MHCC Update

Barbara Epke, Interim President & CEO

February 20th, 2020

MPSC strives to raise the level of patient safety in Maryland among the continuum of caregivers in settings ranging from outpatient, acute, post acute, and specialty centers.

Addressing Trended Safety Issues

- Collaborative Projects
- Education
- Training

Promoting Safety Advocacy

- Patient Safety Officer from each organization
- Quarterly PSO forum
- Listserv
- Coaching

Selective Partnering

- Partnerships enable larger scope projects
- Caring for the Caregiver
- Patient & Family Advisory Council on Quality & Safety®

Alignment of Priorities

- Collaborate with MHCC, HSCRC, MDH, OHCQ

MHCC Update *Outline*

- ***Successes***
    - *Trended Safety Issues*
    - *Collaborative Project Outcomes*
- **Current**
    - Strategic Partnerships
    - Grants
    - Patient Safety Advocacy
    - Alignment of Priorities
    - Education
    - Leadership
- **Strategy**

IMPROVED the care of infants with Neonatal Abstinence Syndrome

REDUCED NICU stays by 3 days

Neonatal Abstinence Syndrome

Transfers to Higher Level Nursery and Specialty Hospital

% of Infants with NAS

Quarter	% of Infants with NAS
Q1 2016 (BASE)	16.8%
Q2 2016	12.7%
Q3 2016	8.1%
Q4 2016	12.0%
Q1 2017	5.3%
Q2 2017	8.1%
Q3 2017	10.0%
Q4 2017	4.5%
Q1 2018	4.6%
Q2 2018	10.0%
Q3 2018	11.9%
Q4 2018	7.4%

Collaborative Kicked Off (Q4 2016)

Collaborative Ended (Q3 2018)

Improvement = (56.0%)

Outcomes:

- NICU length of stay (as measure with a Vermont Oxford Network audit) for infants with NAS decreased by 3 days resulting in a cost savings of $1.8 million
- Transfers out of the birth hospital decreased by 56% from 16.8% to 7.4%
- Multiple presentations at national conferences

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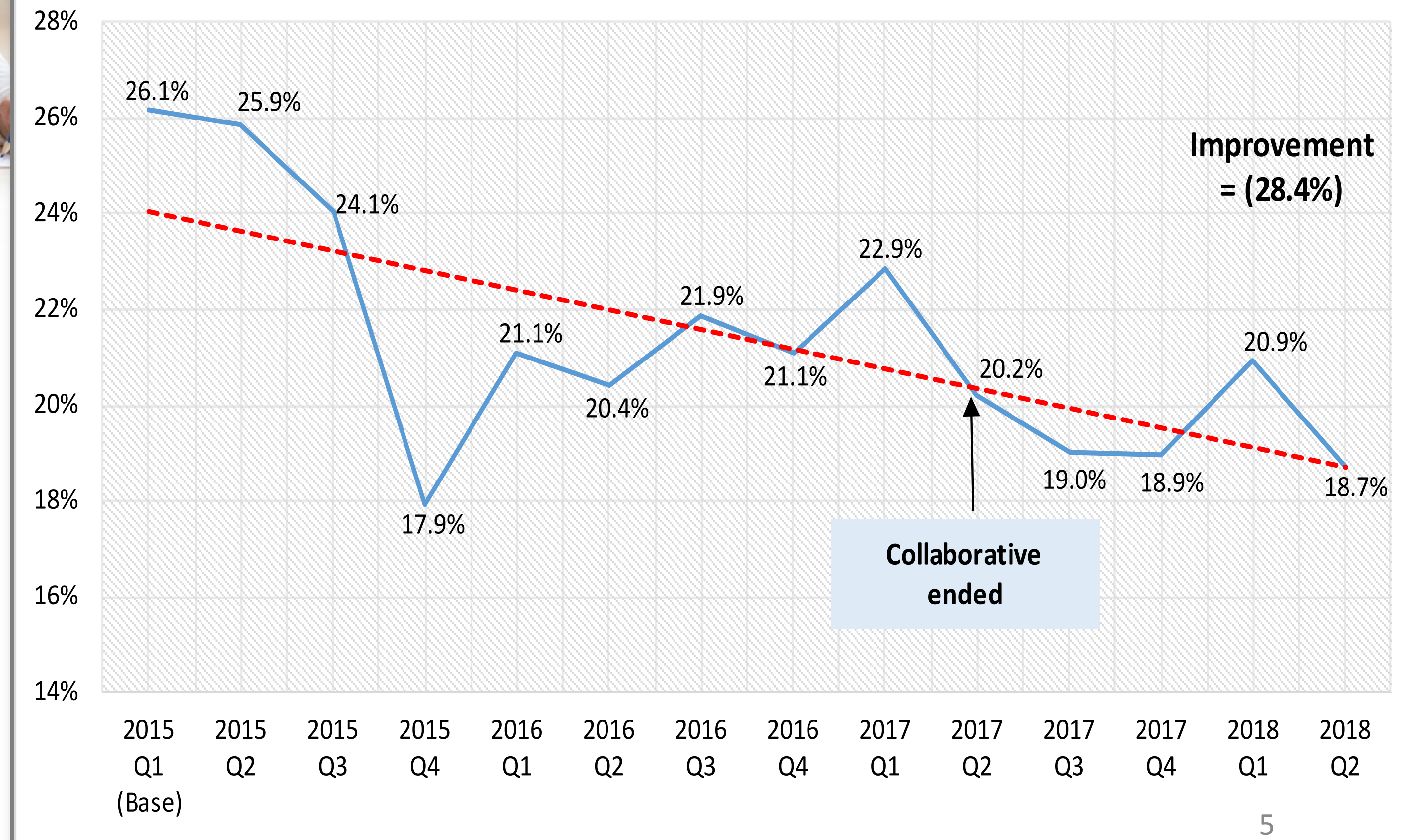
REDUCED the rate of SEPSIS mortality by 25% saving over 550 LIVES

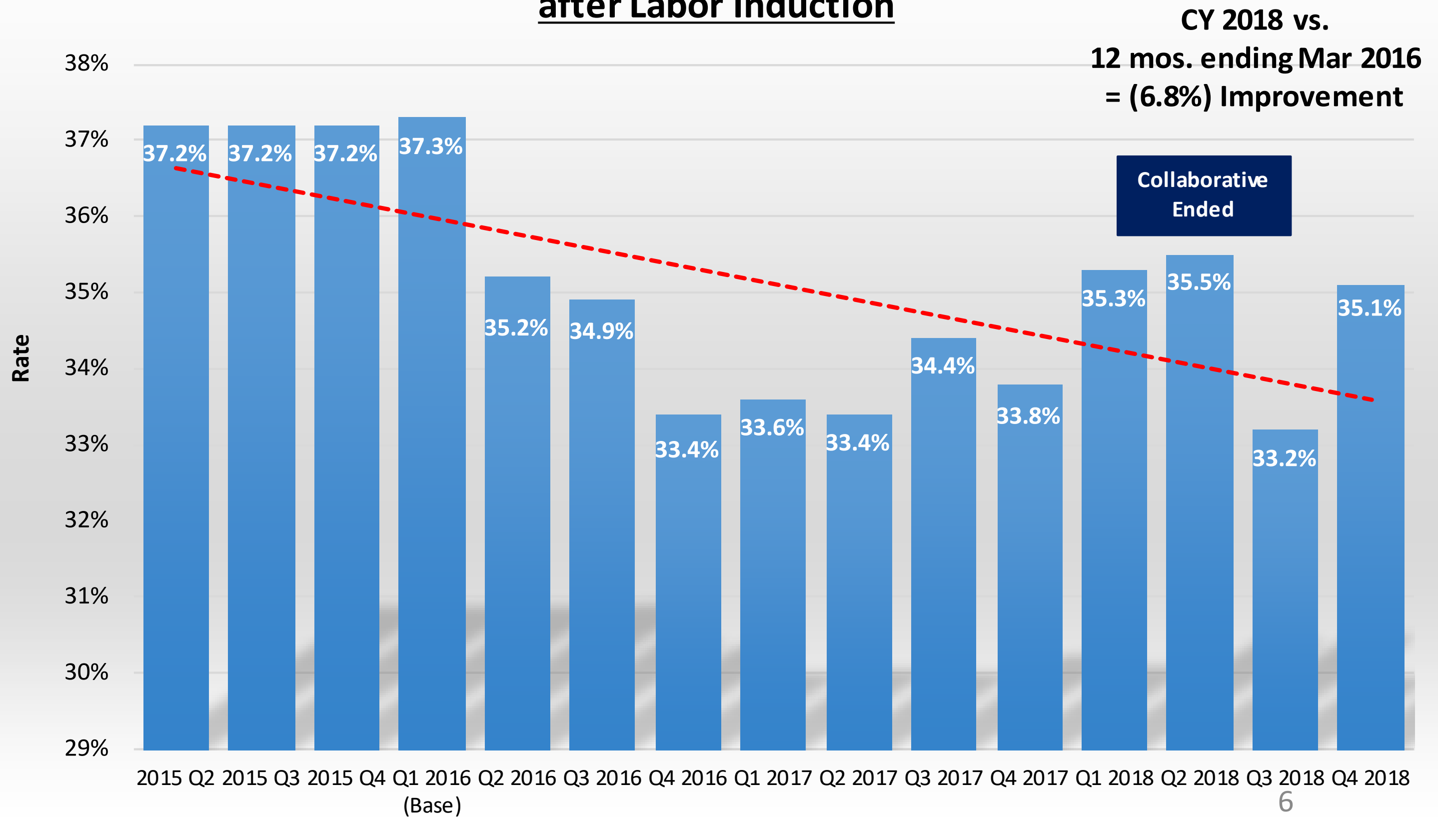
Sepsis Mortality



Outcomes:

- **Cohort I (10 hospitals)-** Reduced sepsis mortality by **12.55%** (HSCRC)
- **Cohort II (11 hospitals)-** Reduced sepsis mortality by **26%** (HSCRC)
- Saving over 550 lives

Primary C-Section Reduction



Outcomes:

- Avoided over 470 C-Sections in Maryland during the two-year collaborative period
- Cost avoidance of **$898,701** during the two-year collaborative period

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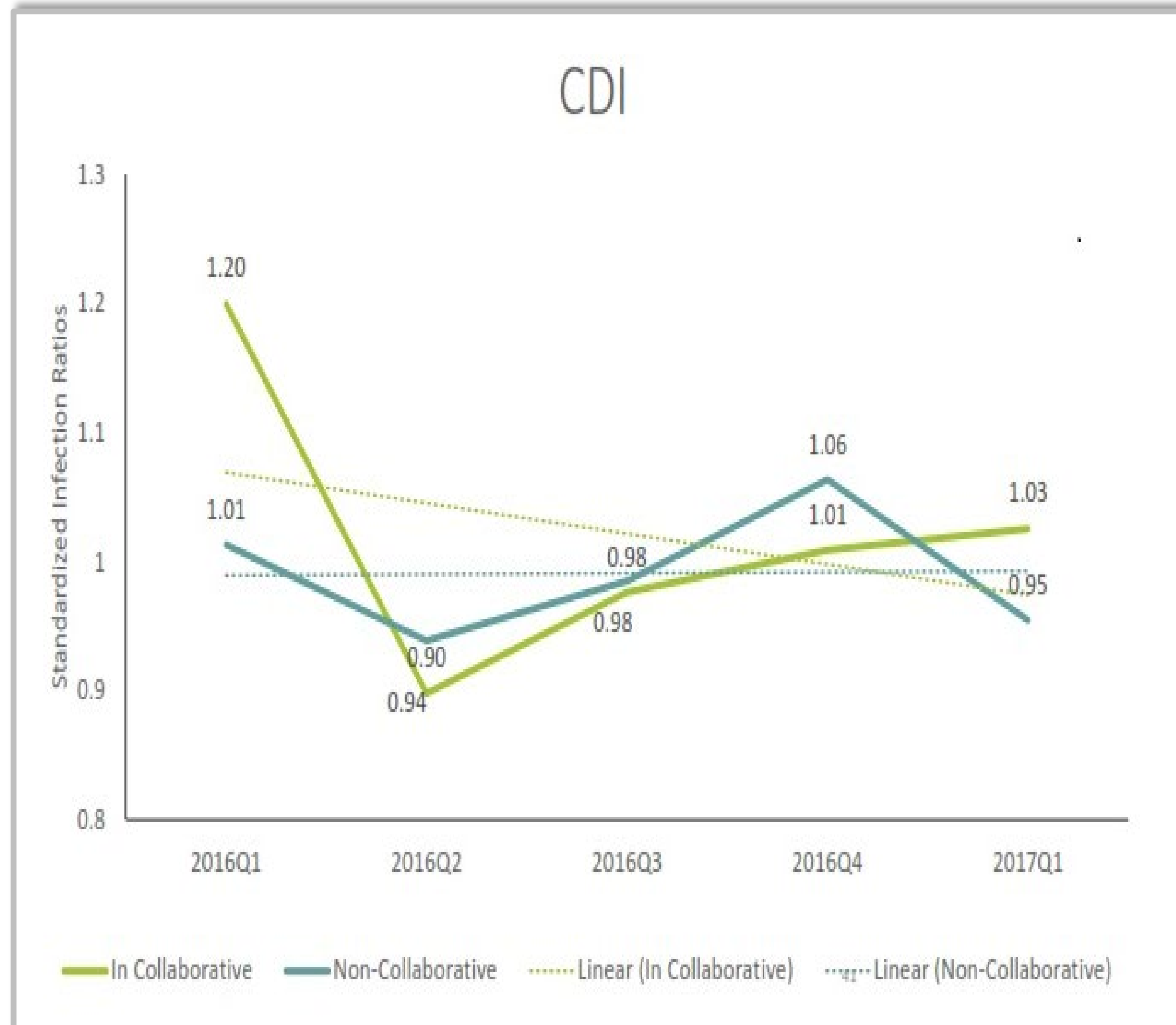
PREVENTED MORE THAN 100 cases of C-Diff over one year in participating organizations

Clean Collaborative & C-diff Reduction



Source: NHSN National Healthcare Safety Network; analysis by Maryland Hospital Association

Outcomes:

- **Phase I-** Contributed to efforts resulting in a **19%** reduction in C-Difficile cases (NHSN)
- **Phase II-** Contributed to efforts resulting in a **45%** reduction in C-Difficile cases
- Prevented more than 100 cases of C-diff in one year.

MHCC Update *Outline*

- **Successes**
  - Trended Safety Issues
  - Collaborative Project Outcomes
- ***Current***
  - *Strategic Partnerships*
  - *Grants*
  - *Patient Safety Advocacy*
  - *Alignment of Priorities*
  - *Education*
  - *Leadership*
- **Strategy**

Strategic Partnerships

Wellbeing

- Caring for the Caregiver: Implementing R.I.S.E.
- *Resilience in Stressful Events*
- Partnership through the Armstrong Institute for Quality and Safety

Patient and Family Engagement

- PFACQS®
- *Patient & Family Advisory Council on Quality & Safety*

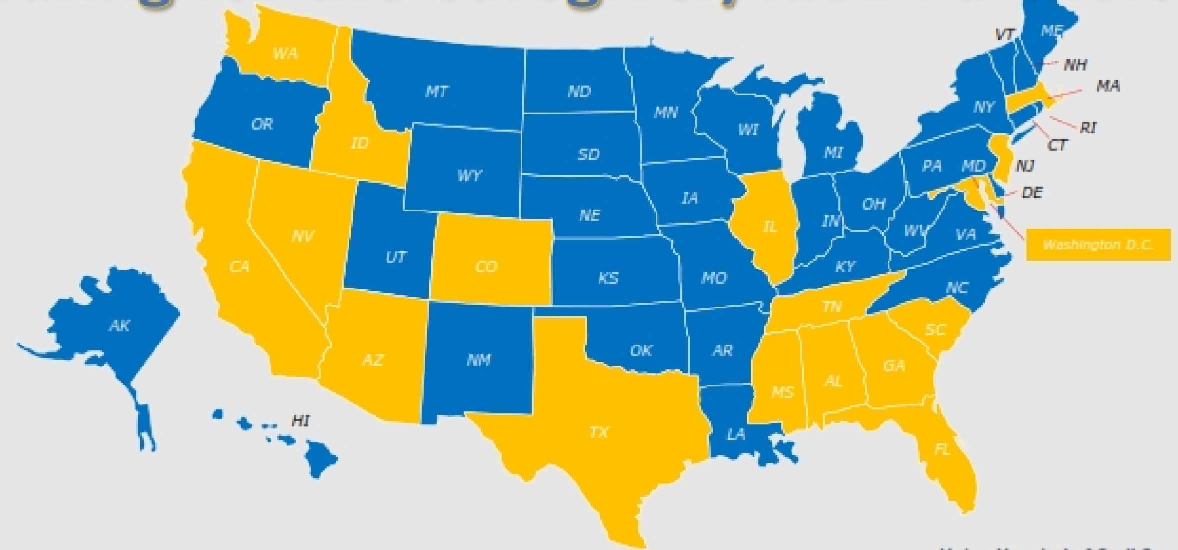
Joint Commission Recommendation

Focus on the Quadruple Aim: Development of a Resiliency Center to Promote Faculty and Staff Wellness Initiatives

Caring for the Caregiver: *Implementing RISE*

- 42 Total Hospitals
- 11 Hospitals in Maryland
- 1 Regional Group of Providers
- 1 National Group of Hospitalists

Caring for the Caregiver/RISE Partnerships



- The Johns Hopkins Hospital
- Johns Hopkins Bayview Medical Center
- University of Maryland Medical Center
- University of Maryland St. Joseph's Medical Center
- University of Maryland Upper Chesapeake Health
- Pelham Medical Center
- Johns Hopkins Howard County General Hospital
- University of Maryland Baltimore Washington Medical Center
- University of Maryland Medical Center Midtown Campus
- Kingdom of Saudi Arabia National Guard Health Affairs
- Denver Health and Hospital Authority
- Children's National Health System
- Atlantic Health System
- Kaiser Permanente- Mid Atlantic States
- Capital Health System
- Lurie Children's Hospital of Chicago
- Baptist Health Care
- Union Hospital of Cecil County
- Parkland Hospital
- All Children's Hospital
- St. Jude Children's Research Hospital
- Gwinnett Medical Center
- Frederick Memorial Hospital
- Memorial Care Health System
- Alabama Children's Hospital
- University of Mississippi Medical Center
- Swedish Medical Center- Ballard
- LifeBridge Health System
- Sound Physicians
- University of Alabama Hospital
- District Medical Group
- Kootenai Health
- Brigham and Women's Hospital
- Saint Mary's Regional Medical Center
- JPS Health Network

Strategic Partnerships

The PFACQS® Program

Elevating and Sustaining Patient and Family Advisory Councils for Quality and Safety (PFACQS®)

www.marylandpatientsafety.org/pfacqs

PFACQS®

Patient & Family Advisory Council on Quality and Safety

CMS Defines Patient and Family Engagement (PFE):

“Patients and families are partners in defining, designing, participating in and assessing the care practices and systems that serve them to assure they are respectful of and responsive to individual patient preferences, needs, and values. This collaborative engagement allows patient values to guide all clinical decisions and drives genuine transformation in attitudes, behavior, and practice.”

- Launch Date: January 13th, 2020

Strategic Partnerships

Grants

Current Grants:

- **Alliance for Innovation in Maternal Health (AIM) Grant:** statewide implementation of best practices to reduce severe maternal morbidity
- **HRSA Maternal Health Innovation Grant:** provide maternal workforce training on implicit bias/stigma related to opioid use disorder
- **CRISP Care Alerts Grant** for reviewing reports, submitting trends, determining abnormalities, variances and changes

Grants in Process:

- **RxALI: Prescription Abuse Leadership Initiative** for community education on the opioid epidemic
- **CareFirst Community Health Grant** on OB care of women with Opioid Use Disorder
- **Baltimore Women's Giving Circle Grant** for OB Emergencies Simulation Training
- **Maryland Department of Health Grant** for management of the state Perinatal Neonatal Quality Collaborative

"Your Listserv is responsible for motivating us to join this group of hospitals that require competency-based credentialing of staff! You are making a difference!"
-Healthcare Risk Attorney

Patient Safety Advocacy

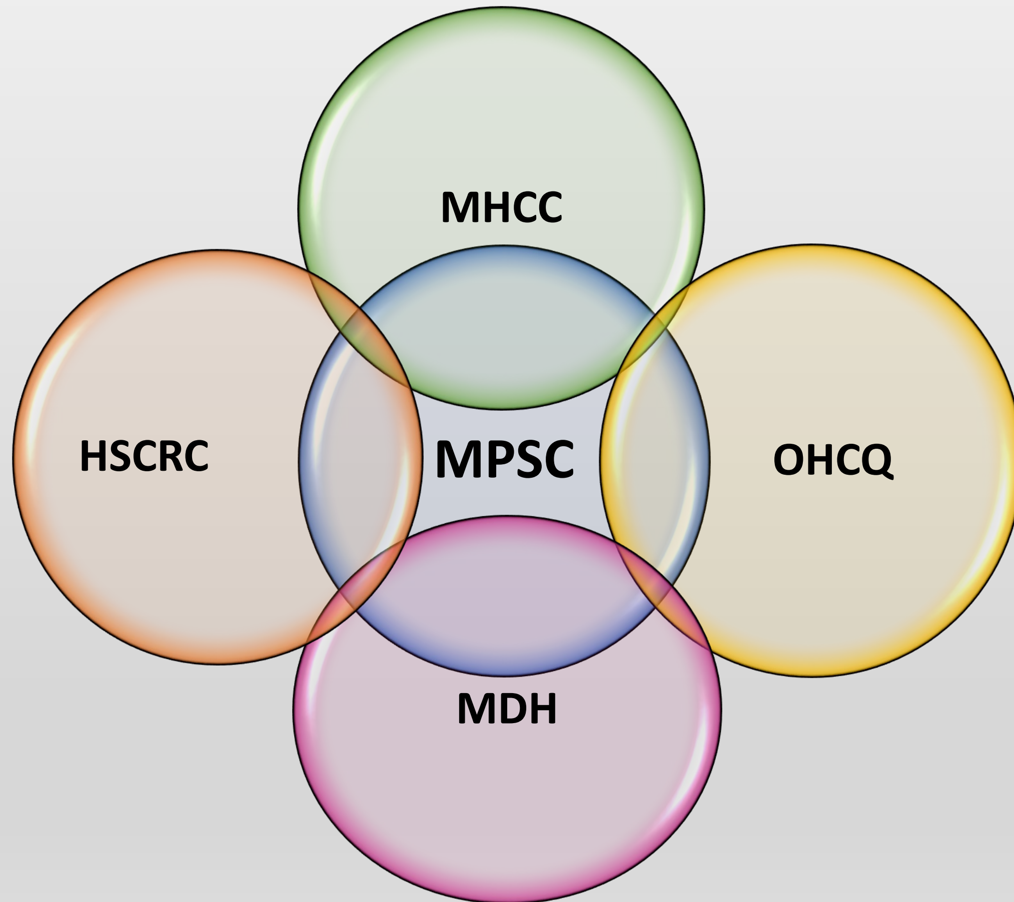
Patient Safety Officer Group

- 149 members of the listserv
- Robust exchange of patient safety information; often a weekly topic
- Recent topics addressed:
  - Process for Rapid Response Teams
  - Concerns related to discharging of patients with TED (thrombo-embolic deterrent hose) stockings
  - Falls reduction programs/tools
  - Drug shortage strategies
- Quarterly statewide forum
- Individual coaching by MPSC

Perinatal/Neonatal Group

- 707 members of the listserv
- Recent topics addressed:
  - Frequency of magnesium testing for pre-eclampsia
  - Staff requirements in electronic fetal monitoring
  - Procedures for fetal demise in utero

Alignment of Priorities



- Implicit Bias
- Healthcare Disparities
- Safe Sleep
- Maternal Opioid Use
- Diabetes
- Errors in Diagnosis
- Treatment Delays
- ED Throughput

Education

Minogue Award for Patient Safety:

- 71 entrants
- 2020 Winner:
  - University of Maryland Baltimore Washington Medical Center
- Top 20 are poster presenters at conference

Annual Patient Safety Conference:

- "Putting the Patient at the Center of Patient Safety"
- March 27th, 2020
- Expected 1500+ attendees
- Nationally recognized speakers

Education

Organizational Patient Safety Training

- 20% increase in adverse event reporting
- Acquired pressure ulcer rate dropped by over 80%
- Readmissions down by 6%
- Falls rate down by 36%

(experience of pilot post-acute facility)

Patient Safety Certification	Patient Safety Specialization	Patient Safety Champion Training
6 full day (8 hour) team training sessions	4 full day (8 hour) training sessions	3 full day (8 hour) training sessions
18 months of data collection	12 months of data collection	No Data Collection
Monthly reporting/consulting calls (x18)	Quarterly reporting/consulting calls (x4)	No post training consultation
Award and logo to use for PR	logo to use for PR	Individual certificates for participants

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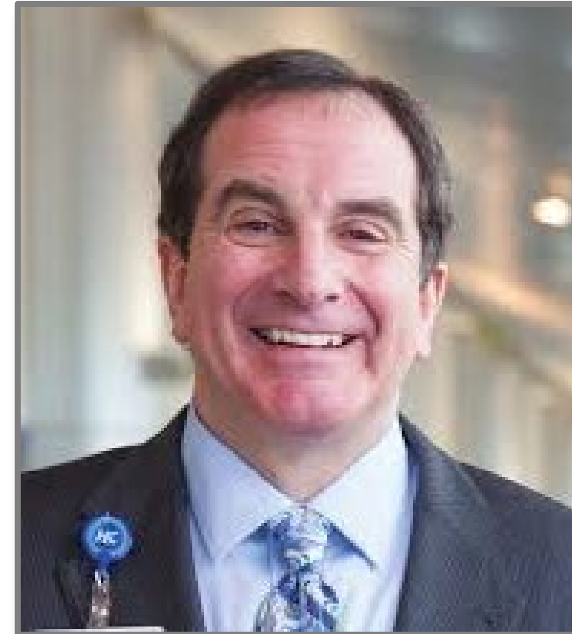
49 MPSC Member Organizations

MPSC Board of Directors

Expanded to include:

- Patients and Family Members
- State Representatives
- Emergency Medical Technicians
- Post Acute Leadership
- Outpatient Leadership
- MHCC Representative (TBD)



Blair Eig, M.D.
Incoming President and CEO, MPSC
Former CMO, Holy Cross Hospital

Leadership

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Strategy

New Partnerships

- Error Disclosure Program

Grants

- Infant Lifetime Care
- Diagnostic Errors

Out of State Targets

- Delaware
- Northern Virginia
- Washington DC
- West Virginia

Alignment

- Regular Meetings: MHCC, HSCRC, MDH, OHCQ

Questions ?