NATIONAL QUALITY FORUM

Moderator: Patient Safety and HIT
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Operator: This is Conference #: 12534863.

Welcome everyone. Please note today's call is being recorded. Please standby.

Adeela Khan: Hello everyone. This is Adeela Khan from NQF. Welcome to the Safety Web Meeting. I'm joined today by Andrew Lyzenga and Hardeep Singh, our co-chair.

I just want to start off quickly by going over our agenda. We'll be doing welcoming introductions. I'll be doing a roll call shortly. We'll be then – we'll then go into committee discussion on the proposed conceptual framework that we sent out last week, going over some of the measure concepts and also our plans for some key informant interviews. After we've had the committee discussion we'll start on having a public and member comment, and then I'll go over some next steps for the committee.

So before we start, I'd like to just do the roll call quickly. I know we have Hardeep on the line, is that correct?

Hardeep Singh: Yes, I'm still here.

Adeela Khan: Jason Adelman?

Jason Adelman: Yes, here.

Adeela Khan: OK, thank you. Gregory Alexander? Gerard Castro?

Gerard Castro: Here.

Adeela Khan: David Classen? Linda Dimitropoulos?

Linda Dimitropoulos: Here.

Adeela Khan: Lisa Freeman? Tejal Gandhi? Andrea Gelzer? Erin Grace? Kevin Haynes?

Kevin Haynes: Here.

Adeela Khan: Laura Heermann-Langford?

Laura Heermann-Langford: Yes.

Adeela Khan: George Hripcsak? And I see Lisa – I see you're raising hand so you must be on mute. But I'll make sure that I've got you here. Jason Jones?

Jason Jones: I'm here.

Adeela Khan: Thanks. Nana Khunlertkit?

Nana Khunlertkit: Yes, here.

Adeela Khan: William Marella?

William Marella: Yes, I'm here.

Adeela Khan: Dena Mendelsohn?

Dena Mendelsohn: I'm here.

Adeela Khan: James Russell?

James Russell: I'm here.

Adeela Khan: Eric Schneider?

Eric Schneider: Yes, present.

Adeela Khan: Mark Segal?

Mark Segal: Here.

Adeela Khan: And Karen Paul Zimmer?

Karen Paul Zimmer: Here. Thank you.

Adeela Khan: OK, great.

George Hripcsak: George Hripcsak back on. I got disconnect.

Adeela Khan: Oh, great. Thank you for letting me know.

Lisa Freeman: And Lisa Freeman is here. I didn't connecting right initially.

Adeela Khan: Great. Thank you for letting me know. So, just want to go over our meeting objectives, again, we're going to be discussing our draft conceptual framework and make any modification. We'll be reviewing the measure concept that were proposed during the February in-person meeting and they were refined by NQF staff and our co-chairs. And we'll be reviewing the preliminary project plan for (key) format interviews and identify some possible key informants.

At this time, I'll turn it over to Andrew to lead us through the framework.

Andrew Lyzenga: Thanks Adeela. Thanks again for everybody – to everybody for joining us. I think we'll – I don't know we'll use the full two hours today. Hopefully we can get through our agenda and give you guys a bit of your time back.

But just to give you a little bit of context around this discussion we've – as you hopefully seen recent out – another draft framework based, you know, very closely on what we previously floated to you, this is based on, you know, largely on the sort of what you might call the thing levels. I guess the three phase or three level model of safe, health, I.T., then using Health I.T. safely, and then using Health I.T. to monitoring and improve safety.

Then have done a bit of modification of the levels underneath that some sort of subcategories and have had a little bit of back and forth with our co-chairs and staff, you know, the level of granularity needed there and the appropriate categories within each of those levels.

But what I – I kind of want to say is that at least in my own mind I've been sort of looking at this as a tool in some ways to help us as we move forward with our effort to the prioritize to identify measures and measure gaps in the area of Health I.T. safety and to do some prioritization of those gaps and measurement areas.

And we're hoping to use this framework as sort of guiding models for that, and also as a model for the field of measure developers as they move forward in this area.

So, all that to say is that sort of – you know, we're hoping that you'll look at this framework in that context and try to think about whether it is useful for those purposes, again, as we more forward into that exercises identifying gaps and prioritizing gaps and measures, whether these are the right – this is the right framework, whether these are the right categories, whether this is – you know, the right level of granularity to be useful in that exercise. So, those are just sorts of some questions and some context to free to think about as we're discussing this.

So maybe – with that, I'll turn it over to Dr. Singh to just start a little bit of discussion around the framework and just tell me your thoughts and feedback on it.

Hardeep Singh: Yes. Thanks, Andrew. Hello everybody, it's nice to be talking again virtually this time. So, the one pager draft framework that you're looking at is pretty much in the lines of what we have discussed to the meeting with the three levels that Andrew talked about it.

Slightly modifying, again, just the wording of the levels, but the goal is to make sure that we have overarching sort of conceptual approach that we're not sort of missing anything and we're not leaving anything behind. And I think most of us, if not everybody, agreed that these three levels is pretty much, you

know, discusses the evolution of Health I.T. and patient safety and covers broadly the things that we're going to be talking about.

So, within each of these levels, the question then became, you know, how do we start operationalizing some of the measurement concepts. And so, we actually relied heavily on, again, safer guides which many of you are familiar with.

And then, we made safer guides, we actually did a lot of sort of thing and, you know, figuring out what is unarguably going to be some concepts that people will, you know, agree with that you cannot sort of question that these are anything which should not be done.

And so, when you look at the each of the levels, what you see is A, B, C underneath essentially the high level principles that we think are the guiding the principles in order to – for instance Level 1 to have safe Health I.T., the guiding principles are you got to have available data or the data has to have integrity and the data has to be secure.

And so, then we went through and so and safer guides the same things has been used.

For Level 2, the two of them will use in safer guide which is actually A and C complete incorrect Health I.T. use as well as Health I.T. system usability. But item B was added mostly based on two things. One is, is all of you familiar with safer guides may have seen – that there's actually a separate safer guide on organizational roles and responsibility. And this came up pretty strongly in the meeting as well, you know, because as you all know, organization plays a very heavy role on making sure that the Health I.T. is being used safely and effectively.

So, we thought that – that should deserve a principle of it's own because it really didn't fit very well with the others, you know, the usability and complete incorrect use because it needs to be sort of the people aspects and the organizational leadership aspects that need to be reflected along these – you know, these high level principles, so we added that.

In Level 3, the monitoring safety which is used of technology to monitor and improve patient safety. The surveillance and optimization is pretty much right out of the safer guides, the principle. In fact, the definitions that you're looking at are exactly from the safer guides which as you know as (ONC) endorsed. So we talked to – these are less of, you know, issue when trying to create new principles.

The principle that we added was unarguably one of the ones that came up in meeting which is that outpatient engagement. And so, we thought Health I.T. is preferred to the engagement would be an important principle to have underneath these categories.

And now the question is, you know, are any of these things, these high-level principles, anything that, you know, has been missed out or anything needs to be modified, we love to sort of hear from you. Where I think this health system think through is when we start thinking of measurement concept. If you have a conceptual approach like this it might help us think better what our measurement concepts should be, you know, the themes that they are going to be looking at after this and the potential measure concept, so Andrew is going to be discussing.

I would think those are things that can be modified and they are basically examples so if it's important to measure data integrity or we could go over the measure concept X with an example of Y and Z and those examples could be different, as long as are meeting the principle of, for instance, data integrity in this case.

So, I would think that that these high-level concepts are essential that we must sort of agree upon those because then it creates our job easier. And again, this is up for modifications. It's not set in stone. We'd love to get your thoughts on, you know, adding and subtracting or editing. Andrew, back to you and time for discussion.

Andrew Lyzenga: Thanks, Hardeep. Yes. So, we just open it up for discussion at this point. Any thoughts you have, again, on the sort of issues that Hardeep highlighted

or anything – any other reflections or thoughts or, you know, questions or concerns you have about the framework?

Mark Segal: So, this is Mark Segal. I have two quick observations, one as it overall and I think this came at our face to face meeting as I kind of work through the framework and then examples. Almost all the effort is focused on dealing with potential risks to safety from Health I.T. and very little, again, I might be missing particularly the summary framework is focused on encouraging those uses of Health I.T. that have been documented to improve patient safety and so it seems from the standpoint of kind of having a balance measurement system, we want to address of both aspects of that.

The second point I wanted to make is on the item B on Level 3 on the Health I.T. facilitates patient engagement. While patient engagement is clearly important and while there is a level of overlap as I look at some of the items that came out of our sort of brainstorm assessment that were in the latter part of group it's felt like things were being included as potential measurement concepts because they address patient engagement but not really because they necessarily tied other than through this the length of patient engagement to patient safety. And so, it's just it felt to me that that one was less directly tied to patient safety and kind of open us up to perhaps sort of measure concept (load). Those are just two initial observations.

Andrew Lyzenga: Yes, I think that's a fair point.

Hardeep Singh: So, let me summarize Mark. I think what you mean is the back part, not this page, but the back part you felt was a bit more heavy on Level 1 and maybe some on Level 2 but in not the measure of concepts we're addressing the use of technology, the monitoring improve safety.

Mark Segal: Well, I guess the Level 3. That's right.

Hardeep Singh: Yes. And the second concept you other – highlighting which is think if we can maybe change the language it will maybe make sense. I think what you're trying to say is we ought to be thinking about how Health I.T. ensures – do you mean sort of the patient engagement promotes patient safety or?

Mark Segal: Wait, in other words, patient engagement is an important concept and an important ending enough itself for care coordination in any number of other reasons but by having it framed, you know, again, there's no addition text right now. I'm just having it framed as it is and then looking at the sort of the specific measure concepts that were linked to it below it felt as though we are dealing with – we are identifying things which were no doubt important for patient engagement but we're probably less directly linked to patient safety.

Hardeep Singh: So, making sure the link is stronger than basically that's …

Mark Segal: And then we sort of have it as a filter to really evaluate potential measure concept, yes.

Laura Heermann-Langford: This is Laura. I like to follow up on that patient engagement item. I completely agree with the conversation thus far. I'm just concern, I don't think that the patient engagement is monitoring safety as much of it for Level 2 of using Health I.T. safely and I think I agree that we need to have it more about the patient if an engagement is safe but I'm not sure that where we've been heading this that we're monitoring the safety as much as that we're using it.

Hardeep Singh: So, do you think it belongs in Level 2?

Laura Heermann-Langford: I do.

Hardeep Singh: So, you would …

Laura Heermann-Langford: Unless we have something different and we have different measures of monitoring but I think some of the – our discussion in such in the past has been around the use, the patient use and I agree that for this we want to have it safe patient use sort of the use by the patients in safe and increase to the patient safety but it's using it and it's not that what you have been talking about monitoring.

Mark Segal: Laura, I think maybe arguing a little bit against where I was before. I think there are definite opportunities just like we might be looking to, you know, clinicians feedback on potential, you know, safety issues that might occur we

would certainly want to have feedback loops if, you know, patients at experiences with Health I.T. that had safety issues. And so, from that standpoint I can see it's being part of monitoring but just in a more focused way than generally about patient engagement.

Laura Heermann-Langford: Well, I could see it in both patient engagement, safety and using the Health I.T. safely and I can see as you are arguing in that saying that we should be doing some monitoring safety with the patient engagement pieces, but if we currently in a lot of our work has been around the using of it safely I think more than monitoring it. And honestly, your point before was well-made that a lot of our discussion has been around not as much just patient engagement increasing safety but just patient engagement overall. That is this we need to be looking at the patient engagement is safe.

Mark Segal: Yes. I agree.

Laura Heermann-Langford: And so I am just saying that because a lot of discussion has been around patient engagement of a use, and so maybe we need to look at both Level 2 and 3 and how the patient piece is there. I mean, even Level 1, honestly, it's not just for the clinicians and data availability, integrity and security, is patients there too. And so, maybe it's just looking at the whole patient engagement piece at all of these levels and calling that out specifically.

Eric Schneider: Yes. This is Eric. I want to echo that as well. The first sentence of the framework emphasizes the clinician using Health I.T. to care for patients but this really is a two-way history and I think it's one of the things about especially mobile health technologies as they really start to change the dynamic between patients and clinicians in a way that I think it would be we would potentially be foreclosing what the future might look like if we focus on a more traditional vision of clinicians and patients interact on the space and I actually I think there could be easily – I think we want to be specific in the way that Mark and Laura are proposing. I really think hard about whether there are patient – it's much more narrow than patient engagement. It the patients use of the I.T. to do X or the patients safe use of the I.T.

Andrew Lyzenga: Yes. And I think there are certainly some safety related issues or relevant issues some of the things like patient validation of abnormal test results or verification of medication list. Certainly, I think speak to safety and that engagement piece something we can think over whether maybe that is sort of a broader kind of umbrella category stretching over each of these levels or something like that.

Hardeep Singh: So, about what I'm hearing then I think we probably could in both Level 2 and 3 we could have – let's say a D, I'm just going to put a strong out there and let you all sort of reflect on it. I think what we're hearing is that will be Health I.T. is use safely to engage patients, is that what we're agreeing upon and if so (inaudible) modify…

(Crosstalk)

Mark Segal: I guess that again seems to be …

Hardeep Singh: Let me hear out – let's hear our Level 3 and then we can do both. So, in Level 3 there will be separate fee which will be I think something like I don't think I wrote this very well, Health I.T. is used by patients to monitor safety is that kind whatever you were going with this because patients will be more engage and they can monitor their own safety to the use of Health I.T.

Andrew Lyzenga: Maybe Health I.T. is facilitates patient monitoring us of safety or something like that.

Hardeep Singh: That's right, yes, that sort where I was going with.

Eric Schneider: No, I like that formulation.

Mark Segal: And that's for safety broadly which could inclusive but not limited to Health I.T. related safety, right.

Hardeep Singh: Absolutely.

Mark Segal: Yes, yes.

Hardeep Singh: So, Health I.T. – Andrew normally you got it down, but Health I.T. is used by patients to – I think we had another word. Health I.T. is used to engage patient to monitor safety, I think that.

Male: Facilitates.

Andrew Lyzenga: Facilitates. Yes, engagement of patients to monitor and.

Hardeep Singh: OK. We're recording this so you guys can go.

Male: Exactly.

Hardeep Singh: And then the separate one in two things Health I.T. is used safely to engaged patient maybe, and Mark go a head now that you heard both those iterations.

Mark Segal: No, I think that's fine I don't have anything to add thanks Hardeep.

Hardeep Singh: All right, and then I think Eric you mentioned in sentence one, you know, we sort of going back and forth with this. That clinician taking care of making sure that end result family center care, we thought the patients will be included. The center was still delivering care to patients. But if you think there are needs to be a separate line or, you know, some few words to emphasize the patient component. Feel free to suggest what you like to see out there.

Eric Schneider: You know, I could be a simple and, you know, this may have profound implication so I don't want to over simplify it. But if the framework is the clinician and the patient and others on that care team using Health I.T. to deliver. I mean deliver is not necessary the right word there. That means anymore either. But those interested parties optimizing Medicare of a patient. That might go toward minor, very minor discomfort with the more what looks like the focus on the clinician.

Hardeep Singh: Yes, that's helpful add it little bit, you know. And we can will, sorry go ahead.

Lisa Freeman: Oh, I'm sorry to interrupt. This is Lisa Freeman. From the patient perspective that was something that also jumped at me when I was reading it. For

instance in the A top section of Level 1. If there is someway to very specifically say all, you know, all care team members including the patient I think we can set a new way of looking at it or, you know, more consistent with the newer way of looking at it so that patient are just part of the team.

And therefore, anything that is successful to the team become somewhat accessible to them as well in the same way.

Hardeep Singh: So if I'm hearing you correctly you would like A to be saying heath I.T. is accessible and usable on a component demand by authorized care team members including patients.

Lisa Freeman: Yes, I think where the time when so much is changing but we still has to sort of explicitly include the patient as a team member.

Hardeep Singh: So, instead of individuals care team members including patients.

Lisa Freeman: Yes.

Andrew Lyzenga: Do you think care team use broadly enough now that we leverage that because often as that's family members and would not that that would …

Lisa Freeman: You know.

Male: … necessarily want to call it everyone but often they play a really important role.

Lisa Freeman: I think in more forward thinking system they do but to what I hear very, very, very often not.

Hardeep Singh: So, how about we define what care team member means at the top of document and just say from now on we'll used the word care team member include X, you know, Y, Z, you know, all the things that we want to them to, you know.

Andrew Lyzenga: I think that probably great.

Lisa Freeman: That will probably great. Yes.

Andrew Lyzenga: Yes.

Jim Russell: So and this is Jim. As someone who's a patient who uses this and also use (attachment by mother) and also the vendor side. It does feel and I agree with Mark on this one here a little bit. Some of this field like Level 2 and some fields like Level 3 and it almost like with meaningful use type the way of looking at patient portal there's the kind of beginning level of patient portal of you're accessing your data, you're reviewing your data, et cetera, and there's the more interactive level of the patient portal where you're doing scheduling, your requesting things, you're doing updates to your record. You know, maybe worthwhile kind of choosing those two things out.

Hardeep Singh: And I think some of the words you mentioned could be engulf by the language and level to Level 3 worth wanting patients to make sure they go and check and make sure they're staff is not wrong and all of that. And then I think the language that we just talk about which Andrew has on record implies some of the things that you're mentioning I think. That the patients are monitoring their own safety using these tool.

Jim Russell: Right, like said there are two levels to it because …

Hardeep Singh: Yes.

Jim Russell: … my experience has a patient side to is the kind of initial (4A) into doing the patient portal is really more reviewing and maybe looking at what appointment I have in reviewing test result and then turns to more interactive over time.

Hardeep Singh: Yes. And I was thinking of both not either or for the two thing that I was adding. Yes, it was going to both.

Gregory Alexander: This is Greg, and sorry I didn't realize that to be on the phone to get through so I was listening on the web. I am – I think – I just wanted to say that I think that we have to be really careful calling out specific lines with just patient in them. Because as I'm looking at Level 2 if call a separate line for

that, then you're really – it almost appear as the feasibility is separate from the patient and really usability to check out across all users.

And so, if you start calling out lines we have patients in one line versus not and others, it could be misinterpreted I think.

Hardeep Singh: So I have – I was looking at this and thinking if we end up the defining care team right upfront and we all agreed that would be a good idea and let me know if you think differently. We could say something like this in Level 2A. Health I.T. feature in functionality a designed and implemented so that care team members can used them, you know, and then use the same word and put it out there and then may not have to have a separate one for patient.

That would suggested ultimate that I would have. I do agree that A and C for sure applies to patient as well.

Eric Schneider: Hardeep, its Eric. I like that approach in the definition of care team members of formulation that we found that worked in some research we were doing was patient caregivers and clinicians, which gets around the problem that or give their often not family members. But again …

Hardeep Singh: That will be great Eric. If got like absolute nice reference to that you want to go head and send that to the NQF folks.

Eric Schneider: Yes, I can probably pull something out.

Hardeep Singh: And if you got clinician defining that it would be in better because were like to say nurses and, you know, everybody not just physician and provide but, you know, nurses and everybody who interacted the EHR's.

Eric Schneider: Right.

Hardeep Singh: Or Health I.T. Other questions and concern?

William Marella: This is Will. I just an overall comment, I thought the categories that came up with under the level to sort put the measure into buckets. I thought the category levels were generally pretty good. The only one that I sort of question was under Level 2. Were you talking about organizational planning

and preparation for Health I.T.? I was expecting that to cover the things that you need to do when you're doing a new implementation.

When in fact, you know, a lot of the measure and the things you're dealing with under there are more ongoing concerns. So, I my just reword that one to talk about Health I.T. safety governance or something like that would encompass implementation but, you know, from most hospitals that horses are left the barn. The other kind of global comment that I make is that a lot the measures seems to me like I would fit in more than bucket.

So, for instance when I look at the data integrity category there were only two measure there. And, you know, I sort went through and kind of picked up about five or six others but I thought would fit into the data integrity bucket. So, you know, depending on whether your envisioning this report that's going to come up with this project as being a very detailed specific inventory or whether we're just trying to get across the concepts, you know, and you might think about if you kind make it more specific we might build out, you know, all the categories in which each measure might fit into it, if it makes sense to take it to that level of detail.

Eric Schneider: I want to comment on what was just said about that organization plan and corporation Health I.T. and I think it's important that we think about that from the – not just from the hospital point of view but from the long-term care point of view too and while those types of things maybe much more advance and acute care side. They're not as advance in the long-term care side.

So, organizational planning and corporation Health I.T. is something is really and many long-term care agent is a very early and so this may have some – it may have some importance in other areas as it is stating.

Hardeep Singh: Yes, you know, this is Hardeep, I agree, you know, I think maybe a good idea to even define organizations in that and I was thinking not just hospital and long-term, I mean ambulatory care is also sort of not as advanced at times in this small dark offices and things and that.

So, we should maybe define the word organization for these properties of the report, and keep a broad definition. Hey, Eric, if you got a definition somewhere up your sleeve you can send that too.

Eric Schneider: I'm not sure I have that one but I'll try.

Hardeep Singh: Any other comments?

Karen Paul Zimmer: This is Karen. I just have a general comment. Just want to make sure when I read it, it's still sounds very hospital centric and what I mean by that is I don't see a lot that's reflecting mobile health or information coming from sources other than, you know, e-mail or when you talk about systems – health information between systems but, you notice that include phones.

So, I just feel like that should be mentioned because this won't capture where we go in the next five year.

Male: Karen, you were thinking of specific measures, so we're supposed for the long?

Karen Paul Zimmer: Yes, and just when you give example systems support health information exchange between systems, you know, the example is EHR, lab, are you going to include mobile that means of communication as well? Because when I think of EHRs, you might be thinking of a computer system or under – where was I'm reading.

Used information about labs and also with the patient engagement, we talked about portal – patient portal data but now patients are actually also communicating by phone.

So, I'm just not sure where that needs to go but that is going to be the direction, we go so – I'm not sure what the right language is. I just don't feel like we're capturing a lot with Telehealth and telemedicine and mobile sources information.

Hardeep Singh: So, I think – well, Andrew, I think we're moving on to sort of second part of the discussion …

Andrew Lyzenga: Yes, yes.

Hardeep Singh: … so I can – if there are no more comments on the conceptual framework on page one, we can just sort of move on and have a bigger discussion.

Andrew Lyzenga: And the truth is really is all kind of part of the same discussion, you know, not too much of a distinction there because the sort of cross for outcome is subsequent pages is really just intended mostly to be an example of the used of a framework in some ways into this sort of show how it might be – you like to categories measures and sort of identify types of measures.

So, yes, we can kind of move in to battle a little bit, again, kind of a same question is it, have we done that categorization correctly. Does it look appropriately, we've already gotten little feedback on that, some of the measures certainly do apply, you know, across multiple areas and I think we can may be modified the language a little bit too encompass some of those things like mobile health as you mentioned.

One of the things also that we want to kind of get some feedback on is thinking forward. When kind of an open question to some extent is how granular or we want to get in our recommendations as well.

I had not and sort of been anticipating that this committee would be making recommendations on specific measure concepts that they wanted to be develop, although we could potentially do that. The – I think, you know, I had kind of invention that is recommending that we would like to see measure development in, you know, some certain topic areas, you know, or like a prior – sort of prioritize list of general – sort of, you know, either general or detailed measurement areas related to Health I.T. safety.

But that's something I might like to throw out to the group for some thoughts and input, how granular do we want to be with our recommendation. Do we want to sort of put out a set of potential measure concepts that we think shouldn't be pursued in themselves and by developers to sort of flesh out into, you know, real fully specify measures or do we want to keep our recommendation a little broader than that, maybe sort of recommend

development around some certain topic areas and saying that it sort of middle column, something like that or even moving to the left column.

So, just, again throwing that to a committee, how – what do you want your recommendations to look like and how should we – and so, that, you know, with that in mind, how should we kind of design both the framework and then our, you know, our planning to facilitate this prioritization exercise.

Male: That's correct. That sort of – I like the idea of being broader and because one you have a potential of leaving some important and novel new way of doing things out and if you wonder if by living things out and without proper direction or without the – with things left out, you wonder how that input impact and, you know, perhaps even future growth of novel ways of doing things.

So, if you're broader, you know, like sense or technology is a matter of type and technology that I work within my research and, you know, it's something that's being used and, you know, want to be include is about that, but if you get really specific, you may leave something out that kind of long and I think we want to do more inclusive than exclusive.

Andrew Lyzenga: And we could also have a blend of those things to some degree and if there are some specific concepts, you know, that we think are just critical to be measured we can say that and I'm kind of making more broader recommendations in some areas and then maybe, you know, suggest some examples, you know, not that this need to be develop but here's the kind of the type of things that we would like to see in that category or that sort of thing.

Male: It also seems that in some of the areas and I was particularly taking note around inoperability that I think there is some opportunities for refinement and consolidation. But I like the idea of us identifying kind of broader measure concepts but I think there's an opportunity for the committee to do a level of refinement beyond, you know, what's the initial level as MAP to the framework.

Male: OK.

Jim Russell: And I would be at the – this is Jim. I'd be at the teams Level 2. I mean, I agree with Mark, we could maybe stretch out the team but for all the reasons, Greg put out there then you start hamstring and people go to – concept as to being very specific. So, I think the broader themes is probably a better way to go.

Andrew Lyzenga: OK. And do you think that the framework itself should kind of incorporate some of that – those beams are something at us slightly more to get granular level or are these kind of broad principles sufficient to describe the general topic areas where we're focusing on.

Gregory Alexander: Well, this is Gregory. That seems to me like there are certain areas like the HIE which was mentioned before I think is a good example is where you have specific criteria that they – that are called out for specific HIE activities that people are striving to meet. And so, we're – if you will lock in to specific safety criteria that have to be followed. And so, versus other things that are maybe novel and they don't have that same level of required participation level and those are – some things you'll want to get specific on, and some things a little more broader.

Andrew Lyzenga: Yes. Yes, that make sense.

Jim Russell: So, I guess just to go back in that just a little bit of, I don't think we want to be recreating safer guides or we want to be recreating things that are required for instance, for meaningful use or for other things and try and keep the focus on what are really the things that are need to be pointed out for Health I.T. safety. I think, you know, focus in on those things and that get to broad or too specific.

Mark Segal: I also worry a little bit, again, living through in what we talk about this that are face to face, some of the issues that have come up in the meaningful used program about sort of over measurement and measurement fatigue and, you know, measurement becoming and in itself. Well, I think that we can be broader around the narrower in terms of the number of potential measure concepts.

At the same time, we may want to make some statements about ultimately being fairly parsimonious about, you know, a priority set of measures that we think are, you know, most, you know, is your most important and most directly, most likely to improve patient safety, because right now there's a list we have, you know, could just leave to kind of an avalanche of measurement burden.

Karen Paul Zimmer: Did we – this is Karen. Did we ever create that crosswalk of a different measures that are being correct so we could see which of those their Health I.T. are already part of organizations infrastructure?

Andrew Lyzenga: No. So that – are you talking measures …

Karen Paul Zimmer: We're talking in the crosswalk for other required that currently all the organization have a number of measurements that they required to report on and looking at all in between all the different agencies which ones are related to Health I.T. safety so we could at least start with that as one set of measurement because they are already submitting it and raise the awareness of what correlates with Health I.T. and seem where that fit in with all these new ones that we've added.

Andrew Lyzenga: OK. So, we can try to pull a list and at least give – sort of take a first path of seems which ones might be HIT against it's sensitive or related might be to – how to phrase that. It will be hard to say, you know, definitive we, you know, which ones are in fact and sort of do relate to HIT without having, you know, I guess some empirical data around that to sort of demonstrate what how Health I.T. impacts, you know, the measure though we can, you know, speculate a little bit to some degree. But we'll see what we can pull together along those lines.

And it's sort of way and we're also getting into something that else that we want to talk over a bit which is that in terms of our doing this prioritization exercise, in addition to the categories kind of laid out in the framework here. We'll also want to have some things in mind that we're sort of just alluded to including potentially, you know, the feasibility of measuring these things.

The impact on patients, you know, or the level of risk implied, you know, by the concepts that being measured or a failure to – so a bit here to that measure or we'll have to think that through a little bit but we would certainly welcome some feedback on those sort of those dimensions that we want to evaluate measurement areas and measure concepts when we're doing the prioritization, because I think that will be an important aspect of it.

Somebody just said something they had to do with the impact on patients and maybe – I would love to hear some thoughts on how the best expressed that sort of as a criteria for prioritizing measures or our recommendations. I don't know if that makes sense or if I need to explain a little bit more.

Eric Schneider: This is Eric. I wonder if you could just say a little more on that.

Andrew Lyzenga: Yes. So, for example, maybe then we could sort of try to as part of our exercise during the prioritization in our next meeting, try to identify some of these, you know, topic either sort of topic – general topic areas or, you know, measure concepts and sort of – I guess, MAP kind of a long and continuum of which ones have the greatest potential to drive improvement, and for example or, you know, which one have the most greatest potential to improve, you know, safety, you know, of patient care, the ones that are easiest or hardest to implement or that are, you know, maybe we have – you know, the easier or more difficult to collect data on.

Some sort of, you know, I guess the scales of that sort that we can kind of use in our thinking about these measures to, again, fit into our what we want to recommend as priority areas because you could, you know, easily envision, you know, in coming up with some measure concepts or topics that, you know, seem really great and theory but may extremely difficult to implement or that, you know, maybe have only marginal impact on the actual safety of patient care.

And so, there are sort of concepts that we want to incorporate into our decision making here.

Eric Schneider: Could it be the sort of classic measure development framework, the importance feasibility, scientific soundness, is that what you're?

Andrew Lyzenga: Yes, I guess so, and they would be difficult to get into the scientific, you know, with soundness or validity question, you know, just that conceptual level because then you're really talking about what the specific, you know, characteristic of a measure and how it's, you know, specified out in whether it can be reliably collected and whether it's a …

Male: So Andrew, I think some of this discussion is relevant for what's on the right hand side which is potential measure concepts or what I think it's sort of examples of the things that we have done. But I think we're still figuring out in what to do with the teams and I kind of – they're about 20 that would be few offs. But I think it could counted there by 20 teams that we need to set of agree upon that these are the teams that we want to focus on, again, whether we do it now or whether we do it after the call and see what's missing and what needs to be added.

I think the teams for us need to undergo that transformation with is it an area which is, you know, relevant information safety that we want to include that we want to let go further. And that further we're going to include some discussions on, is it something we can do and all that.

I think maybe for that discussion we have to disassociate ourselves from the potential measure content and just focus on, you know, what are these themes try to tell us and see if we either by some kind of morning exercise or something narrow that down to a wide measure fatigue, narrow that down to either 10 or 15, and then maybe 10 or 15 go to the next step where we decide which ones to actually come up with otherwise, you know, we'll be just repeating the same steps that have been said or what, again, without giving any prescriptive or at least recommending some kind of areas that need to be taking further, high priority areas that need to be taking further.

Eric Schneider: Yes. It's Eric again, I mean I guess it's just the importance category, right? So, how important are each of this thematic areas …

Male: I think so. I mean, as relevant to base and safety Eric, I mean, you know, this could be …

Eric Schneider: Yes, safe, you know, safe patient care maybe …

Male: Yes, yes.

Eric Schneider: And actually I guess it might also be useful, maybe Andrew since you're driving at us there is importance to various stakeholder. So, how important be the patients, how important the clinicians, how important to – I don't know what the right audiences are but stakeholder, importance to stakeholders.

Andrew Lyzenga: Yes, that's helpful.

Female: In tier point where the one section, the one team which – it seems like a little bit of a waste basket where we've complete corrected appropriate used of Health I.T. I think that varies depending on the stakeholders and is it used, are you really trying to get to workflow process? Because there are a little bit different

Andrew Lyzenga: Yes, that could be parts that a little bit more.

Male: Where dose – can I just ask, where is the developer is having this or maybe that something we don't want to include but – maybe as part of usability that I'm just sort of looking fit because I'm wondering where does the, you know, the software developer, the people that are creating the ITs and that are putting it out in the field, where do they interface.

Female: They should be part of planning, I would think organizational planning.

Andrew Lyzenga: Yes, planning and then and as well I think in the each of the Level 1 areas to some degree maybe or maybe some more than others but sort of the …

Hardeep Singh: So, you know, I was sort of thinking a lot while we were sort of before prior the call about, you know, sort of the issues like shared responsibility and all that. I mean we've discussed. I think it's kind of come up when we decide what are the things that we want to emphasize for measurement.

So, if we decide that we're going to focus on – I'm just going to randomly pick something user experience and satisfaction. And then when you realize you break it down, somebody at the end, you know, we'll figure it out that this area

needs to be measure and the figure, you know, who's going to be responsible for making sure that is measured and improve upon.

And I'm wondering if some of these other additional things will come up as sort of we go down more and more granular.

Male: Yes, sort of – I can sort of see and it's like a timeline of safety issues so that you would have like early on what are that really importance safety issues and measures that you want to see and the development of the product and then the implementation along the whole project lifecycle sort of which measures are critical.

Tejal Gandhi: Hardeep, this is Tejal. I'm sorry I was late getting on the call. So, you guys may have already talked about this as well. So, if you have, let me know. In the Level 3, I was just wondering if that first bullet should be split into two because I feel like the monitoring and testing and reporting measures are going to be quite different than the leveraging Health I.T. to reduce harm in patient safety measure.

And I think that the leveraging that Health I.T. to reduce patient harm and improve safety is such a critical piece that I would want that to get lost to even in terms of, you know, where we're seeing the ultimate value of these systems.

Hardeep Singh: Yes, we can split it up. It's based – I mentioned earlier, it's based directly out one of the safer principles that are used in the guide.

Tejal Gandhi: Yes.

Hardeep Singh: They're going to reword all theses things. I'm not sure how much the conversation for the first half (inaudible) but we're going to reword some of these things than we can I think reword some of the language there as well.

Tejal Gandhi: I think that is two separate concept probably and when I think about measures, I think of them a pretty distinctive well. So, anyway.

(Crosstalk)

Andrew Lyzenga: The two distinct concepts being monitoring and safety and improving safety. Is that what you're saying?

Tejal Gandhi: He's right. Monitoring detecting reporting on safety versus actually leveraging the I.T. to improve safety.

Andy Lyzenga: Sure. OK, yes.

Jason Jones: Hey, this is Jason and I'm – I know that was meant to clarify but I'm confused a little bit more in that when I first wrote it, I thought of it differently, I like saw it the first bullet under Level 2 was sort of about leveraging I.T. to improve safety. And I thought what was meant by the second half of the sentence of the first bullet Level 3 that Tejal always just emphasizing, I thought that was more about monitoring.

You think I.T. to monitor safety but not like HIT safety, for example not like placing orders on the wrong patient like what I've done but more like in a new – and it just had measure they said of say that you can use I.T. to monitor urine catheters, so thought really about HIT safety but using HIT to monitor a very important safety concepts.

So, I thought that's of the second half of the later sentence and decision to port to prevent harm was the first bullet of Level 2.

Tejal Gandhi: Yes and Hardeep can answer this I'm sure. But I thought the first Level 2 was more about making sure we're not over learning and doing things like that but Level 3 is really not the fact that you're – I mean, you've got, you know, implementing geriatric, so we're implementing renal dosing, we're implementing, you know, like are you implementing I.T. to improve safety or bar coding or whatever it might be separate optimizing it would be in preventing unintended consequences is more Level 2 but sort of the actual value of implementing those things would be Level 3.

Hardeep Singh: Right. And I agree, so Jason, you're trigger to just had patient with probably sort of like a wrong patient orders and think that would be using Health I.T. So, anytime that Health I.T. – you use Health I.T. to improve patient safety Level 3 which includes Health I.T. related patient safety as well.

So, if some things are going wrong in the use of Health I.T. and we're causing harm, we could use I.T. to detect those things automatically because as you know, none of these things are OK.

I think Tejal's point is keep the first part about monitoring the (inaudible) and reporting on safety and safe use of Health I.T. on a separate bullet and keep those leverage Health I.T. to review patient harm and improve safety on a second bullet and you're example like for instance, clinical decision support to reduce malpractice claims related to, you know, some abnormal test on follow up.

Putting that system in place in EHR, you know, if you want to (CBS) in place because we lose test results in general. That is also Level 3 because we're using Health I.T. to improve patient safety, and patient safety of any kind. Should I have to clarify?

Male: Well, so Hardeep, why would you say like – right now, our working on using extracting catheter used data from the EMR to have a catheter report and it's much more accurate in the manual data collection that and just send have prior to 2015, because, you know, the typical way of collecting catheterization look at 10 a.m. more catheters in place and that becomes a catheter days but now we can look at the whole 24 hour period.

So, it's monitoring, so I thought it was Level 3, and we're using I.T. which makes it – we can do much more than we ever could before, but it's not really about I.T. safety, it's using I.T. to get, you know, a non-I.T. safety initiative.

Hardeep Singh: Well, no, but if you're trying to reduce catheter use so that we have a less CAUTI, right …

(Crosstalk)

Male: Right.

Hardeep Singh: So, you're trying to improve patient safety, so it's Level 3. If you're trying to used Health I.T. to measure and improve patient safety, yes or no?

Male: Yes. No …

Hardeep Singh: Yes, the answer is Level 3.

Male: OK.

Hardeep Singh: So, basically anytime you use Health I.T. to you know, leverage Health I.T. improve patient safety and that's what I said, any use of new decision support system to prevent – I'm going to make it up, you know, this line infection or falls or any type of none Health I.T. related patient safety also falls under the same umbrella.

(Crosstalk)

Male: I'm sorry. Not to the totally funny here but I mean when we've done that, what we run into which is more in Level 2 is that if we required catheter removal to be, you know, sort of to figure out if we're doing the safe thing for patients we've find we have patients with five catheters because we don't document the removal reliably.

So that might and we find the same thing with ventilators. We don't document one patients come off with ventilators reliably, this is the bunch of stuff and that seems more to be measures of things that indicate in this case the EMR but be just through from mobile devices where we have a conflict between what the members has share his on versus what the pharmacy system thinks.

Those kinds of conflicts I think might fit more into Level 2, is that fair?

Hardeep Singh: Yes, absolutely fair. Any – that's useful – so, I think I'm (have) uses language and then we met, we could have the best Health I.T. or health EMR or PHR in the world, and we'll still screw it up, and that's why there's a Level 2.

Jason does that help or clarify some of the stuff?

Jason Jones: Yes, it is – I mean it's, I guess some of the language is just slightly – what might you said you're going to work on that – I'm trying to – I'm trying to pinpoint where that language I feel is slightly concern.

So, I guess, if you look at the Level 2 definition, it's just big picture said use Health I.T. safely and then when you look at the first bullet under Level 3, it just seems to like overlap a little. And also Level 3 combines the use of technology and monitoring into one, but I get your point, I'm just trying to think of ways to make the language.

Hardeep Singh: But can I …

Jason Jones: Yes.

Hardeep Singh: Yes, you know, the – I don't know whether it's going to help or hurt, but the energy and paper that the reference here might actually give you a little bit more sort of background framework sort of because that's where the levels came from. All right.

And it's just too kind of help think through the differences, there's a lot of overlaps between these categories and you go back and forth on those levels. I mean, I agree that there's a lot of overlap between this – I think Jason pointed out very nicely how they go on.

James Russell: And this is Jim, maybe Jason, you're confused since like minus, it's the word optimize. I feel like sometimes is money is the (inaudible) there.

(Tejal Gandhi): Yes, I agree.

Hardeep Singh: Yes, maybe that's what needs to go.

(Tejal Gandhi): Yes.

Hardeep Singh: I think the reason it was there is because you do surveillance and then you improve things and so maybe you should be something like surveillance and improvement or something or …

(Tejal Gandhi): I guess what's also a little ambiguous is Level 3, you're improving patients safety, and Level 2, you're improving technology but improving technology you indirectly are also improving patient safety and that's why it's a little confusing.

Hardeep Singh: Well, that's why it's a hierarchical framework.

(Tejal Gandhi): Right, right.

Hardeep Singh: Anytime you improve one and two, you know, you kind of making that transition two or three. But I must emphasize, you know, the Level 2 is mostly about the used of technology. I'm making sure that the use is safe.

So, I look at a safe technology, safe used of technology and using technology to improve safety. So, that's the way that we sort of (pop) through this. Again, (inaudible) over that though.

(George Hrispcask): So, all right, this is (George Hrispcask). The Level 1is inherent in the technology, Level 2 is used generally misused and then optimizing so there is no misused, and three is monitoring.

Well, if you look if you have unsafe used that could be due to problems inherited in the technology would that make it Level 1 or two like if you designed a poor system.

Hardeep Singh: I don't know, doesn't – can you give me example and I don't even know if it matters …

(George Hrispcask): So, for example, let's say you ordered the wrong drug. And so, you know, you didn't use – the system didn't use tall man lettering or some kind of thing that should have done, so that might be an inherent publish, safety concern in the technology, although it might have been classified and so on, misused it or they ordered the wrong medication which you can argue that's partly the systems fault.

Andrew Lyzenga: That's the area where I have – this is Andrew – found some ambiguity and as I think through it as well and to some extent I think it reflects my lack of my understanding of where sort of in the process of fine and development and configuration and an implementation for these systems, these sorts of risk emerge whether it is, you know, something like you said, yes, tall man lettering is incorporated into the system, or the CPOE, or whether, you know,

what the alarm configuration is, or what how the alarms are firing. And actually – I could actually use some input from the committee on how that happens because does that I think have an impact on sort of which level your categorizing these problems.

I think we have 'til now sort of categorize those sorts of things and the safe use of technology when I'm presuming less because those risks tend to emerge in the configuration and implementation of the technology but I'm not entirely sure that's the case maybe if …

Male: Yes.

Andrew Lyzenga: … a more of an issue of the design and sort of software development or that's or of thing.

Hardeep Singh: So, I think – we're going back and forth between the discussions about for the safety because if you remember I also presented that 5-point taxonomy which helps us think through with origin of the problem is, so the one that you define is basically a configuration sort of issue and I don't know if those slide are handy or the 5-point configuration is handy which will help people just the refresh memories.

Some of the details is to where things go wrong and where you could classify. So, we have similar issues over the year is how do you carry, right, these things. And so that's why the 5-point taxonomy emerged to categorize the safety concern.

You know, I think some of it is based on that and, you know, maybe if that is a better framework to use then, you know, we can probably use that too. But I think at the meeting people decided that the three levels are better.

Male: And I'm happy with these three levels, we just have to decide configuration as Level 1 or Level 2.

Hardeep Singh: I think configuration will be 2.

Male: OK. And then – I'm sorry, where did we end up on 3? I know it's monitoring, does it include improving patient safety or not? Because we're getting rid of optimization, and that means that just surveillance and not improvement.

Andrew Lyzenga: My understanding was that it did still include improvement but optimization was in some ways muddying the waters because it suggest, you know, the optimization of the technology rather than the safety of care.

Hardeep Singh: Oh I see.

Male: Yes.

Male: I see, OK.

Hardeep Singh: Should we say something like surveillance and safety improvement or?

Male: Yes, something like that.

Male: Yes, yes.

Andrew Lyzenga: All right. So, again, do some words meeting around this second, we've got some helpful feedback. And in terms of, yes, again, for in terms of the prioritization sort of exercise and as we move forward with that I think it – I'm hearing that in addition to are framework here that main thing we want to consider at this point is the impacts of the, you know, the topic area or measure or measure concept on patient safety and trying to sort of honed down a little bit to focus on those measures that are more specific to safety issues rather than, you know, maybe broader quality or usability issues. Is that – am I getting that right?

I'll assume that's a yes.

Lisa Freeman: Well actually, this is Lisa Freeman. I was just trying to think my thoughts through, but the one thing from a patients point view when patients interact with the system, I think usability becomes very important. And I'm not, I agree, I understand, you know, your – what you're emphasizing and trying to clarify but I think for patient involvement is usability becomes an important measure.

Dena Mendelsohn: This is Dena, if we'll reiterate was Lisa was saying that if consumers aren't able to really use the patient portal that access the information, they're not really able to monitor the information that's in there.

Andrew Lyzenga: So that – and I could some these thing that we, you know, have to – want to make a special effort to emphasize, I guess. And, you know, if we're around our recommendations say if our – if we make a recommendation, you know, usability of patient portals being high priority area just emphasized that the impact that does potentially have on patient safety and that's why we're focusing on that, you know, that it does, you know, the usability of, you know, patient interface effects their ability to contribute to the – the safety in their own care.

Dena Mendelsohn: Yes, I think that's important.

Andrew Lyzenga: OK.

Kevin Haynes: So, this is Kevin. So, I just have a quick question. I've been listening pretty intently and I'm just trying to think through, are we going to present sort of some used cases of sort of even future dream up things that would be often to have from a health information technology and sort of walk them through like – so, for example, if there was a magical button in the EHR system I could push and I had the patient – all the administrative claims on that patient from the pharmacy whether they were commercial insured or Medicare.

Of course, we know that doesn't exist in America today, but, you know, how you'd have to go through Level 1 stuff, make sure the data is available, that it's integrated correctly, that it's secure and everything is working in a Level 1 perspective.

And then in a Level 2, making sure that people actually use it and know how to use it and implement it as well as with the organizational planning, making sure that the organizations, the health care delivery systems have integrated into their processes to improve medication reconciliation for patient safety down into the levels of is it being used as intended.

Then stepping into Level 3, are systems now using it to monitor and improve patient safety and then sort of finally use it in a format that is usable to that last point by the patient that they can directly interact and engage with an EHR-based system that can magically talk to its pharmacy administrative claims data.

Hardeep Singh: Yes, Kevin, that's great example actually. I think we're signing up for writing that case up – use case up. No, but this is nice. This is – It's a nice way to sort of think about it. And I'm wondering if, again, the NQF maybe – the NQF staff, would it be good to give some case scenarios? And I think, Kevin, that's what you mean, you mean where we put this, say, for instance, for lab results, you know, build up a case starting from Level 1 and take it to Level 3 and give sort of examples to kind of explain the concepts through. Is that what you were thinking?

Kevin Haynes: Yes, that's actually exactly what I was thinking. I mean, you could even think about it in the dream of a catheter that says, "Hey, I can talk to an EHR system," and, you know, you've got to make sure that it's available, that it's integrating to the EHR, that it's secure and not telling the wrong people the wrong information, you have low Level 1 stuff. And is it being used in any of the organizations implementing it into its standard operating procedures and the workflows and those types of things.

So, I mean, we around this call might be able to come up with, you know, I'm not trying to give us all a homework and assignment, but we might be able to come up with one or two dreams and they could either be dreams that need to go through the system or they could be past experiences that if we had had this framework available as this new technology, you know, call it short scripts, call it whatever it is that's out there that may need to go through this same type of vetting system to see where we all ran into a problem.

Male: I think that would be fantastic if we could do that and I think we would need a little help from you guys to come up with some of those cases and examples. But if we could do that, I think that would be really helpful in explaining how we're thinking about this and sort of explicating the framework as well.

And I think that is, to some degree, trying to get some thoughts on that as we move into our interviews, you know, try to do at least a few sort of key informant interviews and maybe that's something we can try to probe about as well, some examples along those lines.

The – how feasible would it be to come up with some sort of examples or case studies around this from your guys perspective?

Hardeep Singh: I think we should just look around and see what are the main patient safety risks that we want to address and then go with that. We've got plenty of literature …

Male: I guess if we were unable to come up with case examples, we would question whether we should have that on the list.

Male: Right, right.

Male: And I think if we all went around and just even submitted one back to NQF, whether it was theoretical or whether it was a real example, whether it addressed across all three levels or whether it addressed within one level, you know, we won't feel bad when we carry forward only three of them that our time was not well spent because I think that vetting will help build the use case framework for the discussion of whatever whitepaper comes out of it.

Male: Yes.

Male: To the plan of – or points, I guess of wanting to be sort of forward thinking in terms of where is technology going as opposed to where it might have been a couple of years ago and also the patient and caregiver components of the care team. I know a few years ago at least, there was quite a bit of work around medication and medication-related things, reconciliation and how to bridge the gap between what patients and their caregivers thought they were taking versus what the health care delivery system did. Does anyone know has that – has any of that sort of gone from the research realm to more of a formal and operationally standards set of measures?

Female: There is a – NQF has endorsed the (Med Rec) measure that I don't know the details of, but there is a sort of an official NQF (Med Rec) measure. About kind of accuracy of meds that after (Med Rec) or something one year plan.

Male: Yes, I believe so too, although it's not – as far as I know, HIT specific.

Female: That's correct, yes.

Male: I almost wondered if something like that sort of gets us to Level 2 fairly quickly, perhaps leaning towards Level 3 at some point.

Anyway, just one idea.

Male: Well, maybe – yes. I'll take you up on your suggestion to maybe, you know, if you can think of maybe one example of – along the lines that was just described and send it our way, that would be extremely helpful in, for one thing, helping us just sort of think through this, conceptualize everything, and also to, you know, prospectively to put it in the report as examples to help illuminate, you know, our thinking for the readers and audiences of the report.

We can follow up and give a bit more instruction around that. But if you can think of some things to send our way, we really appreciate it. That'd be extremely helpful.

So, I think we've got a good – in a moment. And – sorry?

Nana Khunlerkit: This is Nana, hi. I have one question about the conceptual framework going back there. So, the Level 2 and the Level 3. I think in the Level 2, there is this – the sentence on the first bullet state, "To the satisfaction of the intended users to minimize the potential for harm." And then Level 3, in the first bullet, you also have some something pretty similarly, "Quality assurance and performance improvement." So, if I'm about to measure job performance, workload and workaround, where would that fit? The second or the third?

Male: I would call that in complete correct use I guess. Or maybe, well, it could go in – if you're talking workflow, that might be 2B, the organizational planning

and preparation for Health I.T. as well as correct – maybe complete correct use.

Hardeep Singh: I mean, what aspect of safety are you validating? I'm not sure I follow. What aspect of job performance within safety?

Nana Khunlerkit: So, we can talk about the productivity, we can talk about the stress workload, cognitive stress or even physical stress that people have when they use HIT. So, where would that fit?

Hardeep Singh: So, if that's impacting patient safety, so we are going to say, you know, if we have information overload to providers, they are going to – that's going to cause a safety concern. That then is Level 2. I mean, I'm just using kind of your example of cognitive load.

Nana Khunlerkit: Yes.

Hardeep Singh: I mean, that depends on sort of what, you know, how you're tying this to safety. This is pretty centric on safety.

Nana Khunlerkit: All right. Thank you.

Hardeep Singh: But it – So, it depends on what aspect of patient safety that, you know, would make a difference. I mean, the – I would think anything like I failed to mention earlier as well, anytime you're studying things like overall learning or, you know, nuance alerts that make people miss information, several cases have been defined of, you know, missing – having medication errors because people ignored their alerts, all that is Level 2.

I mean, I think what you're describing is underlying contributory factor as to why they ignored the alerts, but I would still say that generally with the example you're referring to probably will fall into Level 2.

Male: And I wonder is – they sort of speak to questions of, you know, responsibility, accountability for, you know, these sort of risks or hazards and then moving, you know, sort of thinking towards the measurement, you know, what level of analysis these, you know, measures or measure concepts would be geared at.

And I think that would be useful for us to get into a little bit as well when we make our recommendations if we're talking about a particular sort of topic area or getting down to the level of a concept that we would like to see measured. Maybe giving a little bit of guidance around where we think the accountability on that issue should be focused if, you know, we're talking about, you know, the design of workflow, you know, to reduce burden or the, you know, workflow and I.T. have been sort of properly integrated and, you know, maybe the proper level of analysis or level of accountability there is the health care organization.

So, if you're talking about, you know, response to alarms and, I don't know, maybe some other issues, you could sort of focus more on the clinician as the sort of accountable entity, you would say, and some other areas you might think of, the vendor as the accountable entity, I don't know. I think that's worth thinking through and speaking to a bit in our report and our recommendations.

Does that make sense?

Nana Khunlerkit: Yes, it does. I talked about workload because I think it's the contributing factors to many of these. I mean, if you think about Level 1, I think level actually contributes to workload. And then if you think about Level 2, Health I.T. system usability, that can somewhat contribute to the workload as well.

But like – I think Level 3 is the place where we should measure the workload. But somewhat, it's like, in my mind, it's in between the Level 2 and the Level 3.

Andrew Lyzenga: You know, I would kind of think of that in Level 2 myself in the system usability category that the sort of workload, you know, that is entailed by the system is an aspect of the system's usability.

Would others agree with that?

Male: I would.

Gerard Castro: Yes, this is Gerard. I would. It falls under usability but then, you know, obviously if you're measuring that, yes.

Male: So, yes, and you could, you know, think of, you know various different levels at which different organizations, individuals, entities could be accountable for that the usability of that system, you know, kind of along the line.

Male: On the area of measure fatigue and trying to get something for Level 3, is anyone close enough to the ECQM measures to know whether or not there's an option there to piggyback on things that perhaps organizations are collecting already that could be leveraged as indicators of Level 3?

Andrew Lyzenga: We could take a look at some – We haven't had a whole lot of ECQMs submitted to NQF yet, but we could see if any of them sort of speak to the use of Health I.T. to improve safety. I suspect maybe there maybe not but I can't be sure about that.

Male: OK.

Andrew Lyzenga: So, we'll check into that. But I don't know if others have insight into measures and development that we haven't seen here yet at NQF.

Male: I'll just mention that they do have a category of called patient safety. So, I'm pulling up a table now. A good – It's a good suggestion.

The other thing just to note on that is all that will change and evolve as to – with the pass through the SGR fix. So, those measures are going to be consolidated under a new measurement program. That's going to pull together meaningful years, the ECQMs and one other category of measures I can't remember now.

Andrew Lyzenga: Yes, the value-based modifier I think you mean?

Male: Yes, that's the other component. Thank you.

Andrew Lyzenga: Yes.

Hardeep Singh: So, then, how do we make sure that these types of measures are going to be used by somebody? Or is that something that we're not worried about?

Andrew Lyzenga: Yes, well, I don't know. We could maybe make some statements about it, again, in our recommendations or – but yes …

Hardeep Singh: So, I think …

Andrew Lyzenga: … good question.

Hardeep Singh: So, I think the other thing I was going to sort of remind people, I think we've gone a lot into the granular level of this which is actually excellent. But I also think we should not lose sort of the big picture and see where have we – where do we want this to go to address the things that we are, you know, most passionate about in patient safety. So, you know, things like, you know, misdiagnosis or medication errors or, you know, infections. I mean, in general, tying it to sort of the general world of patient safety and whether through the general level, it doesn't matter, you know. In Level 3, we could make a measure on anything related to patient safety, for instance.

Just so that we can – one, I think it'll help us tie it to the general, you know, ongoing movement to improve patient safety, and second, I think it'll help us ensure that we didn't leave other things behind while we were, you know, in the 20 or so measure concepts. And I'm wondering, Andrew, what would be sort of the next steps based on – I think we have about 20 minutes left, maybe 28 or less – what would be the next few things we need to be thinking about or doing in order to make sure that we don't lose the big picture.

Andrew Lyzenga: Yes. So, well, we will do – we'll make some changes to the framework and do a bit of wordsmithing on that and we'll probably recirculate that to the committee for some additional thoughts and feedback. And then I think what we'll also try to do is, again, start to kind of mock up some – sort of an additional framework of sorts to help us with the prioritization exercise and just try to think a little bit more carefully about how that is going to go and how we can – as you said, how we can kind of systematically honed down and focus in on the areas that are most important to the committee and that we feel most passionate about.

And let's see. I don't know. I'll need to think a little bit more about it as well. But that's sort of our main kind of lever as we're doing this. And so, again, that's kind of why we're hoping to get some feedback on how you wanted to move forward with that prioritization exercise and sort of categories or domains we wanted to consider as we're doing that because that will help us sort of design it and make sure that we are enabling you to make the recommendations that you want to and focus in on the areas that you want to.

Male: Well, and if you may all want to dive in to the details on the prioritization exercise but it does seemed like – I mean, the past frameworks and the important areas tended to be around the potentially avoidable morbidity, mortality importance from the viewpoint of stakeholders. So, they're probably is a list of three or four more stakeholders. And the potential cost savings associated with addressing whatever the problem is.

I would probably just go back to the – I think probably the one paper that laid this out was the one by Beth McGlynn and I can dig it up and send it around if that's helpful.

Andrew Lyzenga: Yes, that would be helpful.

William Marella: This is Bill. I guess in terms of, you know, where this is headed and what the final report is going to look like and what kind of recommendations you're going to make, I think the thing that would be most practical to organizations like the ones I work for are – I guess would be a report that not only identifies the gaps in the quality measures and comes out with these themes and we can prioritize, and then that I think is all necessary to do.

And I think if we're thinking about how these measures might actually be used, the most likely users seem to me to be people who would stand up regional quality improvement projects like we've seen with the, you know, the CMS hospital engagement networks and other organizations like that that are bringing providers together to try to move this field forward. And whatever measures developed, they will, you know, most likely be tested in the early days in the context of those quality improvement projects.

So, I think the extent to which we can throw our weight behind, these are principles that you should be – and topic specific principles that you should be looking for in terms of Health I.T. safety measures. These are the characteristics of good measures. These are the things that make measures, you know, not quite sort of valid or reliable in this space. I think that would be a practical value to the field.

Male: OK.

Male: I want to second that. The potential utility of these measures to people who are trying to improve systems isn't really critical. That's the side of stakeholders really, the people are trying to use the results of this measure.

Male: OK.

Kevin Haynes: And you could especially – This is Kevin. You could especially leverage with – as the health care system moves into more pay for performance and quality improvement type being exposed at a local level within a health system but then more broadly with the regional interplay across health systems. I think there's a lot of potential areas for movement and probably everybody on this call has some connection to a stakeholder whether they work for that stakeholder or are engaging that stakeholder. So, I think we would want to be mindful to that and sort of an introduction to the type of white paper I guess that would come out of this to sort of frame where to use this.

Karen Paul Zimmer: And, well, along those lines, whatever metrics we'd come up, whether how we choose to prioritize whether to feasibility, applicability, evidence, exactly whatever metrics we'd come up with that, the end result data has to be actionable. So, for example, I'm just looking at the complete, correct implementation and use, and for example, the percent of CPOE use, that number by itself may not be very useful as something actionable. So, whatever we're asking to measure, we need to make sure it's associated with an action.

Male: OK. That's helpful.

Male: But actually that is actionable, Karen. I mean, if you're not using your CPOE, you're using it only in half the hospitals, you're going to lose important information. And that's why, you know, most of the hospital system should be on CPOE.

Male: So, I'm just going to echo, Karen, just a little bit on that is back to some of those numbers and things is they're all things that could be measured. I think the question turns into it being measured but is there really some sort of benchmark on and what is that benchmark and to what is the action that you can take to improve the number. And without those things, just given saying, you should be (inaudible) use of barcoding or percent use of CPOE without defining how to improve that or what that really means. It just becomes a number.

Tejal Gandhi: But I agree with Hardeep, this is Tejal. I mean, I think that some of these things, I mean, you know, barcoding, for example, I mean, really it should be a measure of, you know, yes, you know, 100 percent of your measure being barcoded and then you could talk about percent of times that the (med) isn't scanned and other things to make sure it's happening effectively.

But – Or even like that example of CPOE, I mean, if you're not using CPOE in your emergency department or your I.T. or whatever, to me like the benchmark is that you would be using them across the house.

Now, is that a published benchmark? Not really, but it's, you know, I think based on the safety, you know, science at this point, that would be kind of if you put a bunch of experts together, they would say, "Yes, you should be doing CPOE in this setting."

So, I think that, you know, it's different levels. There's sort of these raw levels of, are you even doing it, and then there's the deeper levels of, now, are you doing it well, because, you know, yes, you could be barcoding the 50 percent of the time the nurse is there, you know, not actually scanning, that's important information as well. So, there's just different levels of getting at, really, are you achieving a safety benefit.

Male: No, I don't disagree. I just wanted to be careful with jus 100 percent is not always something you can do. And …

Male: Yes.

(Crosstalk)

Tejal Gandhi: No, that's definitely true, yes.

Hardeep Singh: Yes. And, you know, the thing is I'm not sure how prescriptive we're going to end up getting and that's why we're going to – I'm going to rely a little bit on to the NQF staff to tell us. I mean, if we report the measure, I think having actions as to what you can do to sort of, you know, I think it's a relevant point. But for all these things, we're just going to have to either say that the higher it is, the better versus saying greater than 95 percent versus, you know, saying – or, you know, saying that if you don't – if you're below like 70, 80 percent, you know, this is of more for risk than 95 percent.

So, I don't know how we're going to be able to give that information but I guess it's going to depend on the measure concept that we're talking about. I mean, it's probably not OK to have downtime, you know, every week in your possible system, especially the ones that are unexpected to last, you know, more than even, you know, half hour. But it's probably, you know, again, we'll have to sort of think through how much prescriptive do we want to get as we go into the absolute, you know, sort of the measures. Well, there'll be, I'm sure, more discussions and maybe that's what we're going to discuss in September.

Andrew Lyzenga: Yes, I think a lot of the discussion will be around that and I think we'll have some flexibility around how sort of specific and detailed our recommendations are, and I think that can vary a little bit depending on the topic area and how sort of strongly we feel about making some specific recommendations on a certain subject.

Female: And just to echo, I guess I didn't know who was speaking, but kind of was getting to where I was trying to go. We just don't want to have people collecting numbers for number's sake. If you collected like the percentage of

CPOE, OK, then how to needs to be tagged to it because otherwise you're just going to get a lot of people collecting to describe landscape and not acting on it. And people really become immobilized with numbers and they don't seem to get to that next step very well.

Hardeep Singh: Yes. And, you know, that's why I was sort of reemphasizing the prioritization exercise, but I think we're going to have to start narrowing down pretty quickly. We're on to a 20 measurement concepts or themes right now. And, you know, going forward and trying to develop three or four measures of each would be, you know, too much. And so, what's the sweet spot that we're going to try to do and how we're going to do it, that is probably the next step that I think I would like to kind of encourage us to think about.

Andrew Lyzenga: And maybe we can do some pre-work, you know, before the meeting have send out some surveys or something along those lines to start to get some input from the committee on sort of which are the most important topic areas or themes or whatever and start to narrow that down a bit even before our meeting.

So, we'll think through how we can best do that. And again, welcome any thoughts or suggestions you have and feel free to send us e-mail.

So, I think that's a good sort of statement of where we want to go next, Hardeep, and what we want to do. And I think we've gotten some good food for thought here on this call. So, we could probably just move to – very quickly, just, you know, throw this out to the committee if you have any additional thoughts on who we would want to focus on for – in terms of our key informative interviews or particular questions you would want us to ask or, you know, topic areas you'd want us to get at among the groups that we're talking to.

At this point, we'd kind of intended to focus on to the extent that we can get some sort of thoughts from some of these more underrepresented I guess or slightly less advanced groups like ambulatory care or pediatric hospitals, long-term care maybe, that sort of thing, try to get some input on those areas. But, again, we would welcome any thoughts or suggestions from the committee on

stakeholders or groups or – that we would want to speak to or things that we would want to try to – sort of information that we want to try to solicit from them.

If you have any initial thoughts, go ahead and speak up. If you have any thoughts after this call, please do e-mail us as well. So, I'll just open up quickly for the committee and if you don't have any suggestions right now, we can move on. But I just thought I'd throw that out there.

All right. Well, hearing none, we'll go ahead and move on. And if you have any thoughts in the next couple of weeks, if you think of somebody who would be great for us to talk to, have some, you know, interesting things going on around HIT safety or – that might provide an interesting perspective, please let us know.

I think maybe we should actually pause a moment for public comment here. See if there's any comment from the line.

Operator, could you open up the line to see whether there are any members of the public who want to comment or offer any thoughts?

Operator: Yes, thank you. At this time, if you would like to make a comment or have a question, please press star one.

And there are no questions or comments at this time.

Andrew Lyzenga: OK.

Operator: I'm sorry, you do have a comment or question from (David Hunt).

Andrew Lyzenga: OK.

(David Hunt): Hi.

Andrew Lyzenga: Hey, (David).

(David Hunt): Hi. I've just been lurking in the background the whole meeting. I just want to thank everyone. I think that the thought processes that have been going on have been fantastic, and thank you.

Andrew Lyzenga: Great. Thanks, (David).

Operator: And there are no further comments.

Andrew Lyzenga: All right. Well, Adeela, do you want to talk us through the next steps?

Adeela Khan: Sure. Thanks everyone for a really great discussion. What we'll be doing now is we'll just take the feedback that we heard today and revise this framework, as Andrew suggested like just now. We will be compiling criteria for the measure prioritization. So, we'll definitely put something together before our next in-person meeting. And we'll come back to some of the key informant information once we've developed a protocol and that's a little bit more flushed out on our end.

I just want to remind everyone that our next web meeting is actually July 21st, 3:00 to 5:00 p.m. And then our in-person meeting is September 16th to 17th.

That's all we have for today. So, again, thank you very much. Here is our contact information and really looking forward to getting all those e-mails today about definitions and articles. So, you could send them to any one of us.

Hardeep Singh: And I'm just wondering if, you know, if there's any other institutions we should talk. The only one that I was thinking of, you know, (ECRI) has a partnership going on, partnership with patient safety. And it may be good to sort of officially talk to them and, you know, sort of just talk about some of the – maybe just the prioritization part, the high risk or the high, you know, the high impact part that could be used. They're partnering with vendors to try to get data were tremendous as well.

And I think Bill, you can definitely speak more about it, but maybe worth talking to (ECRI) and maybe a couple of other institutions who might be doing some data collection and prioritization.

William Marella: Yes, sure, Hardeep. I'm happy to work with you on that.

Andrew Lyzenga: Great. And great suggestion. Thank you.

Well, any other final thoughts or comments from our committee?

Well, if not, then thanks again for joining us. We really appreciate it. And this has been really helpful. So, we will be following up with you with more information, some – and other sort of a draft to this framework to pass around as well as some – so, we'll kind of further dig into the – our preparation for how we're going to do the prioritization and come up with our recommendation. So, we'll also be circulating some materials, I would imagine, on that some time in the near future. And we'd welcome your feedback on it.

So, again, thanks everybody for joining us, taking the time to join our call today, and we will speak to you again soon.

Male: Thanks so much.

Andrew Lyzenga: Thank you.

Male: Bye.

Male: Bye-bye.

Hardeep Singh: Thanks everyone.

Male: Thanks guys.

Operator: Ladies and gentlemen, this does conclude today's conference call. You may now disconnect.

END