Australian Government
Australian Digital Health Agency

RACP
Specialists. Together
EDUCATE ADVOCATE INNOVATE

The Royal Australasian College of Physicians

My Health Record

Best Practice Guide

For physicians in private practice and rural and remote settings

Australian Government
Australian Digital Health Agency

RACP
Specialists. Together
EDUCATE ADVOCATE INNOVATE

Contents

Australian Government
Australian Digital Health Agency

RACP
Specialists. Together
EDUCATE ADVOCATE INNOVATE

About this guide

This guide is designed to assist physicians working in private practice, and rural and remote settings, to implement and use My Health Record within your organisation. Implementation of My Health Record can take time and regular use is required to realise its benefits.

This guide outlines:

- registration and connection guidance
- policy and procedures, including current regulatory obligations and requirements
- systems security and access requirements, including a password policy
- staff training guidelines, including staff agreement procedures and access templates.

In developing this guide, the RACP has sought the insights and input from members currently using My Health Record. Their views are incorporated throughout this guide.

This guide has been developed by the RACP in partnership with The Australian Digital Health Agency (The Agency).

The Agency is System Operator under the My Health Records Act 2012. The Agency has a range of training and resources available to support you and your practice staff with My Health Record (see pages 20 & 21).

My Health Record overview

My Health Record is a secure, online summary of a patient's health information. It can be accessed throughout Australia and all Australians can elect to have a record. As a physician, you can access My Health Record through conformant clinical information software (CIS) to view and add your patient's key health information, including:

- medical history
- diagnosis
- discharge summaries
- medications (including medication name, dose and reason for medication)
- prescription and dispensing records
- pathology and diagnostic imaging reports.

My Health Record is personally controlled by each patient. This means that your patient can enter and access personal health summary documents and notes (for example, allergy and adverse reactions information), advance care planning documents and custodian details, emergency contacts, and childhood development documents.

Both you and your patient can access the Medicare Benefits Schedule (MBS), Pharmaceutical Benefits Scheme (PBS), Australian Organ Donor Register (AODR) status and Australian Immunisation Register (AIR) records.

Snapshot of My Health Record Statistics as of August 2021

There are 23 million records

Used by 95% of public hospitals

Source: Australian Digital Health Agency website

With a majority of the Australian population now having a My Health Record and more key clinical information flowing into the system, use by Australian healthcare providers has become more prevalent and worthwhile.

Before you decide to use My Health Record, it is recommended that you consider its challenges and benefits when it comes to your practice, patients and the broader healthcare system. Some private practice physicians are hesitant to implement My Health Record due to the time required to establish the systems and policies that accompany it. However, this time investment is not dissimilar to implementing any new system within a practice, and My Health Record offers significant efficiencies and other benefits once in use. These include:

- streamlining information to enable quicker diagnoses
    - makes patient information quickly and easily accessible

    - reduces time spent looking for and receiving information about patients from other providers (e.g. patients with chronic diseases)
- helping to improve clinical decision-making
- avoiding duplication of tests, scans, diagnostics, and other services
- reducing adverse events for your patients
- enhancing patient self-management
- lessening administrative burdens of gathering information
- assisting with medicine reconciliation tasks and prescribing
- providing access to patient immunisation records quickly
- improving patient safety and value
- providing oversight and view of medications.

My Health Record is designed to connect you with information at the point of care, which means less time spent trying to locate missing documents and clinical information.

Use of My Health Record for pathology and diagnostic information can also reduce unnecessary test duplication. Evidence shows that using electronic health records can reduce test duplication by 18%. My Health Record is estimated to reduce pathology test duplication by 6.5% and diagnostic imaging tests by 4.4%.[1]

Broader benefits of My Health Record

'My Health Record now includes discharge summaries from almost all public hospitals in Australia. This is important because the people more likely to be in emergency departments of public hospitals are Australia's more disadvantagedpeople. By making this health information readily available to healthcare providers, we may improve continuity of care and contribute to a decrease in hospital admissions and improved health outcomes.

Furthermore, since people can see their own My Health Record, we can review their records with them, contributing to better understanding of healthconditions, building health literacy.'

- Dr Rosalie Schultz, FAFPHM

Along with breaking down social and economic inequalities when it comes to healthcare, My Health Record affects broader positive change within the healthcare system and from an overall

economic viewpoint. For example, it can provide healthcare practitioners with access to vital patient information in an emergency.

In 2018-19, there were 11.5 million hospitalisations across public and private hospitals.[2] The most common reason for admission to hospital is for other factors influencing health status, which includes examinations, investigations, observation, evaluation, screening, immunisation and other health management.[3] The timely access to information allows for patients with complex and multiple comorbidities to receive better coordinated care, which correlates to reduced hospitalisation and number of readmissions.[2]

From an environmental perspective, electronic health records such as My Health Record reducethe use of paper. In addition, electronic health records aim to complement telemedicine solutions such as telehealth and e-prescribing, making patient consultations more efficient and reducing the need for in-person consults. In turn, this reduces carbon emissions associated with travel and the maintenance of clinic space.

My Health Record removes jurisdictional boundaries seen with state-based records, and provides patients with health autonomy, allowing them to access their health care information easily. The jurisdictional reach of My Health Record removes some of the geographical and sociocultural barriers in healthcare, especially for those patients in rural and remote areas of Australia.

My Health Record provides specific health information that can contribute to improved clinical decision-making, support continuity of care, and avoid duplication of tests. The medication safety benefits may also reduce the risk of prescribing errors; according toresearch ‘up to 50% of medicine-related hospital admissions are potentially avoidable.’[2]

Case studies

Before understanding the technical and procedural aspects of My Health Record, consider the following case studies that demonstrate its benefits in your practice.

Patient and practice benefits when using My Health Record shared health summary

Dr Susan McKinnon is an endocrinologist who provides fly-in fly-out clinical services at Alice Springs Hospital.

She has a patient consultation with a new patient, Jack. Before the consultation, Dr McKinnon allows time to prepare which helps her optimise the time she has with patients. Preparation for consultations involve reviewing her patient's current medical condition and their past medical history, as well as their current or recent use of medications and any immunisation information.

Jack's shared health summary within My Health Record has recently been updatedby his GP in Alice Springs. His record shows Dr McKinnon, under medical history, that he has just last month been diagnosed with type 2 diabetes.

Dr McKinnon invites Jack into her consulting room. After having a yarn, Dr McKinnon says, "I can see you live in Wilora. Is that where you've come from?"

"Yeah, sure is. It's about a two- and half-hour drive," he shares.

"That's a long drive, so let's make the most of our time today. I've read your shared health summary and can see that you've recently been diagnosed with type 2 diabetes," says Dr McKinnon.

"Yeah, that's right. I was pretty crook."

"I can see here from the medication record that you are taking Metformin. Your prescription is for 1 tablet (500 mg) daily with an evening meal. Is that right?"

Jack nods his head. "Yeah, that's right."

For the remainder of the appointment, Dr McKinnon is able to focus on Jack's progress to date. She uses the time more efficiently to chat with Jack about how he is feeling now that he is on the medication. She goes over his recent blood test results found in My Health Record. Dr McKinnon finds it helpful using this time to put together an ongoing management and treatment plan for his type 2 diabetes.

Viewing a more complete medical history

Jonah, a 45-year-old man, presents to a South Australian hospital with an unconfirmed diagnosis of acute intermittent porphyria associated with recurrent abdominal pain. He had previously been on a regime of high dose morphine administered by injection daily. However, onreviewing his record of past treatment in Jonah's My Health Record, the hospital pain specialist finds a long history of negative test results for porphyria. Given the involvement of morphine in his current regime, the pain specialist decides to refer this case to an addiction medicine specialist.

Further investigation of Jonah's discharge summaries in My Health Record reveal that, in addition to being prescribed injectable morphine, Jonah's drug use history included daily cannabis use. The combined morphine dependence and cannabis use had triggered multiple and frequent presentations to the emergency department.

The addiction specialist concludes that Jonah's principal problem was not one of chronic non-cancer pain in isolation, but recurrent pain, distress and dysfunction experienced in the context of long-term opioid dependence. The addiction medicine specialist decides to admit Jonah into the alcohol and drug service inpatient withdrawal unit to address Jonah's long-term opioid dependence and facilitate a sublingual combination buprenorphine naloxone treatment.

Streamlining information to enable quicker diagnoses

Mary, a 35-year-old woman from Brisbane, has been referred to an endocrinologist with an overactive thyroid. She has had a nuclear scan which is showing no uptake in the gland. It is notimmediately clear why her thyroid gland is overactive. Mary's endocrinologist has decided to check her My Health Record to ensure she hasn't been prescribed any thyroid hormone that she may be taking. After checking the current medicines information on Mary's My Health Record and following Mary's confirmation that she does not take any other medicines or supplements, her endocrinologist makes an informed decision that Mary is not taking any medication that may result in her overactive thyroid. However, her endocrinologist was able to see that she had recently been in the local hospital.

Mary did not think this was relevant to her overactive thyroid. She had not thought to mention this to her endocrinologist, as it was a regular procedure to manage a rare disease, Gorlin Syndrome. Gorlin Syndrome causes recurrent cystic structures in different parts of Mary's body.Her dentist inserts gauze into her maxillary sinus every couple of months to manage and suppress inflammation in the maxillary sinus.

Further investigation into the gauze used determined that it contains iodine, which was stimulating her thyroid to be overactive and reducing the uptake within the gland.
While Mary's endocrinologist knows that he probably would have been able to identify the cause of Mary's overacting thyroid, using My Health Record has made this process a lot quicker and easier.

Prepare for My Health Record

'Take one thing at a time. Start with what you can get from the system and then onceyou are familiar with the system, see how you can contribute more.'

- Dr Gregory Katsoulotos, FRACP

This section covers what is required to prepare effectively to register and connect to My Health Record. To connect to My Health Record, your practice will need to:

1. Determine how to participate (registration type, i.e. seed or network organisation).
2. Assign roles and responsibilities in your practice.
3. Become familiar with your legislative requirements.
4. Decide on the type of access required.
5. Comply with legislative requirements (including establishing a My Health Record securityand access policy).
6. Undertake and maintain staff training.

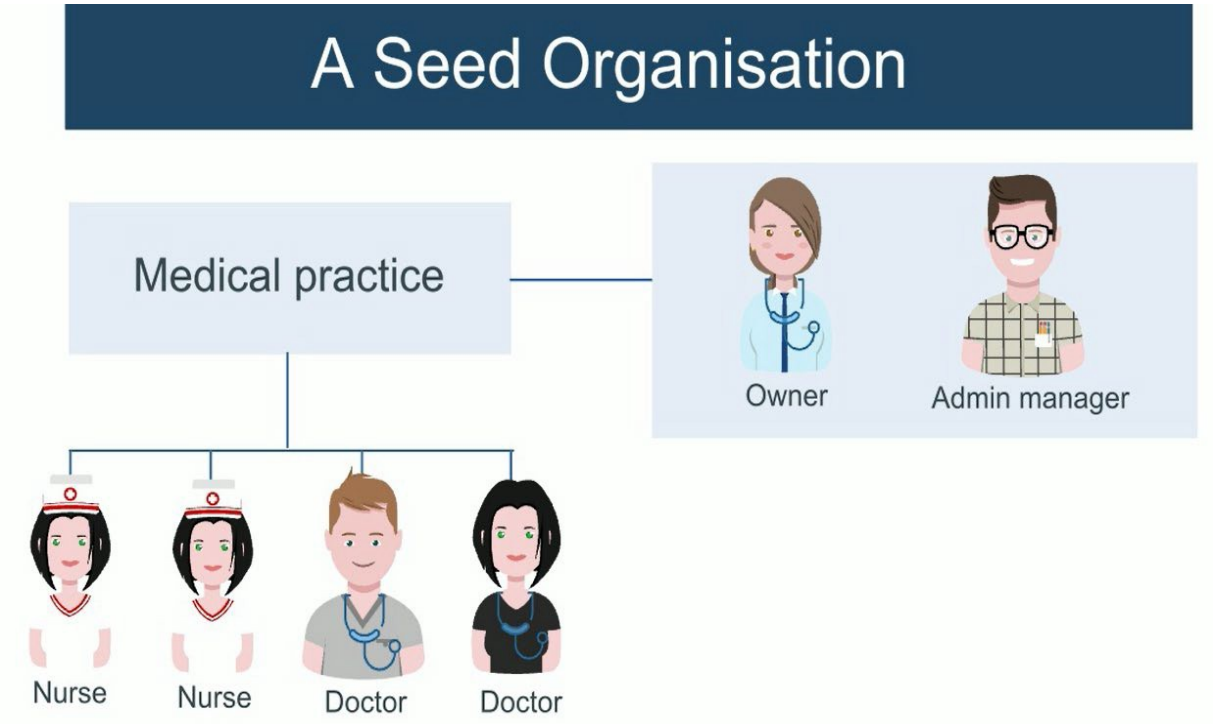
Determine registration type

There are two types of registrations within the Healthcare Identifiers Service (HI Service) and My Health Record:

- **Seed organisations** are entities which provide or control the delivery of healthcare services. Within a network of healthcare organisations, the seed organisation is the principal entity of the hierarchy. Examples of seed organisations could include a sole practitioner, small practice, aged care facility, hospital head office, or an aged care headoffice.

- **Network organisations** stem from the seed organisation. They commonly represent different departments or divisions within a larger complex organisation (e.g. a hospital ormultidisciplinary healthcare practice). They can be separate legal entities from the seed organisation, but do not need to be legal entities in their own right.

Most physicians in private practice will participate as a seed organisation in My Health Record (see example below).



Assign roles and responsibilities in your practice

Before registering your practice, you will need to establish staff roles and responsibilities as they relate to interacting with My Health Record and the HI Service. These roles are set out below.

The HI Service has been established by the Australian Department of Health as a foundation service for e-health initiatives in Australia, including My Health Record.

A healthcare identifier is a unique 16-digit number assigned to individuals, healthcare providers, and organisations that provide health services, it is used on health information records, such as My Health Record to clearly identify who is involved in a patient/ client's care. There are three types of identifiers:

Individual Healthcare Identifier (IHI) allocated to individuals enrolled in the Medicare programor issued a Department of Veterans' Affairs treatment card and others who seek healthcare in Australia (e.g. tourists, visa card holders).

Healthcare Provider Identifier – Individual (HPI-I) allocated to health professionals involved inproviding patient/client care.

You would have received your HPI-I from Ahpra. If you haven't received this correspondence, you can obtain your HPI-I via the Ahpra website using your login account or by calling Ahpra on 1300 419 495.

Note: If you know your Ahpra user ID, simply add 800361 to the front of ID to get your HPI-I.

If your healthcare organisation is registered with the HI Service, your organisation maintenance officer (OMO) (as described in the table on the next page) can retrieve your HPI-I from Health ProfessionalOnline Services (HPOS) for you, provided you have consented to have your details published inthe Healthcare Provider Directory (HPD).

If you are not familiar with the HI Service terms and rules, refer to the information onthe Services Australia website. Registration in the HI Service is essential to use My Health Record.

Roles and responsibilities summary

Role	Responsibilities to the Healthcare Identifiers (HI) Service	Responsibilities to My Health Record
Responsible officer (RO) is registered with the HI Service and has authority to act on behalfof the organisation. This is usually the business owner of a private practice, or in a hospital setting, the Chief Executive Officer.	• Register a seed organisation • Maintain the HPI-O (Healthcare Provider Identifier – Organisation) • Maintain their own RO details • Maintain OMO details • Maintain links between the seed organisation (and any network organisation/s) and any contracted service provider.	• Authorise the addition/removal of HPI-Os • Adjust My Health Record access flags forparticipating organisations within their hierarchy • Set HPI-O/HPI-I authorisation links
Organisational maintenance officer (OMO) acts on behalf ofthe organisation and completes day-to-day administration. This role can be assigned to a practice manager or other seniorstaff who are familiar with the practice's clinical and administrative systems.	• Maintain their own OMO details • Request PKI certificate(s) (or link existing one) • Request a NASH via HPOS • Register a network HPI-O for network levels below • Register OMO details for network levels below • Validate, link or remove linked HPI-Is to HPI-O(s) they are linked to • Publish HPI-O details in the Healthcare Provider Directory (HPD) for HPI-Os they are linked to • If required, maintain a list of authorised employees within the organisation who access the HI Service.	• Set and maintain My Health Record accessflags according to the organisational networkhierarchy • Act on behalf of the seed and network organisation(s) according to the hierarchy • Maintain accurate and up-to-date records of the linkages between organisations within their network hierarchy.

Other digital health roles and responsibilities

In addition to the RO and OMO, you may want to consider who fills the following roles within your practice in relation to My Health Record:

- **Authorised employee (HI Service):** An individual within an organisation who requires access to individual health identifier records and provider identifiers from the HI Service to assist with patient administration.

- **Authorised employee (My Health Record):** A person authorised by a healthcare organisation to access My Health Record on behalf of the organisation. Authorised users may be individual healthcare providers and other local users who have a legitimate need to access My Health Record as part of their role in healthcare delivery.

Become familiar with your Commonwealth legislative requirements

As part of your organisation's legislative requirements of participating in My Health Record, it is recommended that healthcare providers also become familiar with the legislation listed below. Visit the Australian Government Federal Register for Legislation website for more information.

- *My Health Records Act 2012*
- *My Health Records Rule 2016*
- *My Health Records Regulation 2012 (Cth)*
- *Healthcare Identifiers Act 2010 (Cth)*
- *Healthcare Identifiers Regulations 2010 (Cth)*
- *My Health Records (Information Commissioner Enforcement Powers) Guidelines 2016*
- *Privacy Act 1988* – particularly the Australian Privacy Principles (APPs)

Privacy

Establishing and maintaining information security practices is an essential professional and legal requirement when using My Health Record. Physicians have professional andlegal obligations to protect patients' health information.

Authority to upload information

Under the My Health Records Act 2012, healthcare provider organisations are authorised to upload and view information to My Health Record. Generally, this means that healthcare providers do not need to obtain consent prior to uploading information to a My Health Record when providing services to a healthcare consumer.

There may be instances where your patient may specifically ask that a report or other information is not uploaded to their My Health Record. In this situation, you must comply with your patient's final decision and not upload the information.

You should only indicate that a report not to be shared with My Health Record if your patient requests this. You should also not upload reports if the information may cause a serious threat to the life, health or safety of a patient.

If a patient changes their mind about a report upload, after it has been sent to their My Health Record, they can do one of the following:

- they can remove the report online or with the support of My Health Record helpline (1800 723 471)
- they can apply a limited document access code to the report, which will prevent it from being viewed by providers unless they have the code.

In the event a 'do not upload to My Health Record' request is made regarding an investigation report, the reason for this decision should be documented in the CIS or patient record.

Limitations on uploading health information

Healthcare providers cannot upload health information about a healthcare recipient if:

- the healthcare recipient provides advice that they do not want a particular record, all records or a particular class of records (e.g. prescription information) uploaded to My Health Record, or

- they have not obtained consent where it must be provided in a particular way under a state or territory law that is identified in My Health Records regulations. These laws are as follows:

    - sections 56 and 92 of the *Public Health Act 2010* of New South Wales
    - sections 55, 77 to 79, 105 to 107, 175 to 177, 220 to 222, 238 to 240 and 266 to 268 of the *Public Health Act 2005* of Queensland
    - sections 110 and 111 of the *Public Health Act 1997* of the Australian Capital Territory.

These laws generally require express or written consent for disclosure of sensitive health information such as a diagnosis of HIV or sexually transmitted diseases. The content varies by jurisdiction and only applies to healthcare providers in that jurisdiction. This restriction doesn't apply to documents which are uploaded from the Medicare system. Healthcare providers are generally aware of their obligations under local legislation and have business processes and practices in place to support this.

Where uploading of documents is automated in clinical information systems, it is important that these systems and business processes accommodate any exceptions appropriately.

Patients may choose to enable My Health Record privacy settings to control which healthcare organisations can access their records. Currently, however, less than 0.2% of My Health Recordusers use privacy controls. If privacy settings are enabled, providers cannot access certain documents, or the entire record, unless the patient provides them with an access code.

In an emergency where the patient is not able to provide their access code, My Health Record offers emergency access.

Establish security and access policies

Once you are clear on who in your practice meets the requirements for using the HI Service andMy Health Record, this is an opportune time to establish policies and procedures to underpin your team's use of these systems, and train yourself and your team in how to use them. You may also choose to develop these policies and skills while waiting for your registration to be processed.

The My Health Record website has extensive resources for setting policies and upskilling in using My Health Record:

- Registering your organisation
- Specialist practice training and resources
- Security practices and training checklist

As part of the legislative requirements to participate in My Health Record, your organisation needs to have a policy that addresses the areas outlined below.

My Health Record security and access policy

As part of your organisation's legislative requirements to participate in My Health Record, you will need to implement the following security practices and policy prior to registration and connection.

My Health Record Security and Access Policy template (see appendix) addresses the requirements for health provider organisations to have a written policy as detailed in rule 42 of *My Health Records Rule 2016*. Consider whether this template meets your needs prior to implementing it in your practice.

You must communicate this policy and ensure it remains readily accessible to all your employees, including contractors.

The policy should be version controlled and reviewed annually as a minimum standard. If you are audited, you should be able to advise who within your organisation has accessed My Health Record.

Managing user accounts

For the security of patient and clinical records, organisations must ensure access to only those who are authorised to access My Health Record. The Managing User Accounts Policy and Register template (see appendix) will help you to manage user accounts and access.

Staff training

All staff accessing My Health Record as part of their role within the organisations are required toundergo training before accessing the system. The Staff Training Register template (see appendix) can help keep an accurate and up-to-date record of staff training, and ensure that ongoing training for staff is provided at the right time.

The Australian Digital Health Agency has a range of My Health Record training opportunities available for you and yourstaff including:

- eLearning modules
- clinical software simulators
- software summary sheets.

For more information on education and training support, visit the Agency website.

Handling of data breaches

When using My Health Record, your organisation is required to have a procedure that allows staff to inform management of any suspected security or privacy issues, or breaches of My Health Record.

An incident register/log should be kept of any suspected breaches including:

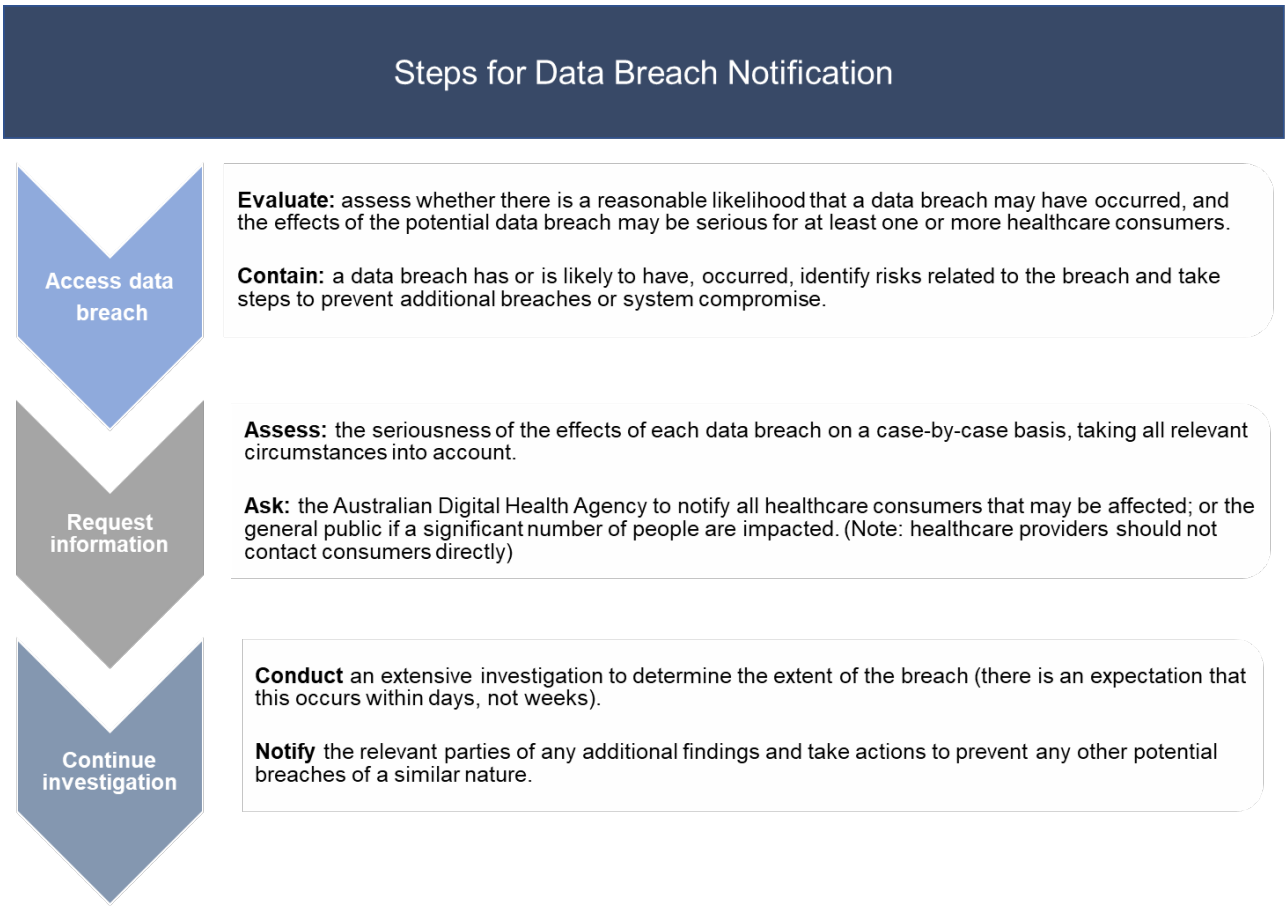
- details of the date and time of the breach
- the user account that was involved
- the patient's information that was accessed (if known).

Entities using My Health Record must notify System Operator(the Australian Digital Health Agency) of any potential or actual data breaches, as soon as possible, even if the data breach has already been resolved.

The RO or OMO is responsible for reporting a breach to the System Operator and will need to ensure a process for notifying a data breach is in place.

Data breach incident register and log template and data breach notification form template (see appendix) may be useful in registering and logging data breaches.

The main steps for reporting data breaches are outlined on the following page.



Risk assessments

It is best practice to conduct periodic privacy and security risk assessments of staff use of My Health Record and your organisation's ICT systems, and implement any improvements as required. Ensure all risk assessments are documented appropriately.

Register for My Health Record

Refer to the instructions in the My Health Record Implementation Guide for specialist practices to register with My Health Record.

Create a PRODA account

Provider Digital Access (PRODA) is an online identity verification and authentication system used to securely access government online services.

To access Health Professional Online Services (HPOS), at least one member of your organisation must register for a PRODA account. Anyone who works in healthcare services is eligible to apply for a PRODA account.

For more information, visit the Services Australia website.

Register for My Health Record in HPOS viaPRODA

It is the responsibility of the RO to register for the HI Service and My Health Record.

The key requirement to register as an individual practitioner with an HPI-I is to have an Australian Business Registration.

Register your organisation with the HI Service

Healthcare identifiers

You will need to enable access to the HI Service in your conformantclinical software to:

- access My Health Record
- validate patients' Individual Healthcare Identifiers (IHIs)
- use Secure Message Delivery
- use electronic prescriptions.

Visit the My Health Record website and read the step-by-step instruction to set up healthcare identifiers in your clinical information system.

Register as a seed organisation

You can register your seed organisation via HPOS, which is accessible via the PRODA portal. To register as a seed organisation with the HI Service and My Health Record, you will need a HPI-O. Registering as a seed organisations will give your organisation a HPI-O.

To register a seed organisation in the HI Service:

- log on to PRODA, select **Go to Service** on the **HPOS** tile
- select **My programs** then **Healthcare Identifiers and My Health Record**
- select **Healthcare Identifiers - Register seed organisation**
- follow the steps to register your seed organisation.

For more information on how to register as a seed organisation, visit the Services Australia website.

Register as a network organisation

You will need to register as a seed organisation before adding one or more network organisations with the HI Service and My Health Record. This step is only relevant if your organisation operates under a complex structure (e.g. hospital departments).

To add network organisations to your seed organisation:

- log on to PRODA, select **Go to Service** on the **HPOS** tile
- select **My programs** then **Healthcare Identifiers and My Health Record**
- select **Manage Healthcare Identifiers**
- select the seed or network organisation the organisation will be under
- follow the prompts to create your network organisation.

For more information on how to register as a network organisation, visit the ServicesAustralia website.

Access My Health Record

There are two ways your organisation can access My Health Record:

- **Conformant clinical software** allows authorised healthcare providers to upload, view and download information and documents.

- **National Provider Portal** allows authorised healthcare providers to view and download information and documents.

Conformant software

Access via conformant software will require you to have a National Authentication Service for Health (NASH) public key infrastructure (PKI) certificate, which is a digital certificate that authenticates an organisation whenever they access My Health Record using conformant software.

You can apply for a NASH PKI certificate via HPOS. Find out how to apply for a NASH PKI Organisation Certificate.

The My Health Record Conformance Register lists software products and the versions that havebeen assessed for conformance with the national digital health requirements. This register

shows which clinical software has the capability to upload various clinical documents and access various My Health Record views.

National Provider Portal

If you do not have conformant software, you can access your patient's My Health Record through the National Provider Portal (NPP) that allows read-only access. To use the NPP, you must have a PRODA account and your HPI-I must be linked to your organisation's HPI-O.

The process for setting up access to the NPP is outlined within the Accessing My Health Recordvia the National Provider Portal Factsheet.

For more information, visit the My Health Record website for a demonstration of how, once registered and connected, to login to the National Provider Portal and view the information available in a patient's My Health Record.

Education and support

The Australian Digital Health Agency has a range of training and resources available to support you and your practice staff with My Health Record:

Education and training sessions

The Agency can also provide face-to-face education and training tailored to your healthcare setting. To organise a session or enquire directly, you can submit an education and training request form.

eLearning modules

Online training modules are available for specialists working across a range of healthcare settings. Each module introduces My Health Record and outlines its benefits, features and functionalities. Enrolment is free and the platform can be accessed via https://training.digitalhealth.gov.au/enrol/index.php?id=24.

Clinical software simulators and demonstrations

'Sandboxes' can simulate viewing and uploading clinical information to a fictional patient's My Health Record using different clinical software products. To access, go to https://onlinetraining.digitalhealth.gov.au/ and use the login details below:

- Username: OnDemandTrainingUser
- Password: TrainMe

Summary sheets

There are a range of demonstrations and summary sheets with step-by-step instructions for viewing a My Health Record and uploading clinical information through different conformant clinical software are available on the Agency website.

Webinars and events

Recording from previous webinar events on a range of digital health topics can be found on theAgency website.

Primary Health Networks

The Agency may engage the Primary Health Networks (PHNs) to assist physicians and other health practitioners with My Health Record. Check with your local PHN to see if they offer support for registering with My Health Record.

RACP resources

Digital health resources including webinars, curated collections and podcasts have been developed and curated to assist fellows and trainees to better understand digital health initiatives, including My Health Record, and provide opportunities for further learning and professional development.

To download these resources, visit the RACP website.

View and contribute clinical information

Any healthcare provider involved in your patients' care and who is authorised by the healthcareorganisation can access that patient's My Health Record.

Event summaries

An event summary captures key health information about significant healthcare events that are relevant to your patient. An event summary is intended for use by physicians who are not the patient's regular physician, to give information about a patient's significant healthcare event/s (for example receiving travel immunisations) or to indicate a change in their health status (for example the end of wound management).

The types of events recorded in an event summary will vary and across healthcare sectors there will be different common scenarios. Some examples of where an event summary is helpfulincludes when seeing travelling/transient patients, patients receiving an after-hours medical service, patients receiving travel immunisations or a flu vaccine, patients receiving a service from a healthcare provider who is not authorised to upload a shared health summary and event summaries.

An event summary may be used to indicate a clinical intervention, improvement in a condition orthat a treatment has been started or completed.

An event summary may contain:
- allergies and adverse reactions
- medicines
- diagnoses
- interventions
- immunisations
- diagnostic investigations.

You can see an example of an event summary at the following link: Example of an event summary.

Create an event summary

Each conformant software type has its own individual method for creating event summaries but document layout will be consistent across any software platform. Any healthcare provider at anyparticipating healthcare organisation that has a Healthcare Provider Identifier - Individual (HPI-I)such as an after-hours GP clinic, hospital, community pharmacy or an allied health organisation
- can upload an event summary to an individual's My Health Record (if they have clinical software with this functionality).

You may upload an event summary or a specialist letter providing details of the diagnosis. This could include the specialist's recommendations, medicine review and diagnostic investigation results.

The information contained in an event summary should be in a format that can be understood by healthcare providers outside of your own organisation. It should describe and summarise thepresentation of the event, the assessment made, and the action taken. As per standard practice, all clinically relevant information should be recorded and saved in the patient's local notes.

If you decide to create an event summary, it should be one of the final tasks at the end of the consultation, after you have entered a progress note, updated medical history and made any changes to the patient's medication regime in the local record.

Shared health summaries

The shared health summary is a clinical document that can be uploaded when you are involvedin the patient's care. Usually, specialists would view the share health summaries, rather than upload these, as ordinarily this is an action taken on by a patient's GP.

A shared health summary represents the patient's health status at a point in time, and may include information such as:

- medical conditions
- medicines
- allergies and adverse reactions
- immunisations.

You can see an example at the following link: Example of a shared health summary.

Create and view a shared health summary

A shared health summary can only be created and/or viewed by a patient's nominated healthcare provider (as defined in My Health Records Act 2012). Nominated healthcare providers can be:

- a registered medical practitioner
- a registered nurse
- an Aboriginal and Torres Strait Islander health practitioner with a Certificate IV in Aboriginal and/or Torres Strait Islander Primary Health Care.

A patient can have only one nominated healthcare provider at a time, who should be delivering coordinated and comprehensive care to the patient. A provider who is not the patient's usual provider could use an event summary instead to upload clinically relevant information to the patient's My Health Record.

An agreement must be in place between you (as the healthcare provider) and your patient that stipulates that you are the patient's nominated healthcare provider for the purpose of authoring/creating the shared health summary. The agreement can be in either verbal or writtenform.

The provisions around who can be a nominated healthcare provider only relate to authoring/creating a shared health summary. Another employee in the organisation can upload the document on behalf of the author/creator.

Upload a shared health summary

It is best practice to upload a shared health summary when completing a patient health assessment, particularly for patients with comorbidities and chronic conditions.

Edit or delete a shared health summary once it is uploaded

As the author of a clinical document, you can delete a clinical document from My Health Record if has been uploaded in error or contains a mistake.

If you wish to change the information in the patient's shared health summary, (e.g. the medicines listed) you will need to upload a new shared health summary with the updated information.

Sections 4.5.3 and 5.4 of the AMA Guide to Using PCEHR provide recommendations to medical practices in these and related areas.

Discharge summaries

'One patient told me he recently had an allergic reaction to a drug in hospital but couldn't recall the name. Pre-My Health Record we would have had to contact the hospital and await the discharge summary. With My Health Record I discovered in just one minute that it was Keflex which helped me guide antibiotic prescription during this consult'

– Dr Gregory Katsoulotos, FRACP

When a discharge summary is created, it will be sent directly to the intended recipient, as per current practices. When a hospital is connected to My Health Record, a copy of the discharge summary can also be sent to the patient's record. If you work in a hospital that may be connected to My Health Record, speak to the health information manager about the capability of uploading a discharge summary.

Refer to the list below to see the list of hospitals registered and uploading to My Health Record:

- Public hospitals
- Private hospitals

You can see an example of a discharge summary here: Example of a discharge summary

Immunisation view

The consolidated immunisation view in the My Health Record displays your patient's immunisations from the Australian Immunisation Register (AIR) and those that are recorded in your patient's shared health summaries and event summaries.

The immunisation view includes an immunisation history, which captures the data of immunisation or diseases, vaccine details including batch number and serial number, does and a link to the source or original document.

The immunisation view is available via conformant clinical information systems and the National Provider Portal.

You can see an example of a discharge summary here: Example of an immunisation view

Medication records

Pharmacies connected to My Health Record have the capability to upload dispensing records. These medication records are displayed in the Prescription and Dispense View within My Health Record.

- View example of a prescription record
- View example of a dispense record
- View example of the Prescription and Dispense View.

Medicines information

The Medicines Information View can quickly sort, and display medicines information held in a patient's My Health Record in date or alphabetical order.

Information in the Medicines Information View is gathered from:

- the patient's most recent (and up to two years') prescription and dispense records and other PBS claims information
- the patient's most recent shared health summary and discharge summary
- recent event summaries, specialist letters and eReferral notes uploaded to the patient's record since their latest shared health summary, and
- the patient's personal health summary that may include any allergies or adverse reactions and other key information.

If available, a link to the pharmacist shared medicines list (PSML) will also be provided in the Medicines Information View. The PSML is a list of all medicines the patient is known to be taking (prescribed, over the counter and complementary medicines) at the time the list is created and uploaded to the patient's My Health Record, by a pharmacist.

The 'Medicines Information' view is available under the Documents tab in the National Provider Portal.

This view can be found in most CIS under the Other Documents list, and in the Documents tab of the National Provider Portal. Please contact your CIS software vendor if you are unable to access the Medicines Information View.

You can benefit from the Medicines Information View by reducing the time usually required to search through recent summaries or relevant documents to find information about a patient's medications. The medicines information view can also assist in the transition of care and medicines management for patients between their treating doctors and pharmacists.

Prescription and dispense records

Prescription and dispense records contain information about medicines prescribed. The recordsalso provide details about the healthcare provider that prescribed the medicine and the healthcare provider organisation that was visited.

These records may include:

- medication brand name and strength prescribed
- generic medication name
- dosage instructions
- maximum number of prescription repeats
- the date the medication was prescribed
- the prescription expiry date.

These records can be viewed in My Health Record as clinical documents and arealso displayed in the Prescription and Dispense View of the system and in the Medicines Information View, so that individuals and their healthcare providers can easily view details of their prescribed and dispensed medicines.

The Prescription and Dispense View can display the name of a medicine, the strength of the medicine, the direction for consumption and the form of the medicine prescribed. It can also display the date a medicine has been prescribed, the date it has been dispensed, and the number of repeats available on the prescription.

Upload a prescription or dispense record

Where you prescribe medication, and where the software has the functionality to prescribe, a prescription record will be uploaded to the patient's My Health Record. If you wish to not uploadthe prescription record (e.g. where the patient requests that it not be), there is typically a 'Do notsend to MHR' or 'Send to MHR' tick box in the software which they will need to tick/untick.

Specialist letters

A specialist letter is the document used by treating specialist to respond to a GP about a referred patient. The letter contains key information about a patient's visit such as diagnoses and medications.

When a specialist letter is created, structured fields give physicians the ability to include information such as:

- patient recommendations
- medications and medication review
- adverse reactions; and
- diagnostic investigations.

Click here to view an example of a specialist letter.

eReferral letters

An eReferral can be securely shared between healthcare providers to include medical records. Referrals are an important clinical process. In Australia, there are many forms of referral-relatedcommunications with the majority originating from GPs to specialists. You can see an example of an eReferral here: Example of an eReferral.

The Agency's eReferral specification supports the seamless exchange of significant patient information from one treating healthcare provider to another via a national system of creating, storing and sharing referral reports.

My Health Record supports the collection of eReferrals. When an eReferral is created it will be sent directly to the intended recipient, as per current practices. A copy may also be sent to My Health Record.

eReferrals can be sent and received directly between healthcare providers (point-to-point), through secure messaging, and/or uploaded to and retrieved from a patient's My Health Record(point-to-share).

When an eReferral is created, structured fields give the sender the ability to include informationabout the patient's:

- current and past medical history
- current medications
- allergies / adverse reactions
- diagnostic investigations (optional).

The Reason for Referral section provides a free text field for the referrer to include additional content regarding the patient's clinical story. As done with paper referrals, this could include a synopsis of the case, presenting problems, the service that is requested, pertinent history or keyphysical findings etc.

Pathology and diagnostic imaging reports

Pathology and diagnostic reports you have requested or have been nominated to receive will besent directly to you using existing processes in your practice. If your patient has a My Health Record, their reports can also be uploaded by the pathology or diagnostic imaging laboratory if the service is connected to My Health Record. The reports will be immediately available to all members of the patient's health care team via My Health Record.

Pathology reports will be available for your patient to view through their My Health Record seven days after the report is uploaded (except for COVID-19 pathology reports which are available after 24 hours). Diagnostic imaging reports will be available for your patient to view through their My Health Record seven days after the report is uploaded. This gives you time to review the report and contact your patient to discuss the results before they can see them in their My Health Record.

For diagnostic imaging and pathology reports, there may be times when you have not been in contact with a patient before their reports are available to them in their My Health Record. It is recommended that you adopt a general policy whereby you indicate reports that should not be included in a patient's My Health Record when you may not have the opportunity to review the report and contact the patient within seven days.

Benefits of viewing reports in My Health Record

Better access to test results will help your patients and other healthcare providers involved in their care make important treatment decisions that could improve patient care and health outcomes.

Sharing pathology and diagnostic reports to My Health Record will support delivery of improved patient care through:

- improved access to information
- reduction of unnecessary duplicate testing
- time saved trying to locate or request copies of results
- improved relationship with patients.

Patients also benefit from being able to access their reports in their My Health Record. This helps them to:

- keep track of their tests and diagnostic imaging results
- monitor results over time
- access and view pathology and diagnostic imaging reports.

You can view pathology reports which have been uploaded to your patient's My Health Record,including reports ordered by other healthcare providers.

Sensitive results

If the pathology or diagnostic imaging test results could be considered sensitive, you may wish to discuss with your patient they wish to have the report uploaded. If the patient requests that it not be uploaded, you should indicate this on the request form as explained below. Pathology services and diagnostic imaging services will not upload a report to My Health Record where existing state or territory legislation prohibits the disclosure of sensitive information without the express consent of the patient.

Uploading of reports

You can see the list of pathology providers and diagnostic imaging providers that are connected to and sharing information to My Health Record.

Notify providers about not uploading to My Health Record

If you do not want the reports uploaded, or the patient requests that they do not want their reports to be uploaded to their My Health Record, you should notify to the pathology or diagnostic imaging provider by:

- checking the 'Do not send reports to My Health Record' check box in your practice management software, or
- checking the 'Do not send reports to My Health Record' check box on the paper referral form, or
- writing 'Do not send reports to My Health Record' on the request form.

Pathology or diagnostic imaging reports will still be sent directly to you. Pathology and diagnostic imaging services may also add a report to a patient's My Health Record unless the patient requests otherwise. However, patients won't be able to view the contents in the report for seven days (except for COVID-19 pathology reports, which are available after 24 hours).

Services may not be connected to My Health Record

There may be a few reasons why you can't find patient pathology or diagnostic imaging reports in My Health Record. One reason may be because the service is not yet connected to My Health Record.

More pathology or diagnostic imaging services will connect over time. Once they are connected, they will be able to add reports to My Health Record. Participation by pathology laboratories has seen increases with over 1 million reports being shared with My Health Record each week.

Find out which pathology and diagnostic imaging services currently use My Health Record.

Access My Health Record in the hospital system

If you work in a hospital that is connected to My Health Record, contact the health information manager to learn how to access My Health Record via the hospital clinical information system. Providers in public and private hospitals have the opportunity to access My Health Record if the organisation is connected and using a conformant software. If you work in a hospital that is connected to My Health Record, contact the health information manager to learn how to access it via the hospital's clinical information system.

Information that may be available to access includes:

- shared health summaries (which include medications, medical history, allergies and immunisations)
- event summaries (including information about a significant healthcare event)
- MBS and PBS claims
- medication prescription and dispense records
- previous hospital discharge summaries
- advance care planning documents and custodian information.

If the hospital has conformant software, you will be able to upload important health information about your patients such as a discharge summary and pathology and diagnostic reports, which can then be viewed by other hospitals and other healthcare providers involved in their care.

Please note that the majority of documents available for upload within hospital and health services are uploaded automatically by each state/territory health department through normal delivery portals unless the patient has requested otherwise.

Patient access to My Health Record

Patients can access their My Health Record via their myGov account. To create an account, patients can visit the myGov website at my.gov.au and follow the prompts. Patients are able to add information to their My Health Record including:

- information about allergies and adverse reactions, and current medications
- details for future medical care preferences
- entries of important emergency and next of kin contacts
- information to help them keep track of their health
- results of their child's scheduled health checks, childhood development and other useful information.

Patients who have a My Health Record can have a nominated representative or authorised representative help them manage their record, decide which healthcare organisations can access their record, and choose to restrict access to specific information within their record.

A nominated representative is a person the patient has invited through My Health Record to view or help manage their record. They might be a family member, close friend or carer.

An authorised representative is a person who manages My Health Record of someone who cannot manage their own. An authorised representative might manage the record on behalf of achild, or an adult who lacks capacity.

Access for minors under 14 years of age

My Health Record allows parents to manage health information for their children aged under 14.

Parents have access to their child's My Health Record from birth to 14 years of age. When their child turns 14, all authorised representative and nominated representative are removed from the child's record.

Parents can use My Health Record to:

- keep track of their child's information online
- share important health details in an emergency
- get a My Health Record for a newborn
- use privacy settings to control access to their children's My Health Record.

When a parent registers their newborn for Medicare, they can choose that a My Health Record is not created for their child.

Patient support

It is important to offer patients more information about their My Health Record and let them know that the organisation participates. You can do this either prior to a consultation at the time the patient is making an appointment, or you can inform the patient at the beginning of the consultation.

Maintaining data and data quality

It is important to ensure that the information you are entering into your conformant software system is accurate. Data shared by your practice and data you receive from other healthcare organisations may be relied upon for clinical decision-making. Hence, it is important that you design and implement effective arrangements for maintaining quality patient records. Ensuring high-quality medical records is essential to continuity of care. Keep in mind that when entering information into your local medical record keeping system the data will be uploaded to My Health Record.

Consider the following these common data quality domains when entering data in My Health Record.

- *Accuracy*. When entering data in your CIS, ensure it is inputted accurately and within thecorrect fields.

- *Completeness*. Ensure the data is complete, avoid uploading blank documents, and ensure that all data entered is whole. This avoids any gaps in information and ensures the integration between the data in your CIS and My Health Record to be transparent and complete.

- *Consistency*. Consistent use of your CIS ultimately contributes to the validity and qualityof data with My Health Record.

- *Relevance*. check that the data is entered into the relevant fields in your CIS, and that allrelevant documents are uploaded.

- *Legibility*. Ensure that the documentation uploaded into your CIS is legible (i.e., can be easily read by others).

- *Timeliness*. Ensure the data is entered at the time of the consultation or just after to ensure continuity of care.

Tips for maintaining quality health records

How you maintain quality records may vary according to your organisation, structure and working methods. The following are useful approaches:

- Allocate time in non-busy periods to check health records
- Allocate a dedicated resource with medical knowledge to maintain quality health records
- Verify demographic information with the patient before and during a consultation
- Use a printout of the patient health summary to allow the patient to verify its accuracy and suggest amendments between or prior to visits with the clinician
- Upload complete and/or relevant documents to patient records (avoid uploading blank documents)
- Formalise clinical coding and agree standards and conventions for recording patient information on clinical software e.g. using drop-down lists or standard terms

- Record results and assessments in the right place, including diabetes reviews, health assessments, pap smears, mammogram, faecal occult blood screening and internationalnormalised ranges
- Conduct scheduled audits of health records
- Archive the records of inactive and deceased patients
- Use tools through your practice software or middleware solutions.

Data quality is about more than fixing data errors

If data quality improvement is not part of an overall and continuous focus on quality improvement, then your organisation is unlikely to achieve sustainable digital health benefits. Ineffect, your organisation needs a culture of continuous improvement for these benefits to be sustainable. This approach would, among other things, prioritise the prevention of data errors in preference to continual remediation.

Data quality checklist

As part of your organisation's planning for digital health, you should design and implement effective arrangements for maintaining quality patient records.

There is a useful checklist for ensuring good quality data with your patients.

Glossary of terms

Authorised employee (HI Service): An individual within an organisation who requires access to individual health identifier records and provider identifiers from the HI Service to assist with patient administration.

Authorised employee (My Health Record): A person authorised by a healthcare organisation to access My Health Record on behalf of the organisation. Authorised users may be individual healthcare providers and other local users who have a legitimate need to access My Health Record as part of their role in healthcare delivery.

Healthcare Identifiers Service (HI Service): A national system which uniquely identifies healthcare providers and individuals.

Healthcare Provider Identifier – Individual (HPI-I): A unique number assigned to an individualhealthcare provider. There must be at least one employee with a HPI-I in order to register for the HI Service and My Health Record.

Healthcare Provider Identifier – Organisation (HPI-O): A number that is assigned to eligible healthcare organisations once they have registered with the HI Service.

Organisational maintenance officer (OMO): A person who acts on behalf of the organisation and completes day-to-day administration. This role can be assigned to a practice manager or other senior staff who are familiar with the practice's clinical and administrative systems.

National Authentication Service for Health (NASH) Public Key Infrastructure (PKI) certificate: A digital certificate that authenticates an organisation whenever they access My Health Record using conformant software.

Responsible officer (RO): A person registered with the HI Service and has authority to act on behalf of the organisation. This is usually the business owner of a private practice, or in a hospital setting, the CEO.

Appendix: My Health Record forms and templates

The forms and templates listed below can be found on the RACP Digital Health webpage directly below this guide.

1. System Security and Access Policy Template

The template addresses the requirements for health provider organisations to have a written policy as further detailed in rule 42 of My Health Records Rule 2016. Please note that this policy template is intended as a guide only. Please tailor this template to meet the needs of your organisation and remove any type of guiding instructions. This policy template must be kept up to date.

2. Managing User Accounts Policy and Register Template

For the security of patient and clinical records, user accounts need to be monitored when your organisation's practice software and My Health Record are accessed. This will help you to manage user accounts and access to My Health Record within your practice.

3. Data Breach Incident Register and Log Template

An incident register/log should be kept of any suspected breaches, including details of the date and time of the breach, the user account that was involved and which patient's information was accessed (if known). This template may be useful in registering and logging data breaches.

4. Data Breach Notification Form Template

This template can be used to notify relevant organisation(s) and can be submitted to the Australian Digital Health Agency and/or the Office of the Australian Information Commissioner.

5. Staff Training Register Template

All staff requiring access to My Health Record need to undergo training before accessing the system. This template can be used to help you keep an accurate and up-to-date record of staff training and ensure that ongoing training for staff is provided at the right time.

References

1. Australian Institute of Health and Welfare. Hospital care [Internet]. Canberra (ACT): Australian Institute of Health and Welfare; 2020 [updated 2021; cited 30 March 2021]. Available from: https://www.aihw.gov.au/reports/australias-health/hospital-care

2. Roughead EE, Semple SJ. Medication safety in acute care in Australia: where are we now? Part 1: a review of the extent and causes of medication problems 2002-2008. Australia and NewZealand Health Policy. 2009;6(18):1-12.

3. Australian Commission on Safety and Quality in Healthcare. Resource library [Internet]. Sydney (NSW): Australian Commission on Safety and Quality in Healthcare; 2018 [Cited 29 March 2021]. Available from: https://www.safetyandquality.gov.au/publications-and-resources/resource-library/implementation-method-and-clinical-benefits-using-national-electronic-health-records-australian-emergency-departments-literature-review-and-environmental-scan-my-health-record-emergency-departments-project