NATIONAL QUALITY FORUM

Patient Safety Advisory Committee Meeting
October 6, 2009

A meeting of the **Patient Safety Advisory Committee (PSAC)** was held on October 6, 2009, in Washington, DC.

PSAC members present: James Bagian, MD (via conference call); Jane Barnsteiner, RN, PhD (via conference call); Bob Bunting, Jr., MSA, CPHRM, DFASHRM, CPHQ, MT (ASCP); David Classen, MD, MS; Michael Cohen, MS, ScD, RPh, FASHP; Dan Ford, MBA; Bruce Hall, MD, PhD, MBA; Helen Haskell, MA; John Hickner, MD, MSc; David Knowlton, MA (via conference call); Nancy Leville, MS, RN; William Maisel, MD, MPH; David Mayer, MD; Philip Mehler, MD; Denise Murphy, BSN, CIC, MPH, RN; Rita Shane, PharmD, FASHP; Arjun Sharma, MD; Sam Watson, MHA, MSA.

PSAC members not present: Richard Hawkins, MD, FACP; Robert Wears, MD, MS, FACEP.

NQF staff present: Peter Angood, MD, FACS; Helen Burstin, MD, MPH; Eric Colchamiro, MPA; Jennifer Hurst, MHS; Andrew Lyzenga, MPP; Melinda Murphy, RN, MS, NE-BC (via conference call); Emma Nochomovitz, MPH; Lindsey Tighe, MS.

Public audience members present: Rita Munley Gallagher, PhD, RN.

INTRODUCTIONS, DISCLOSURE OF INTERESTS, AND PATIENT SAFETY ADVISORY COMMITTEE PURPOSE

Peter Angood, MD, NQF senior advisor, patient safety, welcomed the Committee and asked the members to introduce themselves and state any conflicts of interest.[1] Dr. Angood then explained the need for a new NQF advisory body to provide guidance concerning the organization's evolving patient safety portfolio. In particular, NQF hopes that this diverse panel of experts will be able to provide critically valuable suggestions and perspectives on current and future NQF patient safety activities. Dr. Angood also identified differences between the PSAC and other NQF Steering Committees and Technical Advisory Panels of the Patient Safety portfolio.

ORIENTATION TO NQF AND PERFORMANCE MEASUREMENT

Helen Burstin, MD, MPH, Senior vice president, performance measurement, briefed the group on NQF's origins as a standards-endorsing body according to the specifications of the National

[1] Dr. Classen—Leapfrog Advisor; Ms. Murphy—involvement with Merck's Six Sigma program; Dr. Shane—representative for the American Society of Hospital Pharmacists and member of the The Joint Commission Hospital Professional and Technical Committee.

Technology and Transfer Advancement Act of 1995, as well as its use of the Consensus Development Process (CDP), used to review and endorse performance measures. The forces that drive quality measure development, such as the needs of pay-for-performance programs, also were discussed. Future efforts by NQF were discussed in the following terms:

- driving high performance in healthcare delivery;
- harmonizing measures across sites and providers;
- promoting shared accountability;
- measuring across patient-focused episodes of care;
- moving toward composite measures;
- measuring social disparities that influence health; and
- using electronic health information in a meaningful way.

ORIENTATION TO NQF PATIENT SAFETY PORTFOLIO

Dr. Angood reviewed NQF's mission and current organizational patient safety activities, which include:

- serious reportable events,
- safe practices,
- patient safety measures, and
- common formats for event reporting to patient safety organizations (AHRQ contract).

Additionally, these NQF efforts to drive quality improvement in healthcare were described as they relate to efforts by the National Priorities Partnership (NPP) to help focus, align, and accelerate national priorities and goals for quality improvement. There are six priority areas for NPP; patient safety is one of the six. Dr. Angood described the initial focus for the patient safety priority, including peri-operative safety, surgical site infection, and cross-disciplinary team function. He also described future possibilities.

DISCUSSION OF THE U.S. PATIENT SAFETY LANDSCAPE AND PERFORMANCE MEASUREMENT

Challenges of Measurement and Reporting

Discussion evolved from the NQF patient safety portfolio to the broader U.S. patient safety landscape. Members of the Committee raised challenges to meaningful measurement and reporting. The issues raised included the following themes:

- reliability of current measurement and reporting strategies;
- inadequate evidence base for several measures;
- measurement often focused too much on controlled settings;
- scientific acceptability of patient safety measures;

- feasibility of collecting data without undue burden on providers, while recognizing that excess burden for measurement from multiple initiatives is leading to improvement fatigue;
- challenges faced by small hospitals with limited resources;
- administrative requirements related to patient privacy;
- appropriate risk adjustment given competing risks;
- establishing accountability across an episode of care; and
- encouraging the implementation of measures without creating a punitive environment.

Despite these challenges, the group provided a number of strategies for increasing the value of measurement, particularly as it relates to patient safety and NQF's current patient safety activities. These strategies may be categorized in terms of data collection and implementation, education, and leadership. Specifically, the following strategies were suggested throughout the Committee's discussion of challenges to measurement and reporting:

Data Collection and Implementation

- the use of electronic health records to facilitate data collection;
- the use of risk assessments to predict patient outcomes;
- templates for reporting that contain information about provider hand-off;
- use of rates for reporting (better than simple numerator data) and need for standardization of denominator (e.g., admissions, patient days, episode of care);
- more measures in ambulatory and non-hospital settings with a focus on efficiency, safety, and quality, as well as more pediatric-focused measures;
- capturing the appropriate scope in measurement (i.e., where most harm occurs);
- unified and flexible structure of reporting that could be applicable to various scenarios and care settings;
- promoting and creating standardized reporting of near misses;
- implementation of accreditation programs; and
- evidence of cost-effectiveness or cost efficiency (need to relate measures to the evidence or lack of evidence).

Education and Leadership

- ongoing need for improving the value of measuring the organizational culture;
- strong leadership in healthcare settings;
- clear communication across disciplines of care and throughout chain of command;
- increased compliance efforts and prioritization;
- patients should be recognized as sources of information and may help to "connect the dots" on information;
- building on existing curricula for education of health professionals specific to safety and quality;

- paying attention to successful measurement and reporting strategies—although no specific organizations or strategies were discussed, it was suggested that encouraging small organizations to "pilot test" projects may promote early adoption.

FUTURE FOR NQF PATIENT SAFETY

The Department of Health and Human Services (HHS) has contracted with NQF for a multifaceted project related to quality improvement, performance measurement, and patient safety. The patient safety deliverables are:

- to define "healthcare-acquired conditions" and expand these conditions to other environments of care beyond hospital settings, which includes reviewing and updating NQF's *Serious Reportable Events*;
- to expand patient safety measures to include other environments of care; and
- to develop an issues framework report regarding the measurement, evaluation, and public reporting of healthcare-acquired conditions.

General Discussion

Several strategies for direct NQF involvement in improving the value of performance measurement and patient safety initiatives were discussed. Members of the Committee agreed there is a need for NQF to encourage measurement across episodes of care and care settings. The standard of care should be set at a high level, yet should avoid encouraging a punitive environment for providers. Some members also agreed with the notion that NQF may be most effective by focusing efforts to a limited scope of activities through:

- emphasizing where the most harm occurs and where gaps in measurement exist;
- increasing preventive oversight to prevent repetition of errors;
- recognizing there is no patient safety oversight agency in the United States and considering if NQF can address this need;
- improving awareness of NQF and patient safety activities; and
- aligning NQF efforts with other organizations of a similar nature.

Suggestions for NQF activity outside of its normal scope included:

- becoming involved in medical education of healthcare professionals and patients;
- participating in the development of patient safety curricula for trainees;
- precipitating standardization, as structural issues of inadequacy persist;
- understanding the implications of public reporting laws; and
- facilitating the organization of a national agency to oversee patient safety, such as the National Patient Safety Agency in the United Kingdom.

PRIORITIZATION AND NEXT STEPS

Members of the Steering Committee were asked to provide input regarding NQF's current projects and future goals. A graphic illustration of NQF's past and present patient safety work (within the HHS contract) was used to facilitate this discussion. The following next steps were identified:

- examining the current use of NQF safety-related measures, *Serious Reportable Events*, and *Safe Practices* (currently in progress);
- using environmental assessment for HHS contract work to identify gaps in measurement and areas for improvement with HAC/SREs;
- expanding the current set of healthcare-associated conditions (currently in progress);
- considering how to implement frameworks for reporting;
- identifying best practices to reduce the probability of SREs;
- endorsing measures that are standardized, applicable, and supported by evidence (i.e., reliability and validity analyses, case studies, etc.); and
- clarifying issues related to the risk burden of events occurring with the cost burden related to implementing patient safety initiatives.

The day's discussion culminated in efforts to prioritize NQF's next steps as the group identified priority areas they believed to be most relevant to NQF's future work. While they did not identify a clear prioritization strategy, they discussed the following areas regarding NQF's future work:

- focusing measurement in areas where the most harm occurs and considering what is best for the patient;
- addressing gaps in performance measurement and patient safety and focusing programs more toward areas where the most harm is occurring and less on the low-frequency issues;
- addressing significant patient safety issues that are not targeted by other organizations;
- using NQF's strength as a convening body and an authority on measurement to encourage the harmonization of reporting strategies across the continuum of care;
- increasing NQF marketing to create greater public awareness, which in turn will encourage measurement and reporting;
- contributing to the creation a culture in healthcare that places high priority on patient safety; and
- encouraging better reporting within the context of understanding the potential burden of doing so.

Following a brief discussion of how NQF can best utilize the group's expertise, the meeting adjourned at approximately 3:00 p.m. The PSAC is scheduled for two more face-to-face meetings in addition to bi-monthly conference calls.

Future meetings will bring sharper focus on the above-stated issues and continue to refine the Steering Committee purpose of assisting NQF in prioritizing of the NQF portfolio of patient safety initiatives and future directions.