

THE NATIONAL QUALITY FORUM

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MAINTENANCE STEERING COMMITTEE

NATIONAL VOLUNTARY CONSENSUS STANDARDS FOR
SAFE PRACTICES FOR BETTER HEALTHCARE-2010
UPDATE

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Wednesday, August 19, 2009

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The Maintenance Steering Committee
met at 8:00 a.m., in Capital Ballroom D of the
Embassy Suites Washington-Convention Center,

900 10th Street, N.W., Washington, D.C., Gregg
S. Meyer, M.D., MSc, and Charles R. Denham,
M.D., Co-Chairs, presiding.

MEMBERS PRESENT:

GREGG S. MEYER, M.D., MSc, Co-Chair

CHARLES R. DENHAM, M.D., Co-Chair

MICHAEL R. COHEN, MS, ScD, RPh, FASHP

DAVID R. HUNT, M.D., FACS

MARY LEHMAN MacDONALD

MAURA McAULIFFE, Ph.D., CRNA, FAAN

PATRICK ROMANO, M.D., MPH

GUESTS PRESENT:

HAYLEY BURGESS

DON CASEY

BECKY LAMIS

ALICE TU

STAFF PRESENT:

PETER ANGOOD
SARAH CALLAHAN
ERIC COLCHAMIRO

STACY FIEDLER
JENISSA HAIDARI
ANDREW LYZENGA
MELISSA MARINELARENA
EMMA NOCHOMOVITZ
LINDSEY TIGHE
CHRISTINA TSIATIS

MEMBERS PRESENT VIA PHONE:

PETER PRONOVOST, M.D., Ph.D.

GUESTS PRESENT VIA PHONE:

JOHN BIRKMEYER
BARBARA RUDOLPH

MEMBERS NOT PRESENT:

JAMES B. BATTLES, Ph.D.

PASCALE CARAYON, Ph.D.

JENNIFER DALEY, M.D.

JULIANNE MORATH, MS, RN

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1 P R O C E E D I N G S

2 (8:26 a.m.)

3 DR. ANGOOD: All right, everyone.

4 Good morning. I think that we'll go ahead and
5 get started, and hopefully a few more of our
6 Steering Committee members will make their way
7 in.

8 There may have been a small glitch
9 in some of our meeting materials where some of
10 the individuals thought it started at nine as
11 opposed to eight o'clock.

12 Hopefully you'll have your coffee
13 and your breakfast all organized.

14 My name is Peter Angood. I am now
15 at the National Quality Forum as a senior
16 advisor for patient safety, overseeing the
17 patient safety portfolio for NQF, and the safe
18 practices are part of that portfolio.

19 I would like to welcome each and
20 every one of you for taking some time out,
21 especially in a hot August where we should all
22 be at the beach really. I know that I want to

1 be there.

2 We have a few folks that will be
3 calling in. Is there any who have joined the
4 call yet? Not yet? Okay. So we'll have, I
5 think, two or three individuals calling in,
6 plus whatever public members, and as I
7 mentioned, a couple other folks will be
8 joining as well who are more local and may be
9 thinking that the meeting started at nine.

10 Well, first off, in my new
11 position I would like to make a couple of
12 comments, but most importantly, to thank Chuck
13 and Gregg for co-chairing the Steering
14 Committee through the last couple of years and
15 helping all of us to try and get that recent
16 release of the safe practices out in March.
17 So thanks, Gregg and Chuck, for that.

18 And we certainly can't overlook
19 Hayley Burgess and her hard, hard work in the
20 background. You know, she makes Chuck and
21 Gregg look good. Some days it's harder than
22 others, yes, especially when you're having a

1 bad hair day, right?

2 (Laughter.)

3 DR. ANGOOD: But, no, Hayley,
4 thank you for all of your extremely hard work
5 in making this March version as good and as
6 tight as it is.

7 What we are going to be doing
8 through this meeting and what we've been doing
9 in the background leading up to this meeting
10 is to do a little buffing and polishing, if
11 you will, of the existing safe practices. We
12 are moving into an annual maintenance cycle
13 because there's actually a fairly good flow of
14 updates in the evidence base, et cetera, that
15 need to be taken into account and then an
16 every three-year cycle for the safe practices
17 is just a little bit too long.

18 As well, as you'll hear in a few
19 minutes, we'll be expanding the patient safety
20 portfolio overall, and so for us to be able to
21 remain flexible with the safe practices is
22 exceedingly important. So the annual

1 maintenance cycle will be a critical issue for
2 us.

3 So for this year it's buffing and
4 polishing. We don't really necessarily want
5 to do major deep revisions because that will
6 put us into a very complicated consensus
7 development process, which we just went
8 through, and I don't know as the field wants
9 to go through all of that again. But we are
10 planning for 2010 to do a much more
11 significant revision to the safe practices
12 with the request for new safe practices at
13 that time and further revisions as needed on
14 the existing safe practices, plus or minus the
15 retirement of some of the safe practices that
16 we already have.

17 So we'll be reformatting the
18 Steering Committee. We'll be going into that
19 full consensus development process during
20 '010 for the 2011 version of the safe
21 practices.

22 Chuck and Gregg, did you want to

1 make a few opening comments before we get into
2 the full part of the agenda?

3 CO-CHAIR DENHAM: Sure. Thanks,
4 Peter.

5 For the record, I think also the
6 National Quality Forum staff have done a
7 fabulous job in terms of working on the update
8 to this set of practices, and I think there
9 has been, I think, very ample evidence to the
10 adoption of them. We have about three out of
11 five U.S. hospitals in our research test bed,
12 and we're averaging now in a joint call that
13 we do with the National Quality Forum on
14 Webinars monthly over 1,000 hospital phone
15 lines and averaging maybe three and a half to
16 four people per line.

17 And so we'd like to thank the
18 Committee members and subject matter experts
19 that are here or may be reading the
20 transcripts for their great support because I
21 think that there is very great interest at the
22 front line in the practices.

1 And as Peter said, the objective
2 this year, and we really are so thankful that
3 National Quality Forum agreed to kind of move
4 up the delivery of the 2010 update to 1st of
5 January time frame because the hospitals
6 really on a calendar year basis plan an awful
7 lot of what they do, and this really gives
8 them time to really be familiar with them and
9 understand them and understand where they are,
10 what's been changed, what's been updated and
11 be able to really put them to work in adoption
12 as the payers try to tie their payment
13 mechanisms to these practices.

14 So it's really great that they
15 will have that time, and that is another one
16 of the drivers for this year, an update of the
17 problem statements and the implementation
18 guides, but that as we go through the
19 specifications, you will see, I think, great
20 discipline.

21 So often organizations want to
22 change everything, update everything, and go

1 through Herculean sort of efforts in the
2 narrative updates of things, and then those
3 that have to adopt them have some huge
4 challenges adopting them, and many of the
5 hospitals are now tying their quality and
6 safety programs to adopting what the NQF puts
7 out, and so any little change really has some
8 disruption, although we should be very
9 cognizant of anything that could save lives or
10 has better evidence or whatever.

11 I think the strategy this year is
12 a good one of saying in the 2010 update be
13 disciplined about updates to the
14 specifications because people are still
15 building them into their DNA, as Peter said.
16 The '09 update came out in March. So it is
17 only really a few months old, and in terms of
18 organizations moving their ship to a new
19 course, they're still adopting that, and yet
20 we're going to have 2010 come up in January.

21 So I think the discipline is a
22 good discipline we're hearing from the field,

1 and so a lot of the effort for the update will
2 be in the implementation guides that are not
3 formally specifications and not formally the
4 endorsed standards, but that can really kind
5 of help and assist.

6 So I think this discipline is
7 great. I know that there are a number of
8 folks that really want to see substantial
9 evidence reviews of the practices. I know Dr.
10 Casey is here and has really been a great
11 champion for that, and we had considered doing
12 a big jump on that for 2010, but 2011 I think
13 gives us a wonderful opportunity now to get
14 running room to be able to again have a
15 January kind of release, but still be really
16 able to really go through a thorough review
17 again of the evidence as things go up.

18 And I think the HAI, the health
19 care associated infections practices that were
20 very thoroughly evidence based through the HAI
21 compendium is a great example of
22 harmonization, I mean, not only with the six

1 harmonization partners of Leapfrog, NQF, AHRQ,
2 CMS, the IHI and others, the original
3 harmonization partners, but the exciting thing
4 about the HAIs was that added to that group
5 included CDC, IDSA, the Infectious Disease
6 Society, SHEA, the epidemiologists and APIC,
7 the professional infection control
8 specialists.

9 So I think that harmonization has
10 been a great theme, and we're really thankful
11 that NQF has been able to be a convening force
12 to get them, you know, together.

13 So those would be my preliminary
14 thank-yous to the NQF staff and to the NQF for
15 actually moving up the agenda for January.

16 DR. ANGOOD: Great.

17 CO-CHAIR MEYER: I'd like to
18 extend the same thank-yous.

19 And one of the things that's a
20 benefit, I think, of these meetings and going
21 back and looking at the work is that speaking
22 on behalf of myself and maybe Mike Cohen who

1 is the other sole survivor from the original
2 part of this work, that if you look at where
3 we started and what you see now, it's pretty
4 impressive, on the one hand.

5 On the other hand, I think that
6 this meeting and all the future meetings are
7 going to still struggle with what I see as
8 kind of three essential tensions, and that's
9 why I think the wisdom of the group helps us
10 out, and those tensions are I would say the
11 first one is one between over specifying and
12 being super specific about what we ask a group
13 to do versus being so ambiguous that everyone
14 raises their hands and says, "Well, what do
15 you mean by that?"

16 So, on the one hand, we could
17 handcuff them by being too specific and, on
18 the other hand, we could leave them scratching
19 their heads asking what we really wanted, and
20 trying to titrate that is always a tension
21 that we need your help with.

22 I think the second tension that we

1 have here is around the issue that Chuck
2 mentioned, and that is the evidentiary base in
3 that all of us would like to be able to say,
4 boy, there is super strong evidence, you know,
5 of the highest degree, the kind of thing that
6 U.S. Preventative Services Task Force would
7 say is, you know, top grade, A level evidence
8 supporting each of these, and then, again,
9 balancing that with the reality that there
10 will be some things that we may never have
11 Grade A type evidence for, but, boy, they're
12 really important, and where we strike the
13 balance there.

14 And the third tension is
15 reflected, I think, just in this meeting
16 today, and that how much we want to keep this
17 up to date with the current evidence versus
18 how we don't want to be constantly moving the
19 goal posts on those who are trying to work out
20 there and make progress in patient safety.

21 And so I think that while we'd
22 like to be up to date, we'd like to be real

1 time up to date, on the one hand. On the
2 other hand, I put on my hat when I go back to
3 Boston at Mass. General and say if these
4 things change every three months, I'd just
5 lose my mind.

6 And so those are the three
7 tensions. I think the clear recognition, I
8 think, is that there's not a right answer to
9 any of them. There's just good discussion and
10 hopefully some wisdom that we can distill from
11 our discussion today in the future that will
12 get us in about the right place.

13 And I would say, again, taking the
14 perspective of having been at the very first
15 meetings of this group till today that I don't
16 think we've always gotten it perfectly right,
17 but I think we've come out in a very
18 reasonable place without fail, and more
19 importantly, I think it has gotten better.

20 So we've learned, and it has just
21 gotten better with time, and hopefully this
22 next round will continue that trend.

1 So thank you.

2 DR. ANGOOD: Thank you both.

3 Certainly excellent comments and
4 challenges. I particularly resonate with that
5 over specifying. In my recent position at the
6 Joint Commission in overseeing those national
7 Patient Safety Goals, I kept hearing from the
8 field, "Tell us what to do. Tell us what to
9 do."

10 And the more that we got specific,
11 the more they told us, "Don't tell us what to
12 do."

13 (Laughter.)

14 DR. ANGOOD: You know? So there
15 is that tough balance in all of this, yes.

16 Well, I'm going to spend just a
17 couple of minutes going over where we're at
18 this stage looking as a vision for patient
19 safety at NQF and, given the comments that
20 Gregg just made, I'm certainly going to keep
21 those in mind as we try to continue expanding
22 this patient safety portfolio at NQF, and the

1 safe practices are a pivotal piece in all of
2 this.

3 We have to, I think, look at ways
4 to not only follow the evidence base, but
5 perhaps move into sort of a grading and
6 scoring methodology on the basis of this
7 because patient safety, as we all know, many,
8 many times, we're trying to do things that
9 seem intuitively right. We've got some
10 examples of successes, but we don't
11 necessarily always have the evidence in place
12 to support it.

13 So how do we take that into
14 account as we push the field along in terms of
15 trying to get improvements?

16 And then the whole issue of
17 prioritizing topic areas, we need to continue
18 looking at that and try to make that become a
19 bit more objective and try to help, you know,
20 get towards specific requirements on the
21 prioritizing and try to get specific
22 solicitations coming in so that we build a

1 nice and fully rounded composite that not only
2 fills out the safe practices, but all of the
3 other components within our patient safety
4 strategy.

5 So the emphasis on the word on
6 this title slide is evolving. Okay? So what
7 we say today isn't necessarily going to be the
8 same over time, but I tend to look at our
9 programs as sort of umbrellas within
10 umbrellas, if you will, and the serious
11 reportable events are those clearly the things
12 that should not happen in health care. The
13 safe practices are those things that we can
14 and should be doing to prevent the bad things
15 from happening and to also improve the overall
16 quality and safety while we move forward
17 within the different health care
18 organizations.

19 And then the measures are
20 obviously those tools that we use to try and
21 measure on both our outcomes, but also our
22 processes of care.

1 The National Priorities
2 Partnership, now 32 member organizations, has
3 developed its six main priority areas. Patient
4 safety is an important one of those six, and
5 the NQF is the convening organization for the
6 NPP as well.

7 The six priority areas, patients
8 and families, population health, patient
9 safety, the continuum of care, overuse, and
10 then the appropriate end of life care and
11 choices around end of life are with individual
12 work groups in place now, and they're focusing
13 in on specific activities within that, and
14 we're trying to organize the patient safety
15 component of that to help complement what
16 we're doing with the safe practices as well as
17 with some of these other programs. So it's
18 becoming an underpinning for a lot of what we
19 do at NQF.

20 Obviously measurement and
21 endorsement of measures at NQF has been its
22 mainstay for its first ten years of evolution.

1 We all continue to think of this structure
2 process outcomes. We're moving towards
3 composite measures over time, and when you
4 look at the 525 or so measures within the NQF
5 database right now, slightly less than 100 of
6 them are what you would call patient safety
7 ones.

8 And we don't have as much of a
9 breadth or depth in those safety measures as
10 we would like. So we'll be moving forward in
11 that very much.

12 When I tend to think of health
13 care, there's always the main conditions that
14 are there, and CMS has their top 20 which are
15 mostly chronic conditions, but there's a
16 variety of other top issues out there. Those
17 different conditions are cared for in a
18 variety of environments, the hospitals, the
19 out-patients, the nursing homes, et cetera, et
20 cetera, and they are oftentimes associated
21 with a variety of procedures, and the
22 individual disciplines impact on how those

1 conditions are managed, if you will.

2 So we put all of those into this
3 big filter and then we take on the NQF tools
4 that we have existing right now, which are the
5 safe practices and the serious reportable
6 events and the measurement strategies, and
7 that's going to drive out our portfolio over
8 time.

9 Well, then we have to put it all
10 together because similar to the tensions that
11 Gregg mentioned, there are tensions in all of
12 this as well. So you've got your little Venn
13 diagram with the disciplines right in the
14 middle there, and then we've got the safe
15 practices, the SREs, and these measurement
16 strategies going on. We've got the whole
17 other enterprise of measurement in general,
18 not just focused on patient safety, and they
19 all influence each other overall. How do we
20 make that all function together is, I think,
21 where the hard work is for us as an NQF.

22 And with a lot of the work that's

1 been done at NQF, a lot of the new leadership
2 and new leadership strategies that Janet
3 Corrigan is bringing in, we're clearly moving
4 beyond just endorsing of measures at NQF, and
5 we've got a number of grants, as well as
6 contracts in place, one of which is a large
7 Department of Health and Human Services
8 contract that's providing us with good funding
9 and the ability to expand out in a lot of our
10 NQF programs.

11 We have a fair amount of focus on
12 patient safety in that contract. One of those
13 is to expand the serious reportable events or
14 what they also now want to call health care
15 acquired conditions, not just hospital
16 acquired conditions which the CMS uses, but
17 HHS is wanting us to utilize this term of
18 health care acquired conditions, and the SREs
19 are kind of parallel or a subset of these
20 health care acquired conditions.

21 Not all HACs will need to be
22 reported, but they certainly should be

1 reviewed at least at a local level and should
2 be denied us for trying to make further
3 improvements in care.

4 And we're going to be expanding
5 those out of the hospital environment to all
6 the other environments of care as well. So
7 that's one main component of our project.

8 And then a second main component
9 of this HHS work is to further develop and
10 expand the patient safety measurements, and to
11 really do that in an organized strategy and
12 with a specific focus on HAI.

13 As we all know, HHS has a huge
14 focus on HAI, rightfully so. There's the HHS
15 action plan. If you haven't seen that on the
16 HHS Website, I would encourage you to go and
17 look that up. Four main focuses for them on
18 there are the surgical site infections,
19 ventilator associated pneumonias, the urinary
20 tract infections related to catheters, and
21 then the ventilator associated pneumonias.

22 They also have a specific subfocus

1 on MRSA and Clostridium difficile, and that is
2 an important set of initiatives because there
3 is going to be incentives based on payment or
4 reimbursement between the federal level and
5 the state-based levels, and if there isn't
6 full and robust activity and successes going
7 on at the state levels on HAI, there will be
8 withholding of payment towards that.

9 So that's a huge, huge program
10 that we need to continue to pay attention with
11 through our vehicles here.

12 The third piece of the patient
13 safety work at HHS is on the development of an
14 issues framework report for measurement
15 evaluation and public reporting of these
16 health care acquired conditions, and we'll be
17 convening the various state-based reported
18 agencies. There's 28 of them now. Eleven of
19 them use the serious reportable events
20 verbatim basically, including Massachusetts,
21 and Massachusetts just put out their first
22 report.

1 But they don't talk to each other,
2 and so we need to learn from all of these
3 individual state-based entities what goes on
4 and folk like Mike have been reporting and
5 prompting reporting forever, and we need to
6 continue to learn and figure out how to nudge
7 our whole portfolio along with all of this.

8 So those three main components are
9 going to be an important part of all of this,
10 and the conceptual framework for some of this
11 is then -- if you take the top conditions and
12 you take the environment of care and you take
13 the procedures and to some degree even take
14 the different disciplines and how do you
15 matrix that against our serious reportable
16 events, the safe practices, and the endorsed
17 measures.

18 It looks simple on this diagram,
19 but just kind of envision it out even over 20
20 conditions, and then try to get, you know,
21 sort of serious reportable events, safe
22 practices and measures for each of those

1 different boxes.

2 But, you know, congestive heart
3 failure, top condition is treated differently
4 in the out-patient setting. It's treated
5 differently when it's an acute exacerbation in
6 the in-patient setting. There may be
7 procedures related to that, and then you've
8 got different disciplines of care.

9 So if you're a nurse in the out-
10 patient setting, you want to know what are my
11 issues that I need to take into consideration,
12 not just with the SREs, but for the safe
13 practices, and how are they measuring what
14 we're doing? Similarly, if you're in the
15 hospital, et cetera, et cetera.

16 Some of the information in the
17 boxes of this complex grid as it grows will be
18 the same, but we're trying to drive -- have a
19 nice weave or a nice overlay with each of
20 these programs so that we're able to broaden
21 this all out over time.

22 And that gets us back to the

1 prioritizing and how do we set that, et
2 cetera.

3 I'm not going to take you through
4 this organizational chart. It's just a brief
5 snapshot of where we're at in terms of a
6 patient safety structure now at NQF. This is
7 all new for NQF, but on the far left is our
8 main component programs, the SREs, the safe
9 practices, the measures, and the National
10 Priorities Partnership. We've got a variety
11 of little special projects. We're going to be
12 doing some work for CMF to clarify the issues
13 around standing orders. We've got some AHRQ
14 work that we do for the development of the
15 common formats, around the PSOs, and there's
16 some other projects coming on line.

17 And towards the right there are
18 all new activities that we're getting off the
19 ground, including some robust education and
20 outreach work, of which the productivity from
21 this group is an important component.

22 And then, of course, we all need

1 and certainly in NQF we have to pay attention
2 to the funding and how we're going to make all
3 of this work, and that has been perhaps one of
4 the Achilles heel tender points for NQF over
5 time. There's lots of great ideas, lots of
6 things that could/should be done, but how do
7 we make the funding streams consistent so that
8 we can get that work done?

9 So that's a fairly robust, I
10 think, set of activities. The main goal is to
11 try and weave this all better together. We
12 have looked critically, for example, at how
13 the safe practices and the serious reportable
14 events overlap, and do you know what, there's
15 not much there. You know, there's just not
16 much there, and that's a weakness. We need to
17 get that corrected.

18 And the measures, as I mentioned,
19 we don't have as many as we think. We've got
20 lots of SSI measures, for example, but we have
21 one urinary tract catheter measure. So we
22 have to bring all of these together more

1 robustly.

2 So I went through those for a few
3 moments to try and help you provide what the
4 context of what we're doing with the safe
5 practices and couple that with the comments
6 that Chuck and Gregg made, I think, you know,
7 today's work is certainly highly important,
8 but we can also use this as the teeing up, if
9 you will, for those who like to golf, as to
10 how do we begin to think of growing and
11 expanding and also yet paying attention to
12 those tensions that Gregg challenged us with
13 at the beginning.

14 So I'll close it at that, Some
15 comments or clarifications? Mike.

16 DR. COHEN: Well, yes. First, I
17 really have two things that I want to talk
18 about, but the first thing, which relates to
19 what you were just saying about the serious
20 reportable events, I have to be honest with
21 you. I certainly know about them, and I've
22 read them, and I understand, I think, how

1 they're being used at the state level, but I
2 am at a loss to explain to people how they are
3 actually being used to improve patient safety.

4 Is it just about transparency? Is
5 this something that actually can be
6 transferred into learning so that, you know,
7 people are actually applying information. Is
8 that what you're talking about as far as
9 bringing the states together, et cetera?

10 DR. ANGOOD: Yes.

11 DR. COHEN: Because right now I
12 see it as a count of the various events, you
13 know, that get reported and not much beyond
14 that.

15 DR. ANGOOD: It's a perfect
16 question because I think a lot of people are
17 thinking the same thing. There's all of these
18 challenges going out and all of these things
19 you should avoid, but what is it that we know
20 in terms of the success or failures of these
21 different initiatives.

22 The convening of all of the state-

1 based reporting agencies is just that. Let's
2 try and learn what works, what doesn't work,
3 what new direction should we head with all of
4 this, and then how do we, more importantly,
5 set up for building an evidence infrastructure
6 so that we can accrue the successes and
7 failures over time?

8 You know, the World Health
9 Organization has an initiative, and there was
10 a meeting, as you know, Mike, just a couple of
11 weeks back in Toronto. Their initiative is
12 part of the Patient Safety Alliance. One of
13 them is on reporting for learning, and there
14 were several countries at this meeting and no
15 other countries got this one figured out
16 either.

17 So it's not like we're behind or
18 anything. If anything we're a little bit
19 ahead of most countries, and the WHO is
20 certainly looking to see what occurs in the
21 United States in terms of, you know, how we
22 begin to put this all together.

1 Been throwing these challenges out
2 for a decade or so now, and now is the time to
3 not only make them more actionable, but to do
4 the full assessment. It's part of that HHS
5 contract work. That issues framework will
6 take these issues into consideration, and that
7 will be part of the reporting.

8 CO-CHAIR MEYER: Can I respond?

9 Again, this is a bit of ancient
10 history, but the work on serious reportable
11 events and the safe practices derive from the
12 federal government's response to the consumer
13 report. So I can go back to that. Doing the
14 accounts report, it says that NQF will be
15 asked to do two separate bodies of work.

16 From the beginning there was the
17 notion that they were, in fact, to serve
18 different purposes, and so as originally
19 envisioned, the safe practices were to look at
20 those places where there's evidence that if
21 you do this thing, it is going to have a
22 measurable impact on patient safety, and the

1 notion here was that this was taking the
2 systems approach and saying we're not going to
3 try to measure the unmeasurable in terms of
4 safety because of where we were at at that
5 point in time with measurement, but we are
6 going to -- what we are going to ask
7 organizations to do is to look at this group
8 of safe practices and then the piece to it was
9 that they would report on whether or not they
10 were doing that, yes or no.

11 The second piece was to satisfy
12 the call that said, you know, that's all well
13 and good, but you know, there are some times
14 when we just for accountability purposes, we
15 need to have transparency, and we should have
16 a parsimonious list, and that's where the
17 serious report will eventually go.

18 And so that was, at that time, I
19 think that that was the best thinking about
20 how to go about doing this in a way that
21 respected the need for accountability, but at
22 the same time focused on practices and focused

1 on putting systems in place.

2 I think over time, you know, that
3 was now about a decade ago, and so rethinking
4 that now, I think, is the right time to do
5 that. It's to think about how to pull the
6 pieces together. We had very robust
7 discussions early on around the reality that if
8 we got rid of all of these wrong site surgery
9 in the United States tomorrow, would you or I
10 or our loved ones really be measurably safer
11 in American hospitals.

12 The answer is not unless you have
13 a whole lot of decimal points because they're
14 rare events, and so how to pull these things
15 together, I think, is the next right body of
16 work, and I think coupling the practices, the
17 accountability pieces, and then with the
18 measures to see are we really making a
19 difference is the right next bit of work, and
20 frankly, when I look back ten years ago, I
21 wish we were able to do that, and I don't
22 think we were.

1 And I think that as a measure of
2 some of the progress that has been made -- you
3 know, I'm a half full guy and so I think we
4 have made some progress on these fronts, but
5 now is the time to try to pull them together.

6 DR. COHEN: The other area that's
7 bothered me, and I remember discussing it the
8 last time we had this committee together, and
9 that is the focus almost always on acute care,
10 areas that, for example, would be accredited
11 by the Joint Commission. Let's put it that
12 way.

13 And you know, in my case as a
14 pharmacist I am concerned about what I see
15 personally, the reports that we get, things
16 that we read in the media about the area of
17 community pharmacy. We have problems there,
18 and this is being totally overlooked. I mean,
19 they do not look at things from a systems
20 standpoint as we have learned to do in acute
21 care and other areas.

22 I always see this area getting

1 overlooked. Yet we know, every American uses
2 community pharmacy or some type of an
3 ambulatory care pharmacy practice, and it's
4 not just pharmacy. It's other areas, as well,
5 that are not accredited. Why we continue to
6 overlook that I'm not sure, but to me that
7 would be critically important to start getting
8 involved with that particular community, you
9 know, to change the way we're doing things.

10 DR. ANGOOD: And I think that's
11 very, very important and a high priority. So
12 as we expand this matrix, if you will, we can
13 look at one framework being those top what is
14 it, eight CMS environments?

15 We've used those environments in
16 the existing safe practices, and we've made
17 special areas and we'll review those as we go
18 through, but as we do this weaving of the SREs
19 practices and measures we'll make sure that it
20 expands into the non-acute, non-hospital
21 settings. That needs to be a very important
22 focus for the next five years.

1 Other comments?

2 Patrick Romano, welcome. You've
3 just missed some intro background stuff. So
4 you haven't missed the meat part yet.

5 DR. PRONOVOST: Peter, this is
6 Peter Pronovost.

7 I have been on the call, and thank
8 you for -- joining. I had to do an early
9 meeting.

10 DR. ANGOOD: No problem.

11 DR. PRONOVOST: But thank you for
12 the comments.

13 Two thoughts. One was that I
14 agree with not diving into the evidence review
15 now and typically as -- AHRQ is supporting
16 RAND and others to develop criteria for
17 patient safety practices, and it seems that
18 that framework might actually inform how we
19 look at it, how it behooves us to wait till
20 that report is out in January.

21 And then, second, more of a kind
22 of my hat in the trenches here is Greg's point

1 about the tensions, I think, are very real,
2 and even perhaps in lieu of adding new things
3 it might be beneficial if we could get some
4 more feedback from the trenches about how
5 these are being perceived and are they used
6 and viewed as useful.

7 And I don't know what NQF
8 resources, but before we add new ones, some
9 focus groups or talking to some sample of
10 people who are using these to say what is
11 working for you and what isn't working, I
12 suspect, would be very informative to our work
13 going forward.

14 DR. ANGOOD: Thanks very much,
15 Peter, and your comments actually filled a
16 couple of holes from my opening comments. So
17 thank you for doing that.

18 This RAND project that Peter just
19 mentioned, I think, is going to be very
20 important in terms of helping us learn further
21 how to evaluate and study and develop
22 methodologies around safe practices, and that

1 work should be, as Peter said, wrapping up
2 towards the end of the year, early next year.

3 And, Peter, we are planning to
4 make sure that that becomes part of this scope
5 of work that we're doing at NQF and why I made
6 sure that I was able to at least get close
7 affiliation with that work so that I could
8 follow it in its evolution.

9 And your second comment around the
10 feedback from the field, as part of our HHS
11 contract work we're doing a fair amount of an
12 environmental assessment work, if you will, to
13 help lay the foundation for some of those
14 activities I described, and surveying the
15 field and getting some feedback is one of the
16 ones that we have in the works.

17 There's some mechanical issues in
18 terms of how to do that in a timely fashion
19 when you're working under these heavy
20 government contracts, but I couldn't agree
21 with you more. Feedback from the field on the
22 practical realities of these things is

1 important.

2 Thank you.

3 CO-CHAIR MEYER: And I would just
4 note also we count on those of you around the
5 table to do for us, and I have kind of my view
6 of the world as somebody who's trying to put
7 these into place, but I come from a large
8 academic, you know, health center in
9 Massachusetts, and that is not the world,
10 despite what many people up there think.

11 DR. ANGOOD: Yes, I just felt the
12 quake go through the room there.

13 CO-CHAIR MEYER: Indeed, indeed.
14 So we do count on Committee members to speak
15 up and say what you're hearing from colleagues
16 or what you're experiencing on your own with
17 what's making sense and where we seem like
18 we're hitting these tensions right and when
19 we're off the mark.

20 DR. ANGOOD: Any other comments or
21 clarifications or anything?

22 It's always nice to spend a few

1 minutes on the broader ideas and the vision
2 and all of that sort of stuff, but we do have
3 some meaty work to get through today.

4 So we've got Peter on the phone.
5 Patrick is in the room. We've got a couple of
6 other individuals that are going to need to
7 filter in during the morning time, and we're
8 going to make sure that we try and wrap up by
9 3:30. We've got a healthy set of work.

10 We also have one specific agenda
11 item that we have to be on the mark for at ten
12 o'clock. Arnie Milstein and Barb Rudolph and
13 a couple of others are going to be calling in
14 to talk to us about the evidence-based
15 hospital referral issue, and there's a
16 separate set of discussions. There's a
17 separate document you should have received
18 regarding that.

19 So we need to hit that as one hard
20 stop point, but the rest of the day, the
21 second hard stop point is 3:30.

22 Practical issues, restrooms are at

1 the far end of the hall. If you need somebody
2 in a bit of help, our meeting assistants are
3 on the side of the room, are just outside, and
4 Melissa and Andrew are here to help us in any
5 other ways, and the technical issues, if you
6 have any, the gentlemen on the side there are
7 excellent.

8 All right. With that I'm going
9 to --

10 MS. MARINELARENA: Can we just do
11 some housekeeping?

12 DR. ANGOOD: Other housekeeping
13 that I didn't mention.

14 MS. MARINELARENA: Sorry. If we
15 could just go around the room and have
16 everybody introduce themselves for the
17 transcript and disclose any conflict of
18 interest that you have, just technicalities.

19 Thank you.

20 DR. McAULIFFE: I'm Maura
21 McAuliffe. I'm Professor of Nursing at East
22 Carolina University in Greenville, North

1 Carolina.

2 I've been a part of this
3 Committee, I think, for about four years, and
4 it has evolved and it has really been a great
5 process to be a part of, and when you see the
6 final product, it makes you proud to be part
7 of it.

8 So I think we're doing good work
9 here, and I have nothing to disclose as far as
10 conflict of interest.

11 Thank you.

12 MS. MacDONALD: Hi. My name is
13 Mary Lehman MacDonald. I'm the Director of
14 the Health Care Division of the American
15 Federation of Teachers.

16 We represent 1.6 million consumers
17 of health care and also 70,000 nurses and
18 health professionals who are covered by
19 collective bargaining agreements in usually
20 acute care hospitals and visiting nurse
21 services.

22 So, again, it's a pleasure to be a

1 part of this important work, and I have no
2 conflicts to disclose.

3 DR. COHEN: Mike Cohen from the
4 Institute for Safe Medication Practices.

5 We're a nonprofit organization
6 that operates a national medication reporting
7 program for both practitioners, and as of this
8 January, for consumers as well. We have a
9 consumer Website with access to reporting.

10 And our other major activity is
11 that we also act sort of as a National
12 Transportation Safety Board after there's been
13 an event at a location. We sometimes travel
14 there.

15 And I have no conflicts of
16 interest either.

17 DR. BURGESS: Hayley Burgess,
18 Director of Performance Improvement, Measures,
19 Standards and Practices for TMIT.

20 No disclosures.

21 CO-CHAIR MEYER: I'm Gregg Meyer,
22 Senior Vice President for Quality and Safety

1 at Mass. General Hospital and the physician
2 organization there.

3 And I have no disclosures, sadly
4 no disclosures.

5 (Laughter.)

6 CO-CHAIR DENHAM: Chuck Denham,
7 Chairman, TMIT.

8 And only disclosures are on the
9 form, support of the NQF and support of the
10 Leapfrog Group through TMIT.

11 DR. ROMANO: I'm Patrick Romano.
12 I'm a professor of internal medicine, general
13 medicine and pediatrics at the University of
14 California, Davis.

15 I work with the UC-Davis Center
16 for Healthcare Policy and Research, and I
17 guess my disclosure is that I've worked fairly
18 extensively with the Agency for Healthcare
19 Research and Quality on quality indicator
20 development, refinement and validation.

21 DR. ANGOOD: Thanks, Patrick.

22 And, Peter, did you just want to

1 do a second introduction for yourself, please?

2 DR. PRONOVOST: This is Peter

3 Pronovost. I'm a professor of -- and health

4 policy and management at Johns Hopkins.

5 DR. ANGOOD: Thank you.

6 Anyone else on the phone?

7 (No response.)

8 DR. ANGOOD: Yes, not at this

9 time. Okay.

10 Just again for the record, my name

11 is Peter Angood, Senior Advisor for Patient

12 Safety at NQF, and we have Melissa

13 Marinelarena, which I can never say properly,

14 who is Project Director at NQF on patient

15 safety, and Andrew Lyzenga, who is a research

16 analyst for NQF, as well.

17 Do you want to go around the room?

18 MS. MARINELARENA: Yes, can we

19 have the audience also introduce themselves?

20 Thank you.

21 MS. CALLAHAN: Sarah Callahan.

22 I'm the Director of Education for NQF.

1 DR. LAMIS: Becky Lamis. I'm a
2 fellow at the Institute for Safe Medication
3 Practices.

4 DR. TU: Alice Tu. I'm a FDISMP
5 fellow currently with MICA ISMP.

6 DR. CASEY: Don Casey, Chief
7 Medical Officer of Atlantic Health in
8 Morristown, New Jersey; Vice President of
9 Quality; also a member of the Quality
10 Improvement Advisory Commission for the State
11 of New Jersey Department of Health and Senior
12 Services.

13 MS. TSIATIS: Christina Tsiatis,
14 performance measures intern at NQF.

15 MS. NOCHOMOVITZ: Hi. My name's
16 Emma Nochomovitz. I'm a research analyst in
17 the Performance Measures Department at NQF.

18 MS. TIGHE: Hi. I'm Lindsey Tighe.
19 I'm also a research analyst in performance
20 measures at NQF.

21 DR. ANGOOD: All right. I think
22 that concludes all of our introductions, and

1 with that, roll up your sleeves, get ready,
2 put on your seatbelts, and Chuck and Gregg are
3 going to take us through.

4 We have Andrew here is going to
5 sort of scroll and type as we move along, try
6 to capture the essence. This kind of live
7 capturing of the information is one of being
8 a very useful tool that Hayley and Chuck
9 helped us get refined on.

10 So Chuck.

11 CO-CHAIR DENHAM: We want to be
12 very cognizant of our ten o'clock timetable
13 for the meeting with the subject matter
14 experts regarding evidence-based referrals.
15 So we want to make sure, and we want to
16 acknowledge Dr. David Hunt has just arrived,
17 one of our esteemed Committee members and the
18 Chief Medical Officer for the Secretary of
19 Health's Information HIT Coordinators Office.

20 Hopefully I didn't mismanage
21 that --

22 DR. HUNT: No, that was perfect.

1 CO-CHAIR DENHAM: -- introduction
2 too much, and a great champion for these
3 practices and has served on the Committee for
4 the last three years in a great way, really
5 helping us coordinate with both CMS and the
6 Secretary's Office.

7 So the subject matter for just the
8 next couple of minutes is just to address the
9 time line for the safe practices release, and
10 again, we want to really thank the NQF for
11 being able to target the January 1 release
12 date for the hospitals and the health care
13 organizations that adopt these over a calendar
14 year.

15 So back-planning from that, the
16 timetable for this set of practices -- and
17 correct me if I'm wrong from the NQF staff.
18 I'm just reading from the list -- is public
19 comment for the September 14th through October
20 13; the week of the 19th and the 25th,
21 Committee conference calls; November 1st is
22 targeted for the CSAC Committee for review;

1 and then Board of Directors, presuming that
2 the public review, comments are all reviewed
3 and incorporated and assessed prior to moving
4 forward with the board, presuming that all of
5 that occurs appropriately, which we would
6 probably anticipate it to be fairly simple
7 because the updates to the practices are not
8 substantive. There are just some that are
9 being addressed that the Board of Director
10 would then hopefully approve this set of
11 practices, and then the January sort of
12 release of the practices, again, giving the
13 hospitals a chance to adopt.

14 So let me stop there and ask the
15 NQF staff if there are any other dates that
16 are important to us that we want to make.
17 And, again, these are targeted dates depending
18 on what comes back from the field.

19 So Dr. Angood, Dr. Meyer, any
20 comments on the time line or anything from the
21 Committee regarding the time line?

22 How about from the attendees?

1 Patrick Romano, yes.

2 DR. ROMANO: Hi. Just a quick
3 clarification. The issues that were
4 identified for our attention here in the
5 right-hand column of this table are those
6 issues that have been raised by NQF members or
7 by members of this Committee or what's the
8 mechanism them for that?

9 CO-CHAIR DENHAM: The right-hand
10 column are from all of the above, and more
11 subject matter experts' review of the
12 literature, changes in the Joint Commission
13 work so that the harmonization could occur.
14 So what's in the middle column are the
15 specifications, which are the endorsed
16 practices.

17 And as we know, the book has grown
18 to north of 400 pages, but a substantial
19 proportion of that are implementation guides
20 that are not formally part of the endorsed
21 practices, and then also references so that
22 because the hospitals and health care

1 organizations were really seeking to have as
2 much as they could to kind of refer to.

3 So the both of the endorsed
4 practices, middle column, right column, all of
5 the above, members, subject matters experts,
6 harmonization organizations, and also input of
7 the NQF members.

8 Anything you want to add, Peter?

9 DR. ANGOOD: No.

10 CO-CHAIR DENHAM: So Peter.

11 DR. ANGOOD: No, I'm fine, and
12 what you will do in moving through all of this
13 at a fairly rapid pace with Chuck and Gregg's
14 guidance is to basically go through each
15 practice. Hopefully you will have had some
16 opportunity to at least scan through the
17 materials.

18 Hayley, do you want to just remind
19 me again of your edit style in terms of what's
20 an underline, what's covered in blue, et
21 cetera?

22 DR. BURGESS: Right.

1 DR. ANGOOD: Use your mic please.

2 DR. BURGESS: Anything that's
3 underlines black, that's original text that we
4 wanted to draw your attention to, and then the
5 question, we tried to put them directly out to
6 the right side so you would know what we were
7 asking.

8 If it's blue, then that is a
9 potential change in wording, and red would be
10 a deletion, a potential deletion.

11 CO-CHAIR DENHAM: So in the table
12 that we have, we've addressed a number of the
13 practice in that first preamble, but I direct
14 your attention just in order to get through by
15 10:00 a.m.

16 Practice is Chapter 2, embodies
17 the four practices that address culture.
18 These address leadership, structures, and
19 systems using surveys for cultural measurement
20 and intervention, team work, and team-based
21 interventions, and identification and
22 mitigation of risk and hazards.

1 And so at this point in time as we
2 go through this -- and we'll have additional
3 Committee calls as we have discussion -- there
4 are really no major issues in terms of
5 substantive change, other than updating
6 certain specifications to synchronize them
7 with other NQF reportable events, for example,
8 and other issues that don't pertain to the
9 endorsed specifications of the practices.

10 There will be updates which don't
11 have to go out for review to implementation
12 guides and references, and so we're thoroughly
13 going through the problem statements, and just
14 to refresh everyone, the practices have a
15 problem statement. Then there is a practice
16 statement, and then there are specification.
17 And the additional specifications and the
18 practice statement are formally what is the
19 endorsed practice.

20 The problem statement is an
21 introductory preamble. Then the
22 implementation guide's new horizons, the

1 practice measures that may be available out of
2 525 measures that evolve with the safe
3 practices, all embody the non-endorsed
4 practice sections.

5 So we won't be putting those up
6 for review now, and again, they don't have to
7 be -- they're not part of the endorsed
8 practice, but merely guidance, reference
9 information, and updated information. And so
10 the problem statements will be updated with
11 the latest references both from the medical
12 literature, but also non-medical literature
13 because the NQF has given us the band width
14 over the years to make sure that we can go
15 outside of the medical literature, for
16 instance, in the leadership areas and others.

17 And so there are updates that will
18 occur there. So as we go through these
19 practices and for time, I think that -- how
20 would you like to do this as we kind of look
21 at our ten o'clock stop? You know, there are
22 some clarifications regarding language.

1 Gregg.

2 CO-CHAIR MEYER: I think we should
3 just go methodically through the table and
4 raise the question. I think two things we'd
5 like you to react to the questions that we
6 raise here, but in addition to that, we'd like
7 you to raise other questions as you go
8 through. So if there's something again from
9 your experience or the experience of those you
10 know in the field that you say, "Boy, here is
11 another issue you didn't pick up on," we'd
12 like to hear those as we scroll through.

13 CO-CHAIR DENHAM: So safe practice
14 number -- go ahead.

15 CO-CHAIR MEYER: I'm sorry. I
16 just wanted to make one more comment. The
17 balancing act on this will be, as I said in
18 the opening comments, we're buffering and
19 refining and polishing the existing practices.
20 If there's highly, highly substantive change
21 that needs to be made, then we need to go into
22 the formal consensus development process.

1 If there are issues that don't
2 necessarily change the specs but are issues
3 that should be mentioned, then one of the
4 methods we do use is to move some of that
5 information into the problem statement and
6 then sort of the contextual part of the
7 narrative for the safe practices so that we
8 get the information into the field, but it
9 doesn't necessarily have to change the specs
10 on the practice and kick us into that
11 consensus development process.

12 That doesn't mean we shouldn't.
13 If there is clearly an issue that needs to be
14 pushed into consensus, then we will go that
15 way. But there is the balance.

16 CO-CHAIR DENHAM: Patrick.

17 DR. ROMANO: Yes, I'll just kind
18 of restate a point that I've made over the
19 past year, year and a half, which is that I
20 think that this document or the current
21 version, 2008 version is really a substantial
22 improvement over previous versions and

1 reflects this evolutionary change that we've
2 been working toward.

3 But I think I and Peter Pronovost
4 on the phone and maybe some others are still
5 a bit frustrated by kind of a pseudo
6 specificity. It appears in some of these safe
7 practices, especially the first two or three,
8 where there's an effort to verify specifically
9 delineate aspects of the leadership practice
10 that really aren't evidence based. They may
11 make sense, but there may be 100 different
12 ways that organizations can achieve the same
13 goals.

14 And so that will be a recurring
15 theme in my comments, is looking for ways to
16 move that what I call pseudo specificity
17 because it looks very specific, but it's
18 really not measuring what we want to measure
19 and trying to move that out of the additional
20 specifications, and I think the very first
21 comment is a good example of that.

22 DR. ANGOOD: And by all means keep

1 kind of ringing that bell, and it is the
2 tension that you do. In one of the breaks,
3 Patrick, I'll try to give you a brief update
4 on the small portion that you missed because
5 of your flights and help set some context for
6 you and reassure you that we're headed along
7 that path on a broader context overall because
8 we all agree with you. We need to get there
9 it's just a matter of this tension.

10 DR. PRONOVOST: And, Patrick, this
11 is Peter.

12 I would also add acknowledging the
13 potential risks of driving health care
14 organizations to one specification when it
15 might not be the optimal, and almost certainly
16 will have unintended consequences.

17 DR. ANGOOD: Yes, very good,
18 Peter. Thanks.

19 CO-CHAIR DENHAM: So I think it's
20 really important, Patrick. I think that
21 frequently we can raise the bar of evidence so
22 high that nothing will pass through the bar

1 and will have the catharsis of the discussion,
2 but not have any specifications, and I think
3 this is the dynamic balance that Dr. Meyer
4 came up with.

5 So that if there are I think we
6 need as a Committee to discipline ourselves to
7 not challenge word tooling, a narrative or a
8 style because there's not evidence but look at
9 the specification and say if there is evidence
10 that committee members or as subject matter
11 experts have that say that there's a better
12 way for the specifications to be retooled,
13 that that evidence be provided and that we
14 address it and, really as Peter just said, a
15 better way that has evidence, that's the whole
16 purpose of kind of the process of refining and
17 making them better.

18 I think it's important to strike
19 that dynamic balance though as we go through
20 this of the fact and look back on the history.
21 We now have thousands of hospitals adopting
22 these practices, and actually the first four

1 practices have had very little push-back in
2 terms of not being specific enough or being
3 too specific or not being evidence based, you
4 know.

5 So I think that there are not a
6 first set of practices that have not been test
7 run out into the marketplace. They have not
8 had a major change since the 2006 update, the
9 first four practices, and it's interesting
10 that we have many, many hospitals that are
11 adopting them, and we just haven't had from
12 the field that your test is -- you know, are
13 we off track?

14 We also haven't had subject matter
15 experts really challenging them from an
16 evidentiary standpoint. So I think we should
17 keep that in mind on some of them, you know,
18 as we go through them.

19 So the safe practice, number one,
20 is divided up in awareness, accountability,
21 ability and action categories. The first
22 comment is regarding the third bullet, direct

1 patient input, and the question is information
2 from the satisfaction survey is not enough for
3 discussion. Is this wording too strong?

4 So I want to open that up.

5 Peter, do you want to comment on this one at
6 all? Anyone want to comment regarding this?

7 MS. MacDONALD: I would just say
8 no. I don't think it is too strong. I think
9 it's fine.

10 DR. ROMANO: Well, I think that
11 sometimes the problem comes in with the
12 operationalization. I think that we all would
13 agree that patients should have some
14 involvement or patient representatives should
15 have some involvement and input into the
16 management of the hospital related to safety
17 and quality.

18 The question is what's the
19 appropriate mechanism for that input. The way
20 this particular item was operationalized on
21 the Leapfrog survey was patients and family of
22 patients are formally involved in safety and

1 quality committees that meet on a regularly
2 scheduled basis.

3 Now, that's a little bit
4 problematic because in most hospitals quality
5 and safety committees are constituted as peer
6 review committees, and so it's difficult when
7 they're legally constituted as peer review
8 committees to include patients on those
9 committees.

10 So the NQF language here is
11 perhaps slightly more inclusive than the way
12 Leapfrog has operationalized it, but I would
13 like to hear some discussion about this issue
14 and about whether there are ways of involving
15 patients and their representatives without
16 having them formally on constituted safety and
17 quality committees.

18 DR. McAULIFFE: I guess I would
19 take the opposite point. I think that they
20 should be to the extent possible allowed to be
21 on the committees. I think they bring a
22 valuable input to those committees. I think

1 the challenge is to have a structure such that
2 they are educated into what their role is on
3 the committee. I don't think the patient can
4 change, you know, from month to month, but to
5 be educated into what their role is and
6 perhaps have legal counsel inform them what
7 they can and cannot disclose outside of that
8 committee.

9 But to have their input, I think,
10 is hugely important.

11 MS. MacDONALD: I just -- I also --
12 - oh, I'm sorry.

13 CO-CHAIR DENHAM: I was just going
14 to say I think we need to be very careful and
15 precise about what we're doing. I don't think
16 that the Leapfrog, any organization's use of
17 the practices should be a major discussion
18 point here. I think we're discussing these
19 specifications, and I think that if
20 organizations are misusing or changing, you
21 know, it would be one thing if an organization
22 said, "Hospitals are adopting the

1 specifications as stated."

2 But you're putting a twist in it
3 in how they have operationalized it, a
4 merited, well merited point, but perhaps a
5 discussion with Leapfrog, not a discussion
6 with the NQF.

7 So I think we need to be really
8 careful because I think it's very easy when
9 organizations use these practices for A, B or
10 C, but unless they are using them line
11 precisely the way that they've been written,
12 I think we can waste a lot of time.

13 So I think that Leapfrog is on the
14 call later at ten and if we don't bring up all
15 the 30 minutes that we have for it, that might
16 be a good point to kind of bring it up with
17 them, but I think it's important that we parse
18 out the difference between the two because a
19 lot of challenges of Leapfrog will roll over
20 to NQF, and the water gets kind of muddied,
21 and I think we need to be careful about our
22 specs.

1 MS. MacDONALD: I did want to ask.
2 It was confusing to me how this would work,
3 and if you have any examples. I mean, I think
4 it's great to have a stronger patient voice.
5 Obviously I agree strongly with that, but it
6 is unclear to me how the patients would be
7 selected and if they would be ongoing and how
8 this would actually work.

9 CO-CHAIR MEYER: And I think this
10 may be something again in the next larger
11 rewrite. As we add in some of the
12 implementation examples, the big push for
13 Patient-Family Advisory Counsel, so in
14 Massachusetts, for example, State Department
15 of Public Health now requires there to be a
16 Patient-Family Advisory Counsel, which is one
17 mechanism that accomplishes the same
18 beautifully.

19 And another one is where you can,
20 so peer review rules vary, but being able to
21 put patients onto our Patient Care Assessment
22 Committees in Massachusetts can have them.

1 It's not true elsewhere.

2 And so my sense of this is the
3 information from satisfaction survey is not
4 sufficient. It sets the right tone. I mean,
5 the tone here to me when I read that, it says,
6 you know, perhaps necessary, but definitely
7 not sufficient. There are a number of
8 mechanisms out there. Joint Commission is
9 pushing folks as well to develop Patient-
10 Family Advisory Counsels, and I think we can
11 put those in implementation examples with the
12 bigger rewrite.

13 CO-CHAIR DENHAM: It's also
14 important as we go through these, and we could
15 probably spend a week or two going through how
16 every one of them is worded, but I think to
17 put on the other hat is to say, you know, what
18 harm is done by involving patients and
19 families by having a structure or system in
20 place? Is there harm to anyone to have that
21 in place? I mean, you know, what is the risk-
22 benefit of taking the affirmative approach?

1 Because we could always say
2 there's no evidence today of a randomized
3 prospective trial that shows that patients and
4 families have caused the saving of lives, but
5 there also is probably no one that will take
6 on a trial to prove that involving patients
7 and families is going to harm patients and
8 families in the future.

9 So I think it's this practical,
10 reasonable sort of approach that we have to
11 take to each one of these.

12 DR. ROMANO: Yes. So I think that
13 given that framework, I think the language
14 here is inclusive enough probably and would
15 benefit from perhaps implementation examples,
16 which don't involve classical safety or
17 quality, peer review type committees because
18 that's where some people get stuck.

19 Just to challenge Dr. Denham's
20 comment a little bit, I think that the problem
21 that we confront is that the Leapfrog survey
22 is an effort by an intelligent group of people

1 to implement the NQF or safe practices in a
2 survey form, and they've done this as well and
3 as carefully as they could.

4 And so we have to recognize that
5 if we see misinterpretations in the Leapfrog
6 survey that it probably reflects on lack of
7 clarity in our specifications.

8 So it's not simply pointing the
9 finger at Leapfrog. It's really saying, well,
10 you know, it's sort of like when I'm teaching
11 and the students, you know, do badly on a
12 test. Well, yes, maybe the students didn't
13 study, but it's also a reflection on me and my
14 ability to convey the concepts that were
15 important.

16 CO-CHAIR DENHAM: Great. So
17 that's duly noted, and, Dr. Romano, are you
18 familiar with the chapter on patients and
19 family involvement in the current set?

20 Because I think that is being re-
21 viewed as well. So I think as an action
22 step as we go forward with the implementation

1 guides and that new chapter, which was
2 terrific that the NQF allowed that chapter to
3 be put in to provide further guidance because
4 it is an evolving area.

5 So I think if the Committee is
6 okay, we'll move on to the next one, but we'll
7 duly note that we'll look at the
8 implementation guides section and, as well,
9 the chapter that involves patients and
10 families, and we may even be able to add a
11 sentence or two since they're not part of the
12 specifications to say care must be taken to,
13 you know, apply these principles, or just make
14 reference to that I think is a reasonable
15 thing.

16 Are we okay with that to go
17 forward? Okay.

18 In the next section,
19 accountability structures and systems, down in
20 external reporting activities we have "shall
21 include patient safety organizations and SREs,
22 serious reportable events, specifically in

1 additional specifications and include more
2 supportive language to the implementation
3 example approaches section."

4 And this addresses some of the
5 evolving nature of other entities, such as the
6 patient safety organizations that now provide
7 some protection for patient safety work
8 product. So, Peter, would you like to comment
9 maybe on this one?

10 We're just making an attempt to
11 make this set of practices as clearly
12 connected to these other evolving efforts that
13 Peter is actually in charge of at NQF.

14 DR. ANGOOD: Yes. You know, the
15 external reporting and trying to promote
16 precision in reporting is clearly on a lot of
17 our minds. I don't think that we can be
18 specific in the specifications yet on
19 requiring or suggesting you have to do that,
20 but you know, where we are sitting with this
21 on the bottom of the page there is just trying
22 to be driving the field into recognizing

1 there's an evolving external reporting
2 strategy going on, and that the organization
3 should be flexing and adjusting to accommodate
4 internal and external reporting and to be a
5 participant, an active participant in these
6 external reporting strategies.

7 Clearly, the PSO activity is going
8 to take some time over the next five years or
9 so to gain good, strong traction, but the
10 state-based and mandated state-based reporting
11 entities are clearly gaining popularity, and
12 then we've got other voluntary reporting
13 systems like the Joint Commissions, et cetera,
14 et cetera.

15 So I think we could keep pushing
16 this along and making sure as a minimum we
17 have the PSOs mentioned.

18 Other comments? Mike.

19 DR. COHEN: Yes, I'd like to see
20 us do more in this particular area, external
21 reporting, to promote near miss reporting as
22 well.

1 We mentioned adverse drug events,
2 but near miss reporting, hazardous condition
3 reporting is critically important. We've been
4 to organizations that have had disasters and
5 only to learn that they had the same thing
6 happen before, and it was corrected and it
7 never got reported anywhere, including
8 internally, by the way, not just to external
9 organizations.

10 So I think that's critically
11 important, and I would add those words, and by
12 the way, I used --

13 DR. ANGOOD: Sorry. Just on that
14 point though, is everyone comfortable with
15 adding the near misses? Because that's a
16 volume choice sometimes and, you know, we
17 don't always have the methodologies in place
18 to handle the management of near misses.

19 (Off-mic comment.)

20 DR. COHEN: I'm sorry?

21 CO-CHAIR MEYER: You're using an
22 implementation example as opposed to -- you're

1 not saying --

2 DR. COHEN: Well, I'm just saying
3 it says "report adverse events," and really do
4 think there's more than just adverse events
5 that the external programs want to capture.
6 For example, in Pennsylvania, we do capture
7 near miss events, and it has been the bulk of
8 the reports that we get, and it really helps
9 to inform our hospitals in Pennsylvania about
10 the kinds of things that are going on.

11 DR. ANGOOD: David.

12 DR. HUNT: I think that would be a
13 place in the implementation specifications,
14 and in this situation I think we can do the
15 community a very good service by having as
16 robust a set of how to, where to go sort of
17 guides to allow folks because many
18 communities, small community hospitals, for
19 example, want to, but you know, where do I get
20 started? Okay? How do I report into the FDA?

21 And this would be a wonderful
22 opportunity for a set of links, a set of

1 manuals that folks can just take me right
2 there to get started.

3 DR. ANGOOD: That's actually a
4 very good idea, and almost to the point I
5 think we should as a minimum include it in an
6 appendix, if you will, sort of a here's where
7 you go and here's examples of success, State
8 of Pennsylvania, other specific health care
9 systems. A good suggestion.

10 DR. COHEN: I'd just like to add,
11 this is a point of interest only. When we use
12 the term "near miss" I think we really have to
13 think about using that term. We did a survey
14 recently. For example, in Pennsylvania "near
15 miss" means that the patient wasn't harmed.
16 Basically the patient wasn't harmed.

17 A lot of people think that, but we
18 did a survey of our readership, and we have
19 2,435 responses and 88 percent -- and these
20 are mostly nurses and pharmacists, although we
21 have physicians represented as well -- 88
22 percent believe that it is an issue where

1 almost happened but never reached the patient.
2 So that's the way most people are defining it,
3 and yet we're using it in another way in a lot
4 of our patient safety work.

5 CO-CHAIR DENHAM: So just to deal
6 with this issue specifically, to give you a
7 read-back, I'm hearing that the near miss
8 language with an operational definition or
9 there may not be one that we can import into
10 the implementation guide, but a narrative that
11 captures near miss, near hit, you know, what's
12 being used, but put that in the implementation
13 guide, not in the specifications; is that
14 correct?

15 DR. COHEN: Absolutely.

16 CO-CHAIR DENHAM: The
17 implementation guide, but not the spec.

18 DR. COHEN: All right. Even
19 though there are patient safety organizations
20 that can, you know, provide privilege to the
21 reports, in fact, people are sometimes afraid
22 to report something that they've actually been

1 involved with.

2 This is the kind of thing that,
3 you know, was captured, perhaps, before it
4 even got to the patient. There should be no
5 reason.

6 CO-CHAIR DENHAM: Patrick.

7 DR. ROMANO: yes, I just wanted to
8 point out, as most people probably know, that
9 the common formats that have been adopted for
10 use by patient safety organizations do
11 specifically include incidents, near misses or
12 close calls, and unsafe conditions.

13 So bringing in the terminology
14 about the role of the patient safety
15 organizations and reporting to the PSOs I
16 think will cover this whole spectrum of
17 conditions.

18 DR. ANGOOD: Yes, and we'll look
19 closely at those terms and definitions as used
20 by the common format since we oversee that
21 steering committee. So we'll, again, work at
22 harmonizing.

1 DR. PRONOVOST: This is Peter.

2 I want to agree with that
3 statement that the PSO will take care of that.
4 I'm not sure I would put so much focus on the
5 external reporting. I think we need to do it,
6 but I'll tell you at my organization I make
7 much greater progress by focusing on reducing
8 the risk I've identified already, not
9 reporting more --, and so I wonder if we're
10 going to do anything, add an incentive that
11 says that there be some mechanism in the
12 organization to prioritize and mitigate the
13 risks that are implied.

14 DR. ANGOOD: Okay. I think that's
15 an important one, ongoing efforts at risk
16 identification and risk mitigation. Nice.

17 CO-CHAIR MEYER: If you move on to
18 the next one, I think it's the poster child of
19 the tension I talked about earlier and also
20 the comments that Patrick made earlier, and
21 this is related to review by government
22 supported senior administrative leaders.

1 And so the balance we struck,
2 again, recognized the tension between over
3 specificity and ambiguity was we said on a
4 regular periodic basis. Now, we have no
5 evidentiary base to say it should be annual or
6 biannually or triennial, and so we left it
7 quite open and ambiguous.

8 I think that others could come
9 back, I'm sure, and say, "Well, just tell me
10 what to do," and I think if we put it as it
11 said, no, we changed it to annual, I think
12 folks would go back and say, "What's the
13 evidence base for annual?"

14 And the answer is there isn't one,
15 and so again, I think this is a good poster
16 child for that tension.

17 CO-CHAIR DENHAM: And just to
18 refresh us in terms of how we got to these
19 specifications from over the arc of the 2003
20 practices to the '06 update, to the '09
21 update, and now we're doing the 2010 update
22 was that in some cases with the practices,

1 there was more specificity regarding
2 timetables, and in some less. They went out
3 to the marketplace. They went out to the
4 membership of the NQF and subject matter
5 experts. There was considerable response.

6 We actually also invited certain
7 organizations who were interested to really
8 develop teams to kind of play the eyes of the
9 enemy, if you will, to coin an expression from
10 Boeing, to look at, okay, what are all the
11 things wrong with these if we were to put on
12 that hat.

13 And so we had some organized
14 formal and informal approaches to kind of
15 field test these, and the net that came back
16 was for some too prescriptive because they
17 didn't really fit with their evolutionary
18 process where they felt they were on a regular
19 basis undertaking things, but didn't want
20 specificity of a timetable as Gregg had
21 addressed, and then in others we got, you
22 know, kind of the counter view.

1 And what we arrived at was
2 defining a regular and a periodic, but did not
3 specify the timetable. In some cases as you
4 go through the practices, you'll see that
5 instead of it being a specification, a
6 footnote where the committee would have felt
7 very strongly that a certain frequency was
8 really kind of the floor necessary, but maybe
9 there wasn't enough evidence to support it,
10 and we made it a footnote recommendation that
11 was soft. It wasn't a specification. Your
12 feet couldn't be held to the fire regarding
13 compliance, but at least it gave a little bit
14 of information to those saying, "Well, gosh,
15 how frequently do I do this?"

16 In other cases, we removed the
17 specificity. So as we go back through these,
18 I just want to remind us that these have
19 already been out to the field over two cycles.
20 We got that kind of input from the review, and
21 the way that they exist today were based on a
22 lot of NQF member input and subject matter

1 expert, not that they're perfect and not that
2 they're may be some evidence today that might
3 want to change you, but this is where this is
4 struck.

5 The second thing is that we'll now
6 have a glossary in this 2010 update and seek
7 to have operational definitions for certain
8 things like regular, like periodic, like a
9 number of these that we can kind of put a
10 handle on.

11 David.

12 DR. HUNT: I would just suggest
13 that sometimes we may be looking because we're
14 sort of pushing the envelope. The evidence
15 that we seek may not be in the clinical
16 community. The evidence for regularity should
17 be found in business or organizational theory.
18 So perhaps the regularity portion may not be
19 in the Journal of Patient Safety, but in the
20 Harvard Business Review.

21 DR. PRONOVOST: Chuck, this is
22 Peter.

1 Two comments. One is when you say
2 that we did this field testing, who actually
3 did that and is there a written report?
4 Because I didn't know that we had some formal
5 evaluation about what the field thought about
6 these because that would be real useful
7 information.

8 And second, as a general
9 principle, when there's uncertainty and there
10 always is and there's always going to be, you
11 know, one approach is to I don't want to say
12 just don't acknowledge it or be softer. A
13 more direct approach that I favor would just
14 simply be transparent and unambiguous about it
15 and say, you know, organizations vary and we
16 don't really know whether it should be a year,
17 two years, 18 months, and just put out that
18 uncertainty to the community.

19 And if we have consensus of what
20 we think it could be, we could acknowledge it
21 as such, but I think we would probably have
22 more credibility of being transparent and

1 unambiguous about what is and isn't available.

2 CO-CHAIR DENHAM: Great, Peter.

3 Two good points.

4 What we wanted to do, strictly
5 adhere to the process delineated by the NQF
6 while at the same time wanted to really get
7 these field tested. So the "we" were a number
8 of us as Committee members asked NQF members
9 if they would be interested in taking a
10 careful look at the practices.

11 And so in my case, having a good
12 relationship with the Mayo Clinic who was more
13 interested, who said, "We want to be more
14 involved in providing feedback to the NQF safe
15 practices, and so what we volunteered to do
16 was to give briefings of the safe practices
17 and say, "Here are the safe practices. Here
18 are the chapters. Here is how they are
19 organized. If we can provide any further
20 clarification to you, great. Are you
21 interested in organizing teams to look at the
22 practices? If you are, wonderful, but not

1 working with any one Committee member, please
2 submit them formally through the NQF process,
3 through the field review process, and don't
4 show your assessments to us. We'll provide as
5 Committee members briefings. Go ahead and
6 look at them, but go through the formal NQF
7 process."

8 So as Committee members the first
9 time we see them was through the field reviews
10 that are the formal process of NQF. We
11 thought that was the best and most proper way
12 and most transparent way and with the least
13 conflict and the least ambiguity.

14 And so that's what was done after
15 the 2006 update where there were a number of
16 organizations where we provided Webinars and
17 said, you know, here are the practices. Here
18 are the resources. Is there anybody that we
19 can help provide to you? Please assess them,
20 but don't share with us any one briefing them.
21 Go through the formal NQF, formal field review
22 process, provide them in writing, which they

1 did, Peter, and then all of that input was
2 then put in the tabular format for the
3 Committee that then was reviewed, and that was
4 the input to which I was referring.

5 There were not other NQF led sort
6 of field tests or studies that were
7 undertaken. We basically just tried to be
8 really accountable to NQF members and said we
9 want feedback on these practices. What can we
10 do to provide you feedback? Is there anything
11 we can provide to you? But go back through
12 the formal NQF process so that we all get it.
13 Everybody gets the same factual information,
14 and don't show us the assessment until you
15 formally go through it.

16 So that was the process. I think,
17 Peter, there is a place for us on the second
18 point in the implementation guide to be
19 careful stewards of what we know about the
20 evidence and not know about the evidence, and
21 underscore in the implementation guide that
22 until there is clear evidence as to how

1 periodic or how frequent work needs to be
2 undertaken or reviews or attention to detail
3 and practices, that until we know that you
4 were kind of delegating that back to their
5 organizations and saying, you know, regular
6 means that you do it on a routine basis at
7 intervals that you deem necessary for your
8 organization. That's about as much as you can
9 call.

10 Yes, go ahead.

11 MS. MacDONALD: Yes, I just want
12 to say I don't think we can define regular
13 right now very clearly, but we can put best
14 practices, examples of best practices and how
15 often, you know, people who do this well, how
16 often they meet.

17 I did want to raise one other
18 question. I don't know if now is the right
19 time to do it, if we're done with the
20 conversation about regular, if I could ask
21 another question.

22 CO-CHAIR DENHAM: Peter, did that

1 answer your questions or issue before we move
2 to the next?

3 DR. PRONOVOST: Yes, it did.

4 CO-CHAIR DENHAM: thanks.

5 DR. ROMANO: To me, I don't know
6 about others, but I think that the important
7 concept about regular is that it's something
8 that's planned in advance. It's something
9 that is not prompted by a disaster.

10 CO-CHAIR MEYER: It's not ad hoc.

11 DR. ROMANO: It's not ad hoc
12 because it's so easy to say, "Well, things are
13 going along okay. Okay. We won't worry about
14 this."

15 And then something bad happens and
16 the hospital's name gets in the newspaper.
17 Oh, my gosh, we had better check out what we
18 are doing on patient safety.

19 So regular can be something that's
20 consistent with the planning cycle, with the
21 budgetary cycle of the health care
22 organization, but regular does mean regular

1 and not prompted by ad hoc events or
2 inquiries.

3 MS. MacDONALD: Okay. Thanks.

4 I've worked in enough
5 organizations. I really applaud this
6 standard. I've worked in enough organizations
7 where I know negative information rarely flows
8 uphill, and there's frequently layers of
9 management whose entire function is to make
10 sure the person above them thinks everything's
11 fine. So I think this is great.

12 We work with people often on the
13 front lines, you know, on the floors, and they
14 have a lot of frustration about what they see,
15 the information that they have about what they
16 consider to be unsafe conditions and having it
17 flow upwards.

18 And I'm not sure, and I'd just
19 like your guidance on where that flows in this
20 standard or where that exists in this
21 standard.

22 We frequently tell the nurses that

1 we work with to fill out something called an
2 assignment despite objection form or a short
3 staffing form or a form that indicates they
4 believe that the conditions are unsafe, which
5 they then give to their supervisor, but
6 there's no indication that it ever really goes
7 above the supervisor, and then they become
8 very frustrated and they stop filling out the
9 forms.

10 We had a hospital in New York that
11 had 840 forms in a two-month period of what
12 they believed to be unsafe staffing conditions
13 that never got fixed, and possibly never even
14 got above the supervisor level.

15 So is there a place in this
16 standard for input from the front line
17 caregivers in a regular way to be able to --
18 or is it perhaps in another standard?

19 CO-CHAIR DENHAM: Yes. Well, as
20 you go carefully through the practices, you
21 see the cross-linking of this practice with
22 Safe Practice No. 4, which is identification

1 and mitigation of risk and hazard, which has
2 that kind of hard circuit sort of information
3 flow up.

4 But take another look at them to
5 see if you're comfortable with them, but I
6 think you probably will, that there's a hard
7 wire information flow and a cross-linking of
8 Safe Practice 1 and Safe Practice 4.

9 Any other comments that we want to
10 add to this?

11 So the action item then would be
12 to acknowledge Dr. Romano's comment regarding
13 regular, and we are putting regular into the
14 operational definitions and make sure that it
15 is very clear that it is a proactive approach
16 and not response to events, and we'll be going
17 through that glossary carefully as the fall
18 unfolds, and we'll be probably adding to it
19 with the implementation guides as well, but
20 very careful attention to the specifics.

21 So everyone agreeable to that
22 then, keeping that the way it is but moving

1 with the definition?

2 And, Patrick, if you want to take
3 a careful look at the glossary and see if you
4 like it after it's composed.

5 So next? We're at ten minutes
6 before our call. We move to the action
7 structures and systems. Regular actions of
8 senior administrative leadership; purpose of
9 action of governance; direct administration
10 discussion for the Committee.

11 It's clarifying the statement in
12 the blue underline. The blue underline
13 states, "such actions should be informed,
14 monitored, and directed by engaged governance
15 leadership on a regular basis."

16 Just for your interest, our
17 dialogue in the committee work on the language
18 of this, again, we had considerable feedback
19 from the field on the language, and you would
20 hear various different takes on the style of
21 how things were written.

22 So in the '06 update and as we

1 moved to the '09 update, we were pretty
2 careful to use the same language frequently
3 regarding involvement of leaders, and the
4 informed, monitored and directed was interest
5 by Committee members to really make sure that
6 it just wasn't a general statement, that it
7 really spoke to the issue of responsibility to
8 that information.

9 Openness went up for discussion.

10 Peter, do you want to add anything to what we
11 want to address here?

12 Does the Committee feel like
13 there's enough clarity to that?

14 Again, we went pretty carefully
15 through these, and so some of these that we're
16 going through might be little nits that may
17 not now on re-review be as important, but do
18 we have any problems with the current language
19 as it is?

20 Okay. We'll move to then safe
21 practice, too. So any other conclusionary
22 comments on Safe Practice 1? Dr. Romano.

1 DR. ROMANO: Yes. I have to say
2 that this is one of those sections that drives
3 me crazy a little bit, to be quite frank and
4 a little bit ornery. I mean, I don't have any
5 objection to this particular sentence, but
6 just more generically, you know, as someone
7 who works within a health care organization,
8 you know, I look through this page and find
9 the overall tenor of the page a bit difficult
10 and, again, pseudo specific.

11 I mean, for example, in
12 particular, you know, the idea about, you
13 know, at least annually, annually, the board
14 should document that it has confirmed the
15 behaviors of the organization related to
16 quality and safety mirror its values with
17 respect to patient safety.

18 So that is such a nebulous and
19 broad statement. I mean, how do we possibly
20 document that the behavior of the organization
21 mirrors our values?

22 And even, you know, in the next

1 sentence, again, going through annual training
2 and teamwork, I mean, I think we all recognize
3 the importance of teamwork and we all know
4 that teams fail and there's lots of literature
5 on the importance of teamwork, but yet, you
6 know, how do you actually document that you
7 provided this kind of training in a meaningful
8 way?

9 Many of us have served on these
10 kinds of boards, and we know how this happens,
11 and you know, everybody says, oh, this is our
12 annual teamwork training. We have to go
13 through this again.

14 You know, and so at some point
15 this just becomes a check box. It's not
16 really an investment in improving safety in
17 the organization. It's just like, well, you
18 know, NQF says we're supposed to have teamwork
19 training. So we bring in a consultant to
20 teach us how to be nice to each other.

21 So this is the kind of thing, to
22 be honest, it's probably not the time or

1 place to address it, but it just drives me
2 crazy because of this specificity, this pseudo
3 specificity that's not really rooted in
4 evidence.

5 CO-CHAIR DENHAM: Let me address
6 both of these areas, and I think as we review
7 this, Dr. Hunt brought up the point that and
8 underscored the issue of research that's
9 outside of health care, and I think we could
10 be a little bit more specific in this
11 statement and say "stated values."

12 Actually, the values and behaviors
13 are probably one of the broadest and deepest
14 areas of research in terms of tying values to
15 behaviors outside of health care and aviation
16 and aviation safety specifically and in
17 performance, and Dr. Hunt addressed, you know,
18 some of the publications outside of this.

19 So I think we could go back and
20 look at this and use the term "stated values."
21 there are stated values and stated behaviors
22 that are very specific for the majority of

1 hospitals in the United States. I think we
2 could be a little more clear.

3 That is though tied to evidence
4 that is outside of health care, and the input
5 of this -- and this has been part of the
6 specifications for two cycles -- really came
7 from that evidence, and I think one of the
8 things that we can do as we are tying some of
9 the citations to it, make it more clear,
10 Patrick, so that you can see where that ties
11 to that evidence.

12 The second thing is are you
13 familiar with the Safe Practice 3, the third
14 safe practice regarding teamwork? Because it
15 does get very specific, probably much of the
16 market thought was over specific regarding the
17 teamwork requirements and the specifics of the
18 topics.

19 And so I think rather than just
20 copy and paste all of that Safe Practice 3
21 into Safe Practice 1, I think there is the
22 specificity you seek in Safe Practice 3. In

1 fact, many of the debates of the Committee in
2 the '06 update were regarding how specific we
3 really were about the number of hours, number
4 of hours, number of people, frequency and the
5 detail of the content.

6 So I think I would push back and
7 say that might be in your ordinary category
8 because I think I would go to Safe Practice 3,
9 and I would say you might even call that
10 overly specific when you review that carefully
11 because it was very, very specific.

12 And in Safe Practice 1, we are
13 saying at the end of the practice that it
14 cross-links to Safe Practice 3, which is the
15 one that addresses the teamwork. So you might
16 want to refresh yourself and go back and look
17 at that. It's very specific.

18 Gregg.

19 CO-CHAIR MEYER: This is two
20 follow-up things. When I looked at my kind of
21 won handwritten notes, I had question marks
22 next to the exact same passages that Patrick

1 said what does this mean. I think we ought to
2 look and see if there are some good governance
3 references from, you know, Harvard Business
4 and others that have been publishing on this
5 issue.

6 I think the second, really
7 following more for Peter, is that as you go
8 and do some sort of field study of what people
9 think of this and how they're using them, this
10 the kind of issue where I'd ask to be able to
11 focus on because this may be driving people
12 absolutely nuts. It may be that people out
13 there are saying, "Wow, it's really great that
14 you're saying that you have to document this."

15 In fact, I don't know. I know it
16 from my own very narrow perspective, but this
17 would be a great thing to get more data on to
18 see how this is playing in the field to see if
19 we struck it right.

20 CO-CHAIR DENHAM: Do we have other
21 comments from the Committee? David?

22 DR. HUNT: Yes, I was going to

1 again reinforce the evidence for this may be
2 found in rather obscure things like the Navy
3 subsurface training manual. In the Nuclear
4 Service they're relatively safe because the
5 values that they try to promulgate are
6 specifically discussed at meetings.

7 So the evidence that we seek
8 because remember that you won't find very much
9 evidence of what we're trying to do because we
10 are at the outer edge of the envelope in the
11 places that we are because that's the reason
12 that we need to change, but there may come a
13 point where we're trying to ask ourselves, you
14 know, where's the evidence for *primum non*
15 *nocere*.

16 It is not always going to be there
17 right in front of our faces. That's what I'm
18 saying.

19 CO-CHAIR DENHAM: Mary, did you
20 have a comment?

21 MS. MacDONALD: I kind of agree
22 with Peter only because we're involved in some

1 activities where sometimes management actually
2 has inculcated, you know, the values that we
3 talk about and other times they're just
4 checking the box, you know, that we did this.

5 At least annually the board should
6 discuss its own competency and document its
7 strategy. There may be a need to define what
8 a competent board would know, you know. I
9 mean, there would have to be some standard for
10 me to measure that against, to discuss our own
11 competency without some kind of external
12 standard for what constitutes competency. I
13 don't think, you know, it's necessarily what
14 you're looking for.

15 DR. ANGOOD: Well, again, this is
16 part of the tension and the balancing act.
17 You know, we're trying to drive organizations
18 to figure out what their own behaviors are, to
19 seek out other resources as needed to figure
20 out what methodologies they need to use if
21 they don't have things in place without
22 getting too specific because in the absence of

1 practices like this many places will not have
2 anything. It will be kind of historic
3 practices as usual.

4 MS. MacDONALD: Well, perhaps it
5 could be an implementation guide that would
6 have examples of what would constitute best
7 practices again in some of these situations.

8 DR. ANGOOD: Well, you know, the
9 IHI's board is on board and all of those sorts
10 of things.

11 CO-CHAIR DENHAM: You know, we are
12 at time, but I don't want to cut this up. I'd
13 like to propose so that we could then have our
14 call and have finished this one, that we will
15 go back and tie citations and operational
16 definitions to values and behaviors. It's
17 very clear we're very familiar with this
18 literature, and so there are ample citations.
19 There are ample citations for best practices,
20 and so I think that we can define these terms
21 in the glossary and in the implementation
22 guide and also tie citations or citations to

1 this section of the specs and put some more
2 clarity into the implementation guide.

3 Is that a reasonable next step
4 before we go to our call so that we can put
5 this one to bed?

6 DR. ROMANO: Yes, I agree. I
7 agree completely with Dr. Hunt that the
8 literature that we seek may be in
9 unconventional places. The evidence may be
10 not randomized trials, but there does need to
11 be evidence, and so I think strengthening that
12 base would be very useful.

13 CO-CHAIR DENHAM: Great. Do we
14 have to do anything to establish the call with
15 the Leapfrog Group?

16 (Pause in proceedings.)

17 DR. ANGOOD: So we'll just have
18 one of those momentary pauses, but don't take
19 off on us down the hall. I'm highly attracted
20 to the children's play area down the hall on
21 the left, you know. So we don't want to find
22 you in there with all of the chemistry kids,

1 but as soon as Barb and whoever else from
2 Leapfrog is joining them, we'll deal with
3 their activity right away and then we'll take
4 a short break.

5 (Whereupon, the above-entitled
6 matter went off the record at
7 10:04 a.m. and resumed at 10:05
8 a.m.)

9 DR. ANGOOD: Barb Rudolph, are you
10 on the phone yet by chance?

11 DR. RUDOLPH: Yes, I just got on.
12 Thank you.

13 DR. ANGOOD: Oh, okay. Good
14 timing, and it's Peter Angood. We have a good
15 quorum of individuals from the Steering
16 Committee for the Safe Practices, and we are
17 at an appropriate time to review your guy's
18 materials and to have some discussion around
19 the topic.

20 Are there other individuals
21 joining you, Barb?

22 DR. RUDOLPH: Yes. Dr. John

1 Birkmeyer will be getting on shortly.

2 DR. ANGOOD: Okay, and just the
3 two of you?

4 DR. RUDOLPH: Yes.

5 DR. ANGOOD: Okay. Thank you.

6 What I'll do, Barb, is just
7 provide a few background comments. I'll ask
8 Chuck and Gregg to provide a couple to fill
9 in whatever holes I've missed, and then you
10 can make your presentation in terms of the
11 materials you've provided us, and then we'll
12 open it up for general discussion.

13 DR. RUDOLPH: Great.

14 DR. ANGOOD: This document that we
15 have up on the screen was forwarded in by the
16 Leapfrog Group following some discussion
17 during last year when the safe practices were
18 revised, and then also emanates from a call
19 that we had with Barb and Arnie Milstein,
20 Chuck and myself regarding some potential
21 strategies.

22 And there are sort of two

1 components to this. One is the content of the
2 document that Leapfrog Group has provided and
3 the basic issue focuses around evidence-based
4 hospital referrals. This was a practice in an
5 earlier version of the safe practices. In the
6 revisions, the evidence-based hospital
7 referral practice was dropped and rolled in as
8 a sub-bullet within the informed consent safe
9 practice.

10 And so the two issues are, one,
11 related to the methodology by which NQF
12 retired a safe practice and was sort of
13 adequate due process undertaken before
14 retiring a safe practice or incorporating it
15 into another practice, and then the second
16 issue is actual discussion on the content of
17 this document, which is how to move forward
18 dealing with the issue of evidence based
19 hospital referrals.

20 And I think in all honesty it's
21 fair to say that this topic unmasked a
22 procedural deficit that we had in our

1 management of the safe practices, and we have
2 been looking at our consensus development
3 process overall as part of our ongoing quality
4 improvement efforts at NQF, and we need to pay
5 particular attention for any of the safe
6 practices when there's consideration to retire
7 them or to incorporate them into other safe
8 practices.

9 Another example that will be
10 coming up soon, just to give you a different
11 flavor from this, is the patient safety event
12 taxonomy that's been endorsed by NQF,
13 developed by Joint Commission, but our sense
14 is nobody uses that thing.

15 With the PSOs coming on board and
16 with the WHO's international classification,
17 there probably is not a use for that taxonomy
18 at this stage. So we will make movements
19 towards retiring it, but we need to message
20 the field that that's going to occur, and we
21 did not message the field adequately or
22 effectively enough regarding this change on

1 the safe practice for evidence based hospital
2 referral.

3 So just to reassure the Leapfrog
4 Group and other entities that have concerns
5 about this, NQF has recognized this deficit,
6 and we are moving forward to correct that and
7 message the field, get inputs on any future
8 retirements for reconfiguring of safe
9 practices.

10 The second now issue is more
11 related to the content of this evidence-based
12 hospital referral. Because we are doing a
13 light buff and polish for the recently
14 released safe practices we responded back to
15 Leapfrog Group, and I think Barb and Arnie and
16 Leah Binder were all open to this, is that we
17 kind of staged this in two steps.

18 One, we agreed that the topic of
19 evidence-based hospital referrals is important
20 and continues to gain further evidence that
21 the volume and high risk procedures does
22 reflect on outcomes and so we need to look at

1 our existing safe practice informed consent
2 and how that bullet is written. How do we
3 accommodate some better language around this
4 safe practice?

5 And then the second step would be
6 during the more deep revisions going on during
7 2010 for the '011 release would be to consider
8 having a separate new or revised safe practice
9 on this topic to come back into our safe
10 practices to accommodate this topic.

11 So I have I haven't confused
12 anybody with those comments, and Gregg, did
13 you want to make some further comments or
14 Chuck?

15 CO-CHAIR MEYER: I'll make two
16 comments just for those who may not have been
17 able to participate in the discussions that we
18 have around folding the evidence-based
19 hospital in from a stand alone safe practice
20 and moving it into Safe Practice 5.

21 There were two issues. One was
22 related to the I would characterize this as

1 kind of a relatively rapidly evolving
2 evidentiary base here, that as it was
3 originally constituted, the stand alone safe
4 practice related to evidence-based referral
5 was quite broad, and that narrowed as the
6 evidence moved forward. Perhaps Dr. Birkmeyer
7 will comment on that.

8 The second issue was a little bit
9 more of a philosophical one, and it gets down
10 to what are the units of analysis. What are
11 the groups that we're going to be measuring
12 adoption of safe practices on?

13 And I think to some extent, you
14 know, the notion that consumers should be
15 informed about these relationships and the
16 availability of high volume providers , which
17 would potentially portend for some procedures
18 an improved quality and decreased risk. That,
19 I think that there's no one that would
20 disagree with that. I think practically, the
21 notion that, for example, a small community
22 hospital outside of Boston is going to hand

1 the patient with a newly diagnosed pancreatic
2 lesion and say, "Here's a pamphlet and the
3 pamphlet says go to the Mass. General because
4 they do more than anybody and they have this
5 volume to outcomes relationship."

6 That wouldn't be bad, but the
7 truth of the matter is we didn't think that
8 that was a practically reasonable thing to ask
9 and to measure folks on, and so that's where
10 we ended up with this.

11 So I think that it's just good to
12 have that as context.

13 Chuck, I don't know if you want to
14 add further context to it.

15 CO-CHAIR DENHAM: Yes, and I
16 think, Patrick, you brought up the issue
17 earlier of others outside of NQF using NQF
18 standards and the blend and the challenge of
19 teaching out with some precision what is a
20 recommended specification for a standard and
21 then how folks might use it.

22 And I think, you know, as Leapfrog

1 goes through their presentation, I think we
2 need to recognize that the evidence based
3 referral practice was in the '03 set of
4 practices.

5 When we went to the '06 practices
6 and updated them, there was considerable
7 discussion regarding the issues that the Dr.
8 Meyer just brought up.

9 And then when we went to the '09,
10 there was considerable discussion as to
11 whether with the evolving evidence also that
12 other areas of NQF measures were actually
13 measuring some of these other issues, and
14 there was considerable push-back from the
15 field on this evolving, the all evolving
16 nature and implementation of quality-volume
17 relationship.

18 So it was with a great deal of
19 discussion that the committee pondered and
20 then decided to retire the evidence based
21 practice. The Leapfrog Group, and we'll ask
22 Barb and the group to share their requirements

1 of the field actually migrated away from the
2 practice that we had in 2006 as well. So we
3 actually didn't have an apples to oranges sort
4 of comparison, which also I think, Gregg,
5 factored into the potential retirement of the
6 EBM, which was that there is evolution of the
7 literature. There were the challenges that
8 were faced. There were all of these
9 variables.

10 And then as Peter had stated, we
11 as a committee, there just wasn't a process in
12 place to go out to the field to say a practice
13 is being considered for retirement. There
14 just wasn't one, and I think it's great that
15 NQF is now saying that that is something that
16 we need to have as a process for any time a
17 practice is being considered to be retired or
18 modified that way, that that loop kind of be
19 in there.

20 So that's kind of a little bit of
21 the historical context of, you know, kind of
22 where things migrated, and then we had a call

1 recently and asked the Leapfrog Group to
2 really put together a presentation for us as
3 the Committee, this very important issue, and
4 to suggest they have some suggestions
5 regarding how this could be tied into the
6 informed consent practice.

7 I just want to remind the
8 Committee that the big upgrade to informed
9 consent is anticipated for 2011. This cycle
10 is a short cycle because we want to get the
11 practices out actually to groups like Leapfrog
12 for January so that they can actually tie
13 adoption to a set.

14 So the balance of the decision was
15 the informed consent would get a forklift
16 upgrade for 2011. The timing of this
17 discussion was a good one because here's a
18 great opportunity for that, but we'd like to
19 hear from the Leapfrog Group and to share what
20 they want to propose at this juncture in time.

21 So that's a little bit of the
22 context.

1 DR. ANGOOD: All right. So
2 thanks, Gregg and Chuck, and so the
3 presentation is primarily focused on the
4 importance of the topic, reinforcing our
5 knowledge about that, but our action is to try
6 and figure out how to refine the informed
7 consent safe practice to help accommodate this
8 presentation.

9 The request for a new safe
10 practices is for a later date. That's not for
11 today.

12 Okay. Barb, are you happy with
13 those opening context comments?

14 DR. RUDOLPH: Yes, that's fine. I
15 think Dr. Birkmeyer has joined us.

16 DR. ANGOOD: Okay. So put --

17 DR. BIRKMEYER: Yes. Can you hear
18 me now?

19 DR. ANGOOD: Yes, we can hear you
20 better. Thanks.

21 And so would you guys please give
22 us a brief presentation on the document and

1 we'll assume everyone on our Committee has
2 read through your materials.

3 Thank you. Please go ahead.

4 DR. BIRKMEYER: Well, if you don't
5 mind, Barb, maybe I could make just a few
6 introductory comments. I don't have a formal
7 presentation, but I do have a few comments to
8 put this in perspective and to give you my own
9 thoughts about how to move forward.

10 Again, the context is the extent
11 to which the relative performance providers
12 needs to be incorporated as part of the
13 informed consent process, and I think that
14 there's a few basic principles that everybody
15 that's on this call would generally agree
16 about, and that is that, you know, informed
17 consent is imperative, particularly in the
18 context of interventions with substantial risk
19 to patients.

20 We also would agree that as
21 information is conveyed to patients about the
22 risks and benefits associated with the

1 specific intervention, that it be tailored as
2 much as possible to the specific circumstances
3 of that patient, and obviously that includes
4 both patient characteristics; you would give
5 a different set of expectations around risk
6 and somebody with unstable heart disease than
7 you would in a 25 year old healthy patient,
8 but also to the provider circumstances, you
9 know, and that is that for some procedures,
10 you know, where and by whom the procedure is
11 performed as a much larger impact on
12 prospective risk than do the characteristics
13 of the patient.

14 We also finally would agree that
15 the conveyance of a risk needs to consider the
16 risks and the benefits of alternative options,
17 and you know, obviously we're most familiar
18 with that principle in the context of giving
19 people information about, you know, the
20 consequences of non-surgical treatment for
21 those that are considering a specific surgical
22 intervention.

1 I think you could safely extend
2 that same principle to conveying the risks
3 associated with alternative options in the
4 context of patients undergoing their surgical
5 care in another setting.

6 On the other hand, I think we all
7 would agree that this would be a very hard
8 conversation to have, and I think Gregg made
9 a comment about, you know, the plausibility of
10 a small community hospital having a pamphlet
11 advising their patients to go to the Mass.
12 General. Well, you know, I think as a
13 practicing surgeon I can imagine how this
14 plays out at the level of the encounter
15 between the, you know, physician and the
16 patient. This is a very hard conversation to
17 have, and in the real world it's only going to
18 happen when the circumstances are compelling
19 and the motivation for doing so is very
20 unambiguous.

21 I wasn't an integral part of the
22 document with the language underlying the

1 previous recommendation that came from the
2 Leapfrog Group, although I don't recall
3 whether I read it or gave input, but reading
4 it just recently with a fresh eye, you know,
5 there was a number of problems with it from my
6 perspective that I think, you know, was at
7 least some small part of the reticence of the
8 Committee the last time it looked at the
9 standard, and I think that there's a couple
10 problems with it.

11 The first is that it applied to a
12 number of procedures for which there's either
13 relatively small variation across hospitals or
14 physicians in underlying risk or for which the
15 existing measures really are not up to the
16 task in terms of discriminating the
17 performance of individual hospitals or
18 physicians. Certainly there's a big
19 difference in the variation associated with,
20 for example, PCI than there is with
21 esophagectomy.

22 Second, there was, you know, some

1 of the practicality of applying these measures
2 might vary according to the clinical setting
3 in which those procedures are offered and the
4 extent to which they are elective, and there's
5 time for rational decision making of outside
6 of care and of those for which those
7 procedures frequently, you know, it's more
8 expedient or urgent.

9 And finally, and I think probably
10 the biggest problem was that the trigger for
11 incorporating such information on performance
12 into the informed consent process was somewhat
13 ambiguous. Exactly how large does that
14 potential for risk reduction have to be to
15 warrant that conversation?

16 We'd all agree that if that
17 difference was ten percent in absolute terms
18 that that conversation needs to happen, but
19 does it need to happen if it's one percent, if
20 it's half of a percent? Is it .2 percent? I
21 think that, you know, there was a lot of room
22 for improvement in terms of specifying, you

1 know, when that conversation had to be
2 triggered.

3 So as I spoke with Barb last week,
4 I had a couple of thoughts about where this
5 could go either in the short term or at the
6 next, more substantial iteration. The first
7 was that I thought that the initial focus
8 should be on clinical settings, i.e., surgical
9 procedures, you know, for which there's not
10 only a strong ethical imperative, but also
11 sort of some practicality for having this
12 conversation, and I think that you could make
13 a very strong argument for requirement
14 information on volume, if not other measures,
15 and performance could be very safely and
16 ethically applied to elective, relatively
17 uncommon, very high risk operations for which
18 there's very incontrovertible evidence of a
19 clinically large difference in outcome
20 according to volume.

21 And I think kind of, you know, as
22 five years ago, you know, as now the poster

1 children for those types of procedures are
2 esophagectomy and pancreatectomy.

3 The second recommendation that I
4 had for Barb is that inoperationalizing these
5 guidelines or these recommendations or
6 practice, that there be more specificity in
7 terms of what the trigger is for making sure
8 that this information is conveyed.

9 You know, so with esophagectomy
10 and pancreatectomy just to be concrete about
11 it, I think that you could make a strong
12 argument that this conversation would have to
13 be triggered for, you know, positions
14 operating in hospitals designated as low or
15 very low volume centers. It wouldn't
16 necessarily need to be triggered in hospitals
17 that were medium or high volume as opposed to
18 very high volume.

19 And then finally in terms of
20 recommendations, you know, for the subsequent
21 iterations of this standard, I think that we
22 need to, you know, think about options that

1 move beyond procedure volume alone, you know,
2 as a trigger or as a mechanism for insuring
3 that performance information gets incorporated
4 into the IC process, and much of the
5 measurement science hasn't changed over the
6 last several years that, you know, the
7 Leapfrog Group has been involving its
8 evidence-based hospital referral standards.

9 But I think that the one thing
10 that is evolving and is a significant upgrade
11 on where we've been in the past is the use of
12 composite measures that incorporate volume,
13 but also other parameters into a risk
14 predictor for individual patients undergoing
15 high risk operations.

16 So that's all I had in terms of my
17 perspective on the over arching issues, but
18 also a couple of specific recommendations.

19 DR. ANGOOD: Thanks, John.

20 Good comments and we've got a
21 couple surgeons in the room, and we certainly
22 resonate with this one all of the time.

1 Barb, did you want to make further
2 comments?

3 DR. RUDOLPH: Yes, I just want to
4 indicate that, you know, John and I talked
5 about this and we talked about this as -- also
6 I talked about it with Arnie Milstein and
7 others from Leapfrog and the consumer --
8 disclosure group, and we feel pretty strongly
9 that, you know, some change should be made
10 this cycle, and the one that John has
11 recommended works well for us, and then in the
12 next iteration to take a step beyond what was
13 just a volume based consideration to
14 incorporation of other kinds of information
15 for consumers that would provide them a good
16 sense of what their risk is going into the
17 procedures.

18 Just as an aside, I think where
19 this really comes into play, we had this last
20 year or actually a few months ago, a
21 conversation with Harborview Hospital in the
22 State of Washington where they do a very small

1 number of esophagectomies, like three or four.

2 And the other part, another
3 hospital within their very own system does
4 approximately 40 to 50 of the procedures, and
5 we strongly encouraged them to consider moving
6 those, you know, three or four procedures from
7 Harborview over to their other hospital within
8 their own system.

9 And I think that's the case in a
10 number of different hospital systems where,
11 you know, they will kind of throw the bone of
12 one or two of these procedures to one hospital
13 and then do the bulk in another. I would
14 really like to see that kind of behavior
15 changed rapidly and to move towards the high
16 volume hospitals.

17 So I think as the very last
18 paragraph in the document states, you know,
19 the staged approach would be fine with us, but
20 we do, you know, request that in the next
21 major update that a bigger discussion take
22 place about patient survival and the remaining

1 cardiac procedures that were listed before.

2 So I'll just close with that, and
3 if there are any questions.

4 DR. ANGOOD: Okay. Thanks very
5 much, Barb.

6 Why don't we open it up for some
7 general reaction and comment from our
8 Committee members, see how that goes, and then
9 we'll move towards what type of specific
10 recommendations beyond what's been suggested
11 so far.

12 Gregg Meyer.

13 CO-CHAIR MEYER: Yes. I'll go
14 ahead and start this off. I think that, first
15 of all, let me say that I truly appreciate the
16 evidence here. I'm through with the procedures
17 that we discussed. I think the relationship
18 is strong. It's robust. It's something that
19 people ought to know about.

20 I think there are two issues that
21 I still have that aren't fixed by this change
22 in language. The first one is what was

1 brought up by Dr. Birkmeyer, and that is,
2 reflecting, personalizing this, I literally
3 had this conversation with my patients last
4 week, who literally said to me when they were
5 in an outside hospital with a ruptured aortic
6 aneurism, said, "Shouldn't I be transferred to
7 the Mass. General to get this repaired?"

8 His wife said, "You know, you're
9 his doctor there and you do more."

10 And the answer was, well, yes, but
11 not with a blood pressure of, you know, 70.

12 And so I think that adding in some language
13 around elective versus immersion, immersions
14 are not common, but for that first group, for
15 CABG, PCI, AVR and not so much with AVR but
16 AAA, we see emerging cases.

17 In fact, telling a patient, "Oh,
18 by the way, you will be better off with Mass.
19 General," is actually doing harm, I think, and
20 that may be a little bit controversial, but I
21 think that would raise doubts in patients when
22 that's not helpful.

1 I think the second issue I have
2 which remains is that I feel strongly that
3 this make sense. It's a good thing from a
4 population perspective to move patients with
5 these high volume providers.

6 What I'm less comfortable with is
7 safe practices and specifically the mechanism
8 here of doing it during informed consent as
9 the best mechanism to do that. So I think
10 that the conversation that was had with
11 Harborview was terrific. That's a great
12 example of how a kind of policy maker can work
13 with a hospital group and help them do the
14 right thing.

15 But when I think about what the
16 leverage points are for change, if you said,
17 you know, let's imagine if we could push the
18 elective volumes to those who do the most and
19 do it best. I don't think the lever I would
20 pull is informed consent by providers. I
21 think I would pull levers that involve payers.
22 I think I'd pull levers that involve

1 purchasers, levers that involve policy makers,
2 involve general education of the public.

3 It seems to me that all of those
4 work better than safe practices, and I'm not
5 shutting my mind to it, but it just seems to
6 me that there are other ways to do this that
7 may be much more potent and practical.

8 DR. ANGOOD: Good comments, Gregg.
9 Dave Hunt.

10 DR. HUNT: This is David.

11 Good to hear you, John. I think
12 I'd agree with Gregg. The night before the
13 procedure as you're, you know, getting the
14 surgical consent, it's just a very, very
15 difficult time to be able to have this
16 discussion. I can't imagine.

17 I think that further upstream at
18 the level of the hospital executive making the
19 decision not to do these procedures is far,
20 far better. I can't imagine the risk. You
21 know, I always like to sort of fame things
22 out. Imagine you say this to a patient and

1 they say, "No, Doc. I'd rather have it here,"
2 and they have it and something goes wrong. I
3 mean, what is that discussion like afterwards?

4 I think that there are other
5 places where we can probably effect this
6 change that might be a little bit better.

7 DR. ANGOOD: Other comments?

8 DR. McAULIFFE: Yes, I would like
9 to have some more conversation about these
10 composite measures. Volume is one thing, but
11 something else came out about composite
12 measures that would include other things other
13 than volume of cases, and I'd like to know
14 what some of those other factors would be as
15 we develop those measures.

16 DR. ANGOOD: John, did you want to
17 react to that?

18 DR. BIRKMEYER: Did you say John?
19 Are you talking to me?

20 DR. ANGOOD: Yes. Sorry.

21 DR. BIRKMEYER: Oh, yes.

22 DR. ANGOOD: I had my thing off.

1 I apologize.

2 DR. BIRKMEYER: Oh, sorry. Just a
3 couple of quick reactions. The first is that
4 I agree with both David and Gregg that in
5 terms of where to stop the train for the wrong
6 types of procedures being done in the wrong
7 place, that the informed consent process and
8 the discussion between the surgeon and the
9 physician is obviously not the ideal place for
10 that to be happening. You know, kind of the
11 better and more effective intervention points
12 are certainly upstream of that.

13 The question that I have for both
14 of them though and for the Committee is that
15 is this useful to have for people for when
16 those safeguards aren't in place and by one
17 mechanism or another patients have gotten to
18 that point in scheduling surgery with a
19 surgeon or hospital. That just doesn't do it.

20 The question on composite
21 measures, while there's a number of parallel
22 efforts going on in various shops across the

1 country, I think where most of the work that's
2 come about in partnership with the Leapfrog
3 Group has been done by my colleagues,
4 economists Doug Saiger at Dartmouth and Justin
5 Dimick, who's a statistician and a surgeon
6 here with me at Michigan.

7 There's been a couple of papers
8 most recently in Health Affairs in this
9 month's issue looking at the extent to which
10 incorporation of both information on procedure
11 volume, but also on either observed or risk
12 adjusted mortality does a substantially better
13 job in terms of predicting subsequent risk and
14 in discriminating real performance, i.e., real
15 outcomes across hospitals.

16 There's another paper that was
17 published last year that was by Staiger, et
18 al., showing that the incorporation of
19 additional information about performance with
20 procedures that are correlated with the
21 procedure of interest as an input makes the
22 composite measures better still.

1 So I think that we're very close
2 to being able to operationalize those
3 measures, and I know that other committees
4 within NQF have been deliberating about those
5 measures and when to implement them.

6 Perhaps Barb has additional
7 comments on the logistics.

8 DR. RUDOLPH: Yes. In terms of
9 the survival predictors, they have gone
10 through and they've passed the Steering
11 Committee and they've passed the CSAC and now
12 they're up for potential ratification at the
13 Board of Directors in October.

14 And we at Leapfrog have actually
15 incorporated these measures this past year and
16 have them out now in the public domain on our
17 Leapfrog Website, and there's also more
18 information out there if you want to, you
19 know, take a look at what's in the measure and
20 how it's actually working for hospitals today.

21 But, again, that conversation we
22 would see as part of the next iteration, not

1 what we're looking to add in at this
2 particular point.

3 DR. ANGOOD: Okay. Thanks.

4 Again, we're trying to stage this.
5 How do we accommodate what we have, then move
6 to a more substantive individual safe
7 practice.

8 Patrick Romano has a comment.

9 DR. ROMANO: Yes. I think I would
10 just agree with what Dr. Hunt and Dr. Meyer
11 said about the decision point. The place to
12 have this discussion, the place to exercise
13 leverage, and I would highlight. I was just
14 going back to look at the, you know, text that
15 was in the document that we released, and so
16 what we said at that time was two practices
17 were retired because other measurement
18 strategies are being used to nationally target
19 the same adverse events.

20 And I think that's correct. I've
21 been a strong supporter of those measurement
22 strategies. We've incorporated volume

1 indicators into the AHRQ patient safety
2 indicators or the AHRQ quality indicators, and
3 certainly I and others have strongly advocated
4 the use of volume as a way to educate
5 patients, as a way to make markets work more
6 efficiently.

7 It doesn't seem to me either that
8 this safe practices is really the appropriate
9 setting for this to be imbedded. Our focus
10 here is on specific practices that health care
11 professionals and provider organizations can
12 adopt at the point of care that will improve
13 the safety of the care that they provide, not
14 so much to make the market work more
15 efficiently or to achieve broader regulatory
16 goals, but specifically to make their own
17 practice more safe.

18 So I think in this case separate
19 is not unequal. We can say that these volume
20 -- this volume standard, if you will, is very
21 important, but it doesn't fit very well within
22 the domain of informed consent under the safe

1 practices.

2 DR. RUDOLPH: This is Barbara
3 Rudolph. Can I respond?

4 DR. ANGOOD: Yes, go ahead, Barb,
5 and then Chuck Denham has a question to
6 follow.

7 DR. RUDOLPH: Yes. You know, we
8 did not make the choice at Leapfrog or the
9 disclosure group to have this added into the
10 informed consent. It was put in by the prior
11 maintenance committee, and we are responding
12 to the notion that, you know, we were not
13 given an opportunity at the time the safe
14 practices were changed, and our Safe Practice
15 24 was removed.

16 Yes, this isn't ideal perhaps to
17 have it here, but it's also not ideal to
18 completely exclude this information from the
19 set of safe practices that are going to be
20 coming out.

21 I think it's not a perfect world,
22 but yet, you know, we know that the safe

1 practices do make a difference or we wouldn't
2 be including them in our survey if they
3 weren't, and we know from hospitals that they
4 do pay attention to this.

5 And I think that it sends a clear
6 message to hospitals that are low volume
7 providers that this is not going to be
8 tolerated or at least consumers should be
9 given the information that there are better
10 places to have these procedures done.

11 And I think we had a number of
12 consumer entities respond in comments during
13 the voting period when we couldn't actually
14 vote whether or not it should be excluded, but
15 there were a number of groups that commented
16 saying, please incorporate this information
17 back into the safe practices, and I think the
18 number of purchasers outside of Leapfrog had
19 also submitted comments to that effect.

20 So I think that, yes, maybe this
21 isn't the best place, but it needs to be here
22 somewhere in the safe practices, and since,

1 you know, there wasn't a process for doing
2 that smoothly, I think we're going to have to
3 settle for some bumps here and lumps in this
4 informed consent process.

5 DR. ANGOOD: Yes, thanks, Barb.
6 Those are appropriate and well timed comments.
7 You know, you can use the surgical analogy.
8 We're not doing a major revision here. We're
9 trying to correct from an amputation that was
10 kind of partial. So we're trying to do a
11 little reconstructive surgery, if you will.

12 Gregg has one?

13 CO-CHAIR MEYER: That's right. I
14 do feel compelled to respond to your comments,
15 Barb, because I think that, again, when I
16 think about the mechanism just accept that
17 this is important to inform patients about,
18 and I agree with that wholeheartedly and would
19 work hard to do it.

20 But at the end of the day, I don't
21 think that the effort to do that is going to
22 be damaged by us not adopting or not changing

1 the safe practice.

2 I think the reality of it is that
3 I think the wording that went out around that
4 decision, the process was flawed. We
5 understand that and are trying to fix that,
6 but I think the final word is not that there
7 are more appropriate and more robust
8 mechanisms to do this than inclusion here. I
9 would stand by. I think that that was
10 correct, and to my mind we're going to as a
11 provider, we're going to let people know about
12 this relationship because (a) we participate
13 in Leapfrog and we care about it; (b) because
14 we know the evidence and it's the right thing
15 to do.

16 And I would have to say I can go
17 through (c) through (y) before I got to maybe
18 Z because it was a safe practice. It's not a
19 compelling or at least in my feeling it's not
20 a compelling reason to do this, and frankly,
21 I think its power will not be either diluted
22 or significantly enhanced by making the change

1 proposed here.

2 DR. ANGOOD: Okay. Thanks, Gregg.

3 And Chuck Denham has a question or
4 comment?

5 CO-CHAIR DENHAM: One is just to
6 make sure that we reinforce and underscore
7 that the retirement of the prior practice was
8 a practice that was not synchronized with the
9 Leapfrog standard because -- and if you
10 remember, the Leapfrog standard changed, and
11 so when we looked at the safe practice, the
12 Leapfrog standard had actually changed, and so
13 we weren't retiring a practice that was a one-
14 to-one correlation with the Leapfrog practice.

15 So I think that's important that
16 the Committee remember that that was one of
17 the cases, and that was very acutely brought
18 to me because we are the biggest champion for
19 driving adoption in the country of these safe
20 practices. We put an enormous amount of
21 resources behind driving adoption, and for
22 every meeting we were in, how come the

1 Leapfrog standard is different than the NQF
2 safe practice?

3 So this was a dilemma, and so I
4 think, Barb, one of the most important things
5 is as Leapfrog continues to develop great
6 standards and do a great job at really tying
7 transparency to adoption, any of the standards
8 that got migrated, it would be great to take
9 them back through the NQF process and get them
10 hammered out so that there's a one-to-one
11 correlation. So that is the comment.

12 The second one is to put up for
13 the Committee that Leapfrog has done a great
14 job of organizing their thoughts, their facts,
15 their document. They've really, I think,
16 communicated it well, and we should as a
17 Committee look at their proposal in the
18 document that's part of our package regarding
19 the specific language that they would like to
20 have inserted into the informed consent now
21 that we've heard the discussion and discuss
22 whether this language (a) is something that

1 should be changed on the informed consent
2 practice; (b) if it should be changed, should
3 it be this language or some other language;
4 (c) in parallel Leapfrog would be welcome to
5 resubmit a new safe practice for the next
6 round for 2011 whether or not that happens.

7 So kind of to parse out our
8 discussion is do we make any changes to the
9 informed consent practice in this area. If we
10 do, would it be the language that they're
11 submitting?

12 Another issue is do we recommend
13 that a stand-alone be resubmitted, you know,
14 the next time around.

15 Those are kind of what we've got
16 to discuss here so that we can make decisions,
17 but the other thing that -- now, those are
18 comments. The question back to Dr. Birkmeyer
19 and Barb is: is there any evidence in the
20 literature or do you anticipate funding some
21 research or seeing some research come out in
22 the evidence regarding implementation?

1 Because I hear from Dr. Meyer and
2 as we kind of talk about how this gets
3 implemented at the front line, having some
4 evidence and, you know, more work on
5 implementation of the practice, not just the
6 evidence for the differences in mortality and
7 differences in results, but on implementation
8 which sure helped this Committee a whole lot
9 to say, "Wow, you know, people have been doing
10 this in multiple sites, and it has made a
11 difference, you know, although that's hard to
12 get funded and that kind of thing."

13 But I think evidence regarding
14 implementation is a theme that I'm hearing.
15 So is there anything anticipated before we
16 kind of come back for the discussion on the
17 other issues?

18 DR. BIRKMEYER: So when you talk
19 about evidence of implementation, are you
20 referring to evidence that similar guidelines
21 vis-a-vis the informed consent process have a
22 meaningful impact on clinical decision-making?

1 CO-CHAIR DENHAM: Or even broader,
2 just successful adoption of such methods, kind
3 of just the broad band width of, you know, I
4 think it's so important, and I think some of
5 our Committee members have brought up over and
6 over again implementation, the challenges of
7 taking specs and then putting them to work.

8 You know, any research that might
9 be published out there by the next cycle could
10 sure help the Committee and awful lot to see,
11 you know, that people are actually putting
12 this to work. They're actually adopting it.
13 You know, they've been successful in adoption,
14 even if it hasn't translated, you know, to
15 outcomes in a very pure sense.

16 DR. BIRKMEYER: Well, I'm not sure
17 how broadly you're talking, but we do have a
18 paper that's in review now that suggests that
19 between 2007 that there's been other
20 substantial immigration of patients away from
21 low volume centers for many high risk
22 operations, particularly cancer operations

1 attributable, in part, to a variety of
2 factors, of course, but no doubt a large part
3 of that is the efforts of the Leapfrog Group.

4 That doesn't, of course, get to
5 anything that is specific to the practice that
6 we're discussing now, which is the consent
7 process.

8 DR. PRONOVOST: This is Peter
9 Pronovost.

10 John and Barb, thank you so much
11 for your presentation.

12 The issue that I'm struggling with
13 is I have no doubt that or believe the
14 evidence, John, is exceedingly robust for
15 this, and what we're here with, as Barb said
16 and I completely agree, is really a failure of
17 accountability of other levers that may be
18 more effective, but the reality is consumers
19 are being exposed to risks that they are
20 unaware of and at least I believe they should
21 be aware.

22 What I'm struggling with and

1 perhaps you could ask is these operations are
2 one of many organizational level risks that
3 patients are exposed to unwittingly, and
4 what's our process for deciding which one of
5 those risks we may public?

6 You know, as I was hearing it, I
7 said, oh, well, should we add ICU staffing to
8 that because we feel quite confident that
9 patients are getting exposed to risks. Should
10 we add their infection rates or some of the
11 NSQIP measures?

12 And, you know, John, I think you
13 eloquently discussed to say, well, what does
14 the risk reduction have to be before it's a
15 real risk, but I see this as Patrick was
16 saying. It's really an organizational level
17 risk, and that consumers need to know, but how
18 are we going to decide which one of many risks
19 that are best to include in this?

20 DR. BIRKMEYER: Well, Peter, just
21 in response, I totally agree with you. Volume
22 or mortality information around a specific

1 type of procedure is one of a much longer list
2 of variables that both describe as well as
3 predict prognosis, you know, for subsequent
4 care at those facilities, and certainly ICU
5 staffing is an area that you have mapped out
6 very nicely.

7 But you certainly could put a long
8 list of other things. You know, many would
9 argue that is a slippery slope in terms of
10 where to draw the line about what sorts of
11 information are required to be disclosed in
12 some form, but at the end of the day I think
13 that you need to, you know, be explicit about,
14 you know, how important and or what magnitude
15 of risk difference is sufficient to get you to
16 that level of accountability.

17 And so I don't have a nice answer
18 though about where to draw the line either in
19 terms of scope of variables or in terms of
20 difference in risk.

21 DR. ANGOOD: Thanks, John.

22 Any other comments from our

1 Committee? We're going to have to wrap this
2 up because we've got a busy day and 33 other
3 practices to consider as well. We've done
4 almost an hour on this one.

5 Other comments? I'm not seeing
6 any per se. Any other closing comments, Barb
7 or John?

8 DR. BIRKMEYER: no.

9 DR. RUDOLPH: Just again to refer
10 you to the last paragraph where we indicate
11 more specific language for subspecialty and --
12 as opposed to the language on the front page.

13 DR. ANGOOD: Yes, thanks for
14 clarifying that because we have sort of three
15 items. There's the currently existing bullet
16 under informed consent, which is basically one
17 sentence, and that's on the first page. There
18 was the paragraph on the first page, which was
19 the suggestion for the 2009 update that never
20 got incorporated, and then there is on the
21 very last page general direction that you guys
22 are suggesting in your recommendations.

1 DR. RUDOLPH: Right.

2 DR. ANGOOD: And so for us since
3 we are trying to keep this revision of the
4 safe practices, just a light buffing if you
5 will, I think that we need to look at the
6 existing bullet within informed consent and
7 come up with some language that helps to
8 clarify some of the issues that have been
9 discussed and yet not make it so extensive
10 that it's going to knock us into needing to do
11 a whole formal consensus development process
12 overall.

13 I think there's clear unanimity in
14 the room. This is an important issue that
15 needs to be addressed in some fashion, and I
16 think Peter Pronovost's last comments about
17 all these other risks that are out there as
18 well kind of puts this into perspective of,
19 well, this particular example can be a driver
20 for how to address some of these other risk
21 points, but maybe the safe practices is not
22 the best platform to be doing all of that.

1 What I would suggest in the
2 interest of time and to not have us get into
3 micro editing, as a group -- that's always a
4 problem -- is perhaps, Barb and John, you
5 could look at that bullet, look at a way to
6 clean up the language and the specificity of
7 that language a bit for us for us and submit
8 it, and we will distribute that around to the
9 committee members for their comment on that.
10 Again, trying to strike this balance that
11 we're trying to just do a light buff, and
12 recognizing that, we will delve deeper into
13 these issues as we go into the 2010
14 clarifications overall.

15 Does that make sense for you, Barb
16 and John?

17 DR. BIRKMEYER: yes.

18 DR. RUDOLPH: That looks fine.

19 DR. BIRKMEYER: Chuck has a
20 comment.

21 CO-CHAIR DENHAM: I just want to
22 clarify for the record, Barb and John, that

1 what you're proposing in the very last
2 paragraph of the Word document that you sent,
3 that the verbiage that states, "This
4 information should include comparative
5 hospital mortality and volume for
6 esophagectomy and pancreatectomy for hospitals
7 and the patients' medical service area by
8 those providers with lowest volumes"; that one
9 sentence you're proposing to be added to the
10 last bullet of the specifications that are on
11 page 108 of the current practice. Is that --
12 I just want to make sure I understand clearly
13 that you would like that sentence added to the
14 last bullet of the specs; is that correct?

15 DR. RUDOLPH: Yes.

16 DR. ANGOOD: Either added or that
17 bullet modified to accommodate the intent of
18 that sentence.

19 CO-CHAIR DENHAM: That's what I
20 mean.

21 DR. ANGOOD: Yes. We want to keep
22 it clean, crisp and as short as possible.

1 CO-CHAIR DENHAM: But my thought
2 was rather than take this through a cycle
3 through the Committee, we're so close, I think
4 if we spend -- if you could indulge us like
5 three or four minutes, maybe we can -- that
6 bullet states for you on the phone, "The risk
7 that is associated with high risk elective
8 cardiac procedures and high risk procedures
9 with the strongest volume outcomes
10 relationship should be conveyed."

11 If that sentence that you are
12 proposing, "this information should include
13 comparative hospital mortality and volume of
14 esophagectomy and pancreatectomy for hospitals
15 in the patient's medical service area by those
16 providers with lowest volumes," it sounds to
17 me that that sentence added to that one
18 sentence of the bullet is what you're
19 proposing.

20 I just want to know for clarity if
21 that's what we can discuss as a Committee for
22 just a couple of minutes, maybe we won't have

1 to go through the cycle. I just want it for
2 my own clarity to know that that's what you
3 all wanted at Leapfrog.

4 DR. BIRKMEYER: Well, this is
5 John.

6 I didn't get a chance to review or
7 to provide feedback about the submitted
8 version, but I would propose a greatly
9 simplified verbiage rather than just adding on
10 an additional sentence to what was proposed
11 earlier.

12 DR. ANGOOD: Right.

13 DR. BIRKMEYER: And I think that
14 the language would be something that, you
15 know, was something almost as terse as for
16 patients in need of particularly high risk
17 procedures, comma, particularly esophagectomy
18 and pancreatectomy, that physicians in low or
19 very low volume hospitals make patients aware
20 of -- and I'm paraphrasing here -- volume
21 outcome associations with that procedure and
22 the option of referral to a high volume

1 center.

2 DR. ANGOOD: Okay. So we already
3 have enough discussion going on and into the
4 micro editing. We'll have to -- John, if you
5 can recapture what you just said because I
6 always know how tough it is to repeat what you
7 just stated, but you and Barb clean that up a
8 little bit and keep it short, crisp, and
9 concise and submit it to us.

10 We will rapid cycle it through our
11 Committee on E-mail and make sure it's
12 included after we get through, you know, our
13 electronic approval of it and have that or a
14 version of what you just described as a
15 modification to the safe practice bullet, and
16 then we'll continue to work with you all in
17 terms of the processes of submission for a
18 fresh safe practice that delves into this, and
19 it will generate more of the discussion and
20 the framing of the discussion points that came
21 out in the last hour.

22 Does that work for you?

1 DR. BIRKMEYER: Yes.

2 DR. RUDOLPH: Yes.

3 DR. ANGOOD: Does that work for
4 the Committee?

5 Patrick has one last comment.

6 DR. ROMANO: Yes, I just wanted to
7 say that I think what I heard in Dr.
8 Birkmeyer's restatement, it made this a little
9 bit more acceptable to me and perhaps to other
10 members of the Committee, is the idea that
11 this is not necessarily imbedded in the
12 informed consent document that a patient is
13 actually asked to sign as they're being
14 wheeled into the operating room, but this is
15 part of a broader process of informing and
16 empowering patients.

17 So if there's a way of capturing
18 that distinction and, therefore making it
19 clear that this is not -- it doesn't fit
20 exactly with the previous points in the safe
21 practice because it's not about the patient
22 simply being able to restate that they're

1 going to have their leg chopped off, but it's
2 really about being more broadly informed about
3 the context for what type of surgery they're
4 going to have and where they're going to have
5 it.

6 So if there's a way of doing that,
7 I think it might be more acceptable to some of
8 the members of the Committee.

9 DR. ANGOOD: Okay. That's good.
10 Thanks, Patrick.

11 And I'll just remind the Committee
12 as well as John and Barb. One of the other
13 mechanisms that we have that doesn't kick us
14 into full consensus development is adding a
15 sentence or a paragraph in our problem
16 statement that sort of highlights or brings up
17 the issue, and we can look at how to add a
18 little bit of language in there as well
19 without modifying the specs heavily enough.

20 So, John and Barb, thank you so
21 much for the time. Thank you for the
22 document. That was very well done, and the

1 presentation today. Hopefully our Committee's
2 deliberations are support of where you wanted
3 to go, and thank you for working with us as we
4 resolve how to manage this problem.

5 DR. RUDOLPH: Thank you, Peter.

6 DR. BIRKMEYER: Thank you so much.

7 DR. ANGOOD: Okay. More to follow.

8 Thanks so much, everyone.

9 Why don't we take a quick break?

10 Lunch is probably going to be coming through
11 at what, roughly? It will be a working lunch
12 since we still have 32 practices to go through
13 now.

14 MS. MARINELARENA: Lunch is at
15 11:45.

16 DR. ANGOOD: All right. Well,
17 it's exactly 11:00. Why don't we take ten
18 minutes and freshen up? And then we'll get
19 back in here and keep cranking.

20 Thanks.

21 (Whereupon, the above-entitled
22 matter went off the record at

1 11:00 a.m. and resumed at 11:15

2 a.m.)

3 DR. ANGOOD: All right. Well,
4 hopefully Peter Pronovost will be able to join
5 us again. I know he's trying to balance a few
6 different things.

7 The last few minutes of discussion
8 around the informed consent and the Leapfrog,
9 as we received their proposed change to the
10 language, again, I'll just reemphasize that
11 we're looking for just a buffing and a
12 polishing of the existing language, and if
13 they want to submit something for
14 consideration as another safe practice, that
15 will be done during 2010.

16 And there are obviously several
17 ramifications around this, both on a
18 practical, in the hospital organization level
19 as well as political and policy ramifications,
20 and so I think it's incumbent at least from my
21 perspective on the Steering Committee to
22 really give serious consideration as we move

1 forward with this particular issue.

2 And what resonated for me actually
3 the most was Peter Pronovost's comment about,
4 you know, there are numerous risks in ever
5 organization, and they are not the same for
6 every organization, and so what makes this one
7 so special that it needs to come up to the
8 level that the Leapfrog Group is trying to do?

9 As a surgeon I'm not discounting
10 the importance of that, and I clearly have
11 recognized over time how volume and expertise
12 changes outcomes, but science and the
13 methodology of it may not quite be there for
14 functioning within a safe practice.

15 Gregg or Chuck, did you have any
16 other perspectives on the last hour of
17 discussion?

18 All right. So we have a lot of
19 work to do. We'll do a working lunch. The
20 discussion so far, I think, has been very
21 fruitful, and we're going to rely on Chuck and
22 Gregg to keep pushing us, pushing us.

1 Oh, I had one last question.

2 Sorry. Who's got what flight times? Patrick,
3 are you staying tonight or are you going back
4 tonight? Staying tonight. You're just going
5 across town.

6 About six, you're here. That's
7 right.

8 Mike, you guys are going back
9 when? Fivish?

10 And you guys, Gregg? Okay. So
11 I'm not going to take advantage of your time,
12 but I have a call with Janet Corrigan at 3:30.
13 So I'm out of here at 3:30, but, no, we'll
14 push hard and we'll bear on your patience but
15 also your efforts to help get us through that
16 mark.

17 Chuck or Gregg?

18 CO-CHAIR DENHAM: So moving to
19 Safe Practice 2, this practice nothing
20 substantive is being brought forward on this
21 practice, and we had a team of a number of the
22 culture researchers that were representative

1 of the broad array of culture surveys that the
2 team is looking back with in terms of the
3 problem statement, the references, the eight
4 specific requirements. And so we're not
5 bringing anything substantive back to the
6 Committee today for approval or submission on
7 either Safe Practice 2 or 3, other than on
8 Safe Practice 2 on culture that we will be
9 coming with that input to the Committee, and
10 we'll cross-check again those specifications
11 for anything substantive. The same with
12 three.

13 And both with two and three,
14 synchronizing those practices with the latest
15 evidence, making sure that all of the latest
16 citations, implementation guides would be
17 addressed, and both are scheduled for a
18 thorough re-review for the 2011 update.

19 Specifically on Safe Practice 3,
20 the teamwork, team training and skill building
21 is looping back and synchronizing that with a
22 lot of the work that has been done through

1 funding by AHRQ with the TeamSTEPS programs
2 and other work.

3 Both practices have held up very
4 well over the last two cycles, but again on
5 the 2011 deep dive fork lift upgrade review
6 really taking them apart and maybe at some
7 point later in the day we'll talk a little bit
8 more about the evidence, the potential grading
9 of the evidence for the 2011 set of practices,
10 and at that time going through that thorough
11 review that may dismantle them completely and
12 kind of rebuild them in a somewhat different
13 manner.

14 But more work will be done in the
15 next two or three weeks on both of these, and
16 Safe Practice 4.

17 Yes, sir.

18 CO-CHAIR MEYER: This, again, when
19 you go out to the field and however you're
20 going to assess the way the field is using
21 this, Peter, in terms of the safety culture
22 survey in terms of the periodicity of it, we

1 showed it last time. We had a lot of
2 discussion, annual, biannual, what's the
3 evidence base.

4 I think it's just a great place
5 for us to biopsy what's going on out in the
6 field with that because we struck a
7 compromise, and I'm not sure we hit it right
8 or not, but I think we ought to ask the
9 question and know.

10 DR. ROMANO: Yes, that's exactly
11 what I wanted to comment on, which is I can't
12 speak broadly for a large number of
13 organizations, but within our own
14 organization, UC-Davis Health System, we have
15 found in our own experience and our own review
16 of the literature that for better or for worse
17 safety culture doesn't seem to change that
18 quickly. It doesn't seem to be as rapidly
19 responsive as blood pressure. It's more like
20 bone marrow density.

21 So we've actually made a
22 deliberate decision to use our resources by

1 doing the safety culture survey every other
2 year, and that really seems to be the optimal
3 interval for us to be able to implement
4 changes and then look at the impact of those
5 changes. So we've done that now in 2004, six
6 and eight, and planning for 2010.

7 So I'm not sure if that resonates
8 with any other experience as well, but I think
9 we do need to keep in mind that some of these
10 time intervals may be, again, a bit dubious in
11 their specificity, and perhaps we should
12 consider allowing a somewhat broader range of
13 intervals based on experience in the field.

14 CO-CHAIR DENHAM: Are you aware of
15 any literature that supports moving to two
16 years so that we could examine that?

17 DR. ROMANO: Well, I'm not
18 actually aware of any literature supporting
19 every year. So I think different
20 organizations have just been trying different
21 things, but I'm happy if others are aware of
22 specific literature that I'm not. I'm happy

1 to look at that.

2 CO-CHAIR DENHAM: So we aren't
3 bringing forth to the Committee any
4 substantive changes to safe practices two or
5 three. We'll come back after some
6 synchronization with some of the activities
7 that are going on, but most likely the problem
8 statements will be thoroughly updated with the
9 latest literature that establishes those
10 things in the implementation guides, but will
11 be coming back, you know, to the Committee
12 after review of those.

13 On Safe Practice 4 --

14 DR. ROMANO: I'm sorry. Can I
15 just get some clarity? So at what point would
16 be the opportunity to revisit the
17 specification of annual in safe practices two,
18 three and four?

19 CO-CHAIR DENHAM: The first one
20 would be whatever evidence there is evolving
21 over the next year or so on this, looking at
22 how amenable and how quick it is to change.

1 CO-CHAIR MEYER: I think the
2 second one is whatever information we get from
3 the field about its practicality. So I would
4 say it would probably be the next big rewrite.
5 For now I think we can leave it at annual, but
6 we're doing the same thing. We moved to every
7 other year because we didn't see it changing
8 that fast.

9 MS. MARINELARENA: Can I just say
10 during the comment period we can be very
11 specific about what kind of comments we're
12 seeking, and that would be a good opportunity
13 to get feedback from the field as to how they
14 feel about those time intervals.

15 CO-CHAIR DENHAM: Great. That's a
16 great suggestion. Thanks, Melissa. That's
17 super.

18 We'll direct your attention to
19 Safe Practice 4, identification, mitigation of
20 risk and hazards. In this suggestion is the
21 addition of three levels of events, serious
22 reportable events, sentinel events and adverse

1 events in terms of some clarity there.

2 You can see the underscore
3 suggested changes. Peter, do you want to kind
4 of comment on these?

5 DR. ANGOOD: Well, I don't
6 actually have a lot to comment on. We sort of
7 got back towards some of the discussion about
8 the near misses and the importance of
9 reporting not just the bad stuff, but even the
10 littler stuff, if you will, if "littler" is
11 the right adjective.

12 And it actually ties back in
13 closely with the culture piece, doesn't it?
14 Because if you've got the right culture then
15 you've got the willingness to report and
16 learn. Was it this past weekend or in the
17 last couple of weeks there was an article
18 about Virginia Mason and their high reporting,
19 but it keeps making them look bad?

20 You know, it is that old dilemma
21 of trying to run that balance. So those are
22 just general comments. I think that what

1 we're trying to add in here is to just keep
2 reemphasizing the importance of trying to not
3 only encourage reporting, but to help build
4 that culture of wanting to report and put the
5 systematic processes into place.

6 CO-CHAIR MEYER: Asking a
7 clarifying question, when you look at the
8 third edition here under adverse event
9 reporting, so the blue is the lines you would
10 put in and the red is what we delete, and the
11 issue here I have is the following four words:
12 "for every such event."

13 And so, for example, you know, you
14 can review many, many reports and you triage
15 them, and some we spend very little time on
16 and some we really dive deeply on. Would that
17 qualify that says we did every such event?

18 So that's the question I have, is
19 how -- so the same process for identifying,
20 managing and analysis of events. Well, we
21 don't do a whole lot of analysis of some of
22 events, and we have a -- for one reason or

1 another we feel that there are others that are
2 higher priority, and so my concern here is
3 that unless you kind of sit down and say,
4 "Yes, we've nailed every single one of these,"
5 that you're not going to be in compliance with
6 this.

7 DR. ANGOOD: Yes, I guess that's
8 at some level a semantical question.

9 CO-CHAIR MEYER: I know it is. I
10 wonder how --

11 DR. ANGOOD: Everybody is
12 triaging.

13 CO-CHAIR MEYER: Might you look at
14 hundreds of reports? You know, do you think
15 that you'd, when you read this, yes, we do
16 look at every --

17 DR. COHEN: The method that we use
18 is, well, first of all, we get individual
19 reports from practitioners. They're not
20 incident reports. They're rich with
21 information, and basically because we use
22 this, our whole purpose is for communicating

1 nationwide through, you know, other
2 organizations.

3 We look for things that are
4 particularly serious, newsworthy because we
5 haven't covered it before, things that are
6 easily correctable. It's like a mixture of
7 things that drive us.

8 CO-CHAIR MEYER: Prioritization
9 mechanisms.

10 DR. COHEN: Yes, and we are
11 influenced, too, by data from other programs.
12 We have access to the MEDMARX program and the
13 Pennsylvania Patient Safety reporting system
14 which, you know, they're data driven reports
15 or programs.

16 So we can see the frequency of
17 something occurring, and that also helps to
18 inform our arguments.

19 DR. ANGOOD: So I think, Greg,
20 apparently everybody is triaging and making
21 value judgments, and maybe we need to add a
22 bit of modifier language in here, if you will,

1 that we recognize that.

2 CO-CHAIR MEYER: Or alternatively
3 you can remember the last four words. If you
4 said "process for identifying and managing and
5 analysis of events should be defined and
6 implemented," period, because it's the every
7 such event.

8 DR. ANGOOD: Mary?

9 MS. MacDONALD: You could do that.
10 I was just saying as a lay reader it seems to
11 me that that includes within the idea that
12 you're defining a process includes within it,
13 you know, the possibility that triage is part
14 of that process.

15 DR. McAULIFFE: I just have one
16 comment. I like the -- the level of analysis
17 doesn't have to rise to a very, very high
18 level. I mean, you can triage it if that's
19 the word you want to use. So I think the
20 analysis sort of takes care of it, and you can
21 get rid of every such event.

22 But I like the next statement.

1 When you're closing the loop and you're
2 putting it back into opportunities for
3 improvement, and I think that's the point of
4 it, and it's back to the education point. Are
5 we eliminating that?

6 MS. MacDONALD: Is that being
7 eliminated?

8 DR. McAULIFFE: Are we eliminating
9 the opportunities?

10 CO-CHAIR MEYER: So a read-back on
11 that is what you would propose to say, it
12 would read process for identifying, managing
13 and analysis of events should be defined and
14 implemented" --

15 DR. McAULIFFE: To identify
16 opportunities for improvement.

17 CO-CHAIR MEYER: Yes, "to identify
18 patterns of opportunity for improvement."
19 That works I think.

20 CO-CHAIR DENHAM: So that
21 language, I think, will be in the transcript.
22 So I think that's a reasonable change. Is the

1 Committee entirely in agreement with that
2 verbiage, the combination of those two
3 sentences as stated? Good.

4 DR. COHEN: Just one more comment.
5 Getting down to the bottom where it says
6 external reporting source input, I have to say
7 that, you know, so many of the hospitals and
8 other organizations are at risk of, you know,
9 what we're seeing reported by other
10 organizations, and I think that, you know, to
11 me, and I've been doing this for a long time
12 now; I see that as critically important, as
13 using the information from the external
14 programs rather than -- I mean, it's just
15 going to be so rare that you have one of these
16 events, thank goodness, but you don't want to.

17 And so I think learning from the
18 external reporting programs that exist, and
19 we're going to see more and more of that with
20 the PSOs, to me that's where a lot of
21 attention should be paid and it's not right
22 now.

1 CO-CHAIR DENHAM: And, Mike, we've
2 got that in SP-1 as an input, but I think it's
3 a really good point to put it in the
4 implementation guide of this practices. So
5 let's add that if that's reasonable to the
6 Committee.

7 I'm getting nods around, to add
8 that just to underscore that in the
9 implementation guide of SP-4, although there's
10 a hardwire input on SP-1 for that. But let's
11 just underscore it with a sentence that could
12 address the opportunity in the implementation
13 guide.

14 Are you happy with that? Okay.

15 DR. COHEN: Yes.

16 DR. ANGOOD: Everybody happy with
17 that approach? Okay.

18 The next page on SP-4 was really
19 just a formatting change with nothing
20 substantive. If we moved to safe practices
21 for the section regarding performance
22 improvement programs, just some, again,

1 glossary, we're doing a little bit of clean-up
2 and defining the term "systems solutions" in
3 our glossary and teasing out. You know, most
4 people who are not the technology field don't
5 realize that a technology doesn't meet
6 hardware/software or information technology;
7 that technology can include a method, and that
8 solutions are combinations that saw problems.

9 So I think we're going to be
10 really careful about using some defined terms
11 that come right out of the dictionary and
12 right out of some of the terminology that
13 revolves around technologies just so that
14 we're careful not to migrate and create new
15 operational terms that cause some conflicts.

16 So, David, you know, as a chief
17 medical officer in the HIT area, you know what
18 we're talking about is just being really
19 careful about terms, solutions, technology,
20 information and that kind of thing so that our
21 glossary is really tied to references and not
22 just operational terms we kind of pull out of

1 group think.

2 So if the Committee is comfortable
3 with that as we bring the glossary forward,
4 define that term and then the Committee will
5 have a chance to kind of review the whole
6 glossary.

7 So in the interest of time, we
8 would move the next page. Committee
9 discussion, regarding remove or reevaluate
10 risk assessment and mitigation activities
11 listed for the 2011 update.

12 This is for 2011. Some discussion
13 regarding -- and this isn't for the Committee
14 to make any decision on now. This is kind of
15 a note to the Committee as we go for the
16 update. It was just as we re-reviewed, and
17 some of the folks, not everybody, reviewed the
18 practice, it appears to be there's a little
19 bit of redundance in terminology, but we're
20 not recommending any substantive change. This
21 is just for the 2011.

22 Because we're on a shorter cycle

1 this year, we're really kind of going through
2 carefully everything so that we can then look
3 at the 2011 upgrade and say, "Okay. Now when
4 we really kind of take these apart, look at
5 the evidence, update them, you know, what
6 might be considered?"

7 And just as we read that practice,
8 one of the suggestions is that it might be
9 removed, but then the counterpoint is that
10 many organizations cut each one of the
11 practices separately as a stand alone activity
12 and hand it off to risk or hand it off to
13 pharmacy or hand it off. So even though the
14 document in total looks like of redundant,
15 sometimes, we know operationally as soon as
16 they get the NQF report they're parsing out
17 sections of it, and for clarity we may make it
18 more unclear.

19 So that's kind of a note to our
20 Committee regarding that section. So there's
21 nothing substantive there that we want to
22 address. So that takes us through one through

1 four.

2 We have covered Safe Practice 5
3 only in the context of the Leapfrog
4 suggestion. We haven't addressed other issues
5 that are pertaining to informed consent. This
6 one will likely undergo, again, kind of a
7 forklift upgrade, major surgery for 2011. The
8 only substantive thing we're considering at
9 this point in time, again, with the idea of
10 the light review this year because we're
11 actually at a half year. This is going to
12 come out in January. so our work will go to
13 the board, you know, shortly and they still
14 have the 2009 practices that they just got the
15 7th of March. So it's not like we've got an
16 exposure period between now and, you know,
17 then.

18 So the concept is keep this one
19 relatively intact knowing that we want to
20 really revisit this one carefully, but I'd
21 maybe go back, Peter, to your prior life with
22 Joint Commission. Anything?

1 We had the discussion regarding
2 anything that we might want to synchronize.
3 Do you want to maybe address this just before
4 we move on from consent?

5 DR. ANGOOD: Well, actually, no,
6 not really. I think the informed consent
7 piece is critically important, and you know,
8 there are other groups like the Joint
9 Commission that are pushing this along fairly
10 fast and hard, and what is the true extent of
11 the informed consent and how do you evaluate
12 the comprehension of the content of the
13 informed consent, and that gets us all into
14 the whole issues of, you know, communication
15 and diversity, et cetera, et cetera, et
16 cetera, which may well be too robust for this
17 particular safe practice.

18 But I think we do need to keep
19 paying attention to those things. So that
20 would be my only comment.

21 Patrick or David and then Patrick.

22 DR. HUNT: Oh, okay. I would just

1 say I'm looking at the use of the fifth grade
2 level, which I think is still appropriate, and
3 many of the statutes that we have to work on
4 with regard to language used the term
5 "referred language" rather than "primary
6 language."

7 DR. ANGOOD: Patrick.

8 DR. ROMANO: Well, I actually
9 wanted to just put a comment on the record
10 regarding Safe Practice 4 and the last comment
11 that you made on Safe Practice 4, which is
12 that I would strongly encourage us to consider
13 opportunities to reduce overlap and reduce
14 redundancy across safe practices because I
15 think in the long run that facilitates
16 implementation and improves clarity.

17 So you know, falls, for example,
18 are already covered under another safe
19 practice. Pressure ulcers is another area
20 where risk assessment has emerged as very
21 important, I think, and that's really covered
22 under another safe practice.

1 So if we were deliberately going
2 for overlap, then pressure ulcer risk
3 assessment ought to be in Safe Practice 4 as
4 well, but I would prefer to move in the
5 direction of reducing overlap and thereby if
6 there is specific areas where we think that
7 specific risk assessment and mitigation is
8 necessary, that that should be more clearly
9 delineated in separate safe practices and not
10 sort of rolled up here under Safe Practice 4.

11 And pneumatic tourniquets, I'm not
12 sure even whether that's still, you know, as
13 relevant as it was when this was written.

14 So I think we should take
15 advantage of our opportunity moving forward to
16 try to again simply further and remove some of
17 this detail here that probably doesn't belong
18 here and maybe better fleshed out in separate
19 safe practices.

20 DR. ANGOOD: I think that's the
21 tip of an iceberg on a bigger set of issues,
22 and you know, I think we need to continually

1 need to continually reassess with each version
2 how do we keep these clean, how do we keep
3 them simplified so the field can use them.

4 I can't quote it out, but a few
5 months back I looked at the evolution of the
6 safe practices and almost half of the original
7 safe practices are now gone. Several are
8 renumbered, and when you're a user out there,
9 how do you keep up with these changes even on
10 an every three-year basis, and I would say we
11 even take it to a point of getting rid of the
12 numbering system because you can't follow it.
13 You want to more group it around the concepts
14 or the theme of a practice.

15 And so those are things that we'll
16 work towards in terms of making these
17 practical and actionable in the field.

18 Dave.

19 DR. HUNT: And I would also
20 encourage us to continue to use some more of
21 the more up to date tools like hyperlinks, you
22 know, documents like that. Most people

1 fortunately or unfortunately read off of a
2 screen now. So prepping the document for that
3 type of a review because all of these could
4 just be hyperlinks then.

5 DR. ANGOOD: We've got our
6 communications folks working at least trying
7 to make this existing document much more user
8 friendly along that line, and my goal is to
9 get all of those things I talked about in my
10 opening comments basically on electronic
11 formats, and we're not really relying on paper
12 at all.

13 CO-CHAIR DENHAM: Other comments?

14 So is the Committee comfortable
15 then moving to -- so informed consent, were
16 there any other comments regarding informed
17 consent other than what we covered with
18 Leapfrog?

19 All right, then to Safe Practice 7
20 or -- I'm sorry -- life sustaining treatment.
21 This practice, again, is one scheduled for
22 thorough review for the 2011 update and we are

1 not bringing substantive changes to that
2 practice at this point in time.

3 CO-CHAIR MEYER: So the only
4 comment I would add is that, as I said in the
5 past, this falls into that category of one of
6 these things that's not like the other. In
7 the past we've asked NQF to look and see if it
8 fits someplace else in your portfolio, and in
9 the past there wasn't a place for it. It has
10 been orphaned.

11 So we've kept it in but just ask
12 you to look at that again. One other thing
13 you could say is if you want to buff these up,
14 we could just call this the death panel safe
15 practice.

16 (Laughter.)

17 CO-CHAIR MEYER: That would
18 probably be very popular these days.

19 DR. ANGOOD: I know. The elder
20 death panel, you know. We won't say who did
21 that quote, but one of the priorities within
22 the NPP is the whole appropriate end of life

1 care, et cetera, and as that work comes
2 together, there's an automatic --

3 CO-CHAIR MEYER: People are still
4 kind of scratching their heads and saying safe
5 practice.

6 DR. ANGOOD: Yes, it's good. So
7 any comments on Safe Practice 6?

8 Safe Practice 7 is the disclosure
9 practice, and I would draw your attention to
10 the pH with the underlined statement. The
11 Committee discussion of the statement
12 regarding malpractice liability carriers and
13 error disclosure policies, and this addresses
14 that. So let's just read it.

15 "Health care organizations should
16 implement a procedure to insure and document
17 that all licensed practitioners are provided
18 with detailed description of the
19 organization's program for responding to
20 adverse events, including full disclosure of
21 errors that may have caused or contributed to
22 patient harm. This is done with the

1 expectation that the LIPs will provide this
2 information to their individual medical
3 malpractice liability carriers in the event
4 that they are provided liability coverage from
5 entities outside the organization. All new
6 employees should also receive this
7 information.

8 This has been a discussion area
9 where we've had M.D./J.D.s and a number of
10 folks kind of looking at these. The way that
11 things are handled in large academic centers
12 where all of the physicians are employed are
13 dramatically different scenarios than
14 independent practitioners who might have a
15 whole array of malpractice coverage, and it
16 also is an issue pertaining to nurses and
17 other care providers regarding what statements
18 that they make, and as we will see in the care
19 of the caregiver, this continues to be an area
20 of evolution in terms of how organizations are
21 managing disclosure, but also care of the
22 caregiver after an event occurs and not

1 driving them all to layer up the moment an
2 event occurs, but also providing them the
3 opportunity and the knowledge that they really
4 should be entitled to have some representation
5 or some advice as they go through it.

6 And, Mike, I think the disclosure
7 and care to the caregiver are kind of like
8 Siamese twins. They kind of come together.
9 You have to kind of look at them together. We
10 continue to have a big problem with caregivers
11 being indicted for criminal offenses involved
12 with system failures that occur at hospitals.

13 And some people have said in the
14 past, well, disclosure shouldn't be a safe
15 practice, and neither should be care of the
16 caregiver. Yet the information that's gleaned
17 from it and the barriers that these issues
18 pose have a huge impact on patient safety,
19 probably far greater than many of these other
20 practices, and we know that out in the field,
21 and it is actually being documented in the
22 literature as well.

1 So this is an area where we're
2 carefully going through the disclosure
3 practice, the care of the caregiver practice
4 with people like Tim McDonald, University of
5 Illinois; Rick Boothman, University of
6 Michigan, who are very active in this area of
7 disclosure, care of the caregiver, Lucian
8 Leape in Boston. We're carefully going
9 through these and thoroughly re-reviewing them
10 again in light of what's evolving in the
11 literature and how we can strike the right
12 balance, you know, with these practices.

13 But I kind of open it up. Mike,
14 you've got some thoughts in this area I know
15 and with a lot of the recent things that just
16 keep going on in disclosure.

17 DR. COHEN: One of the things
18 unfortunately that I've observed personally is
19 a situation where it's almost like the
20 practitioner is left to hang out to dry. I
21 mean, there is no information that's given to
22 the patient about many of the system failures

1 that set up this practitioner to make the
2 AHRQ, and that's pretty worrisome.

3 I think there's a situation that's
4 brewing right now where that's the case. So
5 I really think that's an important aspect.

6 DR. ANGOOD: Yes, I couldn't
7 emphasize that enough. You know, as a
8 practicing surgeon for 25 years there was my
9 share of little accidents, nothing major
10 fortunately, but each time that occurred, I
11 always was totally uncomfortable that it
12 wasn't -- you know, even if the
13 anesthesiologist was messing up on my case, it
14 was going to come down to me, you know, and
15 Dave is shaking his head. He knows that, and
16 we all have examples of that.

17 (Laughter.)

18 DR. ANGOOD: It's always the
19 damned nurse.

20 But, no, it's systems; it's a
21 variety of things, all well intended people,
22 but it lightning rods down on the individual

1 practitioner so often and we have to worry
2 about how we use the practice to help drive
3 that change.

4 DR. HUNT: Just to go along with
5 the theme that the way to make a practice or
6 implementation reliable, take the physician
7 out of the loop, would be to also suggest that
8 the hospital provide that information directly
9 to the malpractice carrier. Every place that
10 I have privileges at I write down who my
11 malpractice carrier is, but then there is a
12 second independent step where the hospital
13 accreditation board, they actually make sure
14 that, yes, I actually have coverage with NCRC,
15 and they get a certificate back completely
16 independent of me.

17 That's the opportunity for that
18 communication channel, for the hospital to
19 also provide, to, you know, let it be a two-
20 way street, have the hospital provide that
21 information to the malpractice carrier where
22 this individual is getting privileges at our

1 institution. They put you down as the
2 carrier. These are our basic principles.

3 And that way we can be more
4 assured. The idea of me actually sending
5 something to my malpractice carrier other than
6 a check, I don't know.

7 DR. ROMANO: Yes, I guess that's
8 exactly what I was curious about. I mean I
9 certainly agree with the tone of the
10 discussion here, but to link us to this, I
11 guess the specific sentence here that we're
12 talking about is the sentence regarding the
13 expectation that LIPs will provide information
14 to their individual medical malpractice
15 liability carriers.

16 So it seems a bit unrealistic, I
17 think, to expect that communication to occur
18 in that direction, although certainly we do
19 want to facilitate communication among all the
20 organizations that are involved in the
21 liability process, but that particular channel
22 of communications seems a bit unrealistic.

1 So are we proposing the deletion
2 of that specific sentence? Not the following
3 sentence, right? All new employees certainly
4 should continue to receive information about
5 their organization's policies, but I would
6 support the deletion of that sentence about
7 the expectation on LIPs, if that's the
8 proposal.

9 DR. ANGOOD: Do we need to delete
10 the sentence or change the word "expectation"?

11 DR. HUNT: I would make a
12 recommendation to include the expectation that
13 the health care organization and/or the LIPs
14 provide information to their individual
15 malpractice carriers.

16 DR. ANGOOD: Other comments? Or,
17 Hayley, did you want to provide further
18 context?

19 DR. BURGESS: I was just looking
20 in the example implementation approaches to
21 see what we had as far as that goes.

22 CO-CHAIR DENHAM: We brought this

1 up. We're not bringing this one forward.
2 There's not enough specificity in the column.
3 This was an update to the '06 to revisit, was
4 accepted. The dialogue was with a number of
5 lawyers.

6 If you look at the 2009 update,
7 these are not ads, and I think that's just a
8 bit of an error there, Hayley, because if you
9 look at the specification, this is what we
10 had. We're revisiting it to just see if there
11 has been anything that has kind of morphed in
12 the marketplace.

13 It came from dialogue with a
14 number of NQF members that said, "Hey, how are
15 we going to deal with this issue?" And it was
16 hammered out to then take back out to the
17 marketplace after we got input through our
18 review.

19 And so I think there's a bit of an
20 error here.

21 DR. BURGESS: Well, the black is
22 original language.

1 CO-CHAIR DENHAM: Yes. So we're
2 just bringing it up as a revisit with an
3 abundance of a kind of caution around this
4 issue?

5 CO-CHAIR MEYER: Well, I think
6 David's proposal of saying maybe we should say
7 that the LIPs or their organizations because
8 I agree. I don't think it's hanging there,
9 putting it on the provider to do this every
10 time. It's not going to happen.

11 CO-CHAIR DENHAM: So, David, do
12 you want to restate what you did just so that
13 we have that in the record?

14 DR. HUNT: Yes. I would just say
15 that starting with the underlined sentence
16 this is done with the expectation that the
17 health care organizations and the LIPs will
18 provide this information to the individual
19 medical malpractice liability carriers.

20 CO-CHAIR DENHAM: And the second
21 statement, the second sentence, just for
22 clarification, is in the 2006 update and was

1 not supposed to be changed or removed. so I
2 think we could have been more careful about
3 how we word tool that for you.

4 So, David, that's your
5 recommendation. Patrick, you proposed to
6 remove it?

7 DR. ROMANO: Okay. So just so I
8 understand, this is exactly the text that's in
9 the current 2009 version without underlining,
10 right?

11 Okay, and that sentence about this
12 expectation on LIPs you were saying has been
13 vetted.

14 CO-CHAIR DENHAM: This has already
15 been part of the standard. It was hammered
16 out after input from multiple members in
17 consultation with a number of members who have
18 their risk M.D./J.D. malpractice experts --
19 some of them are malpractice; some of them are
20 on the risk side of the hospitals -- and was
21 an agreed verbiage, and we're just coming back
22 to the Committee with an abundance of let's go

1 back, take a look at it. Has anything moved
2 in the market?

3 We don't think anything has moved
4 that would require changes, and I think it's
5 reasonable, David, to go back to the team that
6 kind of worked on this and say does that seem
7 like a reasonable -- we were not submitting it
8 to have anything removed, Patrick.

9 DR. ROMANO: Yes, I mean, I guess
10 I would say that I don't recall that
11 discussion, whether that came to the Committee
12 or not. I might have missed that phone call,
13 but it just does seem unrealistic.

14 I mean, the way this operates in
15 practice is that, you know, a physician or
16 other licensed professional finds a
17 malpractice carrier and sends them a check and
18 they kind of take the terms of the liability
19 coverage that they've been provided and there
20 isn't really a mechanism for this type of
21 ongoing communication.

22 So I guess I'm -- I don't mean to

1 challenge the process, but I don't see exactly
2 what the safe practice is here that could be
3 implemented, that we're seeking implementation
4 of.

5 If there's an example of how this
6 type of communication has occurred and how it
7 has been shown to improve safety, I'd be open
8 to that.

9 CO-CHAIR DENHAM: Well, I think
10 what we can do, lunch is outside. Dr. Angood
11 has just notified me of the nutritional
12 rounds. Let me propose something to the
13 Committee, that we go back with the add of Dr.
14 Hunt's add, go back to they implementation
15 guide with the team that worked on this and
16 hammered this out actually with NQF members,
17 revisit it just to see if there's anything
18 that's changed in it, see if that
19 recommendation sounds reasonable to this legal
20 team that kind of looked at it, and propose to
21 kind of move forward with this particular
22 version.

1 I understand the practicality
2 issue, but this was a compromise farther away
3 from declaring you shall do this and state the
4 expectation is that, which gave it more
5 flexibility, less specificity, more acceptable
6 to the market, and actually it has held good
7 stead, and we've had no complaints on it as it
8 has been out in the field at least since it
9 has been released. So I think it's reasonable
10 to make the add, see if anything has changed.
11 If nothing has changed with the team kind of
12 thoroughly re-reviewing it, at least for the
13 2010 update, reasonable to kind of move
14 forward with it, and we'll look at the
15 implementation piece, Patrick, just to see if
16 there's anything that we can suggest there.

17 But this is a soft recommendation
18 that the organization will inform the care
19 providers to say that that is an expectation
20 but not a declaration of thou shalt do it and
21 be out of compliance if you're not doing it.

22 DR. ANGOOD: Is everyone hungry or

1 do you want to keep pushing for a little bit
2 longer? We've been going since eight, 8:30,
3 one short break.

4 Hungry, hungry, hungry, yes, I
5 know. Okay. So let's gather some food.
6 We'll continue on as a working lunch, and
7 during lunch we'll try to keep pushing on this
8 and we'll talk about prioritization and
9 scoring and all of that of literature a little
10 bit later on in the day.

11 So it's just outside.

12 MS. MARINELARENA: Can we just
13 make sure there's nobody on the phone that
14 wants to make a comment? We did build in a
15 public comment. I don't think there's anybody
16 there.

17 (No response.)

18 DR. ANGOOD: No.

19 MS. MARINELARENA: Right.

20 (Whereupon, at 11:56 a.m., the
21 meeting was recessed for lunch, to reconvene
22 at 12:15 p.m., the same day.)

1 AFTERNOON SESSION

2 (12:16 p.m.)

3 DR. ANGOOD: We're going to try

4 and get back here on track, and with this

5 fluctuating schedule that we have, we didn't

6 quite get to scheduled public comment phase at

7 around 11:30, and Don Casey is here and he

8 does have some comments that he wants to

9 provide. So we'll open up with our working

10 lunch to have Don provide the opportunity of

11 some comments that he has.

12 We have checked a couple of times.

13 There has not been public members on the

14 phone, but we'll keep an eye on that during

15 the afternoon as well.

16 And then after Don's comments and

17 whatever related discussion, Mike Cohen wants

18 to take us back to a point that he thought

19 needed further emphasis from one of the

20 earlier practices, and then we'll keep moving

21 on.

22 So, Don, are you about ready?

1 Yes, by all means. That's easier,
2 and we're small enough. We can be informal.
3 I don't know as I like the size of that binder
4 though.

5 (Laughter.)

6 MR. CASEY: So these are the safe
7 practices, the safe practice document that we
8 use at Atlantic Health, and we use it
9 effectively, I think.

10 We are nowhere near achieving the
11 success of implementing everything that's in
12 here, and I want to give Peter, Gregg, and
13 everyone here in the room, especially Chuck,
14 kudos, Hayley for her support, for moving this
15 forward, and we look forward, again, to follow
16 you on what we describe as a journey, not a
17 destination.

18 So with that in mind, we are a
19 two-hospital system in northern New Jersey,
20 Morristown Memorial and Overlook. We are a
21 large health system. We have over 1,200 beds
22 between the two hospitals, full services,

1 everything except transplants. We're in UHC.
2 So I know Dr. Meyer's outcomes at MGH right
3 now, and that helps us a lot.

4 So what I want to do is really
5 provide, if it's okay, Chuck, some generic
6 comments. Some of them will be specific, but
7 I wanted to in no particular importance of
8 order or importance, give you some thoughts
9 and then perhaps if it's feasible and you
10 think it's usable, submit some of these or all
11 of them in writing just in summary format to
12 the group.

13 Some of these will be very
14 specific, and some of them will be more
15 generic. I'm not going to get into the micro
16 details that you're working on here, but I do
17 want to hopefully set the expectation now that
18 Peter is here that one thing we get agita over
19 is this notion of harmonization with the Joint
20 Commission national Patient Safety Goals, and
21 we really hope that happens as quickly as
22 possible so that we're not playing two

1 instruments.

2 So that would be helpful. Right
3 now I want to harken to the NQF criteria that
4 are supposed to be used to evaluate measures
5 and, say, practices. I don't see those
6 criteria. I assume the Committee is familiar
7 with them, but I'm not getting a sense of how
8 well you're following them specifically
9 related to this notion of evidence that I know
10 you're going to talk about.

11 And, Chuck, you and I have talked
12 on the phone. Peter and I have talked a bit.
13 We think that -- and not just we, but many
14 other folks that I know of at the provider end
15 -- believe that developing a relevant taxonomy
16 of the grading of the evidence and the
17 classification of recommendations would be
18 extremely helpful. We don't think the U.S.
19 preventative Task Force services criteria are
20 appropriate for this and we would harken
21 against the generic recommendation that people
22 just think that's going to be it.

1 We think, too, that there's an
2 opportunity in the context of what Dr. Hunt
3 said to provide this classification scheme
4 against other industries as well in terms of
5 evaluating the evidence.

6 But let me make an important
7 distinction, Chuck, because I think that the
8 goal here isn't to say that things that don't
9 have a high quality of evidence aren't
10 important or that we don't do this. I think
11 people are getting worried that that's going
12 to be weaponized and I don't think it should
13 be.

14 I think what we should do is
15 instead use it as a tool for several reasons.
16 One is to provide transparency to all end
17 users about the quality and strength of
18 evidence, and secondly to allow organizations
19 to prioritize.

20 As an example, if you are familiar
21 with the Society for Hospital Epidemiology of
22 America, they issued a consensus based

1 document in October that had 111
2 recommendations with classified evidence in
3 each of those recommendations in six
4 categories to prevent infections.

5 And we've taken those 111
6 recommendations and reordered them and tried
7 to use them more strategically because there
8 are 111 of them to implement those that we
9 think have the highest quality of evidence.
10 Incidentally, hand washing had a low quality
11 of evidence, but that still remains a high
12 strategic priority to us.

13 So we're not using this to decide
14 what's better or not. We're simply using it
15 as a way to help us make decisions, and I
16 think that in the interest of transparency, I
17 think the public, the purchasers, whoever else
18 sees these things should be aware of this.

19 So the taxonomy should be
20 developed in the sensitivity to the fact that
21 we're dealing with a lot broader audience than
22 people that do clinical trials who are

1 cardiologists. So that's one strong
2 suggestion.

3 And in the NQF endorsement
4 criteria spelled out by the Board of Trustees,
5 there's a very clear set of language
6 specifications that need to be enhanced, but
7 might be useful in your deliberations as you
8 move forward to go back to and really look at
9 because I do think these are spelled out.

10 I did send in the comment period
11 on behalf of Atlantic last October, I believe,
12 a letter that several of you may have seen
13 that talks about this in detail, and I could
14 provide that to the Committee. I know it's a
15 bit terse, but I did think it was an elegant
16 summary of the issues and might serve as a
17 guide post. I hope you agree, Chuck.

18 The other thing is around priority
19 that, you know, for example I can't remember
20 what the discussion was about culture surveys.
21 Dr. Romano mentioned that and the discussion
22 of the evidence. The evidence I have is going

1 into my CFO's office and saying, "Can I pay
2 for another one this year?" So that's how we
3 use the evidence at our organization.

4 And I would say that the point
5 isn't so much to debate the frequency of that.
6 We're doing it every other year for a variety
7 of other reasons, because we've surveyed the
8 heck out of our individuals already and we're
9 worried about survey fatigue.

10 But also, you know, more
11 generically we think that each of these
12 practices should be -- we should have some
13 financial people in the room talking about
14 fiscal notes both in terms of resource inputs
15 as well as cost savings and, in essence,
16 trying to connect these two, you know, as
17 exact a measurement of efficiency both from an
18 individual episode of care to the organization
19 as possible.

20 You know, we spend 100 hours-plus
21 going through this document every six months
22 to evaluate where we are, and it's a huge time

1 commitment, but also a time sync in many
2 people's minds, and we're not sure we're doing
3 it efficiently. TMIT helps us.

4 So this notion of the
5 transparency, that's really the issue I'm
6 after of using an evidence based taxonomy is
7 important, not the argument about whether a
8 recommendation based upon professional
9 consensus is better or worse than one that has
10 randomized clinical trials on it.

11 If you look at other
12 organizations, they let it fall where it may
13 and they publish the evidence and let people
14 decide. So why should we be afraid of doing
15 that if we do the taxonomy correctly?

16 I also think that we should get
17 disclaimers or we should exact disclaimers
18 from organizations who use, say, practices we
19 believe incorrectly as a measurement system.
20 We don't think, even though we fully
21 participate in Leapfrog and get paid by it,
22 that that's -- it's not clear to everyone.

1 They're sort of acting as if don't steal my
2 lunch, that the measurement scheme they use,
3 which we actually find useful from a quality
4 improvement standpoint, should be made,
5 directly connected to an endorsement.

6 So I think there's this tacit
7 endorsement that I think we need to be more
8 explicit about because I don't think, at least
9 from the provider end, we think that's a
10 direct link, and that needs to be tested and
11 current evidence available shows that there's
12 no direct evidence, as Dr. Cohen was getting
13 to, between the scoring system and
14 improvement.

15 And I have a handout to provide
16 that evidence to the group if they'd like to
17 see that.

18 So we think that such measurement
19 systems are useful for quality improvement,
20 but most definitely not at this phase for
21 public reporting, accountability, pay for
22 performance, and ranking, at least according

1 to NQF's criteria even though others are using
2 it and sort of developing their own way to do
3 it.

4 We think that there are lots of
5 silos with NQF. I think Peter's grid got at
6 this notion, but direct linkages to other NQF
7 endorsed practices and measures would be
8 extremely helpful going forward so that we
9 know how all of these things tie together.

10 I know that's going to be a lot of
11 front end work, but it will pay off in the
12 end. The sensitivity and specificity of, say,
13 practices and measures that reduce harm and
14 have clear and indisputable linkages to
15 outcomes should be evaluated, and some of
16 these will only be evaluated in a qualitative
17 sense, but this notion as we were talking
18 about earlier -- in the micro details you were
19 talking about it with Peter -- about the
20 specificity and sensitivity not just in terms
21 of English language, but in terms of
22 epidemiologic rigor, would be very helpful.

1 We think that relative to your
2 comment, Chuck, highlighting new and high and
3 low tech innovations that support more
4 efficient and effective implementation of the
5 safe practices should be detailed in the
6 specification so that we at least have
7 examples that hopefully have some connection
8 to real world results.

9 I realize that could turn into a
10 marketing and advertising spree, but I think
11 we're big enough to know the forest from the
12 trees on that.

13 Patient centered safe practices, I
14 can just tell you based upon my own experience
15 if you want to have a beer afterward, you
16 know, my ten or 15 near miss or close call
17 events for my own care, that if I weren't a
18 physician would have been close calls or near
19 miss, such as the unintended administration of
20 an access dose of contrast material that
21 wasn't necessary for a procedure based upon
22 poor communication that I intervened on

1 myself. I physically went up to the office
2 where the doctor was and got the order that he
3 had written after the radiology tech had said,
4 "No, they said do it with infusion," and
5 gotten the right thing because they weren't
6 going to do it without infusion.

7 I didn't need the test anyway, by
8 the way.

9 (Laughter.)

10 DR. CASEY: I think relative to
11 Dr. Cohen's experience in Pennsylvania, he's
12 very lucky to have that. In New Jersey, we're
13 not very lucky because we don't put any
14 resources into this serious preventable events
15 as the state likes to call them. I've learned
16 you have to have a different twist in New
17 Jersey than from the rest of the world, but
18 that's all right. I'm from Chicago. So.

19 But making these reporting systems
20 especially at the state level really
21 accountable back to the citizens, that is,
22 demonstrating the real impact on the return on

1 investment of taxpayer money, as well as all
2 the time and effort we spend on these things
3 in terms of impacting patient safety, we know
4 the reports are going up, and there may be
5 some tangible evidence in Pennsylvania because
6 they have some systems, but we really have no
7 clue as to what the impact of the reporting
8 system in New Jersey is, and I've been told by
9 people there who are no longer there because
10 they retired that the state would never be
11 able to do that because they don't have the
12 resources to do it, and I'm like, "What up
13 with that?"

14 So I just think we need to have
15 due diligence, you know, spending taxpayer
16 money on this. I mean, that's an obligation,
17 right?

18 Clarify the role of this work in
19 health system reform. I don't see you guys
20 having as much of a footprint. I know NQF
21 does, but it seems like in the context of
22 several other things that I'm going to mention

1 and then shut up, this would be helpful,
2 especially the impact on my ability reform.

3 Now, right now we don't have
4 positive incentives to avoid defensive
5 medicine. Tort reform doesn't do a darn thing
6 in my opinion to defensive medicine. That's
7 a mindset, and I can tell you that the CYA
8 activities that go on every day in this health
9 system in excess lead to their own errors. So
10 what's going on here?

11 We've got to fix that root cause
12 before we just apply more safe practices to
13 things that aren't necessary. So how do we
14 engineer that? I think you can be creative,
15 and you have enough people power in this room
16 to hopefully get that into people's mindset
17 now especially.

18 Cross-boundary accountabilities
19 that promote collaboration through better
20 incentives to cooperate. In summary, if we
21 have a pressure ulcer issue, we try to get the
22 long-term care facilities in the home care

1 agency together in the same room, as well as
2 people in the ED, the ICU, and the floor to
3 understand that these things just didn't crop
4 up in one spot.

5 And by creating that
6 accountability, we've been much more effective
7 in reducing our pressure ulcers. We're
8 nowhere eliminating them, but we've gotten
9 better. We were semi-finalists for the Codman
10 Award last year on this, and we lost on a
11 technicality, which I won't go into.

12 But I think that could be a safe
13 practice honestly, and I know you're getting
14 at it, but, again, having safe practices for
15 home care, long-term care, physician offices
16 seems to be backward to me.

17 So I know you're trying to get
18 that. I'm almost done.

19 This is one that we really need
20 help with. The lay press is unfortunately
21 pejorative about all of this and, quite
22 frankly, promotes the notion that health care

1 -- and this is from our perspective -- health
2 care providers are criminals and that health
3 care settings are crime scenes.

4 And so how can the safe practices
5 influence this? I don't have the answer, but
6 how can they do it in a constructive way?

7 Because when it happens, it drives this right
8 back into the hole, and anyone who has tried
9 to talk to a press person about anything knows
10 that nothing is going to be spent; no time is
11 going to be spent giving credence to all the
12 good things we're doing.

13 So to me, again, what's the system
14 that we're in and how do we improve that?

15 I think, and maybe you've done
16 this before, that having had the pleasure and
17 opportunity to work with a compatriot of James
18 Reasons, John Riebow who is on the Taxonomy
19 Technical Advisory Panel, that having John in
20 the room as a safety expert with experience in
21 nuclear transportation and other high risk
22 industries has been enormously helpful to us

1 in our work on what we call close calls.

2 For example, he has documentation
3 that if you don't create a way to report near
4 miss or close calls in a shorter time frame
5 than 90 seconds, the frequency by which people
6 report those drops way off.

7 Well, there's good evidence right
8 there. So you know, why don't we get some of
9 those people in with you? It may cost a
10 little more money because I know they can be
11 expensive, but they're good people.

12 And then the last thing is that --
13 and this is really more of a complaint of NQF
14 -- I'm concerned being on the Steering
15 Committee for the outcomes and efficiency
16 group that just promoted the measures for
17 evidence based hospital referral that this
18 group hasn't seen that discussion or
19 understood that there was a lot of polarity in
20 the discussion here. Why aren't we being
21 transparent with this group? Why are my
22 colleagues and compatriots from Leapfrog

1 coming in here and not mentioning that? And
2 why don't we have that as part of the
3 discussion so you can see that, in fact,
4 there's a lot of imperfection?

5 Now, certainly when you're getting
6 at the ones that are very low volume I'm
7 hedging towards believing that's the right
8 thing to do, but still even though it would be
9 self-serving to us because we are high volume,
10 top performers in UHC on all of these, that we
11 think moving this directly to informed consent
12 is a little bit ahead of the game, and so I
13 would just caution this group and suggest that
14 you do maybe not look at all the details, but
15 take advantage of the work that this Committee
16 and the technical advisory panel did around
17 all of those evaluations, which were
18 summarized elegantly.

19 And those are my comments.

20 CO-CHAIR DENHAM: Thank you so
21 much, Don.

22 First off, I think that we owe you

1 a debt of gratitude for your steadfast
2 support, continued communications. You have
3 always been kind of a voice of "hey, how about
4 the evidence? Hey, I'm a front line
5 organization."

6 Your organization, your
7 leadership, people like you and the membership
8 of NQF are what really will make it valuable
9 because you're right there at the front line
10 keeping us out of the academic sand, getting
11 our heads out of the sand to say, "Okay.
12 What's up? What do we really need to do?" and
13 really get prioritized on that.

14 DR. CASEY: Chuck, I should
15 disclose I'm an associate professor of
16 medicine at Mt. Sinai, too.

17 CO-CHAIR DENHAM: All right.

18 DR. CASEY: Does that help.

19 CO-CHAIR DENHAM: That helps.

20 I just want to maybe respond to a
21 couple of these points that I've been taking
22 notes on just to maybe fill in a little bit of

1 as a context and then kind of maybe open --
2 have Peter and Gregg respond and then the
3 Committee, but since you've kind of addressed
4 me, I want to make sure I want to kind of
5 address a couple other things.

6 First off, the harmonization
7 issue. The harmonization issue actually was
8 a bet that we took in 2005, and David
9 remembers this, where I met with the heads of
10 each of these organizations and said, "Take a
11 bet on this Committee that we can get
12 everybody to agree down to the line item
13 specification."

14 And every one of them said, "These
15 guys are not going to do it. Those guys
16 aren't going to do it."

17 And said, "Why not try? Let's see
18 if we can do it."

19 And that was a successful process.
20 However, now when we look retrospectively
21 through the retrospective scope at the specs
22 and you can hear the debate and, you know, the

1 critical thinking and, you know, comments, I
2 think, like Patrick's, you know, regarding
3 this lack of specificity on some of these
4 things. We're actually part of the sausage
5 making process of getting six organizations
6 who had never worked together to get right
7 down to the spec level, which we were very
8 pleased to see. It was a first.

9 Now, NQF with the National
10 Priority Partners has built on that, and
11 actually the truth be known, the HAI
12 compendium was a work product that they sat
13 down with us and we actually quietly advised
14 them on how to get their quasi computing
15 organizations to work on that document that
16 created that evidence, and actually all of the
17 specs and HAIs were thoroughly cross-walked
18 from that evidence based approach, and I was
19 disappointed and we all discussed we really
20 want to grade the evidence of these practices
21 for even this year.

22 With all of the things that are

1 going on with the financial collapse and the
2 focus of getting the practices out for January
3 1, I personally was disappointed that we
4 didn't really tackle them to get them using a
5 grading system that would be felt to be
6 appropriate, that we had graded everything on
7 the current set of the 34 and actually some
8 others, but that I know, and I think Gregg
9 will respond and Peter will respond that there
10 is every intention, in fact, passionate desire
11 to do that because of the importance of it and
12 the critical nature of what it allows us to do
13 when we go out and really say, "Hey, we want
14 to see you adopt these." It's vital,
15 absolutely vital to do it.

16 So this group has really wanted to
17 do it. It was a matter of timetables and all
18 of the powerful events that are kind of a
19 flurry

20 That said, however, this is the
21 most harmonized set of practices ever created,
22 and if it hadn't been for that first Committee

1 work of the 2005 work that led to the '06
2 update, likely the HAI compendium would not
3 have happened, which then gave us an output
4 that was so thoroughly reviewed by the experts
5 that allowed us to actually import them right
6 into those practices, and I think if you said,
7 "Well, what are the best, most evidence based
8 practices we have?" it's going to be that
9 subset.

10 A lot of the practices one
11 through four, we've got good evidence from
12 other industries, but frankly, we just haven't
13 funded leadership, values grounded focus, risk
14 a management, risk identification, and we're
15 dreaming if we want to be critical thinkers
16 and then pot shot our own practices because we
17 don't have the evidence. It's, you know,
18 entirely in the other areas and other
19 industries like health and human factors
20 research, which actually is grounded in those.

21 So harmonization, not there yet,
22 but I can tell you that I really believe that

1 our next go at this for the 2011 could be even
2 more because we had probably nine or ten
3 organizations harmonized on the HAIs.

4 So harmonization, although not
5 perfect yet, I think, you know, it was a
6 winning combination. I think David and I
7 commented over and over again how prayerfully
8 and thoughtfully we were holding our breath to
9 get to that final cut on the '06 update
10 believing that maybe somebody was going to
11 back out and they didn't.

12 So the second point was about
13 evidence based grading. We agree 100 percent
14 that a thorough look at how it would be done,
15 what classification would be done and how
16 those would be tied to the practices has been
17 a disappointment that we couldn't do it this
18 year. I think we all wanted to do it, but it
19 was a disappointment that could it be pulled
20 off this year, was the challenge, and we said,
21 okay, for 2011 you can hear our notes to self
22 all the way through here. Hey, let's relook

1 at this. When we go to 2011, let's look at
2 this.

3 The criteria actually were used.
4 The criteria that are in the practice, that
5 are in the document, and we failed you in this
6 meeting to not bring up and start the meeting
7 with this table because this table actually
8 was used, and all the way through the process
9 even the term "generalizability," which ends
10 up popping up in Word as not being a word, but
11 this idea that this should work for a six-bed
12 hospital in Idaho and a 2,000-bed hospital in
13 Orlando is foremost in the mind of everybody
14 that has worked on these and the tests that we
15 go through, although not perfect, and the
16 criteria not perfected to a very detailed
17 checklist, every one of them go through that,
18 and you can see that's where then we get
19 criticisms for it's too specific or it's not
20 specific enough.

21 One of the reasons is that we are
22 trying to meet two beds or six beds in Idaho

1 and 2,000 beds in Boston, and that is part of
2 the dilemma, but I think we could be more
3 transparent about the fact that this practice
4 has been through the checklist of
5 generalizability, and for the reasons that it
6 has to fit for two beds where there's no
7 patient safety officer and 2,000 beds when
8 they have a Performance Improvement Department
9 and black belts. Trying to get specs that
10 they both could say we are in compliance of is
11 kind of a dilemma, and I'll go through your
12 comments very quickly here, but that criteria,
13 I think it's great. It would be great to
14 relook at this for the 2011 or even sooner.

15 And we know that because we fund
16 probably more adoption implementation work
17 than anybody in the country, and we want to
18 get a return on our investment, and that
19 generalizability is really key, as is the
20 evidence.

21 Financial people right now over
22 the next year, we are probably spending, I

1 would guess, in our organization 60 to 70
2 percent of our resources on the finance issue
3 of being able to validate CFO-validated
4 numbers and models to be able to go in and
5 make the case so that the CFO is the first
6 vote you have before you even go into the
7 room.

8 So I think you'll see that it
9 isn't in the body of these. We've teased and
10 got it in. There's not a lot in the
11 evidentiary base, but it's a major focus of a
12 lot of us that are working, and I'm not
13 speaking for NQF, but I'm speaking as a funder
14 of NQF and a funder of the work for the safe
15 practices, major focus.

16 We couldn't agree with you more,
17 and that we need to have that. The
18 transparency regarding the evidence, I'll
19 defer to Peter, cross-linking the NQF work
20 defer to Peter, but great work is going on and
21 folks at NQF, I think, are coming out with
22 some good product.

1 Now, are we seeing it here? We
2 probably are failing you to share that we are
3 having that dialogue, but I think I'm glad you
4 brought it up. It's really important.
5 Specificity and sensitivity, I think, you
6 know, we've had this conversation with Gregg,
7 and I don't want to dominate the discussion,
8 but I do want to come back and not just say
9 thank you for you comments, Don. I want to
10 address them in a line item fashion because I
11 think they were all excellent.

12 Implementation by technologies,
13 it's really difficult to strike the balance of
14 conflict of interest here, and we've been
15 very, very careful about it, and one of the
16 reasons why we were careful about bar code
17 this year and having some reference to bar
18 code as we get into that and CPOE is to have
19 that balancing act of not endorsing any one
20 area.

21 I will telegraph that we have
22 funded a report that will come out in the

1 first part of December by NQF on automated
2 infection identification and surveillance
3 systems.

4 Now, because we all have conflicts
5 of interest because we've worked with various
6 people over the years, we're actually making
7 sure that a completely unbiased group is
8 assessing all of those vendors so that you
9 have a really, you know, completely thoroughly
10 transparently generated report by a third part
11 completely unrelated to anybody in tech
12 assessment that then will kind of come out and
13 Peter is actually and Janet Corrigan are going
14 to present that in the first week in December.
15 So it's not that these things are not being
16 addressed. It's that they're not all being
17 addressed in every area, but this HAI area is
18 so hot, so important that I think that that
19 will lead to some great things, and I'll have
20 Peter maybe comment, you know, about those.

21 In terms of the liability and the
22 health care reform and this press issue, let's

1 take those all together. The safe practice
2 force held up very, very well, risk
3 identification and mitigation of risk and
4 hazards.

5 Our organization is embracing the
6 journalist and saying, "Listen, guys, you
7 really need to get panels of experts before
8 you go criminalizing these things, but you
9 also need a balanced view."

10 And the other side of it is, Don,
11 that a lot of the biggest payers for media are
12 hospitals, and they spike stories. So there
13 needs to be an opportunity for some balance
14 nationally, and we think there's a national
15 opportunity, and we can talk with you more
16 over coffee or whatever about that, but a hot
17 area, an important area, and an important one
18 that drives safety, the human factors issue,
19 one of our Committee members actually -- Greg
20 recommended one of our Committee members who
21 is not here today is a human factors expert
22 who we had come on just because of your issue

1 about human factors and what to learn from
2 those other issues. She's not here today, but
3 had input on the '06 and the '09 practices.

4 And then the issue of those using
5 the safe practices, as somebody who has
6 supported Leapfrog and supported NQF, I agree
7 with you 100 percent that clarity around if an
8 organization is going to use the practices en
9 bloc and say are you adopting these versus are
10 you morphing them and then attributing, you
11 know, your measurement system to a partial
12 utilization of them has to be more clear, and
13 I think this morning when I was telling
14 Leapfrog -- and I want this on the record --
15 that Leapfrog, if they're going to migrate
16 away from a spec of a safe practice, they need
17 to make that very clear, and if they do
18 resubmit it to Leapfrog.

19 But we were put in a dilemma on
20 the evidence based referral practice of
21 Leapfrog migrated away, but referred to it; we
22 were out there helping drive adoption and the

1 first question that we got every day was how
2 come the Leapfrog requirement is different
3 than the NQF standard.

4 So I think we need to encourage
5 the NQF partners and members that use them to
6 say if NQF is the clearing house, if it has
7 the process, we all need to take measurement
8 systems through the process that's transparent
9 and be more clear about it, and I think that's
10 something we all just need to do together to
11 encourage that.

12 But I think you heard that this
13 morning, was, hey, guys, you know, I wanted to
14 keep reminding us all they migrated away from
15 it. We removed the practice. You can't say
16 that we harmed anybody because your
17 modification of it was dissimilar from the
18 standard, which wasn't clear.

19 So I think every one of your
20 points was great. Sorry for my long winded
21 answer, but I think your thoughtful delivery
22 merited a line item approach, and I'd like

1 Peter maybe to respond and then Gregg.

2 CO-CHAIR MEYER: A couple of quick
3 responses. First of all, I think I appreciate
4 your comments, and I think that they are for
5 the most part right dead on. Adding the
6 financial analysis and safe practices is
7 actually a huge bit of work, and I'm anxiously
8 awaiting for the work product of Chuck's
9 efforts on that.

10 In terms of the transparency of
11 the evidence base, there is a work group that
12 Peter Pronovost is leading funded by AHRQ,
13 done by RAND. Peter Pronovost is one of the
14 leaders of it, and both Peter Angood and I are
15 on that committee because we see ourselves as
16 the important end user of their product.

17 it's a work in progress, and it's
18 supposed to be done early in the New Year, in
19 January. Boy, between there and where we are
20 today and there seems like a very long
21 distance still, but I'm hoping they pull the
22 rabbit out of the hat on that one.

1 In terms of the way that people
2 use these, the only thing I can share on that
3 is my experiences at AHRQ, which is that we
4 did a number of products. One that I was
5 involved very closely with Peter Pronovost's
6 wife, Marlene Miller, I was developing the
7 patient safety indicators, which were
8 developed for a very clear purpose, which was
9 kind of hypothesis generating, and it became
10 very clear that people used them for things
11 that we really didn't think were right.

12 We used to term that off label
13 use, and in fact, the reality of it though, as
14 soon as you put something in the public
15 domain, people are going to use it off label.
16 And I think we would love to have people put
17 an asterisk and say, you know, not endorsed
18 and all of the rest, and to the extent we can
19 do that, it's important.

20 But this off label use phenomenon
21 is really a very big general issue.

22 Finally, I would ask Peter to

1 comment further. The issue you raised about
2 the CSAC and the review of those measures I
3 think is an important one. I pointed that out
4 to Peter earlier today, and Peter was going to
5 address it with the group anyway. So you just
6 prompted us to do that because what you said
7 is a very important message for people to
8 hear.

9 DR. ANGOOD: Well, we're now
10 getting so that we're talking more than you
11 did, Don. So obviously your comments have
12 sparked some -- your critique has sparked some
13 thoughts that are highly relevant, and I won't
14 continue to belabor it, but I, too, though
15 would like to thank you for your insightful
16 comments, and I would encourage you, please,
17 to transcribe it down and send it in as a
18 formal document for us because that would be
19 very helpful.

20 And I agree pretty much with all
21 of the items that you brought up, and we are,
22 as I made comment, although it was a brief

1 presentation this morning in my overview and
2 vision for patient safety, we are pretty much
3 going to be trying to address all of those
4 different components as well.

5 The evidence based, the grading of
6 the evidence, all those other items, all very,
7 very important, and yet I think we have to
8 recognize that NQF as an organization is in a
9 period of transition as well.

10 We have got still relatively new
11 leadership. We're in rapid stages of growth,
12 and we've got new sets of programs that are
13 coming on line, and so we're not only having
14 to reincarnate a little bit internally, but we
15 have to also train the field that we're a new
16 and different NQF as well. And so I think we
17 just have to ask for a little bit of patience
18 as we go through this phase.

19 The last comment that Gregg asked
20 me to sort of expand on, which basically comes
21 down to internal communications and making
22 sure that each group knows what the other is

1 going on, I think it's certainly a priority of
2 mine to make sure that safety is everywhere in
3 NQF and that if they -- other departments in
4 NQF aren't talking to us, we're certainly
5 talking with them, and we actually have a
6 couple of members of our staff who are on that
7 outcomes group, and they help to keep these
8 issues in the forefront, and we've got
9 interactions with all the other departments
10 within NQF.

11 I think that as we in safety
12 challenge the organization to do this cross-
13 communication it's fair to say that we will
14 continue to learn a little bit and make sure
15 that we don't get siloed up.

16 If you look at this large, HHS
17 contract that we have and then you look also
18 at the National Priorities Partnership, if
19 you're an organizational behavioralist,
20 there's just a dozen silos waiting to happen,
21 and our challenge will be to make sure that
22 that does not occur.

1 And certainly as we try within the
2 safety world, as I said, we'll do our darndest
3 to -- we can't break down silos if they have
4 them, but we can certainly figure out how to
5 talk and communicate with silos, and we will
6 do that.

7 And the other point that I wanted
8 to continue to emphasize is as we build up
9 other advisory committees and steering
10 committees and technical advisory panels, we
11 will be looking to populate those groups with
12 cross-disciplinary experts in the different
13 fields, and very much high on everyone's list
14 is the whole issue of human factors and
15 organizational behavior, et cetera. Because
16 without that we can't really get to the nut of
17 this, and I couldn't agree more with you on
18 the need to continue to look and learn from
19 high reliability organizations, and the
20 principles around high reliability.

21 I'm not necessarily a proponent of
22 any particular methodology, but the concepts

1 clearly have to come in there, and we need to
2 do what's right for NQF in our programs.

3 So I want to leave those as my
4 comments, basically agreeing with all that you
5 said, try to reassure you and re-emphasize
6 that we're addressing all of those and we're
7 still in a period of some transition.

8 But thank you again, and please
9 submit your stuff.

10 DR. CASEY: Thank you, Chuck.

11 Can I just take 15 seconds of the
12 Committee's time?

13 CO-CHAIR DENHAM: I'm going to ask
14 Peter because he's paying for your microphone.

15 DR. CASEY: In summary,
16 transparency of science behind the safe
17 practices, number one.

18 Number two, for lack of a better
19 phrase, insuring that disclaimers are properly
20 affixed when other organizations re-engineer
21 what has been endorsed by NQF.

22 And the third is demonstration of

1 accountability to the public taxpayers who
2 fund programs both from a clinical outcomes
3 standpoint and a fiscal responsibility
4 standpoint are my three main messages.

5 CO-CHAIR DENHAM: And, Don, if you
6 could just articulate a letter. You were very
7 articulate; no question. But I think, you
8 know, your prior communications had some great
9 points in them, and what you articulated
10 today, if you could, as Peter said, put that
11 in a letter to the Committee that we can
12 really kind of then create a table and go
13 right over and then respond to you, I think
14 that it will be helpful for everybody.

15 I think every one of them were
16 excellent.

17 DR. ANGOOD: Mike?

18 DR. COHEN: Yes, could you go back
19 to Safe Practice 3 just for a second?

20 DR. ANGOOD: Sorry. Perhaps
21 before we do three, are there any other
22 comments on Don's comments? I just want to

1 make sure. It was a very thorough discussion,
2 and we thank Don for that.

3 Okay, Mike. Go ahead and take us
4 back.

5 DR. COHEN: Okay, and it would be
6 the next page down, I think. There it is.
7 I'm going to use my little laser here.

8 Rapid response assessment, I want
9 to just touch on that. some of the discussion
10 before lunch reminded me that we never touched
11 on this, and I wrote it down on the wrong
12 page. I meant to, and that is the patient
13 activated rapid response assessment or rapid
14 response team.

15 And you know, this may be one of
16 those areas where there's not a lot of
17 evidence, et cetera. Maybe there's been some
18 evidence at least with rapid response teams
19 that isn't necessarily positive, but I have to
20 say we've repeatedly over the years seen
21 situations where family members recognize
22 that, you know, things are not going well

1 here, and they question it.

2 We published the situation just
3 last week that I thought I'd share to bring
4 this home, and these are two individual cases
5 that both happened within a couple of weeks
6 reported to us, and they both involved healthy
7 kids who had surgery and then post-op they
8 were given fluids that lacked enough sodium
9 chloride. So they developed hypernatremia and
10 water intoxication. One was at the wrong
11 rate. It was given much too rapidly because
12 of another error.

13 And in both of these cases when
14 the families questioned the situation because
15 they saw pretty rapid deterioration, they both
16 had seizure disorders, one of which was
17 characterized by a nurse as response to pain
18 medicine. The child was obtunded, and the
19 other one was phenothiazine had been
20 administered, and so the child had supposedly,
21 according to a physician, extrapyramidal
22 effects and then continued to deteriorate and

1 neither one of them were appropriately
2 treated.

3 These were both situations where
4 the family had called attention to it. We've
5 seen this before. I'm sure all of us have at
6 one time or another, and it just hit me that,
7 you know, we should probably at least think
8 about that, and that is adding, you know, the
9 idea of a patient activator, not patient, but
10 family activated rapid response.

11 CO-CHAIR DENHAM: Mike, not part
12 of the specs, but we have a section for
13 strategies of progressive organizations, also
14 new horizons, and there's an opportunities for
15 patient and family involvement. They're on
16 page 89 if you've got the full document, but
17 we can pass it around to you, but because the
18 evidence -- and we've kind of gone -- there
19 isn't anything substantive yet that we've seen
20 that would allow you to say that hit the
21 criteria of the table, but those two are good
22 places, I think, for a reasonable placement of

1 them because there are enough of them out
2 there for people to be aware of them.

3 The new horizons and opportunity
4 for patient and families, they are, again, not
5 specs, and so a proposal could be to insert
6 those into those, and they're part of what
7 we've been calling the implementation guide,
8 and that might be something you might want to
9 recommend.

10 Are there other comments regarding
11 this one?

12 DR. ROMANO: I just have a very
13 technical question which is prompted by
14 Michael's comment, which is is there a way to
15 actually bring the full document into our
16 computers because I can only find through the
17 NQF Website an executive summary. I can't
18 actually get the full document.

19 CO-CHAIR DENHAM: We've sent it to
20 you. You have the full document in PDF. We
21 can send it to you again.

22 DR. ROMANO: No, send it to me

1 now.

2 CO-CHAIR DENHAM: Do you mean
3 right now?

4 DR. ROMANO: Give it to me right
5 now.

6 CO-CHAIR DENHAM: Are you online?

7 DR. ROMANO: Yes.

8 CO-CHAIR DENHAM: Yes, I'll E-mail
9 it to you.

10 DR. ROMANO: Okay.

11 CO-CHAIR DENHAM: Why don't you
12 send it to the whole Committee? Just resend
13 it. It's about a three mg file. It will take
14 a little while with wireless, but you'll have
15 it.

16 CO-CHAIR MEYER: I think now we'll
17 try to move on to Safe Practice 8, and the
18 issue with Safe Practice 8 that we just wanted
19 to highlight is that, in the middle of the
20 page there, that there was an addition that we
21 made really towards the end of the process
22 last time around caring for the caregiver and

1 trying to practice kind of a just culture. It
2 was that if after an event investigation the
3 organization is contemplating a corrective
4 action that could result in a serious loss of
5 livelihood of an individual, that individual
6 should be notified of the potential action,
7 and he or she should be advised that he or she
8 may want to exercise the opportunity to seek
9 the advice of legal counsel before providing
10 a formal statement about the corrective
11 action.

12 And that actually came in. That
13 was not in our original discussions. That
14 came in as a comment from the field when it
15 was vetted by the NQF. It was a hospital in
16 Florida I remember was the one that
17 spearheaded this, and after some discussion,
18 this was language that we landed on for that,
19 but this was really a case where we were
20 responding to the feedback from the Quality
21 Forum's public review process.

22 To me lawyers are going to be

1 involved sooner or later. So getting involved
2 sooner doesn't seem to be a big problem, but
3 we wanted to make sure that people understood
4 that that's where that came from.

5 CO-CHAIR DENHAM: And, again, this
6 one is being just brought up because it was
7 one of the changes that we made last time
8 around. So nothing is proposed to be changed
9 at this point in time. This is only kind of
10 an abundance of caution or an abundance of
11 attention to detail that we bring it up.

12 The process that we followed was
13 that the formal input came through the formal
14 NQF process on this practice, and then a very
15 large hospital with multiple hospitals from 25
16 beds to 2,000 beds and a legal team had
17 reviewed it and had submitted a little bit
18 different language.

19 And so what the Committee did is
20 engage its medical-legal subject matter
21 experts that were really, really familiar with
22 this issue and carefully worked through

1 wording that then became acceptable not only
2 to that organization, but then we deployed
3 this section to other NQF members and
4 hospitals to say, you know, here's the way it
5 was. Here's the challenge and here's the
6 request for the change. Here's the compromise
7 language that meets both issues, not perfect,
8 but this is acceptable to the NQF members that
9 had a problem with it. This is acceptable to
10 the medical-legal team that are the experts
11 that worked on the practice with us, and it's
12 also acceptable to a field group of NQF
13 representative organizations.

14 And so we're just bringing it back
15 to you to say no new changes on it. We have
16 had no complaints on it since it went out as
17 the formal report, but it went out, you know,
18 March 7th, and we're revisiting it again and
19 will come back to the Committee if we think
20 that anything has changed, but it's just an
21 abundance of attention to detail that we
22 wanted to bring it back to you.

1 So we just kind of went through
2 the care of the caregiver. So good.

3 Nursing work for us, this practice
4 has actually stood the test of time relatively
5 well. We've returned to the subject matter
6 experts, nursing leadership subject matter
7 experts that were involved with the practice
8 and revisited it. It's having a thorough
9 update in terms of the problem statement
10 because there's some rich material in the
11 nursing literature that will be added to the
12 problem statement specifically regarding
13 training of new grads and the challenges that
14 are faced.

15 But actually as we went through
16 with the subject matter nursing team and this
17 last couple of weeks we had another team of
18 nursing leaders from all across the country
19 from critical care nursing leadership from
20 AACN, AORN from the surgical nurses and
21 perioperative nurses, AONE, and then we had a
22 number of other chief nursing officers and

1 said, you know, "You all haven't had problems
2 with it, but maybe you haven't looked at it.
3 You know, is there anything that we need to
4 address?"

5 And really the two areas of update
6 are the problem statement and the
7 implementation guide, but the specs, everyone
8 and nurses out in the field have said, you
9 know, the one thing that we will likely bring
10 to the Committee for 2011 is a recommendation,
11 and we've been field testing this as well and
12 asking members of the NQF about this. Is it
13 reasonable at some point in time to have a
14 nursing leadership practice like what we did
15 in 2009 update for a pharmacy?

16 And that has been really well
17 received, and the pharmacy leaders have loved
18 it. It's really helped them an awful lot get
19 organized, get focused, and we'll have maybe
20 Hayley comment in a little bit, but it's
21 likely for the 3011 that it's reasonable to
22 take some of the content of this and organize

1 it around nursing leadership because there's
2 enough evidence to really support the two
3 issues, work force specifically but nursing
4 leadership.

5 And in the same vein, it's very
6 likely that a leadership practice for
7 infection control will likely be one that will
8 be submitted, and this will be in
9 collaboration with APIC and IDSA and SHEA, and
10 have them really kind of be the champions of
11 it.

12 But these leadership practices
13 then really put some tactics. It's not that
14 it's a general soft leadership, "be a good
15 leader." It's actually the tactic and the
16 specific evidence based activities that a
17 leader needs to make sure happen in that area
18 is a more reasonable way to kind of organize
19 them.

20 So we'll bring that back at a
21 later date on the 2011, but in terms of both
22 the direct caregiver and the nursing practices

1 we don't see any substantive changes.

2 Comments, Peter?

3 DR. ANGOOD: No, other than on
4 your last comment about a nursing specific
5 one, I think it's important that we work
6 toward activity that's relevant for the main
7 disciplines within health care, but also
8 within those 90 some odd other kind of allied
9 health professionals. You can't bucket them
10 all into one and the same, and as we have
11 learned through the nursing sensitive
12 measures, this winds up being quite
13 contentious at times, and we know certainly
14 within the physician world as well the whole
15 area of measurement and telling folks how to
16 do things, et cetera, gets to become
17 contentious.

18 So I think it's a set of issues we
19 need to address. It's just going to be
20 fraught with minefields all the way through,
21 and we shouldn't allude ourselves otherwise.
22 Not everybody is going to be as open armed and

1 warm and cuddly as the pharmacist.

2 (Laughter.)

3 CO-CHAIR DENHAM: Mary, Maura, do
4 you all want to comment on the nursing since
5 you all were both very active and really great
6 collaborators on --

7 DR. McAULIFFE: We were very happy
8 with the outcome. I hadn't thought about
9 having a nursing leadership safe practice, and
10 this is the first I've heard of it. So I have
11 to think a little bit more about that, read a
12 little bit more about what pharmacy did, and
13 see where that might go and talk to you all a
14 little bit more about that.

15 I think it probably has merit, but
16 I need to think about it.

17 MS. MacDONALD: I absolutely agree
18 with that. I think it would be a terrific
19 practice, and I hope that the group of people
20 who develop the standards include a wide
21 range. It also would include staff nurses,
22 you know, as well as managers and leaders.

1 So thank you. I think it's great.

2 CO-CHAIR DENHAM: And on this
3 particular practice, we sought input from
4 staff front line nurses, again, just to see.
5 We just weren't getting any criticisms of it,
6 and so we road tested that, again. Is this
7 timely? Is it still up to date? Does this
8 still make sense? Is it relevant and that
9 kind of thing?

10 Hayley, could you just comment
11 just for a couple minutes or a second, couple
12 of seconds, just regarding how well received
13 the pharmacy leadership practice was and the
14 fact that it was really specific and detailed?

15 It wasn't a soft just leadership,
16 but it was really specific and tactical with
17 evidence.

18 DR. BURGESS: Right. The
19 pharmacist leadership practice, which is
20 Practice 18, and that was new this year, when
21 we looked at the medication management chapter
22 from 2006, there were multiple practices

1 around medication management, though even
2 amongst ourselves we felt that we had made
3 MedMan disjointed.

4 So we really started looking at
5 that and decided it would make much more sense
6 to put pharmacists in the leadership role that
7 they deserve and create a road map for them
8 around medication safety programs.

9 And I will tell you as Chuck and I
10 talked about medication management and
11 medication safety -- and, Mike, I know you can
12 attest to this -- many will come to us later
13 and say, "How do you create a medication
14 safety program that's comprehensive?" and
15 these are smart pharmacists, nurses,
16 physicians coming to us.

17 So this practice made a lot of
18 sense because what we did is model it after
19 the first four practices: so leadership,
20 culture, teamwork, risk identification and
21 mitigation.

22 So that was the framework which

1 makes complete sense and is consistent with
2 the practices, but then taking the processes
3 of pharmacy administration, dispensing, high
4 alert meds, all of those pieces and parts,
5 cross-walking that with what's already out
6 there so certainly involving Joint Commission
7 in some of the standards though, not a
8 regurgitation of what they've already put out
9 there, but really streamlining those
10 activities that are most important and
11 relevant at this time.

12 And currently we're working very
13 closely with ASHP, the American Society of
14 Health-System Pharmacists, and we're going
15 through each additional specification and
16 looking for all of that literature that ties
17 specifically to those specs. So, again,
18 getting ready for the 2011 where we'll start
19 grading that evidence, but we're beginning
20 that work with the pharmacist leadership
21 practice.

22 It has been very well received

1 even through public comment. We did expect
2 some push-back maybe from other professions or
3 organizations. We just did not receive that
4 because it completely made sense, and what it
5 does is give pharmacy leadership a nice road
6 map for a comprehensive medication management
7 program, and it also gives them some insights
8 to be part of their senior leadership team
9 because they absolutely have to be.

10 Medication touches every patient in almost
11 every way, as well as the technology.

12 So it has been really an excellent
13 addition. Mike, is there anything you'd like
14 to say about it?

15 DR. COHEN: No, I just echo what
16 you said, and you know, when we look at our --
17 I was saying I echo what she said, but also
18 just add that when we look at our database,
19 about 25 percent of the medical adverse events
20 are medication related. So it is a big chunk.

21 CO-CHAIR DENHAM: So any comments
22 regarding the nursing or direct caregiver,

1 which really mirror each other, and we're kind
2 of looking at them together?

3 (No response.)

4 CO-CHAIR DENHAM: So that being
5 the case, we'll move next. Now, is Dr.
6 Pronovost still on?

7 DR. PRONOVOST: I sure am.

8 CO-CHAIR DENHAM: Peter, would you
9 like to comment regarding the intensive care
10 unit practice and specifically each year, you
11 know, we come back and revisit with you. What
12 Mike had brought up was rapid response teams,
13 level of evidence, and just explain to the
14 Committee what transpired.

15 Over the last two cycles that has
16 been brought up as a potential safe practice.
17 Although relevant and important, it lives
18 currently in Safe Practice 3 regarding
19 teamwork as an example, implementation area,
20 and it has mentioned in a couple of the
21 others, however not yet a stand alone, and
22 we've relied on Dr. Pronovost as a critical

1 care expert and our in-house expert. We're
2 lucky to have him for so many different areas,
3 but this is right up his alley.

4 Peter, comments?

5 DR. PRONOVOST: Sure, yes. I had
6 to step out earlier. I missed the rapid
7 response discussion, but I'm sure the group is
8 aware of it.

9 There are, I think, now three or
10 four systematic reviews evaluating that topic.
11 So I suspect you have those references in
12 there, but the field, no doubt, will be aware
13 of them.

14 For ICU staffing, the bottom line
15 is I don't think there is any evidence that
16 would make us change our recommendations.
17 There was an observational study that was
18 negative, though a lot of the commentary
19 questioned the method, and there was one
20 further study that was positive.

21 There was also an additional study
22 that looked at the relative value of 24

1 versus, you know, a daytime staffing and
2 consensus. I have a group because we evaluate
3 the Leapfrog standard that reviews this, and
4 that group and I really felt that there wasn't
5 sufficient evidence yet to make that
6 recommendation.

7 So I think though there are a
8 couple of new studies, they wouldn't sway what
9 we have put down.

10 CO-CHAIR DENHAM: Great, Peter.
11 So as we are updating the problem statement,
12 implementation guide, and the references,
13 we'll be looping back with you in the next
14 week or so. We just wanted to see if there's
15 anything substantive that you might bring up,
16 and we'll be looping back to make sure we've
17 got the best references and then again revisit
18 this in 2011.

19 And while you were out, Peter, we
20 just talked about the patient activated or
21 family activated rapid response activities as
22 just something that gets honorable mention.

1 DR. PRONOVOST: I was here for
2 that. I heard you reference an earlier
3 discussion that I wasn't there for.

4 CO-CHAIR DENHAM: Okay, great.
5 Thanks.

6 DR. PRONOVOST: Good. So I'll get
7 you those references.

8 CO-CHAIR DENHAM: Great. Thanks,
9 peter.

10 Anything you want to add> Peter
11 Angood has also critical care.

12 DR. ANGOOD: No, I think Peter
13 Pronovost covered it quite well. I come from
14 the world of critical care, as well, and I
15 think we're still well positioned with the
16 safe practice, and I guess the challenge to us
17 is how do we nudge it further if we can at
18 all. There's still numerous organizations who
19 don't have adequate staffing for critical
20 care, and I think we just have to look for
21 ways to freshen up the idea.

22 DR. PRONOVOST: Well, Peter, and

1 that's what we were discussing about volume
2 based surgeries and how consumers often don't
3 know the risk they're getting. I don't
4 believe consumers adequately know the
5 additional risk they're incurring by the type
6 of ICUs they select.

7 DR. ANGOOD: Yes, your point was
8 very well taken actually, peter, and it
9 generated a few sidebars in here that you
10 wouldn't have heard being on the phone, and
11 I'm going to think through further not just
12 necessarily for the safe practices but for our
13 other programs how can we begin to address
14 that issue because it is critically important
15 to not just be transparent but, I guess,
16 unmask some of these risks and figure out ways
17 in which to have them appropriately managed so
18 it doesn't scare the public away from the
19 health care facilities.

20 CO-CHAIR DENHAM: Great. So if
21 the Committee is agreeable, if we're satisfied
22 with our recommendations, there are no

1 substantive changes other than the updates
2 with Dr. Pronovost to make sure that we've got
3 everything ship shape there, we'll move on to
4 the Chapter 5, the Safe Practice 12, patient
5 care information.

6 Again, with this, as Dr. Meyer was
7 stating, the set of this chapter may move
8 fairly quickly for us. I'll take the first
9 one where we went back to our subject matter
10 experts on this. This practice has really
11 stood the test of time. It really hasn't
12 solicited any negative comments.

13 One of the things, I think, Peter,
14 you may have brought up a potential name
15 change to it for a little bit more clarity,
16 communication of patient care information
17 rather than patient care information. Again,
18 these titles are just simple ways for NQF to
19 get you to the practice. The names were kind
20 of shortened versions or they were just used
21 as almost subject matter topics that would get
22 you to the safe practice.

1 The other two issues, just so that
2 we can move quickly, was a question regarding
3 HIPAA and how HIPAA might tie together with
4 what we've got here, and then we also had
5 considered this year, and the Committee will
6 probably remember this, handoffs, the
7 transition in care, the handoffs in care as a
8 potential practice for 2010, but because of
9 the short cycle year and the desire to get
10 them out for January and then do a forklift
11 upgrade on 2011, we decided to hold on that
12 and then really look at that very hard, again
13 over the course of the next year.

14 So those were the three elements
15 for this particular practice.

16 DR. ANGOOD: Just one.

17 CO-CHAIR DENHAM: Yes, sir.

18 DR. ANGOOD: On the HIPAA, we need
19 to make specific mention since we talked about
20 this last -- HIPAA has now been shifted over
21 to Department of Justice or Department of --
22 Dave, help me out here.

1 DR. HUNT: I think it's still
2 going to be in the Office of Civil rights.

3 DR. ANGOOD: Civil Right is it.
4 Yes, it's moving over to Civil Rights and more
5 out of HHS per se, if you will.

6 CO-CHAIR DENHAM: Are there direct
7 actions that we need to take regarding
8 specifically staff-wise on disregarding HIPAA?

9 DR. ANGOOD: We just need to look
10 at what our language is within the problem
11 statements and make sure whether or not we
12 need to reflect this civil rights focus.

13 DR. ANGOOD: Go ahead, Dr. Romano.

14 DR. ROMANO: Was there some
15 specific concern that the current language is
16 not consistent with HIPAA or no?

17 CO-CHAIR DENHAM: So no
18 substantive recommendations other, again, than
19 problem statement implementation. We have had
20 subject matter experts review this from the
21 literature standpoint.

22 So just to remind everybody, we do

1 thorough literature reviews, go through
2 everything, and then have subject matter
3 experts that are in this field.

4 So Dr. Gordy Schiff went through
5 all of the information practices with us to
6 just double check to see if there are any
7 references that may have been missed, should
8 be prioritized implementation elements as well
9 as a number of other experts providing input
10 on these.

11 So for this Practice 12, any more
12 dialogue before we move to 13? And no
13 substantive changes recommended.

14 (No response.)

15 CO-CHAIR DENHAM: Okay. Gregg, do
16 you want to take 13?

17 CO-CHAIR MEYER: Thirteen is read
18 back in abbreviations. I think the only thing
19 there would be when the right timing. I asked
20 Mike to comment when the right timing is to
21 take another look at the list of
22 abbreviations.

1 DR. COHEN: I was thinking exactly
2 the same thing. This started back in the '90s
3 with the Joint Commission National Patient
4 Safety Goal, and there's a lot more than this.
5 This may be one of those issues that you
6 talked about earlier where we're so specific,
7 not that there shouldn't be some minimum list,
8 but we've maintained a list for years. I
9 don't know if others do as well, but there's
10 a lot more on here, drug name, abbreviations
11 that have been fatal. We had two with the
12 same PTU abbreviation last year, for example,
13 and many others. I think, you know, it does
14 need to be looked at.

15 CO-CHAIR MEYER: So the question,
16 I guess is whether or not that -- as it reads
17 right now, at a minimum, you know, I think --
18 but it does. In some sense it has people kind
19 of aiming for the floor.

20 So the big question, when should
21 we add. I guess we could put it into some of
22 the implementation practices to put a more

1 robust list.

2 DR. COHEN: The Joint Commission
3 with a drug name patient safety goal has been
4 referring to the I guess it's the new
5 medication management standard as referred to
6 the list that we maintain, and USP is not
7 involved with it anymore.

8 So this is another thing that we
9 maintain. It's not just drug related
10 abbreviations but other medical abbreviations
11 as well. I don't know if there's others that
12 you would also want to refer to, but it could
13 be handled in that way, that, you know,
14 organizations should check the list.

15 CO-CHAIR MEYER: Fourteen was the
16 diagnostic studies, and we did not recommend -
17 - oh, Patrick?

18 DR. ROMANO: To add something
19 there, yes, I mean, I think there is a bit of
20 a danger that there's an overly formulaic
21 response to this, which is that everybody has
22 their little, you know, index card, a little

1 thing that is supposed to clip on their name
2 tag with the band abbreviations.

3 And although we all know that
4 there are specific adverse events or near
5 misses or in some cases catastrophes that have
6 occurred as a result of the use of those
7 abbreviations, in some cases it seems that
8 that may be overly prescriptive, and that
9 there maybe opportunities within particular
10 health systems; there may be issues that arise
11 as concerns.

12 So at a minimum there's a way of
13 dealing with that, but I would agree that it
14 should be reconsidered.

15 DR. ANGOOD: Well, if I could add
16 onto Mike's and Patrick's comments, maybe as
17 we going into a deeper review of the practices
18 in '010 through '11 we begin to think about
19 how to create systems and process change as
20 the underlying focus of the practice as
21 opposed to keeping a list, et cetera, because
22 it's the danger of utilizing these lists or

1 it's the danger of the mislabeled drugs or the
2 same name drugs or similar name drugs, et
3 cetera.

4 I'm just trying to get this on our
5 record. It's the systems and processes that
6 create this. We're not going to change the
7 industry or the manufacturing very rapidly, as
8 we all know. So we have to keep pushing the
9 field to receive these things to make sure
10 that they put safety -- it's the mitigation of
11 risk issue.

12 CO-CHAIR DENHAM: So Safe Practice
13 14 are labeling of diagnostic studies and
14 although not over in the comments section we
15 just need to make sure for the record that we
16 need to cross-link this over with the
17 laboratory safe practices that have recently
18 come out that address this area as well, and,
19 again, not have the overlap or redundancy
20 issue as a problem, but just make sure that
21 there are linkages that we understand kind of
22 exist.

1 And then I think in the
2 hyperlinked world as we continue to get more
3 and more electronic, they'll be easier to kind
4 of track, but we just want to make sure.

5 Dr. Romano brought up the issue of
6 redundancy and that kind of thing. Here's a
7 nice example of where this is a practice on
8 labeling. It actually is going to evolve in
9 a number of areas, but there is a safe
10 practice that pertains to this in the
11 laboratory area.

12 So as NQF continues to kind of
13 bring things into a more and more synchronized
14 fashion, this is one of those examples and we
15 don't have that over in the comment section,
16 but there are no substantive changes
17 recommended on this one.

18 CO-CHAIR DENHAM: This one needs
19 to be tied back more, again, as well, to the
20 communication of patient information, that
21 continuity of information and not to getting
22 lost, and so it's another way to go at it.

1 DR. ANGOOD: So comments from the
2 Committee on this particular?

3 Discharge systems, this is a very
4 active area as we all know during the health
5 care reform issues that are being addressed,
6 and fortunately for this Committee some of the
7 subject matter experts that are most quoted
8 now in the Beltway on the health reform issues
9 on readmission were our subject matter
10 experts, and so we have that benefit of that
11 knowledge and that foreknowledge.

12 So what's happened over the last
13 24 months is some of the papers have now come
14 out that support this to some degree.

15 Now, again, those papers are more
16 isolated environments. Do they represent the
17 front line perfectly? No, but there is some
18 excellent work that's been done by Dr. Brian
19 Jack who worked with us on this, and then we
20 field tested this, road tested this with a
21 number of subject matter experts.

22 The only thing that's not over in

1 the comment section that we'll want to do to
2 go back and look at is, again, the operational
3 definitions with the glossaries, and one of
4 the areas that we need to make sure that we
5 address is a discharge to nursing home
6 specifically. The practice was kept in a
7 relatively general-speak language, and
8 although we're not recommending language
9 today, we may bring it back at the next
10 meeting to just make sure that when we
11 describe a setting that someone is being
12 discharged to, that it also includes those
13 transitions in care to a nursing home that
14 need to be addressed.

15 So I want to make sure that's in
16 the right column as well, and we'll go back
17 and look at that and tied those, again, back
18 to that CMS care settings where appropriate
19 because in the '06 or the '09 update, we tied
20 care settings to the CMS care settings.

21 And so I think with every
22 iteration of these, more careful attention to

1 operational definitions and settings and that
2 kind of think, I think we're doing a
3 reasonably good job on. We just need to keep
4 vigilant that way. So we'll be doing that to
5 make sure that we address it.

6 Do you want to address some of the
7 work that's done in Boston actually in this
8 area?

9 CO-CHAIR MEYER: Yes. You saw
10 Brian and Jack's paper on re-engineering
11 discharge, and we'll see that this is very
12 powerful. This is going to get a lot of play
13 over the next several months, looking at
14 readmissions. So more to come. I think there
15 will be a lot more evidence.

16 CO-CHAIR DENHAM: So Committee
17 comments?

18 So the recommendations to the
19 Committee is there may be some word changes
20 for specifics so that we make sure that it is
21 clear that it includes nursing homes, but
22 apart from that, no substantive changes, and

1 I'm not sure that would be considered as such,
2 but I just want to be transparent, you know,
3 about that.

4 So there being no further
5 comments, we'll go to Safe Practice 16. This
6 was formerly Safe Practice 12. This practice,
7 when we took the '03 update to the '06 and
8 then the '06 update, the '06 update was really
9 substantial, and the spirit of the substantive
10 changes addressed the readiness of an
11 organization, not just CPOE. This address
12 doing a risk assessment, the care re-
13 engineering, and a great deal of care was
14 undertaken in developing this practice, and
15 our experts were Dr. David Bates, Dr. David
16 Clasen, myself and Dr. Peter Kilbridge, and we
17 worked very carefully through this with a lot
18 of input from the field.

19 And it has actually held very
20 well. I've recently looped back with them and
21 met with Dr. Bates day before yesterday to go
22 through this again with the specs. Would the

1 recommendations for the specs change?

2 This is our recommendation to you,
3 which we may bring back to the Committee in
4 the next couple of weeks. In all probability,
5 no change in the specs, but the changes will
6 be to tie to meaningful use.

7 And so, David, we're going to turn
8 to you and make sure that we get it right, but
9 as you know, David Bates is one of the lead
10 players on the Committee, and so what we will
11 be doing is just carefully going line item
12 through this and make sure that there is
13 synchronization with the definition of
14 meaningful use and the timetables, and then,
15 David, the implementation guide section really
16 providing a nice guide to say these are the
17 expectations for 2011; these are the
18 expectations for, you know, each of the
19 subsequent years and where the bar code and
20 the other elements kind of fit because this is
21 kind of our technology adoption sort of
22 practice.

1 And we had gone through the
2 discussion: do we address bar code as a
3 potential safe practice during this update?
4 And we decided, no, we'll make sure to address
5 it and address it appropriately, but then do
6 a really solid consideration of it for the
7 2011.

8 And so David is prepared to be the
9 submitter of the bar code piece and has
10 actually some papers that will be coming out.
11 So I think we made a good decision to say
12 let's put that one on hold till 2011, and I
13 said, "David, do you feel like we made a good
14 decision holding off?"

15 He said, yes, he thought that the
16 evidence will be more substantive, but the
17 timing of it with everything that's going on,
18 that we probably made a good decision on that
19 one, not that every time we do, but that one
20 we probably made a reasonable decision.

21 So our recommendations to the
22 Committee are we'll be carefully going through

1 all the specs, problem statement and
2 implementation guide, and if any changes occur
3 in the specs, they will likely be only in a
4 synchronization mode to synchronize with what
5 the new requirements are going to be, and
6 we'll also address the CPOE flight simulator
7 portion of that. There's some data that will
8 be coming out shortly, and there are co-
9 authors on that data of what the findings
10 were.

11 And just a quick snapshot is that
12 when you evaluate a system outside by using
13 standardized patients you find out new
14 opportunities for performance improvement and
15 safety. And so that paper will all likely
16 come out through one of the major journals in
17 probably the next 120 days.

18 So we'd like to come back to the
19 Committee with the specific wording, but it
20 will be with their input, and, David, if we
21 could call on you to make sure we get the
22 timetable right and the language right.

1 DR. ANGOOD: In a related but not
2 so related fashion, David, this to me
3 represents a utilization and implementation of
4 technology, and from your seat in other
5 activities, I would ask if you could begin to
6 think of topic areas related to technology and
7 implementation of technology that could become
8 part of the safe practices portfolio because
9 that's now becoming a rapidly moving train.

10 CPOE is kind of old information,
11 if you will, and I'd like us to be as
12 contemporary as we can as we move into that
13 next iteration.

14 Any idea off the cuff right now?
15 Obviously I'll ask for more input later.

16 DR. HUNT: Well, you know, Chuck
17 has already brought it up, the meaningful use
18 train has got to be the bucket where
19 everything is kept and I think this is a
20 wonderful opportunity to make sure we link on
21 with the medication management, but we should
22 always remember that one of the great

1 opportunities will also be with the previous
2 practice because the expectation for
3 meaningful use, not to get into the details,
4 but one expectation will be there will be
5 exchange of information among health care
6 providers and discharge summaries has always
7 for the longest time been highlighted as one
8 very, very good example.

9 So I think that hopefully if we
10 are really on our end going to be meaningful,
11 to use that word a little bit more than it
12 should be, we should have opportunities to tie
13 into a number of other areas, and I think that
14 will be the case.

15 It will be presumptuous to jump
16 forward right now because we're in that really
17 fuzzy period, but I think for the 2011, I
18 think it will be a great time.

19 DR. ANGOOD: Yes, certainly
20 nothing for now, but I don't think -- it's
21 never too soon to start planning for the
22 complexity of this one. So thank you.

1 CO-CHAIR DENHAM: So, peter, it's
2 such a delight for Peter now not to be the
3 Joint Commission guy talking about MedRec
4 conciliation. So you can take --

5 (Laughter.)

6 CO-CHAIR DENHAM: We decided to
7 reduce security. We don't have any bomb
8 threats or anything like that because Peter is
9 not representing the Joint Commission on
10 MedRec, but he will go over the MedRed
11 analysis since he is now our in-house expert
12 at NQF.

13 DR. ANGOOD: A quick little story.
14 Mike has heard this one, but in my role
15 overseeing MedRec and all those other national
16 Patient Safety Goals, I had some of those age
17 over 50, you know, screening tests in December
18 just as I was leaving the Joint Commission,
19 but one of which was to have a CAT scan
20 following some benign lymphadenopathy that I
21 have, and I swear I was literally on the CAT
22 scan table, arms in the air taking my deep

1 breath, and the CT tech started railing on me
2 about medication reconciliation.

3 (Laughter.)

4 CO-CHAIR DENHAM: And what a
5 nuisance this was because he had figured out
6 who I was and what I represented. So Chuck's
7 comments were on the mark, you know.

8 (Off-mic comment.)

9 CO-CHAIR DENHAM: It's a mixed
10 audience, and I did that part, too. I will
11 share since you brought it up.

12 But I was having that other over
13 50 test, and I was lying there feeling quite
14 exposed and vulnerable, and there's this
15 flurry going on behind me, and sure enough,
16 the Joint Commission surveyors show up.

17 (Laughter.)

18 CO-CHAIR DENHAM: This unannounced
19 survey, you know, and I'm in the midst of
20 about to get my test, and the quick thinking
21 nurse says to me, "You know, aren't you taking
22 this tracer methodology just a bit too far?"

1 And the more quick thinking
2 gastroenterologist says, "No, this is poetic
3 justice."

4 (Laughter.)

5 CO-CHAIR DENHAM: So anyway, so
6 enough of my personal tales, but the MedRed,
7 nevertheless, Greg to make some comments as
8 well, this continues to be one of the more
9 complicated challenges for the field, and it's
10 again, not the issue of whether it's
11 important. It's more of an issue of how do
12 you implement and make it useful.

13 The Joint Commission revamped
14 MedRec quite extensively and through a lot of
15 different processes, and we made sure that the
16 MedRec patient safety goal was harmonized and
17 mirrored within this safe practices, almost
18 verbatim basically, and then because of the
19 complexities of it, the Joint Commission
20 decided to back off surveying medication
21 reconciliation.

22 They haven't changed the language

1 and they're reviewing it, and they continue to
2 review. But they have, as near as I'm aware,
3 not come up with any new language or
4 strategies around medication reconciliation.

5 And so we chose to not change any
6 of the language in the safe practice. When we
7 were going to press with this particular
8 version, I spoke quite a bit with Janet
9 Corrigan about, you know, sort of strategies
10 on this, and she was quite comfortable with
11 the language as written and for moving
12 forward.

13 And, you know, if the Joint
14 Commission wants to do something else on its
15 own time, that's the Joint Commission's
16 business, and she was happy with this. And so
17 we did go to press with the current version.

18 We have checked with Jeff
19 Schnipper, who has done a lot of work in the
20 Boston area as well on medication
21 reconciliation. He's still comfortable with
22 where this sits, and I think that from my

1 perspective, while it's complicated, I think
2 we should probably let it sit for a little
3 bit, let the field continue to digest and sort
4 of work around it without now creating further
5 change.

6 But, Gregg, I'd welcome your
7 comments and others from the panel.

8 CO-CHAIR MEYER: So the experience
9 that Jeff Schnipper described is -- well, I
10 think the importance of face value of doing
11 this hasn't diminished at all. The fact that
12 it's not being scored during survey, I think,
13 is actually not particularly relevant to the
14 safe practices written here.

15 I do think that the most important
16 message that was more of a decision by the
17 Joint Commission, more of a reflection of the
18 difficulty people had in doing this rather
19 than the underlying importance of doing it.

20 And so I don't think we need to
21 make any change here unless Mike thinks that
22 there's anything else that needs to happen

1 from your standpoint.

2 DR. COHEN: I said we certainly
3 recognize the importance, but you know, quite
4 honestly, we heard from so many people on this
5 that actually assigned it to someone else.

6 (Laughter.)

7 DR. COHEN: I really don't have
8 anything else to add, but I do think what you
9 have here for now at least, I know the Joint
10 Commission is going to be looking at this
11 again for, you know, I guess for release in a
12 year or two.

13 DR. ANGOOD: Everybody comfortable
14 with that? I guess just stay the course?

15 CO-CHAIR DENHAM: So the next
16 practice is actually the leadership practice
17 for pharmacy. We've already had Hayley kind
18 of comment on how well received that it has
19 been, and so we're working very closely with
20 the pharmacy leadership organizations to just
21 go through and carefully update again the
22 problem statement, implementation guide, new

1 horizons.

2 And the other thing I might
3 mention, we're wanting to move through the
4 briskly, but just to also say that we're
5 working on all of the measures section,
6 although not formally, the safe practice,
7 endorsed practice.

8 Those will also be updated with
9 the right measures that should be referred to
10 out of the 525 that Peter had mentioned.

11 So, Mike, do you want to make any
12 comments regarding leadership practice? We
13 don't see any substantive changes at this
14 point in time.

15 DR. COHEN: Looking at other pages
16 besides page 1, I did have some comments, but
17 on page 1 under storage -- that's page 30
18 actually of the handout -- just to remind you
19 that the Joint Commission has now changed
20 that, and it's a medication management
21 standard. They're asking organizations to do
22 what it states here, but refer to the ISMP

1 list, which we compile and update.

2 So that might be one thing that
3 you need to mention.

4 CO-CHAIR DENHAM: That would be a
5 reference --

6 DR. COHEN: It's on our Website.
7 We can get you a reference.

8 CO-CHAIR DENHAM: We should put
9 the citation in there.

10 DR. COHEN: Yes, it's updated
11 annually.

12 Under the last bullet under
13 preparing and dispensing, many organizations
14 are now using outsourcing for order processing
15 when a pharmacy is closed. So that might be
16 something you should take a look at.

17 CO-CHAIR MEYER: Anything specific
18 around the structuring of those outsourcing
19 arrangements that we ought to have detailed
20 here?

21 DR. COHEN: Yes. They actually
22 have video systems. They have bar code

1 systems. The orders are actually processed at
2 a central location. When questions arise by,
3 you know, folks at the hospital, they can
4 check with the pharmacy that's centralized.
5 I think it's a safer way to operate, and that
6 is an opportunity that any hospital can -- and
7 there's several organizations that do that.

8 And then under medication
9 administration, in that first, where it says,
10 "Organizations should consider," I would
11 change the word "consider" now especially
12 knowing that we're going to be perhaps moving
13 to a bar code safe practice, moving toward or
14 preparing for the use of rather than
15 "consider."

16 I think it is time that they
17 really got serious about this. We're up to
18 about 30 percent of the country that already
19 has bedside scanning. Sixty percent use smart
20 pumps. There are no pumps anymore that are
21 sold pretty much without that drug library.
22 So that's pretty much something everybody can

1 do.

2 CO-CHAIR DENHAM: So prepare for
3 probably -- that's substantive, right?

4 DR. COHEN: Yes.

5 CO-CHAIR DENHAM: And before we
6 kind of moved to the next one. Do we want to
7 kind of visit about that? I mean that sounds
8 reasonable, I think, from what we know of the
9 evidence that's evolving, that has already
10 unfolded and continuing to unfold, but again,
11 it doesn't have specificity for compliance.
12 It's soft, you know. I wouldn't use the term,
13 Patrick, that it's, you know, quasi or I'm not
14 sure the term you used specific or pseudo
15 specific, but it does show an intention, and
16 we already know we're likely going to be at
17 the bar code level.

18 But I think that would be a
19 substantive change rather than --

20 DR. COHEN: Oh, really?

21 CO-CHAIR DENHAM: Well, I don't
22 know. I mean, it depends on how we define

1 "prepare." I mean are we going to define it
2 or are we just wordsmithing?

3 DR. COHEN: I really meant doing,
4 you know, the groundwork, checking your
5 infrastructure, inviting in vendors, things
6 like that, not actually installing it at this
7 point. At least they should be thinking this
8 way though because it's going to happen

9 DR. ANGOOD: Yes, I think if we
10 sort of keep it along the lines of should
11 consider and begin to prepare for or something
12 like that, that keeps us out of any real
13 substantive changes, but it keeps
14 telegraphing: this is coming, this is coming,
15 pay attention to it.

16 CO-CHAIR DENHAM: Actually I
17 think, Patrick, this is kind of where we are.
18 The dilemma we face, it is really easy to put
19 on the critical thinking hat and say those
20 things, but you see the dilemma we face is
21 that we want to get intentionality. We're
22 trying to move the market. The evidence isn't

1 there for preparation in saving lives, but I
2 think this is important, and it's important
3 probably for us to change the word to
4 "prepare," and then define what we mean by
5 "prepare" in the implementation guide.

6 I think that's where we could
7 leverage the implementation guide to say, you
8 know, so that the market sees, hey, we've made
9 a change. We've said "prepare," and then in
10 the implementation guide say what we mean by
11 "prepare."

12 And just to give you a read-back,
13 Mike, is start to assess the state, start to
14 identify the processes that need to change,
15 identifying the technologies that they may
16 need to implement and that kind of thing --

17 DR. COHEN: Exactly.

18 CO-CHAIR DENHAM: -- and put that
19 in the implementation guide.

20 DR. COHEN: In fact, there is an
21 assessment for readiness form that's available
22 that was done by the American Hospital

1 Association, ISMP and the Health Research
2 Education Trust, with a grant from the
3 Commonwealth Fund that people could use
4 actually.

5 And then, by the way, Hayley just
6 pointed out on the previous page under
7 leadership and culture survey you actually do
8 have --

9 DR. BURGESS: Readiness planning.

10 DR. COHEN: -- readiness planning
11 for bar coding.

12 DR. BURGESS: They already have it
13 there.

14 CO-CHAIR DENHAM: Do you want to
15 reread it?

16 DR. COHEN: Only because
17 considering is one thing, but you know,
18 getting ready for it or starting to do
19 planning is something quite different. So I
20 didn't think this was --

21 CO-CHAIR DENHAM: So let's relook
22 at that verbiage and look at the word

1 "prepare," and if we're all in agreement.

2 Patrick, you had a comment.

3 DR. ROMANO: Well, I was just
4 going to say that I think as Michael, I think,
5 has alluded to, it's important to consider the
6 work flow and the implementation that each
7 organization has to implement these types of
8 innovations in the context of the work flow.
9 We've seen and read reports about some of the
10 disasters that happened with EMR
11 implementation at some facilities when they
12 didn't actually, you know, sufficiently
13 consider those issues in advance.

14 I think that our safe practice
15 really covers that very well in terms of the
16 computerized physician order entry
17 implementation, the necessity of really
18 planning for that and implementing it in a
19 systematic and phased manner.

20 And I think, you know, anecdotally
21 we've heard cases of, you know, where bar
22 coding has led to delays in administering

1 necessary medications because of some issues
2 that maybe could have been anticipated in
3 advance.

4 DR. COHEN: Exactly. Thank you
5 very much for that.

6 CO-CHAIR DENHAM: So then just for
7 that piece, before you get to the next one so
8 that we can move quickly, how about if we --
9 I'll propose to work with Hayley on that piece
10 since we do so much tech work. We'll reword
11 and beef up the readiness piece to follow on
12 what Patrick said that follows along the same
13 thematic sort of trend of the CPOE in the
14 implementation guide and suggest to change the
15 word "prepare" and then cite that word in the
16 implementation guide. "By 'prepare,' it
17 means," and then we could go through those
18 activities.

19 Then may we run that by you, Mike?

20 DR. COHEN: Oh, absolutely.

21 CO-CHAIR DENHAM: And then with
22 Mike's approval, we can fire back to the

1 Committee. Is that a reasonable set of steps
2 on that one?

3 I think it's really important
4 because we did decide not to do bar code,
5 knowing that we're going to really focus on it
6 next time. So I think we need to kind of
7 prepare for it and telegraph to the market
8 because this is kind of serious stuff.

9 Okay. Keep going.

10 DR. COHEN: The other issue on
11 this page -- well, there's two more, but one
12 is under proactive risk mitigation strategies.
13 This is for leadership, for pharmacist
14 leadership. It calls for annual review using
15 external sources of reported near miss
16 information or actual information, and I don't
17 think annual is enough. I think it should be
18 ongoing. I mean, there are issues that come
19 up all the time that are major that could be
20 handled rather easily by recognizing it.

21 And just saying once a year isn't
22 enough, I think. So either drop that or if

1 you want to be prescriptive, make it more
2 often. Say ongoing or that's what I think it
3 should be.

4 That's under proactive -- where is
5 it here? Right here.

6 DR. ANGOOD: Mike, on this one is
7 this -- could we just get rid of the time
8 reference in there?

9 DR. COHEN: I think that would
10 work, yes. When you say annually, it's just
11 not frequent enough.

12 DR. ANGOOD: Right.

13 CO-CHAIR DENHAM: Now, here's
14 where we had the debate. We've had this
15 debate every year. Do we say annual so that
16 you can check box? So there's a compliance
17 issue, or do we leave it without a time, which
18 means somebody could interpret that, well, we
19 kind of do that. So we do it.

20 This is the dilemma we always
21 face, is if we put a time on, is it too
22 frequent, too infrequent; are we too specific.

1 This is the dynamic tension that Gregg
2 mentioned. If we don't put a time on, there's
3 weasel room to just not do it, and so we went
4 through this debate last year.

5 So the debate was do we do it
6 ongoing. That's where the terms "regular,"
7 "periodic," "annual" or "continuous," and what
8 does "continuous" mean? Continuous, well, we
9 kind of continuously do that.

10 DR. COHEN: Well, we have this PSO
11 concept. We have the state reporting
12 programs. We have the voluntary programs, and
13 their very purpose is to communicate
14 information, communicate the learning, and if
15 people are just going to wait once a year,
16 which is basically what it says, that's not
17 enough in my mind.

18 So what I'm trying to indicate
19 here is that it should be on an ongoing basis
20 not just once a year that you're looking at
21 external sources. That's the crux of the
22 matter for me.

1 CO-CHAIR DENHAM: Just so we can
2 keep going, I'll give you two options. Let's
3 throw out for discussion two options. It
4 should be ongoing at least annual or we can
5 say ongoing and then in the implementation
6 guide specify what we mean by ongoing, that
7 this should be a continuous process.

8 DR. COHEN: I think the latter.

9 CO-CHAIR DENHAM: The Committee
10 okay with that?

11 DR. HUNT: Yes, I would agree with
12 that. I think the implementation guide, that
13 really is the jewel to this whole thing
14 because just having the practices come down
15 from on high from Mt. Sinai, it's the
16 implementation guide that has been my
17 experience that so many people really refer
18 to.

19 So I would put it there and even
20 make it a parenthetical, for example, annual,
21 ongoing or continuous just to let people know
22 and/or give examples, you know.

1 St. Elsewhere General does it, you
2 know, annually with these type of results.

3 DR. COHEN: Monthly.

4 (Laughter.)

5 DR. COHEN: And then finally very
6 minor, under evaluation it says perform a
7 medication safety self-assessment, and there
8 are many that are out there now, some very
9 specific. The dispensing cabinets, the bar
10 code self-assessment, the smart pumps, et
11 cetera, et cetera. So I think just dropping
12 A and say medication self-assessments would
13 work.

14 CO-CHAIR DENHAM: Okay. So
15 committee agreement with that verbiage change.

16 Anything else, Mike?

17 DR. COHEN: That's it. Thanks.

18 CO-CHAIR DENHAM: Anything else
19 from the rest of the Committee?

20 What we've then got in the
21 narrative of the recording here we'll act on,
22 bring it back to the Committee, and the pass,

1 Hayley and I will work together to get it to
2 Mike; Mike, have you review it carefully and
3 then bring it back to the Committee.

4 DR. COHEN: Okay.

5 CO-CHAIR MEYER: So the next two
6 practices I'll cover. The first one is hand
7 hygiene, and actually with both of them what
8 we chose to do under the safe-practice self is
9 say that the safe practice is to comply with
10 the CDC guideline because we recognize that
11 those guidelines would be changing on a
12 schedule that would not necessarily be the
13 exact same as safe practices update. So we
14 have not gotten into anything more specific
15 there.

16 The one issue that came up in
17 discussions around hand hygiene is that you'll
18 see in the document -- it's actually page 215
19 is where Safe Practice 19 starts -- that we
20 reference the WHO hand hygiene guideline.

21 There was some question whether or
22 not the safe practice itself should say

1 "comply with current . . . control and
2 prevention hand hygiene guidelines," or we
3 don't think it's worth it, frankly. they're
4 close enough to each other, and there's plenty
5 of examples here in the current document, but
6 I don't think there needs to be any change.

7 The way this is written, it should
8 be pretty evergreen. It should always stay up
9 to date.

10 DR. ROMANO: Can that be something
11 that is offered under the implementation
12 guidance that --

13 CO-CHAIR MEYER: yes.

14 DR. ROMANO: -- some organizations
15 choose to follow similar guidelines from the
16 World Health Organization.

17 CO-CHAIR MEYER: Yes, and we
18 already have a fair amount of that, but we can
19 make sure we say that very explicitly.

20 Other comments on hand hygiene?

21 DR. BURGESS: Gregg, just one
22 other thing. We did have a conversation with

1 Paul Schyve and Maureen Carr from the Joint
2 Commission, and if you look under the
3 additional specs, the third one, "insure that
4 all staff know what is expected of them
5 regarding hand hygiene and insure compliance,"
6 what Joint Commission is saying, that around
7 that language since we have referenced them,
8 they are changing the 90 percent compliance to
9 continuous improvement.

10 So just so you know, they are
11 making a change. We won't know until August
12 the 26th exactly what that change will be, but
13 it's not going to change our practice.

14 CO-CHAIR MEYER: It won't change
15 our practice, what we reference.

16 DR. BURGESS: Yes.

17 CO-CHAIR MEYER: The next is
18 influenza prevention, and again, what the safe
19 practices has to do is comply with current
20 Center for Disease Control recommendations for
21 influenza vaccinations for health care
22 personnel and the annual recommendations of

1 the CDC Advisory Committee on immunization
2 practices for patients.

3 So that was the change that we
4 made last time, was including the health care
5 personnel piece there. So, again, I don't
6 think there's any major change that we expect
7 here. This will change each season with the
8 recommendation of the CDC. So buckle your
9 seatbelts for what comes out in the next
10 several weeks on this, but I think the safe
11 practice remains the same.

12 Other comments about that?

13 Safe Practice 21, central line
14 associated bloodstream infections, and so
15 here, Peter Pronovost, are you still on the
16 line?

17 DR. PRONOVOST: I am.

18 CO-CHAIR MEYER: So on Safe
19 Practice 21, and if you have any specific
20 comments about what we have there under the
21 additional specifications or anything else in
22 a lurch that we ought to know about.

1 DR. PRONOVOST: Well, one
2 potential thing you can do is that our
3 supported effort to spread this work with
4 states is all publicly available at
5 www.safercare.net, and it has a whole bunch of
6 tools and resources, and again, it's publicly
7 available, and that may be of --

8 CO-CHAIR MEYER: So we can add
9 that into an example of an implementation
10 approaches. So we'll update that. That will
11 be a great addition.

12 DR. PRONOVOST: And then one
13 other, and I don't know if we put it in the
14 comment, but, you know, one of the things that
15 we've learned is that the largest number of
16 these seem to be preventable, even in a
17 medical sense. So I wonder if we, you know,
18 could phrase it that we are to a large
19 extent --

20 CO-CHAIR MEYER: So then we could
21 look at doing something in the problem
22 statement just to make sure that we make that

1 clear.

2 DR. PRONOVOST: Correct.

3 CO-CHAIR MEYER: Last question I
4 have for you, Peter, is I was not aware of it.
5 Chuck made me aware of it, and that is that a
6 recent study in iodine versus chlorhexidine,
7 and this has chlorhexidine under the
8 additional specification. It sounds like we
9 have bet on the right horse on this one, but
10 I don't know if there's anything else we need
11 to change in light of that study.

12 DR. PRONOVOST: And there has been
13 a systematic review in a number of studies
14 that show chlorhexidine reduces risk by about
15 half.

16 CO-CHAIR DENHAM: Yes, Peter.
17 Chuck here.

18 There will be a study coming out
19 in one of our major journals on showing, as
20 you say, you know, 40, 50 percent. This is in
21 SSI actually, the clean contaminated subset,
22 but I think we did bet on the right horse, and

1 the specifics were the two percent.

2 And, Peter, if you remember, I
3 think about a month ago, six weeks ago I
4 called you regarding the Keystone study and
5 going back, and we're going back to look, and
6 all indications I have is that the
7 concentration matches what the SSI study shows
8 in terms of the use of the chlorhexidine. It
9 appears to be that's kind of the standard
10 solution.

11 So I think we're pretty safe and
12 we were pretty safe last time when we went
13 with that compendium. Don't you feel like
14 we're pretty safe?

15 DR. PRONOVOST: Yes, absolutely.
16 I think there's quite good data supporting
17 that.

18 You know, Gregg, the one
19 controversial thing is, as you know, there has
20 been a number of studies now showing anti-
21 infective catheters, also cut-rates, and
22 biopatch or the anti-infective dressing could

1 be effective, as well as chlorhexidine wipes
2 that seem to be effective at MRSA and VRE.

3 Their contentious about when and
4 how to use those. My own recommendation would
5 be to follow the CDC guidelines, which have a
6 statement on that that basically says you try
7 other things, and you're confident you're
8 doing the other things and your rates are
9 still high. Consider these alternate
10 technologies.

11 CO-CHAIR MEYER: We'll add that to
12 implementation practices.

13 CO-CHAIR DENHAM: So then moving
14 to Practice 22, surgical site infections, and
15 this is, again, -- Peter, do you want to
16 address the Joint Commission issues and then
17 I'll come back to the chlorhexidine? Yes, the
18 Joint Commission updates.

19 Hayley, is there anything you want
20 to address here?

21 DR. ANGOOD: Yes, Joint
22 Commission, you know, continues with its

1 National Patient Safety Goals, and they are
2 part of the consortium that works on the
3 compendium of these guidelines, and as near as
4 I'm aware, they are just continuing to pretty
5 much support what the compendium comes out
6 with, and they have not changed any of the
7 language in their Patient Safety Goals. So I
8 think we're still good on all of these.

9 The compendium is the driver for
10 the HHS, HAI action plan, and it will continue
11 to be so, you know, for the next year to two
12 years. So I think that we stay the course
13 without changing around with the language, and
14 most everybody is going to stay in line with
15 that.

16 You know, we are very well placed
17 with this set of safe practices because of
18 that.

19 CO-CHAIR DENHAM: We had
20 participated in that process, and coming back
21 to the evidence grading that Dr. Casey
22 mentioned in that compendium, we plan to loop

1 back with the leaders of that even though
2 their compendium may not be for a year, year
3 and a half out. We're going to re-review and
4 ask for a regrading as we kind of head into
5 our 2011 so that we've got -- and if the
6 classification, Peter, is different than the
7 one that was used as brought forward by NQF,
8 then we'll go ahead and tackle it from that
9 standpoint.

10 Because this is one of our best
11 sets of graded evidence based practices that
12 we have, and it would be great for 2011,
13 January 2011 to come out with, you know, that
14 as a tip of the spear, and it also helps us
15 with all of the rest of them.

16 So we'll want to do that, and then
17 the other piece on this one, this is where the
18 major study, the randomized prospective trial
19 using the two percent chlorhexidine showed the
20 definitive big delta in SSIs, and so we'll put
21 that language in and bring it back.

22 DR. HUNT: Just one quick note,

1 and it's good news actually. You may see some
2 movement from CMS and the SCIP crew to either
3 remove or change the hair removal measure, and
4 that's again for good news. We've topped out.
5 The national average is around 96 percent with
6 that. Who would have ever thought we actually
7 -- I shouldn't take that.

8 (Laughter.)

9 DR. BURGESS: So just to add onto
10 that, what I understand is that the Surgical
11 Alliance had submitted to HHS, CMS, AHRQ, et
12 cetera, an objection to requiring clippers in
13 their surgery, and that the SCIP TAF will be
14 looking at that and may remove testicles as
15 well as brain, cranial trauma from that.

16 So, Dave, do you want to comment?

17 DR. HUNT: Yes, they did, and it's
18 so funny because the more things change the
19 more they stay the same. There is always --
20 and actually, I think that's a good measure of
21 the fact that, one, folks are actually
22 listening to us, and that we've gotten their

1 attention and that, two, everyone just can't
2 say yes and just do it.

3 So the technical expert panel is
4 going to revisit that area. We have a number
5 of rejoinders as far as the neurosurgeons are
6 concerned. They have issue that in my mind
7 are really non-issues, but you know,
8 neurosurgeons like to be special. So we'll
9 entertain that.

10 DR. ANGOOD: The neurosurgeons,
11 just so you're aware, they have also
12 approached us directly to look at this issue,
13 and we're going to do a little special session
14 for the special boys and just trying to get to
15 the core of their issues and sort of help it.

16 You know, we shouldn't be
17 denigrating neurosurgeons. They're wonderful
18 people, and they do good stuff, but they are
19 ego strong and they do get caught on their
20 issues.

21 DR. ROMANO: I would just point
22 out in theory, I mean, it's wonderful that

1 we're topping out on this, but of course,
2 topping out on a practice from the standpoint
3 of SCIP measurement doesn't mean that it
4 should be removed --

5 DR. HUNT: Oh, no.

6 DR. ROMANO: -- from the safe
7 practices. Obviously, safe practices are more
8 of a statement --

9 DR. HUNT: Absolutely. Thanks for
10 the clarification. Absolutely.

11 CO-CHAIR DENHAM: So are there
12 other comments?

13 David, do you want to -- and maybe
14 when I stepped out of the room, you know, we
15 evaluated normal thermia as a potential issue
16 knowing that there are four benefits. One is
17 that the randomized studies are substantive
18 enough to support SSI prevention only in
19 colorectal; that drug metabolism is affected
20 by the patient being at too low a temperature;
21 cardiac instability and patient comfort were
22 the four kind of issues, and as we evaluated

1 that from the SSI standpoint, you kind of came
2 out or we kind of came out that we're safe
3 where we are with these specifications.

4 Then News at 11, we don't know of
5 any studies that are going to broaden
6 normothermia for colorectal, but if you look
7 at as a composite of safe care of the surgical
8 patient, if we were, Peter, to go where some
9 of the discussion has taken us to composite
10 measures, as we have with the ventilated
11 patient, you know, we broadened with Peter's
12 help, Peter Pronovost's help. We broadened
13 some of the specs from just preventing VAP to
14 safe care in the ventilated patient.

15 If we were to be heading on a
16 trajectory of safe care, the surgical patient,
17 would the evidence for normothermia then be
18 more compelling since we're not just talking
19 about SSI, but we're talking about the other
20 two clinical issues are cardiac instability
21 and drug metabolism. Would they then be
22 compelling enough to say normothermia might be

1 a consideration 2011?

2 DR. HUNT: Absolutely, and you can
3 throw in the coagulation profile, the
4 improvement in the coagulation profile for
5 patients that are kept at a proper
6 temperature.

7 So much so that there was, you
8 know, the whole narrative of how measures come
9 and go and are formed, born and then die is up
10 and down. The good news is that -- I was
11 going to put an editorial comment in. Good
12 sense prevailed, but I didn't put that in --
13 that the additional benefits of normothermia
14 have started to carry the day.

15 Because one particular rubric
16 doesn't have the full flower of strength of
17 evidence, people recognize that it's an
18 artifact of the way we decide to put things
19 together. If you wanted to have a set of
20 practices that were just called really good
21 things to do, normothermia would probably be
22 in there because it goes across so many

1 different areas: cardiac instability,
2 coagulation profile, surgical site infection,
3 and drug metabolism.

4 DR. ANGOOD: Sorry. Just as an
5 adjunct, I had mentioned in my opening
6 comments of how we're going to try and have
7 the work of the NPP patient safety section
8 complement what we're doing with these other
9 components. It's looking like we're going to
10 head on a path of perioperative safety within
11 the patient safety component of NPP, and that
12 will address many of the things that David
13 just sort of mentioned, plus teamwork, cross-
14 disciplinary work, et cetera, et cetera, and
15 how do we not just think about it as an
16 operation with five different disciplines in
17 the room, but a whole composite of teams, and
18 how do you take it from the beginning to the
19 very end, which may or may not include the ICU
20 and the floors, et cetera, et cetera.

21 So perioperative safety just is
22 something that needs to be pushed harder, and

1 we'll try to do that through the NPP.

2 CO-CHAIR DENHAM: So just so we're
3 respectful of the open part of this session,
4 I know some people may have early flights.
5 Are there comments, Don, I know you had before
6 your next flight?

7 (Off-mic comment.)

8 CO-CHAIR DENHAM: Okay. Bullet
9 points, Don think about a minute or so.
10 Anyone else? Anybody on the line that would
11 like to make a comment?

12 Okay. Care of the ventilated
13 patient, Safe Practice 23, and maybe we will
14 turn and just ask Dr. Pronovost if he is on if
15 he'd like to make a comment on that practice.

16 DR. PRONOVOST: Yes, I'm still
17 here. One, I like that broadening, rather
18 than focusing on what outcomes just to say
19 here is what is good care for these patients.

20 You know, I think the only thing
21 that has come out since we've said it is more
22 evidence about the sedation holiday with a

1 nice lancet study, but I think that's probably
2 covered in there.

3 CO-CHAIR DENHAM: Peter, we will
4 come back. We're staging, making sure the
5 specs are all tight, and as we go through the
6 problem statement and the other citations,
7 we'll count on you again if we can to just
8 make another pass with us just to make sure
9 that we've got all the latest, and then in the
10 implementation guide section.

11 Peter, do you want to maybe
12 address the HHS direction towards new
13 definition or towards a more clear definition,
14 and maybe we could tease that. You know, this
15 report will come out in January. You know, we
16 could at least tease the fact that there
17 appears to be, there will be some
18 clarification on definition of outcome.

19 DR. ANGOOD: Well, what Chuck is
20 referring to, again, relates to this HAI
21 action plan that HHS has, and there's several
22 subgroups within that action plan, and the CDC

1 is heading up one component of that, which is
2 helping to clarify the definitions of each of
3 these terms, and that winds up being sort of
4 problematic in terms of getting a clear
5 definition. It's partly related to the
6 radiologic definitions, the sputum traps, et
7 cetera, et cetera, and so the direction will
8 be leaning more towards the processes around
9 prevention and care of patients.

10 I've just gotten an E-mail on
11 Monday morning from Dan Rosenthal on this, and
12 they are getting closer, but they're not quite
13 ready to sort of release their final versions
14 of these definitions.

15 Similarly, the urinary tract
16 catheter related infections is undergoing some
17 scrutiny in this process, and so I think it's
18 important, obviously, for us to make sure that
19 as CDC clarifies their terminology as that
20 gets nailed into the HAI action plan that
21 we're reflecting on all of that directly.

22 There's nothing substantive at

1 this moment that we need to change, but should
2 CDC come up with these clarified definitions,
3 then we'll certainly reflect that.

4 CO-CHAIR DENHAM: So our action
5 plan then on the ventilated patient is to make
6 sure we synchronize with those things perhaps
7 in the implementation guide and then return
8 back to Dr. Pronovost to make sure that we've
9 got all of the latest references and are
10 looking at the care of the ventilated patient.

11 The feedback from the field has
12 been very positive on this, and when we expand
13 it, we thought we might have some push-back as
14 we started to expand beyond just VAP and, you
15 know, we just haven't had any negative push-
16 back, you know, on the expansion of the
17 practice. So, again, this one was at least
18 one of our better decisions, better bets.

19 We'll move to Practice 24, MDROs,
20 and, Peter, do you want to address how that
21 might overlap with the HAI plan and kind of
22 where things are going?

1 And then maybe, David, give us
2 maybe a little bit of an update of where from
3 your vantage point, where the MERSA C. diff.
4 lands.

5 DR. ANGOOD: Yes. Well, bottom
6 line is I don't think we need to change this
7 because it's so fresh and new. The language
8 more accurately harmonizes with the Joint
9 Commission's Patient Safety Goals, and that's
10 where the intent of this was all along.

11 In the consortium that looked at
12 the guidelines compendium, there was a lot of
13 focus on MRSA, and to some degree C.
14 difficile. At the Joint Commission when we
15 constructed this one up, we thought, well,
16 it's more of a systems and processes issue
17 than particular bacteria or particular
18 microorganisms, and so the attempt was made to
19 construct that patient safety goal along the
20 lines of improving systems and processes, and
21 we chose to reflect that inside this safe
22 practice as well.

1 And so that's harmonized very
2 closely to the Joint Commission,. and as near
3 as I'm still aware, the Joint Commission is
4 not intending to change its approaches on this
5 either.

6 David will provide us more
7 specifics probably, but there is clearly a
8 focus and probably to some degree generated
9 politically for taking care of MRSA and
10 Clostridium difficile, and so the HAI action
11 plan has those two specific organisms
12 contained within it as targets, and it will
13 also become part of our other NQF work related
14 to our HHS contract.

15 But I think from a safe practices
16 vantage, it still makes more sense to push it
17 from improving systems and processes of multi-
18 drug resistant organisms.

19 But, Dave, any other comments from
20 your side?

21 DR. HUNT: No. I would agree.
22 The emphasis in the HHS action plan on

1 Clostridia and MRSA really reflects a
2 practicality from the department's standpoint
3 that we don't really have good actionable
4 plans for discussing systemic change, and so
5 being able to focus in on those two allows us
6 to give very practical advice across the
7 department.

8 But when you look at the report
9 from the Committee, there was a very, very
10 clear statement that the systemic approach,
11 and that it is not just these two bugs, that
12 multi-resistant drug bacteria or organisms
13 were a real, real issue, and that these will
14 hopefully be -- those two would be the start
15 of a plan of how to approach that.

16 One of the real challenges, and
17 it's funny because HHS, there's always the
18 issue of you really have to become the change
19 you seek in the world; HHS has really got to
20 and is embarking on an effort to
21 systematically be able to collect, collate and
22 manage information on these organisms

1 throughout the clinical community, through the
2 public health system, as well as through the
3 quality measurement systems, and that has been
4 a true challenge on the order of the challenge
5 that institutions have been having in making
6 this a systemic solution to this problem.

7 And I think that this will really
8 be a measure of how well the department is
9 able to effectively organize across a very
10 complex group of agencies. So we'll see.

11 CO-CHAIR DENHAM: Dave, as we were
12 kind of in an organized fashion providing
13 feedback regarding HACs, and that process
14 unfolded. We found that the front line in our
15 testbed, the fact that even though it was a
16 blunt instrument and even in Tom Valuck's
17 words it represented budget dust in terms of
18 the dollar save and the dollar impact on
19 organizations, it got the attention of the C-
20 suite, and hospital acquired conditions was a
21 "wow." You know, that became the headline.

22 Can you just address the

1 transition to health care associated
2 conditions, the HHS sort of? It should like
3 HAC is going to go from hospital acquired
4 condition to health care associated conditions
5 so that it's broader, but will the blunt
6 instrument and the tying of payment -- and I
7 know you can't commit the government to
8 anything or where it's going -- but as we
9 write in our narrative in the implementation
10 guide and the problem statements that even the
11 purchasers of health care are acutely aware of
12 these conditions, we already got that in there
13 in kind of general terms, but can you help us
14 a little with the language and definition of
15 HAC as we kind of start to head -- I'm
16 thinking as much on the implementation and
17 nothing about specs.

18 But it does help us kind of write
19 the narrative that says new horizons and
20 purchasers are going to do this and that kind
21 of thing. Can you tell us about this
22 trajectory from HAC to HAC but the name change

1 from hospital to health care?

2 DR. HUNT: I think this was more
3 recognition that the settings that we deal in,
4 the rubrics that we have are in some ways
5 artificial, and in many ways those rubrics
6 actually inhibit our ability to make change.
7 A great example is the same situation that we
8 had with the normothermia. We used that one
9 SSI rubric as the placeholder for where that
10 will reside, and it inhibited us and we got a
11 lot of feedback and push-back because of the
12 location we chose.

13 And the same situation actually
14 plays out when you look at these health care
15 associated versus hospital associated. I
16 won't disagree that the hospitals told us that
17 they don't want to necessarily be the only
18 ones in a hot seat because we are talking
19 about a number of different entities now
20 providing clinical services, and that we've
21 got to work across that.

22 So that was in one measure part of

1 the reason for the change, and also a very,
2 very clear recognition that the list of things
3 for which we will be able to make a clear and
4 convincing statement that we no longer should
5 provide that perverse incentive of paying more
6 for outcomes that are substantially worse is
7 going to increase as the evidence base
8 continues to increase and we'll be able to
9 make more rational and very, very pointed
10 decisions on things around payment.

11 So I think it was a recognition
12 that, one, hospitals aren't the only places
13 where we need to be concerned about; two, that
14 the list of topics will most likely increase
15 and that, particularly as the evidence base
16 increases, and the fact that health care
17 services have got to be seen in the context of
18 a full continuity of places that you often
19 will go from an acute care to a short stay
20 facility on, and that everyone on the team has
21 got to have an awareness of these. It's not
22 just your fault or your fault; that we're in

1 this together working toward the benefit of
2 the patient.

3 And we've got to have terminology
4 that better reflects the reality that it's not
5 just one setting.

6 CO-CHAIR DENHAM: So for the
7 tactical purposes of our narrative should we
8 say health care associated condition,
9 parentheses, HAC, end parentheses, and we're
10 safe or is there some deadline where the name
11 is going to change but the purpose is the
12 same? Or has there been -- I'm just thinking
13 so our document is not dated when we have that
14 kind of through it.

15 DR. HUNT: Yes, I'm not sure of
16 any deadlines, but you know, in the government
17 they love deadlines because how else will we
18 be able to miss them?

19 (Laughter.)

20 DR. HUNT: But I think we are in a
21 safe spot if we say health care associated.
22 I think that's the general terminology that's

1 being used, and I don't think there will be
2 any disagreements or discomfort with using
3 that term.

4 DR. ANGOOD: Can I ask one minor
5 question? I think it's acquired, not
6 associated, right?

7 DR. HUNT: Yes, yes.

8 DR. ANGOOD: Okay. So it's health
9 care acquired conditions, and I think as we
10 have opportunity, I think we'd be on the mark
11 to begin using that terminology. We actually
12 pushed back pretty hard in our contract
13 negotiations for safety on do we want to use
14 this term coming from NQF, and it was very
15 clear that term is here to stay. So let's
16 just get used to it, you know.

17 It's actually not a bad term.

18 DR. HUNT: It's not.

19 DR. ANGOOD: It's different.

20 CO-CHAIR DENHAM: So for the
21 purposes of our discussion then, as we look at
22 MDROs and we look at the UTIs, we'll loop back

1 with the compendium leaders just to make sure
2 we're in sync there. Peter will look back to
3 make sure from an NQF standpoint that since
4 you're the representative of NQF on the HHS
5 plan, and so we don't anticipate any
6 substantive changes to the specs. We do
7 anticipates updates to the problem statements
8 and telegraphing that there will be some new
9 definitions. Is that a fair approach on those
10 two practices?

11 Okay. Any discussion on those?
12 And then we'll move to wrong site, wrong
13 procedure and ask peter to address that one.

14 Oh, I know we had some interest.
15 Should we take a break or should we press on
16 and wrap up? Don, you wanted to make a public
17 statement, but we could press on and finish.
18 should we press on?

19 Okay. So, Peter, do you want to
20 take Number 26?

21 DR. ANGOOD: Do we need a break?
22 We've obviously had a very fluid schedule,

1 literally and figuratively. If you want to
2 take a five-minute break and just --

3 CO-CHAIR DENHAM: Maybe we should
4 -- because I know people have flights and
5 there's some anxiety, but no one wants to
6 miss. Why don't we just if people cycle out,
7 we'll do a recap? Patrick, if you slip out
8 and then come back real quick, we'll give you
9 a quick recap and we'll just keep things going
10 perhaps. Because I know people have some
11 flights.

12 People do you want to take wrong
13 site?

14 DR. ANGOOD: You keep trying to
15 give m wrong site surgery.

16 (Laughter.)

17 DR. ANGOOD: Yes, yes, yes.
18 Again, the essence of this I don't think we
19 really need to change in terms of a safe
20 practice. We clearly don't want to have wrong
21 site surgeries occurring, and the Joint
22 Commission is another example here of how we

1 tried to really harmonize, and that's the only
2 other group that's out there pushing on the
3 national level in terms of its universal
4 protocol.

5 And we mirrored that quite closely
6 with the safe practice. The Joint Commission
7 is looking at some modifications on a minor
8 level to their universal protocol, mostly
9 related to who's marking the site and the
10 timing of the time out and a few other minor
11 things, and I think we need to stay very close
12 to that, but that process of theirs is not
13 going to be completed until later this fall as
14 I understand it.

15 The other component that's out
16 there, and it's almost a competing force, is
17 the World Health Organization's safe surgery
18 checklist, which is different than the
19 universal protocol. It's different than our
20 safe practice, and it does feed into more of
21 the perioperative safety strategy. It has a
22 pre-op, inter-op, and postoperative component

1 to this checklist, but it hasn't been fully
2 vetted nor approved into a WHO guideline.

3 It is in the stages of that. The
4 WHO bureaucracy is, as Peter Pronovost knows,
5 is quite dense and at times slow moving, but
6 once product comes out, it's very robust.

7 My own thoughts were that for this
8 year that we didn't necessarily need to
9 incorporate the WHO surgical checklist into
10 our specs. We need to certainly make mention
11 of it in our other narrative, and then as we
12 get into deeper review with the practices,
13 hopefully the guideline process will be
14 complete from WHO on that surgical checklist
15 and, as well, the Joint Commission will have
16 finished its updates, if any, to the universal
17 protocols.

18 So having said all of that, I
19 think we're okay with this practice for the
20 moment, but it will need some further
21 revisions next year.

22 Peter, did you want to make any

1 comments on that?

2 DR. PRONOVOST: Yes, Peter. I
3 completely agree. I think I would do that.
4 The only one thing, Peter, potentially to
5 include is to say, you know, despite
6 promulgating these guidelines, wrong site
7 surgeries continue, and to perhaps help, your
8 organization might need to take a little
9 closer look at staff behaviors rather than
10 just do they have a policy in place.

11 DR. ANGOOD: Yes, I think that's a
12 very strong point. You know, you've got five
13 or six disciplines doing 25,000 cases a year
14 in the same environment. You'd think they'd
15 get it right in many institutions, but the
16 fact is it doesn't get corrected, and this is
17 kind of akin to hand hygiene and medication
18 reconciliation: simple concepts, very
19 complicated to implement. And that's a good
20 point for us to reinforce.

21 Other comments from the group?

22 Okay. Thanks, Peter.

1 CO-CHAIR DENHAM: So our next
2 practice, and so the Committee had no other
3 comments. That would be the approach that we
4 would take, and the other thing we might
5 consider in the narrative piece of the
6 implementation guide on identification and
7 mitigation of risk and hazards, SP-4, I think
8 it may be appropriate to put the checklist in
9 there and put the citation in there.

10 So for the record, let's take a
11 look at that, the SP-4, since there is so much
12 work going on and the wrong site issue is
13 actually, as we're starting to really report,
14 it looks like it's going up.

15 DR. ANGOOD: Yes.

16 CO-CHAIR DENHAM: So the next
17 practice is 27, pressure ulcer prevention.
18 And we wanted to discuss the NQF pressure
19 ulcer framework and also address the skin
20 assessment issues.

21 Peter, do you want to take this
22 one or Melissa?

1 DR. ANGOOD: Actually I'm going to
2 bump this one over to Melissa who has been an
3 integral staff member for that Committee
4 framework, and I consider her our local world
5 expert on pressure ulcers.

6 MS. MARINELARENA: So for this
7 practice we consulted with Theresa Edelstein,
8 who is one of the Steering Committee members
9 on the pressure ulcer project, and she's with
10 the New Jersey Hospital Association, and they
11 did a lot work with the pressure ulcer
12 collaborative. So they had a lot of
13 experience with implementation.

14 One of her recommendations was
15 including a comprehensive skin assessment,
16 which was a combination of a risk assessment,
17 pressure ulcer risk assessment, and then a
18 full skin assessment as well.

19 They found in the work that they
20 did that sometimes you had to very
21 specifically state that you needed the two
22 types of assessments. So that was one of the

1 inclusions that we had there.

2 Let's see. So, yes, and then on
3 this third bullet when we talk about assessing
4 and periodically we assess each patient's skin
5 and risk for developing pressure ulcer, again,
6 being very explicit that you need to do the
7 two assessments hand in hand.

8 We underlined the last bullet,
9 perform quarterly prevalence studies. Another
10 suggestion from Theresa was although pressure
11 ulcer prevalence data is reported quarterly,
12 that hospitals should be or facilities should
13 be obtaining it monthly, and that's also in
14 alignment with what the pressure ulcer
15 framework is recommending as far as looking at
16 more real time data versus waiting a full
17 quarter to look at your data and then do
18 something about it.

19 So if you can look at it sooner
20 and then put into place those interventions to
21 bring down your pressure ulcer prevalence
22 rates.

1 CO-CHAIR MEYER: So you're
2 suggesting that we change the quarterly
3 prevalence studies to monthly prevalence
4 studies.

5 MS. MARINELARENA: Yes, as far as
6 internally to collect data monthly even though
7 it could still be reported quarterly, which,
8 you know, the framework would prefer more real
9 time reporting, but that's still a work in
10 progress.

11 CO-CHAIR MEYER: I'm from an
12 institution that does this already. So I'm
13 not in a good position to kind of -- again, I
14 just wonder where the rest of the field is in
15 terms of their readiness for doing this.

16 CO-CHAIR DENHAM: Comments from
17 the Committee regarding the proposed changes
18 in blue, underlined in blue?

19 DR. McAULIFFE: I don't know
20 whether that change from quarterly to monthly
21 would be a substantive change or whether that
22 would be sort of a buffing change or not, but

1 it seems to me if the evidence is not there
2 maybe we ought to be pushing it forward into
3 the next go-around.

4 DR. ANGOOD: Yes, I think the
5 benefit and the design of the public comment
6 phase is to get the feedback on those, and if
7 the feedback winds up being exceedingly strong
8 in the negative sense for doing that, then
9 we'll have to adjust accordingly and maybe
10 kick it into a more robust process.

11 But I am comfortable that, you
12 know, if we just make that one change from a
13 temporal factor, let's put it out there
14 because the rest of it is all the same.

15 DR. PRONOVOST: But you know, the
16 one other thing we may consider adding, which
17 I think is not feasible with EMRs is moving
18 also to not just prevalence, but incidence.

19 You know, in my hospital, the
20 clinicians, the feedback that's meaningful is
21 did we give this to this patient and not
22 knowing whether they came in with it or we

1 gave it to them was a barrier to us engaging
2 clinicians in working, and now that we've
3 started monitoring incidence rates, you know,
4 who did we give it to when they came in, you
5 know, documenting who has an admission, which
6 they have to do anyway, provides much more
7 meaningful feedback for clinicians and
8 generates a lot more activity.

9 CO-CHAIR DENHAM: Peter, that's a
10 great point, and two places that that could
11 appear in the practice, one is in the measures
12 section where we address process, outcomes,
13 structure and patient centered measures which
14 are not specs so they are not substantive, but
15 they would be a real guide.

16 So I agree with you, Peter. I
17 think we could propose to put that in that
18 section, also add it to the implementation
19 section, and so we'll throw that up to the
20 Committee to just see if that sounds
21 reasonable.

22 And then the second piece is what

1 is in blue, and the question back to the
2 staff, we've got quarterly prevalence studies
3 on the final bullet that's in black. Does
4 that demarcate an add or a deletion?

5 MS. MARINELARENA: That's what's
6 already there.

7 CO-CHAIR DENHAM: Right.

8 MS. MARINELARENA: So we were
9 going to look at it.

10 CO-CHAIR DENHAM: ?So that would
11 be a deletion.

12 MS. MARINELARENA: The thing is
13 the framework hasn't been endorsed yet. It
14 still needs to go for NQF member vote. So all
15 of this would be contingent on the framework
16 passing and being endorsed.

17 CO-CHAIR DENHAM: So the monthly
18 -- go ahead.

19 CO-CHAIR MEYER: So I guess what I
20 would propose is that we leave it as
21 performed, quarterly prevalence studies, as
22 is for now; add the New Jersey collaborative

1 information to the implementation examples;
2 and then chase the pressure ulcer framework as
3 we go forward.

4 So if you have anything more, I
5 don't know how much of a burden this is going
6 to be on folks and how read it is. If we're
7 going from quarterly to monthly, I think it
8 absolutely will raise the question of saying,
9 you know, show me why we need to do this.

10 DR. HUNT: But if you went from
11 quarterly to daily and then fall back to
12 monthly.

13 (Laughter.)

14 CO-CHAIR DENHAM: Is that man from
15 government?

16 Patrick.

17 DR. ROMANO: I just want to point
18 out at the practical level that these
19 prevalence surveys are actually quite
20 expensive. I mean for a 600-bed hospital like
21 ours, this literally means having a staff
22 person roll over and inspect the skin of every

1 one of those 600 patients and finding them
2 when half of them are in the OR or in X-ray or
3 in interventional radiology or whatever on any
4 given day.

5 So the cost is estimated for our
6 hospital at about \$100,000. So I would think
7 a better way to do this moving forward
8 perhaps, as Peter was suggesting, is to
9 supplement the quarterly prevalence survey
10 with ongoing evaluation of incidents, and I
11 think the point is well taken that electronic
12 health information systems make that a little
13 bit more straightforward now.

14 And of course, all of our
15 hospitals are now into paying careful
16 attention to whether those pressure ulcers are
17 hospital acquired conditions or not for CMS
18 purposes.

19 So I think that a more cost
20 effective way of doing this might be a
21 combination of quarterly prevalence surveys to
22 make sure you haven't missed any supplemented

1 by ongoing monitoring of incidents.

2 So I would support basically Dr.
3 Meyer's suggestion thinking towards how can
4 this type of more frequent monitoring be
5 implemented cost effectively.

6 DR. HUNT: I will just point out
7 that I was only half facetious with the daily,
8 only because if you're really going to
9 decrease the incidence of them, some staff has
10 got to find that patient every day, a minimum
11 of every day and do that, and so hopefully in
12 the better world that our office is going to
13 provide, they'll be able to just make a quick
14 notation of that on the electronic health
15 record, but that does have to happen all the
16 time, and it's just a matter of whether or not
17 we document it.

18 and so I was only half facetious
19 with daily.

20 CO-CHAIR DENHAM: So for the
21 purposes of the record and just to recap the
22 committee's approval of going forward, Dr.

1 Meyer, could you restate what you propose?

2 CO-CHAIR MEYER: I propose leaving
3 the language in the additional specifications
4 as is so it would continue to say perform
5 quarterly prevalence studies, and then add the
6 New Jersey collaborative piece to the
7 implementation examples, and then in 2011,
8 we'll have the experience to go back and look
9 and see if we need to update it.

10 CO-CHAIR DENHAM: Great. Thank
11 you.

12 Peter. Go ahead.

13 DR. ANGOOD: And I am fine with
14 that, Gregg. I think that's a more prudent
15 way that keeps in sync. The only other added
16 work for the Committee here is within the
17 existing additional specs, we have underline
18 in blue two areas, which again is coming out
19 of the collaborative, and it is in the first
20 bullet under the second point, which is
21 including a comprehensive skin assessment.

22 And then the other is on the third

1 bullet down there. Each patient's skin and
2 risk for developing a pressure ulcer. It's
3 kind of one of those minor points. Oops, you
4 know, we're assessing for pressure ulcers, but
5 we forget to look at the skin part sometimes.

6 DR. ROMANO: That seems pretty
7 well accepted, I think.

8 DR. ANGOOD: So I just wanted to
9 make sure we're clear on that, and otherwise
10 we'll follow Gregg's recommendation.

11 CO-CHAIR DENHAM: So we're in
12 agreement on those edits. Great. So we'd
13 like Dr. Meyer to take VTE and anti-coag, the
14 two next.

15 CO-CHAIR MEYER: So on VTE
16 prevention, there, again, what we did was we
17 tried to reference other outside protocols and
18 guidelines and did not, I don't think, get
19 overly specific with that, and as a result,
20 even though this does still continue to evolve
21 in the literature, we didn't think that there
22 was anything that required an update of the

1 actual language of the practice or the
2 additional specifications.

3 But I want to just hear if there
4 is anybody who feels that there are any other
5 important studies that we're waiting on that
6 we ought to make sure that we reference.

7 Patrick.

8 DR. ROMANO: Well, My division
9 chief back home happens to have been a member
10 of the NQF committee on DVT/PE and is very
11 interested in that area. So I may solicit his
12 input on that as well, but both this safe
13 practice and the previous one really bring up
14 that situation that we talked about earlier of
15 the overlap with the previous practice related
16 to mitigation of risk, assessment and
17 mitigation of risk.

18 So either these should be sort of
19 co-imbedded under there or we should take out
20 that specific list from the earlier SP for
21 consistency.

22 CO-CHAIR MEYER: So I think you're

1 suggesting two things. One, in terms of we
2 did work with the other committee to make sure
3 that the two kind of matched up tightly there.
4 I think the future you have the notion that we
5 could roll some together and shorten the
6 message a bit is well taken. I think that
7 would be a 2011 task. I think that would be
8 a great idea.

9 Any other comments on VTE?

10 So we'll move to anti-coagulation.

11 Again, we kept what we had here, was quite
12 general. I think the notion that anti-
13 coagulation deserves to be set out is
14 important enough to put among a dedicated safe
15 practice, I think still was the right decision
16 to start, and I think the evidence is it's
17 still the right decision in terms of being an
18 ongoing high risk situation.

19 So I don't know if Mike or if
20 others have other comments about this.

21 DR. PRONOVOST: Gregg, the one
22 thing --

1 CO-CHAIR MEYER: Go ahead, Peter.

2 DR. PRONOVOST: The one thing you
3 may add, and it was some work done by one of
4 the pharmacists here who showed point of care
5 testing devices, you know, which are used
6 widely here and in the community, have a
7 systematic bias in that, and in about 40
8 percent of the time clinicians make the wrong
9 recommendation based on that.

10 I can send you the paper, but
11 essentially the misclassification is
12 clinically informative about half the time.
13 So it will say it's in the normal range when
14 the gold standard lab test says it doesn't or
15 it will advise you to reduce your anti-
16 coagulation level when, indeed, that wasn't
17 appropriate, and it wasn't a matter of just
18 calibration. It was the actual issues with
19 the device.

20 And I don't know how widely that's
21 known, but it can dramatically change how we
22 manage these devices throughout our system.

1 DR. BURGESS: Is that something by
2 Fanikos? Is that who you're talking about,
3 Peter, John Fanikos?

4 DR. PRONOVOST: No, it's Mike
5 Strice and I'm blank on the other guy's name.

6 DR. BURGESS: Okay. We'll look it
7 up.

8 CO-CHAIR MEYER: Yes, if you can
9 get that to Hayley and to us, that would be
10 terrific because that is a bit of a "yikes"
11 moment for me, I think, hearing you say that.

12 DR. PRONOVOST: It is for us, too.

13 DR. BURGESS: Wow. Thanks, Peter.

14 CO-CHAIR MEYER: Other comments on
15 anti-coagulation?

16 DR. COHEN: I don't have any
17 really.

18 CO-CHAIR MEYER: Terrific.

19 Contrast media. Yes, please.

20 DR. ROMANO: There are also some
21 Joint Commission National Patient Safety Goals
22 related to this area of anti-coagulation

1 management. So have we monitored for
2 consistency there?.

3 DR. ANGOOD: Yes.

4 DR. BURGESS: Not changing.

5 DR. ANGOOD: No, they are not
6 changing, and we'll continue to watch those
7 Patient Safety Goals. They are going through
8 a clean-up process as well and mostly language
9 and duplicative, ambiguous terms, et cetera,
10 but you know, that's one of the group that we
11 need to follow and one of the comments early
12 this morning was, you know, the more we can
13 drive practices and the goals closer in terms
14 of harmonizing without being one and the same,
15 then the better off we are.

16 CO-CHAIR DENHAM: We had a call
17 with the Joint Commission on Monday to just
18 kind of go through where they were on their
19 trajectory and kind of monitoring that as we
20 go just to keep track. But thanks for
21 bringing it up. I'm glad you brought it up.

22 Mike.

1 DR. COHEN: You have a glyceimic
2 control, but you never really focus on insulin
3 as a safe practice. Has that been considered?

4 CO-CHAIR DENHAM: I'll tell you
5 what. Let's get this one out of the way,
6 these next two, and then we'll go and have
7 Gregg cover glyceimic control.

8 On the contrast induced renal
9 failure prevention, you know, there is an
10 ongoing evolution of some of the guidelines
11 specifically for MR and gadolinium, and so
12 we're sinking this practice and kind of
13 monitoring those changes and those
14 recommendations along with the American
15 College of Radiology and subject matter
16 experts in that area.

17 One little minor change, and I
18 don't know if that's even a substantive, but
19 the idea of perhaps retooling the name of the
20 practice a little bit to a title of prevention
21 of contrast media induced renal failure and
22 other adverse events because there are other

1 adverse events that come and-- pardon me? --
2 because of NSF is why we're, you know, kind of
3 monitoring this closely, but we'll come back
4 to the Committee with kind of an update on
5 the problem statement with the latest data
6 because this is evolving.

7 We want it to be closer to the
8 time when the board kind of reviews it to make
9 sure the problem statement has all of the
10 latest material in it, but the goal would be
11 to synchronize the guidelines and the
12 recommendations along with society's.

13 Any comments there or is that
14 satisfactory to the Committee?

15 And then organ donation, that was
16 a new practice, Safe Practice 31. It's based
17 on a national collaborative that was very,
18 very successful improving the conversion rate
19 from 50 to 75 percent. We've had very little
20 push-back, and all of the national centers are
21 focused on these best practices, and I think
22 this is really gratifying.

1 For me, I was actually one of the
2 folks involved in watching this evolve, and
3 our new Assistant Secretary of Health, Howard
4 Koh, actually started a lot of initial work in
5 Massachusetts and then eventually was picked
6 up. Best practices were developed, and the
7 NQF Committee, I think, made a good choice to
8 bring this one on line, and we've had very
9 little push-back. So we wouldn't have any
10 substantive changes here.

11 We'll loop back with HRSA as we
12 get closer to our deadline to get done with
13 the report to have the latest data, but we
14 have no substantive changes.

15 Any comments from the Committee on
16 this one?

17 CO-CHAIR MEYER: The only
18 committee I'd make on this one as well is,
19 again, it strikes me a little bit like the
20 life sustaining treatment. It's just a little
21 bit outside of what comes off the top of the
22 mind for a safe practice. So if there's ever

1 another home to think about migrating it.

2 CO-CHAIR DENHAM: The interesting
3 thing is from the life saving standpoint, I
4 think one count just in a year is 4,100 lives
5 saved with this best practice. So if we move
6 it somewhere else, I guess we lose some of our
7 score board, but that's okay. We'll find a
8 home in the NQF scoreboard.

9 Gregg, do you want to take
10 glycemic control?

11 CO-CHAIR MEYER: Glycemic control
12 is probably one of the more controversial
13 issues over the last 12 months in the medical
14 literature, and so that prompted us actually
15 to go back and look at what we originally
16 wrote, and so we had a fair amount of
17 discussion about this while we were developing
18 this version. This was a new practice with
19 the 2009 release, and as we went back and
20 looked at this, we think the language is
21 general enough that, in fact, the new
22 literature is accommodated.

1 What we will do is we will update
2 the references with the latest study on
3 glycemic control. I think the real question
4 comes down to whether or not this should be
5 dropped, and I think that, again, as you read
6 it as it's currently written, it is general
7 enough that the change in kind of the
8 interpretation and the importance of glycemic
9 control and the dangers of tight glycemic
10 control I don't think change this.

11 But I think I'm open to that. I
12 think we're very open to that discussion. I
13 think this is a good time to have it.

14 CO-CHAIR DENHAM: And I think one
15 of the things we did because of this anxiety
16 was we got together with the hospitalist
17 groups and kind of reevaluated the whole thing
18 and revisited to see whether last time around
19 were we too prescriptive, were we not, and
20 actually we were pretty comfortable with how
21 it played out.

22 But I think Mike and then Patrick.

1 DR. COHEN: Yes. Actually I was
2 thinking maybe more of a focus rather than
3 just on glycemic control, but more of a focus
4 on the medications that are used for diabetes,
5 insulin, for example, and obviously other
6 agents as well, but the reason for that being
7 if you have one for anti-coagulants, insulin
8 is actually more of a problem for us when we
9 look at the database. It's pretty consistent
10 across databases, about 11 percent of the
11 patients that, you know, present with serious
12 medication errors or medication adverse
13 events.

14 DR. ANGOOD: And yet I think, you
15 know, your point is good. Maybe this is more
16 you can bump it up a bit higher and take it
17 towards high risk medications because we've
18 kind of got that buried in one of our other
19 practices.

20 DR. COHEN: Yes.

21 DR. ANGOOD: But we don't have
22 specific focus on high risk medications, and

1 that way we can cover the field better. I
2 think, Gregg, your suggestion that maybe we
3 even get rid of this one is a reasonable one,
4 not for right now, but certainly something
5 that we should seriously think the glyceemic
6 control piece, not the medication management
7 piece.

8 And who knows? In time there may
9 be more stabilization of the literature, but
10 I think it's one that will deserve some
11 critical review.

12 Patrick?

13 DR. ROMANO: Yes, I was just going
14 to say that I think that we may have struck
15 the balance about right in the sense that
16 really this is founded on the principle that
17 insulin and long acting oral hyperglycemics
18 are dangerous drugs and that there have to be
19 policies and systems in place to administer
20 them carefully.

21 Most of the controversy I think
22 that you are alluding to, you know, refers to

1 what specific targets should be and should an
2 out-patient target be six percent or seven
3 percent or seven and a half percent, whatever.
4 You know, what should our in-patient targets
5 be?

6 But we weren't that prescriptive
7 about those targets, I don't think, in this
8 document. So there is some latitude still for
9 each institution to come up with slightly
10 different targets based on its own
11 circumstances, but I think the specifications
12 here reflect the fact that there should be a
13 deliberate process for doing that and getting
14 all the stakeholders together to work together
15 on that.

16 CO-CHAIR DENHAM: Peter, did you
17 want to comment, Peter Pronovost?

18 DR. PRONOVOST: Yes, I was going
19 to say, Patrick, I completely agree with it.
20 I almost see this as more of a process
21 recommendation than anything to say that high
22 glucoses are harmful. Low glucoses are

1 harmful, and the evidence about how tight to
2 exactly be is emerging, and I think we should
3 acknowledge all of that, but independent of
4 that, health care organizations need to have
5 a process in place to manage this beneficial,
6 though potentially dangerous drug or these set
7 of drugs.

8 CO-CHAIR MEYER: So I'm taking
9 away from this that we would leave the safe
10 practice essentially as it is now. We'd
11 update the references with the newest
12 literature, and I think, Mike, what I think we
13 ought to do is think about a high risk
14 medication safe practice that we try to get
15 really tight for 2011.

16 CO-CHAIR DENHAM: One thing we
17 might consider just from the standpoint that
18 we live with these practices every day with
19 hospitals every day, and one of the things
20 that is not substantive, but might be an ease
21 of formulation might be anti-coag., glycemic
22 control, and VTE all live right now in this

1 bucket of "other," and it may be that we move
2 them into safe medication management chapter.
3 then we'd end up having the leadership
4 practice, MedRec and those three that might
5 have a little bit NP management in the future
6 because we've talked about that, which we'll
7 kind of conclude it.

8 Thank you, Hayley.

9 That might be a natural functional
10 chapter, although we'd renumber them again,
11 but then you end up having them organized
12 around people that are dealing with meds. and
13 high risk, an so that might be a consideration
14 for 2011.

15 Would we want to shuffle the deck
16 for 2010 and reorganize them again in terms of
17 their order in the book?

18 I'm not proposing that. I'm
19 saying --

20 DR. ANGOOD: No, but I think if
21 we're going to do a fairly thorough review
22 during 2010, as I made in some of my earlier

1 comments, we should look at how we're
2 clustering these, how we're naming them. I
3 would prefer not numbering them and sort of
4 come up with what that year will be, but then
5 begin also to strategically lay out what
6 subsequent years are potentially going to be
7 and begin to message the field so that they're
8 not whipsawed each year, but they know they're
9 going to grow into these things.

10 Because if you believe in that
11 sort of matrix concept that I was talking
12 about earlier, this is going to get to be
13 fairly complicated over time, and
14 communicating to the field is going to be
15 critically important because we don't want
16 them to be shunning away from these practices.

17 We've got good traction. We can
18 refine it certainly, but we don't want to over
19 step it and have a negative reaction.

20 Mike, do you want more comment?

21 DR. COHEN: Well, as you know, we
22 work with ASHP and another organization -- I

1 can't recall who it was exactly right now --
2 to help Joint Commission with the development
3 of the anti-coagulant safe practice or
4 National Patient Safety Goal, which pretty
5 much this matches, and we could easily do the
6 same for opioids and insulin, anti-diabetic
7 drugs in general, whatever. I mean the
8 practices have pretty much been identified.
9 they're in the literature, and you know, they
10 could be listed in whatever.

11 CO-CHAIR DENHAM: So if we're
12 comfortable we'll move to the next practice.
13 We've got two to finish and then we'd like to
14 make Don make a comment and others who want to
15 voice public comments.

16 But one aside is that we do have
17 on our list pain management as a high risk
18 area that might be under consideration for
19 2011, and we've talked with Mike about that
20 and that's kind of been one that's kept
21 surfacing because they're always in the top
22 five of adverse drug events in both PN and

1 sedation.

2 So, Peter, do you want to take
3 falls and then I'll finish up with the last
4 one?

5 DR. ANGOOD: Sure. Well,
6 congratulations to us for getting through on
7 time unless we go seriously off the track in
8 the last 15 minutes, and I've seen that happen
9 before though. And that's not having Don on
10 the microphone.

11 Falls are obviously a high profile
12 item. They continue to be very much in the
13 lay press as well as in the general health
14 care literature, and I think that there has
15 been a good series of work on how to move
16 towards better prevention and assessment of
17 risk for patients.

18 I think we've got a pretty good
19 practice here, and I don't think that we need
20 to have any substantive changes. We've
21 certainly not received any push-back on it,
22 but is there more comments or do we need more

1 specificity on this at this stage?

2 All right, Chuck, it's up to you
3 to derail us for the last 15 minutes then on
4 your last practice.

5 CO-CHAIR DENHAM: As a recovering
6 optimist, my hope is that we'll finish this up
7 quickly and Don will be able to start off with
8 our public review.

9 Pediatric imaging, this was a
10 practice that was submitted by the society's
11 very well substantiated work and really a
12 delight to work with. They followed all of
13 the NQF submission requirements. They got
14 everything organized. It was well done, and
15 then we worked very closely on cross-training
16 radiology. So it was natural to kind of work
17 with them and we've had no push-back
18 whatsoever.

19 Logical, good evidence, processes
20 are there, and it also from a Web linking
21 standpoint allows us to be able to link people
22 out, and this is the prevention of delivering

1 excessive doses of radiation to children.
2 Logical, face validity, good evidence, good
3 numbers, and so nothing substantive to update
4 on that practice.

5 And so to the Committee we would
6 not be updating anything other than the
7 problem statement and implementation guides
8 and tie the citations to those and we've had
9 no push-back from the community.

10 So, Peter, would you like to open
11 things up for public comment?

12 DR. ANGOOD: Sure, and again,
13 thank you everybody on the Committee for some
14 very strong work today. All very good
15 comments, and I think the next version of
16 these safe practices will clearly be more
17 substantially crisp and clear. It sets the
18 stage, I think, quite nicely for moving
19 forward into the next iterations of these.

20 Is there any public comment from
21 the phone lines, anyone who has joined us?

22 All right. We have Don Casey who

1 would like to provide some further -- come on
2 up again. There's no one else in the
3 audience, Don -- so Don Casey will provide
4 some further public comments and then we'll do
5 some wrap-up after that.

6 DR. CASEY: I have to sit next to
7 my old friend, David.

8 Thank you, again. I'll be brief.

9 I am currently the co-chair of the
10 Care Coordination Steering Committee, Chuck,
11 that NQF has convened, and I think there's a
12 lot of opportunity, Peter, for us to work with
13 Nicole McElveen on Safe Practices 12, 15, and
14 17.

15 We're doing a lot of work on
16 preferred practices as we speak. So I don't
17 think this should slow you down, but I think,
18 again, in the interest of harmonization, we're
19 trying to move from the handoff to what the
20 intent of the handoff is.

21 So I think you'll gain a lot of
22 perspective and at least even though it will

1 be -- I don't know time-wise, Peter, how this
2 will go. We may be out for public comment at
3 the same time you are. So we could do some
4 semblance of harmonization there. So that's
5 an offer.

6 Specifically related to 15,
7 discharge systems, I would say that we
8 recently published in the new updated heart
9 failure ACCHA guideline some statements about
10 heart failure discharge instructions with some
11 evidence that was graded, and I think it would
12 be well worth your while to reference that in
13 that section. Because, again, it's getting
14 specifically to showing the systems of care
15 for heart failure, and this could be, while
16 not perhaps totally specific to the paradigm
17 or totally generic to the paradigm, helpful in
18 terms of the elements that go into this
19 because heart failure has had a lot of work on
20 it.

21 Specifically, two to 17, and I
22 didn't get a chance to go through the whole

1 detail of the book in enough time, but I think
2 that, again, we have to think about the intent
3 of what medication reconciliation is, and I
4 think fortunately people are paying more
5 attention to it. Unfortunately most people
6 have now deemed it to be being sure the list
7 is accurate, and again, what's the intent?

8 So I don't know, Chuck, if you
9 have the space in this update to focus on
10 three other issues, which I'm sure Mike Cohen
11 would agree to. One is the issue at the
12 moment of reconciliation, discussing barriers
13 to adherence, and they could be a variety of
14 different things, including one
15 misunderstanding by the patient, economics, et
16 cetera, et cetera.

17 I think the notion of saying,
18 "What is all this junk anyway?" if I can be
19 pejorative, leads to being sure we had a
20 system in place when we reconciled to be sure
21 that the prescriptions are appropriate, and
22 that means having some at least back of the

1 envelope knowledge of potential adverse drug
2 events and drug-drug interactions at the helm
3 of this. So it's not just a list of junk --
4 excuse me -- but really using the opportunity
5 at every moment every day to say, you know, is
6 this working or not.

7 So I think we can push the
8 envelope on that. I realize Joint Commission
9 may not be there yet, but I still think
10 there's an opportunity.

11 With respect to central lines,
12 while I realize that the issue is infections,
13 we've come across some other major issues
14 related to competency, and we're actually
15 working on an organization-wide policy. We
16 found that residents who run codes just
17 routinely put central lines in because it's
18 easy, and we've had serious adverse events
19 related to the misinsertion of the central
20 lines and then subsequent failure recognize
21 complications that went on for a long time by
22 multiple providers.

1 So to me the opportunity to
2 prevent central line infections should relate
3 more specifically to the competencies. While
4 I don't have all that in writing, I could
5 provide that content to the group we're
6 actually meeting now to make a system-wide
7 policy on the criteria, et cetera for how we
8 do this, and there's pretty good evidence for
9 that.

10 And then I would speak against
11 trying to lump VTE and anti-coagulation. I
12 think the VTE really, while it involves the
13 administration of pharmacologic agents, it
14 really is broader than that. We've had a
15 program in place now for three years that's
16 organization-wide, and this is more about
17 probabilistic risk assessment and decision
18 making at every point in the step of, for
19 example, in our case a hospitalization. So I
20 feel that that is a related but separate
21 category of safe practice.

22 With respect to anti-coagulation,

1 we're also taking very seriously the Joint
2 Commission's notion of the systematic
3 approach. We've actually broadened. It looks
4 like it's kind of focused on the usual
5 culprits here, the heparins, the heparinoids,
6 and warfarin, but you know, if you think about
7 all of the medications that can cause bleeding
8 that are given in cardiology, we've actually
9 expanded that to the full list of anti-
10 coagulation and said that our systems
11 shouldn't just be around those two or three
12 classifications. It should be around the
13 entire spectrum.

14 And I could provide some
15 background about that. We've done an evidence
16 based analysis on it that I think would be
17 helpful.

18 I realize on 32 that the numbers
19 are floating around, and Peter knows this
20 better than anyone, but on the other hand, I
21 can say without violating any sort of pre-
22 publication knowledge that in the new STEMI

1 guideline update that I'm involved with for
2 ACC and HA, we are going to make a specific
3 numeric statement about an upper bound for
4 patients with MI.

5 So it's getting to not so much
6 worrying about a number, but rather maybe it's
7 focusing on target populations where there
8 really is good evidence at least on the upper
9 side.

10 We initially had a -- Eric
11 Peterson and I had a statement in the non-
12 STEMI guideline that had a lower bound in the
13 '05, where we've now harmonized that to make
14 it consistent with STEMI, and again, I can't
15 share that with you yet, but it may be out at
16 the same time, and so I'd say a little extra
17 work on that, maybe some collaboration with
18 ACC might at least help you frame MI.

19 So those are my specific comments.

20 DR. ANGOOD: Well, thanks again,
21 Don. I appreciate your thoughtful and
22 considerate critiques, which are always

1 helpful.

2 DR. CASEY: Peter, could I make
3 one more request? I just have this summary of
4 the safe practices score analysis and would
5 respectfully request that this Committee
6 consider referencing that in the update.

7 DR. ANGOOD: Sure, by all means.
8 Please submit that. Circulate it and we'd be
9 happy to have a look at it.

10 The comments that you just made,
11 if you want to submit some written comments
12 from that, that would be terrific as well.

13 The various comments you made
14 about the MedRec, the CLABS and the anti-
15 coagulation, et cetera, we'll certainly take
16 those into serious consideration. I think
17 that the CLABSI is certainly focused in on
18 infection.

19 However, the competency of
20 insertion is an issue that's been within the
21 education and maintenance of competence world
22 for some time. Unfortunately not all of the

1 organizations have adopted assessing
2 competency for the insertion of those lines.
3 Most of the training hospitals have begun to
4 do so, but in terms of maintenance of regular
5 competence for practicing physicians or
6 physician extenders, we still need to have
7 that monitored far more closely.

8 I remember one particularly
9 horrible case where there was a middle of the
10 night ICU resident that asked to insert a
11 central line by a junior, junior nurse who
12 then proceeded to watch this junior resident
13 try to stick this patient for about an hour,
14 and then the patient arrested. We got there
15 in time to realize this was all cardiac
16 tamponade and got the patient to the operating
17 room, opened the sternum and relieved the
18 tamponade and found no less than 12 puncture
19 marks in the aorta at the root of the heart.
20 So the guy was clearly way off base.

21 The patient survived fortunately
22 and all that sort of stuff, but you know, we

1 all have these kinds of horrible stories, and
2 the competency issue is not adequately
3 represented sometimes.

4 The medication reconciliation
5 piece, when I was at the Joint Commission that
6 was one of my biggest concerns always. This
7 is all about the list. This is not about the
8 appropriateness of the medications, and we
9 haven't got in the health care system yet,
10 although the discussions around the medical
11 home might begin to address it, who's in
12 charge of actually overseeing and monitoring
13 the appropriateness of the medications.

14 But MedRec clearly helps to drive
15 it a little bit, but you're right. It's kind
16 of about the list right now, and we need to
17 help look for ways within the safe practice to
18 push it back to the appropriateness of
19 medication as best as we can.

20 Your other comments, as I said,
21 were germane, and we'll certainly take those
22 into serious consideration.

1 Other comments from the panel?

2 And then Chuck has a comment as well.

3 Patrick.

4 DR. ROMANO: Well, I'm interested
5 in thoughts about, you know, this information
6 that you just passed around, and I've seen
7 that, heard about that study previously, and
8 as I mentioned earlier, I have a similar
9 concern about the Leapfrog safe practices
10 survey, and I can take that up with Leapfrog.

11 But I do wonder whether, I mean,
12 in general there's no evidence to my knowledge
13 that the domains particularly related to
14 culture can be adequately assessed in a
15 reliable and valid manner through a survey of
16 the type that Leapfrog and MedStat do.

17 And there have been efforts to
18 improve the validity of that survey in some
19 areas, particularly in the CPOE area, by
20 making things more specific and more
21 validatable, but in general it's still a
22 checkbox, and some of our hospitals, I'm part

1 of this Committee; you go through and we spend
2 many hours going through and checking off and
3 going through minutes and saying, "Well, did
4 we do this? Did we do that? Do we do it
5 annually? Oh, it was 18 months."

6 And I find it frustrating, and I
7 think you do, too. So is there a way that we
8 can put some type of disclaimer or somehow
9 engage Leapfrog in some discussion about what
10 we think some of the issues might be?

11 DR. ANGOOD: I met with Leah
12 Binder and a couple of the other Leapfrog
13 group staff recently, and we talked
14 specifically about that. How can we continue
15 to work better and to synchronize a little bit
16 more smoothly?

17 Chuck has been heavily involved
18 with Leapfrog for quite some time, and
19 certainly we'll ask him to make his own
20 comments on that.

21 I think that while Leapfrog has
22 its own agendas and its own purposes, there is

1 intent to try and work a bit more together.
2 Is it going to happen this summer? No, but I
3 think as we move forward over the next
4 iteration of this practice and the next one,
5 it's certainly part of my intent to figure out
6 how we can work more closely together on that,
7 as well as other patient safety initiatives.

8 CO-CHAIR DENHAM: Yes, I'd like to
9 just address this, you know, what Don has
10 handed out, and this is one of the most
11 important things, I think, that's happened in
12 the last couple of years that has really,
13 really concerned me, and that is that the co-
14 authors of the JAMA report are developers of
15 a competing measurement system.

16 The JAMA report addressed the 2003
17 safe practices measured in 2004. They've been
18 upgraded twice by the time that report was
19 written. That was not adequately addressed,
20 and it leads my hospitals -- and I live in
21 California where the author lives and where
22 the competitive measurement system exists.

1 And I've been in meetings with
2 anger generated by California providers who
3 have a vested interest in defeating Leapfrog
4 in public transparency for two reasons: one,
5 because the measurement system by which
6 they're measured. Number two is they have a
7 competitive measurement system, and to
8 miscarry science this way and to have a JAMA
9 article that does not address the fact that
10 the safe practices had been upgraded twice
11 since then and have no similarity to what was
12 published this year is just an abomination to
13 me, and it's a miscarriage of science, and I
14 think it's inappropriate.

15 And so, you know, I'm the first
16 one to say we need to have evidence, but I'm
17 also the first one to say let's have some
18 integrity in what we're doing. And I do
19 believe that that's why when we go around the
20 table here and we say, we'll, we have no
21 conflicts, anyone sitting on this Committee,
22 you're measured by Leapfrog. You're measured

1 against the safe practices. That really is a
2 conflict, isn't it?

3 Wouldn't it be in your best
4 interest if you had somebody on Wall Street
5 who sat here and said, "Well, your guys that
6 are measuring yourselves are going to kind of
7 defeat things that are hard to do, things that
8 are not in your budget." I mean, that just is
9 a no-brainer.

10 So I think we have to be very
11 transparent. We have to be very, very
12 careful, and I am very concerned about quasi
13 critical thinking. I am very concerned about
14 defeating practices because they don't have,
15 quote, evidence, unquote, when there is so
16 much face validity that it's just shameful.
17 It's absolutely shameful.

18 And I've sat in these committee
19 meetings where people are trying to vote down
20 things that will save lives. It's a no-
21 brainer. It doesn't take somebody to have an
22 M.D. or an R.N. to know it, and yet we're

1 going to sit and debate it, and so that's
2 where you'll find me cross swords with some of
3 the what I would say pseudo critical thinking
4 to defeat things that just have face validity.

5 And this is a complete miscarriage
6 of science. The JAMA article was just
7 absolutely -- and I guarantee you the
8 reviewers looked at the statistical methods
9 that were used, not the fact that they didn't
10 even look at the '09 safe practices or the '06
11 state practices, and the fact that the
12 headlines that came out were that the Leapfrog
13 survey doesn't have any correlation with
14 whether it's safer for patients or not, and so
15 I'm dealing with hospitals out there.

16 So I think that this is a very
17 clear example of the reverse of having
18 evidence. It's when you have got a point to
19 make. Never let the facts get between you and
20 a good story, and the story here was let's get
21 the Leapfrog.

22 So, you know, I mean, if we're

1 going to go on the evidence, if we're going to
2 go on good science, if we're going to go on
3 good work, let's really do it, and so I think
4 it's really important that we have a little
5 bit of common sense when we go through these,
6 and I commend the Committee for defeating some
7 of crazy critical thinking to put down
8 something for evidence for which there will
9 never be a study anyway.

10 That only makes sense, and it's
11 just fundamental good medicine, and so I
12 commend the Committee for doing that, but you
13 know, I think that this kind of material, you
14 know, it's just insanity because we have a
15 JAMA article that doesn't even make reference
16 to the practices that were only 20 percent
17 override.

18 DR. ANGOOD: Yes, and you know,
19 part of this next iteration of patient safety
20 at NQF will be to monitor the literature. I
21 was about ready to pull his balloon down, you
22 know.

1 (Laughter.)

2 DR. ANGOOD: But I just want to
3 have Don hear this. You know, we will monitor
4 the literature and look for these kinds of
5 things and be prepared to react to them and
6 actually the letter to the editor that we
7 wrote on that JAMA article was published two
8 weeks ago, and unfortunately, there's a word
9 count limit on letters to the editor, and you
10 get capped off in terms of the dialogue that
11 you can generate out of all of this, but it's
12 an important part of this patient safety
13 portfolio that we not just defend or react,
14 but we actually promulgate the work and the
15 critical strategies.

16 CO-CHAIR MEYER: So one request I
17 think I would make at a future meeting is for
18 us actually to get as a Committee from the
19 folks that -- I know RAND has been working on
20 this survey. I have gotten, you know, lots of
21 phone calls about it and, you know,
22 participate on focus groups for it and never

1 saw a finished product, and so I'd be anxious
2 for us to as a Committee, for us all to hear
3 from the folks that are developing the surveys
4 and just getting a sense of what's going on
5 out there. I think that would be a useful
6 educational session.

7 DR. ROMANO: IU mean, I don't
8 disagree with you at all, Chuck. I mean, I
9 think this was poor science, but the point is
10 not whether the safe practices make sense, not
11 whether they have face validity. The point is
12 whether this survey directed to administrators
13 in this way can measure the performance of
14 these safe practices in a reliable and valid
15 manner. That's the issue that I'm concerned
16 about, not the underlying merit of the
17 practices.

18 DR. ANGOOD: Okay. Other
19 comments? We've got the juices flowing again
20 after dredging you all through 34 practices
21 all day long.

22 David, is there any other tidbit?

1 Well, actually, I'm going to react
2 to Gregg first for a moment. Part of our HHS
3 work, as I made reference to in our opening
4 comments, is to do a bit of environmental scan
5 work, pre-work, assessment of the field, and
6 will build into future meetings sort of the
7 educational update and where we think the
8 field is moving along. So thank you for
9 challenging us with that.

10 But similarly then, David, any
11 kind of crystal ball scoping from your
12 perspective and where, again, you think we
13 should head not just on the technology, but in
14 general? And then we'll sort of finish it as
15 we go around the table.

16 DR. HUNT: Yes, I'll commend the
17 group because actually the trajectory that
18 we're on, I think, is very consonant with
19 where the Department of Health and Human
20 Services is moving.

21 I also want to point out that
22 other than the two or three opportunities

1 where there's immediate reference to where
2 information technology can plug right into the
3 practices, I'll expect and I'm hoping that
4 we'll be able to see over the course, once we
5 release our full plans, not every practice but
6 I would say 90 percent of the practices will
7 have something relevant to our work in our
8 office that can be linked into.

9 I saw obvious connections there
10 and, to be honest, it will be our job to make
11 sure that we make the obvious connections
12 very, very plain. So I think those are the
13 big things that I would say.

14 There was one other point that I
15 would make. The kids down the hall had double
16 stuffed Oreo cookies sitting out in the hall.
17 They took them down? So while they're
18 napping, I'm going to just suggest that -- no.

19 DR. ANGOOD: No, I like the double
20 stuffed cookies, but I also noted that they
21 had the nap room, you know. So we were almost
22 heading in there for a while, but we got away.

1 Any other comments?

2 DR. McAULIFFE: I'd like to work
3 with David on the technology piece. I think
4 that would be a fun thing to do.

5 But we were talking a little bit
6 ago about putting in central lines and the
7 story about a resident who ran into
8 difficulty, and I think that highlights a
9 larger problem that we haven't really talked
10 too much about, and that is trainees and the
11 supervision of trainees as they learn to do
12 things in hospitals, and it's not just a
13 resident problem. It's across the board, all
14 trainees, and I think it's something that we
15 need to build into some of these safe
16 practices. So I'd be interested in hearing
17 more about that.

18 DR. ANGOOD: Good, good. Mary.

19 MS. MacDONALD: The only thing
20 that I would add is as the consumer
21 representative, I really appreciate the hard
22 work that everyone has put in and the rigor

1 and also the idea that the patient remains the
2 focus in the center of everything that we're
3 talking about, not necessarily -- you know,
4 you tend to think about your own problems and
5 your own organization, but that the patient
6 remains the center of it.

7 And just one other quick
8 suggestion. Peter had suggested that David
9 come up with some ideas for future standards.
10 I think maybe something just on the
11 implementation of electronic charting and
12 electronic health records altogether kind of
13 best practices in terms of patient safety, the
14 kinds of training, you know, that's neither
15 the recognition that there may be, you know,
16 backfill needed as people are training and
17 those kinds of things. It might be something
18 to consider.

19 DR. ANGOOD: Thank you.

20 Patrick, other comments? Mike,
21 any other comments? Gregg and Chuck, do you
22 want to do some wrap-up comments or are there

1 any lingering agenda items that we didn't
2 quite catch?

3 CO-CHAIR DENHAM: We just have a
4 list of areas that were high interest areas
5 that we put kind of on ice for the 2011
6 update, and they include areas like the rapid
7 response teams, simulation, and the number
8 that were on original tables and lists, and so
9 because the decision was made to get these out
10 in January, you know, we've curbed the
11 enthusiasm, if you will, to add new practices.

12 But all of those will go through a
13 thorough review, and we're looping back with
14 a number of folks, and I think you'll be
15 making a call for practices to get on a cycle
16 so we can do a really good job and give the
17 NQF staff enough time to do a really good job
18 on their part to have them out by January 1 so
19 that hospitals have a corridor before payers
20 might start asking them to do thing and that
21 kind of thing, and to get them synchronized.

22 And so we really appreciate NQF,

1 you know, taking the leadership role to do
2 that because our hospitals out in the field
3 really would appreciate that, and so there are
4 some that we didn't address today that will be
5 brought up, that already have been brought up,
6 have some evidence and that kind of thing on
7 the prior listed tables, but for time today we
8 didn't go through them.

9 DR. ROMANO: Were you going to say
10 something more about these complex matrices at
11 the back end or is that for future discussion?

12 DR. ANGOOD: I made more of those
13 comments at the front end. I can work with
14 you through a further phone call or if we have
15 a couple more minutes, by all means.

16 I guess before, Gregg, you make a
17 comment, peter Pronovost, are you still on the
18 line? I thought I heard him check off.

19 So Gregg, please go ahead.

20 CO-CHAIR MEYER: So thanks to the
21 NQF staff and, as always, thanks to Hayley for
22 holding all of this together and all your

1 support.

2 Peter, I think the vision that you
3 place out there trying to pull the pieces
4 together under patient safety and the quality
5 forum is incredibly right-headed. It's not
6 going to be easy, but I think you've got a
7 good group of people here who are interested
8 in working on it.

9 At times when you get into these
10 discussions and you focus on the evidence, you
11 can get a little bit lost in terms of the
12 science here, and I got called out, as you saw
13 here, to deal with a brother-in-law who has a
14 methicillin-resistant Staph. aureus infection
15 in his knee following knee surgery literally
16 as we were talking about infection control,
17 and so it was a little bit of an "O.
18 Henryesque" moment, but it is a starkly
19 important reminder why this work is really,
20 really important.

21 So thank you for your time.

22 DR. ANGOOD: All right. With that

1 we actually met our mark by four minutes, and
2 I don't have to rush to meet Janet.

3 So thank you all, and we will
4 continue to work these. There will be E-
5 mails. There might need to be a conference
6 call, and then we'll continue to build up the
7 program overall.

8 So thank you very much and we'll
9 formally close the meeting. Thank you.

10 (Whereupon, at 3:27 p.m., the
11 meeting was concluded.)

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