**Tennessee Valley Healthcare System| Nashville, Tennessee**

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**Background**

The Tennessee Valley Healthcare System (TVHS) is comprised of two campuses, Nashville and Murfreesboro. This system is the sixth largest in the nation, with 11 community-based outpatient clinics (CBOC). The Nashville Veteran Affairs Medical Center (VAMC) specializes in acute care and has several affiliates such as Vanderbilt. Veteran population is between 350,000 and 400,000; with 804,000 visitations. The TVHS is one of six (Geriatric Research Education Clinical and centers) sites for mental health, which encompasses 76 beds. The TVHS had an approximate budget of $550,000,000 for both 2011 and 2012. Quality Management had an approximate budget of $1,547,000; which constitutes about 0.3 percent of the total health system budget. The Nashville VAMC conducts regular staff town hall meetings, which involves the academic council, Dean, and other community leaders. The town hall meetings are conducted to help resolve situations involving veterans and their care. In June of 2012, the TVHS will train select staff of all levels on customer service and patient satisfaction. Once trained, the staff will provide the training to the remainder of their staff.

**Quality of Care**

TVHS defines health care as safe, effective, patient-centered, timely, efficient, and equitable and to have a work philosophy that encourages every employee to find new and better ways of doing things. TVHS maintains accountability for quality of care through national accreditation, certifications, licensures, and Veteran Health Administration (VHA). 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.

New employees receive orientation under the quality manager program. Employees can take classes in performance improvement, however each department provides quality of care training throughout the year. The Veteran Affairs Office of the Inspector General (OIG) found three issues in the last year, they are as follows; general and limited management oversight, lack of a clinical lab finding follow-up notification system, and lacking performance in some annual training requirements.

*Quality Manager*

The quality manager provides oversight and direction for the health systems quality management system to includes aspects of safety, efficiency, effectiveness, timeliness of care, equality of care and that all aspects are patient centered manner. The quality manager measures and manages quality by comparing the Nashville VAMC with local hospitals and other institutions. Quality is also managed through a Quality Management System that optimizes health care processes and outcomes and fosters explicit lines of communication among members responsible for and involved in quality management.

A challenge for the quality manager is the communication barrier between departments. The VA healthcare system is similar to a silo, no one communicates effectively.

*Patient Safety Officer*

The patient safety officer conducts database analysis, system improvements, and alerts and advises on patient safety issues. This individual conducts investigations within the VAMC to prevent and control an issue. If an issue arises, the patient safety manager has access to a nation wide Root Cause Analysis (RCA) database and a best practices listing that is shared throughout the Veteran Integrated System Network (VISN). High risk patient safety issues are reported to leadership by written report, verbally, in person, and anonymously. There is a 45 day time limit for solving a patient issue, which has been mandated by VHA.

An example of a patient investigation involved a technician took a tumor sample from a patient and on another day, the technician took a sample from a different patient. The second patient sample showed cancer cells, the first patient was told that he or she had cancer. To limit this mistake in the future the Nashville VAMC bought a machine that labels the specimen versus a human.

*Utilization Manager*

The utilization manager’s main responsibility is to ensure the veteran has the correct level of care, time of stay, and reason for stay. This individual supervises the utilization specialists to identify system wide problems. In addition, the utilization manager identifies when a patient needs to go home prior to the actual day of discharge. The utilization manager also identifies if a patient needs support prior to exit and to notify proper staff. The utilization manager is responsible for reporting information to the director and the VISN leadership regarding the utilization program. During the meeting between the director and VISN leadership, reviews are conducted to identifying systematic problems. The utilization manager works with the system redesign manager to make appropriate changes and monitor the actions put in place.

A challenge the utilization manager deals with is the lack of staff. The lack of staff has hindered the action of reviewing 100% of the information quality charts.

*Risk Manager*

The risk manager is responsible for coordinating the Peer Review Committee. The Peer Review Committee is responsible for improving patient outcomes by improving individual provider performance. The committee requires active participation from nurses, physicians, and other health care professionals. The risk manager provides guidance to the medical center staff regarding disclosure of adverse patient outcomes. This individual is also responsible for overall guidance with tort claims process. In addition to tort claims, the risk manager is responsible for pre and post payment of tort claim notifications. The risk manager received training from VA NCPS on RCA’s and other health care training. To ensure quality of care, the risk manager utilizes an automated screening program which reviews all admissions and discharges for readmissions within the last 10 days. The system also screens for deaths within the last 30 days and admissions within 3 days for ambulatory care.

 *System Redesign*

The system redesign manager ensures patient safety and satisfaction are not sacrificed by improving processes. In addition, he or she is responsible for facilitating training and education. The training consist of process improvement principles and tools. An example project is making patient discharge flow easier. The project outcome would ensure patients get their treatment and leave the hospital in a timely manner, which will ultimately free bed space. The system redesign manager has improvement teams that work to decrease cost, maximize resources, and increase efficiencies. Despite the improvements, it is up to the improvement teams to maintain patient safety and satisfaction.

A challenge for the system redesign manager is the ability to reconstruct the system redesign team. In addition, the VISN does not distribute best practices across the region and staff are not given additional training.

 *Chief Medical Officer*

The Chief Medical Officer provides improvements in access to patients through building a telehealth program that allows patients to receive medical care and education near their home. The telehealth program is done through remote audio and visual technology. Additional responsibilities include maintaining and improving the electronic medical record (CPRS), clinical reminders, order sets, and documentation templates. The chief medical officer receives over 84 clinical metrics, 90 out-patient, and 90 in-patient metrics. Tracking of quality performance is used to improve quality and patient satisfaction.

A challenge for the Chief Medical Officer includes a staff shortage with clinical application coordinators. The manager would also like an updated version of the CPRS, the newer systems are more user friendly. This individual believes telehealth is not a top priority for Veteran Affairs Central Office (VACO), he or she would like to see an expansion of telehealth throughout the VISN.

*Women Coordinator*

The women health clinic provides a comprehensive primary care. The clinic is located 1.5 mile away from the Nashville campus. The clinic has two providers and will soon have two gynecologist (GYN). To receive medication the veterans must visit the pharmacy at the main campus.

Currently the clinic has 8000 women veterans and still growing at a rate of 2% every month. The women coordinator created a women veteran health committee (WVHC), this committee includes the director, consumers, and personnel from all hospital departments.

The women coordinator has several challenges, such as not having an overall program budget. The coordinator does not have a distinct women veterans budget, the director delegates funding to the program. The funding is acquired if the hospital has any left over from its overall funding.

In addition, the women coordinator does not have a clear chain of command. The coordinator does not have direct communication with the director. Furthermore, the coordinator is half-time at the clinic and at the VISN level, this has put additional stress on the coordinator. When the women coordinator meets with other coordinators, most mention that their director’s do not acknowledge that the position exists.

**Patient Satisfaction**

The Nashville VAMC measures and manages patient satisfaction via SHEP scores and the Patient Advocate Tracking System (PATS). To ensure patient satisfaction, hourly rounds are conducted in the inpatient units. In addition, the facility ensures patient satisfaction by using PACT, Myhealthy Vet, and secure messaging. The customer service manager, executive leadership, managers and supervisors are responsible for patient satisfaction.

*Director of Patient Care Services*

The Director of Patient Care Services provides oversight and direction to ensure that veteran needs are met on their expectations and in a timely manner. This individual is also responsible for nursing staff indicators such as; courtesy, respect, noise level, privacy, responsiveness, and medication.

*Patient Advocate*

The purpose of the patient advocate is to liaison for veterans and families that have information needs, concerns, or complaints. The patient advocate receives training in customer service, service recovery, and national patient advocate program. When a patient advocate receives a complaint, the concern is entered into the Patient Advocate Tracking Systems (PATS). After the complaint is in the system, it is categorized by type of issue or information request.

*PACT Coordinator*

PACT coordinator has more than 50 teams in Tennessee, with 1200 patients per team. In reference to specialty care, primary care has a formal service agreement with specialty services. The facility has made improvements on primary care transition to specialty care, by ensuring pre-screenings are completed prior to a specialty care visit.

A challenge the PACT coordinator endures is space and how it constricts PACT by limiting staffing space.

*Recommendations*