State Patient Safety Organizations: State-Run, Nationally Integrated, Non-Punitive, Sentinel Events Reporting Systems
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Introduction
Hospital errors rank between the fifth and eighth leading cause of death, killing more Americans than breast cancer, traffic accidents or AIDS. Preventable errors cost a large hospital more than $5 million per year and cost the economy from $8 to $15 billion each year. In 1999 the Institute of Medicine (IOM) called for a nationwide, state-supported adverse events reporting system to provide for the collection, review and dissemination of standard error event information in order to identify health care errors and hold providers accountable for improvements.1

In 2005, the Patient Safety and Quality Improvement Act of 2005 (PSQIA) authorized the development of a state-created and supported network of PSQIA. Patient Safety Organizations (PSO) envisioned to improve, ensure, and promote patient safety by coordinating patient safety efforts. The PSO’s primary focus is educating health care professionals, purchasers, consumers, and policymakers about the nature of medical errors, the culture of safety, and strategies for reducing risks.2

As of September 2005, half of all states have passed legislation or executive orders related to hospitals reporting adverse events.3

Unintended Consequences
PSO as a Central Quality Data Collecting and reporting Agency: Institutions and health care providers would be less likely to cooperate with data collection if the PSO is used to collect non-relevant personal, financial, licensing or discipline data; especially if data collection could lead to adverse publicity, financial or legal punitive action, or unwanted commercial activity.4

Adverse impact on patients’ access to care from reporting adverse events: Health care providers and institutions may avoid sicker patients to avoid poor patient outcomes, data reports, or to maintain or improve performance scores, resulting in decreased access to care.5

Pay for performance: While not incorporated into the present PSQIA legislation, CMS, through central data collecting, may eventually use the PSO database to implement pay-for-performance for hospitals and health care workers.

Unfunded mandate: The Congressional Budget Office estimated the PSQIA-PSO program would cost $5 million in 2006 and another $58 million over the next five years. However, financial support for the activities of the centers is problematic; a reliable source of annual funding is desirable.6

Discussion
The medical system itself is the most common causes of medical errors - not the individuals functioning within the system.7 Patient safety improvement efforts are hampered by fear of discovery via peer deliberations, resulting in under-reporting of events and an inability to aggregate sufficient patient safety event data for analysis.

Deviation from the education mission may well lead to mistrust of the organizations’ motives, interfere with cooperative and voluntary data collection, and destroy confidence in the network as a promoter of patient and health care safety.

For a nationwide, government-sponsored, safety data reporting network to be successful, it must
• Address health care industry and provider concerns;
• Ensure safety initiatives are effective;
• Operate as a voluntary, non-punitive, legally-protected system of reporting;
• Be financially viable; and
• Provide analysis and feedback.

Stakeholders
Stakeholders include consumer advocates; organizations - AARP and Institute for Safe Medication Practices, Physician organizations include the American Osteopathic Association and American Medical Association; Allied health organizations include American Pharmacist Association, American Society of Health System Pharmacists, and American Nursing Association. Health care advocacy organizations include National Committee for Quality Assurance, National Patient Safety Foundation and the Institute for Safe Medical Practices. Institutional organizations include the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and the American Hospital Association. CMS Quality Improvement Organizations and private industry via the Leap Frog Group also support patient safety efforts.

References
6. Young S, Long-awaited Patient Safety Bill Enacted, American Society of Health-System Pharmacists, August 16, 2005