

**Cathie Furman, RN, Senior Vice President of Quality and Compliance,  
Testimony before the Clinical Quality Hearing of the HIT Policy and  
Standards Committee**

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Good morning. My name is Cathie Furman and I am the Senior Vice President of Quality and Compliance for Virginia Mason Medical Center, in Seattle, Washington. I have been a registered nurse for 38 years and I hold a Master's degree in Health Administration.

My responsibilities at Virginia Mason include leading the organization's quality and patient safety functions and programs, and serving as corporate compliance officer. I lead VM's strategic initiative to provide transparent quality performance measurement and on behalf of VM, serve on the board of directors of the Puget Sound Health Alliance (a regional collaborative focused on improving quality outcomes at a reduced cost) and on the executive committee of the Washington Patient Safety Coalition.

Long before entering the ranks of health care administration, I worked as both an inpatient and outpatient nurse. As a nurse providing care to patients at some of their most vulnerable moments, I knew we could do better if only we had the information necessary to reliably engage in life-saving early interventions.

All these years later, I am responsible for quality at an organization that was named one of two Leapfrog Hospitals of the Decade, and still, I know we can do better.

Virginia Mason is lauded as one of the safest hospitals in the country. At our hospital, Virginia Mason teams provide care alongside Group Health Cooperative and Pacific Medical Centers providers. I can tell you that the interoperability between the EMR systems each organization uses is not what it should be – this is the situation at one of the safest hospitals in the country.

Health care IT does hold tremendous promise, but there are factors limiting its ability to support better quality measurement and improvement. It all starts with unnecessary variability in the delivery of health care. All hospitals

use orders but each organization has a homegrown method for recording and acting on those orders. Before we even begin to leverage the potential of health IT, we must eliminate unnecessary variation in the delivery of care.

Further, we must encourage a standard approach to documentation, one that builds reliability into our use of patient information in electronic medical records. If every organization documented a drug-resistant organism, a drug allergy or *any* clinical condition in the same way, in the same field, we would have the information we need, just-in-time, to care for our patients.

Unfortunately, no health IT systems can produce meaningful quality and population data. Without unique patient identifiers, analysis leading to improvement is hospital-specific versus community or population focused.

Representing a provider organization, I can tell you that providers want data to improve but currently vendors lack the ability to extract data from databases in an easy, just-in-time way. We must have methods to provide immediate feedback to care team members, and we need to design the alerts associated with that feedback to minimize alert fatigue.

Creating a role for health IT vendors in quality improvement means changing the vendor focus from meeting requirements to developing usable solutions. Currently, the reporting requirement is driving IT development, which means that we lose the opportunity to create systems designed on evidence based clinical practice. Reporting is the *lowest* bar.

Additionally, it is a common practice for software companies, in every industry, to release new versions with known bugs. In health care, software deficiencies can lead to serious consequences. At Virginia Mason we experienced an update to our Lab software that led to inaccurate results reporting. We should have zero tolerance for bugs in health care software releases.

Today, IT products are sold based on the ability to customize. We need standards and a common language (not based on billing codes). Without standard nomenclature, safety and outcome analysis is resource intensive and available only to those organizations that can afford it.

Further, in the absence of common language, patient information is inaccessible to care team members, making early interventions for evidence-based clinical practice nearly impossible.

Just as important, we need to move toward population trending and reporting, which is functionality currently not available in health IT.

At Virginia Mason, we are fortunate to have a management methodology based on the Toyota Production System, which we call the Virginia Mason Production System. It affords us a framework for building reliability into our systems. Two such projects are the Health Maintenance Module and the Clinical Andon.

The Health Maintenance Module is an enhancement we developed to our Cerner system, which acts as a checklist within the electronic medical record to make sure we offer and deliver just the right preventive care at just the right time, based on the unique needs of each patient. It allows us to deliver on the ambulatory preventive care bundle including evidence-based preventive interventions based on the patient's sex, age and co-morbidities.

We are currently developing a clinical andon, which will move a retrospective, uncorrectable chart audit process into real time, and create a feedback loop *during* a patient's hospitalization. The clinical andon will provide the information the care team needs to give patients the care they need, when they need it.

I am proud of our work at Virginia Mason. But I know we can do much better. Health IT holds tremendous promise, but Meaningful Use is more than reporting, it is the ability to make decisions at each health care organization on behalf of each patient. To be truly meaningful, it must also give us the information necessary to manage the health of our communities. I know our patients are depending on us.

Thank you.