ATTACHMENT 3 – RESPONSES TO COMMENTS

Comment 1:

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Pharmaceutical Research and Manufacturers of America

February 12, 2007

Doris Lefkowitz
Reports Clearance Officer
Agency for Healthcare Research and Quality
540 Gaither Road, room 5036
Rockville, MD 20850

Re: Agency Information Collection Activities; Proposed Collection; Comment Request; Development of an Electronic System for Reporting Medication Errors and Adverse Drug Events in Primary Care Practice (MEADERS) (71 Federal Register 74537, December 12, 2006)

Dear Ms Lefkowitz:

The Pharmaceutical Research and Manufacturers of America (PhRMA) represents America's leading research-based pharmaceutical and biotechnology companies. PhRMA members discover, develop, and produce most of the prescription medicines used in the United States and a substantial portion of the medicines used abroad. PhRMA members have a long-standing and vital interest in obtaining complete and comprehensive information regarding adverse events associated with their products, and in using this information to improve patient safety.

As world leaders in the discovery, research, development, and production of innovative life-saving medicines, PhRMA member firms are actively involved, on a daily basis, in the collection, review, evaluation, and communication of information relating to the benefits and risks of their investigational and marketed products, and we support AHRQ's attempts to enhance systems for capturing information on adverse events and medication errors in an effort to design safer care delivery systems. We appreciate the opportunity to provide comments on the Agency's proposed electronic system for reporting medication errors and adverse drug events in primary care practice. Identification of medication errors and their causes in the outpatient setting is an excellent idea. As mentioned in the proposal, the majority of medical decisions are made in the outpatient arena and most studies of medication errors have been conducted in the in-patient setting.

However, we have some questions about the proposal, and concerns about whether the proposed reporting system will be effective in attaining the stated goals of the program. We include some general comments on the proposal, followed by specific responses to the questions posed in the December 12, 2006 Federal Register notice.

General Comments

1. PhRMA member companies take great pains to ensure that they include as much information as possible, from as many sources as possible, in their review and evaluation of adverse event (AE) and medication error reports. We appreciate AHRQ's plans to forward reports entered into the Medication Errors and Adverse Drug Events Reporting System (MEADERS) to FDA, and would strongly urge AHRQ to include mechanisms by which the information would also be simultaneously shared with the manufacturer of the product in question as well.

This would allow the manufacturer to follow-up with reporters to obtain additional information about the event, as well as providing more complete information to the manufacturer to include in their signal detection and evaluation activities. Depending on the level of detail collected, the information could also provide the manufacturer with better information about potential medication errors and AEs associated with their drug, which would enable them to take action to minimize such medication errors/AEs (e.g., modify product labeling to provide clearer instructions, modify the packaging or other features). In this way pharmaceutical companies can work together with the practitioners and regulators to minimize medication errors and maximize safety for the patients taking their drugs.

2. This proposal has as its primary focus developing a mechanism for reporting medication errors as they occur. However it is not clear how it will evaluate the physicians' ability "to identify their own errors and willingness to report them..." For example, will there be a verification process where sample charts will be independently reviewed to determine occurrence rate of medication errors in the practice in order to determine the percentage of errors that is recognized and reported?
3. Providing a data capture tool for outpatients and doctors offices is different from soliciting medication errors and adverse events. This survey seems to be a proof of concept and as such this project is quite expensive. Is there a time frame associated with the project or is collection of a finite number of events the target?
4. The short-term objective to "create and test a paper- and computer-based system for both capturing medication errors and reporting adverse drug events..." will likely be met. However, this proposal falls short of demonstrating how this electronic system will achieve the longer term goal of improved reporting of medication errors and Adverse Drug Events in primary care practice, or the ultimate goal of improving the quality of care provided to patients. In other words, the ability to implement such a system on a large scale and make it sustainable long term is questionable. Some of the major barriers to implementation are:

   a) Lack of incentive for physicians to invest time and effort

   - The current proposal is for 80% of reporting to be done by physicians. This may work well in the research setting, where the responders are reimbursed for their time. In the primary care setting, however, a successful system would actually need to minimize physician input. Expecting a physician to take even 8 minutes out of a busy day without a meaningful incentive (e.g., CME credit, special certification, payment for submitting a complete report, etc.) is not realistic.
   - With regard to selection of the PBRNs that will participate in the program, will there be a selection bias? Physicians involved in the pilot or who use MEADERS may be individuals who are more likely to report and be compliant with regulator reporting. This can result in biased data that will not be applicable to the general population of primary care practitioners.

b) Fear of lawsuits

- Confidentiality of reporters would have to be assured. Legal implications to MDs may have a prohibitory effect when this pilot is implemented in a real scenario, physicians may be afraid of potential lawsuits. How can they be protected from such things? Are there privacy laws to protect the reporting healthcare provider who committed the medication error? On the other hand, reporting physicians will need to provide sufficient contact information to enable follow-up of incomplete reports. How can these conflicting needs be reconciled?

c) Cost associated with processing and analyzing the information

- Where will the funding for case processing and analysis of data come from if the MEADER system is successfully implemented at the conclusion of this research activity? Who will perform follow-up of the individual reports and of any measures taken to avoid occurrence of the same medication errors in the future? How will the experience of the participating PBRNs be disseminated to a wider audience of primary care physicians to enable them to learn from this experience?

Unless the above questions are answered in advance of the proposed research activity, the potential benefits of this project may be confined to gathering six months of partial data on medication errors and Adverse Drug Events in an outpatient setting. While such data are important, we question whether it justifies a million dollar price tag.

5. The proposal mentions that AE and medication error reports will also be forwarded to FDA. Will the information collected be consistent with the FDA's standard data collection form, the FDA3500/MedWatch form? This is important, so that the information can be entered into FDA's AERS database, and analyzed and evaluated along with reports received from other sources.
6. Will this information be publicly available through FOI or other means?
7. It is difficult to determine from the proposal whether the full scope of medication error reporting is covered in MEADERS. For example, does it include information regarding the prescribing, dispensing, and delivery systems involved in the medication error, the point in the process where the medication error occurred, and possible reasons for/causes of the medication error? This information needs to be included in the system in order to identify possible root causes of the errors, and to take appropriate steps to reduce them in the future.

Questions posed in the Federal Register notice

1. Is the proposed collection of information necessary for the proper performance of health care research and information dissemination functions of AHRQ, including whether the information will have practical utility?

• It would be more efficient to focus on electronic data capture. The word "Survey" suggests an after the fact initiative. The data should be captured at the time of discovery to minimize error and omission. Additional clarity is needed regarding what will be done with the data with regard to patient privacy etc., and actual regulatory reporting of the AEs and medication errors. It is also important to develop a plan to enable industry to receive the reports in a timely manner (e.g., similar to FDA's MedWatch to Manufacturer program), since the manufacturer is in the best position to remediate any root causes directly related to the product itself. What would be the consequences of this reporting for the HCP, if any, and will it be made clear to the participant? Will there be a feedback mechanism which will highlight the positive impact of such a reporting scheme?

• There is no definition of what it means to capture the number of users - does this mean number who log on or number who complete at least one report? It seems like the survey is to be validated as an instrument to collect data but if there is an electronic component that will need to be technically validated as well.

• Further follow-up analysis/studies to identify how to reduce the medication errors identified are needed to complement this initial program.
• Most of the information in the proposal is directed at medication errors and adverse events that result from them. There is little direction regarding the purpose and end points for collecting adverse events not related to medication errors.
  - If the primary purpose of this plan is to identify causes of medication errors it might be more successful if it concentrated on that one goal, rather than expanding it to also include adverse event reporting.
  - If the goal is to increase the number of spontaneous AEs reported, this system must be easier to use than what is currently available to practitioners (e.g., call the pharmaceutical company, tell a drug representative, or call the FDA 800 number).

2. Are AHRQ's estimates of the burden of the proposed collection of information, including hours and costs, accurate?

• Completing surveys after the fact is added work however one looks at it. There is the potential for error, omission and the length of time it may take to collect all pieces of data. It is most likely to be office managers/assistants who copy data into the system.
• More detail needs to be provided as to what information will be collected; from our experience in collecting adverse event and medication errors, the clinician time estimate of 8 minutes is substantially low for the amount of information required to make a meaningful assessment of the root cause of a medication error or adverse event.
• Since actual physician contact during most office visits is less than 8 minutes, a system that takes a physician up to 8 minutes to report an event will probably not be well utilized. We suggest something that will take about three to four minutes at most.
• Medical errors are well-understood to be multi-factorial in origin; how will this be captured? Will there be follow-up investigations to obtain additional details needed? If so, who will do this, and who will perform the analysis?
• For future use when this from the pilot stage to the real world, what software/hardware will participating practitioners need in order to participate and have access to MEADERS? Can it be installed into their already existing computer system, or will additional costs need to be incurred?
• The table in Exhibit 1 listing estimates of cost burdens only refers to medication errors, not to adverse events.

3. Ways to enhance the quality, utility, and clarity of the information to be collected

• The proposal does not define medication errors and it is unclear whether "near-misses" will be collected or how these will be defined.
• The proposal refers to "adverse drug events," but does not clearly define this term. Will adverse events only be collected if there is suspicion that a drug

caused the event? What level of certainty of causality is required and whose judgment will be used (e.g., the physician or the patient or others)?
• Identify methods to collect the data at the time of discovery or at the patient visit. Use electronic methods rather than paper based. Are there any steps to validate the potential adverse event reports? Are the PBRNs expected to follow-up on the reports forwarded in an active manner via this system?
• For efficiency, cost savings and ease of use we would suggest developing a single electronic system for MEADERS, rather than a dual paper and electronic system. Software that could be loaded on a PC and hand held electronic devices would be ideal.
• Adverse event and medication error information must be complete and accurate to enable any meaningful action to be taken. Will the evaluation of the program include an assessment of the completeness and quality of the data collected?
• In order to ensure that information collected via MEADERS is able to be combined with information collected via other systems (e.g., manufacturers, FDA's MedWatch system, etc.) to allow aggregate analysis and evaluation, we urge AHRQ to consult with FDA and pharmaceutical industry representatives in designing the template for MEADERS data collection.

4. Ways to minimize the burden of the collection of information on the respondents

• This is an additional system for the PBRN sites, can there be an electronic link to commonly used systems in place in doctor's offices? There are several initiatives looking at the data mining of electronic medical records. Vendors see this as an opportunity and are working actively to make this a reality although is perhaps some years off at present.
• In order to reduce burden to providers, "near misses" should NOT be reported if caught through already established processes (for example a second check is a standard practice and mistake is caught).
• As noted above, consider developing a single electronic system for MEADERS, rather than a dual paper and electronic system.
• If this project is seen as successful, and is more broadly implemented, the logistics should be aligned with other initiatives so as not to duplicate or add to the burden of work.

Thank you for the opportunity to comment on this important matter.

Sincerely,

Responses to comments from Alan Goldhammer:
General Comments:

1) The forwarding of this information to PHARMA member companies is beyond the capabilities and scope of this project at this time.
2) The pilot project does not intend to address the physicians "ability" to identify errors and adverse events just their ability and willingness to report perceived errors. We will adjust the language to further clarify this in the OMB application.
3) This project is a pilot study of a reporting system and therefore is a proof of concept. The study will be analyzing the errors and adverse events captured by the system over a 6 month period. The original study design has been expanded to double the number of PBRNs from which data will be collected at no additional cost to the government. We are soliciting a minimum number of providers from a broad spectrum of PBRNs who will bring with them their own set of unique experiences and expertise that will add to overall value of the study.
4) While we are very interested in the longer term applications for this tool, the considerations for MEADERS outside of the pilot testing phase is beyond the scope of this particular study.
    a. We are confident that this is an ideal opportunity to test this data collection mechanism despite the lack of reporting incentives. PBRNs are voluntary networks organized around clinical and translational research in real world practices. The researcher/providers associated with PBRN networks are acutely aware of how important their research is to improving the everyday practice of medicine. The estimates of reporting were based upon the limited amount of data available which served to further strengthen the argument that this information should be collected.

       The system will provide aggregated data for practices and groups of practices to use at their discretion for quality improvement activities. This feature is not available in any current national medication reporting system.

       We acknowledge that there might be some bias introduced into the study given that the pilot sites are networks organized around research, however the nature of this type of research does not easily allow for mandatory reporting or randomization of reporters. We have made every attempt to minimize the bias, but given the large variability of primary care practices and the limited scope of this project, bias could not be entirely eliminated.

    b. The data collected will be kept confidential in its entirety. If a MEADERS like system were to into more widespread use it would need to be incorporated into existing Patient Safety Organizations, thus protecting the data from discovery outside of this research setting. Please see sections [A.10] and [B.12] for further information on assurance of confidentiality.

       The system will not permit submission of an incomplete report. Missing data is prompted for when the submit button is clicked. The required data fields include all of the MedWatch requirements and a few other elements.

c. This project is a pilot data collection effort only and the funding for the analysis of the data collected is included in the modification of the AHRQ contract with the PBRN Resource Center to complete this project. While the avoidance of errors is an important goal and this system may certainly assist in the identification of errors and adverse events occurring in primary care, there is currently no follow-up component scheduled for this study to analyze the effect of the data collection effort on patient safety. The results of this study will be analyzed by AHRQ and the study authors will likely publish the findings from the data collection. Additional dissemination may occur through distribution of the findings through the Patent Safety Resource Center and other reports generated by AHRQ on this topic. The key difference between this project and current data collection systems, such as at the pharmaceutical or FDA programs is that this data will be made available for individual institutional improvement efforts, which is not possible with these other systems.

5) The system is compatible with the FDA's MedWatch system. The option to send a report to MedWatch is entirely up to the reporter and is not a requirement of our data collection effort. We have designed the system to be compatible with MedWatch to facilitate broader data collection efforts. The number of reports to MedWatch will be one of the outcomes of this MEADERS field test; however the content of the MedWatch reports will not be included in this outcome analysis.

6) This information is protected by Exemption 6 of the Freedom of Information Act which protects against personal, medical and other similar disclosures which would constitute a clear unwarranted invasion of personal privacy from a FOIA request.

7) In order to reduce the burden of reporting, we balanced required coded information fields vs. free text, keeping in mind not just what we wanted, but what the users would tolerate. We will be collecting some of these variables mentioned in the MEADERS form and most of the rest, if important, will be in the free-text description of the incident. The study team has experience in analyzing hundreds of ambulatory primary care medication errors and has used this expertise and the MedWatch requirements to guide the data collection process.

Questions Posed in the Federal Register Notice:

1) The study intends to focus on electronic data capture of medication errors and adverse events. The Web-based tool and follow-up surveys are both intended to be the primary mechanism for data collection however for a tool to be used across all types practices, including those without computers (hence, the paper-based MEADERS), this is not possible.
   - The data will be able to voluntarily be reported into the FDA MedWatch system and there will be no additional regulatory reporting.
   - The information provided to the Resource Center will be completely de-identified and additional measures will be taken to ensure the

confidentiality and security of the reporters and patients involved. Please refer to sections [A.10] and [A.11] of the OMB application for additional information regarding assurance of confidentiality.

- It is beyond the ability or scope of this study to report the events recorded in the system to the industry. Additionally, the study is not intending to perform or represent any root cause analysis to be used for patient safety remediation. Later analysis to address these issues may be possible using the data provided by the study, but this is outside the scope of this particular pilot project.
- Each user will be assigned a user ID number that will only be known to the practice and there is no goal for number of reports filed or number of reporters accessing the system. There is no way of validating the MEADERS itself during the course of this pilot study. This project is a field test of its usefulness, not the completeness or accuracy of the information collected.
- Yes, we fully agree that additional follow-up studies to identify how to reduce medication errors are needed.
- We are capturing medication errors and adverse events, <u>all</u> adverse events pertaining to treatment of acute and chronic conditions (see section [A.2]) whether caused by an error or not. This includes the "near misses" which might be perceived by providers as either an error or adverse event. We will not provide guidance on "What is a medical error or adverse event" other than basic information about error types. The reporting of events is totally up to the discretion of the provider. There will be some on-site training by Resource Center staff to familiarize the intended users with the functions of the system.
- We capture both adverse events (side effects) and errors related to medication prescribing/administration etc. These are implicit in the categories defined. We feel that the system will provide a much better and easier method for providers to report errors than is currently available.

2) Estimates of Burden

- We agree that there is the potential for error and omission for events that occur after the fact. We feel that the most likely candidates to report events are those that witnessed or were involved in the event.
- The system is not intended to perform or inspire any root cause analysis for a particular event. This is an empiric study of a system designed to capture errors and adverse events. Root cause analysis of the events is not factored into the burden because it is outside the scope of the study.
- The system is for use by the individual practices – they can use the data to do internal quality control if they wish. We have no plans to follow-up after the study is concluded. The intent was for AHRQ to design a system that can be used by the practices internally. The MEADERS form was designed to maximize the amount of information captured for an event with a minimum of time required to capture that information. The result is

a system that utilizes a combination of free text fields and drop down boxes to facilitate a quick and accurate reporting of the event as it occurred. The data collected in theis pilot study may result in additional modifications to the application which includes more closed-ended options.

- This is a Web-based system that requires no software installation. A Windows PC with a fast internet connection and Internet Explorer 6 or better are all that is required to operate the system. The system is designed to be compatible with existing EMR programming, however the practices must create the necessary links themselves (The Resource Center will supply the source code of the application upon request). There are no additional costs involved to install the system at a practice location.
- There is scant information available regarding the differences in the burden for reporting a medication error vs. an adverse event in the private primary care office setting. This study will be examining these variables closely to determine if there is a difference in the reporting times. The estimates of burden shown in Exhibit 1 are based on the limited available peer-reviewed literature on the topic and the prior experience of the study team in analyzing ambulatory primary care medication errors.

3) Clarity of the information collected

- Errors and adverse events that are reported are those that are perceived by the reporter to be worthy of note. We will not provide guidance on "what constitutes a medical error or adverse event" other than basic information about error types. This is a tool that practices can use internally for their own quality improvement and how they define errors is at their discretion. There will be some on-site training by Resource Center staff to familiarize the users with the functions of the system.
- See previous comment.
- There are currently no steps to validate the potential adverse event reports. This is currently beyond the scope of this study.
- AHRQ as an agency prefers to make available a paper version of its data collection instruments to ensure that its studies are all inclusive. The data collection effort for this study will encourage electronic reporting, but will accept paper forms form those reporters who choose not to use a computer to report an error or adverse event.
- The quality of data will be variable depending on what information people are willing to provide. The enforcement of any strict quality measures is beyond the capabilities and scope of this pilot test. If the resources are available we may take a random sample of reports and code them using an established coding system to see if adequate information is available to fully code what percentage of events to a useful level within the coding system.

- MEADERS is compatible with FDA's MedWatch system and the appropriate consultations were made with representatives from that agency as well as other related organizations during the design of this application. USP, a partner in FDA's MedWatch, supplied us with data from their MedMarx program to initially populate our database. Please see Attachment 2 for a list of other consulted individuals and their affiliations.

4) Ways to minimize burden

- The system is a web-based system that was created to be intuitive for primary care providers. The combination of free text and coded fields allows us to capture essential data without overly burdening the reporter. If the practices wish to integrate MEADERS into their current electronic systems, the Resource Center will provide the source code and allow them to modify the application to suit their own needs.
- Near misses will only be reported if the provider perceives an error or adverse event has occurred. The Resource Center is not going to define allowable or non-allowable reporting criteria for the practices.
- As noted above, AHRQ prefers to offer both a paper and electronic versions of its data collection instruments in order to be inclusive.
- We fully agree that if this system is successful and more broadly implemented it should become integrated into the greater effort of increasing patient safety.

Comment 2:

patients reporting medical errors

i agree that all medical/drug mistakes should be captured and investigated and evaluated to avoid the next patient suffering from these causes. however, how will the patient know which caused his problem, the doctor or the drug. the fda is supposedly investigating setting up a system for drug reports. how do we capture every single error - in both drugs and doctors - WITHOUT SOME FALLING THROUGH CRACKS. WE DO WANT THE INFORMATION. HOWEVER WE WANT A FAILSAFE SYSTEM SET UP HERE, NOT POLYGLOT WITH TWO AGENCIES LETTING INFORMATION FALL THROUGH THE CRACKS. WE WANT EVERY SINGLE OCCURRENCE RECORDED, WHETHER IT BE DOCTOR OR DRUG. I DO NOT THINK THIS PROPOSAL PROPERLY EVALUATES THE FULL RAMIFICIATIONS.

ALSO TAXPAYERS HAVE TO PAY FOR THIS SYSTEM SO IT SHOULD BE AN EFFICIENT ONE THAT CAPTURES ALL DATA. THIS PLAN AS PROPOSED DOES NOT MEET THIS REQUIREMENT. FDA IS ALSO INVOLVED HERE.
B. SACHAU
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FLORHAM PARK NJ 07932

Response to Comments from B. SACHAU:

The study authors made every attempt to work with agencies and companies already working on medication eror reporting systems to create an integrated system. MEADERS is compatible with FDA's MedWatch system and the appropriate consultations were made with representatives from that agency as well as other related organizations during the design of this application. USP, a partner in FDA's MedWatch, supplied us with data from their MedMarx program to initially populate our database. This project is a pilot study of a reporting system and therefore is a proof of concept. We are capturing medication errors and adverse events, all adverse events pertaining to treatment of acute and chronic conditions (see section [A.2]) whether caused by an error or not. This includes the "near misses" which might be perceived by providers as either an error or adverse event. We will not provide guidance on "What is a medical error or adverse event" other than basic information about error types.