Reporting to Patient Safety Organizations

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2015 Midas+ Annual Symposium
"Insight-Driven Transformation"

Objectives

- Understand the purpose and benefit of:
  - Patient Safety Organization reporting
  - Midas+ AHRQ PSO Acute Care Toolkit

- Summarize the Midas+ AHRQ PSO Acute Care Toolkit's design and recommended use

Where it started

The Patient Safety and Quality Improvement Act of 2005:

- Established a voluntary reporting system for safety events
- Defined guidelines for Patient Safety Organizations (PSO)

What is a PSO?

- A PSO is an entity or a component of another organization (component organization) that is listed by AHRQ based upon a self-attestation by the entity or component organization that it meets certain criteria established in the Patient Safety Rule.

- The primary activity of an entity or component organization seeking to be listed as a PSO must be to conduct activities to improve patient safety and health care quality. A PSO's workforce must have expertise in analyzing patient safety events, such as the identification, analysis, prevention, and reduction or elimination of the risks and hazards associated with the delivery of patient care. See 42 CFR 3.102 for the complete list of requirements.

http://www.pso.ahrq.gov/psos/fastfacts.htm#ff01

What is the PSO certification process?

Four-step process:

1. Determine organization eligibility
2. Establish policies and procedures for executing patient safety activities
3. Attest that the organization will comply with criteria specified by the patient safety rule
4. Apply to become a PSO

https://www.pso.ahrq.gov/become_PSO

What is the purpose of a PSO?

- The Patient Safety Rule establishes a framework by which hospitals, doctors, and other health care providers may voluntarily report information to PSOs, on a privileged and confidential basis, for the aggregation and analysis of patient safety events.
- The Patient Safety Rule outlines how PSOs can be a source of confidential and privileged external advice for health care providers seeking to understand and minimize the risks and hazards in delivering patient care.

http://www.pso.ahrq.gov/psos/fastfacts.htm#ff01

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

- PSOs serve as independent, external experts who can collect, analyze, and aggregate PSWP locally, regionally, and nationally to develop insights into the underlying causes of patient safety events. Communications with PSOs are protected to allay fears of increased risk of liability because of collection and analysis of patient safety events.

- The protections of the Patient Safety Rule enable PSOs that work with multiple providers to routinely aggregate the large number of patient safety events that are needed to understand the underlying causes of patient harm from adverse events and to develop more reliable information on how best to improve patient safety.

http://www.pso.ahrq.gov/psos/fastfacts.htm#ff01

PSO Selection

AHRQ recommends considering several questions to meet your facility's needs:

- AHRQ-listed PSO
- PSO location
- Offered services
- Protected data
- Common Formats

https://www.pso.ahrq.gov/with_PSO/choosePSO

Development of the Common Formats

Agency for Healthcare Research and Quality (AHRQ), National Quality Forum (NQF) and Patient Safety Work Group (PSWG) developed the Common Formats:

- *"Common definitions and reporting formats that allow health care providers to collect and submit standardized information regarding patient safety events."*

Why use the Common Formats?

- Identify trends
- Comparable data – locally, regionally and nationally
- Opportunities to improve safety
- Increased participation

Common Formats

- Initially developed for two settings of care:
  - Acute care hospitals
  - Skilled nursing facilities
- Acute care
  - Version 0.1 Beta – August 2008
  - Version 1.0 – September 2009
  - Version 1.1 – March 2010
  - Version 1.1a – November 2010
  - Version 1.2 – April 2012

Generic Common Formats

Generic Common Formats specify information that is to be collected for all patient safety concerns—incidents, near misses, and unsafe conditions.

- Healthcare Event Reporting (HERF)
- Patient Information Form (PIF)
- Summary of Initial Report (SIR)

Event-specific Common Formats

Event-specific Common Formats have been developed for frequently-occurring and/or serious events, to allow collection of structured information about these important patient safety concerns.

Event-specific Common Formats

(continued)

- Event-specific Common Formats – Version 1.2
  - Blood or Blood Product
  - Device or Medical/Surgical Supply, including HIT
  - Fall
  - Healthcare-associated Infection
  - Medication or Other Substance
  - Perinatal
  - Pressure Ulcer
  - Surgery or Anesthesia
  - Venous Thromboembolism

What is the Midas+ AHRQ PSO Acute Care Toolkit?

The Midas+ AHRQ PSO Acute Care Toolkit is a package of components that can be installed on version 8.0 or newer of Midas+ to allow data collection and submission of patient safety events to a contracted Patient Safety Organization.

Toolkit Distributed Components

- Distributed Dictionaries
- Process Focus Studies
  - MIDAS+ AHRQ PSO AC MAPPER
  - MIDAS+ AHRQ PSO AC UNSAFE CONDITIONS
- Encounter Focus Study
  - MIDAS+ AHRQ PSO AC
- Virtual Worklist Target
- PSO Transmittal User Role
- Standard Reports
  - MIDAS+ AHRQ PSO ACUTE CARE EXTRACTION FILE
  - MIDAS+ AHRQ PSO ACUTE CARE ORIGINAL DATA

Additional Components

- Legal Counsel Advice
  - Define and document what is considered to be your Patient Safety Evaluation System (PSES) and Patient Safety Work Product (PSWP).
- Policy and Procedure Update
  - Identify those polices and procedures that need to be edited or those that need to be created due to new processes and protections.
- Contact PSO(s)
  - Receive International Organization for Standardization (ISO) identification, branch and provider identification and submission instructions.

What is a Patient Safety Evaluation System (PSES)?

The collection, management, or analysis of information for reporting to or by a PSO. A provider's PSES is an important determinant of what can, and cannot, become patient safety work product.

http://www.pso.ahrq.gov/faq

What is a Patient Safety Work Product (PSWP)?

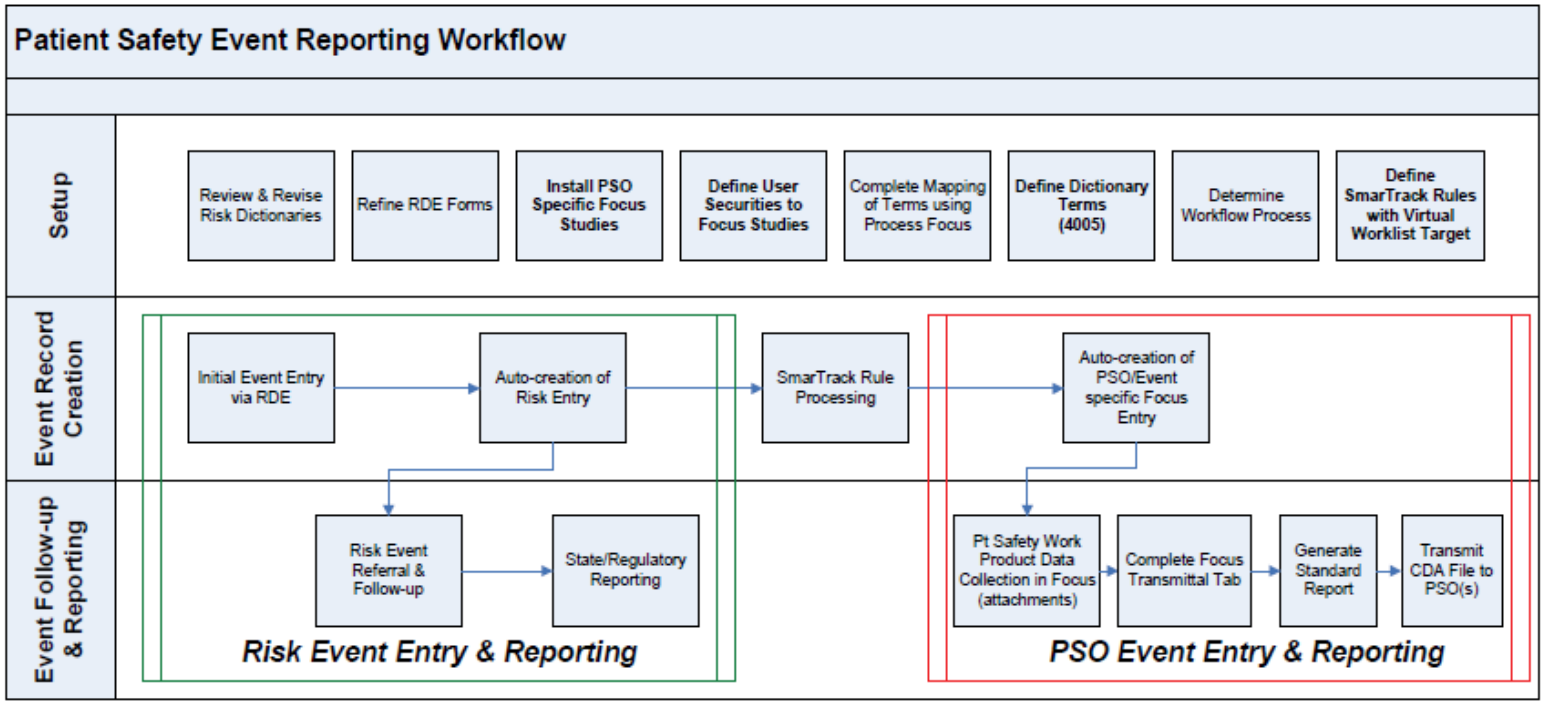
PSWP applies to information that is privileged and confidential under the Patient Safety Rule. For details on what information can, and cannot, become PSWP, the applicable process and purpose requirements, and the important role of the provider's patient safety evaluation system, see the definition of patient safety work product in section 3.20 of the Patient Safety Rule.

http://www.pso.ahrq.gov/faq

Toolkit Benefits

- Risk management process is maintained
- Specific fields are mapped from the Risk Module to the PSO Focus Study
  - Facilitates standardized data for submission to a PSO
  - Eliminates the need to modify client dictionaries
  - Minimizes duplicate data entry
- Flexible data collection and reporting process
- Extraction file created to latest AHRQ specifications – Version 1.2
- Utilize Midas+ reporting tools
- Ongoing maintenance of this Toolkit provided by Midas+

Suggested Data Flow



Standard Protection

Note that the original RDE entry and the auto-created Risk Event sit in this area and are available for internal performance improvement and mandatory reporting. The AHRQ Rule does not apply to data in this area. Only the System Manager, and those with special authorization, can identify the events that have been sent to the PSO, or access the data in the PSO event specific Focus.

AHRQ PSWP Protection

The Focus that is created by a SmarTrack rule is considered PSWP and is completed by the individual designated as part of the PSWP Team. Note that additional documentation can be attached to the Focus, and are also considered PSWP. The data here can be reported to the PSO, or at the discretion of the site, the PSO may access this data directly by logging into Midas+.

Where do I begin?

- Establish Risk Remote Data Entry and Risk Event processes
- Identify which Risk Events will qualify for the Midas+ AHRQ PSO AC Focus Study
- Setup the Midas+ AHRQ PSO AC Mapper Process Focus Study

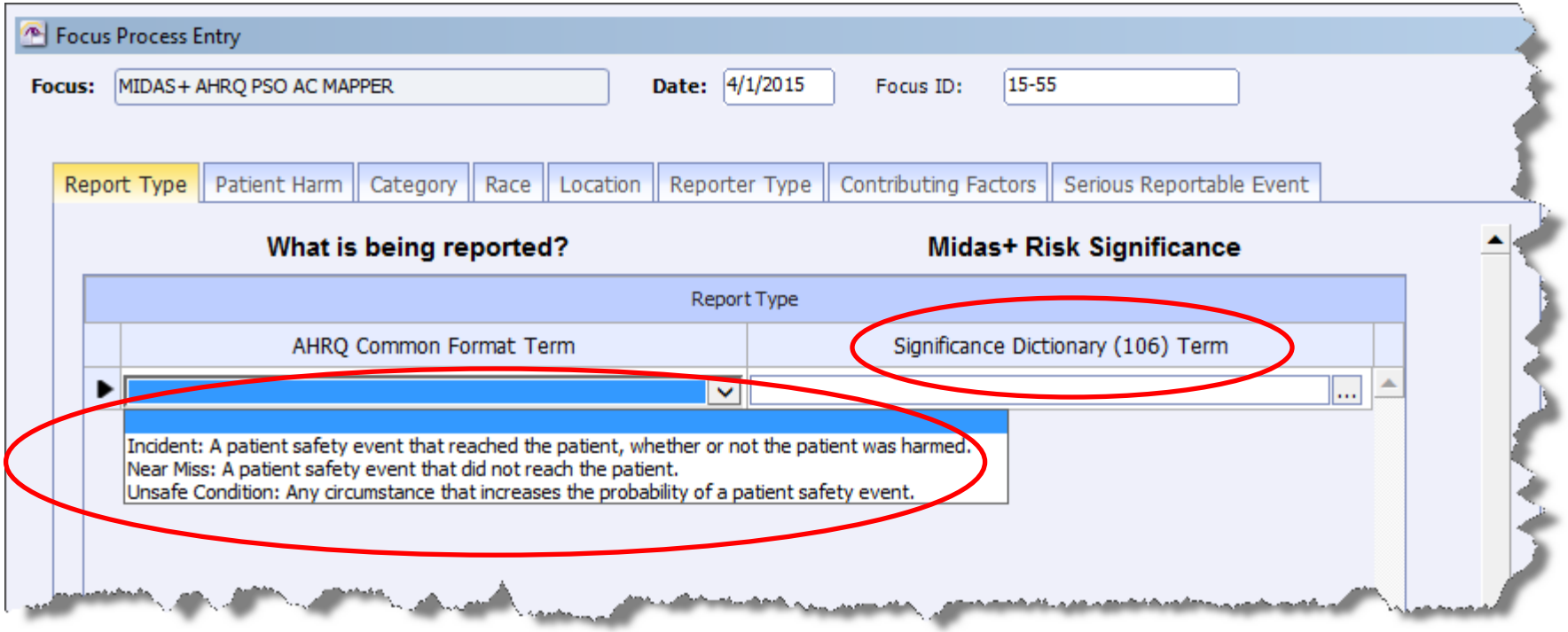
Mapping to AHRQ Common Format Terms

- Create one episode of the Midas+ AHRQ PSO AC Mapper Process Focus Study
- Use each tab to map user-defined dictionary terms to Common Format terms
  - Each user-defined term may only be mapped to one Common Format term
  - Each Common Format term may be mapped multiple times
  - May prompt the need to review user-defined dictionary terms

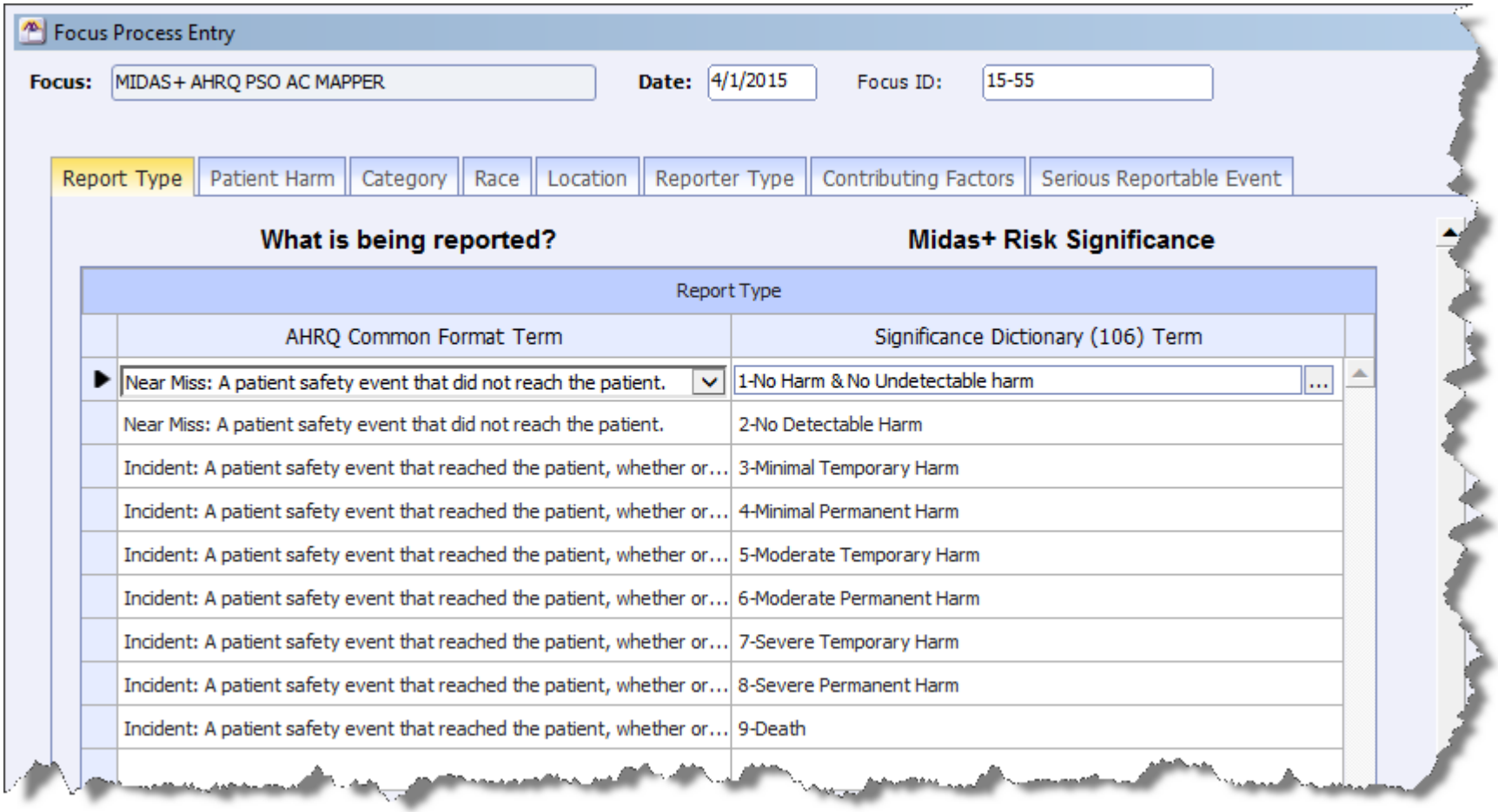
Which data fields can be mapped?

Question	AHRQ Terms	Midas+ Dictionary Name (Code)
What is being reported?	All related	Significance (106)
New: After any intervention to reduce harm, what was the degree of residual harm to the patient from the incident (and subsequent intervention)?	All related	Significance (106)
New: What is the anticipated duration of the harm to the patient?	All related	Significance (106)
Which of the following categories are associated with the event or unsafe condition?	All related	Risk Event Class (192)
Where did the event occur, or, if an unsafe condition, where does it exist?	All related	Location (5)
Who reported the event or unsafe condition?	All related	Info Source (97)
What factor(s) contributed to the event?	All related	Risk Parameters (139)
Was the event a National Quality Forum (NQF) Serious Reportable Event?	Yes only	Risk Outcome (36)
What was the applicable Serious Reportable Event?	All related	Risk Event Class (192) **or** Risk Event Type (8)
What is the patient's race?	All related	Registration: Ethnic Group (166)

Mapping Example

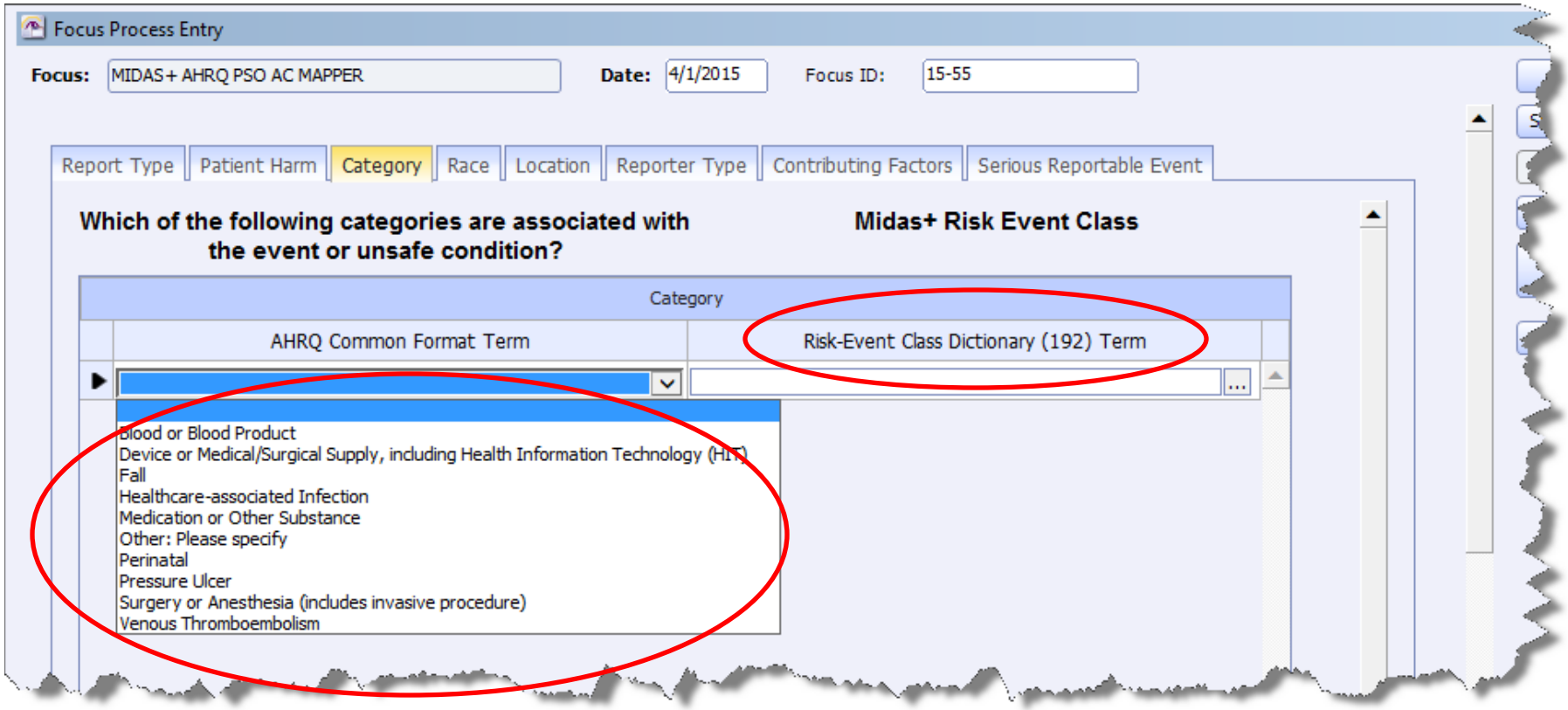


Mapping Example *(continued)*



Mapping Example *(continued)*

Mapping Example *(continued)*

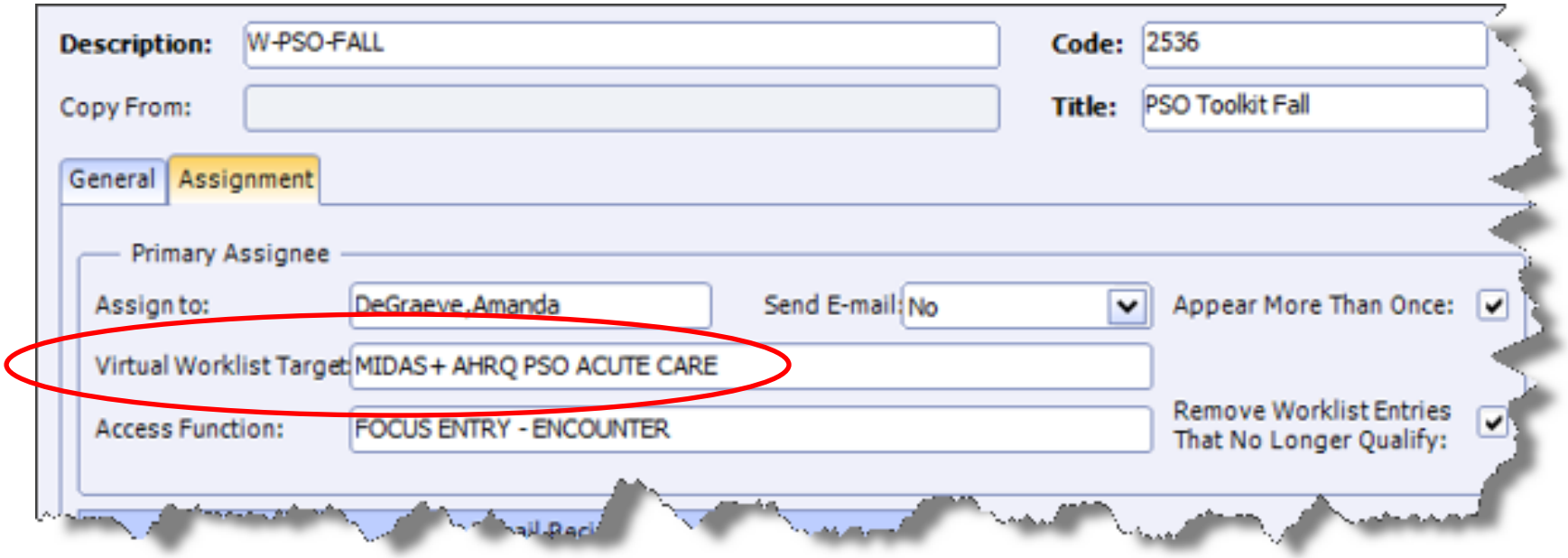


Which data fields will default?

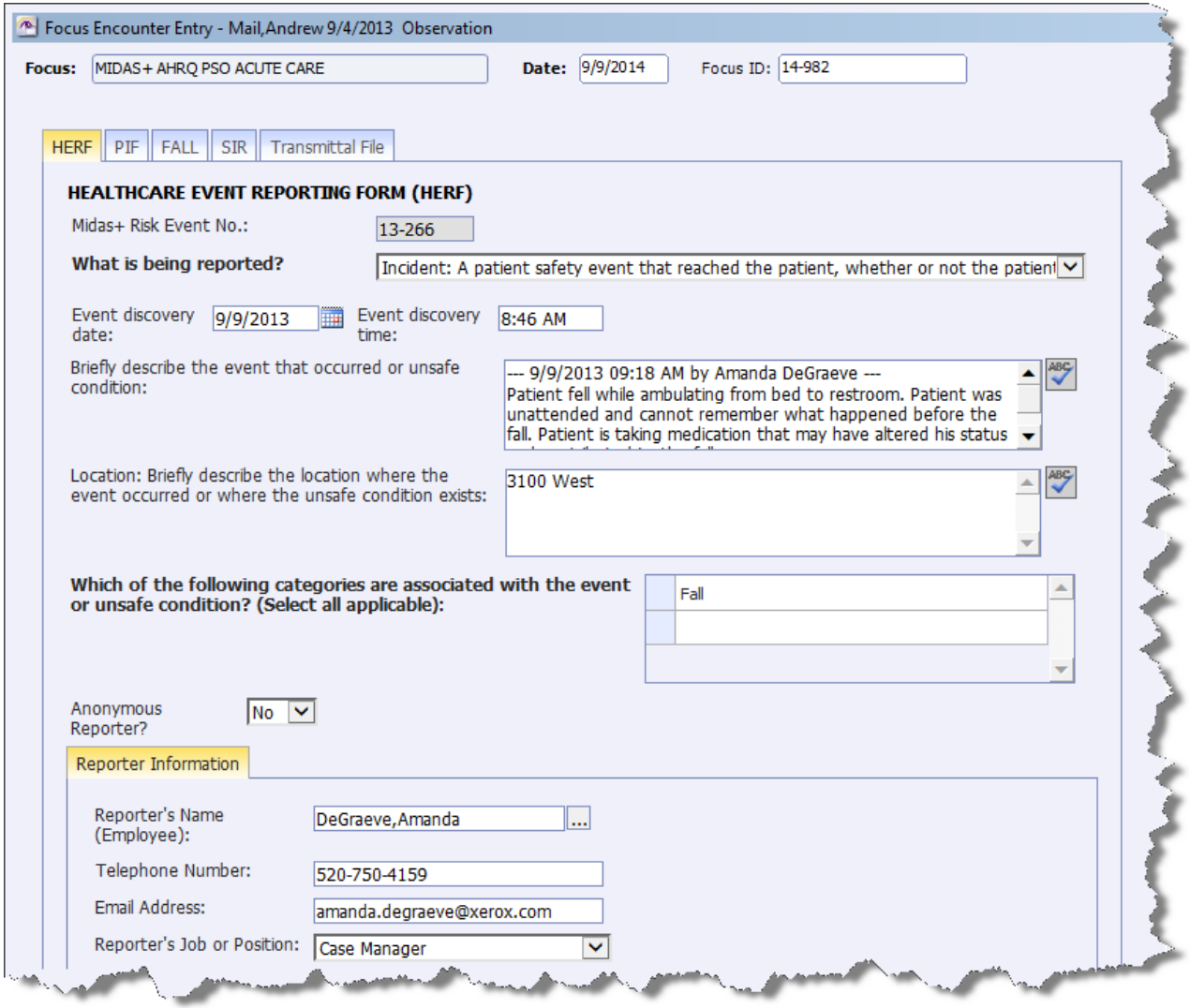
PSO Focus term	Copy from
Anonymous reporter?	Risk:Entered by if RDE,Risk@
Anonymous reporter?	Risk:Entered by if not RDE,Risk@ OR null
Description of event or unsafe condition	Risk:Comments
Description of location of event or unsafe condition	Risk:Location
Event discovery date	Risk:Event Date
Event discovery time?	Risk:Event Time
Hispanic or Latino Descent	Registration: Hispanic
Initial report date (Focus Date)	Risk: Last Update Date upon creation of PSO Focus
Midas+ Risk Event No.	Risk:Event No.
Patient age at event	Calculated based on Date of Event and Date of Birth
Principal diagnosis code at discharge	Encounter:Diagnosis Principal (Code)
Reporter's Email Address	Risk:Entered by Employee Dictionary: Email
Reporter's Job or Position	Risk:Entered by Employee Dictionary:Job Title
Reporter's Name	Risk:Entered by Employee Dictionary: Name
Reporter's Phone	Risk:Entered by Employee Dictionary: Telephone

Add Worklist/Rule Definition with Virtual Worklist Target

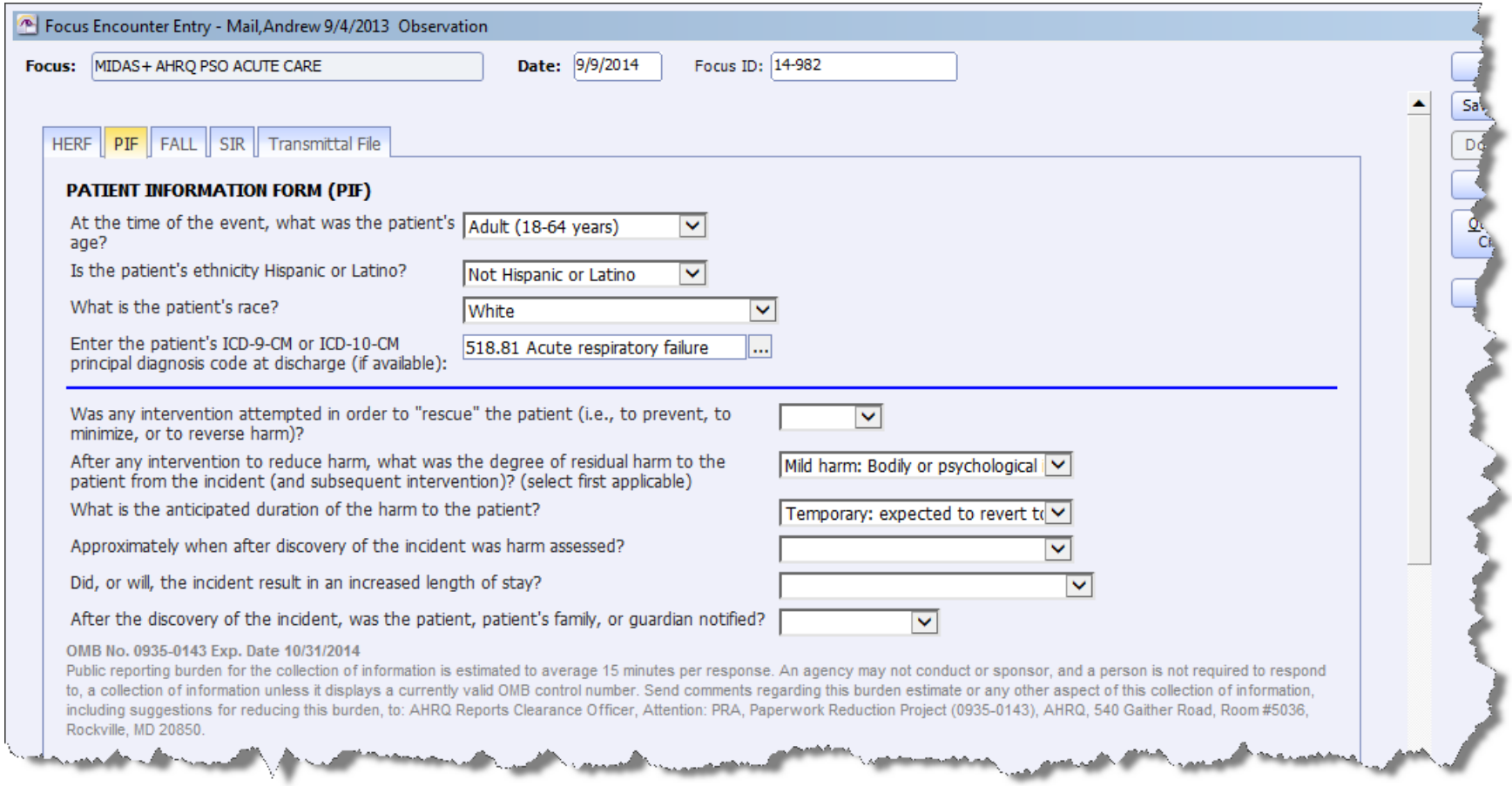
- Define one or more Worklist/Rule Definitions



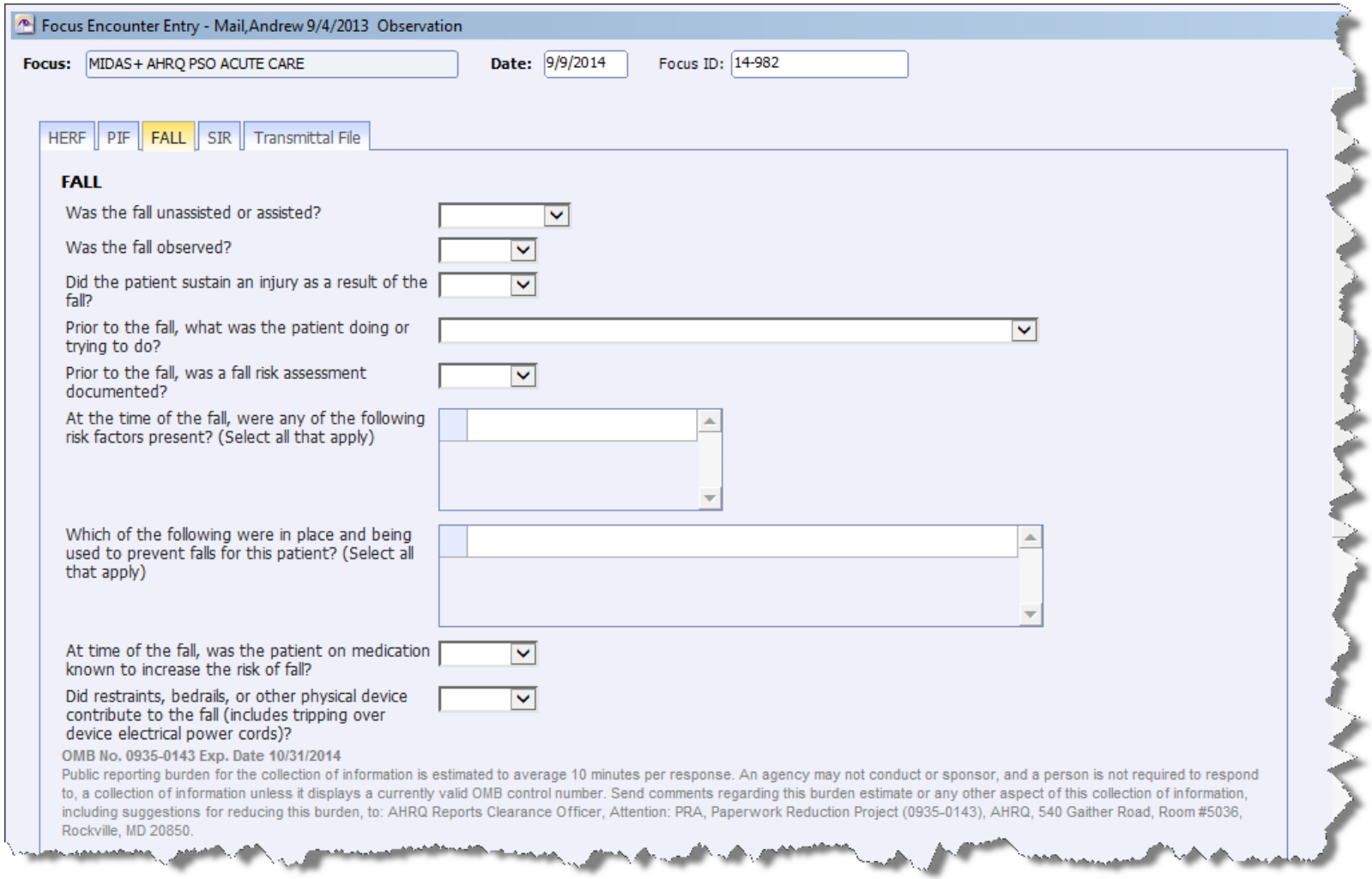
HERF Tab


Focus Encounter Entry - Mail,Andrew 9/4/2013 Observation
Focus: MIDAS+ AHRQ PSO ACUTE CARE
Date: 9/9/2014
Focus ID: 14-982
HERF
PIF
FALL
SIR
Transmittal File
HEALTHCARE EVENT REPORTING FORM (HERF)
Midas+ Risk Event No.: 13-266
What is being reported?
Incident: A patient safety event that reached the patient, whether or not the patient
Event discovery date: 9/9/2013
Event discovery time: 8:46 AM
Briefly describe the event that occurred or unsafe condition:
--- 9/9/2013 09:18 AM by Amanda DeGraeve ---
Patient fell while ambulating from bed to restroom. Patient was unattended and cannot remember what happened before the fall. Patient is taking medication that may have altered his status
Location: Briefly describe the location where the event occurred or where the unsafe condition exists:
3100 West
Which of the following categories are associated with the event or unsafe condition? (Select all applicable):
Fall
Anonymous Reporter?
No
Reporter Information
Reporter's Name (Employee):
DeGraeve,Amanda
Telephone Number:
520-750-4159
Email Address:
amanda.degraeve@xerox.com
Reporter's Job or Position:
Case Manager

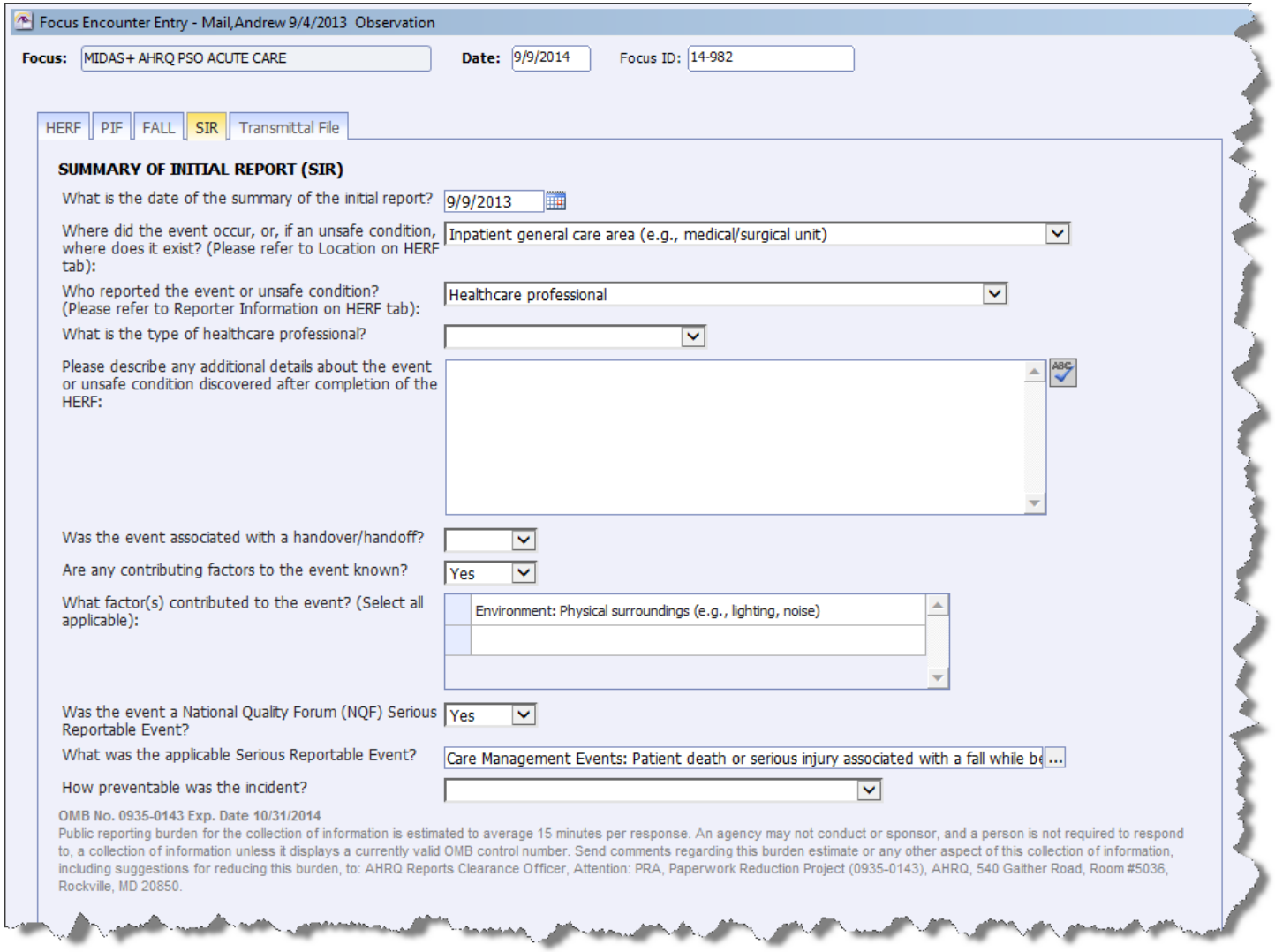
PIF Tab


Focus Encounter Entry - Mail,Andrew 9/4/2013 Observation
Focus: MIDAS+ AHRQ PSO ACUTE CARE
Date: 9/9/2014
Focus ID: 14-982
HERF
PIF
FALL
SIR
Transmittal File
PATIENT INFORMATION FORM (PIF)
At the time of the event, what was the patient's age?
Adult (18-64 years)
Is the patient's ethnicity Hispanic or Latino?
Not Hispanic or Latino
What is the patient's race?
White
Enter the patient's ICD-9-CM or ICD-10-CM principal diagnosis code at discharge (if available):
518.81 Acute respiratory failure
Was any intervention attempted in order to "rescue" the patient (i.e., to prevent, to minimize, or to reverse harm)?
After any intervention to reduce harm, what was the degree of residual harm to the patient from the incident (and subsequent intervention)? (select first applicable)
Mild harm: Bodily or psychological
What is the anticipated duration of the harm to the patient?
Temporary: expected to revert t
Approximately when after discovery of the incident was harm assessed?
Did, or will, the incident result in an increased length of stay?
After the discovery of the incident, was the patient, patient's family, or guardian notified?
OMB No. 0935-0143 Exp. Date 10/31/2014
Public reporting burden for the collection of information is estimated to average 15 minutes per response. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: AHRQ Reports Clearance Officer, Attention: PRA, Paperwork Reduction Project (0935-0143), AHRQ, 540 Gaither Road, Room #5036, Rockville, MD 20850.

Event-specific Tab



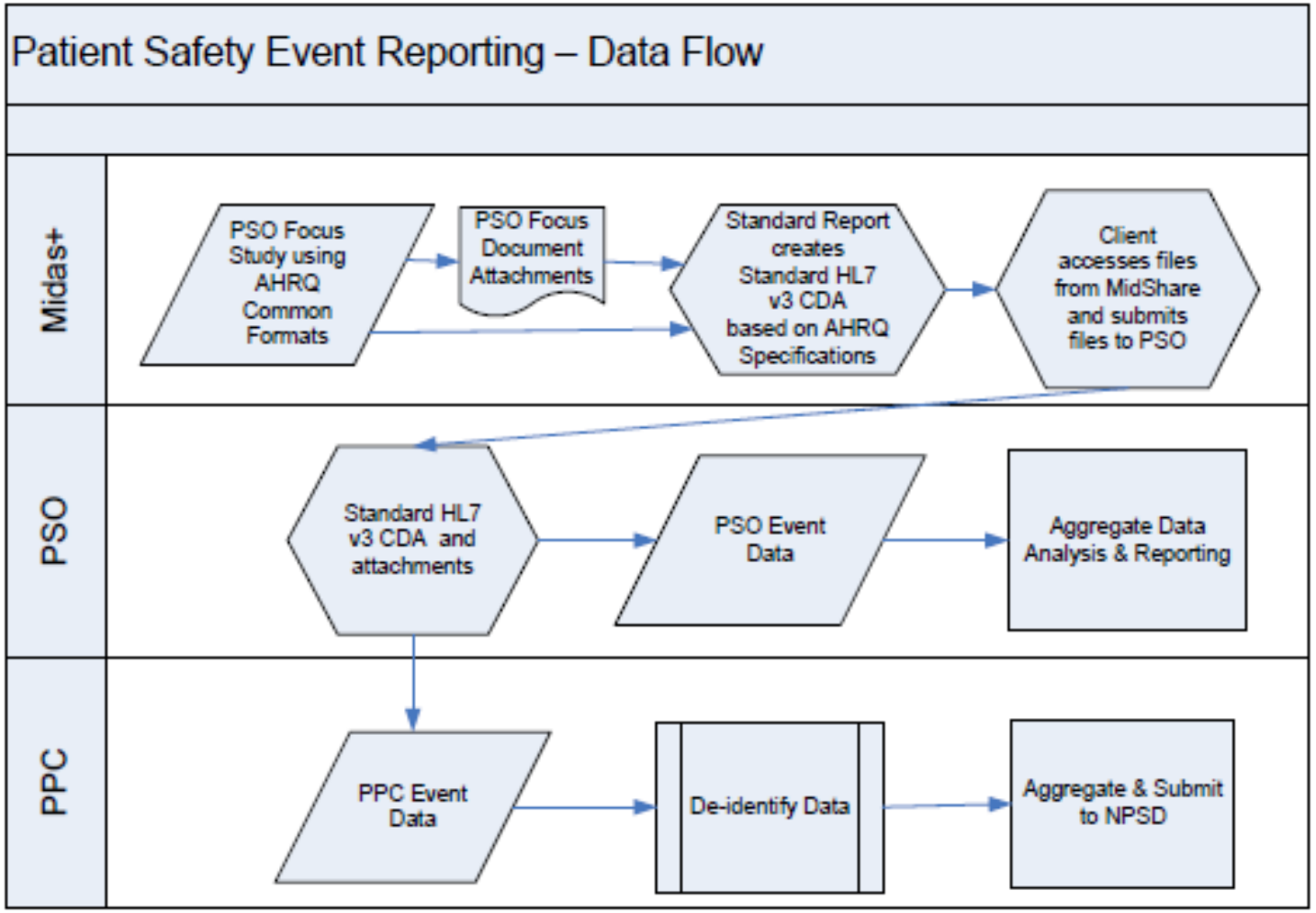
SIR Tab


Focus Encounter Entry - Mail,Andrew 9/4/2013 Observation
Focus: MIDAS+ AHRQ PSO ACUTE CARE
Date: 9/9/2014
Focus ID: 14-982
HERF
PIF
FALL
SIR
Transmittal File
SUMMARY OF INITIAL REPORT (SIR)
What is the date of the summary of the initial report? 9/9/2013
Where did the event occur, or, if an unsafe condition, where does it exist? (Please refer to Location on HERF tab): Inpatient general care area (e.g., medical/surgical unit)
Who reported the event or unsafe condition? (Please refer to Reporter Information on HERF tab): Healthcare professional
What is the type of healthcare professional?
Please describe any additional details about the event or unsafe condition discovered after completion of the HERF:
Was the event associated with a handover/handoff?
Are any contributing factors to the event known? Yes
What factor(s) contributed to the event? (Select all applicable): Environment: Physical surroundings (e.g., lighting, noise)
Was the event a National Quality Forum (NQF) Serious Reportable Event? Yes
What was the applicable Serious Reportable Event? Care Management Events: Patient death or serious injury associated with a fall while be
How preventable was the incident?
OMB No. 0935-0143 Exp. Date 10/31/2014
Public reporting burden for the collection of information is estimated to average 15 minutes per response. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to: AHRQ Reports Clearance Officer, Attention: PRA, Paperwork Reduction Project (0935-0143), AHRQ, 540 Gaither Road, Room #5036, Rockville, MD 20850.

Data extraction and submission

- Complete the Transmittal File Tab
  - Midas+ user must have PSO Transmittal Role assigned
- Compile the Midas+ AHRQ PSO Acute Care Extraction File via Standard Reports
- Access the extracted files from the Midshare folder
- Submit data to PSO(s)

Where does the data go?



Juvo Care Performance

- Juvo Risk Management incorporates AHRQ Common Formats v1.2 and retains most frequently-used fields from Midas+ Care Management.
  - Shift, Info Source, Notified Physician
  - Parameters, Outcomes, Attribution, Witnesses
  - Referrals
    - *Plus…Referral email with hyperlink access to event*
- Value-added features:
  - FDA MedWatch Device fields & automated FDA3500A report
  - Events are auto-set to “OK to Submit” (Risk Manager can edit)
  - Submission Manager function

Future of patient safety event reporting

As of December 2013, the deadline extended to January 1, 2017

(1) ENHANCING PATIENT SAFETY.—Beginning on January 1, 2015, a qualified health plan may contract with—

(A) a hospital with greater than 50 beds only if such hospital—

(i) utilizes a patient safety evaluation system as described in part C of title IX of the Public Health Service Act; and

(ii) implements a mechanism to ensure that each patient receives a comprehensive program for hospital discharge that includes patient-centered education and counseling, comprehensive discharge planning, and post discharge reinforcement by an appropriate health care professional; or

(B) a health care provider only if such provider implements such mechanisms to improve health care quality as the Secretary may by regulation require.

(2) EXCEPTIONS.—The Secretary may establish reasonable exceptions to the requirements described in paragraph (1).

(3) ADJUSTMENT.—The Secretary may by regulation adjust the number of beds described in paragraph (1)(A).

Resources

- AHRQ website – http://www.pso.ahrq.gov
- PSO Privacy Protection Center – https://www.psoppc.org
- Midas+ Clients Only Website – https://www.midasplus.com

Additional Learning Opportunity

- AHRQ Patient Safety Webcast

  "Benefits of AHRQ Patient Safety Organizations: Success Stories from Hospital PSO Members"

  Wednesday, June 10, 2015

  2:00-3:00 PM EDT

  More information:

  - (855) 712-4412
  - PSOWebcast@westast.com

Thanks for attending.
Are there any questions?

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