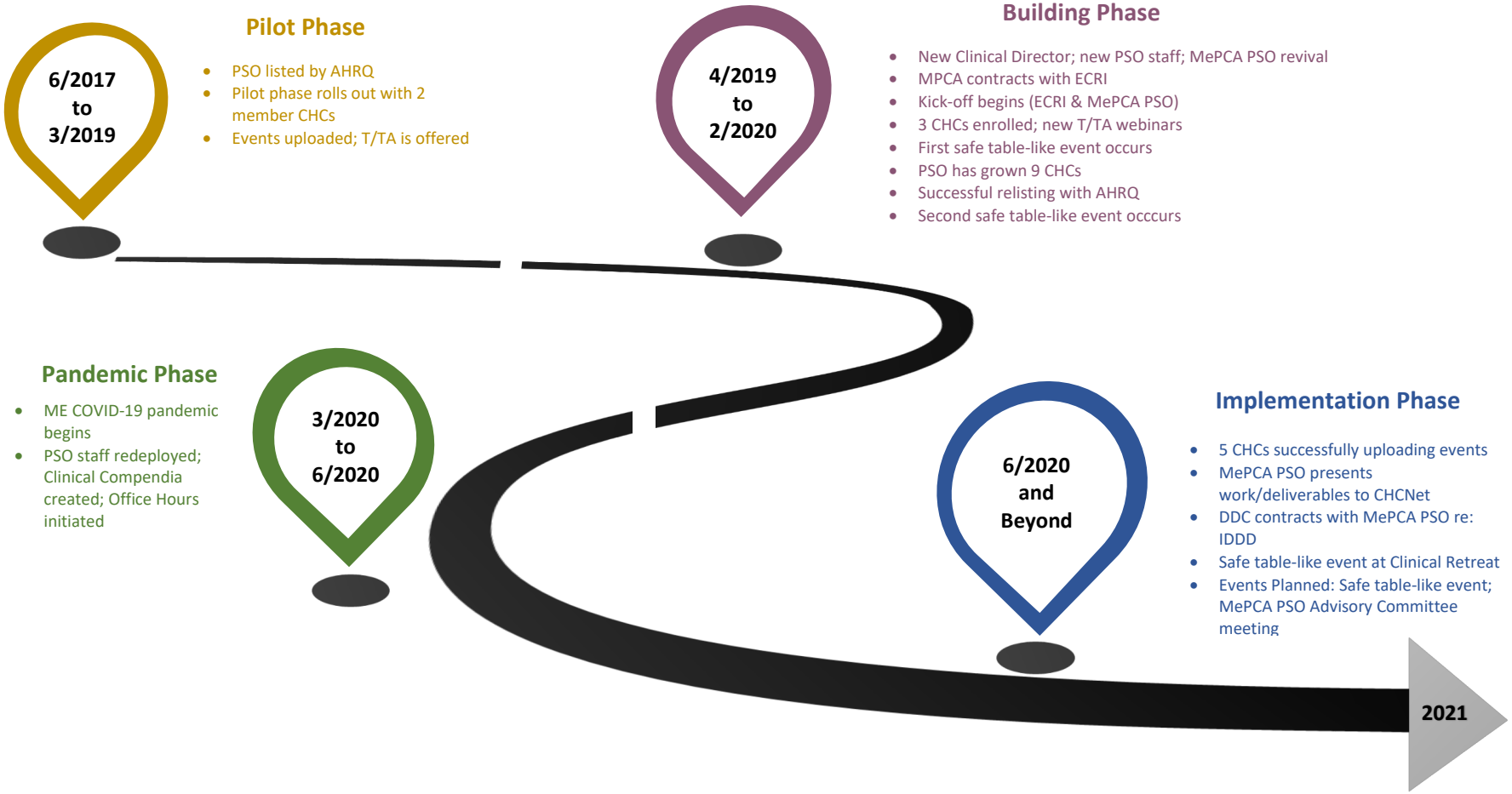
A Patient Safety Organization Comes Together…

Focused on safety, data, quality and health equity.

MePCA PSO: Our Path to Patient Safety



PSO goals

01

Create a sustainable organization that connects strongly with UDS, HCCN, VBP.

02

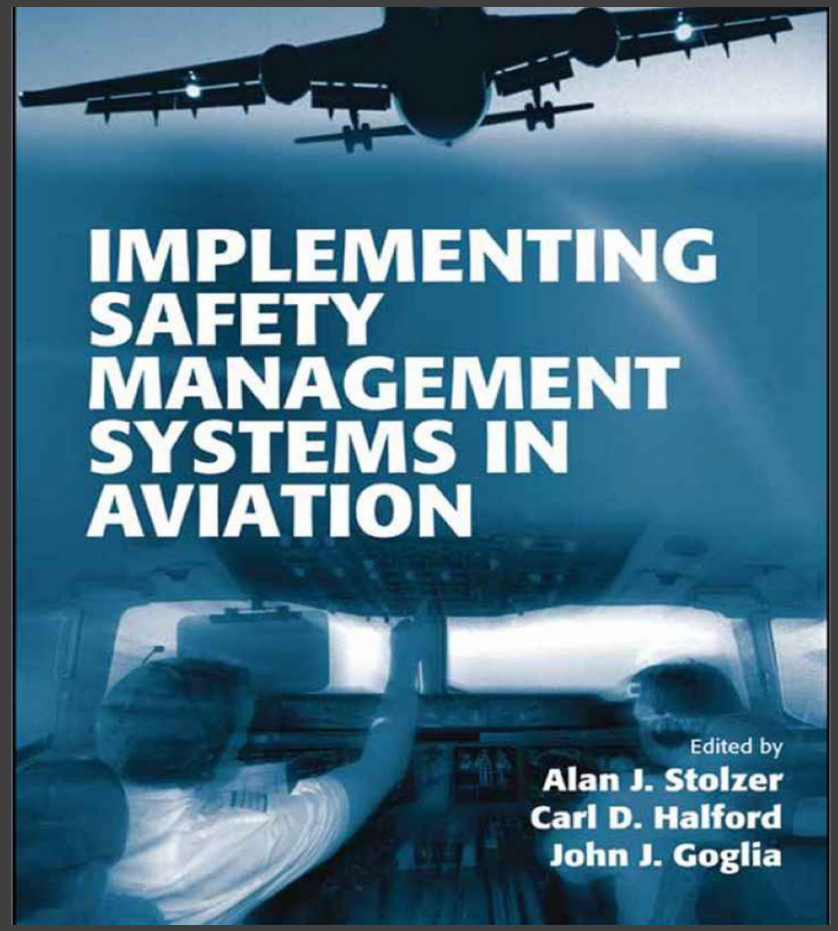
Weave the strands of patient safety, quality, health equity and data throughout all we do.

What is a Patient Safety Organization (PSO)? Part 1

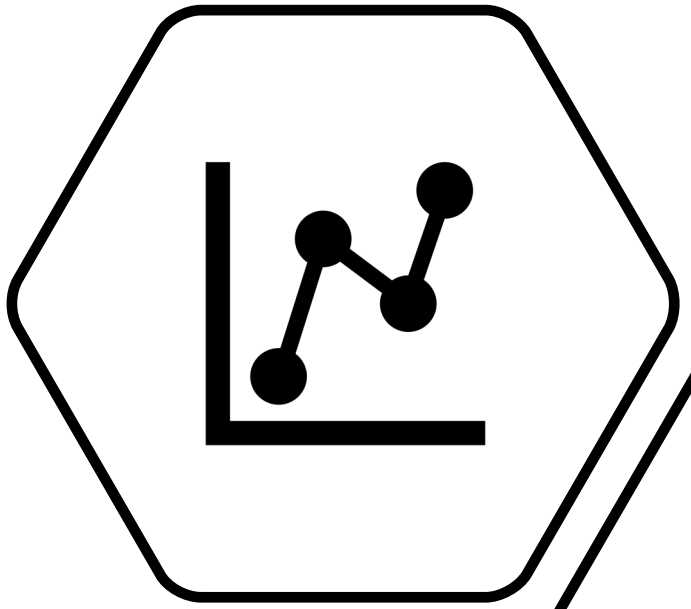
- Patient Safety Organizations (PSOs) are organizations that conduct activities to improve the safety and quality of patient care.
- PSOs create a legally secure environment (conferring privilege and confidentiality) where clinicians and health care organizations can voluntarily report, aggregate, and analyze data, with the goal of reducing the risks and hazards associated with patient care.
- The Patient Safety and Quality Improvement Act of 2005 (PSQIA) authorized the creation of PSOs and the development of Common Formats for uniform reporting of patient safety events.

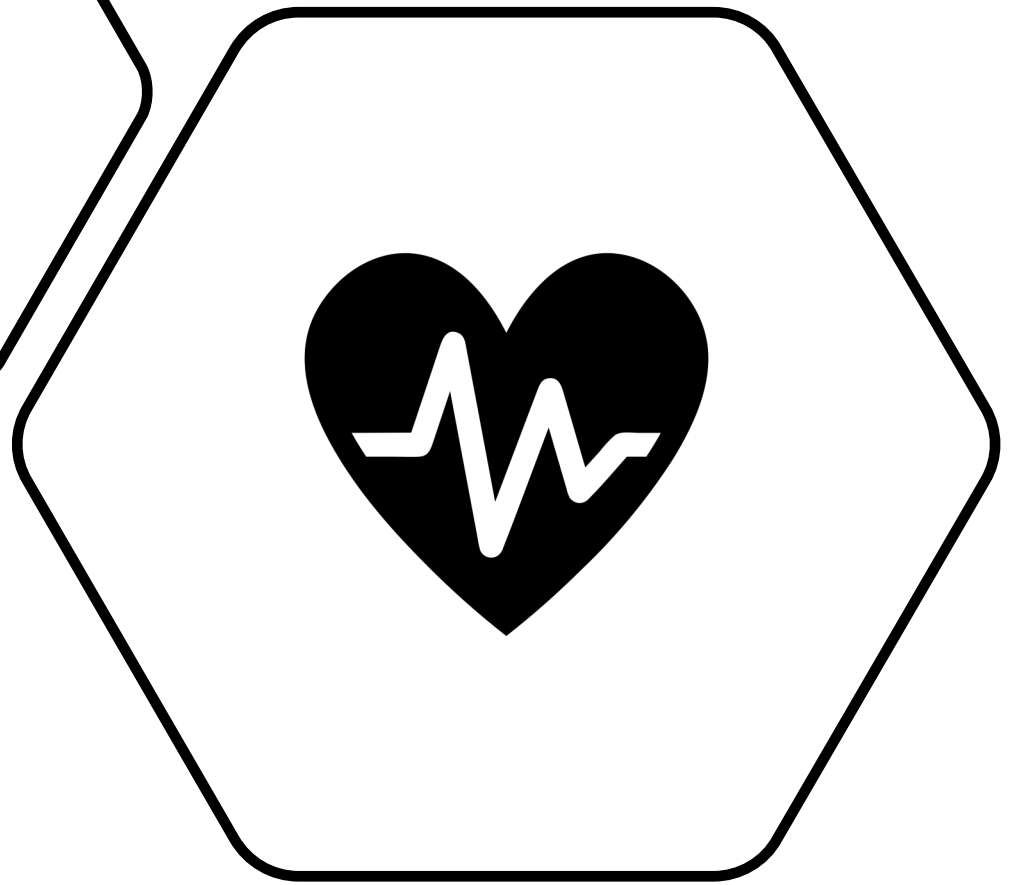
What is a Patient Safety Organization (PSO)? Part 2

- PSOs serve as independent, external experts who can assist providers in the collection, analysis, and aggregation of patient safety events to develop insights into effective methods to improve quality and safety.
- Providers who establish relationships with a PSO receive uniform Federal protections (conferring privilege and confidentiality) that are intended to remove fear of legal liability or professional sanctions.



Why have a PSO?





- The core goals of the Patient Safety and Quality Improvement Act are: (1) **to encourage health care professionals to improve the safety and quality of health care, (2) to understand the underlying causes of hazards in the delivery of health care, and (3) to share those results in all states within a protected legal environment, thereby minimizing any risks related to patient care.**
- In short, this important legislation provides an environment in which health care practitioners can voluntarily and anonymously report safety problems, with the idea that conveying these messages will lead to improved care through a ***CULTURE OF SAFETY.***

Why have a PSO?

- The Patient Safety Act was intended to strike a balance between maintaining confidentiality and legal protections in reporting safety information and maintaining patients' rights.
- The Act was not intended to mandate participation in any specific patient safety organization (PSO).
- It is not an error-reporting system *per se* and does not provide any federal funding for PSOs.

What is “Patient Safety”?

- “…a discipline in the health care professions that applies safety science methods toward the goal of achieving a **trustworthy system of health care delivery**. We also define patient safety as an attribute of health care systems that minimizes the incidence and impact of adverse events and maximizes recovery from such events. Our description includes: why the field of patient safety exists (the high prevalence of avoidable adverse events); its nature; its essential focus of action (the microsystem); how patient safety works (e.g., high-reliability design, use of safety sciences, methods for causing change, including cultural change); and who its practitioners are (i.e., all health care workers, patients, and advocates).”

https://www.ncbi.nlm.nih.gov/books/NBK43629/

MePCA PSO: The 1st PCA-led, FQHC-focused PSO can *redefine* "patient safety"

- Our work can generate a new definition of "patient safety," in which the CHC Network becomes a "trustworthy system of health care delivery" – a *CULTURE OF PATIENT SAFETY* – which not only addresses avoidable adverse events but also gets at inequities and dysfunctions embedded in the system that cause unseen, often normalized harm to specific populations…
- The MPCA PSO must become member-led with the creation of a member advisory board--perhaps a subcommittee of CHC net.

Did you know...

Patient safety issues in primary care are real.

Annually,

1 in 20 outpatients experiences a diagnostic error

55%

of patients said diagnostic errors were a chief concern in outpatient visits

1 in 9

ED admissions are related to an adverse drug event

An estimated **160 million** medication errors occur each year in primary care

up to **80%**

of information shared in a primary care visit is **immediately forgotten** by patients

Improve patient safety by engaging patients and families.

Reduce errors and improve visit efficiency by setting the visit agenda together with **Be Prepared To Be Engaged.**

Encourage safe medicine practices by **Creating a Safe Medicine List Together.**

Improve communication and health literacy through **Teach-Back.**

Support closed-loop and collaborative communication using the **Warm Handoff Plus.**

AHRQ Agency for Healthcare Research and Quality

To learn more and get started, visit https://www.ahrq.gov/professionals/quality-patient-safety/patient-family-engagement/pfeprimarycare/index.html

HCCN Objective C1/Activity 3

Nearly half of CHCNet members joined the PSO during Year 01…**CHCNet will continue to align with the PSO**…and the ECRI Institute, to identify data analysis opportunities and workflows that improve patient and staff safety for all PHCs.

By the end of Year 03 (July 2022), CHCNet, MEPCA PSO, and the ECRI Institute will:

complete enrollment of all PHCs into the PSO;	Develop a PSO business and sustainability plan;	Identify a data analytics use case for the PowerBI platform.

The PSO Fosters a Safety Culture

For patients: improved outcomes.

Accurate, appropriate and timely care; shorter wait times; fewer errors that reach the patient; fully engaged HCPs; improved engagement and satisfaction.

For staff: improved well-being.

Improved team communication; decreased moral suffering; greater connection to organizational values; improved job satisfaction.

For leadership: greater productivity and capacity for innovation.

Decreased staff turnover; improved quality scores; improved efficiency; increased capacity to deliver specific training to meet staff needs.

Rethinking the goals of Patient Safety – drop slide consider recasting bullet 2

- Patient safety in practice is more than reducing rates of errors. *The goal is not just to eliminate risks*.
- Standardized reporting of safety event, near misses and unsafe conditions builds ***a CHC data set*** that can inform Quality Improvement Activities
- Safety Culture protects patients and promotes team communication

Partnership with ECRI increases data capacity

PSO members can:

- Access individual data dashboards
- Compare clinical data to both regional and national trends
- Analyze data from events, near misses, and unsafe conditions (including contributing factors and descriptive text searches)
- Tableau reports can be generated for use with staff and board members

Data driven strategies

- Trend analyses can be linked to customized solutions
- CHC data analysis and feedback drives meaningful QI initiatives
- Network data trends drive quarterly Safe Table exercises
- Network can access templated approaches to common problems
- PSO members can access “Custom Search” queries of national database of evidence-based practice strategies for risk prevention

HRSA-FQHC Partnership through ECRI

ECRI Clinical Risk Management Program

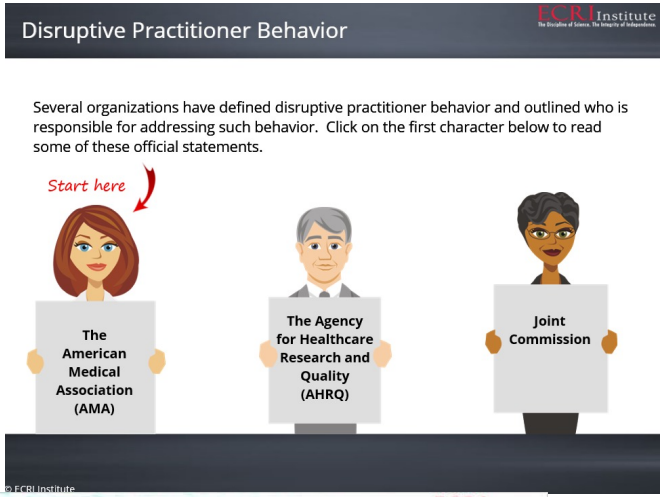
- Website and resources provided FREE to FQHCs, free clinics, FQHC Look-Alikes, and PCAs on behalf of HRSA
- Log in to the website to access:
  - Assessment checklists
  - Guidance
  - Toolkits
  - Archived webinars, National Speaker Series programs, and Virtual Conference
  - Courses for CME/CNE credit
  - Infographics
- Resources cover risk management, credentialing and privileging, infection control, claims management, quality improvement, diabetes, and much more

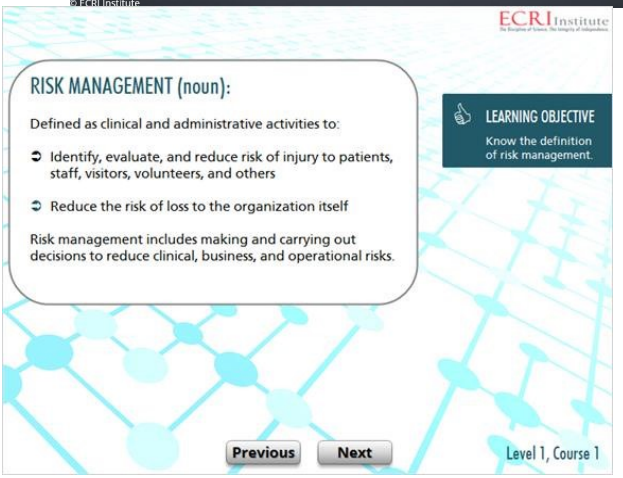
Clinical Risk Management Resources

- New! Pandemic Recovery Guide for Health Centers
- Toolkits:
  - Culture of safety
  - Dental
  - COVID-19 response
  - Credentialing and privileging
  - Risk management
- Risk Management Manual
- Webinar: Vaccine Promotion: Strategies for Increasing Vaccine Awareness and Immunization Rates
- Much more

Clinical Risk Management Education

- Ambulatory Risk Management Certificate Course
  - 4 Levels of 20 courses on risk management basics
  - Intended for anyone in the health center
  - Certificate for completion of each level
- eLearning Course Catalog
  - Courses cover infection control, sexual harassment, communication, and more
  - CME/CNE credit
- Obstetrics Training Suite
  - 40 courses on electronic fetal monitoring and other high-risk OB topics (e.g., shoulder dystocia)
  - CME/CNE credit





Need Access?

- Unlimited number of individuals from FQHCs and FQHC Look-Alikes receive free access to the website, resources, and education
- Contact us at Clinical_RM_Program@ecri.org or (610) 825-6000 for access
  - Include full name, email address, and organization name
- Questions? Use contact info above or cwzorek@ecri.org

MePCA PSO – ECRI partnership

Maine Primary Care Association PSO

Welcome to Maine PCA PSO. Use this page to submit data, run reports, review the latest patient safety news, and access other resources from Maine PCA and ECRI Institute PSO.
(Toggle Member/Public View)

Submit Adverse Event Data ↗

Securely submit data related to adverse events.

Upload Events ↗

Upload batches of events to the PSO reporting system.

PSO Interactive Dashboards (Beta Release) ↗

Explore your safety data in a whole new way.

CONTACT US

General Questions
clientservices@ecri.org
(610) 825-6000 ext. 5891

ECRI INSTITUTE PSO DEEP DIVE™

Meeting Patients' Behavioral Health Needs in Acute Care

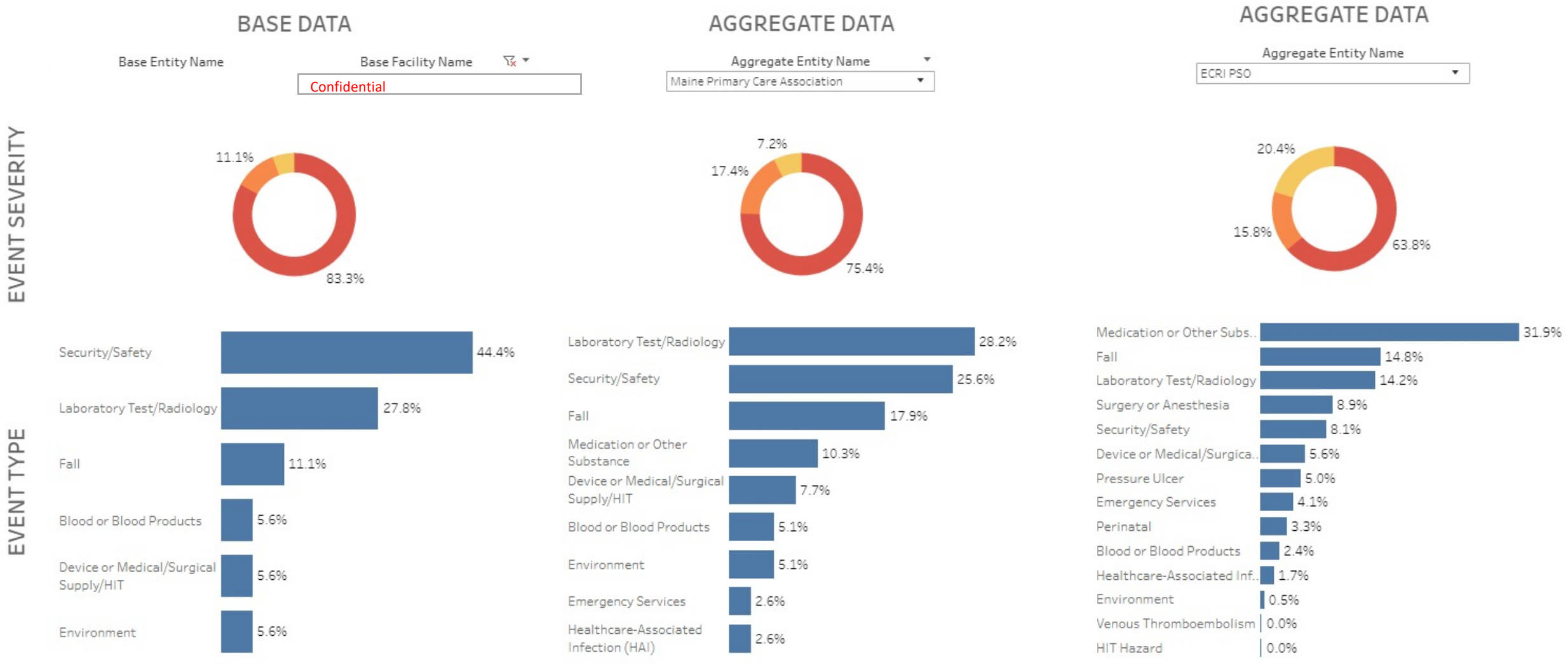
Opioid Use in Acute Care

Patient Identification

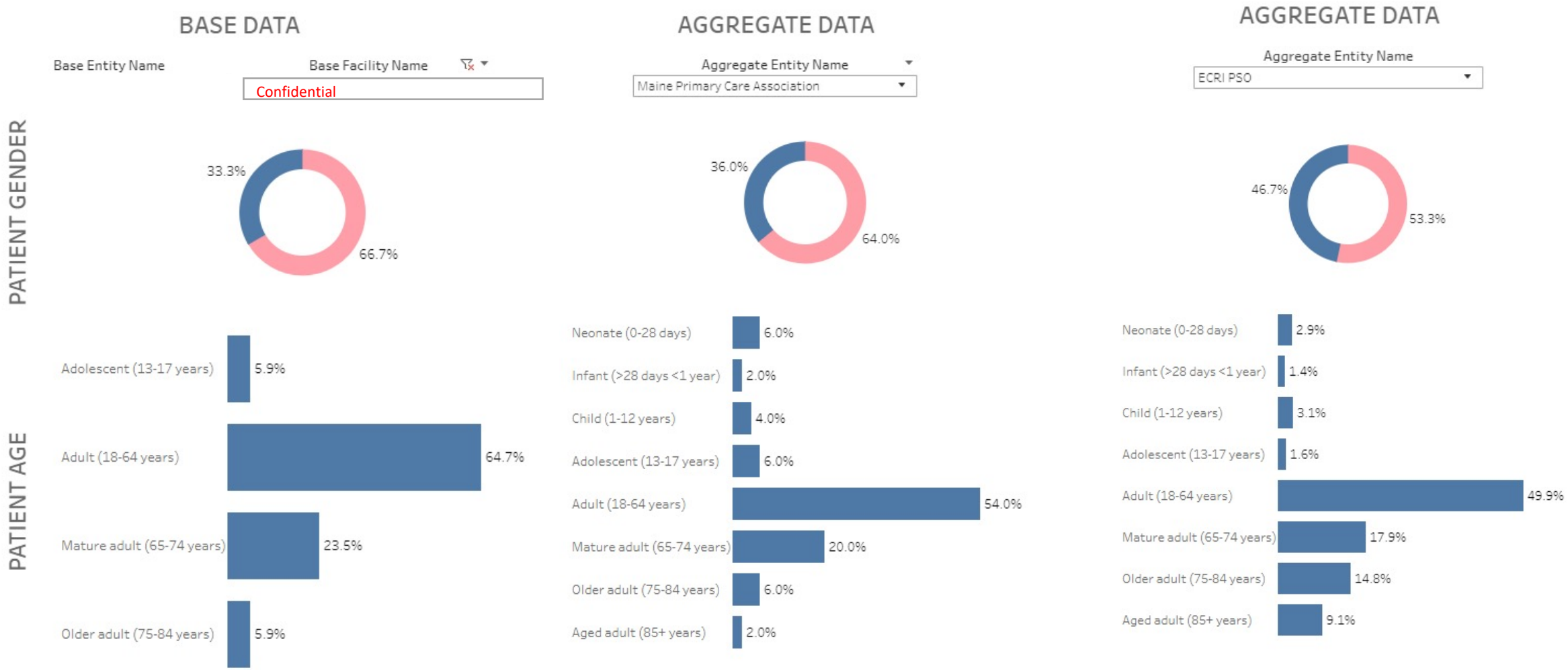
Care Coordination

Laboratory Events

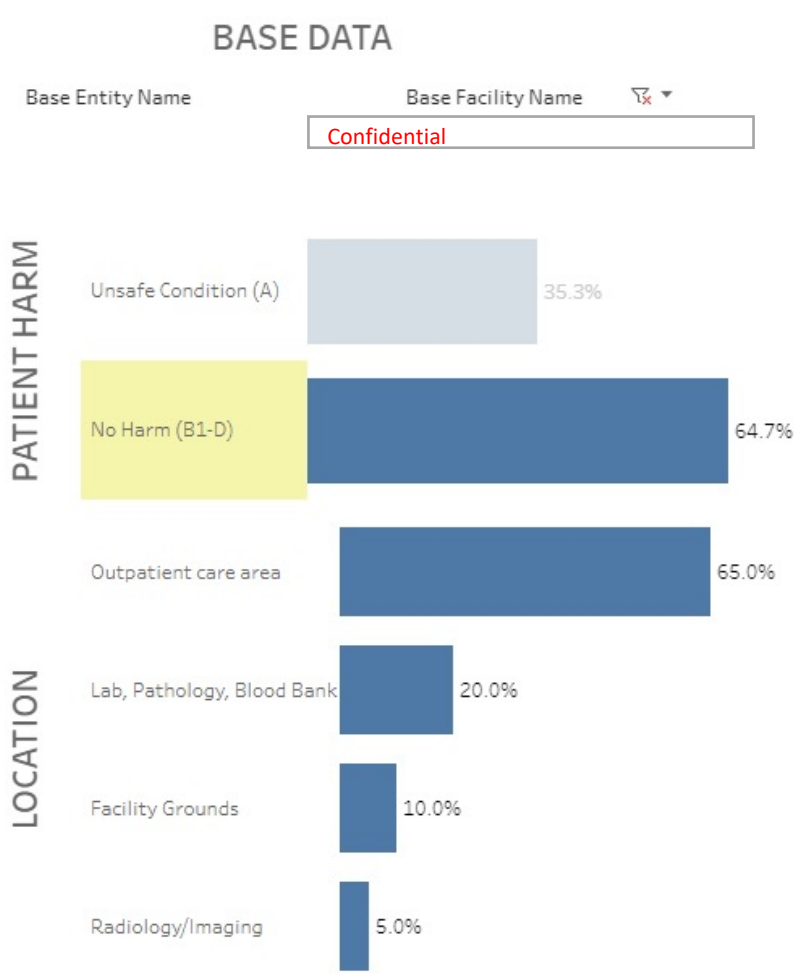
3 Levels of Comparison: Event Data

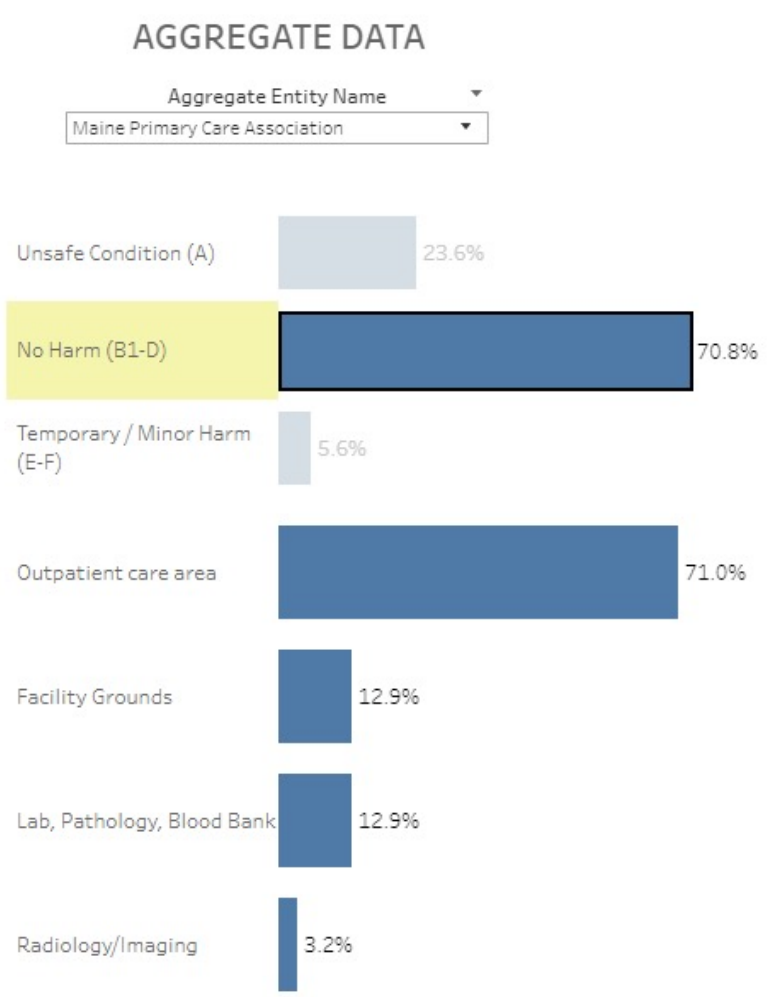


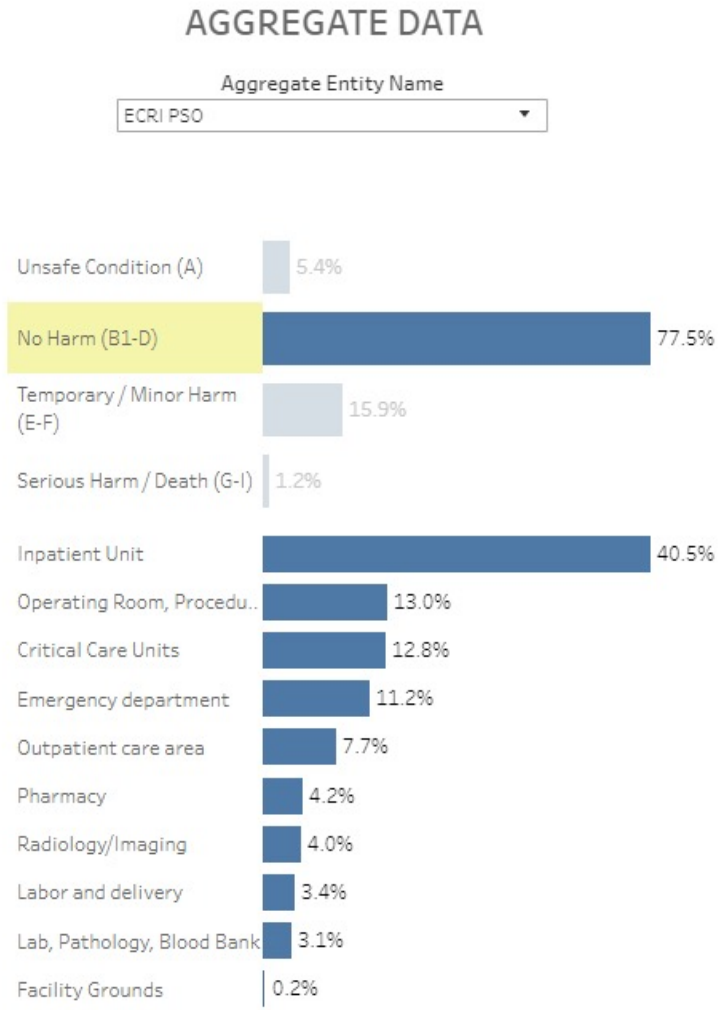
3 Levels of Comparison: Demographic Data



3 Levels of Comparison: Harm Data







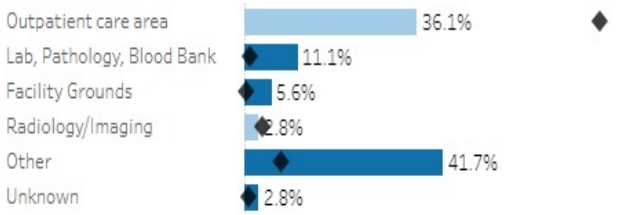
Show Nulls
Hide Nulls

FACILITY DASHBOARD

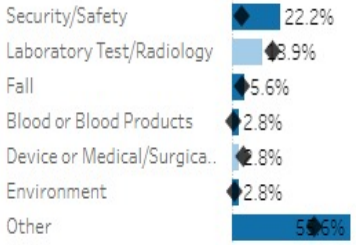
ECRI PSO Institute for Safe Medication Practices

Entity Name: Maine Primary Care Association
Facility Name: Confidential
Facility Type: (Multiple values)
Geography: (All)
Bed Size: (All)
Critical Access: (All)
Teaching Status: (All)

LOCATION



PRIMARY EVENT TYPE



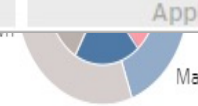
SECONDARY EVENT TYPE

(SELECT A PRIM. ET TO DISPLAY VALUES)

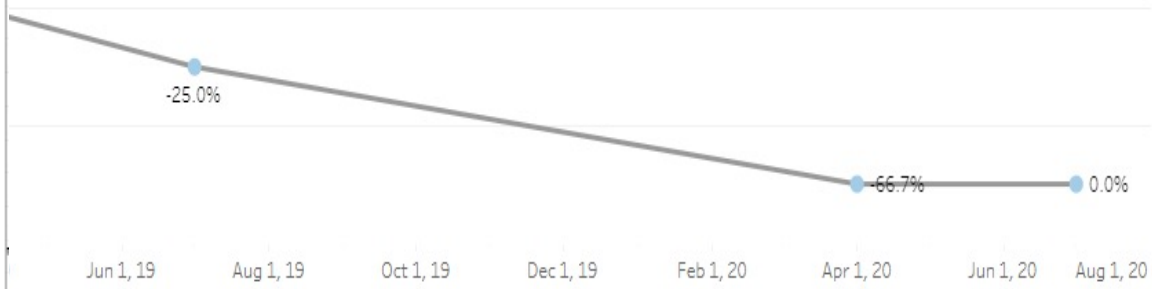
Facility Type

- [ ] (All)
- [ ] Acute Care Hospital
- [x] Ambulatory Care Center
- [ ] Ambulatory Surgical Facility
- [ ] Assisted Living Facility
- [ ] Behavioral Health
- [ ] Blood Bank
- [ ] Children's Hospital
- [x] Community Health Center
- [ ] Community Pharmacy
- [ ] Dialysis Center
- [x] Federally Qualified Health Center
- [ ] Home Health
- [ ] Independent Diagnostic Center
- [ ] Long Term Acute Care (LTAC)
- [ ] Long Term Care Facility
- [ ] Other
- [ ] Other Specialty Hospital
- [x] Physician Practice
- [ ] Rehabilitation Center
- [ ] Skilled Nursing Facility (SNF)/Nursing Facility (NF)
- [ ] Unknown
- [ ] Urgent Care/Emergency Medicine

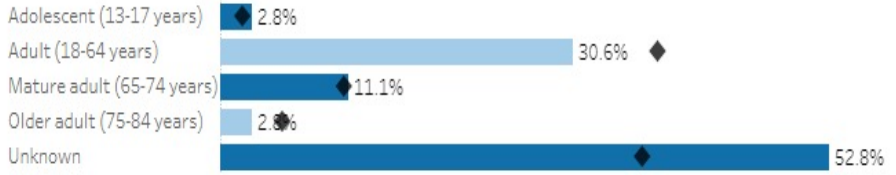
Cancel Apply



1/6/2021 BY Quarter



PATIENT AGE



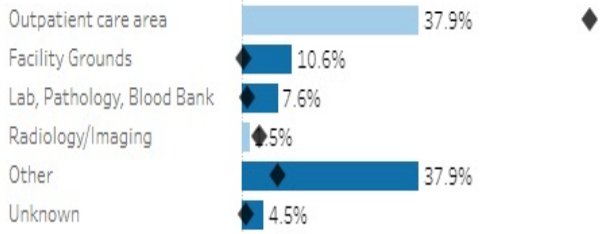
Show Nulls
Hide Nulls

FACILITY DASHBOARD

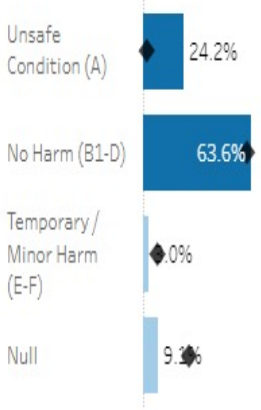
ECRI Institute for Safe Medication Practices PSO

Entity Name	Facility Name	Facility Type	Geography	Bed Size	Critical Access	Teaching Status
Maine Primary Care Association	(All)	(Multiple values)	(All)	(All)	(All)	(All)

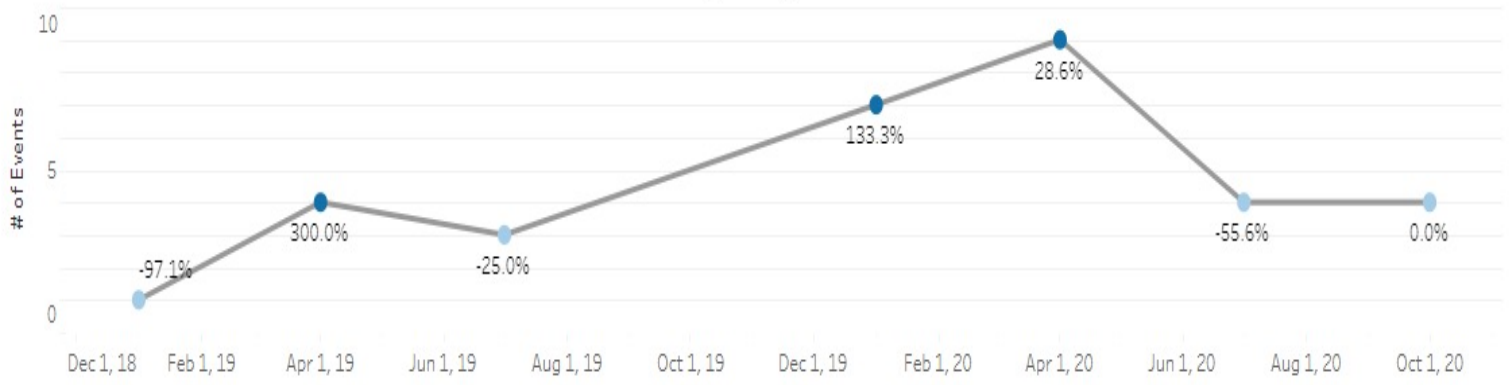
LOCATION



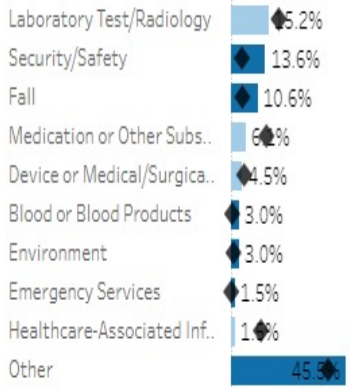
PATIENT HARM



EVENTS FROM 1/5/2019 1/6/2021 BY Quarter



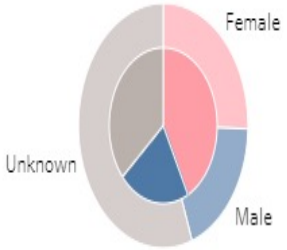
PRIMARY EVENT TYPE



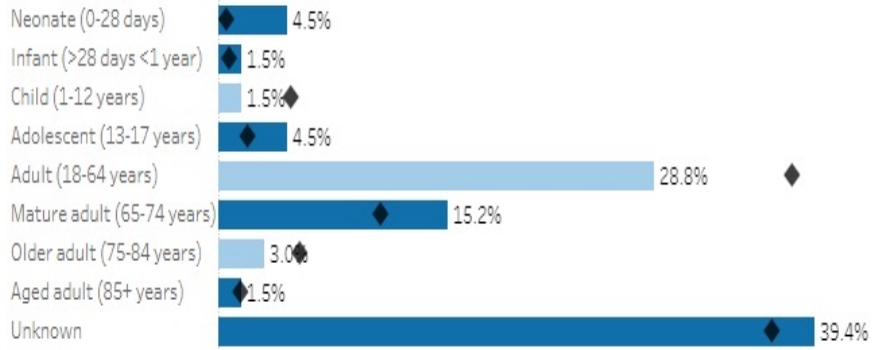
SECONDARY EVENT TYPE

(SELECT A PRIM. ET TO DISPLAY VALUES)

GENDER



PATIENT AGE



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Show Nulls
Hide Nulls

MAIN DASHBOARD

ECRI PSO
Institute for Safe Medication Practices

Entity Name: Maine Primary Care Association
Facility Type: (Multiple values)
...aphy
Bed Size: (All)
Critical Access: (All)
Teaching Status: (All)
Event Date: 3/17/2019 – 12/31/2020

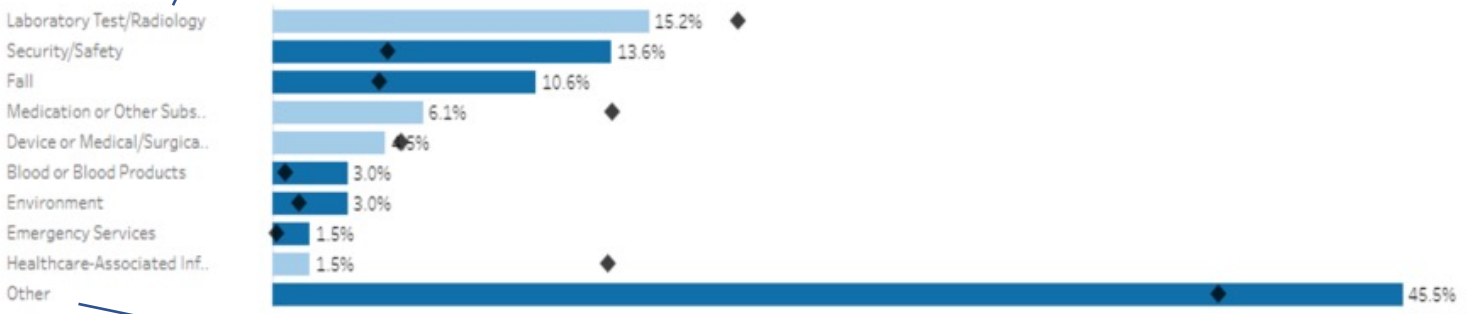
Safe Table 11/8/20

Safe Table 2/11/20

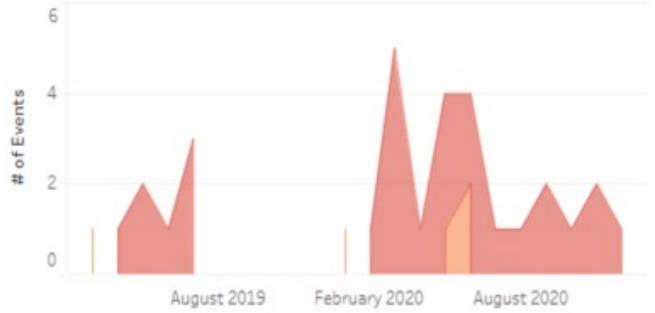
Safe Table 8/21/20

EVENT SEVERITY

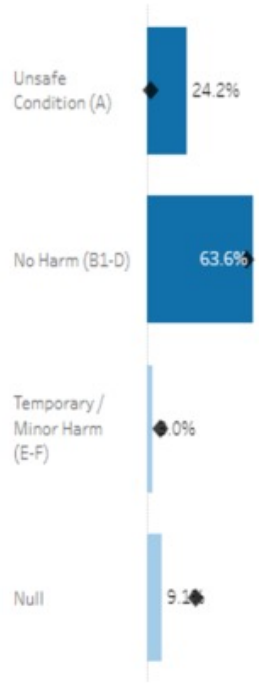
PRIMARY EVENT TYPE



TIME TREND BY SEVERITY

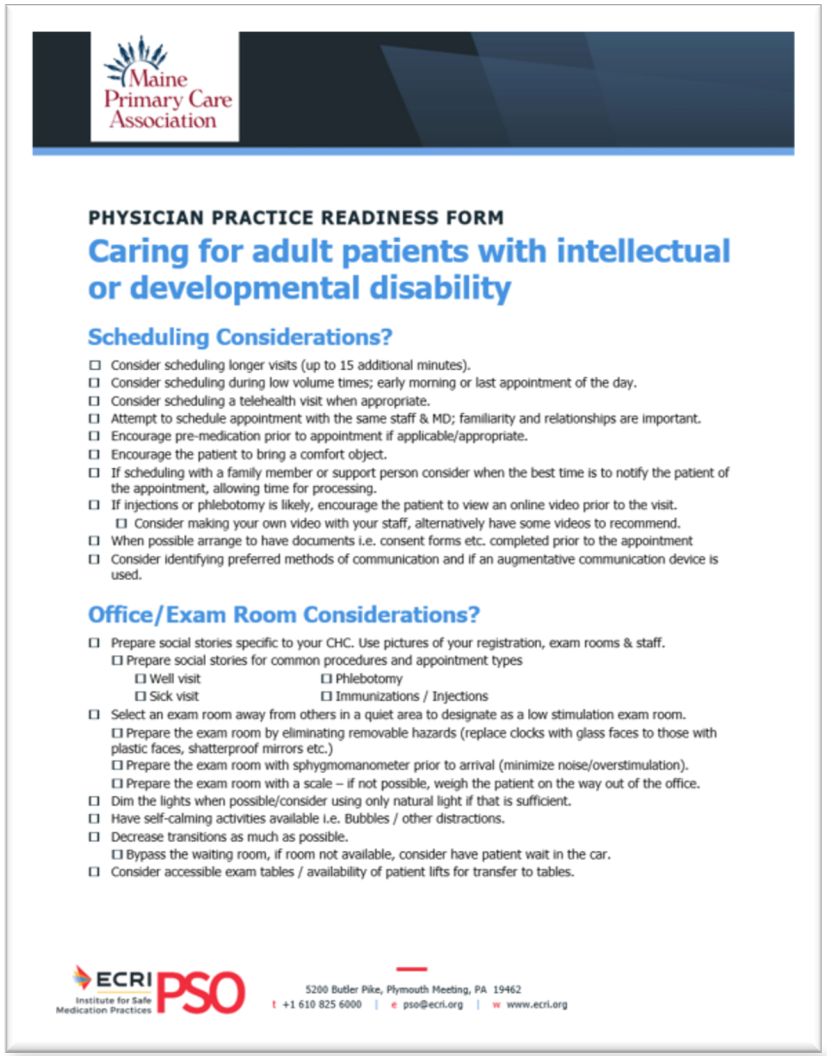


PATIENT HARM



FACILITY

I/DD Readiness Assessment Form



Maine Primary Care Association

PHYSICIAN PRACTICE READINESS FORM

Caring for adult patients with intellectual or developmental disability

Scheduling Considerations?

- ☐ Consider scheduling longer visits (up to 15 additional minutes).
- ☐ Consider scheduling during low volume times; early morning or last appointment of the day.
- ☐ Consider scheduling a telehealth visit when appropriate.
- ☐ Attempt to schedule appointment with the same staff & MD; familiarity and relationships are important.
- ☐ Encourage pre-medication prior to appointment if applicable/appropriate.
- ☐ Encourage the patient to bring a comfort object.
- ☐ If scheduling with a family member or support person consider when the best time is to notify the patient of the appointment, allowing time for processing.
- ☐ If injections or phlebotomy is likely, encourage the patient to view an online video prior to the visit.
  - ☐ Consider making your own video with your staff, alternatively have some videos to recommend.
- ☐ When possible arrange to have documents i.e. consent forms etc. completed prior to the appointment
- ☐ Consider identifying preferred methods of communication and if an augmentative communication device is used.

Office/Exam Room Considerations?

- ☐ Prepare social stories specific to your CHC. Use pictures of your registration, exam rooms & staff.
  - ☐ Prepare social stories for common procedures and appointment types
    - ☐ Well visit
    - ☐ Sick visit
    - ☐ Phlebotomy
    - ☐ Immunizations / Injections
- ☐ Select an exam room away from others in a quiet area to designate as a low stimulation exam room.
  - ☐ Prepare the exam room by eliminating removable hazards (replace clocks with glass faces to those with plastic faces, shatterproof mirrors etc.)
  - ☐ Prepare the exam room with sphygmomanometer prior to arrival (minimize noise/overstimulation).
  - ☐ Prepare the exam room with a scale – if not possible, weigh the patient on the way out of the office.
- ☐ Dim the lights when possible/consider using only natural light if that is sufficient.
- ☐ Have self-calming activities available i.e. Bubbles / other distractions.
- ☐ Decrease transitions as much as possible.
  - ☐ Bypass the waiting room, if room not available, consider have patient wait in the car.
- ☐ Consider accessible exam tables / availability of patient lifts for transfer to tables.

ECRI PSO Institute for Safe Medication Practices
5200 Butler Pike, Plymouth Meeting, PA 19462
t +1 610 825 6000 | e pso@ecri.org | w www.ecri.org

PHYSICIAN READINESS FORM

Caring for adult patients with intellectual or developmental disability

Care Provision Considerations

- ☐ Consider obtaining a problem list and other available/pertinent information prior to the appointment.
- ☐ Always speak to the patient first and not individual accompanying them, unless necessary.
- ☐ Explain what is going to be done prior to doing it, allowing time for internal processing.
  - ☐ Consider incorporating social stories in helping to explain procedures while providing care.
  - ☐ Seek permission and notify the patient prior to touching them.
  - ☐ Provide an estimation as to how long something will take. Be specific, avoid using "a few minutes."
- ☐ Show equipment and if appropriate allow them to handle the equipment prior to using (i.e. autoscope)
- ☐ Assess the patient on the examination table, not in their wheelchair even if they are difficult to transfer.
- ☐ Identify where the patient's safe space is and keep it safe. If their wheelchair is a safe space avoid violating it by administering injections or potentially painful procedures while they are in it.
- ☐ Use numbing cream when appropriate.
- ☐ Establish a signal for the patient to use if they need a break.
- ☐ Limit the time patients are required to be gowned or undressed; or encourage loose fitting clothing that will allow for your assessment.
- ☐ Consider offering a dry run or a walk through prior to completing difficult procedures or examinations
- ☐ Constipation is a common issue consider including this in a differential for abdominal pain visits.

Staff Preparation Considerations

- ☐ Expect to invest more time per visit.
- ☐ Remain comfortable during uncomfortable procedures.
- ☐ Stress may impact the patient's ability to communicate.
- ☐ Behaviors can equal pain/fear.
- ☐ Avoid the use of figures of speech, use concrete terms.
- ☐ Be flexible and not rigid.
  - ☐ If the situation allows and the provider is safe, consider providing an evaluation in their vehicle.
- ☐ Utilize augmentative communication device.
- ☐ Be comfortable with and use Picture Exchange Communication Systems when applicable.
- ☐ Be aware of the specific documentation requirements for service eligibility forms.

Acknowledgement

This document was prepared with the assistance of the Maine Primary Care Association PSO, the Maine Developmental and Disabilities Council and Nemours Children's Health System. ECRI would like to extend its gratitude for their knowledge sharing and in kind endowment of expertise in the area of treating patients with intellectual or developmental disabilities.

Policy Statement

The information provided in this document may be derived from several sources, such as relevant scientific and management literature, published best practices, standards and regulations, surveys and/or questionnaires to healthcare providers and healthcare organizations. This document is intended as an educational tool representing industry answers to address best practices around caring for an individual with intellectual and developmental disabilities in the ambulatory care setting. We make reasonable efforts to ensure that our reports are up to date and our sources are reliable but cannot guarantee the accuracy of information gathered from third parties. The contents of this document should not be regarded as a guarantee of the safety, performance, or cost-effectiveness of any equipment, device, system, or practice. Any recommendations contained in this document do not constitute legal advice. You should consult legal counsel for specific legal guidance and should develop clinical guidance in consultation with clinical staff.

ECRI PSO Institute for Safe Medication Practices

ECRI
Patient Safety Organization

PHYSICIAN PRACTICE READINESS FORM

Caring for adult patients with intellectual or developmental disability

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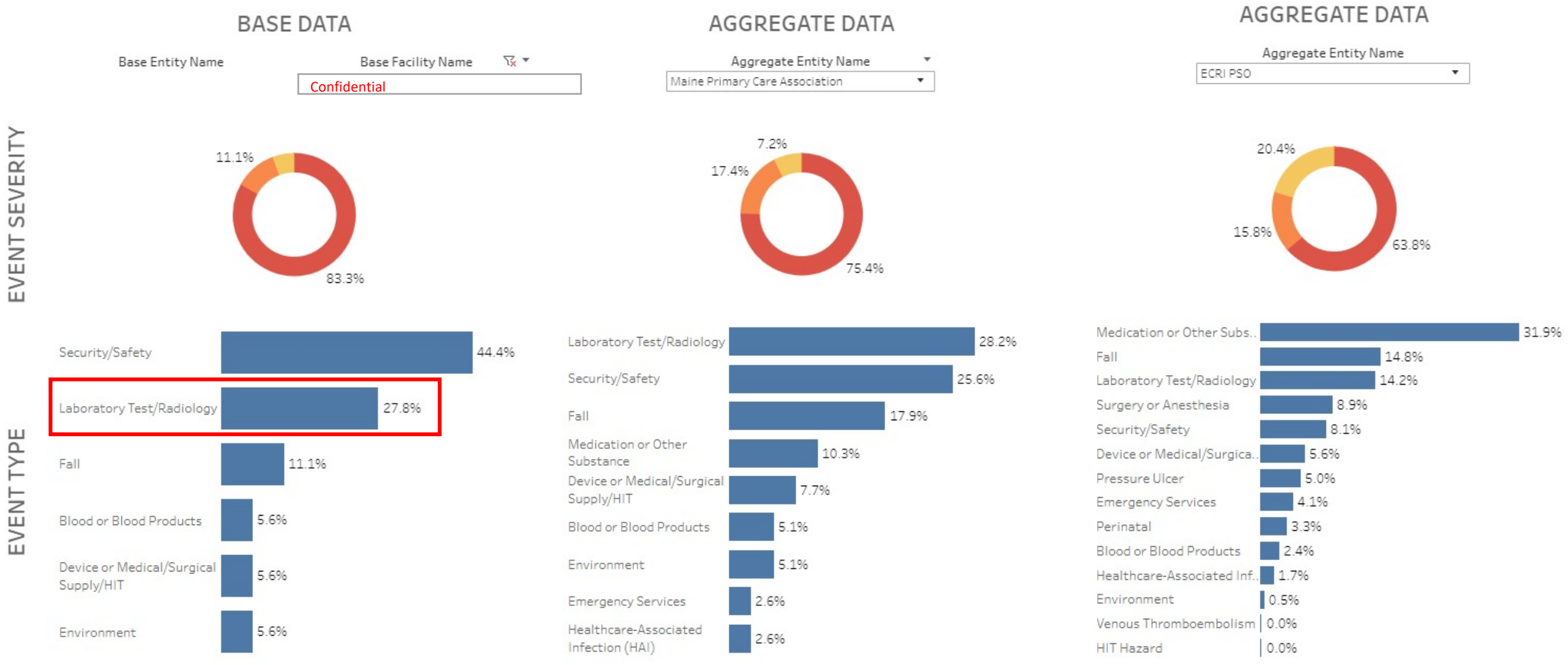
- ☐ Encourage the patient to bring a comfort object.
- ☐ If scheduling with a family member or support person consider when the best time is to notify the patient of the appointment, allowing time for processing.
- ☐ If injections or phlebotomy is likely, encourage the patient to view an online video prior to the visit.
  - ☐ Consider making your own video with your staff, alternatively have some videos to recommend.
- ☐ When possible arrange to have documents i.e. consent forms etc. completed prior to the appointment
- ☐ Consider identifying preferred methods of communication and if an augmentative communication device is used.

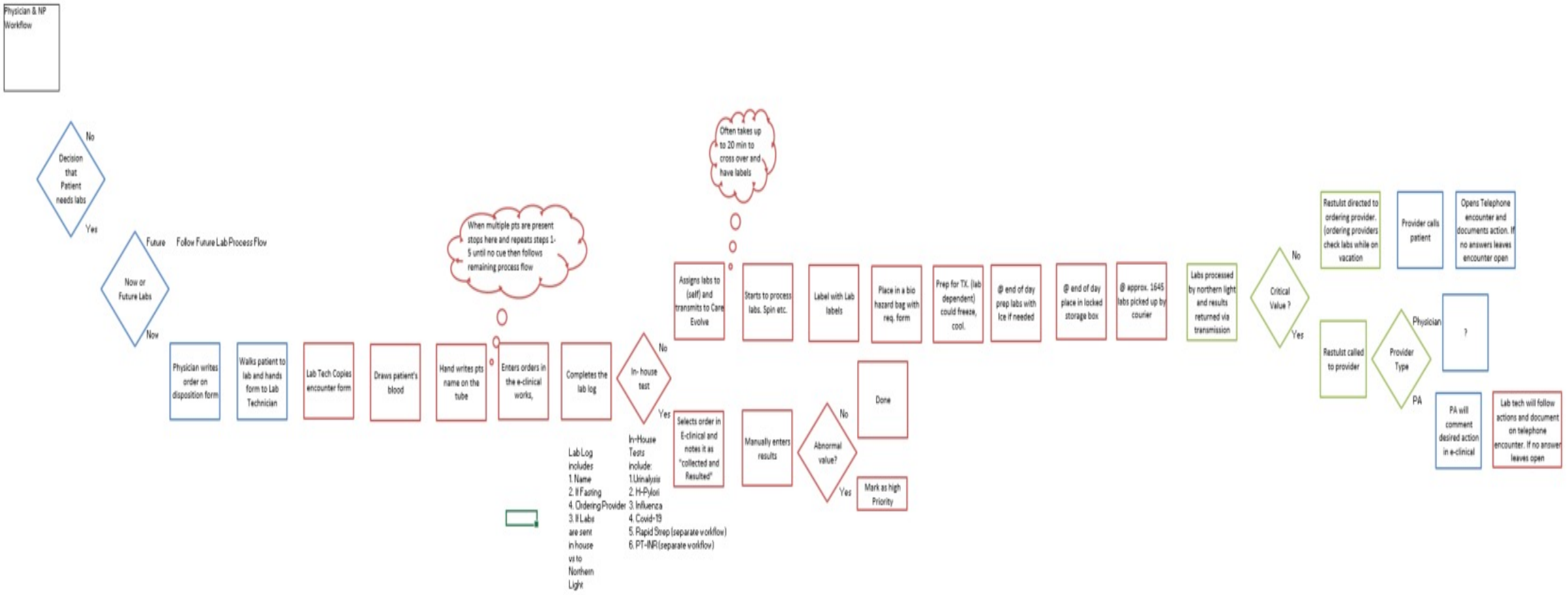
OFFICE/EXAM ROOM CONSIDERATIONS?

- ☐ Prepare social stories specific to your CHC. Use pictures of your registration, exam rooms & staff.
  - ☐ Prepare social stories for common procedures and appointment types
    - ☐ Well visit
    - ☐ Sick visit
    - ☐ Phlebotomy
    - ☐ Immunizations / Injections
- ☐ Select an exam room away from others in a quiet area to designate as a low stimulation exam room.
  - ☐ Prepare the exam room by eliminating removable hazards (replace clocks with glass faces to those with plastic faces, shatterproof mirrors etc.)
  - ☐ Prepare the exam room with sphygmomanometer prior to arrival (minimize noise/overstimulation).
  - ☐ Prepare the exam room with a scale – if not possible, weigh the patient on the way out of the office.
- ☐ Dim the lights when possible/consider using only natural light if that is sufficient.
- ☐ Have self-calming activities available i.e. Bubbles / other distractions.
- ☐ Decrease transitions as much as possible.
  - ☐ Bypass the waiting room, if room not available, consider have patient wait in the car.
- ☐ Consider accessible exam tables / availability of patient lifts for transfer to tables.

3 Levels of Comparison: Event Data



Process Map – Focus your Analysis



FMEA – Action Plan Potential Failure Points

Sequence	Process Step or Function	Input	Potential Failure Mode	Potential Effect(s) of Failure	S E V	Potential Contributing Factors to Failure	O C C	Current Process Controls Prevention	Current Process Controls Detection	D E T	R P N
Sequence & Visit Type Subprocesses ↓	Include step from Process Map in all rows for sorting	Include input from Process Map in all rows for sorting (contributing factors)	Failure or symptom evidenced in the output	Impact on the customer requirements	How Severe is the effect to the customer?	Causes to input failure. Add row for each cause within step/Input	How often does cause or FM occur?	Existing controls that prevent the cause or the Failure Mode	Existing controls that detect the cause or the Failure Mode before defects escape	How well can you detect cause or FM?	Risk Priority #
1	Physician writes order on disposition form			1.1.1							0
				1.1.2							
				1.1.3							
				1.2.1							
2	Walks patient to lab and hands form to lab technician			2.1.1							
				2.1.2							
				2.1.3							
				2.2.1							
				2.2.2							
3	Lab tech copies encoutner form			3.1.1							
				3.1.2							
				3.1.3							
				3.1.4							
4	Lab tech Draws patients blood			4.1.1							
				4.1.2							
				4.1.3							
				4.2.1							
5	Lab tech hand writes pt name on the tube										
				5.1.2							
				5.1.3							
				5.1.4							
				5.2.1							
6	Enters orders in E-Clinical										
				5.1.2							
				5.1.3							
				5.1.4							
				5.2.1							
7	Completes Lab Log										
				5.1.2							
				5.1.3							
				5.1.4							
				5.2.1							
8	Assigns lab to self and transmits to Care Evolve										
				5.1.2							
				5.1.3							
				5.1.4							
				5.2.1							
9	Processes labs										
				5.1.2							
				5.1.3							
				5.1.4							
				5.2.1							

Agency for Healthcare Research and Quality

13th Annual Meeting of PSOs

to be held 4/28 – 4/29

Abstract Submission: A collaboration of efforts; PSOs work together to address access to care issues among a vulnerable population.

Maine Primary Care Association

ECRI Institute for Safe Medication Practices PSO

PSO	ECRI and the Institute for Safe Medication Practices & Maine Primary Care Association PSO
Presenters	• Christopher Pezzullo DO • Andrew S. Martin MSN, RN, CPHRM
Topic	"Other Topics"
The focus	Through care improvements and an overall better understanding of disease process that lead to intellectual or developmental delays, more and more individuals with Intellectual and/or Developmental Delay (I/DD) are living longer and developing into adulthood. An unintended consequence of this is, adult primary care providers are finding themselves ill prepared to meet the needs of this vulnerable population. MePCA PSO was approached through its membership to learn more about the safety events that affect this healthcare disparities and to provide resources for primary care providers to utilize when providing care to this population. In order to address this need, MePCA PSO collaborated with ECRI and the ISMP PSO; analysts explored patient safety data that described events which impacted the care and patient safety of adults with I/DD in the ambulatory care environment that were reported to the PSO between January 1, 2016 and December 31, 2019. In this presentation, we will summarize the collaborative efforts of the PSOs including the evaluative process and creation of the Ambulatory Care Readiness Assessment tool for the Treatment of Individuals with I/DD. The tool was developed based on findings realized in the data review, best practices identified in published literature, and interviews of advocacy group representatives and experts who remain in practice. The tool includes resources that when implemented may improve the access to care of individuals with I/DD.
Why	It is well defined in the literature that healthcare practitioners perceive that they are poorly prepared to meet the specific needs of adult individuals with I/DD in the ambulatory care environment. This feeling of being inadequately prepared may result in suboptimal healthcare visits for the patient and provider, which then impacts the patients' desire for necessary follow-up care. Furthermore it is noted in the literature that preventative measures such as routine healthcare screenings are made available at a lesser frequency to adult individuals with I/DD when compared to adult individuals without I/DD. Researchers purport reasons for this include provider bias, believing that adult individuals with I/DD would not tolerate screening examinations and therefore they are not recommended/prescribed and when screening is attempted adult individuals with I/DD are not adequately accommodated and therefore efforts are aborted.
Strategies	ECRI and the Institute for Safe Medication Practices PSO and the Maine Primary Care Association PSO conducted a Safe Table, created a summary of the problem, identified findings and best practice recommendations, and developed the "Ambulatory Care Readiness Assessment tool for the Treatment of Individuals with I/DD". This tool was designed to evaluate practices in four different areas of focus: 1) Scheduling Considerations, 2) Environmental Considerations 3) Care Provision Considerations and 4) Considerations for Staff Preparedness. The outcomes of this initiative will be published as a PSO Patient Safety Brief and distributed to the membership of both PSOs.

Main Dashboard | Event Details

Show Nulls
Hide Nulls

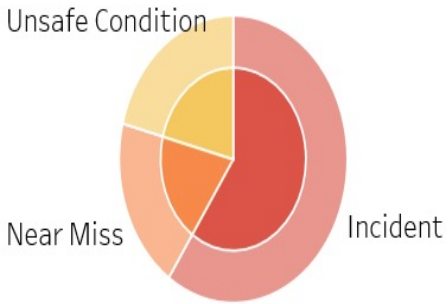
MAIN DASHBOARD

ECRI Institute PSO — Share. Learn. Protect.

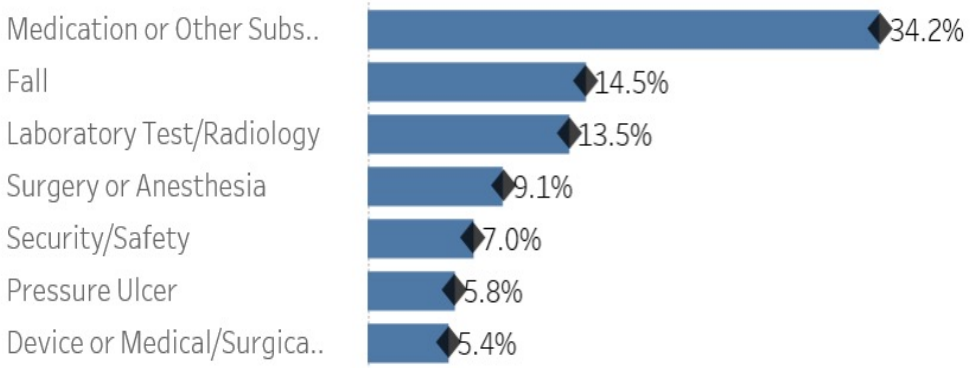
Entity Name: (All) | Facility Type: (All) | Geography: (All) | Bed Size: (All) | Critical Access: (All) | Teaching Status: (All)

Event Date: 1/4/2001 – 6/27/2018

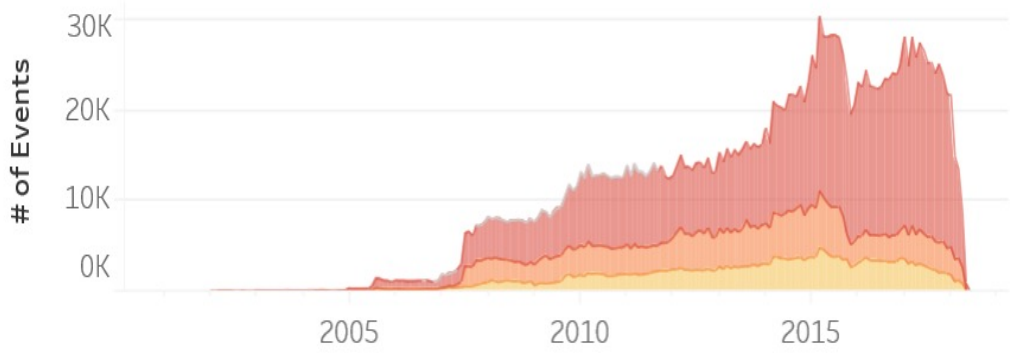
EVENT SEVERITY



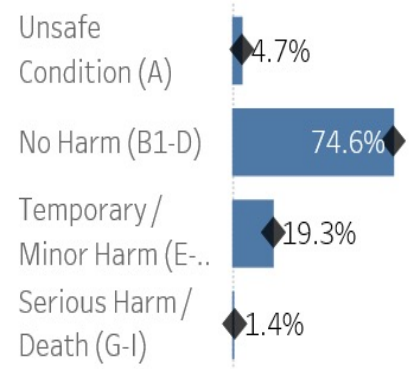
PRIMARY EVENT TYPE



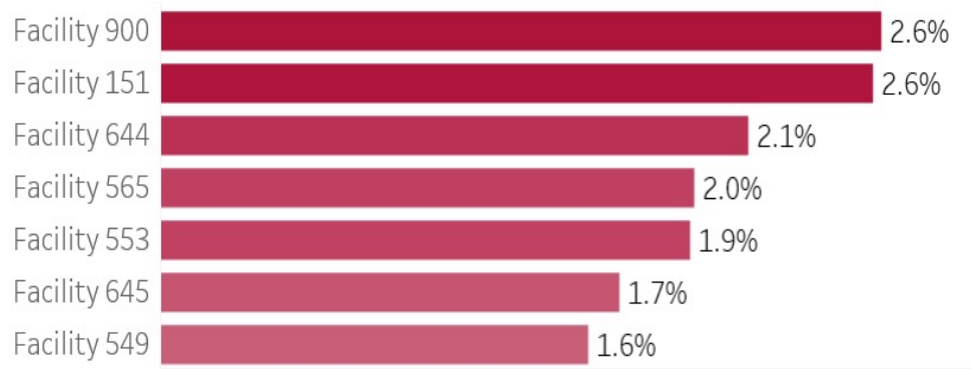
TIME TREND BY SEVERITY

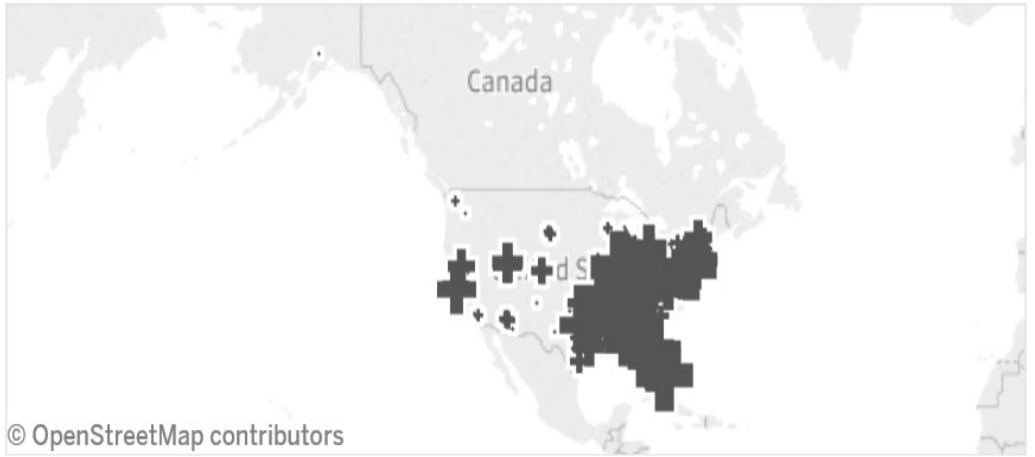


PATIENT HARM



FACILITY





EVENT DETAILS

ECRI Institute PSO Share Learn Protect

Event NK	Internal ID	Event Date	Event Severity	Harm Score	Facility Name	Primary Event Type	Patient Age	Patient Gender	Location	Event Description
2587948	Null	6/27/2018	Incident	No Harm (B1-D)	Facility 1390	Fall	Adult (18-64 years)	Female	Inpatient Unit	Lorem ipsum dolor sit amet, consectetur adipiscing elit, sed do magna aliqua. Ut enim ad minim veniam, quis nostrud exercita commodo consequat. Duis aute irure dolor in reprehenderit in
2587758	11004671..	6/18/2018	Incident	No Harm (B1-D)	Facility 1390	Fall	Adult (18-64 years)	Male	Inpatient Unit	Lorem ipsum dolor sit amet, consectetur adipiscing elit, sed do magna aliqua. Ut enim ad minim veniam, quis nostrud exercita commodo consequat. Duis aute irure dolor in reprehenderit in
2587759	Null	6/17/2018	Incident	No Harm (B1-D)	Facility 1386	Other	Adult (18-64 years)	Female	Unknown	Lorem ipsum dolor sit amet, consectetur adipiscing elit, sed do magna aliqua. Ut enim ad minim veniam, quis nostrud exercita commodo consequat. Duis aute irure dolor in reprehenderit in
2587949	Null	6/11/2018	Incident	No Harm (B1-D)	Facility 1390	Fall	Adult (18-64 years)	Female	Unknown	Lorem ipsum dolor sit amet, consectetur adipiscing elit, sed do magna aliqua. Ut enim ad minim veniam, quis nostrud exercita commodo consequat. Duis aute irure dolor in reprehenderit in

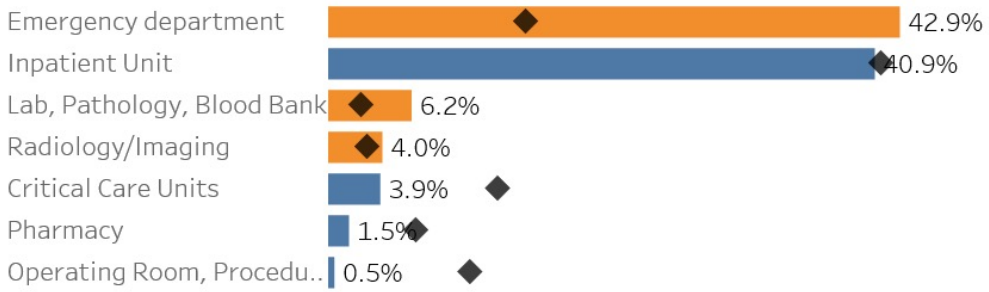
Show Nulls
Hide Nulls

FACILITY DASHBOARD

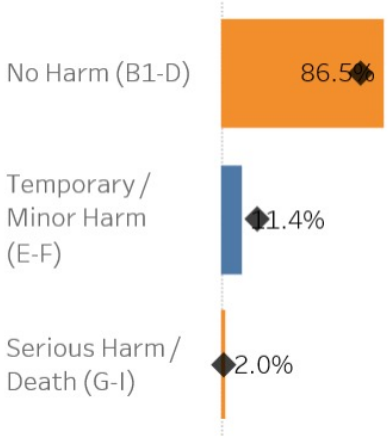
ECRI Institute PSO Share Learn Protect

Entity Name	Facility Name	Facility Type	Geography	Bed Size	Critical Access	Teaching Status
Health System 6	Facility 153	(All)	(All)	(All)	(All)	(All)

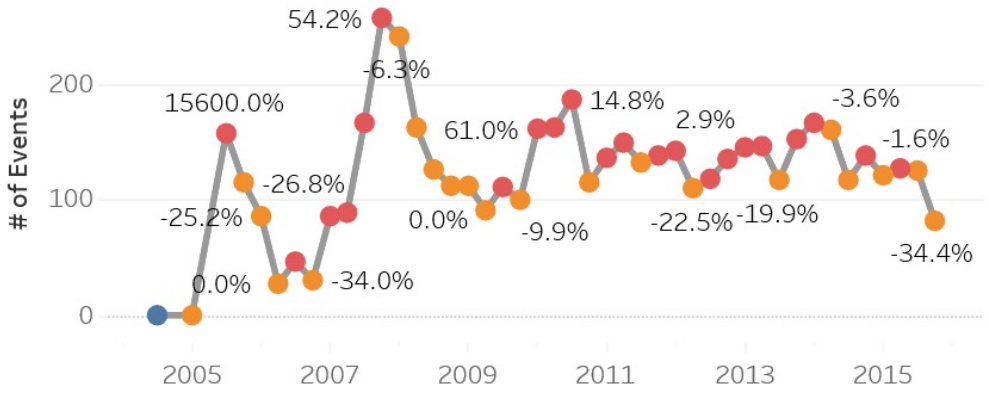
LOCATION



PATIENT HARM



EVENTS FROM 1/4/2001 6/27/2018 BY Quarter



PRIMARY EVENT TYPE

SECONDARY EVENT TYPE

(SELECT A PRIM. ET TO DISPLAY VALUES)

GENDER

PATIENT AGE

DATA QUALITY DASHBOARD

Entity Name: Health System 6

Facility Name: Facility 153

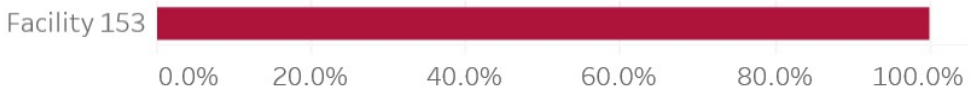
Submission Date: 10/1/2009 9:: 6/1/2018 2:2:

AVG. DAYS TO SUBMISSION
1,214

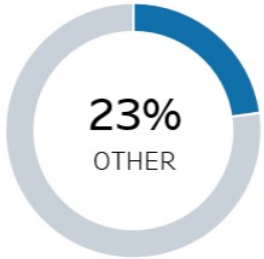
DAYS SINCE LAST SUBMISSION
678.5

AVG. # OF CHAR. IN NARRATIVE
445.0

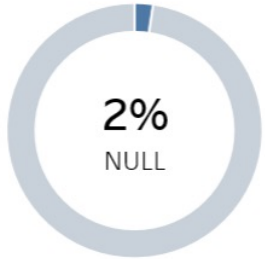
% OF EVENTS BY FACILITY



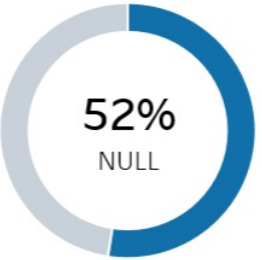
EVENT TYPE



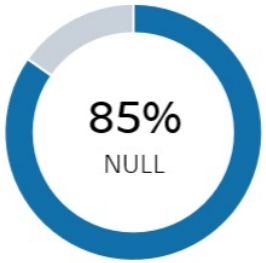
LOCATION



HARM SCORE

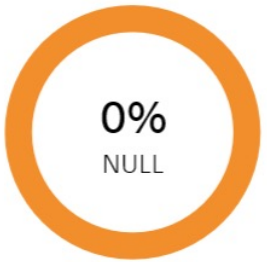


SECONDARY EVENT TYPE



CONTRIBUTING FACTORS

EVENT DATE



1/4/2001 6/27/2018

BASE DATA

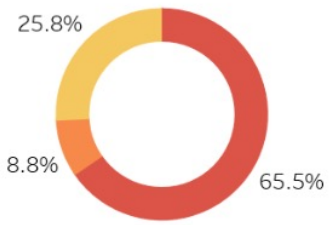
Base Entity Name: Health System 6

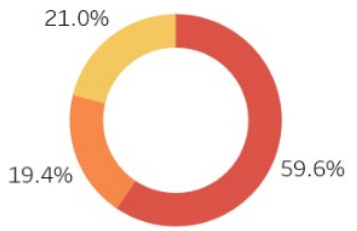
Base Facility Name: (All)

AGGREGATE DATA

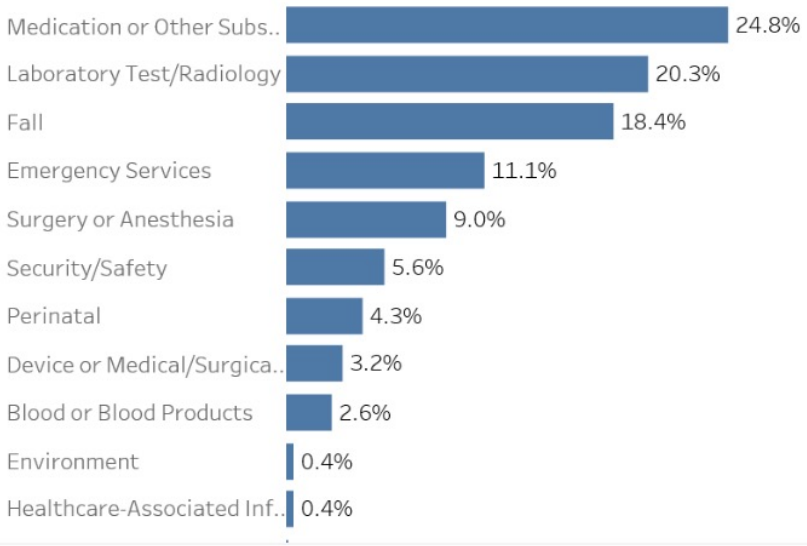
Aggregate Entity Name: PSO 1

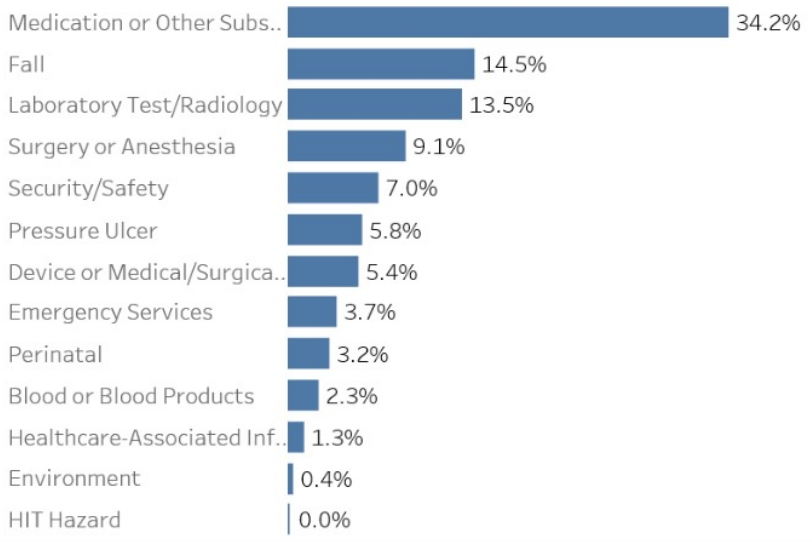
EVENT SEVERITY





EVENT TYPE





Checklist for PSO members

- Contract with MePCA PSO/annually renewable.
- User level agreement.
- Understand terms and conditions (PSO/PSWP/PSES/confidentiality protections/safety culture).
- Create a PSES for added safety.
- Upload events/near misses/unsafe conditions (consider mapping your RMIS).
- Trend and review data.
- Engage in QI with our team.
- Participate in safe tables.
- Reinforce confidentiality training.
- Join compliance partnership with HRSA-ECRI.
- Link HCCN-VBP-PSO-UDS-compliance-quality goals, using shared data analysis (work smarter not harder).
- Strengthen a safety culture, aligned with a culture of continuous quality improvement.

Dear MePCA PSO Member

Did you know that you could automate your event submissions to the PSO? MePCA PSO members who are able to extract event data from their Risk Management Information Systems (RMIS) or event reporting systems have several automated submission options; working with our contractor, ECRI, events can be submitted using the following formats:

- ECRI PSO's file format (CSV)
  - Can only be manually uploaded via the ECRI PSO Upload Events option on the ECRI PSO website.
- AHRQ Hospital Common formats 1.1 or 1.2 (XML)
  - Can be manually uploaded via the ECRI PSO Upload Events option on the ECRI PSO website or sent using secure file transfer protocol (SFTP).
- Customer defined format (CSV or XML)
  - Requires ECRI PSO to map the data elements submitted to the ECRI PSO Event Reporting database and can only be transferred to ECRI PSO using SFTP.

What to expect: MePCA PSO members who wish to automate their event submission process will be assigned an analyst to guide them through the implementaiton process. There would be a small investment of time from their Clinical, IT and Risk Management departments, as well as a possible fee if a customer defined format is going to be used—the fee covers the develpment cost associated with mapping data to ECRI PSO's Event Reporting database (Members who have previously completed the mapping process have noted it to be well worth the initial investment!).

If automating your event submission is something that you want to take advantage of, please notify us at your earliest convenience. We will need the name of your RMIS and we will then work with ECRI to expedite the service.

Thank You!

- Christopher J Pezzullo, DO
- Sarah Morrill, RN
- cpezzullo@mepca.org
- smorrill@mepca.org