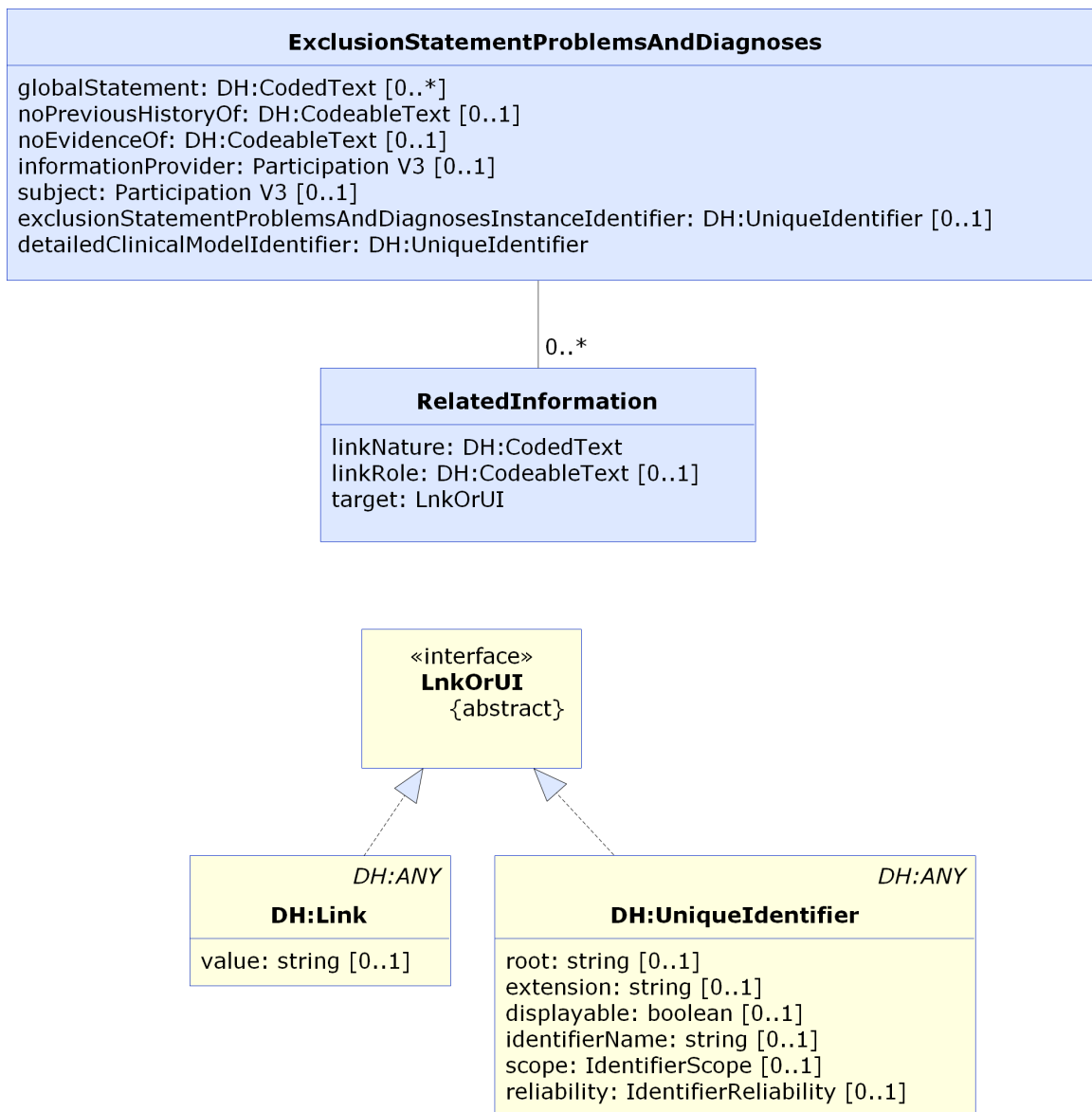


Figure 3.1. Exclusion Statement for Problems and Diagnoses

3.4 EXCLUSION STATEMENT - PROBLEMS AND DIAGNOSES

Identification

Label	EXCLUSION STATEMENT - PROBLEMS AND DIAGNOSES
Metadata Type	Data Group
Identifier	DG-16138
OID	1.2.36.1.2001.1001.101.102.16138

Definition

Definition	Statements to positively assert that the patient does not have the problem or diagnosis.
Definition Source	openEHR Foundation
Scope	To positively record the absence or exclusion of any problems or diagnoses within the health record.
Scope Source	openEHR Foundation

Usage

Conditions of Use	Use to record the positive exclusion or absence of problems or diagnoses within the health record. This data group avoids the need to use terminology to express negation about any problem or diagnosis within the health record. The positive assertion and persistence of absence of problem or diagnosis is time-specific. It is important to note that the patient's condition should be reviewed and required to validate such statement at each encounter.
Conditions of Use Source	openEHR Foundation










Data Hierarchy



Note

Items below whose text is lighter (mid-blue and mid-grey) are technical identifiers whose purpose is to facilitate interoperability, sharing of data and secondary use. Typically, such identifiers will be generated internally by systems and not displayed to users since they rarely have clinical significance.

EXCLUSION STATEMENT - PROBLEMS AND DIAGNOSES			
		Global Statement	0..*
		No Previous History of	0..1
		No Evidence of	0..1

		INFORMATION PROVIDER	0..1
		SUBJECT	0..1
		Exclusion Statement - Problems and Diagnoses Instance Identifier	0..1
		RELATED INFORMATION	0..*
		Link Nature	1..1
		Link Role	0..1
	 	Target	1..1
		Detailed Clinical Model Identifier	1..1

3.5 Global Statement

Identification

Label	Global Statement
Metadata Type	Data Element
Identifier	DE-16302
OID	1.2.36.1.2001.1001.101.103.16302

Definition


Definition	The statement about the absence or exclusion.
Definition Source	openEHR Foundation
Synonymous Names	
Context	This can be used to capture any information that is needed to be explicitly recorded within the record as being absent or excluded.
Context Source	openEHR Foundation
Data Type	CodedText
Value Domain	Global Statement Values

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for CodedText .
Exceptional Values	Absent values are PROHIBITED . Abnormal values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	EXCLUSION STATEMENT - PROBLEMS AND DIAGNOSES	0..*

3.6 Global Statement Values

Identification

Label	Global Statement Values
Metadata Type	Value Domain
Identifier	VD-16299
OID	1.2.36.1.2001.1001.101.104.16299

Definition


Definition	The set of values for the global statements about the exclusion of problems or diagnoses.
Definition Source	openEHR Foundation

Value Domain

Source	Australian Digital Health Agency
Permissible Values	01, None known No information about any problem or diagnosis is known.
	02, Not asked No information about any problem or diagnosis is available because the patient was not asked or not able to be asked.
	03, None supplied No information about any problem or diagnosis is supplied.
	Please see Appendix A, Known Issues .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Global Statement	1..1

3.7 No Previous History of Identification

Label	No Previous History of
Metadata Type	Data Element
Identifier	DE-16303
OID	1.2.36.1.2001.1001.101.103.16303

Definition


Definition	Positive statement about problems and diagnoses that are explicitly known to have not been identified at the time of recording.
Definition Source	openEHR Foundation
Synonymous Names	
Data Type	CodeableText
Value Domain	<i>Not specified.</i>
	In the absence of national standard code sets, the code sets used SHALL be registered code sets, i.e. registered through the HL7 code set registration procedure ¹ with an appropriate object identifier (OID), and SHALL be publicly available.
	When national standard code sets become available, they SHALL be used and the non-standard code sets SHALL be deprecated.

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for CodeableText .
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Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	EXCLUSION STATEMENT - PROBLEMS AND DIAGNOSES	0..1

¹ <http://www.hl7.org/oid/index.cfm>

3.8 No Evidence of

Identification

Label	No Evidence of
Metadata Type	Data Element
Identifier	DE-16304
OID	1.2.36.1.2001.1001.101.103.16304

Definition


Definition	Positive statement about problems and diagnoses that are explicitly known to have no evidence supporting their existence at the time of recording.
Definition Source	openEHR Foundation
Synonymous Names	
Data Type	CodeableText
Value Domain	<i>Not specified.</i>
	In the absence of national standard code sets, the code sets used SHALL be registered code sets, i.e. registered through the HL7 code set registration procedure ² with an appropriate object identifier (OID), and SHALL be publicly available.
	When national standard code sets become available, they SHALL be used and the non-standard code sets SHALL be deprecated.

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for CodeableText .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	EXCLUSION STATEMENT - PROBLEMS AND DIAGNOSES	0..1

² <http://www.hl7.org/oid/index.cfm>

3.9 INFORMATION PROVIDER

Identification

Label	INFORMATION PROVIDER
Metadata Type	Data Group
Identifier	DG-10296
OID	1.2.36.1.2001.1001.101.102.10296

Definition


Definition	Source of the information.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Scope	Only used when the recorder needs to make it explicit. Otherwise, it is assumed to be the subject of care of the enclosing structured document.
Scope Source	Australian Digital Health Agency
Notes	<p>This does not have to be a person and, in particular, does not have to be a healthcare provider. Types of sources include:</p> <ul style="list-style-type: none"> • an agent of a subject of care, e.g. parent, guardian; • a clinician; • a device or software; and • the subject of the DCM, when not the subject of care of the enclosing structured document.

Usage

Conditions of Use	<p>This SHALL NOT be used if the source of the information is the <i>SUBJECT OF CARE</i> of the enclosing structured document.</p> <p>This is a reuse of the <i>PARTICIPATION</i> data group, which is described in Participation Data Specification [NEHT2011v]. Further constraints on this data group that apply to this reuse of it are listed below.</p> <ul style="list-style-type: none"> • Participation Type SHALL have an implementation-specific value equivalent to "Information Provider". • PERSON OR ORGANISATION OR DEVICE SHALL be instantiated as a PERSON or as a DEVICE. <p>Terms used in obligation and occurrence constraints are explained in Appendix B, Specification Guide for Use.</p>
Conditions of Use Source	Australian Digital Health Agency

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	EXCLUSION STATEMENT - PROBLEMS AND DIAGNOSES	0..1

3.10 SUBJECT

Identification

Label	SUBJECT
Metadata Type	Data Group
Identifier	DG-10296
OID	1.2.36.1.2001.1001.101.102.10296

Definition


Definition	The individual about whom the problem/diagnosis information is being recorded.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Scope	Only used when the recorder needs to make it explicit. Otherwise, it is assumed to be the subject of care of the enclosing structured document.
Scope Source	Australian Digital Health Agency

Usage

Conditions of Use	<p>This SHALL NOT be used if the subject of the information is the <i>SUBJECT OF CARE</i> of the enclosing structured document.</p> <p>This is a reuse of the <i>PARTICIPATION</i> data group, which is described in Participation Data Specification [NEHT2011v]. Further constraints on this data group that apply to this reuse of it are listed below.</p> <ul style="list-style-type: none"> Participation Type SHALL have an implementation-specific value equivalent to "Subject". PERSON OR ORGANISATION OR DEVICE SHALL be instantiated as a PERSON. <p>Terms used in obligation and occurrence constraints are explained in Appendix B, Specification Guide for Use.</p>
Conditions of Use Source	Australian Digital Health Agency

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	EXCLUSION STATEMENT - PROBLEMS AND DIAGNOSES	0..1

3.11 Exclusion Statement - Problems and Diagnoses Instance Identifier

Identification

Label	Exclusion Statement - Problems and Diagnoses Instance Identifier
Metadata Type	Data Element
Identifier	DE-16710
OID	1.2.36.1.2001.1001.101.103.16710

Definition


Definition	A globally unique object identifier for each instance of an <i>Exclusion Statement - Problems and Diagnoses</i> evaluation.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Exceptional Values	Absent values are PROHIBITED . Abnormal values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	EXCLUSION STATEMENT - PROBLEMS AND DIAGNOSES	0..1

3.12 RELATED INFORMATION

Identification


Label	RELATED INFORMATION
Metadata Type	Data Group
Identifier	DG-16692
OID	1.2.36.1.2001.1001.101.102.16692

Definition


Definition	Information held elsewhere that is relevant to this instance of <i>Exclusion Statement - Problem/Diagnosis</i> .
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	<p>Items of related information include, but are not limited to, documents, parts of documents, images and web pages.</p> <p>“Elsewhere” includes elsewhere in the same document.</p> <p>1:1 and 1:N relationships between instances of DCMs can be expressed by using one, or more than one, respectively, links. Chains of links can be used to see problem threads or other logical groupings of items.</p> <p>Links are only to be used between instances of DCMs or documents, i.e. between objects representing complete domain concepts. This is because relationships between sub-elements of whole concepts are not necessarily meaningful and may be confusing.</p> <p>When the item of related information is a complete document (including images) or a web page (or part thereof) an appropriate specialisation of the <i>Related Information</i> data group should be used.</p> <p>The document or other data component instance containing the <i>Related Information</i> data group is called the <i>source</i>. The related information is called the <i>target</i>.</p>



Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	EXCLUSION STATEMENT - PROBLEMS AND DIAGNOSES	0..*

Children

Data Type	Name	Occurrences
	Link Nature	1..1

Data Type	Name	Occurrences
	Link Role	0..1
	Target	1..1

3.13 Link Nature

Identification

Label	Link Nature
Metadata Type	Data Element
Identifier	DE-16698
OID	1.2.36.1.2001.1001.101.103.16698

Definition


Definition	The general semantic category of the relationship between this instance of this detailed clinical model (DCM), i.e. the source, and the target DCM instance or target document.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	This is one of two attributes that together communicate the semantics of the relationship between the source and target DCMs or document. This attribute is intended to be a coarse-grained category that can be used to enable interoperability between sender and receiver.
Data Type	CodedText
Value Domain	Link Nature Values

Usage

Examples	<ol style="list-style-type: none"> 1) is related to 2) is confirmed by or authorised by 3) is related to the same problem or health issue
Exceptional Values	<p>Absent values are PROHIBITED.</p> <p>Abnormal values are PROHIBITED.</p>

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	RELATED INFORMATION	1..1

3.14 Link Nature Values

Identification

Label	Link Nature Values
Metadata Type	Value Domain
Identifier	VD-16698
OID	1.2.36.1.2001.1001.101.104.16698
External Identifier	LINK_NATURE

Definition


Definition	Set of values for the general semantic category of the relationship between this instance of this DCM, i.e. the source, and the target DCM instance or target document.
Definition Source	Australian Digital Health Agency

Value Domain

Source	ISO 13606-3:2009	
Permissible Values	The permissible values are those specified in Termlist LINK_NATURE in ISO 13606-3:2009 Health informatics - Electronic health record communication - Part 3: Reference archetypes and term lists [ISO2009a] . The values are listed here with brief descriptions.	
	LINK-A0, is related to	The most general category of Link.
	LINK-B0, is confirmed by or authorised by	The link target contains an instance of a DCM or document that is either a legal or authoritative basis for what is documented in the source DCM instance, or is a declaration of intent to provide (or not provide) requested care.
	LINK-C0, is related to the same problem or health issue	The target instance of a DCM or document describes health or healthcare that concerns the same clinical situation as the source DCM instance.
	LINK-D0, is related to the same care plan, act or episode	The source and the target instances of DCMs or documents both describe parts of the same care plan, act or episode.
	LINK-E0, is a related documentation	The target instance of a DCM or document is an alternative documentary form of the source DCM instance. For example, a re-expression of the same clinical information or supplementary explanatory information.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Link Nature	1..1

3.15 Link Role

Identification

Label	Link Role
Metadata Type	Data Element
Identifier	DE-16699
OID	1.2.36.1.2001.1001.101.103.16699

Definition


Definition	The detailed semantic description of the relationship between this instance of this detailed clinical model (DCM), i.e. the source, and the target DCM instance or target document.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	<p>This is one of two attributes that together communicate the semantics of the relationship between the source and target DCMs. This attribute provides for a specific description of the actual role played by the target in relation to the source.</p> <p>This attribute may be populated from any suitable terminology and therefore might support human readership better than interoperable automated processing.</p>
Data Type	CodeableText
Value Domain	Link Role Values

Usage

Examples	<ol style="list-style-type: none"> 1) unspecified link 2) suggests 3) endorses 4) evidence for 5) outcome 6) is documented by 7) excerpts
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	RELATED INFORMATION	0..1

3.16 Link Role Values

Identification

Label	Link Role Values
Metadata Type	Value Domain
Identifier	VD-16699
OID	1.2.36.1.2001.1001.101.104.16699
External Identifier	LINK_ROLE

Definition

Definition	Set of values for the detailed semantic description of the relationship between this instance of this DCM, i.e. the source, and the target DCM instance or target document.
Definition Source	Australian Digital Health Agency
Context	These values are used within the context of the value of the <i>Link Nature</i> data element. They provide greater specificity and may be selected more for human readership than for interoperable automated processing.
Context Source	Australian Digital Health Agency

Value Domain


Source	ISO 13606-3:2009														
Permissible Values	<p>Values SHOULD be from Termlist LINK_ROLE in ISO 13606-3:2009 [ISO2009a].</p> <p>Values MAY be from any suitable terminology.</p> <p>Some values from Termlist LINK_ROLE in ISO 13606-3:2009 Health informatics - Electronic health record communication - Part 3: Reference archetypes and term lists [ISO2009a], together with brief descriptions, are:</p> <table border="1"> <tr> <td>LINK-A1, unspecified link</td> <td>This can be used to say explicitly “there is no semantic information available for this Link”.</td> </tr> <tr> <td>LINK-B1, endorses</td> <td>The source endorses (agrees with, confirms or verifies) the situation (or interpretation) described in the target.</td> </tr> <tr> <td>LINK-C3, evidence for</td> <td>The source describes evidence for the situation (or interpretation) described in the target.</td> </tr> <tr> <td>LINK-D1, outcome</td> <td>The source describes an outcome of the situation (or interpretation) that the target describes.</td> </tr> <tr> <td>LINK-E1, documented by</td> <td>The source is a less formal description of the situation (or interpretation) documented by the target.</td> </tr> <tr> <td>LINK-E4, excerpts</td> <td>The source is an extract (copy) of part or all of the information contained within the target.</td> </tr> <tr> <td>LINK-E5, derived from</td> <td>The source contains information that has been derived (e.g. calculated) from information in the target.</td> </tr> </table>	LINK-A1, unspecified link	This can be used to say explicitly “there is no semantic information available for this Link”.	LINK-B1, endorses	The source endorses (agrees with, confirms or verifies) the situation (or interpretation) described in the target.	LINK-C3, evidence for	The source describes evidence for the situation (or interpretation) described in the target.	LINK-D1, outcome	The source describes an outcome of the situation (or interpretation) that the target describes.	LINK-E1, documented by	The source is a less formal description of the situation (or interpretation) documented by the target.	LINK-E4, excerpts	The source is an extract (copy) of part or all of the information contained within the target.	LINK-E5, derived from	The source contains information that has been derived (e.g. calculated) from information in the target.
LINK-A1, unspecified link	This can be used to say explicitly “there is no semantic information available for this Link”.														
LINK-B1, endorses	The source endorses (agrees with, confirms or verifies) the situation (or interpretation) described in the target.														
LINK-C3, evidence for	The source describes evidence for the situation (or interpretation) described in the target.														
LINK-D1, outcome	The source describes an outcome of the situation (or interpretation) that the target describes.														
LINK-E1, documented by	The source is a less formal description of the situation (or interpretation) documented by the target.														
LINK-E4, excerpts	The source is an extract (copy) of part or all of the information contained within the target.														
LINK-E5, derived from	The source contains information that has been derived (e.g. calculated) from information in the target.														

Usage

Conditions of Use	Each of the values in LINK_ROLE from ISO 13606-3:2009 identifies a subcategory of a corresponding value in <i>Link Nature Values</i> . That correspondence is indicated by the first letter after the code string "LINK-". For example, the term LINK-A1 is a subcategory of term LINK-A0. If a term in this list is used for the <i>Link Role</i> data element, the appropriate corresponding value SHALL be used for <i>Link Nature Values</i> .
Conditions of Use Source	ISO 13606-3:2009

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Link Role	1..1

3.17 Target

Identification

Label	Target
Metadata Type	Data Element
Identifier	DE-16700
OID	1.2.36.1.2001.1001.101.103.16700

Definition


Definition	The “linked to” or identified information.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	Link UniquelIdentifier

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for Link , and UniquelIdentifier .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	RELATED INFORMATION	1..1

3.18 Detailed Clinical Model Identifier

Identification

Label	Detailed Clinical Model Identifier
Metadata Type	Data Element
Identifier	DE-16693
OID	1.2.36.1.2001.1001.101.103.16693

Definition


Definition	A globally unique identifier for this detailed clinical model.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Conditions of Use	The value of this item SHALL be either the default value or a semantically equivalent value from an appropriate code system.
Conditions of Use Source	Australian Digital Health Agency
Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Default Value	1.2.36.1.2001.1001.101.102.16138
Exceptional Values	Absent values are PROHIBITED . Abnormal values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	EXCLUSION STATEMENT - PROBLEMS AND DIAGNOSES	1..1

4 Procedure Detailed Clinical Model

This chapter describes version 4.3 of the *Procedure (Action)* Detailed Clinical Model.

4.1 Purpose

To record information about the activities required to carry out a procedure, including the planning, scheduling, performance, suspension, cancellation, documentation and completion.

4.2 Use

Use to record information about the activities required to carry out a procedure, including the planning, scheduling, performance, suspension, cancellation, documentation and completion.

The scope of this archetype encompasses activities for a broad range of clinical procedures performed for therapeutic, evaluative, investigative, screening or diagnostic purposes. Examples range from relatively simple activities, such as insertion of an intravenous cannula, through to complex surgical operations.

Additional structured and detailed information about the procedure can be captured using purpose-specific data groups inserted into the *Procedure Detail* slot, where required.

Within the context of an operation report, this DCM will be used to record only what was done during the procedure. Separate DCMs will be used to record the other required components of the operation report, including the taking of tissue specimen samples, use of imaging guidance, operation findings, post-operative instructions and plans for follow-up.

Within the context of a problem list or summary, this DCM may be used to represent procedures that have been performed. The *Problem/Diagnosis* archetype will be used to represent the patient's problems and diagnoses.

Recording information using this *Procedure* DCM indicates that some sort of activity has actually occurred; this will usually be the procedure itself but may be a failed attempt or another activity such as postponing the procedure.

4.3 Misuse

Not to be used to record details about related DCMs, such as use of imaging guidance during the procedure or collection of tissue samples for analysis - use a specific DCM for this purpose.

Not to be used to record a whole operation or procedure report.

Not to be used to record an observation such as a pathology test result or an imaging test.

4.4 UML Class Diagrams

The following figure represents the data hierarchy using a UML 2.0 class diagram. The diagram displays data groups and data elements, together with their names, data types and multiplicities. Data elements are displayed as attributes; data groups are displayed as classes; their label names are represented as association role names. Association role names are only displayed if they differ from the associated class name. When a data element has a choice of data types, the data type of the attribute that represents it is an abstract interface class generalised from the individual data types. The diagram shows the data hierarchy excluding the details of participation. The default multiplicity is 1..1.

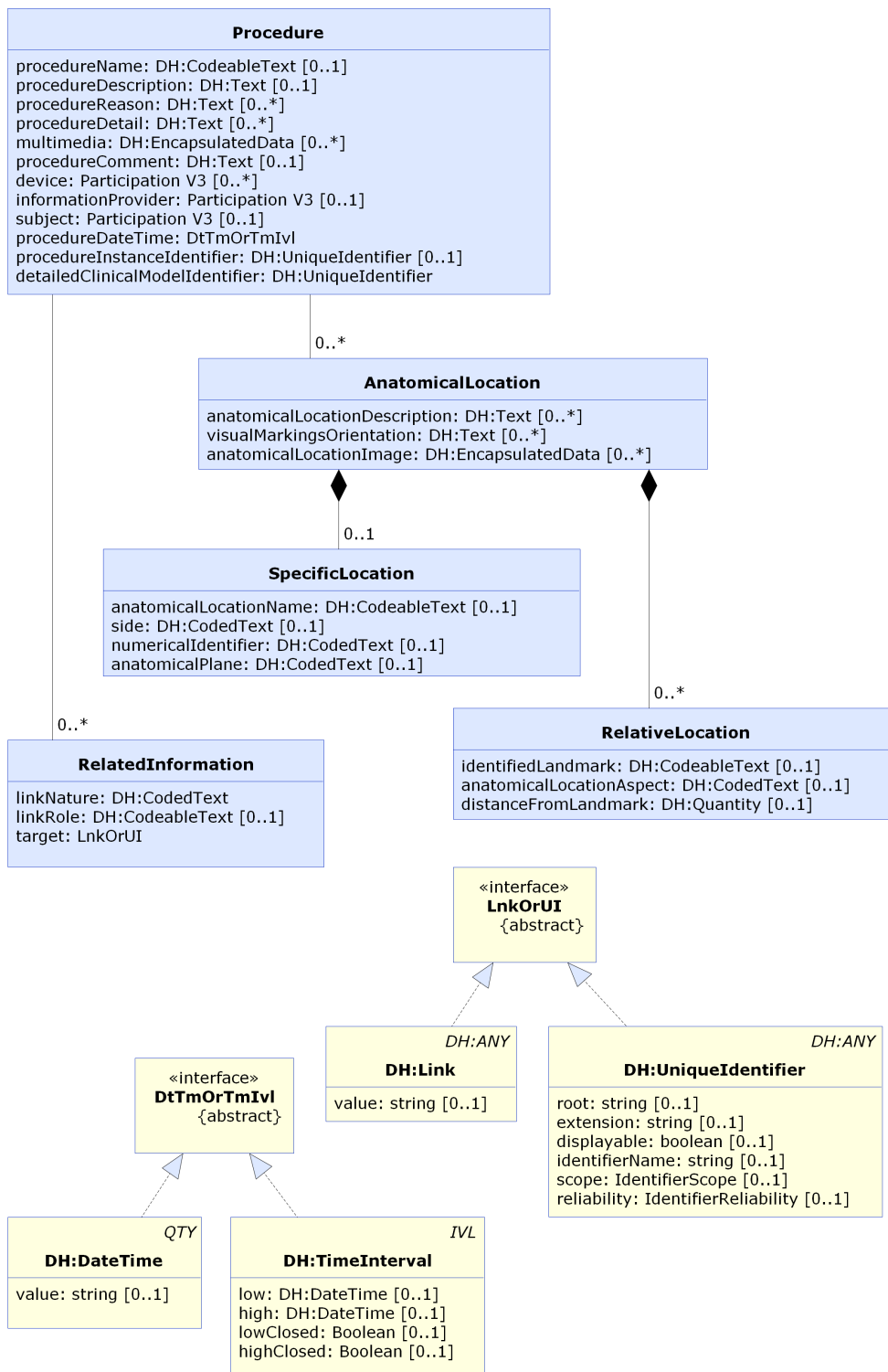


Figure 4.1. Procedure

4.5 PROCEDURE

Identification

Label	PROCEDURE
Metadata Type	Data Group
Identifier	DG-15514
OID	1.2.36.1.2001.1001.101.102.15514

Definition

Definition	A clinical activity carried out for therapeutic, evaluative, investigative, screening or diagnostic purposes.
Definition Source	Australian Digital Health Agency
Synonymous Names	Clinical Intervention

Usage







Misuse	Recording details about related activities such as use of imaging guidance during the procedure or collection of tissue samples for analysis - use specific DCMs for these purposes.
	Recording a whole operation or procedure report.
	Recording an observation such as a pathology test result or an imaging test.



























Data Hierarchy



Note

Items below whose text is lighter (mid-blue and mid-grey) are technical identifiers whose purpose is to facilitate interoperability, sharing of data and secondary use. Typically, such identifiers will be generated internally by systems and not displayed to users since they rarely have clinical significance.

		PROCEDURE	
		Procedure Name	0..1
		Procedure Description	0..1
		Procedure Reason	0..*
		ANATOMICAL LOCATION	
		SPECIFIC LOCATION	0..1

			Anatomical Location Name	0..1
			Side	0..1
			Numerical Identifier	0..1
			Anatomical Plane	0..1
			RELATIVE LOCATION	0..*
			Identified Landmark	0..1
			Anatomical Location Aspect	0..1
			Distance From Landmark	0..1
			Anatomical Location Description	0..*
			Visual Markings/Orientation	0..*
			Anatomical Location Image	0..*
			Procedure Detail	0..*
			Multimedia	0..*
			Procedure Comment	0..1
			DEVICE	0..*
			INFORMATION PROVIDER	0..1
			SUBJECT	0..1
		 	Procedure DateTime	1..1
			Procedure Instance Identifier	0..1
			RELATED INFORMATION	0..*
			Link Nature	1..1
			Link Role	0..1
		 	Target	1..1
			Detailed Clinical Model Identifier	1..1

4.6 Procedure Name

Identification

Label	Procedure Name
Metadata Type	Data Element
Identifier	DE-15579
OID	1.2.36.1.2001.1001.101.103.15579

Definition


Definition	The name of the procedure (to be) performed.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	CodeableText
Value Domain	Procedure Foundation Reference Set

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for CodeableText .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PROCEDURE	0..1

4.7 Procedure Foundation Reference Set

Identification

Label	Procedure Foundation Reference Set
Metadata Type	Value Domain
Identifier	VD-16580
OID	1.2.36.1.2001.1001.101.104.16580
External Identifier	SNOMED CT-AU Concept Id: 32570141000036105 <i>Procedure foundation reference set</i>

Definition


Definition	The <i>Procedure foundation reference set</i> provides the broadest possible terminology to support the recording of clinical interventions in Australian eHealth implementations.
Definition Source	Australian Digital Health Agency

Value Domain

Source	SNOMED CT-AU
---------------	--------------

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Procedure Name	1..1

4.8 Procedure Description

Identification

Label	Procedure Description
Metadata Type	Data Element
Identifier	DE-16582
OID	1.2.36.1.2001.1001.101.103.16582

Definition


Definition	Narrative description about the activity or care pathway step for the identified procedure.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	<p>Examples include descriptions about</p> <ul style="list-style-type: none"> • the performance and findings from the procedure; or • the failed attempt or the cancellation of the procedure.
Data Type	Text

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for Text .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PROCEDURE	0..1

4.9 Procedure Reason

Identification

Label	Procedure Reason
Metadata Type	Data Element
Identifier	DE-16583
OID	1.2.36.1.2001.1001.101.103.16583

Definition


Definition	Reason that the activity or care pathway step for the identified procedure was carried out.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	This can include the reason for the cancellation or suspension of the procedure.
Data Type	Text

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for Text .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PROCEDURE	0..*

4.10 ANATOMICAL LOCATION

Identification


Label	ANATOMICAL LOCATION
Metadata Type	Data Group
Identifier	DG-16150
OID	1.2.36.1.2001.1001.101.102.16150

Definition






Definition	Structured information about the specific anatomical location of the procedure.
Definition Source	Australian Digital Health Agency
Synonymous Names	

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PROCEDURE	0..*

Children

Data Type	Name	Occurrences
	SPECIFIC LOCATION	0..1
	RELATIVE LOCATION	0..*
	Anatomical Location Description	0..*
	Visual Markings/Orientation	0..*
	Anatomical Location Image	0..*

4.11 SPECIFIC LOCATION

Identification


Label	SPECIFIC LOCATION
Metadata Type	Data Group
Identifier	DG-16151
OID	1.2.36.1.2001.1001.101.102.16151

Definition





Definition	Specific and identified anatomical location.
Definition Source	Australian Digital Health Agency
Synonymous Names	

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	ANATOMICAL LOCATION	0..1

Children

Data Type	Name	Occurrences
	Anatomical Location Name	0..1
	Side	0..1
	Numerical Identifier	0..1
	Anatomical Plane	0..1

4.12 Anatomical Location Name

Identification

Label	Anatomical Location Name
Metadata Type	Data Element
Identifier	DE-16153
OID	1.2.36.1.2001.1001.101.103.16153

Definition


Definition	The name of the anatomical location.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	CodeableText
Value Domain	Body Structure Foundation Reference Set

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for CodeableText .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	SPECIFIC LOCATION	0..1

4.13 Body Structure Foundation Reference Set

Identification

Label	Body Structure Foundation Reference Set
Metadata Type	Value Domain
Identifier	VD-16152
OID	1.2.36.1.2001.1001.101.104.16152
External Identifier	SNOMED CT-AU Concept Id: 32570061000036105

Definition


Definition	The set of values for named anatomical locations.
Definition Source	Australian Digital Health Agency

Value Domain

Source	SNOMED CT-AU
---------------	--------------

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
 001011001	Anatomical Location Name	1..1

4.14 Side

Identification

Label	Side
Metadata Type	Data Element
Identifier	DE-16336
OID	1.2.36.1.2001.1001.101.103.16336

Definition


Definition	Laterality of the anatomical location.
Definition Source	Australian Digital Health Agency
Synonymous Names	Laterality
Data Type	CodedText
Value Domain	Laterality Reference Set

Usage

Examples	<ol style="list-style-type: none"> 1) Right 2) Left 3) Bilateral
Exceptional Values	<p>Absent values are PROHIBITED.</p> <p>Abnormal values are PROHIBITED.</p>

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	SPECIFIC LOCATION	0..1

4.15 Laterality Reference Set

Identification

Label	Laterality Reference Set
Metadata Type	Value Domain
Identifier	VD-16312
OID	1.2.36.1.2001.1001.101.104.16312
External Identifier	SNOMED CT-AU Concept Id: 32570611000036103

Definition


Definition	The set of values for identifying the laterality of an anatomical location.
Definition Source	Australian Digital Health Agency

Value Domain

Source	SNOMED CT-AU
---------------	--------------

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Side	1..1

4.16 Numerical Identifier

Identification

Label	Numerical Identifier
Metadata Type	Data Element
Identifier	DE-16338
OID	1.2.36.1.2001.1001.101.103.16338

Definition

Definition	Ordinal value used with anatomical site or part name to identify a specific anatomical site in a collection of enumerable sites, such as vertebrae or ribs.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	CodedText
Value Domain	<i>Not specified.</i>
	In the absence of national standard code sets, the code sets used SHALL be registered code sets, i.e. registered through the HL7 code set registration procedure ¹ with an appropriate object identifier (OID), and SHALL be publicly available.
	When national standard code sets become available, they SHALL be used and the non-standard code sets SHALL be deprecated.


Usage

Conditions of Use	This SHALL be an ordinal number between first and eighteenth.
Conditions of Use Source	Australian Digital Health Agency
Examples	<ol style="list-style-type: none"> 1) First, as in 'first rib'. 2) Second, as in 'second toe'. 3) Third, as in 'third lumbar vertebra'.
Exceptional Values	<p>Absent values are PROHIBITED.</p> <p>Abnormal values are PROHIBITED.</p>

¹ <http://www.hl7.org/oid/index.cfm>

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	SPECIFIC LOCATION	0..1

4.17 Anatomical Plane

Identification

Label	Anatomical Plane
Metadata Type	Data Element
Identifier	DE-16340
OID	1.2.36.1.2001.1001.101.103.16340

Definition


Definition	Line describing the position of a vertical anatomical plane in the body.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	CodedText
Value Domain	<i>Not specified.</i>
	In the absence of national standard code sets, the code sets used SHALL be registered code sets, i.e. registered through the HL7 code set registration procedure ² with an appropriate object identifier (OID), and SHALL be publicly available.
	When national standard code sets become available, they SHALL be used and the non-standard code sets SHALL be deprecated.

Usage

Examples	<ol style="list-style-type: none"> 1) Midline 2) Midclavicular 3) Midaxillary 4) Midscapular
Exceptional Values	<p>Absent values are PROHIBITED.</p> <p>Abnormal values are PROHIBITED.</p>

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	SPECIFIC LOCATION	0..1

² <http://www.hl7.org/oid/index.cfm>

4.18 RELATIVE LOCATION

Identification


Label	RELATIVE LOCATION
Metadata Type	Data Group
Identifier	DG-16341
OID	1.2.36.1.2001.1001.101.102.16341

Definition




Definition	Qualifier(s) to identify a non-specific location.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	<p>An example is: 5cm (distance) inferior (aspect) to the tibial tuberosity (landmark).</p> <p>More than one relative location may be required to provide a cross-reference.</p>

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	ANATOMICAL LOCATION	0..*

Children

Data Type	Name	Occurrences
	Identified Landmark	0..1
	Anatomical Location Aspect	0..1
	Distance From Landmark	0..1

4.19 Identified Landmark

Identification

Label	Identified Landmark
Metadata Type	Data Element
Identifier	DE-16343
OID	1.2.36.1.2001.1001.101.103.16343

Definition


Definition	Identified anatomical landmark from which to specify the relative anatomical location.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	CodeableText
Value Domain	<i>Not specified.</i>
	In the absence of national standard code sets, the code sets used SHALL be registered code sets, i.e. registered through the HL7 code set registration procedure ³ with an appropriate object identifier (OID), and SHALL be publicly available.
	When national standard code sets become available, they SHALL be used and the non-standard code sets SHALL be deprecated.

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for CodeableText .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	RELATIVE LOCATION	0..1

³ <http://www.hl7.org/oid/index.cfm>

4.20 Anatomical Location Aspect

Identification

Label	Anatomical Location Aspect
Metadata Type	Data Element
Identifier	DE-16345
OID	1.2.36.1.2001.1001.101.103.16345

Definition


Definition	Qualifier to identify which direction the anatomical location is in relation to the identified landmark.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	CodedText
Value Domain	<i>Not specified.</i>
	In the absence of national standard code sets, the code sets used SHALL be registered code sets, i.e. registered through the HL7 code set registration procedure ⁴ with an appropriate object identifier (OID), and SHALL be publicly available.
	When national standard code sets become available, they SHALL be used and the non-standard code sets SHALL be deprecated.

Usage

Examples	<ol style="list-style-type: none"> 1) Medial to 2) Lateral to 3) Anterior to 4) Above
Exceptional Values	<p>Absent values are PROHIBITED.</p> <p>Abnormal values are PROHIBITED.</p>

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	RELATIVE LOCATION	0..1

⁴ <http://www.hl7.org/oid/index.cfm>

4.21 Distance From Landmark

Identification

Label	Distance From Landmark
Metadata Type	Data Element
Identifier	DE-16346
OID	1.2.36.1.2001.1001.101.103.16346

Definition


Definition	Distance of location from the identified landmark.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	Quantity

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for Quantity .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	RELATIVE LOCATION	0..1

4.22 Anatomical Location Description

Identification

Label	Anatomical Location Description
Metadata Type	Data Element
Identifier	DE-16319
OID	1.2.36.1.2001.1001.101.103.16319

Definition


Definition	Description of the anatomical location.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	Text

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for Text .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	ANATOMICAL LOCATION	0..*

4.23 Visual Markings/Orientation

Identification

Label	Visual Markings/Orientation
Metadata Type	Data Element
Identifier	DE-16407
OID	1.2.36.1.2001.1001.101.103.16407

Definition


Definition	Description of any visual markings used to orient the viewer.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	Text

Usage

Examples	<ol style="list-style-type: none"> 1) External reference points 2) Special sutures 3) Ink markings
-----------------	---

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	ANATOMICAL LOCATION	0..*

4.24 Anatomical Location Image

Identification

Label	Anatomical Location Image
Metadata Type	Data Element
Identifier	DE-16199
OID	1.2.36.1.2001.1001.101.103.16199

Definition


Definition	An image or images used to identify a location.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Context	This element is intended to be an image, e.g. a photo of the anatomical site such as a wound on the leg.
Context Source	Australian Digital Health Agency
Data Type	EncapsulatedData

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for EncapsulatedData .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	ANATOMICAL LOCATION	0..*

4.25 Procedure Detail

Identification

Label	Procedure Detail
Metadata Type	Data Element
Identifier	DE-16325
OID	1.2.36.1.2001.1001.101.105.16325

Definition


Definition	Further information about the procedure.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	This free text data element is currently a placeholder for further structured data that is as yet undefined. See Appendix A, Known Issues for further information.
Data Type	Text

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for Text .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PROCEDURE	0..*

4.26 Multimedia

Identification

Label	Multimedia
Metadata Type	Data Element
Identifier	DE-16376
OID	1.2.36.1.2001.1001.101.103.16376

Definition


Definition	Multimedia representation of the procedure undertaken.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	Inclusion of any multimedia file to support the recording of the procedure, for example, a link to a video of the procedure performed or a drawing of the wound/surgery.
Data Type	EncapsulatedData

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for EncapsulatedData .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PROCEDURE	0..*

4.27 Procedure Comment

Identification

Label	Procedure Comment
Metadata Type	Data Element
Identifier	DE-15595
OID	1.2.36.1.2001.1001.101.103.15595

Definition


Definition	Additional narrative about the procedure not captured in other fields.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	Text

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for Text .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PROCEDURE	0..1

4.28 DEVICE

Identification

Label	DEVICE
Metadata Type	Data Group
Identifier	DG-10296
OID	1.2.36.1.2001.1001.101.102.10296

Definition


Definition	Structured information about any device used during the procedure.
Definition Source	Australian Digital Health Agency
Synonymous Names	

Usage

Conditions of Use	<p>This is a reuse of the <i>PARTICIPATION</i> data group, which is described in Participation Data Specification [NEHT2011v].</p> <p>The following constraints are additional to those specified in Participation Data Specification [NEHT2011v]. Constraints are explained in Appendix B, Specification Guide for Use.</p> <ul style="list-style-type: none"> Participation Type SHALL have an implementation-specific value equivalent to “Device”. PERSON OR ORGANISATION OR DEVICE SHALL be instantiated as a DEVICE.
Conditions of Use Source	Australian Digital Health Agency

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PROCEDURE	0..*

4.29 INFORMATION PROVIDER

Identification

Label	INFORMATION PROVIDER
Metadata Type	Data Group
Identifier	DG-10296
OID	1.2.36.1.2001.1001.101.102.10296

Definition


Definition	Source of the information.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Scope	Only used when the recorder needs to make it explicit. Otherwise, it is assumed to be the subject of care of the enclosing structured document.
Scope Source	Australian Digital Health Agency
Notes	<p>This does not have to be a person and, in particular, does not have to be a healthcare provider. Types of sources include:</p> <ul style="list-style-type: none"> • an agent of a subject of care, e.g. parent, guardian; • a clinician; • a device or software; and • the subject of the DCM, when not the subject of care of the enclosing structured document.

Usage

Conditions of Use	<p>This SHALL NOT be used if the source of the information is the <i>SUBJECT OF CARE</i> of the enclosing structured document.</p> <p>This is a reuse of the <i>PARTICIPATION</i> data group, which is described in Participation Data Specification [NEHT2011v]. Further constraints on this data group that apply to this reuse of it are listed below.</p> <ul style="list-style-type: none"> • Participation Type SHALL have an implementation-specific value equivalent to "Information Provider". • PERSON OR ORGANISATION OR DEVICE SHALL be instantiated as a PERSON or as a DEVICE. <p>Terms used in obligation and occurrence constraints are explained in Appendix B, Specification Guide for Use.</p>
Conditions of Use Source	Australian Digital Health Agency

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PROCEDURE	0..1

4.30 SUBJECT

Identification

Label	SUBJECT
Metadata Type	Data Group
Identifier	DG-10296
OID	1.2.36.1.2001.1001.101.102.10296

Definition


Definition	The individual upon whom the procedure is (to be) performed.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Scope	Only used when the recorder needs to make it explicit. Otherwise, it is assumed to be the subject of care of the enclosing structured document.
Scope Source	Australian Digital Health Agency

Usage

Conditions of Use	<p>This SHALL NOT be used if the subject of the information is the <i>SUBJECT OF CARE</i> of the enclosing structured document.</p> <p>This is a reuse of the <i>PARTICIPATION</i> data group, which is described in Participation Data Specification [NEHT2011v]. Further constraints on this data group that apply to this reuse of it are listed below.</p> <ul style="list-style-type: none"> Participation Type SHALL have an implementation-specific value equivalent to “Subject”. PERSON OR ORGANISATION OR DEVICE SHALL be instantiated as a PERSON. <p>Terms used in obligation and occurrence constraints are explained in Appendix B, Specification Guide for Use.</p>
Conditions of Use Source	Australian Digital Health Agency

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PROCEDURE	0..1

4.31 Procedure DateTime

Identification

Label	Procedure DateTime
Metadata Type	Data Element
Identifier	DE-16475
OID	1.2.36.1.2001.1001.101.103.16475

Definition


Definition	Date, and optionally time, of the <i>Procedure</i> action.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	This will typically be the date of completion. It may be the start date and time, or even the time period of the action.
Data Type	DateTime TimeInterval

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for DateTime , and TimeInterval .
-----------------	---

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PROCEDURE	1..1

4.32 Procedure Instance Identifier

Identification

Label	Procedure Instance Identifier
Metadata Type	Data Element
Identifier	DE-16561
OID	1.2.36.1.2001.1001.101.103.16561

Definition


Definition	A globally unique identifier for each instance of a <i>Procedure</i> action.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Exceptional Values	Absent values are PROHIBITED . Abnormal values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PROCEDURE	0..1

4.33 RELATED INFORMATION

Identification


Label	RELATED INFORMATION
Metadata Type	Data Group
Identifier	DG-16692
OID	1.2.36.1.2001.1001.101.102.16692

Definition


Definition	Information held elsewhere that is relevant to this instance of <i>Procedure</i> .
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	<p>Items of related information include, but are not limited to, documents, parts of documents, images and web pages.</p> <p>“Elsewhere” includes elsewhere in the same document.</p> <p>1:1 and 1:N relationships between instances of DCMs can be expressed by using one, or more than one, respectively, links. Chains of links can be used to see problem threads or other logical groupings of items.</p> <p>Links are only to be used between instances of DCMs or documents, i.e. between objects representing complete domain concepts. This is because relationships between sub-elements of whole concepts are not necessarily meaningful and may be confusing.</p> <p>When the item of related information is a complete document (including images) or a web page (or part thereof) an appropriate specialisation of the <i>Related Information</i> data group should be used.</p> <p>The document or other data component instance containing the <i>Related Information</i> data group is called the <i>source</i>. The related information is called the <i>target</i>.</p>



Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PROCEDURE	0..*

Children

Data Type	Name	Occurrences
	Link Nature	1..1

Data Type	Name	Occurrences
	Link Role	0..1
	Target	1..1

4.34 Link Nature

Identification

Label	Link Nature
Metadata Type	Data Element
Identifier	DE-16698
OID	1.2.36.1.2001.1001.101.103.16698

Definition


Definition	The general semantic category of the relationship between this instance of this detailed clinical model (DCM), i.e. the source, and the target DCM instance or target document.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	This is one of two attributes that together communicate the semantics of the relationship between the source and target DCMs or document. This attribute is intended to be a coarse-grained category that can be used to enable interoperability between sender and receiver.
Data Type	CodedText
Value Domain	Link Nature Values

Usage

Examples	<ol style="list-style-type: none"> 1) is related to 2) is confirmed by or authorised by 3) is related to the same problem or health issue
Exceptional Values	<p>Absent values are PROHIBITED.</p> <p>Abnormal values are PROHIBITED.</p>

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	RELATED INFORMATION	1..1

4.35 Link Nature Values

Identification

Label	Link Nature Values
Metadata Type	Value Domain
Identifier	VD-16698
OID	1.2.36.1.2001.1001.101.104.16698
External Identifier	LINK_NATURE

Definition


Definition	Set of values for the general semantic category of the relationship between this instance of this DCM, i.e. the source, and the target DCM instance or target document.
Definition Source	Australian Digital Health Agency

Value Domain

Source	ISO 13606-3:2009	
Permissible Values	The permissible values are those specified in Termlist LINK_NATURE in ISO 13606-3:2009 Health informatics - Electronic health record communication - Part 3: Reference archetypes and term lists [ISO2009a] . The values are listed here with brief descriptions.	
	LINK-A0, is related to	The most general category of Link.
	LINK-B0, is confirmed by or authorised by	The link target contains an instance of a DCM or document that is either a legal or authoritative basis for what is documented in the source DCM instance, or is a declaration of intent to provide (or not provide) requested care.
	LINK-C0, is related to the same problem or health issue	The target instance of a DCM or document describes health or healthcare that concerns the same clinical situation as the source DCM instance.
	LINK-D0, is related to the same care plan, act or episode	The source and the target instances of DCMs or documents both describe parts of the same care plan, act or episode.
	LINK-E0, is a related documentation	The target instance of a DCM or document is an alternative documentary form of the source DCM instance. For example, a re-expression of the same clinical information or supplementary explanatory information.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Link Nature	1..1

4.36 Link Role

Identification

Label	Link Role
Metadata Type	Data Element
Identifier	DE-16699
OID	1.2.36.1.2001.1001.101.103.16699

Definition


Definition	The detailed semantic description of the relationship between this instance of this detailed clinical model (DCM), i.e. the source, and the target DCM instance or target document.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	<p>This is one of two attributes that together communicate the semantics of the relationship between the source and target DCMs. This attribute provides for a specific description of the actual role played by the target in relation to the source.</p> <p>This attribute may be populated from any suitable terminology and therefore might support human readership better than interoperable automated processing.</p>
Data Type	CodeableText
Value Domain	Link Role Values

Usage

Examples	<ol style="list-style-type: none"> 1) unspecified link 2) suggests 3) endorses 4) evidence for 5) outcome 6) is documented by 7) excerpts
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	RELATED INFORMATION	0..1

4.37 Link Role Values

Identification

Label	Link Role Values
Metadata Type	Value Domain
Identifier	VD-16699
OID	1.2.36.1.2001.1001.101.104.16699
External Identifier	LINK_ROLE

Definition

Definition	Set of values for the detailed semantic description of the relationship between this instance of this DCM, i.e. the source, and the target DCM instance or target document.
Definition Source	Australian Digital Health Agency
Context	These values are used within the context of the value of the <i>Link Nature</i> data element. They provide greater specificity and may be selected more for human readership than for interoperable automated processing.
Context Source	Australian Digital Health Agency

Value Domain


Source	ISO 13606-3:2009														
Permissible Values	<p>Values SHOULD be from Termlist LINK_ROLE in ISO 13606-3:2009 [ISO2009a].</p> <p>Values MAY be from any suitable terminology.</p> <p>Some values from Termlist LINK_ROLE in ISO 13606-3:2009 Health informatics - Electronic health record communication - Part 3: Reference archetypes and term lists [ISO2009a], together with brief descriptions, are:</p> <table> <tr> <td>LINK-A1, unspecified link</td> <td>This can be used to say explicitly “there is no semantic information available for this Link”.</td> </tr> <tr> <td>LINK-B1, endorses</td> <td>The source endorses (agrees with, confirms or verifies) the situation (or interpretation) described in the target.</td> </tr> <tr> <td>LINK-C3, evidence for</td> <td>The source describes evidence for the situation (or interpretation) described in the target.</td> </tr> <tr> <td>LINK-D1, outcome</td> <td>The source describes an outcome of the situation (or interpretation) that the target describes.</td> </tr> <tr> <td>LINK-E1, documented by</td> <td>The source is a less formal description of the situation (or interpretation) documented by the target.</td> </tr> <tr> <td>LINK-E4, excerpts</td> <td>The source is an extract (copy) of part or all of the information contained within the target.</td> </tr> <tr> <td>LINK-E5, derived from</td> <td>The source contains information that has been derived (e.g. calculated) from information in the target.</td> </tr> </table>	LINK-A1, unspecified link	This can be used to say explicitly “there is no semantic information available for this Link”.	LINK-B1, endorses	The source endorses (agrees with, confirms or verifies) the situation (or interpretation) described in the target.	LINK-C3, evidence for	The source describes evidence for the situation (or interpretation) described in the target.	LINK-D1, outcome	The source describes an outcome of the situation (or interpretation) that the target describes.	LINK-E1, documented by	The source is a less formal description of the situation (or interpretation) documented by the target.	LINK-E4, excerpts	The source is an extract (copy) of part or all of the information contained within the target.	LINK-E5, derived from	The source contains information that has been derived (e.g. calculated) from information in the target.
LINK-A1, unspecified link	This can be used to say explicitly “there is no semantic information available for this Link”.														
LINK-B1, endorses	The source endorses (agrees with, confirms or verifies) the situation (or interpretation) described in the target.														
LINK-C3, evidence for	The source describes evidence for the situation (or interpretation) described in the target.														
LINK-D1, outcome	The source describes an outcome of the situation (or interpretation) that the target describes.														
LINK-E1, documented by	The source is a less formal description of the situation (or interpretation) documented by the target.														
LINK-E4, excerpts	The source is an extract (copy) of part or all of the information contained within the target.														
LINK-E5, derived from	The source contains information that has been derived (e.g. calculated) from information in the target.														

Usage

Conditions of Use	Each of the values in LINK_ROLE from ISO 13606-3:2009 identifies a subcategory of a corresponding value in <i>Link Nature Values</i> . That correspondence is indicated by the first letter after the code string "LINK-". For example, the term LINK-A1 is a subcategory of term LINK-A0. If a term in this list is used for the <i>Link Role</i> data element, the appropriate corresponding value SHALL be used for <i>Link Nature Values</i> .
Conditions of Use Source	ISO 13606-3:2009

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Link Role	1..1

4.38 Target

Identification

Label	Target
Metadata Type	Data Element
Identifier	DE-16700
OID	1.2.36.1.2001.1001.101.103.16700

Definition


Definition	The “linked to” or identified information.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	Link UniquelIdentifier

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for Link , and UniquelIdentifier .
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Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	RELATED INFORMATION	1..1

4.39 Detailed Clinical Model Identifier

Identification

Label	Detailed Clinical Model Identifier
Metadata Type	Data Element
Identifier	DE-16693
OID	1.2.36.1.2001.1001.101.103.16693

Definition


Definition	A globally unique identifier for this detailed clinical model.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Conditions of Use	The value of this item SHALL be either the default value or a semantically equivalent value from an appropriate code system.
Conditions of Use Source	Australian Digital Health Agency
Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Default Value	1.2.36.1.2001.1001.101.102.15514
Exceptional Values	Absent values are PROHIBITED . Abnormal values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	PROCEDURE	1..1

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5 Exclusion Statement - Procedures Detailed Clinical Model

This chapter describes version 1.3 of the *Exclusion Statement - Procedures* Detailed Clinical Model.

5.1 Purpose

To positively record the non-performance or exclusion of general groups of procedures (e.g. "never had a surgical procedure") or specific procedures ("no history of appendectomy") within the health record.

5.2 Use

Use to record the positive non-performance or exclusion of general groups of procedures (e.g. "never had a surgical procedure") or specific procedures ("no history of appendectomy") within the health record. This Detailed Clinical Model (DCM) avoids the need to use terminology to express negation about any item within the health record.

5.3 UML Class Diagrams

The following figure represents the data hierarchy using a UML 2.0 class diagram. The diagram displays data groups and data elements, together with their names, data types and multiplicities. Data elements are displayed as attributes; data groups are displayed as classes; their label names are represented as association role names. Association role names are only displayed if they differ from the associated class name. When a data element has a choice of data types, the data type of the attribute that represents it is an abstract interface class generalised from the individual data types. The diagram shows the data hierarchy excluding the details of participation. The default multiplicity is 1..1.

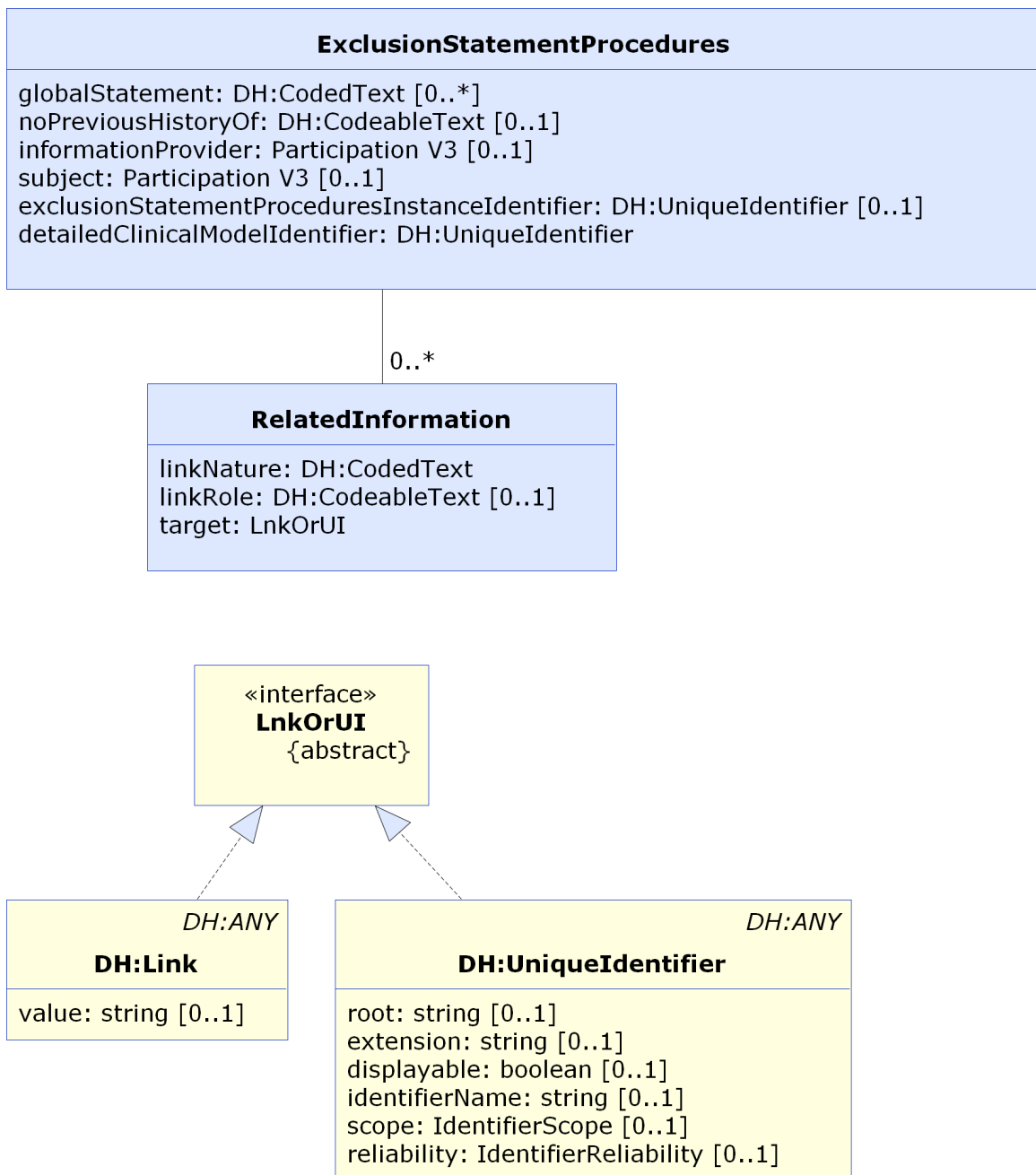


Figure 5.1. Exclusion Statement for Procedure

5.4 EXCLUSION STATEMENT - PROCEDURES

Identification

Label	EXCLUSION STATEMENT - PROCEDURES
Metadata Type	Data Group
Identifier	DG-16603
OID	1.2.36.1.2001.1001.101.102.16603

Definition










Definition	Statements to positively assert that a certain procedure has not been performed on the patient.
Definition Source	Australian Digital Health Agency
Synonymous Names	

Data Hierarchy



Note

Items below whose text is lighter (mid-blue and mid-grey) are technical identifiers whose purpose is to facilitate interoperability, sharing of data and secondary use. Typically, such identifiers will be generated internally by systems and not displayed to users since they rarely have clinical significance.

 EXCLUSION STATEMENT - PROCEDURES	
	Global Statement 0..*
	No Previous History of 0..1
	INFORMATION PROVIDER 0..1
	SUBJECT 0..1
	Exclusion Statement - Procedures Instance Identifier 0..1
 RELATED INFORMATION 0..*	
	Link Nature 1..1
	Link Role 0..1

	 	Target	1..1
	Detailed Clinical Model Identifier		1..1

5.5 Global Statement

Identification

Label	Global Statement
Metadata Type	Data Element
Identifier	DE-16302
OID	1.2.36.1.2001.1001.101.103.16302

Definition


Definition	The statement about the absence or exclusion of procedure performed on the patient.
Definition Source	openEHR Foundation
Synonymous Names	
Context	This can be used to capture any information that is needed to be explicitly recorded within the record as being absent or excluded.
Context Source	openEHR Foundation
Data Type	CodedText
Value Domain	Global Statement Values

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for CodedText .
Exceptional Values	Absent values are PROHIBITED . Abnormal values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	EXCLUSION STATEMENT - PROCEDURES	0..*

5.6 Global Statement Values

Identification

Label	Global Statement Values
Metadata Type	Value Domain
Identifier	VD-16299
OID	1.2.36.1.2001.1001.101.104.16299

Definition


Definition	The set of values for the statement about the absence or exclusion.
Definition Source	openEHR Foundation

Value Domain

Source	Australian Digital Health Agency
Permissible Values	01, None known No information about past procedures is known.
	02, Not asked No information about past procedures is available because the patient was not asked or not able to be asked.
	03, None supplied No information about past procedures is supplied.
	Please see Appendix A, Known Issues .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Global Statement	1..1

5.7 No Previous History of Identification

Label	No Previous History of
Metadata Type	Data Element
Identifier	DE-16303
OID	1.2.36.1.2001.1001.101.103.16303

Definition


Definition	Positive statements about a procedure that are explicitly known to have not been identified at the time of recording.
Definition Source	openEHR Foundation
Synonymous Names	
Data Type	CodeableText
Value Domain	<i>Not specified.</i>
	In the absence of national standard code sets, the code sets used SHALL be registered code sets, i.e. registered through the HL7 code set registration procedure ¹ with an appropriate object identifier (OID), and SHALL be publicly available.
	When national standard code sets become available, they SHALL be used and the non-standard code sets SHALL be deprecated.

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for CodeableText .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	EXCLUSION STATEMENT - PROCEDURES	0..1

¹ <http://www.hl7.org/oid/index.cfm>

5.8 INFORMATION PROVIDER

Identification

Label	INFORMATION PROVIDER
Metadata Type	Data Group
Identifier	DG-10296
OID	1.2.36.1.2001.1001.101.102.10296

Definition


Definition	Source of the information.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Scope	Only used when the recorder needs to make it explicit. Otherwise, it is assumed to be the subject of care of the enclosing structured document.
Scope Source	Australian Digital Health Agency
Notes	<p>This does not have to be a person and, in particular, does not have to be a healthcare provider. Types of sources include:</p> <ul style="list-style-type: none"> • an agent of a subject of care, e.g. parent, guardian; • a clinician; • a device or software; and • the subject of the DCM, when not the subject of care of the enclosing structured document.

Usage

Conditions of Use	<p>This SHALL NOT be used if the source of the information is the <i>SUBJECT OF CARE</i> of the enclosing structured document.</p> <p>This is a reuse of the <i>PARTICIPATION</i> data group, which is described in Participation Data Specification [NEHT2011v]. Further constraints on this data group that apply to this reuse of it are listed below.</p> <ul style="list-style-type: none"> • Participation Type SHALL have an implementation-specific value equivalent to "Information Provider". • PERSON OR ORGANISATION OR DEVICE SHALL be instantiated as a PERSON or as a DEVICE. <p>Terms used in obligation and occurrence constraints are explained in Appendix B, Specification Guide for Use.</p>
Conditions of Use Source	Australian Digital Health Agency

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	EXCLUSION STATEMENT - PROCEDURES	0..1

5.9 SUBJECT

Identification

Label	SUBJECT
Metadata Type	Data Group
Identifier	DG-10296
OID	1.2.36.1.2001.1001.101.102.10296

Definition


Definition	The individual about whom the procedure information is being recorded.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Scope	Only used when the recorder needs to make it explicit. Otherwise, it is assumed to be the subject of care of the enclosing structured document.
Scope Source	Australian Digital Health Agency

Usage

Conditions of Use	<p>This SHALL NOT be used if the subject of the information is the <i>SUBJECT OF CARE</i> of the enclosing structured document.</p> <p>This is a reuse of the <i>PARTICIPATION</i> data group, which is described in Participation Data Specification [NEHT2011v]. Further constraints on this data group that apply to this reuse of it are listed below.</p> <ul style="list-style-type: none"> Participation Type SHALL have an implementation-specific value equivalent to “Subject”. PERSON OR ORGANISATION OR DEVICE SHALL be instantiated as a PERSON. <p>Terms used in obligation and occurrence constraints are explained in Appendix B, Specification Guide for Use.</p>
Conditions of Use Source	Australian Digital Health Agency

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	EXCLUSION STATEMENT - PROCEDURES	0..1

5.10 Exclusion Statement - Procedures Instance Identifier

Identification

Label	Exclusion Statement - Procedures Instance Identifier
Metadata Type	Data Element
Identifier	DE-16711
OID	1.2.36.1.2001.1001.101.103.16711

Definition


Definition	A globally unique object identifier for each instance of an <i>Exclusion Statement - Procedures</i> evaluation.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Exceptional Values	Absent values are PROHIBITED . Abnormal values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	EXCLUSION STATEMENT - PROCEDURES	0..1

5.11 RELATED INFORMATION

Identification


Label	RELATED INFORMATION
Metadata Type	Data Group
Identifier	DG-16692
OID	1.2.36.1.2001.1001.101.102.16692

Definition


Definition	Information held elsewhere that is relevant to this instance of <i>Exclusion Statement - Procedure</i> .
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	<p>Items of related information include, but are not limited to, documents, parts of documents, images and web pages.</p> <p>“Elsewhere” includes elsewhere in the same document.</p> <p>1:1 and 1:N relationships between instances of DCMs can be expressed by using one, or more than one, respectively, links. Chains of links can be used to see problem threads or other logical groupings of items.</p> <p>Links are only to be used between instances of DCMs or documents, i.e. between objects representing complete domain concepts. This is because relationships between sub-elements of whole concepts are not necessarily meaningful and may be confusing.</p> <p>When the item of related information is a complete document (including images) or a web page (or part thereof) an appropriate specialisation of the <i>Related Information</i> data group should be used.</p> <p>The document or other data component instance containing the <i>Related Information</i> data group is called the <i>source</i>. The related information is called the <i>target</i>.</p>



Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	EXCLUSION STATEMENT - PROCEDURES	0..*

Children

Data Type	Name	Occurrences
	Link Nature	1..1

Data Type	Name	Occurrences
	Link Role	0..1
	Target	1..1

5.12 Link Nature

Identification

Label	Link Nature
Metadata Type	Data Element
Identifier	DE-16698
OID	1.2.36.1.2001.1001.101.103.16698

Definition


Definition	The general semantic category of the relationship between this instance of this detailed clinical model (DCM), i.e. the source, and the target DCM instance or target document.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	This is one of two attributes that together communicate the semantics of the relationship between the source and target DCMs or document. This attribute is intended to be a coarse-grained category that can be used to enable interoperability between sender and receiver.
Data Type	CodedText
Value Domain	Link Nature Values

Usage

Examples	<ol style="list-style-type: none"> 1) is related to 2) is confirmed by or authorised by 3) is related to the same problem or health issue
Exceptional Values	<p>Absent values are PROHIBITED.</p> <p>Abnormal values are PROHIBITED.</p>

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	RELATED INFORMATION	1..1

5.13 Link Nature Values

Identification

Label	Link Nature Values
Metadata Type	Value Domain
Identifier	VD-16698
OID	1.2.36.1.2001.1001.101.104.16698
External Identifier	LINK_NATURE

Definition


Definition	Set of values for the general semantic category of the relationship between this instance of this DCM, i.e. the source, and the target DCM instance or target document.
Definition Source	Australian Digital Health Agency

Value Domain

Source	ISO 13606-3:2009	
Permissible Values	The permissible values are those specified in Termlist LINK_NATURE in ISO 13606-3:2009 Health informatics - Electronic health record communication - Part 3: Reference archetypes and term lists [ISO2009a] . The values are listed here with brief descriptions.	
	LINK-A0, is related to	The most general category of Link.
	LINK-B0, is confirmed by or authorised by	The link target contains an instance of a DCM or document that is either a legal or authoritative basis for what is documented in the source DCM instance, or is a declaration of intent to provide (or not provide) requested care.
	LINK-C0, is related to the same problem or health issue	The target instance of a DCM or document describes health or healthcare that concerns the same clinical situation as the source DCM instance.
	LINK-D0, is related to the same care plan, act or episode	The source and the target instances of DCMs or documents both describe parts of the same care plan, act or episode.
	LINK-E0, is a related documentation	The target instance of a DCM or document is an alternative documentary form of the source DCM instance. For example, a re-expression of the same clinical information or supplementary explanatory information.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Link Nature	1..1

5.14 Link Role

Identification

Label	Link Role
Metadata Type	Data Element
Identifier	DE-16699
OID	1.2.36.1.2001.1001.101.103.16699

Definition


Definition	The detailed semantic description of the relationship between this instance of this detailed clinical model (DCM), i.e. the source, and the target DCM instance or target document.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	<p>This is one of two attributes that together communicate the semantics of the relationship between the source and target DCMs. This attribute provides for a specific description of the actual role played by the target in relation to the source.</p> <p>This attribute may be populated from any suitable terminology and therefore might support human readership better than interoperable automated processing.</p>
Data Type	CodeableText
Value Domain	Link Role Values

Usage

Examples	<ol style="list-style-type: none"> 1) unspecified link 2) suggests 3) endorses 4) evidence for 5) outcome 6) is documented by 7) excerpts
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	RELATED INFORMATION	0..1

5.15 Link Role Values

Identification

Label	Link Role Values
Metadata Type	Value Domain
Identifier	VD-16699
OID	1.2.36.1.2001.1001.101.104.16699
External Identifier	LINK_ROLE

Definition

Definition	Set of values for the detailed semantic description of the relationship between this instance of this DCM, i.e. the source, and the target DCM instance or target document.
Definition Source	Australian Digital Health Agency
Context	These values are used within the context of the value of the <i>Link Nature</i> data element. They provide greater specificity and may be selected more for human readership than for interoperable automated processing.
Context Source	Australian Digital Health Agency

Value Domain


Source	ISO 13606-3:2009														
Permissible Values	<p>Values SHOULD be from Termlist LINK_ROLE in ISO 13606-3:2009 [ISO2009a].</p> <p>Values MAY be from any suitable terminology.</p> <p>Some values from Termlist LINK_ROLE in ISO 13606-3:2009 Health informatics - Electronic health record communication - Part 3: Reference archetypes and term lists [ISO2009a], together with brief descriptions, are:</p> <table border="1"> <tr> <td>LINK-A1, unspecified link</td> <td>This can be used to say explicitly “there is no semantic information available for this Link”.</td> </tr> <tr> <td>LINK-B1, endorses</td> <td>The source endorses (agrees with, confirms or verifies) the situation (or interpretation) described in the target.</td> </tr> <tr> <td>LINK-C3, evidence for</td> <td>The source describes evidence for the situation (or interpretation) described in the target.</td> </tr> <tr> <td>LINK-D1, outcome</td> <td>The source describes an outcome of the situation (or interpretation) that the target describes.</td> </tr> <tr> <td>LINK-E1, documented by</td> <td>The source is a less formal description of the situation (or interpretation) documented by the target.</td> </tr> <tr> <td>LINK-E4, excerpts</td> <td>The source is an extract (copy) of part or all of the information contained within the target.</td> </tr> <tr> <td>LINK-E5, derived from</td> <td>The source contains information that has been derived (e.g. calculated) from information in the target.</td> </tr> </table>	LINK-A1, unspecified link	This can be used to say explicitly “there is no semantic information available for this Link”.	LINK-B1, endorses	The source endorses (agrees with, confirms or verifies) the situation (or interpretation) described in the target.	LINK-C3, evidence for	The source describes evidence for the situation (or interpretation) described in the target.	LINK-D1, outcome	The source describes an outcome of the situation (or interpretation) that the target describes.	LINK-E1, documented by	The source is a less formal description of the situation (or interpretation) documented by the target.	LINK-E4, excerpts	The source is an extract (copy) of part or all of the information contained within the target.	LINK-E5, derived from	The source contains information that has been derived (e.g. calculated) from information in the target.
LINK-A1, unspecified link	This can be used to say explicitly “there is no semantic information available for this Link”.														
LINK-B1, endorses	The source endorses (agrees with, confirms or verifies) the situation (or interpretation) described in the target.														
LINK-C3, evidence for	The source describes evidence for the situation (or interpretation) described in the target.														
LINK-D1, outcome	The source describes an outcome of the situation (or interpretation) that the target describes.														
LINK-E1, documented by	The source is a less formal description of the situation (or interpretation) documented by the target.														
LINK-E4, excerpts	The source is an extract (copy) of part or all of the information contained within the target.														
LINK-E5, derived from	The source contains information that has been derived (e.g. calculated) from information in the target.														

Usage

Conditions of Use	Each of the values in LINK_ROLE from ISO 13606-3:2009 identifies a subcategory of a corresponding value in <i>Link Nature Values</i> . That correspondence is indicated by the first letter after the code string "LINK-". For example, the term LINK-A1 is a subcategory of term LINK-A0. If a term in this list is used for the <i>Link Role</i> data element, the appropriate corresponding value SHALL be used for <i>Link Nature Values</i> .
Conditions of Use Source	ISO 13606-3:2009

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Link Role	1..1

5.16 Target

Identification

Label	Target
Metadata Type	Data Element
Identifier	DE-16700
OID	1.2.36.1.2001.1001.101.103.16700

Definition


Definition	The “linked to” or identified information.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	Link UniquelIdentifier

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for Link , and UniquelIdentifier .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	RELATED INFORMATION	1..1

5.17 Detailed Clinical Model Identifier

Identification

Label	Detailed Clinical Model Identifier
Metadata Type	Data Element
Identifier	DE-16693
OID	1.2.36.1.2001.1001.101.103.16693

Definition


Definition	A globally unique identifier for this detailed clinical model.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Conditions of Use	The value of this item SHALL be either the default value or a semantically equivalent value from an appropriate code system.
Conditions of Use Source	Australian Digital Health Agency
Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Default Value	1.2.36.1.2001.1001.101.102.16603
Exceptional Values	Absent values are PROHIBITED . Abnormal values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	EXCLUSION STATEMENT - PROCEDURES	1..1

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6 Uncategorised Medical History Item Detailed Clinical Model

This chapter describes version 2.1 of the *Uncategorised Medical History Item* Detailed Clinical Model.

6.1 Purpose

To record an entry in a medical history when it cannot be determined whether the entry is a *Procedure* or is a *Problem/Diagnosis*.

6.2 Use

Use to record an item that is known to be a Procedure or a Problem/Diagnosis but that cannot be explicitly categorised as one or the other. This covers cases where the source system cannot automatically classify an entry as a Problem/Diagnosis or a Procedure, including cases where:

- the coding system used for medical history item cannot structurally support adequate concept classification; and
- the medical history item is maintained as free text and thus has never been classified.

Since it is not known whether an *Uncategorised Medical History Item* entry is conceptually a procedure or a problem/diagnosis, exclusion statements cannot be used when an *Uncategorised Medical History Item* entry is present, as the entry may, in fact, be a procedure or a problem/diagnosis.

6.3 Misuse

Misuses of this DCM include:

- using it when the item is known to be neither a Procedure nor a Problem/Diagnosis; and
- using it when the item can be identified as either a Procedure or a Problem/Diagnosis.

6.4 UML Class Diagrams

The following figure represents the data hierarchy using a UML 2.0 class diagram. The diagram displays data groups and data elements, together with their names, data types and multiplicities. Data elements are displayed as attributes; data groups are displayed as classes; their label names are represented as association role names. Association role names are only displayed if they differ from the associated class name. When a data element has a choice of data types, the data type of the attribute that represents it is an abstract interface class generalised from the individual data types. The diagram shows the data hierarchy excluding the details of participation. The default multiplicity is 1..1.

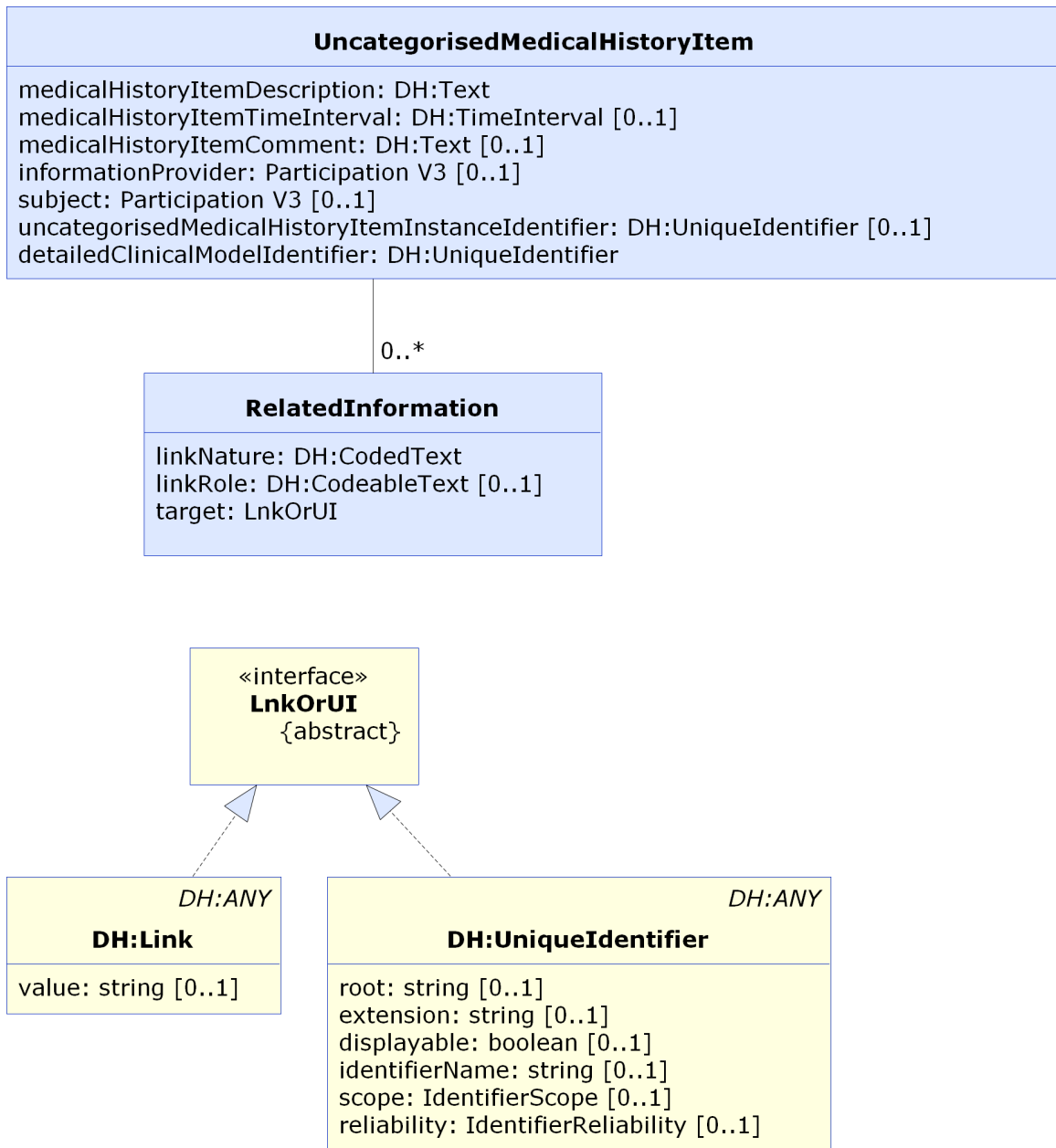


Figure 6.1. Uncategorised Medical History Item

6.5 UNCATEGORISED MEDICAL HISTORY ITEM

Identification

Label	UNCATEGORISED MEDICAL HISTORY ITEM
Metadata Type	Data Group
Identifier	DG-16627
OID	1.2.36.1.2001.1001.101.102.16627

Definition

Definition	A medical history entry that has not been categorised as either <i>Procedure</i> or <i>Problem/Diagnosis</i> .
Definition Source	Australian Digital Health Agency
Synonymous Names	
Scope	For exchanging medical history items from clinical information systems that do not separate problem/diagnosis and procedure data in their data store.
Scope Source	Australian Digital Health Agency
Assumptions	Every entry in a person's medical history is either a procedure or a problem/diagnosis.
Assumptions Source	Australian Digital Health Agency

Usage


Misuse	<p>Misuses of this data group include:</p> <ul style="list-style-type: none"> • using it when the item is known to be neither a Procedure nor a Problem/Diagnosis; and • using it when the item can be identified as either a Procedure or a Problem/Diagnosis.
---------------	---












Data Hierarchy



Note

Items below whose text is lighter (mid-blue and mid-grey) are technical identifiers whose purpose is to facilitate interoperability, sharing of data and secondary use. Typically, such identifiers will be generated internally by systems and not displayed to users since they rarely have clinical significance.

	UNCATEGORISED MEDICAL HISTORY ITEM	
T	Medical History Item Description	1..1

	Medical History Item TimeInterval	0..1
	Medical History Item Comment	0..1
	INFORMATION PROVIDER	0..1
	SUBJECT	0..1
	Uncategorised Medical History Item Instance Identifier	0..1
	RELATED INFORMATION	0..*
	Link Nature	1..1
	Link Role	0..1
 	Target	1..1
	Detailed Clinical Model Identifier	1..1

6.6 Medical History Item Description

Identification

Label	Medical History Item Description
Metadata Type	Data Element
Identifier	DE-16628
OID	1.2.36.1.2001.1001.101.103.16628

Definition


Definition	A full description of the problem, diagnosis or procedure as a medical history item.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	Text

Usage

Examples	<ol style="list-style-type: none"> 1) Hypercholesterolaemia 2) Left total knee replacement 3) Right Lower Lobe pneumonia
Exceptional Values	Absent values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	UNCATEGORISED MEDICAL HISTORY ITEM	1..1

6.7 Medical History Item TimeInterval

Identification

Label	Medical History Item TimeInterval
Metadata Type	Data Element
Identifier	DE-16629
OID	1.2.36.1.2001.1001.101.103.16629

Definition


Definition	The date range during which the problem or diagnosis applied or the procedure occurred.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	TimeInterval

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for TimeInterval .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	UNCATEGORISED MEDICAL HISTORY ITEM	0..1

6.8 Medical History Item Comment

Identification

Label	Medical History Item Comment
Metadata Type	Data Element
Identifier	DE-16630
OID	1.2.36.1.2001.1001.101.103.16630

Definition


Definition	Additional narrative about the problem, diagnosis or procedure.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	Text

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for Text .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	UNCATEGORISED MEDICAL HISTORY ITEM	0..1

6.9 INFORMATION PROVIDER

Identification

Label	INFORMATION PROVIDER
Metadata Type	Data Group
Identifier	DG-10296
OID	1.2.36.1.2001.1001.101.102.10296

Definition

Definition	Source of the information.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Scope	Only used when the recorder needs to make it explicit. Otherwise, it is assumed to be the subject of care of the enclosing structured document.
Scope Source	Australian Digital Health Agency
Notes	<p>This does not have to be a person and, in particular, does not have to be a healthcare provider. Types of sources include:</p> <ul style="list-style-type: none"> • an agent of a subject of care, e.g. parent, guardian; • a clinician; • a device or software; and • the subject of the DCM, when not the subject of care of the enclosing structured document.

Usage

Conditions of Use	<p>This SHALL NOT be used if the source of the information is the <i>SUBJECT OF CARE</i> of the enclosing structured document.</p> <p>This is a reuse of the <i>PARTICIPATION</i> data group, which is described in Participation Data Specification [NEHT2011v]. Further constraints on this data group that apply to this reuse of it are listed below.</p> <ul style="list-style-type: none"> • Participation Type SHALL have an implementation-specific value equivalent to "Information Provider". • PERSON OR ORGANISATION OR DEVICE SHALL be instantiated as a PERSON or as a DEVICE. <p>Terms used in obligation and occurrence constraints are explained in Appendix B, Specification Guide for Use.</p>
Conditions of Use Source	Australian Digital Health Agency

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	UNCATEGORISED MEDICAL HISTORY ITEM	0..1

6.10 SUBJECT

Identification

Label	SUBJECT
Metadata Type	Data Group
Identifier	DG-10296
OID	1.2.36.1.2001.1001.101.102.10296

Definition


Definition	The individual about whom the medical history information is being recorded.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Scope	Only used when the recorder needs to make it explicit. Otherwise, it is assumed to be the subject of care of the enclosing structured document.
Scope Source	Australian Digital Health Agency

Usage

Conditions of Use	<p>This SHALL NOT be used if the subject of the information is the <i>SUBJECT OF CARE</i> of the enclosing structured document.</p> <p>This is a reuse of the <i>PARTICIPATION</i> data group, which is described in Participation Data Specification [NEHT2011v]. Further constraints on this data group that apply to this reuse of it are listed below.</p> <ul style="list-style-type: none"> Participation Type SHALL have an implementation-specific value equivalent to "Subject". PERSON OR ORGANISATION OR DEVICE SHALL be instantiated as a PERSON. <p>Terms used in obligation and occurrence constraints are explained in Appendix B, Specification Guide for Use.</p>
Conditions of Use Source	Australian Digital Health Agency

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	UNCATEGORISED MEDICAL HISTORY ITEM	0..1

6.11 Uncategorized Medical History Item Instance Identifier

Identification

Label	Uncategorised Medical History Item Instance Identifier
Metadata Type	Data Element
Identifier	DE-16479
OID	1.2.36.1.2001.1001.101.103.16479

Definition


Definition	A globally unique identifier for each instance of an <i>Uncategorised Medical History Item</i> evaluation.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Exceptional Values	Absent values are PROHIBITED . Abnormal values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	UNCATEGORISED MEDICAL HISTORY ITEM	0..1

6.12 RELATED INFORMATION

Identification

Label	RELATED INFORMATION
Metadata Type	Data Group
Identifier	DG-16692
OID	1.2.36.1.2001.1001.101.102.16692

Definition


Definition	Information held elsewhere that is relevant to this instance of <i>Uncategorised Medical History Item</i> .
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	<p>Items of related information include, but are not limited to, documents, parts of documents, images and web pages.</p> <p>“Elsewhere” includes elsewhere in the same document.</p> <p>1:1 and 1:N relationships between instances of DCMs can be expressed by using one, or more than one, respectively, links. Chains of links can be used to see problem threads or other logical groupings of items.</p> <p>Links are only to be used between instances of DCMs or documents, i.e. between objects representing complete domain concepts. This is because relationships between sub-elements of whole concepts are not necessarily meaningful and may be confusing.</p> <p>When the item of related information is a complete document (including images) or a web page (or part thereof) an appropriate specialisation of the <i>Related Information</i> data group should be used.</p> <p>The document or other data component instance containing the <i>Related Information</i> data group is called the <i>source</i>. The related information is called the <i>target</i>.</p>



Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	UNCATEGORISED MEDICAL HISTORY ITEM	0..*

Children

Data Type	Name	Occurrences
	Link Nature	1..1

Data Type	Name	Occurrences
	Link Role	0..1
	Target	1..1

6.13 Link Nature

Identification

Label	Link Nature
Metadata Type	Data Element
Identifier	DE-16698
OID	1.2.36.1.2001.1001.101.103.16698

Definition


Definition	The general semantic category of the relationship between this instance of this detailed clinical model (DCM), i.e. the source, and the target DCM instance or target document.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	This is one of two attributes that together communicate the semantics of the relationship between the source and target DCMs or document. This attribute is intended to be a coarse-grained category that can be used to enable interoperability between sender and receiver.
Data Type	CodedText
Value Domain	Link Nature Values

Usage

Examples	<ol style="list-style-type: none"> 1) is related to 2) is confirmed by or authorised by 3) is related to the same problem or health issue
Exceptional Values	<p>Absent values are PROHIBITED.</p> <p>Abnormal values are PROHIBITED.</p>

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	RELATED INFORMATION	1..1

6.14 Link Nature Values

Identification

Label	Link Nature Values
Metadata Type	Value Domain
Identifier	VD-16698
OID	1.2.36.1.2001.1001.101.104.16698
External Identifier	LINK_NATURE

Definition


Definition	Set of values for the general semantic category of the relationship between this instance of this DCM, i.e. the source, and the target DCM instance or target document.
Definition Source	Australian Digital Health Agency

Value Domain

Source	ISO 13606-3:2009	
Permissible Values	The permissible values are those specified in Termlist LINK_NATURE in ISO 13606-3:2009 Health informatics - Electronic health record communication - Part 3: Reference archetypes and term lists [ISO2009a] . The values are listed here with brief descriptions.	
	LINK-A0, is related to	The most general category of Link.
	LINK-B0, is confirmed by or authorised by	The link target contains an instance of a DCM or document that is either a legal or authoritative basis for what is documented in the source DCM instance, or is a declaration of intent to provide (or not provide) requested care.
	LINK-C0, is related to the same problem or health issue	The target instance of a DCM or document describes health or healthcare that concerns the same clinical situation as the source DCM instance.
	LINK-D0, is related to the same care plan, act or episode	The source and the target instances of DCMs or documents both describe parts of the same care plan, act or episode.
	LINK-E0, is a related documentation	The target instance of a DCM or document is an alternative documentary form of the source DCM instance. For example, a re-expression of the same clinical information or supplementary explanatory information.

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Link Nature	1..1

6.15 Link Role

Identification

Label	Link Role
Metadata Type	Data Element
Identifier	DE-16699
OID	1.2.36.1.2001.1001.101.103.16699

Definition


Definition	The detailed semantic description of the relationship between this instance of this detailed clinical model (DCM), i.e. the source, and the target DCM instance or target document.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Notes	<p>This is one of two attributes that together communicate the semantics of the relationship between the source and target DCMs. This attribute provides for a specific description of the actual role played by the target in relation to the source.</p> <p>This attribute may be populated from any suitable terminology and therefore might support human readership better than interoperable automated processing.</p>
Data Type	CodeableText
Value Domain	Link Role Values

Usage

Examples	<ol style="list-style-type: none"> 1) unspecified link 2) suggests 3) endorses 4) evidence for 5) outcome 6) is documented by 7) excerpts
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	RELATED INFORMATION	0..1

6.16 Link Role Values

Identification

Label	Link Role Values
Metadata Type	Value Domain
Identifier	VD-16699
OID	1.2.36.1.2001.1001.101.104.16699
External Identifier	LINK_ROLE

Definition

Definition	Set of values for the detailed semantic description of the relationship between this instance of this DCM, i.e. the source, and the target DCM instance or target document.
Definition Source	Australian Digital Health Agency
Context	These values are used within the context of the value of the <i>Link Nature</i> data element. They provide greater specificity and may be selected more for human readership than for interoperable automated processing.
Context Source	Australian Digital Health Agency

Value Domain


Source	ISO 13606-3:2009														
Permissible Values	<p>Values SHOULD be from Termlist LINK_ROLE in ISO 13606-3:2009 [ISO2009a].</p> <p>Values MAY be from any suitable terminology.</p> <p>Some values from Termlist LINK_ROLE in ISO 13606-3:2009 Health informatics - Electronic health record communication - Part 3: Reference archetypes and term lists [ISO2009a], together with brief descriptions, are:</p> <table> <tr> <td>LINK-A1, unspecified link</td> <td>This can be used to say explicitly “there is no semantic information available for this Link”.</td> </tr> <tr> <td>LINK-B1, endorses</td> <td>The source endorses (agrees with, confirms or verifies) the situation (or interpretation) described in the target.</td> </tr> <tr> <td>LINK-C3, evidence for</td> <td>The source describes evidence for the situation (or interpretation) described in the target.</td> </tr> <tr> <td>LINK-D1, outcome</td> <td>The source describes an outcome of the situation (or interpretation) that the target describes.</td> </tr> <tr> <td>LINK-E1, documented by</td> <td>The source is a less formal description of the situation (or interpretation) documented by the target.</td> </tr> <tr> <td>LINK-E4, excerpts</td> <td>The source is an extract (copy) of part or all of the information contained within the target.</td> </tr> <tr> <td>LINK-E5, derived from</td> <td>The source contains information that has been derived (e.g. calculated) from information in the target.</td> </tr> </table>	LINK-A1, unspecified link	This can be used to say explicitly “there is no semantic information available for this Link”.	LINK-B1, endorses	The source endorses (agrees with, confirms or verifies) the situation (or interpretation) described in the target.	LINK-C3, evidence for	The source describes evidence for the situation (or interpretation) described in the target.	LINK-D1, outcome	The source describes an outcome of the situation (or interpretation) that the target describes.	LINK-E1, documented by	The source is a less formal description of the situation (or interpretation) documented by the target.	LINK-E4, excerpts	The source is an extract (copy) of part or all of the information contained within the target.	LINK-E5, derived from	The source contains information that has been derived (e.g. calculated) from information in the target.
LINK-A1, unspecified link	This can be used to say explicitly “there is no semantic information available for this Link”.														
LINK-B1, endorses	The source endorses (agrees with, confirms or verifies) the situation (or interpretation) described in the target.														
LINK-C3, evidence for	The source describes evidence for the situation (or interpretation) described in the target.														
LINK-D1, outcome	The source describes an outcome of the situation (or interpretation) that the target describes.														
LINK-E1, documented by	The source is a less formal description of the situation (or interpretation) documented by the target.														
LINK-E4, excerpts	The source is an extract (copy) of part or all of the information contained within the target.														
LINK-E5, derived from	The source contains information that has been derived (e.g. calculated) from information in the target.														

Usage

Conditions of Use	Each of the values in LINK_ROLE from ISO 13606-3:2009 identifies a subcategory of a corresponding value in <i>Link Nature Values</i> . That correspondence is indicated by the first letter after the code string "LINK-". For example, the term LINK-A1 is a subcategory of term LINK-A0. If a term in this list is used for the <i>Link Role</i> data element, the appropriate corresponding value SHALL be used for <i>Link Nature Values</i> .
Conditions of Use Source	ISO 13606-3:2009

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	Link Role	1..1

6.17 Target

Identification

Label	Target
Metadata Type	Data Element
Identifier	DE-16700
OID	1.2.36.1.2001.1001.101.103.16700

Definition


Definition	The “linked to” or identified information.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	Link UniquelIdentifier

Usage

Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for Link , and UniquelIdentifier .
-----------------	--

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	RELATED INFORMATION	1..1

6.18 Detailed Clinical Model Identifier

Identification

Label	Detailed Clinical Model Identifier
Metadata Type	Data Element
Identifier	DE-16693
OID	1.2.36.1.2001.1001.101.103.16693

Definition


Definition	A globally unique identifier for this detailed clinical model.
Definition Source	Australian Digital Health Agency
Synonymous Names	
Data Type	UniquelIdentifier

Usage

Conditions of Use	The value of this item SHALL be either the default value or a semantically equivalent value from an appropriate code system.
Conditions of Use Source	Australian Digital Health Agency
Examples	Please see Appendix B, Specification Guide for Use for examples and usage information for UniquelIdentifier .
Default Value	1.2.36.1.2001.1001.101.102.16627
Exceptional Values	Absent values are PROHIBITED . Abnormal values are PROHIBITED .

Relationships

Parents

Data Type	Name	Occurrences (child within parent)
	UNCATEGORISED MEDICAL HISTORY ITEM	1..1

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Appendix A. Known Issues

This appendix lists known issues with this specification at the time of publishing. We are working on solutions to these issues and encourage comments to help us develop these solutions.

Reference	Description
Links to external resources	Certain combinations of web browsers and PDF readers have problems opening URL links (usually found in reference sections) that span more than one line.
Data Hierarchies	Only the parts of these detailed clinical models (DCMs) required for current structured content specifications have been mapped to HL7 CDA. Mapping the remaining parts to CDA may reveal inconsistencies in the data hierarchies, requiring normative change.
Undefined Value Domains	<p>The following data elements lack a defined value domain: <i>Numerical Identifier</i>, <i>Anatomical Plane</i>, <i>Identified Landmark</i>, <i>Anatomical Location Aspect</i>, <i>Item Relationship Type</i>, <i>No Previous History of</i>, and <i>No Evidence of</i>.</p> <p>We are in the process of developing national code sets for these items. In the meantime, you are free to use your own code sets, providing any code set used SHALL be registered, i.e. registered through the HL7 code set registration procedure with an appropriate object identifier (OID), and SHALL be publicly available. Note that when national standard code sets do become available, they SHALL be used and the non-standard code sets SHALL be deprecated.</p>
Undefined Data Structures	<p>The following data components lack a defined data structure: <i>Diagnostic Criteria</i>, <i>Clinical Stage/Grade</i>, <i>Status</i> and <i>Procedure Detail</i>.</p> <p>A free text data element is currently used as an interim solution.</p>
Information Provider	We are considering making <i>Information Provider</i> one of a pair of data components: <i>Information Provider</i> for the source of the information, typically the subject of care of the enclosing structured document and <i>Reporter</i> for the author of the information, typically the author of the enclosing structured document. <i>Reporter</i> has not been added to this DCM. More investigation is needed to make a decision.
Severity	The data element is a candidate for terminology. In the future its data type is to be changed to <i>Codeable Text</i> .
Link to Supporting Clinical Evidence	It has been suggested that cardinality should be 0..*, not 0..1. It is currently under review.
Global Statement Values Value Domain	The list of permissible values is a sample set to initiate discussion and collaboration to develop the correct set of values.
Exclusion Statement	The exclusion statement DCMs are the subject of ongoing development and review and may well change in the future.
Date of Onset and Date of Resolution/Remission	It is possible that <i>Date of Onset</i> and <i>Date of Resolution/Remission</i> should be considered as the start and end of a period. Resolution depends on whether a recurrent problem or diagnosis should be recorded as a single problem or diagnosis, or as a series of them.

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Appendix B. Specification Guide for Use

B.1 Overview

Each detailed clinical model (DCM) and structured content specification (SCS) is designed to be a shared basis for data interpretation. It specifies rigorous business and technical definitions of data that systems may need to share. It is intended to be a logical specification of the data to be persisted within or communicated between systems. It is also the foundation for the compliance, conformance, and declaration process. Our CDA implementation guides are guides to the implementation of HL7 CDA R2 messages based upon these DCMs and SCSs.

Each DCM specifies all of the data components required for any use of a clinical concept; for instance, an entry in a medical record such as a procedure or an imaging test. As such, they are maximal data sets. DCMs are building blocks, which are trimmed to size for use in the construction of SCSs.

Each SCS describes a template of a [Structured Document](#). It specifies the data for a single type of clinical document or information exchange, such as a discharge summary. It is assembled using DCMs that have been constrained to eliminate data components not relevant to the particular context. For example, *Procedure* in a discharge summary uses only some of the data components required by *Procedure* in a specialist report.

B.2 The Structured Content Specification Metamodel

Our metamodel for structured content specifications (see Figure 1) is used to specify the overall structure of a structured content specification. The structure is a tree, so every item in the tree, other than the root node, has a parent node. For an SCS, the root node is a Structured Document. For a DCM, the root node is a Data Group.

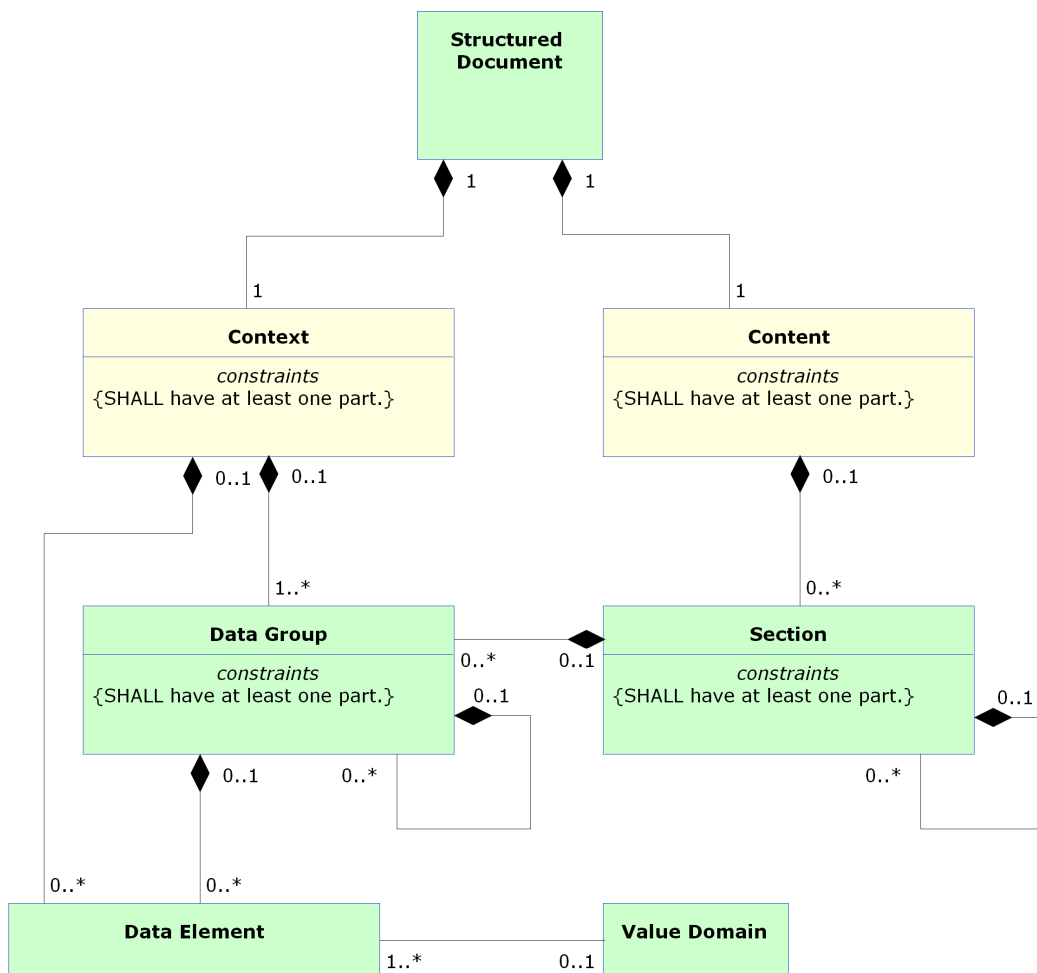


Figure 1: SCS Metamodel

There are two main items used to organise information within an SCS as follows:

Context: This contains information related to the overall context of the document.

Content: This contains information that changes between different SCSs, but is always structured as shown in Figure 1, and consists of the following data components:

- Section
- Data Group
- Data Element
- Value Domain

These data components are described in more detail below.

Structured Document

A structured document is a collection of health information about a subject of care that is relevant to the ongoing care of that person. They are composed of one or more data groups and data elements that are organised into

sections. Examples of structured documents are *Discharge Summary*, *Shared Health Summary*, and *Advance Care Directive Custodian Record*.

Context

The purpose of the context is to identify and classify the document and to provide subjects of care and involved healthcare providers with the information related to the relevant healthcare events.

Content

Content contains a collection of personal information and health information pertinent to a subject of care that is derived from the healthcare event described in the document. The detail is organised into one or more data groups, which are optionally grouped into sections.

Section

A section is composed of data groups, other sections, or both. It is an organising container that cues the reader about expected content. A section organises information in a manner suitable for the primary purpose for which it is collected and provides a way to navigate through the data components within the document, thereby enabling more efficient querying. It is recommended that the section support safe reuse for secondary purposes, e.g. clinical coding or inclusion in a summarised form in an electronic health record. A section is context-specific to the document in which it resides.

Data Group

Each data group is used to represent one concept. A data group consists of other data groups, data elements, or both. Some data groups are reused across DCMs.

Every instance of a data group **SHALL** have at least one child data component instantiated.

Participation

Participation is a special case of a data group that is based on a data group template, which is reused throughout the DCMs and SCSs. Participations are an amalgam of the Actors (see below) operating within a defined healthcare domain and the Roles they are playing within that domain.

A Participant has been defined to align with the concepts of the Agency's [Interoperability Framework \[NEHT2007b\]](#). It equates to an *Entity* that is related to the action described in an SCS as an *Actor*. A Participant can be a human, an organisation, or an IT system.

Our [Participation Data Specification \[NEHT2011v\]](#) defines the full Participation specification.

Choice

Choice represents a selection, to be made at run-time, of a single member from a set of data groups, where the set is defined at design-time, i.e. one and only one member of the set is chosen for each instance of the choice.

For example, at design-time a healthcare provider provides a service, but it is not until run-time that a decision can be made as to whether the provider is a person or an organisation. Hence, when a healthcare provider *Participant* is instantiated, it will contain either an instance of the *Person* data group or an instance of the *Organisation* data group.

Data Element

A data element is the smallest named unit of information in the model that can be assigned a value. For example, *DateTime of Observation* and *Observation Note*. Data elements are bound to data types (see [Data Types Legend](#)). Some data elements are reused in different data groups.

While all data elements are constrained by their data type, some data elements are further constrained by value domains (see [Value Domain](#) below).

Value Domain

A value domain constrains the permissible values for a data element. The values are often a subset of values based on a generic data type.

Value domains are reusable items, therefore the same value domain can be referred to by different data elements in different contexts. Value domains are often specified with reference to a *reference set*. A reference set is a constrained list of SNOMED CT-AU concepts that are appropriate to a particular context or use. Since many of these reference sets have been developed specifically for the context in which they appear, it is recommended that an assessment of fitness for purpose be undertaken before using any of the reference sets in another context.

Value domains constrain either by specifying a lower or upper bound (or both) on the range of permissible values or by specifying a finite set of prescribed values. Such a set of prescribed values can be specified directly within the definition of the data element, or in a separate but associated specification, or else by reference to one or more vocabulary or terminology reference sets. The table below provides some examples of value domains.

Table 1: Value Domain Examples

Data Element	Data Type	Example of Value Domain										
Sex	CodedText	Standards Australia AS 4846 (2006) – Health Care Provider Identification [SA2006a] and Standards Australia AS 5017 (2006) – Health Care Client Identification [SA2006b] derive their values from METeOR 287316, which includes values such as: <table border="1" data-bbox="651 1301 1433 1532"> <thead> <tr> <th>Value</th> <th>Meaning</th> </tr> </thead> <tbody> <tr> <td>1</td> <td>Male</td> </tr> <tr> <td>2</td> <td>Female</td> </tr> <tr> <td>3</td> <td>Intersex or Indeterminate</td> </tr> <tr> <td>9</td> <td>Not Stated/Inadequately Described</td> </tr> </tbody> </table>	Value	Meaning	1	Male	2	Female	3	Intersex or Indeterminate	9	Not Stated/Inadequately Described
Value	Meaning											
1	Male											
2	Female											
3	Intersex or Indeterminate											
9	Not Stated/Inadequately Described											
Diagnosis	CodeableText	A SNOMED CT-AU reference set that references concepts such as “Bronchitis” (Concept ID: 32398004).										
Therapeutic Good Identification	CodeableText	An AMT reference set that references concepts such as “Ibuprofen Blue (Herron) (ibuprofen 200 mg) tablet: film-coated, 1 tablet” (Concept ID: 54363011000036107).										
Individual Pathology Test Result Name	CodeableText	A LOINC subset that references concepts such as “Cholesterol [Moles/volume] in Serum or Plasma” (ID: 14647-2).										






B.3 Icon Legend

These legends describe all icons that are used in the Agency's DCMs and SCSs.

Metadata Types Legend

The following table explains each of the icons used to represent the metadata types within DCMs and SCSs.



Table 2: Metadata Types Legend

Icon	Metadata Types
	Structured Document
	Section
	Data Group
	Participation
	Choice

Data Types Legend

The following table explains each of the icons used to represent the data types bound to each data element in the SCSs. These data types are a profile of the **ISO 21090-2011** data types as specified in [Data Types in NEHTA Specifications: A Profile of the ISO 21090 Specification \[NEHT2010c\]](#).

Table 3: Data Types Legend

Icon	Data type	Explanation
	Any (ISO 21090: ANY)	Use of this icon indicates that instances of the data element can be of any concrete data type. There are no limitations on the data type of the data element. The values that can be required will vary considerably depending on the context. This is an abstract data type that is the basis for all data types and SHOULD NOT be used in an actual implementation.
	Boolean (ISO 21090: BL)	A data type, sometimes called the logical data type, having one of the two values: <i>true</i> and <i>false</i> . Many systems represent true as <i>non-zero</i> (often 1, or -1) and false as <i>zero</i> . Usage/Examples • An actual value entered by a user might be “yes” or could be chosen by a mouse click on an icon such as <input checked="" type="checkbox"/> .



CodeableText
(ISO 21090: CD)

Coded text *with* exceptions; supports various ways of holding text, both free text and coded text.

Often used to support compliance for early adopters of the structured content specifications.

While it is recommended that the values in this data type come from the bound value domain, it allows other value domains to also be used (with or without translations to the bound value domain) or free text alternatives. This is useful when it is not possible to define an entire value domain for a complex concept (e.g. *Diagnosis*) and when there are competing code sets in existence. Note that within exchange specifications or message profiles this data type **MAY** be constrained to mandate compliance with the bound value domain.

Usage/Examples

- The Australian Institute of Health and Welfare (AIHW) defines a data element concept *Episode of admitted patient care-separation mode* (the status at separation of a subject of care and the place to which they are released). An early adopter could have a similar concept (coded or otherwise) that maps to this data element but does not strictly comply with the AIHW values.
- A SNOMED CT-AU coded/complex expression that embodies single or multiple concepts. The SNOMED CT-AU concepts behind these CodeableText data elements are specified in the structured content specification value domains.



CodedText
(ISO 21090: CD)

Coded text *without* exceptions; text with code mappings. Values in this data type **SHALL** come from the bound value domain, with no exceptions.

Often used for reference sets with only a small number of applicable values, e.g. Gender and Document Status.

Usage/Examples

[Standards Australia AS 5017 \(2006\) – Health Care Client Identification \[SA2006b\]](#) specifies the following value domain representing a type of address:

Value	Meaning
1	Business
2	Mailing or Postal
3	Temporary Accommodation
4	Residential (permanent)
9	Not Stated/Unknown/Inadequately Described



DateTime
(ISO 21090: TS)

A single date, optionally with a time of day.

Has the ability to indicate a level of precision, but not whether the date or time is estimated. Cannot represent a time alone.

String representations of known dates **SHALL** conform to the format within the **ISO 21090-2011** standard without the use of extensions, i.e. YYYY[MM[DD[HH[MM[SS[U[U[U[U]]]]]]]]][+|-ZZzz].

Usage/Examples

- Partial dates: 2008, 20081001.
- To indicate 1:20 pm on May the 31st, 1999 for a time zone that is 10 hours ahead of Coordinated Universal Time (UTC): 19990531132000+1000.



Duration

The period of time during which something continues.

(ISO 21090:
PQ.TIME)

Consists of a value and a unit that represents the time value, e.g. hours, months.
Compound durations are not allowed, e.g. 10 days 3 weeks 5 hours.

Usage/Examples

- 3 hours
- 6 months
- 1 year



EncapsulatedData

Data that is primarily intended for human interpretation or for further machine processing outside the scope of this specification. This includes unformatted or formatted written language, multimedia data, or structured information as defined by a different standard (e.g. XML signatures).

(ISO 21090: ED)

Usage/Examples

- JPEG images
- HTML documents
- [\[RFC1521\]](#) MIME types



Integer

The mathematical data type comprising the exact integral values.

(ISO 21090: INT)

Usage/Examples

- 1
- -50
- 125



Link

A general link, reference or pointer to an object, data or application that exists logically or is stored electronically in a computer system.

(ISO 21090: TEL)

Usage/Examples

- URL (Uniform Resource Locator) – the World Wide Web address of a site on the internet, such as the URL for the Google internet search engine – *http://www.google.com*.
- An absolute or relative path within a file or directory structure – e.g. in the Windows operating system, the “link” or absolute path to a particular letter could be *C:\Documents and Settings\GuestUser\MyDocuments\letter.doc*



Quantity

A magnitude value with a unit of measurement.

(ISO 21090: PQ)

This is used for recording many real world measurements and observations. As the default unit of measure is 1, even counts of items can be recorded with *Quantity*.

Usage/Examples

- 100 centimetres
- 25.5 grams
- 3 per month

	<p>QuantityRange (ISO 21090: IVL)</p>	<p>A range of <i>Quantity</i> values.</p> <p>It may be identified using a combination of an optional minimum <i>Quantity</i> and an optional maximum <i>Quantity</i> (i.e. lower and upper bounds).</p> <p>This is typically used for defining the valid range of values for a particular measurement or observation. Unbounded quantity ranges can be identified by not including a minimum or a maximum <i>Quantity</i> value.</p>
Usage/Examples		
<ul style="list-style-type: none"> • -20 to 100 Celsius • 30-50 mg • >10 kg • 2-3 hours 		
	<p>QuantityRatio (ISO 21090: RTO)</p>	<p>A relative magnitude of two <i>Quantity</i> values.</p> <p>Usually recorded as numerator and denominator.</p>
Usage/Examples		
<ul style="list-style-type: none"> • 25 mg / 500 ml • 200 mmol per litre 		
	<p>Real (ISO 21090: REAL)</p>	<p>A computational approximation to the standard mathematical concept of real numbers.</p> <p>These are often called floating-point numbers.</p>
Usage/Examples		
<ul style="list-style-type: none"> • 1.075 • -325.1 • 3.14157 		
	<p>Text (ISO 21090: ST)</p>	<p>A character string (with optional language) containing any combination of alpha, numeric, or symbols from the Unicode character set. Also referred to as <i>free text</i>.</p> <p>Usage/Examples</p> <p>“The patient is a 37 year old man who was referred for cardiac evaluation after complaining of occasional palpitations, racing heart beats and occasional dizziness.”</p>
	<p>TimeInterval (ISO 21090:IVL)</p>	<p>An interval in time.</p> <p>It is identified using a combination of an optional start <i>DateTime</i>, an optional end <i>DateTime</i>, and an optional <i>Duration</i>.</p>
Usage/Examples		
<ul style="list-style-type: none"> • 20080101+1000 - 20081231+1000 • 200801010130+1000 - 200801011800+1000 • 200801010130+1000, duration=16.5 hours 		



UniquelIdentifier

(ISO 21090: II)

A unique value used to identify a physical or virtual object or concept.

In using this data type, the attributes of the UniquelIdentifier data type **SHOULD** be populated from the identifiers as defined in [AS 4846 \(2006\) – Health Care Provider Identification \[SA2006a\]](#) and [AS 5017 \(2006\) – Health Care Client Identification \[SA2006b\]](#) as follows:

- *root*: a globally unique object identifier that identifies the combination of geographic area, issuer and type. If no such globally unique object identifier exists, it **SHALL** be created.
- *extension*: a unique identifier within the scope of the root that is directly equivalent to the identifier designation element.
- *identifierName*: a human readable name for the namespace represented by the root that is populated with the issuer or identifier type values, or a concatenation of both, as appropriate. The content of this attribute is not intended for machine processing and **SHOULD NOT** be used for that purpose.
- *identifierScope*: the geographic span or coverage that applies to or constrains the identifier. It is directly equivalent to the geographic area element. The content of this attribute is not intended for machine processing and **SHOULD NOT** be used as such.

Also, the following constraints apply on the UniquelIdentifier data type:

- 1) The *root* attribute **SHALL** be used.
- 2) For an Entity Identifier, the *root* attribute **SHALL** be an OID that consists of a node in a hierarchically assigned namespace, formally defined using the ITU-T's ASN.1 standard.
- 3) For an Entity Identifier, the *root* attribute **SHALL NOT** be a UUID.
- 4) The *extension* attribute **SHALL** be used.

Usage/Examples

Australian health identifiers (e.g. IHI, HPI-I and HPI-O) and patient hospital medical record numbers are examples of identifiers that may be carried by data elements of this data type.

Keywords Legend

Where used in this document and in DCMs and SCSs, the keywords **SHALL**, **SHOULD**, **MAY**, **SHALL NOT** and **SHOULD NOT** are to be interpreted as described in [Key Words for Use in RFCs to Indicate Requirement Levels \[RFC2119\]](#). Our specifications use the terms **SHALL** in place of “MUST” and **SHALL NOT** in place of “MUST NOT”. The key word definitions in RFC 2119, adjusted to remove the key words not used in the Agency specifications, are presented in the following table.

Table 4: Keywords Legend

Keyword	Definition
SHALL	This word means that the statement is an absolute requirement of the specification.
SHOULD	This word means that there may exist valid reasons in particular circumstances to ignore a particular data component, but the full implications must be understood and carefully weighed before choosing a different course.

MAY	This word means that a data component is truly optional. One implementer may choose to include the data component because a particular implementation requires it, or because the implementer determines that it enhances the implementation, while another implementer may omit the same data component. An implementation that does not include a particular option shall be prepared to interoperate with another implementation that does include the option, perhaps with reduced functionality. In the same vein, an implementation that does include a particular option shall be prepared to interoperate with another implementation that does not include the option (except of course, for the feature the option provides).
SHALL NOT	This phrase means that the statement is an absolute prohibition of the specification.
SHOULD NOT	This phrase means that there may exist valid reasons in particular circumstances when the particular behaviour is acceptable or even useful, but the full implications should be understood and the case carefully weighed before implementing any behaviour described with this label.

Obligation Legend

In DCMs and SCSs obligations on a data component specify whether or not it **SHALL** be populated in the logical record architecture of a message. We intend that all data components that are not **PROHIBITED** will be implemented.

Obligations in statements about values specify whether or not certain values are permitted.

Implementation guides specify the rules and formats for implementing and populating data components in specific messaging formats.

The following table defines the obligations.

Table 5: Obligations Legend

Keyword	Interpretation
ESSENTIAL	<p>Indicates that the data component is considered a mandatory item of information and SHALL be populated.</p> <p>Usage/Examples:</p> <p>The Participant data component for a Subject of Care SHALL include an Entity Identifier data component in order to hold the IHI.</p>
OPTIONAL	<p>Indicates that the data component is not considered a mandatory item of information and MAY be populated.</p> <p>Usage/Examples:</p> <p>Such data components will be implemented, only inclusion and population are optional.</p> <p>This is only needed when a DCM incorrectly asserts that a data component is ESSENTIAL. It will be used with a note stating that the DCM needs revision.</p>
PROHIBITED	<p>On a data component this indicates that the data component is considered a forbidden item of information and SHALL NOT be included.</p> <p>In a statement about values this indicates that the use of the specified values is considered forbidden and they SHALL NOT be used.</p> <p>Usage/Examples:</p> <p>Within a Participation data group depicting a Subject of Care, the Participation Healthcare Role SHALL NOT be populated.</p>

CONDITIONAL Indicates that a data component is considered **ESSENTIAL** only on satisfaction of a given condition. Individual data components specify the obligation of the data component when the condition is not met.

When a condition is met, the data component is considered to be **ESSENTIAL** and **SHALL** be populated.

When a condition is not met, the data component may be considered **PROHIBITED**, or the data component may be considered **OPTIONAL**.

Usage/Examples:

Within a Pathology Result Report, the *Specimen Detail* data group is **ESSENTIAL** if the requested test is to be performed on a specimen; otherwise it **SHALL NOT** be included.

Obligations follow the usual scope rules: where **ESSENTIAL** child data components are contained within **OPTIONAL** parent data components, the child data components **SHALL NOT** be included when the parent is not included.

B.4 Exceptional Values

Occasionally a data element will have an exceptional value: an abnormal value (i.e. the value cannot be described using the expected set of values) or an absent value (i.e. no value is provided). Some abnormal values are only relevant to data elements of certain data types (e.g. positive infinity is relevant to numbers but not Booleans).

Unless otherwise specified, all data elements are permitted to have exceptional values. Constraints on the use of exceptional values are contained in the [Exceptional Values row](#) of the Usage section, except for instances of [Participation](#), when they are in the [Conditions of Use row](#). The most common statements constraining exceptional values are:

- Absent values are **PROHIBITED**.
- Abnormal values are **PROHIBITED**.

The commonly used implementation specifications ISO 21090 and HL7 CDA R2 use *nullFlavor* to manage abnormal and absent values.

The following table provides a classification of *nullFlavor* values as abnormal or absent.

Table 6: Classification of ISO 21090 nullFlavor values as absent or abnormal

Level	Code	Term	Abnormal	Absent
1	NI	No information		Absent
2	INV	Invalid	Abnormal	
3	OTH	Other	Abnormal	
4	PINF	Positive infinity	Abnormal	
4	NINF	Negative infinity	Abnormal	
3	UNC	Unencoded	Abnormal	
3	DER	Derived	Abnormal	
2	UNK	Unknown		Absent
3	ASKU	Asked but unknown		Absent
4	NAV	Temporarily unavailable		Absent
3	NASK	Not asked		Absent
3	QS	Sufficient quantity	Abnormal	

Level	Code	Term	Abnormal	Absent
3	TRC	Trace	Abnormal	
2	MSK	Masked		Absent
2	NA	Not applicable		Absent

B.5 Information Model Specification Parts Legends

This section illustrates the format and parts used to define each section, data group and data element within the Agency’s DCMs and SCSs, and identifies when each part is applicable.

Chapter Name

Each section, data group, data element, value domain or choice has its own eponymous chapter. The chapter name is used in all data hierarchies.

Identification Section Legend

The following table illustrates the layout of the Identification section and describes the various parts of the section.

Table 7: Identification Section Legend

Label	A suggested display name for the data component.
Metadata Type	The type of the data component, e.g. section, data group or data element.
Identifier	An Agency-assigned internal identifier of the data component. Note that if one data component is used twice (e.g. <i>Therapeutic Good Identification</i> is used in both <i>Medication Instruction</i> and <i>Medication Action</i>), both uses of the data component will have the same identifier. A data component identifier identifies a data component, not a use of a data component.
OID	An object identifier equivalent to the data component identifier.
External Identifier	An identifier of the concept represented by the data component that is assigned by an organisation other than the Agency.

Definition Section Legend

The following table illustrates the layout of the Definition section and describes the various parts of the section.

Table 8: Definition Section Legend

Definition	The meaning, description or explanation of the data component. For data groups used in a particular context, the definition MAY be a refinement of the generic data group definition.
Definition Source	The authoritative source for the Definition statement.
Synonymous Names	A list of any names the data component may also be known as.

Scope	Implementers may prefer to use synonymous names to refer to the data component in specific contexts.
	Situations in which the data component may be used, including the Scope circumstances where specified data are required or recommended.
Scope Source	For example, Medication Instruction (data group) has a scope that includes all prescribable therapeutic goods, both medicines and non-medicines.
	This item is not relevant to data elements or value domains.
Context	The authoritative source for the Scope statement.
	The environment in which the data component is meaningful, i.e. the circumstance, purpose and perspective under which this data component is defined or used.
Assumptions	For example, Street Name has a context of Address.
	This item is applicable only to data elements.
Assumptions Source	Suppositions and notions used in defining the data component.
	The authoritative source for the Assumptions statement.
Notes	Informative text that further describes the data component, or assists in the understanding of how the data component can be used.
Data Type	The data type (or data types) of the data element, e.g. DateTime or Text.
	The valid data types are specified in the Data Types Legend .
Value Domain	This item is applicable only to data elements.
	The name of the Value Domain used to define the range of values of the data element, or a statement describing what values to use in the absence of a defined value domain for the related data element.
	The statement is:
	<p>In the absence of national standard code sets, the code sets used SHALL be registered code sets, i.e. registered through the HL7 code set registration procedure with an appropriate object identifier (OID), and SHALL be publicly available.</p> <p>When national standard code sets become available, they SHALL be used and the non-standard code sets SHALL be deprecated.</p>
	This item is applicable only to data elements with data type CodedText or CodeableText.

Data Hierarchy

The top-level data components (a Structured Document in an SCS or Data Groups in a DCM) contain a data hierarchy. Each row contains information about a single data component. The entries are nested to represent inclusion of one data component in another. Each entry contains at least three occupied cells. The left-most cell contains an icon to indicate the entry's data type. The next cell to the right contains the label of the data component (if the label is different from the name, the name is displayed in brackets after the label). The next cell to the right contains the multiplicity range for the data component.

If a row is shaded grey, this indicates that the data component **SHOULD NOT** be used. This will be because analysis of requirements either did not find reasons to use it or found reasons to not use it.

If the text in a row is in a ~~strike-through~~ font and the multiplicity is 0..0, this indicates that the data component **SHALL NOT** be used. This will be because analysis of requirements found reasons to prohibit the use of it.

In some documents the right-hand side of the data hierarchy contains one or more columns under the heading “Core Requirement”. Each column contains information for one document exchange scenario. A cell that is empty indicates that the data component on that row is **OPTIONAL** to implement. That is, software that creates documents made in conformance with this specification **MAY** exclude the data component, and software that reads documents made in conformance with this specification **MAY** ignore the data component. All other data components **SHALL** be implemented.















Sample SCS Data Hierarchy



Note

Items below whose text is lighter (mid-blue and mid-grey) are technical identifiers whose purpose is to facilitate interoperability, sharing of data and secondary use. Typically, such identifiers will be generated internally by systems and not displayed to users since they rarely have clinical significance.

Items below with a grey background are data components that are included in the relevant detailed clinical model specification, but whose use is discouraged in this particular scenario.

 SPECIALIST LETTER			
CONTEXT			
		SUBJECT OF CARE	1..1
		DOCUMENT AUTHOR	1..1
		ENCOUNTER	1..1
		DateTime Subject of Care Seen (DateTime Health Event Started)	1..1
		DateTime Health Event Ended	0..0
		HEALTHCARE FACILITY	0..0
		Document Instance Identifier	0..1
		RELATED INFORMATION	0..0
		Document Type	1..1
CONTENT			
		RESPONSE DETAILS	1..1
		Diagnosis (PROBLEM/DIAGNOSIS)	0..*
		Diagnosis Name (Problem/Diagnosis Identification)	1..1
		Clinical Description	0..0
	and more		

Value Domain Section Legend

The following table illustrates the layout of the Value Domain section and describes the various parts of the section.

Table 9: Value Domain Section Legend

Source	The name of the terminology or vocabulary from which the value domain's permissible values are sourced, e.g. SNOMED CT-AU, LOINC.
Version Number	Version number of the value domain source.
Permissible Values	A specification of the permissible values in the value domain. This may be a list of codes. (Each code is typically presented as a triple with code values, text equivalent, and description) for example: 1, Registered No result yet available. This may be a conformance statement (e.g. "The permissible values are the members of the following seven AMT reference sets: ...").

Usage Section Legend

The following table illustrates the layout of the Usage section and describes the various parts of the section.

Table 10: Usage Section Legend

Examples	Sample values for the data element, with or without notes about sample values. Where a data element has an associated value domain, examples representative of that domain are used where possible. Where the value domain is yet to be determined, indicative examples are provided. Implementation guides may contain specific examples of how data elements may be populated and how they relate to each other. This item is applicable only to data elements.
Conditions of Use	Prerequisites, provisos or restrictions for use of the data component.
Conditions of Use Source	The authoritative source for the Conditions of Use statement.
Misuse	Incorrect, inappropriate or wrong uses of the data component.
Default Value	A common denomination, or at least a usable denomination, from the Value Domain where available or applicable, typically assigned at the creation of an instance of the data component.
Exceptional Values	A statement of limitations on the use of exceptional values, see Exceptional Values . Unless otherwise specified, all data elements are permitted to have exceptional values. The most common statements constraining exceptional values are: <ul style="list-style-type: none"> Abnormal values are PROHIBITED. Absent values are PROHIBITED. This item is applicable only to data elements.

Relationships Section Legend

The Relationships section specifies the cardinality between parent and child data components.

The following table illustrates the layout of the Parent relationships table. Note that the occurrences in the relationships described by this table are from the parent to the child data component, i.e. from the data component listed in the table to the data component described by the section.

Table 11: Parent Legend

Data Type	Name	Occurrences (child within parent)
The icon illustrating the metadata type or data type.	Parent Data Component Name	The minimum and maximum number of instances of the data component described on this page that SHALL occur.

The following table illustrates the layout of the Children relationships table.

Table 12: Children Legend

Data Type	Name	Occurrences
The icon illustrating the metadata type or data type.	Child Data Component Name	The minimum and maximum number of instances of the data component described on this page that SHALL occur.

Appendix C. Change History

A summary of changes from one document version to the next. Changes to the change history are excluded.

C.1 Changes Since Version 1.0 - 18 December 2015

Generic changes

Various changes to rebrand the document from the National E-Health Transition Authority (NEHTA) to the Australian Digital Health Agency (the Agency):

- Definition Source, Scope Source, Context Source, Condition of Use Source and Value Domain Source updated from “NEHTA” to “Australian Digital Health Agency”;
- references to “National E-Health Transition Authority” and “NEHTA” have been replaced with references to the “Australian Digital Health Agency” and “the Agency” respectively; and
- all NEHTA URLs have been updated to redirect to the Agency website.

The generic text in examples that references the appendix specification guide for use has had editorial changes.

Preliminary Pages

Document Information section has been changed to include the latest release details.

Chapter 1 Introduction

Various editorial changes to presentation and wording, including replacing the expression “PCEHR” with “My Health Record”.

Chapter 2 Problem/Diagnosis Detailed Clinical Model

The version has changed from 5.2 to 5.3.

Guidance on data elements with exceptional values has been added. This affects all uses of the following data elements:

- *PROBLEM/DIAGNOSIS > Problem/Diagnosis Identification*
- *PROBLEM/DIAGNOSIS > ANATOMICAL LOCATION > SPECIFIC LOCATION > Side;*
- *PROBLEM/DIAGNOSIS > ANATOMICAL LOCATION > SPECIFIC LOCATION > Numerical Identifier;*
- *PROBLEM/DIAGNOSIS > ANATOMICAL LOCATION > SPECIFIC LOCATION > Anatomical Plane;*
- *PROBLEM/DIAGNOSIS > ANATOMICAL LOCATION > RELATIVE LOCATION > Anatomical Location Aspect;*
- *PROBLEM/DIAGNOSIS > RELATED ITEMS > Item Relationship Type;*
- *PROBLEM/DIAGNOSIS > Problem/Diagnosis Instance Identifier;*

- *PROBLEM/DIAGNOSIS > RELATED INFORMATION > Link Nature*; and
- *PROBLEM/DIAGNOSIS > Detailed Clinical Model Identifier*.

In 2.7 Problem/Diagnosis Reference Set, there was an editorial change to the definition.

In 2.16 Side, there was an editorial change to the definition.

In 2.18 Numerical Identifier, there was an editorial change to the definition.

In 2.20 RELATIVE LOCATION, there was an editorial change to the notes.

In 2.22 Anatomical Location Aspect, the examples were simplified.

In 2.25 Visual Markings/Orientation, there was an editorial change to the definition.

In 2.33 RELATED ITEMS, there was a clarifying change to the definition.

In 2.34 Related Item, there was a clarifying change to the definition.

In 2.43 Status, there was a clarifying change to the definition and clarifying note has been added to describe the context of use.

In 2.44 INFORMATION PROVIDER, this follows current design for specifying Information Provider.

In 2.46 Problem/Diagnosis Instance Identifier, there was a clarifying change to the definition and the note was removed.

In 2.45 SUBJECT, there was an editorial change to the scope and conditions of use.

In 2.47 RELATED INFORMATION, there was an editorial change to the definition.

In 2.49 Link Nature Values, there were editorial changes to the permissible values.

In 2.50 Link Role, there was an editorial change to the notes.

In 2.51 Link Role Values, the permissible values have been updated.

Chapter 3 Exclusion Statement - Problems and Diagnoses Detailed Clinical Model

The version has changed from 1.3 to 1.4.

Guidance on data elements with exceptional values has been added. This affects all uses of the following data elements:

- *EXCLUSION STATEMENT - PROBLEMS AND DIAGNOSES > Global Statement*;
- *EXCLUSION STATEMENT - PROBLEMS AND DIAGNOSES > Exclusion Statement - Problems and Diagnoses Instance Identifier*;
- *EXCLUSION STATEMENT - PROBLEMS AND DIAGNOSES > RELATED INFORMATION > Link Nature*; and
- *EXCLUSION STATEMENT - PROBLEMS AND DIAGNOSES > Detailed Clinical Model Identifier*.

In 3.2 Use, there were editorial changes.

In 3.5 Global Statement, the condition of use constraint to not use “Not asked” has been removed, along with its source.

In 3.9 INFORMATION PROVIDER, this follows current design for specifying Information Provider.

In 3.10 SUBJECT, there was an editorial change to the scope and conditions of use.

In 3.12 RELATED INFORMATION, there was an editorial change to the definition.

In 3.14 Link Nature Values, there were editorial changes to the permissible values.

In 3.15 Link Role, there was an editorial change to the notes.

In 3.16 Link Role Values, the permissible values have been updated.

Chapter 4 Procedure Detailed Clinical Model

The version has changed from 4.2 to 4.3.

Guidance on data elements with exceptional values has been added. This affects all uses of the following data elements:

- *PROCEDURE > ANATOMICAL LOCATION > SPECIFIC LOCATION > Side;*
- *PROCEDURE > ANATOMICAL LOCATION > SPECIFIC LOCATION > Numerical Identifier;*
- *PROCEDURE > ANATOMICAL LOCATION > SPECIFIC LOCATION > Anatomical Plane;*
- *PROCEDURE > ANATOMICAL LOCATION > RELATIVE LOCATION > Anatomical Location Aspect;*
- *PROCEDURE > Procedure Instance Identifier;*
- *PROCEDURE > RELATED INFORMATION > Link Nature;* and
- *PROCEDURE > Detailed Clinical Model Identifier.*

In 4.8 Procedure Description, the examples have been moved into notes. The examples section now references the appendix on specification guide for use.

In 4.9 Procedure Reason, the example has been moved into a note. Examples now refer to the appendix specification guide for use.

In 4.16 Numerical Identifier, there was an editorial change to the definition.

In 4.18 RELATIVE LOCATION, there was an editorial change to the notes.

In 4.20 Anatomical Location Aspect, the examples were simplified.

In 4.23 Visual Markings/Orientation, there was an editorial change to the definition.

In 4.29 INFORMATION PROVIDER, this follows current design for specifying Information Provider.

In 4.30 SUBJECT, there was an editorial change to the scope and conditions of use.

In 4.33 RELATED INFORMATION, there was an editorial change to the definition.

In 4.35 Link Nature Values, there were editorial changes to the permissible values.

In 4.36 Link Role, there was an editorial change to the notes.

In 4.37 Link Role Values, the permissible values have been updated.

Chapter 5 Exclusion Statement - Procedures Detailed Clinical Model

The version has changed from 1.2 to 1.3.

Guidance on data elements with exceptional values has been added. This affects all uses of the following data elements:

- *EXCLUSION STATEMENT - PROCEDURES > Global Statement;*
- *EXCLUSION STATEMENT - PROCEDURES > Exclusion Statement - Procedures Instance Identifier;*
- *EXCLUSION STATEMENT - PROCEDURES > RELATED INFORMATION > Link Nature;* and
- *EXCLUSION STATEMENT - PROCEDURES > Detailed Clinical Model Identifier.*

In 5.5 Global Statement, the condition of use constraint to not use “Not asked” has been removed, along with its source.

In 5.8 INFORMATION PROVIDER, this follows current design for specifying Information Provider.

In 5.9 SUBJECT, there was an editorial change to the scope and conditions of use.

In 5.11 RELATED INFORMATION, there was an editorial change to the definition.

In 5.13 Link Nature Values, there were editorial changes to the permissible values.

In 5.14 Link Role, there was an editorial change to the notes.

In 5.15 Link Role Values, the permissible values have been updated.

Chapter 6 Uncategorized Medical History Item Detailed Clinical Model

The version has changed from 2.0 to 2.1.

Guidance on data elements with exceptional values has been added. This affects all uses of the following data elements:

- *UNCATEGORISED MEDICAL HISTORY ITEM > Medical History Item Description;*
- *UNCATEGORISED MEDICAL HISTORY ITEM > Uncategorized Medical History Item Instance Identifier;*
- *UNCATEGORISED MEDICAL HISTORY ITEM > RELATED INFORMATION > Link Nature;* and
- *UNCATEGORISED MEDICAL HISTORY ITEM > Detailed Clinical Model Identifier.*

In 6.6 Medical History Item Description, an example has been fully expanded to avoid use of an acronym.

In 6.9 INFORMATION PROVIDER, this follows current design for specifying Information Provider.

In 6.10 SUBJECT, there was an editorial change to the scope and conditions of use.

In 6.14 Link Nature Values, there were editorial changes to the permissible values.

In 6.15 Link Role, there was an editorial change to the notes.

In 6.16 Link Role Values, the permissible values have been updated.

Appendix A. Known Issues

Various editorial changes.

Two known issues were added.

Appendix B. Specification Guide for Use

Various editorial changes.

Renamed the section B.4 “Abnormal and Absent Values” to “Exceptional Values” and updated explanatory text throughout accordingly.

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