

## **Making Clinical Decision Support Real & Beneficial Part 1 Put CDS**

### **Quality Imprvmt in Action**

**CONSTANCE GILLISON:** Hello, everyone, and thank you for joining us today. I would like to welcome you to today's edition of the weekly webinar series. Today's topic will provide a broad definition of clinical decisions to forge a framework for improving care, delivery information workflow, and a toolkit for improving targeted health care decisions and outcomes with helpful CDS interventions. I'm Connie Gillison and I will be your host today. Now, I'd like to welcome our presenters. Leading the discussion today will be Phil Deering from Stratis Health, Dr. Jerome Osheroff from TMIT Consulting, and Dr. Paul Kleeberg from Stratis Health. Without further ado, I would like to turn it over to Phil.

**PHIL DEERING:** Good morning or good afternoon everybody, depending on where you sit in the country. And welcome to all my colleagues in REC world. My name, indeed, is Phil Deering and my title is Manager of HIT Program and -- Program Development and Implementation. But what that really means is that I'm the manager of a team of HIT consultants for a regional extension center. And I manage those consultants who work directly with clients. And I work with some clients myself. My goal, and what I'm hoping to do today for you guys, is talk a little bit about our experience as a REC with this concept of working on clinical decision support with providers and how it applies to our thoughts for sustainability of our business over time.

I'm fortunate to be sitting here with Dr. Paul Kleeberg, who has done webinars -- more webinars than any other man. But indeed -- so like I said, I'm the deployment

manager for a regional extension center. We're the regional extension center of Minnesota and North Dakota. Our title is REACH. And REACH is a partnership of Stratis Health, the College of St. Scholastica, the National Rural Health Resource Center, North Dakota Health Care Review, and the University of North Dakota. So we have a lot of great partners and we've done a lot of great stuff. We're proud of what we've done. We work with the entire range of providers. We work with very big integrated networks like MAIL [spelled phonetically]. We work with very small SQHCs [spelled phonetically] and rural health centers. We work with folks who provide health care in the metro area, a very, very diverse metropolitan area of 3 million people, as well as rural health centers and critical access hospitals in very small towns across rural Minnesota and North Dakota.

I think, like many of you, the majority of our clients are now at or very near Stage 1 meaningful use, many of them have attested and many more are attesting or will attest shortly. And so, based on that, we're really looking out towards the future and trying to understand what we need to build on the great client base that we have and build for sustainability. We work, like I said, with big and small, but our real goal and our mission is to make sure that we're bringing support to those smaller clinics and those folks that have fewer resources.

So like I said, you know, the conditions that we're facing, I think, are similar to many of those that you are facing. Although we've got a lot of clients to meaningful use, we still see that many of them are struggling to get the benefits that they really want from their electronic health record. We know that the incentive payments are good to

get, but we also know that they don't defray the true costs of implementing the electronic health record and the push for benefits is still very much there. We know that a lot of people are still looking at meaningful use as an external mandate, a government construct of something they got to do. And we know that we need to help them get to effective use of that electronic record so that they start to use it in a way that makes their business better and that actually improves the health of their patients.

Stage 2, with increased emphasis on QI [spelled phonetically] and clinical decision support, patient engagement is starting to come up to people and we're hearing a lot of concerns about that. And finally, I think you know that providers across the country are facing this huge number of conflicting demands. And they're in a changing sea, right? Where suddenly this whole notion of paying for quality, pay for performance rather than activity, figuring out are they going to be participating in an ACL [spelled phonetically], more and more demands from their payers around quality reporting, not enough time -- too little time, too much to do. And we just -- you know, I think all of us, our hearts go out to so many of the physicians that we work with who are just really challenged to meet all of these new requirements. So again, broadly, we want to make sure that we're supporting our providers and helping them move up the ladder, up the escalator, to the trip lane with getting them focused on quality and how to achieve those kind of goals.

So our goals today, or our agenda, I'm discussing the regional extension center's experience with developing this new business line. I'm going to turn it over Dr. Jerry Osheroff who's going to show you some of the tools and things that have been

developed to help small providers use clinical decision support effectively and talk about a new concept, a new way of thinking about clinical decision support. Finally, Dr. Paul Kleeberg, here with me, is going to take you through and show you some real specific examples. And then we want to open it up -- actually, we are really looking for people to put some questions in the chat box and help us because in the end, this is not the detail instruction, this is more about the tool and talking to you, showing you what we haven't seen, if it's going to fit for you.

Our outcomes are, as such, we want to make sure that people understand how meaningful use requirements mesh with QI requirements, both in Stage 1 and Stage 2. We want you to understand -- now that you've taken your clients through Stage 1 work, how do you keep moving ahead, addressing meaningful use and quality improvement requirements. And finally, the real purpose of this is to get you to start considering incorporating quality improvement approaches as part of your plan for sustainability. I -- this slide, when I think about it I -- really what pops into my head is -- and I'm going to date myself a little bit, but it's a line from The Grateful Dead, who said, "What a long, strange trip it's been." You know, I think all of us -- you know, it's the -- this is the beginning of the fourth year and we've come a tremendous distance. When we started, right, our -- the real emphasis was to help our clients go through those steps of assess, plan, select, and implement an electronic health record. And then further, begin to use that in a meaningful way to achieve at a minimum those 90 days of Stage 1 meaningful use, and hopefully really get that foundation installed.

I think -- you know, there's no doubt that we have been successful. Tens of thousands of providers have attested around the nation. Another great thing is that through HITRC and through ONC [spelled phonetically] guidance, a lot of us have developed and shared tools. I know that I've made friends and learned a tremendous amount from my colleagues across the nation. And I'm really, really hoping that we can continue to do that.

I also think that all of us -- you know, there may be thousands of providers that you've helped attest, but all of us have a soft spot in our heart for certain practices, certain docs who, no way would they have gotten there without us. And we've been able to give them guidance. And I just think that emotionally, personally, in our hearts there's a lot for us to be proud of.

So back to what's going on and this whole notion of, sort of, the theory behind meaningful use. I always call this slide -- and, you know, we've seen it now for years. Essentially, it's the escalator slide. It talks about the development of setting the initial foundation in data capture in Stage 1. And then making sure, as Stage 2 comes along, where the need to push toward quality improvement is now quantified in the Stage 2 regulations. There's increased emphasis on quality measures and also increased emphasis on clinical decision support interventions that will be used to hit those quality measures.

We know that regional extension centers are, right now, sitting in this position between having helped people with Stage 1, looking at Stage 2, and looking at sustainability. So we know this makes sense from a business perspective but also, I

think, a lot of us understand it emotionally, right? We've done too much, we've invested too much to just let this go with a simple implementation of meaningful use. And we need to help our nation move ahead toward truly the triple aim and improving quality output -- or improving quality outcomes, excuse me.

So back to the rule, making sure we understand what the direction is that's coming from the OMC [spelled phonetically] and CMS [spelled phonetically] that's guiding the nation. Stage 1 was really about deployment and getting the EHR established so that we could begin to push toward quality improvement.

Stage 2, we know that text, you know, that actual rule clearly pushes the link between clinical decision support and quality improvement. The title of the slide sort of says it all, right? That if we're going to think about quality improvement, especially in -- now that we have these more powerful tools like an electronic health record, we need to use those and use them effectively. And then we know that Stage 3 is going to continue that push onward. It -- what I like about this is actually when I'm doing regional extension center work and I'm -- when I'm doing meaningful use work, it's really clear that the people who came up with this concept and who -- and all of the forces around the nation that have helped design this rule understand this link between quality improvement and clinical decision support and continue to push it ahead.

Next slide, again, back to our history a little bit. Stage 1, you know, initially -- it's too bad we're on a webinar. I can't see people's faces. But, you know, so many of us got questions, like, "What constitutes a clinical decision support rule, right?" We -- it was a very, very basic understanding that we were helping providers get to. And, you

know, “Why isn’t drug-drug and drug-allergy checks, why isn’t that enough? Why do we have to do more?” And that was the world of Stage 1.

Now it’s Stage 2. We’re all facing lots of questions and suddenly our clients who have looked at the Stage 2 rule realized there’s this big shift going on, that there’s actually, you know, a mandated link between the quality improvement measures, and the CQMs, and the clinical decision support interventions that need to be turned on and enabled in the electronic records. The other thing that I like about this slide is if we look down here in the bottom row, we have that row that says, “Other CDS Requirements.” And if you look at these, send reminders to patients, generate lists to patients, in a lot of ways, that’s not how we think about traditional clinical decision support, right? The classic view of this is that it’s a heart-stopper, an interruption of the provider that keeps them from doing something wrong or forces them to do something. One of the things that we’re going to talk about and why we believe this is a very sustainable business model is that the kind of clinical decision support that is truly going to enable quality is a much broader view of what’s going on. And it looks across all the opportunities for interacting with patients and finds opportunities to take advantage of that.

So based on that understanding, I want to explain a little bit about what REACH has done and how we’ve begun to interact with this notion of CDS4MU. You know, it’s - - if nothing else, it’s a great brand name. It’s a cool brand name. So basically, because we had the good fortune of working with Paul Kleeberg and Jerry Osheroff, early on we were exposed to some of the tools that were being developed. And we did an internal webinar -- excuse me -- and exposed our staff to these concepts. From there, we had a

positive response from the field staff, that these were interesting tools and they wanted to see more. From there, we also worked with another one of our projects, which is a learning and action network. And we provided a -- over two months, we provided two webinars for our clients where we exposed our clients on the learning and action network to some of these concepts and gave people homework. With -- which then a couple of our clients, and especially one from -- one of our FQHCs [spelled phonetically] really, really just grabbed on to this tool and did some exciting work within her clinic about helping to improve outcomes. So the results that we had are that were starting to see some providers that are really resonating to this. And we're interested in continuing to move ahead with this as a product line or a service.

So I'm going to just sum up here. What we've seen, you know, we know that the escalator's pushing us to this link between clinical decision support and quality improvement. We know that regional extension centers need to look for sustainable business lines. We believe we've found something here. And most of all, what I'm hoping as a REC member is to not prove that this is the right one, but rather begin to open this discussion with our colleagues, and friends, and those people that we trust across the REC landscape and see is this the right direction to go? And see if we can continue to build great tools that will help us move the trip lane in -- ahead.

With that, I'm going to pass it to Jerry Osheroff. And Jerry, over to you.

**JERRY OSHEROFF:** Great. Thanks very much, Phil. I appreciate it. Again, I'm Jerry Osheroff. I'm the Principal of TMIT Consulting and one of the subject-matter expert leads along with Paul Kleeberg and others on this CDS4MU project, which I'll

explain in more detail about in just a moment. So I think Phil gave an exciting and compelling example of REACH's journey in terms of thinking about what the meaningful use trajectory looks like and how they can continue their business model and their support for their clients in this unfolding world. And he talked about some new ways of thinking about clinical decision support and quality improvement. And what we're going to do for the remainder of this presentation today is to, sort of -- I'll lay out some of these basic concepts and tools that Phil was eluding to, and then Paul will take things over and talk about how it actually looks to put those tools into action.

So we've used this term, CDS4MU. This is an ONC project to develop tools and resources to support CDS-enabled quality improvement for meaningful use. The goal ultimately is to help all types of provider organizations, move the ball forward, but most especially small practices and critical access hospitals who, as Phil alluded to, can be very challenged in navigating through this journey. So our tools are designed to help these kinds of organizations and most especially help regional extension centers help these providers on this difficult but very, very important journey.

So Phil mentioned a CDS care delivery improvement/ CDS toolkit. And the material that we're presenting today draws from that toolkit. And we're aiming for it to be very robust and very practical. It'll have case studies in it, tools of the sort that Paul will be describing later, and all this material will be posted on [healthit.gov](http://healthit.gov), as well as the HITRC later this year for you to access and use in your work.

So let's jump right into, sort of, the first step that this toolkit is broken down into two primary components. The first lays out these foundational concepts, and tools, and

approaches, and that's what I'll be talking about for the next few moments. And then the second part of the toolkit talks about how you apply this material in your efforts to support providers on this quality improvement journey. And as Phil noted, a lot of what these tools are all about have to do with understanding and improving information flow, and work flow, and care flow, and leveraging, sort of, the hard fought gains from Stage 1 meaningful use to provide the tools to drive those improvements in information flow and outcomes.

So let's start with the definition of clinical decision support. As I think Phil poignantly pointed out, a lot of folks providers and RECs have a somewhat narrow perspective on what clinical decision support is based on the Stage 1 requirement to implement a CDS rule. If you look at the definition of what clinical decision support is in the meaningful use regulation, it defines it fundamentally as a health IT functionality that builds on the EHR foundation to provide people with information to enhance health and health care. So this is the definition directly from the regulation. As you can see, it goes way, way beyond a CDS rule or a pop-up alert. And it includes things that providers are doing already on a daily basis, things that you're helping providers do and, sort of, the point of this whole toolkit and all of this work is to help find ways to address this definition more effectively. In other words, how do you get information to people so that you can effectively enhance health and health care?

Well, a very fundamental tool or approach for doing this is what's known as the CDS Five Rights. And this framework says that if there's a particular health care decision or outcome that you want improve, for example, things related to meaningful

use, clinical quality measures, or other, sort of, related improvement imperatives, and you want to use information interventions or clinical decision support to do that, you have to get all the right information to all the right people through all the right channels in all the right formats and at all the right times. So basically what this means that if you look at how information is flowing through a provider organization, these five dimensions answer the what, who, where, when, and how questions related to that information flow.

So let's dive into a little bit more detail about these dimensions so that you can begin to perhaps think more robustly about how you're approaching, or how you might approach increasingly going forward, helping providers understand this information flow and improve it so that they have better decisions, actions, and outcomes on the -- on key clinical quality measures. So the first dimension is, sort of, the options for what. You know, in other words, the right information, what information are you providing to people? And the right information is, of course, evidence based, and it's current, and it answers questions that clinicians and others have. It's at an appropriate level to be digested at the point when you're delivering it. And it's going to be useful for supporting the decisions and actions that are the ultimate goal of this -- of this work, the appropriate decisions.

The next dimension is who this information is flowing to. And people tend to very often think about providers or physicians as information recipients, and they are, of course, a very important target for clinical decision support interventions. But there are many, many other people that are a part of the care delivery team that we should be thinking about also. And not just the clinical staff, the MAs, the nurses, others, but also

the front office staff, the back office staff, the admitting department, all these people are -- help generate important information and make decisions and have patient interactions that can play an important role in improving outcomes. The bottom item listed with a bold and exclamation mark is patients, because they are very frequently overlooked as a recipient for clinical decision support interventions. And in some ways, they're perhaps the most important recipients because at the end of the day, the performance on a lot of the clinical quality measures depends on things that patients are doing or not doing. So we need to make sure that we're fully supporting them. So that's why this who dimension, it's important to approach that very broadly.

Similarly, there's many different channels through which this information can be delivered, the where options. In other words, how is the information getting to these right people. And of course, there's many different modules in the EHR through which the information can be delivered. There are registries that use data in an EHR to help us understand better what's going on in patient populations. And I'll give an example of that in just a moment. But there's many other channels to consider as well that are listed here. Of course, many important electronic channels, but also we haven't completely gotten rid of paper. So there's a role for paper in certain circumstance, for example, when we want to give a patient a handout, something that they can hold and read to understand their condition, and treatment, and things like that. So we need to think very broadly about this channel dimension as well.

And then, you know, helping to get people past the notion that clinical decision support is the same as a pop-up alert. That's certainly one kind of clinical decision

support intervention. But there are many, many other ways of getting information to people or from them in various formats to support decisions. So you can provide data that's relevant to a decision. So these patient lists that come from registries, flow sheets, graphs, dashboards, there's tools to support the documentation of information tools to support ordering and prescriptions, a whole very broad portfolio. And it's critical to think about the full breadth of this toolkit when we're configuring these dimensions of this CDS Five Rights to address a particular improvement target. And once again, we would emphasize that we should be considering both the clinicians and staff, as well as the patients, as potential recipients for these intervention formats.

So the last of the five dimensions is the right time. When is this right information going to be delivered to these right people, you know, through the right channels, in the right formats? And again, the focus tends to be on what's going on inside the exam room, things that the doctor's making -- the provider -- the decisions that the provider's making. And that's certainly critical, but there are many other phases of care flow opportunities for delivering clinical decision support that we really need to be thinking about. For example, you know, if we're trying to help -- ensure that patients have their blood pressure controlled or their diabetes controlled, the decisions that they make about their diet, and about their care plan, and about taking their medications, and things like that, things that they're doing outside the office, these decisions are going to have a huge impact on these outcomes. So we need to think about what we're doing to support those decisions in that setting. Similarly, when patients are checking in, it's an opportunity to gather formulary information, which helps understand what patient co-

pays for things like medications will be. And that's a major determinant in adherence to medication therapy. So something that seems outside, sort of, the clinical decision support sphere, mainly things that are happening at check-in to gather insurance information, can figure very importantly in the stream of decisions and actions that are going to determine the outcome.

So these things that I've just been mentioning are all specific to an individual patient's interactions with the care delivery system, in this case it's the office, practice you can envision a similar sequence like this pertaining to the in-patient care as well. Sitting on top of this is the notion of population management. So I mentioned earlier the notion of looking at a registry that helps us understand what's going on with all the patients, you know, in the practice that have a particular condition so that we can identify and deal with outliers. Let's say patients who are not in the right place where they need to be in terms of controlling their disease or their condition.

So here's an example of the -- of a patient list. This is, you know, an intervention format that comes through the registry channel. And we can see here a subset of the lists of patients in a particular practice. And we not only know who they are, we know what conditions they have from the left-hand side of the screen. And then critical data that's important to managing the population as a whole and all the patients within the population with these particular conditions. So we can see in the circled area that we not only know who the patients are, perhaps the date of the last visit, the date that particular critical laboratory tests or vital signs were gathered. And as we can see from the highlighting, we have our attention called in a very significant way to identify patients

for whom additional attention is needed to make sure that they achieve the optimal care so that they can have the best, sort of, outcome. So this is a very important and powerful clinical decision support tool that's useful in the population health mode as Phil demonstrated on the chart, having tools like this are related to requirements for meaningful use and can be very valuable in addressing care gaps.

So the -- this CDS Five Rights that we've just walked through in a little bit of detail are a way of putting into action the CDS definition that's part of the meaningful use regulation. In other words, getting information to patients, getting information to people so that we're improving health and care delivery. So the way that we put that into play -- so when you have a provider that's working on a particular measure, a diabetes measure, a smoking measure, or a corresponding in-patient measure, the quality improvement task, one way of looking at it, can be how can we understand how information is currently flowing through the provider organization. In other words, how we're answering those who, what, when, where, and how questions today, and how we can modify those information flows and those work flows, taking full advantage of all the capabilities in the EHR that's been implemented so that we're having better decisions, actions, and outcomes.

So if that's the overall goal, there are quality improvement tools such as PDSA cycles, which stands for plan, do, study, and adjust. So in other words, if we analyze the work flow and information flow using a framework like the CDS Five Rights for a particular target, then we found, as Phil alluded to earlier, that when people use a structured tool for doing that it tends very strongly to surface opportunities for improving

those information flows and work flows. So that takes us to the planning cycle, then we can actually implement those improvements. And the do cycle, study what the effects of these changes are, and then make adjustments so that we're going around this quality improvement cycle hopefully getting to more and more efficient and effective ways of using information, using EHR capabilities, to drive improvements on these targeted measures.

So with that, I'm going to turn it over to Paul who will go into more detail about how these concepts can actually be applied, how you can use them to help your provider clients achieve important goals.

**PAUL KLEEBERG:** Thank you, Jerry. Well next we're going to discuss how to take advantage of these concepts and approaches that Jerry has shared with us to help you target improvements that -- with your particular clients. So as Phil noted, and as you probably all recognize, successful CDS quality improvement is very similar to the type of stuff -- or the tools and the things that you need to do are very similar to the types of stuff that you have already done with your clients to help move to the stage one meaningful use. Essentially, it requires that you pay attention to the culture within the clinic. You have to skills that change management, understand people and processes. But the other piece is that you need to have the adequate capabilities in place to address the array of improvements and the things that need to be done in order to be able to make these changes and these improvements a reality.

So I think the first and foremost thing to think about and, you know, I've seen this in so many clinics who have used -- who have adopted EHR technology -- well, we

shouldn't say clinics, we should say some clinics and some critical access hospitals, is that the IT staff and everybody else do it in the background and they don't want to bother the physicians. Well, that may work the basic Stage 1 of meaningful use, but that does not work when you really want to get the most out of electronic health records. In order to do that, you really need to have all hands on deck and especially involve the physicians in the process.

So what you want to do is you want to gather together the stakeholders. You want to help them understand that it's not just the doctor that makes the decision, or the clinic manager, or the nurse, but they have -- as a team need to come together and number one, figure out what they want to focus their activity on, and number two, then they devote -- or they agree to work together as a team to make these a reality. Now if you're -- the important thing again is to say, "It's not something that you do to people, you're doing it with people." It really is, very much, a team activity.

So as you know, most of our clients, the clinics, the hospitals, the doctors, are phenomenally busy. They've got a lot of stuff going on. Many of them just say, "Just tell me what I have to do. Just tell me what I have to do, okay? And I'll do it, okay?" So you may be fighting an uphill battle to try and get them to do clinical decision support, think about clinical decision support. But the idea is to begin to think about some low-hanging fruit, things that you can score some early wins where they can begin to see outcome changes, where they can begin to see benefits, and they can begin to see the value in what is being done.

So when you identify some of these potentially low-hanging fruits, you also want

to build metrics, metrics around financial, operational measures. You want to get baselines out. You want them to think about where they would like to go with this particular thing. Somebody at the clinic needs to be accountable for the processes, too. When you think of all the different changes, you can't just say, "Well, let's do this," and everybody leaves the meeting because then it's not going to happen. Someone's got to take ownership. And the ultimate ownership, as you know with meaningful use, if the leadership is not there behind it, it ain't going to happen. So you need -- they need to understand it, agree to it, and buy into it. And part of the buy in is that they devote the appropriate resources that are needed in order to make this work.

So there's a -- there's a -- Yogi Berra used to say, "You can see a lot by just looking." And it's really true. That's something you really need to pay attention to in here. Because when you're doing your analysis, there are three things that are elements. One is what people are supposed to be doing, and you might call that policy. Then there's what people think that they're doing. When you ask them, "Oh, I do this, that, and the other." But then you actually look and follow and you find, "Gee, it really is a lot more complex and there are a lot more steps there than they're identifying. And we might be able to eliminate some of those steps." So through doing that, you begin to identify what's working, what's problematic, and where are the potential areas for improvement. It's not that -- in the beginning, you may be the person that begins to identify that for the clinics. But over time, you're wanting to give them the skills so that they can -- number one, they'll see the value in it when you point out what they're doing. "Geez, I didn't know we were doing that. This would be a lot better if we change this."

But then they begin to buy into it and they really say, “Gee, you know, maybe we ought to start doing that.” And they will begin to grab on to this process of actually looking, and documenting, and doing swim lane flowcharts, all those, sort of, cool things that begin to identify how things are going.

So what I’m displaying right now is one particular line from this toolkit that we use to help you identify some of the potential areas for improvement for a particular, let’s say, target. So if you look in the left hand side, this is just one particular event. Remember, Jerry showed you this flow of people who are out there. You know, they’re healthy people, or they’re not at the doctor, or they’re not even thinking about the doctor. But then they -- then they think about they need to make an appointment, and then they show up for the appointment, and they’re in the waiting room, and they’re in the exam room and, you know, the nurse comes in. All those different elements, each of those events can be aligned on this particular template. And actually, personally, I find it very valuable when I’m doing this, I actually put my -- I set up what Jerry was talking about, the WHIM [spelled phonetically]. I set up the WHIMs and think about, “Okay, what are all the who, what -- who, what, where, hows I can do during that WHIM in order to be able to achieve that particular objective?”

So on the left hand side, you’ll see this orange thing that right now we’re talking about. You may not be able to make it out because it’s kind of small. It’s the -- this is not visit related. So this is what Jerry likes to say, when people are out in the wild running around. [laughs]

The next two columns actually identify the performance measurements. For example, a patient needs to take medications, keep appointments, follow a diet. And the middle section of the box is the ones that have dark blue over the top are where you've got those particular five rights that you begin to identify who can do what, when, where, and how in order to be able to have an effect on that particular target during that particular element.

The columns all the way over to the right hand side are where you can document some potential opportunities for improvement. So in a sense, this can become a living document. We're going to spend more time on this during our next session in two months. We'll have some people who will show examples of how they've used it and how it's been valuable. But right now, I just wanted to give you an idea of -- this is part of the toolkit that you'll be receiving to help you identify the particular opportunities within that -- within the patient's life, let's say, outside and inside the clinic, and the people who interact with that patient outside and inside that clinic, in order to be able to change the quality measure or remove the needle, some of us like to say, in order to make improvements.

So again, to recap, this -- two -- we're talking about a toolkit to educate you folks, to give you what you need in order to be able to work with your current clients, and potential future clients, and maybe specialty shops on how they can leverage their EHR, lots of elements within the EHR and even outside the EHR to improve quality measures. And we're calling that all under the umbrella of decision support. So again, you want to select interventions that -- interventions that are most likely to impact the goals and

objectives that this particular provider, clinic or hospital, feels is important, that's consistent with internal evidence based practice, it sticks with the Five Rights that we've talked about -- excuse me, the who, what, when, where, how, consider costs, and then consider the risk and benefit.

And you also -- [laughs] the other thing that we need to pay attention are the unintended consequences. So again, as you do this, you fill out the template, you make changes, you begin to -- they begin to make some of the corrections. And ultimately, you want to pay attention because the best plans of mice and men always wind up causing unusual things and you have to be prepared to correct them. You want that support team. You want to build a good team and it should involve everyone. You know, when we worked in the hospital, and if you're working with hospitals, sometimes the staff that clean the rooms have very good input on things that can be done. So it needs to not just be nurses and physicians, but it needs to be everyone. Everyone has the opportunity, and potentially the eyes, to see where inefficiencies are occurring and how they can be corrected. And then as Jerry mentioned with the PDS [spelled phonetically] methods, measure, report, adjust, and repeat. Just, you know, do like a washing machine. Just keep going around and around and keep improving until you get it right. What do you need to be successful as an extension center in order to be able to help use -- help your clients use decision support for quality improvement? So with that, I'm going to turn it back over to Connie. Thank you all for listening. Connie, take it away.

**CONSTANCE GILLISON:** Okay. Thank you, Dr. Kleeberg. And thank you all

for participating today. We hope you enjoyed the session. Please email the HITRC training team if you have any questions and thanks again for joining. We look forward to seeing you on future webinars.

[end of transcript]