

NCPS Update: September 2022

A Message from the Patient Safety

Program Director Carla Snyder, MHA, MT(ASCP), SBB

In line with our goal of attending each of our founding

organization's state member meetings, our Executive Director, Emily Barr, and I attended the Nebraska Medical Association's Annual meeting held in Omaha on August 19th. We were appreciative of the various NMA members that



both as a NMA member and through the Patient Safety Cash Fund fees included in their Nebraska physician licensing fee. This also gave us the opportunity to inform of what actions we're taking to improve patient safety in Nebraska; though we found most were already aware of our mission. Additionally, it was a treat to get to talk with various physicians that I've crossed paths during my career as well as to met others for which I have not had the privilege to work. Included in the meeting's schedule of events were several items that I found particularly

impactful. One of those was the Celebrating 50-Year Practioners which honored Nebraska physicians that graduated from medical school in 1972. The accomplishments and years of

others continue practicing medicine part time or are involved in other healthcare related endeavors. The final event of the day was the Inspire Medicine Speaker Series. Nine NMA members each delivered a 5 minute talk about a topic for which they are passionate. The format for the presentation was a 5 minute time limit where 20 slides, which autoadvanced, were shown as the speaker delivered his/her presentation. The audience welcomed the speaker to the podium with a standing ovation and then another standing ovation at the end of the presentation. It was truly energizing! Each speaker was extraordinary and the breadth of topics presented excellent. Because of my father-in-law's early death due to a delayed melanoma diagnosis, Dr. Jennifer Adam's presentation titled Build It and They Will Come!, explaining her work to estabish a Dermatology Residency at UNMC inorder to meet the need for dermatologists in our state and Dr. Mehmet Copur's, Out of Reach - Achieving Health Equity in Clinical Trails in Rural Nebraska, describing his work establishing clinical trials in rural Nebraska, truly resonated with me. The day was a reminder of the great achievements in healthcare that are occuring across our state. We at NCPS are proud to be a part of it and are grateful for the support of the Nebraska Medical Association as well as our other founding members which includes the Nebraska Hospital Association, the Nebraska Academy of Physician Assistants, the Nebraska Pharmacist Association, and the Nebraska Nurses Association. We appreciate our partnerships with you all! It empowers us to proceed with our work to improve patient safety in all healthcare settings. NCPS Shared Learning Resources

establishing workforce safety, both physical and psychological, in your work setting. The Workplace Violence Prevention Workplace Safety Alert may be found here as well as on the NCPS website within our members only portal. (www.nepatientsafety.org/members/member-login.html).

CMS recently updated their hospital compare website with 2021 data and the following NCPS members earned a 5 Star Overall Quality rating:

NCPS Member Update - What You Need to Know

Congratulations to NCPS Members Achieving CMS 5 Star Award for Overall Quality

• Bryan Medical Center - Lincoln • CHI Lakeside - Omaha CHI Good Samaritan - Kearney • CHI Midlands - Papillion

Nebraska Methodist Hospital - Omaha

Bellevue Medical Center

• Boone County Health - Albion

- Your work is much appreciated and your recognition well deserved!
 - **Learning Opportunities for NCPS Members** NCPS/HQIC Hospital Virtual Collaborative: Creating a Culture of Patient Safety
- We have an exciting announcement to make! NCPS is collaborating with the Nebraska Hospital Association to offer a 6-part learning on creating a culture of patient safety for HQIC enrolled

hospitals. Some of the topics included in these sessions are Just Culture, Reporting Culture, partnering with your PSO, TeamSTEPPS tools, and the importance of having a strong culture of

on December14th. At the completion of the cohort, you will understand the value of a strong culture of patient safety, what tools and processes support that culture, and how this will allow your organization to offer safe, high-quality care to your patients.

patient safety for quality of care. We will meet every other week begining October 4th and will end

To learn more about this oppportunity or to register for cohort you can access the informational flyer <u>here</u>. **Collaborative Opportunities** AHRQ's Measure DXTool: Improving Diagnostic Safety and Quality Diagnostic errors are a major contributor to events of patient harm. It is estimated that each year 1 in 20 adults experiences a diagnostic error in the outpatient setting; in the inpatient setting an

result in some level of patient harm and yet most diagnostic safety events result in little or no learning or practice change.

of subject matter experts, developed Measure DX. Measure DX is a software tool to help healthcare organizations identify diagnostic safety events and gain insights for improvement.

and does provide a small stipend to participating organizations.

prenatal opiod exposure (infants age 0 -12 months).

A primary care physician

A nurse

You will need to assemble a team of members that may include:

collection to achieve desired outcomes in your practice.

estimated 250,000 harmful diagnostic errors occur annually in U.S. hospitals. Most of these errors

To address this issue, the Agency for Healthcare Research and Quality, in conjunction with a team

The tool has been trialed at 10 sites and AHRQ is now seeking additonal healthcare organizations to collaborate with them to enhance implementation of the tool's use. This collaboration requires an approximate 6-month evaluation of the Measure DX tool, monthly teleconferences to share

learnings and implementation strategies, sharing limited data from your work with the AHRQ team,

AHRQ has prepared an informational webinar which provides great background information about diagnostic error and practical steps to utilize when launching a quality improvement effort (e.g.

establishing useful measurements), as well as the functionality of the Measure DX software tool. In the last 5 miniutes of the webinar the collaborative opportunity is explained. Please note that the

Measure DX tool can be used whether you chose to join the collaborative or not.

NPQIC & AAP ECHO Series: Care of the Neonate with Opioid Exposure The Nebraska Perinatal Quality Improvement Collaboration and the American Academy of Pediatrics are recruiting up to 10 pediatric or primary care practices to join a 6-month learning collaborative whose goal is to improve access to quality healthcare for families affected by

coordinator And you will need to commit to fully participating in the project for 6 months. This includes attending one 1-hour virtual meeting per month.

An additional team member such as front office person, practice manager or care

Improving access to quality care for patients affected by prenatal opioid exposure.

Increase knowledge around connecting families of infants affected by prenatal opioid

Increase knowledge regarding best practices for improving early identification of prenatal

Learn new quality improvement methods and track improvements through monthly data

<u>Learning Collaborative Opportunity for Pediatric or Primary Care Practices (adobe.com)</u>

Patient Safety Resources

 Participating pediatricians will have the opportunity to earn American Board of Pediatrics Part 4 Maintenance of Certification (MOC) credit (pending approval). The first 10 clinics to register will receive a \$500 stipend.

IHI's Aim Statement Worksheet

and hospital care.

reflection here.

Network and problem solve with others.

Register by September 30, 2022 at

exposure to appropriate.

The list of benefits for participation include:

opioid exposure.

Patient Safety in the Ambulatory Care Setting This article from AHRQ's PSNET is a review of safety issues in the ambulatory care setting. It is noted, and well documented, that these were exacerbated during the COVID-19 pandemic.

Diagnostic-related errors are one of the most common issues and continued to be a major challenge in assessing and caring for COVID patients. Also discussed in this article is the

which are not centered around the impact of the COVID-19 pandemic and several strategies to improve safety in ambulatory care. The article can be found here.

An aim statement is the answer to the first question in Model for Improvement, "What are we trying

innovation of telehealth. Lastly, there is a discussion of ongoing issues that affect diagnositic safety

to accomplish?" This worksheet will help you write an effective aim statement with clear, specific plans for the improvement work you are beginning. It is structured so that a checklist to doublecheck your work is included. It can be found here.

A just culture is considered a promising way to improve patient safety and working conditions in the healthcare sector, and as such is also of relevance to healthcare regulators who are tasked with monitoring and overseeing quality and safety of care. This study explores the experiences in healthcare organizations regarding the role of the healthcare regulators in enabling a just culture. The article may be found here.

Implicit bias can be a contributer to events of patient harm and in his reflection on his own biases, Dr. Arthur Lazarus, a member of the Physician Leadership Journal's editorial board, notes how respectful conversations can help overcome implicit bias and improve patient care. Find his

A Reflection on Implicit Bias, "Call Me In, Not Out, for My Transgressions"

Role of the regulator in enabling a just culture: a qualitative study in mental health

COVID-19 RESOURCES FDA Releases a PAXLOVID Patient Eligibility Screening Tool This checklist is intended as an aid to support clinical decision making for PAXLOVID prescribers.

Please note, the use of the cheklist is not required to prescribe PAXLOVID under the EUA. The

Dr. Lawler's August 30th titled How Did We Get Here? is a concise review of the U.S.'s vacinnation's rates and their impact on hospitalizations and deaths due to COVID-19. This information is useful as the CDC's recommendation for COVID boosters has been announced.

For more information about NCPS and the services we offer, please contact Carla Snyder MT(ASCP)SBB, MHA, Patient Safety Program Director at: carlasnyder@unmc.edu

Subscribe to our email list.

You can access the recording here.

document may accessed here or on the FDA website at

James Lawler, MD, MPH Weekly Corona Virus Updates

https://www.fda.gov/media/158165/download.

stopped at our exhibit table allowing us the opportunity to thank them for their support of NCPS

service this group has provided was impressive. Several have only recently retired while

The NCPS learning resource this month is a Workforce Safety Alert on Violence Prevention in the Workplace. The Workfoce Safety Alert is a new category of resource we will be providing and is in response to the well established link between workforce safety and patient safety. Periodically we will share information and resources for this category to aid you in the goal of

Share this email:



View this email online. 986055 NE Medical Center

This email was sent to .

Omaha, NE | 68198 US

To continue receiving our emails, add us to your address book.