Call To Action

Institute for Healthcare Improvement
NPSF
TOGETHER FOR SAFER CARE

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

Originally issued in March 2017 by the National Patient Safety Foundation, which has since merged with the Institute for Healthcare Improvement.

Summary

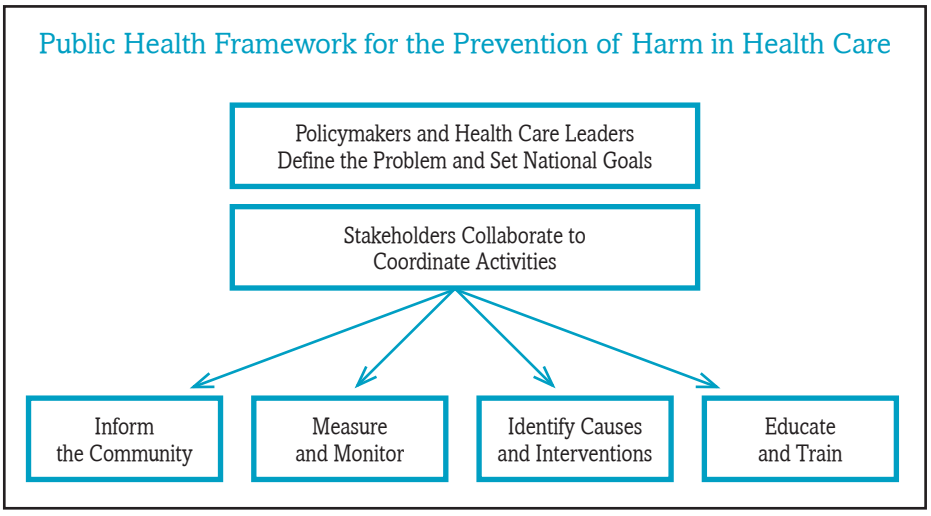
Preventable harm in health care is a public health crisis, with estimates placing it as a leading cause of death in the United States.[1–4]

The Institute for Healthcare Improvement (IHI) 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, IHI 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] IHI 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.

Figure 1.



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

* The Institute for Healthcare Improvement (IHI) and the National Patient Safety Foundation (NPSF) began working together as one organization in May 2017. The newly formed entity is committed to using its combined knowledge and resources to focus and energize the patient safety agenda in order to build systems of safety across the continuum of care. To learn more about our trainings, resources, and practical applications, visit ihi.org/PatientSafety.

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 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.

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

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Figure 2.

Public Health Framework	Recommended Action	Suggested Tactic	Responsible Stakeholders
1. Define the problem and set national goals	Leaders and policymakers must establish preventable health care harm as a public health crisis and commit to reducing this harm across the care continuum	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	• Health Care Organizations / Leaders • Policymakers (Congress, AHRQ, CDC, CMS, HHS, ONC)
2. Coordinate activities across multiple sectors to ensure widespread adoption and evaluation	Create centralized and coordinated national oversight of patient safety involving a broad array of stakeholders	Encourage stakeholders to work collaboratively to implement a National Action Plan for the Prevention of Health Care Harm	• Health Care Organizations / Leaders • Health Care Workforce • Industry • Insurers • Patients/Families • Policymakers (Congress, AHRQ, CDC, CMS, HHS, ONC) • Researchers • Safety Organizations
3. Inform, educate and empower the community	Partner with patients and families for the safest care.	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	• Foundations / Other Funders • Health Care Organizations / Leaders • Health Care Workforce • Industry • Patients/Families • Policymakers (Congress, AHRQ, CDC, HHS)
4. Effectively measure and monitor progress at all levels	Create a common set of objective safety metrics to ensure widespread adoption, evaluation, and accountability	Create a portfolio of national standard patient safety process and outcome metrics across the care continuum and retire invalid measures.	• Health Care Organizations / Leaders • Policymakers (Congress, AHRQ, CDC, HHS) • NQF
5. Identify causes and interventions that work	Ensure that leaders establish and sustain a culture of safety	Develop and implement strategies to improve organizational culture based on existing practices and experience with successful culture change efforts	• Health Care Organizations / Leaders • Policymakers (Congress, AHRQ, CDC, CMS, HHS) • Professional Associations
	Provide sustainable funding for research in patient safety and implementation science	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)	• Foundations / Other Funders • Policymakers (Congress, AHRQ, CDC, HHS, NIH) • Public/Private Partnerships
	Ensure that technology is safe and optimized to improve patient safety	Create a Health IT Safety Center that works to optimize technology and minimize unintended consequences	• Health Care Organizations / Leaders • Industry • Policymakers (Congress, ONC) • Public/Private Partnerships

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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The following organizations have endorsed this Call to Action:

(as of May 2018)

- The AAMI Foundation
- ABIM Foundation
- American Association for Physician Leadership (AAPL)
- American Association of Critical-Care Nurses (AACN)
- American Board of Internal Medicine (ABIM)
- American Board of Medical Specialties (ABMS)
- American Nurses Association
- Anesthesia Patient Safety Foundation (APSF)
- Arkansas Hospital Association
- Association of periOperative Registered Nurses (AORN)
- Aurora Health Care
- Besty Lehman Center for Patient Safety
- Center for Health Services and Outcomes Research (CHSOR)
- Center for Medical Simulation
- Children's Hospitals' Solutions for Patient Safety (SPS)
- Children's Hospital Association (CHA) - Child Health Patient Safety Organization (Child Health PSO)
- The James M. Anderson Center for Health Systems Excellence at Cincinnati Children's
- Citizens for Patient Safety
- Duke University Health System
- Federation of State Medical Boards (FSMB)
- HCA, Inc.
- Healthcare Association of New York State (HANYS)
- Heartland Health Research Institute
- HIMSS
- Hospital Quality Institute (HQI)
- Institute for Healthcare Improvement (IHI)
- Institute for Safe Medication Practices (ISMP)
- John D. Stoeckle Center for Primary Care Innovation
- LifePoint Health
- Massachusetts Coalition for the Prevention of Medical Errors
- MHA Keystone Center
- Minnesota Alliance for Patient Safety (MAPS)
- MITSS (Medically Induced Trauma Support Services)
- National Association for Healthcare Quality (NAHQ)
- Nursing Alliance for Quality Care (NAQC)
- Oregon Patient Safety Commission
- Pacific Business Group on Health
- Partners HealthCare
- Presbyterian Healthcare Services - New Mexico
- Society of Hospital Medicine (SHM)
- Society to Improve Diagnosis in Medicine (SIDM)
- Tufts Medical Center and Floating Hospital for Children
- UC Davis Medical Center
- UC Irvine Health
- UC San Diego Health
- UCSF Health
- University of Utah Health
- UNT Health Science Center
- Vidant Health
- Virginia Mason Health System
- The Visiting Nurse Associations of America (VNAA)

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