Health IT Policy Committee

A Public Advisory Body on Health Information Technology to the National Coordinator for Health IT

Safety Task Force

July 7, 2014

Task Force Members

Health IT Policy Committee
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Name	Organization
Members	
David Bates, chair	Brigham and Women's Hospital & Partners
Peggy Binzer	Alliance for Quality Improvement and Patient Safety
Tejal Gandhi	National Patient Safety Organization
Mary Beth Navarra-Sirio	McKesson Corporation
Pau Tang	Palo Alto Medical Foundation
Toby Samo	Allscripts
Steven Stack	American Medical Association
Marisa Wilson	Johns Hopkins University
Ex-Officio Members	
Jodi Daniel	ONC
Jeannie Scott	Department of Veterans Affairs
Jon White	AHRQ

Meetings

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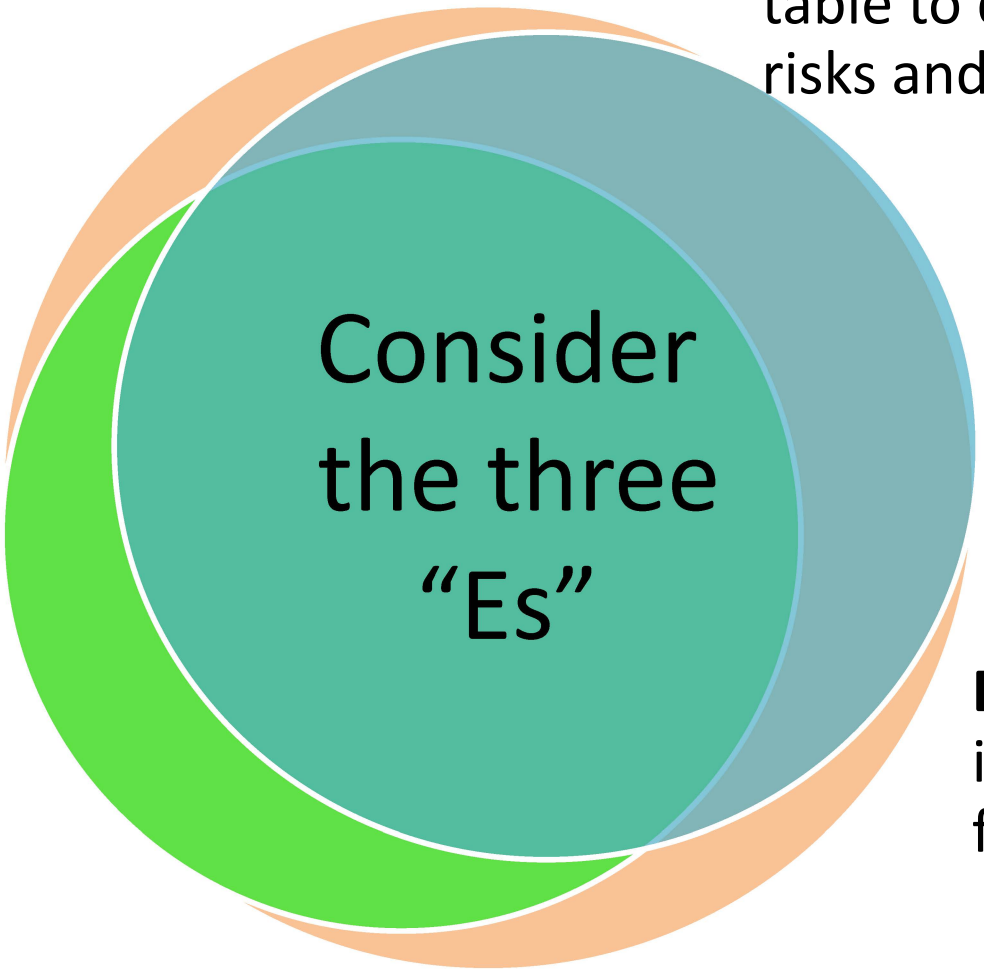
Date	Task	Result
May 29 9:00-10:00	• Introductions • Define scope and charge • Review of FDASIA report	Consider three Es: Engagement, Evidence, Education
June 9 11:30-1:30	• Review of last meeting and next steps • Questions for input	• MITRE assisting w/feasibility plan and options review of functions,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

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)

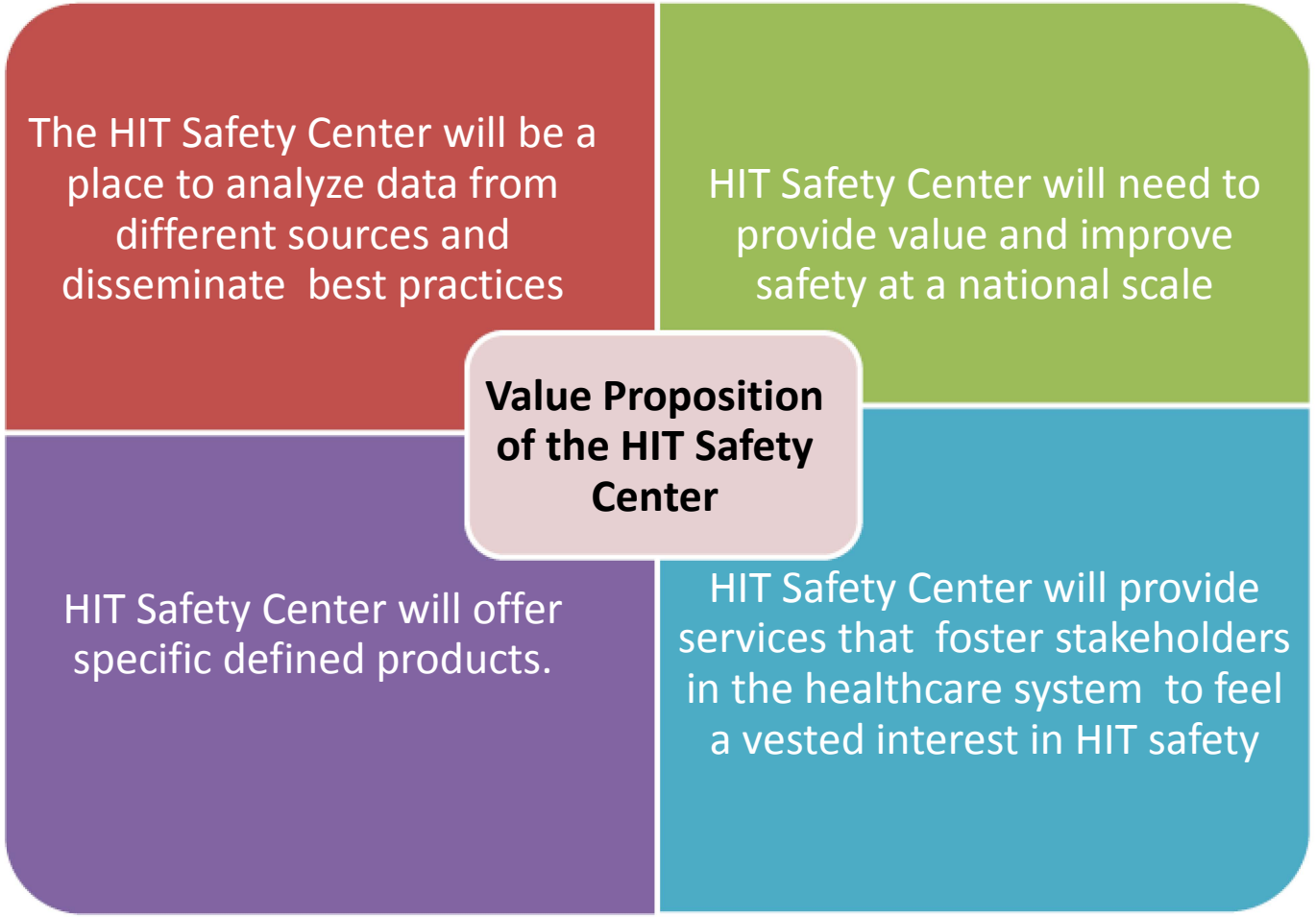
- ASIAS—governance lessons
  - Started small, with interested organizations and providers
    - Now includes 98% of industry
  - Selected manageable problems
    - Health IT example: wrong patient problem in CPOE
  - Conflict between being inclusive and getting things done—there is a large board which 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:



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

Governance (II)

- 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

Governance (III)

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)

Functions (II—Potential Functions)

- 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

Functions (IV—Dissemination)

- 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

Functions (V--Other Issues)

- 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