# NATIONAL QUALITY FORUM

**CONFERENCE CALL OF THE PATIENT SAFETY ADVISORY COMMITTEE**

**March 8, 2010**

*PSAC members present:* James Bagian, MD; Jane Barnsteiner, RN, PhD; Bob Bunting Jr., MSA, CPHRM, DFASHRM, CPHQ, MT (ASCP); David Classen, MD, MS; Michael Cohen, MS, ScD, RPh, FASHP; Charles Denham, MD; Dan Ford, MBA; Bruce Hall, MD, PhD, MBA; Helen Haskell, MA; John Hickner, MD, MSc; Nancy Leville, MS, RN; William Maisel, MD, MPH; Denise Murphy, BSN, CIC, MPH, RN; Arjun Sharma, MD; Sam Watson, MSA; Robert Wears, MD, MS, FACEP

*PSAC members not present:* David Knowlton, MA; David Mayer, MD; Philip Mehler, MD; Rita Shane, PharmD, FASHP

*NQF staff present:* Peter Angood, MD, FACS; Eric Colchamiro, MPA; Lindsey Tighe; Andrew Lyzenga, MPP; Laura Miller, MPA, FACHE; Melinda Murphy, RN, MS, NE-BC

**WELCOME, INTRODUCTIONS, AND DISCLOSURE OF CONFLICT OF INTEREST**
Following Dr. Angood's welcome and roll call, he asked the members of the Patient Safety Advisory Committee (PSAC) to forward any pertinent conflicts of interest to Mr. Colchamiro.

GENERAL COMMENTS
Dr. Angood began by noting that the purpose of the call was to continue the discussion of NQF Patient Safety portfolio. The PSAC is asked to focus the portfolio to optimize its current set of activities and begin planning for future planned and potential activities. He added that the committee has been provided with an outline to the structure of its final report; results of January 2010 survey; a crosswalk of NQF's Serious Reportable Events (SRE), Safe Practices (SP), and NQF-endorsed Patient Safety measures (PM) related to each other; and a listing of all NQF-endorsed Patient Safety measures.

PSAC members have been given ongoing briefings on the portfolio, and NQF staff is now moving toward developing a report on PSAC recommendations; which will be utilized as a planning document for NQF in managing its Patient Safety portfolio going forward.

**OUTLINE OF PSAC REPORT RECOMMENDATIONS**
Dr. Angood introduced the PSAC memo and noted its focus on program harmonization, organizational harmonization, and future charge/next steps. These sections were determined from past PSAC conversations and the January 2010 survey.

1. Programs Harmonization

The committee was provided with an example of Medication Reconciliation. In this example, there is an SRE involving death or disability associated with medication error. This can be linked to SP 17 (Medication Reconciliation), which can then be tied to multiple PMs involving medication management. However, if there was not an appropriate Patient Safety measure in this case, a gap would exist. To fill this type of gap, NQF would need to develop a Call for Measures on this subject. Currently, there are several gap areas where the SREs, SPs and PMs

do not have overlap similar to the medication example. So when this harmonization effort is complete, every SRE would/should map to SP(s) and PM(s).
The committee was given three questions to consider: Does this linkage approach seem like a reasonable strategy for assessing and developing complementarity among SREs, Safe Practices, and Patient Safety measures?; If this strategy is undertaken, which areas in the Patient Safety portfolio should be prioritized?; and Are there other program areas within the portfolio that should be incorporated into this effort?

A PSAC member noted that the measures developed, to fill gaps in program areas, would have to be specific to the category that was covered within the SPs and SREs. Another committee member noted the importance of filling the gaps, as the field seems frustrated by the lack of congruence among these and other efforts. One committee member suggested that prioritization of topic areas be based on impact and utility to the field.

While no committee members disagreed with this harmonization approach, contrasting points were made. Some PSAC members said that NQF may find that it is not possible to meld all SREs, SPs, and Patient Safety measures, and that NQF needs to understand the cost-benefit analysis of its efforts before making its system too complex. One committee member said that NQF should consider that focusing on the SREs ties the work to a small set of unambiguously bad occurrences; and leaves out events that are bad but not as clearly identifiable. Committee members agreed that the language used in harmonizing NQF programs should be meaningful and actionable in the field, do not create confusion, and are not duplicative of past efforts.

Another committee member noted the value of this harmonization strategy for the SPs. The connection between the SREs (events that should not occur) and SPs (the approach undertaken to prevent them from happening) was noted, and would be useful for hospitals and other providers of care. It was mentioned that these same providers may also be coming up with standards of their own.

Dr. Angood next discussed the review and revision of the SREs. He noted that the SRE Steering Committee is focusing on events that are happening more frequently; the SREs will create positive change to minimize these occurrences, and create improved learning from reporting. The impending call for SREs will focus on: ambulatory surgical centers, skilled nursing facilities, and office-based practice settings. He also noted that the 28 states with reporting requirements, CDC, and AHRQ have all been engaged by NQF in the effort to reform the SREs, and improve learning from reporting.

The committee will be further surveyed to help articulate how NQF should prioritize its programs and SREs for harmonization; PSAC members will be offered the opportunity to make comments about SPs and PMs.

2. Organizational Harmonization

The January 2010 survey indicated PSAC's preference that NQF should work closer with three organizations that maintain a focus on patient safety issues: AHRQ, The Joint Commission (TJC), and with the Centers for Medicare and Medicaid Services (CMS). Following this strategy, would represent a national level harmonization for patient safety initiatives between federal payment policies (CMS), standards and accreditation (TJC), research and reporting (AHRQ),

and finally measurement with public reporting (NQF). Committee members also mentioned working with The Institute for Safe Medication Practices, VA, and Institute for Healthcare Improvement.

Committee members were asked which programs NQF should present to other organizations. It was noted that TJC can be approached to link the SREs and TJC's Sentinel Events program; TJC's National Patient Safety goals are also another program to consider. Another committee member noted that AHRQ might be interested in NQF-endorsed patient safety measures. Some committee members noted that culture surveys and the AHRQ PSIs may not be the best avenues for NQF to consider in terms of its harmonization efforts. Dr. Angood noted the value of the broad based initiatives of the National Priorities Partnership as a way to gain initial consensus from partner groups.

The PSAC suggested that it would be valuable to get NQF together with these partner organizations, but to simplify its focus on one program at first. The committee will be further surveyed to assess their thoughts on which specific programs NQF should look to harmonize its efforts with.

3. Future Charge and Next Steps

Dr. Angood reviewed the PSAC's past conversations about how NQF's Patient Safety portfolio is structured. PSAC members agreed on the need to focus NQF's efforts, and that outlining the steps necessary to improve Patient Safety may not be the best approach to consider.

Committee members noted the value of NQF's role as a convener, but also added the difficulty in finding funding for this type of initiative. PSAC members also suggested continuing education, such as device safety, patient, and family education programs, as convening activities that could inform the patient safety portfolio.

Another PSAC member suggested that NQF build on the Safe Practices to gather information about usability evaluations and other areas where NQF can raise consciousness and bring attention to the field.

**REVIEW OF CURRENT NQF PATIENT SAFETY INITIATIVES**

Dr. Angood next led the committee into an update of ongoing initiatives:

- **Serious Reportable Events in Healthcare**

The SREs, mentioned frequently during the call, are under revision. An SRE definition is being finalized and a call for new SREs will be sent shortly.

- **Patient Safety Measures**

A Call for Measures has occurred, and 42 measures have been received. The Steering Committee is getting finalized, and there are a significant number of HAI and Perinatal measures being considered.

- **Common Formats for Patient Safety Data**

Version 1.1 of the Common Formats, including technical specifications, is being communicated to the field. The formats will be expanded to skilled nursing facilities.

- **Framework for the Measurement, Evaluation, and Reporting of Healthcare Acquired Conditions**

The draft report will be released for public comment on March 15th. Committee members are encouraged to view and comment on this robust document.

- **National Voluntary Consensus Standards for Patient Safety**

Mr. Lyzenga noted that this project has issued a Call for Nominations and a Call for Measures to generate potential committee members and Patient Safety measures for this effort. These calls both subsequently closed on February 2, 2010.

- **Safe Practices for Better Healthcare**

The 2010 Safe Practices update is in final edits, including changes around Safe Practice 22; this includes an ad-hoc maintenance review of this practice, and the use of clorhexadine within SP.

**NQF MEMBER COMMENT**

The meeting was opened to NQF member and public comments. Rita Munley Gallagher, of the American Nurses Association, reminded PSAC members that there is an opportunity to create synergy between multiple NPP working groups and different patient safety initiatives. Ms. Gallagher also noted the work of the National Coordinating Council for Medication Error Reporting and Prevention, which is gathering support to oppose the criminalization of medical errors, and would welcome the opportunity to share that work with the PSAC.

**REMINDERS**

The PSAC will be sent meeting minutes, an additional survey of questions raised in the call, and draft report language.

The Patient Safety Advisory Committee will next meet on Monday, May 24, 2010 via conference call from 3:00-4:30 p.m. ET. Materials and dial-in information for the call will be sent via e-mail prior to the call.