NATIONAL QUALITY FORUM

Moderator: Patient Safety and HIT
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3:00 p.m. ET

Operator: Welcome to the conference. Please note today's call is being recorded. Please stand by.

Andrew Lyzenga: Hi, everyone. This is Andrew Lyzenga from NQF. Welcome to the first call, the orientation call for the HIT Safety Committee (inaudible). Newly-constituted committee as you all know, we're very excited about this work.

To start off the call, we figured we could just do a quick round of introductions, both for the NQF staff and then for our committee members. We'll go around and introduce ourselves quickly, and then I will read off the roster, do a bit of a sort of a roll call, and we'll ask you to just give a quick introduction of yourself, if you don't mind.

So, this is again Andrew Lyzenga. I'm a Senior Project Manager here at NQF. I've been at NQF for, you know, about five years now. I've worked primarily on safety issues, mostly in the endorsement process. So this is one of my first experiences with one of our sort of more unusual or unorthodox, I guess, or that's not the right word, but non-endorsement CDP project. So, I'm excited about this as well. It looks like we've got a great committee together, and we're looking forward to working with you.

Adeela Khan: This is Adeela Khan. I'm the Project Manager for this project. Been at NQF for three years and I worked primarily on our consensus development projects. So I'm excited to be working on this new area of HIT safety.

Andrew Lyzenga: Ann?

Ann Phillips: I'm Ann Phillips and I'm the Project Analyst on this project. And I have worked on those safety projects and health I.T. projects.

Andrew Lyzenga: And we've also got Jesse Pines as a consultant on this project. Jesse, do you want to give a quick intro for yourself?

(Off-mike)

Andrew Lyzenga: Jesse, are you there?

Adeela Khan: He might be on mute.

Andrew Lyzenga: He might be on mute. Well, we may have lost Jesse. But Jesse is the emergency room doc over at George Washington and also has had a lot of experience in the safety field. He's worked on a number of projects with us here at NQF. So we're very happy to have him working on this with us as well. He's going to be sort of giving us clinical perspective from the staff item and guidance on our environmental scan and the rest of the project. So, happy to have him with us as well.

(Crosstalk)

(Off-mike)

Jesse Pines: … Jesse here. I just hopped off for a minute, but I'm glad to be on the project. Thanks, Andrew.

Andrew Lyzenga: Thanks, Jesse. So, at this point, I will just do a quick roll call of the roster of the committee and I'll ask you to just give a very brief introduction of yourself and maybe what kinds of work you've been engaged in, in this space. We don't have a whole lot of time in those so try to keep it in around 30 seconds or so.

First, I will call off our two co-chairs. First, Elisabeth Belmont?

Elisabeth Belmont: Hi, Andrew.

Andrew Lyzenga: Hello.

Elisabeth Belmont: I'm Elisabeth Belmont and I'm Corporate Counsel for MaineHealth in Portland, Maine. And I have a specialty in the area of health I.T., quality and patient safety. I've been involved in a number of national and governmental projects including serving on the IOM Committee on Diagnostic Error, participating in some ONC projects and recently participating in a grant for ASRM.

Andrew Lyzenga: Great. Thank you. Our other co-chair is Hardeep Singh.

Hardeep Singh: Hi, can you hear me?

Andrew Lyzenga: Yes, we can.

Hardeep Singh: Andrew, can you hear me OK?

Andrew Lyzenga: Yes, yes, we can hear you, go ahead.

Hardeep Singh: OK, I'm sorry, I'm actually calling from U.K. I'm on an Internet connection …

Andrew Lyzenga: OK.

Hardeep Singh: … so excuse my poor voice comes across that way. So, I'm Hardeep Singh. I'm a general internist and a patient safety researcher. I work at the Houston VA Center of Excellence for Research and at Baylor College of Medicine in Houston. Most of my interest lies in, at the intersection of patient safety, electronic health record. And I've done some work on diagnostic errors and communication of test result and increasingly over last few years, then to work on EHR-related patient safety issues including measurement, and I also was (co-principal) investigator for the project that's funded the ONC SAFER Guides. Thank you.

Andrew Lyzenga: Thanks.

Hardeep Singh: Thanks for having me.

Andrew Lyzenga: Yes. Thank you Dr. Singh. So now, I'll just move through the rest of the list. Jason Adelman, are you on?

Jason Adelman: Yes, hi. This is Jason. Hi, Andrew, and I'm the Patient Safety Officer at Montefiore Medical Center, which is a big health system in Bronx, New York. And I have operation responsibility for patient safety across the system and I also do some patient safety research mostly around HIT. And a lot of my research has been on wrong patient errors. And on another NQF committee that looks at general patient safety measures, and I'm happy to be joining this group.

Andrew Lyzenga: Thanks, Jason. You know, Jason, as he mentioned, is on our Patient Safety Standing Committee. So, we're happy to have that sort of cross-fertilization there as well.

Next is Gregory Alexander?

Gregory Alexander: Hi, Andrew. This is Greg.

Andrew Lyzenga: Hi.

Gregory Alexander: I'm from the University of Missouri Sinclair School of Nursing. I'm an associate professor. I'm a researcher. I've led several grants including two that I'm currently leading. One is the CMS demonstration project that's looking at health information technology and health information exchange communication across nursing homes and hospitals; and the other is the national study about the implementation of health I.T. and measures, quality measures, associations to quality measures, and a national study of long-term care organizations. Thank you.

Andrew Lyzenga: OK, thank you. Next is Gerard Castro. Is he on?

Gerard Castro: Yes, I'm here. Thanks.

Andrew Lyzenga: OK.

Gerard Castro: This is Gerry Castro. I'm Project Director for Patient Safety Initiatives at The Joint Commission. I manage our sentinel event database, and I'm also the

principal investigator for the ONC-funded project investigations of health I.T. related deaths, serious injuries, and unsafe conditions. And I'm also on the NQF Common Formats, expert panel.

Andrew Lyzenga: Great. Thank you, Gerry. Next is David Classen.

David Classen: Hi, I'm David Classen. And I'm an infectious doc from the University of Utah and I also work for PSO. And my role in the field is I chair the NQF Common Formats Expert Panel, and I'm very excited to be on this group as I think this work (inform ours). My work in HIT and Safety began when I began all the safety programs at Intermountain Healthcare. Currently, I'm involved in efforts to build better measures of EHR system for national performance. And David Bates and I just got an article work for five years to refine and further develop the Leapfrog test that (they lead HRC).

Andrew Lyzenga: OK, thanks, Dr. Classen. As he mentioned also, Gerry Castro and David Classen are both on the Common Formats panel at NQF, and we think there will be quite a lot of cross, you know, pollinations there as well and opportunities to sort of look at the Common Formats as a model where as a potential place to get information. And we will be or we're planning to actually run the conceptual framework that's developed through the course of this project, Ask the Common Formats Panel, just to get their feedback and input on it. So we're happy to have these members of the panel there also that just help with that alignment effort.

David Classen: Great. Thank you.

Andrew Lyzenga: Next – yes, thank you. Next is Linda Dimitropoulos.

Linda Dimitropoulos: Hi, yes. I'm the …

Andrew Lyzenga: Hi, Linda.

Linda Dimitropoulos: Hi. I'm the Director of the Center for the Advancement of Health I.T. at the Research Triangle Institute. And I'm the Associate Project Director on the project to develop the roadmap for the health I.T. safety center, which is funded by ONC. And one of my goals for CMS committee is to help with the

cross-pollination between those two big two efforts, this committee and the roadmap work.

Andrew Lyzenga: Great. Thank you. Next, we have Lisa Freeman.

Lisa Freeman: Good afternoon.

Andrew Lyzenga: Hi.

Lisa Freeman: Hi, there. I'm an independent patient advocate. I came to this through a different path than many of you. My husband was injured, seriously injured during surgery, and it did lead directly to his death 18 years later. I've been involved in many patient advocacy roles. I've sat on the readmissions action team at the NQF. I am involved with several patient advisory boards. I have participated in a number of panels and presented at various workshops at conferences, representing and speaking on behalf of the patient's voice. I've been on the faculty at the Academy for Emerging Leaders in Patient Safety: The Telluride Experience. And I sit on the executive board at the Connecticut Center for Patient Safety.

Andrew Lyzenga: Great. Thanks so much, Lisa.

Lisa Freeman: Thank you.

Andrew Lyzenga: Next we have Tejal Gandhi. I'm not sure if Dr. Gandhi was going to be able to make this call.

Tejal Gandhi: I am here. Thank you.

Andrew Lyzenga: Oh, great.

Tejal Gandhi: Hi there. Hi I'm Tejal Gandhi. I am an internal medicine doctor by training and started out my career looking at how health information technology can improve quality and safety particularly in the outpatient setting, and did a lot on medication, safety, test result management and also did some work on unintended consequences of HIT. In addition, I was the Director of Quality and Safety at Brigham and Women's in Boston for about 10 years and then Chief Quality and Safety Officer Partners HealthCare in Boston, and now for

the last year and a half, the present CEO of the National Patient Safety Foundation.

Andrew Lyzenga: Great, thank you so much. Next we have Andrea Gelzer. Are you on the line, Dr. Gelzer?

Sounds like she may not be, so we'll go ahead and move to Kevin Haynes.

Kevin Haynes: Yes, hi. This is Kevin Haynes. I'm a pharmacist and an epidemiologist doing pharmacologic immunology research as a clinical epidemiologist at HealthCore which is a wholly owned research subsidiary of Anthem. I'm also a data core co-lead within the FDA Mini-Sentinel System. I have done a lot of patient safety, health information, technology research when I was at the hospital at University of Pennsylvania with microbiology text page alerts to providers to improve SCIP 3 performance. And now, I'm in a role within a large, ensure, still thinking about patient safety and the impact of health information technology.

Andrew Lyzenga: Great. Thanks, Kevin. And Laura Heermann Langford? Are you here, Laura? Looks like we may be missing Laura.

Next will be George Hripcsak.

George Hripcsak: Hi, there. I'm Chair of Biomedical Informatics at Columbia University, Director of Medical Informatics Services at New York-Presbyterian Hospital. I build the HR and I was co-chair of Meaningful Use.

Andrew Lyzenga: Great. Thank you. Next is Jason Jones.

Jason Jones: Hi, Jason Jones from Kaiser Permanente. I work on decision support and in particular point of care decision support. In the last month, we've seen good and bad out of that as it pertains to HIT. We had two physicians who have been practicing together for fairly 15 years, have a wonderful conversation around their predictive model that helped their relationship, but we also got tripped up by one region starting patients ages in the EMR as YEAR and another is YRS but caused – it didn't cause a safety event but it tripped us up in training for quite a while. So, really looking forward to these discussions.

Andrew Lyzenga: Great, thank you. Next we have Adjhaporn Khunlertkit. Adjhaporn, are you on? Looks like we're missing him.

Andrew Lyzenga: How about William Marella?

William Marella: Hi, this is Bill Marella from the Patient Safety Authority in Pennsylvania.

Andrew Lyzenga: Hi, Bill.

William Marella: And I'm the Program Director for the Patient Safety Authority Surveillance and Response System. I also work for ECRI Institute as Executive Director of Operations and Analytics. And basically, you know, all the programs that I'm associated with are seeing more and more Health I.T. related or at least mediated events. And I've done a number of studies in that area. And I'm looking forward to, you know, working on some of the safety issues around that, as well as a number of years ago, through ECRI, I worked on the National Quality Measures Clearinghouse (for ARC), which we still run. So I'm looking forward to work with the committee.

Andrew Lyzenga: Great. Thank you. Next, we have Dena Mendelsohn.

Dena Mendelsohn: Hi, everybody, this is Dena Mendelsohn. I'm a Policy Analyst at Consumers Union, the policy and advocacy arm of Consumer Report. I focus in health information technology along with the number of other health policy topics advocating from the consumer perspective, and I have a background in quality measurement. I'm looking forward to joining this group.

Andrew Lyzenga: Thanks, Dena. Next, we have James Russell.

James Russell: Hi, I'm Jim Russell. I'm a pharmacist here at Epic. And I'm also our patient safety officer so I have a lot of experience around patient safety-related information for medication management and also working towards other patient safety initiatives that we have here. And I feel for Hardeep because I've done many calls from the U.K. like he has.

Andrew Lyzenga: Great. Thank you. Next, we have Eric Schneider.

Eric Schneider: Hi, everybody, Eric Schneider on. I'm a general internist, primary care internist, by background and training, currently Director of RAND's Boston office. I'm a Principal Researcher at RAND, but in transition, actually, by February, I'll be Senior Vice President for Policy and Research at The Commonwealth Fund.

So, almost 20 years of experience in quality measure development and evaluation and also in the patient safety assessment. And (of course, we're using) consumer (mission) and caregiver, you know, gathering that information to, you know, promote safety in care. I've also done some work through RAND on the safety characteristics of health information technology systems and how to identify and mitigate those risks. That was also joined with ECRI Institute. Hi, Bill.

William Marella: Hi.

Eric Schneider: I've also been co-chair of NCQA's Committee on Performance Measurement for several years. And for over 10 years, I've worked on the National Quality Measures Clearinghouse as a contractor to ECRI. And so, I'm really looking forward to this panel. Thank you.

Andrew Lyzenga: Thank you. Next up is Mark Segal.

Mark Segal: Yes, I am Mark Segal …

Andrew Lyzenga: (Can you hear me, Mark?)

Mark Segal: Yes, I'm here. I was just on mute. All right, hello, everyone. I'm the Vice President for Government and Industry Affairs for GE Healthcare I.T. and a political scientist by training. Although I'm also the Chair of EHR Association and have been involved in the issue that this committee's going to be addressing in my work with EHRA, with the bipartisan policy center of health I.T. safety project and helping to drive our involvement with the ECRI Health I.T. (TSO pilot) and other initiative. And then within my work at GE and more broadly in the Health I.T. developer community, have been focused on both patient safety policy and product issues, and the use of quality measures in EHR as another Health I.T.

Andrew Lyzenga: Great. Thank you. And then finally, we have Karen Paul Zimmer.

Karen Paul Zimmer: Thank you. So I am an active pediatrician and researcher, and I was a former medical director for both ECRI Institute PSO as well as our Patient Safety Risk and Quality Group, where I oversaw the clinical direction that was also responsible for supervision of the analytic development of tools and dissemination strategies and solutions and lead for the Health I.T. My work extends from implementation of I.T. and QI program both at Hopkins to leading several of the AHRQ and ONC HIT government sponsors collaborative. Thank you and I'm really forward to it.

Andrew Lyzenga: Great, thank you. (Inaudible). So that is our committee. We've got a great group together. We're really looking forward to working with you over the next year, so …

David Hunt: Hi, Andrew …

(Crosstalk)

Andrew Lyzenga: Yes.

David Hunt: Hi this is David, David Hunt at OSD. I just wanted to say hi to everyone also.

(Crosstalk)

Andrew Lyzenga: Absolutely.

(Crosstalk)

Andrew Lyzenga: Yes, go ahead.

David Hunt: All right.

Laura Heermann Langford: Laura Heermann Langford also joined in late, my apologies.

Andrew Lyzenga: OK. Laura, do you want to give us a quick introduction of yourself?

Laura Heermann Langford: Oh sure. I'm Laura Heermann Langford. I'm a nurse informaticist that works for Intermountain Healthcare. And I work a lot also with HO7 in a patient care committee and (HAE) and the patient care coordination committees. And so I do a lot of work within standards and applying them to informatics and nursing.

Andrew Lyzenga: Great, thank you so much. Yes, sorry. David Hunt is our government task lead for this project too which is being funded through the Office of the National Coordinator. David, I don't know if you want to say any remarks to introduce yourself or anything about the project.

David Hunt: Sure. Thanks so much and I want to thank all of you for the time and your (counsel) in working with this project. And as you heard, for those of you who don't know me or haven't worked with me, I'm David Hunt, I'm a general surgeon here in the D.C. area and one of the leads on patient safety in the Office of the National Coordinator.

I've been privileged to actually work on a few of the HHS safety programs notably designed SCIP and the Medicare Patient Safety Monitoring System. So we are so absolutely thrilled to get this work going here at ONC, and it will dovetail very, very nicely into a number of other projects that we have going on. And I'm hoping that we'll be able to unveil some of that as time goes on through this work. But again, I want to thank all of you for your time in this project. Thanks.

Andrew Lyzenga: OK. Thanks David. All right, so I'm going to turn it over now to Adeela who's going to just give us a little bit of background on NQF and sort of some background on this project and the project scope.

Adeela Khan: Thanks, Andrew. So for those of you who haven't worked with NQF before, the National Quality Forum is actually a private non-profit voluntary consensus standard setting organization. The NQF, we operate under a three-part mission to improve the quality of American health care. Our aim is to build consensus on national priorities and goals for performance improvement and work in partnerships in order to achieve them. We endorse national standards for measuring and publicly reporting on performance, and we also

aim to promote the attainment of national goals through education and outreach program.

We have our own governance and leadership led by our Board of Directors. We have 21-plus standing committees, currently at NQF, and our membership is actually broken up into eight councils. These councils are consumer, health plan, health professionals provider organization, public and community health agencies, purchasers, and the supplier industry, and last, the quality measurement research and improvement council.

Going on to the next slide, I just wanted to give an overview of our project. Under the guidance of this committee, NQF will be assessing the current environment related to the measurement of HIT safety events and construct a framework with key stakeholder input on a set of recommendations for priorities, for performance measurement to improve the safety of HIT. This framework that we're going to be developing will also include a measure gap analysis and recommendations for gap-filling, and also best practices and challenges in measurement of HIT safety issues to date.

Next slide. The committee's primary work will be to provide input and guidance towards the development of a set of recommendations, which will be our final framework around the measurement of HIT-related safety events. To develop these recommendations, the committee is going to be synthesizing the current evidence around Health IT and safety – sorry, we're fixing the slide deck here. We'll be providing input and direction on the development of a conceptual framework for analyzing measures and safety in HIT. We'll be identifying all relevant HIT patient safety measures that are currently available. Identifying priority, measurement areas, identifying high-priority measure gaps and making recommendations. And lastly, we'll be identifying challenges to effective performance measurements such as the limited infrastructure, currently available for information exchange and lack of evidence.

Just a quick overview of our project timeline. We just wrapped up, meeting our multistakeholder committee which is all of you. Right now, we're kind of in our second phase of work. We'll be talking more about the environmental

scan later during this call. But during this time from now until August of 2015, we'll be working to finalize the environmental scan and also begin working on our conceptual framework. During the third and fourth phases, which last up until February 2016, we'll be finalizing the framework and sharing it with NQF membership for public comments.

At this time, I'll turn it over to Ann, who will be going over the role of the committee.

Ann Phillips: Hi, this is Ann Phillips and your role as members of the HIT safety committee will be to provide guidance on identification of best practices, challenges, and barriers to measuring and presenting HIT-related safety events. You provide – sorry, high impact measures and measurement areas. You provide input on all phases of the project, guidance on our environmental scan, guidance on our framework development, and you'll ask as a proxy for the NQF multistakeholder membership in the general public, and to review and adjudicate input from stakeholders and the public.

Andrew Lyzenga: Thanks, Ann.

Adeela Khan: Does anyone have any questions before we move on to the environmental scan? OK.

Andrew Lyzenga: All right. (Inaudible). So I'll just go over a little bit. We're – As I mentioned, this is sort of a non-traditional project for NQF, our traditional work revolves around the review and evaluation of measures that are submitted to us before evaluation as well as some other work around selection of measures, making recommendations to HHS, around selection of measures for use in federal programs and then some other work as well. But this again is a little bit new, a new type of project. We've got a number of things going on along these lines right now.

But in previous projects or if we're working on a (CDP), I would be telling you, you know, we've got a very structured process. I'll be going through that with you. We've got guide books and all kinds of resources and materials. Whereas, here, we're in some ways, it's kind of, you know, building the plane as we're flying it to some degree. We've done a good bit of pretty work in

establishing sort of our research plan. But we're continually refining that and are going to be working on it continually until we come to the in-person meeting and get some input, additional input from you on finalizing it. But we really are looking to get your engagement and guidance on, as Anne mentioned, all phases of the project including the environmental scan and the development of the framework.

Just as sort of giving you what the sort of purpose of this project to – kind of envision that primary research questions that we are still part of the environmental scan is to find out what is known from the existing literature about measurement and prevention of HIT-related safety events. There are sort of a number of sub-questions that kind of follow from that. What is the most effective way to monitor for it and identify HIT-related safety events? What measures of HIT-related safety events currently exist? Under what circumstances do HIT related safely events occur? How should they be categorized? What kind of barriers exist? So these are all sort of questions that we're looking to explore through the environmental scan that focused primarily around, again, issues related to measurement and how to identify HIT-safety events and measure how well providers and institutions are doing that, ensuring HIT safety; so, again, sort of looking at all of these through the lens of measurement primarily.

Now, the basic approach that we're taking so far as staff is – and this is roughly adapted from a sort of framework approach to qualitative research and health care as described by Pope and colleagues in 2000. Our basic approach is and what we've been doing to this point in addition to working to get the project started up and see if the committee and so on is – to do some preliminary reading and research to gain greater familiarity with the sort of general scope and nature of the literature and other information in this topic area.

Our next step and we've been working to some degree on this as well is to identify conceptual or thematic framework through which the information that we gather can be charted, organized, analyzed and sort of made sense of in a some sort of structure then systematic way. So that is, you know, part of the project is, is the development of this conceptual framework. We're going to

be – not going to be finalizing that framework until a little bit further down the line. So as we're working on this environmental scan to that point, we'll kind of be working with a tentative framework through which we can sort of filter the results of our environmental scan. And certainly we would like to have some input from you on that as well and we'll be following up around that.

Was somebody going to make a remark or ask a question? No? Sorry, I thought I heard something.

So and then after that, sort of our formal application of our search strategy, we're currently developing systematic methodology through which we're going to, which we're going to follow as part of the scan and then assess the results for relevance. We'll come up with some sort of criteria and decision logic to guide us in those decisions. After that, we'll, you know, index some chart information retrieved through the scan, again, using the conceptual framework as a sort of organizing scheme and a lens through which we'll be viewing the information we gather and then to do some analysis of that information that we've gathered through the scans, key findings from the literature and other resources, implications for measurement of the HIT safety, and we will do our best to summarize those points in sort of getting inventory of, again, key findings and implications for the committee to review and consideration as we're moving forward with our report, with our framework development, and for our identification of priority measures and measure gaps.

So just sort of preliminary parameters for our search, we're limiting, for the most part, two things that are published within the last five years, things that are published in English. We really want to focus specifically on HIT-related safety issues that is not just HIT system issues or patient safety issues in isolation but really the impact and interplay between those two things. For the purposes of this review and this is again something that is evolving most certainly. But at a minimum, we think we want to include EHRs and EMRs, CPOE systems, decision support system, and some of those systems around radiology, picture archiving and communication systems, as well as some of the HIT systems around laboratory work. And we would love to get input

from you all on kind of narrowing down or broadening the scope of the project as appropriate. We'll again be following this. It's not really the time on this orientation call to get into that, just yet but we'd certainly love to get your input on all of these kind of ground-laying parts of the environmental scan so that we know we're heading in the right direction, that we're covering our faces, that we're looking at the most appropriate and relevant information, and that we're getting you the information that you need to make your best assessment of the landscape and to make recommendations in this area.

We'll be looking at PubMed, doing a number of searches there. We'll be doing a bit of general and also targeted outreach to our membership as well as the broader public. As part of this project, we've planned for a call, a little bit later on in a project to – a sort of open call for best practices and challenges and just input from the broader public around these issues. And we'll be doing that, I think, in the fall of 2015. We'll be working with our membership department on that.

We'll be reviewing our NQF portfolio of endorsed measures obviously looking at National Quality Measures, Clearinghouse, the CMS health indicators, warehouse, and inventory, previous environmental scans conducted by NQF. And then also we're really looking to you as our advisory committee to give us advice on other resources, materials, unpublished work or anything that we have maybe missed or not identified in our preliminary search as well as people who you think are not on this committee but that we might want to talk to, who may have valuable input or insights into this area, maybe who have experience with some measures or measure concept in this area. So we'll look to you to sort of give us both input and suggestions on other places to look as part of our scan and our investigation of this whole sort of environment and landscape.

As I mentioned, we're – as part of this project, we want to develop a conceptual framework or use a previously existing conceptual framework if appropriate or maybe to adapt, revise, add to an existing framework in order to best suit our project and the needs of our project. We've identified several, sort of major frameworks out there in the literature to this point and that we're considering using sort of as our, at least a preliminary framework through

which we can organize the results of the environmental scan. I'll just run over a few of those very quickly. I'm sure most of you are probably familiar with the eight-dimensional socio-technical model that was developed by Dr. Singh on this committee and his colleague, Dean Sittig, that has eight dimensions of you know, sort of HIT-safety related issues, eight domains, different categories of problems or areas where issues may arise in HIT.

On the next slide, there's sort of a graphic presenting sort of the more interaction between those different elements and domains and, again, we'll – I'm just running over this quickly just to, you know, give you a sense of what we're looking at, at this point. We'll be sending out additional information in the coming weeks and months to get more input from you on this.

We go to the next. Another model we're looking at is the one developed by (Bobby) and colleagues, which has been used in a number of assessments of HIT safety events in the literature as well as sort of those five main categories that are broken down into a number of subdomains. It gets maybe a little bit more, sort of granular than the socio-technical model.

And on the next slide, we can sort of see another – this is probably a little too small for viewing on screen but where that is broken out into those human-related and machine-related factors and kind of, again, the interplay between those.

A third potential place to look is the safer guides for EHRs, which have provided a sort of framework of sorts to the UHIC safety issues and problems intended as a guide for hospitals and providers to improve the safety of their HIT systems, but can be useful for sort of viewing HIT problems and categorizing, hence there are three phases -- the safe use of I.T. or – sorry, safe use of I.T. and then monitoring the safety of HIT, and then a number of sort of sub-principles underneath each of those phases. So I'll go ahead to the next slide.

Just to sort of plant the seed in your mind, again, we don't need to have a whole lot of discussion on this call about this. We'll try to that more moving forward, but this, again, to plant the seeds, some things that we might like you

to think about, consider, whether there are other frameworks that you're aware of that we should consider, whether any of the currently identified frameworks would be appropriate for our purposes. Whether maybe some elements or aspects of this framework should be combined or layered on top of each other as we've seen in some other areas of the literature and then what, you know, are some of the practical challenges or issues that we might face in using a framework to classify HIT safety problems and measures, or else, you know, using it as a framework to guide and organize the results of our environmental scan.

With that, I will just open it up to see if there are any general questions, any input on that previous slide, any other questions we've post there at least initially. I know we haven't given you much to work on, but we will be providing you more detailed information in, you know, shortly and trying to do a bit of work via e-mail or possibly another conference call. But, again, I'll open it up to questions or comments or input from the committee at this point. Anybody got any thoughts?

Jason Adelman: Can I ask a question on how you're thinking about safety?

Andrew Lyzenga: Yes.

Jason Adelman: So if we had, if we took an example like a drug-drug interaction alert and it failed to fire for some reason, a drug was misclassified or something, the data were inaccurate. That I think probably, everyone would agree, would be a safety event. But would we rule out or rule in over alerting for drug-drug interactions, therefore the clinicians blow pass them and they don't get used? Would that sort of thing get counted as a safety then at this point? Do you have thoughts on that?

Andrew Lyzenga: Yes. You know, that that is something that we would, at least to a large degree, look to you to provide us, you know, guiding time. It seems like that, you know, from my perspective, that seems like an issue that we would want to at least consider.

Hardeep Singh: Yes, Andrew, I can – this is Hardeep Singh. I can sort of add on that. Absolutely, I think we'll definitely consider that. So one of the reasons we

really like the safer model that I think Andrew showed in the end is because it sort of walks you through some of these three aspects of, you know, I.T. -- the first one being safe technology, the second one being safe use of technology, and the third one being using technology or improved safety.

So what you just mentioned, and I couldn't catch who that was, what you just mentioned is inappropriate use of technology. And in fact, the model, the paper where this just came from was, it was a paper in New England Journal two years ago where we've specifically given an example of over-alerting safety problem for that place, too, if you will.

David Classen: And, Hardeep, it's David Classen. We're actually already measuring that in the EMR flight simulator we developed which is actually safe practice for CPOE and the NQF safe practices. We're actually measuring the rate of over-alerting as a safety issue.

Hardeep Singh: Yes.

David Classen: And 900 hospitals took that test last year. So we have a dead-on, on a lot of hospitals.

Andrew Lyzenga: Great.

Gregory Alexander: This is Greg Alexander. I'm curious how you will incorporate different environments, for example, going for acute care to long-term care? How are you going to – how would you think about to continue carrying the patient safety issues and identification of safety issues and acute care versus long-term care? I would assume you'd want to get, perhaps, use of technology across settings, but I wasn't really clear on that in your presentation.

Andrew Lyzenga: Yes, that's it. That’s a good question. I think to the extent that we can, we would like to certainly look at those issues to become a question, you know, to some extent of our capacity in the scope of the project. So that's, again, something I think we would look to you for guidance on what the, you know, most appropriate scope of our review should be. I think we can also – we'll also be consulting with Dr. Haynes on those issues. I don't know if, David, you have any thoughts or input on that question from your perspective.

David Classen: I do. But I don't want to sort of spoil the well just yet. I like the idea that if folks are starting to think about these things, and I think to some extent, defining the contours of where we'll go in this will be largely up to the group. But I do have some very definite ideas but I think it's probably best to hold off sharing them right now.

Andrew Lyzenga: Fair enough.

Gregory Alexander: With your discussion a little bit about – I mean one bullet point on one slide where he did talk about the health information exchange …

Andrew Lyzenga: Yes, yes.

Gregory Alexander: … and early on, I mean, there are some issues that you've raised in here that I would think was spread across different venues here.

Andrew Lyzenga: Yes, I would tend to agree, and I think that has been our preliminary thinking to this point. And, you know, we'll be continuing to sort of explore the literature in this preliminary stage and try to refine, you know, our scope. So we'll definitely be looking for you again for guidance and input on that. So, more to come on that. But it sounds like there's interest among the group in at least trying to look at some of the transitions of care these information exchanges between settings of care. And I certainly think that does sound appropriate.

Karen Paul Zimmer: This is Karen, one quick question. If we have some additional thoughts of framework, should we e-mail those? And to whom?

Andrew Lyzenga: Yes, absolutely. You could e-mail them directly to us. We've got our contact info at the end of this slide presentation. Or you could also circulate it to the broader group of the committee and we would love to get some, you know, discussion going via e-mail. So you know, if you want to just send it out to the group with any thoughts that you have, and we can get some reactions from the rest of the committee on it, or if you'd just like to send it to us, we'll certainly bring it into our, you know, consideration and then probably provide it for the committee at some point anyway for their review. But we would

love to get those kinds of suggestions and ideas and things that we may have missed or overlooked or just not found yet.

Karen Paul Zimmer: OK, great. Thank you.

Andrew Lyzenga: Any other questions or thoughts or comments?

William Marella: This is Bill Marella. I just had one additional thought. You know, one of the things I was looking to see in your presentation was, you know, what the scope of this was going to be. And, you know, I think you addressed sort of what applications you're talking about putting in the scope and we just talk a little bit about settings of care. And I guess I'll just add to that sort of what is the object of measurement that is of interest? So, you know, if you think about the EMR, the components of it as designed, the design is largely sort of in the hands of vendors. As you move in to implementation, it's sort of a shared responsibility between the vendors and the provider organizations. And then when you get into actual use, you're really talking about things that are more in the control of a provider organization, and the clinical users.

And so, I guess I would just add to the framework that we conceive of, you know, measurement as I guess the objects of measurement as being within the control of those groups at different stages of development. And that, you know, we you know, look at that when we try to assess where the gaps exist.

Andrew Lyzenga: Yes, absolutely. That's a great, great point ,and we certainly want to incorporate that into our thinking, our framework, sort of where we want to look, who we want to look to measure and how, and, you know, when. And all of those questions are very much in play, I think, in the things that we want this group to think about and give us input on.

Hardeep Singh: You know, this is Hardeep again. I agree, Bill. I think what you're also getting us to think about is what are we measuring? So, you know, you can't really measure what you can't define. So I think we should sort of think about, you know, what is an HIT safety event and a concern or whatever you decide to call it. And so, again, centered around, Andrew, I'll send it to you, we had a paper and – actually, David Classen, you know, and I had a paper where we sort of walked through the types of HIT related safety concerns.

And I think it covers almost all areas because it's very generic. It's actually setting agnostic, application agnostics. So, it sort of covers the broad overview, I think, of the two we're suggesting. So I'll be happy to send that paper (around).

Andrew Lyzenga: OK, great.

Hardeep Singh: I'll send them over.

Andrew Lyzenga: Great, thank you. Any other comments or thoughts of questions? All right, while hearing none, we will – I'll turn it over to Ann again to just give you an overview of our next steps. Some of the things that are coming up in the future and over the course of this project. Go ahead, Ann.

Ann Phillips: OK. The NQF meetings department will contact you each individually in January to arrange your travel logistics. Our in-person meeting is a full committee is February 18 to 19. We're going to have a post-meeting webinar similar to this format. Tuesday, we'll have two, two hours each, Tuesday, April 21st, Tuesday July 21st. We'll have a second in-person meeting of the full committee on September 16th and 17th, 2015, and we'll review our draft report in a post draft report call, Tuesday, January 26th, 2016.

Adeela Khan: You should all have calendars holds for all of those appointments.

Ann Phillips: Yes.

Adeela Khan: And if you don't, just let us know and we'll make sure that you have those. And also, if you have any assistants that we haven't contacted yet, just again, let us know and we'll make sure that they're CC'd on all of your correspondents.

Ann Phillips: We use SharePoint as our final method of document sharing and collaboration. And you should have all received your logins from the Nominations Committee I think earlier probably Monday afternoon. And if you've got any problems accessing SharePoint, you would contact webhealth@qualityforum.org or any one on the project team can forward your issue to (Web mail).

Sometimes we have login issues. Any of us are happy to walk you through SharePoint. It's pretty simple. Those of you who have done NQF projects with us before are probably familiar with that. But this is – we've got a committee reference, library of papers that we've been collecting, and your additions are welcome. I can put those up.

We also have all your meeting calendar and call documents. You'll be able to refer to this meeting by day and run through the presentation if you've got any, if you want to take a look back at it again. And I think that's about it for SharePoint. Please contact us as soon as possible if there's any problem accessing it.

Andrew Lyzenga: Thanks, Ann.

Ann Phillips: And then, this is our project contact info. Andrew, Adeela, and myself, correct direct e-mail. And then you can dial in on the NQF main line and ask for any of us as well.

Andrew Lyzenga: Thanks, Ann. So, that's actually all we've got for now. Again, I would open it up to any comments or questions from the committee if anybody has got anything to add or anything you want to, you know, discuss or say to your colleagues on the committee, any thoughts.

Male: Would – are the slides going to be posted? And when will we expect them to be posted to the SharePoint?

Andrew Lyzenga: Yes, yes, we'll post them up, you know, probably …

Female: Yes, I posted them.

Andrew Lyzenga: Oh, they're posted up already.

Female: Yes.

Andrew Lyzenga: So, if you've got your SharePoint login, you can go ahead and go in there and should be able to access it. If you have any trouble with that, just let me or any of the project team know and we'll walk you through it.

Male: Excellent. Thank you.

Andrew Lyzenga: Yes.

Hardeep Singh: So, Andrew, this is Hardeep again. I think it will be useful for at least me just to sort of clarify in my head.

Andrew Lyzenga: Yes.

Hardeep Singh: What would be sort of some of the deliverables that would come out? And what sort of stakeholders would this deliverables impact? I mean are we trying to change policy around this? Are we just trying to sort of clear reports so that some stakeholders could look at this? Have we got some of this being endorsed? I mean just sort of get a, give us some thoughts or ideas in general what were you thinking?

Andrew Lyzenga: Sure. So, the deliverables for the project will be, one, the environmental scan, the sort of review of the landscape in this area. which we'll be putting to a final report from the project, the development of this conceptual framework, which will also be in the final report, and the report will also include some best practices and challenges and measurements that we've identified. So, again, all within that sort of final report. There are some different elements of that. That's basically our deliverables for the project.

In terms of audiences, I think to some degree all of those audiences that you mentioned certainly to influence or, you know, provide input to policy and policy makers, to all, you know, the public at large, stakeholders in the quality enterprise in terms of future measure development, you know, to the extent that we are identifying measures or measured gap for priority measure areas, we hope that we'll, you know, be an influence to the field and to sort of spur or accelerate development in those areas of measures of HIT safety. And I don't know, David Hunt, did you have any addition?

David Hunt: Yes, thanks. Thanks so much. I think that one other very important use of the work products from this project will be to help inform and to help guide any activities that we may have here at ONC or HHS along the lines of developing

a Health I.T. Safety Center. There is no surprise and no secret that we have a number of other projects that are focused on what's something like a Health I.T. Safety Center might look like. And in as much as we are able to go forward with any of those, the hope and the thought is that this component, this work that you're doing with this group will serve as the intellectual base for the measurement piece for any measures or priorities that are moved on or executed through such a center.

So, if – in other words, with other resource availability, we would have combined all of the work under one large umbrella contract, but for any number of reasons, this is actually a separate opponent. But the expectation is that it will slide in almost seamlessly to any work that we're doing that will help us think and inform in Health I.T. Safety Center.

Hardeep Singh: So, David, that's really good to hear. One of my sort of thoughts about that is I think from what I hear (from memory) conversations, I think there's a lot of emphasis on things like reporting and, of course, we know that there's a lot of issues of that, not many events get reported in time that we don't – we have a good system to collect HIT safety related, you know, events support.

So, with that said, I mean, would – let's say, for instance, David mentioned that there are some sort of – David has been running – (inaudible) and David, feel free to speak after I do. But would there be opportunities to create other measurement mechanisms that are a bit nontraditional and go beyond sort of safety reporting which, you know, may or may not work, but also has not been standardized very (well), especially they are talking (inaudible) HIT-related events. Are we able to influence, number one, things such as the AHRQ Common Formats, and two, things such as going beyond traditional reporting and going into other things, measurement of other, you know, related to other techniques?

Andrew Lyzenga: Yes, so I think those are also appropriate audiences for the work that we're doing again for my perspective. And I don't know if you have anything to add on that as well, Dr. Hunt? But we – again, we have a couple of members of the Common Formats Panel here. And certainly, they will be, you know, hearing what we say and participating in this discussion. And I would

anticipate, you know, in speaking with their colleagues on the Common Formats Panel and at AHRQ to talk about our findings and our recommendations and consider those in the context of their work as well.

David Hunt: Yes. And I'm hoping that as everyone gets real acclamation to the group and understands and takes a look at who has been assembled to work with us, I'm hoping that it will begin to approximate some form of intelligent design. That is to say that the expectation is that these projects will help influence not just one individual aspect of our patient safety work here at ONC, but there'll be strong cross-pollination among the various groups that represented. Many of you actually are wearing more than one hat, some two or three hats, in projects that are, that you're working with us as HHS and with other groups with. And that was (though) the entire point to this.

My fear of fears is that as we make – as we engage with all of these somewhat parallel projects, that once we go to assemble the pieces together, one part will seem almost orthogonal to all the rest. And so, the idea of having group members that actually serve in multiple capacity is one attempt to try to make sure that this all looks like a coherent whole when viewed from far away from someone saying, well, what is HHS doing in patient safety and health I.T. patient safety specifically? So, the thought is that hopefully there will be a tremendous amount of overlap.

Now, to that end, I have every expectation and hope that those of you who are on multiple other committees will bring the benefit of your deliberations to these panels to our meetings and to our discussions. Don't hesitate to step up and inform the larger group over some of the things that are happening in your respective other projects. And if you think it's necessary, we can reach out and bring in more information or more material from those other groups. I have a very good working relationship with most of the other committees and groups that you are also manning.

So, it's a long way of saying I really hope that we'll get the benefit of all of your experiences in this domain with the final expectation that, again, this does not look drastically different or dramatically out of sync with other projects that have obviously similarly aligned goals in patient safety.

David Classen: And, David, hi, this is David Classen. I chair the NQF Experts Panel Committee. We welcome the input of this committee as we continue to have all the Common Formats, especially our HIT Common Formats, which I hope we can send out to everybody on this committee so they can see it.

Male: That will be great. Thank you, David.

Andrew Lyzenga: Thanks to both of you. Any other thoughts or questions?

Well, seeing as we've got almost an hour left actually for a scheduled call, we will let you go pretty soon. We just wanted to kind of pick your brain one more time or just get maybe preliminary sense of what your perspective is on the frameworks and question again, whether one or more of the frameworks we just presented or any other framework that you're aware of might be a good, at least a good starting point for us to focus on in terms of sort of framing the work that we're doing in the environmental scan, organizing the information that we get from that, and trying to, you know, kind of classify it and make sense of it. Does anybody have any thoughts on what the best sort of framework would be to use for those purposes or just, you know, thoughts on some of the strengths or weaknesses of any of them? Just any input that you might have. Again, I don't, you know, we'll sort of get some more – we'll try to get some more input from you on this later on, but I figured that, given that we've got a little bit of time left, we might as well post the question to you tentatively anyway.

Gregory Alexander: So, this is Greg Alexander. Some of the frame – some of the really nice frameworks that I've found have been really across disciplinary or multidisciplinary where you have sort of engineering and clinical and human factors type of components, all sort of embedded into a nice framework that you'd – where you have the technology piece. You also have the human computer interaction piece. You have something that relates to the clinician and the workflows.

And so, those – for example, the framework, it comes out of Wisconsin with (Patty Brennan) and (Her Gary) about there, is a pretty – there's a framework. I can't remember the name of it off the top of my head, but it's – those kinds

of frameworks are nice in a sense that they really capture a lot of the concepts that we're dealing with.

Andrew Lyzenga: OK, great. Well, that's something we'll definitely look into.

Karen Paul Zimmer: This is Karen.

Andrew Lyzenga: I think …

Karen Paul Zimmer: I'm sorry.

Male: No, go ahead, Karen.

Karen Paul Zimmer: I was just going to say I believe when you mentioned the three frameworks, you suggested that the ultimate framework may actually have some additional sources added on top of it. And I appreciate the last comment because we do want to make sure that the frameworks we choose do include enough about the human factor's component, as well as issues before they happen. And I'm thinking of hazard manager. But that we (often) think of events when (maybe) they reach the patient regardless of harm, but I'm really thinking of events even before that. So we need to think of it as a continuum of where – a continuum of action points and finding a framework that will address all those different action points.

Andrew Lyzenga: Great, that's really helpful. Any other thoughts?

Gregory Alexander: I'll just have one. There is a framework called the nurse-patient trajectory framework. It's targeted at nursing, but really could be other clinicians as well as this was written by a nurse. And then it's the – the interesting thing about that framework is that it takes into account patient trajectories involved in safety and also clinician trajectory. And they often look at those opposing points of view even though they may have lots of interconnections with each other. There's a different set of variables in patient safety that patients will experience or be concerned about versus the clinician. And I think we have to be very careful to look at both sides. And I'm glad we have a patient safety advocate on our group to help us remember to do that because they're very

different and we need to make sure that we're addressing issues with both of those angles.

Andrew Lyzenga: Great, very good point. Thank you.

(Crosstalk)

Eric Schneider: This is Eric Schneider. Another thought, sort of throwing in the mix on frameworks. One of the insights (derma) report that we did for Office of the National Coordinator and Karen Zimmer was involved and (Bill Murillo) involved in this was around the different frameworks that risk management departments, quality improvement and safety departments and I.T. departments were using. And so – or actually, it's a difference of language and the way they're conceptualizing events, what constitutes the safety event and the causation.

And so, I don't know what other frameworks exist from risk management, the patient – what people are typically using in patient safety and quality improvement departments of hospital say or clinics. It sounds like we've got the expertise on this panel to represent those perspectives. Whatever framework we land on would be very powerful if it's spoke to or it could be translated into the language of those different audiences, group, several of them. In our project we conducted, some of those departments had never really met together, which presents one of the kind of startling insights from my perspective.

Andrew Lyzenga: OK, great.

Adeela Khan: And one other point I was just thinking about is as we also think of these frameworks, we have to keep in mind who is inputting the data into this various frameworks because we did see with hazard manager very different descriptions and very different types of reporting based on the user. So, I would just ask, if we develop these frameworks, we keep the end user in mind as well as the stakeholders that I know (Bill) he had mentioned earlier.

Tejal Gandhi: Hi, this is Tejal. I just wanted to add to that because I totally agree, we need to keep the end users in mind. But I also would like to make sure we pick a

framework that might reflect some of the new or more innovative ways to obtain this kind of safety hazard information. I don't want to rely on reporting, for example, to really identify all the hazards. So, if we're going to be using things from other sources, whether it's help desk, tickets, or whether it's, you know, pulling data automatically at EHRs, like the work Jason did at Montefiore, you know, the frameworks need to accommodate that as well.

Andrew Lyzenga: Great. Thank you.

Lisa Freeman: This is Lisa Freeman calling. Following up with just said, I think, too, that it would be really good if when we look at reporting of these events and potential events that we in some way involve an opportunity for patients to do self-reporting because very often I think we're aware of things that are happening that providers and other people where in the caregiving capacity may not be aware of.

Andrew Lyzenga: Sure. OK. Thank you, Lisa.

Jason Jones: This is Jason Jones. I know we're sort of focused on the safety part, but I'm curious as to whether the frameworks balance the safety or, you know, what can go wrong with some of the benefits of why we have like HIT and decision support and other elements in the first place. I'm not sure if any of the people who have published on that or thought about it can comment on benefit and the context of safety. And I would sort of look at some of our measures, for instance, of quality and then around the hospital as often largely based on avoidance of iatrogenic harm as opposed to benefit to patients and wonder how we're going to balance that in a framework going forward.

Andrew Lyzenga: Yes, that's actually a good question. And, yes, go ahead.

David Classen: This is David Classen. I was on the (island) committee that published report on health I.T. and patient safety (inaudible). And we felt very strongly about that. And if all we did was measure safety in terms of harm generated by the HIT, we're missing a huge opportunity. We felt very strongly that we should have measures of whether the HIT actually prevented harm as well.

Andrew Lyzenga: Very good.

David Classen: Very strongly. In addition, we built a lot of the frameworks you're building. So, I'm sure you've seen that report, but we spent two years building frameworks as we're outlining it.

Andrew Lyzenga: OK.

(Crosstalk)

Andrew Lyzenga: I'm sorry, go ahead, go ahead.

David Classen: And the only thing I also I'd add is the patient perspective on all of this was of great concern to the committee, and that any framework that didn't include their perspective was not adequately measuring safety in HIT.

Andrew Lyzenga: OK. Any other thoughts or comments, suggestions? All right, well, we've gotten some very good input and feedback already. We will be following up with you again in the next weeks or months to try to get a little bit more sort of formal input from you on some of these questions and other questions around, again, our methodology that we're following, some of the criteria we're using and so on. So I do look forward to that.

Again, we're very excited to have all of you on our committee. We're really looking forward to working with you in the next year. I'm excited about the project. And, yes, just keep an eye out for messages from us. We'll be reaching out to you with both information for, you know, the project as it goes along and to try to solicit some input and guidance from you on a variety of questions and aspect to the project.

So, please do stay engaged to the extent you can. We really appreciate it, and we're definitely looking to you as experts in the field to help us with this work. So, again, I'm just putting that out there and hope that you will remain engaged throughout the course of the project and, you know, give us the best input you can.

Dr. Hunt, did you have any closing remarks or …

David Hunt: No, just thank you all so much. And it's always wonderful to get the gift of 30 or 40 minutes back, so.

Andrew Lyzenga: Yes, yes. All right, great. Well, yes, and we will give you your time back. We really appreciate you joining us on this call and we look forward to speaking with you again soon and communicating via e-mail. Thanks, everyone. Take care.

Female: Thank you.

David Hunt: Thank you, thank you.

Female: Bye.

Male: Have a good day. Bye-bye.

END