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FREQUENTLY ASKED QUESTIONS

WEBINAR

# My Health Record

While GPs learn to effectively use the new My Health Record system, GP supervisors have the added responsibility of ensuring GP registrars are also competent in ensuring a high standard of health records are maintained.

This resource aims to provide answers to some frequently asked questions specific to GPs, and therefore what supervisors need to teach their registrars about the My Health Record system.

## What is My Health Record?

My Health Record is an electronic summary of an individual's health information that can be shared securely online between the individual and registered healthcare providers involved in their care to support improved decision-making and continuity of care.

## Who developed the My Health Record system?

The system has been developed by the Australian Digital Health Agency as part of a national strategy to improve patient outcomes through the implementation of a range of digital health technologies. My Health Record is one of seven components of the National Digital Health Strategy Priority Activities 2018-2022.

**For more information about the National Digital Health Strategy Priority Activities 2018-2022, visit**
https://conversation.digitalhealth.gov.au/strategic-priorities

## What are the benefits of My Health Record's introduction to Australia?

Using My Health Record benefits doctors and their patients by allowing a patient's health information to be available whenever and wherever it is needed. In general practice, it gives the patient's treating doctor access to health information that they may otherwise not have received directly.

**Benefits to the health sector:**
- Improved continuity of care.
- Reduced duplication and wasted resources.

**Healthcare provider organisation:**
- More time to provide health care.
- Improved decision support.

**Individuals:**
- Enhanced patient self-management.

**Benefits for GPs, GP registrars and their patients:**
- Access to key health information means there is no need to call the hospital or other health services.
- My Health Record travels with your patient wherever they go around Australia.
- Sharing information so other doctors, nurses or healthcare workers can see what has been happening.
- Helps patients keep track of their own health.
- Flow of information between different healthcare providers reduces risk of medication errors.
- Reduces duplication of tests and pathology requests because treating healthcare providers will be aware if/when these have occurred, and have access to results.
- Reduces paperwork and amount of time it takes to find key clinical information the health provider/patient is waiting for.
- Assists doctors/registrar seeing a patient for the first time.
- Can help GPs/registrar find information (from other health professionals) they may not have received directly.

## What information can be shared on My Health Record?

My Health Record shares information which is important to an individual's health care. This includes:

**Medicare Information**
- MBS and PBS information
- Organ donor decisions
- Australian Immunisation Register (AIR)

**Clinical documents**
- Shared health summaries
- Event summaries
- Discharge summaries
- Pathology and diagnostic imaging reports
- Prescription records
- Specialist letters
- eReferrals

**Individual (or representative)**
- Advance care planning documents and custodian details
- Personal health summary
- Personal health notes
- Emergency contacts
- Childhood development

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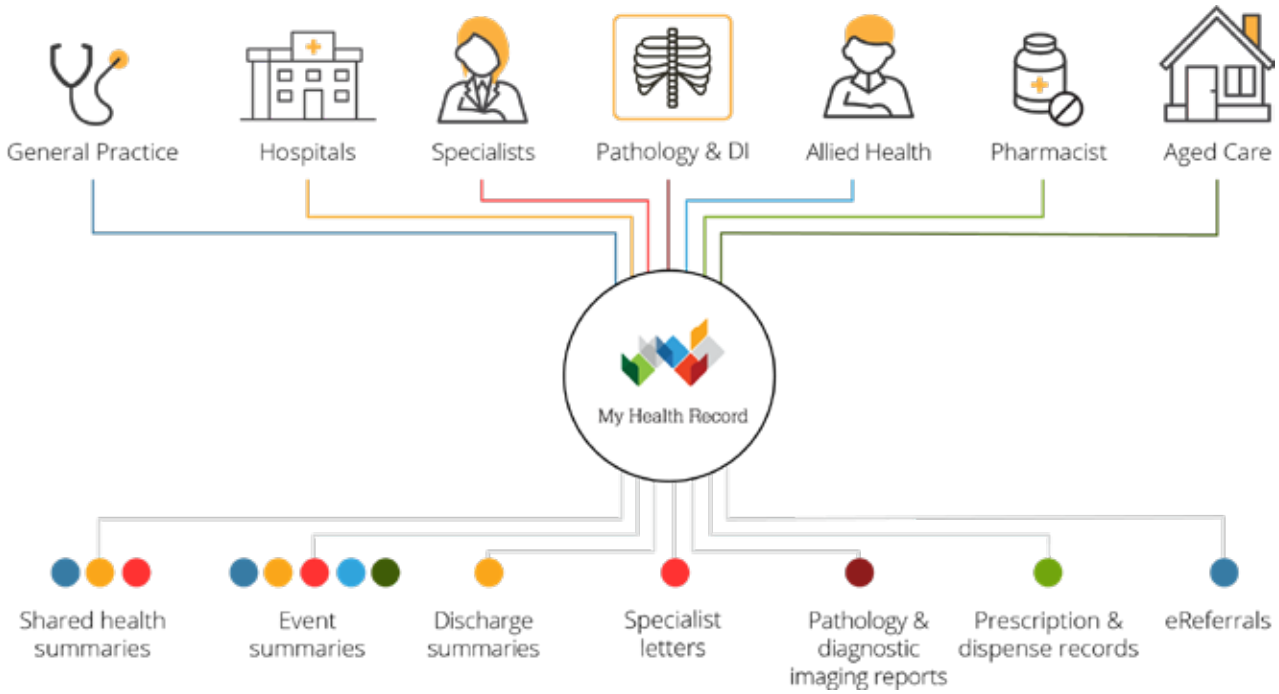
## How does My Health Record work?

Healthcare professionals who are directly involved in a person's care, can use (access and upload information) on that person's My Health Record. Individuals control who has access to their My Health Record.




## What documents are GPs/registrars responsible for contributing to on their patients' My Health Record?

As indicated in the infographic (above), GPs are responsible or uploading Shared Health Summaries, Event Summaries and eReferrals.

The Shared Health Summary is the primary document a GP needs to upload for patients who are under their regular care and have nominated them as their provider.

Event Summaries are a one-off incident, which a treating GP who is not an individual's usual doctor can upload information to. For example, a person travelling interstate is seen by a doctor (not their usual GP or clinic) for a dog bite. The doctor gives the patient stitches and prescribes medication, and then uploads the information to the Events Summaries on their My Health Record (under Events Summary) unless the patient tells them not to.

## How will I know if my patient has a My Health Record?

Most clinical software includes a button or icon that indicates if a patient has a My Health Record, provided the patient's Individual Healthcare Identifier (IHI) is validated with Medicare. While each clinical software system looks slightly different, in most software the My Health Record button or icon changes to green to indicate that the patient has a My Health Record.

Nine out of 10 Australians now have a My Health Record following the conclusion of the opt-out period. While the opt-out period ended on January 31, 2019, Australians are able to cancel and have their My Health Record permanently deleted from the system at any time in the future. Similarly, individuals who may have opted out can create a record at any stage if they choose.

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## When should a GP/registrar access, view or upload to an individual's My Health Record?

There are two questions the GP can ask themselves. As a GP supervisor you should teach your registrar to ask themselves the same questions.

Ask yourself:

- *Might the information in the individual's My Health Record support my clinical decision-making?*
- *Might uploading information to the individual's My Health Record support other healthcare providers' clinical decision-making?*

## Do GPs/registrars need to ask for consent to view and/or upload information to a patient's My Health Record?

Providers who have a legitimate reason to access the system (for example, provide care to a patient) are authorised by law to do so, subject to the patient's My Health Record's access controls. So, you don't need to specifically ask for consent to view a person's My Health Record if you are providing (or about to provide) care to that person.

However, if the patient has put an access control code in place, then that will stop you from accessing specific documents. If this is the case, you may ask the patient if they would like to supply the pin code, or whether they would prefer you do not access their My Health Record.

In terms of uploading information to My Health Record, you are authorised by law to upload clinical documents without obtaining consent from the patient each time.

However, for an initial Shared Health Summary, it is good practice to have the discussion with the patient and confirm the information is accurate and up-to-date, and they are happy to have that information shared.

## Does patient consent mean their GP/registrar can access and upload information to the patient's My Health Record when they are not present?

Yes, see the "How consent works" box (right).

## What are a GP's/registrar's obligations if a patient instructs them not to upload specific information or clinical document?

If a patient instructs you they do not want specific information or clinical document uploaded, then you must conform to that request – do not upload it.

However, you may like to reassure them only registered healthcare professionals involved in their care can access (subject to the patient's access controls) their My Health Record, and if you believe the information would have significance for the decision-making of other healthcare professionals. For example, healthcare professionals in a hospital emergency department may need to know if the patient is taking a particular medication.

If after this discussion the patient still instructs you not to upload the information/clinical document in question, you must abide by their wishes.

| How patient consent works in My Health Record | |
|---|---|
| Authority to access | A provider is authorised by law to view a My Health Record without seeking consent each time, if:<br>• The provider is permitted by the organisation to access the My Health Record.<br>• The provider is accessing in order to provide healthcare to the patient.<br>• The patient has not restricted access to the record. |
| Authority to upload | • A provider is authorised by law to upload clinical documents without gaining consent of the patient each time.<br>• A patient may instruct you that a particular clinical document not be uploaded. If they do, it cannot be uploaded. |

In addition, providers must comply with relevant state and territory laws relating to disclosure of specific health conditions (for example, HIV).

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## How can a GP/registrar load a Shared Health Summary for an individual who has nominated them as their provider for My Health Record?

If the patient has nominated you as their provider and given you consent to upload their Shared Health Summary, you will likely have an extensive history in your existing clinical information system to upload.

My Health Record is conformant to general practice software, and extracts the key information. You can review the extracted information and select what you do/do not want in that document – preferably, you will do this selection in consultation with the patient – and then hit 'upload'.

**For more information about when and how to upload a Shared Health Summary, including software summary sheets with step-by-step instructions, visit** https://www.myhealthrecord.gov.au/for-healthcare-professionals/howtos/shared-health-summaries

## Can the GP/registrar who is the author of a Shared Health Summary upload a more up-to-date version and delete the previous version?

A new updated Shared Health Summary can be created and uploaded whenever there have been significant changes to a patient's medical conditions, medicines, allergies, adverse reactions or immunisations. These clinical documents build up over time and there is no need to delete previous versions. The most recently uploaded shared health summary in a patient's My Health Record is likely to be the first document accessed by any other healthcare professional viewing a patient's My Health Record.

## Can a GP/registrar opt to include historical data?

Clinical information only starts being uploaded to a person's My Health Record once the record is created and builds up from then. A patient's medical history is included in the Shared Health Summary, which is uploaded by the patient's usual healthcare provider. So, if the person has attended the same general practice for several years, then any medical conditions noted in the local clinical information system may also be included in Shared Health Summary. Another source of historical data is the information that comes through from Medicare, which may include up to two years of Medicare claims and Pharmaceutical Benefits Scheme (PBS) information as well as the full list of immunisations as listed in the Australian Immunisation Register (AIR). Medicare information will flow through to a My Health Record when it is first accessed by either the healthcare provider or the individual.

The first time an individual accesses their My Health Record online via myGov they will be taken through a First Access workflow to set up their record. Individuals can consent to include Medicare information in their own, or their dependant's, My Health Record for the previous two years according to these settings:

- Select Yes/No for all four types of information to flow into My Health Record.
- Select preference (Yes/No) for MBS/PBS data going forward and from the past two years.
- Select (Yes/No) for AIR information and AODR preferences to flow into record.

So, the individual can choose to include either the previous two years' Medicare information into their record or just information from the date of consent. Once an individual has provided consent, Medicare information will continue to be added to the My Health Record until consent is withdrawn, the individual cancels their record, turns 14 years of age or, until the individual is deceased.

## Who is responsible if multiple documents from different providers leads to erroneous management because of incomplete or inaccurate information?

Healthcare provider organisations are obligated to take reasonable steps to upload accurate and up-to-date information on My Health Record (this obligation already exists when sharing patient information with other providers).

My Health Record aids in clinical decision-making and providers should rely on their own clinical judgement when using third party information.

So remember, information within My Health Record is not necessarily a complete information source, but gives you another source of possible information: this information gives you (and other health providers) some 'clues' or sources to follow.

In terms of who is responsible for accuracy of information – everyone. That is, part of everyone's requirement of providing information to other providers is to ensure they upload information that is accurate and complete at the time of upload.

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## What measures are in place to ensure privacy and security of every individual's My Health Record?

- **Individuals control their own My Health Record access and privacy setting.**
  - Individuals can choose to restrict access to specific documents in their My Health Record by establishing a Limited Document Access Code (LDAC). Any organisation given the code can access those documents.
  - Individuals can restrict access to their record by establishing a Record Access Code (RAC) that will mean only organisations given the code can access any part of their My Health Record.
  - In an emergency, a clinician can exercise a 'break glass' facility; but instances are monitored and logged and must be for legitimate life-saving purposes.
  - Individuals can subscribe to SMS or email alerts that report in real time when a new health provider organisation accesses their My Health Record or emergency access has occurred.
  - All instances of access to My Health Record are monitored and logged.
- **The Digital Health Cyber Security Centre maintains security of the My Health Record system by:**
  - Continually monitoring the system for evidence of unauthorised access.
  - Utilising specialist security real-time monitoring tools, configured and tuned to automatically detect events of interest or 'notable events'.

    Examples of 'notable' events include:
    - Overseas access by consumers and healthcare providers.
    - Multiple failed logins from the same computer.
    - Multiple logins within a short period of time.
    - Logins to the same record from multiple computers at the same time.
  - Regularly reviews and updates the defined events of interest, based on its knowledge of the likely threats to the My Health Record.
- **Legislation and penalties**
  - The My Health Record system operates under the *My Health Records Act 2012* and *The Privacy Act 1988*. The Acts establish the role and functions of the system; a registration framework; and a privacy framework.
  - In November 2018, the Australian Parliament passed legislation to strengthen privacy protections in the *My Health Records Act 2012*.

    The changes:
    - Allow Australians to permanently delete their records, and any backups, at any time.
    - Explicitly prohibit access to My Health Records by insurers and employers.
    - Provide greater privacy for teenagers 14 years and over.
    - Strengthen existing protections for people at risk of family and domestic violence.
    - Clarify that only the Australian Digital Health Agency, Department of Health, and chief executive of Medicare (and no other government agency) can access the My Health Record system.
    - Explicitly require law enforcement and other agencies to produce a court order to access information in My Health Records.
    - Make clear that the system cannot be privatised or used for commercial purposes.
    - The legislation changes are backed up by harsher penalties and fines for inappropriate or unauthorised use of My Health Records.
- **Healthcare businesses take responsibility for security and privacy by:**
  - Employing cyber security measures, including privacy, passwords, software updates, backups and staff security awareness. The *Information Security Guide for Small Healthcare Businesses* provides simple guidance for non-technical health professionals.

    **Read the *Information Security Guide for Small Healthcare Businesses* and additional guidance regarding specific information security topics at https://www.digitalhealth.gov.au/about-the-agency/digital-health-cyber-security-centre/information-security-guide-for-small-healthcare-businesses**

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- Health organisations need to develop, maintain, enforce and communicate to staff written policies relevant to the My Health Record system to ensure interactions are secure, responsible and accountable.

  Sample policy templates are available on the Australian Digital Health Agency's website, including:

  - Sample Data Records and Clinical Coding Policy.
  - Sample Policies and Procedures for the Use of NASH PKI Certificates.
  - Sample My Health Record Security and Access Policy.

  **For sample policy templates, visit** https://www.racgp.org.au/running-a-practice/technology/workplace-technologies/electronic-records/my-health-record-in-general-practice/my-health-record-resources

## What functions are available to an individual in the My Health Privacy Controls?

| | |
|---|---|
| **Control access** | Provide healthcare providers with a record access code. |
| **Lock documents** | Restrict viewing of specific documents to selected providers. |
| **Nominate representatives** | Nominate people to manage the record on their behalf. |
| **Check activity** | See who has accessed their record. |

## Can a GP/registrar access all information in their patient's My Health Record?

By default, healthcare organisations have 'general access' to records in the My Health Record System. This enables viewing of all documents within an individual's record, except for information in the consumer-only notes section of the record or any documents that the person has previously removed.

If a patient has applied access controls to their My Health Record, the GP/registrar will only be able to open those documents if the patient gives them the relevant access code or uses the 'emergency access' option (see page 7).

**For more information visit** https://www.myhealthrecord.gov.au/for-healthcare-professionals/howtos/patient-access-controls

## Are pathology and diagnostic imaging reports available on My Health Record, and if so, will the patient have access to these before their GP/registrar has a chance to view the results?

- If you are the requestor, pathology and radiology reports will continue to be sent directly to you via the usual process.
- If your patient has a My Health Record:
  - The report will be uploaded to their My Health Record.
  - The pathology or diagnostic imaging report will be available for your patient to view after seven days. This enables you to review the report and contact your patient to discuss the results (if needed) before they can see it in their My Health Record.

    If you or your patient, in consultation with you, **do not** want a pathology or diagnostic imaging report uploaded to the My Health Record, withdrawal of consent should be communicated to the pathology laboratory. This is done by checking the "Do not send reports to My Health Record" box on the request form.

## Can a GP/registrar remove pathology results if the patient requests this?

No, the GP/registrar cannot remove a clinical document authored by another healthcare organisation. If the patient wants a pathology report removed, they can do so by contacting their pathology provider, by logging on to their own My Health Record and removing it, or phone the My Health Record help line on 1800 723 471 and asking for the document to be removed.

## Can a GP/registrar remove an inaccurate pathology result?

If a pathology result is inaccurate, the GP/registrar should contact the pathology provider and request the report be removed and corrected. The GP/registrar should also report incidents/issues of clinical significance as soon as possible to the My Health Record helpline on 1800 723 471 which is available 24/7.

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## If a patient transfers to another doctor, can the new GP/registrar access their old records?

If the patient's previous GP has uploaded a Shared Health Summary or other clinical documents to their My Health Record, then yes, these documents will be available to any other healthcare provider wherever the patient goes.

## If my registrar has seen the patient, am I able to access the patient's My Health Record during a discussion with the registrar?

Yes. If the registrar has seen the patient within your practice, as their GP supervisor you are specifically involved in providing care to that patient.

## Can any GP/registrar in a practice access (group access) a patient's My Health Record?

If the GP is a registered healthcare provider and involved in the patient's care, then yes they can access the individual's My Health Record. If they are not involved in the patient's care, then accessing the My Health Record could constitute inappropriate use.

## Can a GP/registrar exercise 'break glass' access to a patient's My Health Record, to determine if that person is a doctor shopper?

In most cases, a patient's My Health Record is set to 'general access' so there is no need to utilise the emergency 'break glass' function. Emergency access does not need to be used if you can already access the individual's My Health Record using your usual processes.

If the individual has chosen to add access controls to their record, there are certain urgent situations, defined in the *My Health Records Act 2012* (section 64), where it may be permissible for you 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 important to understand when this function can lawfully be used.

It is expected 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.

You **must not** use emergency access:

- To view your own My Health Record or a record of a family member.
- To demonstrate how to use the emergency access function.
- When an individual has forgotten the access code they have set (except where there is a serious threat to the person's life, health or safety).
- To check whether any restricted documents exist (except where there is a serious threat to the individual's life, health or safety and they are unable to provide consent, or to lessen or prevent a serious threat to public health or safety).

It is important to note that unlawful use of the emergency access function is subject to civil and/or criminal penalties under the *My Health Records Act*.

## Will My Health Record be available for patients without Medicare? For example, overseas students.

No, at this point in time, it is not possible to get an Individual Healthcare Identifier (IHI) unless the person is eligible to get a Medicare card. It is not possible to register for My Health Record without an IHI. Overseas students from countries that have 'Reciprocal Healthcare Agreements' with Australia are eligible to register for a Medicare card.

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## How can I teach my registrar the components they need to ensure high-quality health records for their patients?

During an in-practice teaching session, speak to your registrar about the importance of data quality to ensure high-quality health records for their patients. Discuss this approach needs to be consistent for all patients; that is, patients with and without a My Health Record.

Discuss the checklist (below) to ensure their record-keeping is of the high quality expected of GPs.


**For more information about health record quality, read RACGP guide *Improving health record quality in general practice* at https://www.racgp.org.au/running-a-practice/practice-resources/general-practice-guides/improving-health-record-quality/introduction**

## In summary, what do I need to know to use the My Health Record System?

- Check whether your practice is registered and set up to use My Health Record.
- Review local policies.

  **More information about policy requirements can be found at** https://www.myhealthrecord.gov.au/for-healthcare-professionals/howtos/security-practices-and-policies-checklist
- Learn how to access, view and upload to My Health Record.
- Use training resources
  - You and your registrar should be trained in the use of your practice's software system - seek assistance from your practice manager; primary Health Network (PHN), and/or check the software manual.
  - The Australian Digital Health Agency provides:
    - Clinical software simulators for on-demand training
    - Software summary sheets
    - Webinars
    - eLearning modules (endorsed for 2 Category 2 points in the RACGP's QI&CPD Program)

**The above are available via the My Health Record website at www.myhealthrecord.gov.au**

**For more information and healthcare provider support in using My Health Record, contact the My Health Record help line on 1800 723 471 (option 2).**

## Resources

- www.myhealthrecord.gov.au
- https://www.myhealthrecord.gov.au/for-healthcare-professionals/howtos/emergency-access
- https://www.myhealthrecord.gov.au/for-you-your-family/howtos/emergency-access-my-health-record
- www.digitalhealth.gov.au
- https://www.myhealthrecord.gov.au/for-you-your-family/howtos/manage-my-privacy-and-security/allow-others-view-my-record/give-someone-access
- https://www.digitalhealth.gov.au/about-the-agency/digital-health-cyber-security-centre/information-security-guide-for-small-healthcare-businesses
- https://www.racgp.org.au/running-a-practice/practice-resources/general-practice-guides/improving-health-record-quality

Does this resource need to be updated? Contact GPSA: P: 03 5440 9077, E: ceo@gpsupervisorsaustralia.org.au, W: gpsupervisorsaustralia.org.au
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