Partnership for Promoting Health IT Patient Safety

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Health IT Safety: Background

- Health information technology (IT) can provide multiple benefits to enhance patient care if the technology is optimally designed by the system developer, thoughtfully implemented by the healthcare organization, and appropriately used by the organization's staff.
- Health IT's potential can also be undermined by the hazards created when a health IT system operates in unintended and unanticipated ways.

Health IT Safety: Background

Working with PSOs on Safety

- IOM Report *Health IT and Patient Safety: Building Safer Systems for Better Care (2012)*
- ONC *Health IT Patient Safety Action and Surveillance Plan (2013)*
- ECRI Institute *HIT Deep Dive (2013)*
- ONC Guide *How to Identify and Address Unsafe Conditions Associated with Health IT*
- Pennsylvania Patient Safety Authority Advisory (2012)

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Purpose of the Partnership

- To make healthcare safer by understanding and mitigating health IT hazards and safety events

Objectives

- Establish a collaborative model for collecting and analyzing health IT hazards and safety events, and sharing best practices and lessons learned
- Evaluate the use of two health IT reporting taxonomies
- Understand the challenges of a safety reporting system for health IT and prepare for a center for health IT safety

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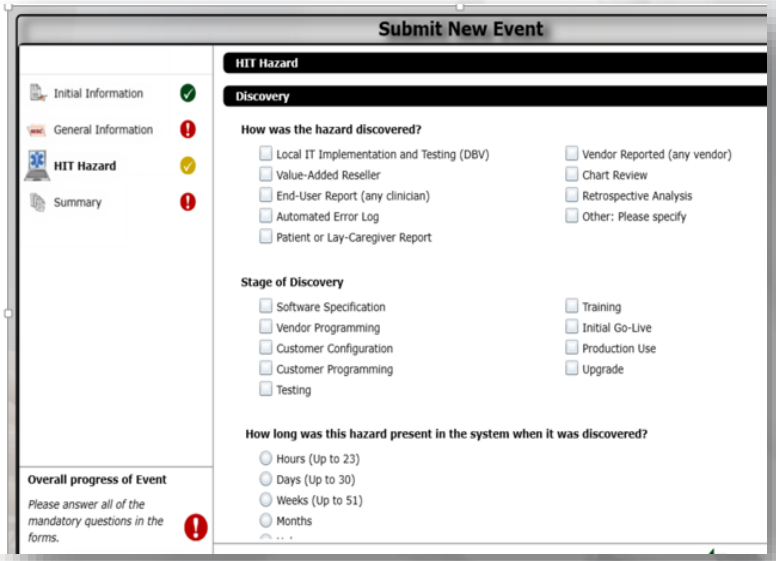
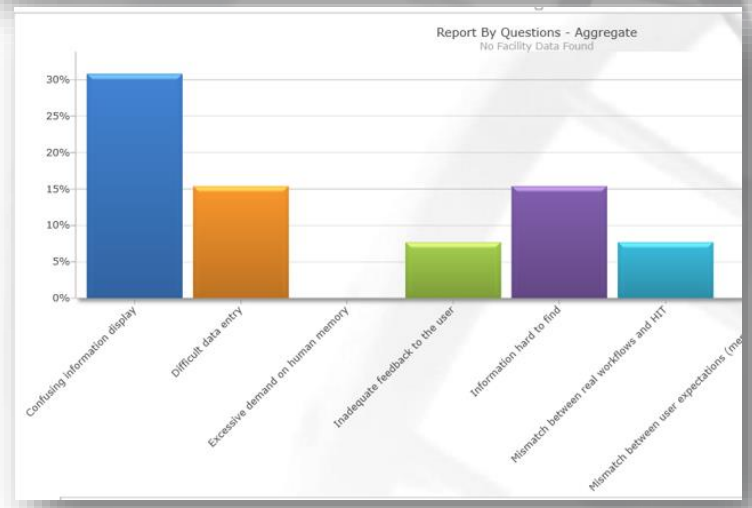
Strategy

- Collaborate among health IT vendors, provider organizations, patient safety organizations, practice experts, industry leaders, and associations
- Study health IT-related events and hazards
- Identify promising solutions and best practices
- Engage clinical stakeholders and professional associations in sharing best practices and lessons learned

Methods

- Participating providers submit hazard and event data using the ECRI Institute PSO web-based reporting system
- ECRI Institute PSO aggregates and de-identifies data
- Collaborators study the data, identify solutions, and aid in disseminating best practices





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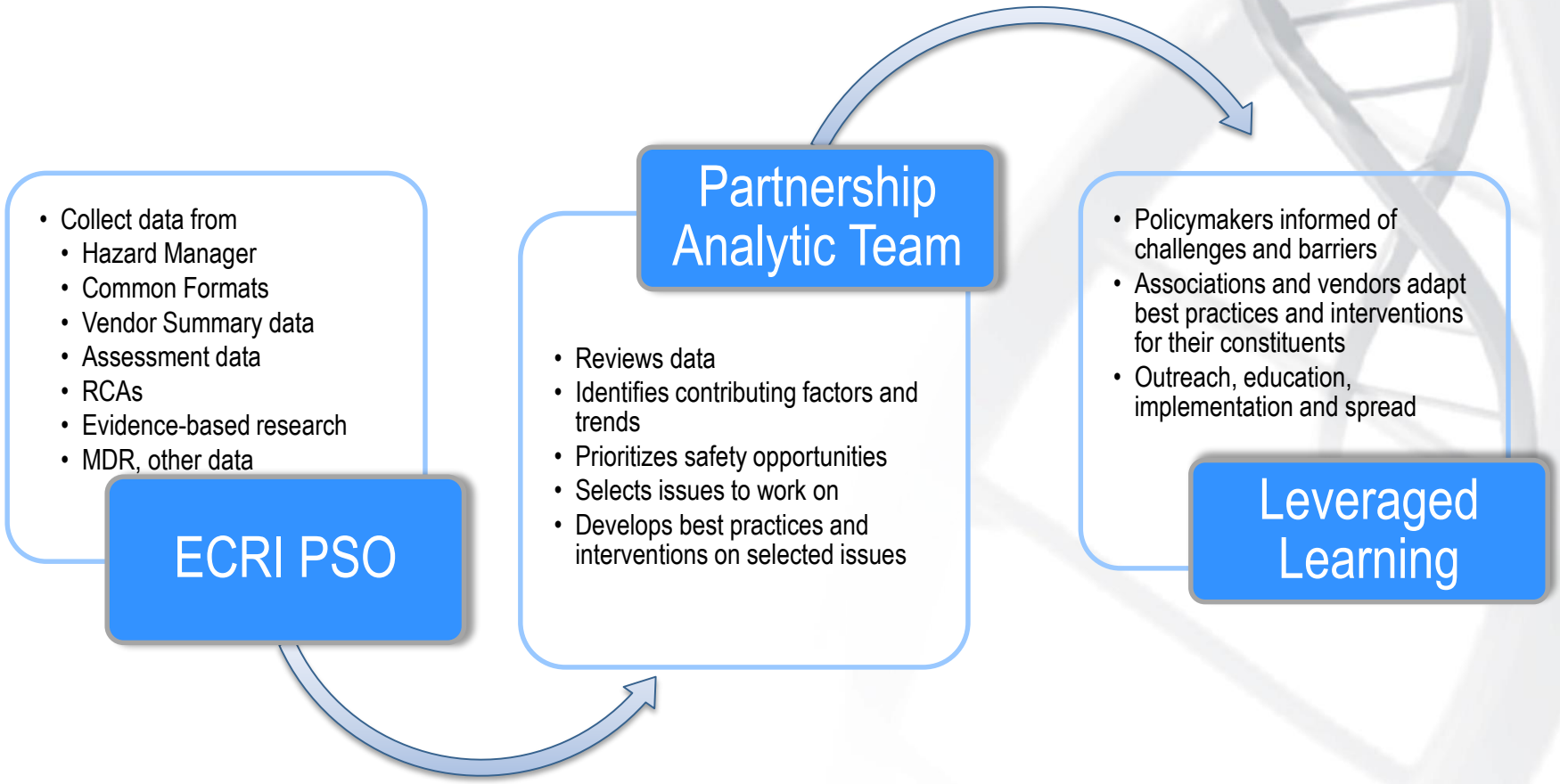
Partnership – A Multi-Stakeholder Collaborative



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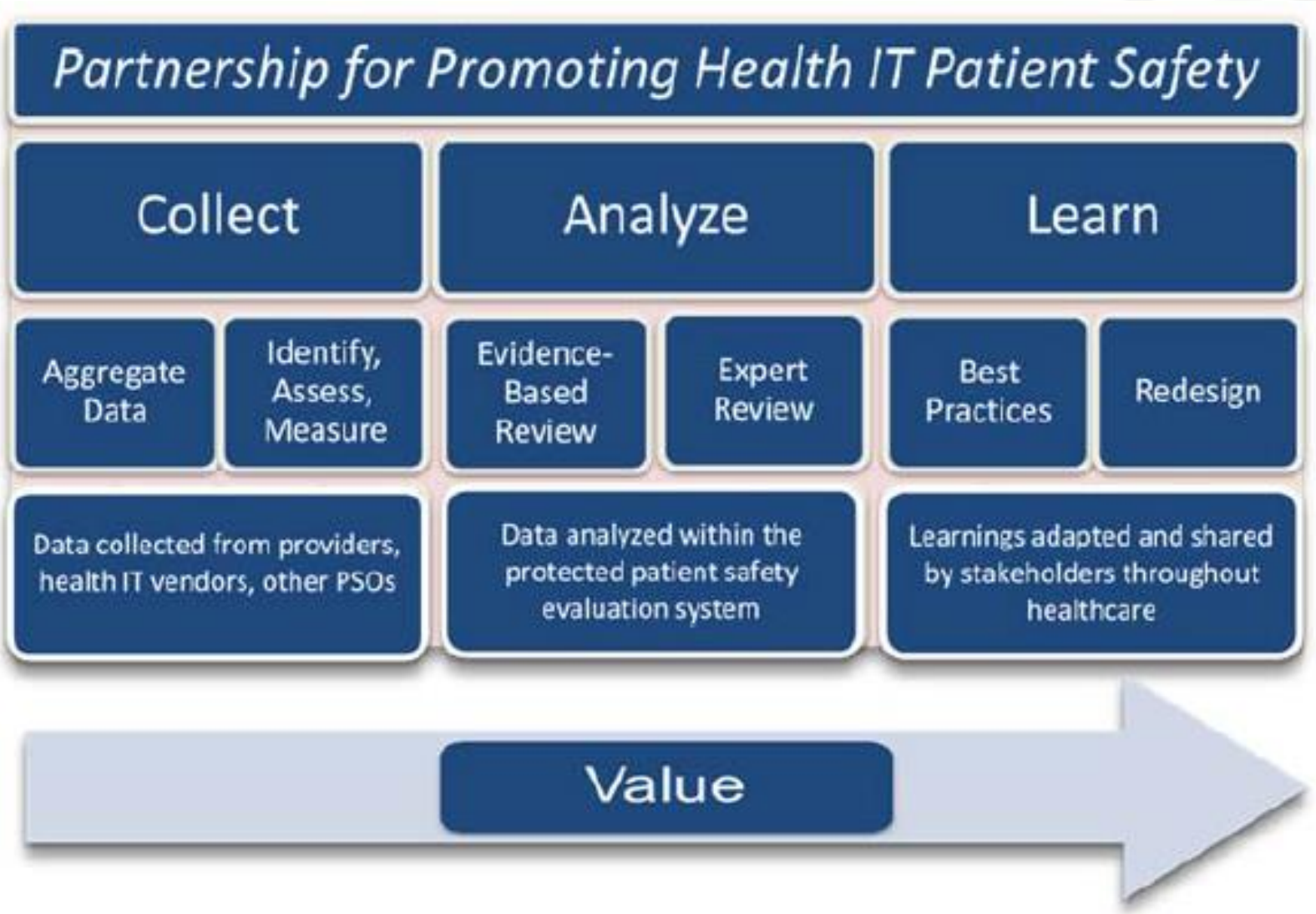

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Areas of Focus

- What events happen?
- Why do they happen?
- How can we prevent and improve?
- How should stakeholders collaborate to assure patient safety?

- Problem types and factors
  - Human-computer
  - Computer-related
  - System interface, configuration
  - Wrong input, wrong records retrieved
  - Patient identification
  - User training, education
  - Functionality, usability
  - Implementation, updates
  - Other

Data Collection

- Agency for Healthcare Research & Quality (AHRQ) Common Formats
- Hazard Manager
- Root Cause Analyses (RCAs)
- Vendors trends
- Follow-up interviews
- FDA data

Benefits from participating in the Partnership

- *Share, Learn, Protect* - advance patient safety
- Aggregate data across multiple organizations
- Recognize and understand emerging risks and hazards
- Identify product, process improvement
- Develop interventions
- Disseminate
- Inform the national safety strategy

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Self-Funded by Collaborators

- Human, intellectual capital contributed by participants
- *ECRI Institute PSO*: communications lead; collaboration website; web-based reporting infrastructure
- *Health IT Vendors*: commitments from 3 – 5 customers; analytic contractor to PSO
- *Providers*: submit reports and share information
- *Expert advisory panel*: review and advise on de-identified findings
- *Associations*: in-kind support, publications, symposia, convention space

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Execution Plan/Next Steps

	HIT Vendor	Users	PSOs	Associations	Experts
Commit to the Partnership	X	X	X	X	X
Recruit	X 3-5 customers		X		
Analytic Contractor Agreement	X				
Submit event data	X	X	X		
Analytics	X	X	X		X
Disseminate lessons learned	X	X	X	X	X

Why ECRI Institute and ECRI Institute PSO?

- Independent, not-for-profit applied research institute
- Leader in patient safety research across the continuum
- Mission - improving safety, quality, and cost effectiveness
- Evidence-based Practice Center
- 45 year history, 400 interdisciplinary person staff
- Over 1,000 PSO participants

Since 1971

Medical Product Reporting

Voluntary

Incidents, RCAs, Near Misses

Since 2003

Contractor for statewide reporting

Mandatory

Incidents

Near Misses

Since 2008

Patient Safety Organization

Voluntary

Incidents, Near Misses, RCAs, more

Over 2.5 million reports

Our State and National Experience

Patient Safety Reporting Systems

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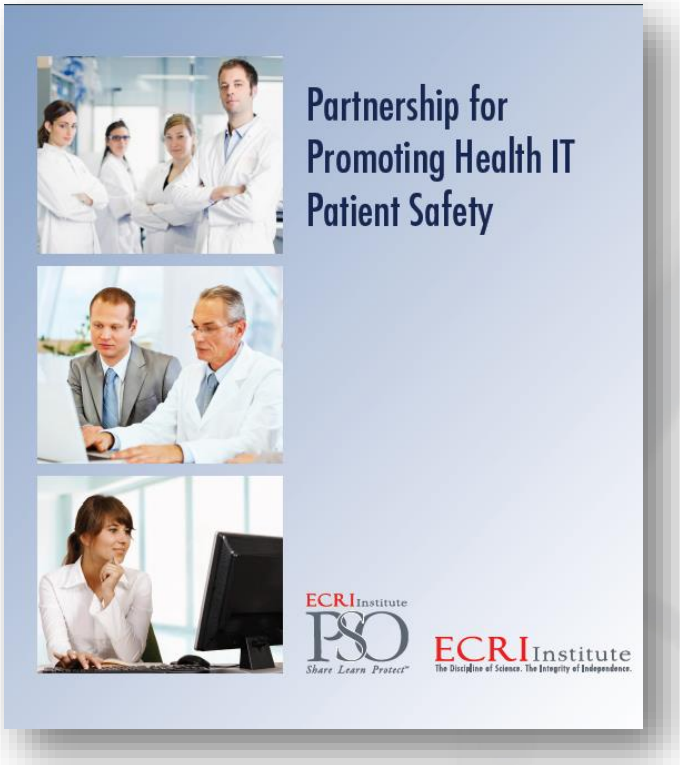
For More Information

Welcome Kit



- Contact Lorraine Possanza, DPM, JD, MBE
- *lpossanza@ecri.org*

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THANK YOU

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