PIP eHealth Incentive Discussion Paper September 2015

AAPM Position

Introduction

AAPM is the professional association for business managers of all healthcare practices including general practice, specialists, dentists and allied health as well as multi-disciplinary clinics. AAPM provides education, support, advice and advocacy for practice managers. Our aim is to ensure that they are able to effectively manage healthcare practices, that they are able to have the infrastructure and systems in place to provide a high quality health services to the Australian community, and that they are up to date with changes in the health sector. Consequently, AAPM is ideally placed to assist in implementing the government's primary healthcare reforms.

This position paper is written in response to the PIP eHealth Incentive Discussion Paper released by the Department of Health in September 2015. AAPM is a strong advocate for the development of the eHealth platform as a key construct for improving the delivery of seamless and integrated healthcare services. AAPM has actively promoted the use of eHealth and particularly the use of the MyHealthRecord by conducting a national education program in collaboration with NeHTA to enable practise managers to assist their clinicians to utilise eHealth.

AAPM fully supports the intent of the discussion paper in terms of promoting the active and meaningful use of the MyHealthRecord. However, we have serious concerns about mechanisms that have been recommended in this paper and particularly object to proposed timeframes for implementation.

The start date of February 6th is not practical as it does not allow sufficient time to properly consult with stakeholders or to implement new processes. To push through these changes while the MBS review, PHC Advisory Group and Opt-out MyHealthRecord trial are all pending is premature and adds further to the disjointed nature of the healthcare system. The industry is already fatigued by constant changes. Implementing yet another change without it being properly planned and aligned with the outcomes of these important national reviews does not make any sense. It is likely to create further fragmentation and inefficiencies when the aim of eHealth is to reduce fragmentation and improve the efficiency of the health system.

AAPM strongly argues that the government should hold off on these measures and develop a strategy for active and meaningful use of MyHealthRecord that is aligned with the outcomes of the MBS review, PHC Advisory Group and Opt-out MyHealthRecord trial.

Criteria for change - questions:

- *Do you agree to maintain the existing criteria 1 to 4 as described at Attachment A?*
  AAPM agrees with these criteria.

- *Is there anything that you would change to any of these criteria? Please outline what you would change and why, and describe how this could be delivered in the general practice setting.*
  No changes. This is all manageable in a Practice setting.

- *Should criteria 2 also be changed to include demonstration of active and meaningful use of secure messaging?*

AAPM has as a very strong view that SMD MUST stay. It is a critical part of future e-health and efficient data sharing and it should be promoted more. Vendors have been funded to provide interoperability and the government should make them deliver. This will give greater value to the eHealth system and will increase use of MyHealthRecord.
Until Allied Health providers and Specialists to begin using secure messaging it would be difficult to demonstrate active and meaningful use

- *Do you agree existing criteria 5 is the most appropriate criteria to move towards active and meaningful use?*

  AAPM supports the active and meaningful use of MyHealthRecord but does not support changes to the PIP eHealth incentive criteria at this time to achieve this objective. As already stated it is premature for the conditions for active and meaningful use of MyHealthRecord to be aligned with the outcomes of the MBS review, PHC Advisory Group and Opt-out MyHealthRecord trial.

Demonstrating active and meaningful use - questions:

- *Do you agree that active and meaningful use of the MyHealthRecord system from general practice and GPs should in the first instance only require the uploading of clinical information in the form of the Shared Health Summary?*

  AAPM agree that uploading the SHS should be the initial priority for demonstrating use of MyHealthRecord for patients with a chronic disease. AAPM does not however support the proposed use of PIP eHealth incentives to achieve this objective. We note again our objection to the timeframes proposed in this discussion paper.

- *Do you agree that active and meaningful use be revised to include other document types and viewing of records in later years of the PIP eHealth Incentive?*

  The uploading of care plans, team care arrangements, and Health Assessments would be a comprehensive and useful tool in a health record.
  While it would make good medical sense to have those documents uploaded, AAPM does not support the proposed use of PIP eHealth incentives to achieve this objective.

- *If you do not agree, what are alternatives and how would these demonstrate active and meaningful use of the MyHealthRecord system?*

  The previous Health & Prime Ministers had publicly stated that the PIP was to be overhauled and that a revised program would support Quality Improvement. The AAPM believe that any changes to the PIP eHealth incentive should be considered as part of the overall PIP move to a QI base; such a QI base would have the capacity to promote meaningful use of the MyHealthRecord through specific practice based initiatives.

Choosing the patient base - questions:

- *Do you agree with linking the PIP eHealth Incentive requirements to patients where a CDM item is claimed?*

  AAPM recommends that a more effective means of increasing the active and meaningful use of MyHealthRecord would be to change the Medicare descriptor for Chronic Disease, Health Assessment and Mental Health MBS items, to include the requirement for uploading of a Shared Health Summary. This would ensure that Shared Health Summaries are uploaded for the patient cohort with chronic disease and mental health care plans and promotion of meaningful use.

  An alternative funding model for Chronic Disease is proposed in the Better Outcomes Chronic & Complex Health Conditions Discussion Paper, August 2015. The new funding model could

include a requirement for upload of SHS. This is an example of why it would be prudent to wait on the outcome of the PHC Advisory Group deliberations before progressing this agenda.

- *Should assisted registration be considered as part of active and meaningful use and count towards any targets?*
  AAPM is opposed to assisted registration being included in the targets for active and meaningful use. Active use is the desired objective and assisted registration is merely a process involved in achieving that objective. A requirement to count the number of assisted registrations is an onerous requirement that does not achieve anything.

- *If you do not agree to linking targets to CDM items, what is the preferred alternative, why and how would this work in practice?*
  AAPM contend that the eHealth PIP incentive is a payment supporting practice infrastructure. The uploading of the SHS should be included in the descriptor for the Medicare items for Chronic Disease and Mental Health care plans, not linked to the eHealth PIP incentive.

  If a block-funding model is implemented for chronic disease and complex conditions, then the requirement for uploading documents should be embedded in the criteria for funding. However, to make this approach worthwhile, the requirement should be extended to the selected allied health providers who would also need to update the health record to receive their share of the funding. That way the record becomes a useful source of information for the allied health providers and improves the efficiency of communication between providers. If the allied health providers could send their reports to the referring practitioner by secure messaging and at the same time upload their reports to MyHealthRecord, there would be genuine use of the system as it was designed, rather than just counting uploads for the sake of achieving a target.

  Furthermore, the increased use of MyHealthRecord by the hospitals for access to history and referral information, as well as discharge summaries and medication changes would also be a major step forward to the active and meaningful use of MyHealthRecord.

Measuring active and meaningful use - questions:

AAPM reiterates its opposition to the use of the PIP eHealth Incentive as the driver for the upload of SHSs. However, if the government decides to pursue this course of action we have articulated our position in respect to the questions below.

- *Should the PIP eHealth Incentive establish a clear link to the training and reinforcement of learnings through uploading SHS for patients?*
  AAPM strongly rejects this proposal to link the eHealth PIP Incentive with training and education requirements. This measure creates greater pressure on general practitioners who already have overwhelming training requirements to maintain their professional knowledge base and credentials. In addition, some clinicians are already using the system effectively and should not be required to undertake mandated training.

  Practices and practitioners should be encouraged to make use of the educational resources available to support the effective use of the eHealth technology, but they should be able to autonomously determine their own strategies for achieving whatever targets are set.

- *Would a requirement for all healthcare providers to upload a tiered target of, say, 5 SHS per quarter in order to receive the PIP eHealth Incentive payment be considered reasonable?*

AAPM is strongly opposed to setting of a specific number of SHSs required to receive the PIP eHealth Incentive. A set figure for all practitioners is not considered fair as it does not take into account their proportional workload and associated patient load.

- *Should the upload number be linked to the patient population of a practice to fairly distribute the target? For example, 10 SHS per quarter per practice WPE of 1,000?*
  AAPM does not support a **counting** approach based on the WPE patient population. This approach will significantly disadvantage practitioners who are already actively uploading SHSs. The strategy should focus on setting targets that encourage practitioners who are not already active using eHealth to start using the system.

- *If you do not agree, how many total uploads do you consider would demonstrate active and meaningful use by a practice per quarter?*
  AAPM recommends that the target be based on a proportion of the claimed CDM, Health Assessment, and MHCP items to ensure capturing the patient group where benefit will be derived.

- *Should a target be based on a fixed number, a proportion of practice population, a proportion of patient type, or a combination?*
  AAPM recommends that any target set is a benchmark target based on a proportion of a practice population. Practices that have already been actively uploading SHSs may have already achieved that benchmark target and are rewarded for doing so.

  The benchmark target should not be prescriptive in terms of patient types. Practices have varying patient profiles and service models. Any specific prescription would limit the scope of practices that would be encouraged to engage with the eHealth system.

  The government should set a target and leave it up to the practices to autonomously determine their strategies for achieving that target.

- *Should a target be smaller at first and grow, or be static? Why?*
  We support initially setting smaller, achievable targets as an incentive for uploading SHSs. For example, the initial benchmark target could be set at 1% of WPE for the first quarter and increase by 1% each subsequent quarter.

  The challenge for practices with this approach is that the medical software programs do not have the reporting measures that would enable the practice to monitor their level of compliance. Requirements should not create additional work for practices in collecting data manually for the purpose of validating compliance.

  For a benchmark target approach to work, there must be an automated process for counting the activity against the target and this should be the responsibility of the PIP and not the responsibility of the practices.

Choosing a timeframe - questions:

- *Should the current quarterly measurement of the PIP eHealth Incentive be maintained? Why or why not?*
  AAPM believes the quarterly measurement should be maintained. Many smaller practices ~~are~~ structure their financial planning and business cash flow around quarterly payments in order to support operational sustainability. This allows for regular measurement of progress and readdressing of practice targets and will encourage continual growth across the whole calendar year and not in concentrated bursts.

SUMMARY

In conclusion, AAPM is very keen to contribute to the promoting and action towards increasing the active and meaningful use of the eHealth infrastructure. We believe that the future viability of our health system is dependent on the effective electronic connectivity and efficient and secure transfer of patient information between providers across the entire system.

AAPM is however concerned that the measures proposed in this discussion paper are ill timed and need to be delayed until the other aspects of health reform are determined.

AAPM proposes that embedding the requirement to upload SHSs in the Medicare descriptors for chronic disease and mental health care plan items is a much more effective approach to driving the outcomes that the government is seeking to achieve.

AAPM is very concerned about the suggested approaches to setting targets to maintain PIP eHealth Incentive compliance and particularly concerned that the practical details regarding data collection and reporting have not been considered or addressed.

The proposed measures to increase the active and meaningful use of the MyHealthRecord in this discussion paper are solely focussed on general practice. For the eHealth system to be an effective tool to support improved service delivery, the engagement of other providers including specialists, hospital and allied health providers is essential.

AAPM believes that ultimately the success of the eHealth system in achieving the objective for which it was designed depends on the broader community understanding the MyHealthRecord and the potential benefits to their health. Raising community awareness and expectation is likely to be the most powerful driver for increased and meaningful use of the eHealth system

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RECOMMENDATIONS FOR THE FUTURE

AAPM recommends that as a future aspiration, medical software companies should be required to enable critical data (such as Medications and Diagnoses) to be automatically extracted from the patient record, and automatically uploaded to the MyHealthRecord system. This would guarantee that the information in a MyHealthRecord is current and accurate. Patient consent to upload to MyHealthRecord should include automatic updates from clinical software until the patient withdraws or amends consent. Uploads of allergies & warnings, immunisations or medication changes would be automatic – not requiring any time or action from the medical practitioner. If it is automatic, targets will not be required. The eHealth PIP could remain linked to the use of compliant software.

Pathology, diagnostic imaging reports, and hospital reports must also become readily available in MyHealthRecord to encourage meaningful use by GPs. If the GP is the only provider uploading information to the MyHealthRecord it will continue to be difficult to encourage “meaningful use” as they already have access to this data in their own clinical software.

The patient’s GP will already have the information contained within the MyHealth Record; it is the other health/service providers who seek to gain benefit from the increased meaningful use of the system and increased inclusion of patient information. The system needs to encourage non-GP involvement, utilisation and participation.