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Health Record Overview Information Requirements v1.1

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Table of contents

1 Introduction 5
1.1 Purpose 5
1.2 Intended audience 5
1.3 Scope 6
1.3.1 Exclusions 6
1.4 Overview 6
2 Health Record Overview 7
2.1 Component: Individual (Subject of Care) 7
2.2 Component: Advance Care Directive Custodian 7
2.3 Component: New Documents 7
2.3.1 Document Author Information 7
2.4 Component: Shared Health Summary 7
2.5 Component: Current and Past Medical History 7
2.6 Component: Allergies and Adverse Reactions 7
2.7 Component: Medicines 8
2.8 Component: Immunisations 8
2.9 Component: Consumer Entered Data 8
2.10 Component: Medicare Overview 8
2.11 Component: Prescription and Dispense View 8
2.12 Component: Health Check Assessment Schedule View 8
2.13 Component: eHealth Pathology Report View 8
2.14 Component: eHealth Diagnostic Imaging Report View 8
2.15 Component: Recent Documents 8
Acronyms 10
Glossary 11

1 Introduction

1.1 Purpose

This document presents the information requirements for Health Record Overview (HRO), which are recommended for use within Australia in association with the national personally controlled electronic health (eHealth) record system.

The HRO information requirements are a logical set of data items for exchange, and are therefore independent of any particular platform, technology, exchange format, or presentation format.

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

This document defines the nationally agreed requirements for information exchange between Australian-based healthcare providers and the national eHealth record system, independent of exchange or presentation formats.

It is anticipated that these information requirements will:

- promote a common understanding of the requirements for the construction and consumption of HRO clinical documents;
- provide a common framework for the development and use of semantically interoperable information components to be exchanged between clinical systems and the national eHealth record system;
- provide a common framework for defining queries using these information requirements at logical levels, which may be adopted for implementations in local, jurisdictional or national electronic health record environments;
- provide a common framework for nationally defined mappings to specific exchange formats; and
- provide a framework (along with other documents and structures) suitable for the development of national terminology sets that associate specific data items with valid values or code sets.[1]

1.2 Intended audience

This document is intended for all interested stakeholders including:

- clinicians;
- early adopter hospitals and health departments in the process of planning, implementing or upgrading eHealth systems;
- software vendors developing eHealth system products;
- senior managers and policy makers, clinical experts, health information managers, IT operations and support teams, system integrators;
- consumers and consumer representatives; and
- the Commonwealth Department of Health project team.

[1] These values will be derived from nationally endorsed terminologies maintained and distributed by NEHTA's National Clinical Terminology and Information Service (NCTIS). The current terminology sources that will provide this content are LOINC for defined areas of Pathology content, SNOMED CT-AU for all other clinical content and Australian Medicines Terminology (AMT) for medicinal products. Administrative content will be derived either from SNOMED CT-AU or specifically defined external code sets.

1.3 Scope

The scope of this document is to define the detailed information requirements for the content and structure of the HRO.

1.3.1 Exclusions

Specifications relating to the way information is formatted for display, and the method of constructing the HRO in portals or local clinical information systems, are beyond the scope of this document.

1.4 Overview

The HRO serves as a clinical front sheet to patient information from the national eHealth record system. For providers, it is intended to offer an overall impression of an individual's current medical condition and general state of health 'at a glance'. For consumers, it is intended to inform them about their own conditions and help them assess whether the data recorded in their eHealth record matches with their own understanding of their personal state of health.

The HRO can be accessed via the provider and consumer portals, or can be downloaded as a clinical document for viewing within the local system. It should be noted that an HRO is a point-in-time clinical document. Once downloaded, it can be stored against a patient's record as a reference. However, to ensure that the latest one is being viewed, a new download request should always be made to the national eHealth record system by the local clinical information system each time the HRO is viewed.

The HRO is composed of:

1 clinical information taken from the latest shared health summary, grouped into categories such as Allergies and Adverse Reactions, Medicines, Current and Past Medical History, and Immunisations;

2 a listing of clinical documents that are more recent than the latest shared health summary;

3 a listing of all clinical documents over the past 12 months; and

4 links to other information maintained within the national eHealth record system such as Medicare Overview, Prescription and Dispense View, etc.

The actual content of an HRO varies depending on the individual, the PCEHR access level afforded to the user, and the availability of information.

2 Health Record Overview

The required components for the Health Record Overview are summarised below.

2.1 Component: Individual (Subject of Care)

The individual is the person about whom the healthcare information has been captured; the subject of the information.

Data relevant to this component are taken from the individual's details as available within the PCEHR Individual Details View.

2.2 Component: Advance Care Directive Custodian

The Health Record Overview allows the user to easily access the individual's Advance Care Directive Custodian information.

2.3 Component: New Documents

This component seeks to bring the user's attention to the fact that there are newer documents other than the latest version of the shared health summary available within the individual's PCEHR.

2.3.1 Document Author Information

Each document is created at a specific time and within a specific context. This contextual and time-based information has to be transferred to the Health Record Overview CDA document to ensure that the provenance of the source data is maintained. This section presents the contextual information that needs to be extracted from the source documents and passed with the clinical data (with their relationships intact) into the Health Record Overview CDA document.

The following are details of the author that will be included in the New Documents section of the Health Record Overview for each item in the list of documents newer than the latest shared health summary.

2.4 Component: Shared Health Summary

This component provides information on the availability of the shared health summary in the individual's PCEHR.

2.5 Component: Current and Past Medical History

This component shows a summary of an individual's medical history. This component consists of information sourced from the shared health summary.

2.6 Component: Allergies and Adverse Reactions

This component shows a summary of an individual's allergies and adverse reactions. This component consists of information sourced from the shared health summary.

2.7 Component: Medicines

This component shows a summary of an individual's medicines information. This component consists of information sourced from the shared health summary.

2.8 Component: Immunisations

This component shows a summary of an individual's immunisation information. This component consists of information sourced from the shared health summary.

2.9 Component: Consumer Entered Data

This component shows information entered by the consumer. Healthcare providers can only view the Consumer Entered Health Summary information component of the consumer entered data.

2.10 Component: Medicare Overview

This component allows the user to gain access to Medicare information by presenting a link to the Medicare Overview in the HRO. This information is comprised of those items under the Medicare Benefits Schedule claims history, the Pharmaceutical Benefits Scheme claims history, Australian Childhood Immunisation Register information, and Australian Organ Donor Registry information.

2.11 Component: Prescription and Dispense View

This component allows the user to gain access to prescription and dispense records by presenting a link to the PCEHR Prescription and Dispense View, in the Health Record Overview.

2.12 Component: Health Check Assessment Schedule View

This component allows the user to gain access to the Health Check Assessment Schedule information in the child eHealth record by presenting a link to the Health Check Assessment Schedule View, in the Health Record Overview.

2.13 Component: eHealth Pathology Report View

This component allows the user to gain access to the individual’s pathology reports by presenting a link to the eHealth Pathology Report View, in the Health Record Overview.

2.14 Component: eHealth Diagnostic Imaging Report View

This component allows the user to gain access to diagnostic imaging reports by presenting a link to the eHealth Diagnostic Imaging Report View, in the Health Record Overview.

2.15 Component: Recent Documents

This component lists the documents that have been recently uploaded or amended, which need to be included in the Health Record Overview. The documents are not

constrained only to those that are newer than the most recent shared health summary.

Recency is within the last 12 months, based on the Date Created (Effective Time) per document. This component contains information on the document author and relating to the document itself.

Acronyms

This table lists abbreviations and acronyms in alphabetical order.

Term	Description
CDA	Clinical Document Architecture
LOINC	Logical Observation Identifiers Names and Codes
PCEHR	personally controlled electronic health record, also known as the eHealth record
SNOMED CT	Systemised Nomenclature of Medicine, Clinical Terminology[2]

[2] SNOMED CT was originally created by The College of American Pathologists. IHTSDO®, SNOMED® and SNOMED CT® are registered trademarks of the International Health Terminology Standards Development Organisation (IHTSDO®).

Glossary

Term	Meaning
Clinical Document Architecture (CDA)	An XML-based mark-up standard intended to specify the encoding, structure and semantics of clinical documents for exchange. CDA is an ANSI-certified standard from Health Level Seven.