

Partnership for Promoting Health IT Patient Safety



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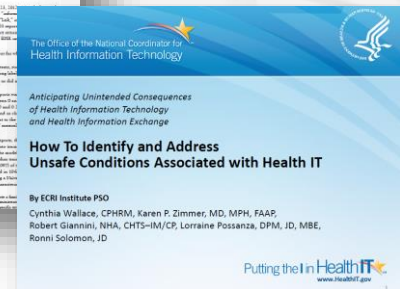
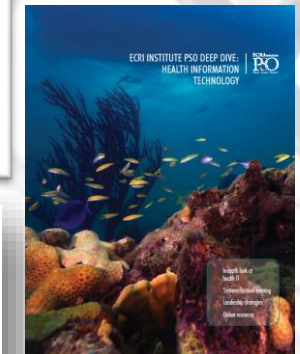
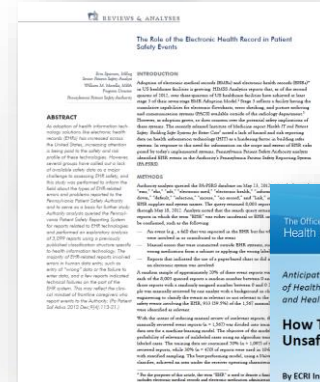
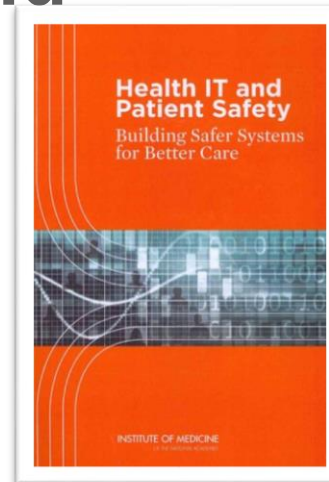
Health IT Safety: Background

- ▶ 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)

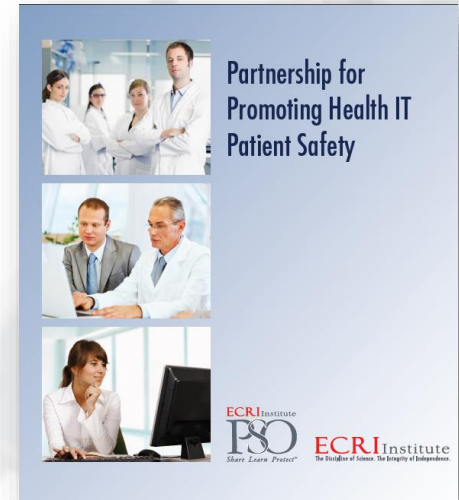


Purpose of the Partnership

- ▶ 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



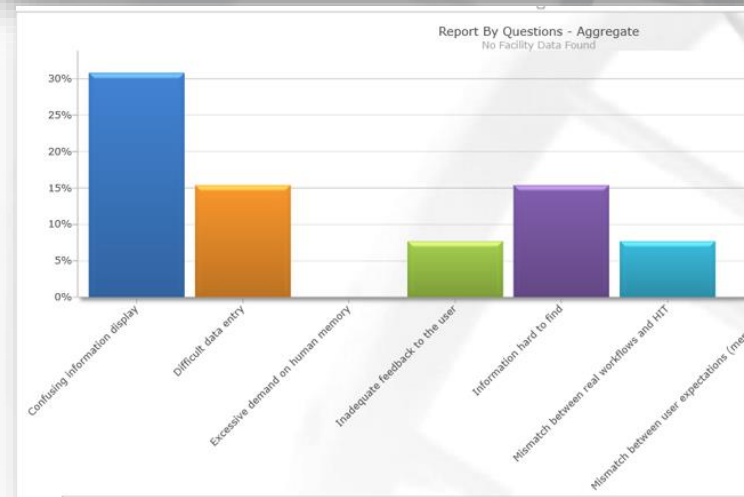
Strategy

- ▶ 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

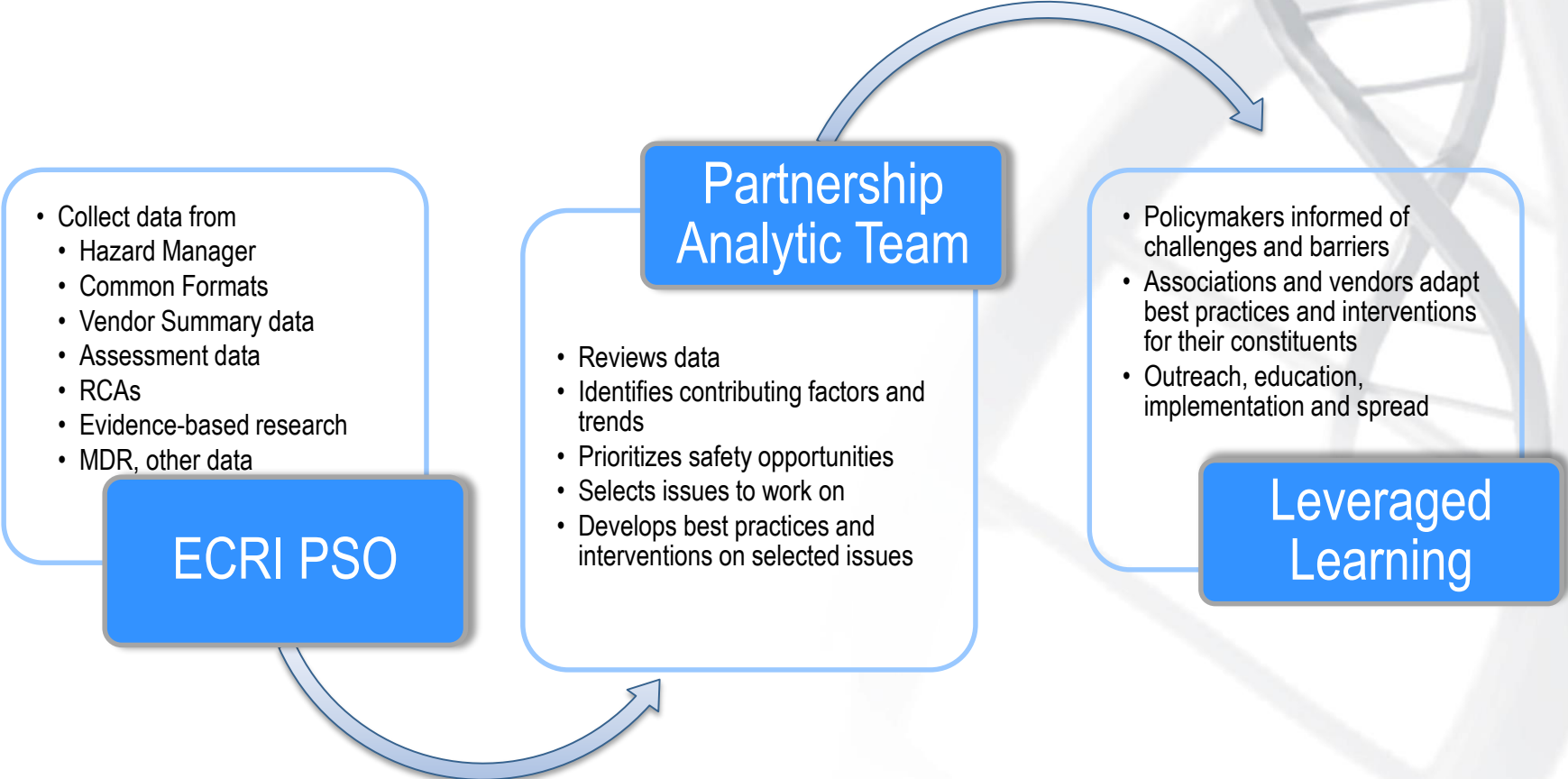
Methods

- ▶ 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

The screenshot shows a web form titled "Submit New Event" with a "HIT Hazard" section. The "Discovery" sub-section asks "How was the hazard discovered?" and lists several options with checkboxes: Local IT Implementation and Testing (DBV), Value-Added Reseller, End-User Report (any clinician), Automated Error Log, Patient or Lay-Caregiver Report, Vendor Reported (any vendor), Chart Review, Retrospective Analysis, and Other: Please specify. Below this, the "Stage of Discovery" section lists: Software Specification, Vendor Programming, Customer Configuration, Customer Programming, Testing, Training, Initial Go-Live, Production Use, and Upgrade. The final section asks "How long was this hazard present in the system when it was discovered?" with radio button options for Hours (Up to 23), Days (Up to 30), Weeks (Up to 51), and Months. A sidebar on the left shows progress indicators for "Initial Information" (green check), "General Information" (red exclamation mark), "HIT Hazard" (yellow check), and "Summary" (red exclamation mark). An "Overall progress of Event" section at the bottom left states "Please answer all of the mandatory questions in the forms." with a red exclamation mark icon.



Partnership – A Multi-Stakeholder Collaborative



Partnership for Promoting Health IT Patient Safety

Collect

Analyze

Learn

Aggregate
Data

Identify,
Assess,
Measure

Evidence-
Based
Review

Expert
Review

Best
Practices

Redesign

Data collected from providers,
health IT vendors, other PSOs

Data analyzed within the
protected patient safety
evaluation system

Learnings adapted and shared
by stakeholders throughout
healthcare

Value

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

Self-Funded by Collaborators

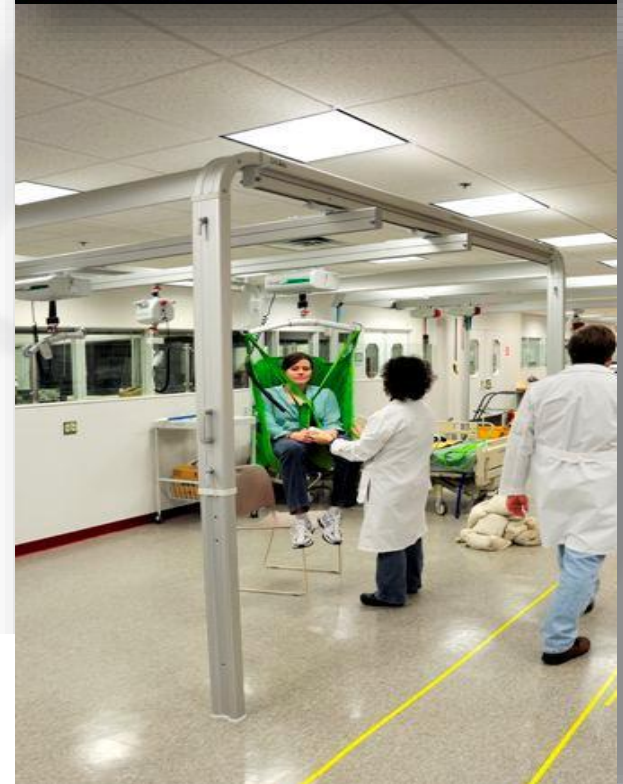
- ▶ Human, intellectual capital contributed by participants
- ▶ *ECRI Institute PSO*: communications lead; collaboration website; web-based reporting infrastructure
- ▶ *Health IT Vendors*: commitments from 3 – 5 customers; analytic contractor to PSO
- ▶ *Providers*: submit reports and share information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

Execution Plan/Next Steps

	HIT Vendor	Users	PSOs	Associations	Experts
<i>Commit to the Partnership</i>	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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