THE NATIONAL QUALITY FORUM

PATIENT SAFETY INITIATIVES 2009-2010

Common Formats for Patient Safety Data

NQF, on behalf of the Agency for Healthcare Research and Quality (AHRQ), is coordinating a process to obtain comments from stakeholders about the Common Formats authorized by the Patient Safety and Quality Improvement Act of 2005 (Patient Safety Act). The Common Formats establish a common method for healthcare providers to collect and exchange information for any patient safety event. Use of the Common Formats will ensure consistency of reporting among patient safety organizations (PSOs) as they begin to standardize the collection of patient safety event information through the use of a common language, definitions and reporting formats.

Framework for Measuring, Evaluating and Publicly Reporting for Healthcare Acquired Conditions

On a parallel track, NQF will be convening a steering committee focused on the development of a framework for measuring, evaluating, and publicly reporting HAC/SREs (e.g., raw counts, days free from an event). The challenges involved in producing accurate, useful reports include gaining an understanding about what constitutes a useful report, the availability and maturity of reportable events, and/or measures sets, that convey a well-rounded picture of care, and ensuring that reports support an improved understanding of patient safety and quality.

Healthcare Acquired Conditions and Serious Reportable Events in Healthcare

In this project, the distinctions between SREs and HACs will be further explored. There will be a focused update of the SREs while addressing expansion to the broader concept of HACs. Serious reportable events remain an important concept - serious adverse events that uncommonly occur but should be reported and reviewed - even in the context of a newer HAC concept. Specifically, the HHS HAC term is meant to be broad-based and so the SREs can be considered as a specialized sub-set of the HACs (combined as HAC/SREs). Through this project, the NQF SREs will be reviewed, perhaps re-focused and expanded in the context of the broader-based intent of the HHS HACs across a variety of environments of care.

NQF Safe Practices for Better Healthcare

NQF quickly developed the NQF-endorsed Safe Practices® following its deployment as an organization and has regularly updated this evidence-based initiative. The original set of Safe Practices were released in 2003, updated in 2006 and then recently updated for 2009 (released March, 2009). These practices were defined to be universally applied in all clinical care settings in order to help reduce the risk of error and harm for patients. Uptake and utilization has been wide spread across a large variety of health care environments. From the beginning there has been a conscious effort to evolve the Safe Practices in a scientifically-sound fashion, to maintain a current evidence-base and to ensure that an evaluation of the effectiveness for this initiative occurs over time. Of the original 30 Safe Practices, 3 were not used in the early Leapfrog

Hospital Surveys, 11 Safe Practices have now been retired or replaced, and the current 34 Safe Practices have all been updated with a contemporary, substantive evidence base.

Patient Safety Advisory Committee

NQF has formed a Patient Safety Advisory Committee (PSAC) to aid NQF in its new and ongoing efforts in patient safety. The PSAC, as with steering committees for all NQF projects, will work with NQF staff and steering committees to develop specific project plans, provide advice about the subject, ensure input is obtained from relevant stakeholders, review draft products, and recommend specific measures and research priorities to NQF members for consideration. The advisory committee represents the range of stakeholder perspectives, including consumers, purchasers, quality improvement professionals, researchers, and healthcare system professionals possessing strong insights related to patient safety issues at the local, regional, national and international levels.

Patient Safety Measures

In the early part of 2010, NQF will convene a steering committee focused on safety-related measures across sites and settings of care. NQF will solicit safety measures to fill gap areas and discuss additional environment-specific patient safety measures with highest potential leverage for improvement. The patient safety measures project will begin with a focus on healthcare associated infections, including MRSA.

State-Based Reporting Initiative

NQF has been conducting environmental assessments to better understand the actual use of current NQF-endorsed SREs at State and Federal organizational levels. NQF staff has been working on an inventory of existing SREs, Safe Practices and endorsed Safety Measures, as well as a literature review and environmental scan to assess utilization of SREs. As part of these efforts, NQF recently convened a meeting of 28 state-based reporting agencies. A workgroup of the states specifically reviewed the successes, barriers, and unintended consequences of SRE (or their equivalents) reporting. The participants were also offered an opportunity to offer their perspectives on the current set of SREs.