Patient Safety Organizations (PSOs): What Every Physician Group and Ambulatory Services Provider Needs to Know

Ellen Flynn RN, MBA, JD
AVP, Safety Program
Vizient PSO

Speaker Bios

Ellen M. Flynn RN, MBA, JD
Associate Vice President, Safety, Vizient
In her role at Vizient, Flynn has oversight of the Vizient Patient Safety Organization (PSO), leading patient safety activities provided by the PSO to help members improve patient safety, health care quality and outcomes. She works with members on topics such as “Just Culture,” “High Reliability,” “Human Factors” and “Culture of Safety.”

Michael R. Callahan, Katten Muchin Rosenman LLP
Michael R. Callahan assists hospital, health system and medical staff clients on a variety of health care legal issues related to accountable care organizations (ACOs), patient safety organizations (PSOs), health care antitrust issues, Health Insurance Portability and Accountability Act (HIPAA) and regulatory compliance, accreditation matters, general corporate transactions, medical staff credentialing and hospital/medical staff relations.

Jill Olinick PT, Manager Safety Events,
Mercy Center for Quality and Safety
Jill Olinick provides leadership oversight of the event reporting system, facilitating any changes to the system and focusing efforts on improving patient safety based on event review trends. Jill is responsible for PSO relations and engaging the right teams in event review discussions as well as development of processes to improve event reporting and response. She has over 25 years of healthcare experience that includes staff PT, leadership and operations as well as initiation of Safe Patient Handling programs, Work Safety and Ergonomics. Jill holds current certification in ergonomics and maintains her PT license. She is a member of ASPPS.

Priya Khatri MBA, MPH, Director, Strategic Analytics and Performance Improvement, UT Physicians
Priya Khatri works in strategic analytics and performance improvement at UT Houston Health Science Center. She is a member of the Patient Safety Leadership team that led the installation and launch of safety event reporting. Currently, Priya helps manage the safety event reporting system. She works with the outpatient practice to identify opportunities for improvement, implement interventions, and spread best practices across clinics.

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Disclaimer

- The opinions expressed in this presentation do not reflect the official position of the Agency for Healthcare Research and Quality (AHRQ) or the Office of Civil Rights (OCR).
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The Vizient PSO provides a full spectrum of safety services

Vizient PSO: What makes us different?

Patient Safety Pioneer

- Long history of turning patient safety event data into actionable information to improve outcomes and collaborating with members to define leading patient safety practices since 2001
- Robust event reporting format and taxonomy developed in 2001

Credibility

- Component of Vizient Inc., the nations largest member owned healthcare performance management companies
- Patient safety learnings regularly highlighted at the AHRQ annual PSO meeting, IHI Patient Safety Congress, and IHI National Forum meetings, published in peer review journals and available to the healthcare community on the Vizient website
- Over 200 healthcare providers collaborate with Vizient PSO to improve patient safety outcomes

Patient Safety Organization key takeaways

- PSOs offer privilege and confidentiality protections that are national in scope
- PSOs aggregate data to identify patterns, trends, and the underlying causes of infrequent, but often tragic, adverse events faster than individual organizations
- PSOs can convene its reporting providers in a protected environment to leverage learning and improvement
- PSOs collect data in a standard format to allow for meaningful comparisons amongst similar providers

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2019 Summary of event types resulting in high harm (Greater than 18 years)

- **Behavioral management**
  - Suicide (post discharge or ambulatory treatment)
  - Elopement
  - Violence (self and others)
  - Forensic patient care
- **Unexpected Cardiac and Respiratory arrest**
  - ED (boarders)
  - Medical Surgical Units
  - Procedural areas
  - Radiology
  - Telemetry patients (alert fatigue)
- **Critical result reporting delays**
- **Provider-patient communication errors/delays relative to results**
- **Delays in treatment (Stroke, Sepsis)**
- **Falls (Post-fall treatment)**
- **Maternal complications**
- **Medication safety**
  - Anticoagulants
  - Opioid overdose (pain management)
  - Procedural Sedation
- **Pressure ulcers**
- **Readmissions from ED and Acute care**

Vizient PSO Data from July 1, 2017 – June 30, 2018

Vizient PSO patient safety activities drives improvement in ambulatory providers

Education

- Topical safety webinars
- High reliability outcomes, culture of safety and CANDOR
- Alerts, Tool kits, White papers

Collaboration within PSES

Privileged and Confidential

- Ambulatory huddles and topical safe tables
- Individual feedback reports with comparative data
- Safe learning space within licensed provider organization and with affiliated providers

Networking

- Semiannual in-person meeting
- Quarterly, Power learning – user group, Listserv
- Leading practice advisory groups

Operations

- Ambulatory reporting format and taxonomy
- SFTP set up for secure data submission events, root cause analysis, failure mode effects analysis, peer review
- PSES documentation

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2019 Vizient PSO Calendar of Webinars

Month	HRO and Safety Culture*	Topical Safety*	Safe Table	PSO operations
January	January 22: Standard work: Changing role of the manager to sustain improvements	January 16: Closing the loop on abnormal laboratory test results (2PM Central Time) (90 min)		January 24: PSO Orientation
February	February 19: Redefining Patient and Provider Relationships	February 7: Closing the loop on incidental radiology findings (90 min)		February 27: PSO Power Learning
March	March 19: Transforming the mid-level leadership role in HROs	March 14: Managing the risks associated with concentrated insulin	March 12: Procedural Sedation	March 6: Case Law updates
April	April 8-10: Semi-Annual In-person PSO Meeting	April 3: Neuromuscular Blocking Agent Administered to an Unventilated Patient April 11: Forensic patient care		April 17: PSO Orientation
May	May 7: Working with a PSO in physician and other ambulatory care practices to improve patient safety outcomes	May 9: Procedural Sedation (90 min)		
June	June 18: Role of event reporting	June 13: Preventing wrong site procedures	June 27:Suicide: Post discharge and during outpatient treatment	June 5: PSO Power Learning
July		July 11: Vaccines		
August	August 20: Safety science	August 8: Suicide: Post discharge and during outpatient treatment (90 min)		August 14: PSO Orientation
September	September 16-18: Semi-Annual In-person PSO meeting at Vizient Summit	September 12: Pressure Injury	September 10: Handoffs: Improving the communication between departments	
October	October 15: Culture of safety	October 10: Handoffs: Improving the communication between departments (90 min)		October 23: PSO Power Learning
November	November 5: Comprehensive safety program	November 14: Cardiac and Respiratory arrest outside the ICU		November 6: Case Law Update
December	December 3: Change management	December 5: Neonatal morbidity and mortality	December 12: Readmission to the ED	

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Vizient PSO Safety Huddle

If it happens at one organization can happen at any organization without the right controls.

Jaundice meters

"0" meaning out of range indication may be misinterpreted as normal leads to recall.

Skull clamps

Breakage of the skull clamp screw pin during the procedure.

Mobile computer workstations

Prevent fires by creating a cleaning, inspection and maintenance schedule.

Go-LYTELY

Evaluate current nursing reconstitution practices to prevent the risk of dosing errors.

Umbilical cord security tags

Determine if your tags have a one-year limited warranty and fail to operate after this period.

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Vizient® Patient Safety Organization (PSO) Aggregate Analyses and Leading Practice Documents

2013	2014	2015	2016	2017	2018	2019
Retained Surgical Sponges	Health IT-related Safety Events	Assaults by Patients in Hospitals	System Wide Management of Clinical Alarms	Discharge care for patients on DOACs	Burns from Light Source Cables	Closing the Loop on incidental radiology findings
					Accurate Perioperative Orders	Closing the Loop Abnormal Labs
Guidewires Unintentionally Retained During CVC	Ventilator-Related Adverse Events	New Standards for Enteral Connectors	Management of Cardiac/Physio-logic Alarms	Periprocedural care for patients on DOACs	Jaundice Meter	Procedural Sedation
					Opioid Safety	Suicide post discharge or in outpatient tx
Suicide Prevention	Surgical Specimen Events	Robotic-assisted Surgery	Health IT-related medication safety	Fall Prevention	Management of Behavioral Issues Violence Prevention	Managing Behavioral Issues in Ambulatory
					Concentrated Insulin	Hand-off Communication ED to Floor
					Prevent injury from skull clamps	Unexpected cardiac/respiratory arrest outside ICU
Errors, Omissions and Delays in Diagnosis	Surgical Specimen Management: A Descriptive Study of 648 Adverse Events and Near Misses	Preventing air embolism from central venous catheters	Anticoagulants	Periprocedural Care Coordination	Air Embolism	Dental Events
					GoLYTELY Reconstitution	ED Readmission
					Surgical Specimen Errors	TBD

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To improve patient safety and reduce medical errors by creating a “culture of safety” to share and learn from information related to patient safety events

Goal 1: Patient Safety and Quality Improvement Act 2005

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To promote health care providers' accountability and transparency through mechanisms such as oversight by regulatory agencies and adjudication in the legal system.

Goal 2: Patient Safety and Quality Improvement Act 2005

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Ambulatory practices can create a safe culture of learning by working with a PSO

Provider (non-PSES) Operations

- Open, honest, transparent communication with patient, family, care team, regulators (consistent with HIPPA requirements)
- Event disclosure and possible reconciliation with patient and family
- Support for patient, family and caregivers

Provider PSES

- Event reporting, RCA, FMEA, peer review
- Deliberation and analysis
- Sharing lessons learned within provider and with affiliated providers
- Action plans

Privileged and Confidential

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Michael R. Callahan
Katten Muchin Rosenman LLP
Chicago, Illinois
+1.312.902.5634
michael.callahan@kattenlaw.com

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Environmental Overview

- Plaintiffs are looking for as many deep pockets as possible in a malpractice action
  - Hospital has the deepest pockets
- Tort reform efforts to place limitations or “caps” on compensatory and punitive damages have increased efforts to add hospitals, health systems, physician groups and any other providers involved in the alleged negligent acts as defendants
- Different theories of liability are utilized
  - Respondent Superior
    - Find an employee who was negligent

Environmental Overview (cont'd)

- Apparent Agency
  - Hospital-based physician, i.e., anesthesiologist, was thought to be a hospital employee by the patient and therefore hospital is responsible for physician's negligence
  - Physician group or ancillary provider which is owned, managed, controlled or affiliated with the hospital and is marketed as such could be treated as an apparent agent
- Doctrine of Corporate Negligence
  - Hospital, CIN, ACO, PHO, ancillary provider issued clinical privileges to a practitioner who provided negligent care who they knew or should have known was not competent

- Industry shift from reimbursing providers based on the volume of services provided to the value of services obtained – must satisfy quality outcomes/metrics in order to be paid

Environmental Overview (cont'd)

- Greater transparency to general public via hospital and other provider rankings, published costs and outcomes, accreditation status, physician licensure status, etc.
- Medicare Shared Savings Program ACOs which require compliance with 33 identified quality metrics in order to share in savings
- Medicare Value Based Purchasing standards based on quality metrics
- MACRA/MIPS
- Payment denials for growing list of never events, i.e., wrong site surgery
- Payment denials for hospital acquired infections
- Payment penalties tied to high readmission rate

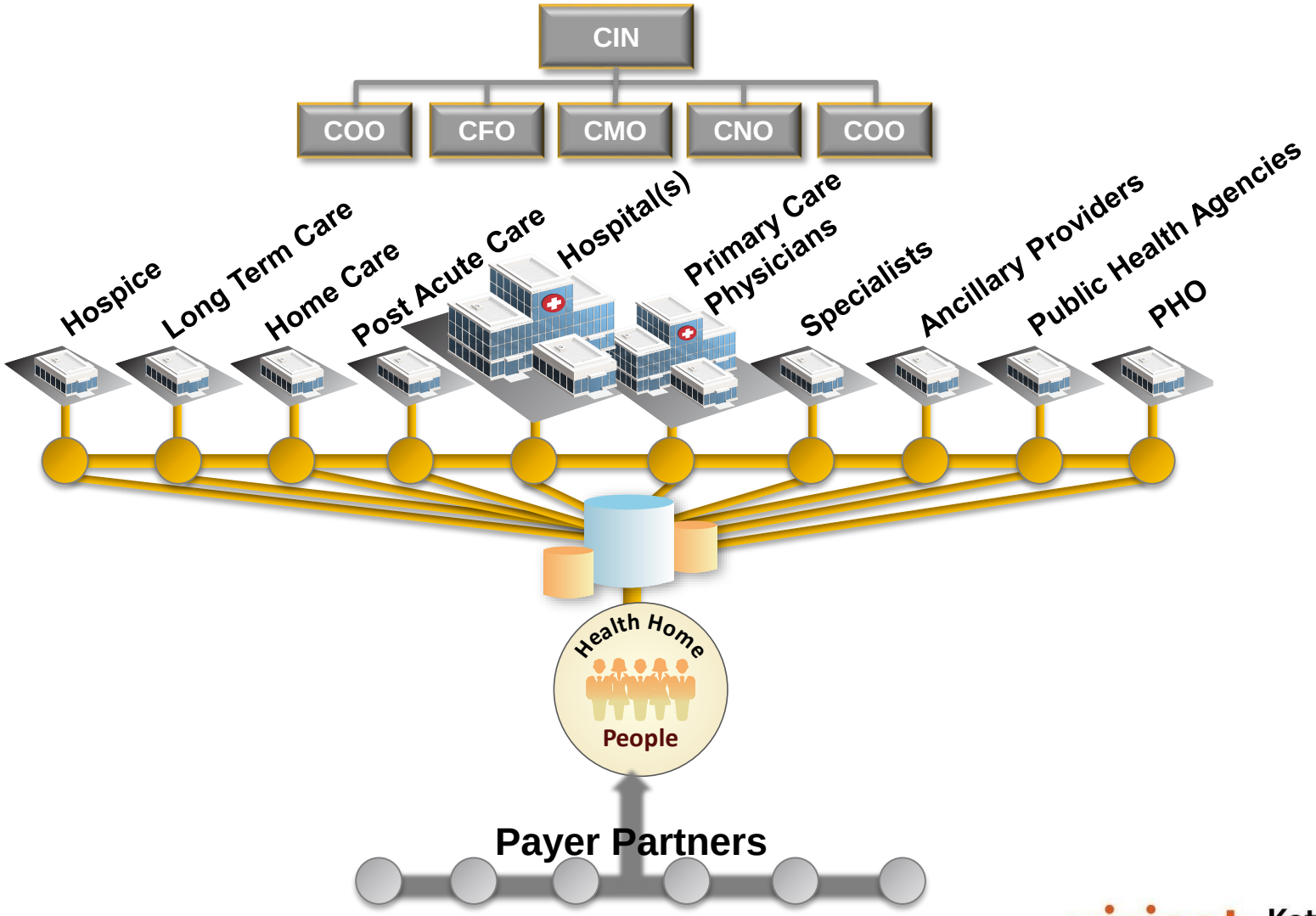
Environmental Overview (cont'd)

- Pay for performance standards required by managed care payors
- This "volume to value" shift will require continuous and ongoing monitoring of provider's compliance with these quality metrics and outcome requirements which will result in the generation of sensitive quality, peer review and risk data, reports and analyses
- Hospitals and physicians are being required to report their outcome data to state and federal agencies which are made available to the public resulting in greater transparency for comparative shopping based on quality and price

Environmental Overview (cont'd)

- All of this and more information must be taken into consideration when appointing, reappointing, credentialing, privileging and monitoring physician/APN/PA performance so as to assess current competencies to perform all clinical privileges at hospitals, managed care organizations, nursing homes, clinics, surgicenters, clinically integrated networks, etc., and to comply with quality outcome and metrics requirements
- The challenge is to utilize and maximize the available state and federal privilege protections in order to protect this information from discovery and admissibility into evidence

Complete view of an operational CIN



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Background

- **Legislative History**
  - Patient Safety and Quality Improvement Act of 2005 (Patient Safety Act)
  - Signed into law July 29, 2005
  - Final rule released November 21, 2008
  - Rule took effect January 19, 2009

Background

- The goal of the PSA was to improve patient safety by encouraging voluntary and confidential reporting of health care events that adversely affect patients. To implement the PSA, the Department of Health and Human Services (HHS) issued the Patient Safety and Quality Improvement Rule (Patient Safety Rule).
- The PSA and the Patient Safety Rule authorize the creation of PSOs to improve quality and safety through the collection and analysis of aggregated, confidential data on patient safety events. This process enables PSOs to more quickly identify patterns of failures and develop strategies to eliminate patient safety risks and hazards.

Background

- **The PSA:**
  - Provides privilege and confidentiality protections for information when providers work with Federally listed PSOs to improve quality, safety and healthcare outcomes
  - Authorizes establishment of “Common Formats” for reporting patient safety events
  - Establishes “Network of Patient Safety Databases” (NPSD)
  - Requires reporting of findings annually in AHRQ’s National Health Quality / Disparities Reports

Patient Safety Act

Learning environment

- Facilitates development of a safe and protected learning space where providers focus on improving care versus legal or disciplinary implications of findings
- Allows provider organizations to maintain a “Just Culture” of accountability with deliberate PSES set-up

Equal consistent enforcement

- Enables all licensed providers to receive equal protections
- Supports new healthcare models that place more and more responsibility on non-physician healthcare providers and corporate parent organizations

Nationwide and Uniform

- Enables healthcare providers to collaborate and learn from quality, safety and healthcare outcome initiatives that cross state lines without legal ramifications

Patient Safety Act

Early recognition

- Enables the PSO to detect patterns and trends not readily visible in patient safety data of a single organization or small health system

Meaningful comparison

- Encourages data collection, aggregation and analysis amongst similar providers in a common format to allow for meaningful comparisons and easier identification of improvement opportunities

Flexible Participation

- Allows providers to negotiate with PSOs about the quantity and type of data reported as well as the type of analysis and feedback provided by the PSO

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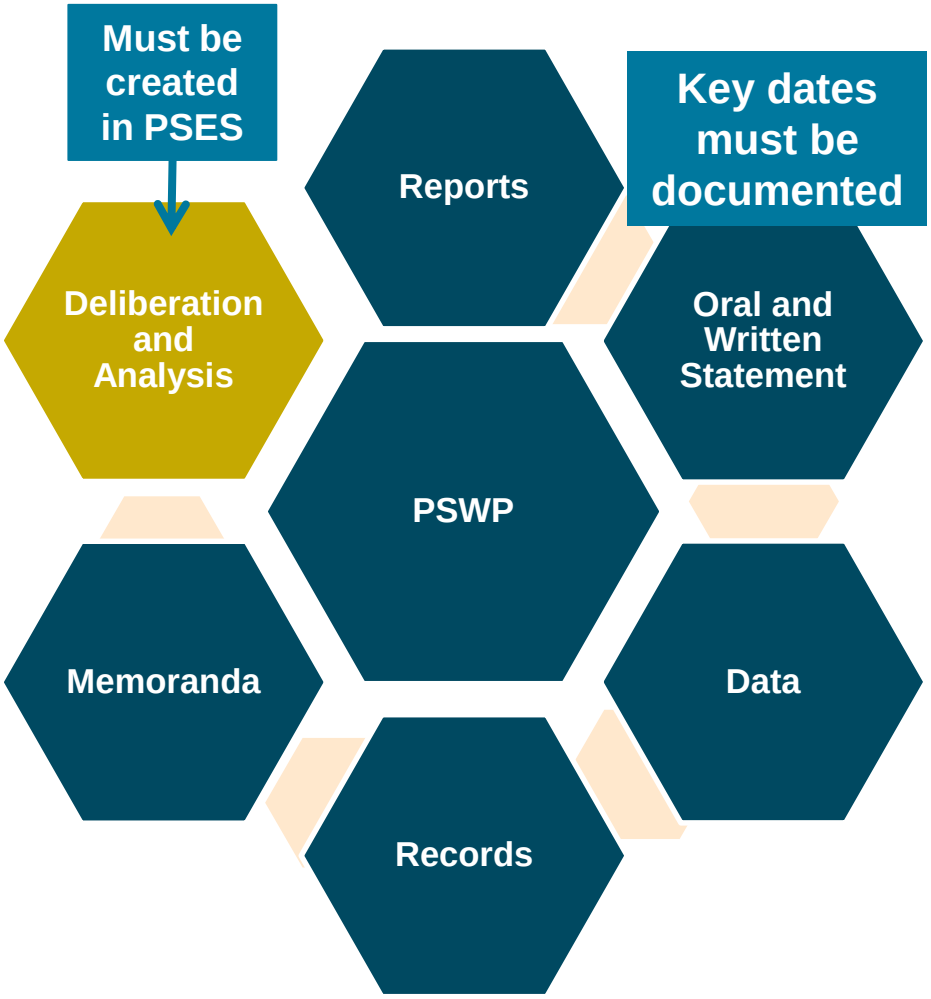
Patient Safety Activities

- Efforts to improve patient safety and the quality of health care delivery
- The collection and analysis of patient safety work product
- The development and dissemination of information with respect to improving patient safety, such as recommendations, protocols, or information regarding best practices
- The utilization of PSWP to encourage a culture of safety and provide feedback and assistance to effectively minimize patient risk
- The maintenance of procedures to preserve confidentiality with respect to PSWP
- The provision of appropriate security measures with respect to PSWP
- The utilization of qualified staff
- Activities related to the operation of a PSES and to the provision of feedback to participants in a patient safety evaluation system.

What is Patient Safety Work Product?



PSA Requirements

- Data which could improve patient safety, health care quality, or health care outcomes
- Data assembled or developed by a provider for reporting to a PSO and are reported to a PSO and/or which constitute
- Analysis and deliberations conducted within a PSES
- Data developed by a PSO to conduct patient safety activities

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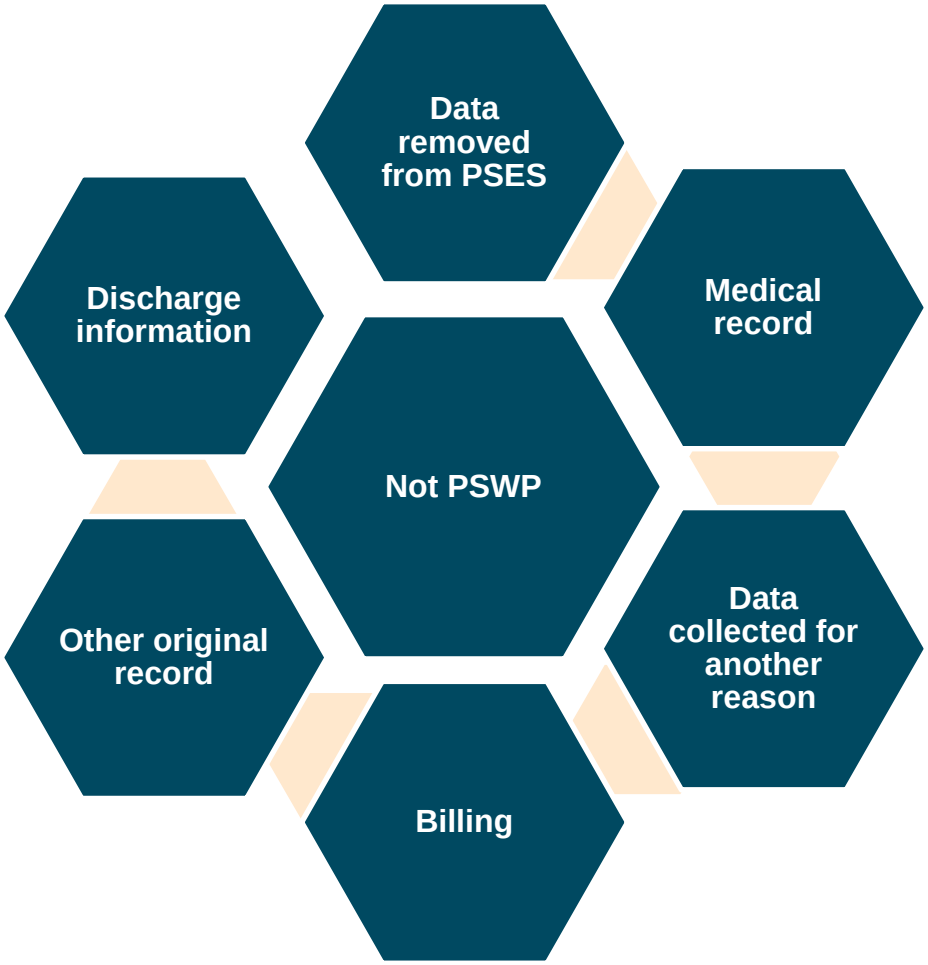
What is Not PSWP?



- Information collected, maintained, or developed separately, or exists separately, from a PSES.
- Data removed from a patient safety evaluation system
- Data collected for another reason
- Mandatory adverse event report

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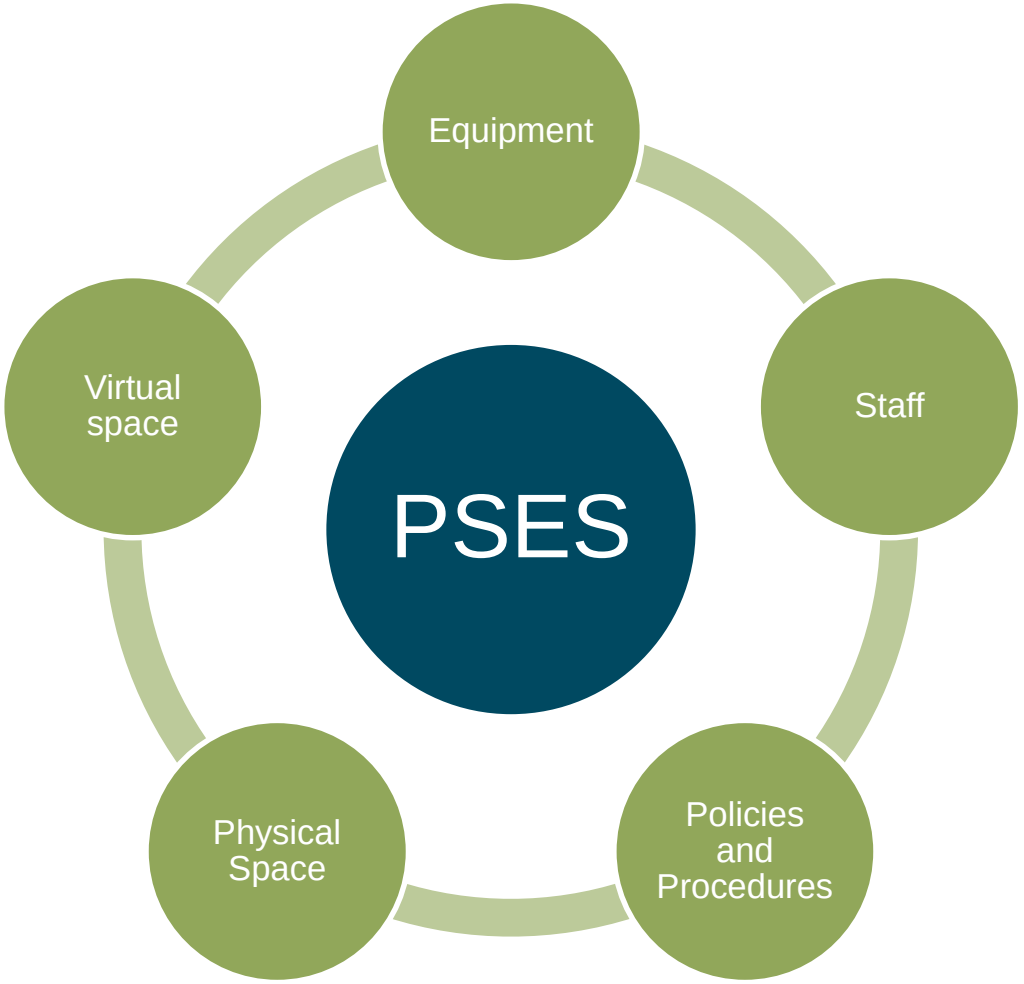
Patient Safety Evaluation System (PSES)

PSES is the collection, management, or analysis of information for reporting to or by a PSO. A provider's PSES is an important determinant of what can, and cannot, become PSWP.



PSA Privilege and Confidentiality Standards Prevail Over State Law Protections

The privileged and confidentiality protections and certain restrictions on disciplinary activity supports development of a Just Learning Culture

State Peer Review

- **Limited in scope of covered activities and in scope of covered entities**
- **State law protections do not apply in federal claims**
- **State laws usually do not protect information when shared outside the institution – considered waived**

Patient Safety Act

- **Consistent national standard**
- **Applies in all state and federal proceedings**
- **Scope of covered activities and providers is broader**
- **Protections can never be waived**
- **PSWP can be more freely shared among affiliated providers throughout a health care system**
- **PSES can include non-provider corporate parent**

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PSWP is Privileged

Not subject to:

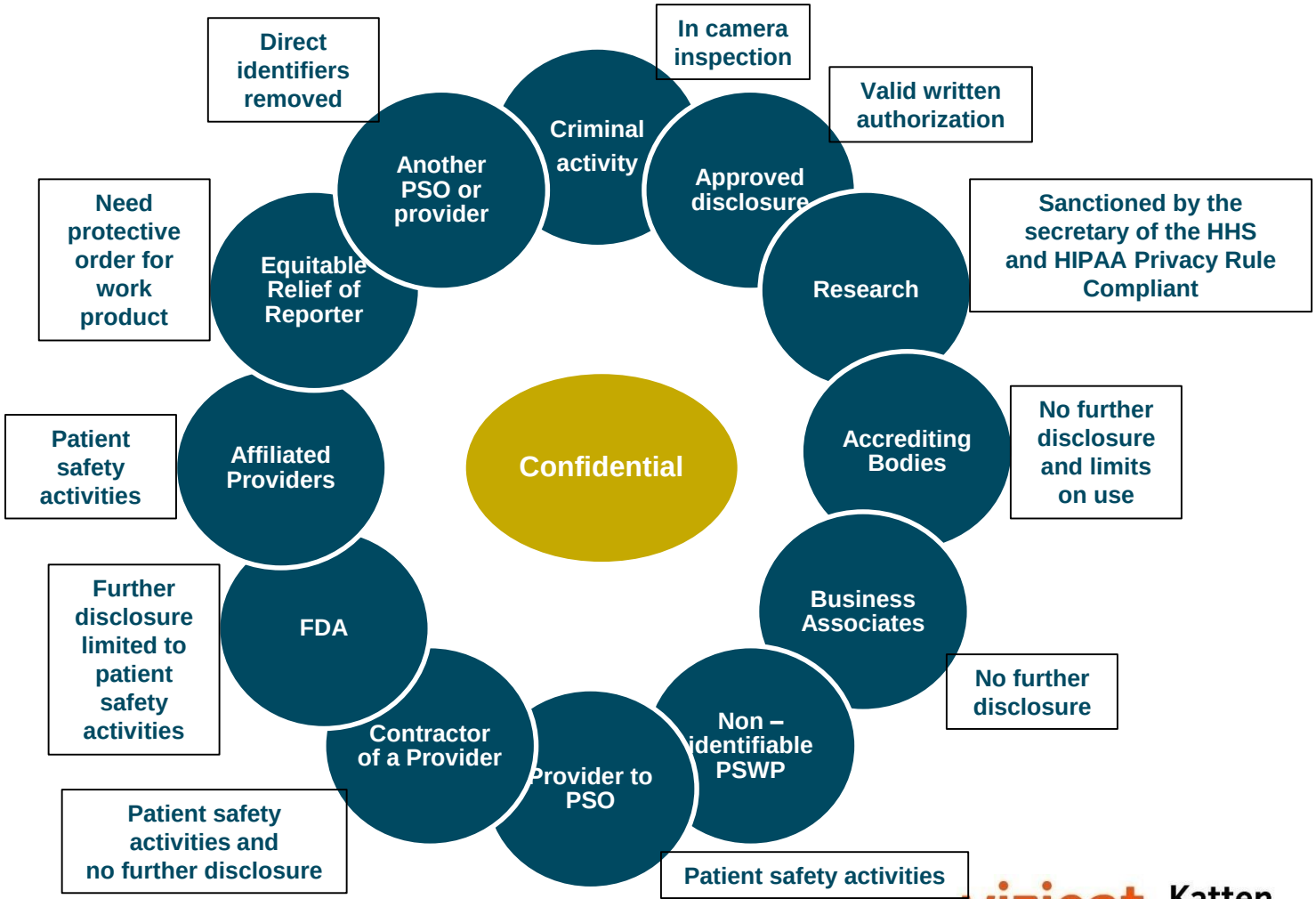
- Subpoenas or court order
- Discovery
- FOIA or other similar law
- Requests from accrediting bodies or CMS

Not admissible in:

- Any state, federal or other legal proceeding
- State licensure proceedings

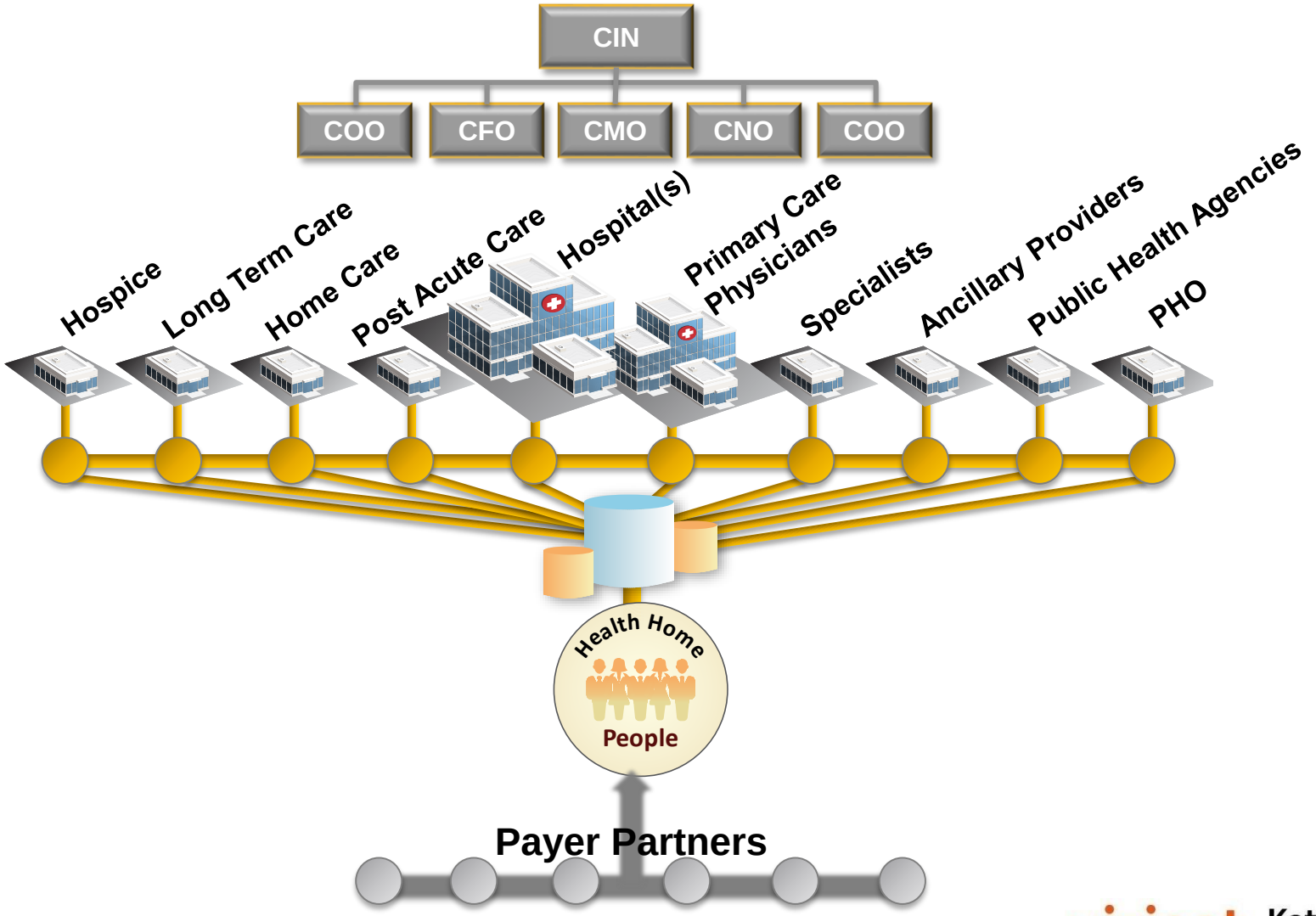
PSWP is confidential and not subject to disclosure with limited exceptions

Please see Patient Safety Final Rule for a complete description



Peer Review Protections For Physician Groups and Ancillary Providers

Complete view of an operational CIN



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What is “Peer Review”

- The term “peer review” is a catch-all reference used by hospitals and other providers to cover and describe a broad range of activities, discussions, analyses and work product involving:
  - Quality assurance and improvement
  - Performance improvement
  - Ongoing monitoring under OPPE/FPPE and other quality standards
  - Tracking outcomes and compliance with quality metrics
  - Monitoring, proctoring, investigating, analyzing and correcting substandard practices and disruptive behavior
  - Similar remedial measures and efforts to evaluate the current competency of physicians, advanced practitioners, nurses and other healthcare practitioners

What is “Peer Review”

- Consequently, if these peer review activities, which is a subset of patient safety activities, are identified, collected, analyzed and utilized for the purpose of improving patient care by the provider as subscribed within the provider’s PSES policy, all of the work product and discussions can be treated as PSWP
- The Final Rule states that PSWP can be used for peer review, credentialing and other peer review and quality purposes within a single legal entity, i.e., hospital, physician group, without limitation if used for patient safety activities
- BUT an employer may not take an adverse employment action against an individual based on the fact that the person reported PSWP in good faith to a provider with the expectation that it would be reported to a PSO or if reported directly to the PSO

Asserting PSA and/or State Peer Review Protections

- Keep in mind that physician groups and other providers may also be able to assert the privileged protections under state law
  - You need to review state statutes and the case law in order to determine the scope of covered entities and covered activities
  - Any state statutes focus on whether the activity or work product in dispute were involved or is produced by a “committee” thereby lending the scope of privilege protections
  - Depending on the document in question, both the state and the PSA privilege protections could apply although PSA protections usually are broader
  - You cannot also assert attorney-client work product privilege for these materials

Sharing PSWP

- Physician/ancillary provider PSWP can be shared by and between affiliated providers
  - Identifiable PSWP may be freely “used” within the physician group or other ancillary entity – a disclosure exception is not required
  - Physician identifiable PSWP may be “disclosed” to other affiliated entities but you must some how obtain the prior written authorization of the provider. Options include:
    - Specific written authorization language in the physician appointment/re-appointment application
    - Specific written authorization language in the employment agreement
    - Use of a specific form each time physician/provider PSWP is disclosed

Need to Choose a PSWP Pathway

- Your PSES policy should identify in some detail all of the patient safety activities, reports, analyses, peer review activities, etc., which the provider wants to treat as PSWP.
- Reporting Pathway
  - PSWP is either electronically or physically reported to APSO.
  - PSWP is "functionally reported" to the PSO.
- Deliberations or Analysis Pathway
  - The definition of PSWP also includes any data, reports, records, memorandum, analyses or written or oral statements which… identify or constitute the deliberations or analysis of, or identify the fact of reporting to a ["PSO"] (Emphasis added).
- Any PSWP which is not physically or functionally reported to a PSO should be categorized as deliberation or analysis within the PSES policy.

Need to Choose a PSWP Pathway

- PSWP which is deliberation or analyses automatically becomes PSWP when collected within the PSES and cannot be “dropped out” and used for other purposes.
- PSWP which is deliberation or analyses does not need to be reported to a PSO in order to be treated as privileged and confidential.
- Because all of the reported Appellate Court cases, including those in which the information was deemed to be PSWP, are actual reporting to the PSO cases, serious consideration should be given to reporting peer review information to a PSO.

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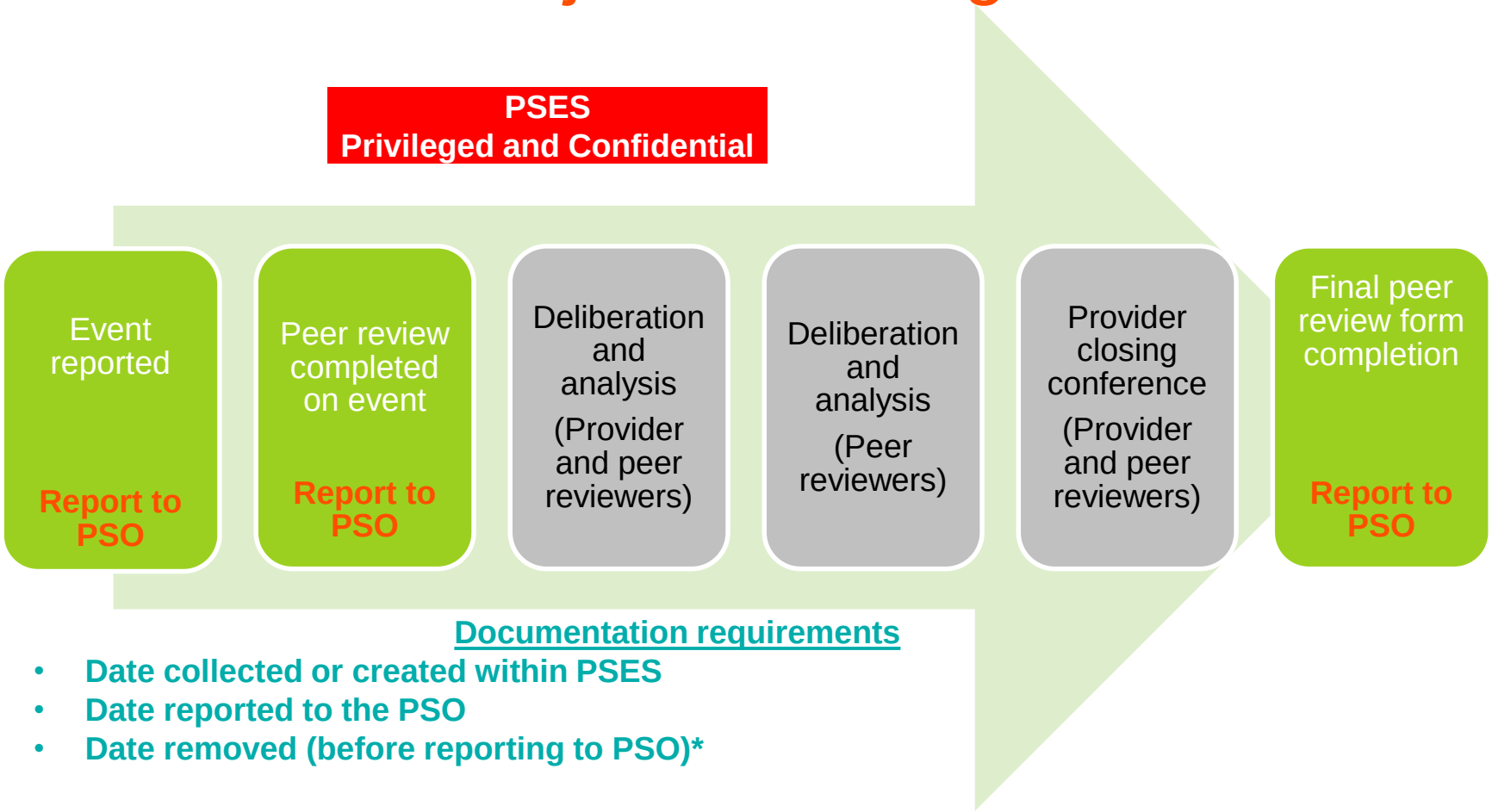
Peer review conducted within a provider's PSES creates a "just" learning culture

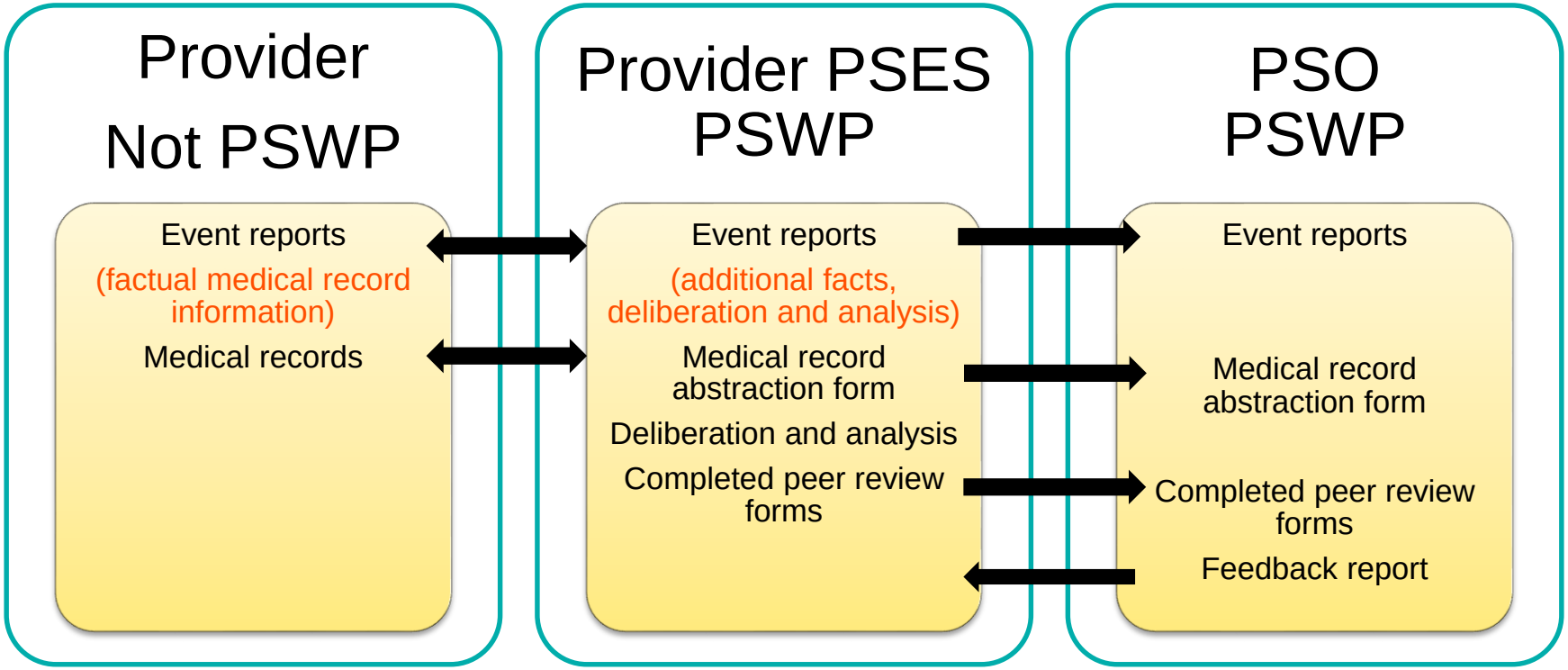


Documentation requirements

- **Date collected or created within PSES**
- **Date reported to the PSO**
- **Date removed (before reporting to PSO)***

PSO submission: event report, peer review initial and final forms

PSWP may be used within the provider organization and maintained within PSES



Documentation requirements

- **Removal from PSES must occur before PSO reporting**
- **Provider has responsibility to document date collected/created within PSES, removal or date reported to PSO**

Peer Review

- Activities conducted in a PSES are PSWP and the ability to disclose PSWP is limited
- Facility would have difficulty demonstrating that it had the required peer review process for example to CMS
- If peer review uncovers information that demonstrates the need to revoke or limit privileges, the PSWP cannot be used in court to support the facility's decision, if challenged
- As a best practice do not conduct any peer review activity in a PSES that has potential to lead to an adverse employment action and meet any required peer review process outside of your PSES

CANDOR and PSOs: Improving patient safety

- CANDOR: Build a just, culture of learning where honesty is normalize and patients family and caregivers are supported to achieve the best outcomes
  - Encourage a team in your organization to become certified in CANDOR at the Vizient November 2019 education

- If not in a PSO, join one and consider Vizient:
  - Establish a safe space to learn about why events occurred and how to prevent future events
  - Leverage a PSO for insights and a forum to teach and learn

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Transform care with PSO participation

Organizations have flexibility when engaging with PSOs to contract for services

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Thank you! Questions?

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Review PSES Consideration Checklist (1)

Workforce
• Develop grid with job titles, responsibilities and level of access to PSWP and purpose
• Identify 2 key contact roles for PSO
Description of the following:
• PSES Workforce training plan
• Non-PSES workforce employees and providers training plan
• Who can enter event reports into the PSES
• Who can conduct additional investigations within PSES
• Who conducts proactive risk assessments within PSES
• Who collect any data outside of event reporting system or conducts deliberation, analysis and documents date
• Who reviews data after it enters PSES
• Who can remove data from PSES before reporting to PSO and record date
• Who can report to the PSO and record date reported
• Who can functionally report to PSO and record date
• Who has access to the functionally reported drive (PSO and internal)
• Who can conduct analyses/deliberations within PSES
• Who disseminates non-identifiable PSWP
• Who determines non-identifiable PSWP
• Who may disclose PSWP

Review PSES Consideration Checklist (2)

Equipment/software
• Patient safety software environment –define what is PSWP and what is not
• Secure functional reported drive within PSES and who has access
• Secure PSES drive and who has access
PSES Operations
• Describe patient safety activities are conducted
• Describe how additional deliberation and analysis may occur within PSES
• Describe how a copy of other data may be reported to PSO
• Describe how data may be used internally
Communication
• Describe how PSWP can be shared across health system and disclosed amongst affiliate providers if applicable
• Describe how PSWP is maintained within PSES
• Describe data collected (consider data inventory)
• Describe who can access PSWP for operation of PSES and/or interactions of PSES

Review PSES Consideration Checklist (3)

Disclosure
• Describe how, when and by whom PSWP may be disclosed, disclosure form used, and record retention (minimum 6 years for provider disclosure)
• Describe what and how PSWP may be disclosed amongst affiliate providers
Functional reporting
• Describe agreement and how PSO has access
Physical space (if any)
• Describe dedicated office space
• Describe any physical storage files
Pertinent policies and other documents that might benefit from review
• Incident report
• Disclosure
• Confidentiality
• Record retention
• Discipline
• Possibly peer review
• Training
• Manager investigation
• RCA
• Privacy and Security policy
• Confidentiality
• Risk Management Policies

Speaker Bio

In her role at Vizient, Flynn has oversight of the Vizient Patient Safety Organization (PSO), leading patient safety activities provided by the PSO to help members improve patient safety, health care quality and outcomes. She works with members on topics such as “Just Culture,” “High Reliability,” “Human Factors” and “Culture of Safety.”
Prior to this position, Flynn had leadership responsibility for quality improvement, patient safety, regulatory compliance and patient engagement. In the past, she had responsibility for quality and accreditation services at University HealthSystem Consortium. She has extensive experience with both academic medical centers and large health systems, such as Children’s Hospital of Wisconsin, Rush System for Health, and Universal Health Services.

Flynn developed one of the first PSOs in the country and has a keen understanding of how to help members operationalize their patient safety activities when working with a PSO.
Ellen holds a bachelor of science in nursing from Loyola University Chicago, a master of business administration with a concentration in management information systems from DePaul University in Chicago, and a juris doctor degree from Loyola University Chicago. She is a certified professional in patient safety.

Ellen M. Flynn RN, MBA, JD, Associate Vice President, Safety (312) 775-4294 Ellen.Flynn@vizientinc.com

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Speaker Bio

Michael R. Callahan - michael.callahan@kattenlaw.com

Michael R. Callahan assists hospital, health system and medical staff clients on a variety of health care legal issues related to accountable care organizations (ACOs), patient safety organizations (PSOs), health care antitrust issues, Health Insurance Portability and Accountability Act (HIPAA) and regulatory compliance, accreditation matters, general corporate transactions, medical staff credentialing and hospital/medical staff relations.

Michael's peers regard him as "one of the top guys […] for credentialing—he's got a wealth of experience" (Chambers USA). Additionally, his clients describe him as "always responsive and timely with assistance," and say he is "informed, professional and extremely helpful" and "would recommend him without reservation" (Chambers USA). Michael's clients also commend his versatility, and say "He is willing to put on the hat of an executive or entrepreneur while still giving legal advice," according to Chambers USA.

He is a frequent speaker on topics including ACOs, health care reform, PSOs, health care liability and peer review matters. He has presented around the country before organizations such as the American Health Lawyers Association, the American Medical Association, the American Hospital Association, the American Bar Association, the American College of Healthcare Executives, the National Association Medical Staff Services, the National Association for Healthcare Quality and the American Society for Healthcare Risk Management.

Michael was recently appointed as chair of the Medical Staff Credentialing and Peer Review Practice Group of the American Health Lawyers Association. He also was appointed as the public member representative on the board of directors of the National Association Medical Staff Services.

He was an adjunct professor in DePaul University's Master of Laws in Health Law Program, where he taught a course on managed care. After law school, he served as a law clerk to Justice Daniel P. Ward of the Illinois Supreme Court.

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