The Society for Vascular Surgery Patient Safety Organization (SVS PSO) was approved by the Agency for Healthcare Research and Quality (AHRQ) in February 2011 to oversee the data sharing partnerships and patient safety initiatives of the Vascular Quality Initiative (VQI).

Formerly the Vascular Study Group Patient Safety Organization, it was established to oversee the data sharing partnerships and patient safety initiatives of customers utilizing M2S’s Clinical Data Pathways platform. Comprising MDs, analysts, and administrative personnel, the SVS PSO staff provides medical expertise, analyses, and has oversight of quality improvement activities conducted through the PSO.

The importance of the Patient Safety Organization for providers and hospitals is that it will protect all quality work products generated from data entered into a PSO from legal discovery in state and federal court. Quality work products include outcome analyses, benchmarked reports, and other aggregated information intended for quality improvement purposes. The identity of hospitals and providers that are compared in benchmarking and other quality analyses generated through a PSO cannot be disclosed or discovered. Another advantage of a PSO for providers and hospitals is that it permits the collection of patient-identified data for quality improvement purposes without requiring consent from individual patients or prior approval from an Institutional Review Board.
SVS PSO Mission

The SVS PSO improves patient safety and the quality of health care delivery by providing web-based collection, aggregation, and analysis of clinical data submitted in registry format for all patients undergoing specific vascular treatments.

Governance

The SVS PSO is overseen by a Governing Council of representatives of SVS and regional vascular quality groups. Dr. Jens Eldrup-Jorgensen serves as medical director.

Vision

The SVS PSO is a nationally distributed network of regional vascular quality improvement groups, collecting common core datasets to allow anonymous pooling of information. The SVS PSO believes that smaller, regional group meetings to discuss quality improvement foster a sense of ownership, individual responsibility, cooperation, and trust. It is in these meetings where shared data are discussed and quality improvement projects are initiated. For this reason, the SVS PSO encourages providers and hospitals to form quality improvement groups, and to use M2S’s web-based data entry and reporting system, to allow sharing of this information. Although it is valuable to collect such data at the individual hospital level, much greater value is achieved by benchmarking clinical data among hospitals.

What is a PSO?

In response to rising health care costs and increasing concerns about the quality of health care delivery in the United States, the Department of Health and Human Services instituted the Patient Safety and Quality Act of 2005 to encourage health care providers to share outcome and patient safety data without fear of reprisal. The Final Rule of this Act, which took effect in November 2008, established an implementation mechanism known as a PSO, through which the objectives of the Patient Safety Act could be achieved. The AHRQ was designated to administer the provisions of the Patient Safety Act and oversee the approval and operations of PSOs.

Get more information on PSOs.