**Charleston, South Carolina VA Medical Center**

*Charleston, South Carolina*

Date: April 26, 2012

National Task Force Member: Past National Commander Ron Conley

Director of Veterans and Rehabilitation: Verna Jones

National Field Service Representative: Kevin Blanchard

**Background**

The Ralph H. Johnson Department of Veterans Affairs Medical Center serves more than 53,000 veteran patients. Their staffing methodology is Nursing Hours per Patient Day (NHPPD) as opposed to staffing ratios. The turnover rate is primary in nursing, but it is low at 4.2% and 18 percent for Licensed Practical Nurses’ (LPN’s). The overall budget for Fiscal Year (FY) 2011 and 2012 is $286 million and $303 million respectively.

**Quality of Care**

The facility defines quality of care simply by “delivering the right care to the right patient at the right time.” Quality is measured and managed as an organizational collaboration involving all services and disciplines. The functional framework for performance improvement of these key functions involves center-wide committee and service level performance improvement activities. Accountability is demonstrated through performance scorecards, outcomes of team initiatives, actions taken as a result of Quality Management processes, committee reports and meeting minutes.

The facility measures and manages quality by organizational collaboration involving all services and disciplines. The functional framework for performance improvement of these key functions involves center-wide committee and service level performance improvement activities.

Each employee attends new employee orientation for 3 days and then enters service level orientation. Service orientation varies according to the service needs. There are numerous annual training requirements for all staff (infection control, safety, etc) and specific needs depending on position. The VA Central Office (VACO) and the Veteran Intergraded Service Network (VISN) provides a national databases and resource websites to help the facility improve quality of care programs and initiatives. **As demands increase, staffing is needed to accommodate patient needs and VHA requirements.** The VACO or VISN should support the facility in meeting these requirements.

OIG conducted an inspection at the end of 2009 in response to allegations the medical center provided poor care to a veteran, contributing to his untimely death. OIG did not substantiate that staff intentionally disregarded the veteran’s medical power of attorney and end of life wishes, kept him overmedicated causing a small bowel obstruction, or cared for this terminally ill veteran in unsanitary room conditions. They also did not substantiate other issues pertaining to nursing care or that the medical record contained discrepancies and lacked documentation of the patient at end of life. There were no recommendations.

*Quality Manager*

The Quality Manager (QM) is responsible for the management, coordination, integration, technical support, and daily oversight of the facility’s Quality Management Program. The QM serves as the quality consultant to the facility leadership, performance improvement teams, and employees. These responsibilities also include internal and external review requirements and findings, monitoring of adherence to established policies and procedures, staff assistance and education on PI activities, Risk Management, Patient Safety, Utilization Review, and Performance Measurement. The QM or designee serves on Medical Center committees as a member or resource. The QM has unrestricted access to data and information that are relevant to quality improvement, performance measurement, and all other topics associated with key quality management components, which are collected, consolidated, or analyzed at the facility level.

Quality of care indicators and measurements are tracked and managed through our formalized committee structures, service chief accountability, and leadership oversight. The Senior Executive Council (SEC) is a standing leadership committee identified to review quality data and ensuring information and key quality components are discussed and data reviewed. This Council evaluates their effectiveness through the assessment of goal achievement, outcome measures of specific performance measures, and the level of implementation of strategic planning initiatives. The VACO, VISN and VAMC facilities demonstrate and maintain accountability for quality of care through the VHA performance measure system, external reviews and accreditation.

With the amount of initiatives and quality performance measurements the VAMC is required to track, it can be challenging to manage and prioritize. Many of these initiatives and performance measurements are directed from VACO and/or the VISN. However, the medical center may have different prioritizes that are more quality driven. VACO and/or VISN need to adhere to the regulations and directives, which is important, but needs to ensure increasing the amount of quality performance

*Patient Safety Manager*

The Patient Safety Manager (PSM) is responsible for implementing and coordinated patient safety improvement program that is based on guidance and tools from the National Center for Patient Safety (NCPS), and which also meets needs and priorities identified by facility leadership, such as addressing important standards, requirements, and recommendations promulgated by The Joint Commission and other organizations working to improve patients' safety. The Patient Safety manager reports to the facility director. The facility has one dedicated patient safety manager and a part-time program assistant.

The patient safety programs and initiatives are as follows: one program that works with risk management to minimize the occurrences of adverse events. Proactive risk assessments and root cause analyses are tools used for this purpose. The facility has an anonymous reporting system so facilitate the reporting of safety issues or adverse events. Patient safety is also involved in environment of care, construction areas, and monitoring compliance to the Joint Commission patient safety goals. When a patient safety hazard occurs, The National Center for Patient Safety is the central office contact. The VISN employs a Patient Safety Officer who reviews facility efforts. The facility Patient Safety Officer responds when a safety hazard occurs and coordinates responses and actions with appropriate facility staff.

A Root Cause Analysis (RCAs) is the primary tool used when an adverse event occurs; the event undergoes an analysis to determine severity. If criteria are met, a RCA team is chartered by the Director. RCAs can be requested by any member of leadership. The team is facilitated by the Patient Safety Manager. Results are presented to the Pentad. RCAs are confidential and protected documents that are not shared with other facilities. Lessons learned, however, are shared amongst facilities if appropriate.

*Utilization Management*

The Utilization Management (UM) nurses conduct facility wide utilization management activities including, collecting, analyzing, and reporting data on admission and continued hospital stays. They effectively analyze the clinical contents of medical records and associated documents in terms of quality and appropriateness of care issues. The Utilization Review and Management Program reviews activities associated with cost effective utilization of resources while maintaining quality patient care within the Medical Center.

Training is provided through an on-line course and internet conferencing. UM nurses are required to undergo inter-rater reliability training on an annual basis.

Measurement tools are used as a mechanism to collate and analyze data in all forums in which quality data is collected. It is the analysis of data by leadership and staff that actually improve the quality of care and patient satisfaction. Although the UM has a critical role in quality data collection, they do not consider themselves in positions to ensure quality of care and patient satisfaction.

*Risk Manager*

RiskManagement (RM) processes related to tort claims, disclosure of adverse events, peer review, Administrative Investigation Boards, occurrence screening, patient incident reporting, and reports to licensure boards and the National Practitioner Data Bank. Training is provided by the national RM office as new requirements are introduced.

Measurement tools are usedto collect and analyze data in all forums in which quality data is collected. It is the analysis of data by leadership and staff that ultimately improve the quality of care and patient satisfaction.

Improvements have been made with risk management and with quality of care and patient satisfaction overall. The program is fully functional and integrated into the medical center, however, patient satisfaction is not under the umbrella of risk management.

*Systems Redesign Manager*

The Systems Redesign Manager implements and facilitates the System Redesign methodology which serves as a primary strategy to analyze and improve systems that affect performance and efficiency of specific processes within the medical center. These processes may be interdisciplinary or specific to a service or program area.Training involves attending trainings relating to Systems Redesign since July 2011, including VERC Green Belt, VERC Yellow Belt.

The measurement tools are tracked daily, weekly, monthly and quarterly. They are reported to all employees, clinic management and/or leadership electronically and/or face-to-face, depending upon the nature of the information. These tools are also used in systems redesign teams in order to determine if a project or a change in a process was successful and to ensure sustainment.

The medical center is always looking for ways to improve their processes and procedures in order to provide the highest quality of care and patient satisfaction obtainable. Once a process or procedure has been changed, the challenges is communications it the entire medical center and ensuring consistence. Improvements and change starts and ends with each employee.

*Chief Health Medical Information Officer/Clinical Lead for Informatics (CHMIO)*

*The CHMIO e*nsures all requirements of external accreditation and VA requirements are being met. The quality of care and patient satisfaction indicators and measurements are tracked and managed only by usingSurvey of Healthcare Experience and Patients score (SHEP).

**Patient Satisfaction**

Patient Satisfactionis measured and managed by utilizing SHEP scores, IRIS internet inquiries, patient feedback cards from both the inpatients and outpatients and discuss the results monthly in the Customer Service Committee. The group brainstorms ideas to enhance the veteran and family experience. The types of measurement tools are utilized for tracking patient satisfaction are, SHEP, IRIS, Feedback Cards, live interactive feedback during rounding and the Patient Advocate Tracking System*.*

These reports are broken down by questions and focus on the low lying scores and develop actions plans to enhance the scores. There are also three Veterans who sit on this committee structure and are asked for direct feedback in how to improve.

Improvements have been made by implementing Bedside Change of Shift Report, Hourly Rounding by nursing, Tent Card from EMS regarding room cleanliness and contact if there is an issue, multidisciplinary rounding by a team for our inpatients, Birthday Cards signed by the Director with a cupcake, USA Today newspapers for our inpatients, Patient and Family Centered Care Training directed at each specific discipline, Patient and Family Lounge with coffee service, ice machine, Dell Touchscreen Technology with Fax, Copy and Printing Capabilities, Child Play area, Music Therapy and Aromatherapy Pilot currently in process to assess effectiveness.

The VACO, VISN and Medical Center facilities demonstrate and maintain accountability for patient satisfaction through monthly discussion regarding SHEP data and ideas to improve services through the Office of Patient and Family Centered Care as well as the VISN 7 office conference calls where information is shared on what to do in each medical center.

Resources from the VISN or VACO are provided to assist the facility through conferences for training for the staff most importantly where demonstrations, information, and idea sharing building relationships with other medical center staff both VA and Non-VA on what is effective, financial support through grants, and research projects when break through treatments are identified that improve Veterans’ outcomes and health status.

*Director of Patient Care Service (DPCS)/Patient Advocate*

The Director Patient Care Services/ Nurse Executive (DPCS/NE), functions as a member of the organization's senior leadership. They collaborate with senior executive management in making decisions about health care services, settings, and organizational priorities.   The DPCS/NE works with senior executive management to ensure that policies and practices promote optimum patient care outcomes. The DPCS/NE provides leadership in the promotion of quality and effectiveness by supporting VHA Clinical Indicators, Performance Measures, T21, and various other outcome measures.   This also includes the quality and effectiveness of nursing programs throughout the organization.   The DPCS/NE provides leadership in the professional community, and governmental bodies that shape health care policy, thereby contributing to the development of the health care delivery system and better health care for society.  In addition as a critical member of the Executive Leadership Team, the DPCS/NE provides input regarding administrative and clinical policy, strategic planning and decision making that impacts the organization and VISN 21 through participation on VISN and VACO national conference calls, tasks forces, committees and other national forums.

The DPCS/NE is accountable to provide guidance and oversight for all nursing practice and the profession of nursing. The scope of the DPCS/NE role extends into all major practice areas: clinical, administrative, research, education.   The DPCS/NE assures that the Nursing Strategic Plan, supports the organization's and VISN's Strategic and the National Nursing Strategic Plans.

The DPCS/NE establishes and promotes nursing standards throughout the Organization and through expert consultation, provides direction to all nursing service staff.   The DPCS/NE incorporates the principles and practices of a nurse executive within a Patient Care Line Service model for all nurses.   The DPCS proactively works with Nursing Labor and Management Relations to promote a positive and safe work environment with the organization.

Patient satisfaction indicators and measurements are tracked and managed by posting monthly to the National Website and they are placed in an excel sheet, shared with staff and the counsel to address. The DPSC is responsible for all patient satisfaction measures.

The results of these measurement tools are utilized to institute changes to improve/enhance quality of care and patient satisfaction. Every patient feedback tool and recording system is evaluated to identify gaps, and performance improvement projects are completed with a veteran involved to enhance the quality of care we are providing to Veterans. The SHEP score, IRIS, My HealtheVet inquires to the Patient Advocate office, Feedback Cards, Focus Groups; live face to face visits are used to improve quality of care and patient satisfaction. A veteran’s recourse for filed complaints and disagreements is the right to appeal that decision. That information is shared with them at the time the information and follow- up is made.

Overall, the patient satisfaction continues to increase over the last year as the journey continues of Patient and Family Centered Care, but ultimately parking has been a problem for several years and a parking deck has been requested and are awaiting approval from Central Office. Additional funding for physicians providing specialty care as it is very difficult to attract physicians with the salaries that VA can offer them.

*Patient Aligned Care Team (PACT) Coordinator*

The PACT duties and responsibilities consist of oversight of the specific goals of PACT to optimize access (including alternatives to face-to-face care) to meet Veteran needs and expectations, redesign primary care practices to become patient-centric and participatory, improve care management and coordination of care, facilitating integration of Mental Health and Specialty Care Services within Primary Care, and to facilitate the development of measurement and evaluation tools pertinent to the Patient Aligned Care Team (PACT), assist with communication among services and between services and patients to better address patient needs and support education for health promotion and maintenance to involve the active participation of Veterans and families with multiple approaches.

The PACT model was implemented initially as a pilot team from the Myrtle Beach Clinic participating in the National PACT Collaborative that started in 2010. That team worked through the implementation of pillars developing process and measuring outcomes for access, care management and changes in practice. Each PACT team developed an action plan to further spread PACT principle within their clinics and developed measureable outcomes to determine the success of those plans. PACT progress is discussed during weekly Primary Care Internal Operation Meetings, monthly Primary Care provider meetings, weekly nurse manager meetings, and site team meetings. Successful PACT practices are shared during weekly morning report with the Directors Staff. The PACT Steering Committee conducts quarterly town halls for all staff to attend for updates and training on PACT initiatives.

Although the PACT model has evolved greatly from the pilot there still remain concerns of overbooking of clinic appointments and staff shortages which result in delayed delivery of care impacting patient satisfaction.