Establishing the Finnish eHealth platform - involving all professionals and providers

Päivi Hämäläinen, EHTEL Board, Director, National Institute for Health and Welfare, Finland
Introduction

• Long history of eHealth implementation on the local and regional level. Finland has a very “digital” health care system (for the professionals) today

• A policy decision 2006, legislation 2007, to build a national health information system for sharing patient data (eArchive, ePrescription)

• All different EPR systems (different vendors) have to join in and start to use structured standarised data sets in their products when they are connected
The question of the day:

How to involve the professionals and the providers in the change process?
Progress in the implementation of the EPR in the 21 hospital districts between 1999 and 2007. The results for 2010 were the same as for 2007. The numbers are shown as absolute numbers.

Progress in the implementation of the EPR in health care centres between 1999 and 2010. The numbers are shown as percentages.

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THL
NATIONAL INSTITUTE FOR HEALTH AND WELFARE, FINLAND

The national health information structure is under construction

The main elements of the Finnish eHealth architecture (2007) Ready by 2015

- Shared structured (standardized) electronic patient records
- National eArchive for the EPRs
- Central consent management
- eView for the patients
- ePrescription system (in operation)
- Shared national patient summary (new element, added 2011)

New elements after 2007
- National project for eSocial Services ongoing
- National project for eServices to citizens and patients has started 2010
# Roadmap for National Solutions

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<td>Preliminary Report for National Solution (2011-2012)</td>
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<td>eAccess</td>
<td>In use with ePriscription (since 2010)</td>
<td>“Data Management Service” from 2012 : Central patients consent management Treatment will or an organ donor will</td>
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## Patient Health Record (Portal)

### Plenty of Local pilots

- Preliminary Report for National Solution (2011)
- "Data Management Service" from 2012: Central patients consent management
- Treatment will or an organ donor will

### Suggestions in 2 categories

- National standards, regional implementation
- "Free implementation"

## 1. Phase

- Diagnosis and Risk factors
- Procedures
- Radiology (and other pictures), Laboratory results
- "Health plan"

## 2. Phase

- Medication
- Immunization
- Physiological measurements
The professionals want a better clinical process from eHealth

1) A patient summary
   Legislation changed to include it 2011 to improve motivation/benefits

2) Electronic support of routine clinical communication (lab+rtg referrals and results, referring, discharge letters, prescribing, consultations)
   They have it on the regional
   Why to struggle for the national?

2) Sharing of patient data

3) Decision support
   Possible with structured data
Core data can be used in patient care, clinical decision support, scientific research, quality assessment, statistics and administration.

e-exchange of patient data needs patient consent, data security and privacy.

The main objective of the structured data is to support exchanges of patient data via the new national eArchive, but the structures enable also collecting statistics and other new innovative ways to use the data.
The activity (%) in the hospital districts (HD, \( n = 20 \) without Åland) and the health care centres (HCC, \( n=140 \)) to participate in defining national EPR structures. (\( n= 140 \)), year 2010 survey

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<tr>
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<th>Participation in expert networks</th>
<th>Participation in workshops</th>
<th>Written replies to communications with the authorities</th>
<th>Direct contacts to with the authorities</th>
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<td>HD</td>
<td>100 %</td>
<td>50 %</td>
<td>100 %</td>
<td>95%</td>
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<td>HCC</td>
<td>36%</td>
<td>16%</td>
<td>44%</td>
<td>35%</td>
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Code management process (new codes and classifications)

- **code needer**
  - code/classification proposal

- **development project**
  - proposed codes

- **expert group for support and implementation**
  - technical quality check

- **need criteria**
  - code server board

**THL is supporting over 20 code/classification expert groups from different clinical areas with representatives from clinics, associations and authorities**

Decision to publish made by director

Code server team at THL gives technical, secretary and expert and management support to the process/groups

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The code server

- Physically situated at Kela
- Responsibilities for the content in THL
- The EPR systems of the health care providers take the codes from the server in to their systems
- The main structures on nationally standardized documents are kept in the code server and the more detailed HL7 CDAR2 definitions are maid according to the structures (responsibility of Kela)
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The ICT-product providers

• All can take the national standardized code/classification sets in to their products free of charge from the code server

• Are invited to open work shops where national data structure suggestion are discussed and can participate in public consultations also with written feedback

• Influence via the Finnish HL7 –Association, that is a member of the code serve board and technical groups

• Have given positive feedback on the possibility to use the common structures from the code server
The health care providers

• Need national support for organising the implementation process within their organization:
  - Training of staff
  - Manuals/guidelines
  - Question/answer support
  - Support in regional networking (seminars, meetings, negotiations …)
Organisational changes to strengthen support

• Changes in Operational responsibility for eHealth development 1.1.2011

  – The **Ministry** of Social Affairs and Health (STM) has responsibility on the **strategic level**
    • Architecture, Legislation, planning of state Funding etc.

  – National Institute for Health and Welfare (**THL**) is in charge of the **operational level** work
    • Planning,
    • Guidance / Steering and
    • Follow up of the Finnish eHealth development
OPER

• Has 15 project leaders/experts operating on national level

• 5 regional experts with a regional responsibility to organize support of the implementation phase

• The providers that are in an active implementation phase meet regularly with a chair from THL and experts from Kela and discuss the common issues/experiences

• Virtual training modules made available
Conclusions

• Implementation of a national health information system needs lots of communication, steering and "by the hand" support. There has to be a dedicated team that provides a networking infrastructure for professionals, health care providers and vendors and this need is never ending (because there always is the next innovation ready for implementation….)

• Professionals need motivation, better processes are the aim

• If standardization is the aim, the standards have to be available for the vendors in a system where all have an equal access to recent updates

• Health care providers need benchmarking opportunities with others in a similar implementation phase
Thank you!

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