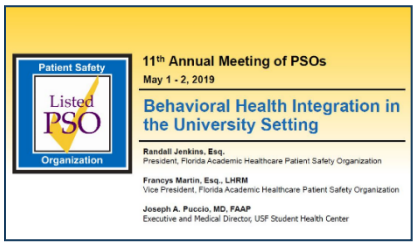
FLORIDA ACADEMIC HEALTHCARE Patient Safety Organization

http://flbog.sip.ufl.edu/florida-academic-healthcare-pso/

As a member of the FAH PSO, your role is vital in the development of our patient safety improvement initiatives. As you can see below, together we have accomplished A LOT recently!

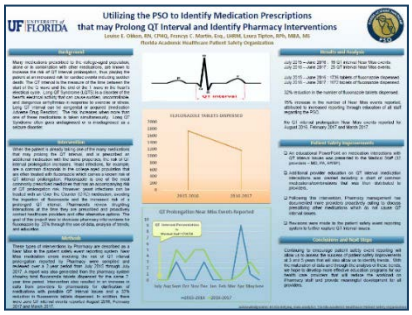


In May 2019, members of the Behavioral Health Integration (BHI) Task Force of the FAH PSO presented their recommendations at the 2019 AHRQ 11th Annual Meeting of PSOs in Rockville, Maryland.

In December 2018, the Behavioral Health Integration Task Force of the FAH PSO published Consensus Recommendations to improve identification and management of behavioral healthcare, with a focus on the integration of multiple services and providers within the university setting and surrounding area providers.

A storyboard version was presented at the Institute for Healthcare Improvement 2018 National Forum.

In the Fall of 2018, the Student Concussion Task Force of the FAH PSO published Consensus Recommendations to improve identification, patient care, and treatment of concussions within the university setting.



The PSO can be utilized in a variety of ways to benefit both providers and their patients. See how the FAH PSO was fundamental in identifying medication prescriptions that may prolong QT intervals and the pharmacy intervention, provider education, and improvements that resulted.

In April 2018, their poster titled Utilizing the PSO to Identify Medication Prescriptions that may Prolong QT Interval and Identify Pharmacy Interventions was presented at the Agency for Healthcare Research and Quality (AHRQ) Patient Safety Organization Annual Meeting.

The Jury is in: Hospitals Say Patient Safety Organizations are Effective in Measurably Improving Patient Care Quality

Upon the 20th Anniversary of the "To Err is Human" Report, OIG reports Patient Safety Organizations are Effective in Preventing Patient Harm and Improving Patient Outcomes.

November marks the 20th anniversary of the release of the landmark report, *To Err is Human: Building a Safer Healthcare System* by the Institute of Medicine, which is now the National Academy of Medicine. The report estimated that as many as 98,000 people died each year due to preventable medical harm. The cornerstone of the Federal response to medical errors was the creation of a national peer privilege, certain provider privacy rights and Patient Safety Organizations (PSOs) through the passage of the Patient Safety and Quality Improvement Act of 2005 (The Patient Safety Act). The goal of the Patient Safety Act is to foster the ability of healthcare professionals to improve the delivery of patient care and patient outcomes by developing a "safety culture" and to ensure accountability by raising standards for continuous quality improvement in healthcare. Today, over half (59%) of the acute care hospitals are members of PSOs.

"Hospitals and other health care entities that work with a PSO are high performing, high reliability healthcare entities that are committed to delivering the highest quality patient care," according to Peggy Binzer, Executive Director of the Alliance for Quality Improvement and Patient Safety (AQIPS), the professional association for Patient Safety Organizations. Quality leaders in pharmacy, EMS assisted living, long term care, rehabilitation hospitals, clinics, community health centers, ambulatory care, specialty medical groups and telemedicine also partake in quality improvement activities through PSOs. The nationally uniform privilege and confidentiality protections allow providers to learn from their peers' mistakes and successes: to prevent the same mistakes from being unnecessarily repeated in hospitals across the nation and to ensure excellence in healthcare delivery.

To determine the value of PSOs, the Office of the Inspector General (OIG) surveyed a statistically representative sample of hospitals to determine PSOs' effectiveness in improving the quality of patient care and safety culture (OIG report 09-25-2019/OEI-01-17-00420). Nearly all hospitals (97%) find working with a PSO to be valuable. 80 percent of these hospitals find that the PSO's activities have helped prevent future patient safety events and therefore prevent patient harm and save lives. Nearly all (95 percent) hospitals that work with a PSO found that their PSOs have helped improve the culture of safety at their facilities. Among the most important reasons why hospitals choose to work with a PSO are to improve patient safety (94 percent) and to learn from PSOs' analysis of patient safety data (87 percent). Importantly, most hospitals (83%) found the privilege and confidentiality protections to conduct patient safety activities very important. Hospitals found peer-to-peer learning to be very valuable and PSO feedback and analysis made measurable improvement in their patient care.

Sincerely yours,

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