Safety Task Force

July 7, 2014
### Task Force Members

<table>
<thead>
<tr>
<th>Name</th>
<th>Organization</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Members</strong></td>
<td></td>
</tr>
<tr>
<td>David Bates, chair</td>
<td>Brigham and Women’s Hospital &amp; Partners</td>
</tr>
<tr>
<td>Peggy Binzer</td>
<td>Alliance for Quality Improvement and Patient Safety</td>
</tr>
<tr>
<td>Tejal Gandhi</td>
<td>National Patient Safety Organization</td>
</tr>
<tr>
<td>Mary Beth Navarra-Sirio</td>
<td>McKesson Corporation</td>
</tr>
<tr>
<td>Pau Tang</td>
<td>Palo Alto Medical Foundation</td>
</tr>
<tr>
<td>Toby Samo</td>
<td>Allscripts</td>
</tr>
<tr>
<td>Steven Stack</td>
<td>American Medical Association</td>
</tr>
<tr>
<td>Marisa Wilson</td>
<td>Johns Hopkins University</td>
</tr>
<tr>
<td><strong>Ex-Officio Members</strong></td>
<td></td>
</tr>
<tr>
<td>Jodi Daniel</td>
<td>ONC</td>
</tr>
<tr>
<td>Jeannie Scott</td>
<td>Department of Veterans Affairs</td>
</tr>
<tr>
<td>Jon White</td>
<td>AHRQ</td>
</tr>
</tbody>
</table>
## Meetings

<table>
<thead>
<tr>
<th>Date</th>
<th>Task</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>May 29</td>
<td>• Introductions</td>
<td>Consider three Es: Engagement, Evidence, Education</td>
</tr>
<tr>
<td>9:00-10:00</td>
<td>• Define scope and charge</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Review of FDASIA report</td>
<td></td>
</tr>
<tr>
<td>June 9</td>
<td>• Review of last meeting and next steps</td>
<td>• MITRE assisting w/feasibility plan and options review of functions,</td>
</tr>
<tr>
<td>11:30-1:30</td>
<td>• Questions for input</td>
<td>governance &amp; priorities</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Public /Private partnership recommended</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• More input requested for review of data analysis options and type of</td>
</tr>
<tr>
<td></td>
<td></td>
<td>functions to be conducted in an HIT Safety Center</td>
</tr>
<tr>
<td>June 13</td>
<td>• Presentations</td>
<td>• Review of function, processes, and priorities of NTSB</td>
</tr>
<tr>
<td>10:00-12:00</td>
<td>• David L. Mayer, NTSB</td>
<td>• AHRQ administers PSO program and Common Formats for patient safety</td>
</tr>
<tr>
<td></td>
<td>• Bill Munier, AHRQ</td>
<td>reporting</td>
</tr>
<tr>
<td></td>
<td>• Jeanie Scott, VHA</td>
<td>• VHA HIT Safety Center plays unique role in analysis and prevention</td>
</tr>
<tr>
<td></td>
<td>• Ronni Solomon, ECRI</td>
<td>of HIT related events</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• ECRI established Partnership for HIT Patient Safety</td>
</tr>
<tr>
<td>June 23</td>
<td>• EHRA / ASIAS presentation</td>
<td>• EHRA discussed vendor role in safety center</td>
</tr>
<tr>
<td>9:00-11:00</td>
<td>• Prep for final presentation</td>
<td>• ASIAS uses data to identify risks and issues before accidents/</td>
</tr>
<tr>
<td></td>
<td></td>
<td>incidents occur</td>
</tr>
<tr>
<td>July 7</td>
<td>• Final presentation review and wrap-up</td>
<td>• Consensus reached on key issues : e.g. PSO level of involvement</td>
</tr>
<tr>
<td>11:30-1:30</td>
<td></td>
<td></td>
</tr>
<tr>
<td>July 8</td>
<td>• Recommendations reviewed with HITPC</td>
<td></td>
</tr>
</tbody>
</table>
HITPC Safety Task Force Charge

• Respond to FDASIA Health IT Report and provide recommendations on Health IT Safety Center
• Governance structure/functions of the Health IT Safety Center (in order for it to):
  – Serve as a central point for a learning environment
  – Complement existing systems
  – Facilitate reporting
  – Promote transparent sharing of:
    • Adverse events/near misses
    • Lessons learned/best practices
May 29th Meeting
Safety Task force Charge

Review of FDASIA report and analysis of charge:

**Engagement:** Bringing Stakeholders to the table to dialogue about best practices, risks and safety of health IT more broadly.

**Evidence:** The Safety Center can serve as a mechanism for education for a broad group of stakeholders, for rapid learning, better safety and broader improvement.

**Education:** Moving data to information to knowledge that fosters improvement.
Selected Findings from Testimony (I)

• NTSB has governance structure which may provide some lessons
  – Main function though investigations which will be different than for Safety Center
• AHRQ PSO program and common formats will be very helpful to safety center
  – Not much data coming in yet to the cross-PSO database but hopefully that will change
• Report from ECRI illustrates how a PSO can target this specific area
Selected Findings from Testimony (II)

• ASIAS model was especially relevant
  – National aggregation of individual airline safety data
  – Integration across multiple data sets
  – Data driven
  – Multiple institutions voluntarily sharing
  – Non-punitive—used for safety purposes only
  – Trusted third party with deep technical expertise
Selected Findings from Testimony (III)

• ASIAS—governance lessons
  – Started small, with interested organizations and providers
    • Now includes 98% of industry
  – Selected manageable problems
    • Health IT example: wrong patient problem in CPOE
  – Conflict between being inclusive and getting things done—there is a large board which is very inclusive, but also an executive
Charge to Task Force

• Address key issues around HIT Safety Center
  – Value proposition
  – Governance
  – Focus
  – Function
Value Proposition

Safety Task Force Discussion of Themes:

The HIT Safety Center will be a place to analyze data from different sources and disseminate best practices.

HIT Safety Center will need to provide value and improve safety at a national scale.

HIT Safety Center will offer specific defined products.

HIT Safety Center will provide services that foster stakeholders in the healthcare system to feel a vested interest in HIT safety.

Value Proposition of the HIT Safety Center
Governance (I)

• The governance structure of the HIT Safety Center should be public/private partnership
  – Outside of government but resourced at least in part by ONC, though private funding also desirable
• HIT Safety Center needs a clearly defined mission, with related priorities
• Avoid duplication of existing activities/complement safety activities in public/private sectors
• Look to other industries for examples of success and their governance models
  – ASIAS and NTSB programs are examples of current aviation safety programs and investigative systems
• Starting with small group of vendors and providers and building is attractive approach
• Board—could be a large board which is very inclusive, and then executive board with 10-12 members which would do decision-making
  – Should include both institutional, individual members
  – Need patient representation—likely from a consumer organization
  – Representation from key leaders who are dealing with this regularly—e.g. CIOs/CMIOs/CNIOs
  – Should be driven by front-line provider concerns which are the burning platform (multidisciplinary)
  – Goal would be to grow organization and then redesign governance structure 18-24 months in—could thus start with just 10-12 member board above
Issues:

• Consumers (healthcare providers & patients) expect systems they use to be safe

• Existing HIT and safety partnership activities provide valuable lessons:
  – E.g. Partnership for Promoting Health IT Patient Safety facilitates providers, PSOs, medical societies, vendors in addressing safety issues using existing adverse safety event data reported to PSOs

• Significant challenges: Need to have incentives for reporting events; and need to be able to identify HIT related events
Focus

• Should address all types of HIT, not just EHRs
• Learning, not enforcement
• Must consider sociotechnical issues as well as just technical
• Incorporate a variety of data streams, not simply adverse event reports
  – Should include near-misses, hazard reports
• Should rely on evidence when possible
• Will need to include multiple disciplines
• Should cover both broad trends and (less often) serious individual events
Functions (I—Key Functions)

• Engagement—of key stakeholders
• Analysis --aggregate data streams of multiple types
  – Including but not limited to data from PSOs
• Convening—identification of best practices
• Education/Dissemination
  – Of vendors
  – Of providers/health systems
  – Of front-line reporters
    • Deciding what to report by putting forward best practices
    • Definitions, examples, tools to standardize reporting (Common Format)
• Usability role if any would need to be defined—could become part of certification (user-centered design already part)
  – Should be two-way learning between safety center and certification program
• Role in post-implementation testing if any would need to be defined
• One potential function could be as clearinghouse for safety-related rules
• Should promote guidelines and best practices (e.g. SAFER)
Functions (III—Data Sources)

• Data sources—must be inclusive—not just PSOs
  – PSOs
    • But they currently represent small proportion of universe
    • Do already have legal protections
  – Vendors
  – Providers
    • Hospitals
    • Clinicians (physicians, nurses, pharmacists, among others)
    • Networks
  – Patients
  – Others
• Should include regular reporting to involved stakeholders
• Main area of focus would be broad trends and not individual events
• Key target groups would vary based on the specific issue involved
• Full Transparency
• Might be better for safety center not to perform independent investigations of specific events itself, even though will be outside ONC
  • Safety centers in other industries do many investigations
  • But HIT Safety Center could partner with others (e.g. PSOs) that do investigations

• Safety center should not be regulatory, make policy, develop standards itself

• Safety center might not have legal protection of PSOs; yet would need to maintain transparency
Things to Avoid

• Interrupting relationship between clients and vendors in which safety information is coming in
• Duplication with existing efforts
• Assuming that reporters can necessarily define whether an incident is HIT-related or not
Conclusions

• Safety center has potential to deliver substantial value
• Will need adequate resources
  – Should be longitudinal
• Will have to engage the key stakeholders effectively
• Key functions: engagement, analysis, convening, education/dissemination