Australian Government

Australian Digital Health Agency

Goals of Care
My Health Record Conformance Profile

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1 Introduction

1.1 Purpose

This document summarises the requirements for producing systems of Goals of Care documents that connect to the My Health Record System.

This document lists the specific conformance requirements for Goals of Care documents that are in addition to the Common Conformance Profile for Clinical Documents [DHA2015]. Together, both documents represent the complete conformance requirements for Goals of Care 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 Goals of Care documents in the context of the My Health Record System.

A My Health Record Goals of Care document is created by an authoring Clinical Information System (CIS).

The My Health Record Goals of Care document is a Clinical Document Architecture (CDA) document that contains a single PDF attachment of a copy of the Goals of Care document.

The following roles may be performed by software systems:

- My Health Record Goals of Care Document producing system – A software system used by a healthcare provider to create and upload the Goals of Care CDA document.
- My Health Record Goals of Care Document consuming system – A software system that can download and render a Goals of Care document.

2   Relevant specifications

Related detailed conformance requirements are listed below:

1. Clinical Documents - Common Conformance Profile [DH2015] provides common conformance requirements that must be adhered to unless specifically contradicted in this document.

2. My Health Record Advance Care Information Content Specification [DH2017a] specifies the data elements and constrained values for a Goals of Care document at a logical level. The Goals of Care clinical document re-purposes the Advance Care Information specification.

3. My Health Record Advance Care Information CDA Implementation Guide [DH2017b] specifies the mapping from the structured content specification into a Goals of Care document using an HL7 CDA structure. The Goals of Care clinical document re-purposes the Advance Care Information specification.

3 Conformance requirements for Goals of Care

This document summarises the requirements for producing systems and consuming systems of Goals of Care documents that connect to the My Health Record System. It lists the specific conformance requirements for Goals of Care documents that are in addition to the common conformance profile for clinical documents [DHA2015].

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

These Goals of Care requirements focus on the upload of a PDF version of a Goals of Care document.

3.1 Requirements for document producing systems

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

028744	**Producing systems**
	The Producing System SHALL NOT be a:
	• Registered Repository
	• Registered Provider Portal
	• Consumer Portal
Priority	Mandatory
Additional Notes	Clinical Information System (i.e. a Healthcare Provider CIS) and CSP systems can be document providers by permitting 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* [DHA2015].
Priority	Mandatory

024980   **Confirm individual electronic communication details to be included**

Software SHALL allow document authors to confirm which (if any) of their individual electronic communication details (e.g. email address, phone number or fax number) may be automatically included. The default SHALL be to include no details.

Priority   Mandatory

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.

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)

028630   **Document Author Entity Identifier value**

When instantiating the document author, the document SHALL contain one and only one personal identifier that is a Healthcare Provider Identifier for Individual (HPI-I), otherwise it SHALL have a value that identifies the document author, and that value SHALL NOT be a nullflavor.

Priority   Mandatory

Additional Notes   The relaxation of the mandatory requirement to include an HPI-I is only available to specific healthcare provider organisations, at the discretion of the My Health Record System Operator.

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].

028732   **Mandatory values**

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

- 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.

028720   **Goals of Care document title**

When instantiating the document title, the software SHALL ensure that:

ClinicalDocument/title

contains the value "Goals of Care Document".

Priority	Mandatory
Additional Notes	The Advance Care Information Implementation Guide specifies the following xpath for document title:

ClinicalDocument/title

This requirement overrides the Implementation Guide.

028733   **Goals of Care Conformance Template**

When instantiating ClinicalDocument/templateId the software SHALL ensure that:

- one instance of the root attribute of the templateId element SHALL be "1.2.36.1.2001.1001.100.1003.100001"; and

- The extension attribute of the templateId element SHALL be "1.0".

Priority	Mandatory

028734   **Goals of Care document sub-type**

When instantiating the document type, the software SHALL ensure that:

Advance Care Information Section > Related Document > Document Details > Document Type

contains the value "100.32016".

Priority	Mandatory
Additional Notes	This requirement over-rides the CDA Implementation Guide by enforcing one and only one permissible value (Goals of Care Document) and is documented in the following link:

https://healthterminologies.gov.au/fhir/ValueSet/advance-care-planning-document-type-1

028735   **Goals of Care section title**

When instantiating the following section title:

ClinicalDocument/component/structuredBody/component/section[code/@code='101.16973']/title

the software SHALL use the value:

"Goals of Care Section"

Priority   Mandatory

Additional Notes   This requirement overrides the Implementation Guide.

3.1.1   Help text during authoring and uploading

This section describes help text requirements on producing systems.

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 Goals of Care documents.

028725 **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 Goals of Care 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 Goals of Care 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 Goals of Care 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.

028726 **Display text to advise the need for an Individual's instruction**

If the software is a CIS uploading a Goals of Care document, the software SHALL provide help text and that help text SHALL display:

"Healthcare Providers can only upload Goals of Care documents when instructed by the patient/client"

Priority Mandatory

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.

028747   **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 Goals of Care documents stored on an individual's My Health Record."

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 Goals of Care 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.

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.
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*.

Term	Meaning
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

[DHA2015]   *Clinical Documents - Common Conformance*, Version 1.6, Digital Health Agency, 2015
[DHA2017a]   *Advance Care Information Structured Content Specification,* Version 1.0, Digital Health Agency, 2017
[DHA2017b]   *Advance Care Information CDA Implementation Guide,* Version 1.0, Digital Health Agency, 2017