



# White Paper

## **Patient Safety Organizations: How to Effectively Work With a PSO**

By: Ellen Flynn and Anna Hajek

**But first a little background** ...Patient Safety Organizations (PSOs) came to be as a result of the Patient Safety and Quality Improvement Act of 2005. This Federal Act, now commonly known as the Patient Safety Act, became effective on January 19, 2009, and is under the administration of the Agency for Healthcare Research and Quality (AHRQ).

*The Patient Safety Act fosters a culture of safety by establishing strong Federal confidentiality and privilege protections.*

According to AHRQ, “The Patient Safety and Quality Improvement Act signifies the Federal Government's commitment to fostering a culture of patient safety. It creates [Patient Safety Organizations](#) (PSOs) to collect, aggregate, and analyze confidential information reported by health care providers. Currently, patient safety improvement efforts are hampered by the fear of discovery of peer deliberations, resulting in under-reporting of events and an inability to aggregate sufficient patient safety event data for analysis. By analyzing patient safety event information, PSOs will be able to identify patterns of failures and propose measures to eliminate patient safety risks and hazards. The Patient Safety Act fosters a culture of safety by establishing strong Federal confidentiality and privilege protections for information assembled and developed by provider organizations, physicians and other clinicians for deliberations and analyses regarding quality and safety.”

Further as it relates to PSOs themselves, we find the following description on the AHRQ website: “PSOs are organizations that share the goal of improving the safety and quality of health care delivery. Organizations that are eligible to become PSOs include: public or private entities, profit or not-for-profit entities, provider entities such as hospital chains, and other entities that establish special components to serve as PSOs. By providing both privilege and confidentiality, PSOs create a secure environment where clinicians and health care organizations can collect, aggregate, and analyze data that enable the identification and reduction of risks and hazards associated with patient care.”

*PSOs create a secure environment to collect and analyse data in order to reduce risks and hazards associated with patient care.*

Given the broad based Federal privilege and confidentiality provided under the Act, it is also important to know what data are afforded this privilege. Data protected under the Act are those classified as Patient Safety Work Product (PSWP). PSWP is data developed by a healthcare provider for purposes of improving healthcare quality and enhancing patient safety and that is collected for purposes of reporting that data to a PSO.

**How to Effectively Work with a PSO ...** By following these steps, a healthcare provider can be well on its way to working effectively with a PSO:

1. Select a fully functioning and federally listed PSO.
2. Prepare your organization internally.
3. Understand the disclosure and confidentiality provisions related to PSWP.
4. Communicate with the PSO to gain the most from reports and resources developed and delivered.
5. Engage in active feedback within your organization to use information provided by the PSO to help ensure the culture of safety is fully supported.

**Select a fully functioning and federally listed PSO**

Federally listed PSOs can be found on the AHRQ website (<http://www.pso.ahrq.gov/listing/psolist.htm>). PSOs must meet specific service and data security requirements under the Act to be listed with AHRQ. The AHRQ website provides an up-to-date list for your use.

But this is just the first step in your due diligence process. As you research the various PSOs, have in mind some questions to ensure the right fit with your organization and needs. Here are some examples of questions you might ask:

- What is your experience in healthcare? What aspects of healthcare delivery have you worked with? How broad is your healthcare quality and safety experience?
- What help can you give my organization to help us prepare to gain the protections under the Act?
- How will my organization provide you PSWP, and how often will that need to be done? Can you help my organization with this process?
- What types of services and reports can I expect from your PSO, and in what time intervals?
- What additional resources will you make available to my organization if I need them?

**Prepare your organization internally**

***Data Inventory***

Healthcare providers have been collecting data for quality improvement purposes for many years. The consistent situation in most organizations, however, is that what is being collected, by whom, how often and for what purposes is seldom known in a collective or systematic way. We recommend that a Data Inventory be done to first understand the overall systems in place in your organization. Finding these pockets of data will help you decide what needs to be protected as PSWP and will also help you to begin to articulate your PSES.

*PSOs must meet specific service and data security requirements to be listed with AHRQ.*

*A Data inventory helps you find pockets of data that will help you decide what needs to be protected as PSWP and will also help you to articulate your PSES.*

It can be unproductive to assume that there will be no changes to time-honored processes if you are to gain the optimum protections under the Act. Engaging people across departmental lines to complete a Data Inventory can be a way to establish strong communication within the organization as all are educated on the provisions and protections of the Act.

### ***Patient Safety Evaluation System Articulation***

The Act calls on healthcare providers to have in place a Patient Safety Evaluation System (PSES) for purposes of designating Patient Safety Work Product. Articulating your PSES is the next step in the preparation process. Healthcare providers focus on quality and safety every day, but the systems that are in place in most organizations, large and small, can be fragmented. Based on your Data Inventory, you have the opportunity to articulate how data are collected, reviewed, and analyzed, and this is the definition of the PSES for your organization. Each organization's PSES might be different in texture, but the goal of internal transparency afforded by consistent review and management is the same for all.

### ***Data Collection***

Data collection is the front end of your PSES. Optimum systems allow for data entry across the organization so that safety and quality issues can emerge quickly for action. AHRQ has promoted the use of Common Formats for data collection. They are not inclusive of every possible scenario or setting, but they are a start at collecting data in a standardized way to help get to the long term goal of a comparative data base in place and also to enable your PSO to provide you with comparative reports on an individual basis. More information on the Common Formats can be found on the AHRQ website (<http://www.pso.ahrq.gov/formats/commonfmt.htm>).

Each healthcare organization owns the responsibility to determine what is considered PSWP. When that data is sent to the PSO it is deemed to be PSWP, and is subject to the disclosure and confidentiality rules in place under the Act. Work with your PSO to ensure that both the data collection and transfer process are appropriate for your organization to maintain its protections under the Act.

### ***Understand the disclosure and confidentiality provisions related to PSWP***

It is important to understand that the use of PSWP is confined to the improvement of patient safety, healthcare quality and outcomes. It cannot be used for disciplinary purposes. In those states that have mandatory reporting requirements for certain events, it is necessary to separate the state reporting system from the PSES. Information called for in state reporting should not be reported to the PSO as PSWP, although meetings, investigations and further analysis taken as a result of the event and not reported to the state, such as a Root Cause Analysis, may be reported as PSWP. The Act itself should be reviewed to ensure your organization understands the types of disclosures that are permitted so that appropriate policies, procedures and staff training can be in place.

*Each healthcare organization owns the responsibility to determine what is has considered PSWP...the use of PSWP is confined to the improvement of patient safety and healthcare quality outcomes. It cannot be used for disciplinary purposes or to meet external reporting mandates.*

*Your PSO needs to be an extension of your organization's safety and quality staff and resources.*

***Communicate with the PSO to gain the most from reports and resources developed and delivered***

When you contract with a PSO you have contracted for help. Your PSO needs to be an extension of your organization's safety and quality staff and resources, and you can expect to have open communication with your PSO in order to gain the most from that contracted relationship. Levels of service will differ depending on your needs and the capabilities of your PSO, but at a minimum you need to review regularly scheduled reports that show comparatively where your organization has opportunities for improvement. Recommendations need to be evidenced-based to provide a sound basis for consideration by your organization's professionals. Keep open communication with your PSO consultant and work together to address areas of concern.

Working with a PSO should not add additional work for your quality and safety team, rather they should be providing you with high quality resources to improve patient safety that may not be available within any single provider e.g., evidence based research, clinical experts and statistical analysis.

***Engage in active feedback within your organization to use information provided by the PSO to help ensure the culture of safety is fully supported***

Working with a PSO provides your organization the opportunity to broaden and support a culture of safety across your system of care. The role of the Act through the PSO structure is to give your organization a safe place to raise issues and learn from real or potential mistakes. Making the PSO and its information an active part of your safety systems is essential to gaining the benefits from the relationship, as well as gaining the protections from discovery afforded under the Act. Engaging your staff in reviewing the information provided to the PSO and from the PSO enables you to make the Culture of Safety a natural part of the daily processes of your organization.

*Engaging your staff in reviewing the information provided to the PSO and from the PSO enables you to make the Culture of Safety a natural part of the daily processes of your organization.*

**A Common Myth ... A Powerful Opportunity**

The Myth: The Patient Safety Act is just another name for a government reporting system that is going to add more work to my organization in order to comply.

The Powerful Opportunity: The Patient Safety Act is NOT a government reporting system. It rather sets the conditions for healthcare providers to do what they have always wanted to do...raise issues and conditions that are detrimental to quality and safety ... act and learn from those issues/opportunities ... and do so without fear of having all the information discoverable in the case of medical malpractice suit. The Patient Safety Act creates a safe learning environment within the organization supported by the analytical and healthcare quality and safety expertise of the PSO to provide insight and resources. This is a Powerful Opportunity for healthcare providers!

*The Patient Safety Act creates a safe learning environment within the organization supported by the analytical and healthcare quality and safety expertise of the PSO to provide insight and resources.*

### **Clarity PSO**

Clarity PSO is an operating division of Clarity Group, Inc. It is one of the first Patient Safety Organization certifications listed by AHRQ. The services of Clarity PSO are provided by healthcare professionals with more than 30 years of healthcare, quality and database analytical experience. In addition, Clarity PSO brings a wealth of knowledge and expertise in the area of healthcare risk management. This additional expertise benefits our Clarity PSO clients as it blends the management of quality and safety with the reduction of harm to patients and residents to help effectively reduce professional liability exposure.

Clarity PSO provides a comprehensive set of services to support healthcare providers across the spectrum of healthcare delivery. We have worked with many types and sizes of healthcare providers from acute care to home care, from physician groups to long term care, and in each case we focus on the specific needs of the organization and constituents being served. Our products and services include Organizational Preparation, Front End Data Collection with our **Healthcare SafetyZone<sup>®</sup> Portal**, and PSO Analytical and Educational Services. Together with our Healthcare Advisory Council, a multidisciplinary group of physicians, nurses, pharmacists, risk managers, statisticians and others, Clarity PSO partners with its clients to support the enhancement of patient safety and healthcare quality across their organizations.

Ellen Flynn, RN, MBA, JD  
Executive Director  
Clarity PSO, A Division of Clarity Group, Inc.  
Chicago, IL

Anna Marie Hajek  
President and CEO  
Clarity Group, Inc.  
Chicago, IL

©2009 Clarity Group, Inc.

### **Resources**

Agency for Healthcare Research and Quality,  
<http://www.pso.ahrq.gov/psos/overview.htm>

For more information on the services of Clarity PSO, please visit our website at  
[www.claritygrp.com](http://www.claritygrp.com)