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AMA Submission to the Australian Digital Health Agency to co-produce the National Digital Health Strategy

The development of a National Digital Health Strategy (NDHS) is an important and welcome step. The AMA has long and consistently advocated for a strategic plan for digital health.

The AMA also welcomes the commitment by the Australian Digital Health Agency to work with all areas of the community to ***co-produce*** the NDHS, based on collaboration on the design of future services.

Doctors are '***mission critical***' to this process and to digital health broadly.

Context

The AMA has engaged in various previous initiatives to refresh, update, and/or develop national ehealth/digital health strategies. These have included targeted consultations with senior AMA members (refresh of the national strategy, 2013), input to a draft National Digital Health Strategy (2016), as well as related matters such as the PCEHR Review, and submissions and other input to the Department and the Parliament on eHealth legislation in 2015.

While the current work to co-produce a NDHS is clearly a new initiative in its own right, it should be situated in the context of relevant previous work.

The NDHS should also note any current and anticipated health care developments that have specific implications for digital health initiatives, such as health care homes.

Issues that should be addressed in the NDHS

Based on the needs of its members, and experience with ehealth/digital health to date, the AMA considers the following matters should be addressed in the NDHS:

Aim of digital health and broader strategy issues

This first section of the NDHS is important – it should inform and set the logic for the strategy overall. It should set out up front that digital health is not an end in itself but instead is a key enabler for the delivery of better healthcare (more effective, efficient) to deliver better results or outcomes. For individuals, clinicians and the health system in general, the value of digital health initiatives should be the degree to which they enhance the efficiency and effectiveness of the delivery of healthcare for patients.

Medical practitioners view digital health as a collective name for a set of clinical tools that should assist the provision of clinical care. They must serve a clinical purpose, fit

into the clinical environment, support clinical workflow, and meet ease of use and integration requirements of medical practitioners and practices. This should be clearly acknowledged up front in the NDHS.

The digital health strategy should have a more balanced and complete coverage of health practitioners' needs, compared to the historic over-emphasis on patient–controlled health records (My Health Record - MyHR) and support for ehealth in general practice.

This must include specific support for **medical specialists** other than GPs to take up digital health, including but not limited to the MyHR.

The completed strategy should include a simple, straightforward list of the expected outcomes and benefits it will deliver.

The strategy should also recognise there is, and will continue to be, movement in the private and commercial sector which impacts on health care providers and strategy. It would be useful for the Strategy to outline what role ADHA might play in managing this.

New digital solutions and products change the way services can be delivered and the current environment is a bit of a directionless free-for-all, with large organisations setting up their own systems with the likelihood they will sit as silos of information and services.

The risk of lack of strategy is that the market develops in an uncontrolled manner, which has the potential to fragment care, and repeatedly disrupt and disenfranchise providers.

Engaging co-production

There is a need to create effective ways to better engage doctors and other healthcare providers in digital health – 'co-producing' should be the ongoing reality.

Co-production is therefore closely linked to governance. The AMA strongly believes that effective governance and effective co-production will both need 'real' levels of actual clinician involvement, both in the governance structure and as a network of advisers that are valued and actually listened to.

The AMA is aware of the long track record, both locally and internationally, of e-Health projects falling over for failing to consider the social aspects of development and implementation. Investment in co-production and governance with clinician involvement is an investment in the success of projects.

The AMA understands and respects the need to 'open-up' digital health to innovation, including with greater involvement of private industry. However, this must be balanced by genuine 'coalface' clinician involvement which understands the realities and safety issues of clinical practice and can apply this to digital health developments. If no other lessons have been learnt from Australia's approach to eHealth, clearly a "build it and they will come" approach, without coalface clinical involvement, will fail.

Coalface involvement in planning does not stop at the 'strategy' level; there is a need for (co-produced) development and operational plans so providers can see where critical services are heading over what time frame and what this means for them. Issues raised by clinicians at the coalface must be addressed, not sidelined. Many doctors and other healthcare providers have a level of scepticism about high level strategy documents, preferring instead to have access to a simple, clear, prioritised and costed list of projects with tangible products and benefits able to be understood by the non-technocrat.

Where there are different, or potentially different, views on strategic and operational issues among co-producers they should be promptly identified and dealt with directly and transparently.

Doctors' digital health needs

Doctors want digital health that supports and enhances their capacity to provide health care.

Doctors' digital health needs extend beyond having secure access to all the 'data, information and knowledge' they need[1];

Just as importantly, they also need access to digital technology and digital health systems and services, including effective implementation support, to provide safe and high quality care to people who use healthcare services.

Progress to date

It is important to be realistic about the foundation elements of digital health and not to overstate their success to date, as the basis for future work.

By some key measures the My Health Record has had a problematic implementation history, with uptake and meaningful use restricted by significant levels of provider and consumer reluctance.

While welcoming the (eventual) move to opt-out participation, the AMA has consistently argued for enhancements to the My Health Record model (for example, around the need for core clinical information, not subject to access controls), and for practical recognition of its usefulness (and limitations) as one source (not the source) of clinical information.

Given this, the My Health Record should not be portrayed as, or assumed to be, a 'real time' or complete record of a patient's relevant health information.

The NDHS should 'nuance' key messages where appropriate. For example, while recognising that giving people 'more control of their health and care when they wish', can be a major benefit, it should also recognise this does not necessarily 'empower and support the care professionals who serve them'[2], nor does such control automatically result in better health.

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[1] Australian Digital Health Agency, *Your health. Your say* p 1
[2] i*bid,* p2

Investing in digital health knowledge and skills

At least as much as (if not more than) any other service industry, health care needs doctors and other healthcare providers who have digital health knowledge and experience and can act as knowledge brokers or translators to inform and translate, demonstrate and convince more novice users and peers about the benefits of digital health and the practicalities of how to take-up new services. This role is sometimes referred to as people 'spanning' across the digital and business (ie clinical) worlds.

The NDHS should recognise this need and include strategies to address and develop these capacities.

Schedule of work done/to be done

A significant source of frustration with the PCEHR and MyHR was the absence of information about current and future enhancements. One example was information on the status of the model for pathology and diagnostic imaging uploads (after significant work and major input by doctors over many meetings).

The value of the NDHS will be enhanced if it includes, or is supported by, a clear and simple statement of the major digital health initiatives and enhancements that are planned to be implemented and in what timeframe, both with development of the MyHR and other digital developments.

There should be a documented forward plan for development of the MyHR, with timelines for additional functionality, including eg diagnostic imaging and pathology uploads.

The MyHR should contain core clinical information that is not subject to access controls (refer to *AMA Position Statement Shared Electronic Medical Records* 2016).

The strategy should include a schedule to move to a full opt-out basis for participation in the MHR.

Similarly, the NDHS will be greatly facilitated by including a simple, straightforward list of the expected outcomes and benefits it will deliver.

Implications for health financing and funding models

The NDHS should also clearly acknowledge that digital health has important and direct implications for the way healthcare is organised, for health financing and funding, and for existing payment models. It should explicitly identify the need to carefully identify implications for payment models for clinicians of coming digital health initiatives.

For example, under some initiatives clinicians will be doing much if not most of the inputting of data - work which is for the benefit of patients. In addition, digital health will likely involve clinicians doing a lot of work in communicating with a patient who is not present in the consulting room- e.g. communicating with the patient by secure messaging.

Funding models - which currently don't even fund phone calls- will need to support this new clinical activity, including by dealing with and responding to new expectations (such as patients who may have an unreasonable expectation that they will be able to contact the doctor without having to see them and without having to pay for their time and skills). The NDHS must seriously look beyond digital health itself and identify the major impacts of its proposals on healthcare broadly. This includes considering how funding models will be impacted by and will need to support the strategy and specific initiatives.

The privacy, security and compliance requirements applying to digital health are complicated. There is a clear need for simple guidance on these requirements that is easy-to-access, easy-to-understand, unambiguous and straightforward to implement. Without such guidance, these requirements can become a major impediment to participation and active use. Requirements that are difficult to understand, combined with severe penalties for non-compliance, are a powerful disincentive to participation.

Specialists are crucial to the success of digital health and MyHR, meaning there is a clear need for specific support and incentives targeted at specialists.

<u>Clinicians views of digital health needs and ideas for future directions</u>

AMA committees and individual members have identified and suggested potential digital health needs and future directions for clinicians. There is scope to build on these views through broader and more structured digital needs assessment processes for the medical profession. The National Digital Health Strategy should include such mechanisms as a critical element of ongoing digital health strategy and capacity.

In the meantime, the following suggestions, which come from considerations by various AMA committees and from individual doctors (including in a consultation videoconference with ADHA on the development of the Strategy), are indicative of doctors views:

There is a need for doctors to be able to get information faster, without having to chase up specific individuals and organisations, and without having to define their requests using complex rules or descriptions. Faxes should become obsolete. A doctor who is on call but away from their practice should be able to receive a call from a patient, have access to their notes through their phone and take any necessary action.

Clinical practice must be supported by an effective and functioning register of health care providers that enables doctors to quickly and seamlessly find the right information for the right person (patient/physician), together with details of their availability/waiting time, service details including consultation costs, extra services, locations etc.

Digital health must support and deliver “Real Time” shared information eg **shared care plans** with real time data, which can be used to involve patients, to plan and provide preventative, reactive, predictive, prompting actions/changes by patients/carers. Plans with real time data go well beyond passive record systems with historical point-in-time data, such as the My Health Record. Historical data such as data contained in PDF’s in

the MyHR must always be re-interpreted, often requiring informed speculation as the patient's circumstances at the time the data was captured, and then re-input to the system.

It may be timely for the Strategy to reassess the continued value of MyHR, as currently designed, meeting current and future requirements. For example, does the MyHR actually enable sharing information in a timely and useful manner? Should the MyHR be able to provide other real-time functionality such as automatic notification (eg to nominated GP/practice) that a patient has checked in to an Emergency Department?

Electronic health records should also provide portability and safety, and assist in how to provide medical care and services to the mobile and technically illiterate populations, such as 'grey nomads', homeless, indigenous etc.

Secure messaging, supported by fully functional provider registries, should be readily available to all doctors.

The MyAgedCare Gateway should be combined with MyHR, incorporating a full view of the resident's medical records/care/treatment, and giving a full and holistic view of all health and care providers involved in the patient's care and what they are providing.

The Strategy should directly address the need for practical resources for specialists/doctors eg consent forms, uploading of digital imaging reports, email templates etc. Practices should not have to invent these themselves.

These resources should also include very clear and accessible guidance on understanding and meeting the Government's privacy and security requirements.

The Strategy should clearly identify what standards are required to support digital health, including connectivity and interoperability, and by who and how such standards should be developed.

In addition to the general points above, internal consultation and digital health strategy input from AMA members identified a range of more specific developments and directions that should inform the strategy, including:

- Development of the MyHR, mobile services , secure messaging and functioning provider registries, making care plans available through digital platforms (web-based, mobile apps, link with wearables/BT devices) and more usable, timely and dynamic, with biometrics, including to support the health care home
- Interoperability of systems
- Safety, real time monitoring, PBS data dumping into the MyHR in structured way i.e. diuretics prescriptions that details a patient having more than one type, getting advanced care plans onto the MyHR
- Ready access to clinical software that meets standards
- Support for technology-based consultations

- Ability to transmit clinical information securely and universally (secure messaging/email)
- standardised medication records, digital referral systems
- remote electronic prescribing
- Ability to access all of a patient's clinical information wherever generated/captured, starting with hospitals
- Electronic directory of providers/organisations
- Shared electronic medical record as per AMA Position Statement
- Other ehealth functionalities and tools, which could include eg:
  - ehealth access to best practice/therapeutic guidelines
  - clinical assessment tools
  - decision support software
  - care planning tools
  - clinical audit tools
  - communication of health alerts
  - Clinical **images** - capture/store/retrieve clinical images as part of the patient record
  - Improving e-discharge summaries that meet the needs of doctors, rather than hospital coders.

Conclusion

The AMA welcomes the development of a National Digital Health Strategy and looks forward to a genuine and ongoing effort of *co-production*.

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