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IHI CONVENES PROMINENT GROUPS TO DEVELOP A NATIONAL ACTION PLAN FOR PATIENT SAFETY

New National Steering Committee for Patient Safety meets in Boston

Boston, MA, May 22, 2018 — Aiming to relaunch the nation’s patient safety agenda with renewed energy and focus, the [Institute for Healthcare Improvement](#) (IHI) today hosts representatives from 25 organizations to begin work on a national strategy for reducing harm in the delivery of health care. The [National Steering Committee for Patient Safety](#), with members from the health care, policy, regulatory, and advocacy communities, is charged with creating a National Action Plan to serve as a roadmap to accelerate progress.

Co-chaired by **Tejal K. Gandhi, MD, MPH, CPPS**, Chief Clinical and Safety Officer, IHI, and **Jeffrey Brady, MD, MPH**, Director, Center for Quality Improvement and Patient Safety at the US Agency for Healthcare Research and Quality, the committee meets for the first time today in Boston ahead of the 20th Annual [IHI/NPSF Patient Safety Congress](#), which gets underway tomorrow at the Hynes Convention Center.

This new effort stems from a 2017 [Call to Action](#) issued by the National Patient Safety Foundation (NPSF), which merged with IHI last year to combine the strengths of the two organizations around patient safety. The Call to Action frames medical harm as an issue that affects all of society, demanding a coordinated response by the health care and public health sectors.

“For decades, experts have called for increased coordination to improve patient safety, but such a strategy has not been fully instituted,” Gandhi said. “There is still so much work to be done in patient safety, in part because we’ve reached the limits of what a project-by-project approach can achieve. Instead of declaring ‘mission accomplished,’ we need to take steps to advance total systems safety — safety that is reliably and uniformly applied wherever care is provided.”

As outlined in a [2015 NPSF report](#), a total systems approach contains elements that have proven to be at the foundation of safety and are key to making sustainable progress in all health settings. They include safety culture, leadership, communication among team members, measurement, and patient and family engagement.

The public was first exposed to the term “patient safety” nearly 20 years ago with the release of *To Err Is Human: Building a Safer Health System*, [a report](#) estimating that as many as 98,000 deaths in the US each year are the result of harm accidentally inflicted during a medical encounter. Recent studies claim that four times as many deaths can be attributed to medical harm, making it by some estimates the third leading cause of death in the US and a source of long-term physical, emotional, and psychological damage.

“We’ve seen success in targeted areas, such as reductions in health care–associated infections and hospital-acquired conditions,” said Brady. “Those gains have been supported by prominent national initiatives and efforts involving governmental agencies and public-private partnerships. This renewed, shared focus on keeping patients safe and the work of the National Steering Committee reflect the importance of effective coordination at all levels — from national organizations to individual clinicians. Teamwork will be necessary to achieve patient safety across the entire continuum of patient care.”

The care continuum includes office practices, ambulatory centers, and clinics where most care is now delivered in the US. Studies about the extent of harm and effective strategies to address problems in these settings, such as errors in diagnosis and lost test results, are only now starting to get attention.

For example, a growing number of people receive care in outpatient settings and in their own homes with very little guidance or knowledge about patient safety. Care in the home is the subject of a forthcoming report from IHI outlining the potential risk of harm to patients along with recommendations for improving safety in this setting. Patient safety in ambulatory care is also one of the focus areas of this year's Patient Safety Congress, with a session addressing safety in home care and others focused on a variety of outpatient settings.

For more information on the work of the National Steering Committee, visit ihi.org/patientsafety. For more information about the 2018 IHI/NPSF Patient Safety Congress, visit ihi.org/patientsafetycongress, follow the Twitter hashtag [#IHICongress](https://twitter.com/IHICongress) for up-to-the-minute developments and commentary, or email requests for press credentials and event photos/video footage to Joanna Clark (joanna@cxocommunication.com).

The National Steering Committee for Patient Safety includes representatives of the following organizations:

Agency for Healthcare Research and Quality (AHRQ)
American Association of Retired Persons (AARP)
American Board of Medical Specialties (ABMS)
American College of Healthcare Executives (ACHE)
American College of Physicians (ACP)
American Hospital Association (AHA)
American Nurses Association (ANA)
Centers for Disease Control and Prevention (CDC)
Centers for Medicare and Medicaid Services (CMS)
Children's Hospitals' Solutions for Patient Safety
DNV GL - Healthcare
ECRI Institute
Health Research and Educational Trust
Institute for Healthcare Improvement and the IHI/NPSF Lucian Leape Institute
Institute for Safe Medication Practices (ISMP)
The Joint Commission
Mothers Against Medical Error
National Association for Healthcare Quality (NAHQ)
National Quality Forum
Nurses Alliance for Quality Care (NAQC)
Occupational Safety and Health Administration (OSHA)
Project Patient Care
Society to Improve Diagnosis in Medicine
US Food and Drug Administration (FDA)
VA National Center for Patient Safety, Veterans Health Administration

About Us

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.

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