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Lessons Learned from PSO Court Cases

So what have the courts taught us? The most critical component of participating in the PSO program and protecting your protections is to deploy a specific and active Patient Safety Evaluation System (PSES). Defined under the Patient Safety Act, a PSES is a system for the collection, management, or analysis of information for reporting to or by a PSO. Though there is a great deal of flexibility in how a PSES operates, there are key elements that you should think about regarding your own system or before you create one. The following are key lessons from the PSO related court cases that will help you with the PSO process elements.

- Documentation. As with many parts of healthcare delivery, documentation is essential, and the same is true for your PSES structure. Interestingly, the implementing regulations that govern the PSO program state that a PSES is a requirement, but it is not a requirement to have a written PSES (by way of something like a policy or other document). It is recommended to do so, and from Clarity PSO's perspective, we require each participating provider to not only construct a PSES, but to also document its structure and processes. Today, the burden of proof is on the provider, so this activity is central to asserting your protections.

- Voluntary vs mandatory reporting and internal vs external reporting. Be sure you are clear on where your data is and where your data goes. If you are clear about your PSES, then you will know what you want to be protected. As a rule of thumb (excluding permissible disclosures), data that you disclose outside of your organization is not likely to be eligible for protections under the Patient Safety Act. Your PSO should help you to determine eligibility for the protections of certain data sources within your organization.

- Active reporting. In line with documenting your PSES structure, you should also document activities that occur within your PSES, namely what and when information is reported to the PSO. This is a requirement, and you can use technology as well as your written policies to help you identify your PSES/PSO reporting processes. At some point, you must prove that you have actually reported information to your PSO. Without this reporting, the real safety work between providers and PSOs, known as Patient Safety Activities, cannot occur.

Want to know more about the recent Tibbs v. Bunnell case? Visit the American Medical Association website for an overview.