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Patient Safety And Quality Improvement Act of 2005

The Secretary of Health and Human Services adopted rules to implement certain aspects of the Patient Safety and Quality Improvement Act of 2005. These rules set forth information for hospitals, doctors and other health care providers to voluntarily report information to Patient Safety Organizations, on a privileged and confidential basis, for the aggregation and analysis of patient safety events.

A Patient Safety Organization (“PSO”) is an organization that:

- Works with clinicians and health care organizations to identify, analyze and reduce the risks and hazards associated with patient care;
- Establishes federal confidentiality and privilege protections for information assembled and developed by provider organizations, physicians, and other clinicians for deliberations and analyses regarding quality and safety; and
- Identified the risks and hazards associated with patient care

This rule also establishes the requirements that entities must meet to become a PSO and the process by which the Secretary will review and accept certifications and list PSOs.

Furthermore, the rule requires PSOs to notify reporting providers of inappropriate disclosures or security breaches related to information they reported; specifies compliance requirements with respect to patient safety work product collected; and clarifies the disclosure requirements that PSOs must file regarding contracting providers with whom they have additional relationships.

This rule also states that a PSO’s listing automatically expires at the end of three years, unless it is revoked for cause, is voluntarily relinquished, or its certifications for continued listing are approved.

For more information please contact Popovits & Robinson at 708/479-3230.

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