Surveys on Patient Safety Culture™

New AHRQ SOPS Health IT Patient Safety Supplemental Items for Hospitals
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Speakers:

Joann Sorra, Ph.D.
Project Director, User Network for the AHRQ Surveys on Patient Safety Culture (SOPS), Westat (Moderator)

Jeff Brady, M.D., M.P.H.
Director, Center for Quality Improvement and Patient Safety, Agency for Healthcare Research and Quality
Rear Admiral, Assistant Surgeon General, U.S. Public Health Service (Presenter)

Tejal Gandhi, M.D., M.P.H., CPPS
Chief Clinical and Safety Officer, Institute for Healthcare Improvement (Presenter)

Naomi Yount, Ph.D.
Senior Study Director, User Network for the AHRQ Surveys on Patient Safety Culture, Westat (Presenter)

Presentation:

Joann Sorra
Sorra (opening), Slide 1

Hello, and welcome to our Webcast today on the New AHRQ Surveys on Patient Safety Culture Health Information Technology Patient Safety Supplemental Items for Hospitals. My name is Joann Sorra and I'll be the moderator for today's Webcast. I'm the Associate Director at Westat, and I'm the Project Director for the contract that supports the AHRQ Surveys on Patient Safety Culture.

Sorra (opening), Slide 2
Before we begin, I have just a few housekeeping details to go over. If you're having difficulty hearing the audio from your computer speakers, you can switch the audio selection by having WebEx call you at a phone number you provide, and you can then connect through your phone. In the event that your computer freezes at any point during the presentation, you can try logging out and logging back into the Webcast to refresh the page. Remember though, that you may just be experiencing a lag in the advancement of the slides due to your internet connection speed. During this Webcast at any time, you can use the Q&A icon to ask questions or request help.

Sorra (opening), Slide 3
Again, at any time during today's presentation if you're having technical difficulties or have a question for our speakers you can use this Question and Answer feature, Q&A. Depending on the browser you're using, your WebEx screen may look slightly different than this slide. So look for the Q&A icon and be sure that the drop down option displays all panelists for you to ask the question so our team can see it. Feel free to share your name or organization, or role when you type your question.

Today's session is being recorded and a replay of today's Webcast and the slides will be made available on the AHRQ Web site.

Sorra (opening), Slide 4

So now that we have some housekeeping items out of the way, I'm very pleased to introduce our speakers for today's Webcast. We're pleased to welcome Rear Admiral Jeff Brady, Physician and Director of the Center for Quality Improvement and Patient Safety at the Agency for Healthcare Research and Quality. Dr. Brady also serves as a Assistant Surgeon General in the Commission Corps of the U.S. Public Health Service. He has served as the director of AHRQ's Center for Quality Improvement and Patient Safety since 2014, and led the

AHRQ Patient Safety Research Program from 2009 to 2014. He leads a part of the agency that conducts AHRQ programs, which include patient safety research and the Surveys on Patient Safety Culture, healthcare-associated infections prevention, the patient safety organization program, the National Healthcare Qualities and Disparities Report, and the Consumer Assessment of Health Care Providers and Systems, or CAHPS Program.

We're also pleased to have Dr. Tejal Gandhi, who is the Chief Clinical and Safety Officer for the Institute for Healthcare Improvement, where she leads programs focusing on improving patient and workforce safety. Dr. Gandhi was President and CEO of the National Patient Safety Foundation from 2013 until 2017 when they merged with IHI. She continues to serve as President of the Lucian Leape Institute and holds an appointment as an Associate Professor of Medicine at Harvard Medical School. Dr. Gandhi is a prominent advocate for patient safety at the regional, national, and international levels driving educational and professional certification efforts and helping to create and spread innovative new safety ideas. She received her MD and MPH from Harvard Medical School and the Harvard School of Public Health, and trained at Duke University Medical Center.

And we also have Dr. Naomi Dyer Yount, who is the Senior Study Director at Westat, and an industrial organizational psychologist with more than 15 years of experience in organizational research and analysis. Dr. Yount has been involved in developing the database reports for AHRQ's Surveys on Patient Safety Culture and has worked extensively in analyzing and exploring data from the Hospital, Nursing Home, Medical Office, and Community Pharmacy Surveys on Patient Safety Culture. She also conducted psychometric analyses for these surveys. Dr. Yount is working on updating the Survey on Patient Safety Culture for Hospitals, to create Version 2.0, and recently worked on the development and release of the Health Information Technology Patient Safety Supplemental Item Set.

Many thanks to our speakers today, and without further ado, Dr. Jeff Brady will be our first speaker. Handing it over to you, Jeff.

Jeff Brady
Brady, Slide 5
Great, thank you, Joann. Just a quick soundcheck, can folks hear me okay?

Joann Sorra
Yes, we can, yes.

Jeff Brady
Great, thank you, Joann. I am really pleased to be introducing this topic and also telling you just a bit about how this patient safety culture and the surveys in particular fit into our broader research programs here at AHRQ.

Brady, Slide 6
Just a brief background on our current priorities on patient safety. I think it's probably clear to many in the audience that we focus on areas of greatest impact so that while we have lots of research looking at assessment of harm, epidemiologic perspective of patient safety where most harm occurs, we also transition through to solutions and understanding broader foundational issues like patient safety culture that you'll hear more about today.

We are also very focused on extending patient safety improvement to all health care settings. Obviously a lot has happened in the hospital. We're focused on a tool that is itself focused on the hospital culture and HIT in particular. However, our interests are quite broad across the full spectrum of care and all settings.

HAIs are a particularly important topic for us, as are all patient safety events and event types. But in particular HAIs, we have more substantial funding for that set of patient safety issues, and with a particular focus on antibiotic resistance and stewardship and related topics. A lot of our work really takes into consideration the capacity that we're trying to make use of, and in fact help build within health care to accelerate patient safety improvement. A key example of that is communication and engagement, not only between clinicians, but with patients, recognizing those foundational factors and the role they play in patient safety improvement. And then within that same vein, whatever our research is showing we want to always translate that into feasible and useful solutions and the simple way we describe that obviously is making the safe thing the easy thing to do.

Brady, Slide 7
You've heard a little bit about the programs that are in our particular center at AHRQ. The first three are patient safety focused. But the others actually are inclusive of patient safety topics and in particular the work that you're hearing today benefits from some of the methodologic expertise we have, not only within the agency, but in our

extended set of partners, the contractors, and grantees that we have. So survey methodology and the importance of making sure that we have the right level of rigor and these tools in resources, we get some efficiencies across our CAHPS Program, which is itself a survey-based tool. So just a little bit about how we try to make use of, again, a broad range of expertise.

Brady, Slide 8
Turning now to the topic of patient safety culture in particular, I think we all appreciate that patient safety culture can be defined as the beliefs, values, and norms that support and promote patient safety within an organization. These beliefs, values, and norms are shared by health care providers and staff in that organization. And the real key point and I think one of the main reasons we're so interested in patient safety culture is because it is one of the main factors that determines behaviors that are rewarded, supported, expected, and accepted within an organization. So when an organization uses a resource like the SOPS survey to measure patient safety culture they're in fact measuring directly these behaviors, again, that are rewarded, supported, and accepted. It's also important to note that culture exists at multiple levels from the unit level in a hospital to the department at larger levels all the way up to the hospital itself, and then finally the system. So these factors are all taken into account based on the structure and the way that the survey instrument is organized.

Brady, Slide 9
Just a little bit about the history of the program, which began in 2001 with the development of the Hospital Survey on Patient Safety Culture. We released that survey in 2004. That gives you a sense of the amount of energy, time, and attention that was put in to making sure that the survey performed as we wanted it to, and that it in fact is something that folks in operational settings can actually rely on to guide their work.

We now have more four more SOPS surveys that are available for the nursing home setting, medical offices, also community pharmacies, and finally the most recent in 2015 ambulatory surgery centers. The patient safety culture concepts that are measured across the surveys are similar. But for each development of each of these different settings the survey for each of these different settings, the team has adapted and tailored the surveys themselves to the issues that are specific to each setting. That's been our really important part of the development, because again, even though foundations are the same, the actual delivery of care differs in ways that actually are important for measuring safety culture.

Brady, Slide 10
We also support the SOPS databases, the intake data from facilities that voluntarily submit their SOPS survey data to AHRQ. The database reports show aggregate results and participating facilities can also receive feedback reports that compare their own individual results to those in the database. The number of sites and provider and staff respondents that are included in each of these databases are shown here on this slide in the screen. So over time this just becomes an increasingly rich resource that appreciates in value with more participation. So we're really excited about what this adds to the field, and again, the value that it brings to interpreting results at an individual organization level.

Brady, Slide 11
AHRQ has also recently released several supplemental item sets that can be added to the end of existing SOPS surveys. So there's the ability to tailor the core survey with the supplements. The Value and Efficiency supplemental item set helps hospitals and medical offices assess the extent to which their organizations place a priority on and adopt practices to promote efficiency, waste reduction, patient-centeredness, and high quality care. Another supplemental item set the SOPS, the Health IT Patient Safety Culture supplemental item set, the topic of today's Webcast, assesses how organizational culture influences HIT and patient safety. Obviously, HIT has enabled the health care system in many different respects to become much more safer. But we also are aware that there's increasing reliance on information technology. So I think this has grown, this resource has grown out of recognition that it's important for hospitals to understand the effects of HIT use on patient safety including some of the unintended consequences of HIT. So with that I'll turn it back over to Joann.

Joann Sorra
Thank you, Jeff. That was a great introduction to the SOPS surveys. Now we're gonna transition to Dr. Tejal Gandhi, who's gonna talk about optimizing the use of health IT to improve safety.

Tejal Gandhi
Gandhi, Slide 12
Thanks, Joann. I'm gonna talk about, as Jeff really alluded to in his comments, the importance of the use of HIT to improve patient safety, and how we really need to work to optimize it, and hopefully then make the link to the reason why this cultural assessment is so important.

Gandhi, Slide 13
At the National Patient Safety Foundation a couple of years ago, we had done a report called Free From Harm. It was really intended to look at where we've been in patient safety and where do we need to go.

Gandhi, Slide 14
One of the key components to this report was really eight recommendations that we came together with an expert panel to create around how do we accelerate our progress in patient safety. Those eight recommendations are listed here. The first, and actually these are not in any particular order, except for the group very unanimously felt that the first should be the first, was around ensuring that leaders establish and sustain a safety culture. Jeff spoke about the importance of that. But the ace was ensure that technology is safe and optimized to improve patient safety. One of the reasons that this ended up as a recommendation, we were really trying to develop foundational recommendations to improve foundational areas in safety, and the fact that technology is so ubiquitous now in the health care that we deliver, we felt like technology needed to be included as a foundational concept that needed to be optimized, again, to achieve quality and safety.

Gandhi, Slide 15
Here are some examples of why technology has really been really critical in trying to reduce errors. Most people, when they see this, see Coumadin 4 milligrams, and it's actually Avandia.

Gandhi, Slide 16
Here's another example of technology benefits as well as challenges. The complex ICU patients that need so many different medications and drips and so forth, and the technology with the pumps can really help to make sure that we're delivering all those, but also it's incredibly complicated to manage and have opportunities for unintended errors as well.

Gandhi, Slide 17
This is, as we think about safety not just in hospitals, but in the out-patient setting, this is the complexity potentially of what patients are having to deal with in the home. And again, I think there are ways that technology can potentially help to improve the medication management process in the entire continuum of care.

Gandhi, Slide 18
There's been a lot written about how IT can improve patient safety and in this article the authors really talk about three major ways that IT can improve safety. First, by preventing errors and adverse events. Secondly, facilitating a more rapid response after an event has occurred. And third, tracking and providing feedback about adverse events.

Gandhi, Slide 19
There's many ways we think about that prevention of errors piece, which was in the first bullet in adverse events using IT. There's many ways that technology can really facilitate that prevention. So technology can improve communication, make knowledge more accessible, require certain key pieces of information, for example, requiring that a creatinine level is present if you're ordering a drug that's cleared by the kidney, assisting with calculations, performing checks in real-time, assisting with monitoring, and providing decision support. So many ways that technology can help with that error prevention.

Gandhi, Slide 20
We know from studies that have been published that some technologies have the potential to reduce errors significantly based on some of those strategies I just went through. These are some of the common examples that we talk about, particularly computerized physician order entry, or provider order entry, which has been around for a long time and probably is the most well studied, and has been shown to significantly reduce medication errors, as well as things like barcode technology, electronic prescribing systems, handoff tools, and test result systems, and referral systems. These are the kinds of technologies that have the potential to really reduce errors significantly.

Gandhi, Slide 21
We also know that technology has been adopted at a rapid pace over the last several years. These are older slides and this curve has continued to move up.

Gandhi, Slide 22
But once incentives started, particularly the adoption of EHRs in the ambulatory care setting and EHRs in hospitals, really went up significantly.

Gandhi, Slide 23
With that significant rate of adoption we've also started to see that there is a need to optimize these systems. As I mentioned, these systems have the potential to reduce errors, like commute the computerized physician order entry and so forth. But unless they're implemented, actually designed and implemented well, they may not actually achieve all of those benefits. So really, I think the attention over the last decade was convincing people to adopt and implement and I think our focus going forward is really around how do we design and implement well so we actually achieve the quality and safety benefits that we think we should be achieving with these systems. In order to do that we have to optimize these systems, thinking about things like over-alerting, for example. We all know that there's far too many alerts in these systems. So how do we reduce over-alerting in a smart way? How do minimize variability across vendors? Improve interoperability? And also improve implementation? A recent statistic from Leapfrog shows that 42% of hospitals are failing to scan both the patient and the medication for at least 95% of administrations. The technology is there but if the patient and medication aren't being scanned we're not gonna achieve the benefits that we're hoping for. And we know there can be unintended consequences. One of the most commonly described one is copy and paste or cut and paste and that fact that clinical documentation have become very difficult to wade through because of the prolific use of copy and paste. Other unintended consequences are the fact that we have medication lists and problem lists now very visible in the EHR, but maintenance of those has become a real challenge and we don't really have robust processes to make sure that those lists stay accurate in the system and are updated as needed.

Gandhi, Slide 24
There's been quite a bit of study about unintended consequences and particularly around CPOE, computerized physician order entry. This is that study that really talked about the fact that anytime you implement a new technology you have to look for those unintended consequences. CPOE, in particular, led to the ones you see here in terms of changes in workflow that were not intended, overdependence on technology, new errors that came in, etc. So it's just a really important lesson to realize that every new technology, although it may have great benefits, also can potentially introduce new problems that need to be identified and addressed.

Gandhi, Slide 25
This, I think, is one of the unintended consequences that perhaps we didn't really foresee. But we're seeing now that EHRs are being identified as a source of burnout for our clinicians. We hear about this both for physicians and for nurses. So again, a really important unintended consequence that needs to be addressed by thinking about design, implementation, usability, etc.

Gandhi, Slide 26
This is a model that was published in 2010 called Sociotechnical Model. It's really getting into the components of how do you successfully implement. As I said, we've focused on adoption, but now we need to focus on better implementation and design. So this model talks about eight components for successful implementation, and you see the eight listed there. It ranges from hardware and software, which I think we focus on a lot on the software side, but there's many other components as well that are really critical. I highlighted in red things related to people, related to workflow, communication, and culture as really being critical components for successful implementation. As I said, we often focus on the technology side, but it's important to understand the culture, people, communication pieces, etc. are also really critical for successful implementation.

Gandhi, Slide 27
This is why I think the HIT culture is critical to HIT success. We need to create a culture of HIT safety that's a critical foundation to improving safety using technology. So what do I mean by that? Things like is our organization open to hearing about HIT-related safety issues? Some of those unintended consequences? Is there feedback about safety issues? If I report a problem with the system do I hear back about what's been changed or not changed? Is there punishment and blame? There's many strategies that exist to make culture change that can be relative to HIT. For example, having robust reporting systems that are able to capture HIT-related issues, doing walkrounds to identify technology-related problems, particularly in times of significant implementation. This need to create a culture is really critical for HIT implementation and it's great that Westat and AHRQ have worked to develop a tool to actually help measure where your HIT culture is, which will be, I think, a significant advancement, especially for organizations that are both in the middle of adopting, about to adopt, and have even gotten past adoption of some of these major systems to understand how their staff really feel about the way technology is managed in the organization. With that, I will pass it back to you, Joann.

Joann Sorra
Great, thank you so much, Tejal. We've had a great background about the AHRQ Surveys on Patient Safety Culture and about use of Health IT as it relates to culture and now we're gonna hear from Dr. Naomi Yount,

who's going to introduce the AHRQ Survey on Patient Safety Culture Health IT Patient Safety Supplemental Item Set. Naomi.

Naomi Yount
Yount, Slide 28
Thank you, Joann. I'm gonna talk with you about the development of the Health IT Patient Safety Supplemental Items, and share results from a recent pilot study we conducted.

Yount, Slide 29
Westat under contract with AHRQ did design a supplemental item set that can be added to the end of the Hospital Survey on Patient Safety Culture. The goal of the item set was really twofold: to raise awareness about the impact of Heath IT on patient safety, and assess how culture influences Health IT and patient safety.

Yount, Slide 30
Our development process for that item set followed our standardized process for the SOPS surveys in general. The first thing we did was review literature and existing surveys to see what's out there and what the key issues were. We also identified technical experts and formed a technical expert panel. We interviewed experts in the field, as well as providers and staff to get the different perspectives of Health IT and patient safety. From these steps we identified key thematic areas that are important for culture and Health IT in patient safety. From those areas we developed draft items, and we cognitively tested those items. So that means we went out to people who would likely take the survey, providers and staff, and made sure they were understanding the items the way that were intended. We made edits to those items based on those tests, and it was an iterative process where we went back then out and cognitively tested more until we had a set of items that we were pretty confident about. Then we went and got more input along the way. We were getting input from our technical expert panel. We agreed on a set of draft items. We pilot tested them. We conducted psychometric analyses to look at the reliability of the items, the variability. And then we shared those results with our technical expert panel and finalized the items, which were released this year in March.

Yount, Slide 31
We had about five topic areas. We had patient safety and quality issues which really get at some of those unintended consequences Tejal was just talking about. We had two composites, an EHR system training of three items, EHR system support and communication, three items, and then the rest are single item measures revolving around workflow and work process, and an overall rating on your EHR system. In sum there were 16 items. The one item that's not listed here is a filter item that's at the beginning that asks do you use your hospital EHR system to enter or review patient information? Because the Surveys on Patient Safety Culture are often administered to all staff, this filter question was added so that staff who are not using the EHR could skip out of the questions.

Yount, Slide 32
We did the pilot test in 44 hospitals in the Spring of 2017. We had a 42% response rate, about 15,000 respondents. Of those 15,000 respondents 69% said yes to the filter question that they use their hospital's EHR to enter or review patient information.

Yount, Slide 33
The first set of items was really about the patient safety and quality issues. They were asked in the past three months how many times did you discover these types of issues, the first one being incomplete information in the EHR system. We see that 66% of respondents found or discovered incomplete information in the EHR system at least one time in the past three months. Also in the survey at the very end of the survey was an open-ended comments box. So after they took the Hospital SOPS and the supplemental items they could do any open-ended comments they wanted to talk about other issues in their hospital and I'll just provide some sample comments as we go through some of these different issues. Some sample comments for incomplete information, we see here "I would have to say I find incomplete charts almost all the time." "There is still often missing information that affects patient care."

Yount, Slide 34
The next item we see 64% of respondents indicated that information was hard to find. Some sample quotes here are "There are way too many places to chart things and it's very hard to find information." "We are using three different computer systems for each patient." "The information is very fragmented and hard to find and put all in one place."

Yount, Slide 35
61% of respondents discovered information was not accurate. Some sample quotes are "A lot of the medication lists are either wrong or patients are having to call us back to update their medication list." "I do a lot of chart reviews and I frequently find wrong information in physician progress notes."

Yount, Slide 36
29% of respondents discovered incorrect information was copied and pasted. Some sample quotes here are "Physicians sometimes copy and paste incorrect information in notes." "I think the errors in the charting occur when people get in a hurry and copy and paste."

Yount, Slide 37
Finally, we see 32% of respondents said that information was entered into the wrong patient health record, or they discovered that it was entered into the wrong patient health record at least one time in the past three months. Just one simple quote here is "Patient information is scanned in the wrong patient chart. I notify the appropriate person of these errors."

Yount, Slide 38
One of the composites was EHR system training. We see that the composite score, which is basically the average of the items scores is 64% positive. By percent positive, it means that they strongly agreed or agreed with the item. This composite is comprised of three items. We are given enough training on how to use our EHR system. Training on our EHR system is customized to our work area with the highest percent positive at 67%. We are adequately trained on what to do when our EHR system is down at 62% positive, or 62% strongly agreeing or agreeing with that item.

Yount, Slide 39
Some sample comments are "There is not formal training for the EHR, you learn as you go." "I have not been trained at all on how to use this program. It seems no one has the time of day to give me any training." "No one really knows what the requirements are for using downtime forms."

Yount, Slide 40
The other composite is on EHR system support and communication. It has a 50% positive. It's got 50% positive, which is a little bit lower than the other one. We see problems with our EHR system are resolved in a timely manner. 55% of people answered strongly agree or agree. 39% answered positively to: We are asked for input on ways to improve our EHR system. And 55% answered positively to: We are made aware of issues with our EHR system that could lead to errors.

Yount, Slide 41
Some sample comments here are "We would like more responsiveness by IT in making adjustments to our electronic charting format." "I wish that nurses would be consulted more frequently on how to improve the EHR." "Changes are made to our charting, and nothing is said. We find out because we open the chart and find new fields, new pages, new requirements."

Yount, Slide 42
Then we have a set of three single item measures that revolve around workflow and work process. The first one is: There are enough EHR workstations available when we need them. Where 69% strongly agreed or agreed with that item. Now we have two negatively worded items or reverse coded items, which means that to be a positive response they have to disagree with the question. The first one is: Our EHR system requires that we enter the same information in too many places. Where we see only 21% strongly disagreed or disagreed with that item. The next one--There are too many alerts or flags in our EHR system. Where again, only 37% strongly disagreed or disagreed with that question.

Yount, Slide 43
Some sample comments for this one are "We need more portable workstations or a computer in every room." "Our EHR has too many places that we have to double document information such as vitals, pain intake and output, that could lead to mistakes." "Everyone just leans to accept they will need to override so many alerts and warnings that people tend not to read them and miss significant drug interactions."

Yount, Slide 44
The item set closes out with an overall rating items, which asks respondents how satisfied or dissatisfied are you with your hospital's EHR system? You can see here only 6% are very satisfied with the EHR system. If you

combine it to very satisfied and satisfied we get 45% of respondents. And then you can see the distribution where 33% are neither satisfied or dissatisfied. 15% are dissatisfied, and 7% are very dissatisfied.

Yount, Slide 45
And the quotes speak to this. "The EHR system at our hospital is the worst EHR system I have ever used." "EHR is not user friendly." "There are too many issues, absolutely not user friendly and potentially can cause serious issues."

Yount, Slide 46
I just briefly went over the results, which are also available in the Pilot Study Results Report on the AHRQ Web site. Also on the Web site are the items available both in English and Spanish. In addition, there's a resource list, which contains links to practical resources to improve patient safety as it relates to the use of Health IT in hospitals. That resource list is organized by the measures in the item set and it has things on how to improve alert fatigue, or the safe use of copy and paste. There is also a data entry and analysis tool. That is an Excel-based tool. Therefore, if you wanted to administer the item set you could data enter it into this Excel tool and it automatically calculates the scores for you for each item and compares it to the pilot results.

Yount, Slide 47
The good news is that during the next Hospital SOPS data submission in 2019, AHRQ will be collecting the Health IT Patient Safety item set data. In order to get this data you would administer the hospital SOPS data with the Health IT patient safety supplemental items at the end. And we would ask that you include the filter questions at the beginning so that those who might not use the EHR or not review information in the EHR they can go ahead and skip out of the supplemental items. A benefit of submitting to the database is that you would receive a customized feedback report that displays your results in addition to that of the database, and also your results would be included in aggregate into a database report that would go onto the AHRQ Web site.

Yount, Slide 48
To stay up to date and informed about when that data submission will occur or any news about the Surveys on Patient Safety Culture in general you can go to the AHRQ Web site. In the top banner you'll see email updates, and if you scroll down there's a lot that you can stay updated on. If you scroll down the Surveys on Patient Safety Culture you'll be able to sign up for updates by the various survey settings. For example, hospital or medical office, nursing homes, pharmacies. And with that I think I'll send it back to you Joann, and thank you.

Joann Sorra
Sorra (closing), Slide 49
Thanks, Naomi. We're gonna now switch to the Q&A portion of the Webcast. As a reminder you can type a question in the Q&A box, which is shown on the slide. To access the Q&A box you may need to select the button with the three dots at the bottom of your screen and select the question mark Q&A for it to appear on the right panel of your screen. Be sure to send your question to all panelists, and feel free to share your name and/or organization or role when you type your question. Depending on the browser you're using, your WebEx screen may look slightly different from the slide. So at this time please submit your questions through the Q&A box.

I see during the webcast we did have a few questions submitted and for our speakers, I'll let you know if any of these questions are targeted for you. But those that I can answer I will answer.

The first question we received was: "For the composite measures are the questions equally weighted?" And yes, the answer is yes. For those composites where they consisted of three items, the scores for those items would then be the percent positive scores would be calculated and then averaged across to come up with the composite score.

The next question was: "Can we administer the Health IT item set as a standalone survey?" I just want to say the supplemental items were designed for use with the core Hospital Survey on Patient Safety Culture. So they should be added at the end of the Hospital SOPS survey. More specifically you would add these Health IT items between section G, which is number of events reported, section H background information, which is at the very end of the survey. You'll also be sure to include the initial filter question and any subheadings.

Another question we received was: "Is it possible to include select items from the Health IT Supplemental Item Set and not the whole item set?" Our answer to that is that the supplemental item set is intended for those who enter or review patient information in your hospital's EHR. And it was not designed to be completed by staff in your hospital's IT or clinical informatics departments. So what we recommend is that you use the questions that

are associated with the composites and that you administer all of those questions because that way you'll be able to compare your results to the composite level results.

Another question: "What other supplemental item sets are there for SOPS surveys?" In addition to the Health IT Supplemental Item Set for the Hospital Survey there's also a supplemental item set on value and efficiency for hospitals and medical offices. And the value and efficiency item set assesses the extent to which organizations place a priority on and adopts practices to promote efficiency, waste reduction, patient-centeredness and high quality care at a reasonable cost.

As a reminder, again, you can submit your questions through the Q&A in the browser. And again, your free to submit your questions at any time.

Another question that we're receiving is: "When will the Hospital Survey of Patient Safety Culture Version 2.0 be released?" AHRQ and Westat are currently doing more cognitive testing of the survey items and will be conducting a pilot test. We're expecting to release the updated version in 2019, most likely in the Summer of 2019. AHRQ will keep everyone posted on data submission dates for the hospital database as we get closer to those dates and at that time the Health IT items can be submitted along with the hospital survey data in the hospital database.

Let's see, the next question I'm seeing here, will these supplemental items be revised or are they compatible when the new hospital Version 2.0 survey is available? At this time, there's no plan to revise these Health IT items. These will be able to be added to the end of either the current Hospital Survey on Patient Safety Culture or the Version 2.0 when it is made available.

Next question is: "We are surveying this Fall, and then adopting a new EHR before the next survey cycle. Do you think it would beneficial to add the Health IT supplement this Fall, and then to survey after implementation to measure for improvement?" Naomi Yount, would you like to answer that question? So again, there's a user who's surveying this Fall, then adopting a new EHR and could potentially survey again. So would you recommend that they administer the survey, the Health IT items, this Fall and then again after implementation? –

Naomi Yount
Hi, thank you. Yeah, I think you could do that. In general, when we did the pilot, when we were in the middle of doing it, we would recommend not administering the survey as people are learning the new or transitioning over. But if you're going to do it in the Fall, and you want to administer it now before you've started that process and then again after, maybe six months after, I think that would be fine. Joann, did you want to add to that?

Joann Sorra
No, I don't think so. Okay, another question, this is for Dr. Brady. "What do you find most interesting or exciting about the Health IT items set from a patient safety perspective?"

Jeff Brady
Yeah, thank you, Joann. I think my answer on this is not much different than the full set of surveys. It's just more directly applicable to health information technology. I think Tejal and Naomi did a great job of describing all the different facets of this issue. In general, I think most hear about these with respect to either provider burnout or just the technical challenges of implementing health information technology and managing this information rich process that we have in health care. I think what's most exciting to me about the surveys is they really help translate that awareness of the fact that there are some challenges and even big problems here, some of which have a direct impact on safety. To translate that awareness and move from anecdote to action at the organizational level. It's really important because every organization is not necessarily the same. The issues may be different. One may be having more issues with duplicate entry. That's one of the items on the survey. We have to enter information in too many places. Another may have more of a challenge with excessive alerts or flags. I think to really manage two of the current problems and appropriately prioritize limited resources, it's important for each organization to know that that kind of information from their staff's perspective. So again, just the ability to translate that general awareness into more specific action is what really impresses me the most.

Joann Sorra
Great, thank you for offering that perspective. Next question I'm gonna send to you, Tejal, and it's about the fact that the Health IT supplemental item set doesn't specifically address this issue of Just Culture or punishment and blame. Does punishment and blame have a role as it relates to Health IT culture? And how do you think about Just Culture as it relates to Health IT use and Health IT culture?

Tejal Gandhi
Sure. I think Just Culture does have relevance, and I know there's components of that that are present on the main SOPS survey. But certainly when you're thinking about HIT, particularly if an error occurs, I think it's really important when doing the deep dive into why those errors occur to really go, again, like we do with any safety event, beyond blame and punishment in terms of the clinician didn't do XYZ with the technology correctly, so let's blame the clinician. We don't want to stop there. We want to actually say why didn't they use the technology as it was intended, and are there usability issues or training issues or other things. So I think we still are seeing that organizations essentially are blaming the user as opposed to really digging deeper into what were the contributing factors that led to the potential misuse or erroneous use of that technology.

Joann Sorra
Yeah, those are great points, and I don't know if, Jeff or Naomi, you have anything you want to add to Tejal's comments on Just Culture as it relates to Health IT.

Jeff Brady
Naomi, anything you'd want to add first?

Naomi Yount
No, go right ahead.

Jeff Brady
Sure, yeah. I think just focusing on maybe one section to add some detail to Tejal's answer, which I completely agree with, I think a big part of culture that we know that's important for patient safety is respect and responsiveness and while those words aren't used explicitly in the survey, I definitely can see those concepts represented in items like problems with our EHR system are resolved in a timely manner, or we're made aware of issues with our EHR system, again thinking about these kinds of responses from a staff perspective. A lot of what's embedded in the way that they answer those questions has to do with respect and responsiveness and just recognition that what frontline clinicians see is critically important to patient safety. I mean, this is a high reliability concept that is fundamental to that conceptual frame. So again, I think I could see how it's a bit harder to trace the connections of blame and punishment in comparison to the other sets of tools in the patient safety culture survey. But I think they are definitely here in health information technology as well.

Joann Sorra
Great, that's actually, that's quite helpful. Thank you for offering that perspective. Two other questions here more around use of the survey. "Can these Health IT questions be used in a medical office population that has an EMR?" Naomi, would you like to answer that question?

Naomi Yount
Sure. What we can say is that it has not been tested in the medical office setting, and not all the items may be relevant. So I think we can't say no, don't use them there, because there are probably many items that are relevant. But they have not been tested in that setting.

Joann Sorra
Okay, great. And then I think we have one final question. "Will AHRQ also be accepting submissions for the value and efficiency supplemental items?" And what we can say is that yes, we're working on that and so the expectation is that when the hospital database is open for submission that both the Health IT item set and the Value and Efficiency item sets will be able to be submitted at that time.

And it looks like we're able to get through all the questions. So we are basically at the end of our time. So, great. And I just want to say that thank you to everyone for attending. Thanks to our speakers.

Sorra (closing), Slide 50
A brief Webcast evaluation will be pop up when you close out from today's Webcast. So we encourage you to please take a moment to provide us your feedback as it helps us improve our offerings and plan future events that meet your needs. We also invite you to visit the AHRQ Web site and contact us at any time by email or phone if you have additional questions or need technical assistance. So thanks again so much to our speakers today for this Webcast and thanks for joining us.

This concludes today's presentation.