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National Rural Health Conference
Australian Journal of Rural Health

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Submission to the Personally Controlled Electronic Health Record (PCEHR) Review

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This Submission is based on the views of the National Rural Health Alliance but may not reflect the full or particular views of all of its Member Bodies.

About the National Rural Health Alliance

The National Rural Health Alliance is made up of 36 member bodies, each a national body in its own right, representing rural and remote health professionals, service providers, consumers, educators, researchers and Indigenous health interests (see Attachment A). The vision of the National Rural Health Alliance is good health and wellbeing in rural and remote Australia.

Alliance involvement in the PCEHR to date

The Alliance has welcomed the significant investments in eHealth made by successive Australian Governments over the past two decades, as eHealth has great potential to contribute to improving health outcomes for the more than 6.7 million people who live in rural and remote areas.

The Australian Government has played a leading role over time in the implementation of eHealth in this country. It has led the computerisation of general practice supported by practice incentives to increase technical capacity among health professionals, established NEHTA with the jurisdictions to build the technical foundations for the Personally Controlled Electronic Health Record (PCEHR), led the development of the National E-health Strategy and the engagement of the information technology sector in the practical solutions for health that are starting to be implemented.

These investments must continue to be realised. Coupled with the expansion of practical eHealth solutions, the eHealth record system will be particularly valuable for people from rural and remote areas. This is because they often have to travel away from home for health care. When this happens the eHealth record can ensure that the health information needed is readily available as they move between their local health professionals and regional clinics, specialists and hospitals, or is provided by visiting or outreach health professionals. The electronic health record will also be particularly valuable to people in areas of workforce shortage where there is a strong reliance on short term or locum health professionals.

Addressing the review areas

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

Given the scale and complexity of the PCEHR project the level of consultation with this organisation and rural stakeholders has been reasoned and appropriate. The length of the project and the adoption into local areas was always going to be incremental over 10 year timeframes and not a short term rollout. Increased awareness and understanding of what the PCEHR can deliver now and as its functionality increases will be absolutely necessary for its widespread implementation and adoption - and will take considerable time.

The Alliance developed a position statement, *The rural and remote implications of a national e-health strategy* in 2009 and has since provided representation on key eHealth committees, speakers at numerous national stakeholder conferences and events, worked with NEHTA to convene a national rural consultation in Alice Springs and provided detailed submissions on considerations from a rural and remote perspective during the development of the PCEHR and the introduction of the legislation and the rules.

In addition, the Alliance has played an important communications role with rural and remote networks during this long lead time. For example, the Alliance has regularly included articles

in its *Partyline* magazine with a hard copy circulation of more than 12,000. E-health and the development of the PCEHR have featured at successive biennial National Rural Health Conferences, generally attended by more than 1,000 people from all parts of Australia. Presentations and displays have included the NT adoption of eHealth records over more than 10 years, NEHTA's progress with foundations for the PCEHR, the development of telehealth and the role of rural health professional organisations in supporting the adoption of the MBS items for telehealth as well as many more local applications of eHealth as they are put into place. We continue to provide information through eNews and on our website to put people in touch with information and developments in eHealth.

The level of use of the PCEHR by health care professions in clinical settings

Remote and rural areas in the Northern Territory already have access to an electronic health record, but this roll-out has taken close to 10 years. It is not surprising that understanding and adoption of the national PCEHR is growing gradually, given the long lead times necessary for raising awareness and for behaviour change. It is important to recognise that the level of uptake by health care professions also depends on the integration of the PCEHR into their usual work practices, the availability of practical applications that add value to work practices and patient care and for a growing body of users – both consumers and health care providers – so that there is useful information in the record to share. It is only a few months since the PCEHR-compliant medical software became available from the major software providers. The practical applications are coming on line gradually. It is entirely predictable that uniform uptake across rural and remote areas will take time and will need ongoing support for GPs and a range of other health professionals to get started, and will be enhanced by the improved utility of the PCEHR over time.

Barriers to increasing usage in clinical settings

The Alliance believes there are some particular barriers to increasing usage of the PCEHR in clinical settings in rural and remote communities that are worthy of special attention by the review, given that people living in rural and remote areas are among those likely to benefit most from the PCEHR's adoption.

For example, poor internet connectivity is a live and ongoing issue for private practitioners in many rural and remote areas and for conducting clinics in smaller towns and centres. Successful adoption of the PCEHR will rely on the health professionals available locally, such as remote area nurses, Aboriginal Health Workers and others who are not necessarily associated with GP clinics and the IT and other support available in larger general practices. Many of these other health professionals will face particular time issues with making changes, given health workforce shortages, higher mobility of staff in many areas and substantial travel times required to provide services across a wider area. In order to reach the full range of health professionals providing front line services in rural and remote communities and to increase their understanding and uptake of the PCEHR, particular attention will need to be paid to the use of communications and support networks that they already use and trust rather than standard city solutions.

The utility of the PCEHR for rural and remote health professionals will also be heavily reliant on its use in the public health system, where many of them do at least a part of their work. A slow flow of discharge summaries from hospitals - including metropolitan, regional and small rural hospitals - would be a significant barrier to the usefulness of the PCEHR for rural and remote clinicians and their patients.

Comments on standards for Terminology, language and technology
The Alliance has no specific comments.

Key clinician utility and usability issues
As mentioned above, it is critical that the PCEHR interfaces easily and effectively with existing systems and starts to be inclusive of health professions beyond general practice in order to reflect the range of health service providers in rural and especially remote communities. Further improvements to accelerate adoption of the platform are discussed below.

Key patient usability issues
The Alliance does not see PCEHR registration and use by rural and remote consumers as the rate limiting step. The targets for the first twelve months for consumer registrations that were set for the eHealth record when it was launched on 1 July 2012 were met in early July 2013. Patients make assumptions about the level of communication now and assume their information is transmitted between professionals. However, there is still limited awareness about the PCEHR, what it can provide now and what is expected in the near future.

Ongoing communications, information and support for people who live in rural and remote areas from sources they trust will continue to remain an important part of their increasing participation in the PCEHR over time. For instance, at the National Rural Health Conference in April 2013, more than 300 registrations for the PCEHR took place when the opportunity was provided.

Further suggestions for improvements that would help to accelerate adoption of the PCEHR by patients living in rural and remote areas are included below.

Suggested Improvements to accelerate adoption of the platform
The Alliance recommends consideration of a range of programs to target uptake of the PCEHR in rural and remote areas, given high need and potential to benefit from its adoption for people who live outside the major cities.

Incentives related to payments
There are a range of MBS items that could be varied to favour or be conditional on uploading of a health summary or use of the PCEHR including enhanced primary care items for chronic disease. There is also the precedent for items that target people living in rural and remote areas, such as MBS telehealth items for consultations with specialists – which are available in residential aged care facilities, through Aboriginal Health Workers and to people living in rural and remote areas.

The eHealth Practice Incentive program could be targeted to provide incentives for rural and remote health care providers.

The practice nurse incentive program could be tailored to include incentives for rural and remote practices to better use the PCEHR. This would be of particular value in recognising the additional time it is likely to take to implement the PCEHR in stretched rural practices.

The Medical Specialist Outreach Assistance Program should be updated to include an expectation of electronic communication.

The Alliance is keen to see maximisation of jurisdictional incentives to ensure the provision of electronic discharge summaries, for example through hospital accreditation processes or Activity Based Funding arrangements.

Ensuring that healthcare providers are engaged
The Alliance would like to see the Australian Government focusing its efforts and expenditure on the PCEHR on work to support and clarify the business case for primary care providers in rural and remote communities.

The PCEHR will offer most benefits when other primary care providers and specialists are inputting to the record and the jurisdictions are providing the links with hospital acute care. Electronic discharge summaries from hospitals are crucial and their provision can be targeted and measured.

The communication of that information and the value case to providers should be the first key message: "*This record will help your patient and will involve and allow review of recent hospital discharge information"*. Emergency Departments would be a good place in which to start raising the profile of the PCEHR, concentrating on those with chronic and complex conditions requiring multiple attendances. This group may well be enrolled in programs to minimise avoidable hospitalisations via Medicare Locals and state health services.

The encouragement of uptake among other identifiable target groups that are likely to benefit particularly from the use of the PCEHR will also be a part of the business case. This focus might include people who live in rural and remote areas, especially those with chronic and complex conditions, older people including those in residential aged care facilities, defence families, and children in out-of-home care.

Increasing the utility for health consumers
The availability of advanced care directives would add significant value to the PCEHR for many consumers and would provide particular value for consumers living in rural and remote areas who may be far from home and friends and family when this information is needed.

The availability of pathology, radiology and medicines dispensing information in the PCEHR would also add particular value for rural and remote health consumers as they move across the health system and between a range of health providers who are not local or regular providers of care.

Also, given the high mobility of many rural and remote health consumers, an App. to ensure easy access to their medical record through mobile devices would be a particular advantage.

Incentives related to major national aged care and disability programs
The launch sites for the National Disability Insurance Scheme provide a potential opportunity for building in information about and encouraging the use of the PCEHR as the new system unfolds and the links are made between health and disability care. This is particularly important in rural and remote areas where services are short and many of the service providers are working across health, aged and disability care.

It would also be particularly useful to people living in rural and remote areas to have the PCEHR integrated with the new Aged Care Gateway, given the links between aged care assessments and health needs for older people. The waiting times for aged care assessments

and for access to aged care once the assessments are made are substantially greater than for the cities (COAG Reform Council Rural supplement to the National Healthcare Agreement Performance Report for 2010-11). Avenues to improve access to Aged Care Assessments in rural and remote areas through the Gateway, such as upskilling of local aged care providers, are being considered and may provide some synergies for better information about the PCEHR.

Conclusion

The Alliance stands ready to continue to support the Australian Government in its work with the jurisdictions on the implementation of the PCEHR. Now is the time to ensure the improvements underway in our health, aged care and disability systems translate into 'a fair go' and better health outcomes for rural people.

Attachment

Member Bodies of the National Rural Health Alliance

ACHSM	Australasian College of Health Service Management (rural members)
ACN	Australian College of Nursing (Rural Nursing and Midwifery Community of Interest)
ACRRM	Australian College of Rural and Remote Medicine
AGPN	Australian General Practice Network
AHHA	Australian Healthcare and Hospitals Association
AHPARR	Allied Health Professions Australia Rural and Remote
AIDA	Australian Indigenous Doctors' Association
ANMF	Australian Nursing and Midwifery Federation (rural nursing and midwifery members)
APA (RMN)	Australian Physiotherapy Association (Rural Members Network)
APS	Australian Paediatric Society
APS (RRPIG)	Australian Psychological Society (Rural and Remote Psychology Interest Group)
ARHEN	Australian Rural Health Education Network Limited
CAA (RRG)	Council of Ambulance Authorities (Rural and Remote Group)
CHA	Catholic Health Australia (rural members)
CRANAplus	the professional body for all remote health
CWAA	Country Women's Association of Australia
ESSA (NRRC)	Exercise and Sports Science Australia (National Rural and Remote Commitee)
FRAME	Federation of Rural Australian Medical Educators
FS	Frontier Services of the Uniting Church in Australia
HCRRA	Health Consumers of Rural and Remote Australia
IAHA	Indigenous Allied Health Australia
ICPA	Isolated Children's Parents' Association
NACCHO	National Aboriginal Community Controlled Health Organisation
NRF of RACGP	The National Rural Faculty of the Royal Australian College of General Practitioners
NRHSN	National Rural Health Students' Network
PA (RRSIG)	Paramedics Australasia (Rural and Remote Special Interest Group)
PSA (RSIG)	Rural Special Interest Group of Pharmaceutical Society of Australia
RDAA	Rural Doctors' Association of Australia
RDN of ADA	Rural Dentists' Network of the Australian Dental Association
RFDS	Australian Council of the Royal Flying Doctor Service
RHEF	Rural Health Education Foundation
RIHG of CAA	Rural and Indigenous Health – interest Group of the Chiropractors' Association of Australia
RHWA	Rural Health Workforce Australia
ROG of OAA	Rural Optometry Group of Optometrists Association of Australia
RPA	Rural Pharmacists Australia
SARRAH	Services for Australian Rural and Remote Allied Health