Safety and Quality Improvement at Scale

Establishing and Leveraging a Network of Patient Safety Committees across a Large National Practice Participating in a Patient Safety Organization

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Disclosures:

None of the authors nor their immediate family members have a financial relationship with a commercial organization that has a direct or indirect interest in the content.
Purpose

Legal protection for patient safety activities vary state to state

▪ Creates variable levels of protection, more and less favorable for providers
▪ Does not provide legal protection of data across state lines
▪ Limits the ability of our large national practice of 3000+ radiologists in multiple local practices servicing all 50 states to share and learn from patient safety activities

▪ These limitations can be overcome by participation in a Patient Safety Organization (PSO) and establishing a system-wide Patient Safety Evaluation System (PSES)
What is a PSO?

PSOs were created under a federal act, the Patient Safety and Quality Improvement Act (PSQIA 42 U.S.C. § 299b-21et seq.) of 2005

- Established a system of patient safety organizations
- Encouraged reporting and discussion of adverse events, near misses, and unsafe conditions
- Provided federal level privilege and confidentiality protections

PSQIA stands for

Patient Safety and Quality Improvement Act of 2005
What is a PSO?

PSOs

- Certified and listed by the Agency for Healthcare Research and Quality (AHRQ)
- Entities that collect and analyze data reported voluntarily by health care providers to help improve patient safety and healthcare quality
- Provide feedback to healthcare providers aimed at promoting learning
Key Concepts of PSO Participation

PATIENT SAFETY WORK PRODUCT (PSWP)

Conducting **Patient Safety Activities** generates Patient Safety Work Product:
- PSWP is *privileged*
- Data, reports, records, analyses, written and oral statements
- Analyses and best practices from the PSO and shared back to with the practice and providers

PATIENT SAFETY EVALUATION SYSTEM (PSES)

- A system created by providers to collect and evaluate PSWP, and report it to our PSO
- A voluntary patient safety system designed to promote robust analysis and learning under federal privilege protection

PATIENT SAFETY ORGANIZATION (PSO)

- Receives and analyzes PSWP, provides feedback to the providers for learning and improvement in patient care delivery
Material & Methods

Expert team assembled to research and implement our national practice’s participation in a PSO and create a system-wide PSES.

- Team consisted of physicians, legal counsel and PSO manager
- Selected an AHRQ-listed PSO for participation
- PSES policy drafted to establish framework for a network of Patient Safety Committees (PSCs) formed by each locally led practice
- Each local practice’s Board adopts PSES policy and establishes their PSC through a resolution document
- Local practices select Chair of PSC, and physician and support teammate members to conduct patient safety activities
Material & Methods

Operations support for implementation of our PSES:

1. Educational videos produced, targeted to different stakeholders
   - Local practice boards
   - PSC members
   - Non-PSC member radiologists and support teammates
   - Hospital clients

2. HIPAA compliant platform built to store all PSWP and report it to PSO

3. PSO’s online event reporting tool launched initially at 2 local practices
   - For submission of patient safety events at outpatient centers

4. Ongoing support to PSCs and local practices by PSO Manager
Results

To date, 47 of our 64 local practices have signed their resolution documents to create their PSCs

- PSCs conduct regular meetings to analyze and discuss patient safety activities such as peer review, peer learning and patient safety events under federal protection
- PSCs of local practices with service locations in more than one state, including our 2 teleradiology practices, conduct patient safety activities across state lines
- PSCs store PSWP securely on the HIPAA compliant platform
- PSWP reported to PSO for analysis
- PSCs utilize PSWP as learning opportunities for all our radiologists to improve quality
Event reporting tool provides an efficient standardized platform

- For reporting and analyzing data from patient safety events at outpatient centers
- To improve patient safety locally and enterprise-wide
Conclusion

Participating in an AHRQ-listed PSO enabled our national practice to develop standardized, scalable systems to conduct all our patient safety activities and improve quality in diverse health care settings enterprise-wide under federal legal protection across state lines.