

Tennessee Hospital Association Forms Patient Safety Organization

The Tennessee Center for Patient Safety now is listed as a patient safety organization (PSO) by the Agency for Healthcare Research and Quality (AHRQ), on behalf of the secretary of the U.S. Department of Health and Human Services (HHS).

In 2005, the U.S. Congress passed the Patient Safety and Quality Improvement Act of 2005 (PSQIA). The act authorizes the creation of PSOs, which are designed to help clinicians, hospitals and healthcare organizations improve the care delivered to patients through the collection and analysis of data on patient safety events. Based on the Federal Aviation Administration of nonpunitive, near-miss reporting, the mission of PSOs is to engage in data collection activities that will enable participating hospitals to work together to create cultures of safety. The national goal is to develop a system where PSOs can use de-identified events and causative factors for shared learning and to prevent future harm.

The Tennessee Center for Patient Safety (TCPS) sought listing by HHS to become a federal PSO and was approved effective July 1, 2009. Being listed as a PSO permits the center to assist member hospitals by receiving, analyzing and reporting patient safety and quality data under the federal confidentiality protections of the PSQIA. Information submitted to PSOs from healthcare providers is privileged and confidential.

The goal of PSOs is to foster shared learning and effective interventions to reduce the risk of harm to patients and improve quality through a common format. THA has been proactive in taking the lead on patient safety and quality through the TCPS' voluntary hospital-led endeavors, such as the infections collaborative and the Tennessee surgical quality collaborative. PSO listing provides additional protection to the hospital-level data submitted to TCPS for these projects.

With the passage of Tennessee Public Chapter 318 during this year's legislative session, the TCPS is evaluating options for the voluntary collection of adverse event information for members. Public Chapter 318 amends the Health Data Reporting Act of 2002 by significantly altering mandatory state reporting requirements for adverse events. The statute encourages providers to continue voluntary reporting to other organizations, such as PSOs, for the purpose of shared learning from adverse events.

When the Health Data Reporting Act passed in 2002, Tennessee was one of only six states with mandatory reporting. The law now has been amended to remove mandatory reporting of "clinical" adverse events at a time when the field of patient safety is experiencing growth and heightened awareness. In 2004, the National Quality Forum (NQF) identified a consensus list of serious reportable

events, a list much more limited than the Tennessee Health Data Reporting Act prior to its amendment. Updated in 2007, the NQF list of 28 serious reportable events now is the gold standard for reportable adverse events.

For more information on the Tennessee Center for Patient Safety and programs, go to www.tnpatientsafety.com. Questions on the PSO should be directed to Chris Clarke at THA, 615-256-8240, cclarke@tha.com.