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FINAL REPORT
Digital Health Case Study / Workflow / Integration 2022

Please note: this report will be published on the RACP website, so please do not include confidential information.

Name	Annalise Unsworth
Report Date	22/3/22
Report Title	Integrating My Health Record with the Electronic Medical Record to prescribe for hospital in the home

Lay Summary: Please provide a brief, plain English summary of your Case Study / Workflow or Integration example.	An 85 year old male from home with right sided lower leg erythema and swelling is referred to the Hospital in the Home service by his local GP with a diagnosis of cellulitis. He had trialled 48 hours of oral flucloxacillin with minimal improvement. A decision is made over the phone to commence him on IV Cephazolin via hospital in the home, with regular nursing visits and follow up with his GP in 48 hours. In order to safely prescribe Cephazolin, his baseline renal function needs to be reviewed and a creatinine clearance calculated. This can be accessed through the My Health Record. In addition, allergies can then be reviewed on the My Health Record home page. Finally, integrating the My Health Record with EMR - 'emeds' prescribing the cephazolin can be charted. In this case he was prescribed IV Cephazolin 2g BD with Hospital in the home.
Case Study/Workflow/Integration Objective: Please state the objective of this example and why you focussed on it.	The objective of this case study is to demonstrate the use of the My Health Record bloods and allergy information to calculate the correct dose of empiric antibiotics that can be commenced in the community via hospital in the home.

Benefits & Considerations: Please outline the benefits and considerations in the use of My Health Record and/or related digital health initiatives in this example.	The main benefit of using My Health Record in this situation is to streamline the time to charting and prescribing of antibiotics. Information about creatinine clearance, previous allergies as well as previously charted antibiotics can be accessed. Additional information from the electronic medical record includes alerts for MRSA, which would be relevant in this case as the patient's failure to improve on flucloxacillin may have been due to a resistant organism and alternative antibiotics may be required. One consideration in this case is that weight should be incorporated into the calculation of creatinine clearance - which is not provided on the My Health Record.
Additional Advice and Comments: Please list any items of interest which have arisen as a result of documenting this particular example.	Nil
Acknowledgements	Nil

Award Recipient Signature:

I certify that the information supplied in this report is true and correct. I consent to enquiries made by the Royal Australasian College of Physicians to verify this information with any institution or individual.

Signature: Annalise Unsworth

Please submit completed and signed report to:
RACP/ADHA Digital Health Scholarship
engage@racp.edu.au

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Name	Annalise Unsworth
Report Date	22/4/22
Report Title	Accessing imaging, bloods and therapeutic drug monitoring in an outpatient clinic

Lay Summary: Please provide a brief, plain English summary of your Case Study / Workflow or Integration example.	A 50 year old man with chronic fungal osteomyelitis is reviewed in a follow up outpatient clinic. He is on voriconazole which requires close therapeutic drug monitoring as well as monitoring for side effects including liver function test derangement. He is receiving regular blood tests through an ambulatory care clinic in a different health district. The My Health Record can be accessed to view blood tests and therapeutic drug levels that are performed in a different local health district. In this case, a subtherapeutic voriconazole level can be identified and the dose increased. Other bloods including liver function test and renal function are also able to be reviewed. Additionally, serial imaging can be viewed from different health services in the outpatient clinic.
Case Study/Workflow/Integration Objective: Please state the objective of this example and why you focussed on it.	This case example demonstrates the use of the My Health Record for accessing blood and imaging results for outpatients. With centrally located data on blood tests and drug levels, complications of treatment can be identified easily. Identifying previous imaging results from other health districts assists in streamlining a busy outpatient clinic, and gives information for comparison scans as well as avoiding unnecessary tests that have already been performed.

Benefits & Considerations: Please outline the benefits and considerations in the use of My Health Record and/or related digital health initiatives in this example.	The main benefit of the My Health Record in this case is the ease of accessing centrally located blood tests. However, this is only applicable if they are being performed through NSW health pathology as private laboratory information is not included.
Additional Advice and Comments: Please list any items of interest which have arisen as a result of documenting this particular example.	Nil
Acknowledgements	Nil

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Name	Annalise Unsworth
Report Date	22/3/22
Report Title	Accessing detailed immunisation history in the My Health Record

Lay Summary: Please provide a brief, plain English summary of your Case Study / Workflow or Integration example.	In an outpatient immunology clinic, a 66 year old female patient with a possible previous anaphylaxis to influenza vaccination is referred by her local GP for consideration of whether she can have COVID vaccination. On the My Health Record, previous immunisations can be viewed. This provides information on which brand of vaccination was administered and for influenza vaccination whether it was a trivalent or quadvalent vaccine. This has implications as the ingredients in each vaccine differs e.g. polysorbate 80 or polyethylene glycol, and subsequent vaccination may be contraindicated. Additionally, if the patient successfully had a vaccination with the same ingredients, it may provide additional information to the clinician. In this patient's case she had successfully had Fluad Quad, which contains polysorbate 80, which is also found in the Astra Zeneca Vaxzevria vaccine and on clinical history there was no previous polyethylene glycol allergy. The patient successfully went on to have two doses of Astra Zeneca Vaxzevria and one dose of Pfizer Comirnaty. In addition to allergy, the My Health Record vaccination information can also ensure that the patient is up to date with age-appropriate vaccination.
Case Study/Workflow/Integration Objective: Please state the objective of this example and why you focussed on it.	The objective of this case is to demonstrate the use of My Health Record for accessing immunisation history. This is particularly relevant for COVID-19 vaccination as a detailed allergy history and understanding of previous vaccines and their ingredients is required to predict risk of future vaccination.

Benefits & Considerations: Please outline the benefits and considerations in the use of My Health Record and/or related digital health initiatives in this example.	The benefit of using the My Health Record in this scenario is for quick and accurate access to vaccination history, which is highly relevant for COVID-19 vaccination. A consideration is that if patients were vaccinated outside of the My Health Record jurisdiction i.e. overseas, their vaccination history will not be recorded so this will need to be clarified with the patient.
Additional Advice and Comments: Please list any items of interest which have arisen as a result of documenting this particular example.	Nil
Acknowledgements	Nil

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Signature: Annalise Unsworth

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