



Maryland Patient Safety Center  
Interim Update to The Maryland Health Care  
Commission (MHCC)  
January 2025

Submitted by:  
Stephanie Peditto  
President and CEO  
January 30, 2025

## Background

The Maryland Health Care Commission (MHCC) is an independent regulatory agency whose mission is to plan for health system needs, promote informed decision-making, increase accountability, and improve access by providing timely and accurate information on the availability, cost, and quality of health services to residents, policy makers, purchasers, and providers of health care services in Maryland. MHCC has statutory responsibility for quality measurement and performance reporting regarding health care facilities and, therefore, has a keen interest in patient safety and quality improvement in hospitals, nursing homes, and ambulatory care settings. MHCC remains responsible under Md. Code Ann., Health Occupations §1-401(b)(14) to designate an organization as the Maryland Patient Safety Center. The Center must have the experience, capabilities, and implementable plans to, among other things:

- √ Assure that a majority of Maryland hospitals will actively participate each year in at least one major patient safety initiative;
- √ Develop initiatives that align with and support the priorities of the Maryland Total Cost of Care Model, as well as the priorities of the Maryland Department of Health (e.g., elimination of health disparities, implementation of the Diabetes Action Plan);
- √ Facilitate collaboration among and have experience collaborating with a broad range of health care providers in diverse health care settings such as nursing homes, ambulatory surgery centers, hospitals, and others.

The Maryland Patient Safety Center (MPSC) is an independent not-for-profit organization committed to improving patient safety across all aspects of healthcare. The entity that later became the Maryland Patient Safety Center was first designated by MHCC as Maryland's patient safety center in 2004. State re-designation has been continued by the Maryland Healthcare Commission since 2004 and is currently in effect through December 31, 2025.

In addition to the state designation, the Maryland Patient Safety Center was one of the first 25 organizations in the nation to be listed as a Patient Safety Organization (PSO) by the federal Agency for Healthcare Research and Quality (AHRQ) under provisions of the Patient Safety and Quality Improvement Act of 2005. These provisions have been maintained and the Maryland Patient Safety Center's Mid-Atlantic Patient Safety Organization (MAPSO) continues to be recognized by the federal government.

Under Maryland's current Total Cost of Care (TCOC) Model—and leading into its participation in the AHEAD (Advancing Health Equity Approaches and Development) model—, it is increasingly important that safety, quality, and equity are continuously improved across all care settings. The Health Services Cost Review Commission (HSCRC)'s payment models, including the Quality-Based Reimbursement (QBR) program, are intended to ensure that any incentives to constrain hospital expenditures under the Total Cost of Care Model *do not result in declining quality of care*. Thus, HSCRC's quality programs reward quality improvements and achievements that reinforce the incentives of the Total Cost of Care Model, while guarding against unintended consequences and penalizing poor performance. Specifically, the Maryland Patient Safety Center supports hospitals in the QBR, which includes incentives to improve patient safety, including healthcare associated infections, and the AHRQ Patient Safety Index Composite (PSI-90), which represents significant breadth of patient safety topics.

The key stakeholders involved with the Maryland Patient Safety Center include hospitals, health systems, patients, physicians, long-term care and post-acute providers, and ambulatory care providers – all groups that are critical to the success of the TCOC and AHEAD Models. To achieve mutual health care goals for these stakeholders, the Maryland Patient Safety Center has collaborated with Maryland's key health policy agencies including MDH (Maryland Department of Health), MHCC, HSCRC and OHCQ to establish and achieve these goals.

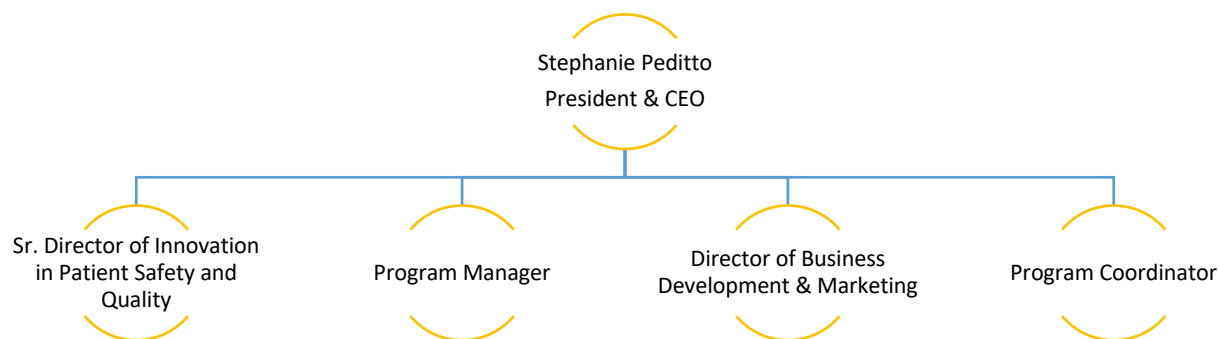
The Maryland Patient Safety Center continues to serve as a trusted patient safety center, assisting Maryland healthcare facilities in their efforts to develop and implement patient safety strategies. As required in the Maryland Patient Safety Center’s designation agreement with MHCC, this report provides the MHCC an interim report of the Maryland Patient Safety Center’s activities. This is the interim report for fiscal year 2025 (July 2024-December 2024).

## The Maryland Patient Safety Center Structure

The Maryland Patient Safety Center is overseen by a Board of Directors that is comprised of members from various hospitals/health systems in the State of Maryland, plus members representing emergency services, the continuum of care outside of acute hospitals, community health centers, the Maryland legislature, and patient/family advocates. This broadly representative volunteer board provides input and strategic guidance to the organization, in addition to its fiduciary responsibilities.

The current Chair of the Board is Roland (Terry) Fairbanks, MD, MS, who is Senior Vice President and Chief Quality and Safety Officer at MedStar Health, and the Executive Director of the MedStar Institute for Quality and Safety. Serving as Vice Chair of the Maryland Patient Safety Center’s Board is Deneen Richmond, President of Luminis Health Doctors Community Medical Center and Chief Quality and Population Health Officer for Luminis Health. In addition, as required in the Maryland Patient Safety Center’s designation agreement with MHCC, an MHCC senior staff person (Ms. Theresa Lee) is a non-voting member of the Maryland Patient Safety Center’s board. The Maryland Patient Safety Center also currently benefits from the fact that one of its board members, Ms. Marcia Boyle, also serves as an MHCC commissioner. Although not mandated in the designation agreement, this additional linkage supports excellent bidirectional communication and strategic alignment between our organizations.

The Maryland Patient Safety Center employs five full-time staff including the President and CEO, Senior Director of Innovation in Patient Safety and Quality, Patient Safety Program Manager, Director of Business Development and Marketing, and a Program Coordinator.



## Maryland Patient Safety Center Activities

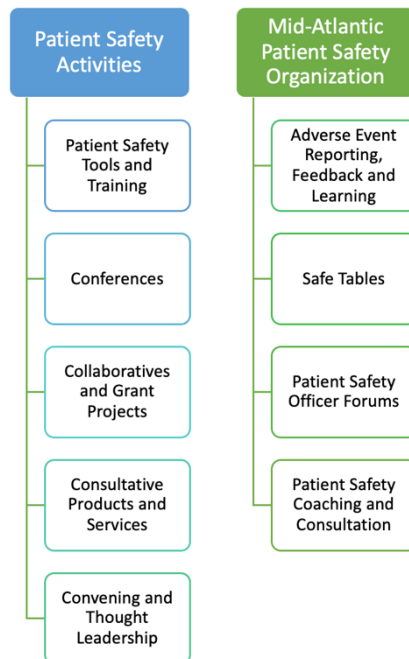
In addition to other activities of the Maryland Patient Safety Center, under the designation agreement with MHCC, the Maryland Patient Safety Center shall implement patient safety strategies, programs, and activities, and shall:

- develop, coordinate, and implement patient safety initiatives across the state;
- be a model for patient safety innovation and implementation in the state; and
- convene health care providers, patients, and families to improve the quality of health care and reduce preventable and avoidable harm; provide safe and equitable health care for state citizens; and share information relating to best practices among providers and patients in the state.

To do this, the Maryland Patient Safety Center:

- Facilitates successful statewide patient safety collaboratives focused on identified needs
- Convenes healthcare providers for education in patient safety
- Holds large annual patient safety conference and medication safety conference annually
- Provides organizational and individual consultative services on patient safety improvement
- Convenes patient safety officers to discuss and share key patient safety topics of importance in the State of Maryland

The Maryland Patient Safety Center also maintains the federally listed Mid-Atlantic Patient Safety Organization (MAPSO). A Patient Safety Organization (PSO) works with healthcare providers to help them improve patient safety and healthcare quality and encourage a culture of safety. PSOs analyze data voluntarily reported by providers and provide feedback aimed at promoting learning and minimizing patient risk. Working with a PSO makes it possible for organizations to receive certain legal protections around patient safety work products.



State funding is being utilized to significantly benefit Maryland in alignment with State goals via educational programs, adverse event reports, and a programmatic emphasis on health equity and reducing Severe Maternal Mortality and neonatal deaths, plus significant patient safety issues identified by the Maryland Department of Health's Office of Health Care Quality (OHCQ). Below is a description of the important work that is being accomplished with support from the State of Maryland funding.

## The Maryland Patient Safety Center Builds Capacity to Improve Patient Safety and Quality in Maryland Via Education and Outreach

This fiscal year, the Maryland Patient Safety Center offered to all healthcare organizations in the State of Maryland an expanded lineup of courses and educational offerings. The Maryland Patient Safety Center:

- ✓ **Holds monthly webinars on timely and compelling topics** aimed at driving critical improvements in patient safety.
- ✓ **Hosts courses designed to develop the skills necessary to lead patient safety and quality improvement** at the system, organizational, and unit level.
- ✓ **Provides year-round opportunities for healthcare organizations to network, collaborate, and innovate** to solve problems, learn from each other, and overcome barriers to improvement in each of the programmatic areas.
- ✓ **Facilitates protected communities and safe spaces which foster shared learning** so that healthcare organizations and providers can avoid duplication of known patient safety hazards across the region and beyond.

The Maryland Patient Safety Center's monthly patient safety forums provide a community for quality and safety champions to network and learn from one another. Patient safety improvement and reduced harm rates resulting from learning health networks have been demonstrated in the literature. Successful examples include CMS's Partnership for Patients, which helped to prevent 20,500 hospital deaths between 2014-2017, and regional networks such as Solutions for Patient Safety, a national consortium of children's hospitals who voluntarily share data and ideas to reduce harm. The Maryland Patient Safety Center utilizes the learnings from these models to share patient safety learnings, and could also use these models to expand the reach and effectiveness of learnings from adverse events submitted to Maryland's Office of Health Care Quality (OHCQ).

In addition, using state and national patient safety priorities to guide planning, The Maryland Patient Safety Center expanded our catalog of offerings for healthcare organizations-- offering added support in three key areas: Emergency Department Safety, Perinatal and Neonatal Safety, and Medication Safety. In each specific area of focus, the Maryland Patient Safety Center is offering even more virtual options to help support organizations across the State of Maryland for which travel to the Baltimore/Central Maryland region might be more challenging.

*In FY25, the Maryland Patient Safety Center is offering over 75 educational offerings open to healthcare organizations and workers across the state of Maryland. Over 3,500 healthcare workers have taken advantage of the patient safety content offered by the Maryland Patient Safety Center this year alone. These expanded offerings and service lines include:*

**Foundational courses in patient safety and quality to increase Maryland healthcare’s workforce capacity in patient safety.** This includes patient safety tools like Root Cause Analyses and Failure Modes and Effect Analysis, plus monthly forums on clinical areas identified as priority patient safety areas.

**Support for patient safety in the Emergency Department.** While organizations are working on throughput and new HSCRC reporting requirements, the Maryland Patient Safety Center supports organizations and patients by helping emergency departments to identify and reduce patient harms that are occurring as a result of overcrowding and boarding.

**Increased perinatal patient safety programming.** The Maryland Patient Safety Center expanded its work to help healthcare organizations with state and national goals to reduce severe maternal morbidity and mortality, stillbirth, and racial disparities in pregnancy-related outcomes. The Maryland Patient Safety Center also offers a year-long fellowship in perinatal safety to increase the capacity for improvement across the State.

**A health system-wide focus on medication safety.** This includes help for pharmacists, medication safety leaders, and clinical staff by identifying innovative strategies to create reliable systems for safe medication use throughout the organization. This is in addition to the Maryland Patient Safety Center’s annual medication safety conference, which was held in November 2024 in a new virtual format to encourage participation across the State.

**Annual Medication Safety Conference 2024**

Medication safety is identified by Maryland Department of Health’s Office of Health Care Quality as an ongoing priority in patient safety, as evidenced by serious reportable adverse events that occur in Maryland. The Maryland Patient Safety Center’s medication safety conference is developed to help address this priority area identified by OHQC.

The Maryland Patient Safety Center held a Virtual Medication Safety Conference in November 2024 aimed at addressing priority areas in medication safety, highlighting innovative ways to improve workflows to reduce medication errors and describe ways to optimize the use of your technology, including computerized clinical decision support, to prevent medication errors and adverse drug events. 357 healthcare providers from across the State registered for this event.



## The Maryland Patient Safety Center Supports our Healthcare Workforce

### Supporting our healthcare workers against workplace violence

The Maryland Patient Safety Center is committed to supporting Maryland's healthcare workforce in many ways. At MHCC's request in 2022, the Maryland Patient Safety Center convened a Task Force to develop a PR campaign on preventing violence against healthcare workers. Our nation's health care workers who have tirelessly helped care for and treat the sick and dying while facing increased violence – especially during and after the pandemic – deserve protection. There are daily examples in Maryland that include everything from verbal threats and physical attacks by patients, or distraught family members who may be abusive or even become an active shooter. The reasons for the aggression vary: patients' anger and confusion about their medical conditions and care; grief over the decline of hospitalized loved ones; frustration while trying to get attention amid staffing shortages, mental health disorders; political and social issues; and gender and race discrimination. And the reality is that workplace violence harms not just healthcare workers, but also patient care and the total cost of care in Maryland. Studies show that workplace violence increases the potential for adverse medical events and has immediate and longer-term impacts on recruitment and retention for staffing levels already on the brink. Quite simply, nurses and physicians cannot provide attentive care when they are afraid for their personal safety, distracted by disruptive patients and family members, or traumatized from prior violent interactions.

The Maryland Patient Safety Center, along with the Maryland Hospital Association and other healthcare organizations, advocated in FY24 for funding for the public awareness campaign that was recognized as a need by the legislature in 2022. The Maryland Patient Safety Center successfully advocated for including funding of \$1M (since reduced to \$750k) to educate the public about the importance of a safe and supportive healthcare environment, where both patients and healthcare workers can thrive.



The Maryland Patient Safety Center launched the \$750,000 statewide healthcare workplace violence prevention public relations effort. With this funding from the state, and in-kind support from the Maryland Hospital Association, and input from MHCC, the Maryland Patient Safety Center introduced the "Care Flows Both Ways" campaign. The ads and website aim to humanize our teams, encourage compassion among patients and families, and educate the public about how disruption in a healthcare setting hurts everyone involved. In addition, there is a value to the healthcare workforce that the state values them and the work they do.



The campaign launched in January 2025 and runs through May 2025, with ads featuring real healthcare workers on billboards, buses, radio, social media, and news sites like the Baltimore Sun. All ads lead to ItTakesPatients.org, where patients can find tips for navigating healthcare visits with empathy, and healthcare workers can access resources and materials for waiting rooms and other spaces. As of the

writing of this report, campaign ads have received over 1.8 million impressions and 10,000 clicks. The landing page has been viewed over 10,000 times, and those people are spending more time on the website than industry averages to read content and explore resources. Further highlighting the success of the campaign, the ad engagement rate at 7%, which is also well above the industry averages for the platforms that are carrying the ads.

### **Trauma informed leadership training**

In conjunction with The Maryland Nursing Workforce Center, part of the University of Maryland School of Nursing, the Maryland Patient Safety Center is offering workshops to nurse educators and leaders on how to apply the principles of trauma-informed care to realize, recognize, respond, and resist the re-traumatization of nurses on their team. Also, attendees will learn foundational debriefing practices that can be used after serious events to identify improvement opportunities and provide support and check in with colleagues.

### **Caring for the Caregiver peer support programs**

On the frontlines of healthcare, resilience has been described as the ability to improvise with materials at hand to develop solutions to unexpected problems, *thereby enabling patient care to be delivered safely despite obstacles*. Preserving organizational resilience, patient safety, and staff retention requires a holistic consideration of the psychological safety of healthcare workers. **Caring for the Caregiver has been described as psychological first aid for “second victims” of work-related traumatic events and/or errors.**

The Maryland Patient Safety Center collaborates with Johns Hopkins Armstrong Institute to offer the Johns Hopkins-developed Resilience in Stressful Events (RISE) Caring for the Caregiver program as a patient safety offering. This was also offered to 29 acute care hospitals, one school of nursing, and one provider group throughout the US during this time period.

This is not just for hospitals. It extends to federally qualified health centers and outpatient settings as well. We continue to serve as consultants to Johns Hopkins University on the \$2.7 million HRSA (Health Resources & Services Administration) funded, “Thriving Together” grant, expanding the *Caring for the Caregiver* program into rural hospitals, clinics, and FQHCs (federally qualified health centers). Training is complete for University of Maryland Shore Regional Health and Johns Hopkins Community Physicians; and on-going for Chase Brexton (FQHC), Whitman Walker (FQHC) Healthcare for the Homeless (CBO), BayHealth, HEBCAC, Roberta’s House, and Franciscan Center (Baltimore-based CBOs (community-based organizations)).

## **The Maryland Patient Safety Center Develops and Implements Collaborative Improvement Initiatives That Support Maryland Priorities and Also Engage Non-Hospital Settings of Care**

### **Pediatric sepsis recognition and treatment in urgent care: Support for implementation of Maryland’s “Lochlin’s Law”**

The Maryland legislature passed, and the Governor signed into law in 2024, the Hospitals and Urgent Care Centers-Sepsis Protocol (called Lochlin’s Law). Among other provisions, Lochlin’s Law requires each hospital and urgent care center in Maryland to implement an evidence-based protocol for the early recognition and treatment of a patient with sepsis, severe sepsis, or septic shock.

In December 2024, the Maryland Patient Safety Center convened leaders from Urgent Care Centers across the State of Maryland to address the requirements for implementation of pediatric sepsis protocols and training provisions in Lochlin’s Law. Urgent Care Centers from across the state attended this forum, shared clinical protocols, and discussed electronic health record support, handoff communications, transfer protocols, and patient/caregiver education. This offered a platform for sharing best practices to improve patient safety at urgent care centers in Maryland.

### **“Maryland Steps Forward” (falls prevention campaign)**

The Office of Health Care Quality’s Hospital Patient Safety Program annual report for 2023, when released, is anticipated to show a significant increase in Level 1 adverse events from patient falls. To help Maryland hospitals address this identified priority, the Maryland Patient Safety Center is offering all Maryland hospitals to participate in a falls prevention campaign. The campaign is a collaborative improvement initiative that aims to reduce the number and severity of falls in hospitals in the region through the implementation of structured post-fall debriefs to identify root causes, create standardized interventions, and shared learnings across the region.

The Maryland Patient Safety Center is supporting enrolled hospitals in implementing a post–fall debriefing program through a “train the trainer” model for site champions utilizing a standardized, evidence-based debriefing tool. Site champions will be equipped to implement post–fall debriefs on their units and share findings with the Maryland Patient Safety Center, who will facilitate shared learning surrounding root causes of falls and effective prevention measures across the collaborative and the region. This 18-month improvement initiative launched in December 2024.

It is expected that this initiative will then be made available to long term care, assisted living, and other post-acute care facilities.

### **Addressing the IV fluid shortage in obstetric settings**

In October 2024, significant supply disruptions in IV fluids affected healthcare organizations across the country, stemming from the closure of a Baxter International plant in North Carolina that had suffered significant damage during Hurricane Helene.. The company supplies about 60% of IV solutions used in the U.S. Healthcare organizations, and this disruption created significant patient safety and operational challenges for obstetric care.

The Maryland Patient Safety Center convened key stakeholders from perinatal settings to provide the opportunity to discuss how they are addressing IV fluid shortages that were occurring as a result of the supply disruption. IV fluids impact maternal hydration status, which can directly impact maternal-fetal well-being. The Maryland Patient Safety Center facilitated statewide conversations around where and how best to utilize IV fluids during this shortage, balanced with conversations around the need to ensure adequate maternal hydration and how to best promote oral hydration during labor. The main areas where the use of IV fluids is being reevaluated are their use during induction of labor, fluid boluses before epidurals or for intrauterine resuscitation, and postpartum Pitocin. This collaborative effort supported obstetric providers during a crisis, and also potentially led to longer-lasting improvements in IV fluid management.

### **Statewide collaborative to illuminate surface contamination in long-term care facilities**

The aim of this 18-month improvement collaborative that ended in 2022 was to enhance environmental cleaning practices to -reduce healthcare associated infections, and associated emergency department visits and hospital admissions. The full data analysis was recently completed and showed an increase in facility cleanliness, and decreases in infections, emergency department visits and hospitalizations. The successful results of this HSCRC-funded effort are being submitted to a national journal.

## **The Maryland Patient Safety Center Supports State Health Improvement Goals to Improve Safety and Equity for Mothers and Babies Across Settings of Care**

In 2019, the State of Maryland collaborated with the Center for Medicare and Medicaid Innovation (CMMI) to establish the domains of health care quality and delivery that the State could impact under the Total Cost of Care (TCOC) Model. Maryland’s Statewide Integrated Health Improvement Strategy (SIHIS) aligns statewide efforts across three domains that are interrelated and, if addressed successfully, have the potential to make significant improvement in not just Maryland’s healthcare system, but in the health outcomes of Marylanders. Through the State strategy, the Maryland Department of Health identified decreasing Severe Maternal Morality (SMM) rates in the State as its maternal health priority, with a focus on decreasing racial and ethnic disparities.

In its March 2024 SIHIS report, the Health Services Cost Review Commission (HSCRC) identifies Programs Using Data to Drive Action, including the Maternal Mortality Review Program, the Maryland Maternal Health Task Force, the Maryland Maternal Health Innovation Program (MDMOM), and the B.I.R.T.H Equity Maryland program of the Maryland Hospital Association in conjunction with the Maryland Patient Safety Center.

Maternal mortality in the United States has more than doubled over the past three decades, with clear and significant disparities in adverse outcomes for Black women. The Maryland Patient Safety Center's goal is to eliminate preventable harm in healthcare and, therefore, eliminate preventable severe maternal morbidity rates for all women.

The Maryland Patient Safety Center supports the Maryland Department of Health's Maternal and Child Health Bureau on their Maryland Perinatal System Standards. These are a set of voluntary standards for Maryland hospitals providing obstetric and neonatal services. The Standards have since been incorporated into the regulations for designation of perinatal referral centers (Level III and Level IV hospitals) by the Maryland Institute for Emergency Medical Services Systems (MIEMSS), as well as the Maryland Health Care Commission's State Plan regulations for obstetrical units and neonatal intensive care units.

In addition, the Maryland Patient Safety Center continues to support this SIHIS goal via multiple programs aimed at different areas of the maternal health ecosystem in Maryland as demonstrated by the following programs.

#### **B.I.R.T.H. Equity Maryland improvement collaborative**

The B.I.R.T.H. Equity Maryland collaborative program was developed by the Maryland Patient Safety Center in conjunction with the Maryland Hospital Association. Meeting the State's ambitious SIHIS maternal health goal is dependent on the way health care providers and other birthing professionals hear and engage with pregnant and post-partum mothers of all demographics. Half of pregnancy-related deaths occur in the year postpartum. Reducing pregnancy-related morbidity and mortality depends on changing the way healthcare providers recognize and respond to obstetric and postpartum emergencies, especially Black mothers who are disproportionately impacted. Postpartum patients have often been seen in an emergency department, primary care office or other health setting where their early symptoms are not recognized as urgent maternal warning signs, are underappreciated or dismissed.

B.I.R.T.H. Equity Maryland includes tools for *non-obstetric providers* to address the substantial disparity in maternal morbidity rate for Black—and all— birthing people in Maryland. The program teaches non-obstetric providers in emergency departments and outpatient settings to recognize emergent signs of severe maternal morbidity and mortality, implement improvements in protocols, identify whether or how potential bias might play a part in care, and have tools to effectively communicate concerns for a patient's wellbeing. The training and resources provided offer solutions for caregivers in Emergency Departments (ED) or non-hospital settings when patients are present with pregnancy-related complications.

Ten Maryland emergency departments and three outpatient sites completed the Maryland Patient Safety Center program, which ended July 1, 2024. Upon completion, the program was evaluated to be a success. After completing the B.I.R.T.H. Equity Maryland program:

- 81.4%(n=672) strongly agreed or agreed they can better identify pregnant and postpartum people who are experiencing an obstetric complication;
- 78.5% (n=647) strongly agreed or agreed the concepts they learned in the B.I.R.T.H. Equity Maryland program applied to their everyday practice; and
- 76.3% (n=629) of participants believed their site's participation was beneficial.

The Maryland Patient Safety Center convened participants in September 2024 to discuss the experience, lessons learned, and opportunities to improve patient safety and mitigate risk for emergency departments and non-obstetric sites of care for postpartum women. The participants made the following recommendations:

- ✓ Educate emergency department and non-obstetric clinicians on obstetric urgent warning signs (including urgent care, other outpatient sites of care)
- ✓ Standardize workflows to screen for pregnancy and postpartum status (for 1 year postpartum)
- ✓ Optimize electronic health records and clinical decision support algorithms to identify urgent maternal warnings
- ✓ Ensure all order sets are appropriate for pregnant and postpartum patients; collaborate with obstetric providers on this
- ✓ Increase access to data on pregnant and postpartum patients that present to emergency departments and other outpatient settings
- ✓ Create workflow to connect pregnant and postpartum patients with complications with appropriate resources (mental health, substance use disorder etc.)

The Maryland Patient Safety Center will share the recommendations and assess funding for next steps.

#### **MDMOM (HRSA grant for Maryland Maternal Innovation Program)**

The Maryland Maternal Health Innovation Program (MDMOM) aims to improve maternal health across the State by coordinating innovation in the areas of maternal health data availability and utilization, training of perinatal providers in birthing hospitals and of home visitors across home visiting programs, and perinatal telehealth. MDMOM is a collaboration between Johns Hopkins University, the Maryland Department of Health, and the Maryland Patient Safety Center. It is funded by the Health Resources and Services Administration (HRSA).

The Maryland Patient Safety Center supported MDMOM with the creation of the Perinatal Health Equity Toolkit, which was implemented in October 2023 with eight hospitals. The Maryland Patient Safety Center is also creating debriefing programs for maternal health caregivers. This kicked off with an in-person event in September 2024 for perinatal leaders at birthing hospitals across the state to provide education and tools on how they can be more trauma informed in their interaction with their staff and providers. To support implementation of a debriefing tool, the Maryland Patient Safety Center has developed and analyzed an electronic survey and held focus groups to determine opportunities to improve debriefing after serious events. Implementation of the debriefing toolkit is planned for Spring 2025. In addition to being an intervention to support maternal health, this work also supports the healthcare workforce and helps address burnout.

#### **MIEMSS (Maryland Institute for Emergency Medical Services Systems) training module**

In partnership with MIEMSS, the Maryland Patient Safety Center created an educational module that is being rolled out for *pre-hospital professionals* on urgent maternal warnings, disparities in maternal mortality, the impact of racism and bias, the need for early identification of signs and symptoms of obstetric complications. Over 160 emergency medical services (EMS) workers have taken the training thus far.

#### **Maryland Maternal Mortality Summit follow-up**

In May 2024, the Maryland Patient Safety Center worked with the Maryland Department of Health to convene the first-ever Maternal Mortality Summit in Baltimore, which was attended by 125 people in-person and virtually by over 250. Based on overwhelming requests to continue the conversation and learning, and without grant funding from the Department of Health, the Maryland Patient Safety Center continues to bring together virtually birth workers and other key stakeholders from Baltimore City and across Maryland to learn, innovate, and collaborate around eliminating preventable maternal mortality and its associated disparities in care, access, and outcomes for birthing people.

### **Count the Kicks stillbirth prevention program**

Reducing stillbirths is an important part of addressing the maternal morbidity and mortality problem. The risk of severe maternal morbidity is more than 4x higher among stillbirth deliveries compared with live births. On average, more than one baby per day is stillborn in Maryland and Black women have a 2x increased risk of stillbirth compared with White women. Addressing stillbirths will reduce the emotional and physical toll on marginalized populations and also help address the state's SIHIS goal. Count the Kicks is an evidence-based stillbirth prevention program that demonstrated a 30% reduction in stillbirth by teaching pregnant women how to monitor fetal movement during the third trimester of pregnancy by doing kick counts daily. The Maryland Patient Safety Center is working to spread the use of this app and educate both pregnant people and childbirth providers around using this information to ensure pregnant peoples' voices are heard.

### **Perinatal/neonatal safety and quality fellowship**

To increase capacity in the State of Maryland for perinatal safety, the Maryland Patient Safety Center offers a yearlong mentored fellowship to help participating individuals design, implement, evaluate, and disseminate a perinatal safety or quality improvement project aimed at improving outcomes and reducing disparities at their site. Seven nurses and physicians, from hospital NICU and labor and delivery units across the state and the District of Columbia, were selected for the fellowship.

### **Perinatal and neonatal safety learning series**

The perinatal and neonatal safety webinar series is offered to all interested healthcare organizations or individuals. The series is designed as education to support hospitals and other outpatient or community settings addressing foundational issues related to perinatal and neonatal safety and quality, including safe standards, teamwork, communication, and other evidence-based interventions. The Maryland Patient Safety Center offers monthly webinars with nationally known speakers.

## **The Maryland Patient Safety Center Supports Adverse Event Reporting and Learning with our Patient Safety Organization Resources**

The Maryland Patient Safety Center is the parent organization of the Mid-Atlantic Patient Safety Organization (called MAPSO). MAPSO is a federally designated Patient Safety Organization (PSO), which is a recognized legal entity by the federal government. PSOs provide a secure environment for healthcare organizations and clinicians to collect and analyze data. PSOs, in partnership with their member organizations, can improve safety and quality in patient care.

PSOs are able to collect and report on patient safety data in a legally protected manner. MAPSO provides federal protections to the members if they choose to submit adverse events through our secure network. Members of MAPSO receive consultation and access to the Maryland Patient Safety Center-hosted Safe Tables where patient safety topics, solutions and lessons learned are discussed and shared in a confidential environment. PSOs offer a wide variety of resources, experts, and collaborative opportunities that can support health care organizations as they seek to achieve further improvements in patient safety culture. Health care organizations with strong patient safety culture learn from their mistakes and evaluate the effectiveness of continuous quality improvement. The mutual collaboration and support that PSOs offer to their members can lead to improvements in patient safety culture not only within a health care organization but across organizations.

Submission of patient safety adverse event data is not mandated in Maryland, except the most serious (Level 1) events that are required to be reported by hospitals to the Maryland Department of Health's Office of Health Care Quality. *There is no regulatory requirement for data submission to the Maryland Patient Safety Center, and thus any data reported voluntarily is used for learning.*

### **Safe Tables: sharing best practices in a safe, protected space**

In addition to the Patient Safety Officer forums listed earlier in this report, the Maryland Patient Safety Center's PSO offers Safe Tables, which are forums where healthcare professionals can discuss patient safety experiences, best practices, and learn from experts and each other. The setting provides a

confidential, legally protected environment that allows healthcare professionals to discuss difficult topics and share learnings across the state. These discussions can focus on a specific safety event or issue, and may include detailed accounts of adverse events, near misses, or situations with systemic concerns. Participants can share their thoughts, feedback, and suggestions, and may also seek advice and solutions.

The Maryland Patient Safety Center’s Mid-Atlantic Patient Safety Organization offers Safe Tables on topics of importance to healthcare in the State of Maryland. In 2024, MAPSO offered Safe Tables on Infant Falls; Patient Safety and Language Barriers-Interpretive Services; Safety Events Resulting from Overcrowding and Boarding in Emergency Departments; Neonatal Resuscitation- Teamwork, Communication and Handoffs; and Overreliance on the Five Rights (Human Factors).

## Use of Maryland State Funding

As noted above, legislation passed in 2022 states that the Governor shall fund the designated Maryland Patient Safety Center for \$1M each year. The Maryland Patient Safety Center has established tracking of the use of this funding as both a good business practice and in compliance with the requirements of the Maryland Patient Safety Center’s agreement with MHCC. The table shows program expenses incurred in FY25 year to date (July 1-December 31), utilizing half a year of the \$1M funding. It should be noted that these are based on preliminary FY25 year to date financial statements and not audited financial statements due to the timing of this report.

Category	Total
Administration	\$ 88,189
Education Sessions	\$ 101,965
Annual Patient Safety Conference	\$ 83,253
Medication Safety Conference	\$ 59,982
Patient Safety Consultation	\$ 39,894
Caring for the Caregiver	\$ 13,058
Adverse Event Reporting System	\$ 30,265
Perinatal/Neonatal Patient Safety Program	\$ 47,294
Continuum of Care	\$ 33,100
Birth Equity Maryland	\$ 3,000
	\$ 500,000

## Looking Ahead: Remainder of Fiscal Year 2025

### Maryland Patient Safety Conference 2025



This year’s Maryland Patient Safety Conference is themed *A New Era in Patient Safety*. This exciting event promises a fresh and innovative experience with a dynamic new format, featuring a continuous plenary session, interactive networking opportunities, and actionable insights tailored to the latest trends in patient safety. As healthcare organizations face new national recommendations and requirements, this event offers a critical opportunity to reflect, learn, and prioritize patient safety. Designed for healthcare professionals from all sectors—from the bedside to the boardroom—the conference focuses on developing a total systems approach to advancing patient safety. Be part of this coordinated national effort to embed strategies that prevent harm across healthcare settings and shape the future of patient safety.

### **Minogue Awards**

Each year, the Maryland Patient Safety Center recognizes the best examples of Maryland healthcare's efforts to improve patient safety through the prestigious Minogue and Turning the Tide Awards. *The 2025 awards will bring Maryland's healthcare community together to honor innovative initiatives that are consistent with the aims of eliminating preventable harm or improving quality and equity.*

The Maryland Patient Safety Center will recognize patient safety innovation projects or initiatives that are submitted by hospitals, pre- or post-acute care organizations, long-term care organizations, home health agencies and other healthcare organizations in the State or region. The project or initiative must be related to eliminating preventable harm or improving quality and equity. In addition, this year there is increased emphasis on initiatives that demonstrate measurable change that impacts patients or the workforce and includes a system that can be replicated or adapted by other organizations. The sharing of improvements across the state is an aim of this prestigious award. The winners will be celebrated at the Maryland Patient Safety Conference 2025.

