The American Legion System Worth Saving Program Questionnaire

Washington, DC Quality of Care and Patient Satisfaction

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| **Domain** | **Sub-Domain** | **Question** | **Responsible Person** | **Response** |
| **Executive Leadership** | **Quality of Care** | What is your overall medical center budget for FY2011? | Brent Bennett | $414,754,866 |
|  |  | What is your overall medical center budget for FY2011? | Brent Bennett | $349,781,588 |
|  |  | What percent of your budget is dedicated to Quality of Care staffing and programs in FY2011 & FY2012? Please describe staffing costs and types of programs | Brent Bennett | Performance Management Center  Quality Management  FY2011 – 1%  FY2012 – 1% |
|  |  | Has the facility received any awards or designations for quality of care? | Ruth Anne Burris | Carey Awards-2008 & 2010  Virginia State Quality Award-2009 |
|  |  | How do you measure and manage quality as a healthcare facility? | Brian Hawkins  Ross Fletcher  Raya Kheirbek | Performance measures are determined by VA Central Office, the VISN, and the facility, culminating in an ECF plan for performance for each fiscal year. |
|  |  | What are the following staff’s responsibilities in ensuring quality of care at the facility? |  |  |
|  |  | Chief of staff | Ross Fletcher | Senior physician executive with direct responsibility for clinical quality and physician practice |
|  |  | Head Nurse (Chief Nurse Executive) | Kathy Barry | Senior registered nurse executive directly responsible for nursing clinical quality, education, and care management |
|  |  | Quality Manager | Ruth Anne Burris | Director-level position responsible for the Quality Management program that includes accreditation & oversight, risk management, and quality/process improvement |
|  |  | Patient Safety Manager | Gaye Broadway | Director-level position responsible for Patient Safety Program |
|  |  | Utilization Management | Ruth Anne Burris | UM is part of the QM program and directly relates to appropriateness of admissions and meeting evidenced-based standards for inpatient visits |
|  |  | Risk Manager | Letitia Gant  Vanessa Aycock | Mid-level position responsible for risk assessment, monitoring, management, and avoidance for clinical care |
|  |  | Systems Redesign Manager | Vacant | Mid-level position responsible for process and system-wide improvements related to reducing inefficiency and waste |
|  |  | Chief Health Medical Information Officer/ Clinical Lead for Informatics | Neil Evans | Senior physician leader dedicated to the integrity, integration, and monitoring of clinical informatics program as they relate to documentation in the electronic medical record |
|  |  | Which staff members/positions at the facility are responsible for managing and tracking quality of care programs and initiatives? | Quadrad | * Senior leadership (i.e., Medical Center Director, Associate Director, Chief of Staff, Chief Nurse Executive, Assistant Medical Center Director) * The Center for Performance Excellence   Quality Management |
|  |  | Please explain the quality of care training employees receive (i.e., type of initial and reoccurring training and number of days)? | Mary Beasley | New Employee orientation (2 hours)  Yellow/Green Belt training ( 4 days) |
|  |  | What resources have the VA Central Office and the VISN provided to help your facility improve quality of care programs and initiatives? | Ross Fletcher  Raya Kheirbek | * Innovation Grants * Rural Health Grant * Telehealth |
|  |  | What future VA Central Office or VISN resources and/or support are needed? | Brian Hawkins  Ross Fletcher  Raya Kheirbek  Kathy Barry | Continued funding that promotes rural health, women’s’ health, and telehealth initiatives that allows the facility to reach more Veterans |
|  |  | What innovative qualities of care programs or studies covered by grants are being conducted at this facility? | Ross Fletcher  Raya Kheirbek  Natalie Merckens | Innovation Grant-associated activities: LiV program, MOVE program, Rural Health, Telehealth,  Patient –centered care |
|  |  | Is your facility working on a “best practice(s)” in quality of care management? | Ross Fletcher  Raya Kheirbek | * **HTN** – Nurses in Primary Care Repeating BPs at least twice, Notifying Provider, Treating if appropriate at visit, then schedule Nurse Appt in 2 weeks to repeat BP. * **Pneumonia** - Dr. Seton & Nurse Manager retrained staff, both nurses and physicians regarding documentation practices in ED and medications that are available in the ED. * **TeleHealth** – Initiating and sustaining TeleHealth to all services. * **Secure Messaging** - Training continuing to involve more services * **e-consults** – Implementing to most clinical services |
|  |  | What other facility staff, not mentioned above, work specifically on quality of care programs and initiatives? Please list position titles, job duties, and responsibilities? | Ross Fletcher  Raya Kheirbek | Dr. Karasik and J. Gannuscio, NP and team **initiated Specialty Care Collaborative- Cardiology** to improve access in cardiology clinics. |
|  |  | Which staff position at the facility is responsible for performance measures (access, clinical measures, ASPIRE/Hospital Compare)? | Ross Fletcher  Raya Kheirbek  Ruth Anne Burris | * **Clinical Measures** - Performance Measures/EPRP Coordinator * **Access** – SR Coordinator & Nadine Nolan * **Aspire/Hospital Compare-** R. A. Burris/Pam Rachal |
|  |  | How many Full Time Employee (FTE) Registered Nurses, Licensed Practical Nurses are on your staff? | Kathy Barry | To date: 720 FTE |
|  |  | Is there sufficient staff to patient ratios? | Kathy Barry | Yes |
|  |  | Has there been any turnover with any of these positions? | Kathy Barry | Yes |
|  |  | How long have these positions been vacant? | Kathy Barry | Position vacancies vary related to type of position to be filled and recruitment outcomes. |
|  |  | Have there been any Government Accountability Office (GAO) quality of care concerns with the past three years? | Ruth Anne Burris | No |
|  |  | What were the findings /recommendations? | Ruth Anne Burris | N/A |
|  |  | Have there been any Office of the Inspector General (OIG) quality of care concerns with the past three years? | Ruth Anne Burris | Yes-Hot Line cases |
|  |  | What were the findings /recommendations? | Ruth Anne Burris | There were no findings supporting medical negligence or malpractice. No recommendations were received. |
|  |  | Have there been any media articles regarding quality of care concerns with the past three years? | Michelle Spivak | No |
|  |  | What were the findings/recommendations? | Michelle Spivak | N/A |
|  |  | When was your last Joint Commission inspection? | Ruth Anne Burris | 2011 |
|  |  | What were the findings/recommendations? | Ruth Anne Burris | Recommendations for Improvement were focused on planning of care, documentation of care, medication management, and environment of care issues |
|  |  | When was your last CARF inspection? | Ruth Anne Burris | Dec, 2011 (Employment & Supportive Services)  April, 2012 (Physical medicine & rehab) |
|  |  | What were the findings/recommendations? | Ruth Anne Burris | Recommendations were related to: screening, documentation, risk assessment, and training |
|  |  | Please list quality of care committees at the VISN and facility level, their mission statements, what members comprise the committee, and how often they meet. | Ruth Anne Burris | **Facility-level:** Quality Council, Medical Executive Committee, Nurse Executive Council, Patient Safety Committee, Peer Review Committee. Membership includes senior level leaders, service chiefs, nurse leaders, support staff, etc., from various departments. Frequency of meetings is determined separately by committee, ranging from monthly to quarterly.  VISN-level: Executive Leadership Council, Clinical Leadership council, Quality Management, Patient Safety, Surgical Quality. Members include representatives from each facility within the VISN. Frequency of meetings ranges from monthly to quarterly. |
|  |  | Are veterans’ participating and/or serving on these committees? | Ruth Anne Burris | No |
|  | **Patient Satisfaction** | What percent of your budget is dedicated to Patient satisfaction staffing and programs in FY2011 & FY2012? Please describe staffing costs and types of programs | Natalie Merckens  Brent Bennett | 9 FTE with goals to expand. However, we partner with all employees in the medical center to improve patient satisfaction scores. Staffing costs include salary, educational efforts, and initiatives such as Patient-Centered Care, WRIISC, Change Academy, Strategic Planning retreats, etc. |
|  |  | How do you define patient satisfaction as a healthcare facility? | Natalie Merckens  Diane Phillips  Gene Groves | A measure of the patient’s level of contentment with the overall experience at the medical center including quality of care and services received. |
|  |  | How do you measure and manage patient satisfaction as a healthcare facility? | Natalie Merckens | Inpatient/outpatient and POC surveys with reports provided daily, monthly, and quarterly, Focus Groups, Clinical Outcome measures, access, etc. |
|  |  | What types of tools are utilized for tracking patient satisfaction? | Natalie Merckens  Diane Phillips | SHEP/Truth Point bedside service recovery tool |
|  |  | How are these tools used to improve patient satisfaction? | Natalie Merckens  Diane Phillips  Gene Groves | Truthpoint provides the ability for on the spot correction and service recovery. It is the voice of the Veteran while they are a patient in the medical center. It also provides prospective information for tailoring patient visits in the future. SHEP scores provide trended data to assess areas requiring focused intervention and provide management teams opportunities to perform rapid cycle process improvements. |
|  |  | Please provide the date & results of the last two SHEP scores | Natalie Merckens  Diane Phillips  Gene Groves | Outpatient Overall –  November 2011 – 44.0  December 2011 – 48.9  Inpatient Overall -  November 2011 – 49.0  December 2011 – 38.5 |
|  |  | Which areas of the most recent SHEP survey did you improve or decline, compared to the last SHEP survey? | Natalie Merckens  Diane Phillips  Gene Groves | **Improve** –  Inpatient –  Privacy in Room  Pain Management  **Decline –**  Quietness of Hospital Environment  Shared Decision Making |
|  |  | What measures have been taken to address improvement in these areas? | Natalie Merckens  Diane Phillips  Gene Groves | Nurse/Patient Daily Plan to improve communication, collaboration, and care coordination.  Multiple patient-centered care initiatives including OR Liaison, Capital Excellence Application. Working with floor staff/EMS to establish quiet times. |
|  |  | How does VA Central Office, VISN, and VA medical center facilities demonstrate and maintain accountability for patient satisfaction? | Natalie Merckens | The VA has established a division of Patient-Centered Care and is rolling out educational initiatives nationwide. At VISN 5, Patient Satisfaction/Patient Centered Care is a standing agenda item for daily morning report and the Executive Leadership Committee. This is mirrored in the facilities. |
|  |  | What resources has the VISN or VA Central Office provided to assist your facility in improving patient satisfaction? | Natalie Merckens  Diane Phillips | A number of programs have been implemented with Central Office funding. These include Narrative Medicine, a contract with the Advisory Board, and an OR Liaison. |
|  |  | How many VAMC staff work specifically on patient satisfaction initiatives. Please list their position titles, job duties, and responsibilities. | Natalie Merckens  Diane Phillips  Gene Groves | The DC VAMC is currently participating in the VA Learning University’s Change Academy. This group of over 90 people will spearhead change initiatives geared specifically to patient satisfaction. The Medical Center Director and Senior Management teams all have direct responsibility for monitoring and improving Veteran satisfaction in all parameters of healthcare services. |
|  |  | Please list patient satisfaction committees at the VISN and facility level, their mission statements, what members comprise the committee, and how often they meet. | Natalie Merckens  Diane Phillips  Gene Groves | The VISN Patient Satisfaction Committee meets monthly. It includes all Assistant Directors, Chief Nurse executives, and Patient Centered Care coordinators. |
|  |  | Are veterans’ participating and/or serving on these committees? | Natalie Merckens  Diane Phillips  Gene Groves | The Washington DC VAMC is endeavoring to have Veteran representation on patient-centered committees. We have historically held focus groups to illicit feedback regarding services rendered. These are segregated by services received, gender, era of service, etc. |
|  | **Quality Manager** | What duties & responsibilities do you have as the quality manager for the facility? | Ruth Anne Burris | This position is responsible for the implementation of the Quality Management program which includes accreditation & oversight, admissions, risk management, quality & process improvement, and utilization management. |
|  |  | How are quality of care indicators and measurements tracked and managed? | Ruth Anne Burris | Performance measures dashboard |
|  |  | How do you measure and manage quality as a health care facility? | Ruth Anne Burris | Quality is managed by everyone in the organization from leadership to the front-line employee. Patient care and satisfaction is a top priority for the medical center and is measured via the ECF performance plans. |
|  |  | What are the quality of care committees at the VISN and/or facility level? Who are they? | Ruth Anne Burris | * Quality Council is facility committee w/multi-disciplinary membership including Quadrad, physicians, nurses, and support services * Medical Executive Committee is senior level committee chaired by the COS w/membership of service chiefs, CNE, QM, and Patient Safety. * Performance Measures Workgroup is multi-disciplinary w/membership representative of teams responsible for specific measure performance |
|  |  | How are you monitoring Quality Assurance within CBOCs? | Ruth Anne Burris | CBOCs quality of care included with facility monitoring of performance measures, patient satisfaction, and CBOC-specific measures including wait times, missed opportunities, scheduling, and customer service |
|  |  | VA-staff CBOCs | Ruth Anne Burris | See response above |
|  |  | Contracted staff CBOCs? | Ruth Anne Burris | No contracted staff CBOCs |
|  |  | How are you monitoring quality assurance with non-VA care? | Ruth Anne Burris | Patient outcomes and contractual indicators for quality are assessed routinely |
|  |  | Of these, which quality measures are you responsible for? | Ruth Anne Burris | None |
|  | **Patient Safety Manager** | What duties & responsibilities do you have as the Patient Safety Officer for the facility? | Gaye Broadway | * PS compliance & monitoring * Root Cause Analysis * HFMEAs * Risk Assessment |
|  |  | What other facility staff reports to you on patient safety programs and care initiatives? | Gaye Broadway | Patient Safety Specialist  Health Systems Specialist |
|  |  | How do you define patient safety as a healthcare system? | Gaye Broadway | “No Blame” Culture |
|  |  | Please describe your patient safety programs and initiatives. | Gaye Broadway | Falls |
|  |  | What patient safety committees do you have at the VISN and/or VA Medical facility? Please explain. | Gaye Broadway | Patient Safety-VISN & facility-level committees |
|  |  | What VA Central Office, VISN, and VA Medical Center facility’s programs are in place to prevent patient safety hazards? | Gaye Broadway | Recall website |
|  |  | 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? | Gaye Broadway | Recall website |
|  |  | How are high risk patient safety issues reported to the medical center’s leadership? | Gaye Broadway | * Adverse event reporting on EiR * Event reporting directly from units * Patient Safety Officer reporting directly to leadership |
|  |  | Please describe the differences at your facility between quality of care and patient safety. | Gaye Broadway | Both are focused on quality of the care provided to the patient. The patient safety program assesses continuously for risk factors that relate to near miss and sentinel events related to human, equipment, or supply factors. Quality of care is focused on practice by healthcare providers and clinicians. |
|  |  | How do you work with the facility’s Quality manager, UM, RM, SRD, and Chief of HIM on quality of care and patient safety programs/initiatives? | Gaye Broadway | Relationship is collaborative and consultative. |
|  |  | Please explain the process taken to conduct a Root Cause Analysis (RCA) | Gaye Broadway | RCA process includes identify an event, reviewing the timeline that led to the event, and assessing for process/system issues or practice variation |
|  |  | How do you use other facilities RCA’s to improve quality of care and patient satisfaction? | Gaye Broadway | Information is used for benchmarking of best practices and to improve our processes to achieve higher level of patient safety & satisfaction |
|  |  | How many staff members work specifically on patient safety initiatives? Please list position titles, job duties and responsibilities | Gaye Broadway | 3 Staff  Patient Safety Program Manager  Patient Safety Specialist  Health Systems Specialist |
|  | **Patient Aligned Care Team (PACT) Coordinator** | What duties & responsibilities do you have as the PACT coordinator for the facility? | Melissa Turner  Alysha Smith | Education of staff about PACT and increasing buy-in, dissemination of data regarding PACT benchmarks, developing action plans on how to achieve benchmarks, weekly PACT meetings with stakeholders, writing minutes for weekly meetings, attending PACT collaborative meetings |
|  |  | How many staff members work specifically on PACT programs & initiatives? Please list position titles, job duties and responsibilities | Melissa Turner  Alysha Smith | All staff in primary care are working on PACT.  \*\*RN Care managers call patients in between appointments to coordinate care, follow-up on recently discharged patients and veterans recently seen in the ER, routinely meet with PCP and health tech about needs of veterans that are on that PCPs panel, answer secure messages  \*\*PCPs are MDs, NPs and PAs that see patients in clinic every day, follow-up on lab results, complete forms for veterans, do telephone appointments, see acute care (unscheduled) patients, answer secure messages, coordinate care with subspecialists  \*\*Health Techs are primarily in charge of evaluating scheduled patients, doing their preventative screens, calling patients reminding them to come in for labs prior to their appointments |
|  |  | Who is in charge of the PACT steering committee at this facility? | Melissa Turner  Alysha Smith | Dr. Navjit Goraya |
|  |  | How often does the PACT committee meet? | Melissa Turner  Alysha Smith | There are weekly meetings |
|  |  | Which VA medical center staff attends the committee? | Melissa Turner  Alyshia Smith | * Nursing: Clinical Director, Primary Care, Primary Care nurse managers, Women’s Health Program Coordinator, Deputy Chief Nurse, Outpatient Operations, Health Promotions Disease Preventions Program Coordinator * Primary Care Health Systems Specialists * Primary Care Team Leaders (MDs) * Systems Redesign team member (ad hoc) * MyHealtheVet coordinator, ad hoc |
|  |  | Are representatives from the Veterans’ community involved in PACT planning process? | Melissa Turner  Alyshia Smith | There are veteran members on the VISN PACT committee |
|  |  | Explain how the PACT was implemented at the facility? | Melissa Turner  Alyshia Smith | * Completed Medical Home Readiness Assessment * Teamlet members and leaders attended series of National and Regional training * Monthly dissemination of PACT data to primary care providers and RNs * Regular evaluation of data to trouble shoot incongruities of data * Obtaining "buy-in" from primary care staff through regular team meetings |
| **Patient Satisfaction** | **Director of Patient Care Services (CNE)** | What duties & responsibilities do you have as the Director of Patient Care Services for the facility? | Kathy Barry | Senior registered nurse executive directly responsible for nursing clinical quality, education, and care management in inpatient and outpatient settings. |
|  |  | What were the results of the last SHEP survey for Inpatient and Outpatient? | Kathy Barry | Outpatient Overall –  November 2011 – 44.0  December 2011 – 48.9  Inpatient Overall -  November 2011 – 49.0  December 2011 – 38.5 |
|  |  | Did the facility improve or decline in any areas since the last SHEP survey? | Kathy Barry | Yes |
|  |  | How are patient satisfaction indicators and measurements tracked and managed? | Kathy Barry | SHEP scorecard and ECF dashboard |
|  |  | Of these, which patient satisfaction measures are you responsible for? | Kathy Barry | Nursing related measures such as patient education, communication, comfort, respect& dignity, pain management, responsiveness |
|  |  | What other facility staff reports to you on patient satisfaction programs and initiatives? | Kathy Barry | Patient Advocate Office and Patient Centered Care report patient satisfaction issues or compliments on a daily basis and when formal reports are available. Other reporting on initiatives may be captured during Director Leadership meeting or other reporting venues. |
|  | **Utilization Management Coordinator** | What job duties and responsibilities do you have to ensure quality of care and patient satisfaction? | Ruth Anne Burris | UM coordinators are responsible for the review, assessment, and monitoring of admissions appropriateness and the continued stay for inpatients in meeting defined criteria for best practice. UM coordinators review patient charts daily evaluating care and patient progress towards discharge. They work collaboratively with physicians, Case managers, and Social Workers, identify the appropriate level of care based upon the patient’s current condition. |
|  |  | What training did you receive initially and what ongoing training do you receive for this position? | Ruth Anne Burris | UM coordinators received VHA sponsored training on UM review and program initially, and complete annual training. In addition, there is certification for a UM reviewer that can be achieved. |
|  |  | How are measurement tools used to improve quality of care and patient satisfaction? | Ruth Anne Burris | National Utilization Management Information database is the program used for data entry and reporting of performance. Indicators for acute care admissions and stays are produced from this database. |
|  | **System Redesign Manager (Coordinator)** | What job duties and responsibilities do you have to ensure quality of care and patient satisfaction? | Raya Kheirbek | The Chief of Staff office has the overall responsibility for quality of care provided to patients. |
|  |  | What training did you receive initially and what ongoing training do you receive for this position? | Raya Kheirbek | Lean six Sigma, access training, national SR training |
|  |  | How are measurement tools used to improve quality of care and patient satisfaction? | Raya Kheirbek | Every morning leads track and follow up on access, wait time, missed opportunity, Secure, messaging, E consult and important clinical quality measures. |
|  | **Risk Manager** | What job duties and responsibilities do you have to ensure quality of care and patient satisfaction? | Letitia Gantt  Vanessa Aycock | * Medical Risk Management involves monitoring for variations in provider practice and their subsequent impacts upon patient care & outcomes. This monitoring includes review of 16 triggers and 3 occurrence screening daily for peer review and patient safety purposes. In addition, Risk Management is involved with Regional Counsel in the review and management of tort claims. Mortality and complications are two primary interests of risk management, and integrated into the peer review process. In addition, this individual plays a key role in disclosures. * Surgical Risk Management involves a Surgical Clinical Nurse Reviewer. This person is responsible for VASQIP which is related to tracking complications and deaths within 30 days of surgery. This in turn provides us with a quarterly Mortality and Morbidity ratio that is measured statistically for quality of surgery. As the chart is reviewed for complications, the SCNR also reviews for issues related to patient satisfaction. |
|  |  | What training did you receive initially and what ongoing training do you receive for this position? | Letitia Gantt  Vanessa Aycock | * Medical Risk Manager has received VHA directed training on RM and Peer Review initially and on an ongoing basis. * As the Surgical Clinical Nurse Reviewer, received 6 weeks of orientation with a competency exam taken at 6 months on the job. Annually a competency exam is completed that is conducted by the National Surgery Office. Monthly Conference Calls are also conducted for education and ongoing training and updates in VASQIP. Annual conference is attended. |
|  |  | How are measurement tools used to improve quality of care and patient satisfaction? | Letitia Gantt  Vanessa Aycock | * For overall risk management, peer review performance measures, mortality outcomes, and performance measures dashboard are used to monitor quality of care. * For surgical risk, the VASQIP program is the measurement tool used and it is based on the observed versus expected ratio for mortality and morbidity. Raw data of complications are provided to attending surgeons on a quarterly basis. This information is used to determine if changes are needed in the care of the surgical patients. |
|  | **Chief Medical Information Officer (ACOS, Clinical Informatics)** | What job duties and responsibilities do you have to ensure quality of care and patient satisfaction? | Neil Evans | The VA’s comprehensive use of its award-winning electronic medical record (CPRS) is more than just a replacement of a paper record. It’s a quality initiative. The 100% availability of the comprehensive record, built-in clinical decision support (clinical reminders), automatic drug interaction checks, and more all have a profound impact on the quality of care delivered. Informatics is responsible for maintaining CPRS and where possible optimizing the record to better ensure quality care delivery |
|  |  | How are quality of care and patient satisfaction indicators and measurements tracked and managed? | Neil Evans | Quality of care and patient satisfaction are measured many ways – some quick examples include: Clinical Reminder Reports, Data Warehouse, SHEP scores, EPRP reviews, Truthpoint Surveys. |
|  |  | 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? | Neil Evans | See above re: how quality and satisfaction is measured. These results are regularly analyzed and subsequent targeted interventions launched to address areas of potential vulnerability. |
|  |  | How are measurement tools used to improve quality of care and patient satisfaction? | Neil Evans | An excellent example is the VISN5 Data Warehouse, which allows point of care analysis of quality of care data by front-line clinical staff, including individualized reports. |
|  | **Patient Advocate/ Patient Centered Care Coordinator** | How do you define patient satisfaction as a healthcare facility? | Diane Phillips  Gene Groves  Natalie Merckens | A measure of the patient’s level of contentment with the overall experience at the medical center including quality of care and services received. |
|  |  | What duties and responsibilities do you have as the patient Advocate for the facility? | Diane Phillips  Gene Groves  Natalie Merckens | The primary purpose of the position as Department Chief is to provide the coordination necessary for an effective, comprehensive, and integrated consumer affairs program that supports VHA (Veteran's Health Administration), VISN (Veteran's Integrated Service Network), and DC VA Medical Center goals. Additional responsibilities functioning as the Chief of Service include serving as a change agent while serving on Medical Center and VISN level committee's along with daily duties of ensuring that quality service is provided to veterans, their families, and other internal and external customers. |
|  |  | How are patient satisfaction indicators and measurements tracked and managed? | Diane Phillips  Gene Groves  Natalie Merckens | SHEP survey and Performance Measures dashboard |
|  |  | Of these, which patient satisfaction measures are you responsible for? | Diane Phillips  Gene Groves  Natalie Merckens | SHEP survey indicators |
|  |  | When was your last patient satisfaction survey? What were the results? How do your results compare with other VAMCs? | Diane Phillips  Gene Groves  Natalie Merckens | The last patient satisfaction survey scores published by SHEP (Survey for Healthcare Experience of Patients) reflected scores from October 2011 through December 2011. |
|  |  | What were your previous patient satisfaction scores? | Diane Phillips  Gene Groves  Natalie Merckens | |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Inpatient Dimensions of Care** | **Natl. Avg** | **October** | **November** | **December** | | Cleanliness of the Hospital Environment | 91.3 | 89.3 | 88.0 | 90.9 | | Communication about Medication | 79 | 71.4 | 71.3 | 68.3 | | Communication with Doctors | 93 | 95.1 | 94.1 | 95.7 | | Communication with Nurses | 93 | 85.1 | 85.5 | 91.1 | | Discharge Information (ECF) | 83 | 84.1 | 89.1 | 86.8 | | Noise Level in Room | 79.6 | 80.0 | 66.7 | 72.2 | | Overall Rating of Hospital | 63.7 | 52.9 | 49.0 | 38.5 | | Pain Management | 89 | 89.5 | 93.4 | 91.3 | | Privacy in Room | 84.2 | 83.8 | 88.6 | 86.4 | | Quietness of the Hospital Environment | 83.7 | 89.9 | 70.4 | 69.4 | | Responsiveness of Hospital Staff (ECF) | 84 | 57.5 | 71.8 | 69.6 | | Shared Decision Making | 71 | 69.1 | 66.0 | 78.9 | | Willingness to recommend | 67.8 | 50.7 | 57.2 | 56.7 |  |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Outpatient Dimensions of Care** | **Natl. Avg** | **October** | **November** | **December** | | Getting Care Quickly | 78.5 | 78.3 | 77.0 | 70.4 | | Getting Needed Care | 79.8 | 75.1 | 85.4 | 69.0 | | How Well Doctors/Nurses Communicate | 90.4 | 94.6 | 94.9 | 85.7 | | Overall Rating of Health Care | 56.2 | 56.7 | 44.0 | 48.9 | | Overall Rating of Personal Doctor/Nurse | 69.1 | 79.8 | 63.5 | 69.9 | | Rating of Specialists | 64.8 | 63.5 | 44.6 | 57.1 | | Pharmacy Mailed | 81.7 | 85.7 | 64.4 | 89.6 | | Pharmacy Pickup | 67.7 | 84.7 | 49.6 | 83.7 | | Provider Wait Time | 76.3 | 68.5 | 69.7 | 71.0 | | Shared Decision Making | 89.9 | 87.0 | 92.0 | 85.0 | |
|  |  | Have there been any GAO, OIG, or media articles about patient satisfaction positive findings and/or concerns? | Diane Phillips  Gene Groves  Natalie Merckens  Michelle Spivak  Ruth Anne Burris | See responses earlier in questionnaire regarding concerns.  Positive articles occur sporadically, such as in response to new programs, or patient care following earthquake in 2011. |
|  |  | How many staff members work specifically on patient satisfaction initiatives. Please list titles, job duties and responsibilities. | Diane Phillips  Gene Groves  Natalie Merckens | The DC VAMC is currently participating in the VA Learning University’s Change Academy. This group of over 90 people will spearhead change initiatives geared specifically to patient satisfaction. The Medical Center Director and Senior Management teams all have direct responsibility for monitoring and improving Veteran satisfaction in all parameters of healthcare services |
|  |  | Please explain the initial and ongoing training these patient advocates review (i.e., type of training and number of days/hours)? | Diane Phillips  Gene Groves  Natalie Merckens | Initial and ongoing training in Customer Service and Patient Centered Care. |
|  |  | Please describe programs and initiatives that relate to patient satisfaction. | Diane Phillips  Gene Groves  Natalie Merckens | **Patient Advocate Liaison Program:** The **(PALS)** Advocate is anemployee designated at the service level, or point of service, who assists front-line staff in resolving issues after first attempts at resolution have not been successful. A Service-level Advocate resolves patient issues, working in collaboration with the Facility or medical center Patient Advocate to identify opportunities for improvement. Service-level Advocates are currently not granted access to enter data into the Patient Complaint/Compliment Tracking Package.  **Service Recovery**: The service recovery is a systematic approach to proactively solicit veteran feedback and simultaneously respond to complaints to build confidence and loyalty, while utilizing veteran feedback to make systems improvements. Service recovery entails taking a negative experience and turning it into a positive memorable experience. ThePatient Advocacy program operates within the structure of Veteran Customer Service and Service Recovery. Further information about Veteran Customer Service is found in Directive 1003 and Handbook 1003.1. Service Recovery information is found in VHA Handbook 1003.2, Service Recovery in VHA.  **Inquiry Routing and Information System (IRIS).** IRIS allows veterans to submit questions, complaints, compliments and suggestions through the VA website. The veteran self-directs inquiries that are routed to the appropriate VA Central Office Program Offices, Network or facility where care was provided (<https://iris.va.gov/scripts/iris.cfg/php.exe/enduser/home.php> ) The preferred method of electronic communication for VHA with its constituents is through the use of IRIS. The Patient Advocates Office is responsible for responding to IRIS Inquiries.  **STAR PERFORMERS PROGRAM:** The Patient Advocates Office Manages the STAR Performers Program. This program allows employees of the medical center the opportunity to nominate their co-workers when they feel they have gone beyond the call of duty. If the employee is selected as someone who may have exceeded the expectation of “Taking Care of Veterans” they may win a $25.00 gift certificate redeemable at the retail store.  **New Employee Orientation**  **New Enrollee Orientation** |
|  |  | What is the procedure when you receive a patient concern and/or complaint? | Diane Phillips  Gene Groves  Natalie Merckens | The Patient Advocate Office is responsible for referring individual patient issues to appropriate staff and for recommending resolution of impasses to the appropriate Medical Center Leadership; Director, Associate Director, Chief of Staff, Nurse Executive, Assistant Director. The Patient Advocate Office will also ensure copies of the Patient Rights and Responsibilities are posted and available in outpatient clinics and displayed throughout the medical center. |
|  |  | Which office and position in VA Central Office, VISN and VA medical center facility oversees Patient Advocates? | Diane Phillips  Gene Groves  Natalie Merckens | The Office of the Assistant Director at the DCVAMC oversees the Patient Advocate Office. |
|  |  | What training do facility Patient Advocates receive? | Diane Phillips  Gene Groves  Natalie Merckens | Ongoing training in Customer Service and Patient Centered Care. |
|  |  | Are any measures or evaluations conducted for Patient Advocates to ensure their professionalism, courteousness, and prompt response/follow up action is taken what a patient complaint outcomes is initially filed? | Diane Phillips  Gene Groves  Natalie Merckens | Patient Advocates receive quarterly, semi-annual and yearly evaluations regarding their continued professionalism, courteousness and follow up responses with regards to patient complaints. |
|  |  | Is there any national 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? | Diane Phillips  Gene Groves  Natalie Merckens | The Patient Advocate Office will initiate a report of contact. The report will be a computer generated alert, and may be provided in hard copy. The report will be forwarded to the appropriate service for documentation of the resolution. The completed report will be electronically sent back to the Patient Advocate Office within the time frame specified, but no longer than seven working days. The Patient Advocate Office will incorporate these reports in the Patient Advocate Tracking System for further analysis, as appropriate. |
|  |  | If so, which office and positions ensures this standard/policy is being met? | Diane Phillips  Gene Groves  Natalie Merckens | 1. In the event that the conflict cannot be resolved within the established sources of resolution, the Patient Advocate Office may:    1. Defer the issue to the Ethics Committee Chairperson to allow for a multidisciplinary approach towards resolution of the conflict.    2. Defer to the appropriate Medical Center Leadership.    3. Address the issue in accordance with the Medical Center’s Clinical Appeals process, MCPM No. 11-107. |
|  |  | Do you have any primary care clinics that take longer than the 30 day wait? If so, which ones? | Diane Phillips  Gene Groves  Natalie Merckens | N/A |