Patient Safety and High Performance
Leadership Summit
Issues in Governance, National Collaboratives, and H.I.T.:
Health Information Technology Reporting and Analytics

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Webinar Transcript

Charles Denham: So we are ready to get started with our next panel. So we'd like to have everybody sit down; and for our national and global audience, we are about ready to start our next panel on Health Information Technology Reporting and Analytics. Could we have everybody sit down and we'll get started.

So we started off the day talking about the Institute of Medicine report, and I think that we want to keep our focus on this area of health information technology and analytics. David, since you were one of the coauthors, and Jim also, and David Classen, frame for us: what are the critical issues that are important today? Specifically, what's most important about this topic that you feel we need to understand nationally and globally – when we think about a 30-minute panel, we can only learn so much? What do we really need to know that's actionable that we can really take to heart?

David Bates: It's essential that providers be able to report issues when they identify them. That's true about safety issues in general. It's also true about safety issues in particular, and one of the things that we found when in doing the report was that there is some instances in which providers have been actively discouraged from reporting. Especially around HIT related issues and that clearly is a problem. It's not a good thing. People need to be able to share their stories, and that's a way of preventing – having these things happen again and again, which is what happens when you don't report them.

Charles Denham: Jim?

James Bagian: Well, I think, just going along with what David said, we see some of those things have to do with, I would say, less with the ones where zeros go, but how they're implemented in the baseline training to realize, and it was mentioned here a little earlier, I think that the HIT (Health Information Technology) is a tool. If we're trying to automate or systemize how we do business, we have to have good processes. We just don't automate lousy processes. Sometimes it might be the software might not be as well-suited a process we need, and in other cases, our processes should be varied or changed to take advantage of the power the HIT gives us. Often that doesn't happen. I think the one thing we talked about a lot was the issue about usability of testing human factors as parts of the interface because there are many cases where the information is there somewhere, but it's not readily accessible. Or it can be manipulated in confusing ways, or people can execute things that they didn't intend to do. How do we learn about that? If there's reporting. Otherwise, sometimes we don't even know the mistakes that occur, or the harm that is caused because they don't, they go unnoted, and that has to be done in a more proactive way than it's done now.

Charles Denham: So let me tell you a little story about this meeting. So when we had HIT in the title, we lost attendance because it said, "Patient Safety and HIT," and no matter how you spin it around, there are people in Patient Safety [who] go, "Oh, that's for CIO." We always see the numbers go down when we cover something technically, if we cover because we are so supportive of what you all are doing in terms of using information in IT, and we believe it's really important. Even though that is the case, and even though we see numbers drop off, we want to support it because we know it's so valuable. When I talk to the people on the board I say, "Listen, when you look at your IT guy right now, he or she is ten percent 'I' and ninety percent 'T,' and in three or four years that person's going to be ninety percent 'I' and ten percent 'T.' You better start paying attention to the 'I' because that's how you're going to get paid, that's how you're going to keep your patients safe." But I have to tell you that the numbers go down. "Oh, this is the IT session," and people might go out for a cup of coffee even though it's patient safety. When I talk to

the people in the boardroom and I say, "You've got to money in this," "Oh, we've already bought the EHR." No, no, no. I say, "This is patient safety, we're using the informa . . ." "No, no, no, that's the – you know, too much to deal with."

David, you are out interfacing with people, how can we communicate to the non-wirehead (forgive the expression) in the boardroom that we need to put money knowing that we're going to have cuts after the election? I mean, I don't have a crystal ball, but I also can do the math and we're going to have cuts. I mean, we are a hundred-trillion-dollar liability; we know they're going to cut things; and it's going to be around training, and safety, and consulting, and all these other areas. How can we get the message in the boardroom to do what Don Berwick said and start an escape fire? When you don't think you should pull out a match and start an escape fire. When you don't think you should pull out a match, you need to light the fuel in front of you so that it's going to save your life. But we see it drop off.

David Classen: I think the answer may be that we're building a learning system, and we will learn after having spent all the money on EHRs and HIT. That just putting them in and turning them on doesn't lead to their improvement in quality, and safety, and all those other things. That the implementation doesn't stop when it's turned on. That's just the beginning, and we'll go through multiple stages, I think, of integration to learn how to use these systems more effectively. I think maybe that's the message that we were trying to basically put in our report when we talked about the life cycle of IT. We had a whole chapter on that, which said that you need to think of this as a continuous process of improvement, not an IT implementation. But I think a lot of organizations, when they start down this road, they tend to think of this as an EHR implementation. Put it in, turn it on, and then that's it.

Charles Denham: Right.

David Classen: And then when they realize that that doesn't give them all the benefits they were promised when they bought the system, I think we get to Farzad's point: it's not about whether we're going to have HIT; we're going to. It's how we're going to use it to improve performance. But I think that's the natural learning thing that occurs for all organizations. And if you look at the pioneers in this area, who have been doing this with home grown systems. David, I think that it's fair to say you guys have learned that at the Brigham for years, right? Which are your improvement cycles, which you and I talked about in an editorial about meaningful use, right? These improvement cycles are critical to learning how to use these systems to improve.

Charles Denham: Farzad?

Farzad Mostashari: I couldn't agree more. Maury and I – a lot of people, when we talk about information technology, they'll say it's the solution to all of our problems. And a lot of times I tell people it's also the problem to a lot of your solutions. If you just think you're going to buy this thing, and it's going to make your patients safer because you paid a lot of money, and you bought the system and you flipped some switches, you're wrong. The safety comes from building the systems that are going to deliver safer care. The Information Technology can be very helpful in helping us understand – getting data out faster, helping us understand how we improve the system. How are we doing? Where are our vulnerabilities? How are we going to be addressing those? But the information technology systems are not going to solve these problems. They are going to help us, give us the information that we need to solve the problems. They'll give us the information faster so that we can get to these solutions faster. But simply thinking that you are going to buy a system that's going to solve all your problems is a big mistake.

Charles Denham: Bill.

William Munier: While there are a couple of things about electronic health records and other Information Technology, and people – when something goes wrong, somebody puts the orders in the wrong record, or what have you, people think about it and they worry about the IT. What people don't realize is, there were a lot of errors with paper record. A huge percentage of paper records aren't there when the patient shows up in the office or in the hospital. So there are errors that happen; they just aren't as visible. Again, back to the point that David reiterated: it's not whether we're going to go to information technology; we

are. It's just, how can we do it in a safe way as possible? What I would submit is that information technology brings tremendous new power in terms of the ability to analyze and understand what's happening with patient safety across the board, not just IT-related patient safety.

One of the things is that a lot of patient safety errors – they can present in a number of different ways. They can come from IT. An infusion pump can malfunction. They can give the patient too much, and they can fall. It presents itself as a fall, but it really relates back to IT. You really need to report on all kinds of patient safety events in one way, not separating them out into the silos as they have been oftentimes. And the other thing about it is, you mentioned before, the cost of collecting information; data collection for reporting to all the different people [who] want to do it. It's very expensive to do that, and it's been very fragmented. Different agencies ask for different information.

A lot of it also, because of the burden of data collection, we go to what's on the bill. We do a lot of reporting around administrative data. The great, huge reservoir of information on clinical performance is buried in paper records, or even buried in IT records where the codes were written out differently for different vendor systems. But if we get together through meaningful use and other ways, and we harmonize things, and harmonize the measures, we can begin to use the power of IT to vastly decrease the cost of reporting, and increase the power of analytics. So IT is going to be a godsend to quality and safety in terms of lowering the cost of obtaining the information, and increasing the power of analytics. I would also say – and it was a point made earlier by Arjun. You should know that those of us [who] are Feds and others [who] are working with us understand that care changes at the local level. At my agency we're not going to – we don't treat patients. We're not going to make care safer tomorrow directly. We do it by what we help to disseminate. But care has to be changed at the local level.

So what we need to work for, and the Partnership for Patients interestingly is highlighted. All the fragmentation, not just at the local level in measurement. But it's highlighted the fragmentation among the agencies. Ideally, what you want to have is that hospital that's out there that has all these reporting requirements. They got the state, they got The Joint Commission, they got the FDA, they got the CDC, and all, etc. They got the PSO now. They're drowning under data requirements. We need to harmonize what makes scientifically supportable clinical sense to report. Focus, as was mentioned earlier. Let that hospital report once into its event-reporting system, and then have that information go off to everywhere it has to go to. That will decrease costs, which will help at least a little bit – maybe not too much – but a little bit with your problem with what happens after the election and costs.

Charles Denham: So we got trustees. How many trustees do we have in the audience? Okay, so for trustees [who] are out listening, who are going to watch this later, who we're targeting, who we're training – we're training trustees and certifying them as leadership and patient safety to help equip them to see – to empower them. One of the things we always say is if you don't need to know all the answers, right, Sharon Rossmark from Chicago? You just need to know the right questions. So given that we're heading into an environment of not getting more money, but probably getting less money; not getting less stress, but probably getting more stress.

What are the questions that really responsible trustees need to ask of their senior professional administrative teams – their CIOs – because we can equip them. They have the ability to open some purse strings that are not part of the budget, because right now, 3,100 hospitals – every one of them – is cutting budgets. They are cutting capital; they're cutting everywhere they can cut. Yet our trustees control money that is sitting on very little investment income that they can put to work to save lives. We've got thirty preventable deaths an hour. They would spend money. They would spend money if they knew it was taking a good bet. So, David, what should a trustee [who] is non-clinical, not IT trustee – what are the questions that are proper questions about resources, other than, "Hey, how much do you want?"

David Bates: Well, I have a couple of specific suggestions. One, I think it's useful to ask, "What are your rates of major safety events? How many hospital-acquired infections are we having? How many adverse drug events? How many falls? How many pressure ulcers?" Those are the main things that hurt patients, and they all result in losses to your institutions.

Second, to the questions that relates to "How are we performing in terms of quality on an ongoing basis?" It turns out that organizations that ask that kind of question on a regular basis, in which the board is involved, do better in terms of quality.

And a third question I would ask: "How is your organization using analytics, and what are you doing to learn from analytics?" Throughout industry, analytics have played a really big role in improving efficiency. I'm a big fan of a book called *Competing on Analytics*, which talks about how a variety of industries have done that successfully.

Charles Denham: David, your thoughts. What does the board or the professional administrative team have – what should they be asking?

David Classen: Yeah. I think in other industries it's sort of an accepted view that technology is adopted aggressively as possible to increase performance of the business, right? And that means aggressively asking, "We made this huge investment; are we really maximizing it to see improvement in quality and safety?" And Bill and I are very involved in how we enhance reporting safety problems through the PSOs, and clearly all that we've done in common formats were done with the idea that we create standards that would be built into electronic systems so people wouldn't be doing this on paper. So we spent an awful lot of time doing that. Now we're very focused on how we might leverage existing data and EHRs through automation and triggers to enhance reporting into PSOs, another very rich area of how we might improve measurement and reporting. This is just sitting there waiting to be harvested as we've talked about. I think there is sort of a philosophy in other industries to get the most of out your investment in IT. And unfortunately, I think we very often lead with, as Arjun said, put it in, turn it on, and we're done. And that's only the beginning …

Charles Denham: Either magical thinking or it didn't work, and we pull out that exception that was a train wreck where they had to tear out the CPOE system and say, you know, the exception though is pulled out. I want to go to Jim.

David Classen: But just let me finish one other thing. Traditionally in safety, we've been retrospective. We look at these events after they happen. Now, with EHR, as I think as Farzad has said, we have the capability of identifying as they're happening, and intervening in a way that sort of throws our old view of preventability right out of the window, right, Bill? We thought of [inaudible]. What if you could identify them as they happen and intervene, mitigate and ameliorate? That to me is the next step in safety, and that's what as I as a board member would want to do. What are we doing to leverage all our HIT to uncover problems as they happen and deal with them?

Charles Denham: So, Jim, you are a very persuasive speaker. Every time you and I get together, you make a compelling argument for things. I'm going to give you a scenario. So election happens, budget cuts, there's $200,000 at play, and you're in the analytics and patient safety IT area, and you've got to make your case to get the $200,000, or not lose your $200,000. What are the two or three things that you can say to a board? Because this is what my board – this is what's going to happen, and happening right now. What's the compelling story to say, "You can't cut my budget" or "I need to get that donation that just came in"?

Jim Bagian: The question first would be … to depend on is, you should've laid the groundwork already of, "What is the utility of the HIT services I provide?" So just to come to me and say "I need $200,000" isn't persuasive. So, well, I think if you're waiting until the story once they're going to cut your budget, it's too late. You've already lost.

Charles Denham: You've already lost.

Jim Bagian: I would say – you need to be saying, "Why is this a priority? How, by using the analytics you have, how has it helped us deliver better care? Deliver it more efficiently, less waste?" If you haven't done that already, then you already haven't done your job, and you should be cut, I would say. I think that's where having prioritized – how do you justify every day? You should always think in your mind, I believe,

"Why is what I'm doing today worth doing? Why shouldn't I be zeroed out?" You almost should start every day with a zero-budget approach. "Why do I value that? Would I have valued that yesterday? What am I doing today?" If you're not always reinforcing that with your board, with your leadership, and if you're not thinking that way and how you guide …

Charles Denham: You'd better start.

Jim Bagian: … your actual activities, it's too late when you finally ask the question and start thinking about it then, because you don't even have a track record to support it.

Charles Denham: You know, Regina Holliday and the team [who] were up here, the consumer group that [was] up here, talked about the fragmentation, and I see that in our tests. I see the fragmented silos – silos kill, they really do. They're going to kill budget if we don't kind of rally together. Arjun, you've got a really great view nationally for those people [who] don't think we can get way down to almost zero in infections, you're seeing some pretty great numbers that are starting – you're seeing things really – people are surfing the tsunami, right? You're seeing people …

Arjun Srinivasan: Absolutely.

Charles Denham: … get the word out, and they're now really moving. What's your message to the rest?

Arjun Srinivasan: Get on board. I think that we know a lot about what works. We know that if you – it comes up over and over again, if you focus on problems that you know have solutions. Healthcare-associated infections are a great example. Central line-associated bloodstream infections are an ideal example where relatively simple measures that are applicable anywhere, in any healthcare setting where you're inserting and using central lines, it's taking those measures and applying them. I think what we're seeing now is the uptake. We are seeing more and more people look at that data and say, "This is unacceptable to do it any other way." I think that's the model that we need to be striving towards, where unsafe care is simply viewed as being unacceptable care. Patients won't accept it, boards won't accept it, commissions won't accept it. When we reach that, that's when we won this battle. We're getting there certainly with healthcare-associated infections, central lines; things that we might have done as residents, or even as young attendings. Now it's unacceptable, and there's a culture that does not accept that. I think that's what we're working toward.

David Classen: And I think that's the next great barrier for us – in safety is – culture is one of our greatest barriers to improvement to actually getting everyone on board, right? We know what to do, and now the question is, "Can we execute it?"

Charles Denham: We've got rural hospitals represented here that have very unique challenges. Mike Williams's, hospitals that are operating at about 50 beds. Fredericksburg, Texas – they only have a certain size, they can only do so much. Many of the other hospitals around the country have far [fewer] staff than you do, Mike, in infrastructure. Any tips, any advice, any good success stories for this, what, 2,200 hospitals that treat about 25% of the care? Between 20 and 25% of the care in America [is] in small hospitals that are in real jeopardy. They're either the number one or number two employers in those communities, and people don't realize [that] when they go under, the community's going to go under; and a lot of them are just barely making it right now. Any tips – small hospitals, don't have a big infrastructure – any tips, advice, stories?

Mike Williams: Yeah, definitely. Let's pick up on the central-line example that Arjun used because – I think we've all talked about the fact that science has revealed certain ways to do things that are safer, and yet the problem is dissemination. Healthcare is a very, very complicated industry, very fragmented; there are millions of people working in it. But how do you get that innovation down to the local level? Working within our agency, and now with the Partnership for Patients, and with CDC, we have a package where we've taken actually some of the things that have been talked about today – checklists, teamwork, culture – and packaged it up in something called Comprehensive Unit-based Safety Program, and rolled it out to the American Hospital Association, all the state hospital associations, and departments of health,

and it's on the web, and it's actually ideal for small hospitals. It's a very easy to adopt package. There's technical systems and help, and we're actually now in 27% of the ICUs in the United States with this very package. We've seen a forty percent reduction from an already reduced base just over the past eight quarters. I think this is an event – now we're planning to move this into other areas.

Charles Denham: I know where you can publish that. I think you should – how many people want to see that published? More work for you guys. Arjun, thanks for coming from Atlanta. We're at time. Great panel, thank you very much. So we'll take a five-minute break, and prepare for our next panel.