Hospitals

# My Health Record expansion program

## Features of My Health Record

### What is My Health Record?

My Health Record commenced in 2012 and was then known as the Personally Controlled Electronic Health Record (PCEHR). Operated by the Australian Digital Health Agency, My Health Record is a secure online summary of a consumer's health information that can be accessed by authorised healthcare providers taking part in their care. Consumers with a My Health Record will be able to set privacy settings, which allows them to control what goes into the record, and who sees it.

### Change in the participation model

In July 2018 the participation model will change from 'opt in' to 'opt out', meaning every Medicare card holding Australian will be offered a My Health Record unless they choose not to have one during the three month opt out period that will run from 16 July to 15 October 2018. This will be followed by a 30 day reconciliation phase to allow for the processing of paper-based forms.

### Clinical documents

My Health Record contains a wide variety of clinical documents including health summaries, discharge summaries, Medicare claim history and hospital discharge information. These documents include key pieces of healthcare information including allergies, adverse reactions, medications and diagnosis.

Participating health services and their healthcare providers can upload these documents to a consumer's My Health Record and if available, can view this information via their clinical software system.

Clinical documents support the continuity of care, and improve the interactions between healthcare providers and patients. These documents support clinical workflow by allowing important patient information to be shared between healthcare providers electronically.

My Health Record will continue to evolve to include other document types and services – according to the needs and priorities of the healthcare system.

This fact sheet may help in educating healthcare providers on the different document types they may see in a patient's My Health Record and what these documents may include.

### Document types

**Shared health summary**

A structured template representing a patient's health status at a point in time. It may include medical history, current medications, allergies and adverse reactions and immunisations received.

The most recently uploaded shared health summary is likely to be accessed by other healthcare providers viewing a patient's My Health Record.

A shared health summary is usually created by the healthcare provider delivering continuing, coordinated and comprehensive care to the individual e.g. general practitioner or nurse.

**Event summary**

Used to capture key health information about significant healthcare events relevant to the ongoing care of an individual. It should summarise the nature of the event, the assessment made and action taken.

It may also include allergies and adverse reactions, medications, diagnosis, interventions, immunisations and diagnostic investigations.

An event summary is usually created by a healthcare provider at an after-hours general practice clinic, hospital or community pharmacy

### Discharge summary

A structured document capturing details of a patient stay in hospital. As of October 2017, over 700 Public Hospitals and health services Australia wide are connected to My Health Record and sending discharge summaries for patients with a My Health Record.

Some health services only upload discharge summaries from inpatient episodes, and others include emergency department discharge summaries too.

### Medication records

Healthcare professionals who use clinical software to prescribe and dispense medications can also upload a copy of this information directly to a patient's My Health Record.

The view displays the name and date a medication has been prescribed and dispensed (both the brand name as well as the active ingredient/s), the strength of the medication (e.g. 2mg, 20mg, etc.), the direction for consumption (e.g. take one capsule daily) and the form of the medication prescribed (e.g. capsule, tablet, inhaler, etc.).

### Electronic referrals (eReferrals)

When coordinating the care of patients, GPs may have to refer to specialists for further diagnosis or treatment. As per current process, the healthcare provider generates an eReferral and sends it directly to the intended recipient. A copy may also be sent to My Health Record.

This structured document includes reason for referral, current and past medical history, current medications, allergies and adverse reactions and diagnostic investigation.

### Specialist letters

The document used by a treating specialist to respond to a GP about a referred patient. It is based on the usual practice where a specialist writes back to the GP.

This structured document takes the paper form and creates an electronic version, allowing for it to be used in communication directly to a GP, and uploaded to an individual's My Health Record. It creates an efficient way of displaying key information about the visit, such as diagnoses, recommendations and medications.

### Medicare records

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, if relevant, details from their Australian Childhood Immunisation Register (ACIR) records.

## Consumer entered information

Information entered by consumers via their My Health Record portal can be viewed by healthcare providers.

### Personal health summary

A personal health summary can include allergies, adverse reactions and current diagnoses and medications.

### Advance care custodians and directives

A copy of the patients Advanced Care Directive can be stored in My Health Record. Consumers can also enter the contact information of a person or organisation who is the holder of their Advance Care Directive (or 'living will').

### Emergency contact details

A list of important emergency contacts entered by the consumer.

### Child development

The child development section of a child's My Health Record contains: an achievement diary, personal observations, immunisations, child health check schedule, child growth charts and information for parents.

This information is currently only visible to healthcare providers through the National Provider Portal, as clinical information systems have not yet built this functionality into their systems.

## For further information

**Select this link: My Health Record or visit <https://www.myhealthrecord.gov.au/>**

**Alternatively, visit the Department of Health and Human Services website <https://www2.health.vic.gov.au/hospitals-and-health-services/quality-safety-service/my-health-record/resources> for additional resources.**

To receive this publication in an accessible format phone **9096 0749** using the **National Relay Service 13 36 77** if required, or email **myhealthrecordexpansion@dhhs.vic.gov.au**

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