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CONNECTING MICHIGAN
for health and more

Background

National eConsent Collaborative   https://econsentcollaborative.org/

NeCC is a nationwide community of practice that advances interoperable exchange to digitally capture, transfer, and adhere to care wishes throughout the patient experience. Its intent is to support national interoperability for advance directives and electronic informed consent.

eConsent: An Emerging Community of Practice https://interop.community/

Transition the National eConsent Collaborative into an Interop.Community "Community of Practice" (CoP). We will continue to advance interoperable exchange to digitally capture, transfer, and adhere to care wishes throughout the patient experience while enhancing our scope and resources.

Community of Practice Workgroups and Work Products

eConsent Collaborative

Workgroup Name	Function	Deliverables	Participants
HL7 Standards Support	Work with PACIO, CBCP, Patient Empowerment to support HL7 and FHIR standards and implementation guides.	New HL7 and FHIR standards and implementation guides authored by existing HL7 workgroups.	Payers, EHR vendors, Advance Directive vendors, eConsent vendors, providers.
BPM Shared Workflows	Work with BPM+ to develop shareable ACP and consent workflows.	Shared workflows complying with BPMN, CMMN and DMN standards authored by BPM+ workgroups.	Payers, EHR vendors, Advance Directive vendors, eConsent vendors, providers.
Interop.Community (I.C)	Function as an I.C Community of Practice, with multistakeholder involvement, support and direction.	Design and test ACP and eConsent implementations in the MELD sandbox. Test integrations of FHIR APIs, BPM Workflows and vendor functionality. Support real world implementations.	Payers, providers, EHR vendors, Advance Directive vendors, eConsent vendors, Digital Identity vendors and services.
ACP Policies and Advocacy	Survey then advocate for ACP and eConsent-friendly policies, regulations and legislation.	Published report on policy, regulatory and legal obstacles to digital ACP and eConsent. Design, implement and operate a program to combat defined obstacles.	Payers, EHR vendors, Advance Directive vendors, eConsent vendors, providers, law firms, advocacy groups.

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Advance Care Planning Journey: Creating ACP Documents

1. Engage & Educate

Community Outreach

- Identify & engage key influencers
- Identify & engage most critical stakeholders for community collaboration
- Bring together influencers & stakeholders
- Form community collaborations
- Identify community programs & promotions
- Educate stakeholders
- Educate consumers
- Capture consumer contact information
- Direct contact information to ACP facilitator

Consumer Conversations

- Engage consumer, advocate, family members
- Review ACP history
- Recap previous conversations
- Review existing ACP documents
- Discuss consumer wishes
- Provide ACP forms & instructions for chosen documents
- Follow-up: status, questions, additional conversations
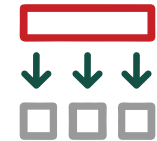
2. Create Documents

ACP Document Development

- Facilitate ACP document(s) development with consumer, family, advocate
- Decide on eACP document(s) & **eConsents** to create
- Complete chosen eACP document(s)
- Complete required **eConsents**
- Review by facilitator for accuracy and completeness
- Execute signatures, eSignatures, or wet ink Signatures (eACP documents & **eConsents**)

ACP Document Upload

- Create & authorize account
- Submit demographics for patient matching
- Select document type(s)
- Upload & submit document(s)*
- Indicate "revised" document(s)
- Upload & submit **eConsents***
- Quality review of:
  - Demographics
  - Documents
  - eConsents
  - Signatures
- Notify submitter of status and disposition

ACP Directory Dissemination

- Send ACP directory document links to EHR systems

  Driven by patient linkages and eConsents

- Notify persons/entities where consent on file
- Indicate version of each eDocument
- **Annual reminder to patient & advocate to review, update documents**

* Upload document to a pre-determined registry and create the pointer in National ACP directory.

Advance Care Planning Journey: Patient Arrives Needing Critical Care

3. Arrival & Treatment	4. Discharge & Follow-up

Patient Arrival at Emergency Dept

- ❑ Registration dept. alerted that ACP documents are available; **Consents verified**
- ❑ If no ACP documents are available, patient/family or proxy asked about availability
- ❑ Note placed in patient's EHR for follow-up by patient relations team
- ❑ Care team notified of patient admission

Patient Admitted to ICU

- ❑ Care team notified of patient admission to ICU
- ❑ Hospitalist alerted via EHR of availability (or lack of) ACP documents
- ❑ Provider direct access to ACP documents via EHR → ACP Directory → Registry

Patient Requires Intubation

- ❑ Attending providers (eg, hospitalist) alerted if POLST, DNI, DNR on file
- ❑ Provider direct access to ACP documents
- ❑ If no DNI or other pertinent ACP documents on file, provider discusses wishes with patient/family/proxy
- ❑ Provider adheres to patient wishes
- ❑ Document discussions (EHR encounter/ clinical notes)

Patient Transferred to Step-down Unit

- ❑ Care team notified of patient transfer
- ❑ If missing ACP documents, social work team (and/or attending physician) visits patient/family/ proxy to discuss ACP
- ❑ POLST (or MOLST) order placed if patient chooses & provider concurs
- ❑ Bill for ACP E&M service

Patient Discharged

- ❑ Care team notified of patient discharge
- ❑ Discharge instructions include ACP follow-up (with/without docs on file)
- ❑ Track outcome of ACP views, acknowledgment by healthcare professionals
- ❑ Update ACP directory, **patient eConsent linkages**

Patient Follow-up Doctor Visit

- ❑ Patient contacted for review of discharge instructions, scheduling of appointment
- ❑ Patient arrives for office visit
- ❑ Provider alerted if ACP documents are available
- ❑ Provider direct access to ACP documents
- ❑ If missing ACP documents or need review for possible updates, discussion with patient and referral to ACP resources
- ❑ "Top of license" intervention by staff (best practice)
- ❑ Bill for ACP E&M service
- ❑ Update ACP views, acknowledgment by HCPs
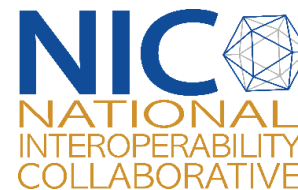
Background…

The Stewards of Change Institute (SOCI) is a nonprofit organization started in 2005 with the purpose of improving the futures of the most under-resourced and under-served populations – by initiating, inspiring and advancing transformational change in health and human services systems at all levels of government, industry and nonprofits.

The National Interoperability Collaborative (NIC) is a "**Community of Networks"** with a mission to increase collaboration across domains, sectors and programs that enhance health, justice, education, race equity and well-being by advancing responsible information-sharing, interoperability and the use of standards-based technology.

Project Unify Vision

Implement proofs of concept to demonstrate replicable, standards-based information sharing across health, education, and human services domains. Achieve the vision by working collaboratively within an open source, open API governance and technology framework.
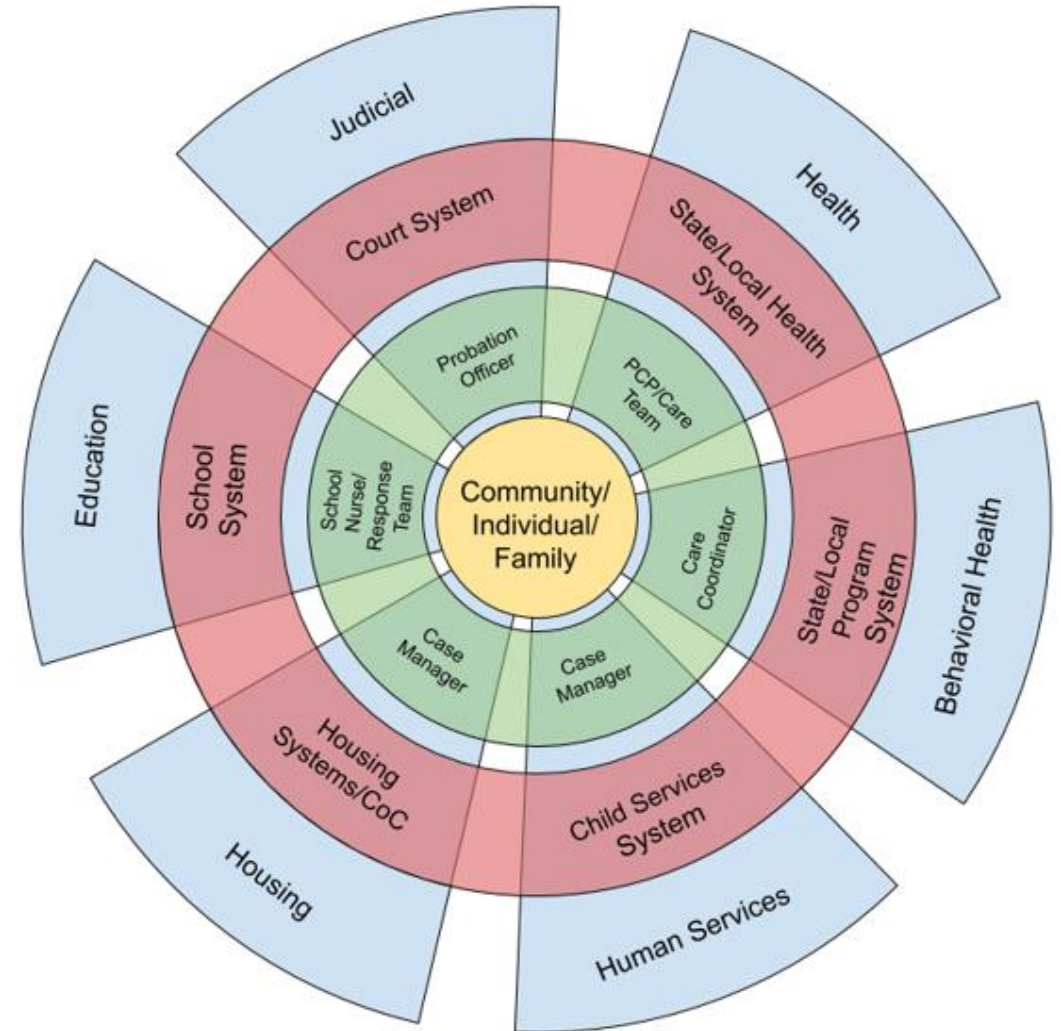
The POC is Modeled on the Integrated Care for Kids Program from CMMI

Programs Include:

- Medicaid/Health
- Behavioral Health
- Children's Services / Child Welfare
- Educations (ECE; K-12)
- Food/Housing Insecurity
- Courts; Criminal Justice

The Case for Developing a Secure, Cross Domain, Replicable Consent Service Utility

Problem:

- There are no electronic applications/tools that individuals can use to provide and manage cross-domain consent for their various SDOH services. And, without a common consent utility, organizations are severely limited in their ability to share information, leverage interoperability and improve care coordination.

Goals:

- Make appropriate information accessible electronically when and where it is needed most by creating a common consent utility that enables sharing PHI/PII.

The Imperative for Developing a Secure and Replicable Consent Service Utility – cont'd

Objectives:

- Increase data exchange capacity to improve equity, care coordination, outcomes and operational processes across multiple SDOH domains.
- Enable and empower individuals to provide (or revoke) their consents with a common, modern, secure application, if they choose.
- Resolve legal hurdles for data sharing, interoperability and care coordination by enabling informed across all SDOH domains/programs.
- Build on progress and innovation from ONC, CMS, ACF, industry and others to create open, secure, replicable solutions.
- Implement POC demonstrations in "shovel ready" sites e.g., Integrated Care for Kids sites in NJ and NY.

Consent Service Utility Roadmap

- Conducting a national scan of Consent practices – supported by the Robert Wood Johnson Foundation to inform requirements. (July – Sept '21)

- Developing requirements and blueprints for implementation of POC with Integrated Care for Kids partner sites in NJ and NY. (December – June '22)

- Enhance working group teams with additional subject matter experts across the spectrum of agencies and programs.

- Seeking resources to sustain Unify/Consent and work teams to create and publish roadmap and blueprints. (Ongoing)

Five Promising Practices Areas

CATEGORIES OF CONSENT-RELATED PROMISING PRACTICES

- Electronic Health Records
- Community Information Exchanges
- Community Referral Services
- Industry and Governmental Initiatives
- Health Information Exchanges

Currently conducting a national scan of Consent practices – supported by the Robert Wood Johnson Foundation to inform requirements.

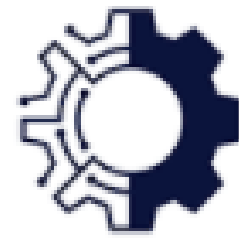# *Participating Organizations in Consent Service Utility Initiative*

Consent Service Utility Ecosystem
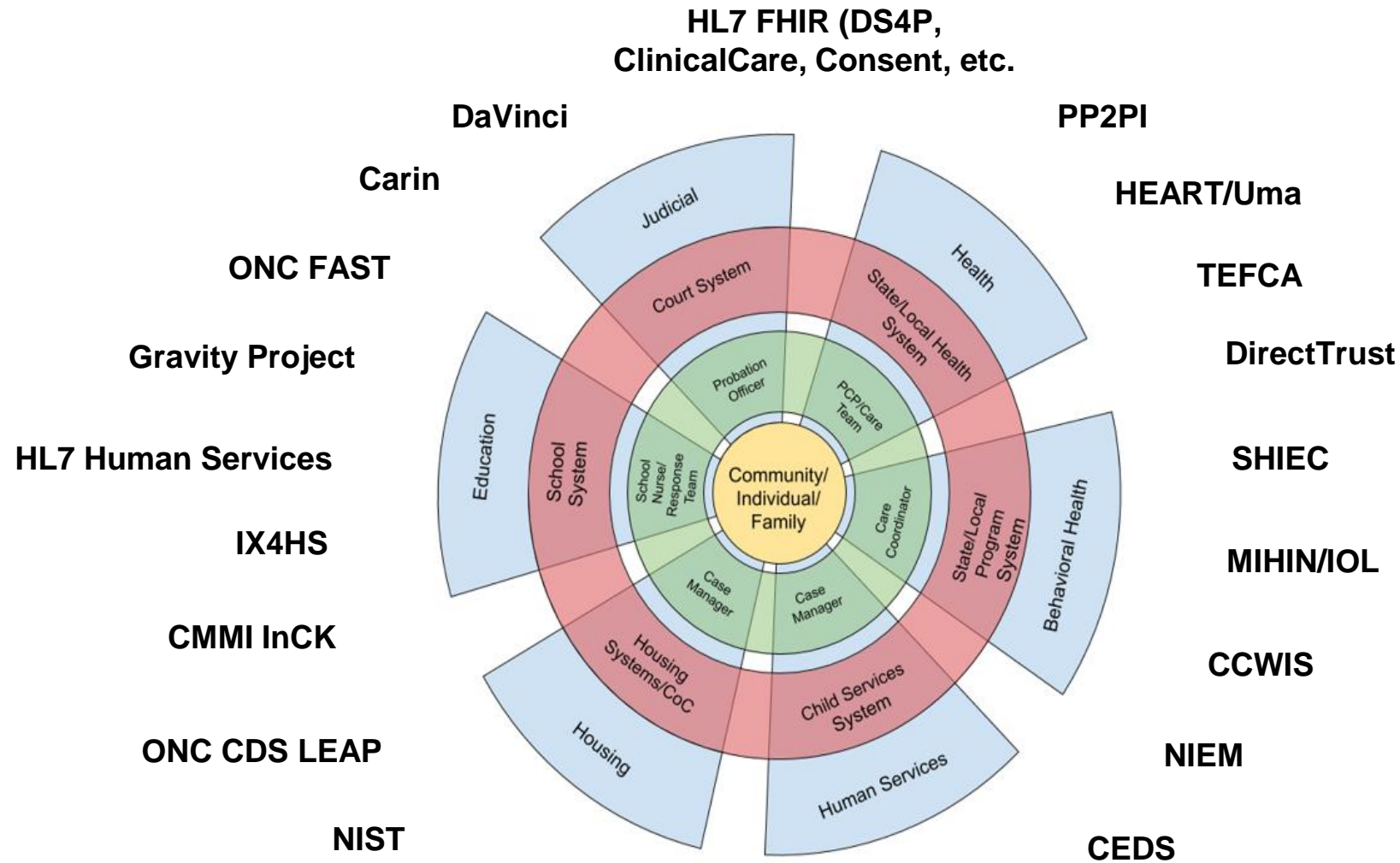
Discussion

InterOp.Community

Mary Kratz, EVP Interoperability Institute

October 2021

# Introducing the Interoperability Community

InterOp.Community is an emerging collaboration to advance the healthcare interoperability agenda via the use of open platforms and open-source software.

MELD.Interop.Community

- First community activity is an Open-source healthcare sandbox called 'MELD'
- Open Source-Code Development
  - FHIR® DSTU2, STU3 and R4
  - Ability to create, edit, delete and/or import data
  - Containerized cloud architecture
  - Patient Data Manager Application
- Synthetic EHR, Bilirubin Risk Chart app, CDS Hooks, and more
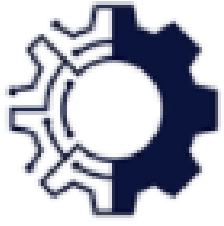
MELD

InterOp.Community
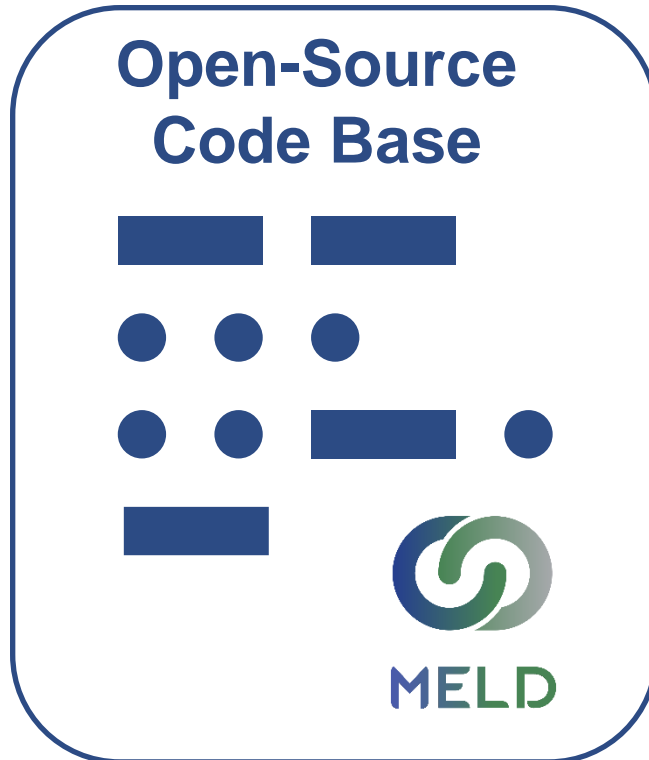
Benefits of Standardized "Sandboxes"

- Many hands create light work
- Rapidly expand functionality & innovation
- Standardize & accelerate testing
- Ability to import "Data Packs"
- Future ability to interconnect sandboxes

Open Source Software (OSS) and An Open Proving Ground (Sandbox)

Open-Source Code Base

Simulate Innovate Training

Validate Collaborate

MELD INSTANTIATED OPEN SANBOX PROVING GROUND

MELD Open Proving Ground

MELD INSTANTIATED OPEN SANBOX PROVING GROUND

- Free sandbox open to the world based on MELD Source Code
- Populated with synthetic FHIR® data
- Used for:
  - Research solutions
  - Educate & Training venues
  - Test tools & Standards Development
  - Collaborate on Use Case Demonstration
  - Create a Reference Implementation

Private Proving Grounds Are Called Lockers

Certified Lockers

Supplier 1

Certified by I.C.

External Lockers

Persona l Project

No Community Support

Because MELD is Open-Source anyone can create their own proving ground

- There are two types of "lockers"
  1. Interop.Community certified lockers
  2. External lockers that have no affiliation but might use MELD opensource code
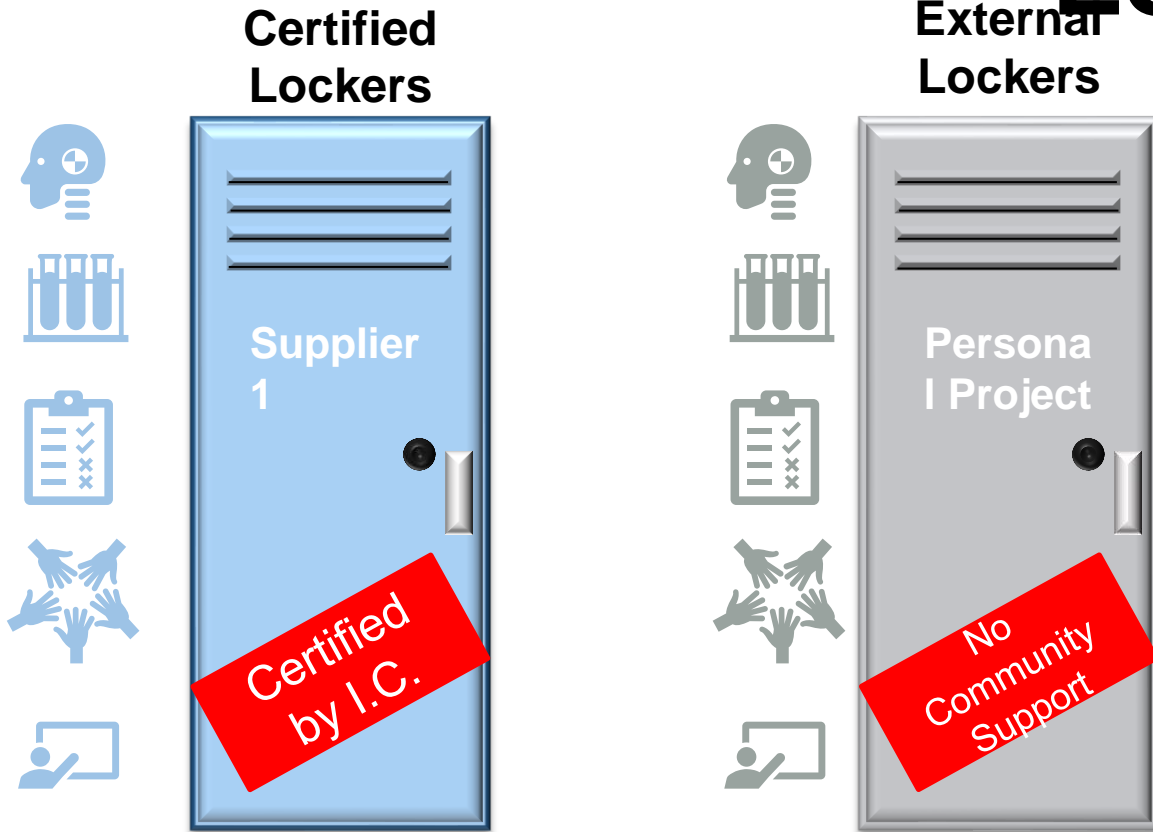
InterOp.Community

What is a Community of Practice (CoP)?

Groups of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly
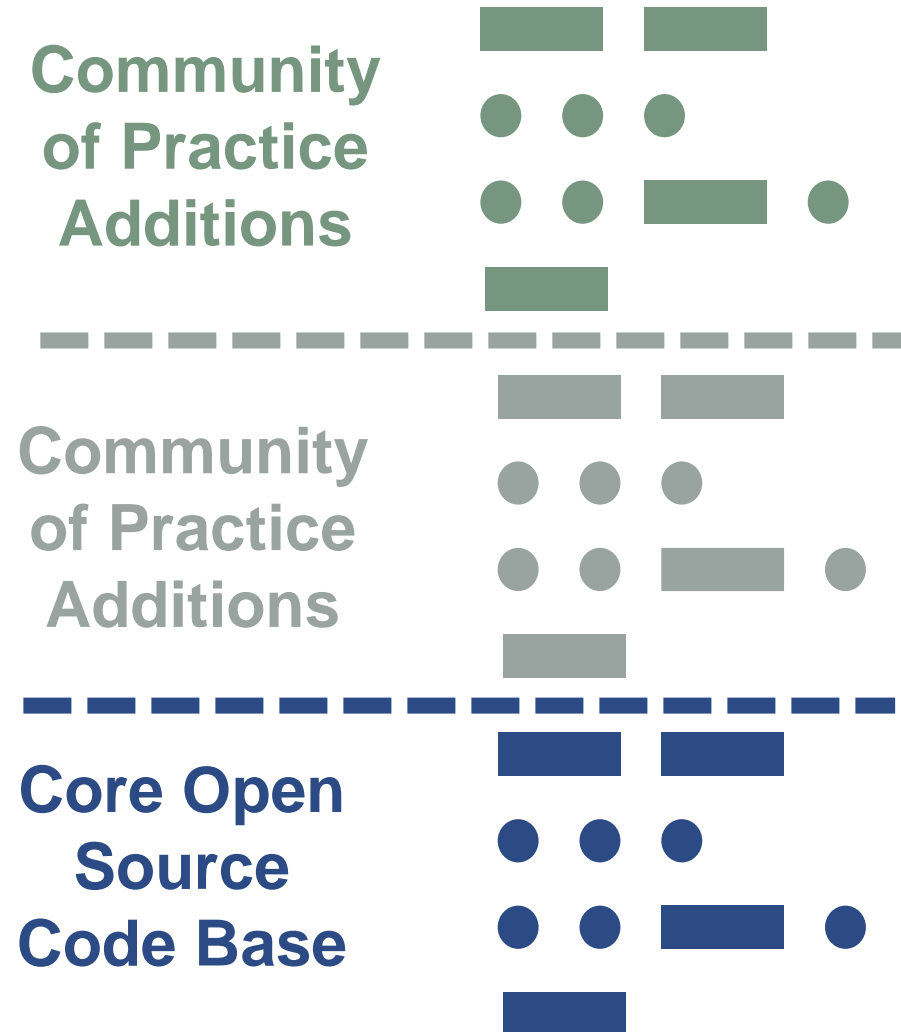

Domain
(Relevance)

Community
(Reflection)

Practice
(Contribution)
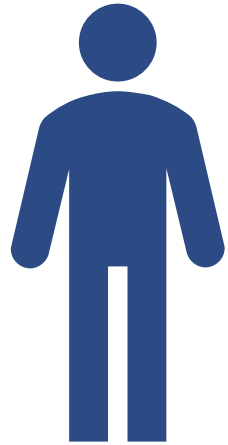
InterOp.Community

CoP's Add to the MELD Open-Source Code Base

CoP's Use the MELD Open Proving Ground or Commission New Proving Grounds

Simulate   **Innovate**   **Training**

Validate   **Collaborate**   MELD

MELD OPEN SANBOX
PROVING GROUND

MELDCoP1

MELDCoP2

InterOp.Community

Next work of eConsent Community of Practice is to sponsor eConsent business process model and sponsor the creation of personas and synthetic data for proof of concept

Thank you!
Mary Kratz
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Advisory Board
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