MARYLAND Patient Safety CENTER

Making Maryland's Healthcare the Safest in the Nation

Presented to:
Maryland Health Quality & Cost Council

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Maryland's Patient Safety Strategy:

A Three-Pronged Approach

Objective	Implementing Entities	Affected Entities
Mandatory reporting of adverse events resulting in death or serious disability	Maryland Department of Health and Mental Hygiene (DHMH)	Hospitals, nursing homes, and potentially other licensed facilities
Provider education and voluntary reporting of de-identified information on adverse events and near misses	Maryland Patient Safety Center (MPSC)	Hospitals, nursing homes, and potentially all facilities
Use of data systems and advanced technologies to improve care	MHCC - State Health Plan, Certificate of Need Program, Hospital and Nursing Home Report Cards. HSCRC: Rate allowances for technology improvement, Payment for Quality.	All facilities regulated by Certificate of Need and rate-regulated hospitals

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PUBLIC SOURCE OF OUR CHARTER

(2003)

- Maryland General Assembly
- Maryland Health Care Commission
- Health Services Cost Review Commission

FOUNDING PARTNERS

- Maryland Hospital Association
- Delmarva Foundation

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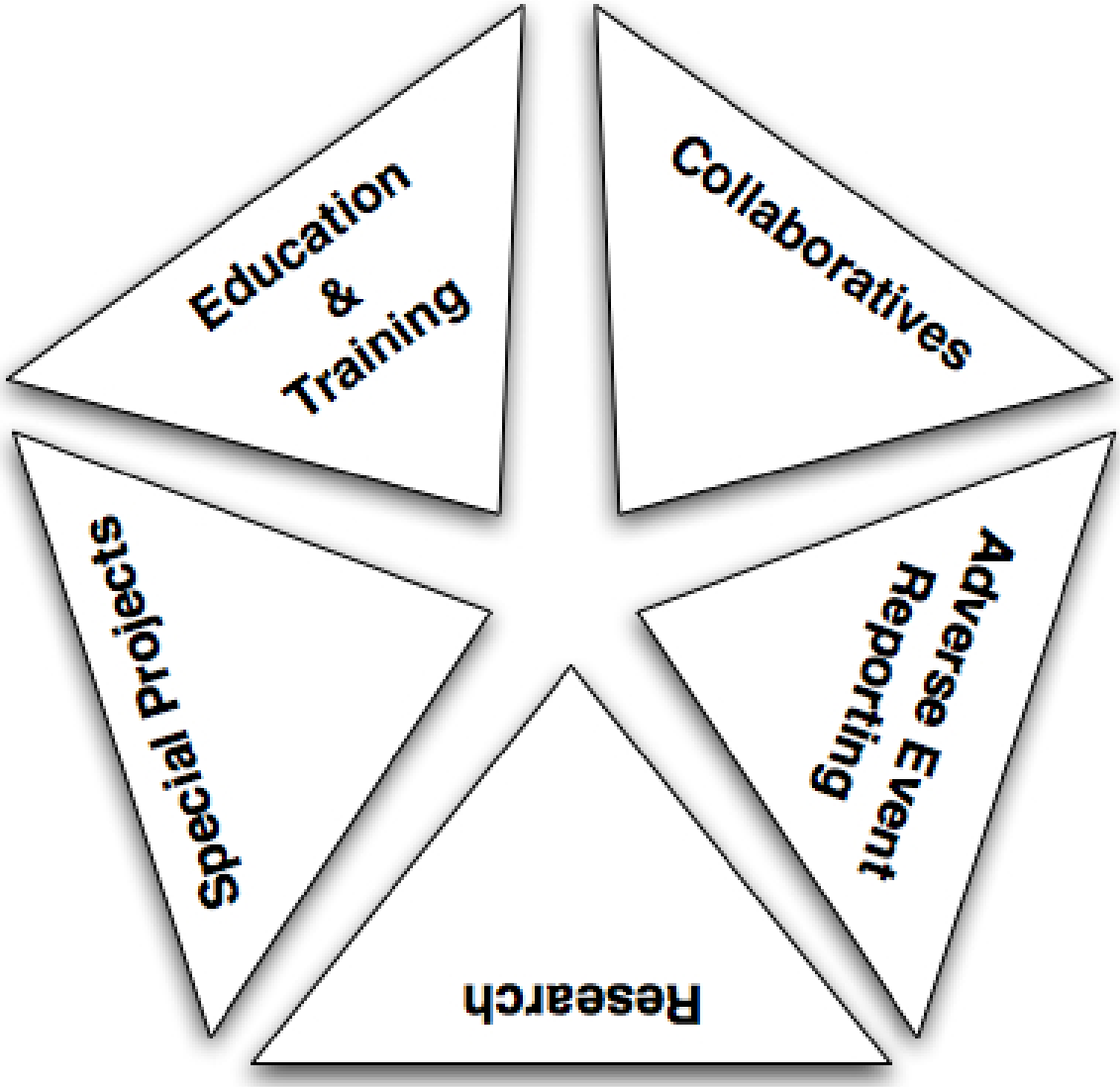
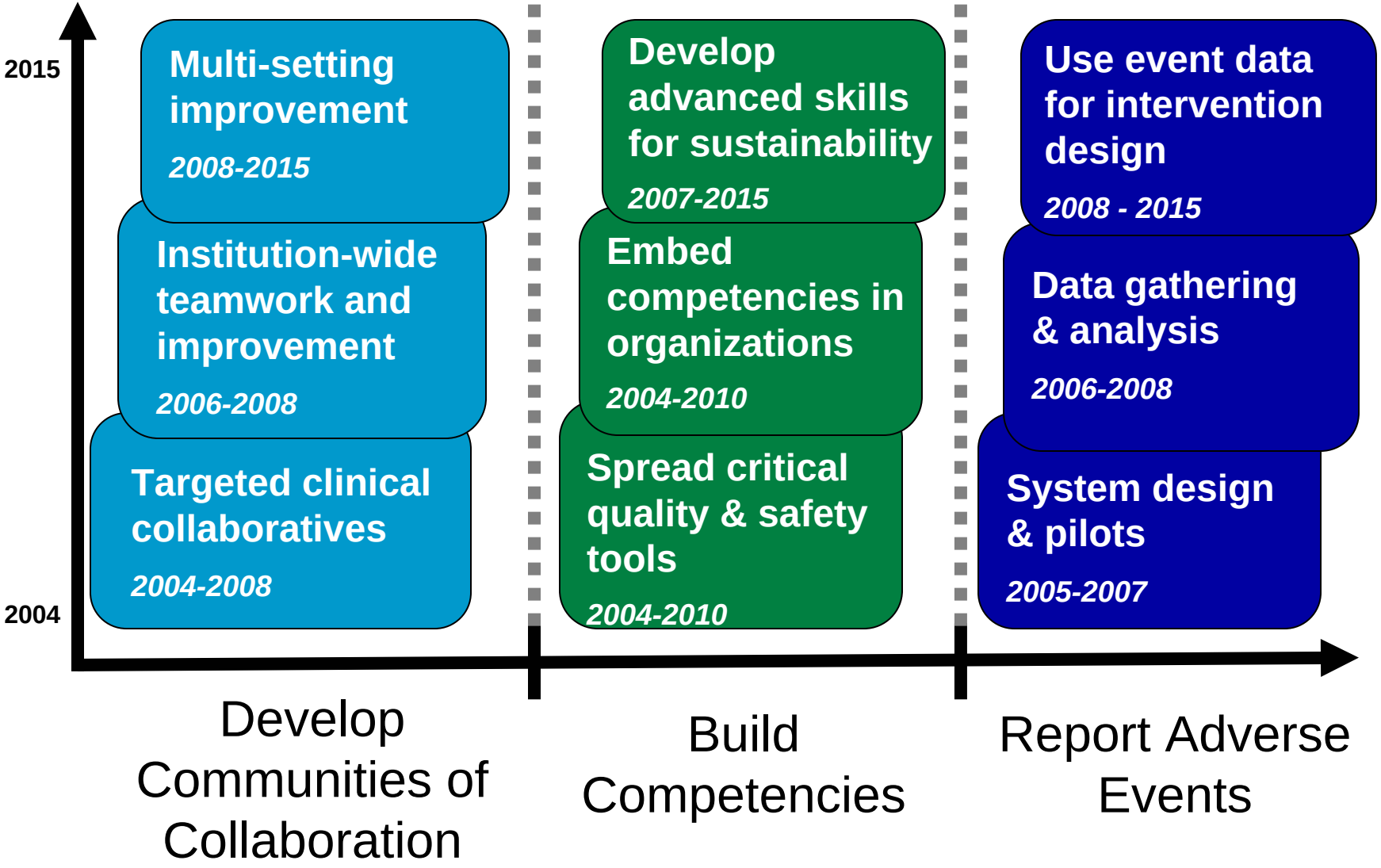


Strategic growth of MPSC activities to engage regional organizations in patient safety



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Key Results

ICU Collaborative
- 1,113 infections avoided
- 140 lives saved
- $40,775,000 saved

ED Collaborative
- 30 minute reduction (LOS)
- Yellow and red alert reductions
- Timely antibiotics

Perinatal Collaborative (DHMH)
- 76% of hospitals
- 64% improved safety culture perception
- AOI – statewide
- 4.4% adverse outcome baseline

MRSA Prevention
- Target – 30% reduction/year
- NHSN data system – CDC

MEDSAFE Conference
- All MD hospitals participate
- 2007 – "High Alert Meds" PANIC + Pitocin
- 2008 – Patient Falls and Meds

Education Programs
- 8,400 professionals participating

Adverse Event Reporting System
- 7 hospitals participating, with 26 additional facilities supplying data

** See pages 2-4 of MPSC's Report to the Council for further details*

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The Challenge We See

- **Poor Quality**…… 3% defect rate
- Impact on individuals…….. 100% defect
- Cost of poor quality……. Billions of dollars
- Impact on those who pay…… Unaffordable
- Access to care ……. Millions without
- Morale of workers…… Low
- Unreliable systems …….. **Poor Quality**

The Task: Introduce New Values That Change the Mind of Medicine

From:
Institutional values currently in place

To:
The values that define a patient safety culture

Louis Pasteur

“It’s not the seed…

It’s the soil”

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The Task: Introduce New Values That Change the Mind of Medicine

FROM	TO
• Provider first	• Patient first
• Waiting is good	• Waiting is bad
• Errors are expected	• Defect-free medicine
• Diffuse accountability	• Rigorous accountability
• Have to add resources	• No new resources
• Reduce costs	• Reduce waste
• Retrospective QA	• Real time QA
• Management oversight	• Management on site
• We have time, no hurry	• We have no time, urgent