State Patient Safety Organizations: Creation of Non-Punitive, Sentinel Events Reporting System

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Health Policy Fellowship 2006-2007

Abstract

Hospital errors kill more Americans than breast cancer, traffic accidents or AIDS. Preventable health care-related errors cost a large hospital more than $5 million per year and cost the economy from $8 to $15 billion each year.

In 2005, the Patient Safety and Quality Improvement Act of 2005 (PSQIA) authorized a state-created and supported network of Patient Safety Organizations (PSOs) intended to improve and promote patient safety by coordinating patient safety efforts. The PSO’s primary focus is educating health care professionals, purchasers, consumers, and policymakers about medical errors, the culture of safety, and strategies for reducing risks.

However, unintended consequences hamper patient safety efforts:

- Institutions and health care providers are less likely to cooperate with data collection if the PSO is used to collect non-relevant personal, financial, licensing or discipline data;
- Health care providers and institutions may avoid sicker patients to avoid poor patient outcomes data reports;
- CMS may (eventually) use the PSO database to implement pay-for-performance for hospitals and health care workers;
- Financial support for the activities of the centers is problematic.

For a safety data reporting network to be successful, it is essential it address health care industry and provider concerns; ensure that safety initiatives perform as envisioned; and function as a financial viable, voluntary, non-punitive, legally protected system of reporting, analysis, and feedback.