CPS SHARES SUCCESSES
AT ANNUAL AHRQ PSO MEETING

ROCKVILLE, MD The Center for Patient Safety (CPS) Executive Director, Becky Miller, and staff, Alex Christgen and Lee Varner, joined other PSO representatives from around the country at the Agency for Healthcare Research and Quality (AHRQ) Headquarters in Rockville, Maryland for the 7th Annual AHRQ PSO Meeting.

As one of 85 PSOs certified nationally, operating within 30 states and District of Columbia, CPS continues to be a leader in PSO activity.

CPS is:

- 1 of nine PSOs with more than 250 PSO contracts
- 1 of only 44 PSOs receiving reports
- 1 of 16 PSOs with more than 10,000 reports
- 1 of 38 PSOs providing services to all specialties
- 1 of 2 PSOs providing services to EMS services
- 1 of 13 PSOs receiving reports in all AHRQ defined safety categories

HIGHLIGHTS OF THE MEETING:

- AHRQ and CMS representatives stated the regulations for Section 1311(h) of the Affordable Care Act are in the process of being written for an effective date of January 1, 2017. The Section requires hospitals with more than 50 beds to participate in a PSO in order to be eligible to participate in Health Insurance Exchanges.
- AHRQ Director, Dr. Richard Kronick, noted that the AHRQ and CMS have "reached an agreement in principle" regarding coordination of PSO activity and protections and needs of CMS state surveyors to ensure regulatory compliance. Additional information should be available to surveyors, providers and PSOs in the near future.
- A mock trial highlighted recent challenges to the PSO protections, raising points from both the plaintiff and defendant perspectives. Presenters cautioned that PSO participants need to have well-defined policies and report to their PSO in order to successfully claim the federal protections of the Patient Safety and Quality Improvement Act of 2005 in court. If you need help updating your PSO policy, contact Eunice Halverson.
- CPS presented on a panel with the Michigan Keystone Center PSO and the Maryland Hospital Association PSO highlighting best practices to perform Safe Tables, the challenges and successes, and how each organization performs its Safe Tables.
- The AHRQ has provided, and will continue to develop, resources to help providers better understand PSOs and select a PSO on its Web site at www.pso.ahrq.gov.
PSOs in the news

We have seen significant interest in PSOs over the past year as more EMS leaders learn the benefits and opportunities for PSO participation. One EMS leader who has taken interest in PSO’s is Allison J. Bloom, Esq. Ms. Bloom is well known as a recognized attorney, writer, and board member of the NEMSMA. Ms. Bloom shares broad experience in EMS as well as high degree of passion and interest in Mobile Integrated Health Care. This interest has led to several articles that have been published in EMS Insider. Watch for more articles as EMS patient safety and quality continues to become an important topic.

If you missed Ms. Bloom’s articles you can find them on the Center’s website. Watch for future articles and papers as we all take greater interest in PSO’s to provide safe care and reduce patient harm. We are excited to have Attorney Bloom as one of our speakers at the Center’s EMS Patient Safety Conference on October 30.

GATHERING of Eagles and Dr. Jay Reich

The EMS State of the Sciences Conference, also known as “The Gathering of Eagles” is a unique conference featuring rapid fire presentations and networking with some of the most highly respected leaders in EMS. Each year the conference offers opportunities to learn the latest science and advances in EMS, including current research, data and industry innovations. Those selected to present at the conference are medical directors from the largest EMS systems in the United States.

In addition, it features other leading experts from around the world who present relative information to advance the practice of EMS.

This year Dr. Jay Reich, medical director from the Kansas City Fire Department (KCFD), was selected to present on work being done at his department. Reich’s presentation titled “PSOs as SOPs! Getting Patient Safety Organization Buy-in for EMS CDI” shared how participating with a Patient Safety Organization (PSO) can protect the quality and safety work in EMS, as well as support the EMS staff including the medical director. Since PSOs are fairly new to EMS, Reich outlined some of the benefits of PSO participation, such as information and key examples of how KCFD is implementing processes to improve patient safety and quality improvement. His presentation focused on the ways a PSO supports the EMS staff to become proactive in preventing adverse events and unsafe conditions instead of just being reactive.

Dr. Reich explained the Patient Safety Quality Improvement Act and the importance of shared learning through reporting adverse events, near misses and unsafe conditions. The Center for Patient Safety thanks Dr. Reich for his support of our PSO, as well as choosing to present information about PSOs. We hope to see more topics about EMS quality and patient safety at the Eagles Conference in the future. Dr. Reich’s presentation can be found at the Gathering of Eagles website under 2015 presentations.

EMS data committee

Data never sleeps and neither does our committee! They are working hard to focus efforts around improving and gathering additional data. One special project led by Jason Shearer is the committee’s effort to learn more about behavioral health and EMS. Part of this work includes on-scene emergency interactions as well as inter-facility transfers.

The Center was approached by EMS leaders and other stakeholders who would like to learn how this patient population impacts EMS, how resources are utilized as well as to identify safety concerns. The PSO offers a confidential space where data can be submitted, de-identified, aggregated and protected under the PSQLIA. “The obvious place to do this work is with the PSO,” remarked Jason White, who has been working with leaders around the state to heighten awareness. The collection of data relative to this patient population is starting as a pilot program and then will be expanded to other PSO participants. Jason went on to say “Our EMS professionals will see another way the PSO supports them”. If you would like to learn more, contact Lee Varner.

PATIENT safety conference

Don’t forget to mark your calendars for the EMS Patient Safety conference. This year’s conference will be October 30th at the Hollywood Hotel and Casino in Saint Louis. We are excited to announce our speakers:

- Peter Antevy, MD
- Allison Bloom, Esq.
- Anthony Garza, MD
- Daniel Patterson, PhD

In addition, Safe Tables will be offered again this year. This shared learning opportunity is only open to PSO participants. Registration will open soon.

GATHERING of Eagles Information

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Now is the time to reserve your place for the EMS Patient Conference on October 30. Reserve early and you will gain more exposure on the Center’s website.

PATIENT safety conference

The work that many of you started years ago in Missouri is now growing coast to coast. Two national contracts were added to the Center’s PSO: Paramedics Plus and LifeTeam Air Evac. The Center is now providing EMS PSO services in 19 states including, most recently, the state of New York. Likewise we are excited to welcome Canandaigua Rescue Squad (CRS) to our EMS PSO family. CRS is a progressive EMS service that has a keen interest in patient safety and quality. Chief Ken Beers quickly saw the importance and value of PSO services.

Within days of first seeing an overview from the Center, he completed his PSO contract and policy to begin receiving PSO services. Congratulations to CRS, Paramedics Plus and LifeTeam Air Evac for taking proactive steps and supporting patient safety in their communities. We look forward to announcing new participants in the near future.

SPONSORS and vendors

Now is the time to reserve your place for the EMS Patient Conference on October 30. Reserve early and you will gain more exposure on the Center’s website.
The Center for Patient Safety Presents
2015 Webinar Series

ES Quality & Patient Safety
LEARNING SERIES
for EMS Leaders and Providers

The Center for Patient Safety staff has the opportunity to meet and listen to EMS leaders and providers from around the country. Frequently we are asked “what is patient safety and how do we improve it”? We believe patient safety is composed of many areas and can’t be defined by one process. Therefore, the goal of this series of free webinars is to offer you information and content that addresses these questions as well as human factors, quality, risk, culture and other new and innovative ideas. If you have the desire to learn and would like to improve what you do as an EMS professional, please join us. Each webinar will focus on topics designed to enlighten and educate as well as encourage participants to take a proactive approach to reducing patient harm.

Register for these webinars at: www.centerforpatientsafety.org/upcoming-events

The Center for Patient Safety (CPS) continues to build on culture services to support adverse event reporting and the learning that results from increased reporting.

JUST CULTURE

Just Culture, the balance between human and system accountability, is a hot topic in patient safety and reduction of errors in today’s healthcare industry. CPS fully supports the implementation of a Just Culture in healthcare organizations across the continuum of care. Reporting events is important as it leads to knowledge and process changes that contribute to future error prevention. Organizations with cultures that support open communication of errors in a non-punitive environment, a “just” culture, are more likely to experience higher levels of improvement in patient safety.

The Center has provided and supported education of hundreds of healthcare individuals across the country to implement Just Culture in hospitals, long-term care, EMS services, individual organizations, and state agencies.

Are you practicing Just Culture in your organization?

If not, you are missing a valuable opportunity to improve your organization by working towards a culture of safety with shared accountability. In partnership with the Missouri Ambulance Association, the Center supports, coordinates and teaches this foundational approach for EMS leaders. If you are interested in learning more, contact the Center or the Missouri Ambulance Association. Classes are being planned for the remainder of the year and 2016. The next Manager class will be on June 22 at the Central Jackson County Fire training center.

Thanks to the certified Just Culture trainers who take time to teach this important program, often as unpaid volunteers:
• Mark Alexander
• Dr. John Russell
• Kim McKenna

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EMS Quality & Patient Safety LEARNING SERIES for EMS Leaders and Providers

SESSIONS:

Mar 11
#1 March 11 at 1200 noon (Central) - FREE
Human factors and the delivery of prehospital medicine: A primer for EMS leadership
Presented by: Joseph R. Keebler, PhD, Assistant Professor, Wichita State University, Department of Psychology and Paul Misasi, MS, NRP, CPPS, Clinical Manager, Sedgwick County EMS

Jun 30
#2 June 30 at 1200 noon (Central) - FREE
Quality Management in EMS: It’s everybody’s game
Presented by: Megan Sorensen, RN, CEN, MHA, Clinical Manager, Critical Care Transport, Children’s Hospital-Omaha, Nebraska. Graduate Studies Coordinator, EMS Education, Creighton University

Sep 3
#3 September 3 at 1200 noon (Central) - FREE
Second Victim: Caring for the Caregiver
Presented by: Laura Hirschinger, RN, MSN, MHA, Clinical Manager, Critical Care Transport, Children’s Hospital-Omaha, Nebraska. Graduate Studies Coordinator, EMS Education, Creighton University

Dec 2
#4 December 2 at 1200 noon (Central) - FREE
Patient Rights, Risk and Refusal
Presented by Lee Varner, BS EMS, EMF-P, Project Manager at Center for Patient Safety and Kathy Wire, JD, MBA, CPHRM, Project Manager at Center for Patient Safety

Questions? Call the Center for Patient Safety at 888.935.8272 or email info@mocps.org
As the Center grows, so grows our data. Our goal is to share information to help prevent the occurrence of events at your organization. Looking at the diagram we see areas of concern, which is a good reminder that we should reach our patients. Looking at the “No Harm” area could be misleading as it might be part of a “Near Miss”. That is when an event almost occurs but doesn’t reach the patient. Near miss information is important to share as it might offer an opportunity to prevent a future event. Not all events are due to human errors; most are the result of a poor design, system or process. Regardless, reporting any event, near miss or unsafe condition helps all of us prevent similar events in the future.

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Reporting to the PSO

Did you know that almost anything can be reported to the PSO? This includes concerns about patient hand-offs or the transfer of care as well as concerns around hand hygiene or infection control. The value of a PSO is to safely share information so we can all learn, it’s not always about adverse events. Make a commitment and set up a plan to submit your events, near misses, unsafe conditions and other documents each week or month. If you need training or assistance, contact us for hands-on support.

In addition, if you are not finding opportunities such as adverse events, near misses or unsafe conditions, just ask your crews. Share with them what the PSO is and how it can support their mission each day on the frontlines. In addition, implementing a Just Culture will offer your providers an improved culture of learning as they become confident to self-report without fearing punitive repercussions.

High Alert Medications

In a case submitted to the CPS PSO, a pediatric patient received a higher than standard dose of Propofol and required resuscitation. In another case, a battery failed on an insulin IV pump and went unnoticed. Approximately one in every five reported PSO medication events involved a high alert medication such as anticoagulants (warfarin, heparin, Lovenox), Propofol, insulin, hypoglycemic agents, opioids and so forth. Events related to prescribing, dispensing, administering and monitoring errors.

High-alert medications are drugs that bear a heightened risk of causing significant patient harm when used in error. Although mistakes may or may not be more common when using these drugs, the consequences of an error are clearly more devastating. Use lists provided by the Institute of Safe Medication Practices (ISMP) to determine which medications require special safeguards to reduce the risk of errors.
UPCOMING events.. i

JUNE 10
BENEFITS OF AHRQ PSOS: SUCCESS STORIES
Webinar
REGISTER

JUNE 22
EMS JUST CULTURE TRAINING
Central Jackson County Education Center
Blue Springs, Missouri
REGISTER

JUNE 30
EMS QUALITY MANAGEMENT: IT’S EVERYBODY’S GAME
Webinar
REGISTER

SEPTEMBER 3
EMS SECOND VICTIM: CARING FOR THE CAREGIVER
Webinar
REGISTER

SEPTEMBER 24
SECOND VICTIM TRAIN-THE-TRAINER
Mid-America Transplant Services
Saint Louis, Missouri
REGISTER

OCTOBER 30
EMS PATIENT SAFETY CONFERENCE
Hollywood Hotel & Convention Center & Casino
Saint Louis, Missouri
REGISTER

CPS SPEAKERS on the circuit

CPS staff are always on the go, sharing their expertise at national, state, and local conferences, events, and meetings. If you see them at an upcoming event near you, stop and say hello!

- Lee presented at Chillicothe Fire Department in Chillicothe, Missouri in February on Patient Safety and the Culture of Safety
- Dr. Michael Handler was a Keynote Speaker at the UMKC School of Medicine in Kansas City, Missouri on the importance of patient safety in March
- Becky presented at the Annual Agency for Healthcare Research and Quality PSO Meeting in Rockville, Maryland in April
- Becky and Kathy spoke to the Society of Healthcare Risk Managers in Wisconsin on “Balancing PSO Protections, Transparency and State Reporting” in April
- Lee presented Protecting Learning and Preventing at the Zoll Summit in Denver, Colorado in May
- Becky presented at the Hospital Association’s Strategic Quality 101 Conference in Missouri in May
- Becky and Kathy will be presenting to students at the UMSL College of Nursing on Safe System Processes and High Reliability Organizations in June
- Kathy will present High Reliability: The Key to Quality and Value for LeadingAge in St. Louis, Missouri in June
- Lee will present Protecting Learning and Preventing at the Kansas EMS Conference in Topeka, Kansas in August
- Becky and Dr. Handler will be presenting to the Missouri Chapter of the American College of Physicians in Osage Beach, Missouri in September
- Kathy presents twice in Texas this Fall, first on Patient Safety Organizations and then Just Culture
- Kathy will conduct a half-day pre-conference session for LeadingAge in St. Louis, Missouri and again in Kansas City, Missouri on Root Cause Analysis: Fertilizer for a Safe and Just Culture
- Becky and Kathy will be presenting, “PSO’s: Your Partners for Managed Care Success” at the Annual Conference of the American Society of Healthcare Risk Managers in Indianapolis, Indiana in October
- Lee will present Protecting Learning and Preventing at the Air Medical Transport Conference (AMTC) in Long Beach, California in October

Have you noticed this icon?
Look for this icon to find additional resources in the articles. You’ll find links to downloadable templates, websites and other resources.
Available in the electronic version of this newsletter.

FOR MORE INFORMATION, CONTACT ANY MEMBER OF OUR PSO TEAM
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For additional information on the Center’s PSO activities, resources, toolkits, upcoming events, safety culture resources, and more, visit our website at www.centerforpatientsafety.org or follow us on Twitter @ PtSafetyExpert for the most up-to-date news.

ABOUT THE CENTER:
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.

www.centerforpatientsafety.org

NOTE
Some articles contained within this newsletter may reference materials available to Center for Patient Safety PSO participants only. If you have questions about any Center-resources or articles within this newsletter, please contact the Center for Patient Safety at info@mocps.org or call 888.935.8272.

The information obtained in this publication is for informational purposes only and does not constitute legal, financial, or other professional advice. The Center for Patient Safety does not take any responsibility for the content of information contained at links of third-party websites.