

Milestones in the Patient Safety Movement

1999 to Present

NATIONAL

1999 IOM Report: “To Err is Human: Building A Safer Health System”

This report, released in 1999 by the Institute of Medicine, offers a comprehensive set of recommendations for government, health care providers, industry and consumers to use to reduce preventable medical errors. Concluding that the “know-how” already exists to prevent many medical errors, the report set a minimum goal of a 50 percent reduction in errors throughout five years.

Read the executive summary [here](#).

NATIONAL

2001 IOM Report: “Crossing the Quality Chasm”

The IOM’s report, “Crossing the Quality Chasm: A New Health System for the 21st Century,” provided a set of performance expectations to close the quality gap. Researchers documented the causes of the quality gap, identified practices that impeded quality care and explored how to use systems’ approaches to implement change.

Read the executive summary [here](#).

NATIONAL

2003 The Joint Commission National Patient Safety Goals

In 2003, the Joint Commission appointed a 20-member committee to consider and make recommendations on ways to strengthen the Joint Commission’s infection control standards. The panel’s work led to the adoption of revised standards for the commission’s leadership and its infection control program.

NATIONAL

2004 IHI 100,000 Lives Campaign

The Institute for Healthcare Improvement launched the “100,000 Lives Campaign” as a nationwide initiative to significantly reduce morbidity and mortality in American health care. Building on the successful work of health care providers throughout the world, the campaign promoted the use of evidence-based practices to help participating hospitals extend or save as many as 100,000 lives throughout the campaign’s 18 months — January 2005 through June 2006. Many of the interventions recommended in the campaign remain central components of hospitals’ patient safety efforts.

Read more about the “100,000 Lives Campaign” [here](#).

NATIONAL

2005 Patient Safety and Quality Improvement Act

The [Patient Safety and Quality Improvement Act of 2005](#) was signed into law July 29, 2005. The act was designed to improve patient safety by encouraging voluntary and confidential reporting of adverse events in health care.

Read more about the act [here](#).

NATIONAL

2007 IHI 5 Million Lives Campaign

The “5 Million Lives Campaign” was a voluntary initiative to protect patients from five million incidents of medical harm throughout two years, between December 2006 and December 2008. The campaign was an extension of IHI’s previous “100,000 Lives Campaign.”

Learn more about the “5 Million Lives Campaign” [here](#).

NATIONAL

2009 CMS Statement of Work

In August 2008, quality improvement organizations began implementing the 9th Statement of Work with the Centers for Medicare & Medicaid Services. The SOW builds on previous federal health care initiatives and growing evidence about how to improve the quality and efficiency of the health care sector. Under the agreement, QIOs began focusing on intervention projects across the spectrum of care rather than in “silos” based on settings of care.

To learn more about QIO efforts, visit CMS’ [Web site](#).

STATE

2004 Missouri Commission on Patient Safety

In 2004, Gov. Bob Holden appointed the Missouri Commission on Patient Safety to recommend processes to improve medical outcomes and prevent errors that lead to litigation. The report recommended adoption of patient safety standards by all Missouri health care providers and creation of a Missouri Center for Patient Safety.

Read the report [here](#).

STATE

2005 Formation of the Missouri Center for Patient Safety

The MoCPS was established by the Missouri Hospital Association, the Missouri State Medical Association and Primaris, Missouri's Medicare quality improvement organization. This private, not-for-profit corporation is dedicated to fostering change through a nonregulatory, collaborative approach that brings consumers and providers together to develop and implement strategies and systems to improve safety.

Learn more about the center [here](#).

STATE

2007 "Banding Together for Patient Safety" Project Launched

The "Banding Together - for Patient Safety" program was implemented to create a uniform set of standards for hospital wristbands to increase patient safety. Wristbands are commonly used for alerts such as allergy warnings, fall risks or do-not-resuscitate orders. However, many health professionals work in multiple facilities and were required to memorize multiple, sometimes conflicting, meanings for colors. The Banding Together project encouraged health providers to adopt the standardized system.

Learn more about the project [here](#).

STATE

2007 Missouri Just Culture Collaborative

The Missouri Just Culture Collaborative was implemented to increase the understanding and management of human error, at-risk behavior and reckless behavior in health care. The collaborative's goal was to achieve an appropriate balance between a "blameless" culture and an "accountable" culture in support of patient safety objectives.

Learn more about the collaborative [here](#).

STATE

2008 MHA Board of Trustees Issues Adverse Event Recommendations

In 2008, the MHA Board of Trustees unanimously endorsed a set of recommended actions in the event of a serious medical error, also known as an "adverse event." The board recommends hospitals take three actions following a serious adverse event — inform the patient; report the incident to a patient safety organization, like the Missouri Center for Patient Safety; and waive payment. The board's action represents a commitment to ensure that adverse events do not happen, and, in the rare occasion when they do, to put the patient first.

More information on the board's recommendations is available [here](#).

STATE

2009 MO HealthNet Providers Must Join a PSO

In 2009, Missouri's Medicaid program, MO HealthNet, updated the state's payment policy on preventable serious adverse events and errors in medical care that are clearly identifiable, preventable and serious in their consequences. The rule requires MO HealthNet hospitals and ambulatory surgical centers to contract with a federally-designated patient safety organization, such as the MoCPS, by January 1, 2010.

View the regulation [here](#).

STATE

2009 Missouri Excellence in Safe Care Awards

The Missouri Excellence in Safe Care Awards are designed to recognize projects implemented by health care providers that increase patient safety. The first awards were presented at the MOCPS's third annual conference in April 2009.

More information about the awards is available [here](#).

STATE

2009 Missouri Safe Surgery Saves Lives DASH!

According to a *New England Journal of Medicine* report, surgery-related complications have been reduced by more than one-third and deaths by 40 percent when a checklist developed by the World Health Organization was used at three critical periods — before anesthesia, before the first incision and before the patient leaves the operating room. The “Missouri Safe Surgery Saves Lives DASH!” encouraged Missouri providers to test and adopt the checklist.

More information about the checklist is available [here](#).

STATE

2009 CUSP/Stop BSI Collaborative

In 2009, the MoCPS and MHA partnered to implement the STOP BSI Collaborative. The program uses an evidence-based system — the Comprehensive Unit-Based Safety Program — developed at Johns Hopkins University to evaluate and improve patient safety in hospitals by reducing central line associated bloodstream infections.

More information about the program is available [here](#).