# A New Solution to Address the Problem of Medical Errors

The goal of the National Patient Safety Board (NPSB) is to prevent and reduce patient safety events in healthcare settings. As a non-punitive, collaborative, independent board, the NPSB is modeled after the National Transportation Safety Board (NTSB) and the Commercial Aviation Safety Team (CAST).[1]

The NPSB, like the NTSB and CAST, would guarantee a data-driven, non-punitive, collaborative approach to preventing and reducing patient safety events in healthcare settings. Its goal is to dramatically improve the understanding of major sources of harm and bring stakeholders together to create solutions. As such, the NPSB's primary functions are to:

- identify and anticipate significant harm;
- provide expertise to study the context and causes of harm and solutions; and
- create solutions to prevent patient safety events from occurring.

Like the NTSB and CAST, the NPSB is *not* the sole solution. The NPSB is designed to augment the work of federal agencies and long-standing patient safety organizations without displacing them. To support this role, the NPSB would also have a public-private partnership team, the *Healthcare Safety Team*, to gain consensus on patient safety measures, autonomous data collection technologies, and solutions.

To identify and anticipate major sources of harm, the NPSB would *not* require additional data submission by healthcare providers and would *not* rely on voluntary reports of patient safety events. Rather, through the *Healthcare Safety Team*, the NPSB would help public and private entities adopt patient safety data surveillance technologies—automated systems with AI algorithms—to capture Big Data and relieve the burden of data collection at the frontline, while also detecting pre-cursors to harm.

Due to the current widespread rate of patient safety events, the NPSB would first focus on understanding the pre-cursors and solutions to major sources of harm instead of conducting studies of all individual incidents. The autonomous, preventive solutions would be designed to avert harm before it occurs. The NPSB would deepen our understanding of 1) the conditions that precede significant harm; 2) how to prevent harm before it occurs; and 3) how to make this prevention function as autonomous and fail-safe as possible. The NPSB's recommendations would favor solutions, with a focus on building a better work environment to enable all providers to provide optimal, safe care.

The NPSB would *not* regulate and would *not* serve as an accreditation, licensing, or public reporting body. Its independence from these bodies would also promote the non-punitive, collaborative nature of the NPSB's functions. The NPSB would also include non-punitive protections for healthcare workers and providers. For example, information from the NPSB's study reports would not be admissible in civil proceedings.

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[1] The NTSB is an independent federal agency that investigates accidents and issues recommendations to prevent future accidents. CAST is an industry-government partnership team that proactively identifies emerging safety risks based on shared data and gains consensus on safety enhancements to voluntary implement before the event occurs.