Task Force Meeting #1

Date: December 15, 2014

Attendance

Task Force Member	Status
Terry Fairbanks, MD, MS Director, National Center for Human Factors in Healthcare and MedStar SiTEL, MedStar Health	Present
Peggy Binzer Executive Director, Alliance for Quality Improvement and Patient Safety	Present
Richard Landen, MBA, MPH QuadraMed, Director of Regulatory Affairs Representing the Healthcare Information and Management Systems Society (HIMSS) Electronic Health Record (EHR) Association	Present
Ronni Solomon, JD Executive Vice President and General Counsel, ECRI Institute	Present
Dean F. Sittig, PhD School of Biomedical Informatics, University of Texas Health Science Center	Hardeep Singh (alt)
Tejal Gandhi, MD, MPH National Patient Safety Foundation	Present
Rebecca P. Snead, BSPharm National Alliance of State Pharmacy Associations, Alliance for Patient Medication Safety	Present
Steven Stack, MD President-elect, American Medical Association	Present
Diane Jones, JD American Hospital Association	Present
David Classen, MD CMIO, Pascal Metrics; Associate Professor of Medicine, University of Utah	Present
Gerard M. Castro, PhD, MPH Project Director, Patient Safety Initiatives; Office of Patient Safety, The Joint Commission	Present
Luke Sato, MD Senior Vice President and Chief Medical Officer, CRICO/Risk Management Foundation	Present
Gilad (Gil) Kuperman, MD, PhD Director, Interoperability Informatics, NY-Presbyterian Hospital	Present
Susan McBride, PhD, RN-BC, CPHIMS Professor, Texas Tech University Health Sciences Center, School of Nursing	Present
Shafiq Rab, MD Hackensack University Medical Center Representing College of Healthcare Information Management Executives (CHIME)	Present
Eugene Heslin, MD Bridge Street Medical Group	Present

Task Force Member	Status
Stephanie Zaremba, JD athenahealth	Present
Missy Danforth Senior Director, Hospital Ratings, The Leapfrog Group	Present
Michael Cohen, MD Professor, Department of Pathology, University of Utah	Present
Emily Barey RN, MSN (Alt: Jim Russell) Director of Nursing Informatics, EPIC	Present
David B. Troxel, MD Medical Director and Secretary, Board of Governors, The Doctors Company	Present
Martha Donovan Hayward Institute for Healthcare Improvement, Public and Patient Engagement	Absent
Marilyn Neder Flack Executive Director, Association for the Advancement of Medical Instrumentation (AAMI) Foundation; Senior Vice President, Patient Safety Initiatives	Present
Bakul Patel, MSEE, MBA Associate Director for Digital Health (Acting), Center for Devices and Radiological Health, Food and Drug Administration (FDA)	Simon Choi, alternate
Andrew Gettinger, MD Office of Clinical Quality and Safety, Office of the National Coordinator for Health Information Technology (ONC)	Present
Amy Helwig, MD, MS Deputy Director, Center for Quality Improvement and Patient Safety, Agency for Healthcare Research and Quality (AHRQ)	Present
Ben Bartolome (Alt: Yahya Shaikh, MD, MPH) Special Counsel, Office of General Counsel, Federal Communications Commission	Yahya Shaikh alternate
Minet Javellana Center for Clinical Standards & Quality, Centers for Medicare & Medicaid Services (CMS)	Present
Project Staff RTI: Stephanie Rizk, Doug Johnston, Alison Banger, Colene Byrne, Dawn McIntyre, Jonathan Wald, Linda Dimitropoulos, Mark Graber, Shellery Ebron ONC: Kathy Kenyon	Present

Topics

Introduction and Background

Doug Johnston, RTI project director, began the meeting with the roll call, introductions of project staff, and a review of project objectives and timeline.

Stephanie Rizk, RTI Task Force Lead, reviewed the facilitation framework and introduced the application used for virtual decisionmaking.

Scoping Document Feedback

Comments regarding the scoping document were solicited prior to the meeting to jump-start the discussion. Most comments were related to the constraints on data collection imposed by the regulatory authority of the initial funding sources (ONC and AHRQ).

Discussion Highlights

Some members were concerned that the value of the proposed Health IT Safety Center was questionable if it was unable to collect data or provide surveillance of health IT-related safety events. Other members felt strongly that other organizations and mechanisms were already in place to collect this information; thus, efforts to collect data would be duplicative.

A number of members suggested that the value of the HIT Safety Center could be to harmonize and improve the methods by which the information is collected. The HIT Safety Center could receive and analyze aggregate data from various patient safety organizations (PSOs), for example. There is a need to aggregate data across the continuum and look at gaps, which also raises an important issue of the safety culture. PSOs are important because they are confidential and protect adverse event reports from discovery. PSOs can share learnings from analysis of adverse events, but not the identifiable adverse event data itself. Without this protection, the data would not be available. PSOs are critical because all parties want to improve safety, but the environment needs to be safe.

The HIT Safety Center should not recreate reporting systems because providers are overburdened with reporting, but the task force should determine ways to make the most of existing reporting systems. Any best practices that the Task Force reviews regarding information collection should consider end users. Reporting systems should develop a reporting process for end users that is integrated with the many different tasks they must juggle. Some members suggested that focus groups and front-line case studies would be helpful.

Challenges exist with reporting information to multiple organizations—in particular, how data from existing sources can be analyzed and aggregated. Agreement is also needed regarding the terminology used to discuss HIT safety issues. Again, end users are very important: defining technology-related events (TRE)s can be very difficult. TREs often come to light during a root cause analysis (RCA) process when one discovers the underlying problem. Some events point to an injury such as a medication error, but when one investigates further, an HIT component may have helped to prevent the error or incident.

Health IT Safety Center Road Map

The meeting 1 discussion focused on brainstorming core programs and partnerships. Using a virtual tool, members were asked to brainstorm various core programs they would envision for an HIT Safety Center. After the brainstorming activity, the group discussed items that generated significant conversation.

Discussion Highlights

Education

Some Task Force members felt that creating educational materials and supporting activities about general HIT safety had low impact/low value. However, most felt that education as a core program was important. The following considerations were discussed:

- Education should be based on evidence of identifying the real problems in HIT safety.
- Education must be applied and focused on specific target audiences: vendors, doctors/nurses, etc.
- The Task Force should begin by agreeing on the audience for these activities and work backwards.

Best Practices

Although support for general education varied, support for disseminating best practices, especially those developed in the private sector and based upon evidence, was extremely high. One specific need is to develop a learning system/community among vendors in this area. Some members suggested that vendor products would only improve with pressure, but vendor representatives on the Task Force suggested that vendors want both better tools to help facilitate conversations with end users and more focus on human factors and other related issues.

Dissemination of best practices allows "all boats to rise" and the entire system can learn from this information. Those working in the PSO realm can often apply what they learn from ambulatory care to inpatient care—in effect, raising both boats. An HIT Safety Center that disseminates best practices and the associated workflows helps the entire community.

Additional Topics from Brainstorming

- Stakeholders
  - The following possible stakeholders were suggested:
    - Provider organizations and care delivery systems
    - PSOs
    - EHR developers
    - Medical liability and health insurers
    - Accreditors
    - Patient safety advocacy organizations
    - Researchers and academic institutions
    - Professional and trade associations, including CHIME and HIMSS
    - Federal partners, including ONC, AHRQ, FDA, FCC, and CMS
- Harmonization and implementation of standards:
  - Better taxonomy and methods for collecting data on events are needed.
  - Specifically noted: there is no need to engage in standards setting.
- Additional details around research and adverse event analysis:
  - Be careful to define the research objectives in a way that ensure applied results.
  - Discuss how to optimize what is currently available and identify gaps.
  - Aggregate de-identified data across AHRQ, medical malpractice, states, and health plans.
  - Accelerate effective analytics; that is, make good data mining tools available.
  - Promote innovation for how adverse events in IT can be reported and collected.
  - Introduce methods to make initial reporting in a health care setting easier, more informative for analysis.

Education—Jon Wald

The Task Force was presented with a draft plan for additional web-based educational sessions supported under the RTI project and provided initial feedback.

Wrap-Up

The meeting ended with a review of upcoming meetings, a discussion of process for assembling, and then meeting as smaller Work Groups (WGs) on major topic areas.