The Foundation for Health Care Quality Patient Safety Organization

Following approval granted by the Agency for Healthcare Research and Quality (AHRQ), the Foundation for Health Care Quality has become a certified Patient Safety Organization (PSO) effective November 25, 2024.

Becoming listed as a PSO is an incredible advancement in our patient safety and quality initiatives, particularly our Communication and Resolution Program. With this designation, FHCQ joins a prestigious roster of over 100 active PSOs who are mission-driven in fostering a culture of safety, improving healthcare quality, and delivery of care. Now, healthcare organizations and providers in any state can participate with the FHCQ to openly discuss adverse events, root cause analyses, and action plans that will lead to better patient outcomes.

The federal Patient Safety and Quality Improvement Act of 2005 led to the creation of PSOs by allowing health care providers to share patient safety data in a protected environment and to work together to cultivate a healthcare system that prioritizes safety. Moving forward, conversations and activities across FHCQ programs are legally protected and non-discoverable. All data collected will be aggregated to produce feedback and identify opportunities to reduce patient harm.

With this designation, we are thrilled to support organizations nationwide with our **Communication and Resolution Program (CRP) Certification**. FHCQ provides free consulting to support organizations with CRP implementation and collect best practices. Learn more about our CRP work here: qualityhealth.org/crp.

If you would like to learn more about FHCQ, upcoming opportunities to collaborate on patient safety measures, or our CRP work, read some FAQs below or send questions to Steve, Executive Director of the Washington Patient Safety Coalition at slevy@qualityhealth.org or Felicidad, Communication and Resolution Program Manager at fsmith@qualityhealth.org.

Frequently Asked Questions

What is a PSO?

- PSOs are federally certified entities that share the goal of improving the safety and quality of health care delivery. This is accomplished by collecting, aggregating, and analyzing health

care data, without the fear of legal discovery. The aim of collecting this data is to enable the identification and reduction of patient care risks and hazards.

Who can be certified as a PSO?

- Only organizations who are able to meet the stringent requirements set forth by the Patient Safety Act are qualified to receive the protections offered under the Act.
- Entities that are excluded from becoming PSOs include health insurers and entities that accredit, license, or regulate health care providers.

What kind of data/information is collected by FHCQ?

- FHCQ programs include the Care Outcome Assessment Programs (COAP), Washington Patient Safety Coalition (WPSC), and Smooth Transitions.
- COAPs collect data on a variety of quality metrics within each specialty: cardiac, obstetrics, spine, and surgical.
- WPSC collects adverse event data from organizations when they use the Communication and Resolution Program (CRP) process to respond to such events. The Coalition also hosts Safe Tables for organizations and providers to freely talk about patient safety events and quality improvement.
- Smooth Transitions collects data on adverse events related to the transfer of care of birthing individuals from a community-based birthing center to a hospital.

What is the significance of PSO information being protected from disclosure?

- Prior to the implementation of the Patient Safety and Quality Improvement Act, providers and healthcare organizations have traditionally been reluctant to report medical errors due to fears of punitive actions, litigation, professional sanctions, or damage to their professional reputations.
- When reporting to a PSO, patient-identifying information, and the name of the caregiver involved and reporting the medical error, is *prohibited* from being disclosed publicly.

How are PSO protections different from protections granted by the Coordinated Quality Improvement Program (CQIP)?

- The Coordinated Quality Improvement Program (CQIP) is a Washington State law that protects confidential information from disclosure.
- CQIP protections only apply to healthcare organizations based in Washington.
- While PSOs also protect confidential information from disclosure, the protections granted to PSOs are at the federal level. This extends protections to organizations outside of Washington and adds an additional layer of protection to encourage data sharing.

Is the FHCQ PSO only for hospitals?

- Participation in the COAPs is focused on hospitals.
- For the WPSC, other licensed health care organizations and providers outside of hospital settings may also benefit from sharing adverse event information and are welcome to participate in WPSC services.

Will information about medical errors reported to FHCQ be made public?

- Among member programs, aggregated data for COAP participants is shared on a quarterly and biannual basis.
- Information on CRP and other adverse events will be de-identified and aggregated.

Will PSO activities prohibit patients and their families from being able to seek legal action after medical errors?

- Participation in adverse event sharing and FHCQ's Communication and Resolution Program *does not* affect the ability of patients or their families from seeking legal action if a medical error has occurred.
- Data sent to FHCQ cannot be disclosed or made available for litigation unless a criminal event has occurred.

I am already a paid member of COAP/WPSC/etc. will the cost of our annual fees be impacted?

- As of 2025, dues for FHCQ programs will remain the same.

Can I be a member of/participate with multiple PSOs?

- Yes! Different PSOs can offer a variety of services that may not be available with one PSO. You are not confined to only working with one PSO.