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Advance Care Planning
My Health Record Conformance Profile

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1 Introduction

1.1 Purpose

This document summarises the requirements for producing systems and consuming systems of Advance Care Planning documents that connect to the My Health Record System.

This document lists the specific conformance requirements for Advance Care Planning documents that are in addition to the common conformance profile for clinical documents [NEHTA2015]. Together, both documents represent the complete conformance requirements for Advance Care Planning documents.

1.2 Intended Audience

The intended audience includes the following:

- Healthcare Providers;
- Vendors and developers of connecting systems; and
- Software test laboratories.

1.3 Scope

The scope of this Conformance Profile is the use of Advance Care Planning documents in the context of the My Health Record System.

An Advance Care Planning document is created by an authoring Clinical Information System (CIS) or a consumer portal.

The Advance Care Planning document is a Clinical Document Architecture (CDA) document that contains a single PDF attachment of a copy of the Advance Care Planning document.

The following roles may be performed by software systems:

- Advance Care Planning Document Producing System – A software system used by a healthcare provider or healthcare individual to create and upload the Advance Care Planning document.
- Advance Care Planning Document Consuming System – A software system that can download and render an Advance Care Planning document.

2 Relevant Specifications

Related detailed conformance requirements are listed below:

1. Clinical Documents - Common Conformance Profile [NEHTA2015] provides common conformance requirements that must be adhered to unless specifically contradicted in this document.

2. eHealth Advance Care Planning Structured Content Specification [DHA2017a] specifies the data elements and constrained values for an Advance Care Planning document at a logical level.

3. eHealth Advance Care Planning CDA Implementation Guide [DHA2017b] specifies the mapping from the structured content specification into an Advance Care Planning document using an HL7 CDA structure.

3 Conformance Requirements for Advance Care Planning

This document summarises the requirements for producing systems and consuming systems of Advance Care Planning documents that connect to the My Health Record System. It lists the specific conformance requirements for Advance Care Planning documents that are in addition to the common conformance profile for clinical documents [NEHTA2015].

This section describes the conformance requirements specific to Advance Care Planning documents when used in communication with the My Health Record system.

These Advance Care Planning requirements focus on the upload of a PDF version of a pre-existing Advance Care Plan.

3.1 Requirements for Document Producing Systems

In this section, the term "producing system" refers to software that creates and prepares the Advance Care Planning CDA document for upload to the My Health Record System. It is often the same software that uploads the CDA document.

023512	**Producing Systems** The Producing System SHALL NOT be a: • Registered Repository • Registered Provider Portal
Priority	Mandatory
Additional Notes	Clinical Information System (i.e. a Healthcare Provider CIS), registered consumer portal and CSP System can be document providers by permitting a clinical document (PDF) to be attached to a CDA document and facilitating the upload of that CDA package.

023590	**Document conformance levels** The document sent to the My Health Record System SHALL conform to the requirements of the following conformance level: • 3A as defined in the *Clinical Documents – Common Conformance Profile* [NEHTA2015].
Priority	Mandatory

024980	**Confirm author's personal electronic communication details to be included**
	If the producing system captures the personal electronic communication details (e.g. email address, phone number or fax number) of the document author, the individual electronic communication details SHALL NOT be automatically included unless stated otherwise.
Priority	Conditional
Additional Notes	Software that don't provide this option can conform to this requirement by not automatically inserting individual's personal electronic communication details into the document as appropriate. The software can also demonstrate conformance by not capturing the individual's personal electronic communication details in the CIS.

023513	**Single valid clinical document**
	The software SHALL upload the document to the My Health Record system as a new document and SHALL NOT upload the document as a superseding document.
Priority	Mandatory
Additional Notes	Updated documents should be uploaded as a new and unique document to alleviate any potential issues regarding currency and validity.

027151	**Labelling attachment author**
	The software SHALL record, in the narrative, the attachment author and the attachment author SHALL be recorded as "Author of the advance care planning document".
Priority	Mandatory

027152 **Labelling contact number**

When known, the software SHALL record in the narrative, one and only one contact phone number for the attachment author and the contact phone number SHALL be recorded as “Contact number for the author of the advance care planning document”.

Priority Mandatory

027153 **Labelling contact details**

The software SHOULD record, in the narrative, contact details such as additional phone numbers, email addresses and addresses associated with the document author.

Priority Recommended

027154 **Labelling Date attachment written**

The software SHALL record, in the narrative, the date the attachment was written as “Date advance care planning document was written”.

Priority Mandatory

027490	**CDA document as a PDF packaged attachment**
	The document SHALL reference one, and only one, attachment that is an electronic representation of the clinical document. The attachment SHALL be a PDF packaged attachment.
Priority	Mandatory
Additional Notes	This requirement applies only to attachments that are clinical documents and not to other attachments (e.g. a company logo). The attachment is in PDF format to ensure the presentation and rendering is as expected by the author. The PDF file is expected to be viewable by the healthcare individual and any healthcare provider that is a My Health Record participant. For example, PDF file should not have any of these features: - Encryption - Password protection - Printing or copying restriction - Embedded fonts (as not all PDF viewers support them)

027491	**Relaxation for mandatory HPI-I for a healthcare provider author**
	If the CDA document author is a healthcare provider the value of one document author entity identifier SHALL be a HPI-I if one is available to the authoring system, otherwise it SHALL have a value that identifies the document author and the value SHALL not be an absent value. See requirement 27576 for information about absent values.
Priority	Conditional
Additional Notes	It is permissible for a healthcare provider or organisation to upload an advance care planning document written by the individual or by a representative. This relaxation supports the ability for a healthcare organisation to upload advance care planning documents in situations where the document was not prepared by a healthcare provider.

027600	**No abnormal values**
	When recording a nullFlavor, the document SHALL only contain absent values according to requirement 27576.
Priority	Mandatory
Additional Notes	The document is not to contain a nullFlavor value other than those described in requirement 27576. See the structured content specification [DHA2017a] for more information on abnormal and absent values.

027576	**Permissible absent values**
	When including an absent value for any element in the document, the absent value SHALL only be one of the following: NI - No information UNK - Unknown ASKU - Asked but unknown NAV - Temporarily unavailable NASK - Not asked MSK - Masked NA - Not applicable
Priority	Mandatory
Additional Notes	See section C.4 in the structured content specification for more information [DHA2017a].

027575	**Mandatory values**
	When producing the clinical document, the following elements SHALL be provided and SHALL NOT contain an absent value: • Subject of care > Family name • Subject of care > Sex • Subject of care > Date of birth • Subject of care > Indigenous status • CDA document author > Electronic communication details for the organisation (if healthcare provider) • CDA document author > Electronic communication details for the individual (if not healthcare provider) • Advance care information > Related document > Document author > Family name
Priority	Mandatory
Additional Notes	This requirement overrides the CDA Implementation Guide when uploading the document to the My Health Record system. See requirement 27576 for more information about absent values.

027599	**Related document author electronic communication details**
	When instantiating Related document > document author > Electronic communications details the software MAY provide an absent value or omit the element from the document.
Priority	Mandatory
Additional Notes	This requirement relaxes the CDA Implementation Guide when uploading a document to the My Health Record system. See requirement 27576 for information about abnormal values.

027601	**Support for upload by care agency employees** The document SHALL permit a care agency employee identifier to be stored as the document author's identifying number.
Priority	Mandatory
Additional Notes	In some cases, the author of the document may be a care agency employee whose identity is not associated with an IHI or HPI-I. The care agency employee identifier may be used instead of an IHI or HPI-I.

3.1.1 On screen warnings and help text

027489	**Displaying help text** If the software is required to display help text, according to this document, then that help text SHALL be displayed at the point of upload and for each and every upload, or prior to each download, depending on the requirement and the action to be performed.
Priority	Mandatory
Additional Notes	Help text and warnings are to be displayed on each occurrence of document upload and downloads to ensure the uploader/downloader is informed of their legal obligations for uploading and reading Advance Care Information.

023514	**Display text to advise for automated system notifications**
	If the software is a CIS, the software SHALL provide help text to remind Healthcare Providers to recommend that the healthcare individual opts to receive email or SMS notifications from the My Health Record system when changes are made to the Individual's Advance Care Planning document on the My Health Record system. The help text SHALL display: "Healthcare Providers should recommend patients/clients choose to receive SMS or email notifications whenever Advance Care Planning documents are uploaded, reinstated or removed from their My Health Record."
Priority	Mandatory
Additional Notes	Healthcare individuals need to be aware of any changes made to their Advance Care Planning documents. This is due to the nature of the document (life and death decisions), and the implications it can have to the medical treatment they receive.

029554	**Display text to advise the need for an Individual's instruction**
	If the software uploading an Advance Care Planning document is a CIS, the software SHALL provide help text and that help text SHALL display: "Healthcare Providers can only upload Advance Care Planning documents when instructed by the patient/client".
Priority	Conditional
Additional Notes	To ensure Healthcare Providers are aware that, under Rule 32A of the My Health Records Rule 2016, they may only upload advance care planning information where the healthcare individual instructs them to do so.

029555	**Display text to advise on recipient's obligations**
	When authoring the document narrative, the software SHALL insert the following text in the document narrative: "Healthcare providers may have state and territory-specific legal obligations when reading Advance Care Planning documents stored on an individual's My Health Record".
Priority	Mandatory
Additional Notes	This help text will be inserted into the CDA document narrative by the authoring system to ensure Healthcare Providers are aware that they may have state and territory-specific legal obligations when reading Advance Care Planning documents. This reflects consultation across all jurisdictions when the advance care functionality was introduced. The software may also include this text in the attachment as well as (not instead of) the CDA document narrative.

023507	**Display text to advise about informing Advance Care Document Custodians**
	The software SHALL provide help text to advise the user that the Advance Care Document Custodian should be informed whenever an Advance Care Planning document is uploaded or removed from the healthcare individual's My Health Record. If the software is a CIS then the help text SHALL display: "If you change any advance care planning document(s), including uploading or removing documents from the My Health Record, you should recommend the individual informs their Advance Care Document Custodian." If the software is a registered consumer portal then the help text SHALL display: "If you change any advance care planning document(s), including uploading or removing documents from your My Health Record, you should inform your Advance Care Document Custodian."
Priority	Mandatory
Additional Notes	It is important that the Advance Care Document Custodian is aware of the currency of the individual's Advance Care Planning documents.

023595	**Display text to advise about malicious content** If the software is a registered Consumer Portal, the software SHALL provide help text to the person uploading the document to refrain from uploading inappropriate or malicious content. The help text SHALL display: "To ensure inappropriate or malicious content is not uploaded, you should keep all your computer security measures and OS (operating system) regularly updated. Run your anti-virus and anti-spyware software often and use them to scrutinise all downloaded files before you open them. Delete dangerous files and malware immediately."
Priority	Mandatory
Additional Notes	The My Health Record system is unable to verify the content of a file that is uploaded, creating a risk that inappropriate files containing malicious content could be uploaded to a My Health Record.

023593 **Display text to advise who can upload**

If the software is a registered Consumer Portal, the software SHALL provide help text to cover the following points:

- Healthcare individuals should be encouraged to keep a copy of Advance Care Planning documents and discuss Advance Care plans with their family members, friends, care givers and providers;

- Healthcare individuals should be encouraged to keep the Advanced Care Custodian record in the My Health Record system up-to-date;

- It should be clear that any person who can access the record is able to view Advance Care Planning documents.

The help text SHALL display:

- "You should provide a copy of your advance care planning document to your doctor and to someone to hold on your behalf (a custodian for the document), and discuss your advance care plans with your family members, friends, care givers and providers."
- "We recommend that you keep the Advance Care Document Custodian record in the My Health Record system up-to-date."
- "Once you have uploaded your document(s) to your My Health Record, healthcare providers that are connected to the My Health Record system and any representatives you may have will be able to see your advance care planning document(s). These documents are important and will be available to anyone who can access your My Health Record."

Priority Mandatory

Additional Notes Individuals should be made aware of their options with regard to Advance Care Planning documents, as well as what they should be doing to ensure future health planning.

027393	**Display text to advise healthcare individuals**
	If the software is a registered Consumer Portal, the software SHALL provide help text to advise that people other than the healthcare individual can upload and view Advance Care Planning documents. The help text SHALL display: "Healthcare providers, individuals, Authorised Representatives and Full Access Nominated Representatives can upload and view advance care planning documents on a My Health Record."
Priority	Conditional
Additional Notes	Other people (such as Authorised Representative, A Full Access Nominated Representative or Healthcare Provider) besides the healthcare individual should be made aware of their options with regard to Advance Care Planning documents, as well as what they should be doing to ensure future health planning.

023508	**Display text to advise documents may not be legally binding**
	If the software is a registered Consumer Portal, the software SHALL display on screen advice that the wishes expressed in an Advance Care Planning document may not be legally binding to Healthcare Providers. The help text SHALL display: "You should be aware that there are variations in state and territory laws which may affect the way in which a healthcare provider is able to respond to your advance care planning document(s)."
Priority	Mandatory
Additional Notes	Each State and Territory of Australia legally recognises Advance Care Planning documents differently. All healthcare individuals should be informed of these legal limitations.

023594	**Display text to advise on limitation on information added to a My Health Record** If the software is a registered Consumer Portal, the software SHALL display information about the limitations of Advance Care Planning document added to a My Health Record. The help text SHALL display: "You, or people acting on your behalf (such as an Authorised Representative or Full Access Nominated Representative) can add your advance care planning documents to your My Health Record. Your document(s) should be: • Written in English, signed and dated by you; • Scanned in PDF format and saved on a computer; • Uploaded to your record (from the 'add an advance care planning document page) from a computer; and • Received by you to make sure it displays correctly on the screen – check that no pages are missing and the document is the right way up. You should be aware that not all healthcare providers are able to access your My Health Record and are not obligated to access it where they do have access. You should not rely on your My Health Record as the only place in which you make your future healthcare wishes known."
Priority	Mandatory
Additional Notes	Healthcare individual's need to be made aware of the implications of adding Advance Care Planning documents to a My Health Record.

3.2 Requirements for Document Consuming Systems

An Advance Care Planning document may be consumed by:

- Clinical Information Systems;
- CSP Systems;
- Registered Consumer Portals;
- Registered Provider Portals; and
- Registered Repositories.

023511	**Display text advising no guarantee of safety of attached file** The software SHALL display advice that the My Health Record System Operator can make no guarantees as to the safety of file content uploaded by third-parties. Healthcare Individuals and Healthcare Providers download and display the attachment at their own risk. The help text SHALL display: "My Health Record System operator makes no guarantees as to the safety of file content uploaded by third-parties. Individuals and healthcare providers download and display the attachment at their own risk."
Priority	Mandatory
Additional Notes	The My Health Record system is unable to verify the content of a document that has been uploaded to the My Health Record, therefore there may be some risk that document consuming systems may be vulnerable to malicious code contained within documents.

Acronyms

Acronym	Description
CDA	Clinical Document Architecture
CIS	Clinical Information System
CSP	Contracted Service Provider
HL7	Health Level Seven

Glossary

Term	Meaning
Clinical Document Architecture (CDA)	An HL7 standard intended to specify the encoding, structure and semantics of clinical documents for exchange.
Clinical Documents (archived)	These are the documents with clinical information available in the Consumer and provider portals. These include: Shared Health Summary, Event Summary and Discharge Summary
clinical information system (CIS)	A system that deals with the collection, storage, retrieval, communication and optimal use of health related data, information, and knowledge. A clinical information system may provide access to information contained in an electronic health record, but it may also provide other functions such as workflow, order entry, and results reporting.
conformance	A measurement (by testing) of the adherence of an implementation to a specification or standard.
contracted service provider (CSP)	A third-party organisation that supplies health software as a service to healthcare organisations.
Health Level Seven (HL7)	HL7 provides standards for the exchange, management and integration of data that supports clinical patient care and the management, delivery and evaluation of healthcare services. Specifically, HL7 creates flexible, cost effective approaches, standards, guidelines, methodologies which enable healthcare information system interoperability and sharing of electronic health records.
healthcare individual	An individual who is, or could be, the subject of care in the context of a healthcare event.
producing system	A software system that has the role of generating and issuing conformant clinical documents suitable for use by other digital health participants.
registered consumer portal	A third-party portal used by consumers to access information on the My Health Record system that is registered with the My Health Record system as a registered portal operator.
registered provider portal	A third-party portal used by healthcare providers to access information on the My Health Record system that is registered with the My Health Record system as a registered portal operator.

Term	Meaning
registered repository	A third-party repository used to store clinical documents and other clinical data that connects to the My Health Record system. A repository may store clinical documents in either a proprietary format or a CDA format.
SHALL	This word, or the term REQUIRED, means that the statement is an absolute requirement of the specification. Source: Network Working Group, 1997, *RFC2119 - Key words for use in RFCs to Indicate Requirement Levels*.
SHOULD	This word, or the term RECOMMENDED, means that there may exist valid reasons in particular circumstances to ignore a particular item, but the full implications must be understood and carefully weighed before choosing a different course. Source: Network Working Group, 1997, RFC2119 - *Key words for use in RFCs to Indicate Requirement Levels.*

References

[NEHTA2015]	*Clinical Documents - Common Conformance*, Version 1.6, NEHTA, 2015
[DHA2017a]	*Advance Care Information Structured Content Specification,* Version 1.0, Digital Health Agency, 5 April 2017
[DHA2017b]	*Advance Care Information CDA Implementation Guide,* Version 1.0, Digital Health Agency, 5 April 2017