PATIENTS FOR PATIENT SAFETY US

Annual Report

2021 / 2022

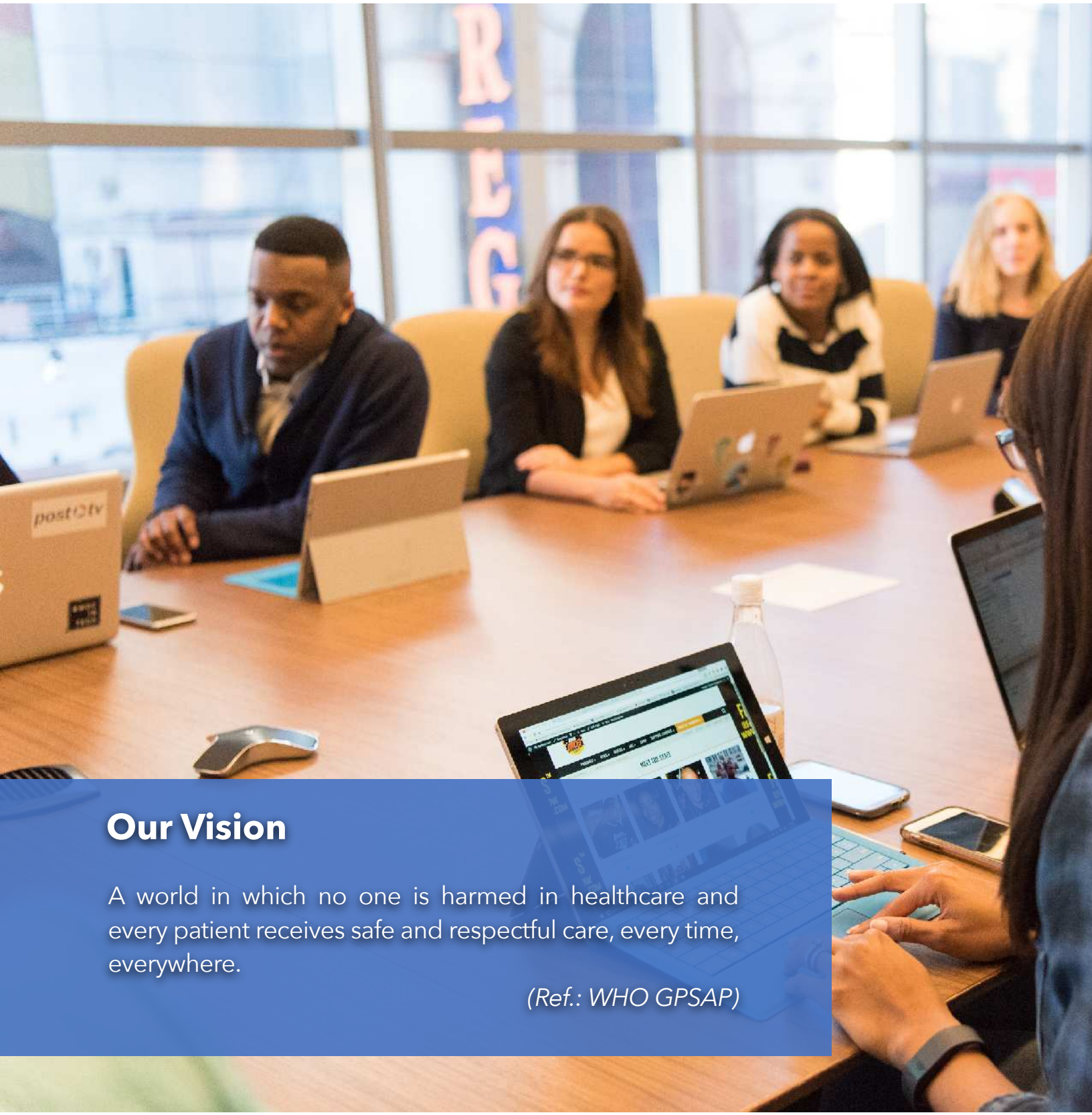
Implementation of the World Health Organization (WHO) Global Patient Safety Action Plan in the United States

December 2022

Annual Report

Index

Our Vision



Our Vision

A world in which no one is harmed in healthcare and every patient receives safe and respectful care, every time, everywhere.

(Ref.: WHO GPSAP)

PROGRESS
SNAPSHOT

Organizational Capacity

• People	10 Founding Members and 44 Champions
• Alliances	32 Strategic Alliances
• Structure	Legal designation, 5 committees
• Tools	Website, social media, orientation, resources

Awareness Raising & Advocacy

• Presentations	45 National & International
• Publications	3 Articles and Op-eds
• Taking a stand and influencing policy	7 Initiatives

Outcomes

• Idea generation process	50 Improvement ideas
• Co-development	7 Patient safety improvement initiatives
• Partnerships/grants	4 Partnerships on grants

10 Founding Members

Margo Burrows
Milwaukee, Wisconsin

Steve Burrows
Milwaukee, Wisconsin

Lt. Col. Steven L. Coffee
Woodbridge, Virginia

Alicia Cole
Los Angeles, California

Martin J. Hatlie
Chicago, Illinois

Carole Hemmelgarn
Denver, Colorado

Soojin Jun
Chicago, Illinois

Armando Nahum
Atlanta, Georgia

Sue Sheridan
Boise, Idaho

Beth Daley Ullem
Newport Beach, California

Bios: https://www.pfps.us/about-us

Welcome
From our FOUNDERS

Our Mission

To implement in the United States the recommendations of the World Health Organization Global Patient Safety Action Plan 2021-2030.

Our Commitment

PFPS US is committed to supporting partners, policies, and protocols which ensure that both health equity and patient safety standards are incorporated across all healthcare, public health, and industry platforms for a safer and healthier system for all.

Founding Member Thought Leadership Engagement

Presidential Committees

- President's Advisory Council to Combat Antimicrobial Resistant Bacteria (PACCARB)
- President's Council of Advisors on Science and Technology (PCAST) Patient Safety Working Group

Boards of Directors

- Institute of Healthcare Improvement (IHI)
- Collaborative for Accountability and Information (CAI)
- Alliance for Integrated Medication Management (AIMM)
- Patient Safety Movement Foundation (PSMF)
- Solutions for Patient Safety (SPS)
- Smart Patients
- Leapfrog Group

National Initiatives

- National Steering Committee for Patient Safety, Safer Together: A National Action Plan to Advance Patient Safety
- National Patient Safety Board Coalition

Founding Member Thought Leadership Engagement (cont.)

Advisory Councils

- MedStar Institute for Quality and Safety
- Pennsylvania Patient Safety Authority
- National Quality Forum Measure Application Partnership (MAP)
    - Health Equity Advisory Group
    - Hospital Workgroup
    - Coordinating Committee

Patient and Family Advisory Councils/Technical Expert Panels

- American Board of Internal Medicine (ABIM)
- Leapfrog Group Patient and Family Technical Expert Panel
- IHI Safety Advisory Forum of Experts (SAFE)
- National Quality Forum Patient and Caregiver Engagement (PACE)
- Yale/YNHH Center for Outcomes Research and Evaluation (CORE)
- MedStar Georgetown University Hospital: Patient and Family Advisory Council for Quality and Safety
- AHRQ: Updating TeamSTEPPS Curriculum
- Georgetown University Executive Master's in Clinical Quality, Safety & Leadership, Academic Oversight Committee

Think Tanks

- Lucian Leape Institute
- Northwestern University Covid Vaccine Communication and Evaluation Network (CoVAXCEN)

Fellowships

- Jewish Healthcare Foundation Salk Health Activist Fellowship

47 Patient Safety Champions

Rebeka Acosta
Las Vegas, Nevada

Sharon Bates
Phoenix, Arizona

Vonda Vaden Bates
Tulsa, Oklahoma

Geri Lynn Baumblatt
Chicago, Illinois

Purnima Gupta Bhoi
Bhubaneswar, Odisha

Isabela Castro
Rio de Janeiro, Brazil

Lilian Chiwera
Weavering, Kent, UK

Wanda Clevenger
Henrico, Virginia

Keri Anne Connaughty
Wausau, Wisconsin

Kayoko Corbet
Ellicott City, Maryland

Adrianne Coward
San Antonio, Texas

Jeanne DeCosmo
Westminster, Maryland

Tracy Fok
Chicago, Illinois

Lisa Freeman
Fairfield, Connecticut

Sherrie Fuller-Benge
Missoula, Montana

Carol Coven Grannick
Skokie, Illinois

Tracy Granzyk
Saint Charles, Illinois

Mary Herold
Fairfax, Virginia

Krista Hughes
Birmingham, Alabama

Heon-Jae Jeong
Seoul, South Korea

Sally Kerr
Boulder, Colorado

Allison G.S. Knox
Pauling, New York

Amy Kratchman
Philadelphia, Pennsylvania

Ariana Longley
Costa Mesa, California

47 Patient Safety Champions

Olivia Lounsbury
Irvine, California

Linda Lowman
Altamonte Springs, Florida

Wendi Martinez
Pasadena, Texas

David B. Mayer
Scottsdale, Arizona

Maryanne McGuckin
Ardmore, Pennsylvania

Sehar Meraj
Marietta, Georgia

Kathleen Merkley
Salt Lake City, Utah

Michael Millenson
Chicago, Illinois

Lisa Morrise
Salt Lake City, Utah

Marlene Nazarey
Rolling Hills Estate, California

Nanci Newberry
Austi, Texas

Stan Pestotnik
Salt Lake City, Utah

Donna Prosser
Raleigh, North Carolina

Marci Romero
Albuquerque, New Mexico

Margaret Scarlett
Atlanta, Georgia

Shadia Shaban
Denver, Colorado

Suz Schrandt
Arlington, Virginia

L. Bradley Schwartz
Chicago, Illinois

Leilani Schweitzer
Palo Alto, California

Heather Sherman
Chicago, Illinois

Daria Terrell
Chicago, Illinois

Debbie Haine Vijayvergiya
Maplewood, New Jersey

Musaddik Waheed
Lebanon, Pennsylvania

Champions in the Spotlight

PFPS US **Champion Keri Anne Connaughty** has been working with representatives in Wisconsin on a bill: ***"Patient's Right to know"*** (Transparency)

PFPS US Champion **Michael Millenson published in Forbes.com:** *"Address 'Plane-Crash Level' Patient Harm, HHS Tells Hospitals, As Political Currents Swirl"*

PFPS US Champion, **Krista Hughes** is the first Alabamian appointed to the influential **National Advisory Council in Health Care at the Agency for Healthcare Research and Quality**

Strategic Alliances

Government Agencies, Health Care Facilities, Safety and Quality Organizations, Civic Organizations, Industry and others

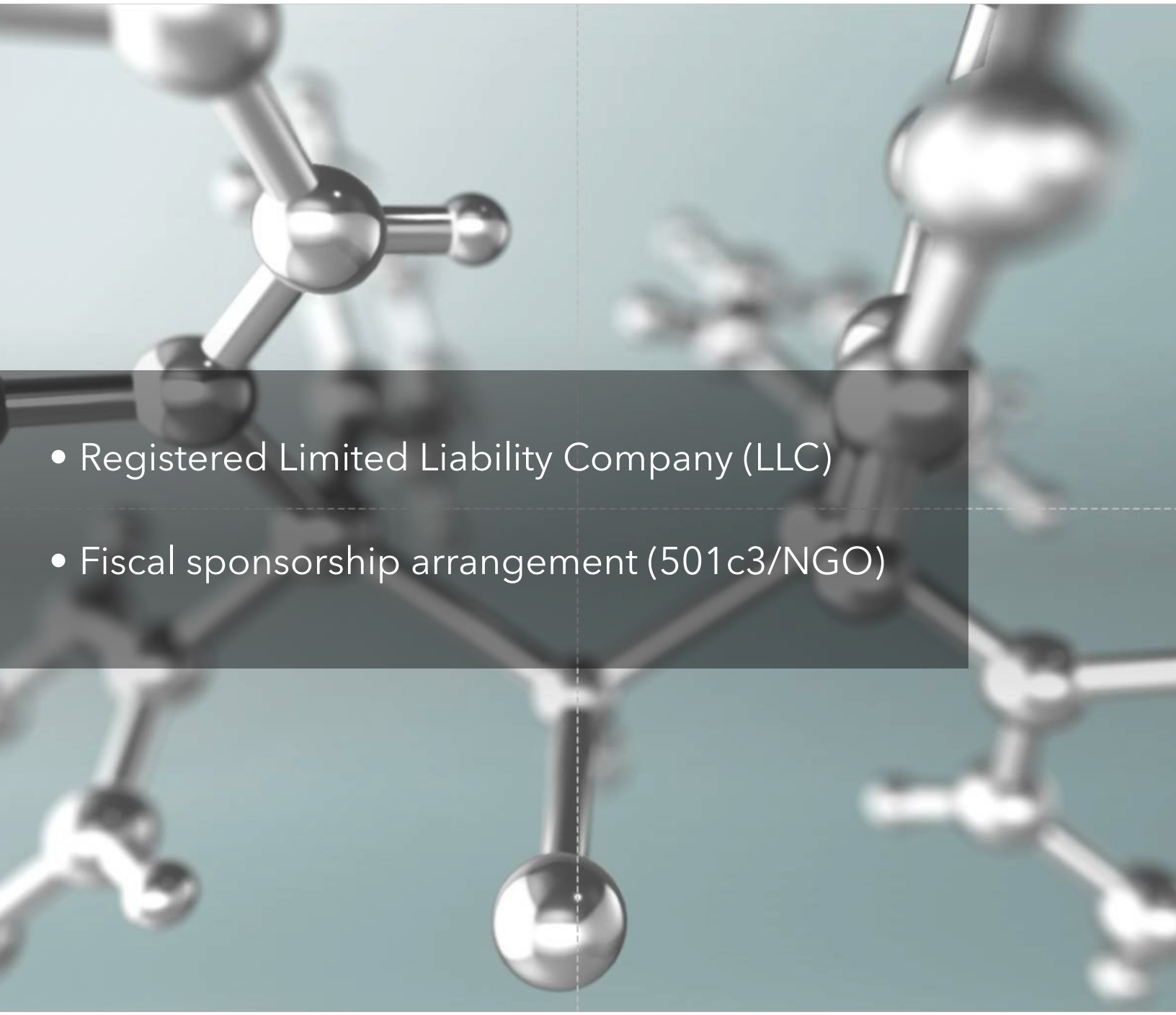
Centers for Medicare & Medicaid Services	Presidents Council of Advisors on Science and Technology	Centers for Disease Control and Prevention	Office of Inspector General-Health and Human Services
World Health Organization	Office of the Secretary (HHS)	Agency for Healthcare Research and Quality	National Quality Forum
MedStar Institute for Quality and Safety	Pittsburgh Regional Health Initiative	John D. Stoeckle Center for Primary Care Innovation	IHI-Lucian Leape Institute
National Association for Healthcare Quality	Ariadne Labs	European Network for Safer Healthcare	Collaborative for Accountability and Improvement
American Academy of Pediatrics	Leapfrog Group	OpenNotes	Connecticut Center for Patient Safety
CommonSpirit Health	Patient Safety Movement Foundation	Institute for Safe Medicine Practices and ECRI	PFCCPartners
The New Agreements	H2Pi	Safe Care Campaign	Parents of Infants and Children with Kernicterus
Yes and Leadership	Anthony Bates Foundation	Project Patient Care	Dòcola

* Colors:

Signed Official Partner

Engaged as collaborator

Legal Structure



- Registered Limited Liability Company (LLC)
- Fiscal sponsorship arrangement (501c3/NGO)

5 Priorities and Committees

Patient Safety as a Strategic Priority

- Reassert patient safety as a budget, measurement and payment priority
- Establish greater national oversight and coordination of patient safety

Patient and Family Engagement

- Put mechanism in place to include diverse patients and families in co-development of policy, standards and guidelines

Patient Safety Reporting

- Establish a standardized system and requirement for reporting harm events
- Redesign reporting of unsafe care to improve accuracy, timeliness and effective learning
- Expand the spectrum of events to be reported and allow patients/families to submit event reports and patient reported experiences of safety

Transparency

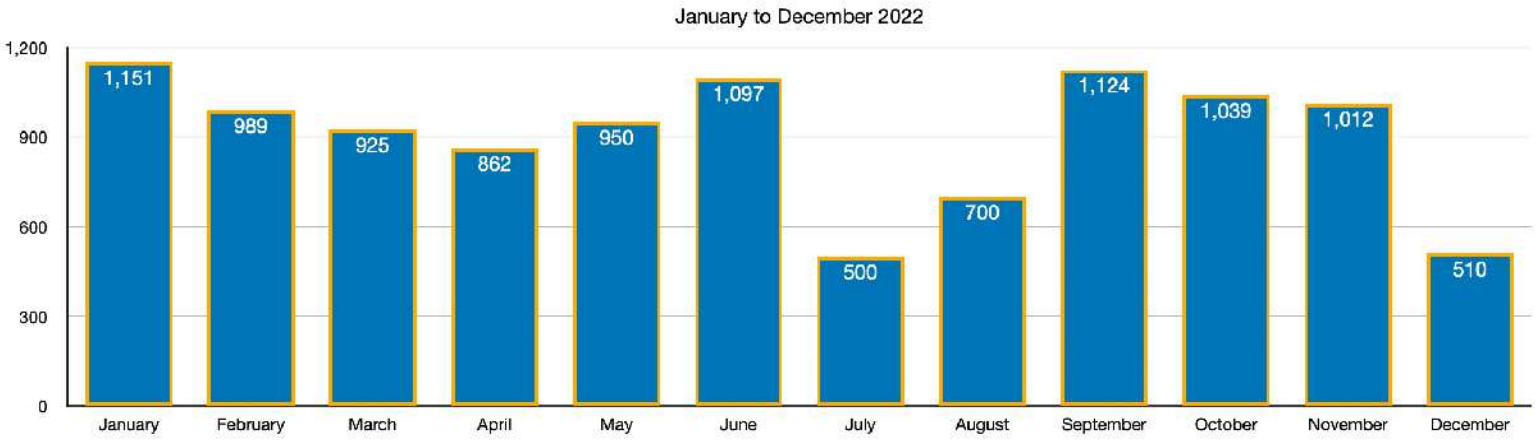
- Require standards for timely communication and disclosure to inform patients/families of a harm event
- Review and enforce standards for patient access to medical records

Safety of Clinical Practices

- Drive infection prevention and control for antimicrobial resistance
- Establish standards and implement "Medication Without Harm"
- Improve maternal and infant morbidity and mortality
- Identify and close the health equity safety gap for all patient population

Tools

State of the Art Website with over 10,000 Views in the past 12 Months



2022 PFPS US Analytics

MONTH	VIEWS
January	1,151
February	989
March	925
April	862
May	950
June	1,097
July	500
August	700
September	1,124
October	1,039
November	1,012
December	510
Totals:	**10,859**

Tools (cont.)

International Views of Website:
79 Countries

Country	Country
United States	Ethiopia
China	Bulgaria
Unknown (personal, not organization)	Qatar
Austria	Thailand
India	United Arab Emirates
Canada	Chile
United Kingdom	Estonia
Romania	Greece
Colombia	Guatemala
Slovenia	Lebanon
Brazil	Turkey
Australia	Ukraine
Ireland	Belgium
Germany	Czech Republic

Italy	Hong Kong
Taiwan	Croatia
Argentina	Jamaica
Jordan	Mongolia
Iran	Malaysia
Portugal	Namibia
Philippines	Panama
Saudi Arabia	Peru
Indonesia	Pakistan
Japan	Puerto Rico
Norway	Sweden
Kenya	Swaziland
Costa Rica	Uruguay
Netherlands	South Africa

France	Barbados
Spain	Bangladesh
Denmark	Algeria
South Korea	Ghana
Poland	Iraq
Russia	Kuwait
Switzerland	Macedonia
Israel	Mali
Egypt	Nigeria
Mexico	New Zeland
Singapore	Oman
Slovakia	

Tools cont.)

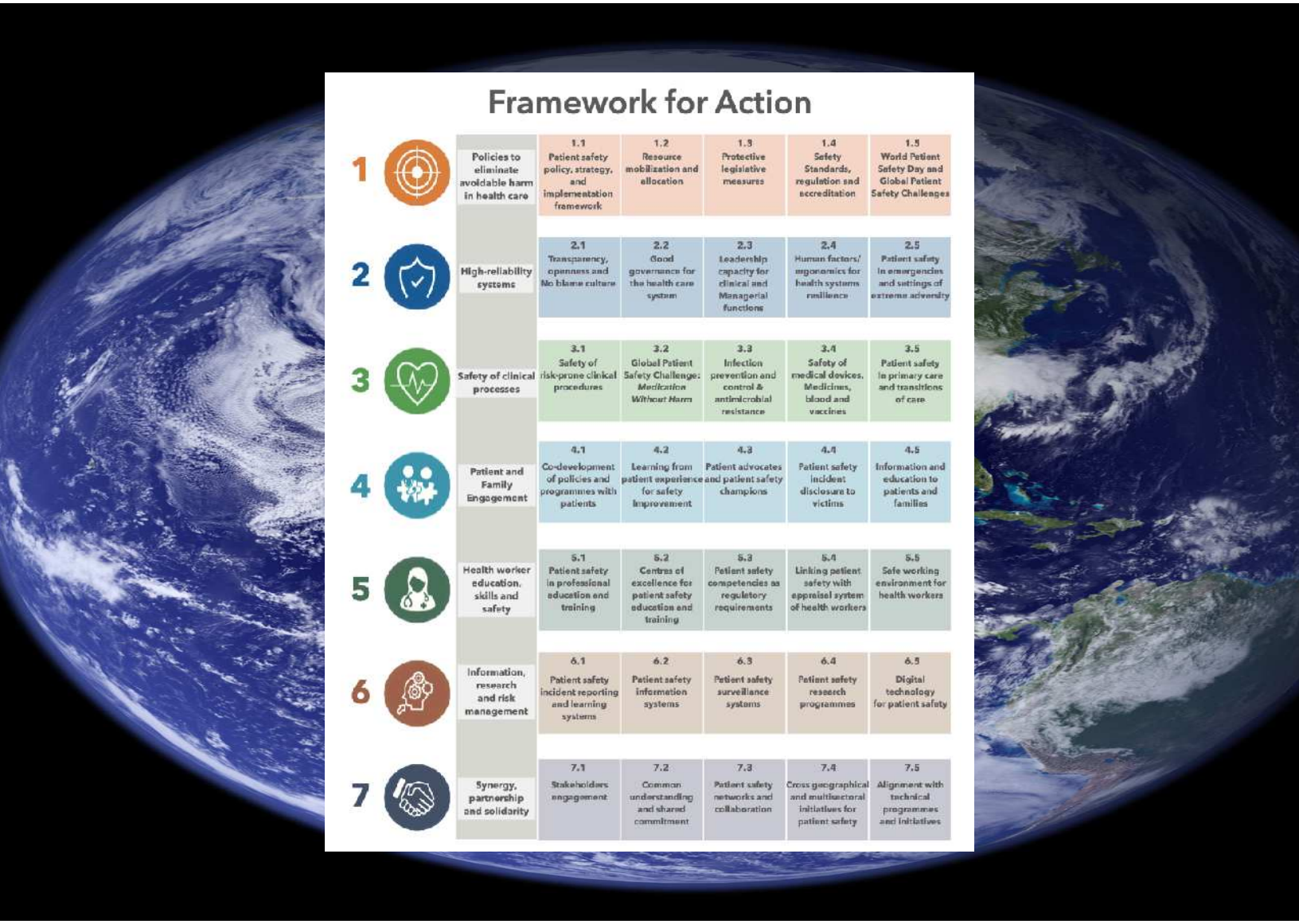

Social Media
Dedicated social media expertise
600 followers on Twitter
1,000 followers on LinkedIn
Facebook
Instagram
Twitter
Spotify
Messenger

Tools (cont.)

PFPS US

Online Orientation for Champions

Resources



(Aligned with elements of the WHO GPSAP 7x5)

Policies & Documents

5

Guiding Policies and Foundational Documents

- Statement of Principles, Values and Beliefs
- Conflict of Interest (COI) and Speaking Engagement Policies
- LLC Registration
- Non-Profit Fiscal Agent Agreement
- Memorandum of Understanding Agreement (MOU)

Awareness Raising & Advocacy

Awareness Raising & Advocacy

42 Presentations: Calling for Actions in WHO GPSAP

- PACCARB (Presidential Advisory Council on Combatting Antibiotic-Resistant Bacteria)
- PCAST (President's Council of Advisors on Science and Technology): *From Harm to Action*
- Secretary of HHS National Healthcare System Action Alliance to Advance Patient Safety
- Northwest Patient Safety Conference: *Who Killed Patient Safety?*
- Maryland Patient Safety Center: *Revolutions are Born of Hope, Not of Despair*
- Leapfrog Group: *The Urgency of Patient Safety*

Awareness Raising & Advocacy

PFPS US Presentations

- IHI Forum 2021: *From Harm to Action*
- IHI Forum 2022: *Patient Safety Revival*
- IHI Forum 2022: *Who Can Save Patient Safety?*
- IHI Forum 2022 Leadership Summit
- IHI Leadership Alliance 2022: *Who Killed Patient Safety?*
- IHI Patient Safety Congress: *Keeping Patients and Families at the Center of the CRP Process for Responding to Harm*
- CMS Quality Conference: *Patient Reaction to CMS Quality Strategy*

Awareness Raising & Advocacy

Presentations (cont.)

- Hope4Med Podcast: *Why We Need Effective Communication in Healthcare*
- RLDatix: *Activating the Patient Voice to Drive Safety and Equity*
- Health Datapalooza: *Policy Opportunities to Address Intractable Patient Safety Problems*
- Hospital Quality Institute
- Wisconsin Legislature's First Patient Safety Day
- BETA Healthcare Group: *We Don't Talk About Bruno - Safety, Implicit Bias and Racism in Healthcare*

Awareness Raising & Advocacy

Presentations (cont.)

- Beta Health Annual Member Symposium: *HEART Workshop*
- American Society for Health Care Risk Management: *Communication and Resolution Programs, The Next Frontier of Harm Response and Prevention*
- Collaborative for Accountability and Improvement: *The Critical Role of Patient Advocacy and Transparency in Healthcare*
- PACT: *Pathway to Accountability, Compassion and Transparency – Co-Design CRP Process*
- University of Washington, Communication and Resolution Program

Awareness Raising & Advocacy

Presentations (cont.)

- DIA Podcast: *Medication Errors Emerge as Global Patient Safety Issue*
- International Alliance of Patients' Organizations (IAPO) and Patient Academy for Innovation and Research (PAIR Academy), in partnership with DakshamA Health, 6th Medication Safety Webinar: *Medication Safety in Polypharmacy and Transitions of Care*
- WHO: *Patient Experience in Transitions of Care for Medication Safety*
- WHO: *The Critical Role of Patient Empowerment in Medication Safety*

Awareness Raising & Advocacy

Presentations (cont.)

- Defense Health Agency Patient Safety Program, John Muir Hospital Lunch and Learn Discussion: *Black Maternal Health*
- The Healthy Project Podcast: *Patient Safety in Healthcare*
- University of Illinois at Chicago Pharmacy School Women Pharmacists Day
- Judie Burrows Education Institute
- Illinois Council of Hospital Pharmacists Continuing Education Program: *Patients for Patient Safety: Learning from the RaDonda Vaught Case*

Awareness Raising & Advocacy

Presentations (cont.)

- National Association for Healthcare Quality: *Culture of Safety Suffers by Penalizing People in an Imperfect System*
- Patient Safety Movement Foundation Science and Technology Summit: *How Can Regulation Support Quality and Value in Healthcare?*
- Patient Safety Movement Foundation Science and Technology Summit: *Patient Advocacy, The Compass for Innovation*
- Lucian Leape Institute: *Introduction to PFPS US*
- G7: *From Harm to Action*

Awareness Raising & Advocacy

Presentations (cont.)

- World Patient Alliance, Strategic Objective 4 of the GPSAP: *Engage and Empower Patients and Families to Help and Support the Journey to Safer Healthcare (Italy)*
- Arezzo Forum Risk Management, Strategic Objective 4 of the GPSAP: *Engage and Empower Patients and Families to Help and Support the Journey to Safer Healthcare (Italy)*
- SingHealth: *From Harm to Action: The Power of Partnerships (Singapore)*
- ISQua: *Engaging Patients and Families for Sustainable Patient Safety Improvements*
- ISQua: *What Matters to You?*

Awareness Raising & Advocacy

3 Hosted National & International Webinars

- CMS Webinar: *Health Care Safety during the Pandemic and Beyond – Building a System That Ensures Resilience*
- OIG Report Webinar: *1 in 4 Medicare Patients Harmed During Hospital Stays*
- HSIB (UK), UKOM (Norway) and SIAF (Finland) Webinar: *Solutions Toward National Patient Safety Oversight*

Awareness Raising & Advocacy

Taking a Stand

7 Initiatives

- Three letters to the Secretary of Health and Human Services calling for patient safety to be a national priority culminated in an invitation to participate in the HHS national launch of the Action Alliance to Advance Patient Safety

- Request to the HHS Office of Inspector General to investigate a failure to report a death from medication error

- Participated in public comment campaign for 2023 CMS Final Rule on Hospital Inpatient Prospective Payment System that resulted in the continuation of transparent patient safety data reporting and new structural measures on health equity and social determinants of health

Awareness Raising & Advocacy (cont.)

Taking a Stand

7 Initiatives

- Organizational endorsement for preservation of a sepsis measure proposed for elimination by the National Quality Forum
- World Patient Safety Day march to the U.S. Capitol
- Organizational public comment for safe radiation dosage measures at National Quality Forum
- Participation in CMS listening sessions on Patient Safety

Awareness Raising & Advocacy

3 Publications

- Journal of Patient Safety and Risk Management: *Who Killed Patient Safety*?
- The Hill: *Action on Patient Safety Will Help Achieve the Health Care System We Deserve*
- The Tennessean: *Patient Advocates Demand Accountability For Medical Error in RaDonda Vaught Case*

Outcomes


Patient Generated Improvement Ideas
Co-development of
Patient Safety Initiatives
Partnerships on Grants

Outcomes

50 Improvement Ideas for Safer Care (Examples)

ISSUE	LEVER	IMPROVEMENT IDEA
National Commitment To Safe Patient Care and Zero Harm Lacking	• HHS oversees AHRQ, CMS, FDA, HRSA and CDC	• Executive Directive to require HHS agencies to prioritize and advance safety accountability oversight within the HHS agencies • Budget review of all funds and accountability of resources committed to safety (within HHS agencies) • Mandate an annual report to Congress on serious safety events, trends and recommendations for improvement

ISSUE	LEVER	IMPROVEMENT IDEA
Expand scope and importance (payment and CoP) of reporting of Patient Safety Harm events	NHSN Databank CMS CoP HHS Department Payments	• Create a national database of safety events (possibly using NHSN databank?) with mandatory reporting and a national dashboard. • Expand list of Patient safety events to include more than HACs. • Event reporting system should include system timeliness and transparency measures not just types of events. • Expanded safety measures should be used in VBP programs and get a higher weighting in the programs. • Non-payment for care related to serious safety events should be enforced. • Expanded safety measures should be digital, all payer and in all sites of care (hospital, ambulatory and post acute) and across all CMS/HHS programs

ISSUE	LEVER	IMPROVEMENT IDEA
Infection prevention reporting system not responded to and not required of health systems	• Infection Prevention Reporting System (CDC's NHSN data reporting system)	• Require all facilities to report infections with a penalty for non reporting • Increase penalty by CMS for non reporting
The US lacks a national repository of healthcare safety events	• CDC's NHSN data reporting system	• Leverage this existing system to require additional safety events to be reported with a joint development of standard safety metrics by CMS and CDC • Annual reporting to congress of patient safety events by category, cost and severity • A national database with mandatory reporting of safety events could be used for both accountability and learning to prevent future harm
Underreporting of Medical Errors as a Cause of Death	• CMMI Pilot Project • CDC Pilot Project • CDC public health reporting	• UK Medical Examiner Model - Expand training to medical examiners to identify medical error as a cause of death and link with risk and claims

Co-development of Patient Safety Initiatives

PFPS Recommendations for a Pending Executive Order on Patient Safety Include (Strategy 4.1):

- Creation of an independent agency for patient safety
- Patient safety as a national priority
- Patient safety rights charter
- Government to develop strategies and budgets to engage patients/families in all patient safety efforts
- Full disclosure of harm from unsafe care to patients/families
- Mandatory reporting of harm to federal and state government and accrediting bodies
- Redesign of the national patient experience surveys to include Patient Reported Experience of Safety Measures
- Elimination of confidentiality agreements that prevent patients, families and clinicians from sharing experiences of harm for learning purposes.
- PFPS US championed the inclusion of diagnostic errors in the top 10 sources of harm

Co-development of Patient Safety Initiatives (cont.)

- National Patient Safety Board Act – H.R.9377 (Strategy 4.1)
- Revision of 2022 American Academy of Pediatrics (AAP) CPG on Management of Hyperbilirubinemia in the Newborn (Strategy 4.1)
- Tools for Communication and Resolution Program (CRP) with Pathway to Accountability, Compassion and Transparency (PACT) – Ariadne Labs (Strategy 4.4)
- Successful development of new measures for informed consent to be included in Leapfrog Group's 2023 national survey of healthcare systems (Strategy 4.4)
- AAP's *Jaundice and your Newborn* parent education materials (Strategy 4.5)

Co-development of Patient Safety Initiatives (cont.)

- AHRQ Grants on Diagnostic Excellence (Strategy 6.4):
  - Achieving Better Cancer Diagnosis (ABCD): Identifying, Supporting and Learning From Marginalized Patients Who Experience Delayed Cancer Diagnosis (Strategy 4.2)
  - Safety-II Together: Coupling Teaming Science With Patient Engagement and Health (Strategy 4.5)
  - The Patient-Partnered Diagnostic Center of Excellence (Strategy 5.2)
- AAP grant: Improving Diagnostic Excellence in Ambulatory Pediatrics: The Pediatric Quality Minute Series (Strategy 5.1, 4.5)

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