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## Dates for All Public Board Meetings in 2019

- January 29, 2019
- March 14, 2019
- April 29, 2019
- June 25, 2019
- September 23, 2019
- November 4, 2019
- December 9, 2019

Find summary minutes of public board meetings at [patientsafety.pa.gov](http://patientsafety.pa.gov).

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**E**ighteen years ago, the Patient Safety Authority (PSA) was founded with a single charge—make healthcare safer in Pennsylvania. To achieve this lofty goal, MCARE put two key pieces into place: a requirement that healthcare facilities report all instances of harm or near harm and a database from which these events could be analyzed. Since then, the Pennsylvania Patient Safety Reporting System (PA-PSRS) has become one of the largest reporting systems in the world.

On several occasions over the years, people have asked variations of the same question, “Has the PSA made Pennsylvania any safer?” Usually, the conversation quickly turns to reporting trends: Does the sixfold increase in the annual number of events in PA-PSRS from 2004 to 2019 indicate an advancing culture of transparency, or does it mean that six times as many actual events transpired? While that question may never have a definitive answer, we can say with certainty that, in many real ways, healthcare is safer because of the PSA.

*About a decade ago, a patient almost died when a traveling nurse mistakenly gave him a wristband indicating “do not resuscitate,” thinking it meant something else. A PSA analyst who read that event report discovered a lack of uniformity in patient wristband colors across Pennsylvania—and, subsequently, the United States—and recognized that a similar event was likely to recur. The PSA led a movement to establish a standard for this ubiquitous part of patient care that has since been adopted by nearly every state and the U.S. military.*

*A few years ago, a facility called with a concern regarding misplacements of nasogastric feeding tubes. Several veteran staff members were suddenly inserting them in patients’ lungs instead of their gastrointestinal tract, and the facility wanted to know if anyone else had reported the same issue. In fact, two other facilities had. Further investigation revealed that a popular manufacturer*

*had stopped producing the enteral devices, forcing facilities to find an alternative quickly. This facility had ordered a replacement of the same size and type, but communication of the change did not reach frontline staff who were placing the feeding tubes. The staff continued to place the tubes as they always had—without realizing they were using a different product. Once the staff became aware of the change, they commented that the new tubes seemed less pliable and slicker than the previous ones.*

*While reviewing high harm events, a PSA analyst noted a report describing the near-death of a newborn after the mother fell asleep with the baby in her arms. The event prompted the analyst to determine whether any other similar events had occurred, and what she found was shocking—dozens of reports of newborns falling across the state, every year. Because an individual facility may only experience one or two newborn falls annually, it was virtually impossible to measure the true scope of the problem without a broader perspective. The analysis—the largest one to date—brought light to an otherwise hidden and life-threatening issue.*

In each of these instances, the broad overview provided by PA-PSRS allowed the PSA to accurately assess potentially lethal situations, develop focused prevention measures, and broadcast them to thousands of healthcare facilities across Pennsylvania, the United States, and abroad.

**While the debate about event reporting will surely go on, the impact of these actionable insights is clear. The task of making healthcare safer in Pennsylvania will continue to be our focus. Contained in these pages are lessons learned from the past year that will continue to propel healthcare forward.**

## Fast Facts

The Patient Safety Authority (PSA) is an independent state agency that collects reports of patient safety events from Pennsylvania healthcare facilities. Pennsylvania is the only state that requires healthcare facilities to report all incidents of harm (serious events) or potential for harm (incidents).

- Founded in 2002 by the Pennsylvania Medical Care Availability and Reduction of Error Act (commonly referred to as “Act 13” or “the MCARE Act”)
- Vision: Safe healthcare for all patients
- PA-PSRS is one of the largest patient safety databases in the world, with more than four million event reports
- Governed by an 11-member board appointed by the governor and Pennsylvania legislature



Long-term care facilities report infections into PA-PSRS, as outlined by Pennsylvania Act 52 of 2007. The PSA analyzes those reports to prevent recurrence—either by identifying trends unapparent to a single facility or flagging a single event that has a high likelihood of recurrence—and disseminates that information through multiple channels.



Patient & Provider Education



Peer-Reviewed Journal



Toolkits & Resources



Consultations



Collaboratives



Safety Alerts

# Highlighted Actionable Insights



Patients can play an important role in academic publishing. Their perspectives as end users can identify lapses in application unaccounted for in a research environment.

The primary contributing factors for medication error events involving infusion pumps were pump programming, tubing/connections, and pre-administration process problems.

Hospitals should evaluate their diagnostic processes to identify areas for systematic improvement.

Harm associated with telemetry events is rare but potentially catastrophic, with death being the most frequent outcome among Serious Events.

Half of reported newborn falls occurred because the caregiver fell asleep, so improvement efforts should focus on supporting exhausted new parents in the hours and days following birth.

# Definitions

## ABORTION FACILITY

Act 30 of 2006 extended the reporting requirements in the Medical Care Availability and Reduction of Error (MCARE) Act to abortion facilities that perform more than 100 procedures per year. At the end of 2019, Pennsylvania had 17 qualifying abortion facilities.

## ADVERSE EVENT

This term is commonly used when discussing patient safety, but it is not defined in the MCARE Act. The Institute of Medicine Committee on Data Standards for Patient Safety defines an adverse event as “an event that results in unintended harm to the patient by an act of commission or omission rather than by the underlying disease or condition of the patient.”

The PSA considers this term to be broader than “medical error,” because some adverse events may result from clinical care without necessarily involving an error. And not all adverse events are preventable.

Although PA-PSRS includes reports of events that resulted from errors, the PSA’s focus is on the broader scope of actual and potential adverse events, not only those that result from errors.

## AMBULATORY SURGICAL FACILITY

The Health Care Facilities Act (HCFA) defines an ambulatory surgical facility (ASF) as “a facility or portion thereof not located upon the premises of a hospital which provides specialty or multispecialty outpatient surgical treatment.

“ASF does not include individual or group practice offices of private physicians or dentists, unless such offices have a distinct part used solely for outpatient treatment on a regular and organized basis. ...Outpatient surgical treatment means surgical treatment to patients who do not require hospitalization but who require constant medical supervision following the surgical procedure performed.” At the end of 2019, there were 327 qualifying ASFs in Pennsylvania.

## ANALYST

The analyst is a member of the PSA with education and experience in medicine, nursing, pharmacy, product engineering, statistical analysis, and/or risk management. Analysts review events submitted through PA-PSRS and compose the majority of the articles included in the PSA’s quarterly, peer-reviewed journal, *Patient Safety*.

## BIRTHING CENTER

The HCFA defines a birthing center as “a facility not part of a hospital which provides maternity care to child-bearing families not requiring hospitalization. A birth[ing] center provides a homelike atmosphere for maternity care, including prenatal labor, delivery, and postpartum care related to medically uncomplicated pregnancies.” At the end of 2019, Pennsylvania had five qualifying birthing centers.

## HOSPITAL

The HCFA defines a hospital as “an institution having an organized medical staff established for the purpose of providing to inpatients, by or under the supervision of physicians, diagnostic and therapeutic services for the care of persons who are injured, disabled, pregnant, diseased, sick, or mentally ill, or rehabilitation services for the rehabilitation of persons who are injured, disabled, pregnant, diseased, sick, or mentally ill. The term includes facilities for the diagnosis and treatment of disorders within the scope of specific medical specialties, but not facilities caring exclusively for the mentally ill.” At the end of 2019, Pennsylvania had 232 qualifying hospitals.

## INCIDENT

An event which either did not reach the patient (“near miss”) or did reach the patient but the level of harm did not require additional healthcare services. The legal definition from the MCARE Act: “an event, occurrence, or situation involving the clinical care of a patient in a medical facility which could have injured the patient but did not either cause an unanticipated injury or require the delivery of additional healthcare services to the patient. The term does not include a serious event.”

## INFRASTRUCTURE FAILURE

A potential patient safety event associated with the physical plant of a healthcare facility, the availability of clinical services, or criminal activity. The legal definition from the MCARE Act: “an undesirable or unintended event, occurrence, or situation involving the infrastructure of a medical facility or the discontinuation or significant disruption of a service which could seriously compromise patient safety.” Infrastructure failures are submitted only to the Pennsylvania Department of Health (DOH) and are not addressed in this report.

## MEDICAL ERROR

A “preventable adverse event”: This term is commonly used when discussing patient safety, but it is not defined in the MCARE Act. The word “error” appears in PA-PSRS and in this report. For example, one category of reports discussed is “medication errors.” The Institute of Medicine Committee on Data Standards for Patient Safety defines an error as the “failure of a planned action to be completed as intended (i.e., error of execution) or the use of a wrong plan to achieve an aim (i.e., error of planning)... It also includes failure of an unplanned action that should have been completed (omission).”

Within the MCARE Act, the term “medical error” is used in section 102: “Every effort must be made to reduce and eliminate medical errors by identifying problems and implementing solutions that promote patient safety.” It is also used in defining the scope of chapter 3, “Patient Safety”: “This chapter relates to the reduction of medical errors for the purpose of ensuring patient safety.”

## NURSING HOME

Act 52 of 2007 revised the MCARE Act to require nursing homes to report healthcare-associated infections (HAIs) to the PSA. Specifically, the act states that “the occurrence of a healthcare-associated infection in a healthcare facility shall be deemed a serious event as defined in section 302.” Reporting from these facilities began in June 2009. For this report, Pennsylvania had 697 qualifying nursing homes at the end of 2019.

## OTHER EVENT TYPE

The Centers for Medicare & Medicaid Services (CMS) requires hospitals to report to DOH any death of patients in restraints or in seclusion, or in which restraints or seclusion were used within 24 hours of death (other than soft wrist restraints).

Deaths in which the restraints or seclusion are suspected of or confirmed as having played a role in the death should be reported as serious events. Other deaths in which the restraint or seclusion use was incidental or not suspected should be reported under this “Other” category.

Reports of serious events and incidents are submitted to the PSA for the purposes of learning how the healthcare system can be made safer in Pennsylvania. Reports of serious events and infrastructure failures are submitted to DOH so it can fulfill its role as a regulator of Pennsylvania healthcare facilities.

## PATIENT SAFETY EVENT

An event, occurrence, or condition that could have resulted or did result in harm to a patient and can be but is not necessarily the result of a defective system or process design, a system breakdown, equipment failure, or human error. They can also include adverse events, no-harm events, near misses, and hazardous conditions.

## PATIENT SAFETY LIAISON

The patient safety liaison (PSL) is a unique resource to Pennsylvania MCARE facilities. Serving as the face of the PSA, the PSL provides education and consultation to MCARE facilities and ensures that facilities are aware of the resources available to them through the PSA, such as educational toolkits, presentations, and webinars. The program has eight liaisons located regionally throughout Pennsylvania.

## PATIENT SAFETY OFFICER

The MCARE Act requires each medical facility to designate someone to serve as that facility’s patient safety officer (PSO). In addition to other duties, the MCARE Act requires the PSO to submit reports to the PSA.

## SERIOUS EVENT

The legal definition from the MCARE Act: “an event, occurrence, or situation involving the clinical care of a patient in a medical facility that results in death or compromises patient safety and results in an unanticipated injury requiring the delivery of additional healthcare services to the patient. The term does not include an incident.”

## STANDARDIZATION

Twenty-eight guiding principles went into effect on April 1, 2015, to improve consistency in event reporting through PA-PSRS. The guidance was developed to help provide consistent standards to acute healthcare facilities in Pennsylvania in determining whether occurrences within facilities meet the statutory definitions of serious events, incidents, and infrastructure failures as defined in section 302 of the MCARE Act.

The PSA, DOH, and healthcare facility staffs have worked together toward a shared understanding of the requirements. The reporting guidelines were identified based on frequently asked questions (FAQs), controversies, and inconsistencies that were evident in the data collected by the PSA and DOH.

# Executive Summary

In 2019, the PSA established its in-house Data Science and Research group and began publishing its peer-reviewed scholarly journal, *Patient Safety*. The September 2019 publication of *Patient Safety* also marked the transition from the Authority's *Pennsylvania Patient Safety Advisory*, which had its final edition in March 2019. The PSA continued to expand the Center of Excellence for Improving Diagnosis, providing leadership, guidance, and support to improve diagnosis throughout the Commonwealth. All these programs are offered at no additional cost to the facilities. The PSA continues to expand its services by organizing and maintaining research collaborations with reporting facilities and other patient safety-centric organizations.

In addition, the PSA offers continuing education and patient safety curriculum development, and continues to provide the Patient Safety Authority speakers bureau. By directly offering clinical guidance, feedback, and educational programs to providers about actual events that occur in Pennsylvania, the PSA provides measurable value back to the healthcare industry that contributes to funding this program.

Read about all the other exciting accomplishments the Authority achieved in the last year and the powerful impact it has on healthcare and patient safety.

- Board Chair Stanton N. Smullens was named a 2019 Influencer of Healthcare for Excellence in Patient Care by *The Philadelphia Inquirer*
- Regina Hoffman was appointed co-chair of the Learning Systems Subcommittee for the Institute of Healthcare Improvement's National Action Plan Committee
- Howard Newstadt received a faculty appointment as an adjunct professor of law at the University of Pittsburgh School of Law.
- Caitlyn Allen joined the Communications Committee for the Philadelphia chapter

- of the American College of Healthcare Executives
- Rebecca Jones was named chair of the Practice Improvement Committee of the Society to Improve Diagnosis in Medicine
- Terri Lee Roberts and JoAnn Adkins received the Heroes of Infection Prevention Award from the Association for Professionals in Infection Control and Epidemiology (APIC), the leading professional association for infection preventionists
- PSA held the 2<sup>nd</sup> Annual Pennsylvania Patient Safety Summit (P2S2) in Seven Springs, Pennsylvania, with keynote speaker John Kruk, MLB All-Star and cancer survivor
- PSA awarded a new contract to MedStar Health Research Institute to perform ongoing aggregate analysis of patient safety events and apply machine learning technologies to identify critical patient safety trends
- JoAnn Adkins and Terri Lee Roberts presented at the 5<sup>th</sup> Annual ASF Symposia, speaking on "Case Studies: Identification of Surgical Site Infection through Application of Criteria."
- PSA held the 3<sup>rd</sup> Annual Long-Term Care Symposia across the state of Pennsylvania
- The Center of Excellence for Improving Diagnosis developed and administered on-site surveys at various hospitals across the Commonwealth
- Cathy Reynolds presented at the 2019 Diagnostic Error in Medicine Conference in Washington, D.C.
- Robert Yonash participated in The Joint Commission Summit on Weighing All Patients in Kilograms in October



## Diagnostic Excellence

- Continued partnership with the Health Care Improvement Foundation (HCIF), co-leading the Hospital and Healthsystem Association of Pennsylvania (HAP) Hospital Improvement Innovation Network (HIIN) collaborative demonstration project to decrease the risk of diagnostic error
- Held a focus group to hear patient and caregiver stories, impact, and ideas for improving diagnosis
- Gave several key presentations, including a webinar for CMS in conjunction with HAP's Patient and Family Engagement team; an overview of the HAP HIIN project work at the annual Diagnostic Error in Medicine (DEM) conference; and additional PSA educational webinars regarding error and uncertainty in radiology, the scope and impact of diagnostic error, and importance of adopting a systems view
- Conducted surveys during site visits at 20 Pennsylvania hospitals to better understand current practices and perceptions about diagnostic error and the diagnostic process



## Long-Term Care

- Held educational symposia in five regions throughout the state, focused on infection prevention topics and pressure injury prevention in long-term care facilities
- Implemented quarterly education resources geared specifically towards frontline LTC staff
- Worked directly with LTC facilities to improve their infection reporting
- Provided education for 258 LTC facilities



## Focus on the Patient

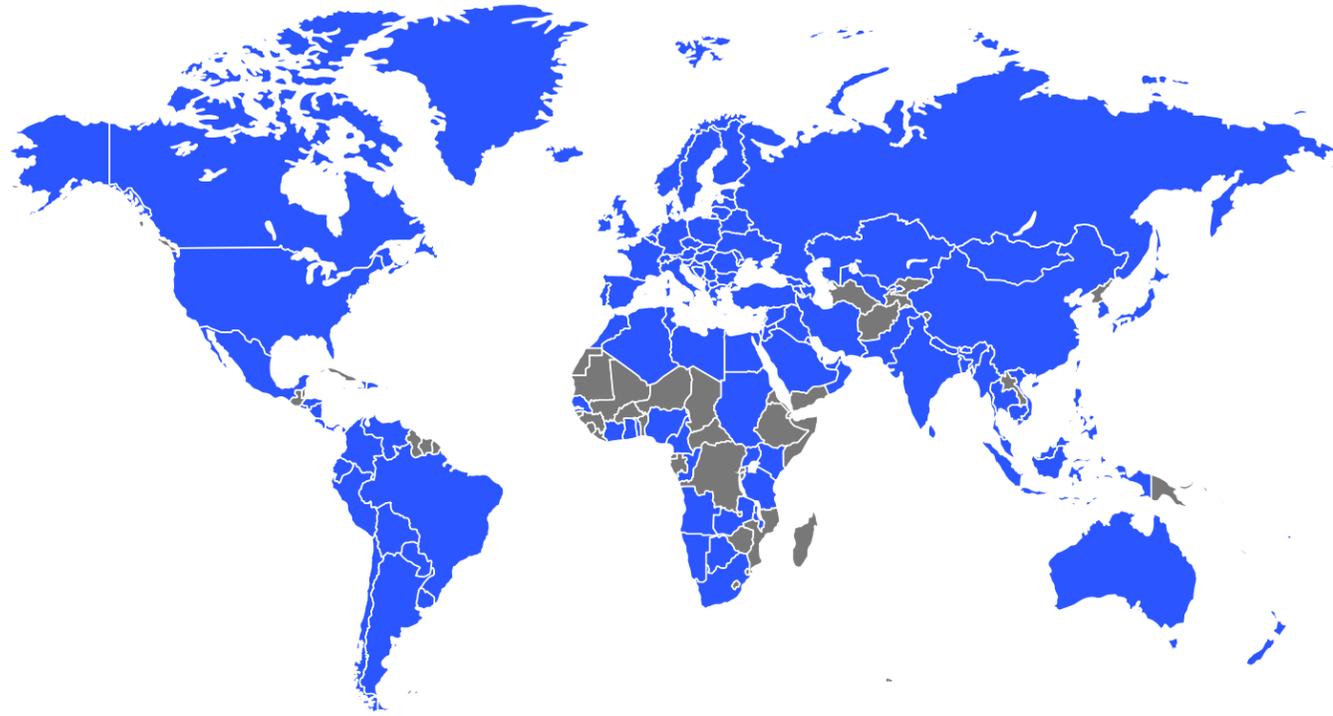
- Created a consumer-focused campaign raising awareness about sepsis that included social media posts, a Q&A with a well-renowned critical care physician, and posters for SEPTA Regional Rail trains that had more than 900,000 views
- Attended more than a dozen health fairs, discussing ways to improve medication safety
- Received designation for *Patient Safety* as a Patients Included™ publication for reaching milestones like recruiting four patient representatives to serve as editorial board members, including patient commentaries in each issue, and having patients regularly review manuscripts
- Presented on *Patient Safety* at Cinderblocks, the annual conference for The Walking Gallery
- Developed nine additional Patient Safety Tips—consumer-facing tip sheets on key healthcare topics—including ones on drug allergies, sepsis, and diagnostic error
- Attended the Philadelphia Trans Wellness Conference to assess LGBTQ experiences with healthcare
- Expanded Patient Advisory Council membership



## Event Reporting

- Conducted a systemic review of the Pennsylvania Patient Safety Reporting System (PA-PSRS) to improve its relevance, function, and contributions to patient safety improvement
- Explored several opportunities to review other data sources to identify future enhancements within PA-PSRS, including court dockets, malpractice claims, and data from the Pennsylvania Insurance Department
- Completed a multiyear project to enhance the reporting system through the PSA's PA-PSRS modernization project

# Patient Safety



In September, the PSA launched *Patient Safety*, a quarterly, peer-reviewed journal whose mission is to provide timely, original scientific research that can be used by healthcare systems and providers to improve patient care and educate frontline staff about safe practices. Its focus is on problems associated with a high combination of frequency, severity, and possibility of solution; novel improvement strategies; and areas in which urgent communication of information could have a significant impact on patient outcomes.

The first two issues were read by more than 15,000 people across every state in the United States and in 139 countries.

*Patient Safety* is proud to be a Patients Included™ publication—patients serve on the editorial board

and regularly review articles, and a patient commentary is featured in each issue.

The journal is a reimagining of the PSA's prior publication, the *Pennsylvania Patient Safety Advisory*. The *Advisory* was launched in 2004 and featured analyses of events reported to the Pennsylvania Patient Safety Reporting System (PA-PSRS).

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**INSIGHT FOR ACTION:** Patients can play an important role in academic publishing. Their perspectives as end users can identify lapses in application unaccounted for in a research environment.

**15k**  
Readers

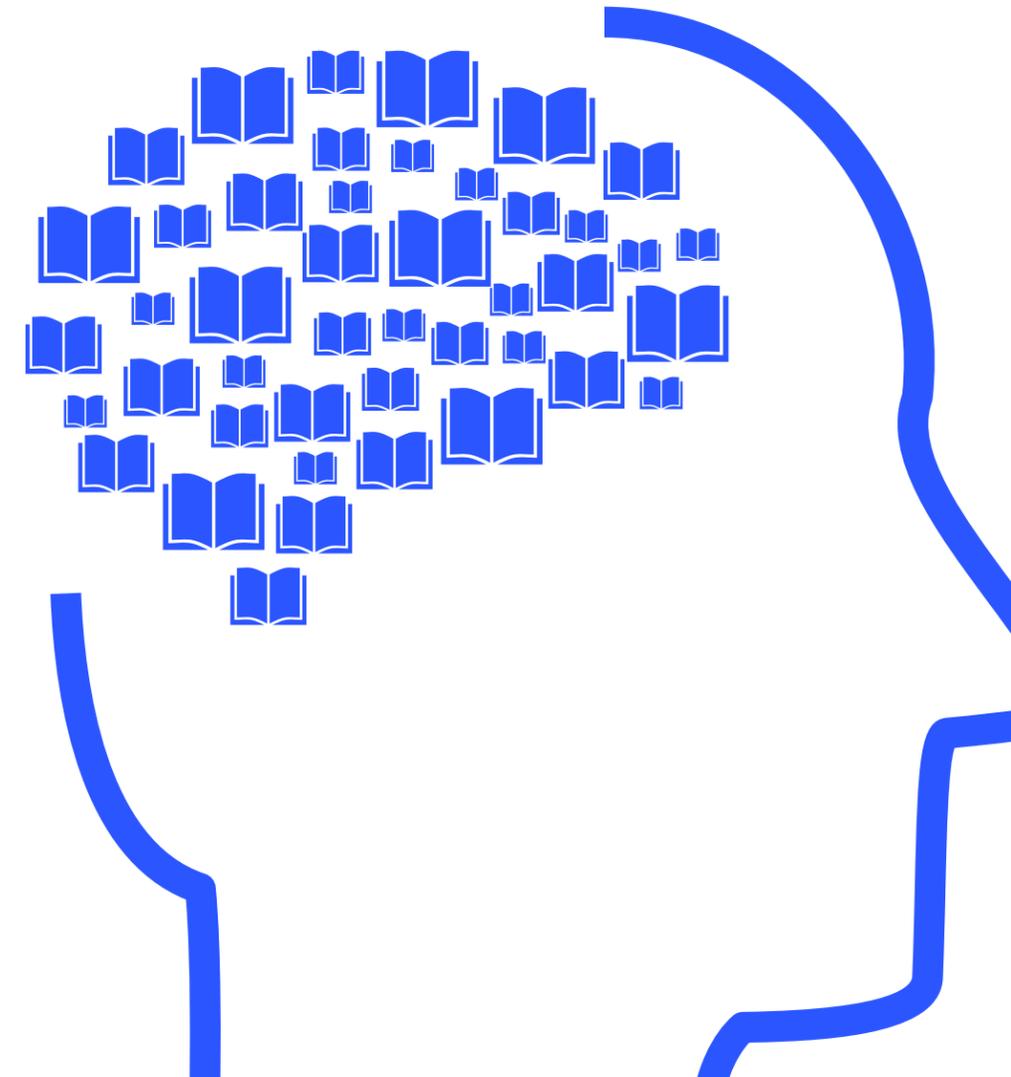
**2.5k**  
Cities/  
Regions

**139**  
Countries

**50**  
States

**24**  
Articles  
Published

“  
If you only  
have five  
minutes  
to read  
something,  
it should be  
*Patient Safety*.”



# I AM Patient Safety

## Annual Achievement Award Winners

### Executive Director's Choice Award

*Tyrone Hospital*

A team spanning the OR, housekeeping, maintenance, infection control, and patient safety departments at Tyrone Hospital demonstrated their commitment to patients by examining the causes of surgical site infections (SSIs) and addressing opportunities for improvement. Their efforts reduced total hip arthroplasty SSIs from 4.1% in 2018 to 0% in 2019!

### Ambulatory Surgery Facility

*Penn Highlands Elk Surgery Center*

Staff at the Penn Highlands Elk Surgery Center worked with physician offices to educate their staff further on the causes and prevention of wrong-site surgeries. By following best practices during pre-procedure verification of patient information they were able to reduce the number of incorrect registrations.

### Focus on the Patient

*Einstein Medical Center Montgomery*

A multidisciplinary Ligature Risk team at Einstein Medical Center Montgomery identified dangers to suicidal patients in care rooms and bathrooms, improved safety by changing their physical environments and processes, then raised the awareness of staff by engaging them with activity stations that challenged them to spot ligature risks in pictures.

### Improving Diagnosis

*Chester County Hospital, Penn Medicine*

The departments of Pharmacy and Infectious Diseases introduced a protocol to clarify and document penicillin allergies in patients through penicillin skin testing (PST). The new process resulted in fewer readmissions for patients who received PST and will improve the care they receive in the future when antibiotics may be prescribed.

### Individual Impact

*UPMC Hamot*

When a teenage girl presented to UPMC Hamot's ED with two adults she didn't seem to know, Char Boyd, a trained sexual assault nurse examiner, became suspicious. She acted quickly to separate the patient from her watchful companions and summon police—resulting in the victim's rescue from human trafficking.

### Innovation

*WellSpan Health*

Dr. MaryEllen Pfeiffer, Mary Zeigler, Melissa Heath, Melinda Jeffries, Nancy Nicholas, Suzanne Gervase, Karla Heberlig, and Duane Patterson crafted an engaging and eye-opening experience for attendees of the annual WellSpan Health Quality Forum: a patient safety escape room in which the narrative of 66-year-old "Marina" unfolded through challenging puzzles, clues, and secret codes.

### Long-Term Care Facility

*Windy Hill Village*

Tara Gregory and the Falls Prevention Team at Windy Hill Village collaborated to decrease resident falls and enhance residents' quality of life. Some of their improvements include additional check-ins with residents, identifying high-risk residents and reviewing information regularly, and ongoing education—which have resulted in fewer resident falls and better outcomes!

### Safety Story (Near Miss/Close Call)

*Pennsylvania Hospital, Penn Medicine*

Recognizing opportunities to improve care for diabetes patients, Sara Cohen worked with Barbara Morrison, Kelly Milligan, and others at Pennsylvania Hospital to align processes and guidelines with best practice recommendations and establish a diabetes task force to engage the entire staff in enhancing their knowledge and the care they provide.

### Transparency and Safety

*Pennsylvania Hospital, Penn Medicine*

An interdisciplinary team from the Women's Health Division, Pennsylvania Hospital, used a TeamSTEPPS program, along with fun and creative activities, to build a culture of safety. Their efforts to engage staff in increasing transparency, improving teamwork, and standardizing interprofessional communication has decreased patient harm events from 12% to 3%.

**INSIGHT FOR ACTION:** The variety in this year's submissions—a nurse saving a young girl from sex trafficking, an OR team eliminating SSIs, a clever "escape" from typical training monotony—proves anyone can have an impact on patient care.

156  
Nominations

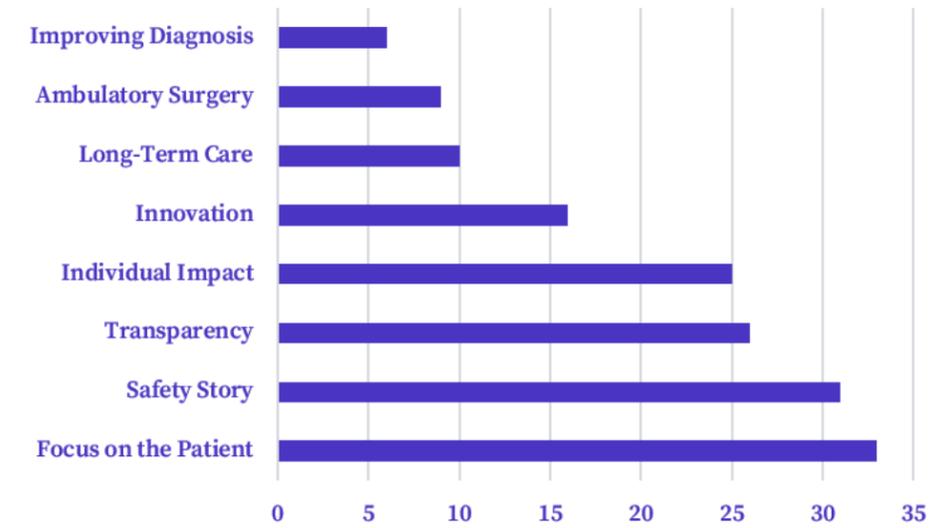
79  
Facilities

20  
Facilities  
with >1  
nomination

2  
Facilities  
with >10  
nominations

16  
Most  
nominations  
by a facility

Nominations by Category



# Education

The 2<sup>nd</sup> Pennsylvania Patient Safety Summit (P2S2) was the flagship event of 2019's educational programs, with more than 280 attendees representing 110 facilities. Held on May 2 in Seven Springs, Pennsylvania, the keynote speaker was former Major League Baseball (MLB) All-Star and cancer survivor John Kruk, who shared how his persistence and a serendipitous injury led to the diagnosis of a difficult-to-detect form of testicular cancer.

Three chief executive officers spanning a diverse range of hospitals/health systems discussed current challenges and offered strategies to improve patient safety.

Breakout sessions included *So, You Want To Know Why You Ended Up at Trial?*—a legal discussion with

plaintiff and defense counsel; *Product Substitution and Change: Who is Making the Decision?*—a review of supply chain purchasing decisions; and *Strategies for Patient Safety: Protecting Staff, Patients and Fellow Patients, and Their Families*—a guide for incorporating patient and family perspective into care.

**INSIGHT FOR ACTION:** Patient safety is a broad umbrella with influences across the care continuum. P2S2 provided a forum for hundreds of patient safety professionals to discuss a wide range of current events and extrapolate concrete strategies that will reduce harm across Pennsylvania and beyond.

“  
**Great conference.  
Great sessions.**

“  
**One of the best presentations I have ever experienced.**

“  
**Thank you for a great summit!**

# 7K

Individuals Trained

# 449

Highest # of Participants at an Event

# 257

Events

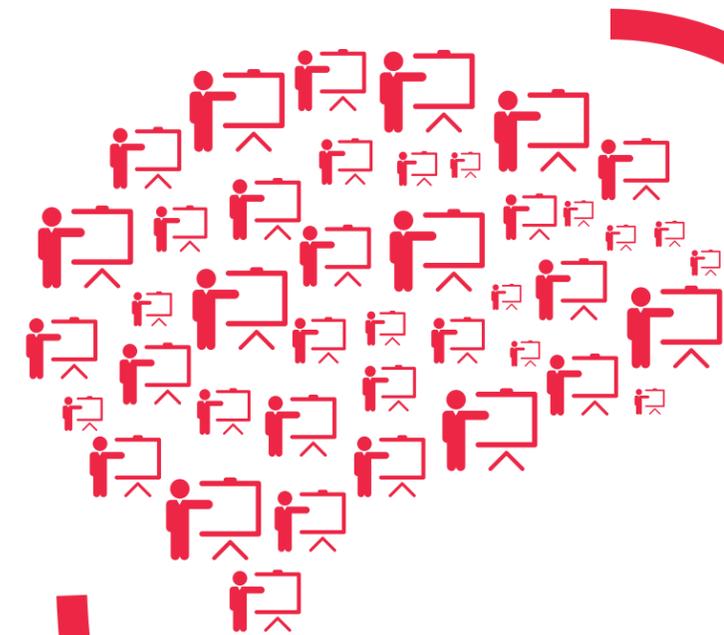
# 107

1:1 PSO Orientations

# 95%

Keystone Participation (% of eligible)

“  
**Great way to bring patient safety to a higher level of awareness!**



# Patient Safety Liaisons

Patient safety liaisons (PSLs) provide consultations and education to acute care facilities across the Commonwealth. Pennsylvania is divided into eight geographic regions with each PSL supporting 80 facilities. This group of experts—with decades of collective experience in nursing, behavioral health, emergency services, intensive care, and patient safety—train new patient safety officers, educate frontline clinicians and administrators, assist with policy development, and consult about facility-specific needs.

**2,325**  
Facility  
Contacts

**5**  
Ambulatory  
Surgery  
Symposia

**243**  
Symposia  
Attendees

**8**  
Patient Safety  
Liaisons

**219**  
Facility  
Contacts

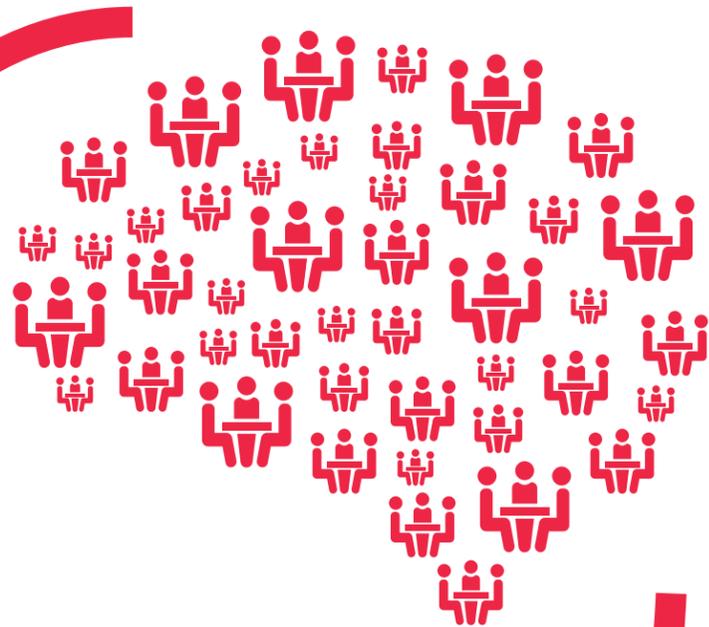
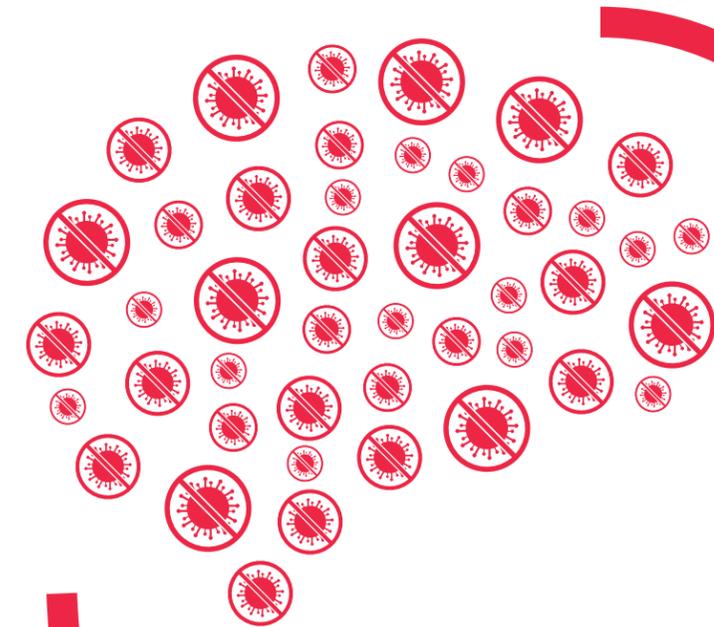
**5**  
Long-Term  
Care  
Symposia

**267**  
Symposia  
Attendees

**2**  
Infection  
Preventionists

# Infection Preventionists

Infection preventionists provide similar support for healthcare facilities, primarily nursing homes, except with a narrower focus. Both of the PSA's senior infection preventionists, JoAnn Adkins and Terri Lee Roberts, were recipients of the 2019 Heroes of Infection Prevention Award, given each year by the Association of Professionals in Infection Control and Epidemiology (APIC), for their contributions in education.



# Patient Engagement

Expansion was the theme for the PSA's patient engagement efforts this year. Whether through new partnerships with demographic groups, like the LGBTQ community; providing a voice to patients in academic literature; or growing its platform for proactive harm prevention, the PSA spent 2019 engaging patients in ways it never has before.

For the first time, the PSA attended the annual Philadelphia Trans Wellness Conference and solicited firsthand accounts of LGBTQ experiences with healthcare—a summary of which was published in *Patient Safety*.

*Patient Safety* proudly received designation as a Patients Included™ journal, an honor given to publications that regularly and robustly feature the patient perspective.

In honor of Sepsis Awareness Month in September, the PSA developed a consumer-focused campaign raising awareness about the often fatal condition. Highlights included a Q&A chat with a nationally recognized critical care physician and posters for SEPTA Regional Rail trains in Philadelphia.

Membership on the Patient Advisory Council—a team of laypeople who work in tandem with the PSA to develop consumer-facing materials—grew to seven.

---

**INSIGHT FOR ACTION:** Patients are an integral part of the care team. Their involvement is key to reducing harm and improving healthcare delivery as a whole.

## 900K

Sepsis  
Campaign  
Impressions

## 201

Sepsis Q&A  
Participants

## 13

Health Fairs  
Attended

## 7

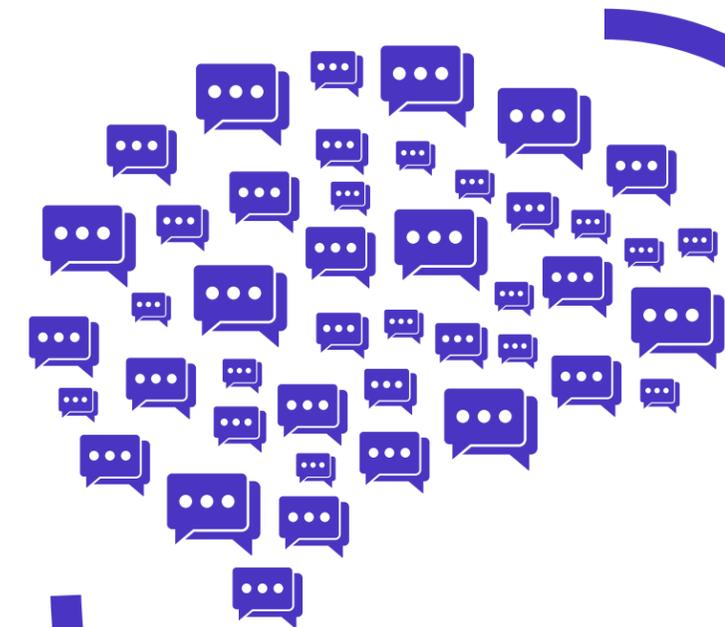
Patient  
Advisory Council  
Members

## 4

Patient  
Editorial Board  
Members

“  
Take care  
of the  
patient and  
everything  
else will  
follow.

—Thomas Frist, MD



# Data Science and Research

Inspiring action through data is at the core of the Patient Safety Authority's (PSA) data science and research work. This year provided many new opportunities for growth, with the formation of an internal data science and research team consisting of professionals with expertise in the areas of patient safety, infection prevention, quality improvement, risk management, nursing, pharmacy, information technology, data science and analysis, statistics, research, and writing.

The PSA's Data Science and Research team performs all daily operational functions, such as performing original research and reviewing and analyzing patient safety and healthcare-associated infection data to identify important trends; communicating key data insights and actionable recommendations through multiple channels, including articles published in *Patient Safety* and other journals; strengthening the integrity and reliability of PA-PSRS data; and providing healthcare facilities with valuable feedback and tools they can use to glean new insights from their data.

In July 2019, the PSA contracted with MedStar Health Research Institute (MHRI). MHRI is assisting with clinical analysis and uses their expertise in human factors science to identify contributing factors and develop tools to support safe practices. Coinciding with this work, MHRI also brings knowledge of machine learning. PSA is excited about the possibilities artificial intelligence can offer and looks forward to further exploration and refinement in this area.

PA-PSRS benefited from a refresh in 2019, implementing enhancements that improved the user experience with single sign-on, event entry, and reporting functionality. The PSA team worked with its software developers at DXC Technology to ensure a seamless transition for both acute care and nursing home facilities. Training sessions were held to review system upgrades and answer questions. Along with these sessions, the *PA-PSRS Training Manual* and user guides were fully revised.

These achievements have set the foundation for the PSA's new approach to data science and research. In the coming years, the team will continue to execute on its mission to provide access to valuable information that sparks data-driven, actionable insights that inspire change and improve patient safety.

**INSIGHT FOR ACTION:** An analysis of medication error events involving infusion pumps revealed that pump programming, tubing/connections, and pre-administration process problems are the primary contributing factors for these events, and shared risk reduction strategies such as ensuring appropriate pump setup, maintenance, and integration; applying a multidisciplinary approach when evaluating and procuring pumps; and developing a process to regularly collect, review, and act on safety-related data.

An analysis of PA-PSRS events involving telemetry monitoring revealed that harm associated with these events is rare but potentially catastrophic, with death being the most frequent outcome among serious events. In the article, the authors identified opportunities for improvement related to processes surrounding common contributing factors such as battery issues, communication breakdowns, and improper alarm settings.

Another article shared findings related to ongoing reports of newborn falls occurring in healthcare facilities across Pennsylvania. As more than half of these events occur because the caregiver falls asleep, improvement efforts should focus on providing support for exhausted new mothers and fathers in the hours and days following birth, and rounding more frequently when new mothers are breastfeeding.

Visit [patientsafetyj.com](https://patientsafetyj.com) to see the full analysis of PA-PSRS data from 2019.

**293K**

Acute Care Reports 2019

**285K**

Incidents

**8.6K**

Serious Events

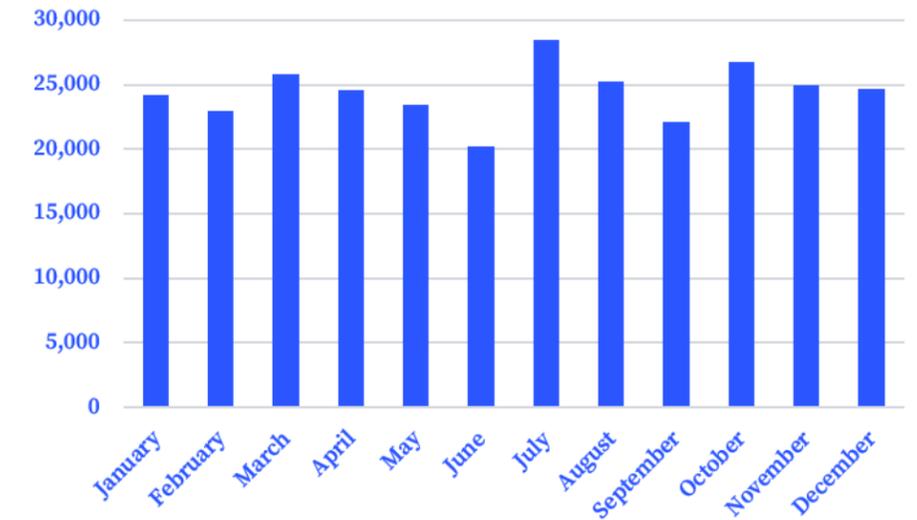
**97%**

percentage of reports that were incidents

**3%**

percentage of reports that were serious events

Monthly Event Reports – Acute Care 2019

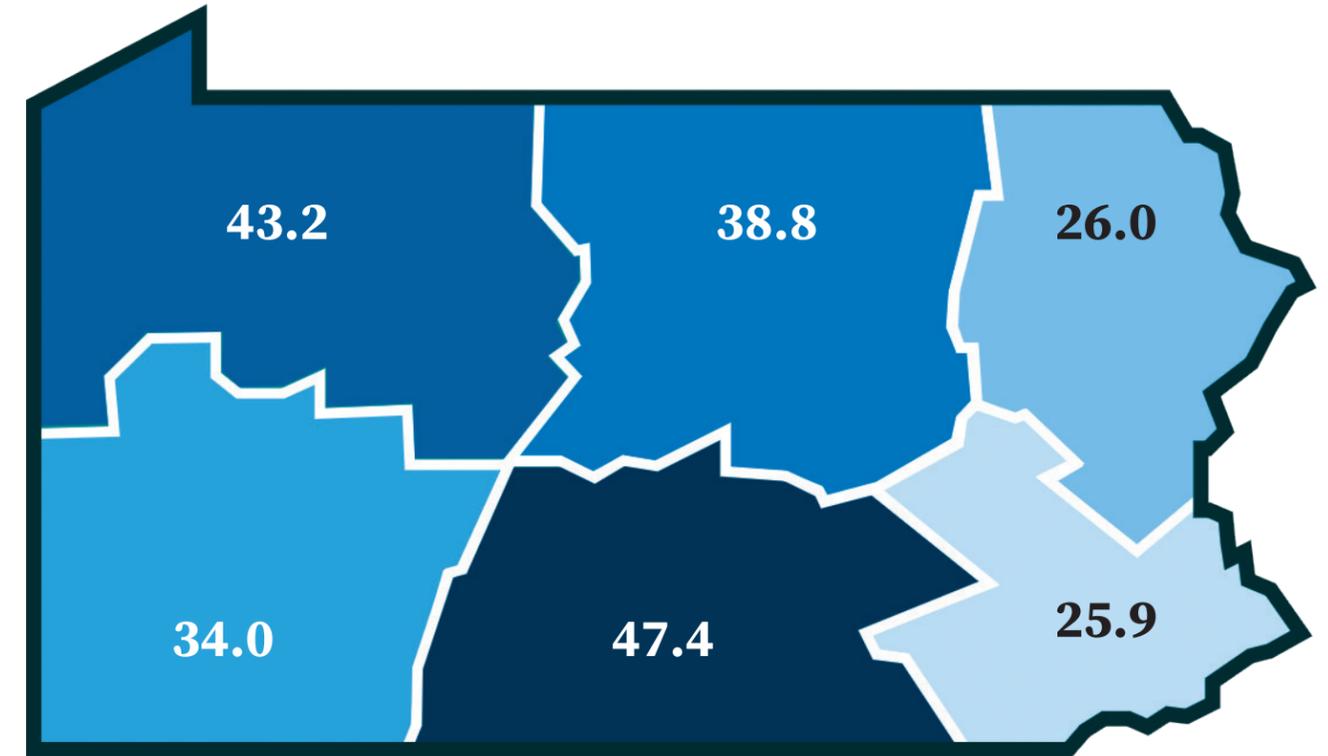


# Acute Care Data – 2019

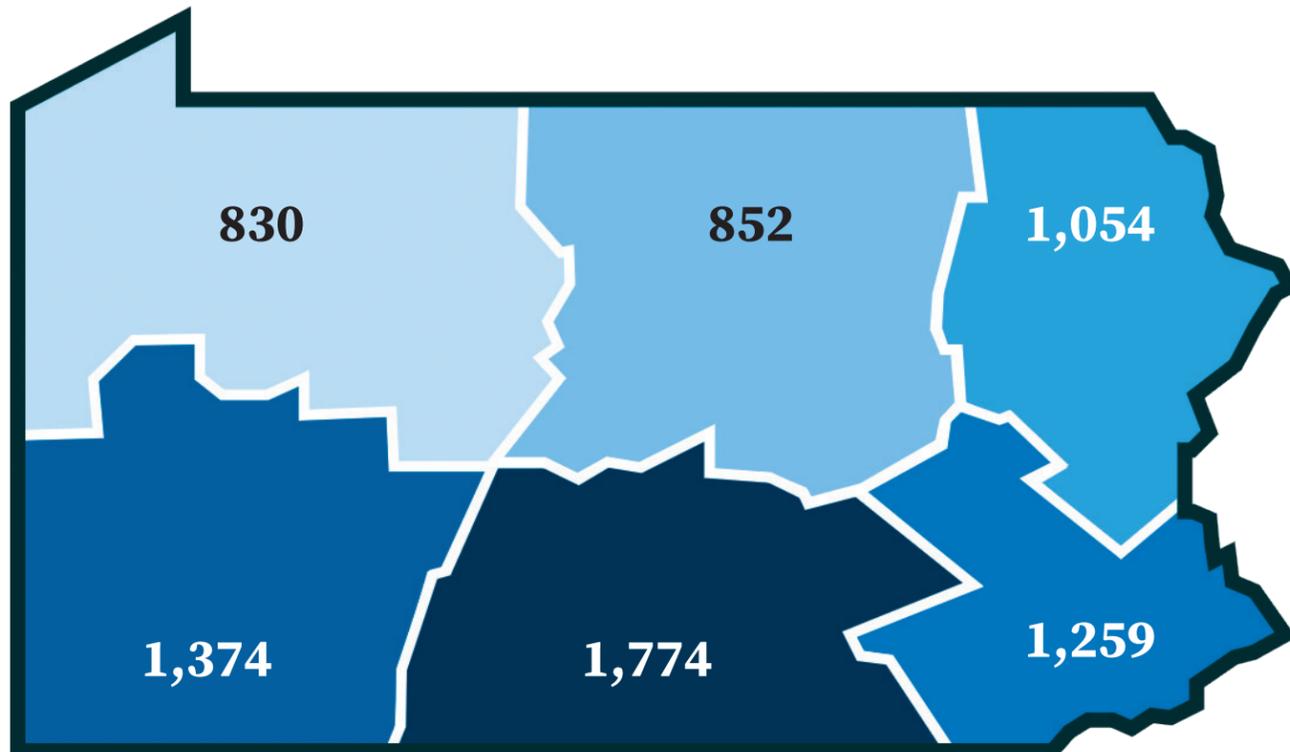
These six regions are based on DOH’s public health districts: Northwest (NW), North Central (NC), Northeast (NE), Southeast (SE), South Central (SC), and Southwest (SW). The differences in events reported by region may be explained by noting variation of reporting patterns, e.g., more reports may be submitted in regions with larger populations and greater numbers of healthcare facilities. The number of patient days is based on 2018 PHC4 data.

Facility Region	2019 Hospital Event Reports	2019 Mean of HSP Reports	2019 Incident Reports	2019 Serious Event Reports	2018 Patient Days	Rate for All Reports	Rate for Incidents	Rate for Serious Events
NW	20,747	830	20,165	582	480,661	43.2	42.0	1.2
NC	17,883	852	17,161	722	460,496	38.8	37.3	1.6
NE	28,445	1,054	27,618	827	1,093,504	26.0	25.3	0.8
SE	96,955	1,259	94,950	2,005	3,745,931	25.9	25.3	0.5
SC	51,438	1,774	50,296	1,142	1,084,181	47.4	46.4	1.1
SW	68,697	1,374	67,309	1,388	2,018,141	34.0	33.4	0.7

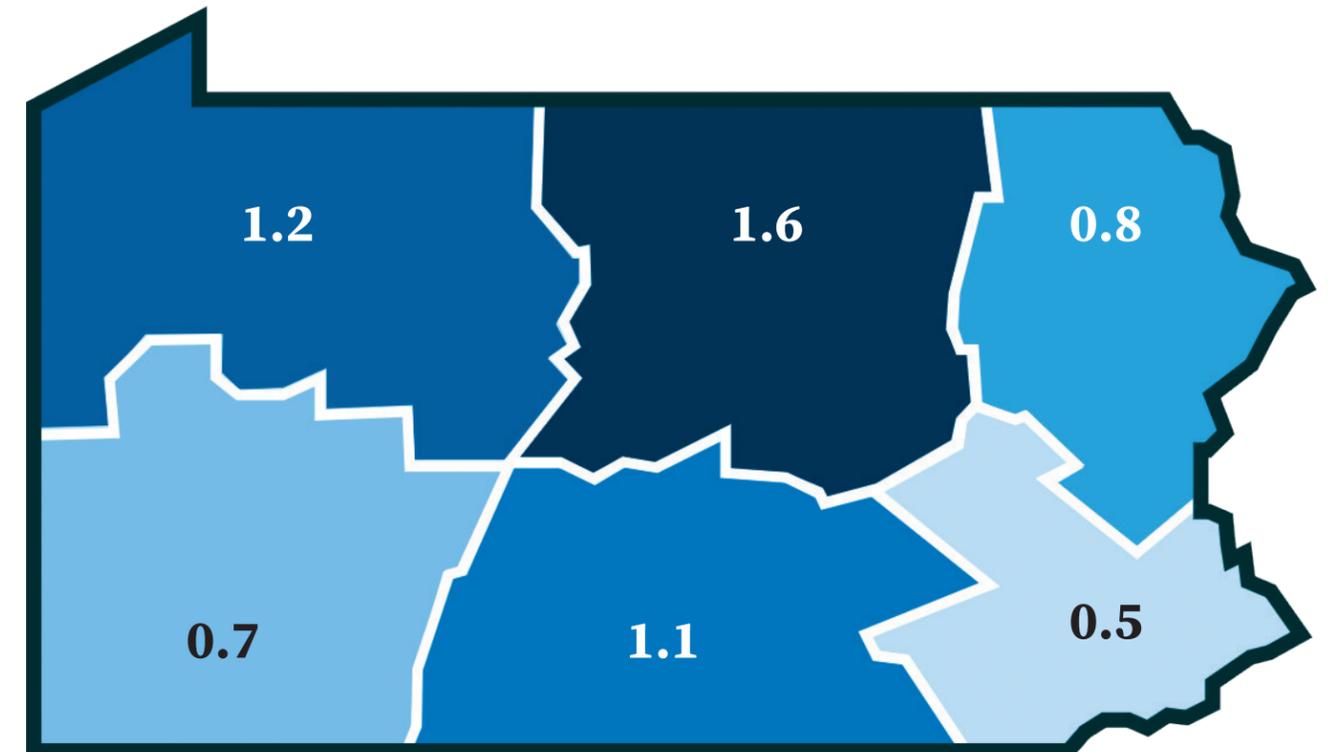
Report Rate – Total Reports by Patient Days



Mean Hospital Reports



Report Rate – Serious Events by Patient Days



# Collaboratives

Teamwork, collaboration, and shared learnings are cornerstones in healthcare. As care delivery becomes more complex and specialized, patients and clinicians benefit from working together.

The PSA participated in two key collaboratives in 2019: a health literacy project in conjunction with HCIF and the HAP Hospital Improvement and Innovation Network (HIIN).

## Health Literacy

Highlights include:

- Plan and facilitate education events for healthcare professionals
- Cultural competence training for all PSLs and infection preventionists
- Development of cultural competence webinars and regional events

## Diagnostic Error (Through the end of August)

Lead of this collaboration was shared with HCIF. Highlights include:

- Focus on patient engagement
- In-person session with the HAP Patient and Family Advisory Committee (PFAC) meeting to solicit input from patient and families about the diagnostic process
- National webinar discussing lessons learned from the PFAC meeting
- Presentation about the collaborative at the Diagnostic Error in Medicine (DEM) conference, hosted by the Society to Improve Diagnosis in Medicine (SIDM)

## Falls

Injurious falls are one of the most commonly reported serious events by Pennsylvania hospitals. Highlights include:

- Some areas of focus: bed alarms, delirium, and statistical analysis for fall prevention
- Facilitate webinars and coaching calls

- Administer facility project survey
- Encourage completion of the following tools: post-fall investigation, self-assessment, and action plan
- Provide data analysis

## Culture of Safety (Ongoing)

In 2019, the project refocused its efforts to strengthen, improve, and advance patient safety culture by working intricately with a core group of healthcare facilities. The team was able to provide more individualized and facility-specific assistance. Highlights include:

- In-person facility consultation
- Review and discussion of facility-specific patient safety culture survey results
- Identify unit-level participation
- Explore focused culture of safety topic
- Facilitate teamwork

## Adverse Drug Events (Through the end of June)

Highlights include:

- Focus on opioid stewardship via consultation and webinars
- Serve as content expert on opioid stewardship partnership (with HAP and the hospital associations of New Jersey and Ohio)
- Encourage hospitals to review the ADE project's organization assessments for opioids, insulin, and anticoagulants
- Promote establishment of opioid stewardship programs to guide organizations towards understanding the concepts of pain and pain management, and a decrease in unnecessary opioid use in facilities

**INSIGHT FOR ACTION:** Collaboratives provide an important opportunity to pool resources and share knowledge to effect change on a broad scale.

# 460

Health Literacy Attendees

# 15

Health Literacy Events

# 842

HAP HIIN Participants

# 528

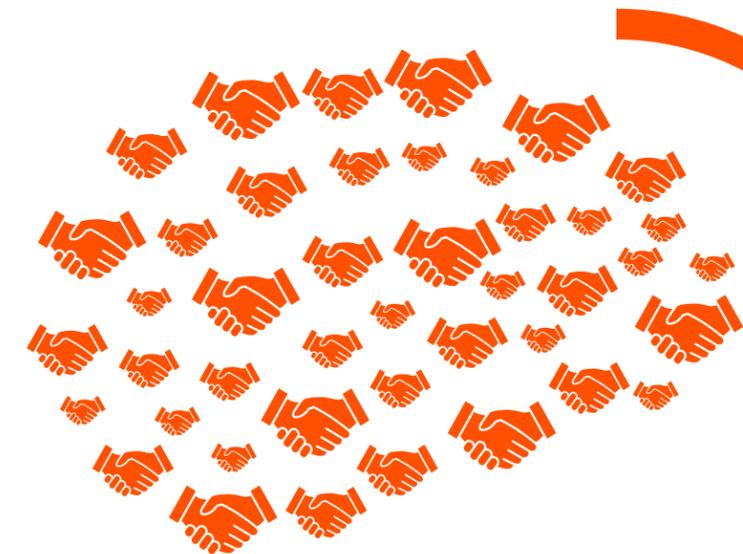
Participants in Falls Webinars/ Coaching Calls

# 20

Facilities Reporting 0 Falls with Injury

“  
Individually,  
we are  
one drop.  
Together, we  
are an ocean.”

—Ryūnosuke Akutagawa



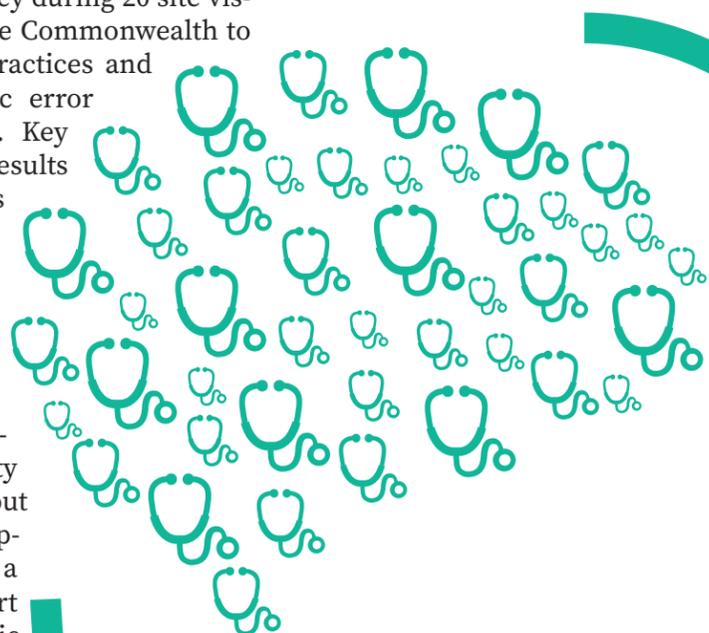
# Diagnostic Excellence

Our Center of Excellence for Improving Diagnosis (CoE) provides a formal structure and dedicated resources to guide strategy, build capabilities, and deliver value to improve diagnosis throughout the Commonwealth. In particular, the CoE team's work is focused on knowledge, connection, and action.

In July 2019, the CoE and Patient Safety Liaison teams embarked on a multiyear project to create a novel, comprehensive assessment tool to identify facility-specific gaps and set priorities to strengthen key domains integral to the diagnostic process. Aligned with developing the tool, the teams created and administered a survey during 20 site visits at hospitals throughout the Commonwealth to better understand current practices and perceptions about diagnostic error and the diagnostic process. Key themes from the survey results include a lack of awareness about the scope and impact of diagnostic error, negative connotation and defensive reaction to the term “diagnostic error,” perception that the issue is a provider problem as opposed to a systems issue, lack of uniformity among leadership teams about how to prioritize and best approach the problem, and a need for resources to support improvement in the diagnostic process. In 2020, the teams will

further explore these themes during focus group meetings across the Commonwealth, which will help inform development of the assessment tool.

**INSIGHT FOR ACTION:** Overall, there is a lack of systematic effort to improve the diagnostic process, both within and across healthcare facilities. Hospital leaders and teams should evaluate their existing projects to identify those related to the diagnostic process and how those projects might be scaled to produce a broader impact across other areas of the organization.



# Fiscal Statements and Contracts

The Medical Care Availability and Reduction of Error (MCARE) Act<sup>1</sup> establishes the Patient Safety Trust Fund as a separate account in the Pennsylvania Treasury. Under the MCARE Act, the Patient Safety Authority (PSA) determines how those funds are used to effectuate the patient safety provisions of the MCARE Act and administers funds in the Patient Safety Trust Fund. Funds come primarily from assessment surcharges made by the Department of Health on certain medical facilities.

The PSA recognizes that Pennsylvania hospitals, birthing centers, ambulatory surgical facilities, abortion facilities, and nursing homes bear financial responsibility for costs associated with complying with mandatory reporting requirements. Accordingly, the PSA has focused on two fiscal goals: (1) to be prudent in the use of moneys contributed by the healthcare industry, and (2) to assure that healthcare facilities paying for the Pennsylvania Patient Safety Reporting System (PA-PSRS) receive direct benefits from the system and from PSA programs in return. Pursuant to Section 304(a)(4) of the MCARE Act, as a general rule, the PSA is authorized to receive funds from any source consistent with the PSA's purposes under the Act. Consistent with this mandate, the PSA at times contracts with and receives funding from other healthcare-related entities to reduce medical errors and promote patient safety in the Commonwealth. These contracts in 2019 are described in the section, “Contracts under which the PSA Received Revenue in 2019 as a Contractor,” which lists contracts with the Hospital and Healthsystem Association of Pennsylvania (HAP) and the Health Care Improvement Foundation (HCIF).

Within the design of PA-PSRS, the PSA includes a variety of integral and analytical tools that provide immediate, real-time feedback to facilities on their own adverse event and near-miss reports and activities. In 2019, the PSA continued to enhance its newly designed public website [patientsafety.pa.gov](http://patientsafety.pa.gov), providing expanded access to the PSA's educational materials and programs, as well as mobile accessibility. In 2019, the PSA completed development of the PA-PSRS Application Modernization (AMOD). The AMOD project entailed a complete redesign of the PA-PSRS application with the release to acute care facilities in June 2019 and to nursing homes in December. Prior

to the AMOD redesign, the PSA released a Pressure Injury module within PA-PSRS.

## Funding Received From Hospitals, Ambulatory Surgical Facilities, Birthing Centers, and Abortion Facilities

The MCARE Act<sup>1</sup> set an initial limit of \$5 million on the total aggregate assessment on acute care facilities for any one year beginning in 2002, plus an annual increase based on the consumer price index (CPI) for each subsequent year. For fiscal year 2019–2020 (FY 19–20), the maximum allowable acute care assessment is \$7,640,763, against the PSA Board's approved aggregate acute care assessment of \$6,360,000.

On December 9, 2019, the Board authorized a recommendation to the Department of Health for FY 19–20 acute care assessment surcharges totaling \$6.36 million. This amount is a \$500,000 or 7.3% reduction from the FY 18–19 acute care assessment total and is 16.7% less than the maximum annual amount that could have been assessed for the fiscal year pursuant to Section 305(d) of the MCARE Act. The PSA utilizes the Northeast Medical Care Services CPI to calculate maximum allowable assessments.

At the time of the FY 19–20 acute care assessment recommendation, the Board considered several points, including the following:

- The PSA's FY 19–20 budget totals \$7.50 million. Of this amount, approximately \$6.20 million is budgeted for acute care-related expenditures, and funded by the \$6.36 million FY 19–20 acute care assessments. The acute care assessments also fund certain HAI infection prevention activities with the acute care facilities; these are separate and apart from Act 52 Nursing Home HAI assessment funded activities.
- The PSA's FY 19–20 budget of \$7.50 million is a \$1.1 million reduction from the \$8.60 million budgeted in each of the two previous fiscal years. The budget reduction was enabled by decreasing dependence on outside consultants, bringing more research, analysis, and publishing functions in-house.

Table 1. Acute-Care Facility Assessments

FISCAL YEAR	NUMBER OF FACILITIES ASSESSED BY DOH <sup>a</sup>	APPROVED ASSESSMENTS	TOTAL ASSESSMENTS RECEIVED BY DOH <sup>b</sup>
2002-03	356	\$5,000,000	\$4,663,000
2003-04	377	\$2,500,000	\$2,542,316
2004-05	414	\$2,500,000	\$2,508,787
2005-06	450	\$2,500,000	\$2,500,149
2006-07	453	\$2,500,000	\$2,500,034
2007-08	526	\$5,400,000	\$5,391,583
2008-09	524	\$4,000,000	\$3,972,677
2009-10	519	\$5,000,000	\$4,989,781
2010-11	542	\$5,000,000	\$4,981,443
2011-12	550	\$5,100,000	\$5,063,723
2012-13	545	\$5,500,000	\$5,504,549
2013-14	556	\$5,500,000	\$5,492,002
2014-15	564	\$6,200,000	\$6,209,459
2015-16	569	\$6,500,000	\$6,494,845
2016-17	575	\$6,675,000	\$6,656,359
2017-18	583	\$6,860,000	\$6,860,164
2018-19	585	\$6,860,000	\$6,834,611
2019-20 <sup>c</sup>	558	\$6,360,000	
<b>Total</b>			<b>\$83,190,870</b>

a. The number of facilities assessed by the Department of Health differs from the number of the Medical Care Availability and Reduction of Error (MCARE) Act's facilities cited elsewhere in this report because of differences in the dates chosen to calculate the number of facilities for these two different purposes.

b. Amounts assessed and amounts received differ because a few facilities may have closed in the interim or are in bankruptcy. In a few cases, the Department of Health has pursued action to enforce facility compliance with the MCARE Act's assessment requirement.

c. 2019-20 missing figures were unavailable at the time of publication and will appear in next year's annual report.

Table 2. Nursing Home Assessments

FISCAL YEAR	NUMBER OF FACILITIES ASSESSED BY DOH	APPROVED ASSESSMENTS	TOTAL ASSESSMENTS RECEIVED BY DOH
2008-09	725	\$1,000,000	\$1,000,782
2009-10	711	\$800,000	\$799,382
2010-11	707	\$800,000	\$799,829
2011-12	707	\$800,000	\$804,473
2012-13	711	\$900,000	\$913,315
2013-14	698	\$1,000,000	\$998,751
2014-15	703	\$1,050,000	\$1,049,842
2015-16	702	\$1,080,000	\$1,079,505
2016-17	704	\$1,111,000	\$1,110,185
2017-18	699	\$1,140,000	\$1,139,483
2018-19	699	\$1,140,000	\$1,139,645
2019-20 <sup>a</sup>	695	\$1,140,000	
<b>Total</b>			<b>\$10,836,063</b>

a. FY 2018-2019 missing figures were unavailable at the time of publication and will appear in the next year's annual report.

- The FY 19–20 acute care assessment of \$6.36 million has increased by \$1.36 million since the PSA's initial FY 2002–2003 acute care assessment of \$5.0 million, a 1.6% per year average increase.
- The PSA grew its staff size from 23 to 29 during 2019, while reducing its contractor budget in FY 19–20 by approximately \$2.0 million. Certain Commonwealth of Pennsylvania mandated benefit rates were also reduced in FY 19–20.

Table 1 shows the number of acute care facilities assessed, approved assessments, and assessments received for each fiscal year.

### Funding Received From Nursing Homes

Act 52<sup>2</sup> of the MCARE Act allows the Department of Health to assess Pennsylvania nursing homes up to an aggregate amount of \$1 million per year for any one year beginning in 2008, plus an annual increase based on the CPI for each subsequent year. In 2008, following the PSA's suggestion, the Department assessed 725 nursing home facilities a total of \$1,000,000 and transferred \$1,000,782 to the Patient Safety Trust Fund for FY 08–09. This money could be spent only on activities related to HAI and implementation and maintenance of Chapter 4 of the MCARE Act. For FY 2019–2020, the Act 52 maximum allowable assessment is \$1,233,562, against the PSA Board's approved aggregate assessment of \$1,140,000.

On December 9, 2019, the PSA Board authorized a recommendation to the Department for FY 19–20 nursing home assessment surcharges of \$1.14 million. This amount is equal to and maintains the FY 18–19 nursing home assessment total and is 8.2% under the maximum annual amount that could have been assessed for the fiscal year pursuant to Section 409(b) of the MCARE Act. The PSA utilizes the Northeast Medical Care Services CPI to calculate maximum allowable assessments.

Table 2 shows the number of nursing homes assessed, approved assessments, and assessments received for each fiscal year.

### Annual Expenditures & Non-Assessment Revenue Receipts

During calendar year 2018, the PSA spent about \$8,090,231 (Table 3a), and received contract and service-related receipts of \$374,866 and investment income of \$184,151 (Table 3b).

Table 3a. 2019 Expenditures

CONTROL LEVEL	AMOUNT
61: Personnel	\$ 3,990,676.53
63: Operating	\$ 4,099,554.34
<b>Total 2018 Expenditures</b>	<b>\$ 8,090,230.87</b>

Table 3b. 2019 Revenue Receipts

REVENUE RECEIPTS	AMOUNT
Acute Care Assessments	\$6,834,941
Nursing Home Assessments	\$1,139,318
Non-Assessment Revenue	\$374,866
Investment Income	\$184,151
<b>Total 2018 Revenue Receipts</b>	<b>\$8,533,276</b>

### Patient Safety Authority Contracts

During calendar year 2019, the PSA received services under the following contracts (FC or funds commitment; PO or purchase order).

- DXC Technology Services, LLC*, FC # 4000022708
  - Five-year contract (including two option years) for PA-PSRS software development and maintenance, and other IT services
  - July 1, 2019 through June 30, 2024
  - Total Contract Amount: \$7,071,540 over 5 years
  - Amount invoiced for 2019 (July–Dec.): \$631,245.60
- MedStar Health Research Institute*, FC # 4000022717
  - Five-year contract (including two option years) for analyzing and evaluating patient safety data
  - July 1, 2019 through June 30, 2024
  - Total Contract Amount: \$3,419,185.85 over 5 years
  - Amount invoiced for 2019 (July–Dec.): \$284,389.34

- ECRI Institute*, FC # 4000018888
  - Four-year, nine-month contract for program administration, clinical analysis, training and data collection, and reporting infrastructure services (contract ended June 30, 2019) October 1, 2014 through June 30, 2019
  - Total contract amount: \$24,227,233 over 4 years and 9 months
  - Total invoiced amount: \$21,440,468 through end of contract June 30, 2019

# Anonymous Reports/Referrals

- Amount invoiced for 2014 (Oct.–Dec.): \$1,135,983.79
- Amount invoiced for 2015 (Jan.–Dec.): \$4,824,833.20
- Amount invoiced for 2016 (Jan.–Dec.): \$4,947,215.02
- Amount invoiced for 2017 (Jan.–Dec.): \$4,757,501.80
- Amount invoiced for 2018 (Jan.–Dec.): \$3,931,143.41
- Amount invoiced for 2019 (Jan.–June): \$1,843,791.19

#### Ricoh USA, Inc.

- Ricoh Color MFD lease, PO # 4500841111
- September 1, 2017 to August 31, 2021 @ \$328.17/month
- 13-month Ricoh lease expense paid in 2019: \$4,266.21

#### XEROX Corp.

- Xerox color MFD lease, PO # 4600015253
- October 1, 2017 to September 30, 2021 @ \$315.41/month
- 12-month Xerox lease expense paid in 2019: \$3,784.92

#### Contracts under which the PSA Received Revenue in 2019 as a Contractor:

##### HCIF (Health Care Improvement Foundation)

- Agreement #3 (ongoing) – Health Literacy Projects
- HCIF 3 Total Receipts in 2019: \$17,726.76

#### HAP/CMS subcontract agreement – Hospital Innovation Improvement Networks (HIIN)

- Total Receipts in 2019: \$345,224.00

#### Other Contracts under which the PSA Received Revenue in 2019:

##### Eventbrite – Online conference registration and payment processing

- Net registration receipts from 2019 Pennsylvania Patient Safety Symposium (P2S2): \$8,145.19

#### Patient Safety Authority Balance Sheet

Table 4, Balance Sheet, reflects the status of the Patient Safety Trust Fund as of December 31, 2019.

#### NOTES

1. Medical Care Availability and Reduction of Error (MCARE) Act of March 20, 2002, P.L. 154, No 13 40. Available: <http://www.legis.state.pa.us/cfdocs/legis/li/uconsCheck.cfm?yr=2002&sessInd=0&act=13>.

2. Medical Care Availability and Reduction of Error (MCARE) Act - Reduction and Prevention of Health Care-Associated Infection and Long-Term Care Nursing Facilities Act of July 20, 2007, P.L. 331, No.52, Cl.40. <http://www.legis.state.pa.us/cfdocs/legis/li/uconsCheck.cfm?yr=2007&sessInd=0&act=52>.

Table 4. Patient Safety Trust Balance Sheet

(Unaudited), as of December 31, 2019

#### ASSETS

Temporary Investments	\$7,791,928
Receivables, net:	
Assessment Revenue	7,500,000
<b>TOTAL ASSETS</b>	<b><u>\$15,291,928</u></b>

#### LIABILITIES AND FUND BALANCE

Accounts Payable and Accrued Liabilities	\$323,342
Invoices Payable	2,061,568
<b>TOTAL LIABILITIES</b>	<b><u>2,384,910</u></b>

Deferred Assessment Revenue	7,500,000
<b>TOTAL DEFERRED INFLOW OF RESOURCES</b>	<b><u>7,500,000</u></b>

Restricted	5,407,018
<b>TOTAL FUND BALANCE</b>	<b><u>5,407,018</u></b>

<b>TOTAL LIABILITIES, DEFERRED INFLOW OF RESOURCES, AND FUND BALANCE</b>	<b><u>\$15,291,928</u></b>
--	----------------------------

This balance sheet reflects the status of the Patient Safety Trust Fund as of December 31, 2019.

Source: Office of Comptroller Operations, Commonwealth Bureau of Accounting and Financial Management. CY19 methodology includes an accrual of Board approved FY19-20 Assessment Revenue.

## Anonymous Reports

The MCARE Act allows healthcare workers to submit an “anonymous report.” Under the provision, a healthcare worker who has complied with section 308(a) of the Act may file an anonymous report regarding a serious event.

The form is available on the PSA’s website and through PA-PSRS. The PSA developed an “Anonymous Reporting” guide to ensure healthcare workers are aware of their option to submit an anonymous report and encourages them to do so when they believe their facility is not appropriately reporting or responding to a serious event.

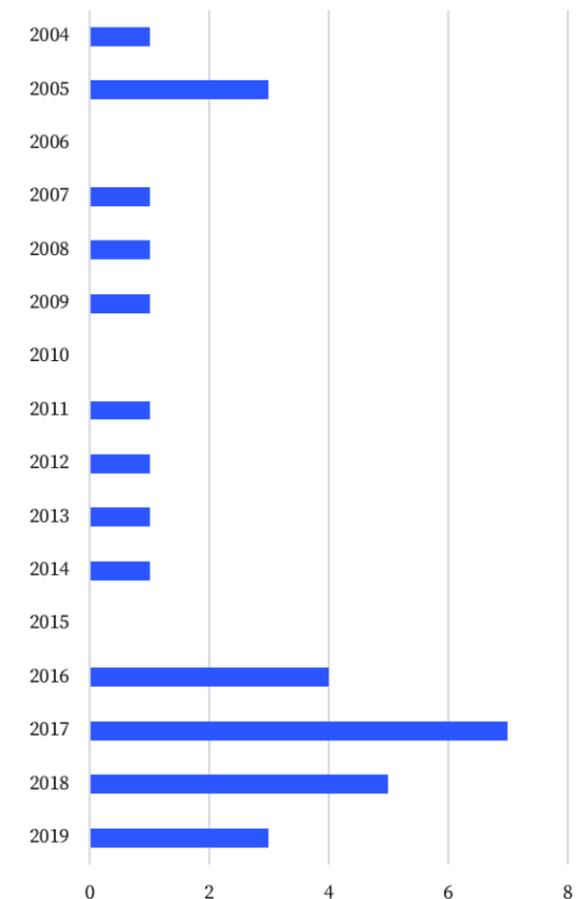
PSLs also review the anonymous reporting process with new PSOs as part of their onboarding program. Individuals completing the form do not need to identify themselves, and the PSA assigns professional clinical staff to conduct any subsequent investigations. In 2019, the PSA received three anonymous reports that complied with MCARE Act requirements.

## Referrals to Licensure Boards

The MCARE Act requires that the PSA identify referrals to licensure boards for failure to submit reports under the Act’s reporting requirements. MCARE specifies that it is the medical facility’s responsibility to notify the licensee’s licensing board of failure to report.

No such situations were reported to the PSA last year. However, the PSA is unlikely to receive information related to a referral to licensure board because PA-PSRS reports do not include the names of individual licensed practitioners.

Anonymous Reports (2004–2019)



# THANK YOU!

Thank you to the members of our Healthcare-Associated Infection Advisory Panel and Patient Advisory Panel for their service and expertise!

**Your insights help us take action.**

## Panels

**Healthcare-Associated Infections**  
Dorothy D. Borton, RN  
Kenneth J. Brubaker, MD  
Susan E. Coffin, MD, MPH  
Bettina Dixon, DNP, CRNA  
Patricia Hennessey, MSN, RN  
James Hollingsworth, MSN, RN  
Darryl Jackson, MD  
Tricia Kradel, PhD, MPH  
Chris Marshall, PharmD, MBA  
David A. Nace, MD, MPH  
David Pegues, MD  
Dana Piatek, MSN, RN  
Jason Raines, MPA, MBA  
Emily G. Shears, MPH  
Paige Van Wirth, MD  
Shane Walker  
Hope Waltenbaugh, MSN, RN  
Mohamed H. Yassin, MD, PhD

**Patients**  
Dory Frain  
Jennifer Hamm  
Danielle Jurgill  
Dwight D. McKay  
Lisa Rodebaugh  
Cindy Sidrane  
Lucas Wickard



