**Veteran Affairs St. Louis Healthcare System, John Cochran Division| St. Louis, Missouri**

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**Background**

The John Cochran Division, named after the late Missouri congressman, is located in midtown St. Louis and has all of the medical center's operative surgical capabilities, the ambulatory care unit, intensive care units, outpatient psychiatry clinics, and expanded laboratory. Currently, the facility has up to four beds in inpatient room, but there are plans for constructing a bed tower that will have one bed per room. The St. Louis VAMC staff is made up of 35 percent veterans. The medical facility’s budget for 2011 was $393,698,897 million and $393,147,914 million in 2012.

**Quality of Care**

The VA St. Louis Healthcare System defines quality as providing a safe and effective care in a timely manner that meets and exceeds veteran expectations. To measure and manage quality, the manager participates in peer reviews, action reviews, veteran satisfaction surveys, and active surveillance of health care.

The St. Louis VAMC maintains accountability through their commitment to veterans. The medical center has an internal executive board that reviews and monitors performance measures and action plans. Performance measures are compared to local community hospitals and other VA facilities.

Quality of care employees receive new employee orientation and Yellow Belt Lean training, which lasts three days. Currently, the facility has 98 LPN’s, 101 NA’s, and 493 RN’s, which has been a safe staff to patient ratio. Patient involvement has been encouraged through Veteran Service Officers meetings and focus groups.

A challenge the executive leadership endures is recruitment, especially in nursing and erasing the stigma of working at the St. Louis VAMC. Currently, 24 percent of staff positions are empty and when hired, there is a 10 percent turnover rate. In addition, the St. Louis VAMC has a 12 million dollar deficit.

*Quality Manager*

The quality manager ensures that the quality management system and patient safety improvement program are properly integrated. This individual also serves on the executive committees for quality data to be reviewed and analyzed. In addition, the quality manager provides education, facilitation, and support to employees to ensure there is an effective program in place.

The quality manager is in charge of both John Cochran and Jefferson Barracks; and four CBOCs. There has been a challenge for the quality manager in having enough operational inpatient beds. Currently, there are 109 inpatient beds, but a patient may have to wait an average of 12 hours. Another challenge has been patient infections, not because of hospital mishaps, but from the surrounding communities. As of 2012, the local communities have an infection rate of 28 percent Methicillin Resistant Staphylococcus Aureus rate.

*Patient Safety Officer*

The patient safety manager performs and supports RCA activities by acting as a advisor to the training groups. This individual assists in meeting the requirements recommended from Joint Commission patient safety goals and standards. OIG and JC requirements include participation in surveys, assessments, and reviews. The patient safety officer acts as a liaison between the quality manager and the Joint Commission, by responding to RCA inquiries.

The VA medical center has an adverse event reporting system for reporting patient incidents, or staff safety issues. The reporting system is located on the St. Louis VAMC webpage and is an electronic form. In the event of a high risk issue, the topic is sent to the executive leadership immediately, or brought up during the morning report. From April 7, 2011 to April 1, 2012, the facility conducted 14 RCA’s.

*Utilization Manager*

Utilization management is an integrated program that promotes incorporation of utilization management into daily patient care activities. The utilization manager assists the facility in approving patient care efficiency and monitors health care resources. Finally, the utilization manager evaluates if a patient is receiving the correct amount of care based on VA directives.

The utilization management team is understaffed, which has hindered their ability to review patient care.

*Risk Manager*

The risk manager monitors and evaluates potentially harmful events that may impact the quality of care of veterans. For instance, if a patient is readmitted within 10 days, a red flag is shown and the case is reviewed to understand why the patient was readmitted. Recently, the risk manager changed the discharge template, which will give patients their next appointment rather than receiving a phone call weeks later. Furthermore, veterans have acknowledged that prescription literature is sometimes hard to read, therefore the risk manager made it mandatory to have it read to patients prior to their departure.

*System Redesign*

The system redesign manager directs and coordinates the administrative, operational, and planning activities. Some of all the planning includes advanced access to all clinics and performance improvement activities. This individual ensures alignment of system redesign objectives are aligned with VISN and national objectives.

A recent project the system redesign manager created was a recruitment initiative. The system redesign team reviews the job announcement from beginning to end and tries to lower recruitment time. This is accomplished by extracting useless processes within the recruitment process. Once the processes are found, best practices are shared throughout the VISN and other VA facilities.

*Chief Medical Officer*

The chief health medical information officer ensures health information systems supports the care and services to improve care through reporting clinical information. Patient records are used to identify health informatics needs. Afterwards, there are committee meetings where patient issues are gathered to limit mistakes.

The chief medical officer would like to have an integrated database system between the DoD and the VA. The database would have all the ships, campaigns, and conflicts, which would list all service members involved.

*Women Coordinator*

The women’s clinic provides comprehensive primary care, but prenatal and maternity care are fee-based. It is a separate clinic within the VA medical center. The women’s coordinator has a women veteran health committee in place, which includes staff, but veterans are not included. The clinic incorporates PACT, part-time GYN, and a social worker.

**Patient Satisfaction**

The John Cochran VAMC defines patient satisfaction as provision of veteran centric care treatment and service that demonstrates our values of integrity, commitment, advocacy, respect, and excellence. Patient satisfaction is measured by SHEP data, once analyzed and graphed it is benchmarked against the national percentage. The tools used to track patient satisfaction are quick cards, national Survey Healthcare Experiences of Patient (SHEP) surveys, executive staff, and patient satisfaction. Currently, SHEP outpatient indicators have shown slow improvement, but in patient indicators remained the same.

The quick cards are available in each department, the cards are collected and reviewed every two weeks. The information is inputted into a share site that allows departments to review feedback of veterans. The concerns are addressed immediately by the appropriate staff and leadership. The staff that works specifically with patient satisfaction initiatives are patient advocates, service chiefs, education specialists, and all performance improvement teams.

*Director of Patient Care Services*

The director of patient care services provides oversight and direction to ensure veteran needs are met. This individual is also in charge of planning and veteran education in a way for the patient to understand. Furthermore, the director of patient care services meets with veterans and their families to understand and improve their overall health.

*Patient Advocate*

The purpose of the patient advocate is to serve as an interface for veterans and their families that have information needs, concerns, or compliments. Currently, there are four patient advocates at the St. Louis VAMC and each of them receives 18 incident reports per day. Each incident is given to the original staff involved and all communications is sent to the patient advocate. When a patient advocate receives a complaint, the concern should be resolved in 24hrs, or 72hrs at the latest and a seven day period to complete an incident report. If the veteran does not agree with the decision, he or she may meet with the director to discuss their concerns. The complaint is sent to the director, it is the director’s discretion if the issue is sent to the VISN level.

*PACT Coordinator*

The PACT coordinator is currently acting as the associate chief nurse, which educates, manages, and supervises the nursing staff assigned to PACT. The PACT model puts the veteran in the center of their care, therefore the PACT team coordinates focus groups to listen to their concerns and input. The facility’s current PACT model has a three support staff per primary care ratio. Currently, the there are 44 PACT teams with 1200 veterans per team and a total of 7,000 veterans served.

The PACT team ensures the patient receives specialty care by meeting a service agreement with specialty care providers. The service agreement lists all the requirements necessary prior to being seen with a specialty care provider. The agreement limits the possibility of the patient being sent back to the primary care provider for prerequisite procedures. The PACT team coordinator sends out a survey to all CBOCs and clinics for patient feedback. A recent survey stressed the problem of PACT teams not giving clear instructions to patients, which has lowered patient satisfaction with their teams.

The PACT team endures a few challenges such as a need for 15 licensed practical nurse (LPN) and 12 clerical staff.

**Town Hall Meeting**

The town hall meeting was located at Post 397 in St. Louis Missouri and had 17 veterans in attendance. Veterans expressed their thoughts of the St. Louis VAMC, which had a mixture of both positive and negative comments. Veterans stressed that 95 percent of hospital staff were courteous and the hospital is vital to the veteran community. Some veterans explained that it took over a year for some to receive a VA card.

In addition, most of the doctors are from India and other ethnicities, this has created complications with patients because of the accent barrier. Customer service has been a problem in the past, a nurse once told a veteran, “If your going to bark like a dog, then your going to be treated like a dog.” Furthermore, veterans stressed that the nursing staff seemed under staffed and are not able to keep up with veteran demand.

*Recommendations*