

Partnership for Health IT Patient Safety

Partnership Update Fall 2016

UPDATE: September 16, 2016, In-Person *Partnership* meeting, Partnering for Transformation: Making a Positive Impact

The *Partnership for Health IT Patient Safety* held its annual face-to-face meeting at ECRI Institute on September 16, 2016. This was the third annual meeting, again funded in part by the Jayne Koskinas and Ted Giovanis (JKTG) Foundation for Health and Policy. It brought together multi-stakeholder *Partnership* members, including provider organizations, health information technology (IT) vendors, expert advisors, professional societies, patient safety organizations, and researchers, to freely exchange ideas and share experiences.

At this year's meeting, the draft Health IT Safe Practices: Toolkit for the Safe Use of Health IT for Patient Identification, developed by the *Partnership's* Patient ID Workgroup, was shared and discussed. The toolkit built upon the information in ECRI Institute's PSO Deep Dive Report on Patient Identification and on the Special Report: Patient Identification Errors, from ECRI Institute's evidence-based Health Technology Assessment Information Service. ECRI's Bill Marella provided additional insight into the Patient Identification Deep Dive and Dr. Amy Tsou provided information as to why assessing the overall strength of the evidence is important in developing safe practices.

The Safe Practices for the Use of Health IT in Patient Identification was derived from looking at technology's influence in catching, matching, and displaying patient-identification information. The focus of the IDENTIFY recommendations involves the attributes needed for identification and the technologies used. *Partnership* input into these DRAFT Recommendations was requested.

Leslie Krigstein, Vice President, Congressional Affairs, CHIME, provided an update on the importance of patient identification and CHIME's ground-breaking challenge in looking for strategies, methodologies, and the best plan for a National Patient Identification Solution. The announcement of the Challenge winner is anticipated in the second quarter of 2017.

Expert Advisory Panel

David W. Bates, MD, MSc
Pascale Carayon, PhD
Tejal Gandhi, MD, MPH
Terhilda Garrido, MPH, ELP
Omar Hasan, MBBS, MPH, MS
Chris Lehmann, MD
Peter J. Pronovost, MD, PhD
Jeanie Scott, MS, CPHIMS
Patricia P. Sengstack, DNP, RN-BC, CPHIMS
Hardeep Singh, MD, MPH
Dean Sittig, PhD
Paul Tang, MD, MS

Collaborating Organizations

Association for the Advancement of Medical Instrumentation (AAMI) • American Association for Physician Leadership (AAPL, formerly ACPE) • Association for Healthcare Documentation Integrity (AHDI) • American Health Information Management Association (AHIMA) • American Medical Association (AMA) • Association of Medical Directors of Information Systems (AMDIS) • American Medical Informatics Association (AMIA) • American Nursing Informatics Association (ANIA) • American Organization of Nurse Executives (AONE) • Alliance for Quality Improvement and Patient Safety (AQIPS) • American Society of Anesthesiologists (ASA) • American Society for Healthcare Risk Management (ASHRM) • California Hospital PSO • College of Healthcare Information Management Executives (CHIME) • Constellation • Council of Medical Specialty Societies (CMSS) • Health Care Improvement Foundation (HCIF) • Healthcare Information and Management Systems Society (HIMSS) • Institute for Healthcare Improvement (IHI) •

Six afternoon breakout sessions resulted in new *Partnership* tools. These tools will be available with the 2016 Proceedings. The participants developed self-assessment tools to facilitate safety in three identified areas: establishing and maintaining an effective health IT safety system, addressing unplanned downtimes, and using automatic end times (aka automatic stop orders) for pain medications, antibiotics, chemotherapy, and other therapies.

Dr. Jeffrey Schnipper, of Brigham and Women's Health, discussed his work on medication reconciliation, and various *Partnership* participants, including the National Institute for Safety and Technology (NIST), provided updates on the copy and paste safe practice recommendations, their usability, and implementation.

New topics for workgroups were also discussed, and *Partnership* participants are voting on their choices for next topics. Voting should be completed by October 21.

The *Partnership* was proud to announce new funding for additional work. The *Partnership for Health IT Patient Safety* is now funded in part by the Gordon and Betty Moore Foundation. The foundation fosters path-breaking scientific discovery, environmental conservation, patient care improvements, and preservation of the special care of the San Francisco Bay Area. The *Partnership* is pleased to have this support as it works to make health IT safer through growing and fostering sustainability of this private-sector multi-stakeholder initiative.

New Workgroup Topic Selection

In preparation for our next workgroups, *Partnership* members were asked to pick three topics from those listed in the [survey](#). Voters can also provide their own recommendations. The goal is to have both a topic-focused and a process-focused workgroup developing safe practice recommendations on the identified topics. The workgroups will refine the topics as needed to best develop these safe practice recommendations.

Please [complete the survey](#). Forward any questions you have to hit@ecri.org.

Data Snapshot: Hidden Alert

A patient at risk for deep vein thrombosis (DVT) was admitted to the hospital. However, this patient was not placed on heparin prophylaxis. No one was aware that prophylaxis had not been ordered for more than a week. Unfortunately, the patient developed a DVT. The day before this patient developed the DVT, a resident physician noticed that the patient was not on the recommended DVT prophylaxis. This came to the

Institute for Safe Medication Practices (ISMP) • Kentucky Institute for Patient Safety and Quality • MCIC Vermont, LLC • MHA Keystone Center • Midwest Alliance for Patient Safety • National Patient Safety Foundation (NPSF) • Ohio Patient Safety Institute • PIAA • PSO of Florida • Tennessee Center for Patient Safety • Virginia PSO

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Upcoming Partnership Events:

Safe Use of Health IT in Patient Identification

Comments were due by October 21, 2016

Next Workgroup Topic Selection

Votes were due by October 21, 2016

Partnership Quarterly Meeting

January 2017

doctor's attention because of a red flag alert under the DVT section in the electronic health record (EHR). (This red flag is a clinical decision support [CDS] tool built into the EHR and triggered based on patient-identified factors.) Investigation of this event revealed that not all clinical providers were aware of the presence of this CDS alerting tool.

Background

[CDS](#) tools are intended to help providers make clinical decisions based on specific information in the patient's record combined with best practices. The goal of CDS is to ensure quality care and safer outcomes. Implementing these tools and safeguards can play a role in detecting and mitigating adverse events.

Events Reviewed

Events submitted to ECRI Institute's Patient Safety Organization (PSO) revealed more than 100 reported events involving CDS. Five of these cases resulted in patient harm. Further analysis revealed that 46% of the reviewed events were classified as "Safeguard did not function as expected" and 27% of the events were classified as "Safeguard not available"; additional classifications of safeguards not acknowledged, bypassed, or not activated were also reported. These events were most often reported as medication errors (65%), because this is where CDS has had the greatest impact on safety to date.

Contributing Factors

CDS tools, when implemented with appropriate technological planning and clinical end-user input, can improve healthcare providers' awareness of conditions and interventions affecting patients and can have a positive impact on outcomes and healthcare delivery. It is unclear from this example whether additional provider training would have alerted caregivers to the presence of this tool, or whether this was a human factor usability issue involving the inappropriate placement of such a reminder. Unclear also is whether a number of these flags and alerts appear on the pages of the EHR, distracting the reader from paying attention to any single indicator for caution.

Lessons Learned

In considering where and when CDS can best improve safety, it is important to evaluate the current uses of the CDS tool within your organization. Are providers aware that these tools are available? Have providers received appropriate orientation to CDS and all of the

current uses? It is important to also give consideration to the number of tools yielding alerts or warnings on any single display. Additionally, the type and appearance of CDS warnings should enhance workflow, not impede it. Allowing tools and technology to enhance patient safety is important. Through appropriate use and monitoring of such tools, we determine these safe practices.

We invite you to send your events, suggestions, and strategies for safe use of CDS, alerts, and other issues that you are seeing, so that these can be shared with others in the Partnership. Please send your comments and suggestions to hit@ecri.org. Remember, if you are submitting events, please use your secure communication portal.

Need Help Logging In?

Have a question that we can answer? Please contact Lorraine Possanza at 610-825-6000 ext. 5634 or at lpossanza@ecri.org.

Get in Touch with the *Partnership*

Do you have questions about any of these articles? Get in touch with us today by e-mailing hit@ecri.org. If you wish to submit information for this publication please submit items using the subject line "Partnership Update" to hit@ecri.org.

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