WHITE PAPER

Patient Safety Reaches a New Milestone
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On January 19, 2009, the Final Rule issued for the operations of Patient Safety Organizations (PSOs) becomes effective. The creation of (PSOs) came about through the Patient Safety and Quality Improvement Act of 2005 (Patient Safety Act – Public Law 109-41) (www.ahrq.gov/qual/psoact.htm) which was signed into law on July 29, 2005. The Patient Safety Act was enacted by Congress in response to a growing concern about patient safety that was raised by the Institute of Medicine (IOM) Report, *To Err is Human,* in 1999. So why is this important to healthcare providers and patients alike?

The Patient Safety Act was enacted by Congress in response to a growing concern about patient safety that was raised by the Institute of Medicine (IOM) Report, To Err is Human, in 1999.

In the decade since the IOM Report, much has been written about the aspects of healthcare delivery that create unsafe conditions for patients. The Healthcare delivery system and the professionals working within that system have undergone scrutiny by accrediting bodies, health plans, employer-oriented organizations, such as The Leapfrog Group, and the government all of which have worked to ensure the safety of healthcare in the United States. Adding to this is a growing crescendo of economic forces that are making the **quality** of healthcare delivered the basis for payment or reimbursement for those services. The confluence of the promulgation of quality standards, public reporting of hospital data to demonstrate their compliance and ability to meet those standards, and the reimbursement pressures to ensure appropriate outcomes has fostered a singular focus on quality and safety by healthcare providers.

While this is noteworthy, one key aspect of the American Healthcare System is its vulnerability to allegations of medical negligence and the litigious nature of the public to bring suit against hospitals, physicians and other healthcare providers. Consumer awareness of terms like medical error, patient safety and healthcare quality has grown considerably and adds to the litigiousness found in the healthcare sector. The juxtaposition of the aspects of patient safety and medical malpractice provides a complex set of circumstances for the work of healthcare providers.

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As stated in the work of David Marx, JD, Patient <u>Safety and the "Just Culture": A Primer for Health Care Executives</u>, "… Advances in patient safety, especially when involving the management of human error, depend upon our collective ability to learn from our mistakes – whether they are near misses or mistakes resulting in actual harm to a patient." Unfortunately, when there is fear of punishment in the form of disciplinary action it is much more difficult to

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surface those events that could be the very basis of the learning that is needed to prevent future events and to improve the quality and safety of the care being delivered.

The enactment of the Patient Safety Act is a way to encourage the voluntary reporting of events that could potentially, or have resulted in, harm to patients in a system that would assure confidentiality of that reporting and that supports an overall culture of safety throughout the organization. The Patient Safety Act creates Patient Safety Organizations (PSOs) to be repositories of information for the purpose of aggregating and analyzing that information to provide learning opportunities for the organizations. Because the Act provides Federal legal privilege and confidentiality protections to information that is assembled and reported by providers to a PSO or developed by a PSO (termed 'patient safety work product') for the conduct of patient safety activities, providers can be assured of confidentiality and can be encouraged to report what they have experienced in the spirit of enhanced patient safety.

Healthcare providers (broadly defined in the Act to include hospitals, physicians, long term care organizations and many other professional groups) need to begin to work internally to meet the specifications for their participation with PSOs in order for them to gain the protections of the Act. This will enable healthcare providers to focus more specifically on learning from the data to create the systems that support safe practices in all actions taken on behalf of patients and residents within their organizations. Having this take hold in the healthcare environment will ultimately accrue to the benefit of the consumers who can be assured that the professionals within the healthcare organization are focused on delivering safe and excellent care.

We have reached a new milestone in Patient Safety with the creation of PSOs under the Patient Safety Act, and a new capability for raising awareness of the attributes necessary to create systems that help ensure the safety of healthcare delivery. PSOs must be listed by the Agency for Healthcare Research and Quality so that healthcare organizations can be assured that they have met the criteria established by the Act for the work they will perform and the security of the data they will collect. Listed PSOs can be found at the AHRQ website www.pso.ahrq.gov/listing/psolist.htm.

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