AN ABBREVIATED HISTORY OF EFFORTS TO CREATE NPSB-LIKE GROUPS

There have been many calls or attempts to establish a federal group focused solely on patient safety to conduct research, recommend solutions, and disseminate best practices. **It's time now for a National Patient Safety Board.**

1985 — The **Anesthesia Patient Safety Foundation** (APSF) called for in-depth, interdisciplinary analyses of single cases of medical harm. Anesthesia remains one of the leading medical specialties advancing patient safety.

1991 — The **Harvard Medical Practice Study** called for a national research agenda for safety that would be interdisciplinary. It was also at the cusp of measuring the extent of harm by focusing on incidence and suggesting the preventability of medical harms.

1997 — **National Patient Safety Foundation** (NPSF) called for enhanced knowledge and national dissemination of interdisciplinary safety discoveries. *NPSF was intended as highly independent and modeled directly on the APSF. It merged with the Institute for Healthcare Improvement in 2017.*

1998 — The Clinton Administration founded the **Quality Interagency Coordinating Task Force** (QuIC) to coordinate federal agencies' work that advances patient safety. *A 2000 QuIC report stressed the urgency of federal action on patient safety.*

1999 — The VA established the **VA National Center for Patient Safety** to reduce inadvertent harm to patients using a systems approach incorporating human factors engineering, root cause analysis, and high-reliability organization concepts from aviation.

1999 — The **National Quality Forum** (NQF) was created by the President's Advisory Commission on Consumer Protection and Quality in the Healthcare Industry. The federal government, states, and private-sector organizations use NQF's measures to evaluate performance and share information with patients.

2000 — The Clinton Administration called for a **Center for Patient Safety** and set aside $20m for safety research. It ended up in AHRQ as the **Center for Quality Management and Improvement**, where it continues work on patient safety research, implementing best practices, and disseminating reports on measurement, reporting, and improvement starting with $50m seed funding appropriated from Congress in 2001.

2001 — The **National Patient Safety Agency** was established in the UK. The purpose was to centralize reporting, conduct research on safety events, and elevate patient safety on a national level. *In 2012, the key functions were transferred to NHS England, and in 2016, the patient safety functions were transferred to NHS Improvement.*

2005 — **Patient Safety Organizations** began to be maintained and certified by AHRQ to help improve safety within hospitals by collecting and analyzing data, maintaining a patient safety network database, and developing and disseminating recommendations regarding best practices. They ensure data confidentiality and legal protections provided by the Patient Safety Act of 2005.

2009 — A proposal circulated to create a **Commercial Aviation Safety Team** (CAST)-like entity in health care that would promote a public-private partnership to address patient safety issues at a national level. Through the CAST model, safety officials and technical experts investigate and propose solutions that can be implemented and scaled.

2009 — The **Pittsburgh Regional Health Initiative** widely advocated for creating a new federal agency to monitor sources of medical errors, identify patterns, and help systems avoid these errors.

2011 — Hardeep Singh, David Classen, and Dean Sittig called for a **national EHR oversight program** to provide dedicated surveillance of EHR-related safety hazards and promote learning from adverse events. They proposed the creation of a **centralized, nonpartisan board** to ensure the safety of EHRs. This would be modeled after the NTSB and funded by Congress.

2011 — The **IOM Report on Health IT and Patient Safety** recommended development of an independent federal entity that could perform the needed analytic and investigative functions in a transparent, nonpunitive manner, similar in structure to the NTSB. The committee believed an independent federal entity would be the best option to provide a platform to support shared learning at a national level.

2012 — Aviators and members of the IOM Patient Safety and Health IT Committee called for the establishment of an **NTSB for health care** and action for healthcare suppliers, providers, and purchasers to reinvigorate adoption of aviation best practices.

2015 — National healthcare safety experts proposed the creation of a **Federal Health Information Technology Safety Center** as an independent federal entity to investigate serious incidents and even devise a roadmap for health IT safety.