SYSTEM WORTH SAVING

2012 TASK FORCE REPORT
QUALITY OF CARE AND PATIENT SATISFACTION

Fang A. Wong, National Commander
Dear Fellow Legionnaires

The American Legion’s primary health-care evaluation tool is a program called System Worth Saving. Since 2003, The American Legion’s System Worth Saving Task Force has visited Department of Veterans Affairs’ medical facilities and written reports for the President of the United States, Congress and senior VA officials to ensure the highest access and quality of care for our nation’s veterans.

The focus of this System Worth Saving report was Quality of Care and Patient Satisfaction. The System Worth Saving Task Force wanted to assess how VA tracks and monitors quality of care and patient-satisfaction programs. To that end, the committee developed an objective assessment to determine how quality is defined, measured and managed, and how VA Central Office and VA facilities demonstrate accountability for quality of care and patient satisfaction.

From April 2012 to June 2012, the System Worth Saving Task Force visited 25 VA medical centers (VAMCs) to evaluate quality of care and patient satisfaction programs at the facilities. During the visits, the System Worth Saving Task Force met with each facility’s executive leadership, quality manager, patient safety manager, utilization manager, risk manager, systems redesign manager, chief medical information officer, director of patient care services, facility patient advocate and Patient Aligned Care Team (PACT) Coordinator and Women Veterans Program Manager to evaluate quality of care and patient satisfaction programs. Additionally, town hall meetings were conducted in American Legion posts near the VAMCs visited, in order to solicit feedback from veterans on their quality of care and overall patient experience.

Our findings suggest there are over 500 different measures used to track quality and patient satisfaction nation-wide. These measures are not always developed from evidence-based research. VA must improve on delineating between Veterans Health Administration Directives and the creation of performance measures to accomplish a specific goal or outcome. The overwhelming number of performance measures limits the time spent with providers during appointments, and appropriate software is needed to alleviate this burden. Veterans experience delays with scheduling their primary care appointments due to a centralized scheduling system. New short term patient satisfaction programs are needed at VA Medical Centers because the Survey of Health Care Experiences of Patient (SHEP) surveys take six months to assess patient feedback.

I encourage you to review our findings and recommendations from the 25 VA facilities we visited. We hope that our findings in this report will help Congress and VA understand what challenges our nation’s returning service members and veterans face with accessing quality VA health care.

Respectfully,

Fang A. Wong
National Commander
The American Legion
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# ACRONYM AND ABBREVIATION LIST

For unlisted items, call us at **202-861-2700**
The American Legion Headquarters, 1608 K Street, NW, Washington, DC 20006

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<td>AAHRP</td>
<td>Accreditation of Human Research Protections Program</td>
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<tr>
<td>ACoS COC</td>
<td>American College of Surgeons Commission on Cancer</td>
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<td>ACR</td>
<td>American College of Radiology</td>
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<td>ADR</td>
<td>Alternative Dispute Resolutions</td>
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<td>ASHP</td>
<td>American Society of Health System Pharmacist</td>
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<td>AWE</td>
<td>Annual Workplace Evaluations</td>
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<td>CAP</td>
<td>Combined Assessment Program</td>
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<td>CAPF</td>
<td>Commission Accredited Rehabilitation Facilities</td>
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<td>Community Based Outpatient Clinic</td>
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<td>Chief Health Medical Information Officer</td>
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<td>CLC</td>
<td>Community Living Center</td>
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<td>CPRS</td>
<td>Computer Patient Record System</td>
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<td>CRC</td>
<td>Community Residential Care</td>
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<td>DoD</td>
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<td>EMR</td>
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<td>FTee</td>
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<td>FY</td>
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<td>GEMS</td>
<td>Green Environmental Management System</td>
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<td>Inpatient Evaluation Center</td>
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<td>IT</td>
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<tr>
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<td>Licensed Practical Nurse</td>
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<td>LTCI</td>
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<tr>
<td>MRSA</td>
<td>Methicillin-Resistant Staphylococcus Aureus</td>
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<td>NA</td>
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<td>OI&amp;T</td>
<td>Office of Information &amp; Technology</td>
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<tr>
<td>OIF</td>
<td>Operation Iraqi Freedom</td>
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<td>OIG</td>
<td>Office Inspector General</td>
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<td>Office of Management Budget</td>
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<td>Occupational Safety and Health Administration</td>
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<td>PACT</td>
<td>Patient Aligned Care Team</td>
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<td>PATS</td>
<td>Patient Advocate Tracking System</td>
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<td>Women Veterans Program Manager</td>
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EXECUTIVE SUMMARY | A SYSTEM WORTH SAVING: 2012

By Michael D. Helm  
Chairman, The American Legion Veterans Affairs & Rehabilitation Commission

Background

In 2003, The American Legion's National Executive Committee created the System Worth Saving program to conduct site visits to VA medical facilities on behalf of The American Legion's national commander. The purpose of the program was to assess the quality and timeliness of VA health care and to provide feedback from veterans on their level of care. Every six months, the System Worth Saving Task Force selects a different health-care topic of focus; currently, the topic selected is quality of care and patient satisfaction. The findings and recommendations are compiled into a publication, which is presented to the President of the United States, members of Congress, senior VA officials and fellow Legionnaires.

History of Quality of Care

According to Avedis Donabedian's triad study in the 1970s, he divided quality of care into three categories; structure, processes and outcomes. Structure is the setting in which quality of care takes place, processes are the methods and procedures by which health care is provided, and outcomes are the consequences of the health care provided.1 In the 1990s, Dr. Kenneth Kizer, under secretary for Health, transformed VA from primarily an inpatient to both an inpatient and outpatient system. This was done through the creation of community-based outpatient clinics (CBOCs). These clinics improved and expanded VA's quality, while bringing care to veteran communities.

In 2000, an Institute of Medicine (IOM) report, “To Err is Human: Building a Safer Health System,” concluded, “at least 44,000 and perhaps as many as 98,000 Americans die in hospitals each year as a result of medical errors.”2 In a landmark follow-up study by IOM, “Crossing the Quality Chasm,” found, “health care today is characterized by more to know, more to manage, more to watch, more to do, and more people involved in doing it than at any time in the nation’s history.”3 Additionally, the study explained, “Care delivery processes are often overly complex, requiring steps and handoffs that slow down the care process and decrease rather than improve safety.”4 The recommendations from the study were that care should be safe, effective, patient-centered, timely and efficient, which would later become the quality attributes that define VA’s core values. While VA has provided high quality of care to veterans, the System Worth Saving Task Force program conducted an assessment of the VA’s quality and patient satisfaction programs.

Methodology

The purpose of the report was to evaluate how VA tracks and manages quality of care and patient satisfaction at the national and facility levels. The System Worth Saving Task Force developed an objective assessment using questionnaires to determine how quality is defined, measured, managed and how facilities demonstrate accountability for quality and patient satisfaction. The goals and objectives of this report were to understand what improvements had been made in VA quality of care and patient satisfaction, determine which areas of quality of care and patient satisfaction could be enhanced, assess the primary challenges and gaps of quality of care and patient satisfaction, and make recommendations to Congress and VA on how to improve quality of care and patient satisfaction programs and initiatives.

From April 2012 to June 2012, the System Worth Saving Task Force conducted a random sampling of 25 VAMC facilities and 24 veteran town hall meetings in American Legion posts near VAMCs being visited. The purpose of the town hall meetings were to gain veterans' perspectives of their VA health care, which was communicated to leadership of the VAMCs.

During the site visits the task force conducted interviews with the facility executive leadership, quality manager, patient safety manager, utilization manager, risk manager, systems redesign manager, chief medical information officer, director of patient care services, patient advocate, women veteran program manager and the Patient Aligned Care Team (PACT) coordinator.

KEY FINDINGS

Quality of Care

VA is the largest integrated health-care delivery system with 152 VAMCs, more than 974 outpatient clinics and close to 300,000 staff. More than 8 million veterans are enrolled into the system,

with approximately 5.8 million receiving appointments in FY 2011. VA has a number of quality offices such as the Office of Quality Safety and Value, the National Center for Patient Safety, VHA Quality and Safety Report/Hospital Compare, and ASPIRE. The Office of Quality Safety and Value integrates system redesign, safety, quality management, and compliance. The mission is to enhance the safety, quality, and value of clinical and business systems for VA’s health-care system.

The National Center for Patient Safety Office was established in 1999 to develop and maintain a culture of safety throughout the Veterans Health Administration. The goal is to reduce and prevent inadvertent harm to patients as a result of their care. To accomplish this goal, patient safety managers conduct Root Cause Analysis (RCAs). There are patient safety managers at 152 VA hospitals. RCA is any structured approach to identifying the factors that resulted in the nature, the magnitude, the location and the timing of the harmful outcomes.

The VHA Quality and Safety Report/Hospital Compare allow veterans, caregivers and their families to compare performances of VA hospitals. The information is divided into four subcategories: (1) LinKS (Linking Information Knowledge and Systems) examines outcomes in acute care, safety, intensive care and other measures; (2) ASPIRE reviews quality and safety goals for VA hospitals and how they are meeting their goals; (3) comparing the veteran’s local VA hospital care with how well each facility treated pneumonia, heart attack, and congestive heart failure; (4) tracking VA progress in minimizing infection, blood clots and cardiac problems.

VA organizes quality-of-care measures and responsibilities into several key positions within VA Central Office, Veteran Integrated Service Networks (VISNs) and the 152 VAMCs. The first position is the patient safety manager, which oversees infection rates, falls and RCAs. Secondly, the system redesign manager manages training and project design. The third position is the utilization manager, who analyzes the clinical contents of medical records and appropriateness of care. A fourth position is the patient-centered care manager, who directs the center of innovation and patient satisfaction. Finally, the risk manager position examines provider’s reviews and performance measures, which includes access, clinical measures and Aspire/Hospital Compare.

VA classifies quality of care functions under three categories: safety, clinical performance, and access and satisfaction plan. Patient safety includes infection rates, surgical safety, reviews of appropriateness of care, and mortality. Furthermore, clinical performance involves diabetes, tobacco use, hypertension and preventions. The access and patient satisfaction plan encompasses readmissions, mental health access, homelessness, tele-health enrollment and PACT implementation.

**Patient Satisfaction**

In terms of patient satisfaction, three years ago VA launched an innovative primary care model known as Patient Aligned Care Teams (PACT). PACT was established to provide comprehensive patient centered care and is managed by primary care providers. Within PACT, there are several teamlets consisting of a provider, nurse, licensed practical nurse and a scheduler. PACT allows patients to have a more proactive role in their health care by placing the veteran in the center of the care. The veteran and VA will be associated with increased quality improvement, patient satisfaction, and a decrease in hospital costs due to fewer hospital visits and readmissions. In addition, VA has created an Office of Patient Centered Care and Cultural Transformation, which prioritizes the veterans’ health care. Veterans are partnered with their providers to increase their overall health, healing and well-being. The key components of this model are personalized health planning, strategies and skill building.

### CHALLENGES

#### Quality of Care

Despite all the advancements and improvements the VA has accomplished over the years, there still remain several challenges. Some of the challenges include recruitment, performance measure complications, Veterans Health Information System Technology and Architecture (VISTA) reporting system, Computerized Patient Record System (CPRS), and women specific services.

VAMC facility leadership stressed their inability to recruit and retain frontline staff positions. Some VA medical facilities’ nursing staff is at 24 percent, with only a 10-percent retention rate. Other medical centers have the need for as many as 15 licensed practical nurses and 12 clerical staff. In addition to frontline staff, there has been an alarming turnover rate within the executive leadership – specifically with directors. More than 60 executive positions across the country within the VISN and medical centers have acting staff in these positions, affecting the morale, culture and quality care throughout the health-care system.

Secondly, VACO’s Network Strategic Plan, which outlines the VISN and facility’s quality of care responsibilities for the fiscal year, was not distributed in October 2011, but in the spring of 2012.
This has left facilities with a half year to evaluate all the necessary performance measures that should be tracked for the entire year. In addition, VA has more than 500 different performance measures that are not always evidence-based. Having too many measures makes it difficult to determine the validity of measurements being used within every facility.

The quality managers emphasized their frustration with performance measures disseminated from VACO and the VISNs. The quality manager frequently receives an overwhelming number of performance measures directed from leadership. The facilities with inadequate staffing are unable to keep pace with the increase and variability of performance measures that change daily. For instance, a medical center visited in 2000 only had 11 performance measures, but currently there are more than 500 measures within each medical center today. Frequently the quality manager may become unclear on what they are measuring and why.

Additionally, the national patient electronic patient incident reporting system is outdated and deters employees from actually reporting an incident that occurs in the hospital. Furthermore, employees will actually forgo reporting an event, rather than inputting data into the system, due to its complex nature. The system has shown faults in managing and ensuring confidentiality, because it generates paper-based patient information administered to several different personnel.

Another system in need of upgrading is the CPRS, which the chief health information officers stressed is 20 years old. Currently, there is an updated system that changes information on records automatically, rather than manually inputting information. Ultimately, the system would limit human error and would create additional time for staff to conduct other duties. Doctors also would be informed if they need to adjust imputation of information in the system.

Finally, a pinnacle in the VA system has been the drastic improvements in women veterans’ health care. To equal the standards of their male counterparts, women coordinators across the nation have expressed their desire to acquire women veteran gender-specific services. Currently, there is a lack of mammography, prenatal, and gynecological services. These services frequently are available on a part-time basis, and may be offered periodically throughout the week. In some instances, clinics have fee-based these services that have created additional costs in the medical center’s annual budget.

**Patient Satisfaction**

As a result of the VA’s quality-of-care initiatives, patient satisfaction has seen drastic improvements in the past decade; however challenges still exist. After conducting 25 site visits, the task force discovered challenges with hiring nursing, overload of patient advocates, PACT and SHEP scores.

The director of patient care services is concerned with the lengthy hiring process. In some facilities 50 percent of the nursing staff is at retirement age. The hiring process could take an astounding six to nine months and, in some cases, much longer. In addition to nurses, there has been frustration in hiring specialty care physicians because their salaries are not competitive with the civilian sector.

The veteran’s greatest ally is the patient advocate. This individual is capable of answering veteran inquiries and processing complaints. The patient advocates have challenges in the amount of incidents they receive on a daily basis. Currently, many facilities may average 200 complaints a month, or as high as 25 per day. Many facilities do not have the number of patient advocates necessary. For example, several patient advocates expressed there may only be one full-time and two part-time advocates throughout the facility.

Over the years, the PACT team has proven to be a valuable exponent for attaining and improving patient-centered care for veterans. However, there have been challenges with coordination of care and integration of specialty services. The PACT coordinators stressed specifically the lack of coordination with behavioral health, pharmacy, nutrition, social work and specialty care. The current PACT management structure has also been proven difficult to maintain. The problem has been the ability to balance administrative tasks and performance measures with clinical practice. In addition to the lack of specialty care services, veterans experiences challenges making appointments with their primary care provider. This is due to VHA’s centralized scheduling system. When veterans call the facility, they are sent to the medical center’s main call center to schedule their appointments, rather than their PACT teamlet.

The executive leadership stressed the deficiencies within SHEP scores. SHEP is a national company contracted through VHA and the VISNs and sends random surveys to patients on a monthly basis regarding patient satisfaction. Once the scores are compiled, they are sent to the medical centers and used for facility improvement. However, SHEP scores are not provided in a timely manner; it can take three to six months before a facility receives the scores. When receiving delayed information, the executive leadership is unable to use the data because it isn’t current.

Based on these findings, recommendations have been developed and are located at the back of this publication. Our country has an obligation to ensure the highest quality of care and patient satisfaction, by critically assessing VA health care. The American Legion and VA strive for one outcome, providing our nation’s heroes with the highest quality of health care.
Background

The Department of Veteran Affairs’ Manhattan Medical Center is part of the New York Harbor Healthcare System (NYHHS) and is one of three medical centers in New York City. It has the capacity to provide services for veterans living in all five boroughs.

The Manhattan VAMC’s overall budget for FY 2011 was $500 million and $521 million in 2012. In 2011, less than 1 percent of the budget was dedicated to quality of care staffing and programs. In 2012, there is a projected .83 percent for quality of care programs. Currently, the facility has 638 full-time RNs and 73 LPNs.

Quality of Care

The Manhattan VAMC defines health care as the ability to provide state of the art care to veteran patients, which includes the highest standards of care, is safe, resource efficient, and meets the needs and expectations of the veteran patient.

NYHHS maintains accountability for quality of care through communication and reporting structure. Quality of care is validated through reviews by JC, CARF, and OIG. The following staff provide oversight for quality of care; chief of staff, head nurse, quality manager, patient safety manager, utilization management, risk manager, systems redesign manager and chief health medical information officer/clinical.

Employees receive annual mandatory training and new training that is sent from VACO. In addition to training, VHA and the Office of Academics Affairs funded a chief resident for safety and quality position for medical service. This individual works on projects with the chief medical service officer, residential staff and administrative staff.

Quality Manager

This individual is responsible for the quality management department at the facility. Their responsibilities include quality of care, patient safety, risk management, utilization management and system redesign. The quality manager serves as the liaison for recommending performance-improvement activities based on analysis of data.

Recommendations are constructed by using quality-of-care indicators that have not met VHA’s performance measures. The quality-of-care indicators are first evaluated by the quality manager and then sent to executive leadership and appropriate committees. A challenge the quality manager has is VHA is not efficient in gathering data from VA facilities. When VHA collects data, the “best practices” are not disseminated nationally.

Patient Safety Officer

The patient safety officer investigates patient safety issues for NYHHS. This encompasses two acute care hospitals, 300-bed CLC, 40-bed domiciliary and four CBOCs. The patient safety officer conducts individual and aggregated RCA, and provides recommendations to the executive staff and submissions to the NCPS. Annual reviews of NYHHS patient safety program are also completed by this individual.

When RCAs are completed, the patient safety officer writes a patient safety feedback issue. Feedback issues describe details of what occurred during a particular event and the actions taken to mitigate the identified hazard. Patient safety is a health-care discipline that emphasizes the reporting, analysis and prevention of medical errors.

A challenge the patient safety officer confronts involves RCAs and the lack of dissemination of problems found. The patient safety officer provides the issues to executive leadership, which are eventually sent to the VISN level; however, other facilities are unaware of the issue.

Utilization Manager

The utilization manager oversees the utilization-management program that complies with VHA directives. The program includes meeting expectations for inter-rater reliability, performance of daily reviews, physician advisors reviews as appropriate, and use of review information for optimizing patient care and redesign of processes to efficiently use resources to provide veterans care. The utilization management program also is used for maintaining admission and length of stay data, which is reviewed by the utilization manager. This process ensures that the patient is receiving the appropriate level of care and quality.

The utilization manager receives initial and periodic training throughout his or her career. This training is administered by trained and approved VA interqual criteria training specialists. The training equips the utilization manager with several measurement tools, which are used to improve quality of care and
patient satisfaction. One such tool involves VHA’s contract with McKesson to use interqual acute and behavioral health criteria sets to review admissions and level of care.

When a patient does not meet the criteria, the issue is discussed with a treatment team and the primary provider. Once the treatment team decides on a solution, it is embedded into the patient’s level of care, thus limiting the avenue for future errors.

**Risk Manager**

This position has evolved into a program called the risk-management program, which incorporates quality management coordinators, a performance manager and the patient safety manager. Risk management focuses at assuring quality and safety of care through a combination of proactive strategies and review of adverse events.

Risk begins with the quality management coordinators, who review electronic screens that provide alerts when there may be quality of care issues present. The screen triggers the issue and staff conducts an analysis of all quality of care issues. The issue is sent to a peer review committee which identifies patterns and process improvements; this data is then used to follow up with the provider.

The performance manager coordinates activities required by the Office of Medical-Legal Affairs. The coordination involves the process of reviewing the tort claims by or on behalf of the beneficiaries. The performance manager contacts the patient’s provider with the opportunity to review and respond to the tort claim.

The risk management program continues to be proactive by having the NCPS provide initial training for both performance manager and patient safety manager; this training is ongoing for leaders and frontline staff. The facility also conducts regular scheduled rounds, especially in high risk areas such as inpatient psychiatry, to ensure patients receive maximum quality of care.

**System Redesign Manager**

System Redesign position is currently vacant; it is being managed by the quality manager and deputy quality manager. The System Redesign manager oversees the training of staff in system redesign methodology, system redesign projects and the management of the system redesign team. The system redesign manager receives both green and yellow belt training, which includes project management and methodology.

In addition, system redesign projects are chosen by both VISN and facility leadership; leadership identifies areas of opportunity to improve quality of care and satisfaction. Furthermore, the system redesign manager has a variety of analytic tools to help understand effective and efficient processes for optimal care. Each project can be measured and have project-specific metrics such as quality of care, access to care and patient satisfaction.

**Chief Medical Officer**

The chief medical officer is responsible for facilitating informatics-related projects that drive the medical center. A current project involves an institution of e-consults for the NYHHS that will benefit the patient by eliminating unnecessary face-to-face visits. Projects are formulated by tracking and managing patient safety; this is done by conducting random audits on a timely basis. The chief medical officer receives a majority of the data from the PACT Compass in VSSC. After the data has been received, the chief medical officer creates a focus group of subject matter experts who would then analyze the data.

The chief medical officer improves quality of care and patient satisfaction by using clinical reminders, which are used to determine the improvements needed at the point of care. For example, the informatics department can generate reports utilizing clinical reminders to focus on quality of patient appointments. Once the reports have been constructed, the information is shared with the practices, and then outreach is administered to find a solution to improve appointment quality.

**Women Veterans Program Manager**

The Women Veterans Program Manager has the capability to provide both primary care and specialty care services. Currently, the women veterans’ clinic is located in a separate department
and has a PACT within the facility. The women veteran program manager developed several committees, such as a PTSD committee and a WVHC; each committee has women veteran participation. The women veteran program manager conducts regular outreach within the veteran community, in addition to publicizing female health care. A challenge the women coordinator is experiencing is there is no full-time GYN clinic, and sometimes the clinic is closed all day.

**Patient Satisfaction**

The NYHHS defines patient satisfaction as the patient’s perception of the total experience of care and services delivered, from making an appointment through aftercare, and including not only quality of care, but accessibility, customer service, communication and the environment of care. Patient satisfaction is measured through questionnaires, inpatient interviews, discharge call interviews and patient contacts through the Patient Representative Program. In a 2011 SHEP survey, responsiveness of hospital staff and shared decision making were deficient. After the study, the facility improved its hospital staff but not shared decision-making. In 2012, the facility made shared decision-making a priority; however, responsiveness of hospital staff was not sustained.

To improve overall rating of the hospital, the facility created a project called “Capstone.” This project consists of a team NYU master’s degree students partnered with NYHHS to study data and best practices. Recommendations from the project included a more robust and decentralized patient representative program, increased staff responsiveness to calls and increased shared decision making.

To address the responsiveness of hospital staff, nursing services initiated a program called “Take 5.” Patient care team coordinators meet every new admission and introduce patients to the unit. The nursing staff conducts regular rounds around the department to ensure patient concerns are addressed. The facility addressed the shared decision-making issue by creating a project called “Reno.” This project engages staff communication with patients on shared-decision making by reviewing questions. This project reinforces patient education and perception of shared decision making.

**Director of Patient Care Services**

The director of Patient Care Services is responsible for managing personnel and assuring the highest patient care outcomes for the disciplines of nursing, pharmacy, social work, respiratory therapy, clinical nutrition, recreation, chaplaincy and sterile processing. Patient concerns are managed by the Customer Service Committee, the Patient Representative program, the Post Discharge Call program, and Service Chiefs/Program Managers.

The Post Discharge Call program ensures all patients who are discharged home are contacted by phone within 48 hours. The call consists of questions such as:

- Do you know who to contact if you have questions?
- Did you receive a list of medications that you are supposed to take?
- Are there individuals that you would like to bring to our attention?

If there is an issue, it is sent to the appropriate leadership staff to conduct a follow up. Any information and resolutions found are sent to executive leadership on a monthly basis.

Furthermore, the NYHHS has piloted a program called “Truth Point,” which allows patients to complete a patient-satisfaction survey prior to discharge. The input data is compiled into a realtime database and sent through the same processes as the Post Discharge Call program. Moreover, the Patient Care Services director mostly is involved with the responsiveness of hospital staff and communication between doctors and nurses. The director works in collaboration with all patient services staff, executive senior management and care-line managers. A challenge that utilization manager endures is more than 50 percent of staff are at retirement age. If positions are not filled at the medical center and affiliated CBOCs, patient satisfaction will decline.

**Patient Advocate**
The patient advocate duties involve addressing complaints that cannot be solved when the incident occurred, and interpreting patient rights, and responsibilities. Patient satisfaction is measured through a variety of mechanisms, including questionnaires, inpatient interviews, discharge call interviews and patient contacts through the Patient Representative Program.

A common issue the patient advocate endures is assisting in improving communication between patients and staff, and the resolution of problems directly affecting the patients’ perception of overall care received. When the patient advocate receives a complaint, information is gathered and appropriate staff is contacted. If the issue cannot be resolved at the time of the complaint, the patient will be contacted within seven days of the complaint. The complaint is entered into the PATS, which executive leadership can monitor for trends and outcomes of all complaints. The most frequent complaint the patient advocate receives is customer service and courtesy of staff. In addition, there is only one patient advocate for both the Bronx and Manhattan campuses.

**Patient Aligned Care Team Coordinator**

The PACT coordinator provides clinical oversight for PACT operations. PACT operations include coordination of staff and resources, staff meetings, providing a weekly progress report and communication with other services relating to PACT. At the Manhattan campus, there are 99 staff members working on PACT programs and initiatives. The PACT coordinator implemented a monthly PACT committee consisting of staff from medical services, patient services, administration, prevention, pharmacy, nutrition, social work, informatics and a patient representative. A challenge the PACT coordinator endures is implementation of specialty care from VHA. The facility is not capable of utilizing all specialty care. This is due to the lack of funding, space and staff.

**Town Hall Meeting**

The town hall meeting was conducted at Post 1291 in Chinatown on April 16. Veterans in attendance brought no issues or concerns regarding the Manhattan VAMC.

**Recommendations**

- SHEP score data needs to be sent to VA facilities in a timely manner, rather than a three- to six-month wait
- VHA should disseminate data collected from VA facilities
- Since 50 percent of all staff at the Manhattan VAMC is at retirement age, it may be wise to create future budget plans
- Manhattan VAMC should incorporate courtesy and customer service classes for staff
- GYN services should be changed to full-time status or half-time, but available seven days a week.
Background

VA’s Central Iowa Healthcare System (CIHCS) is part of VISN 23 and serves a population of more than 100,000 veterans, 1,176 of which are women veterans, throughout 42 counties in Iowa and two counties in northern Missouri. Total medical FTEE for FY11 was 1,332.5. RNs were dedicated 237 and 60 for doctors. In fiscal 2011, 2 percent of the total budget, or $495,000 was dedicated to staffing costs for quality of care; in FY 2012 that number increased to 8 percent, or $1.9 million.

Quality of Care

The CIHCS defines quality of care as quality, patient satisfaction, veteran-centered care, and continuous, systematic, organization-wide improvement through care providers in all clinical and administrative, direct care and support services working within CIHCS.

To ensure quality of care within CIHCS a Quality Management System was implemented to provide a continuous, systematic, organization-wide approach to process design, performance measurement, and continuous quality improvement in support of the VA core missions, to recognize current and emerging veteran needs and to align with VHA strategic guidance.

Sharing information is critical to the success of the CIHCS; therefore, the following committees and councils meet on a regular basis to review quality of data, actions being taken to address quality issues, improvement initiatives and collaboration that involves their area and other issues that influence quality of care:

- Leadership Council meets daily. Includes executive leadership, quality manager, director’s staff, service/service line leadership. The Leadership Council addresses immediate issues/concerns, shares information coordinates daily activities
- Quality Council meets weekly. Includes director, chief of staff, nurse executive, associate director for Resources, quality manager, patient safety manager. The council provides a high-level review and evaluation of information from the regular leadership council meetings, and determines and communicates priorities for initiatives in quality improvement, patient safety and system redesign.

Quality Manager

The quality manager is responsible for ensuring that components of the quality management system and patient safety improvement program are integrated; ensuring a systematic process is in place for monitoring the facility quality data; serving as the quality consultant to the facility leadership, SR/PI teams and employees; and serving on executive committees and workgroups where quality data and information is reviewed, analyzed and acted upon.

Patient Safety Manager

The patient safety manager is responsible for ensuring that components of the Quality Management System and Patient Safety Improvement Program are integrated, and implementing a coordinated patient safety improvement program at the facility level based on guidance and tools from the NCPS that meets the needs and priorities identified by the facility director. These include addressing important standards, requirements, and recommendations promulgated by TJC and other organizations working to improve patient safety.

In FY 2011, the CIHCS completed six RCAs within the established 45-day period. Through monthly conference calls, information is shared with VISN leadership. During a Joint Commission inspection, recognition was provided for the development and preparation for the new MRI machine, including, developing communication to address fire issues, non-magnetic code charts, and holding drills for all personnel, including police, housekeeping and all providers.

Utilization Manager

The utilization manager monitors the appropriate and efficient use of resources, and assists in the promotion and maintenance of high-quality care through the analysis, review and evaluation of clinical practices. Through the use of evidence based criteria, the Utilization Management Process guides the delivery of quality patient care and appropriateness of services at the CIHCS, ensuring the veteran is provided the right care in order to be discharged and returned home quicker.
Risk Manager
The primary responsibility of the risk manager at the CIHCS is to manage the peer-review program. The peer-to-peer program ensures quality improvement and/or resource-utilization purposes relevant to the care provided by individual providers. The peer-review program and processes comply and are in accordance with all applicable laws, regulations, current VHA policy, and requirements of relevant accrediting and oversight agencies. Peer reviews include all critical reviews of patient care by a provider that are performed for the purpose of improving the quality of health care and improving the utilization of health-care resources.

Patient Advocate
The patient advocate serves as the veteran’s voice in addressing concerns with the care the patient is receiving at the medical center. Concerns and issues are tracked through the use of the PATS and the IRIS.

To ensure new veterans are aware of the patient advocate and the resources provided, a new patient orientation is completed. There are pictures of the advocates posted throughout the medical center, including all entrances and in the pharmacy waiting area, and on the CIHCS webpage. Information is also posted in all CBOCs.

Patient Aligned Care Team Coordinator
Currently, the CIHCS does not have a PACT coordinator; in its absence is a PACT core team that meets weekly and a PACT steering committee that meets on a monthly basis.

To address patient satisfaction, all veterans who are discharged from the CIHCS and non-VA facilities are contacted by phone and asked about the care they received. Veterans are asked if they have any questions, including those involving medications received and discharge instructions. These call-backs made VA officials aware of which areas of discharge communication needed to be increased and of the quality of care veterans were receiving through non-VA facilities.

Town Hall Meeting
On Monday, April 16, a town hall meeting was conducted at The American Legion Department of Iowa headquarters in Des Moines, Iowa. During the meeting many veterans praised the facility, stating they had received excellent care; however, some issues were raised, including concerns regarding the patient advocate, medication and communication issues.

During the site visit, all concerns were raised with executive leadership, who acknowledged the concerns and were determined to meet the expectations of the veterans.

Recommendations
- The facility should address communication issues regarding medication information with the veterans. Many times a concern could be the result of a simple miscommunication.
- Address the wait times with specialty providers. Even though the facility has done a notable job in decreasing wait times with primary care physicians, the staff noted that wait times for specialty providers had increased but were unable to determine the increase. This should be addressed ASAP.
Background

Lyons VAMC is part of VAs New Jersey Healthcare System (NJHCS). This system is comprised of two main campuses, East Orange and Lyons. There are 31 FTEE in the quality management team; however, quality of care and patient satisfaction is a responsibility of all employees. There are 355 RNs, 57 LPNs, 188 NAs and five SCI-Hats. Lyons VAMC’s overall medical center budget for FY 2011 was $425 million and $400 million in FY 2012.

Quality of Care

Executive leadership defines quality as the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge, and is further conceptualized as care that is safe, effective, efficient, timely, patient-centered and equitable. Accountability is maintained through daily oversight by leadership reviewing VISN performance, performance-measure results, OIG and JC. The executive staff manages quality through direct problem solving and systematic improvement efforts such as team projects. Employees receive orientation and initial training upon hire. Designated staff and chiefs are afforded Lean Yellow Belt training. Lean Yellow Belt training is a program sent down from VACO.

Quality Manager

The quality manager provides oversight for the risk manager, utilization manager, patient safety, external review and system redesign. This individual tracks and manages quality-of-care indicators by VSSC reports and IPEC link reports. In addition, the quality manager is responsible for performance measures, and Aspire review and reporting.

The quality manager has a dashboard that allows the individual to monitor all aspects of quality of care and patient satisfaction. If a category within the dashboard turns red, the quality manager must address the situation. Furthermore, the quality manager has access to TruthPoint, a program that allows the facility to receive an immediate survey response. TruthPoint works on a tablet sim-
The utilization manager receives initial and continuous training through the national utilization management program office. Training also is provided through a live teleconference meeting every three weeks that administers program updates.

To improve quality of care and patient satisfaction, the utilization staff conducts reviews of patient admissions. The reviews determine if the veteran received correct and quality medical procedures. The data collected is then sent to the utilization management committee, where it is used to guide improvements to meet patient needs.

**Risk Manager**

The risk manager coordinates administrative investigations, screens deaths, manages tort claims, and collaborates with the chief of staff in reviewing malpractice claims. In addition, this individual oversees the Protected Peer Review program and facilitates action plans that emerge from the program. The risk manager receives initial orientation, consisting of a two-day class on all aspects of the position. This individual is also a member of the American Society for Healthcare Risk Management and attends yearly conferences. To limit patient risk and monetary loss, the risk manager conducts analysis peer reviews on morbidity, mortality, disclosure and tort claims. The information retained is used to improve systems and minimize patient risk.

**System Redesign**

The system redesign manager’s core function is to improve quality of care and patient satisfaction. This individual attends several system redesign conferences and meetings, in addition to Green Belt Lean training.

**Chief Medical Officer**

This individual is responsible for working with providers and staff to evaluate current systems. When a deficiency is found, it is the chief medical officer’s responsibility to research possible solutions. Furthermore, the chief medical officer must be knowledgeable on the latest technology to ensure software is current.

To effectively track quality-of-care and patient satisfaction indicators, the chief medical officer adopted the Planetree Model. Planetree is a non-profit organization that collaborates with health care organizations to educate and provide information to create patient-centered care. The VA Office of Patient Centered Care selected Planetree to assist in creating a patient-centered care model for veterans. The challenge of the chief information officer is the technology being used. The technology is outdated, and the new technology being used has been a challenge to put together.
**Women Veterans Program Manager**

The women’s clinic provides complete primary care, including a GYN clinic, but mammograms and prenatal care are fee-based. The women’s clinic is separate and located on the second floor of the Lyons VAMC. The GYN clinic is closed on Wednesday and Thursday; emergency situations are fee-based. If a veteran has MST, the individual is sent to an MST counselor. The women veteran program manager developed a women’s health committee that includes veteran participation.

**Patient Satisfaction**

The executive leadership measures and manages patient satisfaction through the TruthPoint system through a contract with Vertical Systems Inc. This technology is touch screen and used to capture patient feedback from VISN 3 facilities. In addition to TruthPoint, the facility uses SHEP, HCAPS and We’re Listening Patient Feedback System.

The data received from the tools mentioned is analyzed for trends on monthly and daily data. The data is used to drive decisions that will improve patient satisfaction at the executive committees. Since the last SHEP survey, Lyons has made improvements in noise control and quietness beyond the VHA national average. The facility had a decline in responsiveness to patients; therefore, NJHCS received funding to purchase the Vocera Hands Free Communication system for 150 Patient-Care Services and nursing staff. The system enables communication throughout the hospital, helping drive better outcomes for patients.

**Director of Patient Care Services**

The director of Patient Care Services is responsible for all nursing care standards. Patient satisfaction is tracked and managed through TruthPoint, survey questions and monthly tracking. This information is shared with the patient-centered care staff. The director conducts an internal focus group to find the needs of the veterans, sharing the information with the nursing staff. The director of Patient Care Services most challenging issue is supervising both Lyons and Orange campuses.

**Patient Advocate**

The purpose of this position is to work on behalf of the veteran and families to resolve issues and questions. The patient advocate assures patients effective use of their rights and entitlements. This individual receives and listens to grievances from patients or individuals on behalf of the patient. When a complaint arises, the patient advocate informs all levels of leadership. The issue is examined thoroughly, and appropriate action is taken. The patient advocate’s most prominent challenge is the complaints of the food in the facility’s cafeteria.

**Patient Aligned Care Team Coordinator**

The section chiefs and director of CBOCs are responsible for implementing the PACT model. The duty of the coordinator is to insure that PACT teams are educated and trained in PACT principles. PACT data is tracked through the VSSC program, which consists of care coordination, two-day post-discharge call and MyHealthy Vet program, access to same-day visits, access to appointment within seven days, telephone conversations and continuity of provider. PACT has no problems, but the system is too early to find any real issues.

**Town Hall Meeting**

The town hall meeting was conducted at Post 304 on April 18, 2012. Veterans in attendance brought no issues or concerns regarding the Lyons VAMC.

**Recommendations**

- The transition from DoD to VA must improve; currently many veterans are getting lost in transition
- Lyons VAMC should be able to advertise locally. This will benefit families, veterans and VA by making the system feel more community-orientated.
- Mammograms and prenatal services should be made available on-site for women veterans.
- New Jersey HealthCare System needs to improve its regulations and procedures with staff. Currently, its regulations are not consistent with both East Orange and Lyons campuses. Both campuses fall under one leadership team, but the staff is not educated equally.
OMAHA-VA NEBRASKA-WESTERN IOWA HEALTHCARE SYSTEM

Date: April 19, 2012
National Task Force Member: Chairman, Michael D. Helm
National Field Service Representative: Steven J. Henry

Background
The Nebraska-Western Iowa Healthcare System (NWIHCS) currently employs 433 RNs, 22 APRNs and 125 LPNs, for a nurse-to-patient ratio of 5 to 1, with very little turnover. Approximately 1 percent leave for other employment and 1 percent leave due to retirement; recruiting for open positions is ongoing. The total budget for the NWIHCS for FY 11 was $344 million and $363 million in FY 12.

Quality of Care
The NWIHCS defines quality as the sum of quality/safety, access and satisfaction (veteran and employee) divided by cost. The medical center strives to design state-of-the-art, veteran-centric facilities that exemplify world-class ownership, leadership and health-care value. Quality is measured and tracked through the use of the six sigma program and by using evidence performance measures cascaded from VACO that are monitored throughout the medical center. Quality measures are reviewed by quality-of-care committees – most notably the quality board, a group of utilizing tools that provide transparency of quality care through the use of N-Tracks SharePoint, executive-sponsored daily morning meetings and TAMMCS, a process-improvement model. Other quality-of-care committees include:

- The Peer Review Committee. Provides confidential and systematic review of individual provider level contribution to quality within a non-punitive context
- Patient Safety Committee. Meets monthly and is comprised of providers, pharmacy personnel, nurses, veterans and patient advocates
- Integrated Ethics Council. Meets monthly and is an interdisciplinary team comprised of nursing, quality, education and chaplains providing oversight for policies, consultations and preventive ethics

All service line and front-line staff assume the responsibility of providing quality care to veteran patients through a strong readiness program, creating an environment of quality throughout the entire medical center. To ensure the continuity of quality, NWIHHC provides newly hired employees Value-Improvement Equation training, and Six Sigma training is provided for all interested employees. The resources provided to the medical center to assist with improving quality-of-care programs and initiatives include PACTs, funding for NWIHHC’s three-year improvement capability grant, pain management and telehealth.

Quality Manager
The quality manager provides oversight of continuous readiness efforts involving regulatory/accredited surveys leads/participates in process-improvement efforts and serves as the director of MWMVERC.

Monthly audits are conducted at non-VA community nursing homes to ensure quality; CBOCs complete process improvements specific to the respective location, including access, care coordination and management, redesign and patient satisfaction. The quality manager is responsible for VA nursing and social work staff that monitors non-VA contract nursing homes.

Accountability of quality care indicators and measurements is ensured by every staff member, as quality expectations are built into employees’ expectations outlined within their responsibilities. Every employee is responsible for providing quality care beyond what is measured. Although the facility may be meeting quality measures, it is the veteran’s opinion and experience that matters. Positive performance measures do not always reflect happiness of the veteran. Unfortunately veterans will often relate the quality of their care with the age and overall condition of the facility. The aging facility and infrastructure can influence a veteran’s perspective on the care received.

Patient Safety Manager
As evidence of its commitment to safety, the NWIHCS is one of the few facilities that employ an associate chief of staff as the patient safety manager. The patient safety staff works collaboratively with all services/areas in the HCS (clinical and administrative) to identify opportunities for improvement of patient safety and quality of care. Multiple mechanisms are utilized to make improvements, including RCA-individual and aggregate, patient safety alerts and advisories; and HFMEA risk assessments.

The NWIHCS utilizes a spot program for safety reporting that emphasizes an open communication method for employees to report patient safety issues. Employees are encouraged to report safety concerns and have the ability to do so anony-
mously. Monthly conference calls are conducted with VISN leadership; correspondence with national safety leadership is done through monthly emails. Patient safety staff has access to a website where best practices and lessons learned are shared. Due to the broad scope of the spot program, there is difficulty in creating reports and graphs that focus on one specific area. Any requests for more specific information must be approved and completed through VACO. All incident reports must be reentered manually into the national safety database.

Through the use of the EPIR program, incident reports are automatically logged in the spot system. One drawback is the lack of feedback that is offered. An average of six to 12 incidents are recorded on a daily basis, but the current system does not allow for classification of “near miss” or “close calls” incidents. There is a hotline available to employees to anonymously report a “near miss” or “close call” incident.

To ensure a safe environment within the medical facility, all employees are expected to participate in patient safety in their daily duties, in their interactions and care of the patient, as committee members, as process-improvement team members and RCA team members, in reporting actual or close-call patient incidents, and in policy and standard operating procedures development.

Utilization Manager
The utilization manager works collaboratively with clinical staff to ensure veterans are receiving the appropriate care at all levels. The evidence-based national review system that VA has chosen is the Inter Qual criteria system. By using research-based criteria, the facility is able to indicate how and when a veteran should be treated. Documentation improvements have been made to ensure the correct path of care. There is a constant collaboration with providers to come to a consensus on how each department may assist each other to provide the best care to the veterans.

Risk Manager
The risk manager provides oversight of the Peer Review Program, with the ultimate goal of improving quality. Performing peer-to-peer reviews, a non-punitive process, allows for a great deal of feedback to ensure a learning process and improve communication throughout all departments. The risk manager attended an initial training course through the American Society for Healthcare Risk Management, and collaborates with other risk managers and Peer Review coordinators through ongoing training obtained through the Regional Counsel and VACO Risk Management Personnel.

The Omaha VAMC maintains a strong Peer Review program, using multi-disciplinary providers to ensure improvements in quality. There is a “no blame” non-punitive culture, opening the channels of communication for providers to give peer-to-peer feedback and notify of any events. It is essential to provide effective communication throughout all the departments for a successful Peer Review program.

System Redesign
The system redesign manager facilitates all Rapid Process Improvement Workgroups that are formed to complete process-improvement work around a specific problem, serves as a resource to NWIHCs staff regarding process-improvement methodology, and works collaboratively with a variety of workgroups to ensure that VA-TAMMCS is properly utilized.

By teaming with Purdue University, educators trained the system redesign staff on Lean Training and recently completed yellow belt training with 30 employees. PACT teams will send members for training next. The goal is to introduce further concepts and become facilitators.

Chief Medical Information Officer
The chief medical information officer supports the clinical and administrative service design informative data sets to improve care and service to veterans. Reports are generated to address gaps with no data. Performance improvements using clinical reminders are used in mental health and primary care, but not for inpatient care.

Improvements can be made in the current software. Currently, Omaha VAMC is integrated within the Iowa health-care system which complicates the ability to pull data due to both facilities being consolidated. Improvements should be made to segregate the data between Iowa and Omaha by adding naming nomenclature; currently staff must adjust prefixes and suffixes to differentiate between the two sites. The current model
sloths down the process of requesting data. Providers are currently unable to see labs on coversheets within the CPRS.

**Women Veterans Program Manager**

In the past, the NWIHCS offered a separate location for women veterans to receive exams and to see women-specific providers for appointments. However, due to space constraints, the space was converted into regular space and women no longer have the ability or the option to see a female-only provider. After this change was made, each PACT providers received training on how to treat women patients.

There are plans for the Omaha VAMC to be expanded, and construction is set to begin in the near future. A separate women’s clinic is proposed in these plans. There is a women veterans committee that is chaired by the Women Veterans Program Manager and meets on a monthly basis. Veterans sit on the committee, giving them the ability to provide the perspective of the patient.

With 14 percent of all patients being female, it is imperative that the facility make complete and comprehensive care available for this growing population.

**Patient Satisfaction**

In FY 11 and FY 12, FTEE dedicated towards patient satisfaction consisted of one patient centered care coordinator and 2.5 patient advocate staff to ensure a positive experience for the veteran. Patient satisfaction is defined as being present for the veteran, and placing the veteran and his or her support system in the center of everything the medical center does. The patient satisfaction program is measured through the use of mail surveys, including SHEP and Press Ganey. The scores from surveys are collected with each survey tool and compiled and shared with executive leadership, managers, supervisors and staff.

SHEP scores take an average of 90 days, making the data outdated, so the NWIHCS developed a survey through the assistance of Press Ganey and is able to receive results in an average of 30 days, providing more precise data while providing a more accurate depiction of solutions recently implemented to address quality-of-care concerns within the medical center. The results of the most recent survey concluded that inpatient improvements had been made with communication in nursing, medication and discharge information, but declined in areas related to quietness of the medical center. In outpatient, improvements were made in specialist care and pharmacy mail service but declined in the areas of care, communication and pharmacy services. To address the results, a meeting was conducted with the executive leadership and all EMS staff that resulted in the following measures being implemented to address areas of inpatient deficiencies: use of a calling card that includes contact information to leave in the patient’s room, notifying the veteran and his or her family that the room had been cleaned, and training the nursing staff to knock on the door prior to entering a patient’s room. To address outpatient deficiencies, a patient-centered care committee was established and includes establishing a veteran advisory council to solicit input from veterans.

To ensure accountability for patient satisfaction, VACO has established the Office of Patient Centered Care and Cultural Transformation that oversees and regulates performance measure targets set for VA facilities, including the NWIHCS. For FY 12 NWIHCS will be monitoring the SHEP dimension of care “shared decision making” on the inpatient survey tool and SHEP dimension of care “communication with doctor/nurse” on the outpatient survey tool.

**Director of Patient Care Services**

It is the responsibility of all providers and employee of the Omaha VAMC to provide quality care to the veterans. Quality lies in the eyes of those receiving the care. Systems were developed to improve the measurement of quality and patient satisfaction, including contracting with Press Ganey for more accurate survey data and the use of a highly structured patient satisfaction committee. Executive leadership strives for excellence in satisfaction.

**Patient Advocate**

The patient advocate is responsible for the effective administration of the patient advocacy program. The role is to assist veterans, families and advocates with questions about patient care and to provide a mechanism for expeditious resolution of any concerns.

Every time a veteran contacts the patient advocate, the incident is coded and then placed into the PATS system that tracks all incidents at the VISN and through VACO. Best practices and information are shared through monthly conference calls with VISN and VACO.

Throughout the medical center, there are posters that explain what the patient advocates do and how they work for veterans. It was suggested that the posters should be hung in the elevators and CBOCs, and should include a picture of the patient advocate. It is a concern that veterans who use CBOCs may not be aware of the patient advocate and the resources available to veterans.

There is a part-time associate who answers phone calls when the advocate is busy with a veteran. Many times, concerns
raised are due to miscommunication and are taken care of with a conversation with the provider. The NWIHCS patient advocacy program should be enhanced by adding staff. Currently, there is one full-time advocate and a part-time volunteer. The advocate logs an average of 25 incidents every day. The advocate stressed the difficulty in providing service to all veterans with such limited resources.

**Town Hall Meeting**

A town hall meeting was conducted at an American Legion post in Omaha, Neb., on Monday, April 18. During this meeting, concerns were raised regarding the mental health program at the VAMC. A veteran expressed his displeasure with providers on the mental health floor turning away veterans and advising them to go to the Vet Center.

**Recommendations**

- Enhance patient Advocacy program to include adding staff. Currently, there is only one patient advocate who is completely overwhelmed. It’s unlikely that veterans are provided the best possible service when the patient advocate receives an average of 25 complaints per day.
- There are parking spaces mandated for service-connected veterans that are consistently used by facility staff. Space is an incredible challenge.
- There is a severe parking shortage. Veterans will regularly arrive for their appointments and average of two hours early so they are able to find a parking spot.
Background

The Durham Department of Veterans Affairs Medical Center is located in Durham, N.C. The Durham VAMC is part of VISN 6, the VA Mid-Atlantic Health Care Network that includes eight medical centers. The Durham VAMC serves more than 200,000 veterans living in a 26-county area throughout central and eastern North Carolina.

The medical center has 2,043 employees, 33 percent veterans, which provide quality, safe patient care to their veteran community. Through March 2012, there were 506.4 FTEEs RNs and 89.2 LPNs working at the Durham VAMC.

The budget for the Durham VAMC for FY 2011 was $371 million. The budget for FY 2012 is $400 million. The Durham VAMC’s budgets in both years were dedicated towards providing high levels of quality care and patient satisfaction through staffing, programs and initiatives in order to ensure all of the veteran’s needs and expectations are met.

Quality of Care

The Durham VAMC vision of quality is providing safe, effective and efficient patient-centered care in a fiscally responsible way. The Durham VAMC continues to strive to be the employer of choice while maintaining strong academic and community affiliations that provide high quality of care to the veteran community. The medical center measures and manages quality by selecting performance monitors and measures aimed at determining if a process and/or function is performing at levels expected and designed by the medical center.

The medical center demonstrates and maintains accountability for quality of care through an established reporting structure and engaged communication. Each service/section chief and program director is responsible for the planning, implementing, integrating and evaluating all elements of the medical center’s quality-management program. The management of quality by the Durham VAMC is overseen through a medical center governance structure. There are a series of committees and sub-
committees that report their findings and or recommendations to councils chaired or co-chaired by members of the executive leadership team. Each council is chartered with specific charges and measures of effectiveness. The medical center has an effective internal tracer program whereby a trained tracer team of consultants performs internal evaluations of clinical areas to ensure there is a safe environment, and that veteran care is being provided in a safe and high-quality manner.

The VAOIG Office of Healthcare Inspections conducted a CAP review at the Durham VAMC on June 10, 2011. The CAP review focused on Environment of Care (EOC), Management of test results, and coordination of care. There were six OIG-CAP findings and recommendations. The Durham VAMC had a Joint Commission (JC) accreditation inspection on August 15-19, 2011. The Durham VAMC was fully accredited in Hospital, Behavioral Health and the Community Living Center. The medical center has implemented all corrective actions and was approved by the JC.

The medical center provides quality-of-care training to all new employees through their New Employee Orientation program. The training includes patient safety and customer satisfaction training. Employees throughout the year receive additional performance and quality improvement training that are job-specific. Each employee is also required annually to complete job-specific competencies and online trainings through their Talent Management System.

In regards to providing quality and safe patient care, the medical center recently completed major construction to renovate all of the inpatient nursing units, transforming them from their 1953 design to modern units with private and semi-private rooms. For fiscal 2012, the medical center has several construction projects and internal office and clinic moves to improve the overall veterans’ quality-of-care experiences.

A main resource that the Durham VAMC needs from VA Central Office and the VISN is for the VERA model to be modified to properly fund medical centers with rapid workload growth due to increased veteran enrollment.

The main challenge for the medical center is to fill open health-care provider positions as a result of an influx of staff retirements. Another facility challenge is workload growth. The Durham VA has projected that there will be a 5 percent growth in unique veterans, making the Durham VAMC the second-fastest growing site within VISN 6.

**Quality Manager**

The chief of quality management service is responsible for managing and leading the medical center’s quality assurance program. The quality manager maintains responsibility for the medical center’s survey readiness to ensure all VHA, JC, OIG and other accreditation organization requirements are met. Further responsibilities include the overall medical center’s customer satisfaction, systems redesign, utilization management, risk management, and credentialing and privileging programs. The medical center’s quality manager also oversees the external peer review program that measures the clinical quality of care. The challenges that the Durham VAMC quality manager has is that there are too many measures to manage due to limited resources.

**Patient Safety Manager**

The PSM is responsible for ensuring that the medical center has a proactive approach in the overall improvement of the medical center’s patient safety program. The patient safety manager analyzes episodes of care that requires improvement to include near misses, with a focus of systems improvement. The PSM also is in charge of performing RCAs as a result of communication, systematic and/or process failures. The Durham VAMC’s patient safety manager’s main challenge is that there needs to be an increase in staffing in order to do more aggregation of information to increase the overall improvement in patient safety programs and initiatives.

**Utilization Manager**

The utilization manager’s duties and responsibilities for the Durham VAMC are to ensure that quality-of-care standards are met, including the completion of reviews for patients admitted to the medical center, as well as those remaining in the medical center, in order to ensure that they are receiving the appropriate levels of care/treatment and are receiving timely access. The main challenge for the utilization management staff is having the ability to provide same-day access rather than offering veterans the next available appointment.

**Risk Manager**

The RM is responsible for developing and managing the Durham VAMC’s risk-management program in accordance with all regulatory agencies, VHA, VA Network and facility requirements.
The RM is part of the quality management team and participates regularly on PI initiatives. The RM role is to look at processes or failures, and involve the systems redesign and utilization program managers to change current policy. The RM also is involved with facilitating corrective actions to improve quality of care and patient satisfaction issues that have been discovered in a risk management review. The RM also follows-up on veteran concerns brought to them by the veteran representative involving: missing personal property, allegations of negligence/malpractice, allegations of abuse, medication errors and issues related to safety.

**System Redesign Manager**

The SRM is responsible for eliminating waste to improve processes that overlap into providing quality care and patient satisfaction. A challenge for the systems redesign manager is that the scheduling system needs to be redesigned so the medical center can provide same-day health-care services.

**Chief Health Medical Information Officer**

The chief of health information management service is responsible for timely oversight of the quality and accuracy of the medical record and all associated clinical documentation, coding and release of information. The chief health medical information officer also assures that the electronic health record offers accurate efficient quality documentation.

**Women Veterans Program Manager**

The WVPM is responsible for promoting the health, welfare, and dignity of women veterans and their families by ensuring timely access and sensitivity through comprehensive, gender-specific care to more than 4,200 enrolled women veterans. The programs and initiatives that the Durham VAMC women’s health program has to ensure quality of care and patient satisfaction for women veterans are: Comprehensive multidisciplinary women’s health mental health team
- Baseline monitoring for cervical and breast cancer screenings;
- Providing expanded women’s health-care services to include female healthcare providers at all of the affiliated CBOCs;
- Increased outreach programs through partnerships with the OEF/OIF and rural health program managers;
- Expanded mammography services at the Durham site, to include full range of cancer care and screenings; and
- Current expansion of the women’s health clinic in Durham.

The challenges for the women’s health-care program are that there are no available resources for daycare services and an increase in fee-based services for obstetric care.

**Patient Satisfaction**

**Background**

The Durham VAMC is committed to providing the best health care to their veterans. In order to accomplish a high level of patient satisfaction; the Durham VAMC customer service standards are based upon national VA standards for patient satisfaction. The Durham VAMC measures, tracks and manages patient satisfaction through their internal customer satisfaction council. The scope of the medical center’s customer satisfaction council is to discuss issues related to customer service and to identify new ways of providing the highest levels of service and care. Durham VAMC provides evidence-based and metric-proven high quality of care. The Durham VAMC’s goal in regards to patient satisfaction is to mirror the quality of care that is received to the perception of care that the veteran actually receives. In order to accomplish a high levels of patient satisfaction, the Durham VAMC is committed to providing veterans access, coordination of care, continuity of care, courtesy, education, emotional support, physical comfort, patient preferences, transition, pharmacy care and specialist care to its veteran population.

Currently, the medical system is using SHEP and Press Ganey survey scores to measure and track patient satisfaction within their veteran community. VISN 6 has contracted with Press Ganey to provide more timely, unit/provider data to enable the Durham VAMC to improve processes related to customer service and patient satisfaction. Strategic goals from these surveys currently are in place for the overall medical center’s progress and the reports are discussed at monthly patient satisfaction and quality of care meetings.

**Director of Patient Care Services**

The director of patient care services is responsible for the management and oversight of all of the nursing professionals and the overall delivery of inpatient nursing care and sterile processing services. A challenge for the director of patient care services is the current 11 percent turnover rate for the nursing staff. The turnover rate is due to retirements, terminations, educational pursuits, expansion and/or creation of new programs, internal transfers and/or promotions, and personal relocation decisions. Another challenge is currently it takes up to three months to fill a vacant nursing position, depending on the individual circumstances.

**Patient Advocate**

The patient advocate is responsible for ensuring that all veterans and their families who receive their health care from a
VHA facility have their complaints addressed in a convenient and timely manner. The Durham patient advocacy program operates under the broader scope of service recovery and pro-actively promotes VHA initiatives in order to provide high quality service to their veteran population. The most frequent complaints that the Durham patient advocates receives are access to care through communication (telephone, letters, etc.); access to specialty care; and beneficiary travel.

**Patient Aligned Care Team Coordinator**

The PACT coordinators at the Durham VAMC are responsible for the transition and/or transformation of primary care delivery to the PACT model of health-care delivery. The PACT coordinator’s mission is to provide optimal health-care management through collaborative teamwork in an effort towards patient-centered care. The PACT coordinator and its staff conduct veteran focus groups so veterans can be involved in the overall PACT decision-making process.

The challenge that the medical center faces with its existing PACT model is having inadequate staff to care for its 44,000 veterans that are currently enrolled in primary care. Currently, the provider staff assigned to the PACTs split their time between clinic time and their academic affiliation responsibilities.

**Veteran Town Hall**

A veteran town hall meeting was conducted at American Legion Post 7 in Durham, N.C., on April 23. There were 22 veterans in attendance to discuss issues and concerns with the health care they receive at the Durham VAMC. Some of the issues and/or concerns that came out of the town hall meeting were parking, scheduling appointments, and that the automated telephone system is not very user-friendly.

**Recommendations**

- Due to the amount of mandated measures that the medical center needs to review and track, the medical center needs to establish a more effective and efficient mechanism to track all of the measures associated with health-care facilities.
- The medical center needs to hire more patient advocates to address, analyze and track patient-care issues and concerns.
- There needs to be increased funding to the medical center to compensate for the projected 5-6 percent increase in veteran enrollment.
- The Durham VAMC needs to hire a permanent director in order to provide leadership continuity to the staff and the veterans who use the medical center and their affiliated CBOCs.
- The SHEP scores data needs to be sent to VA medical facilities in a timely manner, rather than a three- to six-month wait in order to evaluate “real-time” quality of care and patient satisfaction.
The William Jennings Bryan Dorn VA Medical Center

Background

The William Jennings Bryan Dorn VA Medical Center (VAMC) serves approximately 65,730 patients. The VAMC has sufficient staff-to-patient ratio with a 6 percent turnover rate. The annual budget for FY 2011 and FY 2012 is $352 million and $358 million, respectively.

Quality of Care

The facility defines quality of care as a collaborative organization-wide continuous process fully integrated across services and disciplines to provide safe, effective and efficient patient-centered care. The goal is to continuously improve patient outcomes, reduce variations in patient care delivery and ensure the delivery of safe medical care. The facility measures quality through the monitoring and tracking of all medical center performance improvement and patient safety activities and issues, recommending actions, tracking the resolution of problems addressed and supporting the improvement of processes. Aggregated data review and analysis of key quality indicators help to determine performance-improvement priorities. The data collected for high priority and required areas are used to monitor the stability of existing processes, identify opportunities for improvement, and identify changes that lead to improvement or sustain improvement. Areas for monitoring performance are determined by considering the veterans’ needs, nationally identified high risk areas, sentinel events, and priorities set by leaders at the local, regional and national level. In addition, the medical center identifies those areas needing improvement and identifies desired changes. Performance measures are used to determine whether the changes result in desired outcomes.

The facility demonstrates and maintains accountability through verification of performance via internal and external reviews by the Office of the Inspector General (OIG), the Corporate Accountability Program (CAP), and other federal and state regulatory agencies. Healthcare Inspection Reports are available to the public from the OIG website, and TJC Accountability Measures are available from the Quality Check website and the U.S. Department of Health & Human Services Hospital Care website. The facility openly communicates with state and federal regulatory agencies, as well as veteran service organizations and other community partners, with the intent of maintaining accountability through transparency.

The medical center fully engages a comprehensive and proactive compliance and business integrity program, promoting an organizational culture and encouraging compliance with the laws, regulations and standards. The training employees receive is a comprehensive orientation when employees start at the VAMC that includes multiple quality-of-care training modules and four hours of Employee Patient and Family Centered Care Training. Employees thereafter must complete mandatory annual training modules.

Additionally, there are new policies in place to track and trend the consult system to ensure the VAMC is following national guidelines as related to consult management. VISN 7 has provided resources to the facility to sponsor individuals attending the Access, Flow and Improvement Advisory Academies and has supported attendance to the Veterans Health Administration Improvement Forum. In order to reach and spread the process improvement model, VACO will need to continually support staffing and education related to hardwiring process improvement into the culture of the organization.

Some of the facilities “best practices” have been implementing VA PACE, a T21 grant program designed to help elderly veterans stay in their homes, keeping them as functional and independent as possible, and enabling a high quality of life while providing relief and support for caregivers. Six months prior to enrollment in the VAMC PACE Program, veterans had an average of 3.4 ER visits and 11.9 days of hospitalization. Six months post-enrollment, they had an average of 0.8 ER visits and four days of hospitalization. The average yearly cost-savings is approximately $486,000 for the 10 veterans enrolled. The Dorn VAMC program has been so successful that VACO Geriatrics sent a team to review and get best practices to disseminate to other programs in VA.

The OIG report from May 2012 can be summarized as allegations of inadequate patient care, poor communications with family, poor coordination of care and inappropriate infection control practices. While it was confirmed that some of the alleged conditions existed during a veteran’s hospitalization, in many cases, facility leaders had already taken actions to improve care and service delivery. These allegations were not substantial. OIG recommended that patients assessed to be at nutritional risk are promptly evaluated by appropriate dietary staff, that nursing personnel are trained on the steps required to initi-
ate consult requests through the electronic nursing assessment package, and that actions are taken to evaluate and revise the “Do Not Attempt Resuscitation” template note, as appropriate, to be more patient-specific and patient-centered. The VISN and facility directors concurred with the findings and recommendations and provided acceptable improvement plans.

**Quality Manager**

The QM plans, develops, and maintains a comprehensive program to ensure compliance with the VA directives, Joint Commission standards and other internal/external regulatory agencies. An integral member of the facility’s leadership team, the quality manager is responsible for transition to continuous quality improvement as an approach to assess and improve the quality of patient care, and provides leadership and direction to all services in the development and implementation of process improvement systems.

The quality-of-care indicators and measurements are tracked and managed by the executive leadership, and the QM reviews and analyzes the quality data related to the VA performance measures, Joint Commission measures, access data, patient satisfaction data, business and financial measures, deputy under secretary for Health measures, significant patient safety activities, UM data trends, Risk Management data trends, and actions required in response to internal and external reviews. This is accomplished through oversight and integration of service level and committee performance activities and measures. The executive leadership and QM are responsible for monitoring and tracking all medical center performance improvement and patient safety activities and issues, recommending action, as needed, and tracking problems/issues identified to resolution.

**Patient Safety Manager**

The PS Program is an integral part of the overall performance improvement program. The goal of the patient safety program is to create a culture of safety through anonymous incident reporting that is non-punitive. The purpose is to identify opportunities for improvement in patient care monitoring, incident reporting, analyzing, reviewing, and investigating, any unusual, unexpected or unfavorable adverse events involving a patient, staff or family member during the course of medical management highlighting The Joint Commission National Patient Safety Goals for that current year.

Patient safety as a health-care system can be described as understanding the health-care continuum as a system and exploring system vulnerabilities that can result in patient harm. Reports of adverse events and close calls have provided valuable opportunities to evaluate the identified root causes and contributing factors, as well as associated actions and outcome measures to mitigate future events from recurring within the facility. Emphasizing prevention, rather than punishment, is the preferred method to mitigate system vulnerabilities and reduce adverse events. The three-step approach promotes the implementation of knowledge-based actions that can be formulated, tested, and implemented at the local and national levels to effectively mitigate system vulnerabilities that can lead to patient harm. The benefit of RCAs and other ways of finding adverse events is to locate vulnerabilities in the system. The primary concern is missed opportunities in locating these vulnerabilities. Because RCAs are expensive, the VAMC would like to move to a more proactive method of identifying problems.

**Utilization Manager**

The UM provides clinical and administrative recommendations for relative programs, committees, and/or services relating to patient care and utilization management as an approach to assess and improve the quality of health-care services, including the utilization of resources. The UM nurse is a collaborative member of the quality management team and is involved in performance improvement as an approach to assess and improve the quality of health-care services.

**Risk Manager**

The risk manager develops, implements, and evaluates initiatives and activities in collaboration with patient safety to systematically identify, evaluate, reduce and/or eliminate, and monitor the occurrence of adverse events and situations arising from operational activities and environmental conditions.

**Systems Redesign Manager**

The systems redesign manager’s responsibilities are to ensure quality of care, including education and mentoring for lean
process improvement techniques. Systems redesign focuses primarily on standardization of processes. During the flow mapping process, systems redesign indicates all quality of care-related inefficiencies and plot them on a benefit to impact matrix. Generally speaking, most of the quality-related improvements have high impact and easy implementation, as they are commonly a result of limited transfusion of knowledge and/or communication within the facility.

**Chief Health Medical Information Officer/Clinical Lead for Informatics**

The job duties and responsibilities of the chief medical information officer is acquiring and analyzing data, as well as preparing reports and presentations for facility-wide dissemination as related to performance measures and improvement.

The quality of care and patient satisfaction indicators and measurements are tracked and managed by the quality management program specialist. These measures are related to quality of care and patient satisfaction and communicated to the ELSC, HSC and related quality management-specific performance-improvement initiatives. Job-specific tasks include creating/ updating spreadsheets, databases and SharePoint materials to track, manage, and present quality indicators related to performance improvement from committees, councils and systems redesign.

The quality-of-care and patient-satisfaction indicators relate to performance measures under the Network Director Performance Plan and the Executive Career Field measure that are tracked and trended at the local level through the ELSC performance measures sub-council. Specific measures related to quality of care and satisfactions are tracked and trended based on national and VISN benchmarks. The facility reviews performance-related measures weekly and conducts action plans for areas requiring improvement.

Data reported in the sub-council and during EPRP reports provide specific measurements of performance related to quality of care and patient satisfaction. These measurements allow the facility to target areas for improvement using action plans, Plan-Do-Check-Act cycles, and other service/facility-level improvement initiatives as deemed necessary by the ELSC or other committees. Results of action plans and performance initiatives are scored and relayed to the actionable areas for further study or change in process.

The clinical lead for informatics has a significant impact in assuring quality and patient safety through the development and implementation of clinical reminders and medical record documentation templates in coordination with the medical services. However, informatics does not play a role in tracking and managing quality-of-care and patient-satisfaction indicators and measurements. These responsibilities are allocated to the Quality Management and Stakeholders services.

**Patient Satisfaction**

There are two primary ways to track patient satisfaction: the use of surveys and PATS. These tools are used to improve patient satisfaction by implementing individual department performance improvement plans when applicable. Also, discharge call results are reviewed daily and direct feedback given to nurse managers, physicians, social workers, food service, etc. All services are required to be present for monthly patient panel discussions to hear direct feedback.

The following are programs and initiatives that relate to patient satisfaction: interviews, comment cards, focus groups, panel discussions, mystery shoppers, surveys and speak up/speak out sessions.

The VAMC has initiated ongoing patient-centered care training for all employees, began holding regular meetings with staff to address patient/family concerns immediately, and has provided tools for employees to address patient/family concerns at the lowest level. The VISN has provided numerous training sessions for patient/family centered care during the past year; a VISN 7 Veteran and Family Centered-Care Committee helps support the initiative. The VA has a newly formed Office of Patient-Centered Care. The VAMC has been selected to be one of the first medical centers to work with the Region 3 office of patient-centered care to support an enhanced roll out of patient-centered care. The VACO also has a national contract with Planetree, and two representatives from that organization have been involved in this initiative.

**Director of Patient Care Services**

The director of Patient Care Services serve as chairperson for the Patient and Family Centered Care Committee, ensures employees are trained to meet the expectations of patients and family members, maintains the operation budget, oversees all nursing care – inpatient and outpatient – and manages the Sterile Processing Services.

Patient-satisfaction indicators and measurements are tracked and managed in two different ways: inpatient and out-patient through communication with nursing, and evaluations of how well the nurses and doctor communicate to the patients.

**Patient Advocate**

The PA manages the complaint process, including complaint
resolution, data capture and analysis of issues/complaints in order to support the facility in making system improvements. The PA assists in resolving complaint issues that cannot be resolved at the front line or point of service, working directly with service chiefs and service management to facilitate resolution of problems, and supports the facility in presenting the patient’s perspective of the problem and desired resolution to management. Finally, the patient advocate supports patient rights and responsibilities and assists in development of any customer service training initiatives.

The facility is involved in the implementation of Patient and Family Centered Care initiatives throughout the facility and utilizes performance and patient-satisfaction data in strategic planning and veteran satisfaction initiatives. Currently, the medical center is working with the Region 3 team of the Office of Patient-Centered Care and two Planetree consultants.

**Patient Aligned Care Team Coordinator**

The PACT model consists of a team with no one person in charge of the program. Some of the functions of the program are managing the budget/funding, preparing action plans, coordinating education and participating in monthly calls with the VISN 7 PACT leads.

By not having a structured management team, the model can be difficult to maintain. The ongoing challenge is to balance administrative tasks and performance measures with clinical practice. Without a management team dedicated solely to administration and leadership, and clinicians dedicated to medical care, the model is difficult to manage.
Background

The Salisbury VA Healthcare System is located in Salisbury, N.C., and is one of eight medical centers in VISN 6, the VA Mid-Atlantic Health Care Network. The Salisbury VAMC serves more than 84,000 veterans living in a 24-county area throughout central and western North Carolina.

The medical center has 2,200 employees, 32.8 percent of which are veterans, which provide quality, safe patient care to its veteran community. Through March 2012, there were 359.4 FTEEs RN, 144.5 LPNs and 21 NPs working in patient-care services at the Salisbury VAMC. From April 2011 to March 2012, the health-care system had 16 vacant nursing positions.

The budget for the Salisbury VAMC for FY 2011 was $335 million and $341 million in FY 12. The Salisbury VAMC’s budget in FY 2011 that was dedicated to quality of care was $194 million, or 58 percent of its annual budget. For FY 2012, $214 million is dedicated towards to the quality-of-care program and initiatives. The Salisbury VAMC and its entire staff are dedicated and responsible for providing high levels of quality of care and patient satisfaction through their staffing, programs and initiatives in order to ensure that all of the veterans’ needs and expectations are met.

Quality of Care

Background

The Salisbury VAMC quality-of-care mission is to provide the right care at the right time in the right way to the right patient. The medical center defines quality health care as being safe, effective, patient-centered, timely, efficient and equitable. The health-care facility measures and manages quality by having explicit lines of communications among the staff involved in quality management, and a clear understanding of roles, responsibilities and accountability. The mission of the Salisbury VAMC quality-management system is to encompass and empower all of the staff, which falls under the direction and responsibility of facility’s leadership. Each service and/or section chief reviews quality-of-care and patient-satisfaction concerns. Issues and concerns reviewed by management require action plans and performance-improvement plans to demonstrate how the management staff plans on improving the overall quality-of-care program within its departments. The medical center utilizes the quality framework of VA-TAMMCSS (Vision, Analysis, Team, Aim, Map, Measure, Change, Sustain and Spread) to measure and manage its overall quality-man-
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Management program. Quality-management program activities are reported through a committee structure; all committees report directly to the executive committee of the governing body. The medical center demonstrates and maintains quality-of-care accountability by using an external peer-review program to account for the performance and quality of care. To ensure staff is held accountable for quality, the Salisbury VAMC has initiated several quality-of-care programs, including the Physician Pay for Performance Program, the Executive Career Field Performance Appraisal system, and the creation of a call center on campus that eliminates all phone extensions, ultimately improving the overall veteran experience regarding access and scheduling. The challenges for the Salisbury VAMC are the amount of physician turnover due to retirement and relocation for career advancement, providing the services to meet the demands of the increasing veteran population, growth and integration of health-care delivery through the PACT; expansion of telehealth services, and continuum of care from provisions of simple to complex levels of health-care services.

The VAOIG Office of Healthcare Inspections conducted a CAP Review at the Salisbury VAMC on Dec. 9, 2009. The CAP review focused on the six operational activities: EOC, Coordination of Care, Medication Management, Magnetic Resonance Imaging safety, Physician Credentialing and Privileging, and QM. The CAP review identified organizational strengths and reported accomplishments for improved care for patients with diabetes mellitus and improved access to care. The Salisbury VAMC’s last JC survey was Oct. 1-21, 2011. The medical center was surveyed in four manuals and had eight total findings, including five in the hospital manual: Environment of Care, Life Safety, Provision of Care, National Patient Safety Goals, Long Term Care and Infection Control. The Salisbury VAMC received fewer findings than any other medical centers within VISN 6.

Quality Manager

The Quality Management Department for the Salisbury VAMC is responsible for creating an environment that initiates and facilitates the integration of continuous improvement. This is accomplished through the design of delivery systems into daily operations and transforming the organizational culture of quality through the use of performance improvement projects. The Salisbury VAMC Office of Performance and Quality is responsible for the following programs: performance-improvement projects and training, performance measures, VASQIP, accreditation/survey readiness, utilization management, risk management and peer review. The quality manager designs and implements a comprehensive performance-improvement program that is based upon the organization’s strengths and weaknesses. Within the Quality Management Department is an accreditation manager who monitors accreditation, other external surveys and site visits such as JC, CARF and VAOIG.

The additional responsibilities for the accreditation manager are to follow up and develop action plans from the RFIs that were identified during the accredited and external site visits, and to complete weekly rounds to monitor compliance with standards. The Salisbury VAMC has a robust survey readiness program that includes staff participation in the VISN survey-readiness team, annual VISN survey-readiness exercises, weekly rounds by the accreditation manager to monitor compliance with standards, and an interdisciplinary EOC team that completes weekly rounds to different areas of the medical center to ensure constant survey readiness.

Patient Safety Manager

The Salisbury VAMC PSM is responsible for policy development, providing educational presentations on all patient-safety programs, and serves as a trainer, consultant and assistant with root-cause analysis and health-care failure mode and effect analysis. The medical center PSM serves on committees that...
have influence on and impact patient safety. The PSM also provides patient-safety input, consultation and expertise to medical center leaders and to any department or service within the organization. The PSM has put into place best practices and/or protocols for high-risk fall patients such as treded socks, wristbands, high-risk magnets placed outside patient doors, wheelchair activation devices, low beds, and mats placed next to the beds. Additional plans for the Salisbury VAMC patient-safety program consist of the adoption of fall huddles, medication and falls champions, and quarterly-safety lunch and learn programs, and advocates for the adoption of disease-specific certifications for the medical center.

Utilization Manager

The utilization management program is an integral part of the quality-management system that ensures quality and operational efficiency across the quality-of-care continuum. The utilization management coordinator at the Salisbury VAMC applies strict, evidence-based criteria to evaluate the appropriate care a veteran receives; to assure effective resource utilization; and to increase efficiency and improve access to health care, ultimately leading to increased patient satisfaction. The philosophy of utilization management requires ongoing collaboration and strategic planning with licensed health-care professionals in order to ensure patients are receiving the right care, at the right time, in the right setting for the right reasons.

Risk Manager

The RM works in the Office of Performance Improvement and Quality Management. The RM’s role is to report and analyze ways to reduce risk to patients, employees and visitors at the medical center, as well as working with the PSM in reporting adverse-patient events to the medical center leadership. The risk manager’s responsibilities are:

- Coordinating peer and administrative reviews as a result of the notification of tort claims alleging malpractice and maintaining a database of all such claims for the purpose of identifying trends and potential areas of improvement;
- Coordinating external peer reviews from other VAMCs for the protected peer-review program;
- Maintaining oversight of the peer-review program and reviewing potential adverse events;
- Making recommendations to the medical center leadership and service line managers based on analysis of risk management data; and
- Coordinating performance.

System Redesign Manager

The system redesign program at the Salisbury VAMC develops collaborations between departments in order to improve individual processes and interactions. The Salisbury VAMC system redesign manager is responsible for leading the effort to meet or exceed performance expectations that have to do with access, patient flow, and timely, efficient and cost-effective processes.

Chief Health Medical Information Officer

The Salisbury VAMC’s CHMIO is responsible for oversight of the release of information, medical transcription, medical coding, filing and proper storage of medical records, health information scanning and medical record documentation. The CHMIO also ensures the medical center staff receives education as it relates to the health information management process. The CHMIO frequently works with the medical centers privacy officer in streamlining processes and providing staff education on privacy guidelines and regulations. Quality-of-care and patient-satisfaction indicators and measurements are tracked and managed by the CHMIO, who conducts monthly and/or quarterly monitors/audits to review staff compliance, accuracy and to ensure regulatory indicators are being met. These reports are compiled and brought forward to the Medical Records and Compliance committees for review. If results indicate that the service is not compliant with the medical center’s standards, action plans are required to report processes for improvement in meeting the standards. In order to keep the executive leadership staff abreast of outcomes, medical records compliance reports are run daily and presented at the daily morning huddles conducted by executive leadership staff.

Women Veterans Program Manager

The WVPM is responsible for promoting the health, welfare, and dignity of women veterans and their families by ensuring timely access and sensitivity through comprehensive gender-specific care to more than 5,400 enrolled women veterans. The current women’s veteran population in the Salisbury VAMC catchment area is 20,686. The health-care system is projecting 8,100 women veterans will be enrolled within the next five years and 9,600 enrolled within 10 years.

The Salisbury VAMC women’s health program strictly targets programs and existing facilities to meet the unique demands of female veterans. To ensure quality of care and patient satisfaction for women veterans, gender-specific services offered by female providers are: reproduction and/or contraception, reproductive organ cancer screenings, management of abnormal pap smears, management of abnormal mammograms, diagnosis and treatment of urinary problems, in-
fertility diagnosis and treatment, pelvic ultrasounds, annual examinations, cervical cancer screening and mammography services. The Salisbury VAMC performs gynecological surgeries and provides gynecological consultations to enrolled female veterans from the Fayetteville and Asheville VAMC. In order to continue to provide quality of care and patient satisfaction to their enrolled female veteran population, the medical center has initiated hiring a full-time women’s medical health director as part of the executive leadership team to provide optimum health care and outreach to women veterans; provides a full panel of women’s comprehensive care at all of its affiliated CBOCs, and provides telehealth services at its affiliated CBOCs and medical center for military sexual trauma counseling and maternity care. The challenges for the women’s health-care program are that there are no available resources for daycare services and an increase in fee-based services for obstetric care.

The health-care system provides an environment in which all veterans, families and significant others are treated with courtesy and respect through all aspects of their treatment and health-care services. The Salisbury VAMC leadership staff monitors patient-satisfaction measures through analysis of Press Ganey survey results (VISN 6 recently contracted with Press Ganey to provide up to date and current data), SHEP data and the information received from the PATS. The Salisbury VAMC Press Ganey and SHEP scores recently have shown an increase in the overall outpatient and inpatient scores, exceeding all benchmarks.

In order to constantly increase patient and/or customer service scores, the health-care system has established two patient satisfaction/customer service committees. The Customer Satisfaction Committee reviews all aspects of patient-satisfaction measures, collects and evaluates data either from Press Ganey, SHEP or PATS in order to improve overall patent and customer satisfaction, and reviews and tracks actions plans for each dimension that is identified to improve patient satisfaction. The Preventive Ethics Committee conducts 40-50 observations to assess the medical center’s current level of courtesy and professionalism during check-in and telephone encounters with veterans – in essence, management staff act like secret shoppers in order to evaluate customer service – and conducts telephone surveys with veterans to obtain feedback on the experiences with the medical center services.

**PATIENT SATISFACTION**

**Background**

The Salisbury VAMC defines patient satisfaction as providing veterans access to the health care they need in a timely manner in order to achieve quality outcomes. The medical center has a management support service line with a full-time customer service manager and currently is recruiting for full-time customer service specialist.
Director of Patient Care Services
The director of Patient Care Services at the Salisbury VAMC is a member of the executive leadership staff and is responsible for all patient-care services, including nursing and staff responsible for sterile processing of equipment. The director of Patient Care Services has the final authority over all nursing care policies and procedures. Standards of care are met for all of the staff assigned to patient care services throughout the health-care system; and all Patient Care Service staff credentialing is current.

The challenge for the director of Patient Care Services is the amount of time that it takes to hire and bring aboard a nurse, approximately one to three months, to work at the medical center or in their affiliated CBOCs because of privacy clearances and background checks.

Patient Advocate
The customer service manager at the Salisbury VAMC has six patient advocates and 114 medical center and CBOC staff serving as department-level advocates to address veterans concerns at the point of service. The customer service manager has a lead patient advocate considered a supervisory patient-relations specialist responsible for ensuring that all patient advocates are trained to address the veterans concerns in a timely, professional and satisfactory manner. The medical center is committed to providing its staff patient-satisfaction training annually, as well as during its new employee orientation.

The challenges for the overall customer service program are to raise the veteran’s satisfactory scores for timely and effective phone responses, telephone access for making appointments, and health-care providers not involving veterans in the decision-making process in regards to their own medication management.

Patient Aligned Care Team Coordinator
The PACT is organized through the coordination of the interim chief of staff, acting chief of staff of Primary Care and administrative officer of Primary Care. The duties and responsibilities consist of: the direction and facilitation of the monthly PACT meetings; coordinates the facility data for input to the national reports; and provides feedback to the local PACT teams on measures of success.

The PACT also has within its department a Health Promotion and Diseases Prevention program manager; Health Behavior coordinator; and a psychologist who all function as PACT leads. The Salisbury VAMC has implemented a PACT workgroup consisting of 40 members who participate in PACT programs and conference calls to assist with the overall implementation and improvement of all the PACT practices across the continuum.

The Salisbury VAMC recently received a grant for the Transformation Initiative Learning Center (TILC) Center of Excellence to provide education on PACT programs and initiatives for VISNs 5, 6, 7, 8 and 9. The TILC faculty meets regularly to review the training process and plan for upcoming events.

The PACT and its interdisciplinary workgroup members implemented a veteran council on which veterans sit to discuss quality-of-care and patient-satisfaction issues and concerns that effect delivery of health care to veterans. The challenges for the PACT coordinators are the ability to have all of their PACT members functioning at an optimal level of care, and recruiting quality staff and providers.

Veteran Town Hall
A veteran town hall meeting was conducted at American Legion Post 342 in Salisbury, N.C., on April 25. There were 14 veterans in attendance to discuss issues and concerns with the health care they receive at the Salisbury VAMC. Some of the issues and concerns that came out of the meeting were the high turnover rate in primary care physicians, the communication system in regards to scheduling (return automated phone calls is a problem), not enough waiting areas fin the patient advocate and pharmacy areas, a lack of signage causing confusion with access to their areas of care, and communication gaps between emergency room physicians and primary care physicians in regards to the continuity of care.

Recommendations
• Need to monitor more closely the physician turnover rate in primary care;
• Need to increase waiting area space for pharmacy and patient advocate
• Need to increase directional signage during construction in order to communicate to veterans where new areas, offices, clinic and services have moved
• Need better communication between primary care providers and ER) providers for continuity of services in order to better meet the veterans’ health-care needs
• Need to hire a permanent director in order to provide leadership continuity to the staff and the veterans who use the medical center and its affiliated CBOCs.
• The SHEP scores data needs to be sent to VA medical facilities in a timely manner, rather than a three- to six-month wait, in order to evaluate real-time quality of care and patient satisfaction
Background

The Ralph H. Johnson VAMC serves more than 53,000 veterans. Its staffing methodology is Nursing Hours per Patient Day (NHPPD), as opposed to staffing ratios. The turnover rate is primarily in nursing, but it is a low 4.2 percent and 18 percent for LPNs. The overall budget for FY 2011 and 2012 is $286 million and $303 million, respectively.

Quality of Care

The facility defines quality of care simply by “delivering the right care to the right patient at the right time.” Quality is measured and managed as an organizational collaboration involving all services and disciplines. The functional framework for performance improvement of these key functions involves a center-wide committee and service level performance-improvement activities. Accountability is demonstrated through performance scorecards, outcomes of team initiatives, actions taken as a result of quality-management processes, committee reports, and meeting minutes.

Each new employee attends orientation for three days and then enters service-level orientation, which varies according to the service needs. There are numerous annual training requirements for all staff (infection control, safety, etc) and specific needs, depending on position. The VACO and the VISN provides national databases and resource websites to help the facility improve quality-of-care programs and initiatives. As demands increase, staffing is needed to accommodate patient needs and VHA requirements. The VACO or VISN should support the facility in meeting these requirements.

OIG conducted an inspection at the end of 2009 in response to allegations the medical center provided poor care to a veteran, contributing to his untimely death. OIG did not substantiate that staff intentionally disregarded the veteran’s medical power of attorney and end of life wishes, kept him overmedicated and causing a small bowel obstruction, or cared for this terminally ill veteran in unsanitary room conditions. They also did not substantiate other issues pertaining to nursing care or that the medical record contained discrepancies and lacked documentation of the patient at end of life. There were no recommendations.

Quality Manager

The QM is responsible for the management, coordination, integration, technical support and daily oversight of the facility’s Quality Management Program. The QM serves as the quality consultant to the facility leadership, performance-improvement teams and employees. These responsibilities also include internal and external review requirements and findings, monitoring of adherence to established policies and procedures, staff assistance and education on performance-improvement activities, risk management, patient safety, utilization review and performance measurement. The QM or designee is a member of the medical center committees. The QM has unrestricted access to data and information relevant to quality-improvement, performance measurement and all other topics associated with key quality-management components, which are collected, consolidated or analyzed at the facility level.

Quality-of-care indicators and measurements are tracked and managed through a formalized committee structures, service chief accountability and leadership oversight. The SEC is a standing leadership committee identified to review quality data and ensuring information and key quality components are discussed and data reviewed. This council evaluates their effectiveness through the assessment of goal achievement, outcome measures of specific performance measures, and the level of implementation of strategic planning initiatives. The VACO, VISN and VAMC facilities demonstrate and maintain accountability for quality of care through the VHA performance-measure system, external reviews and accreditation.

With the amount of initiatives and quality-performance measurements the VAMC is required to track, it can be challenging to manage and prioritize. Many of these initiatives and performance measurements are directed from VACO and/or the VISN. However, the medical center may have different priorities that are more quality-driven. VACO and/or the VISN need to adhere to the regulations and directives, which are important, but need to ensure increasing the amount of quality performance.

Patient Safety Manager

The PSM is responsible for implementing a coordinated patient-safety improvement program that is based on guidance and tools from the NCPS, and that also meets the needs and priorities identified by facility leadership, such as addressing important standards, requirements, and recommendations promulgated by The Joint Commission and other organizations working to improve patient safety. The PSM reports to the facility director. The facility has one dedicated PSM and a part-time program assistant.
The patient-safety programs and initiatives work with risk management to minimize the occurrences of adverse events. Proactive risk assessments and root cause analyses are tools used for this purpose. The facility has an anonymous reporting system to facilitate the reporting of safety issues or adverse events. Patient safety also is involved in environment of care, construction areas and monitoring compliance to the Joint Commission patient-safety goals. When a patient-safety hazard occurs, the National Center for Patient Safety is the central office contact. The VISN employs a patient safety officer who reviews facility efforts. The patient safety officer responds when a safety hazard occurs, and coordinates responses and actions with appropriate facility staff.

RCAs are the primary tool used when an adverse event occurs. The event undergoes an analysis to determine severity; if criteria are met, a RCA team is chartered by the director. RCAs can be requested by any member of leadership. The team is facilitated by the PSM. Results are presented to the Pentad. RCAs are confidential and protected documents that are not shared with other facilities. Lessons learned, however, are shared amongst facilities if appropriate.

**Utilization Management**

The UM nurses conduct facility-wide utilization=management activities, including the collecting, analyzing, and reporting of data on admission and continued hospital stays. They effectively analyze the clinical contents of medical records and associated documents in terms of quality and appropriateness of care issues. The Utilization Review and Management Program reviews activities associated with cost-effective utilization of resources while maintaining quality patient care within the medical center.

Training is provided through an online course and Internet conferencing. UM nurses are required to undergo inter-rater reliability training on an annual basis.

Measurement tools are used as a mechanism to collate and analyze data in all forums in which quality data is collected. It is the analysis of data by leadership and staff that ultimately improve the quality of care and patient satisfaction.

Improvements have been made with risk management and with quality of care and patient satisfaction overall. The program is fully functional and integrated into the medical center; however, patient satisfaction is not under the umbrella of risk management.

**System Redesign Manager**

The system redesign manager implements and facilitates the system redesign methodology that serves as a primary strategy to analyze and improve systems that affect performance and efficiency of specific processes within the medical center. These processes may be interdisciplinary, or specific to a service or program area. Training involves attending trainings relating to System Redesign since July 2011, including VERA Green Belt and VERC Yellow Belt.

The measurement tools are tracked daily, weekly, monthly and quarterly. They are reported to all employees, clinic management and/or leadership electronically and/or face-to-face, depending upon the nature of the information. These tools also are used in systems redesign teams in order to determine if a project or a change in a process was successful, and to ensure sustainment.

The medical center is always looking for ways to improve its processes and procedures in order to provide the highest quality of care and patient satisfaction obtainable. Once a process or procedure has been changed, the challenge is communicating the changes to the entire medical center and ensuring consistency. Improvements and change starts and ends with each employee.

**Chief Health Medical Information Officer/ Clinical Lead for Informatics**

The CHMIO ensures all requirements of external accreditation and VA requirements are being met. The quality-of-care and patient-satisfaction indicators and measurements are tracked and managed only by using SHEP.

**PATIENT SATISFACTION**

Patient Satisfaction is measured and managed by utilizing SHEP scores, IRIS Internet inquiries, patient-feedback cards from both the inpatients and outpatients, and from discussing the results monthly in the Customer Service Committee. The group brainstorms ideas to enhance the veteran and family experience. The types of measurement tools utilized for tracking patient satis-
fa... faction are SHEP, IRIS, feedback cards, live interactive feedback during rounding and the Patient Advocate Tracking System.

These reports are broken down by questions, focus on the low-lying scores and develop actions plans to enhance the scores. There also are three veterans who sit on this committee structure and are asked for direct feedback on how to improve.

Improvements have been made by implementing Bedside Change of Shift Report, hourly rounding by nursing, tent card from EMS regarding room cleanliness and contact if there is an issue, multidisciplinary rounding by a team for inpatients, birthday cards signed by the director and presented with a cupcake, USA Today newspapers for inpatients, patient- and family centered care training directed at each specific discipline, a patient and family lounge with coffee service, ice machine, Dell Touch screen technology with fax, copy and printing capabilities, child play area, and a music therapy and aromatherapy pilot currently being assessed for effectiveness.

The VACO, VISN and medical center demonstrate and maintain accountability for patient satisfaction through monthly discussion regarding SHEP data and ideas to improve services through the Office of Patient and Family Centered Care, as well as the VISN 7 office conference calls where information is shared on what to do in each medical center.

Resources from the VISN or VACO are provided to assist the facility through conferences for staff training, using demonstrations, information, and idea-sharing, helping build relationships with other VA and non-VA medical center staff on what is effective. Other assistance comes in the form of financial support through grants, and research projects when breakthrough treatments are identified that improve veterans' outcomes and health status.

**Director of Patient Care Service/Patient Advocate**

The DPCS/PA, functions as a member of the organization's senior leadership. They collaborate with senior executive management in making decisions about health-care services, settings and organizational priorities. The DPCS/PA works with senior executive management to ensure that policies and practices promote optimum patient-care outcomes. The DPCS/PA provides leadership in the promotion of quality and effectiveness by supporting VHA clinical indicators, performance measures, T21 and various other outcome measures. This also includes the quality and effectiveness of nursing programs throughout the organization. The DPCS/PA provides leadership in the professional community and governmental bodies that shape health-care policy, thereby contributing to the development of the health-care delivery system and better health care for society. In addition, as a critical member of the executive leadership team, the DPCS/PA provides input regarding administrative and clinical policy, strategic planning and decision making that impacts the organization and VISN 21 through participation on VISN and VACO national conference calls, tasks forces, committees and other national forums.

The DPCS/PA provides guidance and oversight for all nursing procedures. The scope of the DPCS/PA role extends into all major practice areas: clinical, administrative, research and education. The DPCS/PA assures that the nursing strategic plan supports the organization's and VISN's national nursing strategic plans.

The DPCS/PA establishes and promotes nursing standards throughout the organization and through expert consultation, providing direction to all nursing service staff. The DPCS/PA incorporates the principles and practices of a nurse executive within a patient-care line service model for all nurses. The DPCS proactively works with Nursing Labor and Management Relations to promote a positive and safe work environment within the organization.

Patient-satisfaction indicators and measurements are tracked and managed by posting monthly to the national website and are placed in a spread sheet, and shared with staff and the council to address. The DPSC is responsible for all patient-satisfaction measures.

The results of these measurement tools are utilized to institute changes to improve/enhance quality of care and patient satisfaction. Every patient feedback tool and recording system is evaluated to identify gaps, and performance improvement projects are completed with a veteran involved to enhance the quality of care provided to veterans. The SHEP score, IRIS, My HealthyVet enquiries to the patient advocate office, feedback cards, focus groups and face-to-face visits are used to improve quality of care and patient satisfaction. A veteran's recourse for filed complaints and disagreements is the right to appeal that decision. That information is shared with them at the time the information and follow-up is made.

Overall, the patient satisfaction continues to increase over the last year, but parking has been a problem for several years and a parking deck is awaiting approval from Central Office. Additional funding for physicians providing specialty care has been requested, as it is very difficult to attract physicians with the salaries that VA can offer them.

**Patient Aligned Care Team Coordinator**

The PACT coordinator duties and responsibilities consist of:

- Oversight of the specific goals of PACT to optimize access, including alternatives to face-to-face care, to meet veteran needs and expectations;
- Redesigning primary-care practices to become patient-cen-
tric and participatory;

- Improving care management and coordination of care;
- Facilitating integration of mental health and specialty care services within primary care;
- Facilitating the development of measurement and evaluation tools pertinent to the PACT;
- Assisting with communication among services and between services and patients to better address patient needs; and
- Supporting education for health promotion and maintenance to involve the active participation of veterans and families with multiple approaches.

PACT progress is discussed during weekly primary care internal operation meetings, monthly primary care provider meetings, weekly nurse-manager meetings and site-team meetings. Successful PACT practices are shared during weekly morning report with the director’s staff. The PACT Steering Committee conducts quarterly town hall meetings for all staff to attend for updates and training on PACT initiatives.

Although the PACT model has evolved greatly, there still remain concerns of overbooking of clinic appointments and staff shortages, resulting in delayed delivery of care and impacting patient satisfaction.
Background

The Tennessee Valley Healthcare System (TVHS) is comprised of two campuses: Nashville and Murfreesboro. This system is the sixth-largest in the nation, with 11 CBOCs. The Nashville VAMC specializes in acute care and has several affiliates, including Vanderbilt University. The veteran population is between 350,000 and 400,000, with 804,000 visitations. The TVHS is one of six GRECC (Geriatric Research Education and Clinical Centers) sites for mental health, which encompasses 76 beds. The TVHS had an approximate budget of $550 million for both 2011 and 2012. Quality Management had an approximate budget of $1.5 million, which constitutes about 0.3 percent of the total health system budget. The Nashville VAMC conducts regular staff town hall meetings involving the academic council, dean and other community leaders. The town hall meetings are conducted to help resolve situations involving veterans and their care. In June of 2012, the TVHS will train select staff of all levels on customer service and patient satisfaction. Once trained, the staff will provide the training to the remainder of their staff.

Quality of Care

TVHS defines health care as safe, effective, patient-centered, timely, efficient and equitable, and to have a work philosophy that encourages every employee to find new and better ways of doing things. TVHS maintains accountability for quality of care through national accreditation, certifications, licensures and VHA. Oversight for quality of care is provided by the chief of staff, head nurse, quality manager, patient safety manager, utilization management, risk manager, systems redesign manager and chief health medical information officer/clinical.

New employees receive orientation under the Quality Manager Program. Employees can take classes in performance improvement; however, each department provides quality-of-care training throughout the year. OIG found three issues in the last year: general and limited management oversight, lack of a clinical lab finding follow-up notification system, and lacking performance in some annual training requirements.

Quality Manager

The quality manager provides oversight and direction for the health systems quality-management system to include aspects of safety, efficiency, effectiveness, timeliness of care and equality of care, and that all aspects are patient-centered. The quality manager measures and manages quality by comparing the Nashville VAMC with local hospitals and other institutions. Quality is also managed through a quality-management system that optimizes health-care processes and outcomes, and fosters explicit lines of communication among members responsible for and involved in quality management. A challenge for the
quality manager is the communication barrier between departments. The VA healthcare system is similar to a silo—no one communicates effectively.

**Patient Safety Officer**

The patient safety officer conducts database analysis, and system improvements, and alerts and advises on patient-safety issues. This individual conducts investigations within the VAMC to prevent and control a problem. If an issue arises, the patient safety manager has access to a nationwide RCA database and a best practices listing that is shared throughout the VISN. High-risk patient-safety issues are reported to leadership by written report, verbally, in person and anonymously. There is a 45-day time limit for solving a patient issue mandated by VHA.

An example of a patient investigation involved a technician who took a tumor sample from a patient after previously taking a sample from a different patient. The second patient sample showed cancer cells, but the first patient was told that he or she had cancer. To limit this mistake in the future, the Nashville VAMC bought a machine that labels the specimen, rather than labeling the specimens manually.

**Utilization Manager**

The utilization manager’s main responsibility is to ensure the veteran has the correct level of care, time of stay and reason for stay. This individual supervises the utilization specialists to identify system-wide problems. In addition, the utilization manager identifies when a patient needs to go home prior to the actual day of discharge. The utilization manager also identifies if a patient needs support prior to exit and notifies proper staff. The utilization manager is responsible for reporting information to the director and the VISN leadership regarding the utilization program. During the meeting between the director and VISN leadership, reviews are conducted to identify systematic problems. The utilization manager works with the system redesign manager to make appropriate changes and monitor the actions put in place. A challenge the utilization manager deals with is the lack of staff. The lack of staff has hindered the action of reviewing 100 percent of the information quality charts.

**Risk Manager**

The risk manager is responsible for coordinating the Peer Review Committee, which is responsible for improving patient outcomes by improving individual provider performance. The committee requires active participation from nurses, physicians and other health-care professionals. The risk manager provides guidance to the medical center staff regarding disclosure of adverse patient outcomes. This individual is also responsible for overall guidance with tort claims process. In addition to tort claims, the risk manager is responsible for pre- and post-payment of tort claim notifications. The risk manager receives training from VA NCPS on RCAs and other health-care training. To ensure quality of care, the risk manager utilizes an automated screening program that reviews all admissions and discharges for readmissions within the past 10 days. The system also screens for deaths within the last 30 days and admissions within three days for ambulatory care.

**System Redesign Manager**

The system redesign manager ensures patient safety and satisfaction are not sacrificed by improving processes. In addition, he or she is responsible for facilitating training and education. The training consists of process-improvement principles and tools. An example project is making patient discharge flow easier. The project outcome would ensure patients get their treatment and leave the hospital in a timely manner, which will ultimately free up bed space. The system redesign manager has improvement teams that work to decrease cost, maximize resources and increase efficiencies. Despite the improvements, it is up to the improvement teams to maintain patient safety and satisfaction. A challenge for the system redesign manager is the ability to reconstruct the system redesign team. In addition, the VISN does not distribute best practices across the region, and staff is not given additional training.

**Chief Medical Officer**

The chief medical officer provides improvements in access to patients through building a telehealth program that allows patients to receive medical care and education near their home. The telehealth program is done through remote audio and visual technology. Additional responsibilities include maintaining and improving the CPRS, clinical reminders, order sets and documentation templates. The chief medical officer receives more than 84 clinical metrics, and 90 outpatient and 90 inpatient metrics. Tracking of quality performance is used to improve quality and patient satisfaction.

A challenge for the chief medical officer includes a staff shortage with clinical application coordinators. The manager would also like an updated version of the CPRS; the newer systems are more user-friendly. This individual believes telehealth is not a top priority for VACO and would like to see an expansion of telehealth throughout the VISN.

**Women Veteran Program Manager**

The women health clinic provides comprehensive primary care. The clinic is located 1.5 miles from the Nashville campus. The clinic...
ic has two providers and will soon have two GYN. To receive medication the veterans must visit the pharmacy at the main campus.

Currently the clinic has 8,000 women veterans and growth rate of 2 percent every month. The women coordinator created a WVHC that includes the director, consumers and personnel from all hospital departments.

The women coordinator has several challenges, such as not having an overall program budget. The coordinator does not have a separate budget for the women veterans program; the director delegates funding to the program. The funding is acquired if the hospital has leftover funding from its budget.

In addition, the women coordinator does not have a clear chain of command. The coordinator does not have direct communication with the director. Furthermore, the coordinator is half-time at the clinic and at the VISN level, which puts additional stress on the coordinator. When the women coordinator meets with other coordinators, most mention that their directors do not acknowledge that the position exists.

**Patient Satisfaction**

The Nashville VAMC measures and manages patient satisfaction via SHEP scores and the PATS. To ensure patient satisfaction, hourly rounds are conducted in the inpatient units. In addition, the facility ensures patient satisfaction by using PACT, Myhealthy Vet and secure messaging. The customer service manager, executive leadership, managers and supervisors are responsible for patient satisfaction.

**Director of Patient Care Services**

The director of Patient Care Services provides oversight and direction to ensure that veteran needs are met on their expectations and in a timely manner. This individual also is responsible for nursing staff indicators such as courtesy, respect, noise level, privacy, responsiveness and medication.

**Patient Advocate**

The purpose of the patient advocate is to serve as a liaison for veterans and families that have information needs, concerns or complaints. The patient advocate receives training in customer service, service recovery and national patient advocate program. When a patient advocate receives a complaint, the concern is entered into the PATS. After the complaint is in the system, it is categorized by type of issue or information request.

**Patient Aligned Care Team Coordinator**

The PACT coordinator has more than 50 teams in Tennessee, with 1,200 patients per team. In reference to specialty care, primary care has a formal service agreement with specialty services. The facility has made improvements on the primary care to specialty care transition by ensuring pre-screenings are completed prior to a specialty care visit. A challenge the PACT coordinator has is space and how it constricts PACT by limiting staffing space.

**Town Hall Meeting**

The town hall meeting was conducted at Post 88 in Nashville on May 13. Veterans in attendance brought no issues or concerns regarding the Nashville VAMC.

**Recommendations**

- There needs to be a proactive effort in completing the Chattanooga CBOC. Since the initial construction date of 2010, there have been several political complications hindering their original completion date of 2013.
- To receive SHEP scores in a timely manner, a more efficient system should be used.
- Currently, there are two patients per inpatient room; there should be a proactive effort to change room occupancy to one patient per room.
- Nashville VAMC needs assistance in filling staffing shortages in PACT, such as critical care, mental health and nursing.
- If a new facility or department is being built, VACO needs to ensure not only that the facility receive enough funding for the structure, but for staffing and furnishing.
- A common problem within the Nashville VAMC was departments are working in silos. There needs to be better communication between departments and programs.
- Frontline staff needs to be afforded the proper space to ensure quality care for patients.
- The Nashville VAMC should consider adding additional PACT teams for the increasing number of veterans. The current PACT teams are under stress with their current panel size.
- The Clarksville CBOC should have handicap-accessible doors and ramps, and improve its security.
- The women program manager is half-time at the Nashville VAMC and at the VISN level. This puts added stress on this individual. Perhaps the VISN and the VAMC needs to acquire a full-time program manager.
- The women’s program manager should have a separate budget. Currently, the program manager is unaware of the program’s budget, limiting the program outreach capabilities.
Background
The Baltimore VAMC serves more than 51,229 veteran patients. Its staffing methodology is NHPPD, as opposed to staffing ratios, and its turnover rate is due to retirements, resignations, transfers, career advancements and terminations. The overall budget for FY 2011 and 2012 is $286 million and $303 million, respectively.

Quality of Care
Quality is defined as the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. The PI Program Plan provides the structure and guidance for the design, measurement, assessment and improvement of the medical center’s performance. This is in compliance with the laws, directives, mandates, and regulations of the federal government; VHA, VISN, and organizational strategic goals, objectives and expectations, as well as to external regulatory and accrediting agencies. The PI Plan applies to all disciplines and employees, including contracted staff. It applies to all settings within the full continuum of the VAMC, including all outpatient, inpatient, long-term care, behavioral and home-care settings. Quality also is measured through the results of external reviews, VHA reviews, OIG reviews and ongoing in-house monitoring.

The facility demonstrates and maintains accountability for quality of care by participating in the accreditation processes of external accrediting organizations such as the JC, on CARF, the Association for the AAHRP, CAP, ASHP, ACoS COC and, ACR. Additional non-federal organizations that have conducted reviews include, but are not limited to, Long Term Care Institute, and Mathematica. The VAMC also participates in numerous VHA reviews, as well as other federal reviews.

In 2011, OIG conducted a review to determine the validity of two allegations regarding hospice care at the Baltimore VA Rehabilitation and Extended Care Center, which is part of the VA Maryland Health Care System. OIG substantiated that two patients did not have adequate pain management as defined by Veterans Health Administration policy and hospice industry standards. The review identified five factors that contributed to the pain management deficiencies: (1) facility staff did not develop individualized and comprehensive pain management care plans, (2) patient pain reassessments were not appropriately documented, (3) clinical staff did not have sufficient training on the principles of pain management for hospice patients, (4) hospice interdisciplinary teams were not effectively used, and (5) clinical pharmacists were not actively involved in the pain management process. OIG did not substantiate that the lack of “piped in” oxygen, suction, and air compromised hospice patient safety and comfort. OIG found that the facility provided appropriate oxygen, suction and air. OIG made four recommendations to address the factors that contributed to the pain management deficiencies. Management agreed with the findings and recommendations and provided acceptable improvement plans.

Quality Manager
The QM is responsible for ensuring that a systematic process is in place for monitoring the facility quality data. This individual serves as the performance improvement/quality consultant to the VAMC leadership, PI teams and employees. Additionally, this individual serves on executive committees and workgroups where quality data and information are reviewed, analyzed and acted upon. Also, the QM serves as the primary coordinator for all major facility-wide clinical surveys.

A concern the QM had been that individuals on the quality committee are on a two-year rotating bases. This creates a disruption in processes to craft a new committee every two years. Also, documentation has been an ongoing problem. There is no standardized documentation template, especially from emergency room procedures.

Patient Safety Manager
The PSM is responsible for implementing and coordinating a safety-improvement program based on guidance and tools from the NCPS that meet the needs and priorities identified by the medical center director. The PSM coordinates with the director of Performance Improvement & Accreditation to ensure that components of the Quality Management System and Patient Safety Improvement Program are integrated.

Staffing has been a concern; due to this, the VAMC is unable to track all patient-safety needs. There are only four primary areas of tracking patient safety: falls, suicides, prescriptions and missing patients. There are many other areas the PSM and team should be tracking but are unable to due to lack of staffing.

Utilization Management
The UM is responsible for implementing and maintaining the process, and valuating and determining the coverage and the appropriateness of medical care services across the patient
health-care continuum to ensuring the proper use of resources. This position evaluates the flow of inpatients and outpatients. The primary challenge is determining when a patient is fit to be discharged. Some homeless veterans use the VA health-care system for food, shelter and a veteran-friendly environment although inpatient care is not needed.

**Risk Manager**

The RM is responsible for implementing a comprehensive risk-management program that includes incident reporting, sentinel event reporting and peer review. This review process is to identify, evaluate, reduce, and/or eliminate and monitor the occurrence of adverse events.

**System Redesign Manager**

The system redesign program is intended to embody the capacity for an organization to improve and strategically redesign the system. It is the combination of enlightened leadership strategically driving change. The system redesign manager’s role is critical to ensuring quality of care throughout the facility. This includes serving as a facilitator, teaching, leading, promoting, organizing, arranging, prodding, measuring and doing what’s needed to engage the front line staff in productive, meaningful improvement of systems to improve quality of care to veterans.

**Chief Health Medical Information Officer/ Clinical Lead for Informatics**

This individual is responsible for: managing the process of clinical data, information and knowledge; facilitating storage and retrieval of patient care information; assisting clinicians and administrators in keeping current with new medical technologies; ensuring quality patient care by providing tools for data management; and maintaining the integrity of computerized data (security issues, contingency plans and menu management).

The primary concern is that the current informatics architecture is designed for the user and works well for the veterans, but not for the doctors. It can be extremely time consuming to input data and difficult to navigate.

**Women Veterans Program Manager**

The Women Veterans Program Manager is responsible for coordinating and facilitating all women veteran programs. These programs are dictated by a national directive and implemented under the PACT teams. Some concerns the medical center have are the location of the women’s clinic and sufficient specialty care. The primary challenge is integrating the women’s veterans’ clinic with the PACTs, particularly the specialty providers. Additionally, outreach has been difficult, and hosting the right event and producing the right material to advertise has not been clear.

**Patient Satisfaction**

Patient satisfaction as a health-care facility is the perception of having the patients’ health-care needs met. Patients should have a positive customer service experience in all aspects of their health care. Patient satisfaction is measured and managed as a health-care facility by surveys and assessments evaluating the quality of care as seen from the eyes of the patient and family. Data is analyzed and distributed on a daily, monthly, quarterly, and annual basis to all clinical centers and services to use to assess and develop strategies to meet patients’ needs and concerns. The VAMHCS VVSC is an interdisciplinary committee that oversees efforts to improve patient satisfaction and customer service.

The SHEP Survey and TruthPoint Assessment are the primary measurement tools for accessing patient satisfaction. These measurement tools are designed to promote health-care quality assessment to use for improvement initiatives. Data is analyzed to identify areas for improvement. For example, the inpatient satisfaction performance measure “Discharge Information” was identified as an area for improvement. An action plan was prepared to improve the SHEP patient satisfaction score for this performance measure. From November 2011 to December 2011, the score improved four points.

The areas of the most recent SHEP survey that showed improvement and decline, compared to the last SHEP survey are discharge Information and Shared Decision Making, improved; communication with Doctors and Responsiveness of Hospital Staff, remained the same; and cleanliness of Hospital Environment, Communication with Nurses, Pain Management and Quietness of the Hospital Environment, declined.

Measures taken for improvement included the two performance measures identified by VISN 5 for improvement in FY12 (Discharge Information and Responsiveness of Hospital Staff). Nursing took the lead to prepare action plans to improve patient satisfaction. Individual clinical centers and services, such as medicine and pharmacy, have developed their own action plans to improve patient satisfaction. In addition, a collaborative action team was formed to specifically address inpatient satisfaction in medicine inpatient units.
**Patient Advocate**

The patient advocate defines patient satisfaction as the patients’ perception of having their health-care needs met. Patients should have a positive customer service experience in all aspects of their health care. The duties and responsibilities are to resolve the issues and concerns of veterans in navigating the health-care system. Also, veteran complaints and compliments are tracked by month and by service/clinical center.

The patient-satisfaction indicators and measurements are tracked and managed by surveys/assessments are used to assess the quality of care as seen from the eyes of the patient and family. Data is analyzed and distributed on a daily, monthly, quarterly, and annual basis to all clinical centers and services to assess and develop strategies to meet patients’ needs and concerns. The Consumer Relations Service business manager manages, analyzes and distributes the SHEP patient-satisfaction data. A patient advocate manages, analyzes and distributes the PATS complaint/compliment data. The VAMC VVSC is an interdisciplinary committee that oversees efforts to improve patient satisfaction and customer service. The patient advocate is directly responsible for collaborating with the services and clinical care centers to take action to improve all of the patient-satisfaction performance measures.

Training comes from the national patient advocate conference calls (monthly/two hrs), regional patient advocate training (one day); Society for Healthcare Consumer Advocacy (three days for one patient advocate per year); and VA Training Management System instruction.

Patient advocacy is overseen by conducting interviews (in person or by phone) with veteran/family, followed by immediate contact made with service/clinical center to resolve concern and immediate feedback given to veteran/family, VACO Veteran Experience Program, VISN 5 systems redesign/patient advocate coordinator and VAMHCS Consumer Relations Service oversee the Patient Advocate Program. The PATS is used to monitor compliance with standards. VISN 5 surveyors review the VAMHCS Patient Advocate Program.

The VHA directive that stipulates that a facility patient advocate has seven days to follow up on a complaint or concern filed by a veteran; the VHA national average is 3.3 days, while the VISN 5 average is 1.5 days and VAMHCS’s average is 1.3 days. In general, patient advocates attempt to resolve complaints immediately, but no later than the next business day. Complex cases can require more than one day to resolve.

The chief of Consumer Relations Service, with the assistance of the patient advocates, ensures standards are maintained. Reports are provided to the ECAS and the VAMHCS VVSC.

The principle challenge is taking a different approach to the surveys conducted. The questions asked on any survey require approval from the OMB. The questions that are approved in some cases are not targeted to the local medical center but related more to the perspective of OMB.

**Director of Patient Care Service**

These individuals have administrative responsibility for assuring that the services, functions, and committees under their direct supervision participate fully in the PI program and its identified activities.

**Patient Aligned Care Team Coordinator**

The PACT director, in coordination with primary care, oversees the implementation of PACT in the primary care area. The PACT director also is responsible for development and implementation of a quality program by redesigning clinics and clinic practices to become veteran-centric. A systematic and analytic approach is used in order to improve care and efficiency, to identify constraints and quality issues, and determine needed services in all facilities throughout the VAMHCS.

A challenge the facility faces is to continue to improve care management and coordination of care, including integration of preventative services and transitions between the inpatient and outpatient setting. Another is facilitating coordination between and integration of behavioral health, pharmacy, nutrition, social work and specialty care services with primary care. Lastly, utilizing measurement and evaluation tools pertinent to the PACT to support the VISN 5 mission to honor America’s veterans as heroes by providing the highest quality health care remains a challenge.

**Recommendations**

- Extend the length of time members remain on the quality-of-care committee. There should be more time for each member to understand the current issues and how to solve them.
- There should be a standardized documentation template, especially from emergency room procedures.
- There are only four primary areas of tracking patient safety: falls, suicides, prescriptions and missing patients. There are many other areas the PSM and team should be tracking, but are unable, due to lack of staffing, VA should increase the level of staffing to track other patient-safety concerns.
- Enhance the homeless program to alleviate the number of veterans staying in the hospital without real health-care issues.
Background
The Clement J. Zablocki VA Medical Center is located on 125 acres on the western edge of Milwaukee and is part of VISN 12. The medical center delivers primary, secondary and tertiary medical care in 168 care acute operating beds and exceeds 500,000 visits annually through an extensive outpatient program. Milwaukee employs 589 full-time RNs and 133 LPNs; however, recruitment for open positions is ongoing because of turnover. Milwaukee’s total budget for FY 11 was $500 million and $505 million in FY 12.

Quality of Care
Quality is defined at the Milwaukee VAMC by the veteran through the veteran’s eyes. Key components are quality assurance, performance improvement – including performance measurement – patient-safety improvement, internal and external reviews, internal and external customer satisfaction, utilization management, risk management and system redesign. The quality management functions are an organized and systematic approach to planning, delivering, measuring and improving health care in the medical center’s daily operations so that it can fulfill its mission, visions and values.

Too many performance measures that are not evidence-based are being implemented at the facility level.

Quality Manager
The quality manager collaborates with the medical center director, the top management team, the division/program managers, the patient safety managers and all employees to ensure that the quality management and patient safety programs are in place and monitored.

The quality manager oversees various performance-improvement initiatives, quality-management activities and reviews, analyzes and acts upon quality data and information. The quality manager is supervisor to the PI coordinators, the infection control practitioners, the patient advocates, the risk manager and several support staff. The quality manager is an active mem-
ber of the Improvement and Information Committee, the Quality Management Oversight Committee, the Medical Executive Committee, the Operations Council, and other committees and councils where expertise in quality management, accreditation and regulatory standards is needed.

Unfortunately with the aging facilities that are not aesthetically pleasing, many veterans will relate this to the quality they are receiving. Many VA hospitals are not as “pretty” as private hospitals. VA has always been very transparent with its data; veterans are able to compare the care they receive at the VA to the private sector. Outcomes are what measure the quality of care.

**Patient Safety Manager**

Conducting an RCA is a critical aspect in the process of improving patient safety. The standard to complete an RCA is 45 days or less through VA. The goal of the RCA process is to find out what happened, why it happened and to determine what can be done to prevent it from happening again. Multidisciplinary teams are formed to investigate adverse events and close calls. Close calls are events that could have resulted in a patient’s accident or injury, but didn’t – either by chance or timely intervention. RCAs are used to focus on improving and redesigning systems and processes, rather than focus on individual performance, which is seldom the sole reason for an adverse event or close call. With a non-punitive, no-blame culture, the Milwaukee VAMC ensures that providers report any close calls or events. There is an anonymous phone line where providers can report near misses and events without having to give their names.

Training is held on a regular basis and stresses the importance of reporting near misses and events. The patient safety staff makes themselves visible by conducting daily rounds with executive staff, visiting all the floors, departments and even CBOCs.

**Utilization Manager**

UM nurses review 100 percent of all acute care admissions and continued-stay days for appropriate assignment of level of care. When the assigned level of care deviates from the recommended level of care, the case is referred to a PUMA. Additionally, quality-of-care issues identified in the review process are referred for further review/action. Referrals can be made to quality management or the PUMA. Although UM does not assess the patients’ level of satisfaction, UM actions are focused on assuring that the clinical needs of the patient are being met.

The current reporting system for events is outdated and prevents employees from actually reporting a near miss or event. Employees are able to compare the care they receive at the VA to the private sector. Outcomes are what measure the quality of care.

**System Redesign**

The medical center system redesign coordinator provides consultation, coaching, facilitation and education to facility leadership, providers, and staff and improvement teams, facilitates leadership in determining improvement priorities, makes recommendations for improvement action to be taken at the facility and service levels, and coordinates facility level collaborative and improvement efforts. The system redesign coordinator provides direct support for communicating systems-improvement activities across committee and service lines, and is the facility point of contact with the VISN Office of System Redesign.

**Risk Manager**

The risk manager coordinates the medical center’s peer-review program, mortality reviews and institutional disclosures, in close collaboration with the chief of staff. The risk manager also facilitates peer-review training. Additional responsibilities include assistance with accreditation activities, frequent collaboration with patient-safety managers and others, and analysis of adverse events/prevention planning.

Any close call that is considered to be a process issue is recommended to be reviewed by completing an RCA; a provider issue is reviewed by the peer-review program. It was noted that the incident reporting system is not user-friendly and actually inhibits employees from entering incidents into the system.

**Information Officer**

The information officer serves as a liaison to veterans’ organizations, VSOs, county service officers and other veteran representatives on VA health-care eligibility, enrollment and intake. The medical center has partnered with these groups to assure veterans are aware of their VA health-care benefits. Medical Information Systems Division also serves as the facility point of contact for CHAMPVA, TRICARE and military treatment facility transfers, helping to coordinate benefits and care with these other national programs.

**Chief Medical Officer**

The lead informatics role is played by the manager of CLIMET. This person participates in a wide variety of medical center groups and works closely with medical center leadership to coordinate and prioritize informatics goals and projects.

**Patient Satisfaction**

Patient satisfaction is defined by the patients and measured through a patient-satisfaction survey that equates to the private sector satisfaction survey HCAPS. Patient satisfaction also is re-
flected through the interactions with the facility’s patient advocates. Data from the Patient Advocate Tracking System, PATS, is reviewed for closure of individual issues and trends.

The Customer Service Council reviews the data/results from both the inpatient and outpatient populations on a quarterly basis. Attempts are made to trend those results against what the patient advocates illustrate with their reports. Customer service postcards also are available in many clinics; veterans provide feedback on the cards, which are mailed directly to the medical center director then sent to QM&S for trending.

**Director of Patient Care Services**

The director of Patient Care Services is responsible for understanding and addressing issues related to patient satisfaction. Processes are in place to ensure proper communication of patient-satisfaction data through appropriate hospital committees that perform the functions of monitoring, evaluating and addressing patient-satisfaction indicators, as well as individual patient concerns complaints.

Focus groups are conducted with veterans to receive feedback on existing programs and any concerns and issues.

**Patient Aligned Care Team Coordinator**

Since PACT currently is implemented into primary care, the main responsibility of the PACT coordinator is to implement PACT into specialty care, spinal cord care and mental health. Post-discharge calls are made to veterans to survey them in regards to care received at the VAMC; veterans are asked if they were provided adequate discharge and medication instructions.

There is a lack of space that limits the ability to expand and fully implement the PACT program. After the scandal with the GSA, too many limitations were placed on training. Only 29 employees are able to be sent for training at a time.

**Patient Advocate**

The Patient Advocacy Program was established to ensure that all veterans and their families, served in VHA facilities and clinics have their complaints addressed in a convenient and timely manner. The program operates under the broader philosophy of service recovery, whereby patient complaints are identified, resolved, classified, and utilized to improve overall service to veterans, and serve as an important aspect of patient satisfaction. The patient advocates interact with veterans and their families by providing active listening and assistance by gathering information, and navigating the medical center’s systems and processes to resolve any concerns or issues. After being contacted by a patient with a concern, the patient advocate enters the data into the Patient Advocate Tracking System and refers any serious matters to the appropriate medical center resources.

**Town Hall Meeting**

A town hall meeting was conducted on May 14 at a local American Legion post in Milwaukee to gain the veterans’ perspective on care received at the Zablocki VAMC. Five veterans in attendance spoke highly of the medical center, though few expressed concerns regarding wait times in the emergency department. All concerns were brought to the attention of the executive staff during the site visit.

**Recommendations**

- Increase provider and staff communication. Many times veterans must call the medical center to receive results, and women veterans complained of limited clinic hours. The executive staff refuted these claims during the entrance brief. In both instances, it seems if more communication was provided, these concerns would have been avoided.
Background
The Memphis VAMC has been serving veteran since 1922. It serves 53 counties in western Tennessee, northern Mississippi and northeast Arkansas. The VAMC has the capability to serve its 196,000 veterans. In addition to the medical center, there are 10 CBOCs. The facility’s overall budget in 2012 was $340 million.

Quality of Care
The Memphis VAMC defines quality as providing the best care available, at the right time, by caring, providing exceptional employees and exceeding the veterans’ expectations. The facility measures quality by using performance measures and JC measures. The staffs responsible for quality of care are performance measure champions, quality manager and patient-safety manager. Employees are required to complete annual training to ensure quality standards are met.

Quality Manager
The responsibility of the quality manager is to ensure that the quality-management program is implemented, comprehensive and productive. The quality manager monitors quality in CBOCs by conducting weekly clinical reminder reports, daily morning reports, and monthly and quarterly visits. The quality manager has made improvements in reducing inpatient mortality and morbidity due to hospital-acquired infections.

One challenge the quality manager has involves directives and how they should be made into policies, creating standardization. The policy would ease the initiation of processes at VA facilities.

Patient Safety Officer
The patient-safety officer is responsible for advising the RCA teams, reviewing policies and procedures, reviewing and disseminating patient-safety alerts, educating and reviewing national patient-safety goals, and reinforcing the culture of patient safety throughout the medical center.

The patient-safety manager, patient-safety specialist and program support work specifically on patient-safety issues. The VISN patient-safety manager identifies similar issues and shares best practices throughout the VISN. In addition, The National Center for Patient Safety shares results of RCA actions with the group of patient-safety managers via monthly calls.

Utilization Manager
The utilization manager reviews charts and evaluates patient level of care. The manager must ensure all procedures and treatments have been afforded for each patient. It takes the utilization manager about 15 minutes to review each chart. The reviews are conducted to ensure that the care administered meets the standards. The PUMA board assists in upholding the standard with quality of care. The system redesign manager and utilization manager work together to identify gaps with the health care administered.

Risk Manager
The risk manager provides oversight of the peer review process and tort claim review. This individual looks at all patients, charts, and reason for patients who have been readmitted. If a patient has been determined to be harmed, a review is conducted with staff and leadership. For example, the risk manager would look at all patients who have been readmitted and reviews all the charts. This process involves the system redesign manager, risk manager, and utilization manager. Once all the information is gathered, it is given to leadership and the best course of action is administered.

System Redesign Manager
The system redesign manager provides oversight of system redesign projects and works with improvement teams. The system redesign manager tracks patient flow in each department. When an issue is found, system redesign manager and leadership meet to discuss the details. It is the system redesign manager’s responsibility to find out who was involved and the details of the incident. Every month, system redesign managers throughout the VISN conduct conference calls to communicate best practices. The system redesign manager needs additional staff to help with projects and work load.

Women Veterans Program Manager
The Women Veterans Program Manager has three PACT teams, with 2,800 veterans currently using the clinic. The facility location is a separate location within the Memphis VAMC; a new clinic will be opening on October 1. Currently, the women’s health clinic offers full, comprehensive primary care and a part-time mental health clinician. The Women Veterans Program Manager has a women’s health committee, but committee attendance has declined in the recent years. The women’s health committee includes veterans, Vet Center staff, a mental health nurse, the women’s health director and the associate director.
The Women Veterans Program Manager has a challenge in recruiting veterans and staff to attend the women's health committee. The coordinator would like to have at least one representative from leadership to be more proactive in the committee meetings. The Women Veterans Program Manager is not able to be at all CBOCs and would like to have a women’s health liaison at all CBOCs. Finally, the Women Veterans Program Manager would like to have a full-time GYN and the ability to provide onsite ultrasounds and mammograms; currently both are fee-based.

**Patient Satisfaction**

The Memphis VAMC measures and manages patient satisfaction via SHEP scores and the PATS. To ensure patient satisfaction, hourly rounds are conducted in the inpatient units. In addition, the facility ensures patient satisfaction by using PACT, Myhealthy Vet and secure messaging. The customer service manager, executive leadership, managers and supervisors are responsible for patient satisfaction. The executive leadership reports patient satisfaction data to the VISN level on a monthly basis.

**Director of Patient Care Services**

The VISN leadership assigns performance measures on a yearly basis. The Memphis VAMC reports its scores and action plans on a monthly basis. The director of Patient Care Services works with all staff to develop action plans related to patient satisfaction. In the last SHEP survey, the facility met the patient satisfaction target in 10 out of 13 categories and four out of 10 categories in outpatient.

**Patient Advocate**

The patient advocate is responsible for implementing service-recovery mechanisms in order to assist veterans in resolving their concerns with the Memphis VAMC. Currently, there are three patient advocates. All three document and code patient interactions into the PATS system for the director of patient care services. When a patient advocate receives a complaint, the issue is sent to the director and may be sent to the VISN level if necessary. The complaints are usually solved within 24 hours, 72 at the latest. If a veteran disagrees with the decision, he or she may see the director of Patient Care Services. If he or she is still not satisfied with the decision, a meeting would be scheduled with the director. The patient advocates have a problem with following up with patient complaints. The director only allows the patient advocates two hours to follow up on patient inquiries.

**Patient Aligned Care Team Coordinator**

The Memphis VAMC has 31 care teams, with an average panel size of 1,100 patients. Each appointment block is an average of 30 minutes but may exceed 30 minutes if needed. Once a patient is released, he or she will receive a post-discharge call. The PACT coordinator assists team leaders in each primary care area. The coordinator acts as an interface with the nursing and business office to insure staff are trained. In addition, the coordinator monitors PACT data to formulate action plans for targets not met.

Since the implementation of PACT, the PACT coordinator has experienced a few challenges, such as PACT teams being understaffed. Currently, the PACT coordinator has four teams that are understaffed; one nurse quit due to work load. A second challenge involves Congress and its lack of support for the PACT model. The PACT coordinator would like Congress to be more aware of the PACT model and to administer additional support for the facility.

**Town Hall Meeting**

The town hall meeting took place at Post 27 in Memphis. There were 23 veterans in attendance and all were current or former users of the Memphis VAMC. Veterans stressed that most of their complaints are given to the appropriate staff, but it never reaches the director. To be specific, they said the patient advocate never returns phone calls, nor does the general phone line answer because it seems there is not enough staff. A huge issue veterans stressed was the V AMC call system. Currently, when a patient calls, an automated recording answers and begins with information about the facility’s background. The background summary should be at the end of the recording, in case of an emergency, the recording should have an emergency and suicide number in the beginning of the message. If a patient needs pain medications, he or she must provide a valid phone number and address; however, many veterans do not own a phone. VA requirements hinder veterans who do not have a valid phone number from receiving their pain medications.

**Recommendations**

- Increase the number of nurses for nursing home care.
- Increase the number of case managers.
- VACO should break directives down into policy, making them standardized, rather than leaving room for interpretation by each facility
- The women’s program manager should be afforded a full-time GYN, and ultrasound and mammogram capabilities
Background
The Washington, D.C., VAMC has 1,700 staff members, serves more than 50,000 veterans and has more than 500,000 outpatient visits each year. There are currently 720 full-time RNs and LPNs. The 2011 FY budget was $350 million and increased to $415 million in 2012. One percent of the budget in both years was dedicated to the Performance Management Center and quality management.

Quality of Care
The VAMC measures and manages quality as a health-care facility by performance measures determined by VACO, the VISN, and the facility, culminating in an ECF plan for performance for each fiscal year. There are only two quality-of-care training programs offered; one is a two-hour new employee orientation, the other four-day yellow/green belt training. The facility responded to how quality is measured and managed by noting VA Central Office, the VISN, and the facility, culminating in an Executive Career Field plan for performance. These are an example of how employee performance is measured, but not necessarily quality.

The last CAR was conducted in 2009, and the most recent JC was completed in 2011. Both the CAR and JC responded and had recommendations on improvements on planning, documentation of care, medication management and environment of care issues.

Quality Manager
This position is responsible for the implementation of the QM program, which includes accreditation and oversight, admissions, risk management, quality and process improvement, and utilization management. The quality-of-care indicator and measurements are tracked and managed by the Performance Measures Dashboard. Quality is managed by everyone in the organization, from leadership to the front-line employee. Patient care and satisfaction are a top priority for the medical center and are measured via the ECF performance plans.

The three primary quality-of-care committees at the VISN and/or facility level are:
- The Quality Council, facility committee with multi-disciplinary membership, including Quadrad, physicians, nurses and support services.
- The Medical Executive Committee, a senior-level committee comprised of service chiefs, CNE, QM and Patient Safety.
- The Performance Measures Workgroup, a multi-disciplinary group comprised of teams responsible for specific measure performance.

A challenge has been meeting the demands of VACO and the VISN. There are an overwhelming number of performance measures directed from these offices; however, these performance measures pose a strain on the facility without the sufficient number of staff to perform the tasks.

Patient Safety Manager
The duties and responsibilities of the patient safety officer are patient-safety compliance and monitoring, Root Cause Analysis, and HFMEAs and Risk Assessments. Also, the patient safety specialist and health systems specialist report directly to the patient safety manager. Patient safety is defined as a health-care system with a “No Blame” culture. Everyone is a safety officer, and when issues occur, the blame is not put on each other.

The primary concern is how to change the culture so that everyone is a safety officer. Training in safety could be more present...
in the employee orientation and continue throughout the evolution of the medical center’s patient-safety program.

**Utilization Management**

Utilization management coordinators are responsible for the review, assessment, and monitoring of admissions appropriateness and the continued stay for inpatients in meeting defined criteria for best practices. UM coordinators review patient charts daily, evaluating care and patient progress towards discharge. They work collaboratively with physicians, case managers, and social workers to identify the appropriate level of care based upon the patient’s current condition.

The challenge has been to integrate the Fisher House’s available space with the medical center. There are not enough beds available in the medical center, and it is difficult to account for availability in the Fisher House.

**Risk Manager**

Medical risk management involves monitoring for variations in provider practice and their subsequent impacts upon patient care and outcomes. This monitoring includes review of 16 triggers and three occurrences, and screening daily for peer review and patient-safety purposes. In addition, risk management is involved with regional counsel in the review and management of tort claims. Mortality and complications are two primary interests of risk management and integrated into the peer-review process. In addition, this individual plays a key role in disclosures. The RM also is responsible for annual surgery updates that are related to tracking complications and deaths within 30 days of surgery. This provides a quarterly mortality and morbidity ratio that is measured statistically for quality of surgery. As the chart is reviewed for complications, the SCNR also reviews for issues related to patient satisfaction.

**System Redesign Manager**

The system redesign manager noted that the Chief of Staff office has the overall responsibility for quality of care provided to patients. The manager spoke about the need to be included in more of the planning process. The system redesign manager is responsible for the action but is not included in most of the planning process. An example would be the new construction of the pharmacy, which has had a considerable amount of complaints.

**Chief Health Medical Information Officer/ Clinical Lead for Informatics**

The VA’s comprehensive use of its EMR is more than just a replacement of a paper record – it’s a quality initiative. The 100-percent availability of the comprehensive record, built-in clinical-decision support (clinical reminders), and automatic drug-interaction checks all have a profound impact on the quality of care delivered. Informatics is responsible for maintaining CPRS and, when possible, optimizing the record to better ensures quality of care is delivered.

The DCVAMC is launching a pilot program called “clinic in hand.” This program will allow VA patients to access their personal health-care records through their iPad or mobile device. It will also allow them to make appointments. Most of the barriers that exist are within the security of the program.

**Patient Satisfaction**

Patient satisfaction is defined by measuring the patient’s level of contentment with the overall experience at the medical center, including quality of care and services received.
There are nine FTE, with goals to expand. However, they partnered with all employees in the medical center to improve patient-satisfaction scores. Staffing costs include salary, educational efforts, and initiatives such as patient-centered care, WRIISC, Change Academy, strategic planning retreats and others.

Patient satisfaction is measured and managed as a health-care facility on both inpatient and outpatient care, which is surveyed to generate daily, monthly and quarterly reports, focus Groups, clinical outcome measures, access and more.

These tools are used to improve patient satisfaction through Truthpoint, which provides the ability for on-the-spot correction and service recovery. It is the voice of the veterans while they are patients in the medical center. It also provides prospective information for tailoring patient visits in the future. SHEP scores provide trended data to assess areas requiring focused intervention and provide management teams opportunities to perform rapid cycle-process improvements.

The following are the results of the last two SHEP scores:

Outpatient overall in 2011 – November 2011, 44.0; December 2011, 48.9

Inpatient Overall – November 2011, 49.0; December 2011, 38.5

The following two areas of the most recent SHEP survey showed improvement and decline, compared to the last SHEP survey:

Improve

• Inpatient – Privacy in Room
• Inpatient – Pain Management

Decline

• Quietness of Hospital Environment
• Shared Decision Making

There have been multiple patient-centered care initiatives, including liaisons and capital excellence applications. Also, working with floor staff/EMS to establish quiet times has shown improvement as well.

**Director of Patient Care Service**

The DPCS is the senior registered nurse executive directly responsible for nursing clinical quality, education, and care management in inpatient and outpatient settings. Some challenges the executive leadership notes having as a health-care facility is security with technology used to track quality of care, such as iPAD’s, and smart phones. Secondly, employee engagement has always been a concern. VA should promote a culture and motivate employees to be more proactive and engaged in the veteran’s health care. Lastly, the new pharmacy is causing many delays and confusion in receive medications. There is insufficient space, and it doesn’t have a design to direct the veteran through the medications-filling process. After observation, many veterans seemed confused, standing at the pharmacy’s entrance addressing questions to their peers.

**Patient Advocate**

The primary purpose of the position as department chief is to provide the coordination necessary for an effective, comprehensive and integrated consumer affairs program that supports VHA VISN and DCVAMC goals. Additional responsibilities of the chief of service include serving as a change agent while serving on medical center- and VISN-level committees, along with daily duties of ensuring that quality service is provided to veterans, their families, and other internal and external customers.

**Patient Aligned Care Team Coordinator**

The PACT coordinator educates the staff about PACT and increasing buy-in. They also help the dissemination of data regarding PACT benchmarks, are responsible for developing action plans on how to achieve benchmarks, conducting weekly PACT meetings with stakeholders, writing minutes for weekly meetings and attending PACT collaborative meetings.

**Veterans Town Hall Meeting**

A veteran’s town hall meeting was conducted on May 16 at Post 8 in Washington, D.C. There were 15 veterans that participated; all receive health care from the DCVAMC. Some concerns were in customer service, noting that some of the security guards and staff were not friendly, especially with the women. Also, there is almost no parking, and many veterans are forced to park off campus and walk to the medical center. Lastly, the pharmacy has limited seats and is not easy to navigate.

**Recommendations**

• The VAMC should integrate the Fisher House’s available space with the medical center.
• Develop a customer service program that incorporates employees’ jobs into patient satisfaction.
• Every employee should have ongoing customer-service training and be a vital part of their job.
• Increase space for the pharmacy and streamline the process to obtain medications. The design and signage in the pharmacy should be restructured. After observation, many veterans seem confused, standing at the pharmacy’s entrance and addressing questions to their peers.
**Ensuring the Best Health Care for Veterans**

**JESSE BROWN VA MEDICAL CENTER** | CHICAGO, ILLINOIS

**Date:** May 17, 2012  
**National Task Force Member:** Patrick R. Rourk  
**National Field Service Representative:** Steven J. Henry

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**Background**

The Jesse Brown VA Medical Center consists of a 200-bed acute-care facility and four CBOCs. Jesse Brown VAMC provides care to approximately 58,000 enrolled veterans who reside in the city of Chicago and Cook County, Ill.’s and in four counties in northwestern Indiana. In FY 10, the medical center had more than 8,100 inpatient admissions and 560,000 outpatient visits. A budget of more than $355 million supports approximately 2,000 full-time equivalent staff, including more than 200 physicians and 450 nurses; more than 500 volunteers provide service and care at the VAMC and CBOCs. The total budget for the VAMC in FY 11 was $356 million and $368 million in FY 12.

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**Quality of Care**

Quality is defined as providing the best patient-care services to all patients, and encouraging all staff to provide optimal services to these patients. Quality of care within the VAMC starts with communication, efficient customer service, knowledge of the patients, utilization of skills and intrinsic motivation. The facility relies on a strong culture of quality and patient satisfaction. It realizes the facility is only as strong as its weakest link, and if one area is found to be deficient, then the whole facility is viewed as being deficient.

Recently, the medical facility completed its Joint Commission inspection; the results of the inspection placed it within the top 10 percent of all facilities, both private and VA, confirming its dedication to quality of care by awarding the facility full accreditation. This facility also is on the Magnet Journey; the Magnet Recognition Program recognizes health-care organizations for quality patient care, nursing excellence and innovations in professional nursing practice. Magnet was developed by the American Nurses Credentialing Center and is the leading source of successful nursing practices and strategies worldwide.

The Jesse Brown VAMC is land-locked limiting any chance of expansion beyond its current perimeter. But the design of the facility allows for vertical expansion, allowing for future plans to expand primary care. SHEP scores are not unit-based, consequently providing data too broad to pinpoint concerns, though action plans are still written based on SHEP results.

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**Quality Manager**

This facility has established a structure of strategic planning framework for collaborative, systematic and continuous performance-improvement activities within the health-care facility. Specifically, this is done by measuring and managing quality through interdisciplinary committees, chartered improvement teams, services-and improving outcomes for patients, visitors and staff through a performance-improvement approach. The integrated measuring and managing methodologies include, but are not limited to, VA-TAMMCs, PDSA, Six Sigma, Lean Thinking, RPIW and Project Charter. No matter the methodology, the goal is to manage and manage quality to improve desired outcomes for the patients, removing waste in the process and promoting customer satisfaction.

The chief of Performance Improvement is responsible for leading the medical center Quality program, including the domains of survey readiness, systems redesign, management and risk management. The Quality manager ensures that the Quality Program meets VHA requirements, and that the facility maintains Joint Commission, OIG and other survey readiness. The External Peer Review Program; which measures the quality of clinical care, is also overseen by the Quality manager.

VACO has established quality programs to ensure quality of care though out the VHA, including:

- Promoting effective quality management activities by working collaboratively with medical center leadership, quality-management staff, and patient-safety staff to ensure that services under their supervision support quality-care expectations and those applicable to accrediting body standards and VA policies.
- Participating in collaborative, interdisciplinary process improvement and measurement/monitoring activities related to the care of patients or services provided, consistent with the medical center’s overall plans for ongoing measurement, assessment and improvement of all patient care and organizational functions and involving staff in the development of performance-improvement priorities and monitors/measures and in the implementation of improvements.
- Collecting, aggregating and trending of performance-improvement data gathered in relation to medical center in-
terdisciplinary indicators and reporting the data to the appropriate committees/councils, at intervals directed by the committee/board. The presentation will also include actions taken and the effectiveness of the actions taken.

- Assuring that issues/concerns/problems identified through performance-improvement activities are resolved, and actions are taken when opportunities for the improvement of care/services are identified. Issues are tracked for follow-up in the appropriate meeting minutes.

- Actively encouraging and supporting participation of staff on relevant performance-improvement activities, such as process action teams, system redesign teams, Six Sigma/Lean Thinking Teams, root cause analysis, health care failure mode effects analysis teams and peer review activities.

This facility maintains that the culture in VA has changed. Even with all the performance measures required by VACO, the amount of measures has been reduced over time. The expectations are extraordinary, and many of the programs and measures that VACO implements are short-term initiatives, with little consideration for how much time is needed to effectively execute each initiative. There are difficulties in recruiting qualified staff; for the past two years, the facility has unsuccessfully recruited for a Black belt Six Sigma-certified professional, a process that has been slowed by the length of the hiring process and classification of the position. Turnover seems to be a concern within the medical facility. During an eight-year period, the medical director had changed seven times.

**Patient Safety Officer**

The patient safety manager is responsible for ensuring that the medical center has a pro-active program to improve patient safety. This includes analysis of episodes of care that reveal opportunities to improve, including near misses, with a focus on systems improvement. The patient safety officer participates in root cause analyses, health-care failure mode effects analyses, and leads teams to improve the quality of patient care.

The VHA’s patient-safety program, managed by the VA NCPS, has a straight-forward goal: to reduce or eliminate harm to patients as a result of their care. To further this goal, NCPS has implemented a three-step approach to improving patient safety at this facility and facilities nationwide:

- Understanding the health-care continuum as a system and exploring system vulnerabilities that can result in patient harm.
- Reporting of adverse events and close calls. This is the primary mechanism through which the NCPS learns about system vulnerabilities. Since 2000, more than 900,000 adverse events and close calls have been reported to NCPS from VA medical facilities. These reports provide valuable opportunities to evaluate the identified root causes and contributing factors, as well as associated actions and outcome measures, to mitigate future events from recurring within a facility.
- Emphasizing prevention, rather than punishment, is the preferred method to mitigate system vulnerabilities and reduce adverse events.

With a commitment from leadership, Jesse Brown VAMC was able to develop and execute an RCA program that has been recognized by the Joint Commission as a best practice. The RCA program utilizes a lean concept; the Rapid Process Improvement Workshop is a five-day process in which all time and resources are dedicated to completing the RCA. At the completion of the workshop, an action plan is developed and forwarded to SPOT. For the past two years, this facility has received the Gold Cornerstone Award for safety. Due to the complexity and difficulty to effectively utilize the National Electronic Reporting System, the facility developed their own system based on Access. By utilizing this system, it is more user-friendly, available on all providers’ computers, eliminates the “paper trail” and gives all providers the ability to see and track incidents. However, all incidents must be re-entered into the national reporting system. During morning nursing meetings, providers are able to voice their concerns regarding incidents and then develop an action plan to address those concerns.

With so many incidents, it is difficult to manage and ensure confidentiality when the National reporting system generates a “paper trail.” The national reporting system is based on Vista, which is not user-friendly and actually deters providers from reporting incidents.

**Utilization Manager**

The UM reviews admissions and continuing stays in inpatient care for appropriateness by using InterQual criteria per VHA mandate. The purpose of UM is to ensure that resources are used wisely. Cases not meeting criteria are forwarded for clinician review to determine if the admission or continuing stay is clinically warranted. If not, the physician advises the admitting or treating physician on alternatives to inpatient care. In some cases, systems issues will result in continuing stays or admissions that do not meet criteria. UM data is used to identify causes of inpatient bed days of care not meeting criteria to allow systems improvements in the utilization of resources. The UM team provides a report on a monthly basis during the morning meeting.
A concern was raised in regards to the need for a long-term care facility due to the increased population of older veterans, and the anticipated increase of eligible baby boomer veterans.

**Risk Manager**

The RM is responsible for developing and managing the Jesse Brown VAMC Risk Management Program in accordance with regulatory agencies, VHA, network and facility requirements. This includes interpreting VA handbooks and directives related to risk management. The RM serves as a subject-matter expert for risk management and provides advice and support to the medical center staff, directs the development and maintenance of programs designed to reduce risk at all levels within the health-care delivery system, and provides professional management, educational assistance and policy development and implementation guidance in the area of risk management.

A large portion of RM is the peer-review program. All readmissions are screened; peer reviews are given for any readmission within 10 days, readmission after any emergency room visit and return to surgery after 30 days, and any death. All providers are notified of the peer review and RCA process.

**System Redesign**

The PI office has overall day-to-day responsibility for providing technical guidance in the design, development, implementation, coordination and evaluation of the effectiveness of the facility's quality-management plan and program. The office also provides consultation, education, training and technical support for performance-improvement activities. The service's functions include performance-improvement activities, risk management, patient safety, system redesign, external accreditation monitoring and special program functions.

**Chief Medical Officer**

The CMO assures that the electronic health record offers accurate, efficient and quality documentation. The CMO further assesses that documentation is timely and in the correct record. The CMO also advocates for staff to have adequate numbers and efficient tools for the assessment of care and documentation.

**Women Veterans Program Manager**

The Jesse Brown VAMC utilizes a centralized model of care for their women veteran patients, but there are dedicated providers for women veterans. Services offered within the medical center include mental health, OB-GYN and MST counseling. Currently, mammograms are provided through fee basis at the University of Illinois, which is located in close proximity to the facility.

There is a women veteran's focus group; for the first meeting, 40 invitations were sent out but only two women veterans attended. It was stressed that this group would continue to meet, and outreach efforts would be improved to increase involvement of patients.

The staff has received complaints regarding women veterans having to share a waiting room with male patients. The American Legion offered the idea of reaching out to Vet Centers in the area to reach more women veterans who may be eligible for care through the VA.

**Patient Satisfaction**

Patient satisfaction does not have a dedicated cost-center code. Multiple projects and initiatives supporting customer service and patient-centered care are evident throughout the medical center and have various funding sources.

Since the creation of a customer service program and customer service program manager position, the facility has devoted both staff and fiscal resources to support the delivery of excellent service to its veterans. The following list is an example of activities and initiatives that Jesse Brown VAMC has successfully implemented:

- Parking structure and parking assistance program;
- PACT implementation;
- Secure messaging and the hiring of a MyHealthyVet coordinator;
- Re-implementation of service level patient advocate;
- NEO training for all new hires;
- Veterans focus groups; and
- Veterans service officer meetings

**Patient Advocate**

The patient advocacy program was established to ensure that all veterans and their families served in VHA facilities and clinics have their complaints addressed in a convenient and timely manner. The patient advocacy program operates under the broader philosophy of service recovery, whereby patient complaints are identified, resolved, classified and utilized to improve overall service to veterans. The patient advocacy program is an important aspect of patient satisfaction and contributes proactively to VHA initiatives to provide world-class customer service.
The facility customer service manager and center patient advocates are responsible for:

- Resolving complaints that cannot be resolved at the point-of-service level and/or across disciplines.
- Presenting patient issues at various facility meetings and committees.
- Providing trends of complaints and satisfaction data at the facility level.
- Identifying opportunities for system improvements based on quarterly complaint trending.
- Ensuring any significant single patient complaint is brought to the attention of appropriate staff to trigger assessment of whether there needs to be a facility system analysis of the problem.

The biggest challenge within the Patient advocacy program at the Chicago VAMC is the sheer volume of incidents received on a daily basis; the facility averages 200 complaints a month.

**Patient Aligned Care Team Coordinator**

The implementation of the PACT model was a team effort, including primary care, nursing, PAS, social work, nutrition and food services and pharmacy, among others. The following positions are individually funded: health promotion disease prevention coordinator, behavioral health coordinator and MyHealthyVet coordinator.

By using the PACT model, veterans are placed in the middle, surrounded by all the resources of care. All veterans receive appointments within seven days of the desired appointment date, and many times veterans have the option to be seen on a “same day” status. The biggest challenge for the Chicago VAMC is space. Being landlocked the facility is unable to expand, However, there is an extra floor being added to expand primary care. The facility is able to expand vertically, rather than horizontally.

**Town Hall Meeting**

On May 16, a town hall meeting was conducted at an American Legion post in Cicero, Ill. There were approximately 20 veterans in attendance; 10 veterans actively utilized the Jesse Brown VAMC for care, and 10 veterans used the Hines VAMC. Most veterans praised the facility for the quality of care they were receiving or had received. Issues raised included difficulties in reaching the patient advocate, ID card machine not working, no automatic doors in the parking garage and employees using patient parking spaces in the parking garage.

Prior to the site visit, representatives from The American Legion witnessed many employees parking in mandated patient parking spaces in the parking garage. This issue was raised during an exit brief with the executive leadership team, who acknowledged it was a problem. They were unaware of its scope, yet promised to address the issue. The patient advocate issue was also addressed; executive leadership informed representatives from the Legion that the facility was recruiting to hire two new advocates. Until these positions are filled veterans will continue to experience wait times in contacting the current advocate.

**Recommendations**

- Frustrations were raised regarding difficulties in contacting and reaching the patient advocate. Even though the program is being expanded by hiring two new advocates, veterans will continue to experience extended wait times until those positions are filled.
- Jesse Brown VAMC should streamline the hiring process so that these positions are filled ASAP. The time it takes to hire more advocates is more time veterans must wait to express concerns.
- The parking issue must be addressed. Representatives witnessed at least a dozen employees parking in patient-designated spaces. This is unacceptable and must be addressed sooner than later. Delays in finding a parking space could mean missing an appointment for the veteran.
Background

The John Cochran Division, named after the late Missouri congressman, is located in midtown St. Louis and has all of the medical center’s operative surgical capabilities, the ambulatory care unit, intensive care units, outpatient psychiatry clinics, and expanded laboratory. Currently, the facility has up to four beds in inpatient rooms, but there are plans for constructing a bed tower that will have one bed per room. The St. Louis VAMC staff is made up of 35 percent veterans. The medical facility’s budget was $393 million for both FY 2011 and FY 2012.

Quality-of-care employees receive new employee orientation and Yellow Belt Lean training, which lasts three days. Currently, the facility has 98 LPNs, 101 NAs, and 493 RNs, which has been a safe staff-to-patient ratio. Patient involvement has been encouraged through veteran service officers meetings and focus groups. A challenge the executive leadership faces is recruitment, especially in nursing, and erasing the stigma of working at the St. Louis VAMC. Currently, 24 percent of staff positions are empty, and when hired, there is a 10-percent turnover rate. In addition, the St. Louis VAMC has a $12-million deficit.

Quality of Care

The VA St. Louis Healthcare System defines quality as providing safe and effective care in a timely manner that meets and exceeds veteran expectations. To measure and manage quality, the manager participates in peer reviews, action reviews, veteran-satisfaction surveys, and active surveillance of health care.

The John Cochran Division maintains accountability through its commitment to veterans. The medical center has an internal executive board that reviews and monitors performance measures and action plans. Performance measures are compared to local community hospitals and other VA facilities.

Quality Manager

The quality manager ensures that the quality-management system and patient-safety improvement program are properly integrated. This individual also serves on the executive committees for quality data to be reviewed and analyzed. In addition, the quality manager provides education, facilitation, and support to employees to ensure there is an effective program in place.

The quality manager is in charge of John Cochran, Jefferson Barracks and four CBOCs. There has been a challenge for the quality manager in having enough operational inpatient beds. Currently, there are 109 inpatient beds, but a patient may have to wait an average of 12 hours. Another challenge has been patient infections – not because of hospital mishaps, but from the surrounding communities. As of 2012, the local communities have an infection rate of 28 percent MRSA.

Patient Safety Officer

The patient-safety manager performs and supports RCA activities by acting as an advisor to the training groups. This individual assists in meeting the requirements recommended from Joint Commission patient-safety goals and standards. OIG and JC requirements include participation in surveys, assessments, and reviews. The patient-safety officer acts as a liaison between the quality manager and the Joint Commission by responding to RCA inquiries.

The VAMC has an adverse event-reporting system for reporting patient incidents or staff safety issues. The reporting system is located on the facility’s webpage and is an electronic form. In the event of a high-risk issue, the topic is sent to the executive leadership immediately or brought up during the morning report. From April 7, 2011, to April 1, 2012, the facility conducted 14 RCAs.

Utilization Manager

Utilization management is an integrated program that promotes incorporation of utilization management into daily patient-care activities. The utilization manager assists the facility in approving patient-care efficiency and monitors health-care resources. Finally, the utilization manager evaluates if a patient is receiving the correct amount of care based on VA directives. The utilization management team is understaffed, which has hindered its ability to review patient care.

Risk Manager

The risk manager monitors and evaluates potentially harmful events that may impact the quality of care of veterans. For instance, if a patient is readmitted within 10 days, a red flag is shown and the case is reviewed to understand why the patient was readmitted. Recently, the risk manager changed the discharge template, which will give patients their next appoint-
ment rather than receiving a phone call weeks later. Furthermore, veterans have acknowledged that prescription literature is sometimes hard to read; the risk manager made it mandatory to have it read to patients prior to their departure.

System Redesign
The system-redesign manager directs and coordinates the administrative, operational, and planning activities. Some of the planning includes advanced access to all clinics and performance-improvement activities. This individual ensures alignment of system redesign objectives are aligned with VISN and national objectives.

A recent project the system redesign manager created was a recruitment initiative. The system redesign team reviews the job announcement from beginning to end and tries to lower recruitment time. This is accomplished by extracting useless processes within the recruitment process. Once the processes are found, best practices are shared throughout the VISN and other VA facilities.

Chief Medical Officer
The chief health medical information officer ensures health-information systems support the care and services to improve care through reporting clinical information. Patient records are used to identify health informatics needs. Afterwards, there are committee meetings in which patient issues are gathered to limit mistakes.

The chief medical officer would like to have an integrated database system between DoD and VA. The database would have all the ships, campaigns and conflicts and list all service members involved.

Women Veterans Program Manager
The women’s clinic provides comprehensive primary care, but prenatal and maternity care is fee-based. It is a separate clinic within the VA medical center. The women veteran program manager has a women veteran’s health committee in place that includes staff, but veterans are not included. The clinic incorporates PACT, part-time GYN and a social worker.

Patient Satisfaction
The John Cochran VAMC defines patient satisfaction as a provision of veteran-centric care treatment and service that demonstrates its values of integrity, commitment, advocacy, respect and excellence. Patient satisfaction is measured by SHEP data; once analyzed and graphed; it is benchmarked against the national percentage. The tools used to track patient satisfaction are quick cards, national SHEP surveys, executive staff and patient satisfaction. Currently, SHEP outpatient indicators have shown slow improvement, but inpatient indicators remained the same.

The quick cards are available in each department and are collected and reviewed every two weeks. The information is inputted into a shared site that allows departments to review feedback of veterans. The concerns are addressed immediately by the appropriate staff and leadership. The employees that work specifically with patient-satisfaction initiatives are patient advocates, service chiefs, education specialists and all performance-improvement teams.

Director of Patient Care Services
The director of Patient Care Services provides oversight and direction to ensure veteran needs are met. This individual is also in charge of planning and veteran education in a way for the patient to understand. Furthermore, the director meets with veterans and their families to understand and improve their overall health.

Patient Advocate
The purpose of the patient advocate is to serve as an interface for veterans and their families that have information needs, concerns or compliments. Currently, there are four patient advocates at the John Cochran VAMC, and each of them receives 18 incident reports per day. Each incident is given to the original staff involved, and all communications are sent to the patient advocate. When a patient advocate receives a complaint, the concern should be resolved in 24 hours, or 72 hours at the latest, along with a seven-day period to complete an incident report. If the veteran does not agree with the decision, he or she may meet with the director to discuss their concerns. The complaint is sent to the director, who determines if the issue is sent to the VISN level.

Patient Aligned Care Team Coordinator
The PACT coordinator currently is acting as the associate chief nurse, which educates, manages, and supervises the nursing staff assigned to PACT. The PACT model puts the veteran in the center of their care; therefore, the PACT team coordinates focus groups to listen to their concerns and input. The facility’s current PACT model has a three-support-staff-per-primary care ratio. Currently, there are 44 PACT teams, with 1,200 veterans per team and a total of 7,000 veterans served.

The PACT team ensures the patient receives specialty care by meeting a service agreement with specialty-care providers. The
service agreement lists all the requirements necessary prior to being seen with a specialty-care provider. The agreement limits the possibility of the patient being sent back to the primary-care provider for prerequisite procedures. The PACT team coordinator sends out a survey to all CBOCs and clinics for patient feedback. A recent survey stressed the problem of PACT teams not giving clear instructions to patients, which has lowered patient satisfaction with their teams.

The PACT team endures a few challenges, such as a need for 15 LPN and 12 clerical staff.

**Town Hall Meeting**

The town hall meeting was located at Post 397 in St. Louis, Mo., and had 17 veterans in attendance. Veterans expressed both a mixture of positive and negative comments about John Cochran VAMC. Veterans stressed that 95 percent of hospital staff were courteous, and the hospital is vital to the veteran community. Some veterans explained that it took over a year for some to receive a VA card. In addition, most of the doctors are from India and other ethnicities; this has created complications with patients because of the accent barrier. Customer service has been a problem in the past. A nurse once told a veteran, “If you’re going to bark like a dog, then you’re going to be treated like a dog.” Furthermore, veterans stressed that the nursing staff seemed under-staffed and are not able to keep up with veteran demand.

**Recommendations**

- Increase recruitment capabilities, because nursing staff is at 24-percent capacity, and there is a 10-percent retention rate.
- There is a shortage of PACT space; therefore, an additional annex for PACT teams would be beneficial.
- There is a need for 15 LPNs and 12 clerical staff.
Background
The Southeast Louisiana Health Care System (SLVHCS) consists of eight CBOCs in New Orleans, Baton Rouge, Bogalusa, Franklin, Hammond, Slidell, St. John and Houma. After the New Orleans VAMC was closed due to irreparable flooding damage from Hurricane Katrina, the SLVHCS opened five new CBOCs – New Orleans, Bogalusa, Hammond, Slidell, and St. John. No inpatient services are provided since the closure of the VAMC; however, the SLVHCS purchases non-VA inpatient care with Tulane Medical Center and other providers in the local community. The replacement New Orleans VAMC is expected to start operations in August 2016.

SLVHCS served 37,645 veterans in FY 2011, with 445,895 outpatient visits. SLVHCS is concerned with the budget hiring and salary freezes, along with the aging workforce (doctors and nurses) that will be retiring in a few years. The facility has received authorization to hire 17 mental health FTEE. The also is a partner of the Community Workforce Coalition, which will be assisting with recruitment of critical positions needed for the replacement VAMC. The annual budget for FY 2011 and FY 2012 is $314 million and $317 million, respectively.

Quality of Care
The facility defines quality of care as supporting VA’s core missions; recognizing current and emerging veteran needs; and aligning with Veterans Health Administration (VHA) strategic guidance, resource allocation, and associated VHA policy to produce optimized health-care processes and outcomes through an organized and systematic approach to planning, delivery, measuring and improving care. SLVHCS measures quality though the measurement of clinical outcomes, performance measures, voice of the customer, peer review, accreditation reviews and direct observation of National Patient Safety Goal implementation. The facility manages quality through self-reporting, root cause analyses, systems redesign, implementation of patient-centered care principles, and audit of patient records and continuous data streams.

SLVHCS demonstrates and maintains accountability for quality of care through a number of initiatives. The Office of Quality, Safety and Value (OQSV) plans, directs, coordinates, and evaluates VHA’s national quality, safety, and value-producing programs and approaches. The secretary of Veterans Affairs’ approach to transparency has heightened the visibility of quality indicators, and the OQSV displays data from the facility level to the national aggregate level on a website (ASPIRE) that is available to the public. Additionally, the facility conducts monthly QCCC meetings to address issues that require an in-depth discussion of details of clinical processes.

In April 2011, OIG recommended the SLVHCS Hammond and Houma CBOCs develop a local policy for short-term fee basis. The facility leadership reported that a contract had been under development over the past year and would be finalized by the end of May 2012. The Joint Commission inspection in February 2011 made recommendations for improvement that included:

• Ambulatory health care – ensuring medications that were open were properly labeled;
• Behavioral health care - psychiatric advance directive needed for patients with severe mental illness and no plan of care was documented for mental health program patients; and
• Home care - evaluates effectiveness of emergency operations plan.

The facility has addressed and made improvements in these areas. Some of the challenges the facility addressed regarding quality of care is the number of measures that are being tracked and ensuring communication and coordination of quality of care is tracked by all employees. With the facility contracting out inpatient care, it strives to ensure that all of the veterans care and appointment information is sent back to be inputted into their VA medical record. A major challenge the facility had was that it did not receive its VISN Network Strategic Plan with quality-of-care measures until March 2012, when it should have been sent at the beginning of the fiscal year in October 2011. Staff from the facility said it was difficult to plan what quality-of-care measures would be tracked when they received the plan during the middle of the fiscal year.

Quality Manager
TheQM is responsible for ensuring all components of the QMS and patient-safety improvement programs are integrated; ensuring a system for monitoring the quality data process is in place; serving as the quality consultant to leadership, Quality Improvement (QI) teams and employees; serving on the executive committees and workgroups where quality data is reviewed, analyzed and acted upon; and oversees the functions of the following programs: accreditation, risk manage-
The quality-of-care indicators and measurements are tracked and managed through reports from local patient-care areas, VISN data warehouse reports and national data available to all on the Office of Quality Safety and Value website. SLVHCS trends its data and reports it through weekly and monthly benchmark reports in meetings with frontline staff, managers and executive leadership.

The facility suggested the need to continue to be proactive in preventing patient safety incidents at the facility by incorporating national and facility risk-mapping initiatives into future hospital directives and procedures. Another recommendation identified is that VA should improve on its succession planning to ensure an experienced leader retiring or leaving a position trains a new employee hired into a position to ensure continuity of job responsibilities and prevent loss of quality or critical job functions. VA leadership said that even though the facility is measuring hundreds of different quality-of-care data, there is always concern that not everything can be tracked, and ensuring things that are unknown do not cause system or patient problems. Communication is an ongoing challenge to make sure every staff member is monitoring and ensuring quality of care on a daily basis. SLVHCS created a program called “huddles,” which is a short meeting within each department with all of the staff in the mornings and afternoons to discuss the plan of the day and review any cases requiring follow-up action.

**Patient Safety Manager**

It is the responsibility of the SLVHCS patient safety manager to develop, implement and maintain a health-care system-wide patient safety improvement program that meets the requirements set forth in the Network Patient Safety Improvement Program, the VHA National Patient Safety Handbook and the Joint Commission Patient Safety Standards. It is also the responsibility of the patient safety manager to provide new employee orientation to all new employees relative to the information contained in patient safety policies. The patient safety manager also manages any root cause analyses conducted by the facility to address patient safety incidents and make recommendations for system improvements.

Patient safety as a health-care system can be described as minimizing risk to patients by creating a culture of safety and by communicating lessons learned throughout the system. Some of the patient safety concerns at the facility included fall-risk assessments and improved signage to prevent confusion with the multiple systems of clinics at SLVHCS.

**Utilization Management**

The UM coordinator has responsibilities for ensuring quality of care and patient satisfaction, including: Assisting with the development of the section's standard operating procedures; Interpretation of Joint Commission standards, VA/VHA policies and procedures/directives, VISN 16 directives and any federal regulation(s) governing health care to veterans; Implementing monitors in accordance with the aforementioned to track, trend and report findings to designated committees for performance improvement; and compiling the section's annual and recurrent reports for utilization review and virtual inpatient program.

The UM coordinator received utilization-review training for the implementation of InterQual Criteria, which is now used nationwide, and participates in monthly conference calls designated for utilization management for updates on the practices/policies/procedures. Measurement tools are used to evaluate the appropriateness, medical need, and efficiency of health-care services to veterans in accordance with evidence-based criteria. Monitors are created and data collected and reported, trends identified are discussed and recommendations are given for process improvement. Patient surveys are devised and utilized to capture patient satisfaction of services received.

**Risk Manager**

The RM oversees the Risk Management Program, which consists of: administrative investigation boards, peer reviews, mortality reviews, fact-finding investigations, administrative tort claims (malpractice claims) and adverse event disclosures. The RM is charged with systematically identifying, evaluating, reducing and/or eliminating, and monitoring the occurrence of adverse events and situations arising from operational activities and environmental conditions. The initial training that the RM received included all of the components of the RM program and ongoing training is held via monthly/quarterly RM conference calls and webinar topics.

Measurement tools utilized by the RM are varied. Data is compiled, tracked and trended to identify any patterns and/or opportunities for improvement. Risk techniques are evaluated to
ensure the best technique is being used to mitigate the problem. Continuous monitoring is done to ensure that the risk technique was the appropriate method to use in the particular situation. If monitoring reveals that a technique needs to be changed, necessary change is made.

**System Redesign Manager**

The facility won a VISN 16 Best Practice Bronze award for a system redesign project focusing on timely tracking of non-VA care documentation. The system redesign manager facilitates system redesign projects. When a problem is identified and an improvement team is chartered, the manager works with the team to map the process and identify steps which can be improved and develop a plan and monitor results. The system redesign manager has received a number of system redesign trainings and is yellow belt Six Sigma Lean-certified and presently attending green belt training. VA has several databases that allow measurement of many different processes. SLVHCS utilizes the VA data warehouse, and many specially designed reports to measure quality of care and patient satisfaction.

**Chief Health Medical Information Officer/ Clinical Lead for Informatics**

The chief health medical information officer creates, compiles and guides the review of every patient’s care benchmarked against the VA national set standards every month for all patients. Additionally, the chief medical officer works with clinical staff to improve their performance and deliver better patient care through the use of data. In addition to these responsibilities, the position co-chairs the Medical Records Committee to review appropriateness, timeliness, and ease of use for all the clinical reminders, computer patient record system notes and templates in the electronic medical record. Quality-of-care and patient-satisfaction indicators are reviewed, tracked, trended, managed and discussed on a continuous basis. As soon as new data is available, the results are analyzed and communicated throughout the organization via a multitude of methods. SLVHCS has champions for each quality-of-care and patient-satisfaction indicator, whose responsibility is to lead the organization in constant improvement.

**Patient Satisfaction**

SLVHCS was selected as a center of excellence for patient-centered care and is in the process of setting up an Office of Cultural Transformation that will focus on patient-centered care and system redesigns to streamline processes to achieve the perfect patient experience. The outcome of the project improved the continuity of the patients’ care. VA has enhanced the ICARE initiative, and SLVHCS has begun the Affirming the Commitment program that asks all hospital employees to reaffirm their commitment to patient centered care for veterans.

Patient Satisfaction is measured through weekly comment cards and SHEP surveys. The results of both of these measurements are reported monthly to SLVHCS executive leadership and service chiefs to target trends and any possible process improvement initiatives. On the last Survey Health Care Experiences (SHEP) performance scores as of the first quarter of FY 2012, SLVHCS declined in two areas – getting care quickly and pharmacy mailed program.

SLVHCS stated that with the PACT) implementation, veterans have had increased and open access to primary care. However, the challenge with getting care quickly is mostly related to specialty care, such as orthopedics and urology. The facility has begun adjusting patient care hours and examining specialty-care provider schedules to ensure veterans are provided more timely care. The facility is also emphasizing greater use of telehealth programs and initiatives. The facility implemented a veteran-education program for the mailed prescription process and edited the pharmacy telephone script to simplify ordering, as well as further promotion of My HealthyVet for ordering medications. Another concern identified by the facility is the delay in receiving the results of the SHEP data, which is six months old when it is released. A best practice that the facility has implemented, since the SHEP data is not current, is printed comment cards, which are filled out by patients throughout the hospital and compiled weekly to be addressed by the leadership meeting on Fridays through a program called “Board on Boards.” Each individual comment card is read, the results are tracked by service line, and subsequent improvements or changes are addressed in response to the inquiry, concern or positive experience.

**Director of Patient Care Services**

At SLVHCS, the associate director of Patient/Nursing Services is a member of the leadership executive team and participates in the strategic planning, as well as day-to-day functions of the health-care system. The nurse executive provides oversight of the professional standards of clinical services that support patient care, social workers and dieticians. The director of Patient Care Services serves as chairperson for the Patient and Family Centered Care Committee ensures employees are trained to meet the expectations of patients and family members, maintains the operation budget, oversees all nursing care, inpatient and outpatient, and managing the Sterile Processing Services.
Patent-satisfaction indicators and measurements are tracked and managed in two different ways, inpatient and outpatient, through communication with nursing and evaluations of how well the nurses and doctor communicate to the patients.

**Patient Advocate/ Patient Care Coordinator**

The patient advocates’ duties are to facilitate patient concerns and mitigate any roadblocks that veterans experience in receiving proper and timely care. Patient-satisfaction indicators and measurements are tracked through surveys and phone calls. Trends are managed directly within each service area when reported. The patient advocates are responsible for tracking all satisfaction measures captured in the nine SHEP outpatient performance measures. In addition to tracking all measures, they also are responsible for disseminating information, working with staff on corrective action plans, and bringing it forward if action plans are not working. Surveys are conducted on a daily and monthly basis through SLVHCS comment cards and SHEP. In the two executive career field-performance areas emphasized by VA, SLVHCS trends higher than its peers in how well doctors and nurses communicate and slightly lower on their peer index in overall rating of health-care categories.

The patient advocates received one 40-hour, regionally conducted VISN training program for new patient advocates. There are monthly training calls conducted by the VISN to discuss performance measures and emerging trends in customer service. The facility has a seven-day policy concerning congressional responses and a seven-day policy for complaints filed directly by patients.

One of the concerns identified by the patient advocates was the shortage of staff and delays veterans experience with the laboratory. Other concerns that have been brought to the patient advocates from veterans include billing, patient care, provider wait times, coordination of care for fee-basis appointments, and the mail-out pharmacy program.

**Patient Aligned Care Team Coordinator**

The PACT coordinator at the facility involves strategically coordinating the conversion of each CBOC from the traditional patient-care model to the PACT model of care. This involves setting up the operational structure (administratively and clinically), providing staff education and training, and educating patients and other internal/external customers. This role includes tracking and trending PACT performance measures at the CBOC level and at the team level. The PACT coordinator prepares briefing reports to the leadership and coordinating local participation in national- and VISN-collaborative and other projects. The PACT Steering Committee meets weekly and provides updates to the executive leadership twice a month. The veterans’ community is involved in the PACT planning process through committee membership and focused surveys. Throughout implementation, veteran feedback was sought through the VA Voluntary Service meetings, as well as speaking with patients using the clinic.

**Town Hall Meeting**

The System Worth Saving Task Force conducted a town hall meeting at American Legion Post 175 in Metairie, La., on May 20. Approximately 15 veterans attended the meeting. Some of the concerns identified included VA only seeing patients once a year for primary care, ensuring adequate funding for the new medical center, specialty care/fee basis delays, having a single point of contact for the PACT and third-party billing procedures with Tulane Medical Center. All of these issues and concerns were addressed during the site visit.

**Recommendations**

- VA Central Office and VISNs ensure that the VISN Network Strategic Plan with quality-of-care measures is distributed at the beginning of the fiscal year to all of the facilities to ensure the facility can plan to track which quality-of-care measures are selected during the fiscal year.
- VA Central Office should explore programs and training to incorporate national and facility risk-mapping initiatives into future hospital directives and procedures. Risk mapping is a continuous process that allows risk points to be identified in the facility ahead of time and ensure warm handoffs are in place to avert a potential crisis or incident.
- VA Central Office and VISNs should establish an online weekly survey mechanism, throughout the facility to assess patient satisfaction and feedback from patients and help improve facility programs and patient care, since the SHEP data is three to six months old.
- VA should improve on its succession planning to ensure an experienced leader retiring or leaving a position trains a new employee hired into a position to ensure continuity of job responsibilities and prevent loss of quality or critical job functions.
- The facility should create a map of the SLVHCS clinics and street/building locations of clinics, pharmacy and other critical outpatient services, in the absence of having a full hospital, so veterans understand where they can receive services and assistance.
Background

The Seattle VAMC is the primary referral site for VA’s northwest region, VA Puget Sound, and provides care for up to 80,000 veterans from Alaska, Montana, Idaho and Oregon. The budget for FY11 is $472 million and $494 million in FY12. For FY12 RN FTE is 600, 21 FTE for NP, 146 FTE for LPN, 3 for CNS, 80 for NA and 30 for HT.

Quality of Care

The Seattle VAMC defines quality as an organized, systematic approach to planning, delivering, measuring and improving healthcare, linking VHA’s core values to the day-to-day operations while ensuring safe, effective, patient-centered, timely, efficient and equitable care. Quality encompasses many interrelated activities that are the responsibility of senior leadership. There have been no quality-of-care OIG and GAO inspections done within the past three years. The last Joint Commission inspection was completed July 19-23, 2010, with six direct impact and 21 indirect impact findings.

There is a glaring lack of corroboration between the executive staff of the Seattle VAMC and local veterans service organizations. Turnover seems to be a concern, as the whole executive staff has been on board less than six months.

Quality Manager

The quality manager ensures that components of the quality-management system and patient-safety improvement program are integrated, and that a systematic process is in place for monitoring the facility quality data. The quality manager also serves as the quality consultant to the facility leadership, Quality Improvement (QI) or Performance Improvement (PI) teams, and employees.

Quality is measured through performance measures, including SHEP, and polls that are a small sample but can lead to process review. Seattle is now going to Press Ganey, so that the data may be received quicker and can be focused as small as individual providers. The facility also uses clinical measures, mortality rates and charts to measure performance.

One of the biggest challenges at Seattle VAMC is not a lack of data, but how the data is used. The sheer volume of data through SHEP is overwhelming. A new department was created to analyze the quality management. There is no central clearinghouse as to how this department will take care of the data. The clearinghouse will be a uniform way to clear and pull the data, and compare to national data through various reports. There is an ongoing partnership with Portland for analysis and data management. SHEP scores are used to drive customer satisfaction and comprehensive systems analysis. The quality management team is developing a training library compiled of materials received during training seminars. When a provider attends a training seminar, the information received will be entered into an electronic database that employees will use to receive the same training without the cost to the facility.

Patient Safety Manager

The patient safety manager ensures that components of the Quality Management System and Patient Safety Improvement Program are integrated, and implements a coordinated, patient-safety improvement program that is based on guidance and tools from the NCPS and meets the needs and priorities identified by the facility director. These include addressing important standards, requirements and recommendations to improve patient safety.

The Seattle VAMC has a strong patient-safety program that has been consistently recognized by VACO for excellence by receiving the Gold Cornerstone Award. All RCAs are completed within the 45-day mandated period. During each morning report, patient safety is the first agenda item addressed by members of the Patient Safety committee that is chaired by the associate chief of staff and safety director. The Seattle VAMC culture is one of safety; people are more aware of safety and near misses. Given the blame-free culture, providers are more likely to report events or near misses. Regardless of how exceptional the program is there is always room for improvement. Providers would like to see more opportunities for training and to attend national seminars.
System Redesign

The system redesign manager seeks to find ways to balance patient-care demand with available resources that provide the care and incorporate other organizational programs and leaders in improving the way care is delivered.

An important aspect of system redesign is population. If the patient does not need to be admitted, then the facility will find other ways to treat the patient. If a patient is wrongly admitted, he/she is taking up valuable space. System redesign is infrastructure redesign, so the veteran patient is always in the center; however, the facility would like to change the name to systems innovations.

Health Informatics

The CIO directs the OIT to deliver adaptable, secure and cost-effective technology services to VA and acts as a steward for all VA’s IT assets and resources. The CIO mission is to provide and protect information necessary to enable excellence through client and customer service.

Patient Satisfaction

VA Puget Sound has a dedicated position for customer satisfaction manager, which is a GS-12 position. The position supervises the four GS-11 patient advocates, serves as the patient-centered care coordinator and serves as the co-chair on the Customer Satisfaction Board. In reality, all staff at VA Puget Sound have customer service responsibilities as a collateral duty. Seattle defines patient satisfaction as providing timely and quality care to all veterans. Patient satisfaction is measured mainly through SHEP Surveys. Another method to measure patient satisfaction is post-discharge phone calls. Calls are made to all patients who are discharged from an inpatient stay and then surveyed about the care that they had received; information from these calls is used to improve care. Providers also make rounds throughout the facility, checking on patients and speaking to veterans visiting the facility for appointments. By rounding the facility and visiting with veterans, providers and executive staff are able to ascertain the veterans’ perspective on their experience. Veterans do participate in some committees, giving them a voice within facility leadership.

Patient Advocate

The patient advocate provides concern resolution, addresses compliments with service lines, provides customer-satisfaction training, makes inpatient visits to new patients and provides concern resolution to inpatients. The patient advocate works as the veteran’s voice at the medical facility. If a veteran has a concern, he/she approaches the patient advocate who works collaboratively with the providers to settle the dispute in a non-punitive fashion. All veteran concerns are entered into the PATS system so they may be tracked, and any inconsistencies are addressed in morning meetings.

PACT

The PACT coordinator oversees the implementation of PACT principles at all nine Puget Sound clinic sites and the Seattle VAMC. With the OIF/OEF population growing at an average rate of 8 percent yearly, it is imperative to enroll the veterans ASAP and assign them providers. Veterans complained of difficulties with the phone system, so the facility hired nine operators to assist veterans who call for appointments. By hiring more operators, the average wait time has been reduced to one minute; the facility is striving to reduce the wait time to 30 seconds.

Town Hall Meeting

On May 21, a town hall meeting was conducted at the local American Legion post located in Renton, Wash.

Recommendations

• There is a glaring lack of collaboration between the Seattle VAMC and local VSOs. Currently, the executive leadership does not attend meetings on a regular basis, nor are veterans represented on committees throughout the medical center. To improve outreach and communication, veterans should be added to committees, and executive leadership should make an effort to attend VSO meetings in and outside of the medical facility. This would go a long way with local veterans in showing the facilities dedication to serving local veterans.

• The facility should increased the amount of committees used to track and measure patient satisfaction, including PACT.

• There is a miscommunication regarding the child care pilot. Executive leadership noted that the child care pilot was available to patients using both Seattle and American Lake. However, other staff members noted that the pilot was only available at American Lake. To avoid confusion for veteran patients this should be clarified.
Background

The VA Gulf Coast Veterans Health Care System (VAGCHCS) consists of a VAMC located in Biloxi, Miss., and CBOCs in Mobile, Ala.; Pensacola, Fla.; Fort Walton Beach, Fla.; and Panama City, Fla. VAGCHCS served 60,863 unique veterans in FY 2011, with 575,702 outpatient visits. The annual budget for FY 2011 and FY 2012 is $319 million and $328 million, respectively.

Quality of Care

The facility defines quality of care in multiple ways, but primarily through access and effectiveness. VAGCHCS is constantly striving to improve access and to make sure the care it provides is efficacious. The facility was recognized by the JC for its care of veterans with pneumonia. Quality is measured through performance measures, which give the facility a broad overview of health-care quality and access in such areas as women’s health, mental health, general outpatient services, and specialty services such as homeless care and equal employment opportunity.

VAGCHCS demonstrates and maintains accountability for quality of care by having a monthly performance measures meeting. During the meeting, the director and other members of the facility leadership gather to discuss the current performance plan and their progress. The meeting is led by the facility’s performance measures coordinator who tracks their progress and achievements. Additionally, the facility has a morning report every day to address presented issues immediately.

An OIG report in March 2011 concerned an alleged delay experienced in diagnosis or treatment, and excessive waiting time of one of the veterans using the facility. The facility could not substantiate the delay and the veteran elected to leave the emergency room. Another OIG hotline call concerned a death of a veteran who received services through the facility’s emergency room and later died during a cab ride home. A thorough review of the case was conducted, and the case was closed with no additional follow-up. A JC inspection was conducted in 2009, and it was recommended the facility improve assessment and reassessment practices in relation to pain management, inspect, test and maintain medical equipment to standard, and use at least two patient identifiers when providing care, treatment and services.

Some of the challenges regarding quality of care were the phone system and scheduling of appointments under the new PACT model, patient identification, medication errors and medication reconciliation. In one medication reconciliation case discussed, a patient’s surgery had to be cancelled because the patient was taking medications that precluded having the surgery on the appointed date. Another concern identified by the facility is the delay in receiving the results of the SHEP data, which is six months old when it is released. The facility needs a short-term survey/assessment tool to solicit feedback from veterans for patient satisfaction.

Quality Manager

The QM is responsible for the supervision of the quality and performance management staff. The QM uses professional knowledge of programs to develop, analyze and manage the various aspects of quality management (peer review, utilization management and infection control) and serves on committees, workgroups and teams in support of quality activities.

The quality of care indicators and measurements are tracked and managed by the Performance Measures Committee and the Quality and Performance Management Board. The facility has a number of staff that measure and manage quality and assist service lines, program managers and administration in developing and maintaining quality programs. The measurement and management of those programs are through the Quality and Performance Management Service. Quality items are usually discussed and processed through the Quality Board or the Performance Measures Committee. The areas of concern are highlighted and the information is shared with the facility’s leadership for action.

There were several quality-of-care concerns identified during the site visit. In regards to access and patient satisfaction, the medical center still has a centralized scheduling system, rather than appointments being booked through veterans PACT teams. This has created a lot of confusion because on the automated and generic letters, it has the main number that veterans call to confirm or change their appointments, and the hospital phone system is in need of replacement. The phone system cannot link to PACT teamlets, and during reminder appointment calls the VA operator leaves a message with the hospital’s main number, so veterans are not aware of where their appointments are or who to contact to make any scheduling changes. Training is also needed to ensure the PACT and hospital scheduling staff ensures that “desired date” is not based on availability and pref-
The mission of VHA’s patient safety program, managed by the VA NCPS, is to reduce or eliminate harm to patients as a result of their care. A three-step approach has been developed to improve patient safety at the facility and others: understanding the health-care continuum as a system and exploring system vulnerabilities that can result in patient harm, reporting of adverse events and close calls, and emphasizing prevention rather than punishment as the preferred method to mitigate system vulnerabilities and reduce adverse events.

It is the patient safety officer’s responsibility to coordinate and manage an integrated patient safety program for the facility. This includes consultation with clinical services, management of the NCPS goals, data tracking for efficient processes and resource planning, oversight and training for medical center staff, and active involvement with the VISN 16 patient safety officer.

Some of the patient-safety concerns at the facility included lack of consistent patient identification conducted by staff, 35-40 aggregate medication errors over the past year, and challenges with labs, pharmacy, near medication misses and medication reconciliation.

**Utilization Management**

The UM coordinator reviews admissions and continued stay for appropriateness, attends interdisciplinairy team meetings, identifies trends, compiles, analyzes, and reports data to the Clinical Standards Committee, director, and quality management and performance board, and reports findings to patient safety and risk management departments as needed.

The UM coordinator’s initial training consisted of facility-level training and formal classroom training. During the second year, the UM coordinator attended formal training to become an IQCI and annually recertifies with training. Two measurement tools used by the facility to improve quality of care and patient satisfaction are the National Utilization Management Integration System and McKesson Interqual Criteria to identify a safe and appropriate level of care. McKesson’s Interqual Criteria also are used to identify over- and under-utilization of services which can impact quality of care.

**Risk Manager**

The RM’s responsibility is to ensure that the patient care provided to veterans is of the highest quality. The RM advises the organization of any potential risk to quality of care that exists in the health-care system, such as threats and hazards, and aids in the development of plans to mitigate such risks. Other additional duties include:

- Reporting adverse events to external customers and stakeholders;
- Facilitating the implementation of health and safety measures to limit risks and prepare in the case something goes wrong;
- Conducting audits of policy and compliance to standards; and
- Providing support, education and training to staff to build risk awareness in the facility.

The RM has a background in nursing and several years of both clinical and administrative experience in the provision and oversight of medical and nursing services. The RM at the facility has attended numerous conferences, training and continuing education on managing risk in a health-care setting.

The RM uses various tools to analyze workplace and environmental factors that contribute to health-care risk and quality of care within the organization. Data such as patient-satisfaction scores, mortality rates and established clinical monitors are used in determining if and where the organization may be at risk for not meeting quality patient standards. Established monitors and risk-management tools allow the RM to prioritize risk factors and determine multiple or singular risks that impact the hospital. When performance scores fail to meet the expected benchmark, the appropriate service chiefs and program leaders are consulted in an effort to improve operations.

**System Redesign Manager**

The system redesign coordinators facilitate performance improvement at VAGCHCS, including clinical and administrative practices. Performance improvement is integral to ensuring high-quality systems, which affects patient satisfaction. The facility’s system redesign coordinators use several measurement tools on a regular basis, including variability analysis, queuing, statistical process controls and most Lean tools (time studies, environment (spaghetti) diagrams, etc.) as part of their daily
work. These tools allow them to more specifically identify areas for process improvement.

**Chief Health Medical Information Officer/ Clinical Lead for Informatics**

To ensure patient quality in health information management, the facility has coders, release of information management and scanning. Their coding documentation is used to see trends in patient care, so the facility can focus on areas of need for their population and look at services needing to be provided. Their release of information clerks are trained on how to communicate with veterans to assist them with their information needs, which helps increase satisfaction and clear communication. HIMS staff reviews documents that are being scanned into the patient’s record for appropriateness, with approval of the clinician.

**Patient Satisfaction**

VAGCVHCS continuously measures patient satisfaction by monitoring various data elements that are reviewed in both the Patient Satisfaction Committee and the Customer Service Board. The facility also has a system redesign project to evaluate consolidation of the Customer Service Board and Patient Satisfaction Committee, which essentially have similar functions.

On the last SHEP performance scores from December 2011 to January 2012, there was a decline in scores for inpatient questions on communication about medications, communication with nurses, discharge information, overall rating of hospital, responsiveness of hospital staff and an improvement in pain management. There was a decline in scores for outpatient questions on how well doctors/nurses communicate, overall rating of health care, rating of personal doctor/nurse, pharmacy pickup, and an improvement in scores in provider wait time and pharmacy mailed. The measures that have been taken to address improvements in these areas are development of “ICE—Keeping Cool When Tempers Get Hot,” questionnaires in the outpatient arena, questions regarding communication added to the post-discharge calls, addressing customer service in the annual staff meeting, identification of patient advocates and representatives by facility on an electronic bulletin board, recruited volunteer to assist in the patient advocate’s office, recruited additional veterans to serve on committee, and a new chairperson of the patient satisfaction committee. Another concern expressed by the facility was the delays with the SHEP survey. The SHEP results are six months behind, and a short-term survey/assessment tool is needed to measure patient satisfaction.

**Director of Patient Care Services**

VAGCVHCS does not have a dedicated director of patient care services position; however, all service chiefs are responsible for ensuring their staff communicates with patients and their families in a professional manner, to foster participation in decision regarding patient’s care.

**Patient Advocate/ Patient Care Coordinator**

Patient advocates at the facility define patient satisfaction as an evolving culture that engages all staff at all levels in meeting their patient’s expectations to the best of the facility’s abilities. The patient advocate’s duties are to meet with patients and their family members to assist them in closing the gaps between the service/s they received and the services they expect. When necessary, the patient advocates provide education on the various programs of which the veterans may be unaware.

Patient-satisfaction indicators and measurements are tracked through the Patient Satisfaction Committee and reported into the Customer Service Board and Performance Measures Committee. VAGCVHCS's last SHEP survey results were released in January 2012, and the facility ranked below the peer, VISN and national groups for overall outpatient rating of health care. The facility ranked above the peer group, but below the VISN and national groups ranking, for overall inpatient.

There are three dedicated patient advocates at the facility. The staff assistant to the chief of staff directly manages two patient advocates in Biloxi. Each of the CBOCs have identified representatives who have customer service expectations in their position descriptions: Biloxi, Miss., Medical Center (two patient advocates); Mobile, Ala., CBOC (one administrative officer and one medical administration service supervisor (MAS)); Pensacola, Fla., (one patient advocate and two MAS supervisors); Panama City, Fla., CBOC (one administrative officer and one MAS supervisor) and Eglin, Fla., CBOC (one administrative officer and one MAS supervisor).

There is mandatory, ongoing training for all employees in customer service. The training is tracked through education and service. Written complaints and patient concerns are logged into a master tracking database and assigned to the service/section responsible for addressing these concerns. The formal written response is returned to the executive office for review and final signature by the director. Verbal complaints are usually managed by the patient advocates who enter these complaints into the PATS. The facility follows VHA Handbook 1003.4, which provides guidance on
timely response to patient complaints. It is expected that complaints will be addressed as soon as possible, but no longer than seven days after the initial compliant. If more time is required, an extension may be requested and ongoing status updates must occur.

One of the concerns identified during the town hall meeting was the facility patient advocates were not representing veterans, and, in many cases as well as during the site visit presentation, a facility patient advocate said many of the veterans’ problems were their own fault for not communicating effectively with their medical providers. The patient advocate was reminded that in their position and role, they represent the medical center leadership, and veterans must always be provided with courtesy and professionalism. Another issue identified by the facility was that patient advocates were needed at the outlying CBOC, but those positions have not been authorized because the leadership of the medical center believes that it is everyone’s responsibility to be patient advocates. In the short term, the facility is looking at training volunteers to serve in these positions which will help by having veterans representing fellow veterans.

**Patient Aligned Care Team Coordinator**

The duties of the PACT coordinator include ensuring that all facets of the PACT program are rolled out to the 48 primary-care teams of the Gulf Coast. The duties involved range from ensuring phone systems and communication tools are in place, and ensuring veteran outreach occurs, to the management of the performance metrics and team training for Central Office functions. Programmatically, there are three employees at the facility that work specifically on PACT, including an acting chief of primary care (currently vacant with plans to hire this position in September), primary care management program analyst, and the primary care management module. In addition, all CMOs/AOs and nurse managers in primary care are responsible for rolling out PACT initiatives to the teams. Indirect support for PACT also comes from the Health Promotion Disease Prevention Department, women veterans’ program coordinator and the health behavior coordinator. A steering committee at the VISN level is in charge of the PACT Steering Committee at the facility. There is not a facility-level PACT committee in place. The facility has a Primary Care Council that meets monthly. There are no representatives from the veterans community that are involved in the facility’s PACT planning process or meetings. The facility currently is developing a culture assessment and training since the last mandatory staff training was 18 months ago. The training will be facilitated by student groups to help the facility improve the culture and leadership of the staff.

**Town Hall Meeting**

The System Worth Saving Task Force conducted a town hall meeting at American Legion Post 1992 in Gautier, Miss., on May 20. Approximately 35 veterans were in attendance. Several concerns were identified with the VAMC, including primary care and specialty care appointments, service connection not being identified for fee basis appointments, veterans receiving nursing home care at the facility were not being bathed, medication errors, health care concerns fall on deaf ears and lab results were mixed up due to not checking proper identification of veterans. All of these concerns were addressed during the site visit with the medical center leadership.

**Recommendations**

- The facility should continue to improve on its phone system and scheduling for appointments. It is recommended that the facility decentralize the scheduling process and assign veterans respective PACT teams with the responsibility to send an introductory patient letter with contact information for the PACT team, and the PACT scheduler make all of the veterans appointment (personalize letters and reminder appointment calls with contact information for the PACT team).

  The SHEP results are six months behind, and a short-term survey/assessment tool is needed to measure patient satisfaction.

- A national ID card should be given to any enrolled veterans, with a barcode and/or fingerprint ID process to ensure patient identification

- The facility should have refresher training on quality and patient-safety issues quarterly on patient identification, labs, pharmacy and medication reconciliation to ensure these common errors are not recurring.

- Representatives from the veterans’ community should be involved and serve as a member of the facility’s Customer Service Board and Patient Satisfaction Committee meetings.
Background
In FY 12, 3,200 FTEE was authorized; 2980 are being shared between the Portland and Vancouver VAMCs. The RN to patient ratio is 1-4 and in Long Term Care 1-2. Vancouver has 12,000 unique patients, 72 beds for long-term care and for transfer of critical and acute patients, and 36 domiciliary beds. There is a waiting list for beds, but not for domiciliary beds. The total budget for FY 11 was $644 million and $670 million in FY 12. This includes OIT, research, regional counsel and all med-care appropriations.

Quality of Care
At the Vancouver VAMC, quality is defined as providing appropriate services at the right time and in the right place to maximize health outcome for patients. There is collaboration with all departments, including the patient advocate, to ensure quality throughout the facility. Quality is monitored through the use of performance measures and surveys, including SHEP and Press Ganey that keep the facility in check. By using surveys the facility is able to gain the perspective of the veteran, which is then disseminated to the staff through the use of committees. There are 30 committees directed towards quality of care. Any provider who is not meeting performance measures will be expected to develop an action plan to address deficiencies.

Quality Manager
The quality manager oversees major accreditation preparation/site visits, including JC, OIG CAP and CARF; with continuous readiness, risk management, performance monitors, cancer data center, credentialing and privileging OPPE/FPPE data collection, RCA and HFMEA participation with patient safety program, chart review data collection for VHA and Joint Commission monitors, performance-improvement activities (includes annual poster fair, strategic performance, improvement forum, PI support on hospital committees and divisions/services), education on tools, track and maintain all hospital-wide policies (medical center memorandums), and controlled substance program.

With all the time spent on meeting performance measures and adhering to the requests from OIG, CARF and the Joint Commission, not enough time is left to dedicate to personal engagement with patients. Implementation of the PACT program has been a difficult process due to staffing shortages. Performance measures are not being met on a consistent basis. Currently, there is a vacancy for the system redesign management position. Therefore, all duties and responsibilities are delegated equally to all management staff. It is a challenge to manage the quality program and be tasked with system redesign responsibilities as well, and it is imperative that the position be filled as soon as possible.

Patient Safety Officer
The goal of Vancouver’s patient safety program is to reduce or eliminate harm to patients as a result of their care. This program has a direct relation to quality of care. The degrees to which health services increase the likelihood of desired health outcomes are consistent with current professional knowledge.

Vancouver VAMC maintains a “blame-free” culture throughout the facility to ensure employees are encouraged to report possible events. There is an anonymous reporting system for those employees who wish to report an event without having to give their name. All RCAs are completed within the 45-day mandate, and all errors are disclosed to patients, increasing transparency throughout the program and facility. Approximately 1,000 events are reported annually, consisting of medication errors, falls and patients that go missing.

Recruiting and retaining top talent is an ongoing challenge throughout VA. Most notably, the PACT program is unable to meet performance measures due to short staffing. To provide the highest quality of care and maintain patient safety, more staff should be added.

Utilization Manager
The Vancouver VAMC uses a number of indicators to evaluate the quality of care being provided, including readmission rates, variance data from UM software, time on divert, OMELOS, length of stay, patient-satisfaction data, and one-day lengths of stay.

The Vancouver utilization management program serves as the point of contact for the VISN for post-discharge calls. When a veteran is discharged, he/she is contacted and surveyed in regards to their recent visit to the VAMC, including quality of care. Through the post-discharge call program, the following changes were made: improved meal services, new TVs with more channels, wireless Internet, implementation of noise-free “quiet” areas, and adding additional pharmacists. Compliments from post-discharge calls led to initiatives to change pain management.

Risk Manager
The Risk Managers work under Quality & Performance Service and are facilitators of change by networking within the Vancou-
ver VAMC. Their responsibilities include: examining multiple risk categories and projects, and reporting how a given risk might have implications for the entire organization; collaborating with the patient safety program to assist with focused reviews; root cause analyses and health-care mode effect analyses, participating in various medical center committees that deal with risk, such as Peer Review, Code, and Ethics; collaborating with interdisciplinary groups when writing hospital-wide policies; and reviewing occurrence screens. All readmissions are reviewed to include readmissions within 10 days of discharge, admissions within three days of a clinic visit, returns to surgery, inpatient deaths, outpatient deaths, suicides and suicide attempts.

Any readmission within 10 days of discharge requires a peer-to-peer review.

Chief Medical Information Officer

The Vancouver VAMC is VA’s leading facility for innovation and the use of technology to improve the quality of care. Technology is used to ensure quality of care by building decision-support tools into the electronic medical record. Computers allow the facility to guide clinicians to make decisions based on the best evidence by displaying it to them at key points in the clinical process. Providers now are using secure messaging through My HealthyVet to communicate with their patients, and that result in improved efficiency, quality of care and patient satisfaction.

Patient Satisfaction

The Vancouver VAMC defines Patient Satisfaction as an outcome measure of quality. Patient satisfaction is measured using a variety of programs and initiatives, including the PATS, the director’s weekly morning meeting, and the Patient Satisfaction Committee that meets quarterly and semi-annually. The facility also uses SHEP and Press Ganey. Unfortunately data from the SHEP scores take an average of four months to be obtained, whereas Press Ganey data is provided in an average of 30 days. Furthermore, data from SHEP is very broad. It was explained that receiving data from SHEP is like trying to take a sip of water from a fire hose.

Director of Patient Care Services

The director of Patient Care Services is responsible for the professional practice of 950 nursing staff at the medical center’s two campuses and eight CBOCs, and for Critical-Care, Critical Care Medicine, Medical-Surgical Units, Emergency Department, Emergency Medical Services, Nursing Research, Nursing Professional Services, Escort, IV and PICC Teams, Respiratory Therapy, Utilization Management, medical center education, pharmacy, Food and Nutrition Services, Imaging, Laboratory Services, Audiology, Speech Pathology, Chaplain and Social Work Services. Patient Care Services represents a total of 1,100 employees and a budget of $152 million. Within Patient Care Services are 19 unit-based councils; each council has a chair, minutes and goals. Patient satisfaction is reviewed in each unit. Data comes from two-year strategic plans. There are also nursing committees that discuss research, professional practice, quality care, education and best practices.

Patient satisfaction is tracked through using Daily surveys, Focus Groups, telephone responsive survey, SHEP and Press Ganey. The Vancouver VAMC is a Magnet Facility, a designation from the American Nurses Association for prestigious work in nursing excellence. Unfortunately the Magnet accreditation does not recognize the SHEP scores as validation for excellence in quality of care.

Patient Advocate

The PA captures what veterans are saying through surveys and private meetings. Each time a veteran communicates a concern to the patient advocate it is entered into the PATS system. Surveys and anecdotal testimony are used for improving patient satisfaction. Currently Vancouver employs four Patient Advocates and one Patient Relations Officer. By posting information throughout the facility and conducting an orientation, new patients are made aware of the patient advocacy program. To increase outreach the patient advocate also works very closely with VSOs to assist in getting the word out regarding VA health care and the patient advocacy program. Patient advocates may be met in person or by telephone. Once the PA is contacted, he/she must resolve the issue within seven days. Veterans who leave a message at the PA office are usually called back within one day; however, if a veteran is not called back, he/she has no idea when the issue will be resolved or if it is being addressed. This is an issue the medical center acknowledged and said would be addressed.

Patient Aligned Care Team Coordinator

PACT leadership and other PVAMC stakeholders attended the National VA Summit in Las Vegas in April 2010, where this transformation was launched. They selected a core PACT Traveling Team from the Hillsboro CBOC to participate in
the subsequent sixth national PACT Collaborative where the core team learned the foundational concepts (i.e. building blocks) of PACT and the skills they needed to implement PACT in their home setting in primary care. They also traveled to another 10 sites of care, educating staff, PCD leadership and the Oversight Board on what they had learned.

**Recommendations**

While meeting with the Vancouver staff, a concern was raised regarding a provider who had been deployed to Afghanistan but was still being assigned patients. This issue was brought to the attention of the executive staff, who promised to address the issue, which could have been a simple miscommunication. Either way, it should be clarified to ensure proper information is being disseminated.
Background

VA’s San Diego Healthcare System (VASDHS) is a complexity level 1A medical center located in La Jolla, Calif. The VASDHS is part of VISN 22, the VA Desert Pacific Healthcare Network Care Network that includes five medical centers. The VASDHS and its five CBOCs serve more than 235,000 veterans residing in the San Diego and Imperial Valley counties in southern California.

The medical center has 2,500 employees – 950, or 38 percent, being veterans – who provide quality, safe patient care to their veteran community. Currently, there are 637 FTEEs RNs and LPNs. The VASDHS’s Nursing Department uses the VHA staffing methods in order to ensure proper patient to nursing care ratios. The VASDHS currently has a 4.1 percent turnover rate of its nursing staff.

The budget for the VASDHS for FY 2011 was $537 million, while the 2012 budget is approximately $550 million. All of the VASDHS position descriptions have a patient-entered care component in them that is directly tied to quality. However, the Executive Leadership Team, the Performance Improvement Management Service, systems redesign, patient-centered care and the Patient Advocates Office have been viewed as the facilitators for the health-care systems quality-of-care programs. The dedicated salaries for this quality-of-care focused group equates to approximately $2.85 million, or .518 percent of the VASDHS budget for FY12.

QUALITY OF CARE

Background

The VASDHS defines quality of care as doing the right thing, for the right patient, at the right time, all while maintaining, restoring, and/or improving the health outcomes of individuals and populations. The mission and the priority of the VASDHS is to maintain the aim of providing compassionate, high quality of care to the nation’s veterans. The health-care system measures and manages quality in several ways, including tracking a variety of clinical and administrative performance measures established by the VHA as part of the 2012 Executive Career Field Performance Plan, which includes measures from VISN 22. The VASDHS service chiefs, supervisors and staffs have these measures incorporated into their performance plans and evaluations. Also, the quality-of-care measures also are communicated down from the VA Desert Pacific Network FY 2012-2017 Strategic Plan. performance measures are reviewed and analyzed on
a monthly basis at the medical center level and at the VISN level on a quarterly basis. When performance measures are not met executive leadership requests updates on the action plans for the underperforming performance measures. The medical center demonstrates and maintains accountability for quality of care at the medical center by having a champion for each performance measure. Each of these champions is responsible for meeting the measure that is reasonable for the veteran.

The VAOIG Office of Healthcare Inspections conducted a CAP review at the VASDHS on January 6. The CAP reviewed the effectiveness of patient-care administration and quality management within the VASDHS. The CAP review covered eight activities: coordination of care, colorectal cancer screenings, EOC, medication, management, moderate sedation, polytrauma, psychological rehabilitation and recovery centers, and quality management. All of the recommendations were addressed in the facilities response to the VAOIG.

The VASDHS had a JC accreditation inspection on October 18–22, 2010. The VASDHS was surveyed in hospital, behavioral health, long-term care and home care. The health-care system received 12 RFI’s, including three in moderate sedation, one in quality management, three in colorectal cancer screening and one in polytrauma. All of the RFI’s regarding quality of care was addressed in the Evidence of Standards Compliance and Measures of Success documents that were submitted to the JC. Currently, all of the RFI’s have been addressed, and the medical center has received a three-year full accreditation in all of the programs that have been surveyed. The VASDHS next announced JC survey is due in 2013.

**Quality Manager**

The QM, or the chief of the performance management service, is mainly responsible for providing the leadership, coordination, and technical assistance that is necessary for providing an effective and comprehensive performance-improvement program that is integrated and interdisciplinary. The VASDHS quality manager also has oversight responsibility for all performance improvement, risk management, patient safety, external peer-review programs, continuous readiness programs, and the preventive ethics and accreditation program. The QM at the VASDHS measures and tracks quality of care, providing quarterly detailed data analysis that includes trends and information on changes to the clinical performance measures to executive leadership, clinical service chiefs, and performance improvement teams at the medical center. The QM at the medical center on an annual basis updates all of the clinical reminders to reflect the performance measures in order to provide frontline staff the tools needed to provide timely and quality care to their veteran patients.

Some of the significant challenges consist of staff coverage in order to attend quality programs training, an overload of information from the VA that gets disseminated down, too many performance measures to measure and quantify; the adding more performance measures and never removing the old performance measures; the performance measures have arbitrary targets; and too many accreditation surveys that cover the same topics, creating a lot of time for follow-up and impacting staff’s ability to perform its bedside role.

**Patient Safety Manager**

The VASDHS defines patient safety as a systems approach to the understanding and mitigating vulnerabilities to reduce and prevent inadvertent harm to patients as a result of their care. The health-care systems’ goals for their patient safety programs and initiatives are focused on achieving this goal. The VASDHS PSM is responsible for working with staff throughout the medical center and it’s affiliated CBOCs to develop innovative, evidence-based approaches in order to enhance, establish, modify and improve patient-centered care focusing on patient safety. The PSM also is responsible for developing and managing the health-care system’s patient safety program in accordance with national accreditation and regulatory agency requirements. Being a PSM at the VASDHS also includes overseeing the electronic Patient Event Reporting system, which includes close calls and actual patient events; coordinating and RCAs; aggregate reviews from the RCAs; reviewing HFMEA which is a proactive risk analysis that identifies potential system failures in an effort to implement processes to alleviate the failures from occurring; providing annual patient safety reports to leadership; oversee-
Ensuring the Best Health Care for Veterans

The UM coordinator manages the flow of services that are offered at the V ASDHS. The main responsibility for the UM coordinator at the V ASDHS is to oversee the entire utilization management program, which involves utilization review, transfer center, nurse case managers, escort service and the lodging program. The UM coordinator manages the flow of VISN 22 surgical referrals through the VASDHS and serves as a referral hub for coordinating non-VA care for veterans with special needs, such as radiation/oncology, organ transplantation and the placement of mental health patients. The UM coordinator uses the NUMI system as a measurement tool to improve quality of care and patient satisfaction. From the NUMI system data, the VASDHS generates reports on a daily basis to analyze placements, treatments, diagnoses, lengths of stay and other issues affecting quality of care. The information and data that is gathered and brought to the Performance Improvement Committee, Medical Executive Committee and executive leadership, where changes are followed and monitored through access and satisfaction scores. The challenge and or daily concerns for the UM are not having enough regular beds (medical/surgical) and specialty beds (mental health etc.) for their veteran population, or having an appointment time available when a veteran requests one.

Risk Manager

The RM at the VASDHS serves as the subject matter expert on all of the VHA’s risk-management program and its requirements. The RM at the medical center and affiliated CBOCs provides advice and support to the staff, and directs the development and maintenance of programs designed to reduce risk at all levels within the medical system. The RM provides educational assistance, consultation to the clinical staff, and policy development/implementation in an innovative, evidence-based approach in order to enhance, modify and improve the quality of care with a focus on risk management. The RM’s major responsibilities also include disclosure related to adverse events, protected peer review, and administrative tort claim coordination. The RM also participates and initiates performance-improvement activities in order to improve patient experiences and outcomes. The challenge for the RM is the enforcement by all management staff to adhere to the disclosure policies and procedures for all of the patients as it relates to all aspects of their health care.

System Redesign Manager

The SRM at the VASDHS is responsible for providing direction to systems improvement, strategies and initiatives throughout the medical center. The SRM ensures that all projects are fully integrated with quality improvement and patient-centered care in order to enhance quality and access to care. The SRM’s duties also include collaboration with medical center staff to collect and prepare data for the monitoring and reporting of quality performance measures; providing recommendations for improvement of work methods, procedural changes and new technologies; and participating in meetings and conferences related to quality of care; and coordinating the initial and ongo-

Utilization Manager

The UM coordinator oversees a program that is involved in placing veterans in the appropriate beds that meet their healthcare needs. Part of the responsibilities of the UM coordinator and staff is to transfer veterans into the VASDHS from the community and other VA facilities. The UM coordinator at the VASDHS also work closely with VISN 22 facilities, DoD, OIF/ OEF and all veterans across the country seeking specialty care services that are offered at the VASDHS. The main responsibility for the UM coordinator at the VASDHS is to oversee the entire utilization management program, which involves utilization review, transfer center, nurse case managers, escort service and the lodging program. The UM coordinator manages the flow of VISN 22 surgical referrals through the VASDHS and serves as a referral hub for coordinating non-VA care for veterans with special needs, such as radiation/oncology, organ transplantation and the placement of mental health patients. The UM coordinator uses the NUMI system as a measurement tool to improve quality of care and patient satisfaction. From the NUMI system data, the VASDHS generates reports on a daily basis to analyze placements, treatments, diagnoses, lengths of stay and other issues affecting quality of care. The information and data that is gathered and brought to the Performance Improvement Committee, Medical Executive Committee and executive leadership, where changes are followed and monitored through access and satisfaction scores. The challenge and or daily concerns for the UM are not having enough regular beds (medical/surgical) and specialty beds (mental health etc.) for their veteran population, or having an appointment time available when a veteran requests one.

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ing lean Six-Sigma training. The current and future projects that the VASDHS SRM is working on include improving missed appointments (no shows/cancellations from specialty clinics to include the post-traumatic stress disorder and physical therapy clinics) and currently creating a veteran-focused orientation in regards to increasing the veteran’s comfort level and experience regarding their individual health care at the medical center. The challenge for the VASDHS SRM is trying to figure out how to improve the overall work flow and having the time to analyze what can be done better to improve quality of care and patient satisfaction on a daily basis.

Chief Health Medical Information Officer

The VASDHS CHMIO or clinical lead for informatics works on clinical applications and software development to improve the overall medical center’s quality. The CHMIO also collects data on a monthly basis and manages the VA data repository for the VASDHS. The CHMIO utilizes the collected data to create and validate provider-specific data, as well as provide facility specific feedback to the medical center leadership. They also create automated reports that evaluate patients that are seen by their providers in primary care. These reports that are generated are used by leadership to quantify how often the medical center’s patients are seen by physicians and nursing in an outpatient and inpatient setting. The challenge that the CHMIO has is that the clinical reminder logic created by the physicians and/or nursing staff has to be consistent, accurate and specific to the diagnosis.

Women Veterans Program Manager

The VASDHS women’s health-care program is provided through primary care and provides comprehensive health-care services to meet the unique needs for the 9,000 enrolled women veterans that reside in its catchment area. In order to achieve excellent patient satisfaction and increased quality of care to its enrolled women veteran population, the VASDHS currently is building a new women’s veterans health clinic that will have its own dedicated wing of the medical center.

The challenge for the WVPM at the VASDHS is not having enough staff because of the integrated women’s health program within the medical center’s primary-care clinic. Currently, there is no administrative staff to support and assist the women’s veterans’ program manager with her administrative duties and responsibilities within the Program. As a result of the daily WVPM responsibilities and committee responsibility – such as steering committee, patient advisory committee, women’s health committee co-chair, summer sports clinic steering committee and cycling venue coordinator – the WPM does not have enough time to develop other programs to grow the women’s health-care program.

PATIENT SATISFACTION

Background

The VASDHS defines patient satisfaction as a health-care system through which their veterans feel they got great care, feel they were treated with dignity and respect, and would recommend the hospital to others as a result of their experiences. Patient satisfaction at the VASDHS is measured and managed through tracking quarterly results of the SHEP and the top three complaint issues that are presented to management at the Veteran Employee Service Council. The medical system uses the SHEP survey questions, scores and the reports generated from the PATS to track and measure patient-satisfaction outcomes. In FY 2011, the VASDHS has improved on three of the 13 SHEP measures for inpatient care and improved on seven of the nine SHEP measures for outpatient care. Patient-satisfaction indicators are tracked at the VASDHS by a number of committees and reviewed by the executive leadership on a regular basis. Patient satisfaction data and information is specifically reviewed at the monthly Veterans Employee Service Council and the monthly “One VA” and United Veterans Council meetings.

Director of Patient Care Services

The director of Patient Care Services at the VASDHS is also called the nurse executive of the healthcare system and is a vital member of the Executive Leadership Team. The responsibilities of the Patient Care Services director include personnel management for the clinical staff to include nursing, social work, nutrition and food, and the chaplain services. As a senior member of the executive staff, they are also responsible for budgeting, promoting and ensuring best health-care practices are being adhered to, strategic planning and the overall clinical oversight for timely and continuous quality and safe care that is delivered to their patients within the VASDHS. The director of Patient Care Services also has to adhere to the VHA directives for all programs and services, in addition to meeting all organizational and VISN performance measures for quality of care and patient satisfaction. If the executive leadership team identifies and/or if a performance is identified by the committee as not meeting the standard, the lead/champion is given the task of providing action plans identifying opportunities for improvement that are monitored until measures are met.

The challenges for the director of Patient Care Services at the VASDHS include the process to recruit nurses takes too long, there is no on-call for clinical staff at the medical center, and increased overtime in nursing as a result of having 57 open positions (27 on Family Medical Leave Act, light duty, and military commitments).
Patient Advocate

The VASDHs patient advocates define patient satisfaction as patients who feel they received great care, and all of the bureaucracy was minimized. The duties and responsibilities of the three patient advocates are to serve as liaisons between patients, the medical center and community clinics; act on behalf of the patient; and help veterans understand their rights and responsibilities as patients. The patient advocates also resolve problems by assisting veterans, family members and others in a timely and efficient manner to overcome obstacles within the medical center while working with the existing VA and VHA laws and regulations, and to work in an interdisciplinary approach to identify solutions to patient complaints. The patient advocacy department has patient ambassadors in services located throughout the medical center to assist veterans with problems that are experiencing with a specific service.

The challenges that the patient advocacy department deal with are not having the capabilities of being able to provide the necessities for homeless veterans and not having enough time throughout the day to follow their cases throughout the system. The patient advocate department stated the SHEP scores used by VHA do not report timely information causing difficulties for follow-up and action plans to be developed.

Patient Aligned Care Team Coordinator

The PACT coordinator is responsible for overseeing the interdisciplinary primary care operations for the VADSHS and its affiliated outpatient and contracted clinics. The PACT coordinator directly supervises the physicians who work in primary care and participates as the VISN leader for PACT, co-chairs the Primary Care Committee (meets monthly), and is a member of the VHA Field Advisory Committee for Primary Care. The PACT coordinator is responsible for 48.51 FTEE physicians and NPs (provides direct patient care); 95.2 FTEE nurses (provides intake and outtake of patients, care coordination, phone calls, and huddles); 33 FTEE clerical staff (does the scheduling and administrative tasks); 3.7 FTEE pharmacists (provides counseling, medication management, disease-specific titrations); four FTEE social workers (provides financial resources, disability, counseling); and four FTEE nutritionists (provides counseling).

The challenge for the PACT coordinator is mainly with the teamlet working within the PACT not collectively working together as a cohesive unit. The PACT at the VASDHs has no contingency plans for filling the nursing staff shortages as a result of leaving on short notice i.e. maternity leave and/or military deployments.

Veteran Town Hall

The town hall meeting took place at American Legion Post 434 in Chula Vista, Calif., on June 4. There were 25 veterans in attendance who are enrolled at the San Diego VAMC. The veterans stressed that they were really satisfied with the health-care services that they receive. The only major issue that came out of the town hall meeting that the veterans were mostly dissatisfied with was that the doctors in primary care cannot admit or re-evaluate veterans for new tests. For example, the veteran is sent back through the emergency department to be triaged and re-evaluated.

Recommendations

• The VHA needs to have a good succession plan in place for associate directors and/or senior leadership to be promoted to a medical center director for continuity.
• The VHA needs to streamline initiatives and performance measures and focus on the performance measures that effects veteran health care.
• As a result of the process being cumbersome, the VHA needs to streamline the process for recruitment of nurses and other clinical staff.
• The VHA needs to adopt one patient satisfaction survey tracking tool, making it easier to trend results that are constant and consistent.
• The SHEP scores data needs to be sent to VA medical facilities in a timely manner, rather than a three- to six-month wait, in order to evaluate “real-time” quality of care and patient satisfaction.
• The challenge for the RM is the enforcement by the management staff to speed up the process to disclose adverse events policies and procedures to all of the patients as it relates to all aspects of their health care.
Background

The VANCHCS serves more than 377,700 veterans in 17 counties. There are 463 RNs and LPNs as FTE. There currently is a sufficient amount of staff to patient ratio. The overall medical center’s budget for FY 2011 is $519 million and $529 million for FY 12. This is not including non-recurring maintenance and equipment. In 2011, 43 percent of the budget was dedicated to quality-of-care staffing and programs, but decreased to 39 percent in 2012.

Quality of Care

The VANCHCS uses the Institute for Healthcare definition for quality of care and is defined as, “an organized, systematic approach to planning, delivering, measuring and improving health care linking VHAs core values to the day-to-day operations while ensuring safe, effective, patient centered, timely, efficient and equitable care. Quality encompasses many interrelated activities that are the responsibility of senior leadership. These include, but are not limited to, quality assurance, performance improvement and measurement, patient safety, internal and external reviews and customer satisfaction, utilization management, risk management and systems redesign.”

In addition to the VA Performance Measures and Monitoring Programs mentioned above, VA Central Office, VISN 21 and VANCHCS have an ongoing review that processes both internal and external and continuously monitors the performance and delivery of care at each facility. Internal review is defined as an oversight group within VHS that surveys or monitors VHA performance or adherence to VHA policies and procedures. External reviews are conducted by private or other governmental agencies for the purposes of accreditation and/or monitoring of adherence to VHA policies or other federal laws and regulations. NCHCS participates in external audits by agencies such as OIG, CAP, CARF, FDA, OSHA, LTCI and JC. Additional internal audits are conducted on a recurring basis as well, including AWE, GEMS, VASQIP, SOARS and a VISN lead review team (VORP/GORP/HORP). Once the review or survey is completed, the QM collaborates with organizational leaders to develop, trace, track and monitor action plans to closure.

Quality Manager

The QM ensures that all components of the quality management system and patient safety improvement program are integrated. The QM has a systematic process in place for monitoring the facility quality data. Also, the QM serves as the quality consultant to the facility leadership, QI or PI teams, and employees. Lastly, the QM serves on executive committees and workgroups where quality data and information is reviewed, analyzed, and acted upon.

Challenges exist with keeping up with the amount of performance measures set by central office. The QM notes that in the year 2000 there were 11 performance measures; now there are more than 600. There are even performance measures for performance measures. The QM also notes it becomes unclear what they are measuring and why.

Patient Safety Manager

The patient safety manager ensures that the components of the Quality Management System and Patient Safety Improvement Program are integrate, and also implements and coordinates patient safety improvement programs based on guidance and tools from the NCPS and which meets the needs and priorities identified by the facility director. These include addressing important standards, requirements, and recommendations promulgated by the JC and other organizations working to improve patient safety.

Utilization Management

UM does 100 percent of admission and continued-stay reviews. The goal is to have the right patient at the right level of care at the right time with the right care provider. NCHCS has a very low average length of stay, freeing up beds at all levels for veterans needing hospital admission, minimizing the use of civil hospital admissions and providing optimal continuity of care. Quarterly data is aggregated, summarized and reported through Executive Nursing Council and QM. Particularly, the avoidable reasons are discussed and action plans are defined and acted upon, as able. UM reports any unusual documentation or potential risks/safety questions to QM or risk management, including admissions to non-VA facilities that may be from a complication of care received within the VA.
One of the challenges was that the UM does not track all the outpatient quality of care. The UM only track the financial aspect of sending a patient to an outside clinic, but have no indication of its quality.

**Risk Manager**

At VANCHCS, the risk manager is responsible for the Peer Review for Quality Management process. The peer-review process contributes to quality management efforts at the individual provider level and can result in both immediate and long-term improvements in patient care by revealing areas for improvement in the practice of one or multiple providers. This ultimately contributes to organizational improvements and optimal patient outcomes. Peer review encompasses multiple disciplines and requires active involvement from physicians, nurses and other allied health-care professionals who are required to exercise autonomous clinical judgment. The risk manager reviews the electronic patient incident reports and occurrence screens to determine if the patient event/occurrence meets the requirement for quality peer review. The risk manager is contacted by the facility clinical and administrative services to discuss risk assessments, including ways to mitigate risk in the individual programs. The risk manager collaborates with patient safety manager as a resource to members of the medical staff to perform disclosure to veterans and/or their families regarding adverse events. The risk manager works closely with the chief of staff and regional counsel when tort claims are filed by patients or their families.

**System Redesign Manager**

The SRD manager seeks to find ways to balance patient-care demand with available resources that provide that care. This individual incorporates other organizational programs and leaders in improving the way the facility delivers its care. VANCHCS currently is recruiting a process improvement/system redesign coordinator to oversee the PI activities, provide education, and serve as a resource to the organization on conducting PI project aimed at improving efficiencies of systems. Process improvement activities are embedded within quality management and throughout the services across VANCHCS.

**Chief Health Medical Information Officer/ Clinical Lead for Informatics**

The CIO directs the OI&T to deliver adaptable, secure and cost-effective technology services to VA and acts as a steward for all VA’s IT assets and resources. The CIO mission is to provide and protect information necessary to enable excellence through client and customer service.

The primary challenge is developing an infrastructure that is secure and having the ability to link data collected to quality. Not all services have the ability to funnel quality performance measures through informatics, allowing informatics to aggregate it and interrupt it.

**Women Veterans Program Manager**

The VHA standard for women veterans’ health care is complete, comprehensive primary care. Complete comprehensive primary care, by definition, should fulfill all primary needs, be provided by one primary-care provider at one site, and include care for acute and chronic illness, gender-specific primary care, preventative services, mental health services and complete coordination of care. A designated women's health primary-care provider should be on site, and exclusive space – a separate physical location for the delivery of primary care to women, not shared by male veterans – should be available, and military sexual trauma counseling should be provided. This is the standard for which all women veteran programs are measured.

The Sacramento VAMC consists of the main VA center and nine outlying CBOCs, located in McClellan, Redding, Chico, Yuba, Yreka, Fairfield, Mare Island, Martinez and Oakland. Two of these sites, Redding and Chico, are rural sites. Only three of the 10 sites – Chico, Redding and McClellan – provide comprehensive primary care. Of the three sites that provide comprehensive primary care, only one, McClellan, has a separate clinic and waiting area. The remaining sites that provide comprehensive care, Chico and Redding, provide mixed-gender primary care. The women’s clinic currently under construction at the Sacramento VAMC will have a separate clinic and waiting space for women veterans. Ongoing construction at the Marti-
nez CBOC will result in a separate waiting area and exam rooms for women veterans. The clinic at Yreka is a contract clinic with a family practice physician available, while the Fairfield clinic provides only women’s preventative health exams and breast surgery consultation. Two of the clinics, Oakland and Yuba, provide only women’s preventative health exams, and one clinic, Mare Island, provides nothing specifically geared to women’s health care.

With only three of 10 locations providing comprehensive primary care, and only one of 10 locations having a separate physical location for the delivery of primary care to women veterans, there is clearly room for tremendous progress in delivery of women’s health care within the Sacramento VAMC. Female patients seen at CBOCs must receive the same high-quality comprehensive primary care that is received by female patients at the parent facility; this is currently not available due to the limited services provided at several of the CBOCs. Dedicated women primary-care providers should be located at each site, as well as a women’s health liaison who coordinates and collaborates with the WVPM at the parent facility. This is not an option, as the current primary-care providers are over impaneled and there is no ability for panel reduction. Although this facility has been recognized for its Automatic Mammography Tracking Program, the UM –, who tracks all fee-basis mammograms (those contracted to an outside facility) – was unable to explain how fee-basis mammograms were tracked, whether the results were entered into CPRS at the requesting VA facility, or whether or not patients had received their results within the required timeline. It was clearly stated by UM that this information is not being tracked by UM. The chief health medical information/informatics officer, when asked how he tracked fee-basis mammograms stated, “That’s a good question.” He relayed that he was able to pull any reports requested, but this is difficult to imagine if the information requested is not tracked properly. The women veteran program manager, when asked to clarify the mammogram issue, provided a completely opposite picture. She identified the tracking mechanism used to order, track, and input fee-basis mammograms into CPRS, as well as how the mammogram records were audited to determine if result letters were provided within appropriate timelines.

**Patient Satisfaction**

Patient satisfaction as a health-care facility is defined as to give every veteran an outstanding health and healing experience. They want every interaction with a veteran to be positive and help facilitate each veteran’s health and healing. They also want to do all they can to include in a veteran’s experience, veteran’s family members and/or friends who provide support.

Patient satisfaction is measured by using SHEP scores (monthly reports) and PATS data (compiled monthly). Patient satisfaction is managed by the customer service manager and assistant manager, and is a key performance element of each employee’s standards.

SHEP scores and PATS data are the most current measurement tools used. They also plan on using focus groups for Veterans in FY 2012-2013.

These measurement tools are utilized to improve patient satisfaction from SHEP scores and PATS data are reported to monthly leadership forums, posted on the customer service SharePoint site, and relayed to staff members in town hall meetings to each site in VANCHCS several times per year. They are communicated to staff at all sites on a regular basis. They also identify areas that are scoring below expectations and look for ways to make improvements.

**Patient Advocate/Patient Aligned Care Team Coordinator**

The duties and responsibilities of the patient advocate are to provide a centralized and convenient means for patients to have their complaints and compliments addressed and processed.

The patient-satisfaction indicators and measurements are tracked and managed from patient complaints logged into the Patient Advocate Tracking System database, which is displayed on the Customer Service SharePoint site (monthly) and reported in monthly leadership forums. Service chiefs with significant amounts of patient complaints are notified and asked to identify and implement improvements.

The procedure for receiving patient concerns and/or complaint starts when the complaint is logged into PATS. The concern or complaint is addressed with a solution by the patient advocate or forwarded to the appropriate staff (front line or management) responsible for the assessment and resolution of the complaint. They are asked to resolve the complaint and contact the patient and the patient advocate with the solution(s). The patient advocate will then complete entry of the complaint in PATS.

One of the challenges is that the patient advocate is a full-time position but is pulled to other medical centers to assist other advocates. The other two advocates are part-time and have high turnover rates. Additionally, SHEP scores are almost the only indicators for measuring patient satisfaction, which are not an accurate measure of performance. The other way to track patient satisfaction is by comment cards, but few are filled out, so the sample size is too small.
Veterans Town Hall Meeting

A veteran’s town hall meeting was conducted on June 4th at American Legion Magellan Post 604. There were 17 veteran participants, all of which receive health care at the medical center. Most of the concerns were about the dental clinic. There were complaints that getting an appointment could take months, if at all.

Recommendations

- Additional patient advocates should be hired, as there is only one full-time position, and is pulled to other medical centers to assist other advocates. The other two advocates are part-time and have high turnover rates.
- SHEP should not be the only way of tracking patient satisfaction. The medical center should contract to private organizations such as Truth Point to gather more accurate data.
- A women’s health medical director should be appointed to oversee and coordinate the women’s health-care program, to establish priorities and to ensure implementation of mandated health-care requirements and to provide necessary recommendations to leadership for improving services for women veterans.
- The women veterans’ program manager and members of the Women Veterans Health Committee should be included in the formal review of all plans for renovation and construction to identify potential privacy and safety issues, as well as to ensure the accessibility of appropriate equipment for women veteran medical care.
- Additional women’s health primary-care providers should be hired to prevent over impaneling of current providers and to provide PCPs at each CBOC.
The American Legion | 2012 System Worth Saving Report

VA LONG BEACH HEALTHCARE SYSTEM  |  LONG BEACH, CALIFORNIA

**Date:** June 7, 2012  
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**Background**

The Long Beach Department of Veterans Affairs Healthcare System (LBVAHCS) is located in Long Beach, Calif. The LBVAHCS is part of VISN 22, the VA Desert Pacific Healthcare Network Care Network, which includes five medical centers. The LBVAHCS has 52,000 enrollees and serves more than 183,000 veterans throughout southern California.

The medical center has 2,226 employees, with 801.36 being veterans, who provide quality, safe patient care to their veteran community. Currently, there are 484 FTEEs RNs and 126 LPNs. The LBVAHCS’s nursing department uses the VHA staffing methods in order to ensure proper patient-to-nursing care ratios. The LBVAHCS currently has a .82 percent turnover rate of its nursing staff.

The budget for the LBVAHCS for FY 2011 was $442 million. The budget for FY 2012 is $439 million, a decrease of $3 million from FY11. However, in FY 2012, the LBVAHCS hired 30 FTEEs, which equates to $1.96 million of its annual budget that was allocated for its quality-of-care programs and initiatives. The LBVAHCS is responsible for providing high levels of quality of care and patient satisfaction through its staffing, programs and initiatives in order to ensure that all of the veterans’ needs and expectations are met.

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**QUALITY OF CARE**

**Background**

The LBVAHCS defines quality of care by creating an enterprise-wide culture that mitigates and proactively prevents organizational risks while making every patient’s experience safe, risk-free and informative. The LBVAHCS believes that quality does not exist without safety.

The health-care system measures and manages the effectiveness of its quality-of-care programs and initiatives through internal and external programs such as executive career fields, network directors’ performance plans, external peer-review programs, clinical performance measures, and quality-of-care councils and committees. The entire LBVAHCS staff are involved and responsible for quality activities. The health-care groups and service/section chiefs of the health-care system are responsible for the managing and tracking of all quality care programs and initiatives within their own individual service sections and/or departments. The LBVAHCS service/section chiefs also are members of the health-care system’s quality council and committees that are responsible for the tracking of data and information in order to improve the overall health-care system’s programs and initiatives in regards to quality of care. The councils and committees at the medical center that are quality-of-care focused are the Organizational Excellence Council; Accreditation and/or Continuous Readiness Committee, Patient Safety Committee; Performance Measures Committee, Risk Management Committee, Utilization Management Committee and Executive Leadership Board. The LBVAHCS has veterans participating on the PACT Development Committee, Designing New Spaces Committee and Patient Centered Care Steering Committee, and are involved in new-patient orientation. The LBVAHCS offers initial quality-of-care training to their employees through several training days and sessions that include new employee orientation and new supervisor training.

The Department of VAOIG Office of Healthcare Inspections conducted a CAP review at the LBVAHCS on Sept. 22, 2010. The CAP review focused on QM, EOC, Reusable Medical Equipment, Magnetic Resonance Imaging safety, Physician Credentialing and Privileging, Medication Management and Coordination of Care. The LBVAHCS had a JC accreditation inspection on February 10, 2010. The LBVAHCS was fully accredited in hospital, behavioral health, long-term care and home care.

An ongoing challenge that still exists for the LBVAHCS is the way the medical center communicates and distributes patient information in a timely and effective manner.

**Quality Manager**

The chief quality management department for the LBVAHCS is responsible for the planning, designing, integrating, implementing, modifying, and evaluating of the overall health-care system’s quality management program. The quality management program reviews services for the overall monitoring, measurement and improvement of the quality of patient care and the effectiveness, appropriateness and timeliness of the health-care services that are provided. The quality management service chief, an RN, manages the operations of the quality management department on a daily basis, working very closely and effectively with all levels of the medical center staff to include collaborative efforts with other medical center health profes-
The Quality Management (QM) provides expertise in quality-of-care methods that include providing leadership and guidance in improving patient care, maintaining standards of care; and directing and teaching personnel in a variety of settings.

The challenges for the LBVAHCS and the quality management department are the amount of surveys (approximately 100) that are conducted by national accredited and governmental agencies. Another challenge is due to the medical center always being in continuous readiness and/or survey mode, the staff is continuously concentrating on only meeting the survey measures that are required, shifting the focus away from providing quality patient care.

**Patient Safety Manager**

The LBVAHCS PSM has overall management responsibility for all patient-safety activities. Their specific responsibilities include coordination of all activities that are related to adverse events; overseeing the investigation, reporting and analysis of patient safety and adverse event data and information; facilitating and overseeing the RCA process for the health-care system; initiating and/or recommending systems and process improvements to improve patient safety activities under the medical center director’s direction; referring significant system problems to leadership and the system redesign teams; referring significant cases to risk management for review; ensuring compliance with VA and other regulatory mandates; maintaining official files of all adverse event-related reviews and investigations; maintaining patient incident reports database; tracking, trending analyzing and timely reporting of reviews for the NCPS, VISN Quality Management Office and the JC; and educating health-care system staff in the Patient Safety Improvement Program. All staff at the LBVAHCS shares the responsibility for the awareness and abiding of all of the medical centers patient-safety issues, policies and procedures.

The challenges that the PSM faces are that inputting and reporting near misses and patient safety data into an antiquated system like the VISTA computer system. Some of the PSM information at the medical center is still done for the most part by paper and pencil, which increases the chances for errors.

**Utilization Manager**

The LBVAHCS utilization management coordinator’s responsibilities in regards to quality of care and patient satisfaction consist of supervision of all UM staff nurses and reviewers, co-chairing the health-care system’s UM Oversight Committee, leading weekly UM staff meetings and serving as a member of the VISN 22 UM committee. The UM coordinator has UM nurses attend and participate in daily interdisciplinary medicine and behavioral health rounds that occur on the unit or at the bedside. The measurement tools that the UM utilizes to improve quality of care and patient satisfaction are NUMI software, which automates UM assessments and outcomes which are utilized for data analysis; evidence-based criteria in order to perform screenings; improved quality-of-care results from the right care, right patient, right time and for the right reason methodology; and UM reports that are generated locally and from the VISN.

The challenge that the LBVAHCS UM coordinator has is with the NUMI. The current software program has glitches that cause inaccuracies of documentation. The software needs to have the capabilities of allowing the physicians to document recommendations in the medical records where the providers at the bedside can read their notes.

**Risk Manager**

The LBVAHCS RM responsibilities in regards to quality of care and patient satisfaction consist of: the coordination of the protected peer-review process and committee, identify opportunities for improvement through analysis of trended data to communicate with responsible parties of their individual findings, report analysis of aggregated and or trended data to the Medical Executive Committee, and to orientate and serve as a resource to the protected peer-review coordinator. The RM also uses the analysis of the protected peer-review data and information to identify trends for establishing timelines, educational and training opportunities for staff, and the ability to provide recommendations to the providers and/or committees for actions. The improvements that could be made with the process and with the overall quality of care and patient satisfaction at the VAMCs is the way they utilize the information through automation.

The challenge for the LBVAHCS RM is that there is inadequate training for risk managers due to the technical aspects of the job, which can put the medical centers at risk. The RM at the LBVAHCS medical center has too much data entry, which takes
away from reviewing quality within the veterans medical records. The RM at the LBVACHS does not have an automated risk management program to use. They are currently extracting information and/or data from a 150-line spreadsheet, which is not user friendly.

**System Redesign Manager**

The LBVACHS SRM responsibilities in providing quality of care and patient satisfaction are to review outcomes and patient satisfaction through different measures, identify problems in areas that are not performing at a high quality, and develop systems to improve the health-care system's overall quality of care. The mission of the LBVACHS SRM, through systemic improvements, is to reduce delays, decrease errors and improve communication surrounding patient care. The system redesign manager believes that measurement tools that the medical center uses to quantify quality of care and patient satisfaction are critical to any type of quality-improvement projects that affect the health-care system. The health-care system uses measurement tools as a baseline to assess their quality-of-care programs and initiatives that are being performed at the medical center and affiliated CBOCs. The SRM management at the LBVACHS is engaging all staff in system redesign. In order to reduce fee-basis within the LBVACHS, the SRM and its team developed a bed management system to track veterans across VISN 22. This initiative will ultimately increase inpatient care (hospital stays) and reduce sending veterans out into the community to receive their health care (fee-basis health care).

**Chief Health Medical Information Officer**

The mission of the CHMIO at the LBVACHS is to assist all clinical providers in supplying veterans with excellent quality of care. The CHMIO is responsible for importing and developing evidence-based tools for clinical decision support that relates to clinical reminders, external peer review standards and the JC core measures. The CHMIO also creates and generates monthly reports on quality measures in order to deliver feedback to providers and supervisors.

The main challenge for the CHMIO at the LBVACHS is that the VBA medical assessments are not available to primary-care physicians with the VHA.

**Women Veterans Program Manager**

The WVPM at the LBVACHS women veterans’ health clinic is responsible for offering primary care and specialty care to more than 4,100 enrolled women veterans residing in Los Angeles and Orange Counties. The WVPM’s responsibilities include providing services/health-care access, education, monitoring performance monitors, outreach, environment of care, monitoring staffing and space, and monitoring the internal PACT within the women veterans’ health clinic. It is the overall responsibility of the WVPM to review, analyze and recommend changes to improve the overall care for women veterans. The WVPM also is responsible for all of the performance measures that relate to women’s health, including breast and cervical cancer screenings, mammography screenings, osteoporosis screenings, military sexual trauma screenings; ischemic heart disease screenings and pneumonia vaccine screenings. The WVPM measures and tracks quality of care and patient satisfaction by: performance measures that are gender-specific and tracked, measured and discussed at the Performance Measures Committee and has members throughout the medical center and at the clinical level represented by the women health champions in the PACT, primary care and women veterans health clinic; and satisfaction surveys and feedback from patients and family via the Women Veteran Assessment Tool for Comprehensive Healthcare survey shared at the Women’s Veterans Health Committee and reported up to the Clinical Practice Executive Council.

The challenges for the women’s health-care program are that there are no available resources for daycare services while fee-based services for obstetric care have increased. As a result of the increased need for daycare services, the LBVACHS is currently constructing an on-site daycare center that will be adjacent to the women veterans’ health clinic.

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**PATIENT SATISFACTION**

**Background**

The Long Beach VAHCS views patient satisfaction as the ultimate indicator of quality of care. The health-care system specifically defines patient satisfaction as the value or the patient experience the veteran places on his/her care. The health-care system measures and manages patient satisfaction through utilizing the SHEP scores. The LBVACHS has two offices that measure and manage patient satisfaction: the Office of Quality and Performance is the department responsible for the analytical, methodological, and reporting of the SHEP scores to the staff and leadership at the health-care system and VISN level, and the Office of Patient Centered Care monitors all patient-satisfaction measures and facilitates improvements within the health-care system.

Currently, the medical system is using SHEP scores to measure and track patient satisfaction within their veteran community. The medical center uses SHEP scores to specifically track and trend data to identify opportunities for improvement in their inpatient and outpatient units. Through these scores, the medical center identified several areas for improvement, including pain control, doctors/nurses communication, how veterans score...
their doctors/specialists/nurses, and pharmacy wait times. The medical center had developed teams to develop action plans to improve all areas of decline. The teams then report their progress to the appropriate committees and or councils.

Director of Patient Care Services
The LBVAHCS director of Patient Care Services is also the nurse executive for the health-care system. They have the responsibilities of all clinical and operational aspects of planning, coordinating, implementing and evaluating the delivery of patient care in the following services: nursing, social work, sterile processing, pharmacy, food and nutrition, chaplain, veterans and family assistance, women’s health, telehealth, and the caregiver program.

The challenges that the director of patient care services at the LBVAHCS face are: the VHA is a complex system with many measurements and requirements which can cause barriers in providing constant quality of care and patient satisfaction, VA has inefficient technology such as the SHEP scores which does not provide real time data.

Patient Advocate
The LBVAHCS patient advocate is managed by QM through the Office of Patient Centered Care and is responsible for monitoring the patient survey and evaluation system for the health-care system, responding to patients concerns/complaints in a timely and effective manner, and to monitor the PATS. The health-care system currently is working on a patient satisfaction “best practice” model for improving its communication with veterans by including them on committee work and in development of educational and informational media. All of the staff employed at the LBVAHCS uses the patient-centered care principles while performing their assigned daily duties. In order to improve patient-centered care and patient satisfaction, the patient advocate developed several initiatives to increase quality of care and patient satisfaction among the veteran community. Such initiatives to promote quality of care and patient satisfaction are patient-centered care awards presented to staff who demonstrates those qualities, patient handbooks to advertise hospital information and services, travel and community guides for veterans who come from out of town, creation of a weekly produce market, and several activities to promote wellness for veterans and families.

The biggest challenge that the patient advocate deal with is that the medical center is spread out, making it difficult for veterans to get around, making access for veterans challenging.

Patient Aligned Care Team Coordinator
The LBVAHCS PACT coordinator is responsible for assuring that the PACT is implemented by providing training opportunities, monitoring and measuring performance measures, and working closely with the VISN staff to continuously improve the current PACT model within the health-care system. Many of the LBVAHCS staff involved in primary care is also involved in the PACT programs and initiatives. The health-care system believes that the staff’s responsibilities are to the veteran first, and the PACT model of health care is one model to enhance and improve the overall veteran-centered care experience.

The challenges that the PACT coordinator at the LBVAHCS face are changing the culture at the medical center in terms of the continual implementation of the PACT model, and restrictions placed on travel, which delayed how PACT training occurred. The timeline for VA PACT training changed from 11 months to three months, which resulted in reductions of staff to provide direct patient care.

Veteran Town Hall
A veteran town hall meeting was conducted at American Legion Post 496 in Long Beach, Calif., on June 6. There were 22 veterans in attendance to discuss issues and concerns with the health care they receive at the LBVAHCS. Some of the issues and/or concerns that came out of the town hall meeting were wait times for specialty and outpatient clinics that case management follow-up is not consistent, and veterans cannot get any specific medical history through “My HealthyVet”.

Recommendations
- The quality-of-care and patient-satisfaction metrics that are measured within the medical centers should be based on evidence-based practices throughout the VHA.
- VA needs to continue to support the field by providing virtual collaborations with providers, researchers, educators, etc., in order to provide valuable and accurate communication throughout all entities of the VHA.
- To improve patient safety programs, the VHA needs to focus more on patient disclosure/notification in terms of medication errors, falls, etc., that occur within their health-care facilities.
- In order to improve patient satisfaction, the medical center needs to advertise wait times in the clinics located throughout the medical center to explain the reasons why veterans are waiting. (For example, a board providing explanations to veterans how long and why they are waiting)
- VA needs to provide a more comprehensive and technical training program for risk managers so they can perform their jobs in a professional, effective and timely manner.
- The SHEP scores data needs to be sent to VA medical facilities in a timely manner, rather than a three- to six-month wait in order to evaluate “real-time” quality of care and patient satisfaction.
The San Francisco VAMC provides services to more than 310,000 veterans living in an eight-county area of northern California. The medical center has more than 500,000 veteran outpatient visits each year and 2,079 staff members. The medical center has an operating budget of $500 million.

Quality of Care

Like Sacramento, San Francisco VAMC uses the Institute for Healthcare definition for quality of care as, “an organized, systematic approach to planning, delivering, measuring and improving health care linking VHAs core values to the day-to-day operations while ensuring safe, effective, patient centered, timely, efficient and equitable care. Quality encompasses many interrelated activities that are the responsibility of senior leadership. These include but are not limited to: Quality Assurance, Performance Improvement and measurement, Patient Safety, Internal and External Reviews and Customer Satisfaction, Utilization Management, Risk Management and Systems Redesign.”

The medical center measures and manages quality by data management, and critical analysis is used for each quality and safety component. Also, setting goals, comparisons of internal and external benchmarks, identification of opportunities for improvement and implementation and evaluation of actions until problems are resolved or improvements are achieved form the basis of performance-improvement activities. VHA provides several mechanisms for performance measurement, including but not limited to:

- Access to the national VSSC database (Performance Measurement Dashboards);
- The VA TAMMCS (Team, Aim, Map, Measure, Change, Sustain, Spread);
- Improvement model and systems redesign (balancing supply and demand for services and adapting to changes that improve care delivery);
- The Office of Clinical Consultation and Compliance (ISO 9001 standards for Reusable Medical Equipment and implementing consistent quality systems);
- ASPIRE comparison data and LinKS (Linking Information Knowledge and Systems) for summarizing clinical outcomes (tools that document quality and safety goals for all VA hospitals and the status of meeting compliance with those goals),
- VASQIP (VA Surgical Quality Improvement Program),
- IPEC (Inpatient Patient Evaluation Center),
- EPRP (External Peer Review Program) data, and
- SHEP customer satisfaction data.

The medical center demonstrates and maintains accountability of quality by an Executive Leadership Board, Medical Executive Committee and Peer Review Committee that provide oversight to ensure that quality management components, as defined in VHA Directives 2009-043, are implemented and integrated.

Quality Manager

The QM ensures that all components of the quality management system and patient safety improvement program are integrated. The QM has a systematic process in place for monitoring the facility quality data. Also, this individual serves as the quality consultant to the facility leadership, QI or PI teams, and employees. Lastly, the QM serves on executive committees and workgroups where quality data and information is reviewed, analyzed and acted upon. This description is identical to Sacramento VAMC, and the QM was not able to meet with the System Worth Saving team.

Patient Safety Manager

The patient safety manager ensures that the components of the Quality Management System and Patient Safety Improvement Program are integrated. They also implement and coordinate patient safety improvement programs based on guidance and tools from the NCPS, and which meets the needs and priorities identified by the facility director. These include addressing important standards, requirements, and recommendations promulgated by the JC and other organizations working to improve patient safety. This description is identical to Sacramento VAMC, and staff stated there were no challenges.

Utilization Management

The only job description provided was the following: “Assuring that the right care at the right time in the right setting for the right reason occurs in the healthcare delivery system.” However, the UM did not note any challenges, but it seemed the po-
situation was highly disconnected from any other department of service. Also, the position seemed solely financially ran and not very involved with quality.

**System Redesign Manager**

The medical center does not have a dedicated system redesign manager. There is a PCRC who manages system redesign projects throughout the medical center. There was no one available to speak with the System Worth Saving team.

**Women Veterans Program Manager**

The VHA standard for women veterans' health care is complete, comprehensive primary care. Complete comprehensive primary care, by definition, should fulfill all primary needs, be provided by one primary-care provider at one site, and include care for acute and chronic illness, gender-specific primary care, preventive services, mental health services and complete coordination of care. A designated women's health primary-care provider should be on site in a separate physical location for the delivery of primary care to women, – not shared by male veterans, and military sexual trauma counseling should be provided. This is the standard for which all women veteran programs are measured.

The San Francisco VAMC was awarded one of VA’s first research fellowships in women’s health, and in 1993, the Women Veterans Comprehensive Health Center – one of eight national sites – was established to provide comprehensive primary health-care services to women veterans. The San Francisco VAMC consists of the main VA center and six CBOCs located in Eureka, Clear Lake, Ukiah, Santa Rosa, San Bruno and downtown San Francisco. Each location provides comprehensive primary care on site to include care for acute and chronic illness, gender-specific primary care, preventive services, coordination of care, maternity care referrals and mental health services that include MST, PTSD and depression counseling. In addition to a separate women’s health center, there is also a women’s mental health clinic that provides women’s-only group therapy, individual evidence-based psychotherapy, substance abuse treatment and military sexual trauma counseling. The Women Veterans Health Research Fellowship Program, awarded in 1993, trains health-care professionals interested in clinical research in women’s health issues. In addition, the women’s health staff includes internationally recognized experts in mammography, hormone therapy and incontinence care.

Although the San Francisco VAMC has had the Women Veterans Comprehensive Health Center since 1993, it does not have WVHC. When asked why there was not a WVHC, it was explained that an “informal” committee existed that addressed the responsibilities of the WVHC. This is unacceptable. The WVHC is typically chaired by the WVPM, whose role is to strategically plan, coordinate quality of care, evaluate delivery of care and increase outreach to women. The WVPM has full access to facility leadership because the role of the WVPM is vital, as evidenced by the recently released VHA Handbook 1330.02 that made three major changes: –the WVPM is a full-time position without collateral assignments, it has shifted from a clinical position to an administrative management position in charge of program development, and is responsible for direct supervisory reporting to the facility director or chief of staff. These changes allow full implementation of the WVPM position as originally envisioned, allowing their concerns to be addressed at the facility level. The lack of an official WVHC indicates that the WVPM is not fully leveraged with facility leadership.

In addition to the lack of an established WVHC led by the WVPM, two newly established committees, the Medical Executive Committee and the Leadership Board Committee, do not include the WVPM as a member, when clearly they should, as determined by their purpose. The Medical Executive Committee established July 16, 2010, serves as an advisory and recommending body to the medical center director on clinical issues affecting the medical center and patient care. The Leadership Board Committee, established November 1, 2011, provides guidance for planning, directing, and evaluating clinical and administrative processes throughout the facility; this includes oversight for all aspects of medical center strategic planning to ensure VHA and VISN strategic initiatives are met.

The lack of inclusion of the WVPM on these committees is troubling, and again indicates that the position of WVPM is not fully leveraged with the facility leadership.

**Patient Satisfaction**

**Patient Advocate/ Risk Manager/Patient Aligned Care Team Coordinator**
There was virtually no information provided to the System Worth Saving team in neither the questionnaire nor the actual site visit to the facility. It is unclear as to why these individuals did not provide any useful information. This led the team to question the facility’s legitimacy of their patient satisfaction program.

**Veterans Town Hall Meeting**

A veteran’s town hall meeting was conducted June 6 at American Legion Post 207 with 15 veterans that participated. The veterans were mostly pleased with their health care but had some complaints of mental health. There were complaints that scheduling mental health appointments can be very difficult, and coordination of care when fee-based can be an issue.

**Recommendations**

The patient advocate, risk manager, PACT coordinator should all be separate positions; however, the patient advocate holds all three positions.

That an official Women Veteran Health Committee be established to support the women veteran program manager, as she ensures complete comprehensive primary care is provided to all women veterans.

That the women veteran program manager be included on facility level boards, committees and councils that address clinical and administrative issues affecting health care.
Background
Chalmers P. Wylie VA ACC is located in central Ohio and serves 13 counties. The VA ACC supports four CBOCs, and the ambulatory center does not offer inpatient amenities such as beds. The facility’s overall budget for 2012 is $179 million and was $174 million in 2011. In 2011, the budget for quality-of-care staffing and programs was $599,318. There has been no change for the 2012 budget.

Quality of Care
The VA ACC defines health care as the care, treatment, and services for individuals and populations served to increase the likelihood of desired health. Aspects that ensure quality health care include efficacy, efficiency, timeliness, accessibility, safety, continuity of care and environmental safety. The quality program structure includes areas such as patient safety, infection control and risk control.

This facility measures and manages quality by using multiple electronic data sources. These data sources include customized reports, and data comparison through VACO and the VISN. The facility utilizes best practices through local data monitoring and reporting, in addition to national best practices.

All staff receives general orientation on the day of hire, in addition to their service-specific training. All training is dependent on the specific position and role. VACO offers education and training through programs such as team projects and conference calls. There was a 3.75-percent staff turnover rate in 2011, and recruitment has been above average, with 35 percent of staff being veterans. Currently, the facility has 58 LPNs and 135 RNs.

The VA ACC’s last JC inspection was in August 2011 in reference to laboratory and in October 2010 for ambulatory care, behavioral health and homecare. The last CARF inspection was in June 2011. Both CARF and JC inspection issues have been resolved. Recruitment for mental health providers, specifically psychiatrists, has been difficult, with fee-base up to 69 veterans a year. Currently, Columbus is an outpatient hospital but would like to have inpatient capabilities.

Quality Manager
The quality manager, also known as the quality management coordinator, supports and advises the executive leadership in planning, developing and implementing the quality program. The quality manager analyzes and establishes improvement in models of care, while coaching staff and leaders.
The quality manager has quality-of-care committees that monitor and report performance measures at both VACO and the VISN. At the facility, there are committees reporting on clinical measurement outcomes, non-clinical measures and the CRC committee to ensure compliance to action plans. In general the quality manager is responsible in setting standards for reviewing agencies such as JC, CARF and the OIG.

**Patient Safety Officer**

The patient safety manager ensures that VA ACC provides safe care to all eligible veterans by conducting RCAs and other investigations on concerns that may prevent the delivery of safe and quality care. In addition, he or she monitors all incidents that occur at the facility, this allows the patient safety manager to facilitate RCA teams. The goal of the patient safety program is to improve quality and safety of care to veterans.

To prevent patient safety hazards, the NCPS provides guidance and support to the facility. During an event of high risk, the patient safety manager reports directly to the facility director and senior leadership. The patient safety manager is considered separate from the quality manager, utilization manager, risk manager, and the chief health informatics officer. The patient safety manager may collaborate with the systems redesign manager and cross cover positions.

The facility has conducted six RCAs as of 2012. There have been reviews of medication errors and home oxygen fires. The lessons learned from an RCA can be distributed throughout the nation and is available through the National Center for Patient Safety.

**Utilization Manager**

The utilization manager ensures that appropriate care is provided to the veterans in the appropriate setting. The manager arranges the placement of patients into advanced care settings such as inpatient, outpatient, and extended care; then monitors the care of patients. Every day the status of patient care is evaluated and given in the morning report. During the morning report experts in attendance include quality manager, patient safety manager, director, chief of staff, chiefs of primary care, specialty care, surgery, social work, mental health, and patient advocacy. If there is an issue with patient safety, it is addressed during the morning meeting.

The utilization manager is a highly trained registered nurse who works with a staff of senior nurses and social workers. The utilization manager can call upon the expertise of medical staff for advice. He or she attends annual required training related to their profession and conduct courses required by the VA.

**Risk Manager**

The risk manager is responsible for managing the risk management program including the Protected Peer Review and tort claims. When patient complaints involve practitioner practice and a Protected Peer Review, identified risks or mitigation are addressed using the Open Action Tracking List.

The risk manager participates in committees that impact veteran safety and satisfaction. A list of committees the risk manager attends is as follows; environment of care, infection control, and safe patient handling to name a few. The risk manager receives new employee training and individualized training with the executive leadership. In addition, to the training, the risk manager conducts monthly calls with other risk manager's throughout the VISN and national levels.

**System Redesign**

The system redesign manager focuses on performance improvement issues that cross over multiple clinical and non-clinical service divisions. The purpose of system redesign is to promote efficiency and safety, while eliminating waste that would hinder quality of care. The VISN and national system redesign council provide additional education for this position at VA ACC. The system redesign manager utilizes several tools to improve quality of care and patient satisfaction. Some examples of these tools are data, flow maps, spaghetti diagrams, and value stream maps. All of the tools listed serve to translate data into information that can be used to improve activities.

**Chief Health Information Officer**

The CHIO position was created in 2010 in a VISN workgroup based on VHA guidance. The CHIO collaborates with other services in developing and using IT that impact patient care. He or she also develops and implements standards of practice in the field of IT related to patient care delivery. In addition, the CHIO raises health information issues affecting the delivery of care and identifying solutions to problems in software applications.

The CHIO has a HIT responsible for making recommendations for content of documentation and evaluating compliance with health information management standards. The HIT reports to the medical record committee which reviews timeliness and accuracy of record documentation. The only challenge for the CHIO is there has been a need for informatics staff.

**Women Veterans Program Manager**

The Women Veterans Program Manager currently has 1400 veterans enrolled and two PACT teams with 1 health tech. The women's clinic is located on a separate floor. The coordinator has a GYN provider that administers service once a week on Wednesday and half-time on Monday, in addition to a mental health social worker. Currently, there is a WVHC that meets quarterly involving VBA, OEF, OIF, and CBOC personnel. The Women veteran program manager has a women health liaison...
at all CBOC’s. Presently, the women veteran program manager does not receive specific women veteran complaints.

**Patient Satisfaction**

The VA ACC defines patient satisfaction by tracking and analyzing SHEP scores, veteran focus groups, reduced number of complaints and positive customer comments. Currently, the VA ACC spent $237,000 on patient satisfaction in 2011 and 2012. Patient satisfaction at this facility is measured and managed by compiling data from patient advocates. The info is then reviewed by the patient satisfaction committee, which will then provide recommendations.

The patient satisfaction committee utilizes patient advocate tracking system, patient focus groups, and onsite comment cards. The SHEP is conducted on a monthly basis; recently 70 percent of patients gave the facility a score of nine. The facility improved its SHEP scores in the following areas; getting care quickly, getting care needed, how well doctors and nurses communicate, and share decision making.

VACO and the VISN monitor this facility through SHEP scores and patient comment cards. To improve the facility, the VISN provided training sessions involving patient care services. Recently, the VISN implemented RBC in all VISN 10 facilities.

**Director of Patient Care Services**

The director of patient care services is responsible for establishing, maintaining, and providing oversight for nursing standards of practice. This individual functions as the senior nurse executive within a decentralized nursing service model. He or she also provides assistance to the executive leadership regarding issues with nursing. In addition, this individual participates in strategic planning, executive decision-making, and policy determination.

The VA ACC’s last SHEP score for outpatient was 68 percent. The SHEP scores and data from the patient advocate tracking system is calculated monthly and given to the director. The director of patient care services oversees other staff such as sterile processing and all other services report indirectly, when nurse personnel are involved.

**Patient Advocate**

The patient advocate works with veterans on a daily basis to address concerns, complaints, and help veteran satisfaction. He or she also assists by making the facility patient centered. It is the patient advocate’s job to review SHEP scores and customer comments, and then recommend initiatives to executive leadership. Along with the patient advocate, the customer service coordinator and supervisory patient advocate help with patient satisfaction initiatives.

Patient satisfaction is monitored through the patient advocate tracking system, which is calculated monthly and is reported to the director. The patient advocate is the key for veterans to voice their opinions and issues. To enhance veteran satisfaction, the new valet system and modern atrium patient area has increased patient satisfaction.

When the patient advocate receives a complaint, he or she works with the patient’s health care team to brainstorm a solution. If the patient is not satisfied with the outcome, he or she may speak with the director and executive leadership. The patient advocate has 48 hours to return a phone call and seven days to complete a veteran inquiry. Specialty doctors are part-time; staffing is difficult, because the hiring process is long. Pharmacy is a problem, because the facility does not want to mail medication, but have the patient pick them up.

**PACT Coordinator**

The PACT responsibility is to ensure all PACT teamlets are functioning as a unit. They are also responsible for organizing and leading PACT meetings, generating metrics, and managing CBOC’s. The PACT coordinator identifies needs and delivers training based upon the operational needs of a specific area by training managers, supervisors, and staff.

The PACT coordinator has nine staff members that work specifically on PACT programs and initiatives. In addition, the PACT coordinator is in charge of the PACT Steering committee at the VA ACC, which meets on a monthly basis. The PACT program was developed at VA ACC by formation of a pilot teamlet. The pilot teamlet attended all national PACT training and brought back information learned to VA ACC.

**Town Hall Meeting**

The town hall meeting was conducted at American Legion post 532 in Columbus, Ohio on June 11, 2012. Veterans in attendance brought no issues or concerns regarding the Columbus VAMC.

**Recommendations**

- Recruit mental health providers, particularly psychiatrists
- Columbus is currently an outpatient facility, but there is a need for inpatient capabilities. Currently, the Columbus facility fees bases on average 69 veterans a year. This has cost a substantial amount; it may be cheaper to offer inpatient capabilities in-house. Also, veterans sometime have to drive great distances to receive inpatient care, which adds additional stress to the veteran
- The facility does not have an informatics staff
- Staffing has been a problem due to a lengthy hiring process. VA should find solutions to help candidates transition into the VA system efficiently. This has been especially apparent with specialty doctors
Background

The Cincinnati VAMC is a two-division campus serving 17 counties and five CBOCs. It was opened in 1954 and consists of 116 beds. The medical center provides comprehensive tertiary health care through primary care and specialty outpatient services. The facility offers surgery, psychiatry, physical medicine, neurology, oncology, dentistry and geriatrics. Currently, the Cincinnati VAMC has 210,000 veterans residing in its catchment area and treated 41,000 veterans. In 2011, the Cincinnati VAMC’s overall budget was $355 million and $349 million in 2012. Of the total budget, 62 percent is dedicated to quality-of-care staffing and programs in 2011 and 70 percent in 2012.

Quality of Care

Cincinnati VAMC defines quality as a health-care facility by assessing its outcomes of care, compared to VA and non-VA facilities. To ensure quality of care, the VA VACO provides a blueprint for network directors, which lists all the requirements to establish quality of care.

To measure quality as a health-care facility, the Cincinnati VAMC utilizes SHEP scores and Quikcard surveys. Quikcard surveys enable the facility to receive immediate feedback from patients, rather than waiting three months for SHEP scores. When an employee is hired, he or she receives initial training; most of the training is nationally mandated. A significant amount of training is available online through VAs TMS.

The Cincinnati VAMC is nationally recognized for its innovation and the quality of care and services. Examples of innovated services are PTSD, women’s health initiatives, health promotion/disease prevention programs, and a new initiative to promote healthy lifestyles.

Quality Manager

The quality manager ensures that the quality management plan is integrated and the system to monitor quality is in place. In addition, the manager serves as the quality consultant to the facility leadership, quality-improvement teams and employees. There are several committees and work-groups the quality manager serves on, where quality is reviewed and analyzed and solutions are found. The quality manager has unrestricted access to data and information that are relevant to improve quality of care and other related topics. The quality management program is integrated at the Cincinnati VAMC, CLC, domiciliary, PTSD program and six CBOCs.

Patient Safety Officer

The patient safety manager is responsible for implementing a patient safety program at the facility level. The program is based off of the guidance and tools from NCPS. The patient safety manager addresses the concerns of the director, JC, and other organizations that are working to improve quality of care. The patient safety manager consistently works with other managers and the VISN patient safety manager.
The patient safety manager supports RCAs process in response to an unexpected outcome by providing team training and support. The patient safety officer also serves as the facility point of contact for patient safety alerts/advisories, including tracking actions. The manager is the point of contact for communicating issues to NCPS and serving as the facility expert on the VHA handbook.

**Utilization Manager**

The utilization manager is responsible for ensuring utilization review nurses are examining medical records, attending interdisciplinary rounds daily and collaborating with doctors. It is the utilization manager’s role to ensure every patient receives the proper care at the correct time and in the correct setting. The manager received initial training by teaming with mentors for a five-to six-week orientation. Additional career training is conducted through webinar, conferences, live meetings and software.

The utilization manager uses tools to improve quality of care by using computer software geared to assist utilization review nurses for medical record analyses. In addition, there are data specific tools used to track and trend data that is unique to the facility. The data acquired is used to improve and promote patient flow throughout the facility. The data may address issues that hinder flow, and ultimately decreases patient satisfaction.

**Risk Manager**

The risk manager mitigates risk by proactive identification and management of issues that pose a risk to patients and staff. The manager receives training through VA risk manager conferences, quarterly national risk-management calls and VISN patient/risk management committee. The risk manager collects data to monitor tort claims and provider reviews to improve quality of care. He or she also works with the patient advocates to improve patient satisfaction.

**System Redesign Manager**

The system redesign manager is responsible for serving as a consultant to work groups throughout the medical facility. He or she analyzes performance data, and identifies performance gaps, barriers, and any negative aspects that could hinder quality of care. This individual also serves on the customer focus and quality performance committees.

The manager has received training through national learning collaborative for system redesign by VHA. In addition, he or she has been trained in Six-Sigma black belt certification and participated in national system redesign training conference calls. Currently, the system redesign manager is participating in VHA’s pilot program, field-based analytics to improve data analysis skills. The risk manager uses tools to improve quality of care by monitoring indicators for patient satisfaction and quality of care. The tools help in developing improvement projects based on areas that do not meet expected performance measures. In addition, the system redesign manager is aligned within the quality management office and participates in RCA.

The system redesign manager needs a budget, which the system redesign program currently does not have. This hinders the program manager from purchasing vital equipment required for the program. Furthermore, the Office of Information Technology will be removing Vizio from their computers. Taking this program away would limit the capabilities of the system redesign manager and staff.

**Chief Medical Officer**

The chief medical officer is responsible for the appropriate use of technology as it applies to clinical settings. Indicators are tracked and managed through the quality department by performance measures and quality indicators. The chief provides support for building clinical reminders and templates to track specific measures. Quality of care is reviewed on every department. The IPEC system is available to assist with statistical analysis capabilities.

The measures are used to improve real-time performance by using clinical reminders. Clinical reminders are responsible for maintaining and evaluation of key indicators that affect patient care. The clinical reminders are used in every department to measure quality of care, once the information is acquired, appropriate clinical changes are made.

The chief medical information officer department is its own entity, but does not have a set budget.

**Women Veterans Program Manager**

The Women Veterans Program Manager offers comprehensive primary care for women in a safe secure women’s health center. The facility has full-time staff and a women veteran’s program manager. Currently, the facility has a gynecologist and will have “tele-gyn” for females living in distant regions in June 2012. The Women Veterans Program Manager is ac-
tive with outreach efforts and holds an annual women veterans’ appreciation luncheon.

**Patient Satisfaction**

The Cincinnati VAMC defines patient satisfaction as a facility where veterans want to receive care, rather than have to. In addition, the facility defines patient satisfaction through satisfaction surveys for both inpatient and outpatient veterans. The facility uses SHEP, Quikcards and patient advocate inquiries as tools to measure patient satisfaction. These tools are utilized by regularly sharing information with managers and staff, in addition to creating action plans if the scores fall below the national average. Centralized and decentralized action plans are created annually based off of the tools mentioned. The VISN and VACO maintain accountability over Cincinnati VAMC by reviewing SHEP scores and establishing annual monitors for the director. VISN staff meets and help review scores with the facility and create action plans.

**Director of Patient Care Services**

The director of Patient Care Services provides oversight for nursing service, which includes patient care, quality of care, safe care, compliance with standards and patient satisfaction. Presently, the Cincinnati VAMC has had positive SHEP scores in pain management, as well as communication with nurses in both inpatient and outpatient services. In fact, the facility improved on all categories from last year’s SHEP scores. Patient satisfaction is monitored through customer service committees, unit-based councils, staff meetings and postings.

**Patient Advocate**

The patient advocate defines patient satisfaction as having no complaints and having patients receive care at the facility despite having the option to receive it elsewhere. The patient advocate serves as the liaison between the medical center director, patients, staff and community. On a daily basis, he or she provides an avenue for patients to seek solutions to their concerns. To resolve issues, the patient advocate works with health-care providers and support staff. The patient advocate then assists patients and their families in recognizing provisions to optimize health care to veterans. The patient advocate tracks patient-satisfaction indicators by using SHEP scores, Quikcards and patient advocate reports. He or she meets monthly on a national and local level to discuss and share best practices.

Training is administered on an annual basis, which includes specific training to equal 40 hours and a minimum of four hours of customer service training. Examples of the programs within the training are:

- 12-hour crucial conversation course
- Dealing with toxic behaviors in the workplace
- Team-building
- Facing the tiger
- Treating veterans with care.

The patient advocate is supervised by the chief, patient business services, and the Office of Patient Centered Care provides guidance to advocates nation-wide. The patient advocate must respond to a complaint no longer than seven days. If the complaint requires more than seven days, the advocate must keep the patient informed of his or her status.

**Patient Aligned Care Team Coordinator**

The PACT coordinator trains and monitors the PACT teamlets within the medical facility’s catchment area. He or she also reviews and interprets data for each PACT teamlet. Currently, there are 42 PACT teamlets across the Cincinnati catchment area, with no other staff specifically dedicated to PACT. The PACT coordinator has monthly committee meetings attended by 37 facility staff; there are plans to have veterans in attendance in the near future. The PACT initiative has improved quality of health care by increasing access and coordination of care. Specialty care is a weak point. PACT teams do not have pharmacy, nutritional, and mental health support as they would like. In addition, there is a need for RNs, LPNs and clerical staff.

**Town Hall Meeting**

The town hall meeting was conducted at American Legion Post 123 in Norwood, Ohio, on May 13. Veterans in attendance brought no issues or concerns regarding the Cincinnati VAMC.

**Recommendations**

- The system redesign manager needs a budget to afford all equipment required for the program.
- The Office of Technology should reevaluate their actions of removing the Vizio program. Removing the program will limit the system redesign manager and his staff’s capabilities
- The Cincinnati VAMC should increase its effort in hiring additional RNs, LPNs and clerical staff
- Increase specialty care programs for PACT. Currently, PACT does not have pharmacy, nutritional and mental health support
**FINAL RECOMMENDATIONS**

**Quality of Care**
- VA Central Office (VACO) needs to ensure that VISN Strategic Plans are distributed to VISNs and VA medical centers (VAMCs) in a timely manner, so the VA facilities can plan and provide the correct measures being tracked for the fiscal year.
- VACO needs to delineate between the creation of VHA directives or measures that needs to be tracked.
- VHA directives need to be condensed, similar to Veterans Benefits Administration (VBA) Fast Letters, to provide updates to the field and guidance on how a program/directive should be implemented. In the current form, a directive's length typically exceeds 10 pages and is difficult to implement.
- VACO needs to create a VHA Executive Hiring Task Force to assess the numbers of vacancies and positions with acting staff across the country and to swiftly hire these positions as permanent positions. Additionally, a policy should be developed and enforced on succession planning for hiring executive leadership and critical hospital staffing positions.
- The VHA needs to convene a hiring and tracking task force to monitor and speed up the hiring of primary- and specialty-care positions. VHA needs to establish strategies to expedite the hiring of critical health-care positions such as doctors and nurses.
- The quality-of-care and patient-satisfaction measures developed and tracked within VACO, VISN and VAMCs should be based on evidence-based practices throughout the VHA system. Additionally, VA needs to conduct an extensive review of the more than 500 measures currently being tracked for efficiency and effectiveness.
- The VA medical facilities need better integration between PACT providers and specialty-care providers for continuity of services.
- VACO needs to continue to support the field by expanding virtual collaborations with health-care providers, researchers, educators, etc., in order to provide valuable and accurate communication throughout all entities of the Veterans Health Administration.
- VA needs to provide a more comprehensive and technical training program for risk managers so they can perform their jobs in a professional, effective and timely manner.

**Patient Satisfaction**
- The facility should continue to improve its phone system and scheduling for appointments. It is recommended that the facility decentralize the scheduling process and assign veterans respective PACT teams with the responsibility to send an introductory patient letter with contact information for the PACT team; the PACT scheduler and/or volunteers can assist with making all of the veterans appointment (personalize letters and reminder appointment calls with contact information for the PACT team).
- The medical center needs to hire more patient advocates and utilize volunteers to address, analyze and track patient-care issues and concerns.
- The SHEP scores data needs to be sent to VA medical facilities in a timely manner, rather than a three- to six-month wait, in order to adequately evaluate and measure “real-time” quality of care and patient satisfaction.
- VHA needs to adopt a single and consistent patient-satisfaction survey tool such as Truth point or Press Ganey to utilize as the main tracking tool and make it more efficient and effective to gather results.
- Representatives from the veterans’ community should be involved and serve as a member of the facility’s Customer Service Board and Patient Satisfaction Committee meetings. The VAVS National Advisory Committee has brought forward this recommendation to senior VA officials.