Contents
Executive Summary .............................................................................................................. 3
Recommendations ................................................................................................................ 4
Introduction ........................................................................................................................... 5
Chapter 1 - Greater Engagement with Specialists ................................................................. 6
Chapter 2 – System Improvements and Useability ................................................................. 8
Chapter 3 – The Opt-Out Model and Patient Privacy ........................................................... 11
Chapter 4 – Future Management of PCEHR ....................................................................... 12
Conclusions ........................................................................................................................ 13
Appendices (see attached) ................................................................................................. 14
   A: Panel Review letter of invitation .................................................................................. 14
   B: RACP survey methods ............................................................................................... 14
   C: RACP submission: Concept of Operations ............................................................... 14
Executive Summary

The Royal Australasian College of Physicians (RACP) continues to support the implementation of the Personally Controlled Electronic Health Record (PCEHR) Program and welcomes the opportunity to contribute to the Federal Government Review.

In the RACP’s view, electronic health records have the potential to provide significant benefits to the management of patients’ healthcare. The RACP supports efforts to improve the PCEHR so that it develops into a practical system for electronic health records. Prior to the PCEHR implementation, the RACP provided several submissions to Government in support of the Program (see previous RACP submissions attached).

The RACP urges a far greater level of engagement with specialist physicians in any subsequent changes to the PCEHR. The need for greater physician engagement in the development and implementation of the PCEHR is emphasised throughout this submission. The experience and expertise of specialist physicians are critical to achieving improved useability of the system and maximising the participation of patients and physicians through an ‘opt-out’ model.

Barriers to the uptake of PCEHR for both specialist physicians and patients need to be addressed. Aspects of useability requiring attention include the better integration of systems and the need to avoid duplicating records.

We recognise that there are potential conflicts between the need to protect the privacy of the individual and the potential of filtering information that is in the control of the patient. High quality healthcare requires full knowledge of all aspects of a person’s healthcare. The management of the PCEHR must also address and be seen to address privacy protection concerns, particularly if the private sector is considered for its management.

The RACP reiterates its preference for an ‘opt-out’ model of patient participation. Changing to an ‘opt-out’ model will provide the critical mass necessary for a more useful, universal electronic health record system. Providing patients with details about the benefits of the PCEHR program so that they can make an informed decision about participating is a fundamental requirement of an ‘opt-out’ model.

When managed well, electronic health records can benefit patients with complex and chronic conditions receiving multi-disciplinary team care. The number of patients in this category will increase as Australia’s population ages, making the successful implementation of the PCEHR critically important.
Recommendations

In reviewing the PCEHR the RACP makes the following recommendations relating to the patients’ healthcare journey:

Increasing specialist physician engagement

1. There must be greater involvement of specialist physicians in the development and implementation of the PCEHR in order to maximise the safety and quality of care and realise the intended benefits of the PCEHR. A comprehensive engagement strategy is needed to capture the expertise of specialist physicians.

2. Direct technical assistance needs to be provided to specialist physicians in setting up, accessing and using the PCEHR. This could include installation and basic training in functionality.

3. Communication strategies focusing on the benefits of the PCEHR should engage with specialist physicians on an ongoing basis.

4. The Government’s incentive programs to sign up and participate in the PCEHR should be available to hospital and community-based specialist physicians not just general practitioners.

System improvements and useability

5. The comprehensiveness of the data contained in the PCEHR needs to be expanded to include, for example, pathology and imaging results, allied health and mental health reports and radiology results in order to maximise effectiveness, safety and quality of the PCEHR.

6. The PCEHR needs streamlining and simplification to improve accessibility and enhance ease of registration and use.

7. The PCEHR needs to be better integrated with hospital networks and linked with other databases and systems operating in different jurisdictions and across private, public and community-based health services.

8. The Government must work to resolve the technical issues hindering cross-populating patient information so as to minimise the burden of entering information.

Opt-out model and Patient Privacy

9. The PCEHR should become an ‘opt-out’ model in order to ensure maximum patient participation. Patients should be provided with clear information about the role and benefits of the PCEHR.

10. The community must be provided with information about the security and privacy protections of the PCEHR and have regular opportunities to opt out of the system.
Introduction

The RACP welcomes the opportunity to respond to the Government’s review of the PCEHR in accordance with the Terms of Reference set out by Government (See Appendix A).

The very short timeframe set by the Review Panel has limited the ability to develop a more comprehensive submission to the Review. This submission is based on responses to a targeted survey of RACP members (See Appendix B) and previous policy submissions provided by the RACP throughout the PCEHR development and implementation (See Appendix B).

The RACP supports the concept of an effective electronic health record which provides secure access to patient information across multiple sites to improve care.

The need for greater specialist physician engagement in the development and implementation of the PCEHR is emphasised throughout this submission. The experience and expertise of specialist physicians are critical to achieving improved useability of the system and maximising the benefit to patients and physicians of an ‘opt-out’ model.

The RACP’s submission focuses on the key issues for specialist physicians, details the main barriers to greater participation and offers a number of recommendations. The three major areas detailed in the submission include:

1. The need for greater engagement with specialist physicians in the development and implementation of the PCEHR;
2. Systematic changes to improve the useability of the PCEHR for both physicians and patients; and
3. An ‘opt-out’ model of PCEHR participation to ensure the critical mass needed for a useful system.

The RACP looks forward to the outcomes of the PCEHR Review and would like to be involved in any further policy work on this matter.
Chapter 1 - Greater Engagement with Specialists

The RACP strongly encourages greater engagement with specialist physicians in the development and implementation of the PCEHR and suggests a comprehensive engagement strategy which covers all specialities would be appropriate. More than two thirds of RACP members surveyed are using some form of electronic medical records in their clinical practice. However, only five per cent of surveyed members indicated that they are registered with the PCEHR.

Despite the low uptake, there is strong support amongst specialist physicians for an effective electronic health record system. A majority of members surveyed (56 per cent) would like to use the PCEHR in their clinical practices, and 84 per cent supported efforts to develop a system for electronic health records.

To date, the implementation of the PCEHR has involved only limited engagement with specialist physicians. The overwhelming majority of RACP members surveyed – more than 92 per cent – indicated that they had experienced little to no engagement, including nearly 60 per cent who responded that there had been no engagement.

One of the expected benefits of the PCEHR is the quick and efficient sharing of patient information between general practitioners (GPs) and specialists. However, this benefit is unlikely to be achieved without better engagement and buy-in from specialist physicians.

RACP members reported that the major barriers to greater use of the PCEHR are a combination of a lack of technical assistance and limited specific information on how to adopt or implement the PCEHR.

RACP members identify a need for further information on the benefits of PCEHR and advice on using it effectively. For example, almost 60 per cent of RACP members surveyed did not know if they use PCEHR compliant software. One member responded that, ‘The Government and NEHTA showed complete indifference to considering how physicians would be involved’ and there should be ‘recognition that often physicians take a lead role in [the] management of complex patients’.

Through the RACP PCEHR survey, members pointed to several key issues related to engagement with the PCEHR, including:

- Limited technical preparation: less than 18 per cent had compliant software to connect. This figure was as low as 11 per cent among the paediatric specialists and as high as 24 per cent among general and acute care physicians surveyed.

- Limited information and support that targets specialist physicians: more than a quarter of respondents were unsure if they were registered to participate in the PCEHR.

- Lack of incentives for specialist physicians to sign up and use the PCEHR.

A majority of RACP members (three quarters or more) believe that the current PCEHR has the potential to deliver significant benefits (see Figure 1). This support is consistent across the specialities.
Support for specialist physicians

The RACP supports programs to encourage clinicians to join and use the PCEHR including a combination of financial and software assistance. Survey respondents called for the recording and updating of electronic health records to be considered (with a nominal fee) as Medicare items. To be consistent, the incentive program available to general practitioners should be offered to all clinicians including specialist physicians.

**Recommendations: Increasing physician engagement**

1. There must be greater involvement of specialist physicians in the development and implementation of the PCEHR in order to maximise the safety and quality of care and realise the intended benefits of the PCEHR. A comprehensive engagement strategy is needed to capture the expertise of specialist physicians.

2. Direct technical assistance needs to be provided to physicians in setting up, accessing and using the PCEHR. This could include installation and basic training in functionality.

3. Communication strategies focusing on the benefits of the PCEHR should engage with specialist physicians on an ongoing basis.

4. The Government’s incentive programs to sign up and participate in the PCEHR should be available to hospital and community-based specialist physicians not just general practitioners.
Chapter 2 – System Improvements and Useability

Through the survey, RACP members were asked to nominate three key changes to the current system which could lead to improvements in care. The largest share of respondents, 23 per cent, indicated the need for the PCEHR to be more comprehensive for example, with datasets that include pathology and imaging results, allied health and mental health reports and radiology results.

Additionally, the PCEHR could be used to keep a record of a patient’s immunisation history over the life span. One particular physician noted that ‘this would be incredibly valuable clinically, not just for migrant Australians, but flu shots…chonic disease eligible….older Australians… hep B HH contacts… Health care workers…. I spend half my life chasing poor quality immunisation records.’

The second largest share of respondents (17 per cent) specified that streamlining and simplification of the current PCEHR was required to enhance ease of use. This was followed by the need to provide better system integration with hospital networks and increased linkages to other databases (12 per cent) as well as ease of access for specialist physicians (eight per cent).

Useability Issues

A significant number of RACP members surveyed cited issues of useability as a primary barrier to using the PCEHR. The main issues were that the system is time-consuming, difficult to access, and lacked integration with existing systems (see Figure 2 below).

The top PCEHR issues RACP members would like improved are accessibility, simplification and ease of use and registration. These issues are followed by concerns about privacy and issues related to data accuracy, quality and comprehensiveness and the PCEHR’s potential for linkages to other medical databases. A typical view is represented by a survey respondent who stated: 'Make sure that the system is user-friendly and easy to understand. If we find it helpful, we will use it. It should integrate with existing systems also.'

Another useability issue raised was the accessibility of the system for non-English speaking patients. One respondent commented that “[The PCEHR is] only suitable for English speaking patients with computer access - misses most vulnerable groups.”
Avoiding duplication of records

The PCEHR is designed to complement, and not replace, existing health records for patients. While it would be easier to manage a single system of record capture for patient information, the RACP acknowledges the difficulty of achieving this within our Federated health system. However, it is important that the PCEHR should be set up to make it easy for clinicians to transfer recorded health information to a PCEHR. The RACP therefore recommends that Government resolves the technical issues hindering cross-populating patient information so as to minimise the burden of entering information.

This was a common request amongst RACP members surveyed. As summarised by one respondent: ‘I have little or no extra time to set up and use another records system, it will need to be extremely streamlined, quick to set up and use.’

A linked-up system

In order to avoid the need for making multiple records, a system that easily connects with the existing records management systems in all jurisdictions should be a priority.

For example, some RACP members in the Northern Territory are already users of the Northern Territory Shared Health Record (HealthConnect) which is used extensively, particularly among some Indigenous communities. The PCEHR should seek to integrate effectively with existing systems across Australia’s jurisdictions.

RACP members surveyed identified the lack of integration of the PCEHR with existing systems as a key barrier to greater use by specialist physicians. There were numerous comments made about the PCEHR needing to interface better with existing hospital electronic health records. Additionally, specialist physicians working in private practices expressed concerns about the ability to access information held in the public system. As one RACP member commented: ‘I think this would be a great national system if this was the only system we used in both public and private; due to improving efficiency.’
Recommendations: System improvements and useability

5. The comprehensiveness of the data contained in the PCEHR needs to be expanded to include, for example, pathology and imaging results, allied health and mental health reports and radiology results in order to maximise effectiveness, safety and quality of the PCEHR.

6. The PCEHR needs streamlining and simplification to improve accessibility and enhance ease of registration and use.

7. The PCEHR needs to be better integrated with hospital networks and linked with other databases and systems operating in different jurisdictions and across private, public and community-based health services.

8. The Government must work to resolve the technical issues hindering cross-populating patient information so as to minimise the burden of entering information.
Chapter 3 – The Opt-Out Model and Patient Privacy

To make the PCEHR effective, RACP recommends the adoption of an ‘opt-out’ model which would deliver critical mass participation.

The use of an ‘opt-in’ system is likely to have had a negative impact on both participation rates and the cost of implementation\(^\text{i}\). The low numbers signing up and using the PCEHR to date highlights this issue. By not registering every child at birth and every patient on presentation, the opportunity to create a ‘cradle to grave’ record has so far been missed.

The majority of the RACP’s members surveyed (57 per cent) support an ‘opt-out’ system. RACP members suggested that the PCEHR should provide ‘easy access to opt-out’; that an opt-out model ‘might speed up the very slow adoption in these institutions\(^\text{ii}\)’; and that ‘opt-in will be far too slow/partial to achieve desired aims’. Additionally, as stated by one member ‘if it is to be universal, then it needs to be opt-out. It needs to be universal in order to be useful.’

Privacy and data security are relevant under either model and should not prevent an opt-out model being adopted. These issues can be overcome through better patient engagement and awareness of the benefits of the PCEHR, in conjunction with clear and regular opportunities to opt out of the system. It is important that any decision to continue to use, or alternatively opt out of the PCEHR is made based on up-to-date information about the system. The public should be well-informed about the PCEHR regardless of whether an ‘opt-in’ or ‘opt-out’ model adopted.

Systems that are currently using or testing ‘opt-out’ models should be examined further to inform the decision to convert the PCEHR to an ‘opt-out’ model. The PCEHR’s use of an ‘opt-out’ model would continue to be a voluntary system under the patient’s control, but would allow information to be collected on behalf of patients until they decide to opt out.

Protection of Privacy

RACP members believe addressing privacy or confidentiality-related concerns are key to improving the uptake of the PCEHR. Good privacy control is essential to achieve greater patient confidence in the PCEHR. Over one third of RACP members surveyed indicated that their patients had expressed concerns over the privacy of the PCEHR as a key barrier to their using the system. The RACP believes that privacy control can be managed and should not get in the way of allowing the PCEHR to function as a health record that can readily be used for the benefit of the patient. The RACP has expressed this view in previous submissions (please refer to Appendix C).

Specifically, some RACP members who responded to the RACP survey raised concerns about third parties accessing the private health information of patients with one physician stating the need to ensure ‘...access only for direct medical care and ensure no outside agents such as insurance companies or employers can access’.

Recommendations: Opt-out model and Patient Privacy

9. The PCEHR should become an ‘opt-out’ model in order to ensure maximum patient participation. Patients should be provided with clear information about the role and benefits of the PCEHR.

10. Patients must be provided with information about the security and privacy protections of the PCEHR and have regular opportunities to opt out of the system.
Chapter 4 – Future Management of PCEHR

Private management of PCEHR

The RACP does not hold a preference for either public or private management of the PCEHR.

Audit and Research

The RACP notes some public comments from the Review Panel Chair about the potential for the PCEHR to be used for population health. The potential of the PCEHR to be useful for audit and research purposes could only be realised if the PCEHR is used by a critical mass of patients and is able to be linked to other data sets. As previously mentioned, changing the PCEHR from an ‘opt-in’ model to an ‘opt-out’ model would make significant gains in achieving wider use of the PCEHR by patients.

Strict controls on the use of this information for research and audit purposes would need to be established, including approval by a national ethics committee and the governing body of the PCEHR that aligns with an effective clinical governance model. Research studies using unlinked (de-identified) patient data should be permitted without individual patient consent, but research studies using identifiable patient data should require individual consent.

There is also the potential to use the data to flag a series of alerts or selected health prevention and promotion messages based on available information that is relevant to the patient. This would reinforce the health prevention and promotion messages that are given by health care professionals and will encourage patients to take an active role in their health.
Conclusions

The RACP continues to support the implementation of a viable and effective PCEHR. As indicated by the majority of members who responded to the RACP’s survey, specialist physicians support the PCEHR and want to have greater participation in its further development and implementation.

The RACP urges a far greater level of engagement with specialist physicians in the future rollout of the PCEHR. Specialist physicians across private, public, hospital and community health care are essential to the creation of a comprehensive health record. In order to achieve greater PCEHR useability and participation the experience and expertise of specialist physicians are critical. The RACP therefore recommends the Review support greater specialist physician engagement in the development and implementation of the PCEHR and looks forward to working with the Government on further improvements to the electronic health record program.
Appendices (see attached)

A: Panel Review letter of invitation
B: RACP survey methods
C: RACP submission: Concept of Operations
About The Royal Australasian College of Physicians (RACP)

The RACP trains, educates and advocates on behalf of more than 14,300 physicians – often referred to as medical specialists – and 6,500 trainees, across Australia and New Zealand. It represents more than 32 medical specialties including paediatrics and child health, cardiology, respiratory medicine, neurology, oncology and public health medicine, occupational and environmental medicine, palliative medicine, sexual health medicine, rehabilitation medicine, geriatric medicine and addiction medicine. Beyond the drive for medical excellence the RACP is committed to developing health and social policies which bring vital improvements to the wellbeing of patients. www.racp.edu.au.


ii See appendix C

November 7, 2013

Dr. Jennifer Alexander
CEO
Royal Australian College of Physicians

Dear Dr. Alexander,

I am writing to invite you to submit a response in support of the Federal Minister for Health the Hon Peter Dutton MP’s review of the Personally Controlled Electronic Health Record (PCEHR)

A review Panel has been established to study the implementation of the PCEHR. The key focus of the Panel is to report back on the major reasons for a slow take up of the platform. The Panel will make recommendations on how to improve adoption and usage to help realise the benefits from the investment as part of the refresh of the eHealth strategy.

The Panel would like to invite those interested parties who made formal submissions in the early stages of the PCEHR to provide an addendum to your initial response. Responses should focus on the following areas for the purpose of this review:

- Your experience on the level of consultation with key stakeholders during the development phase
- The level of use of the PCEHR by health care professions in clinical settings
- Barriers to increasing usage in clinical settings
- Comments on standards for Terminology, language and technology
- Key clinician utility and usability issues
- Key patient usability issues
- Suggested Improvements to accelerate adoption of the platform

Submission Summary:

- Submissions should not duplicate earlier submission and should focus on the topics outlined above.
- Responses must be submitted by 5pm AST November 22nd, 2013.
- Submissions will only be accepted into a secure electronic drop box. The location can be found using the following link. https://pcehr.accellion.net/envelope/upload
- An email notifying the Panel of the submission should be also sent at the time of lodgment.
- Submission receipt will be acknowledged within 2 working days.
- Submissions will be made public. Submissions that are intended to remain confidential should be clearly marked as such however confidential submissions may still be subject to access under the Freedom of Information Act 1982.

Yours Sincerely,

Richard Royle

Richard Royle
Panel Chair – Review of PCEHR
INSTRUCTIONS:

- A submission may cover all or some of the points in the requesting letter.
- The Panel will accept electronic submissions uploaded via the secure web portal. The preferred format for electronic submissions is Microsoft Word. The location can be found at https://pemr.accellion.net/envelope/upload.
- An email should be sent at the same time as the submission to pcehrreview@pcehrreview.gov.au.
- Please bear in mind the submission may be published via the internet.
- The Panel may publish the name of the person making the submission. If you have a concern about having your name published on the internet or if you wish to make a confidential submission, you must make this clear from the start.
- If you intend to request that your submission be considered on a confidential basis you must ensure that the actual submission document or documents that you create does not contain your contact details and that you have removed document metadata properties. The Panel will sympathetically consider requests for confidentiality, but cannot make promises in advance. If you have concerns about confidentiality, please discuss with the Panel secretary before you make the submission.
- The online submission site is a secure site and is suitable for uploading sensitive and confidential material.
- Submissions must include your name, phone number and postal address so we can verify them. If it is the submission of an organisation, say so clearly. Show the signatory’s position and say at what level the submission was authorised.
- A submission to the review Panel becomes a panel document, and must not be disclosed to any other person or published by the submitter either in print or digitally. Unless you have requested that the submission remain confidential, it may be published after the panel has received and examined it and authorised its publication.
- The panel may reject a submission or part of a submission that is not relevant to the review.
- If you make a submission, the panel may invite you to give oral input either by interview or by phone.

For further information regarding the background to PCEHR or eHealth log onto www.yourhealth.gov.au

Please direct any enquiries to pcehrreview@pcehrreview.gov.au
RACP Survey methods and barriers/benefits of the PCEHR

The RACP consulted its Australian membership by means of an online survey that was launched on Tuesday, 12 November and closed on Monday, 18 November. The survey covered the key points raised by the PCEHR Review Panel including:

- Physicians’ views on the key advocacy matters the RACP should be taking forward in relation to the PCEHR
- Current benefits and barriers to using the PCEHR for patients and physicians
- Current usage and awareness of the PCEHR amongst physicians
- Engagement of physicians with the development and implementation of the PCEHR to date
- Ways in which the government could further engage and encourage take-up of the PCEHR by physicians
- Physicians’ views on additional changes or features that could be added to the PCEHR to improve patient care

Over 200 members responded to the survey. As shown in Figure 1, respondents were from all States and Territories with the majority of members from New South Wales (35 per cent), Victoria (25 per cent) and Queensland (17 per cent).

Figure 1 Respondents by States and Territories

A majority of respondents had practices in major metropolitan areas (over 70 per cent), followed by regional metropolitan areas (19 per cent), rural areas (8 per cent) and remote areas (over 1 per cent). Over one half of fellow respondents worked in public practice only (53 per cent), 30 per cent worked in both public and private practice and 16 per cent worked in private practice only.

A very wide range of specialties were represented in the survey including general paediatrics (17 per cent), general and acute care (15 per cent), endocrinology (6 per cent), cardiology (6 per cent), geriatric medicine (5 per cent), respiratory and sleep medicine (5 per cent), nephrology (5 per cent), medical oncology (5 per cent), public health medicine (4 per cent), haematology (4 per cent), gastroenterology (4 per cent), neurology (4 per cent), palliative
Benefits for patients

The RACP asked its members about the current benefits of the PCEHR for patients. The top three benefits identified for patients were: ease and convenience of access to medical records (27 per cent), improvement in treatment and care (22 per cent) and patient control over medical history (nine per cent). Some of the comments made by RACP members included:

- ‘avoidance of time wasted in chasing this information and (hopefully) accurate data preventing inappropriate clinical action due to patients’ inaccuracies in recall’
- ‘patients are able to ensure all health care professionals involved in their care have access to accurate information’
- ‘up to date information anywhere, any time as needed to ensure optimum care’

However, over 15 per cent of respondents also saw ‘little or no benefit’ to the PCEHR for patients.

An overarching point for consideration is the potential benefits of an effective PCEHR in managing health throughout the patients’ lives. With this in mind, it is important that the PCEHR is developed to be as user friendly as possible, particularly for elderly patients and other vulnerable patient groups.

Benefits for physicians

RACP members were also asked about the current benefits of the PCEHR for physicians. The top three benefits identified for physicians were: quick and easy access to patient medical history (42 per cent), increased efficiency (22 per cent) and better patient care and management (nine per cent). Some of the comments made by RACP members included:

- ‘Ease of administration for patient care across multiple sites. Reduced time wasted on chasing important information which may not always be available after hours’.
- ‘Potentially an easily accessible source of previous medical history details for all patients which could reduce time searching for and requesting these details from a variety of other sources.’
- ‘Allowing access to medical history and medications to save time and prevent errors due to inadequate information.’

In contrast, over 20 per cent of survey respondents also highlighted that they saw ‘little or no benefit’ to the PCEHR for physicians.

Barriers for patients

When asked about current barriers to the use of the PCEHR by patients, RACP members highlighted the following issues: privacy concerns (32 per cent), low user friendliness/difficulty of use (18 per cent) and lack of awareness (13 per cent).

Some of the comments made by RACP members included:

- “[The PCEHR is] only suitable for English speaking patients with computer access - misses most vulnerable groups.’
- ‘The opt-in nature of the program and general lack of awareness of the service.’
- ‘Too complex to enrol and enter data (those that would benefit most are least likely to be able to access).’"
Barriers for physicians

The survey also asked RACP members about the current barriers to the use of the PCEHR by physicians. The following concerns were raised: usability issues (33 per cent), technological barriers (18 per cent), time consuming/costly (18 per cent), lack of understanding and awareness (12 per cent) and concerns over data integrity (12 per cent).

Below are some of the comments RACP members made in relation to current barriers for physicians:

- ‘In its current format where patients can withhold crucial information from the record, I could never rely on this source to be a complete and accurate representation.’
- ‘Too hard to set up and use for routine clinical practice incredibly complicated process to register. Still trying to work the forms out.’
- ‘Patient controls what information is available to the physician. Physician can be unaware of something significant that would affect diagnosis or management.’
Concept of Operations – Patient Controlled E-Health Record

Submission by The Royal Australasian College of Physicians
May 2011

The Royal Australasian College of Physicians (RACP) welcomes the opportunity to provide feedback on the draft Concept of Operations – Patient Controlled E-Health Record.

Introduction

Electronic health records have the potential to provide significant benefits to the management of patients’ health care. The availability of an electronic health record will support out of hours care, improve access to health information in emergency care and improve access of health care professionals to health information of patients who are travelling interstate.

Electronic health records will be of particular benefit to patients with complex and chronic conditions who are under the care of a multi-disciplinary team. The number of patients in this category will increase as Australia's population ages. Further, as a result of the National Health Reforms, more complex care is expected to be carried out in ambulatory and primary health settings rather than in acute care settings. An easy to use electronic record that can be shared between all members of a multi-disciplinary team, regardless of where they are located, will allow information to be shared in a timely manner, facilitate co-ordinated care and avoid unnecessary duplication. This will improve patient care, decrease avoidable hospitalisations, and provide patients who are coping with complex health problems a better experience in navigating the health system.

There is also significant potential for audit and research that will contribute to the improvement in clinical practice.

The RACP is supportive of efforts to develop a system for electronic health records, although notes that significant issues, such as e-health readiness will need to be resolved. The National E-Health Transition Authority’s (NEHTA), Patient Controlled E-Health Record (PCEHR) is a major development and the associated Concept of Operations is a good starting point for further discussion. The RACP would be pleased to assist in further consultation as the PCEHR develops.

Consolidated View and other summaries

The Consolidated View is derived from information in the Health Summary among other sources. The patient’s usual general practitioner is likely to be the "nominated
provider” and thus responsible for the content of the shared Health Summary and for keeping the PCEHR up to date. This information will be drawn from the general practitioner’s own records and effectively the PCEHR will not contain information that he or she doesn’t already know. From this perspective, the PCEHR is of more benefit to other health care professionals, that is, specialists, other doctors and allied health professionals, who normally only have access to a limited and specific range of information about the patient. Accordingly, the design of the PCEHR, particularly the Consolidated View, should consider their needs.

Data quality will be of key importance to the utility of the PCEHR as it is for any medical record. For this reason, it would be safer for the Consolidated View to be derived from all available information, rather than have it depend on a third party’s interpretation of what should be included. In particular, the quality of the Health Summary, from which the Consolidated View is derived, is likely to vary significantly. General practitioners, who will most likely be the “nominated provider” for their patients, may have to complete large numbers of health summaries in a comparatively short period of time. Some of this data entry may be performed by practice assistance and the general practitioner may not have enough time to review the work done. The other advantage of deriving the information from the original information, the individual who provided each piece of information will be identifiable as responsible for that information.

The information in the Consolidated View is generally well arranged; however it lists medications in the “PBS History” by brand name rather than generic name. All medication records should be by generic name, with brand name possibly given as an alternative or by mouse-over. This is consistent with the Australian government’s aim to improve the acceptance of generic medicines in the community.

All summaries, not only the Consolidated View should have a warning that they are potentially incomplete. There should also be a reminder that where there are, or where there appear to be gaps, this should be confirmed with the patient.

**Additional material for the Consolidated View**

There are additional areas that could be added to the Consolidated View that would enhance its utility. Given that the PCEHR is intended to be used by health care professionals in the hospital setting as well as in the community, there should be a category of information, perhaps labelled “alerts," that is relevant to hospital care.

Information that can be recorded in that section includes:

- whether the patient is known to be colonised with MRSA. If a patient is admitted to a new hospital and does not, or cannot, give this information, the hospital has no way of knowing that the patient has MRSA and of treating the patient appropriately.
- notification that a patient has been admitted to a trial.

There could also be a paediatric specific section of the Consolidated View that records summary information about a child’s growth (in terms of weight, height and head circumference and noting significant change in percentiles) and progress with developmental milestones.

**Additional uses of information**

The PCEHR has great potential for use in audit and research, to improve the provision of medical care. A policy for such access should be developed so that
research against the data is possible. A suggested model is that subject to approval by a national ethics committee and by the governing body of the PCEHR, research studies using unlinked (de-identified) patient data should be permitted without individual patient consent, but research studies using identifiable patient data should require individual consent.

There is also a great opportunity to use the data to flag a series of alerts or selected health prevention/promotion messages based on available information that is relevant to the patient. This would support the health prevention/promotion messages that are being given by health care professionals and will encourage patients to take an active role in their health.

**Enhancing patient participation**

The PCEHR is an opt-in system rather than an opt-out system. This is likely to have a negative impact on participation rates and cost. By not registering every child at birth and every patient on presentation, the opportunity to create a cradle to grave record will be missed. Systems that are using or testing opt out models, such as in Auckland, should be examined.

In 2012, registration alone will offer little unless some attempt is made to pre populate the PCEHR with data from Medicare. This includes

- Australian Childhood Immunisation Register records for children;
- MBS data; and
- PBS data.

It may be possible to incorporate data currently being collected from electronic health systems in the jurisdictions, and this would be worth exploring.

There is a real opportunity to encourage uptake by offering some functionality including through the consumer portal with Health Prevention and Health Promotion functions. There are many good examples of what can be achieved to create risk profiles and prompt age related interventions consistently across the population.

**Specific aspects of the PCEHR**

**Keeping up with changes to downloaded reports (S4.2.1 final paragraph)**

The proposal requires a provider who has downloaded a document from the PCEHR to check periodically to see if it has been superseded. If the request for the download was sent to the originator of the document, the originator would have a record of the copy, and would be able to send an amended copy when necessary. This need only apply to locally-stored copies and would not be necessary in most cases where the document has been examined transiently, however, it might be useful to add the capacity to be alerted to changes in a particular document, as needed.

**Discharge Summary - Medications (S4.2.4)**

"Current medications" and "Ceased medications" alone will not meet clinical requirements, because changes in dosage will not be noted. The important information needed is "Medications on admission", "Medications on discharge" and "Reasons for change".

**Specialist Letter (S4.2.5)**

Australian physicians, particularly those in the private system, are unlikely to have computerised systems that are capable of interacting with the PCEHR. Participation
should not be limited to structured letters, and should allow for scanned or other means of incorporating their content (such as document loader for Word documents) in the transition phase. The RACP’s position on the proposed Specialist Letter is set out in detail in its response to the draft Specialist Letter Package, a copy is included at Attachment B.

Pathology Result Reports and Diagnostic Imaging Reports (S4.2.8 and S4.2.9)
The proposed process for getting Pathology Result Reports and Diagnostic Imaging Reports into the PCEHR involves reporting results back to the requesting clinician who reviews them and sends a message back to the Diagnostic Service Provider authorising the uploading of the reports. This means that the results are not available until they are “released”.

While patients generally should not directly access their results until a medical practitioner has had an opportunity to review them and if, necessary, discuss and explain them, this restriction prevents any other doctor from doing so where the need arises. For various reasons, patients do not always return to the same medical practitioner for follow up of their condition. Some may attend a hospital emergency department. The current situation is that, unless the information can be obtained from the original medical practitioner, other medical practitioners will have to do without that test result, and perhaps order another test. An example of this is a patient who has had a MSU examination done for a suspected urinary tract infection prior to commencing antibiotics, who subsequently presents to the emergency department with pyelonephritis. If the patient has not returned to their general practitioner in the meantime, the results of the MSU, which are relevant to the patient’s treatment, will not be available. The patient will be commenced on antibiotics without the guidance of the antibiotic sensitivities.

If Pathology Result Reports and Diagnostic Imaging Reports are capable of being made available on the PCEHR, there is no good reason for restricting other medical practitioners from getting access to them. To not allow other medical practitioners and appropriate allied health professionals to have access cuts across the very purpose of the PCEHR.

An alternative would be for the Diagnostic Service to upload the report to the PCEHR simultaneously with reporting to the requestor. The report would be visible in the Provider Portal. The fact of that the report exists would be visible in the Consumer Portal but the substance of the report would not be visible there until approved by the requestor. There could be two modifying choices at time of request:

1) automatically release this report to the patient (for example, routine INR for a patient self-managing warfarin) and
2) do not send to the PCEHR (for tests that the patient wishes kept confidential).

Electrocardiograms (S1.8)
Electrocardiograms are relegated to "potential enhancements subject to further work". They are readily captured from existing equipment used in many hospitals, and as vector PDFs are compact (about 40-50kB) documents. These should be accepted from an early phase of the PCEHR, given their importance for diagnosis of future cardiac events.

Privacy and audit
Good privacy control will be essential so that patients have confidence in the PCEHR. Privacy control should however, be reasonable and not get in the way of allowing the PCEHR to function as a health record that can readily be used for the benefit of the patient.
There should also be a mechanism for dealing with downloads and printed records. Although this may be necessary, it creates a real problem in ensuring compliance with patient access controls.

It is unclear whether patient will be able to view the audit trail for their accounts (S1.6 final paragraph). If not, how would they be aware of "suspicious or unauthorised access"?