



# NATIONAL QUALITY FORUM

## Memo

**Date:** July 10, 2015  
**To:** NQF Members and the Public  
**From:** NQF  
**Re:** HIT Safety: Public and Member Open Forum

NQF has convened a multi-stakeholder HIT Safety Committee to (1) develop a conceptual framework for measurement of Health Information Technology (HIT)-related safety issues, (2) identify and prioritize measures and measurement gaps related to HIT Safety, and (3) identify best practices and challenges related to measurement and prevention of HIT-related safety issues.

The HIT Safety Committee will be meeting via conference call and webinar on Tuesday, July 21.

**The purpose of this meeting is to:**

- Provide an overview of the preliminary conceptual framework for measurement of HIT safety
- Provide an opportunity for stakeholders, including healthcare providers, patients, and other interested parties to share experiences, best practices, and challenges with respect to measurement and prevention of HIT-related safety issues

The Open Forum portion of the call will be dedicated to discussion of topics including organizational activities and strategies to ensure the safe use of Health Information Technology (HIT), barriers and challenges in implementing safe and usable EHRs, and measurement of HIT-related patient safety issues.

Participants are encouraged to consider the following questions and topic areas prior to the call:

**Does Your Organization Engage in Activities to Address:**

- EHR system downtime?
- HIT-induced/facilitated adverse medication events?
- HIT-induced/facilitated incorrect lab or imaging (test) ordering and/or processing?

**Has Your Organization Developed Strategies to Ensure Safe Use of HIT to Avoid Unintended Consequences?**

- What triggered the development of these strategies?
- What results have you noticed due to this effort?
- What type of specific actions did the organization take as a result of your patient safety strategy?

- Has your organization ever had a "safety concern" such as a harm or potential harm to a patient as a result of HIT-related issues?

**Has Your Organization Faced any Barriers or Challenges to Patient Safety in the Implementation of its EHR?**

- Were those barriers technological, personnel, resource, others, or a combination?
- What were the root causes of those barriers?
- What strategies have you developed, if any, as a result of these barriers?
- What have been the results to date?

**Is Your Organization Objectively Measuring the Effects of HIT on Patient Safety?**

- What HIT-related patient safety issues are you prioritizing and how are you measuring them?
- What priority areas do you see coming up in the future? (e.g., Physician Order Entry Behavior, Usability Issues, etc.)
- Are you part of a community actively engaged in this area?
- Would you be willing to share measures/concepts/best practices with the National Quality Forum?