FOR SPECIALIST PRACTICES

My Health Record

The following guide provides instruction on how to use My Health Record in your practice, including:

- advice on patient consent,
- information on what is in a My Health Record,
- direction on when might be appropriate to access the system, and
- guidance on how to access and view My Health Record.

Together, these steps will support you in accessing and viewing My Health Record, as well as uploading information into the system for those accessing via conformant software.

NOTE: This guide assumes My Health Record systems have been set up in your practice. The My Health Record Implementation Guide provides step-by-step detail to assist in My Health Record set up.

STEP 1 PATIENT CONSENT

STEP 2 WHAT IS IN A MY HEALTH RECORD?

STEP 3 WHEN CAN I USE MY HEALTH RECORD?

STEP 4 MY HEALTH RECORD USE VIA THE NATIONAL PROVIDER PORTAL

STEP 5 HOW TO VIEW AND NAVIGATE MY HEALTH RECORD VIA THE NATIONAL PROVIDER PORTAL

STEP 6 MY HEALTH RECORD USE VIA CONFORMANT CLINICAL SOFTWARE

+ ADDITIONAL MY HEALTH RECORD USE RESOURCES

Australian Government

Australian Digital Health Agency

Patient Consent[1]

DO YOU NEED CONSENT?[2]

The My Health Record legislative framework authorises all registered healthcare provider organisations involved in a patient's care to access and upload information to a patient's My Health Record. Healthcare providers working in healthcare provider organisations can:

- access an individual's My Health Record during, or regarding, a consultation or clinical event involving the individual,
- view all documents in the My Health Record system, unless the patient has placed access control limits on their My Health Record, and
- upload documents to the My Health Record, unless the individual specifically requests the healthcare professional not to upload the document.

This means that you do not need the consent of a patient to view their My Health Record, and you can access an individual's My Health Record outside of a consultation provided access is for the purpose of providing healthcare to that individual. However, it is still worth considering, as part of good medical practice, advising patients that My Health Record may be accessed and uploaded to as part of their treatment.

EMERGENCY ACCESS

There are certain urgent situations where it may be permissible for a healthcare provider to bypass the access code(s) using an emergency access function available through your clinical information system. This is sometimes referred to as a 'break glass' function.

It is expected that the need to use the emergency access function will be rare as emergency access is only authorised under the My Health Records Act if:

- there is a serious threat to the individual's life, health or safety and their consent cannot be obtained (for example, due to being unconscious), or
- there are reasonable grounds to believe that access to the My Health Record of that person is necessary to lessen or prevent a serious threat to public health or safety. For example, to identify the source of a serious infection and prevent its spread.

Use of the emergency access function is recorded in the access history of the My Health Record, which can be viewed by the individual and their authorised or nominated representative(s). With emergency access, any access controls that the individual has set will be overridden. This means you will have full access to their record. However, information that has been entered in the consumer-only notes section of the record, and any documents that the person has previously removed will not be visible.

For more information, review the emergency access fact sheet.

Privacy and Access Controls

Individuals may choose to enable My Health Record privacy settings to control which healthcare organisations can access their My Health Record. They can limit access to their entire My Health Record (using a Record Access Code) or to documents (using a Limited Documents Access Code). The patient will need to provide their access code to a provider for them to access their My Health Record when prompted by their clinical software to do so, unless it is an emergency in which case a provider can use the emergency access functionality.

For more information, see Patient access controls and Emergency access. Currently, the number of individuals opting to use these privacy settings is fewer than 2 out of every 1000 people. Privacy settings do not restrict the ability of a healthcare organisation to upload to My Health Record.

What is in a My Health Record?[3]

Information available through My Health Record can include the records displayed in the table below. The following sections explore the purpose and function of each of these documents:

- shared health summary,
- event summaries,
- advance care planning information,
- pathology and diagnostic imaging reports,
- prescription and dispense records,
- medicines information view,
- Discharge summaries,
- Pharmacist shared medicines list (PSML),
- specialist letters,
- Medicare overview,
- eReferrals, and
- patient-entered information.

SHARED HEALTH SUMMARY

The shared health summary represents the patient's health status at a point in time. Shared health summaries can be created at any consultation (however, are generally created by the patient's GP) and may include information about a patient's medical history, including medical conditions, medicines, allergies and adverse reactions and immunisations. The most recently uploaded shared health summary is likely to be one of the first documents accessed in My Health Record by any other healthcare professional and is of particular relevance when a specialist is seeing a patient for the first time.

LEARN MORE about shared health summaries and see an example.

EVENT SUMMARIES

An event summary captures key health information about a significant healthcare event that may be relevant to the ongoing care of an individual. An event summary may be used to indicate a clinical intervention, improvement in a condition or that a treatment has been started or completed and may include information about allergies and adverse reactions, medicines, diagnoses, interventions, immunisations and diagnostic investigations. Specialists may upload an event summary after performing a procedural intervention, such as a pacemaker insertion or joint replacement.

LEARN MORE about event summaries and see an example.

ADVANCE CARE PLANNING INFORMATION

Patients can add an advance care plan or upload an advance care directive to their My Health Record to record their wishes for future health care and treatment. Patients can also record details of the person who holds a copy of their advance care plan (known as custodian) to their My Health Record. Other advance care planning information that may be added to a patient's My Health Record is a Goals of Care document. The Goals of Care document is usually completed by the treating clinician in consultation with the patient and/or their carer for a specific episode of care. It is good clinical practice to seek confirmation, where possible, that the recorded wishes are current and up to date before acting on them, in case they may have changed. Advanced care planning can help inform specialist treatment, when patients have lost the ability to make decisions about their care.

LEARN MORE about advance care plans.

PATHOLOGY REPORTS

Pathology reports that have been requested or nominated for specialists to receive are sent using existing processes in the specialist's practice. If a patient has a My Health Record, a copy of their pathology reports can also be uploaded to their My Health Record by the pathology laboratory, which enables specialists to see reports they have not requested. Pathology reports will be available for patients to view through their My Health Record seven days after the report is uploaded.

LEARN MORE about pathology reports and see an example overview.

DIAGNOSTIC IMAGING REPORTS

Diagnostic imaging reports that have been requested or nominated for specialists to receive are sent using existing processes in the specialist's practice. If a patient has a My Health Record, a copy of their diagnostic imaging reports can also be uploaded to their My Health Record by the diagnostic imaging provider, which enables specialists to see reports they have not requested. Diagnostic imaging reports will be available for your patient to view through their My Health Record seven days after the report is uploaded.

LEARN MORE about diagnostic imaging reports and see an example overview.

PRESCRIPTION AND DISPENSE RECORDS

Healthcare providers who use clinical software to prescribe and dispense medications can enable the upload of a copy of this information directly to a patient's My Health Record. These medication records can be viewed in the My Health Record system as clinical documents and are also displayed in the Prescription and Dispense View, which allows individuals and their healthcare providers to easily view details of their prescribed and dispensed medications.

LEARN MORE about medication records and see an example of a prescription and dispense view.

MEDICINES INFORMATION VIEW

The medicines information view can quickly sort, and display medicines information held in a patient's My Health Record documents in date or alphabetical order. The 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 Pharmaceutical Benefits Scheme (PBS) claims information,
- the patient's most recent shared health summary and discharge summary,
- recent event summaries, specialist letters and e-Referral notes uploaded to the patient's record since their latest shared health summary,
- the patient's personal health summary that may include any allergies or adverse reactions and other key information, and
- if available, a link to the pharmacist shared medicines list (PSM).

LEARN MORE about the medicines information view, including example previews.

DISCHARGE SUMMARIES

The discharge summary provides a national standard for capturing details of a patient's hospital stay and recommendation for care after discharge. The information contained in the discharge summary is available to the patient's treating doctors, the referring specialist and their community pharmacy to support the continued care of the patient once they are discharged from hospital.

LEARN MORE about discharge summaries and see an example.

PHARMACIST SHARED MEDICINES LIST

A Pharmacist Shared Medicines List (PSML) contains information about the medicines a patient was known to be taking at the time the list was created by the pharmacist. The list includes medicines that have been prescribed to the patient by their doctors and other non-prescription medication that they may be taking (such as aspirin) and other known over the-counter or complementary medicines. A PSML could be created by:

- a pharmacist after completing an in-pharmacy medicine review,
- a pharmacist in preparing a dose administration aid, or
- a hospital pharmacy for patients when they are discharged.

LEARN MORE about PSMLs.

SPECIALIST LETTERS

A copy of the specialist letter can be uploaded to an individual's My Health Record where it becomes a structured electronic document to create an efficient way of displaying key information about the visit, such as diagnoses and medications.

LEARN MORE about specialist letters and see an example.

MEDICARE OVERVIEW

When a patient's My Health Record is created, their Medicare information will be included automatically unless they elect against this action. This can include past (up to two years of prior transactions) and future MBS and PBS (and RPBS) transaction information, their organ donor status (sourced from the Australian Organ Donor Register) and details from their Australian Immunisation Register (AIR) records. These records may be viewed via the My Health Record Medicare overview.

eREFERRALS

My Health Record supports the collection of eReferrals. When a healthcare provider creates an eReferral, it will be sent directly to the intended recipient, as per current practices. A copy may also be sent to the My Health Record system. eReferrals can uploaded to and retrieved from a patient's My Health Record.

LEARN MORE about eReferrals and here to see an example.

PATIENT-ENTERED INFORMATION (INCLUDING CHILD DEVELOPMENT INFORMATION)

- Personal health summary – patients can enter information about allergies and adverse reactions, and current medications into their My Health Record. This data can be viewed by healthcare providers.
- Advance care plans – patients can upload a copy of their advance care plan or advance care directive to their My Health Record. Having this information readily available in My Health Record can help ensure that treatment and care is in accord with patient's preferences.
- Emergency contact details – patients can create a list of important emergency contacts in their My Health Record, which is visible to healthcare providers.
- Personal health notes – patients can enter information to help them keep track of their health, like a health journal or aide memoire. The system dates each note, which includes an entered title and the entered text. These notes are not visible to healthcare providers.
- Child development – parents can record results of their child's scheduled health checks, childhood development and other useful information. The objective is to provide an integrated view of a child's health status for the parents/guardian and healthcare providers involved in the child's care. It can contain an achievement diary (not visible to healthcare providers), personal observations, immunisations, child health check schedule, child growth charts and information for parents.

Note: A healthcare provider's ability to use these features depends on whether the functionality is included in their clinical information software (CIS). The information provided above is visible to healthcare providers through the National Provider Portal and is also available in some clinical information systems.

When can I use My Health Record?[4 5]

VIEWING MY HEALTH RECORD

Any person who is authorised by a healthcare organisation can access and view an individual’s My Health Record for the purpose of providing healthcare.

An individual’s My Health Record may not include a record of every interaction they have had with the health system or up-to-date information about their health. You should continue to verify the information in the individual’s My Health Record with the patient and where necessary, other healthcare providers and sources of information such as carers or family. While you are not obliged to use the My Health Record system with every individual or for every encounter, it is important to be aware of instances when it will be particularly beneficial.

EXAMPLE SITUATIONS AND CASE SCENARIOS

See below examples of situations in which it might be relevant to use My Health Record, as well as case scenarios that demonstrate the benefits of accessing a patient’s record:

The patient is visiting for the first time
If a new patient presents to a specialist, there could be information from multiple sources in My Health Record to support understanding of their needs. Information regarding the patient's health status could be found, for example, in a shared health summary from their GP or the medicines information view.

The referral is missing information/the patient cannot recall their medical history
Information in My Health Record could assist with identifying any missing information, including the most recent shared health summary and the medicines information view.

After hospital discharge
The hospital may have uploaded a discharge summary providing details of the patient's stay. This could include a clinical synopsis, interventions, diagnosis, medicines and diagnostic imaging results.

After an after-hours GP visit
If a patient visited an after-hours GP service, the GP may have thought the visit warranted uploading an event summary to the patient's My Health Record. The GP may also have prescribed new medicines which could be listed in the patient's record.

After an incident on holiday
If the patient had an incident on holiday in Australia and saw a clinician, that clinician may have uploaded an event summary outlining the incident and treatment provided. The patient's prescribed and dispensed medicines may also have changed due to the incident, which could be visible in their My Health Record.

In an emergency situation
In an emergency situation the patient's My Health Record could give you information about the patient's known allergies, medicines, and discharge summaries in the medicine information view, their wishes for care in an advanced care directive, and their medical history in a shared health summary.

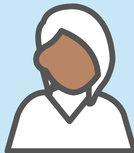
Patient has updated their My Health Record
A patient may tell a specialist that they have a My Health Record in which they have entered information about the current medicines they are taking or their known allergies and adverse reactions. In this instance, the patient's My Health Record may assist a medication assessment.

AN OLDER PERSON

An elderly patient is visiting a cardiologist for a review. She had another appointment with another physician a few weeks ago who ordered some blood tests, scans and made significant changes to her medications. However, she cannot remember where the tests were done and she is unsure of the names of the new medications. The cardiologist accesses My Health Record and reviews the list of her prescriptions through the medicines information view, and accesses her most recent tests through the pathology and diagnostic imaging reports views. The cardiologist is relieved to find all the needed information was there. This has saved a huge amount of time and avoided duplication and potential medication misadventure.

AN INCOMPLETE REFERRAL

Jane Smith, who has sustained a sport-related injury to her right hand, is visiting a hand surgeon for an initial consultation. Jane has a referral from a GP who is not her regular doctor and while the information on her presenting complaint is there, additional information including her relevant allergies is not present. Jane indicated that she had an allergy while in hospital as a child but is unclear on the details. The surgeon decides to access Jane's My Health Record to gain a more in-depth view of her health information. He checks her most recent shared health summary from her regular GP and discovers that Jane is allergic to a common anaesthetic agent. The surgeon is now able to share the details about Jane's allergy to the relevant anaesthetist, who can find a safe and alternative medication.



A COMPLEX PATIENT

Julie, a culturally and linguistically diverse patient, has recently been referred to a cardiologist due to suspected heart complications. A range of tests, including an electrocardiogram and echocardiogram, has revealed that Julie has coronary artery disease. As part of Julie's treatment plan, her cardiologist intends to prescribe new medications; however, Julie has multiple comorbidities, reports taking over nine medications (despite the referral only listing three), and is having trouble describing any known allergies. The cardiologist accesses Julie's My Health Record Medicines Information View which shows all nine prescribed medications from Julie's GP and other specialists. This view also allows quick access to the latest Shared Health Summary which includes a medication list and Julie's drug allergies. Together, this information supports Julie's cardiologist to prescribe medications to safely treat her newly diagnosed condition, while reducing the risk of an adverse reaction.

A RECENT HOSPITAL VISIT

Jeff has chronic pain from an anterior cruciate ligament (ACL) injury and is recommended for knee replacement surgery, scheduled in four months in Sydney. Leading up to this elective surgery, he initially completes all necessary pre-admission clinics without issue. Two months before his elective surgery, Jeff travels interstate to the Gold Coast for his daughter's wedding and unfortunately suffers a minor heart attack. He is admitted into hospital and remained there for a period of time. He was discharged with a new medication plan, a summary of post-operative care and a discharge summary was added to his My Health Record. On the day of surgery, Jeff is having his vital signs checked when he mentions to the attending healthcare provider that he has suffered chest pain recently. The attending clinician check's his My Health Record to discover Jeff's recent heart attack and new prescribed medication (i.e., clopidogrel) through the uploaded discharge summary. Due to the danger of operating on Jeff given his condition and new medication, the surgery is cancelled until he has completed a second visit to preadmission and a cardiology review.

UPLOADING TO MY HEALTH RECORD[6]

Under the *My Health Records Act 2012* (Cth), healthcare provider organisations, such as a private specialist practice or independent clinician, are authorised to upload information to the My Health Record system and view information. How and when you upload information should be guided by the circumstance in which you or another healthcare provider would need information to support your clinical decision-making. The information you choose to upload to the My Health Record system should consider whether that information will be of benefit to other healthcare providers and the individual. Information that is uploaded should be accurate, concise and of high-quality.

The Royal Australian College of General Practitioners describe high-quality health records as:[7]

- accurate,
- complete,
- consistent,
- easily read and understood,
- accessible, and
- up to date.

Healthcare providers do not need to obtain consent prior to uploading information to a My Health Record when providing healthcare to a patient. However, patients can request that a document is not uploaded to their record or that a document is removed, and healthcare providers must comply with such requests. Situations where documents should not be uploaded are discussed below. In addition, patients can restrict access to or remove information contained in their record.

WHEN NOT TO UPLOAD

If a patient specifically asks a healthcare provider organisation not to upload documents or information to their My Health Record, the healthcare provider organisation must comply with the request. This is a condition of an organisation's registration with the My Health Record system. Healthcare providers can advise the patient about the potential risks of excluding information from their My Health Record and explain the benefits of ensuring all information is included. However, final decisions on behalf of the patient must be complied with and information or documents must not be uploaded if this is requested.

The My Health Records Act recognises that under some state and territory laws consent must be given expressly, or in a particular way, before information related to specific areas of health is disclosed. The state and territory laws which have specific consent requirements regarding the disclosure of health information are listed in clause 3.1.1 of the *My Health Records Regulation 2012*. If a state or territory law is listed in this clause, you must comply with consent requirements.

Misuse of My Health Record[8]

Misuse of a person's health information is a serious matter. The potential for damage to an individual or healthcare provider organisation is significant, which is why healthcare providers have professional and legal obligations to protect patient information.

The My Health Record system and the Healthcare Identifiers Service contain health and other important information and are protected by a penalty framework set out in the *My Health Records Act 2012* and *Healthcare Identifiers Act 2010.* Actions subject to penalties includes, but is not limited to:

- unauthorised collection, use or disclosure of health information in a My Health Record,
- unauthorised use or disclosure of healthcare identifiers or other information obtained for the purposes of the Healthcare Identifiers Service,
- failing to give written notice within 14 days if the entity ceases to be eligible to be registered, and
- failing to notify an actual or potential data breach in which they were directly involved.

For more information, see the Australian Digital Health Agency's webpage on penalties for misuse of health information. Civil fines can include a maximum of $315,000, with criminal penalties including up to 5 years' jail time.

My Health Record use via the National Provider Portal[9]

WHY WOULD I USE THE NATIONAL PROVIDER PORTAL?

The National Provider Portal (NPP) is a web-based interface that allows healthcare providers to access the My Health Record system. It is a read-only service that is free and accessible without conformant clinical software, so an electronic clinical information system is not needed to view the My Health Record.

To learn more about access via the National Provider Portal, see the My Health Record Implementation Guide.

HOW TO ACCESS MY HEALTH RECORD VIA THE PROVIDER PORTAL[10]

Healthcare providers are required to access the NPP using their individual PRODA (Provider Digital Access) account. For guidance on how to access My Health Record via this route, see the following Agency webpage, which contains:

- walk-through steps on how to log in via the National Provider Portal, and
- a link to the National Provider Portal login.

How to view and navigate My Health Record via the National Provider Portal

To learn about My Health Record viewing and navigation through the National Provider Portal, watch the video demonstration located on the Australian Digital Health Agency's online training system by logging in as a guest or creating a new account. In addition to login guidance, the video demonstration covers:

- searching for patients My Health Record,
- accessing clinical documents,
- medicine records,
- consumer documents,
- child development,
- Medicare records and Advanced Care Plan, and
- searching for documents.

My Health Record use via Conformant Software

WHY WOULD I USE MY HEALTH RECORD VIA CONFORMANT SOFTWARE?

Healthcare providers can choose to access their patient's My Health Record information through conformant software - a clinical information system that allows healthcare providers to view, download and upload information to their patients' My Health Record.

Review the Australian Digital Health Agency's summary of conformant software products, and see the My Health Record Implementation Guide to learn more about access via conformant clinical software.

VIEWING VIA CONFORMANT SOFTWARE

Each software vendor has their own 'look and feel' for how they display information in the My Health Record. For this reason, the Australian Digital Health Agency offers a range of resources that provide guidance on how to view information in My Health Record via each conformant clinical software provider, including:

- Clinical software simulators (On Demand Training): There are a range of clinical software simulators or 'sandboxes' with which you can simulate viewing a fictional patient's My Health Record.
- Clinical software demonstrations: There are demonstrations for a range of clinical software products showing how to view, upload, and register patients to My Health Record.
- Clinical software summary sheets: There are summary sheets for a range of clinical software products with step-by-step instructions and screenshots for viewing a My Health Record. If your software is not there, please contact your software vendor for guidance material.
- Diagnostic imaging and pathology report access guides: diagnostic imaging and pathology reports can be viewed to gain a quick snapshot of a patient's test result history. These overviews show multiple reports within a specific date range on one page.

Note: If your software is not listed in the resources, contact your software vendor for information about how to upload with your software.

UPLOADING VIA CONFORMANT SOFTWARE

Similarly, while the actual documents themselves are the same regardless of the software used, each software has its own 'look and feel' for viewing and uploading information. Check with your software provider for manuals or guides on how to upload to My Health Record via their software.

There are clinical software simulators in which you can simulate viewing and uploading to a fictional patient's My Health Record through some common software types. There are also clinical software summary sheets and demonstrations with step-by-step instructions for uploading with various software products.

- Clinical software simulators: There are a range of clinical software simulators or 'sandboxes' with which you can simulate viewing, creating and uploading clinical information to fictional patients' My Health Records.
- Clinical software demonstrations: There is a range of slideshows showing how to access and upload to My Health Record in some clinical software products.
- Clinical software summary sheets: There are summary sheets for a range of clinical software products with step-by-step instructions and screenshots. Access these here.

Note: If your software is not listed in the resources, contact your software vendor for information about how to upload with your software.

Additional My Health Record Use Resources

- My Health Record resources | RACGP
- Curated Collection – My Health Record – Physician Toolkit |RACP
- Help Centre | Australian Digital Health Agency

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[1] ADHA, 'View a My Health Record', n.d., accessed 10 September 2020.
[2] ADHA, 'Patient access controls', n.d., accessed 10 September 2020.
[3] ADHA, 'What is in a My Health Record?', n.d., accessed 10 September 2020.
[4] ADHA, 'View a My Health Record', n.d., accessed 10 September 2020.
[5] ADHA, 'Understand when you can view and upload information', n.d., accessed 10 September 2020.
[6] ADHA, 'Understand when you can view and upload information', n.d., accessed 10 September 2020.
[7] Royal Australian College of General Practitioners, 'Improving health record quality in general practice', 2018, accessed 10 September 2020.
[8] ADHA, 'Strengthened privacy protections', n.d., accessed 10 September 2020.
[9] ADHA, 'Access My Health Record using the Provider Portal', n.d., accessed 10 September 2020.
[10] ADHA, 'Access My Health Record using the Provider Portal', n.d., accessed 10 September 2020.