

NATIONAL QUALITY FORUM

CONFERENCE CALL OF THE PATIENT SAFETY ADVISORY COMMITTEE

September 27, 2010

Committee Members Present: James Bagian, MD; Jane Barnsteiner, PhD, FAAN; Bob Bunting, Jr., MSA, CPHRM, CPHQ, MT (ASCP); David Classen, MD, MS; Charles Denham, MD; Dan Ford, MBA; John Hickner, MD, MSc; Nancy Leville, MS, RN; Philip Mehler, MD; Denise Murphy, BSN, CIC, MPH, RN; Rita Shane, PharmD; Arjun Sharma, MD; Sam Watson, MSA

NQF Staff Present: Peter Angood, MD; Eric Colchamiro, MPA

WELCOME AND REVIEW OF AGENDA

Dr. Angood welcomed the Committee and noted that the purpose of this final call of the Patient Safety Advisory Committee (PSAC) was to review revisions and finalize its report, based on recommendations provided by the Committee during its in-person meeting, conference calls, and survey work. NQF Patient Safety project work continues on a rapid pace, including the recent Board endorsement of the *Framework for Reporting Patient Safety Events* report and updates to the Serious Reportable Events in Healthcare project, which will be released in mid-2011. The State-Based Reporting initiative also has done well to facilitate communication among states and between states and federal agencies.

Dr. Angood also noted that the Committee had convened over the past year to advise NQF on its existing patient safety portfolio and to provide insights for future directions for that portfolio. Following this call, the report will be approved by NQF senior management and then posted on the NQF website. Mr. Colchamiro conducted a roll call of Committee members.

PSAC REPORT REVIEW AND DISCUSSION

The Committee next reviewed the edited report. Ms. Murphy asked about the use of the term “never events” and whether it should be included in the report. Dr. Angood noted that the term continues to be used by the Centers for Medicare & Medicaid Services (CMS) and throughout the healthcare reform debate, but he suggested that it was not necessary to make a statement about it within this report. Ms. Shane suggested, and other Committee members agreed, that the current list of all NQF-endorsed[®] patient safety measures be included as an appendix within the report. She added that the report should note the Committee’s previously stated preference of prioritizing measures or practices that help to prevent repetition of the most commonly occurring errors.

Committee members made revisions to the Recommendations section, including changing the term “prioritize harm and guide clearly” to “prioritize harm and provide clear guidance.” Ms. Murphy asked about the phrase “appropriate measures that will be useful to minimizing healthcare acquired infections (HAIs), surgical site infections (SSIs), and Serious Reportable Events.” She asked whether the spectrum of infections should also include those caused by device and multi-resistant drug organisms. Dr. Angood said that a recent National Priorities Partnership (NPP) meeting focused on preventing HAIs and SSIs, and he noted the emphasis placed on SSIs within the HAI Action Plan. The Committee concluded that this sentence on infections should be rephrased to add the word “especially” before surgical site infections, so as to note that there were other infections to be considered. Dr. Angood also added that the report should include the NPP recommendation to augment cross-disciplinary team functioning.

Dr. Classen mentioned the impending Department of Health and Human Services (HHS) Office of the Inspector General (OIG) report on patient safety in the Medicare population, and whether the Committee

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should revise its report further after that report is released. Dr. Angood acknowledged the report; the Committee concluded that after its release, if individuals felt changes to the report were needed, they could move to reconvene and revise the report.

Dr. Mehler noted that CMS will not publicly report healthcare acquired conditions (HACs) and asked whether the Committee's report should offer more directives on the issue of public reporting. The Committee discussed CMS's decision and the use of rates in reporting HACs; committee members felt that the data was not currently reported in an effective fashion.

Dr. Angood said that NQF's *Framework on the Reporting of Patient Safety Events* addresses many of those particular concerns for having valid, publicly reported information. He suggested that the report make mention of the framework report. Dr. Shane said that the Committee should add a sentence regarding the need for integrity and accuracy within publicly reported data, and Dr. Mehler said that there also needs to be mention of accountable care organizations (ACOs). The Committee concluded that once the OIG report is released, it will consider adding a qualifying sentence to the report on this issue.

Mr. Ford spoke about the report's section on how to develop NQF's portfolio in the future. He suggested further addressing the issue of patients and families by adding a sentence that reads "as a matter of principle and practice, patients and families should be invited to participate actively on all related committees in the discussion of future portfolio development." He said that the inclusion of patient advocates in committees is critical and that NQF should continue to do so. The Committee agreed to this revision.

FINAL THOUGHTS

Dr. Angood reminded Committee members that the report will be reviewed by NQF senior management, and he expressed his interest in their reactions regarding the prioritization within the report of events that frequently cause harm (as opposed to rare, serious events).