

e-Health Care Planning System

Facilitating coordinated care for people with chronic health conditions, and supporting early detection and management of those at risk

July 2008

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The development of the South Australian based e-Health Care Planning System will allow health care providers to develop a web-based care plan for patients with chronic conditions.

The care plan will be stored on a secure server, enabling authorised members of the health care team to access and update it at any time, and patients the opportunity to view their care plan online.

The benefits of such a system are significant for both patients and health care providers, facilitating improved collaboration to deliver a more coordinated approach to the provision of health care services.

System development

The development of the e-Health Care Planning System will be via a staged approach. Stage 1 will deliver a system prototype to enable stakeholder testing and approval, in addition to a suite of clinical support tools. Stage 2 will entail a full system build and deployment within South Australia.

The development of the e-Health Care Planning System prototype will enable key stakeholders to be actively involved in the design of the system to ensure that it meet their needs, where possible interfaces with existing clinical software, and is accepted by health care providers and consumers.

To facilitate this process a Development Group, made up of health care providers and consumers who are actively involved in the care planning process, has been established. The Development Group has met with the system designers, and will continue to guide and endorse the design and functional specifications of the system.

What are we delivering in Stage 1?

A key deliverable for Stage 1 is the **Primary Care Sidebar**, which will act as a communication and information hub with data being populated from the health care provider's clinical software as each patient record is accessed.

The Primary Care Sidebar will also host a suite of clinical support tools to improve the quality of patient data, identify at risk patients, and to assist in the prevention and management of chronic disease.

During Stage 1 the following electronic support tools will be offered to health care providers via the interactive Primary Care Sidebar:

- **Clinical Audit Tool (CAT):** the key to identifying people at risk of developing a chronic disease is achieving and maintaining accurate GP practice data. CAT is a software tool that operates in collaboration with the GP clinical desktop. It will allow the practice to audit their clinical system to find patients at risk of developing a chronic disease, or highlight those whose data needs improving. During Stage 1 HCSA will work with SA Divisions of General Practice (SADI), who has secured a three year licence to deliver CAT to general practices in SA.

A new feature of CAT is the **medication alert and review system** that will allow GPs to receive alerts regarding medication issues when patients present, to ensure medication records are up-to-date, and to facilitate Home Medication Reviews and referrals to pharmacists.

- **Best practice decision support for type 2 diabetes and cardiovascular disease,** and assessment tools for **mental health** (depression).
- **Chronic disease prevention strategy** including the **e-Red Book**, the RACGP's current evidence based guidelines for preventive activities in general practice, and **e-Lifescrpts**, an electronic version of the existing paper based tool utilised by GPs to assist their patients to make healthier lifestyle choices.
- **Health Provider Registry (HPRy) and Human Services Finder (HSF).** A new and improved plug and play application, taking feeds from the HPRy and the HSF, will soon be available to improve search functionality for providers. The HPRy, already incorporates general practitioners and specialists, and is currently being expanded to include South Australian allied health providers. The HPRy will provide the electronic address book for the e-Health Care Planning System.

Key benefits

- Improve early identification of patients at risk through increased usage of high quality clinical data.
- Improve collaboration and communication between members of the primary health care team and health consumer.
- Increase efficiency of health care delivery by improving workflow and reducing duplication of services.
- Increase knowledge of, and participation in, self-management of chronic disease by patients.
- Reduce adverse events through provision of up-to-date clinical information at point and time of care, such as current medications and allergies.
- Reduce hospital admissions through better management of patients with chronic disease within the primary health care setting.
- Increase access to relevant and current health information for health care providers including best practice guidelines and decision support.
- Ensure compliance with NEHTA standards and adherence to MBS Chronic Disease Management Guidelines
- Improve health outcomes for patients with chronic conditions.



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What will the Primary Care Sidebar look like?

The Primary Care Sidebar (demonstrated below working with Medical Director) will host a suite of clinical support tools, and interface with health care providers clinical software.

The screenshot displays the Medical Director 2.93 software interface for patient Timothy Jones. The main window shows patient demographics (DOB: 19/06/1972, 36 yrs), address (45 Redman Road, Dee Why, 2099), and clinical history. A consultation record from Friday, June 27, 2008, at 15:54:37 is visible, detailing an examination by Dr. Admin. The examination notes include: Weight: 96kg, Height: 176cm, Waist: 111cm, BMI: 31.0. Smoking assessment is noted as changed on 27/06/2008, with the patient being a daily smoker of 20 cigarettes per day since 1995. Alcohol assessment is also noted as changed on 27/06/2008, with the patient drinking 6 standard drinks per day, 1-2 days a week. The Primary Care Sidebar on the right contains sections for Lifescripts (Smoking, Nutrition, Alcohol, Physical, Weight), Decision Support (Activities, Measure, Assess), Population Tools (Lifescripts Population Manager, PCS Clinical Audit), and Sundry Items. The Windows taskbar at the bottom shows the system date as Friday, 27 June 2008, and the time as 3:59 PM.

How the care plan will be created

When a patient is identified as being at risk of developing a chronic condition, they can be flagged as a candidate for a care plan and placed on a recall system. When the patient next presents, with the patients consent the GP can create a draft care plan for the patient using best practice decision support guidelines. The GP can then tailor the draft care plan to the patients needs.

If the care plan progresses to a Team Care Arrangement (TCA), the proposed team members can be invited through the e-Health Care Planning System and notified via the Primary Care Sidebar. All invited care plan contributors can then interact with the web-based care plan to deliver best practice care.

With permission, all contributors and the patient will be able to view the web-based care plan in real time, ensuring the information they access is always up-to-date.

OACIS users will also be able to activate a read only summary view of the patient's care plan should the patient present to the public system.

About HealthConnect SA

HealthConnect is one of the Australian Government's e-Health initiatives. It is not a software application, but rather a national change management strategy to transition from the paper-based recording, storing and sharing of clinical information to electronic means.

HealthConnect SA is guiding the implementation of secure connectivity and e-Health systems to enable health care teams to manage patients with chronic conditions collaboratively.

Want to know more?

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