



## **DEPARTMENT OF HEALTH AND HUMAN SERVICES**

### **Agency for Healthcare Research and Quality**

#### **Notice of Opportunity to Comment on Strategies to Improve Patient Safety:**

#### **Draft Report to Congress for Public Comment and Review by the National Academy of Medicine**

**AGENCY:** Agency for Healthcare Research and Quality (AHRQ), Department of Health and Human Services (HHS).

**ACTION:** Notice of opportunity to comment.

**SUMMARY:** As required by the Patient Safety and Quality Improvement Act of 2005 (Patient Safety Act), the Secretary of HHS (the Secretary) is making this draft report on effective strategies for reducing medical errors and increasing patient safety available to the public for review and comment. The draft report includes measures determined appropriate by the Secretary to encourage the appropriate use of such strategies.

**DATES:** Send comments on or before [INSERT DATE 60 DAYS AFTER DATE OF PUBLICATION IN THE FEDERAL REGISTER].

**ADDRESSES:** The draft report, Strategies to Improve Patient Safety: Draft Report to Congress for Public Comment and Review by the National Academy of Medicine, can be accessed electronically at the following HHS website: <https://pso.ahrq.gov/legislation/act>. Comments on the draft report must be submitted by email to [PSQIA.RC@ahrq.hhs.gov](mailto:PSQIA.RC@ahrq.hhs.gov).

**FOR FURTHER INFORMATION CONTACT:** Paula DiStabile, Patient Safety Organization Division, Center for Quality Improvement and Patient Safety, AHRQ, 5600 Fishers Lane, Mailstop 06N100B, Rockville, MD 20857; telephone (toll free): (866) 403-3697; telephone (local): (301) 427-1111; TTY (toll free): (866) 438-7231; TTY (local): (301) 427-1130; email: [PSQIA.RC@ahrq.hhs.gov](mailto:PSQIA.RC@ahrq.hhs.gov).

## **SUPPLEMENTARY INFORMATION:**

### *Background*

The Secretary, in consultation with the Director of AHRQ, has prepared a draft report on effective strategies for reducing medical errors and increasing patient safety as required by the Patient Safety Act. The report includes measures determined appropriate by the Secretary to encourage the appropriate use of such strategies, including use in any federally funded programs. The draft report is now available for public comment and will be (or has been) submitted to the National Academy of Medicine for review. The final report is required to be submitted to Congress no later than December 21, 2021. The specific provision describing these requirements can be found at 42 U.S.C. 299b–22(j).

The Patient Safety Act created a framework for the development of a voluntary patient safety event reporting system to advance patient safety and quality of care across the Nation. Without limiting patients' rights to their medical information, the law created Federal legal privilege and confidentiality protections for patient safety work product; that is, information exchanged between healthcare providers and organizations listed by the Secretary that specialize in patient safety and quality improvement, called patient safety organizations (PSOs). The law charged PSOs with analyzing and using this information to provide feedback and assistance to help providers minimize patient risk and improve the safety and quality of their care. More information about the Patient Safety Act, its implementing regulation, and PSOs can be found at <https://pso.ahrq.gov/>.

In addition to creating a protected legal environment where healthcare providers can share information and learning for improvement purposes beyond organizational and State boundaries, Congress also envisioned and created the potential for aggregating and analyzing patient safety data on a national scale. This part of the Patient Safety Act, the network of patient safety

databases (NPSD), is a mechanism that can leverage data contributed by individual healthcare providers and PSOs across the United States into a valuable national resource for improving patient safety. Congress required the draft report that is the subject of this Notice to be made available for public comment and submitted to the Institute of Medicine (now the National Academy of Medicine) no later than 18 months after the NPSD became operational. The NPSD became operational on June 21, 2019. More information about the NPSD can be found at <https://www.ahrq.gov/npsd/index.html>.

### *Overview of the Draft Report*

The draft report contains three chapters. It begins with an overview of the impetus for and objectives of the Patient Safety Act, its key provisions, and some milestones in its implementation. Chapter 2 reviews some of the principles and concepts underlying effective patient safety improvement, provides an overview of research and measurement in patient safety, and presents the strategies and practices for reducing medical errors and increasing patient safety reviewed in AHRQ's Making Healthcare Safer reports, published in 2001, 2013, and 2020. Together, these reports reviewed the existing evidence for the effectiveness of more than 100 patient safety strategies and practices used in hospitals, primary care practices, long-term care facilities, and other healthcare settings. They include cross-cutting strategies and topics such as patient and family engagement and teamwork training; safety topics specific to particular clinical interventions, such as medications and surgery; a variety of tools and processes, such as rapid response teams and antimicrobial stewardship; and practices that target prevention of specific harms, such as healthcare-associated infections and pressure injuries. Hyperlinks in the draft report lead to the full text of the evidence review and to later updates regarding the assessment of evidence for the effectiveness for each strategy and practice. The final chapter in the draft report begins with an overview of learning health systems and concepts underlying effective implementation of patient safety strategies. It provides examples of resources Federal agencies

make available to encourage healthcare providers to use effective patient safety strategies and describes “Safer Together: A National Action Plan to Advance Patient Safety,” recently released by the National Steering Committee for Patient Safety that was convened by the Institute for Healthcare Improvement. The draft report concludes by describing an approach that has a track record of success in encouraging providers to use effective practices to improve patient safety and outlines measures that could accelerate progress in improving patient safety and encouraging the use of effective patient safety improvement strategies.

*Where to View the Draft Report and How to Submit Comments*

The draft report is posted on the AHRQ PSO Program website at <https://pso.ahrq.gov/legislation/act>. The website contains a link to the email address for submitting comments on the draft report, which is [PSQIA.RC@ahrq.hhs.gov](mailto:PSQIA.RC@ahrq.hhs.gov).

Dated: December 10, 2020.

**Marquita Cullom,**

*Associate Director.*

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