

Governance and ownership

- The issue of 'who' will have responsibility for managing and securing the various repositories required to support HealthConnect needs to be determined as a matter of urgency.
- The Business Architecture (BA) refers to downloading information from HealthConnect to a provider's local system. If the consumer decides later to withdraw from HealthConnect completely, is it the intention that all information that has been downloaded by individual providers will need to be tracked down and purged ?

Responsibility, ownership and duty of care.

- Once a health care provider contributes an event summary to HealthConnect, the ownership of the information within HealthConnect then passes to the consumer. Does the provider still retain a responsibility / duty of care for that information ? If so, for how long.

For example, if a provider supplies an event summary and sometime later corrects the source information on his/her own system, is the provider obligated to send an update message to HealthConnect ? If so, does this mean that systems will not be allowed to send messages to HealthConnect if they are not capable of handling version control of data and the transmission of update messages.

- If a provider (other than the one who originally contributed an event summary) thinks that information in a previous event summary is incorrect, perhaps dangerously so in the case of an allergy, is there any process for the provider to get that incorrect information changed ? Does this involve consultation with the original provider ? (These are not technical issues but business rules)
- Is there a 'duty of care' on the HealthConnect repository. For example, if the decision support rules within the repository determines there is a potential for an adverse interaction or allergy with a newly prescribed drug or if new information about a patient's allergies is added ? Who should be notified, how ? Does 'HealthConnect' have a duty to determine that the alert message was actually received ?

Uncontrolled replication.

- Most of the above issues result from the overall HealthConnect data architecture which is one of uncontrolled replication of data. Event summaries will be uploaded from one source system to the repository and that may later be downloaded to another local system. This results in at least three copies of the data, two of which are uncontrolled.

There appears to be no consideration of any means of how these three sets of data may be kept synchronised. Without such a consideration, then there is no means of knowing that the copied data is complete, accurate or current.

Point-to-point communication vs via HealthConnect repository

- Page 68 of the main document refers to a provider receiving from HealthConnect an email message about a patient's visit to an emergency department. There needs to be an explicit statement about which classes of point to point messages will be replaced by HealthConnect and which will have to remain, unless the intention is that all current 'point-to-point' messages will continue and be duplicated to HealthConnect. In which case, this should be explicitly stated. (Again this is a business issue, not a technical one).

Standards Development.

- Ideally information for HealthConnect will be entered once, written twice (as per Pg 7, 9th point). However this will require systems to conform to messaging standards and models being developed for HealthConnect. Although HL7 provides a mechanism for many data items which are commonly communicated today (Demographics, Pathology, Radiology etc.), delivering the HealthConnect Business Architecture will require rapid development of standards in many other areas (Refer items listed in diagram of Pg 8).

Many states, including Queensland are just beginning to seriously progress implementation of Clinical Information Systems. Therefore most states will be currently developing new code sets (eg. for problem and allergy lists) and on-line forms (for discharge summaries etc.). Therefore this may be an opportune time to gain wider agreement on these issues as required for the HealthConnect agenda.

This also raises the question of how the vendors of these systems (and those in other health sectors) are being engaged in the development and implementation of standards for HealthConnect?

- Is there an intention to try to ensure that the rules, reference data and messages which underlay the alert warning in HealthConnect are consistent with those in the providers' own systems? If not, a provider may get differing, inconsistent, messages from HealthConnect and their own system.

Participation

- Many of the benefits of HealthConnect will only be realised if providers trust the system as a reliable and relatively complete source of information. However,

HealthConnect will be voluntary (opt-in) for both providers and consumers (Pg 7, 1st point and Pg 13). Although appropriate as a policy position, this is a key risk for the project, which needs to be mitigated. Various options should be canvassed, but consideration needs to be given to incentives (for both providers and consumers) to participate.

Clinical information value chain:

- QH supports the tenet, as noted on Page 13 of the Overview, that “only critical information considered to be useful to other health care providers involved in the future care of the consumer will be included in the event summary”. We are keen to understand the intended strategies for determining the relative value of information contained in the various potential information sources and to contribute to this work.

Cost model implications

- Page 68 refers to a GP reviewing a patient’s Emergency department information at a time when the patient is not present. At present, it does not appear to be possible for the GP to bill for such an activity. The BA should note where the proposed business model has implications for legislative and funding changes.

BMMS

- The relationship between the HealthConnect Business Architecture and the (implicit) BMMS business architecture should be explicitly stated.