Health Information Strategy for New Zealand

HISAC, THE HEALTH INFORMATION STRATEGY ACTION COMMITTEE

Action Zone 6 - eDISCHARGES

An Initial View

This document is an initial HISAC view of the 'eDischarges' Action Zone of the *Health Information Strategy for New Zealand 2005 (HIS-NZ)*. Its purpose is to stimulate discussion and responses from health and disability sector practitioners, providers and funders, about the issues and opportunities associated with the improved use of existing and emerging information technologies and information management systems in the health and disability sector.

This Initial View is a HISAC informed 'Straw Man' and it does not claim to represent the final direction of the Action Zone. The Initial View is a starting point for the sector informed Preliminary Scope and Approach currently being prepared, by proactive engagement with the sector, for each Action Zone.

If you have a view on the ideas presented below, HISAC wants to hear from you.

HISAC sees the eDischarges Action Zone being delivered by:

- Ensuring that relevant clinical data is captured electronically and used in Discharge summaries.
- Allowing other secondary care documentation to be sent electronically, e.g. clinic letters.
- Extending coverage of electronic Discharges to all hospital services.
- Extending the range of health practitioners and organisations who are able to receive eDischarges.

A VIEW OF eDISCHARGES IN THE FUTURE

VISION

Patients who are discharged from hospital will have relevant and accurate information available to those who continue their care.

STRATEGY

Timely electronic provision of complete and relevant discharge information by hospitals to all of the practitioners involved in a patient's ongoing care.

FEATURES OF eDISCHARGES

For the purposes of this document, a Discharge is defined as the completion of a course of treatment or care.

The treating physician or institution will usually complete care by summarising the salient events in a discharge summary. The patient is then usually returned to the continuing care of the family doctor, or to another physician or institution.

HISAC envisages that a comprehensive eDischarges solution will include these features:

- A summary of relevant information relating to the patient's treatment and ongoing care.
- Population of discharge summaries from the existing data available in hospitals.
- Practitioners able to add free format, summary notes to the pre-populated record.
- Transmission of messages in a standardised, structured format according to HISO Referral Status Discharge (RSD) standards.
- Transmission and receipt of Discharge information is auditable and verified.
- Information about the timeliness and accuracy of Discharges is monitored.

BENEFITS FROM SECTOR INVESTMENT IN eDISCHARGES

Patients will experience the following benefits:

- Follow up treatment will be better informed through the availability of accurate, legible summary information.
- Discharge summaries will consistently arrive before the patient attends a follow-up appointment.

Hospital practitioners will experience the following benefits:

- A clear summary of the admission available at subsequent presentations, for example in outpatients or the emergency department.
- The availability of accurate summary information for research and audit.

Health practitioners who receive Discharge summaries will experience less frustration as:

- Discharge summaries will consistently arrive soon after the patient has been discharged.
- Less time and effort will be spent processing information associated with the discharge.
- Less effort will be required to obtain correct / complete discharge information.
- Practitioners will have consistently better quality information about a patient's condition.
- Eventually, there will be the ability to automatically load structured data from the Discharge summary into the GP's system.

For sector Funders, Policy Advisors and researchers, processes and care pathways around the system will become more consistent. Service standards can be better defined and monitored.

WHAT HAPPENS TODAY

A Discharge Summary contains information about a patient's treatment and progress during a hospital admission or Emergency Department visit. It contains current clinical information about the patient, recommendations for the patient's ongoing management and is used by the patient's General Practitioner (GP) in their ongoing care. Discharge summaries can also be used by hospital staff in future contacts with the patient.

About half the hospitals in New Zealand have implemented some form of electronic discharge summary; typically though in these organisations not all services are included. The Discharge summaries are distributed to health practitioners via a secure messaging system, or via fax, depending on the choice made by the practitioner. Patients are generally given a paper copy of the discharge summary to take with them.

Where electronic discharges have been implemented, a lot of effort is still required from GPs to incorporate the Discharge information into the patients' health record within their patient management system.

In hospitals where electronic discharges have not yet been implemented, the traditional issues associated with the production and handling of paper documents remain. These include the quality, completeness and legibility of information; the timeliness of their arrival at the GP's practice; and the effort required to process the paper when it arrives at the practice.

AREAS FOR IMPROVEMENT

Problems with remaining manual processes for managing discharges include:

- Hospitals and services that do not have electronic discharge facilities may provide hand-written discharges, which are often brief and illegible.

- Discharge summaries that are not sent electronically do not always reach the GP before the patient makes a follow-up appointment.
- Discharge summaries are not tracked between clinicians which creates the potential for a gap to occur in a patient's care.
- Significant administrative overhead is required to process the discharge summaries.
- There is an inherent lack of security around paper-based systems.

Problems with existing electronic processes for managing Discharges include:

- Electronic Discharge summaries are of variable quality and completeness. (A lot of the meaning in a summary is incorporated into notes created by clinicians. These notes vary significantly in both the quality and amount of information that they contain.)
- There are several potential audiences for a Discharge summary and the information included in a summary may not meet the requirements of any of them.
- GPs receiving electronic Discharge summaries cannot necessarily integrate this data into their practice management system.
- There are a variety of different data formats in use. Not all hospitals are using the HISO RSD standard yet.
- In general, electronic discharge information is not available for all services provided by a Hospital. Some services, e.g. outpatients department and mental health, do not create electronic discharge summaries.
- A number of organisations involved in providing care to patients after their discharge from hospital (e.g. residential care providers) are not able to receive electronic Discharge summaries.

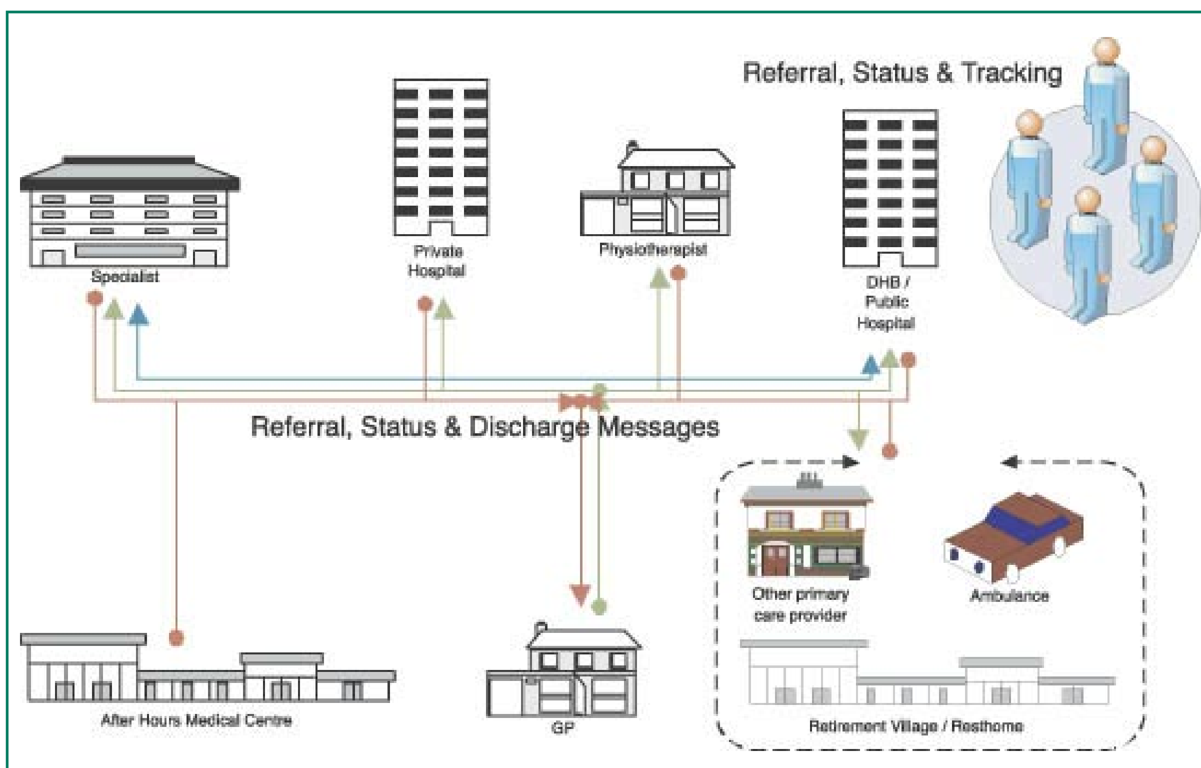

Figure 1: A schematic representation of the flow of discharge (and referral) messages between practitioners.

WHAT HAPPENS NEXT

Responsibility for implementing the Health Information Strategy for New Zealand lies with the whole health and disability sector under the leadership of HISAC. HISAC is working closely with sector representatives to prepare more detailed descriptions of current problems and practitioners' priorities for improvements. If you have any ideas of how the eDischarges initiative could be developed, please communicate with HISAC through enquiries@hisac.govt.nz or write to:

The Action Zone Development Leader
HISAC Office
P O Box 5013
Wellington