**The American Legion**

**System Worth Saving Program**

**Quality of Care and Patient Satisfaction**

**Baltimore Mail Out Questionnaire**

**The American Legion’s System Worth Saving program is focusing on quality of care and patient satisfaction on our current site visits to VA Medical Center facilities from April to July 2012.**

**In our approach, we want to assess how VA tracks and manages quality of care and patient satisfaction at the national, Veteran Integrated Service Networks (VISNs) and VA Medical Center facility level.**

**We developed an appropriate, objective assessment (questionnaire for VA facilities) to examine how quality of care and patient satisfaction is defined, measured, managed as well as to understand how VA Central Office, VISNs and VA facilities demonstrate accountability of these programs at all of these levels.**

**Executive Leadership**

**Quality of Care**

**What is your overall medical center budget for FY 2011? FY 2012?**

FY 2011: $519,362,965

FY 2012: $500,615,065

**What percentage of your budget is dedicated to Quality of Care staffing and programs in FY 2011? FY 2012? Please describe these staffing costs and types of programs.**

Our budget is not broke down by quality of care.

**How do you define quality as a healthcare facility?**

The degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

Has the facility received any awards or designations for quality of care?

**How do you measure and manage quality as a healthcare facility?**

* The VA Maryland Health Care System (VAMHCS) will identify and pursue opportunities for performance improvement in a planned, systematic and organization-wide manner utilizing a number of informational sources, measures and processes.
* The PI Program Plan provides the structure and guidance for the design, measurement, assessment and improvement of VAMHCS performance. This is in compliance with the laws, directives, mandates, and regulations of the federal government; Veterans Health Administration (VHA), Veterans Integrated Service Network (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 VAMHCS including all outpatient, inpatient, long-term care, behavioral and home care settings.
* Quality is also measured through the results of external reviews, VHA reviews, OIG reviews and ongoing in-house monitoring.

**How does your VA Medical Center facility demonstrate and maintain accountability for quality of care?**

* VAMHCS demonstrates and maintains accountability by participating in the accreditation processes of external accrediting organizations including: The Joint Commission (TJC), Commission on Accreditation of Rehabilitation Facilities (CARF), Association for the Accreditation of Human Research Protections Program (AAHRP), College of American Pathologists (CAP), American Society of Health System Pharmacist (ASHP), American College of Surgeons Commission on Cancer (ACoS COC), American College of Radiology (ACR). Additional non-federal organizations that have conducted reviews include but are not limited to Long Term Care Institute, and Mathematica.
* VAMHCS also participates in numerous VHA reviews as well as other federal reviews.

**What are the following staff’s responsibilities in ensuring quality of care at the facility?**

1. Chief of Staff- The COS serves as the President of the organized Medical Staff and has administrative responsibility for medical staff functions and committees under his/her direct supervision and the obligation of full participation in the PI program activities as designated by the Director and ECGB. The EPIC chairmanship is the responsibility of the Chief of Staff who may delegate or share the duties with the Director of the Center for Performance.
2. Head Nurse- 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
3. Quality Manager- 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 VAMHCS 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. Serves as the primary coordinator for all major facility wide clinical surveys.
4. Patient Safety Manager- PSM is responsible for implementing a coordinated safety improvement program at the VAMHCS that is based on guidance and tools from the NCPS and which meets the needs and priorities identified by the VAMHCS Director. Coordinates with the Director, Performance Improvement & Accreditation to ensure that components of the Quality Management System and Patient Safety Improvement Program are integrated.
5. Utilization Management- Is responsible for implementing and maintaining the process of evaluating and determining the coverage and the appropriateness of medical care services across the patient healthcare continuum to ensure the proper use of resources.
6. Risk Manager- Is responsible for implementing a comprehensive risk management program that includes incident reporting, sentinel event reporting, and Peer Review.
7. Systems Redesign Manager- The Systems 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 Systems 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 our Veterans.
8. Chief Health Medical Information Officer/Clinical Lead for Informatics- Responsible to manage and process clinical data, information and knowledge; facilitate storage and retrieval of patient care information; assist clinicians and administrators in keeping current with new medical technologies; ensure quality patient care by providing tools for data management; and maintain the integrity of computerized data (Security issues, contingency plans, menu management).

**Which staff members/positions at the facility are responsible for managing and tracking quality of care programs and initiatives?**

The following are the primary staff/positions responsible but may include others.

* Center for Performance (EPRP, Systems Redesign and Performance Measures Coordinator)
* Performance Improvement and Accreditation (all staff)
* Nursing (Outcomes Coordinator, Committee chairs, and Nurse Managers)
* Patient Safety Officer
* Risk Management (all staff)
* Utilization Management (all staff)
* Project leaders of workgroups and improvement teams within individual Clinical Centers

**Please explain the quality of care training employees receive (i.e. type of initial and reoccurring training and number of days)?**

* During New Employee Orientation (NEO) all employees are exposed to the departments/individuals responsible for measuring/monitoring of quality of care. they are exposure to the VAMHCS philosophy and all policies related to quality of care based on their departmental assignment. Based on departmental assignment the training is 3 days plus varying time periods selected by specific disciplines/clinical areas. NEO is mandatory for all new employees.
* There is no mandatory reoccurring training but staff has wide range of programs to select from an annual basis from VALU as well as presentations available throughout the VAMHCS on an ongoing basis.

**What resources have the VA Central Office and the VISN provided to help your facility improve quality of care programs and initiatives?**

* VA Central Office provides or sponsors various conferences, webinars, and conference calls throughout the year on various topics on or related to quality, utilization management, system redesign, utilization management, and relevant and timely topics.
* VISN 5 sponsors/provides ongoing meetings concerning quality of care topics as well as periodic conferences or conference calls.

**What future VA Central Office or VISN resources and/or support are needed?**

* More onsite conferences for quality staff that allows for networking
* Increased days available for consultation with JCR and other groups

**What innovative qualities of care programs or studies covered by grants are being conducted by this facility?**  **Quality and Patient Safety (CPQRS) - One Chief Resident starting July 2012 thru June 2013.

Is your facility working on a “best practice(s)” in quality of care management?**

* Bed management collaborative
* Palliative Care

**What other facility staff, not mentioned above, work specifically on quality of care programs and initiatives? Please list their position titles, job duties and responsibilities?**

**VAMHCS Staff (all levels)**: As appropriate, staff at all levels participate in the PI Program including activity planning, data collection, evaluation and follow-up to actions taken through collaborative interdisciplinary activities. Staff are encouraged to participate in performance improvement projects on their unit, department and system wide. Information is disseminated directly in staff meetings, through newsletters and via the website.

**Which staff position at the facility is responsible for performance measures (access, clinical measures and ASPIRE/Hospital Compare)?**

Performance Measure Coordinator and System Redesign Coordinator

**How many Full Time Employee (FTE) Registered Nurses, License Practical Nurse is on your staff?**

RN Actual in Nursing Service: 448.6

RN Outside of Nursing Service: 66

LPN Actual in Nursing Service: 71

LPN Outside of Nursing Service: 4

**Is there sufficient staff to patient ratio?**

Yes, we monitor and oversee staffing based on Hours per Patient Day data

**Has there been any turnover with any of these positions?**

Yes, due to retirements, resignations, transfers, career advancements and terminations

**How long have these positions been vacant?**

There are ongoing vacancies – average time to replace a licensed nursing staff takes approximately 6-8 weeks. This process includes, the time needed for credentialing, security background checks, fingerprinting and notifications.

**Have there been any Government Accountability Office (GAO), VA Office of the Inspector General (OIG) or media articles about quality of care concerns within the past three years?**

No media

**What were the findings and recommendations found with Government Accountability Office (GAO)?**

N/A

**What were the findings and recommendations found with VA Office of the Inspector General (OIG)?**

N/A

**What were the findings and recommendations found with the media articles?**

N/A

**When was your last Joint Commission Inspection?**

August 2011

**What were the findings and recommendations?**

The findings are listed below and organizations are required to develop a plan to be in compliance with the standards.

**Program: Hospital Accreditation Program Standards**:

* IC.02.02.01 EP1 - he hospital implements infection prevention and control activities when doing the following: Cleaning and performing low-level disinfection of medical equipment, devices, and supplies.
* MM.03.01.01 EP7 - All stored medications and the components used in their preparation are labeled with the contents, expiration date, and any applicable warnings.
* MM.05.01.07 EP2 - Staff use clean or sterile techniques and maintain clean, uncluttered, and functionally separate areas for product preparation to avoid contamination of medications.
* PC.01.02.08 EP2 - The hospital implements interventions to reduce falls based on the patient’s assessed risk.
* RC.02.01.01 EP2 - The medical record contains the following clinical information: Treatment goals, plan of care, and revisions to the plan of care
	+ EP21 - The medical record of a patient who receives urgent or immediate care, treatment, and services contains all of the following: Conclusions reached at the termination of care, treatment, and services, including the patient's final disposition, condition, and instructions given for follow-up care, treatment, and services
* LD.04.01.05 EP4 - Staff are held accountable for their responsibilities.
* LS.02.01.10 EP3 - Walls that are fire rated for 2 hours (such as common walls between buildings and occupancy separation walls within buildings) extend from the floor slab to the floor or roof slab above and extend from exterior wall to exterior wall.
* LS.02.01.20 EP13 - Exits, exit accesses, and exit discharges are clear of obstructions or impediments to the public way, such as clutter (for example, equipment, carts, furniture), construction material, and snow and ice.
* MS.01.01.01 EP3 - Every requirement set forth in Elements of Performance 12 through 36 is in the medical staff bylaws.
* EP10 - The organized medical staff has a process which is implemented to manage conflict between the medical staff and the medical executive committee on issues including, but not limited to, proposals to adopt a rule, regulation, or policy or an amendment thereto. Nothing in the foregoing is intended to prevent medical staff members from communicating with the governing body on a rule, regulation, or policy adopted by the organized medical staff or the medical executive committee. The governing body determines the method of communication.
* EP20 - The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: The medical executive committee’s function, size, and composition, as determined by the organized medical staff and approved by the governing body; the authority delegated to the medical executive committee by the organized medical staff to act on the medical staff’s behalf; and how such authority is delegated or removed.
* EP30 - The medical staff bylaws include the following requirements, in accordance with Element of Performance 3: Indications for recommending termination or suspension of medical staff membership, and/or termination, suspension, or reduction of clinical privileges
* RC.02.01.05 EP2 - For hospitals that do not use accreditation for deemed status purposes: The hospital documents any use of restraint protocol(s) for non-behavioral health purposes in the medical record.
* TS.03.02.01 EP2 - The hospital identifies, in writing, the materials and related instructions used to prepare or process tissues.

**Program: Long Term Care Accreditation Program Standards:**

* EC.02.03.01 EP1 - The organization minimizes the potential for harm from fire, smoke, and other products of combustion.
* PC.01.03.01 EP1 - The organization plans the resident’s individualized care, treatment, and services based on needs identified by the resident’s assessment (including strengths and goals), reassessment, and results of diagnostic testing.
* EC.02.06.01 EP1 - Interior spaces meet the needs of the patient population and are safe and suitable to the care, treatment, and services provided.
* EP26 - The organization keeps furnishings and equipment safe and in good repair.
* LS.02.01.10 EP3 - Walls that are fire rated for 2 hours (such as common walls between buildings and occupancy separation walls within buildings) extend from the floor slab to the floor or roof slab above and extend from exterior wall to exterior wall.
* LS.02.01.20 EP13 - Exits, exit accesses, and exit discharges are clear of obstructions or impediments to the public way, such as clutter (for example, equipment, carts, furniture), construction material, and snow and ice.

**Program: Behavioral Health Care Accreditation Program Standards**:

* EC.02.06.01 EP20 - Areas used by individuals served are safe, clean, and comfortable.
* CTS.01.04.01 EP1 - For organizations that serve adults with serious mental illness: The organization documents whether the adult has a psychiatric advance directive.
* IC.02.01.01 EP1 - The organization implements its planned infection prevention and control activities and practices, including surveillance, to reduce the risk of infection.

**Program: Home Care Accreditation Program Standards:**

* PC.01.02.03 EP3 - Each patient is reassessed as necessary based on his or her plan for care or changes in his or her condition.

**When was your last Commission Accreditation Rehabilitation Facility (CARF) inspection? What were the findings and recommendations?**

* March 2012
* Final findings and recommendations pending

**Please list the quality of care committees at the VISN and facility level, their mission statements, who is comprised on these committees, and how often they meet?**

VAMHCS

* **Executive Committee of the Governing Body (ECGB)**: This committee is advisory to the Director and meets at least monthly. In relationship to the PI Program, it assists the Director in setting organizational and program priorities through the use of current priority setting guidelines that include but are not limited to: VHA Domains of Value, identification of improvement needs based on use of the performance priorities, mandated program or activity such as VHA reviews, Joint Commission, CARF, FDA., and on issues that impact VHA/VISN/VAMHCS Strategic Initiatives. Membership is senior leadership, quality and patient safety
* **Executive Performance Improvement Council (EPIC)**: This body has oversight responsibility for the PI Program activities as delegated by the ECGB. It may act on behalf of the ECGB on program operational issues to facilitate action and/or avoid process slowdown or delay. The EPIC meets monthly. Reports are submitted quarterly to the ECGB unless otherwise determined by the ECGB. It shares appropriate/applicable information, and has collaborative interface with the ECMS and ECAS on matters pertinent to these bodies. Membership is outlined in VAMHCS MCM “Executive Performance Improvement Council.”

VISN

* **Quality Management/Patient Safety Committee** This group meets monthly to discuss and compare activities and outcomes of various measures. The group is comprised of individuals from quality/performance management, risk management, and patient safety.
* **Utilization Management Committee – T**his group meets on regular basis to discuss new technologies as well as monitors and issues identified at the various facilities.
* **Patients Satisfaction –** This group meets on a regular basis to discuss patient satisfaction results and any VISN wide performance improvement activities.

**Are veterans’ participating and/or serving on these committees?**

* VAMHCS **Veteran Satisfaction Committee (VVSC)**
* VAMHCS **Patient-Centered Care/Planetree Steering Committee**

**Patient Satisfaction**

**How do you define patient satisfaction as a healthcare facility?**

The patient’s perception of having their health care needs met. Patients should have a positive customer service experience in all aspects of their health care.

**How do you measure and manage patient satisfaction as a healthcare facility?** Surveys/assessments are used to assess the quality of our 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 Veterans Satisfaction Committee (VVSC) is an interdisciplinary committee that oversees our efforts to improve patient satisfaction and customer service.

**What types of measurement tools are utilized for tracking patient satisfaction?**

Survey of Healthcare Experiences of Patients (SHEP) Survey (national VHA survey for inpatients and outpatients) and TruthPoint Assessment (local assessments performed each workday with inpatients and outpatients**).**

**How are these measurement tools utilized to improve patient satisfaction?**

The surveys/assessments 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, our score improved four points.

**Please provide the date and results of the last two Survey of Healthcare Experiences of Patients (SHEP) scores.**

November scores:





December scores:





**Which areas of the most recent Survey Healthcare Experiences of Patients (SHEP) survey did you improve or decline, compared to the last SHEP survey?**

Inpatient: 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.

**What measures have been taken to address improvement in these areas?**

For 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 on our Medicine inpatient units.

**How does VA Central Office, VISN and VA Medical Center facilities demonstrate and maintain accountability for patient satisfaction?**

Each year, VACO creates the Executive Career Field (ECF) performance plan that identifies the patient satisfaction performance measures to be focused on for improvement. VISN 5 collaborates with VACO and the VA Medical Centers to identify the specific measures for improvement during the fiscal year. All VAMHCS executives, managers, and supervisors have goals for improving patient satisfaction included in their performance plans.

**What resources has the VISN or VA Central Office provided to assist your facility in improving patient satisfaction initiatives?**

VACO provided further analysis of the SHEP data, called Attributable Effects analysis, to identify the key drivers of patient satisfaction for our medical centers. In addition, VACO now provides SHEP data by inpatient nursing unit on a quarterly basis. In FY11, VACO and VISN 5 collaborated to provide VAMHCS with approximately $350K in funding for patient centered-care initiatives to improve the patient experience and patient satisfaction. These funds were used for a variety of purposes including: Veteran/Family Lounge on Inpatient Unit 3B (to be opened in the near future); chairs for patient rooms; blanket warmers; acupuncture tables; handicapped accessible vans to provide shuttle service to/from the new Annex; and supplies for “Silent Nites” sleep program. Also in FY11, VISN 5 contracted for Planetree to perform a SHEP/HCAHPS Assessment to assist VAMHCS in improving inpatient satisfaction.

**How many VAMC staff work specifically on patient satisfaction initiatives, and please list their position titles, job duties and responsibilities?**

Four staff members: Ron Hoffmann, Chief, Consumer Relations Service; Valery Calm-Coleman, Assistant Chief, Consumer Relations Service; Janice Horton-Rainsbury, Business Manager, Consumer Relations Service; and Donna Felling, Patient-Centered Care/Planetree Coordinator. All have a responsibility to analyze/manage data and collaborate with the clinical centers and services to promote patient-centered care and to improve patient satisfaction.

**Please list the patient satisfaction committees at the VISN and facility level and their mission statements and who is comprised on these committees?**

VISN 5 Patient Satisfaction/Patient-Centered Care Steering Committee has a mission to promote patient-centered care and to improve patient satisfaction throughout the network. The committee has representatives from VISN 5, VAMHCS, Washington, DC, and Martinsburg and includes the Chiefs of Consumer Relations/Customer Service, Chief Nurse Executives, Public Relations representatives, Nutrition and Food representatives, Patient-Centered Care/Planetree Coordinators, and others. The committee reports to the VISN 5 Chief Medical Officer. VAMHCS Veterans Satisfaction Committee (VVSC) has a mission to assess, measure, and improve customer service and patient satisfaction. This is an interdisciplinary committee with the service chiefs and medical center directors as members. This committee is chaired by the Associate Director for Operations and coordinated by the Chief, Consumer Relations Service. VAMHCS Patient-Centered Care/Planetree Steering Committee has a mission to promote patient-centered care and to improve the patient experience. This interdisciplinary committee has representatives from all levels of VAMHCS, including Veteran representation.

**Are veterans’ participating and/or serving on these committees?**

Yes, a Veteran serves on the VAMHCS Patient-Centered Care/Planetree Steering Committee that reports directly to the VAMHCS Veterans Satisfaction Committee (VVSC).

**Quality Manager**

**What duties and responsibilities do you have as the quality manager for the facility?**

* The facility does not have a position entitled Quality Manager but many of the tasks are the responsibility of the Director, Performance Improvement & Accreditation.
* 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 VAMHCS 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. Serves as the primary coordinator for all major facility wide clinical surveys.

**How are quality of care indicators and measurements tracked and managed?**

* The VA Maryland Health Care System (VAMHCS) will identify and pursue opportunities for performance improvement in a planned, systematic and organization-wide manner utilizing a number of informational sources, measures and processes.
* The PI Program Plan provides the structure and guidance for the design, measurement, assessment and improvement of VAMHCS performance. This is in compliance with the laws, directives, mandates, and regulations of the federal government; Veterans Health Administration (VHA), Veterans Integrated Service Network (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 VAMHCS including all outpatient, inpatient, long-term care, behavioral and home care settings.
* Quality is also measured through the results of external reviews, VHA reviews, OIG reviews and ongoing in-house monitoring using PI SubCouncils at the Clinical Center/Service level and the Executive Performance Improvement Council.

**How do you measure and manage quality as a healthcare facility?**

* VAMHCS committees identify the measures warranting performance improvement or monitoring as well as the frequency of collection.
* Collection, tracking and trending and analysis are performed on a monthly, quarterly, semi-annual or annual basis based on the indicator.
* Results are reported to one of the Executive Committees for oversight monitoring.

**How does VA Central Office, VISN and VA Medical Center facilities demonstrate and maintain accountability for quality of care.**

Many of the measures are reported on a regularly scheduled basis. Others are reported periodically based on the measure and reason for collection. External review results are monitored across survey years to determine any repeat findings.

**What are the quality of care committees at the VISN and/or facility level and who are they?**

VAMHCS

* **Executive Committee of the Governing Body (ECGB)**: This committee is advisory to the Director and meets at least monthly. In relationship to the PI Program, it assists the Director in setting organizational and program priorities through the use of current priority setting guidelines that include but are not limited to: VHA Domains of Value, identification of improvement needs based on use of the performance priorities, mandated program or activity such as VHA reviews, Joint Commission, CARF, FDA., and on issues that impact VHA/VISN/VAMHCS Strategic Initiatives. Membership is senior leadership, quality and patient safety
* **Executive Performance Improvement Council (EPIC)**: This body has oversight responsibility for the PI Program activities as delegated by the ECGB. It may act on behalf of the ECGB on program operational issues to facilitate action and/or avoid process slowdown or delay. The EPIC meets monthly. Reports are submitted quarterly to the ECGB unless otherwise determined by the ECGB. It shares appropriate/applicable information, and has collaborative interface with the ECMS and ECAS on matters pertinent to these bodies. Membership is outlined in VAMHCS MCM “Executive Performance Improvement Council.”

**VISN**

* **Quality Management/Patient Safety Committee** This group meets monthly to discuss and compare activities and outcomes of various measures. The group is comprised of individuals from quality/performance management, risk management, and patient safety.
* **Utilization Management Committee – T**his group meets on regular basis to discuss new technologies as well as monitors and issues identified at the various facilities.
* **Patients Satisfaction –** This group meets on a regular basis to discuss patient satisfaction results and any VISN wide performance improvement activities.

**How are you monitoring Quality Assurance within Community Based Outpatient Clinics (CBOCs)?**

a. VA staffed CBOC’s? - All are run by facility therefore participate as part of the PI Plan.

b. Contracted staffed CBOC’s – N/A

**How are you monitoring quality assurance with non VA care?**

* Based on performance measures identified in contracts
* Results are reported to the Executive Committee of the Medical Staff if a clinical service provided.

**Of these, which quality measures are you responsible for?** None

**Patient Safety Manager**

**What duties and responsibilities do you have as the Patient Safety Manager for the facility?**

Oversight of safety issues involving patients, visitors, and staff within VA Maryland Health Care System. In alliance with the VHA National Center for Patient Safety perform safety initiatives that arise from the VA Central Office, regulatory and accrediting agencies, and other health care systems.

**What other facility staff reports to you on patient safety programs and care initiatives?**

Within the Patient Safety /Risk Management Department, risk managers, and patient safety staff.

Within the VA Maryland Health Care System, staff in all disciplines and Clinical Centers report patient safety issues.

**How do you define patient safety as a healthcare system?**

Patient Safety is an integrated program that utilizes processes to view issues from a systems perspective rather than focusing on an individual and/or individual process. The goal is to provide safe, high quality, cost-effective, patient centered care for our Veteran population.

**Please describe your patient safety programs and initiatives.**

The program mirrors VHA’s safety program in its three step approach to improving patient safety which includes:

1. Exploring system vulnerabilities that can result in patient harm

2. Reporting of adverse events and close calls

3. Emphasizing prevention rather than punishment in order to mitigate system vulnerabilities and reduce adverse events.

Examples include: Root Cause Analyses, Healthcare Failure Mode and Effects Analyses, Patient Safety Hotline, Patient Safety Alerts and Advisories, Hazard Recall alerts, safety initiatives, infection control initiatives (handwashing, preventing MDROs), National Patient Safety Goals, Bar Code Medication Administration, computerized patient safety records (CPRS), medication reconciliation, fall prevention, patient identification, environment of care, universal protocols, Medical Team Training, patient safety culture survey, Mental Health environment of care checklist, Suicide Prevention Program, Safe Patient Handling, Emergency Preparedness, Violence Prevention, Sterile Processing Tracers.

**What patient safety committees do you have at the VISN and/or VA Medical Facility? Please explain.**

Maryland Health Care System- monthly Patient Safety/Risk Management meetings, attendance at Clinical Center Performance Improvement Sub-councils, weekly Performance Center meetings, monthly multifunctional team meeting, monthly National Center for Patient Safety meetings by conference call, Disruptive Behavior Committee meetings.

VISN – monthly Patient Safety meetings, quarterly Quality Management/Patient Safety Committee, Quality Leadership Committee

**What VA Central Office, VISN and VA Medical Center facility’s programs are in place to prevent patient safety hazards?**

Hazard Recalls alerts, Patient Safety Alerts and Advisories, Falls Collaborative, Preventing Post-Operative Respiratory Failure, Medication Reconciliation Collaborative, Suicide Prevention Program, MRSA/ MDRO Prevention, Preventing Central Line Bloodstream Infections, Preventing Ventilator Associated Pneumonia, Preventing Catheter Associated Urinary Tract Infections, National Sterile Processing Program, Emergency Preparedness, Violence Prevention, Facility Sterile Processing Tracers, VISN Sterile Processing Inspections.

**What VA Central Office, VISN and VA Medical Center facility’s programs are in place to respond and improve when a patient safety hazard occurs?**

Hazard Recalls alerts, Patient Safety Alerts and Advisories, Root Cause Analyses, Peer Reviews, Focused Reviews, Administrative Boards of Investigation

**How are high risk patient safety issues, reported to the medical center’s leadership?**

Incidents are reported to leadership at morning report and through the Executive Performance Improvement Council, Executive Committee of the Medical Staff, and Executive Committee of the Governing Body.

**Please describe the differences at your facility between quality of care and patient safety?**

Quality of care and patient safety are interrelated. Focusing on patient safety provides the organization with the opportunity to mitigate potential adverse events thus improving quality of care. The patient safety program promotes the implementation of knowledge-based actions that can be formulated, tested, and implemented to mitigate system vulnerabilities that can lead to patient harm and negatively effect quality of care.

**How do you work with the facility’s Quality Manager, Utilization Management, Risk Manager, Systems Redesign Manager and the Chief Health Information Officer on quality of care and patient safety programs and initiatives?**

Participation in the committees identified above provides a forum for a team approach to identify and resolve quality of care and patient safety issues in order to meet the mission and goals of the organization. Active participation in projects/task groups that focus on patient safety issues across organizational boundaries. Examples include: preparation for accrediting bodies surveys/reviews; identification of process improvement initiatives/system redesign strategies to decrease waste and increase efficiency in the delivery of safe patient care.

**Please explain the process taken to conduct a Root Cause Analysis (RCAs)?**

 The RCA process is a specific type of focused review that is used for all adverse events or close calls requiring analysis utilizing the Safety Assessment Code (SAC) Matrix. An interdisciplinary team approach is utilized to focus primarily on systems and processes rather than individual performance. The result of the analysis identifies changes that could be made in systems and processes through either redesign or development of new processes and systems that would improve performance and reduce risk.

**How do you use other facilities RCA’s to improve quality of care and patient satisfaction?**

Communications with other Patient Safety Mangers through conference calls, emails, or blogs on NCPS website. Communication with the VISN Patient Safety Officer and/or Program Manager at NCPS.

**How many staff members work specifically on patient safety initiatives and their position titles, job duties and responsibilities?**

All leaders and levels of clinical and administrative staff at the organizations would on patient safety initiatives.

**Can you provide the date and summary of any Root Cause Analyses (RCA) completed in the last year?**

 During FY 2011 there were 12 individual and 5 aggregate root cause analyses conducted

**Patient Aligned Care Team (PACT) Coordinator**

**What duties and responsibilities do you have as the Patient Aligned Care Team (PACT) Coordinator for the facility?**

1. As the PACT Director, in coordination with Primary Care I oversee the implementation of PACT in the Primary Care area. I am also responsible for development and implementation of a quality program by redesigning clinics and clinic practices to become Veteran-centric. We utilize a systematic and analytic approach in order to improve care and efficiency, to identify constraints, quality issues and determine needed services in all facilities throughout the VAMHCS.
2. Improve care management and coordination of care, including integration of preventative services and transitions between the inpatient and outpatient setting.
3. Facilitate coordination between and integration of Behavioral Health, Pharmacy, Nutrition, Social Work, and Specialty Care Services with Primary Care.
4. Utilize measurement and evaluation tools pertinent to the PACT to support the VISN5 Mission to honor America's Veterans as heroes by providing the highest quality health care.
5. Develop a sustainment model to ensure PACT growth and development.

**How many staff members work specifically on Patient Aligned Care Team (PACT) programs and initiatives and what are their position titles, job duties and responsibilities?**

Director and Deputy Director, Managed Care Clinical Center

E-consult Manager – Development and implementation of electronic consults inter/intra facility

* Access to specialty care from outlying and rural locations is challenging for Veterans and their primary care providers
* E-Consults provide specialty consultation without face-to-face contact by the Veteran with the specialist
* Complements goals of PACT (Patient Aligned Care Team) to shift face to face care to alternative venues

Secure Message Coordinator

* The coordinator leads the facility's efforts to integrate MHV and SM among healthcare providers and patients. She serves as secure message liaison and administrator to the clinical teams. This position is responsible for establishing and managing communications plans that identify target audiences, appropriate messages, activities, and resources needed for effective communication, and effective communications plan for change management.

Health Behavior Coordinator

* Dr. Elyse Kaplan, Licensed Psychologist, is the Health Behavior Coordinator for the VA Maryland Health Care System. She serves as the lead clinical consultant to the medical center staff on health behavior coaching. She maintains awareness of and provides consultation on the evidence basis for health behavior interventions, to promote health and prevent disease, and effective coaching methods by medical center staff. In collaboration with other providers, plans, develops, adapts, implements and assesses efficacy of health behavior interventions for the promotion of general health and to address health risk behaviors as part of disease prevention and chronic disease management. Dr. Kaplan provides consultation and training to Primary Care and Mental Health Service Line staff in the enhancing, maintaining, and supporting health behavior program for the promotion of health and prevention of disease and enhances patient self-management of chronic disease to prevent secondary complications and improve long-term outcomes and enhance quality of life. This work is carried out through training programs and through case discussion. Dr. Kaplan utilizes educational programs developed by the NCP and other national program offices for teaching and/or improving the clinical staff members core behavioral health skills.

Health Promotion and Disease Prevention - Program Manager

* The Health Promotion and Disease Prevention Program Manager (HPDP-PM) provides oversight for the VAMHCS Prevention Program and works closely with the Patient Aligned Care Team to ensure that Veterans are provided comprehensive health education, to support their health behavior changes to enhance self-management of their health conditions to improve their quality of life.
* The HPDP – PM ensures that clinical preventive services are delivered apprpropriately for age, (example PSA, Pap Smears, Mammogram, Colorectal cancer screenings, and Immunizations) to all Veterans receiving care at the VAMHCS.
* The HPDP – PM (chairs) and the Health Behavior Coordinator (HBC co-chairs) the VAMHCS Health Promotion and Disease Prevention Committee Program that is closely aligned with the Patient Aligned Care Team (PACT) initiative and provides resources to support facility HPDP infrastructure. These include staff training and coaching as well as tools to assist PACT and other clinical staff in assessing and addressing Veterans’ health promotion and disease prevention needs and interests.
* The Health Promotion and Disease Prevention Committee meet monthly and have representation for all of the VAMHCS prevention leaders.
* The HPDP – PM ensures that the nine key evidence-based healthy living messages include a brief overall message with more detailed information for those Veterans who are interested. These messages are listed below:
* Be Involved in Your Health care
* Be Tobacco Free
* Eat wisely
* Be Physically active
* Strive for a Healthy Weight
* Limit Alcohol
* Get Recommended Screening Test and Immunizations
* Manage Stress
* Be Safe
* The prevention team work collaboratively with the PACT teamlets and expanded teams to help them devek lop or enhance skills in Patient-centered communication and health coaching. Assist the staff in communication with the Veterans by using these tools (Clinical Staff Guide to Healthy Living Message pocket Guide and My health Choices patient handout).

**Who is in charge of the Patient Aligned Care Team (PACT) Steering Committee at this VA Medical Center?**

Dorothy Snow, M.D., Chief of Staff

**How often does the Patient Aligned Care Team (PACT) committee meet?** Monthly

**Which VA Medical Center staff attends the committee meeting?**

* Chief of Staff, Chair
* Director PACT/Co-Chair
* Director, Managed Care
* Deputy Director Managed Care
* Associate Director for Finance, or designee
* Associate Director for Operations, or designee
* Chief of Pharmacy, or designee
* Women’s Health Coordinator
* Telehealth Coordinator
* Secure Messaging Coordinator
* Preventive Care Coordinator
* Nurse Executive – Primary Care
* Director Mental Health Clinical Center, or designee
* Associate Chief of Staff for Education, or designee
* Labor Partner Representative
* MAS – Ambulatory/Primary Care Supervisor
* Chief Nutrition and Food Services or designee
* Chief Social Work or designee
* Business Manager/Primary Care

**Are representatives from the veterans’ community involved in your Patient Aligned Care Team (PACT) planning process?** YES, as part of the Focus group meetings and also initially as part of the PACT Executive Council.

**Explain how Patient Aligned Care Team (PACT) was implemented at the facility?**

* A charter was developed for the PACT Executive Council The seven key principles include: a practice that is patient driven, team based, efficient, comprehensive, continuous in nature, and strives for excellent communication along with outstanding coordination of services.
* Clinic teams were developed to include 1 RN, 1 Health Tech/LPN and 1 support staff for every provider.
* Home Builder survey to identify strengths and weaknesses The survey submitted to Central Office.
* Union meetings were scheduled with leadership and staff
* Budget requests were submitted to Leadership for personnel and equipment. Some renovation was also required measures for access; care management and coordination were identified.
* Clinic wait times: Data was and continues to be collected with the use of a time motion instrument.
* Patient satisfaction outcome data for quality of care, clinic wait times and appointment wait times is monitored.
* Missed Opportunity rate is measured monthly with the use of the VHA Missed Opportunity Monitor.
* Staff satisfaction was measured biannually with the use of the VAMHCS all employee satisfaction survey instrument.
* The impact of Secure Messaging will be measured by the following parameters: number of messages sent and response time to messages.
* Staff Training: The members of the PACT work in an interdisciplinary manner to ensure that the focus of the Veteran’s visit is the Veteran. Education was provided to staff to assist in development of their new roles.
* The role of the clerical staff is to provide administrative assistance in the check-in process and to assist with face-to-face encounters, telephone calls and Secure Messaging.
* The Primary Care Team nursing staff is responsible for screenings, assessments, education and assistance with communication between the Veteran and other team members.
* The Clinical Pharmacist, Social Worker and Home Telehealth staff are involved in specific care issues related to medications, psychosocial needs and coordination of care from home.
* Set up rooms: Modifications to the process of patient intake had to be made at the time of a Primary Care Clinic visit. Veterans will be administratively checked into for their appointments following current practice. The Veteran will then be taken to an examination room by a Patient Care Assistant who will perform vital signs and complete and screening clinical reminders. The Primary Care Team nurse will then enter the room to complete any assessments and/or education that is needed. Finally, the provider will meet with the patient to complete the medical evaluation. If the patient requires any additional services, such as an injection, the shot will be given in the same examination room. The Veteran will then leave the exam room and proceed to check out from the visit with the clerical staff.
* Secure Messaging (SM) is web-based, encrypted communication between patients and health professionals. Healthcare teams were trained and provided access to the program.
* Clinic Schedule changes – changes had to be made to the provider’s clinic schedule in order to accommodate acute care visits, phone visits, face to face visits, new patients in addition to their huddle time to review patient issues and treatment plans prior to the patient’s visits.

**Patient Satisfaction**

**Director of Patient Care Services**

**What duties and responsibilities do you have as the Director of Consumer Relations for the facility?** To analyze/manage data and collaborate with the clinical centers and services to promote patient-centered care, enhance customer service, and improve patient satisfaction.

**What were the results of the last Survey of Healthcare Experience of Patient (SHEP) survey?**

1. Inpatient



1. Outpatient

 

**Of these measures, which patient satisfaction measures are you responsible for?** Responsible for collaborating with the services and clinical care centers to take action to improve all of the patient satisfaction performance measures.

**What other facility staff reports to you on patient satisfaction programs and initiatives?** The service chiefs and clinical center directors report to the VAMHCS Veterans Satisfaction Committee (VVSC), which is chaired by the Associate Director for Operations. The Chief, Consumer Relations Service reports to the Associate Director for Operations and coordinates this committee. Within the Consumer Relations Service, the Patient Advocates, Consumer Representatives, Patient-Centered Care staff, and Information Desk staff come under the Chief.

**Patient Advocate/Patient Centered Care Coordinator**

**How do you define patient satisfaction as a healthcare facility?**

The patient’s perception of having their health care needs met. Patients should have a positive customer service experience in all aspects of their health care.

**What duties and responsibilities do you have as the Patient Advocate for the facility?**

To resolve the issues and concerns of Veterans in navigating the health care system. Also, we track Veteran complaints and compliments by month and by service/clinical center.

**How are patient satisfaction indicators and measurements tracked and managed?** Surveys/assessments are used to assess the quality of our 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 Consumer Relations Service Business Manager manages, analyzes, and distributes the SHEP patient satisfaction data. A Patient Advocate manages, analyzes, and distributes the Patient Advocate Tracking System (PATS) complaint/compliment data. The VAMHCS Veterans Satisfaction Committee (VVSC) is an interdisciplinary committee that oversees our efforts to improve patient satisfaction and customer service.

**Of these, which patient satisfaction measures are you responsible for?** Responsible for collaborating with the services and clinical care centers to take action to improve all of the patient satisfaction performance measures.

**When was your last patient satisfaction survey? What were the results? How do your results compare with other VAMC’s?**

December 2011:





**What were your previous patient satisfaction scores?**

November 2011:

 



**Have there been any Government Accountability Office (GAO), VA Office of the Inspector General (OIG) or media articles about patient satisfaction positive findings and /or concerns?**

Planetalk (Planetree Magazine), March 2012, “Improving HCAHPS Scores in a VA Network,” by William Sivley, VISN 5 Program Manager for Patient-Centered Care and Mary Ellen Piché, Planetree Consultation Services Specialist.

VA 2010 Hospital Report Card on internet, Annual Medical Quality Report that includes patient satisfaction, <http://www.va.gov/health/HospitalReportCard.asp>:

**Is your facility working on a “best practices” in patient satisfaction?**

**If so, please explain.**

VISN 5/VAMHCS has partnered with Planetree for the past several years to promote patient-centered care in healing environments and to improve patient satisfaction. Last year, the VHA created a national partnership with Planetree as well. Planetree is an internationally recognized nonprofit organization that partners with hospitals to improve the patient experience. Over the past couple of years, approximately 90% of VAMHCS staff members have participated in Patient-Centered Care/Planetree Staff Retreats. VAMCHS created its own “Veteran-Centered Care/Planetree Expectations and Behaviors” guide to assist staff with delivering patient-centered care on a daily basis.

**How many facility staff members work specifically on patient satisfaction initiatives and please list their position titles, job duties and responsibilities?**

Four staff members oversee the program: Ron Hoffmann, Chief, Consumer Relations Service; Valery Calm-Coleman, Assistant Chief, Consumer Relations Service; Janice Horton-Rainsbury, Business Manager, Consumer Relations Service; and Donna Felling, Patient-Centered Care/Planetree Coordinator, Consumer Relations Service. All have a responsibility to analyze/manage data and collaborate with the clinical centers and services to promote patient-centered care, enhance customer service, and improve patient satisfaction. In addition, there are five Patient Advocates: Maria Carelock, Janine Lembo, Robert Johnson, Charlotte Hucik, and Deborah Jolley and two Consumer Representatives: LaTarsha Ward and Dorothy Matthews. All have a responsibility to resolve Veteran issues and concerns with their health care services. In addition, Consumer Representatives administer the TruthPoint Assessments and provide emotional support to Veterans.

**Please explain the initial and ongoing training these patient advocates receives (i.e. type of training and number of days/hours)?**

National Patient Advocate Conference Calls (monthly/2 hrs); Regional Patient Advocate Training (1 day); Society for Healthcare Consumer Advocacy(SHCA), (3 days for one Patient Advocate per year); and VA Training Management System (TMS) instruction.

**Please describe programs and initiatives that relate to patient satisfaction?**

Planetree partnership and Planetree Staff Retreats to promote patient-centered care; CARE Training to improve courtesy and customer service; Veteran-Directed Visitation that allows Veterans to determine family that will provide emotional support during their course of stay; CARE Channel on patient TVs that provides healing music and nature scenes; Quiet/Knock on Door Campaign; two Planetree Model Patient Rooms; project to convert four-patient rooms to two-patient rooms to improve privacy and to reduce noise; project to convert various inpatient rooms to Planetree Rooms; and project to create a Veteran/Family Lounge on Inpatient Medicine Unit 3B.

**What is the procedure when you receive a patient concern and/or complaint?**

Which office and position in VA Central Office, VISN and VA Medical Center facility oversees Patient Advocates? Patient Advocate conducts interview (in person or by phone) with Veteran/Family; 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.

**What training do Facility Patient Advocates receive?**

National Patient Advocate Conference Calls (monthly/2 hrs); Regional Patient Advocate Training (1 day); Society for Healthcare Consumer Advocacy(SHCA), (3 days for one Patient Advocate per year); and VA Training Management System (TMS) instruction.

**Are any measurements or evaluations conducted by VA Central Office or the VISN on the Facility Patient Advocates to ensure their professionalism, courteousness and prompt response/follow up action is taken when a patient complaint outcomes is initially filed?**

The Patient Advocate Tracking System (PATS) is used to monitor compliance with standards. VISN 5 surveyors review the VAMHCS Patient Advocate Program.

**Is there a national Veterans Health Administration (VHA) directive that stipulates the number of days a facility patient advocate has to follow up on a complaint or concern filed by a veteran?**

VHA Handbook 1003.4, VHA Patient Advocacy Program requires Veteran/family concerns to be addressed within 7 days; VHA national average is 3.3 days; VISN 5 average is 1.5 days; VAMHCS 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.

I**f so, which office and positions ensure this standard/policy is being met?**

Chief, Consumer Relations Service with the assistance of the Patient Advocates ensures standards are maintained. Reports are provided to the Executive Committee of the Administrative Services (ECAS) and the VAMHCS Veterans Satisfaction Committee (VVSC).

**Do you have any primary care clinics that take longer than the 30 day wait, if so, which ones?**

Yes. We will provide you with that listing upon your visit, as the list changes daily.

**Utilization Management/Risk Manager/Systems Redesign Manager**

**Utilization Management Coordinator**

**What job duties and responsibilities do you have to ensure quality of care and patient satisfaction?**

Position is responsible for implementing and maintaining the process of evaluating and determining the coverage and the appropriateness of medical care services across the patient healthcare continuum to ensure the proper use of resources. As part of the duties/responsibilities, position supervises the Utilization Management (UM) Nurses, 2 Fee Nurses, the Patient Transfer Coordinator and Patient Flow Coordinator. Additionally, serves as co lead for the Bedside Care Collaborative and supports an initiative of Intentional Rounding lead by a UM Nurse. Serves as VISN 5 point of contact which enables the facility to remain apprised of changes at a regional and national level and chairs the VAMHCS Flow Committee. Recently charged by the Director to develop/open a Care Coordination Center.

**What training did you receive initially and what ongoing training do you receive for this position?**

I am a Master’s prepared nurse in Administration with a minor in Education. When I initially was appointed, I did site visits to the Atlanta and Boston VA Hospitals to get one on one training with the UM, UR and Flow Coordinators . I have attended 3 National Flow Collaboratives as well as the Eastern Regional UM Meeting. I am scheduled to take Yellow Belt Training. I participate in the National UM calls and have taken management classes within and outside of the VAMHCS.

**How are measurement tools used to improve quality of care and patient satisfaction?**

On a facility-wide and clinical center specific basis, the primary UM outcome indicators (e.g. readmission, adm meeting criteria) are sent to committees to assist in the identification of potential gaps in service or care. Further indicators are collected on individual providers to assist them in understanding their practice patterns and identify ways of improving their aggregate care as well as care for individual patients.

**Risk Manager**

**What job duties and responsibilities do you have to ensure quality of care and patient satisfaction?**

Responsible to the VAMHCS Chief of Staff for promoting, educating, and providing consultation in the area of Risk Management consulting in all environments of care throughout the VAMHCS. Participation on executive committees including: Executive Committee of the Governing Body, Executive Committee of the Medical Staff, Executive Performance Improvement Council, and the Veterans Satisfaction Committee. Supervisory responsibility for Risk Managers in each Clinical Center. Collaborate with Administrative and Clinical leadership at the VAMHCS and with the VISN and Regional Council in areas of Risk Management. Track data to identify outcomes which could be improved and initiates/leads teams to analyze results and design changes to improve outcomes.

**What training did you receive initially and what ongoing training do you receive for this position?**

Lean six-sigma; HFMEA; Administrative Board of Investigation Training; Webinars; monthly conference calls

**How are measurement tools used to improve quality of care and patient satisfaction?**

A variety of measurement tools are utilized for planning, data collection, and analysis. Some examples include: process mapping to identify critical steps in a process and actual or potential risk areas for analysis; run charts to show levels of performance over time; control charts to identify the type of variation that exists in a process and whether the process is statistically in control.

**Systems Redesign Manager**

**What job duties and responsibilities do you have to ensure quality of care and patient satisfaction?**

Systems Redesign responsibilities are critical to ensure quality of care throughout the facility. This includes serving as a facilitator, teaching, leading, promoting, organizing, arranging, measuring and doing what’s needed to engage the all staff including front line, managers and leadership in productive meaningful improvement of systems to improve quality of care to our Veterans.

**What training did you receive initially and what ongoing training do you receive for this position?**

The Acting Systems Redesign Coordinator comes with a background in Advance Clinic Access (ACA) as well as System Redesign (SR) for over seven years. The Acting SR Coordinator was a National SR Coach and served on numerous National VHA Committees.

**How are measurement tools used to improve quality of care and patient satisfaction?**

There are formal and informal meetings related to SR and Access issues relating to miss opportunities. Currently VAMHCS is rolling out Yellow Belt Lean training for all leadership and Management positions to ensure the SR efforts are efficiently and effectively rolled out across the Health Care Delivery system. There is extensive Clinical Center involvement and monthly reporting using the all systems redesign tools.

**Chief Medical Information Officer**

What job duties and responsibilities do you have to ensure quality of care and patient satisfaction?

How are the quality of care and patient satisfaction indicators and measurements tracked and managed?

How do you measure the results of quality of care and patient satisfaction indicators? (i.e. PACT) How are these results utilized to improve performance in real time?

How are measurement tools used to improve quality of care and patient satisfaction?