

# Statewide Patient Safety Coalitions: A Status Report

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by

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Patient safety organizations are constantly emerging and evolving. We apologize if we have inadvertently overlooked a new or evolving statewide patient safety organization, and invite you to contact the National Academy for State Health Policy to update our information.

## EXECUTIVE SUMMARY

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In several states, private and public healthcare providers, purchasers, consumers, and regulators have recognized the value of coordinating their efforts to create an environment that enhances safety. Statewide public/private patient safety coalitions have been formed in twelve states.<sup>1</sup> (In all, 17 statewide patient safety organizations have been formed or are developing.) Some coalitions began as small working groups or committees within medical or hospital associations, evolving and expanding into full coalitions as the diversity of their membership and their vision grew. Others started as loosely organized groups of professionals and organizations, evolving with time into larger, more inclusive, and structured organizations.

Patient safety coalitions typically have a diverse membership, often including real or potential competitors and adversaries within the group. They voluntarily, and sometimes warily, come together to address the common goal of reducing the harm that comes to patients, professionals, and institutions when a medical error or adverse event occurs.<sup>2</sup>

Patient safety coalitions are educating health care professionals, purchasers, consumers, and policy makers about the nature of medical errors, the culture of safety, and strategies for reducing risks. The seven most mature coalitions are profiled in this report: Arkansas, Georgia, Massachusetts, Minnesota, Pennsylvania, Virginia, Wisconsin.

Since coalitions are voluntary collaborative organizations, they must accommodate the interests of a wide array of stakeholders to maintain participation. Developing strategies for error prevention is a challenging task, one that may include negotiating major turf issues between stakeholders and reconciling often divergent points of view among coalition members. Coalitions report success in pursuing activities that lend themselves to public/private collaboration, such as educational programs, development of patient safety improvement tools, focused quality improvement projects, and dissemination of best practices. Coalition members report that some issues cannot be managed by consensus within the coalition and are taken “off the table” or are dealt with outside the coalition by interested stakeholders. An example of such an issue might be legislative advocacy for tort reform. Similarly, many coalitions choose not to address mandatory reporting systems, which continue to raise opposition from providers concerned about public disclosure and/or discoverability of the data.

Coalitions are laboratories for safety and quality improvement, blending the skills, knowledge, and influence of both the private and the public sectors. One indirect benefit of coalitions has been better communication between public and private organizations, both within and outside the structure of the coalition, as they identify common quality and safety goals and objectives.

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<sup>1</sup> Patient safety committees or subcommittees in state hospital or medical associations are not within the scope of this report unless they meet the criteria outlined in the section, *Types of Patient Safety Organizations*.

<sup>2</sup> Medical error is the failure of a planned action to be completed as intended, or use of a wrong plan to achieve an aim; the accumulation of error results in accidents. Adverse event is an injury resulting from a medical intervention. Source: Institute of Medicine, *To Err is Human: Building a Safer System* (Washington, D.C.: National Academy Press, 1999), 180.

Among the organizational or environmental factors that influence coalitions' success are:

- **context**, including the historical relationships among stakeholders and the political environment in the state;
- **strategic intent**, or purpose of the coalition, including mission or vision statements, goals, and objectives;
- **membership heterogeneity**, including balancing the size and composition of the group;
- **diversification of resources**; to assure an independent coalition agenda, free of “strings”;
- **coordination**, including communications and accountability mechanisms; and
- **responsiveness to demands for accountability** from members and the public at large.

The oldest coalition is only a few years old, and although much can be learned from the pioneers of this movement, their organizations are continuing to evolve. Their ability to improve patient safety may not yet be measurable, and many coalitions are still in the process of developing measures of effectiveness. However, coalitions hold promise of encouraging the dialogue necessary to create a new public/private paradigm for preventing harm, one that integrates the best elements of professional, consumer, purchaser, and institutional accountability with the most effective regulatory mechanisms.

As newly formed organizations, many coalitions have not had an opportunity to share strategies and successes. This report is intended to inform and assist coalition leaders, policy makers, and stakeholders as they pursue their shared mission of making health care safer. Coalition members share lessons learned in membership development, communication, successful activities, and building trust.

## INTRODUCTION

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### The History of Patient Safety in the United States

There are numerous events that have shaped the direction of patient safety/error prevention efforts in the United States. Among them, six stand out as particularly noteworthy:

- 1991: Publication of the Harvard Medical Practice studies landmark research documenting the extent and type of errors occurring in 30,000 hospital discharges in New York State.<sup>3</sup> Since then, several other researchers have replicated these results in other populations.
- Early 1990s to present: Emergence of several large purchaser coalitions pursuing both cost and quality improvement objectives through a variety of market-based strategies.<sup>4</sup> Private and public purchasers, individually and through purchasing groups, have become involved in helping to protect their employees and other enrollees from medical errors. Strategies have included developing patient safety purchasing standards, recognizing and rewarding providers that work to protect patients, and sharing information with employees to help them make informed choices about where to seek care.
- 1995-97: The media began focusing attention on medical accidents<sup>5</sup> beginning with the 1994 chemotherapy overdose of Boston Globe health columnist, Betsy Lehman, at the Dana Farber Cancer Institute in Boston.<sup>6</sup> Several other tragic events became news within two years. In Florida, a 7-year old boy died from an adrenaline overdose during a tonsillectomy,<sup>7</sup> and a man had the wrong leg amputated.<sup>8</sup> The *New York Times Magazine* printed a story about a Texas newborn who died of an overdose of digoxin.<sup>9</sup> The public's awareness and concern about medical errors began to grow.
- 1996: Institute for Healthcare Improvement (IHI) Breakthrough Series began the Reducing Adverse Drug Events project, a national collaborative of health care institutions using quality improvement (QI) techniques to systematically reduce adverse drug events in their hospitals.<sup>10</sup> A successful endeavor, it demonstrated across many organizations that the

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<sup>3</sup> Lucian Leape, et al., "Incidence of Adverse Events and Negligence in Hospitalized Patients: Results of the Harvard Medical Practice Study I," *New England Journal of Medicine* 324(1991): 370-376.

<sup>4</sup> Irene Frasier, et al., "The Pursuit of Quality by Business Coalitions: A National Survey," *Health Affairs* 18(1999)6: 158-165.

<sup>5</sup> The Massachusetts Health Policy Forum, *Issue Brief Number 10: Medical Errors and Patient Safety in Massachusetts: What is the Role of the Commonwealth?* (Boston, MA: Massachusetts Health Policy Forum, 2000).

<sup>6</sup> "Overdoses still weigh heavily at Dana Farber," *Boston Globe*, December 26, 1995.

<sup>7</sup> "Hospital admits syringe mix-up killed boy," *The Palm Beach Post*, January 11, 1996.

<sup>8</sup> "Expert: King error a group effort," *St. Petersburg Times*, September 14, 1995.

<sup>9</sup> "How can we save the next victim?," *New York Times Magazine*, June 15, 1997.

<sup>10</sup> Institute for Healthcare Improvement, *Breakthrough Series Guide: Reducing Adverse Drug Events* (Boston, MA: Institute for Healthcare Improvement, 1998).

majority of errors could be reduced or eliminated by addressing “systems” issues, rather than focusing on blame or competence questions.

- 1997: The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) unveiled its controversial Sentinel Event Policy, requiring accredited health care organizations to monitor sentinel events and to rigorously analyze the most serious to determine the root causes of these events.<sup>11</sup> Results of these analyses were to be shared with the Commission, although legal barriers have prevented some organizations from doing so. This voluntary reporting system has contributed to over 20 Sentinel Event Alerts, describing high severity types of sentinel events and suggesting strategies for their prevention. JCAHO has gone on to launch a comprehensive patient safety initiative, having revised its standards, created new standards, and established annual national patient safety goals.
- 1999: Release of The Institute of Medicine’s (IOM) landmark report, *To Err is Human: Building a Safer Health System*.<sup>12</sup> The IOM alerted the health care industry, the public, and policy makers to the large number of preventable patient injuries and deaths occurring in U.S. hospitals. Using published sources, it estimated that from 44,000 to 98,000 Americans die each year from medical errors,<sup>13</sup> about half of the deaths being preventable.<sup>14</sup> Although some statistical analyses used in the report have been questioned,<sup>15</sup> the actual numbers of deaths are probably much higher since the IOM’s figures do not include deaths due to adverse events<sup>16</sup> in nursing homes, outpatient facilities, or at home. The IOM report called on public policy makers to take action to reduce medical errors in the United States.

## Stakeholder Response

The IOM advocated a comprehensive strategy to address preventable injuries and deaths based on the expectation that both public and private interests would be responsive to the issues it raised. Publication of its report was immediately followed by media, industry, government, professional, institutional, consumer, and purchaser actions intended to reduce errors and/or stimulate others to reduce them.

Federal and state governments quickly realized that action was needed to address the recommendations in the IOM Report and the growing public outcry about medical injuries. State legislators adopted a number of actions to increase consumer confidence through public

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<sup>11</sup> JCAHO sentinel event policy at [www.jcaho.org](http://www.jcaho.org)

<sup>12</sup> Institute of Medicine, *To Err is Human: Building a Safer System* (Washington, D.C.: National Academy Press, 1999), 180.

<sup>13</sup> *Ibid.*, 1.

<sup>14</sup> Lucian Leape, et al., “Preventing Medical Injury,” *QRB* (May, 1993): 144-149.

<sup>15</sup> Clement J. McDonald, “Deaths Due to Medical Errors are Exaggerated in Institute of Medicine Report,” *JAMA* 284, no.1 (July 5, 2000).

<sup>16</sup> Institute of Medicine, *To Err is Human: Building a Safer System* (Washington, D.C.: National Academy Press, 1999), 179. Definition of adverse event: An injury resulting from a medical intervention.

reporting systems, published report cards, or other mechanisms.<sup>17</sup> State legislation has been passed to create task forces, commissions, and similar groups to analyze, identify, and recommend statewide patient safety interventions. At least 11 medical error related bills were introduced during states' 1999 legislative sessions, 34 during the 2000 sessions, and 61 during the 2001 sessions.<sup>18</sup> States have mandated institution-based training, quality improvement efforts, and/or risk management activities to prevent errors. Medication errors have been singled out by some states for immediate action. Nurse staffing levels are a relatively new and controversial area of legislative action, but a number of states are developing or enacting laws to guide nurse staffing practices or are studying the issue within their states.

Purchasers were also becoming concerned about the impact of errors on their employees and their families, as well as the costs associated with preventable complications and deaths. The Leapfrog Group, a coalition of purchasers interested in health care policy, formed in 1998.<sup>19</sup> It has adopted a high profile set of evidence based standards designed to reduce the likelihood of errors by encouraging hospitals to install computer physician order entry systems and using trained critical care physicians in intensive care units (ICUs). The group is also educating employees and their families about seeking evidence-based hospital referrals for selected complex medical procedures, to assure that patients receive care at facilities with the best outcomes and survival performance.

The medical care community quickly came to realize that improving patient safety would continue to be a high profile issue. The American Hospital Association, the American Medical Association, the Voluntary Hospital Association, the American Society of Health-system Pharmacists, the Department of Veterans Affairs, the Institute for Safe Medication Practices, and the Institute for Healthcare Improvement have taken positions and become major supporters of, and contributors to, initiatives to improve patient safety. At the same time, JCAHO has continued to expand and strengthen its patient safety standards for acute, long-term care, and ambulatory facilities.<sup>20</sup>

Figure 1 identifies many of the organizations, agencies, and major contributors to patient safety in recent years.

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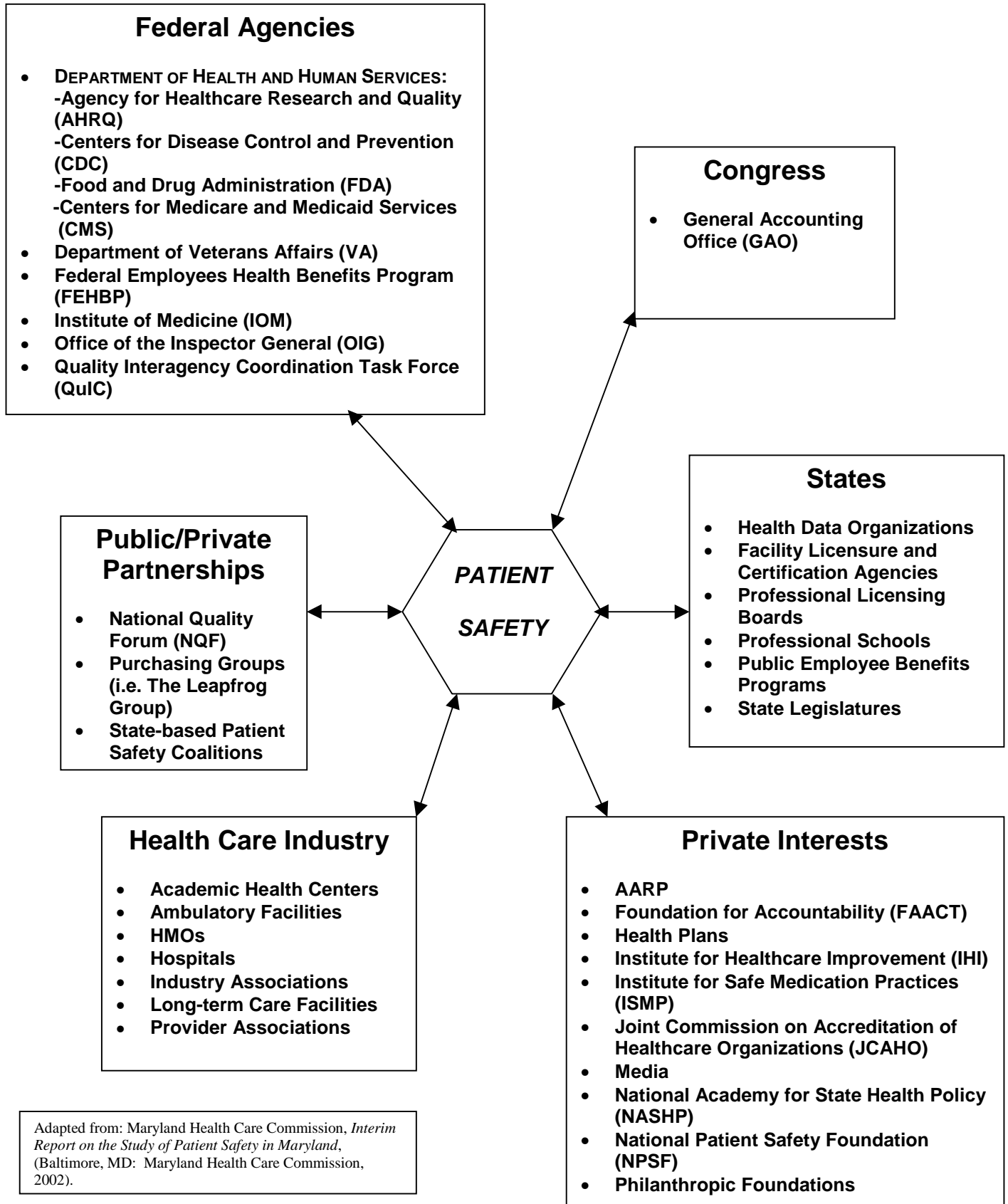
<sup>17</sup> Lynda Flowers and Trish Riley, *How States are Responding to Medical Errors: An Analysis of Recent State Legislative Proposals* (Portland, ME: National Academy for State Health Policy, 2000).

<sup>18</sup> Lynda Flowers, *State Responses to the Problem of Medical Errors: An Analysis of Recent State Legislative Proposals* (Portland, ME: National Academy for State Health Policy, 2002).

<sup>19</sup> [Leapfrog Group](#)

<sup>20</sup> [Joint Commission on Accreditation of Healthcare Organizations](#)

**Figure 1 Organizations and Agencies Contributing to Patient Safety**



Adapted from: Maryland Health Care Commission, *Interim Report on the Study of Patient Safety in Maryland*, (Baltimore, MD: Maryland Health Care Commission, 2002).

## PATIENT SAFETY ORGANIZATIONS

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Healthcare provider organizations have found it difficult to track and respond to the variety and number of patient safety policies, programs, research, and projects emanating from the organizations and agencies described in Figure 1. In several states, stakeholders recognized the value of having a single contact point or clearinghouse for getting information about patient safety activities. These groups also wanted to share information and resources to solve common patient safety problems and to avoid redundant, competing, overlapping, and/or conflicting patient safety initiatives. Patient safety organizations were formed to address these needs.

These groups have been instrumental in educating health care professionals, purchasers, consumers, patients, and policy makers about the nature of medical errors, the culture of safety, and strategies for reducing risks. They have also provided forums for sharing and disseminating best practices for preventing patient injuries.

### Types of Patient Safety Organizations

Patient safety coalitions are part of a larger class of organizations sometimes described as community health partnerships,<sup>21</sup> or public/private collaboratives<sup>22</sup> that form to address important public health issues in their communities. They find common interests among stakeholders and avoid issues likely to cause dissension because as voluntary groups, they cannot function with high levels of internal conflict. These organizations have no statutory authority and cannot assume enforcement of public health standards. They cannot act as “guardians” of patient safety. They can, however, be very important forums for open discussion of important public policy issues. They can also bring about voluntary, systematic changes in healthcare systems to improve patient safety in their states.

Many of the organizations in this report use the word “collaborative” to describe their organizations’ style.<sup>23</sup> The highest levels of collaboration are found in patient safety organizations that: 1) have a diverse membership, 2) invest time and resources in building consensus among members about the mission, goals, and objectives of the organization, 3) keep open communication channels with and between their members, and 4) create an organization whose members are dedicated to a common mission. For this report, patient safety organizations are categorized into four broad groups based on the primary focus of the group and the degree of collaboration within it.

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<sup>21</sup> Community health partnerships are defined as, “...voluntary collaborations of diverse community organizations which have joined forces to pursue a shared interest in improving community health...to include coalitions, alliances, consortia, and related forms of interorganizational relations.” Shannon M. Mitchell and Stephen M. Shortell, “The Governance and Management of Effective Community Health Partnerships: A Typology for Research, Policy, and Practice,” *Milbank Quarterly* 78 (2000): 242.

<sup>22</sup> Gloria J. Bazzoli, et al., “Public-Private Collaboration in Health and Human Service Delivery: Evidence from Community Partnerships,” *Milbank Quarterly* 75, no. 4(1997): 533-561.

<sup>23</sup> Collaboration is defined as “...a mutually beneficial and well-defined relationship entered into by two or more organizations to achieve results they are more likely to achieve together than alone.” Michael Winer and Karen Kay, *Collaboration Handbook: Creating, Sustaining, and Enjoying the Journey* (St.Paul, MN: Amherst H. Wilder Foundation, 1994), 24.

1. **Public/private partnerships**, termed “coalitions” in this report. These groups have diverse memberships, often including providers, government, insurers, health plans, consumers, and community stakeholders like major employers, labor unions, or teaching institutions. Stakeholders determine the mission, goals, objectives, and policies of the group. With the exception of peer review data, these groups share knowledge and resources with other interested parties in the community, including governmental bodies. They take actions to address specific problem areas, for example, medication errors, wrong site surgery, peer review protections for reported adverse events, and education of professionals about error prevention. It is these public/private partnerships, these coalitions, that are the focus of this report.
2. **Advisory committees, commissions, or task forces**. These have been created to collect, analyze, and interpret information to make patient safety recommendations to state policy makers within a particular time span, often one year. Maryland’s Coalition was asked by the legislature to serve in this capacity and now serves both as an advisory group and as a public/private coalition. It is currently the only active advisory group; several others have published reports of their work.<sup>24</sup>
3. **Research focused groups**. These groups are supported by grants with defined research objectives and expected products but have public/private advisory groups working with them. Initiating and completing the research is the primary goal of the group at this time. These groups may use research findings to anchor future interventions, but their current focus is on completing the research.
4. **Provider-driven patient safety alliances**. These organizations are similar in their scope of activities to public/private partnerships but have restricted membership, often limit media access, and have limited or no participation by consumers or governmental agencies. They may or may not participate in peer review activities. One or more environmental factors may be discouraging these groups from more inclusive membership policies, including but not limited to strained relationships between providers and regulators, an aggressive plaintiffs’ bar, strong consumer advocacy groups, and/or a critical media presence.

Table 1 categorizes the 17 statewide patient safety organizations into these four groupings.

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<sup>24</sup>Florida Commission on Excellence in Health Care, “[Final Report to the Legislature](#),” 2/1/01; Illinois Governor’s Task Force on Patient Safety, “[Recommendations To The Governor](#)”; The Massachusetts Health Policy Forum, [Issue Brief Number 10: Medical Errors and Patient Safety in Massachusetts: What is the Role of the Commonwealth?](#) (Boston, MA: Massachusetts Health Policy Forum, 2000); [Interim Report on the Study of Patient Safety in Maryland](#), 2002; [Virginians Improving Patient Care and Safety \(VIPC&S\)](#), October, 2001.

**Table 1 Categories of Patient Safety Partnerships**

<b>Public Private Partnerships (Coalitions)</b>	<b>Advisory Committees</b>
Arkansas Colorado Georgia Maryland Massachusetts Michigan Minnesota Ohio Pennsylvania Tennessee Virginia Wisconsin	Maryland
	<b>Research Focused Groups</b>
	California Iowa Utah
	<b>Provider-Driven Groups</b>
	Florida Texas

See Appendix A for organizational contact information.

Statewide patient safety coalitions are a relatively new phenomenon. The oldest, the Massachusetts Coalition for Prevention of Medical Errors, was founded in 1998.<sup>25</sup> Most are less than three years old and because they are so new, limited networking exists among them. As a result, they are not able to take advantage of some of the products or materials that have been produced by their peers.<sup>26</sup> This report is intended to be a resource for existing and developing coalitions and to promote learning, joint problem-solving, and sharing of useful patient safety products between these quality improvement organizations.

## Project Overview

Seven of the twelve statewide public/private partnerships or coalitions are profiled in a series of tables for this report: Arkansas, Georgia, Massachusetts, Minnesota, Pennsylvania, Virginia, and Wisconsin. These organizations were selected from the seventeen identified statewide groups. They all have unique histories but report many of the same kinds of experiences during their start-up phases. Table 2 provides a description of these coalitions.

<sup>25</sup> [Massachusetts Coalition for the Prevention of Medical Errors](#)

<sup>26</sup> See Appendices for examples of coalition products.

**Table 2 Description of Coalitions**

<b>Arkansas</b>	The Arkansas Patient Safety Initiative (APSI) is a voluntary organization of healthcare stakeholders committed to promoting patient safety. APSI emphasizes systems improvement, data driven clinical studies, dissemination of best practices, and voluntary, anonymous reporting of incidents and near misses. The organization provides a forum for discussion of patient safety issues and policy. It translates experience into action to improve patient outcomes.
<b>Georgia</b>	The Partnership for Health and Accountability (PHA) brings together the healthcare field with community agencies and individuals to achieve improved quality, patient safety, and healthy communities. It educates professionals, policy makers, and consumers about patient safety and hospital performance and utilizes information from voluntarily reported incidents and near misses to improve patient safety in hospitals. PHA is designed to benefit communities and individuals, as well as to support policy makers at the state and local level in making informed, data-driven decisions to improve quality, patient safety, and health.
<b>Massachusetts</b>	The Massachusetts Coalition for the Prevention of Medical Errors is a voluntary, not-for-profit initiative of 30 health care organizations. It seeks to strengthen the public's trust and confidence in the health care delivery system by increasing awareness of error prevention strategies through public and professional education. It is the oldest patient safety coalition in the United States, founded in 1998.
<b>Minnesota</b>	The Minnesota Alliance for Patient Safety (MAPS) is a voluntary coalition convened by the Minnesota Hospital and Healthcare Partnership, Minnesota Medical Association, and the Minnesota Department of Health. The broad-based coalition is represented by more than 50 different health care providers, professional and industry associations, consumer groups, regulatory and accrediting organizations, and purchasers committed to improving patient safety in Minnesota. MAPS facilitates learning and collaboration, serves as a clearinghouse, and provides a forum for leaders to share successful patient safety strategies. The coalition promotes open dialogue about patient safety issues in Minnesota and advocates for an improved culture for reporting and accountability.
<b>Pennsylvania</b>	The Pennsylvania Patient Safety Collaborative is a voluntary network of 27 organizations representing health care providers, insurers, organized labor, private industry, and consumers. Its goal is to address the systematic issues that lead to medical errors and to work to reduce patient injury from errors through identification and correction of the causes of medical errors. The Collaborative does not perform legislative advocacy for patient safety, deferring that to member organizations.
<b>Virginia</b>	The Virginians Improving Patient Care and Safety (VIPCS) is a not-for-profit, voluntary organization involving 37 health care entities. It promotes the conditions that improve patient safety: a non-punitive culture that encourages sharing of information and learning from mistakes, legislative advocacy to permit entity-to-entity sharing of peer review information, professional accountability for error reduction, provider involvement in determining patient safety priorities and interventions, and on-going education for professionals, policy makers, and the public.
<b>Wisconsin</b>	The Wisconsin Patient Safety Institute is a voluntary, not-for-profit organization with representatives from 50 diverse constituency groups. The purpose of the group is to expand existing collaborations to promote adoption of safe practices in Wisconsin hospitals, and eventually, to clinics, long-term care facilities, and home health agencies.

Four characteristics distinguish the organizations profiled:

- All are statewide (as opposed to regional) organizations.
- All are public/private partnerships with governmental and private stakeholders.
- All are at least two years old.
- All are taking direct action to reduce risks to patients in their states, e.g., identifying and promoting best practices, distributing clinical guidelines, selecting error-prone activities for focused improvement efforts, and educating professionals and/or consumers. If they do research, it is secondary to their action oriented goals and objectives.

The authors of this report interviewed leaders and/or staff from each of the seven states. Respondents were asked to describe the processes they went through in creating their organizations, including lessons learned about the human and organizational factors that led to success or failure. Their experiences and observations illustrate the learning process that takes place as diverse organizations and public agencies try to find common ground for joining forces to promote patient safety in their states. Web site and printed materials were used extensively to augment interviews and document the structure and activities of each organization.

## THE ROLE OF STATE GOVERNMENT IN PATIENT SAFETY COALITIONS

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States play many roles in patient safety. Along with their obvious policy maker and regulatory roles, states are purchasers and providers of health care. They are also educators and convenors.<sup>27</sup> They are part of a large universe of public and private industry players who influence or can directly improve patient safety, and as such, have compelling reasons to convene and/or be a part of a patient safety coalition.

State participation in coalitions can be problematic given the regulatory relationship states often have with other coalition members. Because of this complex relationship, the role of state agencies in patient safety coalitions is explored in detail in this report.

State agencies may have some misgivings about participating in coalitions. They are sometimes skeptical of coalitions, seeing them as an effort on the part of the health care industry to avoid additional state oversight. States may elect to take a wait-and-see approach to coalitions, particularly if provider interests dominate them. State agencies that participate in coalitions may also run the risk of being accused of being “co-opted” if provider groups try to argue that the coalition makes regulatory or legislative interventions unnecessary.

On the other hand, state agencies are often among the founding stakeholders of patient safety coalitions. Public officials provide resources and leadership to promote these groups. Patient safety coalitions are forums for stakeholders to learn about other points of view and, as such, can be good sounding boards for states considering new or modified policies. Keen on avoiding unintended consequences or ineffective interventions, states can use the coalition as a laboratory to test ideas before implementing them. Coalitions also offer policy makers an opportunity to gain insight into the concerns of providers, consumers, and purchasers, allowing them to make more informed decisions.

States have played an active role as initiators or founding stakeholders of patient safety coalitions in Georgia, Massachusetts, Minnesota, Pennsylvania, Wisconsin and Virginia.

Providers may have concerns about state participation as well, fearing that it may impede open and honest communication among group members. Hospital and other provider groups may question who from state government to involve, since state internal patient safety efforts are often not well coordinated and are spread across multiple agencies. For example, health care oversight is a responsibility of state professional boards, departments of insurance, licensing agencies, and public health.<sup>28</sup>

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<sup>27</sup> Jill Rosenthal and Trish Riley, *Patient Safety and Medical Errors: A Roadmap for State Action* (Portland, ME: National Academy for State Health Policy, 2001).

<sup>28</sup> Trish Riley, *The Flood Tide Forum: Improving Patient Safety: What States Can Do About Medical Errors*, (Portland, ME: National Academy for State Health Policy, 2000), 9.

However, some states are attempting to better coordinate internal patient safety efforts.

At least four states, Massachusetts, Maryland, Minnesota, and Pennsylvania are considering or have begun interagency coordination of patient safety efforts within state government.

The Massachusetts legislature recently enacted legislation establishing a patient safety center to conduct system-wide analysis of patient safety.<sup>29</sup> Several state agencies in Pennsylvania, including the Departments of Health, Public Welfare, State, Aging, and Health Care Cost Containment Council have formed an interagency task force to explore coordination of several reporting requirements.<sup>30</sup> Minnesota and Maryland are at the initial discussion stage.

Stakeholders may need to work through perceptions about each other's motives and goals, given sometimes competitive or adversarial roles. As voluntary organizations, patient safety coalitions must respect the range of viewpoints represented within their membership. Because coalitions don't function well with high levels of internal conflict, they must seek common interests among stakeholders and avoid issues likely to cause dissension.

***Stakeholders have to decide what patient safety issues can be appropriately managed by consensus in the coalition and what controversial issues are “off the table” and must be managed outside the group.***

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<sup>29</sup> Lynda Flowers, *State Responses to the Problem of Medical Errors: An Analysis of Recent State Legislative Proposals* (Portland, ME: National Academy for State Health Policy, 2002).

<sup>30</sup> Jill Rosenthal, et al., *Current State Programs Addressing Medical Errors: An Analysis of Mandatory Reporting and Other Initiatives* (Portland, ME: National Academy for State Health Policy, 2001).

## Mandatory Reporting Systems: Balancing Learning & Accountability

Coalition members in several states have supported legislation to develop voluntary reporting systems. However, many coalition leaders identified mandatory reporting systems as one of the most contentious or “off the table” issues faced by their organizations.

The collection of data about errors is a controversial issue within coalitions for a variety of practical, legal, and philosophical reasons. The IOM recommended two types of error reporting systems in its 1999 report: a nationwide mandatory system for adverse events that result in death or serious injury (implemented through state collection of standardized data), and a voluntary system as a complement to the more narrowly focused mandatory system.<sup>31</sup>

The notion of complementary mandatory and voluntary reporting systems that serve distinct purposes was modeled in part on the success of the aviation system. One author, David Marx, cites aviation examples that promote safety reporting and still address accountability for egregious or reckless behaviors. He advocates for systems that “...reasonably balance the benefits of a learning culture with the need to retain personal accountability and discipline.”<sup>32</sup>

The IOM suggested that mandatory reporting systems should be narrowly defined and should “...focus on identification of serious adverse events attributable to error.”<sup>33</sup> The IOM noted that since states have the authority to investigate incidents, mandatory reporting systems should originate at the state level. Mandatory reporting systems are generally operated by state regulatory programs.

About one-third of states currently operate mandatory reporting systems and state legislatures are considering the feasibility of implementing them in other states as well.<sup>34</sup> Many states value mandatory reporting for providing an important window into hospital patient safety and strengthening state facility oversight functions. They believe they achieve accountability by investigating events, providing expertise or information to help remedy problems, and insuring that appropriate changes are made and sustained to avoid similar problems in the future.<sup>35</sup>

However, many industry groups and some researchers question mandatory reporting systems and particularly the public reporting of data or findings.<sup>36</sup> They believe that mandatory reporting will discourage future reporting and open institutions and professionals to tort liability. The healthcare community is struggling to reconcile the seemingly conflicting concepts of having a blame-free culture of safety to encourage disclosure and analysis of errors for learning, versus the professional, institutional, and governmental need for accountability.

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<sup>31</sup> Institute of Medicine, *To Err is Human: Building a Safer System* (Washington, D.C.: National Academy Press, 1999), 87.

<sup>32</sup> David Marx, *Patient Safety and the “Just Culture”: A Primer for Health Care Executives*, (New York: Columbia University, 2001), 22

<sup>33</sup> *Ibid.*, 76.

<sup>34</sup> Lynda Flowers, *State Responses to the Problem of Medical Errors: An Analysis of Recent State Legislative Proposals* (Portland, ME: National Academy for State Health Policy, 2002).

<sup>35</sup> Jill Rosenthal and Maureen Booth, *How Safe is Your Health Care?* (Portland, ME: National Academy for State Health Policy, 2001), 5-7.

<sup>36</sup> Troyen A. Brennan, “The Institute of Medicine Report on Medical Errors—Could It do Harm,?” *New England Journal of Medicine* 342, no. 15 (April 13, 2000), and David Marx, *Patient Safety and the “Just Culture”: A Primer for Health Care Executives*, (New York: Columbia University, 2001).

## Special Challenges

States have at least three options to consider when coalitions are forming.

- Should they stand back and let the healthcare community lead and direct the effort?
- Should they provide leadership and take the initiative to get the coalition started? or
- Should they take a role as an active and equal partner in the group?

The answer to these questions is often dependent on the regulatory environment in each state and the relationships that exist among stakeholders.

Tensions between state government and the provider community shape the functions and influence of state representatives serving on patient safety coalitions. The tensions arise, in part, because of the pervasive and sometimes contentious national debate on how best to structure the healthcare system to detect, evaluate, and correct conditions that harm patients.

Some who participate in this debate argue that patient safety is primarily the responsibility of the health care system to solve through existing or enhanced peer review and quality improvement mechanisms. Regulators counter that this approach is not working and that government has a responsibility to protect the public from harm. Provider groups make the argument that the “blame and shame” regulatory mode discourages disclosure and has been unsuccessful at preventing serious errors from being repeated. Absent from this debate is a model that integrates the best elements of professional accountability, market forces, and consumer participation with the most effective regulatory mechanisms, a “best of all worlds” model. Coalitions may enable the dialogue necessary to develop this new paradigm.

Georgia has developed an innovative public/private initiative in part as the result of its coalition. The Georgia Hospital Association’s (GHA) Partnership for Health and Accountability has a peer review protected system for the voluntary reporting, studying, and learning from non-fatal errors and “near misses.” In 2001, the Department of Community Health (DCH) revised its contract requirements for hospitals treating state employees and Medicaid recipients to require that contract hospitals participate in a patient safety program. The GHA’s voluntary error reduction program met the DCH patient safety program criteria. As a result of the state’s support, hospital participation in GHA’s program has increased substantially.

Depending on the character of existing relationships between state government and providers, coalitions have adopted different tactics to foster open dialogue and reduce conflict between state and provider stakeholders during their start-up periods. In states where good working relationships existed between state government and the provider community before the coalition began, both public health and regulatory branches of state government are represented on the coalition. The coalitions become forums for discussing public policy, and stakeholders find ways to join forces outside the coalition, as well as in it.

Where high levels of conflict exist between regulators and providers, particularly hospitals, coalitions have invited public health representatives to join the group, but not representatives from regulatory agencies.

In Pennsylvania, the statewide coalition includes a high-ranking state official, but the state regulatory and purchasing agencies are not included. The state official facilitates communication between the coalition and state agencies on issues of mutual interest.

A few of the seventeen groups exclude the state as a stakeholder altogether, because other stakeholders are inhibited from openly discussing patient safety issues if state agencies are involved in the coalition, or for political reasons. Membership policies that exclude important stakeholders or constituencies inevitably diminish a coalition's public image and its credibility with policy makers.

## Benefits of State Participation

The evidence from several coalitions indicates that public/private collaboration can benefit both providers and state agencies. Coalitions offer states an opportunity to build working relationships around the common goal of making health care safer. There are many activities that lend themselves to public/private collaboration:

- educational programs for professionals, policy makers, and the public;
- development of materials and tools for self-assessment;
- infusion of patient safety into professional education curricula;
- focused quality improvement projects to reduce errors, e.g., medication safety, falls, wrong site surgeries;
- development of awards or other types of recognition for patient safety achievements; and
- dissemination of best practices.

Coalitions with the active sponsorship and participation of state agencies report additional benefits. Some coalitions have received funding, space, or in-kind support from the state. Both the provider community and state stakeholders benefit when states use coalitions as sounding boards for planning new services or developing consensus about a proposed change in policy.

***Policy makers are more inclined to trust coalitions that include state public health agencies and/or regulators, because it reassures them that public interests are being considered when coalition business is being done.***

Virginia, Minnesota, Colorado, Pennsylvania, Massachusetts, and Georgia report that their credibility with policy makers is enhanced because they have state regulators and/or public health department stakeholders. In several instances, legislators have asked coalitions for input about new legislation.

Coalitions are often cautious about being seen as legislative advocates. If they are organized as not-for-profit corporations, they can provide education about patient safety policy issues but do not openly advocate or lobby for particular legislation. Most coalitions defer advocacy to stakeholder organizations, since there may be several different points of view within the coalition and little likelihood of a consensus position.

However, state participation in coalitions can enable the groups to build consensus around potentially controversial measures, e.g., creation of voluntary reporting systems. State regulators, once their concerns were voiced and addressed, have been able to support proposals for voluntary reporting systems, and the legislation has passed in Georgia, Minnesota, and Virginia.

In Minnesota, legislation to allow professional organizations to share peer reviewed adverse event data was passed (despite opposition from plaintiffs' lawyers), in part because two board members of Minnesota's Alliance for Patient Safety are influential legislators.

## ORGANIZATIONAL FACTORS INFLUENCING COALITIONS' SUCCESS

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According to work done by Shannon M. Mitchell and Stephen M. Shortell, successful coalitions have productive, engaged memberships. Management is able to sustain member interest, foster links between the partnership and the external community, communicate membership benefits, acquire resources to support coalition activities, and demonstrate evidence of achievement to both internal and external stakeholders.<sup>37</sup> Successful coalitions have achieved community and policy maker recognition or legitimacy as the state's primary patient safety organization. This recognition brings prestige to the group, facilitates acquisition of resources, attracts and holds stakeholders, and bodes well for long-term sustainability of the organization.<sup>38</sup>

Based on Mitchell's and Shortell's synthesis of the literature, there are at least five complex factors that influence the success or failure of organizations like coalitions. They are:

- the context surrounding the organization;
- its strategic intent;
- maintaining a diversified resource base;
- the degree of membership heterogeneity present;
- coordination skills; and
- how the organization responds to demands for accountability<sup>39</sup>.

### Context

Context includes identification of the internal and external stakeholders, their historical relationships and influence, the presence or absence of human and financial resources, the political environment, public sentiments, and the current challenges facing the community.<sup>40</sup>

Context has a major and multifaceted influence on coalitions. A single adverse event, happening to a prominent person, legislator, or their family, can trigger patient safety activities.

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<sup>37</sup> Shannon M. Mitchell and Stephen M. Shortell, "The Governance and Management of Effective Community Health Partnerships: A Typology for Research, Policy, and Practice," *Milbank Quarterly* 78 (2000):243.

<sup>38</sup> *Ibid.*, 269-279.

<sup>39</sup> *Ibid.*, 242.

<sup>40</sup> *Ibid.*, 261.

The first patient safety coalition, the Massachusetts Coalition for the Prevention of Medical Errors,<sup>41</sup> was initiated after Boston Globe reporter Betsy Lehman died after a chemotherapy overdose in 1994 at the Dana Farber Cancer Institute. Betsy Lehman was a highly visible and respected member of the community. Her death set the stage for stakeholder groups to come together to respond to the concerns of the public about patient safety in Massachusetts hospitals.

Several coalitions have identified the publication of the 1999 Institute of Medicine report and the ensuing calls for action from the public and from policy makers as a triggering event for their coalitions.

The presence or absence of working relationships among stakeholders is another important aspect of the context in which coalitions form.

***The presence or absence of relationships among stakeholders shapes the structure, mission, and membership of the group and determines which organizations are invited to participate, their role, and whether the coalition forms at all.***<sup>42</sup>

For example, one coalition's initial start-up efforts were derailed by a very forceful and vocal representative from a local purchasers' group, whose aggressive style and tactics turned off other potential coalition members and forced some stakeholders to take defensive positions. Conflict in coalitions is usually not fatal, however, and important gains can arise when stakeholders learn about other members' points of view. For example, one stakeholder heard purchasers' desire for hospital specific quality and safety information for consumers and implemented a new program this year to provide the information. Successful coalitions are built upon trust and constructive dialogue. According to coalition members interviewed for this report, it often takes 12 to 18 months of meetings to build the relationships that are necessary for a formally organized and effective group.

The environment within the community can also shape the coalition's structure and membership. Good media coverage, for example, can establish a new coalition's legitimacy with the public, but three of the coalitions profiled in this report expressed caution about their dealings with the media, having found that members of the local press tend to report negatively on the healthcare community. Similarly, an aggressive plaintiffs' bar can cause coalition members to be guarded

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<sup>41</sup> Leslie Kirle, et al. "The Massachusetts Coalitions for the Prevention of Medical Errors," (Annenberg Conference on Enhancing Patient Safety and Reducing Errors in Health Care, Rancho Mirage, 1998).

<sup>42</sup> For a comprehensive discussion of the impact of interorganizational relationships, see Gloria J. Bazzoli, et al., "Public-Private Collaboration in Health and Human Service Delivery: Evidence from Community Partnerships," *Milbank Quarterly* 75, no. 4(1997):533-561, and Shannon M. Mitchell and Stephen M. Shortell, "The Governance and Management of Effective Community Health Partnerships: A Typology for Research, Policy, and Practice," *Milbank Quarterly* 78 (2000):240-289.

about their work, refusing to share information about their sentinel events or what they have learned from them without protections from discoverability.

One organization, now housed as a peer-review protected committee within the state hospital association, reported that four environmental influences have contributed to its keeping its work closely guarded:

- an active and influential plaintiffs' bar,
- a sophisticated health care consumer advocacy group,
- unstable relationships with state regulators, and
- hostile members of the press.

As a result, the coalition chose to operate under the peer review umbrella of the hospital association.

Local context is a powerful influence on the development of coalitions, and often shapes their structure, membership, and activities.

## **Strategic Intent**

Strategic intent refers to the reasons why the partnership is being formed.<sup>43</sup> It is usually expressed in one or more documents, including but not limited to the organization's mission statement, goals and objectives, and guiding principles. (See Appendix B for Minnesota's comprehensive strategic plan.) Strategic intent can change over time and is subject to re-interpretation based on membership dynamics, the addition of new members, and new political or economic forces.

***One of the functions of governance is to guide and maintain the group's strategic intent, keeping goals and objectives aligned with the mission of the group.***

Mission statements typically define the organizations' purpose in terms of patient safety and/or quality rather than in terms of benefits to individual stakeholders. Table 3 outlines the mission or vision statements of the seven profiled coalitions.

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<sup>43</sup> Shannon M. Mitchell and Stephen M. Shortell, "The Governance and Management of Effective Community Health Partnerships: A Typology for Research, Policy, and Practice," *Milbank Quarterly* 78 (2000):262.

**Table 3 Mission or vision statements**

<b>Arkansas</b>	The Arkansas Patient Safety Initiative (APSI) fosters and supports an environment in which critical patient safety issues can be discussed in an educational, non-punitive framework, to encourage the sharing of information and solutions to challenging patient safety problems.
<b>Georgia</b>	Stakeholders collaboratively use data to proactively improve quality, patient safety, and health, and effectively communicate results across the publics served.
<b>Massachusetts</b>	The Massachusetts Coalition for the Prevention of Medical Errors was established to develop and implement a statewide initiative to improve patient safety and minimize medical errors.
<b>Minnesota</b>	MAPS' mission is to promote optimum patient safety through collaboration and supportive efforts among all participants of the health care system in Minnesota.
<b>Pennsylvania</b>	Through education, sharing of effective safety practices, and disseminating resources to aid healthcare organizations, the Coalition is working to make patient safety a top priority across the Commonwealth by all stakeholders who influence patient care delivery.
<b>Virginia</b>	VIPC&S supports systematic efforts to continuously improve quality of care and patient safety. It believes that sharing knowledge about errors in a non-punitive way is essential for improving patient safety.
<b>Wisconsin</b>	To enhance and promote patient safety in Wisconsin through collaborative partnerships among physicians, hospitals, and other health care providers, along with consumers, purchasers, the academic community and government.

### **Goals and Objectives**

Many of the groups have published formal goals, although the format and style of these statements often vary. Common goals include:

- sharing information and resources through collaboration;
- leadership development;
- creation of a “non-punitive” culture to encourage incident reporting;
- education and advocacy to inform professionals, policy makers, and the public about error prevention strategies; and
- avoiding duplication of efforts among the many organizations concerned with patient safety .

***Goals and objectives are critical to demonstrating that the coalition is engaged in activities that make a real impact on patient safety.***

Table 4 describes the goals and objectives of the seven coalitions.

**Table 4 Goals and objectives**

<b>Arkansas</b>	<ul style="list-style-type: none"> <li>• Facilitate local implementation of interventions designed to enhance patient safety</li> <li>• Foster and support an environment in which critical patient safety issues can be discussed in an educational, non-punitive framework that encourages the sharing of information and solutions</li> <li>• Conduct and support interdisciplinary educational forums</li> <li>• Collaborate and establish partnerships to organize and provide assistance with local patient safety initiatives</li> <li>• Identify and share best practices or process improvements that could be implemented with the potential to enhance patient safety</li> <li>• Report events, near misses, or observed hazards voluntarily with the purpose of identifying lessons learned or interventions that have the potential to result in enhanced patient safety</li> <li>• Facilitate event reporting, as deemed appropriate by the affected clinical site, to the FDA, ISMP, and other patient safety organizations</li> <li>• Report information to and receive information from national initiatives regarding potential patient safety hazards</li> </ul>
<b>Georgia</b>	<ul style="list-style-type: none"> <li>• Strengthen ties and intensify collaborative efforts based on mutually agreed upon guiding principles among organizations with common values</li> <li>• Advocate and assist in providing leadership for the ongoing improvement in the safety and delivery of health services demonstrated through measurements of access, patients' perception of care, and best practices</li> <li>• Provide a forum to discuss and advocate for data-driven public policy to create an environment conducive to the development and operation of integrated health systems that would promote the use of clinical best practice guidelines, where appropriate, and provide improved health, coordinated care, and expand health care coverage and access to these health care services</li> <li>• To encourage creation of a culture of safety</li> </ul>
<b>Massachusetts</b>	<ul style="list-style-type: none"> <li>• To establish a mechanism to identify and implement best practices to minimize medical errors</li> <li>• To disseminate knowledge and information about the causes of sentinel events and develop strategies for prevention</li> <li>• To increase awareness of error prevention strategies through public and professional education</li> <li>• To identify areas of mutual interest and minimize duplication of regulatory and JCAHO requirements so that efforts are focused on initiatives that can best improve patient care</li> <li>• To encourage creation of a culture of safety</li> </ul>
<b>Minnesota</b>	<ul style="list-style-type: none"> <li>• Improve patient safety</li> <li>• Improve the culture of patient safety</li> <li>• Mobilize community resources for patient safety</li> <li>• Develop and implement educational processes for patient safety</li> </ul>
<b>Pennsylvania</b>	<ul style="list-style-type: none"> <li>• To foster the sharing of knowledge and information about optimal patient safety practices and models</li> <li>• To identify causes of errors and influence systems changes to prevent recurrences</li> <li>• To encourage creation of a culture of safety</li> <li>• To convene stakeholders for ongoing dialogue in support of patient safety improvements</li> </ul>
<b>Virginia</b>	<ul style="list-style-type: none"> <li>• Collaborative efforts between consumers and other purchasers, providers, health plans, regulators, accrediting bodies, and others</li> <li>• The dissemination and implementation of best practices</li> <li>• Education and training guided by appropriate data collection and analysis</li> <li>• Support of confidential, non-punitive safety reporting systems that are not duplicative</li> </ul>
<b>Wisconsin</b>	<ul style="list-style-type: none"> <li>• Create and foster implementation of specific patient safety recommendations</li> <li>• Facilitate partnerships between health care organizations, purchasers, and consumers to continue to enhance quality healthcare and improve patient safety</li> <li>• Develop recommendations for long-term changes in health systems that constantly monitor and, when needed, make changes that improve healthcare services and enhance safe patient care</li> <li>• Strengthen public and professional awareness of safety and best practice issues and their ethical aspects</li> <li>• Serve as an advocate in healthcare to help shape public policy</li> </ul>

Research and interviews with coalition managers indicate that successful groups often consider the following issues when formulating goals for their organizations:<sup>44</sup>

- Why are we doing this?
- What are the pros and cons for collaboration?
- What do we think the public expects from this group?
- Are these goals congruent with our individual organization's goals?
- Are they realistic in light of resources?

Each stakeholder organization has its own goals or agenda with respect to the coalition and must determine if there are sufficient membership benefits to offset having to subrogate its goals to the public good on some issues.<sup>45</sup> Examples of benefits to stakeholders include:

- achieving more as a member of the group than as a single organization;
- building consensus around issues of common interest, to avoid duplication or conflicting efforts;
- accessing an expanded range of resources;
- accessing information about what other organizations and/or the state is planning to do to address patient safety issues (this may be a defensive strategy for some members);
- achieving economies of scale for addressing common issues, e.g., education/training material production, educational program development and delivery;
- gaining prestige or good will by being perceived as being part of the solution; and
- alleviating fear of being left out.

***During the period that goals and objectives are being considered, controversial “off the table” issues may be identified and eliminated, leaving those issues that can be effectively managed through a collaborative process.***

Coalition goals are often determined by a small group of senior executives from the “founding” organizations, although the broader membership is usually given an opportunity to provide feedback on proposed goals to ensure they are acceptable to all stakeholders. The general membership normally reviews and adopts goals, defines objectives, and identifies activities to implement patient safety initiatives, including consensus panels, task forces, and standing committees.

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<sup>44</sup> Gloria J. Bazzoli, et al., “Public-Private Collaboration in Health and Human Service Delivery: Evidence from Community Partnerships,” *Milbank Quarterly* 75, no. 4(1997):536-7; Shannon M. Mitchell and Stephen M. Shortell, “The Governance and Management of Effective Community Health Partnerships: A Typology for Research, Policy, and Practice,” *Milbank Quarterly* 78 (2000):248-50.

<sup>45</sup> Ibid.

## Membership Heterogeneity

Membership heterogeneity refers to balancing a group's membership size and composition to ensure that it can accomplish its goals.<sup>46</sup> "Too much [membership] diversity, or broad involvement, as well as too little, can lead to discord and lack of outcome."<sup>47</sup> State patient safety coalitions struggle with the right balance of stakeholders in their organizations, the right role for these members, and how to integrate the larger community into coalition activities without losing the *esprit de corps* that develops among regularly attending members. Given the complexity of the health care delivery system, the coalition must be sure that it has members who can provide or access a broad range of skills and resources. At the same time, it must include groups that are compatible and are willing to work together to achieve common patient safety goals.

***Coalitions must balance their desire for broad inclusion against the need for efficient and timely decision-making.***<sup>48</sup>

An early and primary consideration for many coalitions is who should be a member of the executive council or steering group. Most of the coalitions described in this report have a similar governance structure, one that includes a small group of senior leaders or founders who form an executive committee to:

- set broad policy,
- determine membership,
- identify measures of accountability,
- anticipate conflicts and political issues,
- secure resources,
- select participants likely to work well together, and
- maintain the organization's strategic focus.

Typically, the executive committee is comprised of representatives from the hospital association, the medical society, the pharmacy association, a purchaser/insurer, and state government, at a minimum. Several states also include consumer and nursing associations in the executive group.

***In the most inclusive organizations, the full membership represents governmental and private organizations spanning all settings of care, including rural providers.***

Several coalitions have recognized the extent of risks for patients in long-term care and are expanding their membership to reach these patients and providers. Criteria for membership vary, but most coalitions try to be inclusive rather than exclusive. One coalition cautioned against giving a disproportionate "voice" to providers. The group noted that providers may may

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<sup>46</sup> Shannon M. Mitchell and Stephen M. Shortell, "The Governance and Management of Effective Community Health Partnerships: A Typology for Research, Policy, and Practice," *Milbank Quarterly* 78 (2000):262.

<sup>47</sup> *Ibid.*, 251.

<sup>48</sup> Gloria J. Bazzoli, et al., "Public-Private Collaboration in Health and Human Service Delivery: Evidence from Community Partnerships," *Milbank Quarterly* 75, no. 4(1997):556.

dominate meetings until consumers and state agency members speak up, bringing more balance into the discussions.

***Most of the coalitions described in this report are comprised of representatives from 30 to 50 different stakeholder groups, with membership policies evolving as the group expands beyond the founding stage.***

Coalitions may choose not to invite certain groups to join, believing that their involvement in the coalition could inhibit open discussion and learning from adverse events. In making this decision, coalitions must recognize the consequences of leaving certain groups out and the criticism they may face for doing so. Some argue that excluding certain groups makes it difficult for a coalition to maintain its image as a group designed to bring together all stakeholders to address a common problem. In fact, exclusive membership may present an image to the public of a coalition more concerned with protecting turf and guarding the status quo than with bringing about real change. At the same time, excluded groups may continue to address the issue independently in ways that may hinder the coalition's work.

Nonetheless, coalitions mentioned trial lawyers, consumer activists, hostile reporters, purchasers, and commercial vendors as sometimes having goals incompatible with their goals. However, several of the coalitions have one or more of these groups represented. In these instances, coalition leaders were able to identify representatives who could work comfortably with other coalition members. When they are included, these groups may not participate on committees dealing with peer reviewed data; however, they are otherwise full members of the coalition. At least one coalition reached an agreement with local media that the media would not attend meetings if the minutes were made available to the public. This arrangement has worked satisfactorily, relieving members of the fear that they will be misquoted or quoted out of context by the press but still making important information available to the press and the public.

***Several coalitions commented on the value of, and the challenges associated with, having consumers in their coalitions.***

Consumers need to be part of coalitions' public education efforts. They provide valuable feedback to other coalition members who may not be sensitive to the consumer perspective on safety. However, consumers vary in their level of knowledge about the healthcare delivery system. Some may be frustrated when change moves slowly in hospitals and clinics, largely because they may not be familiar with the complexity of these environments. In one coalition, providers became impatient with consumers because they thought the consumers were asking too many questions and did not appreciate the providers' points of view.

Consumers, like all other members, bring their own unique perspectives and levers for change. Consumers are often willing to raise important issues and bring balance into discussions that can become too focused on provider concerns. Their participation may focus greater attention on the coalition's progress in improving patient safety. Coalitions, anxious to keep conflict at a workable level avoid bringing in consumers with strong personal bias against providers. A few have included representatives from AARP as consumer representatives.

Participation in a coalition can take several different forms. Mitchell and Shortell describe three general types of members or partners.<sup>49</sup> All three of these types are present in the coalitions profiled here. First, there is the full working partner, who commits time, resources, and leadership skills to the organization. Some coalitions refer to these partners as founding members or core partners. They often form the governing body of the coalitions. Second is the participating partner or member who commits time and joins in making decisions but does not make a heavy commitment of resources. Third is the informing partner or member who is not actively involved in making decisions but supports the partnership’s activities. These members may receive the coalition’s newsletter but do not routinely attend meetings. Minnesota’s Alliance for Patient Safety (MAPS) invites these members to get involved in committees and task forces, drawing in those with diverse skills and talents and building support for MAPS’ work.

Lastly, coalitions need to be aware of state laws that become applicable when representatives of government agencies participate in coalitions. Often known as sunshine acts or freedom of access laws, these state laws generally require that documents and records in the possession of government agencies and meetings of government officials must be made available to the public unless otherwise protected. Depending on state statute, even if a coalition excludes certain groups or individuals from membership, it may not be able to exclude them from attendance or from accessing meeting minutes if government agencies are involved. One option for coalitions dealing with this issue is to create separate committees with no government participation in order to keep confidential patient data protected from disclosure.

Table 5 illustrates the types of member organizations in the seven profiled coalitions.

**Table 5 Membership**

<b>Membership Category</b>	<b>AR</b>	<b>GA</b>	<b>MA</b>	<b>MN</b>	<b>PA</b>	<b>VA</b>	<b>WI</b>
Professional associations	X	X	X	X	X	X	X
Professional boards or licensing agencies	X	X	X	X		X	X
State public health agencies	X	X	X	X	X	X	X
Legislative representatives		X	X				X
Multi-hospital systems &/or large medical groups		X	X	X	X	X	X
Consumer representation		X	X		X	X	X
State purchasers	X	X	X	X		X	X
Private employers or purchasers		X	X	X			X
Health plans and/or health insurance carriers		X	X	X	X	X	X
Malpractice insurers			X	X	X		X
Quality improvement/peer review organizations	X		X	X		X	X
Health professions educational institutions		X	X	X	X	X	X
National patient safety organizations/accreditors			X	X			X
Labor unions							X

<sup>49</sup> Shannon M. Mitchell and Stephen M. Shortell, “The Governance and Management of Effective Community Health Partnerships: A Typology for Research, Policy, and Practice,” *Milbank Quarterly* 78 (2000):266-67.

## Diversification of Resources

Coalitions, if they become over-reliant on external funding, have found themselves diverted from their original goals in order to pursue the objectives of the funding agency or foundation. According to Mitchell and Shortell, this is a common problem for community health partnerships.<sup>50</sup>

***Coalition directors report that acquiring an independent source of funding is a high priority because grants or significant contributions from one or two members often come with strings attached that can influence the coalition's agenda.***

Some coalitions charge their member organizations some type of annual dues, ranging from \$500 to \$2,500.

Most groups are established using seed money and in-kind support from the founding organizations. In-kind support typically takes the form of staffing for educational events, design and maintenance of a Web site, the provision of office space and utilities, information systems support, and data collection/analysis/reporting activities. Most coalitions have used part-time staff from member organizations or consultants to provide support until the organization reaches sufficient size and complexity to require full-time direction. That progress often takes about three years and for a typical coalition, involves hiring a full-time director, plus 0.5 to 3.0 FTE support staff. A state agency, the hospital association, or the medical society sometimes fund staff positions or provides paid staff to coalitions.

A number of groups are incorporating or have incorporated as not-for-profit organizations (in Colorado, Massachusetts, Virginia, and Wisconsin) to improve their ability to attract funding. Some are exploring the use of unrestricted pharmaceutical company support. Pharmaceutical companies have a long history of supporting professional educational endeavors. Patient safety, because it is not specific to a particular product line, can be funded through unrestricted grants. Coalitions have received pharmaceutical support funds directly, or via a stakeholder, who secures the grant for them. Coalitions that have considered pharmaceutical funds have expressed some concern about being perceived as being influenced by their funders.

The Massachusetts Coalition for Prevention of Medical Errors recently adopted a policy about accepting donations from commercial interests, to facilitate the ethical use of these monies to support their efforts. The policy was adapted from the Standards for Commercial Support established by the Accreditation Council for Continuing Medical Education.<sup>51</sup>

<sup>50</sup> Shannon M. Mitchell and Stephen M. Shortell, "The Governance and Management of Effective Community Health Partnerships: A Typology for Research, Policy, and Practice," *Milbank Quarterly* 78 (2000):262.

<sup>51</sup> [Accme's Essential Areas and their Elements](#)

Several coalitions are involved in or are considering applying for research grants. They view research funds as temporary resources. Stakeholders are often liaisons to funding agencies and may have grant writers on their staff who can help coalitions get support for their activities.

## Coordination and Communication

Coordination refers to the types of internal formal and informal communications and accountability mechanisms used to assure that the business of the group is accomplished as planned.<sup>52</sup> It encompasses both the social interactions between staff and stakeholders and the mechanisms used to encourage stakeholders to put their time and resources into the organization. It ranges from informal communications and verbal commitments when members agree on their roles and tasks to a more formal contractual format, depending on the problems being addressed. Research indicates that "... more informal, informational coordination may be called for when partners have less experience working together and are working on more complex goals and problems."<sup>53</sup> This seems especially true during the start-up phase of the patient safety coalitions, when many stakeholders do not know one another well and may be reluctant to contact each other, but will talk with coalition staff.

Several coalitions—including Georgia’s Partnership for Health and Accountability, the Massachusetts Coalition for the Prevention of Medical Errors, and Minnesota’s Alliance for Patient Safety—report that early and frequent communication is often critical to preventing misunderstandings and keeping the coalition’s work progressing.

## Demands for Accountability

Coalition members’ sense of professional accountability often drives coalition goals and objectives. Community and government agencies feel particularly responsible for quality of care issues, and coalitions provide them with an opportunity to “be part of the solution” for patient safety. As organizations, coalitions must demonstrate to their members and to the external world that they are meeting their goals, are effective, and are efficient. Stakeholders want to see results and enjoy the benefits of the collaborative. Mitchell and Shortell observe, “Providing measurable results that are easily recognizable and accepted by a wide variety of stakeholders is critical to the long-run sustainability of community health partnerships.”<sup>54</sup>

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<sup>52</sup> Shannon M. Mitchell and Stephen M. Shortell, “The Governance and Management of Effective Community Health Partnerships: A Typology for Research, Policy, and Practice,” *Milbank Quarterly* 78 (2000):262.

<sup>53</sup> *Ibid.*, 268.

<sup>54</sup> *Ibid.*, 263.

**Several coalitions that report achieving some early positive results or “quick wins,” describe them as important for keeping members’ interest and commitment.**

Examples include:

- Design and delivery of patient safety conferences, alone or in conjunction with the National Patient Safety Foundation or the Agency for Healthcare Research and Quality.
- Development and dissemination of a variety of self-assessment tools to build baseline measures and/or develop support for focused improvement projects.<sup>55</sup>
- Design and production of educational materials, e.g., Pennsylvania Patient Safety Collaborative’s *The Elements of a Culture of Safety* (Appendix C) and *Your Role in Safe Medication Use: A Guide for Patients and Families* by the Massachusetts Coalition for the Prevention of Medical Errors (Appendix D).<sup>56</sup>
- Clinical outcomes improvement efforts, among them improving the use of preoperative antibiotics (Arkansas), reducing wrong side/site surgeries (Florida, Massachusetts, Minnesota), improving patient outcomes from open heart surgery (Michigan) and reducing medication errors (all).
- Arkansas, Georgia, Minnesota (Appendix E), Virginia, and Wisconsin developed value and operating principles early in their start-up period; they all report that this process helped to build commitment among stakeholders.

External groups, especially those willing to consult with coalitions and/or to defer patient safety policy issues to them, often want to see evidence of meaningful patient safety improvements achieved by the group.

Georgia’s Partnership for Health and Accountability (PHA) is publishing *Insight 2002*,<sup>57</sup> a consumer guide that describes individual hospital performance on several quality measures, as well as the patient safety activities underway in each hospital.

Several coalitions are actively involved in focused clinical improvement and/or error reduction projects and keep stakeholders informed about their progress. The scope and depth of activities varies among coalitions; some are more clinically focused, while others do more coordinating or educational activities (See the *Activities* section of this report for a discussion of the types of activities undertaken by coalitions). Determining the impact of a coalition depends upon how it has defined its goals and objectives and what resources are available to evaluate its activities.

<sup>55</sup> Institute for Safe Medication Practices, “[Medication Safety Self-Assessment](#)”. The American Hospital Association’s “Strategies for Leadership: [Hospital Executives and Their Role in Patient Safety](#)”(2001) and the American Hospital Association /Voluntary Hospital Associations’ “[Strategies for Leadership: An Organizational Approach to Patient Safety](#)” (2000).

<sup>56</sup> Pennsylvania’s [Elements of a Culture of Safety](#);

Massachusetts’ [Your Role in Safe Medication Use: A Guide for Patients and Families](#).

<sup>57</sup> [A Partnership for Health and Accountability](#).

When queried about using data to demonstrate improvement, coalition leaders identified the following potential measures:

- results from surveys of members and other stakeholders to determine if the coalition is meeting its goals and objectives;
- evaluation of the extent that “best practices” are being adopted in the state;
- tracking and trending results of successive self-assessments over time, e.g., medication safety practices;
- number of applications for quality and safety awards;
- number of healthcare organizations involved in statewide safety initiatives;
- number of clinical improvement studies undertaken, level of participation, and results, e.g., reducing perioperative wound infections;
- attendance at educational events, pre-test/post-test results;
- number of requests for materials, Web site visits;
- research activities and the results; and
- ability to attract and retain members.

Many coalitions have developed public Web sites describing the coalition, its membership, activities, project results, and resources and links to other sources of patient safety information. See Appendix A, Patient Safety Organizations, for exact Web site locations.

Coalitions are only one of many approaches to improving patient safety in a state, and it is very difficult to assess their impact on such broad patient safety measures as, for example, the number of reported wrong site surgeries performed each year. Aside from measurement issues, it is very likely that, for high profile errors, a number of entities (federal agencies, specialty organizations, professional associations, insurance companies, and similar groups) may be implementing simultaneous improvement efforts. Coalitions hold themselves accountable for meeting their goals and objectives but are only one part of the patient safety improvement universe. (See Figure 1.)

## MAKING IT HAPPEN: STARTING A PATIENT SAFETY COALITION

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### Start Up

In some states, the legislature, the governor, or the commissioner for health has mandated that a public/private patient safety group be formed; others are voluntary efforts jointly sponsored by the founding partner organizations, often the state health department, hospital association, and/or the medical society. The legal status of each group varies; some have incorporated as independent, not-for-profit organizations, while a number are under the umbrella of the state hospital or medical association structure.

***Coalitions often start after a shared educational experience that firmly establishes the importance of the issue.***

Both the National Patient Safety Foundation and the Agency for Healthcare Research and Quality have convened state or regional patient safety meetings credited with raising stakeholders' awareness about patient safety (Arkansas, Pennsylvania, Minnesota, Massachusetts). Several coalitions use annual patient safety educational meetings to build support and encourage stakeholder and community networking within the state. Membership education is a continuing process. It begins during the start-up process, as the group develops a common vocabulary and understanding about patient safety issues, including education about how, why, and where errors occur; key patient safety terminology such as adverse events, medical errors, and culture of safety; and use of acronyms. It continues as new members are added and require orientation to these same issues.

Coalitions describe the full range of start-up experiences. One group evolved from a series of friendly monthly gatherings of healthcare professionals interested in patient safety. That group is now in the process of incorporating as a not-for-profit corporation. Several coalitions noted that it helps to have a well-respected leader who can attract groups to the table, especially if such an individual can articulate a clear vision of the benefits of collaboration.

A former president of the American Hospital Association was active in the formation of Minnesota's coalition. Several nationally known researchers and executives participated in starting Massachusetts' Coalition. An officer of Virginia's coalition was also a member of the American Hospital Association's team that developed a national medication safety initiative for hospitals.

Many of those interviewed for this report noted the importance of having the "movers and shakers" of various partner organizations serving as representatives to the coalition. It is especially helpful if coalition representatives simultaneously hold office or are very active in their state and/or national professional organizations (Arkansas, Georgia, Massachusetts, Minnesota, Virginia).

Several coalitions describe varying degrees of discomfort among stakeholders, particularly during the earliest meetings. As one study has noted, public/private partnerships evolve incrementally, and getting to the table is only the first step.<sup>58</sup> Once trust forms, the group can focus on longer-term strategic and operational issues. According to Bazzoli and her colleagues, stakeholders typically consider the following questions as they assess the fit between their own organizations' goals and the goals of the coalition.<sup>59</sup>

- Is there a need for this group?
- Is there sufficient will to carry out its work?
- Will sharing resources benefit my organization?
- Are there political benefits to participation?

Coalitions emphasize the need for frequent face-to-face meetings of a core group of public and private stakeholders, often for a year or more before the group is expanded. Sometimes a facilitator can be helpful in turning conflict into constructive dialogue, as stakeholders deal with the sensitive issues surrounding error disclosure and prevention. This is a very vulnerable period for coalitions, and at least two of mentioned in this report changed course or stopped meeting because of incompatible personalities and/or entrenched and conflicting goals within the stakeholder group. Finding the group's common goal and framing it early can be very helpful.

Massachusetts found that the shared goal of making the healthcare system as safe as possible for patients, family members, friends, and staff was the "glue" that held the group together, despite differing and sometimes adversarial views of members.<sup>60</sup>

Arkansas, Georgia, Minnesota, Virginia, and Wisconsin found it helpful to develop a set of core guiding principles or value statements early in the development of the group. These principles describe a variety of ideas, including the values of the group, how it would manage sensitive issues, leadership responsibilities, operating guidelines, and stakeholder accountabilities. Once articulated, the principles established the foundation for stakeholder commitment. Minnesota's Alliance for Patient Safety's principles are included in its strategic plan (see Appendix B or the [coalition's website](#)). Another example can be found on the Virginians Improving Patient Care and Safety's Web site: <http://www.vipcs.org/>.

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<sup>58</sup> Gloria J. Bazzoli, et al., "Public-Private Collaboration in Health and Human Service Delivery: Evidence from Community Partnerships," *Milbank Quarterly* 75, no. 4(1997):557.

<sup>59</sup> *Ibid.*, 536-538.

<sup>60</sup> Leslie Kirle, et al. "The Massachusetts Coalition for the Prevention of Medical Errors," (Annenberg Conference on Enhancing Patient Safety and Reducing Errors in Health Care, Rancho Mirage, 1998).

## Management

At a certain point in their development, coalitions hire a full-time manager, often called the executive director, who is essential for executing and implementing the coalition's objectives. The responsibilities of these managers include:

- keeping members' interest;
- managing conflict;
- providing structure and coordination—a very important function of this role;
- implementing information systems;
- measuring and reporting on performance, and
- identifying opportunities for collaboration for stakeholders with similar goals.<sup>61</sup>

Most coalitions are too new to report on the performance of their executive directors; however, research suggests that they are the institutional glue that keeps stakeholders and leadership informed and attuned to internal and external issues likely to have a material effect on coalition goals and objectives.

## Activities

Most coalition activities have focused on acute care populations, but some groups have adopted programs that cross two or more settings, for example, medication error reduction, clinical guidelines, falls prevention, or improving population based public health outcomes.

***Coalitions' scope of activities tends to expand with time, as their membership and funding stabilize.***

In some cases, a coalition will serve as a forum for discussion and consensus building around an issue, but the activity itself will take place through the direct action(s) of individual stakeholders. Examples include: creating a voluntary reporting system within the state hospital association or lobbying for expanded peer review protections to permit organizations to share information about adverse events with their peers.

## Coordination and Communication

Coalitions engage in a number of activities to facilitate communication among members and with the public at large to encourage sharing of patient safety information. These include:

- Providing a forum for public and private stakeholders to share improvement ideas and constructive dialogue about preventing adverse events;

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<sup>61</sup> Shannon M. Mitchell and Stephen M. Shortell, "The Governance and Management of Effective Community Health Partnerships: A Typology for Research, Policy, and Practice," *Milbank Quarterly* 78 (2000):254-255.

- Providing a forum for discussions about voluntary reporting systems and/or improving existing mandatory reporting systems;
- Providing a forum for discussions about strengthening peer review statutes to permit sharing of error information between health care entities;
- Encouraging coordinated action between member organizations to reduce conflicting, redundant, competing, and/or overlapping patient safety services, programs, or regulations;
- Acting as a clearinghouse or central contact point for information about patient safety activities within the state;
- Adopting policies to strengthen the public's trust and confidence in the health care delivery system, e.g., hosting public forums on safety issues, promoting provider accountability, publishing minutes on the Internet, having inclusive membership policies;
- Communicating important state and national policy issues to members; and
- Developing Web sites and content: self-assessment tools, educational materials, patient safety surveys, links to other resources, program descriptions, patient safety bibliographies.

## Education

Coalitions develop educational programs and materials for a wide audience in order to share information about patient safety. These include:

- Educating providers, professionals, leaders, and consumers about patient safety through conferences, regional forums, and written materials;
- Creating training materials about specific types of errors, e.g., medications, falls, wrong site surgeries;
- Developing materials for health care leaders, e.g., Pennsylvania's monograph, *Elements of Cultural Change*, Minnesota's *A Call to Action: Roles and Responsibilities for Assuring Patient Safety* and its brochure about creating a culture of safety, *Redefining the Culture for Patient Safety* (Appendices B-E); and
- Developing guidelines and training materials about communicating errors to patients and families.

## Promoting Best Practices and Clinical Excellence

Coalitions create and distribute a variety of tools to promote best practices and clinical excellence. They include:

- Identifying, evaluating, and promoting patient safety best practices;
- Promoting creation of a culture of safety to encourage learning from adverse events and near misses;
- Creating and/or disseminating self-assessment tools for medication errors, leadership practices, or safety culture and encouraging member organizations to use the tools and, in some cases, collecting and reporting results of these initiatives;
- Implementing statewide programs to assess and reduce specific types of adverse events, for example, surgical wound infections;
- Promoting adoption of clinical practice guidelines; and

- Developing or sponsoring important patient safety research projects.

## Lessons Learned by the Coalitions

These comments reflect common themes or particular perspectives that coalition leaders or staff wanted to share with peers interested in creating a coalition. Some advice may seem contradictory because these coalitions arose out of different contexts, hence the different approaches.

### Membership

- Get early senior leadership buy-in and support from provider, professional, and regulatory organizations. Don't create "hard feelings" by bringing them in late (AR, GA, MA, MN, VA, WI).
- Seek a legislative representative who believes in the importance of patient safety in health care who will follow that belief with legislative action and commit funds to such initiatives (GA, WI). Educate legislators early on about the coalition and its efforts (MN).
- Consider including consumers or consumer organizations early in the process, to get their input and feedback. It is helpful to articulate up-front that consumers have roles and responsibilities for preventing accidents, too (MN, PA).<sup>62</sup>
- Commit to include all the players, including providers, payors and consumers (WI, PA).

### Building Trust

- Strike a balance between the desire for quick solutions and broad based "buy-in" from all parties. Find ways to build consensus (AR, GA, MA, WI).
- Don't get "stuck" on a particularly controversial issue, e.g., mandated reporting. Agree to respectfully disagree on some issues (ALL).
- Don't let individual organizations' agendas dominate the process (ALL).
- Establish a system that enlists input from clinicians to build support for any practices and/or system changes that are recommended (ALL).
- Focus on framing the issues and understanding the perspectives of the different stakeholders; doing so builds trust and helps to identify opportunities for collaboration (MA, MN, WI).
- Acknowledge the tension that exists between the providers and the agencies that regulate them (AR, FL, GA, PA, VA).

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<sup>62</sup> The "Speak Up" program, sponsored by the Joint Commission on Accreditation of Healthcare Organizations, urges patients to get involved in their care. A ["Speak Up" brochure](#) that provides specific guidance to patients to help them make their care safe can be downloaded at [www.jcaho.org](http://www.jcaho.org).

## Communication

- Consider when and how to engage the media. Some groups have held special briefings for media staff, to educate them about patient safety and the work of their coalitions (GA, MA, MN). Often, member organizations have skilled press relations staff who can engage local press about the work of the coalition and facilitate communication (CO, MA, VA).
- Promote frequent communication between key parties to build trust and credibility (ALL).
- During start-up period, create an environment that permits frank and open dialogue between stakeholders, even if it means keeping the group small (AR, GA, MA, MN).
- Communicate/share. There should be no turf wars. The coalition should not discourage or replace small or regional collaboratives (AR, WI).
- Determine early on how best to communicate among the group (i.e., faxes, e-mails, mailing of minutes). E-mails are fast and they can lead to further communication among individual members (MN, PA).

## Activities

- Don't reinvent the wheel. Recognize the wealth of experience and knowledge that resides within and outside your state (AR, GA, MA, MN, WI).
- Prioritize. Because of the complexity of the issue and the different levels of preparedness among providers of care, identify common areas of interest and focus on the basics first (WI, PA).
- Use evidence-based, national standards to guide clinical improvements (AR, GA, MA, MI).
- Don't be afraid to learn from single sentinel events; you don't need lots of data to justify your priorities. You can use JCAHO sentinel event alerts to guide your efforts, too (AR).
- When you meet, have a clear agenda and adhere to it. Discussions can get side-tracked; try to keep the focus on what the group has identified as priorities. Identify a work product i.e., after a year of meetings, what will the group have to show for its efforts? These efforts can consume significant amounts of time, so it is important to have objective outcomes, especially so that participating organizations will continue to invest in the process (GA, PA).

## CONCLUSION

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Responsibility for patient safety is fragmented across a variety of public and private interests. At present, health care professionals, consumer advocates, purchasers, educators, and policy makers are independently taking action to improve patient safety, using the tools that are available to them. However, there are few examples of concerted, deliberate, and public-spirited integration of these forces at the state and national levels.

State patient safety coalitions are, in part, a response by stakeholders to the fragmentation and ambiguity very much in evidence since the publication of *To Err is Human*. The number of patient safety coalitions is growing; twelve statewide public/private patient safety coalitions have emerged over the past three years. Stakeholders voluntarily commit resources, time, and skills to develop and support coalitions, in part because they believe that more can be accomplished through a coalition than through their individual efforts. These organizations bring together a unique blend of stakeholders, including groups that are normally competitors or perhaps even adversaries on some issues. They are drawn together in pursuit of a common goal: preventing the large number of errors and adverse events that harm patients every year.

### Coalition challenges

Since coalitions cannot be all things to all people, they must focus their efforts on the goals that voluntary organizations do well: coordination, education, and specific improvement projects that meet their members' needs and interests and have real potential to improve patient safety. Anxious to avoid destructive internal conflicts, they often choose not to advocate for controversial policy changes or issues. However, they may play a very critical role in shaping future public policy. Educational policy, for example, could be influenced by patient safety coalitions. Institutions of higher education are not often included in patient safety coalitions, yet they play a critical role in training future healthcare professionals. Their involvement could affect curriculum development that will better prepare graduates for new performance expectations and skill sets, e.g., knowing how to use root cause analysis and understanding the culture of safety.

Coalitions are important forums for stakeholders to share new ideas about error prevention, especially as relationships mature and members feel more comfortable with each other. They offer all parties the chance to test ideas, to learn if there are unanticipated or harmful consequences of actions or policies they are considering, an important benefit, given the lack of well-tested error management models in health care.

A critical element in the success of a coalition is identifying the right blend of stakeholders who bring the talents and resources necessary to achieve coalition goals. Winning the support of key public and private stakeholders is essential, often including the hospital association, the medical society, the pharmacy association, the nursing association, purchasers/insurers, state government, and consumer participation. Assembling a core group of stakeholders may take many meetings to build the trust and relationships necessary for members to work together effectively.

State agency involvement may be a sensitive issue in some states, depending on the political environment and relationship between state government and providers. State agencies have at least three options to consider when coalitions are forming:

- maintain a professional distance and let the healthcare community lead the effort;
- provide leadership and take the initiative to get the coalition started; or
- take a role as an active and equal partner in the group.

Some coalition stakeholders may be reluctant to include representatives from state regulatory agencies in their organizations. Both regulators and coalition stakeholders need to consider the cost of lost opportunities when they accept this situation. Several coalitions have been able to successfully integrate regulators into their groups and report benefits of having them participate. Developing strong leadership and resources may also present a challenge.

## Evaluating success

The IOM's National Roundtable on Health Care Quality<sup>63</sup> identified four forces with the potential to improve quality and safety:

- continuous quality improvement,
- regulation,
- marketplace competition, and
- payment incentives.

The Roundtable reported that, individually, none of these forces was sufficient to remedy the nation's quality problems. While clearly aware of the strengths and weaknesses of each approach, the authors observed that "regulation is the only mechanism we have to protect the public from egregiously poor performers."<sup>64</sup> They charged the health care professions, consumer advocates, purchasers, and policy makers with the responsibility to make health care "not only technologically dazzling but also compassionate, reliable, appropriate to a patient's needs, and safe," and at the same time, "...avoiding unneeded and harmful interventions."<sup>65</sup>

Patient safety coalitions may have the potential, with time and effective leadership, to integrate, temper, and focus their stakeholders' efforts to produce the kind of results the Roundtable envisioned. Coalitions, especially as they mature and stakeholder relationships strengthen, are in a position to support the dialogue necessary to create new public/private paradigms for preventing harm. Ideally, they will be able to integrate the best elements of professional, consumer, purchaser, and institutional accountability with the most effective state regulatory mechanisms, i.e., the "best of all worlds."

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<sup>63</sup> Mark R. Chassin and Robert W. Galvin, "Institute of Medicine National Roundtable Consensus Statement: The Urgent Need to Improve Health Care Quality," *JAMA* 280(1998):1000-1005.

<sup>64</sup> *Ibid.*, 1003.

<sup>65</sup> *Ibid.*, 1004.

Ultimately, policy makers and the public will judge coalitions by tangible evidence that they are improving patient safety. At present, statewide patient safety coalitions are young as organizations go, and many are still in the start-up phase. As a result, it is difficult to evaluate their effectiveness in reducing errors or improving safety. State patient safety coalitions are just one contributor to the solution among many, but they can be very important voices if they are seen as credible, public spirited, and effective. Ongoing evaluation of their effectiveness and of lessons learned will assist coalitions as they emerge, evolve, and mature.

## **LIST OF APPENDICES**

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- Appendix A [Patient Safety Organizations and Contacts](#)
- Appendix B [Strategic Direction for MAPS: Minnesota](#)
- Appendix C [Elements of a Culture of Safety: Pennsylvania](#)
- Appendix D [Your Role in Safe Medication Use, A Guide for Patients and Families: Massachusetts](#)
- Appendix E [A Call to Action: Roles and Responsibilities for Assuring Patient Safety: Minnesota](#)
- Appendix F [Suggested Practices for Preventing and Reducing Medication Errors: California](#)
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