

# A Community-shared Clinical Abstract to Improve Care – at the Half-way Mark



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Donald P. Connelly, MD, PhD  
University of Minnesota  
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State and Regional Initiatives Breakout  
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# Overview

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- Why did we initiate this HIE project?
- What are the project's main objectives?
- How far along are we?
- What lessons have we learned so far?
- Recommendations to others starting out on HIE

# What was looking for?



Agency for Healthcare Research and Quality

- Planning Grants - Transforming healthcare quality through information technology
- Purpose
  - Assist in planning for successful implementation of HIT
  - To promote & **improve patient safety & healthcare quality**
- Objective
  - Support **community-wide planning across multiple orgs that will enable them to develop HIT infrastructure**
  - **Effective exchange of health info. within the community**

# What were we looking for?



- Ongoing discussions with patient safety officer
- Key Objective
  - Use HIT to promote and improve patient safety & healthcare quality
- Guiding Principle
  - Hiding and hoarding clinical information is not an acceptable mode of competition as it compromises the well-being of patients

# Information Gaps in the ED



- Gaps are frequent - 32% of visits
- Gaps are consequential
  - Very important or essential 48%
  - Somewhat important 32%
  - Prolong the ED stay
  - Increase costs
    - Redundant testing & repeated MD assessments

# A Community-shared Clinical Abstract to Improve Care

***A Planning Grant Submitted to***  
Agency for Healthcare Research & Quality  
(AHRQ)



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***Healthcare Partners:***  
Allina Hospitals & Clinics  
Fairview Health Services  
HealthPartners

Submitted on April 22, 2004



# Project Vision

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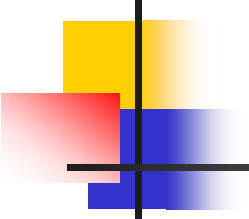


*At the time patients undergo transitions in care, providers will have ready access (via a shared clinical abstract) to the data needed to make informed clinical decisions, including those associated with medication reconciliation, so as to favorably impact the quality of care and patient safety.*

# Our Response to AHRQ



- Focus: fill information gaps that occur at care transitions
  - Patients presenting to ED
  - Patients with chronic illness presenting in other acute care settings
- How: deliver a community-shared clinical record abstract near the point of care
  - Some candidate elements: problems, allergies & adverse reactions, current medications, a subset of recent lab tests, & immunizations
  - Use a federated model of contributing clinical databases not a centralized one
  - Leverage partners' use of a common EHR vendor, Epic
  - Use evolving national standards; we won't roll our own

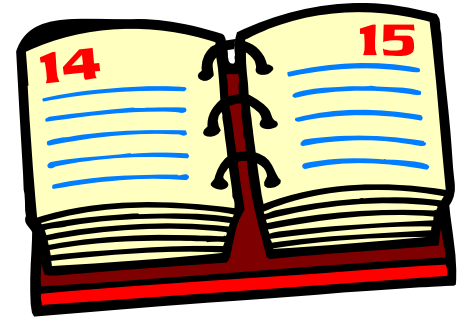


# Rationale for an abstract instead of the entire record

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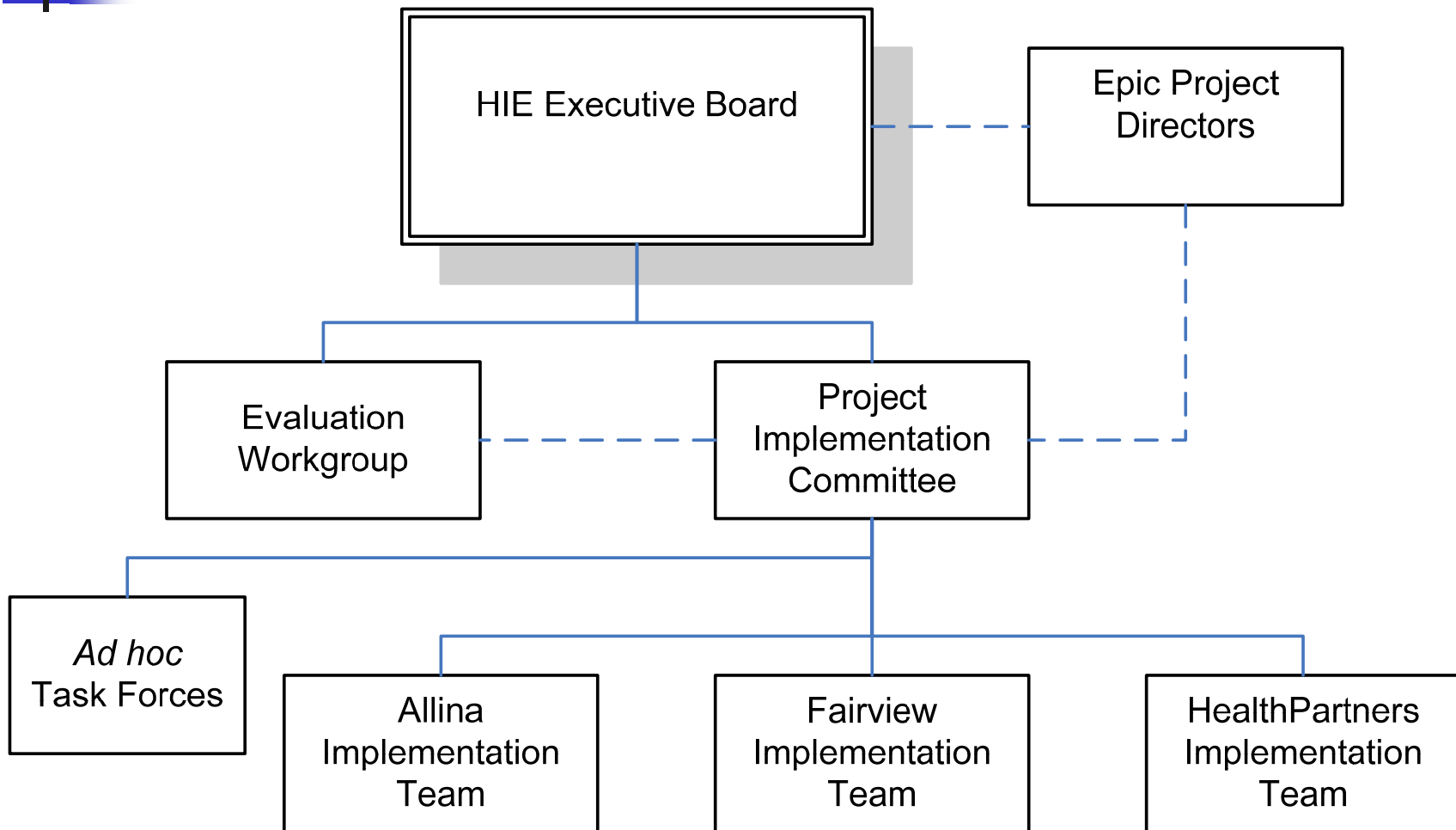
- Contents are bounded & defined
  - A better first step for a public wary of confidentiality breaches
  - Avoiding sensitive content means easier consenting
  - Patients “get it.” They immediately understood the value of “My Emergency Data” for themselves and their providers
  - Greater patient acceptance → easier consenting & wider use
  - While not the entire record, clinicians endorse the abstract as having high clinical value
  - Its succinctness is preferred by emergency room physicians
  - Interoperability across vendor platforms is easier
- Can be viewed as a document from its health system source

# Chronology



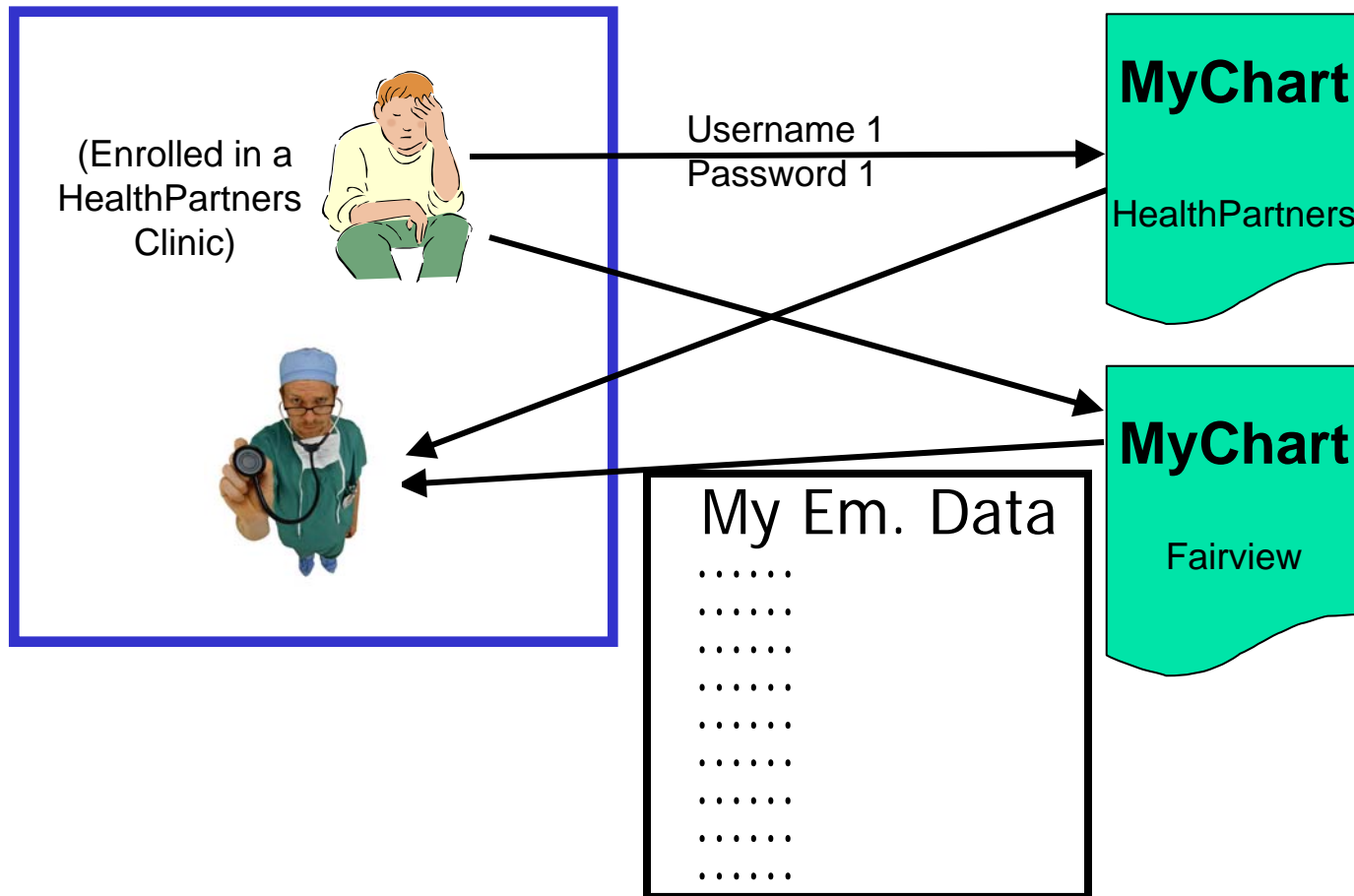
- Apr 04 Our “plan to plan” proposal is submitted
- Oct 04 Award announced. Executing our plan to plan begins
- Apr 05 Our implementation proposal is sent in
- Oct 05 Implementation grant awarded & work begins

# Project Organization



# Phase 1 – MyChart Access

## Buffalo Hospital ER



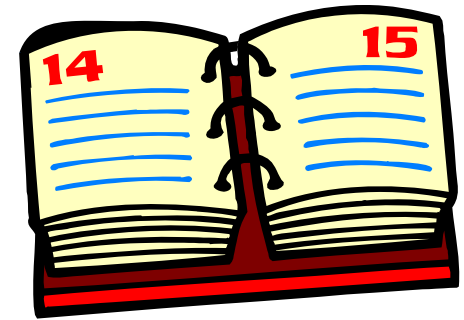


# My Emergency Data Report

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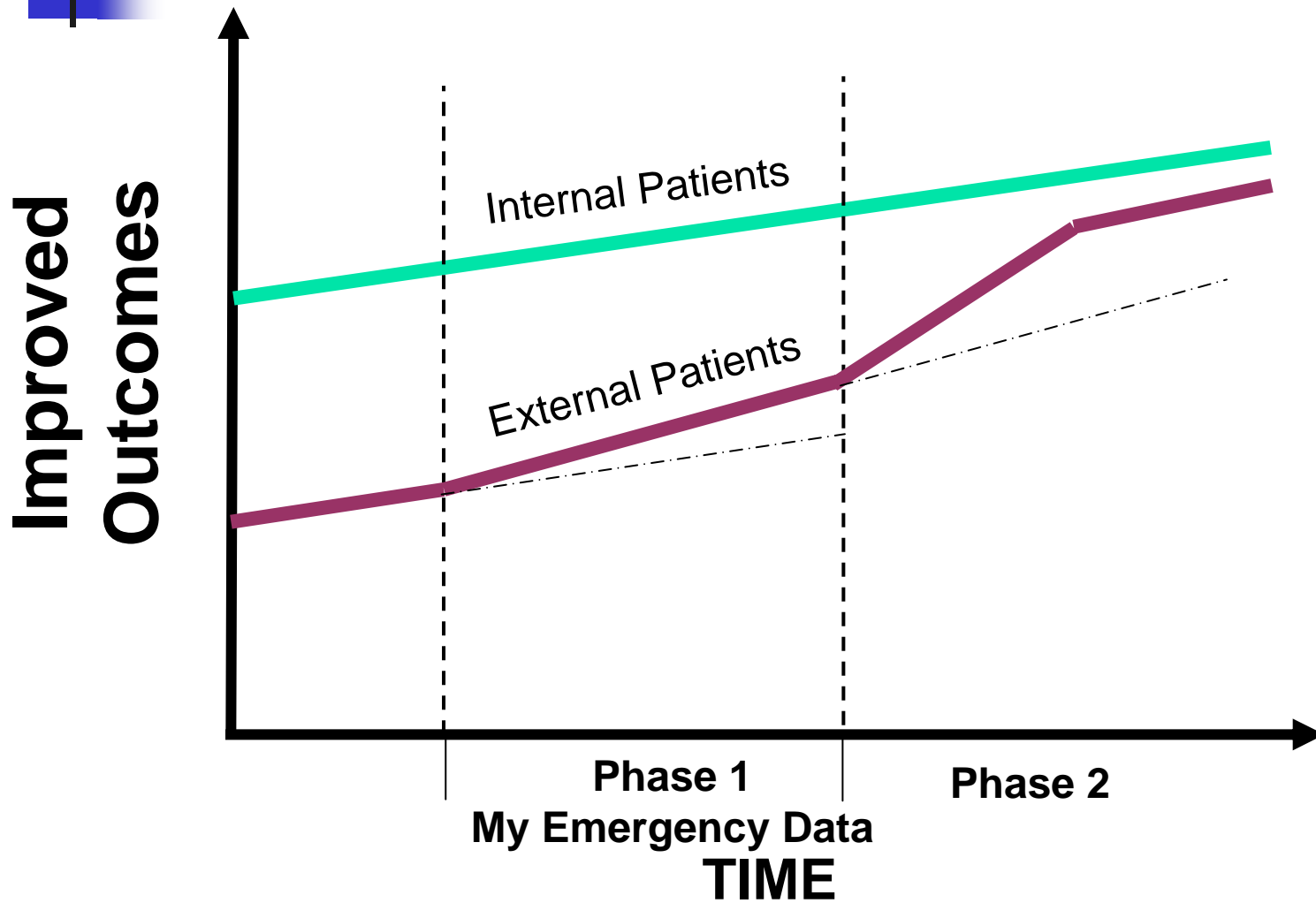
- Patient Information
- Contact Information
- Primary Care MD & Clinic
- Advance Directives
- Current Problem List
- Current Medications
- Allergies
- Immunizations
- Surgical History
- Family Medical History
- Alcohol and Tobacco use
- Hoping for
  - Lab Results
  - Most recent vital signs

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- **Oct 06** Phase 1 (My Emergency Data) in place

# Expected Results



# What we've learned so far:

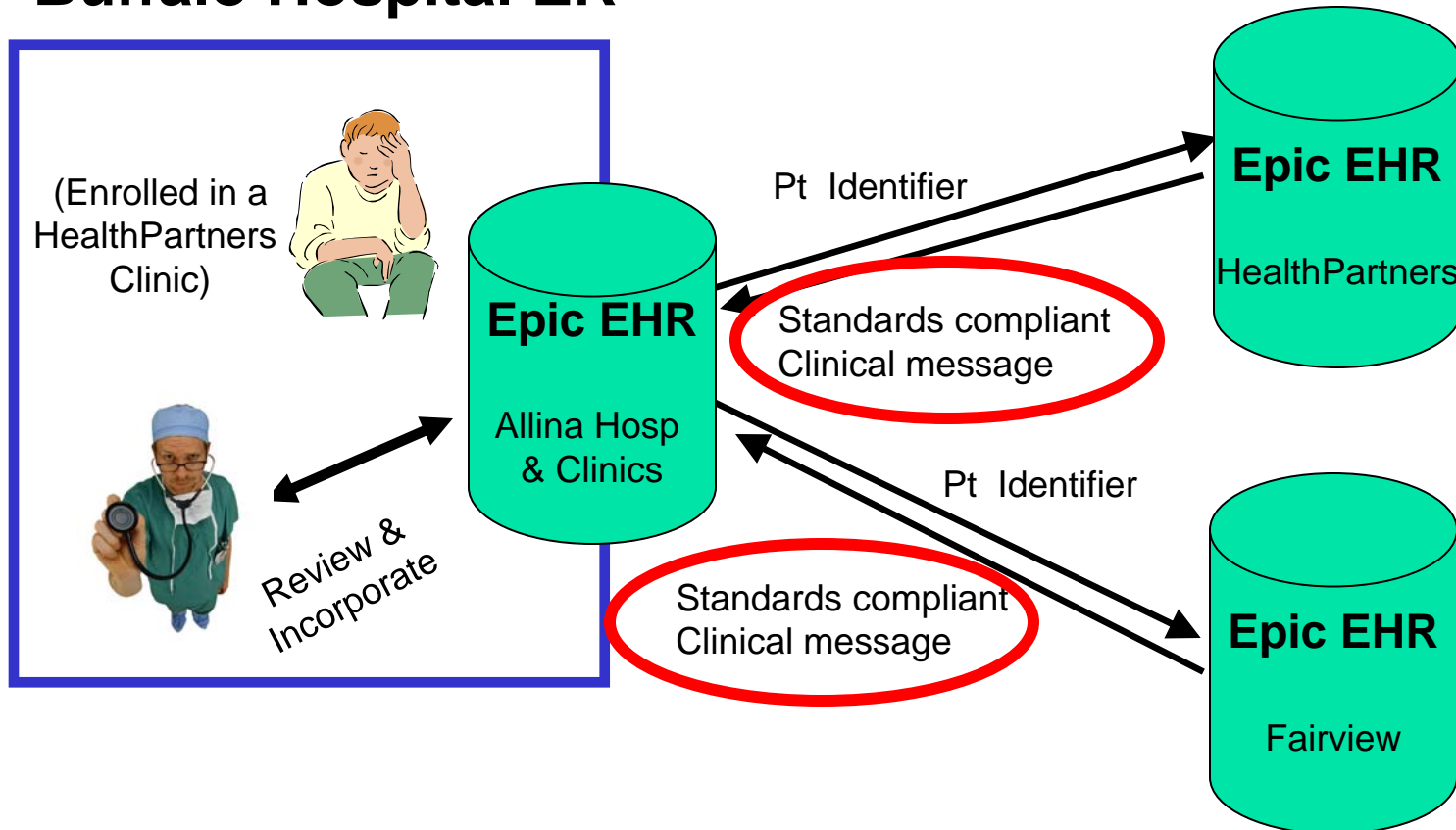
## Phase 1

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- MyChart enrollment rate is too low to yield enough heart failure patients for our analysis
  - An opt-in strategy greatly limits impact
  - This opt-in strategy tends to exclude the elderly with multiple chronic illnesses – the very group which may benefit the most
- MyChart use doesn't integrate well into ED workflow
  - Too few hits in ED to ensure good workflow integration or reliable use
  - Login names and passwords are not uppermost in patients' minds in urgent situations
  - ED not equipped to provide keyboard access to patients
  - MyChart, Abbott and Costello

# Phase 2 – Direct Health Information Exchange

## Buffalo Hospital ER



# An ISSUE recently resolved



## *Harmonizing*

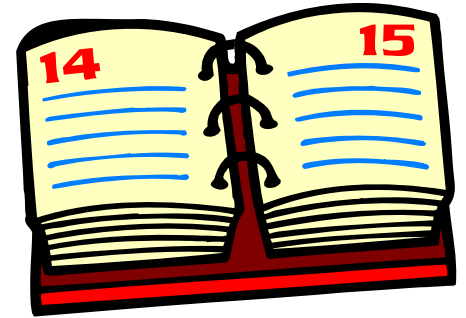
- The ~~Dueling~~ Standards Organizations
  - ASTM & Continuity of Care Record (CCR)
  - HL7's CDA & Care Record Summary (CRS)
  - CDA [CCR]  $\Rightarrow$  CCD (Continuity of Care Doc.)
  - HIMSS EHR Vendors Association supports CCD

# The National HIT Standards Scene



- **Oct 06** Health Information Technology Standards Panel (HITSP) provisionally includes CCD in its report on recommended interoperability specs to the American Health Information Community (AHIC)
- **Dec 06** HL7 balloting of CCD Standard begins; HITSP encourages acceptance
- **Jan 07** HHS Sec'y Leavitt accepts HITSP recommendations
- **Feb 07** HL7 successfully ballots CCD

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- Oct 06 Phase 1 (My Emergency Data) in place
- **Feb 07 CCD approved**
- **NOW**
  - Phase 2 – EHR vendor slowly unfolds/evolves CCD/CDA implementation plans/strategy
  - Privacy has become a very hot issue



# Exchanging abstracts: key privacy challenges

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- Gaining the patient's prospective consent for disclosure
  - For different kinds of abstracts or levels of access
  - For a limited period & how to periodically renew
  - For a particular recipient (e.g., a consulting specialist)
  - Alternate pathways to prospective consenting (e.g., first-day sign-up)
  - Real-time consenting & breaking the glass
- Record Locator Service (RLS) Functions
  - Matching patients across health systems
  - Displaying health systems that hold content
- Authenticating the requestor
- Access control for requesting abstracts
- Audit trails
- Technical communication, messaging, transfer and error handling



# Minnesota Privacy and Security Project (MPSP)

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- Minnesota's component of the Health Information Security and Privacy Collaboration (HISPC) led by RTI International
- Jim Golden, PhD, Minnesota's Project Director
- We participated in Privacy & 4A work groups
- Minnesota law changes will allow RLS (opt-out)
- We're adopting key principles put forth in the MPSP report

# What we've learned so far:



## Phase 2

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### ■ HIT Standards

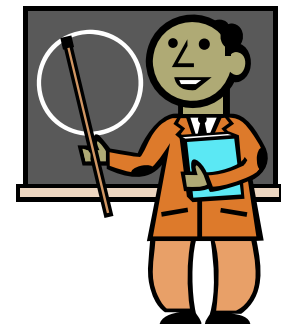
- They're coming along slowly but they are coming
- Hurry up and wait for EHR vendors to integrate standards

### ■ Privacy

- There's a long road ahead
- The dialog is growing – If culture can eat strategy for lunch, all of society discussing privacy may take awhile longer

# Recommendations

- Focus and then focus on what partners want/need to do
- Adopt effective governance models
- Curb your enthusiasm
  - Standards development takes time
  - Vendors take more time to implement them
  - Legal may take even more time
  - But keep moving forward
- Privacy: Society at work
- Show that it works once you get it working



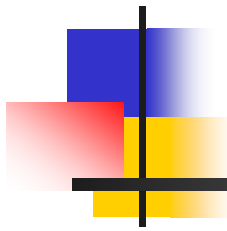


# Thank you

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- Alison Page *Vice President, Patient Safety, Fairview*
- Our faithful Board members
- The numerous dedicated and committed participants from
  - Allina Hospitals and Clinics
  - Fairview Health Services
  - HealthPartners
  - University of Minnesota





# Questions



don@umn.edu