**The American Legion**

**System Worth Saving Program**

**Quality of Care and Patient Satisfaction**

**Cincinnati 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?* Included modeled and non- modeled –FY 2011= $355,510,201

FY 2012 = $349,531,855

*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.*

Medical Services appropriation- FY 2011 = 62% …FY 2012 = 70%

The percentages are all the costs associated with providing direct patient care.  This includes the providers, nurses, clerks, allied health support, etc.  It is for everything we do medically to care for our patients.

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

We define quality by assessing our outcomes of care as compared to VA and non-VA facilities, Veteran satisfaction with our care and services, whether any patient incidents would suggest that our processes for providing care should be improved and by assessing the performance of our staff and others involved in the care process. VA Central Office provides a Network Director Performance Plan each fiscal year which is a blueprint for us of important measures of quality and compliance with requirements. We strongly believe that improving our work is our work and are committed to continuous improvement of our clinical and administrative programs. Whenever an individual measure fails to meet or exceed expectations, we focus on that measure until it fully meets our expectations.

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

Cincinnati VAMC is fully accredited by The Joint Commission, the College of American Pathologists, the Commission on Cancer of the American College of Surgeons, the Commission on the Accreditation of Rehabilitation Facilitates (Physical Medicine and Psychosocial Rehabilitation Programs), AAHRPP, AAALAC, ASHP-Pharmacy Residency and the American College of Radiology.

* + CVAMC was recently awarded the 2011 Outstanding Achievement from the Commission on Cancer and full three year accreditation.
	+ VA’s 2011 William S. Middleton Award for outstanding achievement in biomedical research was awarded to a researcher, Dr. Finkleman.
	+ Three staff members were recognized with national Wolcott Awards for Clinical Excellence.
	+ 2011 Cincinnati Florence Nightingale Winner
	+ CVAMC currently meets/exceeds expectations in external audits. Among them are The Joint Commission, CARF, OIG CAP, CAP review of Laboratory Services and the Longterm Care Institute (LCI) for review of our Community Living Center. We have also performed well on internal and external reviews of our administrative programs.
	+ CVAMC received VHA Awards for Innovation through a national competition.

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

Inpatient Satisfaction

* SHEP survey: 32 questions one of which is “during this hospital stay how would you rate the quality of care you received” – on a scale of 0 (not satisfied) to 10 (best care ever)
* Quikcard surveys: during this hospital stay how would you rate the overall quality of care you received? Excellent, Very Good, Good, Fair, or Poor

Outpatient Satisfaction

* SHEP survey: 32 questions one of which is “Using any number from 0 to 10, where 0 is the worst healthcare possible and 10 is the best healthcare possible, what number would you use to rate all your VA healthcare in the last 12 months?
* Quikcard survey: Rate your overall satisfaction with the quality of care you receive from the VA (from 0 (worst) to 10 (best)

Network Director’s Performance Plan

Secretary’s T-21 Initiatives

Facility and VISN-level quality reviews/quality monitors and measures

A formal facility-level and VISN-level infrastructure of quality oversight, quality measurement, quality review and continuous improvement

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

The medical center tracks measures of quality required by VA, outside reviewers and the Network, as well as locally developed measures. Some measures are reported externally to Veterans. The CVAMC also does very detailed assessments of its degree of compliance with mandated measures required by The Joint Commission, OIG CAP survey processes, CARF and other reviewers. We continually assess our programs and services, using local as well as VISN and national measures/standards. When an incident occurs, we systematically access our processes to determine whether improvements are needed to prevent a recurrence. Employees are evaluated for the quality of care or services they provide, and we actively work to improve performance and conduct among our staff or take appropriate administrative action.

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

1. *Chief of Staff*

The Chief of Staff (COS) for the Cincinnati VA Medical Center is responsible for the clinical staff of this state of the art full service tertiary care hospital in Cincinnati, Ohio. The COS provides oversight at of the quality continuum and in all areas of clinical care. He chairs the Clinical Executive all levels Board (The Medical Staff Executive Committee), where clinician quality is measured, tracked, evaluated and acted upon; and the Peer Review Committee, where individual clinician performance is evaluated, discussed and when necessary acted upon. In addition the COS sits as a member of all the Hospital’s quality, performance, improvement, and resource committees (both clinical and non clinical).  He is responsible for the day to day care provided by the clinical services which report to him through their Chiefs, approval of non VA care, and adjudication of quality and safety related concerns.  Finally the COS is integral to strategic planning and budgeting both of which ultimately impact the quality of Veteran care.

1. *Head Nurse*

The Nurse Executive is responsible for all nursing personnel including RNs, LPNs, Nursing assistants, health techs, transporters,  etc that are under the auspices of Nursing Service.   The nurse executive is a member of the Cincinnati VA Quadrad (Senior leadership), Quality and Performance Committee, Relationship-Based Care Results Council, Clinical Executive Board, Executive Leadership Board, and Clinical Quality and Safety Committee.  Quality is monitored and reported through these committees.  Continuous improvement efforts are a part of our daily lives.

1. *Quality Manager*

Quality manager integrates the quality management program at the Cincinnati VA, Community Living Center, Domiciliary, PTSD Program, and six Community Based Outreach Centers as well as interpretation and application of accrediting body standards. Responsibilities include, however, are not limited to: design, implementation, coordination, and evaluation of an integrated Quality Management Program for the Cincinnati VAMC and all components which include direct oversight of Performance Improvement, Risk Management, External Accreditation, VASQIP, and Utilization Management, operates under a broadly delegated authority to influence the organizational mission, participates in strategic planning and carries out initiatives to meet national, VISN and Medical Center goals and objectives.

1. *Patient Safety Manager*

The Patient Safety Managers support the Root Cause Analysis (RCA) process in response to an unexpected outcome by providing team training, support and developing competencies in team function. We evaluate the RCA process as it functions in the Medical Center and follow-up on actions/outcomes in response to the team findings. The Patient Safety Managers have various programmatic functions such as serving as the facility point of contact for Patient Safety Alerts/Advisories including tracking actions, acting as the Point on Contact for facility patient safety issues to the National Center for Patient Safety (NCPS) and serving as the facility expert on the VHA Patient Safety Handbook.

1. *Utilization Management*

To ensure quality of care and patient satisfaction, the Utilization Review nurses in the Quality Management department review electronic medical records, attend interdisciplinary rounds daily, collaborate with the Attending and Emergency Room doctors regularly concerning patients and the level of care and the timeliness of care that they receive. We strive to ensure that the right patient receives the right care, at the right time in the right setting.

1. *Risk Manager*

Risk management mitigates risk through proactive identification and management of issues that pose a risk to patients, visitors, the organization and its staff.

1. *Systems Redesign Manager*

Responsibilities as the Systems Redesign (SR) Manager are to serve as a consultant to workgroups throughout the Medical Center to analyze performance data related to quality of care and patient satisfaction, identify performance gaps between expected and actual performance, identify process barriers that negatively impact quality of care and patient satisfaction and develop solutions to improve both. The manager is also a member (SR Representative) for both the Customer Focus and Quality and Performance Committees.

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

 Responsible for the appropriate use of technology as it applies to clinical settings.

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

The Facility Director, Quality Manager, Patient Safety Manager, Chief of Staff, Nurse Executive, Associate Director, Service Chiefs and Line Directors, the facility Executive Leadership Board, the facility Quality and Performance Council, the Clinical and Administrative Executive Boards, committees responsible for oversight of some aspect of quality of care (e.g., Infection Control, Safety, Pharmacy and Therapeutics) and all VAMC employees.

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

A significant amount of training is now available online through VA’s Talent Management System (TMS).  Most of the training is nationally mandated.  In addition to TMS training, staff receives training specific to their work areas and clinical or administrative assignments.  Training is ongoing at each facility and in each service.  Since last year, the facility is involved in an exciting transformation called **Relationship Based Care** (RBC). RBC is a process with leverages the power of relationships across the organization to create a caring and healing environment where patients and families are truly the center of caring practice. Many staff are also being trained in the new model of primary care, **Patient Aligned Care Team** Training.  During the year new training is always added for each employee.  The Designated Learning Officer is part of many medical center committees and task forces that present data related to staff competencies and patient issues.  The DLO use medical center data, committee reports and minutes, documented staff incidents, patient incidents, audits, accreditation reports, and patient satisfaction data as part of the assessment of quality of training and the need to add, modify, or delete training.  This is the basic approach used to perform an annual/ ongoing needs assessment.

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

The VISN and VACO have provided more resources than ever before to enhance quality of care and our service to Veterans. Training, directives on new programs, financial support, guidance, webinars, site visits, external expertise and numerous other types of support are made available to the facility to improve quality of care and transform the organization to a patient-centered facility known for the quality of care and services provided.

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

We anticipate ongoing support for both VACO and the VISN as we transform our facility using the models of PACT, patient centered care, Relationship Based Care, Lean, Systems Redesign and other initiatives. The CVAMC is very proactive in applying for participation in new pilot initiatives designed to continuously improve the organization.

***What innovative qualities of care programs or studies covered by grants are being conducted by this facility?***

**The CVAMC is a facility recognized nationally for its innovation and the quality of care and services. Examples of initiatives supported by grants include PTSD programming, Women’s Health initiatives, Health Promotion/Disease Prevention Programs for Veterans and their spouses, programming for inpatient mental health, a new initiative to improve health status and quality of life for Veterans with COPD, a collaborative with the community on cancer care, an initiative to improve health status and wellness of employees, the ongoing mobile van outreach initiative funded by Cintas Corporation’s Farmer Family Foundation, a grant from Proctor and Gamble to beautify the Ft. Thomas campus and create areas for recreational programs and gardening and rural outreach initiatives.***Is your facility working on a “best practice(s)” in quality of care management?*

There are numerous areas recognized as “best practices” by the VA and outside organizations. Examples include our national referral program for PTSD, the inpatient mental health unit, the SUDEP program, robotic surgery, pulmonary care, Systems Redesign, the Relationship Based Care Initiative and the inpatient mental health program. Best practices in quality of care management in particular include the medical center’s Patient Safety Program, which has been recognized four consecutive years with the Gold Cornerstone Award.

*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?*

Facility Quality Manager (QM). The facility QM is responsible for:

* Ensuring that all components of the quality management plan are integrated.
* Ensuring a system for monitoring the quality data process is in place.
* Ensuring Annual Performance Evaluations and Performance Improvement initiatives are completed.
* Serving as the quality consultant to the facility leadership, Quality Improvement (QI) teams, and employees.
* Serving on the executive committees and in workgroups where quality data is reviewed, analyzed, and acted upon.

The facility QM will have unrestricted access to data and information that are 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 and patient safety data must be protected and used only as consistent with 38 U.S.C. 5705 and appropriate agency policies and directives governing confidential data.

Facility Service Chiefs and Service Line Directors. Facility Service Chiefs and Service Line Directors are responsible for:

* 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.
* Developing, in collaboration with the facility COS, Nurse Executive, and QM and approved by the Facility Director, the service line collection, analysis, evaluation, and follow-up of performance improvement activities and records.
* Completing pertinent formal tracking using facility tracking tools.

Facility Executive Committee of the Medical Staff (Clinical Executive Board). The Clinical Executive Board is responsible for:

* Overseeing the quality of care delivered by its members by active involvement in the measurement, assessment, and improvement of the areas mandated by the Joint Commission and VHA policy.
* Participating in other organization-wide performance improvement activities.
* Ensuring that a process is in place to include information for granting privileges from the practitioner’s professional practice evaluation data.

VHA Employees.VHA employees will report issues affecting the quality and safety of health care provided to Veterans through the channels defined by the facility and the VISN. Formal and informal employee suggestions are essential to improve quality patient care and achieve desired patient outcomes**.** Patient safety incidents or concerns need to be reported to the Patient Safety Manager through the mechanism(s) provided (VHA Handbook 1051.01).

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

The Chief of Staff.The facility COS is responsible for:

* Ensuring the quality of clinical medical practice within the facility.
* Contributing toeffective Quality Management through medical leadership.
* Participating in facility quality activities.
* Overseeing the quality of patient care, treatment, and services provided by practitioners.
* Ensuring a sound process for granting and renewing clinical privileges based on appropriate initial and ongoing evaluations of training, competency, and performance is present at the facility.
* Chairing the peer review committee.

*How many Full Time Employee (FTE) Registered Nurses, License Practical Nurse are on your staff? Is there sufficient staff to patient ratio?*

The staff to patient ratio fully meets VA and external measures for both the hospital and the community living center.

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| --- | --- |
| LPN Total Losses for FY 12 |  |
| Facility Total Loss Numerator | 2 | Facility Total Loss Numerator - Total number of employees lost FY 12 |
| Facility Total Loss Rate | 0.018396846 | Facility Total Loss Rate – Any loss, retirement, death, termination, voluntary separation or transfer that removes employee from the selected Facility.   |
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|  |  |  |
| New LPN Hires FY 12 |  |
|  | FYTD Distinct Employee |  |
|  | 2012 |  |
| GAIN | 11 | Total New Hires FY 12 (Part-Time and Full-Time) |
|  |  |  |
|  |  |  |
| Onboard LPN Employees as of end of APR-FY12  |
|  | Onboard Employee |  |
|  | (V10) (539)  MC   CINCINNATI    OH |  |
| 0620 Nurse | 114 | Total Onboard 0620 series LPN's as of Apr 30, 2012 |

|  |  |
| --- | --- |
| RN Total Losses for FY 12 |  |
| Facility Total Loss Numerator | 17 | Facility Total Loss Numerator - Total number of employees lost FY 12 |
| Facility Total Loss Rate | 0.035940803 | Facility Total Loss Rate – Any loss, retirement, death, termination, voluntary separation or transfer that removes employee from the selected Facility.   |
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| New RN Hires FY 12 |  |
|  | FYTD Distinct Employee |  |
|  | 2012 |  |
| GAIN | 36 | Total New Hires FY 12 (Part-Time and Full-Time) |
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| Onboard RN Employees as of end of APR-FY12  |
|  | Onboard Employee |  |
|  | (V10) (539)  MC   CINCINNATI    OH |  |
| 0610 Nurse | 480 | Total Onboard 0610 series RN's as of Apr 30, 2012 |

*Has there been any turnover with any of these positions? See above.*

 *How long have these positions been vacant? Data not available.*

*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

*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)?*

The medical center’s overall performance this fiscal year for both the OIG CAP survey and the OIG survey of our CBOC’s was excellent. A few issues were identified that were timely addressed.

*What were the findings and recommendations found with the media articles? None.*

*When was your last Joint Commission Inspection? October 2010*

*What were the findings and recommendations? See Report*

*When was your last Commission Accreditation Rehabilitation Facility (CARF) inspection? What were the findings and recommendations? March 2012 - See Attached*

*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?*

The VISN quality committee is the Performance Improvement Committee and is lead by the Chief of Staff in Cleveland and the Quality Management Officer. The facility has a Quality and Performance Committee that is chaired by the Director with the Quadrad and the quality manager as members.

*Are veterans’ participating and/or serving on these committees?* We do not currently have veterans participating on these committees. However, we are forming a new Veterans Advisory Committee and have had Veteran focus groups identify areas for improvement.

**Additional Questions**

*Please describe your quality of care programs and initiatives?*

Quality is a part of the medical center’s daily operations and is embedded in every activity. The committee structure is built around quality, with clinical and administrative committees reporting to all of medical center leadership through the Administrative and Clinical Executive Boards. A separate Quality and Performance Committee is chaired by the Medical Center Director and focuses on areas of high risk or those areas where close oversight is required. Every employee has an opportunity to be involved in quality through the Relationship Based Care initiative and the formation of Unit Practice Councils. The UPC’s work on areas they identify that improve relationships with Veterans, self and co-workers and establish a foundation for addressing any concerns about quality that the employees on the UPC can address.

*What programs do you have to ensure quality of care and patient satisfaction for women veterans?*

* We offer Comprehensive Primary Care for Women in a safe, secure environment with the Women’s Health Center, with a full time staff dedicated to the care of female Veterans, as well as a full time Women Veterans Program Manager.
* We have a staff gynecologist in the Women’s Health Center and a TeleGyn program in June to provide access for our distant females and providers.
* There is a female only tobacco treatment class with incentives provided by a grant written by W VPM
* We are using the simulator unit and TMS modules to provide competencies for our Women’s Health providers, covering basic pelvic exam and pap smear collection, contraception, abnormal uterine bleeding, chronic pelvic pain, hormonal replacement, breast mass evaluation and cardiovascular disease in women.
* We hold an annual Women Veterans Appreciation Luncheon to honor our female Veterans.
* Women Veteran Program Manager is active in outreach events throughout the year.

*How does the executive leadership provide oversight and shared governance of quality functions and activities to promote safe high quality care, and high reliability?*

By establishing a standing leadership committee (Quality and Performance Committee)

to review quality data and ensure information and key quality components are

discussed and data reviewed at its meetings.

* This committee meets at least monthly or as warranted based upon the nature of the data.
* The members of this committee must include the Director, the Chief of Staff (COS), Quality Management Officer, Patient Safety Manager, and Nurse Executive. In the event that a key member of the committee is not available for a meeting, a delegate empowered fully to represent the member and reporting back to that member must attend. Other members may be included as appropriate.
* The meeting minutes will be recorded using a standardized committee template that has a method to track issues to completion and to record attendance.
* The data collected for key quality management components will be trended, aggregated data examined for direction and magnitude of change, and reviewed at this meeting. Comparison data and triggering thresholds will be noted in the minutes of the meeting.
* Ensuring use of valid quality improvement tools and methods for documenting the collection and review of quality data by leadership within the facility. The documentation will include decisions for prioritizing actions, developing corrective and quality improvement plans that are tracked to completion, as well as the rationale for when the decision not to take action is made.
	+ This tracking tool will encompass all components of the quality management program and lists all of the organizational priorities that are being tracked.
	+ This tracking tool is reviewed at the standing facility leadership committee assigned to review quality data.
* Ensuring a process for communication of quality data as described in the VHA Directive 2008-061 within the facility. A flow chart or algorithm will be developed as required. This flow chart will:
	+ Reflect the quality management structures present within the facility, including the assignment of accountability and the communication structure.
	+ Include the relationships of the committee assigned to review quality data.
	+ Make explicit important collaborations needed in decisions about data collection, review and reporting, and the development and completion of corrective and quality improvement plans.
	+ Ensuring adverse trends, significant outliers, and strong practices are communicated to the VISN Director.
		- Reporting of adverse trends and significant adverse outliers will occur immediately upon discovery, and contain an analysis of the issue and clear mechanisms and timelines for follow-up for quality concerns.
		- A copy of all such reports will be documented in the minutes of QPC.

*How do assure that the variety of quality, safety, improvement utilization, and risk functions work seamlessly together to resolve known quality problems and anticipate future organizational risk?*

By appointing a Facility Patient Safety Manager (PSM).The facility PSM is responsible for:

* Implementing a coordinated patient safety improvement program at the facility level that is based on guidance and tools from the NCPS, and meets needs and priorities identified by the Facility Director, such as addressing important standards, requirements, and recommendations promulgated by The Joint Commission and other organizations working to improve patient safety.
* Working collaboratively with VISN Patient Safety Officers (PSOs) and those described in the VHA Handbook 1051.01.

*Do you have any construction projects to improve quality of care?*

* Traumatic Brain Injury /Post Traumatic Stress Disorder Program – Fort Thomas Division- This project created more inpatient space for Traumatic Brain and PTSD patients.
* 1st Floor Strategic Plan – Is a project that is responsible for the updating ,remodeling and reorganization of the first floor of the main hospital. Areas affected include Outpatient Pharmacy, Patient Transportation, Agent Cashier, and the Patient Intake area.
* Post Anastasia Care Unit Reorganization- This project has remodeled the pre and post operation recovery space on the third floor and updates the waiting area.
* Lab Renovation- Is a complete remodel of the blood lab and chemistry lab.
* Replace Finishes Emergency Department  & Miscellaneous Areas- This project remodels the emergency department and surrounding areas.
* Renovate Pulmonary / Sleep Lab- The purpose of the renovation work is to expand the Sleep Lab currently located on 9 South, and to consolidate Pulmonary Service functions.
* Renovate Canteen Store & Food Court-  This project updates the Canteen Food Court and store.
* Relocate Community Living Center  (phase I, II and III)- This project relocates the long term patients to the Cincinnati Campus.
* Imaging Center Addition- This project will provide new MRI, CT Scan and Special Procedures space for the facility.
* Outpatient Surgical Center- This project relocates the GI Lab, provides an additional operating room and improves ancillary functions in the area.
* Vocera and Nurse Call- This project was design to provide the nursing staff with instant communication with medical staff.

**Patient Satisfaction**

*What percentage of your budget is dedicated to Patient Satisfaction staffing and programs in FY 2011? FY 2012? Please explain.*

* Staff attendance at a variety of courses:  2011 average staff salary X 9,704 hours= FY 2011 =$448,907
* Staff attendance at a variety of customer courses:  2012 average staff salary X 2,945 hours YTD=FY 2012 = $139,829
* $1,000 annual star luncheon
* $22,500 – Crucial Conversations toolkits
* $8,000 – customer recognition program

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

We define patient satisfaction as no complaints, patients “want” to come here even if they have a choice to go somewhere else, and that we give excellent care (not just OK). It is also defined through our Patient Satisfaction Surveys for both inpatient and outpatient Veterans.

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

Inpatients

* SHEP survey; 32 questions one of which is “during this hospital stay how would you rate the quality of care you received” – on a scale of 0 (not satisfied) to 10 (best care ever)
* Quikcard surveys – During this hospital stay how would you rate the overall quality of care you received? Excellent, Very Good, Good, Fair, or Poor

Outpatients

* SHEP survey; 32 questions one of which is “Using any number from 0 to 10, where 0 is the worst healthcare possible and 10 is the best healthcare possible, what number would you use to rate all your VA healthcare in the last 12 months?
* Quikcard survey: Rate your overall satisfaction with the quality of care you receive from the VA (from 0 (worst) to 10 (best)

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

* Survey of Healthcare Experiences of Patients (SHEP)
* Quikcards
* Patient Advocate complaints

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

* Regularly shared with managers and staff; action plans required when we fall below the national scores for a quarter.
* Annually, used to develop centralized and decentralized departmental action plans.

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

**INPATIENT SHEP**

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| **CLEANLINESS OF ENVIRONMENT** | **4th Qtr. 2011** | **1st Qtr. 2012** | **Jan** | **Feb** | **Mar** | **2012 YTD** |
| National | 91.2 | 91.0 | 90.1 |  |  | 90.8 |
| **Cincinnati** | **93.8** | **95.8** | **82.9** |  |  | **92.2** |
| **COMMUNICATION ABOUT MEDICATIONS** | **4th Qtr. 2011** | **1st Qtr. 2012** | **Jan** | **Feb** | **Mar** | **2012 YTD** |
| National | 78.6 | 79.0 | 80.6 |  |  | 79.4 |
| **Cincinnati** | **84.6** | **86.8** | **82.6** |  |  | **85.5** |
| **DOCTOR COMMUNICATION** | **4th Qtr. 2011** | **1st Qtr. 2012** | **Jan** | **Feb** | **Mar** | **2012 YTD** |
| National | 92.8 | 93.0 | 93.2 |  |  | 93.1 |
| **Cincinnati** | **95.7** | **94.7** | **94.9** |  |  | **94.8** |
| **NURSE COMMUNICATION** | **4th Qtr. 2011** | **1st Qtr. 2012** | **Jan** | **Feb** | **Mar** | **2012 YTD** |
| National | 92.9 | 92.8 | 93.2 |  |  | 92.9 |
| **Cincinnati** | **94.7** | **93.5** | **91.2** |  |  | **92.9** |
| **DISCHARGE INFORMATION** | **4th Qtr. 2011** | **1st Qtr. 2012** | **Jan** | **Feb** | **Mar** | **2012 YTD** |
| National | 83.1 | 83.6 | 83.1 |  |  | 83.5 |
| **Cincinnati** | **83.7** | **85.4** | **77.6** |  |  | **83.1** |
| **NOISE IN ROOM** | **4th Qtr. 2011** | **1st Qtr. 2012** | **Jan** | **Feb** | **Mar** | **2012 YTD** |
| National | 80.4 | 80.0 | 79.9 |  |  | 80.0 |
| **Cincinnati** | **84.1** | **86.8** | **75.2** |  |  | **83.5** |
| **OVERALL RATING OF HOSPITAL** | **4th Qtr. 2011** | **1st Qtr. 2012** | **Jan** | **Feb** | **Mar** | **2012 YTD** |
| National | 64.1 | 63.7 | 64.1 |  |  | 63.8 |
| **Cincinnati** | **64.9** | **62.8** | **61.0** |  |  | **62.3** |
| **PAIN MANAGEMENT** | **4th Qtr. 2011** | **1st Qtr. 2012** | **Jan** | **Feb** | **Mar** | **2012 YTD** |
| National | 89.1 | 89.0 | 88.6 |  |  | 88.9 |
| **Cincinnati** | **93.7** | **91.4** | **78.7** |  |  | **87.6** |
| **PRIVACY** | **4th Qtr. 2011** | **1st Qtr. 2012** | **Jan** | **Feb** | **Mar** | **2012 YTD** |
| National | 84.7 | 84.7 | 85.3 |  |  | 84.8 |
| **Cincinnati** | **89.8** | **81.1** | **75.7** |  |  | **79.6** |
| **QUITENESS AT NIGHT** | **4th Qtr. 2011** | **1st Qtr. 2012** | **Jan** | **Feb** | **Mar** | **2012 YTD** |
| National | 83.9 | 84.0 | 83.5 |  |  | 83.8 |
| **Cincinnati** | **89.3** | **86.4** | **74.5** |  |  | **83.1** |
| **RESPONSIVENESS** | **4th Qtr. 2011** | **1st Qtr. 2012** | **Jan** | **Feb** | **Mar** | **2012 YTD** |
| National | 85.8 | 84.2 | 86.1 |  |  | 84.6 |
| **Cincinnati** | **87.9** | **87.8** | **81.5** |  |  | **86.1** |
| **SHARED DECISION MAKING** | **4th Qtr. 2011** | **1st Qtr. 2012** | **Jan** | **Feb** | **Mar** | **2012 YTD** |
| National | 71.8 | 72.0 | 71.6 |  |  | 71.9 |
| **Cincinnati** | **71.8** | **73.9** | **68.6** |  |  | **72.4** |
|  |  |  |  |  |  |  |
| **1% > than the national score** |  |  |  |  |  |  |
| **1% < than the national score** |  |  |  |  |  |  |
| **Within 1% +/- of the national score** |  |  |  |  |  |  |

**OUTPATIENT SHEP**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **GETTING CARE QUICKLY** | **4th Qtr 2011** | **Oct** | **Nov** | **Dec** | **Jan** | **2012 YTD** |
| National | 77.2 | 78.5 | 77.8 | 77.3 | 76.9 | 77.4 |
| **Cincinnati** | **80.7** | **65.6** | **86.0** | **87.5** | **77.5** | **78.1** |
| **GETTING NEEDED CARE** | **4th Qtr 2011** | **Oct** | **Nov** | **Dec** | **Jan** | **2012 YTD** |
| National | 78.5 | 79.8 | 79.2 | 78.1 | 78.0 | 78.8 |
| **Cincinnati** | 81.7 | **76.7** | **85.9** | **86.0** | **81.0** | **82.4** |
| **DOCTOR/NURSE** | **4th Qtr 2011** | **Oct** | **Nov** | **Dec** | **Jan** | **2012 YTD** |
| National | 89.9 | 90.4 | 90.3 | 89.7 | 90.2 | 90.2 |
| **Cincinnati** | 89.9 | **90.9** | **92.3** | **97.0** | **94.9** | **93.6** |
| **OVERALL QUALITY** | **4th Qtr 2011** | **Oct** | **Nov** | **Dec** | **Jan** | **2012 YTD** |
| National | 54.3 | 56.2 | 54.8 | 53.8 | 55.4 | 55.1 |
| **Cincinnati** | 56.7 | **57.7** | **68.9** | **65.1** | **56.2** | **61.6** |
| **OVERALL DOCTOR/NURSE SATISFACTION** | **4th Qtr 2011** | **Oct** | **Nov** | **Dec** | **Jan** | **2012 YTD** |
| National | 68.2 | 69.1 | 68.7 | 67.4 | 68.2 | 68.4 |
| **Cincinnati** | 71.0 | **73.5** | **82.0** | **74.2** | **78.9** | **76.9** |
| **SPECIALIST SATISFACTION** | **4th Qtr 2011** | **Oct** | **Nov** | **Dec** | **Jan** | **2012 YTD** |
| National | 62.8 | 64.8 | 63.9 | 62.9 | 64.2 | 63.9 |
| **Cincinnati** | 64.9 | **56.0** | **75.5** | **71.7** | **55.3** | **64.1** |
| **PHARMACY MAILED** | **4th Qtr 2011** | **Oct** | **Nov** | **Dec** | **Jan** | **2012 YTD** |
| National | 81.2 | 81.7 | 81.2 | 80.6 | 81.9 | 81.4 |
| **Cincinnati** | 77.6 | **72.2** | **80.1** | **82.6** | **85.7** | **80.1** |
| **PHARMACY PICK-UP** | **4th Qtr 2011** | **Oct** | **Nov** | **Dec** | **Jan** | **2012 YTD** |
| National | 65.7 | 67.7 | 65.0 | 65.5 | 64.4 | 65.7 |
| **Cincinnati** | **35.5** | **40.1** | **65.6** | **56.6** | **38.3** | **47.8** |
| **PROVIDER WAIT TIME** | **4th Qtr 2011** | **Oct** | **Nov** | **Dec** | **Jan** | **2012 YTD** |
| National | 74.1 | 76.3 | 74.5 | 74.8 | 75.1 | 75.2 |
| **Cincinnati** | **71.1** | **89.0** | **79.9** | **84.9** | **87.7** | **84.4** |
| **SHARED DECISION MAKING** | **4th Qtr 2011** | **Oct** | **Nov** | **Dec** | **Jan** | **2012 YTD** |
| National | 89.5 | 89.9 | 90.2 | 90.0 | 90.4 | 90.1 |
| **Cincinnati** | **94.0** | **91.0** | **95.8** | **94.7** | **94.9** | **93.9** |

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

See above.

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

Since there is only a one-month decline and no trend established, managers have been informed of changes. We will require specific action plans if a trend is identified

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

The VISN regularly reviews local scores, and establishes annual monitors for facility directors.

There is a customer service standard listed as part of all staff performance evaluations. VISN staff meet to review scores with the facilities and review actions plans.

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

The VISN supports training staff in Crucial Conversations. The materials per student per course are $225. 70 staff trained 2012 YTD. In 2011, we trained 156 staff. Monthly conference calls are held to share ideas within the VISN.

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

* Joyce Seltzer, Education Specialist (Coordinator for Patient Education and Customer Service, and Chair of the Customer Focus Committee)
* Kim Scott, Patient Advocate
* Kim Rouser, Patient Advocate
* Tina Cole, Education Specialist (Facilitates Treating Veterans with CARE course monthly for new employees, and serves in the absence of Joyce Seltzer; provides support for many customer program initiatives)

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

**Cincinnati Customer Focus Committee**

# MEMBERSHIP

Joyce Seltzer, Chairperson Education

|  |  |
| --- | --- |
| Abel, Jane (Lillian) | Pharmacy |
| Adler, Ivana | Nursing |
| Brown, Sandra Jo | QM |
| Cole, Tina | Educ. |
| Criscillis, Ginny | A&MM |
| Fehr, Cynthia | Primary C. |
| Ford, Bertha | Dental |
| Honerlaw, Ashley | Engr. |
|  Jervis, Jeremy | QM |
| Jablonski, Deborah | CLC |
| Klawitter, Brad | CLC |
| Lehman, Peggy | PM&R |
| Mason, Sandra | Educ. |
| Matho, Ashley | CBOCs |
| Mills, Catrina | Surgery |
| Mohler, Angel | N&FS |
| Mosby, Mary | PC |
| Muehlenhard, Judith | Surg. |
| Norton, Jo Ann | Vol. |
| Patel Dipika | PBS |
| Rouser, Kim | PtAdv |
| Rucker, Sharon | Med. |
| Scott, Kim | PtAdv |
| Seidl, Amy | Nursing |
| Smyth, Mary | Nursing |
| Snyder, Bryan | HRM |
| Spurlock-Watts, Suzette | EMS |
| Stryzek, Paul | MHCL |
| Wilp, Sonia | Nursing |

# MEETINGS

The committee meets eight times a year.

Quorum: 6 members or more.

# CHARGE

The Customer Focus Committee will be responsible to review and analyzethe varioustoolsused to measure patient satisfaction or dissatisfaction, to identify opportunities for improvement, to communicate these to the appropriate managers and/or committees, and to monitor and evaluate activities designed to improve patient satisfaction.

Further, the Customer Focus Committee will be responsible for monitoring the satisfaction of all other external and internal customers.

The Customer Focus Committee will support VHA, VISN and the Medical Center’s mission, strategies, goals and objectives by functioning within the Baldridge framework and by assuring compliance with the JCAHO accreditation standards relating to customer service

# FUNCTIONS

A. Patient Satisfaction (Family/Significant Others)

* Analyze the results of a variety of patient satisfaction tools that have been designed to measure patient and/or their significant others’ experiences with the Cincinnati/Ft. Thomas Medical Center.
* Identify the issues and concerns of our patients that are most meaningful in creating a positive experience.
* Identify the issues and concerns of our patients that are most likely to create an over-all negative experience.
* Facilitate communication of veteran feedback data to internal and external stakeholders.
* Develop recommendations for consideration on improving our patients’ satisfaction.
* Respond to the VISN 10 Patient Stakeholders Committee and implement VISN initiatives directed to improving patient satisfaction.
1. Other Internal and External Customers: Coordinate, evaluate and monitor concerns and trends regarding the satisfaction of other internal and external customers.
* Physician Satisfaction
* Staff Satisfaction
* Trainee Satisfaction
1. Be knowledgeable of, and incorporate the following factors into the Committee activities, strategies and plans, as each relates to customer service:
* JCAHO Standards
* Six Sigma
* National, VISN and Hospital Mission Statements and Strategic Goals and Objectives
* Director’s Performance Measures

**V. RESPONSIBILITIES**

1. Patient Satisfaction
2. Measures of Patient Satisfaction
* QUIK CARDS
* SHEP
* PATIENT REPRESENTATIVE REPORTS
1. Obtain, review and report findings.
2. Solicit and/or generate performance improvement plans based on findings.
3. The Committee will identify common issues and themes that cross all reports, e.g. items often ranked most positively (influencing greater satisfaction), and items often ranked negatively (influencing dissatisfaction).
4. The Committee will identify, prioritize and recommend opportunities for improvement, and will make recommendations as appropriate to the Quality Performance Committee and the VISN (as appropriate) and annually to managers for decentralized action planning.
5. Improved methods for reporting survey findings, on a regular basis, will be identified and implemented.
6. Expectations and feedback mechanisms will be established with those responsible for receiving reports for particular constituencies.
7. Findings will be reported to staff in *Customer Focus Notes*.
8. SHEP scores will be posted throughout the Medical Center and CBOC’s annually.
9. Employee Satisfaction

The committee will support activities designed to monitor and/or improve employee satisfaction. Coordinates a wow-act program, including identifying and recognizing quarterly and annual customer service stars.

1. Staff Education

The committee will implement an on-going employee training and development program to ensure staff expertise and competency in the area of customer service and customer relations.

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

There are typically one to two staff members who are also Veterans.

**Additional Questions**

*Please describe your patient satisfaction programs and initiatives.*

1. Decentralized Action Plans: All departments/services/units having direct patient contact must establish annual customer service action plans and update quarterly.
2. Educational Curriculum
* 4-Hour Treating Veterans with CARE Course for all new employees – mandatory
* All staff required to have a minimum of 4-hours of customer training annually; strongly encouraged to have 8-hours
* Customer Service On-going Curriculum includes:
* 12-Hour Crucial Conversations Course
* Dealing with Toxic Behaviors in the Workplace
* Team-Building (4-hour workshop)
* Facing the Tiger
1. Staff Customer Service Recognition Program
* Wow-Acts (on the spot recognition for staff by Veterans and co-workers); all recorded on a database and monthly recognition items given to staff.
* Quarterly customer stars; employees receiving wow-acts are candidates to be selected as a quarterly star. 12 stars selected each quarter.
* Annual customer stars; nominees are the quarterly stars; selections are made based on a track record of excellence.
1. Fresh Eyes on Service: new employees are utilized as “secret shoppers” to identify opportunities for improvement. They are surveyed during Treating Veterans with CARE, and members of the quadrad meet with them to discuss.

*Which staff member monitors patient satisfaction measurement tools?*

* Joyce Seltzer, Chair of the Customer Focus Committee monitors SHEP and Quikcards and correlates results with the patient advocate reports
* Kim Rouser and Kim Scott are responsible for the patient advocate reports.
* Fresh Eyes on Service; Tina Cole through Treating Veterans with CARE.

*What are your patient satisfaction committees at the VISN and/or facility level?*

Facility – Customer Focus Committee

VISN – Patient Centered Care Council

**Quality Manager**

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

The quality manager integrates the quality management program at the Cincinnati VA, Community Living Center, Domiciliary, PTSD Program, and six Community Based Outreach Centers as well as interpretation and application of accrediting body standards. Responsibilities include, however, are not limited to: design, implementation, coordination, and evaluation of an integrated Quality Management Program for the Cincinnati VAMC and all components which include direct oversight of Performance Improvement, Risk Management, External Accreditation, VASQIP, and Utilization Management operates under a broadly delegated authority to influence the organizational mission, participates in strategic planning and carries out initiatives to meet national, VISN and Medical Center goals and objectives.

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

Performance measures and monitors of all types are tracked over time to identify trends as well as compare with internal and external benchmarks for the purpose of identifying opportunities for improvement.

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

With the increasing number of measures it is important to prioritize. VA Central Office provides a Network Director Performance Plan each fiscal year which is considered high priority. In addition areas of high risk and patient safety concerns are priority for identifying and improving the quality and safety of healthcare that our facility provides to veterans.

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

Each VA facility undergoes rigorous reviews from the Office of Inspector General every three years. In VISN 10, the VISN reviews the quality of care in each facility yearly.

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

The VISN quality committee is the Performance Improvement Committee and is lead by the Chief of Staff in Cleveland and the Quality Management Officer. The facility has a Quality and Performance Committee that is chaired by the Director with the Quadrad, service chiefs and quality manager as members.

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

1. *VA staffed CBOC’s?*

 All of our CBOCs are VA staffed.  All have moved to the PACT model of care.

There is no difference in the quality assurance – all of primary care is the same

* External Peer Review
* Shep
* Quik Cards
* PACT Performance Measures
* Clinical Reminders
* Provider Peer Reviews

*b. contracted staffed CBOC’s* - none

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

There are a number of programs that address quality of non VA care that is paid for by the VA. For example, there is monitoring of Adult Day Health Care by non VA facilities with scheduled timely visits and monitoring of the care provided to our veterans. Contracts for outside vendors that provide quality care as well as medical equipment are closely monitored for compliance with standards. (i.e., Durable Medical Equipment and Home O2 providers).

*Of these, which quality measures are you responsible for?*

The facility is responsible for oversight of these vendors and performs visits to ensure quality.

**Additional Questions**

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

Measurement tools, such as the Fiscal Glide Path Tool, allow our facility to compare with other VA facilities using statistical methods. This allows us to focus on areas in most need of improvement

*What percent of time do you devote to reviewing, analyzing quality data and prioritizing opportunities for improvement?*

Quality Management employs a Data Management/Informatics specialist that spends about 90-100% of their time reviewing and analyzing IPEC data, Oryx (Joint Commission) data, Publicly reported quality data, EPRP data (other quality measurements), Fiscal Glide Path Tool, etc. The Data Management/Informatics specialist monitors for trends and opportunities for improvement and keeps leadership informed

*What impact or breakthrough results have you achieved through your quality, safety and improvement activities?*

VASQIP program was able to reduce Surgery Mortality rates by improving the preoperative risk screening process.

As the result of a Readmission PI Team the facility was able to substantially reduce the % of heart failure readmissions, comparing the baseline, FY09, with FY10. We were unable to sustain the reduction in readmissions. We have re-launched this project with some recent success, (in the last couple of months) which we are monitoring this fiscal year.

*How do you design and develop an integrated quality agenda for this facility?*

The Quality Management Program implements a valid quality improvement process for performance improvement activities at every level of the organization. This process includes: setting quality management goals based upon population assessment and linkage with the strategic plan; collecting, trending, and analyzing data to measure progress towards goals; developing and monitoring action plans based upon the analysis; communicating goals and engaging employees at all levels in action plans; and tracking action plans to completion.

**Patient Safety Manager**

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

The Patient Safety Managers support the Root Cause Analysis (RCA) process in response to an unexpected outcome by providing team training, support and developing competencies in team function. We evaluate the RCA process as it functions in the Medical Center and follow-up on actions/outcomes in response to the team findings. The Patient Safety Managers have various programmatic functions such as serving as the facility point of contact for Patient Safety Alerts/Advisories including tracking actions, acting as the Point on Contact for facility patient safety issues to the National Center for Patient Safety (NCPS) and serving as the facility expert on the VHA Patient Safety Handbook.

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

All members of the Facility Staff report patient safety concerns to the Patient Safety Managers. All committees feed into the Patient Safety Program by referral and/or the Patient Safety managers by representation on the committees that deal with patient safety and care initiatives.

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

The Patient Safety Program uses a system-based approach, driven by organizational leadership, to promote patient safety through the proactive identification and management of actual and potential risks to patients, visitors, the organization and its staff. A critical element of the program is the prompt review of adverse events, identification and review of near-miss events, and communication with patients and families when an unanticipated negative outcome occurs. The program fosters a culture of “No Blame” and thus creates a unique opportunity to learn, and is a critical element in the creation of a safety culture

*Please describe your patient safety programs and initiatives.*

The Patient Safety program includes responding to unexpected outcomes by use of the formal RCA process, informal follow-up on a case-by-case review, and initiating and advising on the proactive process of Healthcare Failure and Mode Effects Analysis (HFMEA) teams. The managers assist in meeting regulatory requirements such as Joint Commission Patient Safety Standards and National Patient Safety Goals (NPSG). We create an environment of patient safety by addressing the results of the safety culture survey with action plans for the facility. The Patient Safety Managers conduct periodic environmental patient safety inspections such as suicidal risk assessments in the emergency department and locked mental health unit, total hospital environmental rounds for falls prevention and tracers in high risk areas for the cleaning and sterilizing of reusable medical equipment (RME). The Patient Safety Managers participate in weekly safety rounds to prevent untoward outcomes from environmental issues. The safety program includes education of staff through identified competencies, new employee orientation and identified needs of staff concerning safety issues.

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

The Safe Handling Program is responsible for the acquisition of equipment and use in clinical areas where patient handling occurs. This program provides staff training, provision of appropriate patient handling injury data in order to make suitable recommendations to decrease patient risk of injury and makes safe handling decisions based on ergonomic processes. The Reusable Medical Equipment (RME) Committee assures that comprehensive policies are in place for the cleaning and sterilization of medical equipment, competencies are performed yearly; the environment is conductive to producing sterile, safe instruments and equipment for use on patients and collection of outcome data to monitor compliance to best practice. The Environmental and Hospital Infection Control Committee (EHICC) is a multidisciplinary committee that oversees the hospital infection control program for surveillance, prevention and containment of infections. The Clinical Quality and Safety (CQS) Committee of the Nursing Department focuses on high risk aspects of care such as prevention of pressure ulcers, falls, use of restraints and effective pain control. The Industrial Hygiene and Safety Management System (IH&S) program is an organization-wide committee that manages the quality and safety of the physical environment in which patient care is provide. Components of the program include Hazard Materials, Equipment, Utility Management, Emergency Preparedness, and Life Safety. All committees such as Pharmacy and Therapeutics, Violent Behavior Prevention Program, Tissue and Transfusion Review , Magnetic Resonance Imaging (MRI) Safety, etc have a component of patient safety.

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

The VA Directive “Recall of Defective Medical Devices and Medical Products” establishes policy on recalls involving medical devices and medical products. The VHA issues Recall Notices, Patient Safety Alerts and Patient Safety Advisories to notify medical facility users about risks associated with drugs, medical devices, medical products, food/food service products or human tissue. The Medical Center then addresses problems with items by immediate removal from services or by correcting identified issues. Urgent notices have immediate, specific actions addressed while other issues allow local facility judgment for resolution. The Cincinnati Medical Center uses a national electronic means of tracking recall notices, Patient Safety Alerts and Patient Safety Advisories and actions related to the safety hazards. The Cincinnati Veterans Administration Medical Center (VAMC) uses the Joint Commission published Sentinel Event Alerts that provide important information relating to the occurrence and management of sentinel events encountered in Joint Commission accredited health care organizations. Use of this information regarding the occurrence of these events allows the Medical Facility to create action plans and ultimately reduce the frequency of medical errors and other adverse events. Sharing of close calls, adverse events and results of Root Cause Analysis findings published by the National Center for Patient Safety allow us to prevent patient safety hazards in our hospital. All close calls, adverse events and sentinel events encountered at Cincinnati VAMC are reviewed for prevention of future negative events.

*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?*

NCPS, VA Central Office, VISN and Cincinnati VAMC are all notified of a significant safety event or sentinel event by entering into a national database and notification by the creation of an Issue Brief and Heads- up communication process. After actions are completed in response to the event, follow-up communication to VISN and VA Central Office are submitted. Results of the Root Cause Analysis and safety event investigation are transmitted to NCPS. After an intense investigation occurs at the facility level a presentation of the findings and action plans is presented to senior leadership.

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

High risk patient safety issues are reported to medical center leadership during morning report, by notification of the Patient Safety Manager and during report out to senior leadership for the RCA findings and action plans.

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

Both are very closely interwoven and at times difficult to separate. However, the actual process of how issues are examined and corrective actions taken may differ. For example, RCA’s look at system issues, not necessarily person specific issues. Person specific issues are dealt with via other means such as Peer Review, Administrative Investigations.

*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?*

Patient Safety Managers work very closely, on a daily basis, with all the identified above. Additionally, they are invited to the RCA reports as appropriate

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

When an event becomes known, the Patient Safety Manager, based on criteria, determines if a RCA needs to be done. The Director charters a team to fully examine the issue and make specific recommendations for organizational improvement. When the project is completed the team reports to leadership and other parties as appropriate. This is treated as a learning opportunity and outcome is communicated to staff in multiple ways.

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

When RCA’s are chartered, the National Center for Patient Safety is electronically contacted to query the data base for similar events in order to learn what other facilities may have implemented etc.

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

There are two Patient Safety Managers, both RN’s. Duties include, but not limited to: The Patient Safety Manager responsibilities include but are not limited to:

1. Providing Guidance regarding actions required following an Adverse Event including a Sentinel Event.
2. Insuring implementation, coordination, evaluation, and integration of various program components.
3. Insuring that informational linkages are maintained between the Environment of Care (EOC)/Safety Council, Clinical Executive Board, Quality Performance Committee, Office of Regional Counsel, and other groups as necessary (Attachment A).
4. Providing education, consultation, and technical assistance to medical center staff regarding Patient Safety.
5. Insuring medical center compliance with VHA and VISN 10 Patient Safety reporting requirements.
6. Facilitate communication with Regional Council to review serious Adverse Events, insure communication with patient and families, and identify opportunities for improvement. (Attachment B)
7. Communicating Patient Safety Alerts & Advisory’s to appropriate staff and ensuring facility response is entered into data base in a timely manner
8. Oversight of NPSG’s
9. Assignment of Severity Assessment Code (SAC) scores to reported incidents
10. Provide annual report to CEB
11. Active participation on various facility committees

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

FY2011 the facility completed 16 RCA’s. Thus far, FY 2012 eight RCA’s have been completed. All have been completed in 45 days or less. The topics have been surgery related, delayed results, procedure complications, medication and/or fall related, and infection related events.

**Additional Questions**

*Of the Root Cause Analysis (RCAs) completed in the last year, what measures have been taken to address improvement in these areas?*

Changes have been made in physical environment, staff education, policy/procedure changes, software/hardware changes, communication/documentation, and coordination of care.

*Is there a “best practice” for Root Cause Analysis (RCAs) and do you review national trends?*

The VA National Center for Patient Safety recommends and teaches what they consider a Best Practice for conducting a RCA. The Joint Commission utilizes a different documentation form, but has recognized the VA tool as meeting the Joint Commission requirements. Patient Safety Managers do review national trends in many ways. It is presented in multiple conferences, NCPS, personal research of literature, etc.

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

All RCA’s are followed to ensure implementation of action/outcomes. In the course of doing this, there is specific documentation identifying how the action/outcome impacted the organization. That is, what degree of improvement occurred as a result of the action/outcome? That is determined based on measurement data identified during the RCA.

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

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

Training and monitoring of PACT teams; facilitate PACT teamlet dynamics; review and interpretation of data and reports; mentor teamlets in the tenets of PACT.

*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?*

There are 42 PACT teamlets across the Cincinnati sites of care. There are no other persons who are specifically dedicated to PACT programs and initiatives. There is a working group who support the PACT programs and initiatives to include those listed below. Responsibilities in the support of PACT are determined by expertise, experience, and sphere of influence/supervisory role.

ACOS Primary Care

Chief Nurse, Primary Care

CBOC Administrator

CBOC Nurse Managers

Administrative officer, Primary Care

Nurse Manager, Primary Care, Main Facility

Health Behavioral Coordinator

Health Promotion Disease Prevention Coordinator

Primary Care Quality Manager

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

ACOS Primary Care (James M. Huey MD) and

 Chief Nurse, Primary Care (Dena Rattermann, RN).

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

Monthly

*Which VA Medical Center Staff attends the committee meetings?*

|  |  |
| --- | --- |
| Huey, James\* |  ACOS/Chief Ambulatory Care |
| Rattermann, Dena\* | Chief Nurse , Primary Care  |
| Smith, Linda | Exec. Sponsor, Medical Center Director  |
| Falcone, Robert | Chief of Staff |
| Cook, Kathryn | Nurse Executive |
| Mosby, Mary | Improvement Advisor, PC QM |
| Fehr, Cynthia | Administrative Officer  |
| Oden, Mary | Designated Learning Officer, Chief Education Service |
| Kim Shockey | CBOC Administrator |
| Caligaris, Karen | Women’s Health Program Manger |
| Clayton, Tujuan | PCMM Coordinator |
| Altum, Sharyl | Health Behavior Coordinator |
| Schmitt, Kristen | Chief Pharmacy Service |
| Mohn, Sara | HPDP Program Manager |
| Jervis, Jeremy | Systems Redesign Coordinator |
| Wilson, James | MyHealtheVet-Vet Coordinator |
| Watson, Dietra | Telehealth Lead |
| Cutright, Karen | OEF/OIF Coordinator |
| Butts, Tracy | Public Affairs Officer |
| Cutright, Garry  | Union Rep-AFGE |
| Hughes, Sadie | Union Rep- NNU |
| Dunlap, Patricia | Social Work Rep |
| Wuest, Scott | Nurse Manager, Georgetown/Clermont/Hamilton |
| Matho, Ashley | Nurse Manager, Dearborn/Bellevue/Florence |
| Larison, Linda | Nutrition Representative |
| Baldock, Wynn | Mental Health Representative |
| Hess, Monica | Pharmacy Representative |
| Toner, Michael | Social Work Representative |
| Schmitt, Kristen | Pharmacy Representative |
| Rouser, Kim | Patient Advocate |
| Patel, Dipika | Call Center Manager |
| Robinson, Jasmine | CCHT |
| Houck, Kim | MOVE program |
| Harris, Doreen | PC Nurse Manager |
| Pugh, Annette | RN, Pilot Teamlet |
| Aubry, Beth | MD, Pilot Teamlet |
| Ghent, Tim | LPN, Pilot Teamlet |
| Robertson, Barbara | Clerk, Pilot Teamlet |

*Are representatives from the veterans’ community involved in your Patient Aligned Care Team (PACT) planning process?*

Veterans were involved in the Pilot Team initiative; it is planned to have veterans involved in the Steering Committee in the future.

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

Rollout of the national initiative in Las Vegas

Presentation of the rollout plan to staff in an all-staff meeting

Process developed which met union approval and staff was divided into teamlets

Primary Care space rearrangement in main facility to accommodate teamlets

Teamlets selected for Pilot and Home Teams

Pilot team attended and contributed to all regional collaborative sessions. The team was recognized for its success.

All Cincinnati and CBOC teams rolled out April-June 2011; half day training involving Pilot Team and Core administrative team. There were didactic presentations and breakout groups by discipline and by teamlet.

First wave of Teamlets attended Learning Center of Excellence.

Core team above has provided continuing training to teamlets, both individual and in small groups.

Pilot team has served as consultants and collaborators to teamlets.

Second wave of Learning Center of Excellence training in June, 2012

**Additional Questions**

*How is coordination of care between Patient Aligned Care Team (PACT) teams and specialty care?*

There are several current initiatives with pulmonary medicine (COPD), endocrinology (Diabetes), and inpatient services/cardiology (Congestive heart failure). Mental health, social work, nutrition, and pharmacy are embedded in primary care teams.

*How is the Patient Aligned Care Team (PACT) model affecting the quality of health care services to veteran patients?*

By quality measures, care at Cincinnati was high prior to PACT. Currently Cincinnati is meeting all external peer review measures except two. Access and coordination of care have improved.

*How is the Patient Aligned Care Team (PACT) model affecting patient satisfaction?*

Pilot team data showed excellent patient satisfaction. Cincinnati outpatient SHEP scores have improved. Anecdotally, there have been very positive comments from veterans at all sites about the new system of care

**Patient Satisfaction**

**Director of Patient Care Services**

*What duties and responsibilities do you have as the Director of Patient Care Services for the facility?*

Oversight of Nursing Service including all aspects of patient care, quality of care, safe patient care, compliance with regulatory standards, patient satisfaction, etc.

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

1. *Inpatient*
2. *Outpatient*

We have very positive SHEP scores in pain management, communication with nurses, etc. in both inpatient and outpatient services. See scores above in the Patient Satisfaction section.

*Did the facility improve or decline in any areas since the last Survey of Healthcare Experience of Patient (SHEP) survey?*

Increased in all categories from previous year

*How are patient satisfaction indicators and measurements tracked and managed?*

Through Customer Service Committee, unit based practice councils, staff meetings, postings

*Of these, which patient satisfaction measures are you responsible for?*

All responses related to patient care areas, I.e. noise level.

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

All inpatient care areas which include MICU, SICU, 3 Med/Surg units, perioperative services, CLC, specialty clinics, Women's Health.

**Patient Advocate/Patient Centered Care Coordinator**

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

We define patient satisfaction as no complaints, patients “want” to come here even if they have a choice to go elsewhere and the care we provide is excellent.

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

The Patient Advocate serves as the liaison between the Medical Center, patients, staff and the community it serves regarding patients’ rights and advocacy. In this capacity the Patient Advocate, on a regular and recurring basis, performs the following: Provides a channel through which patients can seek solutions to problems, concerns and unmet needs. Works with health care providers and administrative support staff throughout the Medical Center in preventing and resolving patient complaints. Interprets the Medical Center’s mission, policies, procedures and available resources/services to the patient and presents the patient’s problems, opinions and needs to appropriate staff and management. Assists patients in understanding their rights in addition to their responsibilities. Represents the Director in safeguarding and ensuring ethical, statutory and constitutional rights of patients. Assists patients, their families and representatives, and facility staff members in recognizing and removing institutional barriers to the provision of optimum health care to veterans. Identifies existing and potential problem areas, suggests solutions or alternatives to existing procedures which contribute to those problems. Acts on behalf of the facility Director to resolve problems, expedite services, or implement necessary corrective measures within established facility policies and where appropriate, through committee participation. Listens to complaints and grievances from patients or from individuals on behalf of patients. Makes inquiry into patient complaints, initiates action or changes necessary to correct problem situations, and reports on corrective measures taken to the patient or the patient’s representative. Monitors and evaluates corrective measures taken. Maintains a working liaison with Veterans service organizations, community groups, and others whose interests are in helping and protecting veterans, their families and their representatives. Maintains liaison with congressional offices responding directly to their staff assistants, when appropriate, on matters involving patient dissatisfaction. Assists with congressional and/or patient inquiry letters with program officials or staff members assigned to this responsibility. Develops and provides in-service education as necessary to bring awareness to the hospital staff of the patient’s perceptions of the patient’s facility experience, thereby contributing to improved staff understanding and attitude. Produces on a regular basis, a cumulative report which includes a categorization of patient inquiries in order to track and trend the patterns and to identify opportunities for improvement of care. Serves as a member of numerous committees which review patient centered care initiatives, patient care and issues of quality improvement.

*How are patient satisfaction indicators and measurements tracked and managed?*

* Survey of Healthcare Experiences of Patients (SHEP)
* Quikcards
* Patient Advocate reports

*Of these, which patient satisfaction measures are you responsible for?*

Patient Advocate reports

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

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*What were your previous patient satisfaction scores?*

See Patient Satisfaction section above for scores.

*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?*

No

*Is your facility working on a “best practices” in patient satisfaction? If so, please explain.*

Yes, the patient advocates meet monthly, nationally and locally (VISN 10) to discuss and share best practices.

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

It is facility policy that all staff is responsible for patient satisfaction.

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

Annual mandatory training and specific training to equal a minimum of 40 hours is required of all staff. All staff is required to have a minimum of 4 hours of customer service training.

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

* 12-hour Crucial Conversations Course
* Dealing with Toxic Behaviors in the Workplace
* Team-Building (4-hour workshop)
* Facing the Tiger
* Treating Veterans with Care

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

The concern/complaint is brought to attention of appropriate leadership for review and action as appropriate for situation. Outcome follow-up provided by leadership or patient advocate as appropriate. Documentation of concern in Patient Advocate Tracking System software.

*Which office and position in VA Central Office, VISN and VA Medical Center facility oversees Patient Advocates?*

National Veterans Service and Advocacy Program, Office of Patient Centered Care and Cultural Transformation, provides guidance to advocates nation-wide. Supervision of advocates is at the local level. At the Cincinnati VA Medical Center, Patient Advocates are supervised by the Chief, Patient Business Services.

*What training do Facility Patient Advocates receive?*

Annual mandatory training and specific training to equal a minimum of 40 hours to include a minimum of 4 hours of customer service training is required.

*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 Director would alert the VISN/Central Office if warranted.

*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?*

Yes. Response to complaints occurs as soon as possible, but no longer than 7 days after the complaint is made. Should the complaint require more than 7 days, staff are responsible for continuously updating the patient on the status of the complaint and/or resolution. VHA Handbook 1003.4, 7.b.(1), dated September 2, 2005.

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

Supervising official/Chief, Patient Business Office.

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

No

**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?*

To ensure quality of care and patient satisfaction, the Utilization Review nurses in the Quality Management department review electronic medical records, attend interdisciplinary rounds daily, collaborate with the Attending and Emergency Room doctors regularly concerning patients and the level of care and the timeliness of care that they receive. We strive to ensure that the right patient receives the right care, at the right time in the right setting.

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

The training requirements for this position are to have a basic knowledge of computers, patient care and understanding of how the facility works. The initial training occurs through on the job training and teaming up with a mentor for 5-6 weeks of orientation. Other sources of training are via webinar, conferences, live meetings and soft ware

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

The tools used to improve quality of care and patient satisfaction come from developed computerized software geared to assist the UR nurse in completing reviews in a more efficient manner, and via data-specific tools developed by the UR nurses to accomplish task, such as; tracking and trending data that is unique to the needs of the facility in meeting the National Directives. The data obtained by the UR nurse is used to improve and promote patient flow throughout the facility by addressing issues that hinder and or stifle flow thus increasing patient satisfaction.

**Risk Manager**

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

Risk management mitigates risk through proactive identification and management of issues that pose a risk to patients, visitors, the organization and its staff.

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

Training received from previous risk manager, national VA Risk Management conferences, ongoing quarterly national risk management calls, and ongoing VISN patient safety/risk management committee.

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

Risk Management trends data to monitor from tort claims and provider reviews to improve the quality of care. Risk management also works with patient advocates regarding Veteran concerns to improve patient satisfaction.

**Systems Redesign Manager**

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

Responsibilities as the Systems Redesign (SR) Manager are to serve as a consultant to workgroups throughout the Medical Center to analyze performance data related to quality of care and patient satisfaction, identify performance gaps between expected and actual performance, identify process barriers that negatively impact quality of care and patient satisfaction and develop solutions to improve both. I am also a member (SR Representative) for both the Customer Focus and Quality and Performance Committees.

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

I have a Masters of Health Administration (MHA) as well as VA-specific training. Within my graduate program, I received training in both quantitative healthcare analytics and continuous process improvement. I have also attended national learning collaboratives for Systems Redesign (both on-site and virtual) through VHA. I received 6-Sigma Black Belt certification and attended LEAN Healthcare training. I also participate in national and VISN SR trainings and conference calls to learn how other facilities are using SR to improve quality of care and patient satisfaction throughout the system. I am currently participating in the VHA pilot program, Field-Based Analytics to improve my data analysis skills as they relate specifically to VHA datasets.

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

Our facility regularly monitors both quality of care indicators and patient satisfaction data and develops improvement projects based on areas that do not meet expected performance measures. In addition to the VA-prescribed performance measures, we also design studies to investigate ongoing issues (e.g. complaints, incident reports, etc) for opportunities of improvement. SR at this facility is aligned within the Quality Management office and participates in Patient Safety root cause analysis and healthcare failure mode effect analysis.

**Chief Medical Information Officer**

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

Responsible for the appropriate use of technology as it applies to clinical settings.

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

These are measured through our quality department via performance measures and quality indicators. We provide support for building of clinical reminders and templates containing health factors to be able to track specific measures. Patient satisfaction is tracked and managed through education. Quality of care and patient satisfaction data is reviewed on a department specific level. The IPEC system is available with statistical analysis capabilities.

*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?*

These are measured through outcomes evaluated through the performance measures mentioned above. Clinical reminders, which we are responsible for maintaining, allow for real time evaluation of key indicators that affect patient care.

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

Reminder reports are run by specific departments, mainly primary care, to measure quality of care and they use this information to make appropriate clinical changes. Patient satisfaction is collected, maintained and addressed through the education department. BCMA reports are run to note trends and improvements in quality of care.