

focus on Patient Safety

A NEWSLETTER FROM THE NATIONAL PATIENT SAFETY FOUNDATION®

How Do You Get Better When You Know You Are the Best?

BY AILEEN KILLEN, RN, PHD, DIRECTOR, PATIENT SAFETY PROGRAM, MEMORIAL SLOAN-KETTERING CANCER CENTER

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Memorial Sloan-Kettering Cancer Center (Sloan-Kettering) uses the slogan, “The best cancer care anywhere.” If that’s indeed the case, why pursue process improvement? Because the best are not satisfied with being the same today as yesterday; they are learning organizations—groups of people continually enhancing their capabilities to create what they want.

Sloan-Kettering uses various performance improvement methods, depending on the task at hand. The art of matching a project to the right methodology is a process of continuous learning for quality and safety leaders.

Can TPS improve patient care processes?

One technique available to Sloan-Kettering teams is the Toyota Production System (TPS). This process focuses on catching mistakes quickly by identifying the small steps to improvement, inspecting those steps and correcting problems at each level in rapid process change.¹

Noted TPS consultant Steven Spear, who had been working with Sloan-Kettering on an ongoing basis, led 3 teams in a 3-day program of training and testing of the process in 2006.² After the initial sessions, there was much discussion at Sloan-Kettering on the value of TPS in improving patient-care processes. The debate focused on the usefulness of TPS in improving production-related problems such as materials management or specimen labeling.

Amy Edmondson, Novartis professor of leadership and management and chair of the doctoral programs at Harvard Business School, describes a problem as “the disruption of a caregiver’s ability to execute a prescribed task because either something he or she needs was unavailable in the time, location, condition, or quantity desired, such that the task cannot be executed as planned.”³

This definition expanded the Sloan-Kettering teams’ view of which problems are amenable to TPS solutions. If a nurse cannot find a suction regulator for the bedside of a patient returning from the post-anesthesia care unit (PACU), that is

a clinical problem. If an endoscopy procedure is delayed or canceled because the correct endoscope is not delivered to the unit, that is surely a clinical problem.

Becoming a high-reliability organization

In the early days of its patient safety program, Sloan-Kettering had been successful with the idea that changing culture in a complex organization required a common goal and a simple set of rules.⁴ But could TPS help make Sloan-Kettering a high-reliability organization?

“You cannot design a perfect process—you can only discover it.”

High-reliability organizations (HROs) are those that function in high-risk environments and experience a minimal amount of failure due to their attention to failure, operations, resilience and a culture of safety. The goal of both TPS and becoming an HRO is zero defects—in the case of Sloan-Kettering, zero patient harm.⁴

Sloan-Kettering was already at a level 1 of reliability where intent, vigilance, and hard work prevail. Level-2 reliability is built on design informed by reliability science and research in human factors. One way to get to level-2 reliability is to design procedures to make failures visible so they can be intercepted.³ This principle is a major tenet of TPS: you cannot design a perfect process—you can only discover it. Thus, TPS could help Sloan-Kettering on its journey to become an HRO.

Complexity theory guides improvement

The NPSF co-sponsored Patient Safety Leadership Fellowship (PSLF) advises healthcare leaders to apply complexity theory by asking “wicked” questions to bring differences to the

Aileen Killen, RN, PhD, is director of the patient safety program at New York's Memorial Sloan-Kettering Cancer Center. She was a Fellow in the premiere year of the NPSF co-sponsored Patient Safety Leadership Fellowship. Contact her at killena@mskcc.org.

This article is based on a presentation given at the 2007 NPSF Patient Safety Congress, Washington DC by Aileen Killen; Steven Spear, DBA, MS, senior fellow, senior lecturer, Institute for Healthcare Improvement, MIT; and Frederic Stell, director, environmental services, Memorial Sloan-Kettering Cancer Center.

References

- 1 Furman C, Caplan R. Applying the Toyota Production System: using a patient safety alert system to reduce error. *Jt Comm J Qual Patient Saf.* 2007;33:376-386.
- 2 Spear SJ. Learning to lead at Toyota. *Harv Bus Rev.* 2004;82:78-86, 151.
- 3 Edmondson AC. Learning from failure in health care: frequent opportunities, pervasive barriers. *Qual Saf Health Care.* 2004;13 Suppl 2:ii3-ii9.
- 4 Weick KE, Suttcliffe KM. Managing the Unexpected – Assuring High Performance in an Age of Complexity. San Francisco: Jossey-Bass; 2001.
- 5 Zimmerman B, Lindberg C, Plsek P. Edgeware: Insights from Complexity Science for Health Care Leaders. Irving, TX: VHA, Inc; 2001.
- 6 Plsek PE, Wilson T. Complexity, leadership, and management in healthcare organizations. *BMJ.* 2001;323:746-749. Available at: <http://www.bmj.com/cgi/content/full/323/7315/746>. Last accessed September 6, 2007.

Examples of TPS Applications

- Increasing supply availability at the bed site
- Improving waste segregation and disposal
- Reducing discharge delays
- Improving lab specimen processing
- Increasing patient bed availability and flow
- Improving cleaning and reprocessing of endoscopes
- Reducing patient transport time from inpatient unit to ancillary services
- Improving linen availability and quality

surface, expose basic assumptions about an issue or situation, address problems that do not have an obvious answer, and create opportunities for creativity and innovation.⁵ This gave rise to Sloan-Kettering's question, "How do you get better when you know you are the best?" The PSLF is offered by NPSF, Health Forum and the Health Research and Educational Trust.

The second lesson from complexity theory is to use "min specs"—minimum specifications—to begin with a vision that is good enough, and not to attempt to define the outcome in detail.⁶ Thus, TPS is compatible with complexity theory.

A major tenet of improvement through TPS is to observe work to identify ambiguities.² Four work components are observed using criteria from a process design worksheet:

1. **System** (output)—What work has to be done, by when, for whom?
2. **Pathway** (responsibility)—Who is responsible for which specific activity, in what order?
3. **Connection** (hand offs)—How does one request that a work activity be started?
4. **Activity** (method)—What are the work elements, content, sequence, timing, location, and outcome?

The team then reviews the worksheet to identify root causes of ambiguities at each step. Counter-measures are proposed and implemented. The team continues its observation cycles with the new process until it reaches the expected results.

Sloan-Kettering has succeeded in TPS applications, as shown in the box above, through projects conducted during visits with the consultant. The challenge has become how to incorporate

the work of TPS into Sloan-Kettering teams' everyday work and to empower them to launch projects on their own.

Where's the bed?

The story of "Where's the bed?" illustrates the success Sloan-Kettering has gained on its own. The team observed a daily shortage of beds in the operating room (OR). Meanwhile, idle beds were found on inpatient units obstructing the hallways and more than a dozen more beds were in a basement corridor getting dirty or damaged because there was not a "bed farm."

The "repair needed" status of these beds was unknown. Worse yet, the beds were left unplugged while in the basement, draining the battery required for power-assist devices. Staff were spending unproductive time roaming the halls looking for beds. The team knew there was a bed for every location on the inpatient units, including pediatrics, PACU, and the intensive care unit (ICU). They also knew that on any given day, several patients were in cribs or specialty beds.

A team of staff members from OR, PACU, escort, and environmental services took on the problem. TPS involves answering key questions at each step of the work process:

- What is the result expected of this step?
- Who is responsible for this step?
- How is the work to be done?
- When should the activity start and stop?

The new process identified an ideal bed farm. Empty beds would be transported to the OR. During construction of a new OR suite, the team built "parking spaces" outside each OR, which is where the bed would first be needed. A space for repairs and spare-part storage was designated in the basement.

Sloan-Kettering has an automated patient escort system but the team discovered there were not codes to accommodate bed transportation requests. The team established codes for 5 different reasons why beds needed to be moved. The project has been so successful that Sloan-Kettering has sent 10 beds into storage.

Making time for process improvement

The final challenge for Sloan-Kettering team members is to find time for improvement work while putting out fires in their day-to-day jobs. The teams have identified other issues that would be amenable to a Toyota Production System project, but are struggling with how to get it done. The work continues. **NPSF**

Risks and Resilience in Pediatric Patient Safety

BY DONNA WOODS, EdM, PhD, ASSISTANT PROFESSOR, FEINBERG SCHOOL OF MEDICINE, NORTHWESTERN UNIVERSITY

Each year, approximately 70,000 children experience adverse events, of which 60% are preventable. About 1 in every 100 children admitted to a hospital annually experiences an adverse event.¹ Despite these findings, there is still limited research to effectively guide pediatric patient safety intervention and improvement.

Safety interventions designed for adult care based on adult safety criteria may not address pediatric safety priorities. These interventions may not be designed appropriately for implementation in pediatrics and at times have been shown to lead to increased morbidity and mortality.²

Children face different safety risks than adults

In adults, the most frequent contexts of error risk leading to injury are surgery and medications; for children, injury related to medical care is most common in diagnostics and at birth. Labor and delivery—for both the newborn and the adolescent mother—appear to be unique, still poorly understood contexts of medical risk.³

Diagnostics are a frequent source of risk and harm for children in all pediatric settings, including office-based practice, the emergency department, and inpatient hospital-based care.^{4,5} Risks in pediatric patients can be related to the varied presentation of symptoms of illness in children, and the subtlety of some findings in the medical care of children.

These challenges can be even more pronounced in settings where there are few, if any, pediatric-trained clinicians. Only 23% of emergency departments have a pediatric emergency physician on staff.⁵

Children are more difficult to diagnose

Because children's normal signs and symptoms vary by age, it is a diagnostic challenge to recognize clinical instability and deteriorating clinical status in pediatric patients.⁶ This lack of recognition by bedside clinicians has been shown to lead to critical delays in treatment, which can lead to preventable cardiac or respiratory arrest.⁷

Rapid-response systems that specify age-based criteria and bring additional attention to the bedside when there is concern about the patient's status have been shown to

improve the identification of patients with early signs of deteriorating status.⁷

The context of diagnostics is a challenging area of safety investigation. Further study is needed to determine the range of specific factors contributing to the increased diagnostic-related risks for children.

“Because children’s normal signs and symptoms vary by age, it is a diagnostic challenge to recognize clinical instability and deteriorating clinical status in pediatric patients.”

Concerns for adolescent patients

Adolescents have been shown to experience the highest rate of both adverse events and preventable adverse events among children.^{1,3} Teenagers have a pattern of hospital admission different from other age groups of children and distinct from that of adults. The most common discharge diagnoses for adolescents are related to labor and delivery, followed by mental health diagnoses of psychosis and depression.³

Most adolescent patients in the U.S. receive hospital-based medical care in either pediatric or adult medical settings, where they represent a change from the routine patient population and most likely also represent a departure from routine practice in the care setting. Thus, adolescents experience a potentially greater risk for patient safety problems.³

Because adolescents are not a substantial part of the patient population in either pediatric or general medical facilities, standard systems may not be designed and put into practice for adolescent patient needs and clinicians also may not be adequately trained to care

Donna Woods, EdM, PhD, is co-director of Northwestern University's Master's Program in Healthcare Quality and Patient Safety and Research Assistant Professor at the Institute for Healthcare Studies, Feinberg School of Medicine, Northwestern University, Chicago. Contact her at (312) 695-7004 or woods@northwestern.edu.

References

- 1 Woods DM, Thomas EJ, Altman S, Holl JL, Brennan TA. Adverse events and preventable adverse events in children. *Pediatrics*. 2005;111:155-160.
- 2 Han YY, Carcillo JA, Venkataraman ST, et al. Unexpected increased mortality after implementation of a commercially sold computerized physician order entry system. *Pediatrics*. 2005;116:1506-1512.
- 3 Woods DM, Holl JL, Klein J, Thomas EJ. Patient safety problems in adolescent medical care. *J Adol Health*. 2005;38:5-12.
- 4 Mohr JJ, Lannon CM, Thoma KA, et al. Learning from errors in ambulatory pediatrics. In: *Advances in Patient Safety: From Research to Implementation*. Rockville, MD: Agency for Healthcare Research and Quality; February 2005. AHRQ Publication Nos. 050021 (1-4):355-368. Available at: <http://www.ahrq.gov/downloads/pub/advances/vol1/Mohr.pdf>.
- 5 Warden GL, Sundwall DN, eds. *Emergency Care for Children: Growing Pains*. Washington, DC: National Academy of Sciences; 2006.
- 6 Woods DM, Holl JL, Mehra M, Shonkoff J, Ogata ES, Weiss KB. Child-specific risk factors and patient safety. *J Patient Saf*. 2005;1:17-22.

References continued on page 4

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- 7 Brilli RJ, Gibson R, Luria JW, et al. Implementation of a medical emergency team in a large pediatric teaching hospital prevents respiratory and cardiopulmonary arrests outside the intensive care unit. *Ped Crit Care.* 2007;8:236-246.
- 8 Marks A, Fisher M, Lasker S. Adolescent medicine in pediatric practice. *J Adol Health Care.* 1990;11:149-153.
- 9 Rudan V. Adolescent development and external influences. *Coll Antropol.* 2000;24:585-596.
- 10 Kashaul R, Bates DW, Landrigan C, et al. Medication errors and adverse drug events in pediatric inpatients. *JAMA.* 2001;285:2114-2120.
- 11 Barkin RM, ed. *The Emergently Ill Child: Dilemmas in Assessment and Management.* Rockville, Md: Aspen; 1987.
- 12 Cote C, Karl H, Notterman DL, Weinberg J, McCloskey C. Adverse sedation events in pediatrics: analysis of medications used for sedation. *Pediatrics.* 2000;106:633-644.

for them. Teenagers may have a higher rate of adverse and preventable adverse events due to less of the physiological resilience that characterizes younger children. However, it is unlikely that this represents the full explanation.³

Although adolescents may physically appear adult-like, they may often respond to medical care interactions in a manner quite unlike an adult. Adolescents experience different social and developmental stresses that can affect their interactions with the healthcare system.^{8,9} Additional research is needed to further clarify the contributors and potential solutions.

Medication safety has been the most widely studied aspect of pediatric patient safety. Errors in the process of medication provision are more common in children than in adults. Previous studies have shown that potentially serious medication errors were found to be 3 times more frequent for children, although harm is relatively infrequent.¹⁰ This underscores the importance of targeting medication safety interventions related to high-alert medications for children.

What are child-specific risk factors?

These studies demonstrate that children are qualitatively different than adults in several significant and important ways that present unique features of frailty and resilience to the context of medical care, which in turn lead to differences in patient safety risk.^{6,6} The epidemiology of illnesses and interventions for children which mediates the types of contact and interaction children have with the healthcare system also has an impact on the nature and types of problems that occur in children's medical care and the aspects of medicine in which these events will most frequently occur.¹¹

These differences of children are important in the context of patient safety because child-specific risk factors have been shown to contribute actively to 50% of clinician-reported patient safety events.⁶ These child-specific risk factors can be used to clarify pediatric patient safety priorities and to customize patient safety interventions for the specific needs of children. These risk factors include:

1. Physical characteristics (eg, small size and weight)
2. Development:
 - Physiologic development and growth

- Cognitive, social, emotional development (including the ability to communicate and express feelings)
3. Minor status and level of parent/caregiver involvement in health care

How child-specific factors contribute to patient safety risk

- **Increased variability.** This occurs, for example, because of the wide range in "normal" results for analyses of blood, urine, or cerebrospinal fluid, which can also lead to challenges in recognizing the signs of clinical instability, an important concern in pediatrics.

There is also a need to maintain and select from a wide range of sizes of medical equipment and supplies, such as endotracheal or suction tubes or face masks in pediatric health care. Only 6% of emergency departments have all the supplies deemed essential for managing pediatric emergencies.⁵

Increased variability also contributes to the relatively common problems of medication-related risk in pediatrics, which is often associated with the variable size, weight, and physiological maturity of children and requires the customization of each dose based on weight and age.^{6,10}

- **Compromised information.** A child's cognitive-social-emotional immaturity, limited communication skills, and inability to understand the impact or consequences of his or her medical care provide challenges to history and physical examination and remove a source of feedback.

- **Increased complexity.** Medication administration in children is complex, requiring several additional steps. With each step, there is increased opportunity for error.

The reduced volume associated with 10-fold overdoses makes identification of these errors more challenging. Information may also be complicated because the changing physiological characteristics of very young children can make test findings more subtle and thus harder to interpret.

- **Increased technical difficulty.** Small size and weight can pose several challenges. Technical tasks, from insertion of an IV to surgical treatment of the heart, can be more difficult to perform on small children.¹¹

- **Limited ability to regulate behavior.** Conscious sedation, needed less frequently in adults, is commonly used in children. Sedation medication can lead to additional risks, and adverse outcomes are associated with all classes of

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NPSF to Issue New Stand Up for Patient Safety® Member Resource Guide

NPSF will soon issue a new version of the Stand Up for Patient Safety Member Resource Guide, a compilation of materials designed to assist Stand Up for Patient Safety (Stand Up) members in enhancing patient safety efforts at their facility. The guide includes ready-to-use tools, articles, fact sheets, brochures, samples of the popular medication wallet card and personal medical journal for patients, DVDs, and bibliographies of additional print and electronic resources.

The redesign project was undertaken to offer new resources and scholarship that have emerged since the creation of the original guide, as well as to more accurately reflect current thinking on patient safety issues and best practices.

Stand Up member feedback shapes new guide

NPSF solicited feedback on the previous guide through phone conversations with Stand Up members and a fall 2006 survey on members' satisfaction with program materials. In response to members' comments, the new guide focuses on providing a succinct set of adaptable, highly effective tools along with guidelines for their application.

The new guide consists of 5 books, each subdivided into several related modules. Topics covered include:

- The case for change
- Safety science
- Teamwork and communication
- Engaging patients and families
- Disclosure and apology
- Event response and analysis
- Leadership and accountability

Companion web site offers more resources

Materials in the guide include selected articles from the patient safety literature, as well as self-assessment questionnaires, team-training manuals, and patient education brochures. A password-protected companion web site provides members with access to downloadable versions of articles and tools. The web site also features continually updated content to supplement the guide.

Along with updated materials, the guide features a new look with revamped graphics and a streamlined layout. Topics are organized according to a practical framework to facilitate access to information and encourage shared use of materials. Users should find the guide a valuable resource, whether they choose to proceed through it sequentially or read up on specific topics.

All current Stand Up for Patient Safety members will receive a copy of the new guide, and organizations enrolling as new members will receive the new guide upon enrollment. Materials from the previous guide will be archived and accessible to all members on the Stand Up members' web site.

The Stand Up program's efficacy is based on its commitment to continually provide member hospitals with practical and relevant tools, resources, and information to facilitate their organizations' patient safety efforts. The redesigned Member Resource Guide reinforces this commitment and NPSF's goal to provide ongoing value and support to Stand Up program members. [NPSF](#)

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sedation medications—even those thought to have a minimal effect on respiration.¹²

Since the 1880s, pediatrics has extended and adapted the practice of medicine to address the particular characteristics and needs of children. To ensure the safety of pediatric patients, it is essential to understand the specific nature of

risk and harm conveyed through children's medical care. Beginning to clarify the contributing causes and underlying latent conditions of these patient safety risks will enable clinicians and institutions that care for children to be better prepared to prevent these risks, and can improve the safety of children's health care. [NPSF](#)

Enhancing Patient Safety Through Improved Health Literacy

BY BARBARA DEBUONO, MD, MPH, EXECUTIVE DIRECTOR, PUBLIC HEALTH AND GOVERNMENT, PFIZER, INC AND BOARD CHAIR, PARTNERSHIP FOR CLEAR HEALTH COMMUNICATION

Communicating—and comprehending—health information effectively is a complex task. Consumers must be able to navigate a complicated series of steps and actions, from following treatment instructions to scheduling diagnostic tests to completing insurance paperwork.

“It is frightening to note that low health literacy affects more adult Americans than diabetes, obesity, HIV/AIDS, and breast cancer combined.”

People from all socioeconomic levels, age groups, and cultures can have difficulty reading, understanding, and acting on health information. These skills are collectively known as “health literacy.” The Institute of Medicine defines health literacy as the degree to which individuals have the capacity to obtain, process, and understand basic health information and services needed to make appropriate decisions regarding their health.¹

It is frightening to note that low health literacy affects more adult Americans than diabetes, obesity, HIV/AIDS, and breast cancer combined. Low health literacy is a reality that millions of Americans experience each day in many ways.

The 2003 National Assessment of Adult Literacy shows that 2 out of every 5 adults have difficulty obtaining, processing, and understanding the basic health information and services needed to make appropriate health decisions.² Nearly 90 million Americans—39% of adults in the US—are limited in their ability to read and understand health information.¹

How does health literacy affect patient safety?

People with limited health literacy cannot:

- Circle the date of a medical appointment on a hospital appointment slip.
- Identify how often a person should have a specific medical test, based on information in a clearly written pamphlet.
- Understand what is permissible to drink before a medical test, based on a short set of instructions.

- Explain why it is difficult for people to know if they have a specific chronic medical condition, based on information in a 1-page article about that condition.²

Does the patient understand what the doctor is saying?

Some of the most hazardous situations for patients are ones that should be the safest—in the doctor’s office, at the pharmacy counter, or speaking to a social worker, to name a few. Imagine the case of a patient who is told by his physician that he has “diabetic neuropathy,” “hypertension,” or “coronary disease.” Would he know what this means?

If instead, the physician tells him he has “nerve problems,” “high blood pressure,” or “heart disease,” the patient may recognize the terms. But does he understand how these conditions will affect his health or what he needs to do to treat them?

Health literacy encompasses more than just the ability to read. It involves a patient’s ability to use numbers, analyze multiple options, and navigate a complex coverage and payment system. The consequences of low health literacy are serious, from a clinical, patient safety, and economic perspective.

What are the risks of low health literacy?

People with low health literacy are more likely to make medication errors, to fail to seek preventive care, and to miss physician appointments.³⁻⁴ All of these occurrences place patients’ health and safety at risk. Fortunately, these risks can be lowered or eliminated through better communication.

According to Paul A. Gluck, MD, and colleagues, depositions in malpractice cases reveal evidence of this disconnect.⁵ Dr. Gluck believes the discrepancy between what the doctor says and what the patient hears is often a result of low health literacy and poor communication.

How can healthcare providers improve communication?

Health literacy experts have identified simple techniques that providers can use to improve communication and understanding with patients and their families or caregivers, whether in an office, clinic, or hospital setting.⁶

- **Use the “Teach Back” method** by asking patients to repeat in their own words what they need to do when they leave the doctor’s office or hospital.
- **Use visual aids and illustrations**, as many people remember information better when it is presented to them visually.
- **Avoid acronyms** patients may not understand.

- **Slow down and take pauses** to give the patient time to digest the medical information and ask for clarification.
- **Be an “active listener”** by encouraging patients to talk and tell their story or information they feel is necessary for their visit.
- **Create a welcoming and supportive environment.** Patients are most comfortable in an office that feels private and encourages communication.

What Is Ask Me 3?

The *Ask Me 3* campaign from the Partnership for Clear Health Communication (PCHC) encourages patients to ask their provider during any medical encounter:

- What is my main problem?
- What do I need to do?
- Why is it important for me to do this?

For more information, visit www.askme3.org.

Health literacy movement is making progress

The health literacy/clear health communication movement has gained momentum in the last few years. The Institute of Medicine issued a groundbreaking report on the subject in 2004 titled *Health Literacy: A Prescription to End Confusion*.¹

Numerous research projects are examining the impact of health literacy, patient-provider communication, and cultural competency issues on patient safety and quality of care. Health literacy and health communication are increasingly on the agenda for public health and literacy programs at the national and local level.

PCHC raises awareness of health literacy issues

As the board chair for the Partnership for Clear Health Communication (PCHC), I have been involved firsthand with this work. PCHC is a nonprofit coalition of national organizations dedicated to increasing awareness of health literacy issues and developing health communication tools to improve health literacy and patient outcomes.

The coalition, established in 2002, now has more than 500 members, including the AMA Foundation, the National Council on Aging, America’s Health Insurance Plans, the National Medical Association, and the American Public Health Association.

NPSF and PCHC form new partnership

In May 2007, PCHC announced it would join forces with NPSF to form the Partnership for Clear Health Communication at the National Patient Safety Foundation. This partnership seeks to draw on NPSF’s established presence in patient safety to extend the influence of PCHC’s efforts. *Ask Me 3* (www.askme3.org) and other PCHC trademarks will be integrated with new and existing NPSF programs.

The Partnership’s work in health literacy and communication has particular relevance for the sphere of patient and family-centered care. *Ask Me 3* materials have already been made available to hospital and health system members of NPSF’s Stand Up for Patient Safety program and in connection with National Patient Safety Awareness Week.

NPSF anticipates that expanded application and dissemination of *Ask Me 3* and other PCHC materials will play an important role in its continued work to assist patients and families in becoming active participants in their health care.

Health literacy takes on new importance

There are several reasons why health literacy is a more pressing issue than in previous decades. Consumers today play a larger role in managing their health care than ever before. At the same time, the incidence of chronic disease is exploding and health care costs are skyrocketing, with no end in sight.

While an abundance of information is available, it has not created sustained behavior change that improves clinical outcomes. Too much information may be useless—even detrimental—if it does not clearly explain the problem and what the patient needs to do to address it.

Focusing on better communication

Clear health communication is the missing link between information and improved health outcomes. Accessible, comprehensible, relevant health information is essential for patients to become more engaged in their health care and manage health decisions as active partners with their providers.

The solution is not more or less information, but better information and communication. Health literacy is every individual’s right—and our collective responsibility. Reaching this goal will result in a healthier public and a safer, more sustainable healthcare system. **NPSF**

Barbara DeBuono, MD, MPH, is executive director, public health and government, for Pfizer, Inc, as well as board chair of the Partnership for Clear Health Communication (PCHC). Contact her at (212) 733-5185 or barbara.debuono@pfizer.com.

References

- 1 Nielsen-Bohlman L, Panzer AM, Kindig DA, eds. *Health Literacy: A Prescription to End Confusion*. Washington DC: National Academies Press; 2004.
- 2 Kutner M, Greenberg E, Jin Y, Paulsen C. *The Health Literacy of America’s Adults: Results from the 2003 National Assessment of Health Literacy*. Washington DC: National Center for Education Statistics, US Dept of Education; 2006. Publication NCES 2006-483. Available at: <http://nces.ed.gov/pubsearch/pubinfo.asp?pubid=2006483>. Accessed August 30, 2007.
- 3 Weiss BD. *20 Common Problems in Primary Care*. New York: McGraw-Hill; 1999.
- 4 Eradicating Low Health Literacy: The First Public Health Movement of the 21st Century. [White paper]. New York: Pfizer, Inc; 2003. Available at: http://www.askme3.org/pdfs/white_paper.pdf. Accessed August 31, 2007.
- 5 Pearlman MD, Gluck PA. *Medical liability and patient safety: setting the proper course*. *Obstet Gynecol*. 2005;105:941-943.
- 6 Help Your Patients Succeed: Tips for Improving Communication with Your Patients. *Pfizer Clear Health Communication Initiative*; January 2007. Available at: <http://www.clearhealthcommunication.org/physicians-providers/tips-for-providers.html>. Accessed August 31, 2007.

Focus on Patient Safety (ISSN 1097-0673) is the official quarterly publication of the not-for-profit National Patient Safety Foundation (NPSF), in North Adams, Mass. The opinions expressed in this publication are not necessarily those of the National Patient Safety Foundation or of its Board of Directors.

To submit articles or publications for possible review in Focus, please direct materials to: Lorri Zipperer, Managing Editor, Focus on Patient Safety, National Patient Safety Foundation, 132 MASS MoCA Way, North Adams, MA 01247. Materials, inquiries, and subscription requests for the publication will be accepted electronically at info@npsf.org or via fax at (413) 663-8905.

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2008 Annual NPSF Patient Safety Congress: Connect, Communicate, Commit

Plan to attend the 2008 National Patient Safety Foundation Annual Patient Safety Congress, May 15-16, 2008 at the Gaylord Opryland Resort & Convention Center, Nashville, Tennessee. Two pre-Congress programs, Leadership Day and Patient Safety 101, will be held May 14, 2008.

Connect, Communicate, Commit is the theme for the 2008 conference. Join us for inspiring plenaries, focused break-

out sessions, and exhibits and poster sessions showcasing innovative developments in patient safety. Come together with colleagues from across the country and around the world to forge new connections, communicate through shared experiences and stories, and renew your commitment to patient safety.

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More Congress information will be posted as it becomes available at www.npsf.org. [NPSF](http://www.npsf.org)

Need SAFE Tool Information? E-mail ahaqualitycenter@aha.org

The previous issue of *Focus* (Vol. 10, Issue 2) featured an article headlined "SAFE Tool Improves Flow—and Patient Safety." SAFE, which stands for Systematic Assessment of Flow and Error, provides a framework to identify fundamental care events and to anticipate the most likely errors. To obtain the SAFE tool and a template to evaluate process flow from the AHA Quality Center, please e-mail ahaqualitycenter@aha.org.

National Patient Safety Foundation®
132 MASS MoCA Way
North Adams, MA 01247

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