NSW HEALTH

P10/475

Ms Vicki Buchbach
Committee Manager
Legislative Assembly
Standing Committee On Broadband In Rural And Regional Communities
Parliament House
Macquarie Street
SYDNEY NSW 2000

Dear Ms Buchbach

Hearing of the Standing Committee On Broadband In Rural And Regional Communities, "Inquiry into transforming life outside cities: the potential of broadband services" & "Are you connected?: Telecommunications available in rural and regional communities".

I refer to your letter dated 28 April 2010 concerning evidence provided by NSW Health representatives at the 23 April 2010 Hearing of the Standing Committee On Broadband In Rural And Regional Communities. I apologise for the delay in responding.

As requested, please find attached responses to:

Tab A: Questions taken on notice during the Hearing.

Tab B: With respect to the accuracy of the Hansard Transcript, the transcript has been reviewed and a copy is enclosed with the relevant alterations made in track changes. Please see the attached table for a summary list of alterations required to correct the Hansard record.

The person to contact at the NSW Department of Health for further information or assistance is Mr Matthew Monahan, A/Deputy Director Executive and Ministerial Services on 9391 9328.

Yours sincerely

Kathy Meleady

Kathy Meleady
Director, Statewide Services Development Branch

26.5.10

NSW Department of Health
ABN 92 697 899 630
73 Miller St North Sydney NSW 2060
Locked Mail Bag 961 North Sydney NSW 2059
Tel (02) 9391 9000 Fax (02) 9391 9101
Website www.health.nsw.gov.au

QUESTION 1:

Mr GEOFF PROVEST: On e-records, during the Garling inquiry, particularly with reference to the Tweed Heads hospital, evidence was given that they have been able to go back only two or three years. They did not have the staff or the resources to go back further, in terms of taking the patient's records and putting them into electronic format. Is that an issue, that fact that when a patient had long-term medical history, they have been able to put on only the last couple of years, rather than if they had been a patient for 10 years because they did not have enough resources allocated to transforming physical records to electronic records?

Mr SMITH: Sorry, I could not comment on that. I am not aware of that particular instance. I am happy to take that on notice and provide an answer. *(Page 13)*

ANSWER:

Based on clinical advice received through general feedback and formal design workshops a decision was made that the program required only 2 years of data to be migrated into the electronic medical record.

QUESTION 2:

Mr GEOFF PROVEST: The Health, Education and Learning Network, HEALNet, the online professional development for health professionals is another project that has received $800,000 in funding under the Digital Regions Initiative. That is a TAFE NSW project to enable nurses and allied health professionals to complete professional development online. How will that course work? Will it be compulsory for medical professionals who will utilise the new technologies? Or, is it just another course that professionals can take to add to their overall qualifications?

Ms MELEADY: I am not familiar with that particular initiative, I apologise. I could take that on notice and provide an answer. It would be fair to comment that Telehealth facilities in NSW Health are significantly used for education, training and medical and nursing up-skilling. We estimate that up to 80 per cent of the capacity of these systems are used for clinical services and training and education. It would be expected that it would be part of a suite available to the clinical workforce. I could get that information. *(Page 13)*

ANSWER:

TAFE NSW North Coast Institute was successful in gaining $800,000 over 3 years from the Digital Regions Initiative to expand an online learning program – HEALNet – for nurses and allied health. This funding will allow the expansion of the 30 topics to over 150 topics. The funding also requires HEALNet to be marketed nationally and expand the topics to support a broader range of health professions.

The one hour programs provide continuing education units on topics related to nursing procedures and theory. The Royal College of Nursing, Australia has accredited the programs enabling the participant to earn points for Continuing Nursing Education (CNE) as part of the Royal College of Nursing Australia Life Long Learning Program.

Each 1 hour program costs $45 and the participant is required to successfully complete a quiz to gain the CNE points. These courses are available to anyone in the general public who pays the fees, and includes medical, nursing, allied, ambulance or other health staff in either public or private sector.

The completion of courses for continuing education through HEALNet is not compulsory for health professionals in NSW Health including medical professionals. The current topic list would be of limited interested to doctors.

NSW Health has had initial discussions with the Project Manager about expansion of subject areas and possible partnerships. HEALNet is seeking to expand the number of courses on offer and has expressed interest in working with partners to increase content. These options will be further explored.

QUESTION 3:

Mr GEOFF PROVEST: On Monday the Committee heard from Justice Health, which said that its organisation was out of scope for the electronic record system. Why is that the case? Will the agency eventually be integrated into the main system?

Mr SMITH: I am sorry; I would have to that question on notice and provide you with a response. I do not believe that to be the case. *(Page 16)*

ANSWER:

Justice Health has a patient administration (PAS) and scheduling system. The systems are not integrated with the statewide electronic medical record (eMR) due to issues with patient identification and the need to protect the privacy of Justice Health patients. The eMR relies on patient ID, and as there is a need to protect the privacy of all patients and at present there is not yet availability of the unique patient identifier and legislation to support: Justice Health patients cannot be isolated from hospital electronic medical records.

QUESTION 4:

Mr GEOFF PROVEST: In December the Federal Government announced that, under the digital regional initiative, NSW Health would receive $5 million in funding for the chronic disease management systems in the Hunter and New England region. This project aims to increase the coverage of facility-based telehealth services. Could you tell us how it will do that and how the funding will be used?

Ms MELEADY: I do not have the fine detail on that particular project. However, I can say that the Hunter and New England region is quite advanced in its use of telehealth. In fact, it is one of the significant area health services that has looked at this rollout of services. My understanding of that submission was that it was made to complement what they already have and to ensure that there is an integrated approach. Chronic disease management is also being rolled out across the State because of its importance for the regular users of the system. That submission was fairly strongly supported in that State. Referring to the detail for the $5 million package, I could provide that out of session *(Page 17)*

ANSWER:

Hunter New England Health received funding to implement an innovative Chronic Disease Management System to improve the effectiveness and efficiency of care provided to patients with chronic disease in regional and remote areas. The Commonwealth Government committed $5 million to the project under the Digital Regions Initiative over the next three years, in partnership with $3 million in funding from NSW Health and $4 million from HNE Health.

The Chronic Disease Management System will address a need to better integrate our systems to treat patients with chronic disease in regional or remote areas of the Health Service. The project will standardise the care of patients with chronic diseases in regional and remote areas. The system provides service providers across the area with standardised care summaries, decision support tools and reminders about preventative care to allow them to ensure patients from all communities and disease groups receive coordinated and well managed treatment.

The project will involve increasing the network capacity of isolated sites with Hunter New England Health to allow them to participate in the use of the telehealth network and allow the sites to efficiently access the clinical information of their patients. Improved broadband infrastructure will allow the Area to get patients' imaging results back to general practitioners faster, ensuring treatment commences as soon as possible.

QUESTION 5 (PLACED ON NOTICE *FOLLOWING* HEARING):

Provide information about the cost benefit analysis of telehealth services compared to traditional methods of providing rural and remote health services (such as transport and time costs for specialists and patients) especially if such analysis was undertaken prior to installing the systems and examples of where telehealth is being used
(*Contained in letter from Committee Manager dated 28 April 2010*)

ANSWER:

There is wide coverage of telehealth within NSW Health with at least 624 videoconferencing sites which are used for a wide range of clinical services and educational activities. Telehealth applications funded to date include emergency care, critical care and medical retrieval, mental health, high risk foot care (diabetes), wound management, brain injury, aged care, renal, maternity, pathology radiology, oncology, spinal cord injury services, paediatric services, and education and support programs for nursing, medical and allied health.

Savings to the health system are difficult to quantify in actual terms as the real cost savings are realised in providing equitable access to healthcare for all residents – regardless of geographical location, the limiting of travel costs by providing a larger range of health services and supporting the recruitment and retention of the workforce.

The following examples are not cost benefit studies, but provide examples of specific savings (which are conservative only). The "saving" is based on a consultation only (represented by patient, case manager and clinical specialist). In addition, savings for each clinical specialty are based on differing criteria, and the telehealth interactive video technology is used for multidisciplinary services where increased scope of clinical services reduces capital outlay; all capital has been met from the telehealth initiative. Savings exclude communication costs.

There is currently no MBS schedule for the delivery of clinical services via telehealth (with the exception of psychiatry) and this has been identified as a major detractor to uptake. The states are currently working with the Commonwealth regarding a funding model that would involve extending the MBS to include other telehealth items.

- **Diabetes Foot Care**
  The National Diabetes Strategy indicates that a significant proportion of lower limb amputations could have been prevented if earlier consultation and intervention had taken place. Through the use of a telehealth foot program and subsequent prevention

of lower limb amputation, it is estimated approximately $27, 600 in hospital and rehabilitation costs are saved (National Diabetes Strategy). This excludes costs and loss in personal terms e.g. travel costs to Sydney for surgery, follow up visits, family and carers accompanying the client, the family accommodation away from home and general intangible costs. For example:

- Flights = $250 one way
- Accommodation = $30 - $99 per night (range hospital-supported accommodation to basic hotel)
- Food and local transport additional

In addition, recent statistics indicate that of the 144 patients presenting to the High Risk Foot Service in 2009, only 28 required hospital admission. This represents estimated savings of $3,737 per patient, excluding the cost of the local management team.

- **Psychiatry Services**
  The estimated cost of a psychiatric consultation e.g. rural client attending metropolitan specialist for treatment of eating disorder, is approximately $1,100 per patient, per consultation. This represents savings per patient of approximately $675.

- **Critical Care**
  The estimated cost of airlifting a critically ill patient to a metropolitan tertiary facility from a rural centre is approximately $7,170 per patient – based on a 2 hour retrieval via helicopter (helicopter fees are calculated on a time basis). This includes the cost of the transport and associated retrieval staff. These costs are deferred if the patient can be treated locally with remote specialist support provided from a metropolitan facility.

- **Paediatric Oncology**
  The estimated cost of the follow-up paediatric oncology service following hospital discharge is estimated at $1,100 per patient per consultation with the specialist, parent, GP and patient. This represents an estimated saving per patient of $675 (deferred travel costs per visit).

- **Clinical imaging**
  The estimated cost of an orthopaedic consultant accessing digitised images for consultation with an emergency physician is approximately $3,800 per patient. This represents an estimated saving per patient of approximately $2,930.

- **Education**
  The cost of a clinician attending a 1 – 2 day workshop at a metropolitan facility is approximately $1,200. This includes registration, the cost of flights and minimum one night accommodation. Delivery of the workshop via videoconference equates to $110 - $280 per day (IP vs. ISDN) and the clinician does not need to travel or take additional time from work to do so. This represents a saving of approximately $1000 per clinician per workshop. In addition, education is currently available to a large number of rural and remote critical care units via the Outreach and Education Support

Network. This program is coordinated by the metropolitan facilities with education now being delivered to a significant proportion of the rural ICU population previously underserved. While it is difficult to put a monetary value on this type of service, it is clear that ongoing educational and professional development is vital to the recruitment and retention of rural and remote staff, in addition to the maintenance of safe and effective patient care.

It should be noted that overall increases in demand for health services will mean that overall costs will continue to increase.