

National E-Health Transition Authority  
Project #2

Priority Event Summaries -  
Descriptions

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## DOCUMENT CONTROL

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Program	National E-Health Transition Authority (NEHTA)
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Project Manager	Dr Frida Cheok

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Document Author	Dr Eric Browne		
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Associated Documents	
Title	Description
Priority Event Summaries and Code Sets, and Jurisdictional Gap Analysis	Final report for NEHTA Projects #1 to #4, and summary of jurisdictional analysis of clinical information requirements.
Index of NEHTA Specifications	Structured hierarchy of the priority data groups for use as an index.
Priority Event Summaries - Descriptions	For each of the event summaries identified as priorities for national standardisation, a description of the context, together with an indication of the clinical data groups that might be expected, and some indication of implementation considerations.
NEHTA Technical Specifications	Technical specification of the completed data groups using the NEHTA specification template (based on ISO/IEC 11179).
NEHTA Specification Template Reference Guide	User guide for the interpretation of NEHTA specifications. Defines and further clarifies the concepts in the NEHTA specification template.
NEHTA Specifications - Guide for Use	User guide to assist with the interpretation and use of NEHTA specifications by those involved in development, implementation or operation of systems.
NEHTA Specifications - Summarised Format	Extract of key elements from the NEHTA technical specifications that provide a high level view of content without the technical detail.
Draft NEHTA Specifications - Summarised Format	Provides a high level view of content for the draft data groups that are near completion.
Adverse Reaction and Alert Archetype Representations	Archetype representations of the Adverse Reaction and Alert data groups. Archetypes allow for direct use by software systems.

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# 1 OVERVIEW

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This document provides an overview of each of the 12 Event Summary types that have been identified by NEHTA as priorities for national standardisation. For each event summary type, a description of the context in which each summary might be sent, together with an indication of the **clinical data groups** that might be expected to comprise the event summary, and some indication of **implementation** considerations are supplied. Readers wishing further detail about the clinical content are referred to the accompanying 'NEHTA Technical Specifications'. Those wishing further detail regarding implementation considerations are referred to the 'NEHTA Specifications - Guide for Use'

## 1.1 Background

In September 2004, the NEHTA Clinical Data Standards group (CDS) identified 12 priority events following national consultations. These priorities were endorsed by the NEHTA Advisory Committee (NAC) and formed the basis of the basis of the NEHTA Project #2 work program for the remainder of the 2004/05 financial year.

These 12 priority events are:

- Initial Health Profile;
- Medical Consultation - General Practitioner;
- Medical Consultation - Specialist;
- Diagnostic Investigation - Imaging;
- Diagnostic Investigation - Pathology;
- Hospital Discharge - Inpatient;
- Hospital Discharge - Emergency;
- Pharmacy Provision;
- Community Based Health Consultation;
- Allied Health Consultation;
- Referral; and
- Event Notification (for example, admission to hospital).

Since December 2004, the CDS has focused much of its development work around the detail of specific data groups to support the above priority event summaries. These data groups include:

- Alert
- Adverse Reaction
- Legal
- Problem/Diagnosis
- Reason for Encounter
- Clinical Intervention
- Medication
- Clinical Synopsis
- Clinical Context
- Diagnostic Imaging
- Pathology Episode
- Immunisation
- Observation
- Standardised Comprehensive Assessment Procedure
- Functional Status
- Management Plan
- Requested Service
- Current Service
- Care Team
- Lifestyle - Drug of Concern
- Lifestyle - Alcohol Consumption
- Lifestyle - Nutrition
- Lifestyle - Physical Activity
- Lifestyle - Tobacco Smoking
- Social Circumstance
- Family Clinical History
- Discharge

The potential use of any of the above data groups for specific event summary types is described in each event summary description following.

## 2 INITIAL HEALTH PROFILE

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The collection of Initial Health Profile (IHP) information is anticipated to be undertaken at, or close to, subject of care registration with shared Electronic Health Record (EHR) programs. The intention is to capture historical and current information about the subject of care pertinent to providing healthcare services, such as adverse reactions, family clinical history and current medications.

The IHP provides a snapshot of the health history of a subject of care used to initialise the EHR.

### When to use

The IHP is used once to initialise the shared EHR with historical information and current health status of the subject of care.

### When NOT to use

The IHP is not intended to be used after any other event summaries have been submitted to the shared EHR. The other event summaries are used to subsequently update the information combined into a current health profile.

### Who sends this

A variety of providers may send this event summary by either a clinical information system using an eHealth standard message or a person submitting a form using traditional communication methods. These providers may include:

- Subject of care's usual General Practitioner;
- Medical Specialist involved in the subject of care's speciality care;
- Public or Private Hospital that has been most commonly involved in the subject of care's inpatient visits; and
- Diagnostic Laboratory performing the majority of the diagnostic investigations on the subject of care.

The subject of care themselves may also provide portions of the IHP, such as *social circumstance* data.

### Who receives this

This event summary is solely intended to be received by a shared electronic health record system or a administrative officer that will transcribe the IHP into the shared EHR.

### How is this sent

The event summary can be sent by a dedicated, secure, eHealth message via the Internet or traditional communication methods including fax, post or secure email as plain text.

### Clinical content

The IHP is expected to contain clinical content from various data groups depending on the findings, assessments, interventions and planned services recorded during the collation of the initial health profile:

- Alert
- Adverse Reaction
- Legal
- Problem/Diagnosis
- Clinical Intervention
- Current Service
- Clinical Context
- Family Clinical History
- Functional Status
- Lifestyle - Drug of Concern

- Medication
- Clinical Synopsis
- Immunisation
- Observation
- Care Team
- Standardised Comprehensive Assessment Procedure
- Lifestyle - Alcohol Consumption
- Lifestyle - Nutrition
- Lifestyle - Physical Activity
- Lifestyle - Tobacco Smoking
- Management Plan
- Social Circumstance

## Implementation

### Electronic Health Record

A single IHP based on one healthcare provider's records may often be inadequate due to logistics and privacy issues. Multiple IHPs will need to be consolidated into a single health profile and a process should be devised to merge information from several sources, either by the allocation of data groups to an information source or by the resolution of duplications and inconsistencies (as mentioned above). Multiple IHP templates with logical sets of data groups may assist in a strictly managed collection of the IHP information for each source.

The shared EHR or its administrators will also need to manage not allowing additional IHP information to be collected, which may be determined simply by the first current event summary being submitted.

### eHealth Messaging

The majority of the IHP summary can be represented using the AS4700.6 Referral and Discharge Summary standard based on the HL7 v2.3.1 REF message type.

## 3 MEDICAL CONSULTATION - GENERAL PRACTITIONER

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The Medical Consultation - General Practitioner event is used to record clinical information relevant to a consultation between a General Practitioner (GP) and a subject of care.

### When to use

A GP, at the end or soon after a consultation with a subject of care, will produce this event summary. It is up to the discretion of the GP, with subject of care consent, to determine the extent to which information is provided within the event summary.

### When NOT to use

The Medical Consultation - General Practitioner summary should not be used as a referral for explicitly referring the subject of care to another provider. A Referral (not a Medical Consultation - General Practitioner summary) should be provided when an explicit transfer of care, for the subject of care, is being requested of the referred to provider. The latter allows the Referred to provider the opportunity to respond with an acceptance or rejection.

### Who sends this

A GP sends this event summary by either a clinical information system using an eHealth standard message or a person using traditional communication methods.

### Who receives this

A healthcare provider will receive this event summary either by a clinical information system capable of receiving standard eHealth message or a person using traditional communication methods. Any healthcare provider on the subject-of-care's care team is a likely recipient of this event summary. This event summary is also an important contribution to a shared EHR.

### How is this sent

The event summary can be sent by a dedicated, secure, eHealth message via the Internet or traditional communication methods including fax, post or secure email as plain text.

### Clinical content

The Medical Consultation - General Practitioner summary is expected to contain clinical content from various data groups depending on the findings, assessments, interventions and planned services recorded during the consultation:

- Alert
- Adverse Reaction
- Legal
- Problem/Diagnosis
- Reason for Encounter
- Clinical Intervention
- Medication
- Clinical Synopsis
- Diagnostic Imaging
- Pathology Episode
- Standardised Comprehensive Assessment Procedure
- Current Service
- Clinical Context
- Family Clinical History
- Functional Status
- Lifestyle - Drug of Concern
- Lifestyle - Alcohol Consumption
- Lifestyle - Nutrition
- Lifestyle - Physical Activity
- Lifestyle - Tobacco Smoking

- Immunisation
- Observation
- Care Team
- Management Plan
- Requested Service
- Social Circumstance

## Implementation

### Electronic Health Record

It has not yet been decided if it is necessary for every GP consultation to provide an event summary into the shared EHR. Some feel that only consultations that have information that is judged to be clinically significant by the GP for the subject of care's longitudinal health record needs to be provided. Others believe that every consultation should be recorded.

### eHealth Messaging

The majority of the Medical Consultation - General Practitioner summary can be represented using the AS4700.6 Referral and Discharge Summary standard based on the HL7 v2.3.1 REF message type even though it was not originally designed for this purpose. Several Health*Connect* trials have successfully used the message for this purpose.

## 4 MEDICAL CONSULTATION - SPECIALIST

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The Medical Consultation - Specialist event is used to record clinical information relevant to a consultation between a specialising physician and a subject of care.

### When to use

A medical specialist, at the end or soon after a consultation with a subject of care, will produce this event summary. This event summary can also be used as a clinical response from the specialist to the provider that originally referred the subject of care to the specialist and to record clinical information relevant to a specialist outpatient consultation.

It is at the discretion of the specialist, with subject of care consent, to determine the extent to which information is provided within the event summary.

### When NOT to use

The Medical Consultation - Specialist summary should not be used as a referral for explicitly referring the subject of care to another provider. A Referral (not this event summary) should be provided when an explicit transfer of care, for the subject of care, is being requested of the referred to provider. The latter allows the Referred to provider the opportunity to respond with an acceptance or rejection.

### Who sends this

A medical specialist sends this event summary by either a clinical information system using an eHealth standard message or a person using traditional communication methods.

### Who receives this

A healthcare provider will receive this event summary either by a clinical information system capable of receiving standard eHealth message or a person using traditional communication methods.

The most common receiver of this event summary is the GP or any provider that originally referred the subject of care to the specialist. Any other clinician or healthcare provider on the subject-of-care's care team could also be a recipient.

This event summary would also be received by a shared EHR system.

### How is this sent

The event summary can be sent by a dedicated, secure, eHealth message via the Internet or traditional communication methods including fax, post or secure email as plain text.

### Clinical Content

The Medical Consultation - Specialist summary is expected to contain clinical content from various data groups depending on the findings, assessments, interventions and planned services recorded during the consultation:

- Alert
- Adverse Reaction
- Legal
- Problem/Diagnosis
- Reason for Encounter
- Current Service
- Clinical Context
- Family Clinical History
- Functional Status
- Lifestyle - Drug of Concern

- Clinical Intervention
- Medication
- Clinical Synopsis
- Diagnostic Imaging
- Pathology Episode
- Immunisation
- Observation
- Care Team
- Standardised Comprehensive Assessment Procedure
- Lifestyle - Alcohol Consumption
- Lifestyle - Nutrition
- Lifestyle - Physical Activity
- Lifestyle - Tobacco Smoking
- Management Plan
- Requested Service
- Social Circumstance
- Implementation

### Electronic Health Record

The Medical Consultation - Specialist summary does not vary greatly in content compared with the Medical Consultation - General Practitioner summary. However, this event summary should be recorded within the shared EHR with a Specialist care setting category along with the more specific speciality to distinguish it from other medical consultation summaries and the different medical specialities to enable listing, grouping and retrieval of different consultation event summaries.

It has not yet been decided if it is necessary for every specialist consultation to provide an event summary into the shared EHR. Some feel that only consultations that have information that is judged to be clinically significant by the specialist for the subject of care's longitudinal health record need to be provided. Others believe that every consultation needs to be recorded even if it does not contain clinical content.

### eHealth Messaging

The majority of the Medical Consultation - Specialist summary can be represented using the AS4700.6 Referral and Discharge Summary standard based on the HL7 v2.3.1 REF message type even though it was not originally designed for this purpose. Several HealthConnect trials have successfully used the message for this purpose.

## 5 HOSPITAL DISCHARGE - INPATIENT

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To provide healthcare providers with consistent and prompt clinical information regarding a subject of care's hospital encounter.

### When to use

This event summary is produced by an inpatient hospital clinician at, or soon after, the discharge of the subject of care.

### When NOT to use

The Hospital Discharge - Inpatient summary should not be used as a referral for explicitly referring the subject of care to another provider. A Referral (not this event summary) should be provided when an explicit transfer of care, for the subject of care, is being requested of the referred to provider. The latter allows the Referred to provider the opportunity to respond with an acceptance or rejection.

### Who sends this

Either public or private inpatient hospitals may send this event summary by either a clinical information system using an eHealth standard message or a person using traditional manual methods.

### Who receives this

A clinician or healthcare provider will receive this event summary either by a clinical information system capable of receiving standard eHealth message or a person using traditional manual methods. The most common receiver of this event summary is the GP but could be any clinician or healthcare provider on the subject-of-care's care team.

This event summary would also be received by a shared EHR system.

### How is this sent

The event summary can be sent by a dedicated, secure, eHealth message via the Internet or traditional communication methods including fax, post or secure email as plain text.

### Clinical Content

The Hospital Discharge - Inpatient summary is expected to contain clinical content from various data groups depending on the findings, assessments, interventions and planned services recorded during the event. The data groups from which this event summary may be composed are as follows:

- Alert
- Adverse Reaction
- Legal
- Problem/Diagnosis
- Reason for Encounter
- Clinical Intervention
- Medication
- Clinical Synopsis
- Diagnostic Imaging
- Pathology Episode
- Current Service
- Discharge
- Clinical Context
- Family Clinical History
- Functional Status
- Lifestyle - Drug of Concern
- Lifestyle - Alcohol Consumption
- Lifestyle - Nutrition
- Lifestyle - Physical Activity
- Lifestyle - Tobacco Smoking

- Immunisation
- Observation
- Care Team
- Standardised Comprehensive Assessment Procedure
- Management Plan
- Requested Service
- Social Circumstance

## Implementation

### Electronic Health Record

Storing detailed demographics of the subject-of-care, clinicians or healthcare provider may not be required within an EHR. A unique identifier for these parties may be sufficient in circumstances where national Client and Provider registries/indexes are available to provide this detail. This approach provides a degree of information security as the health record data is separated from the identities of the parties recorded within the health record.

The event summary should be able to be versioned within the EHR to allow event summary to be revised after the initial contribution to the EHR. Each version should be reproducible retrospectively including attestation details of each version.

The event summary should be recorded within the EHR along with the general Care Setting category to support listing, grouping and retrieval of hospital inpatient event summaries.

### eHealth Messaging

The majority of the Hospital Discharge -Inpatient summary can be represented using the AS4700.6 Referral and Discharge Summary standard based on the HL7 v2.3.1 REF message type.

A HL7 V2.4 edition of the AS4700.6 standard will be released for public comment during 2005 and is expected to be published by the end of that year. This new edition will provide additional support for the Hospital Discharge - Inpatient summary but will not be provide complete support.

A HL7 V3 *Care Record* message is being balloted as a NEHTA Specification within the HL7 organisation. It is anticipated that this Care Record message will provide sufficient support for the entire Hospital Discharge - Inpatient summary.

## 6 DIAGNOSTIC INVESTIGATION - PATHOLOGY

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A pathology provider uses this event summary to report the results for a set of requested pathology investigations performed on a specimen that has been collected from the subject of care. The event summary, in this case is usually the whole report rather than a summary.

### When to use

A pathology specialist produces this event summary after performing the requested diagnostic investigation on the specimen collected from the subject of care.

The same event summary may be used by the ordering provider to authorise the release of the summary/report for shared use within a shared EHR.

### When NOT to use

This event summary is not to be used for any purpose other than as a pathology report or result release authorisation. In particular, it should not be used as a pathology order.

### Who sends this

Both public and private pathology providers may send this event summary by either a clinical information system using an eHealth standard message or a person using traditional manual methods.

A requesting provider can forward the complete or subset of the event summary, received from the pathology provider, to a shared EHR as content contribution or a release authorisation.

### Who receives this

A healthcare provider will receive this event summary either by a clinical information system capable of receiving standard eHealth message or a person using traditional manual methods. The requesting provider will be the primary recipient of this event summary but copies can be sent to any healthcare provider nominated by the requesting provider on the original order.

This event summary would also be received by a shared EHR system.

### How is this sent

The event summary can be sent by a dedicated, secure, eHealth message via the Internet or traditional communication methods including fax, post or secure email as plain text.

### Clinical content

The Diagnostic Investigation - Pathology summary is unlike more general event summary types in that it is expected to contain clinical content from a limited number of data groups. The data groups from which this event summary may be composed are:

- Alert
- Adverse Reaction
- Legal
- Problem/Diagnosis
- Clinical Intervention
- Medication
- Clinical Synopsis
- Diagnostic Imaging
- Pathology Episode
- Observation
- Care Team
- Clinical Context
- Family Clinical History

## Implementation

### Electronic Health Record

Storing detailed demographics of the subject-of-care, clinicians or healthcare provider may not be required within an EHR. A unique identifier for these parties may be sufficient in circumstances where national Client and Provider registries/indexes are available to provide this detail. This approach provides a degree of information security as the health record data is separated from the identities of the parties recorded within the health record.

The event summary should be able to be versioned within the EHR to allow the event summary to be revised after the initial contribution to the EHR. Each version should be reproducible retrospectively including attestation details of each version.

There are issues regarding the process of providing diagnostic investigation results to a shared EHR without the requesting provider releasing the result for shared use. The need to access the diagnostic investigation summaries from a shared EHR for emergency use has been identified. This would require the Diagnostic Investigation - Pathology summary being sent directly to the shared EHR from the Pathology provider. This will require subject of care consent and the ability for the ordering provider to authorise the release of the summary for shared use. However, in the case of an emergency, an emergency override authority could allow access to the event summary that has yet to be authorised for shared use. Additionally, to cater for long term unauthorised event summaries and providers with limited authorising capabilities, an automatic release of the diagnostic investigation summary after a reasonable period of time could be provided.

### eHealth Messaging

The Diagnostic Investigation - Pathology summary can be represented using the AS4700.2 Pathology result standard based on the HL7 v2.3.1 ORU message type. Additionally, a Handbook for Pathology electronic messaging (HB262-2002), published by Standards Australia, provides implementation guidelines for pathology messaging between pathology providers and health service providers.

A HL7 V3 message is being drafted within the HL7 organisation. It is expected that this Laboratory message will provide sufficient support for the entire Diagnostic Investigation - Pathology summary.

## 7 DIAGNOSTIC INVESTIGATION - IMAGING

---

A diagnostic imaging provider uses this event summary to report on requested imaging investigations performed on a subject of care. The event summary, in this case is usually the whole report rather than a summary.

### When to use

An imaging specialist produces this event summary after analysing the requested imaging investigations performed on the subject of care. The images upon which the diagnostic report is based is not part of the event summary.

The same event summary may be used by the ordering provider to authorise the release of the diagnostic report for shared use within a shared EHR.

### When NOT to use

This event summary is not to be used for any purpose other than as a diagnostic imaging report or report release authorisation. In particular, it should not be used as a diagnostic imaging order.

### Who sends this

Both public and private diagnostic imaging providers may send this event summary by either a clinical information system using an eHealth standard message or a person using traditional communication methods.

A requesting provider can forward the complete or subset of the event summary, received from the diagnostic imaging provider, to a shared EHR as content contribution or a release authorisation.

### Who receives this

A healthcare provider will receive this event summary either by a clinical information system capable of receiving standard eHealth message or a person using traditional manual methods. The requesting provider will be the primary recipient of this event summary but copies can be sent to any healthcare provider nominated by the requesting provider on the original order.

This event summary would also be received by a shared EHR system.

### How is this sent

The event summary can be sent by a dedicated, secure, eHealth message via the Internet or traditional communication methods including fax, post or secure email as plain text.

### Clinical content

The Diagnostic Investigation - Imaging summary is unlike most other event summaries where it only contains clinical content from a limited number of data groups. The data groups from which this event summary may be composed are as follows:

- Alert
- Adverse Reaction
- Problem/Diagnosis
- Clinical Intervention
- Medication
- Clinical Synopsis
- Diagnostic Imaging
- Pathology Episode
- Observation
- Care Team
- Clinical Context

## Implementation

### Electronic Health Record

There are issues regarding the process of providing diagnostic investigation results to a shared EHR without the requesting provider releasing the result for shared use. The need to access the diagnostic investigation summaries from a shared EHR for emergency use has been identified. This would require the Diagnostic Investigation - Imaging summary being sent directly to the shared EHR from the Diagnostic Imaging provider. This will require subject of care consent and the ability for the ordering provider to authorise the release of the summary for shared use. However, in the case of an emergency, an emergency over-ride authority could allow access to the event summary that has yet to be authorised for shared use. Additionally, to cater for long term unauthorised event summaries and providers with limited authorising capabilities, an automatic release of the diagnostic investigation summary after a reasonable period of time could be provided.

### eHealth Messaging

The Diagnostic Investigation - Imaging summary can be represented using the soon to be published AS4700.7 Diagnostic imaging results standard based on the HL7 v2.3.1 ORU message type.

## 8 HOSPITAL DISCHARGE - EMERGENCY DEPARTMENT

---

The Hospital Discharge - Emergency Department event provides healthcare providers with clinical information regarding an emergency department presentation.

### When to use

The Hospital Discharge - Emergency Department summary is produced by an emergency department clinician, at or soon after the discharge of the subject of care, when an emergency department presentation does not result in an inpatient hospital encounter. Information gathered by ambulance service providers may also be included in the Hospital Discharge - Emergency Department summary in the absence of an emergency services summary.

### When NOT to use

The Hospital Discharge - Emergency Department summary should not be used as a referral for explicitly referring the subject of care to another provider. A Referral (not this event summary) should be provided when an explicit transfer of care, for the subject of care, is being requested of the referred to provider. This allows the Referred to provider the opportunity to respond with an acceptance or rejection.

This event summary should also not be used when the emergency department presentation does not result in an inpatient hospital encounter. The clinical information relevant to the emergency department presentation should be included within the Hospital Discharge - Inpatient summary produced at the time of discharge.

### Who sends this

Emergency departments send this event summary by either a clinical information system using an eHealth standard message or a person using traditional communication methods.

### Who receives this

A healthcare provider will receive this event summary either by a clinical information system capable of receiving standard eHealth message or a person using traditional communication methods. The most common receiver of this event summary is the GP but could be any healthcare provider on the subject-of-care's care team.

This event summary would also be received by a shared EHR system.

### How is this sent

The event summary can be sent by a dedicated, secure, eHealth message via the Internet or traditional communication methods including fax, post or secure email as plain text.

### Clinical content

The Hospital Discharge - Emergency Department summary is expected to contain clinical content from various data groups depending on the findings, assessments, interventions and planned services recorded during the event:

- Alert
- Adverse Reaction
- Legal
- Problem/Diagnosis
- Reason for Encounter
- Care Team
- Discharge
- Clinical Context
- Family Clinical History
- Functional Status

- Clinical Intervention
- Medication
- Clinical Synopsis
- Diagnostic Imaging
- Pathology Episode
- Immunisation
- Observation
- Lifestyle - Drug of Concern
- Lifestyle - Alcohol Consumption
- Lifestyle - Tobacco Smoking
- Management Plan
- Requested Service
- Social Circumstance

## Implementation

### Electronic Health Record

The Hospital Discharge - Emergency Department summary does not vary greatly in content compared with the Hospital Discharge - Inpatient summary. However, this event summary should be recorded within the shared EHR with an Emergency Department care setting category to distinguish it from an inpatient event to enable listing, grouping and retrieval of different hospital discharge event summaries.

### eHealth Messaging

The majority of the Hospital Discharge -Emergency Department summary can be represented using the AS4700.6 Referral and Discharge Summary standard based on the HL7 v2.3.1 REF message type.

## 9 PHARMACY PROVISION

---

The Pharmacy Provision event is a summary of the provision of medication by a pharmacist to a subject of care including over the counter products.

### When to use

A Pharmacist produces this event summary at the time of supplying/dispensing medication to a subject of care. This provision of medication may be in fulfilment of a medication prescription provided by an authorised healthcare provider or as an over-the-counter request by the subject of care.

### When NOT to use

This event summary is not to be used for any purpose other than as a pharmacy provision notification. In particular, it should not be used as a pharmacy prescription or repeat authorisation.

### Who sends this

Community pharmacies send this event summary by either a clinical information system using an eHealth standard message or a person using traditional communication methods.

### Who receives this

This event summary would be received by a shared electronic health record system and/or an eHealth Message Bank for Pharmacy Prescriptions. The later would be used to indicate that the medication item on the prescription has been filled.

There is no current business practice to notify prescribing providers that the medication has been supplied but it could certainly be supported by this event summary if there did become a business requirement.

### How is this sent

The event summary can be sent by a dedicated, secure, eHealth message via the Internet or traditional communication methods including fax, post or secure email as plain text.

### Clinical content

The Pharmacy Provision summary is unlike most other event summaries where it only contains clinical content from a limited number of data groups. The data groups from which this event summary may be composed are as follows:

- Alert
- Adverse Reaction
- Problem/Diagnosis
- Medication
- Clinical Synopsis
- Observation
- Care Team
- Standardised Comprehensive Assessment Procedure
- Clinical Context
- Lifestyle - Drug of Concern
- Lifestyle - Alcohol Consumption
- Lifestyle - Nutrition
- Lifestyle - Physical Activity
- Lifestyle - Tobacco Smoking
- Management Plan
- Requested Service
- Social Circumstance

## Implementation

There is a general need for both electronic health records and messaging to have a standardised description of medications. These are also required for over-the-counter substances.

### Electronic Health Record

Medication information from a pharmacist may have to be merged with originating information from the prescriber. If this is not handled well, there is potential for duplication. Particular care is needed merging dispensed information with prescribed information where there is a difference in names, quantities etc.

### eHealth Messaging

The Pharmacy Provision summary can be represented using the soon to be published AS4700.3 drug prescription standard based on the HL7 v2.4 RDS Pharmacy Dispense message. However, current *MediConnect* trial implementations implement this event summary using the HL7 RDE Pharmacy Encoded Order message.

## 10 COMMUNITY HEALTH CLINICAL CONSULTATION

---

The Community Health Clinical Consultation event is used to record clinical information relevant to a consultation between a subject of care and community health provider, such as a nursing practitioner, community nurse or aboriginal health worker.

Community health providers consist of units engaged in providing paramedical, nursing and/or health related support services mainly on the account of government agencies or non-profit organisations. These services may be provided either separately from, or together with, services of registered medical practitioners.

### When to use

A community health provider produces this event summary at the end or soon after a consultation with a subject of care. This event summary can also be used as a clinical response from the community health provider to the provider that originally referred the subject of care.

Applicable practitioners working with community care services can also use this event summary to record information about significant clinical events such as assessments performed by a Director of Nursing within an aged care facility.

### When NOT to use

The Community Health Clinical Consultation summary should not be used for recording details about non-clinical events such as routine care activities.

This event summary should also not be used as a referral for explicitly referring the subject of care to another provider. A Referral (not this event summary) should be provided when an explicit transfer of care, for the subject of care, is being requested of the referred to provider. This allows the Referred to provider the opportunity to respond with an acceptance or rejection.

### Who sends this

A community health provider sends this event summary by either a clinical information system using an eHealth standard message or a person using traditional communication methods.

### Who receives this

A healthcare provider will receive this event summary either by a clinical information system capable of receiving standard eHealth message or a person using traditional communication methods.

The most common receiver of this event summary is the GP or any provider that originally referred the subject of care to the community health provider. Any other clinician or healthcare provider on the subject of care's care team could also be a recipient.

This event summary would also be received by a shared EHR system.

### How is this sent

The event summary can be sent by a dedicated, secure, eHealth message via the Internet or traditional communication methods including fax, post or secure email as plain text.

## Clinical content

The Community Health Clinical Consultation summary is expected to contain clinical content from various data groups depending on the findings, assessments, interventions and planned services recorded during the consultation:

- Alert
- Adverse Reaction
- Legal
- Problem/Diagnosis
- Reason for Encounter
- Clinical Intervention
- Medication
- Clinical Synopsis
- Diagnostic Imaging
- Pathology Episode
- Immunisation
- Observation
- Care Team
- Standardised Comprehensive Assessment Procedure
- Current Service
- Discharge
- Clinical Context
- Family Clinical History
- Functional Status
- Lifestyle - Drug of Concern
- Lifestyle - Alcohol Consumption
- Lifestyle - Nutrition
- Lifestyle - Physical Activity
- Lifestyle - Tobacco Smoking
- Management Plan
- Requested Service
- Social Circumstance

## Implementation

### Electronic Health Record

The Community Health Clinical Consultation summary does not vary greatly in content compared with the Allied Health Consultation summary or any other consultation summary in general. However, this event summary should be recorded within the shared EHR with a Community Health care setting category along with the more specific service type to distinguish it from other consultation summaries and the different types of community health services to enable listing, grouping and retrieval of different consultation event summaries.

### eHealth Messaging

The majority of the Community Health Clinical Consultation summary can be represented using the AS4700.6 Referral and Discharge Summary standard based on the HL7 v2.3.1 REF message type even though it was not originally designed for this purpose.

## 11 ALLIED HEALTH CONSULTATION

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A summary of clinical information related to an allied health provider contact with a subject of care. Providers of the Allied Health Consultation<sup>1</sup> may include:

- Audiology;
- Dental Therapy;
- Dietetics;
- Physiotherapy;
- Podiatry;
- Medical Illustration;
- Radiation Therapy;
- Nuclear Medicine Technology;
- Occupational Therapy;
- Social Work;
- Orthoptics;
- Speech Pathology;
- Orthotics; and
- Prosthetics.

### When to use

This event summary is to be used to record clinical information relevant to an allied health visit covering community, private and outpatient clinics.

It is at the discretion of the provider, with subject of care consent, the extent to which information is provided within the event summary.

### When NOT to use

The Allied Health Consultation summary should not be used for recording non-clinical information and insignificant routine events.

This event summary should also not be used as a referral for explicitly referring the subject of care to another provider. A Referral (not this event summary) should be provided when an explicit transfer of care, for the subject of care, is being requested of the referred to provider. This allows the Referred to provider the opportunity to respond with an acceptance or rejection.

### Who sends this

An allied health professional sends this event summary by either a clinical information system using an eHealth standard message or a person using traditional communication methods.

### Who receives this

A healthcare provider will receive this event summary either by a clinical information system capable of receiving standard eHealth message or a person using traditional communication methods.

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<sup>1</sup> Allied Health definition from the Tasmanian Health Professional Council

The most common receiver of this event summary is the GP or any provider that originally referred the subject of care to the allied health provider. Any other clinician or healthcare provider on the subject of care's care team could also be a recipient.

This event summary would also be received by a shared EHR system.

## How is this sent

The event summary can be sent by a dedicated, secure, eHealth message via the Internet or traditional communication methods including fax, post or secure email as plain text.

## Clinical content

The Allied Health Consultation summary is expected to contain clinical content from various data groups depending on the findings, assessments, interventions and planned services recorded during the consultation:

- Alert
- Adverse Reaction
- Legal
- Problem/Diagnosis
- Reason for Encounter
- Clinical Intervention
- Medication
- Clinical Synopsis
- Diagnostic Imaging
- Pathology Episode
- Observation
- Care Team
- Standardised Comprehensive Assessment Procedure
- Current Service
- Discharge
- Clinical Context
- Family Clinical History
- Functional Status
- Lifestyle - Drug of Concern
- Lifestyle - Alcohol Consumption
- Lifestyle - Nutrition
- Lifestyle - Physical Activity
- Lifestyle - Tobacco Smoking
- Management Plan
- Requested Service
- Social Circumstance

## Implementation

### Electronic Health Record

The Allied Health Consultation summary does not vary greatly in content compared with the Community Health Clinical Consultation summary or any other consultation summary in general. However, this event summary should be recorded within the shared EHR with an Allied Health care setting category, along with the more specific service type to distinguish it from other consultation summaries, and the different types of allied health services to enable listing, grouping and retrieval of different consultation event summaries.

### eHealth Messaging

The majority of the Allied Health Consultation summary can be represented using the AS4700.6 Referral and Discharge Summary standard based on the HL7 v2.3.1 REF message type even though it was not originally designed for this purpose. Several HealthConnect trials have successfully used the message for this purpose.

## 12 REFERRAL

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Referral is the communication between a party requesting a healthcare service and the targeted service provider with the intent for transferring the responsibility of the specified care, or seeking a clinical opinion, for a subject of care.

### When to use

A referral is intended to be sent directly from the party requesting healthcare services to another service provider being requested to provide the service. However, a copy of the referral could be directed to additional receivers where it is considered appropriate by the referring party or referred to provider. This may also include a shared EHR.

A referral should allow a service provider being requested to provide a service for subject of care to respond with an acceptance or rejection of the request.

### When NOT to use

A referral is not currently intended to be used for ordering diagnostic investigations.

The referral should not be used as a Hospital Discharge summary when there is no explicit transfer of care or service being requested of the intended recipient of the Referral.

A referral is unlikely to be sent to a shared EHR in its own right but a summary of the referral may be provided as part of the event summary of the consultation in which the referral was generated.

### Who sends this

A healthcare provider sends a referral by either a clinical information system using an eHealth standard message or a person using traditional communication methods.

### Who receives this

A healthcare provider will receive a referral either by a clinical information system capable of receiving standard eHealth message or a person using traditional communication methods.

The most common recipient of a referral is a medical specialist. However, any healthcare provider including GP's may be a recipient of a referral.

A referral would NOT be received by a shared EHR system.

### How is this sent

The event summary can be sent by a dedicated, secure, eHealth message via the Internet or traditional communication methods including fax, post or secure email as plain text.

### Clinical content

A Referral is expected to contain clinical content from various data groups depending on the findings, assessments, interventions and planned services recorded during the consultation:

- Alert
- Adverse Reaction
- Legal
- Problem/Diagnosis
- Current Service
- Discharge
- Clinical Context
- Family Clinical History

- Reason for Encounter
- Clinical Intervention
- Medication
- Clinical Synopsis
- Diagnostic Imaging
- Pathology Episode
- Observation
- Care Team
- Standardised Comprehensive Assessment Procedure
- Functional Status
- Lifestyle - Drug of Concern
- Lifestyle - Alcohol Consumption
- Lifestyle - Nutrition
- Lifestyle - Physical Activity
- Lifestyle - Tobacco Smoking
- Management Plan
- Requested Service
- Social Circumstance

## Implementation

### eHealth Messaging

The majority of the Referral can be represented using the AS4700.6 Referral and Discharge Summary standard based on the HL7 v2.3.1 REF message type.

The Referral is different to event summaries where it needs to support the ability of the Referred-to provider to respond to the request for providing care service for a subject of care. An acceptance or rejection of the referral can be indicated using the HL7 V2 Modify Referral message as described above or specific message designed for the purpose, as is the case in HL7 V3.

A HL7 V2.4 edition of the AS4700.6 standard will be released for public comment during 2005 and is expected to be published by the end of that year. This new edition will provide additional support for the Referral data groups, but will not be provide complete support.

A HL7 V3 message is being balloted as a NEHTA Specification within the HL7 organisation. It is expected that this Care Transfer message will provide sufficient support for the entire data group requirements of Referral.

## 13 EVENT NOTIFICATION

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To notify healthcare providers of critical health events or change of status regarding a planned or unplanned health service encounter by the subject of care.

### When to use

Event notifications are used to notify healthcare providers of significant health events beginning, ending or changing status. Event notifications are not intended to provide clinical content other than that which provides the context of the event being notified such as the subject of care's details and the healthcare providers and services involved.

The priority events currently identified to have associated notifications include:

- Hospital Admission - Inpatient;
- Hospital Discharge - Inpatient; and
- Hospital Discharge - Emergency Department.

These hospital event notifications are generated at the time the patient is admitted or discharged rather than at some point later when the clinical information has been compiled by a clinician.

### When NOT to use

The Event Notification should not be used as an event summary containing clinical information. Currently, event notifications are only used for Hospital events notifications.

Event Notifications are also only intended to be used for provider notifications and not to be used to notify registries such as Notifiable Diseases and Bio-Terrorism.

### Who sends this

A hospital administration officer sends an event notification by either a Patient Administration System (PAS) using an eHealth standard message or Fax, or a person using traditional communication methods.

A shared EHR may generate event notifications when it receives a triggering event notification, such as a Hospital Admission, or event summary such as a Hospital Discharge.

### Who receives this

A healthcare provider will receive this event summary either by a clinical information system capable of receiving standard eHealth message or a person using traditional communication methods.

The most common receiver of this event summary is the GP or provider that originally referred the patient to the Hospital for planned visits. Any other clinician or healthcare provider on the subject of care's care team could also be a recipient.

The Hospital Admission event notification could also be received by a shared electronic health record system, which in turn may route the event notification to interested members of the patient's care team.

### How is this sent

The event summary can be sent by a dedicated, secure, eHealth message via the Internet or traditional communication methods including fax, post or secure email as plain text.

## Clinical content

The Event Notification is unlike event summaries where they are not intended to contain clinical information. However, enough information is required to provide context of the event notification, which may include the following data groups:

- Reason for Encounter;
- Discharge; and
- Clinical Context.

## Implementation

Event notifications may simply be implemented using a plain text secure email when being sent to a provider. Most current Hospital Event Notification implementations are communicated using facsimile. However, to allow a shared EHR to receive and route event notifications, structured eHealth messaging will be required.

### eHealth Messaging

The hospital event notifications can be represented using the AS4700.1 Patient Administration standard based on the HL7 v2.3.1 ADT message type.

A HL7 V2.4 edition of the AS4700.1 standard will be published during 2005. However, this new edition will not provide any additional support for Hospital Event Notifications, nor do they require further support.

A HL7 V3 message is available as a NEHTA Specification. Again, this message does not provide any additional support compared with the HL7 v2.3.1 message provided in AS4700.1.