This was the original list of 'Top 30 questions' (& barriers) I encountered when training My Health Record 4 years ago. I compiled this list at the time with the aim of helping others – mainly Practice Managers and PHN support staff – who are tasked with an enormous change-management challenge when it comes to Digital Health. Questions have evolved over the years and I have recently slightly updated some responses however I will leave the original questions also in case they are helpful.

I have tried to bring my voice to this document, written my responses the way I answer when asked these questions when training. I hope you find this training tool and information helpful and please do not hesitate to contact me – katrina@trainitmedical.com.au if I can be of any further assistance. With best wishes, Katrina Otto.

	Doctor questions, statements & concerns expressed	Katrina's responses
1	Can patients edit what I upload?	"This is by far the most common question I am ever asked. Please know patients **cannot** edit a document you upload. They only have view access and cannot edit. They **cannot** add a back condition and prescribe OxyContin – no way!" Patients can however see their own health summary that you have uploaded (ideally you've done this when you're with them). Therefore, I suggest that at the time of uploading it is a good opportunity to show your patient the list of medications they are on and show them their own medical history list. Then it should not be a surprise for them should they log on and view the uploaded documents themselves. I am quietly hoping that patients knowing their own medications and conditions will help with better understanding and management of their chronic conditions. I read (US) research that said 40% to 80% of what a healthcare provider tells their patient is immediately forgotten, and half of what the patient does remember, they get wrong. We also know patients google everything. This is a new era of patient involvement; it will be helpful if they know their own conditions and can access their health summary themselves when they need to and for other healthcare providers to have immediate access to it at the point of care. By viewing the uploaded health summaries, other healthcare professionals are also informed who the regular GP is so they could touch base to further clarify details if they wish.
2	I heard patients can remove documents?	Yes, they can remove an entire document but why would a patient want to remove a document if they were with you when you uploaded it and had seen what was on it? I hear from the medical indemnifiers that most of our complaints in medical practices seem to stem from the patients feeling they don't know what we are doing and why. If your patient knows you are uploading their health summary information they should not then get a shock if they see that document online themselves or when they are with another clinician. Doctors tell me this is another patient conversation that is going to take up time in a consultation however whether we like it or not it is a new era and patients are wanting to be better informed and more involved in their health & learn more.

		I mean we know how much patients love Dr Google and how scary the answers they get on Yahoo Answers can be. Isn't it better to have that conversation now than a complaint later? I would imagine patients might want to remove a document if their health summary had inaccurate information on it. So I always suggest including the patient in the conversation so what they see is not a surprise to them and there aren't inaccuracies. Being in practices every day I see inaccurate information shared on paper constantly (I could tell you so many stories and problems caused by inaccurate printed documents). Nurses especially tell me it is rare to see a printed health summary that is completely accurate and patients checking their own medication and history list should lead to significant safety benefits. As the 'authoring organisation' you also have authority to remove that entire document. You cannot remove a document another healthcare organisation has uploaded. I have never heard of anyone removing a document but I would imagine this might be the scenario if you discovered you had made an error perhaps in the patient's medication list and quickly wanted to remove the summary and upload the correct one.
3	Patients can omit information, so I may be looking at a document that is not clinically accurate. Will I know if a patient has omitted a condition or medication?	Patients omit information in person now, they forget information and it has been said at times they don't actually tell us the full truth even when directly asked. For example, I wonder how many of your patients actually tell the truth to that 'how much alcohol do you drink' question? We look at paper referrals, health summaries etc all the time now and they are not perfect. We don't solely base clinical decisions on them, we try and verify. Inaccurate data uploaded to the My Health Record system presents clinical risks in the same way as our current work processes do whereby we send health summaries or medication lists or referrals by paper and fax - as we do now all day every day. I am yet to meet a Specialist who would believe that a referral is a perfect accurate health summary of the patient. They would like to trust it I am sure but the reality is far from that. It serves as a guide and hopefully provides some information they did not have at hand before. I am hoping My Health Record will bring an improvement in data quality to lessen the clinical risks that I see all the time with our current processes. What I find is different about the My Health Record is it looks like it should be a perfect record. How about instead thinking of it this way: If you see a patient and are looking at their discharge summary or health summary, show them and ask them if it is correct – anything missing? Are they actually taking that medication the discharge summary lists? Perhaps they had a particularly sensitive issue 25 years ago and will tell you in person but did not want this on their current summary. Perhaps they have never told anyone this sensitive information. If you are worried about the fact a summary may have missing information I would suggest documenting the conversation. You could add a notation in the progress notes to say 'Asked patient if anything was omitted from health summary. Patient said ^'. I suggest creating a shortcut key to minimise typing in future if it's something you feel would be useful.

		In this scenario you have 1) viewed their health summary 2) saved it to your local record as evidence of what you've viewed and 3) documented that you have checked with the patient directly if anything was omitted and documented their response. What more can you do to get the perfect picture? Time to move on with the consultation but hopefully that discharge or health summary offered information you did not previously have. I believe we should always assume there may be information missing and clarify with the patient. It is also part of usual provider obligations for clinical standards of care to ask the patient about any information that may not have been captured in available documents from third parties. We need to always be mindful patients may never have told the uploading doctor about a condition ever so in my opinion it is just safest to clarify each time with the patient.
4	What if a patient asks me to omit information?	What would you do if a patient asked you to do something in a consultation that made you uncomfortable? Most doctors tell me they would just refuse to do it. Same goes If the patient is asking you to omit information and you feel it puts you, them, or other clinicians at risk. Doctors have told me they would say "I feel omitting that information could put you and the treating doctors at risk and I am not prepared to do that". I ask the question - at this point in time, on paper, would you refer a patient to an optometrist and not include their gynae history? When I ask that most doctors say yes, but they say they would include it if it's a referral to a gynaecologist. These are the situations you all face now and it is a judgment call and I imagine there are lots of unclear scenarios regardless of whether the My Health Record is involved. Good conversations to have with your whole practice team though so everyone feels prepared. I find with this discussion everyone always chooses to focus on patients with particularly sensitive conditions/history such as terminations, STIs, HIV etc however I pose a different (true) scenario for you: A patient who is an electrician (one of the most dangerous jobs apparently), working in one of the most dangerous work sites in Australia and is allergic to "just about everything". He has a 30-year-old knee injury (no cruciate ligament) that has never stopped him being an active person or working (or caused pain significant enough for medication) yet he fears the unknown with My Health Record as says that insurance companies may find out about his knee injury and that could affect his future employment prospects. **Question to doctors: Would you upload a health summary for this patient with his major allergies but not include his old knee condition? (By the way, he would tell you in person about his knee as soon as he saw you).** So far 100% of doctors I have asked this question to have said they would upload. Comments have included 'his knee condition is not life threatening' and 'ED seeing those allergies could save his life'.

		There has been a lot of discussion and questions around this but so far I have not yet heard any doctor say a patient has asked for a health summary to be uploaded with information omitted. Remember patients who are particularly worried about sharing health information with healthcare providers will probably choose not to have a My Health Record. I always suggest if you are ever unsure and feel a patient request or situation puts you at risk, contact your medical indemnifier for advice.
5	Why do I need this? I am the GP; I have all the information about my patient I need.	I think it's great that you are willing to be there 24/7 for your patient. I see every day how hard GPs work and I would actually like to lessen that load. What happens when you cannot be there for your patient, when you or they go on holiday? What about your colleagues, wouldn't it be good to make their lives easier and stop them having to chase information about your patient? I find your colleagues in Emergency Departments and After Hours Clinics want health summaries on the My Health Record more than anyone. One GP I know was of the opinion he did not need to be part of the My Health Record system at all as he had all the information about his patient (or his staff could get it for him) but said he has now had the realisation that he can't always be there for his patients and this is for them. Another GP said that most of his patients are elderly or have chronic conditions and he often gets phone calls at night and has to try and remember his patients' details or log-on remotely to his practice. He now routinely uploads health summaries for all his patients (and he is 70+ - the eldest doctor in his 15 doctor practice!) I find GPs really start to embrace the My Health Record system when there is a realisation that they cannot always be there for their patient. I guess historically we have often had doctor-centred care so it is a new way of thinking, a new era!
6	We don't get paid to be the curator of the patient's health record; it's too time consuming.	No and many GPs are really struggling with the Medicare freeze and general uncertainty and from what they tell me, a general lack of recognition and respect. I completely agree that shouldn't be the case and I would march in a rally for General Practice however I would debate with anyone who says it takes a long time to upload a shared health summary. What takes the time is keeping the information up to date ie. Quality data. Good record keeping is part of a consultation fee. Having an accurate health summary in the medical record is the RACGP standard regardless of eHealth. It can also help save valuable time in the consultation such as when generating referrals and chronic condition management because relevant patient information is coded and up-to-date.
7	The incentive payment goes to the Practice not me. Why should I do this extra work for no extra payment?	The incentive payment does go to the practice, correct, but that payment is helping the practice to fund all the technology we use all day - the computers, hardware, peripherals, servers, internet, secure messaging, clinical software, IT support and IT security etc. Practice Principals often tell me about the additional IT costs of running their business these days. It really is an important investment in the business as these technology efficiencies benefit all staff. I see practices where there's been insufficient investment in IT and it just makes everyone's job harder.

		You are charging a consultation fee and updating health summaries and collating information about the patient, writing documents etc and this is part of that fee. If a patient has significant health issues (and these are the patients who will benefit the most from a shared health record) then it would justify a long consultation charge. Someone with say one medication, one allergy, well that should be in their record anyway and uploading takes less than one minute max so hard to justify extra payment for that. I know it's the conversations that take time but that is mainly in this initial phase. This will just become a natural part of the clinical workflow. In reality uploading takes about as long as generating a repeat script. Doctors can do this very fast now (including the conversation) and it's become such a routine part of the consultation. It wasn't always that way. There are practice efficiency workflow processes that may be worthwhile looking at which can make the task of curating the health summary significantly less time-consuming eg. updating information at the point when new correspondence is electronically received into clinical software.
8	Our patient records have years of mess. How do I get GPs in my practice to focus on data quality?	To me this also comes in the form of a common statement 'It takes too much time" or "It takes too much time to clean up the patient history'. It takes 20 seconds to upload a health summary so the time factor often mentioned is all about data cleansing. Maybe a way to get doctors to focus on data quality is a gentle reminder that having an accurate health summary in the medical record for your 'active' patients ie those you've seen 3 times in the past 2 years, is the RACGP standard regardless of eHealth and that good quality clinical documentation a requirement for MBS billing. Accurate record-keeping is a significant medico-legal risk minimisation strategy. I find practices vary greatly but I do see patient records with 10 to 15 years' worth of mess and unfortunately this does take quite a bit of time to clean up. I recognise that for many the time it is going to take to clean up patient records now is by far the biggest challenge and barrier to moving forward. I argue that surely it's a good thing to help your colleagues when they are looking after your patient when you can't be there by having an up-to-date medication and medical history list and allergies recorded. My cheeky response is: "My invoice can't be 50% correct – how come you can print my health summary (with my medications and medical history) and it is only 50% correct? Surely health information is more important than financial information? As far as cleaning up goes, I do see a lot of practice nurses and registrars helping with this clean-up. I also see practices hiring a nurse for an extra day for a set time with a data cleansing type project. This could even have an additional benefit of increasing practice revenue for example, by using the process to identify patients who have not had a Chronic Condition Management Plan etc for several years, but who are eligible.

		I always suggest that if cleaning up is an overwhelming task start by archiving records for patients who have not visited for years. By removing them from the 'clean up list', you will find the task a lot less daunting. I also suggest, if it is a major project to clean up, just start cleaning up the health summaries for your patients you are seeing regularly, patients who are likely to go to hospital. Start with your most vulnerable patients and once cleaned up, maintain that health summary on a regular basis. With good software training you can learn tips to more easily keep the health summary up-to-date, reacting to incoming electronic correspondence. I find a lot of doctors complain about their colleagues and their poor data quality. I see building resentment too within practices because some doctors don't find it a huge challenge and just cannot understand how others don't care about the fact there may be outdated or irrelevant information. The doctors who do work on data quality often tell me they feel it's unfair that they have to clean up after their colleagues who don't seem to care. There seems to be a growing divide of doctors who are now good with technology and those who know the basics and are not interested. As a practice, we should be a team and work together to improve the quality of our collective service. It's important to work with those in the practice who are having trouble with technology by organising training and support. Doctors often tell me they never had any training with their software and this is really the first time it has really become vital that we use the software with conformity eg. coding diagnoses, only putting significant events and chronic conditions on the past history list etc. Now is the time for all practices to implement a quality improvement activity and focus on improving data quality. It will just make everything so much easier moving forward. There are also future improvements planned which could enable streamlined synchronisation of data eg. medications the hospital has put the patient on, so that should lessen the workload of continually 'curating' the health summary.
9	Everything gets hacked. How secure is this data?	Yes, it does seem everything is hackable. Apparently even the Whitehouse got hacked. I am told the National My Health Record system is built to the same standards as internet banking and I sure remember when people said they would never use internet banking. I remember when Medicare Online Claiming was introduced. This too was built using internet banking security technology and at the time was a risk many were reluctant to take. It actually turned out to be a significant time-saving technology improvement that benefitted both patients and practices. I don't know anyone who'd go back to mailing claims or handwriting receipts. I also clearly remember when doctors told me they'd never use medical software at all because "what happens if the computer goes down". At this time this was deemed to be an insurmountable risk. How we addressed this was with good quality IT support, systems and training. Every practice should have a disaster management and recovery plan.

		To be honest I see risk every day in the way we work in practices now and feel we should focus on our practice vulnerabilities and ensure we have the best procedures in place, good quality IT support and educate staff in both use of technology and security and confidentiality processes regularly. We have a professional, ethical and legal obligation to keep patient information confidentiality and secure. Patients take a risk every time they share their personal information with us. They trust us to keep that safe. We should therefore be constantly assessing risk and improving our practice processes to ensure both the practice and patients can feel confident in the way their information is managed. For example, if a patient was worried about their information being seen inappropriately with the My Health Record I would advise them they can set security controls if they want whereby they will need to enter their own code. When they are with a clinician and wish to access, at that point in time, they will supply their code. There is an inbuilt 'emergency access' (break glass) feature eg if the patient was unconscious but again the audit trail would clearly show this had been accessed. The My Health Record has highlighted awareness of data security because it is on a national scale. My Health Record is quite possibly the biggest change to date we have seen in health information management so now is a great time to step up not only IT security processes but train staff in protecting patient information, patient confidentiality and respect and also obtaining consent from patients to share relevant health summary information. Often practices just download a template policy or procedure, insert their practice name but there isn't the quality training that needs to go with that policy. I see a lot of assumptions that clinicians and staff have the requisite skills and knowledge. I am constantly nagging doctors to log off and not share their passwords. I still regularly see practices where staff log on as the doctor (they tell me this is to save the doctor time) and also where staff are not sure if their data is backed-up. We need to not only ensure optimum IT systems and support but educate staff to ensure they follow IT security processes to minimise risk. These days we need one person in particular who takes responsibility for the IT processes within a practice. This is why with the My Health Record the first thing that happens is the setup of the 'Responsible Officer' (RO) and 'Organisational Maintenance Officer' (OMO). I always say paying for good quality IT support is an investment in your business. Unfortunately, a lot of doctors don't agree with me and struggle with the not insignificant costs. This leads to either trying to manage their computer systems themselves or they get someone they know who is 'good with IT' to help. Medical records are too valuable. Hackers have been able to exploit security of practices due to outdated Windows workstations being used or not adhering to good security & privacy protection practices. This has happened in our local medical software systems, not My Health Record! I suggest you invest and pay a company who knows your own medical software very well, tests your system and ensures top of the range security is in place. I would argue that this also then helps with meeting the requirements under the Privacy Act of taking 'reasonable steps' to protect patient information.

10	I fax over information to the hospital when they ask quite a few times every day. It works well, let's just keep doing that.	It's about improving efficiency really. At the moment your admin staff are interrupted (from seeing patients who are actually at your practice) to take a phone call from the hospital, they then have to interrupt you, you stop seeing patients for a time, generate a health summary and then staff are interrupted again to fax that health summary. Multiply this by "many times per day". You are paying for that time which could be better spent on the patients that are present. Instead of this, by routinely uploading health summaries, that information would just be available to the other doctor at the point of care and they can get on with treating them. There are enough interruptions in a medical practice so if we could eliminate some of these that would free up time and save you paying staff to send faxes (and save money on printing!). I also feel we may not be doing everything we can to protect confidentiality as we actually do not need admin staff to be seeing that health summary. Your admin staff handle that document then perhaps an admin person at the hospital end when it's received. They all have to read that information to know who it's for and what to do with it and what happens if the fax is sent to the wrong number? The medical industry is probably the only one still faxing. We have more efficient technology these days than fax machines. I think it would be better for staff to be caring for patients who are in the practice rather than chasing paper all day. Our technology has evolved and so too should our practice processes. We have the choice here to protect patient confidentiality and have information directly going from clinician to clinician yet we are choosing not to do this? I am not sure patients know some practices are not doing everything they can to protect their confidentiality. In my travels I see so many breaches staff don't even seem to realise it. I always say don't assume your staff just have the skills and knowledge – provide them with support and training. I'd like to see training for all staff about Confidentiality, Privacy & Respect as a priority on every practice training plan.
11	I can just print the health summary out each visit and give it to the patient	Yes, you can and I like the idea the patient is seeing their own health summary. However, I would suggest, so it saves some money (your printer, paper, toner etc.) and time for other clinicians down the track, maybe, show the health summary to the patient now and then discuss and update their record and upload a shared health summary with them. Tell them they can access it themselves and other doctors will be able to view it. You might find they'd prefer that than the piece of paper. If they prefer the piece of paper, that's fine, keep printing. The reality of the printed health summary I see is elderly patients with their printed page with items crossed out. I have also seen them not have it when they need it in an emergency situation and other times seen them hand a completely outdated one to an emergency worker. I actually believe it Is cruel what we do to our elderly patients. I have elderly parents and have seen them struggle to remember their complex health information in ED when they are in such distress. I see ambulance officers going through patient medicine cabinets trying to work out what the patient is currently taking and ED spending valuable time trying to piece the health summary information together to enable them to treat the patient. I believe we can do much better and just about every emergency department nurse and doctor I have ever met agrees with me.

		If the emergency clinicians could look up the patient name and see an accurate health summary the GP has uploaded, a list they can clarify with the patient, then that should be a significant help to both them and the patient. Similarly, if you could just look at your clinical software and see a discharge summary or result for your patient that you were not sent directly, this is instantly beneficial.
12	I'd do this if the patients asked me to but they haven't asked. This shows they don't want this.	Most of Australia doesn't even know they can have a My Health Record (my coalface research confirms this every single day). There has been very little advertising by Government (maybe because there was no point telling patients to go and ask your GP to upload a health summary when practices simply weren't ready) so patients just aren't informed. We need to also educate administration staff as receptionists tell me patients have asked them but they have put patients off as they did not know enough about eHealth to help them. These requests never even reach the GP. It would seem to me that some patients do want one as the majority of new patient registrations these days are coming from the consumer portal which means the patients are finding out for themselves and creating their own My Health Record by themselves. The reception you receive from patients is often completely dependent on how you explain it. For example, I was at a practice who had begun registering patients and their local hospital had just become connected to My Health Record so they were at the early stages of registering patients and then the GPs would upload the health summary. The receptionist commented she needed to fax over a health summary to the ED and that it was the 5th time that day she'd had to do this and was looking forward to when they would just view My Health Record and she didn't need to stop her work to send a fax. A patient overhead and asked if she could have a My Health Record 'if it means the hospital would be able to see my health information'. I find that for some reason misinformation and negativity seem to spread much faster than the facts. I would like to see all Australians informed they can register for a My Health Record. We can't wait 2+ years until they are automatically created.
13	It is just a list of documents, they are static and will quickly go out of date.	Yes, test results, discharge summaries, medication lists etc all go out of date quickly. As they do when we receive them on paper. My Health Record will alert us to changes so we can update the patient's health summary. I think of it like online banking, our transactions quickly go out of date and are replaced with new ones but we still want them all listed. We use filters and searches to find important information quickly. It really is fast to upload an updated health summary or event summary when something changes for a patient. I watch how fast GPs print a script these days and it takes about the same time to upload as that. I can see how uploading a new health summary will become embedded in the clinical routine like generating computerised prescriptions has.

14	Is it okay to look at a patient's My Health Record if they are not with me?	True Story: As soon as our local hospital was connected one of the Practice Principals from a large GP practice said to me "all my patients are elderly Katrina, this will be so helpful for the hospital and also save me all those calls at night". His practice started registering all their patients and he routinely uploads health summaries. The hospital rang him and said they had one of his patients in ED and asked him to fax over the health summary. He had created the My Health Record but not yet seen the patient to upload their health summary. The GP wanted to upload the health summary rather than fax it and the question was 'Can I do this without the patient being with me?'. I suggested to him to just ask the caller from ED to just check with his patient verbally. They of course said yes and I always suggest to document in the patient notes for clarity. Provided the doctor was providing healthcare to the patient, he is authorised under the My Health Record system legislation to access and view the record so he did not strictly need permission however I feel it is important that patients understand what we are doing and why - just as a complaint/risk minimisation strategy. This scenario was not ideal of course, much better to upload that health summary in a calm consultation with the patient where they can view their health summary and have the opportunity to advise if there is inaccurate or missing information. I suggest, when first uploading a health summary with your patient and discussing their My Health Record, just ask the patient if it would be okay for you to look at their My Health Record in their absence for example to view a test result, specialist or hospital letter. Again this just means the patient won't be surprised. If we communicate well I find it hard to imagine a patient having a problem with the fact their own doctor is looking at their health record. If we contrast this to our current processes, a GP will often now look at information prior to a consultation (sometimes just hitting a button to file it away). So really, the My Health Record is just a faster way of processing information.
15	Why are other medical specialists not being supported to engage with the My Health Record system?	Since 1999 GPs have been supported either financially or with practice support eg from Divisions of General Practice then Medicare Locals now PHNs) whereas other health professionals haven't. It's not surprising specialists and allied health professionals are nowhere near as computerised as GPs. As a trainer I regularly see specialist practices now which are still completely paper-based. I am teaching 'introduction to scriptwriting' and 'generating computerised pathology & radiology requests'. For general practice I was teaching that 12 years ago. I find it is rare for Specialists to know about My Health Record including the fact that it is integrated into clinical software. I do find however that now that most public hospitals are connected to My Health Record and discharge summaries uploaded routinely, Specialists are interested in viewing the patient's My Health Record as they don't usually receive discharge summaries. This tells me that once it contains helpful information clinicians will use the My Health Record system. Specialists & Allied Health Professionals work so differently from general practice, a different approach is needed. One of the challenges I have found is, in Specialist practices, administration staff do a lot of management of the creation and sending of clinical documents. This poses a challenge as electronic health records are really designed for clinician access and upload.

		This challenge is being addressed and Specialists working for hospitals in the Northern Territory and St Vincent's Hospital in Sydney are regularly uploading their Specialist letters because it has been nicely integrated into their letter writing systems – there is no extra work for them to do. This is key learning for future success as I find asking a busy clinician to do two extra steps will annoy them and detract from time with the patient.
16	The Government is going to use this to monitor what we do, how we prescribe etc.	There are legislative restrictions so that the information contained in the My Health Record system cannot be used by Government for monitoring of individual providers. The secondary use framework for the My Health Record system is currently being developed. I suggest we look at it as we are accountable already whether we like it or not. The Government already knows every rebateable healthcare visit, every medication dispensed, immunisations etc. What is new is the larger scale sharing and it is a new era of sharing that's for sure. On the positive side, looking at healthcare trends will be easier. Computers give us access to population health management and research information on a scale we've certainly never had before.
17	Can I upload a care plan?	There are no care plan templates in My Health Record. Getting every doctor in Australia to use the same care plan template would be quite a feat and allowing the uploading of pdf documents in some ways may lead to a significant decrease in benefits from atomised data population. However it is a common request and we may see it…. Watch this space. In the meantime you can be creative, I have seen practices use the Event Summary as a care plan and copy and paste goals etc into that document. This is effective too as you can include test results and other relevant information into an Event Summary.
18	How often would I upload a health summary? Will a new summary over-ride the last one?	When there is a medication change or new diagnosis, immunisation or allergy added to their record ie a significant change. A new summary will not over-ride the last one. Previous summaries will remain on the list and you can use filters to remove older documents from view if you choose. It is not unlike our online banking whereby older transactions stay on the list in case we want to view them but we use searches and filters to quickly access the most relevant information. Uploading the health summary is incredibly easy however what I see is that the hard part is remembering to do this when you've made that change. This was reflected in the Clinical Useability Program (CUP) enhancements so please know the plan is to build in a prompt to help with remembering. One software product has implemented this improvement and it looks great because, as you close the patient file, you are asked if you would like to upload either a shared health summary or an event summary.
19	Will this show me if patients are doctor-shoppers or drug seekers?	In my opinion anyone doing anything really dodgy is not going to go near an electronic health record as it is way too sharing. Patients have to consent to having one in the first place and they can see when it has been accessed.

20	Can I upload pathology and radiology results?	You can't upload the results in your software as stand-alone documents no, not at this stage, however pathology and radiology is starting to be uploaded from the pathology and radiology providers. It might be helpful to know that if a patient does not want results uploaded the ordering doctor would notate this by ticking a box on the eOrder form in conformant software.
21	Can I upload a scanned document?	Not easily and effectively at this stage. And remember we are not supposed to upload anything from another author for eg. a Specialist should be uploading their own letter not a GP uploading a Specialist letter (and yes I know you fax other clinicians documents regularly now). Being creative again, and only with some software, you could move a scanned document into results and you can upload a result into an event summary. I would only recommend this if it was a result as the labelling process may mean it could be difficult to easily locate the particular document again.
22	I reckon insurance companies are going to get hold of this.	An insurer is not authorised to access the My Health Record system as they are not providing healthcare. Even a doctor working for a healthcare provider would not be allowed to access the patient's My Health Record as they are not providing healthcare for the patient. There are serious penalties for deliberate misuse of the system and remember too that the patient has an audit trail on their My Health Record. Personally I have mine set up so I receive a sms alert if it is accessed by a new organisation. I could set it up so I have to give a pin number for someone to even access it so I always recommend that option for anyone who is particularly concerned about clinicians inappropriately accessing their reord. So, unlike now, the patient will know when their record has been accessed and by whom and have a right to take action if they feel their record was inappropriately accessed.
23	Surely the fact that doctors haven't embraced eHealth it is an indication that it is not helpful.	I absolutely disagree! If we were talking about a new drug or clinical approach I might agree with that thinking however I have never found doctors prioritise technology. They prioritise patients and clinical care. I wouldn't expect people who work often 12 hour days, on call, house-calls etc, who are often from a non-computer generation, to actually have much inclination or energy to try a new electronic medical record. There are a lot of what ifs with technology and I hear a lot of concern about 'the Government'. I'd say that has a lot to do with lack or early adoption and I find as 'evidence-based' scientists, a wait-and-see approach is extremely common. Wanting input into design is extremely common also. There's a huge variance in opinions, rarely agreement I find. The percentage of doctors I know who are early technology adopters is tiny but we move forward slowly. I've been teaching how to code a diagnosis for 10 years now and still going and there are a lot of benefits to coding from a practice and patient perspective. I read recently it took 20 years for the stethoscope to be widely accepted in clinical practice. And that's a clinical benefit! Just the idea that the patient can see their own list of medical conditions, medications, allergies & immunisations is so completely new and foreign. The concept of patients having control over who sees this information has caused reactions like I've never seen before.

		I personally remember how long it took for computerised scriptwriting and pathology to become routine. Some doctors still aren't quite ready. We all know practices who still have paper records. I see first-hand how much easier it is to keep up than have to catch up. I work with practices who are just starting to use a computer or the internet and email and it is hard for them. I always say be risk-savvy not risk adverse. Medical practices need to run like businesses these days and patients are empowered consumers. Technology is not going to go backwards and the My Health Record is just one aspect of Digital Health.
24	Most patients don't have a My Health Record;	Approximately 5 million Australians now have a My Health Record. However, by the end of 2018, 98% of Australians should have a My Health Record as the Government has announced that, mid-year, there will be a My Health Record Expansion program and Australians will be advised they will be given a My Health Record unless they don't want one (they will have a period of time in which they can opt-out). Once the record is created it is then up to the patient whether they want anything uploaded to their My Health Record. With most conformant medical software, you can register your patients for a My Health Record in less than 2 minutes. Rather than waiting until mid-2018 I'd suggest continuing to register patients who you believe are most at risk and ensuring their health summary is uploaded and available for their other treating clinicians if this is something they want. That way, when Australians are told they are being given a My Health Record most of your patients will already have one, know what it is about and they (and you) should be starting to see benefits from improved sharing. At the very least you will have a lot less patients asking you questions (or possibly being concerned if misinformation is spread) as you will have already discussed it with them. The key to success is making My Health Record part of your normal workflow. At the moment printing is our normal workflow – let's make sharing electronically the new normal.
25	Are there Advanced Care Directives?	Yes patients can upload their own Advanced Care Directives now. There is no national standard for Advanced Care Directives and this is why at this point in time clinicians do not create and upload a standard 'template' however patients are welcome to upload their own pdf which will be accessible by connected clinicians. It may also be helpful to know patients can make another person an 'authorised representative' if they wish and give them access to their My Health Record. This may be helpful in the case of family members for example an adult child may help an elderly parent create a My Health Record and upload Advanced Care documentation to it.
26	Radiology or pathology results are yet to be made available to the My Health Record;	The Northern Territory I believe have commenced uploading radiology reports and there is continuing progress with uploading of Pathology and Radiology reports as well within the next 6 to 12 months. Private labs are creating conformant systems with more labs announcing connection regularly. Test results are a big goal of Digital Health in order to save patients having to repeat tests and of course all the money if they don't repeat tests unnecessarily.

27	Doctors will upload rubbish just to meet the ePIP/DHPIP (Practice Incentive Payment for Digital Health) requirements – they won't even tell the patients	Patients will be able to see what the doctor has uploaded and when their record was viewed. Historically we haven't seen high data quality with printed referrals, I am hoping the extra visibility and patient input will drive an improvement in overall data quality in our healthcare world.
28	Are private hospitals on board yet?	Public hospitals in every state are connected with more hospitals connecting regularly. Private hospitals and oncology in particular are continuing to connect with great success stories cited such as Cancer Care Units routinely uploading event summaries for their patients undergoing chemotherapy.
29	There are not enough people using it the system to make it helpful	We need to start somewhere. By the end of 2018, 98% of Australians should have a My Health Record (based on what happened with the opt-out trials). This will be a game-changer. We've wasted a lot of time having to register patients instead of moving forward to data quality and use. Everyone has been so confused about what may or may not happen next (politics!). Right now just keep moving forward, perhaps just focus on your patients who have significant health concerns; register them, upload their health summary and start. I like to focus on all our patients who are having care plans as they are seeing multiple providers. I also focus on patients over 70 as they are often seeing multiple healthcare providers. These patients often really want a My Health Record as they just want their important information available to their doctors. If they don't want their information shared that's fine too, nobody has to have a My Health Record. Even when it does eventually become opt-out nobody has to have anything uploaded to it if they don't want to.
30	Can that eDischarge summary I am viewing in the patient's My Health Record then populate my medical software with those medications?	Ah my favourite question ever! I believe the answer eventually will be yes however not yet. The eHealth ecosystem being built here is massive but we don't do fast massive change in the medical world. Every change needs to be carefully designed, discussed and managed for potential risk. It makes sense to me that we are starting at very basic ie uploading and viewing basic summary information about our patients. Even that has taken 3+ years. I don't envy those tasked with building this system. I remember asking doctors in my early eHealth training sessions if they would like data to synchronise for example 'if you saw a patient who was new to your practice and looked at a health summary the usual or previous GP had uploaded, would you like to be able to import this directly into your own medications and past history list?' From doctors I'd literally get a 50:50 response. 50% "yes that would save so much time" and 50% "no way, I wouldn't trust that information". This is typical of most software changes – some hate the change, others love it. Personally (depending on risk management) I would say having options in our software to cater for preferences are good. I'd like to see this built with the option for tick-boxes, check each one with the patient, and then synchronise data. And of course I always suggest if you're concerned clearly document the conversation in progress notes.

		So unfortunately, the answer is our software does not allow this yet but I do love this question because I know if you are asking this question we've moved beyond basic use to seeing how this could be even more helpful in daily practice. My understanding is that the system has been designed with this synchronisation in mind; the terminology components are still being built and the data is in, apparently, an atomised format to enable this. It's the beginning of reconciliation of medication and while it's a long journey, it has started. I've no idea how this will all look in our software and work but let's take gradual steps and feedback what you like and don't like so we see continual improvements. Over time however atomised data and synchronising clinical data will most likely become routine. This, as well as information directly from the national pharmaceutical dispense repository, should greatly help us maintain accurate up-to-date information with less data entry for clinicians. "

***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, Australian Digital Health Agency, Avant Mutual Group, AHPRA, AHPA etc and regularly present education sessions on behalf of organisations, the feedback and opinions expressed herein are my own.*