

## Alphabet Soup: Current Status of Federal/National Programs and Initiatives Summary of Programs

	<b>AHRQ: Patient Safety Organizations</b>	<b>CDC: National Healthcare Safety Network</b>	<b>CMS: Hospital Acquired Conditions</b>	<b>The Joint Commission: Sentinel Events</b>	<b>National Quality Forum: Serious Reportable Events</b>
<b>Who Reports to Whom</b>	Healthcare providers voluntarily report to listed Patient Safety Organizations (PSOs). De-identified reports are passed to the Network of Patient Safety Databases (NPSD).	Healthcare facilities voluntarily report to CDC/NHSN. Data can also be shared with other entities, such as state health departments, via the "group" function.	Hospitals to Medicare through claims for inpatient hospital services	Accredited organizations to Joint Commission	Intended for use in reporting from "healthcare facilities" as defined in the NQF report directly to the public or through a public agency (or its designee)
<b>What is Reported</b>	Common Formats can be used for reporting any type of patient safety concern, including incidents, near misses, and unsafe conditions. Detailed hospital reporting modules include: blood, devices, falls, healthcare associated infections, medication, perinatal, pressure ulcer, and surgery/anesthesia.	Healthcare-associated infections, e.g., central line-associated bloodstream infections (CLABSIs) and surgical site infections (SSIs). Also, influenza vaccination of patients and healthcare workers and adverse reactions associated with receipt of blood and blood products.	Principal and secondary diagnoses (SDX) and whether the SDX was present on admission	"Reviewable" sentinel events (resulting in serious harm or death)	The 28 NQF-endorsed events listed in <i>Serious Reportable Events in Healthcare 2006 Update</i> (now undergoing maintenance review)

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<b>Reason or Motivation for Reporting</b>	Data submitted to a PSO receives Federal confidentiality and privilege protection through the Patient Safety Act and Rule.	Local quality improvement. Some facilities also report now due to state legislation that requires public reporting of HAIs.	Required by law and also used for determining hospital payments	1. Assistance with root cause analysis 2. Share learning with other organizations	To facilitate reporting of a list of serious events that provide for standardized data collection for the purpose of public accountability and systematic learning and improvement in healthcare safety
<b>How Data are Used</b>	Reports can be used at the hospital and PSO level for quality and safety improvement. AHRQ will publish aggregate data annually in the National Healthcare Quality and Disparities Reports, and through the NPSD.	Data are aggregated to provide national estimates of adverse events among patients and healthcare personnel. Data are also used to estimate adherence to HAI preventive practices. Some states have legislation requiring the collection and reporting of the data to consumers.	Determine payment for Medicare inpatient hospital stays	1. Issue Sentinel Event Alerts 2. Create National Patient Safety Goals	Intended for use for public accountability and systematic learning and improvement across the healthcare industry