**The American Legion**

**System Worth Saving Program**

**Quality of Care and Patient Satisfaction**

**St. Louis 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?**

|  |  |  |  |
| --- | --- | --- | --- |
| FY 11 | FY 11 | FY 11 | FY 11 |
| Medical Support and Compliance | Medical Facilities | Medical Services | Total |
|
| $ 29,751,625 | $ 35,252,842 | $ 328,694,430 | $ 393,698,897 |
|  |  |  |  |
| FY 12 | FY 12 | FY 12 | FY 12 |
| Medical Support and Compliance | Medical Facilities | Medical Services | Total |
|
| $ 28,598,854 | $ 34,762,292 | $ 329,786,768 | $ 393,147,914 |

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

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Medical Support and Compliance | Medical Facilities | Medical Services | Total |
|  |
| MC Budget | $ 28,598,854 | $ 34,762,292 | $ 329,786,768 | $ 393,147,914 |
| PS Costs | $ 24,053,627 | $ 18,599,569 | $ 188,458,635 | $ 231,111,831 |
|  | 84.11% | 53.51% | 57.15% | 58.78% |

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

At the VA St Louis Health Care System we define quality in healthcare by provide safe and effective care in a timely manner that meets and exceeds the Veteran’s expectations.

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

VA Pharmacy Service has received award from national award for customer service

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

* Participate in an External Peer Review Program where a contract abstractor review a sample of Veteran records each month to assess performance with various clinical practices. This includes pneumonia care, heart failure care, acute coronary syndrome care, preventive measures, surgical care, and home care.
* Through occurrence screen this is an internal review that is triggered by certain events for example return to the operating room, in hospital deaths, readmissions. Clinical review is completed using defined assessment criteria.
* Active Peer Review this is an internal critical review of individual provider practices
* Conducting tracers is an internal review to trace patient care processes to observe actual care delivery practices.
* Monitoring of care processes through performance measures local and national.
* Conducting Veteran Satisfaction surveys, focus groups, interviews, rounds to identify and address problems and concerns.
* Conducting interdisciplinary environment of care rounds to ensure the environment is clean and safe
* Active surveillance for health care acquired infections

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

At the Medical Center accountability is demonstrated through our commitment to our Veterans. Internally the Executive Boards including Leadership Performance Advisory Board critically reviews and monitors performance measures and service action plans to improve performance. We compare our performance with other VA facilities as well as local community hospitals performance. Our performance data is publically available.

**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 and Patient Safety Improvement Program are integrated.
* Monitoring the quality and safety of clinical 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.

1. **Head Nurse –**

* Ensuring that components of the Quality Management System and Patient Safety Improvement Program are integrated.
* Monitoring the quality and safety of clinical practice within the facility.
* Contributing to effective quality management through clinical leadership.
* Participating in facility quality management activities.
* Serving as co-chair 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) teams and employees.
* Serving on executive committees and workgroups where quality data and information is reviewed, analyzed and acted upon.
* Responsible for the operational aspects of the performance improvement program. Provide education, facilitation, support & guidance to care teams/service centers & employees to ensure that an effective program is in place.

1. **Patient Safety Manager:**

* Performing and supporting RCA activities by acting as a Team Member, Advisor, or providing “Just in Time” training to groups tasked to perform RCAs;
* Performing and supporting general programmatic functions by maintaining statistics on the number of RCAs and Aggregate Reviews performed monthly or by presenting Patient Safety Program overviews to new employees during their orientation (NEO) and to all employees during annual reviews/training;
* Assisting in meeting regulatory requirements such as The Joint Commission (TJC) Patient Safety Goals and standards;
* Participating in surveys, assessments and reviews such as TJC and the Office of the Inspector General (OIG);
* Acting as a Liaison between Quality Management (QM) and TJC by responding to RCA related inquiries and/or presenting local Patient Safety Program aspects with TJC Surveyors;
* Acting as human factors engineering resources to and for the facility by interpreting TJC standards, teaching staff how to apply HFMEA principles in practice, and/or conducting and evaluating RCAs for clinical pertinence, substance, depth, or quality.

1. **Utilization Management**

* An integrated program that promotes a culture conducive to the melding of UM into daily patient care management activities; such as, patient flow, care coordination and discharge planning. Assists the facility in improving the efficiency of patient care. Monitors and evaluates the overall appropriateness, efficiency and effectiveness of health care resources; reviews all admissions and continued stay reviews of all acute inpatient admissions.

1. **Risk Manager**

* Monitors, identifies, evaluated and correct actual or potentially harmful events which adversely impact on the quality of care of our veterans, staff and/or visitors

1. **Systems Redesign Manager**

* Directs and coordinates the administrative, operational, & planning activities for SR/ACA programs for the Facility. Planning activities for system redesign including advanced access to all clinics and all other related performance improvement activities through the HealthCare System.
* Ensures the Alignment of SR/ACA plans/objectives with the VISN SR/ACA objectives, as well as nationally.

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

* Ensures the health information systems supports the care and service delivery and facilities the improvement of care and services through collection and reporting of clinical information

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

Quality and Performance Management staff as well as service and program leaders. Staff in each have received training in performance improvement processes and tools. In this fiscal year, the medical center has partners with the VACASE to provide several training and certification in lean methods and tools. 60 staff attended Return on Investment training and 110 have completed Yellow Belt Lean Training. The medical center is providing support for each of these staff to apply and become certified as a Yellow Belt. Green and Black Belt training is schedule at the end of the fiscal year.

The Quality Executive Board is responsible for oversight of quality management programs tracking quality improvement initiatives. Leadership Performance Advisory Board is the mean by which performance is monitored and oversight to action plans

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

Initially in new employee orientation, staff receive an introduction to VA-TAMMCS methodology and contact information if interested in further training or involvement. Several TMS classes are available to staff, Yellow Belt Lean training – 3 days, return on investment 1 day.

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

* Improvement Advisor Academy
* Return on Investment
* Executive Yellow Belt Training
* Yellow Belt Training
* ISO 9001: 2008
* Tool Kits for disease specific conditions (such as Colorectal Cancer, Prostate Cancer, and Diabetes)
* Joint Commission Resources Consultation – Onsite and telephone consultation
* Surgical Flow Collaborative
* Rapid Process Improvement Workshops

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

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

**Participate in Patient Safety program on Reduction of health care acquired central line infections.**

**Received grant for 8 patient centered care projects to improve the environment of care.**

Selected as VISN site for Surgical Flow improvement project **Is your facility working on a “best practice(s)” in quality of care management?**

We have many best practices that have been identified through various mechanisms. Our main focus is engagement of front line staff in improving their work

**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?**

Many different staff works on these program and initiatives. It is part of every employees responsibility. “Improving our work IS our work”

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

Director Quality Management in conjunction with other executive team members and service chiefs.

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

* LPN – 98
* NA – 101
* RN – 493

A safe staff to patient ratio is accomplished through overtime, diversion of patients, alternative scheduling.

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

* Positions within nursing are always in flux with staff moving on to new roles, retiring, or moving from the area.  There are vacancies that are being actively recruited.
* **How long have these positions been vacant?**   
  Some positions became vacant within the last few weeks and others have been vacant for 6 months or more.  The recruitment process can be lengthy, ensuring we make the steps necessary to ensure the highest quality staff is selected and their credentials are verified.

**Has 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**?

**GAO:** The GAO visited St. Louis in October 2010. St. Louis was one of six facilities chosen for inclusion in a GAO review of purchasing, tracking and reprocessing requirements conformance.

**OIG:** March 9-12, 2010- The Infectious Disease Program Office conducted a facility wide inspection to evaluate the Sterile Processing Service operations and related areas performing sterilization, high level disinfection and storage of medical and surgical items.

* January 11-12, 2012 -The OIG visited St. Louis to evaluate conformance to recommendations made behind a 2011 OIG report.

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

**GAO Recommendations/Findings for VHA:**

1. Ensure all expendable medical supplies and Reusable Medical Equipment (RME) be tracked in an appropriate inventory management system.
2. Standardize training related to the reprocessing of all critical and semi-critical RME
3. Ensure systematic oversight of selected purchasing requirements.

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

**OIG Recommendations/Findings:**

The recommendations from the March 9-12, 2010 visit were:

1. The VISN Director will ensure the medical center gain compliance with RME reprocessing requirements to include maintenance of the related standard operating procedures (SOP), staff training and competency.
2. The VISN Director ensures the VISN SPD Management Board will oversee that St. Louis SOPs related to RME; the associated training and competencies are kept current.
3. The VISN Director will take appropriate actions based upon findings from Administrative Board of Investigation.

The recommendations from the January 11-12, 2012 visit were:

1. VISN 15 Director will ensure the medical center is compliant with RME reprocessing requirements to include maintenance of the related standard operating procedures (SOP), staff training and competency.
2. The RME Committee will ensure meeting minutes adequately document a strict follow up of agenda items and a detailed analysis of discussion items brought before the committee.

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

Statements have been released to the media by stakeholders acknowledging improvements at the medical center had been made and that good quality care is provided to Veterans. Notwithstanding the improvements, there were some concerns regarding documentation factors as noted in the OIG report.

**Joint Commission:**

Joint Commission visited St. Louis February 10 -11, 2011.

**Recommendations/Findings:**

1. It was observed in the surgical decontamination area the De-Ionization equipment went into alarm on January 10, 2011. The leaders of the organization failed to identify the risk identify the risk associated with the ionization equipment.
2. During review of an anesthesia technician file there was no competency assessment aligned with identified job responsibilities; specifically anesthesia machines, gas cylinders and other anesthesia equipment.
3. During a tour of the surgical suite laryngoscope blades sterilized in SPS were being removed from peel packs by anesthesia department and stored loosely in drawers allowing for cross contamination.
4. It was noted that two multiple dose vials of insulin were not dated with a beyond use date as required by organizational policy 5. Associate Director did not have a process in place to ensure Safety Manager and Chief of Engineering understood and accomplished all Life Safety responsibilities related to ongoing plans for improvement.

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

**CARF:**

Our last CARF inspections occurred November 15 -19, 2010.

* Ten programs were surveyed and gained full three year accreditations. Two clinical programs: Spinal Cord Dysfunction/Injury (SCD/I) and Comprehensive Medical Rehabilitation Programs (CMR) were both previously accredited by the CARF. The following eight programs were initial accreditations: Compensated Work Therapy (CWT), Supportive Employment (SE), Healthcare for Homeless Veterans (HCHV), Substance Abuse Residential Rehabilitation Treatment Program (SARRTP), Domiciliary Residential Rehabilitation Treatment Program (DRRTP), Psychosocial Residential Rehabilitation Treatment Program (PRRTP); Interdisciplinary Pain Rehabilitation Program (IPR) and Comprehensive Amputation Rehabilitation Program (CAR).

**Recommendations/Findings:**

**CWT/SE/HCHV:**

1. 1. Improve consistency of EOC issue resolution documentation
2. Amend rights of person serviced to include specifically: humiliation, retaliation, and financial.
3. Amend diversity memorandums to include additional diversity language.

**CMR/IPR/CAR:**

1. CMR to amend person served education to include number of unplanned transfers to acute care
2. 2. IPR to expand healthcare professional staff education related to appropriate pain management /treatment and/or referral.

**SCD/I:**

1. Provide respiratory care to SCI unit and provide respiratory care continuing education to all SCI unit staff.
2. Expand community advocacy related to Emergency Preparedness
3. Provide estimated length of stay to person served.

**PRRC/SARRTP/DRRTP:**

1. 1. Ensure documentation of post emergency situation debriefing and improve documentation of emergency procedure improvements.
2. Ensure technology and system plan is inclusive of persons served assistive technology needs.
3. Ensure organization documents annual review of accessibility status and ensure reasonable accommodations for potential program participants.
4. Establish staff competency for individual plan development inclusion of measurable goals.
5. Provide written copy of discharge plan.

**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?**

* Executive Board meets weekly and includes executive staff, chief fiscal officer, chief, human resources, and compliance/ethics officer,
* Medical Executive Board meets twice a month and includes the appointed and elected members of the medical staff as well as the Chief of Staff, Deputy Chief of Staff, ADPCS, and MCD
* Clinical Executive Board meets monthly and includesADPCS, Associate Chief Nurses, Chief Clinical Nutrition, Chief, Chaplin Services and Chief Social Work Services.
* Quality Executive Board meets monthly and includes Executive Team, Risk Management, Patient Safety, Service Chiefs, System Redesign, Utilization Management,

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

* Veteran involvement is ensured through our regularly scheduled Veterans Service Officers meetings as well as other focus group efforts.

**Patient Satisfaction**

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

* The percentage of budget is not tracked specifically. It is part of every employee, contractor and volunteer daily activities. The medical centers has invested in several customer service/satisfaction efforts as well as dedicated staff in Veteran Patient Advocate roles.

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

* Provision of Veteran centric care treatment and service that demonstrate our values of integrity, commitment, advocacy, respect and excellence.

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

* SHEP data is provided and discussed at the QEB Committee.
* The data is graphed, analyzed and use the National % as the benchmark.
* Internal quick cards are available throughout specifics clinical areas and entered into a database; which is graphed by location and available to all staff members.
* Patient Advocates meet with assigned services on a quarterly basis to share data related to them.

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

* Quick Cards, national SHEP Survey, Executive Staff walk around, patient advocate rounds

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

* Quick cards are available in each of the clinics and inpatient areas, they are stocked and collected every two weeks. The information is inputted into a share site that the services access to review the feedback from our Veterans. Concerns written by Veterans are sent immediately to a responsible person for resolution. Service Level Liaisons are a group of designated individuals that are identified to resolve any customer service/veteran satisfaction issues.

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

* Dec 2011 for Inpatient and Outpatient sent via email

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

* Generally, outpatient indicators have shown a slow improvement, while inpatient indicators are static.

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

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

* This is part of morning report each day. Issues, trends are identified and discussed. Recognition of excellence in service is also part of the morning report
* Each service identifies and acts on customer feedback to make improvement in services delivered.
* Improvement teams include “Voice of the Veteran/customer” in each project.

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

* Data is provided for comparison
* Monthly national calls on survey and best practices
* Tools via internet
* Access to subject matter experts for consultation
* Training for various groups via TMS, conference calls, live meeting and face to face meetings.

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

* Patient Advocates
* All performance improve teams
* Service chiefs
* Education specialist

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

* Quality Executive Board
* Leadership Performance Advisory Board

**Are veterans’ participating and/or serving on these committees? -** No

**Quality Manager**

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

The Quality Manager is a member of the Executive Team. Responsibilities include performance measures, quality improvement, system redesign, infection prevention, data management, external accreditation and survey processes, compliance, ethics, risk management, utilization management, fee clinical review, patient flow, and oversight of Logistics, Prosthetics and Environmental Management services.

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

Indicator are define monitored and reported through various committees and reports

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

Quality is measured and management through our performance measure system patient safety program, utilization management program, risk management program, ongoing practice monitoring and occurrence screen monitoring

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

Through oversight visits, consultation, review of facility level performance data, and public reporting.

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

* Quality Executive Board
* VISN QM Ops
* Performance Improvement Committee of the Medical Staff
* VISN System Redesign
* VISN Quality and Performance Improvement Committee

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

* Review of related Performance Measures, Environment of Care Visits, Performance score cards for LIPs,
* contracted staffed CBOC’s N/A

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

* Yes through the clinical review of submitted documentation, oversight visits to contracted nursing care facilities

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

Oversight for quality measures process, specific measures related to infection prevention, customer service, prosthetics, environmental management, and logistics

**Patient Safety Manager**

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

The Facility Patient Safety Manager (PSM) oversees, coordinates, and manages all Patient Safety related activities at the facility level. Facility PSM tasks include:

* Performing and supporting RCA activities by acting as a Team Member, Advisor, or providing “Just in Time” training to groups tasked to perform RCAs;
* Performing and supporting general programmatic functions by maintaining statistics on the number of RCAs and Aggregate Reviews performed monthly or by presenting Patient Safety Program overviews to new employees during their orientation (NEO) and to all employees during annual reviews/training;
* Assisting in meeting regulatory requirements such as The Joint Commission (TJC) Patient Safety Goals and standards;
* Participating in surveys, assessments and reviews such as TJC and the Office of the Inspector General (OIG);
* Acting as a Liaison between Quality Management (QM) and TJC by responding to RCA related inquiries and/or presenting local Patient Safety Program aspects with TJC Surveyors;
* Acting as human factors engineering resources to and for the facility by interpreting TJC standards, teaching staff how to apply HFMEA principles in practice, and/or conducting and evaluating RCAs for clinical pertinence, substance, depth, or quality.

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

**I report on Patient Safety to:**

* Quality Executive Board-quarterly (incident reports, patient safety alerts, RCA’s, RCA action/outcome plans
* Executive Board-annual on the patient safety program,
* Safety/EOC committee on patient safety alerts dealing with the environment, mental health EOC inspections and action plan.

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

* The Patient Safety Program's goal is to prevent harm to patients. This is accomplished by taking steps in the way things are done so that the level of faith and trust in the VHA patient safety system is established and behaviors designed to prevent adverse events become a part of all-employee behavior. ***NOTE:*** *This is a never-ending process. In this way a “culture of safety” can be formed.*

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

The program has multiple parts, prospectively learning from others and assess our system for similar risks or problems, concurrently through the reporting system, morning report, executive action line, retrospectively through performance measures, root cause analysis and safety alerts

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

* VISN Patient Safety Committee.
* VISN QM Operations
* STL Executive Board
* STL Quality Executive Board
* Performance Improvement Committee of the Medical Staff

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

Patient safety alerts and recall are addressed whenever they are published, Environment of Care Round identify actual or potential patient safety hazards.

**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?**

* Adverse Event reporting system for reporting of any patient incident or staff safety concern. This reporting system is electronic and is on the St. Louis VAMC webpage.

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

* Either directly after an issue is reported or at the morning briefing with leadership each day.

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

There is no difference. They are hand in hand. Patient safety is quality of care and quality of care in impacted by patient safety events.

**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**?

* We work collaboratively to provide safe practices at this facility.

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

* An event (incident) is reported which after review is been identified to have an RCA team chartered. Team charter is signed by the Medical Center Director
* Once the team has completed the process will present findings to the Executive Team.

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

Reviewing action plans for stronger action and best practices to implement.

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

* Patient Safety Manager-see above.

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

Action plans for each can be provided

|  |  |  |
| --- | --- | --- |
| **Number** | **Title** | Completion Date |
| **TL7181** | **Telemetry communication process** | 4/7/11 |
| ***Med*** | **Med Aggregate review** |  |
| **TL7360** | **HR-RN license** | 5/27/11 |
| **TL7691** | **Inpatient Mental Health fall prevention-pt with injuries** | 7/18/11 |
| **TL7923** | **Inpatient Hip fracture after fall** | 8/12/11 |
| **TL8199** | **JC-hypoglycomeic event** | 10/3/11 |
| ***Fall*** | **Fall Aggregate review** |  |
| ***Missing*** | **Missing Pt aggregate review** | 1/1/12 |
| **TL8780** | **JC-discharge coordination of care** | 1/19/12 |
| **TL8819** | **Outpatient suicide** | 1/26/12 |
| **TL8881** | **OR Fire** | 2/3/12 |
| **TL8890** | **Unexpected death in the Domiciliary program** | 2/7/12 |
| **TL9167** | **JC-Elevator testing process** | 3/19/12 |
| ***Med*** | **Med Aggregate review** | 4/1/12 |

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

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

* Acting Associate Chief Nurse Primary Care – Education, management and supervision of nursing staff assigned to 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?**

* Primary Care Providers (MDs, NPs, and PAs - 4), RN Care Managers – 5, Clinical Associates (LPNs) - 20, and Clerical Associates (Clerks) – 16; (Geriatric Primary Care included) (OEF/OIF not included in these numbers.

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

* Associate Chief of Staff , Primary Care

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

* PACT committee meets monthly.

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

* Acting COS, Acting ACOS PC, AO PC, Chief HAS, CIO OI&T, OI&T, Chief ID, HPDP Program Manager, Health Behavior Coordinator, Chief SW, Pharmacy, Engineering, AFGE Rep, Acting ACN PC, plus Perry, Horace , MD Geriatrics

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

* Veterans input is collected through focus groups and customer comments

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

* Two teams (PCP, RN Care Manager, LPN and Clerk) attended the PACT summit in 2010 and the follow-up PACT Systems Redesign Collaborative learning sessions.
* These teams implemented PACT initiatives then spread the practices to other teams: Same Day Access by reliance on telephone, secure messaging, shared medical appointments, Telehealth and other non face to face modalities.
* We are exceeding the goal for PCP appointment within 7 days of desired date (we are exceeding the benchmark of 90% by 5% and same day appointment with PCP benchmark of 66% by 4.8%).
* We continue to work on Care Management of high-risk patients and Patient care contact within two days post hospital discharge.
* The facility is still working to achieve the three support staff per Primary Care Ratio and as this occurs more teams will be practicing PACT initiatives.

**Patient Satisfaction -**

**Director of Patient Care Services**

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

The Associate Director for Patient Care Service provides oversight and direction to ensure that Veteran needs are met to their expectations and in a timely manner. Discharge planning and Veteran education in a manner they are able to understand and engage in their care. Meeting the Veteran and their family at their level to achieve an understanding that improves their health.

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

1. **Inpatient**
2. **Outpatient**

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

Improvement seen in the Outpatient Scores and Inpatient score have not changed significantly**.**

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

Through the QEB

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

Nursing staff indicators courtesy, respect, noise level on unit, privacy, responsiveness to call light and getting pain medications.

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

Social Work, Clinical Nutrition and Chaplains

**Patient Advocate/Patient Centered Care Coordinator**

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

Service excellence

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

Being the interface with Veterans and families that have information needs, concerns or compliments.

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

SHEP and PATS reports. Concerns, issues and compliments are recorded in PATS Quarterly reports are generated and Patient Advocate meets with services to review trends in reports and progress on actions**.**

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

Providing service PATS reports

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

In general scores are lower than national means.

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

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

No

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

Not best practice but working on many aspects of patient satisfaction

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

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

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

Individual TV for Veterans, Yak Track, Quick Care. Greeters,

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

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

Veteran concerns are entered in to the Patient Advocate Tracking Systems (PATS). They are categorized by the type of issue, information request or compliment.

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

Patient Advocates receive training in customer service, service recovery, national patient advocate program,

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

The STL Director, Quality Management receives and acts on any concerns or complaint o

**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?**

It is not specified.

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

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

St Louis VA Health Care System has no Primary Care clinic wait time of 30 days or greater

**Patient Safety Manager**

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

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

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

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

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

Primary Care has formal service agreements set up with specialty care services at the medical center.  Coordination of care has improved as pre-testing/specific requirements required by the specialty service are completed prior to the veteran’s referral.

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

Care is being coordinated for all veterans which leads to improved care.  Performance monitors are in place to determine areas where we are achieving goals and areas for improvement.

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

Patients are appreciative of the care being provided in the PACT program.  Comments have been received indicating increased satisfaction with VA Health Care.  Local surveys completed within the Primary Care Service indicate that 90% of veterans rate their primary care as very good or excellent.

**Chief Medical Information Officer**

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

Informatics supports quality of care in two major ways.

* We create various products within the electronic health record to support users providing care. These products: orders, templates, reminders, health summaries and other clinical decision support tools support data entry and facilitate clinical workflow. This allows data to be entered into the system in a way that is integrated, appropriate and retrievable.
* We develop reports using the data in the electronic health record that the clinical users can use to track outcomes, manage processes and ensure compliance. Staff have access to a wide range of reports, including reminder reports, fileman reports and queries from the VISN data warehouse.

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

Indicators and measurements are tracked by QM-we support QM if they have reporting needs. We also work with QM to ensure that the electronic health record reflects the most current performance measures and clinical guidelines.

**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**?

Real time tools are available to provide data back to management as quickly as possible.

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

All reports, including those from the data warehouse, are aimed to help the front line staff improve quality, efficiency and safety. For example, there are regular reports regarding BCMA use that are used by Pharmacy, Nursing and Biomedical Engineering staff to make sure that the bar code medication process is functioning properly.