Missouri Center for Patient Safety

2011 ANNUAL REPORT

THE MISSOURI CENTER FOR PATIENT SAFETY (MOCPS) REMAINS DEDICATED TO IMPROVING PATIENT SAFETY SINCE OUR FOUNDING IN 2005

In serving as a hub and coordinator for health care providers, state agencies, and others with an interest in improving patient safety, MOCPS recognizes that engaging these entities and individuals in our work means a better understanding of how harm happens and greater opportunities to find and share solutions to prevent patient harm.

Patient Safety Organization (PSO)

2011 was a year of growth in MOCPS PSO services to enhance opportunities available to our participants from the federal Patient Safety and Quality Improvement Act of 2005 (PSQIA).

For the first time, the MOCPS is reporting what we are learning about safety events (adverse events, near misses and unsafe conditions).

- The most common type of events reported to the MOCPS PSO are falls, followed by medication events and healthcare associated infections.
- Although the majority of reported events (52%) resulted in no harm, the remaining events did lead to some level of patient harm – *this is the harm that we want to prevent!*
- The most frequently reported cause of an event occurring is a failure in communication and teamwork.

(See articles on pages 4-5 for more about MOCPS PSO reporting and data.)

- The **EMS PSO Project** gained 26 new ambulance services, bringing the total to 54 EMS participating agencies. *(See EMS article on page 4 for more)*
- MOCPS PSO training sessions reached more than 900 health care professionals.

Missouri is a national leader in PSO participation compared to the other 77 federally-designated PSOs. At the end of 2011, the MOCPS:

- had received more event reports than 80% of the other PSOs.
- is one of a minority (20%) of PSOs contracted with more than 100 organizations.
- is one of a minority (25%) of PSOs that is successful while NOT part of another organization.

(Source: Agency for Healthcare Research and Quality)

People, Priorities and Learning Together (PPLT)

Comprehensive Unit-based Safety Program (CUSP) Thirteen Missouri hospitals participated in MOCPS' **CUSP Communication and Teamwork Tools**. This new training module builds on the Center's previous **Basics of CUSP** module, in which more than forty hospitals took part. Developed by researchers at Johns Hopkins University, **CUSP** is a safety culture program that is designed to educate and improve awareness about patient safety and quality of care – building a basis for incremental safety improvement.

CUSP/ Stop HAI (Healthcare Acquired Infections)
CUSP/Stop CLABSI (Central line blood stream infections) – In 2011, 15 hospitals participated in this initiative, expanding statewide the 2009 Kansas City region initiative to reduce CLABSIs. Why? Because approximately 250,000 CLABSIs occur annually in the US, are associated with a death rate of 12-25% and costs of up to $56,000 per infection.

PROGRESS IS BEING MADE!
Between 2010 and 2011, 37 fewer CLABSIs occurred at participating hospitals, reducing at a rate faster than the national rate.

CUSP/Stop CAUTI (Catheter-associated urinary tract infections) – In 2011, 29 hospitals statewide participated in this initiative, including a Kansas City region collaborative. Why? Because CAUTIs cost the health care system $ 565 million and cost over 8,000 lives annually.

CAUTIs ARE ON THE DECLINE!
Participating hospitals are using catheters more appropriately, and reducing infections by implementing successful evidence-based practices and strategies as part of this national project.

(Funding for the PPLT initiatives is provided by the Missouri Hospital Association, AHA Health Research & Education Trust, and Blue Cross and Blue Shield of Kansas City.)

Survey on Patient Safety Culture (SOPS) – The Center began offering services to automate safety culture surveys for hospitals and medical offices as well as providing reports that identify priority areas for improvement – it is well known that culture impacts quality, safety, and staff satisfaction; therefore, it is important to be aware of an organization's safety culture and take steps toward improvement. *(See article below)*

Greater participation means more health care professionals recognize and act on the prevention of medical errors, and more patients will go home healthy, as intended. ■

SURVEY ON PATIENT SAFETY CULTURE

In the Fall of 2011, the Missouri Center for Patient Safety started a new service line to promote the **AHRQ Survey on Patient Safety** in an online format. Since implementation, the affordable service has received much interest from facilities in Missouri as well as other states. The survey is an excellent tool to measure the safety culture of hospitals and medical staff offices.

The Center now provides the capability to conduct the **AHRQ Hospital Survey on Patient Safety** for an entire hospital, or just for individual departments, on a quarterly or annual basis. The survey is provided in an online format, allowing staff to take the survey in an anonymous, convenient, online environment. *No more paper, no more data entry, no more hand tabulations!*

At the conclusion of the survey period, comprehensive reports show areas of improvement or decline, compare results to national benchmarks, and provide suggestions for next steps and action plans.

The Center also began providing the **AHRQ Medical Office Survey on Patient Safety** in similar format with comprehensive result reporting.

Services are also available for nursing homes.

Contact Alex Christgen, achristgen@mocps.org, for more information. ■

A Note from the Executive Director:

A mistake, an error, a never event, a sentinel event, an adverse event. In healthcare it all means the same thing. Someone, a procedure, or a system unintentionally harmed or even killed a patient. One patient harmed is too many – whether it is in a hospital, nursing home, in the home, or an ambulatory care setting.

The Missouri Center for Patient Safety (MOCPS) seeks to learn what mistakes occur, understand why they occur, and facilitate implementation of solutions to prevent errors. Our efforts over the past six years have brought health care professionals together to learn how to assess and improve the culture for health care safety, work together to identify improvement strategies, and implement those strategies.

Of particular importance is our continued certification as a federally-designated Patient Safety Organization (PSO), allowing us to support and encourage health care providers to share information about vulnerabilities in the health care system that can lead to harm under the umbrella of federal protections provided by the Patient Safety and Quality Improvement Act of 2005.

In 2011, the MOCPS continued efforts to expand on previous successes. Most significantly:

- **Adverse Event Reporting** – As a federally-designated Patient Safety Organization (PSO) the MOCPS, for the first time, obtained sufficient information for reporting of medical errors, near misses and unsafe conditions. Additionally, the first-ever model of PSO services for ambulance providers was expanded.
- **Culture and Clinical Improvement –** Through the Center's People, Priorities and Learning Together (PPLT) initiative, our work to enhance the safety culture, a necessity to improve safety, expanded through the Comprehensive Unit-based Safety Program (CUSP) Teamwork and Communications initiative, offering Survey on Patient Safety (SOPS) services, providing CUSP training for a national project of over 80 neonatal intensive care units, and expanding Kansas City area healthcare acquired infection reduction collaboratives across Missouri.
- **Education and Training –** A successful Annual Conference that included awarding the Missouri Excellence in Safe Care Award to an additional four organizations, launching the MOCPS Speaker's Bureau, and providing education on PSO-related training to over 900 participants.
- **Expanded Communication Outreach** through an enhanced Web site, social media presence on Linked-in, Facebook and Twitter, and launch of a Press Kit for the media.

As we look toward 2012 and beyond, the MOCPS will forge forward within a rapidly evolving and challenging national landscape building on the momentum we have established over the past six years, moving closer to our vision of "a health care environment safe for all patients, in all processes, all the time".

I invite anyone interested in improving patient safety and reducing patient harm to join us in our efforts. Go to www.mocps.org to see more about our work, including Sponsorship opportunities.

Becky Miller

THE MOCPS BOARD OF DIRECTORS

The Board of Directors governs the Center's operations and is vital in directing the Center's strategies to achieve its mission to lead efforts to improve patient safety and the quality of health care delivery through collaboration. The Center's Board is comprised of the following members, representing the Center's Founding Members and the public.

2011 BOARD EXECUTIVE COMMITTEE

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Lake Waukomis

(Ex-officio) **BECKY MILLER, MHA, CPHQ, FACHE**
Executive Director

Additional information about the Center's Board Members is available on the Center's website. ■

2011

MOCPS published 85 blog posts at www.mocps.org in the second half of 2011 following a new WordPress website build. Join our more than 350 blog subscribers at www.mocps.org, follow us on Twitter, like us on Facebook, and join us on LinkedIn.

350

BLOG & SOCIAL MEDIA

The new blog format on the MOCPS website makes it easy to follow MOCPS activities and find timely information and resources. The MOCPS is also now on **Facebook**, **Twitter**, and **Linked-In**, building a community to leverage social networks to expand its message about the need and importance of improving health care safety. ■

MEDIA OUTREACH

MOCPS hosted a **Patient Safety Awareness Week Tele-Conference in April** with Host Nick Haines. Statewide media were invited to dial in to the audio conference and/or use the recorded audio files of national experts discussing the importance of the projects the MOCPS has brought to Missouri. The audio files are available on the MOCPS website. ■

PREVENTING FALLS

In 2008, over 19,700 older adults died from unintentional fall injuries. MOCPS staff shared personal stories of the impact of falls on loved ones.

"As with most things, awareness is the first step," said MOCPS director, Becky Miller. *"For the sake of our older loved ones, it is important to take time to consider how falls can be prevented in their lives."* ■

19,700

(Press release: "Falls are Leading Cause of Injury Deaths for 65+ Population," Sept. 23, 2011)

PATIENT SAFETY AWARENESS MONTH

Celebrating April as Missouri Patient Safety Awareness Month and its first five years, the Missouri Center for Patient Safety continues its ongoing effort to learn about and prevent medical mistakes locally and regionally.

"The work of MOCPS is proving to be a successful model in creating the synergy needed to exponentially improve the safety of health care, through coordination, collaboration, and facilitation with health care providers, professionals and patients," said MOCPS director, Becky Miller. ■

APRIL

(Press release: "Safe Health Care – What Missouri Providers are Doing for You!" April 14, 2011)

PEOPLE, PRIORITIES & LEARNING TOGETHER

As part of the Missouri Center for Patient Safety PPLT initiative, 13 Missouri hospitals have joined CUSP Teamwork & Communication Tools, launched in June, 2011, to increase patient safety and eliminate medical errors by improving communication and coordination of care at the bedside.

"These short briefings allow unit staff members to stay informed, review work, make plans, and move ahead rapidly," said MOCPS project manager, Kimberly O'Brien. *"They give fuller, more frequent participation for bedside caregivers who often find it impossible to get away for the conventional hour-long improvement team meetings."* ■

TEAM

(Press release: "13 Missouri Hospitals Target Increased Patient Safety with the Missouri Center for Patient Safety's CUSP Teamwork and Communications Tools," July 11, 2011)

REDUCING CATHETER INFECTIONS

Twenty-five percent of hospital inpatients have an indwelling urinary catheter at some point during their hospitalization.

"States, hospitals and units learn from each other while working together in the collaborative model," said MOCPS assistant director, Carol Hafley. *"The Center's role as state coordinator provides hospitals with assistance during implementation to foster this learning and develop a support network to ensure the project's success with every facility."* ■

LEARNING

(Press release: "27 Missouri Hospitals Aim for 25% Reduction in Catheter-Associated Urinary Tract Infections by 2012," July 7, 2011)

ABOUT MOCPS

The Missouri 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 health care environment safe for all patients, in all processes, all the time.

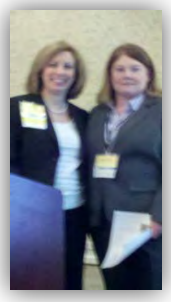
2011 - A YEAR FOR ENHANCED MOCPS COMMUNICATION

Enhanced communication methods in 2011 helped MOCPS expand its important message about improving patient safety to many diverse stakeholders - including the public, health care professionals, government and the media.

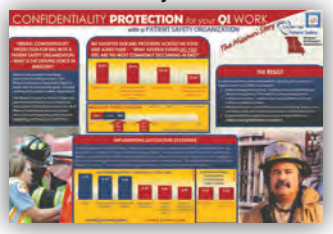
- A streamlined, informative and improved **website**
- Integrated social media outreach through **Linked-in**, **Facebook**, and **Twitter**
- Launched a **Speakers Bureau**
- Developed a **Press Kit** to better inform the media of the Center's important work

Sharing the Center's message nationally and across the state…

- Sharing best practices occurring in Missouri – "Establishing a Patient Safety Evaluation System (PSES)" was presented by **Michelle Hilburn, Jefferson Regional Medical Center**, a MOCPS PSO participant, at the Annual PSO Meeting of the federal **Agency for Healthcare Research and Quality** (AHRQ).



- **American Ambulance Association** meeting – Recognition as a 2nd place Poster Winner for the Missouri **EMS PSO Project**.



- Establishing a Successful Patient Safety Evaluation System (PSES) national Webcast for PSO participants across the nation in collaboration with PSOs in **Kansas**, **North Carolina** and **Michigan**. ■

MEET THE MOCPS STAFF

Executive Director
Becky Miller, MHA, CPHQ, FACHE

Becky is experienced in directing and managing healthcare quality, safety, compliance, medical staff and customer relations efforts, as well as health policy activities. As Executive Director, Becky uses her expertise to direct a successful nonprofit organization, develop and lead Patient Safety Organization (PSO) services, and lead efforts to establish successful clinical collaborative activities (see Becky's message on page 2).

Assistant Director:
Carol Hafley, MHA, BSN, RN, FACHE

Carol has experience in both management and clinical roles. Her clinical background includes cardiac and general surgery, ICU, and home health care. Her expertise in physician documentation, medical coding, and reimbursement makes her leadership role at MOCPS a true asset to the more than 200 health care providers relying on MOCPS for successful patient safety advancement.

Director of Program Development:
Kimberly O'Brien, MHA

Kimberly combines her knowledge and experience leading operations in integrated healthcare delivery systems and a state regulatory division with a background in patient safety, risk management, performance improvement and health care regulatory compliance programs.

Office/Project Coordinator:
Alex Christgen

Alex has experience as a data and project coordinator in both the public and private sector. Her healthcare background includes risk, quality, safety, infection control, employee safety, patient satisfaction, physician engagement and statewide healthcare emergency planning. Together, her experience provides a direct benefit to MOCPS patient safety efforts through experienced and successful data management processes and new project implementation.

Executive Assistant:
Marilyn Lieneke

Marilyn provides Executive Assistant support for the MOCPS, bringing experience from the public sector in providing executive and administrative assistance to support the Center's staff and stakeholders.

"If you don't report it - you don't know it happened; If you don't know it happened - you can't do anything about it; Until you analyze it - you don't know how to prevent it; For safety, identifying the vulnerabilities in the system is what is important, not the statistics. PSOs have the privilege of seeing issues across numbers of providers…we need to capitalize on this high level perspective".

James Bagian, MD, PE
Chief Patient Safety and Systems Innovation Officer, University of Michigan
April 2012 – AHRQ Annual PSO Meeting

NATIONAL HEALTH REFORM & PSOs

Two provisions within the federal **Patient Protection and Affordable Care Act** (PPACA) health reform legislation includes **Patient Safety Organization** (PSO) activities.

1. Beginning January 1, 2015, PSO participation will be required for hospitals to be eligible to participate in health plans that are part of health insurance exchanges. **PPACA** Section 1311 requires states to have health insurance exchanges in place by January 2014, and, beginning January 2015, for hospitals with more than 50 beds to have an established Patient Safety Evaluation System (PSES) in place, an activity that is only applicable for providers that work with a PSO.

2. PPACA Section 399KK calls for the federal **Agency for Healthcare Research and Quality** (AHRQ) to develop a program supporting PSOs in helping hospitals with high readmission rates improve their performance. It also requires PSOs and hospitals to report on processes to improve readmission rates. ■

KEY POINTS ABOUT PSO SAFETY EVENT REPORTING

- The purpose of PSO reporting **is** to learn what safety events (errors, near misses and unsafe conditions) occur and why, and share the learning with others to prevent error and patient harm.

- The purpose of PSO reporting is **not** to compare organizations, regions or states.

- Inadvertent medical errors, near misses and unsafe conditions exist in any health care setting every day. The number of events reported to a PSO does not equate to a "dangerous provider" – it reflects awareness by the provider of potential for error, and willingness to contribute to a "pool of learning" that can exponentially improve patient safety across the nation. ■

THE EMS PSO PROJECT HITS ITS STRIDE IN 2011!

Emergency Medical Services (EMS) represents a vital element of the health care system; in fact, they may be the first health care professionals a patient sees during a medical event. As such, EMS professionals are as accountable for patient safety as other health care professions.

In 2009 the MOCPS and the **Missouri Ambulance Association** (MAA) launched a partnership with funding from the **Missouri Foundation for Health** (MFH).

The EMS PSO project brings federal confidentiality and privilege protection to quality and patient safety data for **Missouri's EMS ambulance districts**, fire and hospital-based services, and first-responder providers. Additionally, a PSO supports agencies in working together to improve regional quality and safety.

MOCPS is pleased to report an active and productive year for the EMS PSO project:

- MOCPS received 26 new ambulance service contracts, bringing the total to 54 participating EMS agencies
- The adverse event reporting system with stroke and heart attack-related quality indicators is fully functioning
- Six **MAA** members became certified as Just Culture instructors. They are now delivering training to EMS managers and staff across the state and beyond
- More than 60 EMS providers attended the second annual EMS PSO Day in Columbia on April 17, 2011

Spearheaded by the **MAA**, and now led by the **MOCPS EMS PSO Advisory Group**, this project brings together a broad base of EMS providers and agencies across the state to work collaboratively to reduce the frequency of serious events and to improve the quality of EMS patient care. ■

MOCPS PSO DATA -

Highlights of Reporting through December 2011, the Learning and Sharing Begins!

TYPES OF REPORT RECEIVED:

- 4,370 adverse events
- 330 near misses
- 19 unsafe conditions

DEFINITIONS:

Adverse Event
Any injury caused by medical care

Near Miss
An unplanned event that did not result in injury, illness, or damage – but had the potential to do so

Unsafe Condition:
A situation that exists that could lead to a "near miss" or "adverse event"

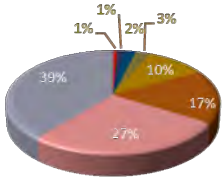
LOCATION OF REPORTED EVENTS/ HARM BY LOCATION

(IN ORDER OF FREQUENCY):

- medical service units
- surgical services
- oncology
- step-down
- critical care services

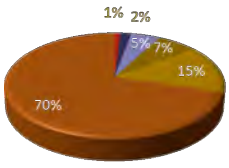
HARM FROM FALLS:

- 39%, temporary harm
- 27%, no harm
- 17%, emotional distress
- 10%, additional treatment
- 5%, permanent/severe permanent harm or death.



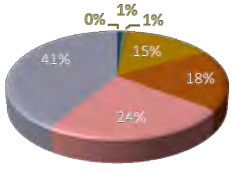
HARM FROM MEDICATION EVENTS:

- 70%, no harm
- 15%, emotional distress
- 5%, temporary harm
- 2%, additional treatment
- 1%, death



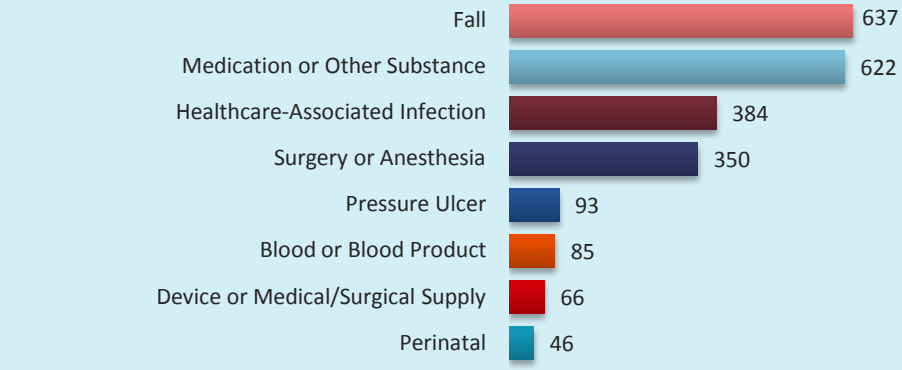
HARM FROM HEALTH CARE ASSOCIATED INFECTIONS

- 41%, additional treatment
- 24%, temporary harm
- 18%, no harm
- 2%, permanent harm, death or emotional distress. ■

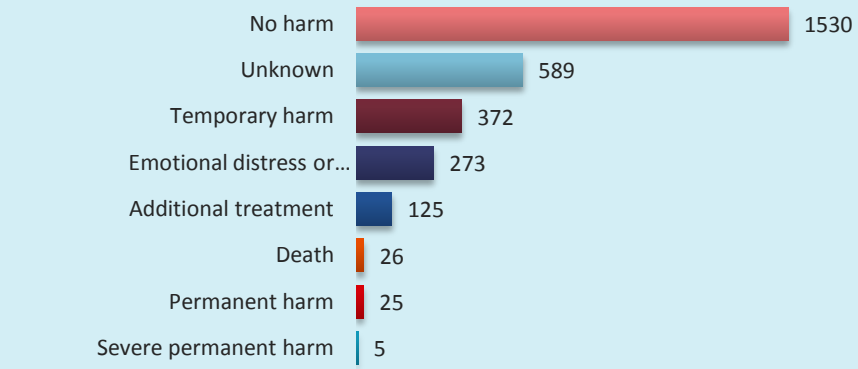


EVENT CONTRIBUTING FACTORS

FREQUENCY OF REPORTED EVENTS



HARM FROM REPORTED EVENTS



SUPPORTING PATIENT SAFETY

In 2011, the Missouri Center for Patient Safety used new and traditional means to share news and information with the public and health care providers.

INSPIRING CHANGE... IMPROVING CARE
MOCPS - 5TH ANNUAL CONFERENCE

In 2011, the Missouri Center for Patient Safety (MOCPS) hosted its fifth annual conference in Columbia. ***Inspiring Change…Improving Care*** brought more than 250 healthcare professionals together to share ideas, seek learning, recognize award-winning safety strategies from Missouri colleagues, and network with national safety experts.

Our guests included health care professionals and others who care about improving patient safety: executives, physicians, nurses and clinicians from a variety of health care settings, health care payors and regulators, and others who have a vested interest in improving the safety of care.

US Health & Human Services Regional Director, Judy Baker shared a federal perspective on the importance of safety improvement work.
Keynote Speaker, **David Maxfield**, who authored the new book ***Change Anything***, shared research on the science of change and how changing human behavior is the surest and fastest path to personal success, improvement in patient safety and many other aspects of human interaction.

Other speakers included **Candace Carnahan**, telling her story of how important it is to speak up about risky situations, and **Dr. Arthur Culbert** of **Health Literacy Missouri**.

The conference also featured a panel on high priority issues for Missouri providers from the 2010 annual conference along with an array of poster presentations.

Winners of the **Missouri Excellence in Safe Care** award shared their successful projects (see right), and attendees got to hear the latest updates on the Missouri Center for Patient Safety activities and how you can get involved.

The conference also provided an opportunity for attendees to network with other patient safety leaders, learn from state experts, and share their own successes through poster displays. ■

(Press release: "Missouri Patient Safety Conference: Learning about Changes to Continually Improve Health Care Safety," April 2011)

COMING IN 2012!

Patient Safety Organization (PSO)

- Publishing the first report of adverse events, patient harm and learning in Missouri.
- Gaining more reports from more contracted organizations.
- Analysis of PSO data to gain more learning for reporting and sharing that will lead to prevention.
- Implementing "Safe Tables" bringing providers together to learn about, discuss, and identify prevention strategies for high priority, high risk, high harm events.
- 5th Annual PSO Participant Day.
- 3rd Annual EMS PSO Participant Day.

EMS PSO

- Through the funding provided by the **Missouri Foundation for Health** (MFH), our aim is to have at least 50 percent of Missouri's ambulance services, reporting adverse events and quality indicators to the PSO by December 2012.
- Pursuing the MOCPS EMS PSO project as a model to improve the culture, quality and safety of ambulance care across the nation.

People, Priorities and Learning Together (PPLT)

- Expanded healthcare acquired infections (HAI) initiatives
- Expand collaborative efforts into other clinical topic areas.
- Integration of CUSP into clinical initiatives.
- Expansion of Survey on Patient Safety (SOPS) for hospitals, medical offices and nursing homes. ■

2011 MISSOURI EXCELLENCE IN SAFE CARE AWARD WINNERS

Citizens Memorial Healthcare (CMH) of Bolivar received an award for the project "Tele-Health for Improved Patient Outcomes." Home monitoring with CMH's fully integrated electronic medical record system showed reductions in ER and hospital admissions for home health patients and long term care (LTC) residents. Physician appointments and conferencing via video is used in ten clinics and five LTC sites.

North Kansas City Hospital's project "No Tumbling After: A Multifaceted Approach to Falls Reduction," was another award-winner. The hospital received the award for using a combination of multidisciplinary team recommendations and clinical staff solutions in a sweeping approach to falls reduction, leading to a 40 percent reduction in inpatient fall rates.

Research Medical Center of Kansas City was recognized for the project "Using Just Culture in Nursing Peer Review" for making its Just Culture philosophy operational by using project tools and algorithms for clinical and non-clinical issues. This reduced the risk of subjectivity in patient analyses, placing focus only on the facts of each case.

St. Mary's Health Center of Jefferson City received an award for its project, "Implementing the Modified Early Warning Scoring (MEWS) System," which increased the use of St. Mary's Health Center's Medical Emergency Team (MET) through use of the MEWS tool. This tool identifies patients at high risk of cardiopulmonary arrest (Code Blue), and led to nearly a 10 percent decrease in mortality rates, through early recognition and treatment. ■

TO GET THE LATEST INFORMATION ON CENTER ACTIVITIES, VISIT US AT www.mocps.org

Please visit our website to learn more about our supporters and participants.

BE A SAFETY SPONSOR: HOW YOU CAN HELP!

The Missouri Center for Patient Safety values partnerships with organizations and individuals who want to support improvement in health care quality and patient safety. **Because MOCPS is a not-for-profit organization, donations are tax-deductible.**

There are three ways to join the effort to spread safety culture throughout the health care community in Missouri: **individual donation**, **organizational sponsorship levels**, and/or supporters can **sponsor an event or initiative**. Opportunities include:

- Education and training activities
- Patient Safety Awareness Week activities and events
- Clinical collaboration
- Surveys, analysis and reports
- Adverse event reporting system
- Research and analysis
- Publications and reports

MOCPS makes the process easy; you can donate online in minutes. And, of course, a MOCPS staff member can answer your questions and provide more information. ■

THANK YOU! TO ALL OF THE MOCPS SUPPORTERS

FOUNDING MEMBERS:

- Missouri Hospital Association
- Missouri State Medical Association
- Primaris

SPONSORS:

- Healthcare Services Group - *Platinum*
- Missouri State Medical Foundation - *Silver*

PANELS AND COMMITTEES:

- Advisory Panel
- Hospital Advisory Committee
- PSO Advisory Committee
- EMS PSO Advisory Committee

MOCPS PARTICIPANTS:

Over the past six years participation in the Center's initiatives has spread throughout the region. We thank all organizations and individuals that have and are actively involved in our important work to improve the safety of health care delivery! ■

MEET MOCPS STAFF JOINING IN EARLY 2012

Eunice Halverson, MA
Patient Safety Specialist

Eunice joined the MOCPS team in March 2012, providing her extensive experience in health care management, policy, quality improvement and risk management. Eunice provides leadership for the MOCPS PSO activities, serving as the primary contact for PSO related activities.

Ginger Schelp, RT, MHA
Project Manager

Ginger joined the MOCPS team in May 2012 bringing her expertise in health care management, clinical care, and healthcare service integration to the MOCPS to lead the MOCPS component of the national and state Hospital Engagement Network activities. ■

2011

Missouri Center for Patient Safety

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