

LOTS – My Health Record



My Health Record is a secure online summary of an individual's health information, and it is available to all Australians.

Healthcare providers who are authorised by their healthcare organisation, can now access My Health Record via their dispensing software to view and add to their patients' health information

Step 1: Register with Medicare Australia

Register your pharmacy for the My Health Record system at <https://myhealthrecord.gov.au/>

Once registered, your Pharmacy will be provided with the following:

- HPI-O Number = the unique Pharmacy identifier
- HPI-I Number = Pharmacist health identifier – Unique to everyone
- A CD containing your Medicare NASH certificate
- A PIC Code, used to access the CD

Step 2: Contact Corum Support on 1300 760022

- Obtain a MyHR Registration code
- Activate the MyHR functionality in LOTS

Mandatory Patient Information

A successful IHI validation requires the patient's personal details to be aligned exactly with what is registered with Medicare Australia.

IHI Number = Patient unique health identifier

Mandatory Information:

- Patient Legal Name
- Date of Birth
- Gender
- Plus, the addition of either a Medicare Number, DVA number or a valid address

Without this information, when attempting to retrieve/validate an IHI number, the User will encounter a warning message along with a failure in retrieving or validating the patients IHI.

It is advised for any reason where a failure is relating to a mismatch in patient information; the patient is directed to their local Medicare Office to validate their personal information.

If the patient's details have been verified as being correct within the LOTS system, unfortunately these issues and errors cannot be rectified by the User or the Dispensing Software.

The User is required to contact Medicare Australia rather than Corum Support, as Corum Support will not be able to assist a site or patient with this confidential information.

LOTS Options

LOTS Start Menu> Tools> Options

LOTS Options now contains a MyHR Tab which displays the Pharmacy HPIO number and relevant details relating to the site's security certificates.

Please note that this information is intended for Support purposes and is read only.

The Corum issued Registration code can also be found in the User Details section of Options.

Modify Staff Module

LOTS Start Menu> Tools> Utilities> Staff Utilities> Modify Staff



To access My Health Record data, the Users MUST obtain a valid HPI-I number.

HPI-I Number = User (Staff Member) health identifier

Mandatory Staff details to successfully retrieve and validate an HPI-I numbers are:

- Staff Last Name – Must be as recorded with Medicare Australia
- AHPRA No

To retrieve an HPI-I number for an existing Staff Member, please verify that the Staff details meet the mandatory requirements, followed by selecting the Validate button. The HPI-I number will then be retrieved, displayed, and stored against that Staff Members details.

To validate a known HPI-I number, enter the User's legal name, AHPRA and known HPI-I number followed by selecting the Validate button.

Please Note: When entering a new Staff Member, the required details must be entered and saved prior to performing the validation.

LOTS Dispense- Supervisor Login

LOTS Start Menu> Tool> Options> Dispense Options – Require Supervisor on Dispensing

To assist with the volume of uploading patient records to MyHR, LOTS dispense now has the option to set a Supervising Pharmacist as a secondary log in.

When this option is enabled, and as long as one of the logged in Staff Members has a valid HPII, all eligible scripts dispensed on that workstation will be uploaded to MyHR.

Staff Member Dispensary Tech Supervisor Supervising Pharm

If this option is enabled, and neither Staff Member has a valid HPII, the User will be prompted as seen below.

- Selecting the Yes button will return the focus to the Supervisor field so the User can enter a different Supervisor Login
- Selecting the No button will close the window retaining the entered Staff Members Login, and dispense will operate as usual, however any script dispensed will NOT be uploaded to MyHR.

LOTS Patient Information Screen

LOTS Start Menu> Dispensary – Patient Information Screen

Located on the LOTS Patient Information Screen is a new field which contains the Patients IHI Number.



IHI Number = Patient unique health identifier

IHI Number	800360866672753	Re-Validate	Active / Verified Last Validated : 23/07/2018 17:00:25
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IHI numbers can be entered manually or automatically populated when retrieved from the My Health Register

To validate a manually entered IHI number –The patient details must contain the mandatory personal information (Please refer to the “Required patient information” section of this document.)

Manually enter the IHI number, followed by selecting the Search button.

Once the IHI has been successfully validated, the button will change to display “Re-Validate”

The IHI number is then stored and saved against the Patient’s details for future reference.

To retrieve an IHI number from the MyHR Service –The patient details must contain the mandatory personal information

Selecting the Validate button will send a request to retrieve the patients IHI number from the MyHR Service.

Once the IHI has been retrieved it will be stored and saved against the Patient’s details for future reference.

It is a requirement that IHI numbers are revalidated on a regular basis.

To assist with this task, existing validated IHI numbers will auto re-validate when a patient is accessed through LOTS Dispense, and the previous validation has occurred more than 48 hours prior.

This validation will only be successful if the patient’s personal details still meet the mandatory requirements.

The text information located next to the Validate/Re-Validate button will display a date and time stamp reflecting the last validation.

This text information also displays the status of the patient.

Active / Verified Last Validated : 23/07/2018 17:00:25

Please note: IHI retrieval and validation can be done by any Dispensary Staff Member, The viewing of the Patient’s Clinical Documents is strictly limited to Staff Members that have an HPI-I

Also located on the Patient Information screen is a Withdrawal of Consent option.

When this option is selected, the Patients script data will NOT be uploaded and therefore, it will not be recorded as a Clinical Document on their My Health Register.

Please Note: This option does not exclude the patient from IHI validation.

MyHR:Withdrawal of Consent <input type="checkbox"/>

Allergy Indicator – Patient Information Screen

A Red Allergy Indicator will be displayed on the Patient Information Screen if the Patient has a recorded MyHR Allergy. This indicator will only display after the Patient’s Clinical Documents have been retrieved for the first time. The indicator will then remain on the Patient Information Screen for future reference.

Please note: The patients MyHR Allergies can only be viewed from within the patient’s clinical documents.

Allergies:	MyHR allergy available	0	+	-

| Access My Health Record

Both the Patient Information and Script screens contain a new MyHR button. This button launches and displays the Patients Clinical Documents, also known as their My Health Record.

Please see the LOTS Dispense – Script screen section of this document, for further information.



LOTS Dispense - Script Screen

LOTS Start Menu > Dispensary – Script Screen

Access My Health Record – Script Screen

The MyHR button located on the Script Screen is used to access the My Health Record interface which displays the Patient's Clinical Documents.

Unlike validating an IHI number, this function and associated data can only be accessed by a User that has a valid HPI-I number.

Dispensary Staff Members who do not have a valid HPI-I number, will not be able to access a patient's My Health Record and associated Clinical Document Information.



When selecting the MyHR button, the My Health Record will appear displaying the patient's Clinical Documents.

Please note that the time may vary depending on network speed and MyHR server response time.



The Patient's Clinical Documents are controlled and regulated by Medicare Australia. LOTS Dispensary is simply a means of viewing this information.

For any concerns or enquiries relating to data, it is advised to contact Medicare Australia directly.

My Health Record – Clinical Document Viewer

A Patients My Health Record is divided up into several individual tabs containing the Clinical document information.

Where applicable the User will have access to document type filtering, printing, and saving of the Clinical Document data.

Please note: In the interest of patient confidentiality, printing or saving of clinical documents must be treated with caution and handled with strict confidentiality.



Prescribed	Medicine Details	First Dispense	Last Dispense	Dispensed
unavailable	ASMOL INHAL 200 DOSE (S3)	18-Sep-2018	18-Sep-2018	unavailable
18-Sep-2018	Dispensed Salbutamol 200dose Inh (AL) — ASMOL INHAL 200 DOSE (S3) — inhaler — Supply 1 inhalers — Original dispense			
unavailable	APO-AMISULPRIDE 200MG TAB	18-Sep-2018	18-Sep-2018	unavailable
18-Sep-2018	Dispensed Amisulpride 200mg Tab (TX) — APO-AMISULPRIDE 200MG TAB — tablet — Supply 60 tablets — Original dispense			
unavailable	VIAGRA 50MG TAB (12 TABLETS)	18-Sep-2018	18-Sep-2018	unavailable
18-Sep-2018	Dispensed Sildenafil 50mg T (PF) — VIAGRA 50MG TAB (12 TABLETS) — Take ONE tablet when required as directed by the doctor — tablet — Supply 4 tablets — Original dispense			
unavailable	LOFENOXAL TAB	18-Sep-2018	18-Sep-2018	unavailable
18-Sep-2018	Dispensed Diphenox & Atropine T (IL) — LOFENOXAL TAB — tablet — Supply 20 tablets — Original dispense			

Prescription and Dispense View

This Tab contains the patient's individual dispense uploads.

Each upload can be expanded to display a more detailed e-Health Record

To expand: Mouse click on the Drug Name detail > e-Health Record will be displayed

ehealth Records can either be printed or saved. If saved, the document will then be list in the Saved Document Tab for future reference.

The search option allows for filtering between defined dates. The list of uploads can also be displayed in collapsed groups, which will display limited information or grouped by prescription, Brand Name, generic name or PBS Item.

Document Search

The Document Search tab allows the User to search for a specific document type. There are several different types of Clinical Documents defined as check boxes, for ease of filtering.

Documents can also be printed and saved from this Tab.

Saved Documents

The Saved Documents tab contains a list of documents that have been saved by the User. Documents saved here will be retained for future viewing.

The options to filter and print are available for this content.

Medicines View

This tab is to assist the User in finding medicine related information contained in the patient's My Health Record. Previews are provided of medicines related information in documents (where available) with links to the source documents where more detailed information can be obtained.

Allergies and Adverse Reactions can also be viewed here if applicable.

Shared health Summary

The Shared Health Summary is an important feature of the My Health Record system. It includes information about a patient's medical history, including medications they are currently taking, allergies and adverse reactions they may have, or immunisations they have received.

Discharge Summary

A clinical report prepared by a physician or other health professional at the conclusion of a hospital stay or series of treatments. It outlines the patient's chief complaint, the diagnostic findings, the therapy administered and the patient's response to it, and recommendations on discharge.



Medicare Overview

The Medicare Overview tab displays an overview of Medicare activity for a 12-month period. Australian Immunisation and Organ Donor information is also displayed on this tab.

Access Control and Emergency Access

Access Control

Emergency Access

Patients have the option to control who can or can't see their Clinical Document/Health information. The changes to privacy and security that they can make are:

- Setting a record access code to give access to selected healthcare organisations
- Controlling access to specific documents to limit who can view them
- Giving access to a nominated representative such as a family member, close friend, or carer.

When a patient has applied an access code, the User will be presented with the below prompt when accessing the patients My Health Record.

To view the restricted information, the patient must provide the User with their access code. Entering the code will grant the User access to the patients restricted clinical information.

Selecting the gain access to General Information option, will only display the general non restricted information.

A screenshot of a dialog box titled 'My Health Record Access'. On the left is the 'My Health Record' logo. The main text reads: 'Record Access or Document Access Code may be required to gain access to My Health Record.' Below this is the 'Access Code' section with two radio button options: 'Gain Access (to all "General Access" eHealth record or documents)' and 'Gain Access with access code (to restricted eHealth record or documents)'. The second option is selected. Below the options is an 'Access Code:' text box. At the bottom right is an 'OK' button.

In a medical emergency, healthcare providers connected to the My Health Record system can access a patient's health information bypassing any set access code with the emergency access option.

Emergency access lasts for a maximum of five days and will show in the patient's record access history

A screenshot of a dialog box titled 'My Health Record Emergency Access'. On the left is the 'My Health Record' logo. The main text reads: 'Conditions of Emergency Access: By selecting the Emergency Access button, you are declaring that access to this eHealth record is necessary to lessen or prevent a serious threat to an individual's life, health or safety or to public health or public safety and your patient's consent cannot be obtained. This will override any access controls set by the individual and will permit access to all active documents for five days. Your Emergency Access will be recorded on the eHealth Record's audit log and the individual may be notified.' Below this text is the question 'Do you wish to proceed?' and two buttons: 'Yes' and 'No'.

Script Queuing

LOTS Start Menu> Tools> Options> Script Queueing – Enable Script Queueing

The Script Queuing window now contains a field to capture the patients D.O.B and Gender.

Patient Edit

LOTS Start Menu> Sales> Edit> Edit Patient> LOTS Patient Details LOTS Start Menu> Debtors> Tools> Edit Customer



A new IHI Number field has been added to the Patient Edit screen.

When adding a new patient, and once the mandatory fields have been populated and saved, the validation button becomes enabled and an IHI validation can occur. The IHI validation result will then update the Patient's Information in the Dispensary module.

For existing patients: When the patient edit window is opened, and if the mandatory information has been previously entered, an auto validate will occur.

The IHI validation result will then update the Patient's Information in the Dispensary module.

The screenshot shows the 'Patient Details' window with the following fields and sections:

- Personal** (selected tab): IHI Number (with Search button), Title, ID: New, ABN, First Name (TEST), Medicare (highlighted in yellow), Family Name (PATIENT), Expiry Date, Address (TEST ADDRESS), Membership, Suburb (TEST SUBURB), Postcode (3168), Phone, D.O.B, Compensation No., Gender (dropdown), Room/Ward ID, Institution (dropdown), Email.
- Dispensary** (tab): End Consumer (checked), Use Mailing Address (unchecked), Don't Send Scripts to Gateway (checked).
- Mailing Address** (section): Address, Suburb, Postcode.
- Medicare Name** (section): First Name, Family Name.
- Family Members** (table):

Name	S'Net	Relationship

Buttons at the bottom: Apply, OK, Cancel.