Participation Trials for the My Health Record

Final Report

November 2016

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# Executive Summary

The participation and use trials of the My Health Record system were designed to achieve the following outcomes:

1. Understand public reaction to an opt-out participation arrangement for the My Health Record
2. Understand the extent to which healthcare provider contribution and use of the My Health Record system improves when the majority of their patients have a My Health Record
3. Understand any implementation issues that would need to be addressed before any decision is made about future participation arrangements.

These outcomes are measured through the extent to which the following is achieved:

* increased awareness and understanding of the My Health Record system
* increased confidence to use the My Health Record system
* increased participation in, and use of, the My Health Record system
* increased understanding of the effectiveness of different approaches for driving participation and use of the My Health Record system.

The evaluation of the My Health Record system participation and use trials was commissioned in late 2015 and commenced in January 2016. Data collection concluded on 31st October 2016. Progressive data analysis (of all sources) occurred between 12th September and 18th November 2016.

The terms of reference for the evaluation were:

*to assess all aspects of the participation and use trials and to make recommendations to Government to inform the future decisions on national participation arrangements to deliver the potential benefits in the shortest possible timeframe.*

A program logic of the overall efforts in the My Health Record system participation and use trials was developed (refer to page 5). This links the trial activities to intermediate outcomes and the end benefits of the My Health Record system. The program logic is built on the premise that the intermediate outcomes are short-term or lead indicators of progress towards the end benefits (long-term outcomes) of the My Health Record system. Due to the timeframe of the trials, progress to achieving intermediate outcomes was evaluated.

Based on a range of selection criteria the Minister identified sites based generally on Primary Health Network (PHN) boundaries. Two opt-out trial sites were identified, the Northern Queensland (NQ) PHN and the Nepean Blue Mountains (NBM) PHN. Two opt-in trial sites were also identified to trial methods of innovative opt-in participation in two different healthcare settings. One opt-in site was in the Ballarat Hospital, Victoria and one covered a number of private general practices in Perth, Western Australia (WA) that used a software product designed to facilitate multi-disciplinary team care of people with an identified chronic illness.

The key elements of trial activities in the opt-out sites were:

* mapping of digital health readiness of healthcare providers
* healthcare provider education and engagement
* individual and community-focused communication and engagement
* work with the hospital (private and public) sector to support use of the My Health Record system
* face to face education and training in general practices and other work places encompassing the full range of healthcare and aged care providers
* consultation with vulnerable and hard to reach population groups

The key elements of trial activities in the opt-in sites were:

* education and training of healthcare providers to prepare them to provide assisted registration and to use the My Health Record system
* dissemination of individual-focused communication resources
* dissemination of healthcare provider-focused resources
* work with software developers to link the My Health Record system to existing clinical information systems
* provision of assisted registration

## The extent of consultation

3,579 individuals participated in the baseline survey, and 3,295 (92%) of them agreed to take part in the follow up survey. 1,918 (54%) took part in the follow up survey during the period allocated to collect data.

Aboriginal and Torres Strait Islander people in remote North Queensland responded to a pen and paper survey – 197 at baseline and 171 at follow-up.

8,251 healthcare providers participated in the baseline survey. A total of 2,036 (24.7%) responded at baseline and follow up, of which only 2,012 were able to be used in the analysis after data cleaning.

Focus groups ranged in size from six to 15 participants. The total number of participants was 391. This consisted of 140 individuals attending focus groups in Northern Queensland, and 117 in the Nepean Blue Mountains trial site. There were 101 participants in the Ballarat focus groups, and 33 in the Western Australia focus groups.

Interviews (n=90) were conducted with a range of healthcare providers, including GPs, nurses, pharmacists, practice managers, clinical practice managers, practice and hospital administration staff

Reflection workshops were conducted with PHN My Health Record team members in each of the trial sites. Interviews were conducted with National Trial Team members and Federal and State Departmental officers involved in the opt-out trials.

## The outcomes of the trial

The evaluation suggests that:

* the opt-out approach to increase both individual and healthcare provider participation and use is the preferred option
* continuation of current or accelerated opt-in approaches is considered to be unsustainable
* the opt-out trial sites achieved better outcomes, in terms of participation, understanding and some aspects of use of the My Health Record system
* key lessons were learned to inform Government’s understanding of the effectiveness of different approaches for driving participation and use of the My Health Record system

## Key Findings

Did opt-out result in greater use and participation in the My Health Record system? – Yes

On most measures, the opt-out participation arrangement yielded stronger statistically significant increases (compared to the opt-in trial sites and the rest of Australia) in My Health Record system uptake and participation. These included increases in:

* individual exposure to information about the My Health Record system
* individual and healthcare provider recall of communication about the My Health Record system
* individual registration and use of the My Health Record system
* healthcare provider organisations registered to use the My Health Record system
* healthcare provider document uploads to and viewings of My Health Records
* My Health Record system activity per healthcare provider

Support for automatic creation of My Health Records? - almost universal, with different reasons given by healthcare providers and individuals

For both individuals and healthcare providers interviewed there is a high level of support for the automatic creation of My Health Records. For healthcare providers, the burden of assisted registration is seen as a major impost that is not practical without additional funding. There is also a belief that, even if these additional resources were available, they would be unsustainable in the health system or could be better used for direct health service delivery.

For most individuals, after automatic creation was explained and the benefits of the My Health Record system were understood, the sentiment was positive. They said the fact that they did not have to do anything to create their My Health Record was a major plus. They expressed the view that they would not have registered for a My Health Record themselves and would have expected that their healthcare providers already would be sharing information with other healthcare providers in this way.

Based on data from all sources available to the evaluation, a national opt-out approach is not only acceptable to individuals, healthcare providers, participating health service and health department managers, it is seen by these participants as the only sustainable and scalable approach.

Concerns about confidentiality and security of the My Health Record system by individuals? – few once the My Health Record system and its benefits were explained

Once the My Health Record was explained to individuals (briefly during focus groups) all but a very small number of focus group participants in both opt-in and opt-out sites were very positive about the My Health Record and its benefits for them, their families, dependants and the health system.

Once the benefits of the My Health Record system were clear, nearly all focus group participants said that their concerns about security and privacy, or about the fact that a My Health Record had been created, disappeared. They most often said that, while they thought that no computer-based systems were totally safe, on balance they thought that the benefits to them, their families and the health system far outweighed those risks. This attitude held firm across general population, people from culturally and linguistically diverse (CALD) backgrounds, Aboriginal and Torres Strait Islander participants, gender, age groups, varying levels of computer literacy and access to computers or reliable internet. This reinforces the need for national awareness activities which make clear the benefits of the My Health Record system as well as the privacy and security protections.

Awareness and understanding of the public? - moving in the right direction

Overall the level of awareness and understanding remains low based on focus groups in all trial sites. There has been improvement in individual exposure to messages about the My Health Record that will raise awareness in the opt-out sites, but less so in opt-in sites and the rest of Australia.

The findings of the focus groups strongly suggest the need for any future national change and adoption strategy to include a much bigger emphasis on awareness and education. This would include:

* putting the My Health Record system on peoples’ radar in a positive way
* alerting people to the existence of the My Health Record system and what they need to do under any participation arrangements (be that opt-in or opt-out)
* informing people that they should not assume that the health system already shares information from one part of it to another
* making clear the benefits of the My Health Record system and the privacy and security protections built into the system

A general population communication strategy, appropriately targeted for each audience segment and using multiple channels of communication (including social media), will also reach healthcare providers, alerting them to expect more of their patients to approach them or their practice staff about the My Health Record.

Data suggests that the mail out of a letter and brochure at the beginning of the opt-out trial period has not worked well. In addition, feedback also suggests that the efforts to produce targeted information resources for some groups, such as Aboriginal and Torres Strait Islanders, have not achieved the desired acceptability, outcome, penetration and reach.

Individuals are still reporting difficulties with the myGov website and in getting assistance from call centre helplines (e.g. long wait times) and staff who cannot answer their questions when they do get through.

Healthcare providers are also still citing instances where call centre helplines were not able to answer all their questions and were sometimes difficult to access in a timely way.

What did trials teach us about communication support for the My Health Record system? – a number of lessons

Any national rollout of changed participation arrangements in the My Health Record system must be supported by a comprehensive, nationally driven but locally supported communication strategy. The strategy needs to focus first on the benefits of the My Health Record system and then promote where people can go to get more detailed information. This would include information on:

* how to make an informed decision about whether to opt out, if they choose to,
* how to use the My Health Record to best effect
* the details of their privacy rights and additional information on the privacy and security provisions

Without this investment, based on the experience of these trials, it is likely that the opt-out rate will remain low; but the use of the My Health Record system by individuals will also remain low and they will not ask their healthcare providers to use it.

A key tool noted by stakeholders to motivate continued engagement with the My Health Record system is a road map that is updated as progress is made towards improving the clinical relevance of information in the My Health Record system. This will encourage engagement with the My Health Record system by individuals and healthcare providers while the maturity of the system builds.

There are champions of the My Health Record system that have been identified during the trial in primary care and in the hospital sector and in State Health Departments who have had a direct line of sight of the trials. These people can play a strong role in persuasive communication efforts.

Taking all the evaluation information together and aligning it with the evidence base for a hierarchy of the determinants of behaviour change in the direction desired (in this case, for use of the My Health Record system), suggests that the next iteration of the change and adoption strategy could include the following range of activities under its communication efforts:

*Agenda setting*: getting the public/target audience segments thinking about the issue

*Information*: education that makes the issue interesting, understandable, personally meaningful

*Incentive*: elaboration of the positive personal and social benefits

*Skills*: providing step by step instruction and resources

*Action*: education to trigger the trial adoption of the new behaviour/s

*Maintenance*: developing social and other support for continuation of the changed behaviour

Should healthcare providers be allowed to ‘opt out’? – a resounding ‘no’ from individuals

There is a consistent view among individuals that the Government should make use of the My Health Record system by healthcare providers compulsory. The logic behind the view is that: ‘if the benefits are so good, then why wouldn’t doctors use the My Health Record system for the good of their patients?’; ‘if the cost to taxpayers [of the system] is as high as it would seem to be, then why wouldn’t the Government make it compulsory for practitioners to use it?’. This sentiment, expressed in focus groups, is also noted in the reflection logs of some PHN staff after their public engagement activities.

What was learned about Aboriginal Community Controlled service providers and the people in remote communities? – overwhelming support but practical barriers

The providers of healthcare in the Aboriginal Community Controlled Health Services (ACCHS) sector have also had significant investment in electronic records internally over a long period of time and are keen to maximise the benefits of the My Health Record system for their clients. Their clients are very keen to have My Health Records that will assist with the management of chronic disease and move with them. The main barrier to healthcare provider and individual participation and use is the impact of remoteness and rurality on access to reliable internet, access to computers and computer literacy. Interestingly the ownership and use of smart phones in remote communities is reported to be high and the introduction of third party applications suitable for smart phones may mean a significant increase in the use of the My Health Record system in these settings if it is matched with reliable connectivity. These findings for Far North Queensland are likely to be generalisable to other remote and very remote parts of Australia.

What was learned about vulnerable groups?

People from CALD backgrounds, especially recently arrived immigrants, greatly appreciate the My Health Record system. Experience in the NQ PHN suggests that the best approach is to work with key community leaders through interpreters in a train-the-trainer model so that they can convey messages and support use of the My Health Record system in their communities. In more established CALD communities, materials and resources translated into the key languages will also be necessary.

PHN staff and others directly involved in the implementation of the trials consistently noted difficulty in answering questions about how My Health Record would work for people in certain situations such as those under child protection orders or those in domestic violence situations, as well as where there may be sensitivities such as for staff of health services who are treated in the facilities where they work. In addition to the privacy provisions in the My Health Record Act, which protect these at-risk individuals, there are processes in place to handle these risk and sensitivity areas, and personal controls which enable people to limit or restrict who can see their health information.

Costs to healthcare providers more or less? – it depends who you ask

Across all healthcare providers interviewed, the average time per patient for using My Health Record was reported to be approximately 3 minutes. Whilst pharmacists reported on average a saving per patient from using the My Health Record system, all other healthcare providers reported an increase in time spent. From surveys, there were no significant differences over time or between trials in the time spent by healthcare providers in using the My Health Record system per patient. Healthcare providers interviewed mainly feel the My Health Record adds time (and therefore cost) to their work, but cannot quantify it. On the other hand, practice managers and practice nurses who do most of the administrative work involved in chasing up information about patients from other healthcare providers (including hospitals) feel that having the My Health Record system has or will decrease that time significantly with overall gains in the efficiency of the practice.

Does the Practice Incentive Program eHealth (ePIP) work? - it depends who you ask

General practitioners interviewed do not see the ePIP as being a major determinant of their use of the My Health Record system. Conversely, their practice managers say it is and believe that without ePIP healthcare provider use of the My Health Record system would decrease. The data from the national infrastructure operator (NIO), when mapped against the key deadlines for meeting targets for payments, suggest that the ePIP has played a significant role in use of the My Health Record system by general practitioners. Further tracking of the data is required to confirm the trends observed during the evaluation period.

Did the extent and nature of media coverage and sentiment change since baseline? - No

Noting the impact of the caretaker period from May to July 2016, where no significant new communication work could be conducted by the Department, it appears that, with the exception of media coverage generated by the launch of the My Health Record in March 2016, there was no significant difference in the amount of coverage or sentiment expressed in media coverage at a national or local level. The capacity to generate positive unpaid editorial about the My Health Record system could be leveraged through cooperative consultation with the media.

Did the trials achieve their objective of informing next steps to promote participation and use? – Yes

The design of the trials and the change and adoption strategy they were built upon were evidence based. They reflected best practice for implementing innovation and change.

In retrospect, the strategy and design assumed a level of awareness of the existence of the My Health Record system in individuals. In the field, based on focus groups, it quickly became evident that individual awareness was very low.

The evaluation design was robust. It was a quasi-experimental field research design.[[1]](#footnote-1) The rest of Australia was used as the business as usual comparison group for both the opt-in and opt-out trial sites. There was no indication in the available data that there were any parts of the comparison area where there was a level of activity in public or healthcare provider education and support that would make the comparison unreliable.

The timeframe for the evaluation means that the impact of a number of activities across all four trial sites (NQ PHN, NBM PHN, WA and Ballarat Hospital) could not be included in the measurement period for the evaluation. Commissioned work has been implemented or continued since the close of the data collection/measurement period for the evaluation. This includes:

* work by the Australian College of Rural and Remote Medicine (ACRRM)
* a Facebook public education campaign
* the evaluation results of kiosks in general practices
* work with medical specialists, residential aged care facilities and allied healthcare providers
* work in the ACCHS sector and in Aboriginal communities (in the case of NQ)

The results of the evaluation will need to be interpreted taking the exclusion of this substantial effort into account.

Within these parameters, we find that the trials:

* were successfully implemented by the hard work of the PHNs involved in the trials the commitment and skill of Departmental officers and the support of key staff from the Australian Digital Health Agency, and a wide range of stakeholders at State Government level in New South Wales and Queensland and health service providers in Ballarat and Perth.
* have met their objective of providing Government with an increased awareness of the effectiveness of different methods to promote participation and use of the My Health Record system.

Did healthcare provider awareness of the My Health Record change? – in the two opt-out trial areas yes, outside no

During the evaluation period, exposure to information about the My Health Record was relatively low, ranging from 20-39%. Exposure to My Health Record information was higher in the opt-out trial sites compared to the rest of Australia. However, there was no difference between the opt-in trial sites and the rest of Australia comparison site. Of healthcare providers, general practitioners were more likely to have seen or heard about the My Health Record system than any other healthcare provider type across the whole of Australia. This difference could be explained by the education and support provided by all PHNs nationally to general practice about the ePIP.

What did we learn about online training for healthcare providers?

There is a very low awareness about the availability of online training across Australia, in all settings and in all types of healthcare providers. The uptake of the online training available has therefore been very low. Advice from those who have completed some of the available modules suggests there is a need to promote them effectively alongside awareness raising about the existence of the My Health Record system and its benefits.

What did we learn about face to face training for healthcare providers?

In relation to face to face training, the participating PHNs, the National e-Health Transition Authority (NEHTA) and the Australian Digital Health Agency (the Agency) achieved as much coverage of general practice in the opt-out trial sites as was possible in the timeframe available. The training was well received and thought to be effective. A key lesson is that it might be best in the future to focus training efforts on practice managers or practice nurses in a train-the-trainer model to ensure even more penetration, reach, sustainability and affordability of the effort.

What is left to understand better?

Work with other medical specialists, allied healthcare providers, with the Aboriginal Community Controlled sector, the hospital and residential aged care sectors began late in the trial period and mostly after the measurement period of the evaluation. Some information provided to the evaluation team in the last weeks of the evaluation suggests progress with these parts of the health workforce and with the other parts of the health system outside the primary care sector. The information available to this evaluation suggests that the work on the digital health readiness of these other parts of the health workforce and the My Health Record system readiness of the hospital and aged care sectors will need to be a major part of the preparation for any future work to improve participation and use by healthcare providers.

## Recommendations

Overarching recommendation

1. We recommend that Government proceed to a national opt-out approach.

Implementation at the national level

1. Taking all the data into consideration we can see no reason not to proceed with an opt-out approach in one national step rather than any progressive staged approach.
2. Priority enhancements and improvements to the My Health Record system identified by the evaluation or implied by it should be addressed prior any significant increase in participation and use. These enhancements include:

* inclusion of Pathology and Diagnostic Imaging Reports (public and private)
* stimulation of the creation and launch of accredited third party My Health Record applications to facilitate access and use by individuals
* improved healthcare provider registration and online authentication processes
* improved individual registration and evidence of identity processes
* improved user-friendliness for both individuals and healthcare providers (e.g. navigation, search functions, improved titles and labelling of individual documents, highlighting of critical data, enhanced display)
* a summary view of medications and MBS data
* improved access to My Health Record for all pharmacies through connected pharmacy software
* streamlining and improving myGov or removing My Health Record from myGov (a major barrier consistently cited by individuals)

1. Work should be undertaken with States and Territories, hospital and health services and software vendors to address and implement these enhancements. In particular, this work should include an assessment as to whether their IT systems can cope with increased volumes of information being uploaded and viewed.
2. Develop and disseminate a clear road map that describes what has been done to improve the My Health Record system to date as well as planned technical enhancements and changes to increase its clinical usefulness.
3. Investigate the extent and nature of software that has been developed (e.g. cdmNet, health pathways, electronic medical records viewer in NQ) to see if they have the potential to add to the value proposition for broader healthcare provider use of the My Health Record system.
4. Ensure that there is adequate capacity to meet demand in call centres and service centres. This includes providing enough staff and training them to adequately answer questions from users or potential users of the My Health Record system. Such support should be available for both individuals and healthcare providers.
5. Ensure dedicated content rich expertise in healthcare and the role of the My Health Record is available to support the next stages of system wide change management and social marketing.
6. Commission a national support, monitoring and evaluation service to support the implementation and change management efforts at the local level. This will ensure those at the local level have access to timely information to guide continuous improvement and refinement of efforts.
7. Monitor key variables in the National Infrastructure Operator (NIO) data. Analysis to date highlighted some interesting usage and participation differences from baseline and between trial sites. The period of time from implementation to analysis makes long term predictions impossible. It is recommended that the following key variables continue to be monitored going forward:

* Shared Health Summaries are a key indicator of use and have an important role in encouraging general practice contributions as part of the ePIP. Given that there was only one ePIP quarter within the evaluation period, continued monitoring of uploads and views is recommended to establish whether increased uploads are maintained in the trial sites and whether this translates to increased views in the long term.
* Proportion of MBS items with an associated activity (upload or view) in the My Health Record system by a healthcare provider. The proportion of MBS attendance items followed by healthcare provider activity in the My Health Record system is a good measure of use at the time of care.
* Individual views of documents. Individuals are likely to view their My Health Record around the time of visiting a healthcare provider. Some key documents of interest for individuals (e.g. Diagnostic Imaging Reports) are not currently being uploaded anywhere except in NT. It would be important to monitor individual views into the future when more individuals are registered and more healthcare providers are uploading.

Education and training

1. Consider sustainable solutions whereby pharmacies are a key place to invest in public education and support for individuals at the local level for a period necessary to achieve optimum My Health Record system uptake.
2. Broaden training for healthcare providers to include education about using the My Health Record system clinically and about its benefits for their patients and the health system, including appropriate scenarios relevant to the full range of healthcare providers across disciplines and clinical settings.
3. Work with academic institutions to embed digital health competencies and awareness and understanding into undergraduate, postgraduate and continuing professional development (CPD) programs of all health professionals, allowing for CPD points to accrue for completion of online modules.
4. In the general practice setting consider reorienting the training and education effort from targeting GPs only to targeting their practice managers or practice nurses as “bridgers” in a train-the-trainer model and provide them with resources and ongoing advice and support to provide the sustained effort that will be needed.
5. Consider face to face train-the-trainer programs for community leaders in local CALD and refugee communities, who also act as “bridgers”.
6. Work with the State and Territory Health Departments to implement solutions and communication to cater for complex privacy and safety issues, e.g. in domestic violence victims, children in the care of the state and people in custody prior to any national rollout; as well as healthcare professionals who are treated in the facilities where they work. Noting that there are privacy provisions in the My Health Record Act, which protect at-risk individuals and processes in place to handles these risk and sensitivity areas and personal controls which enable people to limit or restrict who can see their health information.

Strategy

1. Consider how to use current incentives that promote best practice such as the Indigenous Health Incentive and other chronic disease incentives. This would be consistent with the current PIP consultation and redesign process to achieve quality improvement in the detection and management of chronic conditions.
2. Develop engagement strategies and business cases for different segments of healthcare providers, engaging senior professionals and representative bodies to enhance credibility of the My Health Record within professional groups.
3. Work with accreditation agencies in primary, secondary and tertiary healthcare sectors to develop standards in relation to digital health and My Health Record.
4. Use all mechanisms available in commissioning and funding health services as vehicles to require the use of the My Health Record to obtain funds where practical.
5. Consider ways to require the use of the My Health Record system by all healthcare providers and how to best use the Government’s purchasing power directly (e.g. in the aged care sector), via new initiatives as they arise (such the Health Care Home initiative) or via PHNs commissioning clinical services (e.g. require use of the My Health Record system in all clinical and aged care services that receive Commonwealth funds). Such requirements should have a timeframe within which healthcare providers need to become compliant.
6. Explore with health insurers how they could encourage preferred suppliers and clients to use the My Health Record system as part of their push for preventive care and cost containment.
7. Use the good working relationships established with the New South Wales and Queensland health departments and their participating health services to promote other jurisdictional buy-in and the use of tools and processes that have been developed. For example, NSW Health, Mackay Health Service and Cairns Health Service have developed tools that can showcase how the My Health Record system can be used as the “free highway” between healthcare providers across sectors involved in an individual’s care to bring together key information along the patient pathway.

Communications

1. Engage a suitably qualified social marketing agency, supported by dedicated content rich expertise in healthcare, to develop a multifaceted marketing strategy for each relevant market segment of healthcare providers and individuals. This strategy should include a staged approach that:

* puts the My Health Record firmly on the healthcare provider and public agenda in a positive way through focusing on improving people’s understanding of the benefits at the individual, family, healthcare provider and health system levels
* alerts healthcare providers and individuals to where they can find more detailed information, including about their individual privacy rights and the existing privacy and security frameworks that apply to the My Health Record system
  + makes clear the privacy and security protections built into the My Health Record system, the privacy provisions of the My Health Record Act and the personal controls in the system
* promotes interpersonal communication about the My Health Record so that members of each audience segment become promoters within their sphere of influence
* links healthcare providers into online and face to face training
* outlines the road map for key system enhancements and additions, especially in relation to ease of access (mobile applications, streamlined registrations and evidence of identity, improvements to myGov) and new clinical content
* promotes messages about how the My Health Record system will evolve over time
* notifies individuals and healthcare providers when improvements and milestones have been achieved
* addresses issues specific to key target segments such as children 14 years and over and their parents, victims of domestic violence, children in the care of the state and people in custody. Noting that there are privacy provisions in the My Health Record Act, which protect at-risk individuals and processes in place to handles these risk and sensitivity areas and personal controls which enable people to limit or restrict who can see their health information
* develops communication mechanisms matched to each segment including tools and templates and approved messages for use by PHNs, jurisdictions and private and not for profit health services locally

1. Ensure that whatever awareness raising comes next builds on the results of individual and healthcare provider engagement from this evaluation. The results of individual and healthcare provider surveys, interviews and focus groups contain useful information for the development of key messages and appropriate channels of communication.
2. Include the independent monitoring and evaluation of the marketing strategy in the suggested work of the overall national support monitoring and evaluation service to support continuous refinement of the campaign over time.

Implementation by PHNs

1. Any future national rollout needs to:

* Have appropriate PHN level governance structures that allow for collaborative planning across healthcare disciplines; across public, private and not for profit healthcare providers; across service settings; and includes representation of individuals, Aboriginal and Torres Strait Islander people and where appropriate rural and remote healthcare providers
* Allow adequate time for local mapping of digital capacity, local professional groups and their ways of working
* Allow adequate time for the development of plans based on all available evidence (including evidence from national healthcare provider and individual surveys conducted for this evaluation and location-based NIO data)
* Allow adequate time for recruitment and induction of implementation staff
* Allow flexibility in timing/sequencing of steps to accommodate local issues and contexts (e.g. remoteness, internet access, special populations, local labour force issues that impact on capacity to recruit the right people in a timely way)
* Be supported nationally by people with both health system experience and knowledge of the detail of the My Health Record system, its benefits for all stakeholder groups and change management. This could be achieved by either appropriate recruitment into the Australian Digital Health Agency or through the commissioning of a national support, monitoring and evaluation service.

Implementation by States and Territories

1. Resources made available to assist with the integration of the My Health Record system in hospital and health services should be within a model where the health services employ their own staff. The job design and recruitment of these support and implementation officers should be in line with the plans and strategies for digital health in each jurisdiction and supported, where possible, at the state-wide level by the health system wide digital health functions of each State and Territory.
2. In cooperation with the local health services and health departments, promote materials and processes that were developed to support the integration of the My Health Record system in the public health system.

Implementation in the private and not for profit hospital sectors

1. Use the private and not for profit hospital and residential aged care sectors as key partners in both the integration of the My Health Record system within these settings and as a way to reach visiting medical specialist staff with messages about use of the My Health Record system in their private practices.
2. Work collaboratively with the professional associations, education providers and CPD providers to:

* promote the use of the online training modules developed for the trials
* include My Health Record knowledge and skills in training and education programs
* make CPD points available for completion of relevant online training modules

1. A quasi-experiment is a type of experimental research which uses two or more groups that are chosen on the basis of a pre-existing characteristic rather than through random assignment. [↑](#footnote-ref-1)