Mr Richard Royle
Panel Chair
Review of the PCEHR system

22 November 2013

Dear Mr Royle

The Rural Doctors Association of Australia (RDAA) welcomes the review of the implementation of the Personally Controlled Electronic Health Record (PCEHR) system.

RDAA supports in principle the vision for a national database to ensure important patient information is available to doctors and other health professionals working in different locations and within different systems. However, many of our members remain skeptical about the benefits of participating in the PCEHR system and require convincing to take that leap of faith and begin registering their many thousands of patients.

I look forward to the review panel's consideration of the enclosed submission from RDAA.

If you require any further information, please do not hesitate to contact me on (02) 6239 7730.

Yours sincerely

Jenny Johnson
Chief Executive Officer

REVIEW OF THE PCEHR SYSTEM

RDAA SUBMISSION

INTRODUCTION

The Rural Doctors Association of Australia (RDAA) was formed in 1991 and is a national body representing the interests of all rural medical practitioners and the communities where they live and work.

RDAA's key priority is to ensure that effective policies exist to assist rural and remote communities to attract and retain medical practitioners with the qualifications, skills and commitment to meet the needs of people in those communities. A sustainable rural medical workforce is the key to providing these communities with better access to primary healthcare, general practice and local hospital-based services.

A PCEHR system has particular relevance for rural patients who are most likely to have pieces of their medical history stored in a number of places. They often travel to access health care and are likely to be transferred away from their community in the event of a medical emergency or serious illness. The PCEHR system has the potential to address this fragmentation.

SUBMISSION

RDAA's submission draws on the experiences of some of our members practising at the coalface of rural medicine.

1. Your experience on the level of consultation with key stakeholders during the development phase:

RDAA believes a higher level of consultation with stakeholders was needed during the development phase. In particular we believe that there should have been stronger consultation with General Practitioners (GPs) who are working 'at the coalface', especially in remote, rural and regional areas.

RDAA was not represented on the PCEHR Peak Consultation and Communication Group, or on the Stakeholder Product Consultation Group. RDAA was not even made aware of the existence of these Groups. However, in 2013, RDAA was invited to nominate a representative to the Clinical Usability Program.

The Australian College of Rural and Remote Medicine (ACRRM) is a pioneer in the field of telemedicine and should have been represented on all key stakeholder consultative groups. ACRRM has much to contribute, both in terms of communication with its rural doctor members, as well as its

experience in working with equipment and infrastructure in rural and remote Australia.

RDAA recommends that ACRRM be fully engaged in any further work around the development and promotion of the PCEHR.

2. The level of use of the PCEHR by health care professionals in clinical settings and barriers to increasing usage in clinical settings:

While it is unclear what the uptake of the PCEHR system is amongst rural GPs, feedback from RDAA members indicates that a relatively small number are using the PCEHR.

There are a number of reasons for this:

a) Lack of a MBS rebate for uploading the PCEHR

The lack of a MBS rebate for the time taken to create a shared health summary and uploading the PCEHR is a significant barrier to the uptake of the system. In rural areas doctor workloads are usually high, and there is often limited support in terms of other practice staff. Doctors are under enormous pressure and will not participate in the PCEHR unless they are realistically reimbursed for the time and resources involved.

Feedback from RDAA members indicates that the task of creating and uploading shared health summaries takes a considerable amount of time and generates significant frustration. These members express disbelief that the Government expects them to this as part of a routine consultation.

RDAA believes that doctors should be reimbursed for the time taken to create a shared health summary for a patient. In the absence of proper reimbursements for this work, the uptake of the PCEHR is likely to be limited.

Practices should also receive appropriate supports to adopt the new technology, particularly smaller practices that may not be accredited and therefore ineligible for Practice Incentive Payments (PIP).

(b) IT requirements and complexity of the system

RDAA believe the uptake of the system has been undermined by a lack of IT infrastructure, doubts about internet capacity, the reliability of both hardware and software in many rural and remote areas, and the complexity of the system.

RDAA has received complaints from members that the PCEHR software has placed additional burdens on their existing software and hardware systems, resulting in system failure, or poorer reliability and performance. In rural

areas it is often difficult to access IT maintenance and support and so these impediments become even more significant.

The separate access protocols for the PCEHR and the Department of Human Services' Health Professionals On-line Service is also a source of frustration.

Members report that these systems are complex and not very mobile for doctors who work across several locations. Effective IT support is very expensive and there is no single, fast port-of-call to resolve problems.

Software has to be loaded onto each workstation to be able to access HPOS, which is still not easy to use on anything other than Internet Explorer.
One member working as a locum who decided to access HPOS from home struggled for two hours with multiple phone calls to multiple help lines to get into the system successfully.

The lack of ability to download and install atomic data into a record markedly limits the utility of the record, as does the potential for multiple event summaries sitting in a pile.

Internet capacity and the speed of the system, particularly in rural and remote areas, is a significant problem. In a time-limited environment, delays to wait for the PCEHR system to come online, upload information and generate prescriptions are major deterrents to its uptake. E-prescriptions in particular are reported to be slow to generate. One practice reports that, if the GP attempts to use another part of his or her computer while the e-prescription is being generated, the file is interrupted and corrupted, requiring the GP to log off and log back on. This is frustrating and slows down consultations.

(c) Lack of clinical leadership

Lack of clinical leadership, and especially evidence that rural GPs have not been consulted in the development of the PCEHR, has undermined confidence in the system, as has a perception that the system has not been designed so that it can accommodate the unique circumstances of rural practice.

(d) Limited or no connectivity

Some of our members report that there is little connectivity with hospitals and other health services in many areas. This connectivity is especially important in rural areas, where doctors typically work in both their private practice and also provide services to their local hospital and other health facilities, such as aged care homes. (For example, a rural doctor in NSW has mentioned that the software used by NSW Health does not interact with the PCEHR).

(e) Legal and privacy issues

A significant issue is single point accountability for maintaining a contemporaneous summary over time with potential for serial changes in clinical information to be missed, with the PCEHR's current download framework of PDF documents.

Members also have concerns about data governance, privacy and misuse of information, ownership of the patient's information (including legislative provisions that describe perpetual Government retention of data and use for non clinical purposes – such as insurance and research – without consent).

The definition of personal control and the potential for patients to hide clinically relevant data that may impair clinical care is also a source of concern.

(f) Coordination with other health care providers

There appears to be a lack of coordination with other primary health care providers and also with specialists, many of whom are unfamiliar with the PCEHR and how they will interact with it.

(i) Role of Medicare Locals

Medicare Locals have been funded to support the uptake of the PCEHR, but feedback provided to RDAA indicates that the demands placed on practices in terms of eligibility and reporting have been onerous and restrictive in some areas, and acted as a deterrent.

For example, one practice sought a small amount of funding from a Medicare Local to upgrade their computers to participate in the PCEHR. To receive this funding, the practice is required to sign up 300 new patients to the PCEHR and upload 300 shared health summaries within a six-month timeframe. There is no extra funding to support the intensive administrative activity required to meet these targets. A GP within this practice commented that:

> "*This is an example of Medical Local's destroying any credibility that they would present as an organisation aiming at supporting general practice and primary care. All they seem to want to do is function only as a data collection agency for the Improvement Foundation.*"

Other members have expressed concern that any funding now available for after hours services from some Medicare Locals will require an eHealth component.

3. Suggested improvements to accelerate adoption of the platform.

RDAA believes that there must be a greater degree of involvement from rural doctors and from stakeholders, including ACRRM, in the clinical governance, and in consultation about clinical usability and stakeholder communication and consultation.

The PCEHR must be easy to use and must be appropriate for the circumstances of rural practice. This will only be achieved through consultation and engagement with rural doctors and rural stakeholders.

RDAA has received some positive comments from members who are using the PCEHR and who have now got to the stage where they are able to upload patient records efficiently. One doctor commented that *'the manner in which the whole PCEHR was set up was certainly insanely expensive, complicated, poorly explained and time consuming – However, now that my practice is PCEHR ready, the actual process of sitting down with the patient and uploading Patient Health summary is really very simple...'*

Unfortunately the majority of rural doctors who provided feedback to RDAA have been deterred by the apparent complexity and cost of the process.

Connectivity and integration with hospitals and other health services, including diagnostic services, is essential if rural doctors and patients are to derive maximum benefits from the PCEHR. As outlined above, many rural doctors work in a variety of health care settings and provide a range of clinical services in their communities. Given that they may treat their patients in a number of these settings, this connectivity would be a strong incentive to the uptake of the PCEHR in rural Australia.

Rural patients often travel to access specialist diagnosis and treatment, and the availability of records from these consultations should also be available on the patient's PCEHR in order to provide a comprehensive and useful health record.

RDAA believes that doctors should be reimbursed for the time taken to create a shared health summary for a patient. Practices, particularly smaller and isolated practices, should also receive appropriate supports to adopt the new technology.

Finally, the process for uptake needs to have a single, comprehensive information pack or online portal, with clear instructions and all forms. One person should be dedicated to each Medical Practice who is well trained in getting a practice ehealth ready.

CONCLUSION

RDAA believes rural doctors do not have a clear and common understanding about how the PCEHR system will work, and the expected benefits for rural patients. For example, when the PCEHR went 'live', many rural doctors had never received any information about how to upload a patient record, and the practicalities involved in PCEHR software and management.

This has given rise to a general level of cynicism about the project, especially in terms of the large amount of expenditure that appears to have been made with very little in terms of positive and useful outcomes. The process has created confusion for patients, irritation and costs for practice staff and distrust amongst the GPs of the security and privacy implications.

Practices are reluctant to commit time, resources and energy to the PCEHR system that presently remains in limbo and under review.

The below comments from a RDAA member summarises the experiences of many rural GPs:

"I'm a GP in a small rural community. I have not been involved in any of the roll out or product development. I followed it all in the media and decided to get on board [with what seemed to be] a worth while program immediately and get my PIP reward.

"[I] haven't seen such a shambles of a product launch for a long time. Absolutely useless and not a single patient enrolled or registered six to 12 months later.

"The system is slogging up my software. Every script printed warns me that the program is not operational.

"At the nursing home during offsite logging it freezes the whole program if I activate 3 or more items to print. I have to regularly force quit the program and start from scratch."

One member documented his convoluted journey through the process of implementing the PCEHR system within his rural practice. This journey is outlined at **Attachment A**.

There is considerable work to be done to gain the confidence of rural GPs and obtain widespread adoption of the PCEHR system. A good starting point is to engage rural GPs, simplify processes, pay them for they work they do to generate shared health summaries and explain how the system will add value to the care they deliver to their communities 24 hours a day, seven days a week.

ATTACHMENT A:

A RURAL DOCTOR'S PCEHR JOURNEY

- The GP was informed of a meeting with the Medicare Local representative regarding ehealth the afternoon before the date of the meeting. He spent his evening researching ehealth on the Internet to ensure he was up to speed at the meeting. He reports he learnt nothing extra from the meeting, only the ePIP deadlines.

- The GP then sat through 5 hours of webinars vaguely explaining the steps and deadlines for ePIP payments. He followed these steps and still missed important steps.

- Using the information he had gained so far, he then filled out forms to apply for the practice's HPI-O and acquired the doctor's APHRA user login information to recreate their HPI-Is.

- The GP also filled in and sent off forms to apply for RO and OMO. Later he discovered he needed to be an OMO so he could communicate with Medicare about the eHealth setup.

- The medical software vendor did not have their software ready till almost the first deadline to have it installed. They seemed to be under a lot of pressure and it appeared the software was released with too many bugs. His practice does not, as a rule, install the first build of a new full version and wished to wait for the release of the first 'service pack', as well the practice did not have the hardware to support the new software. In view of this, the practice missed the first deadline.

- The build, in particular, had lots of bugs and caused corruption of patient data. The GP believes the medical software vendors were put under too much pressure to have their software ehealth ready, so the software was released to meet a deadline without enough extensive testing. This in turn put practice data at risk. The medical software vendor did work extensively with them at times to try and fix the ehealth issues.

- The GP reports it took 7 months to get the code right in his medical software for the practice's HPI-O to validate, and then not by the vendor but by the practice's IT remote support personnel.

- The practice then it found they could not validate their HPI-Is and found they had missed the step to publish the GPs in the Healthcare Provider Directory, and had to fill in yet another form for each doctor, fax it and wait untill they were published. There was no notification that this was done once the forms had been faxed. The GP entered the HPI-I into the medical software each day till it would validate.

- The GP also had to apply for his own PKI and become an OMO so he could communicate with Medicare in regard to the practice's ehealth. This took two months to arrive. Several calls to Medicare were dead ends. He would call on a Friday and no one would answer after following the instructions of the automated voice. He would call one number to be told he needed to be transferred, and then talk to someone who ended up transferring him back to the first department who then didn't pick up his call. After several months he did speak to someone who helped him immensely and guided him through to getting the doctors validated.

- It was not evident to the GP that he needed 2 certificates, a location and a NASH. The Medical Software vendors pointed this out to him and another call and form were sent to Medicare.