



eHealth
week



Uachtaránacht na hÉireann ar
Chomhairle an Aontais Eorpach
Irish Presidency of the Council
of the European Union
eu2013.ie



13-15 MAY 2013 | Dublin, Ireland

Patient Administration Systems – A National Approach

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Presentation Overview

Brief History of PAS in Ireland

The Current Status and Context

Where we want to go – The Key Principles

How we are getting there – The Methodology

The Challenges and Learning to date

Brief History of PAS in Ireland

- The provision of acute hospital services in the early 20th century was lead by Voluntary Organisations – the Churches and other Charities, mainly in the larger cities
- Each Hospital evolved independently
- The new State built many acute public hospitals
- The larger Voluntary hospitals were at the forefront of implement computerised PASs as they had more funding
- Early systems: SMS, Clinicom, IMS, McKesson, Keogh, CAPAS, locally developed systems, etc
- There were no standards in relation interoperability, data definitions, patient identification etc.

Standard PAS Functionality

- Patient Index
- OPD scheduling and clinic management
- IP and OPD waiting lists
- Admissions, Transfers, Discharges and Bed Management
- Document Tracking
- Patient Billing
- Clinical Coding
- Management Reporting

The Current Status and Context

- All Acute hospitals have a PAS, to varying levels of functionality and they are generally specific to a hospital
- A number of hospital sites have out dated 'traditional PAS systems' that are either
 - Not supported
 - Locally supported by individuals
 - Product life cycles are at the sunset stage
 - Levels of support vary across hospitals.
- There are a variety of different PAS systems used across what is a small market
- Current systems do not link across service providers
- Within PAS here is a lack of standardisation in data definitions, reference values, reports, patient numbering etc
- Community, Longstay and Primary Care services have little or no local PAS

The Current Status and Context

- The organisation of health service provision is in a continuing state of flux
- We are becoming more effective in our service delivery and there is pressure on ICT to support the care process
- Reporting standards are being defined by the SDU, HIPE, HIQA, etc however PASs are not designed to reflect these requirements.
- Patients are referred between different healthcare providers and have different patient medical record numbers in each organisation
- HSE under huge financial constraints
- A 'national' Patient Management System was purchased in mid 00s – iSOFT (now CSC) Suite of Products inc iPM (PAS)
- This system is being implemented in all sites needing system replacement – CMOD and DOHC

The Key Principles of IPMS

- A Single National Instance of IPMS
 - Single Patient Index
 - Linking of patient activity across health service providers
 - Nationally Standardised Data Definitions and Reference Values
 - Standardised Activity Reporting
 - Meet HIQA, DPC, OPD, SDU, Health Information Bill requirements etc
 - Base system for an EPR
 - Standard interfacing to other national clinical systems
- Product enhancement is ongoing through version releases
 - National Reporting Requirements
 - Electronic GP referrals to OPD
 - Special Requirements for Mental Health, Maternity and Paediatric Hospitals

Benefits to the Hospital

- Replacement of current end of life product with internationally robust proven solution
- Highly configurable and flexible – this can also be a challenge!
- Fully Integrated with other hospital systems
- Can use local user definable fields
- Generates user definable letters/summaries
- Meets national reporting and coding requirements
- Used in different healthcare facilities from acute specialist hospital to small community facilities
- Part of a national product development path
- We have already selected and have a national contract to use the system – no lengthy procurement process.
- System will be hosted centrally

The Costs Involved

- HSE National Programme pays for:
 - iPM Software Licence costs
 - Maintenance and support costs
 - Product development and change requests
 - iSOFT implementation services
 - National IPMS Team support
 - Train the trainer
 - Migration and Integration
 - Central servers and hosting
 - Some local hardware costs
 - All ICT related project costs must be approved by CMOD

The Costs Involved

- Local site pays for:
 - Staff costs associated with Local Project Team
 - Costs associated with training and releasing staff for training
 - There are still some hardware cost clarifications being discuss with CMOD

Methodology

- National Governance Structure – IPMS Programme Board
- National Implementation Team – 5 wte ICT, 4 wte Business
- Local Implementation Structure for hospital groups
- Standard implementation process:
 - Assessment and Project Planning
 - Design and Change Management
 - Build (Migration, Integration, Configuration, etc) and Test
 - Training
 - Go Live
 - Support
- Focus on service buy-in to business opportunity
- Requirement for a level of configuration standardisation
- Tight Implementation Schedule – 3 years

Implementation Schedule

- 51 Hospitals currently run a PAS
- 21 Hospitals run a version of the CSC PAS – iPM (4 sites live in the last 5 months)
- 7 of these are on the national single instance
- 25 sites still to be implemented
- 5 sites do not currently wish to change their PAS
- Current average implementation capacity: 1 site very 6 weeks, ie, 3 years to complete rollout
- Average implementation time per hospital: 9 months

Parallel Streams of Work

- Linking with national agencies, eg SDU, to determine ***standard data definitions*** and ensure system compliance
- Working with national agencies and other ICT projects to standardise sets of ***national reference values***, eg. a single national GP index
- Working with the Clinical Programmes and Medical Records to agree standards for ***Alerts***
- Working with CSC to develop Change Requests to enhance ***product functionality***
- Working with the ***Data Protection*** Commissioner to address relevant DP issues
- Working to migrate earlier versions on iPM onto the ***national instance***
- Working with local sites to ensure iPM is being used to its full potential and ***meeting service user needs***.

The Challenges

- **Securing staff** resources to work on the national team has been difficult as we have no pay budget
- Lack of a **unique patient identifier** to link the same patient across different service providers
- **Data Protection** issues with Voluntary hospitals – implemented individual instances
- Lack of standard **data definitions** and **reference values**
- Difficulty securing **input and commitment** from the service delivery side of organisation
- **User expectations** – we are not trying to be all things to all people, it is only a PAS

Learning to Date

- Individual site implementations take longer to get started than you think
- Understand the cultural difference between Voluntary and HSE hospitals
- The lack of a UPI, a legislative framework to share information and data standards has to date limited our ability to support more effective patient care.
- Lack of clarity regarding healthcare organisational structures and funding mechanisms makes fit for purpose system configuration difficult.
- Professional competent staff need to be valued



Thank You

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