Overview

- Introduction to the Digital Health Strategy & My Health Record Expansion
- Diagnostic sector participation with My Health Record
- Q&A
A healthy pregnancy usually includes **15-20** separate encounters with health care services.

**Death rates** for remote Australians are **40% higher** for coronary heart disease.

**223,000** admitted to hospital due to **adverse drug event** costing **$1.2 billion**.

**14% of pathology tests** are ordered due to lack of access to patients' history.

**Content shared with My Health Record means reduced risk of lost information**.

Digital tools make it easier to access services remotely.

**Medicines information available via My Health Record reduces safety risk**.

People and their clinicians will be able to see results of previous tests.
Health information that is available whenever and wherever it is needed

Health information that can be exchanged securely

High-quality data with a commonly understood meaning that can be used with confidence

Better availability and access to prescriptions and medicines information

Digitally-enabled models of care that drive improved accessibility, quality, safety and efficiency

A workforce confidently using digital health technologies to deliver health and care

A thriving digital health industry delivering world-class innovation
My Health Record
How does My Health Record work?
Key My Health Record system benefits

- Avoid adverse drug events
- Improved systems through secondary use of data
- Enhanced patient self-management
- Improvements in patient outcomes
- Reduced time gathering information
- Avoided duplication services
Individuals control who has access to their My Health Record

Individuals can:

- Restrict access to specific documents in their record by establishing a code (LDAC)
- Restrict access to their record by establishing a code (RAC). Only authorised organisations can access record
- Subscribe to SMS or email alerts that report in real time when a new health provider organisation accesses their record
- In an emergency, a clinician can exercise a ‘break glass’ facility – but instances are monitored and logged
- View the access history – all instances of access to My Health Record are monitored and logged
My Health Record opt out

• This year, every individual with a Medicare or Department of Veterans’ Affairs card will get a My Health Record, unless they tell the Agency they don’t want one.

• A four month opt-out period is now open until 15 November.

• During this period, individuals can opt out by:
  o Visiting www.MyHealthRecord.gov.au or
  o Calling the Help line on 1800 723 471
Diagnostic Sector Participation
What’s being introduced?

• Radiology and pathology reports will still be **sent directly to requesting doctors via the usual process**

• However, diagnostic reports will now **also be uploaded directly to My Health Record**
  
  • Patients and any healthcare professional involved in their care will be able to access the reports wherever and whenever they need it
  
  • **Healthcare professionals** will be able to view the reports as soon as they are uploaded to My Health Record
  
  • **Reports will only be visible to patients** through their My Health Record **after 7 days**. Patients will though be able to see that the report is available as soon as it is loaded.
  
  • **Upload is an automated process** – intervention only required when acting on instruction to not upload.
Seven day delay before consumer can view diagnostic report in My Health Record

- Result of 2014 consultation with Royal Australian College of New Zealand College of Radiologists, Royal College of Pathologists Australasia, Australian Medical Association, Consumer Health Forum, Royal Australian College of General Practitioners and other peak bodies

- Seven day delay before patient can view uploaded report

- This delay enables the requesting doctor time to review the results, and to discuss the results with their patient

- If a report is subsequently amended, the 7 day delay will be reapplied to the amended report
The padlock indicates the report is locked from view.

The patient is able to manage access (restrict view or remove).
Do not send instructions

- A radiology practice or lab is able to share diagnostic reports with My Health Record unless:
  - the patient asks that the report not be uploaded to My Health Record; or
  - the healthcare provider determines the information may cause a serious threat to the life, health or safety of an individual; or
  - the record is not to be uploaded under prescribed laws of a state or territory (NSW, QLD and ACT).

- Some states have adopted local positions that apply to public labs regarding specific tests and patient categories.
Requesting systems and request forms are being updated

**Why the change?**

- There needs to be a mechanism for the requesting provider or patient to indicate if the resulting report(s) should not be uploaded to the patient’s My Health Record.
- Changes are being made to practice management / clinical information systems (CIS) to support the existing request workflow.

**What’s the change?**

- CIS diagnostic imaging and pathology request pages are being updated to include a statement “Do not send reports to My Health Record” and a checkbox (default is unchecked).
- The paper request forms printed from the clinical information system will print the statement “Do not send reports to My Health Record” and will print the value of the checkbox from the ordering page. Note that clinician or patient can manually check the box if necessary.
- Any electronic order originating from the request will include the value recorded in the CIS.
Examples of changes to paper request forms

Consent statement that will be printed on the forms
Requesting System and request form changes

**Some things to note**

- The default position is that reports will be sent to My Health Record unless an indication not to send or legal restriction.
- The consent phrase is present regardless of whether or not the clinician is a participating provider.
- The consent phrase is present regardless of whether or not the patient has a My Health Record.
- There is only one consent question per request and the consent covers all the orderable items within the requesting event.
- Requestors should not override consumer consent by unilaterally determining not to upload results to My Health Record.
- Test results will still be sent to the requestor and ‘copy to’ doctors in the usual way.

Withdrawal of consent/instruction to not upload can be communicated to the diagnostic provider by:

- checking the *Do not send reports to My Health Record* check box in practice management software, or
- checking the *Do not send reports to the My Health Record* check box on the paper referral form, or
- writing the words *Do not send reports to My Health Record* on the request form.

The patient can also inform the diagnostic imaging practice or pathology lab staff directly.
# “Do not send” stats

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pathology</strong></td>
<td></td>
</tr>
<tr>
<td>Large private laboratory group</td>
<td>434/108,345 eOrders received (0.4%)</td>
</tr>
<tr>
<td>Specialist private histo lab</td>
<td>2/9093 reports (0.022%)</td>
</tr>
<tr>
<td>Specialist Cyto, HPV, Chlamydia lab</td>
<td>415/84,718 (0.5%)</td>
</tr>
<tr>
<td><strong>Diagnostic imaging</strong></td>
<td></td>
</tr>
<tr>
<td>Large group</td>
<td>&lt;50/32,915 reports (0.15%)</td>
</tr>
<tr>
<td>Ultrasound practice</td>
<td>62 patients out of 3961 (1.6%)</td>
</tr>
</tbody>
</table>
### Key facts and figures for diagnostic connections

<table>
<thead>
<tr>
<th>Percentage</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>33%</td>
<td>144 pathology labs connected in September 2018</td>
</tr>
<tr>
<td>20%</td>
<td>307 diagnostic imaging practices connected</td>
</tr>
</tbody>
</table>

- >6.1 million people have a My Health Record
- 18,500 records are being created each week
- 13,848 healthcare provider organisations are registered including 6,632 GP organisations, 1,008 hospitals, 3,703 pharmacies, and 188 aged care services
- 7.6 million clinical documents, 24 million prescriptions and dispense records have also been uploaded. 2.2 million path reports and 286K DI reports uploaded.

**Dec 18 Path target 80%**
- 33% of pathology labs connected

**Dec 18 DI target >30%**
- 20% of diagnostic imaging practices connected
Steps to participate

1. Register your organization with the My Health Record system
2. Obtain a Healthcare Provider Individual (HPI-I) number for your clinicians
3. Nominate key people and upgrade to conformant software
4. Implement My Health Record policy
5. Access education and training resources
6. Start using My Health Record
1. My Health Record Registration, HPI-O and NASH PKI certificate

- Use the Health Professional Online Services (HPOS) via the Provider Digital Access (PRODA) to:
  - Register your healthcare organization for the My Health Record system,
  - Register for Healthcare Provider Identifier for Organisations (HPI-O),
  - National Authentication Service for Health Public Key Infrastructure (NASH PKI) Certificate for Organisation

NB: Access to the HI Service will also need to be added to your Medicare PKI site certificate (usually used for Medicare Billing). If you don’t already have one, it can be requested during the registration process above.

- Register Network sites (if required)

2. Nominate key people and upgrade to conformant software

- Confirm document authors and Reporting Pathologist/Radiologist
- Identify staff that require Healthcare Provider Identifiers – Individuals (HPI-I) and obtain these
- Decide on any changes to pre-printed request forms if required
- Co-ordinate testing and upgrade of LIS or RIS with vendor or IT department
- Ensure the certificates from registration process are installed
Conformant software

Upgrade RIS/LIS Software or adopt HIPSS* middleware product:

- Connection to the Healthcare Identifiers Service to search for and retrieve national healthcare identifiers
- Connection to the My Health Record system to:
  - determine if a patient has a digital record;
  - view a patient’s digital health record;
- Package and post clinical documents into this record including:
  - diagnostic imaging and pathology reports
  - discharge summaries, prescription/ dispense records, event summaries, shared health summaries, specialist letters
- Dynamically convert HL7(R) v2 ORU messages in CDA documents for pathology reports and diagnostic imaging reports.
- Other functions

*Health Identifier and PCEHR System
Pathology and Diagnostic Imaging Integration
Data Flow Diagram

Diagnostic Service Provider

- LIS: Order HL7, ADT HL7, Report HL7
- RIS: Order HL7, ADT HL7, Report HL7
- PACS: Order HL7, ADT HL7

Integration Engine

- Order HL7 with Indication of Consent
- Report HL7 with IHI (Optional)
- Validated IHI
- Patient demographic information
- Individual Healthcare Identifier (IHI)
- Check if MHR Exists
- Pathology and Imaging Reports

Messaging System

- Report HL7 with IHI (Optional)
- Order HL7 with Indication of Consent

Hospitals

- Clinical Information Systems

National Infrastructure

- Healthcare Identifier Service
- My Health Record System

GP Clinics

- Clinical Information Systems

Australia Digital Health Agency (HIPS)

- PACS – Picture Archiving and Communication System

Pathology and Imaging Reports

Version 2
02/11/2017
3. Implement My Health Record policy

- Supplement existing policies to cover access and use of My Health Record
## 4. Access education and training resources

<table>
<thead>
<tr>
<th>Activity</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identify project sponsor and engage key stakeholders</td>
<td>Ensure there is a clinical champion for change.</td>
</tr>
<tr>
<td>Digital Health 101</td>
<td><a href="https://www.youtube.com/watch?v=bGCz0EJNYFE&amp;t=8s">https://www.youtube.com/watch?v=bGCz0EJNYFE&amp;t=8s</a></td>
</tr>
<tr>
<td>Receive software vendor training material</td>
<td>Key site staff educated about software changes and how to handle questions about My Health Record and instruction not to upload.</td>
</tr>
</tbody>
</table>
5. Use My Health Record

Upload diagnostic reports

This occurs automatically from within the RIS or LIS, unless the report has been flagged “Do not send reports to My Health Record”.

These uploads are valued by other healthcare providers and patients, and serve to increase the value of the My Health Record system for all users.

View in relevant clinical situations

Access clinical information from other providers including discharge summaries, pathology, medications and health summary information e.g. access to renal function tests may inform choice of contrast for imaging studies

Clinical Details: This is a second trimester ultrasound scan from the EDD of 16th November 2020, the expected gestational age is 22 weeks 2 days.

Findings: There is a single live intrauterine infant.

CHD:

Nuchal Translucency:

- nuchal translucency: 2.0 mm
- increased risk of chromosomal abnormality identified
- the growth pattern is consistent with the gestational age

Comment: Single live intrauterine pregnancy demonstrating growth within the normal range.

Ultrason: 3D Scan NSW

- 18th April 2020
- PAPP-A: 0.720 mIU/mL
- free beta HCG: 0.205 mIU/mL

Risk Assessment:

- Background Risk: 1 in 750
- Adjusted Risk: 1 in 750

There is a low risk pregnancy for Trisomy

Risk assessment is based on maternal age, ultrasound and biochemical data.

For women over 35 years, ultrasound and biochemical data are used to determine the likelihood of having a trisomy.

For women under 35 years, the likelihood of having a trisomy is determined by combining maternal age and biochemical data.

Reporting Doctor: [Redacted]
Information for consumers on-line and waiting room


### Diagnostic imaging and pathology providers uploading to My Health Record

<table>
<thead>
<tr>
<th>State</th>
<th>Pathology reports</th>
<th>Diagnostic Imaging reports</th>
</tr>
</thead>
<tbody>
<tr>
<td>Australian Capital Territory</td>
<td>The Canberra Hospital</td>
<td>The Canberra Hospital</td>
</tr>
<tr>
<td>Australian Capital Territory</td>
<td>University of Canberra Hospital</td>
<td>University of Canberra Hospital</td>
</tr>
<tr>
<td>New South Wales</td>
<td>Newcastle X-Ray and Ultrasound</td>
<td>Central Coast Local Health District</td>
</tr>
<tr>
<td>New South Wales</td>
<td>Far West Local Health District</td>
<td>Far West Local Health District</td>
</tr>
<tr>
<td>New South Wales</td>
<td>Hunter New England Local Health District</td>
<td></td>
</tr>
<tr>
<td>New South Wales</td>
<td>Illawarra Shoalhaven Local Health District</td>
<td></td>
</tr>
</tbody>
</table>
Consumer guidance
Post script

Thanks for the opportunity to present at the conference last week.

In order to clarify points on secondary use please find attached a link to the secondary use framework for My Health Record that was published in May by the Department of Health:


The Australian Institute of Health and Welfare (AIHW) is the Data Custodian for the purposes of the Framework.

The framework addresses requirements for ethics approval, de-identification and privacy protection.

Guiding principle 2.1 confirms that Individual consumers who have a MHR will be able to opt out of the use of their MHR system data for secondary purposes by using the consumer access control mechanism and clicking on the ‘Withdraw Participation’ button.

I would be grateful if you would share this information with participants.

Regards

Paul

Paul Carroll
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Government and Industry Collaboration and Adoption
Questions
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