

## Whole of Health ICT Strategy for Victoria 2009-13

### Discussion Paper – Stage One Consultation Forums

#### 1. Purpose

The purpose of this paper is to provide feedback about the forums held in Stage One, including participants' view of both the current and future state.

The paper will inform the second consultation phase in the process to develop a Whole of Health ICT Strategy 2009 -13 to meet health system challenges. The paper thus does not describe the proposed future state but rather is intended to help stimulate thinking on what is the value of the ideas contained in the paper and which of those (or any others) the sector believes to be of greatest potential benefit to the Victorian health system and why that it is so.

#### 2. Feedback from Stage One Consultation Forums

From focus groups held during July 2008, a number of themes emerged to describe the current perceptions of information and communication technology state in Victorian health services and thoughts on a potential future state. The themes that emerged and a summary of the concerns and opportunities are described below:

##### ***Patient safety and quality***

Current state views included:

- decision support resources for clinicians are in very limited supply.
- very little data on patient outcomes – clinical audits rely on paper
- scanning documents minimises risk of information loss but is only an interim solution
- lack of enforced standards means systems won't talk to one another
- legacy mental health and alcohol and drug systems are inhibiting capacity to provide most effective care to clients
- telemedicine is helping reduce professional isolation but no co-ordinated approach

*"Want all the material collected on line. Paper is a disgrace. Paper kills more people in health care. Important to look at how we use data to improve health care"*

*"Need to get the clinical systems right and the rest will follow"*

*"Have someone at Alfred – supporting Bendigo, Echuca, Swan Hill and Mildura – telemedicine supporting patients remotely is important to access gerontology services."*

*"Vision needed for a clinician to go to a screen and get what they want immediately."*

Future state discussions suggested:

- initiatives that support efficient safe delivery of care, including e-prescribing and electronic ordering
- easy access to pathology and imaging results
- systems that support access to information at the point of care regardless of setting
- systems that are intuitive to use for clinical staff
- systems that are scalable and configurable for local needs
- consistent reliable telemedicine capacity for rural and remote services.
- bringing data together to keep up to date evidence based research, latest protocols, access to journals and the like.

### **Continuity and handover of care**

Current state views included:

- privacy and legislative constraints limit appropriate exchange of information
- referrals remain largely manual – current “e-referral” systems mostly require manual intervention
- multiple service directories are being maintained
- care plans in one system are not accessible to others involved in care
- electronic exchange of information between hospitals, GPs and NGOs only occurs in isolated instances
- hospitals cannot receive ambulance information into their systems

*“Reality is that information does not flow seamlessly – private providers of radiology and pathology – no linking – lots of paper and phone calls. Some e linkages between GP and provider but not with the hospital.”*

*“Implication of how technology is changing – social changes – Google, Facebook – social networking is moving so quickly the ICT strategy may not be able to take advantage of it.”*

*“Danger to focus on hospitals. Journey starts with patient presenting for first contact not the hospital – all that information needs to be commonly shared and accessed. No point re-gathering information at each point.”*

*“part paper part electronic system is fragmented, requiring lots of handovers and different points of approval.”*

Future state discussion included

- the capacity to share information between GPs, community health, community care and hospitals, and give access to information by patients.
- implementation of a universal patient identifier
- enabling legislation to allow exchange of information while still protecting privacy
- enforcement of data and secure transmission standards
- critical information includes patient demographics, referral, imaging, pathology, medication, assessment information and discharge summaries
- in the longer term, an Electronic Health Record or a healthcare smartcard but wait for national developments.

### **Interaction with consumers**

- the public are not well supported by technology in interacting with the health system and increasingly expect to be able to do so
- systems need to better focus on helping people before they need to access acute services

*“The clients want to have access to information systems. Kids who come in want the Internet and patients want to manage their own data through patient portals.”*

*“A common approach to develop content in internet setting – for patient education, patient care, post operative care – would provide true value to patients. Need to develop framework for sharing.”*

*“Focus has been on making things better for agencies – need to look at systems improving outcomes for patients”*

Future state discussion included

- patient centric systems that recognise patients who want to manage their own clinical data and access to information about managing their care
- patient access to their own health record regardless of location – in emergency, in hospital, visiting GP, at home, metropolitan or rural.
- changing technology opens access to opportunities such as Google, Facebook, electronic directories, SMS reminder messages, customer kiosks, on-line booking.

### **Support for the workforce and change management**

Current state views were:

- poor computer literacy, data analysis skills, and use of communications technology, and limited access to training, all impact on support for ICT implementation.
- many agencies are developing learning management systems in isolation
- IT support resources are small for the level of support required within many services.
- reforms are required in cultural views about information ownership, willingness to share information (e.g. primary care and acute), and willingness for services from different sectors to work together and develop common business rules.
- adjustment to electronic work environments has been seen to be primarily for data collection rather than supporting service delivery
- service providers are being required to report duplicated information in varying formats to multiple program areas in DHS and the Commonwealth
- there is not a good understanding about the scalability of applications for rural areas or the constraints due to the lack of a skilled workforce to support implementation.
- the need in rural areas for GPs to be included in the change has not been possible in many places

*“Previous implementations have not engaged clinicians – engaging them is difficult, need to have clinicians as change champions”.*

*“Resources need to be provided beyond the initial implementation to embed the change processes.”*

*“Very complex task to get multiple systems working together – business rules on State/ Commonwealth reporting are too complex and the business systems cannot cope with it.”*

Future state discussion included:

- systems that improve services provided to patients and focus on workflow designs with immediate visible benefits rather than on DHS or agency reporting needs or replicating current processes.
- systems need to be intuitive and learning management strategies included in the implementation of systems.
- ensuring end users and local people who can make it work are involved with the initiatives at the start
- rationalisation of central reporting requirements so that data extraction is natural by-product of information need for service delivery
- establishing and supporting communities of practice to support knowledge sharing

### **Maintaining basic infrastructure**

Current state views presented were:

- current capacity of infrastructure including legacy systems and connectivity infrastructure limits local choices and uptake of strategic state systems.
- multiple network solutions in place with many unable to guarantee quality of service
- replacement of infrastructure often relies on capital grants or opportunistic funding

*“Having a high speed link to the site “front door” is not enough if local networking within the site is not up to standard.”*

*“Do not have funding strategy for replacement of equipment...eg if computers die, they die...no funding to replace servers.”*

*“Infrastructure is a major enabler. A refresh strategy should allow continued renewal of infrastructure”.*

Future state discussions covered

- a standard minimum capacity for communications, data storage and transfer, and security at and across each site.
- a single state wide medical grade telecommunications network for data and voice.
- leasing rather than purchase of infrastructure

### **Funding and governance**

Current state views discussed were:

- the benefits of current system implementations are not necessarily apparent to local decision makers
- those benefits which are achieved are usually not measured against a baseline
- when budgets are constrained, IT is not a priority for implementation nor for product sustainability through adequate recurrent provision.
- economies of scale have not always been leveraged where charges for some products have resulted in resistance to implement
- alliances are struggling to be viable and support small agencies affordably

*“People have struggled with what the benefits are vs financial cost – is there a business case for it?”*  
*“Important to develop a funding strategy for sustainability – need to look at the growth of services and traffic”.*  
*“We are an information business – need to recognise that it is all about sharing information. e.g. 1.5% of GOR on ICT while Justice is 12% on GOR. Needs to be seen as intrinsic to core business”.*

Future state discussions focussed on

- the future funding framework needs to include clear governance and accountability, financial incentives including innovation incentives, and a plan for sustainability.
- executives and government need to be ‘sold’ on the benefits and recognise external benefits realised by community (e.g. discharge summary reducing adverse events)
- strategy should encourage competition within an agreed mandated framework and set of standards.
- capacity to take up local initiatives and nurture into quick wins.
- clear guidance on conduct of implementation planning studies so full impact understood by agency when committing.

### **How can you contribute?**

- Consider the issues raised in the paper.
- Think about the challenges from a systems perspective, not just from your part of the health system including how we may need to change the way we operate.
- Consider the questions for discussion
  - What future state might look like
  - What the priorities should be
  - How we could make that work (eg governance, enablers)

Written contributions are welcome and should be sent to the address below.

### **Contact**

Peter Williams  
Director IM & T Health  
[peter.e.williams@dhs.vic.gov.au](mailto:peter.e.williams@dhs.vic.gov.au)