Task Force Meeting #2

Date: January 26, 2015

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	Absent
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	Present
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
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	Absent
Stephanie Zaremba, JD athenahealth	Present

Task Force Member	Status
Missy Danforth Senior Director, Hospital Ratings, The Leapfrog Group	Absent
Michael Cohen, MD Professor, Department of Pathology, University of Utah	Present
Emily Barey RN, MSN (Alt: Jim Russell) Director of Nursing Informatics, EPIC	Absent
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	Present
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)	Absent
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)	Absent
Project Staff RTI: Stephanie Rizk, Doug Johnston, Colene Byrne, Dawn McIntyre, Jonathan Wald, Linda Dimitropoulos, Shellery Ebron ONC: Kathy Kenyon	Present

Topics

Welcome and Review

Doug Johnston, RTI project director, began the meeting with the roll call and a review of project objectives and timeline. ONC has allotted an extra month to write the HIT Safety Center Road Map; therefore, the third and fourth meetings of the Task Force will be pushed out accordingly. The target date for meeting 3 will be March 9, 2015, and the target date for meeting 4 will be April 13, 2015.

Work Group Report Outs

Three work groups (WGs) were convened in January as a result of Task Force meeting 1. These work groups were given the charge of generating optimal activities of the proposed HIT Safety Center in the areas of Evidence, Education, and Engagement. Each WG used a template generated by RTI to capture information about proposed activities. A representative from each WG presented the summary of these discussions using a subset of the template. Tables 1, 2, and 3 present detail from these discussions.

Evidence

Report out provided by Gerry Castro from The Joint Commission. A summary of the post-report out discussion includes:

- Confirmation that activities around the direct collection of information related to adverse events was a) out of scope for the HIT Safety Center at this time, and b) that a core objective of the HIT Safety Center must be to serve as a trusted, nonpunitive space, which could not be accomplished if it was collecting data directly, as a Federal entity subject to full and open disclosure of activities.
- Specification that many of the proposed activities were related to reportable errors, which constitute only one type of HIT-related safety event. The group should expand its thought process around this to include evidence from sources other than reports and identified using other methods. The group should also make explicit the goals of the current suggested list of activities in supporting additional types of research related to identification of health IT-related safety events.
- Indications that individual organizations, including health IT vendors and various patient safety organizations (PSOs), each maintain data on system errors and safety issues, including items from help desk tickets and from other mining tools. While the analysis of these data is not commonly shared, considering ways to encourage the sharing of findings from analyses of these data sources could lead to a more comprehensive understanding of health IT safety risks.

Table 1. Report Out Detail for Evidence Work Group

Activity	Additional Details	Value/Impact
Aggregate findings and analysis of HIT safety events across data sources; develop reports; summarize findings	Cross data-source analysis/review should have a focus on actionable learning	High. Comprehensive understanding of HIT safety landscape. Will inform areas for additional research
Strengthening and augmenting existing taxonomies (AHRQ Common Formats, etc.) to improve event and hazard reporting related to HIT	Single organizations struggle to describe events and contributing factors consistently	High. End-user focused common "language" is foundational to other activities
Explore different methods and sources for collecting patient safety data	Qualitative and quantitative, could include simulated environments	High. Improvement in data available to support evidence
Foster an environment/culture that would overcome barriers to reporting events and hazards	Identify and share best practices for reporting; improve the way information is reported within user workflow	High. Improvement in data available to support evidence.
Support protected space where vendors can cooperate around HIT-related safety issues, such as EHR interfaces, usability, and design principles to minimize risks	Enables collaboration, allows vendors to work together in a space that avoids antitrust issues	High
Encourage vendors/app developers to consider tools/mechanisms to capture data and generate metrics and analytics on end users' interaction with EHRs	Improving the mechanisms by which HIT safety event data are collected and reported	High. This type of data would strengthen available evidence of HIT safety events

Education

Report out provided by Susan McBride from Texas Tech University. A summary of the post-report out discussion includes:

- The importance of educating patients and families about HIT safety and taking a patient-centered approach to HIT safety.
- Keeping a stated focus on competency and training in simulated environments. Training in simulation labs does not include training around adverse events and reporting nearly as much as it should.

Table 2. Report Out Detail for Education Work Group

Activity	Additional Details	Value/Impact
Identify top ten safety audiences and support development of programs for each	Is this activity occurring currently? Potential audiences: ambulatory care, acute care, those with low technology affinity/knowledge, specific audiences (nurses, clerks)	High. Foundational
Identify, catalog, and promote existing tools and programs that impact HIT safety	Helpful to private sector stakeholders. Many good educational resources, no single source of information. Existing resources could be more effectively promoted	High. Practical application
Develop a learning community that focuses on continuous improvement process for tracking and maintaining HIT safety best practices	Go beyond providing access to educational resources and tools (above); support development/ sharing of guidance on how to use them	High
Develop methods and tools to test the impact of HIT safety interventions	This does not currently exist; this would be a benchmark	Unknown

Engagement

Report out provided by Ronni Solomon from ECRI Institute. A summary of the post-report out discussion includes:

- The idea of a clearinghouse needs to be better defined moving forward. There was broad agreement that stakeholders need a place to sit down and discuss differences in language and interpretation, which suggests more of a town hall or focused workgroup setting.
- Both education and engagement should focus on targeted, high-value activities (narrow focus) in order to achieve early wins and demonstrate the value of the HIT Safety Center. After the value has been established, the range of activities and engagement can expand more broadly.

Table 3. Report Out Detail for Engagement Work Group

Activity	Additional Details	Value/Impact
Establish a "Clearinghouse"–create a process to systematically collect, review, and distribute HIT safety tools and activities	No one in the WG knows of an organization doing this right now	High
Identify and define high-impact stakeholder groups through an environmental scan, updated on a regular basis	Essential information to feed into the continual decision-making process of HIT Safety Center leadership	High
Establish two-fold infrastructure: 1) broad engagement/ generating support, 2) targeted/factor-driven communication pathways with end-users	The effect of #1 is tacit and expected; the effect of #2 would be significant to addressing specific HIT safety issues	High
Establish specific points of connection between public entities (agencies/programs) and the private sector (professional organizations, etc.)	Would allow private stakeholders (CHIME, for example) to have more direct conversations with public and government entities	High
Consider incentives (preferably non-monetary) to support HIT safety event reporting	No incentives currently	High

Feedback and Discussion

After pooling the results across all of the input generated in the individual WGs, RTI staff generated a list of core activities that seemed to transcend all discussions. These included activities to scan, assess gaps, support development, share, and evaluate the impact of health IT safety through:

- Educational content
- Event reporting framework
- Evidence summaries
- Research
  - Broad – example, environmental scan
  - Targeted – example, identified health IT safety risks and events
- Best practices
- Tools and interventions

Discussion Highlights

Core Activities – Gaps

The Task Force members reiterated a need to clarify and/or expand activities around an event reporting framework. That framework should not be limited to voluntary reporting; other data sources and automated reporting tools exist and are being developed, including trigger tools. These resources should be explored. Furthermore, the HIT Safety Center should identify and draw upon a wide range of databases, some of which will focus on specific problems (e.g., e-prescribing or medication errors, patient identification errors) and others may target technology more effectively (e.g., help desk requests, customer complaints to health IT developers). The HIT Safety Center should be proactive in how it approaches risk assessment and mitigation and look at multiple ways to collect data (simulation, automatic reporting from EHRs, the use of triggers, etc.)

Task Force members agreed that an initial strong focus of the HIT Safety Center should be to work on specific areas of concern to the core provider and developer stakeholders. Conducting an initial environmental scan, convening a group to prioritize very specific issues and support cross-industry/organization input on the evidence on those issues, and providing actionable, targeted education in those areas will be essential. Smaller strategic activities would be easier to monitor with regard to how quickly the content is disseminated/used within the target stakeholder groups, which would provide a measureable metric of success. The HIT Safety Center should consider engaging national associations and societies, as they serve as a trusted authority to their members.

Some Task Force members noted, however, that there are some organizations actively working on projects of direct relevance to health IT and patient safety, and that the activities of the HIT Safety Center should be broad enough to build on and learn from their work.

Defining Core Tenets of Health IT Safety

The Task Force members agreed that defining the scope of health IT safety and identifying and categorizing types of health IT safety events or the role of health IT in improving safety and delivering better care will be important. Prior work has defined health IT safety; the Institute of Medicine Report on Health IT and Patient Safety is one example from which the HIT Safety Center can draw. The AHRQ Common Formats and other existing classification schemes offer a starting point for a specific focus on the role of health IT in adverse events. This work on defining the scope of concern about the role of health IT in patient safety should be informed by evidence, including of the experience of safety and safe use by health IT users, so that issues of usability and interoperability are included.

While the HIT Safety Center should initially focus on providers and developers in core areas, other important groups, including patients and family caregivers, should be considered. Safety issues around medical devices are also a potentially emerging area.

Wrap-Up

The meeting ended with a suggestion by RTI to collapse the current WGs into two moving forward: Core Activities (to include discussions on evidence and education related activities) and Operations (to include discussions on engagement, governance, and funding). The Task Force approved these two WGs moving forward.

RTI will follow up with standing meeting times for the two WGs and a summary of the inputs received to date.