The Office of the National Coordinator for Health Information Technology

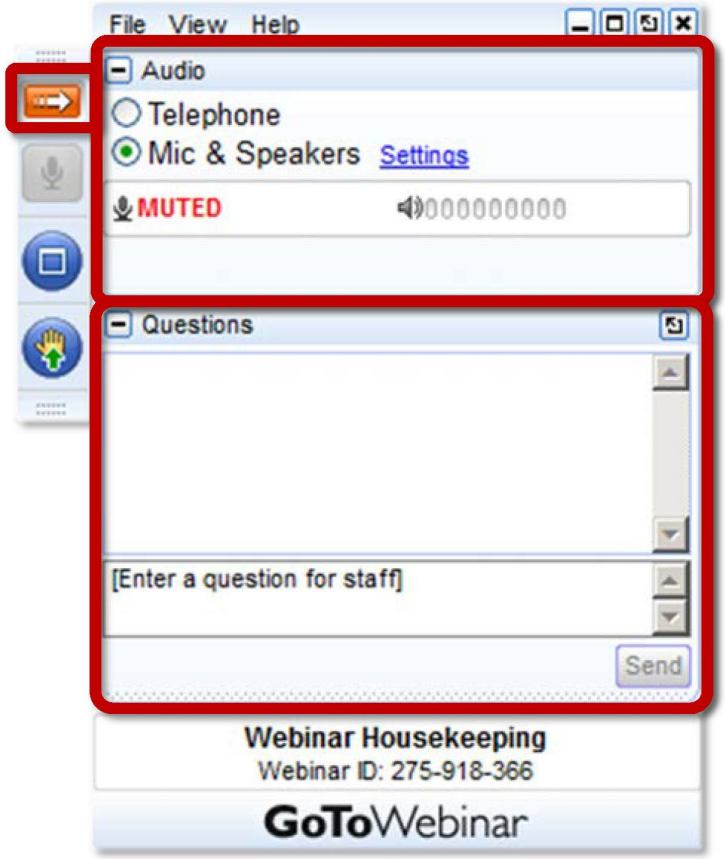
HHS Health IT Patient Safety Action and Surveillance Plan Webinar

July 10, 2013

HealthIT.gov

Welcome to the ONC Webinar!

- Congratulations, you have logged in



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Note: Today's presentation is being recorded and will be provided within 48 hours.

Frequently Asked Questions

Will I be able to get a copy of these slides after the event?

Yes

Is this Webinar being recorded so that I or others can view it at a later time?

Yes

Presenters

- Moderated by Nora Super

  Director of Public Affairs

  Office of the National Coordinator for Health IT

- Jodi Daniel, JD, MPH

  Director

  Office of Policy and Planning, Office of the National Coordinator for Health IT

Presenters

- Jacob Reider, MD,

  Chief Medical Officer
  Office of the National Coordinator for Health Information Technology

- William B. Munier, MD, MBA

  Director
  Center for Quality Improvement and Patient Safety

- Margaret VanAmringe, MHS

  Vice President for Public Policy & Government Relations
  The Joint Commission

Health IT Landscape

ADOPTION

Health IT Landscape

ADOPTION

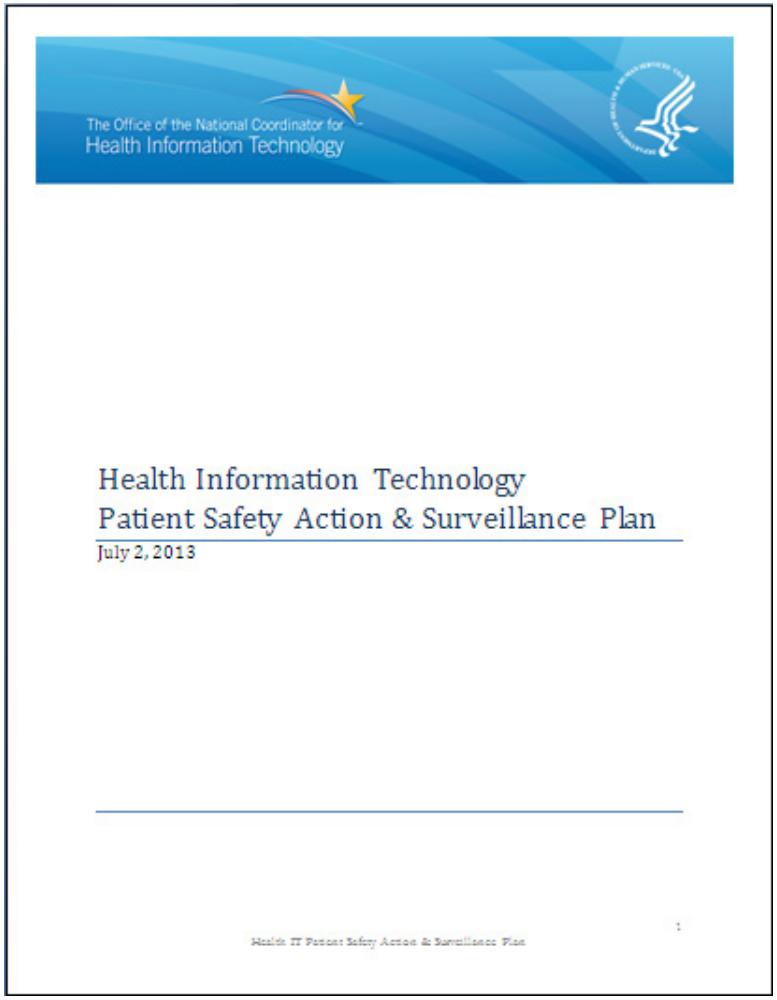
IMPROVED OUTCOMES

Advance patient safety

in an increasingly HIT-enabled healthcare system

Technology

Health IT Patient Safety Action & Surveillance Plan ("HIT Safety Plan")



* The Final Plan and related materials are available at:
http://healthIT.gov/policy-researchers-implementers/health-it-and-patient-safety

Objectives

Use health IT to make care safer

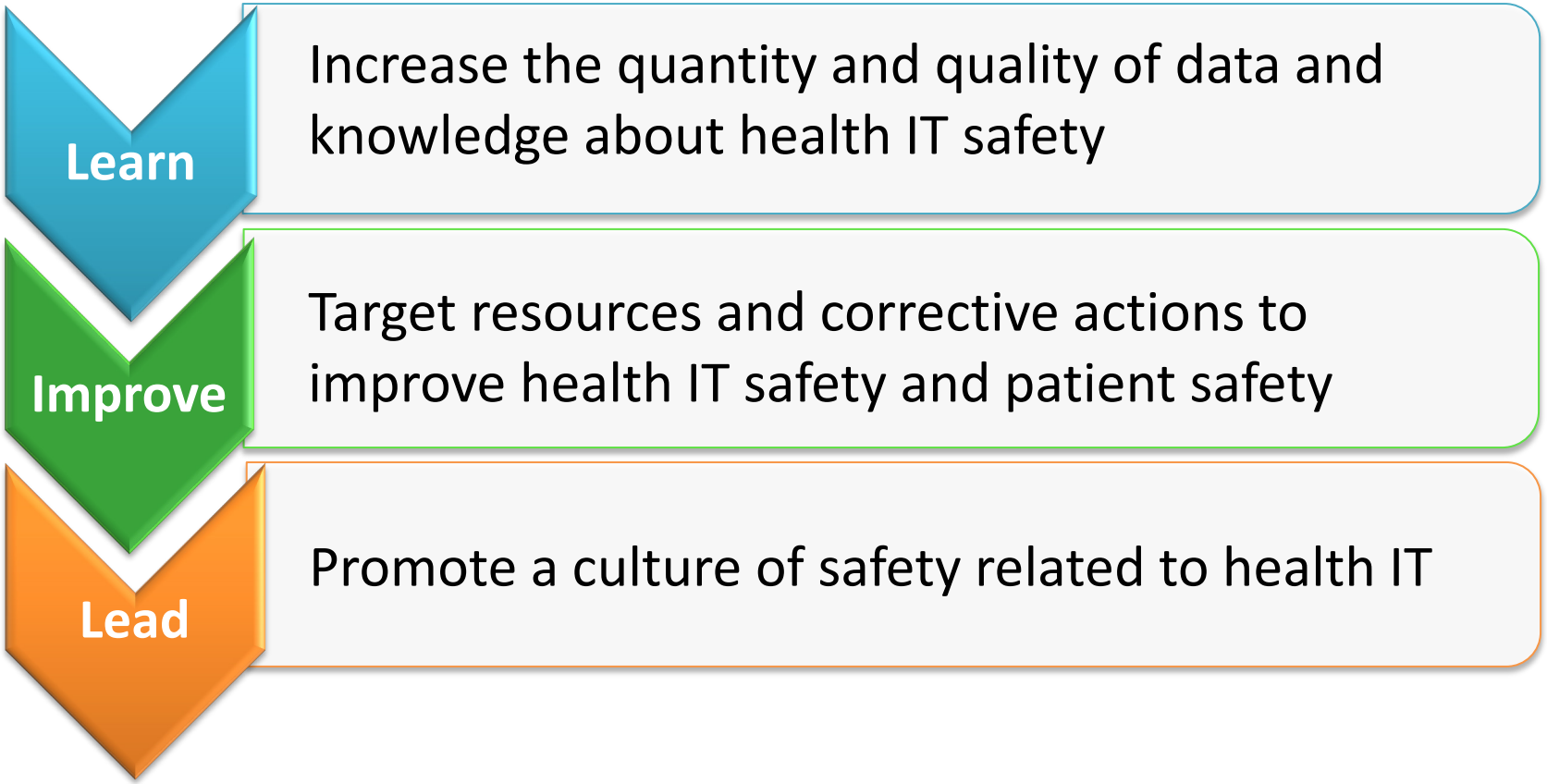
Continuously improve the safety of health IT

Overview

Objectives:

1. Use health IT to make care safer
2. Continuously improve the safety of health IT

Strategies:



HHS Safety Plan

Learn

Improve

Lead

HHS Safety Plan: LEARN

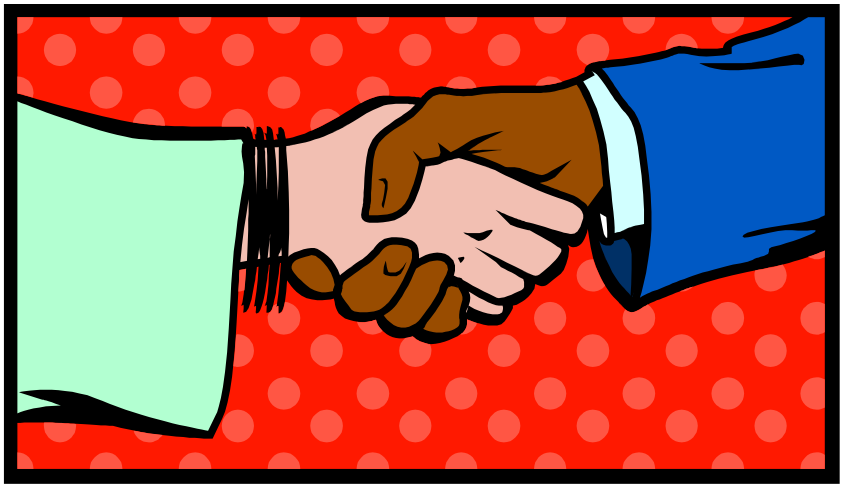
Increase the quantity and quality of data and knowledge about health IT safety

HHS Safety Plan: IMPROVE

Target resources and corrective actions to improve health IT safety and patient safety

Promote a culture of safety related to health IT

- Coordinated action by government and the private sector



HHS HIT Patient Safety Plan
AHRQ's Role

William B. Munier, MD, MBA
Director
Center for Quality Improvement and Patient Safety

HHS Health IT Patient Safety Action and Surveillance Plan
Webinar
10 July 2013

Agency for Healthcare Research and Quality

- A public health agency within the Department of Health and Human Services
- Focuses on long-term and system-wide improvement of healthcare quality and safety
  - Supports research on quality, safety, and effectiveness
  - Supports implementation of proven methods to improve delivery of care

AHRQ's Role in the Safety Plan

1. Collaborating with ONC on Plan development
2. Encouraging reporting of HIT events via PSOs
3. Fostering national reporting of HIT events to the Network of Patient Safety Databases (NPSD)
4. Enhancing the Device/HIT "Common Format"
5. Providing avenues for software developers and vendors to expand reporting on HIT safety
6. Continuing research on HIT safety

PSOs and Common Formats

- AHRQ administers the Patient Safety Organization (PSO) Program
  - PSOs provide the opportunity to report quality and safety issues, including HIT-related adverse events, without fear of discovery (malpractice liability)
  - PSOs can aggregate data for enhanced learning, including reporting to the national Network of Patient Safety Databases (NPSD)
- AHRQ has developed "common definitions and reporting formats" – the Common Formats – to:
  - Harmonize counting of "apples to apples" nationally
  - Facilitate accelerated learning locally, regionally, and nationally

Common Formats and HIT

- At ONC's request, AHRQ and FDA revised the Device Common Format, which specified information to be reporting on patient safety events involving a device, to include specific detail regarding health information technology
- In the future, AHRQ is planning to expand its Common Formats for event reporting beyond the hospital and nursing home settings to ambulatory care, including clinics, doctors' offices, surgery centers, etc.

Software / Vendor Participation

Software developers and vendors have expert knowledge about HIT safety issues, particularly regarding their own software products; they can:

1. Serve as “expert” contractors to PSOs
2. Serve as “expert” contractors to providers (e.g., hospitals, physician groups) working with PSOs
3. Create component organizations that become Federally-approved, or “listed,” PSOs

Continuing AHRQ Research

- Ensuring safety
  - Incidence and type of HIT-related adverse events
  - Best practices for making HIT safer
- Enhancing quality
  - Ways that HIT can contribute to better quality care
- Improving measurement
  - Programs to improve the science of measurement for quality and safety

Contact Information

Agency for Healthcare Research and Quality
540 Gaither Road
Rockville, MD 20850

Information on PSOs and the Common Formats
www.psoppc.org

William B. Munier, MD, MBA
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Investigation of Health IT-Related Deaths, Serious Injuries, or Unsafe Conditions

DHHS Health IT Patient Safety Action and Surveillance Plan Webinar

July 10th, 2013

Margaret VanAmringe, MHS

Executive Vice President, Public Policy & Government Relations

The Joint Commission

About The Joint Commission

- The Joint Commission is the nation's oldest and largest standard-setting and accrediting body in health care
- An independent, not-for-profit organization
- The Joint Commission evaluates and accredits more than 20,000 health care organizations and programs in the United States

Making Care Safer

- We are pleased to be part of the Health IT Safety Plan – value this public-private sector partnership
- Fits into TJC's years of work finding causes to serious patient safety events, and developing & disseminating solutions to healthcare orgs.
- Expands our capacity to learn more from the analysis of these types of incidents of patient harm and near misses to help reduce risks
- Consonant with the IOM's recommendation that an independent entity help identify instances of unsafe HIT situations in a learning environment.

Health Information Technology Patient Safety Action & Surveillance Plan

- ONC Contract:
  - Investigation of Health IT-related deaths, serious injuries, or unsafe conditions
  - Development of health IT patient safety strategies and actions
  - Create a system to better detect & proactively address potential health IT-related safety issues across health care settings
  - Help establish a learning environment that focuses on early detection and information dissemination

TJC's Sentinel Event Work

- Sentinel Event: **A Sentinel Event is an unexpected occurrence involving death or serious physical or psychological injury, or the risk thereof**
  - Serious injury includes loss of limb or function
  - The phrase "or the risk thereof" includes any process variation for which a recurrence would carry a significant chance of a serious adverse outcome
  - Such events are called "sentinel" because they signal the need for immediate investigation and response

Sentinel Event Database

- The Joint Commission collects and analyzes data from the review of sentinel events to increase the general knowledge about patient harms, their causes, and known strategies for prevention,
- These data and information form the content of The Joint Commission's Sentinel Event Database
- Not uncommon today to see IT-related events in the database. May come into the data base with a different primary cause.

Sentinel Event Alerts

- *Sentinel Event Alerts:*
  - Publish important findings from our analyses as a learning tool
  - De-identified aggregate data relating to root causes and risk-reduction strategies form the basis for future error prevention advice to organizations and clinicians through the newsletter ***Sentinel Event Alert***
  - ***Alerts*** present known risks for serious harm and recommendations for risk mitigation.

Health Information Technology Patient Safety Action & Surveillance Plan

Health IT Patient Safety Strategies and Actions

- ONC Contract: Investigation of Health IT-related Deaths, Serious Injuries, or Unsafe Conditions

Investigation of Health IT-related Deaths, Serious Injuries, or Unsafe Conditions

1. Analysis of de-identified data on health IT-related events
2. Expand ability to identify and characterize health IT-related events
3. Investigate 10 health IT-related events
4. Develop educational materials and training opportunities to enable healthcare providers to also investigate & analyze events and develop follow-up, corrective action

1. Analysis of de-identified data on health IT-related events

- Analyze three years of de-identified sentinel event data
- Assess limitations of current reporting system for collecting data on health IT-related events
- Identify high priority areas for expected types of health IT-related sentinel events

2. Expand ability to identify and characterize health IT-related events

- Perform literature review
- Engage expert advisors
- Develop a classification scheme based on literature review, insights gleaned from investigation, expert opinion, etc.
- Integrate AHRQ Common Formats and other health IT-related classifications into the Sentinel Event Database.

3. Investigate Ten Health IT-related Events

- Investigate health IT-related events in hospital and ambulatory care settings
- Support Root Cause Analyses
- Use existing TJC processes for working with organizations and clinicians to investigate, develop follow-up and corrective actions, and share findings

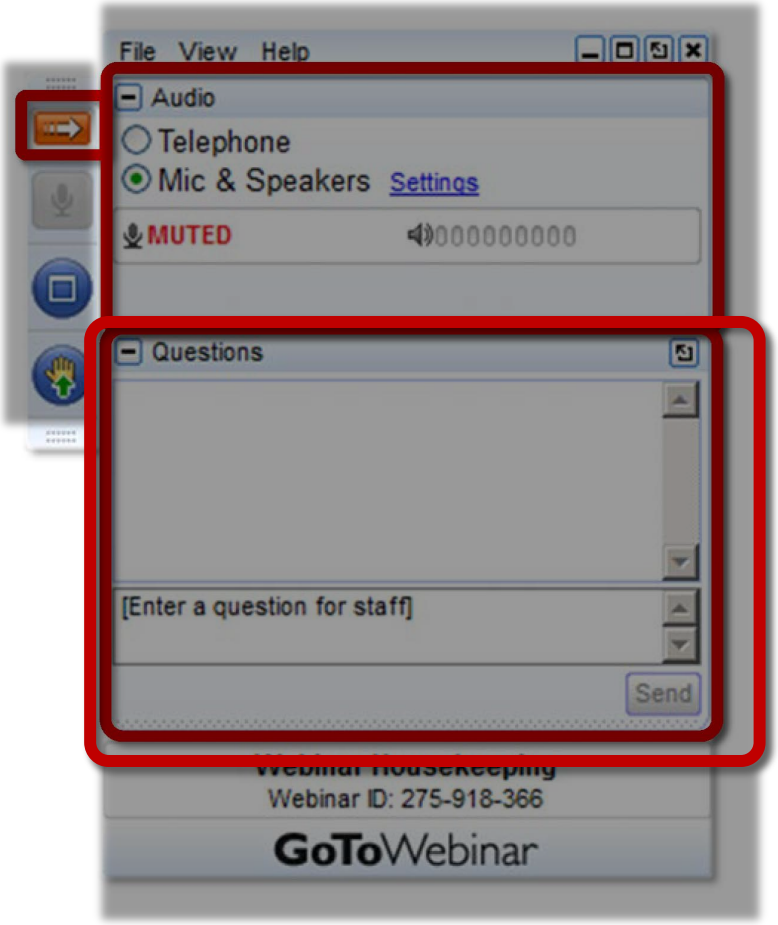
4. Develop educational materials and training opportunities

- Enable health care providers to better identify, investigate, and analyze health IT-related adverse events and develop follow-up and corrective action
- Develop web-based education platform
- Publish a *Sentinel Event Alert* or related publication
- Publish a paper in peer-reviewed literature

After Webinar Questions:

Please contact Gerry Castro at
gcastro@jointcommisison.org

Questions



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- Please raise your hand to be unmuted for verbal questions.

For more information, please [insert contact information]

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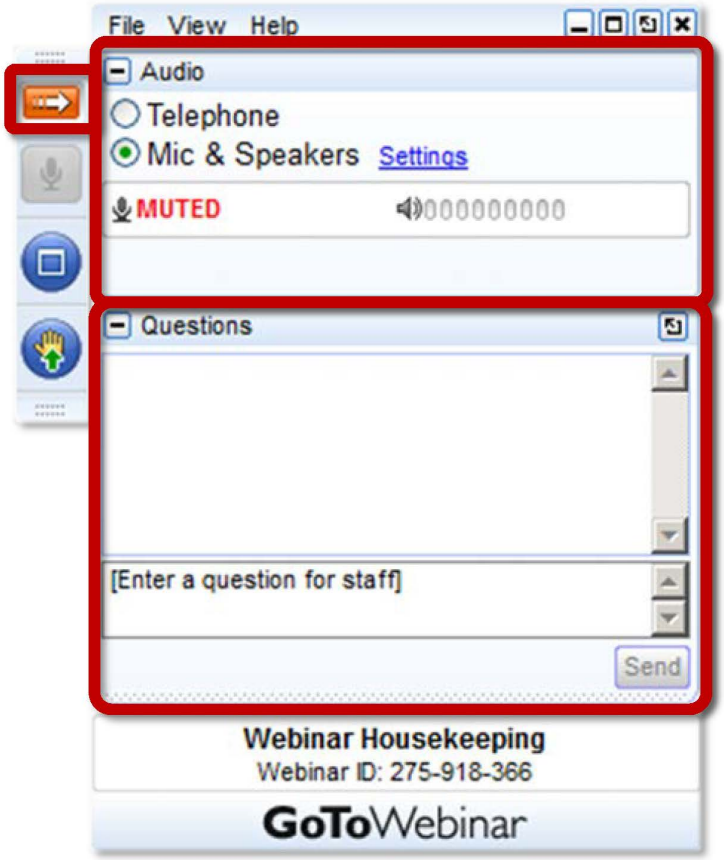
Questions



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