AMA

AMA Submission on the PIP eHealth Incentive

October 2015

Introduction

The purpose of the Practice Incentive Program (PIP) eHealth Incentive must be to build and support the capacity of general practice to utilise eHealth technology to enhance the level and quality of patient care.

The AMA has long argued for appropriate financial support to encourage GPs to take up the electronic health record. However, we do not agree that the PIP e-Health incentive is fit for this purpose. Contrary to the Government's policy intent, it will not encourage GPs to make active and meaningful use of the My Health Record (MyHR). There are fundamental issues with the design of the MyHR that are yet to be fully addressed as well as more relevant funding avenues that could be utilised to much better effect.

The PIP is directed to practices and there are varied arrangements in place that govern whether or not some of this funding flows to the GPs working in these practices. This is fundamental weakness when trying to use PIP to drive GP behaviour as it is practitioners, not practices, who upload the clinical content of Shared Health Summaries (SHS) to the MyHR. The AMA believes that a superior option to encourage and support this work would be to remunerate the practitioner through an MBS item and a SIP payment. This would support all practitioners to upload to the MyHR, including those working in unaccredited practices.

MyHR not fit for purpose

An effective e-health record must be easy to use and provide clinicians with relevant and accurate information that can benefit patient care. Current problems with the existing MyHR include:

- Patients can remove information from view, making the clinical record potentially incomplete and of no clinical value;
- Clinicians viewing the record are unaware if information has been removed from view;
- Radiology or Pathology results are yet to be made available to the MyHR;
- SHS are static documents and quickly out of date;
- Inaccurate data uploads presents clinical risks; and
- Most patients (up to 90%) don't have a MyHR and are unlikely to under 'opt-in' arrangements

Until these problems have been rectified MyHR is neither a meaningful or functional tool, and it is unreasonable to expect GPs to actively use it. Indeed, as one member put it when responding to calls for feedback on this consultation "*If GPs thought it was goer we would have jumped on it to help care for our patients*."

Even those GPs that have sought to engage with the e-health record are becoming increasingly disillusioned. One member who was using recommended templates and procedures, was audited and advised by the Office of the Privacy Commissioner and still found to be wanting. Recommendations from this audit included:

- All doctors using the system need regular training in patient confidentiality
- That this must be documented before they are allowed to use the system

- To keep a separate logbook of interactions with patients eHealth record.

Not surprisingly, this member has now abandoned its use.

The Department must recognise that there is a lot of work to do in the face of previous failures in implementing a relevant, accurate and interoperable eHealth record, and that encouraging a disillusioned and sceptical profession to start actively engaging with the MyHR needs to address these. Trust and understanding are fundamental to the engagement of the profession going forward not just rigid and difficult to obtain financial incentives

If the MyHR is easy for practitioners to utilise, the information it contains is reliable, the system and record transparently interoperable, and practitioners can quickly and clearly recognise how it will enhance patient care then they will readily engage with it. However, we know that the MyHR is none of these things and using the PIP incentive to try and mandate use of the MyHR will not solve this.

Rather than using the eHealth Incentive to drive usage it would be better to focus on supporting practices to embrace and utilise other eHealth technologies. This will enable a greater range of services for patients and enhance patient access to care.

Recommendation 1

Current requirements for the eHealth Incentive should remain unchanged until such time as the My Health Record is an easy to use, clinically relevant and reliable, and an interoperable eHealth record for the majority of the population (ie for all patients other than those who choose to 'opt-out').

Recommendation 2

The Government's primary and initial focus should be on make the necessary improvements to the MyHR.

Recommendation 3

The Department start exploring changes to the eHealth Incentive that would facilitate the use of eHealth technologies to enhance patient care from and access to their usual GP.

Timeframe for implementation of revised criteria

The Department proposes to give general practices three months' notice to prepare for any revision to the requirements. A February implementation date is completely unrealistic for two reasons being:

- In addition to the necessary improvements referred to above, any changes to the requirements of the eHealth incentive should be informed by the outcomes of the Opt-Out trials.

- This period includes the end of year/new year holiday period and is the worst possible time of the year to introduce significant changes such as those proposed.

Recommendation 4

That the Department at a minimum delay the start date of any revised eHealth Incentive as per Recommendation 1 until there is a commitment to move the MyHR to an 'opt-out' basis but preferably until after the outcomes of the Opt-Out trials are known. The eligibility requirements for any PIP incentive should be advised at least 6 months in advance with a clear communication strategy to all GP's.

Criteria for change

The AMA agrees that the existing criteria 1 to 4 of the eHealth incentive should be retained. Primarily, because these are the enablers for access to the MyHR and for sharing securely sharing relevant clinical information with those involved in the patients' care.

Changing criteria 2 as outlined in the discussion paper is premature. General practices are the only health care providers with the capacity for secure messaging and while ever this is the case, its use will be limited. However, this criteria should be retained to ensure that the first layer of capacity is in place while the Government addresses how it will extend support to specialists, allied health providers and other health provider organisations so that they can securely communicate with GPs.

As already mentioned the AMA believes that active and meaningful use of the My Health Record should be supported with a MBS item number and a SIP.

Furthermore, Requirement 5 already requires that compliant software is used for the creating and posting shared health summaries.

Recommendation 5

That the Department refrain from amending Requirement 2 to include demonstration of active and meaningful use until specialists, allied health provider and hospitals can securely interact with GPs via secure messaging.

Recommendation 6

That a MBS item number and SIP be introduced to support the active and meaningful use of the My Health Record.

Recommendation 7

Leave Requirement 5 unchanged as it already requires the creating and posting of shared health summaries but if the Department is determined to link the incentive to greater usage it should focus on the simplest and most relevant measure possible.

Demonstrating active and meaningful use

The AMA agrees that in the first instance active and meaningful use should be defined as the contribution of SHS to patient records. The core information that will most assist another medical practitioners will be that which is contained in the shared health summary. In addition, the uploading of the SHS is a sensible introduction to the role of the MyHR.

When other document types, particularly hospital discharge summaries, pathology and imaging reports, and other key information such as Advanced Care Directives become readily available and accessible in the system, the AMA would expect usage of the MyHR to increase. Provided these documents are readily accessible and support the clinical care of the patient they will be readily used and it should not be necessary to revise the requirements in future years to include them.

The purpose of an incentive is to encourage use – not to set a hard target. An effective MyHR system will attract and generate usage in its own right.

While the activity of uploading or viewing other documents can be recorded in the systems log, measuring how that information was meaningfully used is impossible due to its subjective nature.

Choosing the patient base

Having outlined the lack of necessity in revising Requirement 5, the following comments on the selection of a patient base should not be regarded as an endorsement of this measure. They are provided only to the extent that the Department appears intent on pursuing changes to the eHealth Incentive at this time, notwithstanding our fundamental concerns about this policy direction.

The care of patients with a chronic disease, particularly those who are at risk of hospitalisation, would appear to benefit most from having a SHS uploaded to the My Health Record. Having said that a SHS for a patient with a medication allergy, but who is otherwise in good health, would also benefit their future care, particularly if they are un-expectedly admitted to hospital or require care from someone other than their usual GP. Regardless of what patient base is chosen GPs must be able to exercise their discretion as to which patients they will upload a SHS for.

Future reforms from the Primary Health Care Review may create a more appropriate, contained and discernible patient base than those presented in the discussion paper.

GPs and their staff should not be tasked with assisting patients to register for an eHealth record. This is not a clinical role and the responsibility for encouraging and supporting people to register appropriately lies with the Government.

There is no information in the discussion paper about the volume of work this would entail, and no clear rationale for why the GP workforce should take on this government responsibility.

Members who have been involved with assisted registration tell us it is much more complex than it seems and one they would prefer not be involved with. The subtleties of the system and privacy requirements are more than clinicians or their staff should be expected to cover with patients on behalf of government, with no compensation for time required, to ensure informed consent. In addition, there is no measureable way to record that assistance was rendered.

Recommendation 8

Choosing a patient base should be put on hold until the outcomes of Primary Health Care Review are known as this may provide a distinct patient base, ie patients registered with a Medical Home.

Recommendation 9

That assisted registration is an administrative task that Government through the Department of Human Services should be tasked with and funded to provide.

Measuring active and meaningful use

The AMA appreciates the Department's acknowledgement that training should be made available to practitioners to assist them to transition from readiness to active use. Not all practitioners will need training and it therefore should not be mandatory.

Making effective training readily available to those who need it would be more in line with supporting practice capacity than setting an arbitrary target for SHS uploads.

In relation to the measuring meaningful and active use questions we advise:

- Training should not be linked to the eHealth Incentive as a requirement.
- There should be no upload target with the priority being to make the MyHR fully functional and easy and attractive to use (including 'opt-out' and core clinical information).
- The eHealth incentive is currently correctly focussed on capacity; to support "meaningful use" it should include incentives for individual practitioners (ie a MBS item and a SIP).
- Meaningful use, as included in the discussion paper, can be a misleading term. It does not relate to and cannot measure the clinical value of the interaction with the information in the MyHR. If the information in the MyHR is not useful information to clinicians then they will not use it.

For these reasons the AMA does not support the setting of targets for this incentive regardless of whether those targets are based on a fixed number, or proportion of patient population or patient type.

Targets can be useful when they relate to a mature, sensible and easy to use clinical service. The imperative with the MyHR is a universally accessible and useful clinical resource to facilitate better patient care and outcomes. This is not achieved by setting arbitrary targets to compel clinicians to use a sub-standard product of low or no clinical value.

Recommendation 10

Give further consideration to how the eHealth incentive could be redesigned to support ongoing eHealth capacity and use.

Choosing a timeframe

The AMA would not recommend shifting eHealth Incentive payments from a quarterly basis to an annual basis due the negative impact it would have on practice cash flows.

Recommendation 11

Retain quarterly payments unless changed warranted by a redesigned eHealth incentive.