Australian Government
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My Health Record helps you help your patient: A Mental Health Case study

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My Health Record

ACKNOWLEDGEMENT

We would like to acknowledge the traditional owners of country throughout Australia, and their continuing connection to land, sea and community. We pay our respects to them and their cultures, and to Elders both past and present.

Discussion Points

- Highlight clinical situations where access to information within My Health Record may enhance patient care
- Provide practical advice on security aspects and how to protect personal information
- Communicate with your patient/clients about how sensitive information is managed in the My Health Record

Case Study: Shirley

- *Shirley is in her 50s.*
- *Long history of schizophrenia.*
- *She occasionally travels long distances, including interstate, to visit family.*
- *On such a family trip, she had a psychotic episode and was taken to a hospital where she had never previously been. She ended up remaining in this hospital for over six weeks before finally being discharged and returning home.*
- *During her stay her Medicines were changed also she put on about 5 kilos of weight and is feeling very lethargic*
- *She has a follow up visit with her GP and Psychologist*

Hospital stay for Shirley

With My health Record	Without My Health Record
Shirley has RAC on her record, so when she arrived in a psychotic state, the ED consultant could look at her record with emergency access	ED consultant had to do the emergency treatment to calm her down
There was discharge summary from previous admissions and Medicine view gave a good indication of the treatment she as been on	Taking a detailed history was not possible as the family member attending the hospital did not have much information
They could start treating her right away and change her medicine to control her symptoms	Doctors waited before they heard back from the GP to get an idea of the complexity of her illness
She was discharged on new Medicine in 6 weeks.	She was put on a few Medicines before her symptoms got better and she was discharged 10 weeks later.

Setting an access code ensured Shirley of her privacy but in emergency she received the best of treatment which meant her hospital stay was much shorter than the previous ones.

Follow up visit to Psychologist

With My Health Record	Without My Health Record
Her psychologist could access the discharge summary from the hospital to understand a little bit more about the current episode particularly noting the new medicine that she was started on, in the hospital.	Shirley did not have a copy of her discharge summary with her and had assumed that the psychologist would have received a copy.
Shirley feels good emotionally and no residual psychotic features but she is very tired and concerned about her weight gain.	She gave as much details as possible about the recent episode, but could not remember much details. She did mention she was on a new Medicine but could not say anything more than that. She complained of her lethargy and weight gain as well.
Her psychologist reassured her and asked her to visit her GP and also speak to her pharmacist	The psychologist could only suggest to take it slow and see her GP if her lethargy does not get better.

Her psychologist could offer so much more to her as he could see the information on the discharge summary.

GP follow up for Shirley

With My Health Record	Without My Health Record
Shirley's GP saw her discharge summary on her My health record and saw that she was started on a new Medicine	Shirley thought her GP has received the discharge summary which was not the case. She had to wait about an hour before the nurse could get a copy of the discharge summary from the hospital faxed to the surgery.
On her visit, GP could assess Shirley's current mental state and also any side effects of the Medicines that she maybe experiencing.	A neighbour works in the surgery as the reception staff who receives the fax and could see the details of her admission which made Shirley very uncomfortable.
GP assured her that it was the new Medicine that was causing the lethargy and also the weight gain	GP assessed her and discussed with her about the Medicine side effects
GP wrote a referral to a dietician to help her with weight issues without any changes to Medicine as she did not have any psychotic symptoms on this meds	GP referred her to a dietician and orders blood test for blood sugar and cholesterol
GP orders some blood test to look at her blood sugar and cholesterol.	

Access to information was instantaneous and viewable only by her GP which saved Shirley time, embarrassment and pain.

Shirley visits her pharmacist

With My Health Record	Without My Health Record
Shirley's pharmacist viewed her discharge summary and noted the Medicines, and doses following the discharge	The pharmacist was not able to give much advice as he was not sure of all the changes that might have been made while at hospital
He advised her to take the Medicines at different time of the day to ensure that she was not taking all the meds that can cause lethargy together.	He asked Shirley to come back with the discharge summary copy so he could advice her better
He also asked her to come back and tell him after a week how she was going	Shirley was feeling to tired so she goes back the week after to get repeat scripts filled and the pharmacist does the meds check in that instant.

With relevant information pharmacist could offer Shirley timely advice and she started feeling better within a week

Visit to the dietician

With My Health Record	Without My Health Record
The dietician received the referral for Shirley and during her visit asks her if she can view the discharge summary from the hospital	The dietician had only received a referral from the GP, which did not have a lot of detailed information
Shirley gives her RAC to the dietician and she looks at her discharge summary at the same time notices that Shirley had recent blood tests for blood sugar and cholesterol	She took some history from Shirley who told her that she was on various Medicines and has a complex and chronic mental health issue.
With all the relevant information at hand the dietician could do a thorough assessment of the diet and physical activity pattern	Dietician was a bit concerned if the weight was related to Medicine or simple inactivity as Shirley was hospitalised.
She gave Shirley some dietary advice and also made a plan with her how to try and stop weight gain despite the Medicine and in time loose the additional weight.	Dietician asked Shirley to keep a food diary and bring it in the next visit 2 weeks later

Putting therapy in place timely can save improve patient outcome and also reduce cost.

Shirley's journey

Immediate access to past history
Reduced duration of hospital stay

Psychologist could view Discharge Summary and better coordinate care

GP could follow up Shirley's care needs and make appropriate referrals

Pharmacist could help Shirley better manage the medicine related side effects.

Dietician could view the pathology result and formulate the care plan for Shirley.

How My Health record helped Shirley

- Shirley did not need to repeat herself when seeking care with different providers
- Received coordinated care
- Medication reconciliation was possible
- Had all questions answered
- Most of all Shirley could maintain her privacy

Lucy 17

- *Lucy is a year 12 student relatively healthy except bouts of migraine.*
- *Her mother singed her up for a my health record and Lucy took control of it when she turned 14*
- *But she made her mum a nominated representative*
- *Lucy has come to see her GP on her own today*
- *She has been experiencing irregular, painful periods with extreme mood disturbance which has led to self-harms by cutting her arms on several occasion.*
- *Her GP decides to prescribe the pill to regulate her periods and recommends having counselling.*
- *Lucy asks the GP about antidepressant medication rather than counselling. The GP reluctantly agrees to prescribe this, but strongly urges her to reconsider counselling.*

GP's advice

- *Since Lucy has migraine GP mentions*
  - *she would like to update her My Health Record to reflect the new medication as it is important information*
- *Lucy doesn't want her mother to find out about the self-harming and the medicine as well.*
- *GP advises Lucy that she can have the information on her my health record and control access*
- *The GP gives Lucy a information sheet about how to keep the privacy of her My Health Record.*

How ***My Health Record*** was used in Lucy's case.

- ✓*The GP discussed uploading information to her My Health Record beforehand and respected Lucy's wishes not to upload a Shared Health Summary.*
- ✓*GP could advice Lucy about the importance of having complete medicines information still maintain her privacy*
- ✓ *Lucy set up access code for her record so mum had no view of the prescription and dispense record for the pill and anti depressant .*

Rachel 40

BACKGROUND

- *Rachael is in her 40s.*
- *Long history of complex physical health problems, including type 1 diabetes and coeliac disease.*
- *In 2016, her GP advised her about how My Health Record could be useful with her complex health situation, and she agreed, so she created her own My Health Record.*
- *In recent months, Rachael has developed depression in response to her marriage breaking up.*
- *She has been prescribed antidepressant medication by her GP who has also suggested that she get some counselling.*
- *Last week, Rachael was admitted into hospital over concerns that she was developing complications related to her diabetes. She was stabilised and ultimately discharged, but was surprised when the treating doctor mentioned her recent depression (when she had never said anything to anybody in the hospital about it). The treating doctor said that she had got the information from Rachael's My Health Record, and this greatly concerned Rachael.*

Appropriate use of My health Record

✓ *The information about Rachael's diabetes contained within her My Health Record was useful for doctors treating her in hospital.*

✗ *Rachael later learned that her GP had uploaded information in a Shared Health Summary about her depression. The GP did this without discussing it with Rachael first.*

✗ *Rachael was also not aware that information about her antidepressant medication was available on her My Health Record.*

✓ *Rachael later learned that she was able to remove information from her My Health Record relating to her depression. She also learned how to set privacy controls that allowed only certain healthcare providers access to specific information within her My Health Record.*

✓ *Rachael had a conversation with her GP about her preference for future confidential information.*

SUMMARY: *Rachael became more proactive in using access controls to protect privacy in her My Health Record, and she formed a clearer understanding with her GP about what information she wanted uploaded to her record.*