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Division of General Practice Ltd.

Data Quality and the eHealth Challenge

Noel Stewart

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Disclaimer

What I am about to present and say is a personal view and does not reflect the views of the NEV (CEO, Chair & board members) or, DoHA, NEHTA, RACGP, a Medicare Local or any other organisation on this earth and beyond

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Data quality problem areas

- Medications
- Progress Notes
- Histories and summaries
- Allergies and Warnings
- Family and Social Histories
- Measurements
- Smoking and Alcohol

RACGP Standards for general practices (4th edition), criterion 1.7.2: health summaries. *Our practice incorporates health summaries into active patient health records. Health summaries assist in providing ongoing care, both within the practice and on referral to other healthcare providers*.

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Regulation 4 Health Insurance Act 1999, and Section 81 which says effectively that "each entry needs to be sufficiently comprehensible so another medical practitioner relying on the records can effectively undertake the patient's ongoing care…"

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Medication Lists

RACGP recommendations for the recording of medicines

This includes:

- ❑ diagnosis/problem as to why medicine prescribed (coded)
- ❑ all medicines (e.g. over the counter; complementary therapies; topical therapies) should be captured

It may be the case that there are no medicines to record. Record utilising the functionality of the software: unknown; none; or not asked.

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Medication Lists

Possible data quality problems

- Incomplete medications list - not all medications recorded, including samples, prescribed elsewhere, OTC and complementary medicines
- Examples of expired medications (those in red) - could be partly explained that many may have been OTC
- “Reason for medication” not recorded for prescribed medications
- Underuse of “Confidential” in “Reason for medication”

Remember: The items listed in the current medication screen are what go into the eHealth “Shared Health Summary”

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Progress Notes

"Each entry needs to be sufficiently comprehensible so another medical practitioner relying on the records can effectively undertake the patient's ongoing care…"

Possible findings...

- Inconsistency among the GPs in the recording of "Reason for contact" for all encounters
- Overuse of uncoded items in "Reason for contact"
- Underuse of "Confidential"
- Inconsistency among the GPs in the amount of detail recorded in Progress Notes

Recording "Reason" makes it easy for the doctors to get a quick overview of a patient history by perusing the previous progress notes

Progress Notes do not go into the eHealth "Shared Health Summary"

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Histories and Summaries

"In my experience, this is the biggest problem area in General Practice. 50% of GPs don't know how to, or don't bother to record accurate histories" - Noel Stewart, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013,

Most likely findings...

- Poor understanding of how "Summary" works, resulting in:
  - Repeated items, e.g. Asthma 4-6 times on summary lists
  - All items "Active"
  - No "Summary" items at all
- Uncoded items (free text) misused
- Poor use of "Confidential"

Remember: all items (except those marked "Confidential") go into the eHealth "Shared Health Summary"

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Histories and Summaries

Recommendations...

- A team meeting to discuss ways of assuring that history summaries of all doctors are kept up-to-date so that there is a **clear distinction of Current History (Summary box ticked plus Active) and Past History (Summary box ticked plus Inactive)** – this will mean that Health Summaries will be accurate which is important for re-accreditation, and accuracy of referrals, Care Plans and Health Assessments, <u>but unfortunately not for the PCEHR at this stage</u>.

- Maybe consider the use of "Confidential" in more cases where patient confidentiality needs to be respected (HIV, mental health conditions)

- It is suggested that all GPs be made aware of the RACGP recommendations for the recording of "Reason for contact"

  This includes:

  - comments and free text to provide further detail as relevant
  - problem/diagnosis/procedures and clinical interventions use coded text
  - record so as to protect patient confidentiality (e.g. for HIV status, mental psychosis)

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Histories

How they have worked in the past...

- Correct use of Summary box and whether “active” or not leads to a clear distinction of **Current History** (Summary box ticked plus Active) and **Past History** (Summary box ticked plus Inactive). - this leads to accurate Care Plans, Summaries and Health Assessments

  Let’s see how this works in MD...

  ... And then how it works for eHealth summaries (including the PCEHR)

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eHealth Summaries

There are 3 elements of the history component of the Shared Health Summary:

1. **Problems/Diagnoses**:
   No distinction is made between summary/non summary or active/inactive items. It is a bit disappointing that Problems/Diagnoses don't distinguish between past history (Summary + Inactive) and current history (Summary + active).

2. **Procedures:**
   Certain History coded items are coded as "Procedures". You do not need to use the Procedures button in Progress Notes for items to end up as Procedures.

3. **Other Medical History:**
   This includes all non-coded items as well as coded "administrative items" such as care planning, assessments, reviews and phone calls...
   ... and all the crap items

Only "Confidential" items are left out of the Shared Health Summary – everything else goes in!

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eHealth Summaries

My conclusions:

1. **Good record keeping GPs will be punished**
   Non-summary items go back into the eHealth summary. That is the history list may get "rescrambled" back into a "dog's breakfast"

2. **Limited editing**
   Any editing such as deleting items has no effect on the MD record, which must remain the "true source of truth".

   You cannot **Add** items

   You can sort columns, but date columns don't work properly in MD

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eHealth Summaries

My recommendations:

1. Change to a more meaningful structure for the Shared Health Summary (for a start create a Current History and Past History distinction)

2. Don't include non-Summary items

3. Pay doctors to be trained in accurate recording of histories so they create meaningful Shared Health Summaries and so save the PCEHR from being useless

4. Make it an accreditation requirement that histories are accurate (new standards for PCEHR compliance), or at the very least that all GPs be made aware of the current RACGP recommendations for the recording of histories.

I DO NOT expect anyone at the top of the NEHTA / DOHA / AMLA pecking order to take any notice of what I am saying!

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Clinical Usability Program (CUP)

Are NEHTA and DoHA making changes:

- CUP is a programme of work driving the clinical usability of eHealth products and services.
- It has oversight of specified NEHTA projects that contribute to improved clinical usability.
- The programme sponsors and manages specified projects to ensure that NEHTA has the appropriate focus on clinical usability
- CUP will monitor and track the progress of projects under the programme umbrella, as well as benefits realisation of the programme as a whole.
- CUP Steering Group have representation from most health organisations

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In conclusion...

- I hope that CUP does make it easier for doctors.
- I hope that the RACGP takes more responsibility for guiding the PCEHR to being more usable.
- I hope that the millions of $$$ won't continue to be wasted
- I hope that the Coalition review of the PCEHR will lead to a better product.

I live in hope...