AUSTRALIAN COMMISSION
ON SAFETY AND QUALITY IN HEALTH CARE

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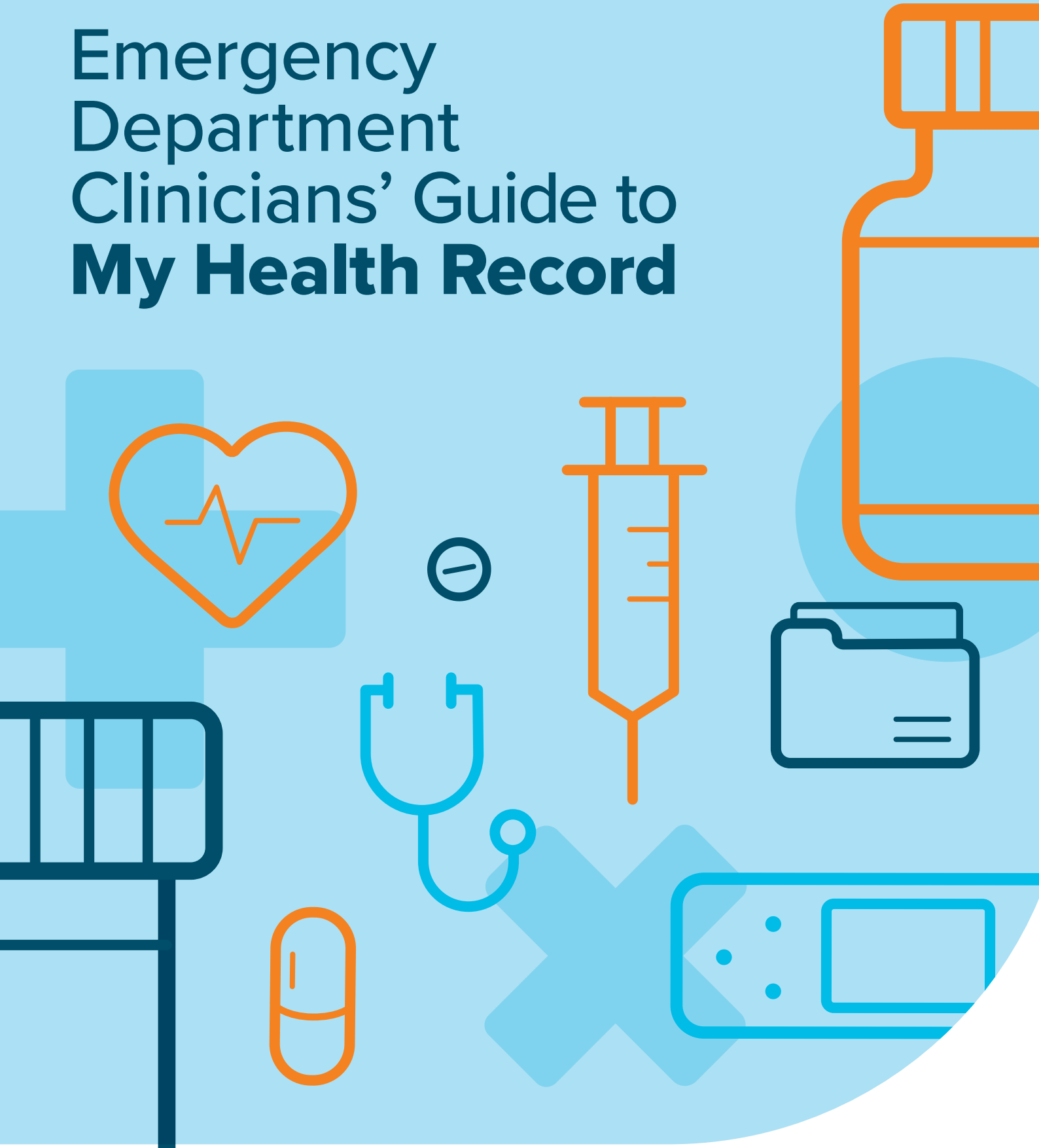
Emergency Department Clinicians' Guide to **My Health Record**



My Health Record

ACEM
AUSTRALASIAN COLLEGE FOR EMERGENCY MEDICINE

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Emergency Department Clinicians' Guide to **My Health Record**

Australian Government
Australian Digital Health Agency

AUSTRALIAN COMMISSION ON SAFETY AND QUALITY IN HEALTH CARE

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Tell me why?

As healthcare in Australia moves into an electronic age, emergency department (ED) clinicians need to be aware of recent developments in digital health to help achieve the best outcomes for their patients.

This guide aims to provide ED clinicians with essential information about the features and capability of My Health Record.

As more consumers and healthcare providers contribute to My Health Record, it is rapidly becoming a more useful source of information to inform clinical decision making.

What is My Health Record?

A My Health Record is an electronic collection of patient health information. A record is available to all Australians registered for Medicare or holding a Department of Veterans' Affairs (DVA) card.

The content in My Health Record is growing as more public and private health services and healthcare professionals connect and upload patient information. In time, this will improve the way healthcare providers manage care for their patients.

Health services will have different levels of readiness when it comes to connecting to and using My Health Record. Familiarising yourself with how to access the My Health Record from your ED is a key step to integrating the system into everyday clinical practice.

Relevant points to remember

My Health Record may not be a complete reflection of every interaction a patient has with healthcare services.

Information may be current at a particular point in time; therefore, My Health Record should be used to supplement additional sources of patient information.

My Health Record is not a complete substitute for thorough clinician-to-clinician handover, but it can be a useful resource in supporting the transition of patient care to and from hospital.

My Health Record

Content

The My Health Record system collects documents from a range of healthcare providers. Some of this information may not be the most up-to-date patient data at the time of access. It's important to always check the accuracy and currency of the available patient information within the My Health Record, using multiple sources to inform your decision making.

The content held in a patient's My Health Record can be divided into 3 categories:

Clinical information

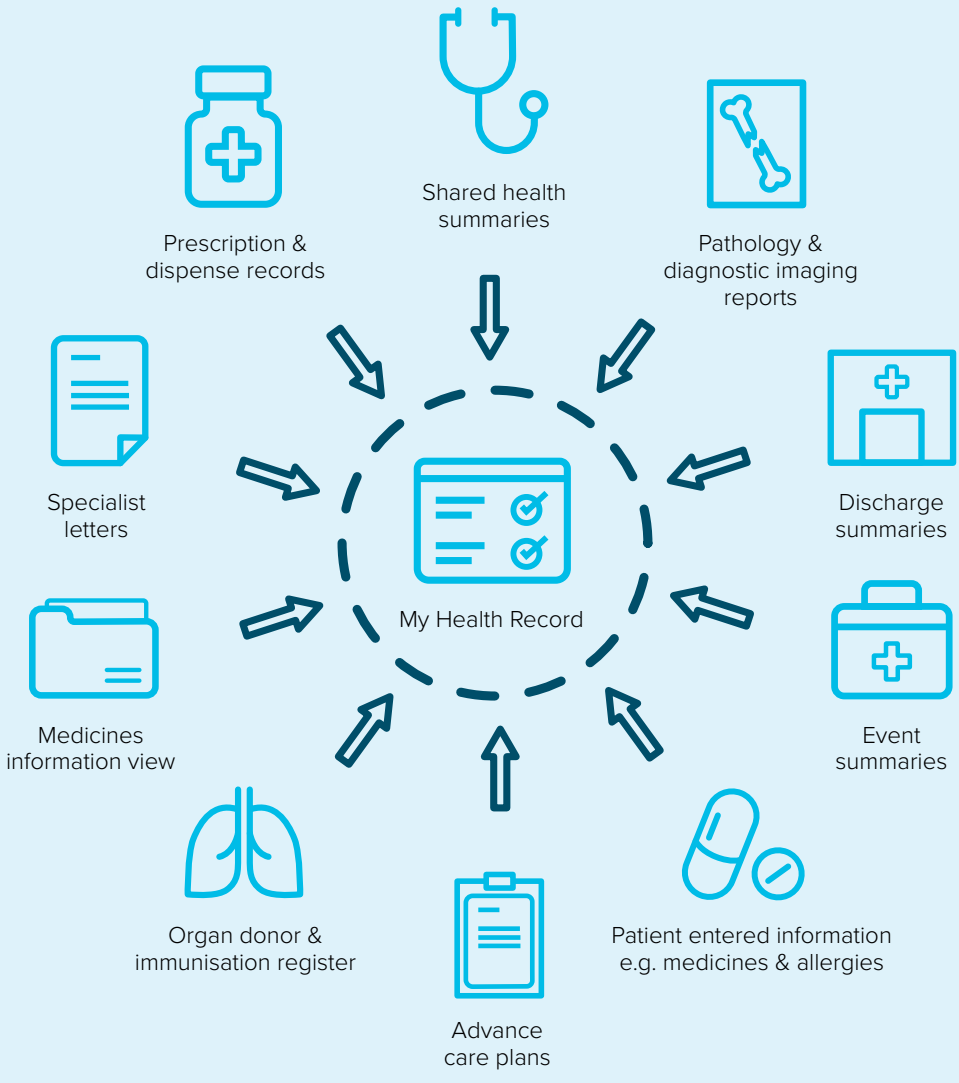
- Medicines information
- Event summaries
- Discharge summaries
- Pathology and diagnostic imaging reports
- Specialist letters
- eReferrals
- Shared health summaries
- Prescription & dispense records

Consumer-entered information

- Advance care plans
- Next-of-kin details
- Emergency contact details
- Child development notes
- Personal health summaries

Medicare and PBS data

- Immunisation records
- Organ donation information
- Medicare claims information
- PBS claims information



My Health Record

Documents

Which documents can I access in a patient's My Health Record?

Medicines information

Sorts and displays medicines information held in a patient's My Health Record documents in date or alphabetical order.

Shared health summary

Useful for accessing summary information documented by a patient's nominated healthcare provider. This may include past and current conditions, medicines information, allergies/adverse reactions and immunisations.

Event summary

Captures key health information about a specific health event that is relevant to the ongoing care of an individual.

Prescription and dispense records

Helpful for conducting medication reconciliation and reviewing a patient's dispensing history.

Discharge summary

May contain information to inform patient history taking.

Next-of-kin details

Contains next-of-kin information and contacts.

Specialist letters

May be used to inform a comprehensive patient history or reveal previous specialist reviews.

Advance care plans, organ donation status

May help to inform decision-making for end-of-life care.

Pathology & diagnostic imaging reports

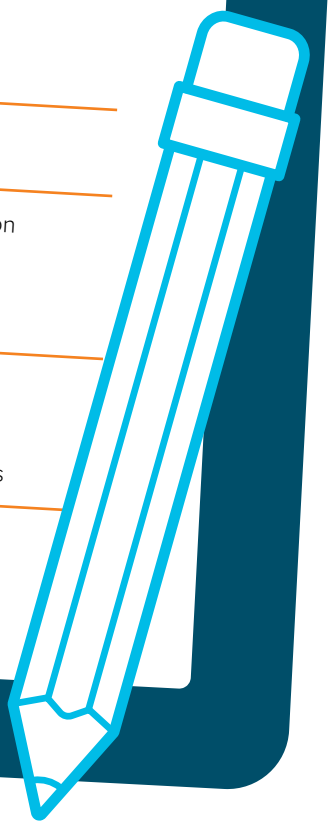
Can be used to find previous pathology and diagnostic imaging results. Helpful for avoiding duplicate testing.

Patient-entered information

Consumers can enter information into a personal health summary including medicines information and allergy and adverse reaction information.

My Health Record use in history taking and assessment

Task/assessment	Consider using
Presenting complaint	Shared health summary eReferral Event summary
History of presenting complaint	Shared health summary Discharge summary Event summary
Past medical and surgical history	Specialist letter Shared health summary Discharge summary
Medications, allergies and immunisation history	Medicines information view Prescription and dispense record PBS information Immunisation record
Social history	Shared health summary
Family and developmental history	Child development information Shared health summary Next-of-kin details
Examination	eReferral Specialist letter Diagnostic & pathology reports
Other relevant information	Organ donation status Advanced care plans



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Benefits

EVOLVING

Capability to upload to My Health Record is evolving.

It is anticipated that eventually all discharge summaries or letters from ED and the broader hospital will be uploaded, even if they aren't now.

CONSOLIDATED

My Health Record is a consolidated collection of patient health documents.

You can find information from outside your local hospital network and from other healthcare providers you wouldn't normally be able to access remotely eg. GPs, private specialists and community healthcare practitioners.

ACCESSIBLE

You can access My Health Record at any time.

There's no need to wait for the GP practice to open when it's after-hours. Summary information can be accessed at any time of the day.

REDUCE TEST DUPLICATION

My Health Record helps to reduce unnecessary testing by collecting a record of pathology and diagnostic imaging reports.

You may find previous results to avoid having to re-take blood or perform scans.

ELECTRONIC

My Health Record is a digital tool and accessible online.

In some cases, this will eliminate requests for faxed or paper records when you need patient information from outside your ED. Patients may also be able to show you their My Health Record via an app on a tablet or mobile device.

Busting Common Myths

Myth: My patient won't have a My Health Record.

Fact: Over 90% of Australians chose to have a My Health Record created for them in February 2019.

Myth: Patients' insurers and employers can access their My Health Record.

Fact: Legislation prohibits any entity from accessing, or even requesting access to, My Health Record information for insurance or employment purposes.

Myth: Patient information is not secure.

Fact: The My Health Record system meets the strictest cyber security standards. It has robust multi-tiered security controls to protect the system from malicious attack.

The system has been built and tested to Australian Government standards to protect the confidentiality, integrity, and availability of information within an individual's My Health Record.

Myth: All law enforcement and government agencies can access My Health Record information.

Fact: Under My Health Record legislation, information cannot be released to law enforcement agencies without the patients consent or a court order in limited circumstances.

My Health Record

In Clinical Practice

The big time wasters in ED

Fax machines & scanners

Commonly, when a patient arrives in the ED, we require information from sources external to the hospital network.

There is often a requirement for records and results to be scanned or faxed through to the ED. This can take considerable time and effort to either send or receive documents in this way.

Bags of medications

Patients on multiple medications can present to the ED without a clear record of their current prescriptions or medication history.

A common occurrence is a plastic bag full of unlabelled, loose medications, causing frustration when performing medication reconciliation.

Paper records

Many EDs are going digital; however, paper records and charts may still be present in some departments.

Sifting through paper charts and records is a common exercise when searching for past medical history. This can be time consuming if they are archived or held off-site.

Clinical Scenario: Emergency Record Access

An 18 year-old woman was travelling as an unrestrained passenger in a motor vehicle that collided with a stationary barrier at high speed.

The woman was thrown from the vehicle and sustained life-threatening injuries as a result. Unconscious, the woman required intubation at the scene of the accident by attending paramedics.

On arrival to the ED, the clinical staff attempted to access the patient's My Health Record, however a Record Access Code (RAC) was in place. The consultant physician determined the patient's condition was serious enough to warrant use of the Emergency Record Access ('Breakglass') feature.

The patient's My Health Record was accessed, revealing details about past medical history, allergies and organ donation decisions. This information was used by the ED team to support their clinical decision making and care provided for the patient.

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Legislation & Clinical Governance

Several key pieces of legislation govern the use of My Health Record by clinicians:

The Privacy Act 1988

Healthcare Identifiers Act 2010

Healthcare Identifiers Regulations 2010

My Health Records Act 2012

My Health Records Regulation 2012

My Health Records Rule 2016

My Health Records Amendment (Strengthening Privacy) Act 2018

There are significant penalties for misuse of My Health Record. It is important to understand which aspects of this legislation might affect you when interacting with the system.

Three simple strategies to avoid misuse

Think Privacy

Protect the privacy of patients and their sensitive information held in My Health Record.

Think Security

Don't provide unauthorised access to a patient's record or share passwords and login details. This means not sharing login details or passwords for systems (e.g. hospital eMRs) that may be used to access the My Health Record.

Think Quality

Remember, your discharge documentation is likely to be uploaded to the patient's My Health Record, meaning there is a much greater audience than a standard GP discharge letter provided to your patient.

Consumer's Rights

Consumers have a right to control and display what information they want you to see in their My Health Record. A consumer can:

Choose to cancel their My Health Record altogether by deleting it permanently.

Apply record access controls to their entire My Health Record, or hide individual documents, requiring a document code for access.

See who has accessed their My Health Record through an audit log, auto-notification email or SMS.

Request that a particular document not be uploaded to My Health Record, by withdrawing their consent to upload.

Allow and restrict record access to a specific healthcare provider or healthcare organisation.

My Health Record

Access

Viewing a My Health Record

Viewing a patient's My Health Record is performed through an icon or link located in your local ED software or via the My Health Record Provider Portal in accordance with your local hospital or State or Territory digital health policy.

Record Access Codes

May be in use on some records, meaning you will need to request the pass code from your patient to view information contained within their record. Once opened for the first time, you will have access to their record for **3 years, unless revoked by the patient.**

Emergency Record Access

In instances where access codes are in effect and consent cannot be provided, you may have to use the Emergency Record Access function (sometimes referred to as the 'Breakglass' feature).

Be aware that significant penalties apply for misuse of this feature – every use of 'Breakglass' is audited.

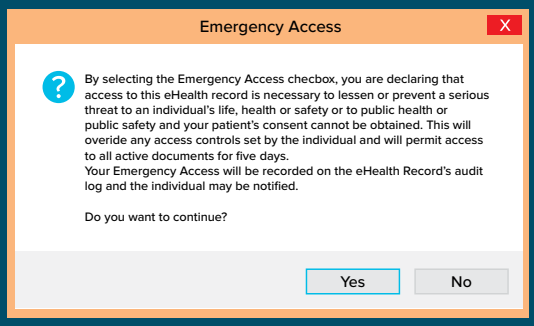
Emergency Record Access is available to clinicians for **5 days** from the initial time of access.

Federal Legislation (outlined in the *My Health Records Act 2012*) governs the Emergency Record Access feature and unauthorised access carries heavy penalties. Therefore, you must only use the 'Breakglass' feature to EITHER:

Lessen or prevent: a serious threat to an individual's health, life or safety and it is unreasonable or impracticable to obtain the healthcare recipient's consent;

OR

Lessen or prevent: a serious threat to public health and safety.



Consent

Under the *My Health Records Act 2012*, healthcare provider organisations are authorised to view and upload information to the My Health Record system, providing it is for the purposes of delivering care.

Remember that a patient can withdraw consent to upload information to their My Health Record at any time. You should also be familiar with local policies in your hospital that outline how to prevent a document from being uploaded and remove a document that your hospital has uploaded.

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Protecting Vulnerable Groups

Vulnerable population groups often access the healthcare system through the ED. Clinicians can support and protect the privacy of vulnerable patients by undertaking simple steps:

BE MINDFUL

Be mindful that the information contained within a patient's My Health Record may be accessed by a broader group of healthcare providers. Reminding a patient that the information from a hospital visit will be uploaded can prompt them to remove or restrict access to a report or document (if they happen to be concerned about sensitive information being uploaded to their record eg. sexual health or mental health history).

BE AWARE

Be aware that adolescents gain control of My Health Record from their parent/s or guardian at age 14. Conversations about My Health Record content can be held with 14-17 year-olds independent of their parent/s or guardian.

DISCUSS

Discuss with your patient whether they are happy to share hidden information with you, as it may impact your clinical decision making. For example, some patients with a mental health history may prefer to restrict access to documents from clinicians by applying a Limited Document Access Code (LDAC).

INFORM

Inform patients with sensitive past medical history that when accessing their record for the first time, they can opt-out of MBS and PBS data being populated into their My Health Record.

Clinical Scenario

Richard, a 25 year-old man presents to the emergency department with a fever and some pain and redness in his left arm. His clinical presentation suggests he may have an infection and requires treatment with IV antibiotics.

Richard tells the triage nurse that he has a My Health Record, but he's worried about revealing some past history with IV drug use that might get accessed by the police. Richard has placed a record access code on his My Health Record.

Andrea, the ED consultant reviewing Richard, explains to him that under legislation, no information can be released to law enforcement or a government agency without his consent or an order from a judicial officer. She requests Richard's access code and views a shared health summary uploaded by his GP.

The summary shows Richard's drug and alcohol history which they are able to discuss together and make a treatment plan. Andrea can also see that Richard has had a previous sensitivity to Cephazolin, and prescribes an alternative antibiotic.

My Health Record could make the difference.

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Frequently Asked Questions

For Clinicians

Why should I use My Health Record?

My Health Record gives clinicians access to documents and clinical information from other healthcare providers. This information helps to inform and improve clinical decision making.

When should I use My Health Record?

My Health Record can be used to help aid patient assessment, view past medical history and inform medication reconciliation activities for your patients.

What are the benefits of My Health Record?

My Health Record can improve the transition of care for patients moving to and from the ED. Improving access to a range of clinical documents and resources external to your hospital can reduce the time it takes to access important information. My Health Record can also facilitate more efficient and better clinical care through avoiding unnecessary duplication of investigations and clinical tasks.

How do I upload a document to My Health Record?

Most My Health Record documents are uploaded automatically via your hospital eMR or Clinical Information System (CIS). This requires no change to normal documentation practice, other than if a patient withdraws consent to have information uploaded.

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 local ED clinical information system. 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 ED clinician?

Discuss with your patient that My Health Record is a patient controlled record, and they can choose to restrict who views or accesses their sensitive information. It's good practice to inform your patient that this information can be helpful in ensuring they get the most appropriate care, while also respecting their rights as a consumer.

From ED Patients

Is the personal information in My Health Record safe and secure?

The My Health Record system complies with the strictest cyber security standards. It has tight security controls to ensure that your information is protected from malicious attack.

Can the police, Centrelink or the Australian Tax Office access my record?

Under My Health Record legislation, no information can be released to law enforcement or a government agency without your consent or an order from a judicial officer.

Which doctors, nurses and healthcare providers can view information stored in my record?

Only the healthcare provider organisations involved in your care, are allowed by law to access your My Health Record. These providers need to be formally registered with the My Health Record system operator and there are significant penalties for unauthorised access.

Will my past medical history be in my record?

Your previous medical history such as older test results and medical reports will not be in your new My Health Record. When your My Health Record is activated by you, or your healthcare professional for the first time, there may be little or no information in it.

If you want details of your medical history to be added to your My Health Record, ask your GP to add a summary next time you see them.

Will my healthcare provider be able to find out about past or current medical issues that I consider sensitive?

You have the right to choose what information is visible in your My Health Record, and who you want to share it with. You can let your clinician, pathology or diagnostic imaging service know during your visit if you don't want them to upload documents or reports to your record. This is also called 'withdrawing consent' for upload.

I don't want a My Health Record anymore, can I permanently delete it?

Yes. When you delete your My Health Record, all information in the record will be permanently deleted. Deleted information cannot be recovered.

If you decide to re-register for a My Health Record, your new record will not contain any of the information from your old record.

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Resources

Need support accessing My Health Record?

Contact your clinical information system support team or hospital trainer for information on how to access patients records, navigate the My Health Record system, or troubleshooting.

Please select your State or Territory for local resources and information:

Additional resources

The Australian Digital Health Agency (ADHA)

http://www.myhealthrecord.gov.au

https://www.myhealthrecord.gov.au/for-healthcare-professionals/hospitals

https://www.myhealthrecord.gov.au/for-healthcare-professionals/what-is-my-health-record/clinical-governance

The Royal Australian College of General Practitioners

https://www.racgp.org.au/download/Documents/e-health/My-Health-Record-A-brief-guide-for-general-practice-June18.PDF

The Office of the Australian Information Commissioner (OAIC)

https://www.oaic.gov.au/privacy-law/other-legislation/my-health-records

Australasian Society for HIV, Viral Hepatitis and Sexual Health Medicine

https://ashm.org.au/products/product/myhealthrecordguide

The Pharmaceutical Society of Australia (PSA)

https://my.psa.org.au/servlet/fileField?entityId=ka17F0000000yk9QAA&field=PDF_File_Member_Content__Body__s

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