Benefits of Joining a Patient Safety Organization:

Maryland Patient Safety Center
Creating a Safer Health Care System

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Agenda

- What is a Patient Safety Organization?
- How does a Patient Safety Organization work?
- Which Maryland Patient Safety Center initiatives are part of the Patient Safety Organization?
- Why participate in a Patient Safety Organization?
What is a Patient Safety Organization?

- Congress established Patient Safety Organizations (PSO) in passing the Patient Safety and Quality Improvement Act of 2005 (PSQIA).

- The purpose of a PSO is to:
  - Encourage a culture of safety and quality in health care by creating a safe harbor in which reporting and analyzing information is insulated from liability or harm to professional reputation.
  - Ensure accountability by raising standards and expectations for continuous quality improvements in patient safety.

How Does a PSO Work?

- **Patient Safety Organization (PSO)** – Maryland Patient Safety Center is listed by AHRQ as a PSO whose mission is to conduct activities aimed at improving patient safety and the quality of health care delivery.

- **Patient Safety Evaluation System (PSES)** – The collection, management or analysis of information for reporting to or by a PSO.

- **Patient Safety Work Product (PSWP)** – Any quality data and analysis, oral statement – assembled or developed by a provider for reporting to a PSO, and are reported to the PSO or which constitute the deliberations or analysis of a PSES.
**Protections for Data and Providers**

- **Privilege** – With limited exceptions, the Act places “Patient Safety Work Product” beyond the reach of federal and state courts and administrative bodies, even if subpoenaed.
  - Information is not subject to subpoena, discovery or admission into evidence
  - Federal privilege preempts state tort laws but not reporting laws
  - Federal privilege does not preempt state laws that provide stronger peer review protections
  - Provides federal liability protections to providers:
    - Federal privilege and confidentiality protections cross state lines
    - Federal privilege preempts state tort laws but not reporting laws (e.g., shield for event reports)
    - Establishes a federal peer review privilege for all providers (e.g., pharmacists, EMT, Nurses)
    - Preempts use of protected information in federal cases (e.g., racial discrimination)

- **Confidentiality** – The Act places a burden upon providers and others not to disclose “Patient Safety Work Product,” absent a permissible disclosure, and imposes penalties for doing so.

**How Does a PSO Work?**

![Diagram of PSO process]

“PSES” – Patient Safety Evaluation System
“PSO” – Patient Safety Organization
“PSWP” – Patient Safety Work Product
How Do We Share the Improvements?

A goal of the Act is for PSOs and providers to protect the data that would otherwise be used for shame and blame but to share and publish the best practices and quality improvements.

– “Use” – means the sharing of Patient Safety Work Product within a legal entity. Use of Patient Safety Work Product within an entity is not regulated. (e.g., Risk Management)

– “Disclosure” – Highly regulated
  • All providers named in the report agree to disclosure (to use in defense in court).
  • The privilege does not preclude disclosure of nonidentifiable patient safety work product.

Why Participate?

- **Health Reform Requirement** - All hospitals over 50 beds must maintain a Patient Safety Evaluation System by 2015 to participate in the state insurance exchanges.

- **Improved Patient Safety** – Encourages a culture of safety and quality throughout the health care system by raising standards and expectations for continuous quality improvement in the practice of evidence-based medicine.

- **Greater Efficiency** – Providers can share risk information to accelerate identification of patient safety trends and accelerate the speed with which solutions can be identified and best practices adopted.

- **Prevention** - By sharing quality data, a PSO will be able to identify patterns that could suggest underlying or systemic causes of patient risks and hazards to prevent their future occurrence and improve patient safety.

- **Peer Review Protections** – All licensed providers are covered by federal peer review protections. Peer review statutes in 14 states provide protections for pharmacy activities and 9 states for nursing activities.
More Benefits

- **Benchmarking** – Comparing regional and nationwide performance.
- **Integrated Care** – Share protected information among unrelated providers.
- **Significant Cost Savings** – Significant savings in reduced healthcare costs and reduced malpractice operational costs.
- **Enhanced Patient and Consumer Confidence** – Aiming to be the safest providers in the nation.
- **Learning** - By facilitating a shared-learning approach, hospitals and providers can learn from each other, make faster improvements and reduce the cost of learning.
- **Malpractice Reform** - Such as the Patient Safety and Quality Improvement Act (PSQIA) - that is spurred by improving quality is supported by the Obama Administration.

Areas of Focus for Maryland Patient Safety Center

- **Quality and Safety Initiatives:**
  - SAFE from FALLS
  - Maryland Hand Hygiene Collaborative
  - Adverse Medical Event and Near Miss Reporting System
  - Outpatient Dialysis
  - Perinatal and Neonatal Learning Network
  - MEDSAFE
  - Functional Reporting for Provider Programs
Examples of Potential Benefits of Patient Safety Programs

- Ascension 5 year study:
  - Preventable deaths: 100% reduction
  - Neonatal mortality: 79% reduction
  - Birth Trauma: 74% reduction
  - Pressure ulcer: 95% reduction (high cost to reduce)
  - Falls with serious injury: 54% reduction
  - Blood stream infections: 32% reduction

- Economics
  - Malpractice operational costs down 56%
  - Workman’s compensation from patient handling injuries down 50%
  - Bond rating improved AA+

  » Modern Health Care 2008

Questions?

Participating in a Patient Safety Organization =

Low risk investment with potential for significant quality improvement, highly favorable public response, reduction in health care costs, reduction in malpractice operational costs, and increased defenses for lawsuits =

Building a Safer Health Care System

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