**New York Harbor Healthcare System| Manhattan, New York**

Date: **April 17, 2012**

National Task Force Member: **Tom Mullon**

National Senior Field Service Representative: **Jonathan Naraine**



**Background**

The Manhattan Veteran Affairs Medical Center (VAMC) is part of the New York Harbor Healthcare System (VANYHHS) and is one of three medical centers in New York City. It has the capacity to provide services for veterans living in all five boroughs.

The Manhattan VAMC’s overall budget for 2011 was $498,296,247 million and $521,045,554 million in 2012. In 2011, .88 percent of the budget was dedicated to quality of care staffing and programs. In 2012, there is a projected .83 percent for quality of care programs. Currently, the facility has 638 full-time Registered Nurses and 73 License Practical Nurses.

**Quality of Care**

The Manhattan VAMC defines health care as the ability to provide state of the art care to veteran patients, which includes the highest standards of care, is safe, resource efficient, and meets the needs and expectations of the veteran patient.

NYHHS maintains accountability for quality of care through communication and reporting structure. Quality of care is validated through reviews by Joint Commission (JC), Commission on Accreditation of Rehabilitation Facilities (CARF), and Office of Inspector General (OIG). The following staff provide oversight for quality of care; Chief of Staff, Head Nurse, Quality Manager, Patient Safety Manager, Utilization Management, Risk Manager, Systems Redesign Manager, and Chief Health Medical Information Officer/Clinical.

Employees receive annual mandatory training and new training that is sent from Veteran Affairs Central Office (VACO). In addition to training, the Veteran Health Administration (VHA) and Office of Academics Affairs funded a chief resident for safety and quality position for medical service. This individual works on projects with the chief medical service officer, residential staff, and the administrative staff.

*Quality Manager*

This individual is responsible for the quality management department at the facility. Their responsibilities include quality of care, patient safety, risk management, utilization management, and system redesign. He or she serves as the liaison for recommending performance improvement activities based on analysis of data.

Recommendations are constructed by using quality of care indicators, which have not met VHA’s performance measures. The quality of care indicators are first evaluated by the quality manager, then it is sent to executive leadership and appropriate committees.

A challenge the quality manager endures is VHA is not efficient in gathering data from VA facilities. When VHA collects data, the best practices are not disseminated nationally.

*Patient Safety Officer*

The patient safety officer investigates patient safety issues for VANYHHS. This encompasses two acute care hospitals, 300 bed Community Living Center (CLC), 40 bed domiciliary and four community- based outpatient clinics (CBOCs). He or she conducts individual and aggregated Root Cause Analysis (RCA), provides recommendations to the executive staff, and submissions to the National Center of Patient Safety (NCPS). Annual reviews of VANYHHS patient safety program is also completed by this individual.

When RCA’s are completed, the patient safety officer writes a patient safety feedback issue. Feedback issues describe details of what occurred during a particular event and the actions taken to mitigate the identified hazard. Patient safety is a health care discipline that emphasizes the reporting, analysis and prevention of medical errors.

A challenge the patient safety officer confronts involves RCA’s and the lack of dissemination of problems found. The patient safety officer provides the issues to executive leadership, which is eventually sent to the Veteran Integrated Service Network (VISN) level, however other facilities are unaware of the issue.

*Utilization Manager*

The utilization manager oversees the utilization management program that complies with VHA directives. The program includes meeting expectations for inter-rater reliability, performance of daily reviews, physician advisors reviews as appropriate, and use of review information for optimizing patient care and redesign of processes to efficiently use resource to provide veterans care. The utilization management program is also used for maintaining admission and length of stay data, which is reviewed by the utilization manager. This process ensures that the patient is receiving the appropriate level of care and quality.

The utilization manager receives initial and periodic training throughout his or her career. This training is administered by trained and approved VA interqual criteria training specialists. The training equips the utilization manager with several measurement tools, which is used to improve quality of care and patient satisfaction. One such tool involves VHA’s contract with McKesson to use interqual acute and behavioral health criteria sets to review admissions and level of care.

When a patient does not meet the criteria, the issue is discussed with a treatment team and the primary provider. Once the treatment team decides on a solution, it is embedded into the patients level of care, thus limiting the avenue for future errors.

*Risk Manager*

This position has evolved into a program called the risk management program, which incorporates quality management coordinators, a performance manager, and the patient safety manager. Risk management focuses at assuring quality and safety of care through a combination of proactive strategies and review of adverse events.

Risk starts with the quality management coordinators, which review electronic screens that alert when there may be quality of care issues present. The screen triggers the issue and staff conducts an analysis of all quality of care issues. The issue is sent to a peer review committee which identifies patterns and process improvements, this data is then used to follow up with the provider

The performance manager coordinates activities required by the Office of Medical-Legal Affairs. The coordination involves the process of reviewing the tort claims by or on behalf of the beneficiaries. The performance manager contacts the patients’ provider with the opportunity to review and respond to the tort claim.

The risk management program continues to be proactive by having the National Center for Patient Safety (NCPS) provide initial training for both performance manager and patient safety manager, this training is ongoing for leaders and frontline staff. The facility also conducts regular scheduled rounds, especially in high risk areas such as inpatient psychiatry to ensure patients receive maximum quality of care.

*System Redesign*

System Redesign position is currently vacant, it is being managed by the quality manager and deputy quality manager. The System Redesign manager oversees the training of staff in system redesign methodology, system redesign projects, and the management of the system redesign team. The system redesign manager receives both green and yellow belt training, which includes project management and methodology.

In addition, system redesign projects are chosen by both VISN and facility leadership, the leadership identifies areas of opportunity to improve quality of care and satisfaction. Furthermore, the system redesign manager has a variety of analytic tools to help understand effective and efficient processes for optimal care. Each project can be measured and have project specific metrics such as quality of care, access to care, and patient satisfaction.

*Chief Medical Officer*

The Chief Medical officer is responsible for facilitating informatics related projects that drive the medical center. A current project involves an institution of e-consults for the VANYHHS. This will benefit the patient by not eliminating unnecessary face-to-face visits. Projects are formulated by tracking and managing patient safety, this is done by conducting random audits on a timely basis. Secondly, the chief medical officer receives majority of the data from the PACT Compass in VISN Support Services Center (VSSC). After the data has been received, the chief medical officer creates a focus group of subject matter experts who would then analyze the data.

The chief medical officer improves quality of care and patient satisfaction by using clinical reminders. Clinical reminders are used to determine the improvements needed at the point of care. For example, the informatics department can generate reports utilizing clinical reminders to focus on quality of patient appointments. Once the reports have been constructed, the information is shared with the practices, then outreach is administered to find a solution to improve appointment quality.

*Women Coordinator*

The women coordinator has the capability to provide both primary care and specialty care services. Currently, the women veterans clinic is located in a separate department and has a Patient Aligned Care Team (PACT) within the facility. The women’s coordinator developed several committees, such as a post traumatic stress disorder (PTSD) committee and a women veteran health committee (WVHC), each committee has women veteran participation. The women’s coordinator conducts regular outreach within the veteran community, in addition to publicizing women health care.

A challenge the women coordinator is experiencing is there is no full-time GYN clinic and sometimes the clinic is closed all day.

**Patient Satisfaction**

The VANYHHS defines patient satisfaction as the patient’s perception of the total experience of care and services delivered, from making an appointment through aftercare, including not only quality of care, but accessibility, customer service, communication, and the environment of care. Patient satisfaction is measured through questionnaires, inpatient interviews, discharge call interviews, and patient contacts through the Patient Representative Program. In a 2011 SHEP survey, responsiveness of hospital staff and shared decision making were deficient. After the study, the facility improved its hospital staff, but not shared decision-making. In 2012, the facility made shared decision-making a priority, however responsiveness of hospital staff were not sustained.

To improve overall rating of hospital, the facility created a project called “Capstone.” This project consists of a team from New York University (NYU) master degree students partnered with VANYHHS to study data and best practices. Recommendations from the project included a more robust and decentralized patient representative program, increase staff responsiveness to calls, and increase shared decision making.

To address the responsiveness of hospital staff, nursing services initiated a program called “Take 5.” Patient care team coordinators meet every new admission and introduce patients to the unit. The nursing staff conducts regular rounds around the department to ensure patient concerns are addressed. The facility addressed the shared decision making issue by creating a project called “Reno.” This project engages staff communication with patients on shared decision making by reviewing questions. This project reinforces patient education and perception of shared decision making.

*Director of Patient Care Services*

He or she is responsible for managing personnel and assuring the highest patient care outcomes for the disciplines of nursing, pharmacy, social work, respiratory therapy, clinical nutrition, recreation, chaplaincy, and sterile processing. Patient concerns are managed by the Customer Service Committee, the Patient Representative program, the Post Discharge Call program, and Service Chiefs/Program Managers.

The Post Discharge Call program ensures all patients who are discharged home are contacted by phone within 48 hours. The call entails questions such as; do you know who to contact if you have questions?, did you receive a list of medications that you are supposed to take?, are there individuals that you would like to bring to our attention? If there is an issue, it is sent to the appropriate leadership staff to conduct a follow up. Any information and resolutions found is sent to executive leadership on a monthly basis.

Furthermore, the NYHHS has piloted a program called Truthpoint, which allows patients to complete a patient satisfaction survey prior to discharge. The input data is compiled into a real time database and sent through the same processes as the Post Discharge Call program. Moreover, the Director of Patient Care Services is mostly involved with the responsiveness of hospital staff and communication between doctors and nurses. The director works in collaboration with all patient services staff, executive senior management, and care line managers.

A challenge that utilization manager endures is over 50% of staff are at retirement age. If the positions are not filled, patient satisfaction will decline.

*Patient Advocate*

The patient advocate duties involve addressing complaints that cannot be solved when the incident occurred, interprets patient rights, and responsibilities. Patient satisfaction is measured through a variety of mechanisms including questionnaires, inpatient interviews, discharge call interviews and patient contacts through Patient Representative Program.

A common issue the patient advocate endures is assisting in improving communication between patients and staff and the resolution of problems directly affecting the patients perception of overall care received. When the patient advocate receives a complaint, information is gathered and appropriate staff are contacted. If the issue cannot be resolved at the time of the complaint, the patient will be contacted within seven days of the complaint. The complaint is entered into the Patient Advocate Tracking System (PATS), which executive leadership can monitor for trends and outcomes of all complaints.

The most important complaint the patient advocate receives is customer service and courtesy of staff. In addition, there is only one patient advocate for both the Bronx and Manhattan campuses.

*PACT Coordinator*

The Patient Aligned Care Team (PACT) coordinator provides clinical oversight for PACT operations. PACT operations include coordination of staff and resources, staff meetings, provides weekly progress report, and communication with other services relating to PACT. At the Manhattan campus, there are 99 staff members working on PACT programs and initiatives. The PACT coordinator implemented a monthly PACT committee, it involves staff from medical services, patient services, administration, prevention, pharmacy, nutrition, social work, informatics, and a patient representative.

A challenge the PACT coordinator endures is implementation of specialty care from VHA. The facility is not capable of utilizing all specialty care. This is due to the lack of funding, space, and staff.

*Recommendations*