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## **Information Requirements**

### **Shared Health Summary**

Version 1.0 - 29 November 2011

Final

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# Document Information

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V1.0	2011-11-29	Rob Eastwood	Integration of final amendments. Feedback from Clinical Safety and the Privacy Unit. Removed the sentence (from section 1.2.1): "Only the current version of the SHS is visible to PCEHR users (but access to historical records for audit and medico-legal reasons is only through the PCEHR Service Provider)."

## Document authorisation

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# Preface

## Document Purpose

This document presents the information requirements for a Shared Health Summary, which are recommended for use within Australia.

The Shared Health Summary Information Requirements are a logical set of data items for exchange and are therefore independent of any particular platform, technology, exchange format or presentation format.

Updates to this document will be published as additional package components are developed, with feedback from the sector.

## Intended Audience

This document is intended for all interested stakeholders including:

- Clinicians, such as general practitioners
- Early adopter hospitals and health departments in the process of planning, implementing or upgrading eHealth systems
- Software vendors developing eHealth system products
- Early adopter general practitioner desktop software vendors
- Senior managers and policy makers, clinical experts, health information managers, IT operations and support teams, system integrators
- Stakeholders associated with the development and use of upcoming eHealth initiatives relating to 'continuity of care'
- Both technical and non-technical readers
- Consumers and consumer representatives

## Document Status

Final.

## Definitions, Acronyms and Abbreviations

For a list of abbreviations, acronyms and abbreviations, see the [Definitions section](#) at the end of the document, on page 33.

## References and Related Documents

For a list of all referenced documents, see the [References](#) section at the end of the document, on page 34.



# 1 Introduction

## 1.1 Overview

This document presents the Information Requirements for Shared Health Summaries, as recommended for use in Australian eHealth systems.

The Information Requirements are the minimum set of data items that are recommended for implementation in any system that creates and transfers Shared Health Summaries, to support the delivery of quality collaborative care. The inclusion of data in this minimum set is determined by two criteria:

1. The clinical relevancy of the data
2. The potential for the data to improve clinical safety in a collaborative care environment.

As these specifications define the Information Requirements for exchange, it is anticipated that some Shared Health Summary templates may contain additional types of data to satisfy specific local or specialty healthcare requirements.

## 1.2 Scope

The following statements regarding scope pertain only to the information requirement specifications herein and not more broadly to the PCEHR scope of work.

### 1.2.1 Scope Inclusions

The aim of a Shared Health Summary (SHS) is to provide key pieces of information about an individual's health status facilitating care across a wide ranging healthcare domain.

The PCEHR Concept of Operations [PCO-2011] states that a SHS "is a clinical document sourced from the individual's nominated provider, which contains key pieces of information about an individual's health status and is useful to a wide range of healthcare providers for delivery of care. SHS's are a key piece of information for populating an individual's 'Consolidated View', which is assembled from multiple sources. To enable easy extraction of SHS's from GP systems, the fields within a SHS will be congruent with the Royal Australian College of General Practitioners (RACGP) standards for health summaries."

A SHS can only be sourced and uploaded by an individual's nominated healthcare provider, which may be an individual or an organisation. If other providers wish to provide information about the individual to the PCEHR, they could use an Event Summary, specialist letter, or other clinical documents.

The nominated provider is not required to update a SHS at every consultation; it should be updated when clinically appropriate to do so at the discretion of the nominated provider.

In scope for the information requirements for the SHS, in the first release is information managed by the patient's nominated provider which is most often their usual GP.

The content of a Shared Health Summary will vary depending on the individual, and the information available. Therefore, information should only be included in a Shared Health Summary where it will be useful to the healthcare provider for the ongoing care of the patient.

The information identified in this document will be electronically extracted from the GP clinical information system to populate the Shared Health Summary.

## 1.2.2 Scope Exclusions

Out of scope is information gathering for the full patient records within the GP clinical information system, the way the data is transferred from GP desktop to PCEHR and how the information is formatted for display.

## 1.3 Purpose

The purpose of the Shared Health Summary Information Requirements is to define the information requirements for a nationally-agreed exchange of information between healthcare providers in Australia, independent of exchange or presentation formats.

It is anticipated that these Information Requirements will:

- Promote a common understanding of the requirements for constructing and consumption of Shared Health Summaries
- Provide a common framework for development and use of semantically interoperable information components to be exchanged between applications, providers, jurisdictions
- Provide a common framework for defining queries using these information requirements at logical levels, which may be adopted for implementations in local, jurisdictional or national Electronic Health Record environments
- Provide a common framework upon which to define nationally-agreed, specialty-specific information requirements
- Provide a common framework for nationally-defined mappings to specific exchange formats
- Provide a framework (along with other documents and structures) suitable for the development of national terminology sets that associate specific data items with valid values. These values will be derived from nationally endorsed terminologies maintained and distributed on behalf of Australia by NEHTA's National Clinical Terminology and Information Service (NCTIS). The current terminology sources that will provide this content are LOINC for defined areas of Pathology content, SNOMED CT-AU for all other clinical content and Australian Medicines Terminology (AMT) for medicinal products. Administrative content will be derived either from SNOMED CT-AU or specifically defined external codesets.

## 1.4 Exchange and Presentation Formats

The information presented here is defined at the logical level, and is therefore independent of specific exchange or presentation formats (e.g. HL7 v2.x or HL7 Clinical Document Architecture [CDA]). The Information Requirements will be mapped to HL7 CDA exchange format and published following the endorsement of the Information Requirements.

Similarly, the requirement that a particular piece of data be exchanged in a Shared Health Summary does not imply a requirement on the user interface. Some data elements (e.g. 'Document Originating System Identifier') are intended purely for purposes of internal processes within the receiving system. Similarly, other data elements (e.g. 'Date of Birth') have a number of different presentation options available (e.g. 'Birth Day' + 'Year of Birth' etc), which are not considered here. In addition to this, the names given to data components and data items are in many cases not appropriate to be used as field labels on a user interface.

Implementations which modify the data item names in the 'Item' column of the following section to accommodate local practices (e.g. 'Person name')

represented as 'Patient Name') may still conform to this specification, but only if the meaning of the variables listed in the other columns are not modified.

Please also note that the order in which the data items are listed in this document is not indicative of the order in which this data should be exchanged or presented to the user.

## 1.5 Adding Data

It is envisaged that Clinical Information Systems operating at the source should be capable of transferring relevant data into the relevant sections of the Shared Health Summary. This will minimise data entry and may reduce the issues of recording data redundantly in multiple data stores. It is expected that where feeder systems are used, the author's discretion is exercised in only allowing information relevant to the ongoing care of the patient to be included in the SHS, and that the author's due diligence is applied to ensure that the information included from the feeder system is current and accurate.

Note that some of the data elements included in this specification are required for ALL Shared Health Summaries whereas others need only be completed where appropriate. That is, a conformant Shared Health Summary implementation must be capable of collecting and transferring/receiving all Information Requirement elements.

However:

- Not all data elements require a value in each and every Shared Health Summary (e.g. items that are categorised with '0..1' or '0..Many'). For example, Medication "Additional Comments" (0..1): not all medications would actually require an additional comment.
- Not all data elements are required to be displayed to users, and their labels may be different from those used in the 'Item' column of the Proposed Data Model table in the following sections.

## 2 Core Components

### 2.1 Overview

The information components include:

Component
Individual
Source of Shared Health Summary
Allergies and Adverse Reactions
Medicines
Current and Past Medical History
Immunisations
Document Control

Each component is firstly described in terms of what the requirements are, providing a rationale.

A small number of indicative samples for usage are included to provide additional clarity but are not intended to be a prescription for display. Note also that all content in the samples is completely fictitious.

This is followed with a representation of the proposed data model for each.

## 2.2 Guide to this document

The proposed data model for each of the components is defined below, using the following columns:

- *Component*: A high level section or group of data elements
- *Item*: An individual data element or data group. A data item may be a single unit of data (e.g. "Date of Birth"), or a set of data that has a standard structure (e.g. "Address")
- *Type*: The type of data associated with the component or data item. Note that this may be a simple data type (e.g. text, date) requiring a single field, or a predefined structure requiring a group of fields. Refer to legend in section 2.2.1 below.
- *Number of Values Allowed*: The number of times that the given component/item may be included in a Shared Health Summary. For items, this is the number of times that the given item may be included, each time the component. Refer to legend in section 2.2.2 below.

The following legends are included to assist the reader with the content of the tables that follow.

### 2.2.1 Data Type legend

The following table provides a description of the various datatypes in use.

Datatype	Notes
Boolean	A Boolean value can be either true or false, or may be empty.
Codeable Text	Codeable Text is a flexible data type to support various ways of holding text - both free text and coded text.
Coded Text	Values in this data type must come from the bound value list, with no exceptions.
DateTime	DateTime is used for specifying a single date and/or time. It can indicate a level of precision, and define estimated or partial dates.
Integer	Whole numbers.
Quantity	The Quantity data type is used for recording many real world measurements and observations. Includes the magnitude, value and the unit.
Text	Free text string.
Time Interval	Time Interval contains a Start DateTime and (optionally) an End DateTime.
Unique Identifier	An identifier that uniquely identifies a given entity.

## 2.2.2 “Number of Values Allowed” legend

In order to facilitate understanding by non-technical readers, the standard notation for cardinality has been mapped to a more readable style, in the following ways:

- The value of “1” is technically represented as “1..1”
- The value of “1..Many” is technically represented as “1..\*”
- The value of “0..Many” is technically represented as “0..\*”

The following table provides a description of the options for Number of Values Allowed.

Value	Minimum	Maximum	Notes	Example
1	1	1	Must have 1 value and only 1	Vaccine Brand Name (i.e. per each immunisation record)
0..1	0	1	Does not need a value in every ES, but when it does, it can only ever have 1	Medicine Additional Comments (i.e. additional comments are not required for all medicines)
1..Many	1	Many	Must have at least 1 value, and can contain multiples	Individual Address
0..Many	0	Many	Does not need a value in every SHS, but when it does, it can contain multiples	Individual Communication Details

Note that the supporting technical documentation (Structured Content Specifications and CDA Implementation Guide) fully complies with the standard technical notation.



## 3 Component: Individual

**Description:** The individual is the person about whom the healthcare event has been captured – that is, the subject of the information.

### 3.1 Requirements

Data item	Requirement statement	Rationale
Component	Each SHS shall always contain information about the individual and shall always contain the following mandatory items.	A SHS is only created pertaining to an individual and one cannot exist without that individual.
Person Name	The name of the individual shall be recorded in every SHS.	Clinical safety. Identification of the individual. Supports the indexing of clinical documents.
	The recording of individual name shall be consistent with Australian Standards of naming.	Allows interoperability. Eliminates ambiguity.
Person Identifier	Every SHS shall contain the individual's Individual Healthcare Identifier (IHI).	Allows interoperability. Eliminates ambiguity. Clinical safety. Supports the indexing of clinical documents.
	A SHS shall also be allowed to contain multiple identifiers for the individual.	Optionally the individual's local identifier to support transition to the use of national identifiers.
Date of Birth	Every SHS shall contain the individual's date of birth.	Clinical safety. Identification of the individual. Supports the indexing of clinical documents.
	An approximation for the date of birth shall be allowed (such as only the year, or the month and year) only when the exact date is not known. That is, when the exact date is known, the full date shall be provided.	The individual's exact date of birth may not be known.
	When the date of birth is an approximation, an indication of such shall be included.	Eliminates ambiguity
Sex	The individual's sex shall be recorded in every SHS.	Clinical safety. Identification of the individual. Supports the indexing of clinical documents.
	The individual's sex shall be recorded using (and be restricted to) the Australian Institute of Health and Welfare Person—Sex Data Element Concept values.	Allows interoperability. Eliminates ambiguity.
Address	The individual's address shall be recorded in every SHS.	Identification of the individual.
	The recording of individual address shall be consistent with Australian Standards of address recording.	Allows interoperability. Eliminates ambiguity.

Data item	Requirement statement	Rationale
	There shall be provision for recording the individual's address as not known or that they have no fixed address.	Individuals may not always have a fixed place of abode nor may the address be known in all cases.
Communication Details	The SHS shall have the provision to record contact details for the individual.	Allows ready access to contact the individual, should the recipient not have those details at hand.
	A value for individual's communication detail shall only be included when it is deemed to relevant/appropriate to do so (i.e. optional to include a value).	A individual's contact may not be available or appropriate to include.
	A SHS shall be allowed to contain multiple individual communication details.	This allows recording of (for example) a home landline, a work mobile and an email address.
	The contact details record shall include provision for the medium (e.g. telephone, email), usage (e.g. home, work) as well as the actual details.	Allows interoperability. Eliminates ambiguity.
Indigenous Status	An indication of whether a person identifies as being of Aboriginal or Torres Strait Islander origin (or an indication of it being not stated etc) shall be recorded in every SHS.	Aborigines and Torres Strait Islanders are eligible for a range of specific services. This will contribute to improved data quality on indigenous health.

## 3.2 Samples & usage

1. The individual has only provided the least amount of information - that is, one address and no contact details. They have declined to state their Indigenous status.

INDIVIDUAL		
<b>Name</b>	Mr William SMITH	
<b>IHI</b>	8003600200002222	
<b>Date of Birth</b>	01/01/1946 (63 years) <sup>1</sup>	<b>DOB Estimated?</b> No
<b>Sex</b>	Male	
<b>Address</b>	Residence: 20 Chapel Street, Lilydale, VIC, 3002	
<b>Contact</b>		
<b>Indigenous Status</b>	Not stated	

2. Later, the same individual provides more demographic information.

INDIVIDUAL		
<b>Name</b>	Mr William SMITH	
<b>IHI</b>	8003600200002222	
<b>Date of Birth</b>	01/01/1946 (63 years)	<b>DOB Estimated?</b> No
<b>Sex</b>	Male	
<b>Address</b>	Residence: 20 Chapel Street, Lilydale, VIC, 3002 Postal: PO Box 123, Lilydale, VIC, 3002	
<b>Contact</b>	Home Phone: 03 3988 7156	

<sup>1</sup> The age of the individual would be a calculated value rather than being a separate data item.

	Mobile: 0411 378 942 Email: <a href="mailto:mwsmith@internetprovider.com.au">mwsmith@internetprovider.com.au</a>
<b>Indigenous Status</b>	Neither Aboriginal nor Torres Strait Islander origin

3. Another Individual does not recall the exact date of their birth.

<b>INDIVIDUAL</b>	
<b>Name</b>	Mr Albert HENRY
<b>IHI</b>	8003600200003333
<b>Date of Birth</b>	1946 (63 years) <b>DOB Estimated?</b> Yes
<b>Sex</b>	Male
<b>Address</b>	Residence: 1 General Street, Broome, WA, 6725
<b>Contact</b>	Home Phone: 06 1212 1212
<b>Indigenous Status</b>	Aboriginal but not Torres Strait Islander origin

### 3.3 Proposed Data model

Data items	Data Type	Number of Values Allowed	Notes
Person Name	Person Name data group	1	The individual's name, structured using a predefined type, consistent with Australian standards of naming (e.g. family name and first name etc), as detailed in NEHTA's Participation Data Specification [PDS2011].
Person Identifier	Unique Identifier	1..Many	The unique identifier of the individual. This must include the individual's Individual Healthcare Identifier (IHI) and optionally the individual's local identifier.
Date of Birth	Date Time	1	The individual's date of birth. Where the exact date of birth is not known, this may be an approximation, which includes only the year, or the month and year.
Date of Birth Estimated?	Boolean	0..1	The level of certainty or estimation of an individual's date of birth.
Sex	Coded Text	1	The sex of the individual. Sex is the biological distinction between male and female. Where there is an inconsistency between anatomical and chromosomal characteristics, sex is based on anatomical characteristics. <sup>2</sup>
Address	Address data group	1..Many	The address of the individual, recorded in a structured format, consistent with Australian standards of address recording, as detailed in NEHTA's Participation Data Specification [PDS2011]. Where the individual's address is not known, the address line can be populated with text entry of "Individual has no known address." This may include "No fixed address" if appropriate.
Communication Details	Electronic Communication Details data group	0..Many	The individual's preferred means of contact should be included to facilitate clinical follow-up. Each Contact Details data item includes the medium (e.g. telephone), usage (e.g. home) and details. A value is not always required because it may not be available or appropriate.
Indigenous Status	Coded Text	1	A description of whether a person identifies as being of Aboriginal or Torres Strait Islander origin. Refer to the AIHW definition and code set. <sup>3</sup>

<sup>2</sup> Source of definition: Australian Institute of Health and Welfare; Person—sex Data Element Concept (METeOR identifier: 269716) <http://meteor.aihw.gov.au/content/index.phtml/itemId/269716> (accessed 19 May 2011)

<sup>3</sup> Australian Institute of Health and Welfare, METeOR, Metadata Online Registry. Person—Indigenous status <http://meteor.aihw.gov.au/content/index.phtml/itemId/291036> (accessed 19 May 2011)

## 4 Component: Source of Shared Health Summary

**Description:** The health provider nominated by the individual as being responsible for managing their Shared Health Summary.

### 4.1 Requirements

Data item	Requirement statement	Rationale
Component	Each SHS shall record details about the person who was the source of the SHS with details as described below.	Medico-legal requirement to clearly identify the person who was the source of the SHS.
Person Name	Every SHS shall record the name of the source.	Clearly identifies the source of the SHS.
	The recording of the name of the source shall be consistent with Australian Standards of naming.	Allows interoperability. Eliminates ambiguity.
	Only 1 name record shall be allowed for the source.	Avoids unnecessary complexity.
Person Identifier	The SHS shall always record the Healthcare Provider Identifier of the author (HPI-I).	Allows interoperability. Eliminates ambiguity. Clinical safety.
	A SHS shall be allowed to contain multiple personal identifiers of the author, as required.	Such as provider or prescriber numbers.
Healthcare Role	The SHS shall record the role of the source.	In many cases the source will be the patient's GP but may encompass a broader range of healthcare providers.
	The Reference set for Healthcare Role shall be derived in such a way that it can be integrated with other related codes sets, such as that required for NESAF.	Allows interoperability and system integration.
Organisation Name	The SHS shall record the name of the organisation/practice to which the source is affiliated.	Eliminates ambiguity.
Organisation Identifier	The SHS shall include the unique organisation identifier to which the source is affiliated; that is the Healthcare Provider Identifier of the organisation (HPI-O).	Whilst the source may practice at multiple organisations, an individual is generally managed at one of those organisations.
Address	The practicing address of the source shall be recorded in every SHS.	Whilst the source may practice at multiple organisations, an individual is generally managed at one of those organisations.
	The recording of the address shall be consistent with Australian Standards of address recording.	Allows interoperability. Eliminates ambiguity.
	A SHS shall be allowed to contain multiple addresses for the source.	Caters for the street address as well as the postal address.

Data item	Requirement statement	Rationale
Communication Details	At least one contact detail for the source shall be recorded in every SHS.	Downstream readers of the SHS may need to contact the source.
	A SHS shall be allowed to contain multiple source communication details.	This allows relevant telephone numbers (i.e. daytime, after hours, mobile, etc.) and email addresses to be recorded for future reference.
	The contact details record shall include provision for the medium (e.g. telephone, email), usage (e.g. after hours) as well as the actual details.	Allows interoperability. Eliminates ambiguity.

## 4.2 Samples & usage<sup>4</sup>

1. The Individual usually sees a particular GP, at a given practice, who authors a SHS.

SOURCE OF SHARED HEALTH SUMMARY	
<b>Name</b>	Dr Ethan JONES [HPI-I: 8003610200002388]
<b>Healthcare Role</b>	General Practitioner
<b>Practice</b>	Family Medical Practice [HPI-O: 8003620000000222]
<b>Address</b>	40 General Street, Brisbane, QLD 4001
<b>Contact</b>	Email: <a href="mailto:admin@fmp.com.au">admin@fmp.com.au</a> Phone: 07 3998 7156

<sup>4</sup> Health identifier numbers are predominantly for system to system usage and as such they may not necessarily be displayed to end users. The HI numbers are only displayed here to provide additional clarity for these specifications and as such, the reader should not consider this a display requirement.

### 4.3 Proposed Data model

Data items	Data Type	Number of Values Allowed	Notes
Person Name	Person Name data group	1	The name of the source, structured using a predefined type consistent with Australian standards of naming (e.g. family name and first name etc), as detailed in NEHTA's Participation Data Specification [PDS2011].
Person Identifier	Unique Identifier	1..Many	The unique individual identifier of the source which must include the Healthcare Provider Identifier of the provider (HPI-I) and optionally other identifiers (such as provider or prescriber numbers).
Healthcare Role	Codeable Text	1	The role the provider is playing in the course of being the source of the SHS. For example, 'Usual GP' or 'Locum GP'.
Organisation Name	Organisation Name data group	1	The name of the healthcare provider organisation at which the source practices. In most cases the source will be associated with an organisation, but in some circumstances they will not. For this reason, a value is not mandatory in all cases. When the source is associated with an organisation, the Organisation Name must be provided.
Organisation Identifier	Unique Identifier	1..Many	The unique organisation identifier of the practice, for which the Healthcare Provider Identifier of the organisation (HPI-O) must be provided. Optionally, local identifiers may also be included.
Address	Address data group	1..Many	The address of the source, recorded in a structured format consistent with Australian standards of address recording, as detailed in NEHTA's Participation Data Specification [PDS2011].
Communication Details	Electronic Communication Details data group	1..Many	The contact details for the source. The preferred means of contact should be included and should include at least one method of communication. Each Contact Details includes the medium (e.g. telephone), usage (e.g. work) and details.



## 5 Component: Allergies and Adverse Reactions

**Scope:** The categories of allergies and adverse medicines events have been combined into this component and therefore includes allergies and adverse reaction to all substances not just medications / medicines. This might include food allergies, bee sting allergies as well as prescription and non-prescription medicines. NB: An indicator of compliance with the RACGP Practice Standard 1.7 on health summaries is that a practice can demonstrate that at least 90% of their active patient records contain a current health summary that includes, where appropriate, a record of known allergies.

These requirements have been developed in collaboration with a specific Medication Management Reference Group (MMRG) Project Working Group and following discussions within Standards Australia.

### 5.1 Requirements

Data item	Requirement statement	Rationale
Component	Information regarding Allergies and Adverse Reactions is required for every GP e-health summary (SHS) and shall contain the following items.	Information regarding an individual's allergies and adverse reactions is vital to ensure high quality safe clinical care.
	Each SHS shall either include one (or more) Allergies and Adverse Reactions or a statement as to why none are included.	Allergies and Adverse Reactions may not be listed in a SHS for a variety of reasons – it has not been asked about, there are none, or this information is unknown. This provides assurance that an absence of Allergies and Adverse Reactions is for a specific reason, rather than having just being omitted.
Agent Description	Every allergy and adverse reaction listed in the SHS shall contain a description of the causative agent.	To ensure high quality safe clinical care.
	Values for the description of the allergy and adverse reaction agent shall be derived from a SNOMED code set with the option for free text.	Allows for electronic transmission of information and decision support.
Reaction Description	There shall be the provision for an allergy and adverse reaction record to include the description of the reaction that was caused by the aforementioned agent.	Unambiguous description of the reaction for clinical safety and allows better informed future management.
	There shall be the provision for more than one reaction to be recorded for a single agent, when appropriate.	An individual may experience multiple adverse reactions to a single agent.
	Preferably, values for the description of the reaction shall be derived from a SNOMED CT (whilst allowing for the option for free text).	Allows for electronic transmission of information and decision support.
	A value for the reaction description shall only be included at the discretion of the SHS author, i.e. when it is deemed relevant / appropriate to do so (i.e. optional	It may not always be known what the specific reaction is to a given agent. Individuals may report that they have been told that they have a reaction to a given agent but it may not be clear what the reaction was.

Data item	Requirement statement	Rationale
	to include a value).	For example, an adult reporting that they were told as a child that they reacted to a given agent but they cannot recall what happened to them.

## 5.2 Samples & usage

1. The individual has not been asked about any allergies and adverse reactions.

Individuals may be acutely unwell or otherwise indisposed and unable to provide the relevant health information to their health provider.. In these circumstances, it is suggested that GP software functionality be configured to default this section's exclusion statement to "Not Asked". Rather than displaying nothing in this section, it is considered clinically safer to record the true state that the individual wasn't asked. Note that a date & time stamp is still required with the exclusion statement.

ALLERGIES / ADVERSE REACTIONS
Not asked

2. The individual has been asked and they do not have any allergies and adverse reactions.

ALLERGIES / ADVERSE REACTIONS
None known

3. An individual has been asked and a number of reactions are recorded. Note that the individual has 2 reactions to penicillin, 1 reaction to Metoprolol, but it is not been ascertained what reaction they have to nuts.

ALLERGIES / ADVERSE REACTIONS	
Agent	Reaction description
Penicillin	Severe urticaria on trunk and legs; Nausea and vomiting
Nuts	Not known
Metoprolol	Acute exacerbation of Chronic Obstructive Airways Disease

### 5.3 Proposed Data model

Data items		DataType	Number of Values Allowed	Notes
One (or more) reactions must be provided or a reason why no reactions are provided. That is, must have one of the following (a or b), but not both:				
	a) Allergies / Adverse Reactions Exclusion Statement	Coded Text	0..1	The exclusion statement allows for explicit assertions of exclusion of all Allergies / adverse reactions, i.e. that the individual has no known Allergies / adverse reactions, the individual has not been asked about this information or that the information is unknown.
<i>IF no exclusion statement THEN...</i>				
	b) Allergies / Adverse Reaction	Group	0..Many	The data group of the known adverse reactions for the individual containing the relevant reaction details. Multiple reactions are allowed and the following 2 data items apply for each reaction added.
	Agent Description	Codeable Text	1	The agent / substance causing the allergy / adverse reaction experienced by the individual. The agent must always be recorded.
	Reaction Description	Codeable Text	0..Many	The signs and/or symptoms experienced or exhibited by the individual as a result of the allergies / adverse reaction to the specific agent/substance.

## 6 Component: Medicines

**Scope:** The Medicines section should contain prescription medications, non-prescription/over the counter medications, medicines self-prescribed by the individual and complementary and alternative medicines. NB: An indicator of compliance with the RACGP Practice Standard 1.7 on health summaries is that a practice can demonstrate that at least 75% of their active patient records contain a current health summary that includes, where appropriate, a current medicines list. Inclusion of medicines will be at the discretion of the clinician; however it is likely that predominantly long-term medicines will be shared.

These requirements have been developed in collaboration with a specific MMRG Project Working Group and following discussions within Standards Australia.

### 6.1 Requirements

Data item	Requirement statement	Rationale
Component	Information regarding medicines is required for every SHS.	Information regarding an individual's medicines is vital to ensure high quality safe clinical care.
	Each SHS shall either include one (or more) medicines or a statement as to why none are included.	Medicines may not be listed in a SHS for a variety of reasons – it has not been asked about, the individual is not on any medicines, or the information is unknown. This provides assurance that an absence of medicines is for a specific reason, rather than having just being omitted.
Item Description	Every medicine listed in the SHS shall include details that fully describe it, including the name of the medication, strength and dose form, where appropriate.	Allows interoperability, eliminates ambiguity and is vital to ensure high quality safe clinical care.
	Preferably, where the medication can be identified by an Australian Medicines Terminology (AMT) concept, this shall be the AMT ConceptID and Preferred Term	Allows interoperability, eliminates ambiguity and is vital to ensure high quality safe clinical care.
	Where the medicine cannot be identified by an Australian Medicines Terminology (AMT) concept, the item description shall be allowed to be carried in free text.	This enables the ability to enter medicines not recognised by AMT e.g. overseas medicines such as those taken by international visitors and students.
Dose Instructions	Every medicine listed in the SHS shall include the dose instructions describing how the medicine is taken.	Vital to ensure high quality safe clinical care.

Data item	Requirement statement	Rationale
Reason for Medicine	There shall be the provision for a medicine record to include the reason why the individual is taking the medicine.	It is important for the GP and other recipients to understand the rationale for medicines, particularly given that some medicines may have multiple purposes.
	A value for Reason for Medicine for a given medication shall only be included when it is relevant / appropriate to do so (i.e. optional to include a value).	It may not be clear to the GP the reason an individual may be taking an over the counter or complementary medicine.
Additional Comments	There shall be the provision for a medicine record to include additional information that may be needed to ensure the continuity of supply, continued proper use, or appropriate medication management. This may include comments regarding medication duration.	Clinical safety.
	An Additional Comment for a given medicine shall only be included when it is deemed by the author to be relevant/appropriate to do so (i.e. optional to include a value).	Not always required.

## 6.2 Samples & usage

1. The individual has not been asked about any medicines.

Individuals may be acutely unwell or otherwise indisposed and unable to provide the relevant health information to their health provider.. In these circumstances, it is suggested that GP clinical desktop system functionality be configured to default this section's exclusion statement to "Not Asked". Note that a date & time stamp is still required with the exclusion statement.

<b>MEDICINES</b>
Not asked

2. The individual has been asked and they are not taking any medications.

<b>MEDICINES</b>
None known

3. It has been determined that the individual taking a number of medications.

<b>MEDICINES</b>			
<b>Medicine</b>	<b>Dose Instructions</b>	<b>Reason for Medicine</b>	<b>Additional Comments</b>
Lasix (frusemide 40 mg) tablet	1 tablet once daily oral	Fluid retention	In Dose Administration Aid (DAA)
Spiriva (tiotropium bromide 18mg per inhalation) inhalant	1 inhalation per day	COPD	Review Inhaler Use
St John's Wort	As directed by packaging		

### 6.3 Proposed Data model

Data items		DataType	Number of Values Allowed	Notes
One (or more) medicines must be provided or a reason why no medicines are provided. That is, must have one of the following (a or b), but not both:				
a) Medicines Exclusion Statement		Coded Text	0..1	This exclusion statement allows for explicit assertions of exclusion of all medicines, i.e. that the individual is not known to be taking any medicines, the individual has not been asked about this information, or that the information is unknown.
<i>IF no exclusion statement THEN...</i>				
b) Medicine		Group	0..Many	The data group for the medicines that the individual is known to be taking. Multiple medicines are allowed and the following data items apply for each medicine added.
	Item Description	Codeable Text	1	The details that fully describe a medicine, including the name of the medicine, strength, dose and form, where appropriate.
	Dose Instructions	Text	1	A description of how a particular product is to be taken. This must include the route, dose, frequency and any additional instructions required. In clinical desktop systems which support the separate collection of dosage instructions, this item only needs to be populated when the separate dosage items are not.
	Reason for Medicine	Codeable Text	0..1	The specific therapeutic effect intended for the use of the medicine.
	Additional Comments	Text	0..1	Any additional information that may be needed to ensure the continuity of supply, continued proper use, or appropriate medication management – e.g. "Patient requires an administration aid", "Dosage to be reviewed in 10 days", "Target INR for warfarin management". This may include comments regarding medication duration.

## 7 Component: Current and Past Medical History

**Scope:** Data structure for capturing information about an individual's current and past medical history which includes problem/diagnosis and medical or surgical procedures performed. The information can then be extracted for display to users as chronologically ordered list. NB: An indicator of compliance with the RACGP Practice Standard 1.7 on health summaries is that a practice can demonstrate that at least 75% of their active patient records contain a current health summary that includes, where appropriate, a record of current health problems and relevant past health history.

### 7.1 Requirements

Data item	Requirement statement	Rationale
Component	Information regarding Current and Past Medical History is required for every SHS and shall always contain the following items.	Information regarding an individual's medical history is vital to ensure high quality safe clinical care.
	Each SHS shall either include one (or more) medical history items or a statement as to why none are included.	Medical history may not be listed in a SHS for a variety of reasons – it has not been asked about, there are none, or this information is unknown. This provides assurance that an absence of medical history items is for a specific reason, rather than having just being omitted.
	A SHS shall be allowed to contain multiple medical history items.	Individuals often have multiple entries in medical history and allows for future decision support capability.
Medical History Description	Every medical history item listed in the SHS shall contain a corresponding description.	This provides the content for the medical history.
	Preferably, values for the description of the medical history items shall be derived from SNOMED CT with the option for free text.	Allows for electronic transmission of information and decision support.
	The semantically distinct concepts of diagnoses and procedures shall be combined into one data item.	A chronological list may reduce clinical risk due to the viewing of information in an expected manner.
Medical History DateTime Range	There shall be the provision for a Medical History record to include the date of onset.	Clearly identifies when a particular medical history item commenced or occurred.
	There shall be the provision for a Medical History record to include the date of resolution.	Clearly identifies when a problem has resolved, if at all.
	The date of onset and resolution shall be allowed to be expressed as an estimate, i.e. dd/mm/yyyy or yyyy.	Provides flexibility as an individual may not always be clear about events occurring in the past.
Medical History comments	There shall be the provision for a Medical History record to include an additional comment.	Provides flexibility to add context or notes etc.



## 7.2 Samples & usage

1. The individual has not been asked about their medical history.

The *RACGP standards for general practice (4th edition)* state that practices demonstrate that at least 75% of the active individual health records contain a current health summary, including current health problems and relevant past health history. However, the individual may be acutely unwell or unable to provide this information. In these circumstances, it is suggested that GP clinical desktop system functionality be configured to default this section's exclusion statement to "Not Asked". Note that a date & time stamp is still required with the exclusion statement.

CURRENT AND PAST MEDICAL HISTORY
Not asked

2. The individual has been asked and there is no known medical history.

CURRENT AND PAST MEDICAL HISTORY
None known

3. It has been determined that the individual has a number of medical history records. It is not known when the hypercholesterolaemia commenced and it is still a current problem. The individual had a total knee replacement on the 27th February 2001. The individual was diagnosed with osteoporosis and Atrial Fibrillation in 2007 and 2009, respectfully and both continue to be problems. The individual was diagnosed with pneumonia in Aug 2010 which resolved the following month.

CURRENT AND PAST MEDICAL HISTORY		
Description	Date Range	Comments
Hypercholesterolaemia		
Left TKR	27 Feb 2001	Cementless
Osteoporosis	2007 -	But T-score greater than -3
AF (Atrial Fibrillation)	2009 -	
RLL pneumomia	Aug 2010 - Sep 2010	

### 7.3 Proposed Data model

Data items		DataType	Number of Values Allowed	Notes
<p><i>One (or more) medical history items must be provided or a reason why no medical history is provided. That is, must have one of the following (a or b), but not both:</i></p>				
a) Current and Past Medical History Exclusion Statement		Coded Text	0..1	This exclusion statement allows for explicit assertions of exclusion of any medical history, i.e. that there is no known medical history, that this information has not been asked about, or that the information is unknown.
<p><i>IF no exclusion statement THEN...</i></p>				
b) Current and Past Medical History		Group	0..Many	The data group for recording the Current and Past Medical History. Multiple items of medical history are allowed and the following data items apply for each one added.
	Medical History Description	Codeable Text	1	A description of the problem, diagnosis or intervention. The datatype of Codeable text allows for free text entry in the short term, with coded options in the longer term.
	Medical History DateTime Range	Time Interval	0..1	The date range (start date and/or end date) during which an individual's diagnosis was active, or that the clinical intervention was performed. If necessary, this may be an estimate (such as April 2005, or 1998 - 2007).
	Medical History comments	Text	0..1	Free text comments providing additional information relevant to the problem, diagnosis or intervention in question.

## 8 Component: Immunisations

**Scope:** Details of immunisations/vaccinations that have been administered (or reported to be administered). NB: An indicator of compliance with the RACGP Practice Standard 1.7 on health summaries is that a practice can demonstrate that at least 75% of their active patient records contain a current health summary that includes, where appropriate, a record of immunisations.

These requirements have been developed in collaboration with a specific MMRG Project Working Group and following discussions within Standards Australia.

### 8.1 Requirements

Data item	Requirement statement	Rationale
Component	Information regarding immunisations is required for every SHS and shall always contain the following items.	To achieve the lowest incidence of vaccine-preventable disease by attaining and maintaining the highest possible levels of effective immunisation coverage, and protect individuals at high risk of vaccine-preventable disease
	Each SHS shall either include one (or more) immunisations or a statement as to why none are included.	Information regarding immunisations may not be listed in a SHS for a variety of reasons – it has not been asked about, there are none, or this information is unknown. This provides assurance that an absence of immunisations is for a specific reason, rather than having just being omitted.
	A SHS shall be allowed to contain multiple immunisations.	An individual may have multiple immunisations.
Vaccine Name	Every immunisation included in the SHS shall include its generic and brand name.	Ensures unambiguous identification of the particular immunisation.
	Preferably, where the immunisation can be identified by an Australian Medicines Terminology (AMT) concept, this shall be the AMT ConceptID and Preferred Term. The name shall include both the generic and brand names.	Allows interoperability, eliminates ambiguity and is vital to ensure high quality safe clinical care.
	Where the immunisation cannot be identified by an Australian Medicines Terminology (AMT) concept, the item description shall be allowed to be carried in free text.	This enables the ability to enter vaccinations not recognised by AMT e.g. vaccinations administered overseas.
DateTime Administration	Every immunisation included in the SHS shall include the date or date and time that a dose of vaccine is administered.	Determines when further doses of immunisations may be required.
	The date shall be recorded in the format of date (and optionally time).	Allows for date calculations to be made for decision support i.e. that a Individual is overdue for the completion of an immunisation dose.

Data item	Requirement statement	Rationale
Sequence Number	There shall be the provision for an immunisation record to include the Sequence Number for the particular immunisation schedule.	Indicates how up-to-date the individual is with the immunisation schedule and when the next dose is due.
	A value for Sequence Number for a given immunisation shall only be included when it is deemed to relevant / appropriate to do so (i.e. optional to include a value).	The Sequence Number may not always be known or relevant for all immunisations.

## 8.2 Samples & usage

1. The individual has not been asked about immunisations.

Individuals may be acutely unwell or otherwise indisposed and unable to provide the relevant health information to their health provider. In these circumstances, it is suggested that GP clinical desktop system functionality be configured to default this section's exclusion statement to "Not Asked". Note that a date & time stamp is still required with the exclusion statement.

IMMUNISATIONS
Not asked

2. Where the individual does not have any known immunisations, the section will be empty apart from the date/time reviewed (that is, that the Nominated Provider saved the complete Shared Health Summary). Alternatively, the software may be configured to convert an absence of immunisations to the text "none recorded" (or similar).

IMMUNISATIONS
None recorded

3. The individual has a number of immunisations over a period of time.

IMMUNISATIONS		
Vaccine Name	DateTime Administration	Sequence Number
Engeryx b (Hepatitis B)	9 Oct 2010	3
Meningitec (Meningococcal)	10 Sep 2010	
Fluvax (Influenza)	3 Oct 2009	

### 8.3 Proposed Data model

Data items	DataType	Number of Values Allowed	Notes
<i>One (or more) immunisations must be provided, or a reason why none are provided. That is, must have one of the following (a or b), but not both.</i>			
a) Immunisations Exclusion Statement	Coded Text	0..1	This exclusion statement allows for explicit assertions of exclusion of any immunisations, i.e. that there are no known immunisations, or that this information has not been asked about, or that the information is unknown.
<i>IF no exclusion statement THEN...</i>			
b) Immunisation	Group	0..Many	The data group for recording the immunisation details, which can include details of immunisations that have been administered as well as those that have been refused by the individual/caregiver.  Multiple immunisations are allowed and the following data items apply for each one added.
Vaccine Name	Codeable Text	1	The vaccine generic and brand name.
DateTime Administration	DateTime	1	The date or date and time that a dose of vaccine is administered.
Vaccine Sequence Number	Integer	0..1	The dose number or sequence of vaccination that makes up a program for each vaccine.

## 9 Component: Document Control

**Description:** A section that describes information about the health summary document. Much of the information contained in Document Control is technical in nature and as such is not described here, but is included in Appendix A. Described below are those elements which have clinical relevance.


### 9.1 Requirements

Data item	Requirement statement	Rationale
Component	Each Health Summary document shall include metadata about the document.	Document management requirements.
	Document control information is predominantly technical and as such does not require display for end users.	
DateTime Attested	The date/time when the HS document was attested (or finalised, or signed off) by the document author.	Clinical safety requirement to ensure that the reader knows exactly when the document was written.

## 9.2 Samples & usage

### 1. Document Header

A health summary may display various elements of the document control near the top of the summary.

<b>PATIENT:</b>	Mr William SMITH	<b>DOB:</b> 01/01/1946 (63 years)
<b>HEALTH SUMMARY</b>		Date completed 14/12/2010 11:25
<b>BENEFITS</b>	<b>PATIENT</b>	

## 9.3 Proposed Data model

Data items	Data Type	Number of Values Allowed	Notes
DateTime Attested	DateTime	1	The date/time when the SHS document was attested (or finalised, or signed off) by the document author.

# 10 Technical Document Control Requirements

The following data items are included for completeness as they represent technical requirements to ensure correct identification of each document etc.

Data items	Data Type	Number of Values Allowed	Notes
Document Instance Identifier	Unique Identifier	1	The universally unique identifier of this instance of the Shared Health Summary document.
Document Set Identifier	Unique Identifier	1	The universally unique identifier of the set of documents related to the same healthcare encounter, of which the Shared Health Summary document is a versioned instance.
Version Number	Integer	1	The version number of the Shared Health Summary document instance.
Document Originating System Identifier	Unique Identifier	1	A universally unique identifier of the system used to create the Shared Health Summary document.
Business Document Type	Coded Text	1	The name of the Shared Health Summary document type used – e.g. 'Shared Health Summary'
Business Document Type Version Number	Integer	1	The version number of the Shared Health Summary document type used to create the Shared Health Summary.
Document Status	Coded Text	1	The status of the document
Language	Coded Text	1	The language primarily used within the document (e.g. 'en-AU')
Structured / unstructured clinical document flag	Coded Text	1	Whilst the PCEHR Concept of Operations describes two options for this flag, the only permitted option is a "structured clinical document".  This is a document which has all the above fields and also contain additional structured data describing the relevant clinical details (e.g. medicines, allergies, etc).



# 11 Shared Health Summary Scenario

An example scenario is as follows:

A patient John has a complex chronic illness and is regularly managed by his usual GP. The usual GP has regularly maintained an up-to-date SHS for John, which has been published to John's PCEHR.

John has a holiday interstate, falls ill and needs to see a GP for management. The new GP reviews John's SHS and gets acquainted with John's available history. As a result of the new problem, the GP makes some changes to John's medications and decides to create an Event Summary which is published to the PCEHR.

On return to home, John is seen by his usual GP and rather than relying upon John's memory of the recent event, he reviews the Event Summary written by the other GP. The usual GP decides to incorporate the new medications listed in the Event Summary into her own clinical records and then updates John's SHS if appropriate.

## 12 Known Issues

The following issues cannot be addressed in time for release 1, and will be dealt with post release 1.

Topic	Issue
Medicines inclusion	There is an issue as to what medicines are to be included in the SHS. The decision is that it is at the discretion of the clinician preparing the SHS as to what should be included.
Name of Past & Current Medical History	It was decided by clinicians associated with the external review of this message and the Clinical Leads Forum that this be named Past & Current Medical History. This package was initial developed around the needs of GP's and as such this position has been reached. Other naming options may be considered in subsequent releases.
Alerts	The idea of alerts has been raised previously but is excluded from release 1. Although this is considered an important area of discussion there are no nationally agreed information components or standards for alerts so this will require a separate piece of work that will be considered by CCRG
Individual's Sex	It is recognised that the inclusion of the data item for Individual's Sex is solely the physiological or biological distinction as defined by the clinician, for the benefit of clinical care. The additional social and cultural "gender role" that an individual identifies with is not captured but is a consideration for future releases.
Individual's Indigenous Status	NEHTA has adopted the label "Indigenous Status" from the AIHW as it is considered a nationally recognised source. However, it is also recognised that the preferred terminology for this label may be "Aboriginal and or Torres Strait Islander Status" and as such this disparity will be addressed in future versions.
Individual's Address	The current specifications mandate an address for a patient, but it is recognised that in some circumstances an individual may be put at personal risk if their address was divulged (e.g. domestic violence). The underlying definition of the data elements for structured address (NEHTA Participation Data Specification [PDS2011]) does include a free text item for "Unstructured Address Line" that may convey a value of "None Supplied" to meet this requirement. However, the preferred option for future versions would be to redefine this data item to be an optional value.

# Definitions

This section explains the specialised terminology used in this document.

## Shortened Terms

This table lists abbreviations and acronyms in alphabetical order.

Term	Description
AMT	Australian Medicines Terminology
CDA	Clinical Document Architecture
GP	General Practitioner
HI	Health Identifiers
HL7	Health Level 7
HPI-I	Healthcare Provider Identifier of the individual
HPI-O	Healthcare Provider Identifier of the organisation
IHI	Individual Healthcare Identifier
LOINC	Logical Observation Identifiers Names and Codes
MMRG	NEHTA Medication Management Reference Group
NCTIS	NEHTA's National Clinical Terminology and Information Service
PCEHR	Personally Controlled Electronic Health Record
SNOMED CT	Systemised Nomenclature of Medicine, Clinical Terminology

## Glossary

This table lists specialised terminology in alphabetical order.

Term	Description
Business Architect	A Business Architect is anyone who looks at the way work is being directed and accomplished, and then identifies, designs and oversees the implementation of improvements that are harmonious with the nature and strategy of the organisation. Source: <a href="http://www.businessarchitects.org">http://www.businessarchitects.org</a>
Development Team	The Developer writes the code for the specifications that the Development leads provide. Source: <a href="http://www.developer.com">http://www.developer.com</a>
Interoperability	The ability of software and hardware on multiple machines from multiple vendors to communicate. Source: The Free On-line Dictionary of Computing. Denis Howe. 21 Apr. 2008. From: Dictionary.com - <a href="http://dictionary.reference.com/browse/Interoperability">http://dictionary.reference.com/browse/Interoperability</a>
Solutions Architect	The Solutions Architect is typically responsible for matching technologies to the problem being solved. Source: <a href="http://www.developer.com">http://www.developer.com</a>
Technical Architect	The technical architect is responsible for transforming the requirements into a set of architecture and design documents that can be used by the rest of the team to actually create the solution. Source: <a href="http://www.developer.com">http://www.developer.com</a>

# References

At the time of publication, the document versions indicated are valid. However, as all documents listed below are subject to revision, readers are encouraged to use the most recent versions of these documents.

## References

The documents listed below are non-package documents that have been cited in this document.

Reference Documents			
[REF]	Document Name	Publisher	Link
[PCO-2011]	Concept of Operations Relating to the introduction of a Personally Controlled Electronic Health Record System, Version 1.0 – 9 Sep 2011	DOHA & NEHTA 2011	<a href="http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/pcehr-document">http://www.yourhealth.gov.au/internet/yourhealth/publishing.nsf/Content/pcehr-document</a>
[PDS2011]	Participation Data Specification Version 3.2	NEHTA 2011	<a href="http://www.nehta.gov.au/connecting-australia/terminology-and-information/clinical-information-mi">http://www.nehta.gov.au/connecting-australia/terminology-and-information/clinical-information-mi</a>  Open menu: Clinical Information Detailed Clinical Model Specifications (previously Data Specification)

## Related Reading

The documents listed below may provide further information about the issues discussed in this document.

Related Documents			
[REF]	Document Name	Publisher	Link
[NEHTAWEB]	NEHTA Web Site	NEHTA	<a href="http://www.nehta.gov.au/">http://www.nehta.gov.au/</a>