Frequently Asked Questions

Personally Controlled Electronic Health Record

General

What is the PCEHR system?

A PCEHR is a Personally Controlled Electronic Health Record. It provides healthcare organisations and their patients with access to summary health information about a patient and their interactions with other healthcare organisations, whenever and wherever it is needed.

How does an eHealth record work?

The national PCEHR system provides access to selected health information from your patients' health records that can be securely shared with relevant healthcare organisations within Australia. Once a healthcare organisation registers for the PCEHR system, appropriate or relevant healthcare professionals within that organisation can be authorised to access the system.

The more healthcare organisations that use the PCEHR system, the more connected it will become, leading to more information from different healthcare organisations being accessible. All healthcare organisations are encouraged to use the PCEHR system to ensure they will receive and pass on the maximum benefits of the system to their patients.

When will the national PCEHR system become operational?

Healthcare organisations will be able to access the PCEHR system from 1 July 2012. However this is only a starting point, as the PCEHR system will grow as more consumers and healthcare organisations become a part of it. For this to occur healthcare organisations need to become 'PCEHR ready' and individual patients need to register.

What kind of information will an eHealth record contain?

An eHealth record will contain summaries of patients' key healthcare events and activities. More detailed information about these healthcare events and activities will remain in health information systems held within a healthcare organisation.

The PCEHR system is not a replacement for your existing medical records or a replacement for taking a note of a patient's history and reviewing existing clinical notes. Instead healthcare professionals can choose what they do or don't upload. Similarly, patients may request that information not be entered if they do not want it shared.

An eHealth record may contain standardised versions of the following:

A shared health summary: a clinical summary written by a patient's nominated healthcare professional, containing information about a patient's health status. This may include information about medications a patient is taking, details of allergies, immunisations, and information on a patient's medical history they may have that would be useful to a wide range of healthcare professionals.

Discharge summaries: Summary information about a patient's care in hospital.

Event summaries: An event summary of a patient's consultation. This can be uploaded by a healthcare professional (provider) at any participating healthcare organisation that is authorised to use the PCEHR system – such as an after-hours GP clinic, hospital or allied health professional. With a patient's consent, the authorised healthcare professional can then create and post to an individual's eHealth record.

As the system grows and becomes more connected over time, a patient's eHealth record will also contain pathology reports, dispense notices, referrals and specialist letters.

What or who is a nominated provider?

A nominated healthcare professional is the initial author of a patient's Shared Health Summary, although other healthcare professionals can add to the eHealth record with event summaries etc.

It is expected that for the majority of Australians, the nominated provider will be from their regular GP surgery. Where a GP surgery is not available, another healthcare professional that meets the criteria set out in regulations may be nominated if they agree to take on this role. This could include a registered nurse, aboriginal health worker or other professional group as permitted under PCEHR regulation.

What will I use the information in a patient's eHealth record for?

An eHealth record will give healthcare professionals instant, secure access to summaries of a broad range of health information about a patient, enabling informed decisions to be made on their care or treatment.

This immediate access will provide information from a range of other healthcare organisations about a patient's health, reducing the risk of errors in diagnosis and treatment decisions. It will also help you manage the use of medications to make it safer and easier to keep track of a patient's treatment.

Benefits of an eHealth record for Healthcare Professionals (HCPs)

What are the benefits of the PCEHR system as opposed to current, health records held within healthcare organisations?

Healthcare in Australia is currently not well connected nationally and clinical records are oriented towards managing information for healthcare professionals within their own organisation. It will take time, but the PCEHR system will allow your patients to collect and facilitate the sharing of this information between their healthcare professionals across geographic boundaries. By doing so, it will support a continuity of care.

How is the PCEHR system going to make things easier for healthcare professionals?

'PCEHR ready' healthcare organisations will have instant access to information from other healthcare organisations about a patient's healthcare, improving treatment decisions.

The PCEHR system will improve access to relevant health information about a patient at the point of care. As it grows it will support healthcare professionals by reducing the time required to search for key patient information such as allergies, medical history and immunisation.

Managing prescriptions and usage of medicines will be safer as a summary of a patient's important health information will be in the same place and in a standardised format. This will assist healthcare professionals to keep track of a patient's treatment. Having access to this kind of information could include life-saving details such as prescribed medication and allergies that will help reduce the risk of human error in diagnosis and treatment decisions.

While the PCEHR system will not be a substitute for a comprehensive assessment of a patient's condition and medical history, it will provide a useful summary and a good starting point.

Becoming PCEHR Ready

How do healthcare organisations prepare to participate with the PCEHR system?

To be able to access your patients' eHealth records, you will need to do four things:

- Ensure your healthcare organisation has obtained a Healthcare Provider Identifier – Organisation (HPI-O) from the Healthcare Identifiers Service Operator (Medicare Australia);
- Obtain your own Healthcare Provider Identifier – Individual (HPI-I) from the AHPRA website or if you have not been assigned a HPI-I by AHPRA apply to Medicare Australia for your HPI-I;
- Check that your healthcare organisation has upgraded and configured its clinical software so that it is 'PCEHR ready'. You can check with your software provider to see when this might be available or you can use the provider portal through a standard web browser in the interim. This will only allow you to view, but not upload information to your patient's eHealth record.
- Register with the PCEHR system operator and accept the prescribed terms and conditions for participation.

What is an IHI, HPI-I and HPI-O?

The Healthcare Identifiers (HI) Service is a national system for uniquely identifying healthcare professionals and individuals. Healthcare Identifiers will help ensure individuals 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 receiving healthcare services;
- Healthcare Provider Identifier – Individual (HPI-I) – for healthcare professionals involved in providing patient care; and

- Healthcare Provider Identifier – Organisation (HPI-O) – for organisations that deliver healthcare (such as hospitals or general practices).

The PCEHR system will use healthcare identifiers to provide greater certainty that patient information is being correctly attributed to their electronic record and ensure accurate communication of their health information.

How do I get an HPI-I?

All healthcare professionals registered through the Australian Health Practitioner Regulation Agency (AHPRA) have been allocated an HPI-I. This may be obtained by logging on to the AHPRA website. Eligible healthcare professionals who are not registered by AHPRA may obtain an HPI-I by registering with Medicare Australia.

What do I need to know about software compatibility?

To be able to upload information into your patients' eHealth records, your organisation's software systems will need to be compatible with the PCEHR system. As the PCEHR system is developed, more information will be made available via the provider portal [include web address once known] as to which vendors will offer compatible software.

You will also be able to access the PCEHR system via the provider portal. However, you can only view patient information via the portal and cannot upload information.

When and how do I prepare for the implementation of the new eHealth records?

Healthcare organisations should start preparing and becoming 'PCEHR ready' now. Training and development materials will be made available for healthcare professionals and associations.

It is also important to make sure you and your healthcare organisation as a whole consider how you can get ready for the PCEHR system. Key steps include:

- Make sure you have a computer and internet access.
- Spring clean your patient healthcare records; i.e. ensure you have only one record per patient.
- Obtain a Healthcare Provider Identifier – Organisation (HPI-O) from the Healthcare Identifiers Service Operator (Medicare Australia).
- Once a healthcare organisation becomes 'PCEHR ready', it will be able to authorise individual healthcare professionals within the organisation to use the system.
- For your healthcare organisation to authorise you to use the PCEHR system, you will also need to find your HPI-I using your letter from AHPRA.
- To be able to access your patients' eHealth records, your organisation's software systems will need to be compatible with the PCEHR system. Alternatively you can also access via the provider portal, however you cannot upload information.
- Ensure your Public Key Infrastructure (PKI) is current.

How will I find out more about how to use the PCEHR system?

The Australian Government is participating in numerous industry conferences and seminars to explain eHealth, the PCEHR system and how healthcare professionals can be part of it. Interactive demonstrations, online tutorials about the PCEHR system and other materials will

become available for healthcare professionals and associations as the PCEHR system is finalised.

How will I access the PCEHR system?

Over time, upgrades to your existing clinical software will be available to allow seamless use of the PCEHR system. In the interim, there will be an easy-to-use Provider Portal (website) which allows healthcare professionals to access information in a patient's eHealth record. If you don't have the right clinical software initially, you will still be able to view your patients' eHealth record through an easy-to-use provider portal, although you will not be able to upload information on to it.

Managing a patient's eHealth record

Will the PCEHR system replace the medical records we already keep?

The PCEHR system does not replace existing clinical records and is not intended as a comprehensive record. Instead, it provides a summary of patient information that has been 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.

Will I need to keep two sets of records when I have to note down some things that patients should not see?

There is no requirement to maintain duplicate records. This is because any existing policies with respect to the confidentiality and privacy of clinical records held within a healthcare organisation will remain. If a patient requests access to clinical records held within a healthcare organisation, they must be made available, subject to any constraints as determined by legislation.

Information sent to the PCEHR will be a summarised copy of some of that information, posted with the patient's consent, and not a full or complete record. This will generally be managed in software and there is no requirement to keep a backup record within your healthcare organisation of what information has, and hasn't, been sent to the PCEHR.

What will be my role (GP, nurse, consultant etc)?

As a healthcare professional – and with your patient's consent – your role will be to update your patient's eHealth record with the outcomes of your consultation. This will be a short summary of the advice, care or treatment provided.

If your patient asks you to be their nominated provider and you agree, you will be asked to develop their shared health summary. You may also be asked to update this on a regular basis or as necessary. To be a nominated provider, you need to meet a set criteria set out in the PCEHR regulations.

How easy will it be to make a health summary for a patient? How long will it take?

The intention is that creating a patient's shared health summary will be very simple. Shared health summaries are based on RACGP standards and therefore the basics are already in GP records and systems. So the intention is that it will just be a matter of reviewing the data to check it before uploading.

What constitutes a healthcare event or activity?

Event summaries or activities are used to capture key health information that is relevant to the ongoing care of an individual. Any healthcare advice, care or treatment – for example a visit to a GP, dental work or pre/post natal care – may constitute a healthcare event or activity.

An event summary is intended to be the 'default' clinical document type and is used when none of the other types of clinical document are appropriate. For example, an after hours GP clinic may use it to provide information that is important to the ongoing care of the patient. Similarly, it can be used in cases where clinical document types have yet to be developed.

Who decides which healthcare events or activities are relevant to put into a patient's eHealth record?

The healthcare professional can make this decision in consultation with their patient. There will be information available to provide further details on what is and what isn't relevant to upload to a patient's eHealth record.

However, patients may request that particular information is not put into their eHealth record, in which case, it will remain only in the patient records held within a healthcare organisation.

Will an eHealth record contain a patient's complete medical history?

The PCEHR system is intended to bring together only a summary of a patient's significant health information that is important to their ongoing care. Patients can request that key historical health events or activities be added to their eHealth record when their Shared Health Summary is created.

Who manages the information in a patient's eHealth record?

A patient will be able to manage their own eHealth record by setting access controls. However, they will require their healthcare professionals to upload information relevant to their care.

Who can upload information into a patient's eHealth record?

An eHealth record may contain information provided by healthcare professionals and patients. Authorised medical practitioners – including GPs, registered nurses and Aboriginal Health Workers – who agree to this, will create the shared health summary for a patient's eHealth record, ensuring the summary information is clinically relevant. This will be done in consultation with the patient. The source (named by healthcare organisation and the name of the healthcare professional who uploaded it) of any data loaded into the PCEHR system will be clearly identified, so that users can form their own opinion on the quality of the information.

Healthcare professionals with a Healthcare Identifier will be able to add to a patient's eHealth record with information related to the care they provide. Your patient will be able to update their eHealth record with key demographic details, basic health information and write notes in a private section that will be visible only to them.

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

Patients will only be able to enter demographic and basic healthcare information as well as keeping a private notes section in their eHealth record. Information uploaded by a patient will be clearly marked as such.

A patient's healthcare professional will be in charge of recording relevant events or activities related to the care they are providing to the patient. The patient-entered basic healthcare information may include details such as over-the-counter medicines being taken and side effects noted. There will be an area in the eHealth record where patients can keep their own notes. This part of the eHealth record will not be visible to healthcare professionals.

Can a patient ask for documents to be removed from their eHealth record entirely?

Individuals will be able to remove a clinical document from their eHealth record. Once a clinical document has been effectively removed from an eHealth record, it is no longer considered part of an individual's eHealth record and is not accessible by either the individual or by healthcare professionals (including emergency access). However, patients will be notified of the potential risks of removing or withholding information. The individual may at a future point in time ask to have the clinical document restored to their eHealth record.

Can healthcare professionals remove information from a patient's eHealth record?

Healthcare professionals can only remove documents from a patient's eHealth record that they have uploaded if they determine that they were uploaded in error or contain certain clinically inaccurate information which may cause harm to the patient. If incorrect information has been uploaded into an eHealth record, that clinical document will be 'locked' to prevent further access with the reason for withdrawal recorded, and a new, correct version of the document would be uploaded to that eHealth record. Replaced documents will still remain in the system and may only be recovered through the system operator subject to request under law.

Will patients see the results of their tests before their doctor?

Diagnostic reports may only be posted to the PCEHR system once their release has been authorised by a professional. This process is specifically designed to avoid a situation where patients may see their results first and get confused or upset. A patient cannot use the PCEHR system to gain direct access to test reports before they are shared by the healthcare organisation.

How will content be managed and structured in a patient's eHealth record?

All clinical documents will need to be in a clinical format, presented in a way that is acceptable to healthcare professionals. A series of templates are being designed to assist in these developments.

If a GP doesn't have time to upload the event summary, can the patient upload it?

No. All clinical information in a patient's eHealth record must have its origin clearly identified and attested by certified healthcare organisations.

Am I automatically authorised to enter data into a patient's eHealth record?

Once a healthcare organisation registers for the PCEHR system, appropriate or relevant healthcare professionals within that organisation can be authorised to access the system. All authorised healthcare professionals working in healthcare organisations that are 'PCEHR ready' will be able to upload content. To upload content, you must have an HPI-I (Healthcare Provider Identifier – Individual) and be authorised by your healthcare organisation with a patient's consent.

Could an organisation rather than an individual be a nominated provider for an individual's eHealth record?

No. Nominated providers must be individuals. However, individuals can request that a different provider in the same practice be their nominated provider at any time.

Can a patient choose to record only some of their health information on their eHealth record?

The PCEHR system is intended to contain only key elements of an individual's health information in one record. This may include a shared health summary, discharge summaries, event summaries and prescription details among other related healthcare information. A patient can request that information is not loaded on to their eHealth record, that information is viewed by only selected healthcare professionals (except in an emergency, when a patient is unconscious) or to have information removed from their record entirely.

Can patients limit the information I can view in their eHealth record?

The PCEHR system allows individuals to restrict access to some information so that it is only available to some healthcare organisations. Patients may choose to remove some information completely so that it is not available to any healthcare organisation. However, patients will be notified of the potential risks of removing or withholding information.

In line with current systems in an emergency situation, when a patient is unconscious, full access to a patient's record will be granted on a temporary basis when a healthcare professional declares that there is a serious threat to life, health or safety. The patient may be notified of this access.

Will healthcare professionals be aware that some information is not available for them to view?

No. In discussions held over the last year with a sample of the Australian healthcare sector, healthcare professionals raised concerns about information being omitted from a patient's eHealth record (for example, in the case of mental health patients). With current health systems, patients are able to choose whether or not to share certain information. This will not change with the PCEHR system as it was found that healthcare professionals would rather not know about concealed patient information.

The PCEHR system is intended to support and enhance, rather than replace the usual examination and question around a patient's history during a consultation.

Are there liability implications around hidden data for healthcare professionals?

The PCEHR system is defined as an 'information system' and not a 'communication system.' Therefore there is no obligation for a healthcare provider to review an individual's eHealth record outside of a consultation.

Furthermore, there is no obligation to review an individual's eHealth record before uploading a clinical document, although there is an obligation to review an individual's eHealth record before uploading a new shared health summary.

If a patient is not able to manage their eHealth record themselves, can they nominate someone else to do it for them?

The PCEHR System will not permit anyone but the patient and their healthcare professional to manage their eHealth record. For people who are unable to make decisions about their own healthcare or are physically unable to use a computer for the purposes of patient-entered information, such as minors or those who require fulltime care, a patient can nominate an authorised healthcare professional to upload information on their behalf such as parents, guardians or those with Medical Powers of Attorney.

If one of your patients has difficulty reading or writing, a participating healthcare organisation can set up, input information and maintain their eHealth record.

Could a GP be a nominated representative of a patient's eHealth record?

Yes, if they agree to do so.

In what situation will emergency access be granted?

In an emergency situation, when a patient is unconscious, healthcare professionals will be able to view all clinical documents in a patient's record on a temporary basis when a healthcare professional declares that there is a serious threat to life, health or safety. The patient may be notified of this access.

How can I be confident that the information in a patient's eHealth record is correct and accurate at the time of viewing the record?

Just like health records that are currently held, the quality and accuracy of information available on a patient's eHealth record will be dependent on the quality of information provided by healthcare organisations. As healthcare organisations and patients adopt the PCEHR system, more information can be shared in a consistent, clinically relevant format.

Will I need to explain the system, how it works and confidentiality features to each patient?

A range of targeted communications programs will be put into place for individuals, healthcare professionals and government agencies amongst others, to specifically raise understanding and awareness of the national PCEHR system.

The public will be made aware of the PCEHR system. This will include details of the services they can access, how to use those services and how these services will give them better control over their healthcare and information.

In a GP practice or other healthcare organisation, when someone goes on holiday and a locum doctor steps in, how does that locum doctor get access to the patient's eHealth record?

In the same way as current practice, consent to collect and use information is provided to the healthcare organisation. Provided the locum doctor is an employee of (or contracting to) the organisation which received your consent, they will be able to access a patient's eHealth record. The locum doctor would also need to have their own HPI-I linked to the organisation's HPI-O.

Access, Privacy & Security

How will I access a patient's eHealth record? Will I have a login and password or photo ID?

When accessing the PCEHR system via software installed at your healthcare organisation, healthcare professionals will login just as they do today. If they are accessing the PCEHR system via the Provider Portal, they will require a Digital Certificate – in the same way as many healthcare professionals do today when accessing Medicare's Healthcare Professional Online Services Portal – HPOS.

With strict privacy measures in place, only healthcare organisations or healthcare professionals with a Healthcare Identifier (HPI-I and HPI-O) number will be able to access the PCEHR system. Healthcare professionals can access eHealth records via a provider portal or through software installed at their healthcare organisation.

Who else will have access to my patient's eHealth record? Will they see everything in it?

A patient's eHealth record may be viewed and updated by any healthcare organisation that has been granted access by a patient. Patients can give different access to different healthcare organisations. Therefore, what can be seen by other healthcare organisations will ultimately depend on the access controls that the patient has put in place.

How can I be sure that this health information will be secure?

The national PCEHR system will be protected by the same laws that are in place for paper-based health records. Additionally, the Government will establish additional safeguards through the introduction of new laws and robust governance arrangements for the national system. This will include the ability to see a list of organisations that have viewed the record and security measures such as log-ins and passwords, as well as technology and data management controls to minimise the likelihood of unauthorised access to information in a patient's eHealth record. The patient will be able to view the audit trail and request an SMS alert when someone views their eHealth record.

How will this health information be protected?

Protecting a patient's health information is a key component of the PCEHR system. The Australian Government will continue to work with leading technology providers to help safeguard the PCEHR system with the most secure technology available to protect the information in it to the highest standards against malicious interference.

Where will the information stored in a patient's eHealth record be held?

The PCEHR system and all individual eHealth records will draw on a range of information that will be stored within Australia in national, state or privately operated databases.

eHealth Site-specific

Is the PCEHR system being trialled anywhere in Australia?

Various eHealth records are being pioneered across Australia both in specific geographic areas and by key healthcare organisations and practices. Work is underway with 13 eHealth sites. The PCEHR system will benefit from the lessons learned from these eHealth sites and from international experience.

What's involved in an eHealth site?

The eHealth sites have been set up to progress elements of the PCEHR system in practical settings. This will allow the Australian Government to learn more about how the different elements of the PCEHR system work ahead of a broader national rollout.

How much is the Government investing in the PCEHR system and these eHealth sites?

In the May 2010 Budget, the Australian Government allocated almost $470 million over two financial years to fund the development of the core national infrastructure, governance, additional standards and tools required for a PCEHR system.

$130.6 million (GST exclusive) has been allocated to establish and operate the eHealth sites.

Who are/ where are the eHealth Sites?

The first eHealth sites include:

- Brisbane South Division of General Practice Limited
- Calvary Health Care ACT Limited
- Cradle Coast Electronic Health Information Exchange (Tasmania)
- Fred IT Group Pty Limited
- GP Partners Ltd (Brisbane)
- Greater Western Sydney eHealth Consortium
- Hunter Urban Division of General Practice
- Mater Misericordiae Health Services Brisbane
- Medibank Private Limited
- Melbourne East General Practice Network Limited
- Northern Territory Department of Health and Families
- St Vincents and Mater Health Sydney Limited

What does DoHA / NEHTA intend to get from these eHealth sites to help shape the PCEHR system?

The eHealth sites have been set up to implement and evaluate eHealth infrastructure and standards in real-life settings. Feedback from the 12 eHealth sites will provide key learnings from their frontline experience to inform the PCEHR system implementation.

How will the eHealth sites fit within the PCEHR system framework going forward?

The eHealth sites have been developed as pioneer settings for how an eHealth record could work, providing valuable lessons learnt locally to inform the development of the PCEHR system.

Plans are in development as to how they will transition towards the national PCEHR system.

Will DoHA / NEHTA appoint more eHealth sites before the launch of the PCEHR system?

There are currently no plans for any additional eHealth sites.

What has the feedback to the PCEHR system been from these eHealth sites so far?

It is still early days for many of these eHealth sites as they are working with the Department of Health and Ageing and NEHTA to evaluate lessons learnt, and how these learnings can help shape the national roll-out. There have already been valuable insights from early adopter areas such as Brisbane South and the Northern Territory where Electronic Health Records have been in place for some time.

Health Reform

How does eHealth and the national PCEHR system fit in with the government's overall health reform agenda?

eHealth is an integral part of the Australian Government's agenda for health reform, an agenda which aims to create a continuously improving national healthcare system for the 21st century. eHealth is important to the future of healthcare in Australia. For consumers and healthcare professionals alike, it will change the way healthcare is delivered and give all Australians access to the information and knowledge they need to take better care of their health.

The Government has committed almost $470 million over two years to develop the critical national infrastructure for the PCEHR system as a key element of the national health reform agenda.

Who is rolling out the PCEHR system?

The Australian Government has provided almost $470 million over two years to deliver the core functionality to deliver a PCEHR system. In conjunction with the National E-Health Transition Authority (NEHTA) and a number of other delivery partners, the Australian Government will make an eHealth record available from 1 July 2012 to all Australians who wish to opt-in.

What are the targets round up-take?

The development of the PCEHR system will be incremental, as is our expectation of the number of consumers that will sign up.

Uptake is intended to be gradual and 1 July 2012 is a starting point. As the PCEHR system grows and becomes more connected, it is expected that more individuals will see the benefits of having an eHealth record and sign up.

Why is the Government introducing this now?

As part of the national eHealth program, the PCEHR system is being designed to meet challenges which threaten the sustainability of current care practices by bringing consumer-focused electronic health capabilities to the Australian healthcare system.

eHealth and the PCEHR system is an integral part of the Australian Government's agenda for health reform. This system is all about connecting and streamlining information sharing for improved healthcare. And by making technology work to our advantage, we will move towards a national healthcare system fit for the 21st century.

eHealth will potentially save lives, save money and make the health system more efficient.