Welcome to

A Safety Leaders Update

Is H.I.T. Evidence Based?

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Welcome

Charles Denham, MD
Chairman, TMIT
TMIT High Performer Webinar
November 17, 2016
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November 17, 2016, 12:00 pm - 1:30 pm CT / 1:00 pm - 2:30 pm ET

**A Safety Leaders Update: Is H.I.T. Evidence Based?**

**Session Overview**

Ross Koppel, PhD, Adjunct Professor of Sociology, University of Pennsylvania in Philadelphia, has provided tremendous insight to our TMIT audience in the area of E.H.R. patient safety in multiple webinars. He is a leading scholar of healthcare IT, and of the interactions of people, computers, and workplaces. His articles in JAMA, JAMIA, Annals of Internal Medicine, NEJM, Health Affairs, Journal of Patient Safety, the Journal of Clinical Care, Journal of Managed Care, Chest, and AHRQ-M&Ms, et cetera, are considered seminal works.

Dr. Koppel will address a great question: Is Health Information Technology evidence based and what do we need to know?

**Webinar Video and Downloads**

*The webinar video will be available within five business days after the webinar airs.*

**Speaker Slide Sets:**

*Slide Sets will be available before the webinar begins.*
If you wish to follow us on Twitter, go to: http://twitter.com/TMIT1 or use #safetyleaders hashtag

Also, go to: www.facebook.com/SafetyLeaders and related sites
Our Purpose:
We will measure our success by how we protect and enrich the lives of families...patients AND caregivers.

Our Mission:
To accelerate performance solutions that save lives, save money, and create value in the communities we serve and ventures we undertake.
Disclosure Statement

The following panelists certify:
that unless otherwise noted below, each presenter provided full disclosure information; does not intend to discuss
an unapproved/investigative use of a commercial product/device; and has no significant financial relationship(s) to
disclose. If unapproved uses of products are discussed, presenters are expected to disclose this to participants.

Ross Koppel, PhD, FACMI, is a leading scholar of healthcare IT, and of the interactions of people, computers and workplaces. Professor Koppel is
on the faculty of the Sociology Department and of the Medical School at the University of Pennsylvania. Koppel is also a Senior Fellow of the
Leonard Davis Institute at Penn’s Wharton School. He has nothing to disclose.

Jennifer Dingman realized, after her mother’s death in 1995 due to errors in medical diagnoses and treatment, that there is little to no help
available for patients and their families in similar situations. This life-changing experience left her feeling vulnerable, and she decided to dedicate
her life to help prevent medical tragedies from happening to others. She has nothing to disclose.

Charles Denham, MD, is the Chairman of TMIT; a former TMIT education grantee of CareFusion and AORN with co-production by Discovery
Channel for Chasing Zero documentary and Toolbox including models; and an education grantee of GE with co-production by Discovery Channel
for Surfing the Healthcare Tsunami documentary and Toolbox, including models. HCC is a former contractor for GE and CareFusion, and a former
contractor with Siemens and Nanosonics, which produces a sterilization device, Trophon. HCC is a former contractor with Senior Care Centers.
HCC is a former contractor for ByoPlanet, a producer of sanitation devices for multiple industries. Dr. Denham is a collaborator with Professor
Christensen.
Speakers and Reactors

Ross Koppel

Jennifer Dingman

Charles Denham
Voice of the Patient and Family

Jennifer Dingman

Founder, Persons United Limiting Substandards and Errors in Healthcare (PULSE), Colorado Division
Co-founder, PULSE American Division
TMIT Patient Advocate Team Member
Pueblo, CO

TMIT High Performer Webinar
November 17, 2016
In the News and Polling Highlights:

*News Update and October 2016 Webinar Polling with Prior Mortality Review Polling*

Charles Denham, MD

Chairman, TMIT

TMIT High Performer Webinar
November 17, 2016
"In reality, HIPAA not only protects personal health information from misuse, it also enables the access, use, and sharing of protected health information among and between providers and their health IT systems when and where it is needed for patient care. Interestingly, survey data tells us that consumers already believe this type of information exchange happens as a matter of course. Sadly, it doesn’t," he said."

"These misunderstandings of HIPAA and other business practices are inhibiting us from realizing the true potential for technology in supporting patients and clinicians," Washington continued. "Providing an individual with easy access to their health information empowers them, it helps put them in control of decisions regarding their health and well-being, and it helps them actively partner with their care teams as well."
Researchers at Baylor College of Medicine have developed a framework of strategies to reduce diagnosis errors in hospitalized patients. While investigating diagnosis errors in hospitalized patients, the researchers identified five dimensions of diagnosis, then analyzed errors to identify improvement opportunities within each dimension. Their work was published in *Annals of Internal Medicine*. The research focused on inpatients, but the dimensions of diagnosis and corresponding improvement opportunities are broadly applicable, Singh said in a statement.

The five dimensions and some suggested improvements include:

- **Patient-physician encounter**: Allocate time to effectively communicate with patients; seek "cognitive support" to assist decision-making in cases of uncertainty
- **Performance and interpretation of diagnostic tests**: Collaborate in person with lab professionals and radiologists to interpret complex test results or in cases of difficult diagnosis
- **Follow-up and tracking of diagnostic information over time**: Do not overlook past diagnostic data during the current hospitalization; clarify responsibilities of follow-up of abnormal test results
- **Subspecialty consultation-related communication and coordination**: Use direct verbal communication when making critical decisions; ensure everyone on the team is on same page about the diagnosis when multiple consultants are involved
- **Patient-focused strategies**: Encourage proactive patient and family participation in the diagnostic process; encourage patients to look at their own medical notes to find inconsistencies

The American Hospital Association (AHA) is urging Congress to move forward with the Electronic Health Record Regulatory Relief Act (S. 3173), legislation introduced this summer aiming to provide regulatory flexibility to providers and hospitals operating under the Meaningful Use program.

According to AHA's letter, the bill “would provide much-needed relief to hospitals as they work to ensure patients receive high-quality care. It would allow participants in the Medicare and Medicaid EHR Incentive programs to be deemed meaningful users if they meet 70 percent of the measures as determined by the Secretary of Health and Human Services. The AHA has long advocated for the elimination of the “all-or-nothing approach” to meaningful use of EHRs. Under this approach, failure to meet any one of the requirements under the Medicare and Medicaid EHR Incentive programs, even by a small amount, results in a large payment penalty. This is unfair to hospitals that make good faith efforts to comply, may actually comply with a large percentage of the requirements, expend significant resources and funds in doing so, but still fall short.” …

AHA's letter continued, MACRA “made changes to the meaningful use program for physicians that calls for greater flexibility in how physicians and other eligible clinicians are expected to use certified technology to support clinical care. As these changes are implemented, it will be essential to ensure that program requirements are aligned across all participants, including physicians, hospitals and critical access hospitals. This alignment is critical to ensuring the ability to share information and improve care coordination among providers across the continuum. The Oct. 14 final regulations for MACRA fall short in this regard.”

A Medical-Tactical Approach undertaken by clinical and non-clinical people can have enormous impact on loss of life and harm from very common hazards:

- **High Impact Care Hazards** are frequent, severe, preventable, and measurable.
- **Lifeline Behaviors** undertaken by anyone can save lives.
"Code Black" promoted new White House initiative, *"Stop the Bleed,"* in a "CBS Cares" PSA broadcast Wednesday, Oct. 12 following an all-new episode.

Source: CBS. American College of Surgeons website. (also available via CBS All Access)
Available at http://www.bleedingcontrol.org/about-bc/news-updates#kit
Learn from Mortality Review AND the Living: Next Generation Safety Learning System

Jeanne M. Huddleston, MD, FACP, FHM

Hospitalist
Chairperson of Mortality Review Subcommittee
Mayo Clinic
Rochester, MN

TMIT High Performer Webinar
July 21, 2016
Omission vs. Commission

Pareto Chart of Categories of Issues Experienced by Patients Hospitalized in Mayo Clinic Hospitals

Mayo Clinic, Mortality Review System
Anonymous Polling Questions

"I am interested an ALL CAUSE HARM approach integrating mortality reviews for Patient Safety and Risk Management"

93% Agreed and 74% Strongly or Very Strongly Agreed, and 57% Very Strongly Agreed

Source: TMIT High Performer Webinar Series; Learning from Collaboration on Mortality Reviews: The Journey – October 20, 2016
ALL CAUSE HARM topics I would like to be covered include:

- All
- Any areas identified
- Appropriate patient triage
- Charting by omission
- Communication, documentation, workplace violence
- COPD, heart failure, sepsis
- COPD, pneumonia, sepsis
- Delay in transfer to higher acuity of care
- Delays in care that arise due to unclear goals on admission (dnr, comfort care). Relates specifically to mortality.
- Drug abuse toxic state in medical icu - safety
- Errors related to insufficient documentation of co-morbidities and complications at admission
- Failure to rescue; opiate use; caregiver health; institutional health
- Infections, respiratory events, staffing issues
- Lack of coordination among hospital employees on each floor...
  - All together
- Medication errors and EHR
- Medication reconciliation
- Medication reconciliation issues
- Medications, HAI, perioperative complications
- Missed diagnoses; failure to rescue; medication reconciliation errors resulting in medication errors
- Missing sepsis in the post-op patient
- Omissions
- Over sedation issue
- Patient identification
- PSIS, HACS, overlap with Truven and leapfrog measurement methodology, shooter/terrorist events,
- Psychiatric patients who want to harm self and others.
- Relationship of readmission to mortality and other harm
- Second victim
- Sepsis
- Sepsis mgmt., infection prevention, failure to rescue
- Sepsis mortality
- Surgical error
- Team coordination of care for our patients
- Wait time in the ER and ultimate expirations

Source: TMIT High Performer Webinar Series; Learning from Collaboration on Mortality Reviews: The Journey – October 20, 2016
Eric Cropp:
The pharmacist sent to prison for the death of a child due to unintentional medication error.
Julie Thao: The nurse indicted for the death of a 16 year old mother due to an unintentional medication error.
Anonymous Polling Questions

"I am interested in a webinar addressing the latest update on Errors and Caregiver (RN MD etc) blame and H.R. Issues"

86% Agreed and 63% Strongly or Very Strongly Agreed, and 51% Very Strongly Agreed

Source: TMIT High Performer Webinar Series; Learning from Collaboration on Mortality Reviews: The Journey – October 20, 2016
"The topics regarding caregiver staff blame and H.R. Issues I want to see addressed in future webinars are:"

- Any
- Attribution misplacement/error system vs caregiver
- Blame across
- Bullying; leadership accountability to staff; HR accountability to staff in a just culture model.
- Care for the caregiver
- Do you have anything regarding just culture?
- Failures related to hierarchy suppression of speaking up.
- Guides to coaching/mentoring behavioral and knowledge issues
- How just culture can be used when addressing errors
- Just culture affect on ability to actually improve systems vs placing blame
- Meeting with caregivers following an event
- Moving beyond blame game (which is never expressed to clinicians) to open reporting to all clinicians so that we can all learn from the experience.
- No comment
- Over sedation issues
- Physician errors
- Related to second victim response
- Some of our peers struggle with staff errors due to the overuse perhaps of system issue" vs. Safely working with the system as designed. At some point the individual is responsible, no system is flawless. Need a medium stance where blame is avoided if possible, however, accountability is required to work within any system. Need a discussion of this issue and potential strategies to have a "just culture" while holding staff (and leaders) accountable for patient care"

- Staffing issues - increasing nursing shortage and inexperience
- System review focusing on omissions
- Transition from classroom to bedside.

Source: TMIT High Performer Webinar Series; Learning from Collaboration on Mortality Reviews: The Journey – October 20, 2016
Although EHRs have largely replaced paper records and brought some efficiencies to the process of delivering health care, there are some important problems that call into question some of the assumptions made by their architects. These are some of the unintended consequences of the widespread adoption of EHRs as they now are:

A 2016 national study in four specialties (family medicine, internal medicine, cardiology, and orthopedic surgery), however, identified some growing frustration with EHRs. Physicians were spending almost two hours of each clinic day for every hour of direct face-to-face time with patients.

Data entry is time consuming and inefficient; physicians are forced to type into the computer during patient visits; when that burden becomes too diverting from relating to and examining the patient, scribes are brought in to deal with computer entry.

A 2013 report from the RAND Corporation confirmed the inefficiency of EHRs, noting inadequate exchange of health information and interoperability, and concluded that template-based notes degrade the quality of clinical documentation and care.

A 2014 study found that less than one-half of U. S. hospitals can transmit a patient care document and that only 14 percent of physicians can exchange patient data with outside hospitals or other providers.

Exchange of health information and interoperability are problematic as manufacturers resist standardization and customize EHRs to their clients; as one example, Wisconsin-based Epic, with the largest market share in the country for EHRs, has placed three different systems in nearby Madison’s three hospitals, requiring attending physicians to learn each system.

The hassle of dealing with EHRs has contributed to increasing frustration and burnout of one-third of their physician users.

A 2012 study found that physicians’ access to EHRs did not reduce their ordering of unnecessary tests. (6) Another 2012 study found that EHRs led to increased costs of tests performed, and that many hospitals raised their ER billings to Medicare.

Anonymous Polling Questions

"I am interested in a webinar addressing the latest update on Electronic Health Records and H.I.T. errors and harm"

89% Agreed and 62% Strongly or Very Strongly Agreed, and 44% Very Strongly Agreed

Source: TMIT High Performer Webinar Series; Learning from Collaboration on Mortality Reviews: The Journey – October 20, 2016
"The topics regarding Electronic Health Records and H.I.T. errors and Harm I would like to be covered include:"  

- all
- Applying Hard stops for protocol measures to impact compliance
- Appropriate alarms and alarm fatigue
- busy, time-consuming data entry vs clear clinical data
- charting by exception
- charting by exception and affect on being able to piece together what really happens
- coding and documentation issues
- confusing orders
- copy & paste
- copy and paste
- copy and paste
- copy and pasting leading to no communication" of patient status in the EMR--flying blind"
- Cut and paste used by practitioners. From a Risk perspective, providers not reviewing patient rx and missing issues in the EHR. In clarification, the information is there (maybe too much information?) but staff are not looking at it and basing care decisions on partial data.
- Cut and pasting errors, work around errors
- cutting and pasting of Pt. information into the record, causing errors and communication errors
- Different EHR views available to different viewers 7 difficulty seeing the whole record
- EHR issues with failure in reporting of abnormal lab/path values
- EHR remediation for errors; Cybersecurity; Cyber threats in healthcare
- ER MDs doing initial admission orders.
- Hybrid record - Physicians resistant to enter orders verbally communicated to nurses COE
- Identified issues and the related patient safety consequences.
- improving medication reconciliation
- in regard to medication administration
- inability to discern the patient's story without the need to look in numerous places for data. Lack of data integration
- Interpretation of health records
- Non-compatible systems within same hospital
- Privacy issues
- Pt. duplicate records; communication from primary care
- Sepsis protocol adherence
- system design issues or alarms

Source: TMIT High Performer Webinar Series; Learning from Collaboration on Mortality Reviews: The Journey – October 20, 2016
Is H.I.T. Evidence Based?

Ross Koppel, PhD, FACMI

Adjunct Professor of Sociology, University of Pennsylvania
Philadelphia, PA

TMIT High Performer Webinar
Part 1 and Part 2
Is Healthcare Information Technology Evidence-Based?

Ross Koppel, Ph.D., FACMI
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Ross Koppel, Ph.D. FACMI

At the University of Pennsylvania:
• Sociology Dept.
• PI. Center for Clinical Epidemiology & Biostatistics (Sch. of Med.)
• Senior Fellow, L Davis Inst. of Healthcare Economics. (Wharton)

At Harvard:
• PI, Study of CPOE & Medication Error. (Harvard & Penn)
• Former Internal Evaluator, Harvard Med. Sch. (SMART Project to create a new HIT architecture.
• Also:
PI: NSA Study of Workarounds to Cyber Security.
PI: Study of Medical Imaging Software Integration

University of Pennsylvania: rkoppel@sas.upenn.edu
Definitions:  **HIT = CPOE, EHRs, eMARs, & BCMA, but mostly EHRs**
Uncontested: EHRs Wonderful Benefits

• Readable text (no handwriting)
• Speed and access to and from the pharmacy, other record systems, most labs
• Basis for CDS
• Potential to reduce duplicate orders, tests, and procedures
• Order formats requiring specification of route, dose, schedule/time, formulation, etc.
• Ubiquity--immediate possible sharing of all information across the hallway and the nation
• Ability to incorporate natural language processing
• Potential ability to mine the vast oceans of data generated by digital data, which could advance medical knowledge in ways that would otherwise take decades to accomplish.*

* Well.... If we had agreed data standards and interoperability
Evidence of what?

• Efficient and effective in practice?
• Is navigation within and among software screens evaluated and modified to be the least burdensome and most intuitive?
• Are clicking and scrolling reduced to the minimum?
• Navigation: Do clinicians know “where they are” and how to get to where they are going, or at least, how to get back?
• Is usability of the systems—as measured via human factors research—tested and progressively improved?
• Are displays of information in graphic and textual form carefully assessed?
• Are they tested on a wide range of users in many real-life settings?
Evidence of what?

- Are observations of clinicians’ use of HIT systematically analyzed as to how information can be amassed and analyzed with minimum distractions and minimum unnecessary cognitive burdens?

- Do we mean we evaluate the implementation of differing systems’ *in situ*? Or implementations of the same system in dozens or hundreds of various medical settings?

- Are we assessing various methods of implementation, incorporating facility design, number of clinicians, number of intersecting offices, expertise of the IT team, etc?

- At what point do we evaluate the success of the implementation? Six months after the “go live” date? A year after the “go live” date? After the third upgrade? After each patch or version is installed?

- Are our evaluations based on random controlled trials (RCT) or double blind RCTs? *Is RCT possible with “evidence” from HIT use?*
Evidence of what?

• Is our CDS examined to ensure:
  • Reduced alert fatigue by careful titration of alerts to only the most essential?
  • Presentation of alerts in ways that align with clinical workflow and thought-flow?
  • Presentation of alert data that are relevant to the user at the point-of-care and the time of decision?
  • Easy access to additional information on how the alerts are determined?

• Do we evaluate how other IT systems are connected to the CPOE/EHR ....and in each setting...including interactions of other IT systems among themselves and with the core HIT systems?

• Do we mean that clinical decision support (CDS), order sets, disease protocols, or dosage alerts are built on the latest medical knowledge?
Evidence of Interoperability?

• Do we have evidence of one of HIT’s most basic promises: **Interoperability**, or at least proof it is **capable** of interoperability—sharing information in usable formats with interpretable data?

• Do our HIT systems allow us to share data across a region, across town, across the hallway, or across the room?
Evidence of improved patient safety

- Evidence of improved patient safety from HIT?
- Improving patient safety is one of the central claims of HIT enthusiasts.
- *But are there systematic data to support this claim?*
Evidence of ROI?

• Have we calculated the return-on-investment in HIT?
  • Are there savings in time? (When....after 3 months? 3 years?)
  • in staff
  • in avoided errors?
  • In fewer repeated tests and laboratory orders?
• Is the ROI logic and purchase based on any valid calculations?
  • or on a *post hoc* justification?
• *Implicit in this question is that we know the cost of the HIT and its implementation.*
• *This is a stunningly difficult figure to determine.*
Evidence of Meaningful Evaluation

• In our evaluations, are we controlling for:
  • Training and re-training of clinicians?
  • Patient loads and acuity?
  • History of technology use in each institution and by each clinician user?
  • The quality (and number) of IT support staff?
  • Roll out time?
  • Big bang or Incremental?
  • One facility or part of a chain or region or national system
The findings: Some supportive (especially if funded by HIMSS or ONC), often dubious, contentious, and always methodologically suspect


28. Koppel, R et al Role of computerized physician order entry systems in facilitating medication errors. JAMA: J of the Amer Medical Assoc. 2005 293(10)1197-1203


To be fair...

Lack of good evidence is not proof of ineffectiveness
Some of the evidence: Let’s look
Perceived Facilitators of Adoption of Electronic-Records Systems among Hospitals with Systems as Compared with Hospitals without Systems
Jha et al. NEJM 360 (16): 1628, Figure 2 (16 April 2009)

No questions asked, nor findings(!), about Usability, Patient Safety, Interoperability, Data Standards, or Clunky Interfaces
The anchor author:

David Blumenthal
Luddite
Resistant
Greedy
Clueless
History of Meaningful Use

- Developed when?
- By whom?
The Use and Meaning of Patient Safety

“Because patient safety is viewed so favorably, our task is to ensure HIT appears to enable patient safety”

Dr. Douglas Peddicord
(American Medical Informatics Association’s Chief Lobbyist)
Washington Health Strategies Group
Oldaker, Belair & Wittie LLP
Phoenix, Arizona, May 2010
“The message to government officials must not appear to be for the purposes of establishing barriers to entry, rather, it must suggest that *meaningful* cost savings & *quality improvements* cannot be achieved without a high standard of “meaningful use.”
RAND 2005: “Can Electronic Medical Record Systems Transform Health Care? Potential Health Benefits, Savings, And Costs” (Health Affairs)

Richard Hillestad, James Bigelow, Anthony Bower, Federico Girosi, Robin Meili, Richard Scoville and Roger Taylor
That RAND Report in 2005:

…this paper compares health care with the use of IT in other industries. It estimates potential savings and costs of widespread adoption of electronic medical record (EMR)… and concludes that effective EMR implementation and networking could eventually save more than $81 billion annually—by improving health care efficiency and safety—and that HIT-enabled prevention and management of chronic disease could eventually double those savings while increasing health and other social benefits. However, this is unlikely to be realized without related changes to the health care system.
The next shoe drops
8 YEARS LATER:
What It Will Take To Achieve The As-Yet-Unfulfilled Promises Of Health Information Technology

A. Kellermann   S. Jones

Health Affairs
2013
Kellerman and Jones 2013: Abstract ....“Seven years later the empirical data on the technology’s impact on health care efficiency and safety are mixed, and annual health care expenditures in the United States have grown by $800 billion. In our view, the disappointing performance of health IT to date can be largely attributed to several factors:

sluggish adoption of health IT systems,
coupled with the choice of systems that are neither interoperable nor easy to use; and the
failure of health care providers and institutions to reengineer care processes to reap the full benefits of health IT.
We believe that the original promise of health IT can be met

- if the systems are redesigned to address these flaws by creating more-standardized systems that are easier to use,
- are truly interoperable,
- and afford patients more access to and control over their health data.

Providers must …reengine[er] care processes to take full advantage of efficiencies offered by health IT,

- in the context of redesigned payment models that favor value over volume.
From Kellerman and Jones, 2013

also note…. “Congressional Budget Office analysis asserted that RAND’s team had overestimated the likely benefits of widespread adoption of health IT. Despite, or perhaps because of, the ensuing controversy, the RAND health IT study continues to be widely cited.
Even more amazing.... The 2005 study was paid for and *guided* by: Cerner, GE, and other vendors of IT products
“ONC Seeks Videos on How Accessing EHRs Could Improve Care” ... The Office of the National Coordinator for Health IT launched a video challenge that invites individuals to submit short videos on how...” [one of many]
To Conclude....

• Is Healthcare Information Technology Evidence-Based?
• Can we answer our question?
But real recent progress:

• Evaluation *In Situ*

• ONC’s Guide to contracts

• Journal of Patient Safety: Electronic Health Record-Related Events in Medical Malpractice Claims. Graber, Mark L. MD, FACP; Siegal, Dana RN, CPHRM; Riah, Heather MBA; Johnston, Doug MTS; Kenyon, Kathy JD

• Willingness to look at all sides
Recent balance:

The SAFER Guides “These guides enable healthcare organizations to address EHR safety in a variety of areas.”

And More.
In conclusion:

- A Legacy of hope and desire
- Honorable intentions
- Commercial motivations
- Limited vision
- But recent positive movement....
- To be continued
- And on which to build
Thank you.

Questions?

Ross Koppel, Ph.D., FACMI

Sociology Department, School of Arts & Sciences, &
Center for Clinical Epidemiology & Biostatistics, Med. School
Leonard Davis Institute for Healthcare Economics, Wharton
School of Engineering and Applied Science
University of Pennsylvania
rkoppel@sas.upenn.edu
Polling Questions

I am interested in an update webinar on MEDICAL TACTICAL emergency response topics

SAFETY topics I would like to be covered include:
Polling Questions

I am interested in a webinar addressing How Caregivers PROTECT THEIR PROFESSIONAL IDENTITY After An Accident

The topics regarding caregiver PROFESSIONAL IDENTITY PROTECTION I want to see addressed in future webinars are:
Polling Questions

I am interested in a webinar addressing the latest update on CONFLICTS OF INTEREST and FINANCIAL DISCLOSURE

Very Strongly Agree

Strongly Agree

Agree

Neutral

Neutral

Negative to Neutral

Disagree

Strongly Disagree

Very Strongly Disagree

The topics regarding on CONFLICTS OF INTEREST and FINANCIAL DISCLOSURE I would like to be covered include:
Q&A Questions

When push comes to shove do you believe there is evidence that H.I.T. really delivers?
Feds Criticized for lax oversight of health IT

“The Foxes are the architects of the hen house
These committees are dominated by the vendors”

“Conflicts of interest are holding back a more rigorous approach to identifying and regulating software problems”

Q&A Questions

What about the H.I.T. vendors not having to report risk areas – anything new?
Q&A Questions

What message do you have for board members regarding H.I.T.?
Q&A Questions

What questions should ask of I.T. leaders?
Q&A Questions

What about Cybersecurity – what should we know?
Q&A Questions

What is your take on consumer access to their medical records?
Q&A Questions

What impact do you believe the new administration will have on H.I.T.?
Speakers and Reactors

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Charles Denham
Voice of the Patient and Family

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Founder, Persons United Limiting Substandards and Errors in Healthcare (PULSE), Colorado Division
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