Workgroup Meeting Minutes

Workgroup 1: Information and Communications Exchange Protocols

Led by Courtney Burke, Director of Health Planning, and Kevin Jobin-Davis, Exec. Director, HCDI

Attendees: Jackie Cabreja (Ellis); Donna Sickler; Valerie McMahon (NE Health); Sara Butterfield (IPRO); Karen Julian (NE Health); Jerry Salkowe, MD; Peter Brown; Jonathan Dougherty (Albany Medical Society); Nora Barrato (St. Peter’s); Lou Snitkoff, MD (CapitalCare); Charlene Schlude (CDPHP); Clifford Waldman, MD (CDPHP); Cathy Pallozzi (Albany Med); Carol McDonald (Albany Med); Linda Ruth (MVP); Pamela Rehak (Seton Health); and Jessica Rose (Saratoga Care).

Following workgroup member introductions, Courtney shared the workgroup’s timetable of Feb. 2011 for developing a plan and reporting back.

Courtney solicited the group for successful local initiatives.

- Lou shared how CapitalCare is in the early stages of developing 8 cabinets for 8 mission-critical service lines, including a primary care cabinet. The cabinets are just getting started but have potential for synergy.
- Sara said information transfer is a major initiative and making sure gaps are filled. IPRO is working with providers to develop a Universal Transfer Tool. Received provider feedback and looking to pilot test tool with skilled nursing facilities. The goal is to make sure the right information is sent. The tool is mostly comprised of check-offs with little narrative. The biggest barrier is people want the tool electronically. Receiving positive feedback from providers, particularly skilled nursing facilities.

Sara said ED docs and PCPs seeking much different information from patients. Nora said that ED docs don’t have time to track down all the various docs treating a patient.

Courtney invited the group to determine the most minimal amount of information to push in the discharge summary.

Jackie noted a lot of Ellis patients come to ED without knowing their assigned PCP. Another group member added that patients often don’t know their PCP because practices groups are so large and patients never see the same doctor at each visit. Valerie mentioned the patient may share PCP information that’s no longer valid so it becomes a moving target. In that event, NE Health needs to find a new PCP for patient.

Jackie added that the vast majority of patients list wrong phone numbers. Lucky if she reaches 5 out of 20 on follow-up calls.

Group reached consensus that pilot should start with ED patients not admitted to the hospital. Much too involved to include inpatients. Lou added that when patients are admitted, their ED care becomes less of concern for PCPs.

Jerry said the priority of pushing information back to PCPs varies from hospital to hospital and has a lot to do with processes in place. Suggested giving ED staff a script to follow.

Cliff said a methodology needs to be developed through claims. Identifying who is the assigned PCP should be left to practices and not individual docs.
Karen brought up that examination needs to be given to roles and responsibilities of staff sending patients to ED. A degree of accountability needs to be added to the system. Even if family members insist a patient be brought to ED, is that the right decision?

Kevin pointed out that not every hospital can implement AMC’s system due to costs and limited resources.

Charlene noted that the HMO model is spiraling out of the industry. More people won’t be required to select a PCP.

Karen observed that discharge summary faxes often sit in a pile at the PCP’s office. An alert needs to be developed.

Kevin added how an ED doc preferred to have access to an e-mail list of PCPs for notification purposes.

Courtney stated that the group reached a consensus and the workgroup should focus on patients using the ED but not admitted and identifying their care provider.

Charlene noted how insurance information won’t always be 100% accurate.

Sara raised the question of who would handle confirming who is admitted and identifying the PCPs. Who will handle the function of pushing information to PCPs?

Carol declined on behalf of Albany Med to be a pilot site but would be happy to participate in future discussions.

Group discussed idea of including urgent care facilities in pilot program but eventually dismissed it.

Courtney solicited group for hospitals willing to pilot the program. Seton and Northeast Health discussed as possible organizations.

Charlene said payers should have a big stake in the pilot since it gets to the heart of inappropriate ED usage. Nora added that in her experiences, some providers actually tell their patients to go to ED for treatment when no appointment slots are available. There is no accountability among some PCPs. Changing the culture that this is an acceptability practice is important. Nora agreed that a dialogue with the PCPs needs to occur.

Jerry observed how the Patient Centered Medical Home model is encouraging practices to be more engaged in patient care. In fact, the model is encouraging practitioners to head in the direction the workgroup is discussing.

Karen observed that dealing with home health providers, with multiple calls inquiring about med checks, takes time out of a PCP’s day and it’s not reimbursed.

Workgroup takeaways:

Courtney identified the two items generated from the group discussion:

1. Pilot will focus on population using ED but are not admitted to hospital. Pilot will include ED docs and PCPs. Seton might be interested in participating electronically. CDPHP expressed some level of interest.
2. Need to develop protocols for when patients are sent to ED. May be outside the scope of this workgroup. Perhaps an opportunity to create another workgroup.
Workgroup2: Integrating Access to Coordinated Community health Record (CCHR) in the ED

Meeting Summary:

Data Elements:
1. Problem Lists
   1a. Medications
   1a. Allergies

Discharge summaries
Laboratory results
Transfer information (reason for transfer)
Social Factors (i.e. older person living alone).
What other organizations and care coordination people is this patient associated with.
Discharge Diagnoses
Surgical History

Data Elements – Timeline:
Allergies – lifetime
Medications – last year
Laboratory results – change very quickly so only most recent are relevant
Discharge Summaries – last one. If the last one was over 1 yr ago, it’s probably not that relevant.

Service/Workflow Considerations:
- Need to have information available like an onion. First thing you see should be is the information you need if you only have 1 minute. Then can get deeper/more information.
- When displaying timeline specific information- should be able to tell if there is more available when you dig deeper or if that’s all there is.
- Automatic printing is not a good idea in the ED setting. Papers get lost, multiple printers and queues, etc.
- Would like to be able to see if there is some information available before the clinician goes looking for it. If information is available, would like the link to that information right there so they just have to click.
- It would be helpful if there could be some kind of numbering or alphabetized system to indicate what types of information are available for that patient.

Next Steps:
HIXNY will look into the percentages of cases that are urgent, emergent, non-emergent.
Develop case scenarios around different types of patients (urgent, non-emergent); if they’re transfers, off the street, or have been to the organization before; different presenting symptoms; etc
Then work to see what information you would want in those scenarios, determine workflow in those scenarios, etc.
Invite other ED staff that could make it, administration staff, IT, pharmacists to the workgroup.

Workgroup should meet at least every other time by phone.

Discussion:
- Try it a little at a time and sit and think out possible workflow. Worried about too much information all at once. (Compared it to early fiber optics?)
  - Build scenarios, present cases and what it would be like for different presentations (MI, Vague Pain in abdomen, etc)
- Always keep in mind what this would look like if you were asking the patient to choose what information they would want to see and how.
- Recommend: Focus on scenarios.
- HIXNY: Get statistics on the mix of patients that present at the regional hospitals. Then get input on the information and services for the different scenarios.
- Community Care happy to help out.
• Transfer patients are a significant population. Would like to see the reason for transfer. Transfer cases are more complex from the get-go.
• For patients that have chronic illness – typically on some care coordination or disease management process with some organization. Would like a quick way to get a lot of information about that stuff.
• Would like to see social factors. i.e. old man living alone immediately affects care coordination and planning.
• One organization:
  • When patients arrive they are assigned as urgent, emergent, and non-emergent. That affects the time you have to get information.
    o Need to be able to peel back the information like an onion. The first page needs to be what you would need in the first minute for urgent situations.

Another organization:
Puts patients into three categories:
  1) Has been to that organizations before
  2) Transfers – Other hospitals are pretty good about sending medical information with their transfer patients
  3) Never been there before, presenting of the street.
For #3 – problem lists above all else are most valuable (including discharge summary information) Then medications and allergies…
  - Can typically get medication information fairly easily from other sources.
Current “Diagnoses” are not accurate, especially if they are actually chief complaints collected at the point of registration. It’s coded in but doesn’t tell you anything pertinent.

Discharge diagnoses would be better – tells you things like pacemaker put in.
Problem lists are what the physician is treating for. Not necessarily chief complaint at admission.

Timeline:
  Allergies – all
  Medications – 1 yr
  Labs – labs can change within a week so it would be a shorter timeframe.
  Discharge summary – the most recent. However if the most recent one is over a year ago it’s not as relevant.

"With complex patients you hope for a discharge summary. a discharge summary within the last 6 months" because you get a lot of information (you almost get all you need in there)

Question:
Is there a way to get the information for the past year, but if there’s nothing in the last year then go back farther? . Or include time-limited data but also show that “More information is available”

Thinking from a PCP perspective → thinking what information do you need to make sure is getting put in the EMR system? Especially, what information would you want/need for walk-ins to the ED?
Also considers EDs to be quasi-PCP sites… about half of the cases are non-emergent.
  • Suggested Problem Lists (active vs. past) and surgical history

Maybe only 10% of the patients that go to an ED are urgent cases. However the gap of information for that 10% is there. They are high risk with no information – that is when you would use the HIE system the most.

**e-Registration:**
Electronic preferred. Paper is a nightmare situation, especially in the ED setting with multiple printers, things getting lost, multiple queues, etc.
Hyperlink with alert if available (easy to see)
Looking every single time would be problematic, especially if they look and no information is there… but if an alert could tell you there was information they would click the link to look. If a Dr is introduced to the system and they look, but 9 out of 10 times there is no information, they are not going to go look anymore.

How acceptable would alert pull for all patients vs. only alert if specific pieces of information are available?
- possibly list the categories of information that is in there…
- possibly have some kind fo numbering/alphabetized system to show the data presence

**Next Steps:**
Who should be invited?
ED departments that couldn’t make it; Registration staff; IT; Pharmacists (example: St Peter’s has pharmacists that “live in the ED”)
Morning meeting time is more efficient. Maybe have every other meeting be a call in.