TNA/TONE Health IT Task Force Webinar 5

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TNA/TONE HIT Task Force Members

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Acknowledgement: Contribution by TNA/TONE HIT Task Force members
Collaboration among Quality, Patient Safety, and Health IT to Effect Safe EHR Use

Introduction

• Background
  – Delivered four previous Webinars (300 – 500 participants from around the country
  – Created a network of informatics professionals on LinkedIn and on an eList
  – Conducting a second Nursing Informatics conference [helps with ANCC NI certification]

• Future Plans/Offerings
  – Advanced topics on safe EHR use, workflow redesign, curricula development, interprofessional education and HIT, hazard reporting
  – Determine the benchmark [and future trends] on nurses’ experience using their EHRs
  – Increased focus on rural/public health IT needs
Objectives

1. Discuss three (3) key specialty areas in nursing important to safe, effective electronic health records deployment
2. Describe how each of these specialty areas contributes expertise to electronic health records deployment
3. Analyze operational models in these specialty areas
4. Describe emerging resources available to clinicians to support collaborative models addressing patient safety and quality as it relates to use of electronic health records
5. Outline steps that clinicians can take to access and use these emerging resources most appropriately
TNA/TONE Health IT Task Force

• Charge: Determine implications of health care informatics for nursing practice and education in Texas

• Include nationally-based Technology Informatics Guiding Education Reform (TIGER) initiative

Vision: To enable nurses and interprofessional colleagues to use informatics and emerging technologies to make healthcare safer, more effective, efficient, patient-centered, timely and equitable by interweaving evidence and technology seamlessly into practice, education and research fostering a learning healthcare system.

TNA = Texas Nurses Association
TONE = Texas Organization of Nurse Executives

http://www.thetigerinitiative.org/
HIT Taskforce Membership

Composed of TNA and TONE Member from practice and academia

Task Force Members

- David Burnett
- Nancy Crider
- Susan McBride
- Mary Anne Hanley
- Molly McNamara
- Mary Beth Mitchell
- Elizabeth Sjoberg
- Mari Tietze

TNA

- Clair Jordan/E. Sanders
- Joyce Cunningham
- Laura Lerma
Why Does HIT Matter
Deep in the Heart of Texas?

Environmental Forces:
- Health Care Reform/ARRA
- Advanced Practice Nurse Roles
- EHR Incentives
- IOM/RWJF Report Advancing Health Care
- Informatics Nurse Standards by ANA

Benchmark Reports on Progress

Involved Constituents

CNE for Practicing Nurses
Educational Content Dissemination
Awareness Campaign
Nursing HIT Curriculum Development

Embrace the Technology
Preserve the Art
For 300,000 Texas Nurses

Advisory Committee: Practice, Administration, Education and Vendors/Suppliers

Nursing Leaders

T.I.G.E.R Phase III Partnership

Introduction
Three Areas of Expertise Critical to Success of our National Agenda on HIT

- Patient Safety and Risk Management Specialists
- Quality Improvement Specialists
- Nursing Informaticists
HITECH: Catalyst for Transformation

Pre 2009
A system plagued by inefficiencies

2009
EHR Incentive Program and 60 Regional Extension Centers

2014
Widespread adoption and meaningful use of EHRs

The National Goal:

Building an Interconnected, Patient-Centric Care System

Resulting in Improved Quality, Safety and Efficiency: *What the HITECH Act is really all about,*…

- More efficient coding and billing
- Safer treatment via e-prescribing
- Faster delivery of information and results
- Better communication and care coordination

Three domains for expertise needed:

1. Patient Safety
2. Quality Improvement
3. Informatics

2. Contributes Expertise

Operational Models

• 3 Domains of Expertise
  1. Patient Safety and Risk Management Specialists
  2. Quality Improvement Specialists
  3. Nursing Informaticists

• All three domains have unique contributions to the end goal of improved care through electronic health records and interoperability

• Yet, in many organizations these operational models work on separate departments that are not always tightly aligned
Practical implications for department independence due to the respective operational models

• **Quality** departments maintain Quality Assurance and Peer Review Protection

• **Patient Safety** information has historically been maintained in Risk Management departments due to the litigious nature of the information relating to a patient safety event resulting in injury or death

• **Health Information Technology** deployment is managed from the Information Technology Departments of most institutions
Many new reporting avenues for EHRs

62 Regional Extension Centers with Help Desk Features

Informal Social Networks & Blogs Discuss EHR Safety Issues

AHRQ Patient Safety Organizations (PSOs)

Hazard Reporting System piloted

EHR Help Desks

It is important to funnel information on a potential EHR Patient Safety Event to the right place
Patient Safety Organizations (PSOs)

- The Agency for Healthcare Research and Quality (AHRQ) is charged with administering the Provisions of the Patient Safety Act related to Patient Safety Organizations. The AHRQ website has a multitude of information concerning PSOs: http://www.pso.ahrq.gov/

- Important purpose of PSOs

PSO’s protect the information reported to them in a secure environment where clinicians and HC organizations can collect, aggregate and analyze data in order “to reduce risks and hazards of care”

Patient Safety Organizations (PSOs)

PSOs have standard reporting formats for several types of events including a new reporting format for Medical Devices & HIT.


ONC Issues a Developers Challenge July 2012


Example of how one organization in Texas is meeting the needs of its providers

- RCHI also houses the CentrEast Regional Extension Center
- Help Desk Reporting feature with their REC
- PSO protections in the event the EHR help desk ticket issue is associated with a patient safety event or potential event (near miss)
Welcome to the Electronic Health Record Support Center

The adoption of electronic health records (EHR), while very important to improving the quality and safety of healthcare, has the potential to introduce new variables into our healthcare delivery system. This event reporting tool was created in an effort to gather such information.

For a demonstration or to evaluate the EHR Support Center, please visit our demo site.

<table>
<thead>
<tr>
<th>EHR Issue</th>
<th>Best Practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>Application, vendor, and/or contractual issue that resulted in a less than optimal or undesired outcome. (HelpDesk feature is included to minimize issues.)</td>
<td>A successful technique or methodology that has improved EHR use in your practice.</td>
</tr>
</tbody>
</table>

3. Oper. Models

Tracking

✓ EHR Usability Issues

✓ Patient Safety Issues

✓ Best Practices

✓ PSO Protections

http://ehrsupport.centreastrec.org
So what might this process of reporting look like,...
Enter important demographic information
Important aspects of what happened such as workflow and general usability information are entered.
Fairly simple and straightforward, but other options available to you,...
Further information what happened is critical
Interprofessional Education (IPE) Enhancing Safety and Reporting [WHO]

- Example training: Health IT, PT, OT, Nutrition and Nursing [telehealth clinical environment]
- Students from different health professional groups gain an understanding of the roles and responsibilities of each member of the healthcare team.
- Experiences from the universities show that information communication technology can be used to help break down established stereotypes and promote equal partnership in patient care (p. 67).
- Strengthens patient safety mechanisms and (p. 32) and diminishes fragmentation

Interprofessional Education (IPE) Enhancing Safety and Reporting [IEC]

This report is inspired by a vision of interprofessional collaborative practice as key to the safe, high quality, accessible, patient-centered care desired by all. Report on an expert panel*.

*IPEC sponsors:
American Association of Colleges of Nursing
American Association of Colleges of Osteopathic Medicine
American Association of Colleges of Pharmacy
American Dental Education Association
Association of American Medical Colleges
Association of Schools of Public Health

Interprofessional Teamwork and IOM Core Competencies and Domains

Competency Domain 1: Values/Ethics for Interprofessional Practice
Competency Domain 2: Roles/Responsibilities
Competency Domain 3: Interprofessional Communication
Competency Domain 4: Teams and Teamwork

Utilize Informatics
Provide Patient-Centered Care
Employ Evidence-Based Practice
Apply Quality Improvement

Work in Interprofessional Teams → Core Competencies

Figure 5

EMERGING RESOURCES:
PSO, HAZARD REPORTING PUBLIC SITES
PUBLISHED LITERATURE
Hazard Reporting [AHRQ]

Hazard Reporting [AHRQ] (Overview)

There are four main categories of hazard attributes that include:

- discovery
- causation
- impact
- mitigation/corrective action

The Beta test is being conducted under the auspices of a Patient Safety Organization, with three levels of security:

- 1) a participating health care organization can enter and see information regarding the hazard it identifies;
- 2) vendors will have the ability to see hazards reported by their customers; and
- 3) health care organizations, vendors, policymakers, and researchers may request access to view aggregated, de-identified reports of hazard attributes.
Hazard Reporting [AHRQ] (Stakeholders)

**Individual CDOs**
- Characterize, manage and understand the variety, frequency, and impacts

**Organizations using the same applications (user groups) sample = 7**
- Understand the variety, frequency, and impacts of hazards associated with the applications and combinations of applications they share.
- Maintain vendor confidentiality outside the user community.

**Health IT vendors**
- Understand the variety, frequency, and impacts of hazards potentially associated with their software applications

**Policymakers**
- Aggregate and analyze health IT hazards as early as one element of a National program of health IT safety.
Public Web Sites: ECRI*

- ECRI Institute is an independent, nonprofit organization that researches the best approaches to improving the safety, quality, and cost-effectiveness of patient care.
- Designated an Evidence-Based Practice Center by the U.S. Agency for Healthcare Research and Quality and listed as a federal Patient Safety Organization by the U.S.
- 1968 - Formally began operation
- Provides reporting mechanism and reports

* Emergency Care Research Institute

https://www.ecri.org/Pages/default.aspx
Public Web Sites: ECRI [Reporting Page]

May we identify you to the manufacturer and/or supplier of the device(s) involved?
- Yes
- No

**Device Identification**

Please be as specific as possible in identifying the devices involved. Please add any other information that might be helpful, and omit items that are not known or that appear to be irrelevant to this particular problem.

- Type(s) of Device(s) involved:
- Manufacturer:
- Model:
- Serial/Lot No:
- Expiration/Use before Date:
- How Long in use:
- Condition:
- Date Last Inspected or Serviced:
- Date Problem Occurred:

If requested, will you send the affected device to ECRI Institute for examination?
- Yes
- No

Were other devices or accessories involved?
- Yes
- No

If yes, please describe:
Public Web Sites: ECRI Annual Hazard Report

THE HAZARDS AT A GLANCE

1. Alarm hazards
2. Exposure hazards from radiation therapy and CT
3. Medication administration errors using infusion pumps
4. Cross-contamination from flexible endoscopes
5. Inattention to change management for medical device connectivity
6. Enteral feeding misconnections
7. Surgical fires
8. Needlesticks and other sharps injuries
9. Anesthesia hazards due to incomplete pre-use inspection
10. Poor usability of home-use medical devices

Blog 4/20/2010

• **Missed diagnosis for soft tissue sarcoma:** In this accident, a soft tissue sarcoma went undiagnosed for at least 3 months, possibly as long as 6 months, because the radiologist’s report from the Radiology Information System failed to file properly in the EHR and the referring physician *didn’t know what they didn’t know* and failed to follow-up on the results of the scan. The young mother of three went untreated, the cancer spread to the point that it was untreatable, and she died. The case was settled out of court for several hundred thousand dollars.

Public Web Sites: HITxChange

https://www.healthitxchange.org/Pages/landing.aspx
Books, Studies and Products

Final Report
May 2012

Health IT Hazard Manager Beta-Test
Contributing Authors:
James M. Walker, M.D.,
Principal Investigator;
Geisinger Health System
AHRQ Publication

Author: Institute of Medicine Committee on Patient Safety and Health IT

Authors: Dean F. Sittig and Joan S. Ash
National eHealth Collaborative University

Keeping EHRs Error-Free: The Value of Patient Engagement

Presented by:
- Erin Poetter, Consumer e-Health Policy Analyst, ONC
- Prashila Dullabh MD, Project Lead, NORC at the University of Chicago
- Norman K. Sondheimer, Co-Director of the Electronic Enterprise Institute (EEI), University of Massachusetts Amherst
- Ethan Katsh, Professor of Legal Studies and Director, CITDR
- Kenneth Mandl, Associate Professor at Harvard Medical School; Director of the Intelligent Health Laboratory at the Children's Hospital Informatics Program

Moderated By:
- Kate Berry, CEO, NeHC

Patient Engagement/Activation
NEXT STEPS: APPROPRIATE USE OF EMERGING RESOURCES FOR EVENT REPORTING
Next Steps for Safe Clinician Use of EHRs

- Know your organization’s approach to reporting [risk management]
- Promote a “just” culture for reporting of events to increase error reporting. Note: estimated that 1-5% of Health IT errors are actually reported [conversation with Dr. Sittig]
- Know available resources to you and your organizations related to reporting patient safety issues with your EHR
- Look for the trends in your events . . . these types of errors are more evident by their patterns than standing alone  [AHRQ HM]
- Have a link where users can report errors/issues/events/negative features right there on the screen, similar to how “broken links” are reported
- Create a culture of patient engagement / activation
Different Views of How IT Works

Source: Jim Turley, PhD, RN, University of Texas Houston School of Biomedical Informatics, Gulf Coast Regional Extension Center
DFW NI Community Nursing Informatics Networking

- You are invited to participate in a DFW Nursing Informatics Community.
- We are on the move in Dallas-Fort Worth for Nursing Informatics.
- Informatics Nurses are coming together to network, collaborate, share best practices, and participate in educational events.
- This is a great way to get involved in Nursing Informatics and learn who your peers and colleagues are in the area.

There are two ways to participate


- Join the DFW NI Community eList- to be included, just send an email to: marybethmitchell@texashealth.org

- Our first event was in July – here is an article about it, in the recent ANIA newsletter [http://www.ania.org/sites/default/files/documents/vol27_no2.pdf](http://www.ania.org/sites/default/files/documents/vol27_no2.pdf)

- Our next DFW NI Community event is tentatively set for Oct. 18th at Medical City Hospital. More to come!
TNA/TONE HIT Task Force Co-Chairs

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