The CUR-IT Team
(Canadian-US Research in IT)

Newsletter #2, March 2010

In this edition

Next meeting details

- **Date :** 16th of April 2010 ; 9:00 - 17:00
- **Location** : Boston - General Medicine Division Conference Room
- **Directions :** From Brigham & Women's Hospital, 75 Francis St, Boston, MA 02115 - cross trolley tracks at Huntington Avenue, 1st building on R, 3rd fl. From elevator, take L, then sharp R into DGM. Conference room is behind the receptionist desk.

This Newsletter is also available online at:

http://www.patientsafetyresearch.org/news.htm
http://www.ohri.ca/newsroom/newsstory.asp?ID=212
http://moxxi.mcgill.ca/pdf/CURIT_MARCH_10.pdf

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Funding Sources for Common Projects

Canadian Institutes of Health Research
Commonwealth Fund

National EHR Initiatives Study

Lessons learned from HIT implementation in US & Canada

The Commonwealth funded National Initiatives to Implement Health Information Technology Study was conducted in order to **summarize, through interviews with key HIT policy and opinion leaders, the Canadian nearly 10-years HIT policy experience**. Through this the researchers aim to draw comparisons and derive lessons learned for the **US** and for **Canada**, as each moves forward to advance national HIT implementation. The investigators developed a semi-structured interview instrument to delineate the key policy **strategies used to stimulate national EMR/HIT implementation and adoption** in the two countries and conducted interviews with 30 opinion leaders from each country representing multiple stakeholders. Through qualitative research methodology, **the team has formulated the key policy related themes**. Currently, the investigating team has concluded all interviews in both countries and are finalizing the analysis.

Interactive Voice Response System (IVRS)

Improving outpatient prescribing using an IVRS

Patients may experience harm from prescribed medications due to adverse drug reactions or prescribing errors. Collectively, such medicine-induced harm is termed **adverse drug events**. In addition to the potential for direct harm, adverse drug events may lead to harm indirectly if the patient stops taking their medication as a result. We have devised an information **technology based method to identify adverse drug events in community practice**, which is based on an **"interactive voice response system"** or **IVRS**. An IVRS is a technology that facilitates human interaction with computers through a telephone interface. IVRS have been evaluated in health care for many purposes. Our novel IVRS design will enable patient-provider information and **ensure providers are informed when patients are not doing optimally**. For this project, we will determine the feasibility of implementing the technology, its acceptability to patients and providers, and its potential **impact in terms of avoided adverse drug events and enhanced medication compliance**. The information derived from this project will inform researchers and policy makers of this technology's potential to improve **health care outcome and its associated costs**.

Patient safety Learning System (PSLS)

A new approach for detecting adverse drug events

The Ottawa Hospital Research Institute (OHRI) is testing a **new approach to managing preventable adverse events**, which they are terming a "**Patient Safety Learning System"**. This approach is being applied at an institutional level and is facilitated by newly developed technologies to support the detection and reporting of adverse events, such as eTriggers. It also leverages a hospital data warehouse that will perform analyses to determine the causes of, and antecedent events predicting, adverse events. The technological advances required for these tasks are minor compared to broader organizational issues. At the heart of these challenges lie the fundamental tasks of **defining what constitutes a medical error** and **overcoming the 'name and blame' culture existing in the healthcare industry**. Their novel approach is focusing on a systems perspective and extend upon prior work completed by their group to **define optimal methods to detect adverse events.**

McGill OHRI IRHO BWH BRIGHAM AND WOMEN'S HOSPITAL