

CALL TO ACTION

Preventable Health Care Harm Is a Public Health Crisis and Patient Safety Requires a Coordinated Public Health Response

Information and technical review provided by the Centers for Disease Control and Prevention.

Summary

Preventable harm in health care is a public health crisis, with estimates placing it as a leading cause of death in the United States.¹⁻⁴

The National Patient Safety Foundation (NPSF) calls on health care leaders and policymakers to initiate a coordinated public health response^{5,6} to improve patient safety and drive the collective work needed to ensure that patients and those who care for them are free from preventable harm (see figure 1). Such an approach has already contributed to significant reductions in health care-associated infections (HAIs).⁷

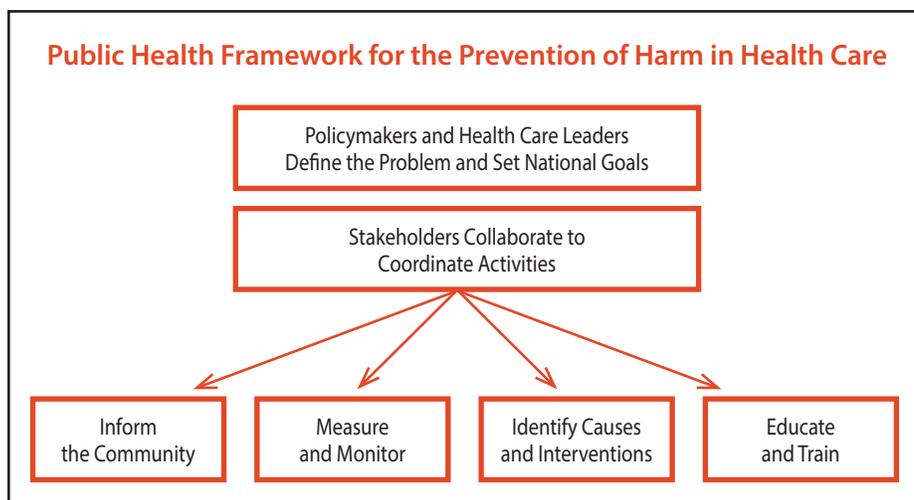
As outlined below, NPSF believes that a public health response — one that draws on the experience and expertise of public health professionals and public health organizations — will accelerate progress in the prevention of harm and establish the critical infrastructure needed to address this challenge across the US health care system consistently and sustainably.

Building on successful efforts to reduce HAIs^{5,8-13} and taking advantage of critical lessons learned,⁷ NPSF proposes the following public health framework to guide efforts. This evidence-based approach identifies effective, replicable interventions for effective propagation across the health care system.

NPSF urges greater collaboration among all stakeholders to address preventable health care harm and recommends widespread adoption of our public health framework to guide collective efforts (figure 1). Too often, efforts to blame individuals and organizations for preventable harm diverts attention and resources away from a more effective and sustainable collective response.

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Figure 1.



The National Patient Safety Foundation’s vision is to create a world where patients and those who care for them are free from harm. A central voice for patient safety since 1997, NPSF partners with patients and families, the health care community, and key stakeholders to advance patient safety and health care workforce safety and disseminate strategies to prevent harm. NPSF is an independent, not-for-profit 501(c)(3) organization.

Problem Statement

Most care provided in the United States is high quality and safe, but technical and treatment advances also create new or expanded opportunities for unintentional, preventable harm to occur. As outlined in the National Patient Safety Foundation (NPSF) report *Free from Harm: Accelerating Patient Safety Improvement Fifteen Years after To Err Is Human*, errors and injuries that occur during care may cause significant mortality and morbidity, and can undermine patients' quality of life.¹⁴

Efforts to improve patient safety have been ongoing for several decades, but the scale of improvement has been limited and inconsistent, with some organizations succeeding more than others. Some health care organizations have been able to successfully implement improvement strategies (e.g., checklists, medication barcoding, revamped care transitions), while others have been unable to introduce these same interventions or replicate the results.

Health care benefits from a dedicated workforce, but the systems and conditions that support safe care practice often fall short. When preventable harm occurs, a host of organizational factors often contributed to the outcome, many outside the control of any one person. A preoccupation with blame has distracted attention away from addressing the broader systemic issues at hand.

Meaningful advancement in patient safety requires a shift from reactive, piecemeal interventions occurring at individual organizations to a coordinated system-wide effort geared at providing safe care delivery across all aspects of care. Also needed is less finger-pointing and more collaboration. All health care stakeholders should work together to anticipate risk and uniformly apply system-wide safety processes across the care continuum (see figure 1). Critical, too, is support for health care professionals and other members of the workforce, as well as engagement of patients and families.¹⁴ This reflects a key lesson of the past decade: Most improvement initiatives only succeed when leadership, culture, and patient engagement are fully aligned with the objective of greater safety.¹⁴ A public health approach and our framework emphasize each of these essential components (see figures 1 and 2).

Using an integrated, evidence-based approach, public health seeks to ensure protection from — and prevention of — harm to the entire population. This approach, as outlined in our framework, identifies sources of

preventable harm — in the case of patient safety, protection from harm related to health care — and then deploys coordinated prevention efforts (e.g., event surveillance and reporting, promotion of behavior change, and evidence-based interventions). It also would provide a structured method for integrating systems and the adoption of key patient safety and implementation science principles.

The advantages of a public health response are visible in work by the US Department of Health and Human Services and the Centers for Disease Control and Prevention to reduce health care–associated infections (HAIs). Established in 2008, the Federal Steering Committee for the Prevention of Health Care–Associated Infections united efforts of the US Departments of Health and Human Services, Labor, and Veterans Affairs. It released the National Action Plan to Prevent Health Care–Associated Infections in 2009 to coordinate and guide efforts among agencies and stakeholders towards the elimination of HAIs and to set specific reduction goals.⁷ The most recent progress report documents significant reductions, including a 50 percent decrease in central line–associated bloodstream infections.¹⁵

Each of us will be patients during our lives. By extension, all members of society have a stake in improving the safety of our health care system. Similarly, successful implementation of a public health response to prevent health care harm requires coordination and partnership among all stakeholders, including government agencies, health care organizations, insurers, foundations, industry and other private sector organizations, as well as policymakers, patients and families, health care leaders, health professionals, and other members of the health care workforce.

Call to Action

By initiating a public health response, health care leaders and policymakers can accelerate progress in patient safety and establish the infrastructure needed to ensure that patients and those who care for them are free from preventable harm across the health care system.

NPSF recommends widespread adoption of the public health framework described in figure 2 to guide collective efforts to address preventable health care harm.

Figure 2.

Public Health Framework	Recommended Action	Suggested Tactic	Responsible Stakeholders
<p>1. Define the problem and set national goals</p>	<p>Leaders and policy makers must establish preventable health care harm as a public health crisis and commit to reducing this harm across the care continuum</p>	<p>Creation of a National Steering Committee for Patient Safety to set national reduction goals and define and establish a National Action Plan for the Prevention of Health Care Harm</p>	<ul style="list-style-type: none"> • Health Care Organizations / Leaders • Policymakers (Congress, AHRQ, CDC, CMS, HHS, ONC)
<p>2. Coordinate activities across multiple sectors to ensure widespread adoption and evaluation</p>	<p>Create centralized and coordinated national oversight of patient safety involving a broad array of stakeholders</p>	<p>Encourage stakeholders to work collaboratively to implement a National Action Plan for the Prevention of Health Care Harm</p>	<ul style="list-style-type: none"> • Health Care Organizations / Leaders • Health Care Workforce • Industry • Insurers • Patients/Families • Policymakers (Congress, AHRQ, CDC, CMS, HHS, ONC) • Researchers • Safety Organizations
<p>3. Inform, educate and empower the community</p>	<p>Partner with patients and families for the safest care.</p>	<p>Actively engage patients in care (e.g., shared decision making, playing an active role in bedside rounding, removing limits on family visiting hours, and making available patient-activated rapid response teams) and in root cause analyses</p>	<ul style="list-style-type: none"> • Foundations / Other Funders • Health Care Organizations / Leaders • Health Care Workforce • Industry • Patients/Families • Policymakers (Congress, AHRQ, CDC, HHS)
<p>4. Effectively measure and monitor progress at all levels</p>	<p>Create a common set of objective safety metrics to ensure widespread adoption, evaluation, and accountability</p>	<p>Create a portfolio of national standard patient safety process and outcome metrics across the care continuum and retire invalid measures.</p>	<ul style="list-style-type: none"> • Health Care Organizations / Leaders • Policymakers (Congress, AHRQ, CDC, HHS) • NQF
<p>5. Identify causes and interventions that work</p>	<p>Ensure that leaders establish and sustain a culture of safety</p>	<p>Develop and implement strategies to improve organizational culture based on existing practices and experience with successful culture change efforts</p>	<ul style="list-style-type: none"> • Health Care Organizations / Leaders • Policymakers (Congress, AHRQ, CDC, CMS, HHS) • Professional Associations
	<p>Provide sustainable funding for research in patient safety and implementation science</p>	<p>Ensure that funding for research on the prevention of health care harm is at a level comparable to research on other top diseases (in contrast to FY 2016, when NIH allocated \$5.4 billion for cancer and just \$0.9 billion for patient safety)</p>	<ul style="list-style-type: none"> • Foundations / Other Funders • Policymakers (Congress, AHRQ, CDC, HHS, NIH) • Public/Private Partnerships
	<p>Ensure that technology is safe and optimized to improve patient safety</p>	<p>Create a Health IT Safety Center that works to optimize technology and minimize unintended consequences</p>	<ul style="list-style-type: none"> • Health Care Organizations / Leaders • Industry • Policymakers (Congress, ONC) • Public/Private Partnerships
<p>6. Educate and train</p>	<p>Support and educate the workforce</p>	<p>Expand or develop resources that support the workforce, including initiatives to improve working conditions, establishing an environment of teamwork and respect, programs to support staff and improve resiliency, fatigue management systems, and communications, apology, and resolution programs</p>	<ul style="list-style-type: none"> • Health Care Organizations / Leaders • Health Care Workforce • Policymakers (Congress, AHRQ, CDC, CMS, HHS, NIH) • Safety Organizations

AHRQ: Agency for Healthcare Research and Quality. **CDC:** Centers for Disease Control and Prevention. **CMS:** Centers for Medicare and Medicaid Services. **HHS:** U.S. Department of Health and Human Services. **NIH:** National Institutes of Health. **NQF:** National Quality Forum. **ONC:** HHS Office of the National Coordinator for Health Information Technology

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