United States Senate
Permanent Subcommittee on Investigations
Hearing On
Patient Safety: Instilling Hospitals with a Culture of Continuous Improvement
342 Dirksen Senate Office Building
9:00 a.m.
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Submitted By

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Patient Safety: Instilling Hospitals with a Culture of Continuous Improvement

I. Case for Change

In 1999, patient safety came into the national spotlight with the November release of the Patient Safety Report by the Institute of Medicine (IOM) of the National Academy of Sciences. The IOM report revealed that 44,000 to 98,000 deaths occur annually due to health care errors. The IOM recommended a four-point plan to reduce errors by 50% over five years: [1]

- Establish a Center of Patient Safety to create national leadership, research, tools and protocol
- Identify and learn from health care errors through mandatory and voluntary reporting
- Raise standards and expectations for safety improvement through actions of oversight organizations, group purchasers and professional groups. Create a culture shift to make safety a top priority.
- Implement safe practices at the delivery level

The second IOM report was released in February 2001. It concluded that the U.S. healthcare industry has failed resoundingly in its ability to consistently provide safe, high quality care to all Americans. The IOM stated that health care is decades behind other industries in terms of creating safer systems. It is the only industry that doesn't know its defect rate (most likely 3-4 sigma). Today, most hospital executives agree that the industry needs a system for capturing, interpreting and acting upon medical errors data. A new agenda was proposed to build a health system for the 21st century: [2]

- Commit to a national statement of purpose for the health care system as a whole
- Engage the Department of Health and Human Services to: Identify a set of priority conditions (chronic); create an infrastructure to support evidence-based practice; expand the knowledge of the workforce.
- Make the health care system safe, effective, patient-centered, timely, efficient and equitable
- Formulate rules to redesign and improve care
- Align payment incentives to have a stronger focus toward quality
- Create an agency for health care research and quality---15 priority conditions
- Leverage information technology…the Internet, video and satellite teleconferencing to widely disseminate information for supporting clinical decision-making

Prior to the IOM reports, there was trouble. The Harvard Medical Practice Study's 1991 publication on the frequency of adverse events in hospitals revealed that iatrogenic injuries occur in 3.7% of hospitalizations. JAMA reported in 1995 that 2.5% of admissions are iatrogenic.

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[1] Institute of Medicine, *To Err is Human: Building a Safer Health System, 1999.*
[2] Institute of Medicine, *Crossing the Quality Chasm: A New Health System for the 21st Century*, 2001.

II. Why is Change so Difficult in Healthcare?

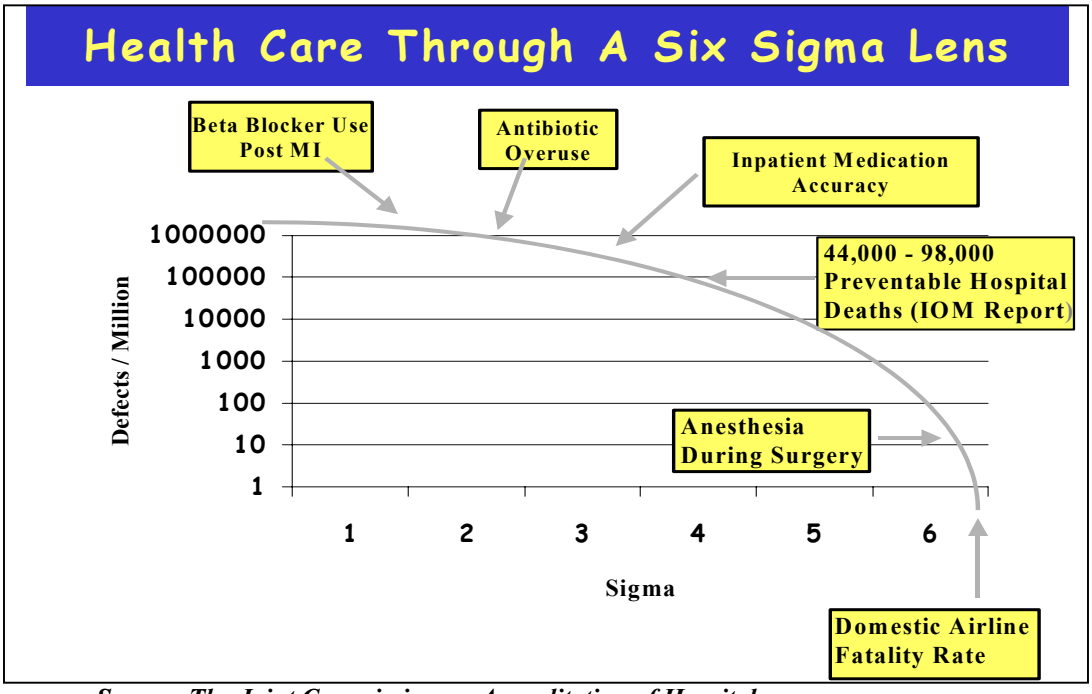
Healthcare is a 1.4 trillion dollar industry which is still based on a pre-industrial revolution craft model—train the clinicians, leave clinical care to them and create parallel administrative/management processes to provide resources for what clinicians do. The legacy of this practice is huge variation in clinical practice, harm to patients, inefficiency, paralyzing misunderstanding and conflict between clinicians and managers.

Regulation and the learning sciences shaped medicine's craft heritage. Regulation of health care started with the Code of Hammurabi in 1750 BC and was influenced by development of the legal system. State Boards added refinements to the regulatory process in the late 1800's and early 1900's. Further enhancements came from hospital accreditation, the opinions of peer review organizations and report cards such as HEDIS and ORYX. Improvements from the learning sciences stemmed from the work of Hippocrates, Nightingale, Codman, and the American College of Surgeons, M&M Conferences and the concept of disease management. The problem with this system is that complex health care processes were unsupported by a carefully designed error-proofing infrastructure. They relied on people checking people during a growing number of "hand-offs".

What happens when processes evolve in a craft-based culture? Highly educated and committed caregivers work within the context of two key factors over which they have no control: the fundamental design of healthcare and the vast complexity of modern healthcare. The processes that evolve contain hazards that can result in fatalities and near misses. Thus, the performance capability of the system ranges from 2-4 sigma (refer to Exhibit I).

Exhibit I

Sigma Level of Health Care Processes



Source: The Joint Commission on Accreditation of Hospitals

During the 20th century, management science was developing and starting to make dramatic quality and safety improvements in other industries. Some say that health care is 50 years behind these industries. The solution is using column three techniques to improve health care.

Quality: 3 Historic Pathways

Regulation	Learning Sciences	Management Science
Hammurabi	Hippocrates	Industrial Technology
Legal System	Nightingale	Tailor: Scientific Management
State Boards	Codman, ACS/Hospital Standardization	Shewart: Statistical Process Control
JCAHO Accreditation	M & M Conferences	Deming, Juran, TQM, Baldrige, ISO
PRO/NCQA	Donabedian, structure, process outcome	Human Factors Engineering
Report Cards (HEDIS< ORYX)	Disease Management	Six Sigma Breakthrough Strategy

III. Patient Safety and Quality

Many definitions exist for both quality and safety. The simple definition of quality is "meeting or exceeding customer expectations". The simple definition of patient safety is "preventing harm to patients in our care". Quality and safety are related. Quality focuses on meeting or exceeding rising customer expectations. Safety is a sub-set of quality. Safety and quality utilize many of the same performance improvement tools. Process changes that improve safety also result in additional quality-related improvements such as faster cycle time, elimination of rework and waste and lower costs. Healthcare quality problems are often classified into three categories:

- Misuse…avoidable complications of appropriate care
- Overuse…services provided when the risk of harm exceed the potential benefits
- Underuse…failure to provide an effective service that would produce a favorable outcome

Misuse is clearly a growing safety problem. In the 2002 Commonwealth Study, more than 20% of adults reported that they or a family member experienced a medical or prescription drug error.

Overuse is a quality problem, but could also be a safety issue. For example: an estimated 40% of hysterectomies are inappropriate or have questionable value and an estimated 21% of all antibiotic prescriptions are written for viral infections.[3]

Underuse is also primarily a quality problem, but could be a safety issue as well. An estimated 60% of patients diagnosed with depression receive no medication and studies show that Beta blockers are given to heart attack patients only 25-40% of the time.[4]

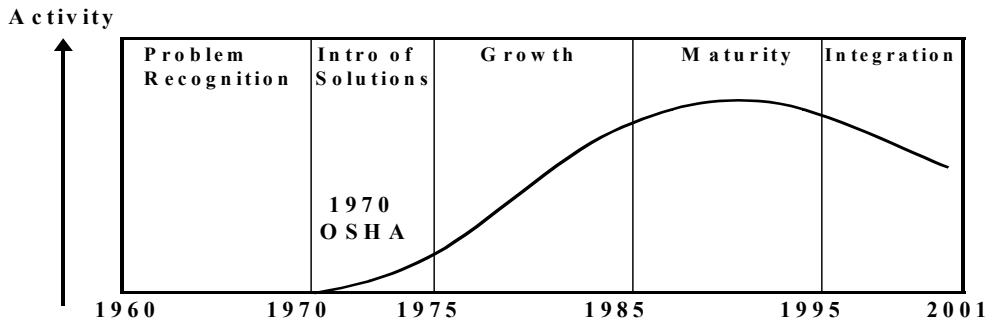
[3] St. Joseph's Hospital, West Bend Wisconsin
[4] Ibid

IV. How Long Does it Take to Change an Industry?

A question that is often asked is, how long does it take to change the culture and performance of an industry? Are we making progress in patient safety? We can turn to the transformation of occupational safety and quality in the U.S. for the answer.

The change cycle consists of five stages: problem recognition, the introduction of solutions, growth in prevention activity, maturity and integration. The problem recognition phase usually lasts about ten years as an industry struggles with denial. Once there is a commitment to find solutions, the length of the change cycle depends on the amount of support that is provided and on the strength of the economic business case. It took about 25 years, after the formation of OSHA, to change the culture in occupational safety and secure dramatic performance breakthroughs as outlined in Exhibit II. The quality transformation in the United States was faster with major improvements in place in the mid-1990's following the Baldrige Act of 1987.

Exhibit II
The Change Cycle
For Occupational Safety



	1960	1970	1975	1985	1995	2001
Deaths	13,800	13,800	13,000	11,500	5,018	5,300
Rate (100,000)	7.7	6.8	6.0	4.8	1.9	1.9

Source: National Safety Council

The Harvard Medical Practice Study's 1991 publication on the frequency of adverse events in hospitals became the initial focus for discussion in patient safety. In 1996, the decision to create the National Patient Safety Foundation was made during the first Annenberg conference. The final catalyst for change came in 1999 with the release of the first IOM Report*, To Error is Human: Building a Safer Health System.*

We are near the end of the search for solutions phase. In 2001, HHS announced the formation of the Patient Safety Task Force and its $50 million investment to improve patient safety. There are numerous patient safety bills moving through Congress. We are have learned the benefits of full disclosure, identified numerous best practices and adopted management science techniques such as human factors engineering, root cause analysis, FMEA, DOE and Six Sigma. The patient safety movement is gathering steam moving into the growth stage of the change cycle.

V. NPSF's Role in Leading Patient Safety Through the Change Cycle

The National Patient Safety Foundation instills a culture of continuous improvement in hospitals. First, we provide unique opportunities to *network* and identify best practices. The need for action is reflected in the theme of NPSF's 5th Annual Patient Safety Congress: "Lets Get Results" and also in its Integrity and Accountability in Clinical Research Conference.

NPSF creates *awareness* of patient safety issues through its public outreach activities such as National Patient Safety Week which takes place in March, its media relations efforts which generated more than 24 million impressions during the past 12 months and its Web site which receives more than 400,000 visits each month. In addition, NPSF's *Focus* newsletter reaches more than 6000 subscribers and its Listserv continues to grow with more than 2,300 participants. Patients can also demonstrate their support for patient safety by becoming a member of NPSF.

NPSF established the Patient and Family Advisory Council to provide guidance and patient perspective on all of NPSF's activities. In March, we released a National Agenda for Action to Support Patients and Families. It provides a high-level road map for action in four areas: education, culture, research and support services. The first step is to raise awareness on these issues. The second step is to address how these actions should be implemented and funded. The complete agenda is included as Exhibit III.

There are a variety of *educational* opportunities. The Patient Safety Store provides the best single source for securing patient safety videos and publications. The Patient Safety Information Center publishes the most comprehensive list of patient safety publications through Current Awareness and its Bibliography. Training is offered through NPSF's Web based patient safety series for physicians, nurses and patients. In 2003, the National Patient Safety Foundations will launch the Training Institute for Patient Safety, which will offer in-house, and classroom training.

NPSF also *convenes* healthcare leaders to reach consensus on patient safety issues and solutions. Using the Harvard Executive Model, Minnesota hospital CEO's have agreed to collaborate and not compete on patient safety. They served as the catalyst for creating model state legislation on disclosure and reporting and have agreed to deploy numerous best practices. Through NPSF's Stand Up for Patient Safety Program, hospital and system CEO's will establish their own agenda for patient safety. NPSF will assist these organizations in creating action learning projects to test improvement strategies linked to this agenda. Stand Up hospitals also participate in monthly audio conference calls and workshops to secure information from thought leaders on important issues such as building safety into new construction, disclosing medical errors, creating Patient and Family Advisory Councils and dealing with hospital workforce shortages. The Corporate Council program provides an opportunity for suppliers to establish an ongoing dialogue with hospital executives that will lead to patient safety solutions. Under the NPSF umbrella, the Corporate Council will conduct demonstration projects intended to further patient safety and construct components of the associated business case.

VI. Breakthrough Strategies

There are several evidence-based strategies that are starting to produce dramatic quality and patient safety improvements. The challenge is to ***close the gap*** between what is known and what is being practiced in most hospitals. The National Patient Safety Foundation's dissemination strategy plays an important role in closing performance gap.

(A) The Baldrige Healthcare Criteria provides an excellent framework for managing the enterprise and securing performance improvements. Hospitals can set their sights on winning the award or just following the criteria. SSM Healthcare in St. Louis is the first award recipient in healthcare. Results include:

- A 50% reduction in mortality rates in coronary bypass surgery
- Significantly lower readmission rates for congestive heart failure and pneumonia
- A drop in the length of stay of Medicare patients resulting in an annual savings of $5 million
- Significant increases in patient satisfaction and market share during the past three years

(B) A full disclosure policy provides the information essential for identifying problems and developing breakthrough solutions. There are two axioms of disclosure. No one makes an error on purpose and no one admits an error if you punish them for it. NPSF distributed the following statement of principle on disclosure to all hospitals:

When a healthcare injury occurs, the patient and the family or representative is entitled to a prompt explanation of how the injury occurred and its short and long-term effects. When an error contributed to the injury, the patient and family or representative should receive a truthful and compassionate explanation about the error and the remedies available to the patient. They should be informed that the factors involved in the injury will be investigated so that steps can be taken to reduce the likelihood of similar injury to mother patients.

Full disclosure provides data to analyze problems and find solutions, improves patient and family satisfaction and reduces malpractice litigation. SSM healthcare established a "blame free zone" for staff to report errors and near misses. This has led to numerous system improvements. Many other hospitals have also adopted effective disclosure policies.

(C) Another important strategy is engaging patients and families to develop valuable new perspectives. They experience the gaps and fragmentation in the healthcare system. Patients and families keep health care professionals and leaders honest and grounded in reality and they provide timely feedback, new ideas and additional creativity. The result is improved quality and safety and reductions in malpractice allegations.

Patient and Family Advisory Councils were first introduced in children's hospitals and pediatric units in the 1980's. They are typically composed of between 12 and 30 patient and family members who meet regularly to propose and develop programs, policies and services. This concept quickly spread to a variety of hospitals.

Dana-Farber Cancer Institute created its first Patient and Family Advisory Council in 1998. Successes include:

- Patient-faculty programs to help first-year oncology fellows understand the patient experience
- Solutions for reducing infections among neutropenic patients
- Eliminating confusion over provider (residents, interns, nurses and attending physicians) roles and responsibilities
- Changes in architectural plans to build in safety and reduce patient anxiety

The typical breast diagnosis process was built around the needs of practitioners. It asks an anxious woman with possible breast cancer to go from doctor to doctor, place to place and healthcare silo to healthcare silo before see learns whether or not she has cancer. There is a lot of variation in cycle time, which averages 1 to 8 weeks. The Park-Nicollet Health System built a breast diagnosis process around the needs of patients and families. Cycle time was reduced to 2 to 4 hours.

(D) There are numerous process improvement tools that hospitals can use to evaluate processes and identify solutions. Examples include process mapping and analysis software, failure mode and effects analysis (FMEA), root cause analysis, design of experiments and comprehensive six sigma programs. Six sigma has set a new standard for organizations in a variety of industries that are reducing errors to only 3.4 per million opportunities. Froedtert Hospital in Milwaukee utilizes the six sigma methodology extensively to reduce process variation. Successes include improving outcomes with high-risk medication and *reducing* the variability of PCA infusion pumps, cycle times in analyzing lab specimens and patient falls.

(E) The National Quality Forum released 30 evidence-based safe practices in May 2003. Hospitals can secure dramatic improvements in quality and safety by adopting these practices to achieve the following goals:

- Creating a culture of safety
- Matching healthcare needs with service delivery capabilities
- Facilitating information transfer and clear communication
- Adopting safe practices in specific clinical settings or for specific processes of care
- Increasing safe medication use

VII. Barriers to Improving Patient Safety and Quality

A recent NPSF environment scan uncovered ten forces that will inhibit hospitals from management practices designed to improve patient safety and quality. The Delphi methodology was use to rank order these forces by importance.

(A) Hospital Workforce Shortages (Delta mean: 3.78)

Trend: The newest threat to America's health care system is a growing shortage of hospital personnel. Problems persist in recruiting and retention creating safety issues.

Implications: Hospitals across the country are struggling to find qualified staff to serve their communities' needs. Unfilled positions in nursing units and in pharmacies, laboratories and x-ray departments cause delays in care delivery. Emergency departments close to ambulances, surgeries are postponed and inpatient and outpatient capacity is reduced.

Observation: Up to 168,000 hospital positions are unfilled in six job categories (75% of the openings are for nurses). Pharmacists have the highest percent of unfilled positions. The root cause is declining enrollment in health education programs, an aging workforce, competition from other health care employers and compensation issues. [5]

[5] The Lewin Group, *AHA Trend Watch,* June 2001, Vol.3. No.2. p. 2.

(B) The Internet is Leveling the Playing Field for Patients (Delta mean: 3.74)

Trend: A growing number of patients are going online to find treatment alternatives.

Implications: Patient demand for the latest drugs and treatments will increase. Physicians are being forced to share decision-making power with patients. Safety may be compromised as patients start making their own assessments without expert consultation.

Observation: In 1998, more than 17 million people in the U.S. went online to research medical conditions on their treatment.[6]

(C) Need for New Designs in Healthcare (Delta mean: 3.65)

Trend: Unless action is taken, the total cost of poor-quality healthcare could run over $1 trillion by 2011.[7] The modest rate of change demonstrated by improving technologies focuses attention on the need for and potential of new designs for healthcare.

Implications: Healthcare organizations are searching for new solutions, however, funding new designs will be a problem for many providers. Technology promises benefits with huge financial risks.

Observation: Healthcare organizations are abandoning continuous improvement strategies.

(D) Patient Safety Legislation (Delta mean: 3.55)

Trend: The AMA is actively working with the Bush Administration and Congress to introduce federal legislation that provides strong legal and confidentiality protections for information that is voluntarily shared to improve patient safety.[8]

Implications: Strong legal and confidentiality protections will be available for information that is voluntarily shared. This will enable the development of metrics to drive process improvements and measure results.

Observation: Accurate data is needed to measure performance, identify root causes and test improvement solutions.

(E) Technology Promises Benefits with Huge Financial Risks (Delta mean: 3.45)

Trend: Growth and interest continues in IT strategies to streamline services and serve patients in innovative ways. Investment in genomics continues to grow. Organization web sites reach out to patients and providers (such as Allina and Mayo).

Implications: IT requires huge portions of provider capital budgets. The net cost benefit of genomics remains to be determined. Complimentary therapies continue to grow amounting to $13 billion in out of pocket expense for patients.[9]

Observation: The cost benefit of many investments is still unknown.

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[6] Ibid, p. 21.
[7] Ibid, p.18.
[8] AMA Advocacy Report, March 2002.
[9] The Institute for Healthcare Improvement, 2002 Business Plan.

(F) Growing Outpatient Care Increases the Need for Patient Support (Delta mean: 3.44)

Trend: Ambulatory patients in office settings are not receiving the same quality of care as in hospitals.[10]

Implications: If this trend is not fixed, inappropriate and unreasonable regulation may result. In addition, the safety record of outpatient care will remain below acceptable levels.

Observation: There is a lack of appropriate staffing with credentialed providers. There is also a lack of concordance between safety, quality and cost.

(G) Consumers Expect More from Healthcare Providers (Delta mean: 3.40)

Trend: Purchasers are becoming more discriminating in selecting providers. There is significant tension for change to make improvements.

Implications: Dissatisfaction drives litigation. High expectations place pressure on provider profit margins. Weak providers will fail. This environment provides competitive advantages for innovators. Patient safety should improve.

(H) Workforce Stress will Continue in Healthcare (Delta mean: 3.38)

Trend: Labor shortages, low worker morale and staff retention highlight the increasing importance of human resource issues to system and medical group executives. Human resource themes were the top three issues identified by the National Forum participants.[11]

Implications: Labor shortages, low worker morale and high turnover drive poor quality and safety. The aging nursing workforce and faculty raise concerns about the future of nursing.

Observation: Aging baby boomers will create surging demand for healthcare services of all types.

(I) Quality Measures Becoming More Prevalent for Healthcare Purchasers (Delta mean: 3.35)

Trend: Problems of preventable errors and overused, misused and under used tests, treatments and procedures are largely hidden from purchasers and consumers.

Implications: Unless action is taken, the total cost of poor-quality healthcare could run over $1 trillion by 2011.

Observation: Purchasers can play a leadership role in addressing the cost of poor quality care as evidenced by the actions of LeapFrog and the Midwest Business Group on Health.

(J) Medical Liability Issues (Delta mean:3.35)

Trend: Malpractice litigation is growing and settlements are becoming larger.[12]

Implications: The medical liability environment undermines patient safety.

Observation: Malpractice insurance is becoming unaffordable causing physicians to abandon practices.

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[10] NPSF *Collaborative Leadership for Ambulatory Surgery in the Office Setting*, September 2002.
[11] The Institute for Healthcare Improvement, 2002 Business Plan.
[12] AMA Advocacy Report, March 2002.

VIII. Benefits of Improved Performance

In a recent study, the Juran Institute estimates that the cost of poor quality exceeds 30% of all direct health care outlays, consisting primarily of overuse, misuse and waste.[13] With national health expenditures of $1.3 trillion in 2001, the 30 percent figure translates into $390 billion spent each year as a result of poor quality. The advantages of performance improvements include greater patient satisfaction, significant improvements in patient safety and dramatic cost reductions that can be shared with purchasers and consumers.

IX. The Road Ahead for Hospitals

There is a compelling need for all hospitals to close the gap between what is known (best practices) and what is being practiced today. A major lesson learned from occupational safety and quality management is that organizations need a formal program to organize and focus their activities before rapid improvements can take place. The elements of an effective patient safety program include the following:

(A) Secure Management Commitment

Patient safety should be part of a hospital's strategic and business planning process and patient safety improvements should be part of the CEO's compensation. A qualified individual should be designated to manage the patient safety program and adequate resources should be provided.

(B) Create Organization Patient Safety Goals and Objectives

All hospitals need to adopt patient safety goals. This can start with the six Joint Commission goals that were released in January 2003. Additional goals can be added from the lists created by the National Quality Forum, the Leapfrog Group or the National Patient Safety Foundation's Stand Up for Patient Safety Founding and Charter Hospitals. All goals should have measurable objectives to track performance.

(C) Develop an effective Information System

Information management starts by adopting a full disclosure policy and effectively managing patient-specific information. This information should be placed in a database that can be used for analysis and for tracking performance.

(D) Develop an Emergency Response Program (when the unexpected happens)

An emergency response program starts with risk analysis to uncover failure modes and effects. Response plans should be put in place. This includes staff training on disclosure of adverse events to patients and families and the media.

(E) Improve Processes

Process improvements should be continuous. Hospitals can start with the Joint Commission's national patient safety goal requirements and the National Quality Forum's 30 evidence-based safe practices. This effort should be supplemented with the hospital's own process improvement strategy utilizing root cause analysis and other quality tools

[13] Midwest Business Group on Health, Reducing the Costs of Poor-Quality Health Care

(F) Provide Education and Training

In a recent survey of NPSF's Stand Up for Patient Safety hospitals, CEO's indicted that the most important service that they need from outside sources is education. This includes staff training on tools and best practices, Board of Trustee education, leadership activities and patient education.

(G) Utilize Networking Opportunities

Networking is important to identify emerging trends and keep up to date on best practices.

(H) Create and Reinforce Awareness

Constant awareness and reinforcement of hazards and solutions is required to change behavior. Programs include campaigns, such as National Patient Safety Week, along with banners, posters, fact sheets and booklets.

(I) Use Reward and Recognition Programs to Change Behavior

Hospitals can use a variety of reward and recognition activities to change and reinforce positive behavior. These include local celebrations, awards and monetary incentives.

(J) Enforce Compliance

Compliance can be enforced by demonstrating management commitment, utilizing inspections and walk a rounds and through the Joint Commission's accreditation process.

(X) How Can Congress Encourage Improvements?

There are a number of ways that Congress can encourage greater effort at continuous improvement in healthcare. These include the following:

(A) Providing funding to support the National Agenda for Action for Patients and families including development of a Patient and Family Resource Center

(B) Support a central role for the Agency for Healthcare Research and Quality (AHRQ) in coordinating a multifaceted, multi-industry national patient safety initiative. This should include sufficient funding to carry out research and development activities to support and advance public and private patient safety initiatives across the nation

(C) Creating financial incentives for hospitals to support the business case for patient safety

(D) Support patient safety legislation aimed at protecting confidentiality and promoting disclosure such as HR 663, which passed the House by a nearly unanimous vote in March, or S. 720, which currently awaits Senate action.

Exhibit III

The National Patient Safety Foundation

National Agenda for Action:

Patients and Families

in Patient Safety

Nothing About Me, Without Me[*]

Executive Summary

This summary (and complete document) is a report developed by the National Patient Safety Foundation's (NPSF) Patient and Family Advisory Council. The NPSF promotes safer medical care through prevention of medical error and improving the health care system for all patients. NPSF established the Patient and Family Advisory Council (PFAC) to provide guidance and patient perspective on all of NPSF's activities. The following is the PFAC's recommended initial strategy for developing a patient-centered culture of patient safety in healthcare. This document is a call to action to all hospitals, health systems, national and local healthcare organizations to involve patients and families in systems and patient safety programs. The document provides a high-level road map for action in four areas: education, culture, research and support services. This is a first step to raise awareness on these issues. The next step will be to address how these actions should be implemented.

I. Education and Awareness

In the next three years, NPSF will take a leading role by providing a central clearinghouse and interactive resource center for education, training and resources on patient safety and prevention of medical error for patients and professionals.

Actions that need to be taken in individual hospitals and health systems (with leadership from NPSF and through the Stand Up for Patient Safety Campaign) include:

- Establishing interactive, interdisciplinary education programs that bring together patients and professionals by targeting:

    1. The general public, including patients, families, media
       Message topics:
       - Definition and principles of patient safety
       - Frequency of medical error
       - How to safeguard your own care and partner with your providers
       - What to do if you experience a mistake or error

    2. Healthcare organizations and professionals
       Message:
       - Patient/family perspective is important and should be actively integrated into culture of institution.

    3. The behavioral health community, including counselors and social workers
       Message:
       - Experience of medical error differs from other types of trauma — patients and families who experience harm due to a medical error may need specific types of support and advocacy.

II. Building A Culture of Patient and Family-Centered Patient Safety

Meaningful change cannot take place without a fundamental change in the culture of patient safety. The following actions are aimed at building partnerships with patients and families.

In the next three years, NPSF will take a leading role by providing a national forum for sharing and disseminating information to local and state coalitions and initiatives.

Actions that need to be taken by individual hospitals and organizations:

- Teach and encourage effective communication skills for patients, their families and healthcare professionals
- Train and utilize patient representatives for patient safety advocacy in hospitals and health systems
- Implement Patient and Family Advisory Councils in each hospital and healthcare organization
- Incorporate patient and family representation on Boards of Trustees
- Develop patient safety task forces and/or coalitions in each state

III. Research

Suggested areas of internal and external research:

- "Bridging the Gap": Effective methods for building relationships and communication between patients, caregivers, and providers
- Disclosure — Methods and their effects on patients and families
- Short- and long-term effects of integrating patients and families into the healthcare system
- Review of current patient safety information and resources available for patients and families, and their effectiveness
- Post-traumatic stress specific to medical error
- Team relationships (including patients and families)

IV. Support Services

There are three phases of medical error: preventing the error, preventing harm caused by the error, and mitigating the effects of a harmful error.
Support services are needed to address this last category.

In the next three years, NPSF will take the lead in these efforts by providing:
- *A national resource center and information line*
- *A peer resource counseling program to connect patients who have experienced a medical error with trained individuals who have already been through the experience*
- *National training programs*

Individual organizations and local coalitions should provide:
- Support groups
- Disclosure and communications programs

A long-term goal in this area is:
- Emergency line

Conclusion

This National Agenda for Action is by no means exhaustive. It represents a first step in depicting the spectrum of activity needed to address the concerns of patients and families involved with the health care process preceding and following preventable medical error. Through sharing experiences and perspectives with a focus on communication skills and team building, we hope to establish common practices and systems that honor and respect the needs of patients and families. This agenda should serve as a launching pad — not a destination.