

My Health Record overview

The My Health Record is a secure, online summary of an individual's health information. It can be viewed by treating healthcare providers, including doctors, nurses and pharmacists across Australia as well as patients. My Health Record gives healthcare providers access to information about a patient's health which they may not otherwise have been able to see. The types of clinical documents and views available through the My Health Record and the current/future implementation plans for Queensland Health are detailed on page 2 of this factsheet.

Connecting to the My Health Record system

There are a number of requirements to fulfil prior to a clinical information system being able to connect to the My Health Record system. Queensland Health has completed a significant amount of work already.

Step 1 - Healthcare identifiers

- Queensland Health has established the Queensland Health Individual Healthcare Identifiers Management Service (QHIHIMS) to manage the process for searching and verifying individual healthcare identifiers.
- A Healthcare Provider Identifiers – Organisation (HPI-O) network structure has been established within Queensland Health. This is used to identify facilities when interacting with the HI service, My Health Record system and other national infrastructure.
- Healthcare Provider Identifiers – Individuals (HPI-Is) are not currently used within Queensland Health.

Step 3 - My Health Record compliant software

- Clinical information systems which connect to the My Health Record system need to meet relevant national eHealth standards and specifications.

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Step 2 - National authentication service for health

- Queensland Health currently utilises the national authentication service for health (NASH) to connect to the My Health Record.
- The NASH provides security and access to national eHealth systems, and allows for the secure delivery of messages (information) between systems.

Step 4 - Policy and procedures

- The My Health Record legislative framework outlines that participating organisations must have a policy suite to inform staff of the requirements for using the My Health Record system. The Department of Health has created a policy suite and can be leveraged by Hospital and Health Services.
- Other considerations when connecting to the My Health Record include consideration of: clinical and business processes implications for authoring clinical documents and viewing My Health Records; departmental guidance around inclusion of address information on clinical documents sent to the My Health Record system; and the consumer consent model relevant to the My Health Record.

Current and planned connectivity with the My Health Record system

Viewing	Description	Current	Future
Document list view	Clinical document list view provides a mechanism to list, group and sort all clinical documents in clinical information systems.	Capability exists through The Viewer application to view the document list.	Capability exists in some primary care clinical information systems to view the document list (systems such as Best Practice, Medical Director, MMEEx).
Prescribe and dispense view	Prescription and Dispense View documents represent an electronic summary of information about medication prescriptions and dispensations contained in an individual's digital health record.		Project will commence in 2016 to provide capability to meaningfully display pathology, diagnostic imaging and medications views into the My Health Record component of the Viewer application.
Diagnostic imaging result report view	The eHealth Diagnostic Imaging Report View provides a mechanism to list, group and sort those reports in clinical information systems.		
Pathology result report view	Pathology Report View provides a mechanism to list, group and sort those reports in clinical information systems.		
Uploading	Description	Current	Future
Discharge summary	A record of an individual's hospital stay and any follow up treatment required.	Capability exists through The Enterprise Discharge Summary (EDS) application to send inpatient discharge summaries.	
Diagnostic imaging reports	Diagnostic imaging reports can be used to share information about diagnostic imaging examinations via an individual's digital health record.		Project will commence in 2016 to provide capability to upload pathology and diagnostic imaging result reports to the My Health Record.
Pathology result reports	Pathology reports can be used to share information about pathology tests via an individual's digital health record.		
Prescriptions and dispense information	Medications information such as dosages and frequency.		Project will commence in 2016 to support implementation of the foundational clinical terminology and terminology browsers. This work will contribute to medicines information to be uploaded to the My Health Record into the future.
Shared health summary	A summary, authored by the treating doctor, of an individual's health status including adverse reactions, medicines, medical history and immunisations.		Capability exists in some primary care clinical information systems to upload clinical documents (systems such as Best Practice, Medical Director, MMEEx).
Event summary	Clinical summaries of health events entered by the healthcare provider who was involved in the patient's care to inform other treating healthcare providers		
eReferrals	Facilitate the transmission of significant patient information from one treating healthcare provider to another for the purpose of making a request for further diagnosis or treatment.		
Specialist letters	Referral letters and reports from one treating healthcare provider to another. Used in replying to a referral or reporting on a health event and contain information related to the event or the requested diagnosis or treatment by a specialist.		