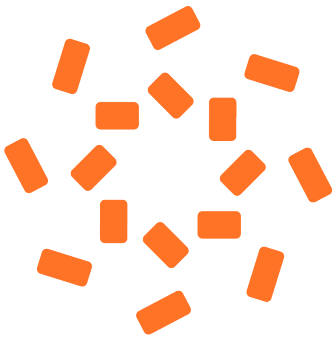

Sparked

Australian Clinical Data for Interoperability Release 2

Patient Summary Component

Version – June 2025

Feedback from Community Comment Period

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Document Control

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1. Document Information

1.1. Document Information

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Community Acknowledgement

We thank all community members – the Sparked Clinical and Technical Design Groups, the Clinical Leads and our founding members who contributed their time, expertise, passion, resources and energy to deliver the Australian Clinical Data for Interoperability.

We look forward to the community continuing to grow and working with you all to share resources and specifications to enable the meaningful use, exchange, and reuse of clinical information.

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2. Introduction

2.1. Purpose of document

The purpose of this document is to outline the feedback received during the Australian Clinical Data for Interoperability (AUCDI) Release 2 Patient Summary Component Community Comment period and provide reflections, comments and summary of actions.

2.2. Intended audience of the document

The intended audience of this document is stakeholders interested in improving health data interoperability in Australia. This includes consumers, clinical and technical subject matter experts, healthcare organisations, peak bodies, technology and software industry partner organisations, jurisdictions, and government organisations.

2.3. How to read the document

This document is broken into three key sections:

- Section 3: high-level summary of the feedback received, and action taken
- Section 4: high-level summary of the changes to the AUCDI R2 PS document made following the community feedback period
- Sections 5-10: detailed feedback as received throughout the community comment period, with responses.

In addition to specific feedback, reviewers were also asked to provide an overall recommendation for each data group. The votes for each of the options were tallied for each data and included in this document. The options provided to reviewers were:

- Accept: if you have no suggestion for further improvement and consider the data group ready for publication without further review or if the suggested changes are trivial (e.g., spelling)
- Minor revision: if you consider that there are only small changes required to make the data group ready for publication
- Major revision: if you consider the data group needs large or significant modifications such as addition/removal of data elements
- Reject: if you consider the data group is not suitable for publication – for example that it is “unfit for purpose” or fundamentally flawed
- Abstain: if you feel you need to deliberately refrain from participating in the recommendation process.

3. Overall Feedback Themes and Actions

The following are the high-level feedback themes and actions taken as part of the AUCDI Release 2 Patient Summary Component community comment review.

A detailed summary of changes is available on the Sparked website, outlining the changes made to AUCDI Release 2 from AUCDI Release 1 and the feedback from the AUCDI Release 2 component releases.

Section	Feedback Theme	Action
Overall document	Information gap on implementation/AUCDI boundary and reporting	Updated document for clarity
	Need for additional data groups and data elements	Added identified data elements to backlog
	Questions around datatypes	Added identified data elements to backlog
	Design feedback	Updated document and website for clarity
Adverse Reaction Risk Summary	Questions and clarifications around data elements & structure of data group	Added identified data elements to backlog
	Questions and clarifications around data format: date	Added identified data elements to backlog
Problem/Diagnosis Summary	Questions around data elements	Updated document for clarity
	Need for additional data elements	Added identified data elements to backlog
Procedure completed event	No feedback received	
Vaccination administered event	No feedback received	
Medication use statement	No feedback received	
Sex and gender summary	No feedback received	
Last Menstrual Period (LMP)	Questions around data elements	Added identified data elements to backlog
Estimated Date of Delivery (EDD)	Questions around data elements	Added identified data elements to backlog
Pregnancy Assertion	Questions around data elements	Added identified data elements to backlog

4. AUCDI R2 Patient Summary Data Group: Adverse Reaction Risk

4.1. Overall recommendations

Accept	Minor	Major	Reject	Abstain	No Vote
9	5	2	0	13	2

4.2. Date/Time of onset of first reaction

Responder	Community Comment Feedback	Sparked Reflection/Action Taken
AUCDIR2002	If this field is meant to represent the onset of the allergy/intolerance as a whole, or when the allergy/intolerance was first identified, then the "of first reaction" wording is confusing. It is possible to identify an allergy/intolerance without there being any reaction, i.e. through blood tests, genomic testing etc. In FHIR and in other clinical systems, allergies and intolerances have specific reaction/manifestations with their own dates and severities. So this field may be better off being renamed and re-described if it is to relate to the allergy/intolerance as a whole.	Comment noted, no change. There are several clinically relevant dates relevant to understanding the onset of a reaction that need to be discussed further with clinical experts. Each date provides unique and valuable information and should not be merged into a single 'Onset' data element, as currently structured in the FHIR resource. By discussing these distinctions with clinical experts will ensure a more nuanced and effective use of the data in clinical settings. For example: • 'Date/time of onset of first reaction', • 'Date/time of onset of last/most recent reaction', and • 'Date time of onset of the most severe reaction'. Additionally, the introduction of a new data element, 'Date/time of clinical confirmation', should be considered. This date supports documenting a propensity identified without a physical reaction but also serves as a universal marker, applicable regardless of whether a propensity is detected through a reaction or testing. This date may

		align with the date of the first reaction or could be the primary date recorded if the propensity is identified solely through testing. It is important to clarify that conflating the 'Date/time of clinical confirmation', obtained through testing, with the unspecified 'Onset' of a propensity is clinically inappropriate. Theoretically the onset of a risk for an adverse reaction universally occurs at conception, which is not at all clinically useful. Therefore, onset dates should be specifically tailored to capture precise, clearly defined data for designated purposes.
AUCDIR003	It is recommended that DDMMYYYY format is utilised for dates wherever possible. DDMMYYYY is the date format commonly used within AIHW's online metadata registry METEOR (https://meteor.aihw.gov.au). It is also recommended that a standardised approach to capturing partial dates is defined that clearly distinguishes partial dates. A suggested approach is use of the numeric value 9 where all or part of the date is unknown e.g. for a date format DDMMYYYY, the value '99052014' indicates that the date was May 2014 with an unknown day. This approach is defined in METEOR for other date/time data e.g. https://meteor.aihw.gov.au/content/428853.	Comment noted, no change. The technical date representation is out of scope for AUCDI, and it would be expected be included in technical standards such as a FHIR IG. Rendering of dateTime is an implementation decision and is also out of scope for AUCDI.
AUCDIR2005	May be too difficult to obtain. It may also be imprecise (eg system generated vrs reported information)	Comment noted, no change 'Date/time of onset of first reaction' is an optional element to allow a clinician to record this if they have it. It is acknowledged that date/times collected may be imprecise however can still serve as an alert.
AUCDIR2006	The proposed data elements are logical and allow for clinical judgement and flexibility in the case of a vague history.	Comment noted, no change. Thank you for your feedback.

	Optometrists could clearly record clinical information about an initial reaction to topical ocular or systemic medicines within these parameters.	
AUCDIR2007	We feel that while the data type timing (DateTime, Interval of Date/Time, Interval of duration) is useful for a human interpreter, allowing multiple types of inputs for this field would make it very hard to use in any automated or population health contexts. We suggest this data type is restricted to a date or date/time field. Our reasons are that: 1. If a date was collected, age of onset could be inferred from a patient's recorded (or estimated) date of birth, reducing the need for the interval data type 2. The comment field would allow for clinical notation about certainty of the date.	Comment noted, no change. Timing is a FHIR data type that allows multiple ways to record a date or less specific dates. It is a technical specification, not purely intended for human interpretation It is true that if a date was collected, age of onset could be inferred, but it also allows precise collection of what the patient says eg "I was 37" requires the clinician to interpret the date as the default 1st of January to record 1/1/1990. The certainty should be recorded implicitly as part of the clinical documentation, not merely as a comment. There are instances where a reaction event is imprecisely recalled by an individual, for example "in the 90s" or "while I lived in Scotland, somewhere between 1975-1980" and so the interval data type would be useful.
AUCDIR2017	We understand that given it says 'Optional' in Occurrence this is not mandatory to complete is that correct? There is a concern that if mandatory this would be difficult in some situations e.g., in relation to a food reaction some clients wouldn't be able to state exactly when this occurred and the clinician may not have the confidence in the clients report to stipulate a date. Time from exposure to onset of reaction will be preferential to record in some instances but it appears this is allowed for is that correct?	Comment noted, no change. Yes, this is not mandatory in AUCDI. Onset of initial exposure, duration of exposure, onset of reaction and duration of reaction are on the backlog for Adverse reaction risk.
AUCDIR2028	This should be replaced with: • "Date/time of onset of last reaction"	Comment noted, added to backlog. Thank you for your feedback. Date/time of last reaction is an important data element and is included in the data group roadmap along with most severe reaction. These have been added to the

	• "Date/time of onset of most severe reaction" (if not the last reaction) This provides the most reliable allergy status of the patient, and can also inform risk stratification for challenge testing (i.e. whether the last reaction was 20 years ago or 1 year ago, and it's severity). Consider the ability to record multiple occurrences where clinically relevant, as well as duration of onset. The above are important aspects of the allergy history There is however a conceptual issue which is relevant here. The title "adverse reaction risk summary" clearly indicates that this is an alert, not an allergy history. The substance should be that which constitutes a risk for the patient (for example, allergy alert= penicillins, where the allergy history is a reaction to amoxicillin) and the manifestation should be that which is likely to occur on re-exposure, not that which occurred in the history (for example, if the history is acute urticaria and the skin tests are positive, the risk is anaphylaxis). Another example- a child with a family history of atopy has a 15mm wheal to peanut but has had no exposure, there is no reaction history (and there is no date/time of reaction because there hasn't been a reaction) but clearly the substance= peanut and the manifestation= anaphylaxis. Further- a patient has a history of anaphylaxis to cashew, the substance (alert) should be cashew and pistachio unless proven otherwise. The alert is a clinically determined extrapolation of the history to predict future risk, as the title suggests.	backlog. The CDG have focused on the minimum data necessary to support patient care, therefore, at this point, any reaction, is significant. We agree that these qualifiers are necessary for more focused review of the propensity of an individual's reaction risk, however in the context of Patient Summary and shared care - the first reaction was prioritised at this point. Within the data group context, this data relates to the clinical assessment that identifies the potential of a harmful or undesirable physiological reaction unique to an individual. It captures the substance and manifestation, and these data elements can be rendered in a clinical system for a history/or substance list, at the time of implementation. The data group does allow recording of multiple occurrences of manifestations as required. An Adverse reaction risk contains the data that can be used as a passive display of an alert on a screen; however, it can also be used to drive clinical decision support, reporting, cohort identification, and a summary for exchange with other systems. Additional information that is required to be recorded around a full history need to be explored and added to the backlog as requirements.

4.3. Severity of Reaction

Responder	Community Comment Feedback	Sparked Reflection/Action Taken
AUCDIR2006	The proposed data elements are logical and easily communicated. The SNOMED- CT categories of mild, moderate severity and severe are clinically universal. Optometrists could clearly record required information regarding adverse reactions to topical ocular medications or systemic medicines within these parameters.	Comment noted, no change. Thank you for the feedback
AUCDIR2014	The user should be able to select ‘unknown’ as a separate option.	Comment noted, no change A clinical determination of 'unknown' is not helpful in the context of a qualifier and would not be used to drive decision support etc. The absence of a qualifier, such as severity, and the determination of how the user interface presents and stores this information is a technical implementation issue and is therefore out of scope for AUCDI.
AUCDIR2018	The Allied Health sector are seeking clarity regarding how mild, moderate and severe will be utilised across varying reactions. For example, is severe only for life threatening situations and does the same categorisation apply across reactions impacting whole of life versus a specific body part such as the eye? In eye care a reaction would be considered severe if a consumer can't see out of their eye but it is not as severe as an anaphylactic reaction. Various professional disciplines already have their own systems for rating in this way in use, will these be accommodated or will everyone need to use the same system?	Comment noted, no change. In clinical practice, severity is assessed based on the impact of the identified manifestation/s, such as distinguishing the relative impact of a mild, moderate, or severe rash. The term 'severity' serves only as a qualifier for the manifestation/s and is not meant to compare impact or suggest equivalency between different manifestations, such as between a severe rash and a severe asthma attack.

4.4. General feedback for Adverse Reaction Risk

Responder	Community Comment Feedback	Sparked Reflection/Action Taken
AUCDIR2005	We are currently in discussion with ADHA regarding descoping medication allergies in MHR. Outcomes of that discussion may need to be carried over into this work. Adverse reactions and/or allergies need to be provided in context, then need to be specifically unattached to any other messaging. They can be sent with other documentation for example, but not attached or embedded. This has ramifications for the updating process. Adverse and/or allergy information needs to be updated on a regular basis and NOT stagnant where it cannot be updated. People make mistakes and retract/update information regularly.	Comment noted, no change.
AUCDIR2006	The existing (from AUCDIR1) Comment section allows for further flexibility and commentary as needed. For optometrists, this may be required in order to describe the type of adverse reaction that does not fall within the clinical metadata of the Clinical manifestation reference set eg, “stinging/ burning”, or “angle closure”. Optometry Australia agrees with the proposed roadmap and does not need to raise any further inclusions to be expediated. We look forward to contributing crucial information for the Adverse reaction risk summary' data group as it is expanded in future updates, especially with regards to data relevant to ocular adverse reactions.	Comment noted, no change. 2070002 |Burning sensation in eye| and 251726002 |Angle closure| are members of the Clinical Finding reference set use in the Manifestation data element. Additional SNOMED CT terms can be requested for inclusion from the National Clinical Terminology Service (NCTS) via the Australian Digital Health Agency.

AUCDIR2012	Software developers have highlighted that the inability to record the 'certainty' of an adverse reaction in structured data in Agency specifications is an issue and poses a potential clinical safety risk. As a result some of them allow healthcare providers to record the substance and the certainty is recorded in the narrative and not in the structured data. As a result the adverse reaction information in a medicines view is potentially incomplete as it does not include the certainty. We suggest that 'certainty' should be included in Australian Core Data for Interoperability Release 2 Patient Summary Component to address these concerns.	Comment noted, no change. Agree. 'Verification status' and 'Criticality' of the propensity of the reaction, and 'Certainty' of the event are in the Adverse Reaction Risk roadmap. These data elements are candidates for expansion in future iterations.
AUCDIR2014	The data group should include adverse drug reactions from non-prescription medicines.	Comment noted, no change. Agree. This data group can be used (but not limited to) any therapeutic substance administered correctly at an appropriate dosage for the individual.
AUCDIR2018	The name substance type doesn't sound inclusive enough of all the aspects allied health will need to include For example people may react to dry needling or manual therapy, pet therapy, materials in a prosthesis but these are not substances and not ingested. It was suggested that perhaps an alternative more holistic name would be Adverse Reaction Agent which is reportedly already included in the NCTS. Other naming convention options for consideration that are more inclusive of therapies and emotional and psychosocial reactions could be adverse events, contraindications. Will substances such as shampoo, dust and washing powder be included here as these are the types of things that often cause reactions in the eye?	Comment noted, no change. The focus of the data group is about the substance (or 'agent' such as insect venom) that will potentially cause harm to the patient if exposure or re-exposure occurs in the future. This data group will be used as a single source of truth for connection to decision support, particularly adverse reaction checking for medications and diet systems. The potentially harmful Substance is the index data element for this reason. Apart from 'Adverse reaction risk' there are a range of other data groups that will cover all types of therapeutic precautions. Future proposals include: • Precautions: "A condition or state of the individual that is clinically significant and unique or idiosyncratic for this individual, and is considered vital information when making

	Does the design of this data group allow for more than one reaction to the same substance? Allied health can provide case studies where this occurs and will be necessary to enter. Perhaps this fits in an alternative data element still to be developed, however, the current information and the roadmap do not appear to include provision for information related to a management plan in response to the reaction. The allied health sector are in agreement that the ability to identify whether a management plan like an EpiPen and/or other has been implemented or still needs to be addressed is a critical piece of information to be prioritised for inclusion to keep consumers safe. Knowing this information will ensure allied health professionals know how to support the consumer if they are having a reaction during their care and also to know whether a management plan is something which still needs to be addressed and where scope allows they can address this need and/or refer to the appropriate professionals as required.	treatment decisions." The index data element is 'Condition'. Examples include 'immunosuppression, renal failure, using anticoagulants. • Contraindications: "A clinical intervention (including, but not limited to, use of a treatment or performance of a test or procedure) that should not be carried out due to the likelihood, or possibility, of harm being caused to an individual". This is where dry needling or cold therapy might fit. This is a bucket of 'Beware that the patient may react if you do this to them' with the index data element being'. Examples: MRI in someone with an implant.
AUCDIR2028	Patient must avoid statement – THIS IS THE ALERT and should be the primary statement Need additional element: "Possible/probable/definite/confirmed", which can help inform clinical decision making, particularly around urgent administration of essential drugs of which the patient may or may not be allergic. Future considerations: • Do not use the terms "active/inactive" status, or "refuted", as they do not mean anything in the allergy space, and may cause confusion.	Wording updated to reflect comment, comment noted. An Adverse reaction risk contains the data that can be used as a passive display of an alert on a screen, however, it can also be used to drive clinical decision support, reporting, cohort identification, and a summary for exchange with other systems. Future clinical decision-making will be based on many potential factors - previous manifestations (AUCDI R1) and severity (AUCDI R2), criticality (AUCDI Backlog), level of certainty (AUCDI backlog). 'Verification status' and 'Active/inactive' status is currently on the AUCDI backlog for future discussion and consideration.

	• Consider the following data elements for future releases:
	  ○ Practitioner role (allergy specialist, nurse practitioner etc.) that completed the assessment
	  ○ Name of healthcare professional that completed the assessment
	  ○ If confirmed, method of diagnosis:
	• Skin prick test
	• Clinical evaluation/history
	• Supervised challenge
	• Serum sIgE
	• Evaluation results
	• Adrenaline autoinjector prescribed (yes/no)
	
	Additional comments:
	
	Under 'Considerations for use' (page 26) and 'Considerations' (Page 30) should this be 'Venom from insect stings and bites'
	
	For discussion:
	
	• Terms “active/inactive” status, or “refuted”- suggest avoiding these terms, however we need to consider penicillin delabeling - is it possible to have the previous entry archived but does not appear in the current adverse reaction risk? This could be relevant also for kids who grew out of their food allergy.
	• Do we need “Reaction type” – where we specify whether the reaction is an allergy, side effect, intolerance, toxicity or idiosyncrasy?
	  ○ ensures that only necessary alerts are fired, however these distinctions can often
		Data elements/data groups supporting a comprehensive allergy assessment are not in scope for the Adverse reaction risk summary - detailed recording of allergy reaction information and the associated workflows may require a range of data groups including problem/diagnosis, test results, history information, examination findings, personnel involved, interventions etc. The Adverse reaction risk summary is used to record the conclusion of the clinical assessment of the range of data to indicate the propensity or risk of a future reaction.
		
		The implementation of the data groups (and how it is presented to users) would be dependent on the clinical (or non-clinical) settings. Guidelines for standardised use, workflow and display of allergy information could be developed by interested stakeholders. The data groups defined by AUCDI can be used to inform those guidelines.
		
		Document has been updated with 'Venom from insect bites and stings' as suggested in both places.
		
		Delabelling is an interesting concept which would combine data requirements and implementation requirements. The implementation requirements are out of scope for AUCDI. Active/inactive status is in the roadmap for future discussion when prioritised.
		
		Reaction type would be captured in the Reaction mechanism data element which is in the road map for future considerations.

	be difficult for non-experts, reaction nature and severity may be more important (as we argued in Shakib S, Caughey GE, Fok JS, Smith WB. Adverse drug reaction classification by health professionals: appropriate discrimination between allergy and intolerance? Clin Transl Allergy (2019) 9:18)	
AUCDIR2030	• Page 31 – there is the addition of new data element 'Date/time of onset of first reaction'. The Considerations listed in the table for this data element state 'The onset may be represented by an actual date and/or time of onset; an imprecise period during which the onset occurred; the age of the individual at the time of the onset, or a textual description'. ○ As age or a textual description can also be included, suggest that the title of the data element be updated to better reflect the information that can be captured for this data element e.g. 'Onset of first reaction'. • More to seek clarity (in case we have missed in reviewing) but in adverse reaction, are chemical reactions included? This is referring to reactions to latex, or to dressings or dyes which are seen and can be quite significant. It seems to be in consideration but not in the initial list?	Wording updated to reflect comment. Data element has been updated to 'Timing of onset of first reaction' Yes, this data group can be used for reactions to latex, dressings and dyes.
AUCDIR2031	Onset of first reaction - assume reported events are included; these are sometimes patient histories? Specific or approximate timing when symptoms or signs of the problem or diagnosis were first observed. -> suggest adding	Wording updated to reflect comment. Agree, this data element includes both reported and observed events, and the wording in the description does not limit this to one or the other.

	or reported to be present * Severity of reaction: suggest clarifying Clinical evaluation of the overall severity of the reaction event, taking into account all manifestations. ->severity *of a* reaction event, taking into account all *associated* manifestations	Severity of reaction - thank you, this has been updated.

5. AUCDI R2 Patient Summary Data Group: Problem/Diagnosis Summary

5.1. Overall recommendations

Accept	Minor	Major	Reject	Abstain	No Vote
11	3	3	0	12	2

5.2. Date/Time of onset

Responder	Community Comment Feedback	Sparked Reflection/Action Taken
AUCDIR2003	It is recommended that DDMMYYYY format is utilised for dates wherever possible. DDMMYYYY is the date format commonly used within AIHW's online metadata registry METEOR (https://meteor.aihw.gov.au). It is also recommended that a standardised approach to capturing partial dates is defined that clearly distinguishes partial dates. A suggested approach is use of the numeric value 9 where all or part of the date is unknown e.g. for a date format DDMMYYYY, the value '99052014' indicates that the date was May 2014 with an unknown day. This approach is defined in METEOR for other date/time data e.g. https://meteor.aihw.gov.au/content/428853.	Comment noted, no change. The technical date representation is out of scope for AUCDI, and it would be expected be included in technical standards such as a FHIR IG. Rendering of dateTime is an implementation decision and is also out of scope for AUCDI.
AUCDIR2004	This is quite valuable in particular for monitoring and QI	Comment noted, no change. Thank you for your feedback
AUCDIR2006	The proposed data elements are logical and the considerations make clinical sense, recognising that some conditions have a very specific time of onset and others have a vague or insidious onset. Flexibility in the data format for recording date/ time of onset is appropriate in	Comment noted, no change. Thank you for your feedback

	order to encompass a wide variety of conditions and circumstances in which the exact onset is unclear. Optometrists could clearly record clinical information about the onset of an ocular or vision problem within these parameters.	
AUCDIR2007	Similar to 8.1.3, we feel that while the data type timing (DateTime, Interval of Date/Time, Interval of duration) is useful for a human interpreter, allowing multiple types of inputs for this field would make it very hard to use in any automated or population health contexts. We suggest this data type is restricted to a date or date/time field. Our reasons are that: 1. Collecting both the onset and resolution in reduces the need for an interval / duration data type. 2. Exact or estimated dates of problem / diagnosis onset and resolution would be highly beneficial for automated healthcare systems and population health analytics to infer problem / diagnosis duration, which would not be easily available with a Timing data type. 3. Comment fields would allow for clinical notation about certainty of the date entered if needed. 4. If a date was collected, age of onset could be inferred from a patient's recorded (or estimated) date of birth, reducing the need for the interval data type	Comment noted, no change. Timing is a FHIR data type that allows multiple ways to record a date or less specific dates. It is a technical specification, not purely intended for human interpretation. It is true that if a date was collected, age of onset could be inferred, but it also allows precise collection of what the patient says; for example, "I was 37" requires the clinician to interpret the date as the default 1st of January to record 1/1/1990. The certainty should be recorded implicitly as part of the clinical documentation, not merely as a comment. There are instances where a time of onset is imprecisely recalled by an individual, for example "in the 90s" or "while I lived in Scotland, somewhere between 1975-1980" and so the interval data type would be useful. Date of resolution is a potentially a separate data element which is unrelated to the previous interval data type.
AUCDIR2014	There needs to be differentiation between procedure that has a definitive date, diagnosis, and symptoms, and a procedure without those elements.	The AUCDI defines Problems/Diagnosis, and Procedures as separate data groups, though in implementation these may be presented to the user as a single list. Implementation requirements are outside the scope of AUCDI.

		Traditionally, differentiating between problems and diagnoses has been difficult because they often exist on a continuum, both conceptually and in practice. As clinical evidence accumulates, what begins as a 'problem' may develop into a definitive 'diagnosis.' Adopting a unified data group for both facilitates the collection of clinical evidence and recognises the dynamic and interconnected nature of their relationship. Both problems or diagnoses can be recorded using this same data model without distinguishing and labelling them as one or the other. The recording pattern is closely aligned, and what may initially be considered a 'soft' problem may evolve towards a formal diagnosis as more clinical evidence is discovered.
AUCDIR2028	For discussion: • include date/time of most recent and/or severe reaction?	Comment noted, added to backlog While a diagnosis of an allergy could be recorded in a Problem/Diagnosis data group, current system workflows require allergies and intolerances to be recorded in a separate data group to drive alerts and clinical decision support. The Adverse Reaction Risk data group would be used in this instance and date of onset of last reaction and date of most severe reaction could be included here, and have been added to the backlog for future discussion. This does not preclude the finding of an allergy being added to problem list using the Problem/Diagnosis data group, however it would not be the primary place of recording non-allergic adverse reaction information.

5.3. Date/Time of Resolution

Responder	Community Comment Feedback	Sparked Reflection/Action Taken
AUCDIR2003	It is recommended that DDMMYYYY format is utilised for dates wherever possible. DDMMYYYY is the date format commonly used within AIHW's online metadata registry METEOR (https://meteor.aihw.gov.au). It is also recommended that a standardised approach to capturing partial dates is defined that clearly distinguishes partial dates. A suggested approach is use of the numeric value 9 where all or part of the date is unknown e.g. for a date format DDMMYYYY, the value '99052014' indicates that the date was May 2014 with an unknown day. This approach is defined in METEOR for other date/time data e.g. https://meteor.aihw.gov.au/content/428853.	Comment noted, no change The technical date representation is out of scope for AUCDI, and it would be expected be included in technical standards such as a FHIR IG. Rendering of dateTime is an implementation decision and is also out of scope for AUCDI.
AUCDIR2004	This is quite valuable in particular for monitoring and QI	Comment noted, no change. Thank you for your feedback
AUCDIR2006	The data elements proposed make clinical and logical sense. Allowances are created in the data set for specific or approximate timing, variations in what can be considered resolution of a diagnosis, recurrence or reactivation, and imprecise period. All of these are important within the context of optometry. Optometrists could clearly record the resolution of an ocular condition where appropriate within these parameters.	Comment noted, no change. Thank you for your feedback
AUCDIR2007	The same comment as Data element: Date/time of onset, we suggest this data type is restricted to a date or date/time field.	Comment noted, no change. Timing is a FHIR data type that allows multiple ways to record a date or less specific dates. It is a technical specification, not purely intended for human interpretation

		It is true that if a date was collected, age of onset could be inferred, but it also allows precise collection of what the patient says eg "I was 37" requires the clinician to interpret the date as the default 1st of January to record 1/1/1990. The certainty should be recorded implicitly as part of the clinical documentation, not merely as a comment. There are instances where a time of onset is imprecisely recalled by an individual, for example "in the 90s" or "while I lived in Scotland, somewhere between 1975-1980" and so the interval data type would be useful. Date of resolution is a potentially a separate data element which is unrelated to the previous interval data type.
AUCDIR2018	This works provided remains mandatory to complete	Comment noted, no change.

5.4. General feedback for Problem/Diagnosis Summary

Responder	Community Comment Feedback	Sparked Reflection/Action Taken
AUCDIR2005	• We note the terms problem and diagnosis are used interchangeably in the documentation. • We suggest defining diagnosis type (eg discharge diagnosis) as we note that there won't be any distinguishing or further labelling. • We note representation is one instance per problem or diagnosis. Clinicians may prefer to see the diagnosis in context to an episode of care. In Victoria, one inpatient episode can capture up to 42 diagnoses. • Depending on the coding system, morphology codes and external cause codes may also be included.	• Comment noted, no change. A unified Problem/Diagnosis data group was intentionally developed as traditionally, differentiating between problems and diagnoses has been difficult because they often exist on a continuum, both conceptually and in practice. As clinical evidence accumulates, what begins as a 'problem' may develop into a definitive 'diagnosis.' Adopting a unified data group for both facilitates the collection of clinical evidence and recognises the dynamic and interconnected nature of their relationship. • Comment noted, added to backlog. Diagnosis type has been added to the backlog • Comment noted, no change.

	• We note information about a pregnancy will be excluded. This may be difficult to achieve. • The list may need to be refined over time to be useful for preventative health and chronic disease management, as it may become voluminous and duplicative. • Suggest ICD-10-AM may be a useful reference set in addition to SNOMED.	• Agree, where a patient has 42 diagnoses, there will be 42 instances of this data group. How it is implemented and represented back to the clinician is out of scope of AUCDI. • Comment noted, added to backlog. External cause of injury and Morphology have been added to the backlog • Noted. It would be expected that problem/diagnosis information related to a pregnancy is acceptable for this data group, however information that would be found in a pregnancy summary (e.g. LMP, EDD, type of care, fundal height) would be modelled separately. • Comment noted, no change. Curation of problem/diagnosis information is an important workflow step but out of scope of AUCDI. • Comment noted, no change. SNOMED CT-AU Is the preferred national terminology for clinical care and a mapping to ICD-10AM may be required for reporting requirements, funding and classification purposes in acute care. This is out of scope for AUCDI.
AUCDIR2006	The problem/ diagnosis summary data group are clear and well designed. Optometry Australia notes that the Problem/Diagnosis name' value set can be extended to include problems identified from an allied health perspective and we welcome such extensions. We look forward to offering invaluable contribution to further describing data regarding problem/ diagnosis as they relate to ocular health. Clinical description and course description will be important data elements for ocular health, as many eye conditions have varying presentations and require free text description to clearly communicate clinical signs and progression.	Comment noted, added to backlog. 'Clinical description' and 'Course description' have been added to the backlog.

	Optometry Australia accepts the Problem/ diagnosis data group but we advocate for expediency in involving further allied health input in this field. Therefore, while we accept the data elements that have been amended in AUCDI Release 2, we recommend a minor revision to the roadmap timeline.	
AUCDIR2014	The data group should include pending results, further clinical management, and where to access results. Further, changes to the medical summary should be time/date/personnel stamped: that is, when there is a change, the name of the person who amends the record and when it occurred should be included. This is currently recorded in the case note on the day it occurred, but in future when the summary data includes social and family history, this becomes critical (eg, when the user makes an entry which states the patient has two children aged 2 years and 4 years, this will be inaccurate in 12 months).	Comment noted, no change. Information around pending results and access to results are wider system implementation issues and are out of scope of AUCDI. System information includes the time/date/personnel of any data entry - these technical attributes are outside the scope of this data group and would sit in the FHIR IG.
AUCDIR2018	Can the impact of the problem / diagnosis be included in the comment section? E.g., a cataract is impacing someone's ability to drive? It is considered this is important to note as helps with triaging and understanding the impact of a situation on someone's every day life. As a sector allied health consider there are two elements within the roadmap which require prioritisation: • Cause - already being routinely recorded and shared and important for reducing repetition of investigating this aspect and being able to use clinical time more optimally if this is known prior to a client's attendance.	Comment noted, added to backlog. 1. Yes, Impact can be included in the comment section, however a data element for Impact has been added to the backlog. 2. Noted. Cause and Severity have been added to the backlog.

	• Severity - the ability to include something like a pain scale here helps to compare quickly from one time to another.	
AUCDIR2023	Seeking clarity about the Misuse chapter for Problem/Diagnosis. It suggests it can't be used for pregnancy summary, does that mean it can't be used to capture the condition of being pregnant? This would be confusing because a finding of pregnancy Is a valid finding in the bound value set "Clinical Condition". there are also various pregnancy disorders in that value set that could be selected based on the preferred Value Set. I would think for the purpose of future clinical decision support models, if a person presents with symptoms and the explanatory finding is pregnancy, it would be good to store that finding in the same place as the other possible findings.	Comment noted, no change. It would be expected that problem/diagnosis information related to a pregnancy is acceptable (e.g. the finding of being pregnant, the diagnosis of gestational diabetes) for this data group, however information that would be found in a pregnancy summary (e.g. LMP, EDD, type of care, fundal height) would be modelled separately.
AUCDIR2028	For discussion: • Add additional element: "Outcome" – it is critical to know the outcome of diagnostic procedures e.g. challenge test results that determine whether a person is or not allergic to a substance. • could this fall under the status element eg allergic (positive challenge) or non-allergic (negative challenge) vs current active/non active?	Comment noted, no change. The Outcome of a diagnostic test would be recorded in a Test result data group which is on the backlog for future discussion.

6. AUCDI R2 patient Summary Data Group: Last Menstrual Period

6.1. Overall recommendations

Accept	Minor	Major	Reject	Abstain	No Vote
12	1	1	0	15	2

6.2. Date/Time of onset

Responder	Community Comment Feedback	Sparked Reflection/Action Taken
AUCDIR2003	It is recommended that DDMMYYYY format is utilised for dates wherever possible. DDMMYYYY is the date format commonly used within AIHW's online metadata registry METEOR (https://meteor.aihw.gov.au). Are partial dates permitted e.g. if the patient only recalls the month but not the day? It would be good for this to be documented under 'Considerations' in the same way as other data elements. If partial dates are permitted, it is also recommended that a standardised approach to capturing partial dates is defined that clearly distinguishes partial dates. A suggested approach is use of the numeric value 9 where all or part of the date is unknown e.g. for a date format DDMMYYYY, the value '99052014' indicates that the date was May 2014 with an unknown day. This approach is defined in METEOR for other date/time data e.g. https://meteor.aihw.gov.au/content/428853.	Wording updated to reflect comment. Noted. The technical date representation is out of scope for AUCDI, and it would be expected be included in technical standards such as a FHIR IG. Rendering of dateTime is an implementation decision and is also out of scope for AUCDI. Noted. Partial dates are permitted for this data element. Document has been updated.
AUCDIR2012	Confirmation requested that this will not be contained within Male Patient Summaries	Comment noted, no change.

		Constraints of populations is an implementation issue and is out of scope for AUCDI.
AUCDIR2014	It is unclear that this can only be used after a positive pregnancy test, and the data group should also include the date and type of pregnancy test. 'Unknown' needs to be included as an option, if not available.	Comment noted, no change. A positive pregnancy test and related details will be recorded in a 'Pregnancy test result' data group, currently on the AUCDI backlog.

6.3. Certainty

Responder	Community Comment Feedback	Sparked Reflection/Action Taken
No comments or feedback received.		

6.4. Last Updated

Responder	Community Comment Feedback	Sparked Reflection/Action Taken
No comments or feedback received.		

6.5. General Feedback for Last Menstrual Period

Responder	Community Comment Feedback	Sparked Reflection/Action Taken
AUCDIR2003	How would clinicians know when this information is out of date and no longer an appropriate clinical reference e.g. when a patient is not pregnant and has had a more recent menstrual period that hasn't been recorded, or when a patient is pregnant but the recorded last menstrual period is from a previous pregnancy? The data will in fact be 'Last	Comment noted, no change. Clinicians face challenges in ensuring that clinical data is both accurate and current. In AUCDI, relevant dates such as 'Last updated' are included to enable them to be prominently displayed on the user interface. This visibility supports clinicians by indicating the currency of the data and cues them to inquire about more recent information

	menstrual period recorded' rather than 'Last menstrual period'. It is recommended that the data element is renamed to more accurately reflect what is being captured. It is noted that there is a 'Last updated' data element but the clinician may not refer to this. The data may suggest that there has been a long period of time without a menstrual period when this is not the case.	if necessary. Business logic in clinical systems can support this, for example removing a LMP assertion after the relevant pregnancy is recorded as having been completed. LMP is not expected to be a data element that is constantly recorded, only at clinically relevant times when it informs clinical decision-making and only accurate at the time of recording. It could become outdated only hours after recording if the woman experiences the onset of a new menstrual period. The naming of the data element as "Date last updated" over "Date recorded" is strategically designed to be more intuitive for users, emphasizing not just the existence of recorded data but its relevance and currency. While both terms could be considered synonyms in the sense that they refer to the recording of data, "Date last updated" specifically conveys that the information displayed is the most recent and updated version of the data. This distinction is particularly important in dynamic environments like healthcare, where patient data can frequently change and the most current information is crucial for making accurate clinical decisions. The term "Date last updated" reassures users that they are not just looking at historical data, but at the latest information that incorporates all known modifications, adjustments, or corrections.
AUCDIR2018	There is some concern among the group who may enter this that it needs to be made clear the information entered would be patient reported rather than able to be verified by the professional.	Comment noted, no change. This data group is a clinical assertion of the LMP by a clinician and used as the basis of critical clinical decision making. A patient could record a menstrual diary which could be used to inform this data group, the clinician would determine the LMP.

7. AUCDI R2 Patient Summary Data Group: Estimated Date of Delivery (EDD)

7.1. Overall recommendations

Accept	Minor	Major	Reject	Abstain	No Vote
12	0	1	0	16	2

7.2. EDD by menstrual cycle

Responder	Community Comment Feedback	Sparked Reflection/Action Taken
AUCDIR2005	This data element may be too difficult to obtain given the reliance on two methods being cycle and imaging	Comment noted, no change. AUCDI contains data elements to support the recording of EDD by cycle or imaging. There is also a 'Agreed EDD' data element in the backlog for future consideration.

7.3. Date of ultrasound

Responder	Community Comment Feedback	Sparked Reflection/Action Taken
No comments or feedback received.		

7.4. EDD by ultrasound

Responder	Community Comment Feedback	Sparked Reflection/Action Taken
No comments or feedback received.		

7.5. Last updated

Responder	Community Comment Feedback	Sparked Reflection/Action Taken
AUCDIR2003	Does the data element 'Last updated' refer to the whole data group or individual data elements? The EDD by menstrual cycle and EDD by ultrasound would likely be updated on different dates, so it would be helpful to know when each data element was updated.	Comment noted, no change. It is intended that this data group should record one instance per pregnancy within a health record; changes or updates over time are captured as a revision rather than a new entry. The last updated date refers to the whole data group. It is expected that the system would be recording the changes which would track changes over time.
AUCDIR2005	Time binding the assertation based on last update and reproductive age may be a useful inclusion	Comment noted, no change. Age of person can be calculated and bound to the last updated element as part of an implementation. This advice is out of scope of AUCDI.

7.6. General Feedback for Estimated Date of Delivery (EDD)

Responder	Community Comment Feedback	Sparked Reflection/Action Taken
AUCDIR2003	Would there be different instances of this data group for different pregnancies? If there is only one instance for a patient across all pregnancies, it won't be clear that the EDD by menstrual cycle may have been updated after the EDD by ultrasound and refer to a different pregnancy.	Comment noted, no change. It is intended that this data group should record one instance per pregnancy within a health record. It would be expected that a separate EDD data group would be used for each pregnancy.
AUCDIR2005	There is some literature that supports reporting on recently pregnant status (within the last 12 months) is clinically useful	Comment noted, no change. Thank you for your feedback
AUCDIR2030	• Page 72 – clarification is needed regarding the summary in Section 8.8, which states 'In this AUCDI Release 2 context, EDD is represented as a more comprehensive model, suitable for inclusion	Comment noted, document update for clarity Comment noted, no change. The By ultrasound in the data group is a grouper, which isn't currently in scope for AUCDI R2.

	within a health record in which multiple EDDs may need to be recorded during a single pregnancy.' However in the table for this Concept (Table 19) under 'Representation' it states 'Record one instance per pregnancy within a health record; changes or updates over time are captured as a revision rather than a new entry'. • Pages 73 and 75 – it appears there is an error in the Concept representation diagram. The 'By ultrasound' should be flagged with the orange icon to indicate Candidate for 'AUCDI R2' as currently it shows as 'Future candidate'.	
AUCDIR2014	Should include Gravity, Parity, Miscarriages and Terminations data as well.	Comment noted, no change. Gravity, parity, miscarriages and termination status information as part of a complete Obstetrics summary is on the backlog for future consideration.

8. AUCDI PS Data Group: Pregnancy Assertion

8.1. Overall recommendations

Accept	Minor	Major	Reject	Abstain	No Vote
11	2	0	0	16	2

8.2. Pregnancy assertion

Responder	Community Comment Feedback	Sparked Reflection/Action Taken
AUCDIR2018	It is suggested that options for pregnant or not pregnant are expanded to include 'pregnancy not detected' as it can be difficult to state in the early phase of pregnancy that someone is not pregnant with the degree of certainty associated with this term.	Comment noted, no change. The intent of Pregnancy assertion is not to record the phase or level of uncertainty about a pregnancy. Instead, it is deliberate binary declaration, made by a clinician at a point in time and based on the best evidence available to them that the patient is or is not pregnant. On the basis of this assertion, appropriate clinical treatment can be made. To complement this, the proposed "Pregnancy summary" data group is intended to provide a more nuanced documentation of the various phases of a pregnancy. This includes capturing states of uncertainty, such as "possibly pregnant" (e.g., in cases like undergoing in vitro fertilization), as well as clearly defined stages like "pregnant" and "postpartum." This detailed categorization helps in managing and aligning the clinical care specific to each phase of a single pregnancy. Typically, the default assumption by clinicians is that any woman of childbearing age could be pregnant, although this is not usually documented unless relevant.

8.3. Justification

Responder	Community Comment Feedback	Sparked Reflection/Action Taken
No comments or feedback received.		

8.4. Date of assertion

Responder	Community Comment Feedback	Sparked Reflection/Action Taken
No comments or feedback received.		

8.5. General Feedback: Pregnancy Assertion

Responder	Community Comment Feedback	Sparked Reflection/Action Taken
AUCDIR2001	Be mindful to use Australian Standards in the first instance as this is what most health agencies would be utilising.	Comment noted, no change. Thank you for your feedback
AUCDIR2030	• Page 76 – Considerations for use – dot point 4 makes reference to 'where a clinician needs to assert that an individual who has been assigned as female at birth is not pregnant ' – clarity is needed on whether the term 'individual' would suffice and removing reference to gender assignment. • There may be value in clarifying whether 'Pregnancy Assertion' is a widely used concept. Feedback from received from a [stakeholder] nursing informatics area has questioned the usage of this concept. • Positive Pregnancy test – yes / no	Comment noted, document updated to "However, the opposite situation where a clinician needs to assert that an individual is not pregnant is often not a straightforward or safe determination." The CDG strategically incorporated 'Pregnancy assertion' into AUCDI in response to the specific requirements for eRequesting. This decision was made to meet clinical requirements for clearly recording the finding of a woman being 'not pregnant', both in clinical systems at the point of clinical decision-making and on requesting forms, especially from a medicolegal point of view. The designation of 'Not pregnant' is often mistakenly treated as an ad

	• Suspected Pregnancy – yes / no • It is unclear how pregnancy assertion will be gathered from the ieMR which is the largest electronic medical record in Queensland. Development may be needed to support this concept.	hoc or constant condition, whereas it should only be asserted based on the current clinical evidence at a specific point in time. The term 'Pregnancy assertion' is not well-known within the healthcare community, largely because the recording of pregnancy status, particularly the 'not pregnant' state, is frequently not well managed in clinical systems. This common error can have significant clinical ramifications, especially when it comes to the suitability of certain medical interventions or medications that are contraindicated during pregnancy. By formalising 'Pregnancy assertion' as a distinct and necessary component within clinical documentation and eRequesting protocols, the CDG is addressing a critical gap in health information management. This ensures that healthcare providers have clear, actionable information regarding findings about a patient's pregnancy status ata specific point in time, thereby supporting safer and more informed clinical decision-making. A positive pregnancy test will be recorded in a 'Pregnancy test result' data group, currently on the AUCDI backlog. The proposed "Pregnancy summary" data group is intended to provide a more nuanced documentation of the various phases of a pregnancy. This includes capturing states of uncertainty, such as "possibly pregnant" or "suspected pregnant"(e.g., in cases like undergoing in vitro fertilization), as well as clearly defined stages like "pregnant" and "postpartum." This detailed categorization helps in managing and aligning the clinical care specific to each phase of a single pregnancy. Agree, that this new concept may require development work within the ieMR.

AUCDIR2005	This data element may be difficult to obtain given the reliance on two methods being cycle and imaging	Comment noted, no change. AUCDI contains data elements to support the recording of EDD by cycle or imaging. There is also a 'Agreed EDD' data element in the backlog for future consideration.

9. General Feedback

Responder	Community Comment Feedback	Sparked Reflection/Action Taken
AUCDIR2003	It is suggested that a data group is included for pregnancy outcomes. Pregnancy outcomes play a significant role in lifelong health and have implications for the care of the patient, including appropriate management of elevated health risks. Useful data elements would be the outcome (e.g. termination, miscarriage, stillbirth, live birth) and date of outcome (e.g. actual date of delivery compared to estimated date of delivery). It seems appropriate to include this data group within the scope of the Patient Summary, given history of pregnancy outcomes is included in the International Patient Summary (https://build.fhir.org/ig/HL7/fhir-ips/StructureDefinition-Observation-pregnancy-outcome-uv-ips.html). As additional information relating to pregnancy is included in AUCDI, it is recommended that data elements align to the National Perinatal Data Collection (NPDC) where appropriate. The data specifications for the NPDC can be found in AIHW's online metadata registry METEOR (https://meteor.aihw.gov.au/content/742052). Of the 10 data groups from AUCDI R1, it is noted that 6 have been included in AUCDI R2 Patient Summary (either unchanged or with enhancements). The 4 data groups from AUCDI R1 that were not included in AUCDI R2 Patient Summary are 'Tobacco smoking summary', 'Measurements and vital signs', 'Biomarkers', and 'Encounters – clinical context'. Are these all considered out of scope for Patient Summary? It seems that it would have been appropriate to include the 'Tobacco smoking summary' data group within the	Comment noted, no change • Pregnancy outcome for each pregnancy (e.g. stillborn, liveborn, miscarriage, etc.) will be part of a Pregnancy summary data group which is on the backlog for development. The overview of all pregnancy outcomes (i.e. the statistics of all pregnancies) will be part of the Obstetric summary which is also on the backlog for development. • Noted, we will work with the AIHW to ensure alignment. • The data groups included as part of 'Patient Summary' were identified as priority by the CDG as this focus was on the 'necessary information' to support a Patient Summary at this time, but that the data groups will grow in align with clinical requirements overtime.

	scope of the Patient Summary, given smoking as an element of social history is included in the International Patient Summary (https://build.fhir.org/ig/HL7/fhir-ips/StructureDefinition-Observation-tobaccouse-uv-ips.html).	
AUCDIR2006	AUCDI R2 encompasses some crucial updates and delivers these with clarity and flexibility where required. Overall, Optometry Australia supports the Draft. The most pertinent information not yet included in the patient summary component with regards to optometry is affect on Activities of Daily Living. Optometrists do provide an insight into effect on ADL for referrals to ophthalmology departments, such as if a patient needs to be prioritized for cataract surgery due to impact of the cataract on ADL. This data also provides a clear insight into the effect of visual impairment on a patient's daily life wellbeing We will continue to work closely with AHPA and the Clinical Design Working Group to advocate for inclusions relevant to optometry where needed. Please do not hesitate to contact Optometry Australia directly for any further comment or input.	Comment noted, no change. Thank you for your feedback
AUCDIR2008	Optimising the availability and use of real world clinical data have a significant impact on strengthen real world evidence, supporting health researchers, evidence-based policy and decision-makers in health related matter. It is a well-known that the Australian health data landscape is fragmented/siloed due to a number of factors including the complexity of the Australian healthcare system (i.e., Federal and States) as well as privacy constraints. Therefore, any effort to integrate Australian health data safely and lawfully is welcomed.	Comment noted, no change. • The implementation and use of data is out of scope of AUCDI. AUCDI focuses on the representation of the clinical content. De-identification and privacy concerns should be considered in the technical representations (such as FHIR IGs) and implementations. • The AUCDI is defining clinical content for clinical care, which may be sent to MHR or for other secondary use purposes. SNOMED CT-AU (and the Australian Medicines Terminology) are Australia's preferred clinical terminology and a map to PBS may be useful. This is out of scope of AUCDI.

	Reading through the proposed content of the Australian Core Data for Interoperability (AUCDI), we would like to advise the following: • Whilst subsection 5.4.2. Scope of AUCDI-2 (p15) does not include primary patients identifiers (patient's names, address, etc), the proposed data element such as medication use statement and patient's demographics (gender and age) may entail privacy concerns such as a potential risk of re-identification through attribute disclosure. • The source of some data seems coming from MHR system which includes PBS. From PBS perspective, the PBS Schedule lists a number of medicines aimed to treat/manage rare and very rare diseases (i.e., Merkel Cell Carcinoma, Dermatofibrosarcoma protuberans, etc) as well as very expensive medicines (i.e., Zolgensma®). This means that the dataset may include special individual features. More information on PBS Schedule can be found at https://www.pbs.gov.au/pbs/home. • It is advisable to stratify clinical information such as admission data by International Classification of Diseases-10 Australian Modification (ICD-10 AM).	• SNOMED CT-AU Is the preferred national terminology for clinical care and a mapping to ICD-10AM may be required for reporting requirements, funding and classification purposes in acute care. This is out of scope for AUCDI.
AUCDIR2013	[AUCDIR2013] has reviewed the attached document and note that there would be subsectors of data that could be captured within this arrangement to enhance our fraud and risk analysis capabilities. We suggest the following inclusions to support our efforts in protecting the integrity of the Medicare system: • Patient identity data, such as birth date and Medicare number	Comment noted, no change. Information around pending results and access to results are wider system implementation issues and are out of scope of AUCDI. System information includes the Patient and provider information, and other system information - these technical attributes are outside the scope of this data group and would sit in the FHIR IG. Billing information may also belong in the FHIR IG depending on the use case.

	• Provider information, including practice location and service date • Billing information, like benefit details • Additional system logs to help detect patterns of unusual or repeated claims	
AUCDIR2016	A field to record date/time shared or uploaded to My Health Record (MHR). Currently hospital discharge summaries lack standard fields to capture how quickly after discharge the information was shared with community-based healthcare providers (eg: GPs or RACFs) directly or made available through MHR (in line with National Digital Health Strategy priority item 1.1.05)	Comment noted, no change. Date/time shared with My Health Record is an implementation issue and out of scope of AUCDI. This may be addressed in a use case specific FHIR IG.
AUCDIR2017	Recent changes to scope of practice at a national and/or jurisdictional level support prescribing by additional health professionals, including registered nurses and pharmacists. To support this, a new data element under the 'medication use statement' could be considered to capture information about the medication prescriber e.g. General Practitioner, Specialist, Nurse Practitioner, Pharmacist. Inclusion of prescriber information would allow the patient's wider multidisciplinary care team to identify the prescriber of a new medication which could enable more efficient communication amongst the care team.	Comment noted, no change. System information including the identification of a health care provider and their role (i.e. medication prescriber) is out of scope for AUCDI and would be expected to be represented in technical specifications such as a FHIR IG.
AUCDIR2005	We note sex and gender summary is unchanged so you are not seeking feedback. However we note ADHA's current discussion paper 'Data matching and data quality improvements' (12/12/24) and wish to highlight the potential impact on the Patient Summary for consideration. • It is suggested that gender may be used as a mandatory matching element if matching based on date of mobile number or email address.	Comment noted, no change. Agreed. Thank you for your feedback.

	• Processes for legally changing gender vary between jurisdictions. Therefore, a patient may self-identify as a gender that does not match with their Medicare recorded gender due to the complex change process. This may result in a failed identity match regardless of information entered into these fields in the Patient Summary.	
AUCDIR2006	Optometry Australia is the peak professional body representing over 85% of Australian Optometrists. Optometry is a diverse profession, encompassing over 7000 practitioners who serve the Australian population by providing over 11 million eye examinations per year in a multitude of clinical settings covering private and corporate practices, ophthalmology clinics, public hospital outpatient clinics, and outreach programs to underserviced priority populations, including First Nations peoples. Optometrists play an integral role within Australia's healthcare system as the primary practitioners responsible for the diagnosis and management of ocular conditions. Optometry is a highly digitised profession, relying on a wide range of diagnostic equipment in the examination, analysis and management of ocular health. Optometrists are the first point of access for some 80% of consumers seeking ocular health services, often identifying eye disease in asymptomatic patients. Optometrists collaborate closely with other health professionals, such as general practitioners, ophthalmologists, neurologists, endocrinologists, and rheumatologists, in order to co-manage ocular and systemic diseases. As such, streamlined and accurate communication of clinical and referral information is paramount to the optometrists' role in	Comment noted, no change. Thank you for your support.

	multidisciplinary care. We welcome the immense work that is involved in producing AUCDI on this basis. Optometry Australia is a member of the Allied Health Profession Australia and has provided feedback through this group. We would also like to submit this feedback directly. Optometry Australia looks forward to continued representation on the allied health clinical design group, and welcomes any further opportunities to be involved in the Sparked collaborative.	
AUCDIR2010	We are supportive of the new changes in AUCDI R2.	Comment noted, no change. Thank you for your support.
AUCDIR2011	Very medically-orientated mainstream document	Comment noted, no change. Thank you for your support.
AUCDIR2012	Please see page 53 figure 15. It is unclear how a healthcare provider will find patients in the event recall information required/provided by TGA without recording the manufacturer and Batch ID. Often these are recorded in paper records/books - is this the assumption here? Similarly, the situation with Expiry date - how will stock management be performed if this date is not recorded where supply management is part of the solution or utilises this data item?	Comment noted, no change. BatchID was not prioritised for inclusion in the AUCDI. It was noted that this information is recorded as part of the Australian Immunisation Register (AIR). It is in on the backlog for development of AUCDI.
AUCDIR2019	The AUCDI R2 looks fine for broad groupings of data collected through health system interactions and resulting patient summaries (this is the main feedback sought as per link to form in email below). However, it's not clear from the information provided how the data will be collected in situ – for example, would a diagnosis of HIV be collected under 'procedure completed event'? How are other communicable diseases identified within the collection groups? There may have more opportunity to comment on this (providing HIV perspective) when the Chronic Condition	Comment noted, no change. A diagnosis of HIV would be expected to be collected in the Problem/Diagnosis data group, as would other communicable diseases. We look forward to your feedback on the Chronic Condition Management component which has now been released for comment We welcome [AUCDIR2019] (and any interested stakeholders) feedback on the AUCDI.

	Management component is released for community comment in early 2025 as outlined below. The HIV Policy Section can contact the [AUCDIR2019] to see if they have been approached for input. This is in relation to the Data Specifications for collection of data to the National HIV Registry. These data fields are agreed through the NBBVSTISSC and consideration of the AUCDI would be beneficial. For example, there is detailed information on what is proposed for 'Sex and gender' data group (Sparked-AUCDI-R2-patient-summary-draft-V1.0.pdf see pages 64-68) and while what is being proposed in the AUCDI R2 is considered (including references to SNOWMED CT-AU) the [AUCDIR2019] may only collect data specific to the identified requirements of the HIV Registry.	
AUCDIR2001	5.4.2 does not include patient (including date of birth and indigenous status) I found this statement overall confusing.	Comment noted, no change. System information including the identification of a patient, or health care provider and their role is out of scope for AUCDI and would be expected to be represented in technical specifications such as a FHIR IG.
AUCDIR2005	We would welcome a demonstration of this proposed release.	Comment noted, no change. The AUCDI is a use case agnostic specification and not a system or app (like an EMR). Vendors will be able to demonstrate use case specific implementations of the AUCDI. Some of these can be found on our website as part of the Sparked Symposium. There are more demonstration videos coming.
AUCDIR2006	AUCDI R2 encompasses some crucial updates and delivers these with clarity and flexibility where required. Overall, Optometry Australia supports the Draft. The most pertinent information not yet included in the patient summary component with regards to optometry is affect on	Comment noted, no change. Agree. Activities of Daily Living is on the backlog for future development.

	Activities of Daily Living. Optometrists do provide an insight into effect on ADL for referrals to ophthalmology departments, such as if a patient needs to be prioritized for cataract surgery due to impact of the cataract on ADL. This data also provides a clear insight into the effect of visual impairment on a patient's daily life wellbeing We will continue to work closely with AHPA and the Clinical Design Working Group to advocate for inclusions relevant to optometry where needed.	
AUCDIR2010	The Patient Summary changes match with our requirements in regard to how we capture patient clinical data.	Comment noted, no change. Thank you for your feedback.
AUCDIR2013	we also suggest that any proposed changes are considered in the context of what is going on within AGD with respect to automatic decision making. There is a paper out for public consultation that discusses the options, with consultation closing mid-January - Automated Decision-Making Reform - Attorney-General's Department - Citizen Space https://consultations.ag.gov.au/integrity/adm/ Separately, there are also recent Privacy Law reforms which will require privacy policies to contain information about substantially automated decisions which significantly affect individuals' rights or interests, including the kinds of decisions and kinds of personal information used - https://www.oaic.gov.au/news/media-centre/pasing-of-bill-a-significant-step-for-australias-privacy-law. The information law section would be able to provide further advice about this.	Comment noted, no change. The implementation and use of data is out of scope of AUCDI. AUCDI is a library of information models that focus on the representation of the clinical content. De-identification, privacy concerns, and impacts due to reuse of data for decision making should be considered in the technical representations (such as FHIR IGs) and implementations.
AUCDIR2014	Use of the term 'medicines' is preferred over 'medications'. There also does not seem to be any indication of which fields are mandatory and which are not. Further, there should be information on to whom the patient care summary was intended to be sent, relevant family history,	Comment noted, no change. • The term 'medications' is broadly used in the international standards world. If the term 'medicines' is preferred as a user interface term, this can be handled in the implementation.

	pregnancy history (Gravity, Parity, Miscarriages, Terminations), suggestions for follow-up (including tests pending at time of discharge and the provider of those tests, together with contact details to request them), and whether the document has been uploaded to My Health Record as a back-up means of documentation.	• Details about occurrence can be found in the information model, where mandatory/optional fields are indicated. The AUCDI specifications are intentionally kept neutral for any specific use case. Data elements are only made mandatory where they are ubiquitous and considered necessary in every possible use case, or when the remainder of the data group makes no sense without a mandatory index data element. Any optional data element in this data group can be mandated in a particular use case, technical specification or implementation. • The data groups included as part of 'Patient Summary' were identified as priority by the CDG as this focus was on the 'necessary information' to support a Patient Summary at this time, but that the data groups will grow in align with clinical requirements overtime. Additional suggestions and details have been added to the backlog for consideration by CDG. Uploads to My Health Record is an implementation issue and outside the scope of AUCDI.
AUCDIR2015	With the note that health and medical researchers will often need to interface with clinical/health data: i. HMRO suggests that the Sparked team considers the Medical Research Future Fund (MRFF)/National Health and Medical Research Council (NHMRC) joint Statement on Sex, Gender, Variations of Sex Characteristics and Sexual Orientation in Health and Medical Research, released in July 2024. https://www.health.gov.au/resources/publications/statement-on-sex-gender-variations-of-sex-characteristics-and-sexual-orientation-in-health-and-medical-research The statement encourages and guides researchers funded by the MRFF and NHMRC to consider sex, gender, variations of sex characteristics and sexual orientation in health and	Comment noted, no change. 1. Noted. This paper has informed the Sex and gender summary data group and its backlog. 2. SNOMED CT-AU Is the preferred national terminology for clinical care and a mapping to ICD may be required for reporting requirements, funding and classification purposes in acute care. This is out of scope for AUCDI.

	medical research. The department, with NHMRC are currently working ways of implementation, as it pertains to research funded through the MRFF and NHMRC. This will include resources that would be available to all researchers. ii. From a Research Scientist's perspective: are there any considerations for the use of the International Classification of Diseases codes ICD-11, under "Problem and Diagnosis summary", to facilitate linkages with both national and international reporting?	
AUCDIR2018	As a group we don't feel patient summary is holistic enough to provide optimal care. At a high level it needs to be considered that two groups from the World Health Organisation International Classification of Functioning structure are missing: Activity level and Participation. Whilst we acknowledge a lot of detailed information fits within these categories and is coming within further iterations of AUCDI and additional data groups, there are key pieces of information which can assist many health professionals and a consumer and their broader network in all interactions they have with an individual that are missing from the patient summary and need to be considered for inclusion as additional data elements. The allied health sector propose careful consideration is given to expanding patient summary as soon as possible to include key aspects related to: • Communication - primary language and whether can speak and understand english; whether assistive technology is required to aid communication e.g., hearing aid, speech boards etc.	Comment noted, added to backlog. The data groups included as part of 'Patient Summary' were identified as priority by the CDG as this focus was on the 'necessary information' to support a Patient Summary at this time, but that the data groups will grow in align with clinical requirements overtime. Activity level - Physical activity and Goals are currently part of the AUCDI R2 CCM. All of your suggestions have been added to the backlog.

	• Cognitive impairment - present or not • End of life information • Domestic violence situation noted (some sort of overarching indicator in the summary that encourages the reader to engage further with additional information so that they don't inadvertently share information which could place the individual at greater risk of harm from a known situation. Australian Association of Social Workers can provide a case example in the future if helpful) • Aspiration risk - that is, if they are given water they could choke as fluid too thin • Assistance required e.g., what do they need to be able to interact at an appointment, interpreter could also be included here or things like a hoist if i need to get from a wheelchair to a bed, need someone with me • Behavioural management plan in place - tick box or yes or no - again so the reader can go and engage with more detailed information if required because without certain strategies being utilised there is a chance consumers won't be able to engage in the care attempting to be provided and could be incorporated with 'risk' as in risks to the client but also that the client might be a risk to others with aggressive behaviours • Mobility status: e.g., typical activity level, assistive technology required for mobility (walker, stick, prosthesis etc.) • Assistive technology in place - aspects such as the mobility aids, hearing aids etc. noted above could potentially be incorporated into a general category which shows the aids in place, including whether the consumer usually has a carer with them and is more	

	encompassing than specific aspects noted in the above categories • Client preferences / goals - will these be incorporated into the summary once these data elements are developed out?	
AUCDIR2019	The structure for documenting a completed procedure markedly differs from that necessary to capture details about a medical condition. This distinction becomes more apparent when comparing the 'Procedure completed' data group to the 'Problem/Diagnosis summary', and the divergence is even more apparent on reviewing the extended, future roadmap models. It is noted that some clinical systems currently use a generic data structure to record both completed procedures and manage active and inactive problems or diagnoses. Vendors of clinical systems will need to consider the shift towards the separated modelling patterns.	Comment noted, no change. Thank you for your feedback.
AUCDIR2020	Page 49: Australian Immunisation Registry (AIR) should be Australian Immunisation Register When referring to vaccines, "vaccine administration" rather than "vaccination administration". Vaccination refers to the procedure. Page 65 Aliases might include genetic or chromosomal sex	Wording updated and new content added to reflect comment. 1. Thank you, this has been updated in the document. 2. Thank you for the feedback. This data group has been updated to "Vaccination" 3. Genetic and chromosomal sex may be used to inform Sex assigned at birth however are more specific, so would not be considered a synonym/alias.
AUCDIR2022	Nil concerns with updated components in R2 Potential aged care policy interactions - Monthly Care Statements, My Health Record/My Aged Care integration. Clinical concepts in Quality Indicators program and Business to Government (B2G). Aligns with:	Comment noted, no change. Thank you for your feedback. The Australian Digital Health Agency is responsible for the implementation of MyHR.

	development of the Aged Care National Minimum Dataset (AIHW led) development of the Aged Care Clinical Information System Standards (ADHA led) Will AUCDI concepts be adopted in My Health Record, and if so, when?	
AUCDIR2023	Data Element: there is a standardised definition of a data element as per ISO/IEC 11179 as "a combination of a Data Element Concept and a Value Domain. in turn it defines a; Data Element Concept: This describes the meaning of the data. For example, "net income of a person." Value Domain: This specifies how the data is recorded, such as the range of permissible values or the format. For instance, "net income in dollars." Together, these components ensure that data is recorded in a consistent and understandable way across different systems and organisations" DAMA DMBOK has a similar definition: "a unit of data that has precise meaning or semantics and is defined by its attributes, such as its name, definition, and permissible values" I think either of these are more useful than the current and survive the FHIR context.	Comment noted, no change. AUCDI leverages the openEHR specification and associated tooling which is based on ISO 13606-2.
AUCDIR2025	[AUCDIR2025] context for our feedback include data about disease incidence, risk and protective factors, exposures, pathogens, health systems, comorbidities, sociodemographic characteristics, determinants, and health, economic and social outcomes. This will allow core public health data (i.e.	Comment noted, no change. It is anticipated that data collected for clinical care using AUCDI should be able to be aggregated to generate data to support public health surveillance. A number of the suggested topics are

	epidemiological data about communicable and non-communicable diseases) to be linked to other data to generate detailed, relevant and actionable insights. A substantial piece of the broader digital health and interoperability work program is embedding the use of consistent digital identifiers for the secure transfer of individual health information. As a core component of the [AUCDIR2025] data system, integration of digital health care identifiers will be beneficial to linking Sparked AUCDI databases with other departments.	on the AUCDI backlog and welcome the addition of specific suggestions to support the [AUCDIR2025] where relevant. It should be noted that the AUCDI is a use case agnostic specification and instantiated database.
AUCDIR2026	With the current focus on medical devices, including the Government's implementation during 2025 both the mandatory reporting of adverse events by hospitals to the TGA and roll-out of the Unique Device Identification scheme, application of the interoperability and data sharing proposals being developed should be considered. More detailed commentary is below including the TGA's international harmonisation efforts with regard to sharing of information with other regulators (and therefore healthcare systems): R1 release indicated that medical devices could be a field that would be incorporated in R2 (p 22 of R1 paper). However, medical devices are listed as out of scope of AUCDI in R2 (screenshot below), although there doesn't appear to be any reasoning within the scope of this project for the exclusion of devices. The exclusion will result in a patient summary that will be created based off the current iteration of AUCDI that may not hold significant relevance to medical devices. R2 does not appear to include any mention of medical devices or capturing relevant information- eg in the case study example provided about a patient (5.4.4, p 22), the diabetes treatment including use of glucose sensors or delivery of insulin are not mentioned even if they are routine for this kind	Comment noted, no change. Noted and thank you for this feedback. Medical device/details is in the backlog for further consideration. The Implanted medical device on the AUCDI backlog can be developed to capture specific device details such as date of expiry, date of insertion/removal device details etc. This data group would be designed to be nested within other data groups such as the Procedure data group and a potential Adverse evet data group (on the backlog). The Procedure data group could be used to record details of procedures with direct involvement with medical devices e.g. implantation, adjustment, etc (examples have been added to reflect this). The Implanted medical device data group containing the device details could be included in the [Procedure detail] extension that is on the backlog for future consideration. The Adverse reaction risk data group does not include adverse events/adverse outcomes from medical devices. A specific data group for this purpose, such as adverse event, is acknowledged and on the AUCDI backlog, but has not yet been developed for inclusion in AUCDI.

	of management. Under “Procedure completed”, surgeries will be captured. There may be potential relevance if the device names is included wither as a specific data element or within the Comment field. It is unclear to me whether devices and boundary products containing substances that are included in the poisons standard would be captured in this context. Adverse reactions have been added to AUCDI R2 (p 25), with the addition of ‘Substance name’ (page 26), but this terminology does not seem inclusive of adverse outcomes from medical devices, such as erosion from mesh implant or anaplastic large cell lymphoma associated with breast implants. There appears to be only one reference to medical devices (p 55), in this version, and this is that ‘misuse’ is not the appropriate field to put medical device information. However, there is still a lack of fields to provide medical device information. In collecting biometric data- there does not appear to be a field about method of collection or product used- eg temperature can be measured via different methods and may return different but equally valid results. For reporting laboratory tests (p 103-105), it only collects the analyte but not the reading or name of the IVD used- depending on test sites and type of tests it may return different results- for continuity of patient care these conditions should be noted. 8.4.4 suggests future state of collecting batch/lot info, also suggest adding UDI information Section 8.8 (p107) discusses use of medication. Similar consideration should be given also for devices used to administer treatment or therapy or diagnostics	Agree, and thank you for your feedback. Method of biometric data collection is provided on the 'Body temperature' roadmap and would be captured under location of measurement and [device]. These data elements are currently on the AUCDI backlog. Agree. The need for a specific data group, such as pathology test result, for this purpose is acknowledged and on the AUCDI backlog, but has not yet been developed for inclusion in AUCDI. Agree, and thank you for your feedback. Unique Device Identifier has been added to the backlog under implanted medical devices. The need for a data groups such as medical devices used to administer treatment, therapy or diagnostics in a clinical context, is acknowledged and on the AUCDI backlog, but has not been developed for inclusion in AUCDI.

AUCDIR2027	One observation is that AUCDI Release 2 won't support care/behavioural information that might be included in a shared care summary in future. For example, a future release might include: care team members, care plans, advanced care directives and social history including health behaviours.	Comment noted, no change. The data groups included as part of 'Patient Summary' were identified as priority by the CDG as this focus was on the 'necessary information' to support a Patient Summary at this time, but that the data groups will grow in align with clinical requirements overtime. Some care/behavioural information has been included in AUCDI R2 Chronic condition management component and additional items are on the backlog for future development.
AUCDIR2019	The AUCDI R2 looks fine for broad groupings of data collected through health system interactions and resulting patient summaries (this is the main feedback sought as per link to form in email below). However, it's not clear from the information provided how the data will be collected in situ – for example, would a diagnosis of HIV be collected under 'procedure completed event'? How are other communicable diseases identified within the collection groups? There may have more opportunity to comment on this (providing HIV perspective) when the Chronic Condition Management component is released for community comment in early 2025 as outlined below. The HIV Policy Section can contact the [AUCDIR2019] to see if they have been approached for input. This is in relation to the Data Specifications for collection of data to the National HIV Registry. These data fields are agreed through the NBBVSTISSC and consideration of the AUCDI would be beneficial. For example, there is detailed information on what is proposed for 'Sex and gender' data group (Sparked-AUCDI-R2-patient-summary-draft-V1.0.pdf see pages 64-68) and while what is being proposed in the AUCDI R2 is considered (including	Comment noted, no change. A diagnosis of HIV would be expected to be collected in the Problem/Diagnosis data group, as would other communicable diseases. We look forward to your feedback on the Chronic Condition Management component which has now been released for comment. We welcome [AUCDIR2019] (and any interested stakeholders) feedback on the AUCDI.

	references to SNOWMED CT-AU) the [AUCDIR2019] may only collect data specific to the identified requirements of the HIV Registry.	

AUCDIR2024	Other data elements that could be useful for better connecting Aged Care to Health care and improve continuity of care as Aged Care patients pass between healthcare settings (a lot of these are gathered via specialised Assessments (IAT), of which there are about 500,000 conducted /year):
	• Functional Status: This is a key area not explicitly covered in the current AUCDI but is highly relevant for aged care.
	  ○ Activities of Daily Living (ADLs): Data elements to capture an individual's ability to perform basic self-care tasks such as bathing, dressing, eating, and toileting [implied by the need for a holistic approach in aged care]. This could include a coded assessment using a tool like the Barthel Index or the Functional Independence Measure (FIM) [outside of source].
	  ○ Instrumental Activities of Daily Living (IADLs): Data elements to record an individual's capacity for more complex tasks needed to live independently, such as managing medications, preparing meals, and using transportation (this could include a patient's AN-ACC classification).
	  ○ Mobility: Data elements to describe an individual's ability to move around, including the use of mobility aids, risk of falls, and overall level of independence.
		Comment noted, added to backlog.
		Agree. Thank you for your suggestions. These have been added to the backlog for future consideration. Living situation, Financial security, Food and nutrition summary, Goals and Interventions have been added to the AUCDI R2 Chronic condition management component.

	• Social Determinants of Health (SDOH): These are factors that impact an individual's health and are particularly important for older adults.
	  ○ Living Situation: Data elements to capture the type of housing an individual lives in, and whether they live alone or with support.
	  ○ Social Support: Data elements to indicate the availability of family, friends, or community support networks (it would be good if this included consent for agency).
	  ○ Financial Security: Data elements to assess an individual's access to financial resources for healthcare and other essential needs.
	  ○ Food Security: Data elements to record whether an individual has reliable access to sufficient and nutritious food .
	• Cognitive and Mental Health: Given the high prevalence of cognitive impairment and mental health conditions in the aged care population, specific data elements are needed:
	  ○ Cognitive Assessment: Data elements to record the results of cognitive screenings or assessments using standardized tools like the Mini-Mental State Examination (MMSE) or Montreal Cognitive Assessment (MoCA) [outside of source].
	  ○ Mental Health Conditions: Data elements to record specific diagnoses like depression or anxiety, including their severity and management.
	• Care Plans and Goals (sometimes called Support Plan in Aged Care):	

	○ Care Plan Summary: Data elements to outline the key components of a patient's care plan, including specific goals, interventions, and responsibilities. ○ Advance Care Directives: Data elements to indicate the existence and content of advance care directives or other legal documents related to end-of-life care preferences. • Sensory Impairments: Data elements to document sensory deficits, such as hearing or vision loss, that can impact communication and daily functioning. • Nutritional Status: Data elements to capture an individual's nutritional status, including weight, appetite, and any dietary restrictions or requirements [implied by the need for a holistic approach in aged care]. • Pain Assessment: Data elements to record the presence, severity, and location of pain, which is a common issue among older adults.	
AUCDIR2025	[AUCDIR2025] is pleased to observe the progress of this work. We also wish to express our support for the Sparked project and are keen to remain informed about opportunities to leverage the resulting technical capacity for standardised data sharing. Standardising data at the point of clinical care represents a significant advancement for any subsequent use of that data. For example, standardisation for clinical purposes supports the necessary mapping to data models for public health analysis, and where applicable from clinical terminologies to statistical classifications. Enhanced transfer of health information facilitated through the AUCDI could support the following functions of the [stakeholder]:	Comment noted, no change. Thank you for your support.

	• Support data flows into the Public Health Data Network • Enhance capabilities in data and analytics • Strengthen evidence-based decision making • Utilise resources more efficiently to support preparedness and response across all jurisdictions • Increase health emergency planning resourcing. For future developments, consider creating a roadmap to consistently include essential information in clinical data exchange, aiding clinicians in managing public health emergencies.	
AUCDIR2027	It would be great if we can stay in touch with Sparked as they put together scope for future releases, so we can include relevant data elements when ready/available (noting we're still some time away from being ready).	Comment noted, no change. Thank you for your support. For updates and information in connection with Sparked program, we encourage registrations on the Sparked website.
AUCDIR2029	Still keen to look at medical devices down the track	Comment noted, no change. Thank you for your feedback. Medical devices is a data group in the backlog.
AUCDIR2020	In primary care reason for encounter is often multiple. Collection of a patient's Aboriginal or Torres Strait Islander or both status is considered important in providing appropriate care.	Comment noted, no change. Agree. Agree that collection of Aboriginal or Torres Strait Islander or both status is important and is on the backlog for consideration. It is considered clinically important will not be defined by the clinicians in AUCDI, but adhere to current national standards.
AUCDIR2021	Pages 26-30: When providing comment on release 1 of the AUCDI, it was raised that the substance name was free text entry which may encourage the inclusion of data that is not codable. It is noted that this has been sufficiently addressed	Comment noted, no change. Thank you for your feedback and support.

	through the addition of a comment that the entry of a substance code should be done where possible (page 30). Page 31: The addition of a data element to capture the timing for the onset of a first adverse reaction is noted. We confirm this will be useful for the identification of safety signals in relation to the use of health technologies. Page 32: The proposal to base the coding for the severity of an adverse reaction on the SNOMED CT severity value set being developed for the FHIR standard is appropriate.	
AUCDIR2022	FYI Key Dates on standards development: • ADHA's ACCISS v2 launches mid Q3 2025 • AIHW's Aged Care National Minimum Data Set (NMDS) v2.0 under development, launches July 2025 • Data domains: person, service, providers – aligning to NACA • AIHW's Aged Care National Minimum Data Set (NMDS) v1 under development, launches July 2025 • Data domains: financial, workforce • NMDS v3 developed October 2025 to April 2026, launches July 2026 • Data domains: person, service, providers, financial, workforce • NBPDS v2 developed October 2025 to April 2026, launches July 2026 • Data domains: clinical/care needs, quality • NMDS v4 developed October 2026 to April 2027, launches July 2027 • Data domains: person, service, providers, financial, workforce, clinical/care needs, quality	Comment noted, no change. Thank you for the information.

AUCDIR2023	[AUCDIR2023] Given the increasing interest in AI/ML and how it might help revolutionise our Clinical Decision Support systems, [AUCDIR2023] Is broadly supportive of the R2 scope and are very pleased to see that secondary use cases are now no longer expressly excluded from consideration of scope. We would recommend ensuring that these standards are communicated directly to some of our cross-agency business partners who could benefit from adoption. Namely the Australian Immunisation Register and the National Cancer Screening Register business areas.	Comment noted, no change. Thank you for your support.
AUCDIR2030	The R1 and R2 AUCDI scope is defined here, but it would be worth adding a vote from an Aged Care perspective to add the other IPS groups: Plan of Care, Functional status and disability assessment, medical devices and equipment and Advanced Care directives would all be useful to better connect Aged Care with healthcare Procedure Completed Event: How can the 'Procedure completed event' data group be used to document procedures relevant to aged care residents, such as wound care, falls prevention measures, or assistive device fitting? Medication Use Statement: This says it's for a single medication, however in Aged Care polypharmacy is widespread. Does this element cater to this complexity? Digitisation of Aged Care Medication Charts is a current initiative; we should connect with the project team working on this to determine if this data group standard could be adopted as a collection to ensure better interoperability of medication charts to ensure continuity of care as aged care recipients are transfers between care settings. Sex and Gender Summary: this standard is different from the ABS standard. As the new aged care act creates opportunities	Comment noted, no change. • Thank you for the suggestions. These are all on our backlog for future development. • 'Procedure completed event' could be used for wound care procedures. In the AUCDI R2 Chronic Condition Management that has been recently released for public comment, additional intervention data groups such as 'Medical equipment supply', 'Health education' and 'Physical assistance' have been included which may be useful. • 'Medication use statement' is per medication, so there may be multiple instances of this data group can be used to record medication use of an individual. • Thank you for your support.

	to redefine our client management data models, we will bring this standard to the new Reform Implementation Division's Data Governance forum to have it considered.	
AUCDIR2030	The paper refers to SNOMED CT-AU being adopted as the standard for recording structured clinical data in health records (p 14). SNOMED is the systematized nomenclature of medicine. There is also reference to LIONC which is used for medical laboratory observations (p15). There would be benefit in consideration to whether medical devices or other therapeutic goods are appropriately represented in the terms available in SNOMED or LIONC. Currently, this may be insufficient for the mandatory reporting of adverse events by healthcare facilities, or align with how adverse event reports for medical devices are received and coded by the TGA. The International Medical Device Regulators Forum (IMDRF) Adverse Event Terminology Terminologies for Categorized Adverse Event Reporting (AER): terms, terminology and codes | International Medical Device Regulators Forum	Comment noted, no change. Medical device recording should follow national standards.
AUCDIR2030	[AUCDIR2030] would be interested to see how the International Patient Summary fits with discussion regarding uplifting My Health Record.	Comment noted, no change. The Australian Digital Health Agency has responsibility of the My Health Record.
AUCDIR2030	• It is not clear whether patient identifiers such as the Individual Healthcare Identifier (IHI) is used as the basis for Patient Summary. Best practice is for an international standard relating to a common patient identifier to be created. Cyber security will need to be considered for this approach and may be a limiting factor. • Consideration of a national approach to data collection on DFSV is required as jurisdictions may utilise different approaches.	Comment noted, no change. System information including the identification of a patient, or health care provider and their role is out of scope for AUCDI and would be expected to be represented in technical specifications such as a FHIR IG. Agree. DFSV is on the backlog for future consideration, however this may be a broader conversation than Sparked can facilitate.

AUCDIR2030	Problem/Diagnosis summary
	• Page 39 – there is the addition of new data element 'Date/time of onset'. The Considerations listed in the table for this data element state 'Symptom/sign onset may be represented by an actual date and/or time of onset; an imprecise period during which the onset occurred; or the age of the individual at the time of the onset'.
	  ○ As age can also be included, suggest that the title of the data element be updated to better reflect the information that can be captured for this data element e.g. 'Onset of symptoms or signs'.
	• Pages 39 and 40 – there is the addition of new data element 'Date/time of resolution'.
	  ○ The Description in the table for this data element states, 'Specific or approximate timing when a 'clinician asserts' that the problem or diagnosis is completely and permanently resolved'. What if the patient reports that the problem has resolved? Is the description too restrictive? For the onset of the problem or diagnosis there is no requirement (in the description) for the clinician to assert its occurrence.
	  ○ The Considerations listed in the table for this data element state 'The timing may be represented by an actual date and/or time of onset; an imprecise period during which the onset occurred; or the age of the individual at the time of the onset'.
		Comment noted, no change.
		'Date/time of onset' is the name of the data element, however the description and datatype indicates how the data element can be used. How it is presented at the user interface is dependent on the implementation.
		Comment noted, no change.
		'Date/time of resolution' is a clinically determination that a condition has resolved, based on evidence rather than the disappearance of signs or symptoms.
		Thank you, this has been updated
		Thank you, this has been updated
		Comment noted, no change.
		'Date/time of resolution' is the name of the data element, however the description and datatype indicates how the data element can be used. How it is presented at the user interface is dependent on the implementation.

	○ Suggest that the wording be reviewed, and 'onset' is replaced by resolution'. ○ As age can also be included, suggest that the title of the data element be updated to better reflect the information that can be captured for this data element e.g. 'Resolution of symptoms or signs'.	
AUCDIR2030	Procedure • For clarity – procedure appears to cover what some would say are investigations e.g. electrocardiogram (ECG). It is not clear where interventions such as echocardiogram and echo stress tests fit vs an ECG based stress test? For example, echo is perhaps deemed an imaging exam and therefore diagnostic? While ECG is not a procedure it is an investigation which many would say an Echocardiogram is as well. • Functional status/disability assessment is part of the international summary – some of this may actually fall within the problems/diagnosis. • When reviewing in the context of a patient summary, the items that would deliver value to the patient summary but do not appear to be part of the AUCDI release 1 scope include: ○ Ethnicity (in the overview of AUCDI scope 5.4.2 it mentions more specifically ATSI status which may fit under Ethnicity?) ○ Languages ○ Family member history ○ Care team members • The patient summary goal is to facilitate more informed consistent care and understanding the clinical relevance of these additional pieces of	Comment noted, no change. • Diagnostic investigation such as ECG, echo stress stest and ECG based stress test are in scope for the Procedure data group, however the request and the results of the investigations would be represented in different data groups. • Recording functional status will require multiple data groups, including ADL assessments, IADLs, Barthel index, etc. which are already on the AUCDI backlog. The conclusions of the assessments may be diagnoses and so will fall under the Problem/Diagnosis data group. • Agree. These are on the AUCDI backlog. • Agree. These are on the AUCDI backlog.

	information may not be viewed the same by all clinicians. Ethnicity and languages are important as ethnicity can indicate risk factors that are relevant to clinical decision making (and should not be assumed). Along with languages, is important to understand to ensure the provision of culturally safe care for these individuals.	
AUCDIR2030	• In terms of family history, this is similar to past medical history as it indicates risk factors – and part of the goal of the patient summary is providing consistent information up front to clinicians and reducing the need for clinicians to seek the information from patients or other sources. • Care team members would include both clinicians and community providers and the individual's carers – important to know this information to help guide discussions, understand decision making (does the person have an Enduring Power of Attorney (EPOA) etc), and can sometimes give better visibility of a patients longstanding relationship with another care provider and therefore ensure care is handed over, or not duplicated. • Advance Care directives – it mentions to be part of the summary, but it could be part of a broader item 'administrative' which could include Next of Kin, statutory decision maker, EPOA (health and financial) etc. All important information needed for a patient summary. • Suggest consideration be given to the inclusion of Social History (health behaviours) and Plan of Care (chronic disease management) in scope for Release 1 as per the International Patient Summary to better	Comment noted, no change. Agree. All suggested data groups/elements are on the AUCDI backlog. The data groups included as part of 'Patient Summary' were identified as priority by the CDG as this focus was on the 'necessary information' to support a Patient Summary at this time, but that the data groups will grow in align with clinical requirements overtime.

	support information sharing for the purposes of evaluating and planning health services and public health (preventative) interventions. • Proposed clinical content for data elements appears correct however for Problem and Diagnosis summary, there is a need to ensure the data elements guide both current diagnosis/issue and prompts all past medical history as well. • Agree with the detail about prioritising Past History of Illness and labelling this as Past Medical History. • Great to see inclusion of person informatics/demographics, cardiovascular disease risk, vaccination administration, vital signs, problem/diagnosis and biomarkers to support information sharing for the purposes of evaluating and planning public health services.	
AUCDIR2030	• Opportunities for future development for Vaccination 8.4.3 including batch and expiry may also benefit from the addition of a new data field of 'brand'. This aligns with the Australian Immunisation Record/PRODA requirements of documentation (https://www.servicesaustralia.gov.au/view-vaccination-provider-reports?context=20#accordion1). Dataset nomenclature can be from Australian Medicines Terminology (AMT). • Consider mapping of CSIRO's SNOMap dataset with the Emergency Data Collection's SNOMED CT codes. • Whilst Sex Parameter for clinical use was is listed in the backlog, variation of sex characteristics may need to be included. • Section 8.2.4 for future consideration:	Comment noted, no change. • Noted, these are on the AUCDI backlog • Noted. SNOMED CT-AU Is the preferred national terminology for clinical care and a mapping to ICD-10AM may be required for reporting requirements, funding and classification purposes in acute care. This is out of scope for AUCDI. • Specific variations of sex characteristics would be expected to be recorded as a problem/diagnosis e.g. Klinefelter syndrome, Turner syndrome, Androgen Insensitivity Syndrome, 5-alpha reductase deficiency, Congenital Adrenal Hyperplasia. • Noted. Cause of injury and Aetiology is on the backlog. • Intervention would be considered not specific enough to be an alias of Procedure name.

	○ Suggest a data element for aetiology and manifestation to indicate cause and affect relationships between diagnoses and/or sequelae of injury or disease. • Section 8.3.3 Procedure name, Alias(es) ○ Suggested alias 'intervention' or 'procedural intervention' • As this is a National Data Summary, should there be a flag or events log included relating to consumers under a treatment authority via Mental Health Act 2016?	• Notification, flags, or event logs are an implementation issue and are out of scope for AUCDI, however, the underlying data groups that could be used to drive these functions may be developed in the future for inclusion in AUCDI.
AUCDIR2030	• The current AUCDI Backlog document currently includes a 'Personal Safety Summary' as a new backlog item for consideration, as provided at – AUCDI Backlog – Sparked (csiro.au). ○ The 'Personal safety summary' currently includes one consideration of 'childhood trauma'. ○ It is recommended that a new consideration of 'history of domestic, family and sexual violence' (DFSV) also be added to the 'personal safety summary' item. ○ Consideration of how the health service system responds to victim-survivors who disclose or are at risk of DFSV, particularly in a hospital setting is important. ○ Given the focus at the national level of the need of health service systems to appropriately recognise, respond and refer to victim-survivors of DFSV, it is important that data on DFSV is collected and considered.	Comment noted, added to backlog. Thank you for the suggestions. We agree and these have been added to the backlog.

	○ This is supported by the recent release of two position statements, namely the Joint position on family violence by regulators of health practitioners, published by the Queensland Office of the Health Ombudsman (OHO), Australian Health Practitioner Regulation Agency (AHPRA) and the National Boards, the Health professionals Councils Authority, Health Care Complaints Commission and New South Wales Councils, and the publication of the position statement on family violence in Queensland by OHO. ○ [AUCDIR2030] currently collects data on episodes of admitted patient care for assault by family member by month and sex, public and private hospitals each month.	
AUCDIR2030	• Suggest consideration of comorbidities and multimorbidities to provide for more dynamic information capture to improve public health intelligence and information for action to better guide public health effort through targeted investment. • This dataset seems to be focussed on Episodic Inpatient separations. It lacks any primary care and preventative data.	Comment noted, no change. Noted and thank you for your feedback. Comorbidities and multimorbidities is an implementation issue dependent on the context and use case which leverages the problem/diagnosis data group. AUCDI is context and use case agnostic, so designating a problem/diagnosis as a comorbidity from the view of a user is out of scope for AUCDI. AUCDI contains data groups that are context and use case agnostic, designed to collect data across the healthcare continuum.
AUCDIR2030	• The document would benefit from having worked examples of how the future AUCDI language will function in practice for both primary clinical use and secondary use of data. Providing realistic scenarios would help readers better understand the tangible	Comment noted, no change. Consumer journeys have been developed as part of the AU Patient Summary development. These can be found on the Sparked website. Thank you for the suggestion, we agree that data collected at the point of care should flow into secondary use

	benefits AUCDI will bring to the healthcare system and patients. Additionally, these examples would provide much needed context and clarity to inform and shape constructive feedback from a wider audience. ○ i.e. primary clinical use: a patient visits a new specialist/hospital or secondary use for quality assurance: clinician/healthcare professional wants to conduct quality assurance study, or secondary use for research: a researcher wants to access data for a specific purpose. ○ To provide maximum clarity, these examples should show scenarios before and after AUCDI implementation. This comparative approach would help readers visualise the challenges AUCDI addresses and the improvements it will bring to the healthcare system and patient outcomes.	of data. Sparked presented at the AIDH on a case study looking at a patient data story from point of care to population health. We will look to incorporate that into our resources.
AUCDIR2030	• The datasets identified in the AUCDI [e.g. problems/diagnosis; adverse immunisation register information; sex/gender; pregnancy and menstrual information] may include identifying patient information ['confidential information' as defined in s.139 of the Hospital and Health Boards Act 2011 (Ql) (HHB Act), and accordingly, there must be an identified authority under Part 7 of the HHB Act to: ○ disclose data within the department/Hospital and Health Services (HHSs) for collation for the AUCDI report; and ○ disclose data outside the department/HHSs for the purpose for the AUCDI report. • With respect to standardisation of clinical nomenclature to improve interoperability of systems,	Comment noted, no change. AUCDI is a use case agnostic data standard and not a reporting specification. Agree that privacy and confidentiality is important however sharing or disclosing of information between services is an implementation issue, out of scope for AUCDI. Noted, thank you for the feedback.

	[AUCDIR2030] would strongly support the approach proposed in the AUCDI document for review – wide adoption and recognition of SNOMED CT – AU. ○ The Australian College of Nursing recently published a position statement (link to media release below), promoting the importance of standard terminology in nursing (SNT) related activity/interface with digital systems and software. ○ Without computerised coded nursing care data/information, health services and systems planners have no way of being able to accurately and consistently collect, analyse and demonstrate nursing's contribution to patient safety and health care outcomes to collect, analyse, and measure critical aspects of nursing care. (https://www.acn.edu.au/wp-content/uploads/media-release-acn-calls-for-national-standardised-nursing-terminology-snt-to-improve-nursing-data-collection.pdf)	
AUCDIR2030	• Suggest an editorial review prior to publication e.g.: ○ Page 8 - Spelling error in the definition for HL7. 'Heath' should be 'Health'. ○ Page 72 - Purpose – typo: the word 'dated' should be 'date'. ○ Page 77 - Spelling error in the first paragraph below the table. 'representatons' should be 'representations'.	Typographical error corrected. Thank you for the feedback. Document has been updated.