Message from the Executive Director

The Center for Patient Safety’s seventh year was one of growth.

One highlight in 2012 was establishing a “doing business as” (DBA) for the Center for Patient Safety to more accurately reflect the work that we continue to perform outside of Missouri. As we experienced growth in services along with our new name, we were also pleased to welcome new staff members and our new Medical Director, Dr. Michael Handler.

Our mission remains the prevention and reduction of harm to individuals who receive medical care. To achieve this target, we have focused our efforts on learning what kinds of medical mistakes occur, understanding why they occur, and facilitating implementation of solutions to prevent harm. To show you how we are reaching our goals, I am pleased to share the following highlights of 2012 with you and encourage you to read more about our work throughout this report. I also invite you to follow our work through our Web site, Twitter, LinkedIn, and Facebook.

- As a federally designated Patient Safety Organization (PSO), we saw a 21 percent increase in hospitals and ambulatory surgery centers reporting events to the Center and an 84 percent increase in the number of events reported. Today, with more than 8,800 events in the Center’s database for analysis, we can expand on the learning and sharing that can lead to prevention of adverse events.

- Culture is the underlying maker or breaker of safe care. As such, the Center takes a lead role in safety culture assessment and training. In 2012, more than 7,700 safety culture assessments were performed through our automated process to collect and report responses to the AHRQ Survey on Patient Safety (SOPS). Additionally, over 200 individuals were trained in Just Culture, the Comprehensive Unit-based Safety Program (CUSP) and the 2nd Victims Program.

- 2012 was a year for completing and launching clinical collaboratives. Wrapping up three years of work to reduce healthcare acquired infections, led to saving of lives, patient harm and is estimated to have saved over $4 million in healthcare costs. Additionally, we began new efforts in collaboration with the Missouri Hospital Association for the Missouri Hospital Engagement Network (HEN), leading efforts to reduce falls, surgical site infections and ventilator associated events as well as expanding the CLABSI and CAUTI reduction activities.

In 2013 and beyond, we expect even more growth in PSO services, culture and clinical activities as we take a leading role in the continual efforts to fill gaps in healthcare systems that result in harm.

As always, we invite you to join us on our journey by visiting our website for resources and information about safe care, the Center, and opportunities to support our work through sponsorships.

Sincerely,

Rebecca G. Miller, MHA, CPHQ, FACHE
Executive Director

BECKY MILLER
MHA, CPHQ, FACHE
Executive Director
Center for Patient Safety
Message from the Medical Director

As medical director of the Center for Patient Safety, one of my goals is to enhance the engagement of physicians in the Center’s important work in support of its vision, “a healthcare environment safe for all patients and healthcare providers, in all processes all the time”.

As physicians, we strive to provide the best and safest care for our patients every day; the Center’s knowledge and resources can assist us in that goal. For example, as a federally-designated Patient Safety Organization (PSO), the Center supports safe, confidential reporting of adverse events, near misses and unsafe conditions by licensed healthcare providers. Such reporting allows for analyses to identify learning that can lead to prevention of harm in addition to providing venues for diverse healthcare providers to come together to collectively share, learn and implement error prevention strategies.

In addition, the Center’s safety culture services help providers assess the safety culture in hospitals, medical offices, nursing homes and pharmacies, including identification of priority areas to improve the culture to better support safe care. And, trainers are also available on Just Culture and the Comprehensive Unit-based Safety Program (CUSP).

While studies reveal preventable harm continues to occur and providers continue to be challenged for resources and legal pressures increase (evidenced by Missouri’s recent loss of medical malpractice caps), the Center’s work becomes even more important.

I welcome and challenge you to become involved!

See my entire message online.

Sincerely,

Michael Handler MD, MMM, FACPE

Dr. Michael Handler is the Vice President of Medical Affairs/CMO at SSM St. Joseph Hospital West in Lake Saint Louis, Missouri
2012 was a very active year for PSO services at the Center.

- Reporting hospitals and ambulatory surgery centers grew by 21 percent in 2012, expanding the number of organizations receiving support to improve patient safety, participate in the sharing and learning, and obtain federal protections that are available through the Center PSO.
- An additional 2,762 reports of medical errors, near misses and unsafe conditions were reported to the PSO in 2012, bringing the Center’s database of voluntarily reported events to over 8,900 by year end 2012.
- Quarterly training on reporting and PSO participation was held throughout the year. Consistently since 2010, 92-93 percent of all reports submitted to the Center as a PSO are adverse events, 7 percent are near misses and <1 percent are unsafe conditions (see table below).

### 2012 EMS PSO ACTIVITY SUMMARY

Steady progress has been made as participation in EMS PSO services continued to climb, ending the year with a total of 70 ambulance service contracts. We expanded the focus of EMS PSO Day to include many different topics related to patient safety. The Center hosted the third annual EMS Patient Safety Conference with over 80 individuals representing more than 60 EMS agencies.

The spread of Just Culture in EMS continued in 2012, with several Manager’s Training classes being conducted by Missouri Ambulance Association certified trainers in Missouri and out-of-state. Additionally, we launched the EMS PSO News, and recognized the first adverse event reports from EMS being reported to the PSO.

The Center participated in a poster session hosted by the Kansas Healthcare Collaborative at their Fourth Summit on Quality, with a display entitled “Improving Quality and Safety in Emergency Medical Services through a Patient Safety Organization”, giving the Center the opportunity to educate participants on this great work being carried out by EMS in Missouri.

As the Center continued to focus efforts on the expansion of EMS PSO services outside of Missouri, we presented the EMS PSO project at the Oklahoma Ambulance Association’s annual convention in October, and also hosted a vendor booth at the American Ambulance Association Annual Convention and Trade Show in late November.

We anticipate continued growth in EMS PSO participation in 2013 with the goal of increasing adverse event reporting to publish our first report on patient safety in EMS, and securing our first out-of-state contracts.

### Federal PSO Protections Upheld in Courts in 2012

Three cases addressed various aspects of and challenges to the federal Patient Safety and Quality Improvement Act of 2005 protections with each challenge upheld in the courts:

1) An Illinois appellate court upheld PSO protections in a case brought by the state’s professional licensing board that requested disclosure of incident reports. IDFPR v. Walgreen, Company, 2012 IL App (2d) 110452, N. 2-11-0452.

2) A Franklin Ohio County court upheld the federal PSO protections in a case brought by a plaintiff’s attorney who requested incident reports in a case in which the defendants admitted liability. Counsel successfully argued that the Act’s protections extends even when liability is admitted due to the intent of Congress to improve the quality of care by creating a “culture of safety” through non-punitive reporting.

3) A Kentucky Appeals Court overturned a lower court ruling to release incident reports and quality assurance documentation defined as being protected with the federal PSO protections. In doing so, this Appeals Court not only upheld the PSO protections but noted the federal PSO protections preempt state law.
EVENTS BY CATEGORY
The most common types of events reported to the PSO database, based on the Common Data Format categories defined by the Agency for Healthcare Research and Quality (AHRQ) are medication/other substance, falls, healthcare-associated infections, and surgery/anesthesia events. A large number of events reported as “other” have been identified to be safety, security, and healthcare technology related events.

CAUSAL FACTORS OF EVENTS
The PSO database contains information about causes of events. The most common causal factors reported in 2012 remained the same; however, “communication” moved from the 1st most common factor to the 3rd.

One explanation for this change may reflect the efforts of PSO participants to assess the safety culture and take improvement action through Just Culture or the Comprehensive Unit-based Safety Program (CUSP), efforts led by the Center, as well as TeamSTEPPS™.

All Database Top 5 Contributing Factors (in order of priority):
1. Communication among staff or team members
2. Competence (qualifications, experience, etc)
3. Accuracy
4. Clarity of policies
5. Training

2012 Top 5 Contributing Factors (in order of priority):
1. Accuracy
2. Competence (qualifications, experience, etc)
3. Communication among staff or team members
4. Clarify of policies
5. Training

PSOs – A National View
National Health Reform Encourages PSO Participation

Effective January 1, 2015, PSO participation will be required for hospitals with more than 50 beds in order to be eligible to join defined health plans that are part of health insurance exchanges (HIEs). ACA PROVISIONS - PPACA, Section 1311

The federal Health and Human Services Health IT Patient Safety Action and Surveillance Plan calls for coordination of information technology, health and safety efforts and consistent reporting of IT-related events, near misses and unsafe conditions using the Common Data Format of PSOs.
In March, the Center joined the national Partnership for Patients (PfP) focused on improving the quality, safety and affordability of care across the nation. In addition, the Missouri Hospital Engagement Network (HEN) was established, as a component of PfP and the American Hospital Association’s HEN in which the Center is participating in collaboration with the Missouri Hospital Association.

As a part of the Missouri HEN, the Center is expanding on its previous Central Line Associated Blood Stream Infections (CLABSI), Catheter Associated Urinary Tract Infections (CAUTI) and Fall reduction efforts in addition to Surgical Site Infections (SSI) and Ventilator Associated Events (VAE).

Quarterly PSO Reports and PSO News were launched sharing updates on data reported to the Center’s PSO and other news of interest on patient safety. Highlights of newsletters were:

- Transparency
- MOCPS – a Leader within the national PSO Landscape
- Integration of National Health Reform & PSOs (see article, page 5)
- PSOs Offering a Safe Haven for Safety Culture
- PSO Federal Protections Upheld in Court (see article, page 4)
- Case study on Unexpected Death – Suicide
- Value of PSO Reporting
- Retained Surgical Items Multi state Study
- Harm of Disrespectful Behavior
- Overview of PSO Data Reporting

The Center moved into a new location on Hyde Park Road in Jefferson City, Missouri.

The Center’s Survey on Patient Safety services were enhanced, adding medical office safety culture surveys to the hospital survey services. Based on results from 7,277 survey responses obtained in 2012, the following weakest and strongest dimensions of safety culture have been identified. These results help inform organizations about areas to focus efforts to improve their safety culture.

**WEAK Dimensions**
- Handoffs and Transitions
- Nonpunitive Response to Error
- Teamwork Across Units

**STRONG Dimensions**
- Teamwork Within Units
- Supervisor/Manager Expectations & Actions Promoting Patient Safety
- Management Support for Patient Safety

The Center offers services to assist in addressing areas of weakness through training and PSO services.

The Center was pleased to provide training on the Comprehensive Unit-based Safety Program (CUSP) as part of a nine-state collaborative that resulted in a 58 percent reduction in central line associated blood stream infections across 100 neonatal ICUs, estimated to have prevented 131 infections, 41 deaths and $2 million in healthcare costs (see table below).

Project performed under agreement with the AHA’s Healthcare Research and Education Trust funded by the Agency for Healthcare Research and Quality.

**2012 ACTIVITY TIMELINE**

**JANUARY**
- The Center moved into a new location on Hyde Park Road in Jefferson City, Missouri

**MARCH**
- Quarterly PSO Reports and PSO News were launched sharing updates on data reported to the Center’s PSO and other news of interest on patient safety. Highlights of newsletters were:
  - Transparency
  - MOCPS – a Leader within the national PSO Landscape
  - Integration of National Health Reform & PSOs (see article, page 5)
  - PSOs Offering a Safe Haven for Safety Culture
  - PSO Federal Protections Upheld in Court (see article, page 4)
  - Case study on Unexpected Death – Suicide
  - Value of PSO Reporting
  - Retained Surgical Items Multi state Study
  - Harm of Disrespectful Behavior
  - Overview of PSO Data Reporting

**FEBRUARY**
- The Center’s Survey on Patient Safety services were enhanced, adding medical office safety culture surveys to the hospital survey services. Based on results from 7,277 survey responses obtained in 2012, the following weakest and strongest dimensions of safety culture have been identified. These results help inform organizations about areas to focus efforts to improve their safety culture.

**WEAK Dimensions**
- Handoffs and Transitions
- Nonpunitive Response to Error
- Teamwork Across Units

**STRONG Dimensions**
- Teamwork Within Units
- Supervisor/Manager Expectations & Actions Promoting Patient Safety
- Management Support for Patient Safety

The Center offers services to assist in addressing areas of weakness through training and PSO services.

In March, the Center joined the national Partnership for Patients (PIP) focused on improving the quality, safety and affordability of care across the nation. In addition, the Missouri Hospital Engagement Network (HEN) was established, as a component of PIP and the American Hospital Association’s HEN in which the Center is participating in collaboration with the Missouri Hospital Association.

As a part of the Missouri HEN, the Center is expanding on its previous Central Line Associated Blood Stream Infections (CLABSI), Catheter Associated Urinary Tract Infections (CAUTI) and Fall reduction efforts in addition to Surgical Site Infections (SSI) and Ventilator Associated Events (VAE). The Center was pleased to provide training on the Comprehensive Unit-based Safety Program (CUSP) as part of a nine-state collaborative that resulted in a 58 percent reduction in central line associated blood stream infections across 100 neonatal ICUs, estimated to have prevented 131 infections, 41 deaths and $2 million in healthcare costs (see table below).

Project performed under agreement with the AHA’s Healthcare Research and Education Trust funded by the Agency for Healthcare Research and Quality.

**Table 9: Estimation of infections prevented**

| Source: Eliminating CLABSI, A National Patient Safety Imperative, Agency for Healthcare Research and Quality, October 2012 | Baseline Jan Feb Mar Apr May Jun Jul Aug |
|---|---|---|---|---|---|---|---|---|
| Total CLABSI (Numerator) | 27 | 15 | 11 | 24 | 18 | 22 | 20 | 18 | 10 |
| Total Central Line Days (Denominator) | 13,215 | 15,187 | 15,655 | 17,728 | 18,257 | 19,558 | 17,296 | 16,318 | 11,690 |
| CLABSI Rate per Thousand Line Days | 2.043 | 0.988 | 0.703 | 1.354 | 0.986 | 1.125 | 1.156 | 1.103 | 0.855 |
| CLABSI at Baseline CLABSI Rate (Baseline Rate x days/1000) | 31 | 32 | 36 | 37 | 40 | 35 | 33 | 24 |
| CLABSI Prevented (CLABSI at Baseline Rate - CLABSI at Quarterly Rate)* | 16 | 21 | 12 | 19 | 18 | 15 | 15 | 14 |

*Total CLABSI prevented may not sum to 131 due to rounding.

Rose Porter, PhD, MA, BSN, Professor Emeritus and former Dean of the Sinclair School of Nursing, joined the Center’s Board of Directors.

Source: Rose Porter, PhD, MA, BSN, Professor Emeritus and former Dean of the Sinclair School of Nursing, joined the Center’s Board of Directors.
APRIL

April was a very busy month for the Center, sponsoring Patient Safety Awareness Month, our 6th Annual Conference, awarding the Missouri Excellence in Safe Care Awards and holding our 4th Annual PSO Participant Day.

The CUSP Experience – Strategies that Work – Representatives shared their experience on implementing CUSP and the impact it has had on their quality and safety efforts - Gina Glisson, RN, BSN Fitzgibbon Hospital Nancy Noedel, RN, MSN Saint Louis University Hospital & Mary Fine, RNBC, QMHP, SANE Ozarks Medical Center

Becky Miller, Executive Director, presented at the Annual AHRQ PSO meeting in Baltimore MD as part of a panel on PSO participation in ambulatory settings, sharing the Center’s experience in evaluating the safety culture, developing Common Data Formats and providing PSO services for ambulance services.

American College of Healthcare Executives (ACHE) Congress Becky Miller, Executive Director, presented “PSOs in the World of ACOs” at the American College of Healthcare Executives Congress in Chicago, sharing information about how Patient Safety Organizations (PSOs) can support the new Accountable Care Organization (ACO) model of care in evaluation and improvement of quality and safety.

Alex Christgen, Program Manager, manned the CPS booth in St. Louis, MO, at the Missouri State Medical Association Conference, sharing information about the Center’s safety culture assessment and PSO services and resources.

4th Annual PSO Participant Day
Over 60 individuals participated, hearing a national update on PSO activity, including successful legal challenges, an update on learning from the Center’s PSO reporting, and participated in the first ever “Safe Tables”. Participants used a “Learning from Defects” tool to evaluate actual cases of medication, device-related and fall mistakes to identify proactive prevention strategies and discuss recent literature on the topics.

Missouri Excellence in Safe Care Awards
In 2012, projects from Golden Valley Memorial Hospital and Harry S. Truman Memorial Veterans Hospital joined ten previous safety projects receiving the Missouri Excellence in Safe Care Award:

Fall Team from Golden Valley Memorial Hospital, a multidisciplinary approach to reducing falls in the hospital setting that led to remarkable results since its implementation in 2007.

Sustaining Patient Safety Culture Through Leadership WalkRound® from the Harry S. Truman Memorial Veterans Hospital whose Executive Leadership Team implemented a program based upon the work of Dr. Allan S. Frankel, including an education needs survey as part of the employee performance evaluation, development of targeted educational offerings and Executive Walk Rounds. The program yielded significant positive results in the 2009 and 2011 surveys.

The 6th Annual Patient Safety Conference keynote was a team from the Mercy-Joplin facility sharing their heroic and inspiring story of managing during and after the May 2011 devastating tornado that destroyed their hospital.

“Our lives begin to end when we become silent about things that matter”
George Washington
3rd Annual EMS Patient Safety Conference

The Center sponsored its 3rd annual EMS Patient Safety Conference. More than 80 attendees representing more than 60 EMS agencies from across the state of Missouri gathered to learn the latest information on patient safety topics specific to their field. Topics included the importance of communication, the importance of response times and other safety issues related to establishing a “Just Culture” in EMS.

Dr. Coy Callison, researcher in communications from Texas Tech, presented his latest findings regarding communication in the workplace and its important role in patient safety in EMS.

3rd Annual EMS Patient Safety Conference

The Center sponsored its 3rd annual EMS Patient Safety Conference. More than 80 attendees representing more than 60 EMS agencies from across the state of Missouri gathered to learn the latest information on patient safety topics specific to their field. Topics included the importance of communication, the importance of response times and other safety issues related to establishing a “Just Culture” in EMS.

Dr. Coy Callison, researcher in communications from Texas Tech, presented his latest findings regarding communication in the workplace and its important role in patient safety in EMS.

Patient Safety Organizations and Transparency: Working Together to Improve Patient Safety

White paper published on how PSOs and transparency work together to improve safe care.

Authors:
Sue Kendig, JD, MSN, WHNP-BC, FAANP
Rebecca G. Miller, MHA, CPHQ, FACHE

PSOs – A National Perspective, Past, Present, and Future

The Center hosted staff from the federal Agency for Healthcare Research and Quality for this webinar to learn about the initial intent for PSOs to improve the safety of care and expectations of PSOs and healthcare providers going into the future.

The Center partnered with the National Safety Patient Foundation to offer a discount to membership in the American Society of Professionals in Patient Safety, the 10-module patient safety curriculum and certification as a patient safety professional.

Center Supports Missouri HEN with Culture Training and Culture Survey Services

The Center provided Comprehensive Unit-based Safety Program (CUSP) training for over 100 HEN participants and performed the Survey on Patient Safety (SOPS) culture for 32 hospitals, helping to assess safety culture strengths and weaknesses for improvement and learn skills to improve teamwork and communication.

Recognition of CUSP/CLABSI Success

The Center was pleased to receive acknowledgement from Johns Hopkins Armstrong Institute for Patient Safety and Quality for participation in the national project that led to reduced central line associated blood stream infections and improved safety culture.
OCTOBER

The Center for Patient Safety was launched as a dba for the Missouri Center for Patient Safety. A “doing business as” was established for the Center to more accurately reflect our work as a non-governmental, independent, not for profit organization providing resources and services for healthcare providers across Missouri state boundaries.

Kansas Healthcare Collaborative 4th Annual Summit on Quality
Carol Hafley, Assistant Director, presented a poster “Improving Quality and Safety in Emergency Medical Services through a Patient Safety Organization” at the Kansas Healthcare Collaborative 4th Annual Summit on Quality on the Missouri EMS PSO project.

NOVEMBER

PSO ALERT
In November, the Center issued an alert related to Ambien associated with increased fall rates as identified by the Mayo Clinic revealing a quadruple fall rate for inpatients taking Ambien as a sleep aid. The Alert included recommendations to assess current practice, evaluate the study and literature and discuss with medical staff and committees, in hospitals, home care and nursing home settings.

American Ambulance Association Annual Convention and Trade Show
Carol Hafley and representatives of the Missouri Ambulance Association hosted a booth at this national tradeshow, highlighting the EMS quality and safety work performed in Missouri and the benefits of EMS agencies working with a PSO.

MHA’s 90th Annual Convention & Trade Show
Alex Christgen, Program Manager and Ginger Schelp, Project Manager manned the Center’s booth at the MHA Annual Convention.

Launch of PSO Program for Long-Term Care
The Center’s PSO 3-year program for long-term care was launched in December with grant funding from the Missouri Foundation for Health. The project will provide culture assessment and training and resources to report and analyze adverse events, near misses and unsafe conditions in participating nursing homes.

CUSP/Stop CAUTI
(Catheter-associated Urinary Tract Infections)

The Center’s work with funding from the Blue Cross and Blue Shield of Kansas City within the metropolitan Kansas City area and statewide collaborative as part of the AHA Healthcare Research and Education Trust wrapped up in December 2012. Results revealed a statewide decrease in CAUTI rates of 50.6 percent compared to national rate decrease of 15.4%.

Results revealed a national and statewide overall reduction in catheter use and improvement in the use of catheters based on appropriate indications. (see graphs at right)
Social Media Presence
EXPLOSION in 2012!

The Center’s Website continued to evolve in 2012, welcoming over 14,000 visits, 9,000 new visitors in 2012, increasing by 36 percent and 60 percent respectively from 2011 through 2012. The Center’s presence on Facebook, LinkedIn and Twitter solidified in 2012 by welcoming 170, 240 and 265 followers respectively, increasing LinkedIn and Twitter participation by an over 3,000 percent increase from 2011 through 2012.

Be a Safety Sponsor: How you can help!

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

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

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

The Center makes the process easy; you can donate online in minutes. And, of course, any of the Center staff can answer your questions and provide more information.

Looking Ahead Through 2013...

Looking toward 2013, the Center anticipates another year of growth in all of our strategic areas of focus and more. Highlights of 2013 will be:

PSO SERVICES
- Enhanced learning and sharing from increased reporting to the PSO by hospitals and ambulatory surgery centers.
- Enhanced learning through increased reporting to the PSO by ambulance services, enhancing regional quality and safety opportunities.
- Developing long term care PSO services assisting nursing homes in improving the culture for safety and learning from reporting of adverse events, near misses and unsafe conditions.

SAFETY CULTURE SERVICES
Expansion of safety culture services, including
- Training by the Centers’ certified Just Culture trainers.
- Training on the Comprehensive Unit-based Safety Program utilizing the Center-developed resources, toolkit and customized training.
- Services for completing, reporting and targeting improvement from the Survey on Patient Safety services for hospitals, medical offices and nursing homes.

EDUCATION
- The 7th Annual Patient Safety Conference in March as a series of 5 virtual sessions with national speakers allowing for increased participation across the nation.
- A 3rd train-the-trainer session on “The 2nd Victims Program” will be held in 2013 expanding knowledge of how to implement this program to help healthcare professionals deal with serious events.

COMMUNICATION
- Sponsoring Patient Safety Awareness Month in March.
- Expanding on Website and social media communication.

CLINICAL
- Continued leadership of 5 of the 10 clinical focus areas of the Missouri Hospital Engagement Network and training on teamwork and communication as well as safety survey culture assessment and reporting.
- Completion of the Comprehensive Unit-based Safety Program (CUSP) Sustainability Toolkit.
CENTER FOR PATIENT SAFETY BOARD OF DIRECTORS
2012 Board Executive Committee

CHAIR
H. JERRY MURRELL MD
Columbia, Missouri

VICE-CHAIR
RICHARD ROYER MBA
Primaris
Columbia, Missouri

SECRETARY-TREASURER
STEVEN J. BJELICH MHA
Saint Francis Medical Center
Cape Girardeau, Missouri

Board Members
EDMOND CABBABE MD FACS
St. Louis

THOMAS L HOLLOWAY
Missouri State Medical Association, Jefferson City

S. GORDON JONES, JR., MD
Sikeston

DANIEL LANDON
Missouri Hospital Association, Jefferson City

ROSEMARY T PORTER PHD MA MSN
Columbia

BRENT VANCORIA MS MBA
St. Mary’s Health Center, Jefferson City

GAIL VASTERLING JD
Missouri Dept of Health and Senior Services, Jefferson City

BRUCE R WILLIAMS DO
Lake Waukomis
(Ex-officio) BECKY MILLER MHA CPHQ FACHE
Executive Director

CENTER FOR PATIENT SAFETY STAFF

BECKY MILLER MHA, CPHQ, FACHE
Executive Director

CAROL HAFLEY MHA, BSN, RN, FACHE
Assistant Director

GINGER SCHELP MHA, RRT
Project Manager

ALEX CHRISTGEN
Office/Program Manager

EUNICE HALVERSON MA
Patient Safety Specialist

Marilyn Keilholz
Executive Assistant

Katy Loesch
Administrative Assistant

Center Welcomes Dr. Steven R Smith in 2013
The Center is pleased to welcome Steven R. Smith MD to our Board of Directors. Dr. Smith is a practicing Anesthesiologist in Ballwin, Missouri.

Center Welcomes Kathryn Wire in 2013
The Center is pleased to welcome Kathy Wire, JD, MBA, CPHRM to our staff as Project Manager for the long-term care PSO project.
Kathy has worked with the Center as a consultant on PSO activities for several years and will now bring her expertise in risk management, claims, long term care and PSOs together in management of this exciting new project. Visit our website to read Kathy’s bio.

THANK YOU! TO ALL OF THE CENTER 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
• LTC Steering Committee

CENTER PARTICIPANTS:
Over the past seven years participation in the Center’s initiatives has spread throughout the country. We thank all organizations and individuals that have and are actively involved in our important work to improve the safety of healthcare delivery!
ABOUT THE CENTER FOR PATIENT SAFETY

The Missouri Center for Patient Safety, d/b/a 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. 

ⓘ