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Discharge Summary
My Health Record Conformance Profile

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1.6	08/09/2022	Subtyping of Discharge Summary

Table of contents

1 Introduction

1.1 Purpose

This document summarises the requirements for producing and consuming system of the Discharge Summary clinical document that connect to the My Health Record (MHR) system.

This document lists the specific conformance requirements for the Discharge Summary clinical document that are in addition to the *Common Conformance Profile for Clinical Documents* [AGENCY2013]. These documents represent the complete set of conformance requirements for the Discharge Summary clinical document.

1.2 Intended audience

The intended audience includes the following organisations:

- healthcare providers
- vendors and developers of connecting systems, and
- software test laboratories.

1.3 Scope

The scope of this conformance profile is limited to the use of Discharge Summary clinical documents in the context of the national My Health Record system.

1.4 Overview

Any comments or feedback should be sent to the Agency at: help@digitalhealth.gov.au

2 Conformance Requirements for Discharge Summary

2.1 Introduction

This section describes the conformance requirements specific to the Discharge Summary clinical document type.

Although Discharge Summary is designed for point-to-point communications, it is also possible to send a Discharge Summary to the My Health Record system. These conformance requirements only apply when it is used in communication with the national MHR system.

2.2 Relevant specifications

The detailed conformance requirements are listed in Table 1.

Table 1 - Specifications for discharge summary

Specification	Notes
Discharge Summary Structured Document Template [AGENCY2011]	Specifies the data elements and constrained values for a clinical document at a logical level.
Discharge Summary CDA Implementation Guide [AGENCY2012]	Specifies the mapping from the structured content specification into a clinical document using an HL7 CDA structure

2.3 Conformance requirements for producing systems

2.3.1 Objects of conformance

The objects of conformance requirements are subject to the following requirements:

1. Discharge Summary clinical documents MAY be produced by:
    a. clinical information systems, and
    b. contracted service provider (CSP) systems.
2. Discharge Summary clinical documents SHALL NOT be produced by:
    a. registered repositories,
    b. registered consumer portals, or
    c. registered provider portals.

2.3.2 Conformance levels

A Discharge Summary sent to the My Health Record system SHALL conform to the requirements for one, and only one, of the following conformance levels: 1A, 1B, 2, 3A or 3B, as defined in the Common Conformance Profile for Clinical Documents [AGENCY2013].

2.3.3 Temporary relaxation of inclusion of HPI-I

The *Discharge Summary Structured Document Template* [AGENCY2011] and the *Discharge Summary CDA Implementation Guide* [AGENCY2012] include mandatory conformance requirements for the inclusion of HPI-Is when producing a discharge summary. These specifications state the conformance requirement:

"The value of one Entity Identifier SHALL be an Australian HPI-I"

This applies to the following data elements:

- Document Author > Participant > Entity Identifier
- Event > Encounter > Responsible Health Professional at Time of Discharge > Participant > Entity Identifier
- Health Profile > Healthcare Providers > Nominated Primary Healthcare Provider > Participant > Entity Identifier
- Plan > Arranged Services > Protocol > Service Provider > Participant > Entity Identifier and
- Plan > Record of Recommendations and Information Provided > Recommendations Provided > Recommendation Recipient > Participant > Entity Identifier.

The *Discharge Summary CDA Implementation Guide* [AGENCY2012] states the following conformance requirement:

"If the Other Participant has an Australian HPI-I, then Entity Identifier is ESSENTIAL, otherwise it is OPTIONAL. If the Other Participant has an Australian HPI-I, then one value of Entity Identifier **SHALL** be an Australian HPI-I."

This applies to the following data element:

- Other Participant > Participant > Entity Identifier.

However, the mandatory requirements for an HPI-I for these data elements are temporarily modified:

1. The value of one Document Author > Participant > Entity Identifier SHALL be an HPI-I if one is present in the Discharge Summary producing system, otherwise it SHALL have a value that identifies the document author and the value SHALL NOT be a nullFlavor.
2. The value of one Event > Encounter > Responsible Health Professional at Time of Discharge > Participant > Entity Identifier SHALL be an HPI-I if one is present in the Discharge Summary producing system, otherwise it SHALL have a value that identifies the responsible health professional at time of discharge, and the value SHALL NOT be a nullFlavor.
3. The value of one Health Profile > Healthcare Providers > Nominated Primary Healthcare Provider > Participant > Entity Identifier SHALL be an HPI-I if one is present in the Discharge Summary producing system, otherwise it SHALL have a value that identifies the nominated primary healthcare provider (person) and the value SHALL NOT be a nullFlavor.
4. The value of one Plan > Arranged Services > Protocol > Service Provider > Participant > Entity Identifier SHALL be an HPI-I if one is present in the Discharge Summary producing system, otherwise it SHALL have a value that identifies the service provider (person) and the value SHALL NOT be a nullFlavor.

5. The value of one Plan > Record Of Recommendations And Information Provided > Recommendations Provided > Recommendation Recipient > Participant > Entity Identifier SHALL be an HPI-I if one is present in the Discharge Summary producing system, otherwise it SHALL have a value that identifies the recommendation recipient (person) and the value SHALL NOT be a nullFlavor.
6. The value of one Other Participant > Participant > Entity Identifier SHALL be an HPI-I if one is present in the Discharge Summary producing system, otherwise it SHALL have a value that identifies the other participant and the value SHALL NOT be a nullFlavor.

   Notes:

   a. The Common Conformance Profile for Clinical Documents [AGENCY2013] provides requirements for the inclusion of a local identifier for a document author.
   b. The relaxation is only available to specific healthcare provider organisations, at the discretion of the My Health Record System Operator. The relaxation is provided to allow time for large healthcare provider organisations to incorporate HPI-Is for their personnel in their systems.

2.3.4 Separation Mode

Separation Mode is a concept descriptor with codeSystemName AIHW Mode of Separation and codeSystem 2.16.840.1.113883.13.65 [AGENCY2012].

The Discharge Summary Structured Document Template [AGENCY2011] lists separation mode values and descriptions. The description has been used as the display name for the corresponding value. A new set of display names is now provided that replaces the use of the displayName values in the Discharge Summary structured document template.

A Separation Mode code and displayName SHALL have one of the values in Table 2.

Table 2 - Codes and displayNames for separation mode

Code	displayName
1	Other Hospital
2	Aged Care Service
3	Psychiatric Care
4	Health Service
5	Administrative Discharge
6	Self-discharged
7	Administrative from Leave
8	Deceased
9	Other/Home

2.3.5 Address of the individual

When authoring the individual's address, the document SHALL contain one of the followings:

- an address, or
- a nullflavor, or
- both, BUT NOT
- an address AND an MSK nullflavor.

Rationale:

The address of the healthcare individual can be masked due to privacy or safety concerns.

Additional Notes:

The document author is permitted to suppress or not include the individual's residential address through the use of nullflavor. If the address is known, but not included in the document, then it is preferred the "MSK" nullflavor is used. The masking of the address may be used when there are patient privacy or safety concerns.

It is prohibited to include a MSK nullflavor AND an address because a masked address should not be available in the CDA/XML document.

Other nullflavors are also permitted.

2.3.6 Document subtype

To support clinical document discoverability, the producing system is encouraged to include a document subtype in the clinical document. The document subtype is intended to assist healthcare providers and individuals to discover the most relevant clinical documents and identify the clinically relevant content easily in the healthcare individual's MHR.

The Document Type Register is a comprehensive list of all document types and its associated subtypes supported by the MHR system. Each document type and subtype will be supplemented with a description to inform implementers about the intention of the subtypes. Implementers should refer to the Agency's Developer Centre (https://developer.digitalhealth.gov.au) for information on how to access the Document Type Register.

The national Document Type Register will be maintained by the Agency and it may change over time for additional or to update subtypes. Because the locally stored list of subtypes provided by the CIS is sourced from the national Document Type Register and cached periodically it is expected the local list of subtypes will not perfectly align to the national Document Type Register. This is acceptable provided that the update of the local Document Type Register will be performed by the CIS within a reasonable timeframe. See requirement 2.3.6.5 for detail.

The conformance requirements in this section refer to the local version of Document Type Register that is implemented within the local CIS at the time of authoring. See requirements 2.3.6.1 to 2.3.6.5 for the inclusion of subtypes known to the local CIS.

2.3.6.1 Document subtype name

If instantiating the document subtype, the producing system SHALL instantiate the following XPaths with the same subtype name:

a. ClinicalDocument/code/originalText

b. ClinicalDocument/title

This SHALL be one of the subtypes in the local Document Type Register for the document type.

Rationale:

To differentiate the document with a subtype and reflect the document subtype name in the MHR document title.

Additional Notes:

The local Document Type Register contains the list of document types and its subtypes for the My Health Record. Implementers should refer to the Agency's Developer Centre for information about how to access and synchronise with the national Document Type Register.

2.3.6.2 Authoring a document with subtype

When authoring the first version of a subtyped document, the document SHALL only contain a subtype that is "active" in the local system.

Rationale:

To ensure CIS's local document type register is updated regularly and transition to the new subtypes where appropriate. To prevent document rejection by the MHR system when the subtype becomes retired.

Additional Notes:

The first version of the document is a newly authored document that is authored at the first instance (i.e., new document set ID), and not a superseding document.

The local Document Type Register stored in the CIS may not be up-to-date with the version in the MHR system. Once the CIS has updated to a newer version of the national Document Type Register, the CIS must incorporate any new "active" subtypes for authoring.

2.3.6.3 Superseding a document with the same subtype

When superseding a subtyped document, the subtype of the superseding document SHOULD be the same as the subtype of the preceding document and that subtype MAY be deprecated or retired.

Rationale:

To ensure document versions in the My Health Record system contain consistent subtypes.

Additional Notes:

The system that is superseding a document with the same subtype should acquire the subtype from the superseded document, and not from a source (i.e., Document Type Register) that might encourage an inconsistent subtype.

2.3.6.4 Superseding a document with a different subtype

When superseding a document with a subtype that is different from that of preceding document, the subtype of the superseding document:

- SHALL NOT be “retired” in the local system, and
- SHALL NOT contradict the content of the clinical document.

Rationale:

To allow flexibility for CIS to update and correct the document subtype from the preceding document where appropriate.

Additional Notes:

A superseding document may contain a different subtype from the preceding document. For example, to correct an incorrect subtype; to transition to a more specific subtype; or up-to-date subtype.

The subtype of the subsequent versions of the document must be relevant.

2.3.6.5 Document Type Register

The producing system SHALL provide a mechanism to update the local Document Type Register in real time, on a schedule or on request (e.g., manual input).

Rationale:

To ensure the producing system maintains an up-to-date Document Type Register in the local CIS. Prevent document rejection by the MHR system when subtype becomes retired.

2.3.6.6 Automated assignment of subtype

When authoring a subtyped document, the producing system SHOULD support automated assignment of the subtype to the document.

Rationale:

To promote software usability and conformity when CIS automatically subtypes a document. To mitigate the risk of human errors when document author manually selects a subtype.

2.4 Conformance requirements for consuming systems

2.4.1 Objects of conformance

The objects of conformance requirements include:

Discharge Summary clinical documents MAY be consumed by:

- clinical information systems
- contracted service provider (CSP) systems
- registered consumer portals
- registered provider portals, and
- registered repositories.

2.4.2 Search or filter subtype

When viewing a subtyped document, the CIS SHOULD provide a mechanism to search or filter a particular subtype(s).

Rationale:

Allow robust searching or filtering functionality in the CIS to discover the relevant document subtypes easily.

Additional Notes:

Depending on the software design, the viewing functions may present a long list of subtypes for the healthcare providers to choose from. The CIS should make it easy for healthcare providers to discover the subtyped documents.

Acronyms

Acronym	Description
AIHW	Australian Institute of Health and Welfare
CDA	Clinical Document Architecture
CSP	contracted service provider
CIS	clinical information systems
HL7	Health Level 7
MHR	My Health Record
MSK	masked

Glossary

Term	Meaning
CDA	Clinical document architecture, an XML-based mark-up 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	A system that deals with the collection, storage, retrieval, communication, and use of health-related data, information and knowledge pertaining to subjects of care [AS5021]. The system may comprise one or more applications or components.
conformance	A measurement (by testing) of the adherence of an implementation to a specification or standard.
Consumer	In this document 'Consumer' refers to a software system that has the role of being a consumer of discharge summaries.
Contracted service provider (CSP)	An entity that may offer health software as a service and support access to the MHR system on behalf of healthcare organisations. A CSP provides under a contract with the healthcare provider organisation: a) information technology services relating to the MHR system; or b) health information management services relating to the MHR system.
CSP system	A software system operated by a CSP that deals information and knowledge pertaining to subjects of care [AS5021]. The system may comprise one or more applications or components. A CSP system may perform some or all the functions of a CIS.
healthcare consumer	A person who is the subject of care. (For the software system, see 'Consumer'.)
Individual	A person who is, or could be, seeking care in Australia. Individual is sometimes referred to as patient, client, and consumer. For the purposes of the My Health Record system, an individual must have an IHI.
MAY	When appearing in a conformance requirement, the verb **MAY** indicates an optional requirement.
Producing system	A software system that has the role of generating and issuing conformant clinical documents suitable for use by other digital health participants.
registered consumer portal	A third-party portal used by healthcare recipients to access information on the MHR system.
registered provider portal	A third-party portal used by healthcare providers to access information on the MHR system.

Term	Meaning
registered repository	A third-party repository used to store clinical documents and other clinical data that connects to the MHR system. A repository may store clinical documents in a proprietary format or a CDA format.
SHALL	When appearing in a conformance requirement, the verb SHALL indicates a mandatory requirement. Its negative form SHALL NOT indicates a prohibition.
SHOULD	When appearing in a conformance requirement, the verb SHOULD indicates a recommendation. Its negative form SHOULD NOT indicates an option that is not recommended.

References

[AGENCY2011] Discharge Summary Structured Document Template, Version 3.3, Australian Digital Health Agency, 2 Dec 2011

[AGENCY2012] *Discharge Summary CDA Implementation Guide, Version 3.4*, Australian Digital Health Agency, 7 Mar 2012

[AGENCY2013] *Common Conformance Profile for Clinical Documents, Version 1.4*, Australian Digital Health Agency, 2013

[AS5021] *AS 5021:2005 - The language of health concept representation*, Standards Australia, 2005, https://infostore.saiglobal.com/en-au/Standards/AS-5021-2005-R2016-121393_SAIG_AS_AS_254729/