



**Advance Care Document Custodian
My Health Record Conformance Profile v1.0**

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Product version history

Product version	Release comments
v1.0	Initial release as a standalone document. It was previously part of the <i>PCEHR Conformance Profile for Consumer Entered Information Clinical Documents</i> and titled " <i>Advance Care Custodian Record</i> ".

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1 Introduction

1.1 Purpose

This document lists the specific conformance requirements for the Advance Care Document Custodian record that are in addition to the *Clinical Documents - Common Conformance Profile* [NEHTA2015a]. Both documents represent the complete conformance requirements for Advance Care Document Custodian record.

1.2 Intended audience

This document is intended for the following organisations:

- 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 Document Custodian record in the context of the My Health Record system, that is, in a “point-to-share” environment.

2 Advance Care Document Custodian

This section describes the conformance criteria specific to the Advance Care Document Custodian record.

2.1 Relevant specifications

Related specifications are listed below:

1. *Advance Care Directive Custodian Record Structured Content Specification* [NEHTA2011a]
2. *Advance Care Directive Custodian Record CDA Implementation Guide* [NEHTA2011b]

2.2 Objects of conformance

027375 Types of producers

An Advance Care Document Custodian record **SHALL** only be produced by:

- Registered consumer portals
- Registered care agency employee portals

Priority Mandatory

Additional Notes Care agency employee portals are only available to employees who have a care agency employee identifier assigned to them. A care agency employee is typically not a healthcare provider.

2.3 Conformance criteria for producers

027376 Document conformance levels

A CDA document sent to the My Health Record system **SHALL** conform to the requirements for one, and only one, of the following conformance levels: 3A or 3B, as defined in *Clinical Documents - Common Conformance Profile* [NEHTA2015a].

Priority Mandatory

027246 Support for authorship by care agency employees

The Advance Care Document Custodian record **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 an individual's Advance Care Document Custodian record may be a care agency employee whose identity is not associated with an IHI. The care agency employee identifier may be used instead of an IHI.

Glossary

Acronyms

Acronym	Description
CDA	Clinical Document Architecture
HL7	Health Level Seven

Glossary terms

Term	Description
Clinical Document Architecture (CDA)	An HL7 standard intended to specify the encoding, structure and semantics of clinical documents for exchange.
conformance	Conformance is a measurement (by testing) of the adherence of an implementation to a specification or standard.
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.

References

- [NEHTA2011a] *Advance Care Directive Custodian Record Structured Content Specification*, version 1.0, NEHTA, 9 Dec 2011
- [NEHTA2011b] *Advance Care Directive Custodian Record CDA Implementation Guide*, version 1.0, NEHTA, 9 Dec 2011
- [NEHTA2015a] *Clinical Documents – Common Conformance Profile*, version 1.6, NEHTA, 2015