



PSO Monthly Brief

April 2011

Insights from Three Years as a PSO

It has been about 3 years since ECRI Institute first broadcast its Webinar: Patient Safety Organization (PSO) Regulations: What Healthcare Providers Need to Know . The AHRQ regulations kicked off the Patient Safety and Quality Improvement Act implementation, and we thought we would take this opportunity to highlight some lessons learned and to re-examine what to consider when deciding to engage a PSO and what to look for when evaluating a PSO. Let's start with a couple lessons learned over the past three years:

- ▶ PSO's are not just for acute care facilities and in support of this AHRQ has just released new Common Formats for Skilled Nursing Facilities.
- ▶ So far, three federal district courts in different judicial circuits have issued decisions related to the Patient Safety and Quality Improvement Act of 2005 and the PSO regulations; a lesson that can be drawn from them is that the Act only protects patient safety information that is or will be reported to a PSO.
- ▶ Alarm fatigue, wrong site surgery, and surgical fires continue to be issues facing healthcare providers, as seen in reports to ECRI Institute PSO.

Now, imagine you are your organization's "go-to" leader on PSOs and what it means to be a healthcare provider participating with a PSO. With nearly 80 listed PSOs, your colleagues may look to you for guidance and you might encounter some confusion among individuals who are less steeped in the PSO details as you are.

The value and impact of an individual PSO is determined primarily by the providers that use its services on an ongoing basis. It was the intention of the lawmakers and regulators to minimize barriers to entry for entities seeking listing and create maximum transparency to create a robust marketplace for PSO services. Providers thus become the ultimate arbiters of the quality of services that an individual PSO provides.

Here are some tips on what to look for when evaluating the marketplace of PSOs:

- ▶ Is the PSO focusing narrowly or broadly? For example, a specialty group focusing on specific issues such as radiology or orthopedics, or a broad focus across the spectrum of patient safety concerns. Related to this, if a PSO does address the spectrum of patient safety concerns, does it provide an opportunity for focused collaboration and learning on a particular topic or concern?

- What is the PSO's experience in providing recommendations on how to prevent adverse events and near misses from occurring? Data collection only begins the task. The real challenge is in sustainable approaches to fixing underlying systems issues.
- How confident is your organization that clinical events will be analyzed in an unbiased manner? Are there any real or perceived conflicting priorities of the PSO? Conflicts of interest between the parent organization and component PSO must be disclosed and are published on the Agency for Healthcare Research and Quality (AHRQ) Web site that lists PSOs. Still, take into account your organization's confidence in the independent analysis provided by a PSO when an adverse event occurs that is associated with a medical device, drug, biologic, or health information technology system.
- How large is the PSO's existing client pool and what types of providers share data?
- What is the PSO's experience and resources for analyzing the data it receives?
- In what format or context will data be given back to your organization? Will you need an FTE analyst just to interpret it? Or, will the information that is returned be meaningful and useable?
- What is the PSO's "staying power"? Do you anticipate they will remain a listed PSO for years to come. Some PSOs already have "delisted" and others may do the same.

As pointed out in the preamble to the final PSO regulations, PSOs are not a Federal program in the traditional sense. Their project goals, priorities, and the specific analyses that they undertake are not federally directed and they are not federally funded. This contrasts, for example, to a Quality Improvement Organization (QIO) with a federally directed scope of work.

Now you're better able to educate and facilitate meaningful dialogue with your stakeholders and colleagues. These are only some ideas from questions that have been raised to us at ECRI Institute PSO; let us know other questions you may have.



How Can We Help You?

Whether you have questions about the final rule or want to learn more about ECRI Institute PSO and/or support for other PSOs, we would be happy to hear from you. Please contact ECRI Institute at pso@ecri.org or call (610) 825-6000, ext. 5558.