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nursing federation

Submission to Department of Health and Ageing in
response to consultation on the Draft Concepts of
Operations – Relating to the introduction of a personally
controlled electronic health record (PCEHR) system

May 2011

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1. Introduction

Established in 1924, the Australian Nursing Federation (ANF) is the largest professional and industrial organisation in Australia for nurses, midwives, and assistants in nursing, with Branches in each State and Territory of Australia. The core business for the ANF is the professional and industrial representation of our members and the professions of nursing and midwifery.

The ANF has a membership of over 200,000 nurses, midwives and assistants in nursing. Our members are employed in a wide range of settings in urban, regional, rural and remote locations, in both the public and private health and aged care sectors.

The ANF participates in the development of policy relating to: nursing and midwifery practice, professionalism, regulation, education, training, workforce, and socio-economic welfare; health and aged care, including reform agendas, community services, veterans' affairs, occupational health and safety, industrial relations, social justice, human rights, immigration and migration, foreign affairs and law reform.

Given that nursing and midwifery form the largest cohort within the health and aged care sectors, and are the most geographically dispersed of all health care workers, the ANF has a keen interest in the development of health information management in the electronic environment. The ANF participates through a variety of forums in the work of the National E-Health Transition Authority (NEHTA) and welcomes the opportunity to contribute to the development of electronic health records by providing comment on the draft Concept of Operations – relating to the introduction of a Personally Controlled Electronic Health Record (PCEHR) system.

2. Draft Concept of Operations for introduction of Personally Controlled Electronic Health Record (PCEHR) system

The ANF submission addresses the following five points identified by NEHTA as feedback from individuals or organisations that:

- identifies additional information they would like provided regarding the PCEHR System,
- highlights questions they consider important to the PCEHR planning discussions,
- provides comments, opinions and perspectives on current thinking around the design and planning for the PCEHR System,
- provides comments, opinions and perspectives on the implementation opportunities and challenges, and
- identifies other areas that the PCEHR implementation planning should consider.

2.1. Additional information to be provided regarding the PCEHR System

The majority of consumers and health professionals have little knowledge or awareness of the PCEHR system and e-health in general. For consumers of health and aged care services, the PCEHR system must be explained in plain language with clear instructions on how to use the system. The boxed anecdotes in the document *e-health: have your say* are seen as useful adjuncts to the explanatory text.

For health professionals, it is important that a very detailed explanation of the system is provided together with the specific documents which will be released with the implementation of the PCEHR system. The Concept of Operations document describes the individual who will be able to register from July 2012 to participate in the PCEHR system. Furthermore, the individual is given the option of nominating a healthcare provider to actively maintain their Shared Health Summary. The concept of operations document only refers to the regular General Practitioner (GP) or health care organisation as the nominated health provider. A number of consumers never visit a GP for their health care needs. The document must state examples of nurses, including and not limited to, rural and remote nurses in bush hospitals, community nurses, maternal and child health nurses, mental health nurses, nurse practitioners, midwives and allied health professionals who may be the nominated health provider for the individual. Registered Nurses have the capacity, competence and legal authority to be a nominated health provider and write to the Health Summary Record.

2.2 Issues considered important to the PCEHR planning discussions

Currently all health professionals registered under the National Registration and Accreditation Scheme (ARAS) managed by the Australian Health Practitioners Regulation Agency (AHPRA) are assigned a Health Professional Identifier number by Medicare. The ANF recommends that the authorised user remains within the domain of a Health Professional with a HPI-I and valid credentials. It is important that guidelines and policies are developed in order to have transparency, privacy and confidentiality safeguards and an audit system for participating organisations which include health professionals who do not have a HPI-I with access to the PCEHR (for example, Dietitians).

The event summary is used to capture key health information about significant healthcare events that are relevant to the ongoing care of an individual. The examples of health professionals who can use the event summary is further restricted in the document to after-hours GP, emergency department, an outpatient clinic, a community pharmacy or an allied health clinic. No mention is made of nurse practitioners, mental health nurses, midwives, maternal and child health nurses, school nurses, community nurses, rural and remote nurses or nurses in bush hospitals. This group of nurses provide vital health services to the community, often where no general practitioners or specialists are available, and it must be ensured they have access to the event summary where such a report is inherent to their work role.

2.3 Comments, opinions and perspectives on current thinking around the design and planning for the PCEHR System

Privacy and security are a significant challenge for every health care organisation and concern for all Australian citizens. People in Australia have an expectation and trust that the use of information in the health environment is secure and that all health professionals will provide the systems and processes that will protect this information on their health status. It is essential that the legislation, privacy, security mechanisms, secure messaging, governance and quality systems that underpin the PCEHR are explained to everyone in the community so that they will use the system with confidence and trust.

The issue of trust in the system is also pertinent to health professionals. For example, nurses working for Queensland Health are currently working in a 'low trust' environment brought on by the failure of the new electronic pay system. There is therefore an understandable potential distrust in the large scale introduction of further technology with the PCEHR, despite the proposed advantages.

The most important message and perspective around the design and planning for the PCEHR system is that all consumers and health professionals must have a very clear expectation and understanding of the use and limitations of the initial system to be implemented. That is, that the Health Summary Record:

- provides the essential health information of the individual on a one page document,
- is not intended to replace the medical record, and
- will only provide a snapshot of the patient's identification and limited medical information.

It is important that the PCEHR system in the future is integrated into existing health records. The incorporation of medical records would reduce duplication of documentation and ensure that up to date health information is stored in the PCEHR system. However, it is acknowledged that the technical design and storage systems are still in the development stage and will require a more mature technology platform in order to implement this next stage.

Consumers of health and aged care systems will naturally be curious as to mechanisms for linking information currently held in paper formats, with the PCEHR and later iterations of electronic health records. This will include future plans for hard copy records (will they be stored or disposed of, and if the latter, how this will occur and over what timeframe).

The need for a clear risk management strategy is evident and the development of policies in relation to how this information is to be used (for general information) both by individual consumers and health professionals.

2.4 Comments, opinions and perspectives on the implementation opportunities and challenges

The proposed implementation strategy is based on core principles:

1. Governance;
2. Legislation;
3. Policy integration, including integration with the national hospital and health reform agenda;
4. Change and adoption, including engagement and communications as well as change management support;
5. Lead e-health sites;
6. Outcomes and benefits evaluation.

The ANF agrees that these principles are essential to provide the framework that will establish a complex system across the nation and include individual PCEHR patient/user, health professionals and health organisations in all health settings and regions. The ANF considers that quality and safety are two important inclusions.

The change and adoption process must be developed to provide incentives for the individual/consumer/user and health care professionals and providers to be motivated and supported to use the system. The incentives must include a review of the funding mechanisms including MBS and PBS arrangements. Currently, Nurse Practitioners are not receiving equitable reimbursement from MBS and PBS payments for health services provided for the consumer. The ANF recommends changes to the MBS and PBS reimbursement payments for Nurse Practitioners so that funding for their services is equitable with other health professionals. This means a funding model which recognises that the Nurse Practitioner provides nursing services in a range of consultation environments including but not limited to face to face interactions, such as telemedicine, and for a spectrum of conditions such as the management of patients with chronic disease and co-morbidities, aged care and palliative care management, which are more suited to different funding mechanisms.

This health reform initiative is based on a model which allows access to health information and updating this information for the consumer by a nominated health provider, and does not rely on the face to face service provision under the MBS and PBS system. The fee for service model is not the most appropriate funding mechanism in an e-health environment. The funding model must be designed around telemedicine with multiple consultations with health professionals, and service provision in an e-health clinical setting.

Furthermore, funding is required for all aspects and implementation stages of the health reform initiative. A large proportion of health organisations, clinics and community centres, particularly in the rural and remote settings, do not have the resources and computer infrastructure to adopt the PCEHR system. The installation costs of hardware and software must be considered and funded otherwise the vast majority of health care professionals will not have an incentive to operationalise and enhance the essential foundations of the proposed system. There is a huge need for investment in infrastructure, software and IT support across the health sector prior to the implementation of the new system. Successful implementation is also dependent on crucial investment in tertiary level programs and creation of positions in health facilities, for health informaticians.

The initial strategy of information and explanation of the PCEHR system will require a significant undertaking in marketing, communication and engagement with all consumers in Australia and all health professionals and organisations. It is also important to note that not all consumers are computer literate and/or have access to a computer or a reliable wireless connection. Disadvantaged groups, such as the aged, homeless, unemployed or those from lower socioeconomic backgrounds in the community, will not have access to this health reform initiative. Yet these are the groups that often suffer poor health and are frequent users of the health care system. The National Broadband Network (NBN) will need to address access to the internet in rural towns and remote locations as there is simply no access at present.

Given that the requirement of the system is that consumers choose to “opt-in” to the PCEHR it is important that a very detailed approach is undertaken to ensure that all people in Australia understand the system and have trust and confidence in the model. The concept of trust is an important issue that will motivate and influence the individual PCEHR user to register and participate in the system.

The consumer and health professional alike must have an understanding of the different levels of access to sensitive information, and the consequences of screening from view important health information which may impact on health care delivery if the health professional is not aware of this information. Furthermore, if information is being suppressed by the consumer then the health professional will not rely on the information in the health summary record.

If nurses and midwives are to rely on the information in electronic records in future, their ability to make an informed judgement in relation to patient care may be compromised if certain information is not disclosed. In the event that patient care is compromised due to a lack of disclosure of important information by the patient, the health professional should not be held legally or professionally accountable for the outcome.

The inclusion of a feature allowing limiting of access to clinical documents means that all consumers will require improved health literacy so that they have a clear understanding of potential consequences of such limitations. The communication and marketing strategy must include language that is understood by non-English speaking people, with caution used in approaching any perceived culturally sensitive health concerns.

People are the centre of the PCEHR system and in some circumstances the patient may register for a personal Health Identifier number, consent to opt-in, but if the health summary document has not been completed with the required health information the document will not be used and the consumer will lose confidence in the system. Furthermore, other health professionals will lose confidence in the system if the health information is not available when they attempt to access it. It is important in the implementation of the PCEHR that the nominated health professionals have an understanding of, and have received education about, the requirement to complete the initial Health Summary Document with the patient who has agreed to opt-in.

The lead sites will play a significant role in the implementation process of the PCEHR system. The two waves of lead sites which have been funded by the Australian Government will provide the foundation and evaluation of the design of the national system. As stated in the Concepts of Operation document “the early adoption of the PCEHR System for individuals participating in the e-health lead sites” will already target a significant number of consumers who will be familiar with the concepts across the States and Territories and demonstrate the early benefits of the system.

Under this strategic approach it should be anticipated that as the national PCEHR system becomes available in July 2012, the health professionals and consumers in lead sites will be ready to migrate to the national system as it becomes operational. It is noted in the Concepts of Operation document, that the national e-health strategy proposes an incremental and staged approach to implementation. This model should be adopted as a staged approach across Australia.

2.5 Other areas that the PCEHR implementation planning should consider

The PCEHR system implementation process is not just limited to its design and capability. The PCEHR system relies on the fact that health professionals in all health care settings, hospitals, community centres, aged care facilities, and rural and remote areas, will have access to a computer. Access is often limited to one computer on the desk of a workplace which is available to a large number of nurses, doctors, allied health professionals and receptionist staff. The computer is also accessed by health professionals for patient information systems, risk management systems, booking systems and other programs which are essential systems in every health facility and hospital.

Nurses and midwives are change agents in health and represent the largest health professional work group. Fundamental to the success of the PCEHR system is dissemination of information across all health sectors. Nurses and midwives are employed across a range of health organisations and services, such as: in rural and remote areas, Aboriginal and Torres strait Islander health services, aged care services, community, general practice and municipal councils, schools, acute public and private hospitals, sub acute care, occupational and rehabilitation services, to name a few. Therefore, nurses and midwives are very well situated to play a major role in the change and adoption program. It is imperative though that they are provided with funded educational support and resources.

The PCEHR system implementation process must identify that computer access is available to support the health professional in the workplace, without adding to their workload in such a way that it becomes a deterrent. A number of health professionals are not information technology literate, and/or may be part time or casual workers. Education programs and on-going support systems in the workplace must therefore be provided for all health workers across the 24 hour time period, including weekend shift times, to ensure coverage for all staff, including casual and agency staff.

In some health settings, for example aged care, there is a plethora of documentation involved in the care provision - the implementation of the PCEHR system must not be seen as an addition to this load. Another workload impact factor is ensuring that there is no duplication of information – that is, a requirement to hold written records in addition to electronic records.

Other practical issues raised by ANF members for consideration include:

- availability of information technology to access device at Point of Care
- language and literacy skills of the user
- responsibility for the maintenance of the technology
- space at the bedside or in the clinical environment for electronic information systems equipment
- workplace redesign to accommodate computers (acknowledging that there are still many facilities where this is not commonplace)
- impact on budgets
- need for risk assessment
- integration with other systems

3. Conclusion

Having participated in many forums relating to the establishment of electronic health information management, the ANF welcomes the opportunity to continue to contribute to the development of processes for the introduction of personal electronic health records systems.

With a large cohort of members in the health and aged care sectors, the ANF has a genuine interest in the implementation of an electronic environment for managing health and aged care information. Nurses, midwives and assistants in nursing (however titled) need the assurance that electronic systems will give them tools to enhance their practice, and therefore the health and well-being of the people for whom they provide care.

The ANF continues to argue for the need for governments to invest in education, and people and material infrastructure, to support the implementation of electronic health records systems. The introduction of the PCEHR is an essential building block in the development of such a system across the country. Attention to detail in the implementation of the PCEHR will not only improve the quality and efficiency of the more comprehensive system to which it belongs, but just as importantly, will provide confidence in the system for the public and health professionals.

As the largest single component of the health and aged care sectors the nursing and midwifery professions must be specifically targeted in change and adoption plans for the implementation of the PCEHR, and subsequently, electronic health records systems more broadly. There is high variability of IT literacy within these professions and, of even more concern, limited access to IT hardware, software and support infrastructure. The ANF urges the Department of Health and Ageing to give careful consideration to the issues raised in this submission and by nursing and midwifery clinical advisors to NEHTA.

The ANF looks forward to continuing to contribute to the work of creating an electronic health information management systems environment across the health and aged care sectors.