

NATIONAL QUALITY FORUM

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PRIORITIZATION OF HEALTH IT PATIENT
SAFETY MEASURES
IN-PERSON MEETING
HIT SAFETY COMMITTEE

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THURSDAY
SEPTEMBER 17, 2015

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The HIT Safety Committee met at the National Quality Forum, 9th Floor Conference Room, 1030 15th Street, N.W., Washington, D.C., at 9:09 a.m., Elisabeth Belmont and Hardeep Singh, Co-Chairs, presiding.

PRESENT:

ELISABETH BELMONT, JD (Co-Chair)
HARDEEP SINGH, MD, MPH (Co-Chair)
JASON ADELMAN, MD, MS, Montefiore Medical Center
GREGORY ALEXANDER, PhD, RN, FAAN, University of
Missouri School of Nursing
GERARD CASTRO, PhD, MPH, The Joint Commission
DAVID CLASSEN, MD, MS, Infectious Disease
Society of America
LINDA DIMITROPOULOS, PhD, RTI International
LISA FREEMAN, Connecticut Center for Patient
Safety and Patient Advocacy of Connecticut
ANDREA GELZER, MD, MS, FACP, AmeriHealth Caritas
Family of Companies
ERIN GRACE, MHA, (ex officio member,) Agency for
Healthcare Research and Quality (AHRQ)
KEVIN HAYNES, PharmD, MSCE, HealthCore, a
subsidiary of WellPoint Inc.
LAURA HEERMANN-LANGFORD, PhD, RN, Intermountain
Healthcare

GEORGE HRIPCSAK, MD, MS, Columbia University and
New York-Presbyterian Hospital
JASON JONES, PhD, Kaiser Permanente
NANA KHUNLERTKIT, PhD, Johns Hopkins Medicine
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Quality
WILLIAM MARELLA, MBA, Pennsylvania Patient
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DENA MENDELSON, JD, MPH, Consumers Union /
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JAMES RUSSELL, Rph, Epic
ERIC SCHNEIDER, MD, Msc, RAND Corporation
MARK SEGAL, PhD, GE Healthcare
KAREN PAUL ZIMMER, MD, MPH, FAAP, Independent
Consultant, Health IT, Patient Safety and
Quality

NQF STAFF:

HELEN BURSTIN, MD, MPH, Chief Scientific Officer
MARCIA WILSON, Senior Vice President, Quality
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SHELIA CRAWFORD, Administrative Manager
JASON GOLDWATER, Senior Director
ANDREW LYZENGA, Senior Project Manager
ANN PHILLIPS, Project Analyst, HIT
JESSE PINES, Consultant for NQF

ALSO PRESENT:

DAVID HUNT, Government Task Lead, ONC

* present by teleconference

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1 P-R-O-C-E-E-D-I-N-G-S

2 9:09 a.m.

3 MR. LYZENGA: All right, everybody, I
4 think we're going to get going. We have a little
5 bit of time here at the beginning to sort of
6 recap and talk about the goals for the day, but I
7 think we all are pretty clear on that at this
8 point.

9 We probably want to just jump into our
10 report out, so we have as much time as possible
11 to do that, and then get together as a full group
12 and, sort of, review and reconcile all our
13 concepts and ideas and come up with our final
14 list of prioritized concepts. With that, I'll
15 turn it over to Bill Marella to report out on
16 Workgroup B.

17 MEMBER MARELLA: Ann, do you have a
18 clicker? Are you going to forward for me? Okay,
19 thanks. I'll just say a couple of words about
20 our methodology, which borrows a little bit from
21 the other groups, probably not as orderly as
22 Eric's nine-step program, but we did some of the

1 same things in trying to cut the list of 27
2 concepts down to our top five. We ended up not
3 going through some of the rating of the
4 individual items for importance and feasibility.
5 These were the things that rose for the top for
6 us, so the high in both categories is implied in
7 most of these. We also applied a bit of game
8 theory to this. If you are inclined to judge us
9 generously, you'll think we were pragmatic.

10 If you want to judge us harshly,
11 you'll think we were opportunistic because we saw
12 a lot of things on our list that we knew were on
13 other groups' lists, so we didn't want to waste
14 some of our votes on things we thought other
15 people would address. In terms of the concepts
16 that we brought up and we thought were highest,
17 the burden of data entry we thought was very
18 important and under laid a lot of the individual
19 measure concepts that were on our list.

20 Usability evaluation was something
21 that we thought was also very important, and
22 documentation quality. We didn't talk about this

1 in the group yesterday, but I kind of looked at
2 documentation quality and the burden of data
3 entry as linked. Those are measures that might
4 be paired with one another. I'll talk a little
5 bit more about that. We thought that a
6 risk-management infrastructure for both the
7 vendors and provider organizations was important.
8 There were probably about 10 or 12 individual
9 measures that were on our list that were focused
10 on patient engagement, but we didn't necessarily
11 think they were safety measures. They were
12 patient satisfaction measures.

13 They were patient engagement measures.
14 They weren't clearly linked to safety, but we
15 still thought it was important to have something
16 in there that was patient focused, so we came up
17 with something that I'll go down and drill down
18 in more detail on that. We can go to the next
19 slide. The burden of data entry. We basically
20 felt that data entry burden for clinicians leads
21 to workarounds. You could put a lot of things in
22 that workaround category.

1 You would consider scribes to be
2 potentially a workaround. We can consider lousy
3 documentation to be a workaround, verbal orders,
4 for instance. We thought a potential measure
5 would assist in identifying those workarounds and
6 their use, figuring that the more often those
7 workarounds are used, the higher the data entry
8 burden, and the facility and vendor could take a
9 look at that. We also thought practitioners were
10 responsible for this, as well, in terms of the
11 quality of their documentation. If we go to the
12 next slide. In terms of data sources and data
13 collection methods, we were mindful of the burden
14 of data collection when you're looking at quality
15 and safety, so we wanted to see if metadata would
16 be a useful source.

17 One of the measures on our list was
18 number of orders entered by someone other than
19 the ordering provider. This started out being a
20 conversation about whether physicians are using
21 scribes to basically avoid having to do their own
22 interaction with the EHR. The concern with that

1 is that you are then exposing the clinical
2 decision support to somebody other than the
3 person who's making the decision.

4 We think that limits the usefulness of
5 clinical decision support. But then I think it
6 might have been Gerry that raised the issue of
7 how is that very different from nurses entering
8 verbal orders, which is very common? We sort of
9 put this in a bucket of any time someone other
10 than the decision-maker is entering orders,
11 you're potentially limiting the effectiveness of
12 the EHR and decision support. That was how we
13 framed that measure. One of the difficulties in
14 calculating that measure, based on metadata, is
15 whether an EHR application and implementation
16 discretely identifies all the different entities,
17 based on their role, and whether those are
18 discretely identified in the EHR and calculable
19 in that way. Next slide.

20 Concept 2, usability evaluation.
21 Usability evaluation can take a number of
22 different forms. I think everyone agreed that

1 it's critically important to do, both in the lab,
2 at the EHR developer, the vendor site, and to
3 emphasize a point that Karen made at the end of
4 the day yesterday, that's very different from the
5 way usability would be evaluated in situ, after
6 implementation. We think both are necessary.

7 That usability evaluation, one of the
8 difficulties with it is the time constraints on
9 clinicians to participate in usability
10 evaluations. That can take a form -- I think
11 there's a NIST standard on usability evaluation
12 that's something like 150 pages long. It's
13 unrealistic to think clinicians are going to take
14 several days off to go through that. On the
15 opposite end of the spectrum, though, there are
16 validated instruments for evaluating usability of
17 IT systems, in general, that are very quick and
18 dirty, but show good validity and reliability,
19 like the simple usability scale.

20 You've also got, certainly in academic
21 medical center level institutions, you have
22 informatics staff that are able to do usability

1 evaluations by directly observing clinicians, and
2 that doesn't impose any burden on the clinicians.
3 Next slide. I think I covered that already. Go
4 on to the next one. Documentation quality. We
5 think it's important that all stakeholders
6 acknowledge that they are obligated to assess the
7 quality of clinical documentation. We put that
8 in three buckets, the completeness of
9 documentation, its accuracy, and its timeliness.

10 In terms of the accountable entities,
11 we think providers, facilities and users and
12 vendors all have roles to play in that. Next
13 slide. Possible data sources and collection
14 methods. Vendors would need to obtain metadata
15 from the EHR to calculate the timeliness of
16 documentation. System time can be used to look
17 at how timely discharge orders are signed off on
18 and things like that, how quickly orders are
19 co-signed, they're put in as verbal orders, or
20 things like that. There's also an existing
21 quality measure in the National Quality Measures
22 Clearinghouse focused on medical record

1 completeness and quality. Comes from a French
2 healthcare quality organization, but it's very
3 specific in what it's looking for.

4 There are ten domains of completeness
5 that they look at, and then there are other
6 measures of timeliness and things like that.
7 It's a composite measure that looks at quality
8 and timeliness. Go on to the next slide. In
9 terms of risk management infrastructure, where we
10 left things yesterday in our group was that we
11 think it's important that organizations use
12 multiple methods to assess and identify safety
13 risks.

14 We talked about IT help desk tickets,
15 risk management information systems, most of
16 which are in place in most hospitals, trigger
17 tools, patient complaints and corrections to the
18 EHR and things like that. Something that I added
19 afterwards -- I thought about this -- everything
20 that we discussed in our group was very inward
21 focused on the institution, but of course, there
22 are many sources of safety data outside the

1 institution, so I added this, that organizations
2 should have formal processes for evaluating and
3 responding to risks identified by other
4 organizations, such as patient safety
5 organizations.

6 Many of the vendors have user groups
7 that address this, and, of course, the published
8 literature. Next slide. The data sources and
9 data collection methods are sort of implicit in
10 that, but we also recognize that what it's
11 reasonable to expect a provider organization, and
12 maybe even a vendor organization, to do is
13 different in different settings and for different
14 sizes and scales of organization. So you're not
15 going to have the same standards for a hospital
16 as you would for, say, a small physician
17 practice.

18 Next slide. Finally, engaging
19 patients in identifying safety problems. This is
20 the one where I said there were about 12
21 different patient-related measures that we didn't
22 think were too focused on safety, so we tried to

1 craft one that was. We said do patient portals
2 have mechanisms to identify errors, omissions,
3 and other safety problems and have corrections
4 reflected in other information systems, such as
5 the EHR, if there's an open notes initiative, for
6 example.

7 We didn't think it would make sense
8 for -- if that mechanism existed in a patient
9 portal, it doesn't make sense to focus strictly
10 on IT issues, but it could also include other
11 safety concerns that they didn't feel comfortable
12 sharing with the provider at the time. A
13 structural measure focused on this issue might
14 look at whether that feature is present in a
15 patient portal.

16 A process measure would look at
17 something like how often that feature is used, or
18 how often patients are engaged in that way. I
19 think that is it. I'll ask my committee members
20 to mention anything that I've overlooked, or if
21 someone else wants to emphasize something else.

22 Any questions?

1 MEMBER JONES: I have a question. The
2 charting quality, I don't know how to do this at
3 scale, but I'm wondering if, in the group, there
4 was any discussion of charting utility. Are the
5 things that get charted predictive diagnostically
6 or prognostically in ways that we expect? We see
7 a lot of variation in practice with that, and we
8 see that gets -- we see important changes in
9 documentation when we put in decision support
10 that actually uses it.

11 So the documentation is less of a
12 homework assignment, and it actually becomes
13 something meaningful to clinical practice. We
14 then get the side benefit that people start
15 documenting well because it matters. There's a
16 difference between a respiratory rate of 16 and
17 20 all of a sudden, where it never mattered
18 before. It matters if you document whether the
19 patient's disoriented or not. That never
20 mattered before. Did that come up at all?

21 MEMBER MARELLA: Not in that way, but
22 I think something that relates to it is we did

1 have a couple of measures that were related to --
2 there was one about the presence of order sets
3 for most common diagnoses and the presence of --
4 what else was it? Something about alerts. We
5 thought there was another group that had a number
6 of things related to clinical decision support
7 and how that affects documentation, so we sort of
8 put that on our tabled list.

9 CO-CHAIR SINGH: We talked a little
10 bit about -- I would really like to get to things
11 like copy/paste, things that could make a
12 difference of what you suggest, but we're not
13 there yet. One of the things I'd like to measure
14 is differential diagnoses done on a patient who
15 presents with new problems, or the length of your
16 note, or excessively long notes, which make no
17 sense. I think the measurability, the
18 feasibility was a problem that we just didn't
19 know how you would go around measuring these
20 things right now, so we kind of kept it fairly
21 broad. We just need something on documentation.

22 MEMBER MARELLA: But you could imagine

1 things like looking for problems identified in
2 free text notes that don't appear in the problem
3 list. You could probably come up with a list of
4 discrete things that could be --

5 MEMBER JONES: Yes. That's a hard --
6 if you have to do NLP, that immediately increases
7 the feasibility lift, but I'm thinking if
8 anyone's tried to look at the CMS sepsis measure.
9 That's fairly technical and clinically oriented.
10 Most measures are not constructed that way, but
11 if that's a trend, I think it opens up -- you
12 have things like what's the initial lactate, and
13 do you reduce it over time, and how long until
14 you measure it, and all of things which tend to
15 fit -- it's a little bit onerous, but at the same
16 time, tend to fit more with a clinical workflow
17 at the point of care, as opposed to something
18 that's totally discharge diagnosis or DRG
19 dependent and something that is not observable,
20 like mortality for 30 days or something like
21 that.

22 I just wonder if we're going to get to

1 a point where with EMRs and electronic measures
2 and changes in the way that even the government
3 measures things, do we have an opportunity to
4 link safety and quality in a meaningful way to
5 the actual delivery of care?

6 MEMBER MARELLA: The other way that
7 came up in our group, I think, was when we did
8 talk about the presence of order sets and things
9 like that and clinical decision support, it
10 wasn't just the presence of those things because
11 those things are already in meaningful use, but
12 rather, is the organization actually monitoring
13 the extent to which those things are used and
14 used appropriately?

15 MEMBER SEGAL: Just two fairly small
16 clarifications. We talked about this in our
17 group. I think I became annoying on it, on the
18 mention of portals, just because different ways a
19 patient -- the modes of patient engagement are
20 evolving.

21 I would just look at, in some places,
22 where we mention things like portals, we maybe

1 more generalize it, in terms of the use of
2 technology for patients to interact with the
3 record. There's a lot of dissatisfaction with
4 portals, as a model. People do secure messaging,
5 patient/physician, patient/clinician secure
6 messaging, not through the portal. Then also,
7 sort of similarly, I think, where you talked
8 about the vendors providing metadata for the
9 timeliness, I would probably generalize that.

10 Because again, it's going to vary by
11 product, and in many cases, there just may be the
12 capability in the EMR for people to generate
13 reports, that just EHR should have the capability
14 for assessing the timeliness of documentation and
15 focus on -- our engineers always tell me, tell me
16 what you want to happen, not how to do it.

17 MEMBER MARELLA: Right, good point.

18 MEMBER SEGAL: I think in this
19 instance, I think in this instance, I would focus
20 more on the outcome or the broader capability you
21 want.

22 MEMBER MARELLA: Okay, good point.

1 MEMBER HRIPCSAK: Just to say in our
2 session, Jason, when we talked about
3 documentation, we were focused -- quality of
4 documentation is important. We were focused on
5 efficiency and usability. We were thinking of
6 different metrics, like do you get your
7 documentation done within the time period you
8 have available? How much time do you spend
9 documenting after work was one question, but we
10 didn't know how to measure that.

11 Then we came up the timeliness. The
12 specific thing was do you finish or do you sign
13 off on your notes as complete within your
14 outpatient session? That was the actual concrete
15 metric we came up with for that one. That's
16 where we're looking, but I agree, we could also
17 look at the quality of documentation. That, I
18 think, would fit into -- the vendor's the thing.
19 We want to be able to say how many notes -- for
20 the patients who are registered during a session,
21 how many notes were completed during that
22 session?

1 MEMBER MARELLA: That's right. That's
2 the capability you want to have. People will
3 skin the cat different ways.

4 MR. HUNT: One problem with
5 documentation that constantly comes to mind is
6 that in so many other instances, we have a good
7 sense of what the prototype or the best case
8 would be. If we look back and think back on
9 documentation on paper, some of us who are older,
10 how many times did you finish all your notes at
11 the end of the session? How timely were your
12 orders before? We've never, as a profession,
13 done documentation very well, so it's hard to get
14 back to that golden era because we've never been
15 there yet.

16 MEMBER HRIPCSAK: We actually talked
17 a lot about how it was on paper. We had exactly
18 that discussion.

19 MEMBER MARELLA: David, back in the
20 day, you had so many fewer handoffs, and you had
21 fewer people taking care of -- people are using
22 the medical record in a way today that I don't

1 think they used the paper record before. A lot
2 of times, it was basically a physician maybe
3 documented enough to jog their own memory the
4 next time this patient shows up in their
5 practice. Whereas now, you're dealing with this
6 is the primary method for clinicians to
7 communicate with one another. I think the bar's
8 a little bit higher in what we have to expect of
9 the documentation.

10 MEMBER CLASSEN: I was wondering if
11 you guys discussed that now that we sort of moved
12 the dragon's net, I call it, up to the real time
13 -- because we all used to get the reminders from
14 medical records that your charts aren't
15 documented, and they're not finished, and if you
16 don't do it, we're going to remove your staff
17 privileges.

18 Having been in medical staff
19 leadership, that was the bane of my existence,
20 going after the doctors who didn't do their chart
21 finalization. We've moved that up to make it
22 much more acute. What's happened is people have

1 responded to that by doing end runs and
2 workarounds. It's not only the fact that we
3 don't document reliably, but we've really
4 decreased the quality of the documentation
5 through charting by exception and everything
6 else. When I look through my medical record now,
7 when I'm seeing patients, there are an awful lot
8 of same forms over and over again with very
9 little information in them. Narrative has
10 largely disappeared. My physician notes, as you
11 are well aware, basically copied information from
12 laboratory and radiology, with very little
13 narrative and impression.

14 It's very hard, especially for old
15 records, for me to find any valuable information
16 in this sea of information. What I'm wondering
17 is if all we're doing is saying are you
18 documenting with the same mindless template
19 that's charting by exception, and you're doing it
20 rapidly, is that helping me? What I was
21 wondering is were you thinking of the quality of
22 documentation, rather than just completing some

1 awful template?

2 MS. ZIMMER: This one will come up
3 with our group, as well, but a couple things just
4 to think about when we talk about documentation
5 because I think there's really two issues that
6 are happening. On the one hand, while technology
7 increases the access of information, which is
8 incredibly positive, it also has increased the
9 ability to increase the volume of patients we
10 see. When it does go down for an hour, whatever
11 that time we decide, everyone's heads are
12 spinning. They actually, today, can't handle
13 seeing their patients without technology.

14 We are at a point where we can never
15 go back because technology has pushed us forward,
16 but the other pressure that is not realized and
17 hasn't been talked about is we have to see
18 patients every 15 minutes. There's never a break
19 in the day that says, now take this hour to go
20 document, never. All that documentation is
21 happening on physicians' or clinicians', nurse
22 practitioners', nurses' time after work, unpaid.

1 Keep those pressures in mind when we're talking
2 about what's the reality.

3 MR. HUNT: I think it has been said
4 before, but I think it may bear repeating that
5 this is a direct correlation to the discussion of
6 the accuracy of diagnoses. I think the
7 relationship between the quality of documentation
8 and accurate diagnosis is direct, and it's
9 relatively proximate.

10 DR. PINES: Okay, any other comments
11 on Group B? I guess we'll move to Workgroup D.
12 Karen, I think you're up.

13 MS. ZIMMER: It's interesting going
14 last because you see which of the methods we
15 used, and of course, it's a hybrid of what
16 everybody's been doing. We really spent a lot of
17 time on narrowing from 27.

18 Unlike, I think, Eric's group, where
19 I think he said they only threw out one, we
20 actually went from 27 to 16, with a lot of rich
21 discussion in there, and then we did a lot of
22 regrouping, refining, rewriting, which went from

1 12 to 9, and then we rated them. That took a lot
2 of our time. The reason I'm saying that is we
3 did not flesh out, the way the rest of the groups
4 did, in terms of the resources and the rest of
5 that, the next detailed piece. I want to spend a
6 little time here because I have to tell you I was
7 surprised the way this fell out.

8 We'll go into the top five -- top six
9 because we had a tie, but I want to point out the
10 bottom three that did not make it into our top
11 six. One was the number of alerts, overrides and
12 times with clinical decision support modules are
13 turned on and off. I was surprised by that. I'm
14 kind of happy that it ended up in someone's
15 group. I have to be honest, I'm not sure if it's
16 just the way we all have alert fatigue, I almost
17 felt like we have alert solution fatigue. I
18 almost feel like it's one of those terms that
19 keeps coming up because do you turn it on, do you
20 turn it off? If you turn it off, you have
21 problems, if you turn it on, it's ignored.

22 I think I kind of sensed that our

1 group -- we have really a diverse group of
2 representation of stakeholders. I think we
3 almost weren't sure where to go with this, except
4 that it's a nice proxy for workarounds. That one
5 ended up lower, but as you saw, it ended up
6 higher in other groups. Identifying the number
7 of records, data elements and type of fields for
8 cut and paste.

9 Again, we thought it was highly
10 important, but how to do that, we thought the
11 feasibility was so low, it didn't rise up. I've
12 heard some people say that the text color will
13 change, but can you just imagine your eyes trying
14 to figure out what you added, and then what do
15 you add on top of that? It could be a little bit
16 -- it hasn't been fleshed out how you would do
17 that. We like the idea a lot, but we haven't
18 really seen great models of it, other than a
19 concept stage. However, we thought this was
20 really important because if you see people are
21 cut and pasting certain elements that would
22 inform your hospital or outpatient what data

1 elements are either -- could automatically be
2 brought over, like if it's to keep bringing over
3 the same demographic information, or are things
4 being brought over that shouldn't be and need to
5 be fleshed out.

6 It just could be very telling for
7 process improvement, but again, the tools we
8 didn't feel like were really there. The review
9 of all external sources, like care plan,
10 transition records, HIE to ensure appropriate
11 care. This one, we felt like the whole concept
12 of care plans is a very, very important area, so
13 I don't want to minimize that, but it's new.

14 It's in such early stages, we weren't
15 sure that needs to be part of the scope of our
16 group. The other piece that didn't even make it
17 to the top nine is on patient engagement. We had
18 a lot of similar discussions, as you did, Bill,
19 in your group. For us, we finally just decided
20 the patient engagement piece was a little bit out
21 of the scope of where we were. There were so
22 many other things to worry about. What we see

1 today for patient engagement will not be what's
2 tomorrow. What we see as portals are going to
3 have a whole different look and feel. There is
4 good evidence that people using patient portals
5 is not reaching the majority.

6 It's a very select group that use
7 patient portals, and it's variable. Some it's
8 just text messaging, some it's appointment
9 making, some it's labs. Again, we just thought
10 there's enough other things we could work on, and
11 you'll see our top five actually reflect a lot of
12 what the other groups also put in theirs. We can
13 go to the next --

14 MR. HUNT: The columns of numbers to
15 the right, what did they represent again?

16 MS. ZIMMER: It's just the total. If
17 you go back -- sorry. We just added them. We
18 were just looking for a quantitative way to rank
19 them. We can just go to the -- here you can see
20 the top five -- or six, sorry. The number in
21 front of it goes back to the original sheet, if
22 you want to see what the original was. With

1 that, I think we'll just go through them because
2 we don't have that much fleshed out. You can go
3 to the next one. Go through, sorry, it's the way
4 we -- chart that we created. Okay. Timely
5 clinical documentation and timely transmission,
6 when there is a transition of care, whether post-
7 visit or time of referral.

8 We see that there's a lot of delays in
9 documentation and access that have a downstream
10 patient safety consequence. For example, if you
11 don't put in the information that your patient is
12 on a certain medicine, you may not get the alert
13 that there's a drug-drug interaction, or you may
14 not -- there's a lot of smart sets and things
15 like that there that things have been programmed
16 and wired -- at least I know in EPIC because
17 that's the one I'm using -- but those won't rise
18 to the occasion if your documentation's late.

19 At the same time, with transition of
20 care, I can't tell you the number of times people
21 come post-ER visits and I don't have anything, so
22 you're kind of stuck. Again, we thought this was

1 facility and clinician. It's interesting. We
2 did not end up holding vendors accountable, and
3 it's not because Mark was in our group.

4 PARTICIPANT: But I tried.

5 MS. ZIMMER: I actually believe -- I
6 think that going back to, I think, Elisabeth's
7 point, there's a shared responsibility, but
8 someone ultimately has to move the boat forward.
9 You want them on the team, and you want them to
10 participate, but I'm not sure they're necessarily
11 accountable for that. Accountable is a small
12 word with a lot of meaning. Next one.

13 CO-CHAIR BELMONT: Mark and I had a
14 discussion at dinner last night, and following
15 your presentation, we're going to flash up some
16 language which I think captures some of that
17 point, so we can state it to you.

18 MS. ZIMMER: Wonderful. So again,
19 data sources, admission discharge transfer files.
20 We talked a lot about HIE and EHR. Again, we did
21 really flesh that out too much, except there they
22 are. Some of the concepts -- it sounds like

1 we're going to have a team to really delve into
2 metrics, which makes a lot more sense, but just
3 more of top of our brain ideas. You could look
4 at records closed within X time, once they're
5 open. As we know, there's many of us who are not
6 very good about completing our documents at the
7 time. One, because we don't have the time, but
8 as Bill had -- you had mentioned. It's true. A
9 lot of times, we'll put down just enough to jog
10 our memory later to put that down. We all know
11 the quality of that. The timeline between
12 physical disposition of patient and electronic
13 disposition of data, as well.

14 We just thought there are metrics to
15 get in there, so we thought obviously this was
16 feasible. Next. The next one's a timely follow
17 up on diagnostic tests. This would include
18 communication to the patient, ordering necessary
19 tests or documentation as follow up. The
20 original one we had was just labs, but we thought
21 it didn't just end with labs. It should also be
22 any diagnostic tests, imaging. It's not just

1 negative, but positive.

2 How many times do women, because it
3 has such a high sensitivity, do they get false
4 positives on mammograms, they're waiting to hear,
5 and there's a delay. You can say it was
6 positive. That's great, but they're stressed at
7 home and freaking their whole family out right
8 now. It's really important about the follow up
9 of all diagnostic tests. It needs to be
10 associated with workflow, should be configured,
11 implemented, and used in a way that ensures
12 diagnostic test results are identified and
13 communicated. Again, we lump this communication
14 piece to the patient, as well as ordering of the
15 next follow-up tests, if it's needed. There just
16 needs to be -- a big theme is follow-up.

17 Again, this was, again, facility and
18 clinician. Next. EHR and interface systems, and
19 then we thought, again, measure time from result
20 availability to outcome, whatever that outcome
21 may be, if it's communication, clinician follow-
22 up. We're not saying that all these metrics

1 should be in one, but just to give ideas to
2 stimulate for future thinking. Also, the percent
3 of charts with active problems versus allergies,
4 meds, coding and free text versus not in
5 structured, designated fields.

6 Again, we think that would be a really
7 useful kind of metric to assess on. It affects
8 the communication and follow up. Actually, I
9 feel like that was supposed to go in quality.
10 Actually, that was not supposed to go there, but
11 that's okay. That doesn't -- yes, that one we
12 ended up putting in later. I don't know if you
13 got that, so that part doesn't belong there.
14 Anyway, next.

15 MEMBER SEGAL: Just go back over it.

16 MS. ZIMMER: Yes, that one I have in
17 a different location.

18 MEMBER SEGAL: I think part of the
19 thought was in free text only, and not in
20 structured.

21 MS. ZIMMER: Yes, but that's -- it's
22 not even in the right place, so let's not

1 confuse. If we go back -- that's about timely
2 follow-up and diagnostic tests and the idea of
3 just measuring result availability to outcome,
4 end of story. Next one. Discharge and
5 transition note quality and completeness. This
6 is where we were talking about you might want to
7 look at the percentage of charts with active
8 problems, allergies, meds, in free text, versus
9 not in structured, designated fields.

10 As an example of when we're talking
11 about quality, there's actually an article -- I'm
12 sad to say because this was from 2010, so it
13 shows you we haven't gotten very far -- from
14 Jeffrey Schnipper in the Joint Commission
15 Journal, where they developed a consensus set of
16 12 required fields on discharge, and the
17 discharge deficient rate changed from 65 to 96
18 percent. Here, one of the challenges, of course,
19 is you have to figure out what the consensus
20 fields are. But we all know in discharge and
21 transition there are key elements we all need to
22 know.

1 It used to be the verbal handoff,
2 where we had a criteria. Well guess what? We
3 also need something in documentation. Discharge,
4 by itself, has been an issue since 2010, with no
5 improvement. That also feeds well into what Bill
6 and your group talked about, I think. No quality
7 is very important. Next one. Again, on EHR
8 reporting. Considerations.

9 As I said, what makes this one more of
10 a 2 in feasibility, as opposed to a 3, is you do
11 need to define the necessary data elements at a
12 local level and consider using natural language
13 processing. However, there's a false sense that
14 natural language processing is a little bit the
15 end all. There's a lot of work that goes into
16 that, as well. But my group did reassure me that
17 there are great apps out there that can do this
18 in a little bit more simple way than the
19 traditional fashion of the more labor-intensive
20 NLP. Next. The use of barcoded scanning in
21 medication preparation and administration. This
22 one's kind of interesting that it made it up

1 there because it's so focused compared to the
2 other ones, which are higher level goals. I know
3 I like this one because it does get to a little
4 bit of the workarounds.

5 Workarounds, by itself, is such a --
6 is a nebulous term that has so many elements that
7 how can you just address workarounds? You have
8 to kind of drill down. This one is a little more
9 concrete, systems and associated workflows should
10 be designed, configured, and implemented to
11 enable and ensure proper delivery of care, and
12 they should use the features and functionality as
13 intended.

14 This is one where there's been start
15 to be work, where again, everyone thought
16 barcoding and scanning would be the end all. It
17 is, if it's used correctly, but I sat on a number
18 of safety committee meetings knowing where it's
19 not and in these cases, where a person says
20 here's the negligent provider, it turned out it
21 was the culture of the entire department, so it's
22 a problem. Next. The last thing I would like to

1 point out with the metrics --

2 No, just a point. Because we really
3 didn't get to flesh out the metrics and things,
4 and I know that's going to be the next stage, one
5 thing I would encourage is if we break out into
6 groups and work on our defined metrics, we get to
7 our top ten, before we are asked with that
8 charge, is there a way to do a crosswalk of the
9 metrics that already exist that fit into the top
10 ten that we are going to be asked to address?
11 Because the idea of creating all new metrics,
12 we're not going to get great buy-in from our
13 stakeholders.

14 DR. PINES: Sure. Just to clarify how
15 the rest of the day is going to go. For the next
16 little while, we're going to discuss Karen's
17 presentation and comments. Next we're going to
18 talk about Elisabeth's work on shared risk
19 models. Then we're going to take a break, and
20 then Andrew's in the process of actually trying
21 to basically put the four presentations together.
22 We're going to be actually reviewing slides

1 together and trying to do some, actually,
2 wordsmithing for the measures that percolated to
3 the top. Because I think there was several
4 measures that multiple groups presented.

5 CO-CHAIR SINGH: I think just before
6 we do that, we might just sort of recap. I'm
7 trying to make a list here of all the concepts
8 that I heard across -- including matching our
9 patient engagement one, for instance, or
10 something like that. Did I miss one? You said
11 timely clinical documentation, timely follow up
12 on test results, discharge and transition note
13 quality, barcode scanning. What was your fifth
14 one?

15 MS. ZIMMER: There are six. It's
16 timely clinical documentation, timely
17 transmission when there's a transition of care,
18 timely follow up on diagnostic tests and labs,
19 imaging, that include communication to patient,
20 ordering necessary tests and documentation.
21 There's discharge and transition note quality,
22 incompleteness, and then use of barcoding and

1 scanning in medication preparation. Oh, I'm
2 sorry, you're right. We only hit those four.
3 The other two we didn't even get to. The other
4 ones were respond to patient electronic
5 communication. We used that word instead of
6 portals because that could include telemedicine,
7 portals within 48 hours. I know places right now
8 where they have people on call for telemedicine.
9 The way it works is you literally write an email,
10 and they will put you in the queue of when they
11 will respond to you on telemedicine.

12 That is yet another way that we are
13 responding to patients electronically. That's
14 why we use that wording. Then the last one was
15 med reconciliation performed, including patient
16 verification either during the encounter or
17 through technology, such as patient portals or
18 HIE, if available, kind of thinking forward.
19 That med rec, again, is really important, but
20 there's already been a lot of work on that by
21 NQF.

22 But those last two, five and six, we

1 actually didn't get to, in terms of fleshing out
2 details of resources and measurement
3 considerations. I just apologize. Does anyone
4 on our team want to comment on any more?
5 Because, as I said, they had so many thoughtful
6 comments, and I don't want to miss any.

7 MEMBER GRACE: I have a question.
8 What was the slide that said something about EHR
9 reporting? Was that a data source?

10 MS. ZIMMER: I believe it was. Maybe
11 that was the wrong word. The EHR reporting was
12 probably not great semantics. It was EHR
13 something.

14 MEMBER GRACE: There was a slide where
15 the top part of it -- it was in one of the more
16 detailed slides, and it talked about EHR
17 reporting. I might just not have looked at it
18 correctly. EHR reporting might have said --
19 might have been the source of data.

20 MEMBER GRACE: Yes. It's this one,
21 the data source. Okay, thanks.

22 DR. PINES: Just a process comment.

1 If you have a question or a comment, just go
2 ahead and put up your name tag like this. David,
3 go ahead.

4 MEMBER CLASSEN: Did the group talk
5 about how you're sure the patient actually got
6 the information and was aware of it?

7 MS. ZIMMER: I'm chuckling because we
8 were commenting that just because information
9 goes to a patient portal, there is no notice.
10 That even came up with medications. Again, I
11 can't comment on other systems, but it used to
12 be, in EPIC, where we would e-prescribe, and we
13 had no idea if the patient ever picked up their
14 medication. Now, that is in the chart, so now at
15 least you know if they picked it up. Of course,
16 you don't know if they take it, but you at least
17 now know they pick it up. To your point, there
18 is that challenge with information and ensuring
19 there's a closed loop.

20 DR. PINES: George.

21 MEMBER HRIPCSAK: Just a comment on
22 the natural language processing part. We've been

1 doing it for 25 years. I would say the main --

2 PARTICIPANT: At least 25.

3 MEMBER HRIPCSAK: And still haven't
4 gotten there.

5 PARTICIPANT: Exactly.

6 MEMBER HRIPCSAK: We think in the next
7 75, we're definitely going to be there. We're
8 going to nail it. It's actually quite accurate.
9 It works quite well, but you have to be careful
10 when you put in a quality measure because it's
11 very easy to game because they're usually using
12 these heuristics. You just have to be cautious
13 that they don't realize that if I just do this,
14 I'll get through the thing. Just when you're
15 using it in a metric, it's more dangerous.

16 MS. ZIMMER: Also, just to clarify how
17 we were thinking of using it was, for example, in
18 the one where we talked about information that
19 needs to be in structured fields that's in free
20 text, if you create queries looking how many
21 times do people put allergies in the free text,
22 that could be really useful because then it makes

1 you question is there something wrong with the
2 template? There's ways to do very targeted look
3 of the essential fields that you believe should
4 be structured to make it easier to send a report
5 to someone. We were thinking of it that way.

6 CO-CHAIR SINGH: I would like to give
7 everybody a reality check here because I really
8 think even with structured data right now, we
9 can't extract information from our EHRs. I'll
10 give you a real example here. We asked --
11 unknown system, I want to tell you that, IT to
12 simply extract hemoglobin, written queries.
13 Wrong, wrong output, hemoglobin A1C was sent,
14 wrong dates were sent. It's unbelievable how
15 much little data we extract from the EHR. As we
16 develop these measures today, please think if we
17 can't get structured data right now, in this
18 current day and age, despite these institutions
19 leading meaningful use, we're going to have a
20 hard time getting any NLP done.

21 DR. PINES: I think we've got Jason,
22 then Kevin, and then Mark.

1 MEMBER JONES: One of the things that
2 -- I guess Eric's not here today, but he brought
3 up yesterday as someone who's done a lot of work
4 in developing measures is immediately going to
5 what would we do differently as a result of this
6 measure? We've talked about a couple things.
7 You've mentioned some. That idea about
8 after-hours charting, which is really meaningful
9 to a lot of clinicians because I don't know
10 anyone who likes it.

11 Also, most patients don't like it
12 because it means they can't get the information
13 right away. If we can develop a measure
14 appropriately, that's something where we've
15 actually gone to the point, within Kaiser
16 Permanente, of offering courses for physicians,
17 which we realized we'd never done -- and nurses,
18 which we'd also never done -- about how do you
19 use an electronic medical record system? It has
20 resulted both in a net decrease in an hour
21 post-shift charting for clinicians and an
22 increased patient satisfaction by offering a

1 course. When we have things -- because I noticed
2 that a lot of this fell back to the clinician and
3 the facility.

4 If we start to think what are some of
5 the practical things that we could do, in our
6 experience, that was really profound, just
7 thinking about it. We never really taught people
8 how to do this in a consistent way. We just
9 assumed they'd be able to navigate the EMR in a
10 way that was easy for them and satisfactory to
11 the patient, but we never did it. Measures that
12 can help us get to that point, figure out what
13 might be effective, and then actually see the dot
14 move, both in terms of patient satisfaction and
15 clinician well-being would be fantastic.

16 MS. ZIMMER: I just want to comment.
17 It's a very good point. Even in our clinic --
18 because I work with a lot of the medical
19 students. They, depending on which attending
20 they're assigned to, have different expectations.
21 Some want it done in the room, some say you can
22 work on it later. One of the things I've worked

1 -- and a lot of this will change, I think,
2 eventually, when they can use something where
3 you're facing the patient and can type as you're
4 talking to the patient. Some of it is just a
5 style. One of the things -- I am just giving
6 this example.

7 I said to the medical students, you
8 can actually, after you talk to the patient, say,
9 I'm now going to summarize what I've heard. Can
10 you tell me if I got it right? So you're now
11 engaging the patient. You're getting your note
12 done, and they're clarifying because oops, they
13 forgot to tell you X, Y, and Z when they hear it
14 back of what you're typing. The other thing, I
15 know this is really novel, and I doubt anyone's
16 done this, but tell me how many of you have gone
17 to a visit where your provider has moved your
18 chair over to the computer, as opposed to a lot
19 of the retrofitted rooms, where the chair is
20 against the wall, my desk is on the opposite
21 side.

22 I had to teach the med students you

1 can actually pick up the chair and have them join
2 you and look over your shoulder because it's
3 their record. They can see what's in there. To
4 your point, a lot of it is an educational piece
5 of how to work with that. Then some people use
6 scribes. I know in the ED, scribes have become
7 very popular, and even dictation, again, which we
8 used 20 years ago.

9 DR. PINES: Kevin?

10 MEMBER HAYNES: A couple comments from
11 what I've heard, both from our group, as well. I
12 come from a world where we have beautiful
13 structured data because everybody around the
14 table loves to get paid. You guys do a really,
15 really good job of structuring the data in such a
16 way to get paid. But even there, there is a
17 very, very messy data world. I know we've talked
18 about lab around this table. Marsha Raebel and I
19 from Kaiser actually have a nice paper about the
20 number of different ways you get units for
21 hemoglobin A1Cs from 18 of the largest systems
22 across the country.

1 So you can just imagine the number of
2 ways you can do percent. It's incredible. I
3 want to highlight that structured data piece as
4 another example. The CVS that was below the
5 hotel last night has better medication
6 reconciliation data on me than when I hit the
7 front door at George Washington University this
8 afternoon, if I were to have a heart attack. We
9 know how to communicate structured data. It's
10 out there, so we did a lot of talk, in our group,
11 about the HIE. We recognized some of the
12 limitations there. I wanted to just comment
13 quickly on the NLP.

14 We weren't necessarily thinking about
15 NLP in a real-time quality type piece, but it was
16 more to see if I had, in a free text note,
17 allergy penicillin, but in a structured, I have
18 no known drug allergies, that's an issue because
19 -- it can just be done tomorrow, retrospectively,
20 and say all of this data is bad. It's not like
21 I'm trying to game the system because the
22 clinicians don't even know that it's real time,

1 but it could be done. That's why we gave it a 2
2 because I know there's a big lift.

3 But if you see, ALL: penicillin, and
4 they have a penicillin allergy, and their
5 structured text, to Hardeep's point, yes, it's
6 really -- it's bad because not only is it not
7 right in the structured, it's conflicting in the
8 free text. That was the discussion that we had
9 there. Those were just a few global thoughts.

10 DR. PINES: Thanks. Mark is next.

11 MEMBER SEGAL: On the patient use of
12 the data that's been made available, just two
13 quick thoughts. One is I think one of the things
14 I like about the measure of response to a query
15 is you sort of have a loop already established,
16 in a sense, for at least those people who are
17 motivated to seek information.

18 The other is just a thought -- and
19 there's probably people who know much better than
20 I do -- surveys like HCAHPS. I'm wondering if
21 either they already have measures that look at
22 patients' use and/or judgment of the availability

1 of their information, and/or just however that
2 survey is maintained over time, whether there's
3 an opportunity to add in some of these.

4 Because again, there is a ready-made
5 patient-oriented survey that's more and more
6 important that's used for payment, and that it
7 seems would be a basis to evaluate patients'
8 perception of EHRs, of portals, of whatever.

9 DR. PINES: David, do you have a
10 comment?

11 MR. HUNT: No, I'm good.

12 DR. PINES: Nana.

13 MEMBER KHUNLERTKIT: I just want to
14 comment on the second one, which is the timely
15 clinical documentation and transmission for
16 transition of care. I really like this one
17 because it's somewhat -- it's in relation to the
18 patient ID as a downstream effect.

19 As a healthcare system who have
20 multiple hospitals in which we share the same
21 electronic medical record for a patient, we found
22 multiple cases in which there is no timely

1 clinical documentation, in which when they get
2 referred out of one hospital and arrive another
3 hospital, they cannot register the patient in the
4 system because they have found an open bed at
5 encounter, or an open encounter, so they end up
6 creating a duplicate medical record for the
7 patient. I think the second one is really
8 important.

9 DR. PINES: Karen.

10 MS. ZIMMER: I'm sorry, one last
11 comment. I just wanted to share. When I first
12 was looking through this, before I had the wealth
13 and brilliance of the team, I almost saw
14 documentation -- 13 of ours fell into
15 documentation. I thought four of them were
16 dealing with reviewing data, two of them were
17 dealing with location of data, three of them were
18 dealing with the quality/accuracy, and four of
19 them were dealing with timeliness. We ended up
20 merging and combining and bringing in everybody
21 ideas, but I just wanted to point out a huge part
22 of our 27 were documentation. There was four on

1 patient engagement, and then I put three of them
2 in operation-type things. When we look at
3 overarching things, when we talk documentation,
4 we have to break it down, is my point. There's a
5 lot of nuance to it.

6 MEMBER HAYNES: And to that end, it
7 came up a couple of different ways, and similar
8 to your comment. First of all, the information
9 has to be there. Second of all, then, it has to
10 be transmitted, either pushed or pulled.

11 I think if your data warehouse only
12 pulls at 2:00 in the morning, and you get
13 discharged at 10:00 a.m. to a nursing home that's
14 even within the same system, it's not there --
15 let alone if the note is still open and the
16 person doesn't actually close the note until 3:00
17 a.m., when their kids are down and they close out
18 that note. This issue of documentation has a
19 couple of pieces to it, with regards to not only
20 does it have to be there, then it has to be
21 looked at by the admitting service of the nursing
22 home. There's a bunch of different pieces to

1 measure, so it's a really important concept, and
2 it's come up a couple of different times.

3 MEMBER GRACE: I think it was Mark who
4 said it, the comment about putting something in
5 HCAHPS survey. I'll have to check the HCAHPS. I
6 think there is some information, not the specific
7 question that you asked, but one thing that AHRQ
8 is working on right now is adding health IT into
9 the safety culture surveys. We'll start with the
10 hospital survey of patient safety culture. We're
11 sort of trying to figure that out. It's an
12 interesting question because you can look at it
13 from two ways.

14 As we talk about for some of the
15 health IT safety things we've talked about here,
16 is it a culture of how do you use your health
17 information technology to improve safety, or is
18 it how do you build a safety culture around your
19 use of health information technology? To me,
20 those are two different things. Anyway, we're
21 just starting the work on that.

22 MS. ZIMMER: Thank you for bringing

1 that up. I forgot Tejal had mentioned that to us
2 because that was our first one, and we all
3 decided since AHRQ was working on that, we didn't
4 necessarily need to work on that.

5 DR. PINES: David.

6 MR. HUNT: Erin, thank you so much for
7 saying that word. I made a note to myself for
8 when we have the roundup of all of the different
9 concepts. I was struck by the absence of that,
10 the discussion of culture, although almost --
11 I've been making notes -- almost in every one of
12 the measure concepts, the culture is looming
13 behind timeliness certainly, the quality of
14 documentation, diagnostic accuracy. In so many
15 aspects -- usability -- the concept of a culture
16 of safety is really the specter that's looking
17 over our shoulders. I was waiting to see how
18 long it would take before we at least even made
19 some recognition of it.

20 CO-CHAIR SINGH: Erin, we developed
21 some kind of early version of a survey to measure
22 HIT safety -- David's nodding his head -- we were

1 trying to work with Pascal Metrics to try to do
2 something about it. We submitted a grant to
3 AHRQ, but it didn't get good reviews two times,
4 so we thought there was no interest on the part
5 of the reviewers to take this concept forward. I
6 think we dropped the idea of doing anything with
7 it. It's up to -- if you really have interest,
8 you have access to the grant. You can look at it
9 and see if you want to do something useful with
10 it.

11 I'm sure all of us will work with you
12 to make whatever you want happen. It is exactly
13 the questions you asked. Is it about making the
14 culture safe about HIT or all of that stuff? We
15 have some items developed already, but it needs
16 testing, and Pascal knows this. We told him it's
17 not ready for the field right now, but that's why
18 it needs a grant.

19 MEMBER CLASSEN: We surveyed culture
20 in about 59,000 units across the country.
21 There's no doubt that culture is the key
22 determiner of outcome at the unit level here. We

1 really don't have a good culture assessment of
2 HIT, and I think that's why Hardeep's comments
3 are so incredibly important.

4 DR. PINES: Erin.

5 MEMBER GRACE: Hardeep, who's
6 submitted as the PI on that one?

7 CO-CHAIR SINGH: Jason Etchegaray. He
8 was at UT; now he's at Rand.

9 MEMBER GRACE: How do you spell that
10 last name?

11 CO-CHAIR SINGH: I'll send it to you.

12 MEMBER GRACE: Okay; thanks.

13 CO-CHAIR SINGH: I'm going to have a
14 tough time spelling that name, by the way.

15 MEMBER CLASSEN: I mean, it's so
16 important. Culture actually should be considered
17 as a measure of safety and HIT.

18 DR. PINES: Other comments? Thanks
19 Karen and Group D. Next, we're going to move on
20 to Elisabeth. She's going to share with us a
21 document that she's been working on -- and get it
22 up on the screen in just a minute -- on a

1 shared-risk environment.

2 CO-CHAIR BELMONT: Basically what I
3 did, it was Workgroup A who had come up with
4 several measures relating to vendor
5 accountability yesterday. They were
6 vendor-centric. I was very fortunate to sit next
7 to Mark at dinner last night, and he was very
8 gracious about bouncing ideas around with me for
9 how to approach this. Basically, what I did was
10 to take the measures that had been written from a
11 vendor-centric perspective and I changed the
12 concept to a more collaborative model.
13 Basically, what we want -- and I know the print
14 is kind of small, so I'll read it to you.

15 What the measure concept would be is
16 collaboration between providers, organizations,
17 and vendors that foster detection, fixing, and
18 learning from EHR system vulnerabilities,
19 including transparent exchange of information
20 relating to patient safety and user experiences.
21 This shared accountability needs to include
22 appropriate confidentiality provisions. Let me

1 just also share with you -- because again, the
2 print is small on that slide -- what we came up
3 with for measurable items. Hardeep was great
4 this morning at looking at what we did and offer
5 his thoughts as well.

6 The first measureable item would be
7 the sharing of best practices for EHR
8 implementation and best uses of EHR technology to
9 manage knowledge, and to ensure that those are
10 shared across provider organizations and vendors
11 on an ongoing basis. The second relates to
12 timely vendor notifications which are sent to all
13 users regarding: (1) concerns that are unique and
14 specific to technology; (2) concerns created by
15 the failure to use health IT appropriately, or by
16 misuse of health IT; and (3) the use of health IT
17 to monitor risk, healthcare processes and
18 outcomes, and to identify potential safety
19 concerns before they can cause harm to patients.

20 The third measure we came up with was
21 timely vendor response to resolving
22 provider-reported EHR safety concerns. No. 4 is

1 that vendor user groups will incorporate and
2 share current user experiences, and the fifth
3 measure is that software and hardware agreements
4 -- as actually implemented -- permit (1) the
5 sharing of user experiences with colleagues; (2)
6 timely vendor response to provider requests for
7 information; and (3) the use of either identified
8 or de-identified vendor product information in
9 research studies for peer review journals.

10 That last one recognizes that in some
11 case, the vendor may have legitimate reasons in
12 protecting certain information, so again, we want
13 to have a collaborative approach with vendors,
14 and that's why we included identified or
15 de-identified vendor product information. In
16 terms of methods of measurements, we had several.
17 One would be to survey users, providers, and
18 organizations regarding the timeliness of vendor
19 notifications. We could also survey users
20 regarding the timeliness of vendor responses to
21 reported EHR safety concerns.

22 One set of users we could survey would

1 be AMIA membership, for example. The last would
2 be an audit of applicable contract provisions and
3 the number of research articles that used EHR
4 screenshots or other vendor information that
5 looked at EHR patient safety concerns in peer
6 review journals or other scholarly dissemination
7 outlets. What I tried to do, in sum, was to
8 capture everything that Workgroup A had
9 identified and shift it from a vendor-centric
10 model to more a collaborative model. I certainly
11 would be interested in everyone's thoughts.

12 MEMBER FREEMAN: I appreciate what
13 you're doing here by expanding it, but I'm
14 wondering if we don't need to explicitly include
15 patient input as well, as part of that
16 collaborative team, because it's clearly not
17 assumed.

18 CO-CHAIR BELMONT: Good point. We can
19 easily do that. Other thoughts, comments?

20 MEMBER MARELLA: Elisabeth, as I read
21 some of these, a lot of them seem somewhat
22 qualitative, so member in AMIA, some things like

1 timeliness of response to specific events. That
2 would be pretty objective and discretely
3 measurable.

4 I'm wondering if this is something you
5 envision pursuing through maybe EHRA or something
6 like that, so that even for those things that may
7 be more qualitative or subjective, where these
8 principles aren't followed, whoever is pointing
9 that out can appeal to this. I know EHRA has
10 already established some standards for how
11 vendors should respond to safety information. I
12 don't know how many vendors have explicitly
13 subscribed to it.

14 CO-CHAIR BELMONT: There is a
15 voluntary code of conduct that EHR has, which
16 incorporates some of those concepts. I think
17 following up there, that makes sense, as well. I
18 think if we hit this from a variety of
19 perspectives that it makes sense. In terms of
20 AMIA membership, that was just meant as one
21 example. There are certainly other user groups
22 that we can survey. Another we can pursue this,

1 I'm in discussions right now with ONC to update
2 some contract guidance on EHR implementation and
3 software and hardware purchases that I did for
4 them a couple years ago.

5 We're talking about including a
6 section on health IT and patient safety. Some of
7 these concepts can be included in that work as
8 well. The other thing we can do is work on some
9 of the qualitative concepts to make them more
10 measurable. What I was hoping today is to see if
11 we could get consensus on whether this general
12 approach made sense to folks. Mark, please --

13 MEMBER SEGAL: I just want to follow
14 up on Bill's point because it's very timely
15 because I'm on the EHRA workgroup. We're looking
16 at a revision of the code of conduct. Some of
17 these aspects are already in it. I'd certainly
18 be happy, after this is processed through the
19 group -- and recognizing it's in draft -- to
20 bring some of these thoughts to the group.
21 Because again, that does -- I think we're looking
22 at multi-methods, multiple approaches. I think I

1 would agree that becomes one -- it's sort of a
2 basis for -- the way it's constructed, it's a
3 basis for a customer, for example, to hold a
4 vendor -- who says they subscribe to the code of
5 conduct -- accountable for what they do, in the
6 unique circumstances of that vendor/customer
7 interaction. In any event, I think you're
8 absolutely right that there's overlap, and I
9 think it's just really timely to kind of have
10 this injected as information.

11 CO-CHAIR BELMONT: The nice thing
12 about the overlap is I think it helps us get to a
13 tipping point, in terms of accepting this new
14 notion of shared accountability. David.

15 MEMBER CLASSEN: Just wanted to add to
16 that. I completely agree with this, Elisabeth.
17 What's interesting is when we do studies with a
18 flight simulator, what we find is that about 25
19 percent of the performance of a hospital's
20 implemented operational system is related to the
21 vendor they chose; 75 percent is related to their
22 local configuration and implementation. So

1 really, it is a shared responsibility because we
2 all customize the vendor products for our
3 implementations. So I don't think there's any
4 way around this. You can't say the vendor's
5 responsible because actually, it's only 25
6 percent of the performance that goes to the
7 vendor product. It's really the local operator.
8 I think they're both in this together, and we
9 must craft a way where both can allow this
10 information to be shared.

11 We've talked a lot about sharing
12 screenshots, but guess what? A screenshot from
13 one health system looks a lot different than a
14 screenshot from another because the local health
15 system configured it. It may not look at all
16 like what was certified on the shelf. That's why
17 I keep coming back, and why the IOM report so
18 screamed at this. This is a shared
19 responsibility because they're both in it
20 together. You can't really say one's guilty and
21 the other's not. They're both guilty, or they're
22 both involved.

1 CO-CHAIR BELMONT: Exactly. I think
2 that you need both perspectives to have a true
3 healthcare learning system. The other point I
4 would make, Mark and I agreed that if we are
5 going to share, it needs to be shared in what IOM
6 and I have called safe spaces. That's why we
7 said with appropriate confidentiality
8 protections. David, I would be interested in
9 your thoughts on this.

10 MR. HUNT: Yes. I like what I see.
11 I think that this really -- we talked a little
12 bit about the collaboratory yesterday. I think
13 this is one piece of work that actually would
14 find a good home in some type of shared safe
15 space, where a number of the stakeholders could
16 get together and work together. One thing I'm
17 struck with is -- and I just made a note to
18 myself -- the concept -- I don't know exactly how
19 we get around -- this is perhaps one good step,
20 but we've danced around the concept of
21 prohibitions in sharing intellectual property.
22 I'm just trying to figure out -- that always

1 seems to be a stop.

2 Once the intellectual property
3 discussion comes, that means there's a stop of
4 any progress on any process. I'm wondering if
5 that would mean that there's some way to make it
6 such that that's not a stop for the whole
7 process. It just means further engagement from
8 the intellectual property holder -- that they've
9 got to put more at stake. They've got to put
10 more resources to one, work through the process,
11 discuss more, and work directly with those
12 involved in trying to solve the issue, rather
13 than let it sit over on the side. I think that
14 might be a way of having some balance to this.

15 CO-CHAIR BELMONT: That's a great
16 point. The way I approached this from
17 MaineHealth is to actually draft a carve-out, if
18 you will. I certainly understand, in this
19 competitive age, why the vendors want to be
20 careful about who they share intellectual
21 property with, but I think sometimes we can ask
22 for information that relates to patient safety

1 that is not necessarily considered intellectual
2 property. Again, I think it goes back to the
3 collaborative sharing, getting the vendor feeling
4 comfortable, and saying, "What is the information
5 that we need?"

6 That's why also, in the language,
7 where I said that the vendor would share either
8 identified or de-identified product information,
9 that language was in there to address the
10 intellectual property concerns because the vendor
11 may not want to share certain identified
12 information. I think we can work with the vendor
13 on that. The reason that I put de-identified
14 information in there, as well, is that I don't
15 want the vendor community to think that we want
16 to highlight errors that some of their products
17 may have. I think what we can do, again, if we
18 offer them the protection of de-identified
19 information, it allows us to flag the issues, but
20 we're not pointing fingers.

21 MEMBER SEGAL: Could I just respond
22 real quickly on David's point of IP being a full

1 stop? My sense is that's not exactly the case.
2 In some instances, IP concerns can be, let's say,
3 a speed bump, or adding some friction. For
4 example, it may then require somebody who wants
5 to use a screenshot to ask for permission, but
6 the fact that one has to ask for permission in
7 some cases doesn't mean it won't be granted.

8 Again, one of the things we wanted to
9 have was the timely response to that. I think
10 you also have -- again, I'm not an attorney, but
11 I've dealt with IP issues in past lives. In
12 order to protect IP, as you know, particularly in
13 technology, you have to have contractual
14 provisions you have to enforce. But at the same
15 time, I think that these provisions are
16 typically, particularly in the current
17 environment, let's say implemented in a fairly
18 sensitive fashion. I can tell you, for example,
19 just for our company, that our user group -- and
20 Elisabeth and I talked about that -- it's an
21 independent group. Again, it's sort of archaic.
22 They have a bulletin board that they still -- for

1 exchange.

2 There's free discussion of issues that
3 people find with their product. I think that's
4 common of the industry generally. I think it's
5 one where -- whether again, as Elisabeth is
6 talking about, having it model contract language
7 to have better contracts that both parties agree
8 with, but I think it's one where it's clearly a
9 consideration and a concern. I wouldn't frame it
10 as it stops the discussion. In some cases, it's
11 the starting point for a discussion.

12 But that's also -- just the final
13 point I'd make is why we wanted to focus on sort
14 of an actual outcome. Rather than evaluating a
15 contract provision, let's look at how that
16 actually affects what happens in practice.

17 CO-CHAIR BELMONT: I think by focusing
18 on an outcome, as Mark suggested, that helps you
19 draft a limited carve-out that the vendor would
20 be more receptive to doing on the intellectual
21 property front. I think we have Greg, then
22 Karen. David, did you have your tent up again?

1 MR. HUNT: No.

2 CO-CHAIR BELMONT: Okay, so Greg and
3 Karen.

4 MEMBER RUSSELL: I just want to
5 actually say I appreciate a lot of the changes
6 that you made with Mark's input. They really
7 actually do hit us. Just want to go back to
8 really some of the occurrence we have typically
9 -- as Mark's already addressed -- is really just
10 not a free-for-all, but people actually
11 thoughtfully using the information, the
12 intellectual property, screenshots, things like
13 that. As David said, I think one of the things
14 we see consistently when people ask for
15 permission for screenshots and they send them in,
16 they're all over the place.

17 They don't really reflect,
18 necessarily, what we would expect people to do.
19 They may be something different. That's one.
20 No. 2, we see so many screenshots come in with
21 PHI, all sorts of other things. They're in
22 terrible shape. We just want to make sure that

1 if there's a screenshot that is included and we
2 give the permissions for it, that it does have --
3 it looks appropriate, and it's appropriately
4 representing what the system has, not just
5 something somebody clipped off that doesn't
6 necessarily reflect things accurately.

7 I actually like the idea that you're
8 talking about that it's a shared responsibility
9 between the people who want to share the
10 screenshot and the vendor who wants to not only
11 just protect IP, but also want to make sure that
12 things are being reflected accurately. The one
13 question I did have is just on the timely vendor
14 notifications are sent to all users.

15 Maybe just need a clarification there
16 because that can be construed that you have to
17 try and find every single user of the system,
18 which is actually not even possible, so just
19 organization or something provider level.

20 Otherwise, I have to Karen down and let her know
21 specifically, and that's just not even doable.
22 But otherwise, much cleaner and nicer.

1 CO-CHAIR BELMONT: Thank you. We can
2 certainly make that change that you recommend.
3 In terms of the screenshots, since this is such a
4 big issue, I think that your comments are
5 helpful. I think in the text of the report, we
6 can include some of those points so people
7 understand. Karen.

8 MS. ZIMMER: This would be great.
9 This is a great idea. One of the questions with
10 surveys is would you have users -- I know it's
11 generic. It says providers and organizations. I
12 just want to make sure when you get more granular
13 that in providers, you're including IT
14 departments, and not necessarily end-user
15 clinicians or nurses -- just them.

16 The reason I'm saying this is when we
17 had done the usability study with hazard manager,
18 the IT issues that came in were described very
19 differently when it came in from the IT
20 department for the pilot study sites that use the
21 IT department versus those that use their risk
22 quality. I just --

1 CO-CHAIR SINGH: IT included in the
2 organizations. That's where the IT departments
3 have --

4 MS. ZIMMER: Okay, because every time
5 I see providers, I think people jump right to ---
6 it says providers/organizations. I would almost
7 put IT departments in there to give them more. I
8 think they're crucial and essential.

9 CO-CHAIR SINGH: So what I'm hearing
10 -- and again, I'm just going to summarize --
11 there should be no reason for vendors to refuse
12 sharing or dissemination of the screenshots, as
13 long as it's de-identified in, let's say, peer
14 review journals?

15 MEMBER RUSSELL: I don't know if it's
16 that broad. I think we just need to have more
17 discussion on what that really means and what's
18 the context of it and how we're going to -- I
19 guess the big thing we want to have is just not
20 the idea of there's a free for all of just being
21 able to just take a screenshot and put it
22 anywhere you want to at any time.

1 With more of the give and take I think
2 that we just talked about of making sure that
3 they're being used appropriately, they are the
4 appropriate screenshots, and the people asking
5 are the appropriate people to be asking too. I
6 think there's a lot of nuance there yet. I think
7 there may be times where you say -- I think
8 there's got to be an opportunity to sometimes say
9 no because of the appropriateness, for IP reasons
10 or whatever, but I think we're certainly going to
11 be more open.

12 CO-CHAIR SINGH: I'll give you an
13 example. We have a paper where we compared eight
14 different EHRs on their graphing capabilities.
15 There's only two screenshots in that paper, and
16 you know why. If we were to redo the paper in
17 two years from now, would we be able to publish
18 all those screenshots of all the vendors?

19 MEMBER RUSSELL: I'm not in a position
20 to say, to be honest with you.

21 CO-CHAIR SINGH: But then who is?

22 MEMBER RUSSELL: I think that's

1 something, again, back to the shared
2 responsibility piece of coming up with what are
3 the guidelines around what's going to be
4 appropriate as to when to share what, in what
5 context.

6 CO-CHAIR SINGH: Because actually, for
7 all -- I actually de-identify the sites when I do
8 research because I don't want the sites to get in
9 trouble because most of the work that I do makes
10 every site that I work with look bad. I would
11 like to de-identify the vendors, too --

12 PARTICIPANT: That's why you're so
13 popular.

14 CO-CHAIR SINGH: Yes, exactly. I
15 would like for anybody to use that information
16 for improvement. If that means that the six
17 vendors or five vendors or whatever that were
18 involved take that information that was displayed
19 in that paper, use their ranking to make
20 improvements amongst themselves and share those
21 lessons that we put in that paper out there,
22 amongst their teams or wherever, as long as it's

1 useful.

2 But I don't see that kind of
3 dissemination from the current peer review
4 literature that's coming out, or from anywhere
5 else, being translated openly into improvements,
6 or at least the providers can see it. That's why
7 you see a lot of anger built up that vendors
8 aren't letting us -- they're putting gag clauses
9 on us. That's what they mean by gag clauses. I
10 think that's an issue we'll have to address, in
11 terms of shared responsibility.

12 CO-CHAIR BELMONT: As much as I would
13 like to give you a definitive yes, I think there
14 are some --

15 CO-CHAIR SINGH: Oh, I know I'll never
16 get it.

17 CO-CHAIR BELMONT: I honestly think
18 that there's some education that needs to be
19 done. This is an issue that the vendor community
20 feels strongly about. I think picking up on
21 Greg's point, and if we can include in the text
22 and report circumstances under which this will be

1 done, I think we can make the vendor community
2 more comfortable with those.

3 At the end of the day, we want to do
4 that because we want the vendors to collaborate
5 with us. I think we may need to walk before we
6 run on this point, but I think addressing this
7 here, addressing this in the ONC contract
8 language -- as Mark has graciously agreed,
9 carrying it back to his peers -- I really do feel
10 that we are approaching a tipping point. I think
11 it's important that we approach this in the right
12 way. David. Sorry, Jason.

13 MEMBER ADELMAN: As someone interested
14 in health IT safety and an advocate for patient
15 safety, I think that vendors should share all of
16 their good, so that everyone can learn from each
17 other. In the United States, in a free market,
18 in a capitalist market, it would almost seem like
19 it'd take an act of legislation to mandate that.
20 The president of Cerner today may be all for it,
21 and the next president may not be. I guess we
22 can make a recommendation, but I don't -- it

1 would be quite something, I think, to just say
2 you must share everything all the time. We had
3 conversations yesterday about why a particular
4 vendor chooses to be careful about screenshots.

5 They want to make sure it looks good.
6 They want to make sure it's used in the right
7 context. But the thing that's not often said is
8 they also just don't want to constantly share
9 their secrets. They're competing with each
10 other. I just don't know how far we get to go
11 with this.

12 CO-CHAIR SINGH: Actually, I would
13 like to add to that. I think what researchers
14 and the public wants to know is the bad stuff.
15 We don't necessarily need to show this vendor is
16 the one that had the worst screen. We want to be
17 able to show here's an example of a screen that
18 should never exist. You should talk to some of
19 the lab people. They're the ones who I get the
20 most horror stories from. I don't think we need
21 to know every beautiful screen. In fact, if the
22 screen's in the paper, there's a reason it's in

1 the paper -- because it's really bad. We had
2 graphs that were graphing backwards. We had
3 graphs that were graphing with different
4 intervals for different times. That's high
5 school math, guys.

6 CO-CHAIR BELMONT: How about this as
7 a compromise? What if I work with Greg, Hardeep,
8 Jason and David and we come up with some text
9 that will go in the report that talks about this
10 issue? I think we can provide the vendor with
11 some compelling reasons as to why we want to
12 share this information for patient safety concern
13 and, again, indicate that we will work with them
14 to make sure that the screen is displayed in a
15 way that they are comfortable with.

16 I think that three quarters of a loaf
17 may be better than no loaf at all. If we're
18 trying to do a paradigm shift here, I think we
19 have to do it in a way that makes the vendor
20 community comfortable. David, do you --

21 MEMBER CLASSEN: All I would say is
22 that we need to find a way to do this in a safe

1 learning space. So as we think about this, I
2 think given the litigious aspect of our industry,
3 it's not just vendors who don't want to share
4 safety problems. It's health systems, as well,
5 as we understand. I think we need to end up at
6 the point where we have a safe learning
7 environment, where safety's not something we
8 compete on, we collaborate on.

9 I think that's where many other
10 high-risk industries got to, but it took them a
11 long time to get there. Just imagine Boeing
12 saying, after a crash, "You can't see this part;
13 its proprietary." That just doesn't happen. But
14 it took them a while to get there. I think we
15 have to have a safe space that we can all learn
16 together because we're just far too litigious to
17 get there without it.

18 CO-CHAIR BELMONT: I think, David,
19 that goes back to the PSO discussion that you and
20 have been flirting with. I think sharing the
21 information through PSOs is one way. There are
22 also confidentiality agreements that you can

1 enter. There might be some protection under
2 state peer review statutes. Again, if Greg,
3 David, Jason and Hardeep are willing, I think we
4 can include some text that will make a compelling
5 case for this.

6 MR. HUNT: With this process, I don't
7 want to hang out on the clothesline Mark and Jim,
8 if there's a way that we can see a process to
9 bring in some of those -- on the legal side -- of
10 the vendor community. So many times, you can't
11 speak, and I understand, but is there a way to
12 somehow or another bring in those who actually
13 can and begin to engage in this process? I know,
14 Elisabeth, when lawyers start talking, that's
15 just -- you can talk that stuff that you talk.

16 CO-CHAIR BELMONT: I actually have a
17 lot of friends in the vendor community. I can
18 chat with some of them about that. But as I said
19 to Mark last evening, the way I tend to work with
20 vendors on contracts, even though I'm aggressive
21 on certain things, at the end of the day, if both
22 parties want to make a deal, there's always a way

1 to meet in the middle.

2 I firmly believe that there's a way to
3 meet in the middle on these issues here. I think
4 one can respect vendors' intellectual property
5 issues and still be able to share certain
6 information that will help advance patient safety
7 goals. I think it's looking for that balance.
8 Other thoughts?

9 MEMBER HEERMANN-LANGFORD: I just
10 wanted to reiterate, I think what David was
11 saying, about the provider or the clinical side
12 of the house, when it comes to screen designs --
13 my observation of what's happening with
14 Intermountain and designing within Cerner,
15 there's a lot that Intermountain is having to
16 say.

17 The screen designs are not just vendor
18 owned, so it's not just the IP out of the vendor.
19 It's the IP out of the clinical house, and it's
20 what Hardeep is saying as well. I have no
21 confidence that every screen that we're designing
22 at Intermountain meets our standards even, at

1 times, because it is such an army of people, and
2 some that have never done this before, that I
3 have no doubt that we're not going to have a few
4 little flubs here and there.

5 I think what you were saying,
6 Elisabeth, is it really is coming to the middle,
7 not just within the vendor communities, but
8 finding that we have the safe environment and
9 bring everybody to the table. Because it is the
10 configuration as much as anything else that's
11 going on in there.

12 CO-CHAIR BELMONT: I'd encourage -- if
13 other people have thoughts that you want to
14 include in the text that describes that measure,
15 please send me your thoughts by email and we'll
16 incorporate those, and then we'll redistribute it
17 to the entire community. Are people generally
18 happy, then, with the direction that we are going
19 with the additional modifications that we agreed
20 on? Thank you all.

21 DR. PINES: Is there another comment,
22 David?

1 MEMBER CLASSEN: I think this is an
2 absolutely critical issue because you can't
3 really effectively have safety measures if you
4 don't resolve this issue.

5 CO-CHAIR SINGH: So are we getting
6 ready for a break in a few minutes? Should I do
7 my summary now and let people think about it, or
8 after the break? I have just a little summary of
9 the 20 concepts. Here's what I sort of just did.
10 I'm thinking all the group leaders are here,
11 right? Perfect. I'm going to just repeat what I
12 heard from you in terms of your top five, just
13 for people to sort of think about -- and I'm only
14 going to talk about the measure concept at a high
15 level. I'm not going to go over the measure or
16 anything like that, but just make sure that you
17 get it right. I'll stop after every one of them.
18 You people will see some things are also coming
19 together. Eric, I'm going to start with you.

20 Your top five measure concepts
21 revolved around measuring safety of the patient
22 interaction with the clinical provider,

1 simulation-based measurements, such as Leapfrog
2 tests, but on multiple other types of safety
3 issues, not just DDIs, getting clinical distance
4 reports and alerts right, such as the need to
5 reduce alert overload, measuring safety around
6 patient-facing technologies and getting these
7 technologies to fix safety issues as well, such
8 as corrections done to errors that patients find
9 in their medical records.

10 The fifth was measurement related to
11 EHR availability, integrity, confidentiality,
12 realizing that was not as much fleshed out, but
13 around that general area. We talked about real
14 and functional downtimes. Does that sum up your
15 five concepts? Okay, awesome.

16 Gerry, you ready? Yours was measuring
17 safety related to test results' availability and
18 display in the EHRs, including when test results
19 were not either crossing over or displayed
20 poorly, measuring unexpected downtimes. Third
21 was measuring risk of misidentification issues
22 through looking at duplicate patients in the EHR,

1 such as the Hopkins measure that Nana talked
2 about.

3 No. 4 was measuring time spent on
4 testing versus development, again, a measure that
5 was not very well thought through, but had some
6 nice overlap with some other types of measures,
7 but really an important one that we discussed
8 quite a bit about. Your fifth one was a big
9 checklist which discussed, I think, most
10 importantly, the shared risk environment and
11 responsibilities, so I'm going to just sort of
12 maybe say that Elisabeth's discussion sort of
13 helped build on that checklist.

14 We can go back to the checklist to see
15 if there's really important things that you may
16 want to include going on to our discussion.

17 Okay, fair? Bill, you ready? Measuring data
18 entry burden as a proxy for safety, measuring
19 documentation quality as it relates to
20 implications for improving diagnosis or
21 treatment, measuring the usability testing and
22 evaluation so it's being done right to improve

1 patient safety, including using end users to
2 improve design and development. Then we proposed
3 a structural measure related to the organization
4 of risk management infrastructure, so that
5 organizations are actually measuring safety
6 through retrospective and prospective approaches
7 and learning through the data.

8 We talked about local safety teams,
9 help desk logs, and other things, measures of
10 data that the organization is collecting, the
11 concept being unless we merge HIT safety with
12 what organizations are already doing in their
13 risk-management programs, we're not going to be
14 able to get the leverage we need.

15 The fifth one was around patient
16 engagement and safety, very much overlapping with
17 Eric's No. 4 around patient-facing technologies.
18 Anything I missed? Karen, you're ready for your
19 five? Measures of timeliness and accuracy of
20 clinical documentation in high-risk transitions,
21 measures of timeliness of follow up of test
22 results, measurement of discharge and transition

1 documentation not quality -- again, documentation
2 quality being overlapping with other areas as
3 well. No. 4 was barcode scanning. No. 5 was
4 measuring response to patient-initiated
5 communication -- electronic patient-initiated
6 communication. The sixth one was med rec as some
7 sort of a safety measure. Got your six, right?

8 There was two overarching issues that
9 we needed to think about, which haven't been
10 covered well elsewhere, measurement enabled
11 through items in safer guides -- either in part
12 or as a whole -- and then safety culture. We had
13 a discussion on measurement of safety culture.
14 Anything I missed that any of the groups -- or
15 any other concepts -- because I think we've got
16 stuff written, but I think these 22 items -- or
17 23 items, actually, is going to help us push
18 forward.

19 I couldn't help myself but to write
20 them down because otherwise, I wouldn't have.
21 Anything you want to add? Anything I said that
22 anybody -- last minute thoughts? No? Okay, back

1 to you.

2 MS. PHILLIPS: Is there anyone on the
3 line for public comment? Operator, can you open
4 the line for public comment?

5 OPERATOR: At this time, if you would
6 like to make a comment, please press star, then
7 the No.1. And there are no comments at this
8 time.

9 MS. PHILLIPS: Let's take a 15-minute
10 break. That'll be until 11:00.

11 (Whereupon, the above-entitled meeting
12 went off the record at 10:44 a.m. and went back
13 on the record at 11:11 a.m.)

14 DR. PINES: All right, if everyone
15 could have a seat, we're going to go ahead and
16 get started again. All right, so essentially,
17 what we're going to do -- let's go ahead and get
18 started here as everyone sits down. Thanks for
19 -- got to herd the cats here.

20 So again, thanks for bearing with us.
21 We took a little longer break so we could get
22 ourselves organized. What we're going to do here

1 is really try to do a harmonization exercise,
2 where we're hopefully going to be able to come to
3 some agreement on the measure concepts. What
4 we've done is taken a lot of the work that's come
5 from you and tried to really summarize this
6 information on the slides. We weren't able to
7 get all the information from the PowerPoint
8 presentation onto the slides, so we're going to
9 have Hardeep basically moderate a discussion,
10 where we're going to really try to come to some
11 agreement on these concepts, specifically the
12 areas -- at the top, we have the overall measure
13 concept.

14 We have some examples, accountability.
15 And accountability may differ a little bit from
16 example to example, but what we want to do in
17 that box is list pretty much all the accountable
18 entities for the overall measure concept, data
19 sources, and any other additional measurement
20 issues and considerations. On the fly, we're
21 going to be trying to populate from the group
22 discussion, and also from some of the information

1 from the PowerPoint. I know that some of this
2 information has already been presented. Let me
3 turn it over to Hardeep.

4 CO-CHAIR SINGH: I think we'll have to
5 sort of all learn how we're going to do this.
6 Maybe what we could do is have final thoughts --
7 we're going to walk through probably 20, maybe,
8 slides, by the time we consolidate, maybe a
9 little less, 18 slides.

10 DR. PINES: I think we have less than
11 that, yes.

12 CO-CHAIR SINGH: We've got
13 accountability information on a lot, but you're
14 going to populate, and we can refine it as we go,
15 on the fly. For data sources, you've got
16 information. We'll all contribute to data
17 sources, modify it, put it in there. Then if
18 there's major measurement issues and
19 considerations, you already have some, we'll put
20 it in there. I think first, I think what I'm
21 going to do is start discussing this as the
22 example while you all populate, and then let's

1 just go down the list and see if we can do that
2 every slide.

3 MEMBER SCHNEIDER: Hardeep, I'm sorry,
4 just to -- I apologize if I missed this -- it was
5 said earlier, but where do you want to end up,
6 which will help us calibrate our thinking a
7 little bit?

8 DR. PINES: I think the overall goal
9 is to have all the ideas on these slides and
10 hopefully, on at least some of the slides, some
11 sort of group agreement and harmonization across
12 the groups.

13 MR. LYZENGA: Are we trying to cut
14 down to a certain number of concepts here is the
15 question.

16 DR. PINES: I think our ideal would be
17 potentially ten concepts as a target, but if it's
18 a few more than that, I think that's okay.

19 CO-CHAIR SINGH: Yes, but I think this
20 exercise might help us realize that actually, a
21 couple of these are obviously duplicates, but
22 also we don't think that they are as important as

1 we thought they were, even though they were on
2 the paper that I read out earlier.

3 MEMBER SCHNEIDER: So the end product
4 would be a list of somewhere around ten in
5 priority order, or just the ten?

6 CO-CHAIR SINGH: I don't think it
7 would be priority order, no.

8 DR. PINES: We'll see how far we can
9 get today. If we can get through all this and
10 have some voting and overall prioritization at
11 the end, we could potentially do that today, but
12 we'll see how far we can get. Another
13 alternative would be to do a voting after the
14 meeting.

15 CO-CHAIR SINGH: I think the ten was
16 arbitrary. David, if we end up saying I think
17 it's 15, not 10, that's probably okay, as well,
18 as long as we can maybe decide later if some of
19 them are higher priority.

20 All right, we'll give you five, then.
21 Let's go through this. This measure would
22 address -- on the top is basically the principle,

1 and maybe the issue, so this is EHR system
2 issues, system to system interface issues, which
3 we know is a problem. The measure and the
4 measure concept -- I'm thinking this is close to
5 a measure -- is number of times an important test
6 result is not available as a result of a system-
7 to-system interface issue.

8 Jesse, this kind of combines the
9 display? This is probably raw, written from
10 before. I would like to first vote and say which
11 should be available or displayed, in addition.
12 Did you mean displayed? Do you know if you
13 combined -- is there a separate one on display?
14 There's probably not, right? This is the only
15 one? Display is what I added to --

16 DR. PINES: I think this was just on
17 data availability, so basically being able to see
18 the information that's necessary in the
19 electronic health record to best treat the
20 patient.

21 MR. LYZENGA: We can maybe wordsmith
22 this based on --

1 CO-CHAIR SINGH: Yes, let's work this.
2 I would say -- and I'm not sure if it's number of
3 times, or we can just say -- I guess we have to
4 pick a number because we don't have a denominator
5 -- we don't need a numerator or denominator,
6 correct?

7 PARTICIPANT: Not at this point.

8 CO-CHAIR SINGH: Not at this time,
9 okay. The number of times -- key test results or
10 any test results? How do we know what's key?
11 Maybe remove the word key, maybe? Please, I'm
12 just putting in my thoughts. Feel free to
13 modify. Test results not available or displayed,
14 I think, should be said. That takes care of two
15 things as one. Example, to facilitate diagnosis
16 of treatment as a result of system-to-system
17 interface issues.

18 MEMBER SEGAL: Couple of questions and
19 thought. For this one, my recollection is this
20 was more about intra, within organizational
21 interfaces. I think we ought to be clear on
22 that. Secondly, I think we probably want to have

1 some concept when such availability would be
2 expected. In other words, if the hospital had
3 not developed an interface, let's say, between
4 two systems, then they're going to know.

5 They wouldn't have an expectation. I
6 think it would be where there's an interface in
7 place that either did not perform as expected or
8 was down or what have you. I think you need to
9 have some sense that there was a reasonable
10 expectation of the data being available.

11 CO-CHAIR SINGH: As a result of a
12 problem at the system-to-system interface in an
13 organization's EHR?

14 MEMBER SEGAL: I want to get at the
15 EHR issue. I think that it's -- you could
16 imagine two systems that no one bothered to
17 interface them. They could be operating at a
18 health system. I think that's different than if
19 you have an interface between a lab information
20 system and an EHR, or PACs and an EHR, and it
21 doesn't work. I think we just want to bound it
22 by when we would expect --

1 CO-CHAIR SINGH: So number of times
2 test results not available or displays as
3 expected.

4 MEMBER SEGAL: As expected, yes. Then
5 the other on the EHR is I think -- this is a
6 general point. I think we're really talking
7 about health IT safety. Particularly if you
8 think about issues like what we were just talking
9 about, it could easily not involve an EHR. It
10 could involve a PACs to a RIS. It could involve
11 a lab information system to a surgical system. I
12 just think we want to make sure we're
13 generalizing it, where an EHR may be one of the
14 parties, but it's really health IT.

15 CO-CHAIR SINGH: As a result of
16 system-to-system interface --

17 MEMBER SEGAL: I think as written,
18 it's fine. I just think we want to make sure
19 that we're not intending that this is only
20 relevant when one of the systems is an EHR
21 because it could be two systems, neither of which
22 one would consider an EHR.

1 CO-CHAIR SINGH: Do you propose
2 modification to system to system language?

3 MEMBER SEGAL: No, it's more just the
4 commentary as you presented it. I think as
5 written, it's fine.

6 CO-CHAIR SINGH: I think Kevin, then
7 David, and then Karen. Kevin.

8 MEMBER HAYNES: I was going to
9 actually say that I think you should modify it
10 because system-to-system -- otherwise, then data
11 source could be administrative claims. My
12 imaging is available. It is available in a
13 system at Temple. I'm now presented to HUD.
14 They can't see it. How broad are we really
15 talking about here? I think system-to-system
16 actually is a big issue because you could go to
17 the claims to know that last week, I had a CPT
18 code, and there's a beautiful radiology report
19 over at Temple, but HUD can't see it.

20 CO-CHAIR SINGH: That's why I was
21 saying system-to-system interface issue, or in a
22 system within an organization's EHR, or within an

1 organization's --

2 MEMBER HAYNES: I think if you mean
3 that, you should say that.

4 MEMBER SEGAL: Again, it's just in a
5 hospital, it's not just going to be the EHR.
6 They're going to have a number of systems that
7 are connected or not. I think maybe the focus is
8 on available within the clinical health IT in the
9 organization.

10 CO-CHAIR SINGH: So what am I saying?
11 System-to-system interface, health IT issue or
12 something like that?

13 MEMBER SEGAL: Or clinical system to
14 clinical system, perhaps.

15 CO-CHAIR SINGH: Or clinical health IT
16 system?

17 MEMBER SEGAL: Whichever, yes.

18 CO-CHAIR SINGH: Clinical health IT
19 system to another clinical health IT system
20 interface. Kevin, that addresses you?

21 MEMBER JONES: How about between
22 clinical health --

1 CO-CHAIR SINGH: Between two different
2 clinical -- yes, thank you.

3 MEMBER JONES: Darn prepositions.

4 CO-CHAIR SINGH: Always helps when
5 there's about 25 people on the grammar.

6 MR. HUNT: To understand the
7 distinction, I always -- I have blinders in this,
8 as I'm always thinking about patient care. To
9 that end, in what occasions will it be displayed?
10 I can see radiology, but more times than not,
11 what occasions will it be displayed that it's not
12 in an EHR?

13 MEMBER SEGAL: It could be a
14 cardiology system, it could be any number of
15 "ology" focused systems. It could be -- for
16 example, we happen to have perinatal systems,
17 which may interface with other systems. I think
18 -- and increasingly, the whole notion, in part
19 due to what ONC's done with the modular focus of
20 what is the EHR, and the EHR itself becoming more
21 modular -- but I think there still are systems,
22 as defined by the market, that may interface with

1 other systems, where the EHR wouldn't be a
2 component.

3 MEMBER CLASSEN: I might add a little
4 more specificity to this measure to make it
5 address what is a known patient safety hazard.
6 It's not general availability. It's availability
7 at a critical transition in care or an ED visit.

8
9 COURT REPORTER: I'm sorry, sir, your
10 microphone is off.

11 CO-CHAIR SINGH: -- post discharge.
12 Is that what you mean?

13 MEMBER CLASSEN: Yes, exactly. In
14 other words --

15 CO-CHAIR SINGH: But isn't this true
16 for any outpatient care setting too, so I just --

17 MEMBER CLASSEN: It could be. All I'm
18 thinking is making it really specific to what we
19 know is a very high risk patient safety
20 situation.

21 CO-CHAIR SINGH: So can we put that
22 under additional measurement rather than modify

1 the text? Okay, great. I think Karen was next,
2 and then Erin.

3 MS. ZIMMER: I would expand tests to
4 be diagnostic tests, or consider it. And David,
5 to your point, we've seen where labs will go to a
6 main mothership system, but not, then, to the
7 specialists, like the oncologist. People manually
8 take the data from the EHR and put it into the
9 specialist system. That's where there's a lot of
10 breakdown. As long as our -- I think that covers
11 it now, but you just wanted to make sure it's
12 between the two different clinical systems and,
13 of course, the fix would be the lab went to both,
14 but they don't.

15 MEMBER SCHNEIDER: This is really
16 helpful, and I really like having a list. I was
17 looking at Nos. 2 and 3, and I apologize for
18 reading ahead, but under 3, it looks like the
19 first bullet point is on the same topic -- system
20 supports interoperability, both internally and
21 externally. I wondered if those are distinct, or
22 if that -- whatever's intended in that bullet

1 point is really aligned with this metric?

2 Then the second issue that this
3 raised, as I looked at the first three, was
4 whether this first indicator is really about how
5 the system operates? When it's operating
6 normally, what's it capable of? But then there's
7 the downtime issue, so key test results might not
8 be available in the system, as designed, but they
9 also might not be available because of a downtime
10 event. I was just curious as to how we might
11 start thinking about reconciling these first
12 three areas?

13 CO-CHAIR SINGH: For the system
14 interoperability stuff, it is broader right now,
15 as written. But I would argue and say there's a
16 huge discussion going on around interoperability
17 that I don't know if we need to get into as far
18 as health IT safety because we don't even know
19 how we're going to deal with that, not just the
20 safety aspects of it. I don't know whether it's
21 worth going down that path because that's what
22 they say externally between sites, organizations,

1 or vendors.

2 It's broad. I think it's broad to the
3 extent that Kevin was mentioning between two
4 different universities, for instance. You know,
5 separate one on --- I think we're going to have a
6 separate one on downtime, anyway, which is going
7 to be broader, because it applies not just to
8 tests, to everything. So probably we can revisit
9 downtime in the next few slides.

10 MEMBER MARELLA: I think I heard you
11 advocating dropping the first bullet point under
12 No. 3, I guess.

13 CO-CHAIR SINGH: I would for that.

14 MEMBER MARELLA: Maybe when we get
15 there.

16 CO-CHAIR SINGH: But I'm not sure if
17 anybody else will.

18 MEMBER GRACE: I was in this group.
19 I think that -- and maybe Gerry will say the same
20 thing, but one of the things that we had -- or at
21 least I had in my mind, and maybe I didn't say
22 out loud, where we get to the number of times

1 diagnostic test results not available or
2 delivered as expected, which I think Mark brings
3 a good point about: if you don't have the
4 interfaces, then it's not expected to be
5 available.

6 But I, going to David's point of at
7 critical transitions in care, was thinking when
8 needed because is that critical transitions in
9 care, but when the patient's sitting in your
10 office, in the outpatient, and you've got to make
11 a diagnosis, that's when you need the test
12 results. So maybe when needed is too generic,
13 but something to get at, it's at the time when
14 the clinician and the patient are potentially
15 together, or when the clinician needs it or the
16 team needs it to make the appropriate decisions.

17 MEMBER SEGAL: Just a few quick things
18 on this. One is I guess I would disagree a
19 little with David for this one on just the focus
20 on transitions of care because I think there's
21 the need, from a clinician standpoint, for
22 diagnostic or treatment decisions could be in the

1 middle of a hospitalization. Secondly, just as
2 it's written, I don't think it's as expected at
3 the interface. I think it's as expected as a
4 result of the interface. In other words, it just
5 --

6 PARTICIPANT: Sort of as expected
7 because of a problem in it.

8 MEMBER SEGAL: It's with the
9 interface. At the interface, the mental picture
10 to me of where the two are connecting, but it's
11 really as a result of the interface between the
12 two systems, it's not available.

13 PARTICIPANT: As expected --

14 MEMBER SEGAL: As a result of the
15 interface or something like that.

16 PARTICIPANT: As a result of a problem
17 with the interface?

18 MEMBER SEGAL: Potentially, yes. The
19 third is I think we just want to make it clear to
20 whom they're available. So you could frame this
21 as available for the clinician. You could also,
22 frankly, frame it as available to the patient

1 because you can imagine, for example, lab results
2 showing up in a portal as a result of an
3 interface, let's say, between the lab system to
4 the EHR to the portal. I'm fine with the focus
5 on clinician, but I think we just want to be
6 clear on available to whom. I'm fine with that.
7 Then I guess the final point I'd make is I do
8 think we may want to consider making this part of
9 interoperability.

10 Because so much of the
11 interoperability discussion, and whether we do or
12 don't have interoperability, focuses on across
13 organizational, but I think if you talk to a
14 hospital CIO or chief medical information officer
15 or clinician, they're going to be every bit as
16 focused, perhaps even more so, on the
17 interoperability within their organization.

18 CO-CHAIR SINGH: But this looks fine,
19 then?

20 MEMBER SEGAL: Yes.

21 DR. PINES: I'm sorry, just as a
22 question. For Eric's comment, do we want to

1 merge in the No. 3, system interoperability now,
2 or do we want to discuss that separately?

3 MS. ZIMMER: I'm just going to jump on
4 because I agree. I think this is a subset of
5 interoperability. I agree with Eric and Mark. I
6 know right now -- I feel like there's a certain
7 framework that might be where you started, but I
8 think you should consider it because it --

9 CO-CHAIR SINGH: Consider what?

10 MS. ZIMMER: This bullet we're
11 looking, to me, is a subset or an example of an
12 interoperability case that you're going to want
13 to focus in on.

14 CO-CHAIR SINGH: Right, but the
15 question to the group I think Eric's also sort of
16 posing is do we need to go into everybody else's
17 interoperability world, rather than just stay
18 within an organization, which is where the real
19 problems are right now? We can't even get the
20 organization interoperability right.

21 MS. ZIMMER: But this is
22 interoperability. I don't see them as separate.

1 I really feel like it belongs under
2 interoperability.

3 MEMBER SEGAL: I'd move it under No.
4 3, and then we make the decision about what
5 aspects of interoperability we choose to focus
6 on.

7 MS. ZIMMER: Exactly.

8 CO-CHAIR SINGH: Okay, I think Greg
9 has a --

10 MEMBER ALEXANDER: Yes. I just had a
11 question about -- I think David had that first
12 bullet point under additional measurement that
13 says, potentially focus on known patient safety
14 hazards. I'm not sure I understand that, from a
15 standpoint that if you start dealing with these
16 measures and implementation of things, other
17 types of patient safety hazards that are not
18 currently known may occur, unintended
19 consequences or things happen that you can't
20 predict or expect, especially when you start
21 working with trying to do health information
22 exchange and different kinds of things across

1 settings.

2 Making it very specific to known
3 patient safety hazards makes me think that we're
4 sort of leaving out the potential of something
5 else that's unexpected to happen. I don't know
6 if that makes sense. I wondered what you were
7 referring to there.

8 MEMBER CLASSEN: I was referring to,
9 based on my own experience, data availability
10 becomes a threat to the safety of my patients
11 when I see a new patient and I don't have access
12 to all the data. That's what I was referring to.
13 That's just the way my workflow works. It can be
14 either a new consult in the hospital or a new
15 consult in the outpatient.

16 CO-CHAIR SINGH: Does anybody else
17 have any more comments on this? Do we have a
18 separate one on interoperability now?

19 MR. LYZENGA: We actually pulled up
20 these ones from No. 3 into this slide here. I
21 guess we can discuss whether we want to keep
22 them, or whether that first bullet is sufficient,

1 or if we want to have a couple other examples of
2 measures here.

3 CO-CHAIR SINGH: Can you remind me
4 what sub-bullet point this came from, system
5 supports, mobile applications, and external data
6 can be added? They were not in the top 23 that I
7 read. Who came up with this, which group,
8 anybody?

9 PARTICIPANT: I think this was Group
10 A.

11 CO-CHAIR SINGH: Is this one of Group
12 A's 20-point checklist?

13 MEMBER CASTRO: Yes, I think it was.

14 CO-CHAIR SINGH: Can we get rid of
15 that listing?

16 MEMBER CASTRO: Yes, it was one of the
17 -- part of the checklist. Just to remind the
18 group, the external data, there were a lot of
19 concepts dealing with health information exchange
20 and the integration of that kind of data into
21 your workflows. Then also, the support of mobile
22 applications as a separate concept. We didn't

1 want to lose those two ideas because we thought
2 they were still important.

3 CO-CHAIR SINGH: Right, but we could
4 be talking about interoperability here all day.
5 Do you want to do that?

6 MEMBER CASTRO: Do I want to do that?
7 No.

8 CO-CHAIR SINGH: Does anybody really
9 want to do that? We can have an interoperability
10 safety measure, but we'll be here all day, and do
11 you want to do that?

12 MS. ZIMMER: You could do two
13 different clinical health IT systems or
14 applications. Because that's what you're saying.
15 If someone is using a phone to the EHR, or
16 someone's using some other technology, isn't that
17 the issue? I'm trying to paraphrase what you're
18 saying.

19 PARTICIPANT: As worded right now,
20 though, it is specific to diagnostic test
21 results. I think we're talking about whether the
22 system supports mobile applications more broadly,

1 as well.

2 MEMBER JONES: Yesterday, there was
3 mention -- I think I gathered you guys thought
4 this could be generated in some kind of an
5 automated fashion. The broader we make it, the
6 less likely it's going to be automated. I don't
7 know how we're going to establish this mattered
8 in patient care.

9 If it started with some sort of a
10 safety system, quality safety tracking system,
11 and we said how many of those does the reviewer
12 feel were attributable to a system issue, that
13 may change how we thought about it. If the
14 denominator starts with, there was a safety
15 event, and we say of those safety events, how
16 often -- I'm trying to remember, David, with your
17 standard lists of things that we check off, is
18 one of those I didn't have the data I needed or
19 something like that?

20 CO-CHAIR SINGH: It's worth having a
21 discussion on interoperability as it generalizes
22 to beyond organizations if we can actually get

1 hold of any data. Has anybody got hold of data
2 across multiple organizations that connects
3 patients? Not administrative data.

4 MEMBER JONES: I'm trying to punt for
5 you, to David, to say he has the checkmark, and
6 we've got this handled.

7 MEMBER CLASSEN: What was your
8 question? I'm sorry.

9 CO-CHAIR SINGH: I'm trying to see its
10 point, moving the interoperability discussion to
11 broader, beyond just an organization, only when
12 we know that we'll actually be able to have a
13 measure that measure stuff across organizations
14 using EHR clinical data.

15 MEMBER ALEXANDER: I'm part of a CMS
16 demonstration project where we're implementing a
17 health information exchange across 16 nursing
18 homes and six hospitals in St. Louis. Some of
19 the issues that we have with that -- the only
20 reason that we've been successful in beginning to
21 transfer documents, to begin to understand
22 interoperability, is by having every person

1 responsible for those types -- for technologies
2 at the table in the stakeholder group. You can't
3 just have one organization there. You have to
4 have them all there because each of them have
5 different systems that have different looks and
6 feels to their interfaces. The stakeholder group
7 has to be broad and all-inclusive.

8 The measures that you have for one
9 organization will impact what happens downstream
10 with another organization receiving or sending
11 information to and from those people. In my
12 brain, I'm thinking interoperability has to go
13 across the organizations, and you have to begin
14 to think of that in the beginning, as you're
15 developing these measures, versus later
16 downstream. If you think one organization now,
17 later downstream, it's going to have to change, I
18 think. I don't know if that was a response to
19 your question or not.

20 CO-CHAIR SINGH: Maybe a response, but
21 may not be the response I was hoping to hear.

22 MEMBER ALEXANDER: Sorry.

1 DR. PINES: Are you saying that we
2 would change the accountability, too, also at the
3 regional level or state level, potentially?

4 MEMBER ALEXANDER: Are you talking to
5 me?

6 DR. PINES: Yes.

7 MEMBER ALEXANDER: For example, one of
8 the issues that we had -- I'll just give you an
9 example. We're working with multiple HIEs. In
10 order to get a readable document in a CDA, we had
11 to have a style sheet. Each of the HIEs didn't
12 feel it was their responsibility to apply a style
13 sheet, so we were at a point of not moving
14 forward because there was this discrepancy
15 between who was going to do that.

16 That's a very specific example. If
17 those things aren't discussed at a table, and we
18 don't understand what that decision has -- any
19 implication it has downstream for people that are
20 trying to open documents, then the measures
21 aren't going to really make any difference
22 because you're not going to have a usable system.

1 That's sort of part of the measure, isn't it, is
2 having a usable system? You have to have all
3 people around the table, in my opinion.

4 CO-CHAIR SINGH: If we can maybe -- do
5 the structural considerations need to be there to
6 reflect both internal and external
7 interoperability, those two items? If you just
8 keep it broad and say number of times diagnostic
9 test results, which is needed information, not
10 available, and I think somebody said transmitted
11 or something like that, or is that available,
12 transmitted, or displayed? So make it available,
13 transmitted, or displayed for the clinician or
14 the patient as expected because of or as a result
15 of a problem with the interface between two
16 different clinical health IT systems. Is it
17 broad enough to capture all types of
18 interoperability?

19 MEMBER CLASSEN: But the question is
20 why do you even have to have that description?
21 If it's not available, isn't that a much more
22 important measure than because of certain

1 interoperability issues?

2 CO-CHAIR SINGH: It may not be
3 available because it's not being done yet. The
4 lab hasn't finished the test. I think some
5 amount of specificity, as Mark was saying, would
6 be good because this targets a problem at the
7 interface, either because the interface is broken
8 or hasn't been built yet. I think we probably
9 have to say something about the system interface.

10 MEMBER CLASSEN: I guess clarification
11 about whether this has to do with the internal
12 interoperability or external interoperability.

13 CO-CHAIR SINGH: That's why we've been
14 having this discussion.

15 MEMBER CLASSEN: I can tell you,
16 internally, interoperability has gotten a lot
17 better. We've been measuring that with the
18 flight simulator. Initially, when we started the
19 testing ten years ago, a lot of places had
20 standalone pharmacy systems that were not in
21 their EMR. They did very badly on the test.
22 Many of them have integrated pharmacy into their

1 EMRs. They do much better in the test. Internal
2 interoperability has improved a lot, at least
3 based on the results of the test. You may have a
4 measure here that doesn't have lots of room for
5 improvement.

6 CO-CHAIR SINGH: I'm not sure if
7 that's correct. The error logs -- we visited
8 Geisinger and they were still -- after 15 years
9 of doing this, they were still running daily
10 error logs of results that never crossed this
11 phase.

12 MEMBER CLASSEN: No, never crossed it.

13 CO-CHAIR SINGH: I'm thinking it's
14 happening, and unless we have a measure -- that's
15 why maybe good to keep it broad, then, internal
16 and external, and that way it applies for
17 external interoperability, as well.

18 MR. LYZENGA: So just to be clear, for
19 the structural considerations, did we want to
20 take that out from the example?

21 CO-CHAIR SINGH: I vote for it to be
22 out, unless somebody wants to keep it in. Both

1 of those structural things could go in a bullet.
2 slide's going to be big anyway.

3 MR. HUNT: Let me just make a case
4 that if there's some way that we put that --
5 there's some reference to both internal and
6 external, my fear is -- and I'm trying to think
7 two or three steps down the road -- when folks
8 look at an issue and one of them is
9 interoperability, I'll be honest, everyone throws
10 up their hands and says whew. It feels like a
11 mountain that oh, my God, who's going to really
12 work on that?

13 When we had this really focused on a
14 test is not available, it's absolutely right that
15 this does -- the solution comes down to
16 interoperability. There's no doubt about it.
17 But I feel as though people get -- they don't see
18 a path to a solution if we're working on
19 interoperability. If in some way we can make
20 sure we provide some notation or annotation that
21 this is both internal and external, so that folks
22 can begin to think about working on that problem

1 of where's my test.

2 CO-CHAIR SINGH: Jesse, can you add,
3 under additional measurement issues or
4 consideration, measure could address both
5 internal and external interoperability?

6 MEMBER HEERMANN-LANGFORD: I think he
7 kind of covered some of what I was going to say.
8 The term that we often use is clinically
9 consumable because we can have interoperability
10 where the data goes from one system to the other,
11 but it's not really consumable by the clinician
12 at the clinical bedside. It takes too much
13 effort to find it, to go in and find a report and
14 read it.

15 When you talk about a test result,
16 it's a good example. The other one's allergies
17 to medications, to actually get them into System
18 B in a way that it's clinically usable and
19 consumable. You can actually make decisions.
20 You can do decision support with it, that type of
21 thing. Because otherwise, it's useless to us if
22 it's just oh, yes, check the box. It's

1 interoperable. We've got it there. Whether or
2 not you stick with -- it has to be internal and
3 external. You can't do this one way or the other
4 if you're going to get it across. Whether or not
5 you want to go beyond test results, there are a
6 few other nice, discrete data elements that are
7 useful for us.

8 CO-CHAIR SINGH: Allergies, things
9 like that?

10 MEMBER HEERMANN-LANGFORD: Allergies,
11 medication reconciliation. We could support a
12 lot more if we did this with coded, discrete
13 data.

14 CO-CHAIR SINGH: Jesse, you might want
15 to say something -- I think downtime will be
16 addressed later. It'll just confuse it. I would
17 delete that. I would say things like could
18 potentially be exportable to other critical data,
19 such as allergies. What else did you say?

20 MEMBER HEERMANN-LANGFORD:
21 Medications.

22 CO-CHAIR SINGH: And medications.

1 MEMBER HEERMANN-LANGFORD: Problem
2 lists. You would start with the basics. There's
3 a lot more that you could do, but --

4 CO-CHAIR SINGH: Even if you just put
5 allergies, people can think broadly as to yes, we
6 can use the measure for some other stuff as well.

7 MEMBER HEERMANN-LANGFORD:
8 Immunizations would be huge, duplicating
9 immunizations because we don't know what they
10 had.

11 CO-CHAIR SINGH: David, did you have
12 another comment? Okay. Mark.

13 MEMBER SEGAL: Just thinking about the
14 structure of this, if we're talking generally
15 about interoperability, I would be inclined to
16 add a second example that focuses on the
17 cross-organization interoperability, what we were
18 just talking about. I think from a measure
19 standpoint, they ought to be discrete measures.

20 I don't think we want to have a
21 measure that lumps in mobile and
22 cross-organization within interface. I think

1 ultimately, from a measure standpoint, we want to
2 prioritize. But if we're having sort of a
3 general concept right now, I would definitely
4 keep the interface issue as within organization,
5 have a second example that focuses on consumable
6 or usable information coming outside of the
7 organization.

8 CO-CHAIR SINGH: What would you say
9 the measure would be?

10 MEMBER SEGAL: I would have a second
11 example. I think the measure -- I think we
12 actually have some -- there were some things on
13 the list. Again, external data can be added.
14 Again, I don't know if this is exactly the right
15 end point. We've got the external data can be
16 added to the patient record, but that's kind of
17 the starting point, and then you have to think
18 about are you incorporating it, or is it
19 accessible? But I think if we're dealing at the
20 concept level -- I would just pull maybe some of
21 the other concepts here.

22 CO-CHAIR SINGH: The big thing that

1 I'm hearing from HIEs is even when the data is
2 available to somebody in the EHR, clinicians are
3 not looking at that data. Is it fair to propose
4 some HIE --

5 MEMBER HEERMANN-LANGFORD: Because
6 it's stuck in a repository in a document
7 somewhere. It's too hard to get.

8 CO-CHAIR SINGH: Exactly.

9 MEMBER HEERMANN-LANGFORD: We're not
10 breaking it out in a way that they can actually
11 then insert it into their own data.

12 CO-CHAIR SINGH: Should we have a
13 measure of something that available data is not
14 being used -- available HIE data is never
15 accessed, despite a patient visit?

16 MEMBER HEERMANN-LANGFORD: I'm not
17 sure that it's the clinicians' access problem as
18 much as it's our way of how we're storing it and
19 present it from the IT side.

20 MEMBER SEGAL: Again, it's that shared
21 issue, but I think it would be -- again, I
22 wouldn't call it HIE. We talked about that. It

1 would be externally available data -- because
2 again, that could be a lab or whatever.

3 If you want to focus on whether it's
4 actually used, and again, a measure of how well
5 we're all doing our job, I think it would be a
6 measure of the extent to which externally
7 available data is used in making diagnosis and
8 treatment decisions or care management or what
9 have you. Then you don't focus so much on was it
10 incorporated, or was it a separate tab, but were
11 people relying on it, and if they're not relying
12 on it, then that's actually a good diagnostic
13 that we're all not doing a good job. Again, I'd
14 focus it on the outcome. It's using the outside
15 data to do what the clinician needs to do.

16 CO-CHAIR SINGH: The extent to which
17 externally available data is used to make
18 diagnosis or management decisions, is that good?

19 MEMBER SEGAL: Mm-hm.

20 MEMBER CLASSEN: All I'd add is it
21 probably would be a survey of the users to say
22 how often did you not have critical information

1 available to you?

2 MEMBER SEGAL: I think that would be
3 one way to do it.

4 MEMBER CLASSEN: One way to do it,
5 right?

6 PARTICIPANT: Absolutely.

7 MEMBER ALEXANDER: I would even take
8 it a step back from that, just to even ask a
9 simple yes/no question, can you exchange a
10 document that is readable, that has clinical data
11 in it? Because there's a lot to just getting a
12 document to be able to be exchanged internally
13 and externally, mostly externally, where people
14 can actually read it. If they can actually get a
15 document they could read, they're more likely to
16 use it, if it's structured the right way.

17 CO-CHAIR SINGH: Can we say externally
18 available meaningful data?

19 CO-CHAIR BELMONT: The only other
20 challenge we have with this, and you and Mark and
21 I discussed this briefly at dinner last night,
22 sometimes externally available data can be

1 available, like with EPIC Care Elsewhere and EPIC
2 Care Everywhere, but the volume is such that a
3 clinician may not go all the way through it, or
4 they may not appropriately summarize it in the
5 medical record. It can be available, but not
6 necessarily in an easily accessible or manageable
7 format. Some of the continuing care documents
8 can be up to 30 pages.

9 DR. PINES: Also, just to remind you,
10 we do have usability as a separate domain, so
11 this is sort of, is the data -- is it there, and
12 then potentially think about is it actually
13 useful or useable?

14 CO-CHAIR SINGH: This implies
15 usability a little bit. Not usability as
16 Elisabeth said, but you're using the data to make
17 diagnosis management decision, and the extent is
18 zero because you're not using the data.

19 PARTICIPANT: So if the availability
20 is no data?

21 CO-CHAIR SINGH: No, we already said
22 externally available, meaningful data. There's

1 two aspects of this measure. One, there's
2 nothing available, therefore we score badly, or
3 it's available, but as Greg said, it's not
4 meaningful, and we don't use it, or maybe it's
5 too much, and we don't use it.

6 PARTICIPANT: What if it's available
7 but not in a usable form?

8 CO-CHAIR SINGH: Is that good enough?

9 PARTICIPANT: Yes.

10 MS. ZIMMER: Just a thought. After we
11 end up going through this, another way to maybe
12 look at this is going back to match it with our
13 workflow process. When we were talking about
14 transmission of data, readability of data, which
15 you have on here -- they're listed here, but in
16 the end, we may re-order this so it fits the
17 workflow process of how data comes through, and
18 readability, follow-up.

19 CO-CHAIR SINGH: I think we spent
20 35-40 minutes on this slide, so we're going to
21 have to move a little bit faster than this.
22 Thanks. I think the next one is availability

1 again, but this time it's downtime. I'm hoping
2 this will be a little bit simpler than what we
3 just went through. Unexpected downtime affecting
4 clinical care and lasting more than an hour. We
5 didn't decide anything on the unilateral vendor
6 lockout of clinicians.

7 Can we just remove that? People
8 weren't impressed. I think availability of
9 disaster preparedness plan is a good thing;
10 frequency of drills is a good thing; frequency of
11 security risk assessment, was that using a
12 specific tool when we came up with that, or
13 SAFER?

14 CO-CHAIR BELMONT: That was being
15 consistent with the requirements of the HIPAA
16 security rule.

17 CO-CHAIR SINGH: Okay, so just say
18 consistency with requirement?

19 CO-CHAIR BELMONT: How about
20 consistent with regulatory and accreditation
21 requirements?

22 CO-CHAIR SINGH: That addresses,

1 actually, some of the issues that Eric's group
2 brought out broadly around confidentiality,
3 security types of things, and downtime and
4 availability, so that's good.

5 PARTICIPANT: So the same goes for
6 disaster drills and that sort of thing?

7 CO-CHAIR SINGH: Frequency of disaster
8 drills, I don't know if there's a protocol --
9 Bill.

10 MEMBER MARELLA: Do we want to focus
11 on the frequency of disaster recovery drills and
12 the frequency of security risk assessments or
13 something about the organization's response to
14 their performance on those things? Or is that
15 too hard to quantify?

16 CO-CHAIR BELMONT: Our discussion
17 yesterday did focus on frequency -- it focused on
18 frequency because our concern was there was a
19 plan in place. It was in the file. It was
20 stale. Then as David pointed out with some of
21 the new physicians, they may have no familiarity
22 with manual processes at all. We wanted to have

1 a more ongoing approach to this. Eric, do you
2 want to add anything?

3 MEMBER SCHNEIDER: Yes. The thought
4 was that might be a next-generation measure that
5 these are maybe the entry point. One other
6 comment, and I think members of our group
7 persuaded me that system downtime is not
8 necessarily -- isn't necessarily the best
9 umbrella for the issue of security risk
10 assessment and drills on disaster recovery and
11 disaster preparedness. Security risk assessment,
12 in particular, unless you mean data availability
13 in the sense of data availability to hackers and
14 other nations, it feels like an awkward fit
15 there.

16 CO-CHAIR SINGH: We don't have
17 anything else where security assessment goes,
18 correct?

19 MS. ZIMMER: We do have risk
20 management later, don't we?

21 PARTICIPANT: Yes, we can potentially
22 move it to risk management.

1 MS. ZIMMER: Yes, risk management
2 infrastructure, and to me, security risk
3 assessment goes under that.

4 CO-CHAIR SINGH: Yes, because that's
5 a pro-active way to do it, yes, because I have
6 retrospective and prospective stuff on that.
7 Actually, you could leave the drills in here
8 because it's generally to do with how you -- when
9 the system's gone, how do you -- I guess it's
10 more broad than that.

11 PARTICIPANT: Maybe you can do
12 frequency of downtime drills?

13 CO-CHAIR SINGH: Yes, I think it
14 should be downtime drills. Then you can move
15 security risk assessment to organizational
16 responsibilities for risk management, and just
17 either put it in the notes or something, or come
18 back to it. Data source vendor facility
19 accountability looks good. Data sources, EHR,
20 people could do surveys -- could send surveys
21 out, how many downtimes you had in the last
22 month. I'm not sure if people would report, but

1 this is EHR available -- this is data you can
2 access, right?

3 MEMBER SEGAL: I think some of it, but
4 a lot of it, like the frequency of drills, I
5 think that's going to be administrative records.

6 CO-CHAIR SINGH: Administrative
7 records, yes, that's good.

8 CO-CHAIR BELMONT: Another data source
9 would be -- say that you had an accreditation or
10 other regulatory inspection and see what the
11 report said about whether you're in compliance
12 with those.

13 CO-CHAIR SINGH: Does the Joint
14 Commission do any of this?

15 CO-CHAIR BELMONT: Yes, they prepare
16 --

17 CO-CHAIR SINGH: They do some of
18 these, right?

19 CO-CHAIR BELMONT: Yes.

20 CO-CHAIR SINGH: Perfect. Any
21 additional measurement issues or considerations?
22 We're doing good here.

1 DR. PINES: Specifically for that one
2 hour, did we agree that one hour is okay? I know
3 there was some concern about --

4 CO-CHAIR SINGH: Could we just say
5 lasting one hour and put in parentheses time
6 frame could be adjusted based on --

7 MEMBER HEERMANN-LANGFORD: We had just
8 a little bit of conversation in our group about
9 -- just not the hour, but that I'm not sure that
10 we say what time. Because when we were talking
11 about downtime and disaster planning is when do
12 you go into the process? How long do you wait?
13 People tend to -- they hesitate because if it's
14 only 15 minutes, they'll use the paper towels
15 until they can get it back in. We had a little
16 bit of discussion about having in your plan how
17 do you initiate downtime procedures, how long do
18 you wait? It may need to be specific per the
19 site, based on what their systems are like or how
20 they manage it, and then this plan would -- not
21 only when and how you initiate it, but then how
22 you come out of it and test everything's up and

1 running again. That might play into the hour
2 part of it because I'm not sure --

3 CO-CHAIR SINGH: Should we just say
4 something like frequency and length of unexpected
5 downtimes and just let people decide, rather than
6 putting an hour?

7 MR. LYZENGA: Would it be sufficient
8 to just say affecting clinical care, however long
9 that is, or no?

10 CO-CHAIR BELMONT: I think that makes
11 sense because we were talking yesterday that if
12 this was in an emergency department, an hour
13 would be a long time to wait. I think it's
14 context dependent.

15 MEMBER GRACE: That's exactly right,
16 or the OR, as David mentioned yesterday. Maybe
17 unexpected downtime affecting clinical care, and
18 then if there's a way to put in there, if you
19 want a time frame in there, you could say
20 reflective of your disaster preparedness plan or
21 something like that, if you want the time frame
22 piece, and make your disaster preparedness plans

1 then say if it's in the OR, this is the time
2 frame, and if it's in the ED, it's this, and if
3 it's on the unit, it's this.

4 CO-CHAIR SINGH: You could say time
5 frame may be setting-specific, depending on the
6 risk or something like that.

7 PARTICIPANT: No. Context-specific.

8 CO-CHAIR SINGH: Context-specific
9 depending on the risk. Do we need to say
10 frequency and timing of unexpected downtime or
11 just unexpected --

12 MEMBER CLASSEN: Or you could just say
13 total number of minutes or hours of downtime in a
14 year.

15 CO-CHAIR SINGH: Yes. Frequency is
16 length.

17 MEMBER CLASSEN: We actually track
18 that. We know clinical system downtime.
19 Everybody tracks that if you use total number of
20 minutes.

21 CO-CHAIR SINGH: Frequency.

22 MEMBER CLASSEN: You could also ask

1 how many times was your downtime procedure
2 activated in a year? That would be very alluring
3 because if you had a lot of minutes of downtime
4 and you never activated it, that would be a
5 concerning measure.

6 CO-CHAIR BELMONT: I like that idea.
7 I think that's a good one.

8 MEMBER CLASSEN: Very objective.

9 CO-CHAIR SINGH: You think add one
10 more saying how many times you had to activate?

11 MEMBER CLASSEN: Yes, total number of
12 minutes of clinical system downtime in a year and
13 total number of times you activated your downtime
14 procedures.

15 CO-CHAIR SINGH: So just put total
16 number of -- that needs to go as a separate --

17 MEMBER CLASSEN: Very objective.
18 Everybody tracks that, right?

19 CO-CHAIR SINGH: Karen, Erin, you
20 still have your cards up. Do you still need to
21 -- okay. Does anybody have any additional
22 measurement considerations before we move to the

1 next slide? Our average is getting better.

2 (Laughter.)

3 MEMBER CLASSEN: Time to extend the
4 hotel say.

5 (Laughter.)

6 CO-CHAIR SINGH: I just hope we don't
7 have a fire drill right now, and we all leave.
8 Next one is user-centered design. This was a big
9 decision about -- I think this includes that
10 concept of involving end users. Does it also
11 touch upon the testing one that I -- yes, the
12 test versus -- Gerry's group.

13 DR. PINES: We have -- four and five
14 are -- we've got user-centered design and
15 usability testing and evaluation. We could
16 potentially combine this into one.

17 CO-CHAIR SINGH: Yes, I think so. I
18 think so because they are part of the same --
19 this is really important, and we'll have to think
20 about how we make this into a measure. Nana and
21 I were talking. This is going to be a tough one
22 to make into a measure. What do people think?

1 Mark?

2 MEMBER SEGAL: Just on the one that
3 got moved, I would expand that -- I don't know if
4 we have it up there yet -- from development to
5 also configuration and implementation. Because
6 particularly, and I think to the point David
7 made, if we're looking at the shared
8 accountability, you need the user-centered
9 approaches both in how providers implement.

10 CO-CHAIR SINGH: Absolutely true.

11 MEMBER SEGAL: So I think that
12 particular language needs to look at a larger
13 life cycle.

14 CO-CHAIR SINGH: Can we just say life
15 cycle of health IT?

16 MEMBER SEGAL: Perfect.

17 MEMBER HEERMANN-LANGFORD: I always
18 take issue with end user involvement because how
19 do you measure that, and what is meaningful? You
20 have them in the room and they are sitting at the
21 table, so yippee, I checked the box; I had end
22 user involvement. Did you listen to them? Did

1 anything that is pertaining to workflow or
2 clinical needs actually get into the development
3 or the configuration process? I just feel like
4 there's some way we need to be able to articulate
5 that a little bit more clearly, besides yes, we
6 had the token person in the room.

7 CO-CHAIR SINGH: Yes. Just so
8 everybody's thinking -- the certification and the
9 usability requirements of the vendors have been
10 recently -- the papers that came out had a
11 specific 15-physician requirement. Correct me if
12 I'm wrong. Maybe there are already some existing
13 standards that we could look into, in terms of
14 certification and usability. David, I'm not sure
15 whether there is something -- David Hunt, I'm not
16 sure whether there's something that you think we
17 should discuss with NIST a bit more about this
18 measure, or is there something that ONC could
19 help us with? Because you've done this thing
20 quite a bit.

21 MR. HUNT: I think we can
22 specifically, after the timing of some of our

1 regs come out --

2 CO-CHAIR SINGH: Yes, I've been
3 hearing about these regs quite a bit, so is this
4 --

5 MR. HUNT: I don't know anything about
6 them.

7 CO-CHAIR SINGH: I've heard quite a
8 few good things about them.

9 MR. HUNT: I have no knowledge,
10 whatsoever, of --

11 CO-CHAIR SINGH: But do you think this
12 could be a measure that we could wait to see in
13 your regs? Because I've heard through the
14 grapevine there's something about this stuff in
15 your regs in the future, if you can say that
16 openly.

17 MR. HUNT: Top secret. Let's just
18 wait. It'll be easier, let's just say.

19 CO-CHAIR SINGH: Thank you. Can we
20 just have a little consensus here that this is a
21 measure which is really important but needs to be
22 developed a little bit with discussions with ONC

1 and NIST. We can have a timeline within a month
2 of some of the regulations coming out of ONC. We
3 can circulate that around the group, and even
4 have a little call to go through the similar
5 slide arrangement here.

6 MEMBER KHUNLERTKIT: Can I suggest
7 adding the design and probably development
8 implementation after the HIT end users'
9 involvement in life cycle, HIT design development
10 and implementation?

11 CO-CHAIR SINGH: Do you want to just
12 make it very clear, life cycle includes --

13 MEMBER KHUNLERTKIT: Yes, because this
14 is not clear.

15 CO-CHAIR SINGH: Yes, just say end
16 user involvement in life cycle design,
17 development, implementation, use, and evaluation.
18 Karen and Mark.

19 MS. ZIMMER: The third bullet point,
20 system supports information transfer at
21 transitions in care, either it goes to your No.
22 10 on transitions in care, or our system

1 interoperability.

2 CO-CHAIR SINGH: So we can leave the
3 others if people are happy with it just so that
4 it'll help us think through when the report comes
5 out. Is that good? We've got to have a separate
6 one on simulation, so I'm not sure whether the
7 simulation stuff should stay here, or we should
8 go into simulation as a separate measure.

9 DR. PINES: I think we had put
10 simulation under usability.

11 CO-CHAIR SINGH: Oh, really? Okay.
12 Because I was thinking simulation could be --
13 David Classen, do you think simulation stuff,
14 which I think is critically important and should
15 be included maybe as its own measure of some
16 kind, do you think it should go under usability
17 testing, or should we have a separate measure
18 just focused on simulation as a way to test
19 various aspects of safety?

20 MEMBER CLASSEN: Yes. I think the
21 latter.

22 PARTICIPANT: I think so, too.

1 MEMBER CLASSEN: We've both done it at
2 the organization level and at the user level. I
3 think it could be used to test a lot of aspects
4 of these systems we've only just scratched the
5 surface.

6 PARTICIPANT: I'm going to go ahead
7 and put that in the slide, simulation.

8 CO-CHAIR SINGH: There's too many mics
9 on. We could take out the simulation part from
10 here, and then put it as a separate slide, as a
11 separate measure concept. I think it's important
12 to develop simulation as a measure itself, not
13 just as a way to get to usability.

14 MEMBER HEERMANN-LANGFORD: I would
15 agree with that. One concept, when we were
16 talking about simulation, we talked at length
17 about using simulation to maintain and gain
18 competency of use, so not just the usability, but
19 competency.

20 CO-CHAIR SINGH: Absolutely.

21 MEMBER SEGAL: Hardeep, a couple
22 things, if we can go back to the prior slide.

1 Maybe this was where we -- on the second bullet,
2 I would just bring in the reference to usability
3 because it's not just -- it's the end user
4 involvement with respect to -- particularly on
5 the usability aspect. I think that's worth
6 calling out. Secondly, you mentioned standards.
7 There are standards for both presentation, which
8 NIST has, and standards for how to -- for
9 approaches to usability. I think it's worth it,
10 as we're doing our little bit of a parking
11 garage, to your point, we consider whether we
12 want to have measures that actually look at the
13 use of available standards, without saying it has
14 to be Standard A versus Standard B.

15 CO-CHAIR SINGH: Exactly.

16 MEMBER SEGAL: Then third, I'll just
17 repeat it, but I don't think we need extensive
18 discussion. I'm still uncomfortable with the
19 first bullet on the testing versus time spent on
20 development, both because the testing itself is
21 very heterogeneous, and because testing is part
22 of development. I understand what people are

1 getting at, but I'm just uncomfortable with that
2 measure as framed.

3 CO-CHAIR SINGH: Actually, Mark, I
4 would actually put your suggestion of use of
5 existing standards in place of that because I
6 think some of what you're talking about is
7 probably addressed within that. That could mean
8 the new ONC standard when it comes out, whatever
9 that is.

10 MEMBER JONES: Can I just clarify that
11 people are referring to all users, including
12 patients and caregivers, or is this limited to --

13 CO-CHAIR SINGH: I think that's
14 something that we could do as sort of a preface
15 to the whole report. When we say users in this
16 report it fits broadly to all HIT users,
17 including patients, caregivers, healthcare,
18 nurses, pharmacists, fair? Karen, do you have a
19 comment? Are we done with the third slide?
20 People must be getting hungry.

21 DR. PINES: Let's go back to
22 simulation because we didn't really --

1 CO-CHAIR SINGH: Yes, which is a
2 separate bullet. You want to do it now? We can
3 do it now. It's not in order, but we -- oh, yes,
4 because you had it there. All right, simulation.
5 What I had sort of written is simulation based
6 measurements, such as Leapfrog tests put on
7 multiple safety issues. That's the concept I had
8 in mind. Let's look and see is everything we
9 want to do similar. I think one of the things we
10 are saying is almost like all organizations use
11 simulation of some type. Should we be bold
12 enough to say something like that?

13 MEMBER CLASSEN: I think virtually
14 every healthcare organization has some sort of
15 simulation already going on.

16 CO-CHAIR SINGH: Can we just say
17 testing/simulations of systems are being used in
18 organizations to identify potential safety risks?
19 Are being used is the essential thing. They
20 could be doing simulation and safety training,
21 but not EHRs.

22 MEMBER CLASSEN: Right, exactly.

1 MEMBER GRACE: Would smaller
2 organizations or community hospitals, things like
3 that -- are they using simulation, do you think?

4 MEMBER CLASSEN: Absolutely. In one
5 form or another, most everybody's using
6 simulation. Their simulation might be around
7 codes and running codes, but almost everybody
8 does that. Because if you're a medical staff
9 member, you have to have BLS certification. To
10 do that, you have to go through simulation
11 training and certification.

12 CO-CHAIR SINGH: But as an example,
13 David, if, let's say, a small community hospital
14 with 50 beds doesn't have any simulation lab or
15 nothing, calls upon you or somebody, "Can you
16 help us do a Leapfrog test," that's considered
17 doing -- you'll be able to do it, right?

18 MEMBER CLASSEN: -- I'll just do it
19 over the net access to it, so they don't need any
20 special facilities to do it.

21 CO-CHAIR SINGH: Anybody could do it.

22 MEMBER CLASSEN: Anybody could do it.

1 MS. ZIMMER: I would change the
2 language of the first one, where it says, "Or
3 problems as conducted prior to release," because
4 it also includes post implementation as probably
5 --

6 PARTICIPANT: Maybe life cycle.

7 CO-CHAIR SINGH: Yes, you could use
8 the same thing, yes.

9 MS. ZIMMER: I know life cycle sounds
10 so wonderful, but I would probably put it in
11 parentheses.

12 CO-CHAIR SINGH: Yes, the five or six

13 --

14 MS. ZIMMER: Something, yes, because
15 post-implementation is lost a lot of times.

16 MEMBER KHUNLERTKIT: I agree with
17 Karen, and I think we need to add a
18 pre-implementation, so before release,
19 pre-implementation and post-implementation.

20 CO-CHAIR SINGH: Then you can specify
21 -- just copy and paste including evaluation onto
22 the next slide. Accountability vendor/facility,

1 data source is simulation data. Additional
2 measurements or considerations, anything?
3 Anything else regarding those three bullets?

4 MEMBER CLASSEN: The other area you
5 consider -- some people have used it -- is to
6 test after unexpected downtimes, when the system
7 crashes and things get turned off people don't
8 know about, or after upgrades.

9 CO-CHAIR SINGH: I would say testing
10 -- maybe add a bullet? You want it as an example
11 of a measure? I think he wants a No. 4 bullet
12 saying something like testing at -- simulation
13 testing be used at high-risk situations or
14 scenarios.

15 MEMBER GRACE: That's an additional
16 measurement or consideration, right? You mean
17 you would like to see that under big bullet four,
18 not the fourth bullet under examples, right?

19 CO-CHAIR SINGH: You want to see it
20 under additional measurement? Okay, cool,
21 thanks. Nana, and then Karen.

22 MEMBER KHUNLERTKIT: I just want to

1 add it, I don't know if it's a bullet or anything
2 here that, just like Laura was saying, that
3 simulation can be used for training, for building
4 competency. I would want to add the workflow
5 analysis and sociotechnical analysis in there,
6 too.

7 CO-CHAIR SINGH: Workflow analysis,
8 competency testing, training --

9 MEMBER KHUNLERTKIT: Training, and
10 sociotechnical analysis, and probably usability
11 testing can be in there, too.

12 CO-CHAIR SINGH: Usability testing,
13 sociotechnical analysis, five things we must put
14 as additional consideration? Training,
15 competency evaluation, usability --

16 MEMBER KHUNLERTKIT: Usability
17 evaluation --

18 CO-CHAIR SINGH: -- evaluation,
19 workflow analysis --

20 MEMBER KHUNLERTKIT: Workflow
21 analysis, and sociotechnical analysis.

22 CO-CHAIR SINGH: -- and sociotechnical

1 analysis.

2 MEMBER CLASSEN: And probably both at
3 the user and the organizational level, right?

4 MEMBER KHUNLERTKIT: Right.

5 MS. ZIMMER: Two just picky things
6 because I heard you say to cut and paste as we go
7 forward. Under life cycle, design, development,
8 pre and post-implementation, I'm not sure use and
9 usability is part of the life cycle.

10 CO-CHAIR SINGH: It is. Design,
11 development, implementation, use and evaluation
12 is the life cycle, but we probably will add
13 usability just to emphasize it. It's under use -
14 -

15 MS. ZIMMER: Oh, okay, sorry, just
16 because we're going to keep bringing it forward,
17 so I want to make sure that phrase we all agree
18 on.

19 CO-CHAIR SINGH: Put evaluation in
20 there.

21 MEMBER SEGAL: It should say use, not
22 usability.

1 MS. ZIMMER: Right.

2 CO-CHAIR SINGH: Yes, use, yes.

3 (Simultaneous speaking.)

4 CO-CHAIR SINGH: You want it to
5 emphasize usability. Mark wanted to emphasize
6 usability, so Mark, if you see --

7 MEMBER SEGAL: That's fine.

8 MS. ZIMMER: Then the other is when we
9 talk simulation, do we need to be a little bit
10 clearer what we mean? Are we talking about
11 simulation like David's tool with EHR? Are we
12 talking they're using simulation, as someone
13 said, for BLF courses? Are we talking simulation
14 where they have now ancillary staff actually do
15 simulation with cleaning of the room? Is it the
16 simulation itself, or is it the simulation of
17 what, and do we need to clarify that?

18 CO-CHAIR SINGH: David, do you have
19 any thoughts?

20 MEMBER MARELLA: I was going to make
21 a similar comment in relation to the second
22 example there because I think there's two

1 different purposes of simulation that are kind of
2 being combined there. One is -- and David,
3 correct me if I'm wrong, but the Leapfrog flight
4 simulator, what you're testing and evaluating is
5 the IT system, itself, whereas the first part of
6 that measure, percent of users that are tested in
7 a simulator, I think that's getting more to
8 individual competency and making sure that --

9 MEMBER CLASSEN: Correct. I'd say
10 both organizational and individual is the
11 possibilities here in this measure. I think
12 Bill's right. You're looking both at
13 organizational performance, which is very driven
14 by the HIT systems, but also the configuration of
15 them, so it's measuring both the IT systems and
16 the way the organization implemented it, that's
17 one aspect. Another aspect is your individual
18 users are tested through simulation to see how
19 effectively they use the system.

20 MEMBER MARELLA: I've seen some
21 hospitals where they're using simulation in a
22 test environment for people. Basically, they

1 have very rigorous programs. They're giving CME
2 credits to people, and they want to make sure
3 that everybody uses a clinical information system
4 in a test environment before they're exposed to
5 it in production.

6 MS. ZIMMER: That's what I was trying
7 to say. We've got to clarify what the
8 simulation's being used for, I think.

9 (Simultaneous speaking.)

10 CO-CHAIR SINGH: You don't think the
11 first bullet is enough?

12 MEMBER HEERMANN-LANGFORD: I think
13 she's right that it would be helpful to have
14 something in the title of it.

15 CO-CHAIR SINGH: Oh, okay.

16 MS. ZIMMER: I'm just thinking, as you
17 said, CME credit --

18 CO-CHAIR SINGH: Can we just say
19 simulation to promote safe health IT, so
20 simulation to promote safe health IT or something
21 like that? Jason what?

22 (Simultaneous speaking.)

1 MS. ZIMMER: -- IT usage or what --
2 that's fine.

3 CO-CHAIR SINGH: It's not only use,
4 right? It's design --

5 MEMBER JONES: I'm afraid I can't come
6 up with better words, but I'm hopeful that where
7 this leads is that it's less about just harm
8 avoidance and more how we learn through this to
9 build better systems in the first place.

10 CO-CHAIR SINGH: Proactive.

11 MEMBER JONES: Yes, and how we build
12 competency. When someone comes in and we just
13 say, "Here's the EMR, have it."

14 CO-CHAIR SINGH: So simulation to
15 promote safe health IT life cycle proactively?

16 MEMBER JONES: I don't know. If other
17 people agree with that, someone else will have a
18 better command of the language, and we can find
19 it later. But if we're conceptually not aligned
20 with that, and we only want to focus on the
21 safety part, then it's different.

22 CO-CHAIR SINGH: No, it's prevention

1 of risk. SAFER Guides is all about prevention of
2 -- risk mitigation.

3 MEMBER SCHNEIDER: This is an instance
4 where I might argue for splitting them because
5 they are different objectives from a quality
6 improvement standpoint and from a measurement
7 standpoint. The system design issues are one set
8 of issues. The staff competency -- actually, the
9 staff training is a second set of issues, and the
10 staff competency and performance seem to be a
11 third set of issues. The denominator's different
12 for each of those three measures and the intent
13 and the objective and how improvement would
14 follow. It's one of the things I think I
15 struggled a bit over, and this is natural, at
16 this stage of the process, is how our overall
17 framework is ultimately going to look, and then
18 how it's consumed by the public or the other end
19 users of this product.

20 CO-CHAIR SINGH: Do you think it's
21 worth splitting it now into two different slides?
22 We already have the material in there. I think

1 you would agree. But I think you're saying it
2 needs to be structured a bit differently.

3 MEMBER SCHNEIDER: I would probably
4 split it now, just so the issue doesn't get lost.
5 If we end up re-sorting, then you've got the two
6 pieces that you can --

7 (Simultaneous speaking.)

8 CO-CHAIR SINGH: What would the point
9 -- user centered and organizational centered, and
10 the user centered includes training and
11 competency and all that, and that organization
12 centered is, you know, working and things like
13 that?

14 MEMBER SCHNEIDER: Yes, as a first
15 approximation, I think that's a good solution.

16 CO-CHAIR SINGH: What he means is
17 literally duplicate -- you can do this later, I
18 think -- just duplicate the slide and take out
19 everything for use in one, and take out
20 everything for the organizational system in the
21 other.

22 MS. ZIMMER: Could you take what you

1 were saying and put it under clinical decision
2 support?

3 CO-CHAIR SINGH: Yes, that system --
4 (Simultaneous speaking.)

5 MEMBER SCHNEIDER: The sorting can be
6 done later, but I just think disentangling -- if
7 the title doesn't suggest the components, that's
8 always a risk.

9 CO-CHAIR SINGH: Eric, look at the
10 last bullet. You happy with that?

11 PARTICIPANT: We can't see it in the
12 audience.

13 CO-CHAIR SINGH: Oh, sorry. Create
14 two slides, user centered and organization/system
15 centered. That good? Wow. Yes, sorry.

16 MEMBER KHUNLERTKIT: I want further
17 clarification on the user scores on simulation
18 testing. What exactly does that mean?

19 CO-CHAIR SINGH: I was making sure
20 everybody will get lunch today. Yes, you will
21 get lunch today.

22 MEMBER KHUNLERTKIT: I was asking

1 about the last bullet, the user scores on
2 simulation testing, under example. I want more
3 clarification on what that means exactly.

4 MEMBER CLASSEN: Is that test results,
5 like what the scores were on the exam?

6 (Simultaneous speaking.)

7 CO-CHAIR SINGH: They don't know how
8 to use a CPOE system, and they show that on a
9 simulator. You could test, on a simulator,
10 whether they can use a CPOE.

11 MEMBER CLASSEN: Right, whether they
12 can effectively use a system or not.

13 MEMBER KHUNLERTKIT: So basically, the
14 result whether or not they have enough training
15 or competency to use the system.

16 MEMBER CLASSEN: Correct, that's one
17 way to use it. Another way to use it is just
18 say, "Here are a variety of scenarios, and how
19 would you handle them on the system?" and
20 effectively look at how they handle those
21 scenarios.

22 CO-CHAIR SINGH: Yes, order this drug

1 --

2 MEMBER CLASSEN: Order this drug, see
3 what happens.

4 MEMBER KHUNLERTKIT: Because what I
5 saw the user scores, somewhat I think for them to
6 rate the usefulness of the training.

7 MEMBER KHUNLERTKIT: Yes, for them to
8 rate the usefulness of using simulation for
9 training.

10 MEMBER HEERMANN-LANGFORD: I think you
11 need to say user competency scores on simulation
12 testing. I think that's what we're getting at.

13 MEMBER CLASSEN: I think that's what
14 we're getting at. We're not using this to say
15 how much users like the system. We're trying to
16 decide how well they can use the system.

17 CO-CHAIR SINGH: Everything with user
18 centered stuff will be user competency evaluation
19 and training grade, correct? When you split it,
20 Jesse, just make sure that we capture that.

21 MEMBER KHUNLERTKIT: But I don't think
22 this last points are only getting at user

1 competency, though. It's getting at the gap in
2 the workflow, too, right? Because if user cannot
3 perform the task successfully, it may not be
4 because they don't know how to do that, but it's
5 because of the gap in the workflow.

6 CO-CHAIR SINGH: Okay, so let's just
7 go back and look at those five elements.
8 Training, competency evaluation, and workflow
9 analysis could probably move to the user. Is
10 that correct?

11 CO-CHAIR SINGH: Training, competency
12 evaluation, and workflow analysis could move to
13 the user slide. Whereas the rest of it could
14 move to the organizational system centered slide.
15 No?

16 MEMBER KHUNLERTKIT: I feel really
17 reluctant to that because one simulation can
18 capture all of those. If you separate them into
19 two slides, are we going to do simulations?

20 CO-CHAIR SINGH: I think Eric was
21 saying those are two different concepts, aimed at
22 two different people. You wanted to make sure,

1 Eric, the concept doesn't get lost, and we don't
2 overlap, even though it's within the same --

3 MEMBER SCHNEIDER: Simulation is a
4 tool or a standard. I agree with your point that
5 it's a tool or standard that should be
6 consistent, but when we're thinking about quality
7 measurement, we're thinking about what are the
8 users going to do, and how are they going to
9 improve? That's actually different across the
10 different uses of the simulation tool. That was
11 my argument.

12 MS. ZIMMER: If we're thinking about
13 flight simulator, you get a score. Someone may
14 not be able to perform not because they don't
15 know what to do, but because the system
16 technologically can't operate successfully. But
17 yet, their score will be low. I think the issue
18 is how the score's interpreted goes between the
19 two slides. Maybe take the word score out and
20 just use it as both a competency tool, as well as
21 a --

22 MEMBER HEERMANN-LANGFORD: I disagree.

1 There are definitely more than one of these tests
2 happening because they're happening at different
3 points in time of the life cycle. When we talked
4 about the competency, we talked at length about
5 an initial competency, but this is something that
6 they need to maintain because there are updates
7 to the system on a regular basis and things
8 drift. They figure out their own workarounds and
9 things like that.

10 If we want to ensure that the system
11 is safe, we would purport that they need to do
12 regularly simulated competency tests, just like
13 we're doing for BLS, ACLS, all these things that
14 clinicians are being tested on and going through
15 on an annual basis. This is another thing that
16 we should include in that type of thing. Yes,
17 there are multiple simulations happening over
18 time and over the different cycle -- a usability
19 test that you can support the workflow for that
20 task is a very different test than when the user
21 is doing a competency exam on whether or not they
22 can use it.

1 CO-CHAIR SINGH: Right. Are you
2 saying that we should just leave it on one slide
3 and just let this be one concept or split it up?

4 MEMBER HEERMANN-LANGFORD: No, I can
5 still support that there are two different
6 concepts, but I think what we have to do is tease
7 out that there are these different uses, and
8 there may be some different scores in there for
9 the different uses.

10 MS. ZIMMER: I think the confusion at
11 least I was having is I was reading the slide
12 with only the Leapfrog flight simulator, but to
13 your point, there's other simulation tests out
14 there for competency, and I think that needs to
15 be somewhere acknowledged that there's different
16 --

17 CO-CHAIR SINGH: I think everybody is
18 just sort of looking at the nuances. I think
19 we're all happy with what's the content on the
20 slide, correct? What's the next one? Should we
21 take a break now?

22 PARTICIPANT: Lunch is over there.

1 Why don't we work through lunch?

2 CO-CHAIR SINGH: Working lunch is okay
3 with everybody, which means you still get to eat,
4 so that's good. We should just break then, five
5 minutes. Just get food and come back, and we'll
6 restart. Don't go anywhere.

7 (Whereupon, the above-entitled meeting
8 went off the record at 12:26 p.m. and resumed at
9 12:44 p.m.)

10 CO-CHAIR SINGH: All right. Thank you
11 for bearing with us for a quick lunch. We should
12 probably get started.

13 The good thing is a measure that we
14 have first after lunch is, I think, an easier
15 one. So, yes, I think so.

16 Where's Jason gone? He should -- he
17 needs to be here for the -- no, Jason? Oh, he
18 had to go a meeting. Oh, yes, that's right.

19 I know, right. We'll see.

20 (Laughter.)

21 CO-CHAIR SINGH: So, can we have
22 everybody -- all right. So, it sounds good. So

1 this measure is about patient identification.
2 We've got good examples here.

3 We've got presentation potential
4 duplicate patients EHR. That's a measure of
5 Hopkins. Nana, you can talk more about this.

6 The retract and reorder tool, which
7 Jason is using. Almost an NQF measure. And then
8 user barcode scanning in medications.

9 Everybody okay with these examples?

10 MR. LYZENGA: I realized we also left
11 off the -- I don't know if we want to incorporate
12 as a separate concept, but the patient overlay of
13 information?

14 And how would you phrase that, Nana?
15 The patient overlay?

16 MEMBER KHUNLERTKIT: Phrase it for
17 what?

18 MR. LYZENGA: For a measure concept I
19 guess. Or is it part of the duplicate patients?

20 MEMBER KHUNLERTKIT: It's a different
21 problem. Yes. Because under patient --

22 MR. LYZENGA: The rate of information

1 overlaid in the same patient or something like
2 that?

3 MEMBER KHUNLERTKIT: I'm sorry, what
4 did you say?

5 MR. LYZENGA: Could you do like a rate
6 of information overlay in the same patient? Or
7 patients with information overlay? Or number?
8 Or something like that?

9 MEMBER KHUNLERTKIT: I think we can
10 probably track how many records are -- I don't
11 know how we're going to track that.

12 MEMBER MARELLA: So -- if it's a
13 standard measure for a -- at the registration
14 process.

15 MEMBER SEGAL: In the registration
16 process? Yes.

17 MEMBER MARELLA: So, it's called
18 record overlay is the way they describe it. And
19 it's basically instead of having duplicate
20 records for the same person, when somebody shows
21 up, you wind up thinking you already have a
22 record for them when you don't.

1 And you put information in that
2 patient's record. So you wind up screwing up two
3 people's information.

4 MEMBER GRACE: Or you have two records
5 open and you see a patient. And then you
6 document in the wrong record, is another way of
7 thinking of it too.

8 MR. LYZENGA: So, would it be just
9 something like incidents of overlay of patient
10 information?

11 MEMBER RUSSELL: So, it's really -- at
12 the end of the day, what you really have is you
13 have documentation in the wrong record at the end
14 of the day.

15 And then the only problem with
16 measurement on that is it's going to be only if
17 someone catches it. And then you get a chart
18 correction.

19 So, when you get a measurement for it,
20 it's going to be, can you measure how many times
21 you do a chart correction.

22 MEMBER CLASSEN: Jim, do you guys

1 think that's so critical that you would almost
2 call it a Sentinel event?

3 MEMBER RUSSELL: It depends -- it's
4 one of those that depends on the context I think
5 too. And how quickly it's caught. And when you
6 make the correction.

7 So, theoretically, yes, it could go
8 all the way out to a Sentinel event. But then it
9 could also be very simple where you catch it
10 right away and you make the changes right away.

11 So, anywhere in between.

12 MEMBER CLASSEN: I believe if it
13 happens once, it's probably happened multiple
14 times. And an indicator of a serious problem.
15 Fair to say?

16 MEMBER MARELLA: If it happens quite
17 a bit. And actually -- and we've got a lot of
18 reports of this that are coming up in our patient
19 ID deep dive.

20 And the other thing that we're hearing
21 is that people don't really have good solutions
22 for this right now. So, once you create a record

1 overlay and you start making orders on this
2 patient, basically everyone seems to wait until
3 that patient gets discharged before they can
4 separate out the records.

5 It's a very difficult process.

6 MEMBER RUSSELL: Does it get all the
7 way to the point of billing the wrong payer? And
8 if I have to cover my ears I will.

9 MEMBER MARELLA: Never. That never
10 happens.

11 (Laughter.)

12 MEMBER MARELLA: And I'm forbidden
13 from naming names.

14 CO-CHAIR SINGH: So, what am I hearing
15 as a measurement piece here? Is there some way
16 we can measure?

17 So, when Erin was talking about the
18 two records open, the other thing apart from
19 Jason's tool, is the way we do it, is our notes
20 become so erroneous notes. And you can't see
21 them.

22 And that was because somebody entered

1 their note on a wrong patient. So you go to
2 medical records and say can you just take this
3 note out.

4 And it's called erroneous notes. So,
5 how do other systems do it? And is that
6 something we are thinking of sort of measuring?
7 Some kind of erroneous type things in the EHR?

8 MEMBER MARELLA: Well both the
9 duplicate records and record overlay, AHIMA has
10 very explicit standards for how those two things
11 get measured. Those are sort of the core
12 measures of quality improvement for patient
13 registration processes.

14 So, that already exists.

15 CO-CHAIR SINGH: Can we all just put
16 those in there? Can we put those as measures
17 here?

18 MEMBER MARELLA: Sure.

19 CO-CHAIR SINGH: So, can you repeat?

20 MEMBER MARELLA: Yes. I'll send you
21 the documentation on this.

22 CO-CHAIR SINGH: Can you repeat what

1 -- so he can put it?

2 MEMBER MARELLA: I forget where I saw
3 this. I think it was in an ONC report on patient
4 matching is where I came across it.

5 But, the duplicate records and record
6 overlay, there are explicit calculation
7 specifications that AHIMA, I think, put out. But
8 I'll send them to you.

9 CO-CHAIR SINGH: Eric?

10 MEMBER SCHNEIDER: Does the --

11 MEMBER MARELLA: AHIMA, A-H-I-M-A.

12 MEMBER SCHNEIDER: Does the record
13 overlay also include identity theft? Which seems
14 to be a growing problem.

15 And then the creation of -- the entry
16 of information into a patient's record based on a
17 fraudulent identity thief?

18 MEMBER MARELLA: Yes. I mean,
19 everybody who's talked about patient ID has
20 brought up the identity theft issue. I don't
21 know if that's captured in these measures.

22 CO-CHAIR SINGH: Kevin, did you have

1 something else? Fine.

2 Okay. Accountability? Vendor,
3 facility, clinician. Everybody okay with that?

4 MR. HUNT: And Patients.

5 CO-CHAIR SINGH: Patients.

6 MR. HUNT: In know a few who would
7 like --

8 (Laughter.)

9 COURT REPORTER: I'm sorry sir, your
10 microphone is off.

11 MR. HUNT: To make sure that there's
12 someone engaged in recognizing one that they need
13 to actively be involved in the identification.

14 And not provide or understand why in
15 some instances we're taking a picture. We're
16 doing other things to help with the
17 identification.

18 CO-CHAIR SINGH: Excellent. There are
19 sources at EHR? Anything else? Oh, sorry, Lisa.

20 MEMBER FREEMAN: I don't want to
21 diminish the patient's role in any of this. But
22 at the same time, often when you're talking about

1 accountability, the patient is not well.

2 They're possibly a patient with
3 diminished capacity for a number of different
4 reasons. So, I think we have to be careful in
5 the way we phrase the accountability of the
6 patient.

7 CO-CHAIR SINGH: And I think David,
8 the way you meant it was when patients catch
9 these things. Patients should look for these
10 things.

11 And when they catch them, they should
12 sort of do something about it. And I know
13 there's one for patient portal -- reporting stuff
14 through patient portals are reporting it to the
15 organization.

16 The other source is just EHR?
17 Anything else? I mean, I guess patient reports
18 of some kind?

19 Does AHIMA run any reports on a
20 regular basis that we are going to say can be
21 used as measures?

22 MEMBER MARELLA: I don't know -- I

1 don't know the extent to which ADT systems may
2 capture these numbers automatically or anything
3 like that.

4 But, it's -- if those numbers are
5 monitored, they're monitored probably by the
6 registration staff as part of their QI process.

7 CO-CHAIR SINGH: So we could just say
8 something like yes, administrative record
9 monitoring of some kind. And then we can sort of
10 look into the AHIMA guidelines and then go from
11 there.

12 Anything else on this slide? Average
13 getting better. All right. Let's go to the next
14 one.

15 Okay. So this is feedback. Is this
16 the shared accountability one? Shared
17 responsibility?

18 DR. PINES: Yes so what we wanted to
19 do, and we can actually replace this potentially
20 with Elizabeth's presentation. And you know, I
21 think which is pretty nicely specified.

22 But I just wanted to make sure that we

1 didn't lose any of these concepts before we do
2 that.

3 CO-CHAIR BELMONT: I'm guessing what
4 I could do so we can save time today -- oh, thank
5 you.

6 What I can do to save time, I can go
7 back and double check. I think everything's in
8 there. But I'll do a final check and send you a
9 follow up.

10 CO-CHAIR SINGH: Yes. Actually I
11 think you used their five bullets.

12 CO-CHAIR BELMONT: I did.

13 CO-CHAIR SINGH: Or six bullets.

14 CO-CHAIR BELMONT: Yes.

15 CO-CHAIR SINGH: So I think we should
16 be good.

17 CO-CHAIR BELMONT: Yes.

18 CO-CHAIR SINGH: I think so.

19 DR. PINES: Okay.

20 CO-CHAIR SINGH: I mean, everybody
21 should just read it just because you might see
22 just a near final version. And we didn't want

1 any surprises in there.

2 Did we discuss data sources for this?
3 Did you do data sources this morning?

4 CO-CHAIR BELMONT: No. We didn't.

5 CO-CHAIR SINGH: So we know
6 accountability, it's shared.

7 CO-CHAIR BELMONT: Yes.

8 CO-CHAIR SINGH: Should we just
9 discuss data sources quickly? That's to --

10 CO-CHAIR BELMONT: I think that would
11 be helpful.

12 CO-CHAIR SINGH: We had the
13 publications with, you know, vendor screen shots
14 as maybe something we mentioned this morning.

15 DR. PINES: Could it be the contracts
16 themselves?

17 CO-CHAIR SINGH: Yes. Contracts
18 themselves. Yes.

19 CO-CHAIR BELMONT: Yes. Contracts.
20 Hardware and software agreement.

21 MEMBER SEGAL: So just on the first
22 item, I wouldn't say institutions. Because, you

1 know, I think it's organizations or practices.

2 And again, the all, it should be all
3 relevant or pertinent.

4 CO-CHAIR SINGH: Yes. Mark, sorry.
5 This is the stuff from yesterday's slide.

6 MEMBER SEGAL: Okay. All right.

7 CO-CHAIR SINGH: And the modification
8 we made this morning.

9 MEMBER SEGAL: That's right. Okay.

10 CO-CHAIR SINGH: Yes, sorry. We're
11 not going to reflect it. But as a concept, just
12 make sure everything is there.

13 DR. PINES: We'll take this and refer
14 it to together. But in terms of -- sorry, in
15 terms of data sources, I just wanted to make sure
16 we got.

17 CO-CHAIR BELMONT: Yes. Jesse, I'm
18 confident that all of those have now been
19 included in what I did --

20 DR. PINES: Yes.

21 CO-CHAIR BELMONT: With the revisions
22 requested by everyone.

1 DR. PINES: Yes. So it won't be one.

2 CO-CHAIR BELMONT: Yes. She might
3 want to just take it out so we don't get
4 confused. And just say, see shared
5 accountability.

6 CO-CHAIR SINGH: Yes. Just see
7 document.

8 CO-CHAIR BELMONT: Yes.

9 CO-CHAIR SINGH: So, contracts? What
10 -- any other ideas for measures? We had I think
11 a number of publications with screen shots.
12 Verified screen shots from vendors.

13 CO-CHAIR BELMONT: Right.

14 MEMBER SEGAL: Again, I wouldn't have
15 contracts. I don't think we had contracts in the
16 prior for data source.

17 Because I think we were focusing more
18 on the outcomes rather than looking at specific
19 contract provisions. And I don't think contracts
20 is frankly --

21 CO-CHAIR SINGH: Yes. And we may not
22 be able to look at them either.

1 MEMBER SEGAL: And they also vary.

2 CO-CHAIR SINGH: Yes.

3 MEMBER SEGAL: I mean, you know, there
4 are both standard, but also negotiated.

5 So, if you're trying to do a measure,
6 again I think it's best -- I think at least where
7 we left it with what Elizabeth did, is we focused
8 on the outcome piece rather than the existence of
9 particular provisions.

10 CO-CHAIR BELMONT: We could do
11 surveys. You know, to focus on some of the
12 timeliness of the notifications and the shared
13 learnings.

14 So, Jesse, do you want to include
15 surveys?

16 DR. PINES: Sure.

17 CO-CHAIR BELMONT: User surveys?

18 CO-CHAIR SINGH: I was trying to see
19 if you had anything else written on there. Could
20 we -- so you know, one broad thing is this vendor
21 sharing across institutions and across vendors.

22 How would we get to that? Because I

1 think that's sort of essential. And I think
2 everybody's in agreement that we all need to sort
3 of share that learning.

4 David?

5 MR. HUNT: Also, --

6 CO-CHAIR SINGH: Mic.

7 MR. HUNT: Oh, I'm sorry. Also it may
8 tie into this, the ACBs, the accredited
9 certifying bodies as entities. Because vendors
10 are expected to report this type of information
11 to them.

12 And they are an opportunity to -- they
13 can be seen as a hub.

14 CO-CHAIR SINGH: Okay. Greg?

15 MEMBER ALEXANDER: Yes, I was just
16 curious. So, what about help desks where they
17 take reports of potential things that occur?
18 Would that be a data source?

19 And then I also question -- I have a
20 question about bullet five. It says free and
21 transparent exchange of information about Health
22 IT user experiences.

1 So, I'm curious, is this a bilateral
2 exchange? Or is this only vendors or -- it seems
3 to me like some of the bullets only refer to
4 vendors sharing information.

5 And it's not a bilateral exchange from
6 users to vendors.

7 CO-CHAIR SINGH: Yes.

8 MEMBER ALEXANDER: Should it be
9 bilateral?

10 CO-CHAIR SINGH: Absolutely. And I
11 think researchers too. So if I have something
12 that I found based on a research, I need to also
13 sort of share that with the vendors.

14 MEMBER ALEXANDER: Okay.

15 CO-CHAIR SINGH: So, it will be good
16 to sort of point that out.

17 MEMBER ALEXANDER: Thank you.

18 CO-CHAIR SINGH: There were some
19 things in your document that I think I want to
20 mention just because we're at this sort of
21 measure piece.

22 Timely response to resolving vendor

1 reported EHR safety concerns. Vendor user groups
2 incorporate and share user experiences.

3 We're not going to go into agreements
4 as Mark rightly pointed out. They may not be
5 able to have good access to them.

6 We talked about peer-reviewed journals
7 having identified screen shots as a source.
8 Timely response to requests for information. And
9 timely vendor notifications.

10 Anything that could be measured here?
11 I'm just giving people ideas to think about
12 specific measurables that we could put down.

13 CO-CHAIR BELMONT: WE did have a
14 section under the methods of measurement where --

15 CO-CHAIR SINGH: And surveys.

16 CO-CHAIR BELMONT: You know, so we
17 talked about surveys.

18 CO-CHAIR SINGH: Maybe surveys of
19 people? Something there? Already in there?
20 Yes. That's already in the document. Okay.

21 All right. Yes, it sounds good.

22 Okay, so the next one is safe use of clinical

1 decision support.

2 Now, there was a lot of sort of cross-
3 talk -- so across a couple of groups these
4 concepts of alerts came out.

5 So I think we definitely need to do
6 something about alert. You know, whether we do
7 it on overrides, straight up alerts.

8 And here's where I want to bring in
9 one of the additional items I mentioned. You
10 know, there is a safer guide on clinical decision
11 support in CPOE, which has a few items that are
12 going to be relevant for this discussion.

13 So one thing could be, we could say,
14 you know, either look at the items. Or say, you
15 know, the organization conducts an assessment and
16 then leave decision support out.

17 Because they should be conducting
18 assessment on several other things as well. What
19 do people think about clinical decision support
20 as a separate measure?

21 So one -- another thing I can sort of
22 tell you quickly is there are people working on

1 this.

2 So maybe their research is not out
3 yet. But errors in clinical decision support
4 that means over time that it was a problem that
5 didn't get fixed.

6 So we could look at -- we could have
7 a broader measure saying organization monitors
8 the content of clinical decision support in terms
9 of, you know, alerts and reminders and whatever
10 on a periodic basis.

11 Which could be fairly broad. But then
12 you get to the concept of bad decision support.
13 You don't want an 85-year old man getting a PSA
14 reminder. Right?

15 Yes, Karen?

16 MS. ZIMMER: We don't have to move it
17 over. But this is where I think there is some of
18 that cross discussion with this simulator.

19 With the Leapfrog tool. And you could
20 just be referred in this section, see section
21 whatever. But that is a -- that does lend itself
22 to clinical decision support gaps.

1 CO-CHAIR SINGH: And the other thing
2 is what about overrides? Are we addressing --
3 let's say that some alert has been put in.

4 And it has a 99.5 percent override.
5 Does an organization do something about it?

6 And I think there was something about
7 three level loading. Where did that go? Is that
8 here?

9 MS. ZIMMER: We put it with some --

10 MEMBER CLASSEN: So, we have an aspect
11 of the flight simulator that gives things that
12 should never be alerted on as a test to see what
13 their override -- what their over alerting rate
14 is.

15 And it can basically calculate a score
16 of what your override rate is. But this is such
17 an important area.

18 I really think this should be a
19 special focus of more work on measure
20 development. Because there's just so much going
21 on here both in terms of over alerting and under
22 alerting.

1 CO-CHAIR SINGH: Yes. So, you know,
2 David, could we be as broad to say something like
3 measurement of under alerting and over alerting
4 as well as sort of wrong content of CDS?

5 MEMBER CLASSEN: Right.

6 CO-CHAIR SINGH: In addition, the CDS
7 measure is supported by Leapfrog, --

8 MEMBER CLASSEN: Right.

9 CO-CHAIR SINGH: SAFER as additional
10 sort of area of improvement.

11 MEMBER CLASSEN: I think so.

12 MEMBER JONES: Yes, so, this is one
13 where I think we ended up focusing on things that
14 we thought we could measure. And we're sort of
15 discouraged that it wasn't really getting at some
16 of the important aspects.

17 There's nothing in here about order
18 sets. There's nothing -- there are many -- alert
19 fatigue we can sort of get at.

20 So, it's a measure. It's what we can
21 measure. But I don't think it's what we really
22 want to measure. So --

1 CO-CHAIR SINGH: Yes.

2 MEMBER JONES: If we can -- but at the
3 same time there's so much work around what can
4 you measure around CDS? Hopefully someone can
5 come up with good ideas.

6 But this is -- the focus on alerts I
7 think is too narrow. And yet at the same time,
8 what we discussed as a group, if we improve that,
9 it would be meaningful progress.

10 CO-CHAIR SINGH: So Jason, that's why
11 I mentioned SAFER Guides because they go into all
12 those things. They go into order sets as well.

13 MEMBER JONES: Would there be a role
14 for user surveys here? Then sort of the concept
15 of -- I mean, probably the best people to ask
16 about whether or not the clinical service support
17 is there yet.

18 CO-CHAIR SINGH: I mean, you could,
19 but no one going -- you don't want too many
20 surveys to rely on user experience.

21 MEMBER JONES: Yes.

22 CO-CHAIR SINGH: Because the user will

1 never answer them. But I think if some alert is
2 99 percent override, the user is trying to tell
3 you something.

4 That's a, you know --

5 MEMBER JONES: We did talk about an
6 inbox alert for when you didn't respond to your
7 survey.

8 (Laughter.)

9 CO-CHAIR SINGH: Yes.

10 MEMBER ALEXANDER: I just was curious
11 what bullet point two meant? Percent alerts that
12 provide context. What's context mean?

13 CO-CHAIR SINGH: I would remove that.
14 So I think it --

15 MEMBER CLASSEN: So, we talked about
16 that. That very often the way, the method, the
17 process you use for alerting is just out of
18 decision making.

19 By that I mean, rather than getting an
20 alert when you order a medication at the time of
21 ordering it, you get it hours later when the
22 system said, oh, you know, this medication was

1 ordered. And this patient might be allergic to
2 it, you know.

3 And so very often we get alerts that
4 are completely out of context of decision making
5 or patient care. And it touched on the process
6 of alerting.

7 And the process as Hardeep knows, is
8 a really complicated one. Right? And compliance
9 with alerts and how we handle them.

10 And whether we make them hard stops or
11 soft stops for everything, there's just a whole
12 lot going on there. And the context of alerts
13 may ultimately change.

14 As when we show you an alert, we may
15 put it in the context of all the other things
16 going on with the patient. Rather than this one
17 specific issue.

18 CO-CHAIR SINGH: Yes. And you know,
19 I think David, you are also sort of discussing
20 sort of the five rights of CBS. And the good
21 thing about SAFER Guides, it captures some of
22 that information as well.

1 So that's why maybe sort of one of the
2 easier ways out, saying, you know, for clinical
3 decision support and actually for CPOA too, you
4 just have to do a SAFER assessment. It's just
5 one guide by the way.

6 MEMBER ALEXANDER: Yes, so thanks for
7 that clarification. That helps me.

8 So that makes me think that, you know,
9 sometimes information systems are designed and
10 built where alerts depending -- it depends on how
11 it's built and the algorithms when the alerts are
12 generated.

13 Whether they're generated
14 automatically. Or whether generated every 24
15 hours. Depending on what kind of setting you're
16 in.

17 And I'm thinking of assisted living
18 facilities where we're using sensors and
19 generating alerts for clinicians about functional
20 decline. And we generate those alerts every 24
21 hours because it's a different environment.

22 It's not an acute care environment.

1 It's over a longer period of time. So, that
2 context changes depending on the setting.

3 And the algorithms underlying in the
4 structure, underlying that information system
5 change according to setting. So I'm wondering
6 where does the structure and architecture of a
7 clinical decision support system come into play?

8 It seems like that's relevant to the
9 context. But I don't really see that in here.
10 You know, algorithms for decision support. And
11 when those alerts are generated in response to
12 the actual event.

13 CO-CHAIR SINGH: Yes. There's so many
14 different types of scenarios, right?

15 MEMBER ALEXANDER: Right.

16 CO-CHAIR SINGH: You could build a
17 scenario for every kind of setting.

18 MEMBER ALEXANDER: Right.

19 CO-CHAIR SINGH: Now people want to
20 generate alerts to providers about data that
21 patients have in variables. So, constant blood
22 pressure monitoring. Constant glucose, weight.

1 How much data do you want providers to
2 look at? So, there's no end to it. So I think
3 we could again, go on with this alerting
4 business.

5 But at least SAFER -- as David, you
6 said, SAFER Guides are a start. I don't know
7 whether Greg you want to just look at that and
8 see of some of your concerns get addressed.

9 But I think as long as somebody gets
10 a start, we could sort of preface this by saying
11 you really need to have strategies to monitor the
12 content of clinical decision support. Because
13 sometimes I think people just sort of put it in
14 and think that everything's working.

15 But they ought to be looking for new
16 evidence of errors. And I can ask the people who
17 are doing some research in this area if they've
18 got some measure coming up and get back to you.

19 Yes, Sorry, go to three.

20 MEMBER RUSSELL: Yes, I could comment
21 on number two. It just says, occur at the right
22 time.

1 And back to the five rights. Is the
2 right person -- I think we need to clarify --
3 it's not just the right time. There's multiple
4 components to that.

5 Right person, right context. And we
6 could go on.

7 CO-CHAIR SINGH: Yes.

8 MEMBER RUSSELL: And that's why I was
9 wondering. Is one and two redundant, David, do
10 you think? I think they're redundant in a way.
11 Okay.

12 CO-CHAIR SINGH: Okay. Any other?
13 Jason, do you have another comment? Okay.
14 David? Oh, yes, sorry.

15 CO-CHAIR BELMONT: So, for additional
16 data sources, we could look at -- oh, thank you.

17 For additional sources we could look
18 at metadata too.

19 CO-CHAIR SINGH: Okay. Anything else?
20 Karen, do you have anything? I think David is
21 not there right now. No? Okay.

22 In his absence. Okay. So, I think

1 everybody agreed, we need something on CDS as a
2 standalone.

3 We can sort of refine it a little bit
4 using SAFER Guides. And using a broad sort of
5 concept of organization measuring their content.

6 Okay. So, is transitions in care a
7 concept? Measure concept? What was the measure
8 concept? What was the underlying?

9 DR. PINES: I think the broader
10 measure concept was this documentation quality
11 where this was I think one of the subcomponents.
12 And there was a lot on transitions in care.

13 So we decided to make it a separate
14 concept.

15 CO-CHAIR SINGH: Okay. There's quite
16 a few things in here. Did you want to --
17 Elizabeth, do you want to make a comment first?

18 CO-CHAIR BELMONT: Sure. One of the
19 things that I didn't see in here that we might
20 want to consider adding, is readmissions
21 following discharge. Which can be an indicator
22 of whether something was missed at the time of

1 transition of care.

2 CO-CHAIR SINGH: And the other thing
3 we should think about is, do we want to keep
4 documentation as a stand-alone item? Or do you
5 want to merge it with things like, you know,
6 follow up of test results and medication
7 reconciliation?

8 So, if we want to merge it, then we
9 should sort of reframe this measure concept as
10 measurement of information technology safety at
11 transitions of care. Or something like that I
12 think.

13 That would be more useful. And then
14 you could include many of the items in there.
15 Are we allowed to have so many measures in there?

16 Because I have a feeling three or four
17 of those are actual measures that are actually
18 going to go forward. Do you want to have this
19 under one umbrella?

20 MEMBER ALEXANDER: Is it really
21 information? Or is it -- are you interested in
22 HIT?

1 CO-CHAIR SINGH: No ID. Safety.

2 MS. ZIMMER: So I'm just -- the first
3 bullet point, again, I think to your point, I
4 think we kind of addressed in other places. So
5 you might just put it under there, but refer.

6 It's been talked about. The discharge
7 and transition note quality is really -- and even
8 the readmissions you talked about is -- that's
9 where there's great literature on this that show
10 the importance of this that affects readmissions
11 as well as --

12 CO-CHAIR SINGH: Right. But what's
13 going wrong with Health IT use in that setting is
14 what I think we need to be thinking about.

15 So, here's literature that
16 electronically communicated test results, we're
17 still losing them. We lose about eight percent
18 of abnormal test results.

19 So there's good documentation that if
20 bad notes would probably correlate with bad
21 diagnosis. Or diagnosis or management decisions.

22 MS. ZIMMER: Where the technology

1 piece at least in that article, talks about is
2 again going back to where we talked about things
3 in free text versus structured fields, where
4 there's a guarantee that certain elements are in
5 a note.

6 And one of the ways it was helped is
7 by better templates. So technology was part of
8 enhancing that piece. It plays a role.

9 CO-CHAIR SINGH: Is the data burden
10 one that we had in our group? I don't see those
11 here. In here? In a separate slide? Okay.

12 MEMBER JONES: I'm not so sure about
13 the --

14 COURT REPORTER: I'm sorry sir, your
15 microphone isn't on.

16 MEMBER JONES: The readmissions and
17 med rec. The med rec having tried the -- that's
18 really easy to defeat with HIT. You can put a
19 button that says reconcile all the meds.

20 And the readmissions is so
21 multifactorial. I'm all for outcomes that
22 matter. But that one seems like it would be very

1 difficult to tie -- like an -- the HEDES PCR
2 would be awfully hard to tie to HIT I think.

3 DR. PINES: And also just to clarify,
4 the med rec and the admissions are already --
5 readmissions are already NQF approved measures.

6 MEMBER JONES: For HIT? Or --

7 DR. PINES: For just general measures
8 of safety.

9 MEMBER JONES: Yes. Sure. Sure. No,
10 I'm sorry, I just meant within this context.
11 That's all.

12 DR. PINES: I guess the question is,
13 should we include this under the Health IT
14 umbrella? Or should we take it out is your
15 question?

16 MEMBER JONES: Yes. I would have
17 suggested taking them out. Because it doesn't
18 focus on the issue. It's too difficult to tie
19 back.

20 DR. PINES: And also to clarify, so
21 the med rec -- current med rec measure in the
22 safety portfolio is an attestation measure.

1 And does not involve actual -- any
2 actual sort of, you know, objective or sort of
3 HIT use of information. It's just the clinician
4 says yes, I did med rec.

5 CO-CHAIR SINGH: Lauren, go ahead.

6 MEMBER HEERMANN-LANGFORD: So what I'm
7 struggling to find here, I'm not sure that I have
8 a solution, is just the piece around the bigger
9 picture of care plans. So I know in physicians
10 it's orders and activities.

11 But for the rest of us that are non-
12 physicians, care plans are a very contextual
13 document that talks about preferences and
14 barriers to care. And you know, environment of
15 the care that's being provided at home. Goals,
16 things like that.

17 And it's a huge piece of transitions
18 from a patient going from one site to another.
19 And I'm not really seeing that come through here.

20 And I don't know, I mean, now with the
21 discussion on is it an IT problem? Is it not?
22 Is it, you know, under this umbrella?

1 But I feel like somewhere, somehow, we
2 need to encourage our IT tools to help manage all
3 of this content in a way that is helpful to our
4 clinicians. So, I'm not sure how to do that.

5 CO-CHAIR SINGH: Okay. So, we could
6 relabel this and say Health IT is used safely
7 across the care continuum. And that would
8 include almost everything.

9 And then we could give specific
10 examples underneath that. Would that sort of get
11 it to you?

12 MEMBER HEERMANN-LANGFORD: It would
13 help. Yes, exactly. Because I feel otherwise
14 it's a little too narrow. And it's important in
15 this.

16 CO-CHAIR SINGH: Jesse, do you want to
17 change the title? I think -- yes. Kevin's
18 first.

19 MEMBER HAYES: So just to comment both
20 on medication reconciliation and readmission
21 after discharge. I think it's really had to do
22 without health information exchange data.

1 And almost one of your other data
2 sources could actually be the payer data. I
3 actually can probably do an outpatient medication
4 reconciliation on about ten percent of the entire
5 United States right here with Anthem data.

6 Right?

7 Because it's all their outpatient
8 fills. So it would be way beyond checking a
9 button.

10 I mean, with all scripts dumping data
11 back in with picking up. And knowing what --
12 that they got an antidepressant from some health
13 system outside of their health system.

14 I mean, I think this landscape ought
15 to change. And should change. And I think
16 medication reconciliation is something that HIT
17 can really potentially begin to measure.

18 But maybe not today. If all you're
19 measuring is clicking a button that you did
20 medication reconciliation.

21 And similarly with readmission after
22 discharge. I think as you get into actually

1 being able to know what happened across the
2 street through ACO models and pay for performance
3 measures, I think this landscape is going to
4 change over the future.

5 CO-CHAIR SINGH: Okay. So how about
6 this as sort of a middle ground. Can we just
7 sort of think of measures as measures we could do
8 now?

9 Which is documentation and follow up.
10 Which is what I see at the top. And then
11 aspirational measures for the future to think
12 about. Which will include things like what you
13 all are mentioning.

14 Can we do that? And that way we could
15 give two concrete measures, which I see out there
16 at the top. Maybe three. Two or three in the
17 top as concrete measures that we could do now.
18 Fair? Maybe?

19 Well, I think dividing them up into
20 two sort of examples we can focus on now. And
21 put -- we'll have to refine one and two.

22 I think one and two are promising. So

1 we've got to keep them. I'm still having an
2 issue with three.

3 And people can sort of talk about
4 this. I think four and five which is med rec and
5 readmission, everybody agrees, Health IT should
6 be used for these concepts.

7 It should be used safely. Right now
8 I don't know if we have the measures in order to
9 measure that kind of safety.

10 If we are, please let me know. And we
11 can put that in there.

12 MS. ZIMMER: So, I feel like this is
13 more about documentation quality, which is number
14 13. It's more overarching.

15 But as I tried to stress when we
16 talked about a number of these, at least that we
17 were assigned, were in documentation. There is
18 the quality and the timeliness.

19 And those are the two nuances I was
20 saying we want to make sure they don't get lumped
21 together. Because the documentation quality is
22 the med rec. Is the assurance that information

1 is being completed in the chart.

2 CO-CHAIR SINGH: Yes.

3 MS. ZIMMER: I think the follow up is
4 separate.

5 CO-CHAIR SINGH: I think Karen, we can
6 move that bullet forward. There's one bullet a
7 little further along on the quality.

8 Can we have quality and timing in the
9 same one? Or you think keep it separate?

10 MS. ZIMMER: That I defer to everyone
11 else. But either way, it's the two concepts.
12 It's documentation quality and timeliness.

13 If you want to put that as the
14 overarching idea. And then have measures below
15 that. Or --

16 CO-CHAIR SINGH: Or can you put under
17 documentation quality, can we put documentation
18 timeliness as well? And that we can just focus
19 on follow up or test results as a concrete
20 measure which is almost ready for, you know, NQF
21 to even look at.

22 Because that's the easiest thing you

1 can do in terms of diagnosis.

2 MS. ZIMMER: Right.

3 CO-CHAIR SINGH: If you go -- all
4 right, so --

5 DR. PINES: Is that what?

6 CO-CHAIR SINGH: I don't know. Does
7 everybody agree that timely clinical
8 documentation and timely transmission when
9 there's a -- well, this is transition of care.
10 It's too long.

11 DR. PINES: It's too much?

12 CO-CHAIR SINGH: Timeliness -- it's
13 still timely clinical documentation.

14 MS. ZIMMER: I don't know that you
15 need the safe use of Health IT across the
16 continuum. Because the reality is, you need
17 documentation quality within a hospital. Within
18 units, across units. At discharge.

19 And then that's the big overarching.
20 And then we give examples of what we're really
21 drilling down to. Or giving people specifics.

22 Because documentation quality and

1 timeliness is kind of huge. But we're really
2 talking about, are elements in the document that
3 need to be there?

4 Are they being used at discharge? Are
5 they being used in care plans?

6 CO-CHAIR BELMONT: Just to pick up on
7 what you're saying, what if we said that it's
8 documentation quality and timeliness at
9 transitions of care? Because I think that's what
10 the focus has been on.

11 CO-CHAIR SINGH: Across the continuum
12 I'm guessing.

13 CO-CHAIR BELMONT: Ye. But that
14 seemed broader. I guess do we went to focus on
15 it across the continuum?

16 MS. ZIMMER: I like transition of care
17 because it speaks to even from like an ICU down
18 to a floor. Which there's always a lot of
19 problems.

20 And I had one other quick comment.
21 When we talk about where it says follow up
22 includes communication onto the patient.

1 Could we say patient and other care
2 providers? Or just other providers?

3 MEMBER CLASSEN: Yes. If you looked
4 at one of the critical tests of the health system
5 capabilities, medication reconciliation would be
6 one, wouldn't it.

7 Because it requires a lot of
8 competencies. And everywhere it's being done now
9 seems to be done with the IT, right? I've not
10 seen.

11 And yet in my last three primary care
12 visits, the meds list was wrong every single
13 time. I don't know about the rest of you, but
14 when I see my patients, it's almost always wrong
15 when I do medication reconciliation with them.

16 So this is a process that's still
17 completely broken. And I almost think of it like
18 clinical decision support. It's a whole system
19 measure if you will, right?

20 We're really looking at a critical
21 thing we do. The most common intervention in
22 all.

1 So I think this probably, med recon,
2 deserves more focus. Because there are a lot of
3 measures ways to measure this. Right?

4 You could measure it looking at
5 percent changes in medications. Each step that
6 medication reconciliation's done.

7 You could look at it as a survey from
8 patient's point of view. How often were your
9 meds accurate when you went to see your doctor?

10 You could look at it from a
11 physician's point of view. How often were the
12 patient's meds accurately recorded in the system?

13 I mean, there are lots of ways to look
14 at this. And it's such an important system
15 measure.

16 CO-CHAIR SINGH: Okay. Are you
17 proposing that we add something here that's not
18 on there? Or are you just saying that we should
19 keep it as a --

20 MEMBER CLASSEN: Keep it. And I would
21 say almost expand the number of measures that you
22 might have in this area.

1 CO-CHAIR SINGH: I think it's Erin
2 then Jim and then Lisa.

3 MEMBER GRACE: So, is -- I'm just a
4 little concerned about is timely documentation
5 only important at transitions in care?

6 I mean, let's say somebody's staying
7 on the ICU ward and the doctor has been called
8 for some reason. I'm not a clinician, so, this
9 may not make any sense.

10 But doesn't that physician need to do
11 timely documentation because two hours later a
12 different physician might, you know, it's a
13 different attending on call. Or whatever it has
14 to go see the --

15 CO-CHAIR SINGH: So it's still, thanks
16 to ACGME rules, it's still a care transition
17 because we have so many transitions in the
18 hospital. That literally is, right?

19 MEMBER GRACE: It's still a transition
20 because it's a different provider?

21 CO-CHAIR SINGH: Yes. We can say
22 that.

1 MEMBER GRACE: Okay.

2 CO-CHAIR SINGH: We can say at, you
3 know, at patient or provider transition. And
4 that would address exactly I think what you're
5 saying.

6 I think Jim did you?

7 MEMBER RUSSELL: So, just to kind of
8 go more on what Kevin said. There's just not the
9 claims data.

10 There's pharmacy data and data source.
11 Because not every pharmacy prescription gets done
12 as a claim with all the \$4.00 prescriptions out
13 there.

14 And I know you can get the data
15 because --

16 MEMBER HAYNES: I respectfully
17 disagree. A pharmacist who doesn't show the
18 insurer that the person is meeting their
19 deductible, they're almost -- even zero dollar
20 copays come through.

21 MEMBER RUSSELL: It depends on the
22 insurer. So the \$4.00 ones don't necessarily

1 come through because not everybody's on a whole
2 plan.

3 So I just want to say that there's
4 other data out there that we should take
5 advantage of. And just wanted to -- I'm
6 expanding on you.

7 And then well, I got a couple more,
8 just kind of say.

9 CO-CHAIR SINGH: All right.

10 MEMBER RUSSELL: And then just go --
11 and to go into more of what Dave was saying.
12 There are measurements for med rec that can be
13 captured just through the technology such as --
14 and they're not great measures.

15 But they're at least measures that we
16 know a percent of patients who actually have that
17 done. The number of changes made. Those are all
18 things that are really easily measured.

19 We measure those all the time. We
20 actually use them as measurements of success when
21 people go live.

22 The third one on the readmissions

1 after discharge, there are a lot of tools that we
2 can actually put out there to help people try and
3 identify patients up front.

4 So, there's tools out there like lace
5 plus scores and things like that that you can
6 actually score against the patient while they're
7 still as an inpatient for instance. So you know
8 that there's somewhere you need to follow on that
9 transition of care.

10 CO-CHAIR SINGH: Yes. So you need to
11 say prospectively you can predict who might be
12 readmitted? Is that what you mean?

13 MEMBER RUSSELL: Absolutely.

14 CO-CHAIR SINGH: So, you know, I think
15 Jim can you just forward those things maybe you
16 use? Unless it's proprietary, to Jesse.

17 And then we can just put that on there
18 for med rec?

19 MEMBER RUSSELL: Sure.

20 CO-CHAIR SINGH: And for the discharge
21 one, I would, you know, if there's anything that
22 you want to say, we can just say proactive

1 measurement through, you know, last score rec.

2 MEMBER RUSSELL: We can do proactive
3 measurements and I can send some things.

4 CO-CHAIR SINGH: Yes.

5 MEMBER RUSSELL: Like, I will just add
6 that stuff.

7 CO-CHAIR SINGH: Yes. Perfect. We'll
8 just add that. And that will make it look really
9 robust. Just like I think David was thinking we
10 should do.

11 Is everybody otherwise happy with
12 those two measures? The third one, it says
13 discharge in transition note quality and
14 completeness.

15 And I think that could mean a lot of
16 things. And then it goes onto charts with active
17 problems. Allergies, med quoting and free text.

18 That's a separate issue I think. I
19 don't know whether we want to keep it or not.

20 MS. ZIMMER: You'll want to include
21 those into documentation in the end.

22 CO-CHAIR SINGH: Yes. Why don't we

1 put -- well, that's still not documentation. The
2 third bullet, say charts with active problems,
3 allergies, meds quoting and free text, that's a
4 different issue.

5 You could either put it in a parking
6 lot or you can put it under documentation quality
7 if we ever get there today. Have we merged it?
8 Did we merge the documentation quality?

9 Okay. I think that you could put it
10 -- it's useful. But I would put it out of there.
11 Because it doesn't have -- I don't know if it's
12 anything to do with it.

13 Yes. Make it into a separate.

14 MS. ZIMMER: At the time I think we
15 were thinking it was a way to -- it was a proxy.
16 If people are supposed to be sharing information
17 in structured fields, it was just another way to
18 change that.

19 CO-CHAIR SINGH: Yes. I know. But I
20 mean, meaningful use encourages people to code
21 allergies and other stuff. Doesn't it?

22 MS. ZIMMER: Yes.

1 CO-CHAIR SINGH: I mean, you've got
2 other things. I mean, they're not doing it. But
3 MU encourages people to do the structured coding.
4 Correct?

5 The structured use of some of these
6 things. And I'm not sure whether you need a
7 separate measure for that.

8 MEMBER SCHNEIDER: I would just weigh
9 in that when we tried to implement something like
10 this in a recent study in two Medicaid states, it
11 was almost un-implementable.

12 CO-CHAIR SINGH: Because they didn't
13 have structured data?

14 MEMBER SCHNEIDER: Not -- there was
15 not enough structured data.

16 CO-CHAIR SINGH: Yes.

17 MEMBER SCHNEIDER: And there was
18 judgement calls about, is this adequate? Not
19 adequate? You have no way of knowing what's
20 missing.

21 CO-CHAIR SINGH: Yes.

22 MEMBER SCHNEIDER: It becomes really

1 a feasibility -- measurement feasibility issue.

2 CO-CHAIR SINGH: And it's structured
3 differently in different EHRs. The same thing.
4 So, that's another challenge.

5 MEMBER SCHNEIDER: A lot of labor and
6 the end result is not a reliable measure.

7 CO-CHAIR SINGH: Do you think from
8 ONC's perspective do we still need to talk about
9 structuring data in this? I mean, we're five
10 years into this now.

11 Okay. Well, I think this needs to be
12 a separate measure then. Put this structured
13 stuff out. Take all of that.

14 This whole thing and put it
15 separately. We'll have to visit it at the end if
16 it doesn't get covered elsewhere.

17 Sorry, Lisa, you're --

18 MEMBER FREEMAN: It's okay. I was in
19 and out already.

20 In terms of the idea of transitions
21 versus continuum of care, where does the
22 chronically ill, home care patient fit into this?

1 Because that's -- there's not transitions, but
2 there is a continuum where we need to have a, you
3 know, accurate timely records.

4 DR. PINES: Should we -- but we can
5 put back across the continuum.

6 CO-CHAIR SINGH: Yes. Because the
7 word transition is already there, I think,
8 somewhere in that.

9 MR. LYZENGA: Just sort of a check,
10 for my own purposes, are we -- can we -- is there
11 any way we can kind of focus these a little more
12 closely around -- on each IT?

13 I feel like a lot of these have to do
14 with just sort of basic healthcare processes and
15 documentation. And I just want to make sure we
16 are focusing them on the aspects of -- that are
17 related to HIT that, you know, where HIT maybe,
18 you know, inhibiting these things or facilitating
19 better.

20 CO-CHAIR SINGH: So maybe we could
21 just say technology is used safely and
22 effectively to facilitate medication

1 reconciliation. That's maybe their concept or
2 something that we're looking at.

3 And then -- yes, I think that would
4 address what Andrew was --

5 DR. PINES: And then the same thing
6 for the ones above.

7 CO-CHAIR SINGH: And then the ones --
8 yes. Well, the other one we can -- let's just
9 get to that.

10 But the second one will say something
11 like this again. Technology is used, you know,
12 safely and effectively to prevent all predatory
13 admissions.

14 I think Jim, you were saying predict
15 as well, right? Not --

16 DR. PINES: So you're saying move this
17 up the fence?

18 CO-CHAIR SINGH: No, no, no. No, no,
19 just you could leave it there.

20 MR. LYZENGA: For the top level of
21 one, should we do something similar?

22 CO-CHAIR SINGH: Okay. So for the top

1 level.

2 MEMBER JONES: It's just that this --
3 it's about the quality and timeliness of
4 documentation. Lace has nothing to do with
5 quality and timeliness of documentation.

6 It's a good thing to do. It's
7 clinical decision support. It just doesn't have
8 anything to do with quality and timeliness of
9 documentation. That's all.

10 So I just worry that we're going to
11 lose that piece. Because if we don't get the
12 quality and timeliness of the documentation
13 correct, then everything else in HIT fails.
14 Right?

15 CO-CHAIR SINGH: Yes.

16 MEMBER JONES: So that's like the core
17 upon which we build everything else.

18 CO-CHAIR SINGH: Can we put
19 readmissions to a parking lot too then? And move
20 it -- see if it fits elsewhere?

21 MEMBER JONES: It's a specific example
22 of clinical decision support basis.

1 CO-CHAIR SINGH: Well, we'll just move
2 that into, yes. Move that into a box somewhere
3 else right now. Look at it later.

4 MEMBER JONES: But then if we focus I
5 think on like where is HIT in quality and
6 timeliness of documentation. If we can find a
7 way to measure that to help systems actually have
8 better core data on which to operate it, so
9 that's a huge deal.

10 CO-CHAIR SINGH: Is this good --
11 better now? So, okay, so the first one is
12 probably okay, correct?

13 Can we put it in the EHR?

14 DR. PINES: Just to address what Jason
15 said. So, you know, you're saying that we should
16 focus more on the ability of HIT to do -- to
17 facilitate this.

18 But that the actual clinical action
19 may have fallen under a separate bucket of --

20 MEMBER JONES: Yes. That would be my
21 suggestion. Which people can disagree with. But
22 yes, that's what I'm suggesting.

1 CO-CHAIR SINGH: Tell us what to do
2 with the slide. What do you want to do in this
3 slide?

4 MEMBER JONES: Well I think it's done
5 now.

6 CO-CHAIR SINGH: Okay.

7 MEMBER JONES: I think -- I mean, yes.
8 We'll have to figure out how we actually measure
9 these things meaningfully.

10 So here we say we need to focus on how
11 technology facilitates this.

12 CO-CHAIR SINGH: So for timely follow
13 up on diagnostic test results, you could say as
14 determined by either manual or electronic review.
15 So there are triggers that we're building to
16 identify missed follow ups.

17 MEMBER JONES: Yes.

18 CO-CHAIR SINGH: So you could do it
19 electronically as well.

20 MR. LYZENGA: And I gather the way
21 these things are enabling safe use of an HIT in
22 terms of clinical decision support. Providing a

1 foundation that makes those things useful.

2 I just want to make sure we can
3 capture this in the report.

4 CO-CHAIR SINGH: And I think what
5 we're getting at is level three. Which is using
6 technology to improve safety related to
7 readmissions or transitions or med recon and
8 things like that.

9 Did you capture the timing follow up
10 on diagnostic test results as determined by
11 manual or electronic audit?

12 And the first one says timing clinical
13 documentation and timely transmission. Do we
14 need to have the timely transmission?

15 Or just say timely transmission of
16 critical information and then there's the
17 transition of care. So, when we admit patients
18 to our hospital, we almost never get records from
19 the prior hospital that they were sent from.

20 So, is that important enough? Yes?
21 Or do we just say timely clinical documentation
22 and leave it at that?

1 CO-CHAIR BELMONT: I was concerned
2 about transmission because the example we were
3 talking about last night when there might be a
4 test that the result has not come back yet, and
5 someone has been transferred.

6 CO-CHAIR SINGH: Kevin?

7 MEMBER HAYNES: Yes. So I think this
8 came out of our workgroup. Or we had talked
9 pretty extensively about is the data there.

10 And then is the data available for
11 transmission. And then is somebody at the
12 patient receiving location actually pulling or
13 looking at the data.

14 So we still felt that this was
15 somewhat important. So for example, if a patient
16 is just simply transferring from the hospital to
17 the long term care facility.

18 If that long term facility is even
19 within the same health system. So I'm trying to
20 make this a really, really simple example.

21 If the data at the end of the night
22 goes to some data warehouse and that's when it's

1 available. Well, then it's not available. It's
2 like negative infinity available. Right?

3 To the long term care facility. To
4 your point. It's never available. Right?

5 But there are other upstream issues
6 there that even if it was available
7 instantaneously, is the note closed at the one
8 place? So did the person finish the
9 documentation at the one place?

10 Even if the second step is
11 instantaneous. It is push-able or pull-able from
12 the receiving.

13 And then sort of lastly, when they get
14 to the LTCH, do we just always assume, oh, it's
15 never available. I'm not even going to check.

16 Well, then it was available but nobody
17 ever pulled it or nobody ever looked at it. So,
18 there were a couple of different trigger points
19 in this availability of information in the
20 exchange between two facilities.

21 And that's when they own one another.

22 CO-CHAIR SINGH: So Kevin, should we

1 say timely clinical documentation and timely
2 transmission of available clinical -- I guess it
3 should be clinical information, at the transition
4 of care.

5 But what you're saying is also
6 clinical, not just available, it's used. That
7 your use concept is not -- oh, I guess the next
8 bullet says information sent/received in view.

9 Is that good enough? Or?

10 MEMBER HAYNES: I think so.

11 CO-CHAIR SINGH: Viewed and then used.

12 Okay.

13 MEMBER HAYNES: Viewed and used. I
14 mean, I don't know that you can measure could you
15 use it.

16 CO-CHAIR SINGH: Right.

17 MEMBER HAYNES: But if you didn't view
18 it, you clearly didn't use it.

19 CO-CHAIR SINGH: Correct. Okay. Well
20 at least you'll think of people as you develop
21 the numerator and denominator of this
22 information. Okay.

1 MS. ZIMMER: It poses -- Oh, I'm
2 sorry.

3 MR. HUNT: Those two bullet points are
4 the definition of interoperability.

5 MS. ZIMMER: I was just going to say,
6 opposed to my group, could we move that as a
7 subset of the data availability/interoperability?
8 Because I feel like those two points should move
9 up and let this literally be about a quality
10 meaning.

11 What elements are in the document?

12 CO-CHAIR SINGH: Yes. We could do
13 that. Where did we -- did we lose a -- okay. It
14 says discharge and transition of quality.

15 But we're not only focusing on
16 quality, right? On transition and discharge, are
17 we?

18 MS. ZIMMER: Because -- no. But when
19 we talk about timeliness, and that's why I'm
20 posing it to my group. It just feels like we're
21 trying to fit it here. But we've kind of talked
22 about data availability/system interoperability.

1 And it just seems like that is a nice
2 subset that fits up in that earlier discussion.

3 CO-CHAIR SINGH: Yes. I think that
4 bullet one looks like it might have to go to the
5 first one. Does everybody think so?

6 So, under the interoperability one
7 about the test that we had? Across the
8 interface. But that's sort of going across the
9 interface, which --

10 DR. PINES: But I think the concept of
11 care transitions is about the, you know, the
12 timely creation of the information. And making
13 sure it's in the system.

14 And then the interoperability is sort
15 of the viewability across systems. So I'm not
16 sure it's totally the same.

17 MS. ZIMMER: Then at least if you keep
18 it there, I would then refer people to the other
19 one. Because again, our construct is a little
20 bit different.

21 Our construct is as we were thinking
22 of it as a workflow process data. You have data.

1 You transfer data. You read data. You use data.

2 DR. PINES: Right.

3 MS. ZIMMER: And then how else are
4 those pieces working. So it's -- we just were
5 thinking of it from a little bit of a different
6 aspect.

7 CO-CHAIR SINGH: So do we need to have
8 the timely transmission part in here? Can we not
9 just focus on timeliness of clinical
10 documentation that everybody agrees is an issue?
11 And quality of clinical documentation that
12 everybody agrees is an issue?

13 And we already said at the top, it's
14 across the continuum.

15 MEMBER SEGAL: And I think the timing
16 as the transmission is important because it's a
17 sender who's not necessarily going to benefit.
18 It's sort of their role as a good citizen and as
19 a key participant in the healthcare system.

20 But I think it's somewhat of a
21 different role if you're a user in a hospital
22 let's say. And the issue is what information you

1 have available.

2 I think it's worth distinguishing
3 whether you timely send the information.

4 CO-CHAIR SINGH: So, how do we
5 distinguish it from the broader discussion of
6 interoperability on a broader scale that, you
7 know, David and sort of Kevin brought up?

8 MEMBER SEGAL: It might go with
9 interoperability. I mean, it can fit here
10 because again, its interoperability is only a
11 means to an end.

12 Right? It's a tool? And this slide
13 here is really focusing closer to the end.

14 CO-CHAIR SINGH: Yes.

15 MEMBER SEGAL: Which is good quality.
16 So, I just think it's -- I think it's worth
17 measuring just as meaningful use does, looking at
18 what people are doing.

19 Not only -- in fact meaningful use
20 started with focusing on whether people were
21 sending the data. And what's proposed in the
22 regulation David can't talk about, is what you do

1 when you receive it.

2 So, in any event, I just think that
3 wherever it is, it's worth separating out the
4 transmission piece.

5 CO-CHAIR SINGH: Eric?

6 MR. LYZENGA: Do you want to put it in
7 our context of our framework, we can think of
8 these things as sort of the safe use aspect. Are
9 these things being done correctly and
10 appropriately?

11 Whereas the interoperabilities are the
12 systems themselves enabling that to be done.

13 MEMBER SCHNEIDER: I'm going to hold
14 my comment. I'm not sure if it will make things
15 better or worse.

16 (Laughter.)

17 CO-CHAIR SINGH: It depends. How long
18 you want to be here?

19 (Laughter.)

20 CO-CHAIR SINGH: No, no. Go ahead,
21 Eric.

22 MEMBER SCHNEIDER: Yes. You asked for

1 it. Okay.

2 (Laughter.)

3 MEMBER SCHNEIDER: And maybe it's so
4 basic it's already been said. And then just tell
5 me it's already been said.

6 But the reason to focus on transition
7 is because different decision makers who may not
8 be communicating with one another, patient
9 information that may be new to the new setting
10 that they're going to. So, it's a time of
11 vulnerability for the patient and risk, safety-
12 related risk.

13 Is that -- am I understanding that?

14 CO-CHAIR SINGH: Yes.

15 MEMBER SCHNEIDER: Which would be the
16 counter -- I think would be the argument for
17 saying yes, this is an aspect of
18 interoperability.

19 But we're calling it out because of
20 that set of vulnerabilities for the patient. Am
21 I understanding it?

22 MS. ZIMMER: No. And actually -- for

1 that reason because I like the work transition to
2 be in the title, to emphasize the importance. I
3 would go back to the quality and timeliness in
4 transition or at transition of care.

5 And just take out the work continuum.

6 CO-CHAIR SINGH: Well, it addresses
7 some of the other issues Lisa was bringing up
8 about some home care and all that.

9 MS. ZIMMER: That's not a transition?

10 CO-CHAIR SINGH: Long-term care.

11 MS. ZIMMER: Oh, okay. Got it. All
12 right.

13 MEMBER SCHNEIDER: Yes. I was posing
14 it more as a question of are we trying to get at
15 the unique -- those unique features I described?

16 Or are we interested in all types of
17 transmission between decision makers? In which
18 case it seems like there is an argument to put it
19 back with interoperability.

20 CO-CHAIR SINGH: I think it's the
21 second one. So maybe Eric, you could help us
22 refine some of the language in these bullets to

1 get to what you are saying.

2 I think that's where we are getting
3 at. The risk between, you know, when there are
4 different providers and there is vulnerability.

5 MEMBER SCHNEIDER: Is it -- does the
6 longitudinally and the care transitions capture
7 that?

8 MS. ZIMMER: It's semantics. I mean,
9 continuum care, most people know about more than
10 a lot do. So, and then it becomes quality and
11 timeliness at transitions and continuum of care.

12 MEMBER SCHNEIDER: So hold on, you
13 know, maybe it's because we're talking about
14 different settings. Maybe that's what the -- but
15 the -- rather than continuum, continuum kind of
16 implies that -- I mean, continuum can exist where
17 it's the same provider over and over again.

18 That's not the continuum we mean. We
19 mean different providers. Different settings.

20 CO-CHAIR SINGH: Across care settings?

21 Or --

22 MEMBER SCHNEIDER: Across care

1 settings might fix it.

2 MS. ZIMMER: Yes.

3 CO-CHAIR SINGH: Okay. Across care
4 settings. All right.

5 MR. LYZENGA: Although Erin did
6 mention within a hospital possibly, you know,
7 this being an issue.

8 CO-CHAIR SINGH: There are settings.
9 And that way it includes everything. Because
10 then home care is a setting as well.

11 MS. ZIMMER: So, quality and
12 timeliness at transition and across care
13 settings. Because by putting at transitions
14 first, we tend to think of within before we think
15 of without.

16 MEMBER SCHNEIDER: And then across
17 care transitions captures that the patient maybe
18 in the same place. But the communication is
19 across events.

20 CO-CHAIR SINGH: Okay. Is it within
21 care settings? Or across?

22 MEMBER SCHNEIDER: No, I think we mean

1 across care settings.

2 CO-CHAIR SINGH: Okay. Anything else
3 you want to change Eric, based on?

4 MEMBER SCHNEIDER: No.

5 CO-CHAIR SINGH: All right.

6 MEMBER SCHNEIDER: I think that works.

7 CO-CHAIR SINGH: Okay.

8 (Laughter.)

9 CO-CHAIR SINGH: You change the title
10 so everybody's in agreement. So -- okay. Should
11 we move to the next slide that we have?

12 Yes. Okay. All right. Excellent.
13 What was this? Oh, this is the structured --
14 wasn't that under documentation quality?

15 MS. ZIMMER: Yes. That's -- first of
16 all it didn't even make it in our top five. So,
17 -- because we thought logistically the
18 feasibility of that was so low.

19 MEMBER SCHNEIDER: And then I think
20 this -- that one was in something else.

21 MS. ZIMMER: Yes. That was somewhere
22 else. So, I think we probably can just --

1 CO-CHAIR SINGH: We put that in the
2 parking lot, right?

3 MS. ZIMMER: Yes. Yes.

4 CO-CHAIR SINGH: So, you already moved
5 that? So you can delete that slide.

6 MS. ZIMMER: Yes.

7 CO-CHAIR SINGH: Yes. Okay. So we
8 can -- well, you know, the complete correct use
9 comes up. You can copy the title over.

10 What's the title for the one that you
11 just created? Because that is complete and
12 correct EHR use.

13 If you're not structuring a data, it's
14 not complete and correct use. Okay. So move
15 bullet one, right?

16 Yes. Because we've talked about
17 documentation in -- with respect to other stuff.

18 DR. PINES: So we already have that?
19 Or take that out?

20 CO-CHAIR SINGH: Right. Because we
21 covered completeness accuracy. And we're going
22 to touch it again on burden, right? When we

1 discuss burden.

2 Okay. So this is what people agreed
3 that you all wanted a separate call out for
4 people to not, you know, allergies and things in
5 free text.

6 So we -- I mean, that is a SAFER Guide
7 item by the way. It can be easily be put as a
8 measure.

9 MEMBER GRACE: Didn't we already
10 address that in the quality?

11 CO-CHAIR SINGH: No, we moved it.

12 MEMBER GRACE: Documentation of
13 quality?

14 CO-CHAIR SINGH: No, we moved it. We
15 had to move it because it didn't have anything to
16 do with documentation.

17 I mean, it's not --

18 MEMBER GRACE: That is documentation.

19 CO-CHAIR SINGH: You could consider it
20 documentation. But it's, you know, its allergy
21 field, is sort of a different field then --

22 MEMBER GRACE: Again, I'm going to

1 defer to our group. But I thought that was an
2 example of a type of quality documentation.

3 DR. PINES: Right. And I think that
4 was -- yes, I think that was very much about the
5 quality.

6 CO-CHAIR SINGH: Okay. So you're
7 broadening the definition of documentation.
8 Which is fine.

9 DR. PINES: So we're throwing it back
10 to where it was.

11 CO-CHAIR SINGH: Okay. That's a very
12 broad definition of documentation. But that's
13 okay. Kevin, did you have a question? No.

14 Yes, Karen?

15 MS. ZIMMER: Just from the wording of
16 that, I don't know where it went now. Is it on
17 this slide? Did you put it back on this slide?

18 DR. PINES: I think it's in very small
19 text there. Yes, above HIT should be used in
20 facilities with it.

21 MS. ZIMMER: Oh, okay. So, I think
22 it's -- I think you've got two negatives in

1 there.

2 I think you want to say the -- in free
3 text versus in structured designated fields. I
4 think you want to take that not out.

5 CO-CHAIR SINGH: And the other thing
6 is, this is more like data. I think we're going
7 into data.

8 Documentation is, you know, I don't
9 know, maybe who's -- who can help us here? I
10 mean, I'm not sure is --

11 DR. PINES: Well, it's the clinician
12 setting in the active problems and the allergies.
13 And so they're putting it free text versus. I
14 mean that's clinical documentation.

15 CO-CHAIR SINGH: Okay. I was thinking
16 because you have medications in there too. So,
17 you want to label everything --

18 MS. ZIMMER: Yes. So, I was again, I
19 --

20 CO-CHAIR SINGH: Do you all -- so the
21 vendors -- do you all consider all of this to go
22 under documentation? Medications, allergies, any

1 type of active problem areas?

2 MS. ZIMMER: For example, people don't
3 update their problem lists.

4 CO-CHAIR SINGH: That's fine. I think
5 that could be done too.

6 MS. ZIMMER: But yet, if I go to
7 reencounter I can find all their problems.

8 CO-CHAIR SINGH: No, that's fine.
9 What about medication? Yes? Broadly you want to
10 put that under documentation?

11 MEMBER SEGAL: What I wouldn't
12 necessarily consider documentation per se is the
13 timely follow up. Because that's not about the
14 quality of the documentation.

15 That's sort of about -- that's the use
16 of clinical information. So, again, I like the
17 bullet. I'm just not certain this is the right
18 category. Particularly it's getting overloaded.

19 CO-CHAIR SINGH: So, we could put that
20 in. Because what providers do when they look at
21 the abnormal, is they first document that, you
22 know, say I followed up and there's the result.

1 Or I called the patient. So, we could
2 potentially leave it. That's the one I'm least
3 concerned about actually.

4 MEMBER SEGAL: Okay. Okay.

5 CO-CHAIR SINGH: Okay. Fine. That's
6 two slides gone. Well, what slide are we on?
7 Okay, three more slides. Maybe four.

8 So, patient engagement. So this says
9 patients are engaged in HIT safety I think
10 broadly is the measure concept.

11 And how we sort of --

12 MR. LYZENGA: And I think HIT enables
13 patient engagement. Safe patient engagement.

14 CO-CHAIR SINGH: Yes. So, can we say
15 acknowledgment of lab results via patient facing
16 tools? Or we have patient facing technologies?

17 Yes. Instead of for. Remember Mark
18 reminded us to be broader. Because they could
19 get it on their phone or whatever.

20 CO-CHAIR BELMONT: And Hardeep, on
21 that point, rather than just lab test results, do
22 we want to say diagnostic test results?

1 CO-CHAIR SINGH: Yes. All types of
2 diagnostic test results. Yes. And should we
3 start being a little specific in the examples?

4 We could just say something like
5 percentage of diagnostic test results
6 acknowledged by patients via -- in patient facing
7 technology.

8 So that way if we send them 100 -- if
9 we send 100 patients their results, and only five
10 look at them, that's five divided by 100. So we
11 can -- the ones that we can clearly come up with
12 measures now, we could just -- and so this would
13 be the same.

14 So, I think our measure could be
15 percentage of patients who look at their medical
16 record, who suggest corrections because of
17 incorrect data. Or similar to that.

18 Yes?

19 MEMBER SEGAL: So is that -- thinking
20 about how you would evaluate a result, if you
21 have a high percentage of patients who suggest
22 corrections, is that positive for patient

1 engagement? Or is it negative for accuracy?

2 CO-CHAIR SINGH: So, definitely it's
3 good. The patients are noticing these things.

4 MEMBER SEGAL: Okay.

5 CO-CHAIR SINGH: So we know our
6 records have our, you know, some information
7 that's not correct.

8 MEMBER SEGAL: This one in particular
9 just says we kind of create a record. We might
10 want to indicate that higher is better?

11 CO-CHAIR SINGH: Yes. As we create
12 the measure, yes.

13 MEMBER SEGAL: Really? I mean, that's
14 -- I mean, I guess if we start planting fake
15 information and see if they correct it, then we
16 know.

17 (Laughter.)

18 CO-CHAIR SINGH: Okay. So, maybe it
19 should be the number of -- or the ratio or
20 something of some kind?

21 MEMBER SEGAL: Yes.

22 CO-CHAIR SINGH: If you've got 100

1 patients looking into their medical records and
2 zero have found anything in five years, that's
3 not a good sign.

4 MEMBER SEGAL: No.

5 CO-CHAIR SINGH: There is information
6 there that is incorrect.

7 MEMBER JONES: No doubt.

8 CO-CHAIR SINGH: Yes.

9 MEMBER JONES: But if a -- yes. If
10 100 do, I'm not sure we say awesome.

11 CO-CHAIR SINGH: Right. Right. So,
12 I don't know what the right measure is. Eric, do
13 you have a suggestion?

14 MEMBER JONES: Well, when we were --
15 I mean, when our group discussed this, I think we
16 were the next bullet point down. Which was the
17 notion that it's -- that it happens.

18 Some percentage of patients actually
19 do annotate the record. And I don't remember a
20 discussion about the frequency with which that
21 happens being a good or bad indicator in our
22 group.

1 But if it's not occurring, I guess
2 that's the other way to frame it. If that is not
3 occurring, that patients are never annotating,
4 correcting or entering the record, entering data
5 in the record, then I would consider that a
6 negative.

7 CO-CHAIR SINGH: Yes. So maybe we can
8 reverse it somehow?

9 MEMBER JONES: That would be fine.
10 Would you want to say the ability to?

11 MEMBER SCHNEIDER: Well, that's
12 actually the next bullet point below that one.
13 Which says that the system enables that
14 capability.

15 So, if you thought of that as a
16 facility level measure, you'd say the percent of
17 hospitals that can -- that have that cap -- or
18 percent of EMRs or percent of hospitals that have
19 that capability.

20 The next measure up from that is the
21 percent of patients who use that capability or
22 don't use that capability. And then the

1 frequency question I think is a lot harder to get
2 my head around.

3 CO-CHAIR BELMONT: One of the ways
4 that you can look at the frequency, is the number
5 of patient of complaints that you receive about
6 inaccurate information in the EHR. That might be
7 an appropriate data source too.

8 MEMBER SCHNEIDER: Well, that might be
9 a positive indicator that they're actually
10 noticing what's in their record. And that's
11 something that we're trying to promote that they
12 do notice.

13 So, I might like the complaints to go
14 up for a while before we fix the problem.

15 CO-CHAIR SINGH: Yes. It's like, if
16 you never do a root cause analysis for five years
17 in your hospital because you didn't have a
18 medical error.

19 MS. ZIMMER: I agree with Mark. I'm
20 starting to wonder, does that fall under
21 quality/accuracy as a -- for documentation?

22 CO-CHAIR SINGH: No. This is patient

1 engagement. We want to have a separate measure
2 concept on patient engagement.

3 And this is the best one. We've got
4 too many measures. Some of them could be
5 consolidated.

6 I don't think this goes under
7 documentation quality.

8 DR. PINES: Well, I guess the question
9 is, is the -- so you're saying if it was
10 corrected, it was wrong. But maybe the
11 contribution is here and the correction is in
12 documentation quality?

13 CO-CHAIR SINGH: I mean, there's an
14 overlap here of sort of the safety issues we're
15 trying to improve. We're trying to improve
16 documentation quality. And we have a separate
17 sort of measure on that.

18 This is about improving sort of
19 patient engagement. Although it does make some
20 difference to documentation of quality.

21 Because if I keep telling you, hey
22 doc, you know, you wrote the wrong stuff on my

1 record again and again, I'm probably going to
2 improve your documentation giving you the
3 feedback.

4 So, I think they're two different
5 things.

6 MEMBER SCHNEIDER: Yes. So the logic
7 model here is that the patient -- that if
8 patients go into their records and correct
9 erroneous information, care will be safer.

10 So what we want to measure is the
11 percent of times where patients that are actually
12 taking advantage of that. I would start with the
13 percent of patients that actually are taking
14 advantage of that opportunity.

15 Because that's something that's going
16 to vary across facilities. And how friendly the
17 portal is. And those are actionable to enhance
18 this.

19 Whether we'd ever get to 100 percent
20 of patients annotating the record, I have no
21 idea. I have no idea what the frequency is now.

22 CO-CHAIR SINGH: So, do we need -- so

1 annotating, so describe -- I know you guys are
2 viewing mistakes.

3 Annotating is a little -- it's a
4 little different. That is basic, what are they
5 actually doing there?

6 They're co-creating the record with
7 the provider? They're entering notes into it?
8 What are they doing?

9 MEMBER SCHNEIDER: Well, annotation is
10 probably just a broader just category of patients
11 adding or contributing information to the record.
12 Within annotation would be actually, this is
13 erroneous, I want to correct it.

14 Would be under that umbrella I think.
15 I'm not sure that I've seen a framework for that.

16 CO-CHAIR SINGH: So could we clarify
17 and say able to access the record and annotate it
18 when the record is incorrect?

19 MEMBER SCHNEIDER: I don't think you
20 can get there.

21 MEMBER RUSSELL: Well, it doesn't have
22 to be incorrect. Yes, that's my point.

1 MEMBER SCHNEIDER: Yes. So, I don't
2 think you can get to it -- to that information
3 was incorrect.

4 Basically what you've got now is the
5 record says this. The patient says that.

6 We don't -- if there's a discrepancy,
7 we can't -- we don't have a way of characterizing
8 it. What's the gold standard for deciding who
9 was correct.

10 MEMBER RUSSELL: Right.

11 MR. HUNT: It could be there needs to
12 be -- it just could -- the information could be
13 incomplete. Or it could need modification.

14 CO-CHAIR SINGH: Can we reflect that
15 to say that about annotation? Because people are
16 going to think about different things when they
17 look at annotation if this measure goes through.

18 Or anything like this goes through.

19 MEMBER SCHNEIDER: Yes. It can.

20 CO-CHAIR SINGH: Annotating record
21 when whatever. Well, whatever's comfortable.
22 Incomplete or whatever.

1 Ambiguous information, incomplete
2 information or information that needs to be
3 annotated.

4 MEMBER SCHNEIDER: Yes. I don't know
5 if there maybe -- maybe somebody's developed a
6 taxonomy of annotations. That would be really
7 useful.

8 I don't know that one exists.

9 MS. ZIMMER: I'm just having a hard
10 time with -- I feel like the goal is we want
11 patients engaged. We want to show that they're
12 involved in their care. Right?

13 But I'm having a hard time because
14 when you think of a measurement, I won't know how
15 to interpret it as if it's a good or a bad thing
16 without the contest of it.

17 Like for example, when someone cuts
18 and pastes PE because they went physical exam,
19 and another person thought this person had a, you
20 know, a pulmonary embolism for years, there's an
21 issue there.

22 Or they put he when it's a she. Or,

1 you know, and they just keep perpetuating things.

2 So, on the one hand, it's really hard.
3 Again, I'm having a hard time with this
4 measurement because I won't know if the number is
5 good or bad.

6 Where all the other ones were so
7 obvious if you want it high or low, this one I'm
8 not sure.

9 CO-CHAIR SINGH: I think it's Jim and
10 then Lisa. Oh, it's Jim, Laura and Lisa, sorry.

11 MEMBER RUSSELL: Okay. I'll go. So,
12 as being on the vendor side and also being a
13 patient who actually really uses their portal --
14 both on my phone and on a laptop -- I think
15 there's three ways we can tease it out.

16 And I'm actually agreeing with you
17 quite a bit Karen. I think one of the ideas is
18 just acknowledging the fact that you have a
19 certain percent of patients who are actually
20 accessing the records.

21 That's kind of a really easy thing to
22 measure. We measure that all the time. That's

1 number one.

2 I think number two, it's this -- and
3 I correct -- I'm starting with the word
4 corrections. Because it's not necessarily
5 corrections.

6 It's additions, it's editing, it's --
7 I take this a little bit differently. So, I
8 think we need to just do that.

9 And at least the data we're seeing so
10 far is of the percentage of patients who actually
11 access the records, the percent of patients who
12 actually ask to have something changed is very,
13 very low.

14 And it's usually -- at least
15 anecdotally, it's usually just minor corrections
16 and things. So, I think that's number two.

17 And then number three on the
18 annotating/editing the medical record. Until you
19 get down to OpenNotes, are you really annotating
20 or editing the medical record?

21 Because you don't know what it
22 contains except for the things that are

1 discretely passed off to you like the diagnostic
2 tests. Like your meds, allergies, problem list.
3 Your scheduling information, things like that.

4 So, I just think this could be again,
5 I think you were right. It could be compressed
6 down. There's a lot of things here.

7 But we could probably be a little more
8 discrete on what those things are and what you're
9 actually trying to measure.

10 CO-CHAIR SINGH: I think Laura, you
11 were next. And then Lisa. And then Karen.

12 MEMBER HEERMANN-LANGFORD: Well I was
13 just -- I mean, I agree there's lots about the
14 whole creating, editing, annotating, et cetera
15 that we need a wordsmith for.

16 But, I still think we need to step
17 back like Karen was saying. And just what
18 exactly do we want out of this to say patient
19 engagement?

20 I mean, it may just be that they have
21 interacted in some way. And maybe it's at a
22 level of reading and viewing.

1 And another is that they are
2 contributing in whatever. And just try to
3 simplify it. Because it seems a little
4 complicated.

5 CO-CHAIR SINGH: So, you know, maybe
6 we could sort of think about it just a little
7 bit, going back to our framework. Because we
8 haven't sort of applied it to just sort of
9 patients.

10 So it could be patient engagement in
11 relationship to safe IT, which means my portal is
12 bad. I can't -- you know, the graph is bad. Or
13 my -- there's no display of data. Or something
14 is wrong with my portal.

15 The second could be patient engagement
16 and safe use of Health IT, which many of these
17 things over here are.

18 And then the third one would be how
19 patients are using technology to improve their
20 safety. So, I saw my lab results. And I noticed
21 my hemoglobin was five points lower.

22 And now I'm calling my doc and saying

1 hey, by the way, I think I need a colonoscopy.
2 So, maybe we could think about having a measure
3 or two.

4 (Laughter.)

5 CO-CHAIR SINGH: The amount of
6 anemia's that I've seen missed in my life. So, I
7 had to make that one up.

8 So, maybe within each of these we
9 could have sort of, you know, one or two
10 measures. And that way, we can clearly link back
11 to what Karen and Laura are trying to get us to
12 do.

13 Is to getting something out of each of
14 these dimensions for patients.

15 CO-CHAIR BELMONT: I really like that
16 suggested framework a lot.

17 DR. PINES: So, can patients see the
18 information?

19 CO-CHAIR SINGH: So the first is safe
20 techno -- yes. So, if you -- everything with
21 safe technology would be in there.

22 DR. PINES: And do they use it to

1 change --

2 CO-CHAIR SINGH: Yes. We can go
3 through -- I'm being mindful of time. We can go
4 through easily --

5 DR. PINES: Yes. We can --

6 CO-CHAIR SINGH: And pick up which one
7 is level one and which one is level two and which
8 one is level three.

9 And that way we could justify so many
10 measures. Because this is the one that is the
11 longest I think.

12 DR. PINES: Yes.

13 CO-CHAIR SINGH: In addition to the
14 documentation and quality one. Which there I
15 refuse to put more data.

16 All right, is that good? Oh, sorry,
17 Lisa?

18 MEMBER FREEMAN: I just -- I loved the
19 way you framed it. And I just want to say
20 though, if we're measuring patient engagement,
21 and I'm not, you know, this isn't my forte.

22 But, it's really about, are they

1 engaging. So, just counting whether they're
2 viewing and then whether they're adding or
3 notating really measures patient engagement.

4 Because patients aren't used to
5 engaging at all at that level.

6 CO-CHAIR SINGH: So do you think we
7 should think about, and I don't mean to say sort
8 of active or passive. But there could be sort of
9 passive engagement.

10 MEMBER FREEMAN: Um-hum.

11 CO-CHAIR SINGH: Versus more active
12 engagement. So, if I'm calling you and saying
13 this stuff is wrong. It's more like active.

14 But passive is, you know, I'm looking
15 at the stuff you're sending me. And I, you know,
16 went through my portal. That's passive.

17 And are you saying we should separate
18 them out? And do both?

19 MEMBER FREEMAN: I think it's kind of
20 helpful. Because it will show in the end what we
21 need -- where we need to focus attention.

22 If that's, you know, and I'm assuming

1 that's part of this. Is that if we want patients
2 to be more engaged and we see that, you know,
3 okay, well we're making headway in terms of their
4 accessing their records in various ways.

5 But, we're just not getting them to
6 actively engage yet. We -- there's a safety
7 factor that can be raised the more we engage them
8 actively.

9 CO-CHAIR SINGH: So maybe we could
10 just say sort of basic patient engagement, and
11 then advanced patient engagement.

12 So there's two levels of some kind.

13 MEMBER FREEMAN: Yes. I'm not, you
14 know, I'm not good at dicing the words. But the
15 point is that there's certainly two distinct
16 points.

17 And I don't know that we have to get
18 that -- I don't think it has to get that complex.
19 Because I think right now, we're at such a very
20 beginning state where patients are just starting
21 to get use to looking at their records.

22 CO-CHAIR SINGH: Yes.

1 MEMBER FREEMAN: That we've got such
2 a long way to go. Let's start with something we
3 can just really grab hold of and work with.

4 CO-CHAIR SINGH: Or maybe the, you
5 know, the concept of aspirational we were
6 thinking of before. Sort of, you know, immediate
7 versus future?

8 Maybe we could -- we'll have to
9 reorganize this slide a little bit.

10 MEMBER HEERMANN-LANGFORD: So, just a
11 couple of things come to mind listening to her.
12 Is like we said before, do they view it? Do they
13 actually annotate it?

14 But it could be, is it a one-time
15 only? Or frequent -- you know, how frequent does
16 each patient come in? Are they coming in and
17 looking at it at a timely after -- a visit after
18 a test is drawn after.

19 Or is it just a curious perusal
20 because there's no event that happened that they
21 just kind of went in.

22 I mean, there's different ways that we

1 could look at how a patient is engaging with
2 their care.

3 CO-CHAIR SINGH: Um-hum. Okay.

4 Anymore about this slide before we go over to the
5 next one? Slide 13.

6 DR. PINES: So, we can -- we will do
7 some edits on this then.

8 CO-CHAIR SINGH: Yes. Well, we can
9 rearrange. Because rather than sort of --

10 DR. PINES: Rather than do it right
11 now.

12 CO-CHAIR SINGH: Yes. Yes.

13 DR. PINES: Yes. Unless you want to
14 just sit.

15 CO-CHAIR SINGH: So I think
16 everybody's agreeing that these things look good.
17 They just need to be rearranged a little bit.

18 DR. PINES: Okay.

19 CO-CHAIR SINGH: Right? Yes. Okay.
20 Burden of data entry. So, this was when -- is
21 Bill gone? Has Bill left? Okay.

22 So, this was mostly discussed in our

1 group. And I'd like for our group to sort of
2 just chime in whenever they want to.

3 But, the burden of data entry is a
4 huge thing when you start talking to anybody.
5 That's what the most important thing they are
6 concerned about.

7 We want to make this easy, measurable,
8 safe. Because it also distracts. It overlaps a
9 little bit with Eric's group's interaction with,
10 you know, the doctor/patient interaction where
11 the doctor is so busy just looking at the screen
12 versus, you know, and entering data versus
13 talking to patients.

14 And we thought of ways to identify
15 this measure or creating measures could be
16 workarounds for instance. And that's where the
17 scribes came in.

18 And say if I'm using scribes to enter
19 my data, there's probably a problem in my data
20 entry skills --- or whatever you want to call it.

21 So, again, it's an important one where
22 I think maybe some more needs to be discussed as

1 to what people think should be in here. In terms
2 of a measure.

3 We had one on scribes. But it didn't
4 go in here. Did we remove that? Or --

5 DR. PINES: It didn't make it into the
6 prioritized list.

7 CO-CHAIR SINGH: Okay.

8 DR. PINES: So, I guess one question
9 is: could this be moved under usability, or is
10 this a separate concept where burden of data
11 entry is just a piece of use?

12 MEMBER SEGAL: I mean, I think it
13 could go to usability. And again, the other
14 accountability on this one that I would think
15 about adding is government or regulatory.

16 Because many of the specific
17 requirements --- but I think in terms of how it's
18 going to be perceived by the end user, it's
19 really part and parcel of the usability spectrum
20 I think.

21 CO-CHAIR SINGH: So the reason to keep
22 it separately I think is, Mark, as I think you

1 rightly put it. And I mean, this is -- some of
2 this issue is beyond just the EHR screen.

3 Some of it is, and that falls under
4 usability. But a lot of it is not. Why do I
5 have to document twice? Why do I have to have
6 long notes?

7 I mean, there's a reason. Why do I
8 use templates? Right? I'm trying to speed up.

9 So, should we as a group think about
10 having this as a separate measure concept? And I
11 think we're getting ready to sort of even decide
12 very quickly, you know, when we wait.

13 So, you know, you could say let's
14 merge it with usability and keep it rather than
15 getting rid of it.

16 MEMBER SCHNEIDER: Well, did we lose
17 the -- did we lose the construct of the way in
18 which technology interferes with the
19 clinician/patient protocol?

20 CO-CHAIR SINGH: Well, that's why I
21 was saying, this is where I think your stuff
22 falls in. Yes, it --

1 MEMBER SCHNEIDER: Well, but the
2 burden of data entry is just one potential cause
3 of trouble in -- between patients and clinicians.

4 CO-CHAIR SINGH: So, do you think we
5 should focus this on the quality of
6 doctor/patient interaction in front of an EHR, or
7 something of that?

8 MEMBER SCHNEIDER: Well, and again,
9 this is a very ambitious item. I'm not sure how
10 you would measure this exactly.

11 CO-CHAIR SINGH: Okay.

12 MEMBER SCHNEIDER: And it probably
13 does fit into the usability domain if I had to
14 guess. But it's usability not just for the
15 clinician, but usability for the clinician and
16 the patient.

17 CO-CHAIR SINGH: The dyad.

18 MEMBER SCHNEIDER: And the usability
19 in the dyad or in the encounter, whether that's
20 telephonic or in person.

21 CO-CHAIR SINGH: I do want to sort of
22 remind everybody that for the usability we were

1 going to wait for some of the regs coming out of
2 ONC. And I have a feeling that's going to be
3 fairly sort of high level, broad on the sort of
4 the macro level.

5 We will probably miss out on Eric,
6 what, you know, our concerns here are. That
7 clinicians -- front line clinicians are dying
8 entering data into the EHR.

9 MEMBER HAYNES: So, I was just going
10 to add for accountability, you could put payers
11 there too. Because --

12 CO-CHAIR SINGH: Oh, yes. That should
13 be number one there.

14 MEMBER HAYNES: Throw Anthem under the
15 bus.

16 CO-CHAIR SINGH: Yes. Put them number
17 one.

18 MEMBER HAYNES: Put CMS under the bus.

19 CO-CHAIR SINGH: Yes. And CMS number
20 two.

21 (Laughter.)

22 CO-CHAIR BELMONT: In addition to

1 payer, you should probably already also want to
2 add accrediting agencies.

3 CO-CHAIR SINGH: You know, and I would
4 say just because of that reason, we should
5 probably have this as a separate measure.

6 MEMBER SCHNEIDER: So this is a
7 regulatory burden measure? I thought we were in
8 an HIT quality and safety line here?

9 CO-CHAIR SINGH: Well, it's -- yes,
10 you're getting the point.

11 MS. ZIMMER: Well, as much as I
12 appreciate that point, going back to what you
13 said, we are a Health IT metric, whatever. I
14 worry about accountability for -- this is going
15 to come out wrong. So I apologize.

16 For people who can't make that change
17 happen at a -- timely enough. Is that fair?

18 So, like vendor again at a facility,
19 no offense with policy makers, but like, you
20 know, everybody in this room has been saying, why
21 can't all the government agencies talk together
22 and have one data set that we enter?

1 We've been asking that since, you
2 know, many of us could talk. But that doesn't
3 exist.

4 And we're not -- I'm not trying to be
5 a naysayer, but we're not going to make it exist.
6 If they haven't figured that out now, this
7 measure isn't going to necessarily do that.

8 Not to mention, I don't even know how
9 you'd begin to measure it except do a survey that
10 everyone writes down their frustration. But I
11 think people have been writing that frustration
12 for a very long time, and that change still isn't
13 happening.

14 So, I don't want to -- we have really
15 good stuff here of things that are concrete and
16 actionable. I don't know that this is exactly
17 actionable except to vent our frustration.

18 CO-CHAIR SINGH: I'm not sure if it's
19 not completely either measurable or actionable.
20 I mean, I'm not -- yes, maybe the aspirational is
21 a word where we'll put it in there.

22 But I must -- I mean we can merge it

1 or we can call it separately. But this is where
2 -- this is where --

3 MS. ZIMMER: Then maybe -- then I
4 think it's more --

5 CO-CHAIR SINGH: This is where you
6 lose the docs.

7 MS. ZIMMER: But then I think it's
8 regulatory burden, and we maybe conduct surveys
9 or something, and send all that paper to
10 Washington to show the frustration.

11 CO-CHAIR SINGH: Well, I mean, AMA has
12 done that. You know, it's not like we're not the
13 only ones. I mean, AMA is doing all that.
14 They've been talking to people.

15 I don't know. I mean --

16 DR. PINES: Just as a place we could
17 potentially put this in the report. We're going
18 to have sort of an overarching issues section
19 where, you know, this could potentially fit
20 there.

21 Even if there's not a very specific
22 measure that goes there. But I think the --

1 MS. ZIMMER: It's a data entry piece
2 because it's under usability. Is the data entry
3 piece the difficulty of entering that
4 information?

5 Or is the burden of the number of
6 fields that we're required, which is a different
7 idea. One's a capability, and one is just the
8 time it takes.

9 And which one are you trying to get
10 at?

11 CO-CHAIR SINGH: It's a socio-
12 technical challenge. And that has eight
13 dimensions. And I can name you all those eight
14 dimensions.

15 MS. ZIMMER: I was waiting for that
16 word to come up in the two days.

17 CO-CHAIR SINGH: Yes.

18 MS. ZIMMER: And so thank you.

19 CO-CHAIR SINGH: So, when you leave
20 out the external regulatory agencies, you leave
21 out a whole dimension of people who could
22 influence the HIT safety.

1 MS. ZIMMER: Then it's not necessarily
2 burden of data entry, but just data collection in
3 general because of all the regulatory
4 requirements.

5 CO-CHAIR SINGH: I think this is data
6 entry. No, this is front line clinician data
7 entry.

8 DR. PINES: Right. So, I think the
9 example is -- you know, a good example is all the
10 information that must be collected from a patient
11 when they show up at triage in the emergency
12 department by the nurse out front.

13 I mean, it is a list of 25 different
14 things. And everyone's little, you know,
15 domestic violence and everything needs to be
16 collected up front.

17 And I think that creates a huge burden
18 that, you know, I think is not necessarily a
19 quality metric, but I think it's a consideration
20 or an overarching issue.

21 MS. ZIMMER: So, I'm going to play
22 devil's advocate. When we come out with

1 vaccines, it has to be some -- or at least in
2 pediatric, when you come out with something, it
3 has to be something, a criteria.

4 It has to be something that's
5 measurable, actionable. This feels so --

6 CO-CHAIR SINGH: I think David's been
7 trying to say something.

8 MR. HUNT: I sort of -- I hear what
9 you're saying. One question I would ask is,
10 absent Health IT, in the paper world, will we
11 have this problem still?

12 I think the answer will be yes. I
13 know I really got ticked off, you know, filling
14 out forms.

15 And so, I agree with you that I think
16 that --- particularly for credibility at the
17 front line clinicians -- they need to at least
18 see that there's some recognition of this problem
19 at multiple levels and including this.

20 But, I'm not sure if it will -- if we
21 can really affect it.

22 CO-CHAIR SINGH: Nana and then

1 Elizabeth.

2 MEMBER KHUNLERTKIT: So when I read
3 the word burden of data entry, I interpret that
4 as a workload issue. And so I think we are
5 trying to address two things on there.

6 So, it's a work around and a workload.
7 So which work around can be, you know, the result
8 of workload.

9 So, it makes me wonder if we should
10 also include the measurement of workload and
11 workarounds in the simulation. Because we can
12 get it on there.

13 CO-CHAIR SINGH: You mean on the
14 simulation slide, right?

15 MEMBER KHUNLERTKIT: Right.

16 CO-CHAIR SINGH: Yes, we can easily
17 add workarounds and workload to that slide.
18 Jesse, could you remember to do that later?

19 Okay. That's a good idea. I think it
20 was Elizabeth and then Mark and then Eric.

21 CO-CHAIR BELMONT: So, I have a couple
22 of thoughts. You know, in terms of the burden of

1 data entry, it is a workload issue.

2 But I think it's an issue that can
3 affect quality of care was well. Because I have
4 heard a number of physicians complain about the
5 number of hours they're spending at 9:00 and
6 10:00 at night to doing it.

7 So I think, you know, it does have an
8 effect on quality. Two in terms of
9 accountability, I think we should add accrediting
10 organizations there.

11 And then my next comment won't make me
12 popular. But I'll be remiss if I don't mention
13 it.

14 When we think about burden of data
15 entry, there's also data that's required for
16 medical/legal issues or requirements. For
17 example, workers' comp.

18 I have a lot of physicians who
19 complain about how much documentation you have to
20 do for a workers' comp case, or if a patient has
21 been in a personal injury, or even just basic
22 medical/legal considerations to defend against a

1 potential med mal claim or a board complaint.

2 CO-CHAIR SINGH: Yes. Good point.

3 And I quickly want to move it over. I want to
4 remind everybody, in the Ebola case in Dallas,
5 the physicians spent more time at the computer
6 then they did with the patient.

7 And they were completely lost in the
8 computer and entering data about all sorts of
9 stuff then just the fever that the patient had.

10 MEMBER SEGAL: So, I think in part to
11 David's point, yes many of these things came from
12 paper -- I mean, things like CPT E/M
13 documentation guidelines.

14 But I think they have particular
15 consequences when those paper era requirements
16 are put in a Health IT context. For example, a
17 lot of the copy/paste issues.

18 Or the kind of the template bullets
19 really are a consequence of that. So, in terms
20 of the practical, clearly providers and vendors
21 have opportunities to do a better or worse job
22 with the reality we all live in.

1 And so, from that standpoint, taking
2 sort of the hand we're dealt and doing the best
3 is probably worth measuring. But nonetheless, if
4 we think about how we're broadly construing
5 accountability, where sometimes it's going to be
6 who's being measures.

7 And sometimes it's going to be who
8 kind of in a shared system. I think A, as long
9 as we're clear that ultimately we want measures
10 that can be acted upon by kind of the key actors,
11 I think A, it's worth keeping.

12 And B, I think it is worth having the
13 accrediting orgs and the payers and policy makers
14 as accountability, even though it's going to be a
15 different kind of accountability.

16 So, that's kind of how I would view
17 it. But I think again, to me the key point comes
18 back to as you layer these paper era requirements
19 into Health IT, it generates almost a certain
20 pathology that then has to be understood and kind
21 of dealt with.

22 Again, copy/paste being a notable

1 example.

2 CO-CHAIR SINGH: Yes. And you know,
3 Mark, I'm going to add that, you know, we are --
4 there's a scribe industry proliferating now.

5 And the discussion we had, you know,
6 yesterday, which made us sort of think about this
7 much more. If you're using a scribe for
8 documentation, great.

9 If you're using a scribe to enter
10 orders on medications and, you know, other types
11 of things where you get clinical assistance
12 support, not a great idea.

13 So, getting to concrete things that we
14 could potentially measure, would something to do
15 with scribes -- as Nana also pointed out -- you
16 know, workarounds, could we measure that as a
17 real life thing that we can actually feel, touch?
18 We'll get a lot of that.

19 Eric?

20 MEMBER SCHNEIDER: Yes. I think Mark
21 is suggesting this. But it's -- the title burden
22 of data entry has political connotations that

1 maybe not helpful.

2 But the consequences of poorly
3 designed and implemented data entry technology
4 might be the category. And then we get at what
5 are the con -- the measures get at what are the
6 consequences that we care about related to IT
7 safety?

8 CO-CHAIR SINGH: Yes.

9 MS. ZIMMER: But I'm hearing two
10 different things. Because to be fair, it's not
11 necessarily that it's poorly designed.

12 But, we have to amp up the number of
13 requirements that they have to put in. So, --

14 MEMBER SCHNEIDER: Implemented was the
15 other part.

16 MS. ZIMMER: It sound -- sorry, I'm
17 not even a vendor. But, that sounds too vendor-
18 centric.

19 (Laughter.)

20 MS. ZIMMER: And no offense, I argue
21 against you many times too.

22 (Laughter.)

1 CO-CHAIR SINGH: So, if we put --

2 MS. ZIMMER: I go both ways here. So

3 --

4 CO-CHAIR SINGH: So, could we put
5 design develop -- design implemented and used.
6 And then you could say used, then you could get
7 into the poorly used because --

8 MS. ZIMMER: Well, I guess maybe I --
9 maybe -- I like what -- I see where you all are
10 going and I get it.

11 But, maybe it's not burden of data
12 entry. Maybe it's just general data collection.

13 So, for example, one other thing that
14 would be interesting is to have physicians dock
15 how many hours after clinic they're working on
16 their records. I mean, they'll be honest.

17 So I think that would be an
18 interesting thing. Because then you're getting
19 real data saying, look what they're doing outside
20 of work to deal with all this documentation.

21 So, I mean, I'm just thinking of a
22 measure where --

1 MEMBER SCHNEIDER: Yes. And if each
2 of those consequences is tied -- because each of
3 those then creates erroneous data. And erroneous
4 data, you know, and other safety problems.

5 MS. ZIMMER: Right.

6 MEMBER SCHNEIDER: But tying the logic
7 model to those, not -- right now there's a
8 hypothesis here that burden of data entry is
9 correlated to patient safety issues.

10 Well, actually there are a number of
11 pathways through which that occurs. And I think
12 the measure should address those pathways, not
13 try to say we can measure burden in this
14 instance.

15 Because burden -- I mean, I spent a
16 lot of time entering medication lists when we
17 first implemented our EHR.

18 MS. ZIMMER: Um-hum.

19 MEMBER SCHNEIDER: That was very
20 burdensome. But the benefits were downstream.
21 And it was time well spent.

22 So, I think it, you know, there's a

1 whole timing investment versus return sort of a
2 calculus that comes in.

3 MS. ZIMMER: So, even though they mean
4 the same thing, maybe labor intensive data
5 collection. I don't know, something just -- just
6 --

7 MEMBER SCHNEIDER: I would stick with
8 the logic model that ties, you know, clinicians
9 entering notes at 9:00 p.m. You know, that's
10 just not a good practice.

11 I would try to focus in on the
12 practices that are being caused by -- maybe
13 caused by the burden. I agree.

14 MS. ZIMMER: And I agree with that.
15 And I see -- I think that would be an interesting
16 measure. Is how getting that type of
17 information.

18 CO-CHAIR SINGH: So could we --

19 MS. ZIMMER: So I don't -- poorly
20 designed to me sounds more like a usability.

21 CO-CHAIR SINGH: So could we say
22 something like measuring safety as related to

1 data entry, or something like that? To make it
2 more --

3 MEMBER HEERMANN-LANGFORD: What about
4 something like consequences of EHR use? And then
5 go down your path of the patient safety issues
6 that we know and we could measure.

7 I mean, the how we're spent.

8 CO-CHAIR SINGH: Or inventory
9 consequences of data entry?

10 MEMBER HEERMANN-LANGFORD: Well, I
11 mean, quite frankly, it's consequences of our
12 electronic health records.

13 MS. ZIMMER: It's like Pandora's box.

14 MEMBER HEERMANN-LANGFORD: It's
15 increasing our time spent after clinic hours.

16 CO-CHAIR SINGH: Consequences of data
17 entry. So, what you're saying is intended? Or
18 unintended?

19 MEMBER HEERMANN-LANGFORD: No. Okay,
20 unintended.

21 CO-CHAIR SINGH: Unattended
22 consequences of data entry.

1 MEMBER HEERMANN-LANGFORD: Unintended
2 consequences of --

3 CO-CHAIR SINGH: Of EHR related data
4 entry?

5 MEMBER HEERMANN-LANGFORD: Yes. Use
6 though. It might be just --

7 MS. ZIMMER: Why not just workload of
8 data entry?

9 MEMBER HEERMANN-LANGFORD: There are
10 100 messages in your alert box is almost another
11 consequence of this -- or unintended consequence
12 of an EHR. I now can give you 1,000 alerts in a
13 day.

14 CO-CHAIR SINGH: Wait. You know, I
15 was thinking, do we have information overload
16 related safety measure? We don't?

17 MS. ZIMMER: Oh, I like that. That's
18 a great one to do this.

19 CO-CHAIR SINGH: Because it would come
20 under CDS where you get lost. I'm wondering
21 actually if you just create one for information
22 overload and couch all the thoughts, nobody would

1 argue.

2 Information overload is a huge safety
3 risk. We've connected it. Then we can put in
4 all of these things. It becomes concrete.

5 That -- any suggestion?

6 MS. ZIMMER: As a high level?

7 CO-CHAIR SINGH: And then it gets put
8 in the in-basket. In-basket alert is one of the
9 number one things clinicians are going to
10 complain about.

11 MS. ZIMMER: No, no, no. I absolutely
12 disagree.

13 CO-CHAIR SINGH: They've been
14 complaining about them at the VA ten years. And
15 now ten years later, now it will spill over to
16 the private world.

17 MS. ZIMMER: No, I like that a lot.

18 CO-CHAIR BELMONT: I think that's a
19 fabulous idea.

20 CO-CHAIR SINGH: So I just say -- yes,
21 information overload related to EHR use. And
22 then everything comes under that umbrella. And

1 nobody would argue with it.

2 MEMBER HAYNES: Can we still tie it
3 back to Kevin?

4 COURT REPORTER: You're microphone's
5 not on.

6 (Laughter.)

7 MEMBER HAYNES: We don't need these
8 on. Well, we -- obviously we contribute to the
9 overload.

10 But in one aspect, you know, back in
11 the '80s when you actually had to fill out the
12 UB94, whatever the heck it was -- 492, thank you,
13 to actually get paid, that that stated to
14 generate the, oh, I need to record this.

15 And I need to record this accurately.
16 And I need to, you know, get -- so, I understand
17 information overload.

18 But at the same time that the
19 requirements for documentation in some places are
20 burdensome, and in some places are helping.
21 Right?

22 Being able to have the information is

1 better than not having the information. So, I'm
2 tenuous on the true word overload.

3 I get the inbox. I get the CDS. I
4 get that there's too much out there to have to
5 fill out. Anyway.

6 MEMBER SCHNEIDER: Well, I would just
7 add to overload, IT is the solution to overload
8 as well as it can create overload. And it can be
9 the solution to information overload.

10 So, I'm not sure how we reconcile
11 that.

12 MS. ZIMMER: Would you use
13 information, or information and documentation?
14 Because when I think of information, I feel like
15 I'm receiving versus we're talking about the
16 inputting.

17 CO-CHAIR SINGH: Well, we can just say
18 information and documentation overload, or we can
19 say information and data entry related overload.

20 I mean, something like that.

21 CO-CHAIR BELMONT: Or information
22 requirements?

1 MS. ZIMMER: That's good.

2 CO-CHAIR SINGH: The thing about
3 information or data overload is everybody
4 understands that and gets it. Because everybody
5 gets email, and they know exactly what that feels
6 like.

7 That's a good part.

8 MEMBER SCHNEIDER: Well, there's also
9 big literature that you can point to on human-
10 factors engineering.

11 CO-CHAIR SINGH: Yes. Exactly. Human
12 factor.

13 MEMBER KHUNLERTKIT: Yes.

14 (Laughter.)

15 MEMBER KHUNLERTKIT: But the word
16 information overload is kind of one of the
17 domains for usability design.

18 CO-CHAIR SINGH: Yes.

19 MEMBER KHUNLERTKIT: So, I would avoid
20 using information overload. If --

21 CO-CHAIR SINGH: But it's not only
22 related to, you know, for design. Because if you

1 look at the eight dimension socio-technical
2 model, it will remind you of all the other
3 dimensions that are involved in causing
4 information overload.

5 We actually in one of our papers, it
6 wasn't the number of alerts people were
7 receiving, but it was their perception. So,
8 people who received the same amount of alert, one
9 was overloaded and the other one was not.

10 Same system.

11 MEMBER KHUNLERTKIT: So, the word
12 information overload, I think when I interpret
13 it, I would mean something like you get one
14 paragraph of text and you would only need like
15 one sentence of that text.

16 You know what I mean? That's what I
17 refer to as information overload.

18 MR. HUNT: Could you say that again?
19 I missed it.

20 MEMBER KHUNLERTKIT: So, it's like if
21 you get a paragraph of text, only one sentence of
22 those paragraph is important to you. So, that's

1 information overload.

2 And that should be identified since
3 usability testing.

4 CO-CHAIR SINGH: But also it signals
5 the noise ratio, right? So if your signal is
6 buried within a whole lot of noise, if you got
7 200 alerts out of which, you know, you miss a few
8 criticals because you were trying to get through
9 the 198 that were not, then that was probably
10 related to information overload as well. Right?

11 DR. PINES: So, how is increased tasks
12 related to information overload? Is that what
13 we're getting at?

14 That there's so much more stuff to do
15 to get because there is too many -- too much
16 information coming in. You've got to input too
17 much information to capture it.

18 CO-CHAIR SINGH: The other thing is,
19 you know, I was thinking back, if people are
20 relying there -- you know automation related
21 consequences could be another sort of way to look
22 at this.

1 These are some of the things that we
2 are talking about all sort of related to
3 automation in EHRs. Which will get to sort of
4 David's point that, I mean, that we not have this
5 problem in paper.

6 CO-CHAIR BELMONT: And Jesse, is it
7 increased tasks, or increase and more time
8 consuming tasks?

9 DR. PINES: It's probably both. Yes.

10 MEMBER HAYNES: So, in one case we're
11 talking about information overload. And most of
12 the rest of the day we've been talking about how
13 I don't have the information that I need to make
14 the decisions that I need.

15 I don't even think that we've even
16 scratched the surface of information overload.
17 Because on one hand, from a patient safety
18 perspective, all the repeat testing that gets
19 done, all the med rec stuff that can't get done
20 right now, because it's information that's locked
21 in somebody else's health information system --
22 EHR system -- you don't even have the information

1 that you need.

2 You're not even overloaded yet. And
3 yet I know we're still also talking about the
4 information overload.

5 There's a very important sentence in
6 that one long paragraph that needed to get
7 transmitted over from that other institution.
8 And that was that, you know, I have an adverse
9 reaction to Codeine.

10 And that's the most important
11 information that's needed. Yes, it's buried.
12 But it's information that you haven't even
13 overloaded yourself with from across the street
14 to know.

15 And it's not an allergy. It's an
16 intolerance. Or it's not an intolerance; it's a
17 true allergy. Anaphylactic response, something.

18 And you didn't even get that
19 information. You're not even yet overloaded.

20 CO-CHAIR SINGH: Okay. Could you
21 suggest any -- do you suggest we make any changes
22 here? Because we've got two more slides to go

1 through, and we have about 30 minutes.

2 MS. ZIMMER: I would change unattended
3 safety consequences of data entry requirements.
4 Because then what you're -- we could then ask is
5 physicians, how long are you taking to document
6 after clinic has ended because you don't have
7 time during clinic.

8 CO-CHAIR SINGH: Okay. Does that get
9 into in-basket alerts, which is going to be
10 killing people very quickly?

11 MS. ZIMMER: And I would get rid of
12 the information overload task out. Because we
13 might as well be transparent.

14 This really is more about policy. And
15 in that policy these government regulations are
16 impacting clinicians' time. And so they're not
17 being able to -- they're not able to be as
18 effective as they could be.

19 I mean, who wants to be up until two
20 in the morning filling out their charts? It's
21 not right.

22 MR. LYZENGA: But then back to the

1 question that's sort of posed by David. In the
2 absence of EHRs, that's still an issue.

3 Do we want to focus this somehow
4 specifically around the impact of EHRs or HIT?
5 Or --

6 MS. ZIMMER: So, I don't think we have
7 enough data on this, which is why I'm saying I
8 love this. Because I think -- I don't think it's
9 actually --

10 CO-CHAIR SINGH: No, no. We've got
11 data. Clinicians are getting hundreds of alerts
12 every day. I mean, we've got data on information
13 overload as much as you want.

14 I mean --

15 MS. ZIMMER: I don't -- I think you
16 really need to be careful about information
17 overload as opposed to data entry overload.

18 CO-CHAIR SINGH: That's why I'm saying
19 maybe another different word. Either
20 signaturized ratio or automation related types
21 of, you know, unintended consequence.

22 Something. I don't think this is just

1 about data entry. I mean, largely it is.

2 But we got to -- then we'll forget
3 some of the other things that cause it.

4 MS. ZIMMER: Well, what it is, is then
5 you can have cut and paste measurements. You can
6 have how many hours people are working beyond
7 clinics or in the hospitals.

8 CO-CHAIR SINGH: Yes. That's related
9 to unintended consequences of automation.

10 MR. HUNT: What if we took out the
11 word entry? Because data entry requirement seems
12 to put the burden completely on just typing in,
13 you know, putting in information into the system.

14 And it doesn't speak to the issue of
15 getting, you know, information bombarding me.

16 CO-CHAIR SINGH: Yes. That will get
17 to both actually if you remove the word entry.
18 I'm okay with it.

19 I would put in-basket alerts in there.
20 Everybody okay with this?

21 All right. Next slide. Okay. Yes,
22 that's good. Oh, so this is the parking -- is it

1 two more or one more?

2 MS. ZIMMER: One more.

3 DR. PINES: I think this is the last
4 one.

5 CO-CHAIR SINGH: Last? What
6 happened to 14?

7 DR. PINES: It was completely
8 addressed. And I think we pulled everything out
9 of it.

10 CO-CHAIR SINGH: We pulled it out?
11 Okay. Beautiful. Oh, man, okay.

12 Well, so this slide basically just --
13 we want to make sure that we have a way at the
14 organizational level to do the measurements that
15 we are proposing. Or that people ought to be
16 looking at multiple sources.

17 Help desk tickets, using trigger
18 tools. Reports, I mean AHRQ.

19 MS. ZIMMER: We also moved security
20 over to this one.

21 CO-CHAIR SINGH: I'm sorry?

22 MS. ZIMMER: We had moved Eric's

1 security over to here.

2 CO-CHAIR SINGH: Yes. And then they
3 also will do both retrospective and perspective
4 measurements. As a perspective measurement the
5 example is a security checklist and SAFER Guide.

6 Retrospective is, you know, safety
7 reporting systems, help desk tickets, lawsuits,
8 trigger tools. So, multiple sources of data.

9 And then the organization uses that to
10 improve safety. I don't think this concept is
11 covered elsewhere.

12 And, again, we'll have to think about
13 how do we measure this. But, you know, okay.

14 CO-CHAIR BELMONT: And we didn't talk
15 about this yesterday, but if we want institutions
16 to take this seriously, could we suggest sharing
17 some of these measures with the governing board?

18 Because safety starts from the top
19 down. And Health IT safety measures typically
20 are not shared with the governing board.

21 CO-CHAIR SINGH: Actually, I would put
22 that as a measure. I think she's recommending.

1 You're saying put that as measure. Do
2 you share your EHR safety metrics with the
3 governing board?

4 CO-CHAIR BELMONT: With the governing
5 board, yes. Or a subset of those measures.

6 MR. HUNT: And that helps also speak
7 to the issue of culture.

8 CO-CHAIR SINGH: Absolutely.

9 CO-CHAIR BELMONT: Yes. And Jesse and
10 Andrew, if you want, I've got a whole background
11 on suggested governing board metrics that I can
12 share.

13 CO-CHAIR SINGH: So, accountability
14 will be organization level? Facility level,
15 right?

16 I think that's what the accountability
17 level is. Okay. Karen?

18 MS. ZIMMER: Just to clarify, when
19 we're talking about risk management
20 infrastructure, is it targeted just to Health IT?
21 Because you might want to --

22 CO-CHAIR SINGH: Yes, I think it was

1 supposed to say it should -- the Health IT stuff
2 should fit within the existing risk management
3 infrastructure.

4 So, right now the quality and safety
5 people at most organizations are either unaware
6 of these things. They don't know enough about
7 it.

8 I think Gerry, you should tell us what
9 your experience has been. And what kind of
10 feedback you got once you released the education
11 model on safe Health IT.

12 Are people sort of doing that? Are
13 they finding it useful? And saying oh, we never
14 knew about these things, and now we do. Or
15 whatever? Any thoughts on that?

16 MEMBER CASTRO: Well, I think, you
17 know, with the release of the Sentinel level
18 alert and then of course the education module, it
19 gives organizations the tools to approach their
20 leadership with this conversation. And start to
21 develop that infrastructure within the
22 organization.

1 But, you know, outside of that, we
2 have existing leadership standards --- and I was
3 just looking those up right now --- that says the
4 organization has to have this overall process in
5 place already. But, to make it -- what we're
6 trying to do is make it Health IT specific now.

7 CO-CHAIR SINGH: Yes.

8 MEMBER CASTRO: So, and to sensitize
9 the organizations on what specifically to look
10 out for, and what to report up to.

11 CO-CHAIR SINGH: So can we actually
12 say that as a measure that if you are a risk
13 management program, like 10 people in the OR, or
14 whatever, all of them have to be doing the Joint
15 Commission educational module on safe Health IT?

16 Can we put that as a measure? I mean,
17 if none of them have done it, it's like a bad
18 sign if they haven't looked at the education
19 model from the Joint Commission.

20 MEMBER CASTRO: Is that we decided to
21 do?

22 CO-CHAIR SINGH: Basically the number

1 of people within the risk management program or
2 risk patient quality, whatever management program
3 at the facility level that have been certified --
4 is it a -- what is it? Is it a certification or
5 something?

6 MEMBER CASTRO: It's just continuing
7 education credits.

8 CO-CHAIR SINGH: Have received
9 continuing education credits from the Joint
10 Commission Safe Health IT education module.
11 Because that will bring awareness up drastically.

12 Because then they'll, you know.

13 MR. HUNT: And just to be clear, that
14 module is available free of charge to everyone?

15 CO-CHAIR SINGH: Um-hum.

16 MR. HUNT: Okay.

17 MS. ZIMMER: The first bullet should
18 probably read organizations assess Health IT
19 risks?

20 CO-CHAIR SINGH: Sure. Any other
21 types of measures we could think about from a
22 local perspective?

1 Okay. Back to you guys. Because I
2 think we're done with the slides.

3 DR. PINES: Okay. So, I know so this
4 has been an amazing discussion. We've really
5 covered a lot of ground.

6 So, I know we have to do the public
7 comment and then comments in the room.

8 I did want to give everyone a chance
9 for any sort of final comments or sort of any
10 overarching thoughts that you'd want to make at
11 the end. So we can make sure to include that in
12 the report.

13 I don't want -- we don't necessarily
14 have to go around the room. But any sort of
15 final thoughts? And I don't know, David if you
16 wanted to?

17 MR. HUNT: I'm just incredibly
18 grateful to everyone who -- it's been a wonderful
19 but, you know, exhausting in some ways, a couple
20 of days.

21 And I'm just thankful that everyone
22 took the time.

1 CO-CHAIR SINGH: I must add that this
2 has been a really good exercise working with all
3 of you here. Because you've been, you know, it's
4 been getting everybody's input. And making --
5 doing such an exercise.

6 So I really enjoyed this, even though
7 I may have been a little tough sometimes. But I
8 think we really achieved a lot.

9 So, thank you to all of you. Because
10 without your contributions, nothing would have
11 happened here.

12 CO-CHAIR BELMONT: And I would second
13 that. And I wish there was some way that this
14 group can stay in touch.

15 Because things happen so fast. And we
16 all have a little bit different areas of
17 expertise. And it would be great if there was a
18 LISTSERV or some continuing way we could stay in
19 touch and share.

20 MR. LYZENGA: Yes. I mean, we can try
21 to make sure that happens. And on that note, we
22 will have more work for you yet.

1 (Laughter.)

2 MR. LYZENGA: You're not done.

3 CO-CHAIR SINGH: Did you say we're not
4 done today?

5 MR. LYZENGA: You're not done. There
6 is more.

7 CO-CHAIR SINGH: But we're done.

8 MR. LYZENGA We have in fact yet to --
9 we're going to have to do a bit of prioritization
10 around these sort of areas that we've identified
11 I think.

12 And so we're going to follow up with
13 you via email and --

14 CO-CHAIR SINGH: Yes. And maybe, you
15 know, we could just go around the room since --
16 just to get people to think if we have time --
17 are there any ones that you feel extremely
18 strongly about?

19 This would be a time to sort of, you
20 know, get that in sort of writing or recording,
21 or whatever. Out of the -- we have 14 or 15?
22 What did we actually end up having?

1 So, we only have three to eliminate if
2 we need to.

3 MEMBER SCHNEIDER: Hardeep, I just --
4 I mean, in general, I think it's better to use a
5 process to get to that information than to just
6 take one off comments.

7 CO-CHAIR SINGH: All right.

8 MEMBER SCHNEIDER: Because the report
9 should reflect that there was a systematic
10 process of it. That would be my recommendation.

11 CO-CHAIR SINGH: So, do we have a
12 process in place? Are we going to do this in our
13 own voting?

14 MR. LYZENGA: Well, maybe we could get
15 some input actually on that. Do -- would you
16 like to, for example, rank order these areas?

17 Is that something you would think
18 would be appropriate? Do we want to do sort of a
19 rating on a scale of each of these?

20 Like again, a high, moderate, low
21 priority? Do you have any other suggestions on
22 how we can prioritize them most appropriately?

1 MEMBER SCHNEIDER: I'll weigh in since
2 I've done this a fair amount. I would give it a
3 -- if it's really just what's the priority, a one
4 to five scale. High priority to low priority.

5 Let people vote on each one. That
6 will be an analyzable data set.

7 MR. LYZENG: And we can do that
8 through a survey instrument online. Did you?

9 MEMBER SCHNEIDER: Do you plan a full-
10 blown Rand method? I can tell you about that
11 too. But I'm not sure you do.

12 MEMBER JONES: I like the importance
13 and feasibility split out, and that should be
14 fairly easy to implement electronically with
15 Survey Monkey or something. I don't know, but
16 there's got to be a way to do that.

17 MR. LYZENG: Yes. We can do that.
18 And we can maybe do the -- yes, we can do
19 importance, feasibility and then an overall
20 priority rating, one to five. Something like
21 that.

22 CO-CHAIR SINGH: So then will ONC get

1 like a top -- like a ranked 13 or a 14?

2 MR. LYZENGA: I'm not sure we'll do a
3 -- it depends on I guess, how the results come
4 out. But I'm not really sure we'll get a rank.

5 But we may have a -- end up having a,
6 you know, them fall out into some tiers, yes.

7 CO-CHAIR SINGH: Okay.

8 MS. ZIMMER: A quick question.
9 Because we haven't gotten to the exact metrics
10 that would potentially be used.

11 If we are doing that importance and
12 feasibility, would we, over the phone, discuss
13 any where someone put a one as feasibility versus
14 two or three?

15 Because I think, at least I saw in our
16 group, feasibility -- someone might think it's a
17 one, but someone knows of something that does
18 exist to help with this.

19 And so, when there's a real
20 difference, and I'm not saying between two and
21 three. But anything that has a one for
22 feasibility almost deserves a discussion if

1 anyone else put a two or three where someone put
2 a one.

3 DR. PINES: What we could also do is
4 actually have a comment. You know, we could
5 allow for some comments in the Survey Monkey.

6 So, if there's a -- you know, someone
7 knows they think is -- what they have is not
8 common knowledge, they can add that in. Or have
9 the opportunity to do that.

10 MR. LYZENGA: And in general, it would
11 be really helpful if you could comment when we
12 have these, you know, for your ratings.

13 All right, well let's ask for public
14 comment at this point. Operator, could you open
15 the lines?

16 OPERATOR: Yes, sir. At this time if
17 you would like to make a comment, please press
18 star then the number one.

19 (No response.)

20 OPERATOR: There are no public
21 comments at this time.

22 MR. LYZENGA: Anything in the room?

1 (No response.)

2 MR. LYZENGA: All right. Well, thanks
3 everyone for your hard work. This has been
4 fantastic.

5 And we will be following up with
6 again, some prioritization survey of some sort
7 most likely. And yes, some additional work.

8 So, go ahead, David.

9 MR. HUNT: One last thing. A debt of
10 thanks to our Co-Chairs who did an absolutely
11 fantastic job.

12 MR. LYZENGA: Absolutely.

13 MR. HUNT: As well as the group
14 leaders.

15 (Applause.)

16 (Whereupon, the above-entitled matter
17 was concluded at 2:44 p.m.)
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C E R T I F I C A T E

This is to certify that the foregoing transcript

In the matter of: Prioritization of Health
IT Patient Safety Measures

Before: NQF

Date: 09-17-15

Place: Washington, DC

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my direction; further, that said transcript is a
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