NATIONAL QUALITY FORUM

Ambulatory Care Patient Safety

Web Meeting 3 – Post-Comment Web Meeting

May 8, 2018

Over 420 Members Strong

Agenda

- Review of the Comments Received on the Environmental Scan Draft Report
- Proposed Draft Report Updates
- NQF Member and Public Comment
- Next Steps

NQF Project Staff

- Andrew Lyzenga, MPP, Senior Director
- Andrew Anderson, MHA, Senior Director
- Christy Skipper, MS, Project Manager
- Vanessa Moy, MPH, Project Analyst

Advisory Group

- **Peter Brawer, PhD**
  - Vice President, Quality and Safety, Mercy Health
- **Sonali Desai, MD, MPH**
  - Medical Director of Ambulatory Patient Safety, Brigham and Women's Hospital
- **Richard Roberts, MD, JD**
  - Professor of Family Medicine; Family Physician, University of Wisconsin School of Medicine & Public Health; Belleville Family Medicine
- **Urmimala Sarkar, MD, MPH**
  - Associate Professor, University of California, San Francisco (UCSF)
- **Kevin Sheahan, MD**
  - Chief of Nemours duPont Pediatrics, Nemours Children's Health System
- **Saul Weingart, MD**
  - CMO and SVP Medical Affairs, Tufts Medical Center

Federal Liaisons

- Centers for Medicare & Medicaid Services
  - Brendan Loughran, MA
- Agency for Healthcare Research and Quality
  - Barbara Bartman, MD, MPH

Review of the Comments Received on the Environmental Scan Draft Report

Comments Received

- Three comments from advisory group members
- Eight comments from three organizations
- Two major themes:
  - Expansion of measures and or concepts included in inventory
  - Need for a framework

Expansion of measures/concepts included in inventory

Continuity of care is a positive factor for patient safety which often results in fewer missed diagnosis and improved transitions.
Pediatric developmental screening.
In examining the well visit "system" we urge NQF to expand the measure concept to reflect a course of care, not a discrete measure completed each time a well visit occurs. For example, a missed well-child visit may increase the risk of having late diagnosed, unrecognized or untreated developmental delays.
Use of a recall/reminder system.
Adolescent privacy. No standard method exists to transmit sensitive information between physician colleagues and be assured it will also be handled and maintained appropriately.
Pediatric specific electronic health record functionality. Pediatricians are trained to diagnose and treat the health care needs of children and need fully functional health IT systems that facilitate the collection of unique data points for newborns, infants, children, adolescents and young adults.
A safety promotion measure that includes complex care coordination for a set of high risk diagnoses. For example, all children diagnosed with sickle cell disease should have a certain number of hours per year of billing codes submitted for Care management.
Post discharge phone calls after a pediatric hospitalization occurs or transition of care
Measure of access to child specific subspecialty care and therapies.
Proportion of Diabetes patients that have Potentially Avoidable Complications (PACs) (Health Care Incentives Improvement Institute)
Serious Hypoglycemic Events Requiring Hospital Admission or ED Visit Associated with Anti- Diabetic Medications (Pharmacy Quality Alliance; Under Development)

Expansion of measures and concepts included in inventory

- Committee Action: Would the Committee like to include these measures/concepts in the inventory?

Proposed Draft Report Updates

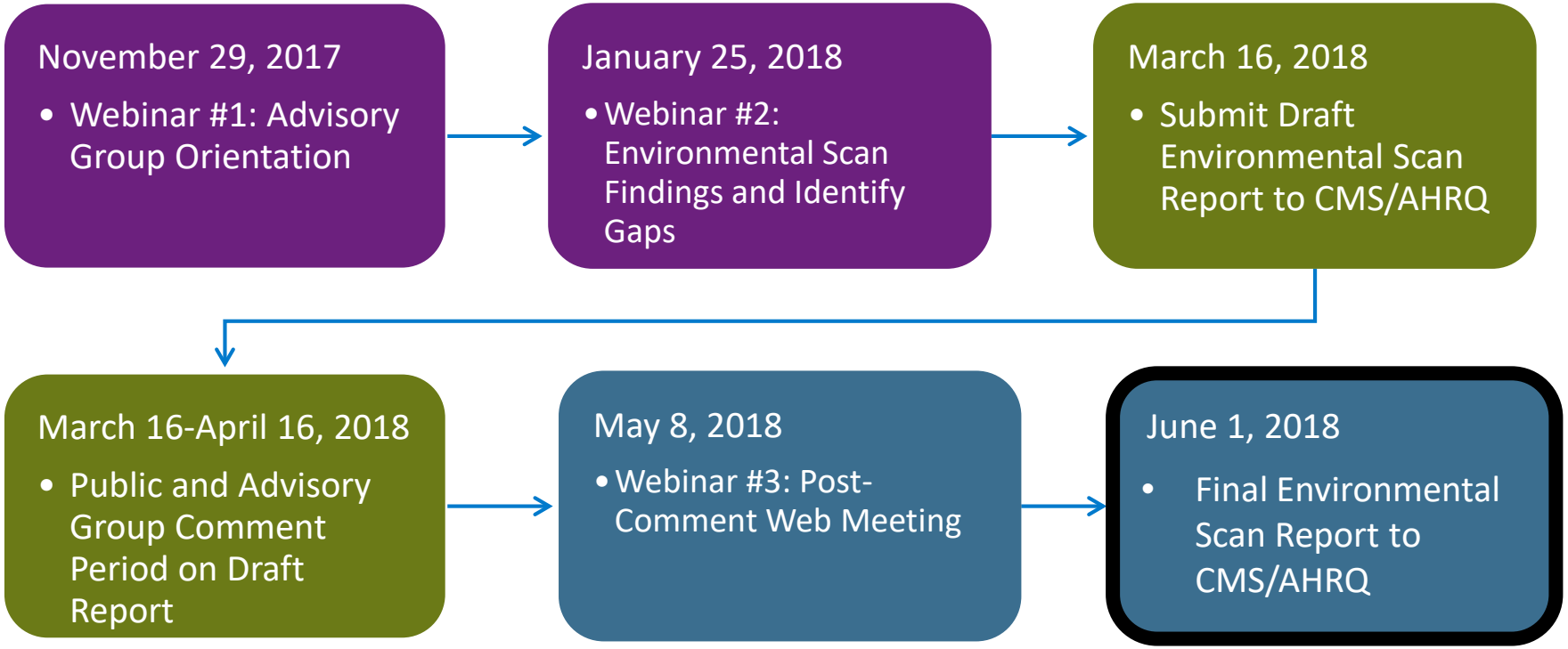
Report revisions

- Executive summary
- Project purpose and scope of work

NQF Member and Public Comment

Next Steps

Project Timeline



Project Contact Info

- Email: ambulatorycareps@qualityforum.org
- NQF Phone: 202-783-1300
- Project page: http://www.qualityforum.org/Ambulatory_Care_Patient_Safety_2017-2018.aspx
- SharePoint: http://share.qualityforum.org/Projects/Ambulatory%20Care%20Patient%20Safety/SitePages/Home.aspx

Questions?

Thank you