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My Health Record

FAQ

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What's in it for Pharmacists?

- More time with customers – less time chasing clinical information and investigations.

- Better information sharing between healthcare providers.

- Important customer information being available when needed.

- Helping customers, including those with chronic and complex conditions, to better manage their health.

- You will be able to view when prescriptions were dispensed from other pharmacies using digital health across Australia.

- The Prescription and Dispense record will allow you to view when a medication was prescribed by the doctor using digital health that has not been dispensed at your pharmacy.

- You will gain access to a patient's Discharge Summary after the patient has been discharged – saving time by reducing the likelihood of having to chase-up or clarify information from the hospital.

- You can view a Shared Health Summary and promptly access accurate and up-to-date information about the patient's medical history, medication profile, allergies, adverse reactions and immunisations.

- The My Health Record system is a useful reference when you conduct Medscheck, Diabetes Medscheck, Home Medication Reviews and Residential Medication Management Reviews.

- Event Summaries can be promptly accessed to verify recent clinical interventions, allergies, prescribed medicines and diagnoses. This can save time in the pharmacy by reducing the need to call healthcare professionals when information in regards to the event or a consultation is ambiguous.

Why is it important for Pharmacists to participate in digital health?

- Improved information sharing among healthcare professionals and other pharmacies.

- The Prescription and Dispense Record can confirm medication history for both you and GPs.

- Allows for smoother continuity of care for the patient.

- You can view Event Summaries to access relevant information identified in consultation. This includes allergies, adverse drug reactions, additional over the counter medicines purchased or recommended and pharmacist clinical interventions.

- Minimises the burden on the patient to remember complex issues relating to the management of their health.

What information can you view from the My Health Record System?

Prescription Record

A Prescription Record is used to share information about prescribed medications and is an electronic copy of the paper-based prescription.

Dispense Record

A Dispense Record is a copy of information about a patient's dispensed medications.

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Symbion Pty Ltd Trading as Minfos ®
ABN 25 000 875 034

Level 7/737 Bourke St
Docklands Victoria 3008

minfos.com.au
sales@minfos.com.au

P 1300 887 418
F (03) 9918 5592

Shared Health Summary

A Shared Health Summary is a clinical document that summarises a patient's health status at a point in time, and includes information about their allergies and adverse reactions, medicines, medical history and immunisations.

Event Summary

An Event Summary is a clinical document which summarises a significant consultation with a patient. It could relate to a broken leg, chest pains, or any condition or episode that the healthcare provider deems to be clinically significant. When the provider has a consultation with an individual, the provider may choose to upload an Event Summary to the patient's My Health Record from the clinical desktop software.

Discharge Summary

Discharge Summary documents support the transfer of a patient from a hospital back to the care of their nominated primary healthcare provider. They capture details about the patient's hospital stay, including the diagnosis, diagnostic procedures performed, the prognosis, medications prescribed and recommended follow-up actions. The information contained in the Discharge Summary can be shared between the patient's doctor, the referring specialist and a community pharmacy to support the continued care of the patient after they are discharged from hospital.

Pathology and Diagnostic Imaging Reports

The benefits of viewing and storing a patient's test results in the one place are significant for both the patient and their treating healthcare providers as it enables patients to share their test results with any number of treating providers.

What information is uploaded to the My Health Record system from your system?

A Dispense Record of the patient can be viewed in the My Health Record system as clinical documents, and are also displayed in the Prescription and Dispense View. This view details the name and date a medicine has been prescribed and dispensed (both the brand name as well as the active ingredient/s), the strength of the medicine (e.g. 2mg, 20mg, etc.), the direction for consumption (e.g. take one capsule daily) and the form of the medicine prescribed (e.g. capsule, tablet, inhaler, etc.).

Where do you start?

In order to access and effectively use the My Health Record system, you will first need to:

1. Register your pharmacy online.
   Visit https://forms.digitalhealth.gov.au/

2. Configure your dispense software and digital eCertificates (Medicare and NASH PKI Certificates) to access the My Health Record System.

3. Train your pharmacy staff and pharmacists on how to use the My Health Record system.

Once you have submitted your applications and received your HI numbers and PKI Certificates from the Department of Human Services, we will assist you with configuring your dispense software and PKI Certificates.

What is, and why do you need a NASH PKI certificate?

- A NASH PKI certificate authenticates an individual provider or organisation each time they access the My Health Record system.

- This is necessary in order to make sure each individual or organisation that accesses and use the My Health Record system, is authorised to do so.

- Healthcare Providers and participating supporting organisations must have a **National Authentication Service for Health (NASH)** PKI certificate to access the My Health Record system and to send messages securely to other healthcare provider organisations.

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