**The American Legion**

**System Worth Saving Program**

**Quality of Care and Patient Satisfaction**

**Sacramento, CA 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**

**Quality of Care**

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

*FY12  NCHCS Budget excluding NRM & Equipment  $529,387,493*

*FY11  NCHCS Budget excluding NRM & Equipment   $518,658,192*

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.

*FY12 QM staff   .39%  with 17.5 FTE*

*FY11 QM staff    .43% with 20.5 FTE*

How do you define quality as a healthcare facility?

*NCHCS uses the Institute for HealthCare definition of healthcare quality.*

* *“Healthcare quality is defined as an organized, systematic approach to planning, delivering, measuring and improving health care linking VHAs core values to the day-to-day operations while ensuring safe, effective, patient centered, timely, efficient and equitable care. Quality encompasses many interrelated activities that are the responsibility of senior leadership. These include but are not limited to:*

*Quality Assurance, Performance Improvement and measurement, Patient Safety, Internal and External Reviews and Customer Satisfaction, Utilization Management, Risk Management and Systems Redesign.”*

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

* *National Center for Patient Centered Care Bronze Award 2011 for RCAs resulting in both process/system improvements as well as the development of new and the revisions of existing policies.*
* *Transitioning Levels of Care Redesign Team won 1st Place Emergency Medicine/Inpatient Flow Category in 2011 and 4th place in 2010*

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

* *Data management and critical analysis are used for each quality and safety component. Use of goals, comparisons of internal and external benchmarks, identification of opportunities for improvement and implementation and evaluation of actions until problems are resolved or improvements are achieved. VHA provides several mechanisms for performance measurement including but not limited to:*
	+ *Access to the national VSSC database (Performance Measurement Dashboards)*
	+ *VA TAMMCS (Team,Aim,Map,Measure,Change,Sustain,Spread) improvement model and Systems Redesign (balancing supply and demand for services and adapting to changes that improve care delivery)*
	+ *Office of Clinical Consultation and Compliance( ISO 9001 standards for Reusable Medical Equipment and implementing consistent quality systems )*
	+ *ASPIRE comparison data and LinKS(Linking Information Knowledge and Systems) for summarizing clinical outcomes(tools that document quality and safety goals for all VA hospitals and the status of meeting compliance with those goals)*
	+ *VASQIP(VA Surgical Quality Improvement Program), IPEC(Inpatient Patient Evaluation Center) and EPRP(External Peer Review Program) data*
	+ *SHEP(Survey of Healthcare Experiences of Patients) customer satisfaction data*

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

*In addition to the VA Performance Measure and Monitor Programs mentioned above, VA Central Office, VISN 21 and NCHCS have an ongoing review processes both internal and external which continuously monitor the performance and delivery of care at each facility. Internal review is defined as an oversight group within VHS that surveys or monitors VHA performance or adherence to VHA policies and procedures. External reviews are conducted by private or other governmental agencies for the purposes of accreditation and/or monitoring of adherence to VHA policies or other federal laws and regulations. NCHCS participates in external audits by agencies such as, Office of Inspector General (OIG), College of American Pathologists (CAP), Commission on Accreditation of Rehabilitation Facilities (CARF), Food and Drug Administration (FDA), Occupational Safety and Health Administration (OSHA), Long Term Care Institute (LTCI)and Joint Commission (JC)just to name a few. Additional internal audits are conducted on a reoccurring basis as well, such as Annual Workplace Evaluations (AWE), Green Environmental Management System (GEMS), VA Surgical Quality Improvement Program (VASQIP), System-wide Ongoing Assessment and Review Strategy (SOARS) and a VISN lead review team (VORP/GORP/HORP). Once the review or survey is completed the QM collaborate with organizational leaders to develop, trace, track, and monitor action plans to closure.*

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

1. ***Chief of Staff***
* *Ensuring that components of the Quality Management System are integrated.*
* *Monitoring the quality and safety of clinical medical practice within the facility.*
* *Contributing to effective quality management through clinical leadership.*
* *Participating in facility quality management activities.*
* *Ensuring a data driven process for granting and renewing clinical privileges*
* *based on appropriate initial and ongoing evaluations of training, competency, and*
* *performance is present at the facility.*
* *Chairing the Peer Review Committee.*
* *Ensuring timely medical staff participation on Peer Review, Performance*
* *Improvement and System Redesign activities.*
1. **Head Nurse (Nurse Executive)**

*Ensuring that nursing and ancillary staff are knowledgeable regarding the principals of quality management and its implementation as it is applied in an integrated patient care delivery system:*

* *Ensuring that components of the quality management plan are integrated.*
* *Monitoring the quality and safety of clinical nursing practice within the facility.*
* *Contributing to effective quality management through clinical leadership.*
* *Participating in facility quality management activities.*
* *Serving as a member of the Peer Review Committee.*
1. **Quality Manager**
* *Ensuring that components of the quality management system and patient safety improvement program are integrated.*
* *Ensuring a systematic process is in place for monitoring the facility quality data. Serving as the quality consultant to the facility leadership, Quality Improvement (QI) or Performance Improvement (PI) teams, and employees.*
* *Serving on executive committees and workgroups where quality data and information is reviewed, analyzed, and acted upon.*
1. **Patient Safety Manager**
* *Ensuring that components of the Quality Management System and Patient Safety Improvement Program are integrated.*
* *Implementing a coordinated patient safety improvement program that is based on guidance and tools from the National Center for Patient Safety (NCPS) and which meets the needs and priorities identified by the Facility Director. These include addressing important standards, requirements, and recommendations promulgated by The Joint Commission (JC) and other organizations working to improve patient safety.*
1. **Utilization Management**
* *Assuring that the right care at the right time in the right setting for the right reason occurs in the healthcare delivery system.*
1. **Risk Manager**
* *In coordination with other programs such as Patient Safety and Quality, the risk manager systematically identifies, evaluates, reduces and/or eliminates and monitors the occurrence of adverse events arising from operational activities and environmental conditions.*
* *As a counterpart of Enterprise Risk Processes, the risk manager examines multiple risk categories and projects how a given risk might have implications for the entire organization.*
1. **Systems Redesign Manager**
* *The SRD manager seeks to find ways to balance patient care demand with available resources that provide that care.*
* *Incorporates other organizational programs and leaders in improving the way we deliver our care.*
1. **Chief Health Medical Information Officer/Clinical Lead for Informatics**
* *The Chief Information Officer (CIO) directs the Office of Information & Technology (OI&T) to deliver adaptable, secure and cost effective technology services to the Department of Veterans Affairs (VA) and acts as a steward for all VA's IT assets and resources. The CIO mission is to provide and protect information necessary to enable excellence through client and customer service.*

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

*Executive Leadership, Service Chiefs, Program Managers, Site Managers, Quality Manager, Patient Safety Manager, Accreditation Specialist, Performance Management Specialist, Infection Control Practitioners, Risk Manager, Medical Staffing Coordinator.*

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

* *TMS quality training modules, new employee orientations, Annual facility retreats/knowledge fairs, Nationally sponsored quality seminars/conferences, etc. (Please insert types and specific # of days for each)*

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

* *Performance Measurement Systems and Monitoring Dashboards*
* *Office of Quality Safety and Value (Accessible Subject Matter Expert Improvement Strategies)*
	+ *Integrity, Mindfulness, Reliability and Value*
		- *Compliance and Business Integrity*
		- *Evidenced -based clinical practice guidelines*
		- *Utilization and Efficiency Management*
		- *Quality Standards and Programs*
		- *Division of ISO 9001*
		- *Division of Mission Ready Consultation Strategy*
		- *Division of External Accreditation and Programs*
		- *Safety and Risk Awareness*
		- *NCPS*
		- *Risk Management*
		- *Credentialing and Privileging*
		- *Medical –Legal Affairs*
		- *High Reliability Systems and Consultation*
		- *Systems Redesign and Improvement*
		- *Veterans Engineering Resource Centers*
		- *Healthcare Value*
		- *Training Education Core Competency Development*
		- *Strategic Directions for Organizational Measurement*
		- *Strategic Communication*
		- *Transparency*

What future VA Central Office or VISN resources and/or support are needed? *None*

**What innovative qualities of care programs or studies covered by grants are being conducted by this facility? *None***Is your facility working on a “best practice(s)” in quality of care management?

*NCHCS has been recognized for best practices in the following:*

* *Time Out Process for procedures to promote Patient Safety*
* *Patient Transition of Care Strategies across different levels of care*
* *Automatic Mammography Tracking Program*
* *Community Partnerships for Reducing Homelessness in Veterans*

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?

*NCHS is in the process of the implementing Nursing Magnet*

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

*Facility Director, Chief of Staff, Associate Director, Patient Care Services, Associate Directors, Service Chiefs, Program Managers, Site Managers, Quality Manager and other key leaders as well as every employee.*

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

*FTE – RNS = 358, FTE – LVNs = 105, Yes – there is sufficient staff to patient ratio.*

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

How long have these positions been vacant? *The longest these positions have been open is 6 months, and the shortest is 1 month.*

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*

*OIG Aug 2010, April 2011, June 2011, July 2011, Dec 2011, Feb 2012, April 2012*

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

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

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

When was your last Joint Commission Inspection?

*March 2010*

What were the findings and recommendations?

When was your last Commission Accreditation Rehabilitation Facility (CARF) inspection?

*Dec 2011*

What were the findings and recommendations?

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?

*Quality of Care is a priority of all NCHCS committees. Below is a listing of the primary committees which oversee a variety of aspects of care delivery. The committees below meet monthly.*

***Leadership and Quality Performance Forum***purpose is to assure, organize, and coordinate organizational performance at a high level and to encourage process improvement at all levels across all services and sites.

***Medical Executive Council***which serves as an advisory regarding all clinical issues arising from the reporting clinical committees.

***Nursing Executive Council***serves as the recommending body on all nursing professional and practice issues within VANCHCS. It provides a venue for overall coordination of activities and recommendations arising from Nursing Committees

***Provision of Care Committee*** focus to ensure the patients at NCHCS receive care, treatment and services provided through the successful coordination and completion of a series of processes in the delivery of patient care.

***Patient Centered Care Committee/Customer Satisfaction*** is to develop and implement processes and programs that demonstrates the commitment of the VANCHCS to providing outstanding customer service and quality healthcare in both a patient- and staff-focused service delivery system; to be innovative in the design and development of external and internal customer service initiatives, and to benchmark with other exemplary organizations to utilize all available resources in providing unsurpassed customer service and health care.

***Workforce Development Committee*** through its strong association with the various departments within VANCHCS, it supports the organization's ongoing efforts to recruit, develop and retain a competent, committed and diverse workforce, making VANCHCS an employer of choice.

***Infection Control Committee*** to provide a mechanism for the prevention, surveillance and control of infections, and to assure the facility’s compliance with the requirements of the VHA and the JC requirements and standards.

***Environment of Care Committee*** to create an effective safety organization that will implement the overall safety and health programs, provide a safe environment for patients, staff, volunteers and visitors and manage staff activities to reduce the risk of injury.

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

*Veterans do participate on the Customer Service focus groups and process improvement teams.*

**Patient Satisfaction**

**What percentage of your budget is dedicated to Patient Satisfaction staffing and programs in FY 2011? FY 2012? Please explain.** Those figures are not available.

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

*Our goal related to Patient Satisfaction is to provide every Veteran an outstanding health and healing experience. We want every interaction a Veteran has with VA Northern California Health Care System (VANCHCS) to be positive and help facilitate each Veteran’s health and healing. We also want to do all we can to include in a Veteran’s experience, Veteran’s family members and/or friends who provide support.*

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

*We measure patient satisfaction using Survey of Healthcare Experiences of Patients (SHEP) scores (monthly reports) and Patient Advocate Tracking System (PATS) data (compiled monthly). Patient satisfaction is managed by the Customer Service Manager and Assistant Manager, yet a key performance element of each employee’s standards.*

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

*Survey of Healthcare Experiences of Patients (SHEP) scores and Patient Advocate Tracking System (PATS) data are our current measurement tools. We also plan on using focus groups for Veterans in FY 2012-2013.*

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

*SHEP scores and PATS data are reported to monthly leadership forums, posted on the Customer Service SharePoint site, and relayed to staff members in Town Hall meetings to each site in VA Northern California Health Care System several times per year. They are communicated to staff at all sites on a regular basis. We also identify areas that are scoring below expectations and look for ways to make improvements.*

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

*December (Cumulative):*

* *Overall Outpatient Quality: 53.4%*
* *Overall Inpatient Quality: 77.3%*

*January (Cumulative):*

* *Overall Outpatient Quality: 53.5%*
* *Overall Inpatient Quality: 72.6%*

*(See attachments)*

***Note:*** *SHEP scores are best reviewed, assessed, and trended over a 3-5 months time frame. The N is generally on the low side in any particular month, especially at the site level. Focus on one month or two can be misleading and will generally not provide an accurate assessment of the data/trends.*

**Which areas of the most recent Survey Healthcare Experiences of Patients (SHEP) survey did you improve or decline, compared to the last SHEP survey?** *For Outpatient Quality of Care, we have seen a 2.9 point decrease to 53.5 in FY 12 VANCHCS scores, since the year end score in FY 11 of 56.4. For FY 12 Inpatient Quality of Care, we have seen a 5.9 point increase to 72.6 in the score, since the year end score in FY 11 66.8.*

**What measures have been taken to address improvement in these areas?** *1) Training & education (TEACH & Motivational Interviewing) for the Patient Aligned Care Teams (PACT) at all sites, Leadership Accountability training; 2) implementation of the PACT at all sites (OPT care), which consists of a team approach for patients; 3) increased staffing in many areas (not limited to, but including Mental Health, Tele-medicine, Care Giver Support; 4) recognition of staff who provide excellent patient care; 5) Your Concerns Cards (pilot at Sacramento VAMC) to clarify patient expectations for each Primary Care appointment; 6) INP Care – in the process of ordering new white boards to improve communication between patients, family, and staff.*

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

*Accountability for patient satisfaction scores is done primarily at the VISN level in the quarterly Performance Measurement reviews (VISN staff and VANCHCS leadership). A strong emphasis is placed on patient satisfaction. In the last year, VA Central Office and VISN 21 have placed a strong emphasis on adopting Patient-Centered Care (PCC) and Systems Redesign (SR), with the intent of improving 1) the Veteran’s (healthcare) experience and 2) Veteran’s clinical health outcomes. VA Central Office has created the Office of Patient-Centered Care that is providing education and training related to PCC. VANCHCS has recently received their PCC Program Implementation Plan, currently under review by VANCHCS Director Brian J. O’Neill, MD.*

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

*See above.*

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

*Quality Management Chief and QM staff*

*Utilization Review*

*Infection Control*

*Customer Service Manager*

*Customer Service Assistant Manager*

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

*VISN 21 has a Patient-Centered Care Collaborative with representation from each VISN 21 facility. We share important information and activities we are working on to advance PCC.*

*VANCHCS will be implementing in June 2012 a Patient-Centered Care Steering Committee to oversee and direct PCC initiatives here.*

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

*Yes, and the number of them is increasing.*

**Quality Manager**

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

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

*Key Oversight components are:*

 *(1) Quality and performance improvement, including performance measurement;*

 *(2) Patient safety improvement;*

 *(3) Internal reviews and External reviews;*

 *(4) Internal and External Customer Satisfaction;*

 *(5) Utilization management;*

 *(6) Risk management;*

 *(7) Process Improvement and Redesign;*

 *(8) Credentialing and Privileging*

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

*NCHCS systematically monitors and evaluates the quality of care through the measurement and tracking of key processes and indicators. NCHCS uses a combination of VHA, VISN 21 and local facility quality of care indicators to develop our performance plans each year. The goal of performance measurement is to identify opportunities for improvement through the quantitative measurement of the quality of care and services. Measurement data is collected, aggregated and analyzed. Data are aggregated at the frequency appropriate to the activity or process being studied. Statistical tools and techniques are used to analyze and display data. We also utilize a variety of external databases/benchmarks to track and monitor NCHCS performance on identified quality of care indicators and monitors. Data are compared internally over time and externally with other available resources such as Joint Commission ORYX performance measures, Patient Satisfaction Surveys, National Surgical Quality Improvement Program, External Peer Review Program, Inpatient Evaluation Center, and the Utilization Management Program.*

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

* *Data management and critical analysis are used for each quality and safety component. Use of goals, comparisons of internal and external benchmarks, identification of opportunities for improvement and implementation and evaluation of actions until problems are resolved or improvements are achieved. VHA provides several mechanisms for performance measurement including but not limited to:*
* *Access to the national VSSC database (Performance Measurement Dashboards)*
* *VA TAMMCS improvement model (Systems Redesign)*
* *OCCC ISO 9001 standards for RME (to be exported to other improvement areas within VHA)*
* *ASPIRE comparison data and LinKS for summarizing clinical outcomes*
* *VASQIP, IPEC and EPRP data*
* *SHEP customer satisfaction data*

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

* *Leadership at all levels of the organization have established monitors and reporting mechanisms that demonstrate facility/organizational status of the quality of care. These tools may include Executive Quality Councils, Medical Executive Committees, Quality and Safety Committees, Financial QA, etc. VISNs perform quality overview conferences with individual and collective network facilities. VHA performs scheduled conferences and informational conference calls with VISN’s and facilities related to Performance Measures, clinical and operational functions, and other issues related to quality of care initiatives/compliance.*

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

*Quality of Care is a priority of all NCHCS committees. Below is a listing of the primary committees which oversee a variety of aspects of care delivery. The committees below meet monthly.*

***Leadership and Quality Performance Forum***purpose is to assure, organize, and coordinate organizational performance at a high level and to encourage process improvement at all levels across all services and sites.

***Medical Executive Council***which serves as an advisory regarding all clinical issues arising from the reporting clinical committees.

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***Infection Control Committee*** to provide a mechanism for the prevention, surveillance and control of infections, and to assure the facility’s compliance with the requirements of the VHA and the JC requirements and standards.

***Environment of Care Committee*** to create an effective safety organization that will implement the overall safety and health programs, provide a safe environment for patients, staff, volunteers and visitors and manage staff activities to reduce the risk of injury.

How are you monitoring Quality Assurance within Community Based Outpatient Clinics (CBOCs)?
*All of NCHCS CBOC’s undergo are subject to the same oversight processes as the primary campus. All of the clinical performance measures, monitors, and indicators are applicable to the CBOC’s. Both Internal and External audits are conducted at all CBOC’s including an OIG CBOC audit focused on oversight of CBOC’s. CBOC representatives participate in NCHCS committees and councils to provide communication venue into decision making and dissemination of information.*

 a. VA staffed CBOC’s? See above

b. contracted staffed CBOC’s See above

How are you monitoring quality assurance with non VA care?

* *The Office of Compliance and Business Integrity (CBI) oversees purchased care business integrity and reports to Executive Leadership. An annual CBI Risk Assessment, audit and plan is required. Organizations have a CBI Committee/Advisory Board; the committee consists of section leads and meets quarterly (minimum). The Committee vets and prioritizes risks. Committee activities and recommendations move forward to Leadership.* *Many facilities have fee-basis oversight and monitors specific to the care they have agreements with (i.e. Women’s health fees to ensure access and timeliness).*

Of these, which quality measures are you responsible for?

**Patient Safety Manager**

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

*The Patient Safety Manager leads, coordinates and implements the Dept of VA Patient Safety Program. She implements the National Patient Safety Goals, developed by the National Center for Patient safety (NCPS) and supports and develops the patient safety process, while promoting a culture of safety throughout the organization. The Patient Safety Managers conducts Root Cause Analysis and proactive risk assessments in order to solve complex problems.*

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

*The Patient Safety Manager works collaboratively with all departments throughout the organization in obtaining and sharing patient safety reports. She facilitates patient safety improvement projects and provides training and consultation on the RCA process.*

How do you define patient safety as a healthcare system?

*To reduce or eliminate harm to patients as a result of their care. This includes a three-step approach to improving patient safety at our facility.*

* *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. 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.*

Please describe your patient safety programs and initiatives.

*Our patient safety programs and initiatives include the below.*

* + *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.*
	+ *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, we have adapted 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.*
	+ *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. We use this in our inpatient units and have customized the document which include a number of items relevant to care, such as: medications, nutrition and allergies.*
	+ *Patient Safety Assessment Tool. This Web-based assessment tool allows the patient safety manager to complete a detailed assessment of the status of their facility’s program. The questions relate directly to the Joint Commission's requirements.*
	+ *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.*
	+ *Patient Safety Culture Survey. The surveys are performed nationally every three to five years to measure changes in the patient safety culture. The VA National Center for Patient Safety can provide us with an individualized data analysis that allows us to drill down into the various occupation groups. Occupation groups that contribute most significantly to the perception of patient safety are identified. Facility results for each occupation group can also be compared to the network and national results for that group.*
	+ *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 patient safety committees do you have at the VISN and/or VA Medical Facility? Please explain.

*The Patient Safety Manager consults on a variety of committees to include: Environment of Care, Accident Review Board, Safety Committee, Bar Code Administration, Ethics, Falls Prevention, Disruptive Behavior and others.*

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

* *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.*
* *Clinical Crew Resource Management. Aimed at front-line nurses in the VA, this program is based on techniques developed in aviation that mitigate error through the effective use of all available resources in operational decision making: information, equipment, and people. Nursing units received training as part of the initial pilot, which included a six-hour learning session and two-hour clinical simulations, using high-fidelity patient simulators*

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 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.*
* *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.*

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

*Patient safety issues are reported daily to supervisory and management staff via an extensive electric Patient Incident Reporting system, (ePIR) that is available to all employees. Relevant discussions occur during morning leadership meetings and are followed through with management staff in collaboration with Patient Safety and Quality Management Staff.*

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 Patient Safety Manager provides consultation and works collaboratively with each of these roles on Joint Commission requirements, National Patient Safety Goals, and NCHCS policies and procedures related to patient incidents, identified areas of risk and other facility, VISN and national initiatives.*

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.*
* *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 any other potentially identifying information are removed.*

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

*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.*

*The VISN shares “Lessons Learned” and these are additionally shared with appropriate leaders and chiefs of services for applicability to our program.*

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

*The Patient Safety Managers conducts RCAs and proactive risk assessments that include multidisciplinary groups which can involve multiple departments and all levels of staff. She works closely with Quality Management staff to include risk management in assuring that patient safety initiatives are addressed and implemented. She also works closely with engineering, Infection control, pharmacy, laboratory as well as all clinical departments in identifying and addressing patient safety concerns.*

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 regulations*

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

What duties and responsibilities do you have as the Patient Aligned Care Team (PACT) Coordinator for the facility? *VANCHCS does not have a designated PACT Coordinator. PACT is administered by a leadership team that includes all of the disciplines involved in PACT.*

How many staff members work specifically on Patient Aligned Care Team (PACT) programs and initiatives and what are their position titles, job duties and responsibilities? *There are 225.5 FTE assigned to PACT. These individuals include primary care providers, RN care managers, LVNs, clerks, social workers, pharmacists and dieticians.*

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

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

Which VA Medical Center staff attends the committee meeting? *COS and leadership from Primary Care, Nursing, BDMS, Social Work, Pharmacy, Nutrition, Customer Service, and others as needed.*

Are representatives from the veterans’ community involved in your Patient Aligned Care Team (PACT) planning process? *Each of our sites has been asked to include Veterans in their own team meetings. This may be accomplished through regular participation at team meetings, Veteran focus groups, or some other approach.*

Explain how Patient Aligned Care Team (PACT) was implemented at the facility? *PACT was implemented as a multidisciplinary program including providers, RN care managers, LVNs, clerks, social workers, pharmacists and dieticians. In the first year, six pilot teams were created at different sites across our system. In the second year, the PACT model was rolled out to all of primary care. Teams receive ongoing training through quarterly facility PACT collaborative meetings, and have regular interaction with coaches and PACT champions.*

**Patient Satisfaction**

**Director of Patient Care Services**

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

1. Inpatient *72.6% (January)*
2. Outpatient *53.5% (January)*

Did the facility improve or decline in any areas since the last Survey of Healthcare Experience of Patient (SHEP) survey?  *For Outpatient Quality of Care, we have seen a 2.9 point decrease to 53.5 in FY 12 VANCHCS scores, since the year end score in FY 11 of 56.4.  For FY 12 Inpatient Quality of Care, we have seen a 5.9 point increase to 72.6 in the score, since the year end score in FY 11 66.8.*

How are patient satisfaction indicators and measurements tracked and managed?  *We measure patient satisfaction using Survey of Healthcare Experiences of Patients (SHEP) scores (monthly reports) and Patient Advocate Tracking System (PATS) data (compiled monthly).  Patient satisfaction is managed by the Customer Service Manager and Assistant Manager, yet a key performance element of each employee’s standards.*

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

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

*Customer Service Assistant Manager, Jeff Langham*

*Patient Representative, Leslie Anderson*

*Patient Representative, Ed Vandiver*

**Patient Advocate/Patient Centered Care Coordinator**

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

*Our goal related to Patient Satisfaction is to provide every Veteran an outstanding health and healing experience. We want every interaction a Veteran has with VA Northern California Health Care System (VANCHCS) to be positive and help facilitate each Veteran’s health and healing. We also want to do all we can to include in a Veteran’s experience, Veteran’s family members and/or friends who provide support.*

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

*To provide a centralized and convenient means for patients to have their complaints and compliments addressed and processed.*

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

*Patient complaints are logged into the Patient Advocate Tracking System database which is displayed on the Customer Service SharePoint site (monthly) and reported in monthly leadership forums. Service Chiefs with significant amounts of patient complaints are notified and asked to identify and implement improvements*

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

*The Patient Advocate is not responsible for patient satisfaction performance measures.*

**When was your last patient satisfaction survey?** *May 2012*. **What were the results?** *These won’t be available until August 2012. Our most recent results are from January 2012.* **How do your results compare with other VAMC’s?** *See patient satisfaction survey attachments.*

**What were your previous patient satisfaction scores?** *See patient satisfaction survey attachments.*

**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?**

*Yes*

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

*We are beginning the steps to implement PCC. We have also implemented the PACT model for the delivery of Veteran/patient care.*

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

*This question was answered in above.*

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

*Initial training consists of orientation to the Patient Advocate Office policies and procedures. The amount of time required for this is dependent upon how long it takes for the incoming Patient Advocate to become proficient with the policies and procedures. One of our Patient Advocates has been here for over 10 years. The other has been here about three years.*

*Ongoing trainings include: quarterly meetings with Patient Advocates are conducted, which consist of various trainings, 4 hours per quarter. We also send 1-2 patient advocates to the annual Patient Advocate Conference (April 2012). All patient advocates are required to do annual VHA mandatory training. They are also encouraged to identify VA and non-VA training they want to attend to improve their professional skills.*

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

*This question was answered above.*

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

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

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

*The VHA Office of Patient-Centered Care, Associate Director for the Veteran Experience, oversees VHA Patient Advocacy. VISN 21 has appointed the VISN 21 Safety Officer to coordinate VISN 21 Patient Advocacy Program. For Sacramento VAMC, the Patient Advocates (2) are supervised by the Customer Service Manager. Sacramento VAMC also has a Volunteer (part-time) in the Patient Advocate Office and has just refilled a (part-time student) data entry position (temporary). The Martinez VA Patient Advocate is supervised by the Martinez VA Site Manager. Each of the other Community Based Outpatient Clinics have a collateral duty Patient Advocate supervised by the Site Manager. Collateral duty Patient Advocates are assigned Patient Advocacy as an additional work responsibility, but is not considered their full time position.*

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

This question was answered above.

**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 does not conduct evaluations of Patient Advocates. They do collect Patient Advocate nationally via PATS. VISN 21 does not conduct measurement or evaluation of Patient Advocates. They will contact us if there are delinquent VHA computer generated contacts that are not resolved within the appropriate time frame (five days). Accountability for VANCHCS Patient Advocates is done at the facility level by their supervisor.*

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

*Yes, VHA Handbook 1003.4, Patient Advocacy Handbook states the Patient Advocate should follow up within 24 hours of the patient’s complaint. The Patient Advocate has 7 business days to close out/complete processing of the Veteran/family complaint/concern.*

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

*The Customer Service Department/Manager.*

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

*Not currently*

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

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

* *UM does 100% of admission and continued stay reviews.  Goal: to have the right patient at the right level of care at the right time with the right care provider.  NCHCS has a very low average length of stay, freeing up beds at all levels for Veterans needing hospital admission, minimizing the use of Civil hospital admissions, and providing optimal continuity of care.*
* *Quarterly data is aggregated, summarized and reported through Executive Nursing Council and QM to LQPC.  Particularly, the avoidable reasons are discussed and action plans are defined and acted upon, as able.*
* *UM reports any unusual documentation or potential risks/ safety questions to QM or risk management, including admissions to non-VA facilities that may be from a complication of care received within the VA.*
* *Fee UM reports all non-VA care for suicidal ideation or gestures to the Suicide Prevention coordinator and sends the discharge summary to them.*
* *Fee UM notifies care managers and primary care providers of Veterans who have several non-VA care ER visits with all surrounding hospitals who appear to be ‘drug-seeking.’*
* *Fee UM and the Associate Chief of Staff/Ambulatory Care review all Fee consults for medical necessity, medical standard of care, and administrative eligibility criteria.  Consults are reviewed within 24 business hours and approved consult appointments are coordinated by the Non-VA Care Coordination team with the Veteran and non-VA provider.  Post appt calls are made to the non-VA provider to validate the Veteran did show up for the appt and medical documentation is requested to be faxed at that time.  That documentation is scanned into our electronic system and will be available for the VA provider to provide timely care as needed.*

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

* *Attended McKesson’s 2.5 day InterQual training course.*
* *Take and pass the Inter-rater Reliability testing, done each Spring, for any RN who has been conducting reviews for a minimum of six months.*
* *One UM RN is the UM Administrator and a certified InterQual trainer.  She trains all staff who conduct reviews, provides hours of one-to-one training, and monitors the performance of all who conduct reviews. She has to take the annual course by McKesson, with new fiscal year updates, and take and pass all of the tests for the course content the following week.*

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

1. *The NVCC team will be calling Veterans after their non-VA care to ask three quick questions to assess their satisfaction with the NVCC process and the care they received at the non-VA facility.  This data will be reviewed and any negative responses will be validated.*

**Risk Manager**

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

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

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

*Risk Manager training was provided by the Office of Quality and Performance, VISN 21 QM and on the job training at NCHCS.*

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

*Measurement tools are a means to monitor and track our performance, identify trends, analyze risk/gaps, and guide planning/action.*

**Systems Redesign Manager**

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

*NCHCS currently recruiting a Process Improvement/System Redesign Coordinator to oversee the PI activities, provide education, and serve as a resource to the organization on conducting PI project aimed at improving efficiencies of systems. Process Improvement activities are embedded within Quality Management and throughout the Services across NCHCS.*

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

*Multiple key staff received training in Lean Management and Process Improvement tools. Several Quality Management staff completed a Green Belt Project for certification in Lean Management at the Green Belt Level. NCHCS has approached Continuous Process Improvement as a culture of how we do our work.*

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

*Measurement tools are a means to monitor and track our performance, identify trends, analyze risk/gaps, and guide planning/action.*

**Chief Medical Information Officer**

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

* *Develop custom clinical reminders.*
* *Create venue specific documentation platforms.*
* *Design FileMan reports to capture specific patient cohorts.*
* *Build task specific order sets and clinical pathways.*
* *Participate in system redesign planning sessions.*

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

* *Patient surveys.*
* *Clinical performance guideline reports.*
* *Internal audits.*
* *The above tools are used in PACT / flow meetings to inform decision making and guide clinical practice.*