CLARITY PSO
A Patient Safety Organization

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The Network of Patient Safety Databases

The Network of Patient Safety Databases (NPSD) is a national database for providers participating in the PSO program to voluntarily submit safety event information so it can be analyzed and aggregated. The NPSD will offer regional and national comparisons of the safety event information as well as reports and analyses to help reduce events and improve the quality of healthcare.

Though it has taken some time to begin live data reporting to the NPSD, there are a few PSOs (9 including Clarity PSO) who have taken the necessary technological approaches in order to feed the database with de-identified error reports from their contracted healthcare providers.

The process continues to improve, and we are seeing more and more commitment from our providers to contribute to this important endeavor. To date, there really isn’t a national database designed to record and analyze medical errors. We have some indicator-types of databases and registries, which are designed to identify patient outcomes overall, but these don’t reflect the specific issues of where we make mistakes. Part of the reason (and the motivation for the Patient Safety and Quality Improvement Act) we don’t have a patient safety database is because in today’s healthcare world, we are still fearful of litigation and punitive measures when we do cause errors/harm to patients. Not all errors are reported, making it hard to build a database. As we improve overall PSO reporting, we also continue to make our primary goal that of fostering a culture of safety and looking towards fail safe system processes versus individual provider faults. PSOs create a secure environment where providers can share information, such as event reports, and learn from each other’s experiences without fear.

Curious as to how the NPSD process works? Here it is at the highest level:

1. Healthcare providers work with their PSO and IT teams to create templates/forms/modules that collect the appropriate data elements. The foundation for these templates is the AHRQ Common Formats, a standardized set of common definitions and reporting formats to help providers uniformly report patient safety events.
2. Once the templates are created in local reporting systems, providers work through their safety management process (and Patient Safety Evaluation System) and then report certain event information to the PSO.
3. We at the PSO then apply the required technical specification coding in preparation for data submission to the PSOPPC.
    a. The Patient Safety Organization Privacy Protection Center (PSOPPC) assists PSOs in rendering the data they submit to the NPSD contextually non-identifiable and maintains the AHRQ Common Formats.
4. The PSO submits the event data to the PSOPPC for de-identification and transmission of the data to the Network of Patient Safety Databases.

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PSO and Provider Profile Data

Each year, PSOs are asked to complete the PSO Profile form, which provides retrospective information about a PSO's operations and the numbers and types of providers it serves. 67 out of 84 listed PSOs, or 80%, submitted Profile forms in 2015 regarding 2014 activities. The following information was garnered from those forms and presented at AHRQ's 2015 Software Developers Meeting:

- In 2014, provider types included:
  - Specialized treatment facilities (e.g., dialysis, chemotherapy, psychiatric) – 29
  - General hospitals – 1,850
  - Licensed practitioner groups – 335
  - Specialty hospitals – 354
  - Long-term care facilities – 35
  - Other, such as ambulance/EMS services, ambulatory surgery centers and retail pharmacies – 874
- Count of PSOs by types of business (a PSO may choose more than one type):
  - Healthcare provider – 21
  - Association – 20
  - Consulting – 10
  - Insurer (non-health) – 6
  - University – 6
  - Software developer – 5
  - Consumer – 1
  - Other – 9
- 44 PSOs collected quality and/or safety reports that included at least one safety event category
- According to the 2014 PSO Profile responses, PSOs collected a total of 2,049,317 quality and/or safety reports from their contracted providers
- The PSOPPC has received reports for 139,524 patient safety events:
  - 65% of the reports received were full or complete reports where all data elements were answered for a particular module
  - 22% of the reports received were considered partial reports where more than the minimum data set was answered, but not all data elements were answered for a module
  - 13% of the reports received were minimum reports where only the minimum data set was answered for a respective module
- Event types submitted to the PSOPPC included:
  - Medication
  - Pressure ulcer
  - Perinatal
  - Fall
  - HAI
  - Surgery or Anesthesia

For more information on Patient Safety Organizations, view AHRQ's published document, *Patient Safety Organizations: A Summary of 2013 Profiles*.

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