Working With Patient Safety Organizations (PSOs) – The Value for Hospitals During COVID-19 and Beyond

We will get started in just a few minutes.
All lines are currently muted. We will have a Q&A period at the end of the presentation.

Chat Function: Use chat to ask a question.

Recording: This webinar will be recorded.
Working With Patient Safety Organizations (PSOs) – The Value for Hospitals During COVID-19 and Beyond

Welcome!
Speakers

• Andrea Timashenka, J.D.
  » Director, PSO Division, CQuIPS, AHRQ
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• Terrie Van Buren, R.N., B.S.N., M.B.A., C.P.P.S.
  » Vice President, Patient Safety Officer, CHS PSO, LLC
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• Janet Pue, D.P.T., N.C.S.
  » PSO Coordinator, Carolinas Rehabilitation PSO
  » Equadr@atriumhealth.org
What does AHRQ’s Patient Safety Organizations (PSO) Division do?

• Implements the Patient Safety and Quality Improvement Act of 2005 (PSQIA), including:
  ► Certifying and listing PSOs (and “de-listing” PSOs, as applicable)
  ► Developing Common Formats
  ► Maintaining the Network of Patient Safety Databases (NPSD)

• Note: The HHS Office for Civil Rights enforces compliance with the confidentiality provisions of the PSQIA.
What is a Patient Safety Organization (PSO)?

• PSOs collect and analyze data voluntarily reported by healthcare providers to help improve patient safety and healthcare quality. PSOs provide feedback to healthcare providers aimed at promoting learning and preventing future patient safety events.

• Working with a PSO makes it possible for information from healthcare providers to receive certain legal protections and to be contributed to the Network of Patient Safety Databases (NPSD).
What is a Patient Safety Organization (PSO)?

- Many “flavors” of PSOs. They vary by:
  - Profit status
  - Scope (e.g., specialist or generalist)
  - Component or own entity
  - Other characteristics
What is a Patient Safety Organization (PSO)?

• AHRQ is not involved in the providers and PSOs’ work together

• You determine with your chosen PSO(s) the scope of improvement activities that meets your organization’s specific needs
Who works with PSOs?

Under the PSQIA’s implementing regulation, providers include:

• **All types of individuals and entities** licensed or otherwise authorized under State law to provide health care services can work with a PSO.
  ▶ For example: hospitals, nursing homes, pharmacies, physicians, nurse practitioners, etc.

• Also,
  ▶ government organizations that deliver health care, and
  ▶ parent organizations* of licensed provider entities and government organizations that deliver health care.

*See Patient Safety Rule at 42 C.F.R. §3.20 for definition of parent organization.
Who works with PSOs?

• According to a 2018 survey conducted by HHS’ Office of the Inspector General (OIG), 59% of general acute-care hospitals participating in Medicare work with a PSO.

• The OIG found that among hospitals that work with a PSO:
  ► 97% find it valuable
  ► 80% found the PSO’s feedback and analysis helped prevent future patient safety events

OIG Report: Patient Safety Organizations: Hospital Participation, Value, and Challenges
What is protected under the PSQIA?

• Information that meets the definition of “patient safety work product” (PSWP). It can be developed by the provider or PSO.

• The PSWP definition includes (but is not limited to):
  ► Information (any data, reports, records, analyses, statements, etc.) that
    - Could improve patient safety, health care quality, or health care outcomes and which
    - The provider assembles or develops for reporting to a PSO and are reported to a PSO
What’s the scope of the PSQIA protections for PSWP?

- The PSQIA provides **broad confidentiality and privilege protections** (inability to introduce the protected information in a legal proceeding).
- Benefits of the PSQIA protections:
  - **Nationwide and uniform.** Apply in all U.S. states and territories, and across state lines.
  - **Not limited to the peer review process.** Can apply to a wide range of patient safety activities.
  - **Allows for shared learning.** For example, a health care system can pool data and share experiences across facilities and clinicians.
  - **Backed by penalties.** The PSQIA imposes significant monetary penalties for violations of the confidentiality provisions.
Why start working with a PSO now?

• COVID-19
  ► Increased stress on healthcare systems
  ► Potential new patient safety issues

• PSOs can help!
  ► **Reduce burden on your organization**: Use the PSO’s expertise to analyze and aggregate patient safety data, and to develop customized approaches to improve quality and reduce adverse outcomes.
  ► **Increased data volume**: A PSO can identify and help your organization learn from rare and novel events, even before they happen to you.
Where Can I Learn More About PSOs?

- Visit the PSO website: https://pso.ahrq.gov, including:
  - Work With a PSO section
  - Resources, such as:
    - Choosing a PSO Brochure
    - Working with a PSO: One Approach
  - Listed PSOs page
What if I still have questions?

- **Contact us!**
  - Email: PSO@ahrq.hhs.gov
  - Telephone (toll free): 866–403–3697
  - Telephone (local): 301–427–1111
  - TTY (toll free): 866–438–7231
  - TTY (local): 301–427–1130
Terrie Van Buren, Vice President
Patient Safety Officer
CHS PSO, LLC
About the CHS PSO, LLC

• CHS PSO is a component PSO
  o As a component PSO, patient safety work product must remain separate from the rest of the parent organization.
  o We do share staff….

• AHRQ approved & officially listed CHS PSO, LLC effective 1/11/12 as a component PSO of CHS/Community Health Systems, Inc. Continued Listing 2015, 2018, and 2021.

• Only CHS affiliated provider (including Physician Office Practice & ASC’s) are members of the PSO as evidenced by executed membership agreements
How we became PSO

- Engaged outside counsel expertise
  B. Page Gravely, Jr.
  804.967.9604  pgravely@hancockdaniel.com
- Determined operational structure, dedicated and shared staff (LLC, Board of Directors)
- Developed policies and procedures, workflow, both at the PSO and member provider levels
- Insourced and developed IT platform for our Patient Safety Evaluation System – security/confidentiality (6 months)
- Executed member provider agreements and leader confidentiality agreements
- Hosted webinars for member providers to orient them to the CHS PSO, member and PSO responsibilities, PSQIA Act protections, confidentiality provisions, policies, quarterly attestations, flow of patient safety work product
- Organized and chartered quarterly Patient Safety and Medication Safety Councils of subject matter experts, CHS PSO and member staff
  - Review current issues in our industry, trends, issues, common causes
  - Prioritize and focus patient safety and quality efforts
  - IT platform opportunities for improvement
  - Dissemination of alerts, lessons learned, education
PSO Activities

• Efforts to improve patient safety and quality of health care delivery
• Collection and analysis of patient safety work product (PSWP)
• Operates a patient safety evaluation system (PSES) with feedback to participants
• Member/PSO operating policies and procedures which define roles at each provider to submit and receive PSWP, confidentiality and privilege, and ‘How to report to PSO (SBAR format)’:
  • Event Reporting (Safety Event/Sentinel event)
  • Patient Safety Plan
  • Root Cause Analysis
  • Confidentiality and Privilege of PSWP
  • PSWP Security Policies and Procedures
  • Responding to Requests for PSWP
  • CHS PSO Hospital Operating Policy and Procedure
PSO Activities

• Monthly, department specific, annual Comprehensive Risk Assessment
  – lessons learned from past events and ISMP recommendations high-alerts
• Quarterly CHS PSO, LLC Orientation- virtual workshop (2 hours)
• Standardized RCAs
  – Quarterly Cause Analysis virtual workshops (Press Ganey/HPI model) approx. 3500 have taken this course since 2014
• Bimonthly, anonymous Safety Event “Coaching Call” - “Safe Tables” – moderated by CHS PSO staff
• Online, web-based education on key Patient Safety topics
• Education and support of Highly Reliable Organization journey
• Development and dissemination of information regarding patient safety, such as recommendations, protocols, or information regarding best practices
  a. SBAR Safety Alerts
  b. Patient Safety Communication (designated to/from)
  c. Patient Safety Alerts
  d. Guidance Re: Sentinel Event Alerts, ISMP, etc.
  e. Quarterly, comparative analysis reports by region in the PSES (APD rates)
The purpose of this Patient Safety Alert is to share common causes for recent SSEs related to the COVID-19 pandemic and reopening efforts and to initiate preventative strategies to guard against deviations in ‘safety critical’ policies and procedures. 

Committed to Quality and Safety

By leveraging techniques from high-risk industries such as nuclear power and aviation, CHS is creating inherently safe hospital environments for patients and staff.

**DRIVERS OF HIGH RELIABILITY & SAFETY**

- **SAFETY IS A CORE VALUE**
- **STANDARDIZED PROGRAM ELEMENTS**
- **PEOPLE, PROCESS, & TECHNOLOGY**

**SERIOUS SAFETY EVENT RATE (SSER)**

Consistent Reduction

NOTE: Hospitals are compared to an April 2013 baseline, same store as of 9.1.20.
THANK YOU!
Staying Ahead of the Curve: How PSO Participation Impacts Quality and Patient Safety Performance

Janet Pue, DPT, NCS
Carolinas Rehabilitation PSO Coordinator
EQUADR@atriumhealth.org
Who is Atrium Health
About Carolinas Rehabilitation PSO EQUADR\textsuperscript{SM} (Exchanged Quality Data for Rehabilitation)

- Component PSO of Atrium Health
- Designated as a PSO in 2010
- First PSO dedicated to rehabilitation care
- Fee based
- 42 IRFs or IRUs currently enrolled and submitting data on rehab-specific quality measures
The EQUADR™ Network Members
### The EQUADRSM Network Members

<table>
<thead>
<tr>
<th></th>
<th>Adventist HealthCare Rehabilitation Rockville, MD</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Adventist HealthCare Rehabilitation Takoma Park, MD</td>
</tr>
<tr>
<td>3</td>
<td>Baptist Health Rehabilitation Institute Little Rock, AR</td>
</tr>
<tr>
<td>4</td>
<td>Brooks Rehabilitation Hospital Jacksonville, FL</td>
</tr>
<tr>
<td>5</td>
<td>Burke Rehabilitation Hospital White Plains, NY</td>
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<td>6</td>
<td>Carolinas Rehabilitation Charlotte, NC</td>
</tr>
<tr>
<td>7</td>
<td>Centra Acute Rehabilitation Center Lynchburg, VA</td>
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<tr>
<td>8</td>
<td>Cone Health Rehabilitation Center Greensboro, NC</td>
</tr>
<tr>
<td>9</td>
<td>Cottage Rehabilitation Hospital Santa Barbara, CA</td>
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<tr>
<td>10</td>
<td>Craig Hospital Englewood, CO</td>
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<tr>
<td>11</td>
<td>Good Shepherd Rehabilitation Hospital Allentown, PA</td>
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<tr>
<td>12</td>
<td>Helen Hayes Hospital West Haven, CT</td>
</tr>
<tr>
<td>13</td>
<td>Innovia Rehabilitation Center Alexandria, VA</td>
</tr>
<tr>
<td>14</td>
<td>Intermountain Healthcare Ogden, UT</td>
</tr>
<tr>
<td>15</td>
<td>J.L. Bedsole/Rotary Rehabilitation Hospital Mobile, AL</td>
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<tr>
<td>16</td>
<td>Magee Rehabilitation Philadelphia, PA</td>
</tr>
<tr>
<td>17</td>
<td>Mary Free Bed Rehabilitation Hospital Grand Rapids, MI</td>
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<tr>
<td>18</td>
<td>Memorial Hermann Katy Rehabilitation Katy, TX</td>
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<tr>
<td>19</td>
<td>Memorial Rehabilitation Institute at MRHS Hollywood, FL</td>
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<tr>
<td>20</td>
<td>Methodist Rehabilitation Center Jackson, MS</td>
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<tr>
<td>21</td>
<td>MossRehab Elkton, PA</td>
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<tr>
<td></td>
<td>National Rehabilitation Hospital Washington, DC</td>
</tr>
<tr>
<td>22</td>
<td>New Hanover Regional Medical Center Wilmington, NC</td>
</tr>
<tr>
<td>23</td>
<td>Ohio State University Wexner Medical Center Dodd Hall Inpatient Rehabilitation Columbus, OH</td>
</tr>
<tr>
<td>24</td>
<td>Pineville Rehabilitation Hospital Pineville, NC</td>
</tr>
<tr>
<td>25</td>
<td>Rehabilitation Hospital Nantucket Health Nantucket, MA</td>
</tr>
<tr>
<td>26</td>
<td>Rehabilitation Hospital of Indiana Indianapolis, IN</td>
</tr>
<tr>
<td>27</td>
<td>Rehabilitation Institute of Michigan Detroit, MI</td>
</tr>
<tr>
<td>28</td>
<td>Reid Hospital Richmond, IN</td>
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<tr>
<td>29</td>
<td>Roger Rehabilitation Hospital Charleston, SC</td>
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<tr>
<td>30</td>
<td>Scotland HealthCare System LaFayette, NC</td>
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<tr>
<td>31</td>
<td>Shirley Ryan AbilityLab Chicago, IL</td>
</tr>
<tr>
<td>32</td>
<td>St. John Hospital for Physical Rehabilitation Chattanooga, TN</td>
</tr>
<tr>
<td>33</td>
<td>Spaulding Rehabilitation Hospital Boston, MA</td>
</tr>
<tr>
<td>34</td>
<td>Spaulding Rehabilitation Hospital Cape Cod East Sandwich, MA</td>
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<tr>
<td>35</td>
<td>Sunnyview Rehabilitation Hospital Schenectady, NY</td>
</tr>
<tr>
<td>36</td>
<td>TIRR Memorial Hermann Houston, TX</td>
</tr>
<tr>
<td>37</td>
<td>University of Michigan Inpatient Rehabilitation Facility Ann Arbor, MI</td>
</tr>
<tr>
<td>38</td>
<td>University of Utah Rehabilitation Salt Lake City, UT</td>
</tr>
<tr>
<td>39</td>
<td>Vidant Health Regional Rehabilitation Center Greenville, NC</td>
</tr>
<tr>
<td>40</td>
<td>WakeMed Rehab Hospital Raleigh, NC</td>
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What does EQUADRSM Provide?

<table>
<thead>
<tr>
<th>Facility-level data reported</th>
<th>Data from all participating facilities is aggregated</th>
<th>Quarterly conference calls/Safe Tables</th>
</tr>
</thead>
</table>
| • Quarterly  
  • Monthly  
  • Secure web portal | • Compare performance against EQUADRSM members  
  • Comparison Groups: Acuity, Size, IRF/IRU | • General webinar and Infection Prevention/Pediatric webinar (8 Total)  
  • Review data/trends  
  • Share best practices and discuss challenges |
Membership Guide and Data Specifications

- Definitions and specifications for each measure
- Instructions and deadlines for reporting process
- Measures reviewed annually at Measurement Consensus Work Groups
EQUADR℠ Advisory Council

- Established Jan 2016
- Comprised of representatives from EQUADR℠ members
- Includes permanent seats and rotating seats
- Provide a member’s perspective on matters related to strategic growth and development
# EQUADR™ Data Screen

<table>
<thead>
<tr>
<th>Data Year: 2018</th>
<th>Data Quarter: 3</th>
<th># of Beds: 182</th>
</tr>
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<tbody>
<tr>
<td><strong>Metrics</strong></td>
<td>April</td>
<td>May</td>
</tr>
<tr>
<td>Total Patient Days °</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Discharges °</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Discharges to Acute Care - Early</strong></td>
<td>April</td>
<td>May</td>
</tr>
<tr>
<td>No Data</td>
<td></td>
<td></td>
</tr>
<tr>
<td># of Patients Discharged to Acute care on or before rehab day °</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent of Early Acute Care Discharges</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td><strong>Discharges to Acute Care - Late</strong></td>
<td>April</td>
<td>May</td>
</tr>
<tr>
<td>No Data</td>
<td></td>
<td></td>
</tr>
<tr>
<td># of Patients Discharged to Acute care after rehab day °</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent of Late Acute Care Discharges</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td><strong>Discharges to Acute Care - Planned</strong></td>
<td>April</td>
<td>May</td>
</tr>
<tr>
<td>No Data</td>
<td></td>
<td></td>
</tr>
<tr>
<td># of Patients Discharged to Acute Care as planned</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percent of Planned Acute Care Discharges</td>
<td>%</td>
<td>%</td>
</tr>
<tr>
<td><strong>Physical Restraints Usage</strong></td>
<td>April</td>
<td>May</td>
</tr>
<tr>
<td>No Data</td>
<td></td>
<td></td>
</tr>
<tr>
<td># of Restraint Days</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rate of Restraint Days per 1,000 patient days</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Falls (Assisted &amp; Unassisted Falls)</strong></td>
<td>April</td>
<td>May</td>
</tr>
<tr>
<td>No Data</td>
<td></td>
<td></td>
</tr>
<tr>
<td># of Falls</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Falls per 1,000 Patient Days</td>
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</tbody>
</table>
EQUADR™ Data

Over 5.5 Million Patient Days Worth of Data in the Database
Current EQUADR<sup>SM</sup> Measures

- Discharges to Acute Care
  - Early, Late, Planned, Unplanned
- Restraint Utilization
- Falls/Unassisted Falls
  - By Diagnosis Group
- Injuries Resulting from Falls/Unassisted Falls
  - By Diagnosis Group
- Pressure Injuries
- Venous Thromboembolism

- Healthcare-Associated MRSA Infections
- Healthcare-Associated C. difficile Infections
- Healthcare-Associated CAUTI Infections
- Oncology Specific Metrics
- Outpatient Therapy Falls
- Pediatric Specific Metrics
- Labor & Productivity
Quartile Performance - Last 4 Quarters

Sample data used for demonstration purposes
Discharges to Acute Care

Sample data used for demonstration purposes
Sample data used for demonstration purposes
Each Quarter, facilities may compare their results to 4 Comparison Groups:

- **Acuity** = facilities of similar acuity based on average CMI
- **Size** = facilities of similar size based on average daily census
- **Facility Type** = similar type facilities, i.e. free standing (IRF) vs inpatient rehab units (IRU)
- **ALL** = overall EQUADRSM aggregate rates of our entire membership.

### Discharges to Acute Care

<table>
<thead>
<tr>
<th></th>
<th>Q3 2013</th>
<th>YTD 2018</th>
<th>Q2 Low</th>
<th>Q3 High</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Gh</td>
<td>Gh</td>
<td>Gh</td>
<td>Gh</td>
</tr>
<tr>
<td>Acuity: Tier 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acuity: Tier 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>IRF</td>
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<tr>
<td>ALL</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Size: Tier 3</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>GH</td>
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</tr>
<tr>
<td>ALL</td>
<td></td>
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</tr>
</tbody>
</table>

Sample data used for demonstration purposes
“The measure of success is not whether you have a tough problem to deal with, but whether it is the same problem you had last year.”

– John Foster Dulles
Best Practice Sharing

2019
• Our Recent TJC Survey Experience
• Eliminating CAUTI among patients with spinal cord injuries
• PME: Personalized Medication Experience
• Influenza Outbreak Management in Rehabilitation Settings
• School of Nursing Outreach Program
• Writing an Infection Control Plan for Joint Commission Survey
• Durability of Outcomes/Readmission Prevention/Chronic Disease Management Discussion
• C Difficile
• IRF-PAI Changes

2020
• Developing a “Usual” Strategy
• MRSA: Are Isolation Precautions Necessary?
• COVID-19 Experience
• Flexibility and Teamwork in the age of COVID
• Reduction in Catheter-Associated Urinary Tract Infections (CAUTIs)
EQUADR℠ COVID-19 Webinars

• What are you seeing? What do these patients look like?
• Setting up separate units (staff, gym space)
• Adapting equipment
• Visitor restrictions
• Criteria for moving patients off a COVID unit
• Redeployment opportunities
• Clearance for patients to go to rehab, SNF, dialysis
• Patients experiencing isolation depression
• Use of virtual family training
• CMS waivers
• Re-entry measures
• Teammate appreciation and engagement

Source: statnews.com
Restraint Utilization

()} (Restraint Days per 1,000 Patient Days)

58.4% Decrease from 2010 to 2019
Unassisted Falls

(Unassisted Falls per 1,000 Patient Days)

37.7% Decrease from 2010 to 2019
MRSA Bacteremia LabID Events

Healthcare Facility – Onset MRSA Bacteremia LabID Events
(Infections per 1,000 Patient Days)

91.9% Decrease from 2010 to 2015
33.3% Decrease from 2015-2019

Only blood specimens reported
C. difficile LabID Events

Healthcare Facility – Onset C. difficile LabID Events
(Infections per 10,000 Patient Days)

55.1% Decrease from 2012 to 2019
Catheter-Associated Urinary Tract Infections

Healthcare-Associated (Infections per 1,000 Device Days)

64.6% Decrease from 2010 to 2019
Urinary Catheter Utilization Ratio

(Device Days / Patient Days)

50.0% Decrease from 2011 to 2019
### EQUADR<sup>SM</sup> Cost Savings 2010 to 2019

<table>
<thead>
<tr>
<th>EQUADR&lt;sup&gt;SM&lt;/sup&gt; Adverse Event</th>
<th>Events Averted (rounded)</th>
<th>Cost Per Event 2010/2014</th>
<th>Overall Cost Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td>MRSA</td>
<td>195</td>
<td>$1,580</td>
<td>$308,074</td>
</tr>
<tr>
<td>CAUTI</td>
<td>307</td>
<td>$1,000 / $13,493</td>
<td>$1,590,784</td>
</tr>
<tr>
<td>C. difficile</td>
<td>229</td>
<td>$9,600 / $17,260</td>
<td>$3,641,305</td>
</tr>
<tr>
<td>Unassisted Falls w/injury</td>
<td>171</td>
<td>$7,234 / $6,694</td>
<td>$1,151,982</td>
</tr>
<tr>
<td>Pressure Ulcer</td>
<td>247</td>
<td>$17,000 / $14,506</td>
<td>$3,780,804</td>
</tr>
<tr>
<td>VTE</td>
<td>120</td>
<td>$8,000 / $17,367</td>
<td>$1,840,217</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>1270</strong></td>
<td></td>
<td><strong>$12,313,166</strong></td>
</tr>
</tbody>
</table>
2019 AHA Quest For Quality Prize
Value of Sharing Through a PSO

• Sharing of processes and outcomes
  o Reduces individual facility “trial and error”
  o Develops understanding of industry averages, as well as reasonable expectations for improvement
  o Rapid dissemination of best practices across the industry

• Move from a culture of reporting to one of performance
  o Reporting is a must
  o Utilize the data that you must report to gain value from other’s performance and experience
Value of Sharing Through a PSO

- Justifies the importance and uniqueness of inpatient rehabilitation in the care continuum

- Provides a “safety zone” to discuss sensitive issues such as falls and restraint use

- Sense of community – “We’re not alone!”
“Success teaches us nothing; only failure teaches…Develop the capacity to learn from experience.”

- Admiral Hyman G. Rickover
Questions?

• If you have questions, please either:
  ► Submit them through the chat feature, or
  ► Unmute yourself and ask