Public Webinar Resource

Supporting Material for "Quality Counts, Safety Matters: Prioritizing Patient Safety Through Quality Measurement"

The 2024 MMS public webinar, "Quality Counts, Safety Matters: Prioritizing Patient Safety Through Quality Measurement," was held on March 6 and March 21, 2024. During those sessions, several questions were answered by presenters from the Agency for Healthcare Research and Quality (AHRQ), the Centers for Disease Control and Prevention (CDC), the Centers for Medicare & Medicaid Services (CMS), and the Veterans Health Administration (VHA). Additional questions that were within the scope of the presentation are answered within this Question & Answer (Q&A) Summary.

AHRQ Patient Safety and Reporting

1. **Where can the dashboard on patient safety measures from AHRQ be found? Or is that not available yet?**

That dashboard is in progress, and it will be accessible on the National Action Alliance website when it is complete later this year. With that, there are several dashboards on the AHRQ website that include patient safety data, such as interactive dashboards available from the Network of Patient Safety Databases, and Patient Safety Indicator data that is currently available in the National Healthcare Quality and Disparities Reports data tool.

2. **For the proposed dashboard that includes AHRQ patient safety indicators (PSI) performance where will that data be pulled from?**

The PSI data are currently available in the National Healthcare Quality and Disparities Reports data tool and are applied to data from the Healthcare Cost and Utilization Project.

Artificial Intelligence (AI)

1. **Does your work account for how AI will impact healthcare delivery?**
2. **How do you see AI improving patient safety in the future?**

CMS' Dr. Michelle Schreiber said she sees AI outpacing safety. She recently attended a conference that highlighted ways AI is improving the ability to make diagnoses and help with clinical decision support. Through natural language processing, AI is drawing more information from text, which is common in electronic medical records. She also noted that technology, in general, can help improve safety through home monitoring or an early warning system that can alert when a patient is deteriorating.

One of the concerns with AI is around data. Dr. Schreiber noted that data are not always clean, and data that are not clean may not produce the necessary results. Office of the National Coordinator for Health Information Technology (ONC) is working to address this issue through

standardized data elements. To learn more about AI in health care, visit the Coalition for Health AI. Additionally, MMS recently held an Information Session on this topic. View the slides from that presentation.

COVID-19

1. **You discussed lessons learned from COVID-19 on the safety strategy. In your opinion, what were the greatest opportunities for improvement?**

Dr. Schreiber explained several really important factors. First, safety systems need to be constructed so they can withstand significant stress. During the pandemic, the systems were not resilient amid unprecedented stress on health care. She noted the need embed safety actions, beliefs, attitudes, skills, and knowledge so deeply into health care that they don't dissipate during times of stress.

The second important lesson is the issue of equity because vulnerable populations were even more disadvantaged, and we need to be very careful in building our safety systems that we have equity at the forefront.

Lastly, the need for date and for having it quickly is significantly important. At the beginning of the pandemic there was a rush to build a number of data systems to get fundamental information. Now, CMS is looking to ensure there are interconnected data system where questions can be answered quickly.

The CDC's Dr. Arjun Srinivasan expanded on Dr. Schreiber's points, noting that the pandemic revealed a lot of gaps in data infrastructure, especially when data are needed for rapid action. He explained that CDC continues to collaborate with CMS and ONC to address these data gaps. There is currently a pilot being rolled out in a number of states to capture capacity data and report it electronically. Dr. Srinivasan said this is an exciting pilot, but there is a lot of work still to be done to build data infrastructure.

Digital Quality Measures

1. **When FHIR is being mentioned as reducing burden, is the assumption this is via APIs and the like?**

In general, yes.

Get Involved

1. **What are your recommendations for getting involved in the noninfectious measure opportunities?**

One of the best ways to get engaged in measure opportunities is through Battelle's consensus-based entity that reviews and recommends measures for use in CMS programs and endorses measures. Battelle's Partnership for Quality Measurement (PQM) is free to join. Learn more on the PQM website.

Harms / Adverse Events

1. **As presenters here are aware, State Medical Boards publish disciplinary actions against physicians for medial incompetence, and/or other reasons that warrant**

disciplinary action. How is CMS and/or CDC measuring or capturing the following two under-recognized or under-reported types of adverse events inflicted on patients by providers, or healthcare systems when patients report safety events to regulatory organizations, and the following factors have even been included as a measure of safety: 1. Adverse health care events in patient safety resulting from medical incompetence committed by physician/providers, and 2. Harm (including criminal conduct that is different from adverse health care events) caused to patients by physicians/providers due to reporting of unprofessional conduct and prohibited conduct, or occurring otherwise.

Generally, this has been left to peer review and is often confidential and maintained by risk departments and State licensing boards.

2. **How do we get others to understand that even though our standardized infection ratio (SIR) rates are low - and below national average - we still can get to zero harm mentally. The CDC appears to operate in terms of rates vs. events of occurring. This conflict between CDC and CMS has physicians disregarding the patient safety journey.**

Dr. Schreiber said as a former chief quality officer, she used to translate the SIR vs. actual numbers of harm for system leaders. She noted it is easier to understand the information when discussed in number of cases. With patient's consent, including a patient's photo can help personalize the data. Dr. Schreiber noted the CDC is trying to make data comparable across the country through the SIR.

3. **Currently, at our hospital we are trying to encourage close calls to be reported in our system. However, it is not the norm. What strategies do you recommend to encourage this culture?**

Dr. Schreiber shared four recommendations. First, it is important to identify precursor events that can be intervened on. Once these are in place, it is important to socialize success stories to help motivate adoption. Second, make reporting simple. Filing an incident report can be burdensome for a busy nurse or practitioner, so it is important to make the process straightforward. Third, leadership must be engaged and support these efforts to encourage wide participation. Lastly, she said it is important to celebrate those who are submitting near-miss data.

AHRQ's Dr. Umscheid emphasized a few points. He said as users are interacting with their electronic health record, it should be easy to submit near-miss data. Once this information is received, it is critical that users receive confirmation of their submission and assurance lessons will be learned from their input. Lastly, engage those providers in root cause analyses and other opportunities to from and address events.

National Action Alliance

1. **Why isn't skilled nursing represented in the potential partners for the Alliance program (AHCA and/or LeadingAge)? Such an important part of healthcare should not be left out.**
2. **Why aren't home care and hospice mentioned in this presentation?**

Dr. Craig Umscheid said all settings are important to the National Action Alliance for Patient and Workforce Safety. In late 2022, AHRQ released a request for information after the U.S. Secretary of Health and Human Services recommitted to patient safety. Across respondents, the consistent feedback was the Action Alliance needed to include all settings, not just acute care hospitals. It needed to include ambulatory settings, nursing homes, skilled nursing facilities, the home environment, and so on.

3. **Regarding AHRQ's National Action Alliance, I see you are planning on collaborating with EHR vendors. Will you also include human factors experts in that group? EHR vendors have not typically included human factors perspectives in EHR design, which does have impacts on patient safety errors related to health information technology safety hazards.**

Consideration of human factors is critical to AHRQ's patient safety portfolio, and human factors engineers are an important part of AHRQ's staff. AHRQ is proud to have funded about 50 research studies in the last ten years that use systems engineering approaches to address patient safety issues. For the Nation Action Alliance, AHRQ will convene a group focused on incorporating safety into health technologies and into practice, through collaboration with colleagues at ONC and the U.S. Food and Drug Administration (FDA). AHRQ would like to include EHR vendors as relevant in these discussions and human factors will be essential in these discussions.

4. **It appears the application window has passed for the R01 funding related to Healthcare Worker Safety, is that correct?**

The funding opportunity remains open (Funding Opportunity Number PA-24-093), under AHRQ's typical funding cycle. Applications can be submitted multiple times annually. Learn about AHRQ funding opportunities.

5. **Where can we seek funding opportunities for Culture of Safety?**

In response to requests from researchers interested in using data from the AHRQ Surveys on Patient Safety Culture™ (SOPS®) for research purposes, AHRQ has established a process whereby researchers can request de-identified data files and hospital-identifiable SOPS Hospital Survey data files from the AHRQ SOPS Databases. Please visit this website to learn more: https://www.ahrq.gov/sops/databases/research-datasets.html. To learn more about AHRQ funding opportunities, visit: https://www.ahrq.gov/funding/fund-opps/index.html.

6. **I understand that that the Action Alliance has tools on the AHRQ website, but will there be references to safety goals and how to measure those? I assume that some of those goals and measures revolve around the already established CMS requirements.**

There are currently resources from AHRQ on the Action Alliance website, including tools, implementation pilot opportunities, and funding opportunities. Those tools include measurement tools, such as those from the Quality Indicator program and tools to measure diagnostic safety. Resources from other federal agencies will be added soon. To learn more, visit: https://www.ahrq.gov/action-alliance/resources/index.html.

National Healthcare Safety Network (NHSN)

1. **Would the (potential) introduction of NHSN measures being used for risk-adjustment also go into effect for the Inpatient Rehabilitation Facility Quality Reporting Program (IRF QRP)?**

CMS often uses NHSN measures in various Value-Based Purchasing programs, such as (such as IRF QRP). In those instances, CMS uses their risk adjustment. Risk adjustment information is available in measure specifications. Learn more about measure specification.

2. **I am not aware of NHSN measures being used as covariates or coefficients for risk-adjustment in the IRF QRP (discharge self-care, discharge mobility, discharge function score) unless perhaps there is overlap with some comorbid conditions... could you expand more on this?**

Those measures are calculated from the assessment instruments as opposed to NHSN.

3. **I am wondering if any NHSN measures may be added as risk adjustors?**

NHSN measures are all risk adjusted based on facility level factors, e.g. bed size etc. Some NHSN measures themselves could also be useful in risk adjusting other measures. For example, we are currently exploring ways that data submitted to the Antimicrobial Resistance Option could be used to meaningful risk adjust antibiotic use data.

4. **When will the new measure for Healthcare Facility-Onset, Antibiotic Treated *C. Difficile* Infection (HT-CDI) and Hospital Onset (HO) bacteremia be live in NHSN? Will CMS make these a required measure and, if so, when?**

We hope to release them in the NHSN application this year.

Quality Measures

1. **Where can healthcare providers provide comments on the draft Patient Safety Structural measures? Are comments being accepted?**

The Patient Safety Structural measure was presented for comment in December and January as part of Battelle's Partnership for Quality Measurement (PQM) Pre-Rulemaking Measure Review (PRMR) process. If the measure is introduced into rulemaking this year, it will be in the inpatient rule, which is usually released in late March or early April. Following its release in the Federal Register, there will be a 60-day public comment period.

2. **To Precious's point, measures presented here focus on events taking place within provider settings. Her experience points to the need to monitor and measure time to diagnosis. We consider these types of measures to be about "access" measures, but Precious's story demonstrates that we should be thinking about time to diagnosis as a patient safety priority. Is anyone working to incorporate patient perspectives like this into prioritizing areas for measure development?**

Diagnostic safety and time to diagnose are very important topics. Currently, there aren't many very good measures around diagnostic safety, although there is a lot of work being done in that area. For example, AHRQ is in the early stages of determining what a diagnostic measure or measure set entails. AHRQ's Quality Indicators program, which includes PSI data, is leading

that work. There are also tools available from AHRQ to help providers and systems measure diagnostic safety.

3. **Are there any current definitions for how the electronic Clinical Quality Measure for sepsis will be measured?**

The work on this measure is still in progress.

4. **I recently learned that the Sepsis Outcome measure will not be live in 2024. Would you be able to share more information on the timeline for this measure?**

CMS is still working on the measure and measure testing. CMS hopes to introduce the measure next year.

5. **Are there plans for quality measures in the outpatient accredited areas such as Ambulatory Surgical Centers and Rural Health Clinics?**

The Prevention Quality Indicators and the Emergency Department Prevention Quality Indicators include measures of hospital and emergency department use, respectively, that may have been avoided by access to high quality outpatient care. Learn more about AHRQ's Quality Indicator program.