Health*Connect* Implementation in South Australia

Selection of geographical scope

Version 0.1

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Background

The National Electronic Health Records Taskforce outlined the need for a national network of electronic health information (Health*Connect*) in its July 2001 report to Health Ministers. The objective of Health*Connect* is to improve the delivery of health care and provide better quality of care, patient safety and health outcomes through a seamless, integrated system of electronic health records.

Based on the recommendations of the Taskforce, Health Ministers agreed to fund two years of research and development work from 2001-2003 to test the feasibility and value of the Health*Connect* concept ahead of a decision to implement it on a national scale (Phase 1 of the project).

The second phase (2003-2005) involves work to prepare for implementation at the whole of state level as a prelude to national deployment. In particular, major work is being completed on the architectural design, system and data standards and other key building blocks required for a national patient record system. This will enable the three-tier storage model to be built; comprising a national coordination layer, Health*Connect* Record Systems to be developed by each state and a source system user layer. Other projects are focussing on national policies for requirements that include privacy, consent, registration, identification, messaging and data standards.

As part of the MedicarePlus package released in April 2004, Minister Abbott announced $80 million would be spent over next three years to implement Health*Connect* (Phase 3). South Australia and Tasmania have been selected as the lead states to implement Health*Connect*, with a number of additional projects being progressed in other states.

Introduction

South Australia is well positioned to implement Health*Connect* given the established, highly developed Open Architecture Clinical Information System (Oacis) in Adelaide's public hospitals. The Programme is currently rolling out the Separation Summary, providing summary discharge information for GP's and specialists across the State. Oacis steering committee's and working parties include representation from general practitioner groups and consumers. By building on the progress achieved in the Oacis ~~project~~ Programme and community interfaces developed as part of Phase 2 of the Health*Connect* trials, Oacis can be leveraged as a key feeder system for a state wide Health*Connect*. ~~The states~~South Australia also leads the *HealthConnect* Clinical Information Project, which focuses on the development of specifications for a national hospital discharge summary; a core feature of Oacis functionality.

A workshop was held ~~was held~~ in Adelaide on 23 April 2004 for representatives from SADI, Chief Medical Officers from the Western and South Divisions, the F~~f~~ederal Department of Health and Ageing (DoHA) and the Department of Human Services (DHS) and the Tasmanian members of the Health*Connect* trial.

The in-principle agreed scope of the initial phase of the state-wide implementation is involvement by GP's, hospitals and residential aged care facilities in the urban Divisions (Southern and Western and potentially some early adopters in the other Divisions), with improved medication management being a key focus. To establish this scope in more detail, the

following criteria set out a framework to identify potential geographical locations within each of the Divisional boundaries. It is expected that SADI, DoHA and DHS will use this as a basis to form a recommendation.

~~Methodology for Implementing~~Criteria for selection of geographical boundary ~~-~~of initial phase of Health*Connect* in South Australia

Criterion 1 – Local GP Divisional support

What about specialists? Are we going to look at this? (Suggest two additional criteria for Specialists and Residential Aged Car Facilities with the same bullet points as below)

- Assess the level of infrastructure support provided to GPs in each Division, ie:

- The level of existing IT support offered by the Division.
- Use of prescription writing software amongst doctors.
- Software vendor (Medical Director since initial estimate indicate approx. 90% of GP's in South Australia use this product) commitment to provide support.
- Availability of PKI and or other means for security/encryption

- Assess the level of interest and commitment of each Division to participate in the implementation of Health*Connect*.
- Assess the strength of the Division and the support structure in place.

Criterion 2 – Adequate performance capacity of Internet Service Providers (ISP)

What is the purpose of assessing the capacity of ISP's? Surely this criteria should be – "Adequacy of broadband coverage "within each of the Divisional Boundaries".

An accurate assessment may be difficult to undertake, given a full line check to providers telephone numbers would be required, however data on the geospatial coverage of ADSL by postcode can be obtained. A rating can then be applied according to the level of coverage.

- Level of ADSL coverage in each Division.
- Level of existing support provided by ISP's (across all Divisions)
- Incentives on offer to cover minimum infrastructure costs.

Criterion 3 – Number of hospital providers using Oacis and GPs using Medical Director

- Sufficient numbers of providers using the systems to facilitate electronic information exchange that would lead to improved medication management. (Note that from an in-scope hospital perspective, all patient discharges from them will trigger a separation summary being sent to the GP, with or without Health*Connect*. This is not necessary so on the GP's end a sit will only be with patients that have given consent).

Criterion 4 – A Division has a Public hospital and residential aged care facility

- Proximity of public hospitals, GP's specialists and residential aged care facilities within Divisional boundaries
- Patient flow between GPs, specialists and ~~an~~ residential aged care facilit~~y~~ies is demonstrated in a defined area.
- A picture of the existing synergies that exist between the Division, specialists, hospitals and residential aged care facilities.

Criterion 5 - There is an adequate cross section of health status and medication use to maximise benefits.

- Health status and medication use data can be measured via Medicare and Pharmaceutical Benefits Scheme (PBS) claims for 2002/03 as a proportion per person for each location.

Criterion 6– Existing electronic health programs and projects within each Division

- The number of existing relevant electronic health programs within the acute, community and aged care sectors that could be used to leverage implementation.
- Of these, the number with local commitment, infrastructure and support structures in place.

Criterion 7 – A Division has a supportive National Prescribing Service (NPS) officer

This is the first time NPS has been mentioned. Purpose and Impact?

Filtering processes

The criteria have been categorised into mandatory, highly desirable and desirable rankings to reflect their importance in determining the geographical scope. (Table below will need to be updated to reflect the suggested changes to the criterion).

Location Selection Criteria.		Weighting
	Mandatory	**4**
1	Evidence of local GP Divisional support	
2	Adequate performance capacity of Internet Service Providers (ISPs)	
3	Sufficient numbers of hospital providers using Oacis and GPs using Medical Director	
4	A Division has a hospital and residential aged care facility	
	Highly Desirable	**3**
5	There is an adequate cross section of health status and medication use to maximise benefits	
7	Existing electronic health programs and projects within each Division	
	Desirable	**2**
6	A Division has a supportive National Prescribing Service (NPS) officer	

Weightings

Each criterion is scored out of 10 points. Weightings have been applied to each category to reflect their importance in the decision making process. Mandatory criterion are given a weighting of four, highly desirable a weighting of three and desirable a weighting of two.

It also needs to take into consideration what the Health Connect programme will deliver to the stakeholders. As an example, it would be hard for GP's to volunteer support and commitment without knowing what they get in return, whether benefits, assistance etc.

I believe we need another section to describe what the GP's age care, etc get in return for participation. (Possible heading "Value Prospective for participants in Health*Connect* Implementation").