Subcommittee of the National Advisory Council: Informing the National Action Alliance to Advance Patient and Workforce Safety

Final Report: December 19, 2023

Submitted by:

Lucy A. Savitz, Ph.D., MBA on behalf of the AHRQ Subcommittee

Subcommittee of the AHRQ National Advisory Council to Advance Patient and Workforce Safety

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The Subcommittee of the Agency for Healthcare Research and Quality's (AHRQ) National Advisory Council is pleased to provide our report on recommendations in support of the National Action Alliance to Advance Patient and Workforce Safety. Our work was guided by the four foundational areas detailed in *Safer Together National Action Plan to Advance Patient Safety* (National Steering Committee for Patient Safety, 2020)—(1) Culture, Leadership, Governance; (2) Patient and Family Engagement; (3) Workforce Safety; and (4) Learning Systems. In the following sections we describe our Subcommittee Charge, the Process Used to Make Recommendations, Subcommittee Recommendations, Results of the AHRQ National Advisory Council Vote, and Final Subcommittee Reflections.

Subcommittee Charge

The Subcommittee of the National Advisory Council (SNAC) was charged with addressing the following:

- Develop bold aim(s) that will galvanize the country around patient and workforce safety.
- Develop a measurement strategy that will answer the question: "How will we know that the changes that are being implemented are resulting in improvement?"
- Ensure that healthcare equity is a key piece of the National Action Alliance.

Our SNAC was tasked with working under a compressed timeline with five meetings convened between September and December 2023. Deliverables from the SNAC included an in-person presentation to the AHRQ National Advisory Council on November 16, 2023, and a final report due December 19, 2023.

Key Context in Meeting Our Charge. In conducting our work, we considered several key issues. One was **equity**, focusing on two distinct aspects that are: (1) inclusive of all persons impacted by issues of patient and workplace safety; and (2) inclusive of all settings across the care continuum—not just hospital settings (thus, our reference to "health systems" refers to health service organizations providing care to patients and employing or contracting with healthcare workforce members). We also focused on **system-level actions** to advance patient and workforce safety. Lastly, we **focused on "what" needed to be done** versus "how" it could/should be done. The Subcommittee Chair worked to prepare an environmental scan of related activities, available resources/tools, and potential partnerships that was reviewed and updated with input from the full SNAC. The background information in the environmental scan is important in understanding how our work fits into a larger public-private ecosystem and provides leverage opportunities for our recommendations in "drawing

> *Drawing a red thread through* is an expression used to "connect thoughts, ideas or opportunities that are related." This way the wildest brainstorming can become coherent.
>
> A Nordic expression

a red thread through." Recognition of related activities and potential partners is consistent with the National Action Plan's emphasis on the need to coordinate and align related efforts. We believe this background will be useful to the Agency in moving forward with our recommendations.

Level-Setting. Given the diversity of expertise and varying perspectives of the SNAC members, it was important to focus on level-setting. The first two meetings were dedicated to this activity beginning with a presentation by Dr. Brent James, a leading patient safety expert, and presentations from Federal partners on their safety programs together with available data/metrics. We also featured a patient story at our second meeting and a workforce safety story at our third meeting. These presentations coupled with information provided via an environmental scan, pre-read materials (Gandhi et al., 2018; James et al., 2022; Farley et al., 2023), and selected presentations on the National Action Plan and PCAST Recommendations were important to our process moving forward. **Appendix A** provides agendas for all Subcommittee meetings with notation on topics and presenters.

Process Used to Make Recommendations

Our 16-member Subcommittee was led by our chair, who worked with AHRQ staff to create a safe space for all member perspectives to be respected and heard. In addition to meeting discussion, in some cases off-line email and telephone conversations were scheduled for in-depth discussion of questions and comments on key points and/or upcoming topics. Most importantly, the Chair worked to leverage group discussion in building consensus in meeting our charge.

The timeline for our meetings and high-level discussion topics are listed below:

September 7 (10am-2pm)	Post Pandemic Level Setting
September 20 (1-5pm)	Federal Partner Programs; The Patient Voice
October 10 (1-5pm)	Workforce Safety; Recommendation Processing
October 20 (1-5pm)	Recommendation Processing
December 4 (1-5pm)	NAC Comment Review & Report Detail

Several key questions illustrate the nature and breadth of our discussion in considering our charge. These include:

1. The National Action Plan provides a thorough roadmap of 17 recommendations in 4 foundational areas. What can we do to operationalize the plan in supporting public-private efforts over the next 3 years to achieve safer care everywhere for all?

2. A great deal of work has been done with a disproportionate amount of attention focused on hospital-based patient safety. How does hospital-based safety evidence translate across the care continuum?

3. Given the fragmented U.S. delivery system and care shifts across the continuum (including telehealth and home-based care), how can we more effectively spread and scale innovative, evidence-based solutions to patient and workplace safety?

4. The healthcare workforce is vulnerable to staffing shortages due to burn-out based attrition and increases in workplace related violence. How can we work to support better reporting, resolution feedback, and evidence-based safety practices for staff?

5. The pursuit of safety involves human interaction between patients, families/caregivers, and healthcare workers. How can we fully engage these actors together with our vendors and the delivery system to deliver safer care everywhere for all?

The final point was a focal thread running through conversations as the SNAC reflected on the vital interaction between clinicians and the patients/families that they served. Ziegelstein (2015) describes this vital human interaction and the role of humans, and in this context, as sources of safety in customizing care to the needs of the individual patient (Farley et al., 2023).

We worked to create consensus in developing our recommendations using a modified Delphi process (Okoli & Pawlowski, 2004) between our October meetings that consisted of 3 interactive rounds. Each round was conducted by email with instructions to rank individual recommendation areas and included the option to add any missing areas for group consideration. Each subsequent round included aggregate feedback on the mean, mode, and range of ranking scores from the prior round. The ranking forms for these rounds are included in **Appendix B**.

Subcommittee Recommendations

Through our consensus building process, our SNAC created a pre-amble to our work, guiding principles, four aims and one research recommendation. Our aims are detailed in hierarchical fashion with the aim followed by subgoals and associated measures. These are provided below.

Preamble

We stand for a healthcare delivery system that is free from preventable harm, inspires continuous improvement in the delivery of care across the continuum, and promotes a culture of safety in an environment that is healing for all.

Our aims are intended to ensure that all healthcare systems strengthen their foundations in patient and workforce safety through assessing and addressing the four foundational areas outlined in the National Action Plan (culture, leadership, and governance; patient and family engagement; workforce safety; and creation of learning health systems).

Principles

- Policymakers should evaluate all future health policy choices, including the impact of funding decisions, through a lens of patient safety.
- Efforts to address patient and workforce safety must include a focus on targeting health inequities and eliminating disparities.
- The human connection between patients (with their families/caregivers) and healthcare providers is the fulcrum of person centered, safe care.
- Policies aimed at improving patient safety must be based on evidence-based practices and acknowledge and reflect patients' social risk factors.

Recommendations

Overarching Aim: Every healthcare system and supporting organization in the United States will commit to operationalizing the foundational elements of the National Action Plan to assure *safer care everywhere for all*.

- Healthcare systems will complete a baseline self-assessment by December 2024.
- Healthcare systems will ensure the voices of patients, families/caregivers, and employees are at the core of their safety strategy by reviewing the self-assessment and identifying areas of potential improvement.
    - Healthcare systems will develop a safety plan that empowers the voice of patients and families by 2024.
        - Safety plans will include provisions for patient access to submit safety concerns, inclusion in event review, key input on the development of safety initiatives, implementation of communications and resolutions programs.
        - Organizations will include relevant structure, process and outcome measures.
    - Implementation of robust safety measurement systems including solicitation of patient and employee concerns by 2025 and documented improvements by December 2026. Example metrics include:
        - Increase in the percentage of claims identified in reporting systems within 48 hours of an event.
        - Improvement in speaking up scores (psychological safety).
    - Implementation of robust communication and resolution programs with reported event feedback provisions by 2026.

Engineering Safe Practices Aim: Through partnership with technology vendors, FDA, ONC, and other relevant partners, the HHS Action Alliance will drive measurable changes in healthcare technology to increase the proportion of devices and software that incorporate “safety by design” features that make it easy to follow the safer practices and hard to follow less safe practices.

- HHS will convene human factors engineers, safety science experts, bedside clinicians, and technology leaders to identify 5 key actions that stakeholders (including patients and families) agree will facilitate engagement between stakeholders (care delivery organizations, regulators, and vendors including

software developers, medical device developers, pharma, etc) for optimized safety design of new/future high-frequency + high-risk healthcare technology to optimize safety by design by December 2024.
    - We will measure both adoption and impact of above metrics throughout 2025 and beyond.
- HHS will work with industry partners to create safety standards, evaluation protocols, and certification processes for devices, software, AI applications, and other technology tools that balance the support for rapid-cycle innovation with the need to build-in safety by design beginning January 2025.

Learning Capacity Aim: We aim to develop a healthcare safety focused Learning Network (LN) with a vision and aim to provide reliable safety for patients and staff. This LN will use design and co-production methods, which have been shown to be successful, including those focused on safety (e.g., Solutions for Patient Safety). The LN will have a decentralized leadership and a centralized infrastructure to continuously learn and transparently track and report on improvement progress while minimizing reporting burden by patients and staff.

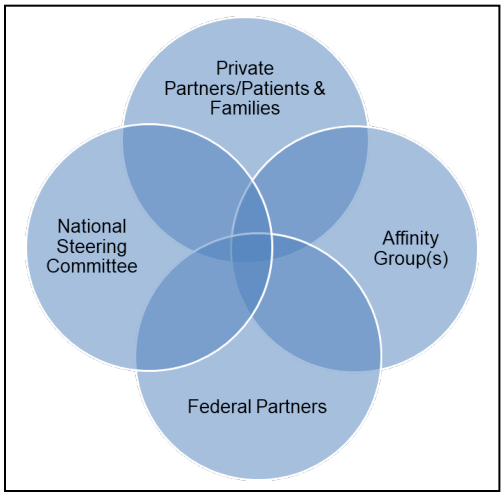
- Working with industry and federal partners, including independent regulatory agencies, we will create the continuous monitoring and reporting systems that will enable rapid-cycle improvement in patient and workforce safety resulting in:
    - Transparent sharing of process and safety outcome data on a near real-time basis to enable continuous improvement.
    - A new, scalable bundle of safe practices across the care continuum and phasing out of numerous current, misused, misrepresentative, and misaligned measures.
    - Building adequate quality improvement science capability across all LN participants.
    - In addition to a focus on process reliability, the LN will transparently learn and share on all aspects of the National Action Plan including governance and leadership and inclusive engagement with patients and families.
- Working with a cross-section of the nation's healthcare systems willing to serve as change leaders who agree to transparently document and share promising practices for implementation of safety practices and strategies to overcome barriers to adoption.
    - Demonstrated 50% improvement in patient and workforce safety among hospitals/health systems actively participating in the LN within 24 months (December 2026).
- Progression of the LN will be measured and assessed based on:
    - Progress against goal of 50% reduction in harm.
    - Active data sharing and participation by LN participants.
    - Participant retention and growth.
    - Maturation of LN annually using an adapted maturity model rubric (Lannon et. al, 2020).

Education and Training Aim: We aim to establish a set of safe practice competencies that can be used in the education of healthcare safety leaders. Basic competencies can be developed for clinicians, healthcare administrators, and partners (e.g., developers, manufacturers, pharma) who are involved in safety management activities.

- We will develop a set of safety science competencies that can be used in education and continuing education training programs by July 2024.
- DHHS will work with professional societies and educational accrediting bodies to adopt and report on demonstrated competencies by the end of December 2025.

Research Recommendation: We recommend establishing and funding a cross-agency research agenda on high-priority safety gaps to address policy, payment, and practice knowledge needs that will support the National Action Alliance.

The collective "we" in our expressed aim recommendations is referenced in the adjacent text box. The National Steering Committee, active engagement of Federal partners, and private partners including patients and families will be tasked with recommending how our SNAC recommendations may move forward.



An important opportunity in engaging these stakeholders will be affinity groups; one example would be convening a group of technology manufacturers and users to assist with the Engineering and Safe Practices Aim. At our December 4 meeting, we discussed alternative applications of affinity groups around topics like telehealth/virtual care, artificial intelligence or AI, cybersecurity, and development of educational competencies. Affinity groups tasked to work to address specific safety challenges and opportunities have the potential to inform operationalization of the recommended aims.

Results of the National Advisory Council Vote

The AHRQ National Advisory Council (NAC) received a pre-read in advance of the November 16 meeting to allow sufficient time for review and reflection. Dr. Savitz presented the Subcommittee recommendations and answered questions in-person.

Several important constructs were brought up in discussion with the NAC. Some highlights include:

- Successful actions moving forward will require a cultural change to embrace communities of learning.

- A safe harbor for transparent, shared learning on patient and workforce safety (vs. all innovations) is important.
- The focus of return on investment or ROI needs to be expanded to value.
- As we implement safe practices for patients and the workforce, we need to focus on what to do as well as what we should not be doing via de-implementation.
- There are gaps in our evidence base (e.g., safety by design, selected measures, telehealth), and clearly AHRQ can play a role in implementation science to advance spread and scale of what works, where, and for whom under what circumstances.

At the conclusion of the presentation and discussion period, NAC members voted to unanimously accept and approve the recommendations of the Subcommittee.

Final Subcommittee Reflections

Reflecting on our recommendations and the recap from our National Advisory Council meeting report, three issues emerged. The operationalization of our recommendations will require attention to the design and use of financial and non-financial **incentives** that support adoption and active participation in advancing patient and workforce safety. **Measurement** reporting is at the heart of safe and effective medical care, but the implementation of safety measurement programs should take account of the burden of data collection and reporting, data quality, focused measurement on actionable issues that are important to practicing clinicians, patients, and families (e.g., time to respond to an unexpected event), and the need to foster an environment that supports transparent reporting and shared data to drive improvement. Finally, a Learning Network must create a **data-driven community of learners** that is committed to problem solving collectively (for example, see Lyren et al., 2018). The problems of patient and workforce safety cannot be solved by any one care delivery system or policy action. Progress in patient and workforce safety requires collective and well-orchestrated efforts.

References

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Agency for Healthcare Research and Quality

National Advisory Council
Subcommittee on the National Action Alliance to Advance Patient and Workforce Safety

Thursday, September 7, 2023
10:00 am – 2:00 pm EDT
Virtual Via Zoom

AGENDA

Zoom Link: https://ahrq-hhs.zoomgov.com/j/1600729861?pwd=M0NpU3ZzZkJDeHFRaWh2c2NVN1daQT09

Questions We are Running On:

- What was the state of healthcare safety pre-pandemic?
- What is the state of healthcare safety post-pandemic?
- How does the current state impact what we should collectively aim to achieve?
- What national aim should we establish that will ensure that our health system is safe for all?
  - What, if any, subgoals or prioritization should be established to help us achieve the aim?

10:00 am – 10:15am **Welcome and Framing**
Robert Otto Valdez
Craig Umscheid

10:15 am – 10:30 am **Introductions (Round Robin)**
Lucy A. Savitz (Chair)

10:30 am – 10:50 am **Why Patient Safety is Still a National Concern**
Brent James

10:50 am – 11:00 am **Audience Debrief/Processing**
Brent James
Lucy A. Savitz

11:00 am – 11:15 am **Review of the National Action Plan**
Patricia A. McGaffigan

11:15 am – 11:30 am	**Review of PCAST Recommendations** Peter Pronovost
11:30 am – 11:45 am	**Break**
11:45 am – 12:00 pm	**Environmental Scan Review** Lucy A. Savitz
12:00 pm – 12:15 pm	**State of Workforce Safety** Karen S. Garvey
12:15 pm – 12:30 pm	**Violence in the Workplace** Cammie Chaumont Menéndez
12:30 pm – 12:45 pm	**Debrief on Workforce Safety** Lucy A. Savitz
12:45 pm – 1:05 pm	**Advancing Health Equity in Patient Safety: a Reckoning, Challenge and Opportunity** Marshall Chin
1:05 pm – 1:15 pm	**Break**
1:15 pm – 1:45 pm	**Open Discussion** Lucy A. Savitz
1:45 pm – 2:00 pm	**Closing** Lucy A. Savitz
2:00 pm	**Adjournment**

Agency for Healthcare Research and Quality

National Advisory Council
Subcommittee on the National Action Alliance to Advance Patient and Workforce Safety

Wednesday, September 20, 2023
1:00 pm – 5:00 pm EDT
Virtual Via Zoom

AGENDA

Zoom Link: https://ahrq-hhs.zoomgov.com/j/1605492475?pwd=M3hrZkRUSFdXNGk3VmxYNkxzcWE4Zz09

Questions We are Running On:

- Recap from Mtg #1 - How does the current state impact what we should collectively aim to achieve?
- What national aim should we establish, that will ensure that our health system is safe for all?
  - What, if any, subgoals or prioritization should be established to help us achieve the aim?
- What are some best practices for establishing an aim?
  - In Depth Discussion on establishing an aim
- What are some of the levers and available data of our Federal Partners that may support the work of the Action Alliance?

1:00 pm – 1:15 pm	**Welcome, Meeting Goal Review, and September 7th Meeting Recap** Lucy A. Savitz (Chair)
1:15 pm – 1:30 pm	**FDA and Patient Safety: Overview of Resources and Data Available** Erika Torjusen
1:30 pm – 1:45 pm	**CMS and Patient Safety: Overview of Resources and Data Available** Michelle Schreiber
1:45 pm – 2:00 pm	**CDC and Patient Safety: Overview of Resources and Data Available** Arjun Srinivasan
2:00 pm – 2:15 pm	**ONC: The Role of Technology & AI in Patient Safety** Steven Posnack
2:15 pm – 2:30 pm	**AHRQ and Patient Safety: Overview of Resources and Data Available** Craig Umscheid

2:30 pm – 2:45 pm	**Break**
2:45 pm – 3:05 pm	**Debrief from Overview of Federal Safety Programs** Lucy A. Savitz Federal Partners
3:05 pm – 3:25 pm	**Patient & Workforce Safety Stories**
3:25 pm – 3:45 pm	**Best Practices for Establishing an Aim** Jade Perdue-Puli
3:45 pm – 4:05 pm	**Prioritize Aim(s) & Goal(s): Open Discussion** Lucy A. Savitz
4:05 pm – 4:15 pm	**Break**
4:15 pm – 4:30 pm	**Research Gaps: Open Discussion** Lucy A. Savitz
4:30 pm – 4:45 pm	**Meeting Reflections and Reactions**
4:45 pm – 4:55 pm	**Next Steps** Lucy A. Savitz
4:55 pm – 5:00 pm	**Closing** Lucy A. Savitz
5:00 pm	**Adjournment**

Agency for Healthcare Research and Quality

National Advisory Council
Subcommittee on the National Action Alliance to Advance Patient and Workforce Safety

Tuesday, October 10, 2023
1:00 pm – 5:00 pm EDT
Virtual Via Zoom

AGENDA

Zoom Link: https://ahrq-hhs.zoomgov.com/j/1611812889?pwd=SzU1VjlWNHFCaUlYUml6d0JHYTREdz09

Questions We are Running On:

- Recap from Mtg #2 - What are some best practices for establishing an aim? What are some of the levers and available data of our Federal Partners that may support the work of the Action Alliance?
- Meeting goal: consensus on final aim(s) and subgoal(s) (if chosen)

1:00 pm – 1:15 pm	**Welcome, Meeting Goal Review, and September 20th Meeting Recap** Lucy A. Savitz (Chair)
1:15 pm – 1:45 pm	**Debrief of Proposed Aims**
1:45 pm – 2:00 pm	**Open Discussion**
2:00 pm – 2:20 pm	**Workforce Safety Story** Ken Rothfield (Texas Health Arlington Memorial Hospital)
2:20 pm – 2:35 pm	**Break**
2:35 pm – 2:55 pm	**Research Gaps**
2:55 pm – 3:25 pm	**Collaborative Opportunities Discussion**
3:25 pm – 3:35 pm	**Break**

3:35 pm – 4:45 pm	**Working Session: Consensus on Aim(s) & Subgoal(s)**
4:45 pm – 4:55 pm	**Next Steps**
4:55 pm – 5:00 pm	**Closing**
5:00 pm	**Adjournment**

Agency for Healthcare Research and Quality

National Advisory Council
Subcommittee on the National Action Alliance to Advance Patient and Workforce Safety

Friday, October 20, 2023
1:00 pm – 5:00 pm EDT
Virtual Via Zoom

AGENDA

Zoom Link: https://ahrq-hhs.zoomgov.com/j/1611812889?pwd=SzU1VjlWNHFCaUlYUml6d0JHYTREdz09

Meeting Goal: Consensus on final aim(s) and subgoal(s) with measures (if chosen)

Questions We are Running On:

- What are the powerful words we want to convey about the healthcare delivery system we want to see?
- What clear-cut, sticky language** should we include, that will help people remember what we seek to achieve?
- What are our best ideas about how to measure the speakable/actionable aim(s)?

1:00 pm – 1:10 pm	**Welcome, Meeting Goal Review, and October 10th Meeting Recap** Lucy A. Savitz (Chair)
1:10 pm – 1:25 pm	**Brief Review of the National Action Alliance Framework and Plans Underway for Input** Jade Perdue-Puli
1:25 pm – 3:00 pm	**Working Session: Consensus on Aim(s) & Subgoal(s)**
3:00 pm – 3:15 pm	**BREAK**
3:15 pm – 4:30 pm	**Propose measures for the aim(s) & subgoal(s).**
4:30 pm – 5:00 pm	**Wrap Up and Next Steps**
5:00 pm	**Adjournment**

Agency for Healthcare Research and Quality

National Advisory Council
Subcommittee on the National Action Alliance to Advance Patient and Workforce Safety

Monday, December 4, 2023
1:00 pm – 4:00 pm EDT
Virtual Via Zoom

AGENDA

Zoom Link: https://ahrq-hhs.zoomgov.com/j/1611812889?pwd=SzU1VjlWNHFCaUlYUml6d0JHYTREdz09

Meeting Goal: Finalize report

1:00 pm – 1:15 pm	**Welcome and Thank You**
1:15 pm – 1:45 pm	**Meeting Goal Review and Nov 16th NAC Meeting Recap** Lucy A. Savitz (Chair)
1:45 pm – 2:15 pm	**Working session: Affinity Group Discussion**
2:15 pm – 2:30 pm	**Break**
2:30 pm – 3:15 pm	**Working session: Final Report Discussion**
3:15 pm – 3:55 pm	**Reflections of the Process**
3:55 pm – 4:00 pm	**Wrap Up and Next Steps**
4:00 pm	**Adjournment**

Round 1: Aim Ranking

This ranking will likely involve 2-3 rounds to achieve consensus on the top aims to be developed.
You may add more aims for the group. Rank 1-10, with 1 being most preferred and 10 being least.
If you believe a draft aim should be deleted, give it a score of 0.

Draft Aim Statement Goals with measures & time frame will come later.	**Priority Rank** **1=most; 10=least**	**Comments**
Ensure all healthcare clinicians and clinical trainees across the nation develop proficiency in system science.		
Promote universal review by healthcare system boards of patient and workforce safety harm data, inclusive of internal incident report data, independent healthcare worker reports, and reports from patients/family/caregivers.		Expanding harms defined to include physical, emotional, and financial.
Promote standardization of fundamental healthcare technologies to reduce human error and improve patient safety.		Consumer Reports – opportunities to advocate and drive standardization https://www.youtube.com/watch?v=h2JxuySrCw0
***We stand for a healthcare delivery system that is free from preventable harm and promotes a culture of safety in an environment that is healing for all who enter.		From Chat GPT during meeting #2.
The National Action Alliance to Advance Patient and Workforce Safety aims to achieve Zero harm, Zero inequities, Zero waste by XXXX.		
The National Action Alliance believes that the secret to great healthcare is respect for one another, and that our purpose is to meet people where they are in their healthcare journey, to heal, to comfort, and above all else, to do no harm.		
We will transform the healthcare delivery system by instituting high reliability principals in every healthcare system in the country by XXXX.		The thought here is that by working with leadership of healthcare systems that we are able to more rapidly improve care across the full delivery system.
The National Action Alliance to Advance Patient and Workforce Safety will improve patient and workforce safety by 75% while reducing waste in the healthcare delivery system by XXXX.		The thought is that by reducing "waste" we can allow more time for patient and provider interaction which will result in a potential decrease in harm and readmissions.
We will reduce all cause harm across settings of care for patients and the healthcare workforce 75% by XXXX.		Thinking acute care, skilled nursing, LTACs and IRFs as starting points, but would depend on available data.

We aim to empower patients in their healthcare journey and ensure the patient's voice is elevated, allowing them to take ownership of their care resulting in a decrease in all-cause patient harm.		
We aim to ensure all healthcare systems strengthen their foundations in patient safety through assessing and addressing the four foundational areas outlined in the National Action Plan (culture, leadership and governance; patient and family engagement; workforce safety; and creation of learning health systems).		We will need to define "high performance".
The National Action Alliance promotes a holistic awareness of harm, with the aim to ensure patients and the healthcare workforce are free of physical, emotional , and financial harm.		
We will promote the design of medical technology so that it's easy to do the right thing and hard to do the wrong thing		
Add:		
Add:		

Round 2: Aim Ranking

Rank 1-10, with 1 being most preferred and 10 being least. Now is the time to critically appraise by deleting those of lower priority. If you believe a draft aim should be deleted, give it a score of 0. If you see something missing, you may add more aims for the group to consider.

Draft Aim Statement Goals with measures & time frame will come later.	Priority Rank 1=most; 10=least 0=delete	Round 1 Mean	Round 1 Mode	Round 1 Range
Promote universal review by healthcare system boards of patient and workforce safety harm data, inclusive of internal incident report data, independent healthcare worker reports, and reports from patients/family/caregivers.		5.1	3	3 to 9
Promote standardization of fundamental healthcare technologies to reduce human error and improve patient safety.		6	7	1 to 10
**We stand for a healthcare delivery system that is free from preventable harm, inspires continuous improvement in the delivery of care, and promotes a culture of safety in an environment that is healing for all who enter.		5.8	2	2 to 9
We will reduce all cause harm across settings of care for patients and the healthcare workforce 75% by XXXX.		6.25	3	2 to 10
We aim to empower patients in their healthcare journey and ensure the patient's voice is elevated, allowing them to take ownership of their care resulting in a decrease in all-cause patient harm.		6.8	6	2 to 9
We aim to ensure all healthcare systems strengthen their foundations in patient safety through assessing and addressing the four foundational areas outlined in the National Action Plan (culture, leadership and governance; patient and family engagement; workforce safety; and creation of learning health systems).		3	1	1 to 8
The National Action Alliance promotes a holistic awareness of harm, with the aim to ensure patients and the healthcare workforce are free of physical, emotional , and financial harm.		6	4	1 to 9
We will promote the design of medical technology so that it's easy to do the right thing and hard to do the wrong thing		6.1	2	1 to 10

Our willingness (promise) to include the patient's voice in each of the four foundational areas of the National Action Plan across the care continuum as the key (pathway) that leads to total system safer care, which will result in Zero Harm				
The National Alliance will foster dialogue and action across all communities to make health care safer for patients and their caregivers.				
50% of health care delivery organizations will have completed the NAP assessment tool and develop improvement plans and measures for each of the four domains by Dec 31, 2024.				
Humans are an essential source of patient safety in complex systems; technologies, policies and regulations should be designed to leverage human judgment and ability to meet individual patients' needs.				
Continuity of relationships within healthcare teams and with patients is another essential source of patient safety. Physicial, technological, policy and practice infrastrcutures should be built to maximize continuity.				

Round 3: Aim Ranking

Rank 1-5, with 1 being most preferred and 5 being least. Note that there are 3 added aims to consider in rating. If you believe a draft aim should be deleted, give it a score of 0.

Draft Aim Statement Goals with measures & time frame will come later.	Priority Rank 1=most; 5=least 0=delete	Round 2 Mean	Round 2 Mode	Round 2 Range
Promote universal review by healthcare system boards of patient and workforce safety harm data, inclusive of internal incident report data, independent healthcare worker reports, and reports from patients/family/caregivers.		5.3	5	3 to 8
Promote standardization of fundamental healthcare technologies to reduce human error and improve patient safety.		6.2	2	2 to 8
**We stand for a healthcare delivery system that is free from preventable harm, inspires continuous improvement in the delivery of care, and promotes a culture of safety in an environment that is healing for all who enter. (Modified Chat GPT)		4.5	3	1 to 9
We aim to ensure all healthcare systems strengthen their foundations in patient safety through assessing and addressing the four foundational areas outlined in the National Action Plan (culture, leadership and governance; patient and family engagement; workforce safety; and creation of learning health systems).		3.8	1	1 to 7
We will promote the design of medical technology so that it's easy to do the right thing and hard to do the wrong thing		5.6	2	2 to 8
Augment measurement of harm by expanding to include emotional harm through the use of electronic detection systems		Added		
Optimize incentives for health systems to drive adoption of safety best practices		Added		
Create a learning network across all hospitals with the specific aim to eliminate all serious harm for patients and staff.		Added		