
NJHA's PATIENT SAFETY ORGANIZATION ("PSO")

A 2013 Update

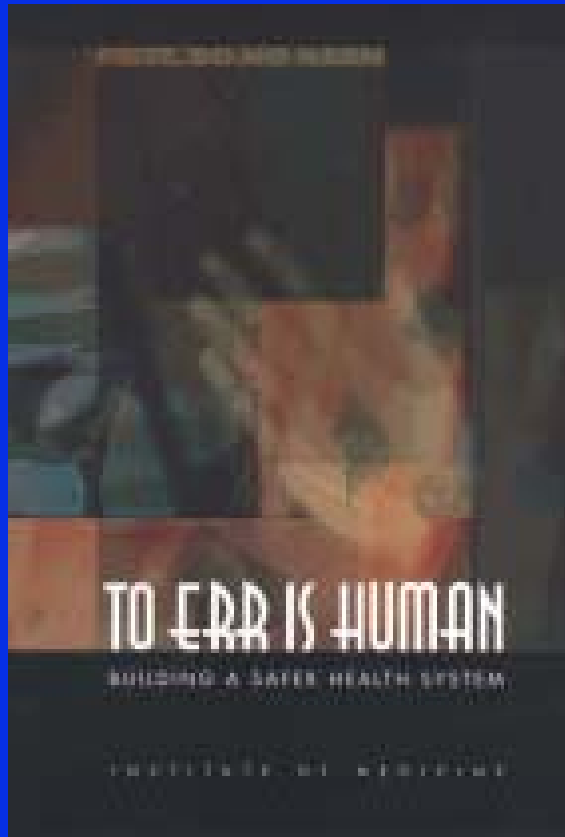
Outline for Today's Presentation

- **Evolution of Patient Safety laws**
- **NJ Patient Safety Act**
- **PSO basics & NJHA PSO**
- **Benefits of being in NJHA PSO**

Evolution of Patient Safety



'99 IOM Report – To Err is Human



Landmark Study

**44,000 – 98,000 people die
in hospitals each year
as a result of medical errors
that could have been prevented.**

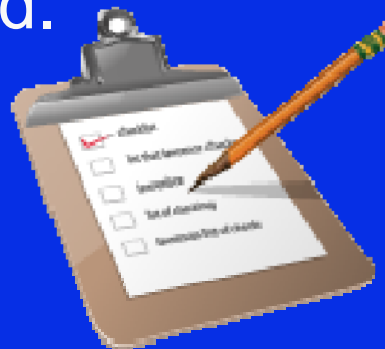
IOM: Conclusions



- Medical errors may be under reported - fear of malpractice suits, disciplinary actions, loss of employment.
- Majority of medical errors not a result of individual recklessness.
- Errors caused by faulty systems and processes.
- Blaming an individual doesn't make the system safer or prevent the same error from being committed again.

IOM: Recommendations

- Identify and learn from errors
- Develop a nationwide/public mandatory reporting system
- Encourage healthcare organizations to develop and participate in voluntary reporting
- Congress should enact laws to protect the confidentiality of certain information collected.



New Jersey Patient Safety Act

- New Jersey's response to IOM
- Effective in late 2004
- Mandatory and Voluntary Adverse Event Reporting System
- Data is submitted to NJ Dept. of Health
- Must have a Patient Safety Committee & Plan
- Provides confidentiality protection if followed



NJ Patient Safety Act – State Reporting System

- **Must** report “Serious Preventable Adverse Events”
- **May** report other “Adverse Events” or “Near Misses”
- **Must** have Patient Safety Committee for analysis of adverse events
- Committee **must** develop Patient Safety Plan
- State de-identifies collected data
- Uses to alert providers of harmful practices to avoid



Confidentiality At Issue



- NJ Courts considering NJ Act's Confidentiality & Privilege protections for first time
- Appellate Court **upheld** protections with caveats:
 - documents must have been created & used exclusively for the Act
 - hospital must have followed the requirements of the law
- If not, court will apply a fact based test and review whether document is factual or evaluative
- Supreme Court to rule this year.

U.S. Patient Safety and Quality Improvement Act of 2005

- Federal response to IOM Report
- Known as the **Patient Safety Act**
- Authorized creation of **Patient Safety Organizations (PSOs)**
- Allows for voluntary reporting and sharing of patient safety information, through the PSO, without fear of legal discovery

Agency for Healthcare Research and Quality (AHRQ)

- AHRQ administers the Patient Safety Act
- Final rules at www.pso.ahrq.gov/regulations/regulations.htm
- Certifies PSOs
- Ensures PSOs meet their obligations
- Provides resources: www.pso.ahrq.gov



NJHA created a PSO

NJHA's Institute for Quality & Patient Safety
certified and listed as a PSO with AHRQ
on January 20, 2010

<http://www.pso.ahrq.gov/listing/psolist.htm>.



Source: New Jersey Hospital Association
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What is a PSO?



- Entity that improves patient safety and health care quality.
- Staff with expertise in analyzing patient safety events.
- Provides standardized patient safety data collection practices.
- Protects communications from disclosure as authorized by law.

PSOs' Purpose & Characteristics

- Serve as independent, external experts
- Do not receive federal funding
- PSOs can't be:
 - insurance companies
 - regulatory agencies
 - licensing entities
 - accreditation agencies
 - organizations that require reporting of patient safety data



PSO is Voluntary *for Now*

- Currently participation is voluntary
- However in Missouri.....
- However ACA....



Affordable Care Act Requirement

*As of **January 1, 2015**,
a qualified health plan may contract
with a hospital with >50 beds **only if**
such hospital utilizes a **patient service
organization**. (ACA Section 1311)*

Meaning it will be required by contracts.



PSOs' Patient Safety Activity



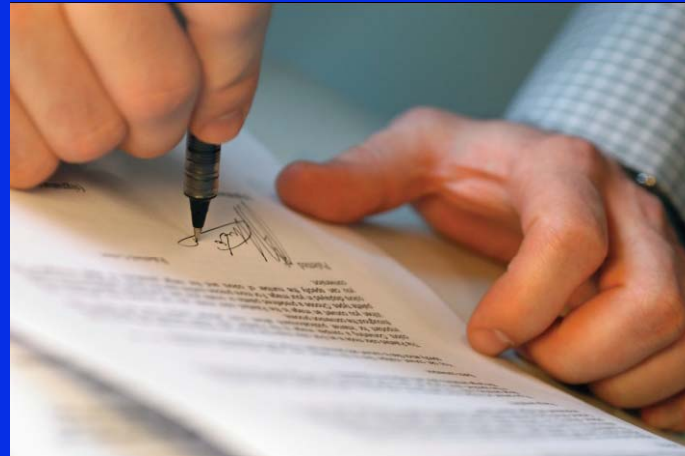
- Collection and analysis of patient safety work product (PSWP)
- Developing and disseminating patient safety recommendations and best practices
- Using submissions to provide feedback and assistance
- Preserve confidentiality and security
- Provide qualified staff
- Operate evaluation system & give feedback to participants

Source: New Jersey Hospital Association
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What is Patient Safety Work Product?

- Data or documents assembled for and submitted to a PSO are called **Patient Safety Work Product (PSWP)**
- PSWP is protected by confidentiality and privilege safeguards under the Patient Safety Act.



PSO Privilege Protections



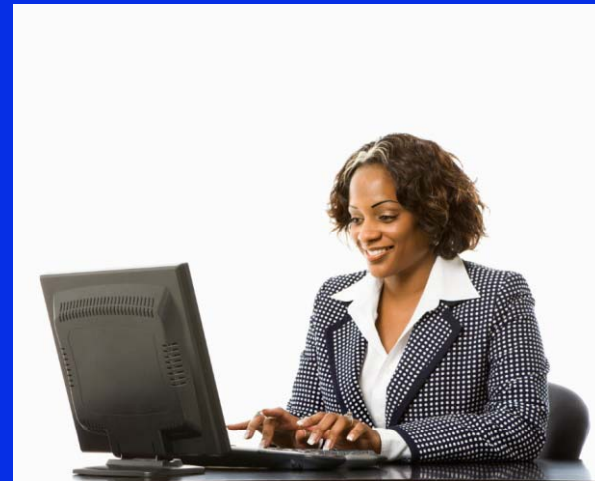
Subject to certain specific exceptions, **PSWP** may not be used in the following legal proceedings:

- Criminal
- Civil
- Administrative
- Disciplinary

PATIENT SAFETY EVALUATION SYSTEM (“PSES”)

Must design system:

- To collect
- To manage
- To analyze
- To report



Patient Safety Work Product (“PSWP”) to the PSO

What **is** PSWP?

Subjective Reports

Staff Impressions

Objective Facts not part of Mandatory Reporting

What documents **are** PSWP?

Peer Review Documents

Clinical Practice Protocols

Evaluations of staff, equipment

Root Cause Analyses

Written or Oral Statements

What documents **are** PSWP?

Quality and Safety Reports

Committee Minutes; Deliberations, Recommendations

Notes, Checklists

Outcome data

Original Source Documentation is **not** PSWP

Medical Records

Billing
Information

Mandatory
Reporting Data

Discharge
Information

Information on a
Criminal Act

Original
Patient/Provider
Information

Benefits of the NJHA PSO



- #1 Legal Protections to Promote Reporting
- #2 Collaborative Entity to Assist to Improve Safety
- #3 Standardized Data Reporting & Collection
- #4 Participate in National Repository

Benefit #1

Legal Protections to Promote Reporting



Key to voluntary patient safety data collection.

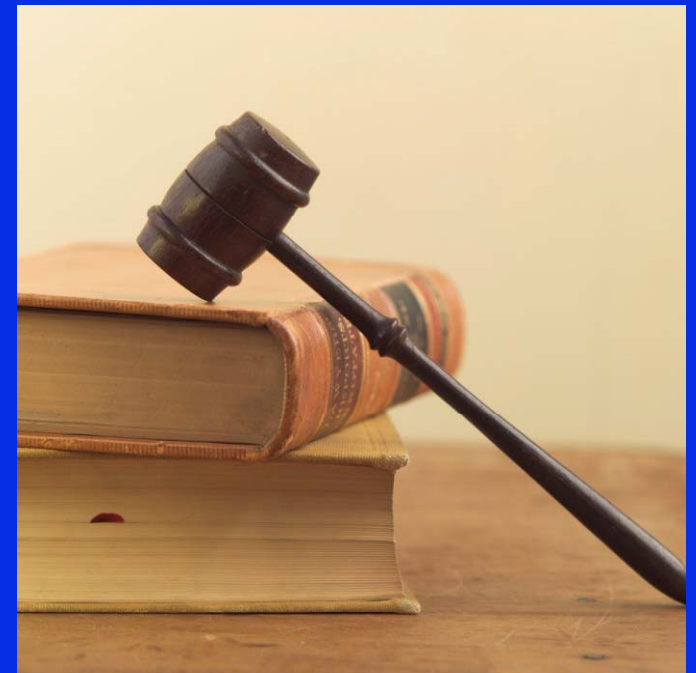
PSO Legal Protections

- **Confidentially:** store and protect voluntarily reported patient safety documents and data.
- **Privilege:** limits or forbids the use of information from legal discovery or disclosure



What is Privilege?

Allows the holder of the privilege to refuse demands for information from third parties such as trial lawyers, government agencies and accrediting bodies in connection with legal and regulatory proceedings.



Storing Documents in PSOs

- Patient Safety Evaluation System designee logs in
- Designee reports incident to PSO
- Download the PSWP documents related to the incident to NJHA PSO secure website
- Document storage is completely voluntary



NJHA Website to Store Data

The screenshot shows a web browser window with the URL https://www.psoevent.com/Help/NJHA_Institute_for_Quality_and_Patient_Safety/Help/NJHA_Institute_for_Quality_and_Patient_Safety.aspx. The browser's address bar shows the URL, and the page title is "NJHA Institute for Quality and Patient Safety". The page content includes a sidebar with a "Contents" menu and a main area titled "Manage Uploaded Documents". The sidebar menu includes links for "Welcome to the NJHA Institute for Quality and Patient Safety", "Add an Event", "Deleting Events", "Manage Uploaded Documents", "Search", and "Contact Us". The main area has a "Manage Uploaded Documents" header and a "Upload Document(s)" section. The "Upload Document(s)" section contains a paragraph explaining that documents specific to a patient event can be uploaded through the Event Queue prior to event submission. Below this, there is an "Add Documents" section with a list of instructions: 1. From the event queue click icon in Docs column. 2. New window will open: A form titled "Add New" with fields for "Description" and "Select file" (with a "Browse..." button), and "Save" and "Cancel" buttons. Below the form is a section titled "Attached Documents". The Windows taskbar at the bottom shows the time as 8:35 PM on 8/14/2012.

File Edit View Favorites Tools Help

Blackboard Learn Suggested Sites Web Slice Gallery

Contents Index Search

Search - GO

Organization

Manage Uploaded Documents

Upload Document(s)

Documents specific to a patient event can be uploaded through the Event Queue prior to event submission. Documents are at the patient level for an Incident, while they are at the event level for an Unsafe Condition or Near Miss.

Add Documents

1. From the event queue click icon in Docs column
2. New window will open:

Add New

* Description:

* Select file:

Attached Documents

Greater Protection

When healthcare providers submit patient safety documents to PSOs, there is greater protection from legal discovery and disclosure. But see Applegrad for now.



Legal Implications

- PSWP can be shared with an attorney, but can't be used in litigation once submitted to the PSO.
- Any data collected for external reporting to regulatory agencies, is **not** PSWP and doesn't receive protection.
- PSO is characterized as a "business associate" for the purposes of HIPAA.



Benefit #2

Collaborative Environment

Healthcare organization can talk about and work on ways to prevent “adverse events” in a protected environment.



PSO Collaborative Activities



- **Collect** data on the prevalence and details of errors.
- **Analyze** sources of error by root cause analysis.
- **Propose and disseminate** methods for error prevention.
- Design and conduct **pilot projects** to study safety initiatives.
- **Raise awareness** and inform the public, health professionals, providers, purchasers and employers.
- **Advocate** for regulatory and legislative changes.

Readmission Rates

- ACA designates PSOs to help hospitals with high readmission rates to help improve their performance.
- ACA calls for the Department of Health and Human Services (HHS) to support PSOs in this work.



Benefit #3

Standardized Data Collection

- PSOs are required to collect data in a standardized electronic manner.
- PSOs can use nationally standardized common data formats for reporting patient safety events.
- NJHA PSO uses ARHQ common data formats



Common Format

- AHRQ developed and posted instructions for the common data format
- Easy to use with important prompts
- Recent CMS request to increase use of common format.



Common Format

- Currently limited to two care settings
 - acute care hospitals
 - skilled nursing facilities
- Future versions are being developed for:
 - ambulatory settings (i.e. surg centers)
 - physician and practitioner offices.
- Types of events:
 - Incidents
 - Near misses or close calls
 - Unsafe conditions



NJHA PSO Database



- NJHA developed a Web based patient safety database
- Utilizes AHRQ Common Formats
- Password protected
- Encrypted
- Data is submitted de-identified and can be submitted anonymously

Database Event Categories

Event Specific Categories

**Medications or
Other Substances**

Falls

Perinatal Events

Pressure Ulcers

Surgery or Anesthesia

**Healthcare
Associated Infections**

Blood or Blood Products

**Device of
Medical/Surgical Supplies**

**Venous Thromboembolism,
DVTs and PEs (pilot)**

Readmission Rates (pilot)

Benefit #4

Be Part of National Repository

- PSOs can populate an AHRQ national repository, the National Patient Safety Database (NPSD)
- NJHA can send data to AHRQ through its data base.
- PSO members can decide voluntarily whether or not to submit data to AHRQ.



Summary - PSO Benefits

- #1 Provides confidential and privilege protections for healthcare providers on patient safety documents.
- #2 Offers a full array of activities to improve patient safety and develop best practices.
- #3 Standardized data reporting and collection.
- #4 Ability to be part of a national repository.



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