Mark Segal specific comments on draft NQF HIT Safety Report – January 8, 2015

Overall, very well written and conceptualized.

Page 4 – Para 1, Bullet 2, Interoperability does not depend on central storage. For example, much query-based interoperability and HIE architecture uses federated databases and pointers or standards and/or standards for query. Also, at end of the bullet, add "and other HIT and data sources". Bullet 4 – Expand to eRx, Bar code Medication Administration and also add other examples of where EHRs and HIT can enhance patient safety.

Page 4 – Para 3 – The discussion overstates the criticality of having a single coordinated effort and understates the value and reality of multiple efforts.

Page 7

HIT Design – add "can" in first line after "Challenges related to the design of HIT"

HIT Implementation – Especially good discussion on a critical factor.

Page 8 – First Full Para – Good discussion of "There is a high degree of overlap and interaction between these areas, and a wide, complex network of factors influencing the behavior and performance of people, systems, and organizations involved in the HIT enterprise."

Page 9 - I wonder if the Phase approach really make sense temporally at an organizational level as organizations may look to use of EHRs to improve safety (phase 3) from the start. Implementers, even early implementers, will be addressing all three "phases "at the same time.

Page 11, Table 1 – See comment on Page 9

Page 11, Level 2.C. - "Correct" is not the best term. Use as intended is important but may also be value in using beyond as intended and HIT is likely to permit use in multiple workflows, including those determined by the end users.

Page 11, Level 3.B. - Is the issue "safe patient engagement" or "effective patient engagement that enhances safety"?

Page 15 - Was the ranking driven/affected by the High/Moderate/Low data? Need to be clear on method for ranking; was this from voting on top five measures vs the H/M/L?

Page 16 – Per the comment on page 15, the ranking of "System Interoperability" may be too high and "Use of HIT to Facilitate Timely and High-Quality Documentation" too low given the actual numbers for each item in the High and Medium columns. Worth further consideration.

Page 17 – Many of the measure concepts for Clinical Decision Support seem especially challenging in terms of measurement feasibility.

Page 17 – The discussion of Interoperability seems too negative and overly focused on EHRs vs. overall infrastructure. Certainly, there are high levels of intra-organization interoperability, which is especially relevant to this project.

Page 18 – Interoperability – “Improving interoperability depends not only on actions and interventions by organizations and IT vendors across diverse internal systems—challenging tasks in their own right—but also on a wide range of external factors, including the cooperation and performance of other healthcare providers, the existence of regional databases facilitating information exchange, and the legal, policy, and regulatory environment.” – Good
Page 18 – Interoperability measure concepts – These will be hard to measure

Page 21 – Simulation most relevant for enterprises vs. small/medium medical groups.

Page 22, Para 1 – There are issues identified with the applicability of some of the new NIST UCD guidelines and use cases.

Page 25 – Feedback and Information Sharing

“Committee members raised concern that some vendor contracts contain broad non-disclosure and confidentiality provisions as well as other intellectual property protections which prevent certain EHR software information, including screenshots and comparative user experiences, to be publicly shared.” - Is less the provisions and their terms than how applied and process used by provider and journals. Need for technology developers to protect IP and have processes to do this.

“The Committee believed that such contract terms should not be broader than reasonably necessary to protect the vendor’s legitimate intellectual property interests when balanced against patient safety concerns.” – OK formulation

“The Committee further believed that such provisions are in direct conflict with the goal of sharing patient safety knowledge for quality improvement purposes across settings.” – This statement is two sweeping.

p. 26 – Measure Concepts – some are hard to measure.

“Software license and hardware purchase agreements permit shared learning of comparative user experiences, timely vendor response to provider requests for information, and use of vendor product information in research studies for peer reviewed journals (e.g. screen shots) and promote shared accountability for HIT safety.” - Not sure that there should be NQF standards for contract provisions and who would evaluate?

Page 29 – Para 1 on portals, Portals may be especially challenging in the hospital context, given the episodic nature of hospitalizations. Also the issue of multiple portals if use multiple medical groups or hospitals.

Page 29 – Measure Concepts, In general, these concepts seem less ready for prime time than others. It is not so clear they really get at core patient needs/wants. “% of patient portals that include viewable patient progress notes – Open Notes Initiative” – Seems premature to be a measure.

Page 30 - 9, HIT-focused risk-management infrastructure- Think this should be higher after reviewing the discussion

Page 31 – Item 1 - Be careful on HIT as medical device statement. There is not consensus that EHRs or all HIT is a device.

Page 31 – Item 2 – Good

Page 32 – Item 3 – Need to bring in cost/benefit consideration of measures.

Page 32 – Item 4 – Need to include burden of providing data for measures, such as those being proposed.

Page 33 – Item 9 - Need to be careful in relaxing NQF approval criteria for approval given costs of measure development, use, and follow-up.