PSO? PSES? PSWP? You Have Questions, We Have Questions – **Webinar Series**
Question & Answer Follow-up
November 12, 2013

QUESTION	ANSWER
Q: If there are no PSOs in my state, what would be the process to join one?	PSOs are not required to provide services only within their respective state of business. A healthcare provider can work with any PSO that accepts participants. Some PSOs limit their services to providers within an association or other organization or to a particular type of provider or type of adverse event. However, many PSOs, such as the Center for Patient Safety, provide services to a broad range of providers. Resources: Listed PSOs: www.pso.ahrq.gov/ Tips for choosing a PSO: www.pso.ahrq.gov/psos/psochoice.htm Center for Patient Safety: www.centerforpatientsafety.org/patient-safety-organization-pso/ .
Q: Are there only 4 University Hospitals submitting to a PSO? If so why do you believe the number is so low?	The slide in the presentation indicates that four university systems have formed a PSO for their providers; it does not indicate the number of providers within each of the four systems that are participating in the system-based PSO, which would be many more than four.
Q: Can you describe the difference between the format of the retrospective surveillance system and the IHI Global Trigger tool?	This was answered live. The answer is available on the audio recording at http://www.youtube.com/watch?v=BplBUa9YVo4&feature=youtu.be at approximately 1:14:45. The global trigger tool is used to retrospectively look at aspects that highly correlate with adverse events and is the tool used by the OIG for their report on the lack of comprehensiveness of event reporting. The tool requires chart reviews and can be very costly and time consuming. The surveillance tool is more of a measurement tool vs. a trigger tool. The gold standard is still humans reviewing records and the ideal is to utilize humans and technology together to obtain the highest specificity.
Q: Where do you find the surveillance tool being discussed?	AHRQ has no plans to employ the surveillance system beyond its currently-envisioned role replacing the 10+ year-old Medicare Patient Safety Monitoring System (MPSMS). MPSMS has been used for a decade to generate national incident rates from a statistically-significant sample of hospital charts available to CMS. It is currently being used to track national adverse event rates for PfP. When completed, QSRS software will be freely available, a natural consequence of being developed by the Federal government.
Q: Can you provide more detail on reference - AHA July 2013 Advisory Supportive of PSO?	The Advisory was issued on July 31, 2013, by the American Hospital Association. Members of the Association have access to the full Advisory on-line with their user name and password. In general the Advisory noted that the ACA regulations pertaining to PSO participation have not yet been issued and that questions are being worked through with the CMS prior to regulations being published for comment.
Q: Please address the indicator most used nationally and the indicator AHRQ is leaning toward to use as the denominator for event comparison among systems (i.e. Patient Days/1000).	Hospital Common Formats for Surveillance do not base denominators on indicators. The basic denominator is discharges, rather than patient days/1000. The system is being developed for use by the Department (HHS) for tracking national incident rates, based on abstracting a statistically significant number of medical records (patient stays). The same would hold true if someone were to use the software system (Quality and Safety Review System or QSRS) in an individual hospital or in a group of hospitals. Denominators stem from, firstly, the

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	number of charts abstracted and, secondly, the sub-denominators established by QSRS through smart clinical logic (e.g., number of patients receiving a blood product as the denominator for an adverse event involving blood products). The basic assumption for a hospital is that either all discharges are abstracted or, perhaps more likely, a random sample of all discharges. We continue to believe that the most helpful points of comparison are the rate and type of adverse events that occur per hospital admission. This approach was the one employed by the Office of the Inspector General in their several recent reports on hospital adverse events.
Q: Dr. Munier, page 70783 of the Final Rule states "Survey and licensure...entities are not entitled to receive patient safety work product voluntarily from provider under this provision." **Q: We've had reports that CMS surveyors DEMAND to see, in spite of evidence of compliance through other means, items within PSES or that have been designated as PSWP. We've talked with AHRQ about this, brought it up at the 2013 AHRQ Patient Safety meeting in April of this year. What do you need from us to further a solution on this matter?** **Q: When do you expect resolution on the conflict between PSO protections and CMS/State requirements?**	This was answered live. The answer is available on the audio recording at http://www.youtube.com/watch?v=BplBUa9YVo4&feature=youtu.be at approximately 1:20:00. AHRQ is seeking information about incidents of surveyors requesting PSWP. An alliance of PSOs is working together to address the CMS and PSWP issue, and PSOs are encouraged to continue working on the issue. AHRQ has been raising the issue on an ongoing basis. The hope is resolution will occur in 2014; however, several federal government agencies are involved so it takes time to coordinate, organize and reach consensus. Options may be addressing through regulation, consensus, and/or guidance.
Q: Our patient grievance process is one component of our PSES; are there any plans to develop a Common Format for submission of patient grievance related PSWP to PSO's?	This was answered live. The answer is available on the audio recording at http://www.youtube.com/watch?v=BplBUa9YVo4&feature=youtu.be at approximately 1:11:45. AHRQ is interested in consumer reporting, but Common Data Formats have not been developed to incorporate the patient grievance process into reporting to a PSO. An organization that works with a PSO has the latitude to best define and develop its PSES to meet the organization's needs. In doing so, the organization will need to incorporate the federal requirements for responses to grievances and should give thought to what will be shared with the patient/family.

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