

Sharing Your Patient Data: Talking Points

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A. With Anesthesiologist Colleagues

1. Why share data?

The specialty of anesthesiology has a long history of advancing the art and science of medicine through measurement and observation. Data sharing contributes to advancing the state of the art. Data can be shared both within an institution and with national repositories. Sharing data within your institution can lead to more robust quality assurance and performance improvement (QA/PI) programs. In particular, benchmarking against national data can help identify common patient care processes that would benefit from re-tooling. Aggregating data from multiple practices can help develop guidance on the prevention or treatment of rare complications.

2. How will data be reported?

Data can be shared with and without identification of specific patients or providers. Data shared within an institution for QA/PI purposes typically contain identifiers so that data from multiple internal databases can be reconciled. Generally, national repositories accept only deidentified data (both patients and providers).

3. What are the HIPAA implications of sharing data with a national repository?

The existing national repositories are being created with safeguards to make them HIPAA compliant. Certain documentation, such as a written business agreement, may be required.

4. Are my colleagues sharing their data?

A recent survey (2008) found that close to half of academic anesthesiology departments have or are installing anesthesia information management systems (AIMSs). Having an AIMS is typically the first step in data sharing. As AIMSs improve and reimbursement is increasingly linked to pay-for-performance indicators, the use of an AIMS and subsequent data sharing are expected to increase fairly rapidly.

5. Who could I share my data with?

The American Society of Anesthesiologists has created the Anesthesia Quality Institute (AQI, <http://www.aqihq.org/>) and the National Anesthesia Clinical Outcomes Registry (NACOR). The AQI intends to become the primary source of information for quality improvement in the clinical practice of anesthesiology. The NACOR will house the data shared by anesthesia practices. Additionally, numerous patient registries have been organized by the American College of Surgeons (ACS) and surgical subspecialty groups. The ACS National Surgical Quality Improvement Program (NSQIP, <http://www.acsnsqip.org/>) is the largest.

6. Will I increase my exposure to a malpractice suit by sharing data?

Data shared outside of your institution will be deidentified in such a way that it could not be used to link back to a specific case. A recent survey suggests that use of an AIMS either had a beneficial effect or had no effect on the outcome of malpractice cases. (Feldman JM. Do anesthesia information systems increase malpractice exposure? Results of a survey. *Anesth Analg*. 2004;99:840-843)

B. With Surgical Colleagues

1. Why share data?

Data can be shared within an institution and with national repositories. Data sharing can lead to more robust QA/PI programs. For instance, institutional data sharing can track compliance with timely antibiotic administration guidelines. Benchmarking against national data from both surgical and anesthesia databases can help identify common

patient care processes that would benefit from retooling. Aggregating data from multiple practices can help develop guidance on the prevention or treatment of rare complications: particularly in areas with a paucity of data on best practices.

2. How will data be reported?

Data can be shared with and without identification of specific patients or providers. Data shared within an institution for QA/PI purposes typically contain identifiers so that data from multiple internal databases can be reconciled. Generally, national repositories accept only de-identified data (both patient and providers [anesthesiologists as well as surgeons]).

C. With Administrative Partners

1. What role do administrative partners play in data sharing?

The usefulness of any database correlates directly with the quality of input data. Missing or incorrectly coded information can render a database unreliable or useless. Thus, the development of a robust data entry process that involves coordination and monitoring of the accuracy of data entry must occur between the point of patient care and the transmission of data to the national repository.

Administrative partners must work with clinicians to stay abreast of ongoing national and international efforts to standardize definitions and specifications for data elements.

D. With Public Sector Representatives

1. Why should patient data be shared?

Sharing patient data can help to identify ways to improve the quality and safety of care before, during, and after a surgical procedure. Particularly for rare but serious complications, data sharing is the only way to aggregate enough information to identify and develop guidelines for the prevention of these complications.

2. Can individual patients be identified?

No. Data shared with national repositories is deidentified: All information that could link the data to a specific individual is removed before the data are sent to the national database.

E. With Industry Representatives

1. What role do industry representatives play in data sharing?

Industry representatives play a critical role in providing ongoing technical enhancement of AIMS to improve the ease of use of the interface and its accuracy as it interacts electronically with both institutional and national or international data repositories. Working closely with clinicians and database administrators to update definitions and specifications for data elements will be an important ongoing function for the foreseeable future.