

## Advisory Committee Meeting Record March 11, 2010

### Today's Meeting Objectives:

- Workgroup Session

### Attendees

Julie Aldrich, *The Ohio State University Medical Center*  
Mike Blue, MD, *Immediate Health Associates*  
Les Boyer, *Mount Carmel*  
Natasha Davis, *Nationwide Children's Hospital*  
Deanna Gingrich, RN, *Lower Lights Christian Health Center*  
Dan Haber, *Battelle*  
Jeff Hoffman, MD, *Pediatric Academic Association*  
Sonja Howard, RN, *Mount Carmel Health System*  
Darren Huff, *Columbus Neighborhood Health Center*  
Bruce Jones, DO, *EMP of Franklin County*  
Matt Kellar, *Emergency Services*

Mysheika LeMaile-Williams, MD, *Columbus Public Health*  
Colleen Opremcak, MD, *OhioHealth Behavioral Health*  
Joy Parker, RN, *Heart of Ohio Family Health Center*  
Anne Robinson, *National Alliance on Mental Illness-Franklin Co.*  
Jack Rupp, Jr., *Franklin County Chiefs Association*  
Susan Tilgner, *Franklin County Board of Health*  
Tim Tilton, *Franklin County Chiefs Association*  
Sophia Tolliver, *James Cancer Hospital*  
Chris VanCuyk, *OhioHealth*  
Michelle Vander Stouw, *United Way of Central Ohio*  
Andy Wagner, MD, *The Ohio State University Medical Center*

### Collaborative Partners

Nancie Bechtel, *Central Ohio Trauma System*  
Jeff Biehl, *Access HealthColumbus*  
Phil Cass, *Central Ohio Trauma System*  
Jeff Klingler, *Central Ohio Hospital Council*

### Guests

Teresa Garcia, *Access HealthColumbus consultant*  
Marisa Gard, *Central Ohio Trauma System*  
Bill Mitchin, *Access HealthColumbus consultant*

## WELCOME & FRAMING

Phil Cass welcomed everyone to today's advisory committee meeting. He reviewed project purpose & vision, went over today's agenda and asked everyone to introduce themselves around the room.

## PATIENT-CENTERED PRINCIPLES VERSION 1.5

Cass shared draft Version 1.5 of the Patient-Centered Principles. The advisory committee provided their feedback and the Patient-Centered Principles workgroup incorporated them into Version 2.0, which can be viewed in **Attachment A**.

## WORKGROUPS

The committee spent the next hour in their workgroups to:

- Discuss learning completed since last session
- Connect with other workgroups
- Identify April objectives
- Update on next steps

The following next steps and April objectives were shared:

Workgroup	Next Steps/April Objectives
<p><b>Shared Patient-Centered Principles</b> (draft version 2.0 can be viewed in <b>Attachment A</b>)</p>	<ul style="list-style-type: none"> <li>• Incorporate committee feedback and share draft Version 2.0 of Patient-Centered Principles</li> <li>• Finalize Version 2.0 at April advisory committee meeting</li> <li>• Take on Public Notification/Public Education in April</li> </ul>
<p><b>Shared Policies &amp; Procedures</b> (notes can be viewed in <b>Attachment A</b>)</p>	<ul style="list-style-type: none"> <li>• Coordinate process with hospitals' attorneys around legal HIPAA implications</li> <li>• Coordinate conference call with Dr. John Whitcomb from Milwaukee</li> <li>• Create first draft of data elements</li> <li>• Transition Public Notification/Public Education to Patient-Centered Principles workgroup</li> </ul>
<p><b>Shared Tools</b> (notes can be viewed in <b>Attachment A</b>)</p>	<ul style="list-style-type: none"> <li>• Conduct interviews in April &amp; May with vendors and present recommendations to the committee</li> <li>• Review survey instrument for Phases II-IV capabilities</li> <li>• Question session with Policies &amp; Procedures workgroup at April advisory committee meeting</li> </ul>
<p><b>Shared Measures of Evaluation</b> (notes can be viewed in <b>Attachment A</b>)</p>	<ul style="list-style-type: none"> <li>• Begin to convene the different health systems and discuss methodology for return on investment to put in business plan</li> <li>• Complete return on investment discussion by the end of May</li> </ul>

**CLOSING AND CHECK-OUT**

The next Advisory Committee meeting is scheduled for April 8<sup>th</sup> from 7:30-9:30AM. The purpose of the meeting is to continue the workgroup session.

## Shared Patient-Centered Principles Workgroup

### Patient Centered Care Coordination Principles

#### Draft v.2.0

**Project Purpose:** To improve patient-centered care coordination across emergency departments and with community health centers for all people in central Ohio-starting with hospitals located in Franklin County.

**Preamble:** Patients have ongoing relationships with multiple health care providers and health institutions that contribute to layers of patient information that can lead to a fragmented and incomplete profile of the patient. Shared patient centered information is used to create a more complete patient profile that supports good decision making on the part of the health care team, thus improving care of the patient.

- Patient centered care starts with the assurance that clinical patient information is made available by the provider of care and then is accessed and used by subsequent providers (always use the system).
- Patient centered information should be complete, unbiased, accurate, available and accessed in a timely manner.
- Patients and families (within legal guidelines) should be made aware that patient information, has been shared between providers and that the system assures confidentiality and security of the patient information.
- Patients and their families (within legal guidelines) are the beneficiaries of this shared patient information.
- Shared patient information supports a whole person orientation where patients are understood to be more than their disease and where they have a history and preferences that should be valued and utilized within the context of their own cultural, racial, language, age, gender, sexual orientation and disability experiences (worldviews).
- The sharing of patient information should support the coordination and integration of care. This patient information supports a learning community around the patient. While the treating provider at the point of care is responsible for the care being delivered, hospital systems (health-care teams) are working together with the patient, for their benefit.
- Shared patient information supports a safer, higher quality and financially responsible health care system.

## Shared Policies & Procedures Workgroup

**Purpose:** Working collaboratively to define shared policies and procedures for the Central Ohio Care Coordination Project's business plan

### Responsibilities:

- Establish written policies and procedures that:
  - Delineate what information is shared and why
  - Document system processes for how and by when data is shared
  - Address patient confidentiality
  - Include public notification/public education aspect
- Establish the list of patient record data elements to be shared amount emergency departments
- Establish memorandum of understanding among hospitals to share the information

**Collaborative Staff:** Nancie Bechtel, RN

**Co-Chairs:** John Drstvensek, MD  
Duane Kusler, RN

**Participants:** Nancie Bechtel, RN, *Central Ohio Trauma System*  
Mike Blue, MD, *Immediate Health Associates*  
Natasha Davis, JD, *Nationwide Children's Hospital*  
Duane Kusler, RN, *Nationwide Children's Hospital*  
Matt Kellar, MD, *Mount Carmel Health System*  
Marisa Gard, *Central Ohio Trauma System*  
Sonja Howard, RN, *Mount Carmel Health System*  
Bruce Jones, DO, *OhioHealth Doctors*  
Collen Opremcak, MD, *OhioHealth Behavioral Health*  
Sophia Tolliver, *James Cancer Hospital & Solove Research Institute*  
Andrew Wagner, MD, *The Ohio State University Medical Center*

**Absent:** Avni Cirpili, *OSU Harding Hospital*  
John Drstvensek, MD, *Ohio Health*  
Richard Nelson, MD, *The Ohio State University Medical Center*

### Shared Policies & Procedures Notes:

**KNOW:** The group discussed a list of items that was previously decided upon.

1. SSN Numbers will NOT be a component.
2. All desired components will be included in the initial "draft" of the snapshot layout and will be revised at a later date based upon IT capability, HIPAA and other legal issues.
3. An opt-out/do not consent form option is not endorsed by the Work Group.
4. Pulling patient information from as far back as possible is endorsed by the Work Group.
5. The system can allow remote access by a specialty or consulting physician assisting with ED care and the information can be pulled up outside the ED by the floor, an internal medicine staff physician, the cardiology department, etc. if it is determined legal.
6. A preliminary list of data elements will be included.
  - Discussion ensued regarding #3, the opt-out/do not consent form. It was suggested that the consent be added into the general ED forms, without drawing a great deal of attention to it. This would mean changes for all hospitals' registration forms. Natasha Davis will research the topic and bring back information for further discussion at the April meeting.

**OUTSTANDING QUESTIONS (as of February 11, 2010):** The group reviewed and discussed a list of questions that were considered to still be outstanding.

1. What are the legal repercussions if an ED physician overlooks a detail on the electronic snapshot?
  - Discussion ensued regarding putting “time periods” on the data elements. The group discussed laying the data out on the snapshot differently depending on the physician/nurse’s preference, based on information they prefer to see, how far back to pull data from, etc.
  - Group members present felt that there might be no more liability issues once the system is in place than there is currently. Natasha Davis will research the legal repercussions if an ED physician overlooks a detail on the snapshot and bring it back to the next meeting for further discussion.
  
2. What is the legality of including sexual assault and psychiatric information on the electronic snapshot?
  - It was decided that images regarding sexual assault were not needed in the forward care of a patient.
  - A new question was generated, are there certain scenarios or issues that should be flagged on a patient’s snapshot?
  - Natasha Davis will do research on the legality of including sexual assault information on the snapshot and bring it back to the next meeting for further discussion.
  
3. How will the Work Group define security parameters (e.g. recording who looks at the snapshot, creating an authorization check box, etc.)?
  - Discussion ensued regarding the ability of the unit clerk pulling up the initial patient in the system and having it ready for the physician to sign in their username and password, which would retrieve the medical information. Doctors present felt that there should be varying levels of access and a necessity for flexibility.
  - Group members also discussed the frequency physicians may need to pull up the snapshot and if there are any standards for pulling up data so as not to profile patients. The solution may be to include that “retrieving the data would be done if it is in the best interest of the patient” on the general ED consent form.
  
4. Will fingerprint and/or palm scanners be a viable identifying mechanism for this project?
  - Group members decided that the scanners may be something to keep in mind for the future, but will not be considered at this time. The topic is parked.
  
5. Can the information be used by hospitals to conduct Process Improvement (PI) activities?
  - Natasha Davis will research the legality of using snapshot information for PI.
  
6. Can the information be used by an ED if a patient calls on the phone with a complaint after the patient has already been seen in the ED?
  - It was decided that detailed information is not given out over the telephone currently, nor will it be done when the system is put in place.

**Group members came to the following decisions:**

- A conference call between group members and Dr. Whitcomb, from Milwaukee, will take place prior to the April 8 meeting. Duane Kusler will help coordinate the call which will be recorded for those that cannot participate.
- Group members from both the Shared Policies & Procedures and Shared Tools agreed they should carve out time for discussion at the April 8 meeting.
- Group members agreed to transition the Public Notification/Public Education work to the group that was previously Shared Principles.
- Natasha Davis will get in contact with the hospitals’ attorneys; bring them up to speed with a “short executive summary” of the project, along with the outstanding questions she is researching for the next meeting and a deadline to respond. Dr. Opremcak and Sonja Howard would like to remain a part of the process as well. Dr. Wagner will get Natasha contact information for OSU’s attorney(s). Group members will contact their legal staff to let them know Natasha will be getting in contact with them.
- Nancie will start drafting the initial policies and procedures to review at the April 8 meeting.

**Shared Tools Workgroup**  
**NOTES from March meeting**

**Proposed Timeline of Workgroup Activities**

- April/May – Conduct interviews with potential vendors:
  - IBM
  - Oracle
  - Microsoft follow up – additional questions include:
    - Where did \$500K savings per ED come from?
    - Besides Milwaukee, what other communities is Microsoft partnering?
- April meeting – review survey instrument (Chris and Dan to develop draft)
  - Distribute survey after meeting
- May meeting – review survey results
- August meeting – presentation/recommendation to full advisory committee, seek feedback

## Shared Measures of Evaluation Workgroup

Central Ohio Care Coordination Project

Topic: Financial ROI

Purpose: Clarity on financial ROI methodology

### What ROI should we use?

- Is it ROI of ED as a cost center?
- Is it ROI of ED and inpatient services?
- Is it ROI for the collective community?
- Is it ROI for EMS?
- Is it ROI of value for national accreditations?
- It is all of the above?

### What are we measuring?

- Reduce high utilizers of ED services that when viewed collectively are costing all of us plenty?
- Improve efficiency by reducing those clogging the ED with non-urgent needs?
- Connect those without a regular source of health care with primary care – so downstream admissions are better managed?
- Others?
- All of the above?

### What is the proposed approach for gaining clarity on ROI?

- Convene hospital ED leadership to gain from their individual and collective wisdom
- Convene hospital CFO and ED leadership towards gaining clarity

### What is the value to project?

