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**PSO Florida Staff and Presenters**

- ▶ *Bill Bell, General Counsel, Florida Hospital Association*
- ▶ *Jaime Caldwell, Vice President, South Florida Hospital and Healthcare Association*
- ▶ *Dan Fridman, Holland and Knight*
- ▶ *Amy Goldberg-Alberts, Program Director, ECRI*
- ▶ *Mike Smith, Director of Alliances, rL Solutions*
- ▶ *Cathy Pusey, State Liaison, ECRI*




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**Benefits of Joining PSO Florida**

- First-ever national system for providers to voluntarily report medical errors and near misses
- Allows providers to seek expertise in understanding patient safety events to prevent their occurrence in a protected legal environment
- Comparative data – among system, PSO Florida, ECRI Institute PSO




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## Overview of Florida State Law



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## Overview of the Federal Patient Safety and Quality Improvement Act



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## Patient Safety and Quality Improvement Act



- ▶ Act passed in July 2005
- ▶ Final regulations: Published Nov 21, 2008; effective Jan 19, 2009
- ▶ ECRI Institute PSO federally certified 11/5/08; PSOF 2/25/09
- ▶ Agency for Healthcare Research and Quality (AHRQ), Office for Civil Rights (OCR)



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### Patient Safety and Quality Improvement Act (PSQIA)

- Authorized the creation of federally certified *Patient Safety Organizations (PSOs)*
- Provides uniform national privilege and confidentiality protections for *patient safety work product*
- Is completely voluntary

#### Share and Learn




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### Patient Safety and Quality Improvement Act

- **SHARE** information about events so you can learn from them
  - facilitate learning about best practices from your peers
- **LEARN** from data aggregation, in-depth patient safety analytics and Advisories, statewide and national comparisons
- **PROTECT** patients from harm through evidence-based solutions
  - Get legal protection and confidentiality for data submitted under




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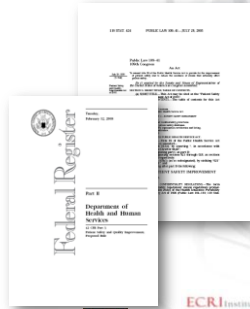
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### Patient Safety Act: Important Terms

- Patient Safety Organization
- Provider
- Patient Safety Activities
- Patient Safety Evaluation System (PSES)
- Patient Safety Work Product (PSWP)
- HIPAA Confidentiality Regulations




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### Patient Safety Act: PSO Requirements

1. Efforts to improve patient safety and quality of health care delivery
2. Collection & analysis of patient safety work product (PSWP)
3. Development/dissemination of information to improve patient safety:
  - > Recommendations, protocols, best practices
4. Use PSWP for:
  - > Encouraging a culture of safety
  - > Providing feedback/assistance to minimize patient risk
5. Procedures to preserve confidentiality of PSWP
6. Security measures with respect to PSWP
7. Qualified staff, including medical professionals.
8. Operation of a patient safety evaluation system (PSES) and provision of feedback to participants in a PSES.




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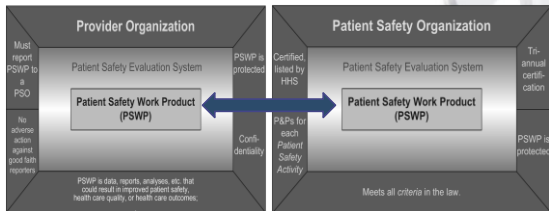
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### Oversight of PSOs: AHRQ & OCR




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### Patient Safety Act: Legal Protections

- ▶ Not subject to subpoena in civil, criminal, administrative proceedings
- ▶ Not subject to discovery
- ▶ Not admissible into evidence
- ▶ Not subject to FOIA
- ▶ Goes beyond state law for some
- ▶ Participation with a PSO is voluntary—legal protections only kick-in if provider participates
- ▶ PSWP cannot be disclosed except as permitted under the Act/regulations; improper disclosure can trigger money penalties




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### Patient Safety Act: Permissible Disclosure

- 1. Criminal proceedings
- 2. Consent of all providers
- 3. Patient safety activities
- 4. Non-identifiable PSWP
- 5. Limited research purpose
- 6. To FDA
- 7. Voluntarily, to accrediting bodies
- 8. Business operations
- 9. To law enforcement
- 10. Equitable relief of reporters




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### Special Considerations: Voluntary Disclosure to Accrediting Bodies

- ▶ With permission of all identified providers other than the one voluntarily making the disclosure
- ▶ Direct identifiers removed (e.g., names, addresses, telephone, SS no., DEA/license numbers, URLs, etc.)
- ▶ Accrediting body may not further disclose
- ▶ May not take accrediting action based on good faith participation by provider
- ▶ May not require a provider to reveal communication with a PSO




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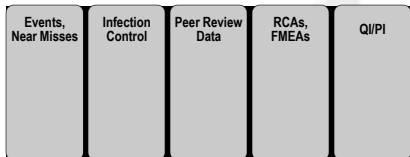
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### Getting Started – Submitting Information

- ▶ Establish a **Patient Safety Evaluation System**
  - **Defined as:** the collection, management, or analysis of information for reporting to or by a PSO
  - Meant to be flexible and scalable to individual operations
  - Best practice is to document the PSES




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## PSOFLORIDA Member Services

### ▶ SHARE

- Secure Web-based Data Collection and Reporting System
- Secure mechanism for RCA submissions
- Participate in Webinars/Audio conferences

### ▶ LEARN

- Aggregate and Facility-based Real-time Reports
- Independent Critique of RCAs
- Aggregate RCA experience
- PSOfLorida Advisory—Statewide supplement and National ECRI Institute PSO
- Additional training/Webinars

### ▶ PROTECT

- Evidence-driven solutions to reduce patient harm
- Legal protections




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## Learn – PSOfLorida Patient Safety Navigator

### PSOfLorida Navigator as well as an ECRI Institute PSO Navigator

- ▶ Created quarterly
  - Recommended strategies
  - Best Practices
  - Lessons learned
  - Trends
- ▶ Web-based
  - E-mailed to colleagues




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## RCA Evaluation

- ▶ Narrative report
- ▶ Individual feedback or de-identified lessons learned
- ▶ Independent critique
  - Defining the problem and reviewing the literature
  - Collecting data
  - Documentation
  - Process
  - Root Cause Determination—contributing causes; root causes
  - Corrective actions
- ▶ Secure communication vehicle PSWP exchange




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## Learn – Additional Assistance

- ▶ **Member Forums**
- ▶ **Best Practices for Setting up your Patient Safety Evaluation System (PSES)**
- ▶ **FAQs on the Patient Safety Act**
- ▶ **Ongoing Patient Safety Webinars/Audioconferences**

### Patient Safety Organization Final Regulations: Issues for PSOs and Hospitals

A Free Audio Conference from ECRI Institute  
Originally recorded Monday, December 15, 2008

- ▶ **Download the Recording (registration required)**

On November 21, 2008, the federal government issued a final rule for implementing the Patient Safety and Quality Improvement Act of 2005, including establishing a protected legal environment within which healthcare providers voluntarily report patient safety data—such as errors, near misses, and quality-related data—to Patient Safety Organizations (PSOs). The patient safety data submitted by providers to PSOs and, in turn, the analyses provided by PSOs to providers are subject to federal statutory legal privilege and confidentiality. The rule takes effect January 19, 2009.

ECRI Institute's free audio conference addresses key aspects of the final rule. Subjects include: requirements from AHCA and the legal and provider requirements. Plan to participate in this one-hour audio conference, learn about the final rule, and have your questions answered about how to plan properly your organization to voluntarily participate with or set up its own PSO. Participation in this program is free. But space is limited to one phone line per facility. Hurry, only 200 spots available.

#### Key areas to be discussed:

- ▶ Overview of final PSO regulations
- ▶ What's protected and what's not
- ▶ Legal considerations for PSOs and their structure
- ▶ Best practices for providers participating in PSOs



## Share - Data Collection & Reporting



Access at:

<http://pso.ecri.org>



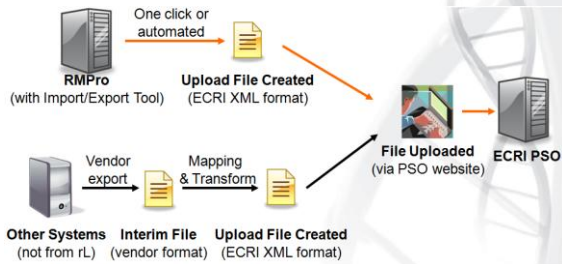
Live Demo



## Uploading Data



## Data Exchange



## Upload Events from In-house Systems




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## Upload Events from In-house Systems




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## Upload Events from In-house Systems




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## Data Mapping

- Mapping links fields in your Adverse Event Reporting System to fields captured in PSO System
- Ensures data in these systems gets put in the right place in PSO system, key for reporting and analysis
- Mapping not difficult but can be time consuming

Fields in Your System	Maps To	Fields in The PSO System
Given Name	→	First Name
Surname	→	Last Name
Middle Name	→	Middle Name
Sex	→	Gender
MRN	→	Medical Record #
Fall, Slip, Trip	→	Falls
Medication Error	→	Medication and Other Substances
Pressure Ulcer	→	Pressure Ulcer
In what type of location did the event occur	→	In what type of location did the event occur
Inpatient Facility	→	Inpatient Care Area
Outpatient Facility	→	Outpatient Care Area
Cafeteria	→	Inside Non-Care Area
Chapel	→	Inside Non-Care Area
Gift Shop	→	Inside Non-Care Area
Campus Grounds	→	Outside Area
Unit	→	Throughput Unit or Facility
Unknown	→	Unknown

Patient Information Field Mapping

Mapping of Event Types

Mapping of Field Values




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Next Steps

- Who to contact
  - Bill Bell, General Counsel at [billb@fha.org](mailto:billb@fha.org)
  - Jaime Caldwell, Vice President at [jcaldwell@sfhha.com](mailto:jcaldwell@sfhha.com)



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Questions?



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