

ONC Health IT Patient Safety Action & Surveillance Plan

Constance Gillison: For today's session, we will be discussing the National Coordinator's Health IT Patient Safety and Action Surveillance Plan. I'm Connie Gillison, and I will be your host today. Now, I'd like to introduce our guest speakers. Leading the discussion today will be LaVerne Perlle, Sandra Rausch, also known as Sandy, and Dr. David Hunt. LaVerne Perlle is a nurse consultant at the Office of the National Coordinator in the Office of the Chief Medical Officer. She also provides support to the Office of Provider Adoption and Support. LaVerne functions as a nurse informaticist across the domains of health IT adoption, patient safety, and electronic clinical quality measures specification.

Sandy is also a nurse consultant at ONC within the Office of the Chief Medical Officer, focused on patient safety. She has more than 35 years' experience as a registered nurse in federal, military, and private sector health care environments. Dr. Hunt, a general surgeon that has been with ONC since 2007, is the medical director for patient safety. Without further ado, let me turn it over to LaVerne.

LAVERNE PERLIE: Welcome to our presentation on the Health IT Patient Safety Action and Surveillance Plan, which was recently released in July of 2013. At the end of this webinar, you'll be able to understand how federal health information technology safety policy is applied to clinical practice, and you will be able to learn how to -- the use of upcoming patient safety resources can be used to guide providers in improving quality and reducing patient harm across practice settings.

I've been a nurse for 19 years, working in various specialties across hospitals, medical facilities, insurance companies, and federal agencies within Maryland. My federal career began at the Centers for Medicare and Medicaid Services about five years ago in the clinical standards and quality division. I also have worked as a nurse consultant in the Office of Financial Management in the Division of Recovery Audit Operations. My role as a nurse consultant/nurse informaticist here at the Office of the National Coordinator includes: strategic planning. Also, my real focus is on meaningful use impact assessment, health IT adoption, patient safety, nursing informatics collaboration, some work groups, and barrier [spelled phonetically] analysis of EHR adoption among healthcare providers. And next, I'll turn it over to Sandy.

SANDRA RAUSCH: Thanks, LaVerne. Like LaVerne, I also have a varied nursing background. I have over 35 years of nursing experience, 30 of which has been with the Air Force. I retired in 2008 as a colonel. It seems I can't stay away from government work, as I served at DoD as Director of Quality, with the VA as Patient Safety Manager, and now I'm with the ONC in the Office of the Chief Medical Officer since March. I'm currently working in the same project areas as LaVerne, mainly patient safety, which is my primary focus.

This afternoon, we will describe OCMO functions, the Health IT Patient Safety Action and Surveillance Plan, recent legislations related to patient safety, an overview of patient safety organizations, and provide you resources for additional information. Now, I would like to turn over the presentation to Dr. David Hunt, medical officer for ONC, who will speak about safety from a provider's perspective.

DAVID HUNT: Sandy, LaVerne, thank you both very much. I really appreciate this opportunity to really speak about the safety plan, but more specifically and in particular, to talk a little bit about the provider's perspective. One of my primary roles here at ONC, and by extension today, is really to give a greater context for this work, as well as to go into a bit more depth for some of the areas that are directly relevant to the everyday clinical work of providers, and thus, relevant to your work in helping providers as regional extension centers.

Now, you should know that I approach everything by starting with this historical context, and it may surprise you, or it may not, that safety and health IT isn't really new. You know, way, way, way, way back, back in 2003, Paul Tang led a team that issued an IOM report focusing on patient safety and health IT. And while he was also on the team that wrote this latest IOM report that prompted our ONC plan, I always like to say that his work from 2003 really still holds up, and it more than holds up. You will actually find the formulation of the foundations for our current work in health IT safety in that report. In particular, the team from 2003 most clearly articulated the relationship between work in patient safety and work in quality when they wrote that patient safety is indistinguishable from the delivery of quality healthcare. Now, I want you to remember that, because that's a really key concept.

Now, let's fast forward just a bit to 2009 and the HITECH section of the recovery act, in which is a bold statement to reflect -- that reflects that health IT is formally and inextricably linked to improvements in our healthcare system. You know, that statement -- that act, actually, encoded our office as an operational division of HHS, and it

advanced the proposition that we are at a strategic point of inflection, and that ONC has the very interesting task of enabling the widespread use of information technology, and thus is a key element at this point of inflection.

A summation of this statement can be seen in the very first section on which I've highlighted here. You can see the verbs and the nouns that are used actually. We are to ensure, we are to improve quality, reduce errors and reduce disparities, reduce costs, provide appropriate information, ensure. It goes on and on. As you can see, this is no mere undertaking, because a realistic translation of this is that we have to improve safety and the coordination of care, as well as inform our institutions of public health, as well as promote -- prevent -- promote prevention and reduce disparities. And all of this is really a prelude to what we're going to talk about in terms of how we see health IT and patient safety making a major step toward all of these issues and improvements in all of these issues.

I'm going to let LaVerne tell you a little bit more specifically about our mission and vision in the Office of the National Coordinator in our Office of the Chief Medical Officer. But I wanted to make sure that that was an essential prelude to this discussion. So LaVerne?

LAVERNE PERLIE: Thank you, Dr. Hunt. The Office of the Chief Medical Officer is one of the offices within the Office of the National Coordinator. And looking at its vision and mission, as you can see, our responsibilities are, we're service champions for innovation and meaningful use of health information technology to improve the health experience for all Americans. We also serve as the clinical voice within this

agency. We engage and coordinate health IT stakeholders, including federal, state, provider organizations, vendors, and professional organizations, with the purpose of fostering relationships, sharing information, and to help us achieve our health IT strategic goals. We also provide clinical and health informatics perspectives on policies and standards for health IT adoption and development of increased technology. Our office has five primary areas of focus: patient safety being one, clinical decision support, quality improvement, and usability, and health IT adoption. Our team is composed of 14 members, including seven physicians, three nurses, a pharmacist, an attorney, an additional program, and business analyst. Our leadership strategies include coordination, consultation, and collaboration. Coordination of health information technology across the agency is our primary responsibility. However, we service consultants on current health policies aimed at leveraging technology to improve care outcomes focusing specifically on patient safety. And now, Sandy will explain why ONC developed a health IT safety plan.

SANDRA RAUSCH: Yes indeed, LaVerne. So why a safety plan? In the wake of more widespread use of health IT, the Department of Health and Human Services asked the Institute of Medicine to evaluate health IT safety concerns, and to recommend ways that both government and the private sector can make patient care safer using health IT. The IOM finds that safe use of health IT relies on several factors, clinicians and patients among them. Safety analysis should not look for a single cause of problem, but should consider the system as a whole when looking for ways to make a safer system.

Vendors, users, government, and the private sector all have roles to play. IOM's recommendations include improving transparency in the reporting of health IT safety incidents and enhanced monitoring of health IT products. The Health IT Patient Safety Action and Surveillance Plan addresses the role of health IT within the department's commitment to patient safety. Building on recommendations in the 2011 IOM report, the safety plan provides a roadmap for increasing knowledge of health IT safety and ensuring that health IT is used to make care safer. The final version of the plan was published in July of this year. ONC is coordinating the implementation of the plan through the ONC Health IT Safety Program. More information about the plan and its implementation is available at the healthit.gov website, which we will share at the end of this presentation.

The plan has two fundamental objectives: number one is to promote the healthcare industry's use of health IT to make care safer, and the second is to continually improve the safety of health IT. Proceeding from the premise that all stakeholders have a shared responsibility to ensure that health IT is used to make care safer, the plan leverages existing authorities to strengthen patient safety efforts across government programs and the private sector, including healthcare providers, health IT developers, patient safety organizations or PSOs, and accrediting or oversight bodies. The plan also identifies specific strategies and actions for increasing knowledge about the impact of health IT on patient safety and using that knowledge to improve the safety of health IT and patient care.

Now, I would like to describe in detail the plan's objective. The first objective is to use health IT to make care safer focuses on the use of health IT as a tool to mitigate or prevent adverse events and hazards, regardless of their cause. For example, clinical decision support systems can warn providers of drug allergies or dangerous drug-drug interactions before the patient receives the drugs. The second objective, continually improving the safety of health IT, focuses on preventing adverse events and hazards that are caused by or closely associated with health IT itself: for example, medical errors caused by incomplete or poorly-designed graphical user interfaces.

Achieving these objectives is a shared responsibility. No one entity or group can fully realize the potential of health IT to improve patient safety. Therefore, this plan seeks to coordinate the actions of the relevant stakeholders, those being clinicians, care delivery organizations; and within those would be IT staff, quality improvement staff, administrators, of course patients and their caregivers, federal and state governments, health IT developers, and so on. The department's goal is that patients and providers have confidence in the safety of the healthcare system, including its health IT infrastructure based on evidence of safety. So will ONC meet this goal? Through these three actions: protect confidentiality, integrity, and availability of health information; inform individuals of their rights; and increase transparency regarding the uses of protected health information; and to improve safety and effectiveness of health IT.

So how will this be accomplished? Through three ways: the first is learning. To achieve the objectives of this health IT safety plan using health IT to make care safer while continually improving the safety of health IT, a better understanding is needed regarding

the impact of health IT on patient care, both as a cause of and means of preventing patient harm across a wide array of care settings. The need for more research on the role of health IT and the delivery of safe care was emphasized throughout the IOM report. In addition, improving: This health IT safety plan seeks not only to increase knowledge about the impact of health IT and patient safety, but also to use that knowledge to improve the safety of health IT and make care safer.

As early as 1999, the IOM recognized the enormous potential of health IT to improve patient safety. Compared with paper-based systems, health IT provides an efficient mechanism with which to identify problem areas, monitor trends, measure success, and implement improvements. As knowledge of health IT safety continues to improve, the department will take steps to ensure that such knowledge is used to make health IT safer and to realize its potential to deliver safer care.

And finally, leading: leadership is essential to building high-reliability organizations with strong safety cultures. The department will collaborate with the private sector to promote patient safety in the health IT-enabled care delivery system. The department will also take steps to improve federal coordination and integrate health IT patient safety into existing federal programs. And now LaVerne will discuss these three health IT patient safety strategies with their actions in detail.

LAVERNE PERLIE: Thank you, Sandy. First, we will talk about learning. We would like to make it easier for clinicians to report patient safety events, engage health IT vendors to embrace their shared responsibilities, and we want to provide support to patient safety organizations. Therefore, our plan includes supporting the use of

common formats and standards development to assist providers in reporting patient safety events. Our approach also includes ongoing collaboration and engagement with internal and external stakeholders to ensure electronic health records have the capability to be utilized for adverse event reporting.

By encouraging unidentified event reporting through patient safety organizations, our focus includes reviewing adverse events and their consequences by having a systematic data collection, aggregation, and analysis mechanism. We're currently in the process of exploring options to help us achieve these goals. Additionally through learning, we're aligning efforts across federal agencies, which will allow us to streamline processes that will guide hospitals and healthcare providers in helping them to understand how to respond to safety events, and which corrective actions they should follow. The plan allows health IT vendors to consider options for ensuring that their products are safe. The plan includes working together with survey and certification at CMS, and the ONC's authorized certification bodies.

This group will also review health IT developers' processes for receiving and responding to complaints about their certified products. While reviewing developers' complaint processes, ONC's ACBs will be expected to focus on safety-related capabilities. Later within the presentation we will highlight some regulations regarding this. As far as improving is concerned, we'll be targeting resources and corrective actions to improve health IT safety. Working with our federal partners, EHR vendors, private sector organizations, we will utilize existing policies and initiatives, such as

meaningful use, the national quality strategy, and the federal health IT strategic plan to leverage the safe use of electronic health record technology and health care.

Through ongoing data collection, and aggregation, and analysis, we're better able to conduct research on the consequences of health IT-related adverse events, and promote the quality and improvement outcomes for patient care. Sandy, will you share with the audience our governance role?

SANDRA RAUSCH: Thanks, LaVerne. To support our governance role, the establishment of the Health IT Patient Safety Center is scheduled for fiscal year 2015 and will have three core functions. Looking to the left of the circle, public and private process, this function ensures broad and sustained stakeholder engagement in all activities, including development of improvement goals, measures, and metrics. The Health IT Safety Center's governments and participation policies would ensure trust in engagement of a broad range of stakeholders, including EHR users in related professional associations, EHR Technology developers, patient advocacy organizations, patient safety oversight entities, healthcare informatics professionals, and federal agencies.

Looking to the right of the circle, learning and analytics, this function expands quantity and types of available data, enables a mechanism for voluntary investigations and analyses, catalyzes private sector research. The safety center would develop strategies to include analysis of HIT-related safety issues of certified users with benchmark data to ONC, follow-up on reported HIT safety events, studying the feasibility of automated EHR safety reports, incorporating learning from federal data

sources. Looking to the bottom of the circle, “improve,” the safety center would improve -- would provide a full suite of tools, services, and web and informational resources to help stakeholders achieve improvement priorities.

So as you can see, the safety center’s depicted as a circle, and this new safety center has the potential to offer an unprecedented approach to obtaining nationwide data analysis and providing a host of process improvement tools and information for all stakeholders interested in fostering a culture of health IT patient safety. LaVerne will now talk about how we will get the data to achieve the goals of this Health IT Patient Safety Plan.

LAVERNE PERLIE: Thank you, Sandy. How will we get the data from electronic health records to achieve the goals of the plan? The Structured Data Capture Initiative was formed out of the standards and interoperability framework with the purpose of developing standards for capturing and storing structured data from electronic health records. For patient safety reporting, the standards will consist of identified common-data elements used to fill specified forms or templates. Standards for how electronic health records will interact with these forms are also being developed. There will be additional standards developed to enable forms or templates to auto-populate with data extracted from existing EHRs.

There are two workgroups: use case and functional requirements workgroups, and there’s also a standards and harmonization workgroup. Within these workgroups are four sub-workgroups: one formed, common-format, patient-centered outcomes

research content. We plan to begin pilot testing of this work in November. And now, I'm going to ask Dr. Hunt to speak to us some more about physicians and patient safety.

DAVID HUNT: Thanks so much. I appreciate that. I'd like to talk to you a little bit more about some of the core work that you do, primarily with physicians. But to do that I really -- again, I always like to go back to some of the beginning. We always talk about patient safety as being synonymous with the old tagline by Claudius Galen, "Primum non nocere," or, "First do no harm." And most of us in patient safety are tenuously comfortable with that. But one thing I want to point out, and it's a very important concept for you to understand as you work with your physicians, and practices, and hospitals -- providers in general -- about working with patient safety: namely that in -- if you look up safety -- the definition in the dictionary, there's no mention of error. There's no mention of the word "error," and likewise, you see that Galen didn't say anything about error. He said this and -- because it is a very strong temptation to think about the use of information technology as a way to close the book on patient safety by taking error completely out of the question.

Well, first off, I will always like to point out that computers don't eliminate errors -- if you ask your accountant or your tax attorney as far as that's concerned. But not only that, I always like to say that if we focus on the question of error, it automatically brings up the question of who made that error, and that's typically a -- in the realm of providers or iatrogenic. If we want to be really patient-centered, if we want to be focused on the patient, then we can't have as our end point of measurement or of success a measure of provider activity or inactivity would a adopt a may or may not do. We really only have

a singular consideration of, what is the patient experiencing? And so I will say that there is ample -- there's ample room in patient safety for error reduction, but the sole endpoint of concern can't be what happened -- what was done by the physician or the provider. It only has to be what happens to our patient.

And I always like to point out this slide -- I always like to use this slide to really focus on the real essence of what we're talking about and what we're doing, and this is really the heart of Galen was trying to get at. But all of this -- I speak to all of these things to really highlight the point that when you work with providers, when you're talking with them and working with them on issues of patient safety, either in general, writ large, or in the specific case of using it to improve their -- using health IT to improve patient safety, remove from your consideration or try to get out of your lexicon the consideration or the discussion of medical error.

It puts a pall over a little bit of everything and actually makes it a little bit more uncomfortable the discussion to move forward, because at the end of the day, no matter what happens, we have to have useful willing partners to work with us. And if you use the word error, which is a normal synonym for negligence -- and you know where the litigation mob will go as far as that's concerned -- it puts an overall uncomfortable culture or uncomfortable area on the discussion of patient safety. So that's one of the first things that I like to say about that.

Now, having said that, I will say that in terms of making -- health IT making care safer, we are -- there are a number of places that you absolutely can go, but we've decided to really dovetail closely on the work of our partner at CMS in the partnership

for patients, in which we were actually highlighting the priority areas that have the greatest impact as far as patient safety is concerned. So we're going to talk about things that -- areas that you can focus on with the EHR to work on improving patient care and patient safety in general. These are the priority areas that we like to focus on: adverse drug events, and in particular, anticoagulants are a big and major area to work on; catheter-associated UTIs, bloodstream infections, obstetrical adverse events -- you can look at the whole list.

This should be a relatively familiar list of priority areas for you, particularly any of you who are working with other quality improvement programs with your eligible providers and all -- of all. Now, I've spent a fair amount of time telling you -- time telling you a little bit about the way to approach physicians, I've told you a little bit about the HITECH Act, which we all knew about. I've even gotten into a little of Hypocrites there. But I tell you that talking about section 301 of HITECH and Hypocrites, that's not going to be a very practical value next month when one of your eligible providers asks you to help her improve the safety of her EHR.

Who do we have to help as far as that's concerned? We do have some very practical tools that you and your staff can use to help guide the providers that you're working with, either hospitals or small practices, through a series of best practices, actually, to help them improve the safety of their EHR system. Now, we have a set of guides, and they're known as the SAFER Guides. Now, in our infinite wisdom, SAFER is actually an acronym for S-A-F -- or S-A-F-E-R for Safety Assurance Factors for EHR Resilience. Yeah, I know, we do this kind of thing all the time, but if you get beyond the

name itself, okay, the guides are incredibly useful and actually the kernel of what we'll be doing in our health IT safety program on a very practical lesson -- very practical level.

The guides are actually self-assessment checklist tools that can be used to guide an organization through the process of optimizing their EHR safety profile. There are nine primary guides in areas such as CPOE and clinical decision support; high-priority and high-risk areas of EHR safety; what are the organizational responsibilities with using an EHR safely; a down time guide, what to do and how to prepare for down time; test results review and follow-up; patient identification; hardware and software contingency planning; and clinical communication. Now, each guide will have a series of recommended practices as well as implementation tips and references. Now, at the foundation of these guides is the painstaking work that's been done by a group of clinicians and health IT specialists that were actually led through -- that were done through a contract with ONC.

They were over a year and a half in the making and then they're scheduled to be released at the end of this month. They will be available on the healthit.gov website in downloadable and interactive PDF formats. Now, I highlight this because these guides are the kernel of our initial programs in health IT safety. We actually will highlight one theme or one guide every other month on the patient safety section of healthit.gov, and kick that off with a webinar such as this to discuss in depth a little bit more information about the guide itself. You will see more information on the guides from us as we roll

into 2014, but I'll also invite you all to join us next -- next month, I'm sorry, next month, Friday, December 6th for a more detailed discussion of the guides.

We actually are going to have one of the authors of the guides and the ONC lead on the development of the guide here to actually talk a little bit more and give you a very thorough introduction to the guides. And as I said, through the course of next year we're going to highlight one theme or one guide every other month and go into some deep dives into what the actual practices, recommendations, and the references will say about these opportunities for improving safety.

Now, I'll finish up my section actually highlighting Professor James Reason, who actually first coined the Swiss cheese model of safety. He's a safety guru, and it -- really did most of his work in aerospace, but in human safety and aero modeling in general. And in that Swiss cheese model, he actually recognized that harm is rarely, if ever, the result of failure at any one level. More often it's the failure at multiple levels, with hazards passing sort of inexplicably through many intent -- of the intended safeguards. Now, I placed this diagram and this quote into our materials to remind us all that health care is complex and multifaceted, and health IT really represents an opportunity to place one more slice of cheese in that stack to mitigate a potential harm. But ultimately, this all comes down to us making a conscious and concerted effort at systematic changes in the way we deliver care to make it safer. And with that, I'll actually pass the ball over to Sandy Rausch to talk a little bit about some of the systematic changes that HHS has put in place through the Patient Safety and Quality Improvement Act. So I'll pass it on to Sandy.

SANDRA RAUSCH: Thanks, Dr. Hunt. Let's turn to a short overview of current legislation driving health IT patient safety and patient safety in general. The Patient Safety and Quality Improvement Act of 2005, otherwise known as the Patient Safety Act, authorized the creation of patient safety organizations, PSOs, to improve the quality and safety of U.S. health care delivery. The Patient Safety Act encourages clinicians and healthcare organizations to voluntarily report and share quality and patient safety information without fear of legal discovery. To implement the Patient Safety Act, the department issued the Patient Safety and Quality Improvement Final Rule. The Agency for Healthcare Research and Quality administers the provisions of the Patient Safety Act and the Patient Safety Rule dealing with patient safety organizations operation. What, then, are patient safety organizations or PSOs? A patient safety organization, or PSO, is an entity or a component of another organization that is listed by the Agency for Healthcare Research and Quality based upon a self-attestation by the entity or component organization that it meets certain criteria established in the Patient Safety Rule. The primary activity of an entity or component organization seeking to be listed as a PSO must be to conduct activities to improve patient safety and healthcare quality. A PSO's workforce must have expertise in analyzing patient safety events, such as the identification, analysis, prevention, and reduction or elimination of the risks and hazards associated with the delivery of patient care.

While reporting to a PSO is not mandatory, the time is coming when elements of participating in a PSO will be required. Specifically, by 2015, the Affordable Care Act stipulates that hospitals with 50 or more beds can only participate in a health insurance

marketplace if the hospital has established a patient safety evaluation system and participates in a PSO. The ECRI Institute, which is an independent non-profit organization that researches the best approaches to improving the safety, quality, and cost-effectiveness of patient care, has recently stated that, quote, “By actively participating in a PSO, healthcare providers have the benefit of learning not only from their own experiences, but from the experiences of hundreds of other providers in a collaboration that transcends business competition to provide optimal care to the populations they serve and improve health care on a global level,” end quote. A PSO can offer valuable support to a healthcare organization, be it through a review of reported events or through trend and data analysis.

Each shaded state on this map is the home of at least one PSO. Currently there are over 4,000 hospitals with over 50 beds in the United States, and 78 Agency for Healthcare Research and Quality-registered PSOs. So you can see there is a great need for additional PSO registration and educational outreach to these hospitals. You can find a list of registered PSOs at the Agency for Healthcare Research and Quality website, which we will give you at the end of this presentation. There, you can see if you have a PSO registered in your state. We would recommend that if you do have a PSO in your area, it would be beneficial to contact them for information. RECs are encouraged to have a collaborative relationship with the PSOs serving in the same geographical area.

Another ONC initiative to foster improved surveillance of health IT patient safety-related events is our new partnership with the Joint Commission. The Joint

Commission has been at the forefront of patient safety as the largest accrediting body for healthcare organizations in the United States. ONC and the Joint Commission are committed to ensuring that electronic health records are a strong foundation for a culture of safety in health care built on continuous learning and process improvement. But we both recognize that health IT creates its own new safety issues. ONC's contract with the Joint Commission will ensure that we have an early detection system on health IT-related safety issues, including those associated with EHRs.

The Joint Commission will enhance the use of its de-identified database under its Sentinel Events program to identify, investigate, and ultimately prevent Sentinel Events, including death, serious injuries, and potentially unsafe conditions associated with health IT. The results of the Joint Commission's work will inform ONC's Health IT Patient Safety Program as we engage all stakeholders in activities that achieve the objectives of the ONC Safety Plan to use health IT to make care safer and to continually improve the safety of health IT. Now, Dr. Hunt would like to share a few final words with you. Dr. Hunt?

DAVID HUNT: Thanks so much. Thanks to Sandy and LaVerne, and thank you to all of you for listening and sharing -- spending some time with us. You know, from the very start of your work as regional extension centers, this has been the nature of your world right here, the HITECH and the activities that you all know very, very well from ONC. This was the guiding model that we all had and that we still do have in moving forward with meaningful -- the meaningful use of EHRs as the centerpiece of our work. And with that, we actually see a way for the meaningful use of EHRs to really

affect the tripling that we hear in so many different formats: improved health for the individual, improved health outcomes for our communities, increased transparency and efficiency, and the ability to improve their care delivery.

The reality, though, is, for our -- for your practices and providers that you work with, they have a lot more on their minds that definitely relate to the activities that we talk about and are triple aim, but there are many other things that factor into the day-to-day work that they have. Safety is among them, and safety is one of them, along with medical education, health literacy, nutrition, basic science, and clinical research. What I'm saying is I'm hoping that you're seeing that this work with patient safety is a wonderful way for all of you to begin that transition to that bolder new world beyond the immediate concerns of HITECH, and our immediate initial concerns of the adoption and implementation of EHRs.

We -- I'm hoping you're seeing that HHS -- with the work in patient safety combining with the work that the PSOs and AHRQ are doing around patient safety, as well as partnering with CMS and other HHS agencies, I hope you see that this is a systematic way of having us all as a department -- and the work that -- and have the work that we do continue to transform health care and the delivery of quality care to everyone in this -- in our nation.

I hope you also see that with this transition on to working with patient safety as well as other areas, that you'll find a way to provide a compelling value proposition to the practices and organizations that you serve. Meaningful use will always be important, and the triple aim: I can't see it every going out of style any more than I can

see “primum non nocere” going out of style. But I’m hoping that we’re going to be able to begin, particularly in 2014, with the transition to more robust work in patient safety to provide you with some tools, some resources, and a path to help you continue to sustain and work with providers and organizations around the areas that they are daily concerned with, and to help them actually deliver better care.

So with that, actually, I’ll just highlight that we have some additional resources that are available, and as you can see right here, these are some of the federal regulations associated with some of the discussions that we have around the surveillance plan, as well as we have some additional resources that were highlighted in some of the comments that we made about structured data capture, as well as the AHRQ common formats, and of course, we should all invite you all to join with us -- or to join us at the patient safety section of healthit.gov. And one thing that you’ll be able to read there is the actual Health IT Safety Plan. I think with that I’m going to thank LaVerne, and Sandy, and actually the whole team, Connie and Patrick. Thank you all, and -- show you our email addresses.

CONSTANCE GILLISON: Well, all right. Well, I just want to thank everybody for participating today, and I hope enjoyed the session. Please email the HITRC training team if you have any questions, and thanks again for joining, and we look forward to seeing on future webinars.

DAVID HUNT: Thank you.

LAVERNE PERLIE: Thank you.

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