EMR-Mediated Information Delivery from the Patient & Family Library: A New Opportunity for Outcomes Research

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Outline

Background & Development
- Physicians’ concern
- Health System IT Fair

Launch
- Filling “prescriptions”
- Nurses’ concern
- Marketing & training

Results & Future Plan
- Usage
- Retrospective chart review
- Prospective study?
- Recommendations
Timeline

Background & Development
Mar ‘15 – June ‘16

Launch
July ‘16 – Dec ‘16

Results & Future Plan
2+ years’ usage data
Clarification of Scope of Practice

- Patient & Family Library (PFL) opens March ’15
- Steering Committee physicians (and other LIPs) question:
  - What exactly are you giving my patients?
  - How can I know what you’re giving them?

“The information complements, and does not replace, the doctor-patient relationship.”*

Key Partner - HIT

- Health Information Technology (HIT) hosts innovation fair in Sept ’15
- PFL and HSL (academic library) separately invited to bring innovative idea
- 100% positive feedback to “Information Rx” idea, including from bedside staff and from the CMIO Mike E Williams, MD
- HIT project manager spearheads the collaboration to connect Epic EMR teams with PFL manager
**Process for Providers**

- Very different for INP versus OUTP

- Barriers include the way orders are placed in Epic – requires an LIP to “sign” even if a nurse initiates the order (creates problem for OUTP order follow-up and research)

- Possible changing of the Epic order structure from a prescription to a protocol, which could be librarian-approved

- PFL Steering Committee (inter-professional) provides feedback
Process for Librarians

- Very different for INP versus OUTP
- Privacy/HIPAA concerns; workflow of librarians must protect people’s PHI
- Challenges lead to development of disclaimer
- Decisions re contact methods (e-mail encryption, etc)
- Patient Advisory Council consulted
Info needed in Dari language
Clarification of Scope of Practice – Again!

- Several nurse leaders expressed concern about confusing the issue of patient education (a nursing responsibility), especially for inpatients

- Regulation/requirements around patient education, documentation

- Strategy developed with Patient & Family Education Coordinator (a nurse leader)
  + emphasize the difference between background and foreground information (general info v instruction)
  + reassure that librarians are trained to refer back to the clinical care team, nurse, etc, when needed

The information complements, and does not replace, the nurse-patient relationship.
Marketing/Training

- Always difficult to reach the many different teams and departments on INP and OUTP sides

- Huddles, staff meetings, anywhere!

- Initial steep learning curve for librarians in Epic®

- Eventually integrated into semi-monthly on-boarding Epic® training for nurses, but inconsistent between trainers
PFL Usage, 3 fiscal years

July '16: Launched Info Rx
Analysis of Use and Results

• ≥ 11 INP orders placed, ≥ 6 OUTP orders, in 24 months

• Difficult to determine exact number. E.g. impossible to track number of OUTP orders with only Epic® data (because filled orders “disappear”)

• Retrospective chart review was planned for Aug ‘17 (12 months); not completed because order isn’t associated with a cost code / payment

• Possible formal prospective study with IRB approval, to look for knowledge gained post-library (pre- and post-test), b/c the health education field doesn’t have much clinical outcomes research or even knowledge outcomes research*

Recommendations / Caveats

• Just because data is in the EMR, doesn’t mean you can get it out!!!

• Plan carefully for future reporting / data access; this should be done ***while you are building the tool***
  - E.g. Ask how coding can be used so that a report can be pulled in future

• What other ways can an EMR be used to study the impact of patient education?
  - OptionGrid from EBSCO creates EMR data – how could this be used for research?
  - Can de-identified data be pooled from different institutions?
“Despite the fact that the use of certified electronic health records grew in less than two decades from nearly non-existent to 2016 levels of more than 95 percent in hospitals and 75 percent in ambulatory care settings, actual interoperability is very limited for most digital tools, including health records, devices, and mobile applications. ...

Today, the increasing complexity in health care, the need for more seamless interfaces among clinicians, patients and families, and the increasing urgency of linking health care with social service interventions for high-need patients, has made digital interoperability even more essential across clinicians, care units, facilities, and systems. The absence of digital interoperability is no longer acceptable.”

From: “Procuring interoperability : achieving high-quality, connected, and person-centered care,” Peter Pronovost [and 12others], editors. NAM 2018. 193 pages. Learning health systems series. nam.edu/interoperability
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Questions?

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