FROM THE EXECUTIVE DIRECTOR

I am pleased to share with you the Center for Patient Safety’s successes in 2014 and invite you to join our 10-year celebration in 2015! We are proud to have been part of the solution to improving healthcare safety for ten years and expect to continue to do so for many more.

At the Center, we believe that safety is THE most important topic in healthcare and that culture is the KEY to safety. Our work focuses on developing and supporting a strong safety culture that leads to the outcome desired by everyone who works in healthcare, reduced patient harm.

The safety of patients, residents, visitors and workers in any healthcare setting is a requirement for building and improving the quality of care, patient and staff satisfaction, clinical processes and outcomes, sustainability of the organization – and ultimately the health of our communities.

In 2014, we have worked with over 400 organizations to assess the safety culture based on over 25,000 surveys; teach how to improve safety culture; safely report over 27,000 adverse events, near misses and unsafe conditions and identify how to improve care. These efforts allow the Center and those working with us to learn more about what medical errors occur, why and how to prevent them through shared learning, ultimately leading to reduced harm.

At the Center, we are proud of our work and are thankful to the organizations and individuals that support us and work with us to continuously improve the healthcare safety through Patient Safety Organization (PSO) services, safety culture assessments and training, educational opportunities and clinical safety improvement activities.

As we celebrate our first 10 years, from 2005 to 2015, we hope you will join us! We look forward to many more!

Becky Miller, MHA, FACHE, CPHQ, CPPS
Executive Director
MEDICAL DIRECTOR’S NOTE

Congratulations to the Center for successes in 2014 and many more to come in the future. It is a pleasure to work every day with dedicated individuals that continually strive to improve the safety of health care regardless of where that care occurs (physician offices, ambulances, hospitals, nursing homes, in the home).

I couldn’t be more proud to be part of the great work of the Center in 2014 and to be part of its 10 year celebration in 2015!

If you are looking for patient safety tips as a provider or consumer, ways to safely collaborate with others to improve safety across a community, state, region or nation or need help with education, training and support to improve your organization’s safety culture and learn more about prevention through event reporting, contact the Center.

We all want to prevent error and harm, a goal that takes a village to accomplish. The Center is a leader of our village!

Michael Handler, MD, MMM, FACPE
Medical Director
NATIONAL OUTREACH

The Center’s national outreach grew, providing services in 28 states, and sharing information via social media and the Center’s website to more than 60,000 consumers and healthcare providers throughout 2014.

Social Media

Facebook 49%↑  Twitter 74%↑  LinkedIn 109%↑

Website

71%↑ PAGES VISITED  77%↑ NEW VISITORS  75%↑ SITE VISITORS  5,000+ MORE THAN 5,000 E-NEWS SUBSCRIBERS

“These resources have helped us share the importance of safety with staff, physicians and visitors. Thank you for helping us by providing these great resources.”

Patient Safety Awareness Week

Recognizing the Importance of Safe Care

Again, in 2014, the Center provided resources and a customizable, downloadable toolkit used by over 100 organizations to help recognize efforts toward providing safe care 24 hours a day, 7 days a week, 365 days a year.

In collaboration with nursing and pharmacy colleagues, Patient Safety Awareness Week was recognized by a Proclamation from Missouri Governor Jay Nixon.

100+ HEALTHCARE PROVIDERS DOWNLOADED THE CPS TOOLKIT TO CELEBRATE PATIENT SAFETY AWARENESS WEEK.

CALL TO ACTION

Join Us, Follow Us, Find Us today on LinkedIn, Twitter, or Facebook, or subscribe to receive biweekly email updates on the latest patient safety trends and notices.

www.centerforpatientsafety.org  Sign up for the Safety Snapshot on the Center’s website.
In 2014, the Center shared its safety expertise through a variety of presentations to audiences varying from PSO colleagues, national EMS leaders, long-term care providers, health systems and hospitals, regulators and others.

### Presentations Around the Country

**Missouri Association of Nursing Home Administrators**

**COMPLYING WITH IMPENDING FEDERAL REQUIREMENTS FOR QUALITY AND SAFETY IMPROVEMENT ACTIVITIES AND PROCESSES WHILE MAINTAINING CONFIDENTIALITY.**

**Long Term Care Safety Culture Training**

**OPPORTUNITIES FOR EMS PROVIDERS TO IMPROVE THE QUALITY AND SAFETY OF CARE DELIVERY AND ADDRESS UNIQUE CHALLENGES TO LIABILITY EXPOSURE FOR EMS.**

**National ESO Healthcare Connected**

**INTEGRATION OF SAFETY CULTURE ACROSS VARIOUS HEALTH CARE PROVIDERS AND ITS IMPACT ON THE SAFETY OF CARE.**

**Missouri League of Nursing**

**Agency for Healthcare Research and Quality (AHRQ) PSO Meeting**

**THE CENTER SHARED ITS EXPERIENCE IN PROVIDING PSO SERVICES FOR HOSPITALS AND ASCS AS WELL AS EMS AND LONG TERM CARE, SHARING THE DIFFERENCES IN APPROACHES TO WORKING WITH VARIED PROVIDERS.**

**Illinois Critical Access Hospital Network Patient Safety Boot Camp**

**Joint Regulators Patient Safety Conference**

**Missouri Association of Nursing Home Administrators**

**National ESO Healthcare Connected**

**Centers for Medicare and Medicaid Services**

**Missouri League of Nursing**

**Agency for Healthcare Research and Quality (AHRQ)**

**American Nurses Credentialing Center**

**Missouri Association of Nursing Home Administrators**

### Publication: ACOs & PSOs

Accountable Care Organizations (ACOs), defined by the federal Affordable Care Act, are designed to provide incentives for healthcare providers to work together to coordinate patient care. One ACO requirement is to ensure the quality and safety of care delivered by organizations and providers within the ACO. The question is how can open and honest collaboration on quality and safety of care be supported across varying providers without incurring liability exposure for such collaboration? Participation with a PSO may be an answer! To explore this issue, the Center published, **PSOS: Essential to ACO Success in 2014**.

**CALL TO ACTION**

Let us know how we can help you or your organization by offering our expertise. Check out the Center Speaker’s Bureau for opportunities and expertise.
In 2014, CPS continued to be a leader in PSO activity and participation. Out of 65 PSOs reporting to AHRQ, CPS is one of only seven with more than 250 contracts and one of 12 with more than 10,000 reports.

National CPS PSO Services

PSOs promote the reporting of adverse events, allowing healthcare organizations to reduce medical errors and patient harm; learn more about what errors occur, why they occur and how to prevent them; and network with others on sensitive patient safety topics. Healthcare organizations can submit event information to the PSO where patient safety experts analyze the events across hundreds of healthcare organizations across the country, monitoring trends, issuing alerts, and sharing ways to prevent future harm.

The Center for Patient Safety is one of the largest and most active PSOs in the country, working with hospitals, EMS services, medical offices and long-term care facilities.

CALL TO ACTION

For more information on PSO reporting and case studies from the reports, see the Center’s Annual PSO Report Supplement.

www.centerforpatientsafety.org
“PSOs are becoming a more integral part of the patient safety landscape and a more important role in patient safety research… AHRQ is committed to continued support for the [PSO] program.”
Agency for Healthcare Research & Quality (AHRQ)

“EMS agencies can become members of PSOs and, not only achieve protection of their own processes, but also benefit from the collective knowledge and understanding provided by the PSO and its members.”
National Association of Emergency Medical Technicians (NAEMT)

EMS PSO Highlight
Fueling the Center’s leadership status as a national PSO was expansion of hospital and EMS PSO services across the United States in 2014.
In 2014, CPS joined the American Ambulance Association (AAA), expanding previous collaborations on education and participation in the AAA annual conference.
CPS EMS participants are proudly displaying decals showcasing their focus on quality and safety improvement.
CPS is pleased that the National Association of Emergency Medical Technicians (NAEMT) supports the importance of PSO participation and Just Culture in EMS.
CPS hosted a webinar for interested EMS professionals and organizations from across the country to specifically address legal and confidentiality protections available through PSO participation: Ask the Lawyer: PSOs & the Law (recording available online).

CALL TO ACTION
Find more information about EMS PSO Services online and see the Center’s Annual PSO Supplements.
PSO activity (continued)

**CALL TO ACTION**

Contact the Center at info@centerforpatientsafety.org for information about PSO participation if your organization wants to:

- reduce medical error and patient harm.
- learn more about what errors occur, why they occur and how to prevent them in a protected environment.
- network with others on sensitive patient safety topics.
- obtain federal legal and confidentiality protections that will enhance error reporting, learning and prevention.

**Learning, Sharing, Prevention**

PSOs were established to help providers learn about adverse events and share the learning to prevent harm. In 2014, CPS used a multi-faceted approach to share learning to improve the quality and safety of care within the provisions available through the federal Patient Safety and Quality Improvement Act of 2005.

**Education and Training**

In 2014, all CPS PSO participants had an opportunity to learn more about benefits of PSO participation and best practices through convenient webinars:

- A 2-Series Webinar for PSO Participants “PSO Participation and Protections – a Practical and Legal Perspective”, July 17, September 24
  Cohosted by NC Quality Center PSO and Center for Patient Safety PSO
- PSO Series 101-104 – To help Center PSO participants get the most value from their PSO participation, a series of training sessions were scheduled throughout the year

**Federal Interest & Court Activity**

The Affordable Care Act provision, Section 1311(h), requires hospitals with more than 50 beds to participate in a PSO to be eligible for health plans that are part of the Health Insurance Exchange. Although the initial implementation was delayed from January 2015, it is expected to become effective January 2017.

The Office of the National Coordinator published progress made since its July 2013 Health IT Patient Safety Action and Surveillance Plan. The [ONC Health IT Safety Program – Progress on Health IT Patient Safety Action and Surveillance Plan](http://www.hie-onc.gov/safety) continues to identify the important role of PSOs in identifying, learning and preventing health information technology related adverse events.

The [Agency for Healthcare Research and Quality](http://www.ahrq.gov), the federal agency overseeing the PSO program, continues to see the importance of the PSO program, as evidenced from the following statement of their new Director, Richard Kronich.

“PSOs are becoming a more integral part of the patient safety landscape and a more important role in patient safety research... AHRQ is committed to continued support for the program.”

Courts across the country have taken action on cases challenging the federal Patient Safety and Quality Improvement Act of 2005 confidentiality protections that encourage reporting, evaluation and sharing of information to reduce medical errors. All final judgments to date have supported the protections. [A summary of these court cases](http://www.centerforpatientsafety.org) is available at the Center’s Web site.

[www.centerforpatientsafety.org](http://www.centerforpatientsafety.org)
Safe Tables
Five Safe Tables were held in 2014 for hospital and EMS PSO participants. Safe tables allow participants to openly discuss adverse events and vulnerabilities, evaluate and analyze them and identify prevention strategies. Results of a causal analysis and identification of prevention strategies are consolidated and made available to participants.

Our first ever EMS PSO Safe Tables was a breakout session for EMS PSO participants during the 5th Annual EMS Patient Safety Conference and was a huge success. The session brought EMS professionals together to discuss adverse events, causal factors and prevention strategies. A participant’s comment confirmed we accomplished one goal of safe tables by encouraging reporting, discussion and evaluation of unsafe conditions: “We will be more open with the employees and our QI data outcomes to help self-directed performance improvement.”

Quarterly PSO Newsletters
Published for PSO participants and made available on the Center’s Website, newsletters include patient safety case studies from literature, safety alerts, recent events and an overview of CPS PSO reporting. Find a newsletter ►

Quarterly Dashboards for PSO Participants
Dashboards are provided to CPS PSO participants to summarize information reported to the PSOs for their own organization and the entire PSO database. The number of events by type, category, severity and level of harm are included.

PSO Alerts and Watches
Adding to PSO Alerts previously issued, in 2014, the Center began issuing PSO Watches providing information about less critical and time-sensitive, yet important, safety issues.

2014 hospital-based safe table topics:
• medical gas shut offs
• alarm fatigue
• hospital shooting

2014 EMS safe table topics:
• medication errors
• missing equipment
• stretcher malfunctions

2014 Alerts and Watches:
• a Kentucky court case ruling on PSO protections
• a Morphine vs. Midazolam mix-up
• stretcher malfunctions
• lack of availability of cricothyrotomy kits
• the need for vigilance in preparing for emergency situations

“I love the safety watch. I share it with our Patient Safety Committee and ask them to share it with their staff at staff meetings.”
CULTURE SERVICE ACTIVITY

A culture for safety is the KEY to improving patient safety! As such, the Center supports efforts to improve safety culture through Survey on Patient Safety Culture services and culture training.

Survey on Patient Safety Culture

31%↑
INCREASE OVER 2013

25,000+
MORE THAN 25,000 SURVEYS FROM HEALTHCARE STAFF

28 OF 42
NUMBER OF QUESTIONS IMPROVING FROM BASELINE TO REMEASUREMENT

80+
MORE THAN 80 HEALTHCARE ORGANIZATIONS HAVE UTILIZED THE CENTER’S CULTURE SURVEY SERVICES

“We love the Center’s patient safety culture survey feedback reports. The department level reports give a level of granularity we were lacking with previous surveys.”

“The Center staff has been extremely helpful and the reports and analysis are very beneficial! We’re excited about the opportunities the analysis helps point us to!”

CPS focuses solely on patient safety, including Just Culture and CUSP training, and therefore, the survey is a clear connection between the services provided by the Center to positively impact the safety and the quality of healthcare organizations across the country and support a culture that encourages reporting of adverse events.

The Center has administered over 25,000 safety surveys for over 80 hospitals, medical offices, home care and nursing homes, utilizing the Survey on Patient Safety Culture (SOPS) measurement and diagnostic tool created by the Agency for Healthcare Research & Quality (AHRQ).

Results of ongoing safety assessments reveal improvements and continuing challenges.

Highest scoring dimensions:
- Teamwork within units
- Supervisor/manager expectations & actions promoting patient safety
- Organizational learning - continuous improvement

Greatest improvement over time:
- Dimension: Nonpunitive response to error
- Dimension: Handoffs & transitions
- Question: Staff feel like their mistakes are held against them
- Question: When an event is reported, it feels like the person is being written up, not the problem
- Question: Important patient care information is often lost during shift changes

Priorities for improvement are identified in the three lowest scoring dimensions:
- Handoffs & transitions
- Nonpunitive response to error
- Teamwork across units

www.centerforpatientsafety.org

Sign up for the Safety Snapshot on the Center’s website.
As an effort to sustain the Center’s initial work in Just Culture from 2007, our Just Culture trainers were very busy in 2014, providing customized training upon request and focusing on training for long-term care as part of a grant from the Missouri Foundation for Health and for EMS in collaboration with the Missouri Ambulance Association.

“The Center’s reach and dedication of their staff to collaborative efforts, particularly their introduction of Just Culture to long-term care, distinguishes them in this work.”

CALL TO ACTION
Contact the Center at info@centerforpatientsafety.org to schedule your next survey or let us help you identify and prioritize safety culture improvement needs at your organization. Learn more about the Center’s culture services online.

“The Center has introduced Just Culture to long-term care organizations to insure the safety of residents in nursing homes.”

Just Culture

As an effort to sustain the Center’s initial work in Just Culture from 2007, our Just Culture trainers were very busy in 2014, providing customized training upon request and focusing on training for long-term care as part of a grant from the Missouri Foundation for Health and for EMS in collaboration with the Missouri Ambulance Association.

LTC AND HOSPITAL
JUST CULTURE TRAINER
KATHY WIRE JD, CPHRM

EMS
JUST CULTURE TRAINER
LEE VARNER, EMT-P

Center for Patient Safety
Annual Report
SPECIAL PROJECTS

In 2014, the Center continued to facilitate national projects in collaboration with the Missouri Hospital Association with funding from the AHA’s Hospital Research and Education Trust.

CLINICAL COLLABORATIVES

“Implementation of CUSP was so successful in one unit that a process was developed to roll it out among other floors throughout the hospital.”

Prevention of Catheter-Associated Urinary Tract Infections (CAUTIs) – Acute Care and Nursing Homes

Twenty-two units (ICUs, medical/surgical and emergency departments) within ten participating hospitals continued work to improve unit safety culture and reduce CAUTIs. Support for these efforts includes national and state-based coaching calls for participants, defined data collection, culture evaluation and learning and on-site visits. Congratulations to the following hospitals participating in these collaboratives.

- Carroll County Memorial Hospital
- Centerpoint Medical Center
- I70 Community Hospital
- Landmark Hospital of Joplin
- Mineral area Regional Medical Center
- Nevada Regional Medical Center
- Northwest Medical Center
- Saint Louis University Hospital
- St. Luke’s Hospital
- Twin Rivers Regional Medical Center

New in 2014 is participation in a national CAUTI prevention project with long-term care. Ten nursing homes in Missouri are participating in this project to improve their facility safety culture and reduce healthcare acquired infections.

- Excelsior Springs
- Katy Manor Nursing Home District
- Living Community of St. Joseph
- McLarney Manor
- Nodaway Nursing Home
- Oregon Care Centers
- Pleasant View Nursing Home
- Schuyler County Nursing Home
- Sunnyview Nursing Home
- Tiffany Heights

CALL TO ACTION

Contact the Center at info@centerforpatientsafety.org to learn how to obtain the Center’s culture assessment, training and PSO services to assist in QAPI implementation and safety improvement. Find more information about LTC safety services online.

www.centerforpatientsafety.org
“The key to successful implementation of these activities is educating the C-suite and getting their involvement in the project.”

**Hospital Engagement Network Participation**

In 2014, the Center continued its participation supporting Missouri’s activity as part of the national Hospital Engagement Network (HEN) to reduce hospital-acquired conditions by 40% and readmissions by 20%. The Center led the following clinical and safety topics for the initiative.

- Central-line Associated Blood Stream Infections
- Catheter-associated Urinary Tract Infections
- Ventilator-associated Events
- Surgical Site Infections
- Sepsis
- C.Diff
- Safety Culture Assessment
- Comprehensive Unit-based Safety Program (CUSP) Training

**University of Texas AHRQ Patient Safety Research Grant**

The Center is excited to have begun a 5-year project in 2014 as part of a project with the University of Texas Health Sciences Center in Houston. The project is a $1.2 million grant for patient safety research by the Agency for Healthcare Research and Quality run by Associate Professor Yang Gong, MD, PhD. The project will investigate patient safety events and the procedures healthcare organizations follow for reporting. The results will identify ways to improve reporting and effective learning from medical incidents.
8th Annual Patient Safety Conference

“This was a fantastic event to attend. The planning, speakers, environment, location, and people were all wonderful. I enjoyed the entire event and look forward to future events. Thank you for all your hard work and dedication.”

Moving to St. Louis in 2014, the Center hosted its 8th Annual Conference, again recognizing safe care is the focus 24/7/365. The day brought national speakers to St. Louis to share and network with over 120 leaders and stakeholders in patient safety. Highlights of the day included returning speakers, Dr. Michael Leonard and Scott Griffith plus an inspirational Keynote from Dr. Stephen Post. Again in 2014, attendees were inspired by the poster session sharing of successful safety practices.

The following 2014 poster topics are now included in a compendium of practices available on the Center’s Website.

- An Organizational Approach to Effective Communication of Lessons Learned from Safety Events; MacNeal Hospital
- Assessing Harm Risk to Increase Patient Safety; CoxHealth
- Redesigning Blood Specimen Collection and Labeling; Barnes Jewish St. Peters Hospital
- Use of the VAP bundle in Chasing zero and VAP free ICU for 48 months; Houston Methodist Willowbrook Hospital
- Reducing Falls on Inpatient Rehabilitation; Saint Francis Medical Center
- Interprofessional Health Partners Program; AT Still University
- Focusing on Safety: St. Louis Children’s Hospital Initiates a Daily “Morning Briefing”; St. Louis Children’s Hospital
- ATSU-KCOM Open School Chapter; A. T. Still University
- Choosing Improvement Projects Wisely: Selecting Successful Projects for YOUR Organization; TheEvidenceDoc
- Evidence Transfer in Diagnosis: Exploring Value and Reliability; University of Missouri Health Sciences Library
- Armed Violent Intruder Education Research Project; Research Medical Center

CALL TO ACTION
Want to see these project presentation summaries and more virtual posters? Visit our Sharing the Learnings page!
5th Annual EMS Annual Conference

“Very worthwhile conference. Great speakers. Exciting to be on this path with the Center.”

The Center for Patient Safety’s Annual EMS Patient Safety Conference was a success, attended by over 110 EMS professionals! Great speakers brought new ideas and concepts that helped stretch the imagination of those attending.

- David Williams from the Institute for Healthcare Improvement shared the Plan-Do-Study-Act method for organizational change and success.
- Tom Judge, Executive Director of Lifeflight of Maine having years of EMS experience, offered practical advice regarding the changes that he has witnessed in EMS. He also discussed how organizations can utilize a culture of safety to help manage risk.
- Michael Bachman from Wake County EMS in Raleigh, North Carolina, shared his insights and experience regarding the coordination of patient safety using mobile integrated healthcare, focusing on “For the patient, not to the patient”.

Additional education and training activities are highlighted in Learning, Sharing and Prevention on page 8-9.

“I think this was the best EMS Patient Safety Conference that I have attended. I am looking forward to next year’s conference.”
Supporters & Volunteers

Thank you to organizations and individuals who voluntarily support the Center’s work.

Board Members
Steven C Bjelich, FACHE-D, Chair
Edmond B Cabbabe, MD, FACS, Vice-Chair
Richard A Royer, Secretary-Treasurer
Thomas Holloway
S Gordon Jones, Jr, MD
Susan Kendig, JD, MSN, RNP; new Board Member in 2014
Leslie Porth, PhD-C, MPH, RN; new Board Member in 2014
Steve Smith, MD
Brent Vanconia
Gail Vasterling, JD
Bruce Williams, DO

Advisory Panel

PSO Advisory Committee
EMS PSO Advisory Committee
LTC Steering Committee

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Missouri Hospital Association

Silver Sponsor
Missouri State Medical Foundation

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Missouri State Medical Association
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Sphere3
C.C. Swarens
The St. Johns Companies
University of Missouri Health Care
VergeSolutions
Jeanette Warren
Jennifer Wilbers

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A Message from the Executive Director

We are excited about our 10th year as a part of the solution to address the multitude of issues surrounding patient safety. Safety culture is the KEY! Medical error prevention and reduced patient harm occurs in organizations with a strong safety culture, supporting and encouraging the reporting of adverse events, near misses and unsafe conditions; reporting that leads to learning what and why errors occur and to sharing of solutions.

BECKY MILLER, MHA, CPHQ, FACHE, CPPS
Executive Director

Center for Patient Safety Team

MICHAEL HANDLER, MD, MMM, FACPE
Medical Director

KATHY WIRE, JD, MBA, CPHRM
Project Manager
LTC PSO Onboarding & Implementation
LTC CAUTI Project
Just Culture Trainer

EUNICE HALVERSON, MA
Patient Safety Specialist
Hospital PSO Onboarding & Implementation
EMS PSO Onboarding & Implementation

LEE VARNER, BS EMS, EMT-P
Project Manager, EMS Services
EMS PSO Onboarding & Implementation
Just Culture Trainer

ALEX CHRISTGEN, BS BA
Project/Operations Manager & Analyst
Survey on Patient Safety Culture
PSO Technical Support

TINA HILMAS, RN, BSN
Project Manager
Clinical Collaboratives

JENNIFER LUX
Office Coordinator

DIANA PHELPS
Administrative Assistant

AMY VOGELSMEIER, PHD, RN
Researcher

No photo
CPS has worked with hundreds of organizations since 2005, and many continue to work with CPS in various projects or for services to improve patient safety. Additionally, many new organizations begin working with CPS every day.

Adair County Ambulance District
Air Evac EMS Inc. (110+ bases in 15 states)
Allen County Hospital
Alton Memorial Hospital
American Ambulance Association
American Society of Cons. Healthcare Advocates
Andrew County Ambulance District
Audrain Ambulance District
Barnes Jewish St. Louis
Barnes-Jewish St. Peters Hospital
Barnes-Jewish West County Hospital
Barton County Memorial Hospital
Bates County Memorial Hospital
Bates County Memorial Hospital
Big River Ambulance District
Boone Hospital Center
Boone Hospital Center Ambulance Service
Bothwell Regional Health Center
Buchanan County EMS
Callaway Community Hospital
Callaway County Ambulance District
Cameron Ambulance District
Cameron Regional Medical Center
Cape County Private Ambulance Service Inc.
Capital Region Medical Center
Carondelet Health
Carroll County Ambulance District
Carroll County Memorial Hospital
Cass Regional Medical Center
Cedar County Memorial Hospital
Center for Behavioral Medicine
Centerpoint Medical Center
Center/Pointe Hospital
Central Jackson County Fire Protection District
Chariton County Ambulance District
Chillicothe Fire Department
Christian Hospital EMS
Christian Hospital Northeast-Northwest
Citizens Memorial Healthcare
Citizens Memorial Hospital
City of St. Charles Fire Department
City of St. Louis Fire Department
Clark County Ambulance District
Clayton Fire Department
Cole Camp Community Ambulance District
Cole County EMS
Community Hospital – Fairfax
Cooper County Memorial Hospital and Clinics
Cox Health Systems EMS – Ava Area
Cox Health Systems EMS – Christian Co.
Cox Health Systems EMS – Dade Co.
Cox Health Systems EMS – Greene Co.
Cox Health Systems EMS – Republic, MO
Cox Health Systems EMS – South Barry Co.
Cox Health Systems EMS – Stone Co.
Cox Health Systems EMS – Webster Co.
Cox Medical Center Branson
Cox Monett Hospital
CoxHealth
Crittenton Children’s Center
Cushing Memorial Hospital
DeKalb-Clinton Ambulance District #1
Des Peres Hospital
Doctors Hospital, LLC
Ellent Memorial Hospital
Endoscopy Center East
Endoscopy Center Liberty
Endoscopy Center North
Excelsior Springs Fire Dept.
Excelsior Springs Hospital
Excelsior Springs Hospital Convalescent Center
Fitzgibbon Community Home Health
Fitzgibbon Hospital
Forest Park Community Hospital
Fort Osage Fire Protection District
Freeman Health System
Freeman Neosho Hospital
Fulton State Hospital
Gerald Area Ambulance District
Golden Valley Memorial Hospital
Grand River Regional Ambulance District
Greater Joplin Area EMS (METs)
Hannibal Regional Hospital
Harrison County Community Hospital
Harry S. Truman VA Hospital
Hawthorn Children’s Psychiatric Hospital
HCA Midwest
Heath Literacy Missouri
Healthcare Services Group
Heartland Long Term Acute Care Hospital
Heartland Regional Medical Center
Hedrick Medical Center
Hermann Area Ambulance District
Hermann Area District Hospital
Herrin Hospital
Howard A Rusk Rehabilitation Center
I-70 Community Hospital
Illinois Critical Access Hospital Network
Independence Care Center of Perry County
Inter City Fire Protection District
Iron County Hospital
John J. Pershing Veterans Affairs
Johnson County Ambulance District
Kansas City Cancer Center
Kansas City Fire Department
Katy Manor Nursing Home District
Keaton Fire and Rescue Protection District
Kenneth Hall Regional Hospital
Kindred Healthcare
Kindred Hospital Kansas City
Kindred Hospital Northland
Kindred Hospital St. Louis
Kindred Hospital St. Louis – St. Anthony’s
KU Medical Center
Lafayette Regional Health Center
Lake Regional Health System
Lakeland Behavioral Health System
Landmark Hospital of Cape Girardeau
Landmark Hospital of Columbia
Landmark Hospital of Joplin, LLC
Lee’s Summit Medical Center
Liberty Fire Department
Liberty Hospital
Lifeflight Eagle
Lincoln County Ambulance District
Lincoln County Medical Center
Linn County Ambulance District
Living Center, The
Living Community of St. Joseph
Madison County Ambulance District
Madison Medical Center
Maries-Osage Ambulance District
Marion County Ambulance District
Marthasville Community Ambulance District
Maryland Heights Fire Protection District
Mclarney Manor
MedChoice Clinics
Mehlville Fire Department
Memorial Hospital of Carbondale
Memorial Hospital of Carbondale
Menorah Medical Center
Meramec Ambulance District
Mercy Continuing Care Hospital
Mercy Health
Mercy Health System EMS (Aurora)
Mercy Health System EMS (Cedar Co)
Mercy Health System EMS (Dallas Co)
Mercy Health System EMS (Mt. Vernon)
Mercy Health System EMS (Mtn View)
Mercy Health System EMS (Shannon Co)
Mercy Health System EMS (Springfield)
Mercy Health System EMS (Wright Co)
Mercy Hospital Aurora
Mercy Hospital Berryville
Mercy Hospital Cassville
Mercy Hospital Jefferson
Mercy Hospital Joplin
Mercy Hospital Lebanon
Mercy Hospital Springfield
Mercy Hospital St. Louis

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COMING IN 2015!

Throughout the year, be looking for the Center’s celebration activities!

Outreach & Thought Leadership
- Hosting the Center’s 9th Annual Patient Safety Conference
- Hosting the Center’s 6th Annual EMS Patient Safety Conference
- Hosting and Providing Resources for 2015 Patient Safety Awareness Week
- Continued Expansion of Social Media Outreach
- Speaker’s Bureau Opportunities
- Publications on Key Safety Topics

Culture Services Growth and Value
- Expanding Survey on Patient Safety Culture (SOPS) Assessments for Hospitals, LTC, Home Care, Medical offices and EMS
- Just Culture Training Series for LTC
- Expanding Just Culture Training for EMS in collaboration with the Missouri Ambulance Association

Special Projects
- Continuing the CUSP/CAUTI ED Project in collaboration with the Missouri Hospital Association
- Continuing the CUSP/CAUTI LTC Project in collaboration with the Missouri Hospital Association
- University of Texas AHRQ Patient Safety Research Grant Participation

Education and Training
- Hosting an EMS Quality Webinar Series
- Speaker’s Bureau Opportunities
- Hosting a Second Victim Train the Trainer Sessions in collaboration with University of Missouri HealthCare
- Collaboration with MHA on its Quality Learning Series

PSO Growth and Value
- Enhancing Reporting, Analysis, Sharing and Learning Opportunities
- Educating and Training on PSO Participation and Key Safety Issues
- LTC PSO Participant Recruitment

CALL TO ACTION
Join the Center's efforts in 2015 to improve the safety of health care delivery and reduce patient harm. Visit our sponsor information page to learn how to become a Safety Sponsor or contact us directly to get involved.

www.centerforpatientsafety.org
888.935.8272

ABOUT THE CENTER FOR PATIENT SAFETY
The Center for Patient Safety was founded by the Missouri Hospital Association, Missouri State Medical Association and Primaris as a private, non-profit corporation to serve as a leader to fulfill its vision of a healthcare environment safe for all patients and healthcare providers, in all processes, all the time.