



NACCHO eHealth

Administrative Guide

FAQ's

ACCCHS sites to PCEHR

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6. FAQ's

6.1. General

6.1.1. What is a personally controlled electronic health [eHealth] record?

An eHealth record is an electronic summary of your patient's key health information, drawn from their existing records. The Australian Government's eHealth record system has the potential to deliver better care for patients and make the healthcare system more efficient.

As the system develops, it will give healthcare professionals access to patient information such as medications, test results, discharge summaries, allergies and immunisations. The system is designed to be integrated into existing local clinical information systems and will provide faster and easier access to patients' health information, meaning better, more efficient care.

6.1.2. Why do we need an eHealth record system?

Pressure on Australia's healthcare system and healthcare professionals is increasing due to factors that include:

- a growing and ageing population
- more patients with complex and chronic care needs
- increasing patient expectations and demands

Every year consumers have multiple visits to health care professionals. Until now, all this information has been held in separate locations with different medical practitioners, pharmacists and hospitals. Most of these records have not been shared electronically.

More effective and innovative approaches, including those using technologies such as eHealth are needed to sustain the quality of health care. The eHealth record system will help ensure health care is delivered more effectively and efficiently by minimising unnecessary repeat tests, managing medication better and improving continuity of care.

6.1.3. How will the eHealth record system work?

The eHealth record system provides access to key health information drawn from a patient's health records. With the patient's consent, this information can be quickly shared between healthcare organisations and other healthcare professionals involved in the patient's care.

Over time, an eHealth record will grow to contain a summary of a patient's key healthcare events and activities, including medical history, allergies and current medications. The system is designed to be integrated into existing local clinical information systems.





6.1.4. Does an eHealth record replace existing records?

eHealth records will not replace existing medical records. Healthcare professionals will continue to take and review clinical notes. More detailed patient information will be available on local clinical information systems, as per current practice.

The eHealth record system provides an active online record that follows patients as they move through Australia's health system, and includes important clinical and treatment information.

It is expected that, in the future, the availability of eHealth records will save healthcare professionals valuable time.

6.1.5. Who is eligible for an eHealth record?

People seeking health care in Australia are eligible for an eHealth record. Registration for an eHealth record is voluntary and is not required to receive health care.

6.1.6. What information can an eHealth record contain?

An eHealth record can contain two sets of information – clinical and personal. Only authorised healthcare professionals can enter information into the clinical section of a patient's eHealth record, ensuring it is clinically relevant and as accurate as possible.

Patients will have their own section in the eHealth record, separate from the clinical section, where they will be able to enter basic health information, and keep notes for their own use.

As clinical software is updated to communicate with the eHealth record system, more clinical information can be added by healthcare professionals. As the system grows, an eHealth record may contain standardised versions of the following:

- **Shared health summary:** This will include information about a patient's medical conditions, medications they are currently taking, allergies they may have or relevant family medical history. The shared health summary is prepared by a patient's nominated provider, who can be a medical practitioner, registered nurse or Aboriginal and Torres Strait Islander health practitioner. The structure of a patient's shared health summary is underpinned by the RACGP [Royal Australian College of General Practitioners] template for a GP health summary.
- **Event summary:** This is a summary of a significant consultation. It can be uploaded by a healthcare professional at any participating healthcare organisation that is authorised to use the eHealth record system – such as an after-hours GP clinic, hospital or allied health clinic.
- **Hospital discharge summary:** This can be uploaded by healthcare professionals who have access to the eHealth record and were involved in the patient's hospital care.
- **Specialist letter:** When a specialist creates a specialist letter, it will be sent directly to the intended recipient, as per current practices, and a copy of the specialist letter may also be uploaded to the eHealth record system.



- eReferral letter: When a healthcare professional creates a referral, it will be sent directly to the intended recipient, as per current practices, and a copy of the referral may also be uploaded to the eHealth record system.

6.1.7. What is the physical form of the eHealth record?

An eHealth record will be held online on secure servers. Patients can choose whether or not they want to view their record online. Some patients may only make enquiries by telephone or at Department of Human Services service centres offering Medicare services. If they do want to view their eHealth record online, they can login and access it.

6.2. Registering for an eHealth Record

6.2.1. When do registrations open?

People seeking health care in Australia can now register for an eHealth record. This is only the first step in building Australia's eHealth record system, which will grow and evolve over time.

When people register for an eHealth record they will be able to:

- add their own personal health notes, emergency contact details and location of their advance care directive ['living will'], if they have one
- set privacy controls or deactivate their record
- register their children for an eHealth record

6.2.2. How can patients register?

People can register for an eHealth record in the following ways:

- Online
- Over the phone – by calling 1800 723 471 and selecting option one
- In person – by visiting a Department of Human Services service centre offering Medicare services
- In writing – by completing a registration application form, available from a service centre offering Medicare services or from www.ehealth.gov.au, and posting it to: Personally Controlled eHealth Record Program, GPO Box 9942, in your Capital City
- Assisted registration - at their regular health service if they are participating in the eHealth Record System



6.2.3. How can I participate in the eHealth record system?

Healthcare professionals do not need to register individually for the eHealth record system. Only healthcare organisations need to register. Healthcare organisations in Australia can register now to participate in the eHealth record system. Once an organisation is registered, authorised users in that organisation will be able to access the system via either a conformant clinical information system with an individual logon, or via the [eHealth record provider portal](#) [read only] using their PCEHR compliant digital credential.

To participate in the eHealth record system, your healthcare organisation will need to authorise you to access the system on their behalf, once it has registered with the eHealth record system.

Healthcare professionals with a Healthcare Provider Identifier – Individual [HPI-I] will be able to upload information to the clinical section of a patient's eHealth record, once their organisation has a conformant clinical information system. Authorised users who don't have an HPI-I, but are important to an individual patient's care, will be able to access that patient's eHealth record but will not be able to upload information.

To register for an HPI-I, or to find out what your HPI-I is, and to obtain a PCEHR compliant digital credential, please go to the HI Service page on the [Medicare Australia](#) website and download the appropriate application form.

6.2.4. How does a healthcare organisation register for the eHealth record system?

To register for the eHealth record system, a healthcare organisation will first need to register with the Healthcare Identifiers [HI] Service for a Healthcare Provider Identifier – Organisation [HPI-O]. They will also need to apply to the HI Service to obtain PCEHR compliant digital credentials. To register an organisation for an HPI-O and to obtain PCEHR compliant digital credentials, go to the HI Service page on the Medicare Australia website and download the appropriate application form.

Once an organisation has registered with the HI Service, they will need to register for the eHealth record system by completing and submitting the Application to register as a healthcare provider organisation form and the Participation agreement for healthcare provider organisation.

6.2.5 How do I access the eHealth record system?

If you have been authorised to access the eHealth record system on behalf of a healthcare organisation, you will be able to access the eHealth record system via either a conformant clinical information system, or via the provider portal using their PCEHR compliant digital credential.

To gain access via clinical software you will need to use registered and approved clinical information system [CIS] desktop software and have a PCEHR compliant digital credential installed.

To gain access via the provider portal, go to www.ehealth.gov.au to log in. The provider portal is a read- and download-only facility and will not enable healthcare professionals to contribute to a patient's eHealth record. Over time, if healthcare professionals and their organisations are registered, the provider portal will give them access to the information that has been entered by patients.



6.2.6. What is the benefit of upgrading to Clinical Information System [CIS] desktop software?

If your organisation upgrades to clinical software that is conformant with the eHealth record system, you will be able to perform additional functions such as:

- Create an event summary – This is a summary of a significant consultation. It can be uploaded by a healthcare professional at any participating healthcare organisation authorised to use the eHealth record system.
- Create a shared health summary – This is a clinical document summarising a patient's health status. The shared health summary includes information about a patient's medical conditions and medications they are currently taking, and allergies they may have. This is likely to be the first document accessed by any new healthcare professional viewing a patient's record. This document is created by the healthcare professional who is responsible for the coordinated care of the patient.

6.2.7. What are Healthcare Identifiers?

The Healthcare Identifiers [HI] Service is a national system for allocating a unique identifier to healthcare professionals, organisations and consumers. Healthcare Identifiers will help ensure consumers and healthcare professionals can have confidence that the right information is associated with the right individual at the point of care. The HI Service allocates three types of healthcare identifiers:

- Individual Healthcare Identifier [IHI] – for individuals [consumers] receiving healthcare services
- Healthcare Provider Identifier – Individual [HPI-I] – for healthcare professionals involved in providing patient care
- Healthcare Provider Identifier – Organisation [HPI-O] – for organisations that deliver health care [such as hospitals or general practices]

6.2.8. How do I get an HPI-I or HPI-O?

You can obtain a HPI-I and a HPI-O now. Healthcare professionals who are registered with the Australian Health Practitioner Regulation Agency [AHPRA] will have been assigned a HPI-I, and AHPRA will advise them of this number.

Healthcare professionals in a field of practice not covered by AHPRA must complete an application for a HPI-I via the Department of Human Services. Go to www.medicareaustralia.gov.au, follow the link to individual healthcare provider forms and click on the application to register a healthcare professional. You can also follow the links on this page to download the forms to register your organisation for an HPI-O.

If you have not received your HPI-I, or have forgotten it, call the Healthcare Identifiers Service on 1300 361 457.





6.2.9. Is my HPI-I unique? What if I work for more than one healthcare organisation?

Your HPI-I is unique to you. You will only need one HPI-I regardless of the number of qualifications obtained or healthcare organisations for which you work.

6.2.10. I have obtained my HPI-I from AHPRA, but where do I obtain an HPI-O?

A healthcare provider organisation will need to register for an HPI-O with the HI Service [Department of Human Services]. Organisations that are eligible for an HPI-O must be an entity that has conducted, conducts, or will conduct, an enterprise that provides healthcare services.

An HPI-O may be linked to all relevant HPI-Is in the organisation. Organisations can apply directly to the HI Service by completing the application form on the [Medicare Australia](#) website.

6.2.11. What is a National Authentication Service for Health [NASH] individual Public Key Infrastructure [PKI] certificate?

A National Authentication Service for Health [NASH] individual Public Key Infrastructure [PKI] certificate is a part of the security measures put in place to protect the privacy of eHealth records and is an important part of the system. A NASH location PKI certificate is needed to authenticate healthcare professionals accessing the eHealth record system.

6.2.12. How can I learn more or receive training?

Training materials are available for healthcare professionals, organisations and other associations. Industry bodies are also being briefed on the system so they can better support their members.

For more information and training on how to use the system contact:

1. nicolle.marchant@nacchoehealth.net; or
2. State Affiliate; or
3. Alternatively go to the [eHealth](#) website and follow the link to the Learning Centre or call the helpline on 1800 723 471.



6.3. Managing a Patients eHealth Record

6.3.1. Will I have access to everything in a patient's record?

If a patient chooses to have an eHealth record, they will be able to control what information is stored in the record and which healthcare organisations can access that information. This ability to set access control measures is a key privacy feature of the eHealth record system. While privacy is important, it is best for all information to be available to enable healthcare professionals to deliver the most appropriate care.

Only healthcare professionals from authorised Australian organisations with software that can communicate with the eHealth record system will be able to upload information to a patient's eHealth record.

6.3.2. What does this mean for my existing records?

The eHealth record system does not replace existing clinical records. It is an additional tool that provides a summary of patient information entered by healthcare professionals from different healthcare organisations. It will enable a single view of a summary of a patient's information from across the health system. It will only contain information that a patient has consented to have included in their eHealth record.

If a healthcare professional sees a new patient with an eHealth record for a consultation, with the patient's consent the healthcare professional can view their key medical information, which will save time questioning the patient or chasing missing information.

6.3.3. Can I import data from the eHealth record system back into my own local clinical information system?

A healthcare organisation that is registered for the eHealth record system will be able to copy information out of the national system into their local clinical information system.

6.3.4. Are patients able to read what doctors and other healthcare professionals write about them in full?

Patients can read in full everything that is added to their eHealth record. You may choose to include additional information in your own local clinical information system that is not included in the eHealth record. In any event, patients have a right under the *Privacy Act 1988 [Cth]* to access the personal information that healthcare professionals hold about them. For more information, please contact the [Office of the Australian Information Commissioner](#) or 1300 363 992.



6.3.5. Once the information is in the eHealth record system, how can I be sure that it is up to date?

All clinical documents in the eHealth record system will be accompanied by document source information stating where, when and by whom the document was created. All clinical documents will also be digitally signed by the supplying healthcare organisation to ensure they have not been modified since they were submitted. Based on the above information, a healthcare professional will then be able to make a professional judgement about the reliability of the information.

It should also be noted that healthcare organisations have an obligation to take reasonable steps so that any personal and health information uploaded to a person's eHealth record is as accurate as possible and up-to-date at the time of uploading.

6.3.6. Is there a log showing who has looked at eHealth records?

Yes. A patient's eHealth record will have a view showing the activity history related to their record. This will show when information has been added or removed as well as the organisation that viewed the record and when. Healthcare professionals will be able to see an audit log of their own activity on the eHealth record system.

6.3.7. What about in an emergency?

Healthcare organisations participating in the eHealth record system may access a patient's eHealth record in an emergency, where patient consent is not possible. This is consistent with existing privacy laws.

In life-threatening cases where it is unreasonable or impractical to obtain a patient's consent to access the eHealth record, healthcare professionals may assert emergency access. This will override any access controls that have been set and provide your organisation with unrestricted access to a patient's eHealth record for five days. Your use of the emergency access function will be logged in the audit log and may be notified to the patient if they requested notifications.

Asserting emergency access is warranted where you believe that access to the information is necessary to lessen or prevent a serious threat to:

- an individual's life, health or safety and the patient's consent cannot be obtained. This might occur for example, if the patient is unconscious; or
- public health or public safety.

6.3.8. Can a patient enter their own health information into their eHealth record?

Only authorised healthcare professionals can enter information in the clinical section of a patient's eHealth record, ensuring it is clinically relevant and as accurate as possible.

Patients will be able to enter basic healthcare information which can be shared with healthcare professionals, and keep private notes for their own use.





6.3.9. When I view a patient's eHealth record, will there be any indication that certain documents have been classified as confidential or not readable?

If a patient has restricted your organisation's access, their eHealth record will contain a message on the provider screens that states that it is not a complete record. However, there will be no indicator on a record to tell healthcare professionals how a patient may have set their access controls or if a document has been deleted by the patient. **[Confirm]**

6.3.10. If a patient chooses to withhold information about psychiatric history, will the medications the patient may be taking be visible?

A patient is able to choose what information is viewable through their eHealth record. Just as they are able to limit access to their psychiatric information, they may also limit access to any related medications prescribed or dispensed.

6.3.11. What are my obligations if I identify an error in a patient's eHealth record?

Only authorised healthcare professionals can enter information in the clinical record, ensuring it is clinically relevant and accurate. However, if you or a patient find an error in a clinical document, you or the patient must notify the healthcare organisation from which the document originated. That organisation can then upload a corrected document.

6.3.12. Can lists of medications in the eHealth record be altered?

To maintain the integrity of the system, information uploaded to the eHealth record system, including medications, cannot be altered or edited. The system requires a new document to be uploaded, so while the old version will still be visible, the uploaded document will take precedence. If a nominated provider wishes to change the medications listed in the shared health summary, they will need to upload a new shared health summary with the updated medication information.

6.3.13. Can a patient have more than one nominated provider, [e.g. two GP's]?

The nominated healthcare provider is the author of a shared health summary. There can only be one nominated provider at one time. If a patient wishes to appoint a new nominated provider, they can ask another authorised healthcare professional to author and upload their shared health summary for them.



6.3.14. Will the eHealth record system be available on smart devices [e.g. iPad, tablet, smart phone]?

Patients will be able to view their own eHealth record on a device of their choosing. However, specific 'applications' for mobile devices such as iPads, tablets and smart phones have not been developed.

6.3.15. How will consent be managed with children?

Except in special circumstances, parents or authorised representatives will have control of their children's eHealth records from 0 to 14 years, including decisions as to which healthcare organisations have access to the child's record and which clinical documents they can see.

After a child turns 14, they will be able to choose whether to manage their own eHealth record in the same way they can apply for their own Medicare card. This includes which healthcare organisations have access to their record, which clinical documents they can see and which representatives are authorised to access to their record.

If a child chooses not to take control of their eHealth record between 14 and 17, their authorised representative[s] can continue to manage their record until they turn 18. Once an individual turns 18, authorised representative[s] will automatically lose access to their eHealth record. If an individual still wants their parent[s] or guardian[s] to view information in their eHealth record after they turn 18, they will need to take control of their record and set up nominated representatives.

In line with Department of Human Services' policy regarding the Medicare Benefits Schedule [MBS], parents will not be able to view the MBS details of children aged over the age of 14.

6.3.16. What clinical safeguards are being developed as part of the eHealth record system?

The eHealth record system is expected to improve access to clinical information and enhance patient health outcomes over time. As such, the eHealth record system has been designed with active contribution from healthcare professionals from across the health sector, key professional bodies and other quality and safety experts.

Existing clinical standards apply to the use of information sourced from the eHealth record system. Healthcare professionals can access further information about the safe use of eHealth records, including how eHealth considerations can be integrated into existing standards and clinical governance frameworks across the health sector, on the [eHealth](#) website.

6.3.17. How can I be sure that health information will be secure?

The eHealth record system implements high grade security protocols to detect and mitigate against external threats. The system will be tested frequently to ensure these mechanisms are in place and robust.



Healthcare professionals and organisations already have a duty to keep their patient's health information confidential and secure and that requirement will continue for the eHealth record system.

In addition to the limits on who can access or update an eHealth record, the eHealth record system is protected by legislation.

Security is a key design element of the system, which adheres to Australian Government security frameworks. Design features include audit trails, technology and data management controls, as well as appropriate security measures to minimise the likelihood of unauthorised access to information in a patient's record. It is important to follow the guidance available from the RACGP or your medico-legal organisation on information security.

The Australian Government strongly encourages businesses and organisations to take steps to ensure they are operating safely or providing services securely online. The Australian Government's website [Stay Smart Online](#) offers a lot of useful advice and tips for small and medium businesses about IT security.

6.3.18. How has the insurance industry been involved in the development of the eHealth record system?

Key members of the indemnity insurance industry have been involved in consultations for the development of the eHealth record system.

These critical stakeholders have attended face-to-face consultations, made submissions in response to the consultation processes run by the Department of Health and Ageing and have commented on specific sections of the legislation affecting them and their members. Their views have been sought and considered in relation to system design, legislation and change and adoption activities.