FACT SHEET

FOR SPECIALIST PRACTICES

My Health Record

WHAT IS MY HEALTH RECORD?[1]

My Health Record is a secure online summary of a patient's health information and is available to all Australians. Healthcare providers and other staff that are authorised by their healthcare organisation can access My Health Record to view and add patient health information. Information that can be accessed via My Health Record includes shared health summaries, medicines information, discharge summaries, prescription and dispense records, pathology reports and diagnostic imaging reports. My Health Record does not replace existing health records and clinical notes. Rather, it supplements these with a high-value, shared source of patient information that can improve care planning and decision making.

WHAT IS IN A MY HEALTH RECORD?[2]

Documents and/or information available through My Health Record include:

- **Shared health summaries**
  A summary of the patient's health status at a point in time
- **Event summaries**
  A summary of key information about a significant healthcare event
- **Advance care planning information**
  A document containing a patient's wishes for future health care
- **Pathology & diagnostic imaging reports**
  Pathology reports and diagnostic imaging reports
- **Prescription and dispense records**
  Records of medicines that have been prescribed or dispensed
- **Medicines information view**
  A view that sorts and displays medicines medication information held in a patient's My Health Record documents
- **Discharge summaries**
  A summary providing the details of a patient's hospital stay
- **Pharmacist shared medicines list (PSML)**
  A list of medicines a patient is known to be taking
- **Specialist letters**
  A copy of a specialist's letter
- **Medicare overview**
  An overview of a patient's Medicare data
- **eReferrals**
  A copy of an eReferral
- **Patient-entered information**
  Information provided by the patient including a personal health summary

Australian Government
Australian Digital Health Agency

Note: Within My Health Record, the Medicines Information View can quickly sort and display medicines information held in a patient's My Health Record documents by date or alphabetical order. The medicines information is gathered from:

- the patient's most recent prescription and dispense records, and other Pharmaceutical Benefits Scheme claims information,
- the patient's most recent shared health summary and discharge summary,
- recent event summaries, specialist letters and e-Referral notes,
- the patient's personal health summary, and
- if available, a link to the PSML (Pharmacist Shared Medicines List).

ADDED VALUE FOR SPECIALIST PRACTICE

In terms of value for specialists, My Health Record can assist with the following:

Specialist Action	My Health Record
Medication reconciliation/ prescribing	Medicines information view
History taking and patient assessment	Shared health and discharge summaries
Avoid duplicate testing/scans/ diagnostics	Pathology and diagnostic imaging reports
Help to inform end-of-life care decisions	Advance care planning documentation
Communication aid	Specialist Letters
Planning before consultations	Medicines information view, shared health summaries
Avoiding medication errors/adverse drug interactions	Prescription and dispense records, medicine information view

WHAT ARE THE BENEFITS OF MY HEALTH RECORD?[3]

Patients

may benefit through:

- health providers having access to their health information in an emergency,
- secure, convenient and controlled access to a snapshot of their health,
- safer, faster and more efficient care, and
- less reliance on having to remember key aspect of their medical history.

Specialists

may benefit through:

- quick and easy access to key health information that has not been received directly,
- less administrative burden gathering patient information,
- improved clinical decision making through access to patient-specific information,
- avoidance of duplicating tests, scans and diagnostics, and
- access to information that can inform end-of-life care decisions.

Practice Managers

may benefit through:

- reduced staff time spent gathering patient information and less duplication of services,
- less reliance on requesting paper or faxed records located outside your practice,
- improved practice efficiency and reduced costs, and
- a higher quality of care for patients through reduced adverse events.

WHEN SHOULD I USE MY HEALTH RECORD?[4]

It is up to the specialist and their clinical judgement as to when they use the system, provided that it is for the purpose of providing healthcare to a patient. Examples of when to use My Health Record include:

- **The patient is visiting for the first time**

  Information in My Health Record could assist with assessing clinical needs, including a shared health summary or a record of the patient's prescribed and dispensed medicines.

- **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 with the patient's stay details, including clinical synopsis, interventions, diagnosis, medicines list and diagnostic imaging results.

- **After an after-hours GP visit**

  The GP may have uploaded an event summary with incident and treatment details and may have prescribed new medicines which may be listed in the patient's My Health Record.

- **After an incident on holiday**

  The GP or treating practitioner may have uploaded an event summary with incident and treatment details and prescribed and dispensed medicines may have changed.

- **In an emergency**

  The patient's My Health Record could give you information about the patient's known allergies, medicines, immunisations and medical history in a shared health summary.

- **The patient has updated their My Health Record**

  A patient may tell you they have a My Health Record, in which they have entered information about the current medicines they're taking or their known allergies and adverse reactions.

THE BUSINESS CASE FOR MY HEALTH RECORD

Health information exchange and electronic health records allow access to a broad range of patient information across clinical contexts and clinicians. Electronic system such as My Health Record may:

- reduce duplication in medical procedures, including radiology tests and imaging,
- reduce costs through efficiencies of improved test utilisation and reduced staff resources on patient management, and
- increase patient quality of care, through improved medication reconciliation and reduced care disparities.

NATIONAL ADOPTION[5]

My Health Record is widely used and healthcare providers are increasingly connecting to the system. As of June 2020:

- over 15,000 healthcare providers are connected,
- 90% of Australians have a My Health Record,
- 22.78 million My Health Records exist,
- over 75 million clinical documents exist,
- over 143 million medicine documents exist, and
- 93% of GPs, 95% of public hospitals, and 99% of pharmacies are registered.

See the latest My Health Record statistics for more information on adoption rates.

NEXT STEPS

- Learning module: My Health Record case studies, use, and security.
- Implementation guide: Instruction on how to set-up My Health Record.
- User guide: Instruction on how to view and upload information in My Health Record.

[1] ADHA, 'For healthcare professionals', n.d., accessed 10 September 2020.
[2] ADHA, 'What is in a My Health Record', n.d., accessed 10 September 2020.
[3] ADHA, 'Benefits of My Health Record for healthcare professionals', n.d., accessed 10 September 2020.
[4] ADHA, 'View a My Health Record', n.d., accessed 10 September 2020.
[5] ADHA, 'My Health Record statistics', n.d., accessed 10 September 2020.