

## **Minutes from National iMedConsent™ VANTS Call**

Wednesday, August 1, 2007

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### **1. Upcoming Release**

Charlotte Richardson of Dialog Medical reviewed the new functionalities and content for the latest release. (This release was announced shortly after the conclusion of the POC call.) This release includes removal of the User ID column in the “All Documents to Sign” folder. You will recall that there was some recent discussion on the listserv about the fact that some facilities include the practitioner’s SSN in the User ID. Because of the privacy concern, we decided to remove this information from the folder. For further details on this issue and other functionalities and content included in the release, please refer to the release notes. The next release will be announced after Labor Day.

### **2. Technical Issues Affecting iMed Implementation**

David Bradley, Program Analyst in the OI Office of Service Coordination, joined the call again this month to discuss the technical issues and challenges that impact iMedConsent implementation and usage. Grand Junction reported that they have lead walls in their radiology department that are impacting their ability to implement iMedConsent wirelessly in this setting. Apparently, their radiologist refuses to obtain the patient’s consent until the patient is lying on the table. The group began discussing the challenges in changing substandard informed consent practice. We all agree that more needs to be done to bring these issues to the attention of facility and VISN leadership. The Ethics Center has acknowledged the problems (see the November 2006 [National Ethics Teleconference](#) on this subject) and I will be working on this issue further.

### **3. Document Purging**

Dialog Medical has noticed on VA iMedConsent servers a large number of files in the ImagingShare and StoreToPurge folders. These files use up a lot of memory, and can cause sluggish behavior on the server. Dialog Medical is asking each VA facility to delete all the files from both folders that are older than 90 days. Deleting these files will free up space on the D:\ drive and make these folders more easily accessible.

Here are the locations for each of these folders on the iMedConsent server:

D:\DocumentStore\ImagingShare

D:\DocumentStore\StoreToPurge

If you have any questions, please feel free to contact Dialog Medical Customer Support ([enterprise@dialogmedical.com](mailto:enterprise@dialogmedical.com)).

### **4. VistA Failure**

The group discussed the problem of VistA Imaging failure and the impact on the

iMedConsent process. At this point, we are not sure what we can do about this, but we will ask the Office of Service Coordination to investigate.

#### 5. **2007 eHealth University**

As we have discussed on previous calls, there will not be an administrator-level class offered this year at VEHU. If you would like to see one next year, please let the organizers know! There will, however, be two provider-track classes offered—one lecture and one hands-on. I believe that they are both filled, but there is a possibility that a second hands-on class will be added to the schedule for an evening session. In addition to these provider-level classes, Dialog Medical will have an exhibit in the exhibit hall. If you are coming to VEHU this year, please stop-by and visit with the folks from Dialog Medical, especially if you have questions or concerns you would like to chat about.

#### 6. **2007 DUSHOM Performance Monitor**

The group had a lively but somewhat frustrating discussion about the required info submissions for the 2007 performance monitor. It appears that conflicting information continues to float around and there continues to be a lot of confusion. Some have suggested that I have given conflicting information myself. (Please accept my apologies!!) For the minutes, I thought I would go back to square one, and begin the notes with the “official” instructions for the monitor submissions:

This monitor is intended to measure iMedConsent usage in specialties that perform treatments/procedures requiring signature consent. The instructions for the monitor will identify the specialties at each facility in which iMedConsent activity should be registered. National rollup data will be used to establish whether iMedConsent is being used in these specialties. **The monitor is being amended to make it clear so that services/specialties that do not perform signature consent treatments/procedures, and those that offer such services only in extraordinary or unusual circumstances, should be reported as "Not Applicable."**

Instructions:

- If the service/specialty performed treatments/procedures requiring signature consent during the quarter, select "Services Available" for that specialty.
- If the service/specialty did not perform treatments/procedures requiring signature consent during the quarter, select "Not Applicable."
- Please answer either "Services Available" or "Not Applicable" for each specialty listed.

First off, please note that the instructions do not refer in any way to the number of consent forms saved using iMedConsent. Whether a service/specialty is considered “Available” or “Not Applicable” depends on whether treatments/procedures were performed in the quarter.

Referring to the background, highlighted in yellow above, you’ll note that there is one caveat. If there was a procedure(s) performed in the specialty/service, but the performance of the procedure was an “extraordinary or unusual” event”, you

should report the specialty as “Not Applicable.” I interpret “extraordinary” as meaning that there was some event, probably an emergency, where the practitioner needed to perform the procedure as a last resort. I suspect that you’ll find this interpretation rather uncontroversial.

But how do you determine whether the performance of treatments/procedures is *unusual*? Websters defines “unusual” as meaning “uncommon or rare.” Since the reporting periods are by quarter (90 days), how infrequently would treatments/procedures need to be performed to qualify as uncommon or rare?

In my interpretation of this element of the monitor, I think it is important to consider the intent of the monitor. What we are trying to do is gauge whether facilities are using iMedConsent in every clinical specialty in which they perform treatments/procedures requiring signature consent. If your facility performed 2 procedures that required signature consent in otolaryngology, and iMedConsent was used in both instances, you have met the intent of the monitor. Does the performance of 2 procedures over 90 days indicate that this is an uncommon occurrence? I think we can all agree that it does, and the procedure may be marked “Not Applicable.” So what’s the cutoff when the “uncommon” becomes “common”?

**My conclusion:**

I am comfortable with the proposal that respondents may mark a specialty as “Not Applicable” when the *number of treatments/procedures performed is less than 9* if they can demonstrate that *they met the intent of the monitor* (iMedConsent was used for all or almost all of the treatments/procedures performed in the specialty in that reporting period).

Remember that the following specialties are not counted in the 2007 monitor. While you are supposed to implement iMedConsent and use it in these specialties, it will not matter whether you mark them “Available” or “Not Applicable” because they will not be counted against you:

- Allergy
- Mental Health
- Nephrology
- Neurology

Don’t lose hope... 2008 is right around the corner.