Australian Government

Australian Digital Health Agency

Advance Care Information

CDA Implementation Guide

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Document Information

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Product Version History

Product version	Date	Release comments
1.0	21 Dec 2017	Initial public release. This specification is published to support the My Health Record advance care planning document (2016).

Related Documents

Name	Version/Release Date
Advance Care Information Structured Content Specification	Version 1.0, Issued 21 December 2017
Representing Coding in CDA Documents Implementation Guidance	Version 1.0, Issued 10 October 2011
Participation Data Specification	Version 3.2, Issued 20 July 2011
CDA Rendering Specification	Version 1.0, Issued 07 March 2012
Clinical Documents Common Conformance Profile	Version 1.6, Issued 10 April 2015

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Acknowledgements

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1 Introduction

1.1 Document Purpose and Scope

This document provides a guide to implementing the logical model detailed by the Australian Digital Health Agency's Advance Care Information (ACI) Structured Content Specification (SCS) as an HL7 Clinical Document Architecture (CDA) Release 2 XML document. This implementation guide is based on Version 1.0 of the ACI SCS [DH2017e]. The primary aim of the implementation guide is to take implementers step by step through mapping each data component of the ACI SCS to a corresponding CDA attribute or element.

This implementation guide contains descriptions of both constraints on the CDA and, where necessary, custom extensions to the CDA, for the purposes of fulfilling the requirements for Australian implementations of ACI. The resulting CDA document can be used for the electronic exchange of ACI information between healthcare providers.

In addition, this implementation guide presents conformance requirements against which implementers can attest the conformance of their systems.

This release is intended to inform, and seek feedback from, prospective software system designers and their clinical consultants.

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

1.2 Advance Care Information Definition

An Advance Care Information is defined in the ACI SCS [DH2017e] as:

> Container for a copy of a statement of a person's decisions about their future care, should they become incapable of participating in medical treatment decisions.

1.3 HL7 Clinical Document Architecture

CDA is a document markup standard that specifies the structure and semantics of clinical documents for the purpose of supporting interoperable exchange and use at human and system levels.

We have chosen CDA as the format for electronic clinical documents because it is consistent with our commitment to a service and document–oriented approach to electronic information exchange, which will contribute to future electronic health records.

Some of the advantages of CDA are:

- It is machine computable and human-readable.

- It provides a standardised display of clinical information without loss of clinical meaning.

- It provides assurance of clinical quality and safety more effectively than message-based interfaces, by storing and displaying the clinical data as entered by the clinician.

- It provides better support than HL7 V2 messages for:

  ○ more complex information structures, such as pathology synoptic reporting; and

  ○ terminologies such as SNOMED CT.

- It supports legal attestation by the clinician (requiring that a document has been signed manually or electronically by the responsible individual).

- It is able to be processed by unsophisticated applications (displayed in web browsers, for instance).

- It provides a number of levels of compliance to assist with technical implementation and migration.

- It aligns Australia with e-health initiatives in other countries (such as Canada, UK, USA, Brazil, Germany and Finland).

1.4 Intended Audience

This document is aimed at software development teams, architects, designers, clinicians and informatics researchers who are responsible for the delivery of clinical applications, infrastructure components and messaging interfaces, and also for those who wish to evaluate the clinical suitability of the Agency-endorsed specifications.

This document and related artefacts are technical in nature and the audience is expected to be familiar with the language of health data specifications and to have some familiarity with health information standards and specifications, such as CDA and Standards Australia IT-014 documents. Definitions and examples are provided to clarify relevant terminology usage and intent.

1.5 Document Map

This implementation guide is not intended to be used in isolation. Companion documents are listed below:
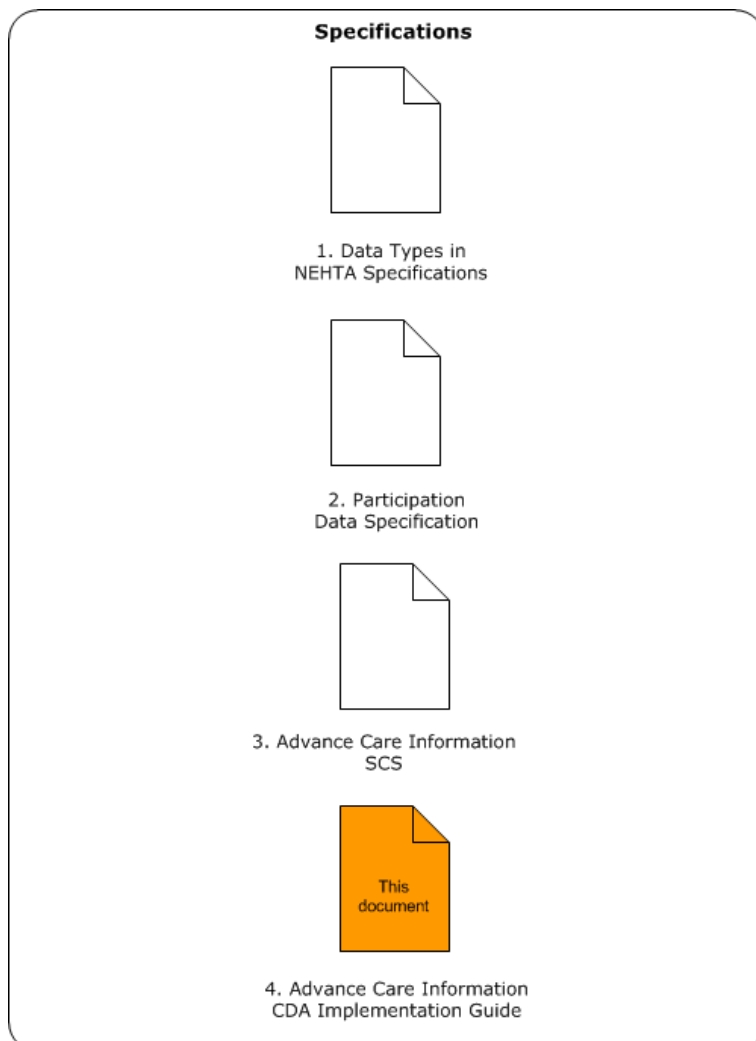
1. *Data Types in NEHTA Specifications: A Profile of the ISO 21090 Specification [NEHT2010c]* is a detailed description of the data types used within the structured content specification.

2. *???* contains the full specification that forms the basis of all participations contained in our structured content specifications.

3. *Advance Care Information Structured Content Specification [DH2017e]* is a clinical content specification describing the logical data structures, data components, and value domains that constitute an Advance Care Information.

1.6 Acronyms

ACI	Advance Care Information
CDA	Clinical Document Architecture
DCM	Detailed Clinical Model
HL7	Health Level Seven
HPI-I	Healthcare Provider Identifier - Individual
HPI-O	Healthcare Provider Identifier - Organisation
IHI	Individual Healthcare Identifier
NCTIS	National Clinical Terminology and Information Service
OID	Object Identifier
RIM	Reference Information Model
SCS	Structured Content Specification
UUID	Universally Unique Identifier
XHTML	Extensible Hypertext Markup Language
XML	Extensible Markup Language
XSD	XML Schema Definition
XSL	Extensible Stylesheet Language

1.7 Keywords

Where used in this document, 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]*.

Keywords used in this document

Keyword	Interpretation
SHALL	This word, or the term **REQUIRED**, means that the statement is an absolute requirement of the specification.
SHOULD	This word, or the term **RECOMMENDED**, means that there may exist valid reasons in particular circumstances to ignore a particular item, but the full implications must be understood and carefully weighed before choosing a different course.
MAY	This word, or the term **OPTIONAL**, means that an item is truly optional. One implementer may choose to include the item because a particular implementation requires it, or because the implementer determines that it enhances the implementation while another implementer may omit the same item. An implementation which does not include a particular option must be prepared to interoperate with another implementation which does include the option, perhaps with reduced functionality. In the same vein, an implementation which does include a particular option must be prepared to interoperate with another implementation which 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, or the phrase **NOT RECOMMENDED** 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.

1.8 Conformance

This document describes how the ACI SCS is implemented as a CDA document. Conformance claims are not made against this implementation guide directly; rather, they are made against additional conformance profiles documented elsewhere. Any document that claims conformance to any derived conformance profile **SHALL** meet these base requirements:

- It **SHALL** be a valid HL7 CDA instance. In particular:

  - It **SHALL** be valid against the HL7 CDA Schema (once extensions have been removed, see W3C XML Schema).

  - It **SHALL** conform to the HL7 V3 R1 data type specification.

  - It **SHALL** conform to the semantics of the RIM and Structural Vocabulary.

- It **SHALL** be valid against the Australian Digital Health Agency CDA Schema that accompanies this implementation guide after any additional extensions not in the Australian Digital Health Agency extension namespace have been removed, along with any other CDA content not described by this implementation guide.

- It **SHALL** use the mappings as they are stated in this document.

- It **SHALL** use all fixed values specified in the mappings (e.g. @attribute="`FIXED_VALUE`").

- If the vocabulary has been explicitly stated as 'NS' it **SHALL** be interpreted as:

  NS = 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.

- It **SHALL** be valid against the additional conformance requirements that are established in this document (i.e. any normative use of the word 'shall' identified by the term presented in uppercase and bold typeface).

- The narrative **SHALL** conform to the requirements described in this implementation guide.

- The document **SHALL** conform to the requirements specified in the CDA Rendering Specification [NEHT2012s].

- The data as contained in the data types **SHALL** conform to the additional data type specification [NEHT2010c].

- Any additional content included in the CDA document that is not described by this implementation guide **SHALL NOT** qualify or negate content described by this implementation guide and it **SHALL** be clinically safe for receivers of the document to ignore the non-narrative additions when interpreting the existing content.

A system that *consumes* ACI CDA documents may claim conformance if it correctly processes conformant instance documents, including correctly understanding all the information in the header. It may, but is not required to, reject non-conformant documents. Conformant systems that consume ACI CDA documents are not required to process any or all of the structured data entries in the CDA document, but they **SHALL** be able to correctly render the document for end-users when appropriate (see Clinical Document Architecture Release 2).

Conformance profiles of this document **MAY** make additional rules that override this document in regard to:

- Allowing the use of alternative value sets in place of the value sets specified in this document.

- Allowing the use of alternative identifiers in place of the Healthcare Identifiers Service identifiers.

- Making required data elements and section divisions optional.

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[1] http://www.hl7.org/oid/index.cfm?ref=footer

1.9 Known Issues

This section 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
Throughout document: XML Examples	The examples present in this specification are taken from multiple sample or test referrals, each XML fragment is a standalone fragment that may not fit with other fragments present in the specification. While every effort has been taken to ensure that the examples are consistent with the normative mappings in this message specification, care needs to be taken when copying XML examples for implementation and validation. Where there are conflicts with the written message specification or schema and the XML examples, the specification or schema takes precedence.
Throughout document: R-MIMs	While every effort has been taken to ensure that the R-MIM diagrams are consistent with the normative mappings in this message specification, there may be a few discrepancies between R-MIM diagrams and CDA mapping tables. The CDA mapping takes precedence if there are discrepancies.
Throughout document: Participation types	The participation types in the OID register are not exhaustive, hence the absence of a participation type is not an error.
Throughout document	Australian vs American spelling - in cases where definitions have been taken from HL7 documentation, the American spelling has been preserved, e.g. organization rather than organisation.
6.1.1 SUBJECT OF CARE :: LOCATION OF PARTICIPATION	LOCATION OF PARTICIPATION is not currently mapped.
6.1.2 DOCUMENT AUTHOR :: LOCATION OF PARTICIPATION	LOCATION OF PARTICIPATION is not currently mapped.
6.1.2.1 DOCUMENT AUTHOR as a PERSON - Not a Healthcare Provider :: ENTITLEMENT	Prohibition of ENTITLEMENT is not currently mapped.
7.1.1.1.1 DOCUMENT AUTHOR :: LOCATION OF PARTICIPATION	LOCATION OF PARTICIPATION is not currently mapped.
7.1.1.1.1 DOCUMENT AUTHOR :: ENTITLEMENT	Prohibition of ENTITLEMENT is not currently mapped.
8.5 Person Name :: Preferred Name Indicator code	A code for representing "preferred name" has been requested from HL7 International but is not currently available. The proposed code "PRF" for representing preferred name is replaced with "D" *Customary Name*. In October 2015, the HL7 Patient Administration Workgroup approved a change to the description of *Customary Name* with code "D" to incorporate the preferred name. This change applies to HL7 Table 0200 Name Type. The definition of *Customary Name* was changed from "Known as/conventional/the one you use" to "Known as/conventional/the one you use. May also be known as a preferred name". An updated Australian Digital Health Agency schema allowing use of a code for preferred name will be made available after HL7 V2.9 (which contains the above updates) is published.

Reference	Description
10 Vocabularies and Code Sets: AS 4846-2006 and AS 5017-2006 superseded	AS 4846-2014 *Person and provider identification in healthcare* has been published and supersedes both AS 4846-2006 *Healthcare provider identification* and AS 5017-2006 *Healthcare client identification*.
10.2 AS 5017-2006 Health Care Client Identifier Sex	The codeSystemName value in 10.2 AS 5017-2006 Health Care Client Identifier Sex is not the name associated with the OID in the HL7 OID Registry[2].
10.7 AS 5017-2006: Health Care Client Identifier Geographic Area	The Health Care Client Identifier Geographic Area vocabulary table lists displayName, code, codeSystemName and codeSystem, while only the displayName is used in the mapping. Verification of using only the displayName needs to be performed.

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[2] http://www.hl7.org/oid/index.cfm?ref=footer

2 Guide for Use

This document describes how to properly implement the ACI SCS [DH2017e] as a conformant HL7 CDA XML document. The ACI specification is contained in two publications:

1) A logical specification, which, in conjunction with its related documents (see Document Map), describes the Advance Care Information in a form that is consistent with other Agency specifications. It has the potential to be implemented in multiple different exchange formats as is most suitable for a particular context. It describes the data content of an Advance Care Information as a hierarchy of data components and provides documentation concerning their use and meaning.

2) An implementation guide (this document), which specifies how the data described in the SCS is properly represented in a CDA document.

In order to properly implement this specification, the reader should be familiar with the ACI SCS and the HL7 CDA documentation, and understand how to read this document.

For further information regarding our structured content specifications, see the links in Document Map.

2.1 Clinical Document Architecture Release 2

A CDA document is an XML document built following the rules described in the CDA specification, which conforms to the HL7 CDA Schema provided by HL7. The CDA document is based on the semantics provided by the *HL7 V3 RIM, Data types and Vocabulary [HL7V3DT]*.

A CDA document has two main parts: the header and the body.

The CDA document header is consistent across all CDA documents, regardless of document type. The header identifies and classifies the document and provides information on authentication, the encounter, the patient, and the involved providers.

The body contains the clinical report. The body can be marked-up text (narrative, renderable text) or a combination of both marked-up text and structured data. The marked-up text can be transformed to XHTML and displayed to a human. The structured data allows machine processing of the information shown in the narrative section.

It is a requirement that all of the clinical information **SHALL** be marked up in CDA narratives. These narratives are CDA-defined hypertext, able to be rendered in web browsers with only a standard accompanying transformation. This transformation is produced and distributed by HL7.

It is a conformance requirement that the rendered narrative **SHALL** be able to stand alone as a source of authenticated information for consuming parties. Content from the CDA body **SHALL NOT** be omitted from the narrative.

Further information and guidance on the CDA narrative is available in Appendix A, *CDA Narratives*.

The following references are recommended to gain a better understanding of CDA:

- *HL7 Clinical Document Architecture [HL7CDAR2]*

- *HL7 V3 RIM, Data types and Vocabulary [HL7V3DT]*

- *CDA Examples [RING2009]*

- *CDA Validation Tools: infoway_release_2_2X_18.zip [INFO2009]*

2.2 Mapping Interpretation

The core of this implementation guide is a mapping from the ACI SCS to the CDA document representation.

The mappings may not be deterministic; in some cases the differences in approach between the logical model specified in the SCS and the CDA implementation guide makes it inappropriate to have a 1:1 mapping, or any simple mapping that can be represented in a transform. This is especially true for names and addresses, where the SCS requirements, based on Australian Standards such as AS 5017 2006, differ from the HL7 data types and vocabularies which are not based on these standards.

Many of the mappings use one of several common patterns for mapping between the SCS and the CDA document. These common mapping patterns are described in 8 *Common Patterns*.

An example of a mapping section of this implementation guide is illustrated below.

x.x ITEM NAME

Identification (normative)

Name	ITEM NAME
Metadata type	Metadata type e.g. Section, Data Group or Data Element

Relationships (normative)

Children

Data Type	Name	Occurrence
Icon illustrating the Metadata or Data type.	ITEM NAME (This is a link to another section containing the mapping for this item. Item names in upper case indicate that the item is a section or data group. Item names in title case indicate that the item is a data element).	The number of instances of this child item that may occur.

Parent

Data Type	Name	Occurrences (child within parent)
Icon illustrating the Metadata or Data type.	ITEM NAME (This is a link to another section containing the mapping for this item. Item names in upper case indicate that the item is a section or data group. Item names in title case indicate that the item is a data element).	The number of instances of the child item within the parent that may occur.

CDA R-MIM Representation (non-normative)

The text contains an explanation of the mapping.

The model is a constrained representation of the R-MIM. The colours used in the CDA model align with the usage in the R-MIM. In many cases the cardinalities shown in the model will be less constrained than those shown in the mapping table.
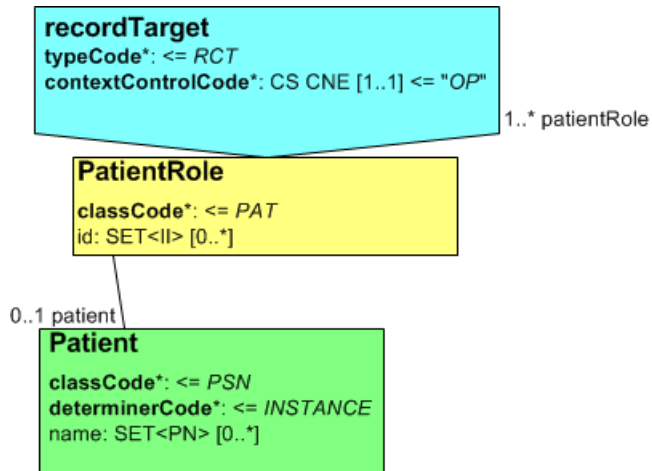
Figure 2.1. Example - Header Part
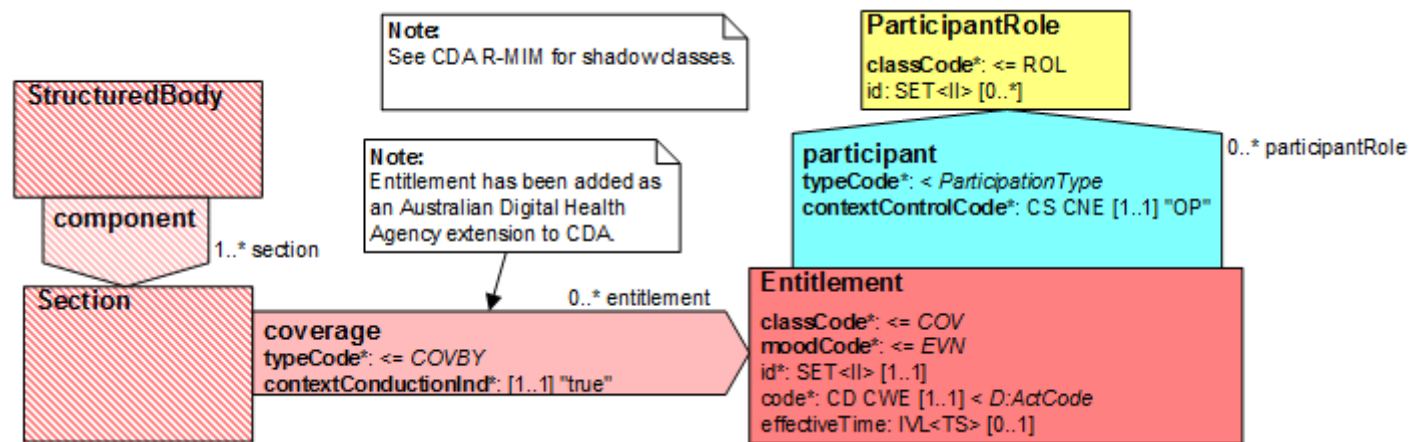
Figure 2.2. Example - Body Part

CDA Mapping (normative)

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Element Type (Header, Body Level 2 etc.)			Context: Parent of elements below		
The path in the SCS. Each section in this document corresponds to an SCS section or data group, and is scoped by that section or data group. The hierarchical path uses ">" as a separator for paths within the SCS data hierarchy. If there is a name in round brackets after the path, this is the name of the reused data group for the SCS component. The data component in **bold** text (the last in the path) is the data component for this row. i.e. Parent Data Component > **Child Data Component**	The definition of the item from the SCS.	The cardinality of the data element in the SCS. The cardinality of the data element in the SCS maps to the cardinality of the element in the CDA document. Where the cardinality of the SCS data element is more constrained than the cardinality of the CDA element then the SCS cardinality takes precedence. That is, if an element is mandatory in the SCS and optional in CDA then it will also become mandatory in the CDA document. If an item with a maximum cardinality > 1 maps to an XML attribute, the attribute will contain multiple values separated by spaces. No such item will have valid values that themselves contain spaces.	The schema element(s) in the CDA document that correspond(s) to the SCS data component. The syntax for this is similar to XPath: {/name[index]}}n{/<pattern>} Where: • {} indicates optional • {}n means a section that may repeat • <pattern> contains a link to a common pattern • [index] differentiates two similar mappings Examples: 1. component/act/participation[inf_prov]/role/**<Address>** 2. **participant** participant/**@typeCode="ORG"** participant/**associatedEntity** participant/associatedEntity/**@classCode="SDLOC"** participant/associatedEntity/**code** A sequence of names refers to the XML path in the CDA document. The path always starts from a defined context which is defined in the grey header row above each group of mapping rows. The last name is shown in bold to make the path easier to read. The last name may be a reference to an attribute or an element, as defined in the Australian Digital Health Agency CDA Schema. The cardinalities of the items map through from the SCS. It is possible to specify an index after the name, such as 'participation[inf_prov]' in Example 1. The presence of the index means there are two or more mappings to the same participation class that differ only in the inner detail. The indexes show which of the multiple mappings is the parent of the inner detail. Note that each of the indexed participations may exist more than once (as specified by the SCS group cardinality). To determine the mapping for these kinds of elements, a document reader must look at the content inside the element. It is possible for one SCS data component to map to more than one CDA schema element as in Example 2. Any fixed attribute values are represented as a separate line of the mapping, such as those shown in Example 2. The path may end with a pattern designator, such as <Address>. This indicates that the mapping involves a number of sub-elements of the named element following the pattern, as shown in the name (which is a link to the appropriate pattern in this document).	The name of the vocabulary.	Helpful additional information about the mapping.

How to interpret the following example mapping:

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Header Data Elements			Context: /ClinicalDocument/		
Subject of Care	Person who receives healthcare services.	1..1	recordTarget/**patientRole**		
n/a	n/a	1..1	recordTarget/patientRole/**id**		Required CDA element. If there are any entitlements for Subject of Care, this value **SHALL** be the same as: ClinicalDocument/ component/ structuredBody/ component[admin_obs]/ section/ entry/ act/ participant/ participantRole/ **id** where participantRole/ @classCode = "PAT".
Subject of Care > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > **PERSON**	An individual who is in the role of healthcare provider, who uses or is a potential user of a healthcare service, or is in some way related to, or a representative of, a subject of care (patient).	1..1	n/a		Not mapped directly, encompassed implicitly in recordTarget/ patientRole/ patient.
Subject of Care > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > **PERSON NAME**	The appellation by which an individual may be identified separately from any other within a social context.	1..*	recordTarget/patientRole/patient/**<Person Name>**		See common pattern: Person Name.
CDA Header Data Elements			Context: /ClinicalDocument/component/structuredBody/component[admin_obs]/section/		
Subject of Care > PARTICIPANT > **ENTITLEMENT**	The entitlement or right of a participant to act in a given capacity (as defined by Entitlement Type) within a healthcare context.	0..*	**ext:coverage2/@typeCode="COVBY"**		See Australian Digital Health Agency CDA extension: Entitlement. All data elements within this section **SHALL** be deemed as CDA Header data elements for conformance assessment.
			ext:coverage2/**ext:entitlement**		
			ext:coverage2/ext:entitlement/**@classCode="COV"**		
			ext:coverage2/ext:entitlement/**@moodCode="EVN"**		
			ext:coverage2/ext:entitlement/**ext:participant/@typeCode="BEN"**		
			ext:coverage2/ext:entitlement/ext:participant/**ext:participantRole/@classCode="PAT"**		
			ext:coverage2/ext:entitlement/ext:participant/ext:participantRole/**ext:id**		**SHALL** hold the same value as ClinicalDocument/ recordTarget /patientRole/ **id**.

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
Subject of Care > PARTICIPANT > ENTITLE-MENT > **Entitlement Number**	A number or code issued for the purpose of identifying the entitlement or right of a participant to act in a given capacity (as defined by Entitlement Type) within a healthcare context.	1..1	ext:coverage2/ext:entitlement/**ext:id**		
Subject of Care > PARTICIPANT > ENTITLE-MENT > **Entitlement Type**	The description of the scope of an entitlement.	1..1	ext:coverage2/ext:entitlement/**ext:code**	NCTIS: Admin Codes - Entitlement Type	See <code> for available attributes.
Subject of Care > PARTICIPANT > ENTITLE-MENT > **Entitlement Validity Duration**	The time interval for which an entitlement is valid.	0..1	ext:coverage2/ext:entitlement/**ext:effectiveTime**		
Subject of Care > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > **EMPLOYMENT DETAIL**	A person's occupation and employer.	0..0	recordTarget/patientRole/patient/**ext:asEmployment**		

The Subject of Care (Patient) section is part of the context section of the SCS (as opposed to being part of the content section of the SCS). Although it is located in the context section of the SCS, it contains data components that map to the CDA body, as well as data components that map to the CDA header. The information specifying the location of the elements is in the shaded context header row located above each group of mapping rows. The context remains the same until a new context header row starts.

The first row of the mapping (after the context header row), 'Subject of Care', is a CDA Header element and has a context of '/ClinicalDocument' (the root element of a CDA document). Adding together the context and the mapping using '/' gives a full path of:

1) /ClinicalDocument/recordTarget/patientRole

Due to the fact that 'Subject of Care' is part of the context section of the SCS (as opposed to a content element), information about it and its child elements can be located in the SCS document by finding the data component 'Subject of Care' in the table of contents under the context section, and navigating to the relevant page.

If the data component is part of the content section of the SCS, information about it could be located by finding the data component (or its parent) in the table of contents under the content section of the SCS.

2) The next row in the mapping (n/a) is a row that is not defined in the SCS but which is required by CDA. The CDA schema data element is recordTarget/patientRole/id. This is a technical identifier that is used for system purposes, such as matching ENTITLEMENT details back to the Subject of Care (patient). This identifier **SHALL** be a UUID.

3) The next row in the mapping table (Subject of Care > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE >PERSON) is defined in the SCS but is not mapped directly to the CDA because it is already encompassed implicitly by CDA in recordTarget/patientRole/patient.

Moving to the next row in the table (Subject of Care > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > **PERSON NAME**) and concatenating the context and the mapping, we get:

4) /ClinicalDocument/recordTarget/patientRole/patient/**<Person Name>**

<PersonName> holds a link to the common pattern section where a new table lays out the mapping for the PERSON NAME common pattern.

Moving down the table to the context row '**CDA Header Data Elements**', any data components after this row (until the occurrence of a new context row) map to the CDA body. Because there is no equivalent concept in CDA, an Australian Digital Health Agency CDA extension has been added in order to represent ENTITLEMENT. This extension is indicated by the presence of the 'ext:' prefix. ENTITLEMENT CDA elements **SHALL** be deemed CDA Header data elements for conformance assessment. For the data component 'ENTITLEMENT', adding together the context and the mapping using '/' gives the following paths for the CDA body level 3 data elements ([index] is dependent on context):

5) /ClinicalDocument/component/structuredBody/component[index]/section/**ext:coverage2/@typeCode="COVBY"**

6) /ClinicalDocument/component/structuredBody/component[index]/section/ext:coverage2/**ext:entitlement**

7) /ClinicalDocument/component/structuredBody/component[index]/section/ext:coverage2/ext:entitlement/**@classCode="COV"**

8) /ClinicalDocument/component/structuredBody/component[index]/section/ext:coverage2/ext:entitlement/**@moodCode="EVN"**

9)   /ClinicalDocument/component/structuredBody/component[index]/section/ext:coverage2/ext:entitlement/**ext:participant/@typeCode="BEN"**

10) /ClinicalDocument/component/structuredBody/component[index]/section/ext:coverage2/ext:entitlement/ext:participant/**ext:participantRole/@classCode="PAT"**

11) /ClinicalDocument/component/structuredBody/component[index]/section/ext:coverage2/ext:entitlement/ext:participant/ext:participantRole/**ext:id**

This id is also a technical identifier and **SHALL** hold the same value as the /ClinicalDocument/recordTarget/patientRole/id mentioned in comment 1.

The order of the SCS data components is not always the same as the order of the CDA elements. In addition, the CDA elements need to be in the order specified in the Australian Digital Health Agency CDA Schema.

The id element is not specified in the SCS and **SHOULD** be filled with a UUID. This element may be used to reference an act from other places in the CDA document.

The next row in the table (Subject of Care > PARTICIPANT > ENTITLEMENT > Entitlement Number) maps to the id element:

12) /ClinicalDocument/component/structuredBody/component[index]/section/ext:coverage2/ext:entitlement/**ext:id**

The next row in the table (Subject of Care > PARTICIPANT > ENTITLEMENT > Entitlement Type) maps to the code element:

13) /ClinicalDocument/component/structuredBody/component[index]/section/ext:coverage2/ext:entitlement/**ext:code**

The next row in the table (Subject of Care > PARTICIPANT > ENTITLEMENT > Entitlement Validity Duration) maps to the effectiveTime element:

14) /ClinicalDocument/component/structuredBody/component[index]/section/ext:coverage2/ext:entitlement/**ext:effectiveTime**

The next row in the table (Subject of Care > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > **EMPLOYMENT DETAIL**) maps to the ext:asEmployment element:

Where the SCS explicitly prohibits a data component, it is shown in the CDA mapping table with a cardinality of [0..0].

This is interpreted as an absolute prohibition against inclusion.

15) /ClinicalDocument/recordTarget/patientRole/patient/**ext:asEmployment**

See comments in the example below.

Example 2.1. Mapping Interpretation (non-normative)

```
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table.  It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
```

```
the specification or schema will take precedence. -->

<ClinicalDocument
 xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
 …
 >

        …

    <!-- Begin Subject of Care - Header Part -->
    <recordTarget>
        <!-- 1 Corresponds to:
                '//recordTarget/patientRole'
           in the mapping. -->
        <patientRole>
            <!-- 2 Corresponds to:
                    '//recordTarget/patientRole/id'
               in the mapping -->
            <id root="989da303-3bbd-44b9-bc0f-ab98dd0b6dde"/>

            …

            <telecom value="tel:0499999999" use="H"/>
            <!-- 3 -->
            <patient>
                <!-- 4 Corresponds to:
                        '//recordTarget/patientRole/patient/<Person Name>'
                   in the mapping -->
                <name use="L">
                    <prefix>Ms</prefix>
                    <given>Sally</given>
                    <family>Grant</family>
                </name>

                …

            </patient>
        </patientRole>
    </recordTarget>
    <!-- End Subject of Care - Header Part -->

 …

    <!-- Begin CDA Body -->
    <component>
        <structuredBody>

            <!-- Begin section -->
            <component>
                <section>

                    …

                    <!-- Begin SUBJECT OF CARE ENTITLEMENT -->
                    <!-- 5 Corresponds to:
                        '//ext:coverage2'
                       in the mapping. -->
                    <ext:coverage2 typeCode="COVBY">
                        <!-- 6, 7, 8 Corresponds to:
                                '//ext:coverage2/ext:entitlement',
                                '//ext:coverage2/ext:entitlement/@classCode="COV"',
                                '//ext:coverage2/ext:entitlement/@moodCode="EVN"'
```

```xml
                    in the mapping -->
              <ext:Entitlement classCode="COV" moodCode="EVN">
                  <!-- 12 Corresponds to:
                          '//ext:coverage2/ext:entitlement/ext:id'
                      in the mapping -->
                  <ext:id root="1.2.36.174030967.0.5" extension="1234567892"
                     assigningAuthorityName="Medicare Identifier"/>
                  <!-- 13 Corresponds to:
                      '//ext:coverage2/ext:entitlement/ext:code'
                  in the mapping -->
                  <ext:code code="1" codeSystem="1.2.36.1.2001.1001.101.104.16047" codeSystemName="NCTIS Entitlement Type Values" displayName="Medicare Benefits" />
                  <!-- 14 Corresponds to:
                          '//ext:coverage2/ext:entitlement/ext:effectiveTime'
                      in the mapping -->
                  <ext:effectiveTime>
                      <low value="200701010101+1000"/>
                      <high value="202701010101+1000"/>
                  </ext:effectiveTime>
                  <!-- 9 Corresponds to:
                          '//ext:coverage2/ext:entitlement/ext:participant/@typeCode="BEN"'
                      in the mapping -->
                  <ext:participant typeCode="BEN">
                      <!-- 10 Corresponds to:
                              '//ext:coverage2/ext:entitlement/ext:participant/ext:participantRole/@classCode="PAT"'
                          in the mapping -->
                      <ext:participantRole classCode="PAT">
                          <!-- 11 Corresponds to:
                                  '//ext:coverage2/ext:entitlement/ext:participant/ext:participantRole/ext:id'
                              in the mapping -->
                          <!-- Same as recordTarget/patientRole/id -->
                          <ext:id root="989da303-3bbd-44b9-bc0f-ab98dd0b6dde"/>
                      </ext:participantRole>
                  </ext:participant>
              </ext:Entitlement>
          </ext:coverage2>
          <!-- End SUBJECT OF CARE ENTITLEMENT -->

                …

          </section>
      </component>
      <!-- End section -->

    </structuredBody>
  </component>
  <!-- End CDA Body -->
</ClinicalDocument>
```

2.3 CDA Extensions

The SCS is based on Australian requirements, either as expressed in existing Australian Standards, or based on extensive consultation with major stakeholders. Not all of these requirements are supported by HL7 Clinical Document Architecture Release 2 (CDA).

CDA provides a mechanism for handling this. Implementation guides are allowed to define extensions, provided some key rules are followed:

- Extensions have a namespace other than the standard HL7v3 namespace.

- The extension cannot alter the intent of the standard CDA document. For example, an extension cannot be used to indicate that an observation does not apply where the CDA document requires it.

- HL7 encourages users to get their requirements formalised in a subsequent version of the standard so as to maximise the use of shared semantics.

Accordingly, a number of extensions to CDA have been defined in this implementation guide. To maintain consistency, the same development paradigm has been used as CDA, and all the extensions have been submitted to HL7 for inclusion into a future release of CDA (Release 3 currently under development).

The extensions in Version 3.0 are incorporated in the namespace `http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0` as shown in the CDA example output throughout this document. Future versions of CDA extensions will be versioned as per the following example:

```
http://ns.electronichealth.net.au/Ci/Cda/Extensions/4.0
```

2.4 W3C XML Schema

This document refers to an accompanying CDA W3C XML Schema (referred to in this document as the Australian Digital Health Agency CDA Schema). This schema differs from the base HL7 CDA W3C XML Schema (referred to in this document as the HL7 CDA Schema) as mentioned below:

- Australian Digital Health Agency CDA extensions have been added to the Australian Digital Health Agency CDA Schema.

CDA documents which include extensions will fail to validate against the HL7 CDA Schema – this is a known limitation.

An Advance Care Information document that conforms to this specification **SHALL** validate against the Australian Digital Health Agency CDA Schema that accompanies this specification, and **SHALL** validate against the HL7 CDA Schema once the extensions have been removed. Note that merely passing schema validation does not ensure conformance. For more information, refer to Conformance.

2.5 Schematron

Many of the rules this document makes about CDA documents cannot be captured in the W3C XML Schema language (XSD) as XSD does not provide a mechanism to state that the value or presence of one attribute is dependent on the values or presence of other attributes (co-occurrence constraints).

Schematron is a rule-based validation language for making assertions about the presence or absence of patterns in XML trees. The rules defined by this document may be captured as Schematron rules. As of this release, the matching Schematron assertions have not yet been developed. We are considering the distribution of these rules in association with future releases of this implementation guide.

2.6 Implementation Strategies

There are many platform-specific implementation options for readers implementing a CDA document according to this guide. Examples of these implementation options include:

- Read or write CDA documents directly using a Document Object Model (DOM) or 3rd Generation Language (3GL) code (or both).

- Transform an existing XML format to and from a CDA document.

- Use a toolkit to generate a set of classes from HL7 CDA Schema or the Australian Digital Health Agency CDA Schema provided with this implementation guide, to read or write documents.

- Use existing libraries, possibly open source, that can read and write CDA documents.

The best approach for any given implementation is strongly dictated by existing architecture, technology and legacy constraints of the implementation project or existing system.

3 Advance Care Information Data Hierarchy

The data hierarchy below provides a logical representation of the data structure of the ACI SCS data components.

The data hierarchy is a logical representation of the data components of an Advance Care Information, and is not intended to represent how the data contents are represented in a CDA document.

Note

Items below whose icon is 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.

ADVANCE CARE INFORMATION					
CONTEXT					
	SUBJECT OF CARE				1..1
	DOCUMENT AUTHOR				1..1
	Document Instance Identifier				1..1
	Document Type				1..1
	Document Title				1..1
CONTENT					
	ADVANCE CARE INFORMATION SECTION				1..1
		Advance Care Information Section Instance Identifier			0..1
		RELATED DOCUMENT			1..1
			Link Nature		1..1
			Document Target		1..1
			DOCUMENT DETAILS		1..1
				Document Type	1..1
				DOCUMENT AUTHOR	1..1
				Document Identifier	0..1
		Section Type			1..1

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Approved for external use

4 Administrative Observations

The ACI SCS contains a number of data elements that are logically part of the SCS context, but for which there are no equivalent data elements in the CDA header. These data elements are considered to be "Administrative Observations" about the encounter, the patient or some other participant. Administrative Observations is a CDA section that is created to hold these data components in preference to creating extensions for them.

CDA R-MIM Representation

Figure 4.1 Administrative Observations shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Body elements.

The Administrative Observations section is composed of a Section class related to its context ClinicalDocument.structuredBody through a component relationship.
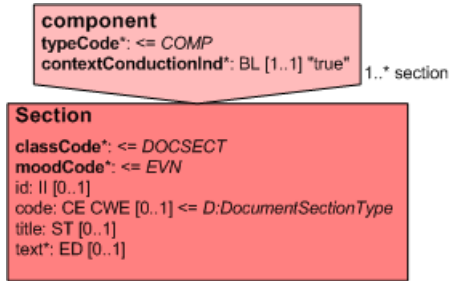
Figure 4.1. Administrative Observations

CDA Mapping

At most one instance of Administrative Observation section **SHOULD** be present in a CDA document. The cardinality of this section comes from its linking context data elements (e.g. CDA context data element(s) mapped to Administrative Observation Section). If any of the linking context data elements are mandatory, then this section **SHALL** be marked as a mandatory section.

This section **SHALL NOT** be populated if there are no entries or text to go in it.

This section **SHALL** contain a code if provided.

All data elements (with the exception of narrative text) within this section **SHALL** be deemed as CDA Header data elements for conformance assessment.

The <text> data element is **OPTIONAL** and **SHALL** be treated as a Level 2 CDA data element.

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Body Level 2 Data Elements			Context: /ClinicalDocument/component/structuredBody/		
n/a	n/a	Cardinality comes from linking context data elements	**component[admin_obs]/section**		
		0..1	component[admin_obs]/section/**id**		See <id> for available attributes.
		1..1	component[admin_obs]/section/**code**		See <code> for available attributes.
			component[admin_obs]/section/code/**@code="102.16080"**		
			component[admin_obs]/section/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			component[admin_obs]/section/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			component[admin_obs]/section/code/**@displayName="Administrative Observations"**		
			component[admin_obs]/section/**title="Administrative Observations"**		
		0..1	component[admin_obs]/section/**text**		See Appendix A, *CDA Narratives*.

Example 4.1. Administrative Observations XML Fragment

```xml
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<ClinicalDocument
    xmlns="urn:hl7-org:v3"
    xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
    …
    >
    …

    <!-- Begin CDA Body -->
    <component>
        <structuredBody>
            …

            <!-- Begin Administrative Observations -->
            <component typeCode="COMP">
                <section classCode="DOCSECT" moodCode="EVN">
                    <id root="8c173d55-e8d7-43c1-b06b-e427b39342d4"/>
                    <code code="102.16080"
                        codeSystem="1.2.36.1.2001.1001.101"
                        codeSystemName="NCTIS Data Components"
                        displayName="Administrative Observations"/>
                    <title>Administrative Observations</title>

                    <!-- narrative block -->
                    <text/>
                    …

                </section>
            </component>
            <!-- End Administrative Observations -->
            …

        </structuredBody>
    </component>
    <!-- End CDA Body -->
</ClinicalDocument>
```

5 CDA Header

This chapter contains CDA-specific header elements (both **REQUIRED** and **OPTIONAL**) that are not specified in the ACI SCS specification. The CDA Schema Data Element describes each element.

All the definitions in this chapter are sourced from "HL7 Clinical Document Architecture, Release 2" [HL7CDAR2].

5.1 ClinicalDocument

Identification

Name	ClinicalDocument
Definition	The ClinicalDocument class is the entry point into the CDA R-MIM, and corresponds to the <ClinicalDocument> XML element that is the root element of a CDA document.

Relationships

Children

Name	Occurrence
LegalAuthenticator	0..1
Custodian	1..1

CDA R-MIM Representation

ClinicalDocument

classCode*: <= DOCCLIN
moodCode*: CS CNE [1..1] < D:EVN
id*: II [1..1]
code*: CE CWE [1..1] < D:DocumentType
title: ST [0..1]
effectiveTime*: TS [1..1]
confidentialityCode*: CE CWE [1..1] < D:x_BasicConfidentialityKind
languageCode: CS CNE [0..1] < V:HumanLanguage
setId: II [0..1]
versionNumber: INT [0..1]
completionCode: CE CWE [0..1] < D:DocumentCompletion

Note:
completionCode is added as an Australian Digital Health Agency extension to CDA.

Figure 5.1. ClinicalDocument

CDA Mapping

CDA Schema Data Element	Definition	Card	Vocab	Comments
CDA Header Data Elements	Context: /			
ClinicalDocument	The ClinicalDocument class is the entry point into the CDA R-MIM, and corresponds to the <ClinicalDocument> XML element that is the root element of a CDA document.	1..1		
ClinicalDocument/**typeId**	A technology-neutral explicit reference to the CDA Release 2 specification.	1..1		
ClinicalDocument/typeId/**@extension="POCD_HD000040"**		1..1		The unique identifier for the CDA Release 2 Hierarchical Description.
ClinicalDocument/typeId/**@root="2.16.840.1.113883.1.3"**		1..1		The OID for HL7 Registered models.
ClinicalDocument/**templateId**	A templateId signals the imposition of a set of template-defined constraints.	1..*		One or more template identifiers that indicate constraints on the CDA document that this document conforms to. One of the identifiers must be the templateId that identifies this specification (see immediately below). Additional template identifiers may be required by other specifications, such as the CDA Rendering Specification. Systems are not required to recognise any other template identifiers than the one below in order to understand the document as a [type] but these identifiers may influence how the document must be handled.
ClinicalDocument/templateId/**@root="1.2.36.1.2001.1001.100.1002.226"**		1..1		The healthcare context-specific name of the published Advance Care Information CDA Implementation Guide.
ClinicalDocument/templateId/**@extension="1.0"**		1..1		The identifier of the version that was used to create the document instance.
ClinicalDocument/**id**	Represents the unique instance identifier of a clinical document.	1..1		See <id> for available attributes. id/@nullFlavor **SHALL NOT** be present.

CDA Schema Data Element	Definition	Card	Vocab	Comments
ClinicalDocument/**code**	The code specifying the particular kind of document (e.g. History and Physical, Discharge Summary, Progress Note).	1..1		code/@nullFlavor **SHALL NOT** be present. Container for a copy of a statement of a person's decisions about their future care, should they become incapable of participating in medical treatment decisions.
ClinicalDocument/code/**@code="100.16975"**				
ClinicalDocument/code/**@codeSystem="1.2.36.1.2001.1001.101"**				
ClinicalDocument/code/**@codeSystemName**			The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
ClinicalDocument/code/**@displayName="Advance Care Information"**				
ClinicalDocument/**title="Advance Care Planning Document"**	Represents the title of the document.	1..1		title/@nullFlavor **SHALL NOT** be present.
ClinicalDocument/**effectiveTime**	Signifies the document creation time, when the document first came into being. Where the CDA document is a transform from an original document in some other format, the ClinicalDocument.effectiveTime is the time the original document is created.	1..1		See common pattern: time.
ClinicalDocument/**confidentialityCode/@nullFlavor="NA"**	Codes that identify how sensitive a piece of information is and/or that indicate how the information may be made available or disclosed.	1..1		
ClinicalDocument/**languageCode**	Specifies the human language of character data (whether they be in contents or attribute values).	0..1	[RFC3066] – Tags for the Identification of Languages	<Language Code> – <DIALECT> The <Language Code> **SHALL** be "en". The <DIALECT> **SHOULD** be "AU".
ClinicalDocument/**setId**	Represents an identifier that is common across all document revisions.	0..1		
ClinicalDocument/**versionNumber/@value**	An integer value used to version successive replacement documents.	0..1		
ClinicalDocument/**ext:completionCode**	The lifecycle status of a document.	1..1	NCTIS: Admin Codes - Document Status	See Australian Digital Health Agency CDA extension: ClinicalDocument.completionCode.

Example 5.1. ClinicalDocument XML Fragment

```xml
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table.  It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<ClinicalDocument xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
 xmlns:xs="http://www.w3.org/2001/XMLSchema"
 xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance">
 <!-- Begin CDA Header -->
 <typeId extension="POCD_HD000040" root="2.16.840.1.113883.1.3"/>
 <templateId extension="1.0" root="1.2.36.1.2001.1001.100.1002.226"/>
    <templateId extension="1.0" root="1.2.36.1.2001.1001.100.1002.226.1"/>
 <id root="460158a6-984b-472f-8e9f-1e434ad0c342"/>
 <code code="100.16975"
  codeSystem="1.2.36.1.2001.1001.101"
  codeSystemName="NCTIS Data Components"
  displayName="Advance Care Information"/>
 <title>Advance Care Planning Document</title>
 <effectiveTime value="201211061639+1100"/>
 <confidentialityCode nullFlavor="NA"/>
 <languageCode code="en-AU"/>
 <setId root="a933d726-db2e-4553-b424-737e309ea65d"/>
 <versionNumber value="1"/>
 <ext:completionCode code="F"
  codeSystem="1.2.36.1.2001.1001.101.104.20104"
  codeSystemName="NCTIS Document Status Values"
  displayName="Final"/>
 …

 <!-- End CDA Header -->

</ClinicalDocument>
```

5.1.1 LegalAuthenticator

Identification

Name	LegalAuthenticator
Definition	Represents a participant who has legally authenticated the document.

Relationships

Parent

Name	Occurrences (child within parent)
ClinicalDocument	0..1

CDA R-MIM Representation

Figure 5.2 LegalAuthenticator shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Header elements.

The LegalAuthenticator maps to the CDA Header element legalAuthenticator. The legalAuthenticator participation class represents who has legally authenticated the document. The role is AssignedEntity and is represented by the Person, and optionally Organization, entities.
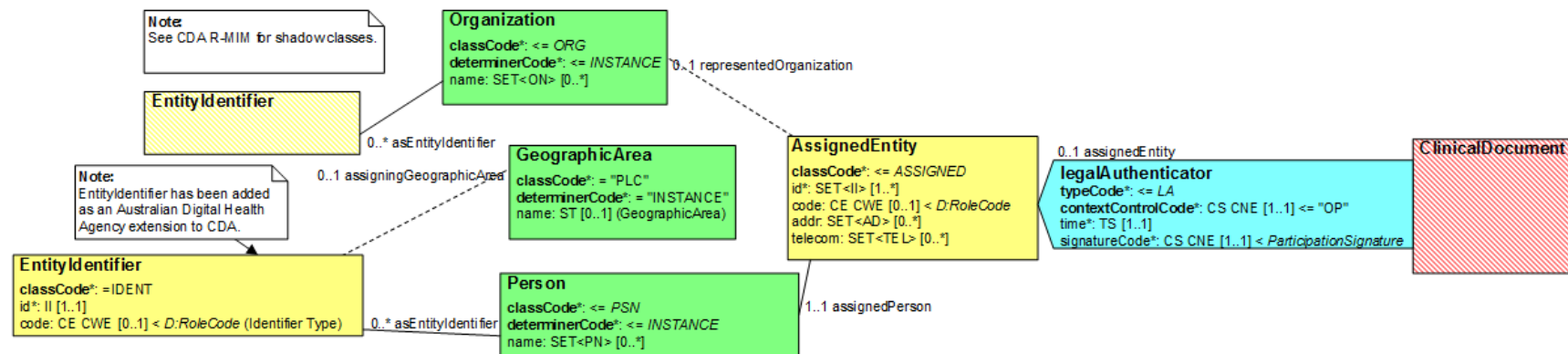
Figure 5.2. LegalAuthenticator

CDA Mapping

Note

NS = 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.

CDA Schema Data Element	Definition	Card	Vocab	Comments
Context: /ClinicalDocument/				
legalAuthenticator	Represents a participant who has legally authenticated the document.	0..1		
legalAuthenticator/**time/@value**	Indicates the time of authentication.	1..1		
legalAuthenticator/**signatureCode/@code="S"**	Indicates that the signature has been affixed and is on file.	1..1		
legalAuthenticator/**assignedEntity**	A legalAuthenticator is a person in the role of an assigned entity (AssignedEntity class). An assigned entity is a person assigned to the role by the scoping organization. The entity playing the role is a person (Person class). The entity scoping the role is an organization (Organization class).	1..1		
legalAuthenticator/assignedEntity/**code**	The specific kind of role.	0..1	NS	See <code> for available attributes.
legalAuthenticator/assignedEntity/**id**	A unique identifier for the player entity in this role.	1..1		See <id> for available attributes.
legalAuthenticator/assignedEntity/**assignedPerson**	The entity playing the role (assignedEntity) is a person.	1..1		
legalAuthenticator/assignedEntity/assignedPerson/**<Entity Identifier>**	The entity identifier of the person.	0..*		See common pattern: Entity Identifier.
legalAuthenticator/assignedEntity/**<Address>**	A postal address for the entity (assignedPerson) while in the role (assignedEntity).	0..*		See common pattern: Address.
legalAuthenticator/assignedEntity/**<Electronic Communication Detail>**	A telecommunication address for the entity (assignedPerson) while in the role (assignedEntity).	0..*		See common pattern: Electronic Communication Detail.
legalAuthenticator/assignedEntity/assignedPerson/**<Person Name>**	A non-unique textual identifier or moniker for the entity (assignedPerson).	0..*		See common pattern: Person Name.
legalAuthenticator/assignedEntity/**representedOrganization**	The entity scoping the role (assignedEntity).	0..1		
legalAuthenticator/assignedEntity/representedOrganization/**<Entity Identifier>**	A unique identifier for the scoping entity (represented organization) in this role (assignedEntity).	0..*		See common pattern: Entity Identifier.
legalAuthenticator/assignedEntity/representedOrganization/**name**	A non-unique textual identifier or moniker for the entity (representedOrganization).	0..*		

---

[1] http://www.hl7.org/oid/index.cfm?ref=footer

Example 5.2. LegalAuthenticator XML Fragment

```xml
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table.  It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<ClinicalDocument xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
 …
 >
 <!-- Begin CDA Header -->
 …

 <!-- Begin legalAuthenticator -->
 <legalAuthenticator>
  <time value="200910201235+1000"/>
  <signatureCode code="S"/>
  <assignedEntity>
   <id root="b830b9a6-4ea7-4a1a-92eb-ddf18b82a291"/>
   <code code="253111" codeSystem="2.16.840.1.113883.13.62"
    codeSystemName="1220.0 - ANZSCO - Australian and New Zealand Standard Classification of Occupations, First Edition, Revision 1"
    displayName="General Medical Practitioner"/>

   <!-- Address -->
   <addr use="WP">
    <streetAddressLine>1 Clinician Street</streetAddressLine>
    <city>Healthville</city>
    <state>QLD</state>
    <postalCode>5555</postalCode>
    <additionalLocator>32568931</additionalLocator>
   </addr>

   <!-- Electronic Communication Detail -->
   <telecom use="WP" value="tel:0712341234"/>

   <assignedPerson>
    <!-- Person Name -->
    <name>
     <prefix>Dr.</prefix>
     <given>Good</given>
     <family>Doctor</family>
    </name>

    <!-- Entity Identifier -->
    <ext:asEntityIdentifier classCode="IDENT">
     <ext:id assigningAuthorityName="HPI-I"
      root="1.2.36.1.2001.1003.0.8003611566682112"/>
     <ext:assigningGeographicArea classCode="PLC">
      <ext:name>National Identifier</ext:name>
     </ext:assigningGeographicArea>
    </ext:asEntityIdentifier>
   </assignedPerson>

   <representedOrganization>
    <name>Good Health Clinic</name>

    <!-- Entity Identifier -->
    <ext:asEntityIdentifier classCode="IDENT">
```

```
        <ext:id assigningAuthorityName="HPI-O"
         root="1.2.36.1.2001.1003.0.8003621566684455"/>
        <ext:assigningGeographicArea classCode="PLC">
         <ext:name>National Identifier</ext:name>
        </ext:assigningGeographicArea>
      </ext:asEntityIdentifier>
    </representedOrganization>

  </assignedEntity>
 </legalAuthenticator>
 <!-- End legalAuthenticator -->
 …

 <!-- End CDA Header -->

</ClinicalDocument>
```

5.1.2 Custodian

Identification

Name	Custodian
Definition	The organization that is in charge of maintaining the document. The custodian is the steward that is entrusted with the care of the document. Every CDA document has exactly one custodian.

Relationships

Parent

Name	Occurrences (child within parent)
ClinicalDocument	1..1

CDA R-MIM Representation

Figure 5.3 Custodian shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Header elements.

The Custodian maps to the CDA Header element custodian. The custodian participation class represents the organisation that is in charge of maintaining the document. The role is Assigned-Custodian and is represented by the CustodianOrganization entity.
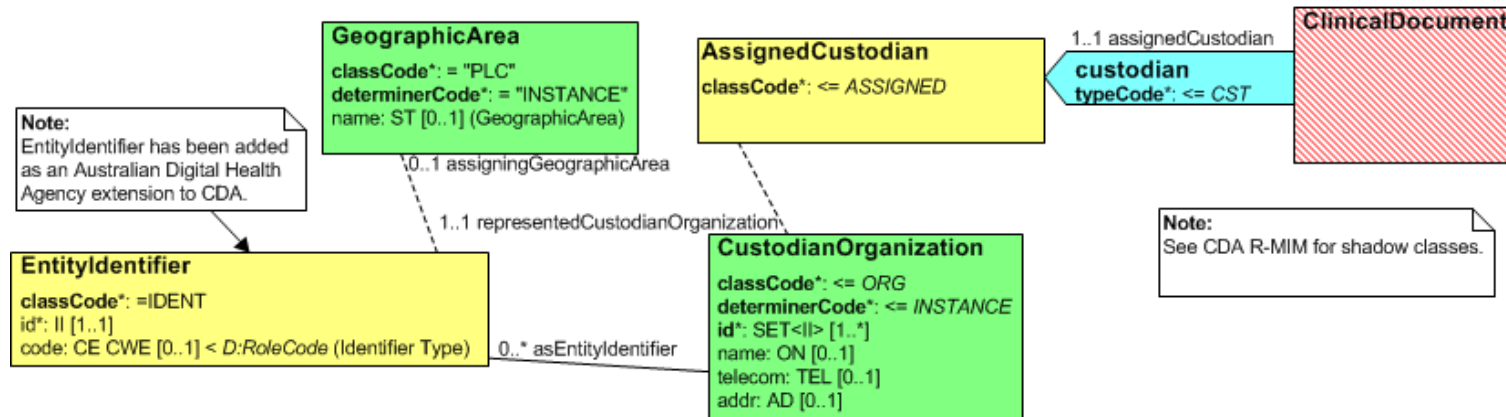
Figure 5.3. Custodian

CDA Mapping

CDA Schema Data Element	Definition	Card	Vocab	Comments
Context: /ClinicalDocument/				
custodian	Represents the organization that is in charge of maintaining the document. The custodian is the steward that is entrusted with the care of the document. Every CDA document has exactly one custodian.	1..1		
custodian/**assignedCustodian**	A custodian is a scoping organization in the role of an assigned custodian.	1..1		
custodian/assignedCustodian/**representedCustodianOrganization**	The steward organization (CustodianOrganization class) is an entity scoping the role of AssignedCustodian.	1..1		
custodian/assignedCustodian/representedCustodianOrganization/**id**	A unique identifier for the scoping entity (representedCustodianOrganization) in this role.	1..*		See <id> for available attributes.
custodian/assignedCustodian/representedCustodianOrganization/<**Entity Identifier**>	The entity identifier of the custodian organization.	0..*		See common pattern: Entity Identifier.
custodian/assignedCustodian/representedCustodianOrganization/**name**	The name of the steward organization.	0..1		
custodian/assignedCustodian/representedCustodianOrganization/<**Electronic Communication Detail**>	The telecom of the steward organization.	0..1		See common pattern: Electronic Communication Detail.
custodian/assignedCustodian/representedCustodianOrganization/<**Address**>	The address of the steward organization.	0..1		See common pattern: Address.

Example 5.3. Custodian XML Fragment

```xml
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table.  It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<ClinicalDocument xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
 …
 >
 <!-- Begin CDA Header -->
 …

 <!-- Begin Custodian -->
 <custodian>
  <assignedCustodian>
   <representedCustodianOrganization>
    <!-- id is used for system purposes such as matching -->
    <id root="c9c04faf-d7a8-4802-8c69-980b0ce4d798"/>
    <name>Acme Hospital Group</name>

    <!-- Electronic Communication Detail -->
    <telecom use="WP" value="tel:0712341234"/>

    <!-- Address -->
    <addr use="WP">
     <streetAddressLine>1 Clinician Street</streetAddressLine>
     <city>Healthville</city>
     <state>QLD</state>
     <postalCode>5555</postalCode>
     <additionalLocator>32568931</additionalLocator>
    </addr>

    <!-- Entity Identifier -->
    <ext:asEntityIdentifier classCode="IDENT">
     <ext:id assigningAuthorityName="HPI-O"
      root="1.2.36.1.2001.1003.0.8003621566684455"/>
     <ext:assigningGeographicArea classCode="PLC">
      <ext:name>National Identifier</ext:name>
     </ext:assigningGeographicArea>
    </ext:asEntityIdentifier>
   </representedCustodianOrganization>

  </assignedCustodian>
 </custodian>
 <!-- End Custodian -->
 …

 <!-- End CDA Header -->

</ClinicalDocument>
```

6 Context Data Specification - CDA Mapping

6.1 ADVANCE CARE INFORMATION

Identification

Name	ADVANCE CARE INFORMATION
Metadata Type	Structured Document
Identifier	SD-16975

Relationships

Children

Data Type	Name	Occurrence
👤	SUBJECT OF CARE	1..1
👤	DOCUMENT AUTHOR	1..1

CDA R-MIM Representation

Figure 6.1 ADVANCE CARE INFORMATION Context shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Header elements.
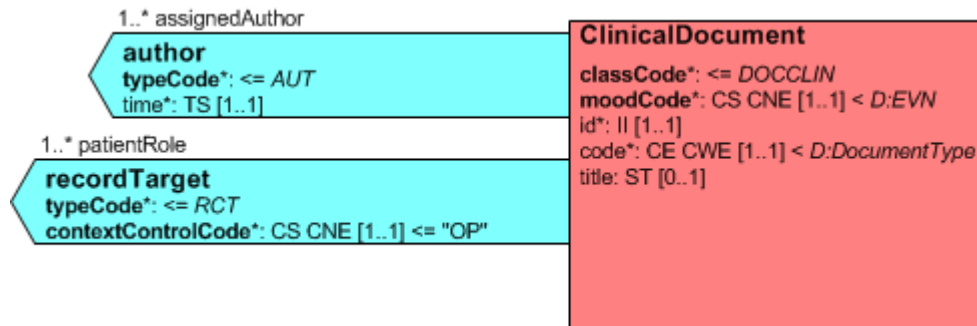
Figure 6.1. ADVANCE CARE INFORMATION Context

CDA Mapping

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Header Data Elements			Context: /		
ADVANCE CARE INFORMATION	Container for a copy of a statement of a person's decisions about their future care, should they become incapable of participating in medical treatment decisions.	1..1	**ClinicalDocument**		
ADVANCE CARE INFORMATION > **SUBJECT OF CARE**	Person who receives healthcare services.	1..1	See: SUBJECT OF CARE		
ADVANCE CARE INFORMATION > **DOCUMENT AUTHOR**	Composer of the document.	1..1	See: DOCUMENT AUTHOR		
ADVANCE CARE INFORMATION > **Document Instance Identifier**	Globally unique identifier for each instance of an Advance Care Information document.	1..1	ClinicalDocument/**id**		See <id> for available attributes. id/@nullFlavor **SHALL NOT** be present.
ADVANCE CARE INFORMATION > **Document Type**	Type of document.	1..1	ClinicalDocument/**code**		See <code> for available attributes. code/@nullFlavor **SHALL NOT** be present.
			ClinicalDocument/code/**@code="100.16975"**		
			ClinicalDocument/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			ClinicalDocument/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			ClinicalDocument/code/**@displayName="Advance Care Information"**		
ADVANCE CARE INFORMATION > **Document Title**	Display name of the document.	1..1	ClinicalDocument/**title="Advance Care Planning Document"**		title/@nullFlavor **SHALL NOT** be present.

For CDA Header mappings and model which are not explicitly included in the SCS, see ClinicalDocument.

Example 6.1. Advance Care Information Context XML Fragment

```xml
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table.  It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<ClinicalDocument xmlns:xsi="http://www.w3.org/2001/XMLSchema-instance" xmlns="urn:hl7-org:v3"
    xmlns:xs="http://www.w3.org/2001/XMLSchema"
    xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0">
    <!-- Begin CDA Header -->
    …
    <!-- Document Instance Identifier -->
    <id root="8f281000-498d-11e2-bcfd-0800200c9a66"/>
    <!-- Document Type -->
    <code code="100.16975"
     codeSystem="1.2.36.1.2001.1001.101"
        codeSystemName="NCTIS Data Components"
        displayName="Advance Care Information"/>
    <!-- Document Title -->
    <title>Advance Care Planning Document</title> …
    …

    <!-- Begin SUBJECT OF CARE -->
    <recordTarget>
        …
    </recordTarget>
    <!-- End SUBJECT OF CARE -->

    <!-- Begin DOCUMENT AUTHOR -->
    <author>
        …
    </author>
    <!-- End DOCUMENT AUTHOR -->
    …

    <!-- End CDA Header -->

</ClinicalDocument>
```

6.1.1 SUBJECT OF CARE

Identification

Name	SUBJECT OF CARE
Metadata Type	Data Group
Identifier	DG-10296

Relationships

Parent

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

CDA R-MIM Representation

Figure 6.2 SUBJECT OF CARE - Header Data Elements and Figure 6.3 SUBJECT OF CARE - Body Data Elements show a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to both CDA Header and CDA Body elements.

The SUBJECT OF CARE data group maps mostly to CDA Header elements. The recordTarget participation class represents the medical record to which this document belongs. The recordTarget is associated with the Patient class by the PatientRole class. In order to represent the Date of Death of the Subject of Care, Patient.deceasedTime has been added as an Australian Digital Health Agency CDA extension.
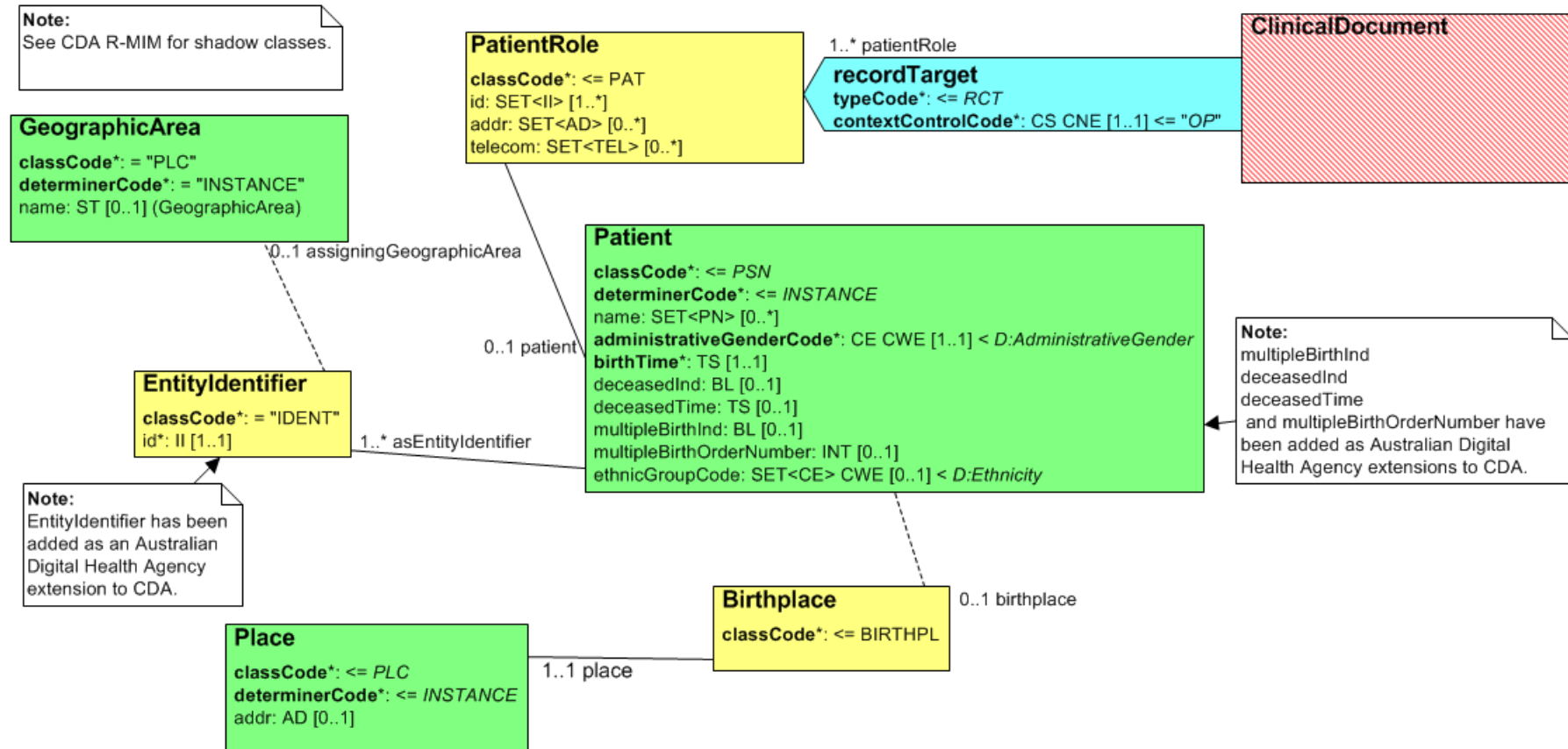
Figure 6.2. SUBJECT OF CARE - Header Data Elements

Note

Several data elements contained in the SUBJECT OF CARE data group could not be mapped to CDA Header elements. These data elements have been mapped to Observations in the Administrative Observations section (see *4 Administrative Observations*).
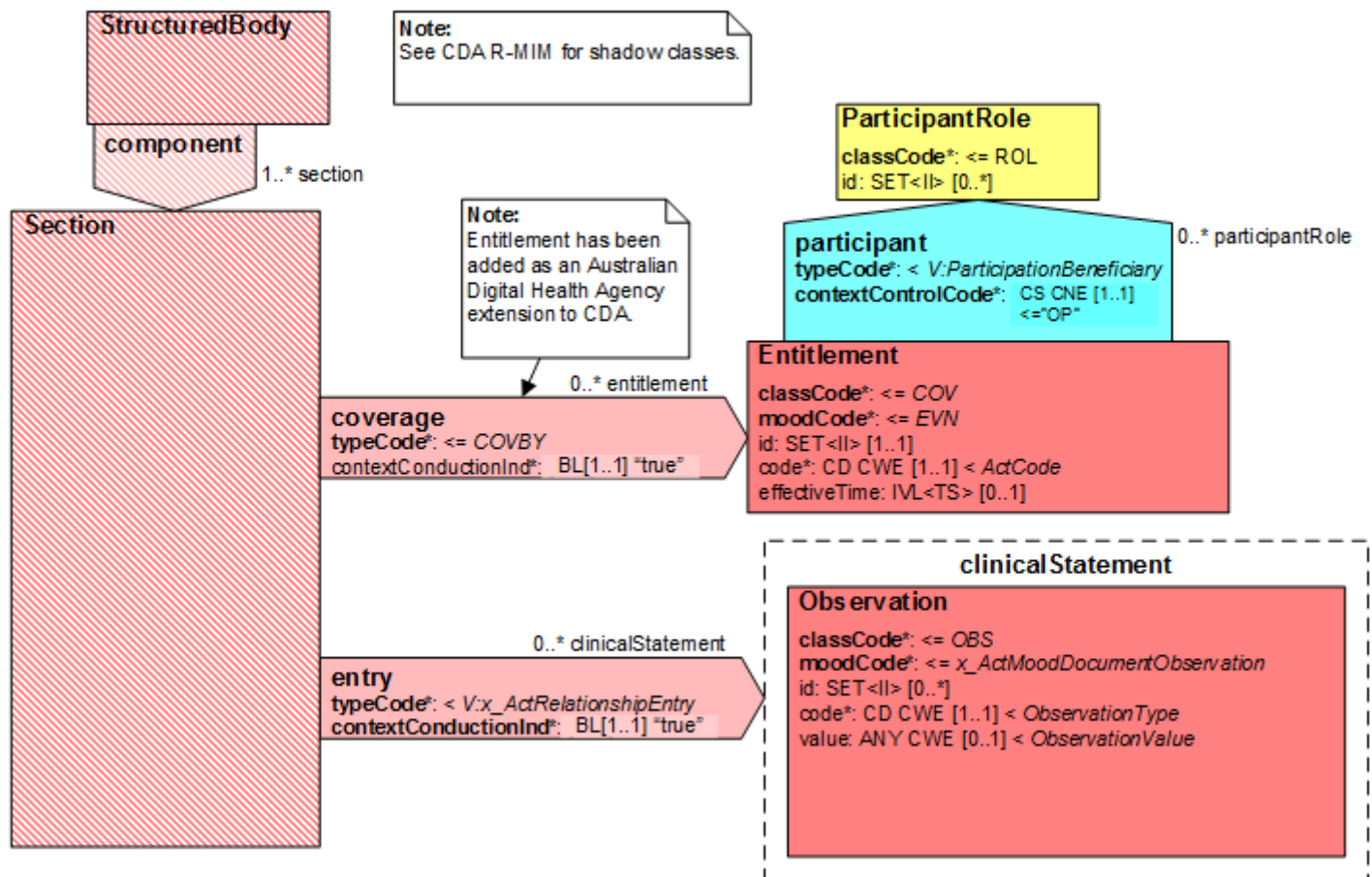
Figure 6.3. SUBJECT OF CARE - Body Data Elements

CDA Mapping

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Header Data Elements			Context: /ClinicalDocument/		
SUBJECT OF CARE	Person who receives healthcare services.	1..1	recordTarget/**patientRole**		
n/a	n/a	1..1	recordTarget/patientRole/**id**		Required CDA element. See <id> for available attributes.
SUBJECT OF CARE > **Participation Period**	The time interval during which the participation in the healthcare event occurred.	0..0	n/a		This logical data component has no mapping to CDA.
SUBJECT OF CARE > **LOCATION OF PARTICIPATION**	Specifies the geographic site (building, room, etc) where the participation of a healthcare event occurs.	0..0	See Known Issues.		LOCATION OF PARTICIPATION is not currently mapped.
SUBJECT OF CARE > **Participation Type**	The categorisation of the nature of the participant's involvement in the healthcare event described by this participation.	1..1	n/a	Participation Type **SHALL** have an implementation-specific value equivalent to "Subject of Care".	Not mapped directly, encompassed implicitly in recordTarget/ typeCode = "RCT" (optional, fixed value).
SUBJECT OF CARE > **Role**	The involvement or role of the participant in the related action from a healthcare perspective rather than the specific participation perspective.	1..1	n/a	Role **SHALL** have an implementation-specific value equivalent to "Patient".	Not mapped directly, encompassed implicitly in recordTarget/ patientRole/ classCode = "PAT".
SUBJECT OF CARE > **PARTICIPANT**	Details pertinent to the identification of an individual or organisation or device that has participated in a healthcare event/encounter/clinical interaction.	1..1	recordTarget/patientRole/**patient**		
SUBJECT OF CARE > PARTICIPANT > **Entity Identifier**	A number or code issued for the purpose of identifying a participant within a healthcare context.	1..*	recordTarget/patientRole/patient/**<Entity Identifier>**	The value of one Entity Identifier **SHALL** be an Australian IHI.	See common pattern: Entity Identifier. The Subject of Care's Medicare card number is recorded in ENTITLEMENT, not Entity Identifier.
SUBJECT OF CARE > PARTICIPANT > **ADDRESS**	The description of a location where an entity is located or can be otherwise reached or found and a description of the purpose for which that address is primarily used by that entity.	1..*	recordTarget/patientRole/**<Address>**	AUSTRALIAN OR INTERNATIONAL ADDRESS **SHALL** be instantiated as an AUSTRALIAN ADDRESS.	See common pattern: Address.
SUBJECT OF CARE > PARTICIPANT > **ELECTRONIC COMMUNICATION DETAIL**	The electronic communication details of entities.	0..*	recordTarget/patientRole/**<Electronic Communication Detail>**		See common pattern: Electronic Communication Detail.

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
SUBJECT OF CARE > PARTICIPANT > **PERSON OR ORGANISATION OR DEVICE**	Represents a choice to be made at run-time between PERSON, ORGANISATION or DEVICE.	1..1	n/a	PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as a PERSON.	This logical data component has no mapping to CDA. The cardinality of this component propagates to its children.
SUBJECT OF CARE > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > **PERSON**	An individual who is in the role of healthcare provider, who uses or is a potential user of a healthcare service, or is in some way related to, or a representative of, a subject of care (patient).	1..1	n/a		Not mapped directly, encompassed implicitly in recordTarget/ patientRole/ patient.
SUBJECT OF CARE > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > **PERSON NAME**	The appellation by which an individual may be identified separately from any other within a social context.	1..*	recordTarget/patientRole/patient/<**Person Name**>		See common pattern: Person Name.
SUBJECT OF CARE > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > **Relationship to Subject of Care**	The relationship of a participant to a subject of care (patient).	0..0	n/a		This logical data component has no mapping to CDA.
SUBJECT OF CARE > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > **EMPLOYMENT DETAIL**	A person's occupation and employer.	0..0	recordTarget/patientRole/patient/**ext:asEmployment**		
SUBJECT OF CARE > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > **DEMOGRAPHIC DATA**	Additional characteristics of a person that may be useful for identification or other clinical purposes.	1..1	n/a		This logical data component has no mapping to CDA. The cardinality of this component propagates to its children.
SUBJECT OF CARE > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > DEMOGRAPHIC DATA > **Sex**	The biological distinction between male and female. Where there is inconsistency between anatomical and chromosomal characteristics, sex is based on anatomical characteristics.	1..1	recordTarget/patientRole/patient/**administrativeGenderCode**	AS 5017-2006 Health Care Client Identifier Sex	administrativeGenderCode/@nullFlavor **SHALL NOT** be present.
SUBJECT OF CARE > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > DEMOGRAPHIC DATA > **DATE OF BIRTH DETAIL**	Details of the accuracy, origin and value of a person's date of birth.	1..1	n/a		This logical data component has no mapping to CDA. The cardinality of this component propagates to its children.
SUBJECT OF CARE > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > DEMOGRAPHIC DATA > DATE OF BIRTH DETAIL > **Date of Birth**	The date of birth of the person.	1..1	recordTarget/patientRole/patient/**birthTime**		See <time> for available attributes.

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Body Level 3 Data Elements			Context: /ClinicalDocument/component/structuredBody/component[admin_obs]/section/ (See *4 Administrative Observations*)		
SUBJECT OF CARE > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > DEMOGRAPHIC DATA > DATE OF BIRTH DETAIL > **Date of Birth is Calculated From Age**	Indicates whether or not a person's date of birth has been derived from the value in the Age data element.	0..1	**entry[calc_age]**		
			entry[calc_age]/**observation**		
			entry[calc_age]/observation/**@classCode="OBS"**		
			entry[calc_age]/observation/**@moodCode="EVN"**		
			entry[calc_age]/observation/**code**		See <code> for available attributes.
			entry[calc_age]/observation/code/**@code="103.16233"**		
			entry[calc_age]/observation/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			entry[calc_age]/observation/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			entry[calc_age]/observation/code/**@displayName="Date of Birth is Calculated From Age"**		
			entry[calc_age]/observation/**id**		See <id> for available attributes.
			entry[calc_age]/observation/**value:BL**		If the date of birth has been calculated from the age this is true, otherwise it is false.

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
SUBJECT OF CARE > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > DEMOGRAPHIC DATA > DATE OF BIRTH DETAIL > **DATE OF BIRTH ACCURACY INDICATOR**	The level of certainty or estimation of a person's date of birth.	0..1	**entry[dob_acc]**		
			entry[dob_acc]/**observation**		
			entry[dob_acc]/observation/**@classCode="OBS"**		
			entry[dob_acc]/observation/**@moodCode="EVN"**		
			entry[dob_acc]/observation/**code**		
			entry[dob_acc]/observation/code/**@code="102.16234"**		
			entry[dob_acc]/observation/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			entry[dob_acc]/observation/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			entry[dob_acc]/observation/code/**@displayName="Date of Birth Accuracy Indicator"**		
			entry[dob_acc]/observation/**id**		See <id> for available attributes.
			entry[dob_acc]/observation/**value:CS**	AS 5017-2006 Health Care Client Identifier Date Accuracy Indicator	
SUBJECT OF CARE > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > DEMOGRAPHIC DATA > DATE OF BIRTH DETAIL > DATE OF BIRTH ACCURACY INDICATOR > **Date of Birth Day Accuracy Indicator**	The accuracy of the day component of a person's date of birth.	1..1	n/a		Encompassed in the mapping for DATE OF BIRTH ACCURACY INDICATOR (above).
SUBJECT OF CARE > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > DEMOGRAPHIC DATA > DATE OF BIRTH DETAIL > DATE OF BIRTH ACCURACY INDICATOR > **Date of Birth Month Accuracy Indicator**	The accuracy of the month component of a person's date of birth.	1..1	n/a		Encompassed in the mapping for DATE OF BIRTH ACCURACY INDICATOR (above).
SUBJECT OF CARE > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > DEMOGRAPHIC DATA > DATE OF BIRTH DETAIL > DATE OF BIRTH ACCURACY INDICATOR > **Date of Birth Year Accuracy Indicator**	The accuracy of the year component of a person's date of birth.	1..1	n/a		Encompassed in the mapping for DATE OF BIRTH ACCURACY INDICATOR (above).

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
SUBJECT OF CARE > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > DEMOGRAPHIC DATA > **AGE DETAIL**	Details of the accuracy and value of a person's age.	0..1	n/a		This logical data component has no mapping to CDA. The cardinality of this component propagates to its children.
SUBJECT OF CARE > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > DEMOGRAPHIC DATA > AGE DETAIL > **Age**	The age of a person/subject of care at the time.	1..1	**entry[age]**		
			entry[age]/**observation**		
			entry[age]/observation/**@classCode="OBS"**		
			entry[age]/observation/**@moodCode="EVN"**		
			entry[age]/observation/**code**		
			entry[age]/observation/code/**@code="103.20109"**		
			entry[age]/observation/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			entry[age]/observation/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			entry[age]/observation/code/**@displayName="Age"**		
			entry[age]/observation/**id**		See <id> for available attributes.
			entry[age]/observation/**value:PQ**		

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
SUBJECT OF CARE > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > DEMOGRAPHIC DATA > AGE DETAIL > **Age Accuracy Indicator**	The accuracy of a person's age.	0..1	**entry[age_acc]**		
			entry[age_acc]/**observation**		
			entry[age_acc]/observation/**@classCode="OBS"**		
			entry[age_acc]/observation/**@moodCode="EVN"**		
			entry[age_acc]/observation/**code**		
			entry[age_acc]/observation/code/**@code="103.16279"**		
			entry[age_acc]/observation/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			entry[age_acc]/observation/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			entry[age_acc]/observation/code/**@displayName="Age Accuracy Indicator"**		
			entry[age_acc]/observation/**id**		See <id> for available attributes.
			entry[age_acc]/observation/**value:BL**		If the age is considered to be accurate, this is true, otherwise it is false.
SUBJECT OF CARE > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > DEMOGRAPHIC DATA > **Birth Plurality**	An indicator of multiple birth, showing the total number of births resulting from a single pregnancy.	0..1	**entry[brth_plr]**		
			entry[brth_plr]/**observation**		
			entry[brth_plr]/observation/**@classCode="OBS"**		
			entry[brth_plr]/observation/**@moodCode="EVN"**		
			entry[brth_plr]/observation/**code**		
			entry[brth_plr]/observation/code/**@code="103.16249"**		
			entry[brth_plr]/observation/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			entry[brth_plr]/observation/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			entry[brth_plr]/observation/code/**@displayName="Birth Plurality"**		
			entry[brth_plr]/observation/**id**		See <id> for available attributes.
			entry[brth_plr]/observation/**value:INT**		

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Header Data Elements			Context: /ClinicalDocument/		
SUBJECT OF CARE > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > DEMOGRAPHIC DATA > **Birth Order**	The sequential order of each baby of a multiple birth regardless of live or still birth.	0..1	recordTarget/patientRole/patient/**ext:multipleBirthInd**		See Australian Digital Health Agency CDA extension: Multiple Birth.
			recordTarget/patientRole/patient/**ext:multipleBirthOrderNumber**		
SUBJECT OF CARE > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > DEMOGRAPHIC DATA > **DATE OF DEATH DETAIL**	Details of the accuracy and value of a person's date of death.	0..1	n/a		This logical data component has no mapping to CDA. The cardinality of this component propagates to its children.
SUBJECT OF CARE > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > DEMOGRAPHIC DATA > DATE OF DEATH DETAIL > **Date of Death**	The date or date and time at which a person was estimated or certified to have died.	1..1	recordTarget/patientRole/patient/**ext:deceasedInd**		See Australian Digital Health Agency CDA extension: Deceased Time.
			recordTarget/patientRole/patient/**ext:deceasedTime**		See <time> for available attributes.

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Body Level 3 Data Elements			Context: /ClinicalDocument/component/structuredBody/component[admin_obs]/section/ (See 4 *Administrative Observations*)		
SUBJECT OF CARE > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > DEMOGRAPHIC DATA > DATE OF DEATH DETAIL > **DATE OF DEATH ACCURACY IN-DICATOR**	The level of certainty or estimation of a person's date of death.	0..1	**entry[dod_acc]**		This logical data com-ponent has no map-ping to CDA. The cardinality of this component propagates to its children.
			entry[dod_acc]/**observation**		
			entry[dod_acc]/observation/**@classCode="OBS"**		
			entry[dod_acc]/observation/**@moodCode="EVN"**		
			entry[dod_acc]/observation/**code**		
			entry[dod_acc]/observation/code/**@code="102.16252"**		
			entry[dod_acc]/observation/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			entry[dod_acc]/observation/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Compon-ents". See CodeSystem OIDs.	Optional CDA element.
			entry[dod_acc]/observation/code/**@displayName="Date of Death Accuracy Indicator"**		
			entry[dod_acc]/observation/**id**		See <id> for available attributes.
			entry[dod_acc]/observation/**value:CS**	AS 5017-2006 Health Care Client Identifier Date Accuracy Indicat-or	
SUBJECT OF CARE > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > DEMOGRAPHIC DATA > DATE OF DEATH DETAIL > DATE OF DEATH ACCURACY INDIC-ATOR > **Date of Death Day Accuracy Indic-ator**	The accuracy of the day component of a person's date of death.	1..1	n/a		Encompassed in the mapping for DATE OF DEATH ACCURACY IN-DICATOR (above).
SUBJECT OF CARE > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > DEMOGRAPHIC DATA > DATE OF DEATH DETAIL > DATE OF DEATH ACCURACY INDIC-ATOR > **Date of Death Month Accuracy Indicator**	The accuracy of the month component of a person's date of death.	1..1	n/a		Encompassed in the mapping for DATE OF DEATH ACCURACY IN-DICATOR (above).

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
SUBJECT OF CARE > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > DEMOGRAPHIC DATA > DATE OF DEATH DETAIL > DATE OF DEATH ACCURACY INDICATOR > **Date of Death Year Accuracy Indicator**	The accuracy of the year component of a person's date of death.	1..1	n/a		Encompassed in the mapping for DATE OF DEATH ACCURACY INDICATOR (above).
SUBJECT OF CARE > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > DEMOGRAPHIC DATA > **Source of Death Notification**	The person, location, organisation or other originator of information relating to the date of death.	0..1	**entry[src_notif]**		
			entry[src_notif]/**observation**		
			entry[src_notif]/observation/**@classCode="OBS"**		
			entry[src_notif]/observation/**@moodCode="EVN"**		
			entry[src_notif]/observation/**code**		
			entry[src_notif]/observation/code/**@code="103.10243"**		
			entry[src_notif]/observation/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			entry[src_notif]/observation/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			entry[src_notif]/observation/code/**@displayName="Source of Death Notification"**		
			entry[src_notif]/observation/**id**		See <id> for available attributes.
			entry[src_notif]/observation/**value:CD**	AS 5017-2006: Health Care Client Source of Death Notification	See <code> for available attributes.

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
SUBJECT OF CARE > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > DEMOGRAPHIC DATA > **Mother's Original Family Name**	The original family name of the person's mother.	0..1	**entry[mothers_name]**		
			entry[mothers_name]/**observation**		
			entry[mothers_name]/observation/**@classCode="OBS"**		
			entry[mothers_name]/observation/**@moodCode="EVN"**		
			entry[mothers_name]/observation/**code**		
			entry[mothers_name]/observation/code/**@code="103.10245"**		
			entry[mothers_name]/observation/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			entry[mothers_name]/observation/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See _CodeSystem OIDs_.	Optional CDA element.
			entry[mothers_name]/observation/code/**@displayName="Mother's Original Family Name"**		
			entry[mothers_name]/observation/**id**		See <id> for available attributes.
			entry[mothers_name]/observation/**value:PN**		
CDA Header Data Elements			Context: /ClinicalDocument/		
SUBJECT OF CARE > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > DEMOGRAPHIC DATA > **Country of Birth**	The country in which the person was born.	0..1	recordTarget/patientRole/patient/**birthplace/place/addr/country**	_1269.0 - Standard Australian Classification of Countries (SACC), Second Edition [ABS2008]_	Use the name, not the numbered code.
SUBJECT OF CARE > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > DEMOGRAPHIC DATA > **State/Territory of Birth**	The identifier of the Australian state or territory where a person is born.	0..1	recordTarget/patientRole/patient/**birthplace/place/addr/state**	AS 5017-2006 Australian State/Territory Identifier - Postal	
SUBJECT OF CARE > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > DEMOGRAPHIC DATA > **Indigenous Status**	Indigenous Status is a measure of whether a person identifies as being of Aboriginal or Torres Strait Islander origin.	1..1	recordTarget/patientRole/patient/**ethnicGroupCode**	METeOR 291036: Indigenous Status	ethnicGroupCode/@nullFlavor **SHALL NOT** be present.

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Body Level 3 Data Elements			Context: /ClinicalDocument/component/structuredBody/component[admin_obs]/section/ (See 4 *Administrative Observations*)		
SUBJECT OF CARE > PARTICIPANT > **ENTITLEMENT**	The entitlement or right of a participant to act in a given capacity (as defined by Entitlement Type) within a healthcare context.	0..*	**ext:coverage2[sub_care]/@typeCode="COVBY"**		See Australian Digital Health Agency CDA extension: Entitlement.
			ext:coverage2[sub_care]/**ext:entitlement**		
			ext:coverage2[sub_care]/ext:entitlement/**@classCode="COV"**		
			ext:coverage2[sub_care]/ext:entitlement/**@moodCode="EVN"**		
			ext:coverage2[sub_care]/ext:entitlement/**ext:participant/@typeCode="BEN"**		
			ext:coverage2[sub_care]/ext:entitlement/ext:participant/**ext:participantRole/@classCode="PAT"**		
			ext:coverage2[sub_care]/ext:entitlement/ext:participant/ext:participantRole/**ext:id**		This **SHALL** hold the same value as ClinicalDocument/ recordTarget/ patientRole/ **id**.
SUBJECT OF CARE > PARTICIPANT > ENTITLEMENT > **Entitlement Number**	A number or code issued for the purpose of identifying the entitlement or right of a participant to act in a given capacity (as defined by Entitlement Type) within a healthcare context.	1..1	ext:coverage2[sub_care]/ext:entitlement/**ext:id**		See <id> for available attributes.
SUBJECT OF CARE > PARTICIPANT > ENTITLEMENT > **Entitlement Type**	The description of the scope of an entitlement.	1..1	ext:coverage2[sub_care]/ext:entitlement/**ext:code**	NCTIS: Admin Codes - Entitlement Type	See <code> for available attributes.
SUBJECT OF CARE > PARTICIPANT > ENTITLEMENT > **Entitlement Validity Duration**	The time interval for which an entitlement is valid.	0..1	ext:coverage2[sub_care]/ext:entitlement/**ext:effectiveTime**		See <time> for available attributes.
CDA Header Data Elements			Context: /ClinicalDocument/		
SUBJECT OF CARE > PARTICIPANT > **Qualifications**	A list of professional certifications, and certificates recognising having passed a course.	0..0	n/a		This logical data component has no mapping to CDA.

Example 6.2. SUBJECT OF CARE XML Fragment

```xml
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<ClinicalDocument
 xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
 …
 >
 <!-- Begin CDA Header -->
 …

 <!-- Begin SUBJECT OF CARE - Header Part -->
 <recordTarget typeCode="RCT">
  <patientRole classCode="PAT">
   <!-- This system generated id is used for matching patient Entitlement -->
   <id root="52b9470e-db0b-45aa-9a81-86e5243b84df"/>

   <!-- ADDRESS -->
   <addr use="H">
    <streetAddressLine>1 Patient Street</streetAddressLine>
    <city>Healthville</city>
    <state>QLD</state>
    <postalCode>5555</postalCode>
    <additionalLocator>32568931</additionalLocator>
    <country>Australia</country>
   </addr>

   <!-- ELECTRONIC COMMUNICATION DETAIL -->
   <telecom use="H" value="tel:0499999999"/>

   <!-- Begin PARTICIPANT -->
   <patient>

    <!-- PERSON NAME -->
    <name use="L">
     <prefix>Ms</prefix>
     <given>Sally</given>
     <family>Grant</family>
    </name>

    <!-- Sex -->
    <administrativeGenderCode code="F"
     codeSystem="2.16.840.1.113883.13.68"
     codeSystemName="AS 5017-2006 Health Care Client Identifier Sex"/>

    <!-- Date of Birth -->
    <birthTime value="19480607"/>

    <!-- Indigenous Status -->
    <ethnicGroupCode code="4" codeSystem="2.16.840.1.113883.3.879.291036" codeSystemName="METeOR Indigenous Status"
     displayName="Neither Aboriginal nor Torres Strait Islander origin" />

    <!-- Multiple Birth Indicator -->
    <ext:multipleBirthInd value="true"/>
    <ext:multipleBirthOrderNumber value="2"/>
```

```xml
    <!-- Date of Death -->
    <ext:deceasedInd value="true"/>
    <ext:deceasedTime value="20101201"/>

    <!-- Country of Birth/State of Birth -->
    <birthplace>
    <place>
     <addr>
      <country>Australia</country>
      <state>QLD</state>
     </addr>
    </place>
    </birthplace>

    <!-- Entity Identifier -->
    <ext:asEntityIdentifier classCode="IDENT">
     <ext:id assigningAuthorityName="IHI" root="1.2.36.1.2001.1003.0.8003608833357361"/>
     <ext:assigningGeographicArea classCode="PLC">
      <ext:name>National Identifier</ext:name>
     </ext:assigningGeographicArea>
    </ext:asEntityIdentifier>

   </patient>
   <!-- End PARTICIPANT -->
  </patientRole>
 </recordTarget>
<!-- End SUBJECT OF CARE - Header Part -->
…

<!-- End CDA Header -->

<!-- Begin CDA Body -->
<component>
 <structuredBody>
  …

  <!-- Begin Administrative Observations -->
  <component>
   <section>
    <code code="102.16080"
     codeSystem="1.2.36.1.2001.1001.101"
     codeSystemName="NCTIS Data Components"
     displayName="Administrative Observations"/>
    <title>Administrative Observations</title>

    <!-- narrative block -->
    <text>
     <table>
      <tbody>
       <tr>
        <th>Date of Birth is Calculated From Age</th>
        <td>True</td>
       </tr>
       <tr>
        <th>Date of Birth Accuracy Indicator</th>
        <td>AAA</td>
       </tr>
       <tr>
        <th>Age</th>
        <td>54</td>
       </tr>
       <tr>
```

```
     <th>Age Accuracy Indicator</th>
     <td>True</td>
    </tr>
    <tr>
     <th>Birth Plurality</th>
     <td>3</td>
    </tr>
    <tr>
     <th>Australian Medicare Card Number</th>
     <td>2296818481</td>
    </tr>
    …

   </tbody>
  </table>
</text>
…

<!-- Begin SUBJECT OF CARE - Body -->
<!-- Begin Date of Birth is Calculated From Age -->
<entry><!-- [calc_age] -->
 <observation classCode="OBS" moodCode="EVN">
  <id root="fe8bdabd-d5c9-4957-9fd7-bc706b6677e4"/>
  <code code="103.16233"
   codeSystem="1.2.36.1.2001.1001.101"
   codeSystemName="NCTIS Data Components"
   displayName="Date of Birth is Calculated From Age"/>
  <value value="true" xsi:type="BL"/>
 </observation>
</entry><!-- [calc_age] -->
<!-- End Date of Birth is Calculated From Age -->

<!-- Begin DATE OF BIRTH ACCURACY INDICATOR -->
<entry><!-- [dob_acc] -->
 <observation classCode="OBS" moodCode="EVN">
  <id root="27750576-64de-4e5c-9ec8-06c35b55c31d"/>
  <code code="102.16234"
   codeSystem="1.2.36.1.2001.1001.101"
   codeSystemName="NCTIS Data Components"
   displayName="Date of Birth Accuracy Indicator"/>
  <value code="AAA" xsi:type="CS"/>
 </observation>
</entry><!-- [dob_acc] -->
<!-- End DATE OF BIRTH ACCURACY INDICATOR -->

<!-- Begin Age -->
<entry><!-- [age] -->
 <observation classCode="OBS" moodCode="EVN">
  <id root="f3ca6643-d9c0-4112-80ef-0afe478ed11f"/>
  <code code="103.20109"
   codeSystem="1.2.36.1.2001.1001.101"
   codeSystemName="NCTIS Data Components"
   displayName="Age"/>
  <value xsi:type="PQ" value="54" unit="a"/>
 </observation>
</entry><!-- [age] -->
<!-- End Age -->

<!-- Begin Age Accuracy Indicator -->
<entry><!-- [age_acc] -->
 <observation classCode="OBS" moodCode="EVN">
  <id root="55f4cdea-ef2d-4771-a600-800f95fc0abf"/>
  <code code="103.16279"
```

```xml
            codeSystem="1.2.36.1.2001.1001.101"
            codeSystemName="NCTIS Data Components"
            displayName="Age Accuracy Indicator"/>
           <value value="true" xsi:type="BL"/>
         </observation>
        </entry><!-- [age_acc] -->
        <!-- End Age Accuracy Indicator -->

        <!-- Begin Birth Plurality -->
        <entry><!-- [birth_plr] -->
         <observation classCode="OBS" moodCode="EVN">
          <id root="344b0577-750c-48e6-998d-b38f4ec86d0e"/>
          <code code="103.16249"
           codeSystem="1.2.36.1.2001.1001.101"
           codeSystemName="NCTIS Data Components"
           displayName="Birth Plurality"/>
          <value value="3" xsi:type="INT"/>
         </observation>
        </entry><!-- [birth_plr] -->
        <!-- End Birth Plurality -->

        <!-- Begin DATE OF DEATH ACCURACY INDICATOR -->
        <entry><!-- [dod_acc] -->
         <observation classCode="OBS" moodCode="EVN">
          <id root="455bee4e-ee44-43f1-b722-5ddff67a18c6"/>
          <code code="102.16252"
           codeSystem="1.2.36.1.2001.1001.101"
           codeSystemName="NCTIS Data Components"
           displayName="Date of Death Accuracy Indicator"/>
          <value code="AAA" xsi:type="CS"/>
         </observation>
        </entry><!-- [dod_acc] -->
        <!-- End DATE OF DEATH ACCURACY INDICATOR -->

        <!-- Begin SUBJECT OF CARE ENTITLEMENT -->
        <ext:coverage2 typeCode="COVBY">
         <ext:entitlement classCode="COV" moodCode="EVN">
          <ext:id assigningAuthorityName="Medicare Card Number" root="1.2.36.1.5001.1.0.7.1" extension="2296818481" />
          <ext:code code="1" codeSystem="1.2.36.1.2001.1001.101.104.16047" codeSystemName="NCTIS Entitlement Type Values" displayName="Medicare Benefits"/>
          <ext:effectiveTime>
           <high value="20110101"/>
          </ext:effectiveTime>
          <ext:participant typeCode="BEN">
           <ext:participantRole classCode="PAT">
            <ext:id root="52b9470e-db0b-45aa-9a81-86e5243b84df" />
           </ext:participantRole>
          </ext:participant>
         </ext:entitlement>
        </ext:coverage2>
        <!-- End SUBJECT OF CARE ENTITLEMENT -->
        <!-- End SUBJECT OF CARE - Body -->
        …

       </section>
      </component>
      <!-- End Administrative Observations -->
      …

    </structuredBody>
   </component>
   <!-- End CDA Body -->
</ClinicalDocument>
```

6.1.2 DOCUMENT AUTHOR

Identification

Name	DOCUMENT AUTHOR
Metadata Type	Data Group
Identifier	DG-10296

Relationships

Parent

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

Choices

Note

Mentioned below are the possible mutually exclusive 'DOCUMENT AUTHOR' instantiation choices.

Data Type	Name
	DOCUMENT AUTHOR as a PERSON - Not a Healthcare Provider
	DOCUMENT AUTHOR as a PERSON - Healthcare Provider

6.1.2.1 DOCUMENT AUTHOR as a PERSON - Not a Healthcare Provider

CDA R-MIM Representation

Figure 6.4 Document Author shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Header elements.

The DOCUMENT AUTHOR data group instantiated as PERSON is related to its context of ClinicalDocument by the author participation class. An author is a person in the role of assignedAuthor (AssignedAuthor class). The entity playing the role is assignedAuthorChoice (Person class). The entity identifier of the participant is mapped to the EntityIdentifier class (Australian Digital Health Agency CDA extension) and is associated to the assignedAuthorChoice.

Figure 6.4. Document Author

CDA Mapping

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Header Data Elements			Context: /ClinicalDocument/		
DOCUMENT AUTHOR	Composer of the document.	1..1	**author**		Document Author **SHALL** be filled with either the Subject of Care or Subject of Care's Representative depending on who authored the document.
n/a	n/a	1..1	author/assignedAuthor/**id**		Required CDA element.
DOCUMENT AUTHOR > **Participation Period**	The time interval during which the participation in the healthcare event occurred.	1..1	author/**time**	Although the definition of this element states that it is a time interval, the following applies: "The end of the participation period of a Document Author participation is the time associated with the completion of editing the content of a document." Thus only the end time need be recorded.	Required CDA element. The author/time element **SHALL** be implemented as either: • a value attribute (populated with the end time of the authorship or encounter, as appropriate); or • a high element AND a low element, both with value attributes and neither with a nullFlavor attribute.
DOCUMENT AUTHOR > **LOCATION OF PARTICIPATION**	Specifies the geographic site (building, room, etc) where the participation of a healthcare event occurs.	0..0	See Known Issues.		LOCATION OF PARTICIPATION is not currently mapped.
DOCUMENT AUTHOR > **Participation Type**	The categorisation of the nature of the participant's involvement in the healthcare event described by this participation.	1..1	n/a	Participation Type **SHALL** have an implementation-specific value equivalent to "Document Author".	Not mapped directly; encompassed implicitly in author/typeCode="AUT" (optional, fixed value).
DOCUMENT AUTHOR > **Role**	The involvement or role of the participant in the related action from a healthcare perspective rather than the specific participation perspective.	1..1	author/**assignedAuthor/code**	The code **SHALL** be "AGNT" if the "Document Author" is a "Subject of Care's Representative". The code **SHALL** be "SELF" if the "Document Author" is same as the "Subject of Care". HL7 RoleCode and RoleClass codes	See <code> for available attributes. Role **SHOULD** have an implementation specific value equivalent to "Subject of Care" or "Subject of Care's Representative". However, other similar values **MAY** be appropriate.
DOCUMENT AUTHOR > **PARTICIPANT**	Details pertinent to the identification of an individual or organisation or device that has participated in a healthcare event/encounter/clinical interaction.	1..1	author/assignedAuthor/**assignedPerson**		
DOCUMENT AUTHOR > PARTICIPANT > **Entity Identifier**	A number or code issued for the purpose of identifying a participant within a healthcare context.	1..*	author/assignedAuthor/assignedPerson/<**Entity Identifier**>	The value of one Entity Identifier **SHALL** be an Australian IHI or a Care Agency Employee Identifier.	See common pattern: Entity Identifier.

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
DOCUMENT AUTHOR > PARTICIPANT > **AD-DRESS**	The description of a location where an entity is located or can be otherwise reached or found and a description of the purpose for which that address is primarily used by that entity.	0..*	author/assignedAuthor/**<Address>**		See common pattern: Address.
DOCUMENT AUTHOR > PARTICIPANT > **ELECTRONIC COMMUNICATION DETAIL**	The electronic communication details of entities.	0..*	author/assignedAuthor/**<Electronic Communication Detail>**		See common pattern: Electronic Communication Detail.
DOCUMENT AUTHOR > PARTICIPANT > **PERSON OR ORGANISATION OR DEVICE**	Represents a choice to be made at run-time between PERSON, ORGANISATION or DEVICE.	1..1	n/a	PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as a PERSON.	This logical data component has no mapping to CDA. The cardinality of this component propagates to its children.
DOCUMENT AUTHOR > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > **PERSON**	An individual who is in the role of healthcare provider, who uses or is a potential user of a healthcare service, or is in some way related to, or a representative of, a subject of care (patient).	1..1	n/a		Not mapped directly; encompassed implicitly in author/assignedAuthor/assignedPerson.
DOCUMENT AUTHOR > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > **PERSON NAME**	The appellation by which an individual may be identified separately from any other within a social context.	1..*	author/assignedAuthor/assignedPerson/**<Person Name>**		See common pattern: Person Name.
DOCUMENT AUTHOR > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > **Relationship to Subject of Care**	The relationship of a participant to a subject of care (patient).	0..0	author/assignedAuthor/assignedPerson/**ext:personalRelationship**		
DOCUMENT AUTHOR > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > **EMPLOYMENT DETAIL**	A person's occupation and employer.	0..0	author/assignedAuthor/assignedPerson/**ext:asEmployment**		
DOCUMENT AUTHOR > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > **DEMOGRAPHIC DATA**	Additional characteristics of a person that may be useful for identification or other clinical purposes.	0..0	n/a		This logical data component has no mapping to CDA. The cardinality of this component propagates to its children.
			author/assignedAuthor/assignedPerson/**ext:administrativeGenderCode**		
			author/assignedAuthor/assignedPerson/**ext:birthTime**		
CDA Body Level 3 Data Elements			Context: /ClinicalDocument/component/structuredBody/component[admin_obs]/section/ (See 4 Administrative Observations)		
DOCUMENT AUTHOR > PARTICIPANT > **ENTITLEMENT**	The entitlement or right of a participant to act in a given capacity (as defined by Entitlement Type) within a healthcare context.	0..0	See Known Issues.		Prohibition of ENTITLEMENT is not currently mapped.
CDA Header Data Elements			Context: /ClinicalDocument/		
DOCUMENT AUTHOR > PARTICIPANT > **Qualifications**	A list of professional certifications, and certificates recognising having passed a course.	0..0	author/assignedAuthor/assignedPerson/**ext:asQualifications**		

Example 6.3. DOCUMENT AUTHOR as a PERSON - Not a Healthcare Provider XML Fragment

```xml
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<ClinicalDocument
 xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
 …
 >
 <!-- Begin CDA Header -->
 …

 <!-- Begin DOCUMENT AUTHOR -->
 <author>

  <!-- Participation Period -->
  <time value="200910201235+1000"/>

  <assignedAuthor>
   <!-- id is used for system purposes such as matching -->
   <id root="b830b9a6-4ea7-4a1a-92eb-ddf18b82a291"/>

   <!-- Role -->
   <code code="AGNT"
    codeSystemName="RoleClass"
    codeSystem="2.16.840.1.113883.5.110"
    displayName="agent"/>

   <!-- ADDRESS -->
   <addr use="PST">
    <streetAddressLine>11 Agent Street</streetAddressLine>
    <city>Healthville</city>
    <state>QLD</state>
    <postalCode>5555</postalCode>
    <additionalLocator>32568932</additionalLocator>
    <country>Australia</country>
   </addr>

   <!-- ELECTRONIC COMMUNICATION DETAIL -->
   <telecom use="H" value="tel:0712341235"/>

   <!-- PARTICIPANT -->
   <assignedPerson>
    <!-- PERSON NAME -->
    <name>
     <prefix>Mr</prefix>
     <given>Robert</given>
     <family>Grant</family>
    </name>

    <!-- Entity Identifier -->
    <ext:asEntityIdentifier classCode="IDENT">
     <ext:id assigningAuthorityName="IHI" root="1.2.36.1.2001.1003.0.8003608833357362"/>
     <ext:assigningGeographicArea classCode="PLC">
      <ext:name>National Identifier</ext:name>
     </ext:assigningGeographicArea>
```

```
        </ext:asEntityIdentifier>

      </assignedPerson>
    </assignedAuthor>
  </author>
  <!-- End DOCUMENT AUTHOR -->

  …
  <!-- End CDA Header -->

</ClinicalDocument>
```

6.1.2.2 DOCUMENT AUTHOR as a PERSON - Healthcare Provider

CDA R-MIM Representation

Figure 6.5 DOCUMENT AUTHOR shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Header elements.

The DOCUMENT AUTHOR data group instantiated as PERSON is related to its context of ClinicalDocument by the author participation class. An author is a person in the role of assignedAuthor (AssignedAuthor class). The entity playing the role is assignedAuthorChoice (Person class). The entity identifier of the participant is mapped to the EntityIdentifier class (Australian Digital Health Agency CDA extension) and is associated to the assignedAuthorChoice.
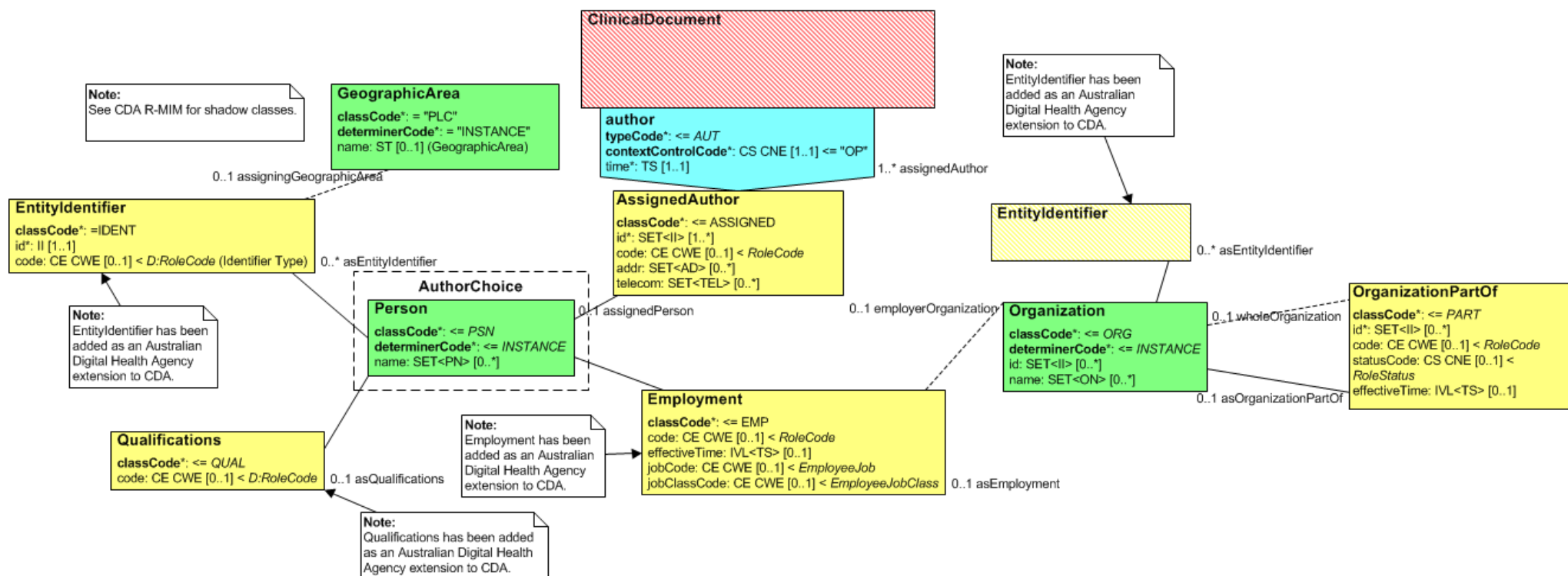
Figure 6.5. DOCUMENT AUTHOR

Figure 6.6 DOCUMENT AUTHOR - Entitlement shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Body elements.
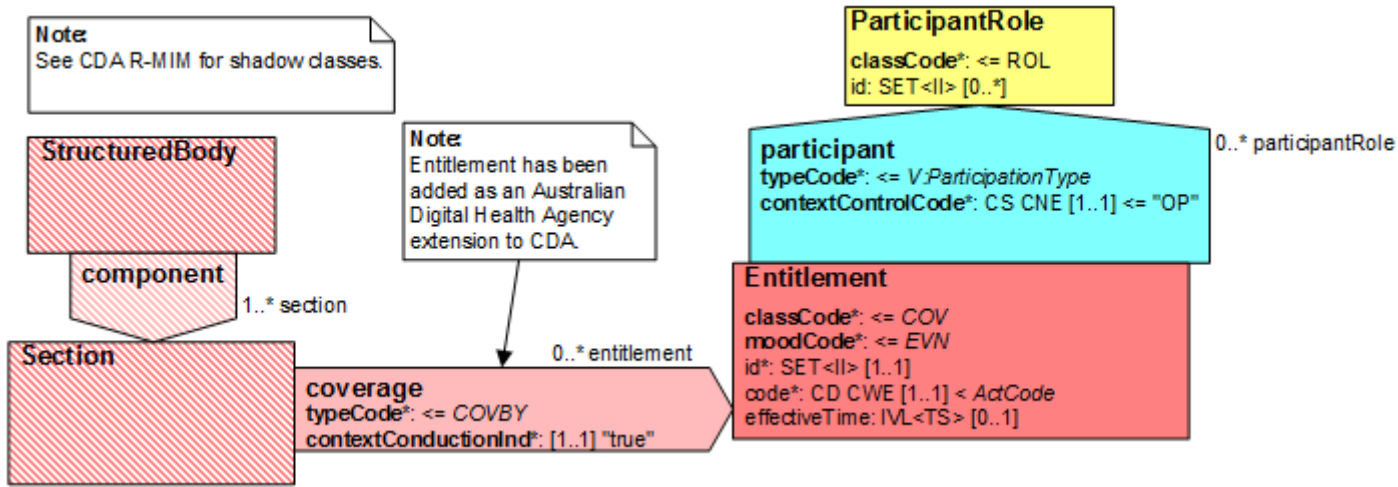
Figure 6.6. DOCUMENT AUTHOR - Entitlement

CDA Mapping

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Header Data Elements			Context: /ClinicalDocument/		
DOCUMENT AUTHOR	Composer of the document.	1..1	**author**		Document Author **SHALL** be filled with the Healthcare Provider who authored the document.
n/a	n/a	1..1	author/assignedAuthor/**id**		Required CDA element. See <id> for available attributes.
DOCUMENT AUTHOR > **Participation Period**	The time interval during which the participation in the healthcare event occurred.	1..1	author/**time**	Although the definition of this element states that it is a time interval, the following applies: "The end of the participation period of a Document Author participation is the time associated with the completion of editing the content of a document." Thus only the end time need be recorded.	Required CDA element. The author/time element **SHALL** be implemented as either: • a value attribute (populated with the end time of the authorship or encounter, as appropriate); or • a high element AND a low element, both with value attributes and neither with a nullFlavor attribute.
DOCUMENT AUTHOR > **LOCATION OF PARTICIPATION**	Specifies the geographic site (building, room, etc) where the participation of a healthcare event occurs.	0..0	See Known Issues.		LOCATION OF PARTICIPATION is not currently mapped.
DOCUMENT AUTHOR > **Participation Type**	The categorisation of the nature of the participant's involvement in the healthcare event described by this participation.	1..1	n/a	Participation Type **SHALL** have an implementation-specific value equivalent to "Document Author".	Not mapped directly; encompassed implicitly in author/typeCode="AUT" (optional, fixed value).
DOCUMENT AUTHOR > **Role**	The involvement or role of the participant in the related action from a healthcare perspective rather than the specific participation perspective.	1..1	author/**assignedAuthor/code**	Role **SHOULD** have a value chosen from *1220.0 - ANZSCO - Australian and New Zealand Standard Classification of Occupations, First Edition, Revision 1 [ABS2009]*. However, if a suitable value in this set cannot be found, then any code set that is both registered with HL7 and publicly available **MAY** be used.	See <code> for available attributes.
DOCUMENT AUTHOR > **PARTICIPANT**	Details pertinent to the identification of an individual or organisation or device that has participated in a healthcare event/encounter/clinical interaction.	1..1	author/assignedAuthor/**assignedPerson**		
DOCUMENT AUTHOR > PARTICIPANT > **Entity Identifier**	A number or code issued for the purpose of identifying a participant within a healthcare context.	1..*	author/assignedAuthor/assignedPerson/<**Entity Identifier**>	The value of one Entity Identifier **SHALL** be an Australian HPI-I.	See common pattern: Entity Identifier.

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
DOCUMENT AUTHOR > PARTICIPANT > **AD-DRESS**	The description of a location where an entity is located or can be otherwise reached or found and a description of the purpose for which that address is primarily used by that entity.	0..*	author/assignedAuthor/**<Address>**	Address Purpose (addr/@use) **SHALL** be set to Business (see AS 5017-2006: Health Care Client Identifier Address Purpose).	See common pattern: Address.
DOCUMENT AUTHOR > PARTICIPANT > **ELECTRONIC COMMUNICATION DETAIL**	The electronic communication details of entities.	1..*	author/assignedAuthor/**<Electronic Communication Detail>**	Electronic Communication Usage Code (telecom/@use) **SHALL** be set to Workplace (see HL7: Telecommu-nicationAddressUse).	See common pattern: Electronic Communication Detail.
DOCUMENT AUTHOR > PARTICIPANT > **PERSON OR ORGANISATION OR DEVICE**	Represents a choice to be made at run-time between PERSON, ORGANISATION or DEVICE.	1..1	n/a	PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as a PERSON.	This logical data component has no mapping to CDA. The cardinality of this component propagates to its children.
DOCUMENT AUTHOR > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > **PERSON**	An individual who is in the role of healthcare provider, who uses or is a potential user of a healthcare service, or is in some way related to, or a representative of, a subject of care (patient).	1..1	n/a		Not mapped directly; encompassed implicitly in author/assignedAu-thor/assignedPerson.
DOCUMENT AUTHOR > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > **PERSON NAME**	The appellation by which an individual may be identified separately from any other within a social context.	1..*	author/assignedAuthor/assignedPerson/**<Person Name>**		See common pattern: Person Name.
DOCUMENT AUTHOR > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > **Relationship to Subject of Care**	The relationship of a participant to a subject of care (patient).	0..0	author/assignedAuthor/assignedPerson/**ext:personalRelationship**		
DOCUMENT AUTHOR > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > **EMPLOYMENT DETAIL**	A person's occupation and employer.	1..1	author/assignedAuthor/assignedPerson/**<Employment>**		See common pattern: Employment.
DOCUMENT AUTHOR > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > **DEMOGRAPHIC DATA**	Additional characteristics of a person that may be useful for identification or other clinical purposes.	0..0	n/a		This logical data component has no mapping to CDA. The cardinality of this component propagates to its children.
			author/assignedAuthor/assignedPerson/**ext:administrativeGenderCode**		
			author/assignedAuthor/assignedPerson/**ext:birthTime**		

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Body Level 3 Data Elements			Context: /ClinicalDocument/component/structuredBody/component[admin_obs]/section/ (See *4 Administrative Observations*)		
DOCUMENT AUTHOR > PARTICIPANT > **EN-TITLEMENT**	The entitlement or right of a participant to act in a given capacity (as defined by Entitlement Type) within a health-care context.	0..*	**ext:coverage2[doc_auth]/@typeCode="COVBY"**		
			ext:coverage2[doc_auth]/**ext:entitlement**		
			ext:coverage2[doc_auth]/ext:entitlement/**@classCode="COV"**		
			ext:coverage2[doc_auth]/ext:entitlement/**@moodCode="EVN"**		
			ext:coverage2[doc_auth]/ext:entitlement/**ext:participant/@typeCode="HLD"**		
			ext:coverage2[doc_auth]/ext:entitlement/ext:participant/**ext:participantRole/ @classCode="ASSIGNED"**		
			ext:coverage2[doc_auth]/ext:entitlement/ext:participant/ext:participantRole/**ext:id**		This **SHALL** hold the same value as author/assignedAuthor/id.
DOCUMENT AUTHOR > PARTICIPANT > ENTITLEMENT > **Entitlement Number**	A number or code issued for the purpose of identifying the entitlement or right of a participant to act in a given capacity (as defined by Entitlement Type) within a healthcare context.	1..1	ext:coverage2[doc_auth]/ext:entitlement/**ext:id**		See <id> for available attributes.
DOCUMENT AUTHOR > PARTICIPANT > ENTITLEMENT > **Entitlement Type**	The description of the scope of an entitlement.	1..1	ext:coverage2[doc_auth]/ext:entitlement/**ext:code**	NCTIS: Admin Codes - Entitlement Type	See <code> for available attributes.
DOCUMENT AUTHOR > PARTICIPANT > ENTITLEMENT > **Entitlement Validity Duration**	The time interval for which an entitlement is valid.	0..1	ext:coverage2[doc_auth]/ext:entitlement/**ext:effectiveTime**		See <time> for available attributes.
CDA Header Data Elements			Context: /ClinicalDocument/		
DOCUMENT AUTHOR > PARTICIPANT > **Qualifications**	A list of professional certifications, and certificates recognising having passed a course.	0..1	author/assignedAuthor/assignedPerson/**ext:asQualifications**		See Australian Digital Health Agency CDA extension: Qualifications.
			author/assignedAuthor/assignedPerson/ext:asQualifications/**@classCode="QUAL"**		
			author/assignedAuthor/assignedPerson/ext:asQualifications/**ext:code/originalText**	Qualifications is a text field, so the text list is entered in the original-Text field of the code element.	

Example 6.4. DOCUMENT AUTHOR as a PERSON - Healthcare Provider XML Fragment

```xml
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<ClinicalDocument
 xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
 …
 >
 <!-- Begin CDA Header -->
 …

 <!-- Begin DOCUMENT AUTHOR -->
 <author>

  <!-- Participation Period -->
  <time value="200910201235+1000"/>

  <assignedAuthor>
   <!-- id is used for system purposes such as matching -->
   <id root="b830b9a6-4ea7-4a1a-92eb-ddf18b82a291"/>

   <!-- Role -->
   <code code="253111" codeSystem="2.16.840.1.113883.13.62"
    codeSystemName="1220.0 - ANZSCO - Australian and New Zealand Standard Classification of Occupations, First Edition, Revision 1"
    displayName="General Medical Practitioner" />

   <!-- ADDRESS -->
   <addr use="WP">
    <streetAddressLine>1 Clinician Street</streetAddressLine>
    <city>Healthville</city>
    <state>QLD</state>
    <postalCode>5555</postalCode>
    <additionalLocator>32568931</additionalLocator>
    <country>Australia</country>
   </addr>

   <!-- ELECTRONIC COMMUNICATION DETAIL -->
   <telecom use="WP" value="tel:0712341234"/>

   <assignedPerson>
    <!-- PERSON NAME -->
    <name>
     <prefix>Dr.</prefix>
     <given>Good</given>
     <family>Doctor</family>
    </name>

    <!-- Entity Identifier -->
    <ext:asEntityIdentifier classCode="IDENT">
     <ext:id assigningAuthorityName="HPI-I" root="1.2.36.1.2001.1003.0.8003619900015717" />
     <ext:assigningGeographicArea classCode="PLC">
      <ext:name>National Identifier</ext:name>
     </ext:assigningGeographicArea>
    </ext:asEntityIdentifier>
```

```
<!-- Begin EMPLOYMENT DETAIL -->
<ext:asEmployment classCode="EMP">
 <!-- Position In Organisation -->
 <ext:code>
  <originalText>GP</originalText>
 </ext:code>

 <!-- Occupation -->
 <ext:jobCode code="253111" codeSystem="2.16.840.1.113883.13.62"
  codeSystemName="1220.0 - ANZSCO - Australian and New Zealand Standard Classification of Occupations, First Edition, Revision 1"
  displayName="General Medical Practitioner" />

 <!-- Employment Type -->
 <ext:jobClassCode code="FT" codeSystem="2.16.840.1.113883.5.1059"
  codeSystemName="HL7:EmployeeJobClass"
  displayName="full-time" />

 <!-- Begin EMPLOYER ORGANISATION -->
 <ext:employerOrganization>

  <!-- Department/Unit -->
  <name>Acme Hospital One</name>

  <asOrganizationPartOf>
   <wholeOrganization>
    <!-- Organisation Name -->
    <name use="ORGB">Acme Hospital Group</name>

    <!-- ELECTRONIC COMMUNICATION DETAIL -->
    <telecom use="WP" value="tel:0712341234" />

    <!-- ADDRESS -->
    <addr use="WP">
     <streetAddressLine>1 Clinician Street</streetAddressLine>
     <city>Healthville</city>
     <state>QLD</state>
     <postalCode>5555</postalCode>
     <additionalLocator>32568931</additionalLocator>
    </addr>

    <!-- Entity Identifier -->
    <ext:asEntityIdentifier classCode="IDENT">
     <ext:id assigningAuthorityName="HPI-O" root="1.2.36.1.2001.1003.0.8003621566684455" />
     <ext:assigningGeographicArea classCode="PLC">
      <ext:name>National Identifier</ext:name>
     </ext:assigningGeographicArea>
    </ext:asEntityIdentifier>

   </wholeOrganization>
  </asOrganizationPartOf>
 </ext:employerOrganization>
 <!-- End EMPLOYER ORGANISATION -->

</ext:asEmployment>
<!-- End EMPLOYMENT DETAIL -->

<!-- Qualifications -->
<ext:asQualifications classCode="QUAL">
 <ext:code>
  <originalText>M.B.B.S</originalText>
 </ext:code>
</ext:asQualifications>
```

```xml
    </assignedPerson>
   </assignedAuthor>
  </author>
  <!-- End DOCUMENT AUTHOR -->
  …

  <!-- End CDA Header -->

  <!-- Begin CDA Body -->
  <component>
   <structuredBody>
    …

    <!-- Begin Administrative Observations -->
    <component>
     <section>
      <code code="102.16080" codeSystem="1.2.36.1.2001.1001.101" codeSystemName="NCTIS Data Components" displayName="Administrative Observations"/>
      <title>Administrative Observations</title>
      <!-- narrative block -->
      <text>
       <table>
        <tbody>
         <tr>
          <th>Australian Medicare Prescriber Number</th>
          <td>049960CT</td>
         </tr>
        </tbody>
       </table>
      </text>
      …

      <!-- Begin DOCUMENT AUTHOR ENTITLEMENT -->
      <ext:coverage2 typeCode="COVBY">
       <ext:entitlement classCode="COV" moodCode="EVN">
        <ext:id assigningAuthorityName="Medicare Prescriber number" root="1.2.36.174030967.0.3" extension="049960CT" />
        <ext:code code="10" codeSystem="1.2.36.1.2001.1001.101.104.16047" codeSystemName="NCTIS Entitlement Type Values"
         displayName="Medicare Prescriber Number" />
        <ext:effectiveTime>
         <low value="200501010101+1100" />
         <high value="202501010101+1100" />
        </ext:effectiveTime>
        <ext:participant typeCode="HLD">
         <ext:participantRole classCode="ASSIGNED">
          <!-- Same as the author (assignedAuthor) id -->
          <ext:id root="b830b9a6-4ea7-4a1a-92eb-ddf18b82a291" />
         </ext:participantRole>
        </ext:participant>
       </ext:entitlement>
      </ext:coverage2>
      <!-- End DOCUMENT AUTHOR ENTITLEMENT -->
      …

     </section>
    </component>
    <!-- End Administrative Observations -->
    …

   </structuredBody>
  </component>
  <!-- End CDA Body -->
 </ClinicalDocument>
```

7 Content Data Specification - CDA Mapping

7.1 ADVANCE CARE INFORMATION

Identification

Name	ADVANCE CARE INFORMATION
Metadata Type	Structured Document
Identifier	SD-16975

Relationships

Children

Data Type	Name	Occurrence
	ADVANCE CARE INFORMATION SECTION	1..1

CDA R-MIM Representation

Figure 7.1 ADVANCE CARE INFORMATION shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Body elements.

ADVANCE CARE INFORMATION is composed of a ClinicalDocument class, which is the entry point into the CDA R-MIM. The ClinicalDocument is associated with the bodyChoice through the component relationship. The StructuredBody class represents a CDA document body that is comprised of one or more document sections.
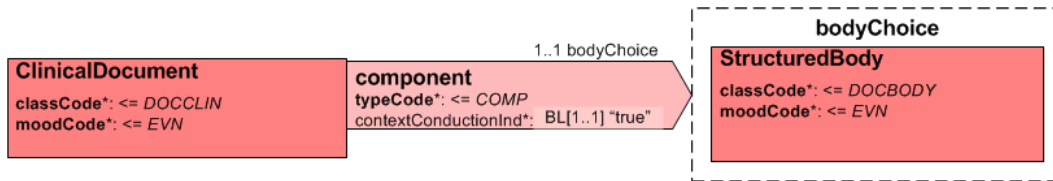
Figure 7.1. ADVANCE CARE INFORMATION

CDA Mapping

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Header Data Elements			Context: /		
ADVANCE CARE INFORMATION	Container for a copy of a statement of a person's decisions about their future care, should they become incapable of participating in medical treatment decisions.	1..1	**ClinicalDocument**		
CDA Body Level 2 Data Elements					
ADVANCE CARE INFORMATION (Body)	See above.	1..1	ClinicalDocument/**component/structuredBody**		

Example 7.1. Advance Care Information Body XML Fragment

```
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table.  It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<ClinicalDocument xmlns="urn:hl7-org:v3"
    xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
    …
    >
    …

    <!-- Begin CDA Body -->
    <component>
        <structuredBody>
            …

            <!-- Begin ADVANCE CARE INFORMATION SECTION -->
            <component>
                <section>
                    …
                </section>
            </component>
            <!-- End ADVANCE CARE INFORMATION SECTION -->

        </structuredBody>
    </component>
    <!-- End CDA Body -->
</ClinicalDocument>
```

7.1.1 ADVANCE CARE INFORMATION SECTION

Identification

Name	ADVANCE CARE INFORMATION SECTION
Metadata Type	Section
Identifier	S-16973

Relationships

Parent

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

Children

Data Type	Name	Occurrence
	RELATED DOCUMENT	1..1

CDA R-MIM Representation

Figure 7.2 ADVANCE CARE INFORMATION SECTION shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Body elements.

The ADVANCE CARE INFORMATION SECTION section is composed of a Section class related to its context ClinicalDocument.StructuredBody by a component.
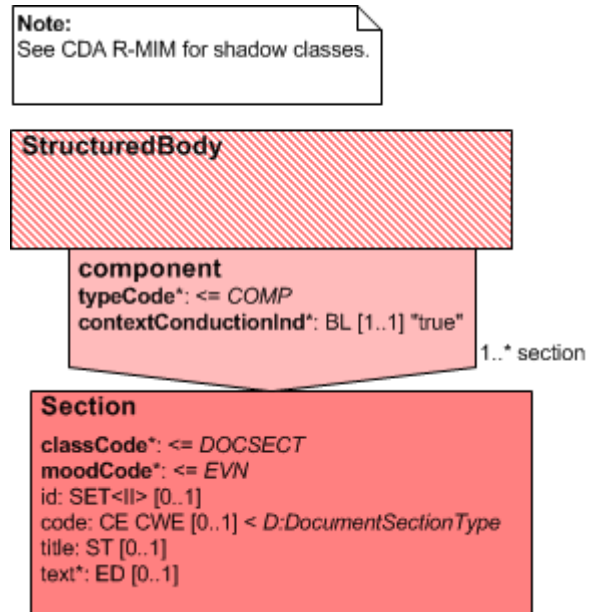
Figure 7.2. ADVANCE CARE INFORMATION SECTION

CDA Mapping

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Body Level 2 Data Elements			Context: /ClinicalDocument/component/structuredBody/		
ADVANCE CARE INFORMATION SECTION	Section that contains a statement of a person's decisions about their future care, should they become incapable of participating in medical treatment decisions.	1..1	component[adv_car]/**section**		
			component[adv_car]/section/**title="Advance Care Information Section"**		
			component[adv_car]/section/**text**		Required CDA element. See Appendix A, *CDA Narratives*.
ADVANCE CARE INFORMATION SECTION > **Advance Care Information Section Instance Identifier**	Globally unique identifier for each instance of Advance Care Information Section section.	0..1	component[adv_car]/section/**id**		id/@nullFlavor **SHALL NOT** be present. See <id> for available attributes.
ADVANCE CARE INFORMATION SECTION > **Section Type**	Type of section.	1..1	component[adv_car]/section/**code**		code/@nullFlavor **SHALL NOT** be present.
			component[adv_car]/section/code/**@code="101.16973"**		
			component[adv_car]/section/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			component[adv_car]/section/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			component[adv_car]/section/code/**@displayName="Advance Care Information Section"**		
ADVANCE CARE INFORMATION SECTION > **RELATED DOCUMENT**	Information about a document of interest.	1..1	See: RELATED DOCUMENT		

Example 7.2. ADVANCE CARE INFORMATION SECTION XML Fragment

```xml
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<ClinicalDocument xmlns="urn:hl7-org:v3"
 xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
 …
 >
 …

 <!-- Begin CDA Body -->
 <component>
  <structuredBody>
   …

   <!-- Begin ADVANCE CARE INFORMATION SECTION -->
   <component typeCode="COMP">
    <section classCode="DOCSECT" moodCode="EVN">
     <!-- Advance Care Information Section Instance Identifier -->
     <id root="50846572-EFC7-11E0-8337-65094924219B" />
     <!-- Section Type -->
     <code code="101.16973"
      codeSystem="1.2.36.1.2001.1001.101"
      codeSystemName="NCTIS Data Components"
      displayName="Advance Care Information Section" />
     <title>Advance Care Information Section</title>
     <!-- narrative block -->
     <text>
      <!-- Add narrative text here -->
      <renderMultiMedia referencedObject="MM1"/>
     </text>

     <!-- Begin RELATED DOCUMENT -->
     <entry>
      <act>
        …

      </act>
     </entry>
     <!-- End RELATED DOCUMENT -->
     …

    </section>
   </component>
   <!-- End ADVANCE CARE INFORMATION SECTION -->
   …

  </structuredBody>
 </component>
 <!-- End CDA Body -->
</ClinicalDocument>
```

7.1.1.1 RELATED DOCUMENT

Identification

Name	RELATED DOCUMENT
Metadata Type	Data Group
Identifier	DG-16971

Relationships

Parent

Data Type	Name	Occurrences (child within parent)
	ADVANCE CARE INFORMATION SECTION	1..1

Children

Data Type	Name	Occurrence
	DOCUMENT AUTHOR	1..1

CDA R-MIM Representation

Figure 7.3 RELATED DOCUMENT shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Body elements.

The RELATED DOCUMENT data group is represented by an Act class related to its containing Section class by an entry relationship. Document Target is represented by an externalDocument class related to its containing Act class by a reference relationship (representing Link Nature and Link Role). The id attribute of that externalDocument class represents Document Identifier.
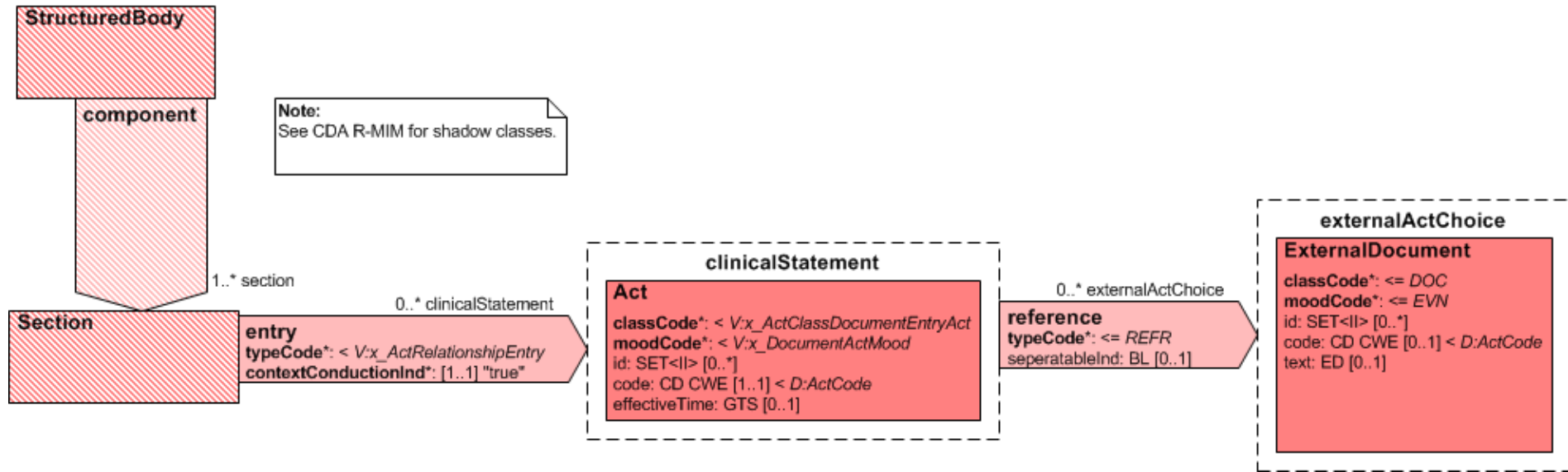
Figure 7.3. RELATED DOCUMENT

CDA Mapping

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Body Level 3 Data Elements			Context: /ClinicalDocument/component/structuredBody/component[adv_car]/section/		
RELATED DOCUMENT	Information about a document of interest.	1..1	**entry[doc_detail]**		
			entry[doc_detail]/**act**		
			entry[doc_detail]/act/**@classCode="ACT"**		
			entry[doc_detail]/act/**@moodCode="EVN"**		
			entry[doc_detail]/act/**id**		See <id> for available attributes. Optional CDA element.
			entry[doc_detail]/act/**code**		
			entry[doc_detail]/act/code/**@code="102.16971"**		
			entry[doc_detail]/act/code/**@codeSystem="1.2.36.1.2001.1001.101"**		
			entry[doc_detail]/act/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			entry[doc_detail]/act/code/**@displayName="Related Document"**		
RELATED DOCUMENT > **Link Nature**	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.	1..1	entry[doc_detail]/act/**reference[document]**		"LINK-E0" (is a related document-ation) is mapped to typeCode="REFR".
			entry[doc_detail]/act/reference[document]/**seperatableInd/@value="true"**		
			entry[doc_detail]/act/reference[document]/**@typeCode="REFR"**		

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
RELATED DOCUMENT > **Document Target**	'Linked to' or identified document.	1..1	entry[doc_detail]/act/reference[document]/**externalDocument**		
			entry[doc_detail]/act/reference[document]/externalDocument/**@classCode="DOC"**		
			entry[doc_detail]/act/reference[document]/externalDocument/**@moodCode="EVN"**		
			entry[doc_detail]/act/reference[document]/externalDocument/**text:ED**		The link **SHALL** also be present in the corresponding CDA Narrative in a <linkHtml> element. text/@nullFlavor **SHALL NOT** be present.
			entry[doc_detail]/act/reference[document]/externalDocument/text/**@mediaType**		The My Health Record system requires all Advance Care Information documents to use only PDF format files.
			entry[doc_detail]/act/reference[document]/externalDocument/text/**@integrityCheck**		The file **SHALL** be one of the following formats: • GIF (image/gif) • JPEG (image/jpg, image/jpeg) • PDF (application/pdf) • PNG (image/png) • TIFF (image/tif, image/tiff)
			entry[doc_detail]/act/reference[document]/externalDocument/text/**reference**		reference/@nullFlavor **SHALL NOT** be present.
			entry[doc_detail]/act/reference[document]/externalDocument/text/reference/**@value**		
RELATED DOCUMENT > **DOCUMENT DETAILS**	Information about a document of interest.	1..1	n/a		This logical data component has no mapping to CDA.
RELATED DOCUMENT > DOCUMENT DETAILS > **Document Type**	Type of the document of interest.	1..1	entry[doc_detail]/act/reference[document]/externalDocument/**code**		code/@nullFlavor **SHALL NOT** be present. See <code> for available attributes.
			entry[doc_detail]/act/reference[document]/externalDocument/code/**@code="100.16998"**		
			entry[doc_detail]/act/reference[document]/externalDocument/code/**@codeSystem= "1.2.36.1.2001.1001.101"**		
			entry[doc_detail]/act/reference[document]/externalDocument/code/**@codeSystemName**	The value **SHOULD** be "NCTIS Data Components". See CodeSystem OIDs.	Optional CDA element.
			entry[doc_detail]/act/reference[document]/externalDocument/code/**@displayName="Advance Care Planning Document"**		

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
RELATED DOCUMENT > DOCUMENT DETAILS > **DOCUMENT AUTHOR**	Composer of the document of interest.	1..1	See: DOCUMENT AUTHOR		
RELATED DOCUMENT > DOCUMENT DETAILS > **Document Identifier**	Unique identifier of the document of interest.	0..1	entry[doc_detail]/act/reference[document]/externalDocument/**id**		The unique identifier of the target document. See <id> for available attributes.

Example 7.3. RELATED DOCUMENT XML Fragment

```xml
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<ClinicalDocument xmlns="urn:hl7-org:v3"
    xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
    …
    >
    …

    <!-- Begin CDA Body -->
    <component>
        <structuredBody>
            …

            <!-- Begin ADVANCE CARE INFORMATION SECTION -->
            <component typeCode="COMP">
                <section classCode="DOCSECT" moodCode="EVN">
                    …

                    <!-- narrative block -->
                    <text>
                        <paragraph>
                            <linkHtml href="attachment.pdf">Attached Report</linkHtml>
                        </paragraph>
                        …
                    </text>
                    …

                    <!-- Begin RELATED DOCUMENT -->
                    <entry typeCode="COMP">
                        <act classCode="ACT" moodCode="EVN">
                            <!-- Technical Identifier to uniquely identify this act -->
                            <id root="31c45290-2883-11z2-81c1-0800000c9a67" />
                            <code code="102.16971" codeSystem="1.2.36.1.2001.1001.101" codeSystemName="NCTIS Data Components" displayName="Related Document" />

                            <!--  Begin Link Nature / Link Role -->
                            <reference typeCode="REFR">
                                <seperatableInd value="true" />
                                <!--  End Link Nature / Link Role -->

                                <externalDocument classCode="DOC" moodCode="EVN">
                                    <!-- Document Identifier (optional) -->
                                    <id root="50846672-EFC7-11E0-8337-66094924019B" />

                                    <!-- Document Type -->
                                    <code code="100.16998" codeSystem="1.2.36.1.2001.1001.101" codeSystemName="NCTIS Data Components" displayName="Advance Care Planning Document" />

                                    <!-- Document Target as encapsulated data -->
                                    <text integrityCheck="IiZNlyLY4gyewfICeWhFe2NcDDw=" mediaType="application/pdf">
                                        <reference value="attachment.pdf" />
                                    </text>

                                </externalDocument>
                            </reference>
```

Approved for external use

```
                    <!-- Being DOCUMENT AUTHOR -->
                    <author>
                        …
                    </author>
                    <!-- End DOCUMENT AUTHOR -->

                </act>
            </entry>
            <!-- End RELATED DOCUMENT -->
                …

        </section>
    </component>
    <!-- End ADVANCE CARE INFORMATION SECTION -->
        …

    </structuredBody>
    </component>
    <!-- End CDA Body -->
</ClinicalDocument>
```

7.1.1.1.1 DOCUMENT AUTHOR

Identification

Name	DOCUMENT AUTHOR
Metadata Type	Data Group
Identifier	DG-10296

Relationships

Parent

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

CDA R-MIM Representation

Figure 7.4 DOCUMENT AUTHOR shows a subset of the CDA R-MIM containing those classes being referred to in the CDA Mapping. This data component maps to CDA Body elements.

The DOCUMENT AUTHOR data group instantiated as PERSON (Non-Healthcare Provider) is related to its context of ClinicalStatement by the author participation class. An author is a person in the role of assignedAuthor (AssignedAuthor class). The entity playing the role is assignedAuthorChoice (Person class). The entity identifier of the participant is mapped to the EntityIdentifier class (Australian Digital Health Agency CDA extension) and is associated to the assignedAuthorChoice.

Figure 7.4. DOCUMENT AUTHOR

CDA Mapping

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Body Level 3 Data Elements			Context: /ClinicalDocument/component/structuredBody/component[adv_car]/section/entry[doc_detail]/act/		
DOCUMENT AUTHOR	Composer of the document of interest.	1..1	**author**		
n/a	n/a	1..1	author/assignedAuthor/**id**		Required CDA element.
DOCUMENT AUTHOR > **Participation Period**	The time interval during which the participation in the healthcare event occurred.	1..1	author/**time**	This element will hold the datetime on which the attached document is authored. Although the definition of this element states that it is a time interval, the following applies: "The end of the participation period of a Document Author participation is the time associated with the completion of editing the content of a document". Thus only the end time need be recorded.	Required CDA element. The author/time element **SHALL** be implemented as either: • a value attribute (populated with the end time of the authorship or encounter, as appropriate); or • a high element AND a low element, both with value attributes and neither with a nullFlavor attribute.
DOCUMENT AUTHOR > **LOCATION OF PARTICIPATION**	Specifies the geographic site (building, room, etc) where the participation of a healthcare event occurs.	0..0	See Known Issues.		LOCATION OF PARTICIPATION is not currently mapped.
DOCUMENT AUTHOR > **Participation Type**	The categorisation of the nature of the participant's involvement in the healthcare event described by this participation.	1..1	n/a	Participation Type **SHALL** have an implementation-specific value equivalent to "Document Author".	Not mapped directly; encompassed implicitly in author/typeCode="AUT" (optional, fixed value).
DOCUMENT AUTHOR > **Role**	The involvement or role of the participant in the related action from a healthcare perspective rather than the specific participation perspective.	1..1	author/**assignedAuthor/code**	Role **SHALL** have an implementation-specific value equivalent to "Not Applicable".	See <code> for available attributes.
DOCUMENT AUTHOR > **PARTICIPANT**	Details pertinent to the identification of an individual or organisation or device that has participated in a healthcare event/encounter/clinical interaction.	1..1	author/assignedAuthor/**assignedPerson**		
DOCUMENT AUTHOR > PARTICIPANT > **Entity Identifier**	A number or code issued for the purpose of identifying a participant within a healthcare context.	0..*	author/assignedAuthor/assignedPerson/**<Entity Identifier>**		See common pattern: Entity Identifier.
DOCUMENT AUTHOR > PARTICIPANT > **ADDRESS**	The description of a location where an entity is located or can be otherwise reached or found and a description of the purpose for which that address is primarily used by that entity.	0..*	author/assignedAuthor/**<Address>**		See common pattern: Address.

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
DOCUMENT AUTHOR > PARTICIPANT > **ELECTRONIC COMMUNICATION DETAIL**	The electronic communication details of entities.	1..*	author/assignedAuthor/<**Electronic Communication Detail**>	In one Electronic Communication Detail the value of Electronic Communication Medium (telecom/@value) **SHALL** be set to Telephone or Mobile (see HL7: TelecommunicationAddressUse) and telecom/@nullFlavor **SHALL NOT** be present.	See common pattern: Electronic Communication Detail.
DOCUMENT AUTHOR > PARTICIPANT > **PERSON OR ORGANISATION OR DEVICE**	Represents a choice to be made at run-time between PERSON, ORGANISATION or DEVICE.	1..1	n/a	PERSON OR ORGANISATION OR DEVICE **SHALL** be instantiated as a PERSON.	This logical data component has no mapping to CDA. The cardinality of this component propagates to its children.
DOCUMENT AUTHOR > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > **PERSON**	An individual who is in the role of healthcare provider, who uses or is a potential user of a healthcare service, or is in some way related to, or a representative of, a subject of care (patient).	1..1	n/a		Not mapped directly; encompassed implicitly in author/assignedAuthor/assignedPerson.
DOCUMENT AUTHOR > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > **PERSON NAME**	The appellation by which an individual may be identified separately from any other within a social context.	1..*	author/assignedAuthor/assignedPerson/<**Person Name**>		See common pattern: Person Name.
DOCUMENT AUTHOR > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > **Relationship to Subject of Care**	The relationship of a participant to a subject of care (patient).	0..0	author/assignedAuthor/assignedPerson/**ext:personalRelationship**		
DOCUMENT AUTHOR > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > **EMPLOYMENT DETAIL**	A person's occupation and employer.	0..0	author/assignedAuthor/assignedPerson/**ext:asEmployment**		
DOCUMENT AUTHOR > PARTICIPANT > PERSON OR ORGANISATION OR DEVICE > PERSON > **DEMOGRAPHIC DATA**	Additional characteristics of a person that may be useful for identification or other clinical purposes.	0..0	n/a		This logical data component has no mapping to CDA. The cardinality of this component propagates to its children.
			author/assignedAuthor/assignedPerson/**ext:administrativeGenderCode**		
			author/assignedAuthor/assignedPerson/**ext:birthTime**		
CDA Body Level 3 Data Elements			Context: /ClinicalDocument/component/structuredBody/component[admin_obs]/section/ (See 4 *Administrative Observations*)		
DOCUMENT AUTHOR > PARTICIPANT > **ENTITLEMENT**	The entitlement or right of a participant to act in a given capacity (as defined by Entitlement Type) within a healthcare context.	0..0	See Known Issues.		Prohibition of ENTITLEMENT is not currently mapped.
CDA Header Data Elements			Context: /ClinicalDocument/		
DOCUMENT AUTHOR > PARTICIPANT > **Qualifications**	A list of professional certifications, and certificates recognising having passed a course.	0..0	author/assignedAuthor/assignedPerson/**ext:asQualifications**		

Example 7.4. DOCUMENT AUTHOR XML Fragment

```
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<ClinicalDocument xmlns="urn:hl7-org:v3"
    xmlns:ext="http://ns.electronichealth.net.au/Ci/Cda/Extensions/3.0"
    …
    >
    …

    <!-- Begin CDA Body -->
    <component>
        <structuredBody>
            …

            <!-- Begin ADVANCE CARE INFORMATION SECTION -->
            <component typeCode="COMP">
                <section classCode="DOCSECT" moodCode="EVN">
                    …

                    <!-- Begin RELATED DOCUMENT -->
                    <entry typeCode="COMP">
                        <act classCode="ACT" moodCode="EVN">
                            …

                            <!-- Begin DOCUMENT AUTHOR -->
                            <author typeCode="AUT">
                                <!-- Participation Period -->
                                <time value="201110201235+1000" />

                                <assignedAuthor>
                                    <!-- id is used for system purposes such as matching -->
                                    <id root="b830b9a6-4ea7-4a1a-92eb-ddf18b82a291" />
                                    <!-- Role is not applicable -->
                                    <code nullFlavor="NA" />

                                    <!-- ADDRESS -->
                                    <addr use="H">
                                        <streetAddressLine>20 Author Street</streetAddressLine>
                                        <city>Healthville</city>
                                        <state>VIC</state>
                                        <postalCode>3002</postalCode>
                                    </addr>

                                    <!-- ELECTRONIC COMMUNICATION DETAIL -->
                                    <telecom use="H" value="tel:0333333333" />
                                    <telecom use="MC" value="tel:04111378942" />

                                    <!-- PARTICIPANT -->
                                    <assignedPerson>
                                        <!-- PERSON NAME -->
                                        <name>
                                            <prefix>Ms.</prefix>
                                            <given>Sally</given>
                                            <family>Fairfochild</family>
                                        </name>
```

```xml
                              <!-- Entity Identifier -->
                              <ext:asEntityIdentifier classCode="IDENT">
                                  <ext:id assigningAuthorityName="IHI" root="1.2.36.1.2001.1003.0.8003608833357362"/>
                                  <ext:assigningGeographicArea classCode="PLC">
                                      <ext:name>National Identifier</ext:name>
                                  </ext:assigningGeographicArea>
                              </ext:asEntityIdentifier>

                      </assignedPerson>
                  </assignedAuthor>
              </author>
              <!-- End DOCUMENT AUTHOR -->
                  …

            </act>
          </entry>
          <!-- End RELATED DOCUMENT -->
              …

          </section>
        </component>
        <!-- End ADVANCE CARE INFORMATION SECTION -->
            …

      </structuredBody>
    </component>
    <!-- End CDA Body -->
</ClinicalDocument>
```

Approved for external use

8 Common Patterns

8.1 code

The <code> element pattern refines the kind of act being recorded. It is of data type CD CWE (Concept Descriptor, Coded With Extensibility). It may have:

- a null attribute (*nullFlavor*)

- *originalText*

- *code* and *codeSystem*

- *qualifier* (CD)

- *translation* (CD)

- any combination of the above.

A *displayName* is highly recommended.

Where used, the *code* attribute **SHALL** contain a code from the relevant vocabulary.

Where used, the *codeSystem* attribute **SHALL** contain the OID for the relevant vocabulary. Values for coding systems can be obtained from the HL7 OID registry accessible from the HL7 home web page at www.hl7.org[1].

Where used, the *displayName* attribute **SHALL** contain a human-readable description of the code value that is provided by the code system; *displayName* is a case insensitive value except where explicitly stated otherwise by the code system. A preferred interface term for display that is not a member of the description set supplied by the code system **SHALL NOT** be used to populate the *displayName* attribute.

The *codeSystemName* **MAY** be present and, where used, **SHALL** contain a human-readable name for the coding system.

Where used, the *originalText* element **SHALL** be used to carry the full text associated with this code as selected by, typed by or displayed to the author of this statement including the contents of the *qualifier* if present.

---

[1] http://www.hl7.org

Where used, the *qualifier* element **SHALL** carry a code from the same code system as the code; for example if the main concept code is from SNOMED CT the *qualifier* also has to be taken from SNOMED CT as the use of a different code system for a *qualifier* is not allowed. The use of the *qualifier* element is governed by the code system used and cannot be used with code systems that do not provide for qualifiers (e.g. pre-coordinated systems).

Codes can be obtained from a variety of sources. Additional vocabularies are also available from the HL7 Version 3 Vocabulary tables, available to HL7 members through the HL7 web site. In some cases, the vocabularies have been specified; in others, a particular code has been fixed or there is no vocabulary specified. For guidance on coding common clinical concepts in CDA documents see *Representing Coding in CDA Documents Implementation Guidance [NEHT2011bv]*.

Where a code is used from a different code system to that specified, or where the code lies outside the reference set specified, or where a code system or reference set is not specified, the code value **SHALL** be consistent with the meaning of the associated data component from the structured content specification.

If a vocabulary is specified in this implementation guide and no suitable code can be found, the *originalText* element **SHALL** be used to carry the full text as selected by, typed by or displayed to the author of this statement.

If a vocabulary is specified in this implementation guide and it is not possible to use this vocabulary, but an alternate vocabulary is in use, the *originalText* element **SHALL** be used to carry the full text as selected by, typed by or displayed to the author of this statement. The *code* element **SHALL** be used to carry the relevant information from the alternate vocabulary and the alternate vocabulary **SHALL** be registered with HL7 and allocated an appropriate OID.

If an alternate vocabulary is in use and a translation into the specified code system is available, the *originalText* element **SHALL** be used to carry the full text as selected by, typed by or displayed to the author of this statement. The *code* element **SHALL** be used to carry the relevant information from the alternate vocabulary and the alternate vocabulary **SHALL** be registered with HL7 and allocated an appropriate OID. The *translation* element **SHALL** be used to indicate the translation code from the specified vocabulary.

Example 8.1. code

```xml
<!-- Specified code system in use -->
<code
    code="271807003"
    codeSystem="2.16.840.1.113883.6.96"
    codeSystemName="SNOMED CT"
    codeSystemVersion="20101130"
    displayName="Skin rash" />


<!-- Specified code system in use with a qualifier -->
<code
    code="23986001"
    codeSystem="2.16.840.1.113883.6.96"
    codeSystemName="SNOMED CT"
    displayName="Glaucoma" >
    <originalText>Glaucoma, left</originalText>
    <qualifier>
        <name
            code="272741003"
            codeSystem="2.16.840.1.3883.6.96"
            codeSystemName="SNOMED CT"
            displayName="Laterality" />
        <value
            code="7771000"
```

```xml
                    codeSystem="2.16.840.1.113883.6.96"
                    codeSystemName="SNOMED CT"
                    displayName="Left"
                    xsi:type="CD" />
        </qualifier>
</code>


<!-- Alternate code system in use and a translation into the specified code system is available -->
<code
    code="J45.9"
    codeSystem="2.16.840.1.113883.6.135"
    codeSystemName="icd10am"
    displayName="Asthma, unspecified">
    <originalText>Asthma</originalText>
    <translation
        code="195967001"
        codeSystem="2.16.840.1.113883.6.96"
        codeSystemName="SNOMED CT"
        displayName="Asthma"/>
</code>


<!-- Alternate code system in use and no translation into the specified code system is available -->
<code
    code="J45.9"
    codeSystem="2.16.840.1.113883.6.135"
    codeSystemName="icd10am"
    displayName="Asthma, unspecified">
    <originalText>Asthma</originalText>
</code>



<!-- No suitable code can be found or there is no code system in use -->
<code
        <originalText>Asthma</originalText>
</code>
```

8.2 id

The <id> element pattern is of data type II (Instance Identifier). The II data type may have:

- a null attribute (*nullFlavor*)

- a *root*

- a *root* and an *extension*

- a *root* and an *extension* and an *assigningAuthorityName*

- a *root* and an *assigningAuthorityName*

- a *root* and an *assigningAuthorityName* and a *displayable*

- a *root* and an *extension* and a *displayable*

- a *root* and an *extension* and an *assigningAuthorityName* and a *displayable*

- a *root* and a *displayable*

The root attribute is **REQUIRED** and is a unique identifier that guarantees the global uniqueness of the instance identifier. The root alone **MAY** be the entire instance identifier. The root attribute **SHALL** be a UUID or OID.

The extension attribute **MAY** be present, and is a character string as a unique identifier within the scope of the identifier root.

In the case of Entity Identifier, assigningAuthorityName is **RECOMMENDED**.

Identifiers appear in this implementation guide for two different reasons. The first is that the identifier has been identified in the business requirements as relevant to the business process. These identifiers are documented in the SCSs, which make clear the meaning of this identifier.

In addition, the implementation makes clear that identifiers may also be found on many other parts of the CDA content model. These identifiers are allowed to facilitate record matching across multiple versions of related documents, so that the same record can consistently be identified, in spite of variations in the information as the record passes through time or between systems. These identifiers have no meaning in the business specification. If senders provide one of these identifiers, it **SHALL** always be the same identifier in all versions of the record, and it **SHALL** be globally unique per the rules of the II data type.

Example 8.2. id

```
<id root="2.16.840.1.113883.19" extension="123A45" />
```

```
<ext:id assigningAuthorityName="HPI-O" root="1.2.36.1.2001.1003.0.8003621566684455" />
```

8.3 time

When a time value is supplied it **SHALL** include hours and minutes.

When a time value is supplied it **MAY** include seconds and fractions of seconds.

When a time value is supplied it **SHALL** include a time zone.

The <time> element pattern is of data type TS (Point in Time) and can also be an interval between two times (IVL_TS), representing a period of time. Both forms can either have a nullFlavor attribute or child components following allowed patterns.

A simple timestamp (point in time) will only contain a value attribute containing the time value, expressed as a series of digits as long as required or as available.

Example 8.3. Simple timestamp

```
<time value="20091030" />
```

This represents "October 30, 2009" to calendar day precision. In cases where the containing element is defined in the CDA schema as "ANY" data type, it is useful to provide an xsi:type attribute, set to the value "TS".

The period of time pattern is defined in terms of one or both of its lowest and highest values. The low and high elements are instances of the timestamp pattern described above. More complex time period concepts can be expressed by combining a high, low, or centre element with a width element.

Example 8.4. Low time

```
<period>
    <low value="20091030" />
</period>
```

This represents "a period after October 30, 2009". In cases where the containing element is defined in the CDA schema as "ANY" data type, it is useful to provide an xsi:type attribute, set to the value "IVL_TS", as in the next example.

Example 8.5. Interval timestamp 1

```
<period xsi:type="IVL_TS">
    <high value="200910301030+1000" />
</period>
```

This represents "a period before 10:30 a.m. UTC+10, October 30, 2009". A discretionary xsi:type attribute has been provided to explicitly cast the pattern to "IVL_TS".

Example 8.6. Interval timestamp 2

```
<period xsi:type="IVL_TS">
    <low value="2007" />
    <high value="2009" />
</period>
```

This represents "the calendar years between 2007 and 2009". The low element **SHALL** precede the high element. As per the previous example, a discretionary xsi:type attribute has been provided to explicitly cast the pattern to "IVL_TS".

Example 8.7. Width time

```
<period>
    <high value="20091017" />
    <width value="2" unit="wk" />
</period>
```

This expresses "two weeks before October 17th, 2009". A low value can be derived from this.

8.4 Entity Identifier

CDA Mapping

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Data Elements					
Entity Identifier	A number or code issued for the purpose of identifying a participant within a healthcare context.	The cardinality of the group comes from the linking parent and the cardinality of the children data elements comes from the R-MIM diagram.	**ext:asEntityIdentifier**		See Australian Digital Health Agency CDA extension: EntityIdentifier.
			ext:asEntityIdentifier/**@classCode="IDENT"**		
			ext:asEntityIdentifier/**ext:id**		
			ext:asEntityIdentifier/ext:id/**@root**	Attribute @root **SHALL** be used, **SHALL** be an OID and **SHALL NOT** be a UUID. Attribute @root **SHALL** be a globally unique object identifier (i.e. OID) that identifies the combination of geographic area, issuer and type. If no such OID exists, it **SHALL** be defined before any identifiers can be created.	
			ext:asEntityIdentifier/ext:id/**@extension**	Attribute @extension **MAY** be used and, if it is used, **SHALL** be a unique identifier within the scope of the root that is populated directly from the designation.	
			ext:asEntityIdentifier/ext:id/**@assigningAuthorityName**	Attribute @assigningAuthorityName **SHOULD** be used and, if it is used, **SHALL** be a human-readable name for the namespace represented in the root that is populated with the issuer, or identifier type, or a concatenation of both as appropriate. This **SHOULD NOT** be used for machine readability purposes.	
			ext:asEntityIdentifier/**ext:code**		See <code> for available attributes.
			ext:asEntityIdentifier/**ext:assigningGeographicArea**		
			ext:asEntityIdentifier/ext:assigningGeographicArea/**@classCode="PLC"**		
			ext:asEntityIdentifier/ext:assigningGeographicArea/**ext:name**	Element ext:name **MAY** be used and, if it is used, **SHALL** be the range and extent that the identifier applies to the object with which it is associated that is populated directly from the geographic area. This **SHOULD NOT** be used for machine readability purposes. For details see: AS 5017-2006: Health Care Client Identifier Geographic Area.	

Example 8.8. Entity Identifier

```
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<!-- person -->
<xs:asEntityIdentifier classCode="IDENT">
 <xs:id root="1.2.36.1.2001.1003.0.8003608833357361" assigningAuthorityName="IHI" />
  <xs:assigningGeographicArea classCode="PLC">
       <xs:name>National Identifier</xs:name>
      </xs:assigningGeographicArea>
</xs:asEntityIdentifier>

<xs:asEntityIdentifier classCode="IDENT">
 <xs:id root="1.2.36.1.2001.1005.29.8003621566684455" extension="542181" assigningAuthorityName="Croydon GP Centre" />
    <xs:code code="MR" codeSystem="2.16.840.1.113883.12.203" codeSystemName="Identifier Type (HL7)" />
</xs:asEntityIdentifier>

<!-- organisation -->
<ext:asEntityIdentifier classCode="IDENT">
    <ext:id assigningAuthorityName="HPI-O" root="1.2.36.1.2001.1003.0.8003621566684455" />
    <ext:assigningGeographicArea classCode="PLC">
        <ext:name>National Identifier</ext:name>
    </ext:assigningGeographicArea>
</ext:asEntityIdentifier>
```

8.5 Person Name

CDA Mapping

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Data Elements					
PERSON NAME	The appellation by which an individual may be identified separately from any other within a social context.	Cardinality comes from linking parent.	**name**		
PERSON NAME > **Name Title**	An honorific form of address commencing a name.	0..*	name/**prefix**		
PERSON NAME > **Family Name**	That part of a name a person usually has in common with some other members of his/her family, as distinguished from his/her given names.	1..1	name/**family**		
PERSON NAME > **Given Name**	The person's identifying names within the family group or by which the person is uniquely socially identified.	0..*	name/**given**		
PERSON NAME > **Name Suffix**	The additional term used following a person's name to identify that person.	0..*	name/**suffix**		
PERSON NAME > **Preferred Name Indicator**	A flag to indicate that this is the name a person has selected for use.	0..1	name/**@use**	A code for representing "preferred name" has been requested from HL7 International but is not currently available.	If both Preferred Name Indicator and Person Name Usage have been provided, the use attribute **SHALL** include them as space separated list of codes.
PERSON NAME > **Person Name Usage**	The classification that enables differentiation between recorded names for a person.	0..1	name/**@use**	AS 5017-2006: Health Care Client Name Usage	If both Preferred Name Indicator and Person Name Usage have been provided, the use attribute **SHALL** include them as space separated list of codes.

Example 8.9. Person Name

```
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<!-- registered name -->
<name use="L">
    <prefix>Ms</prefix>
    <given>Sally</given>
    <family>Grant</family>
</name>
```

8.6 Address

CDA Mapping

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Data Elements					
ADDRESS	The description of a location where an entity is located or can be otherwise reached or found and a description of the purpose for which that address is primarily used by that entity.	Cardinality comes from linking parent.	**addr**		In an event where the address is 'Unknown' or 'Masked / Not to be disclosed for privacy reason', the following conditions **SHOULD** be applied. The nullFlavor = "UNK" **SHOULD** be permitted if the value of address is not known and the value of 'No Fixed Address Indicator' is false. The nullFlavor = "MSK" **SHOULD** be permitted if the value of address is masked and the value of 'No Fixed Address Indicator' is false. The nullFlavor = "NA" **SHOULD** be permitted if value of 'No Fixed Address Indicator' is true. (This is the same as the current CDA IG constraint). The value of the <addr> data group **SHALL** be populated in all other circumstances.
ADDRESS > **No Fixed Address Indicator**	A flag to indicate whether or not the participant has no fixed address.	1..1	addr/**@nullFlavor**	If true, nullFlavor="NA". If false omit nullFlavor and fill in address.	
ADDRESS > **AUSTRALIAN OR INTERNATIONAL ADDRESS**	Represents a choice to be made at run-time between an AUSTRALIAN ADDRESS and an INTERNATIONAL ADDRESS.	1..1	n/a		This logical data component has no mapping to CDA. The cardinality of this component propagates to its children.
ADDRESS > AUSTRALIAN OR INTERNATIONAL ADDRESS > **INTERNATIONAL ADDRESS**	The description of a non-Australian location where an entity is located or can be otherwise reached or found.	0..1	n/a		This logical data component has no mapping to CDA. The cardinality of this component propagates to its children.
ADDRESS > AUSTRALIAN OR INTERNATIONAL ADDRESS > INTERNATIONAL ADDRESS > **International Address Line**	A composite of address details comprising a low level geographical/physical description of a location that, used in conjunction with the other high level address components, i.e. international state/province, international postcode and country, forms a complete geographic/physical address.	0..*	addr/**streetAddressLine**		
ADDRESS > AUSTRALIAN OR INTERNATIONAL ADDRESS > INTERNATIONAL ADDRESS > **International State/Province**	The designation applied to an internal, political or geographic division of a country other than Australia that is officially recognised by that country.	0..1	addr/**state**		

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
ADDRESS > AUSTRALIAN OR INTERNA-TIONAL ADDRESS > INTERNATIONAL ADDRESS > **International Postcode**	The alphanumeric descriptor for a postal delivery area (as defined by the postal service of a country other than Aus-tralia) aligned with locality, suburb or place for an address.	0..1	addr/**postalCode**		
ADDRESS > AUSTRALIAN OR INTERNA-TIONAL ADDRESS > INTERNATIONAL ADDRESS > **Country**	The country component of the address.	0..1	addr/**country**	Australia Bureau of Statistics, Standard Australian Classification of Countries (SACC) Cat. No. 1269 [ABS2008]	Use the name, not the numbered code.
ADDRESS > AUSTRALIAN OR INTERNA-TIONAL ADDRESS > **AUSTRALIAN AD-DRESS**	The description of an Australian location where an entity is located or can be otherwise reached or found.	0..1	n/a		This logical data component has no mapping to CDA. The cardinality of this component propagates to its children.
ADDRESS > AUSTRALIAN OR INTERNA-TIONAL ADDRESS > AUSTRALIAN AD-DRESS > **Unstructured Australian Ad-dress Line**	A composite of one or more low level standard address components describing a geographical/physical location that, used in conjunction with the other high level address components, e.g. Australian suburb/town/locality name, Australian postcode and Australian State/Territory, forms a complete geographical/physical address.	0..*	addr/**streetAddressLine**		
ADDRESS > AUSTRALIAN OR INTERNA-TIONAL ADDRESS > AUSTRALIAN AD-DRESS > **STRUCTURED AUSTRALIAN ADDRESS LINE**	The standard low level address components describing a geographical/physical location that, used in conjunction with the other high level address components, i.e. Australi-an suburb/ town/locality name, Australian postcode and Australian State/Territory, form a complete geographic-al/physical address.	0..1	n/a		This logical data component has no mapping to CDA. The cardinality of this component propagates to its children.
ADDRESS > AUSTRALIAN OR INTERNA-TIONAL ADDRESS > AUSTRALIAN AD-DRESS > STRUCTURED AUSTRALIAN AD-DRESS LINE > **Australian Unit Type**	The specification of the type of a separately identifiable portion within a building/complex, marina etc. to clearly distinguish it from another.	0..1	addr/**unitType**	AS 5017 (2006) - Healthcare Client Identification: Australian Unit Type [SA2006a] AS 4846 (2006) - Healthcare Provider Identification: Australian Unit Type [SA2006b]	
ADDRESS > AUSTRALIAN OR INTERNA-TIONAL ADDRESS > AUSTRALIAN AD-DRESS > STRUCTURED AUSTRALIAN AD-DRESS LINE > **Australian Unit Number**	The specification of the number or identifier of a build-ing/complex, marina etc. to clearly distinguish it from an-other.	0..1	addr/**unitID**		
ADDRESS > AUSTRALIAN OR INTERNA-TIONAL ADDRESS > AUSTRALIAN AD-DRESS > STRUCTURED AUSTRALIAN AD-DRESS LINE > **Australian Address Site Name**	The full name used to identify the physical building or property as part of its location.	0..1	addr/**additionalLocator**		
ADDRESS > AUSTRALIAN OR INTERNA-TIONAL ADDRESS > AUSTRALIAN AD-DRESS > STRUCTURED AUSTRALIAN AD-DRESS LINE > **Australian Level Type**	Descriptor used to classify the type of floor or level of a multistorey building/complex.	0..1	addr/**additionalLocator**	AS 5017 (2006) - Healthcare Client Identification: Australian Level Type [SA2006a] AS 4846 (2006) - Healthcare Provider Identification: Australian Level Type [SA2006b]	
ADDRESS > AUSTRALIAN OR INTERNA-TIONAL ADDRESS > AUSTRALIAN AD-DRESS > STRUCTURED AUSTRALIAN AD-DRESS LINE > **Australian Level Number**	Descriptor used to identify the floor or level of a multi-storey building/complex.	0..1	addr/**additionalLocator**		

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
ADDRESS > AUSTRALIAN OR INTERNATIONAL ADDRESS > AUSTRALIAN ADDRESS > STRUCTURED AUSTRALIAN ADDRESS LINE > **Australian Street Number**	The numeric or alphanumeric reference number of a house or property that is unique within a street name.	0..1	addr/**houseNumber**		
ADDRESS > AUSTRALIAN OR INTERNATIONAL ADDRESS > AUSTRALIAN ADDRESS > STRUCTURED AUSTRALIAN ADDRESS LINE > **Australian Lot Number**	The Australian Lot reference allocated to an address in the absence of street numbering.	0..1	addr/**additionalLocator**	The word "Lot" **SHOULD** precede the lot number and be separated by a space.	
ADDRESS > AUSTRALIAN OR INTERNATIONAL ADDRESS > AUSTRALIAN ADDRESS > STRUCTURED AUSTRALIAN ADDRESS LINE > **Australian Street Name**	The name that identifies a public thoroughfare and differentiates it from others in the same suburb/town/locality.	0..1	addr/**streetName**		
ADDRESS > AUSTRALIAN OR INTERNATIONAL ADDRESS > AUSTRALIAN ADDRESS > STRUCTURED AUSTRALIAN ADDRESS LINE > **Australian Street Type**	A code that identifies the type of public thoroughfare.	0..1	addr/**streetNameType**	AS 5017 (2006) - Healthcare Client Identification: Australian Street Type Code [SA2006a] AS 4846 (2006) - Healthcare Provider Identification: Australian Street Type Code [SA2006b]	
ADDRESS > AUSTRALIAN OR INTERNATIONAL ADDRESS > AUSTRALIAN ADDRESS > STRUCTURED AUSTRALIAN ADDRESS LINE > **Australian Street Suffix**	Term used to qualify Australian Street Name used for directional references.	0..1	addr/**direction**	AS 5017 (2006) - Healthcare Client Identification: Australian Street Suffix [SA2006a] AS 4846 (2006) - Healthcare Provider Identification: Australian Street Suffix [SA2006b]	
ADDRESS > AUSTRALIAN OR INTERNATIONAL ADDRESS > AUSTRALIAN ADDRESS > STRUCTURED AUSTRALIAN ADDRESS LINE > **Australian Postal Delivery Type**	Identification for the channel of postal delivery.	0..1	addr/**deliveryAddressLine**	AS 5017 (2006) - Healthcare Client Identification: Australian Postal Delivery Type Code [SA2006a] AS 4846 (2006) - Healthcare Provider Identification: Australian Postal Delivery Type Code [SA2006b]	
ADDRESS > AUSTRALIAN OR INTERNATIONAL ADDRESS > AUSTRALIAN ADDRESS > STRUCTURED AUSTRALIAN ADDRESS LINE > **Australian Postal Delivery Number**	Identification number for the channel of postal delivery.	0..1	addr/**deliveryAddressLine**		
ADDRESS > AUSTRALIAN OR INTERNATIONAL ADDRESS > AUSTRALIAN ADDRESS > **Australian Suburb/Town/Locality**	The full name of the general locality contained within the specific address.	0..1	addr/**city**	Values in this data element **SHOULD** comply with descriptions in the Australia Post Postcode File (see www.auspost.com.au/postcodes).	
ADDRESS > AUSTRALIAN OR INTERNATIONAL ADDRESS > AUSTRALIAN ADDRESS > **Australian State/Territory**	The identifier of the Australian state or territory.	0..1	addr/**state**	AS 5017-2006 Australian State/Territory Identifier - Postal	
ADDRESS > AUSTRALIAN OR INTERNATIONAL ADDRESS > AUSTRALIAN ADDRESS > **Australian Postcode**	The numeric descriptor for a postal delivery area (as defined by Australia Post), aligned with locality, suburb or place for the address.	0..1	addr/**postalCode**	Values in this data element **SHOULD** comply with descriptions in the Australia Post Postcode File (see www.auspost.com.au/postcodes).	

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
ADDRESS > AUSTRALIAN OR INTERNATIONAL ADDRESS > AUSTRALIAN ADDRESS > **Australian Delivery Point Identifier**	A unique number assigned to a postal delivery point as recorded on the Australia Post Postal Address File.	0..1	addr/**additionalLocator**		
ADDRESS > **Address Purpose**	The purpose for which the address is being used by the entity.	1..1	addr/**@use**	AS 5017-2006: Health Care Client Identifier Address Purpose	Space separated list of codes.

Example 8.10. Address

```xml
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<!-- No Fixed Address -->
<addr nullFlavor="NA" />

<!-- Australian home address (unstructured) -->
<addr use="H">
    <streetAddressLine>1 Clinician Street</streetAddressLine>
    <city>Healthville</city>
    <state>QLD</state>
    <postalCode>5555</postalCode>
    <additionalLocator>32568931</additionalLocator>
</addr>

<!-- Australian business address (structured) -->
<addr use="WP">
    <houseNumber>1</houseNumber>
    <streetName>Clinician</streetName>
    <streetNameType>St</streetNameType>
    <city>Healthville</city>
    <state>QLD</state>
    <postalCode>5555</postalCode>
    <additionalLocator>32568931</additionalLocator>
</addr>

<!-- International postal address -->
<addr use="PST">
    <streetAddressLine>51 Clinician Bay</streetAddressLine>
    <city>Healthville</city>
    <state>Manitoba</state>
    <postalCode>R3T 3C6</postalCode>
    <country>Canada</country>
</addr>
```

8.7 Electronic Communication Detail

CDA Mapping

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Data Elements					
ELECTRONIC COMMUNICATION DETAIL	The electronic communication details of entities.	Cardinality comes from linking parent.	**telecom**		
ELECTRONIC COMMUNICATION DETAIL > **Electronic Communication Medium**	A code representing a type of communication mechanism.	1..1	telecom/**@value**	AS 5017-2006: Health Care Client Electronic Communication Medium > HL7:URLScheme	Makes up part of the value attribute as 'tel:phone number', 'mailto:email address', 'http:URL', etc.
ELECTRONIC COMMUNICATION DETAIL > **Electronic Communication Usage Code**	The manner of use that is applied to an electronic communication medium.	0..1	telecom/**@use**	HL7: TelecommunicationAddressUse > HL7:TelecommunicationAddressUse	Space separated list of codes. The section AS 5017-2006: Health Care Client Electronic Communication Usage Code explains how to map AS 5017-2006 to HL7 TelecommunicationAddressUse (HL7 TAU) code.
ELECTRONIC COMMUNICATION DETAIL > **Electronic Communication Address**	A unique combination of characters used as input to electronic telecommunication equipment for the purpose of contacting an entity.	1..1	telecom/**@value**		Makes up part of the value attribute as 'tel:**phone number**', 'mailto:**email address**', http:**URL**', etc.

Example 8.11. Electronic Communication Detail

```xml
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<!-- home telephone number -->
<telecom value="tel:0499999999" use="H" />


<!-- pager -->
<telecom value="tel:0499999999" use="PG" />


<!-- home email address -->
<telecom value="mailto:clinicial@clinician.com" use="H" />
```

8.8 Employment

CDA Mapping

Note

NS = 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.

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
CDA Data Elements					
EMPLOYMENT DETAIL	A person's occupation and employer.	Cardinality comes from linking parent.	n/a		This logical data component has no mapping to CDA.
EMPLOYMENT DETAIL > **EMPLOYER ORGANISATION**	The organisation that the individual is working for in respect to the role they are playing in the nominated participation.	1..*	**ext:asEmployment/ext:employerOrganization** ext:asEmployment/**@classCode="EMP"**		There is a known issue in the Participation Data Specification ??? for this logical data component's cardinality. Furthermore the corresponding CDA elements ext:asEmployment and ext:employerOrganization do not allow the cardinality to be multiple. The cardinality range **SHALL** be interpreted as '1..1'.
EMPLOYMENT DETAIL > EMPLOYER ORGANISATION > **Entity Identifier**	A number or code issued for the purpose of identifying a participant within a healthcare context.	1..*	ext:asEmployment/ext:employerOrganization/asOrganizationPartOf/wholeOrganization/**<Entity Identifier>**	The value of one Entity Identifier **SHALL** be an Australian HPI-O.	See common pattern: Entity Identifier.

---

[2] http://www.hl7.org/oid/index.cfm?ref=footer

SCS Data Component	Data Component Definition	Card	CDA Schema Data Element	Vocab	Comments
EMPLOYMENT DETAIL > EMPLOYER ORGAN-ISATION > **ADDRESS**	The description of a location where an entity is located or can be otherwise reached or found and a description of the purpose for which that address is primarily used by that entity.	0..*	ext:asEmployment/ext:employerOrganization/asOrganizationPartOf/wholeOrganization/**<Address>**		See common pattern: Address.
EMPLOYMENT DETAIL > EMPLOYER ORGAN-ISATION > **ELECTRONIC COMMUNICATION DETAIL**	The electronic communication details of entities.	0..*	ext:asEmployment/ext:employerOrganization/asOrganizationPartOf/wholeOrganization/**<Electronic Communication Detail>**		See common pattern: Electronic Communication Detail.
EMPLOYMENT DETAIL > EMPLOYER ORGAN-ISATION > **ORGANISATION**	Any organisation of interest to, or involved in, the business of healthcare service provision.	1..1	n/a		Not mapped directly, encompassed implicitly in assignedAuthor/ext:asEmployment/employerOrganization.
EMPLOYMENT DETAIL > EMPLOYER ORGAN-ISATION > ORGANISATION > **Organisation Name**	The name by which an organisation is known or called.	1..1	ext:asEmployment/ext:employerOrganization/**asOrganizationPartOf/wholeOrganization/name**		
EMPLOYMENT DETAIL > EMPLOYER ORGAN-ISATION > ORGANISATION > **Department/Unit**	The name by which a department or unit within a larger organisation is known or called.	0..1	ext:asEmployment/ext:employerOrganization/**name**		
EMPLOYMENT DETAIL > EMPLOYER ORGAN-ISATION > ORGANISATION > **Organisation Name Usage**	The classification that enables differentiation between recorded names for an organisation or service location.	0..1	ext:asEmployment/ext:employerOrganization/asOrganizationPartOf/wholeOrganization/name/**@use**	AS 4846-2006: Health Care Provider Organisation Name Usage	
EMPLOYMENT DETAIL > **Employment Type**	The basis on which the person is employed by the employer organisation.	0..1	ext:asEmployment/**ext:jobClassCode**	NS	
EMPLOYMENT DETAIL > **Occupation**	A descriptor of the class of job based on similarities in the tasks undertaken.	0..*	ext:asEmployment/**ext:jobCode**	*1220.0 - ANZSCO - Australian and New Zealand Standard Classification of Occupations, First Edition, Revision 1 [ABS2009]*	The corresponding CDA element ext:jobCode does not allow the cardinality to be '0..*'/multiple. The cardinality **SHALL** be interpreted as '0..1' instead of '0..*'.
EMPLOYMENT DETAIL > **Position In Organisation**	A descriptor of the job or the job role based on the management hierarchy of the organisation.	0..1	ext:asEmployment/**ext:code**	NS	

Example 8.12. Employment

```xml
<!-- This XML fragment is provided to demonstrate an example instance of each structured element in the CDA Mapping table. It is illustrative only.
Logical model constraints on allowed combinations of child components are ignored in order to provide coverage of structured elements. This fragment cannot be treated as clinically valid.
While the values in the fragment are conformant with the CDA Mapping table they are typically exaggerated to highlight the semantic meaning of the structured elements and
may not be indicative of the expected values in a clinical document.
While every effort has been taken to ensure that the examples are consistent with the message specification, where there are conflicts with the written message specification or schema,
the specification or schema will take precedence. -->

<!-- Begin EMPLOYMENT DETAIL -->
<ext:asEmployment classCode="EMP">

    <!-- Position In Organisation -->
    <ext:code>
        <originalText>Chief Oncologist</originalText>
    </ext:code>

    <!-- Occupation -->
    <ext:jobCode code="253314" codeSystem="2.16.840.1.113883.13.62"
        codeSystemName="1220.0 - ANZSCO - Australian and New Zealand Standard Classification of Occupations, First Edition, Revision 1"
        displayName="Medical Oncologist"/>"/>

    <!-- Employment Type -->
    <ext:jobClassCode code="FT" codeSystem="2.16.840.1.113883.5.1059" codeSystemName="HL7:EmployeeJobClass" displayName="full-time"/>

    <!-- Begin EMPLOYER ORGANISATION -->
    <ext:employerOrganization>

        <!-- Department/Unit -->
        <name>Oncology Ward</name>

        <asOrganizationPartOf>
            <wholeOrganization>
                <!-- Organisation Name -->
                <name use="ORGB">Acme Hospital</name>

                <!-- ELECTRONIC COMMUNICATION DETAIL -->
                <telecom value="tel:0499999999" use="WP" />

                <!-- ADDRESS -->
                <addr use="WP">
                    <houseNumber>1</houseNumber>
                    <streetName>Clinician</streetName>
                    <streetNameType>St</streetNameType>
                    <city>Healthville</city>
                    <state>QLD</state>
                    <postalCode>5555</postalCode>
                    <additionalLocator>32568931</additionalLocator>
                </addr>

                <!-- Entity Identifier -->
                <ext:asEntityIdentifier classCode="IDENT">
                    <ext:id assigningAuthorityName="HPI-O" root="1.2.36.1.2001.1003.0.8003621566684455"/>
                    <ext:assigningGeographicArea classCode="PLC">
                        <ext:name>National Identifier</ext:name>
                    </ext:assigningGeographicArea>
                </ext:asEntityIdentifier>

            </wholeOrganization>
        </asOrganizationPartOf>
        <!-- End EMPLOYER ORGANISATION -->
```

```
        </ext:employerOrganization>
</ext:asEmployment>
<!-- End EMPLOYMENT DETAIL -->
```

9 Australian Digital Health Agency CDA Extensions

As part of the CDA, standard extensions are allowed as follows:

Locally-defined markup may be used when local semantics have no corresponding representation in the CDA specification. CDA seeks to standardize the highest level of shared meaning while providing a clean and standard mechanism for tagging meaning that is not shared. In order to support local extensibility requirements, it is permitted to include additional XML elements and attributes that are not included in the CDA schema. These extensions should not change the meaning of any of the standard data items, and receivers must be able to safely ignore these elements. Document recipients must be able to faithfully render the CDA document while ignoring extensions.

Extensions may be included in the instance in a namespace other than the HL7v3 namespace, but must not be included within an element of type ED (e.g., <text> within <procedure>) since the contents of an ED datatype within the conformant document may be in a different namespace. Since all conformant content (outside of elements of type ED) is in the HL7 namespace, the sender can put any extension content into a foreign namespace (any namespace other than the HL7 namespace). Receiving systems must not report an error if such extensions are present. "HL7 Clinical Document Architecture, Release 2" [HL7CDAR2]

As such the following extensions have been defined where Australian concepts were not represented in CDA.

This section is provided for clarity only. Please see the relevant mappings section where these extensions have been used for actual mapping details.

9.1 ClinicalDocument.completionCode

Figure 9.1 ClinicalDocument.completionCode shows a subset of the CDA R-MIM containing those classes with the relevant Australian Digital Health Agency CDA extension represented.

ClinicalDocument

classCode*: <= DOCCLIN
moodCode*: <= EVN
id*: II [1..1]
code*: CE CWE [1..1] < DocumentType
title: ST [0..1]
effectiveTime*: TS [1..1]
confidentialityCode*: CE CWE [1..1] <= x_BasicConfidentialityKind
languageCode: CS CNE [0..1] < HumanLanguage
setId: II [0..1]
versionNumber: INT [0..1]
completionCode: CE CWE [0..1] < DocumentCompletion

Note:
completionCode has been added as an Australian Digital Health Agency extension to CDA.

Figure 9.1. ClinicalDocument.completionCode

9.2 Multiple Birth

Figure 9.2 Multiple Birth shows a subset of the CDA R-MIM containing those classes with the relevant Australian Digital Health Agency CDA extension represented.

Note:
multipleBirthInd and multipleBirthOrderNumber have been added as Australian Digital Health Agency extensions to CDA.

Patient
classCode*: <= *PSN*
determinerCode*: <= *INSTANCE*
id: II [0..1] (Deprecated)
name: SET<PN> [0..*]
administrativeGenderCode: CE CWE [0..1] < *D:AdministrativeGender*
birthTime: TS [0..1]
multipleBirthInd: BL [0..1]
multipleBirthOrderNumber: INT [0..1]
maritalStatusCode: CE CWE [0..1] < *D:MaritalStatus*
religiousAffiliationCode: CE CWE [0..1] < *D:ReligiousAffiliation*
raceCode: CE CWE [0..1] < *D:Race*
ethnicGroupCode: CE CWE [0..1] < *D:Ethnicity*

Note:
multipleBirthInd and multipleBirthOrderNumber have been added as Australian Digital Health Agency extensions to CDA.

SubjectPerson
classCode*: <= *PSN*
determinerCode*: <= *INSTANCE*
name: SET<PN> [0..*]
administrativeGenderCode: CE CWE [0..1] < *D:AdministrativeGender*
birthTime: TS [0..1]
multipleBirthInd: BL [0..1]
multipleBirthOrderNumber: INT [0..1]

Figure 9.2. Multiple Birth

9.3 Deceased Time

Figure 9.3 Deceased Time shows a subset of the CDA R-MIM containing those classes with the relevant Australian Digital Health Agency CDA extension represented.

Note:
deceasedInd and deceasedTime have been added as Australian Digital Health Agency extensions to CDA.

Patient

classCode*: <= *PSN*
determinerCode*: <= *INSTANCE*
name: SET<PN> [0..*]
administrativeGenderCode: CE CWE [0..1] < *AdministrativeGender*
birthTime: TS [0..1]
deceasedInd: BL [0..1]
deceasedTime: TS [0..1]

Note:
deceasedInd and deceasedTime have been added as Australian Digital Health Agency extensions to CDA.

SubjectPerson

classCode*: <= *PSN*
determinerCode*: <= *INSTANCE*
name: SET<PN> [0..*]
administrativeGenderCode: CE CWE [0..1] < *D:AdministrativeGender*
birthTime: TS [0..1]
deceasedInd: BL [0..1]
deceasedTime: TS [0..1]

Figure 9.3. Deceased Time

9.4 EntityIdentifier

Figure 9.4 EntityIdentifier shows a subset of the CDA R-MIM containing those classes with the relevant Australian Digital Health Agency CDA extension represented.
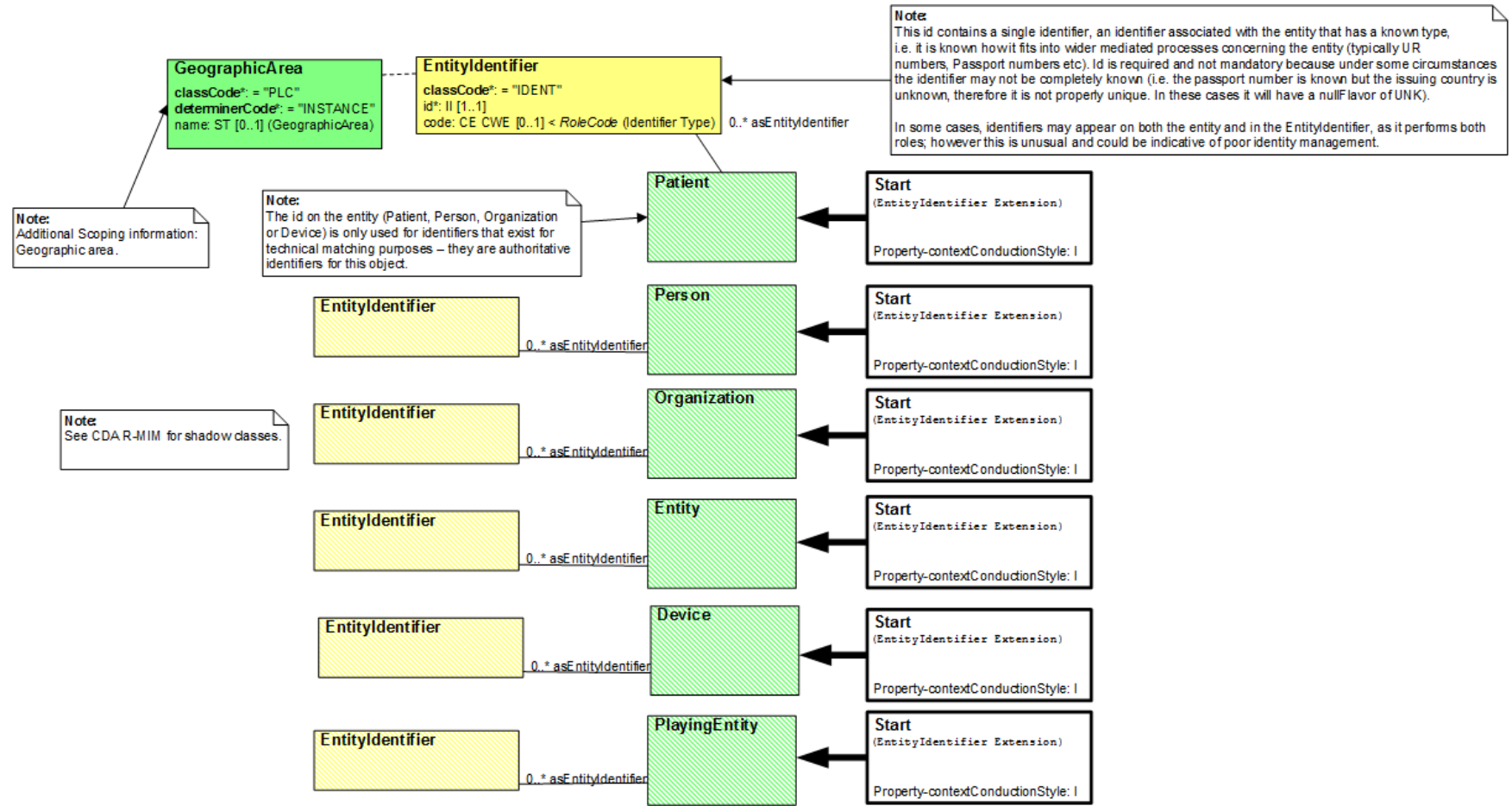
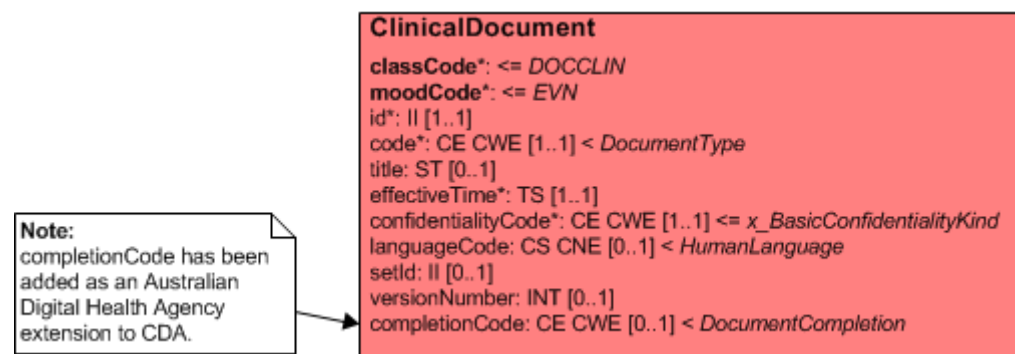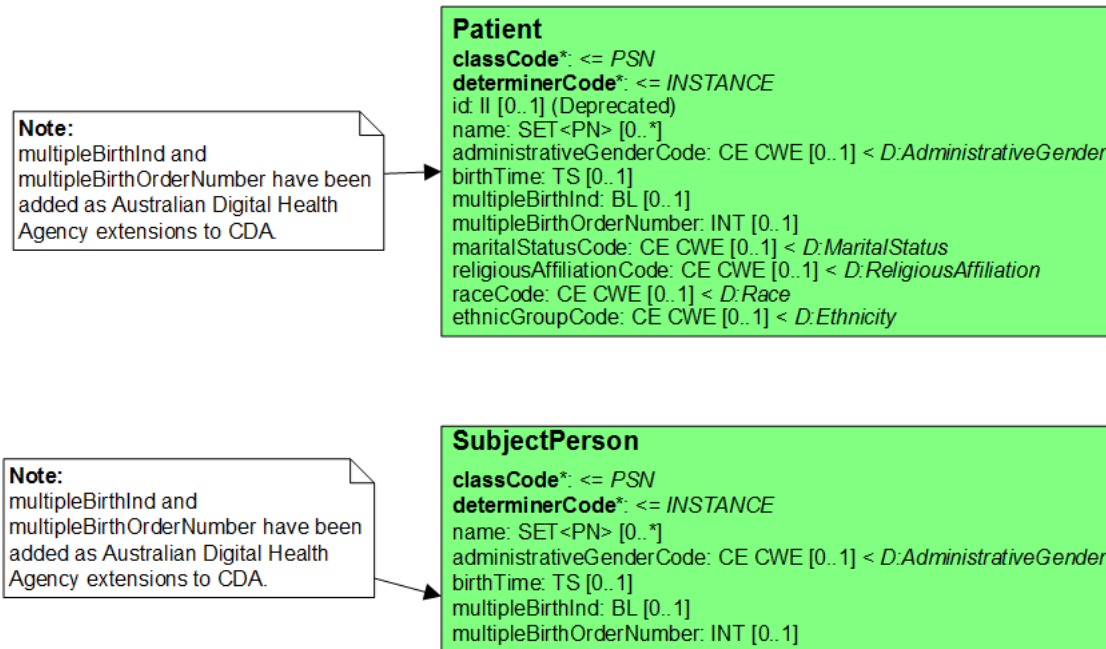**Figure 9.4. EntityIdentifier**

9.5 Employment

Figure 9.5 Employment shows a subset of the CDA R-MIM containing those classes with the relevant Australian Digital Health Agency CDA extension represented.

Figure 9.5. Employment

9.6 Qualifications

Figure 9.6 Qualifications shows a subset of the CDA R-MIM containing those classes with the relevant Australian Digital Health Agency CDA extension represented.

Figure 9.6. Qualifications

9.7 Entitlement

Figure 9.7 Entitlement shows a subset of the CDA R-MIM containing those classes with the relevant Australian Digital Health Agency CDA extension represented.

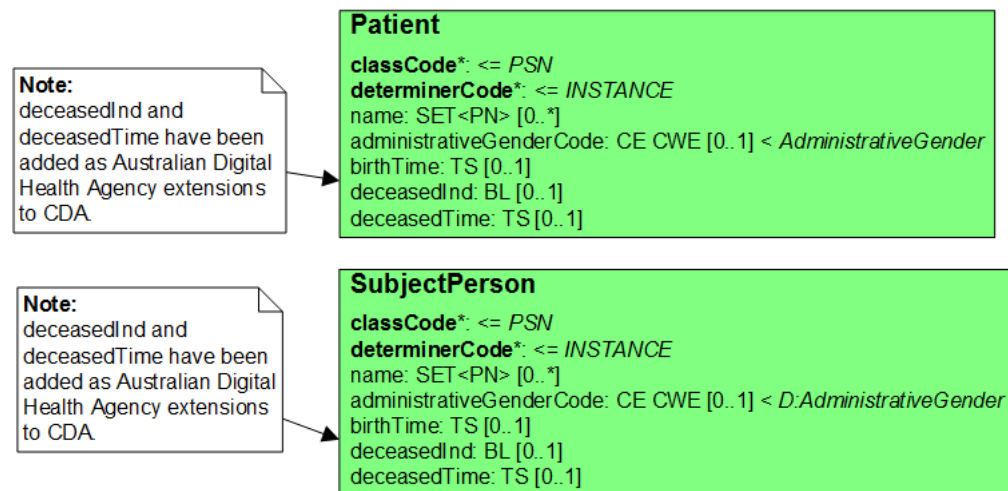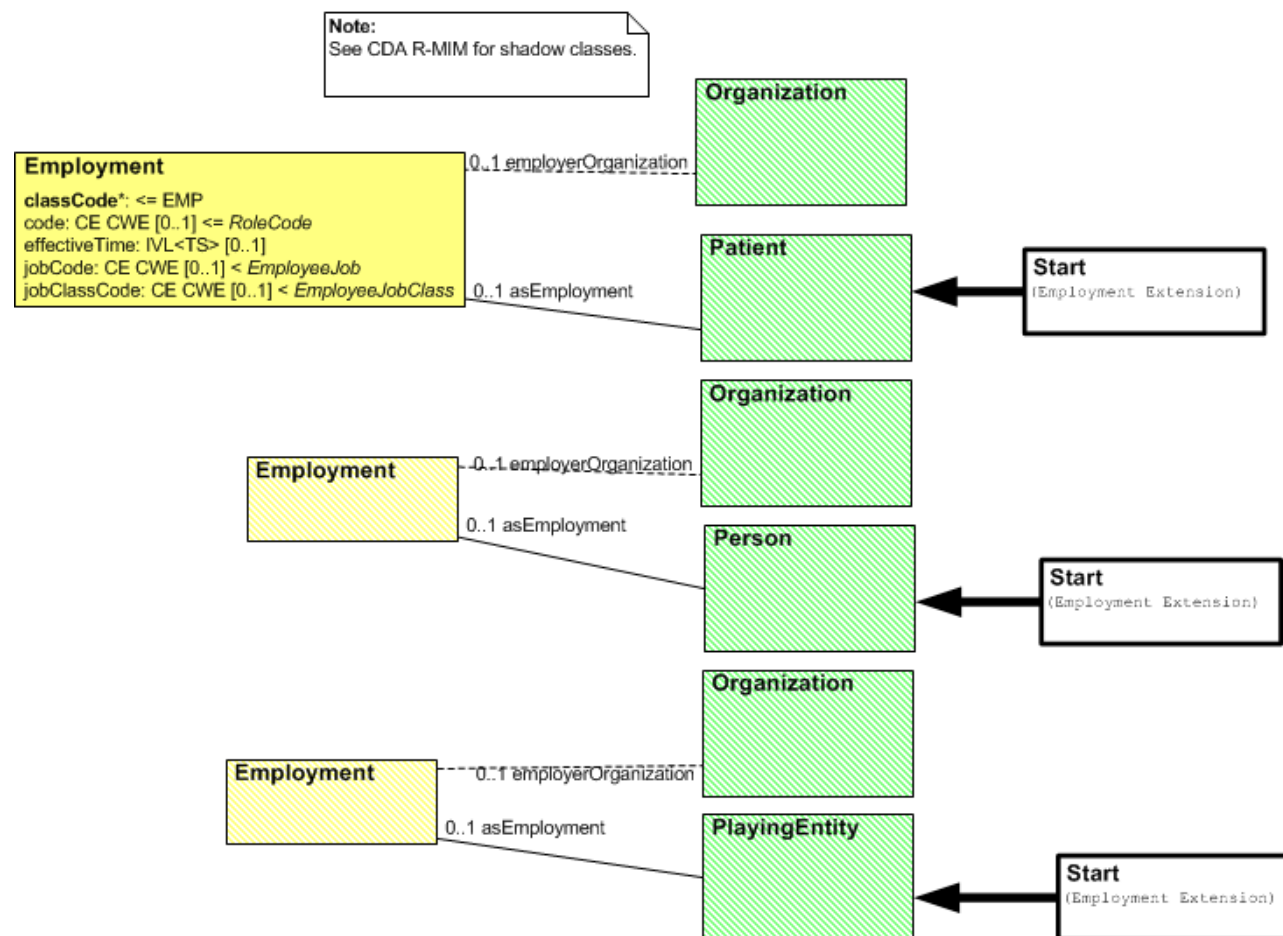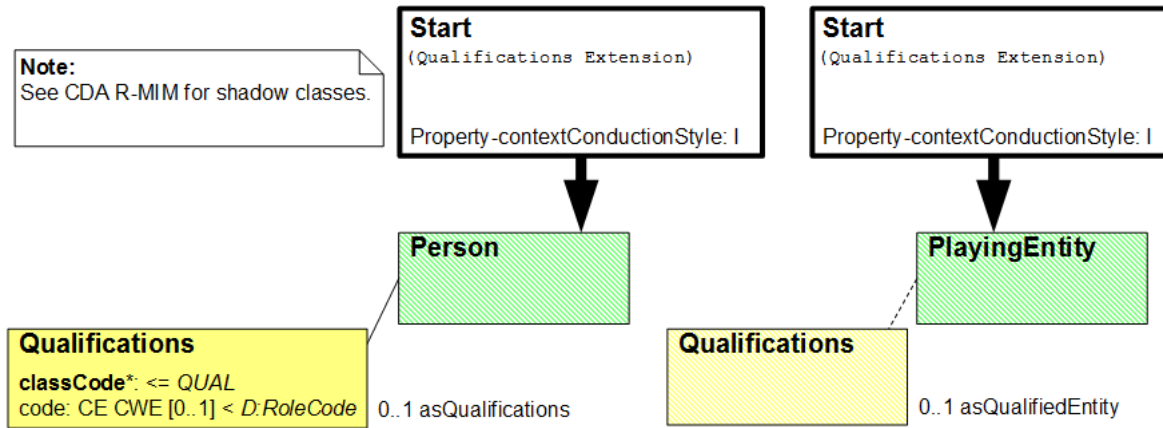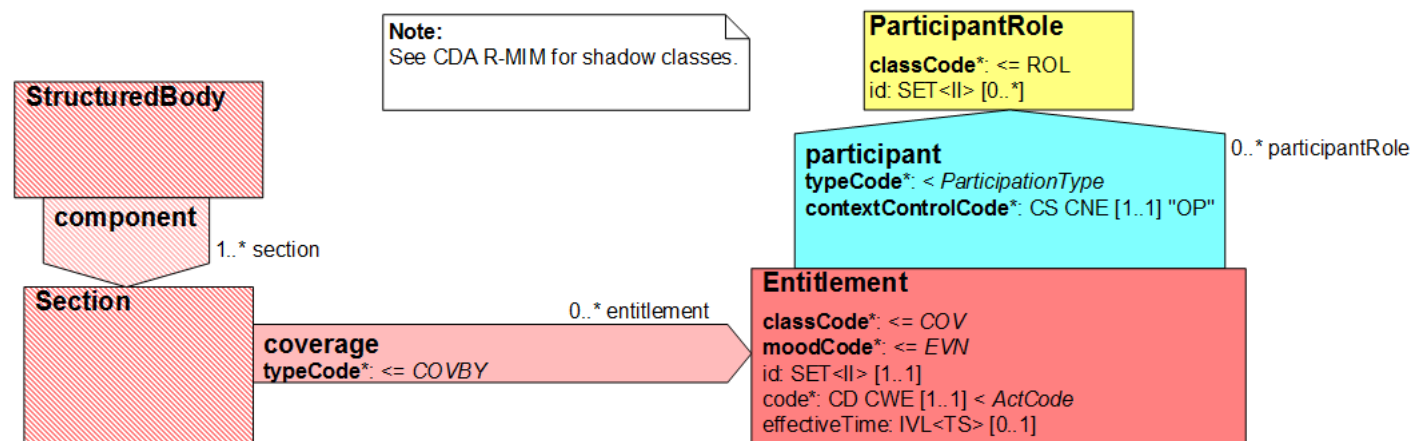**Figure 9.7. Entitlement**

10 Vocabularies and Code Sets

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When using the following vocabulary tables, if one column in the code set table is bolded, use the code in that column, otherwise use the values in all columns.

Example 10.1. One value

```
<name use="L">
    {name}
</name>
```

Example 10.2. All values

```
<code
    code="103.16044.4.1.1"
    codeSystem="1.2.36.1.2001.1001"
    codeSystemName="NCTIS Data Components"
    displayName="Additional Comments" />
```

10.1 HL7: TelecommunicationAddressUse

Code	Value
H	Home
HP	Primary Home
HV	Vacation Home
WP	Workplace
AS	Answering Service
EC	Emergency Contact

Code	Value
MC	Mobile Contact
PG	Pager

10.2 AS 5017-2006 Health Care Client Identifier Sex

displayName	code	codeSystemName	codeSystem
Male	M	AS 5017-2006 Health Care Client Identifier Sex	2.16.840.1.113883.13.68
Female	F	AS 5017-2006 Health Care Client Identifier Sex	2.16.840.1.113883.13.68
Intersex or Indeterminate	I	AS 5017-2006 Health Care Client Identifier Sex	2.16.840.1.113883.13.68
Not Stated/Inadequately Described	N	AS 5017-2006 Health Care Client Identifier Sex	2.16.840.1.113883.13.68

10.3 AS 5017-2006: Health Care Client Name Usage

Code Set AS 5017-2006 mapped to HL7 Entity Name Use Code

When referencing the following vocabulary tables, if one column in the code set table is bolded, use the code in that column; otherwise use the values in all columns.

Note

CDA Release 2 uses HL7 Data Types Release 1. For some of the AS 5017-2006 values, there are no satisfactory equivalents in the HL7 Entity Name Use R1 code set. In these cases (marked R2), an HL7 Entity Name Use R2 code has been used.

Note

In cases (marked EXT) where there are no suitable HL7 codes, extension codes have been created.

AS 5017-2006 Code	AS 5017-2006 Alternative Code	AS 5017-2006 Descriptor	HL7 Entity Name Use Code	HL7 Entity Name Use Name	HL7 Name Use Definition
1	L	Registered Name (Legal Name)	**L**	(R1) Legal	(R1) Known as/conventional/the one you use.
2	R	Reporting Name	**C**	(R1) License	(R1) As recorded on a license, record, certificate, etc. (only if different from legal name).
3	N	Newborn Name	**NB**	(EXT)	(EXT)
4	B	Professional or Business Name	**A**	(R1) Artist/Stage	(R1) Includes writer's pseudonym, stage name, etc.
5	M	Maiden Name (Name at birth)	**M**	(R2) Maiden Name	A name used prior to marriage.
8	O	Other Name (Alias)	**P**	(R1) Pseudonym	(R1) A self-asserted name that the person is using or has used.

10.4 AS 4846-2006: Health Care Provider Organisation Name Usage

Code Set AS 5017-2006 Organisation Name Usage mapped to HL7 Name Use Code

When referencing the following vocabulary tables, if one column in the code set table is bolded, use the code in that column; otherwise use the values in all columns.

Note

There are no suitable HL7 codes, so extension codes have been created.

AS 4846-2006 Code	AS 4846-2006 Alternative Code	AS 4846-2006 Descriptor	HL7 Name Use Code	HL7 Name Use Name	HL7 Name Use Definition
1	U	Organizational unit/section/division name	**ORGU**	(EXT)	(EXT)
2	S	Service location name	**ORGS**	(EXT)	(EXT)
3	B	Business name	**ORGB**	(EXT)	(EXT)
4	L	Locally used name	**ORGL**	(EXT)	(EXT)
5	A	Abbreviated name	**ORGA**	(EXT)	(EXT)
6	E	Enterprise name	**ORGE**	(EXT)	(EXT)
8	X	Other	**ORGX**	(EXT)	(EXT)
9	Y	Unknown	**ORGY**	(EXT)	(EXT)

10.5 AS 5017-2006: Health Care Client Source of Death Notification

displayName	code	codeSystemName	codeSystem
Official death certificate or death register	D	AS 5017-2006 Health Care Client Source of Death Notification	2.16.840.1.113883.13.64
Health Care Provider	H	AS 5017-2006 Health Care Client Source of Death Notification	2.16.840.1.113883.13.64
Relative	R	AS 5017-2006 Health Care Client Source of Death Notification	2.16.840.1.113883.13.64
Other	O	AS 5017-2006 Health Care Client Source of Death Notification	2.16.840.1.113883.13.64
Unknown	U	AS 5017-2006 Health Care Client Source of Death Notification	2.16.840.1.113883.13.64

10.6 AS 5017-2006: Health Care Client Identifier Address Purpose

AS 5017-2006 mapped to HL7 AddressUse Code

When referencing the following vocabulary tables, if one column in the code set table is bolded, use the code in that column; otherwise use the values in all columns.

AS 5017-2006 Code	AS 5017-2006 Alternative Code	AS 5017-2006 Descriptor	HL7 AddressUse Code	HL7 AddressUse Name	HL7 AddressUse Definition
1	B	Business	**WP**	Work Place	An office address. First choice for business related contacts during business hours.
2	M	Mailing or Postal	**PST**	Postal Address	Used to send mail.
3	T	Temporary Accommodation (individual provider only)	**TMP**	Temporary Address	A temporary address, may be good for visit or mailing.
4	R	Residential (permanent) (individual provider only)	**H**	Home Address	A communication address at a home.
9	U	Not Stated/Unknown/Inadequately Described	**In this case simply omit the Address Use Code**		

10.7 AS 5017-2006: Health Care Client Identifier Geographic Area

displayName	code	codeSystemName	codeSystem
Local Client (Unit Record) Identifier	L	AS 5017-2006 Health Care Client Identifier Geographic Area	2.16.840.1.113883.13.63
Area/Region/District Identifier	A	AS 5017-2006 Health Care Client Identifier Geographic Area	2.16.840.1.113883.13.63
State or Territory Identifier	S	AS 5017-2006 Health Care Client Identifier Geographic Area	2.16.840.1.113883.13.63
National Identifier	N	AS 5017-2006 Health Care Client Identifier Geographic Area	2.16.840.1.113883.13.63

10.8 AS 5017-2006: Health Care Client Electronic Communication Medium

When referencing the following vocabulary tables, if one column in the code set table is bolded, use the code in that column; otherwise use the values in all columns.

AS 5017-2006 Code	AS 5017-2006 Descriptor	AS 5017-2006 Alternative Code	HL7 URLScheme Code	HL7 URLScheme Name	HL7 URLScheme Definition
1	Telephone (excluding mobile telephone)	T	**tel**	Telephone	A voice telephone number.
2	Mobile (cellular) telephone NOTE: Mobile will also need a TelecommunicationAddress Use code of MC (Mobile Contact) (see HL7: Telecommu-nicationAddressUse)	M	**tel**	Telephone	A voice telephone number.
3	Facsimile machine	F	**fax**	Fax	A telephone number served by a fax device.
4	Pager NOTE: Pager will also need a TelecommunicationAddress Use code of PG (Pager) (see HL7: TelecommunicationAd-dressUse)	P	**tel**	Telephone	A voice telephone number.
5	Email	E	**mailto**	Mailto	Electronic mail address.

AS 5017-2006 Code	AS 5017-2006 Descriptor	AS 5017-2006 Alternative Code	HL7 URLScheme Code	HL7 URLScheme Name	HL7 URLScheme Definition
6	URL	U	Use the most appropriate code from the list below:		
			file	File	Host-specific local file names. Note that the file scheme works only for local files. There is little use for exchanging local file names between systems, since the receiving system likely will not be able to access the file.
			ftp	FTP	The File Transfer Protocol (FTP).
			http	HTTP	Hypertext Transfer Protocol.
			mllp	MLLP	The traditional HL7 Minimal Lower Layer Protocol. The URL has the form of a common IP URL e.g., mllp://<host>:<port>/ with <host> being the IP address or DNS hostname and <port> being a port number on which the MLLP protocol is served.
			modem	Modem	A telephone number served by a modem device.
			nfs	NFS	Network File System protocol. Some sites use NFS servers to share data files.
			telnet	Telnet	Reference to interactive sessions. Some sites, (e.g., laboratories) have TTY based remote query sessions that can be accessed through telnet.

10.9 AS 5017-2006: Health Care Client Electronic Communication Usage Code

AS 5017-2006 mapped to HL7 TelecommunicationAddressUse (HL7 TAU) Code

When referencing the following vocabulary tables, if one column in the code set table is bolded, use the code in that column; otherwise use the values in all columns.

Code	Descriptor	Alternative Code	HL7 TAU Code	HL7 TAU Name	HL7 TAU Description
1	Business	B	**WP**	Work place	An office address. First choice for business related contacts during business hours.
2	Personal	P	**H**	Home address	A communication address at a home, attempted contacts for business purposes might intrude privacy and chances are one will contact family or other household members instead of the person one wishes to call. Typically used with urgent cases, or if no other contacts are available.
3	Both business and personal use	A	**WP H**	Both Work place and Home address	

10.10 AS 5017-2006 Australian State/Territory Identifier - Postal

Code	Descriptor
NSW	New South Wales
VIC	Victoria
QLD	Queensland
SA	South Australia
WA	Western Australia
TAS	Tasmania
NT	Northern Territory
ACT	Australian Capital Territory
U	Unknown

10.11 AS 5017-2006 Health Care Client Identifier Date Accuracy Indicator

The data elements that use this value set consist of a combination of three codes, each of which denotes the accuracy of one date component:

A – The referred date component is accurately known.

E – The referred date component is an estimate.

U – The referred date component is unknown.

The data elements that use this value set contain positional fields (DMY).

Field 1 (D) – refers to the accuracy of the day component.

Field 2 (M) – refers to the accuracy of the month component.

Field 3 (Y) – refers to the accuracy of the year component.

Note
The order of the date components in the HL7 date and time datatypes (YYYYMMDD) is the reverse of that specified above.

The possible combinations are as follows:

code	descriptor
AAA	Accurate date
AAE	Accurate day and month, estimated year
AEA	Accurate day, estimated month, accurate year
AAU	Accurate day and month, unknown year
AUA	Accurate day, unknown month, accurate year
AEE	Accurate day, estimated month and year
AUU	Accurate day, unknown month and year
AEU	Accurate day, estimated month, unknown year
AUE	Accurate day, unknown month

code	descriptor
EEE	Estimated date
EEA	Estimated day and month, accurate year
EAE	Estimated day, accurate month
EEU	Estimated day and month, unknown year
EUE	Estimated day, unknown month, estimated year
EAA	Estimated day, accurate month and year
EUU	Estimated day, unknown month and year
EAU	Estimated day, accurate month, unknown year
EUA	Estimated day, unknown month, accurate year
UUU	Unknown date
UUA	Unknown day and month, accurate year
UAU	Unknown day, accurate month, unknown year
UUE	Unknown day and month, estimated year
UEU	Unknown day, estimated month, unknown year
UAA	Unknown day, accurate month and year
UEE	Unknown day, estimated month and year
UAE	Unknown day, accurate month, estimated year
UEA	Unknown day, estimated month, accurate year

10.12 NCTIS: Admin Codes - Document Status

displayName	code	codeSystemName	codeSystem
Interim	I	NCTIS Document Status Values	1.2.36.1.2001.1001.101.104.20104
Final	F	NCTIS Document Status Values	1.2.36.1.2001.1001.101.104.20104
Withdrawn	W	NCTIS Document Status Values	1.2.36.1.2001.1001.101.104.20104

10.13 NCTIS: Admin Codes - Entitlement Type

displayName	code	codeSystemName	codeSystem
Medicare Benefits	1	NCTIS Entitlement Type Values	1.2.36.1.2001.1001.101.104.16047
Pensioner Concession	2	NCTIS Entitlement Type Values	1.2.36.1.2001.1001.101.104.16047
Commonwealth Seniors Health Concession	3	NCTIS Entitlement Type Values	1.2.36.1.2001.1001.101.104.16047
Health Care Concession	4	NCTIS Entitlement Type Values	1.2.36.1.2001.1001.101.104.16047
Repatriation Health Gold Benefits	5	NCTIS Entitlement Type Values	1.2.36.1.2001.1001.101.104.16047
Repatriation Health White Benefits	6	NCTIS Entitlement Type Values	1.2.36.1.2001.1001.101.104.16047
Repatriation Health Orange Benefits	7	NCTIS Entitlement Type Values	1.2.36.1.2001.1001.101.104.16047
Safety Net Concession	8	NCTIS Entitlement Type Values	1.2.36.1.2001.1001.101.104.16047
Safety Net Entitlement	9	NCTIS Entitlement Type Values	1.2.36.1.2001.1001.101.104.16047
Medicare Prescriber Number	10	NCTIS Entitlement Type Values	1.2.36.1.2001.1001.101.104.16047
Medicare Pharmacy Approval Number	11	NCTIS Entitlement Type Values	1.2.36.1.2001.1001.101.104.16047

10.14 HL7 RoleCode and RoleClass codes

displayName	code	codeSystemName	codeSystem
agent	AGNT	RoleClass	2.16.840.1.113883.5.110
Self	SELF	RoleCode	2.16.840.1.113883.5.111

10.15 METeOR 291036: Indigenous Status

displayName	code	codeSystemName	codeSystem
Aboriginal but not Torres Strait Islander origin	1	METeOR Indigenous Status	2.16.840.1.113883.3.879.291036
Torres Strait Islander but not Aboriginal origin	2	METeOR Indigenous Status	2.16.840.1.113883.3.879.291036
Both Aboriginal and Torres Strait Islander origin	3	METeOR Indigenous Status	2.16.840.1.113883.3.879.291036
Neither Aboriginal nor Torres Strait Islander origin	4	METeOR Indigenous Status	2.16.840.1.113883.3.879.291036
Not stated/inadequately described	9	METeOR Indigenous Status	2.16.840.1.113883.3.879.291036

10.16 CodeSystem OIDs

Note

This table is provided as a quick look up table; it is not an exhaustive identification of all code systems referenced in this implementation guide. The entries in the codeSystem (Name) column enable identification of the codeSystem OID to be used, but may not be the proper name of that codeSystem, i.e. the value of the codeSystemName attribute. The value of codeSystemName **SHOULD** be the name associated with the OID in the HL7 OID Registry[1].

codeSystem (OID)	codeSystem (Name)
1.2.36.1.2001.1001.101	NCTIS Data Components
1.2.36.1.2001.1001.101.104.16047	NCTIS Entitlement Type Values
1.2.36.1.2001.1001.101.104.20104	NCTIS Document Status Values
2.16.840.1.113883.12.62	1220.0 - ANZSCO - Australian and New Zealand Standard Classification of Occupations
2.16.840.1.113883.12.62	1220.0 - ANZSCO - Australian and New Zealand Standard Classification of Occupations, First Edition, Revision 1
2.16.840.1.113883.13.64	AS 5017-2006 Health Care Client Source of Death Notification
2.16.840.1.113883.13.65	AIHW Mode of Separation
2.16.840.1.113883.13.63	AS 5017-2006 Health Care Client Identifier Geographic Area
2.16.840.1.113883.13.68	AS 5017-2006 Health Care Client Identifier Sex
2.16.840.1.113883.3.879.291036	METeOR Indigenous Status
2.16.840.1.113883.6.96	SNOMED CT
2.16.840.1.113883.6.96	SNOMED CT-AU
1.2.36.1.2001.1004.100	Australian Medicines Terminology (AMT) v2
2.16.840.1.113883.6.96	Australian Medicines Terminology (AMT) v3
2.16.840.1.113883.6.1	LOINC

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[1] http://www.hl7.org/oid/index.cfm?ref=footer

Appendix A. CDA Narratives

CDA requires that each section in its body include a narrative block, containing a clinically complete version of the section's encoded content using custom hypertext markup defined by HL7. The narrative is the human-readable and attestable part of a CDA document, and **SHALL** stand alone as an accurate representation of the content of the document without any need to consult entries in the body.

There is no canonical markup for specific CDA components, but some conformance points apply:

- The narrative block **SHALL** be encapsulated within the text component of the CDA section.

- The narrative contents **SHALL** conform to the requirements specified in the CDA Rendering Specification.

  - In accordance with the requirement to completely represent section contents, values of codedText or codeableText data elements defined in the SCS **SHALL** include an originalText or a displayName component (or both). Where available, the originalText **SHOULD** be found in the narrative, otherwise the displayName **SHOULD** be found in the narrative.

- The narrative contents **SHALL** completely and accurately represent the clinical information encoded in the section. Content **SHALL NOT** be omitted from the narrative.

- The narrative **SHALL** conform to the content requirements of the CDA specification [HL7CDAR2] and the XML Schema.

Clinical judgement is required to determine the appropriate presentation for narrative. We may release additional guidance in this regard. The examples provided in sections of this document offer some guidance for narrative block markup and may be easily adapted as boilerplate markup.

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