



Maryland Patient Safety Center  
Interim Update to MHCC  
January 2024

Submitted by:  
Stephanie Peditto  
President and CEO  
January 30, 2024

## Background

The Maryland Patient Safety Center (MPSC) is an independent not-for-profit organization committed to improving patient safety across all aspects of healthcare. The Maryland Patient Safety Center (MPSC) was established by the Maryland Legislature in 2003 and first received designation as the state patient safety center by the Maryland Healthcare Commission in 2004. State re-designation has been continued by the Maryland Healthcare Commission since 2004 and is currently in effect through until April 2025.

In addition to the state designation, MPSC 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 MPSC's Mid-Atlantic Patient Safety Organization (MAPSO) continues to be recognized by the federal government.

MPSC's mission is to keep Maryland healthcare safe. To accomplish this, MPSC's vision is to be a model of patient safety innovation and implementation, convening providers, patients, and families across the healthcare continuum to prevent avoidable harm and provide safe and equitable healthcare for all. MPSC engages a growing number of healthcare providers from around the state through ongoing initiatives, including education and training, safety culture collaboratives, special projects, research, and near miss reporting. As a result of their participation, health care providers, working with patients and their families, discover and create new ways to deliver improved care in Maryland.

Under Maryland's Total Cost of Care (TCOC) Model for healthcare, it is increasingly important that safety and quality are continuously improved across all care settings. The key stakeholders involved with MPSC include hospitals, patients, physicians, long-term care and post-acute providers, and ambulatory care providers – all groups that are critical to the success of the TCOC Model. To achieve mutual health care goals for these stakeholders, MPSC has collaborated with Maryland's key health policy agencies including MDH, MHCC, HSCRC and OHCQ to establish and achieve these goals.

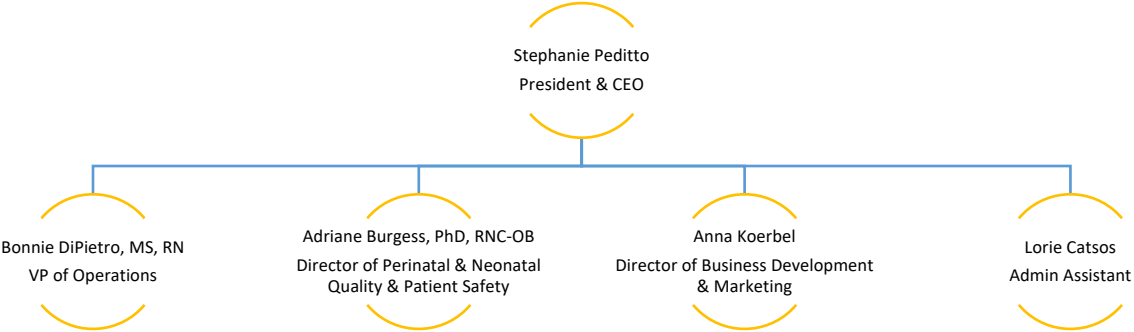
MPSC continues to serve as a trusted patient safety center to assist Maryland healthcare facilities in efforts to develop and implement patient safety strategies. MPSC conducts regular communication with patient safety officers, as well as leaders in patient and family engagement and peri- and neonatal services across the state to share best practices, resources and consultation, and coaching in order to improve safety and reduce cost and redundancy.

**As required in MPSC's designation agreement with MHCC, this report provides the MHCC an interim report of the MPSC activities from July 2023 through December 2023.**

## MPSC Structure

The MPSC 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. In addition, as required in MPSC’s designation agreement with MHCC, an MHCC senior staff person (Ms. Theresa Lee) is a non-voting member of MPSC’s board. The MPSC 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 MPSC employs five full-time staff including the President and CEO, Vice President of Operations, Director of Perinatal and Neonatal Quality and Patient Safety, Director of Business Development and Marketing, and an Administrative Assistant. Upon the retirement of Dr. Blair Eig as President and CEO of MPSC, the MPSC Board of Directors in November 2023 named Stephanie Peditto the new President and CEO. Stephanie has worked nationally and internationally in patient safety and quality for most of her career. She brings to the Maryland Patient Safety Center a deep appreciation for the challenges facing Maryland’s healthcare organizations and frontline clinical staff, a record of building new programs and services, an understanding of member organizations, and experience in policy and advocacy to support members’ goals. In her previous 25-year career at the Johns Hopkins Medicine, Stephanie developed a deep understanding of hospital operations and implementation of large-scale initiatives. For their Armstrong Institute for Patient Safety and Quality, Stephanie led national and international collaborations to build capacity and infrastructure and tools to end preventable harm, improve patient outcomes and experience, and eliminate waste in healthcare. Prior to that Stephanie was Director of Innovation, and Director of Inpatient Services at Johns Hopkins Hospital. Stephanie also served on faculty of the Johns Hopkins University Carey Business School in their business of medicine programs.



### MPSC Activities

The Maryland Patient Safety Center conducts activities to improve healthcare safety and quality in and around the State of Maryland. To do this, the MPSC:

- 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 key patient safety topics of importance in the State of Maryland

The MPSC 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 information to receive certain legal protections. The Maryland Patient safety Center’s PSO, MAPSO serves the State of Maryland:

- Tracks and trends adverse events from participating facilities
- Conducts Safe Tables – a members-only shared learning meeting among healthcare providers to exchange patient safety experiences, in an open, confidential and legally protected environment



As noted in the approved FY24 planned allocation of state funding to the MPSC budget, 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. 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

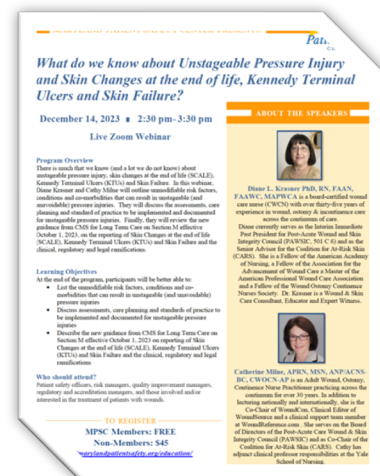


### Annual Medication Safety Conference: “Optimizing Technology to Improve Medication Safety”

- The conference was held on November 3, 2023; there were 113 pharmacists, medication safety officers, nurses, risk managers, and other clinical staff attending in person, and 146 attending in the virtual format for a total of 259. With support from State of Maryland funding, the conference is complimentary for most Maryland hospitals.
- This inventive program covered how better interoperability and technology could improve medication safety, and also critical case study discussions of technology-related events and steps taken to mitigate future events.
- The in-person format created excellent opportunities for cross-organizational sharing and learning.

### Education: Patient Safety Tools and Training to Build Capacity in Maryland and Beyond

- In addition to the neonatal safety series outlined later in this report, the MPSC also recently offered
  - Lean Six Sigma Greenbelt Certification (October 10-12, 2023 – In person for 16 people).
  - Sharing and disseminating quality improvement work to improve patient safety (September 27, 2023-in person for 21 people)
  - Root Cause Analysis- onsite at Calvert Health Medical Center (November 2, 2023)
  - A new webinar course called Coaching your Team to Improve Patient Safety (November 29, 2023 for 130 people)
  - Failure Modes and Effects Analysis (December 8, 2023 – In person for 27 people )
  - What Do We Know about Unstageable Pressure Injury and Skin Changes at the End of Life? (December 14, 2023 – Webinar for 52 people)



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.**

### Caring for the Caregiver Peer Support Program

- MPSC 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 seven hospitals and health systems through the US during this time period.
- We continue to serve as consultants to Johns Hopkins University on the \$2.7 million **HRSA funded, “Thriving Together” grant**, expanding the *Caring for the Caregiver* program into rural hospitals, clinics, and FQHCs. Training is complete for University of Maryland Shore Regional Health and Johns Hopkins Community Physicians; and on-going for Chase Brexton (FQHC), BayHealth (rural hospital system in DE), HEBCAC, Roberta’s House, and Franciscan Center (Baltimore-based CBOs).
- The ***Caring for the Caregiver: Implementing RISE*** 10-module e-learning course is now available for purchase on the Siemens Healthineers platform.



## The Maryland Patient Safety Center Supports State Goals to Improve Safety and Equity for Mothers and Babies: Pregnancy-Related Morbidity and Mortality Perinatal and Neonatal Safety

MPSC has a role in reducing pregnancy-related deaths and stillbirths

- 53% of pregnancy-related deaths occur between 7 days and one year postpartum.
- 80% of pregnancy-related deaths are preventable.
- Black women are 2x more likely than White women to have severe complications of pregnancy and 3-4x more likely to die from pregnancy related complications.

Improving this and reducing pregnancy-related morbidity and mortality depends on changing the way healthcare providers hear and engage with postpartum patients, especially Black mothers who are disproportionately impacted. These 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 postpartum, are underappreciated or dismissed. Pre-hospital and emergency departments should assess for pregnant and postpartum status, and for urgent maternal warning signs.

- On average, more than one baby per day is stillborn in Maryland.
- Black women have a 2x increased risk of stillbirth compared with White women.
- The risk of severe maternal morbidity is more than 4x higher among stillbirth deliveries compared with live births.

Improving this and reducing stillbirths in Maryland depends on teaching pregnant people how to monitor fetal movement (count the kicks) during the third trimester of pregnancy, and also by ensuring birthing peoples' voices are heard by their care team.

**B.I.R.T.H. Equity Maryland:** Tools for *non-obstetric providers* to address the substantial disparity in maternal morbidity rate for Black birthing people in Maryland. This also includes tools and training to help these providers identify and mitigate their biases.

- 15 Maryland emergency departments are currently enrolled in this MPSC program.
- The MPSC program includes a dashboard created to monitor completion of each step by site.
- Several new patient education Tik Toks have been completed on Safe Sleep, Maternal Mental Health, Count the Kicks and Your Birth Team. Those can be viewed in the [BIRTH Equity patient education materials](#) on MPSC's website.

April 2023 Cohort												
Organization	Utilization	Total Users	Activation		Step 1		Step 2		Step 3		Step 4	
			Count	%	Count	%	Count	%	Count	%	Count	%
Montgomery Medical	Dashboard	78	57	73.1%	49	62.8%	24	30.8%	13	16.7%	4	5.1%
Primary Care North	Dashboard	12	12	100.0%	11	91.7%	11	91.7%	8	66.7%	10	83.3%
Shady Grove	Dashboard	103	97	94.2%	75	72.8%	86	83.5%	74	71.8%	70	68.0%
White Oak	Dashboard	78	61	78.2%	57	73.1%	39	50.0%	17	21.8%	0	0.0%
<b>Total</b>		<b>271</b>	<b>227</b>	<b>83.8%</b>	<b>192</b>	<b>70.8%</b>	<b>160</b>	<b>59.0%</b>	<b>112</b>	<b>41.3%</b>	<b>84</b>	<b>31.0%</b>

July 2023 Cohort												
Organization	Utilization	Total Users	Activation		Step 1		Step 2		Step 3		Step 4	
			Count	%	Count	%	Count	%	Count	%	Count	%
Anne Arundel	Dashboard	92	87	94.6%	75	81.5%	85	92.4%	79	85.9%	75	81.5%
Doctors	Dashboard	80	75	93.8%	74	92.5%	72	90.0%	3	3.8%	1	1.3%
Frederick Memorial	Dashboard	126	101	80.2%	94	74.6%	86	68.3%	24	19.0%	23	18.3%
GBMC	Dashboard	203	118	58.1%	113	55.7%	102	50.2%	6	3.0%	0	0.0%
Meritus	Dashboard	142	73	51.4%	63	44.4%	57	40.1%	0	0.0%	0	0.0%
Saint Agnes	Dashboard	101	69	68.3%	62	61.4%	56	55.4%	1	1.0%	0	0.0%
<b>Total</b>		<b>744</b>	<b>523</b>	<b>70.3%</b>	<b>481</b>	<b>64.7%</b>	<b>458</b>	<b>61.6%</b>	<b>113</b>	<b>15.2%</b>	<b>99</b>	<b>13.3%</b>

August 2023 Cohort												
Organization	Utilization	Total Users	Activation		Step 1		Step 2		Step 3		Step 4	
			Count	%	Count	%	Count	%	Count	%	Count	%
Carroll Hospital	Dashboard	57	48	84.2%	47	82.5%	45	78.9%	13	22.8%	10	17.5%
Carroll Hospital	Dashboard	30	9	30.0%	7	23.3%	6	20.0%	0	0.0%	0	0.0%
Carroll Hospital	Dashboard	10	5	50.0%	3	30.0%	3	30.0%	0	0.0%	0	0.0%
Carroll Hospital	Dashboard	211	71	33.6%	43	20.4%	31	14.7%	0	0.0%	0	0.0%
<b>Total</b>		<b>308</b>	<b>133</b>	<b>43.2%</b>	<b>100</b>	<b>32.5%</b>	<b>85</b>	<b>27.6%</b>	<b>13</b>	<b>4.2%</b>	<b>10</b>	<b>3.2%</b>

### MIEMSS (Maryland Institute for Emergency Medical Services Systems) Training Module

- In partnership with MIEMSS we have created an educational module that will be required for all *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, and advocacy from all EMS providers across the state.

### **Count the Kicks Stillbirth Prevention Program**

- Count the Kicks is an evidence-based program that educates expectant people on the importance of tracking their babies' movements.
- MPSC offers complimentary to Maryland birthing organizations a phone app for patients to count kicks, and educational materials. The MPSC logo is on all educational materials provided throughout the state.
- Since our kickoff meeting in April we have seen significant growth in both orders of materials as well as app downloads: 126 individual sites/organizations have ordered over 44,000 materials and we have over doubled the number of app users monthly.
- Currently, 63% of birth hospitals have ordered materials, emails have been sent to all other hospitals to engage them in the program. 79% of the state's health departments have also ordered materials.

### **MPSC Perinatal/Neonatal Safety and Quality Fellowship:**

- 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.
- 10 individuals, both nurses and physicians, from hospital NICU and labor and delivery units across the state and the District of Columbia were selected for the fellowship.
- Fellows have been attending monthly cohort and one-one meetings learning key quality and safety skills while receiving individualized mentorship to support their project development.
- Didactic learning has been on data visualization and appropriate measures.
- Projects from fellows include implementing non-pharmacologic bundles for babies with neonatal abstinence syndrome, postpartum depression screening in the NICU, improved workflows to address postpartum hemorrhage, and lower NTSV c-section to name just a few.

### **Perinatal and Neonatal Safety Learning Series:**

- A neonatal safety webinar series started September 2023 and is offered free to MPSC members. The series is designed as education to support hospitals and other settings address foundational issues related to perinatal and neonatal safety and quality, including safe standards, teamwork, communication and other evidence-based interventions.
- Since its inception, MPSC has offered four webinars with four nationally known speakers on topics such as safe sleep, hyperbilirubinemia, breastfeeding and Eat. Sleep Console..
- Calendar year 2024 series topics are being planned.

**In addition to funding from the State of Maryland, the MPSC seeks additional grants to support our Maternal Morbidity/Mortality work**

### **Trauma Informed Care Training for all birth workers in Maryland**

- MPSC was named as a consultant on a Maryland Department of Health grant aimed at providing trauma informed care training to birth workers in Maryland. We will hold free 2-hour interactive trauma informed care training for all birth workers in Maryland in early 2024.

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

- MDMOM is a collaboration between Johns Hopkins University, Maryland Department of Health and Maryland Patient Safety Center, and funded by Health Resources and Services Administration.
- The MDMOM Perinatal Health Equity Toolkit was implemented with a kick-off at MPSC in October with 8 hospitals.
- A renewed version of this program began in October as “MDMOM2.”
- MPSC has been funded through MDMOM 2 for another 5 years to support the creation of debriefing programs for maternal health caregivers

### **Maryland Department of Health Maternal Mortality Review**

- MPSC continues to provide support to the Maryland Department of Health in its process for reviewing for maternal deaths; the review process was completed in December for maternal deaths that occurred in 2021.
- Recommendations for improvements and interventions were developed by the Maternal Mortality Review Team in January. Reviews of 2022 maternal deaths will begin in February 2024.
- The CDC visited the MD MMR team September 11-12, 2023. MPSC provided a presentation on our process of obtaining and reviewing records via the EHR, removing the necessity for records to be copied, mailed, stored and reviewed in person. There is a plan for us to share the process with other teams nationally via CDC webinars at some time.

### **Maryland Department of Health- Maryland Maternal Mortality Summit**

- MPSC was awarded a Maryland Department of Health grant to further support the Maryland Maternal Mortality Review Program by convening a Maternal Mortality Summit to discuss drivers of maternal mortality in Maryland.
- An Advisory Group which included state legislators, academic, nursing and physician leaders in maternal health from across the state, as well as representatives from the Department of Health and MHA came together to assist with planning the Summit. Through survey and discussion, themes were identified that were considered drivers of maternal mortality in Maryland. The summit will be held on May 9, 2024 at a location to be determined.

## 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 (PSO). The PSO provides a secure environment for healthcare organizations and clinicians to collect and analyze data. PSOs, in partnership with their member organizations, are able to improve safety and quality in patient care.

### Adverse Event Reporting

July-September highlights:

- 87% of reports (n=1,385): error reached patient; *no harm to patient*
- Of the serious safety events, the majority were related to surgery/anesthesia procedure, pressure ulcers, perinatal, and medications.

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

- Complimentary for MAPSO organizations.
- In-person October 2023 Safe Table on Infant Falls

### Patient Safety Officer Forums

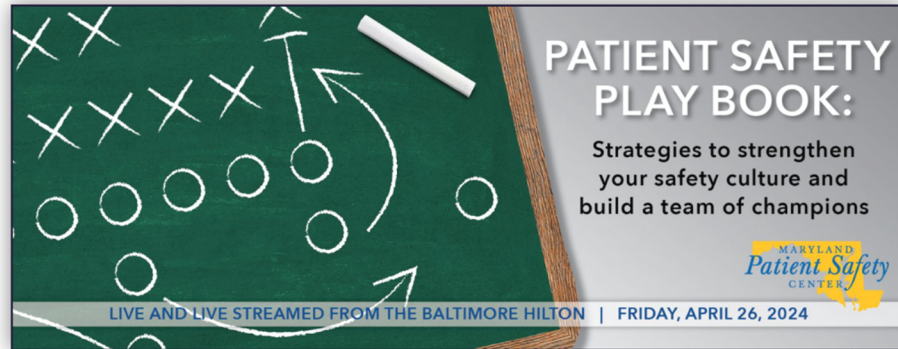
- August 2023 PSO Forum on Safe Sleep events in Maryland and best practices to mitigate harm
- December 2023 PSO Forum on recent regional publicity about adverse events in Maryland

**Patient Safety in Assisted Living:** MPSC is reviewing the recent MHCC's January 2024 Small Assisted Living Programs Study Recommendations Report to assess a potential role for the Maryland Patient Safety Center in this space.



## Looking Ahead: The Maryland Patient Safety Center Will Continue to Use the MHCC/State of Maryland Funding to Build Capacity and Improve Patient Safety in Maryland

20th Annual Maryland Patient Safety Conference | April 26, 2024



In its 20th year this conference will focus on the importance of tackling patient safety priorities with a team approach. Every member of the team has a role in patient safety and this conference will offer implementable strategies for a variety of healthcare professionals. Experts from across the country will present data and solutions that inspire and impact safe, high quality care delivery and positive patient outcomes.

## The Maryland Patient Safety Center and the Mid-Atlantic Patient Safety Organization Announce Annual Call for Solutions!



## State Funding Tracking

As noted above, Maryland state legislation passed provides funding of \$1M each year for MPSC activities. MPSC has established tracking of the use of this funding as both a good business practice and in compliance with the requirements of MPSC's agreement with MHCC concerning the funding. The approved budget is below; program expenses have been incurred year-to-date, as forecast for the budget. The following shows year-to-date expenses as of December 31, 2023.

<b>State Categories</b>	<b>FYTD State-Funded Expenses</b>	<b>Fiscal Year Total State Funding Allocation</b>	<b>Total MPSC Budget for These Programs</b>
Administration	33	59,617	618,628
Education Sessions	29,233	70,516	73,516
Annual Patient Safety Conference	70,520	189,100	389,100
Medication Safety Conference	133,664	136,304	183,304
Perinatal/Neonatal	25,191	45,172	57,172
Patient Safety Consultation	14,542	28,257	28,257
Patient and Family	14,493	31,401	31,401
Adverse Event Reporting	38,597	82,729	82,729
Opioid Misuse	3,818	7,474	7,474
Birth Equity Maryland	161,940	349,430	349,430
	<b>492,031</b>	<b>1,000,000</b>	<b>1,821,011</b>

*Note: Perinatal/neonatal programs have been combined in this report.*