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Susan Wallace, MPH, Senior Patient Safety Liaison
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Public Board Meetings in 2022
• January 27, 2022
• March 17, 2022
• April 28, 2022
• June 23, 2022
• September 22, 2022
• December 8, 2022

Find summary minutes of public board meetings online at patientsafety.pa.gov.

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Annual Report Production Staff
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More than two decades ago, a dedicated group of trailblazers embarked on a journey with no roadmap or compass—just a general sense of where they needed to go. The Institute of Medicine had recently released their landmark report, *To Err is Human*, which was the first time anyone publicly decreed that sometimes patients experience harm.

Without knowing exactly how or what, this group of Pennsylvanians set out to do something. That something became the Medical Care Availability and Reduction of Error (MCARE) Act: the first statewide legislation enacted to track and reduce harm and create a dedicated agency to oversee the process. And with that the Patient Safety Authority was born.

Twenty years later, MCARE is still the most robust reporting law in the nation and fosters the largest event reporting database in the United States. And 20 years later, the Patient Safety Authority continues to capture, analyze, and address concerns across the commonwealth.

“I will not follow where the path may lead, but I will go where there is no path, and I will leave a trail.”

– Muriel Strode
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 acute care facilities to report all incidents of harm (serious events) or potential for harm (incidents). Long-term care facilities report infections into the Pennsylvania Patient Safety Reporting System (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.

- Founded in 2002 by the 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 4 million event reports
- Governed by an 11-member board appointed by the governor and Pennsylvania legislature
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 2022, 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 the Pennsylvania Patient Safety Reporting System (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 2022, there were 332 qualifying AFs in Pennsylvania.

BIRTHING CENTER
The HCFA defines a birthing center as “a facility not part of a hospital which provides maternity care to childbearing 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 2022, 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 2022, Pennsylvania had 222 qualifying hospitals.

INCIDENT
A “potential adverse event”: 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 690 qualifying nursing homes at the end of 2022.

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. It 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.

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

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.
As such, the PSA prioritized enhancing reporting in 2022—both to determine whether all events are being captured into the Pennsylvania Patient Safety Reporting System (PA-PSRS) and to improve the quality of the information received through the database.

To address reporting compliance, PSA staff identified facilities who entered fewer events than their peers. The team also identified categories of reports that are likely to be miscategorized as incidents and communicated their findings to the facilities. PSA staff aided those facilities, offered education on which events are reportable, and discussed opportunities to remove barriers to reporting.

To improve data quality and expand its ability to identify potential disparity and equity issues, PSA implemented mandatory PA-PSRS demographic data fields (i.e., race, ethnicity, sex assigned at birth, gender identity, sexual orientation, and ZIP code). PSA also piloted an internal study to use natural language processing as a way to improve the accuracy of event reporting, and staff began a project to identify opportunities to add to, eliminate, or modify current PA-PSRS questions.

After extensive analysis of PA-PSRS data, the PSA identified neonatal complications as a key focus area for the upcoming year.

Event reporting is at the center of all Patient Safety Authority (PSA) activity, whether it’s uncovering trends unapparent to individual facilities or deriving educational resources from their analysis.
Event Reporting

Improving event reporting was a key focus of PSA activity throughout 2022. Staff identified two strategic areas: evaluating whether events are being reported to the PSA in compliance with the Medical Care Availability and Reduction of Error (MCARE) Act and assessing whether individual reports could provide additional data for analysis that would improve advisement and recommendations to healthcare facilities.

Reporting Compliance

PSA staff reviewed reporting practices among peer groups and identified those who were entering fewer events than their peers. Staff offered education to low volume reporters on which events are reportable and discussed opportunities to remove real and perceived barriers to reporting.

PSA staff identified and communicated categories of reports that are more likely to be miscategorized in severity, including returns to the operating room and deaths reported as incidents.

Data Quality

To improve data quality and expand its ability to identify potential disparity and equity issues, PSA implemented mandatory PA-PSRS demographic data fields (i.e., race, ethnicity, sex assigned at birth, gender identity, sexual orientation, and ZIP code). PSA also piloted an internal study to use natural language processing as a way to improve the accuracy of event reporting, and staff began a project to identify opportunities to add to, eliminate, or modify current PA-PSRS questions.
Data Science & Research

Developing new knowledge and revealing patient safety trends through research is at the center of the Data Science & Research (DS&R) team’s work. PA-PSRS data aids in understanding the inner workings of the complex patient/healthcare environment and brings to light new insights. Every patient safety event report is an opportunity to share information that can be analyzed and evaluated, leading to safety strategies that positively impact patients, families, and healthcare workers.

In January 2022 PA-PSRS was updated to add new mandatory demographics questions including race, ethnicity, sex assigned at birth, gender identity, sexual orientation, and ZIP code. These data can provide PSA and facilities with key information to begin analyzing event reports on specific populations and to identify critical patient safety concerns related to disparities in healthcare. Having a more comprehensive and inclusive view within event reports will lead the way for using demographics data to reduce harm and improve patient safety and health equity in Pennsylvania.

Quality data is imperative to the DS&R team performing accurate analyses and sharing patient safety information and emerging trends across the commonwealth and beyond. Throughout 2022 the DS&R team prioritized ways to strengthen the quality of PA-PSRS data. These projects included the use of natural language processing techniques to evaluate the accuracy of event classification and the development of anomaly reports to identify outliers and highlight significant trends at the facility level.

In 2022, the DS&R team’s research was shared via publication in Patient Safety and provided continuing education content for nurses and physicians. The following is a list of articles on a wide range of topics published in Patient Safety in 2022:

- Study of Patients’ Return to Surgery Post-Tonsillectomy and/or Adenoidectomy: A Relation Between Patient Age and Timing of Uncontrolled Bleeding
- Tracheostomy and Laryngectomy Airway Safety Events: An Analysis of Patient Safety Reports From 84 Hospitals
- Patient Safety Trends in 2021: An Analysis of 288,882 Serious Events and Incidents From the Nation’s Largest Event Reporting Database
- Long-Term Care Healthcare-Associated Infections in 2021: An Analysis of 17,971 Reports
- Visitor Behaviors Can Influence the Risk of Patient Harm: An Analysis of Patient Safety Reports From 92 Hospitals
- Pennsylvania Patient Safety Reporting: Updated Rates for Acute Care Event Reports
- A Perioperative Intervention to Prevent and Treat Emergence Delirium at a Veterans Affairs Medical Center

Visit patientsafetyj.com to see the full analysis of PA-PSRS data from 2022 in the June 2023 issue of Patient Safety.
Outreach & Education

Last year, the PSA developed a new educational mission statement that reflects and focuses its ongoing support for healthcare workers: “Inspire change to clinical practice and promote patient safety by increasing knowledge through timely, innovative, and credible education programs that leverage Patient Safety Authority’s unique skills, insights, and data.” To advance this goal, the PSA convened an interdisciplinary education committee to help ensure clinical staff receive the information and training they need to provide safe care to their patients.

A major emphasis of these efforts continued to be onboarding new patient safety officers (PSOs) and infection preventionists (IPs), as well as reinforcing the existing knowledge and expertise of staff already serving in these roles. This was accomplished through formal educational offerings (including live and recorded webinars), the quarterly long-term care newsletter The Lowdown, and frequent touchpoints with patient safety liaisons (PSLs). PSA also developed and conducted two virtual sessions for Pennsylvania Department of Health surveyors on Medical Care Availability and Reduction of Error (MCARE) Act components.

In addition to being available to answer questions and provide on-site instruction as needed, PSLs and IPs proactively reached out to facilities to offer assistance for specific types of events, such as wrong-site surgery and telemetry-related reports. In order to assure accurate information is being captured in the Pennsylvania Patient Safety Reporting System (PA-PSRS), they also contacted facilities to ask clarifying questions about events (e.g., high harm, deaths reported as incidents) and data (e.g., low volume reporting, anomaly reports); in 2022, PSA notified 43 acute care facilities that their reporting trends were not consistent with expectations.

Building on the ASF Preoperative Screening Facility Collaboration of 2014 and the ASF Cancellation and Transfer Survey of 2021, PSA introduced the ASF Preoperative Screening Program workbook tracking tool. This encompasses four different workbooks to enable ASF staff to track cancellations, costs associated with cancellations, and transfers. To facilitate use of the tool, PSA released a comprehensive reference guide in conjunction with a targeted webinar on interpreting its insights.

2022 Webinar Topics:

- Ambulatory Surgical Facility Tracking Tool: How to Gain Insights Into Cancellations and Transfers
- Long-Term Care Emergency Preparedness Educational Series
- Discontinuing Telemetry for Your Hospitalized Patient: Translating Practice Standards From the AHA Statewide
- Perioperative Pain Management – Emphasizing the Role of Multimodal Analgesia
- Preparing for an Emerging Pathogen: Candida auris
- Treatment Innovations for the Behavioral Health Emergency Room Patient
- What’s in Your Endoscopes? A Facility’s Journey With Endoscope Reprocessing and Strategies for Reprocessing Effectiveness
- The Patient and Family Advisory Council: Persevering Through COVID-19
- Using Feedback to Break the Hold on the “Black Hole” of Event Reporting
- Avoiding the Clinical Equipment Land Mines – WellSpan Health’s Mission for Zero Patient Harm
- Work Product Protection for Patient Safety Information

63 Education Events
4.5K Individuals Trained
2,482 Facility Contacts
Wheelchair Safety

Wheelchairs are one of the most common assistive devices used in healthcare facilities, from admission to discharge. They are often found at the entrance of a facility for use by both patients and visitors with mobility issues.

Hospital volunteers, transport staff, and clinical staff use wheelchairs to take patients to different care areas to have tests performed. Many facilities require that patients be transported in a wheelchair upon discharge. While risks of falls and injury during transport are commonly recognized, some types of wheelchairs can cause injury when they are being unfolded. However, not knowing the proper method of unfolding a wheelchair or where to place your hands when sitting down in the seat can cause injuries, specifically to fingers, ranging from lacerations to amputations.

Prompted by an event reported to PA-PSRS in 2022 in which a patient’s finger was amputated while opening a wheelchair, PSA patient safety liaison Molly L. Quesenberry, BSN, RN, analyzed event reports from PA-PSRS and the U.S. Food and Drug Administration’s Manufacturer and User Facility Device Experience (MAUDE) reporting system. Her findings, including the most common causes and types of injuries, and safety strategies for healthcare facilities were published in the September 2022 issue of Patient Safety and disseminated in a Patient Safety Alert, “Wheelchair-Related Harm,” on September 27, 2022.

To further raise awareness of the hidden risk of wheelchair use, PSA produced a complementary educational video that was shared via press releases, articles, and on social media, as well as other downloadable wheelchair safety resources, such as printable wheelchair tags.

“Patient was being discharged. As patient went to sit in wheelchair, it was not fully opened. She placed both of her hands on the seat. She sat down, the chair snapped into place, partially amputating her right distal 5th digit. [pinky finger].”

-PA-PSRS Report

Not knowing how to unfold or even sit in a wheelchair the right way can cause a catastrophic injury to patients, visitors, volunteers, and staff of a healthcare facility.
Learning Management System

Although geared toward healthcare professionals, our online learning platform is freely accessible to anyone with a passion to improve the safety and quality of healthcare.

Learning Management System (LMS) digital courses developed by the patient safety experts at the Patient Safety Authority cover a variety of content, including:

- Patient safety topics
- Infection prevention strategies
- *Patient Safety* journal articles
- Recorded webinars

Courses are always available on demand, and select courses offer Pennsylvania nurse continuing education credits.

Among our most essential course offerings is "Learning the Basics of Patient Safety in Pennsylvania (PSO Basics)." This four-part education provides a robust overview of event reporting requirements in Pennsylvania, developed primarily to assist new patient safety officers (PSOs) in understanding their roles, as well as to offer a refresher for experienced PSOs. In addition to outlining the history of patient safety legislation in the commonwealth, it provides strategies, tools, and resources to help PSOs identify what events are reportable to the Pennsylvania Patient Safety Reporting System (PA-PSRS), including the reporting decision tree for event report classification and a simulated event investigation that reinforces and tests participants’ knowledge and skills.
Like the Advisory before it, we created *Patient Safety* as a mechanism to disseminate novel and actionable information to advise clinicians, administrators, and patients.

In 2022, the journal featured 50 first-of-its-kind analyses and perspectives, including an in-depth look at risks during tonsillectomies, an initiative to prevent emergence delirium in veterans, and ways visitors prevent and contribute to patient harm.

We also focused upstream by helping busy bedside clinicians draft their manuscripts through our Quality Improvement Writing Workshop. Applicants from across the commonwealth submitted recent quality improvement studies. Those selected participated in a two-part Master Class where moderator, Olivia Lounsberry, walked them through each component of a publishable academic paper.

*Patient Safety* editors Caitlyn Allen and Eugene Myers shared tips and best practices to ensure a smooth peer review and publication process.
• PSA researchers responded to inquiries from seven other organizations about information captured in the Pennsylvania Patient Safety Reporting System (PA-PSRS).

• Director of Outreach & Education shared an overview of Pennsylvania event reporting to patient safety program managers from Utah.

• PSA showcased Healthcare Excellence Canada in the September issue of Patient Safety.

• Pennsylvania Medical Society featured four articles from Patient Safety for continuing medical education (CME):
  - Perioperative Delirium/Agitation Associated With the Use of Anesthetics and/or Adjunct Agents: A Study of Patient Behaviors, Injuries, and Interventions to Mitigate Risk
  - Visitor Behaviors Can Influence the Risk of Patient Harm: An Analysis of Patient Safety Reports From 92 Hospitals
  - Tracheostomy and Laryngectomy Airway Safety Events: An Analysis of Patient Safety Reports From 84 Hospitals
  - Victory is Ours: Winning the Battle Against Superbugs
Executive Director’s Choice Award
**Jesse Hixson at Allegheny Health Network, Monroeville Ambulatory Surgery Center**

In May, a patient was in the facility to have a procedure. When Jesse Hixson, the nursing leader, was made aware that this patient had been seen in a hospital for suicidal ideations, he took the patient to a quiet consult room to discuss that they were not going to have the procedure due to the hospital visit and medications that were given. The patient threatened him and the staff. Uncertain whether the patient had a weapon, Jesse de-escalated the situation and distracted the patient so they could alert other staff to call for help. He was barricaded in the room with the patient for almost 30 minutes to ensure that staff and visitors were safe behind the locked doors, until police arrived and apprehended the patient for transport to the hospital. Through this difficult and dangerous incident, Jesse remained clearheaded and proactive, going above and beyond to keep the patient, staff, and visitors safe. As a result, security systems were improved and on-site security has been provided.

Ambulatory Surgical Facility
**Mary Houton, Susan Walker, and the Ambulatory Surgical Center and Infection Prevention Registered Nurses at Penn Medicine/Pennsylvania Hospital**

The nursing staff at the Ambulatory Surgical Center and Infection Prevention teamed up to create a competency-based education collaboration. They designed an infection prevention training program for healthcare personnel and created measurable competencies, which contained observable skills and behaviors that one demonstrates as part of their job performance. To ensure that this education and training was translated effectively to practice, the team performed audits and encouraged feedback from staff. The goal was to promote adherence with standards of care and help sustain effective practices. Benefits of this intervention include building relationships between operating room clinical staff and the infection prevention department, maintaining compliance and creating a culture of safety.

Runners-Up
- Adrienne Bellino-Ailinger — Einstein Endoscopy Center Blue Bell
- The Direct Access Colonoscopy Team — Einstein Endoscopy Center Blue Bell

Improving Diagnosis
**Jung Yun, MD, Kevin Lo, MD, Peter Wang, MD, Meera Kasireddy, Terence Matalon, MD (Radiology Department), and Ryan Lee, MD (Internal Medicine Department), Einstein Healthcare Network, Part of Jefferson Health**

This team sought to improve compliance rates of radiologist-recommended follow-up imaging studies by engaging the patient in their own healthcare. They collaborated with a startup software company to develop and implement a natural language processing algorithm and tracking-and-reminder system that identifies patients requiring follow-up imaging based on radiology reports, organizes follow-up recommendations by due date, and reminds patients of due or overdue recommendations via mobile text messages. This new automated system significantly improved rates of imaging follow-up, and subsequently improved patient care and outcomes. This workflow has been fully implemented to include all patients in the network.

Runners-Up
- Kara Mascitti, MD, MSCE, FACP, FIDSA, Medical Director, Healthcare Epidemiology and Infection Prevention; Alex Matika, PharmD, Pharmacist, Clinical Specialist; and Lauren Allen, PharmD, Pharmacist, Clinical Specialist — St. Luke’s University Health Network
- Critical Care Unit — WellSpan Health York
Individual Impact

Jenny Rex MSN, RN, Nursing Professional Development Specialist, Pediatric Intermediate and Intensive Care Units, and Adrian Zurca, MD, MEd, Staff Physician, Pediatric Intensive Care Unit, at Penn State Health Milton S. Hershey Medical Center

During routine rounds, a graduate nurse asked Jenny Rex how staff would perform CPR on a complex patient with severe spinal hyperextension. Rex and Dr. Adrian Zurca explored the literature and collaborated with the Simulation Center and the fabrication shop teams to design and create a custom backboard that would allow clinical staff to safely and effectively perform CPR for this patient. They tested the methods of providing compressions with the board and once the most effective approach was identified, Rex provided comprehensive hands-on training to clinical staff who cared for this patient to ensure proficiency in the techniques needed to use the board effectively. When a resuscitation event required the use of the custom board and innovative CPR techniques, the patient experienced a positive outcome.

Runners-Up
- Kristen Farrell, Oncology Infusion Center — St. Christopher's Hospital for Children
- Alyssa Tousignant, RN, BSN — Allegheny Health Network-Allegheny General Hospital

Long-Term Care Facility

Donelle Grove, RN, Infection Preventionist at South Mountain Restoration Center

Donelle Grove was a floor nurse at South Mountain for many years before taking over as infection preventionist in January 2022. Shortly after coming on board, she helped the facility navigate a COVID-19 outbreak. Due to her efforts, only six residents became acutely ill, all on the same unit of 33 residents. Among Grove’s many accomplishments, she has taken over vaccination clinics for COVID and the flu, ensuring that the majority of residents are up to date on vaccinations. She coordinates the sterilization of reusable equipment used by clinical staff and trains staff on the use of personal protective equipment (PPE), glucometers, and maintenance and cleaning of the equipment. She was instrumental in understanding the new Enhanced Barrier Precautions and assisted in developing the necessary policies and procedures and upgrading the management of PPE supplies on the units for efficiency and accountability.

Runners-Up
- Nicole Ross, Angela Borgo, Susan Bell, Kerri Brooks, Lynn Sauers, Jake Thieret, Douglas Zundel, Rachael Blank, and Lisa Painter — UPMC Senior Living
- Sugar Creek Station Managers — Sugar Creek Nursing and Rehabilitation

Nationwide Warriors

Cyndi Brinkley at Riverside Walter Reed Hospital

When the health system transitioned to a positive pressure, needless intravenous site connector, Cyndi Brinkley raised a concern about its design posing a high risk of spilling nuclear medicine when the syringe is removed. Such spills can result in unnecessary exposure and temporary shutdown of the room, delaying patient testing and care. The product representative confirmed this was expected and a change in technique may not avoid the risk. Supply chain leadership supported the safety concern and sent a neutral valve to be used with the at-risk nuclear med patients across the health system, until further evaluation can be conducted.

Runners-Up
- Chrissie Blackburn — Project Patient Care
- Vidya Saldivar, Pharm D, Medication Safety Specialist; Mobolaji Adeola, Pharm D, Medication Safety Specialist; and Archana Sadhu, MD, Chair of Diabetes Action Council — Houston Methodist Hospital

Physician Offices

Quality Department at OSS Health

With many surgeries being outpatient or inpatients being discharged within a few days after surgery, hospitals and ambulatory surgical centers can have a hard time identifying postop complications. This department created a process between a hospital and the clinic where patients were seen for their postop visits for infection control surveillance, to identify postop infections. An opportunity to identify other postop complications or events was identified and merged with the surgical surveillance process. In this program, for three months postop staff ask every surgical patient a series of questions to identify postop complications. Although this unique process is time intensive it shows a commitment to identifying issues and improving patient outcomes.

Runners-Up
- Amy Coppersmith — WellSpan Health
- Tiffany Irwin, Practice Coordinator — UPMC Hamot
Safety Story
Suzanne Swift, 4 South, and Nancy Patterson, Professional Development/Med-Surg, at St. Christopher’s Hospital for Children

When a patient with diabetes and his mother had difficulty learning how to calculate the proper dose of insulin, nurses Suzanne Swift and Nancy Patterson developed a simple addition sheet that used verbal and visual cues to help them understand the process and figure out how much insulin the child should receive easily and safely. The insulin dose calculation sheet has been used for many patients since and has made a huge difference for families with health illiteracy, so they can leave the hospital confident that they can manage their child’s care at home.

Runners-Up
- The Operating Room Department at Forbes Hospital and Sara Angelilli — Allegheny Health Network
- Beth Lindell, OR Manager — Allegheny Health Network, Saint Vincent Hospital

Sepsis
Jaber Monla-Hassan, MD, Olivia Johnson, PharmD, Christopher Anderson, PharmD, and Kim Mikula, MSN, RN, at Einstein Medical Center Montgomery

To improve compliance with three-hour and six-hour sepsis bundles, this team in Adult Intensive Care worked with the technology department to build a smart notification to fire in the electronic medical record when the sepsis order set was being signed. This notification not only reminds the provider to document focused exams, but also opens the specific field for documentation. Combined with provider education when this alert went live, this implementation has improved compliance from 67% in February 2022 to 100% throughout the first and second quarter of fiscal year 2023.

Runners-Up
- Jenna Mastromarino Riley — Penn State Health St. Joseph Medical Center
- Jefferson Health Sepsis Team — Jefferson Health

Time-Outs
Sara Frey, PharmD, at Lehigh Valley Health Network

An order was placed for compounded sodium chloride 0.22% for enteral use for a 23-day-old infant. Pharmacist Sara Frey, recognizing the gravity of providing hypertonic saline to an infant who does not require it—including major fluid shifts and brain side effects—performed her own time-out after the solution was compounded and scanned appropriately. Upon visual inspection, she realized that the dispense prep computer program had a malfunction which allowed incorrect components to be barcode scanned without an error alert—and the order had been prepared using 23% sodium chloride instead of 0.22% sodium chloride. Had this solution reached the patient it would have barcode scanned for Nursing without error and could have resulted in serious harm to the patient. The dispense prep system was fixed so that this error does not occur again.

Runners-Up
- Emily Roth, BSN, RN, Oncology Nursing — Children’s Hospital of Philadelphia
- Samantha Braverman — Einstein Medical Center Montgomery

Transparency and Safety in Healthcare
Behavioral Health 6 Spruce Shared Governance at Pennsylvania Hospital

This team created a form to help behavioral health patients and families identify two support people who the patient approves to be informed. To ensure communication is safe and efficient, they used the last four digits of the patient’s medical record number as verification of this consent and designated times when the support people can call for information. The result was less-distressed calls from support people around their loved one’s care and more confidence in knowing who the patient wants to receive information about them.

Runners-Up
- Patient Safety Officers — Allegheny Health Network
- Vicenta Gaspar-Yoo, MD, President; William Bailey, DO, Chief Medical Officer; Milissa Hammers, Chief Nursing Officer; Quality Safety Value Team (Patient Safety Officer, Regulatory Manager, Infection Control Nurse and Quality Manager) — Allegheny Health Network
The Medical Care Availability and Reduction of Error (MCARE) Act 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 collected by the Pennsylvania Department of Health (DOH) from licensed MCARE medical facilities.

Pennsylvania hospitals, ambulatory surgical facilities, abortion facilities, birthing centers, and nursing homes bear the financial responsibility for funding the MCARE mandatory reporting program. 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 in return direct benefits from PA-PSRS and other PSA programs. 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. In 2022, the PSA received no contract funding additional to MCARE Assessments.

Within the design of PA-PSRS, the PSA includes a variety of integral and analytical tools providing immediate, direct feedback to each facility on adverse event and near-miss reports and activities. Additionally, in 2022, the PSA continued to enhance its public website patientsafety.pa.gov, with expanded access to the PSA's educational materials and programs, as well as mobile accessibility. The PSA continued its PA-PSRS Application Modernization (AMOD), with both functional and design upgrades, including a significant expansion in 2022 of demographics data collection. The AMOD project began with a complete redesign of the PA-PSRS application in 2019.

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

The MCARE Act section 305(c) set an initial base amount assessment payment of $5 million on acute care facilities in the first year of the MCARE Act beginning in 2002, with an annual increase based on the consumer price index (CPI) in each subsequent year. For fiscal year 2022–2023 (FY22–23), the maximum allowable acute care assessment totals $8,648,159, while the PSA Board authorized a FY22–23 acute care assessment totaling $6,530,000.

On December 8, 2022, the PSA Board authorized a recommendation to the DOH for FY22–23 acute care assessment surcharges totaling $6.53 million. The FY22–23 acute care assessment increased the prior fiscal year’s acute care assessment by 2.67% and is 24.5% less than the maximum allowable acute care assessment permitted under section 305(d) of the MCARE Act. The PSA utilizes the Northeast medical care services consumer price index (CPI) to calculate maximum allowable assessments.

In making the FY22–23 acute care assessment recommendation, the PSA Board considered several points, including the following:

• The PSA’s FY22–23 budget totals $7.7 million. Of this amount, approximately $6.5 million is budgeted for acute care-related expenditures and funded with $6.53 million in FY22–23 acute care assessments. The acute care assessments also fund certain infection prevention activities within the acute care facilities; these are separate and apart from Act 52 nursing home healthcare-associated infection (HAI) assessment-funded activities.
• The PSA’s FY22–23 budget of $7.7 million is a $200,000, or 2.67%, increase over the FY21–22 budget of $7.5 million. The $7.7 million budget remains substantially lower than budgets during the period FY13–14 through FY18–19, which averaged $8.5 million.

• The FY22–23 acute care assessment of $6.53 million represents a $1.53 million increase since PSA’s initial FY2002–2003 acute care assessment of $5.0 million, a 1.5% annual average increase.

• The FY22–23 assessment levels provide the PSA with liquidity and programmatic planning flexibility moving into FY23–24 budget year.

Table 1 shows the number of acute care facilities assessed, authorized assessments, and assessment receipts for each fiscal year.

Funding Received From Nursing Homes

Act 52 of the MCARE Act allows the DOH to assess Pennsylvania nursing homes through license surcharges 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 DOH assessed 725 nursing home facilities a total of $1,000,000 and transferred $1,000,782 to the Patient Safety Trust Fund for FY08–09. This money can only be spent on activities related to HAI and the implementation and maintenance of chapter 4 of the MCARE Act. For FY22–23, the Act 52 maximum allowable assessment is $1,396,201.

On December 8, 2022, the PSA Board authorized a recommendation to the DOH to set FY22–23 nursing home assessment surcharges at $1.17 million, a $30,000 or 2.63% increase over the FY21–22 assessment of $1.14 million, which had remained at that level since FY17–18. The FY22–23 nursing home assessment is 16.2% below the maximum nursing home assessment permitted pursuant to section 409(b) of the MCARE Act. The PSA utilizes the Northeast medical care services CPI to calculate maximum allowable assessments.

<table>
<thead>
<tr>
<th>FISCAL YEAR</th>
<th>NUMBER OF FACILITIES ASSESSED BY DOH</th>
<th>APPROVED ASSESSMENTS</th>
<th>TOTAL ASSESSMENTS RECEIVED BY DOH</th>
</tr>
</thead>
<tbody>
<tr>
<td>2002–03</td>
<td>356</td>
<td>$5,000,000</td>
<td>$4,663,000</td>
</tr>
<tr>
<td>2003–04</td>
<td>377</td>
<td>$2,500,000</td>
<td>$2,542,316</td>
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<tr>
<td>2004–05</td>
<td>414</td>
<td>$2,500,000</td>
<td>$2,508,787</td>
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<tr>
<td>2005–06</td>
<td>450</td>
<td>$2,500,000</td>
<td>$2,500,149</td>
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<tr>
<td>2006–07</td>
<td>453</td>
<td>$2,500,000</td>
<td>$2,500,034</td>
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<tr>
<td>2007–08</td>
<td>526</td>
<td>$5,400,000</td>
<td>$5,391,583</td>
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<tr>
<td>2008–09</td>
<td>524</td>
<td>$4,000,000</td>
<td>$3,972,677</td>
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<tr>
<td>2009–10</td>
<td>519</td>
<td>$5,000,000</td>
<td>$4,989,781</td>
</tr>
<tr>
<td>2010–11</td>
<td>542</td>
<td>$5,000,000</td>
<td>$4,981,443</td>
</tr>
<tr>
<td>2011–12</td>
<td>550</td>
<td>$5,100,000</td>
<td>$5,063,723</td>
</tr>
<tr>
<td>2012–13</td>
<td>545</td>
<td>$5,500,000</td>
<td>$5,504,549</td>
</tr>
<tr>
<td>2013–14</td>
<td>556</td>
<td>$5,500,000</td>
<td>$5,492,002</td>
</tr>
<tr>
<td>2014–15</td>
<td>564</td>
<td>$6,200,000</td>
<td>$6,209,459</td>
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<tr>
<td>2015–16</td>
<td>569</td>
<td>$6,500,000</td>
<td>$6,494,845</td>
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<tr>
<td>2016–17</td>
<td>575</td>
<td>$6,675,000</td>
<td>$6,656,359</td>
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<tr>
<td>2017–18</td>
<td>583</td>
<td>$6,860,000</td>
<td>$6,860,164</td>
</tr>
<tr>
<td>2018–19</td>
<td>585</td>
<td>$6,860,000</td>
<td>$6,834,611</td>
</tr>
<tr>
<td>2019–20</td>
<td>558</td>
<td>$6,360,000</td>
<td>$6,300,845</td>
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<tr>
<td>2020–21</td>
<td>557</td>
<td>$6,360,000</td>
<td>$6,388,433</td>
</tr>
<tr>
<td>2021–22</td>
<td>553</td>
<td>$6,360,000</td>
<td>$6,404,134</td>
</tr>
<tr>
<td>2022–23</td>
<td>549</td>
<td>$6,530,000</td>
<td>$6,530,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td><strong>$108,788,894</strong></td>
</tr>
</tbody>
</table>

a. The number of facilities assessed by the DOH differs from the number of the 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 DOH has pursued action to enforce facility compliance with the MCARE Act’s assessment requirement. Amounts received by DOH are then transferred to the Patient Safety Trust Fund.

c. FY2019–20 acute care assessment receipts include $66,301.70 transferred to Patient Safety Trust Fund in calendar year (CY) 2021.

d. FY2020–21 acute care assessment receipts include $15,737.27 transferred to Patient Safety Trust Fund in CY2022.

e. FY2022–23 Assessments Received projected.
Table 2 shows the number of nursing homes assessed, approved assessments, and assessments amounts received for each fiscal year.

### Annual Expenditures and Non-Assessment Revenue Receipts

During calendar year 2022 (CY2022), the PSA spent about $7,023,179 (Table 3a). The PSA received no contract- or service-related receipts in 2022, and received investment income of $143,457 (Table 3b).

### Patient Safety Authority Contracts

The MCARE Act requires the PSA to identify a list of contracts entered into pursuant to the Act, including the amounts awarded to each contractor.

#### Table 2. Nursing Home Assessments

<table>
<thead>
<tr>
<th>FISCAL YEAR</th>
<th>NUMBER OF FACILITIES ASSESSED BY DOH</th>
<th>APPROVED ASSESSMENTS</th>
<th>TOTAL ASSESSMENTS RECEIVED BY DOH</th>
</tr>
</thead>
<tbody>
<tr>
<td>2008–09</td>
<td>725</td>
<td>$1,000,000</td>
<td>$1,000,782</td>
</tr>
<tr>
<td>2009–10</td>
<td>711</td>
<td>$800,000</td>
<td>$799,382</td>
</tr>
<tr>
<td>2010–11</td>
<td>707</td>
<td>$800,000</td>
<td>$799,829</td>
</tr>
<tr>
<td>2011–12</td>
<td>707</td>
<td>$800,000</td>
<td>$804,473</td>
</tr>
<tr>
<td>2012–13</td>
<td>711</td>
<td>$900,000</td>
<td>$913,315</td>
</tr>
<tr>
<td>2013–14</td>
<td>698</td>
<td>$1,000,000</td>
<td>$998,751</td>
</tr>
<tr>
<td>2014–15</td>
<td>703</td>
<td>$1,050,000</td>
<td>$1,049,842</td>
</tr>
<tr>
<td>2015–16</td>
<td>702</td>
<td>$1,080,000</td>
<td>$1,079,505</td>
</tr>
<tr>
<td>2016–17</td>
<td>704</td>
<td>$1,111,000</td>
<td>$1,110,185</td>
</tr>
<tr>
<td>2017–18</td>
<td>699</td>
<td>$1,140,000</td>
<td>$1,139,483</td>
</tr>
<tr>
<td>2018–19</td>
<td>699</td>
<td>$1,140,000</td>
<td>$1,139,645</td>
</tr>
<tr>
<td>2019–20</td>
<td>695</td>
<td>$1,140,000</td>
<td>$1,137,933</td>
</tr>
<tr>
<td>2020–21</td>
<td>693</td>
<td>$1,140,000</td>
<td>$1,139,038</td>
</tr>
<tr>
<td>2021–22</td>
<td>681</td>
<td>$1,140,000</td>
<td>$1,136,317</td>
</tr>
<tr>
<td>2022–23</td>
<td>670</td>
<td>$1,170,000</td>
<td>$1,170,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td><strong>$15,418,480</strong></td>
<td></td>
</tr>
</tbody>
</table>

a. FY2022–23 Assessments Received projected.

#### Table 3a. 2022 Expenditures

<table>
<thead>
<tr>
<th>CONTROL LEVEL</th>
<th>AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>61: Personnel</td>
<td>$4,764,651</td>
</tr>
<tr>
<td>63: Operating</td>
<td>$2,258,528</td>
</tr>
<tr>
<td><strong>Total 2022 Expenditures</strong></td>
<td><strong>$7,023,179</strong></td>
</tr>
</tbody>
</table>

#### Table 3b. 2022 Revenue Receipts

<table>
<thead>
<tr>
<th>REVENUE RECEIPTS</th>
<th>AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acute Care Assessments</td>
<td>$6,404,134</td>
</tr>
<tr>
<td>Nursing Home Assessments</td>
<td>$1,136,317</td>
</tr>
<tr>
<td>Non-Assessment Revenue</td>
<td>$0</td>
</tr>
<tr>
<td>Investment Income</td>
<td>$143,457</td>
</tr>
<tr>
<td><strong>Total 2022 Revenue Receipts</strong></td>
<td><strong>$7,683,908</strong></td>
</tr>
</tbody>
</table>

During CY2022, the PSA received services under the following contracts (FC or Funds Commitment; PO or Purchase Order):

**Gainwell Technologies, LLC**
(previously DXC Technology Services, LLC and DXC MS, LLC)
FC # 4000022708

- Five-year contract (including two option years) for Pennsylvania Patient Safety Reporting System (PA-PSRS) software development and maintenance, and other IT services. DXC MS, LLC spun off from DXC Technology Services, LLC in 2020 as the result of a merger and assignment of the contract. On October 1, 2020, DXC MS LLC became a wholly owned subsidiary of the newly formed Gainwell Technologies, a holding of Veritas Capital. In CY2021, DXC MS, LLC was renamed and invoiced as Gainwell Technologies, LLC (Gainwell). On September 23, 2021, the PSA Board authorized extending the Gainwell contract through the two option years (through June 30, 2024).

- July 1, 2019, through June 30, 2024
- Total Contract Amount: $7,071,540 over 5 years
- Amount invoiced for 2022 (12 months, Jan–Dec): $1,246,773
MedStar Health Research Institute,
FC # 4000022717

- Five-year contract (including two option years) for analyzing and evaluating patient safety data. On September 23, 2021, the PSA Board authorized extending the MHRI contract through the two option years (through June 30, 2024).
- Contract period: July 1, 2019, through June 30, 2024
- Total Contract Amount: $3,419,185.85 over 5 years
- Amount invoiced for 2022 (12 months, Jan–Dec): $596,633

Patient Safety Authority Balance Sheet

Table 4 reflects the status of the Patient Safety Trust Fund as of December 31, 2022.


Table 4. Patient Safety Trust Balance Sheet

<table>
<thead>
<tr>
<th>ASSETS</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Temporary Investments</td>
<td>$9,822,653</td>
<td></td>
</tr>
<tr>
<td>Receivables, net:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accounts</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Assessment Revenue</td>
<td>7,700,000</td>
<td></td>
</tr>
<tr>
<td><strong>TOTAL ASSETS</strong></td>
<td><strong>$17,522,655</strong></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>LIABILITIES AND FUND BALANCE</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Accounts Payable and Accrued Liabilities</td>
<td>$427,155</td>
</tr>
<tr>
<td>Invoices Payable</td>
<td>287,977</td>
</tr>
<tr>
<td><strong>TOTAL LIABILITIES</strong></td>
<td><strong>715,132</strong></td>
</tr>
</tbody>
</table>

| Deferred Assessment Revenue | 7,700,000 |
| **TOTAL DEFERRED INFLOW OF RESOURCES** | **7,700,000** |

| Restricted                  | 9,107,523 |
| **TOTAL FUND BALANCE**     | **9,107,523** |

**TOTAL LIABILITIES, DEFERRED INFLOW OF RESOURCES, AND FUND BALANCE** $17,522,655

NOTES


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 patient safety officers 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 2022, the PSA received two anonymous reports that met the 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 (2004–2022)
Thank you to the members of our Healthcare-Associated Infection Advisory Panel and Patient Advisory Panel for your service and expertise!

Your insights help us take action.

Panels

Healthcare-Associated Infection Advisory

Nicole Diefenderfer, RN
Bettina Dixon, DNP, CRNA
Chris Marshall, PharmD, MBA
David Nace, MD, MPH
Ellen Novatnack, RN, BSN
David Pegues, MD, MPH
Jason Raines, MPA, MBA
Pamela Rohrback, MSN, RN
Danielle Roman, RN, BSN
Emily Shears, MPH
Eileen Sherman, MS
Lisa Vavala, MHA, BSN
Shane Walker
Hope Waltenbaugh, MSN, RN
Mohamed Yassin, MD, PhD
Kelly Zabriskie, MLS, BS

Patient Advisory

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

patientsafety.pa.gov