



HIT Policy Committee Implementation, Usability & Safety Workgroup Final Transcript September 22, 2014

Presentation

Operator

All lines bridged with the public.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Thank you. Good afternoon everyone this is Michelle Consolazio with the Office of the National Coordinator. This is a meeting of the Health IT Policy Committee's Health IT Implementation, Usability and Safety Workgroup. This is the first meeting of this new Workgroup.

This will be a public call and there will be time for public comment at the end of the call. As a reminder, please state your name before speaking as this meeting is being transcribed and recorded. I'll now take roll. David Bates?

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women's Hospital & Partners

Here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, David. Larry Wolf?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Larry. Alisa Ray?

Alisa Ray, MHSA - Executive Director & Chief Executive Officer - Certification Counsel for Health Information Technology

I'm here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hello. Bennett Lauber?

Alisa Ray, MHSA - Executive Director & Chief Executive Officer - Certification Counsel for Health Information Technology

I'm here.

Bennett Lauber, MA – Chief Experience Officer – The Usability People, LLC

Hello, here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Bernadette Capili?

Bernadette Capili, DNSc, NP-C, MS – Assistant Professor, Associate Director, Division of Special Studies in Symptom Management – New York University

Here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Bernadette.

Bernadette Capili, DNSc, NP-C, MS – Assistant Professor, Associate Director, Division of Special Studies in Symptom Management – New York University

Hi.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

George Hernandez?

George Hernandez – Chief of Applications and Development - ICLOPS

Here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, George. Janey Barnes?

Janey Barnes, PhD – Principal & Human Factors Specialist – User-View, Inc.

Here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Janey. Jeanie Scott? Joan Ash?

Joan Ash, PhD, MLS, MS, MBA, FACMI – Professor & Vice Chair, Department of Medical Informatics & Clinical Epidemiology – School of Medicine – Oregon Health & Science University

I'm here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Joan. John Berneike? Jon White?

P. Jonathan White, MD – Director, Health IT – Agency for Healthcare Research & Quality (AHRQ)

Hello.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Jon. Lana Lowry?

Lana Lowry, PhD – Project Lead Usability and Human Factors for Health Information Technology – National Institute of Standards & Technology

I'm here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Lana. Megan Sawchuk?

Megan E. Sawchuk, MT (ASCP) – Lead Health Scientist, Center for Surveillance Epidemiology & Laboratory Services – Centers for Disease Control and Prevention

Here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Megan. Michelle Dougherty?

Michelle L. Dougherty, MA, RHIA, CHP – Director of Research & Development – AHIMA Foundation

Here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Michelle. Michael Lardieri?

Michael Lardieri, LCSW, MSW – Assistant Vice President Strategic Program Development – North Shore-LIJ Health System

Yeah, here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Mike. Paul Egerman?

Paul Egerman – Businessman/Software Entrepreneur

Here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Paul. Robert Jarrin?

Robert Jarrin, JD – Senior Director, Government Affairs – Qualcomm Incorporated

Here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Robert. Steven Stack? Steven might be muted. Tejal Gandhi? And Terry Fairbanks?

Rollin (Terry) Fairbanks, MD, MS – Director, Emergency Room Physician, Associate Professor of Emergency Medicine - National Center for Human Factors in Healthcare, MedStar Health Washington Hospital Center, Georgetown University

Here.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Terry. And is Ellen Makar on from ONC?

Ellen V. Makar, MSN, RN-BC, CPHIMS, CCM, CENP – Senior Policy Advisor, Office of Consumer eHealth – Office of the National Coordinator for Health Information Technology

Yes, I am.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, Ellen.

Ellen V. Makar, MSN, RN-BC, CPHIMS, CCM, CENP – Senior Policy Advisor, Office of Consumer eHealth – Office of the National Coordinator for Health Information Technology

Hi.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Are there any other ONC staff members on the line? Okay, with that I'll turn it to you David and Larry.

John A. Berneike, MD – Clinical Director & Family Physician, St. Mark's Family Medicine - Utah HealthCare Institute

Sorry, John Berneike, I just joined.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Hi, John, thank you.

Alisa Ray, MHSA - Executive Director & Chief Executive Officer - Certification Counsel for Health Information Technology

Alisa Ray is here I'm not sure if you got me?

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

I heard you, thank you.

Alisa Ray, MHSA - Executive Director & Chief Executive Officer - Certification Counsel for Health Information Technology

Okay, thanks.

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women’s Hospital & Partners

Great, so, I’m David Bates. What we’re going to do today is first we’ll go through some introductions. I’m the Chief of General Medicine at Brigham and Women’s Hospital and the Chief Quality Officer here, and the Medical Director of Clinical and Quality Analysis at Partner’s Information Systems. I’m a General Internist and sit on the HIT Policy Committee. Larry, do you want to introduce yourself?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Sure, so I’m at Kindred as a Health IT Strategist there. I’ve been involved with ONC Policy Committee work in various ways over the last few years. I’m currently a member of the JASON Task Force. I previously was Co-Chair of the Certification, Adoption and Workforce Workgroup. I’m happy to see that we’ve been able to keep some of the people from that Workgroup to continue on this one, so looking forward to some continuity as well as a lot of new people and some new perspectives. I think those are the highlights for me.

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women’s Hospital & Partners

Great and what I’d like to do next is just to go around the Workgroup so that we can get to know each other at least a little bit virtually. Joan could you introduce yourself?

Joan Ash, PhD, MLS, MS, MBA, FACMI – Professor & Vice Chair, Department of Medical Informatics & Clinical Epidemiology – School of Medicine – Oregon Health & Science University

Yes, hi, I’m Joan Ash I’m at Oregon Health and Science University and I was on the Adoption Certification Workgroup. My research focuses on the implementation of EHRs and EHR safety.

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women’s Hospital & Partners

Great and if everybody, as we go along, could underscore kind of what their expertise is that would be great in one of these three areas because everybody has expertise in one or more of the areas. Janey?

Janey Barnes, PhD – Principal & Human Factors Specialist – User-View, Inc.

Hi there my name is Janey Barnes and I’m a Human Factors Specialist and Principal at User-View and we do human factors consulting with EHR vendors, hospitals and doctor’s offices.

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women’s Hospital & Partners

Great. John?

P. Jonathan White, MD – Director, Health IT – Agency for Healthcare Research & Quality (AHRQ)

And by Jon do you mean Jon White?

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women’s Hospital & Partners

Sorry, John Berneike, I’m going alphabetically. John are you on...

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Do you mean John Berneike?

John A. Berneike, MD – Clinical Director & Family Physician, St. Mark’s Family Medicine - Utah HealthCare Institute

Oops, I’m sorry, I had it on mute, sorry. Yeah, John Berneike St. Mark’s Family Medicine in Salt Lake City. I come from an IT background before having a midlife crisis and going to med school, and with that dual background I’ve been quite involved in Health IT here locally. I’m on the board of our statewide HIE in Utah operated by UHIN. I’ve been working quite a bit with our local REC on a number of different HIT type projects and obviously the physician champion here in our clinic.

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women’s Hospital & Partners

Great. Bernadette?

Bernadette Capili, DNSc, NP-C, MS – Assistant Professor, Associate Director, Division of Special Studies in Symptom Management – New York University

Yeah, hi, I’m Bernadette Capili from New York University, my first time being a member of a Workgroup. I am a Symptom Management Outcomes Researcher and Clinical Trialist which is my area of focus and chronic illness.

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women’s Hospital & Partners

Super. Michelle?

Michelle L. Dougherty, MA, RHIA, CHP – Director of Research & Development – AHIMA Foundation

Hi, this is Michelle Dougherty I’m the Senior Director of Research and Development at the American Health Information Management Association Foundation. I was previously a member of the Sub-Workgroup on Workforce and have expertise in the implementation and usability areas.

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women’s Hospital & Partners

Great. Paul?

Paul Egerman – Businessman/Software Entrepreneur

Hi, I’m Paul Egerman, I suppose you could call me an old-timer, I’m the author of one of the very first electronic health records back in 1971 at Mass General Hospital and I’ve started two Healthcare IT companies one was IDX and the other one was eScription. So, I have a huge amount of experience over a large number of years with implementations of systems and also designing Healthcare IT systems and I’m also on the Board of Boston Medical Center where I Chair the Patient Safety and Quality Committee or Chair of that Committee.

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women’s Hospital & Partners

Great. Terry?

Rollin (Terry) Fairbanks, MD, MS – Director, Emergency Room Physician, Associate Professor of Emergency Medicine - National Center for Human Factors in Healthcare, MedStar Health Washington Hospital Center, Georgetown University

My name is Terry Fairbanks I'm with Georgetown University in MedStar Health, I'm the Director of the National Center for Human Factors in Healthcare and I'm an Emergency Physician and a Human Factors Engineer and my group does applied research in Health IT implementation and usability.

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women's Hospital & Partners

Great. Tejal have you joined? Okay, George?

George Hernandez – Chief of Applications and Development - ICLOPS

Hi, I'm George Hernandez with ICLOPS. I'm a Chemical Engineer by background but I switched over to IT. ICLOPS does clinical quality measures so we have done PQRS since, what was it 2008, we collect data from all sorts of hospitals and physicians and stuff like that then we report to CMS.

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women's Hospital & Partners

Great. Jarrin?

Robert Jarrin, JD – Senior Director, Government Affairs – Qualcomm Incorporated

Hi guys, Robert Jarrin Senior Director of Government Affairs. I participated in the FDASIA External Stakeholders Working Group this past year and I also presently serve on the Federal Communications Commission's Consumer Advisory Committee. I'm a lawyer by training and my area of expertise is wireless and mobile healthcare products and services including their implementation and use. Thanks.

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women's Hospital & Partners

Mike?

Michael Lardieri, LCSW, MSW – Assistant Vice President Strategic Program Development – North Shore-LIJ Health System

Yeah, hi, I'm Michael Lardieri and currently I'm AVP of Strategic Program Development at the North Shore-LIJ Health System. Before that I was Vice President for HIT and the Strategic Development at the National Council for Behavioral Health. I focus on the behavioral health sector integration of physical and behavioral health care and do a lot of consulting with behavioral health around usability and implementation, and was also part of the Subgroup on Certification.

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women's Hospital & Partners

Great. Bennett?

Bennett Lauber, MA – Chief Experience Officer – The Usability People, LLC

Hi, I'm Bennett Lauber, I'm the Chief Experience Officer of the Usability People. This is the first time that I'm taking part in a Workgroup such as this. I've had about a 25 year career working in the software human factors world and maybe the past five or so years working in the usability of electronic health record systems.

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women's Hospital & Partners

Great. Alisa?

Alisa Ray, MHSA - Executive Director & Chief Executive Officer - Certification Counsel for Health Information Technology

Hi, I'm Alisa Ray and I'm CCHIT's Executive Director and have been in that role since 2005. We've worked with ONC since that time both in developing and operating certification programs with the goal of accelerating adoption of EHRs. In that work we've worked closely with the provider community as well as the vendor community to really understand or continue to try to understand sort of the boundaries between what certification can help with in assuring a successful adoption and what it can't do so I'm looking forward to that discussion.

We've also done some early work, preliminary work in piloting some usability programs and actually back in 2009/2010 probably had about 70 different products that participated in that so have had some experience in that area too. Thanks.

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women's Hospital & Partners

Great. Lana, let's see, no Steven?

Steven J. Stack, MD – Chairman - American Medical Association

Steven Stack?

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women's Hospital & Partners

Yeah, Steven Stack, sorry.

Steven J. Stack, MD – Chairman - American Medical Association

Hi, thank you very much. So, Steven Stack I'm an Emergency Physician who practices in Lexington, Kentucky. I'm the President Elect of the American Medical Association, the Secretary of eHealth Initiative and I think this is around my seventh iteration on a Workgroup or Task Force with ONC. And I would describe my focus as blending a practicing physician's perspective with the kind of broad-based national input...physicians as a professional first, so thank you for the opportunity.

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women's Hospital & Partners

Lana?

Lana Lowry, PhD – Project Lead Usability and Human Factors for Health Information Technology – National Institute of Standards & Technology

Hi, yes, this is Lana Lowry with the National Institute of Standards and Technology and I have been the Project Lead for the Health IT Usability for the past four years and we have ongoing research and development on the technical guidance for the metrics and measurements of the usability as well as establishing usability and safety framework, and the mission of the program is to lead the industry in the best practices and to ensure the objective metrics of the certification criteria. And again, thank you so much for allowing me to join the group.

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women’s Hospital & Partners

Megan?

Megan E. Sawchuk, MT (ASCP) – Lead Health Scientist, Center for Surveillance Epidemiology & Laboratory Services – Centers for Disease Control and Prevention

Hi, this is Megan Sawchuk with the Centers for Disease Control and Prevention in the Center for Surveillance Epidemiology and Laboratory Services. My background is a Medical Technologist by Degree and I Lead what we call the Laboratory Health Information Technology Team here at CDC and our team has a long-standing experience with contributing to numerous Workgroups and partnering with ONC and CMS on developing policies, standards and certification to support Health IT and implementation of Meaningful Use.

And this year our primary interest in this Workgroup is safety and usability. We released a report to engage clinical lab professionals that profiles three patient cases with unintended consequences or near misses that’s of interest to the field. Thank you.

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women’s Hospital & Partners

Great. Janey? I didn’t hear Janey earlier. Jon White?

P. Jonathan White, MD – Director, Health IT – Agency for Healthcare Research & Quality (AHRQ)

Hey, this is Jon White I’m a family physician by training and a public servant by avocation. Before joining the federal government I was proto-CMIO at a healthcare system in Pennsylvania and I am at the Agency for Healthcare Research and Quality where I just celebrated a decade not too long ago. I am the Director of the Division of Health IT at AHRQ.

One of my first jobs here was to be David Bates Project Officer on a grant and over those 10 years, which spans the 10 years of all of our National Coordinators at this point, we’ve funded several hundred research demonstration, evaluation, infrastructure projects, worked very closely with our colleagues at ONC and CMS, and several other federal partners several which have focused on implementation, usability and safety.

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women’s Hospital & Partners

Great. Ellen?

Ellen V. Makar, MSN, RN-BC, CPHIMS, CCM, CENP – Senior Policy Advisor, Office of Consumer eHealth – Office of the National Coordinator for Health Information Technology

Me, Ellen Makar?

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women’s Hospital & Partners

Yeah, Ellen Makar, yeah.

Ellen V. Makar, MSN, RN-BC, CPHIMS, CCM, CENP – Senior Policy Advisor, Office of Clinical Quality and Safety – Office of the National Coordinator for Health Information Technology

Yeah, I’m the Staff Lead for ONC on this Workgroup many of you I’ve spoken to as we’ve gotten the Workgroup together. I’m an RN and I’ve worked in Health IT most of my career. My last job was at Yale-New Haven Hospital where I was the Director of Nursing and Critical Transformation as we input our Epic records. And now I’m with the Office of the National Coordinator in the Office of Clinical Quality and Safety.

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women’s Hospital & Partners

Great. Michelle, do you want to introduce yourself?

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Sure, thanks, David. This is Michelle Consolazio, I’m what’s called the DFO, the Designated Federal Officio for all of our FACAs so we have both the HIT Policy Committee and the Health IT Standards Committee, and I work with all of the Workgroups underneath the two committees and just make sure that we’re all in the right place at the right time, and some other stuff too.

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women’s Hospital & Partners

Great. And anybody else on from ONC?

Tejal K. Gandhi, MD, MPH, CPPS – President – National Patient Safety Foundation

David, this is Tejal.

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women’s Hospital & Partners

Oh, hi, Tejal.

Tejal K. Gandhi, MD, MPH, CPPS – President – National Patient Safety Foundation

So, hi, everyone, this is Tejal Gandhi, I am the President of the National Patient Safety Foundation currently. I started my career doing patient safety research particularly around using IT to improve safety at Brigham and Women’s which is where I was based and then I became Director of Patient Safety at Brigham and Women’s and then Chief Quality and Safety Officer at Partner’s Healthcare, and then about a year ago transitioned to NPSF, so glad to be with the group. Thank you.

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women’s Hospital & Partners

Great and anybody else who joined since we started? Could we go back a couple of slides on the...great, so we’ve gone through introductions we’re going to talk about our three areas of focus. As you can see we have people who have a broad range of experience with respect to implementation, usability, safety both from the theoretical and practical perspectives. We will go through our work plan today and then there will be time for public comment.

And before...I’ll actually go through some of the stuff about the work plan before we discuss what the backdrop is and the three areas of focus, but there will be lots of time for discussion today. Could we go to the next slide?

So, this slide shows how we sort of fit into the broader framework. There are six Workgroups under the Policy Committee, there is one on HIT Strategy and Innovation, there is another on Advanced Health Models and Meaningful Use, then yet another on Interoperability and Health Information Exchange, another on Privacy and Security, and then the last one focuses on the Consumer Perspective and Consumer Engagement. Next slide.

Within this Workgroup we expect you to be actively engaged, we’ll be looking that the membership on a quarterly basis to make sure that people are participating actively, people who miss more than five meetings will be removed from membership unless you have some sort of extenuating circumstances, if you do no worries just let us know.

Differing opinions are welcome and they’re encouraged but we just want everybody to be respectful. Participants should try to be prompt and we want you to try and minimize personal interruptions during the calls so just mute your phone if you do need to do something else.

We will try also to be respectful to you in that we’ll try and have all meeting materials ready at least 24 hours in advance of Workgroup meetings sometimes people have been frustrated when they haven’t had time to review materials. And we want you to try and review the materials in advance of the meeting and then be actively engaged in our discussions. Next slide. And then go to the next one.

So, our charge is to provide input and to make recommendations on policy issues and opportunities for improving how Health IT is designed, certified, implemented and used to minimize safety risks and deliver its data to support improvements in patient care and health outcomes.

And we’ve been asked to consider existing work including the IOM Report on Health IT and Patient Safety, the FDASIA Report on Health IT Safety, I Chaired the FSASIA Subgroup and got to know some of you through that work, the National Quality Strategy and the ONC Safety Plan.

And an important charge of this group is to be reflective of the summary of experience in the field so far and to create a forum for public discourse and learning. Some of the issues that we’re expected to consider are included but this doesn’t...we’re not limited to these, include lessons from some of the implementation experiences so far, transparency on usability and safety, improvements to the certification program, safety reporting and then analysis of aggregate data for lessons learned.

I will just stop here, Larry, things to add about our charge?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Speaking of keeping mute on when I'm off-line. So, I think that you've summarized it really well David. The focus here really is on usability and safety. We recognize implementation is a really key piece of that. During our planning calls we looked sort of broadly at what our charge might be given the history of some of the Workgroups that have come together on this and this sense here of really focusing in this area felt like that was the right thing to do at this time.

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women's Hospital & Partners

Great, so questions from the group about the charge? Okay, so let's keep going, next slide. So, you know, for us to be most effective we have to be thinking about how we fit into the broader picture of the FACA milestones and there are a number of other groups that are meeting, the JASON Task Force has been meeting over the summer, there is an Interoperability Governance Subgroup, then there will be some joint recommendations from the JASON and the Governance Groups.

A key milestone for us is that the Federal HIT Strategic Plan will be posted for comment in December and the FACA final Interoperability Roadmap Regs will be available in roughly December. We'll have an opportunity to comment on the Strategic Plan as will everyone else and the Interoperability Roadmap will also be posted for comments.

Larry, do you want to just say a word or two about what the JASON Group is doing because everyone may not know about that and you're serving on that group?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Sure, so the background on JASON is that they have a long history as being advisors to the federal government, they're based at MITRE. The specific identity of the JASON members is obscure on purpose to, I guess encourage free dialog among the JASON participants and then to produce some kind of integrated report out.

In this case they were asked by HHS and I guess all the way up to the White House to comment on where we should be going with Health IT and how to move the ball forward and where there ways we could be accelerating it, and they produced a report that was based on data collected mostly in 2012 and 2013 and then released this past spring although it was pretty much written up a year ago.

So, the Task Force was put together to review what was in the report and make some recommendations. We're focusing on the issues around architecture and APIs, the sense of having an open API what we're calling an orchestrated architecture so that there is more of a framework to help people move forward on improved interoperability and access to data.

We're looking for some creative solutions to the...sort of the dual dilemma of we don't want to push standards before they're ready but on the other hand we want to accelerate adoption. So, looking at what is out there in the marketplace that we could leverage and the FHIR standard coming out of HL7, while it may not be specifically endorsed by the Task Force, is getting a lot of attention as the example of the kind of APIs that we're talking about.

So, we'll see where we come down in terms of actually recommending a specific API or set of APIs here. And again, the focus really of the Task Force is how to address this issue of providing improved access to data for consumers, for healthcare providers and for research.

So, there is some intersection with the activities of this Workgroup. There is an implied safety consideration that the fewer interfaces we need to hop through the better interoperability you can get the safer the interaction between the two systems is going to be and the less opportunity for confusion. So, clearly that's a piece that is, if you will, the underlying assumption about why good interoperability is important.

And we haven't specifically addressed usability although there is definitely a sense that given open APIs there would be a lot more development of Apps and that there is likely to be then more options for how people then interact with the electronic data.

And finally, I'm open for input from any of the Workgroup members, it's really not part of our agenda for today to go deep into JASON but I'm happy to sort of take some questions and get back to people off-line.

Paul Egerman – Businessman/Software Entrepreneur

Larry, this is Paul, I'm just confused on the schedule. When do you expect the Task Force to complete its work, it shows it being kicked off in June, but what's the duration and what's the final outcome, it is a recommendation?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Yeah, so...

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Larry, I can speak to that if you'd like?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Okay, sure.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Do you want to speak to it?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Speak to it.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

So, Paul, the plan...we've already had the JASON Task Force present draft recommendations at the last Policy and Standards Committee meetings. They're planning to have a final report out at the October meeting which is actually a joint meeting between the Policy Committee and the Standards Committee.

We're also planning to have Governance recommendations from the Subgroup under the Policy Committee at the joint October meeting. At that October meeting we will then charge the new Interoperability and HIE Workgroup with taking the recommendations from JASON and Governance and informing the Interoperability Roadmap that at least is prior to the publication of the Interoperability Roadmap to the Federal Register. We're planning for it to hopefully be published around January and then once it's published to the Federal Register we'll open it up to many different Workgroups to provide comment on the Interoperability Roadmap.

Paul Egerman – Businessman/Software Entrepreneur

Thank you, that's helpful, so as I understand it then, at that October meeting basically the JASON Task Force will be disbanded, it will have completed its work.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Correct.

Paul Egerman – Businessman/Software Entrepreneur

And all of that work will shift into, sort of on the screen, shift down into the various appropriate Workgroups predominately the Interoperability Workgroup?

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Yes.

Paul Egerman – Businessman/Software Entrepreneur

Okay, thank you.

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women's Hospital & Partners

Okay, next slide. So, I'm going to go through our work plan and the meeting schedule but, you know, this is open to change and, you know, we can decide what things we think are the most important, what we want to hear about, what we want to work on. This is our kickoff meeting, in just a little bit I'll go through some of the evidence so that we can just sort of level set, begin to think about some of the things that we want to talk about.

What we are currently planning to do is to hear some about some of the current state around safety and usability in the next couple of meetings, and then to focus in the November to December timeframe around users concerns and vendors experiences with usability testing around that time and through the next period we want to make sure that we go through some of the usability tools which have been developed by SHARP-C that's some work that was funded by ONC.

We want to make sure that we're ready to comment on the Federal HIT Strategic Plan which will be released sometime in the period shown here, we don't know exactly when it will be. We felt like it would be useful to at some point talk about the state of implementation science especially as it relates to implementation of HIT systems.

And then in the new year start talking about post implementation usability and safety, risk management shared responsibility and then we have to plan to be ready to comment on the MU3 and/or the certification NPRM which would be early in the new year. So, that's kind of a very high level summary of what we're thinking about doing. Larry, anything you want to add there?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, the only thing I want to add is if you were concerned, the members of the Workgroup, were concerned about the flood of documents that came out today many of those were historic documents to give you background on some of the work that prior Workgroups have done and they're meant to be generally informative we're not going to be reviewing them in detail but they might be useful background.

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women's Hospital & Partners

Oh, exactly, I meant to mention that I just forgot, thank you. Okay, next slide. So, in terms of the meetings this is the schedule, today we're planning to go through our charge talk a little bit about history, begin to think about some preliminary goals and deliverables.

In the next meeting we'll have some more discussion about goals and deliverables, also have a presentation of studies, we're hopeful that we'll be able to reach consensus about what our goals and deliverables will be in the following meeting.

On November 7th we'll have more discussion, we'll be getting ready for the Policy Committee presentation. On November 25th there will be a draft strawman which will be presented to the Policy Committee and some discussion about the 2014 certification and usability summative testing.

Then in December we'll be able to review the Policy Committee discussion, update our documents based on the feedback that we get and then on the 12th do a report out on the safety center and realign our timeline and goals. So, that's again a very high level overview, again, we might change what we do at some of those based on our discussion and what we think is important and so on, but that's the general game plan. Okay, next slide.

So, we'll come back and spend some more time on that as we just open things for discussion, but next I just want to take us through a little bit of backdrop. It's clear that implementations are done variably and part of the reason that this has gotten so much attention is some of the worst issues relating to safety with HIT have been associated with poor implementation.

There have been a number of studies that have been done to suggest best practices, Joan Ash is on this group and has done many of those, Ross Koppel has also done work in this area. The SAFER guidelines have been developed, that work was led by Dean Sittig, but these best practices are not necessarily used in the field today. Next slide.

One study that really galvanized a lot of interest and attention in this area was a study that was published by Han in the Journal of Pediatrics in 2005, they studied children who were transported in for special care, these were children who were coming in often in helicopters or sometimes in ambulances and what that group found was that the mortality rate went up from 2.8 to 6.3% for kids who were transported in, the odds ratio there was 3.3, after the introduction of a commercial computer order entry application.

Now that study design was before/after and there were many other changes that were made at the same time as computer order entry was implemented. The authors did not report the overall mortality rate in their unit or in the institution. Next slide.

But when you examined how computer order entry was implemented there were a number of things that stood out and computer order entry was introduced very rapidly over a six day period. After implementation order entry was not allowed until the patient had actually physically entered the hospital and had been logged into the system when the prior practice was to have a number of orders written while the child was in the helicopter on the way in so that everything would be ready when they got there but that couldn't be done after this implementation.

In addition, all the drugs including some of the vaso-active drugs were moved to the central pharmacy which was physically a long way away from their intensive care unit. The pharmacy was not allowed to process medication orders until after they were activated. They also made the call not to implement many order sets and that may or may not seem important but it turns out that when you computerize ordering it's much faster to write orders if you write them using order sets and it's much slower to write them one at a time and the net result from all of this was substantial delays in care delivery. Next slide.

So, this study was weak methodologically but obviously this was a big increase in the mortality rate and the delays may have caused this. And the organization broke a lot of their rules for implementation. A conclusion about this was that it's essential for other organizations to handle sociotechnical aspects of implementation better and Joan Ash's work again has focused a lot on sociotechnical aspects. Next slide.

I want to note that a couple of other groups also studied this issue after this and they studied exactly the same vendor's computer order entry system and they found that the mortality rate actually went down both for all children and for those who were transported in and the same was true at Montefiore suggesting that really probably what the biggest factor here was how the system was implemented. Next slide.

Clearly implementations involve lots of issues besides safety they can have short and long-term effects on efficiency and want to focus on things with respect to implementation that go beyond safety. Implementation though has not been directly addressed by Meaningful Use so the intent is for us to explore this area and to discuss what might be done from the policy perspective to improve implementations nationally. Next slide.

Usability is also clearly an important issue and the usability of HIT software is quite variable. There have been a lot of complaints from the broad community about the usability of HIT software. There is evidence, for example, that decision support works better if you follow human factors principle, for example, in one study that our group did users were 4.75 times as likely to accept an alert when the display was high quality. This affects both safety and efficiency. Next slide.

Usability can now be reliably assessed, it is often divided into several areas semantics can be equated to terms like ease of use or user friendliness, features here usability is sometimes equated to the presence or absence of certain features in the user interface or operations when the term is defined in terms of performance and effective levels manifest by users for certain tasks and environmental scenarios. And we have a number of experts on our group in human factors, this is something that we just have not leveraged as well as we should. Next slide.

Again, usability has not been directly addressed so far by Meaningful Use, it's been hard to access independent comparisons of vendor systems according to how useable they are and our intent is that this group will need to delve into the issues involved here, understand some of the current situations and then make some suggestions about what strategies ONC might pursue to improve the situation. Again, there has been some other work done in this area already and we should make sure we try and leverage that. Next slide.

From the safety perspective the literature suggests that HIT clearly appears to improve safety overall, there are a number of studies that support the benefits but there are also many anecdotes and studies suggesting that Health IT creates new risk.

And the magnitude of harm and the impact of HIT on patient safety is uncertain in part because of the heterogeneous nature of healthcare IT because we have very diverse clinical environments and workflows and the evidence and the literature is still limited.

The FDA has the authority to regulate HIT but it has not done so except in limited ways and its authority is limited to HIT so far that meets the definition of a medical device. Next slide.

But here are a few examples of some of the problems associated with HIT. In one study that was done a flight simulator across 63 hospital electronic records detected only 53% of fatal medication orders. There is a clear problem in many institutions of providers writing electronic orders on the wrong patient because they don't recognize what record they're in at a given time.

There are other examples like a sensor being attached to an asthma rescue inhaler which records the location where the rescue medication is used but not the time and then when the information is uploaded to a computer at the time of the upload, sorry the time of the upload but not the time that the patient actually used the medication is recorded.

There are a number of examples nationally in which the decision support in part of a clinical system stops working because of some minor coding change or an upgrade but then no one notices that it's not working for six months and that represents a risk.

And finally, when even serious safety related issues with software occur there has not been a single central national place to report them to and they don't get aggregated at the national level. Next slide.

So, some of the things that we could contribute would include recommendations about changes in the certification process. We could also make suggestions about changes around Meaningful Use.

We could make recommendations to ONC to address gaps in other ways, for example through dissemination of best practices, that's something that ONC is able to do.

And we could also address some of our recommendations to the HIT Safety Center which is not yet established but hopefully it soon will be. Next slide.

So, to wrap up and then I'm just going to open things up for discussion. Clearly implementation, usability and safety are interrelated. If you have implementation issues that can cause safety problems, if your usability is poor implementation will be harder and so on.

We need to figure out what contributions we can make in each area that will be most useful to ONC at this point given the levers that it has and clearly there are opportunities for improvement in each of these three areas and hopefully we'll come up with some ideas and recommendations that will be able to make things better in these areas. So, let me stop there, if we could go back to the work plan slide. And Larry thoughts or comments?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, that was a pretty good overview rapid fire summary David of a lot of the topics so thank you for taking us through that. I don't have anything particular to add other than I think you're closing comments about in some ways it's the intersection of these three things I think is going to be the most powerful area for us to focus on because that will give us, you know, the most synergy and connectivity among these issues.

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women's Hospital & Partners

Great, so, let me just open things up and people should feel free to, you know, make comments or suggestions or offer their thoughts.

Joan Ash, PhD, MLS, MS, MBA, FACMI – Professor & Vice Chair, Department of Medical Informatics & Clinical Epidemiology – School of Medicine – Oregon Health & Science University

David, this is Joan, I had one question.

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women's Hospital & Partners

Sure?

Joan Ash, PhD, MLS, MS, MBA, FACMI – Professor & Vice Chair, Department of Medical Informatics & Clinical Epidemiology – School of Medicine – Oregon Health & Science University

You mentioned an HIT Safety Center could you tell us more about that and what the timing might be and how our timing might intersect with that timing?

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women's Hospital & Partners

Sure, you know, and Ellen or Michelle you might know more about the timing, do you want to say something about that?

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Ellen, can you speak to that?

Ellen V. Makar, MSN, RN-BC, CPHIMS, CCM, CENP – Senior Policy Advisor, Office of Clinical Quality & Safety – Office of the National Coordinator for Health Information Technology

Yeah, we're...right now there is a task order out that will be awarded by the end of this month so imminently the 30th is when it should be awarded and then that contract is going to be for planning the Safety Center. So, I would think that they would spend a year in planning and making recommendations and then we would look to at least 2016/2017 for it start to become operational.

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women’s Hospital & Partners

Great.

Joan Ash, PhD, MLS, MS, MBA, FACMI – Professor & Vice Chair, Department of Medical Informatics & Clinical Epidemiology – School of Medicine – Oregon Health & Science University

Thank you.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, it’s Larry, I think that the Safety Center came out of the FDASIA Report is that right? That was part of their response to that?

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women’s Hospital & Partners

It was, yeah.

Ellen V. Makar, MSN, RN-BC, CPHIMS, CCM, CENP – Senior Policy Advisor, Office of Clinical Quality & Safety – Office of the National Coordinator for Health Information Technology

It was one of their recommendations, yes.

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women’s Hospital & Partners

And actually the Workgroup that I Chaired before this one was a group that focused on what the Safety Center might do. So, there is a publically available set of recommendations around, you know, how it might be organized and what it might do and that’s an input to the group that will get this task order.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

This is Michelle, I just want to note that the final recommendations from the Safety Task Force that David just mentioned were actually distributed with the materials, the background materials for today’s meeting.

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women’s Hospital & Partners

Great, thanks. So, other questions or thoughts, I’ll start asking questions if no one comes to...

Paul Egerman – Businessman/Software Entrepreneur

David, this is Paul, a simple question I have is as I look at this work plan are we giving recommendations to the Policy Committee at the end of each one of these topics or are we sort of waiting until the end to do it as a package? I mean, how are we going to approach this?

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women’s Hospital & Partners

No, so we...it will probably be...it will be staged so we’ll do it...we’ll provide recommendations along the way and we have to basically do it in a way that kind of fits with the rest of the federal process so that our recommendations, you know, have a chance of having some impact. But, you know, our thought was that each of these areas is pretty big and we could spend a lot of time on each of them.

Paul Egerman – Businessman/Software Entrepreneur

And when we make recommendations what part of the process are we trying to impact because somehow I'm under the thought, maybe I've got it wrong, that Stage 3 is sort of like it's too late to make recommendations on Stage 3 so is that correct or is that not correct?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Well...

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

This is Michelle, so I think one of the biggest impact areas that this group will be able to have is to respond to NRPMs once they are released. So, whether it be MU3 or the certification NPRM there could be different areas that this group could respond to with comment.

Paul Egerman – Businessman/Software Entrepreneur

But we wouldn't be able to impact the NPRM before it's issued because that's already underway is my sense, is that correct?

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Correct. But these are public calls and people can still listen.

Rollin (Terry) Fairbanks, MD, MS – Director, Emergency Room Physician, Associate Professor of Emergency Medicine – National Center for Human Factors in Healthcare, MedStar Health Washington Hospital Center, Georgetown University

This is Terry Fairbanks, I'm going to make a comment about the usability part and when it was presented there was a real focus on the user interface design piece the straightforward UI and as many of you know our group did a visit to 11 vendors to learn about their user center design process as part of ONC's SHARP-C Program and what we found is that some were good at that basic user center design but the second piece of usability that's often left out is understanding what functionality to support and often that impacted the usability in the end and so I think it's important that when we talk about usability we consider both categories.

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women's Hospital & Partners

Great and Terry could you just repeat what category two was?

Rollin (Terry) Fairbanks, MD, MS – Director, Emergency Room Physician, Associate Professor of Emergency Medicine – National Center for Human Factors in Healthcare, MedStar Health Washington Hospital Center, Georgetown University

Yeah, category two is the function, the support of functionality and the cognitive support of the end-users and its particularly important because it takes a lot of resources and work to really understand it, and it's so context specific that it is often hard for one vendor to be good at in all domains, so what a nurse in a GI suite needs from a functionality stand-point may be very different from what an ER doctor needs or even the GI physician and these have to do with what commands can be done at what time, what kind of decision support is available and what data can be visualized at what time so the right data comes in the right form at the right time. So, it's a whole different form of usability which many of the vendors are starting to get better at but many are still even more behind than they are in the basic user interface design usability.

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women’s Hospital & Partners

Okay, maybe let’s stay with usability for a little bit and if we could get people to weigh in on what things are the biggest gaps in terms of usability from their perspective. Janey, do you have thoughts about that?

Janey Barnes, PhD – Principal & Human Factors Specialist – User-View, Inc.

Sure, I mean, I think...did you say Janey?

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women’s Hospital & Partners

Yeah.

Janey Barnes, PhD – Principal & Human Factors Specialist – User-View, Inc.

So, this is Janey Barnes I’m going to speak up anyway, sorry. Yeah, so our company was involved with...I think we’re up to about 14 or 15 summative tests for different vendors as part of their Meaningful Use Program and like Terry just described some are very usability mature and some are very usability immature and one of the things that I want to be sure that the Workgroup does is take advantage of the data that’s out there in the reports mainly because while a lot of the reports are subpar there are good reports and good data out there to show out of the prioritized criteria right now that some of those lend themselves to more serious errors than other errors.

And just like what Terry was...when he was pointing out the cognitive support even if you just go to how clinical decision support was treated for Meaningful Use testing it treated all clinical decision support the same way, so clinical decision support that interrupted the workflow was treated the same as clinical decision support that didn’t interrupt the workflow and just in the way that those two presentations happened it has not only has efficiency impact but it also has safety impact and so I’m looking forward just to working with the group to take advantage of what we’ve learned from the first rounds of testing with the safety enhanced design work.

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women’s Hospital & Partners

Great.

Lana Lowry, PhD – Project Lead Usability and Human Factors for Health Information Technology – National Institute of Standards & Technology

This is Lana Lowry; can I just please add a couple of sentences to the discussion. I heard the statement let us focus on usability and I cannot agree more but I just want to make it very clear that usability is a broad term and it does include this objective and objective aspects of usability. And it has been the focus of NIST research, it tells us that it is the usability that directly impacts safety because not everything can be as critical at the same time.

So, my recommendation would be to focus our effort on those aspects of usability that directly impacts safety and probably to define those aspects, same thing as the Meaningful Use right now has certification for safety, eight safety related forms, it just is something that I would like to comment on.

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women’s Hospital & Partners

Thank you. Bennett do you have thoughts?

Bennett Lauber, MA – Chief Experience Officer – The Usability People, LLC

I was on mute, did I get myself off of mute?

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women’s Hospital & Partners

You did.

Bennett Lauber, MA – Chief Experience Officer – The Usability People, LLC

Hello?

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women’s Hospital & Partners

Yes.

Bennett Lauber, MA – Chief Experience Officer – The Usability People, LLC

Okay, yeah, I will second exactly what Janey said we’ve worked with quite a number of EHR vendors and there is a broad range of experience and knowledge about the user center design process. Some of the vendors that we’ve worked with, the summative usability test that we’ve performed for them was probably the first time that they’ve ever done anything in regards to the usability.

So, I would really like to be able to address that issue and maybe in the best practices recommendation to maybe recommend some more formative testing in order to...and the summative test not being the very, very first time we’ve done any usability evaluation.

Janey Barnes, PhD – Principal & Human Factors Specialist – User-View, Inc.

So, this is Janey, just one comment off of that, because everybody who is certified, you know, clearly they had to attest that they were doing user center design and so what we found is people were doing activities that could be used to provide evidence that they were bringing users in early and often, that they were getting input from end-users and that they understood the end-users task things like that are required for user center design process.

What was the differentiator was if they were doing methods that were effective from a human factors and usability background or if there were doing what was effective from a software development process that didn’t have user center design and so like to Bennett’s point to say do more formative activities I think that, you know, what we were trying to do is to educate vendors about where was the biggest bang for their buck and really moving them away from focus group kind of customer calls to task-based formative testing and I think that there is still a lot of education to be done there.

And then just one point with what Lana was saying is there is no doubt when it comes to the regulatory process that safety is an area where regulation has to make the biggest impact, but one of the things that I want...that I see is that, yes safety is important and the most important.

Most of the physicians that we do work with when we are actively working with, you know, an implementation or when we're working at the provider level is again it's more about the efficiency and the lack of efficiency of the EHRs and so either there has to be better education that regulation really is focused on safety and safety enhanced design and not usability or we need to start doing some more things to impact to improve efficiency along with shining the light on the safety problems.

Paul Egerman – Businessman/Software Entrepreneur

And this is Paul Egerman, can I make a comment David?

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women's Hospital & Partners

Sure.

Paul Egerman – Businessman/Software Entrepreneur

So, I'm listening to all this and one comment I have is I think we can do, we can improve the job that we do if we narrow our focus and make it clear what we're focusing on because as I saw the slides earlier there was a slide that said...talked about usability in HIT. And if I look at HIT I say "well that's kind of broad." I mean that includes like a radiologist at a PAC station, that includes some very specialized things...it could include an inventory employee, it could include lot of different things that are part of HIT and other people as they been talking have been talking about EHR, which is narrower than HIT but still pretty broad, and then there are the issues about what Meaningful Use is addressing which is even narrower than EHR.

And my feeling is, to whatever extent we can like define our scope and hopefully narrow our scope I think we might be able to make a lot more progress because the issues that are faced by say a primary care provider during an office visit interacting with a system are very different than issues faced by a radiologist interacting with a PACS machine.

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women's Hospital & Partners

Good point Paul.

Megan E. Sawchuk, MT (ASCP) – Lead Health Scientist, Center for Surveillance Epidemiology & Laboratory Services – Centers for Disease Control and Prevention

This is Megan, can I make a comment?

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women's Hospital & Partners

Sure.

Megan E. Sawchuk, MT (ASCP) – Lead Health Scientist, Center for Surveillance Epidemiology & Laboratory Services – Centers for Disease Control and Prevention

Thank you. So, I wanted to thank Terry for bringing up earlier the work that he had done on some of those panels and the report because one of the background piece of information that came in our e-mail today is a draft summary from a hearing on July 23rd on usability and implementation, and I thought it was most interesting and what really caught my eye in that report were there were comments from participants that the end-user and we're all saying the end-user needs to be considered but that the end-user themselves is not always the best...does not always have the best insight into what will work as far as their workflow or maximizing their work setting.

So, David, when you asked about what gaps we might have I'm just thinking that we might need to look at the development process to make sure it includes those observations early on but that the experts, which are probably going to be people like human factors engineers or usability experts be included in that process because right now I think the business model hasn't focused on that.

So, I think we may have to look at what can we do as far as levers in the policy, standards certification process to promote and encourage engagement of those experts within the existing business models.

George Hernandez – Chief of Applications and Development – ICLOPS

This is George Hernandez, may I make a comment?

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women's Hospital & Partners

Please?

George Hernandez – Chief of Applications and Development – ICLOPS

I'm personally from an IT side but I've noticed a phenomenon where people who are engaging in the system if they come from a clinical side they're not focused on IT and they're focused on their workflow.

I've found that there is more success... there is a phrase in politics that all politics is local so every person has...every department, oncology department here an oncology department there they've got different workflows and they do things differently.

So you have greater success as far as implementation, usability and safety if you start off with what they're used to and then gradually, okay, well the experts, the usability people they say, okay, you know, we've got...we can tweak it here and improve the flow but if you have an EHR and you try to implement the oncology that the vendor's EHR oncology system in different places out of the box it doesn't work because every place wants to tweak it to their own thing.

So, I personally feel that if you start with what the user is familiar with they will accept the system more readily and then you make gradual changes to what are considered best practices but otherwise...I mean, this is why you have gaps where you've got gaps in the data where there are near misses, you know, this prescription was lethal, because if they're working with a system and it's unfamiliar, uncomfortable to them it's...right away you've got a psychological barrier against it and it slows things down.

So, in my experience it has been to just, okay, listen to what the user wants do that first and then gradually tweak it to best practices.

John A. Berneike, MD – Clinical Director & Family Physician, St. Mark’s Family Medicine – Utah HealthCare Institute

John Berneike; I agree generally with those previous comments but, you know, I would, you know, compare healthcare to the airline industry which, you know, is a frequent comparison and, you know, the preflight check list for instance and things like that, you know, preflight check lists are not a local issue they’re done the same way nationally or probably even worldwide and I agree that, you know, making major changes to get everybody to do the same thing is, you know, going to be major shock for some and doing it gradually incrementally would certainly be wise.

I, in general, don’t think that allowing every clinic, every physician, every hospital to customize their own workflow is an appropriate goal. I think there should be, you know, best practices that are adopted nationwide.

Janey Barnes, PhD – Principal & Human Factors Specialist – User-View, Inc.

This is Janey...

Rollin (Terry) Fairbanks, MD, MS – Director, Emergency Room Physician, Associate Professor of Emergency Medicine – National Center for Human Factors in Healthcare, MedStar Health Washington Hospital Center, Georgetown University

Yeah, this is Terry Fairbanks I just want to really agree with John’s statement and I think we’re also seeing a lot of hazards and errors, and adverse events on implementation because at the local level there is not a lot of expertise and people are trying to do it all over again what others have figured out by trial and error.

So, while I think that the local implementation is important the standardization as much as possible is going to help us do it in a wiser way overall.

Paul Egerman – Businessman/Software Entrepreneur

Yeah and this is...

Tejal K. Gandhi, MD, MPH, CPPS – President – National Patient Safety Foundation

This is Tejal, I totally agree with that. I think one of the tensions is going to be efficiency versus safety because I think, you know, often the frontline providers tend to be more focused on the efficiency aspect than safety so I think that’s going to be something we’re going to have to think about.

But then I also agree that there needs to be both some standardization and also, as Terry pointed out, there are some best practices out there and yet I think we’re constantly reinventing the wheel on a lot of these things and so how do we think about, and this is David I guess to the HIT Safety Center conversation, how do we really learn from those best practices and make sure they’re spread so that it’s not everybody at the local level constantly reinventing.

Paul Egerman – Businessman/Software Entrepreneur

And this is Paul, Paul Egerman, my comment is this is a good discussion but the fact of the matter is there are very large variations from one site to another and how they operate and also what terminology is used. And in my experience those variations frequently can cause implementation challenges and also challenges in usability.

And I can think of a specific example where, you know, we had a site that was using software that had been used in a large number of places of before but one particular site was totally confused by a single word, the signal word was “clinic” but in their context the word “clinic” was used very differently than it was used pretty much the rest of the country. And so this was something that they were like tripping over and having a lot of trouble and it took a while for people to figure out why it was that there was a misunderstanding.

And I use that as an example to simply say the reality is that we’re trying to standardize on lots of things and standardize and usability but there is so much variation in health, healthcare has trapped us in terminology and in workflows that creates a huge challenge for implementations and a huge challenge for usability.

Joan Ash, PhD, MLS, MS, MBA, FACMI – Professor & Vice Chair, Department of Medical Informatics & Clinical Epidemiology – School of Medicine – Oregon Health & Science University

So, this is Joan and I really agree because no matter what the vendor supplies it could be the safest system in the world some customization always seems to be necessary, you know, depending on even the location or where the implementation is taking place and state laws and all.

So, given that some customization is always necessary the best practices and the dissemination of them at that site is just as important as anything having to do with certification of the vendor product to start with.

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women’s Hospital & Partners

Great, other thoughts or comments?

Janey Barnes, PhD – Principal & Human Factors Specialist – User-View, Inc.

So, just a comment, so there is...like when you get...whenever we get into this discussion about customization versus standardization that there are so many issues that are out there in the systems that we’ve seen and that we’ve, you know, did the testing for and others that we haven’t done the testing for, that even if you just go back to some very basic safety issues and we always try to point back to a standard source and that’s the NIST EUP document that has the heuristic at the end of it and that in the heuristic they call out areas of the user interface that are known already to cause problems in terms of safety issues and this would be things like “don’t truncate the names of medications and don’t truncate the names of...or don’t truncate doses” and things like that.

And so whenever the argument or the discussion comes up about standardization versus customization that certainly, you know, the arguments that Paul and Joan put forward that there are going to be valid places to have customization but things are so bad that even if you just go back to really are there people still truncating the names of medications and the doses of medications that are being ordered, yes it is, so there are plenty of places to go back and get to the standardization where we are saying, are we really having to talk about these very basic things.

I know in a lot of the testing that we did those were two big areas where when we would come back from testing and be talking about the results with the client we had already gone through and said “look you can’t have these truncated” even before we started testing. During the testing people would confirm that’s the way it is at their actual site and then you have finger pointing “well that’s not our fault.” Then the sites kind of customize it and then we would say to the software vendor or to the EHR vendor “well, you need to make it so that they cannot truncate” and then it would be like “oh, we have to provide fields that are, you know, 50 characters long” and the answer is “yes if you want to prevent them from making the error.”

So, the point is that there is places for customization but there are still lots and lots of primary areas for standardization that will make sweeping improvements and we need to focus on those areas where we can actually start doing standardizations to improve safety and in fact deficiencies.

Paul Egerman – Businessman/Software Entrepreneur

And this is Paul, those are good comments. The one thing I’m thinking though is we need to also be aware that some, perhaps some, of the complaints about usability is really resistance to standardization.

Rollin (Terry) Fairbanks, MD, MS – Director, Emergency Room Physician, Associate Professor of Emergency Medicine – National Center for Human Factors in Healthcare, MedStar Health Washington Hospital Center, Georgetown University

This is Terry Fairbanks, I would actually take a different perspective on that, I think from our experience it’s standardization...I think we need to be clear that when we’re talking about standardization we’re not talking about designing a rigid user interface that can only be used in one way. There is always a customization component to it, but I think we all know that there is a lot of customization that goes on which is really reinventing the wheel.

So, I think that it needs to be a blend with a lot of standardization that’s involved that allows some flexibility in customization and I agree with the piece that the resistance is because the system isn’t working to support the person’s work at the end.

And I’ll make one other comment about the standardization versus customization comment is Bob Wears and his group did some work where they looked at several emergency departments around the country in the transition from whiteboards to electronic systems and found that even in disparate different types of emergency departments the physicians were using different symbols on their whiteboards but it all had to represent the same function and if they looked at it as an artifact that was developed by the end-users to support their work nobody developed it for them it speaks to the fact that the functionality...there is a discrete group of functions that certain groups of end-users need and that’s the type of thing that I think we need to focus on standardizing better.

And I wonder if we could...one thing that might be useful is to direct the conversation towards...in fact, I think David said in the beginning, where can we have the most impact and as we talk about this usability discussion how can we funnel it into something that will have impact and is it to effect the future Meaningful Use iterations?

I guess I’d look from advice from our committee leadership about or Workgroup leadership about how we can focus this good conversation into something that could have impact.

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women’s Hospital & Partners

Right, well, I think as Paul noted earlier the...you know it’s probably a little late to have an impact on MU3. We can make our recommendations around the NPRM but, you know, we can also make recommendations about changes in certification.

We can make recommendations to address some gaps in other ways and we can also make some recommendations which would be addressable to the HIT Safety Center which is not going to be set up for a bit. But those are some of the main ways that I think we can make a difference and Larry do you want to add anything?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Yeah, so I think we heard, you know, two themes here, a lot of the discussion is focused specifically around safety issues and there also was some discussion around usability and I know that usability certainly on the physician ambulatory EHRs is getting an awful lot of recognition these days and in some ways feels like it’s an essential area to address but in a focused way because if there is not sufficient usability to get adoption then all the rest of it kind of falls away.

So, I sort of feel like there is a piece around the implementation that does need to be addressed and also a piece around safety and in both areas I think I’d look to see where we have any evidence of specific pain points, specific kinds of problems that are the highest issue that ought to be focused on, because even within either of those areas things could very quickly get very defocused.

Robert Jarrin, JD – Senior Director, Government Affairs – Qualcomm Incorporated

Larry, this is Robert Jarrin, Qualcomm, I’m glad that you brought the adoption issue because I think something that we all tend to gloss over unfortunately is what aspects of usability really deal with the patient as opposed to the aspects of usability that we deal with healthcare providers and systems, and systems integrators, etcetera, etcetera, very different usability.

In my world, the mobile world, you know, I tend to think immediately about the stuff that, you know, patients and consumers are in contact with, they being the end-user not necessarily a doctor or clinician, etcetera, etcetera.

And, you know, one thing that we were involved in or I was involved in a little while ago was a technical expert panel on patient generated health data and one of the things that we had discussed was how patient updated medication information or for example home monitoring of blood pressure or blood glucometer readings, etcetera, could be perceived by the patient as being really beneficial yet when they got to, you know, the healthcare facility or whatever backend system they were using that stuff may not even be looked at and it would really actually be quite irrelevant unfortunately.

So, I think that we really need to factor in, you know, who our end target is. Are we just going to focus on the clinicians, on the systems, etcetera or are we going to focus all the way down to, you know, the patient. So, I’m glad that you brought up adoption because when I always think of adoption I think of the people who are going to be using it.

And another question/comment, David, I think you outlined four areas that our recommendations could really focus on which included a certification process, MU, best practices and the Health IT Safety Center. Well, as you just said MU maybe a little late, you know, I'm concerned that the Health IT Safety Center may not receive the funding that congress still has to provide in order for it to move forward and I hear rumblings that, you know, on the house in particular they're going to be proposing legislation specific to this area that may impact the future of the Safety Center so I'm not sure what that will be.

So, I think that, you know, given that then we're looking at certification processes and best practices that are probably our greater goals. Just my two cents, thanks for asking.

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women's Hospital & Partners

No, thank you it's certainly uncertain as to what will happen with the Safety Center. Great, so, you know, I've heard a lot of things, you know, that we clearly need to focus on both parts of usability not just the front end but also support of the functionality and cognitive function of end-users which tends to be relatively neglected.

That we think about considering narrowing our focus perhaps to the EHR, perhaps particularly to focus on safety. I'm personally a little reluctant to narrow our focus too much just because I see usability as such an important issue and I would really like to see it get better and if we focus just for example on safety there are a lot of things that could be made better by usability that don't have much to do with safety, but at the same point I recognize the wisdom of Paul's suggestion in that if the more you focus the more you can make useful recommendations.

And then another thing is that we need to clearly point to some of the existing documents and best practices like the NIST EUP which I think is going to be an important resource.

Michael Lardieri, LCSW, MSW – Assistant Vice President Strategic Program Development – North Shore-LIJ Health System

Could we have that sent around, the NIST EUP?

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women's Hospital & Partners

I'm pretty sure we could do that.

Michael Lardieri, LCSW, MSW – Assistant Vice President Strategic Program Development – North Shore-LIJ Health System

Thanks.

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women's Hospital & Partners

Lana, could we do that? Is that something we could organize? I'm sure it is.

Michael Lardieri, LCSW, MSW – Assistant Vice President Strategic Program Development – North Shore-LIJ Health System

Great.

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women’s Hospital & Partners

Maybe we could just shift our focus a little bit and talk about what contributions we might make in the implementation area. So, thoughts about that?

Michael Lardieri, LCSW, MSW – Assistant Vice President Strategic Program Development – North Shore-LIJ Health System

Well, this is Mike Lardieri, I think this document from NIST will be very important, if we’ve already identified areas that we know that have a heavy impact just on safety, I’m not saying we shouldn’t look at other areas, but to identify that and get that out to all the folks who are implementing, because every time I’ve been in implementation the organization wants to customize and the vendor will do whatever you want but if we can point to folks and let them know that “hey, don’t do this because it’s not good” you know, hopefully we could stop some folks from even asking for some changes that we know will have not a good impact.

And getting some of this information out to the regional extension centers if they’re still going to be involved with helping organizations I think that would be important as well.

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women’s Hospital & Partners

Great. Joan, maybe I could call on you because you obviously have done a lot of...a great deal of work in this area?

Joan Ash, PhD, MLS, MS, MBA, FACMI – Professor & Vice Chair, Department of Medical Informatics & Clinical Epidemiology – School of Medicine – Oregon Health & Science University

Well, I’ve just been thinking about the whole focus aspect and we went through a lot of this when we were figuring out for the SAFER guides what our foci should be and we deliberately focused on the EHR rather than HIT in general so that we weren’t considering things like barcode medication administration.

We also were focusing pretty much on the provider end of things rather than the consumers just because that seemed to be something fairly different and we only had two years to work on it. So, those were our two foci basically EHRs and the providers and that helped us a great deal I think.

And you know another focus we could look at...and I’m just throwing this out, if we do want specifically to look at safety we went through a process in developing the SAFER guides of prioritizing with the help of experts and many, many different methodologies what the top eight pain points are, the most dangerous EHR safety risks and so eight of our guides are focused on those areas and we might want to revisit those eight areas as part of the exercise we’re doing now.

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women’s Hospital & Partners

It sounds like that would be helpful.

Michael Lardieri, LCSW, MSW – Assistant Vice President Strategic Program Development – North Shore-LIJ Health System

Yeah and this is Mike Lardieri again, I think we need to expand I think a step beyond EHRs and certainly around health information exchange or, you know, since care coordination is going to be such a focus, and should be a focus, a lot of the health information exchanges are providing that middleware, but we want to make sure that if somebody does something right on the EHR side then when it gets up to the middleware they don't start truncating things at that level. So, it would need to stay consistent across providers and across patients, because if you're sharing their information through the health information exchange that would be important as well.

Rollin (Terry) Fairbanks, MD, MS – Director, Emergency Room Physician, Associate Professor of Emergency Medicine – National Center for Human Factors in Healthcare, MedStar Health Washington Hospital Center, Georgetown University

This is Terry Fairbanks, I like the direction this discussion is going because I think a lot of the things when we think about usability, implementation and safety, a lot of the things that we can do to have impact can be applied broadly to all these different areas and I would encourage us to think broadly in what we do because we don't want to limit our impact to just one of the smaller areas.

Megan E. Sawchuk, MT (ASCP) – Lead Health Scientist, Center for Surveillance Epidemiology & Laboratory Services – Centers for Disease Control and Prevention

Yeah, this is Megan, and when I've looked at the SAFER guides I just think they establish such an excellent foundation for assessing the EHR and I think that there is probably still an opportunity to promote and encourage that type of assessment by not only the actual end-users but specialty disciplines like the pharmacist the laboratory, you know, radiologist, etcetera to see how they're information is displayed to the end-user.

And what's interesting is, you know, we have had a lot of work so far put into patient safety event reporting which is great and we're going to make strides in that direction but it makes me wonder that perhaps we need a more formalized reporting structure to capture that sort of usability assessment information in a constructive way and I have...I'll just say I have previously thought AHIMA would be positioned for that, but there may be others as well who could do that.

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women's Hospital & Partners

Good point, this is David Bates again, I also have felt that it would be good to have a more formal approach to assessing usability. So, others...thoughts of others around implementation?

Rollin (Terry) Fairbanks, MD, MS – Director, Emergency Room Physician, Associate Professor of Emergency Medicine – National Center for Human Factors in Healthcare, MedStar Health Washington Hospital Center, Georgetown University

David, I just wanted to make a quick comment on what you said is that in our work that we recently did we started to wonder if it would be better to assess the agency's way of doing user center design rather than to do hard assessments of the end usability because of the fact that once you customize and change for implementation usability can change so much.

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women's Hospital & Partners

That's a fair point, absolutely.

Janey Barnes, PhD – Principal & Human Factors Specialist – User-View, Inc.

Hey, this is Janey, and I just want to second the idea of focusing on assessing the process as opposed to specific milestones because when you have groups that are out there that have very mature uses and design processes in place and just because their specific way doesn't map up with what the regulation as you put in, you are putting a burden on the ones who are really doing a good job and that again also is to get education about what is a user center design process and what separates affective and effective activity within a user center design process.

Megan E. Sawchuk, MT (ASCP) – Lead Health Scientist, Center for Surveillance Epidemiology & Laboratory Services – Centers for Disease Control and Prevention

This is Megan, I just wanted to mention that my comment was actually really targeted at the question about implementation even though I mentioned usability I meant that at the point of implementation. Although I also agree that evaluating the front end of the process is as valuable as assessing the back end.

Janey Barnes, PhD – Principal & Human Factors Specialist – User-View, Inc.

So we've seen some vendors where they are actually applying a user center design process to implementation and again that's for, you know, very mature groups and again one of the areas where we see that the folks are using it is again that they are relying on the SAFER guides and implementing, like incorporating the SAFER guides into their...so that when they help customers go through implementation. So, the SAFER guides they truly are like a wealth of resource for all those three areas that we're talking about.

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women's Hospital & Partners

Great, so it seems like there is a lot of support of the SAFER guides which I buy into also. Are there other things that we could do or contribute on the implementation front that would change things that would help organizations implement more safely than they do today?

Joan Ash, PhD, MLS, MS, MBA, FACMI – Professor & Vice Chair, Department of Medical Informatics & Clinical Epidemiology – School of Medicine – Oregon Health & Science University

Well, this is Joan and I'll ask a naïve question, but I have not kept track of what's happening with the regional extension centers and it seems they were doing a good job helping smaller places through the implementation process, are they still able to do that?

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women's Hospital & Partners

Somebody from ONC want to weigh in around that? I don't know what the very latest is in that area.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Well, so for the REC program, and Ellen if you know more you can speak to it.

Ellen V. Makar, MSN, RN-BC, CPHIMS, CCM, CENP – Senior Policy Advisor, Office of Clinical Quality & Safety – Office of the National Coordinator for Health Information Technology

Sure.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

But from what I know the grant period has ended but there has been no cost extension for some of the regional extension centers to continue their work. So, a number of them are continuing on, but there are no longer...there is no longer funding available to continue their work. If there are specific data or information that you're interested in we could certainly gather that and either have a presentation around that or, you know, share it as FACA material.

Ellen V. Makar, MSN, RN-BC, CPHIMS, CCM, CENP – Senior Policy Advisor, Office of Clinical Quality & Safety – Office of the National Coordinator for Health Information Technology

I do think that we...

Joan Ash, PhD, MLS, MS, MBA, FACMI – Professor & Vice Chair, Department of Medical Informatics & Clinical Epidemiology – School of Medicine – Oregon Health & Science University

It would be good for us to know if our recommendations could possibly be carried out by RECs in the future.

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women's Hospital & Partners

Yeah, I mean, my impression is that they are being sunseted.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Right.

Joan Ash, PhD, MLS, MS, MBA, FACMI – Professor & Vice Chair, Department of Medical Informatics & Clinical Epidemiology – School of Medicine – Oregon Health & Science University

Thank you for answering my question.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

My sense is that states are providing support more through their Medicaid Programs as part of outreach for Medicaid but that...and a few of the RECs have found a consulting model that seems to work but in general they seem to be either disappearing or scaling back.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Because the funding period has ended, so...

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Right, the federal ONC funding has ended.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Yes.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, maybe that's a good segue. We focused a lot in the discussion about, you know, sort of where the gaps are around safety and communication but I'm wondering, and this is sort of, you know, going from the focus to the very broad, if we should be also considering some of the policy options in kind of a post HITECH, post Meaningful Use era whether it's ONC as kind of bully pulpit and convener or whether it's very focused on certification processes where we think things could be leveraged as foundational elements beyond just HITECH and Meaningful Use.

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women's Hospital & Partners

I think that's a good point, I definitely agree with that.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, this could either be things where there is market forces that we want to encourage or, you know, picking up on the consumer piece, certainly consumer tech is getting a lot of attention these days, Apple Healthkit, Google has Fit, Samsung has S Health, I'm sure there's, you know, another dozen or two folks trying to push their platform out there and, you know, so maybe there needs to be a broad base set of education and maybe we need to be looking at other approaches that could broadly effect, you know, the world outside of EHRs in the closed system of the healthcare providers. And when I say "closed" I mean within an organization and where there is a lot of organizational levers.

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women's Hospital & Partners

Okay, let me just...let's just move onto to the safety area, we've talked about implementation some, but perhaps we could have a brief discussion about where we could make a difference on the safety front directly. Obviously, safety has come up as we've talked about the other two areas and there is a lot of intersection.

So, I'll throw out one thing that I have been interested in which is some sort of post implementation testing. As people have noted there is an awful lot of customization that occurs and we showed, in this prior piece of work, that there was an enormous variability among organizations in terms of what medication safety related decision support they'd put in place and in fact there was enormous variation within vendors, there was almost no correlation between vendor and what your score was on the safety testing that was put in place and that, from my perspective, suggests the need for some sort of post implementation testing so that organizations have a sense of how they're doing. We also found that after they took the test and got some feedback they were able to improve their scores.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, this is suggesting actually a framework that could be very helpful for whether it's process or guidelines for organizations to know there is value in testing their system after they've implemented it and then planning their response to the results they get as an improvement cycle.

Megan E. Sawchuk, MT (ASCP) – Lead Health Scientist, Center for Surveillance Epidemiology & Laboratory Services – Centers for Disease Control and Prevention

Yeah, I think...this is Megan, I think it's a good suggestion because even though they might be very focused just on the EHR and applying whatever standards might be suggested if it's SAFER guides or something else, national guidelines it's a moment of education where then the next time they're looking at another piece of software or any other end use they'll mentally be sort of, you know, applying those requirements indirectly because they know they've seen them before.

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women's Hospital & Partners

Thank you, other comments?

Joan Ash, PhD, MLS, MS, MBA, FACMI – Professor & Vice Chair, Department of Medical Informatics & Clinical Epidemiology – School of Medicine – Oregon Health & Science University

Well, this is Joan and I was heartened that you just said that it's the flight simulator I think you were talking about David...

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women's Hospital & Partners

It is, yeah.

Joan Ash, PhD, MLS, MS, MBA, FACMI – Professor & Vice Chair, Department of Medical Informatics & Clinical Epidemiology – School of Medicine – Oregon Health & Science University

So it's actually improving things as people reuse the flight simulator.

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women's Hospital & Partners

Yes, yes, so those data are not published but, yes, people have improved substantially actually after using the flight simulator.

Joan Ash, PhD, MLS, MS, MBA, FACMI – Professor & Vice Chair, Department of Medical Informatics & Clinical Epidemiology – School of Medicine – Oregon Health & Science University

You probably have some ideas yourself on how the idea of a flight simulator may be simplified for ambulatory environments...

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women's Hospital & Partners

Yeah, there is actually...

Joan Ash, PhD, MLS, MS, MBA, FACMI – Professor & Vice Chair, Department of Medical Informatics & Clinical Epidemiology – School of Medicine – Oregon Health & Science University

Recommendation...

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women's Hospital & Partners

A version of that has been developed and it's a matter of taking that and refining it and as it turns out I have a grant now through AHRQ and through Jon's group which is intended to take the flight simulator to the next level. But it will obviously be a lot more effective if there are some incentives for organizations to actually use it.

Joan Ash, PhD, MLS, MS, MBA, FACMI – Professor & Vice Chair, Department of Medical Informatics & Clinical Epidemiology – School of Medicine – Oregon Health & Science University

I think we really should think about that.

Rollin (Terry) Fairbanks, MD, MS – Director, Emergency Room Physician, Associate Professor of Emergency Medicine – National Center for Human Factors in Healthcare, MedStar Health Washington Hospital Center, Georgetown University

This is Terry Fairbanks, I like that idea too and I think it ties into an idea that I was going to bring up with safety and somebody mentioned this in the earlier beginning introduction slides, but I think we need to find a way to make it easier for end-user organizations and end-users to describe the hazards that they're encountering so that others can learn from it and the vendors and the other implementers can learn from it, and in particular I think we should look at trying to find ways to open up access to screen shots without violating any proprietary issues or HIPAA, which I know is complicated but I think it's going to take a global action in order to do that.

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women's Hospital & Partners

Yeah, I would...this is David again, I strongly endorse that it was a recommendation in the IOM committee report, we made that recommendation again in the FDASIA recommendations and yet the vendors are still resisting around that and the last I saw it didn't make the final FSASIA recommendations. So, that particular recommendation somehow got left out.

George Hernandez – Chief of Applications and Development – ICLOPS

This is George Hernandez with ICLOPS; I like the model that we do with the clinical quality measures where basically there is a user story or use case of something that will happen and when this happens these codes are generated, the CPT codes or ICD-9s or whatever and you can prove whether you did or did not do good to improve your quality measures your outcomes by whether you generate the expected codes or not.

So, I don't know if we could do that similar model as far as, okay, here's different safety scenarios and these are the codes it should generate and we don't care how you implement it but if you can prove to us, okay, well let's run the scenario, does your system generate these numbers and if it does or does not that you can validate that you're doing what we're expecting you to be doing.

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women's Hospital & Partners

That makes sense. Other thoughts? Tejal are you still on? You may not be. Okay, other thoughts about what we should be doing from the safety perspective?

Michael Lardieri, LCSW, MSW – Assistant Vice President Strategic Program Development – North Shore-LIJ Health System

Yeah, this is Mike Lardieri, I'm not sure if it's just from the safety perspective but I think getting people to use whatever we recommend or suggest I think would...maybe difficult because without some...and it was mentioned before, without some real levers how are you going to get 70% of all the medical practices that have already implemented to go back and relook at their implementation and then make adjustments, I mean, they're running trying to just keep up with what they've done so far. So, it may be difficult and there is going probably need to be some teeth in it someplace I just don't know where right now.

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women’s Hospital & Partners

Good point.

Joan Ash, PhD, MLS, MS, MBA, FACMI – Professor & Vice Chair, Department of Medical Informatics & Clinical Epidemiology – School of Medicine – Oregon Health & Science University

Well, this is Joan, and again we thought about this a great deal when we were developing the SAFER guides and we made a real effort to involve the Joint Commission, the Medical Group Management Association, the American Hospital Association and as many professional organizations as we could so that they were part of the development process and knew what was going on and of course our hope was that they would eventually use the guides in some way, and of course none of them actually said that they would but they did say things like “well, the consulting arm of the Joint Commission could possibly use the SAFER guides” and when they’re consulting with organizations getting ready for visits and such.

So, we didn’t have any complete agreement but we had a lot of interest and I would love to see some of that really come to fruition because those organizations have teeth.

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women’s Hospital & Partners

Yeah, that’s a good point. Yeah and NCQA and other folks, you know, looking at medical home and that kind of thing that’s a good point to try to include those organizations.

Megan E. Sawchuk, MT (ASCP) – Lead Health Scientist, Center for Surveillance Epidemiology & Laboratory Services – Centers for Disease Control and Prevention

You could...

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

This...

Megan E. Sawchuk, MT (ASCP) – Lead Health Scientist, Center for Surveillance Epidemiology & Laboratory Services – Centers for Disease Control and Prevention

I’m sorry, this is Megan, I’m just...I’m just thinking about different levers that are in the system and, you know, I don’t know if this would be valid to look at but you could approach the malpractice insurers and, you know, if insurers made it like a requirement for insurance you’d have a lever.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

So, this is Larry, possibly a softer lever than malpractice insurance, I think a lot of providers are feeling a lot of very real pain and while a small practice might not have the resources to do something actively about it bigger practice groups or mid-sized to larger hospitals, healthcare organizations certainly are looking for ways to improve their user’s experience. So, I think issues around efficiency and user pain are very real and they’re already on the stick side and we could give them some carrots that might be helpful.

And I think that the safety issues are also areas where there is a lot of general pressure under some of the payment reform initiatives to have high quality and improvements in quality and that anything you can do that improves your safety is probably going to be a positive thing in the marketplace.

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women’s Hospital & Partners

Great, other thoughts? Can I ask people just to take a look at the work plan and offer any comments about that?

We’ll have an opportunity to hear from some specific groups which we’ll be thinking about but as you look at this are there things that you definitely want to learn about. We’ve already agreed that we’ll get the NIST report that was mentioned earlier around to people. Okay, I’m not hearing a lot of thoughts or suggestions about that.

Let me just ask if there are other thoughts or suggestions before we go into public comment?

Michael Lardieri, LCSW, MSW – Assistant Vice President Strategic Program Development – North Shore-LIJ Health System

This is Mike I probably want to know more about implementation science further up in the process than down at the bottom.

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women’s Hospital & Partners

Okay.

Michael Lardieri, LCSW, MSW – Assistant Vice President Strategic Program Development – North Shore-LIJ Health System

I’m not sure...

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women’s Hospital & Partners

Yeah, and the issue will just be fitting everything in.

Michael Lardieri, LCSW, MSW – Assistant Vice President Strategic Program Development – North Shore-LIJ Health System

Yeah.

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women’s Hospital & Partners

But, no that’s a fair point. Other thoughts or comments? Larry anything else that you want to bring up?

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

I think we’ve covered a tremendous amount of ground today, we’ve got some background things planned for the next couple of sessions and I guess David you and I will have to go back through our notes and see if we can’t give this group a good summary.

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women’s Hospital & Partners

Yes.

Larry Wolf – Senior Consulting Architect – Kindred Healthcare

Try to focus up for where we’re going to try to take some action.

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women’s Hospital & Partners

Right, I’ve taken a lot of notes but there are many, many directions that we could go in and as Paul so aptly noted, you know, the more we focus the more effective we’ll be, so, you know, we have to consider that.

All right, well I just want to thank everybody for agreeing to join this group. I hope that we will be able to make some contributions in these areas which are clearly really important and which have not been effected to a great extent so far by Meaningful Use, you know, Larry and I both think these are very important areas. We know everybody is really busy and we greatly appreciate your spending your time on this. We’ll try to make the use of your time as efficient as possible.

So, Michelle could you go ahead and open things up to public comment?

Public Comment

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Sure, operator, can you please open the lines?

Lonnie Moore – Meetings Coordinator – Altarum Institute

If you are listening via your computer speakers you may dial 1-877-705-2976 and press *1 to be placed in the comment queue. If you are on the phone and would like to make a public comment please press *1 at this time. Thank you.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

We have no public comment, so thank you all again for joining and agreeing to volunteer for this Workgroup. Our next call is on Friday, October 10th at 1:00 p.m.

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women’s Hospital & Partners

Great, well, thank you all.

W

Thank you.

Michelle Consolazio, MPA – Federal Advisory Committee Program Lead – Office of the National Coordinator for Health Information Technology

Thanks everyone.

M

Thank you.

Michael Lardieri, LCSW, MSW – Assistant Vice President Strategic Program Development – North Shore-LIJ Health System

Thank you, bye-bye now.

David W. Bates, MD, MSc, FACMI – Senior Vice President for Quality & Safety and Quality Officer – Brigham & Women’s Hospital & Partners

Bye-bye.

M

Bye everybody.

Public Comments Received During the Meeting

1. I was concerned about some of the comments about levers. Some of the conversation was about penalizing providers if they did not put additional resources and work into proper implementation of HIT. That would be like making drivers properly implement seatbelts, airbags, and catalytic converters before they could get car insurance. The inappropriate burden on the user is not acceptable in the automotive industry and should not be acceptable in the health care industry. Thanks for considering my comments.