15 July 2010

Consultation on PMS
Requirements

By email: pms@gpnz.org.nz

PMS Requirements – Discussion Document – June 2010

We are pleased to be able to provide comment on this document. We have been unable to consult with our members as fully as we would have liked due to responses being required one week from its receipt. The extension until Wednesday 14 July has ameliorated this somewhat.

Our comments are as follows:

Patients First

We note the name change to Patients First. Although a minor point, we wonder whether the name properly conveys to the reader what the programme is aimed at or what its boundaries are.

In the last paragraph on the Patients First background it states that

> "Patients First seeks to define and refine the strategy for primary care health information and quality and build a single, integrated governance group around this".

In this regard we would like to know whether the quality work stream has been included, and if it remains a separate workstream within the College or whether its work has been completed.

PMS Project

We believe this is an important project and we are very pleased that it is being led from within Primary Care rather than being done by a government department or vendor group.

> "Practice Clinician   Improved ease of use functionality and information accessibility, including having access to a continuum of care view of patients records, whoever is providing that care."

In respect of this objective we would expect to see something added about the need for a vendor to be responsive to user requirements. The GP practice must remain the prime customer and any system must be responsive to the needs of practices. It is usually the practice that is responsible for the monthly fee.

> "PHO/MSO   A structured framework for recommending preferred PMS vendors to enrolled practices, improved information flows to make funding / claiming / administration more efficient and for better practice / PHO population health analysis for contract reporting and service design / monitoring."

This objective assumes that it is the PHO/MSO's job to choose/recommend the PMS system. Most practices however view it as a business decision to be made by the practice. While there are advantages to having a larger organisation do the evaluation, and obvious advantages to the PHO/MSO to have all their practices using the same system, we do not believe that the assumption, that this should be a PMS/MSO role, should simply be accepted.

> "Patient
> & Whānau   To be able to access appropriate functionality to improve the clinical relationship, including potentially appointment management, prescription renewals**, and access to other aspects of the patient's record and education material to improve their understanding and management of their health.** As Personal Health Records (PHRs) become more available and networkable monitoring devices options for sharing that information with their doctor or other care provider will be needed." (Emphasis added)

In our view, the most important part of this objective are the words highlighted above. Anything that can be done to give patients access to their records, in a manner which assists with their understanding and management of their health, is not only worthwhile, but should have priority. The more functional examples given such as appointment management and prescription renewals are much more complex activities than might be assumed, and often benefit from personal discussion between the patient and the receptionist.

Patient access also needs to be controlled by practices. Some may want very little access and others might want patients to be able to make appointments on-line. Most will be somewhere in between.

Programme Governance
Although no comment has been requested on the programme's governance we think this is an area where input is required. Issues that need to be addressed are the ways in which feedback can be provided to those on the governance group, and who will set the priorities for new developments/improvements of PMS. In our view the

make up of this governance group should be weighted towards clinicians, who should have broad representative backing from all facets of general practice

GP2GP – Patients First

The report states:

> "It is also recognised that broader information sharing will need agreement on the standards that vendors will need to support. To that end, the GP2GP Project has been brought within the Patients First programme".

GP2GP is a separate programme with the clearly defined objective of safely transferring a patient's clinical record from one practice to another in a useable form. It was not our understanding that GP2GP was brought into Patients First to allow for broader information sharing on the standards vendors will need to support. Indeed, our understanding of the reason for moving GP2GP into Patients First was the much more pragmatic one of wanting to complete the project in a shorter timeframe at a reduced cost, compared to the programme established within the Ministry of Health. Having said that we believe that the GP2GP project could be used to drive this initiative.

Scope

In regard to the sharing of all information we stress that the key will be the sharing of **relevant** information as there are significant issues around patient privacy that will need to be considered and addressed. We are concerned that, at this point, privacy issues do not appear to have been given sufficient weight.

Approach to Developing Requirements

Given the importance of this document to general practice, in that PMS systems are a key tool used by all in general practice on a daily basis, we would like to see all general practices consulted. In this way, we anticipate the project leaders are likely to get a better appreciation of "bottom up" needs and concerns.

Litmus Test for Success

We suggest that you add the following to your list of principles which will act as a litmus test: *"Improved satisfaction with the PMS systems by the users and purchasers of the system".*

Funding Network

You have set out a diagram of the funding network. An important source of funding that seems to have been omitted is the patient co-payments and payments by other parties (e.g. insurers, employers etc).

National Collections/Population Health Network

Not stated in the report, which we think should be, is the requirement that any health information which is sent to National Collections should either be non-patient identifiable or, in those limited circumstances where patient identification is necessary, with the patient's express consent.

Appendix

  3.1 The appropriateness of recommending adoption of particular research based user interface guidelines.

We believe that a workshop on this, is the only way the group will be able to get full and detailed discussion of this issue. We suggest that you hold one if this has not already occurred.

  3.2 The requirement for a published API and the appropriateness of the GP2GP standard as a basis for that

We think it is entirely appropriate that previous work is used, and built on, in terms of cost-effectiveness and to avoid problems with incompatibility of components of the system.

  3.3 Use of LOINC codes, Universal list of Medicines and other future coding systems mandated by standards.

In our view this is essential.

  3.4 Whether the requirements for patient and whanau access should be strengthened to require support for at least minimum access capability

Whānau access requires a different level of discussion around privacy and confidentiality to patient access. This discussion needs to occur before the capability for whānau access is mandated.

  4.2.4 Whether a standard for transfer between commercial PHR services is required, similar to that being adopted with the GP2GP standard for PMS transfers.

We believe this would help with future proofing.

We hope our comments have been of help and look forward to further consultation and discussion on this.

Yours faithfully

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Chair, NZMA