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Achieving an Integrated, Engaging and Collaborative Healthcare System was the theme of the CeBIT eHealth Conference, with broad representation of speakers from around Australia as well as internationally (US and Scandinavia). Featured speakers included Ray Brown, CIO Queensland Health, and Dr Mukesh Haikerwal AO, NEHTA National Clinical lead. Main topics included interoperability of technology and software across health-care; improved systems for the transfer and convergence of patient data; integrated and unified communication technology in hospitals; mobility, e-care, telemedicine, remote access and real-time tools that aid in healthcare self-management and consultation; improving the patient experience through the latest technology; and connectivity and e-health with the National Broadband Network (NBN).

A number of papers demonstrated how patient-centric care is becoming a reality; for example Dr Gail Casper of Project HealthDesign at the University of Wisconsin described projects that enable the collection of data by patients. Applications included medication support, chronic disease management, pain diaries and care plans that work around patients’ lives and put them in the centre of managing their healthcare. I particularly liked the heart monitors in gym equipment networked to GP centre of managing their healthcare. I particularly liked the heart monitors in gym equipment networked to GP advice, enabling useful remote consultations!

The role of the personally-controlled electronic health record (PCEHR) and the management of chronic disease was the theme of Professor Michael Georgeff’s presentation. The path to transforming healthcare is crippled by current knowledge failures. The key to success is to learn from accurate assumptions and develop an adaptable knowledge-based industry. Development of applications that enable collaborative care, embed evidence-based care plans, prompt for follow-up and automatically collect data for evidence-based care improvement are required. Unbound, lightweight, future-proof, internet model healthcare technologies will be required to transform healthcare.

With the same emphasis on patient-centric care, Dr Mukesh Haikerwal AO talked about the four pillars of the National Health and Hospitals Reform Commission: taking responsibility – the individual/better information; connecting care – comprehensive lifetime care; facing inequalities – causes and impact of health inequalities; driving quality performance – best use of people, resources and evolving knowledge.

Following on from the February Council of Australian Governments (COAG) agreements, e-health will be a driver to improve quality and safety, reduce waste and improve continuity of care. A business case needs to be made to ensure data are available to prove safer care through e-health. Consumers are being seen as the aggregators of care. Secure messaging to link primary and acute care is essential to this development and the NEHTA standard will be available from July 2012. The PCEHR, available from 1 July 2012, was described as a health summary; a one-core, curated record with consumer permission where provenance of entries is crucial for success. Areas for patient supplied information and respected source information with incentives for clinicians is required.

Several case studies provided valuable insights into what made the difference to the success of particular projects. A case study of a rollout of an e-health project in aged care was described by Jenny Zirkler from Nambucca Valley Care. She had some useful hints for those at the coalface. She was able to lead the geographically isolated facility through a transition to real time clinical data entry from a paper-based system that had resulted in duplication of information and delayed capture of data. A combination of awareness of ‘what’s in it for me’, active listening, a phased roll-out and creative problem-solving were valuable tools. Executive support and encouragement of champions with mixed skill sets was critical. She recommended being sure to sit with users and see what they were reporting as problems and was able to resolve many of these issues at the time. It was also important to celebrate success. Notifying patients that staff were learning new skills and would therefore be slower in the early stages was also something that may be overlooked.

Another case study from Dr Calin Pava from the Devonport GP Superclinic, established in 2006 and expanded in 2009, was an example of a multipurpose facility that had assessed community needs and combined dedicated areas for chronic disease management, tele-health and allied health. One electronic record supports all clinic activity which provides a paperless, real-time clinical tool. An online appointment facility is proving very popular with patients, with 30-40% of appointments made this way. However, progressing to this stage did not come easily as marketing techniques were confusing and there was a fragmented decision making process at practice level that made calculating the cost/benefit ratio difficult. Recommendations included using cloud computing.
computing to reduce costs and to bypass the need for local IT expertise. Problems with encryption of data flows were also highlighted. A wish list for the future included better cooperation among software providers, user level research, greater participation from specialists in a paperless record and for state governments to talk and plan together more. They now have a GP retention rate of 98% and a positive community response to more facilities available in one place.

Practical applications of telehealth were illustrated by several speakers, including Dr Anthony Smith, Deputy Director and Associate Professor of the Centre for Online Health, University of Queensland, who described remote and mobile delivery of care in paediatrics. A centralised coordination centre for paediatric telehealth has been running at the Royal Children’s Hospital in Brisbane since 2000. A 1800 number links patients and GPs to 37 sub-specialties. Over the last 10 years, 11,250 consultations have been completed. The service started small with two sites, whereas there are now 97 sites with 17% of burns management accomplished via telehealth. ENT diagnosis has proved to be 99% accurate through audit results. An Indigenous health outreach program using a purpose-built mobile clinic has resulted in a drop in middle-ear infections from 83% to 39% in 12 months.

Medicare rebates for telehealth for both parties (e.g. GP and physician) will be a catalyst for change with the NBN being a key driver.

Dr Jenny Prentice, Project Director of WoundsWest in WA, described facilitating evidence-based wound management incorporating mobile technology. Wound prevalence surveys are able to be done via mobile phone, which provides data to back up telehealth facilities and online education. Reductions of 25% to 33% in wound/pressure ulcer/skin tear prevalence has been demonstrated, saving $4m in care. The education package is available on-line at www.health.wa.gov.au/woundswest/home/

It is important to be able to present the benefits to clinicians for engagement, Dr James Sartain from Cairns Base Hospital maintained, when describing the Automated Anaesthetic Record Keeping Project (AARK). This system has helped to break down ‘system silos’. It was developed in Cairns in 1999-2001 and rolled out from 2008. Dr Sartain said it was already live in 26 hospitals, and by the end of June 2011 it would be live in 40 Queensland hospitals. The system automates and integrates pre- and post-operative information, automatically capturing monitoring output. This has resulted in a readable, reliable, retrievable, real-time record. Therefore, remote help can be provided with the benefit of all the information available. Other benefits include quicker data entry time (able to select default drug sets), and good defence for practice and improved quality of record keeping. Data can be automated for college credentialing, staff training purposes and clinical indicators. The success of the project was attributed to collaboration, acknowledging the different ‘languages’ of the stakeholders and the common clinical goals held.

Details of the Winchart system are available at www.medtel.com.au

All that was left to do was to walk through the CeBIT exhibition halls (all five of them), which was comprehensive to say the least. The Austmove NBN conference, Cloud Computing Conference, eGovernment Forum, Retail, WebForward and eHealth conferences were all held at this venue, so the scope of the information on display was immense.

The CeBIT eHealth Conference successfully brought together industry, government and healthcare providers. I found the case studies particularly interesting and relevant to my role as an Electronic Health Information System Project Manager, and it was useful to have the many e-health advances around Australia and internationally placed in context. Patient-held records and the fast growing telehealth developments pose challenges for managing privacy, data and scope of practice; all areas where Health Information Managers can provide much needed expertise. There is no doubt that e-health will be a critical enabler of achieving an integrated, engaging and collaborative health system.


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