

# MISSOURI CENTER FOR PATIENT SAFETY

## OVERVIEW

The Patient Safety and Quality Improvement Act of 2005, established a network of Patient Safety Organizations to encourage voluntary, provider-driven initiatives to improve the safety of health care. The final rule to implement the act was finalized in January 2009. These actions provide significant federal legal protections to health care providers that report adverse events to PSOs to facilitate rapid learning about the cause of risk and harm and to share those findings to speed the pace of improvement.

In Missouri, three activities have further encouraged statewide patient safety improvement.

- In 2005, the Missouri Center for Patient Safety (MOCPS) was established based on the recommendation of the Missouri Commission on Patient Safety. When established, it was envisioned that the MOCPS would serve as a PSO once federal law and regulations were finalized. This vision was completed when the MOCPS became one of the first 10 organizations to be listed by the Agency for Healthcare Research and Quality as a PSO on November 5, 2008.
- In September 2008, the Missouri Hospital Association Board of Trustees adopted the “Adverse Events in Missouri’s Hospital” initiative. In addition to asking MHA-member hospitals to voluntarily inform patients about the occurrence of serious adverse events and to waive payment for such events, hospitals are encouraged to report these events to a federally-designated PSO.
- Following the lead of the Centers for Medicare & Medicaid Services, the Missouri Department of Social Services’ MO HealthNet Division adopted a rule on non-payment for certain serious, preventable reportable events that occur in hospitals and ambulatory surgery centers that treat Medicaid patients. **The rule requires these MHN providers to contract with a PSO by January 2010 to report, analyze and prevent such events.**

Standard PSO services provided by MOCPS, as outlined in this document, are being funded by MHA to assist member hospitals in complying with the MHN regulation, and to decrease the financial effects of compliance.

## ABOUT THE MISSOURI CENTER FOR PATIENT SAFETY

The center was founded in 2005 as an independent, statewide, not-for-profit organization, by MHA, the Missouri State Medical Association and Primaris.

MOCPS has undertaken several successful statewide projects, including the Banding Together—for Patient Safety and the Missouri Just Culture collaborative. MOCPS also serves as a statewide resource on patient safety and provides various education and training opportunities.

Now, as a federally-listed PSO, the MOCPS has established a safe, confidential environment to collect adverse events and to analyze, report, and share its findings to improve the safety of care provided to Missourians.

For hospitals, a statewide PSO like MOCPS can help health providers prevent more than 7,000 adverse events resulting in annual savings of approximately \$8.5 million in health care costs.

## **How will MOCPS help MHA hospitals comply with the MO HealthNet Regulations?**

PSOs that will have the largest effect on improving the safety of care are those that have a large number of diverse organizations reporting and participating in its activities. MOCPS hopes to assist all Missouri hospitals in complying with the MO HealthNet regulation, implementing safety improvements shaping health policy and answering the following important questions.

- What types of medical errors occur in Missouri?
- Why do these errors occur?
- What can be done to prevent errors from occurring?
- How is the safety of care improved throughout time?
- What events require special alerts to inform providers about potential risk? How are they prevented?
- What are the safety priorities for Missouri providers and the state as a whole?

MOCPS will provide the following standard services to each participating hospital. The Services are funded by MHA for MHA-member hospitals.

- federally-designated legal protections
- a Web-based platform to submit data, analyze and report on defined adverse events and root cause analyses
- real-time reports of facility-specific data and information entered into the system
- comparative and benchmarking reports
- an automated culture of safety survey tool
- assistance in establishing policies, procedures and processes for participation with the MOCPS as a PSO to meet definitions for Patient Safety Evaluation System and Patient Safety Work Product to achieve protections under the law
- ability for participating hospitals to have input into reporting processes
- state and national networking opportunities for patient safety improvement
- safety updates with key findings from data analysis
- access to a patient safety resource library

Additional fee-based services are available through MOCPS, including technical support for patient safety process reviews and implementation, enhanced analysis and reporting, and electronic interfaces with automated adverse event reporting systems. These services and others can be requested by participating hospitals.

## **What data and information will be reported?**

MOCPS' user-friendly Web-based system will initially be capable of collecting, analyzing and reporting events as defined in the MHN regulation. The system will accommodate additional data reporting as needed in the future, including the AHRQ Common Data Formats.

Adverse events to be reported by MHN hospital and ASC providers are preventable events that result in unintended injury or illness. These events are defined by the National Quality Forum or on the CMS list of Medicare Hospital-Acquired Conditions (HACs), non-payable by Medicare as of December 15, 2008. Providers also are to report the root cause of such events to the PSO.

### **How can I access MOCSP Services?**

Complete the enclosed PSO follow-up form to obtain additional information about participating with MOCPS as your facility's PSO.

### **What is a PSO?**

A PSO is a public or private entity that meets criteria established in the Patient Safety and Quality Improvement Act and is listed by the AHRQ. It is not an insurance issuer, accreditor, licensing authority or agent of an oversight agency. A PSO must have defined policies and a primary activity of conducting activities to improve patient safety and health care quality. The PSO also must have qualified staff and contract with more than one provider for PSO services.

### **What is the purpose of a PSO?**

PSOs provide a framework for health care providers and professionals to report information about adverse events on a privileged and confidential basis, and to aggregate, analyze and share information about such events. PSOs are also a source of confidential and privileged external assistance for health care providers seeking to understand and minimize the risks and hazards in delivering patient care. Through the analysis, sharing of learning and implementation of improvement activities, PSOs are expected to contribute to a significant reduction in adverse events and their associated costs.

### **What are the benefits to health care providers who work with a PSO?**

- significant federal legal protection for patient safety and quality improvement work performed by the provider for the purpose of reporting to the PSO
- learning from safety alerts, education, training and information based on data analysis
- access to PSO services for data collection and technical assistance related to patient safety events and activities
- mechanisms to collect, analyze, and aggregate data and information for comparative and benchmarking purposes
- participation in regional, state and national patient safety networking opportunities

### **Who can report to a PSO?**

Any health care provider or professional licensed by the state and government-based agencies, organizations and individuals that provide health care services may participate with a PSO and receive the benefits. Decisions about staff within participating organizations who will report information to a PSO will be determined between the PSO and individual participants.

### **What is to be reported to a PSO?**

Any data and information on quality improvement and patient safety collected within a Patient Safety Evaluation System (PSES) and defined as Patient Safety Work Product (PSWP) may be reported to a PSO by a participating provider. Data, information and documents defined as PSWP for reporting to a PSO will be established between the PSO and its participating providers.

Many PSOs are initially collecting NQF's Serious Reportable Events. In addition, AHRQ has developed common data formats, definitions and formats as an option to assist PSOs in collecting and reporting safety events.

### **What is a Patient Safety Evaluation System?**

A PSES is defined with the act and final rule. Generally, the PSES consists of the processes established by a provider and the PSO to collect and manage confidential PSWP for transmission to the PSO and management of such data and information by the PSO.

### **What is Patient Safety Work Product?**

PSWP is an important component of the Act. PSWP, also defined in the act and final rule, is the data and information submitted to a PSO that receives the federal privilege and confidentiality protections under the act and final rule. PSWP is any data, report, record, memoranda, analysis or written or oral statement assembled or developed by a provider for reporting to a PSO or is developed by a PSO to conduct patient safety activities. A patient's original medical record, billing and discharge information cannot be defined as PSWP and is protected. However, copies of selected parts of such documents and analysis based on the documents may be defined as PSWP and receive protection.

### **How is data and information protected through reporting to a PSO?**

The act provides strong privacy and confidentiality protections for PSWP to encourage participation with PSOs and allows for detailed discussions about the cause of events without the fear of liability. Both providers and PSOs must adhere to strict guidelines for maintaining the confidentiality of PSWP. PSWP also may not be used in criminal, civil, administrative or disciplinary proceedings, unless such disclosure meets the narrow exception defined in the act.

### **What is the relationship between the patient safety rule and HIPAA?**

PSWP may contain individually identifiable health information as defined in the HIPAA Privacy Rule. Health care providers that are HIPAA-covered entities must comply with the use disclosure exceptions for PSWP, as well as the permissions and disclosure requirements concerning protected health information in the HIPAA Privacy Rule and the limitations on disclosure of information found in the Act when disclosing PSWP. PSOs that are business associates of HIPAA-covered entities also are subject to such requirements.