**Southeast Louisiana Health Care System**

*New Orleans, Louisiana*

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**Background**

The Southeast Louisiana Health Care System (SLVHCS) consists of eight community based outpatient clinics (CBOCs) in New Orleans, Baton Rouge, Bogalusa, Franklin, Hammond, Slidell, St. John and Houma. After the New Orleans VA Medical Center was closed due to irreparable flooding damage from Hurricane Katrina, the SLVHCS opened five new CBOCs – New Orleans, Bogalusa, Hammond, Slidell, St. John. No inpatient services are provided since the closure of the VA Medical Center; however, the SLVHCS purchases non-VA inpatient care with Tulane Medical Center and other providers in the local community. The replacement New Orleans VA Medical Center is expected to be opened and start operations in August, 2016.

SLVHCS served 37,645 veterans in FY 2011, with 445,895 outpatient visits.  SLVHCS is concerned with the budget hiring and salary freezes along with the aging workforce (doctors and nurses) that will be retiring in a few years. The facility has received authorization to hire 17 Mental Health Full Time Employee Equivalent (FTEE). The facility is also a partner of the Community Workforce Coalition which will be assisting with recruitment of critical positions needed for the replacement VA Medical Center. The annual budget for Fiscal Year (FY) 2011 and FY 2012 is $314 million and $317 million respectively.

**Quality of Care**

The facility defines quality of care as a supporting VA’s core missions; recognizing current and emerging veteran needs; and aligning with Veterans Health Administration (VHA) strategic guidance, resource allocation, and associated VHA policy to produce optimized health care processes and outcomes through an organized and systematic approach to planning, delivery, measuring and improving care. SLVHCS measures quality though the measurement of clinical outcomes, performance measures, voice of the customer, peer review, accreditation reviews and direct observation of National Patient Safety Goal implementation. The facility manages quality through self-reporting, root cause analyses, systems redesign, implementation of patient centered care principles, and audit of patient records and continuous data streams.

SLVHCS demonstrates and maintains accountability for quality of care through a number of initiatives. Office of Quality, Safety and Value (OQSV) plans, directs, coordinates, and evaluates VHA’s national quality, safety, and value producing programs and approaches. The Secretary of Veterans Affairs (VA) approach to transparency has heightened the visibility of quality indicators and the OQSV displays data from the facility level to the national aggregate level on a website (ASPIRE) that is available to the public. Additionally, the facility holds monthly Quality of Care Committee (QCCC) meetings to address issues that require an in-depth discussion of details of clinical processes.

An Office of the Inspector General (OIG) conducted in April 2011 recommended the SLVHCS Hammond and Houma CBOCs develop a local policy for short-term fee basis. The facility leadership reported that a contract had been under development over the past year and would be finalized by the end of May 2012. The Joint Commission inspection in February 2011 made four recommendations for improvement which included: ambulatory health care – ensuring medications that were open were properly labeled; behavioral health care - psychiatric advance directive needed for patients with severe mental illness and no plan of care was documented for mental health program patients; and home care- evaluate effectiveness of emergency operations plan. The facility has addressed and made improvements in these areas.

Some of the challenges the facility addressed regarding quality of care is the number of measures that are being tracked and ensuring communication and coordination of quality of care is tracked by all employees. With the facility contracting out inpatient care, the facility strives to ensure that all of the veterans care and appointment information is sent back to be inputted into their VA medical record. A major challenge the facility had was that they did not receive their VISN Network Strategic Plan with quality of care measures until March of 2012, when it should be have sent at the beginning of the fiscal year in October 2011. Staff from the facility said it was difficult to plan what quality of care measures would be tracked when they received the plan during the middle of the fiscal year.

*Quality Manager*

The Quality Manager (QM) is responsible for ensuring all components of the QMS and patient safety improvement programs are integrated; ensuring a system for monitoring the quality data process is in place; serving as the quality consultant to leadership, Quality Improvement (QI) teams and employees; serving on the executive committees and workgroups where quality data is reviewed, analyzed and acted upon; oversees the functions of the following programs- accreditation, risk management, patient safety, systems redesign/performance improvement, and infection control.

The Quality of Care indicators and measurements are tracked and managed through reports from local patient care areas, VISN data warehouse reports and national data available to all on the Office of Quality Safety and Value website. SLVHCS trends their data and report it through weekly and monthly benchmark report in meetings with frontline staff; managers and executive leadership. Selected performance measures are used by the VISN and VA Central Office to compare their performance with other facilities, VISN and nationwide. SLVHCS has many quality of care committees such as: VISN Executive Leadership Committee; Quality of Care Committee; Executive Committee of the Medical Staff; Executive Leadership Board; Performance Improvement; Patient Safety and Systems Redesign Committee; Quality and Safety Nursing Council.

The Quality Manager suggested the need to continue to be proactive in preventing patient safety incidents at the facility by incorporating national and facility risk mapping initiatives into future hospital directives and procedures. Risk mapping is a continuous process that allows risk points to be identified in the facility ahead of time and ensure warm handoffs are in place to avert a potential crisis or incident. Another recommendation identified is that VA should improve on its succession planning to ensure an experienced leader retiring or leaving a position trains a new employee hired into a position to ensure continuity of job responsibilities and prevent loss of quality or critical job functions. The Quality Manager said that even though the facility is measuring hundreds of different quality of care data, there is always concern that not everything can be tracked and ensuring things that are unknown do not cause system or patient problems. Communication is an ongoing challenge to make sure every staff member is monitoring and ensuring quality of care on a daily basis. SLVHCS created a program called “huddles,” which is a short meeting within each department with all of the staff in the mornings and afternoons to discuss the plan of the day and review any cases requiring follow up action.

*Patient Safety Manager*

It is the responsibility of the SLVHCS Patient Safety Manager to develop, implement and maintain a Health Care System-wide Patient Safety Improvement Program that meets the requirements set forth in the Network Patient Safety Improvement Program, the VHA National Patient Safety Handbook, and the Joint Commission Patient Safety Standards. It is also the responsibility of the Patient Safety Manager to provide New Employee Orientation to all new employees relative to the information contained in Patient Safety policies. The Patient Safety Manager also manages any Root Cause Analyses conducted by the facility to address patient safety incidents and make recommendations for system improvements.

Patient safety as a healthcare system can be described as minimizing risk to patients by creating a culture of safety and by communicating lessons learned throughout the system. Some of the patient safety concerns at the facility included fall risk assessments, improved signage to prevent confusion with the multiple systems of clinics at SLVHCS.

*Utilization Management*

The Utilization Management (UM) Coordinator has responsibilities for ensuring quality of care and patient satisfaction, such as: assisting with the development of the section’s standard operating procedures, interpretation of Joint Commission Standards, VA/VHA policies and procedures/directives, VISN 16 directives and any federal regulation(s) governing health care to veterans, implement monitors in accordance with the aforementioned to track, trend, and report findings to designated committees for performance improvement, compiles the section’s annual and recurrent reports for utilization review and virtual inpatient program. The UM Coordinator received utilization review training for the implementation of InterQual Criteria, which is now used nationwide, and participates in monthly conference calls designates for utilization management for updates on the practices/policies/procedures. Measurement tools are used to evaluate the appropriateness, medical need, and efficiency of health care services to veterans in accordance with evidence-based criteria. Monitors are created and data collected and reported; trends identified are discussed and recommendations are given for process improvement. Patient surveys are devised and utilized to capture patient satisfaction of services received.

*Risk Manager*

The Risk Manager (RM) oversees the Risk Management Program, which consists of the following activities: administrative investigation boards, peer reviews, mortality reviews, fact finding investigations, administrative tort claims (malpractice claims) and adverse event disclosures. The RM is charged with systematically identifying, evaluating, reducing and/or eliminating, and monitoring the occurrence of adverse events and situations arising from operational activities and environmental conditions. The initial training that the RM received included all of the components of the RM program and ongoing training is held via monthly/quarterly RM conference calls and webinar topics. Measurement tools utilized by the RM are varied. Data is compiled, tracked and trended to identify any patterns and/or opportunities for improvement. Risk techniques are evaluated to ensure the best technique is being used to mitigate the problem. Continuous monitoring is done to ensure that the risk technique was the appropriate method to use in the particular situation. If monitoring reveals that a technique needs to be changed, necessary change is made.

*Systems Redesign Manager*

The facility won a VISN 16 Best Practice Bronze award for a systems redesign project focusing on timely tracking of non-VA care documentation. The Systems Redesign manager facilitates systems redesign projects. When a problem is identified and an improvement team is chartered, the manager works with the team to map the process and identify steps which can be improved and develop a plan and monitor results. The System Redesign Manager has received a number of Systems Redesign trainings and is yellow belt Six Sigma Lean certified and is presenting attending green belt training. VA has several databases which allow measurement of many different processes. SLVHCS utilizes DSS, the data warehouse, and many specially designed reports to measure quality of care and patient satisfaction.

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

The Chief Medical Information Officer creates, compiles and guides the review of every patient’s care benchmarked against the VA national set standards every month for all patients. Additionally, the chief medical officer works with clinical staff to improve their performance and deliver better patient care through the use of data. In addition to these responsibilities, the position co-chairs the Medical Records Committee to review appropriateness, timeliness, ease of use, for all the clinical reminders, CPRS notes and templates in the electronic medical record. Quality of care and patient satisfaction indicators are reviewed, tracked, trended, managed and discussed on a continuous basis. As soon as new data is available, the results are analyzed and communicated throughout the organization via a multitude of methods. SLVHCS has champions for each quality of care and patient satisfaction indicator whose responsibility is to lead the organization in constant improvement.

**Patient Satisfaction**

SLVHCS was selected as a center of excellence for patient centered care and is in the process of standing up an Office of Cultural Transformation, which will focus on patient centered care and system redesigns to streamline processes to achieve the perfect patient experience. The outcome of the project improved the continuity of the patients’ care. VA has enhanced the ICARE initiative and SLVHCS has begun the Affirming the Commitment program that asks all hospital employees to reaffirm their commitment to patient centered care for veterans.

Patient Satisfaction is measured through weekly comment cards and SHEP surveys. The results of both of these measurements are reported monthly to SLVHCS executive leadership and service chiefs to target trends and any possible process improvement initiatives. On the last Survey Health Care Experiences (SHEP) performance scores as of the first quarter of FY 2012, SLVHCS declined in two areas- getting care quickly and pharmacy mailed program.

SLVHCS stated that with the Patient Aligned Care Team (PACT) implementation, veterans have had increased and open access to primary care. However, the challenge with getting care quickly is mostly related to specialty care such as within orthopedics and urology. The facility has begun adjusting patient care hours and examining specialty care provider schedules to ensure veterans are provided timelier care. The facility is also emphasizing greater use of telehealth programs an and initiatives. The facility implemented a veteran education program for the mailed prescription process and edited the pharmacy telephone script to simplify ordering as well as further promotion of myhealthEvet for ordering medications. Another concern identified by the facility is the delay in receiving the results of the SHEP data, which is six months old when it is released. A best practice that the facility has implemented since the SHEP data is not current is printed “Comment Cards.” These comment cards are filled out by patients throughout the hospital and compiled weekly to be addressed by the leadership meeting on Fridays through a program called “Board on Boards.” Each individual comment card is read the results are tracked by service line and subsequent improvements or changes are addressed in response to the inquiry, concern or positive experience.

*Director of Patient Care Services*

At SLVHCS, the Associate Director, Patient/Nursing Services is a member of the leadership executive team and participates in the strategic planning as well as day to day functions of the health care system. The Nurse Executive provides oversight of the professional standards of clinical services that support patient care, social workers and dieticians. The Director of Patient Care Services serves as chairperson for the Patient and Family Centered Care Committee, ensures employees are trained to meet the expectations of patients and family members, maintains the operation budget, oversees all nursing care, inpatient and outpatient, and managing the Sterile Processing Services.

Patient satisfaction indicators and measurements are tracked and managed by two different ways, in-patient and out-patient through communication with nursing and evaluations of how well the nurses and doctor communicate to the patients.

*Patient Advocate/ Patient Care Coordinator*

The Patient Advocates duties are to facilitate patient concerns and mitigate any road blocks that veterans experience in receiving proper and timely care. Patient satisfaction indicators and measurements are tracked through surveys and phone calls. Trends are managed directly within each service area when reported. The Patient Advocates are responsible for tracking all satisfaction measures captured in the nine SHEP outpatient performance measures. In addition to tracking all measures, they are also responsible for disseminating information, working with staff on corrective action plans, and bringing it forward if action plans are not working. Surveys are conducted on a daily and monthly basis through SLVHCS comment cards and SHEP. In the two executive career field performance areas emphasized by VA, SLVHCS trends higher than their peers for how well doctors and nurses communicate and slightly lower on their peer index in overall rating of health care categories.

The Patient Advocates received one 40 hour VISN training program for new patient advocates, which is conducted regionally. There are monthly training calls conducted by the VISN to discuss performance measures and emerging trends in customer service. The facility has a seven-day policy concerning congressional responses and a seven-day policy for complaints filed directly by patients.

One of the concerns identified by the Patient Advocates was the shortage of staff and delays veterans experience with the laboratory. Other concerns that have been brought to the Patient Advocates from veterans includes: billing, patient care, provider wait times, coordination of care for fee basis appointments and the mail out pharmacy program.

*Patient Aligned Care Team (PACT) Coordinator*

The PACT Coordinator at the facility involves strategically coordinating the conversion of each CBOC from the traditional patient care model to the PACT Model of Care. This involves setting up the operational structure (administratively and clinically), providing staff education and training, educating patients and other internal/external customers. This role includes tracking and trending PACT performance measures at the CBOC level and at the team level. The PACT coordinator prepares briefing reports to the leadership and coordinating local participation in National and VISN Collaborative and other projects. The PACT Steering Committee meets weekly and provides updates to the executive leadership twice a month. The veterans community is involved in the PACT planning process through committee membership and focused surveys. Throughout implementation, veteran feedback was sought through the VA Voluntary Service meetings as well as speaking with patients using the clinic.

*Town Hall Meeting*

The System Worth Saving Task Force held a Town Hall meeting at The American Legion Post 175 in Metairie LA on May 20, 2012. Approximately 15 veterans attended the town hall meeting. Some of the concerns identified included: VA only seeing patients one a year for primary care, ensuring adequate funding for the new medical center, specialty care/fee basis delays, having a single point of contact for the PACT and third party billing procedures with Tulane Medical Center. All of these issues and concerns were addressed during the site visit.

**Recommendations**

VA Central Office and VISNs ensure that the VISN Network Strategic Plan with quality of care measures is distributed at the beginning of the fiscal year to all of the facilities to ensure the facility can plan to track which quality of care measures are selected during the fiscal year.

VA Central Office should explore programs and training to incorporate national and facility risk mapping initiatives into future hospital directives and procedures. Risk mapping is a continuous process that allows risk points to be identified in the facility ahead of time and ensure warm handoffs are in place to avert a potential crisis or incident

VA Central Office and VISNs should establish an online weekly survey mechanism, throughout the facility, to assess patient satisfaction and feedback from patients and can help improve facility programs and patient care, since the SHEP data is 3-6 months old.

VA should improve on its succession planning to ensure an experienced leader retiring or leaving a position trains a new employee hired into a position to ensure continuity of job responsibilities and prevent loss of quality or critical job functions.

The facility should create a map of the SLVHCS clinics and street/building locations of clinics, pharmacy and other critical outpatient services, in the absence of having a full hospital, so veterans understand where they can receive services and assistance.