FREQUENTLY ASKED QUESTIONS

FOR SPECIALIST PRACTICES

My Health Record

Australian Government
Australian Digital Health Agency

What is it and why use it?

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 view and add patient health information in a timely manner. See the My Health Record Learning Module for more information about the functions and purpose of My Health Record.

WHAT IS IN A MY HEALTH RECORD?

Information available through My Health Record can include:

- shared health summaries,
- 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.

WHY USE MY HEALTH RECORD?

My Health Record gives specialists access to documents and clinical information from other healthcare providers. This information may help to inform and improve clinical decision making. The benefits of electronic health information exchange 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.

Increase patient quality of care through improved medication reconciliation and reduced care disparities.

WHAT ARE THE BENEFITS OF MY HEALTH RECORD?

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.

IS MY HEALTH RECORD USED NATIONALLY?

Yes, it is used widely throughout Australia and healthcare providers are increasingly connecting to and using the My Health Record system. As of June 2020, over 15,000 healthcare providers are connected, 22.78 million My Health Records exist and 90% of Australians have a My Health Record. Higher uptake and use of My Health Record can lead to greater utility in supporting health care planning and decision making.

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

Setting up and using My Health Record

HOW TO ACCESS MY HEALTH RECORD?

The My Health Record can be accessed via conformant clinical software or via the National Provider Portal.

- **Conformant Software:** Healthcare providers can access their patient's My Health Record through conformant software which allows them to view, download and upload information to their patient's My Health Record. Once registered, practices using this option will need to contact their software vendor to configure their software to access the My Health Record system. A list of conformant software providers can be found on the Australian Digital Health Agency's website here.
- **National Provider Portal:** For healthcare providers who do not have conformant software, the National Provider Portal (NPP) allows them read-only access to their patient's My Health Record. This enables viewing, downloading and printing of the contents of My Health Record. You will not be able to contribute by uploading information.
- Practices will need to implement a My Health Record security and access policy, train staff in the use the system and manage user access to the system (e.g. deactivate accounts when staff leave the practice). It is recommended that practices follow the Australian Digital Health Agency's security practices and policies checklist to help ensure compliance with the *My Health Records Rule 2016.*

For further information, review the Implementation Guide, which provides detailed guidance and steps on setting up My Health Record in your practice.

HOW DO I USE MY HEALTH RECORD SAFELY?

Legislation governs the use of My Health Record by healthcare providers, including the *My Health Records Act 2012* (Cth), *My Health Records Regulation 2012* (Cth), and *My Health Records Rule 2016* (Cth).

Organisations must confirm they have a My Health Record security and access policy in place before participating in the system. Additionally, practices using conformant software need to confirm they have a National Authentication Service for Health (NASH) Public Key Infrastructure (PKI) Certificate policy. Sample policies can be found here:

- My Health Record system policy
- NASH PKI Certificates policy.

To meet requirements and avoid misuse, follow the Australian Digital Health Agency's security practices and policies checklist. Additional considerations to follow include:

- **Think privacy** – Store patient information, online or paper-form, in a secure location. Ensure you are only disclosing information to patients with authorised access to a patient's My Health Record.
- **Think security** – Only provide My Health Record access to authorised people. Passwords should be unique to the clinician and should never be shared, and generic logins must never be used.
- **Think quality** – Ensure entered information is accurate, complete, consistent, easily read and understood, accessible, and up to date.

WHEN CAN I USE MY HEALTH RECORD?[2]

Specialists are under no legal obligation to use the My Health Record system. It is up to the specialist and their clinical judgement as to when they use the system. Consider the potential examples of when it might be beneficial to use My Health Record below:

- the patient is visiting for the first time,
- the referral is missing information,
- the patient cannot recall their medical history,
- after hospital discharge,
- after an after-hours GP visit,
- in an emergency, and
- when the patient has updated their My Health Record.

Access the My Health Record User Guide to learn more about how and when the system may be used in your practice.

WILL USING MY HEALTH RECORD PROVIDE A RISK TO MY PRACTICE?

My Health Record is intended to improve the safety of clinical practise and is designed to be a highly secure system.

It should be noted that My Health Record doesn't include a record of every interaction patients have had with the health system, however, My Health Record may contain additional patient information, reduce duplication in work conducted and support a higher quality of care. The system can be used to supplement patient care where information should be verified with the patient and, where necessary, other healthcare providers to ensure well-informed and thorough clinical decision-making.

WILL USING MY HEALTH RECORD BE EXPENSIVE TO IMPLEMENT FOR MY PRACTICE?

My Health Record will not add expenses to your practice if you already have a clinical software product that integrates with the system, or you are accessing via the National Provider Portal.

If you are seeking to use My Health Record via clinical software and you do not have conformant software, then you will need to invest in a conformant software product for your practice.

Note: access via the National Provider Portal allows viewing and printing of information only.

IS MY HEALTH RECORD SECURE?

The My Health Record system is managed in line with the Australian Government Protective Security Policy Framework. My Health Record data is stored in Australia and is protected by high grade security protocols to detect and mitigate against external threats. The system is tested frequently to ensure these mechanisms are robust and working as designed.

Design features include many safeguards to protect the information stored within the system, including audit trails, technology and data management controls, as well as appropriate security measures to minimise the likelihood of unauthorised access to information in a patient's record. Legislation governs how the My Health Record system is accessed, managed and used. There are significant civil and criminal penalties for deliberate misuse of information stored within My Health Record.

Patient Considerations

DO I NEED CONSENT FROM PATIENTS?

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

- access the patient's My Health Record during, or regarding, a consultation or clinical event involving the patient, and
- view all documents in the My Health Record system and upload documents to the My Health Record, unless the patient specifically requests the healthcare professional not to upload the document or if the patient has set access controls on viewing.

You do not need the specific consent of a patient to view their My Health Record and you can access a patient's My Health Record outside of a consultation, provided that access is for the purpose of providing healthcare to that patient.

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

WHAT IS MY HEALTH RECORD'S EMERGENCY ACCESS FUNCTION?[3]

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 2012 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.

WHAT HAPPENS IF A PATIENT WITHDRAWS THEIR CONSENT TO UPLOAD A DOCUMENT TO MY HEALTH RECORD?

If a patient withdraws consent to upload a document, the 'do not send to My Health Record' (or similar) tick box should be checked in your clinical software. Withdrawal of consent after an upload occurs can be handled by the My Health Record Helpline on 1800 723 471.

WHAT IF A PATIENT HAS CURRENT OR PAST SENSITIVE INFORMATION THEY MIGHT WANT HIDDEN FROM THEIR CLINICIAN?

Discuss with your patient that My Health Record is a patient-controlled record and they can choose to restrict who views their sensitive information. It is good practice to inform your patient that this information can be helpful in ensuring they get the most appropriate care and also respect their rights as a consumer. Patients can remove documents, however, if you are the author of that document, this will be indicated to you in the software (speak with your software vendor about how you can view this). Patients cannot edit clinically authored documents.

WHAT ARE THE ACCESS SETTINGS THAT PATIENTS CAN USE?[4]

There are four document settings patients can apply to documents:

- **General Access:** allows healthcare providers and patient representatives to view a document.
- **Restricted:** only healthcare providers and patient representatives with 'restricted access' can view the document.
- **Hidden:** patients, their healthcare providers and representatives cannot view this document in the patient's My Health Record. To view this document, patients or their representatives need to reinstate the document.
- **Removed:** patients, their healthcare providers and representatives cannot view this document in your My Health Record including in a medical emergency.

WHERE CAN I ACCESS TRAINING FOR MY HEALTH RECORD?

Available training options include:

- Australian Digital Health Agency online eLearning Modules.
- On Demand Software Training simulators and demonstrations. (Username: OnDemandTrainingUser and password: TrainMe.
- Access to software Summary Sheets or My Health Record manuals requested from your software vendor.
- Presentations/educations sessions by Australian Digital Health staff

See also the Australian Digital Health Agency's list of My Health Record training and resource options available for healthcare providers.

WHERE DO I GET HELP?

My Health Record
Web: www.myhealthrecord.gov.au
For assistance, contact the Help

Centre on 1300 901 001 /

help@digitalhealth.gov.au

Australian Digital Health Agency
Web: www.digitalhealth.gov.au
Email: help@digitalhealth.gov.au

[1] ADHA, 'For healthcare professionals', n.d., accessed 10 September 2020.
[2] ADHA, 'View a My Health Record', n.d., accessed 10 September 2020.
[3] ADHA, 'Emergency access', n.d., accessed 10 September 2020.
[4] ADHA, 'Remove information', n.d., accessed 10 September 2020.