Connect Care Physician Adoption

Summary

Growing awareness of the Alberta Health Services (AHS) Connect Care initiative, and its supporting clinical information system (CIS), causes Alberta physicians to ask how Connect Care might affect them. Will they be required, or have the opportunity, to use the full Connect Care CIS?

This backgrounder offers a framework for decisions about how clinicians may experience Connect Care, depending upon whether AHS is responsible for the record of care or not. Physician (including prescriber and trainee) clinical practice contexts can be divided into three categories that differ by digital health record accountability:

1. Current use of an AHS-provisioned record of care
2. Current use of an independent non-AHS record of care
3. Current use a hybrid record of care, with AHS and non-AHS components

The three categories are derived from a review of business arrangements between AHS and physicians.

Context

The Connect Care clinical information system (CIS) can help transform how patient care is delivered and experienced. Success depends upon seamless connections between care in all contexts, including inpatient, ambulatory and community care. Accordingly, a robust CIS technology was selected for scalability and sustainability across domains, disciplines, settings, generations, geography and the continuum of care. CIS capabilities differ significantly from those of the Electronic Health Record (EHR, Netcare) and Electronic Medical Records (EMRs, see digital health record definitions).

Early approaches to defining Connect Care's considered where care is provided. Presumably, Connect Care would serve practitioners working in AHS "facilities". By contrast, independent EMRs and Netcare would serve practitioners working in the "community".

The facility/community construct proved difficult to apply. While many physicians work in settings operating independently of AHS, most provide at least some care within AHS facilities. Many physicians lease space from AHS but operate as independent practices. AHS-operated health services may be delivered in locations not owned by AHS. Moreover, AHS-operated primary care, continuing care, home care, extended care, public health, community mental health, cancer care, telehealth and other services are integrated with AHS secondary and tertiary care programs throughout Alberta.

Care increasingly is provided through networks and joint initiatives that bridge AHS and non-AHS facilities. Indeed, as virtual health services grow, it can be difficult to know what the term "facility" means, let alone who owns or operates a facility. Mixed business models exist. Parts of an episode of care, even on the same day, are received in a building or lab that might be considered "private" while other parts are received in a facility co-run with universities, while yet others are received in AHS buildings staffed by non-AHS employees. The same digital health record may be used in all contexts.

A different construct is needed to identify practice contexts that are in-scope for Connect Care CIS adoption during the initiative's implantation phase. The proposed "Connect Care Physician Adoption" framework is informed by consultations with AH policy advisors, AHS Connect Care leadership, AHS Medical Affairs, AHS Legal, AHS Health Information Management, physician focus groups, Alberta Medical Association advisors and the Connect Care Council.

Framework

Physician (including prescriber and trainee) clinical practice contexts can be divided into three categories that differ by digital health record accountability. This categorization is resilient to clinic location, ownership, employment and business relationships.

The primary test is whether an AHS-provisioned, operated or controlled health record serves as the legal record of care for the services delivered by physicians in a particular context. A secondary test is whether a physician serves as part of a program for which AHS is accountable or in a facility which AHS operates.

Applying these tests allows physician practice contexts to be mapped to one of three groups:

1. Current use of an AHS-provisioned record of care
2. Current use of an independent non-AHS record of care
3. Current use a hybrid record of care, with AHS and non-AHS components

Inclusion Test

A physician practice context passes the AHS record-of-care test if:

- An Information Management Agreement exists
  - AHS is specified as a custodian or as an information manager in a Health Information Act (HIA) compliant information management agreement (IMA).
  - An IMA need not be current, as long as it was previously ratified and the business arrangement has not changed.
- A business management agreement exists
  - Some practice plans, care networks, alternative reimbursement plans and other formal business arrangements include provisions for AHS to provide information services, with explicit or implicit expectation that AHS provide or arrange for the provision of a health record system.
- A professional standard applies
  - If a chart audit initiated by the College of Physicians and Surgeons of Alberta, or like body, requires permission for access from AHS, then health record services may be an AHS accountability.
- Patient access requests are handled by AHS Health Information Management (HIM)
  - If a chart access or transfer request requires HIM (medical records) intervention, then health record services may be an AHS accountability.
- AHS otherwise behaves as steward of the health record
  - AHS may license an EMR, contract with an EMR service provider, host an EMR on its servers or otherwise be responsible for the ongoing support of the EMR.
  - AHS may provide the space and support services for the maintenance of a paper-based health record.

A physician practice context fails the AHS record of care test if:

- All health record management functions are hosted and managed independently of AHS.
- Health record services are outsourced to an entity other than AHS.
- Access to the health record for regulatory or investigative purposes can be had without obtaining AHS permission, help, awareness or systems.
- Patient access requests can only be satisfied by non-AHS persons or entities.

A physician practice context fits the hybrid definition if:

- Key parts of the health record (e.g., patient registration, scheduling, referral and communication, order-entry) are managed by AHS while other health record components (e.g., dictation, consult letter management, clinical documentation) are managed independently.
- Information services critical to the provision of health services (e.g., registration, scheduling) are provided by AHS, even if physicians manage notes and letters.

Implications

Use of the proposed framework implies that neither location (community, facility, acute care, etc.), employment (AHS staff, private staff, university staff, etc.) or business arrangement (lease, ownership, partnership, etc.) determines eligibility for Connect Care adoption by physicians. Instead, primary

accountability for the provision, support, maintenance, curation, archiving and storage of the health record constitutes the primary determinant of Connect Care eligibility.

The record-of-care test is applied to a physician's practice context, not to the individual physician. Physicians may be nomadic (e.g., locum tenens physicians moving from practice to practice), multi-practice (e.g., working with a non-AHS record of care in a community practice but then working with an AHS record of care when rounding in hospital), or rotating (e.g., trainees shifting from site to site or doing extender shifts in AHS record contexts). Physicians may also work with both AHS and non-AHS records of care during transition periods while Connect Care deploys.

Expectations

Connect Care expectations of physicians are context-dependent.

Context 1: Current use of an AHS-provisioned record of care

- All physicians who work in settings and contexts where AHS is responsible for the record of care will be expected to train, demonstrate competence, and adopt the full Connect Care CIS.
- While all documentation, order entry and patient management must use the CIS, some business functions (e.g., professional billing) may be managed externally.
- Adherence to Connect Care CIS minimum use norms is expected and monitored.
- Physicians endorse and adhere to the Connect Care Clinical Information Sharing Approach.

Context 2: Current use of an independent non-AHS record of care

- Physicians will be encouraged to take advantage of Connect Care bridging services (e.g., provider portal, eDelivery, etc.) but will not use the full Connect Care CIS in settings where AHS is not responsible for the record of care.
- Where space in an AHS facility is leased from AHS by a group using an independent EMR, AHS may petition to re-negotiate business relationships, become the information manager, and so enable transition of the practice context to the Connect Care record at some future date.

Context 3: Current use a hybrid record of care, with AHS and non-AHS components

- Each hybrid record context will be evaluated to determine who is accountable for key health record functions.
- Where key functions (e.g., documentation, ordering) are supported by AHS, the practice setting will be strongly encouraged to transition to the full Connect Care CIS.
- Where an independent EMR is used for key clinical functions, the practice setting may need to stay with its non-CIS system until Connect Care has fully deployed and has capacity for additional implementations.
- Paper-based hybrid practices may be prioritized for transition to Connect Care, as staff will be CIS-trained for registration, scheduling and other functions for which AHS has responsibility.
- Where hybrid record care is provided in an AHS facility in the absence of an independent business arrangement, physicians may be required to adopt the full Connect Care CIS.

Application

No classification scheme can reliably differentiate all practice scenarios. Physicians may serve in multi-specialty or multi-disciplinary contexts, or move between contexts in the course of a day or week. While most wish for a seamless experience everywhere they work, the present focus is on where they have, or do not have, early expectation of an AHS-provisioned health record system.

Context 1: Current use of an AHS-provisioned record of care

There are many situations where physicians use a health record provisioned, operated, licensed and serviced by AHS. In some, a full AHS CIS (eCLINICIAN, Sunrise Clinical Manager, Meditech) is used. In others, an AHS-operated EMR is used. In yet other situations, a paper-based record is maintained using AHS services and resources.

Most physicians using AHS-provisioned health records understand that, as AHS transitions to Connect Care, they will either retire paper records, transition from a legacy AHS CIS or migrate from an AHS-operated EMR. As clarified by the Connect Care Clinical Information Sharing Approach, they serve as health information "affiliates" where AHS is the "custodian" of the health record. Refusal to adopt the Connect Care CIS would imply leaving their current AHS business arrangement, be that employment, contract, alternate reimbursement relationship or facility privileges.

The following practice contexts expect Connect Care CIS adoption:

AHS Legacy CISs

- eCLINICIAN CIS
  - ~3,700 health care providers, ~1,100 nurses, ~570 physicians, ~120 trainees; many collaborating on what may be considered primary care activities (e.g. primary prevention, chronic disease management).
  - ~2,000 clinical support staff (e.g. scheduling, office management, etc.), employed by AHS, Universities, independent programs, private practices.
  - ~6 or more multi-physician family medicine, family care, urgent care or mixed primary care practices.
  - Multi-disciplinary outpatient programs that include primary care providers (e.g. Seniors Health, Woman's Health, Sports Medicine, Mental Health, Pain Clinic, etc.).
  - Includes virtual hospital program.
- Sunrise Clinical Manager (SCM) CIS
  - >600 specialist and generalist physicians providing ambulatory care using SCM as the legal record of care.
  - Includes paramedic, complex medicine hub, "hospital at home" users.
  - Includes pediatric primary care.
- Meditech CIS
  - One pilot project for ambulatory care involves a small number of primary care providers using Meditech as legal record of care for urgent care.
  - Extensively used by family physicians providing continuing care services.

AHS hosted EMRs

- A number of business arrangements have resulted in AHS licensing, operating and servicing EMRs for family medicine or specialty clinics. AHS serves as information manager.
- Most are expected to integrate with the rest of AHS offerings and transition from their EMR to the Connect Care CIS, with the timing of transition considered in sequencing plans.
- Examples of specific EMRs include:
  - Accuro - operating on AHS servers supporting mix of family medicine and specialists.
  - MedAccess - family medicine clinics where AHS operates the EMR infrastructure.
  - Practice Solutions - run by AHS for family medicine services in different cities.
  - Wolff - run by AHS for family medicine and specialty clinics.
  - Soprano (a Netcare extension) – where run by AHS in service of multi-disciplinary diabetes chronic disease management programs.

Context 2: Current use of an independent non-AHS record of care

Many physicians operate independent EMRs or paper records and have no formal informational relationship with AHS. Most use EMRs qualifying under the former Alberta Physician Office System Program (POSP).

To belong to Group 2, physicians are presumed to wish to continue with their current health record arrangement. The option to adopt the Connect Care instance of Epic Systems software (which underlies the Connect Care CIS) is not possible until after the last wave of Connect Care implementation. AHS and AH will work with stakeholders to further define whether and how this may become possible.

Given Epic's recent release of an offering for small practices and facilities (Sonnet), it may also become possible for Group 2 practices to implement Epic and interoperate with Connect Care.

Context 3: Current use a hybrid record of care, with AHS and non-AHS components

Some physicians lease space or otherwise operate semi-independently within AHS facilities. The historical business arrangements are diverse. A group of surgeons, for example, may have offices co-located with AHS outpatient clinics. The surgeons pay rent, employ their own support staff, are remunerated fee-for-service, and resource their own dictation services. While some may store and retrieve independent office records, they use AHS charts when in clinic or when performing procedures. The record of an "episode" (pre-operative, operative and post-operative) of care is fragmented.

This is a gray area. More than one record of care may relate to the same episode of care. Hybrid records can be hard to disentangle when paper, legacy CIS, EMR and Netcare co-mingle. Scheduling, registration, ordering and some documentation (e.g., nursing and allied health) may be an AHS responsibility while physician communications (e.g., clinic letters) are a physician responsibility.

Physicians working in group 3 contexts may ask to adopt the Connect Care CIS. Motivations may include reducing the number of systems the physician must contend with, easing collaboration with other team members, supporting trainees and clinical assistants or better integrating inpatient and outpatient phases of care. Requesting physicians may belong to an AHS-affiliated Primary Care Network, multi-disciplinary collaborative, or program where other team members already have full Connect Care access.

Where hybrid records occur in AHS facilities, and the physicians request Connect Care adoption, preparation of a new AHS information manager agreement can be expedited. This shifts the practice context to Group 1. Actual Connect Care implementation timing is determined by sequencing and resource considerations.

Other physicians working in group 3 contexts may prefer to keep key health record functions independent, effectively declining to join Connect Care even if offered. The dangers associated with a persisting hybrid record may be evaluated by AHS Medical Affairs and AHS clinical operations. AHS may have strong motivation, indeed requirement, to consolidate information management in the facilities it operates. Public perception of AHS accountability may further incline AHS to re-negotiate lease or other business relationships, effectively mandating the move of some Group 3 record contexts to Group 1, where full Connect Care adoption is expected.

Challenges

Unfortunately, many health care providers have multiple roles, with their work sometimes fitting the definition of one health record context while other parts of their work better fit another context.

More importantly, patients may not fit any one context. Their advocates prioritize de-fragmentation of the health information space.

Gray areas could expand. As Alberta progresses towards its vision of a pan-provincial integrated health record, it may become increasingly difficult to use the legal record of care as a clean test for "who's in" and "who's out" of Connect Care.