Event Summary
Release Note v1.4

10 April 2015
Approved for external information

EP-1817:2015 Event Summary v1.4

Release rationale

This release of the Event Summary end product provides updates aimed at:

- Addressing issues identified during the implementation of ES specifications;
- Clarifying existing requirements;
- Improving interoperability, clinical safety and privacy through additional requirements;
- Improving usability by incorporating selected recommendations from the Clinical Usability Programme (CUP);
- Supporting additional use cases through relaxation of requirements;
- Supporting additional use cases through additional fields;
- Supporting version 3 of Australian Medicines Terminology (AMT);
- Aligning clinical modelling and CDA®[1] mapping with other document types;
- Resolving errors.

For a comprehensive list of all updates, please refer to the change logs included in the updated documents.

The template packages for Event Summary documents have been updated in alignment with the changes to the specification documents. The updated template packages are contained in the updated version of the Template Package Library and can be identified using their template package IDs, as stated in the table below.

Document type variant	Conformance level	Template package ID	Template package version	PCEHR adoption status
HPIIRelaxed	3A	1.2.36.1.2001.1006.1.16473.12	36678	from PCEHR Release 6
	3B	1.2.36.1.2001.1006.1.16473.13		
default	3A	1.2.36.1.2001.1006.1.16473.14		
	3B	1.2.36.1.2001.1006.1.16473.15		

The full list of published template packages can be found in the *Template Package Directory* published as part of the *Common – Clinical Document v1.3*[2] end product.

[1] CDA® is a registered trademark of Health Level Seven International.
[2] https://www.nehta.gov.au/implementation-resources/clinical-documents/EP-1818-2015

Previously published template packages for the Event Summary document type will continue to be supported for a transition period of 24 months after publication of this release. After the end of the transition period, those template packages will no longer be accepted by the PCEHR system for uploads of Event Summary documents.

This release of the Event Summary end product aligns with the following approved change requests: CCB-0345; CCB-0357; CCB-0380; CCB-0388.

Package inclusions

New

None

Updated (supersedes previous version)

Identifier	Name
NEHTA-1846:2015	*Event Summary - CDA Implementation Guide v1.3*
NEHTA-1845:2015	*Event Summary – Information Requirements v1.2*
NEHTA-1844:2015	*Event Summary - PCEHR Conformance Profile v1.4*
NEHTA-1842:2015	*Event Summary - Release Note v1.4* (this document)
NEHTA-1847:2015	*Event Summary – Structured Content Specification v1.2*
NEHTA-1843:2015	*Event Summary – Template Package Library v1.4*

Removed

None

No change

Identifier	Name
NEHTA-1921:2014	*Event Summary - PCEHR Usability Recommendations v1.1*

Stakeholders

The following stakeholders have been involved in the development of this release:

- Implementers of clinical systems producing or consuming Shared Health Summary clinical documents
- Commonwealth Department of Health
- National Infrastructure Operator

Audience

- Implementers of clinical systems producing or consuming Event Summary clinical documents
- Senior managers and policy makers, clinical experts, health information managers, IT operations and support teams, and system integrators

Known issues

None known

Support

For further support, or to provide feedback, please email help@nehta.gov.au.

Future releases

Further changes may occur from time to time in accordance with customer feedback or changes to source information. Supplementary guidance may also be provided from time to time based on implementation experience from vendors.

Previous releases

EP-1961:2014 Event Summary v1.3.3

Release note: NEHTA-1963:2014, 31 December 2014

Release rationale

This incremental release of the Event Summary end product introduces an updated version of the *Event Summary - PCEHR Usability Recommendations* and provides a defect fix for the *Template Package Library.*

Updated PCEHR Usability Recommendations

This version of the *Event Summary - PCEHR Usability Recommendations* adds guidance for the authoring of the clinical synopsis field in the context of the Health Record Overview introduced with PCEHR Release 5 (new recommendation EVS.13) and minor clarifications.

The updated *Event Summary - PCEHR Usability Recommendations* aligns with updated versions of the *Shared Health Summary - PCEHR Usability Recommendations* [3] and *Common – Clinical Document - PCEHR Usability Recommendations*[4]. Together, these three documents represent the result of the Clinical Usability Programme (CUP) Release 3.

The PCEHR Usability Recommendations have been developed by NEHTA in consultation with key general practice peak bodies to improve the user experience of general practice software products. Vendors of clinical information systems used outside of general practice settings are encouraged to consider the extent to which these recommendations are applicable to their software products.

Template Package Defect Fix

The previous version of the Template Package Library contained a defective, too narrowly defined validation rule that led to the rejection of some conformant Event Summary documents by the PCEHR system. The updated version of the Template Package Library now contains the corrected validation rule.

Please refer to the Change Details section below for further details about the resolved defect.

There is no need for implementers to update their systems, as all documents that would have passed the previous version of the template packages will continue to pass the new version. All template packages within the Template Package Library have been updated using their original template package IDs:

Document type variant	Conformance level	Template package ID	Template package version	PCEHR adoption status
default	3A	1.2.36.1.2001.1006.1.16473.6	35754	superseded
default	3A	1.2.36.1.2001.1006.1.16473.7	35755	superseded
HPIIRelaxed	3A	1.2.36.1.2001.1006.1.16473.9	35754	accepted
HPIIRelaxed	3B	1.2.36.1.2001.1006.1.16473.8	35754	accepted
default	3A	1.2.36.1.2001.1006.1.16473.10	35754	accepted
default	3B	1.2.36.1.2001.1006.1.16473.11	35754	accepted

[3] https://www.nehta.gov.au/implementation-resources/clinical-documents/EP-1981-2014/NEHTA-1922-2014
[4] https://www.nehta.gov.au/implementation-resources/clinical-documents/EP-1962-2014/NEHTA-1923-2014

The full list of published template packages can be found in the *Template Package Directory*[5] published as part of the *Common – Clinical Document v1.2.1*[6] end product.

This defect fix for the Event Summary Template Package Library aligns with approved change request CCB-0378.

Package inclusions

New

None

Updated (supersedes previous version)

Identifier	Name
NEHTA-1963:2014	*Event Summary - Release Note v1.3.3* (this document)
NEHTA-1964:2014	*Event Summary – Template Package Library v1.3.1*
NEHTA-1921:2014	*Event Summary - PCEHR Usability Recommendations v1.1*

Removed

None

No change

Identifier	Name
NEHTA-0989:2012	*Event Summary - CDA Implementation Guide v1.2*
NEHTA-0991:2011	*Event Summary – Information Requirements v1.1*
NEHTA-1450:2013	*Event Summary - PCEHR Conformance Profile v1.3*
NEHTA-0995:2011	*Event Summary – Structured Content Specification v1.1*

Change details

All Event Summary template packages currently supported by the PCEHR system (adoption status "accepted" or "superseded") previously contained a validation rule condition that was formulated too narrowly. As the result, some conformant documents were rejected by the PCEHR system and the following error message was returned:

> *Event Summary - 7.1.4 Diagnoses/Interventions - Each instance of 'Diagnoses/Interventions' section SHALL have at least one instance of 'Problem/Diagnosis' or 'Procedure' OR 'Medical History Item'. Refer to section 7.1.4 of the Event_Summary_CDA_Implementation_Guide_v1.2.*

The defective validation rule led to the rejection of some documents that did contain a "Procedure" subsection within the "Diagnoses/Interventions" section.

The updated template packages contained in the Template Package Library of this release contain a corrected version of the validation rule. Affected documents will no longer lead to the rejection of such Event Summary documents.

[5] https://www.nehta.gov.au/implementation-resources/clinical-documents/EP-1962-2014/NEHTA-1849-2015
[6] https://www.nehta.gov.au/implementation-resources/clinical-documents/EP-1962-2014

Stakeholders

The following stakeholders have been involved in the development of this release:

- Commonwealth Department of Health
- Australian College of Rural and Remote Medicine (ACRRM)
- Australian Medical Association (AMA)
- Aboriginal Medical Services Alliance Northern Territory (AMSANT)
- Australian Primary Health Care Nurses Association (APNA)
- Improvement Foundation (Australia) (IF)
- Royal Australian College of General Practitioners (RACGP)
- Australian Association of Practice Management Ltd (AAPM)

Audience

- Implementers of clinical systems producing or consuming Event Summary clinical documents
- Senior managers and policy makers, clinical experts, health information managers, IT operations and support teams, and system integrators
- Technical and non-technical readers

Known issues

None known

EP-1749:2014 Event Summary v1.3.2

Release note: NEHTA-1773:2014, 18 August 2014

Release rationale

This incremental release of the Event Summary end product introduces the *Template Package Library* as a new product component. The version of the Template Package Library included in this version of the end product contains all template packages available for the Event Summary document type at the time of publication.

Of those template packages, the following are aligned with the most recent PCEHR Conformance Profile for Event Summary documents that is contained in version 1.3 of the Event Summary end product[7]:

Document type variant	Conformance level	Template package ID
HPIIRelaxed	3B	1.2.36.1.2001.1006.1.16473.8
HPIIRelaxed	3A	1.2.36.1.2001.1006.1.16473.9
default	3A	1.2.36.1.2001.1006.1.16473.10
default	3B	1.2.36.1.2001.1006.1.16473.11

Future versions of the Template Package Library will only contain template package aligned with the most recent version of the PCEHR Conformance Profile.

The full list of published template packages can be found in the *Template Package Directory*[8] published as part of the *Common – Clinical Document v1.1.3*[9] end product.

This end product has a dependency on *Clinical Documents - Common Conformance Profile v1.4*[10] published as part of the *Common – Clinical Document v1.1*[11] end product.

Package inclusions

New

Identifier	Name
NEHTA-1772:2014	*Event Summary – Template Package Library v1.3*

Updated (supersedes previous version)

Identifier	Name
NEHTA-1773:2014	*Event Summary - Release Note v1.3.2* (this document)

Removed

None

[7] https://www.nehta.gov.au/implementation-resources/clinical-documents/EP-1430-2013
[8] https://www.nehta.gov.au/implementation-resources/clinical-documents/EP-1754-2014/NEHTA-1738-2014
[9] https://www.nehta.gov.au/implementation-resources/clinical-documents/EP-1754-2014
[10] https://www.nehta.gov.au/implementation-resources/clinical-documents/EP-1457-2013/NEHTA-1446-2013
[11] https://www.nehta.gov.au/implementation-resources/clinical-documents/EP-1457-2013

No change

Identifier	Name
NEHTA-0989:2012	*Event Summary - CDA Implementation Guide v1.2*
NEHTA-0991:2011	*Event Summary – Information Requirements v1.1*
NEHTA-1450:2013	*Event Summary - PCEHR Conformance Profile v1.3*
NEHTA-1567:2014	*Event Summary - PCEHR Usability Recommendations v1.0*
NEHTA-0995:2011	*Event Summary – Structured Content Specification v1.1*

Scope

The scope of the Event Summary end product has not been changed as part of this release.

Stakeholders

The updates performed for this incremental release of the end product did not warrant any stakeholder consultations.

Audience

- Implementers of clinical systems producing or consuming Event Summary clinical documents
- Senior managers and policy makers, clinical experts, health information managers, IT operations and support teams, and system integrators
- Technical and non-technical readers

Known issues

None known

EP-1590:2014 Event Summary v1.3.1

Release note: NEHTA-1594:2014, 5 May 2014

Release rationale

This incremental release of the Event Summary end product introduces *Event Summary - PCEHR Usability Recommendations*. This new product component contains implementation guidance in the form of usability recommendations. This format makes it easy for implementers to assess whether their software conforms to the guidance.

PCEHR *usability recommendations* are not part of PCEHR *conformance requirements*. Only the latter are used as the basis for conformance assessments performed as a prerequisite to PCEHR system integration. PCEHR usability recommendations can be used by implementers to perform usability assessments on a voluntary basis, for example, with the aim of providing their users with a consistently high level of usability.

PCEHR usability recommendations provided with this release have been developed as part of NEHTA's Clinical Usability Program (CUP) Release 2.

Please refer to the Capabilities section for more details.

This end product has a dependency on NEHTA-1446:2013 *Clinical Documents - Common Conformance Profile v1.4* (part of EP-1457:2013 Common – Clinical Document v1.1).

Package inclusions

New

Identifier	Name
NEHTA-1567:2014	*Event Summary - PCEHR Usability Recommendations v1.0*

Updated (supersedes previous version)

Identifier	Name
NEHTA-1594:2014	*Event Summary - Release Note v1.3.1*

Removed

None

No change

Identifier	Name
NEHTA-0995:2011	*Event Summary – Structured Content Specification v1.1*
NEHTA-0991:2011	*Event Summary – Information Requirements v1.1*
NEHTA-0989:2012	*Event Summary - CDA Implementation Guide v1.2*
NEHTA-1450:2013	*Event Summary - PCEHR Conformance Profile v1.3*

Scope

The scope of the Event Summary end product has not been changed as part of this release.

Stakeholders

Stakeholder groups involved in the development of this release include:

- Commonwealth Department of Health
- Australian College of Rural and Remote Medicine (ACRRM)
- Australian Medical Association (AMA)
- Australian Medicare Local Alliance (AMLA)
- Aboriginal Medical Services Alliance Northern Territory (AMSANT)
- Australian Primary Health Care Nurses Association (APNA)
- Improvement Foundation (Australia) (IF)
- Royal Australian College of General Practitioners (RACGP)

Audience

- Implementers of clinical systems producing or consuming Event Summary clinical documents
- Senior managers and policy makers, clinical experts, health information managers, IT operations and support teams, and system integrators
- Technical and non-technical readers

Known issues

None known

Capabilities

CUP Release 2

CUP Release 2 has been focused on resolving key usability issues with clinical information systems used by general practitioners. The usability recommendations provided as part of this release represent the outcomes of several workshops with clinical consultation groups.

Information related to Event Summary documents is documented in the new product component *Event Summary – PCEHR Usability Recommendations v1.0*.

Note that additional usability recommendations resulting from CUP Release 2 have been released in a separate document, *Clinical Documents – PCEHR Usability Recommendations v1.1,* which is part of the Common – Clinical Document v1.1.2 end product.

EP-1430:2013 Event Summary v1.3

Release note: NEHTA-1439:2013, 9 October 2013

Release rationale

This release of the Event Summary end product introduces updates to the conformance profile for Event Summary documents, as mandated by the following approved change requests.

More detailed information about the referenced change requests is provided in the Capabilities section of this document and can be accessed by following the provided hyperlinks.

Change Request ID	Change request title	Impact on this release
CCB-0116	Relaxation of the mandatory use of HPI-Is in uploaded documents	New conformance requirement added for inclusion of local identifier in case of HPI-I omission
CCB-0222	Support for CSP Certificates in CDA Documents	Removed conformance requirements for digital signatures. This requirement has been replaced with an expanded conformance requirement in the *Clinical Document - Common Conformance Profile v1.4*.

This end product has a dependency on: NEHTA-1446:2013 *Clinical Documents - Common Conformance Profile v1.4* (part of EP-1457:2013 Common – Clinical Document v1.1)

Package inclusions

New

None

Updated (supersedes previous version)

Identifier	Name	Version
NEHTA-1439:2013	*Event Summary - Release Note*	1.3
NEHTA-1450:2013	*Event Summary - PCEHR Conformance Profile*	1.3

No change

Identifier	Name	Version
NEHTA-0995:2011	*Event Summary – Structured Content Specification*	1.1
NEHTA-0991:2011	*Event Summary – Information Requirements*	1.1
NEHTA-0989:2012	*Event Summary - CDA Implementation Guide*	1.2

Removed

None

Scope

The scope of the Event Summary end product has not been changed as part of this release.

Stakeholders

The following stakeholders have been involved in the development of this release:

- DOHA
- Accenture
- CCA Governance Group

Audience

- Implementers of clinical systems producing or consuming Event Summary clinical documents
- Senior managers and policy makers, clinical experts, health information managers, IT operations and support teams, and system integrators
- Technical and non-technical readers

Capabilities

The following sections provide additional details for each of the change requests addressed in this release.

CCB-0116

The change request introduces the temporary and limited relaxation of the mandatory requirement to include HPI-Is for a number of clinical document types, including Event Summary documents. It also introduces additional conformance requirements for local identifiers that need to be included in an Event Summary document wherever an HPI-I has been omitted.

CCB-0222

The change request introduces support for digital signatures created with CSP digital certificates for all types of clinical documents. New conformance requirements have been added in the *Clinical Documents - Common Conformance Profile v1.4*.

These new conformance requirements expand on and replace the conformance requirement for digital signatures in the *Event Summary - PCEHR Conformance Profile v1.2*. With version 1.3 of the *Event Summary - PCEHR Conformance Profile* this conformance requirement has been removed.

Known issues

None known

EP-0939:2012 Event Summary v1.2

Release note: NEHTA-0994:2012, 26 September 2012

Introduction

A Personally-Controlled Electronic Health Record (PCEHR) can contain Event Summaries, in addition to a number of other clinical documents relating to their healthcare, including Discharge Summaries, Referrals, Specialist Letters and Pathology Reports.

An Event Summary is used to capture health information about a significant healthcare event as relevant to be shared.

Event Summaries can be uploaded to the PCEHR System by any participating healthcare provider.

An Event Summary is intended to be used to record information about a significant event, when no other type of clinical document is appropriate. It can be used in cases where clinical document types have yet to be developed.

The Event Summary package forms part of the foundational set of specifications to support the development of an individual's PCEHR.

Release rationale

The solution bundle has been updated to include a revised version of the PCEHR Conformance Profile for Event Summary; this document summarises the requirements for producers and consumers of the Event Summary Clinical Document that connect to the National PCEHR System.

The document lists the specific conformance requirements for the Event Summary Clinical Document that are in addition to the Common Conformance Profile for Clinical Documents [NEHTA2012b]. Both documents represent the complete conformance requirements for the Event Summary Clinical Document.

Scope

The aim of an Event Summary is to provide information to the individual's Personally Controlled Electronic Health Record (PCEHR) of significant healthcare events, at the discretion of the clinician, with the consent of the individual. The information may be used by the nominated primary provider to update their local record and the PCEHR.

The PCEHR Concept of Operations states that "an Event Summary is used to capture key health information about significant healthcare events that are relevant to the ongoing care of an individual." Event Summaries can be submitted to the PCEHR System by any participating organisation.

Stakeholders

The following stakeholders have been involved in the development and testing of this release:

- Continuity of Care Reference Group (NEHTA stakeholders)
- Clinical Terminology and Information (NEHTA)
- Compliance, Conformance and Accreditation (NEHTA)
- Reference Platform (NEHTA)
- Implementations (NEHTA)

Audience

The intended audience of this document includes:

- Early adopter hospital networks, Lead eHealth Implementation sites and jurisdictional health departments in the process of planning, implementing or upgrading eHealth systems.
- Software vendors developing eHealth system products.
- Early adopter GP desktop software vendors.
- Senior managers and policy makers, clinical experts, health information managers, IT operations and support teams, and system integrators.
- Technical and non-technical readers.

Additions

The following products are associated with this solution bundle release to assist vendors to build and test the new messaging capability:

- . Event Summary Schematron Library
- . Event Summary Clinical Document Test Data
- . Event Summary CDA Library – Sample Code
- . CDA Validator
- . CDA Rendering Specification

These additional products (except for *CDA Rendering Specification*) are initially available as a limited release to enable a small group to test them before being generally available to the broader vendor community. For further details on access to this limited release please send an email to nehtasupport@nehta.gov.au.

Changes

Refer to the "Change Log" located at the back of each specification. This itemises all changes between specification versions.

Removals

None.

Solution Bundle Content

Structured Content Specification

Title	Status
Information Requirements v1.1	(unchanged)
Structured Content Specification v1.1	(unchanged)

Technical Services Specification

Title	Status
Event Summary CDA Implementation Guide v1.2	(unchanged)

Title	Status
CDA Rendering Specification v1.0 ○ (Common message rendering specification. Located in "Common Specifications Folder".)	(unchanged)
CDA Package v1.0 ○ (Common logical model for bundling of clinical documents with referenced attachments. Located in "Common Specifications Folder".)	(unchanged)

eHealth Conformance profile

Title	Status
Event Summary Conformance Profile for Clinical Documents v1.2	(replaces v1.1)
Conformance Profile for Clinical Documents – Common v1.3 ○ (Located in "Common Specifications Folder".)	(unchanged)

Clarifications

(Refers to Event Summary CDA Implementation Guide v1.2)

Clinical

Medical History

A number of NEHTA clinical content specifications (Structured Content Specifications – SCS) contain an information component known as Medical History (also known as "Current and Past Medical History").

NEHTA specifications on Referral, Specialist Letter, Shared Health Summary and Event Summary contain an information component known as Medical History (also known as "Current and Past Medical History"). Clinically speaking, Medical History in the Discharge Summary is represented by Primary Problem/Diagnosis, Co-Morbidity and Clinical Interventions.

Structuring Medical History Clinical Information Model

The Medical History information structure contains two distinct categories:

- *Problem/Diagnosis* and *Procedure* to meet information capturing and persistence requirements of acute care/hospital sector; or
- Uncategorised *Other Medical History Item* to meet information capturing and viewing requirements of primary care/general practice sector.

The design intent is for software vendors to design for the first two data categories:

- *Problem/Diagnosis* and
- *Procedure*.

The constraint for use is to use EITHER "*Problem/Diagnosis*" and "*Procedure*" OR "*Other Medical History Item*", but NOT both.

These categorisations are technical design decisions and do not impose any rendering constraints on the clinical desktop applications used by healthcare providers. These items can be rendered using screen names in accordance to the preferences of individual healthcare providers or the healthcare sector.

It is also acknowledged that the technical name "Other Medical History Item" can be misinterpreted during technical implementation as relatively unimportant medical history items. For clinical safety reasons, it was decided that this technical name will be changed to "uncategorised medical history" and include a clear definition and description of this item in the next release.

Processing of Medical History Data by Local Clinical Systems

The different *Medical History* information structures may create information reconciliation challenges for importing clinical systems when attempting to extract and load medical history information from the eDischarge Summary, Event Summary or Shared Health Summary, etc. into local databases with different information structures. Uncategorised Medical History items, if encoded in SNOMED CT[12] codes, can be algorithmically analysed, categorised using the SNOMED CT codes and stored as Problem/Diagnosis or Procedure items accordingly. Unencoded items will require manual processing before they can be incorporated into local databases.

For clinical safety reasons, linkage must be maintained between extracted data that are stored in local databases and the source Medical History data from the downloaded CDA document which should also be persisted in its entirety.

Please note that duplicate medical history entries may result if uncategorised Medical History data are extracted and incorporated into local system databases without undergoing algorithmic or manual reconciliation processes.

Patient Medicines Change Type Code Values

NEHTA specifications for Specialist Letter and Event Summary contain a "Medication" section which is used to transmit information about a patient's medicine. It contains a number of data items to indicate change(s) to a patient's medicine(s) that have been made by the authoring healthcare provider: change type, change status (i.e. whether the action is an actual change or it is a recommendation to change), change description and change reason(s).

The change type data item is of data type "coded text". A national codeset of change type values (code system OID = "1.2.36.1.2002.1001.101.104.16592") has been recommended for use with the change type data item. A code definition of this codeset will be published by NEHTA following this release.

Technical

"NullFlavour Attributes"

A clarifying FAQ note is available from the implementation portal for software vendors.

Representing fully structured addresses

The Structured Content Specifications use the address model defined in the participation specification and that is based on the address models defined in AS 5017 and 4846. These divide a real world address into a highly structured address that is consistent with the official Australia Post database (called the PAF). AS 5017 has 17 fields for address. Most implementations (in and outside health) do not collect this many fields. The norm is between 1-3 lines of text, followed by suburb, state, postcode, and country, though systems vary wildly. The HI Service address type uses a full AS 5017 structure.

Because of this, the NEHTA address model for Australian addresses (as defined in the Participation Specification) has the following fields:

[12] IHTSDO®, SNOMED® and SNOMED CT® are registered trademarks of the International Health Terminology Standards Development Organisation.

- Unstructured Address Line [0..*]
- STRUCTURED ADDRESS LINE [0..1]
- Suburb/Town/Locality [0..1]
- State/Territory [0..1]
- Postcode [0..1]
- Delivery Point Identifier [0..1].

And the Structured Address line in turn has the following elements:

- Unit Type
- Unit Number
- Address Site Name
- Level Type
- Level Number
- Street Number
- Lot Number
- Street Name
- Street Type
- Street Suffix
- Postal Delivery Type
- Postal Delivery Number.

All have cardinality [0..1]. For definitions of these, consult AS 5017.

So an address can either contain multiple unstructured lines, or can populate the structured fields. If both are populated, they should agree.

Issues will be encountered when any of the address types in either HL7® v2 or CDA are used. For CDA, the address type is AD from the v3 data types R1. This doesn't have the same finely granulated fields as AS 5017, and as a consequence, the mapping cannot be a round trip 1:1 mapping. Therefore, an address fully structured as above cannot be (per AS 5017) represented in the CDA document, and still be able to identify the parts. This table summarises the mappings:

Field Name	**Address Element Name**
Unstructured Address Line	StreetAddressLine
STRUCTURED ADDRESS LINE:	
Unit Type	unitType
Unit Number	unitID
Address Site Name	additionalLocator
Level Type	additionalLocator
Level Number	additionalLocator
Street Number	houseNumber
Lot Number	additionalLocator

Street Name	streetName
Street Type	streetNameType
Street Suffix	direction
Postal Delivery Type	deliveryAddressLine
Postal Delivery Number	deliveryAddressLine
Suburb/Town/Locality	city
State/Territory	state
Postcode	postalCode
Delivery Point Identifier	additionalLocator

As a consequence of this, in the CDA® document, it is not possible to distinguish the difference between Address Site Name, Level Type, Level Number, Lot Number, and the Delivery Point Identifier, and between Postal Delivery Type and Postal Delivery Number. In practice, most systems use the simple address model, and will be unaffected by this. Systems that use a fully specified address per AS 5017, or that endeavour to match addresses against the PAF will need to continue to use special matching algorithms/software to overcome the CDA® limitations here (as would already be required to overcome v2 limitations).

Any system that populates the structured address should also populate one or more unstructured address lines too.

Representing MRNs and other identifiers

This specification provides a code element on ex:asEntityIdentifier that may be used to indicate the type of an identifier for non-national identifiers such as IHI, HPI-I, HPI-O. However in this version, the specification does not specify a value set that should be used in the code element. This will be addressed in a future version. The HL7 v2 table 0203 is a candidate for interim use (see http://www.healthintersections.com.au/?p=721 for examples).

Mapping error in imaging examination report/result group/anatomical location

The mapping for "Anatomical Location" in "Imaging Examination Result Group" is incorrect – it is attached to the individual results rather than the group of results by virtue of the context: `entryRelationship[im_res_gp]/organizer/component[ind_im_res]/observation/targetSiteCode` (should not use `ind_im_res` in the context). This will be fixed in future versions of the specification, and this mapping should not be used. Please consult NEHTA if the use of this data element is required.

SNOMED CT-AU version issues

This specification uses some SNOMED CT-AU codes for identifying sections and entries, and identifies these as being taken from a particular SNOMED CT-AU release. Future specifications will clarify whether implementations are required to identify this particular version or any other in the CDA® documents. In addition, the specification may contain example fragments using older releases of either SNOMED CT or SNOMED CT-AU. These older versions of SNOMED CT and SNOMED CT-AU should not be in use in Australia: these examples will be fixed in a future release. The syntax of the codeSystemVersion attributes may be affected by ongoing IHTSDO deliberations about how to represent SNOMED CT versions.

Representation of Diagnostic Reports

The new industry practice, which aligns with IT-14 standards currently in preparation, is to send multiple different formats for diagnostic service reports (e.g. PDF, RTF, XHTML). Each report contains the same content, but the renderer can choose the format that they are best able to support when showing the content (depending on platform and tools available). This is what is intended when the definition of the Test Result Representation includes the remark:

> "Multiple formats are allowed but they must be semantically equivalent".

The cardinality of the Test result Representation is [0..1] in this specification, and therefore precludes sending multiple formats. This issue will be addressed in a future release. The same issue applies to the Examination Report Representation, though its definition does not include a "multiple formats" note.

Conformance Criteria

The Common Conformance Profile for Clinical Documents defines five levels of conformance for clinical documents. These are levels 1A, 1B, 2, 3A and 3B, where 3B is the highest. A minimum level of conformance applies to clinical documents sent to the PCEHR System. The minimum level for a specific type of clinical document is specified in the associated PCEHR Conformance Profile. Documents sent to the PCEHR System that do not meet the minimum level of conformance will be automatically rejected. For most document types the minimum level of conformance is 1A but for some document types the minimum conformance level is 3A. NEHTA welcomes feedback about the minimum level of conformance from early adopters of the PCEHR System.

Please note that the minimum conformance level required for a conformant implementation of the Event Summary is defined as 3A and is specified in the PCEHR Conformance Profile for Event Summary Clinical Documents v1.2.

Release history

Version	Date	Comment
Event Summary v1.2	26 September 2012	Update
Event Summary v1.1	21 March 2012	PCEHR Release
Event Summary v1.0	02 December 2011	PCEHR Release

Publication date: 10 April 2015

Contact for enquiries
Telephone: 1300 901 001 or email: help@nehta.gov.au

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