**The American Legion**

**System Worth Saving Program**

**Quality of Care and Patient Satisfaction**

**Milwaukee VAMC 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 – Milwaukee VAMC**

**Quality of Care**

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

2011: $500,263,163

2012: $505,690,324

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.

We did not receive any Special Purpose Funding for Quality of Care Staff or Programs.  If any General Purpose Funds were used, they would have been expended from one of the Divisions associated with Quality of Care.

How do you define quality as a healthcare facility?

The Medical Center’s Quality Management Program encompasses many interrelated activities that fall under the responsibility of the Medical Center leaders. Key components are 1) quality Assurance 2) Performance Improvement, including Performance Measurement 3) Patient Safety Improvement 4) Internal and external Reviews 5) Internal and External Customer Satisfaction 6) Utilization Management 7) Risk Management and 8) System Redesign. The Quality Management functions are an organized and systematic approach to planning, delivering, measuring and improving health care in the medical center’s daily operations so that it can fulfill its mission, visions and values.

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

The Medical Center is continuously accredited in four programs by the Joint Commission: home care, behavioral health, acute care hospital and long term care. The Joint Commission is a voluntary, not-for-profit standard setting organization that accredits and certifies more than 19,000 healthcare organizations and programs in the United States. Joint Commission accreditation and certification is recognized nationwide as a symbol of quality that reflects an organization’s commitment to meeting quality and safety standards. The Medical Center has received the highest accreditation status, a 3 year accreditation, in each of six programs by the Commission on Accreditation of Rehabilitation Facilities, or CARF. CARF is an international, not-for-profit standards setting organization that accredits organizations working in human services fields. The following six programs are CARF accredited: Spinal Cord Injury, Comprehensive Integrated Inpatient Rehabilitation Program, Advanced Low Vision Services, Behavioral Health Residential Treatment, Veteran’s Recovery and Resource Center and Compensated Work Therapy/Transitional Residence. The Homeless Programs (HUDVASH, Healthcare for Homeless Veterans and the Grant Per Diem Programs) have completed their first CARF survey and are awaiting an accreditation decision. The American College of Surgeons Commission on Cancer recognized the Milwaukee VA Medical Center’s commitments and performance in maintaining its cancer program in March 2012 by granting the maximum accreditation of 3 years. The medical center also received 7 commendations associated with 7 standards for which the medical center had excelled. The goal of the American College of Surgeons Commission on Cancer is to reduce morbidity and mortality of cancer through education, standard setting and the monitoring of the quality of cancer care. By undertaking these voluntary, onsite evaluations, the Milwaukee VA Medical Center demonstrates its commitment to quality care, ongoing improvement and public accountability for the care and services provided.

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

Data are collected to monitor the stability of existing processes, identify opportunities for improvement, identify changes that will lead to improvement, and sustain improvement. Priorities may be identified by VHA leaders, e.g., VHA Performance Measures. Facilities also determine local priorities such as patient health outcomes, Veteran satisfaction, employee satisfaction and staffing effectiveness. The Joint Commission also has data collection requirement in important aspects of care. Analysis is performed for the following: confirmed transfusion reactions, serious adverse drug events, significant medication errors, major discrepancies between preoperative and postoperative diagnoses, adverse events or patterns of adverse events during moderate or deep anesthesia and anesthesia use, hazardous conditions, staffing effectiveness issues, and Joint Commission core measurement data. If three or more consecutive quarters show data outside of the desired range, improvement initiatives are planned and initiated and appropriate oversight is also arranged.

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

The Medical Center compares its internally derived data with external comparative databases. These are used to determine if there is excessive variability or unacceptable levels of performance. The Medical Center initiates action plans to resolve undesirable trends.

The Medical Center has defined and implemented an ongoing, proactive program for identifying and reducing unanticipated adverse events and safety risks to patients. Actual or potential process breakdowns are identified, prioritized and analyzed. The process and/or underlying systems are then redesigned, tested, implemented and monitored.

The Medical Center reports process measures and outcomes measures on the Hospital Compare Website.

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

1. Chief of Staff

The Chief of Staff is the lead clinician and in this role is accountable for the quality of care in the facility. To that end, the Chief of Staff is heavily involved in performance measures, peer review, and is also the chair of the Medical Executive Committee, which contains all of the clinical department heads and other key staff who are involved in the delivery of care and its measurement/improvement in the medical center.

1. Associate Director for Patient/Nursing Services

As a member of the executive team, I am responsible for understanding and addressing issues related to quality of care and patient satisfaction.

1. Quality Manager

The Quality Manager collaborates with the Medical Center Director, the Top Management Team, the Division/Program Managers, the Patient Safety Managers and all employees to ensure that the Quality Management and Patient Safety Programs are in place and monitored. The Quality Manager oversees various performance improvement initiatives, quality management activities and reviews, analyzes and acts upon quality data and information. The Quality Manager is supervisor to the PI Coordinators, the Infection Control Practitioners, the Patient Advocates, the Risk Manager and several support staff. The Quality Manager is an active member of the Improvement and Information Committee, the Quality Management Oversight Committee, the Medical Executive Committee, the Operations Council and other committees and councils where expertise in quality management, accreditation and regulatory standards is needed.

1. Patient Safety Manager (PSM)

See response to first question in the PSM section.

1. Utilization Management

Utilization Management (UM) Nurses review 100% of all acute care admissions and continued stay days for appropriate assignment of level of care. When the assigned level of care deviates from the recommended level of care, the case is referred to a Physician UM Advisor (PUMA). Additionally, quality of care issues identified in the review process are referred for further review/action. Referrals can be made to Quality Management or the PUMA.

1. Risk Manager

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

1. Systems Redesign Manager

Our Systems Redesign Coordinator takes the lead role in coordinating, teaching, and overseeing SRD projects in close collaboration with Medical Center Leadership.

As a member of the Medical Center’s Improvement team, the Systems Redesign Coordinator provides support and guidance in the analysis of current processes and the redesign and implementation of activities and initiatives to improve access and flow, thus helping the Hospital to achieve its goal to improve access to care for all veterans.

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

Our lead Informatics role is played by the Manager of CLIMET (Clinical Informatics and Medical Technology. This person participates in a wide variety of Medical Center groups and works closely with Medical Center Leadership to coordinate and prioritize Informatics goals and projects.

This role also is key in Medical Information: Program Manager, Health Information Management (from the medical record perspective).

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

The following staff members track quality improvement and/or compliance with accreditation or regulatory standards, including but not limited to VHA standards, Office of Inspector General, Occupational Safety and Health Administration, Centers for Disease Control and Prevention, The Joint Commission, Commission on Accreditation of Rehabilitation Facilities, Long Term Care Institute, American College of Surgeons Commission on Cancer, and Mathematica:

David Bertino Elizabeth Miller

Jean Boticki Barbara Pilak

Lydia Chenoweth Gaylyn Raduenz

Catherine Cole Kathryn Ryan

Margaret Edelstein Shabbir Shivji

Marylouise Felhofer Kimberly Urbain

Sean Hayes Jon Wardecke

Emily Jackson Diana Weber

Karen Janicek Gail Wietor

Christopher Kloiber Carolyn Williams

Debra Levine Rayvon Bufkin

Cindy Luker

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

Employees receive annual training in quality of care.

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

We did not receive any Special Purpose Funding from VACO or the VISN for Quality of Care Staff or Programs.  Finance was not aware of any programs or initiatives that would have received resources.

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

Finance was not aware of any needs for resources and/or support.

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

**Please explain what you mean by “grants”.**Is your facility working on a “best practice(s)” in quality of care management?

The Milwaukee VA Medical Center is participating in the Institute for Healthcare Improvement’s 5 Million Lives Campaign. This is a nation-wide initiative to use evidence-based medicine to reduce illness, medical harm, surgical complications and mortality. Several evidence-based care bundles are in effect including activities to prevent pressure ulcers, healthcare acquired infections, complications of and readmission for congestive heart failure, prevention of catheter associated urinary tract infections, prevention of ventilator-associated pneumonia and prevention of central line associated bloodstream infections. The Medical Center also participates in a Surgical Care Improvement Project, or SCIP as well as the Veteran Affairs Surgical Quality Improvement Project, or VASQIP.

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?

The Medical Center Director and top management team have ultimate accountability for the quality of care programs. The top management team includes the Deputy Medical Center Director who serves as a chief operating officer, an Assistant Director, an Associate Director for Patient Care/Nursing Services and a Chief of Staff. Also responsible for the quality of care and improvement initiatives are numerous Division and Program Managers. The Clinical Informatics and Medical Technology (CLIMET) team includes the System Redesign staff and other staff who are involved with performance measures and improvement of processes that support high performance under those measures.

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

Both the Informatics section of Clinical Informatics and Medical Technology (CLIMET) and the Quality Management Service have important roles in performance measures.

How many Full Time Employee (FTE) Registered Nurses, License Practical Nurse is on your staff? Is there sufficient staff to patient ratio? 589 full time RNs; 133 full time LPNs

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

How long have these positions been vacant? This varies based on the position and specialty.

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?

See responses below and in the section on the

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

The Milwaukee VA Medical Center has not had an onsite review or inspection from the Government Accountability Office; therefore, there are no findings or recommendations to report at this time.

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

The most recent Office of the Inspector General Combined Assessment Program review for the Milwaukee VA Medical Center occurred January 23 – 27, 2012. There were findings in 5 areas, but no repeat findings.

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

When was your last Joint Commission Inspection?

The most recent Joint Commission inspection was June 1 – 5, 2009. The Joint Commission’s reviews are unannounced. We anticipate a visit shortly, but cannot tell you exactly when the visit will occur.

What were the findings and recommendations?

The most recent Joint Commission Survey was completed in June 2009 for the Hospital, Behavioral Health Care, Long Term Care, and Home Care Programs.  The Medical Center received findings in six areas for a total of ten direct impact and six indirect impact Requirements for Improvement.

There were no findings in the Behavioral Health Care Program.

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

The most recent CARF accreditation visit occurred on March 26 – 28, 2012. Three programs were surveyed: the Therapeutic and Supported Employment Services Program, the Comprehensive Integrated Inpatient Rehabilitation Program and the Homeless Program. Results of this onsite survey are pending. The Spinal Cord Injury Program was surveyed October 27 – 28, 2011, receiving a three year accreditation award, expiring in December 2014.

There were three recommendations. Several areas were noted for their exemplary conformance.

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?

**VISN Quality of Care Committees**

The VISN 12 Quality Council and the VISN 12 Health Services Council meet monthly to enable an integrated VISN systematic approach to planning, delivering, measuring, and improving health care. Both councils report monthly to the VISN Executive Leadership Council, which is chaired by the VISN 12 Network Director and whose membership includes VISN 12 leadership members and all VISN 12 hospital directors.

The VISN 12 Quality Council will demonstrate the following: a.) Communicating quality management priorities and maintaining a mode for communication with VA Central Office Program Offices to ensure alignment and coordination with national priorities b) Promoting a culture conducive to patient safety and continuous quality improvement c) Reviewing and analyzing trended, aggregated data collected for the quality management components and d) Tracking facility action plans which address non-compliance, to completion. Membership on the VISN 12 Quality Council includes the VISN 12 Network Director, Co-Chairperson, the VISN 12 Quality Management Officer, Co-Chairperson, the VISN 12 Chief Medical Officer, the VISN 12 Patient Safety Officer, the VISN 12 Continual Readiness Council Chairperson, the VISN 12 Customer Service Committee Chairperson, the VISN 12 Patient Safety Chairperson, the VISN 12 Risk Management Chairperson, the VISN 12 Safety Leadership Chairperson, the VISN 12 System Redesign Coordinator, the VISN 12 Mental Health Lead, the VISN 12 Long Term Care Lead and the VISN 12 Utilization Management Manager.

The VISN 12 Health System Council a) advises the Executive Leadership Council (ELC) on all matters pertaining to clinical care, research and education (affiliated) and proactively defines the clinical priorities of VISN 12, b) Provides the coordination of health care services delivery to ensure uniformity of benefit based on VHA and VISN priorities, c) Advises the Chief Medical Officer and Network Director on national clinical program initiatives, d) Defines the clinical, academic and research goals for VISN 12, and present to ELC for concurrence and e) Evaluates and coordinates clinical programs in VISN 12 to determine value. Value is defined as the relationship between cost, quality and access. ((Cost + Quality)/Access).

Membership on the VISN 12 Health Services Council includes VISN 12 Chiefs of Staff, VISN 12 Associate Directors for Patient and Nursing Services, VISN 12 Chief Medical Officer and Deputy, VISN 12 Quality Management Officer and Deputy.

**Facility Quality of Care Committees**

The Milwaukee VA Medical Center has two quality of care committees: the Improvement and Information Council (I & I Council) and the Quality Management Oversight Committee (QMOC).

Improvement and Information Council. The Improvement and Information Council is responsible for developing, maintaining and disseminating the Medical Center Quality Management (QM) and Information management (IM) Plans. The I&I Council will also assess trended quality management and patient safety data; prioritize and coordinate Performance Improvement Teams (PITs) for issues that fall outside of division-specific or other operational improvements; and provide oversight and assistance to the Health Information Management Committee (HIMC), Data Input and Integrity Group (DIIG), Clinical Reminders Committee, Performance Measures Committee, and the Medical Device Informatics Committee. The Council is chaired by the Associate Chief of Staff (ACOS) for Clinical Affairs. Other members include: the Management Information Systems Manager, Spinal Cord Injury Nurse Practitioner, Program Manager/Employee Education, Medical Media, Library and MIS, the Medical Imaging Supervisor, the Program Manager/Health Information Management, the Office of Quality Management and Safety Manager, the Office of Quality Management and Safety Deputy Manager, the Administrative Officer/Medicine Division, The Associate Chief of Staff for Education, the Social Work Executive, the Program Manager, 5CN/Dialysis, the Program Manager, Informatics/CLIMET, a Spinal Cord Injury Program nurse, the Domiciliary Program Manager, the Training Specialist, EE/MIS, the Division Manager/CLIMET, the Program Management Officer of the Northeastern Community Based Outpatient Clinics, the RN Performance Facilitator/CLIMET, the Mental Health Administrative Officer, the Program Manager/Physical Therapy, the Program Manager/Rehabilitation and Extended Care, a Rehabilitation and Extended Care nurse, the Mental Health/HUD VASH Coordinator, the Anesthesiology CRNA, the Pharmacy Program Manager, the Nursing Division Data Analyst, the Home Telehealth Lead and the Chief Information Officer. The Improvement and Information Council meets monthly.

Quality Management Oversight Committee. The Quality Management Oversight Committee is a standing leadership committee responsible for oversight of all key quality management components and for meeting the requirements for external accreditation within the facility, as outlined in VHA Directive 2009 – 043. The Committee is chaired by the Medical Center Director. Other members include: The Executive Assistant/Medical Center Director, the Chief of Staff, the Administrative Assistant/Chief of Staff, the Associate Director Patient/Nursing Services, The administrative Assistant/Associate Director Patient/Nursing Services, The Associate Medical Center Director, the Deputy Medical Center Director, the Manager/Office of Quality management and Safety, the Deputy/Office of Quality Management and Safety, the Patient Safety Manager, the Performance Improvement Coordinator/Risk Management, a CLIMET Representative, Administrative support and Division Managers and Subject Matter Experts as requested to attend on an as needed basis. The Quality Management Oversight Committee meets quarterly.

There are many other councils and committees that indirectly address various aspects of quality of care and services.

Are veterans participating and/or serving on these committees?

There are no veterans currently represented on the VISN Quality Council or VISN Health Systems Council. The VISN Veterans Advisory Council, chaired by VISN 12 Network Director meets quarterly and has Veterans and Veteran Service Organization representation. Veterans do not serve on the facility quality of care committees due to the confidential nature of the activities discussed. The Medical Center does have a monthly Veterans Service Officers meeting where input from veterans is elicited and information is shared.

**Patient Satisfaction**

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

We did not receive any Special Purpose Funding for Patient Satisfaction staffing and programs.  If any General Purpose Funds were used, they would have been expended from one of the Divisions associated with Patient Satisfaction.

The Customer Service Council is the locus of activity on patient satisfaction—this committee does not have any budget. All members of the Council are employees who volunteer to work with these issues on a collateral basis.

How do you define patient satisfaction as a healthcare facility?

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

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

The VISN 12 Performance Measures scorecard tracks 20 patient satisfaction indices on a monthly basis. CLIMET monitors this data, analyzes it for changes in trending and outlier data and reports to Medical Center Management monthly.

Patient satisfaction is measured through a patient satisfaction survey that equates to the private sector satisfaction survey HCAPS. The Customer Service Council reviews the data/results from both the Inpatient and Outpatient populations on a quarterly basis. We attempt to trend those results against what the Patient Advocates illustrate with their reports. We also utilize Customer Service postcards that are available in many clinics; the Veterans provide us feedback on these cards and they are mailed directly to the Medical Center Director, then sent to QM&S for trending.

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

See answers to previous questions in this section.

How are these measurement tools utilized to improve patient satisfaction?

If we observe a trend that is negative our first method of responding is having Customer Service Council members bring that observation back to the respective area of the Medical Center for feedback. If we see consistently negative trends we attempt to isolate what factor might be causing dis-satisfaction. A recent example is our Outpatient Rating of Specialists score was below the VISN 12 and national benchmark for several quarters. We arranged to use a specialized comment card survey for areas of the Medical Center that utilize specialists. Results of this initiative can be shared during your visit.

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

 

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

The majority of our scores have exceeded or been relatively close to benchmark scores and the critical benchmarks are the national VA scores and VISN 12 scores. When we see any score that is consistently below benchmarks we attempt to ascertain what might be causing the lower than hoped for scores. If we can clearly identify what the problem is then we develop a list of possible actions to take.

There are always subtle changes in scores in both directions. We try to always do three things:

1. Compare trends from Patient Advocate Reports to patient satisfaction survey results. If the two reports correlate on a specific item that can help identify a potential problem area.
2. Watch for scores consistently below benchmark; if this happens make sure Customer Service Council, Medical Executive Committee and Ops Council are aware of this finding. The list of possible actions to take (described above is shared with organization leadership and may be shared with the noted committees and others as appropriate.
3. Watch for scores consistently above benchmark to see if we can isolate the reasons for our success.

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

A recent example is our Outpatient Rating of Specialists score was below the VISN 12 and national benchmark for several quarters. We arranged to use a specialized comment card survey for areas of the Medical Center that utilize specialists. (Data are available upon request.)

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

At the facility level, organizational leadership is accountable for patient satisfaction.

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

We did not receive any Special Purpose Funding from VACO or the VISN for improving patient Satisfaction.  Finance is not aware of any programs or initiatives that would have received resources.

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

In a sense all employees of the Medical Center are responsible for understanding how their role impacts the patient satisfaction experience of our Veterans. All areas of the Medical Center constantly fine tune their process(s) to improve patient satisfaction.

The two patient advocates clearly work to improve patient satisfaction by addressing patient concerns.

Please list the patient satisfaction committees at the VISN and facility level and their

mission statements and who is comprised on these committees?

Bell, Matthew

Bolgrien, Helen K.

Boticki, Jean M

Casey, Joyce

Collingwood, Jane

DAmato, Sue

Delacruz, Jennifer

Dewitt, Drew A.

Feldman, Jill S

Flynn, David

Jantz, Timothy

Jashinsky, Denise

Johnson, William B.

Kolden, Kasmira L.

Labinski, Kimberly

Lundh, Paul

Mahendran, Roshandran

Massey, Nancy

McCollum, Dorothy R.

Oswald, Norman

Parker, Jessica M

Powell, Delon R.

Pulsfus, Stephanie

Quinn, Sean E.

Roth, Mark C.

Schwaller, Dean

Sergeant, Nancy

Toney, Salem

Urrutia Comas, Alexandra

Wroten, Jeri

Young, Mike

Zahn, Jill



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

Many of the employees on the Customer Service Council are Veterans.

**Quality Manager**

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

See “What are the following staff’s responsibilities in ensuring quality of care at the facility?” a previous question.

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

Please see “How do you measure and manage quality as a healthcare facility?” a previous question.

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

Please see “How do you measure and manage quality as a healthcare facility?” a previous question.

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

Directives are initiated and maintained for aspects and standards of care. These guide facility operations so that veterans’ care can be standardized as much as possible where possible. VHA also determines system wide performance measures. Facilities and the VISN undertake specialized projects and participate in VISN level committees to ensure adequate flow of information and best practices between facilities and that interfacility collaboration is cultivated. National conferences, audioconferences and interfacility meetings occur on an as needed basis. Facility data is reported on the Hospital Compare Website so that Veterans and other stakeholders are afforded the opportunity to compare the outcomes in VA and non-VA care. The medical center’s Chief of Staff also meets with patients and families in the event of medical error.

VA Central Office, the VISN and VA Medical Centers also demonstrate accountability for quality care by establishing core values, behavioral expectations, competencies, orientation and training opportunities, and a compliance and business integrity program. Each facility has a patient advocate function, a Veteran satisfaction survey and an employee satisfaction survey, affording the opportunity to learn of trends and problem areas. A variety of policies and standard operating procedures exist to assist staff. The medical centers operate an event reporting system, another vehicle in which staff can report untoward events and close calls in the interest of improving care.

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

Please see previous question “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?”

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

a. VA staffed CBOC’s?

b. contracted staffed CBOC’s

a. All Medical Center CBOCs are VA staffed. Milwaukee does not have any

contracted CBOCs.

b. The CBOCs are fully integrated into the Medical Center’s Quality Management

and Patient Safety Programs. They participate in ongoing performance

improvement activities through the Primary Care and Mental Health Divisions and

report both patient incidents and close calls.

How are you monitoring quality assurance with non VA care?

The Contracting Officer’s Representatives in the clinical services monitor the quality of non-VA care according to the contracts under which the care is provided.  The quality data is then reviewed by the Medical Executive Committee prior to any decisions to continue or renew a contract.  This review process meets the intent to the Joint Commission, which accredits both VAMCs and private-sector hospitals.

Of these, which quality measures are you responsible for?

See response, to the question above.

**Patient Safety Manager**

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

The PSM is responsible for reporting, entering and tracking Safety Reports (patient incident reports), in “SPOT,” a VHA national database. Some medical centers have an additional database for tracking incidents to meet local needs for data sorting and analysis.

The PSM also ensures that the components of the Quality Management Plan and Patient Safety Improvement Program are integrated.

Implements a coordinated Patient Safety Improvement Program at the Medical Center level that is based on guidance and tools from the VA National Center for Patient Safety, and which meets the needs and priorities identified by the Medical Center Director and Chief of Staff.

These include addressing important standards, requirements and recommendations promulgated by The Joint Commission and other organizations working to improve patient care.

Goal to create a ‘Culture of Safety” within VHA by:

• Encouraging 5705 protected non-punitive reporting and analysis of medical errors, adverse events, and close calls

• Analyzing systems and processes using tools such as Root Cause Analysis and Health Care Failure Mode Effects Analysis *(HFMEA)*

• Focusing human factors engineering based solutions on system level vulnerabilities rather than individuals

• Learning from aviation and other High Reliability Organizations outside of health care to make processes safer

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

No other staff directly report to us, however; we collaborate with PI Coordinators who maintain expertise in medication errors, missing patients, and falls.

How do you define patient safety as a healthcare system?

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

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

The three-step approach promotes the implementation of knowledge-based actions that can be formulated, tested, and implemented at the local and national levels to effectively mitigate system vulnerabilities that can lead to patient harm*.*

Please describe your patient safety programs and initiatives.

The patient safety program has been described in previous answers in this section of the report. Following are several initiatives that are centered around improving patient safety:

The Daily Plan – A daily report that is reviewed between nursing and patients detailing what cares and medications are to be expected that day, what type of diet the patient is on and when the patient can anticipate being discharged.

Safe Patient Handling – Ensuring we have the equipment necessary to help transport patients and reduce injury to patients and staff

Multidisciplinary Safety Inspection Team – A team comprised of multiple disciplines which evaluates the locked mental health unit and ensures all potential areas which could be used by patients to harm themselves or others are minimized according to expert guidance provided by the National Center for Patient Safety.

Reusable Medical Equipment – Ensuring sterile processing for all reusable medical equipment is performed according to the manufacturer’s instruction.

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

Facility level:

1. Safe Patient Handling committee
2. Environment of Care Committee
3. Integrated Ethics Council
4. Reusable Medical Equipment Committee
5. Improvement and Information Council
6. Multidisciplinary Safety Inspection Team (MSIT)

**VISN level Committees include:**

VISN 12 Patient Safety Council (PSC): Membership includes facility Patient Safety

Manager’s, Biomed engineering, VISN logistic, recall, pharmacy, environmental safety

and suicide prevention staff. PSC evaluates Patient Safety issues including recalls,

alerts and medical device safety. Data is reviewed at PSC for significant network

trends, solutions and best practices. Patient Safety Managers share lessons learned and serious close calls across the network in efforts to prevent harm and reoccurring adverse events which could result in harm to patients.

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

At the facility level we have all the VISN 12 and national programs implemented at the Milwaukee VAMC (see below).

**VISN 12 Programs/Policies:**

1. **Clinical Adverse Event Reporting Policy**. Serious or significant adverse events are reported to the network for review and aggregation for possible trends and network solutions. Adverse events resulting in serious injury may be reported to the Joint commission as Sentinel Events.
2. **Defective Product Protocol:** A VISN 12 process/checklist which provides facility staff with guidance on the process of handling an issue with a defective product or medical device safety incident which may require reporting to the FDA.
3. **VISN 12 Suicide Prevention Team:** This team reviews facility quarterly summaries on suicide attempts and completions in order to aggregate data, share best practices, and lessons learned in the overall prevention of suicides.
4. **VISN 12 Safe Patient Handling Program:** The facility Safe Patient Handling Coordinators meet on an ad hoc basis to evaluate issues surrounding the safe and effective use of patient equipment.
5. **VISN 12 Care Coordination/Home Telehealth Programs**

Urban, care coordination programs utilizing technology and a team approach to assist in coordinating the care of elderly veterans at risk for hospitalization and emergency room visits. The Care Coordination/ Home Telehealth (CCHT) Programs use technology to monitor certain chronic health conditions in the home. The goal of these programs is to reduce resource utilization (ER visits, hospitalizations) and delay onset of long term care placement, while improving the quality of care provided to the veterans.

**T-CARE** - This care coordination program utilizes technology and a team approach to assist veterans with diabetes, hypertension, heart failure, and/or chronic lung disease.

**Telephone Linked Care for Dementia** – The Telephone Linked Care (TLC) program utilizes technology and a team effort to coordinate care for veterans' with dementia. TLC uses technology to educate and support caregivers of veterans with dementia in the home.

NCPS/VACO:

* **Mental Health Environment of Care Checklist.** The checklist was developed for VA medical facilities to review inpatient mental health units for environmental hazards, decreasing the chance a patient could commit suicide or inflict self-harm.
* **Patient Safety Alerts and Advisories.** Each alert or advisory concerns a specific issue relating to equipment, medications and procedures that might cause harm to patients. Patient Safety Alerts communicate urgent notices that require immediate and specific action(s) by specific parties by a specified deadline. Advisories communicate recommendations, are more general in nature, and implementation may be subject to local judgment.
* **The Daily Plan®.** This initiative enhances patient safety by involving patients in their care. A single document is provided to them that outlines what can be expected on a specific day of hospitalization.Facilities can customize the document and include a number of items relevant to care, such as: medications, nutrition and allergies.
* **Patient Safety Assessment Tool.** This Web-based assessment tool allows patient safety managers to complete a detailed assessment of the status of their facility’s program. The questions relate directly to the Joint Commission's requirements.
* **Product Recall Office.** VA's Product Recall Office is tasked to manage recalls of all medical devices and products initiated by manufacturers or the FDA that are applicable to the VA.Following its December 2008 establishment at the VA National Center for Patient Safety, recalls compliance – removing recalled products from the supply chain – has risen to and is holding at 98 percent. The Recall Office receives more than 12,500 recall notices from a variety of sources annually.
* **Medical Team Training.** This program was developed to improve patient care outcomes through more effective communication and teamwork among providers. The focus of the first phase of the program, completed June 2009, was to improve patient outcomes through more effective communication and teamwork among providers in critical care areas, such as the operating room and intensive care unit. The second phase of the program is underway and focuses other clinical areas, such as cardiac catheterization labs, endoscopy units, and primary care clinics.
* **Ensuring Correct Surgery.** Incorrect surgical procedures or incorrect diagnostic and therapeutic invasive procedures are relatively uncommon adverse medical events, but often devastating when they occur. To prevent or avoid such adverse medical events, the VA National Center for Patient Safety developed a straightforward, five-step process to identify the correct patient, mark the correct surgical site, and ensure the correct procedure is performed. Instituted in 2002 for surgical procedures inside the operating room, the Ensuring Correct Surgery Directive was modified in 2004 to also address invasive procedures outside the operating room.
* **Root Cause Analysis.** This is a multi-disciplinary team approach is used to study adverse medical events and close calls (sometimes called “near misses”). The goal of each root cause analysis is to find out what happened, why it happened, and what must be done to prevent it from happening again. Training programs, cognitive aids, and companion software have been developed by the VA National Center for Patient Safety to support facility root cause analysis teams.
* **Healthcare Failure Mode Effect Analysis.** Similar to the root cause analysis method, Healthcare Failure Mode Effect Analysis is based on a five-step process used by interdisciplinary teams to proactively evaluate a health care process. Specifically designed for use by health care professionals, the process offers users analytical tools such as flow diagramming, decision trees, and prioritized scoring systems. The tools enable the user to proactively identify vulnerabilities and deal with them effectively.

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?

The Milwaukee VAMC follows recommendations from all Safety Alerts/Advisories; and uses RCA and HFMEA’s to improve/correct any potential patient safety hazards.

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

Leadership has an open door policy and we will call immediately and follow up electronically with any high risk issues, while others are reviewed at the daily leadership briefing. Off tour we will call leadership at home.

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

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

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?

The QM, RM, and Patient Safety Manager (PSM) partner and collaborate on daily activities that include, but are not limited to:

1) continuous readiness for internal and external reviews

2) ethical issues in patient care

3) disclosure of adverse events to patients

4) identification and reporting sentinel events and subsequent actions

5) process and system improvements

System Redesign, Utilization Manager, Chief Health Information Officer are integrated into the Quality Management Oversight Committee and the Improvement and Information Council with Patient Safety, Quality Management and Risk Management.

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

Conducting an RCA is a critical aspect in the process of improving patient safety. The goal of the RCA process is to find out what happened, why it happened, and to determine what can be done to prevent it from happening again.

Multidisciplinary teams are formed to investigate adverse events and close calls. Close calls are events that could have resulted in a patient’s accident or injury, but didn’t — either by chance or timely intervention.

RCAs are used to focus on improving and redesigning systems and processes — rather than focus on individual performance, which is seldom the sole reason for an adverse event or close call. A previously unheeded or unnoticed chain of events most often leads to a recurring safety problem, regardless of the personnel involved.

RCA teams improve patient safety by formulating solutions, testing, implementing, and measuring outcomes. NCPS enters all RCA data into the Patient Safety Information System — an internal, confidential, non-punitive reporting system

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

Throughout the VISN and in our National Patient Safety Monthly Meetings, Lessons Learned from other facilities are presented if they are best practices. The SPOT database enables us to query subjects of RCAs throughout the country and look at root causes, and actions taken at other facilities.

The NCPS shares findings, upon request, if there is a clear benefit for multiple facilities.

Findings can be shared nationally if there is a clear benefit for multiple facilities; however, RCA reports are considered confidential quality improvement documents and are protected from release by Title 38 United States Code (U.S.C.) 5705 and its implementing regulations.

To ensure that the findings are focused on systems improvement, before dissemination, all personal and facility names, facility locations, and other potentially identifying information are removed, as noted above.

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

There are two Patient Safety Managers, and three Patient Safety Fellows, and various staff members are engaged from time to time in working on Patient Safety initiatives as Patient Safety is an essential part of the care we deliver and an expectation that all staff are engaged in keeping our patients safe.

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

No. RCAs are confidential quality improvement documents and are protected from release by Title 38 United States Code (U.S.C.) 5705 and its implementing regulation.

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

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

To implement PACT into the Specialty Care, Spinal Cord care and Mental Health. PACT in Primary Care is implemented.

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? 11 (Other detail will be provided during the visit as requested.)

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

The Division Manager for Primary Care, Deborah Hagen, MSN, RN is the chair of the PACT Steering Committee at the Milwaukee VAMC. This committee reports up to the Chief of Staff.

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

Monthly

Which VA Medical Center staff attends the committee meeting?

Clinical staff involved with PACT implementation.

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?

This information will be provided during the visit if requested.

**Patient Satisfaction**

**Associate Director for Patient/Nursing Services**

What duties and responsibilities do you have as the Associate Director for Patient/Nursing Services for the facility?

As a member of the executive team, I am responsible for understanding and addressing issues related to patient satisfaction. Processes are in place to ensure proper communication of patient satisfaction data through appropriate hospital committees which perform the functions of monitoring, evaluating, and addressing patient satisfaction indicators, as well as individual patient concerns complaints.

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

1. Inpatient
2. Outpatient

See section on patient satisfaction that immediately preceeds the section on the Quality Manager.

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

See section on patient satisfaction that immediately preceeds the section on the Quality Manager.

How are patient satisfaction indicators and measurements tracked and managed?

VISN 12 Performance Measures scorecard tracks various patient satisfaction indices on a monthly basis. CLIMET monitors this data, analyzes it for changes in trending and outlier data and reports to Medical Center Management monthly.

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

The organization’s leadership is responsible for all of the measures.

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

Facility staff share information on patient satisfaction with the Customer Service Council, Medical Executive Committee, Operations Council, and other groups as requested. In addition, specific patient care concerns are addressed during our daily Director’s report.

**Patient Advocate/Patient Centered Care Coordinator**

How do you define patient satisfaction as a healthcare facility?

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

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

The Patient Advocacy Program was established to ensure that all veterans and their families, who are served in VHA facilities and clinics, have their complaints addressed in a convenient and timely manner. The Patient Advocacy Program operates under the broader philosophy of Service Recovery, whereby patient complaints are identified, resolved, classified, and utilized to improve overall service to veterans. The Patient Advocacy Program is an important aspect of patient satisfaction and contributes proactively to VHA initiatives to provide world-class customer service. The patient advocates interact with Veterans and their families by providing active listening and assistance. The advocate may assist in gathering information, navigating the medical centers’ systems and processes, in resolving any concerns or issues. The patient advocates also actively participate in the medical center’s outreach initiatives. The patient advocates enter data into the Patient Advocate Tracking System and refer any serious matters to the appropriate medical center resources. The patient advocates are active members of numerous committees, representing the voice of the patients/families.

How are patient satisfaction indicators and measurements tracked and managed?

The PATS data is tracked through the Quality Management and Safety section. Patient satisfaction data indicator and measurements have been spoken to as answers to other questions in this document.

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

This question has been answered in other sections of this questionnaire.

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

Please see Powerpoint presentation on the results of the surveys on page 9.

What were your previous patient satisfaction scores?

Please see Powerpoint presentation on the results of the surveys on page 9.

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?

From time to time there have been stories in the local paper and broadcast media about services we offer at the VA. Most have been overwhelmingly positive. However, there have been some occasions when Veterans express concerns about our services and we do address those issues. This happened during extensive coverage of an instrument reprocessing issue we had in December 2010 when we temporarily halted all medical procedures because of safety concerns. Our goal at that time was to reassure Veterans by providing accurate information, and we worked one-on-one with those who had complaints. A couple times in the past year, Veterans have expressed concern to the press about services we offer in the domiciliary or the wait time for care. In each case, we believe, Veterans were upset because of misinformation, and we viewed the media interest as a chance to tell a full, complete story, show why we are following certain procedures, the importance of the changes and how it helps Veterans. Most recently, a Veteran was upset at changes to the drug treatment program. This gave us a chance to show how our evidence-based program is successful. Some Veterans who had not been treated here in years, recently stated we weren’t able to provide Mental Health care in a timely manner. This gave us an opportunity to discuss our Mental Health programs and how we have added staff and programs, and how we have met the 14-day window to get new patients care, 96 percent of the time. We view this as a success and an opportunity to tell our story, which we hope encourages other Veterans to get their care at the Milwaukee VA.

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

The Customer Service Council is sponsoring a patient satisfaction activity in April, the Thank You For Smiling Campaign. Photos of smiling employees are posted near the canteen. The campaign was undertaken to encourage a simple and always available customer service tool, the opportunity to create a more pleasant environment for the Veterans by simply smiling. The medical center has a valet parking service and has relocated some gender specific services to the Women’s Resource Center. Additional initiatives are described below.

* Each VISN 12 Facility provides Veteran’s with information capturing “Just the Facts” type documentation.  We acknowledge that during New Orientation Veterans may be overwhelmed with the amount of information provided.  With this in mind, Patient Advocates continue to support the need for VA Staff and Veterans to have easy access to area specific information for every area throughout the VA Medical Facility and keep information current.
* Continual encouragement to Department Program and Division Managers along with Care Leaders to support educational opportunities for Veterans.  Information with area specific topics/benefits placed in the vicinity of Prosthetics, Dental, Pharmacy, and Billing, etc.  Providing related information and having it available as needed is a proactive approach for setting expectations, understanding entitlements and VA regulations.  The medical center empowers frontline VA Staff members to communicate information directly to Veterans and assist them with issues and concerns.
* The medical center offers training and support through its “Treating Veterans with CARE” and “I CARE” initiatives. These are patient-centric customer service programs and VA Core Values that encourage consistent communication and positive interactions for all employees dealing with patients.
* The PATS Subgroup will continue to develop action plans to improve patient/family involvement in decision-making.   Patient Advocates become involved with PACT, proactively gathering information as it is identified as a concern either by a VA Staff member, a Veteran and/or Family member.

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

The Milwaukee VA Medical Center has two full time patient advocates.

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

The patient advocates receive an initial new employee orientation, a departmental orientation and on the job training as needed. Role specific training is ongoing. Examples include monthly patient advocate conference calls, focused educational opportunities, national conferences such as those offered by the Society of Healthcare Advocacy, VHA, other advocacy organizations and Planetree. There are also monthly VISN 12 Customer Service calls and a biannual VISN conference.

Please describe programs and initiatives that relate to patient satisfaction?

Responses to this question can be found in other sections of this document.

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

A Medical Center Patient Advocate is an employee who is specifically designated to manage the complaint process, including complaint resolution, data capture and analysis of issues/complaints in order to make system improvements. Medical Center Patient Advocates assist front line staff in resolving issues that occur at the point of service and address complaints that were not able to be resolved at the point of service. Facility or Medical Center Patient Advocates work directly with Division and Program Managers and all employees to facilitate resolution to problems beyond the scope of front-line staff, and participate in resolution of system problems by presenting the patient’s perspective of the problem and desired resolution.

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

The Milwaukee VA Medical Center Patient Advocates represent the Medical Center Director and are supported by the Manager/Office of Quality Management and Safety and the Deputy/Office of Quality Management and Safety. The VA Central Office and VISN do not oversee the patient advocates from a supervisory perspective, however, VISN level patient advocate activities support the growth and development of the facility’s patient advocate function and the Office of the Patient Advocate/VACO give direction to the program and provide oversight. The facility patient advocate function takes direction from the Associate Director, Established Centers of Innovation, Integration and Alignment/VHA Office of Patient Centered Care and Cultural Transformation.

What training do Facility Patient Advocates receive?

Please see previous question “Please explain initial and ongoing training these patient advocates receive (i.e., type of training and number of days/hours)?”

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?

VA Central Office and the VISN have access to all data in the Patient Advocate Tracking System (PATS). Select VA Central Office and VISN staff can review turnaround times. The Manager/Office of Quality Management and Safety supervises the patient advocates on behalf of the Medical Center Director and is responsible for the conduct and professionalism of the patient advocates. The Manager/Office of Quality Management and Safety receives Veteran complaints and concerns in the event that the patient advocate does not meet the Veteran’s expectations.

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?

Patients must have their complaints addressed in a timely manner. There must be sufficient staffing devoted to the Patient Advocacy Program to ensure timely resolution of complaints, identification and resolution of system issues, and tracking, trending and reporting to appropriate areas. 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. The response expectation for visits, drop box and phone calls to the patient advocate is the same day or next working day for making initial contact. The turnaround time for written correspondence is 30 days. Freedom of Information/Privacy Contacts inquiries must be responded to with 20 days and the turnaround time for the Inquiry Routing and Information System (IRIS) program is  5 days. The VHA Patient Advocacy Program is guided by VHA Handbook 1003.4

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

The Manager/Office of Quality Management and Safety supervises the patient advocates on behalf of the Medical Center Director and is responsible for the conduct and professionalism of the patient advocates.

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

None

**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?

Daily reviews of 100% of acute care admissions and continued stay days are evaluated against standardized evidenced based criteria. This is done to assure that patients receive care at the level that is most appropriate for their clinical needs and consistent with available services. Although UM does not assess the patients’ level of satisfaction, UM actions are focused on assuring that the clinical needs of the patient are being met.

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

All UM staff members receive initial training from an InterQual Certified Instructor (IQCI) in the application and interpretation of standardized evidenced based criteria. VISN 12 has two IQCI’s. Annual updates are provided by the IQCI’s on any changes in the criteria.

Staff members also complete an annual Inter-Rater Reliability assessment. In 2012, the results of the Inter-Rater Reliability assessment were composite average scores of 95% for acute care and 94% for Behavioral Health.

Staff meetings are held monthly and any changes in practice are reviewed at these meetings.

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

Through the application and interpretation of standardized criteria, assessments are completed to determine the most appropriate level of care for each patient. The data gathered in this process is collated and reported in daily, monthly or quarterly reports.

Additionally, specific projects are completed to improve quality of care. One such example is the completion of a guardianship process review. The purpose of this study was to improve the timeliness of the guardianship procedure. Another example of a process review was the completion of an analysis of patients who were admitted to observation status. Both of these studies were aimed at improving care and ultimately patient satisfaction.

**Risk Manager**

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

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

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

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

**Systems Redesign Manager**

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

The Medical Center Systems Redesign Coordinator provides consultation, coaching, facilitation and education to facility leadership, providers, staff and improvement teams. The Systems Redesign Coordinator facilitates leadership in determining improvement priorities, makes recommendations for improvement action to be taken at the facility and service levels, and coordinates facility level collaboratives and improvement efforts. The Systems Redesign Coordinator provides direct support for communicating Systems Improvement activities across committee and service lines and is the facility point of contact with the VISN Office of Systems Redesign.

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

Systems Redesign staff receive Lean Six Sigma training from various sources. Lean training has been provided by the VISN for the last 2 fiscal years at each facility. Participation in network and national Systems Redesign initiatives include Lean training in the VA TAMMCs format.

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

Measurement is the first M in the VA TAMMCS improvement framework. Every process change that is part of a SR project has a metric associated with it. Baseline data is compared to data that is collected throughout the project to determine if changes result in improvement. Run charts and bar graphs are the usual format.

A “voice of the customer” is completed as part of every Systems Redesign project to assure improvements align with the needs of the customer. Quality metrics that are not being met can be used to identify the need for a SR process improvement team.

**Chief Medical Information Officer (in this section, defined as the Program Manager for Health Information Management in the Medical Information Systems Division)**

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

I serve as a Liaison to veterans’ organizations, VSOs, County Service Officers and other veteran representatives on VA Health Care eligibility, enrollment and intake. We’ve partnered with these groups to assure veterans are aware of their VA Health Care benefits. Medical Information Systems Division also serves as the facility Point of Contact for ChampVA, Tricare, and Military Treatment Facility transfers, helping to coordinate benefits and care with these other national programs.

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

Patient Satisfaction reports (SHEP/HCAPS, Patient Advocate reports, etc) are reviewed as they related to eligibility, enrollment, beneficiary travel, purchased care and other MIS departments. We look for trends and adjust processes as needed to better meet veteran expectations.

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?

The Health Information Management program works very closely with members of the medical staff, including PACT members, to assure encounter data and medical record documentation is complete and accurate. A multi-disciplinary team, for example, recently reviewed the practice of “copying and pasting” medical record documents. The team took baseline data, analyzed the data and created business rules and educational plans to assure documentation is accurate and timely.

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

MIS uses the “plan-do-study-act” improvement model to review and improve processes. We also participate in Root Cause Analysis teams and other process review teams reviewing processes to improve patient satisfaction and outcomes. For example, the Beneficiary Travel was the subject of a comprehensive review by the Preventative Ethics team using the ISSUES (Identify, Study, Select, Undertake, Evaluate, Sustain) model.