Realizing that health care providers must gather information, analyze it, and share the results with others in order to learn from medical errors, the House of Representatives passed the Patient Safety and Quality Improvement Act (H.R.663). The Act encourages providers to conduct research and gather data about the causes of medical mishaps and then share their findings with other providers in order to learn ways to remedy systems and practices.

H.R. 663 protects any “information, report, memorandum, analysis, deliberative work, statement, or root cause analysis” created by or reported to a Patient Safety Organization. Such organizations have yet to be named but will probably include groups already in place to survey quality and operations among health care providers (e.g., the Joint Commission on Accreditation of Healthcare Organizations).

The information described in the Act will be protected from civil or administrative subpoenas or orders, discovery process, disclosure under the Freedom of Information Act, disclosure as evidence in State or Federal civil or administrative proceedings, or use by an accrediting organization in the accreditation process or to remove accreditation. This protection will allow hospitals and others to share information freely without fear that the information will be used against them by malpractice attorneys or others.

If passed by the Senate and enacted, the Act would establish Patient Safety Organizations to collect data from providers on a voluntary basis and store it in a national database. Data would be analyzed to determine best practices and alternative methods for correcting or improving operations within health care facilities to prevent future errors from occurring.

This Act supports the role of Health Information Management (HIM) professionals who identify and code each diagnosis and condition affecting a patient in a health care facility. The diagnoses and conditions identified and coded include any complications and contributing causes of death. HIM professionals can profile and trend the data in a number of ways and use the information to identify and track issues. Ongoing data analysis can also be used to alert responsible individuals when a pattern may indicate an increased risk of error. Protecting such statistics and patterns and the investigations and reports which result will open up discussions, increase positive outcomes, and reduce medical errors.

The significance of the data to be used in analyzing and trending patient safety emphasizes the importance of thorough, accurate, and timely recording of codes to identify the diagnoses, significant conditions, and procedures for each patient. A shortage of well-trained coding professionals, poor documentation by health care providers, and pressures to provide the coded data faster can be obstacles to thorough and accurate data. Each of these issues must be addressed, because only if the data used in recording and studying medical errors is reliable will the vision created by H.R. 633 become a reality.

**Cheryl Servais**  
Vice President, Compliance  
and Privacy Officer  
Precyse Solutions  
Dallas, TX