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1. What organizations are eligible to work with PSOs?

Providers, as defined by HHS's final rule implementing PSQIA, are eligible to receive federal confidentiality and privilege protections for PSWP collected for submission to PSOs. HHS broadly defines "provider" as an individual or entity licensed or authorized under state law to provide healthcare services. Examples of entities that are considered providers include hospitals, nursing facilities, comprehensive outpatient rehabilitation facilities, home health agencies, hospice programs, renal dialysis facilities, ambulatory surgical centers, pharmacies, physician and healthcare practitioner offices (including group practices), long-term care facilities (including state-licensed or -authorized assisted-living residential care facilities that provide healthcare services and other community-based care providers), behavior health residential treatment facilities, clinical laboratories, and health centers.

Examples of individuals who are considered providers include physicians, physician assistants, registered nurses, nurse-practitioners, clinical nurse specialists, certified registered nurse-anesthetists, certified nurse-midwives, psychologists, certified social workers, registered dieticians and nutrition professionals, physical and occupational therapists, and pharmacists, among other individual healthcare practitioners.

2. What organizations are eligible to become PSOs?

A PSO can be a public or private entity. Its mission and *primary activity* must be to improve patient safety and the quality of healthcare delivery. To become listed as a PSO by AHRQ, an agency within HHS, the organization must attest that it meets 15 requirements for certification—8 patient safety activities and 7 operational activities. The types of organizations that may become PSOs are wide-ranging. State hospital associations have formed component organizations that serve as PSOs for their member hospitals. Other PSOs have been established by health systems, consulting firms, and professional organizations. Nonprofit organizations focused on patient safety have also established PSOs.

Some organizations interested in becoming a PSO may have difficulty demonstrating that their primary activity is to improve patient safety. Hospitals, for example, may engage in other activities that are equally important, such as supporting provider education. These organizations can create a component organization, define the component's primary activity as improving patient safety and healthcare quality, and seek PSO listing for the component.

3. What are the benefits of working with Virginia PSO?

Virginia PSO works with PSO members to provide feedback and analysis about the PSWP submitted by the provider. The feedback will help providers identify strategies to improve patient safety and healthcare quality using:

- Web-based data collection with standardized data formats
- Automated reports on events submitted by members and on aggregated events at the national level
- PSO Navigator™, ECRI Institute's quarterly advisory, which provides aggregate and deidentified data, lessons learned, and evidence-based best practices and solutions
- Independent critique of root-cause analyses and other patient safety and quality analyses, which is available to Virginia PSO Plus members only

Another benefit of working with Virginia PSO is tracking patient safety trends from multiple providers. Virginia PSO will be able to aggregate patient safety data—with all identifying information removed—and spot trends that an individual provider, with a limited pool of data, may not be able to detect. By collecting data in a standardized format, Virginia PSO will be able to aggregate data in order to reduce adverse events and improve healthcare quality in your organization.

Importantly, by working with Virginia PSO, providers receive privilege and confidentiality protections for PSWP managed within a PSES. Providers can work with Virginia PSO to improve patient safety without fearing that the information submitted could be used in a malpractice case. Specifically, the final rule states that PSWP is privileged from the following:

- A federal, state, local, or tribal subpoena or order, whether civil, criminal, or administrative, including those related to disciplinary proceedings against a provider
- Discovery in connection with a civil, criminal, or administrative proceeding, including disciplinary proceedings against a provider (note: the rule contains a separate provision granting a court permission to use confidential information for a criminal proceeding)
- Disclosure under the federal Freedom of Information Act
- Admission into evidence during a civil, criminal, or administrative adjudicatory proceeding, including any proceeding against a provider
- Use in a professional disciplinary proceeding

There are some exceptions to the privilege protections, such as when each of the identified providers authorizes the disclosure or when the data are nonidentifiable. Also, HHS notes in the preamble to the final rule that facts regarding any corrective actions implemented by the provider as a result of feedback from the PSO are not considered PSWP and, therefore, could be used in a legal proceeding, depending on the facts and circumstances and applicable rules of evidence.

It is up to the courts and disciplinary bodies to apply the privilege protections; this is not something HHS has the authority to interpret and enforce. Therefore, providers should document what constitutes PSWP and other aspects of complying with PSQIA, as discussed in FAQ 14.

HHS, through OCR, enforces other protections to keep PSWP confidential—another incentive for

providers to work with PSOs. Except in the case of certain disclosures permitted under PSQIA, PSWP is confidential and must not be disclosed by anyone holding the information.

The privilege and confidentiality protections remain in place even if PSWP is impermissibly disclosed. In other words, if a PSO impermissibly discloses a hospital's root-cause analysis of a wrong-site surgery to another hospital, the hospital can still claim the privilege and confidentiality protections attached to the root-cause analysis—assuming it was properly collected within the hospital's PSES.

4. Will my organization violate HIPAA by providing protected health information to Virginia PSO?

No. PSQIA establishes that PSOs are business associates, as defined by HIPAA, of the providers they serve. This ensures that in giving PSWP with protected health information to the PSO, the provider does not violate HIPAA. To meet obligations, Virginia PSO executes a business associate agreement with its PSO members.

HHS's OCR (http://www.hhs.gov/ocr) which enforces the privacy provisions of HIPAA and the HITECH Act, will closely follow the enforcement measures outlined in HIPAA to investigate written complaints of confidentiality breaches related to PSQIA and, if noncompliance is found, will attempt to resolve the matter through informal means before turning to enforcement measures, such as levying financial penalties. A confidentiality breach will not be treated as violating both PSQIA and HIPAA unless the breach is a civil violation under one law and a criminal violation under the other.

5. How is an organization "certified" to operate as a PSO?

Organizations seeking to be listed as PSOs by AHRQ complete an application process certifying that they meet specific criteria. AHRQ purposefully chose a streamlined process for PSO listing because the initiative is voluntary and unfunded. AHRQ reviews the application and, if the certification criteria are met, grants the organization PSO status for up to three years.

AHRQ provides basic information about every listed PSO on its Web site at http://www.pso.ahrq.gov/listing/psolist.htm. Information provided includes address and contact information, information on the PSO's compliance with the minimum contract requirement, and whether the PSO is a component PSO. If the organization is a component PSO, AHRQ will provide required disclosure statements from the component PSO regarding its relationship with its parent organization.

6. When must my organization have arrangements in place with a PSO?

The federal government's framework for provider reporting to PSOs is a voluntary system. Providers are not obligated to establish a relationship with a PSO, although the arrangement offers many benefits, as described in FAQ 3. Nevertheless, as discussed in the preamble to the final rule implementing PSQIA, the regulations do not preclude organizations such as multihospital systems from requiring their provider members to report to a designated PSO.

HHS does not specify the type of arrangement a provider should establish with a PSO, although a good practice is for providers to enter into a contract with a PSO defining the arrangements for

accepting PSWP and providing feedback based on the PSO's review of the information, as well as other matters.

7. How are PSOs funded?

There is no federal funding to implement PSQIA. PSOs are likely to fund their activities by charging a provider for reviewing, analyzing, and providing feedback regarding the provider's PSWP. Virginia PSO is funded through membership fees and contracts.

8. How does my organization obtain access to the Virginia PSO data collection and reporting system?

Each provider must name one reporting system administrator (who may also be the provider's primary contact). The reporting system administrator will be able to submit event reports and run reports. In addition, the reporting system administrator will be able to assign a unique user name and password to other individuals so that they can access the data collection and reporting system in order to view run reports run reports, and send secure communications (i.e. secure e-mails). Requests to allow other users to access the Virginia PSO web portal should be submitted to Virginia PSO. Requests should specify the level of access (e.g. web-access only, event submission, report generation, secure communication).

9. What criteria must a PSO meet to become listed by AHRQ?

A PSO must certify that it adheres to 15 requirements—8 involving patient safety activities and 7 involving its operations. The eight patient safety activities are listed in the section, "Common PSO-Related Terms," under the definition for patient safety activities. The seven operational activities are as follows:

1. Ensure that the mission and primary activity of the PSO is to conduct activities to improve patient safety and the quality of care.
2. Use appropriately qualified staff, including licensed or certified medical professionals.
3. Within the 24-month period after initial listing as a PSO, and within each sequential 24-month period thereafter, have at least two contracts with different providers for a reasonable period of time to receive and review PSWP.
4. Demonstrate that the PSO is not a health insurer or a component of a health insurer.
5. Make required disclosures to HHS, such as the number of contracts with providers and any relationships with contracting providers that extend beyond the activities of PSQIA.
6. Collect PSWP in a standardized manner to permit valid comparisons of similar cases among similar providers.
7. Use PSWP to provide direct feedback and assistance to providers to minimize patient risk.

10. Does AHRQ or another government agency oversee the quality or value of PSO services?

Although AHRQ assesses PSO compliance with PSQIA, the agency does not oversee the quality of services that PSOs provide. Advocating a marketplace approach to PSOs, AHRQ says providers are the ultimate arbiters of the quality of PSOs' services. Providers, therefore, must judge the value of the service they

receive from a PSO and, if they are satisfied, will continue to work with the PSO. Providers that are dissatisfied with a particular PSO will likely "shop" for another PSO that offers better services; a PSO that fails to renew its business with providers is unlikely to survive.

AHRQ provides basic information about each listed PSO (e.g., its location, whether it is a component PSO, whether it complies with the two-contract requirement) but does not release specific performance information.

11. How can my organization be assured that Virginia PSO is complying with PSQIA?

To assess compliance, AHRQ performs random site visits for about 5% to 10% of all PSOs each year. During these visits, the agency will ask, for example, that the PSO demonstrate that it has performed all eight patient safety activities as required by the final regulation.

Rather than adopt a punitive approach, HHS will work with a PSO to correct its deficiencies. Such deficiencies can include not fulfilling the requirements that it certified it met when seeking listing as a PSO, failing to adhere to the requirement to have two contracts in place, failing to perform patient safety activities "fairly and accurately" because of its relationship with other contracting providers, and failing to fulfill the requirements of PSQIA. However, if a PSO fails to work with HHS to correct its deficiencies, the agency will require the PSO to correct its deficiencies. If HHS's mandatory approach fails, it will begin a process to revoke the PSO's listing. Also, HHS can fine a PSO for "knowing or reckless" breaches of confidential PSWP. While HHS will not publicize information about a PSO's deficiencies, a provider considering establishing a contract with a PSO can ask the PSO about any previous deficiencies identified by HHS.

HHS will follow an expedited process to revoke the PSO's certification if any of the three following circumstances exists:

1. The PSO is or is about to become an entity excluded from listing as a PSO; for example, the PSO is about to become a component of a health insurer.
2. The parent organization of the PSO is an excluded entity, such as an accrediting organization, and cannot be listed as a PSO but uses its authority over providers to require them to use the services of its component PSO.
3. The HHS Secretary determines that the failure to act promptly to revoke a PSO's certification due to the PSO's reckless or willful misconduct in its protection or use of PSQP would lead to serious adverse consequences. For example, a PSO is reckless in its protection of the identity of individuals named in PSWP or engages in fraudulent or illegal conduct.

Each time a PSO seeks a new listing or relisting, AHRQ reviews any previous findings regarding the PSO or its senior managers and officials. AHRQ will consider any current activities or history reflecting noncompliance. The federal government may seek additional information from the PSO to increase its confidence that despite the entity's history or the history of its senior managers and officials, the entity can be relied upon to comply with its statutory and regulatory obligations.

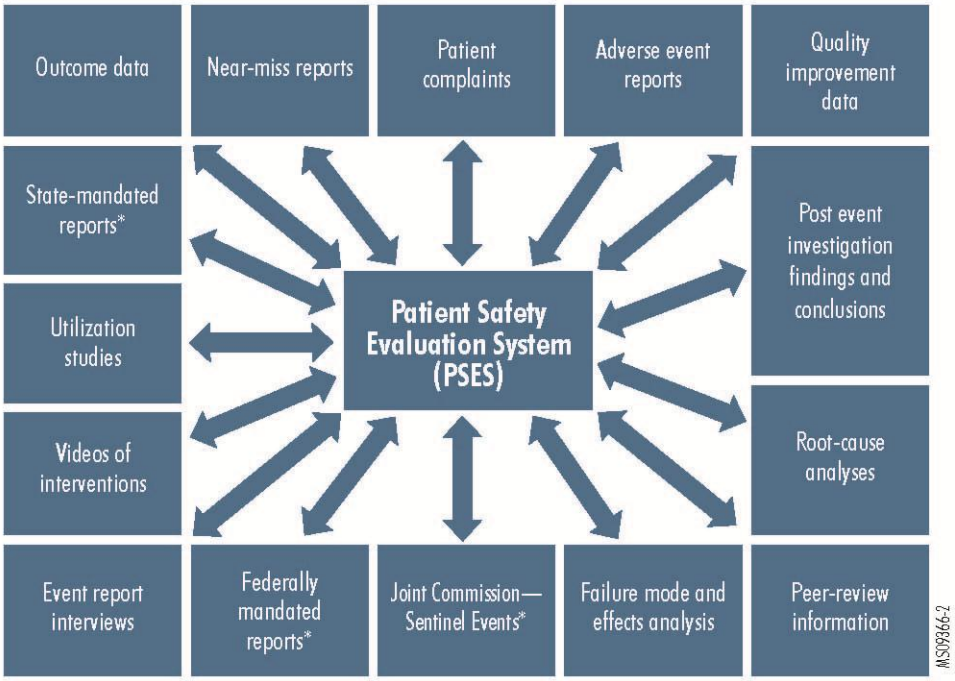
12. How does my organization establish a PSES?

The regulation purposely avoids outlining requirements for a PSES in order to give providers and PSOs flexibility in establishing systems best suited to their specific needs and settings. Nevertheless, providers must consider the PSES in the context of their state peer-review laws and legal privilege protections. The PSES should not jeopardize any existing state protections and must carefully consider what categories of patient safety information are appropriate for the organization to collect and analyze for reporting to a PSO and what patient safety information should remain outside the PSES. Information that must be reported to states under mandatory reporting laws, to FDA or the National Practitioner Data Bank, or to other federal agencies under other mandates (e.g., the Medicare Conditions of Participation) does not gain PSQIA's protection from disclosure by virtue of being reported to a PSES. However, reporting this category of data to the PSES allows for more inclusive and accurate data analysis.

Providers may rely on programs already in place when developing their PSES. For example, some providers may find that their existing event reporting programs can serve as the basis for a patient safety reporting system. How a PSES operates depends on its functions and the provider's tolerance regarding access to sensitive information within the system. A single hospital might establish a PSES within a particular office, such as the risk management department. A multihospital system could designate a single PSES for all its hospitals and the parent organization to use.

A provider might also consider designating secure physical and electronic space for the PSES. And, although there is no requirement to document policies and procedures related to the PSES, Virginia PSO can aid providers and PSOs in establishing best practices for documenting.

Documentation of the PSES will support claims that the data and information that is part of the system is privileged and confidential. Also, if the provider documents what data and information is part of the PSES, employees of the provider will be less likely to make unintended or impermissible disclosures.



13. What constitutes PSWP?

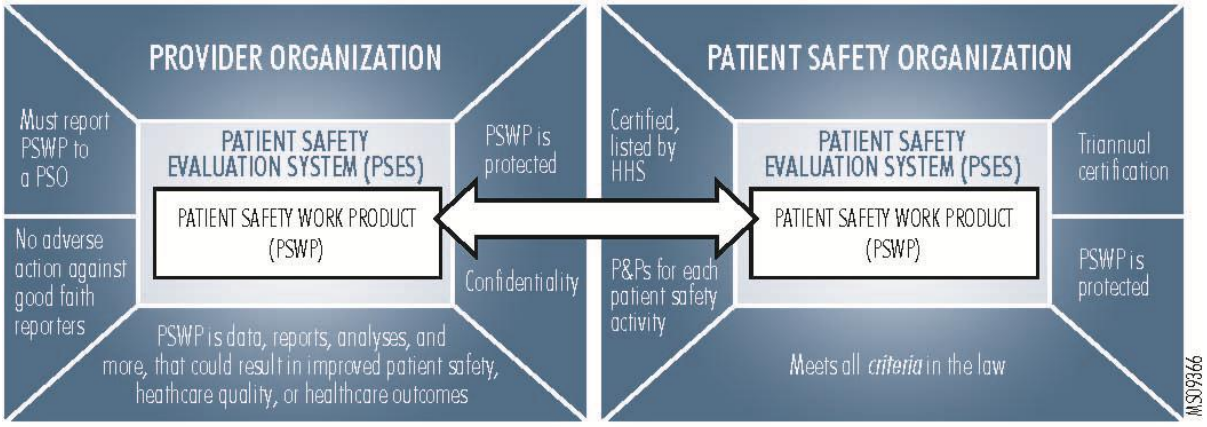
PSWP can include data, reports, records, memoranda, analyses (e.g., root-cause analyses), and written and oral statements—all of which can be used and analyzed to improve patient safety, healthcare quality, and healthcare outcomes provided that theinformation is collected by the provider within a PSES for reporting to a PSO. It is subject to federal statutory legal privilege and confidentiality protections.

Information can be considered PSWP if it is collected for the purpose of reporting to a PSO; the period of collection may extend as far back as to the passage of PSQIA on July 29, 2005. Excluded from PSWP are original patient and provider records, such as a patient's original medical record, and billing and discharge information. While a medical record is not considered PSWP, analysis of information in the medical record is protected. Thus, if the medical record indicates that a patient received an incorrect dose of medication, this information is not protected by legal privilege. The organization's root-cause analysis of the event, however, is considered PSWP if it is developed for reporting to the PSES. PSWP does not include information that is collected, maintained, or developed separately from, or that exists separately from, a PSES.

14. What steps should my organization take to optimize protection of PSWP?

By carefully documenting what PSWP is included in their PSESs, providers can ensure that the protections extend to all appropriate information. The protections begin at the time of data collection by the provider. If, upon analysis, the provider determines that data collected within the PSES does not constitute PSWP (e.g., because it is needed to fulfill external reporting obligations), the provider can remove the information from the system if it has not yet been reported to the PSO. Once removed from the PSES, the information is no longer PSWP ; however, such information can still be submitted to a PSO.

Although providers and PSOs are not specifically required to label the information as PSWP, providers should consider labeling as a recommended practice to prevent inappropriate disclosures. While labeling PSWP as such is a good practice, there is no guarantee that a court will accept the label if it is subject to a legal challenge. If the provider chooses to label its PSWP, it could also require the PSO to follow a similar approach with PSWP that the provider gives to the PSO for analysis. Of course, if the information is removed from the PSES, the label designating it as PSWP should also be removed.



15. How far back can we submit event reports or other documents to the PSO for protection?

According to the PSQIA Final Rule published November 21, 2008, in the *Federal Register*, information can be collected for the purpose of reporting to a PSO from the date of the act's passage on July 29, 2005. Information collected prior to July 29, 2005, can be collected for reporting to a PSO but the original documents remain unprotected. If the date of the event is prior to the passage of PSQIA but the event was not identified until after PSQIA's effective date and information about the event was not collected until after that date, that information can still be reported and protected. Please consult with your counsel for detailed interpretation of the rule. For the specific details on this topic, please refer to PSQIA's final rule at http://edocket.access.gpo.gov/2008/pdf/E8-27475.pdf.

16. Must all of my organization's confidential deliberations be conducted within the PSES?

Not necessarily. Providers need to define what works best for them. For example, even though PSQIA permits an organization's peer review proceedings to occur within the PSES, the hospital must consider the ramifications of this approach. Should a credentialing or disciplinary decision be challenged, a hospital would not be able to use its deliberations in court to defend its actions if the information is protected within the PSES unless all identified providers agree to the disclosure. Significantly, HHS notes that providers within a single legal entity—such as physicians participating in morbidity and mortality rounds at a hospital—are free to discuss and share PSWP in identifiable and nonanonymous form for educational, academic, or other professional purposes.

In general, as noted in the preamble to the final rule, the regulation avoids specifying internal uses of PSWP, stating that "sufficient incentives exist" for providers to "prudently manage the internal sharing of sensitive patient safety work product."

17. Should my organization's peer review activities be conducted within the PSES?

As discussed in FAQs 12 and 13, a provider must establish its PSES in a manner that best suits the organization. A hospital could choose to organize its peer-review activities within a PSES and submit data to the PSO as PSWP. The PSO can provide feedback, which the hospital may, in turn, share with the peer-review committee or other committees as it sees fit. However, because PSO feedback is categorized as PSWP, the hospital cannot use the PSO feedback to defend a disciplinary action it takes against a provider should the hospital's actions be challenged in court. Impermissible release of PSWP is treated as a breach of confidentiality and can be sanctioned by OCR.

18. My organization plans to submit adverse events and our analysis of them to our PSES for further review by Virginia PSO. Can the organization still disclose the event to the patient and the patient's family?

PSQIA does not prohibit disclosure of an adverse event to the patient or resident and his or her family. Indeed, with the increasing emphasis on patient-centered care and a culture of safety in healthcare, effective communication among caregivers and patients, including communication of unanticipated outcomes and medical errors, should become part of a healthcare organization's values and culture. Any staff comments about the possible cause of the error should be considered for reporting to the PSES and PSO. Similarly, any deliberations and analysis that were part of the investigation into the cause of the error should be considered for reporting to the PSES for submission to the PSO.

19. My organization already reports adverse events and near misses to a state-mandated reporting program. Are there any prohibitions on reporting the same data to Virginia PSO?

No, there are no restrictions on reporting the same data to a PSO, although the mandatory reporting requirements must still be satisfied. Indeed, AHRQ encourages organizations to report patient safety

data to the PSO, as well as to the state-mandated reporting system, so that the information is included in any aggregate analysis. If such information is not submitted to the PSO, significant data about adverse events would be missing from the aggregate analysis. It is best to consider the data that is reported to the PSO as a virtual "copy" of the original data reported to a state-mandated reporting program. Any original patient safety data that providers report to external mandatory reporting programs is not PSWP and, therefore, does not have the privilege and confidentiality protections of PSWP that is part of the PSES. In addition to data reported to a state-mandated reporting program, such information could include adverse drug event information reported to FDA, certification and licensing records maintained for compliance with health agency requirements, physician disciplinary actions reported to the National Practitioner Data Bank, and reporting required by the Medicare program (e.g., restraint-related deaths).

Nevertheless, to ensure aggregation of all of its patient safety data, a provider may want to record all patient safety events within its PSES as long as it has a mechanism to designate data that is "removed" from the PSES and does not constitute PSWP.

If the mandatory-reportable data is sent to a PSO for analysis, the PSO's analysis would remain privileged and confidential. Any additional analysis of the data conducted by the provider and not submitted to a mandatory program, such as a root-cause analysis of the event, can be submitted to the PSES as PSWP and thus obtains legal protection, regardless of whether the original data was removed from the PSES.

20. Employees and clinicians within my organization are concerned that Virginia PSO findings and feedback will be used to reprimand individuals who make mistakes. Is that permissible?

Not at all. The intent of PSQIA is to foster an environment that supports efforts to improve patient safety. Individual providers' identities are protected and cannot be disclosed outside the provider's PSES or the PSES of the PSO used by the provider. The efforts of PSOs are intended to be nonpunitive. Also, PSQIA provides protections for reporters. For example, providers cannot take adverse employment actions against an individual based on good faith reporting to or for the PSO.

21. My organization would like to use some information classified as PSWP as evidence in a malpractice case. Is this a permissible disclosure under PSQIA?

Yes, but with a caveat: Each provider identified in the PSWP intended to be used as evidence must authorize and permit the disclosure.

22. What protections are in place to ensure that information reported to Virginia PSO remains privileged and confidential?

PSOs must ensure that PSWP is provided only to those entitled to review it, such as employees and contractors of the PSO who will analyze the data. The federal government will investigate confidentiality breaches and has the authority to impose a civil monetary penalty of up to $10,000 for each "knowing or reckless" confidentiality violation. A PSO could be levied separate penalties for multiple violations, each costing up to $10,000. Violations may also be sanctioned as criminal acts.

PSOs must inform a provider if any of its submitted PSWP is inappropriately disclosed or security is breached.

23. Will the feedback my organization receives from Virginia PSO establish a standard of care for my organization?

The establishment of a legal standard of care falls under the jurisdiction of courts and professional organizations' issuing of standards and guidelines. The preamble to the final regulation implementing PSQIA states that it is "highly unlikely" that the PSO's feedback will establish a standard of care given that the feedback is provided within a legal environment with confidentiality and privilege protections.

24. Is Virginia PSO obligated to analyze and provide feedback on all PSWP it receives from a provider?

No. A PSO is not required to analyze *all* information received from providers; however, one of the patient safety activities a PSO is generally required to engage in is to provide feedback. Virginia PSO provides feedback to its PSO members and aggregates and deidentifies the data to provide feedback on regional and national trends, among other activities.

25. PSQIA allows for certain disclosures of PSWP. What are these exceptions?

PSWP that is impermissibly disclosed will lose legal protections provided by federal law. As such, it is important to understand what is meant by "disclosure" of PSWP and which types of disclosures are permissible. Disclosure refers to the release of, transfer of, provision of access to, or divulgence in any manner of PSWP by an entity or person maintaining that PSWP to another legally separate entity or person other than a workforce member of, or health care provider holding privileges with, the entity holding the PSWP.

Limited exceptions to privilege and confidentiality apply. Disclosures of PSWP will not violate either confidentiality or privilege in the following four situations:

1. If a court in a criminal proceeding makes an *in camera* determination regarding whether the PSWP contains evidence of a criminal act, is material to the case, and is not reasonably available from any other source
2. To the extent required to permit equitable relief under the Public Health Service Act, provided that a protective order has been obtained from the court or administrative tribunal to protect the confidentiality of the PSWP in the course of the legal proceedings
3. If authorized in writing by each provider identified in the PSWP before disclosure is made
4. If the PSWP meets specified standards to ensure that it does not identify any providers, patients, or reporters

In addition, limited exceptions to confidentiality apply although the legal privilege remains. Disclosures of PSWP will not violate confidentiality in the following situations:

1. Disclosure to law enforcement personnel, if the PSWP is related to an event the discloser reasonably believes constitutes a crime and the discloser reasonably believes the PSWP is necessary for criminal law enforcement purposes.
2. Disclosure between providers and PSOs or to contractors who perform patient safety activities on their behalf. Disclosure to a provider or a second PSO also is permitted as long as the PSWP is stripped of identifying information (made anonymous). Disclosure to an affiliated provider such as a parent organization is permitted even if the information is not made anonymous.
3. Disclosure to professionals, such as attorneys or accountants, in the course of business operations. However, these professionals may not further disclose the PSWP.
4. Disclosure to FDA, to entities that are required to report to FDA, or to entities with which FDA contracts for these purposes.
5. Voluntary disclosure to an accrediting body that accredits the provider if the information is made anonymous.
6. Disclosure to persons carrying out research, evaluation, or demonstration projects that are funded or otherwise sanctioned by the Secretary of HHS.
7. Disclosure to the Secretary of HHS so that the Secretary can conduct compliance reviews and investigations of the PSO's adherence to PSQIA and its confidentiality measures and to HIPAA privacy provisions.

As long as no information is disclosed for the purposes of assessing the quality of care or actions or failures of an identifiable provider, the rule also creates a narrow "safe harbor" for inadvertent mistakes in disclosing PSWP so that legal protections are not lost. This safe harbor applies only to providers and their responsible parties, such as employees—not to PSOs. (Details about privilege and confidentiality protections and exceptions are available in Subpart C of the *Federal Register* [73(226):70805-6].)

26. How is confidential data deidentified for sharing?

Information that could identify a provider, a reporter, or a subject (e.g., a patient) is removed from PSWP in order to deidentify it. Deidentification of PSWP is conducted by PSOs for aggregate analysis of the data. Deidentification of data can be accomplished in one of two ways: (1) use of statistical and scientific methods to ensure that the information is not individually identifiable or (2) removal of specified categories of direct identifiers. The removal of individually identifiable information is consistent with the HIPAA privacy rule.

Virginia PSO
Virginia Patient Safety Organization

27. Where can my organization obtain more information about PSQIA?

Available resources for understanding PSQIA include:

The text of PSQIA, available online at http://www.pso.ahrq.gov/statute/pl109-41.htm

The November 21, 2008, final rule implementing PSQIA, which was published in the *Federal Register* and is available online at http://edocket.access.gpo.gov/2008/pdf/E8-27475.pdf

The AHRQ Web site on PSOs, available at http://www.pso.ahrq.gov/index.html

The Virginia PSO Web site, which is available at https://members2.ecri.org/components/psocore/Pages/virginiapso.aspx , and provides advisories, answers to FAQs, and recordings of audio conferences about PSOs

The Web site of the PSO Privacy Protection Center, available at http://www.psoppc.org