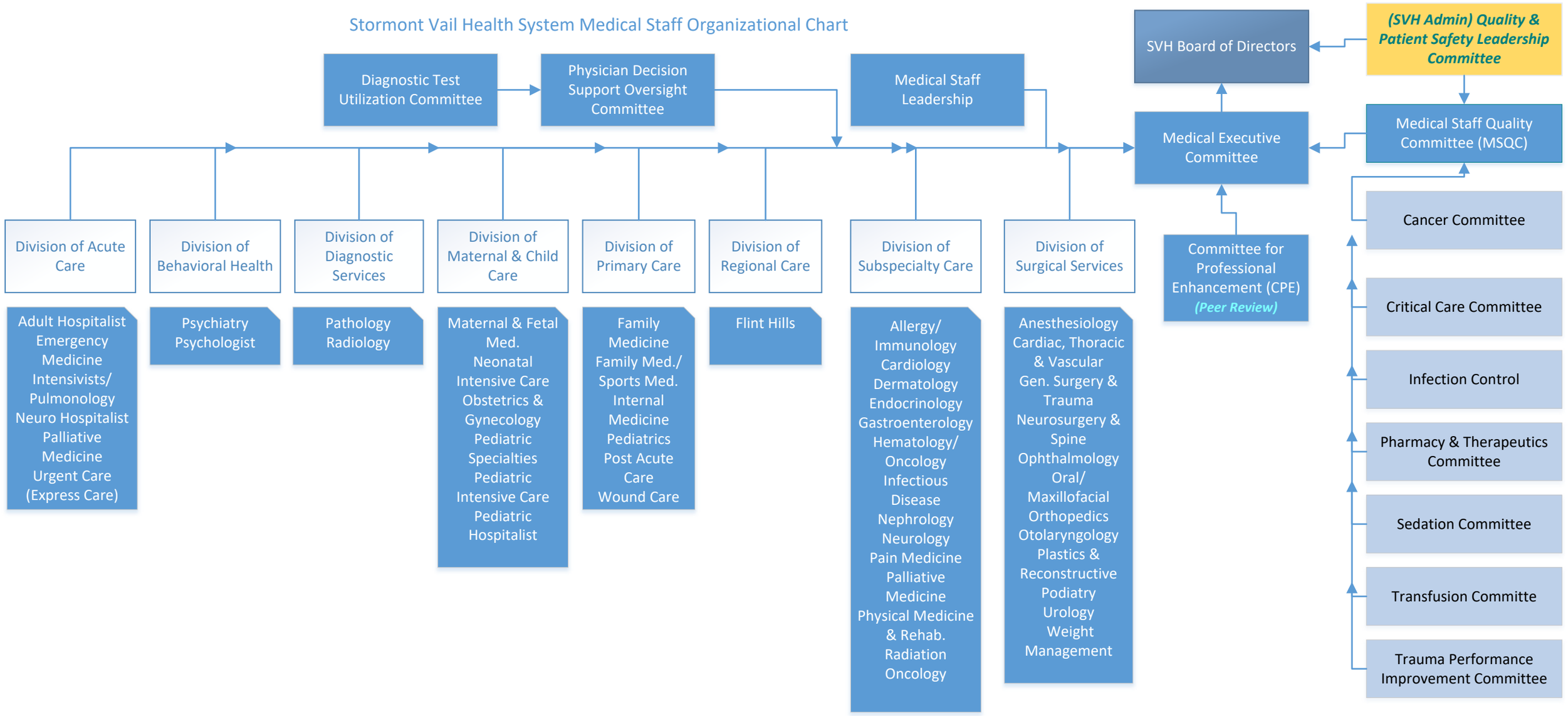
Stormont Vail Health System Medical Staff Organizational Chart



Last Revised: 2023.02.27

STORMONT VAIL HEALTHCARE

Appendix A: Flowchart of Professional Practice Evaluation Process

Events That Trigger a Review

- Specialty-Specific Triggers
- Reported Concerns
- Other (defined in PPE Policy)

Assigned Reviewer

1. Serves as consultant to CPE or CPE member and assists in reviewing case
2. Completes review form and forwards findings to CPE or CPE member, if requested

(Discretionary referral) (Findings)

Committee for Professional Enhancement ("CPE")

1. For cases referred to CPE for assessment:
   - A. CPE member will conduct initial review on behalf of CPE
   - B. If a matter involves an Employed Practitioner (as defined in the Policy), see ***Note 1***
   - C. Refer to the ***CPE Case Review Guidelines*** on the next page of this Appendix for additional guidance on the case review process

2. Determination

- A. No issue – close case
- B. Exemplary care – notify Practitioner
- C. Educational Letter
- D. Collegial Counseling
- E. Performance Improvement Plan ("PIP")
- F. Refer to Employer for disposition, after consultation with Employer (with a report back to CPE of final action taken by Employer) *(if applicable)*
- G. Refer to MEC

(Obtain input from Practitioner before any intervention)

Referral for review under Credentials & Procedural Policy, if questions or concerns cannot be resolved by CPE

PPE Specialists

1. Log in concern to peer review database
2. Follow up with individual who reported concern
3. Consult with the Chief of Professional Enhancement or designees, as necessary, for assistance regarding appropriate determinations to be made in #4 below

4. Determination
(Report to CPE)

- A. No issue – may close cases identified via triggers based on criteria approved by CPE; cases initiated via reported concern may not be closed by PPE Specialists
- B. Send Awareness Letter
- C. Refer case to CPE; or
- D. Refer to Leadership Council:
  - (i) clinical case requires immediate review or an external review due to lack of expertise on Medical Staff;
  - (ii) conduct issues; and
  - (iii) health issues.

4.C

4.D

(Clinical Issues)

Leadership Council

1. Address any matter requiring immediate review or arrange for external review if clinical expertise not available on Medical Staff, then refer to CPE, as needed
2. Address any case or matter as requested by CPE
3. Address behavioral issues pursuant to Medical Staff Professionalism Policy, if needed after triage process
4. Address health issues pursuant to Practitioner Health Policy

If Practitioner is an Employed Practitioner (as defined in the Policy), see ***Note 1***.

Notice of PIP ***Acceptance of PIP***

Practitioner Whose Care Is Under Review

MEC

Possible determinations same as for CPE, as well as those outlined in Credentials & Procedural Policy

Referral for review under Credentials & Procedural Policy, if questions or concerns cannot be resolved by Leadership Council

SYSTEM ISSUES identified at any level shall be referred to the appropriate person/committee and reported to CPE, which shall monitor the issue until resolved.

The Leadership Council or CPE may refer a case for review during a PEER LEARNING SESSION or request that the LESSONS LEARNED from the case be otherwise disseminated, after the review process for an individual Practitioner has been completed.

Note 1: If the Practitioner is employed by SVH ("Employer"), the Leadership Council or CPE may notify an SVH representative with employment responsibilities of the review and request assistance in addressing the matter. If the Practitioner is employed by an SVH-related entity or a qualifying private entity (both also referred to as "Employer"), the Leadership Council or CPE may notify a representative of the peer review committee within the Employer and request assistance in addressing the matter. In all these situations, a representative of the Employer may be invited to attend meetings of the Leadership Council or CPE, participate in deliberations, and participate in interventions.

Stormont Vail Health

Unique ID:
MRN:
DOS:

Provider Name
Department

Education/Awareness Letter

To:

From: , Chief of Professional Enhancement

Date:

Re: Order Management

As part of its ongoing and routine quality improvement efforts, Medical Staff Leadership has identified specific performance issues that can be successfully addressed solely by providing timely feedback to the Practitioners involved, rather than proceeding with a more formal review. One such opportunity for improvement has been identified with respect to order management.

The purpose of this feedback is to increase your awareness, improve patient safety and allow you to self-correct and improve. No response is required and no further review of this matter will be conducted unless a pattern is identified. However, if you would like to respond your response will be included in the event file.

Report: *(summary of reported event)*

We hope that you will receive this letter in the spirit of continuous improvement and support our efforts to create a positive approach to our review processes. Thank you in advance for your cooperation. Please let me know if you have any questions or if I can provide any further assistance to you in addressing this matter.

Enclosure: policy/procedure/rules&regs document here

STORMONT-VAIL HEALTH
COMMITTEE FOR PROFESSIONAL ENHANCEMENT
November 3, 2022

Chair: _____ Date: _____

VOTING MEMBERS:
Present = X
**X = Phone In*

ADMINISTRATIVE:

GUESTS:

Topic	Information/Discussion	Recommended Action(s)	Follow-up/ Responsible Party
I. Call to Order	The meeting was called to order at _____ by _____. *Was a confidentiality reminder provided:* ❑ *Yes* ❑ *No*		
II. Review of Minutes	The minutes from the _____ meeting were presented for review and approval.		

III.CASES REVIEW
*(This Section 3 is to be completed for **each** case reviewed by CPE at meeting)*

Unique ID:	
Date of Event:	**Practitioner:**
Event Details:	

❑ **No Further Review is Required**	❑ No further review is necessary. Notify Practitioner that review has been completed and the case has been closed.
❑ **Additional Review or Information Required Prior to CPE Determination**	❑ Seek additional input from Practitioner. ❑ Review additional cases or data related to the Practitioner to better understand any potential concerns. ❑ Invite specialist with appropriate clinical expertise to attend next CPE meeting. ❑ Request review by specialist with appropriate clinical expertise and have results provided at next CPE meeting. Review assigned to: _____ ❑ Obtain external review.

❑ **Determination**	❑ No further review is necessary. Notify Practitioner that review has been completed and the case has been closed. ❑ Exemplary care was provided. Congratulate Practitioner. ❑ Prepare Educational Letter for Practitioner. Focus of Letter: _____ ❑ Conduct or facilitate Collegial Counseling session with Practitioner. Focus of Counseling: _____ ❑ Recommend Voluntary Enhancement Plan to Practitioner. Brief summary of VEP elements to be included: *(details of VEP and its implementation will be provided to Practitioner for review and agreement)* _____ _____ ❑ Refer to Employer for disposition, with a report back to CPE for review *(if applicable).* ❑ Refer to Leadership Council. ❑ Refer to MEC for its independent review and action.

Unique ID:	
Date of Event:	**Practitioner:**
Event Details:	
❑ **No Further Review is Required**	❑ No further review is necessary. Notify Practitioner that review has been completed and the case has been closed.
❑ **Additional Review or Information Required Prior to CPE Determination**	❑ Seek additional input from Practitioner. ❑ Review additional cases or data related to the Practitioner to better understand any potential concerns. ❑ Invite specialist with appropriate clinical expertise to attend next CPE meeting. ❑ Request review by specialist with appropriate clinical expertise and have results provided at next CPE meeting. Review assigned to: _____ ❑ Obtain external review.
❑ **Determination**	❑ No further review is necessary. Notify Practitioner that review has been completed and the case has been closed. ❑ Exemplary care was provided. Congratulate Practitioner. ❑ Prepare Educational Letter for Practitioner. Focus of Letter: _____ ❑ Conduct or facilitate Collegial Counseling session with Practitioner.

	Focus of Counseling: _____ ❑ Recommend Voluntary Enhancement Plan to Practitioner. Brief summary of VEP elements to be included: *(details of VEP and its implementation will be provided to Practitioner for review and agreement)* _____ _____ ❑ Refer to Employer for disposition, with a report back to CPE for review *(if applicable).* ❑ Refer to Leadership Council. ❑ Refer to MEC for its independent review and action.

Unique ID:	
Date of Event:	***Practitioner:***
Event Details:	
❑ **No Further Review is Required**	❑ No further review is necessary. Notify Practitioner that review has been completed and the case has been closed.
❑ **Additional Review or Information Required Prior to CPE Determination**	❑ Seek additional input from Practitioner. ❑ Review additional cases or data related to the Practitioner to better understand any potential concerns. ❑ Invite specialist with appropriate clinical expertise to attend next CPE meeting. ❑ Request review by specialist with appropriate clinical expertise and have results provided at next CPE meeting. Review assigned to: _____ ❑ Obtain external review.
❑ **Determination**	❑ No further review is necessary. Notify Practitioner that review has been completed and the case has been closed. ❑ Exemplary care was provided. Congratulate Practitioner. ❑ Prepare Educational Letter for Practitioner. Focus of Letter: _____ ❑ Conduct or facilitate Collegial Counseling session with Practitioner. Focus of Counseling: _____ ❑ Recommend Voluntary Enhancement Plan to Practitioner. Brief summary of VEP elements to be included: *(details of VEP and its implementation will be provided to Practitioner for review and agreement)* _____ _____ ❑ Refer to Employer for disposition, with a report back to CPE for review

	(if applicable). ❑ Refer to Leadership Council. ❑ Refer to MEC for its independent review and action.

Topic	Information/Discussion	Recommended Action(s)	Follow-up/ Responsible Party
I. Call to Order	Hana Albrecht, DO called the meeting to order at _____PM. *Was a confidentiality reminder provided:* ❑ *Yes* ❑ *No*		
II. Review of Minutes	The minutes from the _____ meeting were presented for review and approval.		

4. STATUS OF ACTIVE VOLUNTARY ENHANCEMENT PLANS

(VEPs remain on the CPE's agenda until they are successfully completed.)

Practitioner #	***Status***

5. SYSTEM PROCESS ISSUES IDENTIFIED

(System process issues remain on the CPE's agenda until they are successfully addressed.)

Description	***Referred to:***	***Resolved (Y/N)***

6. EDUCATIONAL OPPORTUNITIES IDENTIFIED *(Lessons learned remain on the CPE's agenda until the Peer Learning Session has been held or the information is otherwise disseminated.)*

Description	***Referred to:***	***Completed (Y/N)***

7. OLD BUSINESS

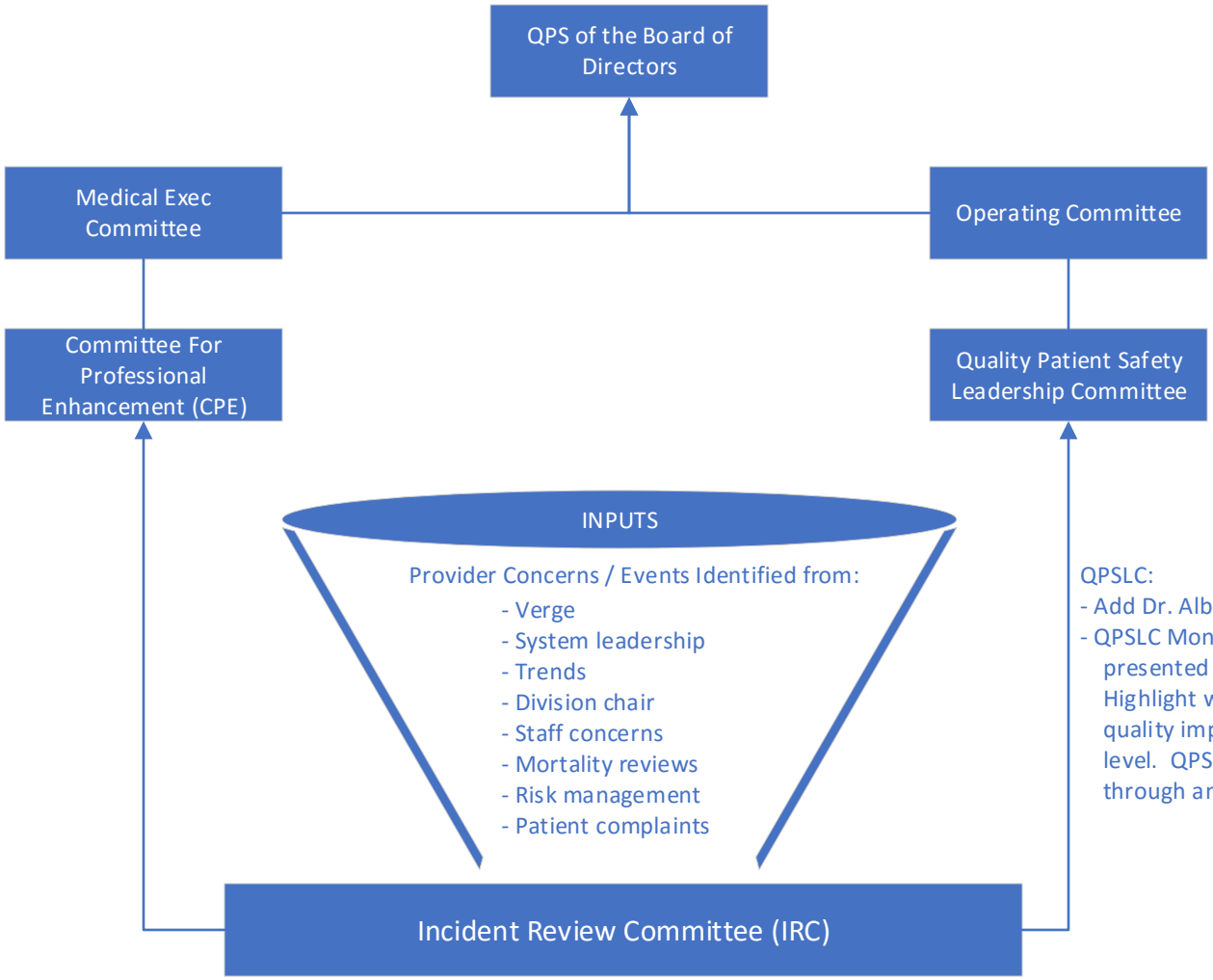
Description	***Follow-Up***

8. NEW BUSINESS	
Description	***Follow-Up***

9. ADJOURNMENT AND NEXT MEETING

Meeting was adjourned at _____

Next meeting scheduled for _____



QPSLC:
- Add Dr. Albrecht to QPSLC
- QPSLC Monthly Report: IRC summary presented each month in aggregate. Highlight where new standard process or quality improvement is needed at a system level. QPSLC will be forum to ensure follow through and implementation.

Chair: CPE Chair (Albrecht)
Administrative Coordinator: Peer Review Program Manager (Lambeth)
Membership:
- Risk Management (Shultz)
- Clinical VPs (Sachs, Lexow, Najm, Jones)
- Chief of Staff (Brey)

Frequency: Every week

STORMONT-VAIL REGIONAL HEALTH CENTER
MEDICAL STAFF POLICY AND PROCEDURE

Policy Name	Medical Staff Peer Review Plan
Initial Approval Date	12/02
Revision Dates	04/07; 08/09; 06/13
Approved by	Board of Directors

Section 1 Objective

1.1 The Stormont-Vail Medical Staff and Stormont-Vail Regional Health *Center* are responsible for the quality of care and services provided to patients throughout our organization. The Medical Staff supports peer review and performance improvement activities through non-biased activities that monitor measure and assess the care delivered by the Hospital and individual practitioners. When necessary, changes will be developed or recommended to the Hospital and individual practitioner's practice to improve care and services.

Section 2 Medical Staff Quality Improvement Committee (QIC)

2.1 Within the umbrella of peer review (K.S.A. 65-4915, et seq.) the Quality Improvement Committee coordinates and integrates the medical staff's peer review and performance improvement process.

2.1.1 The Quality Improvement Committee conducts medical staff peer review in compliance with K.S.A. 65-4915 and makes recommendations to the Medical Executive Committee and the Kansas Board of Healing Arts as required by K.S.A. 65-4923.

2.1.2 The Quality Improvement Committee coordinates and integrates performance improvement activities that are conducted by medical staff committees and departments.

2.1.3 For the composition of the Quality Improvement Committee, please refer to the Medical Staff Bylaws and Procedural Manual, Part IV, Organization and Functions Manual, Section 2.3.1

2.1.4 The Medical Staff designates the Clinical Performance Improvement Analyst-Quality Analyst Peer Review as a "Peer Review Officer" with the associated responsibilities and authority as allowed in state statute.

Section 3 The Peer Review Process

3.1 Definitions/Process:

3.1.1 Peer Review Matter: The care provided by a physician may be identified for review by an incident report completed in compliance with K.S.A. 65-4916.

3.1.2 Standard of Care Determination: Each peer review matter will be evaluated, and assigned a Standard of Care (SOC) Score according to the following

3.1.2.1 A SOC of 1 will be assigned if it is determined that a clinical concern has been identified, but no deviation from the standard(s) of care has been identified.

3.1.2.2 A SOC of 2 will be assigned if it is determined that the standard(s) of care are not met, without any probability of causing injury.

3.1.2.3 A SOC of 3 will be assigned if it is determined that the standard(s) of care are not met, with injury occurring or reasonably probable.

3.1.2.4 A SOC of 4 will be assigned if possible grounds for disciplinary action are identified.

3.1.3 Preliminary peer review shall be completed for each peer review matter by the Peer Review Quality Analyst. The Peer Review Quality Analyst shall close standard of care level 1's when in the judgment of the Peer Review Quality Analyst the incident does not warrant physician peer review.

3.1.4 Each peer review matter will have a worksheet completed by the Peer Review Analyst prior to presentation to the physician peer with supporting documentation as applicable. (See Medical Staff Peer Review Assessment Form, pp 8 & 9)

3.1.5 Peer Review shall be conducted by a Physician Peer for each Peer Review Matter assigned a Preliminary SOC of 2 or greater or when, in the judgment of the Peer Review Quality Analyst, consultation is indicated.

3.1.6 Conclusions specifically address the issue for which the peer review is conducted. Peer Review is based on processes that are supported and defensible by referencing the following, as appropriate

3.1.6.1 Published professional society guidelines

3.1.6.2 Clinical literature

3.1.6.3 Recognized community specialty specific standards of care

3.1.6.4 Privileging criteria

3.1.6.5 Bylaws including rules and regulations

3.1.6.6 Medical Staff Policies

3.1.6.7 Relevant clinical practice guidelines; and

3.1.6.8 Regulatory or accrediting body requirements

3.1.7 A physician peer is a member of the medical staff in good standing. For peer review purposes, a peer is a member of the same clinical department as the individual whose case is under review.

3.1.8 Individuals who function as a Physician Peer Reviewer shall not have performed any medical management surrounding the event under review.

3.1.9 Physician Peer reviewers may consult with or request information from a sub-specialist in the same sub-specialty as the individual whose case is under review, when care or treatment issues are greater than the general body of knowledge of the physician peer reviewer.

3.1.11 Other medical staff peers (members in good standing on the medical staff, not privileged in the same specialty as the individual whose case is under review)

may offer, and have their opinions considered, regarding specific issues related to the management of the case under review if these individuals are members of the Quality Improvement Committee, either standing, or requested as ad hoc committee members.

3.1.12 Peer review panels may be selected in certain circumstances when additional consideration is necessary to adequately review a specific case. Panelists may be selected for their expertise in a given subject of medicine or in a specific medical specialty.

3.1.13 An external Peer Reviewer is an individual who meets the above listed criteria, but who is not a member of the medical staff. External peer review may occur in lieu of Internal physician peer review when the following situations exist:

3.1.13.1 A need for specialty review is identified, when there is not a similarly trained or experienced medical staff member available.

3.1.13.2 The Quality Improvement Committee cannot make a SOC determination and requests external review.

3.1.13.3 The individual whose case is under review requests external peer review.

3.1.13.4 The Quality Improvement Committee, Credentialing Committee or Medical Executive Committee requests an external review.

3.1.13.5 Refer to External Peer Review Process Flow Chart (Page 5)

Section 4 Completion of the Peer Review Process (Refer to Flow Chart Page 6)

4.1 Information may be requested from a practitioner by the peer reviewer for cases under review.

4.2 Practitioners who receive three (3) or more Level 2 SOC assignments of the same or similar type of events in any consecutive 52 weeks will be presented to the QIC for review and if appropriate recommend to the MEC further action. (eg. focused review)

4.3 When an initial SOC Level of 2 or greater is assigned by the Physician Peer, the physician will be notified in writing and may be requested to respond to the peer review matter.

4.3.1 Following receipt of the provider response to the case is re-evaluated by the initial reviewer.

4.3.2 If SOC Level 2 or greater is assigned, then the matter will be referred to the Quality Improvement Committee for final SOC determination. The initial reviewer will provide a summary for the Quality Improvement Committee.

4.4 When a final SOC level of 2 or less is assigned by the QIC the case is considered closed. However, the clinician may provide a written response to the level II determination.

4.5 When a SOC Level of 3 or greater is assigned by the Quality Improvement Committee, the physician will be notified in writing, and offered the opportunity/right to meet with the Quality Improvement Committee.

4.6 To preserve the integrity of the Peer Review Process, a practitioner who appears before the Quality Improvement Committee and/or the Medical Executive Committee with reference to a peer review matter must do so without legal or other representation.

4.7 If the physician accepts the opportunity to meet with the Quality Improvement Committee, the physician will be asked to provide additional information and discuss the case with the QIC.

4.8 After meeting with the physician, the Quality Improvement Committee shall make a final SOC determination.

4.9 In the event that a SOC Determination of Level 3 or greater has been upheld by the Quality Improvement Committee, the physician is notified in writing and the Peer Review Matter is referred to the Medical Executive Committee.

4.10 The Medical Executive Committee reviews the case and makes its SOC determination. If the Medical Executive Committee upholds the determination, the physician is advised in writing, and notified of the right to meet with the Medical Executive Committee to provide additional information and discuss the case with the Medical Executive Committee.

4.11 The Quality Improvement Committee may make a decision to recommend a focused review, such as, but not limited to, a 100% case review on a prospective basis based on trends or patterns identified through the peer review process.

4.11.1 The details of the focused review will be determined by the Credentials Committee and may include but is not limited to:
- 4.11.1.1 100% case review prospectively for a specific time period.
- 4.11.1.2 Monitoring by exceptions from standards for a specific time period.
- 4.11.1.3 Data from incident reporting system for a specific time period.

4.11.3 Results reported to QIC for further action

4.11.4 The individuals will be notified in writing when focused review is initiated.

Section 5 Peer Review Process Time Frames

5.1 Time periods for processing medical staff peer review: All individuals and groups required to act on a peer review case should do so in a timely and good faith manner. Except for good cause, each medical staff peer review case should be processed within the following periods (calendar days unless otherwise stated):

Peer Review Quality Analyst (to review, analyze and summarize)	15 days
Medical Staff Peer Reviewer (to review, analyze and recommend)	21 days
Practitioner whose case is being reviewed and assigned a Level 2 or greater (provide additional information)	20 days
Quality Improvement Committee, Level 3 or greater (review, analyze	

and recommend)	30 days
Practitioner whose case is assigned a Level 3 or greater by the QIC (to present and discuss)	30 days
Medical Executive Committee, Level 3 or greater (review, analyze and recommend)	30 days
Practitioner whose case is assigned a Level 3 or greater by the MEC (to present and discuss)	30 days

Section 6 Performance Improvement (PI)

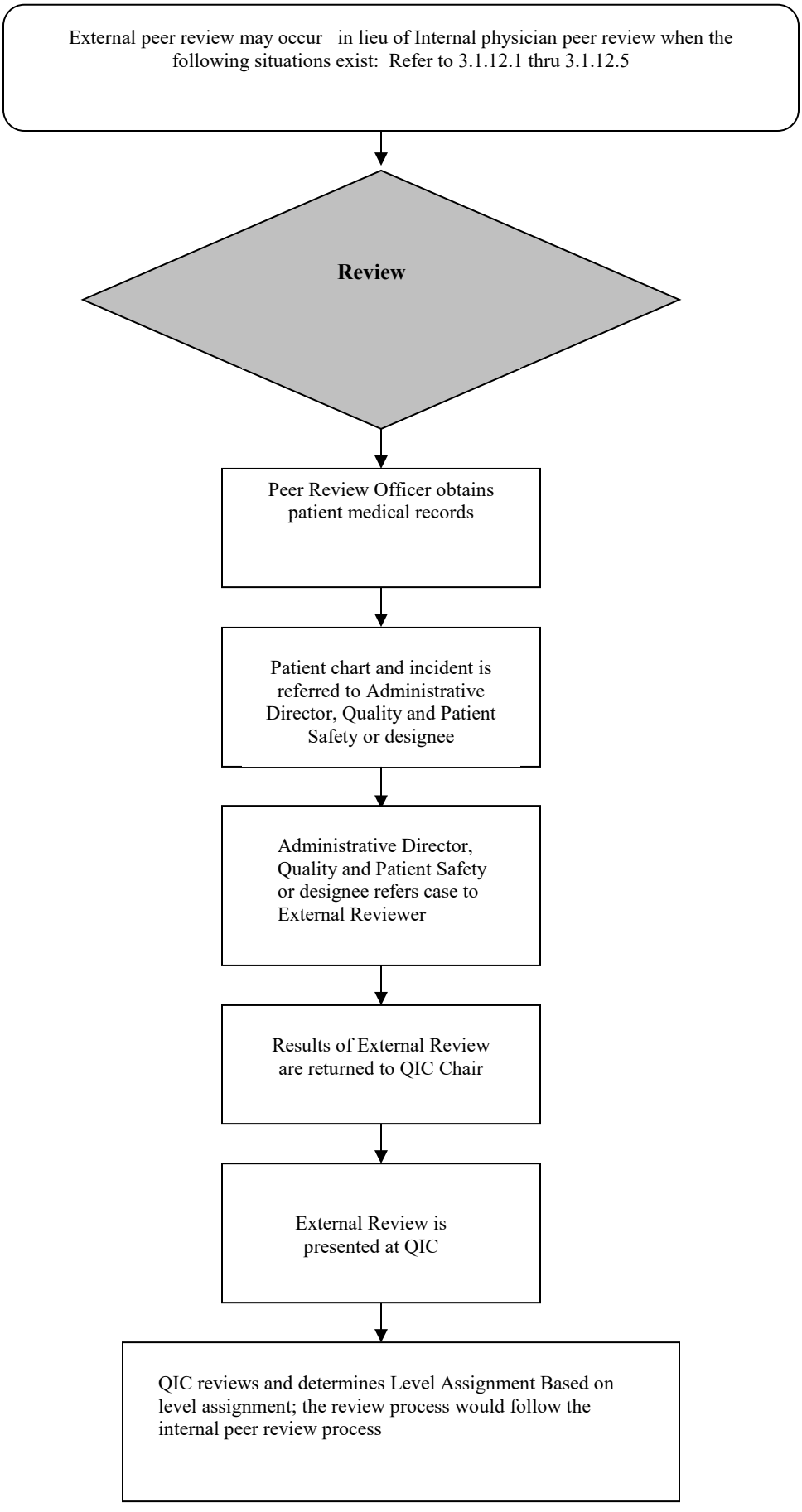
6.1 Medical Staff PI indicators are defined by medical staff departments and approved by the Quality Improvement Committee, in accordance with KSA 65-4923.

6.2 Indicator selection will be based on accepted or recognized standards of care of the Medical Staff, specialty societies, other healthcare professional organizations or as required by third parties such as regulatory and accrediting bodies.

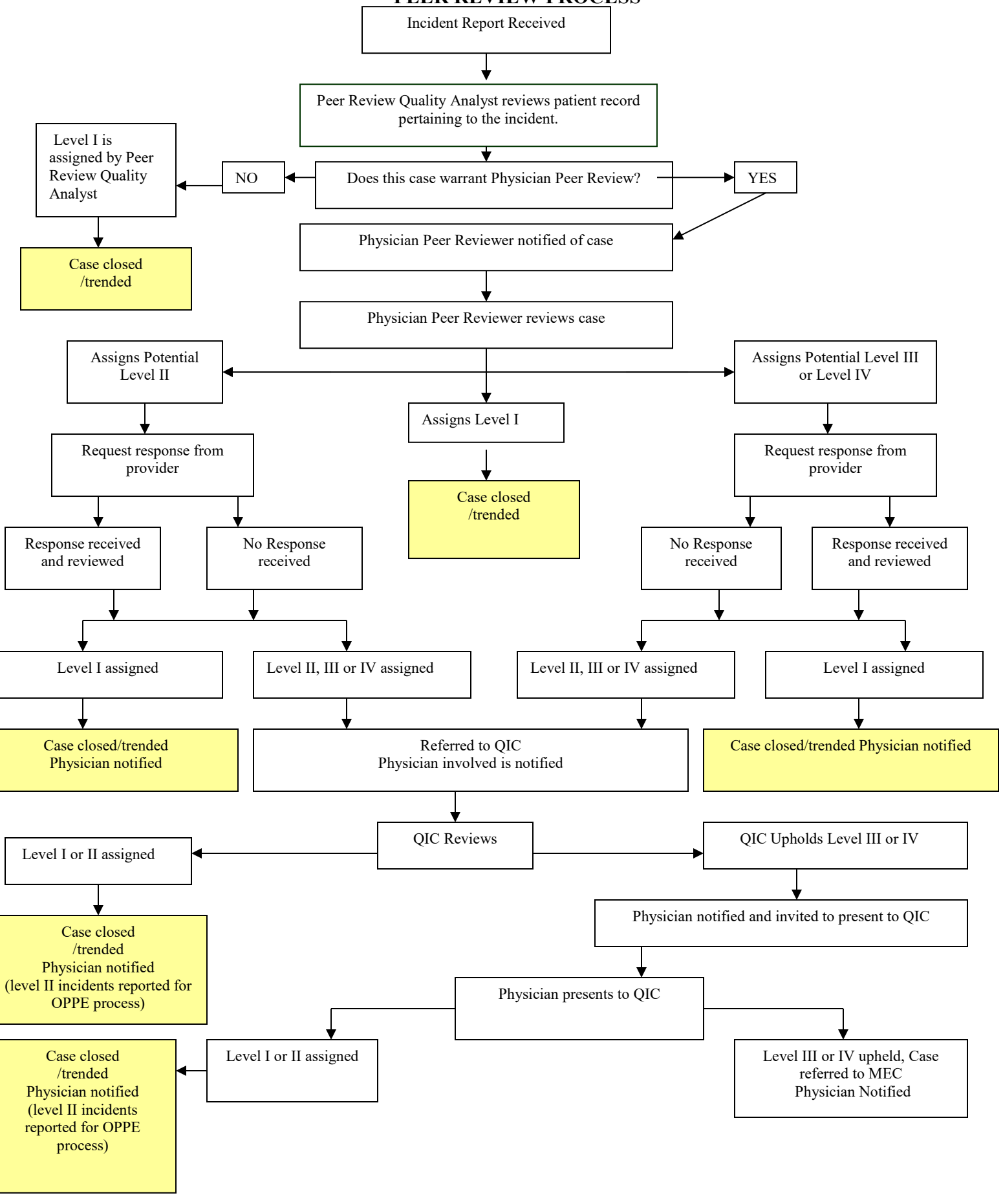
6.3 Indicator revisions/changes may be made, as deemed necessary, by medical staff departments, the Quality Improvement Committee.

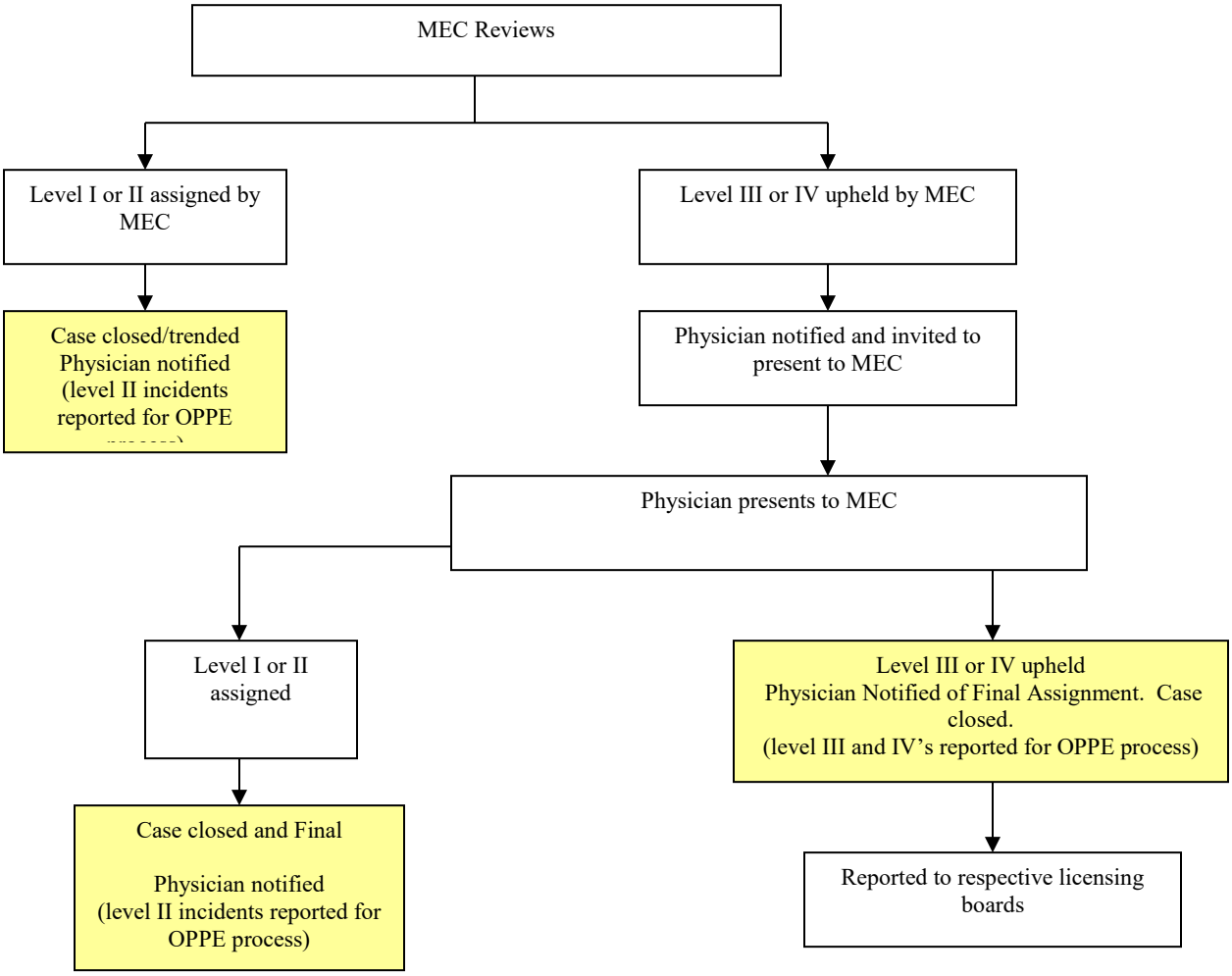
6.4 QIC will identify indicators to be regularly reported to QIC.

EXTERNAL PEER REVIEW PROCESS



PEER REVIEW PROCESS





6.5 Indicators include but are not limited to:

6.5.1 Medical assessment and treatment of patients
6.5.2 Patient satisfaction involving physicians
6.5.3 Medication management
6.5.4 Blood and blood produce use
6.5.5 Operative and other procedures
6.5.6 Appropriateness of clinical practice patterns
6.5.7 Significant departure from established patterns of clinical practice
6.5.8 Use of developed criteria for autopsies
6.5.9 Organ Procurement
6.5.10 Infection Control/Surveillance
6.5.11 Major discrepancies between preoperative and postoperative (including pathologic) diagnosis
6.5.12 ORYX core measures
6.5.13 Mortality rates
6.5.14 Sentinel event data
6.5.15 Patient safety data
6.5.16 Accurate, timely, and legible completion of the patient's record

Section 7 Reporting

7.1 Peer review results are aggregated, reported and reviewed by the QIC on a quarterly basis and used in the organization-wide performance improvement program.

7.2 Peer review results are reviewed at the time of medical staff reappointment to provide for practitioner specific appraisal of competency and renewal of clinical privileges.

7.3 A practitioner specific performance profile is completed and available to the Credentialing Committee prior to medical staff member reappointment.

7. 4 Peer review results, conclusions and actions, including recommendations are reported in writing, to the practitioner involved.

Section 8 Integration

8.1 The Medical Staff Peer Review Plan is a Component of the organization-wide Performance Improvement Program. (See Stormont-Vail Health*Care* Improvement Program for Clinical Services)

ISSUE:
Diagnosis:
EVENT:

Provider#: **Event Date:**
Category: **MRN:** **Review Date:**
Patient Name:
MSQA:

SECTION II - EVENT (To be completed by the Initial Physician Reviewer)
***When assigning a level II or above, requesting a response from provider is required prior to final determination**

Level I [] Level II* [] Potential: Level III** [] Level IV** []

Comments_____

Request response from involved physician addressing the following: [] **(Required if assigning level II or above)**

Send Educational Memorandum addressing the following: []

_____ _____
Physician Reviewer Review Date

SECTION III: Physician Response is Reviewed by Peer Review Physician

Level I [] Level II* [] Potential Level III** [] Level IV** []

Forward to Quality Improvement Committee []

_____ _____
Physician Reviewer Review Date

Level I: **Standard of Care Met; no quality concern. (Trend)**
Level II: **Standard of Care NOT met; but low risk or no reasonable probability of causing injury. ***
Level III: **Standard of Care NOT Met; with injury occurring or reasonable probability that injury could occur. ****

Level IV: **Action by provider is possible grounds for disciplinary action. (Behavioral events are trended as previous levels.)****

- *3 or more within a 12-month period is referred to QIC.
- ** Event reported to the Board of Healing Arts (per K.S.A. 65-4921 & 65-4923)

Patient Name: **MRN:** **DR#**

SECTION IV: Review by the Quality Improvement Committee

Level I [] Level II* [] Level III** [] Level IV** []

Notify Physician of Disposition and Opportunity to Appeal: [] Date: _ _____

_____ _____

Chair, QIC Review Date

SECTION V: Quality Improvement Committee (Physician Appeal)

Level I [] Level II* [] Level III** [] Level IV** []

Recommended Disposition forwarded to Executive Committee. [] Date: _____

Notify Physician of Disposition and Opportunity to Appeal [] Date: _____

_____ _____

Chair, QIC Review Date

SECTION VI: Executive Committee will review recommended disposition.

Level I [] Level II* [] Level III** [] Level IV** []

Notify Physician of Disposition and Opportunity to Appeal [] Date: _____

_____ _____

Chair, Executive Committee Review Date

SECTION VII: Physician appeal heard by Executive Committee (Final Disposition Assigned)

Level I [] Level II* [] Level III** [] Level IV** []

Notify Physician of Disposition: [] Date: _____

_____ _____ Chair,

Executive Committee Review Date

Level I: **Standard of Care Met; no quality concern. (Trend)**
Level II: **Standard of Care NOT met; but low risk or no reasonable probability of causing injury.***

Level III: **Standard of Care NOT Met; with injury occurring or reasonable probability that injury could occur. ****
Level IV: **Action by provider is possible grounds for disciplinary action. (Behavioral events are trended as previous levels.)****

***3 or more within a 12-month period is referred to QIC.**
**** Event reported to the Board of Healing Arts (per K.S.A. 65-4921 & 65-4923)**

Stormont Vail Health (SVH)

Quality and Patient Safety Leadership Committee Charter

Charter 12/15/21

Updated: 11/17/22

Establishment and Authority

As approved by the Stormont-Vail Health*Care*, Inc. (SVH) Governing Board, authorized by the SVH organized medical staff and in support of the SVH Risk Management Program, the Quality and Patient Safety Leadership Committee (Committee) is hereby established. The Committee reports to the Governing Board, Operating Committee, SVH Medical Staff and the SVH Quality and Risk Management Program in support of the overall coordination of the quality of care and safety to be afforded to patients and staff. Consequently, the information obtained by the Committee, as well as reviews conducted, determinations made and recommendations issued, are to be considered confidential, privileged and protected as Peer Review and/or Risk Management information under the provisions of Kansas Statutes Annotated (K.S.A.) Sections 65-4915 and 65-4921 et. seq.

Purpose

The purpose of the Committee is to review, evaluate and make recommendations related to clinical quality / patient safety improvement at SVH in support of the organized medical staff and Risk Management Program by:

- Reviewing, screening and evaluating patient care practices, events and/or event trends that warrant further investigation, evaluation or study in order to promote patient safety, quality and reduction of clinical risk/improvement of patient safety;
- Supporting collaborative clinical improvement to achieve clinical quality and safety;
- Supporting just culture and organizational learning by referrals for additional process improvement, peer review, learning/communication follow up to significant clinical events; and
- Prioritizing and making referrals to Medical Staff Committees, Quality / Process Improvement Teams, Operational Leadership, peer review and others as needed in order to assure effective follow up and systematic learning.

Committee Composition and Governance:

1. *Quality and Patient Safety Leadership Committee Membership*

a. The Committee will be composed of the following Members, or their designees as described in Section 3.f, infra.:

- Senior Vice President, Chief Medical and Quality Officer

- Vice President of Clinical Quality

- Senior Vice President and Chief Nursing Officer or designee

- Vice President of Clinical Operations

- Clinical Vice Presidents

- Vice President of Patient Care Services

- SVH Medical Staff - Chief of Staff

- SVH Medical Staff - Chief of Quality

- Director of Medical Staff Services

- Director of Quality and Infection Prevention

- Associate General Council

The Committee may appoint and/or invite ad hoc participation of any individual as needed to address specific issues or needs of the Committee.

The Committee may establish appropriate subcommittees and / or quality improvement (QI) teams whose membership may include individuals who are not members of the "Committee" in order to achieve its purposes. Individuals identified will participate as members of the subcommittee / QI teams and will maintain appropriate confidentiality of information, to include the peer review and risk management privileges as afforded by Kansas statutes, and will fulfill the commitment to achieving the Committee's goals.

b. There are no term limits.

2. Leadership

a. The Chair shall be the Vice President of Clinical Quality, who will manage the Committee and oversee the Committee's meetings

b. In the Chair's absence, the SVH Chief of Staff or the Chief Medical and Quality Officer will carry out the Chair's duties;

c. The Chair will have no term limit.

3. Meetings

a. The Committee will attempt to meet ***monthly*** or as often as is required to fulfill its assigned duties. The Committee Chair will approve the agenda for the Committee's meetings, and any member may suggest items for consideration. Briefing materials and meeting packets will be provided to the committee as far in advance of meetings as is reasonably practical.

b. A quorum for meetings shall be at least 7 members.

c. While most decisions will be made through consensus, in the event a vote is taken, decisions shall require a majority vote of those members present. Only Committee Members identified in Section 1.a *supra*, are voting members. Sub-committee members, QI Teams and invitees may offer input but do not vote.

d. Subcommittees / QI Teams will provide reports to the Committee including content and frequency as agreed upon by the Committee.

e. Attendance at meetings may be in person or by web/conference call, as determined by the Chair.

f. Committee Members who are unable to attend will advise the Chair and, as appropriate and approved, identify the designated substitute to attend on their behalf. Due to the confidential nature of the work of the Committee and to assure continuity of knowledge, substitute representatives must be approved and oriented prior to participation in the meeting. Committee Members who request their approved substitute to attend are expected to brief/prepare the substitute to allow them to present/actively participate in the identified agenda items as appropriate.

Committee Responsibilities.

a. Assess and monitor clinical quality outcomes / analytics for SVH from various sources including but not limited to Vizient Clinical Database, disease specific registries, externally reported regulatory specific quality data and ConVerge reports
b. Prioritize, charter and oversee the implementation of clinical quality improvement initiatives
c. Refer to clinical peer review as individual provider quality opportunities are identified
d. Support and facilitate the needs and objectives of the SVH Risk Management Program
e. Maintain confidentiality of discussions and the various privileges and protections afforded to the information obtained or reviewed by the Committee.

Reporting

The Committee shall report to the Operating Committee and the Quality and Patient Safety Committee of the Board as appropriate and provide information at least quarterly on its activities and any recommendations.

The frequency and content of additional reporting will be determined in conjunction with the Chairs of the Operating Committee, and SVH Medical Executive Committee and the System Director of Risk Management Reporting of risk management and peer review privileged activities may only occur within Committees and venues that have similar peer review protection. High level activity and lessons learned reports, with specific risk management and/or peer review privileged information may be provided to other groups within the organization as appropriate and approved.

Review and Changes to the Charter

The Committee shall review this charter periodically and record and communicate any changes to the Operating Committee, SVH Medical Executive Committee.