AAPM Submission to Electronic Health Records and Healthcare Identifiers: Legislation Discussion Paper

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Summary:

The Australian Association of Practice Management (AAPM) supports the intent of the Government's proposed legislative changes to the PCEHR system and the Healthcare Identifiers (HI) Service. In the majority of healthcare practices, the Practice Manager is responsible for implementing new systems and processes including eHealth systems, registering healthcare providers and their organisations for Health Identifiers Service, teaching clinicians to use these effectively and promoting the use of the PCEHR system within their practice. AAPM supports the consideration of the Practice Manager in implementing the changes to the PCEHR System and the HI Service.

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Overview:

AAPM supports the Government's aim to implement changes to the Personally Controlled Electronic Health Record (PCEHR) system and the Healthcare Identifiers (HI) Service to increase the number of individuals and healthcare providers participating in the PCEHR system and to increase the clinical utility and usability of the PCEHR system for the benefit of improved patient healthcare.

For effective, sustainable implementation and use of eHealth (including the eHealth Record System) it will be critical to consider both the clinical and business aspects of healthcare practices. Nearly 20 years of reform to improve healthcare in general practice has strongly demonstrated this need. Evidence and experience from Divisions of General Practice, Medicare Locals & the Australian Primary Care Collaboratives has shown that sustainable change not only requires change in clinical practice, it also needs changes in business processes and systems, including: financial management, human resource management, planning and marketing, information management, risk management, governance and organisational dynamics, business and clinical operations and professional responsibility.

In the majority[1] (87%) of healthcare practices, Practice Managers have primary responsibility for business processes and systems. They also have responsibility for clinical staff, on non-clinical matters. Therefore not surprisingly, the evidence and experience has been that it is critically important to have Practice Managers involved throughout healthcare improvement activities such as those referred to above.

The Discussion Paper notes that the introduction of the PCEHR system into clinical practice requires a complex registration process, implementation of new software capabilities and changes to clinical practice. Practice Managers are ideally placed to provide support and assistance to enable individuals and healthcare providers to start using the PCEHR system.

Examples of the critical role Practice Managers play in implementing sustainable change in healthcare practices are with data quality (clinical and non-clinical), billing (e.g. use of appropriate MBS items) and access and care design. Changes to improve these aspects of practice performance require a whole-of-practice approach, involving both clinical and non-clinical staff, and the development and implementation of supporting policies, processes, procedures and systems. Practice Managers drive these changes and their sustained operation.

Overall, AAPM supports the Legislative changes outlined in the Discussion Paper. Particular issues that we wish to identify are discussed below.

[1. AAPM Salary Survey 2013. (Conducted by InSync Surveys)]

Legislative proposals: PCEHR system and HI Service

1. Preliminary

3.1.2 Definitions

AAPM strongly agrees that the PCEHR Act definitions for "healthcare" and "health information" should align as closely as possible to those equivalent terms in the Privacy Act to ensure the PCEHR system is consistent with the operation of the Commonwealth privacy framework. Privacy arrangements should be the same whether or not healthcare practices are using the PCEHR.

2. Governance

3.2.1 Establishment of ACeH

AAPM strongly recommends that the ACeH Board and Advisory Committees include individuals with expertise in healthcare management to provide input to processes required to operationalise eHealth initiatives.

3. Participation

3.3.1 An opt-out PCEHR system?

The implementation of the trial of the Opt-Out system requires targeted and specific communication and promotion activities.

AAPM believes it is important that at a minimum, the current level of education and awareness raising activities around PCEHR is maintained in the areas where PCEHR continues on an Opt-In basis. The credibility of the PCEHR system has been hit by the low level of activity in 2013/2014 and it has taken 12 months of constant information and education to the health sector to rebuild the credibility and confidence that the system will continue. This momentum must now be maintained.

AAPM agrees that the use of revised incentives and education and training services will encourage Healthcare provider organisations to use the PCEHR system and that this should include Specialists and Allied Health Professionals. There is a need for education to address the current level of confusion, eg that a decision to not upload a care plan or event summary at the patient's request will not result in a cut in Medicare payments.

AAPM welcomes the target date of around July 2016, that healthcare providers will be able to access PCEHRs created for individuals in the trial regions and will be able to upload records. With the requirements of an opt-out period and transition period in the preceding months and the work required to extend access to PCEHR and the facility to upload to the PCEHR to all health providers, including Allied Health, it will be essential to notify practices and healthcare providers in the Opt-Out regions as soon as possible so that this timetable can be achieved.

4. Obligations of parties

3.4.1 Obligation to enter into participation agreement

AAPM agrees with the proposal to reduce red-tape and rationalise core obligations for participants in the PCEHR system, by removing the need for healthcare provider organisations, contracted service providers, repository operators and portal operators to enter into participation agreements. We also agree with the proposed approach to handling key obligations currently in participation agreements.

3.4.3 Obligation for organisations to have PCEHR policy

AAPM has assisted members to develop a PCEHR Policy for their practice. We agree that data quality is integral to the effective use of the PCEHR and support the inclusion of a requirement in the healthcare organisation's PCEHR Policy to ensure good data quality.

3.4.6 Obligations to use PCEHR system

AAPM recommends that circumstances in which healthcare providers not be required to upload a health assessment, comprehensive assessment, mental health plan, medication review report or chronic disease plan should be very clear and simple. If the patient requests that specific information is not uploaded, then the healthcare provider cannot be required to upload the information.

3.4.9 Obligation for System Operator to provide system testing

AAPM strongly supports the proposal that the PCEHR System Operator be given a function to develop and implement a test environment. It is essential that vendors and others can test innovations before they are implemented.

5. Privacy

3.5.3 Healthcare Provider Directory (HPD)

AAPM supports the removal of the need for organisations to provide consent before they are listed in the HPD. This will assist with the efficient use of e-referrals from GPs to Specialists and Allied Health Professionals, and also with the distribution of hospital discharge summaries.

3.5.4 Penalties for misuse of information

AAPM considers that serious misuses of PCEHR should incur penalties consistent with current legislation relating to confidentiality and interferences with privacy.

Further information or clarification may be sought from:

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