Train IT Medical
Competence with Confidence

Questions received from participants during the My Health Record Webinar held on 7 April 2016

Please note many questions asked were also in my previously published 'Top 30 Questions doctors ask about My Health Record' so I have not listed those questions again here. Please refer to the previous blog post for that list (including my responses).

***Disclaimer**: Please note I am an independent trainer and Practice Management Consultant with my own Practice Management Consultancy & health IT training business – Train IT Medical. While I am an approved trainer for MedicalDirector, Best Practice Software, Nehta, Avant Mutual Group, AHPRA, PenCAT, Tyro Payments etc. and regularly present education sessions on behalf of organisations, the responses and opinions expressed herein are my own. This document may change over time so if sharing please link to current version on website rather than saving this pdf.*

1	Are there training packages Practice Managers can download and present to their staff and clinicians ie these slides, scripts etc.?	There are many training materials available on www.nehta.gov.au. There is also a national eLearning program that is due for release any day now from the Department of Health and their newly updated website www.myhealthrecord.gov.au . There will also be more free Webinars and training opportunities coming soon.
2	How do allied health professionals not registered with AHPRA get an individual identifier?	Individual healthcare providers not registered with AHPRA, such as a dietician or social worker, can apply for a HPI–I directly to the HI Service operator by filling out the 2977 – Application to Register a Healthcare Provider form available at humanservices.gov.au.
3	Do patients need to give consent for the summary to be uploaded? Does this consent need to be included in patient notes?	Here is the formal information regarding consent: *You don't need your patient's consent each time you view or upload information to their My Health Record. You can access an individual's record as part of providing them with care, subject to any access controls they have set.* *The only instances when you can't upload information are when a patient has asked you not to, or if it is sensitive information prohibited by specific laws in the My Health Records Regulations.*

		When creating a My Health Record a patient is essentially consenting to information being viewed and uploaded by their healthcare providers ("for the purpose of providing healthcare") however I believe it is good practice to clearly communicate with our patients at all times so they are fully informed that information is being uploaded (they will be able to see it themselves when they log on). When you upload a summary your software should auto-document in the patient notes and if you wanted you could add an extra notation as to whether they were in consultation with you or not as well as any discussion that took place.
4	Is there an incentive payment for specialist practices or is it only for GP practices?	At the moment it is for General Practices only.
5	If a patient doesn't want this, then presents in ED, how does the medical team access the medical record?	If a patient has not opted for a My Health Record, then the medical team will not be able to access the record.
6	Can specialist letters be uploaded by the GP?	Not at this stage no. The idea is Specialists will upload their own letters. Currently I hear Specialist letters are being uploaded regularly from both the Northern Territory and St Vincent's Hospital in Sydney.
7	Is this system compatible with iCare? This is the system that our Aged Care Facility uses.	Yes, iCare is compatible with the My Health Record system. Through iCare directly clinicians can view documents uploaded into the My Health Record System and upload both Shared Health Summaries and Event Summaries.
8	If a shared health summary is uploaded at the end of a consultation upon a diagnosis being added - does this replace the previous summary or is the previous summary still there?	The previous summary is still there. It is like your online banking, all the history remains in there and we just use filters and searches so that only we easily view the most recent information.

9	What item numbers should be used?	Here is the billing information as per www.myhealthrecord.gov.au - *'Under MBS item 3 for general practice attendances, GPs can account for the time taken to prepare Shared Health Summaries and Event Summaries for a My Health Record, if the activities are undertaken with any form of patient history taking and/or other clinically relevant activities form part of a consultation. These activities are considered to be part of the documentation for treatment of the patient and count towards the calculation of consultation time for billing. Please note that the patient does not need to be present at the time of uploading the Shared Health Summary'*
10	The Genie simulation still requires uploading a scanned consent - is this still a requirement or can this be skipped with the informed consent?	The Genie software simulation (and others) still need to be updated to reflect the new Assisted Registration requirements. Informed consent is still required to register a patient however it is now up to the organisation's discretion whether they still want to use the form, scan or not. It is recommended that, when creating your practice policy around Assisted Registration: • *confirm whether an individual has given consent* • *the process and criteria they will use in identifying an individual for assisted registration.* www.myhealthrecord.gov.au
11	How can I find the information from Pen Cat about which patients have a EHR?	I have put a helpful presentation from Central & Eastern Sydney PHN on the 'Free Resources' page of my website which you can download and follow for steps on extracting information using Pen CAT4.I:\Desktop\PenCAT - eHealth Update 040216 from CESPHN.pptx
12	Can nurses apply for their own HPI-I?	Individual healthcare providers registered with AHPRA are automatically assigned a HPI–I by the agency. Healthcare providers can get their HPI-I by contacting AHPRA or the HI Service operator.

13	Do you need to ask permission from patients every time you consult if they want that information uploaded?	Patients essentially consent for you to view and upload when they create a My Health Record and choose to see you as their nominated healthcare provider. I always suggest however obtaining and documenting specific consent and including the patient in the entire process (especially for the first upload) so they do not get a surprise when they get home and find their health summary on their record. By including them in the conversation it also allows an opportunity for patients to review their own health summary and they will often advise changes to the medications they're currently taking which will lead to improved data quality and clinical safety. In early conversations perhaps also discuss with the patient that you may upload and access their record at times when they are not with you. This is a courtesy rather than a requirement.
14	What responsibility does GP have if a patient does not want to upload a significant diagnosis eg: Hep C?	I'd suggest following your usual practice decision-making processes as I find this applies now when doctors print referrals and sensitive information may be withheld. As per your usual practice process if a patient is ever asking you to do something that you feel puts you or others at risk you have the right to refuse and I'd suggest if anyone ever feels they are in a questionable situation to contact your medical indemnifier for advice.
15	Allied Health practices could be seen as 'competitive' businesses. Can you please share any concerns that have been raised in this respect?	I have not actually had any concerns or questions raised in this regard as yet. We should only be accessing the patient's My Health Record if a designated healthcare provider for the patient. Fines do apply for deliberate misuse of the system.
16	How do we encourage GPs that give pushback?	I am always interested in the reason for the 'pushback' as this will be important to identify and address first. Technology change is always difficult as GPs are so time-poor and of course focussed on patient care rather than technology. We need to pinpoint any concerns and address these first then find a way forward that will benefit patients and GPs in your own practice. I would suggest a gentle progressive approach eg. Let's just register and

		upload a health summary for all our patients who may be likely to go to hospital or are over 80 perhaps.
17	Will Government departments have access to the patient records, ie Medicare, Centrelink. Also what happens when children are registered and they become teenagers, at what age do parents no longer have access to their records?	Information from Government departments is included in the My Health Record system now eg Medicare upload MBS billing, PBS information, ACIR and organ donor information is included if the patient selects this option when registering for a My Health Record. When a child reaches the age of 14 parents will no longer have access to their children's records.
18	What's been your best example which you have seen in terms of patient consent - given there is the implied consent model, we still want to add an extra level of cover in this regard	I like to create a shortcut in progress notes which just auto-documents the process. I usually suggest leaving a variable (caret) stop to enter the patient comment, ideally quoting the patient's own words eg. Patient said 'yep that's all fine'. Some doctors tell me this is 'over the top' and unnecessary but as you say, when an extra level of cover is required... When using a shortcut, it can be as simple as entering 3 characters so it can be fast and helpful if doctors are worried about consent.
19	Is the HPI- the same as our Medicare ID	No, it is a different unique identifier.
20	How do you upload advanced care directives, is there a template to use?	At the moment patients log onto their My Health Record and can scan and upload their advanced care directive as a pdf. I believe we may see changes soon to enable healthcare providers to also upload ACDs.
21	We use clinical software Medinet. Is there any chance of getting a demonstration updated?	I will send your request through to Nehta.
22	We use Practix. Resources?	There are Practix resources available on www.nehta.gov.au including a helpful software video.
23	Houston VIP.net - can we do on demand training?	I am told Houston VIP.net (now owned by Best Practice software) has the ability to view and upload to the My Health Record System. I have also sent

		your suggestion through that it be included in the On Demand (test) training environment.
24	In summary, now to meet requirement 5, now practices have to upload minimum numbers of 0.5% of SWPE per practice per GP, and this can be done by one or more clinician in the practice. Is it right? 1. How do you bill for through the MBS for time spent creating and uploading a health summary?	The number of uploads can be done by one or more clinicians in the practice. Here is the billing information as per www.myhealthrecord.gov.au - Under MBS item 3 for general practice attendances, GPs can account for the time taken to prepare Shared Health Summaries and Event Summaries for a My Health Record, if the activities are undertaken with any form of patient history taking and/or other clinically relevant activities form part of a consultation. These activities are considered to be part of the documentation for treatment of the patient and count towards the calculation of consultation time for billing. Please note that the patient does not need to be present at the time of uploading the Shared Health Summary.
25	You just said 5 uploads per day but the slide says 5 per quarter per GP. Can you please confirm?	It is approximately 5 uploads per GP per quarter. I did say that once doctors are using the My Health Record system regularly I imagine they would probably upload 5 shared health summaries per day easily. If you were seeing a lot of elderly patients and changing medications, even 5 per morning! It will just become embedded into the clinical workflow so every time a medication is changed or diagnosis added a new summary will be uploaded. I imagine our software will evolve to prompt this process to help clinicians remember.
26	Are all the old versions of HPI_O, Nash certificate etc. still current or do we have to start all over again	Your HPI-O will be the same however your Nash certificate may have expired. If it has you would have been mailed a new one so have a look for that and load it into your software. If you can't find it, you revoke that one and reapply for a new certificate. I have included links for revoking or reapplying on the Free Resources – Digital Health page on my website - Digital Health (eHealth) Free Resources | Train It Medical

27	So what program or website are our staff going to use to register patients using informed consent??	Informed consent is the process of educating patients about your practice process and obtaining their consent. Have the 'Essential Information' handout ready for patients and I usually suggest when training, for staff to have a dialogue prepared and practise so they feel confident having these discussions with the patients. In addition, write your specific practice process into your official practice policy document. If you have conformant clinical software eg. Best Practice, MedicalDirector, Zedmed, Genie etc the registration process has been integrated so you can just use your usual practice software and it only takes a minute. More info on www.nehta.gov.au
28	Do clinicians still need to use the USB to be inserted to the pc each time they upload a My Health Record? We have done the set up work but not using them yet, we will be converting to Best Practice in 3 weeks	Best Practice Software is integrated with the My Health Record system so no, once your certificates are loaded and your HPI-O and HPI-Is entered into Bp you will not need to use USBs to view and upload to My Health Record as it is all nicely integrated. It takes approx 30 seconds to upload a health summary if the summary information (medications, allergies, medical history and immunisations) is up-to-date.
29	If a client wishes to opt out how is this done at not very clear on gov site and are they able to opt back in at a later date?	There is a link on the landing page of www.myhealthrecord.gov.au. It says 'Do you live in the Northern Queensland or the Nepean Blue Mountains area?' Opting out only applies to these areas as for the rest of Australia patients only get a My Health Record if we create one for them or they create their own. It is currently an 'opt-in' system nationwide with the two trial sites testing how the opt-out process will work.
30	Can patients access other uploads from specialists/ AHP etc?	If the Specialist and AHP has uploaded information the patient would be able to see that information when they log on.
31	My principal is not interested as long as patients can alter their clinical records... how should this be approached?	I remind doctors it is not meant to replace their usual clinical records and even with usual clinical records we would rarely have the absolute complete picture and need to clarify information that may be missing with the patient. We never know if the patient actually swallowed a medication without asking

	Is there any way for My Health Record to detect which shared summary is valid and which is not? In other words, how My Health Record will make sure that the uploaded data is useful?	them so this is the way I think of it; we do need to check every health summary in the consultation with the patient to assess currency. I am very much hoping that clinicians will ensure the health summary is up-to-date and accurate to the best of their knowledge before uploading.
32	We received recent communication from Medicare that the will not change the name they will be keeping E-PIP not D-PIP	Thanks for that. You are correct ePIP it is. Much easier to say than the full name: Practice Incentives Program Digital Health Incentive.
33	Can you please clarify if it is Aboriginal Health Worker or Aboriginal Health Practitioner who can upload? AHWs are not registered with APHRA	It is Aboriginal Health Practitioners who are registered with AHPRA and can get a HPI-I to enable viewing and uploading to My Health Record System.
34	if a patient attends 2 clinics and has requested uploaded summaries at both clinics - is this possible	Yes, patients can choose who their nominated practitioner is at a that point in time and ask them to create their health summary and upload to their My Health Record.
35	So, in far north QLD will patients already have a My Health Record (unless opted out), meaning that staff do not have to register these patients and/or patient register themselves?	That's right, patients in the opt-out trial areas will not have to register as they will have a record (an empty one) created for them. They will then see their healthcare provider and have documents such as a shared health summary uploaded to their My Health Record.
36	What do certificates look like?	They still commonly arrive on CD. Passwords are often received in a separate envelope. HPOS certificates are usually a USB token/key.
37	When do children have privacy? Do the children automatically separate from parents at a certain age? I think this could be problematic for some teens.	14 is the age at which a child is no longer included on their parents My Health Record.
38	Can DIV 1 and DIV 2 nurse upload the shared health summary?	Yes, they can contact AHPRA for their HPI-I and upload shared health summaries if appropriate in their own practice.

39	Do you need to get the patient's approval to upload a shared health summary?	There is 'standing consent' however I believe from a risk minimisation perspective it is always best to clearly communicate with patients our processes so I'd suggest having the discussion that at times you will be accessing and uploading to their My Health Record. Write your practice process into your policies and procedures and educate your patients (and all staff) as to how the My Health Record system works.
40	Q: Once we start to upload, is there a way to view our % of uploads? Or a daily upload number? Ie track who is uploading within our surgery. (and who isn't)	Clinical audit tools such as Pen CAT4 will enable this kind of extraction. I also understand currently both MedicalDirector and Best Practice software are building searches/reporting tools to enable easy extraction of this information.
41	How long does it take the My Health Record to become active after registering the patient at the practice?	This can vary. I have seen it almost immediately and then I have seen it take hours. I imagine it depends on IT variables but I am no expert on that one sorry. I will endeavour to find out more.
42	When is My health going to be integrated with the Physiotherapy Practice Management programs. We are in Cairns and will be part of the trial.	I'd ask your Physiotherapy Practice Management software vendor and let them know this is something you want. I find that demand from customers is the best way to drive software enhancements and the more voices the better.
43	Are Doctors alerted to the fact the patient has removed a document from their My Health record?	No although there is an audit trail kept of interactions with the My Health Record System.
44	Is there a way through Best Practice that we can extract how many patient charts have been uploaded?	I understand reports are being designed at the moment. In the meantime you can contact Bp Support for help with extracting via a search query. You can also use data extraction tools such as PEN CAT4 with Best Practice.

45	Medical Director ART requires a signed form. Do we just tick the button and not upload a form?	Until the software has changed we will need to tick the box. I suggest you detail in your practice policies and procedures what this means in your practice and detail the process your staff follow to obtain informed consent from patients eg. Staff tick the box to indicate informed consent has been obtained. In this practice this is via ……etc.
46	With the Assisted Registration done in your practice do we still need to hand the patient the essential Information sheet to them before we register them????	Yes. I find it can be helpful to have laminated copies for those patients who do not want to take one as they can read and return it to you. Please know also there will also be My Health Record patient brochures delivered to you soon.