



U.S. Department of Health and Human Services



Agency for Healthcare Research and Quality

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Benefits of AHRQ Patient Safety Organizations (PSOs): Success Stories from Hospital PSO Members

Webcast

June 10, 2015

2:00 – 3:00 pm ET





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Using the Webcast Console and Submitting Questions



The screenshot shows the AHRQ webcast console interface. At the top left is the AHRQ logo and the text "Agency for Healthcare Research and Quality Advancing Excellence in Health Care". Below this is the "Slide Area" which displays the U.S. Department of Health and Human Services logo, the AHRQ logo, and the title "Benefits of AHRQ Patient Safety Organizations (PSOs): Success Stories from Hospital PSO Members". Below the title is the text "Webcast June 10, 2015 2:00 - 3:00 pm ET" and a photograph of a doctor examining a patient. To the right of the slide area is the "Speaker Bios" section, which lists three speakers: Diane Cousins, RPh (Health Scientist Administrator, AHRQ), Vereline Johnson, MSN, RN (Patient Safety Officer, Saint Francis Medical Center), and Chris Dickinson, MD (Chief Medical Officer, C.S. Mott Children's Hospital). Below the speaker bios is the "Q&A" section, which includes a "Refresh Now" link, a text input field, and a "Submit" button. A red arrow points from the "Submit" button to a red-bordered box containing instructions.

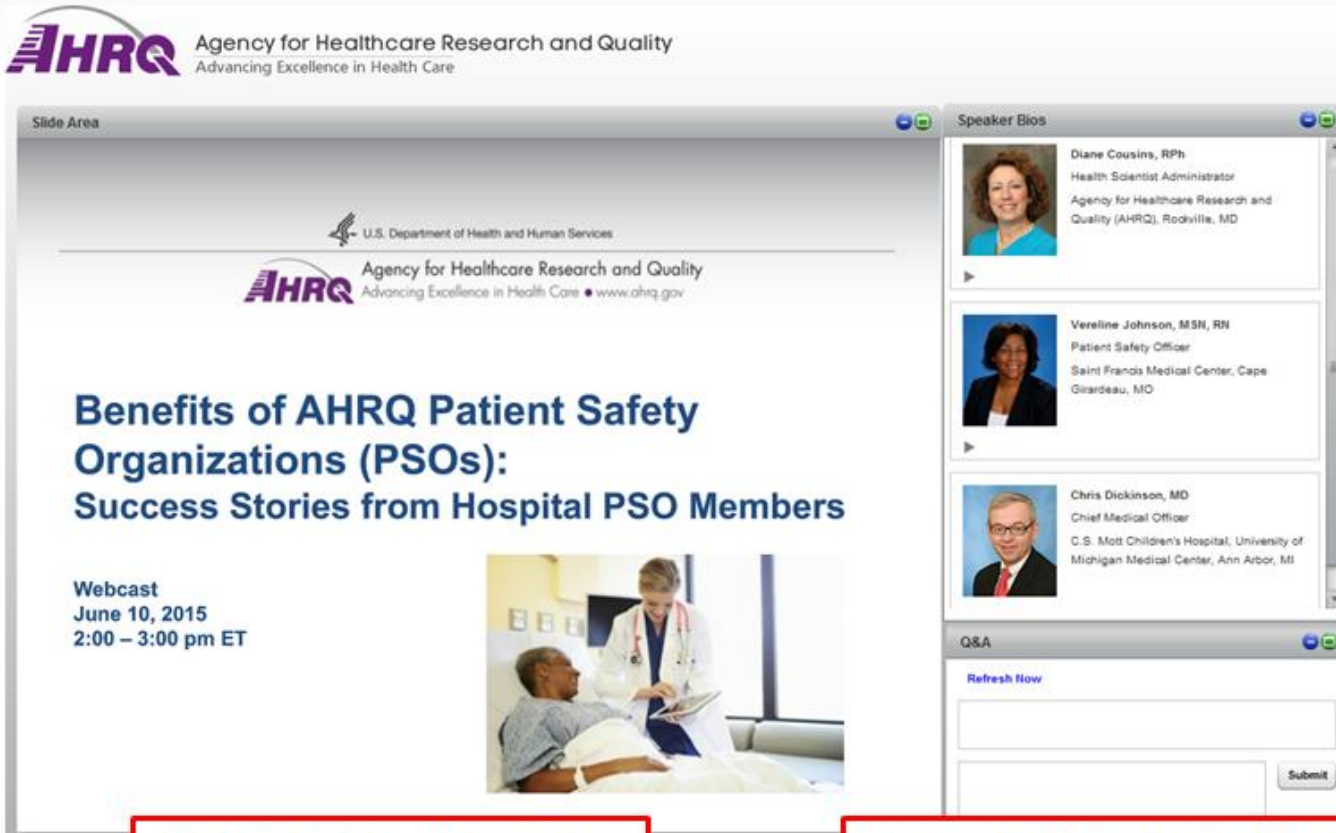
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Accessing Presentation and Resources



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- Diane Cousins, RPh**
Health Scientist Administrator
Agency for Healthcare Research and Quality (AHRQ), Rockville, MD
- Vereline Johnson, MSN, RN**
Patient Safety Officer
Saint Francis Medical Center, Cape Girardeau, MO
- Chris Dickinson, MD**
Chief Medical Officer
C.S. Mott Children's Hospital, University of Michigan Medical Center, Ann Arbor, MI

Q&A

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Today's Speakers



- ▶ **Diane Cousins**, RPh, Health Scientist Administrator, AHRQ



- ▶ **Vereline Johnson**, MSN, RN, Patient Safety Officer, Saint Francis Medical Center



- ▶ **Chris J. Dickinson**, MD, Chief Medical Officer, CS Mott Children's Hospital, University of Michigan Medical Center



The Patient Safety and Quality Improvement Act of 2005

- Authorizes “Patient Safety Organizations” (PSOs)
- Provides privilege & confidentiality protections for information when providers work with Federal PSOs to improve quality, safety and healthcare outcomes
- Authorizes establishment of “Common Formats” for reporting patient safety events
- Establishes “Network of Patient Safety Databases” (NPSD)
- Requires reporting of findings annually in AHRQ’s National Health Quality / Disparities Reports



Key Components

- **PSOs –**
 - ▶ Almost any entity can be or have a PSO.
 - ▶ PSOs serve as independent, external experts who can collect, analyze, and aggregate Patient Safety Work Product to develop insights into the underlying causes of quality and patient safety events.
- **Providers –**
 - ▶ A provider can be an individual, facility (e.g., hospital) or an establishment (e.g., retail pharmacy, ASC), or their parent organization.
- **Patient Safety Events –**
 - ▶ Incidents or near misses or unsafe conditions
 - ▶ Any type of event that adversely effects healthcare quality, patient safety or healthcare outcomes
- **Common Formats –**
 - ▶ Provide a uniform way to measure patient safety events clinically & electronically and to permit aggregation & analysis locally, regionally, & nationally.



Benefits of Working With A PSO

- A provider can work with one or more PSOs.
- Confidentiality & privilege protections are national in scope because this is a Federal law.
- A PSO:
 - ▶ Focuses on improving quality, safety and healthcare outcomes;
 - ▶ Provides a level of expertise in areas of importance to the provider;
 - ▶ Can convene its reporting providers in a protected environment to leverage learning; and
 - ▶ Aggregates greater numbers of events than any single provider.

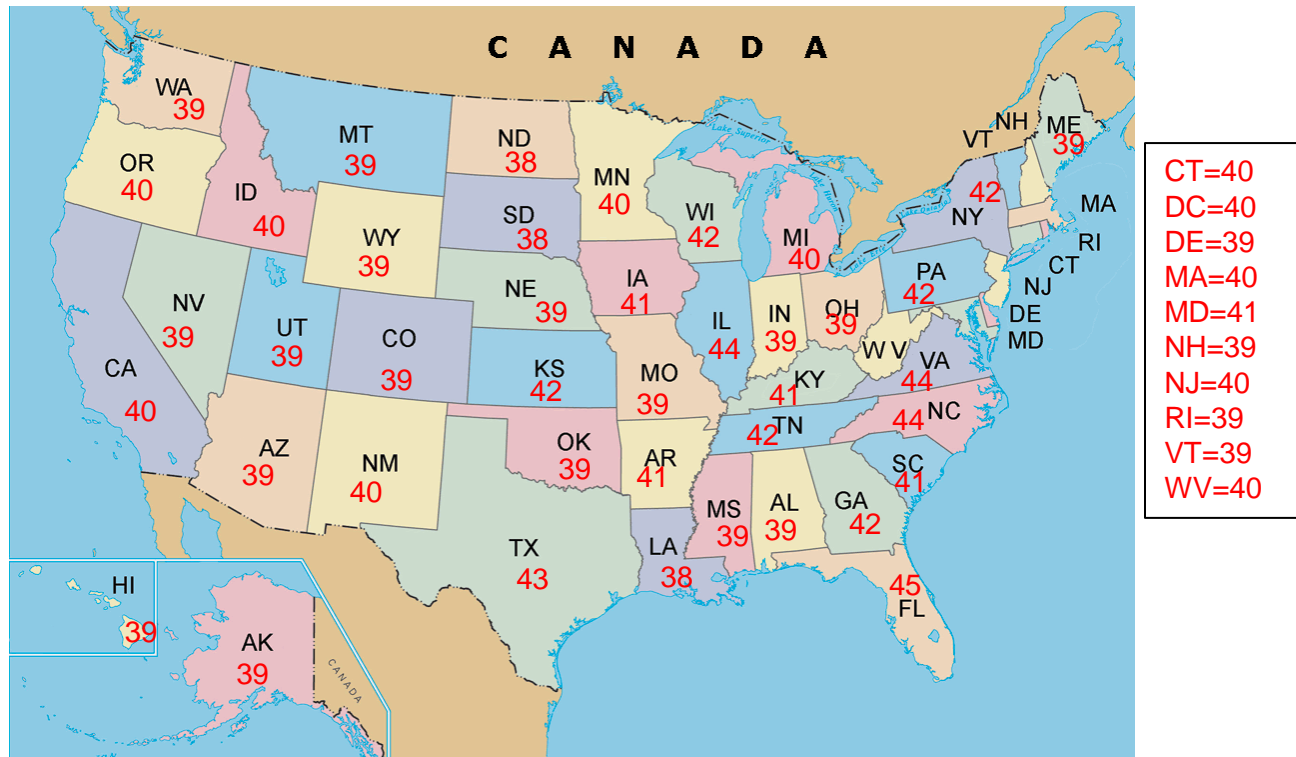


Affordable Care Act Sec. 1311(h)

- (1) ENHANCING PATIENT SAFETY.—Beginning on January 1, 2015, a qualified health plan may contract with—
 - ▶ (A) a hospital with greater than 50 beds only if such hospital—
 - (i) utilizes a **patient safety evaluation system** as described in part C of title IX of the Public Health Service Act; and
 - (ii) implements a mechanism to ensure that each patient receives a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional; or
 - ▶ (B) a health care provider only if such provider implements such mechanisms to improve health care quality as the Secretary may by regulation require.

State Coverage of Listed Patient Safety Organizations

Patient Safety Organizations Provide Protections Across the US



Note: a PSO may operate in any or all states and territories regardless of its headquarters location; each state shows the number of PSOs that serve that state.



AHRQ's PSO Website and PSO Selection Tool

- The official publication of all Federally-listed PSOs
- Providers can search for PSOs by different variables, including:
 - ▶ Region served – whether it operates locally, regionally or nationally
 - ▶ PSO specialty – such as anesthesiology, emergency medicine, pediatrics
 - ▶ Provider type served – such as skilled nursing facility or retail pharmacy
 - ▶ Resources provided – such as comparative reports, analytics, networking sessions

PSO Website: www.pso.ahrq.gov/listed



Saint Francis Medical Center (SFMC)

Vereline Johnson, MSN, RN
Patient Safety Officer

Saint Francis Medical Center

- 284-bed regional tertiary care facility located in southeast Missouri
- Serves more than 560,000 people throughout 5-state area



Decision to Join a PSO

Center for Patient Safety (CPS) forms relationship with SFMC

CPS becomes federally listed PSO

Missouri required hospitals to join federally listed PSO

SFMC contracts with CPS



How Saint Francis Medical Center Uses the PSO

- Reporting patient safety events
- Educational offerings and practice collaboratives
- Guidance and assistance in establishing PSO-related processes
- Other uses:
 - ▶ Legal consultation
 - ▶ PSO alerts
 - ▶ PSO Newsletter
 - ▶ Practice recommendations



Original Expectations

- Expectations were limited.
 - ▶ Believed data submission and the publication of periodic practice alerts would be the focus.
- When the final rule was published in 2008, we hoped to receive assistance in developing our PSO processes and policies.



Actual Experience

- Our work with the CPS PSO has far exceeded our expectations:
 - ▶ PSO Implementation Toolkit
 - ▶ Educational Offerings – PSWP, PSES, Confidentiality
 - ▶ Policy Development Templates
 - ▶ Quarterly Facility Dashboards
 - ▶ Annual PSO meetings with “Safe Tables”
 - ▶ PSO Participant Meetings
 - ▶ PSO Alerts and Watches
 - ▶ PSO Annual Report
 - ▶ Legal and operational support



PSO Fulfillment of Facility's Needs

- The CPS PSO provided much needed assistance in creating our work processes by providing:
 - ▶ Educational opportunities on specific requirements of the legislation
 - ▶ Assistance in setting up the electronic database and our patient safety evaluation system
 - ▶ Policy and PSO form templates
 - ▶ Legal consultation regarding legal protections and privilege
 - ▶ Integration of safety culture and patient safety improvement activities

The Good Catch Program

- In an effort to encourage staff reporting of near miss events, we introduced the “Good Catch” Program* in 2010.
- The Good Catch program:
 - ▶ creates a positive atmosphere for submitting potential errors.
 - ▶ allows leadership to recognize staff and present an award certificate.
 - ▶ features award recipients in our monthly newsletter.
- Since implementation, we have presented 218 Good Catch awards.

*Based on the program created by the M.D. Anderson Cancer Center in Houston, TX.





Benefit of Good Catch Program

- Another tool used to improve patient safety
- Overview and benefits were shared with members of the PSO via the quarterly newsletter
- Examples of process improvement:
 - ▶ Clarifying C-spine and L-spine x-rays (3-view vs. 5-view) helped to decrease patient exposure to radiation.
 - ▶ Reporting a medication with nearly identical labels led to a national change in the label.



Value of the PSO

- Before contracting with the PSO, our focus was on reporting actual events that reached the patient and/or caused harm.
- The PSO analyzes data and reports trends and we now report trends related to near miss events.
- PSO Alert – High Alert Medications
 - ▶ 1 in 5 medication errors reported to PSO in 2014 involved high alert medications.
 - ▶ PSO alert issued to participating facilities

Lessons Learned

- Contract with a PSO that has a history of conducting patient safety and improvement work.
- Ensure complete and accurate data are entered into the PSO database to ensure accurate data analysis and feedback.
- Establish roles and develop policies and procedures among the PSO workgroup to help ensure all PSO responsibilities are carried out and the facility adheres to the requirements of the legislation.

Evolving Needs

- Assistance with more robust event reporting and analysis at the facility level.
- Collaboration with the PSO IT staff to assist us in moving toward electronic event reporting.
- More information and best practices for reducing unnecessary hospital readmissions.





Overall Benefit of the PSO Program

- Allowing our facility's event data to be used with other organizations' data (locally and regionally) to pick up on trends and hotspots that need to be addressed.
- Having a team of knowledgeable staff available to assist with patient safety activities and to promote a safety culture that encourages open reporting on every level.



University of Michigan Health System C.S. Mott Children's Hospital

**Chris J. Dickinson, MD
Chief Medical Officer**

CS Mott Children's Hospital

- Part of the University of Michigan Health System
- 220 children's beds
- Physically attached to adult hospital



Mott Background

- Shared resources with University of Michigan Health System (UMHS)
 - ▶ Risk management
 - ▶ Quality improvement (QI)
 - ▶ Mott Chief Medical Officer (CMO) and Chief Nursing Officer (CNO) report to system CMO and CNO
- Within the UMHS structure, fair amount of flexibility to engage in QI/safety activities that are unique to pediatric care
 - ▶ E.g. medication safety
- UMHS is a leader in QI efforts for adult care
 - ▶ Aim to be a leader in children's care
- But how to do this?

Decision to Join a PSO

- We also felt strongly that we had a responsibility to help other hospitals improve the care for children.
- Locally we had a long-standing policy of sharing medical errors with families
 - ▶ Share errors even if families did not know about the error
 - ▶ Quickly settle claims
 - ▶ Share openly experiences about mistakes/harm to improve
- PSO was merely an extension of this philosophy



Why work with two PSOs?

- We felt we needed to learn from others – both locally (state) and nationally
- 2 PSOs worked out
 - ▶ Michigan Hospital Association PSO (local)
 - ▶ Child Health PSO (national)



Michigan Hospital Association (MHA) PSO

- Michigan Hospital Association (MHA) created pediatric-specific PSO which we eagerly joined
- We meet every quarter
- We expected to be “leaders and best” but this is not always true
 - ▶ Problems and issues similar at many places
 - ▶ Solutions come from many ideas and organizations
 - “All teach – all learn”
 - ▶ The free sharing of information is the biggest win for us – we learn from everyone else



Child Health PSO

- But what about the very specialized services we provide?
 - ▶ E.g. 20 bed pediatric CT ICU?
- For this we needed to speak with other children's hospitals
 - ▶ Child Health PSO
 - ▶ Affiliated with the Children's Hospital Association with 51 member hospitals
- This was spurred by the Solutions for Patient Safety (SPS) Hospital Engagement Network
 - ▶ SPS funded with a CMS grant-transformational
 - ▶ Groups of children's hospitals working on HAC reduction
 - ▶ Learning a great deal from SPS and CH PSO



How do we use our PSOs?

- Mostly, we just listen
 - ▶ And learn ---- a lot
- As you listen you are inevitably drawn into the conversation
 - ▶ How did you get your CLABSI rate that low?
 - ▶ Did you use a bundle?
 - ▶ How do you train staff?
 - ▶ How do you retrain?
 - ▶ How do you change culture?



Original Expectations

- We are different
- Our patients are sicker
- Our families are more difficult
- We are really struggling in this area



Actual Experience

- We are similar
- Some of our patients are sicker
- Families are families
- We are actually ahead of the curve



The PSO's fulfillment of our needs

- We have lots of issues to work on
 - ▶ How to prioritize?
 - ▶ How to implement change?
 - ▶ How to break down barriers?
 - ▶ How do we fit in relative to other organizations?
- PSO helps with all of these issues
 - ▶ Reading publications is very helpful but does not answer all the questions on any topic

Pediatric Medication Standards

- Like many children's hospitals we have major issues with medication safety
 - ▶ Dosing based on weight and can vary 100 fold
 - 1 kg baby to 100 kg adolescent
 - Most doses are patient-specific
 - ▶ 1.3 million doses dispensed each year
 - 99.9% accurate – yields 3/day that are wrong
 - Not good enough for a high reliability organization
 - ▶ Compounded oral medications a particular problem
 - No “standard” concentrations for non-commercial drugs
 - E.g. survey showed metronidazole had 9 “standard” concentrations
 - >50% had 3 or more standard concentrations



Pediatric Medication Standards

- Need a statewide compounded oral medication standard
 - ▶ But how to do this?
- Get buy-in from pharmacists, doctors, and hospitals
 - ▶ Starting point was the MHA PSO
 - ▶ Every other hospital had the same problem and liked the idea

Medication Standards

- Standards developed
- Website created – mipedscompounds.org
 - ▶ Includes standards, recipes, references





Lessons Learned and Evolving Needs

- Listen and listen some more
 - ▶ Bring as many disciplines as possible, MD's, nurses, pharmacists, RT, etc.
- Report your events so we can “all teach, all learn”
- How to prioritize issues?
 - ▶ Scoring systems
- How do you get work done if you are a smaller unit within a larger organization?
 - ▶ Can you really manage from the middle?



Value of the PSO Program

- PSOs help to build or reinforce an internal culture where it is safe to talk about real safety concerns
- PSOs allow you to learn from others and also share your expertise
- Use of multiple PSOs allow for sharing at various levels
 - ▶ State and national
 - ▶ Specialty area

Questions?



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 - ▶ Email: PSO@ahrq.hhs.gov
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