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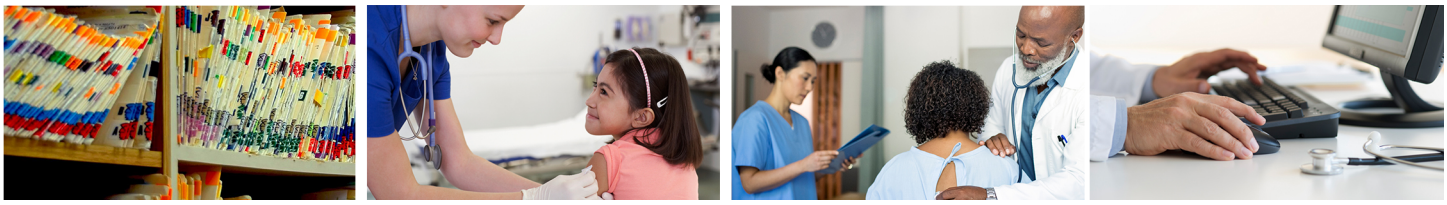

DE-IDENTIFICATION
Project Overview

The Memphis Community Health Record Project[1]

Community health record (CHR) pilot successfully balances privacy.

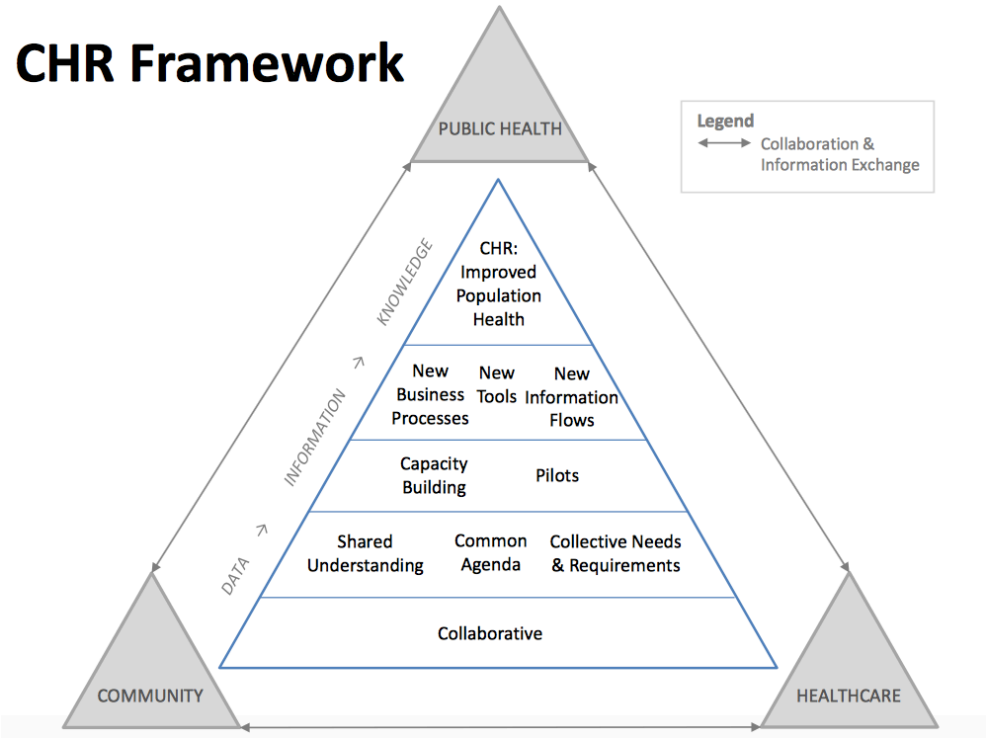

Figure 1. The community health record framework. The framework presents a multitiered, multisector model illustrating an iterative, flexible, and participatory process for achieving collaboration and information exchange among health care, public health, and community groups and organizations to aid population health decision making. Abbreviations: CHR, community health record; CH, community health. Source: https://www.cdc.gov/pcd/issues/2016/16_0101.htm.

“Health begins in the community.”

Public health, health care, government, education, health care payers, business, housing, community based organizations and community members share the goal of improving community health and reducing the burden of chronic disease. These diverse actors typically do not exchange information or collaborate. Each sector collects its own data with its own technology, performs its own assessments and there is no roadmap to guide everyone to collaborate, or to bring themselves and their data together.

Community Health Record is a framework and a tool.

The Shelby County Health Department, Methodist Le Bonheur Healthcare, the Common Table Health Alliance, Tennessee Department of Health, State of Tennessee, and the Centers for Disease Control and Prevention (CDC) piloted the development of a CHR for heart disease and stroke. The CHR is a framework and tool for multi-sector decision makers to simultaneously use, aggregate and integrate data and information. This project included electronic health record data, personal health record data and county level health data from the Robert Wood Johnson Foundation’s County Health Rankings and Roadmaps to Health Program. Because the CHR focuses on and is used by a geographic community, its scale is small and very local; it “integrates and presents multisector information at scales ranging from residential address to census block, census tract, neighborhood, or zip codes.” To remain relevant and useful, the CHR requires ongoing collaboration and information exchange by all of the stakeholders.

Trust is key for collaboration and data exchange.

One of the drivers behind this pilot’s success was its ability to achieve and sustain momentum behind the collaboration. These stakeholders focused on their common vision of improving the health of their community. They listened and learned from one another and, over time, developed trust. Each stakeholder invested in the pilot and was willing to do things differently collectively.

Development of a shared understanding, common agenda and defined measures follows.

A critical step in the process of development of the CHR is to facilitate an understanding of all stakeholders’ problems and potential solutions, and then develop a common agenda. “Community health stakeholders need an array of clinical, public health, socioeconomic, environmental, and behavioral data and measures at relevant temporal and geographic scales to understand health, document disparities, and design and target effective interventions.” Identifying a set of measures that is feasible and balanced is a process. Each measure should be supported by data that is available at the appropriate temporal and geographic scale, so that the multi-sector stakeholders can each monitor community health interventions. The pilot started with a wish list of over 100 measures of health outcomes and determinants, and through a prioritization process, was reduced to less than 20.

Privacy is a balance.

The resource load and time to achieve data sharing within a community is considerable. For data sharing to occur, it must be interoperable; however, achieving technical interoperability is much easier to achieve than the social aspect. Data sharing requires ongoing collaboration. Recognizing that there were different stakeholders with varying levels of data sensitivity, the pilot’s information governance embraced flexibility; data providers controlled who could access their data, with varying access levels available. The pilot highlighted the importance of starting with small wins, building trust and evolving to larger efforts.

Execution of a data use agreement preceded all data sharing. Data use agreements between the data providers and the end-users detailed access rights, as a "compromise among need, privacy, security, confidentiality, and trust." To ensure that each stakeholder's needs were met and maximized, use cases were developed. These use cases provided insight into requirements and information needs.

One use case depicts the hospital Chief Financial Officer who needs quick information as to how her hospital is faring with respect to preventing readmissions in a specific zip code. The hospital is part of a larger health system in the urban core of a city with overall poor health status. The CHR provides ready information in its dashboard as to the last quarter's status on the hospital's readmissions, charity care and acuity of illness in that zip code, but also additional information as to what percentage of patients have a regular primary care home, the percentage of patients who enter the hospital through the emergency department or through ambulatory care offices, and the percentage of net income spent on health care per household. The CHR reflects the effects of the multi-sector community effort in collaborating and sharing data to improve their health, such that the hospitals' readmissions rate is greatly reduced, resulting in savings to the hospital.

Another use case shows a pastor with a health ministry who uses the CHR to track progress in housing, economic and workforce development, education and health status in the church's neighborhood. The pastor utilizes the CHR to obtain specific data on how many local residents had wellness exams and saw that there was a 10% increase since the year before. This information is shared with the city Office of Faith Based Initiatives which needs it for an application for Federal funding.

A third use case reflects a Shelby County Health Department practitioner going to the CHR and opening it at the start of the day. The practitioner considers the many ways that the CHR will assist him in getting his work done: community health assessment, a way to enhance their epidemiological analysis, a tool to design programs and interventions, a common platform for data sharing, proof of improvement in health outcomes and many more.

Shelby County, Tennessee is moving from pilot to implementation.

Shelby County, Tennessee is now implementing a CHR that provides metrics to assess the overall health of the community. The CHR is not relying upon electronic health record data, but offers aggregate data reflecting overall patterns that show opportunities to improve health and well-being. http://wherewelivemidsouth.org/ Go Shelby County!

SUPPORTERS

Robert Wood Johnson Foundation

This document was developed by Sallie Milam, JD, CIPP/US/G, Deputy Director, Network for Public Health Law – Mid-States Region Office, and reviewed by Denise Chrysler, JD, Director, Network for Public Health Law – Mid-States Region Office. **The Network for Public Health Law provides information and technical assistance on issues related to public health. The legal information and assistance provided in this document does not constitute legal advice or legal representation. For legal advice, please consult specific legal counsel.**

1. King RJ, Garrett N, Kriseman J, Crum M, Rafalski EM, Sweat D, et al. A Community Health Record: Improving Health Through Multisector Collaboration, Information Sharing, and Technology. Prev Chronic Dis 2016;13:160101. DOI: http://dx.doi.org/10.5888/pcd13.160101; and, email from David Sweat, Chief of Epidemiology & Infectious Diseases, Shelby County Health Department, 814 Jefferson Ave., Suite 207, Memphis TN 38105 (March 15, 2017).