

AGPN eHealth Conference – Melbourne 16-17 June 2010

The key messages I came away with from the Conference are:

1. This year's federal budget has assigned \$467M over 2 years from 1 July 2010 to deliver real system changes and benefits through a Personally Controlled Electronic Health Record (PCEHR), for which registration by the general public will commence by July 2012.
2. The PCEHR was recommended in the NHHRC report to improve safety; reduce waste and inefficiency, and; improve the continuity of care/patient outcomes.
3. All eHealth development is dependent on the Unique Healthcare Identifiers Bill which was passed by the Senate at the 11th hour last Thursday (24 June). NeHTA can now work with DoHA to achieve a roll-out of HIs over the next 18 months. (Details on the Healthcare Identifiers and eHealth in general can be found at: <http://www.ehealthinfo.gov.au/>.)
4. The Key Solutions Focus for NeHTA will be ePathology, eDischarge, eReferral and eMedications. They will use a strategy of Early Adopters, Fast Followers and then the general roll-out. Peter Fleming's presentation (NeHTA CEO) contains their initial plan for implementation. (All Conference presentations can be found at: <http://agpn.com.au/programs/ehealth-and-information-management/agpn-ehealth-conference-2010/1.1>).
5. Majority of software vendors have confirmed that they will be able to modify their software within 6 months following the passage of the Healthcare Identifiers Bill and the drafting of the relevant regulations.
6. There are plans and visions, but detailed specifications are evolving slowly. There are certainly not answers to every question because things are still at such a formative stage of development. Lots of comments on "we want it to do this or that", but until detailed specifications are available it's all very much a wish list. Detailed specifications already exist or are being developed for the 4 Key Solutions, but there is nothing for the PCEHR. A classic question asked about the PCEHR was: *will consumers have the opportunity to formally record their own self-help/self-medication/self-management in their own PCEHR?* The answer is "yes" but in the absence of any detailed specifications how it will be achieved is unknown.
7. The three overriding concerns of all speakers were:
 - The quality of data currently held in clinical databases;
 - The need to involve both the practitioners and consumers in the decision making process; and
 - Do not underestimate the enormity of the change management component of eHealth.
8. Tony Lembke (APCC) made the statement: *when we knew that data was only 10% accurate we didn't trust it; but once it reaches 90% accurate then it becomes dangerous because we are more inclined to trust it.*
9. Andrew Dalley (Illawarra Division) made two most telling comments:
 - It is difficult to answer when a practitioner asks the question: what's in it for me with an EHR, when the benefits generated by one practitioner are utilised by another.
 - Spend the money on data quality before we spend it on an EHR.
10. On the subject of data quality, consider this point: we know how many people we jab with a needle, but we don't know how many had adverse reactions and how many were effectively immunised. We have to be able to be smarter with the collection and use of data.
11. Enrico Coiera (UNSW) made the following points:
 - When transforming the system we must recognise that by 2020 practitioners will have to deal with a larger proportion of patients and sicker patients proportionally because of the aging demographics.
 - Part of the budget must allow for evaluation.
 - If we build a PCEHR, based on international experiences, only 4% of patient visits will use the shared record. Does this make it a priority task?
 - Must adopt a "middle out" strategy as opposed to a "top down" or "bottom up". The feeling is we were working with a "middle out" strategy but it has now reverted to a "top down" strategy; i.e. being talked to from a position of power rather than consulted and involved.
12. Mukesh Haikerwal (Clinical Lead NeHTA) is currently working on Data Governance; methods of collecting, storing and managing data.

13. Judy Evans (eHealth Project Manager RACGP) defines three steps in data management: define what data quality means; establish metrics; link to organisations goals and objectives. Judy is developing case studies on data cleansing and one she quoted was a practice which prints out a patient's clinical summary and gives to the patient in a sealed envelope when they arrive for their appointment with an explanatory letter from their GP.
14. Emil Djakic (Chair AGPN) in his conference wrap-up touched on the following points:
 - \$10/annum/patient is the government budget for the next 2 years – a mere shoestring.We've seen and heard:
 - a) Government commitment to eHealth
 - b) Plans for national eHealth roll-out
 - c) GP network will play a central role in supporting change and adoption
 - d) Some expressions of concern – though all believed that eHealth has to happen
 - e) eHealth development must occur in collaboration and partnership with consumers and clinicians
 - f) not green fields sites – build on what works
 - g) must have strong business case, adequate investment and be sustainable
 - h) eHealth increases the probability of a successful outcome – it will not guarantee a successful outcome
 - i) need rigour in software standards
 - j) must be consumer driven.

All in all, I thought it was a very successful conference. One of the better I have attended.

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