Workshop on e-Health

MEETING DOCUMENT

2013
DIRECTORATE GENERAL FOR INTERNAL POLICIES
POLICY DEPARTMENT A: ECONOMIC AND SCIENTIFIC POLICY

WORKSHOP

e-Health

Brussels, 24 September 2013

MEETING DOCUMENT
Organised by the Policy Department A-Economy & Science for the Committee on the Environment, Public Health and Food Safety (ENVI)

Workshop on e-Health

Tuesday, 24 September 2013 from 09.00 to 12.30
European Parliament, Room P7C050, Brussels

AGENDA

Opening Session

09.00 - 09.10
Welcome and opening by MEP Ms Pilar AYUSO, ENVI Committee Rapporteur
Introduction by MEP ENVI Shadows

Part 1

The current e-Health situation in Europe

Chair: MEP Ms Pilar AYUSO

09.10 - 09.20
The position of the European Commission: perspectives/challenges
Mr Benoît ABEOLOS, DG CNECT, EC
Mr Jerome BOEHM, DG SANCO, EC

09.20 - 09.30
The e-Health in Spain: a strategy for a decentralized National Health Service
Mr Juan Fernando MUÑOZ MONTALVO. General Adjoin vice-director, Information Technology, Spanish Ministry (ES)

09.30 - 09.40
e-Health investment: The use of information and communication technologies (ICT) for health
Ms Jillian ODERKIRK. Senior Economist and Policy Analyst, Health Information Infrastructure Project, Health Division, OECD

09.40 - 09.50
Shared challenges in eHealth at the regional and global level
Ms Diana ZANDI, World Health Organization (WHO)
Part 2

e-Health: better care at a lower cost

Chair: Ms Jill EVANS

09.50 - 10.00
The Estonian experience.
Mr Raul MILL. Member of the Management Board of the Estonian eHealth Foundation. The task force for the EC (EE)

10.00 - 10.10
E-health records in Ambulatory Care
Ms Siri BJØRVIG. Manager Personal Health Systems. Norwegian Centre for Integrated Care and Telemedicine, (WHO Collaborating Centre for e-Health) (NO)

10.10 - 10.20
The e-Hospitals
Dr. Vicent MONCHO MAS, Hospital Marina Salud, Denia, (ES). EMRAM stage 7 hospitals ES)

10.20 - 10.30
E-Health: easing the transitions in healthcare
Prof. Dr Antoine GEISSBUHLER, President of IMIA, Professor of Medical Informatics at Geneva University School of Medicine and Director of the Division of the Medical Informatics at Geneva University Hospitals

Part 3

Developing funded European Projects

Chair: Mr James NICHOLSON

10.30 - 10.40
European Reference Networks (Directive on Cross border Healthcare) and the key role of e-Health
Ms Nathalie CHAZE, Health Care Systems Unit, SANCO, EC

10.40 - 10.50
The road towards the effective use of data in health
Prof. Dr. Georges DE MOOR. SemanticHealthNet project (FP7) partner. Head of Department Medical Informatics and Statistics, Gent University, Belgium EuroRec Board Member

10.50 - 11.00
epSOS: From strategies to services – eHealth as the enabler for cross-border healthcare
Ms Lisa HAGBERG. epSOS European Project. Swedish Association of Local Authorities and Regions/Sveriges Kommuner och Landsting (SALAR) (SE)
Part 4
Innovative health technologies: the Enterprise and Industry Initiative

Chair: Ms Antonyia PARVANOVA

11.00 - 11.10
e-Health solutions in European healthcare systems
Mr Hartmut SCHAPER, Senior Vice President Health Services International at Siemens Healthcare

11.10 - 11.20
Title tbc
Mr Ray PINTO, Senior Government Affairs Manager, Public Sector EMEA, Microsoft

Part 5
The voice of patients and professionals

Chair: Mr Claudiu C. TĂNĂSESCU

11.20 - 11.30
The e-Health revolution
Ms Nicola BEDLINGTON, Executive Director of European Patient Forum (EPF)

11.30 - 11.40
Mapping e-Health strategies across the EU
Mr Sascha MARSCHANG – Policy Coordinator for Health Systems, European Public Health Alliance (EPHA)

11.40 - 11.50
e-Health new challenges for professionals
Dr Konstanty RADZIWILL. Immediate past president and Chair of the eHealth Working Group of the Standing Committee of European Doctors (CPME, Comité Permanent des Médecins Européens)

Open discussion

11.50 - 12.25
With the participation of the Committee of the Regions represented by Mr Johan Sauwens and the DG RTD (EC)

12.25 - 12.30
Conclusions by the Rapporteur, MEP, Ms Pilar AYUSO
SHORT BIOGRAPHIES OF EXPERTS

Mr Benoît Abeloos

Policy Officer – Interoperability and Standardization - epSOS, Health and Well Being Unit, Directorate General Communications Networks, Content and Technology, European Commission

As policy officer, Benoit is in charge of the policy activities of the Health and Well Being Unit related to interoperability and standardization and to the Connecting Europe Facility. He wrote the chapter on Interoperability and Standardization of the eHealth Action Plan. He is also in charge of several eHealth projects in the area of Interoperability and eHRs, including the large scale pilot epSOS, Smart Open Services for European Patients (www.epsos.eu), Network of Excellence in Semantic Interoperability (SemanticHealthNet), Antilope, Trillium Bridge, Granatum... He conducted the study on the eHealth Interoperability Framework. He is also involved in the interoperability and standardization activities of the eHealth Governance initiative, the eHealth Network and the eHealth Stakeholders' group.

Mr Jerome Boehm

Policy co-ordinator, Team Leader, European Commission DG SANCO

Jerome is an economist. He is working in the European Commission, in the Health and Consumers Directorate General, after having worked as a business manager and as consultant in the private sector. His work objectives are the following:

1. to promote EU cooperation on Health Technology Assessment (HTA) in Europe, through the directive on patients’ rights in cross border care;
2. to promote EU cooperation on e-Health, through the same directive;
3. to contribute to the EU position on the health related parts of the 2012 Commission's proposed regulation on data protection.

Ms Jillian Oderkirk

Jillian Oderkirk is a Senior Economist and Policy Analyst with the Health Division of the Organisation for Economic Co-operation and Development in Paris, France. She leads a project on developing health information infrastructure including the development of electronic health record systems; the use of personal health data for health system performance monitoring and research; and the privacy and data protection challenges associated with the secondary use of data. Jillian also leads efforts to model health systems within the OECD including the development of decision-support platforms and health expenditure forecasting methods. Prior to joining the OECD, Jillian had a long career with Statistics Canada in Ottawa, Canada and was the Director of the Health Analysis Division at Statistics Canada from 2006 to 2011. Jillian has a Master's Degree in economics from McMaster University, Hamilton, Canada.
Mr Raul Mill

Mr Raul Mill is a Member of the Management Board of the Estonian eHealth Foundation, which is an organisation created by leading Estonian healthcare service providers and the Estonian Ministry of Social Affairs with the aims of promoting and developing national e-solutions. Mr Mill has experience in working in the medicine, financial and IT sectors. He has been involved in the activities and organisation of both private and public sector organisations. Mr Mill studies medicines, business development and IT. As a CEO of eHealth Foundation, Mr Mill deals with strategic development and partnership.

Ms Siri Bjørvig

Siri Bjorvig is a Section Manager at the Norwegian Centre for Integrated Care and Telemedicine (NST). NST is the world’s largest centre for research and development in telemedicine and e-health. The centre has strong interdisciplinary expertise, and aims to shape the health care of the future. Through user-oriented research and development, NST has contributed to the integration of care between levels in the health sector since 1993. Telemedicine solutions and e-health give patients easier and better access to health services. Effective collaboration makes the skills and services of health personnel available to more people, and society's resources are used more effectively. Ms Bjorvig has been working at the NST since 1998. She is experienced in telemedicine, eHealth and Ambient Assisted Living (AAL). Facilitating processes for financing, accomplishing and managing several research and development projects on national and international levels, finding innovative approaches to healthcare provision by the use of ICT and implementing these have been her main responsibilities. Ms Bjorvig has also been a member of several national committees and expert groups forming national policy, especially within the personal health care/AAL area. At international level, she has gained experience while being an evaluator within the AAL Joint Programme. Currently, she is the Manager of the Personal Health System Section at the Centre, where she manages a group of multidisciplinary advisers in the field. NST is participating in several EU-funded projects and Ms Bjorvig is responsible for the on-going RENEWING HEALTH, MOMENTUM, United4Health, Implementing Transnational Telemedicine Solutions (ITTS) and RemoDem projects. She has an academic degree in Economics from the University of Tromsø.

Dr. Vicent Moncho Mas

Vicent Moncho is currently the Director of the Organization and Information Technologies Department of Hospital de Denia, and a member of the steering committee of Marina Salud S.A. His aim is to change the medical culture that can adapt easier and faster to the possibilities offered by new technologies. Dr Moncho participated in the implementation of electronic health record system in the primary care of the region of Valencia with 1,120 primary care centres and with a capita of 5,200,000 patients. He also participated in the redesign and implementation of equipment for data centres of the network in the 23 public hospitals in the Valencian community. In 2006, he joined the Marina Salud S.A. project dealing within the setting up of the new hospital in Denia with the aim of having a pioneer hospital in technology and information systems. The hospital opened in February 2009 and during 2012 achieved HIMSS Stage 7 award, being the first hospital in Spain and second one in Europe.
Prof. Dr Antoine Geissbuhler

Antoine Geissbuhler is a Professor of Medicine, Chairman of the Department of Radiology and Medical Informatics at Geneva University, Director of the Division of eHealth and Telemedicine at Geneva University Hospitals. He is also President of the executive committee of the Health-On-the-Net Foundation, and President of the International Medical Informatics Association.

He was trained as a physician at Geneva University where he specialised in internal medicine, then, after a post-doctoral fellowship, became Associate Professor of biomedical informatics at Vanderbilt University. In 1999, he returned to Geneva to take the responsibility of medical information systems at Geneva University Hospitals. In 2005, his efforts in developing telemedicine and tele-education are recognised by the creation of the UNESCO chair for telemedicine and multidisciplinary teaching, and, in 2010, of the World Health Organization collaborating center for eHealth and telemedicine.

Author of more than 130 original scientific publications, his current research focuses on the development of innovative, knowledge-enabled information systems and computer-based tools for improving the quality, safety and efficiency of care processes, at the local level of the hospital, the regional level of a community healthcare informatics network, the implementation of the national eHealth strategy for Switzerland, at the global level with the Health-On-the-Net Foundation (http://www.hon.ch) and with the development of a large telemedicine network in developing countries (http://raft.hcuge.ch). He is also leading an effort by Geneva University Hospitals to develop a world-class medical tele-expertise network.

Prof. Dr. Georges de Moor

Professor Dr. Georges J.E. De Moor studied Medicine and specialized in Clinical Pathology and Nuclear Medicine at the State University of Ghent (Belgium), where he also obtained in 1994 his PhD in Medical Information Science. He is head of the Department of Medical Informatics and Statistics at the State University of Ghent, Belgium, where he teaches Health Informatics, Medical Statistics, Decision Theory and Evidence Based Medicine.

He is past president of RAMIT (Research in Medical Informatics and Telematics) and has been involved in both European and International Research and Development projects (+95), as well as in Standardisation activities. For seven years, Prof. De Moor acted as the Founding Chairman of CEN/TC251, the official Technical Committee on standardisation in health informatics in Europe. As a result of his research conducted, Prof. De Moor has been founding or co-founding a number of spin-off companies (e.g. MediBridge and Custodix) mainly active in eHealth, including the domain of privacy protection.

In 2004, he was elected President of the European Institute for Health Records EuroRec, (http://www.eurorec.org) which is the de facto body for certification of Electronic Health Record systems in Europe. He is now past president and member of the board of EuroRec.

Dr. De Moor is also Head of the Clinical Pathology Laboratory in the Sint-Elisabeth Hospital of Zottegem, Belgium. Prof. De Moor chairs in Belgium and in Europe a number of official Committees related to ICT in Health or to Laboratory Medicine. He has edited twelve books related to ICT in Health and published over 200 articles in scientific journals. In 2005 he was awarded with the International Rory O’Moore Medal (presented by Bertie Ahern, in Dublin) for Health Informatics.
**Ms Lisa Hagberg**

Lisa Hagberg coordinates the project Smart Open Services for European Patients (epSOS) on behalf of the Swedish Association of Local Authorities and Regions (SALAR) and the Swedish Ministry of Health and Social Affairs. epSOS is a 5-year long European project delivering interoperable solutions for exchange of patient summaries and e-prescriptions across Europe. 49 organizations from 25 nations participate in the project.

Lisa has a background in political science. Prior to joining the epSOS project, she worked for diplomatic missions of both the Swedish and foreign governments.

**Mr Hartmut Schaper**

In his role as Senior Vice President of Siemens Health Services (HS) International, Hartmut Schaper is responsible for the healthcare IT business outside the US (basically all healthcare IT with the exception of syngo). Moreover, Mr Schaper drives the Next Generation Healthcare IT initiative across all of Siemens Healthcare.

Hartmut Schaper has more than 25 years of experience in Software and IT, including 12 years at SAP and 4 years as CTO of IXOS AG. Furthermore, Mr Schaper has been Principal at BCG for 2 years.

In 1986, Hartmut Schaper graduated with a MSc in Mathematics and Computer Science from the University of Warwick (UK).

**Ms Nicola Bedlington**

Nicola Bedlington is British and was born in Kirkcaldy, Scotland.

She studied business and human resource management in the UK. She lived for almost 10 years in Brussels, and has lived near Geneva for the last 12 years, recently moving to Vienna.

Nicola was the founding Director of the European Disability Forum, an umbrella organisation uniting over 70 European disability NGOs and National Councils of Disabled People to advocate for the human rights and inclusion of disabled citizens in Europe (1996 to 1999), and prior to this she headed the NGO unit within the HELIOS Programme, a European Commission Action Programme promoting equal opportunities for disabled people (1991-1996).

From 2004 to mid-2006, she was mandated to lead the Environment and Schools Initiatives Secretariat (ENSI), an international government-based network set up by OECD focussing on innovation, action research and policy development in the field of Education for Sustainable Development.

Whilst in Switzerland, she has also worked as an independent consultant/evaluator, specialising in European social and development policy and health advocacy. She joined the European Patients’ Forum as its first Executive Director in June 2006.
Mr Sascha Marschang

A dual German and Canadian national, Sascha holds a Masters degree in Communication and Cultural Studies from York University (Toronto). His policy portfolio at EPHA comprises the areas of health tools (eHealth / mHealth, Digital Agenda), health workforce, pharmaceutical policy, health threats, as well as other developments impacting on health systems. He is a member of the eHealth Stakeholder Group led by the European Commission’s DG CONNECT. He has written a number of articles and briefings on eHealth/mHealth and is particularly interested in their impacts on vulnerable groups.

Prior to EPHA, Sascha worked in different functions at the Government of Ontario, and he also spent several years working and studying in London, England. He speaks fluent English, French and German, with a working knowledge of Spanish and Dutch.

Dr Konstanty Radziwiłł

Dr Konstanty Radziwill, MD. PhD. was born in 1958 in Wroclaw, Poland. He graduated from Medical University in Warsaw in 1983.

Since 1984 he has been working as a primary care physician in Warsaw. From 1983 till 1991 he worked also in emergency and occupational medicine; since 2005 he is a lecturer in the Family Medicine Department of the Warsaw Medical University. Since 2010 he works also for the Polish Center for Health Information Systems. In 1996 he set up his private practice in family medicine in Warsaw. He is a family medicine specialist. He has finished also Postgraduate Faculty of Bioethics in the Cardinal Stefan Wyszynski University in Warsaw and Postgraduate Faculty of Health Care Economics in the Warsaw University.

He is a member of College of Family Physicians in Poland and of Polish Society of Family Medicine.

He was a president of the Polish Chamber of Physicians and Dentists from 2001 to 2010. Since then he is a vice-president of the Chamber.

From 2010 to 2012 he was a president of the Standing Committee of European Doctors (CPME).
PRESENTATIONS
Presentation by Mr Benoît Abeloos

eHealth Action Plan

Benoit Abeloos
Health and Well-being Unit
Standardisation and Interoperability

eHealth Workshop
24 September 2013
European Parliament

WHY A NEW eHEALTH ACTION PLAN?

TO REFLECT THE PROGRESS MADE SO FAR

TO ENSURE MORE COHERENCE BETWEEN HEALTH POLICY DEVELOPMENTS AND eHEALTH DEPLOYMENT

TO SCALE UP eHEALTH FOR EMPOWERMENT, EFFICIENCY AND INNOVATION IN HEALTHCARE

TO CONTRIBUTE TO MORE JOBS AND GROWTH

REQUESTED IN THE COUNCIL CONCLUSIONS (DEC. 2009)
eHealth Action Plan: Vision
Tackle eHealth challenges related to:

- Personal Health (chronic disease management, prevention and health promotion)
- Health Systems (unlocking innovation, enhancing patient-centric care, encouraging organisational changes, cross-border care, universality, equity...)
- Legal / Market aspects (improving legal and market conditions)

eHealth Action Plan 2012 – 2020
Operational Objectives

- Achieving wider interoperability of eHealth services
- Supporting research, development and innovation
- Ensuring wider deployment & facilitating uptake
- Promoting international cooperation
Achieving wider interoperability of eHealth services

**eHealth Interoperability Framework** to be proposed by 2015

**Supporting this:**
- eHealth Network Work Programme (guidelines and standards endorsement)
- R&I projects and studies (SemanticHealthNet, epSOS, eHealth Interoperability Framework, Antilope...)
- Interoperability testing and certification system
- Maintenance of assets under CEF

Legal Clarity

- Staff Working Paper on legal issues in telemedicine
- Guidance on how to apply EU data protection law in the area of health data (following adoption of DP regulation)
- Green Paper on Legal Framework applicable to Health & Wellbeing Apps
**PURPOSE OF THE GREEN PAPER ON m-HEALTH**

- The *Green Paper on mHealth* will launch a debate among stakeholders on what should be done at EU level to release the potential of mHealth in Europe.

- It will be accompanied by a **SWD explaining the legal framework applicable to health and wellbeing apps**

  →Due before the end of 2013

---

**Research & Innovation**

**Focus on competitiveness**

- **Research:**
  - Health & Wellbeing solutions (user-centric focus)
  - Longer-term focus: Virtual Physiological Human...

- **Innovation:**
  - User-driven innovation
  - Law incubators
  - PCP / PPI
  - Piloting
Ensuring Wider Deployment and Facilitating Uptake

- Connecting Europe Facility (CEF) from 2014
- Cohesion policy: broadband access and supporting ICT applications and services
- EIP on Active and Healthy Ageing
- Focus on Digital Health Literacy for professionals and citizens
- Clinical Practice Guidelines for telemedicine services: emphasis on nurses, social care workers

International Cooperation

- Benchmarking and data collection (WHO, OECD ...)

EU-US:
- Memorandum of Understanding signed in Dec 2010
- Published roadmap on eHealth interoperability and ICT skills (June 2013)
- In the frame of the EU-US free trade negotiations
Conclusion

- Action Plan responds to climate of budgetary constraints of health systems; ageing population; citizens’ expectations
- Promoting innovation for: better health and care; transparency and empowerment; more skilled workforce; more efficient and sustainable health and care systems; new business opportunities in Europe and beyond
Thank you

Benoit Abeloos: benoit.abeloos@ec.europa.eu

eHealth®

ec.europa.eu/ehealth

@EU_ehealth
@EU_ehealthweek

EU.ehealth
Ehealthweek.eu
Presentation by Mr Jerome Boehm

eHealth action in the EU

Workshop on eHealth
EP ENVI committee
24 September 2013, Brussels
Jerome Boehm
DG SANCO
eHealth and Health Technology Assessment

General Health Objectives of the EU cooperation on eHealth

✓ Patients empowerment
✓ Access to healthcare
✓ Quality and safety of healthcare
✓ Continuity of healthcare
✓ Sustainability of health systems
✓ Cooperation & improvement of health research
eHealth – why an EU co-operation?

- continuity and quality of care, across borders
- great cross-border potential
- enhance the quality of eHealth research and development
- strengthen the eHealth market

How – Some EU instruments for eHealth

1. Implementing Directive on patients' rights
2. eHealth Action Plan 2014-2020
3. Financing under the FP7 and Horizon 2020
4. EU regulation on Standardisation

Draft proposals:
- Regulation on eIdentification
- Regulation on Data Protection
- Green paper on mHealth
Directive on patients' rights in cross-border care

- Implementing act on prescriptions: minimum data to be shared across borders (Art 11)
  - Paving the way to ePrescription
- eHealth Network (Art 14)
  - Common identification (eID) for electronic transferring of health data
  - Guidelines on semantic and technical interoperability
  - Guidelines on non-exhaustive list of data to be included in patient's summary

The eHealth Network
A Strategic Tool
Strategic eHealth Network

Aim: to lead the improvement in cooperation on eHealth, among Member States, based on Directive of patients' rights.

Gives directing on main eHealth developments under the Action Plan, such as interoperability, minimal patient data, ePrescription.
Priorities of the eHealth Network

- eIdentification and authentication
- Interoperability: semantic and technical
- Legal barriers to interoperability, including Data Protection issues
- Guidelines on patient summary set of date for cross-border exchange
- Guidelines on e-Prescriptions
- Sustainability of eHealth action in the EU

Conclusions

- Commission: eHealth is essential for efficient and sustainable health systems
- We need interoperable systems to bear the fruits of eHealth solutions (Single Digital Market)
- Health sector to be involved in non-health regulations on standardisation, eGovernance, data-protection, etc.
THE USE OF INFORMATION AND COMMUNICATION TECHNOLOGIES (ICT) FOR HEALTH: WHERE ARE WE?

Workshop on "e-Health"
Tuesday, 24 September 2013 from 09.00 to 12.30
European Parliament, PHS 7C050, Brussels

Jillian_Oderkirk@oecd.org
Niek.Klazinga@oecd.org
Eleftra.Ronchi@oecd.org

Agenda to improve health information infrastructure

» In 2010, health ministers called for improvement in national information infrastructure to provide evidence to improve health care quality
» Ministerial Communiqué called for more effective use of data that has been already collected
» OECD Health Committee supported projects in 2011/12 and 2013/14
  • Work is guided by the Health Care Quality Indicators Expert Group (HCQI)
From data to evidence for health care improvement

» Two key prerequisites
   » Collection and storage of data at the level of individual patients/persons
      » E.g. registries, administrative data, surveys
   » Capacity to follow patients through the cycle of care to relate care to outcomes
   » Often requires data linkage because few databases have all of the information needed
   » Could be based on electronic health records

Electronic health record systems

» The **longitudinal** electronic record of an individual patient that contains or virtually links together records from **multiple** electronic medical records which can then be **shared** (interoperable)

» Such systems aim to improve the quality, safety and efficiency of health care
### Progress report...

<table>
<thead>
<tr>
<th>Progress</th>
<th>Europe (15 countries)</th>
<th>Other (10 countries)</th>
<th>Total (25 countries)</th>
</tr>
</thead>
<tbody>
<tr>
<td>70%+ of Doctors using EMRs</td>
<td>11</td>
<td>2</td>
<td>13</td>
</tr>
<tr>
<td>70%+ of Hospitals using EPRs</td>
<td>11</td>
<td>4</td>
<td>15</td>
</tr>
<tr>
<td>National plan to implement EHRs</td>
<td>12</td>
<td>10</td>
<td>22</td>
</tr>
<tr>
<td>Implementation started</td>
<td>12</td>
<td>8</td>
<td>20</td>
</tr>
<tr>
<td>Exchange among doctors and hospitals including medications, lab tests and images</td>
<td>8</td>
<td>6</td>
<td>14</td>
</tr>
</tbody>
</table>


### EHR system components

18 countries have defined a minimum data set and most include medications, lab tests and images

From EHRs to Scientific Discovery

» Stratifying patients into groups that share common characteristics (age, sex, disease history, medications, lab or image results) has been difficult

» With large national databases and international cooperation it becomes possible to:
  » Identify the treatment pathways that are effective for different types of patients
  » Combine with bio-bank data to further stratify the patients and discover personalised/effective drugs
  » Efficiently select large and homogenous groups of patients for clinical trials of new therapies

From EHRs to High Quality Health Care

» Timely and accurate post-market surveillance for adverse drug events

» Timely monitoring of adherence to clinical care quality guidelines and guideline revision

» With administrative data:
  » Timely monitoring of health care pathways, costs and outcomes

» With predictive analytical modelling tools:
  » Support physicians in identifying the most appropriate care
  » Enable health care managers to plan, to optimise care provision and minimise costs
Planned and implemented uses of EHR data

- Public health monitoring
- Supporting physician treatment decisions
- Health system performance monitoring
- Research
- Patient safety monitoring
- Facilitating and contributing to clinical trials

Countries: Europe=15, Other=10


Views about the next 5 years

Over the next 5 years:
How likely is it your country will use any data from EHRs for national health care quality monitoring?

- Finland
- Indonesia
- Israel
- Singapore
- Sweden
- United Kingdom
- Belgium
- Canada
- Estonia
- France
- Iceland
- Japan
- Korea
- Poland
- Portugal
- Slovakia
- Denmark
- Slovenia
- Spain
- United States
- Mexico
- Austria
- Germany
- Netherlands
- Switzerland

Very Likely
 Likely
Unsure
Unlikely
Very
Beyond EHRs – what about other data?
Too few countries are harnessing value from their data for performance monitoring

<table>
<thead>
<tr>
<th></th>
<th>Hospital in-patient data</th>
<th>Primary care data</th>
<th>Cancer registry data</th>
<th>Prescription medicines data</th>
<th>Mortality data</th>
<th>Formal long-term care data</th>
<th>Mental hospital in-patient data</th>
</tr>
</thead>
<tbody>
<tr>
<td>National dataset available</td>
<td>20</td>
<td>16</td>
<td>18</td>
<td>14</td>
<td>20</td>
<td>16</td>
<td>17</td>
</tr>
<tr>
<td>Contains a UPI</td>
<td>15</td>
<td>12</td>
<td>14</td>
<td>12</td>
<td>15</td>
<td>11</td>
<td>12</td>
</tr>
<tr>
<td>Contains other identifiers</td>
<td>15</td>
<td>12</td>
<td>17</td>
<td>12</td>
<td>17</td>
<td>12</td>
<td>15</td>
</tr>
<tr>
<td>Used for data linkage studies</td>
<td>14</td>
<td>10</td>
<td>14</td>
<td>12</td>
<td>16</td>
<td>11</td>
<td>8</td>
</tr>
<tr>
<td>Used regularly for data linkage studies to monitor health care quality</td>
<td>12</td>
<td>4</td>
<td>12</td>
<td>7</td>
<td>12</td>
<td>4</td>
<td>5</td>
</tr>
</tbody>
</table>

Table 1: Number of countries reporting linkable data and reporting data use
Source: OECD HCQI Country Survey, 2011/12

Country variation

<table>
<thead>
<tr>
<th>National health data linkage projects conducted on a regular basis...</th>
<th>Country</th>
</tr>
</thead>
<tbody>
<tr>
<td>With many national databases</td>
<td>Australia, Belgium, Denmark, Finland, France, Israel, Republic of Korea, Sweden, United Kingdom and Australia</td>
</tr>
<tr>
<td>With several national databases</td>
<td>Canada, Malta, Norway and Switzerland</td>
</tr>
<tr>
<td>With 2 national databases</td>
<td>Cyprus, Portugal, Singapore</td>
</tr>
<tr>
<td>None</td>
<td>Japan, Poland, Germany</td>
</tr>
</tbody>
</table>

Source: OECD HCQI Country Survey, 2011/12
Challenges

» Balancing data privacy and access to data
» Reluctance to share data
» Lack of standards for content and interoperability
» High prices for data access
» No unique patient numbers to link or track over time
» Data quality problems
» Lack of skilled resources
» Deficits in computing power/analytic software
» Reluctance of health professionals

Success factors

**Data governance** including...

» Strategic planning
» Legislation enabling secure data sharing, processing, and analysis
» Effective data privacy and security measures
» Engagement with citizens, businesses, health sector
» Public communication about data availability and access
» Incentives/investments/grants
» Data utility evaluation and quality auditing
» Data analytic skills in health education/training
For more information

Health policy brief and final report (2013):
http://www.oecd.org/els/health-systems/strengtheninghealthinformationinfrastructure.htm
Estonian Health Information System

Raul Mill
Estonian E-Health Foundation

Estonia

Estonia - 45 000 km²
1.29 milj. inhabitants

GDP:
Agriculture 12,7%
Industry 26,3%
Service 74,5%
HEALTHCARE IN ESTONIA

30 hospitals
512 family doctors (juridical persons)

Healthcare expenditures 2011
- 5.9% from GDP
- 944.6 mlj. EUR

Background of the Estonian HIE platform

- 2000 start to plan eHealth projects
- 2003-2005 eHealth project preparation
- April 2005 – Ministry of Economic Affairs that coordinates allocation of structural funds made the funding decision for four eHealth projects:
  - Electronic Health Record (1.6 mln €)
  - Digital Registration (0.2 mln €)
  - Digital Images (0.2 mln €)
  - Digital Prescription (0.24 mln €)
- 26 October 2005 Estonian eHealth Foundation was established
- 2006-2008 eHealth projects
- December 18th, 2008 the National HIE went in production
Acceptance

- ePrescription covers 94% of issued prescriptions
- Over 90% of Hospital discharge letters – digital
- Over 95% of stationary case summaries have been sent to the central DB
- 1,069,075 persons have documents (82% of population)
eHealth approximate expenditures

- Estonia: 12 mil EUR
- Ireland: 56 mil EUR
- Portugal: 69 mil EUR
- Norway: 105 mil EUR
- Scotland: 117 mil EUR
- Denmark: 183 mil EUR
- Finland: 203 mil EUR
- Sweden: 347 mil EUR
- Netherlands: 430 mil EUR
- Spain: 713 mil EUR
- Germany: 1,352 mil EUR
- UK: 1,980 mil EUR
- Australia: 4,976 mil EUR
- US: 30,712 mil EUR

Source: [Provide source information]
Workshop on e-Health

Documents total – 10.8ml

1 069 075 persons medical data (growth 20% during 2012)

PATIENT PORTAL (UPGRADE)

The structure of Estonian Health Information System

- Institutional level—users cooperation model
- Data Exchange level—different e-services
- Central System—Database and related services

- Partnerships
- User needs
- Training programs
- Process Descriptions
- Notifications
- User Interface
- User software
- Data input
- Data Visualisation
- Data filters (within user software)
- Web-interfaces
- Data transmission standards (HL7)
- Set of data
- Data Standards
- Data filters relating to the central system
- Legal Framework
Standards

- HL7 and DICOM (Picture Archive)
- International classification: ICD-10, LOINC, NCSP, ATC
- Estonian eHealth’s OID registry
- Local eHealth classifiers
  - Published in publishing centre
  - Classifiers are regulated by government act
    https://www.riigiteataja.ee/akt/12910889
Main services of the e-health in Estonia

Documents in e-health system:
- 31.12.2009 0.4 mio
- 31.12.2010 3.6 mio
- 31.12.2011 5.8 mio
- 31.08.2013 10.8 mio

FUTURE OUTLOOK

Connecting health
Better services

Usability & Interoperability

• Faster data input
  – Voice recognition, statistics based text input assistant

• Faster and better output
  – Important information on “one screen”
  – Combining information from multiple sources
  – Graphical solutions
  – Precaching

• Single sign on
Workshop on e-Health

INTERNATIONAL CO-OP

epsos
sustains
momentum
Thank you!
E-health records in Ambulatory Care
Future perspectives

Siri Bjørvig
Section Manager

"Excellent health services for everybody, independent of time or place"
Goal

Provide new solutions and new knowledge within telemedicine and e-health

Facilitate improved cooperation in the health services through research and advisory services

NST history…

1987
Telemedicine department

1993
Norwegian centre for telemedicine (NST)

1999
National resource-centre

2002
WHO collaboration centre

2006
Tromsø Telemedicine Laboratory (TTL)

2008
Norwegian Centre for Integrated Care and Telemedicine
Government’s goal

• Health personnel shall have easy and secure access to patient information
• The citizens shall have access to easy and secure digital services
• Data shall be accessible for quality improvement, health monitoring, management and research

One Patient – One Record
Health and care sector in Norway

Population 5 mill
- 250,000 employees in health and care sector

Primary care
- 428 autonomous municipalities
- 4100 GPs (private) in agreement with their local municipality

Specialist care
- 4 regional health authorities, 24 health thrusts, 70 hospitals
- Owned by the government

Challenges
- The technological possibilities have not been used
- Many independent organisations
- Many IT systems, little integration
Future

- Access
- Sharing
- Participation
- Structured data
- Processes
- Decision making

Thank you!
Siri Bjørvig
siri.bjorvig@telemed.no
Introduction

Marina Salud is an avant-garde hospital thanks to its modern open and light architecture design that gives a sensation of tranquility to its patients. It is also a new model of public and private partnership based on per capita financing where the provider is the one assuming the risk. Finally, it is an innovative experience in information technology – one of the basic elements of the company.

Angel Giménez Sierra
CEO Marina Salud
**Definition of EHR**

An EHR is an evolving concept defined as a systematic collection of electronic health information about individual patients or populations.

It is a record in digital format that is theoretically capable of being shared across different health care settings. In some cases this sharing can occur by way of network-connections, enterprise-wide information systems and other information networks or exchanges.

EHRs may include a range of data, including demographics, medical history, medication and allergies, immunisation status, laboratory test results, radiology images, vital signs, personal statistics like age and weight, and billing information.


---

**Electronic Health Record**

The electronic medical record involves incorporating the Information Technology and Communication (ICT) at the heart of healthcare. It stops being a record of the information generated in the relationship between a patient and a health care professional and starts to be part of a truly integrated clinical information.

It is accessible, with appropriate limitations, in all cases in which medical assistance is required (emergency, primary, specialty, hospital admissions, etc.)

There are some problems with the conceptualization of the care process and its implementation which does not clearly show the real impact on the quality of care, morbidity and mortality.
Efficiency

In the health world, efficiency refers to the achievement of a health objective at minimum cost.

It is understood that efficiency is when fewer resources are used to achieve the same goal. Or conversely, when more goals are achieved with the same number or fewer resources.

Paperless office

The paperless office is an old concept dating back to the 1940s when the idea of the office of the future was proposed. With the advent of personal computers, this idea took on new impetus.

Today, the paperless office is considered an innovative philosophy that allows us to work with the minimum amount of paper by converting all types of documents to digital format.

The implementation process has several barriers to overcome:

- Business processes already established.
- Government regulations.
- Lack of technology and tools.
- The longevity of digital documents.
Efficiency = Paperless?

Efficiency <> paperless office

- Electronic processes = paper processes
- No one is more efficient by not having paper processes.

The EHR can be the starting point because:
- We can improve attendance
- We can improve cost efficiency
- We can improve quality

What HIMSS says

Very few hospitals have HIMSS stages 6 and 7

The impact of the EMR is evident in stages 6 and 7 (and not in previous ones) in:
- Quality of care
- Patient safety
- Operational efficiency
- Investment analysis

The major conclusions from this survey are:
- Hospitals with advanced EMRs have purchased their EMRs for the specific purpose of improving clinical quality and patient safety.
- Hospitals with advanced EMRs explicitly target clinical objectives such as ADE reduction, core measure improvement and other patient safety improvements; they pursue these objectives with a number of explicit benefit realization strategies.
- Hospitals with advanced EMRs report achieving a broad range of benefits from their EMR implementations, including both clinical quality, patient safety and operational efficiencies.
- Hospitals that target specific areas of benefit are more likely to report achieving those benefits.

This survey is the first to report results from a large number of EHRAM Stage 6 and 7 hospitals. These results paint a very different picture than those from other recent studies of hospitals with EMRs across all EHRAM levels, supporting the conclusion that hospitals with more advanced EMRs may be more able and likely to realize substantial benefits.
**2011 two years after**

**The needs of HIMSS level 6**

- Physician Documentation and Closed Loop Meds
- Physician Documentation with Clinical Decision Support
- Closed Loop Medication

**HIMSS Level 6**

**PHYSICIAN DOC**
- Structured documentation
- Transversal Clinical pathways

**CLOSED LOOP MEDS**
- Close look to transversal process for both Doc and Meds
- Alerts
- Closing the 5 rights

**THE MUST:**
- Physician use of the system: physician adoption 100%
- Nurse use of the system: nurse adoption 100%
- Adaptation of Cerner best practices to local needs
- Demonstrate Benefits

**2012 three years after**

**Achieve HIMSS level 7**

- Paperless EMR and Data Driven
- Paperless Validation
- Clinical Decision Support Capabilities
- Enterprise DataWarehouse
- Downtime process

**Paperless Validation**
- Exception to ideal workflow determine need for 100 paper scanned

**CDSC**
- Dose range checking
- Sepsis algorithm
- Decrease unnecessary Tx Xray Prep

**DWH**
- Conselleria communication
- Government reporting: i.e. ED triage time

**THE MUST:**
- Clinical teams not only use but TRUST the system. The system belong to the need of Clinical Transformation
- Able to demonstrate the transformation of Healthcare through results
- To Transform the Healthcare you need a partner that assess you with the best practices understanding your local workflows, needs and differences
Nursing improvements

All discharged patients have a nursing discharge report:
• 50% of the report's content is generated automatically saving 5 minutes per report.

Continuity of care between departments:
• Avoiding 15 minutes per discharge.

Reduced variability in nursing practice:
• Wound care plans: 100% of patients.
• Forms: documentation.

Reduction of the time dedicated to documentation and tasks of little added value:
• Medications: requisitions and relevant information.
• Diets: requisitions.

ED Tracking Board:
• Informs us of the patient workload and severity in real time.

Records related to quality:
• Falls.
• Pressure ulcers.
• Urinary tract infections.

Physicians improvements

Interconsultations and remote follow-up visits are 5% of the total.

Remote home connection for providers on-call remotely reduced physical presence time.

Structured clinical information available anywhere, at any time.

Clinical protocols are integrated in the system.

There is continuity of care between areas.

Operating Room with integration of monitoring devices.

Implementation of process guides in medical orders.

Integration of the prescription with primary care systems.

Process-oriented management reduces variability in clinical practice.
### Other improvements

**Preference cards**
- Costs per process.

**Autoverification**
- 24-hour pharmacist is not required.
- 4 pharmacist.

**Tx Xray rule**
- Avoids pre-operative X-rays in patients under 60 years of age except pathologies that require them.
- Effect on costs.
- Effect on queue management.

**Blood bank management**
- Multi-phase plan for pre-operative consultation.
- Cancellations due to lack of blood have decreased.
- Time between order and surgery has decreased.

**Cervical cancer multiorder**
- Alert in case of alarming results.
- Reduced gynecologist time visiting.
- Automated sending of letters in case of normal results.

**Scheduling system**
- Availability to schedule from any part of the Department (not only the hospital).
- The patient can make an appointment from any location, avoiding travel time.
- High specialisation is not required for scheduling appointments.
- Simplifies the management of human resources: Higher efficiency due to higher versatility.
- Allows providers to schedule appointments.
- Allows establishing complex scheduling processes, making several people responsible.
- Clinical information related to the appointment.

---

"The definition of insanity is doing the same thing over and over again and expecting different results".

Albert Einstein
Easing transitions in healthcare
experiences from the Geneva Health Information
Exchange and EU projects

Prof. Antoine Geissbühler, MD

Division of eHealth & telemedicine, Geneva University Hospitals
Past-president, International Medical Informatics Association
Board Member, Health On the Net Foundation

Key points

- Most healthcare systems are broken
- Health IT is now expected to fix them
- Institutional healthcare information systems are reaching their limits
- The IT landscape is being transformed by mobile, collaborative, and consumer-driven computing
Supporting evidence is not new

Physician Inpatient Order Writing on Microcomputer Workstations
Effects on Resource Utilization

William M. Tierney, MD; Michael E. Miller, PhD; J. Marc Overhage, MD, PhD; Clement J. McDonald, MD
JAMA, January 20, 1993—Vol 269, No. 3

Conclusions. — A network of microcomputer workstations for writing all inpatient orders significantly lowered patient charges and hospital costs. This would amount to savings of more than $3 million in charges annually for this hospital’s medicine

-13%

Outcome improvement is linked to usage

Clinical Information Technologies and Inpatient Outcomes

A Multiple Hospital Study

Raben Amarasingham, MD, MBA; Laura Plantinga, ScM; Marie Dieuer-West, PhD;
Darrell J. Gaskin, PhD; Neil R. Powe, MD, MPH, MBA

Arch Intern Med. 2009;169(2):108-114

Conclusion: Hospitals with automated notes and records, order entry, and clinical decision support had fewer complications, lower mortality rates, and lower costs.
Careful implementation is important

Unexpected Increased Mortality After Implementation of a Commercially Sold Computerized Physician Order Entry System

Yong Y. Han, MD\textsuperscript{\dagger}; Joseph A. Carcillo, MD\textsuperscript{\dagger\dagger}; Shekhar T. Venkataraman, MD\textsuperscript{\dagger\dagger\dagger}; Robert S.B. Clark, MD\textsuperscript{\dagger\dagger\dagger}; R. Scott Watson, MD, MPH\textsuperscript{\dagger\dagger\dagger\dagger}; Trung C. Nguyen, MD\textsuperscript{\dagger}; Hülya Bayir, MD\textsuperscript{\dagger}; and Richard A. Orr, MD\textsuperscript{\dagger\dagger\dagger\dagger}

Pediatrics 2005;116:1506-1512

« e-iatrogeny »

Hospital IT: towards learning institutions
Real-time patient flow, logistics

Intelligent, integrated decision support

FIGURE 2. Total hospital charges on consecutive radical retropubic prostatectomy patients before and after implementation of the collaborative care/critical pathway program.
But transitions remain dangerous

Lost in Transition: Challenges and Opportunities for Improving the Quality of Transitional Care
Eric A. Coleman, MD, MPH, and Robert A. Berenson, MD

Medical Errors Related to Discontinuity of Care from an Inpatient to an Outpatient Setting
Carlton Moore, MD, Juan Wunivesky, MD, Stephen Williams, MD, Thomas McGinn, MD

Gaps in the continuity of care and progress on patient safety
Richard I Cook, Marta Render, David D Woods

Improve continuity of care
Geneva Health Information Exchange

- Shared dashboards
  - Care coordination for chronic diseases & complex patients

- Patient summary

- Shared treatment plan
  - Between prescribers
  - In collaboration with pharmacists, home care nurses, and patients
An evolving professional-patient relationship

- Informed healthcare professionals
  - Informed patient care
  - Patient-informed care

eHealth 2.0

- Social web tools
  - forums, communities, PatientsLikeMe
  - push: alerts, reminders, eCompliance

- Patient empowerment
  - reputation and trust becomes key

- Collective wisdom competes with established knowledge sources
  - information prescription
The paradigm

- Simple, agile apps
- Mobile, connected
- Context-sensitive
  - Activity, location, vital sign, emotional state...
- Based on robust infrastructures
  - Open architectures
  - Interoperability standards

The Alpine Space

alias

NATHCARE

Networking Alpine Health for Continuity of Care

Europe-wide projects

epsos

EUROPEAN PATIENTS SMART OPEN SERVICES
Challenges

- Fostering trust is a central issue
  - For citizens and patients
  - For care professionals

- Towards patient-informed care
  - Truly give the voice to the patient

- Technical and semantic interoperability
  - Across systems, languages and national barriers
  - Interoperability of access and privacy models is key

- Capacity building is essential
  - Certification of health informatics professionals

Thank you for your attention!

ag@hcuge.ch
The Road towards the effective Use of Health Data

(the SemanticHealthNet project)

Prof. Dr Georges De Moor
Prof. Dr. Dipak Kalra

RAMIT, Ghent University, Belgium
University College London, UK
The EuroRec Institute

Capture, combine, co-interpret data from diverse Information Sources

- Genomic data
- Population registries, Clinical trials data
- Care pathways, decision support systems, trends and alerts
- Environmental data
- Bio-sensors data
- Social networks
- Mobile devices
- EHRs, PHRs, other Clinical Applications

Prof. Dr. G. De Moor - European Parliament eHealth Workshop  
September 24, 2013
Electronic Health Records (EHRs): trends

- Patient-centered (gatekeeper?), life long records
- Multi-disciplinary / multi-professional / participative
- Transmural, distributed and virtual
- Structured and coded cf. semantic interoperability
- More metadata (tagging and coding) at a “granular” level
- Intelligent cf. decision support, clinical practice guidelines...
- Predictive e.g. genetic data, physiological models
- More sensitive content (cf. privacy protection!)
- Personalised
- Integrative

A Trans Atlantic Project

"The adoption, use and interoperability of EHRs has become a major focus of European and US eHealth policies, strategies and investments”

IOS Press: editor Georges J.E. De Moor

Foreword by Herman Van Rompuy - E. Council President

Memorandum of Understanding signed by:
- Neelie Kroes - Eur. Commission Vice-President
- Kathleen Sebelius - Secretary of HHS, US

Policy briefs for Transatlantic cooperation
- Certification of Electronic Health Records in the US & Europe
- Semantic Interoperability
- The Virtual Physiological Human
- A Common Approach towards Measuring Adoption, Usage and Benefits of eHealth
- eHealth Informatics Workforce challenges
Drivers for Semantic Interoperability

- The Drivers for Integrated EHRs and Semantic Interoperability are:
  - Manage increasingly complex clinical (multi professional) care
  - Support collaboration between multiple locations of care delivery
  - Deliver evidence based health care
  - Need for intelligent decision support in medicine
  - Input to and exploitation of biomedical research
  - Improve safety and cost effectiveness of health care
  - Enrich population health management and prevention
  - Empower and involve citizens

Essential needs for Semantic Interoperability

- Guideline and decision support systems, notification and alerting components, and analytic tools need to process integrated health data drawn from multiple EHR systems in a consistent manner.
- Intelligent personal health guidelines interoperating with PHRs and EHRs need to support the centering of care on patients.
- Health services, insurers and public health bodies need fine grained activity and outcome data to inform service planning, and prevention/wellness programmes.
- New generation personalised medicine, underpinned by ‘omics sciences and translational research such as the VPH, needs to integrate EHRs with data from research: fundamental biomedical science, clinical and population health research, and clinical trials...
Semantics in medicine and health

- Natural Languages (in Europe: 23 official languages!)
- Structured versus unstructured (narrative) records/messages
- Concepts and relations between concepts (many views!)
- Terms (many medical terminologies!)

- Ontologies
- Information Models (e.g. EHR reference models…)
- Semantic resources (detailed clinical models/ clinical archetypes/templates)

How to represent and convert “meaning” from a “human understandable” form in a “computer processable” form?

Semantic Interoperability: Recommendations

Nine strategic actions that now need to be championed, as a global mission

1. Establish good practice
2. Scale up semantic resource development
3. Support translations
4. Track key technologies
5. Align and harmonise standardisation efforts
6. Support education
7. Assure quality
8. Design for sustainability
9. Strengthen leadership and governance
• European Commission sponsored a Network of Excellence in Semantic Interoperability
  – Dec 2011 to Nov 2014
  – 3m Euro
  – 17 Partners
  – > 40 internationally recognised (clinical) experts

• A global and singular representation for each distinct clinical expression is not realistic, and may not be desirable
  – different representations might be optimal for different use cases
  – different levels of detail, different levels of granularity, different kinds of data entry options might be suitable for different clinical settings
  – clinical practice is too diverse, and evolving, for such fine grained standards to be set or adopted
  – different cultures, and natural languages, may need to represent clinical meaning differently
  – patients and carers might need to enter and read a different level of jargon from health care professionals
**Suspected heart failure caused by ischaemic heart disease**

- Three heterogeneous representations of the same statement
- Three different atomic information entities

**Semantic interoperability resource priorities**

- Widespread and dependable access to maintained collections of coherent and quality-assured semantic resources
  - clinical models, such as archetypes and templates
  - rules for decision making and monitoring
  - workflow logic

- which are
  - mapped to EHR interoperability standards
  - bound to well specified multi-lingual terminology value sets
  - indexed and correlated with each other via ontologies
  - referenced from modular (re-usable) care pathway components
**SemanticHealthNet concept and objectives**

- Leverage a **clinically-driven work-plan**
  - heart failure, exemplifying chronic disease management, evidence based care and shared care: focus on individuals who are patients
  - cardiovascular prevention, exemplifying public health and national/global strategies: focus on populations who are citizens
- Bring together the **globally best of breed** semantic resource producers including commitment from the top SDOs
- Draw on a **rich body of expertise** including past EU projects in the EHR, semantics, semantic interoperability, wide-scale record sharing and eHealth governance + new projects
- Maximise stakeholder engagement and resourced commitment to ensure we focus on **usable and useful and affordable solutions**
- Robust **business approach**: people, processes, products, platforms
- Develop a **scalable, sustainable, well-governed** European Virtual Organisation for semantic interoperability

---

**Multi-stakeholder communities will:**

- set priorities for the clinical content to be standardised
- collate the state of the art evidence of best practice
- clarify the extent of consensus practice
- confirm the useful and realistic level of detail of clinical information and knowledge that should be standardised, that is likely to be implementable, adoptable and usable
- purposefully combine modelling, terminology, ontology & workflow representations to produce relevant harmonised semantic resources
- evaluate them, drawing on and extending best known practice
- evaluate published standards and feed back to improve them
Semantic interoperability: key stakeholders

- Patients, patient associations
- Clinicians, professional associations, clinical specialty associations
- Healthcare provider organisations
- Healthcare payers: public health authorities, insurers
- Health ministries
- Public health organisations
- EHR system vendors, medical device vendors, ICT infrastructure vendors, Industry associations
- Pharma, research organisations
- Standards Development Organisations
- The European Commission, ONC, WHO, OECD...

For cross-border patient care, population health, comparisons, surveillance, research, products and services

Industry “soundbites”

- Slowly but steadily industry is realising the importance of semantic interoperability, although many don’t understand fully what this involves.

- Semantic Interoperability (S.I.) will ... increase the Business Intelligence capabilities and make our systems more competitive.

- Industry lacks a clear growth path and guidance on the implementation of semantic interoperability.

- As long as industry is not actively involved in engineering the solution, the whole effort is deemed to fail.

- S.I. will benefit the user much more than the vendor but in the long run it will increase competition and therefore improve the quality and competitiveness of the systems.
SHNet sustainability activities

- Work with the clinical, public health and patient stakeholders to define a formal process for the governance of semantic interoperability resources

- Design an overall infrastructure (a virtual platform and services) that can publish or reference resource “bundles” and manage their maintenance

- Specify how EHR systems, public health systems, CRO systems etc. should ensure consistent and verifiable adoption of semantic interoperability resources

- Develop a business plan for certifying semantically interoperable systems

- Liaise with industry, professional bodies, ministries, insurers, SDOs on business drivers and incentives to foster rapid adoption of semantic interoperability resources and certification of such systems

THANK YOU!

Prof. Dr. Georges J.E. De Moor

demoor@ugent.be
http://www.eurecom.org
1. Establish good practice

- Develop criteria for assessing the quality of semantic resources
- Establish projects to develop good practice in the design and validation of clinical models bound to terminologies and ontologies and guideline-based pathway models
- Ensure projects are well-grounded and practical relevance to the management of clinical conditions of national and international priority
  - e.g. chronic conditions, like heart failure
  - e.g. population health issues, like childhood obesity
- BUT: still adopting a holistic - not a piecemeal - approach
2. Scale up semantic resource development

- Develop sustainable approaches to scaling this up across disease areas and stakeholders, importantly with patients
- Showcase convincing cases: successful pilots
- Ensure wide-scale clinical engagement during the design and piloting of clinical models and terminology
- Involve other stakeholders who will create or use health data
- Address wider health system needs and support future research

3. Support translations

- Resources need to be multi-lingual to support cross border shared care, cross-border health planning and global scale research
- Specifically consider the challenges of supporting multiple levels of “clinical jargon” for different stakeholders including patients and caregivers
- Develop and validate mappings amongst the different terminology systems in use by different communities
4. Track key technologies

- Monitor the evolving capability and potential uses of natural-language technologies,
  - including the reliability of such approaches for population-level and patient-level decision making

- Similarly track technology for automatic encoding of free text or diagrammatic data entry

5. Align and harmonise standardisation efforts

- Having understood the clinical modelling that is really needed...
- conduct a gap analysis of
  - interoperability standards
  - informatics tools
  - knowledge representation formalisms
  - clinical content
- which are needed to support this scaling up, including
  - embedding such resources within EHR systems
  - providing formal recommendations to SDOs on the scope and level of detail that is needed and would be usable
6. Support education

- Invest in education that enables clinical and patient/citizen acceptance, creation and use of knowledge-rich EHRs
  - to create good quality (faithful, accurate) and re-usable information
  - to better trust and use information from external sources
  - to take better advantage of semantically interoperable systems and services

- Grow capacity in health informatics expertise including in semantic interoperability

7. Assure quality

- Support research efforts on
  - what parts of, and how much of, a health record is useful to structure/code/make interoperable: focus on benefits versus effort
  - the quality assurance of semantic resources when used together: clinical and technical validation

- Collaborate across countries on
  - common conformance criteria for systems and system components
  - practical methods for testing interoperability (e.g. for vocabularies, ontologies)
  - validating the correctness and consistent usability of solutions (including human factors)
8. Design for sustainability

- Develop and align with a business model to justify strategic investments in this field
- Understand the value propositions (ROI) for key stakeholder groups and decision makers, including
  - clinicians, patients, residents, caregivers
  - EHR system vendors
  - healthcare provider organisations
  - health authorities
  - insurers
  - academic, bio-science and pharma research
  - standards developers
- Find win-wins and relevant incentives

9. Strengthen leadership and governance

- Strong leadership within and across all relevant stakeholders will be essential to drive these actions and oversee benefits realisation
- In the longer term a governance organisation needs to be nominated
  - to support, co-ordinate and quality manage the future development of semantic interoperability resources for health
  - to develop an action plan for future research and educational investments
Policy Department A: Economic and Scientific Policy

---

**Health information flows needing semantic interoperability**

- Wellness
- Fitness
- Complementary health
- Citizens in the community
- Social care
  - Occupational health
  - School health

---

- Teaching
- Research
- Clinical trials
- Explicit consent
- Disease registries
- Screening recall systems
- Real-time knowledge-directed care
- Implicit consent
- Continuing care
  - (within the institution)
- De-identified
  - +/- consent
- Long-term shared care
  - (regional, national, global)
- Public health
- Health care management
- Clinical audit

---

Prof. Dr. G. De Moor - European Parliament eHealth Workshop
September 24, 2013
Artefacts used to represent clinical meaning

Concept representation
- Hierarchical terminology systems
- Ontology
- Post-coordinated terms
- Defined subsets of terms

EHR information models
- EHR reference models
- Clinical document registries

Use Case Driven

Clinical models
- Archetypes
- Templates
- Datasets
- Data dictionaries

Figure 5 - Overview of artefacts used to represent clinical meaning
Source: The Vision of the eHealth European Interoperability Framework (2013), Deloitte and DG Connect

An example case for investing in interoperable EHRs

- 80% of EU spending on healthcare goes on the chronically ill
- Cardiovascular diseases alone cost the EU Economy €192 billion annually and accounts for 57% of healthcare costs
  - contributes to 21% of productivity losses and 42% of deaths in the EU
- A recent study across 3 EC countries showed that home tele-monitoring pilots have delivered
  - 26% reduction in hospital days per patient
  - 10% overall cost savings through nurse remote support
  - 15% improved survival rates
Example of a Representation of a Clinical Practice Guideline
Presentation by Ms Lisa Hagberg

epSOS project
From strategies to services

Lisa Hagberg
Swedish Association of Local Authorities and Regions
Swedish Ministry of Health and Social Affairs
Background

- Large Scale Pilot funded by European Commission and participating nations (€ 40 million)
- Project start in 2008 with 12 participating nations and industry team
- Extension and expansion in 2011-2013. Currently 25 participating nations
- Pilot operation 2012-2013

Scope and Aim

- Provide concrete cross border services that ensure safe, secure and efficient medical treatment for citizens when travelling across Europe
- Focus on services close to the patient:
  - Patient summary
  - ePrescription and e-dispensation
- Build on existing national eHealth projects and use experiences and knowledge from all Member States
Main Achievements

- Services for exchange of ePrescriptions and patient summaries in cross-border setting.
- Currently six participating nations in live mode, more on the way
- Support to the EC in providing all EU MS, through the eHealth network, with a non-exhaustive list of data to be included in patient summary

Achievements

For the scope of the project, the following has been defined, agreed and implemented:

- Data sets
- Requirements for access to information
- Legal framework
- Model for semantic interoperability
- Design, implementation and tests of a practical technical solution;
- Establishment of national contact points (NCP);
- Building blocks available in Open Source
- Final prioritization of extended services.
Added value

In addition to the concrete achievements, epSOS:

- Supports overall eHealth progress and convergence in Europe
- Tests national solutions against an interoperability framework.
- Contributes to standards and profiles
- Provides practical and theoretical experience of cross-border services which has supported related processes
Pilot plans 2013

Patient summary service
- Estonia, Hungary, Luxembourg, Malta, Portugal, Slovenia, and Turkey (7)

ePrescription service
- Croatia, Denmark, Finland, Hungary, Spain and Sweden (6)

Challenges & Opportunities
use of services

- Large scale deployment necessary to generate the use of service
- Use of services necessary to motivate large scale deployment
- Catch 22 – creates a need to revise project strategies based on reality
- Political decisions are necessary
Working towards sustainability

- Focus on open source – supporting market opportunities
- Close ties and cooperation with the policy level
- Engagement with SDOs, PDOs, industry and other stakeholders
- Exploiting the potential provided by the epSOS network in defining good practices and reusability
What to expect in the future

- Continued interest in participation from new countries
- epSOS services integrated in national infrastructure - services here to stay
- Work continues based on epSOS. For example, Nordic ministerial eHealth cooperation continues to build on project results
- Ongoing political, strategic and practical discussions within the EU and its members to enable sustainability of project achievements
Presentation by Mr Hartmut Schaper

Today, the European healthcare industry is facing conflicting pressures

- Increasing healthcare costs unsustainable
- Consolidation in all parts of the value chain (payers, pharma, providers)
- Worldwide financial crisis
- Aging population and increasing patient’s health awareness
- Govt. mandated health infrastructure and safety standards
- Ongoing innovations enabling breakthrough diagnostic and therapeutic advances for patients
- Increasing amount of data and knowledge enabling better decisions – if it can be accessed and interpreted in the right way
e-Health can be a key lever to address these challenges

1. Right Living
   - Targeted disease prevention
   - Data-enabled adherence programs

2. Right Care
   - Alignment around proven pathways
   - Coordinated care across providers

3. Right Provider
   - Giving care in the right care setting
   - Reducing re-admission rates

4. Right Value
   - Payment innovation and alignment
   - Provider performance transparency

5. Right Innovation
   - Accelerating discovery in R&D
   - Improving clinical trial operations

Enabled by e-Health

The exploding amount of patient-related data offers the chance to continually improve care

- Making data from different sources available across departmental and sectorial borders in a secure way needs to be the base infrastructure

- Generating and accessing knowledge out of this data becomes even more important – for single patients (personalized medicine) as well as for whole populations (care management)

- Efficient collaboration beats isolated optimizations – already practiced today in oncology (e.g. tumor boards) but should and can be extended based on the right infrastructure and knowledge
The patient needs must be the center of all critical trade-offs

Optimal patient care
Maximum of information about patient improves quality of care

Data privacy
Minimum of information about patient protects privacy

EU-wide framework for standards should define boundary conditions
- The patient should have options to choose the right amount of data generation and access within a protective enough framework
- Providers should have options to choose the optimal implementation (e.g., managed services, cooperation with other care providers) within a flexible enough framework

New technologies will continue to optimize care ... in the right regulatory framework

Big data and advanced analytics

Mobility and augmented reality

Remote monitoring and telehealth

Cloud computing
Siemens e-Health approach

Siemens portfolio covers all major e-Health topics based on the patient's needs
In Germany, Siemens’ e-Health solutions enable a paperless hospital through innovative IT

Hamburg-Eppendorf University Hospital (UKE), Germany

UKE: no paper in use any more:
- Provides a consistent workflow-supporting Electronic Patient Record (EPR) and integrates individual departmental requirements
- First European hospital that achieved Stage 7 EMRAM* award by HIMSS** Analytics Europe in 2011
- Digital patient data can easily be exchanged with other healthcare providers such as ambulatory practices or medical insurances

"With Soarian we have a solid basis for future challenges".
Dr. Peter Gocke, former Head of information technology at the University Hospital Hamburg-Eppendorf

In Denmark, Siemens’ e-Health solution enables digital data access across various platforms

Hospitals of the Midjylandt region, Denmark

A region connects and exchanges data:
- Enables authorized parties to access health data and images digitally across various care providers and platforms
- Region-wide data exchange and connection with national image index
- Reports and images made available securely and reliably via a central multimedia archive
- Huge benefits for both, patients and doctors

"With the new solution Denmark has exceeded the international standards and principles in health IT. For the region it means that we have created a platform for further new projects and continue the path for standardization."
 Lars Simesen, IT architect of the Region Midjylandt, Denmark
In Austria, Siemens’ e-Health solution enables digital data access across various providers

Wiener Krankenanstaltenverbund (Vienna, Austria), one of Europe’s biggest health care provider hospital groups chooses Siemens to implement “ELGA”. Easy and save access to all relevant data of a patient for all health providers involved:

- Innovative technological infrastructure enables ELGA and IHE compliant exchange of data
- Fast exchange of patient data means better care for patients
- No duplicate treatments mean less cost for the healthcare system

ELGA is an information system based on a government initiative driven by the federal states that bundles existing patient reports no matter where in Austria they were created.

In Sweden, Siemens’ e-Health solution helps make the patient safer and the doctor’s work more efficient

Gävle hospital, Gävleborg, Sweden

Remote monitoring can save lives:

- Provides a consistent workflow-supporting Electronic Patient Record (EPR) together with remotely controllable pacemaker™.
- Delivers efficient patient care despite long distances and few hospitals independent of the patients location
- Delivers quick information about the status of the patient such as vital signs for authorized personnel.
- Saves time for patients and physicians
- Patients feel safe and supported

“Combining Scarian with remotely controllable pacemakers means a safer and easier life for the patient, and a more efficient healthcare system.”

Dr. Per-Erik Gustafsson, Cardiologist, Gävle hospital, Gävleborg, Sweden
The digital hospital remains an essential building block towards seamless care delivery and shared knowledge, and is a response to the patient’s empowerment.

Smart e-Health solutions will further empower the development of approaches in personalized medicine. The EU should continue to highlight the broader meaning of e-Health in this regard.

Siemens is prepared to engage in the implementation process of clinical information systems and to further develop and improve the e-Health solutions of the future.

Many e-Health concepts are developed and available: It is finally time to implement them together – involving care providers, industry and policy makers.

It is time to further strengthen European e-Health policy as driver for “innovation made in Europe”.

Need for joint implementation of available e-Health concepts
Predictions are difficult, especially about the future…
(Nils Bohr)

“It is less important to predict the future than to be prepared for the future.”
Perikles (~495-429 BC)

Thank you for your attention

Hartmut Schaper
SVP Health Services International
Siemens AG Healthcare Sector
Customer Solutions Division
Hartmannstraße 16
91502 Erlangen, Germany
Phone: +49 (9131) 84 8817
Mobile: +49 (173) 5385921
E-mail: hartmut.schaper@siemens.com
Presentation by Ms Nicola Bedlington

PATIENTS’ TRUST AND UNDERSTANDING OF EHEALTH

Based on EPF work with our membership
Nicola Bedlington
EPF Executive Director

24 September 2013
European Parliament

“A STRONG PATIENTS’ VOICE TO DRIVE BETTER HEALTH IN EUROPE”

Background

EPF and eHealth

• Membership organisation – 61 umbrella patients’ organisations
• VISION All EU patients exercise their rights to access high quality, equitable healthcare that is designed and delivered to meet their needs and preferences.
• eHealth – key priority for EPF in recent years
  – ‘Chain of Trust’, Renewing Health, Sustains, Smartcare
  – eHealth Governance Initiative, eHealth Stakeholder Group, High Level Task Force on eHealth
  – On – going policy imperative

“A STRONG PATIENTS’ VOICE TO DRIVE BETTER HEALTH IN EUROPE”
Objectives

1. Knowledge gathering

To improve available knowledge of the specific views - needs, perceptions on the added value and concerns - among patients and health professionals with regard to telehealth services.

2. Raising awareness and understanding

To increase awareness and understanding of users' perspective on telehealth amongst patients' and health professionals' organisations and health authorities at European and Member State level.

MAIN ISSUES REGARDING USERS’ TRUST AND ACCEPTANCE

The human dimension

‘Telehealth has been mainly driven by technology rather than by the needs of people’

- Trust plays more than ever a key role in patient-health professional relations
- Patients perceive a risk of ‘impersonality’ and of neglect of ‘psychological factors’

Capacity of Users

- Patients fear the burden of responsibility and lack of skills - telehealth services need to integrate eHealth literacy skills
- Self-confidence has to be supported with training and user-friendly applications
MAIN ISSUES REGARDING USERS’ TRUST AND ACCEPTANCE II

- Telehealth as a complement/added value to and not as a replacement of conventional services
- Access and health inequalities: telehealth should fill the gap and not exacerbate inequalities
- Decisions on whether to adopt telehealth will depend to a great extent to its perceived effects on patient safety
- Organisational aspects: change in routine, workload and lack of support from management are barriers for health professionals’ buy in.
- Privacy and confidentiality issues

“A STRONG PATIENTS’ VOICE TO DRIVE BETTER HEALTH IN EUROPE”

MAIN BENEFITS FROM THE USERS’ PERSPECTIVE I

- Improved quality of care through more personalised, continuous, efficient and responsive services
- Improved access to healthcare for:
  - patients living in underserved areas
  - socio-economically disadvantaged patients
- Improved patients’ adherence through more active involvement of patients and more regular monitoring from health professionals

“A STRONG PATIENTS’ VOICE TO DRIVE BETTER HEALTH IN EUROPE”
Benefits specific to patients

- Patient empowerment – telehealth improves knowledge of the condition, and facilitate involvement in the care process in partnership with health professionals.
- Quality of life – e.g. increased self-confidence, better awareness of symptoms or improved independence
- Economic benefits: e.g. from e.g. less travel and days off work

MAIN KEY DRIVERS FOR USERS’ ACCEPTANCE

- Telehealth-user-centric as opposed to technology-driven.
- Telehealth should not affect negatively the patient–health professional relationship, increase mutual trust;
- Telehealth needs to deliver real benefits and add value to users in relation to solely conventional healthcare;
- at least the same safety and reliability standard as conventional health services;
- Self-confidence and competence in using telehealth services and mutual confidence between users, are crucial and should not be underestimated
Presentation by Mr Sascha Marschang

**eHealth - A tool for tackling Health Inequalities in Europe?**

ENVI Committee Workshop on eHealth
Part 5 – The voice of patients and consumers
24 September 2013, European Parliament

Sascha Marschang
Policy Coordinator for Health Systems
European Public Health Alliance (EPHA)

OVERVIEW

**Discussion points**

- EPHA: membership, mission, vision / values
- eHealth activities
- Position on eHAP
- Health Inequalities
- mHealth - example to illustrate key issues
- Recommendations
WHO ARE WE?

The European Public Health Alliance (EPHA)....

- is a Brussels-based network representing the public health community throughout Europe
- comprises +/- 90 member organisations based in EU-28 and EFTA, EU applicant and candidate countries & beyond
- Members include disease-specific organisations (e.g. cancer, diabetes, cardiovascular, respiratory, HIV/AIDS, mental health), health professionals (e.g. nurses, doctors, pharmacists), regional interests, academic groupings, vulnerable groups (e.g. Roma, migrants, older people) & many more
- Advocates for more citizen involvement and transparency in political decision-making processes on health policy at EU level

WHO ARE OUR MEMBERS?

Organisations
- HAI Health Action International
- AGE Platform Europe

Voluntary groups
- TIA

European Level
- AGE Platform Europe
- HAI Health Action International

Associations
- Royal College of Physicians
- CANCER RESEARCH UK

National Level
- EHRN European Roma Rights Centre

Regional Level
WHO ARE WE?

EPHA...

- Is a "change agent". EPHA’s mission is to bring together the public health community to provide thought leadership and facilitate change; to build public health capacity to deliver equitable solutions to European public health challenges, to improve health and reduce health inequalities.
- “Our vision is of a Europe with universal good health and well-being, where all have access to a sustainable and high quality health system: A Europe whose policies and practices contribute to health, both within and beyond its borders.
- Overarching values: equity, sustainability, diversity, solidarity, universality, good governance.

EPHA eHealth activities

- Members of eHealth Stakeholder Group led by DG CONNECT (issue leader on Health Inequalities)
- EPHA Briefing on eHealth (2011)
- EPHA Position on 2012-2020 eHAP
- EPHA Briefing on mHealth (Sep 2013)
- Articles on eHealth / Digital Agenda for Europe / ICT diffusion
- Focus: impacts on patients, health professionals, vulnerable groups in EU
- Efficiency gains vs. high investments in technology: public health implications?
- Need for stratified health services: EU older, more diverse & complex!
EPHA POSITION
2012-2020 eHAP

‘To achieve the proposed goals and limit some of the causes for the above-mentioned health inequalities, digital literacy must be enhanced in the wider framework of health literacy so that users are well informed not only about why and how to use eHealth solutions, but also about proactive health prevention and the consequences of using technology erroneously or not at all. Pressing a wrong button should not mean increased responsibility for patients thereby leading to mental health problems and uncertainty related to interacting with machines instead of human beings. The safety dimension is especially important also because of the negative effects of conflicting messages, unsavoury advertising, etc. on both vulnerable adults and children.’

EPHA POSITION
2012-2020 eHAP

‘(…) For every successful technology there is one that fails, whether due to lack of accessibility, poor operability or failure to integrate with other technologies. Given these caveats, it is important that the design of eHealth solutions is developed in collaboration with - and for the benefit of - their users.

Therefore EPHA strongly suggests that the (…) objectives of the eHAP must keep in mind technology’s reliability, added value and usability, trust and acceptability for end users first and foremost.’
eHealth
Prerequisites

- Common scope & ambition across EU: what is included, what are the goals?
- Equal access & infrastructure
- Unambiguous legal framework (e.g. ‘loopholes’ between eHealth, medical devices and other health tools)
- Removal of legal & technical implementation obstacles (e.g. cost, interoperability, data protection, identification/authentication, confidentiality, consent...)
- Transferable best practices between MS
- Innovation takes many forms – low-tech solutions can be more inclusive for some end users
- Need impact assessments/data on health outcomes to avoid competition with traditional HS investments
- Emphasise eHealth’s complementarity
- Partnership approach to ensure that needs of vulnerable groups are taken into account (e.g. EIP on AHA)
- Solidarity: health is a human right not (only) a consumer good!

Health Inequalities
Activities

Inclusion off- and online

- Consultation response re: EU action to reduce health inequalities (2009)
- EPHA Briefing on Health Inequalities (2010)
- EPHA European Charter for Health Equity launched 2010 (signed by over 250 individuals and organisations)
- Institute of Health Equity consultation re: role of health professionals (2012)
- Collaboration with European Patients’ Forum
- Roma health fellowship pilot programme & capacity building events
- Healthcare access (e.g. austerity impacts, economic governance, access to medicines, European Platform against Poverty & Social Exclusion...)
- EHSG subgroup on Health Inequalities
- Identifying best practices at EU, national, regional & local level (e.g. eHealth strategies, eInclusion initiatives by civil society and industry)
- Ensuring that health inequalities are not exacerbated online!
mHealth

Advantages

- Accessing health content ‘on the go’: better integration into routines?
- Tailored (public) health messages for vulnerable groups, e.g. by SMS
- Bringing the Internet & social media to non-traditional ICT users
- Direct contact health professionals & patients, incl. most vulnerable
- Real-time monitoring of chronic conditions & location, allowing better follow-up for patients unable to travel
- Encouraging self-control and ‘competitive health behaviour’
- Smartphones: user-friendly interface, easy to navigate, pictorials, video-content, voice-generated commands, camera, GPS, gaming, etc.: making health interactive, engaging & fun (?)
- Work-related tools and apps: supporting health professionals at bedside (e.g. taking notes more easily, recording, photographs, etc.)
mHealth
Concerns

- High market fragmentation and driven by commercial interests
- Lack of regulation and standards for ‘apps’ & unclear scope
- Difficult distinction between ‘good’ and ‘bad’ health information: trusted sources vs. unknown authors
- Incorrect data & use of gadgets, differences in accuracy and capability (sound, vibrations, light, etc.)
- Cannot replace face-to-face contact and professional advice: risk of compromised patient safety (e.g., incorrect decision-making, self-harm)
- Marketing & advertising of unhealthy behaviours to children, vulnerable groups
- Danger of producing additional workload and ‘eHealth bureaucracy’ for health professionals if no time allocation for ICT tasks

eHealth literacy

**eHealth literacy** is complex and involves a number of different **literacies** that require cognitive and behavioural competences applied at the same time:
- basic literacy (e.g., reading, writing, speaking, numeracy)
- digital literacy (using and navigating ICT tools and Internet)
- media literacy
- health literacy (being able to find, understand, contextualise, appraise and act upon health information)
- (…)

How meaningful is online health information to non-traditional ICT users? How can it become more relevant and inclusive?
EPHA supports eHealth solutions that...

- play a clear role as part of overall health system policies
- improve health system efficiency and patient safety via new forms of collaboration between & amongst health professionals and patients
- facilitate health professionals’ tasks by freeing up time for patient contact
- offer meaningful, ‘tailored’ content to meet the needs of disease-specific patients and their families, as well as non-traditional ICT users
- involve end users in the design and policy-making process for ‘real life’ input
- increase quality and continuity of care, e.g. interdisciplinary healthcare teams in primary and hospital settings allowing active participation of all health pros.

- offer patient-centred care, incl. possibilities for ‘co-managing’ health by patient-consumers
- increase health awareness (and self-responsibility?) thanks to improved health literacy
- empower individuals by stimulating prevention and health promotion
- ‘include everyone’, especially individuals unable to access quality healthcare services offline due to geographic isolation, health professional shortages, irregular residence status, poverty / homelessness, physical / mental disability…
- acknowledge that everybody is different: provision of stratified health services off- and online, respecting individual ICT competences, needs and preferences
Thank you for your attention.

Sascha Marschang  
Policy Coordinator for Health Systems  
European Public Health Alliance (EPHA)

Rue de Trèves 49 – 51, 2nd floor  
BE - 1040 Brussels  
+32 (0) 2 233 3883  
s.marschang@epha.org  
www.epha.org
Presentation by Dr Konstanty Radziwiłł

**eHealth**

New challenges for professionals

Dr Konstanty Radziwiłł
Immediate Past President
Chair of the eHealth working group

Standing Committee of European Doctors – CPME

ENVI Workshop - European Parliament, Brussels
24 September 2013

Standing Committee of European Doctors – CPME

- Founded in 1959, CPME has been promoting for more than half a century the highest standards of medical training and medical practice in order to achieve the highest quality of healthcare for all patients in Europe.

- We are committed to contributing the medical profession’s point of view to EU and European policy-making through pro-active cooperation on a wide range of health and healthcare related issues.

- We are concerned with the promotion of public health, the relationship between patients and physicians and the free movement of physicians within the European Union.
CPME activities in the field of eHealth

- eHealth WG meets twice a year + webmeetings
- Participation in the eHealth Governance initiative (eHGI) + eHealth Stakeholders Group (eHSG)
- Analysis and opinion on the General Data Protection Regulation
- Participation in the “Chain of Trust” project on assessment of the perspective of the main end users of telehealth services across the EU
- Participation in the “Momentum” project on advancing telemedicine adoption in Europe
- Analysis and opinion on eHealth Action Plan (2012-2020)

Benefits

- Better access to care and information for the patients
- Better quality of care (readability, accuracy, comparability, transportability of the data)
- Support for epidemiology and public health
- Better working conditions for health workers
- Better efficiency of the health care systems
Conditions (1)

- A patient-centered and patients/doctors driven approach
- Education of the patients and training of the personnel are essential
- European/national guidelines for legal certainty
- A must of more research confirming value (effectiveness and safety)
- A need for reimbursement schemes

Conditions (2)

- Interoperability of the systems (incl. trans-border)
- Dictionaries/language friendly to medicine (reflecting true medicine)
- Data value and protection
- Public support for introduction of e-Health and of R&D in this area
Thank you for your attention!

Dr Konstanty Radziwill
Immediate Past President
Chair of the eHealth working group

Standing Committee of European Doctors
Rue Guimard 15, 1040 – Brussels, Belgium
Tel: +32 2 732 72 02
constance.colin@cpme.eu
www.cpme.eu
Policy Department A
Economic and Scientific Policy

Role
Policy departments are research units that provide specialised advice to committees, inter-parliamentary delegations and other parliamentary bodies.

Policy Areas
- Economic and Monetary Affairs
- Employment and Social Affairs
- Environment, Public Health and Food Safety
- Industry, Research and Energy
- Internal Market and Consumer Protection

Documents