Glenda Cunningham

The Congress opened with a presentation by Dr Ian Reinecke, CEO of Australia’s National E-Health Transition Authority (NEHTA), who discussed the progress of Australian e-health initiatives. Dr Reinecke stated that investment in e-health needed to include factors such as interoperability and data quality. It was observed that progress to date had been slow because projects were often conducted in isolation, there was a lack of confidence in ICT in the health sector and standards development was slow due to fragmentation within healthcare. NEHTA was established as a vehicle for national collaboration, and is independent of all nine Government sectors; it is, however, owned by them all. NEHTA was formed in July 2005 and has been given base funding of $28 million over four years. NEHTA will be developing e-health foundations including:

- unique patient identifiers
- use of a common language
- national directories to identify medicine, medical products, devices and consumables
- agreed specifications and standards for authenticating users
- design of national system of shared electronic health record

The Federal Government has allocated $2 million for specific projects. Three initiatives funded over three years are:

- national clinical terminology ($32 million)
- national individual identifier ($45 million)
- national provider identifier ($53 million)

NEHTA is looking at national standards to support an electronic health record at the national level.

The rest of the morning and some of the afternoon was spent looking at the different HealthConnect strategies in South Australia, the Northern Territory, New South Wales and Queensland. Each State has had a somewhat different approach.

In South Australia some important short term goals, such as improvement in sharing of information (secure connectivity), and improvement of communications between GPs, hospitals and aged care were identified. South Australia’s goal was the implementation of an electronic care planning program (proof of concept – does communication and collaboration work in the electronic environment?). It was discovered that a number of important building blocks were needed before moving to an electronic health record: unique identifiers, healthcare provider identifier and directory are needed as well as data messaging and clinical terminology standards. The care planning program is web based and is being used to enable GPs and other health team members to communicate with each other. The current focus of the care plans is on chronic disease and mental health. With regard to consent issues, South Australia has chosen an ‘opt-in’ method.

The Northern Territory has based their project around one central repository, with sharing of event summaries and key health information (health profile, discharge summaries, ED presentations, pathology results). Over 7000 consumers have signed up to this concept, which equates to 90% participation. It was found that most viewing of a client’s information occurred when the client attended a health service away from their home location. In the Northern Territory the system incorporates Katherine Hospital and Katherine West Health Board, as well as Binjari, Sunrise and Wurli Wurlingang clinics. Two types of event summaries are stored: medical and hospital discharge summaries. Consumers are able to ask for a printout of an audit trail that logs access to their information, identifying those who have accessed the record as well as what parts of the record were accessed.
New South Wales has developed the Health elink project. This pilot program is running in two regions. In the Hunter Valley the pilot focuses on people 65 years and older, and in the Greater West children aged 0-15 are targeted. The participation model in New South Wales is ‘opt-out’ with a 30-day ‘cooling off’ period. During the cooling off period no information is available on the system. Using the opt-out system, only 13 of 474 eligible people so far have taken advantage of this choice.

The HealthConnect project in Queensland is a point of care to point of care scenario, using PKI (public key infrastructure). This trial has been running for 18 months and there have been some data quality issues between the different systems. Queensland felt that a point of care system was easier to implement rather than a shared electronic health record because of privacy and technology issues. For this trial, Queensland used a service oriented architecture which will not easily allow Statewide rollout. Queensland is currently working on a single identifier.

Our speaker in the afternoon was Klaus Veil, who discussed an interoperable framework. He documented all the existing and emerging healthcare standards, then talked about electronic health record standards and HL7, a form of computer messaging, and discussed why it was important to have standards.

The last speaker of day one was a Health Information Manager from Logan-Beaudesert Hospital who discussed this organisation’s experience with a hybrid electronic medical record. This facility is using a web based interface, and scan progress notes, care plans, consent forms and corporate forms into a program called ERIC, which is an oracle database. Scanned documents are stored on optical disk in a juke box. The storage capacity of the juke box is 5.2 GB per disk, but juke boxes are becoming obsolete and as a result Logan-Beaudesert Hospital is planning the move to magnetic storage and retrieval, which will allow faster retrieval in high demand situations. The speaker highlighted the reduction of medical record staffing from 22 EFT (effective full time) to 7.5 EFT. It was pointed out that, because of the electronic storage of documents, this produced other work such as ensuring that clinicians signed off on orders and this had to be monitored more vigorously than in a paper world.

I found the Congress to be very beneficial in updating my knowledge. I would like to thank HIMAA for the opportunity to attend.

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