AMA Guide to Medical Practitioners

on the use of the

Personally Controlled Electronic Health Record System

Contents

1 President's introduction

This Guide has been developed by the AMA to assist medical practitioners consider how they might use the Personally Controlled Electronic Health Record (PCEHR) System as a clinical tool.

You will all be familiar with electronic records, sharing patient information within your practice and electronic information sharing as point-to-point sharing between practices. The PCEHR system will allow point-to-many information sharing.

The PCEHR system is intended to provide Australian health consumers - our patients - with a prompt electronic system of access to a snapshot of their current health information. It is not intended to replace our own patient medical records which we will need to maintain for our own purposes as we do now. Participation in the system is voluntary for patients, medical practitioners and other healthcare providers.

This Guide has been developed taking account of the information in the *Concept of Operation: Relating to the introduction of a Personally Controlled Electronic Health Record System* document and the *Personally Controlled Electronic Health Records Act 2012*. It provides guidance on the use of a new tool in medical practice. In any conflict between this Guide and the relevant law, the law takes precedence.

The use of the PCEHR system by medical practitioners does carry new responsibilities for you, as decisions need to be made about how to use the tool in clinical practice and what information should be shared via the PCEHR system with other medical practitioners and healthcare providers. There are also provisions to be aware of, such as the ability to include the names of healthcare providers who have previously provided healthcare to the consumer with the consumer's PCEHR.

This Guide has been written by medical practitioners for medical practitioners and after consultation with the medical defence organisations and representatives of medical colleges, associations and societies. I hope that it will assist you to understand the medical professional responsibilities of the use of the PCEHR system and the record itself.

The Guide has been prepared in the very early stages of the implementation of the PCEHR system. I urge all medical practitioners to maintain an interest in the development of the system. As you learn more about the system during the course of its incremental rollout, I am sure you will find aspects of this Guide will inform your thinking about the PCEHR system. I hope this Guide assists you to consider how you might adopt the use of the PCEHR in your day-to-day practice, in a way and at a time that suits your practice.

Dr Steve Hambleton
President
30 August 2012

2 Basic facts: the PCEHR:

2.1   Requires voluntary participant registration

2.1.1   *Medical practitioners* participate in the PCEHR system through the healthcare provider organisations in which they work (their practice or hospital), and will not have to register directly with the system operator.

2.1.2   *Healthcare provider organisations* that choose to register with the PCEHR system operator can grant access to authorised users within that organisation, including registered medical practitioners and medical students, and other employees they choose to authorise.

2.1.3   *Patients* in their personal capacity can choose to use the PCEHR (opt in) by registering personally with the system operator directly.

2.1.4   Medical practitioners may decide to assist some or all of their patients to register for a PCEHR by a facilitated registration process in their practice.

2.2   Is voluntary for patients

2.2.1   A patient is not required to have or use any form of shared electronic health records, including the PCEHR.

2.2.2   Patients who have opted in to participate in the PCEHR system can choose to opt out at any time.

2.3   Is voluntary for medical practitioners

2.3.1   A medical practitioner is not under any duty or obligation to use the PCEHR system.

2.3.2   Medical practitioners who decide to use the PCEHR system are free to apply their clinical judgement to determine when and how they will use the system, including using the PCEHR for some of their patients but not for others.

2.3.3   Medical practitioners who decide to use the PCEHR system can choose to stop using it any time, including ceasing using the PCEHR for some of their patients but not for others.

2.3.4   Even if you decide not to use the PCEHR system, you do have a professional obligation to be familiar with it and be able to advise patients about how they could use this personally controlled system to manage their own healthcare.

2.4   Is personally controlled

2.4.1   A PCEHR is "owned" and therefore controlled by the patient.

2.4.2   A PCEHR is a tool for the patient to use to record and remember their health information.

2.4.3 Each patient has the right to determine what information is included in their PCEHR, and who is able to access how much of that information.

2.4.4 When registering for a PCEHR, patients give 'standing consent' to all healthcare providers uploading the patient's health information to their PCEHR.

2.4.5 Patients, by legislative right, may control the information that is included or accessed in their PCEHR by:

2.4.5.1 Accepting the default (or basic) access controls, which allow all healthcare providers involved in the care of a patient access to the patient's PCEHR;

2.4.5.2 Applying more advanced access controls, which may put in place access restrictions on their entire record, on certain organisations, or on certain information within the record;

2.4.5.3 Expressly advising medical practitioners not to upload certain healthcare information;

2.4.5.4 Removing a document in its entirety from their PCEHR; or

2.4.5.5 Requesting the Nominated Healthcare Provider to modify the Shared Health Summary.

2.4.6 There will be no indication to medical practitioners who view the patient's PCEHR how a patient may have modified their PCEHR.

2.4.7 A patient cannot compel you to include or exclude particular information in their PCEHR.

2.5 Information includes:

2.5.1 A single 'Shared Health Summary' that includes up-to-date, curated information about the patient's healthcare status. This is a special document created by a 'Nominated Healthcare Provider' who is chosen by the patient.

2.5.2 Clinical documents created and uploaded by participating healthcare providers about healthcare events (such as event summaries, discharge summaries and pathology and radiology reports).

2.5.3 Automatic population of information from the following data repositories (which may include the names of healthcare providers who have provided the healthcare referred to):

2.5.3.1 Medicare Benefits Schedule;

2.5.3.2 Pharmaceutical Benefits Scheme;

2.5.3.3 Australian Childhood Immunisation Register; and

2.5.3.4 Australian Organ Donor Register.

2.5.4 Information and diary notes added to the record by the patient themselves, of which only contact details, medications, allergies and location of advanced care directives will be visible to medical practitioners; diary notes will not be visible to any healthcare provider.

2.6 Information access

2.6.1 Authorised access to a PCEHR can only occur in accordance with the access controls set by the patient.

2.6.2 Patients can access their own PCEHR, and can also grant access to their Nominated Representatives. For example a spouse or carer might be a Nominated Representative of a person with a chronic illness.

2.6.3 The system operator may recognise Authorised Representatives to operate the PCEHR on behalf of the patient. An Authorised Representative may be a person:

2.6.3.1 With parental responsibility for patients aged under 18; or

2.6.3.2 Who can act for patients with no or limited capacity to act on their own behalf.

2.6.4 Medical practitioners, medical students, employees, contractors, volunteers and designated others can access a patient's PCEHR under the authorisation of the healthcare organisations with which they are associated.

2.7 Information disclosure

2.7.1 *Disclosure* means disclosing any information that a medical practitioner can access from the PCEHR to anyone, even the patient.

2.7.2 As long as your access accords with the access controls set by the patient, you may disclose information in a patient's PCEHR to:

2.7.2.1 The patient in the course of delivering health care to that patient;

2.7.2.2 A patient's Authorised Representative; or

2.7.2.3 A patient's Nominated Representative.

2.7.3 Circumstances where information in a patient's PCEHR may be disclosed, but are not covered by patient-set PCEHR access controls, are:

2.7.3.1 To the patient, by the patient, or for any purpose with the patient's consent;

2.7.3.2 For the provision of emergency care to the patient if they are unable to consent;

2.7.3.3 As authorised by law, to courts and tribunals, or for law enforcement purposes; and

2.7.3.4   In the course of providing indemnity cover to a healthcare provider.

2.8 Emergency access

2.8.1 For any patient, including one who has applied advanced access controls that prevent access to some information in their PCEHR, and who is incapable of providing consent to PCEHR access, treating medical practitioners may gain emergency access if they make a clinical judgement that this would lessen or prevent a serious threat to an individual's life, health or safety. Such emergency access is subject to retrospective audit.

2.8.2 There is no obligation on any medical practitioner to access a patient's PCEHR in an emergency situation. Any access attempt should be determined by an assessment of the clinical scenario.

3 Good patient care

Your use of the PCEHR in patient care should be guided by the principles of good medical practice being applied to PCEHR clinical information.

The information contained in the PCEHR that is accessible to you may have been posted by other medical practitioners or healthcare providers. They may have already used PCEHR information in their care of the patient, and think that the information is useful for patients to provide to other health care providers.

3.1   Basic principles for using the PCEHR

3.1.1   A medical practitioner's duty of care to exercise reasonable care and skill in the provision of professional advice and treatment to their patient extends to the medical practitioner's use (accessing, disclosing, uploading) of the PCEHR.

3.1.2   Even if a patient has a PCEHR, it remains the treating medical practitioner's responsibility to take a clinical history from their patient, including a list of all medications that a patient is currently taking, allergies, and perform a relevant clinical examination of the patient .

4 Working with patients

Patients may seek the advice of their medical practitioner about the PCEHR system, particularly when a long-term doctor-patient relationship exists. You should engage in the conversation in good faith based on your unique relationship with each patient.

4.1 Effective communication

4.1.1   Patient contributions to their PCEHR should not be regarded as a substitute for personal communication between a doctor and their patient.

4.1.2   Information in a patient's PCEHR can be used as an *aide memoire* by the patient, and by you to inform and guide consultations and increase the effectiveness of communication with that patient.

4.1.3   When providing a clinical history, a patient may provide information that is not included in their PCEHR, and which the patient may wish never be included in it.

4.2 Advising patients about the PCEHR system

4.2.1   If a patient asks for advice about the PCEHR system, the most important topics to consider for discussion are:

4.2.1.1   Information about the PCEHR system, supported by appropriate Government-provided educational materials, which you may be prepared to display or distribute;

4.2.1.2   How you and your practice use the PCEHR system, supported by practice protocols or patient information material if your healthcare provider organisation has developed these documents;

4.2.1.3   Potential benefits of having a PCEHR, including the potential to reduce adverse events and the likelihood that the patient may enjoy benefits of easier coordination of care; and

4.2.1.4   Potential inconvenience of not having a PCEHR, including discussion of the likelihood that the patient may require duplication of tests causing delayed treatment.

4.2.2   Where clinically appropriate, counsel patients about the importance of full disclosure of all clinically relevant information on the accessible areas of their PCEHR to all medical practitioners who may need to access their record from time to time to facilitate their care in future clinical situations.

4.2.3 Advising patients about the PCEHR may also include advice about the complexities facing medical practitioners who use the PCEHR for their patients.

4.2.4 Emphasise that because registration for the PCEHR system initiates a relationship between the patient and the system operator, it is the patient's responsibility to read, understand and agree to the PCEHR system terms and conditions before deciding to opt in.

4.2.5 If a medical practitioner discusses the PCEHR with their patient, it is recommended that they record that the discussion occurred in their own patient's notes.

4.3 Patient engagement with their PCEHR

4.3.1 Patients may enter information into their PCEHR that is visible only to them (and perhaps their Nominated Representative), and which will never be visible to any healthcare provider. A medical practitioner cannot be expected to know what the patient does not permit them to know.

4.3.2 When considering a PCEHR's patient entered information for inclusion in deriving a clinical decision, the treating medical practitioner should take into account the content, accuracy accessibility and relevance of this information.

4.4 Patients with additional needs

4.4.1 When working with patients who have additional needs it is especially important to consider the roles that partners, carers and relatives may have in the patient's care. Consider how they can be involved in managing the patient's PCEHR, perhaps as an Authorised or Nominated Representative, and seek their involvement where appropriate.

4.5 Informed consent related to use of the PCEHR

4.5.1 New patients, or existing patients where you are using their PCEHR for the first time, should be informed that use of the PCEHR will form part of the therapeutic relationship. The patient should also be given the opportunity to ask advice or request more information related to the use of the PCEHR itself within your practice.

4.5.2 Use of the PCEHR can be expected to differ for each patient, and informed consent to use a patient's PCEHR should be obtained in a way that is appropriate to the nature of its expected use based on your clinical relationship with your patient.

4.5.3 Uploading information (writing) to the PCEHR system:

4.5.3.1 In registering for the PCEHR system, patients provide all medical practitioners 'standing consent' to upload clinical information. There is no

requirement to obtain consent on each occasion prior to uploading of clinical information.

4.5.3.2 Good medical practice involves advising the patient you will upload information to their PCEHR. It is prudent to record this advice in your own patient file.

4.5.3.3 While patients can expressly advise you not to upload a document or fact, you are not under any obligation to give the patient a specific opportunity to object to the uploading of a document.

4.5.3.4 If the information is potentially sensitive and you consider that the patient may have reservations about it being uploaded to the PCEHR you should discuss the uploading with the patient.

4.5.4 Accessing information (reading) on the PCEHR system:

4.5.4.1 Where possible, the patient's informed consent for you to access their PCEHR should be established by direct communication with the patient, before their PCEHR is accessed. The nature of this consent will be based on your relationship with your patient together with the protocols for using the PCEHR established by the healthcare organisation in which you work.

4.5.4.2 The PCEHR system allows patients to communicate "forward consent" to treating healthcare providers, so that they can access the patient's PCEHR absent an opportunity to discuss this with the patient directly. In this situation, it is recommended that you inform the patient during any subsequent consultation that their PCEHR was accessed.

4.5.5 Medical practitioners should note on their patient's file that their patient has consented to the medical practitioner interacting with the patient's PCEHR every time that consent is obtained.

4.6 Patients with limited capacity to make decisions

4.6.1 In some circumstances it may be appropriate for the treating medical practitioner to make a clinical judgement that their patient either does or does not have the capacity to make decisions about sharing their health information electronically, including in a PCEHR.

4.6.2 In these circumstances, the treating medical practitioner should consider three important guiding principles in making a judgement about the capacity of their patient to make decisions about sharing their health information electronically via the PCEHR system:

4.6.2.1   That the capacity to make decisions about sharing health information is different from the capacity to make decisions about healthcare;

4.6.2.2   Whether the patient has the capacity to make decisions about sharing their health information electronically, or not; and

4.6.2.3   Whether the circumstances are such that changing the existing assessment of the patient's capacity would clearly be of benefit to the patient's care.

4.6.3   The treating medical practitioner should then apply this judgement of the patient's capacity to their subsequent use of the patient's PCEHR. This may involve providing advice about the patient's capacity to the system operator, if requested.

4.7   Authorised Representatives

4.7.1   The PCEHR legislation permits patients up to 18 years of age, or who otherwise do not have sufficient capacity to make decisions about their own healthcare, to have "Authorised Representatives" who hold all the responsibility for managing the patient's PCEHR. They are "authorised" by the system operator to "be" the patient for the purposes of the PCEHR system.

4.7.2   If a patient has an Authorised Representative, medical practitioners must ensure that the Authorised Representative makes all decisions involving the patient's PCEHR.

4.7.3   Authorised Representatives are assigned or removed by the system operator, not by the patient's medical practitioners, including the Nominated Healthcare Provider.

4.8   Nominated Representatives

4.8.1   Patients may nominate representatives (for example family members or carers) who will be able to view and/or control information in the patient's PCEHR as the patient chooses.

4.8.2   If a patient has a Nominated Representative, you do not need to discuss decisions involving the patient's PCEHR with anyone but the patient.

4.9   Minors and the PCEHR

4.9.1   Parents or guardians of children less than 18 years of age are usually the child's authorised representatives.

4.9.2   Parents or guardians will remain the authorised representatives for young people aged from 14 to 18, unless the young person chooses to manage their own PCEHR by personally registering with the system operator.

4.9.3   In exceptional circumstances of maturity and independent interaction with the healthcare system, the system operator may

grant children aged less than 14 years of age responsibility for their own PCEHR.

4.9.4 The system operator may request advice from the minor's medical practitioner to determine whether or not the minor should be granted responsibility for their own PCEHR.

4.9.5 As there is no specific test of maturity, and the law regarding the capacity to make healthcare decisions in minors varies between jurisdictions, it is appropriate for medical practitioners to consider in their advice to the system operator:

4.9.5.1 Whether any independent request by a young person to take independent control of their PCEHR would aid the care of that patient, or not;

4.9.5.2 Whether they consider the young person is capable of making an independent decision to share their health information; and

4.9.5.3 The benefits and risks to the patient of involving their parents or guardians in decisions about the patient's PCEHR.

5 Working with the PCEHR system

Your contribution of quality information to the PCEHR, including a Shared Health Summary, will mainly benefit your patient's future treating clinicians. Medical practitioners should also be mindful that there may be diminishing benefit if the PCEHR contains large amounts of information about low acuity events or unstructured or low quality information – which may be worse than no information at all.

5.1 Medical Practitioners' own medical records

5.1.1 The PCEHR system is not intended to, and should not, replace a medical practitioner's own patient files and medical records system.

5.1.2 Each healthcare provider organisation that has provided health care for a patient will have its own record for that patient. Those records will contain detailed information pertaining to the patient's care, will be different from one another, and from the patient's PCEHR.

5.1.3 There is no obligation for any healthcare provider organisation to ensure their own patient records entirely match the information in the patient's PCEHR.

5.1.4 It remains your responsibility to ensure that the information in your own medical records is accurate and complete for your purposes.

5.1.5 You should ensure that information from the PCEHR that you have used in the course of decision making or caring for your patient is included in your own records and that the origin of this information is documented. Note that information in the PCEHR can change at any time (by the patient removing a document or a healthcare provider amending a document). You cannot be certain that specific information will be available to you at a later time.

5.2 Contributing information to the PCEHR system (uploading)

5.2.1 If you provide medical treatment that you consider to be a significant clinical event, you should consider uploading relevant clinical documents (such as event summaries) to the patient's PCEHR.

5.2.2 Clinical documents uploaded to the PCEHR system must be authored by a healthcare provider who has an individual healthcare provider identifier.

5.2.3 Those who upload patient information or Event Summaries to the PCEHR should consider how the information they choose to add will benefit subsequent users.

5.2.4 A patient's PCEHR, particularly the Shared Health Summary, should contain the core critical information about the patient that would assist any other medical practitioners or healthcare providers to provide safe patient care. Factors that might be considered when determining whether to upload information to a patient's PCEHR include the:

5.2.4.1 Complexity of the patient's care requiring coordination between a variety of healthcare providers;

5.2.4.2 Likelihood that the patient will present to other healthcare providers or healthcare organisations where the patient has not previously presented;

5.2.4.3 Clinical significance of the information to your current management of the patient;

5.2.4.4 Potential for the information to contribute to the clinical assessment of the patient at future presentations; and

5.2.4.5 Sensitivity of the information.

5.2.5 When you first start using the PCEHR, you may consider uploading key clinical information such as medications, adverse events, discharge summaries and recent results of diagnostic tests.

5.2.6 Medical practitioners should seek to ensure that the clinical information they upload onto a patient's PCEHR is complete, relevant, accurate, and up to date, at the time of uploading.

5.3 Using information from a patient's PCEHR

5.3.1 Medical practitioners should generally only access a patient's PCEHR in the course of making a clinical decision relating to the patient's care. This includes decisions made outside of direct patient consultations, such as when preparing for a consultation or a clinical service.

5.3.2 It is appropriate to access and use clinically relevant information in a patient's PCEHR to update the Shared Health Summary if you are the Nominated Healthcare Provider.

5.3.3 It is safest to assume the information in a patient's PCEHR is not a completely accurate record of the patient's clinical history or current health status, so all information should be verified from other sources of patient information, and ideally, with the patient.

5.3.4 When you access a patient's PCEHR you may choose to only access relevant parts or Event Summaries to assist you in your clinical decision making. You should use your clinical judgement to determine which documents are relevant to the care of your patient.

5.3.5 There is no obligation for you to review any or all of the information in a patient's PCEHR.

5.3.6 You should not access the PCEHR to write reports for third parties. Reports for third parties should be based on your own clinical notes and/or your assessment of the patient.

5.4 Nominated Healthcare Provider and the Shared Health Summary

5.4.1 Nominated Healthcare Providers prepare, create, upload and curate a Shared Health Summary on the patient's PCEHR.

5.4.2 Nominated Healthcare Providers may be medical practitioners, registered nurses or Aboriginal and Torres Strait Islander health practitioners.

5.4.3 The Shared Health Summary provides a single, curated description of the patient's health status at a particular time, incorporating clinically useful information such as allergies and adverse reactions, current medications, medical history and immunisations.

5.4.4 The decision for a medical practitioner to become a patient's Nominated Healthcare Provider is made voluntarily in an agreement between the medical practitioner and their patient such that:

5.4.4.1 There is no obligation on any medical practitioner to agree to be a patient's Nominated Healthcare Provider or to create a Shared Health Summary for the patient;

5.4.4.2 Medical practitioners can continue to treat their patient as usual regardless of a decision not to be the patient's Nominated Healthcare Provider or not to create a Shared Health Summary;

5.4.4.3 The patient can choose to establish a new agreement with a different Nominated Healthcare Provider at any time; and

5.4.4.4 The medical practitioner can choose to cease to act as a patient's Nominated Healthcare Provider at any time.

5.4.5 When a medical practitioner agrees to be a patient's Nominated Healthcare Provider, they should clearly specify what the terms of the agreement are. For example, you should consider addressing:

5.4.5.1 When the agreement will cease;

5.4.5.2 The circumstances and frequency the patient's Shared Health Summary will be updated; and

5.4.5.3 The expectations of the patient.

5.4.6 There is no additional responsibility for Nominated Healthcare Providers to curate, monitor or review any other information on their patients' PCEHRs, outside of creating or reviewing a Shared Health Summary for the patient.

5.4.7 Any discussion, decision or agreement relating to Nominated Healthcare Providers and Shared Health Summaries should be recorded in your patient's file, including the content of the discussion, any decisions made, reasons for any decisions, and actions resulting from the discussion.

5.5 Preventing and correcting errors

5.5.1 It is the nature of shared electronic health record systems including the PCEHR system that errors affecting information that is added to a patient's PCEHR may be shared and perpetuated.

5.5.2 Shared electronic health record systems including the PCEHR system are subject to errors of many kinds, including:

5.5.2.1 Errors in the information that is uploaded by the patient or a health care provider to the record;

5.5.2.2 Errors resultant from storage and transfer of the information; and

5.5.2.3 Errors made when retrieving information from the PCEHR.

5.5.3 Even if it is not possible to conclusively identify that information in the PCEHR is erroneous, it is important to consider the variable quality of this information in relation to the confidence you place in that information.

5.5.4 Patients should be encouraged to exercise their responsibility/control over their PCEHR by seeking to have errors addressed by their healthcare providers that uploaded the document.

5.5.5 Measures that can be taken to increase the quality and reliability of information as it is used in clinical decision making include but are not limited to:

5.5.5.1 Before uploading information, review the clinical judgments that led to your decision to upload information, and check that the information you are uploading is consistent with those judgments;

5.5.5.2 When selecting or preparing information for uploading, select structured over unstructured (i.e. free text) information;

5.5.5.3 When uploading information, review and crosscheck the information, the patient and the record, particularly if the patient is not present;

5.5.5.4 When retrieving information, test its accuracy by comparing it to other documents and by asking the

patient to judge the accuracy of the information for you; and

5.5.5.5   When retrieving information, avoid editing or deleting that information and in preference, add information describing any quality concerns you have.

5.5.6   If you become aware that information you have uploaded to a patient's PCEHR is erroneous you should upload a new updated and corrected version of the clinical document with the error corrected and record in your own notes that you have done so.

5.5.7   If you become aware of erroneous or poor quality information in a PCEHR that has been contributed by another healthcare provider, you should:

5.5.7.1   Inform the patient that you consider an error has been discovered; and

5.5.7.2   Document this in your own record.

6 Professional use

6.1 Working with the "personally controlled" nature of the PCEHR

6.1.1 Each patient "owns" his or her PCEHR record, determines what information is included, and who has access to it.

6.1.2 Where information has been effectively removed from a patient's PCEHR, or if advanced access controls have been set limiting access to information, there will be no indication to medical practitioners who view the patient's record that this has occurred.

6.1.3 Work with your patient to manage his or her own health information safely.

6.1.4 Consider counselling the patient about the:

    6.1.4.1   benefits of full disclosure of clinically relevant information to all medical practitioners who may need to access the patient's PCEHR in the future; and

    6.1.4.2   risks of removing information or limiting access.

6.1.5 If you become aware that a patient has removed a document from their PCEHR that they had previously consented to being uploaded by you, consider discussing this with the patient, advising the patient of the potential consequences of removing the document and recording the conversation on your patient's file.

6.1.6 If you are expressly advised by a patient not to upload a document or other piece of clinical information to the patient's PCEHR:

    6.1.6.1   Ask about why the patient does not want to share that information and address any concerns;

    6.1.6.2   Consider whether there are any foreseeable clinical risks to the patient associated with not uploading the document and counsel the patient accordingly;

    6.1.6.3   Avoid leaving clinically material facts which are part of a clinical episode out of a document at a patient's request. Instead, the entire clinical document should not be uploaded to the PCEHR; and

    6.1.6.4   The medical practitioner can reasonably consider declining to use the PCEHR for that patient in future.

6.1.7 If you make a clinical judgement that limitations on the information included in a patient's PCEHR pose a risk to the effective management of the patient's health, you may choose to advise the patient that you will no longer access that patient's PCEHR.

6.2 Information in a Shared Health Summary

6.2.1 If a patient advises you, as their Nominated Healthcare Provider, not to include some clinical information on their Shared Health Summary you should make a clinical judgment about:

6.2.1.1 Whether the omission of those clinical facts creates an inaccurate or misleading summary of the patient's current health status;

6.2.1.2 Whether not including that information would be a breach of your professional duties/standards/ethics; and

6.2.1.3 The risks to the patient of not including that information.

6.2.2 If a patient advises you, as their Nominated Healthcare Provider, not to include some information in a Shared Health Summary, and you form the judgment that the omission of that clinical information would present a risk to the patient during a future healthcare episode, or if the resulting Shared Health Summary would be potentially misleading or inaccurate to another medical practitioner, you should:

6.2.2.1 Counsel the patient about the risks of not including that clinical information;

6.2.2.2 Record that this conversation occurred in your patient's file; and

6.2.2.3 Consider refusing to be, or continuing to be, the patient's Nominated Healthcare Provider.

6.3 Documenting use of shared records

6.3.1 You should record all decisions and discussions with a patient about their PCEHR in your own patient record-keeping system.

6.3.2 If you access a clinical document or other information on a patient's PCEHR, you should document on your own patient record:

6.3.2.1 The nature of the interaction with the patient's PCEHR;

6.3.2.2 Patient consent obtained to do so, or if not, why not;

6.3.2.3 Time of the interaction;

6.3.2.4 Which documents on the record were involved; and

6.3.2.5 Any observations or conclusions reached as a result.

6.3.3 If you rely on information sourced from a patient's PCEHR to make a clinical decision, diagnosis or recommendation to the patient, that information should be contemporaneously downloaded or printed from the PCEHR and incorporated into your own patient record, as a record of the information used to derive the clinical diagnosis and treatment decision at that time.

6.3.4 If you made an attempt to interact with a patient's PCEHR but were not successful in doing so, or where consent has been requested and denied, this should be documented on your own patient record.

6.4 Working with other health care professionals

6.4.1 The use of any shared electronic health record, including a PCEHR, is not a substitute for communicating directly with other health care providers about your patient as you deem clinically necessary.

6.4.2 When using the PCEHR system, you should maintain all your current procedures to communicate patient information to other healthcare providers, such as sending a letter or fax, or giving a copy to the patient for hand delivery.

6.4.3 Healthcare providers from a variety of professional groups are permitted to upload information to a patient's PCEHR. When considering information from the PCEHR system in the course of making a clinical decision, it is reasonable to include the scope of practice of the originating healthcare provider in your assessment.

6.5 Using the PCEHR system to the advantage of the healthcare system

6.5.1 The responsibility to ensure that healthcare resources are used wisely and that they are transparently and equitably allocated in the care of all patients within the healthcare system extends to the use of any shared electronic health records.

6.5.2 When using the PCEHR system, you should take account of the primary goals of the PCEHR system for the safe and effective provision of healthcare. These goals are:

6.5.2.1 Help overcome fragmentation of health information;

6.5.2.2 Improve the quality and availability of health information;

6.5.2.3 Reduce adverse medical events, and duplication of treatments; and

6.5.2.4 Improve the coordination and quality of healthcare provided.

6.5.3 It is appropriate to consider which of your patients will benefit most from having their health information shared electronically between health professionals, and to ensure that your use of and interaction with the PCEHR system reflects these considerations.

6.6 If you choose not to engage with the PCEHR

6.6.1 If you choose not to engage with the PCEHR system, there is no obligation for you to change your current practice in any way, or take any action in relation to the PCEHR system other than being familiar with its existence and aims.

6.6.2 Within one healthcare organisation or medical practice, some medical practitioners may participate in the PCEHR system while others decide not to participate. Where this is the case, the details of how this is managed should be recorded and described in practice protocols.

6.6.3 If after participating in the PCEHR system you decide to discontinue your participation, you should consider how you have previously used the system, and advise your patients and colleagues of your decision according to the impact that discontinuation might have on patient care and clinical workflows. For example, those who have uploaded their referrals may wish to advise their colleagues that they will no longer be participating in the system and therefore their referrals will no longer be uploaded.

6.6.4 There is no requirement for medical practitioners to justify to their patients their decision not to use the PCEHR system. However to ensure that patients have no recourse to your decision, you should consider recording an explanation:

6.6.4.1 In your patient file, if you have an express conversation with your patient about your decision; and

6.6.4.2 In your practice protocols.

6.7 Medico-legal considerations

The medico-legal risks for medical practitioners and medical practices are unknown until case law develops. Accurate contemporaneous notes about your interaction with your patient will assist defending any medico-legal action.

6.7.1 It may be that you are exposed to medico-legal risk relating to the PCEHR system or the record itself whether or not you or your patients use the PCEHR system.

6.7.2 Defending any medico-legal action requires clear documentation about your interaction with your patients. This consists of:

6.7.2.1 Deciding how you will use the PCEHR system yourself and in your practice;

6.7.2.2 Recording this in a practice protocol;

6.7.2.3 Implementing the practice protocol consistently; and

6.7.2.4 Documenting the details of any action that is not consistent with the protocol in patient notes.

6.7.3 Where you have made a decision to use the PCEHR in a particular way for a patient, you should record this in the patient's notes in your own record keeping system.

6.7.4 Recommendations throughout this guide describe how interactions that involve the PCEHR should be recorded.

6.7.5 If you have any doubts or uncertainties, or if you believe that you have been exposed to medico-legal risk either as a result of using the PCEHR or not using the PCEHR, contact your medical indemnity provider immediately. You may always obtain your own independent legal advice.

7 Practice preparation

It is your responsibility to ensure that your information technology system meets your needs. It is prudent to assume that no data is secure so you should ensure that you have taken appropriate steps and sought appropriate advice to minimise inadvertent disclosure of PCEHR information. This may be assisted by the development of practice protocols. Although practice protocols are intended to guide medical practice staff in their use of the PCEHR, they may also be made available to patients who are interested to understand how the practice works with the PCEHR system. It is important to consider this and to draft practice protocols in a way that is appropriate to patient audiences.

7.1 Establishing and maintaining practice protocols

7.1.1 It is recommended that medical practices, whether or not they use the PCEHR system either wholly or in part, develop a practice protocol, including specific descriptions of how and why they use or don't use the PCEHR system.

7.1.2 Different medical practitioners within one practice may use the PCEHR itself differently. Practice protocols should allow for and describe this variety.

7.1.3 Those medical practices which choose to develop a protocol relating to use of the PCEHR system should establish a timeline to review any new developments in the system and amend their practice protocol accordingly. Consider reviewing information about the PCEHR received from:

7.1.3.1 The PCEHR system operator;

7.1.3.2 Medicare Australia;

7.1.3.3 The Australian Government (in a capacity different from being the system operator);

7.1.3.4 Professional and standards organisations; and

7.1.3.5 The providers of any clinical software your practice uses.

7.2 Suggested content of practice protocols

7.2.1 Access to the PCEHR system through clinical practice software at practices who have registered to use the PCEHR is available to all users in that practice, and it is expected that each practice will set controls over (authorise) who accesses PCEHR records. Practice protocols should identify what those controls are and how they apply to people with different roles in the practice such as:

7.2.1.1 Medical practitioners (eg, only medications, read only, or read and upload);

	7.2.1.2	Practice nurses and allied health practitioners;
	7.2.1.3	Administrative and support staff; and
	7.2.1.4	Trainees and students.

7.2.2 Practice protocols should describe how, why and when people with different roles in the practice might use the PCEHR system. This might also address how, why and when specific features of the PCEHR system will be used, such as:

	7.2.2.1	Uploading patient information to the record (Event Summary);
	7.2.2.2	Viewing and downloading (accessing) information from the PCEHR; and
	7.2.2.3	Creating, maintaining and curating Shared Health Summary records and agreeing to be a patient's Nominated Healthcare Provider.

7.2.3 Practice protocols should describe processes for establishing informed consent to share patient information on the PCEHR, including how this applies not just to medical practitioners but to all practice staff. Particular attention should be applied to:

	7.2.3.1	Your application of 'standing' consent to upload patient information that is established when patients register to use the PCEHR; and
	7.2.3.2	How the patient's consent to access their PCEHR might apply to instances outside the consultation in which it is granted.

7.2.4 A statement of the policies and procedures used to protect the security and confidentiality of electronic records, including information from the PCEHR system, should be included in practice protocols about the PCEHR system.

7.3 Data Governance

7.3.1 To access the PCEHR system in a healthcare delivery environment, individual users must do so under the auspices of a registered healthcare provider organisation. Healthcare organisations that use the PCEHR system are required to report sufficient information to the system operator to identify each of their users, each time that the user accesses the PCEHR system.

7.3.2 At the time of purchasing clinical practice software for use with the PCEHR system, medical practitioners should seek confirmation from the vendor that once installed and configured, their software will:

	7.3.2.1	Identify each individual user; and
	7.3.2.2	Send identification information to the system operator, each time a user accesses the PCEHR system.

7.3.3 Medical practitioners and their staff should understand that their login credentials identify them when they use the PCEHR system.

7.3.4 Passwords and other credentialing data such as usernames or access codes should be restricted to use by one individual user, and be confidential to that person.

7.3.5 Relevant topics for medical practices to consider are:

7.3.5.1 Security of technological capabilities of practice software to share information with shared electronic health record services, including the PCEHR;

7.3.5.2 Responsibility on medical practitioners and medical practices to ensure the integrity and appropriate feature set of their information communication technology services;

7.3.5.3 Strategies to ensure that health information remains current, consistent, accessible and accurate;

7.3.5.4 Consideration of secondary use and implied consent with respect of information shared to healthcare providers; and

7.3.5.5 Advice on using information in shared electronic health records including the PCEHR to improve delivery of patient care over time.

7.3.6 If a medical practitioner encounters a practical or technological impediment to uploading a document (Event Summary) or other clinical information onto a patient's shared electronic health record including the PCEHR it is recommended they notify the patient of that failure, preferably in writing. You should make a note in your patient file recording the notification to the patient. It is also recommended you make a note that you attempted to access the record but were unsuccessful.

8 Other considerations

8.1 *Doctor as patient*

8.1.1 Medical practitioners are under no obligation to register for a PCEHR as a patient.

8.1.2 If a medical practitioner elects to use the PCEHR system as a patient, he or she:

8.1.2.1 should accord the treating medical practitioner the professional courtesies necessary to permit the treating medical practitioner to share their patient information electronically.

8.1.2.2 should not be their own Nominated Healthcare Provider.

8.1.2.3 has a right to withhold access to the PCEHR from any organisation in which he or she works.

8.2 *Teaching*

8.2.1 Undergraduate and post-graduate medical trainees will need to be familiar with the practice policies of any organisation in which they are being taught.

8.2.2 Supervision of trainees will necessarily extend to how they interact with the PCEHR system according to the practice policy.

8.2.3 Each trainee will need to have a unique login arrangement and password so that they may be individually identified.

8.3 *Consider changing your appointment systems to allow for more time taken for PCEHR*

8.3.1 Consider style of practice and appointment system because initial use of the PCEHR system and/or the record itself at the time of its introduction can be anticipated to take more time.