

My Health Record Enablement (using MedicalDirector Clinical Software)

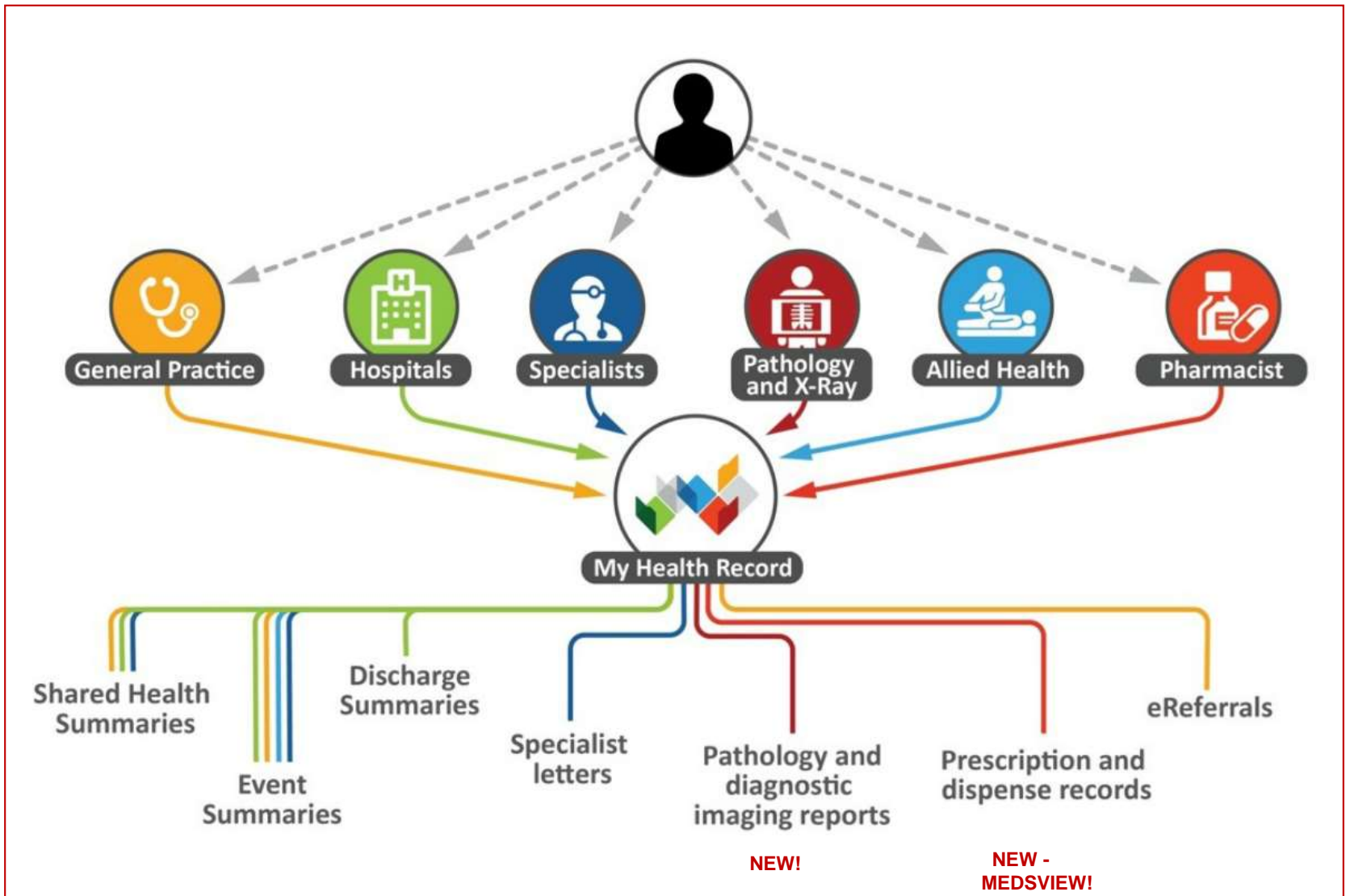
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Learning Objectives:

1. Describe how more comprehensive clinical information (access via My Health Record) can contribute to patient care.
2. Describe how to use your clinical information system to curate, upload and view My Health Record.
3. Discuss practical case studies.
4. Participate in hands-on training.



www.digitalhealth.gov.au

www.myhealthrecord.gov.au

My Health Records Amendment (Strengthening Privacy) Bill 2018

These changes:

- Allow people to permanently delete their records.
- Prohibit by law access for insurance or employment purposes.
- Strengthen privacy for teenagers 14 years and over.
- Strengthen protections for people at risk of family and domestic violence.
- Require law enforcement and other government agencies to produce an order from a judicial officer to access information in a My Health Record.

[Read more.](#)

New Stronger My Health Record Privacy Laws



Watch the youtube your patients may see: <https://youtu.be/BusMRjuHlhk>

Standard 1.3 “Expect to Share”

“Health Professionals should expect to share their health information with colleagues and with patients to facilitate safe and effective health care”

RACGP Quality Health Records in Australian Primary Healthcare



“The Health Summary is a window into the medical record.”

- Dr Suzanne Williams, Inala Primary Care

“I update the health summary every time I see the patient.”

Dr John Aloizos,
Garden City Medical Centre Principal & Clinical Lead,
Australian Digital Health Agency



PEER LEADERSHIP



My Health Record -



MedicalDirector



Practise in the 'On Demand' test environment

See what My Health Record looks like from a consumer perspective.




ON DEMAND TRAINING

Our digital health training tool – no booking required.

Learn how to use the My Health Record system in real time using a simulated version of your clinical software.

You can upload a Shared Health Summary, view a My Health Record, and more!



Best Practice ODT

Communicare ODT

Consumer Portal ODT

Fred Dispense ODT

Genie ODT

Medical Director ODT

Zedmed ODT

[Go to On Demand Training Environment](#)

View your patient's My Health Record



MedicalDirector

MyHealthRecord

DOB: 15/03/1979 Gender: Male Occupation: On 10s

Ph: Record No: ATSI: Aboriginal

Pension No: Ethnicity: Australian Aboriginal

Smoking Hx: ? Smoker IHI No: 8003 6081 6669 0511

MyHealthRecord: Exists with access permission as of 26/02/2017

- **Exists requires access code as of DD/MM/YYYY:** The patient has a My Health Record record but it requires an access code. The patient has setup the access code for his/her My Health Record.
- **Exists with access permission as of DD/MM/YYYY:** The patient has a My Health Record record and you may access the patient's My Health Record.
- **Does not exist or not disclosed as of DD/MM/YYYY:** The patient either does not have a My Health Record or the My Health Record record is hidden.
- **IHI not recorded as of DD/MM/YYYY:** The patient does not have an IHI recorded.

Access information

eg Discharge Summary or Health Summary

Discharge Summary
23 Dec 2014

Mr Caleb **DERRINGTON** DoB 15 Jun 1933 (81y) SEX Male IHI 8003 6080 0004 5922

START OF DOCUMENT

Hospital

Author Dr. Chris Craig (Specialist Medical Practitioner)
Phone 3553-6666
Discharge To Other/Home
Discharge From Orthopaedic Unit

Health Profile

This section may contain the following subsections Adverse Reactions and Alerts.

Adverse Reactions (Health Profile > Adverse Reactions)

Adverse Reactions

Substance/Agent	Manifestations
Phenoxyethylpenicillin	• Urticaria

Event

This section may contain the following subsections Problems/Diagnoses This Visit, Clinical Interventions Performed This Visit and Clinical Synopsis and Diagnostic Investigations.

Clinical Synopsis (Event > Clinical Synopsis)

Patient was brought in following a fall at home. Upon examination patient found to have mild concussion and a fractured neck of femur (left leg). Admitted for pin and plate surgery and rehabilitation for two weeks before discharge.

Problems/Diagnoses This Visit (Event > Problems/Diagnoses This Visit)

Type	Description
Problem Diagnosis	Fractured neck of left femur
Problem Diagnosis	Mild concussion

file:///C:/Users/Administrator/AppData/Local/Genis/Solo_2122187938/TempDocs/CDA_69_2_25_173366225455623862818303389193566077302/DHE_XDM/SUBSET01/CDA_ROOT.html

Stylesheet Version: 1.2.7

Go Back View Stylesheet Update Stylesheet Print XML Cancel **Save**

Upload from within LetterWriter

The screenshot shows a software window titled "New" with a red border. A red arrow points to the "e-Health" tab. The window is divided into three main sections:

- Left Panel:** A list of templates under the "e-Health" tab:
 - CDA e-Referral
 - CDA Event Summary
 - CDA Shared Health Summary
 - CDA Specialist Letter
- Middle Panel:** Action buttons including "Rename", "Delete", and a "Filter" section with "All Users" and "Current User" buttons. At the bottom are "OK" and "Cancel" buttons.
- Right Panel:** A "Preview Template" window showing a sample referral letter for "Sample Practice". The letter includes fields for patient name, date, and various medical notes.

Privacy Controls and Patient View

The screenshot displays the 'My Health Record' patient portal interface. At the top, the Australian Government logo and 'My Health Record' branding are visible on the left, and the user's name 'BRIANNA CURTIN' and birth date 'Born 20-May-1998' are on the right. A navigation bar includes 'RECORD HOME', 'DOCUMENTS' (highlighted), 'PRIVACY & ACCESS', and 'PROFILE & SETTINGS'. Search and help icons are also present. The main content area is titled 'Clinical Records' and includes a sub-header: 'These are documents with clinical information entered by healthcare providers in My Health Record.' Below this, six categories of records are listed in a grid:

- Diagnostic Imaging Reports**: Imaging results, such as scans and x-rays.
- Discharge Summaries**: Records of hospital stays and any follow up treatment required.
- e-Referrals**: Referrals from one treating healthcare provider to another.
- Event Summaries**: Information about healthcare events or consultations.
- Pathology Reports**: Test results, such as blood tests.
- Shared Health Summaries**: Summaries of your health status added by healthcare providers.

My Health Record – Medicines Preview

Available medicines in this My Health Record - sorted by Date
22 Nov 2017

Caleb **DERRINGTON** DoB 15 Jun 1933 (84y) SEX Male IHI 8003 6080 0004 5922

[Allergies and Adverse Reactions](#)
Penicillin, Penicillins

[Medicines Preview](#)
22-Nov-2017 (now)

[Shared Health Summary](#)
22-Nov-2017 (now)
Author: Dr Terrance Walker
[Own Organisation](#)
tel:0455555555

No Discharge Summary found

[\[Back to top\]](#) [\[<<\] First](#) [\[<<\] Previous](#) [\[Help\]](#)

Medicines Preview - Latest Documents - sorted by descending event date.
22-Nov-2017 (now)

Source/Author	Date	Medicine - Active Ingredient(s)	Medicine - Brand	Directions
Event Summary by Own Organisation	22-Nov-2017 (now) changed		Monodur 120mg Tablet	1 Tablet Daily for 0
Shared Health Summary by Own Organisation	22-Nov-2017 (now)		Actonel EC 35mg Tablet	1 Tablet Once a week for 0
			Avanza 30mg Tablet	1 Tablet Before bed for 0
			Avapro HCT 300/12.5 300mg;12.5mg Tablet	1 Tablet Daily for 0
			Crestor 20mg Tablet	1 Tablet Daily for 0
			Madopar 200mg;50mg Tablet	1 Tablet Three times a day for 0
			Monodur 120mg Tablet	1 Tablet Daily for 0

Navigation panel

Provides access to each section within the view and also to the most recent Shared Health Summary and Discharge Summary (if available).

The blue underlined hyperlinks can be used to navigate between the sections

Pathology and Diagnostic Imaging included

My Health Record Document List - Mr Caleb Derrington

DocumentType: All Show last 3 months only

Exclude Medicare documents Exclude prescription and dispense records Exclude superseded or removed documents

Current filter: Excluding Medicare documents; Excluding prescription and dispense records; Excluding superseded or removed records

Document Date	Service Date	Document	Organisation	Organisation Type
22/11/2017		Medicines View		Local Government Healthcare Administration
22/11/2017		Event Summary	Medical Center	Local Government Healthcare Administration
22/11/2017		Shared Health Summary	Medical Center	Local Government Healthcare Administration
03/04/2017		Shared Health Summary	Medical Center	General Practice
03/04/2017		e-Referral	Medical Center	General Practice
03/04/2017		Specialist Letter	Medical Center	General Practice
03/04/2017		Discharge Summary	Medical Center	General Practice
27/03/2017		Pathology Report	Sullivan Nicolaides Pathology	Pathology and Diagnostic Imaging Services
27/03/2017		Diagnostic Imaging Report	Imaging Queensland	Pathology and Diagnostic Imaging Services
17/03/2017		Diagnostic Imaging Report	Wesley Medical Imaging	Pathology and Diagnostic Imaging Services
17/03/2017		Pathology Report	Mater Pathology	Pathology and Diagnostic Imaging Services
10/03/2017		Pathology Report	Pathology Queensland	Pathology and Diagnostic Imaging Services
10/03/2017		Diagnostic Imaging Report	Brisbane Diagnostics	Pathology and Diagnostic Imaging Services
01/03/2017		Diagnostic Imaging Report	Queensland Diagnostic Imaging	Pathology and Diagnostic Imaging Services
01/03/2017		Pathology Report	QML Pathology	Pathology and Diagnostic Imaging Services

Prepare for patients seeing their own results

Now might be a good time to start to explain to your patients:

- doctors will still receive results first. Detail your practice process for follow-up.
- just because a result is marked red/‘abnormal’/outside the value range doesn’t mean the result is not normal for them.
- just because a result is marked ‘normal’ doesn’t mean further discussion or investigations are not necessary.
- patients can let the doctor know if they do not want a specific result uploaded to their My Health Record.

▶ D. Our practice team can describe how patients are advised of the process for the follow up of results.

▶ E. Our practice team can describe how we follow up and recall patients with clinically significant tests and results.

[Factsheet: Pathology Reports for Clinicians](#)

www.racgp.org.au

Quality patient information



Lab Tests Online^{AU}
EXPLAINING PATHOLOGY

<https://www.labtestsonline.org.au>



<https://www.insideradiology.com.au/>

Patient Consent

- Patients provide "**standing consent**" to upload clinical information to their record. **There is no requirement for a provider to obtain consent on each occasion prior to uploading clinical information.**
- Advise a patient of upload to their My Health Record, particularly if this information might be considered sensitive. (AMA Guide)
- If a patient requests that a clinical document is not uploaded, a provider is obliged to follow this request.
- Any person involved in an individual's healthcare and [authorised by a healthcare organisation](#), can access and view an individual's My Health Record.
- [My Health Record legislation](#) does not prevent a healthcare provider from accessing and viewing an individual's My Health Record outside of a consultation, provided that access is for the purpose of providing healthcare to the individual.



Improve revenue

Improve relationships

Improve data



Past History List [coding]

Past History

Date: / / 2013 9/12/2017

Condition:

Condition

- Total knee replacement
- Total knee replacement revision

Left Right Bilateral

Acute Chronic

Mild Moderate Severe

Active Inactive

Provisional diagnosis

Fracture:

Displaced Undisplaced

Compound Comminuted

Spiral Greenstick

Further detail:

Send to My Health Record

Confidential

Include in summaries

✓ Only for chronic conditions & significant events

✓ Significant active or inactive conditions

✓ Add detail

Data Quality Checklist for all 'active' patients

- 1 Demographics – are the contact details up-to-date?**
 - Double-click on the patient's telephone number to check and update details
- 2 Medication List – is the Current Meds list accurate?**
 - Right click to delete/cease medications no longer relevant [they can then be found in the Old/Past Scripts thereafter]
 - If none, tick No medications
- 3 Past History List – does it contain only significant conditions that a hospital or specialist would need to know?**
 - Right click to edit, delete or add new
 - If none, tick No significant past history [PMH] box
- 4 Allergies – have you also recorded adverse reactions?**
 - Double-click in allergies box and Add, Edit, Delete
 - If none, tick No Known Allergies/Adverse Reactions/Nil Known
- 5 Immunisations – have immunisations been recorded?**

www.myhealthrecord.gov.au www.digitalhealth.gov.au

[Download the 'Data Quality' Checklist](#)

– GP Consultation Checklist

WORKFLOW & MINIMUM CLINICIAN DATA ENTRY

- Review previous consultation notes
- Review or collect history
- Current Medications
- Recent side effects/allergies
- Check Result/Documents and MARK AS NOTIFIED
- Examination & Management
(enter all observations BP, pulse etc in correct fields)
- Findings/Diagnosis
- Patient Education
- Add/Remove Recall or make next appointment
- Reason for contact
- MBS item/voucher

? Upload a new shared health summary?

Apps that connect to My Health Record:

	HealthEngine HealthEngine Pty Ltd	More information about HealthEngine
	Healthi Chemonix Health Solutions Pty Ltd	More information about Healthi
	HealthNow HealthNow	More information about HealthNow
	My Child's eHealth Record The Australian Digital Health Agency	More information about My Child's eHealth Record
	Tyde Tyde Australia Pty Ltd	More information about Tyde

<https://myhealthrecord.gov.au/internet/mhr/publishing.nsf/Content/appconnect>

*Evidence has shown
that quality
improvement activities
lead to positive change
in practices,
particularly when a
whole practice team
approach is adopted.*

Extra Resources

RACGP

[RACGP Standards for General Practices 5th edition](#)
[Using Data for Better Health Outcomes](#)

[PIP eHealth Incentive](#)

Australian Digital Health Agency & My Health Record

[New legislation](#)

[My Health Record: Frequently Asked Questions](#)

[Importance of Data Quality](#)

[Data Cleansing & Clinical Coding](#)

[Data Quality Checklist](#)

[My Health Record Opt-out](#)

Train IT Medical

[Data Aggregation using Pen Clinical Audit Tools](#) (blog)

[Cancer Screening & Prevention – Free Resources](#) (blog)

[5 Steps to Data Quality Success](#) (blog)

[Pen CAT4 summary sheet](#)

Other

[CAT4 Recipes](#)

[‘A quality improvement tool for primary health care’](#) Crossland, Upham, Janamian and Jackson



IT ALWAYS SEEMS
IMPOSSIBLE UNTIL
IT'S DONE.

Nelson Mandela

Thank you for inviting me

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Keep in touch! With best wishes, Katrina Otto