**The American Legion**

**System Worth Saving Program**

**Quality of Care and Patient Satisfaction**

**Columbia, SC 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 11      $352,166,843

FY 12      $358,119,974

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.

% of budget dedicated to Quality of Care:

FY 11      84%

FY 12      86%

The % above includes nursing, physicians, and other medical staff who work directly with Veterans. This figure is also inclusive of all medical care contracts (direct patient care), equipment & medical supplies. Programs include Dental, Community Living Center, Homeless Program, Mental Health, Primary Care, Surgery, etc.

How do you define quality as a healthcare facility? Quality care is a collaborative organization-wide continuous process fully integrated across services and disciplines to provide safe, effective, and efficient patient-centered care. The goal is to continuously improve patient outcomes, reduce variations in patient care delivery, and ensure the delivery of safe medical care.

Has the facility received any awards or designations for quality of care? WJB Dorn was recognized by The Joint Commission’s Annual Report on Quality and Safety (2011) as a ***Top Performers on Key Quality Measures***.™ This program recognizes accredited hospitals and critical access hospitals that attain and sustain excellence in accountability measure performance. The Joint Commission established this program to recognize hospitals achieving exemplary performance in using evidence-based care processes closely linked to positive patient outcomes.

How do you measure and manage quality as a healthcare facility? Quality is measured through the monitoring and tracking of all medical center performance improvement and patient safety activities and issues, recommending actions (as necessary), tracking the resolution of problems addressed, and supporting the improvement of processes. Aggregated data review and analysis of key quality indicators helps to determine performance improvement priorities. The data collected for high priority and required areas are used to monitor the stability of existing processes, identify opportunities for improvement, and identify changes that lead to improvement or sustain improvement. Areas for monitoring performance are determined by considering the Veterans’ needs, nationally identified high risk areas, sentinel events, and priorities set by leaders at the local, regional, and national level. In addition, the medical center identifies those areas needing improvement and identifies desired changes. Performance measures are used to determine whether the changes result in desired outcomes.

How does your VA Medical Center facility demonstrate and maintain accountability for quality of care? Accountability is maintained through verification of performance via internal and external reviews (The Joint Commission, Office of the Inspector General [OIG], Commission on the Accreditation of Rehabilitation Facilities [CARF], the College of American Pathologists [CAP], and other federal and state regulatory agencies. Healthcare Inspection Reports are available to the public from the OIG website and TJC Accountability Measures are available from the Quality Check website as well as on the U.S. Department of Health & Human Services Hospital Care internet site. The facility openly communicates with state and federal regulatory agencies as well as Veteran Service Organizations and other community partners with the intent of maintaining accountability through transparency. The Medical Center fully engages a comprehensive and proactive Compliance and Business Integrity program promoting an organizational culture and encourages compliance with the laws, regulations, and standards.

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

1. Chief of Staff:

* **Weekly Performance Measures Subcouncil (Chair):** Meets to review performance measures and patient access to medical care. In FY 11, Met 53/53 (100%) of clinical performance measures. Columbia, SC received 3 “Gold Stars”, which represented 100% compliance with composite measures.

Columbia was recognized by The Joint Commission’s Annual Report on Quality and Safety (2011) as a ***Top Performer on Key Quality Measures***.™ This program recognizes accredited hospitals and critical access hospitals that attain and sustain excellence in accountability measure performance. The Joint Commission established this program to recognize hospitals achieving exemplary performance in using evidence-based care processes closely linked to positive patient outcomes.

* **Monthly Health Systems Council (Chair):** Reviews all clinical functions and policies to ensure compliance with OIG, TJC, SOARS, and other regulatory agencies.
* **Weekly Clinical Leaders Meeting (Chair):** Discusses patient care issues with clinical service chiefs.
* **Monthly Peer Review Committee (Chair):** Peer review of medical records to determine appropriateness of care.
* **Monthly Patient Safety Committee (Member):** Reviews RCAs and Safety Alerts, ensuring appropriate actions are completed in an efficient, timely manner
* **Monthly Executive Leadership Subcouncil – Performance Improvement Member):** Reports performance improvement initiatives to clinical leaders.
* **Daily Morning Meeting – Data Review:**  Reports tracking and trending analysis of performance and quality improvement data with focus on consistent improvement.
* **Dorn Research Institute - Non-profit (Chair):**  Reviews and recommends/approves actions to further  medical science by promoting research and educational activities of the VA Medical Center, Columbia, South Carolina. In the strategic planning process, will be further refining the DRI mission.
* **R&D Committee (Member):** Reviews research proposals to ensure compliance with patient safety involving human research.
* **Professional Standards Board:**
* Reviews and recommends appointments and credentials of staff physicians, dentists, optometrists & podiatrists.
* Establishes Physical Standards Board, when needed.
* **Medical Executive Subcouncil (Chair):**
* Reviews credentials and privileges of all other physicians, dentists, optometrists & podiatrists. (i.e.fee basis, WOC, contract, etc.)
* Recommends approval of privileges.
* Reviews Focused Professional Practice Evaluations (FPPE) that are started at the time a provider initially comes on board, as well as changes in privileges, or questions regarding practitioner’s professional practice during the course of the Ongoing Professional Practice Evaluation (OPPE).
* Reviews/discusses and recommends actions to the Director regarding privileging/licensure issues.
* Reviews The Joint Commission/VA regulations to ensure compliance with all standards.
* Reviews quarterly reports from the Peer Review Sub-council, Residency Review Sub-council and Reuseable Medical Equipment Committee.
* Annually reviews privileging forms, medical contracts, service specific criteria.
* Acts on behalf of the Medical Staff for changes to Medical Center By-laws between the annual Medical Staff meetings.

1. Head Nurse: - The Associate Director for Patient Care and Nursing Services

is responsible and accountable for the quality of nursing care provided at our medical center and CBOC’s.  Within nursing is a shared decision making model of governance that includes quality improvement.  The AD PC/NS is involved in all levels of performance improvement at the medical center and co-chairs the Health System Council with the Chief of Staff to ensure quality clinical care.  She is also a member of the Executive Leadership Steering Council that is the overall performance improvement coordinating body for the Medical Center.

1. Quality Manager: The Quality Manager plans, develops, and maintains a

comprehensive program to ensure compliance with the Department of Veterans Affairs (VA) Directives, Joint Commission Standards, and other internal/external regulatory agencies. An integral member of the facility’s leadership team, the Quality Manager is responsible for transition to continuous quality improvement as an approach to assess and improve the quality of patient care and provides leadership and direction to all services in the development and implementation of process improvement systems.

1. Patient Safety Manager: The Medical Center’s Patient Safety (PS) Program

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

1. Utilization Management: The Utilization Management (UM) Program provides

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

1. Risk Manager: The Risk Manager develops, implements, and evaluates

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

1. Systems Redesign Manager - Systems Redesign responsibilities to ensure

quality of care include education and mentoring for lean process improvement techniques.  Systems Redesign focuses primarily on standardization of processes.  During the flow mapping process we indicate all quality of care related inefficiencies and plot them on a benefit to impact matrix.  Generally speaking most of the quality related improvements have high impact and easy implementation as they are commonly a result of limited transfusion of knowledge and or communication within the facility.

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

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

Which staff members/positions at the facility are responsible for managing and tracking quality of care programs and initiatives? Leaders at all levels of the medical center plan, support, and implement key systems critical to this effort and are responsible for creating a culture of quality and safety. By demonstrating their commitment and taking actions to maintain and sustain programs and initiatives throughout all organizational processes, leadership provides effective functioning of the hospital with focus on standardization of best practices. The medical center focuses on key functions and integrates indicators from all the services, committees, teams, and programs to measure, assess, and improve the functions or processes.

Please explain the quality of care training employees receive (i.e. type of initial and reoccurring training and number of days)? The Dorn VAMC requires a comprehensive orientation when employees first arrive that includes multiple quality of care training modules and 4 hours of Employee Patient and Family Centered Care Training. Employees and employees thereafter must complete mandatory annual training modules. The courses are included here:

 

There is an additional orientation for health care professionals, which include fee basis care training, CPRS training, medical record documentation training, and medication/pharmacy training. Furthermore, the Dorn VAMC offers BLS, ACLS, and AED training multiple times per month.

What resources have the VA Central Office and the VISN provided to help your facility improve quality of care programs and initiatives? Our facility has received an ICG grant in 2010 to assist with quality of care measures related to the coordination of Non-VA care (NVCC).  This grant has allowed our facility to do a deep dive into our system of consult management to improve coordination of care to ensure a timely return to our facility for patients that require services to be provided in the community.  Additionally, we have new policies in place to track and trend the consult system to ensure we are following national guidelines as related to consult management.  VISN 7 has provided resources to our facility to sponsor individuals attending the Access, Flow and Improvement Advisory Academies and has supported attendance to the Veterans Health Administration Improvement Forum.

In addition to systems redesign, VISN 7 is committed in investing in annual trainings that continue to improve the quality care that we provide our Veterans. The annual Joint Commission Training and Patient Safety Training are of special note.

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

In order to reach the sustain and spread portion of the VA-TAMMCS process improvement model VA Central Office will need to continually support staffing and education related to hardwiring process improvement into the culture of the organization.

**What innovative qualities of care programs or studies covered by grants are being conducted by this facility?** Wellness coaching has been part of the strategy of health and wellness in multiple venues to include: hospitals, corporations, specialty clinics, franchises, schools, fitness centers, the military and others for over 20 years. Research from multiple universities, including Stanford and Duke, continues to show Wellness Coaching is a successful approach to develop and maintain a healthy lifestyle.

The Dorn VAMC was selected for a grant through the Office of Patient-Centered Care to develop a program on developing wellness through focused health coaching. Four Coaching for Wellness classes were held weekly starting in October 2011 for five weeks. 61 staff members were approved for attendance representing: nursing, social work, pharmacy, nutrition, mental health, providers, technicians and administrative support. 57 staff members met 100% attendance and passed final test, and four staff members were not able to fully complete one to two classes due to illness. Graduates are incorporating the tools and skills in their routine practice. Plans for coaches meetings to identify and develop best practices based on achieved Veteran goals are underway for March 2012.

The Dorn VAMC was just notified that our staff will be in receipt of an additional grant through the Office of Patient-Centered Care. More information will be provided at your upcoming site visit.

Is your facility working on a “best practice(s)” in quality of care management? The Dorn VAMC is involved in VA PACE, a T21 grant program designed to help elderly Veterans stay in their homes, keeping them as functional and independent as possible, and enabling a high quality of life while providing relief and support for caregivers. Six months prior to enrollment in the Dorn VAMC PACE Program, Veterans had an average of 3.4 emergency room (ER) visits and 11.9 days of hospitalization. Six months post-enrollment, they had an average of 0.8 ER visits and 4 days of hospitalization. The average yearly cost-savings is approximately $486,000 for the ten Veterans enrolled. The Dorn VAMC program has been so successful that VACO Geriatrics sent a team to review and get best practices to disseminate to other programs in VA.

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?

Leaders at all levels of the medical center are dedicated to ensuring that quality of care programs and initiatives are supported and sustained as a manner of enhancing the care that we provide our Veterans.

Which staff position at the facility is responsible for performance measures (access, clinical measures and ASPIRE/Hospital Compare)? The External Peer Review Program (EPRP) Coordinator is responsible for data collection, analysis, evaluation, and trending relevant to EPRP and Performance Measures activities.

How many Full Time Employee (FTE) Registered Nurses, License Practical Nurse is on your staff? Is there sufficient staff to patient ratio? We currently have 606.8 assigned FTE on our Nursing staff, including Registered Nurses, Licensed Practical Nurses, and Nursing Assistants.  The Dorn VA diligently monitors workload and vacancies to ensure that necessary resources are allocated to ensure sufficient staff to provide quality care and safety of our Veteran patients.

Has there been any turnover with any of these positions? As the Dorn VAMC has a large nursing staff, turnover is expected and realized.  As vacancies occur, the Dorn VAMC analyzes workload and allocates resources to ensure that appropriate positions are filled in a timely manner.  Our turnover for Registered Nurses is about 6%.

How long have these positions been vacant? As mentioned above, turnover is expected with such a large nursing staff. The frequency of these vacancies varies greatly, but each vacancy is addressed by Senior Management and Human Resources in a timely manner.

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? Yes, we have had OIG visits within the past three years.

What were the findings and recommendations found with Government Accountability Office (GAO)? We have not had any GAO visits within the past three years.

What were the findings and recommendations found with VA Office of the Inspector General (OIG)? The CBOCs in Rock Hill, Sumter, and Florence were reviewed in November 2011 and received six (6) findings: one (1) related to documentation of patient education; two (2) related to service specific professional practice evaluations, one (1) regarding temperature control in a tele-communication closet and two (2) related to acquisition and disbursement.

What were the findings and recommendations found with the media articles? We are unaware of any media articles about quality of care concerns within the past three years.

When was your last Joint Commission Inspection? February 2010

What were the findings and recommendations? The Medical Center is surveyed across four (4) separate manuals: Hospital Care, Behavior Health Care, Home Care, and Long Term Care. In the 2010, the medical center received nine (9) findings under the Direct Impact Standards and fourteen (14) findings under the Indirect Impact Standards. Evidence of Standards Compliance was demonstrated in all areas within the required timeframes. The facility received full Joint Commission Accreditation in all programs.

When was your last Commission Accreditation Rehabilitation Facility (CARF) inspection? What were the findings and recommendations? September 26-28, 2011: Three year accreditation was awarded and the facility received no recommendations from this accreditation survey.

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 facility has three main Quality Committees responsible for the overarching performance improvement program of the medical center. The committees include:

* The Executive Leadership Steering Council - meets twice each month – Chair:

Director. Purpose: To ensure an adequate management and governance structure is in place to enhance organizational culture and performance improvement and monitor operations through the planning and designing of services, integrating and coordinating those services, and managing the safety and quality of care provided.

* The Health Systems Council – meets monthly – Chairs: Chief of Staff and Associate

Director of Patient and Nursing Services. Purpose: To recommend policies and plans and provide oversight of clinical practices and performance improvement activities, health care services delivery, research, clinical education, national disaster preparedness, affiliate relations, and Veterans Affairs/Department of Defense (VA/DoD) clinical sharing for the Wm. Jennings Bryan Dorn Department of Veterans Affairs Medical Center (Dorn VAMC) and its Community-Based Outpatient Clinics (CBOCs). Center (Dorn VAMC) and its Community-Based Outpatient Clinics (CBOCs).

* Performance Measures Meeting – meets weekly – Chair: Director. Purpose: To

provide accountability and transparency of high profile quality measures and indicators. This committee meets weekly to review and analyze quality data related to the VHA performance measures, Joint Commission ORYX measures, access data, patient satisfaction data, business and financial measures, and UM data.

Membership for all three committees is extensive and includes at a minimum the Director, the Associate Director, the Chief of Staff, the Associate Director of Patient Care and Nursing Services, the Chief of Quality Management, the Patient Safety Manager, Service Chiefs, Medical Staff, and Program Coordinators.

All other councils and sub councils report to one of these three committees. Other sub-councils include: Integrated Ethics, Compliance and Business Integrity, Affiliations Partnership Council, Veteran/Family Centered Care, Environment of Care, Information Management, Veteran/Customer Satisfaction PACT Steering Committee, Cancer Care Sub-council, Health Promotion and Disease Prevention, Home Care Sub-council, ICU Sub-Council, Medical Executive Sub-council, NonOR Invasive Procedure and Moderate Sedation, Pain Management, Palliative Care, Perioperative, Patient Safety Committee, Transfusion Utilization Committee, Telehealth Committee, and Women Veterans Health Committee.

Are veterans’ participating and/or serving on these committees? Yes, Veteran/Family Centered Care.

**Patient Satisfaction**

What percentage of your budget is dedicated to Patient Satisfaction staffing and programs in FY 2011? FY 2012? Please explain. All staff is responsible for patient satisfaction, no matter what their role. Regarding customer service and patient advocates, we have ten FTEE dedicated to patient advocate/customer service

How do you define patient satisfaction as a healthcare facility? An quality outcome measure from the patient’s perception of one or more aspects of their healthcare.

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

* National Survey-Survey of Healthcare Experiences of Patients (SHEP)
* Monthly Patient Panel Discussion
* Veteran Town Hall Meeting
* Focus Group Meeting
* Comment Cards
* Speak Up and Speak Out for Patients to voice their concerns/compliment
* 48 hours discharge telephone follow up calls
* Inpatient Proactive Visits

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

* Surveys
* Patient Advocate Tracking System(PATS)

How are these measurement tools utilized to improve patient satisfaction?

* Individual department performance improvement plans when applicable to address identified system issues and resolve patient concerns
* Discharge call results are reviewed daily and direct feedback given to nurse managers, physicians, social workers, food service, etc.
* All services are required to be present for monthly patient panel discussions to hear direct feedback.

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

* Latest available data, October 2011 and November 2011

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| --- | --- | --- | --- | --- | --- | --- | --- |
| **Target-92%** | | | **Oct-2011** | **Nov-2011** | **Dec-2011** | **FY12 QTR1** | **FY12 YTD** |
| **Inpatient Service Lines** | **Dimension of Care** | **Survey Question** | **Score** | **Score** | **Score** | **Score** | **Score** |
| All Excluding Psychiatry | Communication with Nurses | Communication with Nurses Composite | 84.2 | 95.7 | 93.7 | 91.5 | 91.5 |
| All Excluding Psychiatry | Communication with Nurses | Q1 -During this hospital stay, how often did nurses treat you with courtesy and respect? | 94.4 | 98.0 | 97.9 | 96.9 | 96.9 |
| All Excluding Psychiatry | Communication with Nurses | Q2 -During this hospital stay, how often did nurses listen carefully to you? | 77.1 | 96.1 | 90.5 | 88.3 | 88.3 |
| All Excluding Psychiatry | Communication with Nurses | Q3 -During this hospital stay, how often did nurses explain things in a way you could understand? | 81.0 | 92.9 | 92.8 | 89.2 | 89.2 |

1. Outpatient

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Target-89%** | | **Oct-2011** | **Nov-2011** | **Dec-2011** | **FY12 QTR1** | **FY12 YTD** |
| **Dimension of Care** | **Clinic** | **Score** | **Score** | **Score** | **Score** | **Score** |
| How Well Doctors/Nurses Communicate | Columbia Overall | 91.1 | 94.0 | 90.8 | 92.0 | 92.0 |

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

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Q2 -During this hospital stay, how often did nurses listen carefully to you? | 77.1 | 96.1 | 90.5 | 88.3 | 88.3 |

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

The Dorn VAMC has initiated ongoing patient centered care training for all employees, began to hold regular meetings with staff to address patient/family concerns immediately, and has provided tools for employees to address patient/family concerns at the lowest level.

How does VA Central Office, VISN and VA Medical Center facilities demonstrate and maintain accountability for patient satisfaction? VA Central Office, VISN and VA Medical Center facilities demonstrate and maintain accountability for patient satisfaction through monitoring and tracking uniform Performance Measures.

What resources has the VISN or VA Central Office provided to assist your facility in improving patient satisfaction initiatives? The VISN has provided numerous training sessions for patient/family centered care over the past year. There is a VISN 7 Veteran and Family Centered-Care Committee that helps support the initiative. VA Central Office has a newly formed Office of Patient-Centered Care under the leadership of Dr. Tracy Gaudet. The Dorn VAMC has been selected to be one of the first medical centers to work with the region 3 office of patient-centered care to support an enhanced roll out of patient-centered care. VA Central Office also has a national contract with Planetree, and two representatives from that organization have been involved in this initiative.

VISN Committees identified to support facilities within the VISN in improvement initiatives towards patient satisfaction. (List all of these): Veteran and Family Centered Care Committee for VISN 7.

How many VAMC staff work specifically on patient satisfaction initiatives, and please list their position titles, job duties and responsibilities? All VA staff is involved in patient satisfaction initiatives. This is part of our VA mission. In Stakeholder Relations Service, there is one Chief, 3 patient advocates, 1 program support assistant, and 5 customer service representatives.

Please list the patient satisfaction committees at the VISN and facility level and their mission statements and who is comprised on these committees? Honor American’s Veterans by providing exceptional health care that improves their health and well-being.

Veteran and Family Centered Care Committees (Multidisciplinary Team-Providers, Nurses, Program Coordinators, Facility Management, Pharmacy, Laboratory, Social Workers, Customer Service, Patient Representatives, Community Based Outpatient Clinic (CBOC) staff, Patients/Family Members, Volunteers, Patient Family Centered Coordinator, Education Suicide Prevention Coordinator, My HealtheVet Coordinator, Public Affairs Officers, Voluntary Services, Systems Redesign Coordinator, Prosthetics, and Union Members.

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

**Quality Manager:**

What duties and responsibilities do you have as the quality manager for the facility? The Quality Manager plans, develops, and maintains a comprehensive program to ensure compliance with the Department of Veterans Affairs (VA) Directives, Joint Commission Standards, and other internal/external regulatory agencies. An integral member of the facility’s leadership team, the Quality Manager is responsible for transition to continuous quality improvement as an approach to assess and improve the quality of patient care and provides leadership and direction to all services in the development and implementation of process improvement systems.

How are quality of care indicators and measurements tracked and managed? Executive Leadership and QM review and analyze quality data related to the VHA performance measures, Joint Commission ORYX measures, access data, patient satisfaction data, business and financial measures, Deputy Under Secretary for Health measures, significant patient safety activities, UM data trends, Risk Management data trends, and actions required in response to internal and external reviews. This is accomplished through oversight and integration of service level and committee performance activities and measures. The Executive Leadership and QM are responsible for monitoring and tracking all medical center performance improvement and patient safety activities and issues, recommending action, as needed and tracking problems/issues identified to resolution.

How do you measure and manage quality as a healthcare facility? Quality is measured through the monitoring and tracking of all medical center performance improvement and patient safety activities and issues, recommending actions (as necessary), tracking the resolution of problems addressed, and supporting the improvement of processes. Aggregated data review and analysis of key quality indicators helps to determine performance improvement priorities. The data collected for high priority and required areas are used to monitor the stability of existing processes, identify opportunities for improvement, and identify changes that lead to improvement or sustain improvement. Areas for monitoring performance are determined by considering the Veterans’ needs, nationally identified high risk areas, sentinel events, and priorities set by leaders at the local, regional, and national level. In addition, the medical center identifies those areas needing improvement and identifies desired changes. Performance measures are used to determine whether the changes result in desired outcomes.

How does VA Central Office, VISN and VA Medical Center facilities demonstrate and maintain accountability for quality of care? Accountability is maintained through verification of performance via internal and external reviews (The Joint Commission, Office of the Inspector General [OIG], Commission on the Accreditation of Rehabilitation Facilities [CARF], the College of American Pathologists [CAP], and other federal and state regulatory agencies. Healthcare Inspection Reports are available to the public from the OIG website and TJC Accountability Measures are available from the Quality Check website as well as on the U.S. Department of Health & Human Services Hospital Care internet site. The facility openly communicates with state and federal regulatory agencies as well as Veteran Service Organizations and other community partners with the intent of maintaining accountability through transparency. The Medical Center fully engages a comprehensive and proactive Compliance and Business Integrity program promoting an organizational culture and encourages compliance with the laws, regulations, and standards.

What are the quality of care committees at the VISN and/or facility level and who are they? The facility has three main Quality Committees responsible for the overarching performance improvement program for the medical center. The committees include: The Executive Leadership Steering Council (meets twice each month), The Health Systems Council (monthly), and the Performance Measures Meeting (weekly). The Executive Leadership Steering Committee is chaired by the Director. Membership for all three committees is extensive and includes at a minimum the Director, the Associate Director, the Chief of Staff, the Associate Director of Patient Care and Nursing Services, the Chief of Quality Management, the Patient Safety Manager, Service Chiefs, Medical Staff, and Program Coordinators. All other councils and sub councils report to one of these three committees.

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

a. VA staffed CBOC’s?

b. contracted staffed CBOC’s

The WJB Dorn VA Medical Center serves Veterans from a 30 county area in South Carolina. In addition to the main medical center, we offer services to our patients in seven community-based outpatient clinics: Anderson, Florence, Greenville, Orangeburg, Rock Hill, Spartanburg, and Sumter. Rock Hill utilizes contract staff; the other six (6) CBOCs are VA staffed.

All seven CBOCs are fully integrated in our Quality Assurance programs to include: EPRP reviews, Environment of Care Rounds, Police and Security Risk and Vulnerability Assessments, and internal/external survey review programs (i.e., TJC, OIG, etc), and other reviews as applicable.

How are you monitoring quality assurance with non VA care? Services and programs provided to our Veterans through contracted care are incorporated in our quality assurance and review programs. For example, the home oxygen program is a contract service provided by an outside vendor. The facility maintains a collaborative relationship with the company through our VA staff in the Prosthetics and Home Oxygen Programs. Direct oversight is through the Prosthetic Chief and Home Oxygen Coordinator with reporting to the Home Care Sub Council. This vendor is inspected by our staff on a regular basis (at least quarterly) via patient site visits and home oxygen warehouse inspections. Membership of the sub council includes the infection control coordinator, quality management representative, Prosthetics and Sensory Service, Home Based Primary Care, Home Oxygen, and Geriatrics and Extended Care. This sub council reports to our Health Systems Council which is chaired by the Chief of Staff and Associate Director for Patient Care Services/ Nurse Executive. Membership includes the Chief, QM and the Patient Safety Manager.

Of these, which quality measures are you responsible for? Service chiefs and program managers are responsible for key functions and priorities defined within their respective programs. They are responsible for the establishment of quality measures, ensuring reports are prepared and presented to the appropriate sub council and council as scheduled. Service Chiefs and program managers are active participants in these committees and address quality assurance initiatives, plans of actions, and ongoing monitoring of these activities. The Quality Manager serves consultatively to assist with service/program indicators and evaluate reports to ensure key functions are addressed and accountability is maintained.

**Patient Safety Manager**

What duties and responsibilities do you have as the Patient Safety Officer for the facility? The Medical Center’s Patient Safety (PS) Program is an integral part of the overall performance improvement program. The goal of the Patient Safety Program is to create a culture of safety through anonymous incident reporting that is non-punitive. The purpose is to identify opportunities for improvement in patient care monitoring, incident reporting, analyzing, reviewing, and investigating (if necessary), any unusual, unexpected, or unfavorable adverse events involving a patient, staff or family member during the course of medical management.Patient Safety oversees all Root Cause Analysis teams and submits Aggregate reviews for all Falls, Medication Errors, Elopements (Missing at Risk Patients) to the National Center for Patient Safety. Patient Safety is a member of Suicide Risk Reduction teams that conducts aggregate reviews of all Suicide Attempts Gestures and Completions. Patient Safety serves as a member of multiple Hospital Wide Committees and Sub Councils including: Patient Safety Sub Council, Executive Leadership Steering Committee, Health Systems Council, Environment of Care Council, ICU Sub Council, Non OR Invasive Procedures, Barcode Medication Administration Council, Construction Safety Sub Council, Integrated Ethics, Pharmacy Benefit Management, Anticoagulant Work Group, and Veterans Family Care Steering Committee, Falls Committee, Medication Aggregate Committee and Medication Reconciliation Work Group. Patient Safety participates in weekly Environmental rounds and monthly Mental Health Environment of Care Rounds. Patient Safety is also involved in providing education to staff. All New Employees receive Patient Safety Orientation during their initial Hospital orientation, and nursing staff receives education on reporting of adverse events via the Electronic reporting system. Each March during Patient Safety Week a Hospital wide educational offering is presented highlighting The Joint Commission National Patient Safety Goals for that current year.

What other facility staff reports to you on patient safety programs and care initiatives? Any staff member can contact Patient safety and report concerns. Staff serve on Medication Aggregate Team, Falls Committee, Medication Reconciliation, and Patient Safety Sub Council.

How do you define patient safety as a healthcare system? Patient safety as a healthcare system can be described as understanding the health care continuum as a system, and exploring system vulnerabilities that can result in patient harm. Reports of adverse events and close calls have provided valuable opportunities to evaluate the identified root causes and contributing factors, as well associated actions and outcome measures to mitigate future events from reoccurring within our facility. Emphasizing prevention rather than punishment this is the preferred method to mitigate system vulnerabilities and reduce adverse events .The three-step approach promotes the implementation of knowledge-based actions that can be formulated, tested, and implemented at the local and national levels to effectively mitigate system vulnerabilities that can lead to patient harm.

Please describe your patient safety programs and initiatives. Patient Safety is a part of multiple programs as a member and has a key function in Medication Aggregate Team, Falls Committee, Medication Reconciliation, and Patient Safety Sub Council.

What patient safety committees do you have at the VISN and/or VA Medical Facility? Please explain. Dorn has a Patient Safety Sub Council that meets monthly. The Patient Safety Staff of each facility in our VISN meets with the VISN Patient Safety Officer annually.

What VA Central Office, VISN and VA Medical Center facility’s programs are in place to prevent patient safety hazards? The National Center for Patient Safety oversees the reporting of Patient Safety for all VAs. They have a VHA Alerts and Recalls Website that all recalls, alerts and advisories are posted and tracked to completion.

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? Patient Safety Concerns are sent through the Director to the VISN and to the National Center for Patient Safety.

How are high risk patient safety issues, reported to the medical center’s leadership? Patient Safety issues are presented to Leadership through individual reports and through Quarterly reports submitted by Patient Safety through Health Systems Council, Environment of Care Council and Executive Leadership Steering Committee.

Please describe the differences at your facility between quality of care and patient safety? Quality of Care covers all areas of care delivered at our facility. Patient Safety is involved in quality of care delivery, but focuses on systems issues to improve on the 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? Any events reported to Patient Safety that may benefit from Quality reviews are referred to the Risk Manager and Chief of Quality. Quality Management may also be aware of events that are systems issues that need to be referred to Patient Safety for additional review. Quality Management staff have served with Patient Safety on Process Action teams and have jointly provided educational opportunities for staff.

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

All adverse event reported to Patient Safety are reviewed for level of harm. All events that are scored 3 on a SAC score established by the NCPS are reviewed through the RCA process. A Multidisciplinary team approved by the Director is chartered to review the events, to identify Lessons Learned and establish action plans to prevent future occurrences of the events.

How do you use other facilities RCA’s to improve quality of care and patient satisfaction? We do not have access to other facility RCAs. RCAs are protected quality improvement documents.

How many staff members work specifically on patient safety initiatives and their position titles, job duties and responsibilities? We have one staff member in Patient Safety. Our FTEE is 2 positions. We are in the process of posting the 2nd position and advertising for a Patient Safety Specialist to fill that vacancy.

Can you provide the date and summary of any Root Cause Analyses (RCA) completed in the last year? We completed a total of 19 RCAs for FY 2011 October 1, 2010-Septmeber 30, 2011. For FY 2012 October 1, 2011-April 6, 2011 we have completed 5 RCAs.

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

What duties and responsibilities do you have as the Patient Aligned Care Team (PACT) Coordinator for the facility? Chair the PACT Steering Committee and have championed the initiative at our VAMC. Managed the budget/funding, prepared action plans, and coordinated education. Participate in monthly calls with the VISN 7 PACT leads.

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 is no staff dedicated solely to PACT program and initiatives. There are many of us that are working on this initiative.

Who is in charge of the Patient Aligned Care Team (PACT) Steering Committee at this VA Medical Center? The Associate Director Patient Care/Nursing Services

How often does the Patient Aligned Care Team (PACT) committee meet? The PACT Committee meets monthly.

Which VA Medical Center staff attends the committee meeting? Director, Stakeholder Relations, Chief, Patient and Community Services; Chief, Social Work; Assistant Chief, Mental Health; HPDP Program Manager; Health Behavior Coordinator, Associate Nurse Executive for Primary Care and Specialty Clinics; Nurse Manager Surgery Clinics; Chief, Primary Care; Chief, CBOC’s, Lead Nurse Manager, CBOC’s; Supervisory Pharmacist; My Healthe Vet Coordinator; Budget Analyst; PACT Social Worker; Women’s Health Coordinator; Director, Staff Education; AFGE representative; Associate COS for Primary Care/Mental Health; Assistant Chief, Social Work.

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

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

We started with a champion. Dorn sent approximately 15 people to provide the initial education about PACT. We also did self study and educated ourselves. Education of staff was completed on site, and we started with primary care. We conducted an assessment and selected a team to be our pilot. We formed the steering committee to provide oversight. We had a multidisciplinary team participate in the PACT Collaborative that involved 6 learning sessions. We have had numerous educational sessions here to include 2 formal summits, with another one planned for May 2012*.*

**Patient Satisfaction**

**Director of Patient Care Services**

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

* Serve as chairperson for the Patient and Family Centered Care Committee
* Maintain a high standard and quality services for patient
* Ensure employees are trained to meet the expectations of patients and family members
* Maintain operation budget while maintaining high quality care
* Oversee all nursing care, inpatient and outpatient
* Sterile Processing Services
* Voluntary Service
* Chaplain Service

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

1. Inpatient

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **Target-92%** | | | **Oct-2011** | **Nov-2011** | **Dec-2011** | **FY12 QTR1** | **FY12 YTD** |
| **Inpatient Service Lines** | **Dimension of Care** | **Survey Question** | **Score** | **Score** | **Score** | **Score** | **Score** |
| All Excluding Psychiatry | Communication with Nurses | Communication with Nurses Composite | 84.2 | 95.7 | 93.7 | 91.5 | 91.5 |

1. Outpatient

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Target-89%** | | **Oct-2011** | **Nov-2011** | **Dec-2011** | **FY12 QTR1** | **FY12 YTD** |
| **Dimension of Care** | **Clinic** | **Score** | **Score** | **Score** | **Score** | **Score** |
| How Well Doctors/Nurses Communicate | Columbia Overall | 91.1 | 94.0 | 90.8 | 92.0 | 92.0 |

Did the facility improve or decline in any areas since the last Survey of Healthcare Experience of Patient (SHEP) survey? The Dorn VAMC has improved since the last SHEP Survey, and it can be at least partially credited to the Patient Centered Care Training that is now provided to all Employees, Patient Advisors, and Volunteers.

How are patient satisfaction indicators and measurements tracked and managed?

* Survey
* Patient Advocate Tracking System (PATS)

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

* Inpatient: Communication with Nurses
* Outpatient: How Well Doctors/Nurses Communicate

What other facility staff reports to you on patient satisfaction programs and initiatives? Stakeholder Relations (includes Patient Representatives and Customer Service)

**Patient Advocate/Patient Centered Care Coordinator**

How do you define patient satisfaction as a healthcare facility? Patient satisfaction is a quality outcome measure from the patient’s perception of one or more aspects of their healthcare.

What duties and responsibilities do you have as the Patient Advocate for the facility? Patient Advocates manage the complaint process, including complaint resolution, data capture and analysis of issues/complaints in order to support the facility in making system improvements.  Assists in resolving complaint issues that cannot be resolved at the front line, or point of service working directly with Service Chiefs and Service management to facilitate resolution of problems beyond the scope of front line staff and support the facility in presenting the patient’s perspective of the problem and desired resolution to Management.   Support patient rights and responsibilities and assists in development of and customer service training initiatives.

How are patient satisfaction indicators and measurements tracked and managed?

Patient satisfaction indicators and measurements are tracked and managed through performance measures.

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

* Inpatient: Communication with Nurses
* Outpatient: How Well Doctors/Nurses Communicate

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

Through December 2011

Inpatient: Communication with Nurses

|  |  |  |
| --- | --- | --- |
| **Target 92%** | **December 2011** | **FY12 YTD** |
| All Excluding Psychiatry | 93.7 % | 91.5% |

Outpatient: How Well Doctors/Nurses Communicate

|  |  |  |
| --- | --- | --- |
| **Target 89%** | **December 2011** | **FY12 YTD** |
| How Well Doctors/Nurses Communicate | 90.8 % | 92.2% |

What were your previous patient satisfaction scores?

|  |  |  |
| --- | --- | --- |
| **Target 92%** | **November 2011** | **FY12 YTD** |
| All Excluding Psychiatry | 95.7 % | 91.5% |

|  |  |  |
| --- | --- | --- |
| **Target 89%** | **November 2011** | **FY12 YTD** |
| How Well Doctors/Nurses Communicate | 94.0% | 92.2% |

Comparison to other VAMCs in VISN 7

|  |  |
| --- | --- |
| Medical Center | **How Well** |
| **Doctors/Nurses** |
| **Communicate** |
| **Score** |
| **N** |
| **Peer Index** |
| **VISN 7** | 89.8 |
| 3,367 |
| 89.4 |
| 508 - ATLANTA OUTPATIENT CLINIC | 91.5 |
| 476 |
| 89.2 |
| 509 - AUGUSTA DOWNTOWN DIVISION | 90.4 |
| 340 |
| 89.8 |
| 521 - BIRMINGHAM OUTPATIENT CLINIC | 87.1 |
| 559 |
| 89.2 |
| 534 - CHARLESTON OUTPATIENT CLINIC | 91.1 |
| 451 |
| 89.9 |
| 544 - COLUMBIA SC OUTPATIENT CLINIC | **92** |
| **704** |
| **89.8** |
| 557 - CARL VINSON OUTPATIENT CLINIC | 86.7 |
| 306 |
| 89.2 |
| 619 - MONTGOMERY OUTPATIENT CLINIC | 83.5 ▼ |
| 412 |
| 88.2 |
| 679 - TUSCALOOSA OUTPATIENT CLINIC | 93.5 ▲ |
| 119 |
| 89.3 |
| **Peer Index** | 89.4 |
| 53,038 |
| **National** | 90.2 |
| 53,826 |

Outpatient-Columbia VAMC is second in VISN7, higher than National and Peer Index

|  |  |
| --- | --- |
|  | **Communication** |
| **with Nurses** |
|  |
| **Score** |
| **N** |
| **Peer Index** |
| **VISN 7** | **92.4** |
| **751** |
| **92.4** |
| 508 - ATLANTA VAMC | **94.5** |
| **134** |
| **92.7** |
| 509 - AUGUSTA DOWNTOWN DIVISION | **93.3** |
| **89** |
| **92.7** |
| 521 - BIRMINGHAM VAMC | **91.1** |
| **130** |
| **92.3** |
| 534 - CHARLESTON VAMC | **91.3** |
| **129** |
| **92.7** |
| 544 - COLUMBIA SC VAMC | **91.5** |
| **120** |
| **91.7** |
| 557 - CARL VINSON VAMC | **95.3** |
| **70** |
| **91.6** |
| 619 - MONTGOMERY VAMC | **88.4** |
| **80** |
| **92.4** |
| 679 - TUSCALOOSA VAMC |  |
| **0** |
| **Peer Index** | **92.4** |
| **13,420** |
| **National** | **92.8** |
| **13,863** |

Inpatient-Dorn VAMC has improved overall and will continue to work on areas that need improvement to increase patient satisfaction. Dorn at (91.5%) is slightly lower (0.2) than the Peer Index (91.7%).

(Identified two questions from the Survey of Healthcare Experiences of Patients (SHEP) that would improve patient satisfaction at Dorn VAMC)

|  |
| --- |
| Q2 -During this hospital stay, how often did nurses listen carefully to you? |
| Q3 -During this hospital stay, how often did nurses explain things in a way you could understand? |

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? There have been articles in the news related to VA care “as the best care anywhere”.

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

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

How many facility staff members work specifically on patient satisfaction initiatives and please list their position titles, job duties and responsibilities? All facility staff are required to  support and participate in patient satisfaction initiatives and receive customer service training in treating Veterans with CARE, service recovery and Patient and Family Centered Care initiatives.

Please explain the initial and ongoing training these patient advocates receives (i.e. type of training and number of days/hours)? Patient Advocates receive Customer Service Training, Veteran Customer Service vision and expectations, and 40 hours of performance improvement training per year.

Please describe programs and initiatives that relate to patient satisfaction? Interviews, comment cards, focus groups, panel discussions, mystery shoppers, surveys, speak up/speak out sessions are many of the programs and initiatives through which the Dorn VAMC supports patient satisfaction.

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 Advocates support resolution of complaints at the lowest level.  If a complaint is presented to the Patient Advocate as much feedback is possible is gathers from the patient, family or caregiver regarding their experience with the facility as close to the event as possible.  The Patient Advocate then addresses the concern with the specific area to determine what actions need to be taken to resolve the concern to the Patient’s satisfaction.  Actions are taken to create the best possible outcome for the patient after a negative experience that is the basis of the complaint to ensure the patient feels the organization recognizes and understands the complaint and will strive to resolve to the extent possible.  The patient is then informed of the complaint resolution.  If a complaint regarding a clinical decision cannot be resolved to a Patient’s satisfaction then the patient is provided information for clinical appeal.

Which office and position in VA Central Office, VISN and VA Medical Center facility oversees Patient Advocates? VHA Office of Patient Centered Care and Cultural Transformation.

What training do Facility Patient Advocates receive? Selection of advocates are based upon Performance-based interviewing techniques to ensure hiring of staff members with competencies that focus on meeting or exceeding Veterans Health Care Service standards.  Customer Service training such as Treating Veterans with Care, Service Recovery are required and additional VISN wide training seminars and conferences.  Advocates also receive ongoing training on-the-job by other experienced Advocates and educated about service and to deal effectively with service issues.

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?Each VISN and facility Director supports an effective Veteran Customer Service program and hold staff accountable for excellence in the delivery of services to veterans.  All staff are accountable to this standard and this is ensured by an effective performance based reward and recognition program and Veteran Customer Service standards which all staff are educated

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 Directive 1003.4, Patient Advocacy.

If so, which office and positions ensure this standard/policy is being met? Director Stakeholder Relations, Director Patient Care and Nursing Service and Medical Center Director.

Do you have any primary care clinics that take longer than the 30 day wait, if so, which ones? We currently do not have any primary care clinics that take longer than 30 days.We have two CBOC’s that will be losing providers so a wait list will be generated as needed for new patients.

**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? The Utilization Management (UM) Program provides clinical and administrative recommendations relative to programs, committees, and/ or services relating to patient care and utilization management as an approach to assess and improve the quality of healthcare services, including the utilization of resources. The UM nurse is a collaborative member of the Quality Management team and is involved in performance improvement as an approach to assess and improve the quality of health care services.

What training did you receive initially and what ongoing training do you receive for this position? I was trained initially by our Certified InterQual Instructor for VISN 7 in Atlanta and took a test at the end of training. I also took an InterRater Reliability Test for both Acute and Mental Health after doing reviews for 6 months and am required to take one every 6 months.

Since my initial training, I have completed additional training from the VISN 7 Certified InterQual Instructor on new InterQual criteria. Continued education is also offered through monthly National Utilization Management calls by the VA. Lastly, the maker of InterQual, McKesson, offers webinars, power point presentations and the ability to ask questions through the McKesson hub.

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

1. Daily reports of reviews not meeting IQ criteria go to our Physician Utilization

Management Advisors, (PUMA’s.) We have one PUMA for Mental Health, one for Surgery and one for Medicine. Each PUMA decides whether to agree or disagree with the primary review and to take action if needed.

1. Biweekly reports go to the bed huddle which the Deputy Nurse Executive resides

over. An interdisciplinary team discusses each patient and incorporates Utilization Management information into the decision making process on the patient’s care.

1. A Quarterly Aggregate report goes to the Health Systems Council. This report

includes information on readmission rates, Lengths of Stay, percentage of reviews meeting and not meeting, recommended level of care for reviews not meeting and reasons for reviews not meeting. Recommendations to improve patient care are made at the end of this report.

**Risk Manager**

What job duties and responsibilities do you have to ensure quality of care and patient satisfaction? The Risk Manager develops, implements, and evaluates initiatives and activities in collaboration with patient safety to systematically identify, evaluate, reduce and/or eliminate, and monitor the occurrence of adverse events and situations arising from operational activities and environmental conditions.

What training did you receive initially and what ongoing training do you receive for this position? Initial training included one-on-one instruction with another risk manager at VA medical facility.  Ongoing training included quarterly nationwide calls headed by the national Risk Manager Yuri Walker.  There is also a website through the Office of Quality, Safety, and Value that contains information and additional resources.

How are measurement tools used to improve quality of care and patient satisfaction?  The Risk Manager tracks outcomes related to deaths.  A mortality report is completed quarterly and reported to the Health Systems Council.  Outcome data such as readmissions and adverse events are also reviewed to identify areas of improvement both at the individual provider and system level to identify areas of improvement.

**Systems Redesign Manager (Coordinator)**

What job duties and responsibilities do you have to ensure quality of care and patient satisfaction? As a Systems Redesign professional my core function is providing process improvement expertise to the facility through the management of Performance Improvement teams and projects with the overall goal of providing Quality, Safety and Value within the services we deliver to our internal and external stakeholders. Value is the core structure in the implementation of Lean Healthcare through the elimination of non value added processes.  We utilize Voice of the Customer to measure customer satisfaction for both our patients and our employees as the end users of the improved system.  We utilize the feedback to ensure our deliverable is aligned with what our patient feels is value added in the delivery of healthcare services.

What training did you receive initially and what ongoing training do you receive for this position? I have attended Lean Healthcare certification at the Yellow and Green Belt level in addition to my Six Sigma Green belt training.  I am attending the Inpatient Flow Academy and the VISN 7 Lean Black Belt certification course this year.

How are measurement tools used to improve quality of care and patient satisfaction? We utilize the Voice of the Customer at the beginning, during and end of our improvement cycles to ensure out improvement teams are consistently aligned with the patient’s perception of what activities are value added.  We utilize tools such as Spaghetti Diagrams, Process Flow maps, Value Stream maps to measure the current state and aim to validate the accuracy of the data captured from the perspective of the users in our system.  We utilize the future state mapping process to create the vision for the team to follow to ensure we are staying on target to provide Quality, Safety and Value. Each of our improvement tools and project teams are captures through the improvement cycle on our Systems Redesign Share Point site to promote transparency in our efforts to improve our quality of care and satisfaction.

**Chief Medical Information Officer**

What job duties and responsibilities do you have to ensure quality of care and patient satisfaction? Our Chief Medical Information Officer is not as involved in ensuring quality of care and patient satisfaction as our Program Specialist is in Quality Management. He is involved in acquiring and analyzing data, as well as preparing reports and presentations for facility-wide dissemination as related to performance measures and improvement.

How are the quality of care and patient satisfaction indicators and measurements tracked and managed? The Quality Management Program Specialist tracks and manages measures related to quality of care and patient satisfaction from the Executive Leadership Steering Committee (ELSC), Health Systems Council (HSC), and related Quality management-specific performance improvement initiatives. Job-specific tasks include creating/updating spreadsheets, databases, and SharePoint materials to track, manage, and present quality indicators related to performance improvement from committees, councils, and systems redesign.

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

How are measurement tools used to improve quality of care and patient satisfaction? Data reported in the sub-council and during External Peer Review Program (EPRP) EXIT reports provide specific measurements of performance related to quality of care and patient satisfaction. These measurements allow the facility to target areas for Improvement using action plans, Plan-Do-Check-Act cycles, and other service/facility level improvement initiatives as deemed necessary by the ELSC or other committee. Results of action plans and performance initiatives are scored and relayed to the actionable areas for further study or change in process.