

# Australian Government Department of Health - General practice data and electronic clinical decision support – Issues Paper

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## College Details

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## Initial Comments

ACRRM welcomes the opportunity to provide feedback on the Issues Paper relating to general practice data and electronic clinical decision support.

Data collected from general practices and more broadly across Primary Care is important in providing detailed information on the diversity of practice scope occurring in primary healthcare practice models. Particularly demonstrating the Rural Generalist model of care that often occurs in rural and remote areas where the scope of primary care necessarily extends into secondary and tertiary care as well as to allied health areas in order that patient needs can be met.

Care needs to be taken that the data collected, and the information produced is accurate in defining the essential healthcare and service needs of communities to inform planning, training and resource allocation. The risk of primary care data only reflecting urban trends should be mitigated to avoid the rural context not being reflected in the outputs

The College supports the importance of general practice data in informing policy decisions regarding sustainable business models for primary care practice especially in rural and remote areas which have distinctive practice challenges. It is Importance of having a consistent definition of Primary Care and its scope. A lack of definition leads to a risk that these datasets misrepresent what services are provided and needed.

## Policy objectives

1. Do you agree with the policy objectives outlined?

### Policy objectives

General practice data provides a range of benefits to primary health care stakeholders, including improved patient treatment and care, general practice quality and business improvement, better access by patients to their own information and improved service and system planning.

The Department is proposing the following objectives for the sharing of general practice data to allow these benefits to be realised:

- ensure general practice data is available into the future to support GPs, PHNs and other health system actors to carry out their respective roles and participate in continuous quality improvement at individual practice and regional, jurisdictional and national health system levels
- ensure any access to or sharing of general practice data is conducted safely and securely and that privacy continues to be protected, including through effective de-identification of personal information
- ensure that the safe, secure sharing of de-identified general practice data is not inhibited by systems or costs
- support continuous improvement in the quality and comparability of general practice data.

2. Are there other objectives Government should consider?
3. Are there other current or potential future benefits or uses of general practice data that should be considered?



The College would highlight the following additional benefits to using general practice data that have the potential to broaden the scope of the policy objectives.

- The ability to take a population health approach and tailor services to meet the needs of a community.
- Monitor appropriate equity and agency for patients and providers in accessing health services.
- Support the workforce in meeting the healthcare needs of the community and that the community can attract and retain the health professionals it needs to meet their healthcare needs.
- Identify workforce education and training needs to ensure patient treatment and care is delivered to meet best practice guidelines.

Suggestions of other policy objectives for consideration.

- Informing policy decisions regarding sustainable business models for primary care practice especially in rural and remote areas which have distinctive practice challenges.
- Demonstrating the value and scale of the contribution of primary care to overall patient care.

## Governance arrangements

ACRRM would view it as essential that its representatives are included on any advisory group and working group. Our several thousand rural doctor members have a unique perspective which has major implications for the care of people in rural and remote communities that currently experience considerable inequity both in terms of healthcare services access and health status.

## Some issues with current general practice data arrangements

4. What aspects of the current system in relation to general practice data work well?
5. What aspects of the current process in relation to general practice data are of concern?
6. What general practice data should be shared, with whom and for what purposes?
7. Under which conditions should governments have access to aggregate general practice data?
8. Are there any issues not covered above that impact on ongoing access to general practice data?
9. What is the single, most pressing issue facing ongoing access to general practice data?
10. What upcoming developments may impact the flow of general practice data?

The Rural Generalist model of care that often occurs in rural and remote areas of Australia is where the scope of primary care necessarily extends into secondary and tertiary care as well as to allied health areas in order that patient needs can be met. It is important to identify the full scope of what primary care doctors, nurses and allied health professionals do and mapping the patterns geographically.

The sharing of general practice data (if key data / information was recorded) would support identifying evidence of service gaps/opportunities for primary care particularly outside major cities (e.g. number of potentially avoidable patient transports, use of locums, patient visits to specialists in cities etc.)

We see considerable risk that the proposed emphasis on GP data only, will lead to omission of data from many other important sources of healthcare services that occur in rural areas (AHS's, hospitals and state-run healthcare centres, nurse-led clinics). The College supports the GP to PHN flow model only on the understanding that there will be policy and processes in place to incorporate data from other important sources.



#### Additional sources of primary health care data

- Jurisdictional hospitals and healthcare centres – recognising that emergency healthcare, afterhours care, obstetrics and gynaecology, surgery and anaesthetics are all commonly delivered in these workplaces by general practitioners as a natural extension of their primary care practice. Also recognising that healthcare centres may provide primary care led by nurses and other health professionals.
- Aboriginal Community-Controlled Health Organisations
- Aged care and disability care centres
- Aeromedical services including the RFDS
- Telehealth services involving combinations of different healthcare practitioners
- Australian Defence Forces medical services
- Prisons
- Not-for-profit charity sector provided services (e.g. travelling health trucks)
- Nursing, allied health and dental services

There is a risk that the proposed GP data is based on a fairly narrow definition of the scope of primary care. It would be important to understand and recognise how care may be delivered differently in a rural or remote setting for example that Point Of Care Testing (POCT) may occur within the practice, that the general practice staff may be performing procedures in the hospital, and also to allow for the complex interactions that may occur between the various healthcare team members through telehealth consultations. It is also important to remain adaptable to any future models of healthcare that will be delivered differently from today.

When stakeholders use general practice data it is important that any findings are shared back with the data source organisations. There must be value in the provision of the data, in the first place and, importantly for the stakeholders to receive confirmation that the findings (interpretation) from the data is agreed to by the data source organisation.

We see value in incorporating PHNs as locally-based providers of service, that would be able to review and assess the quality of the data before it was used and could also provide some local on the ground support with data recording and data provision and action following feedback.

#### Areas of concern include

- aggregated primary care data is overwhelmed by urban trends and does not reflect rural and remote practice and patient needs
- the data can only reflect what services are being delivered and this data is often used as a proxy indicator of what services patients' need. In rural and remote areas patients commonly go without access to many services considered essential in cities. There's very little evidence that data is being recorded when services are not provided or they weren't available and why.
- primary care is the frontline of healthcare services and is necessarily broad and flexible to meet the needs of communities in their diverse contexts. There does not appear to be a clear and comprehensive definition of primary care – its scope, constituent parts, targets and outcomes. The broadness and diversity of primary care makes it difficult to define and there is considerable risk that a data set based on definitions which are too narrow will misrepresent what services are provided and what services are needed.
- ensuring that the data-set scopes the full range of areas of practice/services that are provided by primary care doctors in non-urban contexts including (Rural Generalist) areas such as emergency medicine, mental health, obstetrics and anaesthetics where they are provided by general practitioners as essential primary care in rural and remote areas. Data should also scope the distinctive roles of nurses, Aboriginal Health Workers and allied health workers that occur in rural and remote areas.



### Additional Risks

Rural and remote locations are made up of low population numbers which can mean their information could be statistically insignificant.

The biggest risk is producing information which gives an inaccurate or distorted picture of primary care and especially patient need and will be in a position to contribute to a worsening of public policy decisions and actions.

These risks can be mitigated by:

- Ensuring appropriate and broad stakeholder engagement and input both in development and delivery. We would view the ACRRM membership of rural primary care doctors and rural generalist doctors as having an important perspective which should be given consideration.
- Identifying the full diversity of primary health care delivery contexts including
  - Population size and geographical spread
  - Visiting services
  - Health lifestyles
  - Culture
  - Access to services and quality foodand ensuring the data can be collected and subsequently separately interrogated according to these contexts.
- Providing a focus at all levels of operation to the potential for distortions and ensuring that aggregated data is presented in a manner which will not lead to misinterpretation.

## Examples of systems and solutions implemented overseas

11. Are these examples relevant to Australia?
12. What other examples might inform the secure future for general practice data in Australia?

Primary Care is funded and delivered differently in Australia compared to the UK and NZ making a comparison with these countries difficult. We would be supportive of defining the Australian criteria for Practice Management Systems (PMS) that are fit for purpose and having a panel of approved PMS available for selection when procuring and implementing a new system. It is worth noting that organisations procuring new systems are unlikely to include the requirements of a third party in their selection of a system unless the needs of the third party (such as ones extracting data to use outside of the PMS) were mandatory.

The strategic plans of the Commonwealth for digital health, digital economy and healthcare workforce should all be influencing the goals of primary care including their collection and use of data.

## Electronic clinical decision support (eCDS) for GPs at the point of care

13. What aspects of the current system in relation to eCDS work well?
14. What aspects of the current process in relation to eCDS are of concern?
15. What upcoming developments may impact eCDS functionality and integration into clinical workflows?

Rural doctors use eCDS in their patient consultations and in their population health activities to assist with complex decision making for an accurate diagnosis and treatment plan and screening for



preventable diseases. The prompts from the eCDS assist to identify appropriate interventions, medicine dosage and administration, potential adverse drug events and locally supported pathways to access services.

The aim of the eCDS is to improve the safety and quality of decisions made about diagnosis, treatment and prevention. Not only should they recommend actions to be taken but also prevent over prescribing of medications and investigations (pathology and diagnostic imaging)

Not all eCDS are the same in their output and their user interface design. Most importantly for the rural context is the inclusion of clinical guidelines that support Aboriginal and Torres Strait Island people who have specific responses to treatment that need to be considered.

Appropriate clinical guidelines for Australians and those living in rural and remote communities need to underpin the eCDS to ensure patient safety and quality of care.

There needs to be consistency in the eCDS used across all health care organisations so that the systems are providing the same consistent advice as the patient moves from one healthcare setting to another

In addition to locally applied eCDs used in the local medical record system there needs to be improved integration with other medical record sources such as My Health Record to ensure all known information about a patient is taken into account. For example, recent medicines that exist in the patient's My Health Record (and not in the local PMS) should be used by the eCDS when prescribing takes place. This would assist to minimising the number of medication safety events and support the prescriber in assessing the complete medication plan with the patient. Developments of this nature have started to take place with the development of real time prescription monitoring solutions for high risk medicines

## The current regulatory framework for eCDS

16. What do you think is the appropriate level of Australian Government involvement in the governance/oversight of eCDS?

Current systems would benefit from improvements in the design of the user interface so that the presentation of health information and its associated alerts and warnings were delivered in a consistent manner. This removes the need for the health workforce to learn the nuances of each system, which builds frustration and likelihood of turning off key features when they are not seen to be providing value (from a quality and safety perspective). Doctors in training, in particular, work in a number of different settings and are exposed to using different systems each with their own user requirements. This lack of consistency in the user interface and functionality is a safety risk where human error is more likely to occur due to the complexities of having to learn the many different systems. The College recommends these systems be intuitive to use and consistent in the way they present information and interact with the user.

We would recommend that eCDS need to demonstrate conformance to a standardised set of Australian test cases demonstrating they meet the quality and safety requirements for the way healthcare is delivered in Australia. Including using terminology standards for medicines and pathology and including Australian specific clinical guidelines such as those that relate to Aboriginal and Torres Strait Islander people.



## Some benefits, issues and challenges with eCDS design and use

17. What do you see as the benefits of eCDs use for shared decision making at point of care?
18. What do you see as the issues/challenges of eCDs design and use and what are the associated impacts?
19. Do you have any suggestions as to potential next steps to address any identified issues and challenges?

Several current issues and concerns with using an eCDS can be eliminated by setting Australian design standards for eCDS and for vendors to either demonstrate conformance to the design standards or for the eCDS to be rated against the standard.

Through our involvement with the CSIRO project to develop a minimum data-set for the transfer of care it is clear that more PMS vendors and eCDS vendors are willing to enhance their software in a stable environment of standards and compliance/conformance. The most recent enhancements to produce electronic prescriptions and the introduction of active ingredient prescribing has shone a light on the need to use national terminology to deliver an integrated solution across both prescribing, repository and dispensing vendors. This creates an ideal opportunity to further build on these developments and to have eCDS solutions leveraging off these developments.

## Some opportunities

20. Are there other levers the Government should consider introducing?
21. What impact might different levers have?
22. Which of these levers of change should be further explored and why?
23. What specific options might be considered?

The College supports the importance of improving the digital health literacy of rural and remote communities, which includes patients, providers, carers and the community more broadly. The awareness, education, training and support needs to be provided at the community level and for the community to work together on the input of data and the output of information in a number of different systems in a way that enables interoperability and supports shared decision making.

The College's involvement in the Australian Digital Health Agency 'Communities of Excellence' program demonstrated what can be achieved at the Community level and the College subsequently produced draft standards and guidelines for a digitally connected community. There is significant power in orchestrating change at the community level.

## Final Comments

ACRRM is pleased to support this review of primary health care data and the use of electronic clinical decision support systems as a mechanism to improve the understanding of the nature, importance and diversity of primary care in Australia and to hopefully direct policy towards understanding its importance and better supporting the people most in need.

We would emphasise that people in rural and remote Australia and especially Aboriginal and Torres Strait Islander people generally have a lower socio-economic status relative to their counterparts in major cities and experience significant inequity both in their access to government supported health services and in their health status. The lack of information recorded (that could be attributed to a lack of services) may not be a good indicator of what is needed. There would be a risk in making policy decisions based only on what services are provided, rather than what is needed and that data needs to be collected to support the need in addition to provision.