Shared Health Summary

Supplementary Guidance for Implementers v1.0.1

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National E-Health Transition Authority

National E-Health Transition Authority Ltd
Level 25
56 Pitt Street
Sydney, NSW, 2000
Australia
www.nehta.gov.au

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Key information

Owner Manager eSolutions (Clinical Documents)

Contact for enquiries NEHTA Help Centre
t: 1300 901 001
e: help@nehta.gov.au

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1 Introduction

1.1 Purpose

This document is a supplement to NEHTA's specification bundle for Shared Health Summary documents and provides implementation guidance on areas not covered in these specifications. It is intended to promote usability of software and greater consistency of information presentation to clinicians.

The guidance was prepared as part of NEHTA's Clinical Usability Program (CUP) in consultation with clinicians. It should be read in conjunction with *Clinical Documents – Supplementary Guidance for Implementers v1.0*.[1]

1.2 Intended audience

This document is intended for vendors implementing shared health summary document authoring functionality.

1.3 Scope

This document is limited to guidance that is specific to shared health summary clinical documents. It does not add, modify or remove requirements from shared health summary clinical document specifications or conformance profiles.

Supplementary guidance on other clinical documents is covered in *Clinical Documents – Supplementary Guidance for Implementers v1.0*.

[1] See: http://www.nehta.gov.au/implementation-resources/clinical-documents/EP-1477-2013/NEHTA-1476-2013

2 Authoring a shared health summary

2.1 Applicability

Applies to shared health summary authoring systems

2.2 Context

The *Shared Health Summary – PCEHR Conformance Profile v1.5* [2] (conformance profile) states that:

> A Clinical Information System shall display the final version of a Shared Health Summary to the author and prompt the author to attest to the content of the Shared Health Summary before the Clinical Information System uploads the Shared Health Summary to the PCEHR System and to assert the healthcare provider individual (i.e. the author of the Shared Health Summary) is a Nominated Healthcare Provider as defined by the *Personally Controlled Electronic Health Records Act 2012*.

There are multiple ways to implement this requirement. The conformance profile states:

> One option for meeting this requirement is for a Clinical Information System to display the Shared Health Summary along with a user interface button with the statement "By uploading this Shared Health Summary, I acknowledge that I am a Nominated Healthcare Provider for this patient as defined by the *Personally Controlled Electronic Health Records Act 2012.*

Software vendors have taken a variety of approaches to implementing these requirements; some have introduced extra steps or checks concerning accuracy and patient consent.

This recommendation pertains to how the shared health summary authoring review should be presented to the user.

2.3 Recommendation

It is recommended that:

1. Software applications display the following text on the shared health summary review screen described above:
   - I am the patient's nominated healthcare provider in accordance with the *Personally Controlled Electronic Health Records Act 2012*.
   - I am providing ongoing care to this patient.
   - I have prepared this Shared Health Summary in consultation with the patient.
2. The default user interface action (i.e. "Enter" key) should not upload the document.
3. The default user interface action should not lose the document. Having a separate checkbox for this text does not bring any value to this process. The user interface should make it clear to the user that, by proceeding to upload,

[2] See: http://www.nehta.gov.au/implementation-resources/clinical-documents/EP-1432-2013/NEHTA-1452-2013

the user is making the above assertion and the text above should therefore be located next to the “Upload” or “Cancel” button.

2.4 Discussion

There is no need for the practitioner to request patient consent prior to uploading a shared health summary to the patient’s PCEHR – the consent required has already been given when the patient consents to having a PCEHR. Asking for additional “consent” when the shared health summary is uploaded introduces additional confusion for authors around a sensitive and potentially already confusing area.

Note also that the following professionals are eligible to be nominated healthcare providers as defined by the *Personally Controlled Electronic Health Records Act*:

- medical practitioners
- registered nurses
- Aboriginal and/or Torres Strait Islander health practitioners (with a Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care (Practice)

The shared health summary authoring software is not required to enforce that the author falls into one of these categories, and doing so reliably may not be possible.

The wording described in Section 2.3, recommendation 1, meets the requirements of the conformance process, addresses and encourages best clinical practice as agreed by clinicians consulted during the Clinical Usability Program, and does not intrude on the natural workflow of a clinician.

Note that the wording does not ask the clinician to confirm that the document is either complete or accurate, since the patient may ask to withhold information from the document.

3 Populating a shared health summary

3.1 Applicability

Applies to shared health summary authoring systems.

3.2 Context

When creating a shared health summary, it should be possible for the clinician to readily manage the relevant clinical data items to be included. Current implementations typically present lists of data items drawn from the patient record with a check box against each list item denoting inclusion or exclusion in the health summary. Each list corresponds to a health summary document section – that is, adverse reactions, medications, medical history or immunisations.

The methods and rules that determine the initial check box state (that is, whether a data item is included by default) have not been specified, and, as a consequence, there are considerable differences between software products. Various inconsistent approaches based on clinical entry "shared data flags" (for example, include in summary, include in correspondence) and direct selection on authoring have been implemented in systems.

3.3 Recommendation

It is recommended that:

1. One or more flags control whether entries are selected for inclusion in shared health summaries by default. Users will need to have a clear understanding of how the flags affect the default inclusion of the entry in shared health summaries. *Note that clinical feedback demonstrated that the users of the GP systems are very vague about the exact impact of these flags on data sharing in their current systems.*
2. Clinical data entry "shared data flags" should only affect the default automatic selection of items for inclusion in a shared health summary. They should not prevent an item from being added at the time of clinical document creation (that is, by checking the check box) nor should they prevent items from being excluded from specific shared health summary document instances. That is, all entered clinical data should be available for inclusion regardless of "shared data flags".
3. When a shared health summary is created, it should always be possible to change the selection of clinical data entries from their default selection status. That is, available items may be selected or de-selected as appropriate, regardless of their initial inclusion status.
4. The selection and de-selections made at the time of creation need not be retained between shared health summary document instances; instead 'shared data flags' can be used to control the initial default selections.
5. Some types of clinical data are more suited to "shared data flags" than others – if a clinical data type does not have "shared data flags" on entry, then it is assumed that all entries of that type will be selected for inclusion in shared health summaries by default. For example, allergy, immunisation and medication types typically do not have "shared data flags", while past medical history items typically do.

4 Formatting medical history narrative

4.1 Applicability

Applies to shared health summary authoring systems.

4.2 Context

The clinical requirements for the Medical History Section (as specified by the *Shared Health Summary - Information Requirements v1.0* [3]) describe a single list of medical history items, with a single exclusion statement. However the *Shared Health Summary - CDA Implementation Guide v1.3* [4] (CDA implementation guide) separates medical history into three sub-groupings: Problems/Diagnosis, Procedures, and Medical History Items. There are two exclusion statements: one for Problems/Diagnosis and another for Procedures. The need for two statements is due to the way the information is modelled and handled internally – it was not intended to impact on the way that the information was gathered from the user, nor how it was displayed. However, the CDA implementation guides do not directly address the question of how documents are presented and, since they suggest separate lists, this is how the shared health summary has been implemented.

4.3 Recommendation

Shared health summary authoring systems should follow the advice described in Section 2.4 "Medical History" of *Supplementary Notes for Implementers Relating to Clinical Document Presentation v1.0.*[5]

Specifically, although the CDA implementation guide contains multiple different entries with different types, when rendered in the clinical information system, there should only be one list of items in the medical history section, in chronological order with undated items at the top. There is no need to differentiate between diagnoses, problems and procedures in the presented list.

[3] See: https://www.nehta.gov.au/implementation-resources/clinical-documents/EP-1074-2012/NEHTA-0990-2011
[4] See: https://www.nehta.gov.au/implementation-resources/clinical-documents/EP-1074-2012/NEHTA-0988-2012
[5] See: https://www.nehta.gov.au/implementation-resources/clinical-documents/EP-1094-2011/NEHTA-1328-2013

5 Using exclusion statements for medical history items

5.1 Applicability

Applies to all systems authoring shared health summaries that record exclusion statements.

5.2 Context

The "Medical History" section of shared health summary CDA documents allows three possible types of medical history entry and two types of global exclusion statements, as shown below.

Medical History Entry

- Problem/Diagnosis
- Procedure
- Other Medical History Item

Global Exclusion Statement

- Exclusion Statement – Problems and Diagnoses
- Exclusion Statement – Procedures

5.3 Definition

A clarified definition of "Other Medical History Item" based on the *Shared Health Summary - Structured Content Specification v1.1* [6] definition is:

> *"A medical history entry which cannot be categorised into one of the categories such as Procedure and Problem/Diagnosis."*

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.
- The medical history item is maintained as free-text and thus has never been classified.

Note: When the entry in the source system is not actually a Procedure or Problem/Diagnosis, it is not suitable for inclusion in the Medical History section of a shared health summary document.

5.4 Recommendation

Since it is not known whether an "Other Medical History Item" entry is conceptually a Procedure or a Problem/Diagnosis, exclusion statements cannot be used when an "Other Medical History Item" entry is present, as the entry may, in fact, be a Procedure or a Problem/Diagnosis.

[6] See: http://www.nehta.gov.au/implementation-resources/clinical-documents/EP-1074-2012/NEHTA-0997-2011

Therefore, the following explicit constraints apply based on the *Shared Health Summary – CDA Implementation Guide v1.3* [7] and *Shared Health Summary – FAQ Clarification of Medical History v1.0* [8]:

1 If both "Procedure" and "Other Medical History Item" entries are absent, there SHALL be an 'Exclusion Statement – Procedures' entry present.

Medical History Entry	
Problem/Diagnosis	
Procedure	**No entry**
Other Medical History Item	**No entry**

Global Exclusion Statement	
Problems and Diagnoses	
Procedures	**Required**

2 If both "Problem/Diagnosis" and "Other Medical History Item" entries are absent, there SHALL be an "Exclusion Statement – Problems and Diagnoses" entry present.

Medical History Entry	
Problem/Diagnosis	**No entry**
Procedure	
Other Medical History Item	**No entry**

Global Exclusion Statement	
Problems and Diagnoses	**Required**
Procedures	

3 When "Procedure" and "Problem/Diagnosis" and "Other Medical History Item" are all absent, both "Exclusion Statement – Procedures" and "Exclusion Statement – Problems and Diagnoses" entries SHALL be present.

Medical History Entry	
Problem/Diagnosis	**No entry**
Procedure	**No entry**
Other Medical History Item	**No entry**

Global Exclusion Statement	
Problems and Diagnoses	**Required**
Procedures	**Required**

4 If an "Other Medical History Item" is present, then both "Exclusion Statement – Procedures" and "Exclusion Statement – Problems and Diagnoses" SHALL NOT be present.

Medical History Entry	
Problem/Diagnosis	
Procedure	
Other Medical History Item	**Entry**

Global Exclusion Statement	
Problems and Diagnoses	**Not allowed**
Procedures	**Not allowed**

The reason for this rule is that if "Other Medical History Item" is present, it may be either a problem/diagnosis, or a procedure, so there should not be an exclusion statement for either of these.

[7] See: http://www.nehta.gov.au/implementation-resources/clinical-documents/EP-1432-2013/NEHTA-0988-2012
[8] See: http://www.nehta.gov.au/implementation-resources/clinical-documents/EP-1432-2013/NEHTA-1125-2012

Note that the blank cells in Medical History Entry above indicate either an entry or blank. A medical history section is allowed to contain procedures, problem/diagnosis, and other medical history items.[9] Having both categorised items (procedures and problem/diagnosis) and uncategorised medical history items would be unusual, because generally if a system is able to differentiate some items, it is able to differentiate them all. However a system may be able to categorise some, and not others – because of legacy data, or partial classification in the underlying terminology, for instance. For this reason, the rules allow a mix of categorised and uncategorised items.

[9] Page 5 of the *Shared Health Summary Release Note* v1.3 says "Use EITHER "Problem/Diagnosis" and "Procedure" OR "Other Medical History Item", but NOT both". This should be understood as product guidance and is consistent with this advice.
(See: https://www.nehta.gov.au/implementation-resources/clinical-documents/EP-1074-2012/NEHTA-1076-2012)