



Australian Digital Health Agency's National Digital Health Strategy Framework for Action – Feedback from the Health Information Management Association of Australia

Introduction

The Health Information Management Association of Australia (HIMAA) welcomes the opportunity to provide feedback to the Australian Digital Health Agency (ADHA) on the Framework for Action on its National Digital Health Strategy (NDHS). The feedback provided in this document followed a submission to ADHA on the strategy itself, and general engagement by HIMAA throughout the development of the NDHS, which HIMAA supports as a national digital health initiative. HIMAA was also pleased to engage with ADHA recently (26/03/2018) on the Interoperability Road Map for the Framework of Action.

While HIMAA is generally supportive of the Framework for Action, which has clearly been thought through on the basis of the extensive consultation to date, there are a number of issues on which we provide feedback in this document:

- Use of the term 'data'
- Conflation of health information and clinical information
- Health information management and governance
- Workforce Development
- Interoperability
- Telehealth
- Innovation

We will outline our thinking on these issues in the FEEDBACK section of this document.

Scope

As the peak professional body for health information management (HIM) professionals in Australia, HIMAA has been serving the HIM profession since 1949.

Health information management professionals contribute to the health outcomes and delivery of the healthcare system through best practice health information management. Occupations recognised by the Australia and New Zealand Standard Classification of Occupations (ANZSCO) include health information managers (HIMs) and clinical coders (CCs). HIMAA members hold the systems key to the integration of patient information and funding flow in efficiency as well as effectiveness improvements to quality patient care.

HIMAA provides competency standards for the delivery of education and training across the learning life of the HIM practitioner, and strives to promote and support our members as the universally recognised specialists in information management at all levels of the healthcare system. The association provides a comprehensive program of qualifications accreditation and quality assurance to the profession, employers, and the community. We are committed to improving the health of all Australians through professional information management of the highest practice standards.

As a not for profit organisation HIMAA is governed by a Board of Directors who are HIMAA members. The Association has a national office in Sydney staffed to deliver functionality in membership services, education and training, publications and resources, positioning and advocacy, communication and corporate services. We rely on the volunteer contribution of members to achieve our objectives and deliver organisational governance. Membership support is provided through State and Territory branches at the local level, and nationally through our annual conference, which is of international standing. We are proud that our peer-reviewed academic journal, the *Health Information Management Journal*, achieves a positive international Thomson Reuters impact rating.

HIMAA members are currently playing key roles in the digitisation of health information services to tertiary health sector in Australia, and have canvassed at national HIMAA conferences, and at the first National Health Information Workforce Summit in 2015, the potential role for HIM in the digitisation of health information services in the primary care sector. The Queensland government has recently informed CEOs of its public health institutions that HIMs have agreed to lead implementation, change management and training in regards to the My Health Record (MyHR). HIMAA's experience is that the NSW government's eHealth strategy increasingly looks to HIMs to implement the introduction of Electronic Health Records system (EHRs) across the state.

HIMAA members in other jurisdictions experience varying involvement in the implementation of digital health information systems, but stand ready to ensure the interests of patients and frontline healthcare providers are served by the effective management of health information in the process of digitisation to ensure the benefits of eHealth can flow in both quality of care improvement and cost efficiencies.

It is from this perspective that HIMAA provides feedback to the ADHA in this document.

Where comment is not specifically made on specific sections of text in the NDHS Framework for Action document, HIMAA's support for those sections can be assumed.

FEEDBACK

HIMAA agrees with the ADHA that "*Australia's National Digital Health Strategy – Safe, Seamless and Secure* – outlines a vision for 2022 focused on an evidence base of benefits prioritising national-level digital health activity which will result in:

- Hospital admissions avoided

- Fewer adverse drug events
- Reduced duplication of medical tests
- Better coordination of care for people with chronic and complex conditions, and
- Better informed treatment decisions

Achievement of the outcomes in the Strategy will depend on continued co-production with patients, consumers and carers – and the governments, healthcare professionals, organisations and industry innovators who serve them.'

HIMAA is also please that the Framework for Action is "will be a living document that is regularly updated to reflect the continuing progress on the Strategy's outcomes", as HIMAA believes there are changes to the Framework that should be considered before it proceeds with further implementation.

These changes involve:

- Use of the term 'data'
- Conflation of health information and clinical information
- Health information management and governance
- Workforce Development
- Interoperability
- Telehealth
- Innovation.

1. Data and Information

There is confusion over the use of the term 'data' that weakens the conceptual cogency of the Framework for Action. It is sometimes unclear whether the data referred to is the raw output of engagement between frontline health practitioners and between practitioners and patients that provides the basis for meaningful translation into health information, or the meta-data resulting from that information, itself an informational output.

When researchers talk about data they usually mean meta-data - numerical information usually, produced from a highly structured process of producing information based on data researched, and producing numerical computations which are meaningful at the level of meta-data - data which has informational meaning.

The use of the term 'data' in the Framework for Action as either actual data or meta-data is not the only source of confusion, for 'data' is sometimes also used interchangeably with 'information'.

In section 1.2 (p.12) for instance, it is difficult to determine what kind of "data" used from "the My Health Record system" would "improve population health outcomes, health service planning, and research" if it were the kind of data emerging from a clinical consultation from which HIMs extract health information. The nominated sort of "data" would be more likely to emerge from health information itself and, through clinical classification, converted into the meta-data of clinical codes, or numerical quantifications of health care resulting from the generation of health information, again as meta-data.

In Action 3 (p. 18), the "High-quality data with a commonly understood meaning" that forms the subject of this action is what, by definition, information is – data that has undergone interpretation and translation such that it has "commonly understood meaning". The data emerging from the generation of such information is usually meta-data - data that in fact signifies the outputs of information, in the same way that information signifies the interpretation of data as meaning.

The "common understanding" is the material factor in this action. Information needs to be tailored to its user. It is the management of information such that commonality of meaning can be produced for a *variety* of users that is required. Information thus managed would be one measure of its quality. To reduce quality information to quality data, as in this context, is to confuse the issue. Statements throughout this section perpetrate the confusion generated by the misguided conceptual conflation of information and data.

Again in action 3.3 (p.22), on interoperability, the term "data" is used with insufficient clarity. What type of "data" does this action seek to "promote"? What sort of "data services" would, if enhanced, "support interoperability and improve data quality"? Is the intention here to improve the quality of communication data emerging from, for instance, the frontline healthcare encounter to enable its easier translation into health information – through perhaps clinical documentation improvement – or is it meta-data resulting from the information itself, information resulting from health information management?

Examples in 3.3.1 such as "precision medicine", "genomics" and "the efficacy of medical devices" might indicate data direct from the health data-gathering frontline, but this is confused by reference to 'clinical terminology', which is the content more of processed health information. The reference to "barcoding" is further confounding.

The conflation in 3.3.1 of clinical terminology, which is informational in content, and barcoding, which is electronic data in content, implies that the same standards of quality can be applied to both whereas, in reality, the use of each is fundamentally different in a health system. Barcodes can be used in any data management system, including health. Clinical terminology would be of limited use in a Supermarket supply-chain-to-point-of-sale retail stock management system.

To its credit, the Framework in Action area 4.1 reveals a clearer understanding of the relationship between data and information. It understands, for instance, that the name of a

medicine is a signifier and, as such, can be electronically managed as a datum. Whereas what consumers need is “medicines information”, which therefore needs to be managed as information in which a range of signifiers bring together meaning for the reader.

But even with a “National Medicines Data Service”, medicines need to be accompanied by information that provides advice about them, such as contra-indications of other medicines taken in conjunction with them, dosage information, results of ongoing testing and research which changes recommended use, and so forth. This information is variable, and needs to be managed as information rather than as all part of the single signifier subtended by the name of the medicine. Brand names for the same medicine are another variable which will change over time.

Action 4.1.7 in particular, on incident and adverse event reporting capabilities through digital solutions, highlights the need for strong information management in relation to a National Medicines Data Service. Such data digitally gathered needs to be managed as information for it to be meaningful in adverse outcome prevention.

Recommendations 1

- 1.1 The Framework of Action be revised to ensure clarity about the difference between data and meta-data, the latter being informational in production where the former constitutes the ‘raw material’ in the production of information.
- 1.2 Further, that the Framework document is clear about the difference between ‘data’ and ‘information’, ensuring any reader can understand that ‘data with a commonly understood meaning’ are, in fact, ‘information’, so that a reader can further understand the difference between the need for quality data, and the value of quality information.
- 1.3 Finally, that the Framework is clear about the difference in standards required for assessing and managing quality in data, quality in information, and quality in meta-data. For instance, that quality in data is technically achieved, quality in information is linguistically and textually achieved, and quality in meta-data is achieved through the signification of information, which itself signifies data.

2. Clinical vs Health Information

In a similar way to the conflation in meaning of ‘data’ and ‘information’, the term ‘information’ itself is used with insufficient clarity. For instance, ‘clinical’ information and ‘health’ information seem to be used interchangeably, as if they were the same unit of meaning. In Action 2, for instance, about the secure exchange of health information, the only information referred to on pp.11 (x1), 14 (x2), 15 (x2), and 16 (x1) is ‘clinical information’, even though the heading at the top of each page clearly refers to ‘health information’ as its subject. Some of these uses refer to ‘clinical information systems’ rather than ‘health information systems’.

In Action 3 (p.20 x2), ‘clinical information’ seems to be the sole form of information valued in the need for interoperability in the exchange of information, rather than the kind of health information that might be useful to all providers of frontline healthcare.

HIMAA does not in any way question or dispute the value of clinical information. HIMs and CCs alike depend on clinicians as the primary source of communication data from health encounters that enables the development of health information in the form of, for instance, medical records.

But it is presumed by health information management practitioners that health information in the medical records will be useful to, and provided input to by, other health providers on the care service frontline, such as nurses and allied health. Health information coded using an international classification of diseases (ICD-10-AM) is also used by finance departments in tertiary health facilities for funding purposes, by the executive for planning purposes, and by researchers for population health analysis. Clinicians are not the only users, nor are

clinicians a universal user. The language and semantics of specific medical specialties, for instance, are necessarily variable from each other.

Recommendation 2: That the Framework for Action clarifies the difference between clinical information and health information by a. acknowledging that clinical information is a subset of health information and b. by detailing ways in which the NDHS will support the development, classification, storage and transmission of quality health information other than clinical information, so that the reader can gain a whole-of-health system appreciation of the positive impact of digitisation on health information.

3. Management and Governance of Health Information

HIMAA has had cause to point out the exclusion of health information management as an object of professional endeavour from eHealth discourse since 2013. In that year a review report on the Personally Controlled Electronic Health Record (PCEHR)¹, as the MyHR was then known, commissioned by the Australian Government mentioned ‘information’ 235 times outside proper noun use. This term was most commonly qualified as ‘clinical’, but only 25 times. Next most common referent of meaning is ‘health’, but only in 15 occurrences. ‘Health information professionals’ are mentioned just once in appendices, and ‘health information management’ did not occur anywhere in the Review report.

HIMAA is reluctant to report that the same is true of ADHA’s NDHS Framework for Action: the terms ‘health information’ and ‘management’ do not occur together as “health information management” anywhere in it. HIMAA looked to the repeated pages on “Roles of participants in order to achieve benefits” for each of the seven Action areas in the framework, and found it hard to find a role for health information management.

Of the roles provided – healthcare consumers and providers, industry & technology sector, peak organisations, ADHA and governments – industry & technology and peak organisations seemed to be the two streams to which HIMAA might look for a role for the health information management professional. But the Industry and technology role seemed to focus very much on technological infrastructure, where peak bodies roles were construed as being for the clinical professions.

In one of the two Action areas relating to health information, for instance, Action 2 (p.14), the Peak Bodies are to provide “clinical expertise and leadership on behalf of their members to support the development and adoption of standards and guidelines” while industry & technology are to “Co-design and co-develop national infrastructure ensuring adoption of technical standards, governance, data lifecycle management and operations.”

The use of the term ‘governance’ here again reflects the conflation of ‘data’ and ‘information’ that seems germane to the Framework. In Action 2 it seems to relate to data management/operations and technical standards, rather than information management. In Action 3.3.1 on enhancing national data services, “data governance” is specified. Yet in this same action so is “health information governance”, as an object of improvement along with “data quality”. Health information governance appears one more time, along with “health informatics” as topics to be included in curriculum, education and training materials requiring the embedding of digital health for delivery by “universities, health services, PHNs, peak bodies and training organisations”.

So in relation to both governance and management, the conceptual confusion in the Framework for Action document between data and information in turn confuses the jurisdiction of “governance” and “management”.

There seems to be no unitary function in the future imagined by the ADHA in which the accuracy and reliability of information over time can be managed, along with the legal and

¹ No publishing information was included with this report Australian Government, not suggested citation.

ethical aspects of access and ongoing management of these, in a systemic context of enterprise health information governance, as is currently the role of health information management professionals.

There seems no appreciation of the informational chain of meaning, in which data represents the raw material from which information abstracts meaning, and by which information provides the raw material for knowledge within the system, and information governance is the overarching regulation by which knowledge, information and data are managed within an enterprise system.

Who is managing the impact of changes in technology – hardware and software – over time on the quality of information to ensure that information in is information out across time and place, if not the health information management professional? The digital usability of the system is useless if the information by the time it's accessed is unintelligible due to corruption by un-interoperable software clashes and edition updates.

Just as information in the paper-based health system has been managed as a dynamic entity with multiple users and rules/principles around access regarding legal and patient safety parameters, so information in a digitised access, transmission and storage system needs to be equally managed. Where is this management in this action framework, if not in the hands of health information management professionals?

In Action 1.1.2 on making the MyHR “an unprecedented platform for innovation” (p.11), ADHA writes about “the capture of available and relevant information in the system” as if the information already exists in some pre-determined form. The management of the information seems not to have a role; information is assumed to be a fixed entity, like a commodity, rather than a dynamic medium of communication that requires active curation. The relevance of information depends upon the user accessing it. Health information *management* is required to tailor relevance of information to user.

Recommendations 3

3.1 HIMAA recommends the embedding of the current practice of health information management by health information professionals in its Framework for Action.

3.2 The role of health information governance in regulating an enterprise information governance system for health institutions in order to ensure the management of knowledge, information and data within an enterprise system should also be clearly embedded in the Framework for Action

4. Workforce

Action area 6 on workforce (p.33) encourages “the workforce” to adopt “the changes and opportunities created by digital health innovation through helping people and organisations develop the capabilities needed to embed these innovations into their work flows.” This assumes that digital health services are in a ready-to-use form in which users merely require education in order to adapt and incorporate into practice. The assumption is that digital health services will themselves manage the quality of themselves and ensure they adapt to changes in supply knowledge, in supply technology, and in the environment to which users will apply usage.

There may even be an assumption that the sheer processing power of information technology hardware will, in conjunction with information technology software, be able to develop the ability in the technology to self-audit, adapt to changes and maintain itself as a service without the need for human intervention. And this is a lovely idea. We've seen artificial, machine-driven intelligence depicted in literature and movies from the days of Arthur C Clarke and Issac Asimov. But we are, according to two acolytes of the impact of IT

on today's professions, Richard and Daniel Susskind², still a good 50 years away from that level of artificial intelligence.

In the meantime, the health information workforce (HIW) that currently *produces, generates* and *monitors* digital services, such as health information managers, clinical coders, health informaticians, and health librarians, require not only intensive support in the development of digital health service *provision*; they also require workforce *development*.

The current shortfall in supply of HIMs in the tertiary health sector is notable, and certainly insufficient to supply needs the primary healthcare sector is yet to properly identify and quantify in its provision of health data and health information. The supply of clinical coders is even worse, and stymied by a reluctance in industry to acknowledge that professionals in health information workforce require as much in terms of practice placement and internship during their education and training as the clinicians and other health professionals they work with. HIMAA is by far the largest supplier of Clinical Coder graduates in Australia, and in the years 2010-2015 was not able to provide half the minimum 1,750 Clinical Coders forecast by the AIHW as needed in addition to those lost by natural attrition³. While ABS data shows increases in self-reported numbers of CCs and HIMs between 2011 and 2016, the CC figure is still 450 short of the AIHW forecast minimum requirement. Increases in the two foundation occupations of the HIM profession have also declined between 2001 and 2016 censuses, indicating that workforce supply is not keeping pace with demand.

ABS Census Data	2001	2006	2011	2016	Census ↑↓ % 01→06 / 06→11 / 11→16 / 01→16	2009 FTE AIHW
Clinical Coders [ANZSCO 599915]	1805	2183	1069	1309	↑21% / ↓51% / ↑22% / ↓27%	1186
Health Information Managers [ANZSCO 224213]	865	1255	1473	1566	↑45% / ↑17% / ↑6% / ↑100%	630
Total Profession	2670	3438	2542	2875	↑29% / ↑26% / ↑13% / ↑8%	1816
Total %↑↓	↑29 %	↑26 %	↑13 %	↑8%	Difference '09→	-63%*

*assumes linear growth/decline in ABS data 2006→2016

As the above table shows, comparison between Census data and the more substantive AIHW study indicates HIM and CC workforce data is far from reliable. However, as a result of National HIW Summits in 2015 and 2016, a Health Information Workforce Alliance of peak bodies in HIW is currently engaged in supporting the research of a national dataset on the current composition and supply status of HIW in Australia, being conducted by the Universities of Tasmania and Melbourne.

HIWA is also commencing initial work on the development of a national capability framework with which it can, with education providers, industry and government, develop and support emerging occupations in digital health information services such that they can rapidly be incorporated into workforce structures, supported by qualifications and competency standards.

If the development of HIW is not a priority of this Framework for Action, all of the clinician and other health services provider education proposed in the Framework will come to nothing, because the digital health services themselves will not be there; certainly not in a form that is of measurable quality, sustainability and reliability.

The adoption referred to in 6.1.1, and the accreditation in 6.1.3, need to be led by this HIW, and HIW itself needs to be supported in developing capability in supporting adoption and accreditation. Members of the HIWA are well placed to negotiate with authorities auspicing the development of digital health information, such as ADHA, the development of this HIW

² Susskind R, Susskind D. *The Future of The Professions*; Oxford University Press, Oxford, UK, 2015.

³ Australian Institute of Health and Welfare 2010. *The coding workforce shortfall*. Cat. no. HWL 46. Canberra: AIHW.

capability. It will require funding. But it is a rate-determining step for the implementation of the current Action area 6.

Recommendations 4

4.1 That the ADHA support the Census of HIW to be conducted by the Universities of Tasmania and Melbourne financially and by incorporation into Action 6 of the Framework for Action as an HIW initiative.

4.2 That the development of the HIW be incorporated into Action 6 of the Framework as a rate-determining step co-requisite to Actions 6.1.1, 6.1.2 and 6.1.3, and becomes a new Action 6.1.1 to the renumbered Actions 6.1.2-4.

4.3 That the ADHA assume responsibility for, in the new Action 6.1.1, securing the funding for and actively supporting the Health Information Workforce Alliance peak HIW bodies in take the lead agency role in implementing the renumbered Actions 6.1.2-4

4.4 In particular, in Action 6.1.1 ADHA commits to securing funding and infrastructural support for the development of a national HIW capability framework as recommended by HIWA as Strategy B of a series of 8 strategies resulting from the 2016 National HIW Summit.

5. Interoperability

As noted above, Action area 3 on interoperability focuses erroneously on the quality of data. High quality data with a commonly understood meaning is information, not data. The data involved in such information is usually meta-data - data that in fact signifies the outputs of information, in the same way that information signifies the interpretation of data.

Statement throughout this section perpetrates the confusion generated by the mistaken conceptual conflation of information and data. For instance, the adoption of clinical terminology is irrelevant to the quality of data and interoperability of data. Clinical terminology is already pre-requisite to the management of health information, even in paper-based systems of HIM. It will remain essential to the quality of information in digital systems of information generation, classification, storage and transmission. Interoperability between IT and information software is essential to the accuracy, reliability and sustainability of health information in transmission and storage over time. Information 'in' must be the same as information 'out' across geography and time regardless of the IT systems or software programs involved.

The meta-data referred to in this section as "data" is an output of information; a further level of signification to the information itself as signifier of meaning. Its management as part of information management requires additional sophistication from information management systems. But the meta-data itself is not the unit of management. Information is the unit of management. It is high quality information, including informational meta-data, that needs to be seamlessly shared, not just high quality data.

As noted above under Data and Information, information is converted into one form of meta-data, clinical codes, through clinical classification. This meta-data, coded using an international classification of diseases (ICD-10-AM), is used by finance departments in tertiary health facilities for funding purposes, and by the executive for planning purposes, and by researchers for population health analysis. But the MyHR uses a different system of generating categorisation of health information as meta-data for storage, SNOMED CT. Primary care uses yet another system of classification, when it uses any system of classification at all: the International Classification of Primary Care (ICPC).

These classification systems also need interoperability if functions in the health system depending on them, such as health planning and funding, can also benefit from the digitisation of health information.

So at the level of health information, there is a need for informational interoperability. And at the level of meta-data, there is a need for classification interoperability.

Recommendations 5: That informational interoperability and classification interoperability are included in Action area 3 of the Framework of Action as of equal importance to interoperability of information and communication technology hardware and software.

6. Telehealth

Action 5.1.2 Harmonising models of telehealth - HIMAA understands that telehealth can provide immediate improvements to access to health care, particularly of a multidisciplinary nature, to rural and remote individuals and communities which can positively influence the disparity in health care experienced in rural and remote Australia. However, it can also make immediate improvements to healthcare in the home anywhere in the country, and therefore equally of benefit to people with disability or with chronic conditions.

Regardless of demography of application, the management of information involved in telehealth activity is essential, particularly around security of information, patient privacy, and ownership. The owner of the health information in a telehealth consultation, either provider to provider or by providers with a patient, is responsible for that information, and other participants in the consultation need to be aware of their disposition to that ownership, including access and confidentiality.

Recommendation 6: That the need for clarity on the ownership of health information generated or used by a telehealth consultation or process is incorporated into Action 5.1.2 of the Framework to ensure that all parties to a telehealth act are clear of their disposition to information ownership in terms of responsibility for the ongoing integrity of the information, confidentiality, privacy and access.

7. Innovation

Action area 7 seeks to foster “a thriving digital health industry delivering world-class innovation”. HIMAA agrees that “adoption will be accelerated by the provision of best practice design principles and guidelines to improve usability and user experience”. The Association also agrees that “Australians should have better and more informed access to safe, quality applications, tools and content.” Traditionally marginalised and/or disenfranchised groups in the community such as Aboriginal and Torres Strait Islanders, the Culturally and Linguistically Diverse (CALD), the disabled and the aged, merit inclusiveness strategies to engage them in the benefits of digitised health information. So HIMAA has no issue in supporting the actions in Action Area 7.1

We question, however, the value of a digital services endorsement framework recommended in Action 7.2, as this assumes that services will arrive at the adjudication table ready for endorsement or not, as the case may be. That entrepreneurs can be relied upon, thanks to the regulatory screening of market forces, to develop user-ready product or service. They will do this through innovation which requires only the removal of barriers to it in order to generate the successful user-ready product for endorsement. And that all entrepreneurs need do to hone their product or service development efforts to ensure market fit in collaboration with clinicians and researchers, at the design level as well as, presumably, in product/service development.

The entrepreneurs themselves require no education or training, no regulation by standards applied to other professionals in the health industry, no career structure or occupational support structure. Through natural self-selection, aided by the advisory lens of collaboration with clinicians and researchers, they will be the natural suppliers of digital information services for endorsement.

If medical practitioners were to be supported in the same way, anyone who could develop a suit of medical services they could front up to a medical services endorsement framework, with a bit of mentoring from clinicians and researchers, could as a result hang up their

shingle as endorsed suppliers of medical practice. The agency responsible for the endorsement framework will even work with their potential customers to ensure that the new medical practice innovations will not 'leave them behind', thus aiding 'market forces'.

The market, with all of its forces, will love this approach to it by government. But it's hard to see quite how it fits in with all of the standards and guidelines identified in the preceding six action areas of this framework to ensure patient safety and privacy, security and accuracy of information, and its reliability and quality over time, in improving the quality of health care through the structured, audited and otherwise monitored introduction and provision of digital health information services.

Suddenly a whole new occupational group - the entrepreneur / innovator - is thrown into the mix, as if from the stages of the dozens of motivational, inspirational business meets that occur around Australia every year based on no science, no research, and very little of material substance except that immeasurable and elusive but inevitably charismatic quality, success in making money.

HIMAA is not sure this area of action has been well substantiated at all as a direction of practice worthy of the investment of taxpayers' funds when there are much more immediate and pressing priorities, such as the development of a Health Information Workforce that can pathfind the vanguard of health information digitisation.

Recommendation 7: That the "innovators" referred to in Action 7.2, and "entrepreneurs" referred to generally in Action are 7, are required by the digital services endorsement framework proposed in this Action to meet the same criteria and standards of professionalism expected of every other professional involved in the development and provision of digitised health information services discussed in Action areas 1-6.

Conclusion

There is much to recommend the ADHA's NDHS Framework for Action, but HIMAA believes the Framework needs to be revised in response to the following eight recommendations prior to implementation.

Recommendations 1

- 1.1 The Framework of Action be revised to ensure clarity about the difference between data and meta-data, that latter being informational in production where the former constitutes the 'raw material' in the production of information.
- 1.2 Further, that the Framework document is clear about the difference between 'data' and 'information', ensuring any reader can understand that 'data with a commonly understood meaning' are, in fact, 'information', so that a reader can further understand the difference between the need for quality data, and the value of quality information.
- 1.3 Finally, that the Framework is clear about the difference in standards required for assessing and managing quality in data, quality in information, and quality in meta-data. For instance, that quality in data is technically achieved, quality in information is linguistically and textually achieved, and quality in meta-data is achieved through the signification of information, which itself signifies data.

Recommendation 2: That the Framework for Action clarifies the difference between clinical information and health information by a. acknowledging that clinical information is a subset of health information and b. by detailing ways in which the NDHS will support the development, classification, storage and transmission of quality health information other than clinical information, so that the reader can gain a whole-of-health system appreciation of the positive impact of digitisation on health information.

Recommendations 3

3.1 HIMAA recommends the embedding of the current practice of health information management by health information professionals in its Framework for Action.

3.2 The role of health information governance in regulating an enterprise information governance system for health institutions in order to ensure the management of knowledge, information and data within an enterprise system should also be clearly embedded in the Framework for Action

Recommendations 4

4.1 That the ADHA support the Census of HIW to be conducted by the Universities of Tasmania and Melbourne financially and by incorporation into Action 6 of the Framework for Action as an HIW initiative.

4.2 That the development of the HIW be incorporated into Action 6 of the Framework as a rate-determining step co-requisite to Actions 6.1.1, 6.1.2 and 6.1.3, and becomes a new Action 6.1.1 to the renumbered Actions 6.1.2-4.

4.3 That the ADHA assume responsibility for, in the new Action 6.1.1, securing the funding for and actively supporting the Health Information Workforce Alliance peak HIW bodies in take the lead agency role in implementing the renumbered Actions 6.1.2-4

4.4 In particular, in Action 6.1.1ADHA commits to securing funding and infrastructural support for the development of a national HIW capability framework as recommended by HIWA as Strategy B of a series of 8 strategies resulting from the 2016 National HIW Summit.

Recommendations 5: That informational interoperability and classification interoperability are included in Action area 3 of the Framework of Action as of equal importance to interoperability of information and communication technology hardware and software.

Recommendation 6: That the need for clarity on the ownership of health information generated or used by a telehealth consultation or process is incorporated into Action 5.1.2 of the Framework to ensure that all parties to a telehealth act are clear of their disposition to information ownership in terms of responsibility for the ongoing integrity of the information, confidentiality, privacy and access.

Recommendation 7: That the “innovators” referred to in Action 7.2, and “entrepreneurs” referred to generally in Action are 7, are required by the digital services endorsement framework proposed in this Action to meet the same criteria and standards of professionalism expected of every other professional involved in the development and provision of digitised health information services discussed in Action areas 1-6.

HIMAA wishes once more to express its appreciation of the opportunity to provide feedback on the ADHA National Digital Health Strategy’s Framework for Action.

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