



ACRRM SUBMISSION

Electronic Health Records and Healthcare Identifiers: Legislation Discussion Paper

June 2015

COLLEGE DETAILS

Category:	Organisation
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**The College would like its submission to be publicly available.*

The Australian College of Rural and Remote Medicine supports the Commonwealth government's change in approach with both the personally controlled electronic health record (PCEHR) system and the Healthcare Identifiers (HI) service. Increasing the use of the PCEHR system by rural generalists and broadening access to other healthcare professionals, in particular specialists and allied health would support the College and its members in the continuity of care of their patients. Access to more relevant clinical information through an improved user interface for the doctor should lead to an increase in clinical utility of this solution along with other eHealth tools used in General Practice.

The College recognises that the clinical usability program (which the College has been a member of for the past 12 months) managed by NEHTA has led to a number of enhancements in the usability of the clinical software to access and use the system along with improvements in the registration process for health professionals and patients. These improvements now need to be communicated effectively to allow doctors to see that some of the barriers to using the solution, that has prevented doctors from using it, have been recognised and dealt with. Providing an effective method for users to report issues and future requirements along with a feedback mechanism on proposed enhancements is essential to build doctor confidence that their needs are recognised and being addressed.

Preliminary Matters

The College supports changing the name from the personally controlled electronic health record (PCEHR) to 'My Health Record', MyHR.

Clarification of the term 'healthcare' to include health-related disabilities, palliative care and aged care services does not appear to provide wider coverage for all allied health and ancillary health services. The College would recommend 'healthcare' is inclusive of the person's 'healthcare team' from birth to death. The College supports allowing regulations to exclude activities performed for reasons other than care or treatment, such as the purpose of life, health or other insurance.

The College agrees with the clarification of the definition of "health information". In that health information includes information about the *physical*, *mental* and *psychological* health or disability of an individual, and is not limited to just information about physical matters.

In relation to the current situation where the same level of privacy protection is given to organisations and individuals restricting the ability to share information about organisations involved in the PCEHR. The College is unable to comment at this time about information relating to organisations no longer being treated as personal information. We would recommend contacting the College about this issue.

The College has a preference for using the term 'individual' to replace the current references in Acts for 'consumers' and 'healthcare recipients'.

Governance

The College supports the establishment of a Commonwealth statutory authority known as the Australian Commission for Electronic Health (ACeH) from July 2016. We also support the scope of this authority to be responsible for all national eHealth systems, including the PCEHR system and

that this authority will assume responsibility for the governance and operation of all national eHealth development and operations across Australia.

The College recommends that the end user representation on the board and the advisory committees include a number of users and non-users of the national eHealth systems and that their advice is reflective of the organisation that they represent. As leaders in rural and remote medicine the College is well positioned to provide advice about the impact and use of eHealth on rural generalists working in rural and remote locations throughout Australia and how it can be integrated into shared care arrangements where health professionals work more broadly to fill the gap from a lack of health services. We represent the interests of rural and remote patients, their communities and their healthcare providers. Issues of distance, access to services and support including IT support occur daily for our members. The College brings work experience across a number of health services in both a public and private capacity and the use of technology to support rural generalists operating at the top of their license. The College has a strong history of providing systems, support and education to its membership and to other affiliated organisations.

The College supports the continuation of the Clinical Useability Program and its involvement on the Steering Committee. A number of significant software changes have occurred in the practice management software as a result of this program which has removed some of the barriers to clinicians and practice staff using the system.

It is also important to have a revised National eHealth Strategy published to drive the plans for eHealth nationally and this should occur before July 2016 when the new governance structure is to be established.

Participation

The College notes that the changes in legislation for participation in the PCEHR only apply to individuals and not healthcare providers. Rural generalists will continue to participate under an opt-in model and individually register their agreement to use the system. To facilitate increased use the registration and renewal process should be seamless, with minimal barriers, for the provider and the organisation(s) they work for.

For the opt-out trials the regions selected should include areas that are considered either rural or remote and have limited access to GP and Specialist services. The College would expect the trial to include these areas to understand how a limited workforce could manage patient requests for information about having an eHealth record, requests to opt out and how these requests would be managed when access to Medicare or Primary Health Network staff would be limited, especially with the increase in physical area that some PHNs are managing. The College would be happy to provide advice to the government on the selection of the trial regions.

The College understands that individuals in the 'opt-out' region that did not opt-out will have an eHealth record created for them, this will have as a minimum two years Medicare data and information from the vaccination and donor registers. Individuals will then have six weeks before their records can be accessed to set their access controls on the record, should they wish to alter the default setting that allows all registered users to access the record when caring for the individual. The College would recommend that clear and concise information is made available to everyone in the 'opt-out' region to understand what levels of security and privacy they can apply to their record.

There will also need to be a support mechanism in place to enable individuals to make those change in the six week period, which should include consideration to those who would not have access to a computer, those who may not be able to travel or travel long distances and those requests that would come from patient representatives.

During the trial the College recommends that systems are in place that make it very clear to the clinicians and practice staff that a patient has chosen to 'opt-out'. This will help practice staff manage and taken further action, if necessary, for their patients who want an eHealth record.

The College does have concerns about the pressure that would be applied, from various sources (such as peers and patients), to the practices in the trial regions to participate in the PCEHR. The period between selection of the region and the commencement of the individuals' two month 'opt out' period should be great enough to enable the practice to get the support they need to apply for and implement the HI service and PCEHR system including registration, implementation, data review and change management for those willing to participate. Appropriate resourcing and support should be given to all healthcare organisations in the trial region that fosters a win-win situation without perverse outcomes or disincentives. Practices that are not able to participate should not be duly impacted by that decision during the trial.

Consideration also needs to be given to the trial region boundaries and the impact this may have on staff that work across those boundaries, including healthcare professional working in outreach services and their ability to work in both an opt in and an opt out model during the trial period.

The discussion paper proposes that healthcare organisations will be encouraged to use the system through revised incentives, and education and training services. The College is willing to work with the department on the development of the incentives, education and training services to link these to outcomes and centred on general practice.

The College would expect that information would be provided to patients who live within the trial region from a number of sources. This should include suitable material for the rural generalist and the practice to provide the right information to the patient and include support from the Primary Health Network. Consideration should also be given to patients who travel outside of the trial site and how knowledge of the trial may be transferred to the clinicians they visit outside of the trial region.

One of the possible scenarios for practices in the 'opt-out' region is that all of their patients are registered and have a PCEHR. The College acknowledges that during the past twelve months there has been an improvement in the usability of the clinical information systems making it easier to review the patient history and create a health summary. However there will be an impact on the practice to perform additional tasks to obtain the patient's healthcare identifier (and any issues associated with this) and then review their current clinical record, make the necessary updates and to create and send the health summary information (in a format that is understandable to other clinicians) to their patient's PCEHR, and doing this for a great percentage of their patients then would occur under the opt-in model. It is therefore important to have the process as seamless as possible with minimal resources and designing incentives to support this increased workload.

Obligations of parties

The College in principle supports changes to reduce red-tape and the Department of Health is recommending that practices would no longer complete a participation agreement. The completion of the agreement does bring to the attention of the practice the PCEHR Rules and associated penalties. Consideration should be given on how the rules and penalties can be brought to the attention of the organisation and the staff who use the system. The PCEHR rules require registered organisations to have a policy in place to address security and training matters. The College supports the departments' suggestion of adding to this policy, how the organisation will ensure data quality.

The dependence on uploading a clinical document to the PCEHR to receive payment for certain Medicare items that occur in general practice today is a concern to the College. Given the flexibility in place for a patient to request the doctor not send information to their PCEHR and that a patient can opt-out of having a PCEHR. There would be a number of circumstances where the rural doctor would complete the clinical assessment but no document is sent to the PCEHR system. The College is willing to work with the Department on defining a suitable incentive model that supports shared care arrangements but does not impact on the payment of existing services.

Privacy and Security

The College supports the move from a prescriptive approach to a principles based approach for the PCEHR system and the HI service presenting it in a simpler manner but not relaxing the privacy framework or the nature of the authorisations.

We also support the addition of a new notification where an individual can be notified by email or SMS text if their record has been opened. We would however request that this feature is made explicit to doctors using the system and they understand all the scenarios under which this notification could be generated. The College would note that accidental selection of a PCEHR button on a clinical information system could result in the patient being notified of access – whether it was intentional or not. It may be wise to introduce a second step within the doctor's clinical information system to confirm that they do wish to access the PCEHR system for this patient and that this confirmation then results in a notification of access to the patient.

The College does have concerns about increasing the range of enforcement and penalty options available should a person breach the PCEHR ACT. Introducing Civil penalties (up to 120 penalty points) in addition to criminal penalties, as suggested in the discussion paper, would be supported by the College for less serious misuses of the healthcare identifiers. But increasing the penalties for misuse of PCEHR information to criminal penalties may hinder further clinical use becoming a barrier to participation. Appropriate training and ongoing practice support and resources for their mobile workforces in rural and remote areas should be considered.