Australian Government
Australian Digital Health Agency

# Shared Health Summary Information Requirements

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# Document information

## Key information

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## Product or document version history

| Product or document version | Date | Release comments |
|---|---|---|
| 1.0 | 29 Nov 2011 | First publication |
| 1.1 | 10 Apr 2015 | Please refer to the change log in Appendix A. |
| 1.1 | 22 May 2025 | The document presentation has been enhanced to align with current branding guidelines, however the content has not been changed. |

## Transition of terms

Certain terms used within the context of this document have changed. The table provides a clear comparison of the historical terms used in text and their current equivalents for your reference.

| Historical term | Current term |
|---|---|
| Personally controlled electronic health record (PCEHR) | My Health Record (MHR) |
| National eHealth Transition Authority (NEHTA) | The Australian Digital Health Agency (ADHA) |

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# 1 Introduction

## 1.1 Purpose

This document presents the information requirements for shared health summaries, as recommended for use in Australian eHealth systems.

These 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.

They are the minimum set of data items that are recommended for implementation in any system that creates and transfers shared health summaries, to support the delivery of quality collaborative care. The inclusion of data in this minimum set is determined by two criteria:

1 the clinical relevancy of the data; and

2 the potential for the data to improve clinical safety in a collaborative care environment.

Additionally, they define the information needs for a national consensus on information sharing between healthcare providers in Australia, independent of exchange or presentation formats.

It is anticipated that these information requirements will:

- promote a common understanding of the requirements for the construction and use of shared health summaries;
- provide a common framework for development and use of semantically interoperable information components to be exchanged between applications, providers, jurisdictions;
- provide a common framework for defining queries using these information requirements at logical levels, which may be adopted for implementations in local, jurisdictional or national electronic health record environments; and
- provide a common framework for nationally defined mappings to specific exchange formats.

## 1.2 Intended audience

This document is intended for all interested stakeholders including:

- clinicians, such as general practitioners;
- early adopter hospitals and health departments in the process of planning, implementing or upgrading eHealth systems;
- software vendors developing eHealth system products;
- early adopter general practitioner desktop software vendors;
- senior managers and policy makers, clinical experts, health information managers, IT operations and support teams, and system integrators;
- stakeholders associated with the development and use of upcoming eHealth initiatives relating to 'continuity of care'; and
- consumers and consumer representatives.

## 1.3 Scope

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

### 1.3.1 Scope inclusions

The information managed by a patient's nominated provider, which is most often their regular GP, falls within the scope of the information requirements for the shared health summary (SHS).

### 1.3.2 Scope exclusions

The scope of these information requirements does not include:

- information-gathering practices involved in the creation or modification of patient records within any given GP clinical information system (CIS);
- the way the data is transferred from GP desktop to the PCEHR; or
- the formatting of information for display purposes.

## 1.4 Exchange and presentation formats

The information presented in this document is defined at the logical level, and is therefore independent of specific exchange or presentation formats. For example, HL7® v2.x, or HL7® CDA®.[1]

Similarly, the requirement that a particular piece of data be exchanged in a shared health summary does not imply a requirement on the user interface. Some data elements (e.g. “Date of Birth”) have a number of different presentation options available (e.g. “Birth Day” + “Year of Birth” etc.), which are not considered here.

In addition, the names given to data components and data items are in many cases not appropriate for use as field labels on a user interface.

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

## 1.5 Adding data

Clinical information systems that generate shared health summaries should be capable of transferring relevant data into the relevant sections of the shared health summary. This is intended to minimise data entry duplication, and reduce the issues of recording data redundantly in multiple data stores. It is expected that, whenever data is obtained from a CIS following a clinical interaction with a patient, the author’s discretion is exercised in allowing only information relevant to the ongoing care of the patient to be included in the shared health summary.

Additionally, it is expected that the author’s due diligence is applied to ensure that such CIS-sourced information is both current and accurate.

## 1.6 Core components

The information components include:

- Individual;
- Shared Health Summary Author;
- Allergies and Adverse Reactions;
- Medicines;
- Current and Past Medical History;
- Immunisations; and
- Document Control.

Each of the above components is described in the following sections, in terms of their detailed requirements, and in providing a rationale for each.

[1] CDA® and HL7® are registered trademarks of Health Level Seven International.

# 2 Use of shared health summaries

## 2.1 Overview

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

A shared health summary can only be sourced and uploaded by an individual's nominated healthcare provider. A nominated healthcare provider must be a medical practitioner, a registered nurse, or an Aboriginal or Torres Strait Islander health practitioner. If other providers wish to provide information about the individual to the PCEHR, they could use an event summary, specialist letter, or other clinical documents.

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

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

The information identified in this document will be electronically extracted from the clinical information system to populate the shared health summary.

## 2.2 Example scenario

John is a patient with a complex chronic illness and is regularly managed by his usual GP. The usual GP has regularly maintained an up-to-date shared health summary for John, which he has published to John's PCEHR.

John has a holiday interstate, falls ill, and needs to see a different GP for management. The new GP visits the PCEHR where she reviews John's shared health summary and becomes acquainted with his available history. As a result of the new problem, she makes some changes to John's medications and decides to create an event summary, which she publishes to John's PCEHR.

On his return home, John is seen by his usual GP and - rather than relying upon John's memory of the event - he reviews the event summary written by the other GP, which is now available on the PCEHR. The usual GP decides to incorporate the new medications listed in the event summary into his own clinical records, and again updates John's shared health summary.

# 3 Individual

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

## 3.1 Individual (Core)

| Data item | Req No. | Requirement statement | Rationale |
|---|---|---|---|
| Individual Healthcare Identifier (mandatory) | 022082 | The document **SHALL** contain the individual's Individual Healthcare Identifier (IHI). | Enables interoperability. Eliminates ambiguity. Supports the indexing of clinical documents.<br>If an IHI is not available then the individual's PCEHR cannot be identified. |
| Individual's Title (optional) | 022081 | The document **SHOULD** contain at least one title for the individual. | Titles such as 'Mrs', 'Mr', 'Dr' etc. are useful when communicating with the individual. |
| Individual's Given Name (optional) | 023056 | The document **SHOULD** contain at least one given name for the individual. | To enable consistent and correct identification of the individual's document. Assists in verifying that the document relates to the individual. |
| Individual's family name (mandatory) | 023058 | The document **SHALL** contain the individual's family name. | To enable consistent and correct identification of the individual. This is a required field when validating IHIs against the Healthcare Identifiers (HI) Service. |
| Individual's Name Suffix (optional) | 023059 | The document **SHOULD** contain the individual's name suffix where applicable. | Suffixes such as 'Snr', 'Jnr' etc. can be a useful aid in the correct and unique identification of the individual. |
| Individual's Sex (mandatory) | 024032 | The document **SHALL** contain the individual's sex. | To enable consistent and correct identification of the individual. This is a required field when validating IHIs against the HI Service. The individual's sex is also useful in clinical decision making. |
| Individual's Date of Birth (mandatory) | 023060 | The document **SHALL** contain the individual's date and time (time is optional) of birth. | To enable consistent and correct identification of the individual. This is a required field when validating IHIs |

| Data item | Req No. | Requirement statement | Rationale |
|---|---|---|---|
| | | **Additional Notes**<br>Time of birth may be recorded during care immediately following birth. | against the HI Service. Date of birth is also useful in clinical decision making. |
| Date of Birth accuracy indicator (optional) | 024026 | The document **SHOULD** contain a date of birth accuracy indicator. | To assist in the correct identification of the individual.<br>It is important for clinicians to know when a provided date of birth is an approximation to assist in clinical decision making. |

## 3.2 Individual (extension)

| Data item | Req No. | Requirement statement | Rationale |
|---|---|---|---|
| Individual's Address (mandatory) | 024041 | The document **SHALL** contain at least one address for the individual. | To enable consistent and correct identification of the individual. |
| Individual's Electronic Communication Details (optional) | 024042 | The document **SHOULD** contain at least one set of electronic communication details for the individual. These include (but are not limited to) telephone number, mobile phone number, email address etc. | To enable electronic communication with the individual. |
| Indigenous Status (mandatory) | 024033 | The document **SHALL** state whether a person identifies as being of Aboriginal and/or Torres Strait Islander origin, or give a clear indication that their indigenous status was not stated. | Members of the Indigenous community may have specific health needs and be eligible for a range of specific services. Access to this information may contribute to improved indigenous health. |

# 4 Shared health summary author

**Description:** The health provider nominated by the individual as being the author of their shared health summary.

| Data item | Req No. | Requirement statement | Rationale |
|---|---|---|---|
| Healthcare Provider Professional Role (mandatory) | 024040 | The document **SHALL** contain the healthcare provider's professional role (e.g. General Practitioner). This data item MAY carry a value equivalent to 'unknown'. | Describing the professional role a healthcare provider is acting in the provision of healthcare can provide context and assist in interactions between healthcare providers to the benefit of individuals receiving healthcare. |
| Healthcare provider organisation name (mandatory) | 023070 | The document **SHALL** contain the name of the organisation the healthcare provider is representing at the time of CDA® document creation. | To enable consistent and correct identification of the healthcare provider organisation. This is a required field when validating HPI-Os against the HI Service. |
| Healthcare Provider Employer Organisation Address | 025064 | The document **SHALL** contain the Healthcare Provider Employer Organisation's address. | To ensure that contact details are always provided for the author's address. |
| Healthcare Provider Employer Organisation Electronic Communication Detail | 025063 | The document **SHALL** contain the healthcare provider employer organisation's electronic communication detail. | To ensure that contact details are always provided for the author's organisation. |

## 4.1 PCEHR participating Healthcare Provider (core)

| Data item | Req No. | Requirement statement | Rationale |
|---|---|---|---|
| Healthcare Provider Identifier-Individual (mandatory) | 023066 | The document **SHALL** contain the Healthcare Provider's Individual Identifier (HPI-I). | To enable consistent and correct identification of the healthcare provider. |
| Healthcare Provider Identifier- Organisation (mandatory) | 023071 | The document **SHALL** contain the Healthcare Provider Identifier-Organisation (HPI-O) of the organisation the healthcare provider is representing at the time of the CDA® document creation. | To enable consistent and correct identification of the organisation or practice that the healthcare provider is representing at the time of document creation. |
| Healthcare Provider's Title (optional) | 023061 | The document **SHOULD** contain at least one title for the healthcare provider. | Titles such as 'Mrs', 'Mr', 'Dr' etc. are useful when communicating with the healthcare provider. |
| Healthcare Provider Given Name (optional) | 023062 | The document **SHOULD** contain at least one given name for the healthcare provider. | To enable consistent and correct identification of the healthcare provider. |
| Healthcare Provider Family Name (mandatory) | 023064 | The document **SHALL** contain the healthcare provider's family name. | To enable consistent and correct identification of the healthcare provider. This is a required field when validating HPI-Is against the HI Service. |
| Healthcare provider name suffix (optional) | 023065 | The document **SHOULD** contain the healthcare provider's name suffix where applicable. | To enable consistent and correct identification of the healthcare provider.<br>Suffixes such as 'Snr', 'Jnr' etc. can be a useful aid in the correct and unique identification of the healthcare provider. |

## 4.2 Healthcare Provider (extension)

| Data item | Req No. | Requirement statement | Rationale |
|---|---|---|---|
| Healthcare Provider Individual's Workplace Address (optional) | 024035 | The document **SHOULD** contain the Healthcare Provider Individual's Australian workplace address. | To enable consistent and correct identification of the Healthcare Provider. |
| Healthcare Provider Individual's Workplace Electronic Communication Details (optional) | 024036 | The document **SHOULD** contain at least one set of electronic communication details for the workplace of the individual. For example (but not limited to) telephone numbers, mobile phone numbers, email addresses etc.<br>**Additional Notes**<br>A healthcare provider may work for more than one organisation. These are the workplace communication details of the individual - not the organisation. | To enable electronic communication with the healthcare provider. |

# 5 Allergies and adverse reactions

**Scope:** The categories of allergies, and adverse medicine reactions, have been combined into this component. Consequently, it includes allergies, intolerances and adverse reactions to all substances; and not only those arising from medications or medicines. These might include food allergies or intolerance, an allergy to bee venom, as well as adverse reactions to prescription and non- prescription medicines.

Note: An indicator of compliance with the RACGP Practice Standard 1.7[2] on health summaries is that a practice can demonstrate that at least 90 per cent of their active patient records contain a current health summary that includes, where appropriate, a record of known allergies.

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

| Data item | Req No. | Requirement statement | Rationale |
|---|---|---|---|
| Component | 022870 | Each shared health summary **SHALL** include either relevant allergies and adverse reactions, or a statement as to why none are included (i.e. an 'exclusion statement'). | To ensure that a shared health summary always contains information about allergies and adverse reactions.<br><br>Allergies and adverse reactions may not be listed in a shared health summary for a specific reason (e.g. there are none, or this information has not been supplied). This provides assurance that an absence of allergies and adverse reactions is for a specific reason, rather than having been simply omitted. |

[2] http://www.racgp.org.au/your-practice/standards/interpretiveguide4thedition/practice-services/1-7/overview/

| Data item | Req No. | Requirement statement | Rationale |
|---|---|---|---|
| | 024962 | When present, the Allergies and Adverse Reactions exclusion statement **SHALL** either have the value *none known* or *none supplied*.<br><br>**Additional Notes**<br><br>A “none known” exclusion statement is only to be used when the clinician has made a positive statement that there are no known items.<br><br>The “none supplied” response is the value that is to be used when no items have been selected for inclusion in the shared health summary, and the clinician has not explicitly chosen “none known”. This may be because a patient has elected not to share any of the given items. | An exclusion statement makes it explicitly clear that the question about Allergies and Adverse Reactions has been asked and the response recorded. |
| Agent Description | 022871 | Every allergy and adverse reaction listed in the shared health summary **SHALL** contain a description of the agent that is assessed to be associated with, or that may have caused, the adverse reaction. | To support high quality safe clinical care. |
| | 023235 | Values for the description of the allergy and adverse reaction agent **SHALL** be derived from a SNOMED CT-AU or Australian Medicines Terminology (AMT) reference set, with the option for free text. | Allows for electronic transmission of clinical information and future decision-support capability. |

| Data item | Req No. | Requirement statement | Rationale |
|---|---|---|---|
| Reaction Type | 024963 | For each adverse reaction, there **SHALL** be the provision to record the type of adverse reaction.<br>**Additional Notes**<br>It is optional to provide a value. | When determining a treatment plan, it is often necessary to consider the patient's response to a known allergen. For example, in a medical emergency it might be appropriate to administer a medication where a minor intolerance exists; however, if the response is anaphylaxis, an alternative protocol would be sought. |
| | 024964 | The value choices for the Reaction Type **SHALL** be limited to a SNOMED CT-AU reference set. | A constrained vocabulary results in better consistency and encourages higher quality data entry. |
| Reaction Description | 023239 | There **SHALL** be the provision for an allergy and adverse reaction record to include the description of the reaction that was caused by or related to the exposed agent. | To support safe clinical care. |
| | 022887 | Values for the manifestation of the reaction **SHALL** be derived from a SNOMED CT-AU reference set, while allowing an option for free text. | Allows for electronic transmission of clinical information and future decision-support capability. |
| | 023240 | There **SHALL** be the provision for more than one reaction description to be recorded for a single agent, when appropriate. | An individual may experience multiple adverse reactions to a single agent. |
| | 023241 | A value for the reaction description **SHALL** only be included at the discretion of the shared health summary author, when it is deemed either relevant or appropriate to do so (i.e. optional to include a value). | An individual's specific reaction to a given agent may not necessarily be known. For example, an adult may report that they were told as a child that they reacted to a given agent, but cannot recall what happened to them. |

# 6 Medicines

**Scope:** The Medicines section should contain prescription medications, non-prescription, over-the-counter medications, medicines self-prescribed by the individual, and any complementary or alternative medicines.

Note: An indicator of compliance with the RACGP Practice Standard 1.7 on health summaries is that a practice can demonstrate that at least 75 per cent of their active patient records contain a current health summary that includes, where appropriate, a current medicines list. Inclusion of medicines will be at the discretion of the clinician; however, it is likely that longer-term medicines will be shared.

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

**Out of scope:** Note that vaccines are excluded from this section and are managed by the Immunisation section.

| Data item | Req No. | Requirement statement | Rationale |
|---|---|---|---|
| Component | 022746 | Each shared health summary **SHALL** either include relevant medicines, or a statement as to why none are included (i.e. an 'exclusion statement'). | To ensure that a shared health summary always contains information about medicines.<br><br>If medicines are not listed in a shared health summary, it must be for one of several specific reasons (e.g. the individual is not on any medicines, or the information has not been supplied). This provides assurance that an absence of medicines is for a specific reason, rather than having been simply omitted. |

| Data item | Req No. | Requirement statement | Rationale |
|---|---|---|---|
| | 024965 | When present, the medicines exclusion statement **SHALL** either have the value *none known* or *none supplied*.<br><br>**Additional Notes**<br><br>A “none known” exclusion statement is only to be used when the clinician has made a positive statement that there are no known items.<br><br>The “none supplied” response is the value that is to be used when no items have been selected for inclusion in the shared health summary, and the clinician has not explicitly chosen “none known”. This may result because a patient has elected not to share any of the given items. | An exclusion statement makes it explicitly clear that the question about medicines has been asked and the response recorded. |
| Item Description | 023242 | Every medicine listed in the shared health summary **SHALL** include details that fully describe it, including the name of the medication, strength, and dose form, where appropriate. | Eliminates ambiguity, and is vital to support high quality safe clinical care. |
| | 023243 | If the medication can be identified by an AMT concept, Item Description **SHALL** be the AMT ConceptID and Preferred Term. | Allows interoperability, eliminates ambiguity, and is vital to support high quality safe clinical care. |
| | 023244 | If the medicine cannot be identified by an AMT concept, the Item Description **SHALL** allow free text. | This enables the user to enter medicines not recognised by AMT (e.g. overseas medicines taken by international patients). |
| Dose Instructions | 023245 | Every medicine listed in the shared health summary **SHALL** include the dose instructions describing how the medicine is taken. | Vital to support high quality, safe clinical care. |

| Data item | Req No. | Requirement statement | Rationale |
|---|---|---|---|
| Reason for Medicine | 023246 | There **SHALL** be the provision for a medicine record to include the reason (indication) for the individual to be taking the medicine. | It is important for the GP and other recipients to understand the rationale for medicines, particularly given that some medicines may have multiple purposes. |
| | 023247 | A Reason for Medicine value for a given medication **SHALL** only be included when it is either relevant or appropriate to do so (i.e. optional to include a value). | The reason an individual may be taking an over-the- counter or complementary medicine may not be clear to the shared health summary author. |
| Additional comments | 023248 | There **SHALL** be provision for a medicine record to include additional information that may be needed to ensure the continuity of supply, continued proper use, or appropriate medication management. For example, comments regarding medication duration. | To allow the provision of additional medicine information if the clinician considers it will contribute to the future care of the patient. |
| | 023249 | An Additional Comment for a given medicine **SHALL** only be included when it is deemed by the author to be either relevant or appropriate to do so (i.e. optional to include a value). | Not always required. |

# 7 Current and past medical history

**Scope:** Data structure for capturing information about an individual's current and past medical history which includes problem/diagnosis and medical or surgical procedures performed. The information may be extracted for display to users as a chronologically ordered list.

Note: An indicator of compliance with the RACGP Practice Standard 1.7 on health summaries is that a practice can demonstrate that at least 75 per cent of their active patient records contain a current health summary that includes, where appropriate, a record of current health problems and relevant past health history.

| Data item | Req No. | Requirement statement | Rationale |
|---|---|---|---|
| Component | 023250 | Each shared health summary **SHALL** include either relevant medical history items or a statement as to why none are included (i.e. an 'exclusion statement'). | To ensure that a shared health summary always contains information about medical history.<br>Medical history may not be listed in a shared health summary for specific reasons (e.g. there is none, or this information has not been supplied). This provides assurance that an absence of medical history items is for a specific reason, rather than having been simply omitted. |
| | 023251 | A shared health summary **SHALL** be allowed to contain multiple medical history items. | Individuals often have multiple entries in medical history. |
| | 024966 | When present, the current and past medical history exclusion statement **SHALL** either have the value *none known* or *none supplied*.<br>**Additional Notes**<br>A "none known" exclusion statement is only to be used when the clinician has made a positive statement that there are no known items.<br>The "none supplied" response is the value that is to be used when no items have been selected for inclusion in the shared health summary, and the clinician has not explicitly chosen "none known". This may be because a patient has elected not to share any of the given items. | An exclusion statement makes it explicitly clear that the question about current and past medical history has been asked and the response recorded. |

| Data item | Req No. | Requirement statement | Rationale |
|---|---|---|---|
| Medical History Description | 023252 | Every medical history item listed in the shared health summary **SHALL** contain a corresponding description. | This provides the content for the medical history. |
| | 023253 | Values for the description of the medical history items **SHALL** be derived from SNOMED CT-AU with the option for free text. | Allows for the electronic transmission of clinical information and future decision-support capability. |
| | 023236 | The semantically distinct concepts of diagnoses and procedures **SHALL** be combined into one data item. | A chronological list may reduce clinical risk due to the viewing of information in an expected manner. |
| Medical History DateTime Range | 024947 | There **SHALL** be provision for a medical history record to include the date of onset. | Clearly identifies when a particular medical history item commenced or occurred. |
| | 024948 | There **SHALL** be the provision for a medical history record to include the date of resolution. | Clearly identifies when a problem has resolved, if at all. |
| | 024949 | The date of onset and resolution **SHALL** be allowed to be expressed as an estimate (i.e. dd/mm/yyyy or yyyy). | Provides flexibility as an individual may not always be clear about events occurring in the past. |
| | 024991 | The dates for problems/diagnoses within the medical history record **SHALL NOT** include time. | The inclusion of a time of problem/diagnosis onset or resolution is unnecessary. |
| Medical History comments | 024950 | There **SHALL** be the provision for a medical history record to include an additional comment. | Provides flexibility to add context or notes etc. |

# 8 Immunisations

**Scope:** Details of either immunisations or vaccinations that have been administered (or have been reported as administered).

Note: An indicator of compliance with the RACGP Practice Standard 1.7 on health summaries is that a practice can demonstrate that at least 75 per cent of their active patient records contain a current health summary that includes, where appropriate, a record of immunisations.

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

| Data item | Req No. | Requirement statement | Rationale |
|---|---|---|---|
| Component | 023254 | Each shared health summary **SHALL** include either relevant immunisations, or a statement as to why none are included (i.e. an 'exclusion statement'). | To ensure that a shared health summary always contains information about immunisations.<br>Information regarding immunisations may not be listed in a shared health summary for specific reasons (e.g. there are none, or this information has not been supplied). This provides assurance that an absence of immunisations is for a specific reason, rather than having been simply omitted. |
| | 024924 | A shared health summary **SHALL** be allowed to contain multiple immunisations. | An individual may have multiple immunisations. |
| | 024967 | When present, the immunisations exclusion statement **SHALL** either have the value *none known* or *none supplied*.<br>**Additional Notes**<br>A "none known" exclusion statement is only to be used when the clinician has made a positive statement that there are no known items.<br>The "none supplied" response is to be used when no items have been selected for inclusion in the shared health summary, and the clinician has not explicitly chosen "none known". This may be because a patient has elected not to share any of the given items. | An exclusion statement makes it explicitly clear that the question about immunisations has been asked and the response recorded. |

| Data item | Req No. | Requirement statement | Rationale |
|---|---|---|---|
| Vaccine Name | 024925 | Every immunisation included in the shared health summary **SHALL** include the name of the immunisation. | Ensures unambiguous identification of the particular immunisation. |
| | 024926 | If the immunisation can be identified by an AMT concept, this **SHALL** be the AMT ConceptID and Preferred Term. | Allows interoperability, eliminates ambiguity, and is vital to support high quality safe clinical care. |
| | 024927 | If the immunisation cannot be identified by an AMT concept, the item description **SHALL** allow free text. | This enables the ability to enter vaccinations not recognised by AMT (e.g. vaccinations administered overseas). |
| DateTime Administration | 024928 | Every immunisation included in the shared health summary **SHALL** include the date, or date and time, that a dose of vaccine is administered. | Determines when further doses of immunisations may be required. |
| | 024929 | The date **SHALL** be recorded in the format of date (and, optionally, time). | Allows for date calculations to be made for decision- support (i.e. that an individual is overdue for the completion of an immunisation dose). |
| Sequence Number | 024930 | There **SHALL** be the provision for an immunisation record to include the sequence number for the particular immunisation schedule. | Indicates how up-to-date the individual is with the immunisation schedule and when the next dose is due. |
| | 024931 | A value for sequence number for a given immunisation **SHALL** only be included when it is deemed either relevant or appropriate to do so (i.e. optional to include a value). | The sequence number may not always be known or relevant for all immunisations. |

# 9 Document control

**Description:** A section that describes information about the shared health summary document. Much of the information contained in Document Control is technical in nature and as such is not described here.

Elements with clinical relevance are described below.

| Data item | Req No. | Requirement statement | Rationale |
|---|---|---|---|
| Date/Time Attested (mandatory) | 024038 | The document SHALL contain the date and time the document was attested (or finalised, or signed off) by the document author. | Clinical safety requirement to ensure that the reader knows exactly when the document was written. |

# Acronyms

| Acronym | Description |
|---|---|
| AMT | Australian Medicines Terminology |
| CDA® | Clinical Document Architecture |
| GP | general practitioner |
| HI | healthcare identifier |
| HL7 | Health Level 7 |
| HPI-I | Healthcare Provider Identifier of the individual |
| HPI-O | Healthcare Provider Identifier of the organisation |
| IHI | Individual Healthcare Identifier |
| MMRG | NEHTA Medication Management Reference Group |
| NCTIS | NEHTA's National Clinical Terminology and Information Service |
| PCEHR | personally controlled electronic health record |
| RACGP | Royal Australian College of General Practitioners |
| SNOMED CT | Systematized Nomenclature of Medicine - Clinical Terms |
| SNOMED CT-AU | Australian extension to SNOMED CT |

# Glossary

| Term | Meaning |
|---|---|
| Australian Medicines Terminology (AMT) | The intended national standard coding system for selecting, recording and communicating categorical descriptive medicines information within and between Australian eHealth applications. |
| Clinical Document Architecture (CDA®) | An XML-based markup standard intended to specify the encoding, structure and semantics of clinical documents exchanged between health software systems. |
| clinical document | A digital file containing personal health information about an individual, containing unstructured (narrative) information and optionally structured (atomic) information. |
| clinical information system (CIS) | A system that deals with the collection, storage, retrieval, communication, and use of health related data, information and knowledge pertaining to subjects of care.<br>The system may comprise one or more applications or components. |
| event summary | An event summary is a clinical document that may be uploaded to an individual's eHealth record, summarising one or more episodes of care.<br>Source: Glossary |
| exclusion statement | This provides the means of identifying the reason why clinical data has been omitted. For example, immunisations may be absent because the clinician has assessed the individual as having had none (i.e. '*none known*'). |
| GP desktop | Examples of clinical information systems that are used by GPs to manage their patients. |
| Healthcare identifier (HI) | An identifier assigned to a healthcare provider (individual or organisation) or a healthcare recipient. |
| HPI-I | Healthcare Provider Identifier – Individual<br>The Healthcare Provider Identifier for individuals (HPI-I) is a 16 digit unique number used to identify providers who deliver healthcare in the Australian healthcare setting. |
| HPI-O | Healthcare Provider Identifier – Organisation<br>The Healthcare Provider Identifier for Organisations (HPI-O) is a 16 digit unique number used to identify organisations who deliver care in the Australian healthcare setting. |
| IHI | Individual Healthcare Identifier – Individual (Subject of Care)<br>An IHI is a unique 16 digit number that identifies individuals within Australia who receive healthcare, for example Australian citizens, permanent residents or visitors to Australia. |
| jurisdictions | Australian state and territory government health departments. |
| **MAY** | When appearing in an information requirement, the verb **MAY** indicates an optional requirement. |
| NCTIS | Established by NEHTA to function as Australia's national terminology release centre. |

| Term | Meaning |
|---|---|
| nominated healthcare provider | A nominated healthcare provider is the author of a shared health summary. Under the *Personally Controlled Electronic Health Records Act 2012*, a nominated healthcare provider must be a medical practitioner, a registered nurse or an Aboriginal or Torres Strait Islander health practitioner. The healthcare provider and the individual must agree that, for the purposes of the eHealth record system, the healthcare provider is the individual's nominated healthcare provider.<br>Source: Glossary |
| PCEHR | personally controlled electronic health record |
| PCEHR system | National eHealth infrastructure for managing records in eHealth records. The PCEHR system includes the PCEHR repository and the national prescription and dispense repository. |
| **SHALL** | When appearing in a requirement, the verb **SHALL** indicates a mandatory requirement. Its negative form **SHALL NOT** indicates a prohibition. |
| **SHOULD** | When appearing in a requirement, the verb **SHOULD** indicates a recommendation. Its negative form **SHOULD NOT** indicates an option that is not recommended." |
| SNOMED CT | SNOMED Clinical Terms (SNOMED CT®) is the internationally pre-eminent clinical terminology that has been identified as the preferred national terminology for Australia and has been endorsed by all Australian governments.<br>Source: https://www.snomed.org/ |
| SNOMED CT-AU | The Australian extension to SNOMED CT. |

# Appendix A Change log

This appendix lists the major changes and fixes applied to this document.

## A.1 Changes from Version 1.0 (29 Nov 2011) to Version 1.1 (10 Apr 2015)

| ID | Section | Change Detail | Rationale |
|---|---|---|---|
| 1 | 2.1 | Updated description of nominated healthcare provider to align with legislation. | Alignment with PCEHR Act. |
| 2 | 3 | Requirements for Individual have been updated to align with current methodology. | To ensure that document modelling is appropriate. |
| 3 | 3.1 | Requirement #023060 Added clarification about<br>individual date of birth, that time values are supported during care immediately following birth. | Providing clarification on use of date values. |
| 4 | 4 | Requirements for Shared Health Summary Author have been updated to align with current methodology. | To ensure that document modelling is appropriate. |
| 5 | 4 | Added requirement #025064 mandating the Healthcare Provider Employer Organisation's address. | The author's organisation address must always be supplied. |
| 6 | 4 | Added requirement #025063 mandating the Healthcare Provider Employer Organisation Electronic Communication Detail. | The author's organisation electronic communication detail must always be supplied. |
| 7 | 5 | Requirements #022870 &<br>#024962<br>Removal of "not asked" as an option for exclusion statement.<br>Improved wording of the exclusion statement requirement and rationale. | The author must always supply some information regarding Allergies and Adverse Reactions, rather than having absent content. If there is no information at all, then a shared health summary cannot be created. |
| 8 | 5 | Modified requirement #023235 to allow AMT as well as SNOMED CT-AU. | Alignment with current medications management initiatives. |
| 9 | 5 | Added requirements #024963 & #024964 for new data element 'Reaction Type'. | Providing additional clinical content for Allergies and Adverse Reactions. |

| ID | Section | Change Detail | Rationale |
|---|---|---|---|
| 10 | 6 | Requirements #022746 & #024965<br>Removal of “not asked” as an option for exclusion statement.<br>Improved wording of the exclusion statement requirement and rationale. | The author must always supply some information regarding medicines, rather than having absent content. If this information is unknown, then a shared health summary cannot be created. |
| 11 | 7 | Requirements #023250 & #024966<br>Removal of “not asked” as an option for exclusion statement.<br>Improved wording of the exclusion statement requirement and rationale. | The author must always supply some information regarding current and past medical history, rather than having absent content. If this information is unknown, then a shared health summary cannot be created. |
| 12 | 7 | Added requirement #024991 for disallowing the inclusion of time for problems/diagnoses date of onset or resolution. | This detail is unnecessary. |
| 13 | 8 | Improved wording of the exclusion statement requirement and rationale. | Clarity. |
| 14 | 9 | Requirements #023254 & #024967<br>Removal of “not asked” as an option for exclusion statement. | The author must always supply some information regarding immunisations, rather than having absent content. If this information is unknown, then a shared health summary cannot be created. |
| 15 | 10 | Grammatical revisions throughout. | |