

**History and Overview**  
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SAFER  
CALIFORNIA  
HEALTHCARE

# *The Purpose of SAFER California Healthcare*

The *Strategic Alliance For Error Reduction in California Healthcare (SAFER)* grew out of a series of meetings held from 1999 to 2001 to address patient safety issues by the Medical Directors of the University of California system, i.e. San Francisco, Davis, Los Angeles, Irvine, and San Diego. The Directors recognized that quality improvement was universally agreed upon as being a serious and common concern of all five (5) campuses, and saw the appropriateness of a formal infrastructure to coordinate and share previously independent patient safety efforts. The Directors rightly foresaw that there was much that they could do collectively that they could not do as independently-acting sole institutions; SAFER California Healthcare was born of that consensus and is now charged with the following purposes:

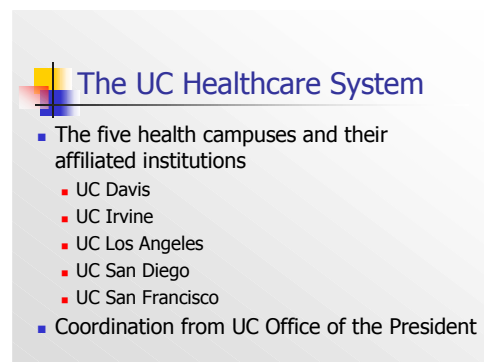
- To build a well-functioning, multidisciplinary team with broad representation of stakeholder groups, including patients and families served by the healthcare delivery system;
- To strengthen the Alliance's research capacity and collaborative relationships to conduct research, over time developing into a Center of Excellence;
- To develop, implement and disseminate model interdisciplinary health provider continuing education programs and graduate program curricula on patient safety;
- To provide technical assistance and expertise to community healthcare facilities throughout California;
- To develop and implement university-wide projects that promote the sharing of information systems resources and data on medical error; and
- To translate into practice evidence-based recommendations for improving patient safety, including patient education strategies, and evaluate the impact of these interventions on patient health outcomes.

## *Who We Are*

The five University of California Medical Centers at San Francisco, Davis, Los Angeles, Irvine, and San Diego form the right arm of SAFER California Healthcare. Each University currently serves a diverse and complex patient population, provides undergraduate and graduate education for medical and allied health professional students, has strong community outreach programs, and performs a broad spectrum of research, ranging from the very basic sciences to health services research. In addition to the five campuses, SAFER California Healthcare is also supported by the University of California Office of the President, which has helped to organize and prepare much of the initial work in setting up the infrastructure for the Alliance.

Besides these five medical centers, their affiliated professional schools, and the Office of the President, there is also a broad representation of partners holding seats on the SAFER California Healthcare Advisory Board. These organizations include:

- California Medical Association
- California Office of Statewide Health Planning and Development (OSHPD):
- The Medical Board of California
- The Pacific Business Group on Health
- The California Healthcare Foundation
- The California State Legislature



# How We Work Together

SAFER California Healthcare is among the first of AHRQ's Developmental Centers for Evaluation and Research in Patient Safety, and is unique in that it is an alliance of large and complex members; therefore, the size of the Alliance demands a comprehensive coordinating body. The SAFER California Healthcare leadership is currently organized into three different leadership committees: the Executive Committee, the Planning Committee, and the Advisory Board.

All boards rely on a collection of different communication tools to meet and exchange information: the steering committees (Planning and Executive) meet several times monthly by conference call and use electronic mail to share developing information. The Advisory Board is currently scheduled to have its first meeting as part of our Annual Patient Safety Summit. Once the Advisory Board meets, we will be able to decide on the frequency of subsequent meetings.

### The Executive Committee:

**Function:** The Executive Committee is guiding the planning effort, which includes hosting the Planning Committee and soliciting membership for our Advisory Board. We will, following the first meeting of the Advisory Board, establish relevant subcommittees to work on priority areas – with members of the Executive Committee chairing these working groups.

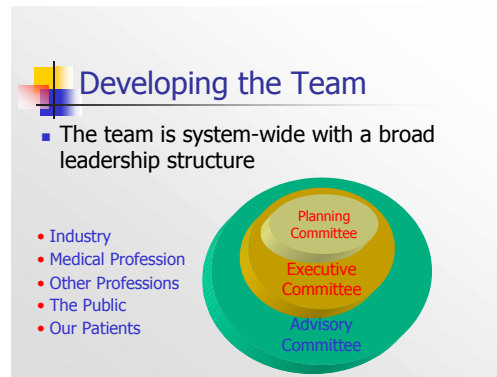
**Members:** The Executive Committee is comprised of the following individuals: Lee Hilborne (Director, UCLA), David Taylor (Co-director, UCOP), Joanna Weinberg (Co-director, UCSF), Eugene Spiritus (Co-director, UCI), Quang-Tuyen Nguyen (Project Director, UCLA), Theodore Schrock (Medical Director, UCSF), Cecilia Smith (Medical Director, UCSD), Gibbe Parsons (Medical Director, UCD), Joseph Tupin (Consultant, UCOP); Julie Klinger (Consultant, UCOP); Felicia Cohn (Consultant, UCI).

**Lee Hilborne, MD, MPH, Director,** serves as the Planning Director for SAFER California Healthcare. Dr. Hilborne's combined experience in academic research, clinical management, and administrative leadership makes him ideally suited to assume effective leadership of this effort. Dr. Hilborne is currently a Professor of Pathology and Laboratory Medicine at the University of California, Los Angeles and serves as a consultant to the Health Sciences program at RAND in Santa Monica, California. After directing the Clinical Laboratories at Olive View-UCLA Medical Center from 1992 to 1995, Dr. Hilborne assumed the role of Director of Quality Management Services (now the Center for Patient Safety and Quality), UCLA Healthcare.

**David Taylor, MD, Co-Director.** Dr. Taylor is an Assistant Professor of Psychiatry at UCSF and Director of Medical Services, Clinical Services Development at the University of California Office of the President. He is a member of the Scientific Program Committee of the American Psychiatric Association and is slated to chair the APA CME subcommittee in 2001. Dr. Taylor has been active in medical staff affairs since joining the staff at UCSF/LPPI and chaired the hospital-wide Quality Council. Dr. Taylor has been involved in numerous performance improvement projects including developing educational materials for patients and families, improving drug information for patients, and leading a redesign and modernization of the entire medical record.

**Joanna Weinberg, JD, LL.M, Co-Director.** Dr. Weinberg is currently an Associate Professor of Health Policy and Health Services at UCSF and an Adjunct Professor at Hastings College of Law. Dr. Weinberg is Curriculum Coordinator for the UCSF Postdoctoral Program in Health Policy within the Institute for Health Policy Studies. In this role, she has incorporated a cross-disciplinary and cross-methodological approach to health services research into the curriculum. Dr. Weinberg teaches courses on Ethics and Law, Public Benefit Law, and State and Local Government Issues at UCSF and Hastings as well as the Foundations of Patient Care for the UCSF School of Medicine.

**Eugene Spiritus, MD, Co-Director.** Dr. Spiritus was appointed Senior Medical Director for the University of California, Irvine (UCI) in 1997. He has responsibility for managing the performance improvement initiatives of both the inpatient and out patient facilities. In addition he is responsible for risk management, case management, the medical staff office and infection control. Dr. Spiritus spent 20 years in private practice and was involved in the initial development of the PSRO in Orange County. He was a founding member of the largest Physician-Hospital PPO in California focusing on



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Quality Measurement and Outcomes. Two years ago at UCI, Dr. Spiritus spearheaded efforts to initiate electronic order entry in the UCI health system, which now enters more than 88% of all orders by computer. He also developed a unique patient education program to encourage patients to ask health care providers about hand washing and medications.

**Quang-Tuyen T. Nguyen, BA, Project Director, University of California, Los Angeles.** Ms. Nguyen recently joined the SAFER California Healthcare team as project director. Last year she completed her undergraduate training at Harvard University in History of Science, with an emphasis on 20<sup>th</sup> century medicine. She is very interested in patient safety research and plans to pursue a medical career following her work with SAFER California Healthcare.

**Gibbe Parsons, MD, Medical Director, University of California, Davis.** Dr. Parsons is a Professor in Pulmonary and Critical Care Medicine and has served as the Medical Director for the UCD Health System since 1995. As the Medical Director, Dr. Parsons is responsible for the oversight of patient quality of care throughout the UCD Health System. Dr. Parsons has been at the forefront of evaluating the effectiveness and efficiency of health care delivery within UCD and developing innovative interventions to improve the quality of care.

**Theodore R. Schrock, MD, Medical Director, University of California, San Francisco.** Dr. Schrock, Chief Medical Officer at UCSF Medical Center, is responsible for directing and managing the physicians who practice at UCSF. He oversees the quality of professional medical services as well as the integration of patient care, education and research. Additional duties include the oversight of primary care services, care coordination, compliance, quality assurance, risk management, medical staff affairs and clinical resource management.

**Cecilia Smith, DO, Medical Director, University of California, San Diego.** Dr. Smith has been Medical Director for the UCSD Health System since 1996. In that role, she is responsible for the oversight of quality management, risk management and all medical staff activities and functions. Dr. Smith has initiated several efforts to improve patient safety at UCSD. She established a medication error committee to track and trend all adverse drug events. To encourage reporting, a simplified, non-punitive reporting mechanism was created. Adverse events are examined individually and in aggregate to identify root causes of error. Dr. Smith has also led efforts to develop a first-of-its-kind anonymous survey for house staff, consultants, and attending physicians to identify problems in communication and supervision. The survey results will be used to develop interventions to resolve the problems identified.

**Joseph Tupin, MD, Consultant, Office of the President, University of California.** Dr. Tupin recently retired from service with the University Office of the President. Dr. Tupin became Chair of Psychiatry in 1977 and remained in that position until 1984, when he accepted the position of Medical Director of the University of California, Davis Medical Center in Sacramento. As Medical Director, he participated in long-range planning and directed the medical staff administration, risk management, and resident education programs. In 1996, he began serving as the Director of the Clinical Policy Review Team in the Office of the President, University of California. In that role, he acted as the Chief Medical Officer of the University with responsibility for oversight of the quality of clinical programs at all UC hospitals and medical schools, including monitoring professional liability and human subjects research for effective function and compliance with UC, government and accreditation policies.

**Julie Kliger, MPA, BSN, Consultant, Office of the President, University of California.** Ms. Kliger joined the UC Office of the President in the Division of Clinical Services Development as Associate Director of Quality of Care in January 2002. She works with the Medical Services Director, the quality improvement directors at the five UC academic medical centers and with others across the UC system who are involved in operations of quality management, risk management, patient safety, and JCAHO accreditation. She has held the post of Chief Operating Officer for a consortium of non-profit clinics in Oakland, California, instituting its first ever quality improvement program. Ms. Kliger spent many years in the private sector as an Executive Director of Quality and Risk Management for EPMG, an emergency physician's staffing company. In this role she helped develop and implement medical quality and operational standards across 25 emergency departments in 5 states. Over the last several years, Ms. Kliger has spent her time focusing on the role of emerging technologies in patient safety, patient education and disease management.

**Felicia Cohn, PhD, Consultant,** is the Director of Medical Ethics Education at the University of California, Irvine College of Medicine, where she teaches medical students, residents, and faculty, develops the ethics curriculum for the College of Medicine, and conducts research on ethical issues. She came to UCI from the Institute of Medicine of the National Academies of Sciences, where she directed and published a study entitled *Confronting Chronic Neglect: The Education and Training of Health Professionals to Respond to Family Violence*. Prior to the IOM, she directed the Program in Medical Ethics at the George Washington University School of Medicine and served as a Senior Scientist with the Center to Improve Care of the Dying at George Washington, where she taught and conducted research on end-of-life care issues. Dr. Cohn has served on several ethics committees, the District of Columbia Health Policy Council, and maintains adjunct appointments at George Washington University and Vanderbilt University. Her publications have focused on care at the end-of-life care and medical education. She completed her doctoral work in Religious Ethics, with a concentration in Bioethics at the University of Virginia.

### The Planning Committee:

**Function:** In examining why interventions to improve patient safety had failed, investigators found that the most important factor was an absence of support at the top of the organization. The Planning Committee is supported by the senior leadership of the UC system, including the Office of the President. In addition, the Committee also includes directors, CEOs and deans. Within the

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Committee, the Medical Directors are a core group and will help the team define and carry out its mission. However, the Medical Directors do not function. The Planning Committee also includes representatives who are quality managers, risk managers, nursing directors, clinical pharmacists and educators, all of whom offer different perspectives and responsibilities for patient safety. We have had a general meeting of this group and have had more focused subcommittee meetings over the last year.

### The Advisory Board

**Function:** The Advisory Board has been selected to represent both internal and external constituencies. Members of the Board include individuals who represent our three key missions (i.e., Education, Research and Clinical Care), our five campuses, our key partners, and our government. The Board's role is to provide general direction to SAFER California Healthcare, assist in selecting research, education and clinical care priorities, and assist the Alliance to both seek funding and disseminate findings from our research efforts.

## *Eight Months Out*

The SAFER California Healthcare leadership committees have done much to accomplish what we promised to do in original proposal. Thus far, we have:

- Successfully built an awareness of our mission, including attracting such partners as the California Medical Association, the Medical Board of California and other academic institutions;
- Received pilot project RFP responses from four of our five campuses;
- Planned a patient safety summit with the medical centers agreeing to fund participants to attend;
- Implemented a common IR system;
- Developed several education proposals that are awaiting funding;
- Developed a research agenda;
- Started to explore a host of new opportunities to further our mission, including using the UCTV television network and the internet for distance learning.

But by far, our greatest achievement has been in laying the foundation for a working infrastructure that is capable of capitalizing on the strengths of all our partners. This is no small task, considering the size and complexity of the University of California system.

### Brick by Brick

Coordinating the infrastructure has been challenging because the UC Medical Centers have had a history of operating autonomously since their inception. While the five institutions recognize that they are all publicly funded and operate under the auspices of the Regents of the University of California, they have always operated independently and managed their own, separate affairs. SAFER California Healthcare, therefore, is revolutionary in that it is trying to supercede this tradition, and build relationships beyond superficial ties—it is in fact, trying to advocate collaborative partnerships between institutions that have previously only operated independently of one another.

At present, the core SAFER California Healthcare leadership has:

- Developed relationships with partners across the state;
- Established a functioning executive committee; and
- Solidified an advisory board.

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These steps, in and of themselves, are quite significant for SAFER California Healthcare for the Alliance consists of very large, complex, and diverse partners.



## *SAFER California Healthcare's Vision*

SAFER California Healthcare is building an infrastructure that is conducive to patient safety improvement. The Alliance will do so by committing to the following projects:

- Formalize a system for collecting ongoing information about patient safety activities at the five UC Medical Centers, as well as bring professionals working on patient safety efforts together to effectively collaborate;
- Enable UCs and partners to share patient safety efforts, strategies, and information;
- Keeps patient safety efforts effective by providing concerted focus to all the relevant healthcare administrators, government officials, and providers.

### So We Decided to Increase Our Capacity for Improving Patient Safety

- Create a "focus" on patient safety
  - SAFER California Healthcare
- Expand representation
  - Nursing, pharmacy, educators, others
- Establish priorities
  - Teaching
  - Research
  - Clinical Care Delivery

## *Our Plans*

There are currently several concrete projects that SAFER California Healthcare would like to develop. Some of these have been long planned and written into our initial proposal, but others have arisen as our work with patient safety has progressed and we learn from and assess our initial experiences. These activities, listed below, are all projects we would like to pursue, but have not yet finalized our strategic plans.

In addition, SAFER California Healthcare will continue cultivating many of the relationships required to affect broad change in culture, education, research, and legislation.

- Our Annual Patient Safety Summit is designed to provide a venue where researchers, administrators, healthcare providers, and patient safety leaders can convene to brainstorm, discuss, share, and focus patient safety efforts. The Summit is intended to be an avenue for researchers from all ends of the patient safety spectrum to have an opportunity to meet one another.
- Promote research by providing platforms for collaboration. To supplement the community building efforts from the Annual Patient Safety Summit, the SAFER California Healthcare website is building a directory that allows users to search for colleagues with similar research interests. This tool will also be developed to disseminate information through an appropriate listserv (e.g., funding opportunities, research results, and patient safety tools). The website is intended to be the foundation for a virtual community capable of finding, disseminating, and sharing information about various patient safety activities.
- There are also several plans for clinical delivery interventions at all five campuses—one of these is the online Incident Reporting (IR) program. UC Davis and UC San Francisco have already implemented the program; UCI is currently finishing installation, UC San Diego is preparing for installation, and UCLA will go "live" by the end of 2002. While this initial version of the IR program is a huge improvement over our traditional paper system, the system is still limited by its inability to capture all potential errors and analyze and learn from the events reported. We would like to better develop the online incident reporting system so that it is sufficiently robust

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enough to meet both risk management and quality improvement missions. The online system will also help us to study trends and patterns by providing us with data and help us to study the success of different clinical interventions. The studies are important if we are to find quantitative ways of improving our system. A multidisciplinary group is working to improve the system to realize its full potential.

- Develop a quality managers consortium, as a second system-wide, consensus-based initiative. This quality managers consortium will convene and meet regularly to share, disseminate, and discuss clinical delivery interventions in place at the separate institutions. The consortium will also serve as a clinical delivery advisory board and help to shape the success of future clinical delivery interventions.
- The quality consortium, collaborating with researchers and other administrators, can perhaps define a useful patient safety standard in addition to the ones currently in place (e.g., JCAHO) and determine how the UC campuses can better progress towards it.
- Develop a training curriculum that can be standardized and used at all UC medical centers to orient new and existing staff members on patient safety issues and performance improvement perspectives. There will first, however, need to be an inventory and a needs assessment done of the existing programs. Joanna Weinberg, JD, is leading this effort.
- We would also like to develop a curriculum for studying patient safety at the medical graduate level that can be offered at all five University of California campuses. We have assembled a panel of experts who will assess the suitability of such a program, and have written a proposal that we hope to be able to submit to the appropriate funding agencies for support. We have, at the moment, a proposal that is spearheaded by LuAnn Wilkerson, MD.
- Education, and advocacy activities across the state for leadership to familiarize one another with individual projects and successes. This also involves disseminating successful patient safety performance improvement strategies and a set of materials and tools that can educate community and rural hospitals in the state about patient safety issues.
- We also want to create general tools that can be readily customizable to any number of different healthcare institutions across the state and country to improve their own systems to ensure patient safety. This is specifically to help those community institutions that may not have the ready expertise for patient safety improvement that we do.
- Finally, SAFER California Healthcare will continue the work it has done this first year, reaching out to the healthcare foundations across the state and nationwide. The Alliance recognizes that many of its successes can come only from consistent collaboration with other agencies pursuing the same common goals and visions. The Alliance has started discussions with other California academic medical centers including the University of Southern California and Stanford University Schools of Medicine, who have expressed an interest in coordinating their patient safety efforts with ours.

SAFER California Healthcare will be successful when:

- Everyone knows its purpose;
- Other institutions are able to learn from us and adopt our practices, even as we are continually learning from and improving the performance of our own Alliance members;
- We affect public policy for the common good;
- Our researchers work collaboratively and resourcefully;
- Our patients are happier; and
- University of California healthcare systems are safer.

# Collaborations

We have been partnering with many different kinds of organizations. Internally, i.e., within the UC system, there is a large membership of medical directors, risk managers, clinical pharmacists, nursing directors, healthcare attorneys, performance improvement specialists, and clinical researchers. These members often act as a large group when serving on separate advisory boards, consortiums, and the Planning Committee.

Externally, we collaborate with:

- Government agencies
- SAFER California Healthcare has established relationships with several key state agencies. We have been working with the **Medical Board of California** and the **California Office of Statewide Planning and Development**. These are two agencies with key responsibilities for statewide patient safety efforts.
- Lee Hilborne is a member of the **Centers for Disease Control and Prevention** planning committee for a patient safety conference: “Making Health Laboratories A Partner in Patient Safety”. This establishes broader linkages to those developing a national patient safety agenda.
- Professional agencies
- Our group now works with the **California Medical Association**. We realize, through initial meetings, that we have common goals and that we can be much more effective working on patient safety issues together. We hope that this model will teach us how to work collaboratively with other key constituencies across the state (e.g., nursing, pharmacy) as we develop educational and related resources for patient safety.
- Academic institutions
- Several SAFER California Healthcare leaders are very involved in leadership positions with the **University HealthSystem Consortium**. Through this relationship, we are sharing patient strategies with 80 academic medical centers across the country. We have active representation on the **Clinical Evaluative Sciences Council**, the **Patient SafetyNet** program, the **Nursing Council**, and others. As an example, we have used the input from this group to guide our electronic event reporting system.
- Business
- We have started discussions with the individuals in California responsible for flight operations and safety for **United Airlines**. United Airlines is the largest carrier in California with key hubs in Los Angeles and San Francisco. We will be working with United to learn how they address airline safety and have asked them to work with us on educational program development.

Each of these collaborations will allow us to:

- Increase audience and the ability to disseminate education;
- Leverage power to encourage and enforce change;
- Ability to build a comprehensive, multidisciplinary network;
- Opportunity to study different systems, strategies; and
- Provide greater representation and broader impact when approaching external organizations.

Specifically, these collaborations will help to further the Alliance’s research capacity by:

- Providing synergy and comprehensive research capacity;
- Ability to share resources;
- Tap into different areas of expertise; and
- Allow us to be a more powerful force when competing for funding.

### *We've Cast a Wide Net*

When the Medical Directors first proposed to expand their scope, to apply to be a Developmental Center, and to intensify their focus on patient safety, we did so by focusing on our collective strengths. This presented both a challenge and an opportunity. Given that research, education and clinical care comprise the primary missions of the University, expanding our patient safety focus was a logical fit – leading to the formation of SAFER California Healthcare. To accomplish these goals, we quickly recognized the importance of expanding or internal representation to include additional key stakeholders in safe medical practices.

#### Strengthening Research Capacity

- UC has some of the country's top health services researchers
- We have affiliations with other key researchers
- Together we are building a core to share experiences, leverage expertise, and seek funding for key initiatives
- A summit of UC researchers, clinical leaders and educators is being planned

### *Learning from Other Systems*

We have only started to examine other systems and cultures. However, it is very clear that the potential is great to apply lessons learned from other industries and settings to healthcare. We have had initial meetings with individuals responsible for flight operations with United Airlines. Those discussions have been both enlightening and encouraging. While there are clearly differences between aviation and healthcare, there appear to be more similarities than differences.

For example, the airline industry does not permit its flight crews to perform “sunrise turnarounds”. That is, to fly a return or ongoing flight following an overnight trip. Yet in healthcare, our physicians and other staff regularly perform the equivalent type of activity (e.g., overnight operations followed by subsequent daytime surgery).

Cockpit crews have intensive programs to ensure that junior and senior team members work well together and established protocols for how to handle what any crew member believes represents an unsafe situation. For the most part, those relationships are much less structured in healthcare, whether between physicians and allied health personnel or between junior and senior members of the same discipline.

Building on these lessons from aviation, we have “piloted” a survey to assess the comfort that residents have seeking help from their senior attending physicians. The survey is designed to collect data on resident-attending communication and an appropriate research team will analyze the results and suggest interventions.

This survey was originally conducted at UC San Diego, but we have decided to expand this survey to all of our campuses. The findings will be generalizable to other academic and training programs across the country and should elucidate some of the root causes that threaten patient safety related to trainee supervision.

Airline cockpit and cabin crews regularly refer to checklists and protocols to ensure all steps in a procedure are safely performed. Healthcare teams, particularly physicians, have resisted checklists as being too much like “cookbook medicine”. We are working with United to help us develop programs for our physicians that parallel airline programs. We also anticipate observing some training sessions where United works with crew members to improve and strengthen relationships.

### *Sharing*

In addition to working with external organizations and bringing what we have learned to our colleagues, we have also used SAFER California Healthcare as a forum to share lessons from unsafe practices. For example, several of our centers observed problems with removal of central venous catheters. The information was shared amongst all campuses and the campuses have initiated educational interventions to prevent such occurrences from happening in the future. As an example, UCLA's SAFER publication from March and May highlight issues related to central venous catheter safety (attached).

### *How and Why it all Fits Together*

To meet the goals of SAFER California Healthcare, both as a Developmental Center and as a University of California organization, we have developed and strengthened ties within our system and from our system to other organizations. The first months of SAFER California Healthcare have been invested strengthening and interconnecting those ties and meeting with organizations outside the University, including our state medical association, local safety net hospitals, and others. Through these relationships, we have developed both the proposals submitted for pilot project consideration and others for which we will now seek funding. The partnerships we have developed will allow us to more aggressively compete for limited funds, expand the number of partners we have, and influence the number of individuals that can be impacted by our work. The proposals attached highlight some of the areas for our expanding focus.

### *Staying Focused*

Despite being spread over California, the Alliance has adapted incredibly well to its geographic constraints—in fact, in many ways our being in many places at the same time keeps us alert to all the ongoing activities of each region and campus.

As we reach out to organizations and build research and education projects with an eye towards collaboration and open dissemination—SAFER California Healthcare is egalitarian in that it wishes to engage all levels of the medical community in the discussion of patient safety. Urban hospitals and rural clinics are all intended to benefit from this large, collaborative infrastructure and have access to patient safety expertise to promote tangible changes in the way the medical care is delivered, just as all members of the healthcare team must be similarly engaged to affect a significant cultural shift.

Furthermore, the Medical Directors continue to meet face-to-face six to eight times annually and address many of the issues raised by SAFER California Healthcare. As the Alliance has strengthened the intercampus relationships, this group now also meets every two weeks by conference call. The Alliance therefore has the opportunity to discuss the patient safety agenda, make recommendations for clinical delivery interventions, and advocate for research.

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## Phase II

We are looking forward to discussions with AHRQ and WESTAT regarding phase II activities – and learning more about the experiences and plans from other centers. Given the success we have had over the first six to eight months of the DCERPS, we plan to continue the efforts we started as part of the phase I. We will work with our current collaborators and partners to develop new projects while at the same time build new relationships with other partners. We would hope that further interactions with other patient safety grantees would provide us the opportunity to share intervention strategies and use each other’s delivery systems as additional venues to test the generalizability of research findings.

In terms of educational materials to be developed, other parts of this document highlight our current efforts to reach medical and allied health professional students, patients, and the public. We hope as our Alliance grows, we will have additional resources necessary to more broadly disseminate our educational materials. Partnering with UCTV and the California Medical Association, for example, will allow us to reach broader public and professional audiences. Because of our ties with our delivery system, and our relationship with many teaching and public hospitals throughout the state, we expect to use our delivery systems to evaluate findings and transform them into action.

We would appreciate guidance from AHRQ regarding metrics that would be useful for judging our success.

	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
<b>Capacity Building</b>												
Hire Project Staff		X					X					
Identify Planning Committee and Advisory Panel Members				X	X							
Create Plan for Team Growth												
Plan Patient Safety Summit												
<b>Strengthening Research Efforts, Collaborations</b>												
Create SAFER California Healthcare Web Site			X									
Develop Curriculum for Workshop In Health Services Research												
Conduct Workshop For Planning Committee												
Obtain Guidance from Legal Counsel Regarding Patient Safety Research				X	X							
Select pilot study topic												
Develop pilot study methodology												
Evaluate Pt Safety Risks Associated With Training Programs												
<b>Developing Health Provider Continuing Education, Graduate program curricula</b>												
Develop Curricula for Undergraduate And Graduate Programs												
Develop plan for UC Health Provider Survey												
Explore Opportunities to Use UCTV to Disseminate SAFER Message												
<b>Implementing University-wide projects that share Information Systems Resources and Data</b>												
Implement Systemwide Electronic Event Reporting System												
<b>Translate into practice evidence-based recommendations, including patient education and advocacy</b>												
Consult with Medical Board of California on Pt Safety Legislation												X

**Legend**  
 Original Plan  
 Current Progress

## *What We Face*

The Alliance has started to make a difference – by breaking down barriers and building bridges between what have traditionally been independent organizations within our system. Our responsibility for training the majority of California trained physicians and a significant number of California trained allied health personnel, over time, assures that a growing number of California (and national) practitioners will be familiar with SAFER California Healthcare’s mission, products and services.

SAFER California Healthcare will be able to demonstrate early successes by the time the initial DCERPS funding is completed. We expect these early efforts will catalyze future collaborative research between the members of our Alliance and between our Alliance and our collaborators and partners. SAFER California Healthcare has already been successful in seeking some support for our research initiatives and for our Patient Safety summit. We will continue to seek funding through relationships with local organizations and foundations for pilot projects while looking to larger organizations in collaboration with our partners for higher profile, complex projects.

We are a large system with both independence and interdependence. Increasing the synergy between members of our system to conduct patient safety research is a primary goal as is expanding our network of partners and collaborators. We hope to increase our relationships with other AHRQ funded centers – and look forward during this site visit and through conference calls and meetings to identifying an increasing number of research centers with common interests.

## *Where We Need Help*

Despite the tools we have been able to amass, the expertise from our Advisory Board, Planning Committee, Executive Committee, and the resources at our separate institutions--there are several key operational areas where we welcome assistance.

### Operational Management and Planning

Tangibly networking and building communication lines between large, complexly organized institutions has been hard and we would appreciate a more systematic approach on how to best accomplish this. Although we have succeeded thus far in bringing together a sizeable leadership and have managed to build communication ties between them, the larger network—i.e. the larger body of healthcare providers at each of the separate medical institutions—remains relatively untapped. A primary challenge, therefore, is how to best operationalize the outcomes of our work at the actual delivery level.

We would also appreciate learning about any innovative communication strategies that can help better bridge our geographic separation.

### Getting to Self-Sufficiency

Although we are actively looking for foundations and agencies with an interest in funding research proposals, this is only one aspect of getting to self-sufficiency. We need to better understand how to seek public and private funding for operational purposes as well as project support. Better grantseeking tools would be helpful, as would an expert who can advise us on how to plan to become self-sufficient in two and a half year