

AGENCY FOR HEALTHCARE RESEARCH AND QUALITY

AHRQ

HHS Convening to Advance Patient Safety

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Safety issues are not equally distributed

Misdiagnosis, overdiagnosis, and poor treatment and management contribute to unsafe practices and quality inequities

Number and percentage of quality measures for which selected racial or ethnic groups experienced worse, same, or better quality of care compared with White

Racial or Ethnic Group	Worse	Same	Better
Black (n=190)	85 (45%)	86 (45%)	19 (10%)
AI/AN (n=110)	47 (43%)	50 (45%)	13 (12%)
Hispanic (n=190)	73 (38%)	84 (44%)	33 (17%)
NH/PI (n=73)	27 (37%)	33 (45%)	13 (18%)
Asian (n=172)	48 (28%)	76 (44%)	48 (28%)

Note: AI/AN = American Indian or Alaska Native; NH/PI = Native Hawaiian/Pacific Islander.

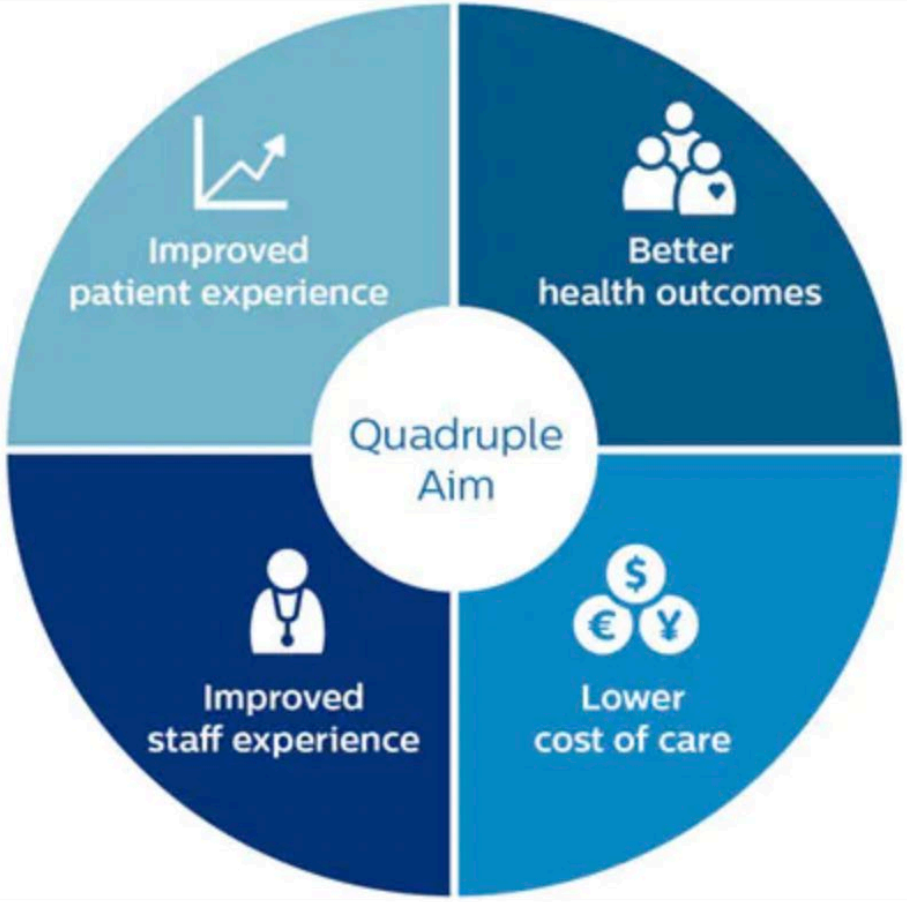
2022 National Healthcare Quality and Disparities Report

Healthcare is not safe, until it is safe for all

AHRQ Assists Healthcare Systems Deliver Safe & Effective Care

Safety Culture Drives Patient and Staff Experience leading to Better Outcomes

Patient and Family Engagement tools



Actionable Knowledge & Data for Improving Care Delivery

Hazard Identification and Mitigation tools

For Discussion:

- What are the most pressing evidence and other needs of larger and smaller systems to improve patient and workforce safety?
- What kinds of patient safety improvement measures are needed for internal operational efforts in different care settings?
- What data, tools, and advice are needed for a shift to a learning health systems approach in advancing patient safety?