AAAPC response to Department of Health General Practice Data and Electronic Decision Support. Issues Paper

1. Do you agree with the policy objectives outlined?

We agree with the overall objectives. However, we seek greater clarity about ensuring general practice data are available to researchers, with due governance processes in place. It is unclear who 'other health system actors' are but this needs to include researchers who wish to access data for quality improvement, population health planning, and clinical and health services research. Furthermore, the document needs to clarify that data currently collected by PHNs should also be available for analysis by researchers. There need to be established frameworks to support access to GP data for research rather than limiting it to use by PHNs and AIHW.

A further point in relation to objective bullet point 3: we believe the sentence could be reworded to 'ensure that the safe, secure and timely sharing of de-identified general practice data is not inhibited by systems or costs.' This issue of timely access to data is especially relevant in the context of GP data for cross-jurisdictional sharing and linkage.

2. Are there other objectives Government should consider?

No, other than the points raised in response to question 1.

3. Are there other current or potential future benefits or uses of general practice data that should be considered?

In the context of Fig 1, while not wishing to overcomplicate the diagram itself, there are other sources of data which could be fed back into the PMS either directly or via eCDS in the near future for potential benefit: data arising from hospital and specialist care, and data generated by patients such as PROMs, wearables etc.

4. What aspects of the current system in relation to general practice data work well?

Practices have choice in terms of what data are shared and with whom, including PHNs, NPS Medicine Insight and universities. Some of these organisations have very well established mechanisms to support data access for researchers.

5. What aspects of the current process in relation to general practice data are of concern?

There are several areas of concern:

Variable data governance and processes for access by different organisations who hold the data. Some are far more rigorous and transparent than others.

The apparent move of PHNs to take over control of GP data, for example in relation to the ACCC granting of a five-year anti-competition ruling. This is of significant concern to other groups who wish to access data or develop clinical decision support tools.

Variations in data extraction tools, and systems of coding data. We agree about potential benefits of using SNOMED terms across PMS/EMR systems but also propose consideration of the role of OMOP as a common data model, especially to support linkage to other datasets.

We share concerns about current models of local data storage by practices and potential risks to data security. However, the move to cloud-based storage is a significant threat to data access for research and service planning.

6. What general practice data should be shared, with whom and for what purposes?

We agree that predefined data fields from GP EMRs are required by government to support local, regional and national planning and policy. More extensive data extracted from the GP EMR has significant potential benefits for research including health services and clinical research, and development of decision support tools using algorithms derived from the GP data. With appropriate mechanisms for de-identification and research governance, and for specific research questions, we believe there is a case for access to the free text clinical notes data.

7. Under which conditions should governments have access to aggregate general practice data?

Pre-defined limited data fields for specific purposes and with explicit research governance processes.

8. Are there any issues not covered above that impact on ongoing access to general practice data?
   No

9. What is the single, most pressing issue facing ongoing access to general practice data?

The potential threat to access to data from cloud-based data storage, and from growing corporatisation of general practices.

10. What upcoming developments may impact the flow of general practice data?

See response to q9.

11. Are these examples relevant to Australia?

These are relevant examples to an extent, but the complex federated model of government adds an additional complexity within Australia, especially when considering linkage of GP data. We believe there is benefit, as exemplified by GP IT Futures, in having a limited set of PMS providers that meet technology and data standards, rather than a single PMS solution such as ProCare in Auckland. NHS Digital provides transparent processes for storing GP data and making it available to third party organisations for research. It also supports linkage studies, for example for CPRD linkage that enables access to richer GP data linked, via NHS Digital, to other national healthcare datasets.

12. What other examples might inform the secure future for general practice data in Australia?

NPS Medicines Insight; CPRD (UK); RCGP Research & Surveillance Centre (UK).

13. What aspects of the current system in relation to eCDS work well?

There are limited examples of eCDS working well in routine practice at present.

14. What aspects of the current process in relation to eCDS are of concern?

There are several issues of concern:

Problems of integrating eCDS into PMS, even where evidence exists of potential benefit of its use in general practice. This reflects significant barriers by PMS companies to engage with developers of eCDS and uncertainty about the commercial benefits of incorporating eCDS tools into the PMS.

Problems of how eCDS integrate in the clinical workflow as point of care tools. This includes problems of prompt fatigue, and GPs knowing when/how to access a specific eCDS to support a clinical decision during the consultation.

For eCDS developers, the ACCC anti-competition ruling in favour of PHNs and its eCDS tool could potentially affect innovation and choice of eCDS tools.

Lack of a centralised repository of relevant Australian clinical practice guidelines to be implemented within eCDS.

15. What upcoming developments may impact eCDS functionality and integration into clinical workflows?

Advances in AI-based eCDS could eventually enable use of data within the PMS/EMR to flag patients at risk of missed diagnoses and other adverse events. This would potentially be more accurate than existing rules-based algorithms but risk being less transparent in the reasoning for specific recommendations.

Developments in FHIR and API functionality could have important impacts on integration of eCDS into the PMS and potentially on integration into clinical workflow.

16. What do you think is the appropriate level of Australian Government involvement in the governance/oversight of eCDS?

We support the current role of the TGA and its updated guidance on software as a medical device, including eCDS.

We believe there is a role for government in setting standards for PMS that would better support integration of eCDS into GP EMR systems.

Finally, given the significant potential of eCDS to improve the quality of care in primary care, we suggest that this is a priority area for future research funding through the MRFF including both trials to test cost-effectiveness of eCDS, and implementation research to understand how eCDS can be integrated into the clinical workflow in general practice.

17. What do you see as the benefits of eCDs use for shared decision making at point of care?

There is strong evidence of benefits from using eCDS at the point of care including: improved access to and implementation of clinical guidelines; improved risk communication and shared decision making; reduced medical errors for example in relation to medication errors or missed diagnoses; improved use of investigations. The challenge is implementing this evidence, much of which is from standalone eCDS tools, and integrating the eCDS tools into the PMS so that they are more likely to be used in routine consultations.

18. What do you see as the issues/challenges of eCDs design and use and what are the associated impacts?

Some of these have already been discussed above but there are several issues:

Integration of evidence-based eCDS tools into the PMS.

Design of point-of-care eCDS tools that operate within the PMS and prompt clinical action when required in the consultation.

Models of funding GPs to have access to evidence-based eCDS tools and commercial drivers for PMS providers to integrate eCDS into their systems.

Current variable state of GP digital infrastructure which means no capacity to implement eCDS in some practices.

19. Do you have any suggestions as to potential next steps to address any identified issues and challenges?

Government to set standards and create commercial drivers for PMS to integrate evidence-based eCDS tools into the GP EMR systems.

Targeted research funding schemes that support partnership between industry, researchers and clinicians and test integrated eCDS (eg MRFF TTRA scheme; NHMRC partnership grants).

20. Are there other levers the Government should consider introducing?

Practice digital infrastructure funding to upgrade systems so that they have the capacity to use eCDS.

Incentives for PMS providers to integrate evidence-based eCDS tools.

21. What impact might different levers have?

Potential improved access to and uptake of evidence-based eCDS.

22. and 23. Which of these levers of change should be further explored and why? What specific options might be considered?

Regulation and incentives for PMS providers to work with developers of evidence-based eCDS tools to integrate them and promote their use in practice.

Incentives for GPs to demonstrate access to and use of eCDS via ePIP.