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Better Medication Management System

This paper is intended for Victorian division boards, CEOs, and pharmacy facilitators and staff engaged in practice support activities.

In May 2001, the Commonwealth Government released an Exposure Draft of the *Better Medication Management System Bill 2001*. Comments are sought by DH&AC's BMMS Implementation Taskforce, by 9 July 2001.

The first half of this paper provides summary information on the BMMS for divisions.[1] The second half discusses some of the issues arising from the scheme for general practice and divisions.

GPDV plans to provide feedback on the issues to the BMMS implementation taskforce by 9th July, and would welcome divisions' comments on these or other issues. Specifically, we would appreciate your input to these questions:

- Practice-level or individual sign-up to BMMS (see point 5 under *Discussion*)
- Input by/representation of division-based practice support staff, to inform development of implementation plan (see point 6)
- Whether BMMS should allow for provision of more accurate prescribing data for NPS and Quality Use of Medicines activities (see point 8).

If your division responds, or has responded to the taskforce independently, we would be interested to receive a copy of your feedback. (Please send a copy to l.willis@gpdv.com.au)

SUMMARY

What is the BMMS?

- An opt-in system, for practitioners, consumers and suppliers, for a central database of consumer medication records.

Why?

- The goal of the BMMS is to improve provider and consumer access to information about medicines.
- It seeks to address the problem of "poor access by prescribers, dispensers and consumers to accurate information on a consumer's medicines [which] can result in adverse outcomes, including unnecessary hospitalisation." (BMMS website)

How?

The system will create a personal electronic medication record, a centralised database to hold it, and a communication network.

The system:

- involves pharmacists, GPs and dentists, although dentists do not seem to be targeted in any meaningful way at this stage.

[1] This information is based on the information and documents released by the BMMS taskforce, which can be found at www.health.gov.au/hfs/bmms/index.htm and on a BMMS briefing held in Melbourne on 15th June, where members of the taskforce and its secretariat made presentations and answered questions.

- will ultimately involve hospitals, but not at this stage. It will target community practices and pharmacies first.
- forms the first part of *HealthConnect*, which aims for a national electronic health record.
- relies on GPs and pharmacists engaging in electronic prescribing.
- requires doctors and suppliers to have an authentication mechanism (almost certainly public key infrastructure (PKI) technology)[2].

The opt-in system

Doctors, consumers and suppliers may choose whether or not to participate.

To participate, a consumer must give consent. There are different types of consent that consumers may give:

- 'specific consent' to a particular doctor or supplier to allow them to interact with the BMMS record
- 'standing consent' for a particular doctor/supplier, so consumers do not have to give specific consent every time they see their doctor/pharmacist
- 'general consent' to allow any participating doctor or supplier to interact with record in an emergency.

The consumer can:

- withdraw consent.
- 'suppress' information. This means that the doctor and supplier who are involved in a particular event **will** see the information, but no-one else will. However that information will be available to the BMMS Board and the participating consumer.
- ask for his/her record to be destroyed (destruction will be carried out as far as possible, though some information may be unable to be destroyed e.g. archived records that are not able to be deleted for technical reasons, though links that would allow the record to be identified may be removed).

The information

The record will contain:

- consumer information. Participation information such as name, address, medicare number, start and end dates, concession/safety net entitlement, interaction listing, consumer's agent if there is one, and the consumer's decisions about access to record in case of emergency and the use of their record for research purposes.
- medication information. Medication event information (drug name, dosage, dates etc., from specific prescription or supply) & background information (e.g. allergies).

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[2] "There is a new security process and technology called Public Key Infrastructure or PKI. The HIC has established an independent subsidiary called the Health eSignature Authority (HESA) to take responsibility for registering parties from the health sector.
Registration and use of PKI will enable parties communicating by email to know:

- who sent the message (authentication)
- the message content has not been altered in any way between sending and receiving (integrity)
- the sender cannot at some later stage dispute they created and sent the message (non-repudiation), and
- that only the person the message is directed to can open it (confidentiality)

Unfortunately it is not as simple to register, setup and use this technology as it first sounds, although this should change in the near future." (Source: Otway Division of General Practice Weekly Fax, 15th June 2001, No. 271.)

Other implementation issues

- There will be a 8 member Board (ministerial appointment) to oversee the BMMS.
- The system will be administered by the Health Insurance Commission.
- BMMS Board can provide a copy to the consumer of his/her own record (or a summary of it) up to 4 times a year, without charge.
- There will be incentives for the implementation (detail yet to be determined). It is planned that the legislation will be finalised this year; that there will be field tests in early 2002; and rollout of the scheme from later in 2002.
- It is envisaged that participating GPs will be able to download the medication record at the time of a consultation and, depending on the software capabilities in the practice, the record may then be integrated with the GP's practice record. At this point, the downloaded record becomes a practice-based record and will no longer be considered part of the BMMS record.

DISCUSSION

1. Potential advantages

The BMMS presents the possibility of greatly improved information to inform decisions by doctors about prescribing and to allow consumers to be well informed about their own medication. It may address some of the problems brought about by seeing different GPs, and reduce adverse events related to polypharmacy – especially once the scheme has wide patient and doctor participation and involves hospitals, so that GPs have access to information on medications administered in hospitals and, importantly, hospitals have access to information on medications taken by patients in the community.

2. Relevance to divisions

Encouraging adoption of BMMS among practices would be highly relevant to the work of divisions of general practice. The BMMS may enhance decision support for prescribing, and improve communication and coordination between providers. It also requires improved IT/IM capacity in general practices, which is an area to which divisions make an important contribution through their practice support activities.

3. Incomplete medication records

Elements of the scheme give rise to the possibility of incomplete medication records. Suppression and specific consent (to some individual events and not to others), and the provision of consent to *particular* doctors and suppliers, address consumer concerns about privacy, making it more likely that consumers will participate. But these elements of the scheme also mean that some doctors may not be able to view a patient's record and even if they do, will not know whether information has been suppressed. It is argued that, at worst, this is no different from the current situation of incomplete and fragmented records, and that the BMMS record is likely to be more complete than current records. It is however important that doctors realise that the presence of an electronic record does **not** necessarily mean a full medication history.

4. GP incentives

Incentives for GPs were mentioned by taskforce members at the briefing meeting in June, but no details have been developed. There would be significant resource implications in implementing the BMMS, especially when we consider the resource-intensive nature of the rollout of the GP Immunisation Incentives Scheme (GPII) which largely depended on division support and education for its success. Although important, the individual GP-level and practice-level incentives alone are not enough to ensure a successful program.

5. GP or practice participation?

The participation of pharmacists in the BMMS appears to be based on the business where they work, rather than participation as individual suppliers – i.e. where a particular supplier has permission to access the record, his/her employee has the same access in his/her absence. However the same system does not apply for GPs. Should it? Perhaps the question of whether a *practice* should be deemed to participate (or not) in the scheme should be considered. Given that one of the benefits of group practice is the sharing of patient records, it may make more sense for a practice to participate as a unit, rather than for individual doctors within it to make different decisions about their participation. **GPDV would welcome divisions' comments about whether to raise this issue with the BMMS Implementation Taskforce**.

(This problem will also arise when the system is extended to hospitals: if an Emergency Department has a doctor who does not participate in the scheme, how will the record be accessed? In the absence of hospital involvement in the first instance, the 'general consent' to the BMMS record in case of emergency will be of limited value.)

6. Implementation in practice

There will be significant issues about how the BMMS could be implemented in practice. Obviously, a high level of electronic prescribing in practices (and also PKI[3]) will be needed. A significant challenge for the BMMS will be to ensure that GPs are well enough informed to offer patients the opportunity of participating, and to deal with some quite complicated questions, given the rather complex layers of consent. If participation remains at the individual GP, rather than practice level, another issue may arise in ensuring confidentiality, especially if it is likely that another practice staff member may download or update records on behalf of the GP.

These and many other practice-level issues need to be addressed very early on in the process of developing the scheme. GPDV suggests that input from division-based practice support workers would be invaluable in this task, as they are extremely well-informed about the day-to-day practice issues across a wide variety of practice structures in their local area. **We propose to suggest to the BMMS Implementation Taskforce that it appoint to the relevant implementation working groups a rural and a metropolitan representative who works in practice support activities at a division. If someone in your division might be interested, please let us know.** (l.willis@gpdv.com.au)

7. Representation of GPs

The draft bill states that there will be two representatives on the 8-member BMMS Board who are 'medical practitioner nominees' (appointed by the Minister) but does not distinguish between different types of medical practitioner. Given the central place of general practice in the intended roll-out of the BMMS, GPDV suggests that there should be specific general practice representation on relevant committees, and on the board. Divisions of general practice would be the most appropriate organisations to provide representation, given their key role in implementation of government-funded initiatives at the practice level.

8. Identified data

Although identified consumer data can be used in certain circumstances (e.g. research), with appropriate consent, the legislation contains prohibitions on using identified prescribing information. We appreciate that some practitioners may have reservations about the Health Insurance Commission holding more information on their prescribing behaviour. On the other hand, the current Quality Use of Medicines proposals under consideration (which will return

[3] See note 2 for information on PKI.

any savings from improved prescribing to general practice) and the current NPS Prescribing Practice Reviews are both adversely affected by the incomplete nature of the PBS information that is returned to GPs.

The Practice Reviews provide information only on those items claimed through the PBS but some items are not claimed. The PBS has data on prescriptions for:

- concession card holders (who pay less than the co-payment amount, so the remainder is claimed by the pharmacist, from the PBS)
- Items above the co-payment for patients without a concession card (as pharmacists claim the portion above the co-payment from the PBS).

This means that "those prescriptions for PBS items which cost less than the patient co-payment are not available from pharmacy claims data. This is a recognised deficiency in the data and explains the disparity between … [a] known practice and the profile as provided for some drugs."[4] The QUM proposal uses the same data, with the same problem that not all of a GP's prescribing is included when calculating baselines or measuring change in prescribing.

At some future time, if there is wide patient participation in the scheme, the BMMS might provide an opportunity to redress the deficiency in the data used for this sort of education, review and feedback which provides an opportunity for GPs to enhance their own prescribing without taking any sort of punitive approach. This will not be possible if legislation prohibits using identified prescriber data for any purpose. We suggest that consultation with the National Prescribing Service and any other relevant sections of the Department of Health & Aged Care would be wise, before passing legislation that will prevent BMMS prescribing information from being used to improve quality prescribing patterns.

If the prohibition were removed, policies would need to be in place to ensure that the HIC will not use the data in a punitive way, in order for prescribers to have confidence in the system, and to protect data from breaches of confidentiality. The legislation might specify that identified data may be used for the sole purpose of prescriber feedback, where the participating prescriber has agreed to this.

GPDV welcomes divisions' comments on this issue.

If your division has any comments (particular on discussion points 5,6 and 8), please contact Louise Willis (l.willis@gpdv.com.au) by 8th July.

[4] NPS web site, section on *Understanding the Data in the Practice Prescribing Review* at http://www.nps.org.au/

Further information:

- Web site: www.health.gov.au/hfs/bmms/index.htm
- Basic information describing the scheme http://www.health.gov.au/hfs/bmms/administrative.htm
- Summary of legislation (12 pages) http://www.health.gov.au/hfs/bmms/summarybmms.pdf
- Full draft bill http://www.health.gov.au/hfs/bmms/legislation.htm

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