

A System Worth Saving:

Examination of Quality Measurement in the VHA and
Civilian Hospital Systems, 2012-2013

A Report to the American Legion

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I. Executive Summary and Recommendations

Efforts to measure of the quality of care in the institutional health field have accelerated sharply since the 1998 Institute of Medicine Study showed 49,000 to 98,000 unnecessary deaths each year in American hospitals.

The Veterans Health Administration (VHA), likewise, has dramatically increased efforts involved in attempting to improve the quality of VHA medical center services. These efforts stem primarily from the leadership and effort of Dr. Kenneth Kizer, his colleagues in the VHA and VA, and have been documented extensively (see Longman and others in the bibliography appended to this report).

More recently, the American Legion has begun an effort (“System Worth Saving”) to provide national patient (Veteran)-oriented oversight of VHA quality improvement efforts. This effort takes place through extensive pre-visit and visitation questionnaires, and personal meetings of Legion and VHA leaders. See the web site, <http://vhahospitalqualitystudy.org/> for a complete set of pre-visit and visitation questionnaire results from the 25 medical centers visited by Legion leaders in 2012.

Now the Legion has expressed interest in this comparison: measurement of quality in the VHA system (153 medical centers, see Exhibit A to this report), and measurement of quality in the civilian hospital system (over 4,000 non-governmental hospitals).

Attempts to measure quality in the civilian hospital system center around the “Hospital Compare” activity of the Centers for Medicare and Medicaid Services (CMS), the governmental agency responsible for establishing the rules and reimbursement through which hospitals participate in the Medicare and (with the states) Medicaid programs. Hospital Compare data has been used by HealthGrades, Leapfrog, U.S. News and World Report, Consumer Reports and other commercial and non-profit agencies to “grade” quality of care in the civilian hospital system. In addition, “reputational” surveys (especially in the U.S. News ratings) heavily influence some of these “grades” for community hospitals.

The VHA has adopted many of the tools also used in the community hospital quality assurance system, including accreditation of medical centers by The Joint Commission, adoption or adopted variations on the National Patient Safety Goals and participation by some of the medical centers in a VHA variant of the Hospital Compare program.

How do the VHA medical centers “stack up” in a comparison of the Hospital Compare surveys? What additions or changes should be made to the quality assurance measurements and metrics of the VHA system? Those are the subjects of this report.

Beyond metrics—which have proven, to date, unsatisfactory as complete measures or guarantors of quality—is personal, individual and subjective attention to the work of the VHA medical centers. This paper demonstrates that the System Worth Saving effort has positioned the American Legion as a national “Board of Visitors” for the VHA medical centers, an unprecedented attempt to provide consumer-patient-Veteran perspective in the quality assurance work of the nation’s largest integrated health system.

These recommendations come from review of the American Legion surveys (available on a companion website to this report, and summarized in exhibit 4).

Recommendation: Reports from task force members, after review by the individual medical center chief executive, should be offered to the VHA for “posting” online, together with other patient safety and quality reports for the individual centers. The appearance of American Legion-sponsored interviews and conclusions would add “consumer” and “board of visitor”-type credibility to VHA organizational reports. In addition, it might have the same impact as the public reporting (US News, Consumer Reports, Leapfrog and others) in the private sector, namely, rewarding the attention of executives in the VHA system on patient safety and quality assurance.

Recommendation: That the Legion and VHA leadership encourage VHA medical centers to participate in the HCAHPS reports, given (1) the importance of demonstrating the value of VHA services, (2) the relative numeric weight of over 4,000 hospitals participating in

HCAHPS, compared to 153 medical centers participating in SHEP, and (3) the increased information which would inure to the VHA system for internal management purposes.

Recommendation: The VA should do everything possible to avoid emulating the adverse consequences of the linkage of “pay for performance” which is the theory behind private sector reporting, and which is proving to have results and consequences the very opposite of those intended.

Recommendation: That the VHA system examine outpatient “metrics” which might be used to compare performance of the VHA outpatient services with those of the civilian hospital population.

II. Introduction and Background of this Study

The purpose of this study - - not an academic or clinical review - - is to assist the Legion in its assessment of the quality of care measures utilized, and outcomes achieved, in both VHA (Veterans Health Administration) medical centers (hospitals) and private hospitals.

In this endeavor, we have developed a “side-by-side” comparison. Moreover, we have analyzed the results of the implementation of these standards in the VHA and private medical centers.

Finally, we have made recommendations for quality measurement, derived from the VHA and private sector, for implementation in the VHA system, with the goal of improving the quality of service provided to the U.S. Veteran.

Quality, Measurement and Controversy

Measuring the “quality” of services delivered by hospitals and health systems is an area of active development, generally, aside from the application of such measures in the Veterans Health Administration.

Since 1998, with publication of “Too Err is Human,” quality has become a top issue, including (1) development of numerous scales and ratings, many of them unduly skewed toward institutional promotion, (2) continued attempts by academics and study groups to turn such efforts toward outcome measurements, and (3) attempts by parties who pay for care to link that payment to quality measurements, however accepted or flawed those measurements are perceived as being.

Recently, for example, the Centers for Medicare and Medicaid Services added “relative” safety performance measurements to the Hospital Compare website. However, the addition of this information has been protested by The Joint Commission and by industry groups, on grounds that it is based on claims data, not clinical data.

Dr. Patrick Conway, Chief Medical Officer at CMS, Director of CMS's Office of Clinical Standards and Quality, has defended the CMS decision, on grounds that it represents the data which is available. The recent publication follows issuance in March 2012 of a hospital-by-hospital comparison of "hospital acquired conditions (AHCs)," in comparison to "expected" rates for each.

The Joint Commission itself, in its recent annual report, and for the first time in the issuance of these annual reports, identified the "top" (405 out of approximately 4,800) acute general care hospitals in the country.

In part, the arguments are technical. Measurement of hospital acquired conditions are based on secondary diagnoses coded for billing purposes, which may be subject to variability not only in the incidence and prevalence of the condition, but in the coding. Also at issue is adjustment for relative risk factors, in the addition of new mortality measures. However, the risk standardized mortality measures appear to have some academic backing. Thirty day mortality measures, for example, were compared to medical record-based models, and were found to be highly correlated.

The relevance of each of these measures to the quality performance in the VHA System will depend upon the origin, integrity and interpretation of data. While this report will attempt to concentrate on structure (issues influencing quality), process (work flow and process issues) and outcome (as measured), it will also attempt to provide, at a minimum, a "checklist" for quality measures, based on objectivity (to subjectivity), integrity and reproducibility (compared to anecdotal), and pertinence (or relevance of the information to the patient's outcome).

The challenges facing the VHA are significantly greater than any faced in the past. In their book, "The Three Trillion Dollar War," Nobel Prize winner Joseph Stiglitz and Harvard Professor Linda Bilmes noted that nearly one in two returning troops suffered from a disability, from depression to multiple amputations.¹ They note that the number of Iraq and Afghanistan Veterans receiving government medical care has grown to more than 800,000, and that most have applied for permanent disability benefits. They indicate that the VA's budget is likely to hit \$140 billion this year [2013], nearly triple its budget of 2001. Moreover, the bill for benefits, at least based on past wars, comes due decades later, with the peak year for Second World War benefits 1969. They think the eventual cost of caring for Veterans of the Afghanistan war will exceed \$1 trillion.

¹ Stiglitz, J. and Bilmes, L, "There will be no peace dividend after Afghanistan," *Financial Times*, January 24, 2013, page 11

They note that “Spending on Tricare, the healthcare programme for the US military and their families, is likely to reach \$56bn this year. Tricare is growing even faster than Medicare or Medicaid, and will soon consume 10 per cent of the defence budget.”

Hence, any comment on or analysis of quality and value in the VHA system should take in mind the enormous challenges, as well as those coming, to the financial integrity of the system (adequacy of facilities, number of personnel, the extraordinary costs to be met.)

The Difficulty of Measuring Quality and Other Parameters of Medical Care

Attempts to look more broadly at the interrelationship of quality and other important variables in hospital performance² have also proven difficult and inconclusive. The modern era (beginning with Archie Cochrane and carrying through the work of the Cochrane Collaboration) has attempted to assess the performance of hospitals across the dimensions of efficiency, effectiveness and equity. Effectiveness, in turn, means “quality” and “safety.”

Davis attempted to develop a “balanced scorecard” across these dimensions for the period 2001 – 2009 and found that “There is little consistency across dimensions.” For any given hospital amongst the thirty-five Davis studied, there was little consistent ranking in the dimensions of efficiency, effectiveness and equity. So “conceptual correlation” - - having the appropriate aspects of hospital care - - have proven as yet difficult to measure with any confidence.

“Quality” Comparison Compromised by “Cost Containment” Issues

Finally, even within the civilian hospital world quality comparisons will be skewed, to the extent they are based on the Centers for Medicare and Medicaid Services Value-Based Purchasing, readmission or other incentive and penalty programs.

² Davis, Peter, “Assessing Hospital Performance in Three Dimensions,” Presentation CUMC, Mailman School, January 30, 2013

CMS, in its role as overseer of direct payments for the Medicare program, and “influencer” of payments under the state-federal Medicaid programs as well as many of the private health insurance programs, needs to “save” approximately \$716 billion over the next decade, that is, it needs to spend that much less than otherwise would have been spent, given normal medical inflation trends.³ These “savings” or reduced expenditures, in turn, are a “source” for the expansion of benefits, in expanded Medicaid programs and through subsidization of the purchase of health insurance by individuals or small businesses in state or federally-sponsored health exchanges (now “marketplaces”). In other words, CMS needs to take some money - - \$716 billion - - out of one pocket (ordinarily projected increases in spending on providers and Advantage plans) - - and put it in another (the extension of benefits to those currently uninsured). To that end, CMS has developed a variety of tools which are, roughly summarized, applied behavioral economics, “nudging” providers toward desired behavior.

Among these tools is the Value-Based Purchasing program, which is 70% dependent on “process” questions. These questions include: timely and effective care; readmissions, complications and deaths; patient survey results; and use of medical imaging.

Under timely and effective care, in turn, there is timely heart attack care, effective heart attack care, effective heart failure care, timely pneumonia care, effective pneumonia care, timely surgical care, and effective surgical care, effective children’s asthma care, timely emergency department care, and preventive care.

Each one of these, in turn, involves subcategories. To name just one, the timely heart attack care includes the average number of minutes before outpatients with chest pain or possible heart attack who need specialized care were transferred to another hospital; the average number of minutes before outpatients with chest pain or possible heart attack got an EKG; outpatients with chest pain or possible heart attack who got drugs to break up blood clots within thirty minutes of arrival; outpatients with chest pain or possible heart attack who got aspirin within 24 hours of arrival; heart attack patients given fibrinolytic medication within thirty minutes of arrival; heart attack patients given PCI (percutaneous coronary intervention) within ninety minutes of arrival.

³ Congressional Budget Office Report, July

The other 30% of the Value-Based Purchasing is dependent upon the HCAHPS program, that is, on surveys of discharged patients. The HCAHPS program asks questions like whether patients reported that their nurses or doctors always communicated well, that they received help when they needed it, that their pain was well controlled, that their medicines were explained, that their room and bathroom were clean, that the area around their room was quiet at night, that they were given information on what to do during recovery at home, and whether or not they would recommend their hospital to others. These are the main categories for the HCAHPS portion of the Hospital Compare project.

Together, the 70% process measures and 30% HCAHPS patient survey constitute a reward or punishment system under Medicare which, for example, in 2013, could be as much as a 1% increase in total Medicare reimbursement or, in the alternative, as much as a 1% decrease.

Also included in the initiatives of CMS - - again, under the general rubric of behavioral economics, that is, attempting to push or pull providers toward more cost effective, economical “quality” oriented behavior -- is a financial penalty for what CMS believes to be avoidable readmissions of patients to hospitals from which they have only recently been discharged. In 2013, the penalty is up to 1% of Medicare reimbursement for readmission (within 30 days) of patients who were discharged with a diagnosis of congestive heart failure, myocardial infarction or pneumonia. (There is no “bonus” for very low levels of readmission.)

Parenthetically, continued research in this area casts doubt on the likelihood that the readmission penalty has any direct relationship to the quality of medical care. For example, Krumholz has recently shown that the overwhelming majority of readmissions of patients who have been discharged with these diagnoses are not directly related to those diagnoses.⁴ In other words, the hypothesis - - that the patient was “pushed out” of the hospital too quickly - - is not sustained on examination of the evidence. To the contrary, Krumholz postulates the existence of a general level of deterioration on the part of recently hospitalized patients, such that the most likely indicator for admission of a patient to a hospital is in fact a recent discharge. In other words, civilian hospitals will be penalized under the “Readmission Penalties” for reasons that have nothing to do with the quality of care which they delivered to the patient, but, to the contrary, which have everything to do with the general overall condition of the patient, and the likelihood that one or another additional malady will lead to that patient’s hospitalization (or “re-hospitalization” if within thirty

⁴ Krumholz, Harlan, “Post-Hospital Syndrome – An Acquired, Transient Condition of Generalized Risk,” *NEJM*, 368;2, January 10, 2013

days). In addition, Krumholz points out the obvious, which is that there is nothing magic about thirty days, that is, there is nothing that indicates quality or lack of quality or compromised quality or high quality in the thirty day bar; it merely indicates a regulatory rule, imposed as part of a much larger, global approach to cost containment, which is free of evidentiary support. Finally, others have pointed out that the hospitals which do best on this readmission measure are those whose patients have died during hospitalization, and, thereafter, will never be readmitted (!).

All of this - - the Value-Based Purchasing bonus and penalty, and the readmission penalty - - was the subject of an initial report in December (CMS, 12-20-2012, publication of results for 3,429 hospitals) which ranked the hospitals from top to bottom, that is, from the high reward to the high penalty, and from zero penalty for readmission to maximum penalty for readmission. In theory, one could see which were the “best” and “worst” hospitals in the nation. Of course, that previous statement isn’t really true: all you could see from this list was what was measured, and what was measured had no basis in evidence that it would ultimately influence patient outcomes. Embarrassingly for CMS, eight of the “top ten” hospitals in the nation turned out to be physician owned, a category of hospital ownership outlawed by another section (6001) of the statute (Patient Protection and Affordable Care Act) which also calls for the “quality” measures..

Here, then, is the central problem facing the VA System in the adoption of CMS measurement techniques: CMS has an agenda. That agenda is to impose penalties (or rewards) on hospitals that use (in CMS’s judgment) the right amount (for rewards) or too many (for penalties) resources in the care of patients. CMS is driven to develop, implement and maintain these “penalties” (and rewards) by the necessity to extract the \$716 billion from what would otherwise have been governmentally sponsored and paid for health insurance benefits over the decade 2012 – 2022. Much attention has been focused on the achievement of the goals and sub-goals of that overall agenda (meaningful use for electronic medical records, for example), but little if any attention on the relationship between the outcomes for patients and the achievement of these various goals. These measures all embody interesting hypotheses, which would, in the course of orthodox clinical research, be demonstrated in different settings over different times and conditions by different researchers, perhaps even by the “gold standard” of research, namely a randomized clinical trial. In the absence of evidence, however, they are merely hypotheses which - - under the lash of economic necessity - - CMS has made requirements.

In summary, CMS is caught in a bind, having to save money, and to apply tools to that end, which tools, however, despite their label of “quality” rewards or penalties, have no demonstrable relationship to patient **outcomes**--the aspect of “quality” with which we are most concerned. To reprise Donabedian, process, structure and outcome are the areas of our focus, but outcome (that is, “How did the patient do?”) is the only important one, and of course the most important one to the Veteran and those supporting and sponsoring health services for the Veteran. Therefore, in the long run, CMS has less to offer than might originally meet the eye. However, as will be discussed below, the various commercial alternatives (Consumer Reports, Leapfrog, HealthGrades, state-level report cards, US News) offer even less, as they have been configured either in the interest of particular sub-agendas of their sponsors (Leapfrog), or have casually adopted CMS’s methodology without demonstrating and understanding of its limitations (Consumer Reports), or are plainly based on reputation (“eminence”-based ratings, such as US News).

The Difficulty of Measuring Quality With International Standards and Comparisons

Moreover, international comparisons have also proven extremely difficult. Burnett et al⁵ report a study pursuant to a 2011 European Union directive which “places a requirement on all member states to provide patients with comparable information on health-care quality, so that they can make an informed choice.” This group studied outcome indicators and common processes for quality and safety in England, Portugal, The Netherlands, Sweden and Norway. They found that, given current tools, neither government nor patients can “make informed choices” and “will remain in the dark” concerning comparability and safety issues. Among the challenges: different indicators, different definitions for the same indicators, differing mandatory vs. voluntary data collection requirements, different types of organizations involved in data collection, different levels of aggregation of data, different levels of public access and, finally, different accreditation and licensing systems.

In summary, the measurement of quality has proven difficult, as between the various commercial and governmentally-sponsored systems in the U.S. Attempts to correlate “quality” with efficiency and equity issues have yielded little by way of results. Cross-national or international comparisons have obstacles, of the types described. It would appear that the VA System might be best served by concentrating on its internal

⁵ Burnett, et al, “*Prospects for Comparing European Hospitals in Terms of Quality and Safety: Lessons from a Comparative Study in Five Countries*,” International Journal for Quality in Healthcare, January 4, 2013

quality improvement mechanisms, and its responsiveness to the individual Veteran, rather than by rearranging or attempting to conform its quality reporting and quality improvement means to fit imperfect and developing models.

III. The VHA System

America's Largest Integrated System

The Veterans Health Administration (VHA) is America's largest "integrated" (hospitals and doctors part of the same system) health network, with 153 medical centers, over 800 community-based clinics and tens of thousands of dedicated health professionals. As a public (tax dollar) sponsored organization, the VHA is accountable to Congress (from whom authority for the expenditure of funds originates), the administration and of course to the hundreds of thousands of Veterans who have benefited from its services.

The VHA has been likened to the national health system in the United Kingdom and to the Kaiser Health system in the United States, both (largely) integrated (the former publicly supported, the latter privately). Students of health policy and management have discussed (see Bibliography) patient safety, risk reduction and quality assurance in both systems, the backdrop being comparisons of public and private management.

This paper attempts to outline the means through which the VHA assesses quality in its own system, comparing those means to those which are available in the private (civilian) hospital sector, with recommendations for further development.

While the VHA remains our largest single system, its size (153 medical centers) is dwarfed by the approximately 4,800 acute inpatient general care hospitals also serving the American public. The lessons and experience from the latter are no doubt of use in the former, just as the pioneering efforts of the VHA (for example in the development of automated health care information reporting systems) have been useful worldwide. Steps taken to make outcomes (especially in risk reduction and quality improvement) more nearly comparable can only help in this cross-fertilization. At each point in this report, recommendations are made based on the findings of the "System Worth Saving" task force of the American Legion, and observations of this report's author.

Background, Quality in the VHA

In general, the history of measuring quality in the VA System has been one of “good news” for Veterans. For example, many of the leading organizations in health services research have looked to the VA System. The Rand Corporation has done a number of studies. An independent author (Phillip Longman) has written three editions of the same book, examining quality in the system. More than seventy-five individual quality assurance studies (see Bibliography) have been undertaken. The Joint Commission (formerly known as the Joint Commission on Accreditation of Healthcare Organizations, or JCAHO) has checked in, finding 17 of the nation’s top hospitals to be VA medical centers. HCAHPS (the CMS program inquiring about patient experiences) has studied the VA. AHRQ, the Agency for Healthcare Research and Quality has also checked in.

The Rand Corporation found that VA patients were more likely to receive recommended care than were patients in a national sample of hospitals. Based on their definition of “quality” indicators, quality of care was better for VA patients in all measures except in acute care, where they were equivalent.

Other researchers have had a consistent message. When compared, VA results are superior to those in the general population. In comparing “insurance” type programs, VA results are superior to those in the Medicare Advantage program.

Finally, AHRQ sponsors the Patient Safety Improvement Corp jointly with the VA. This means that the nation’s primary “quality and value” enterprise (AHRQ) is intimately involved in VA activities. One area of focus is validation of patient safety indicators, for example, surgical site infection risk.

In sum, quality in the VA System has been shown in the studies cited to be at least the equivalent of and in many cases superior to that available in the civilian system. However, cost pressures bear down on both civilian and Veteran care. Those aspects of quality that are measured in the civilian system do not always pertain to the “patient experience” - - in this case, what the Veteran perceives to be quality. Many are aimed,

especially after passage of the Patient Protection and Affordable Care Act, at reducing Medicare and Medicaid expenditures, under the “banner” of quality improvement.

Comparison of Civilian and VHA Hospitals and Medical Centers

There is overlap between civilian and VA systems sufficient to enable comparison, where appropriate. The two most important overlaps are in the survey and accreditation of individual medical centers by The Joint Commission, finding, as noted, 17 of the top 405 hospitals (out of approximately 4,800) to be VHA medical centers. The other area, HCAHPS, has, as noted above, an “agenda,” but is still potentially useful. Further comparisons will encounter these problems: that the services in civilian and Veteran hospitals are not necessarily familiar; the long-term rehabilitation of the Veteran requires lengths of stay and coordination not generally found in the civilian population system; and “quality” issues in the VHA system tend to be defined as “patient experience” issues - - how long did I have to wait, how far did I have to travel, what kind of coordination took place in my care, what was my out of pocket payment . These are the important questions, rather than the “cost containment” quality indicators in the civilian system.

In short, there is enough basis for comparison currently between VA and civilian hospitals, if the individual VHA medical centers choose to take advantage of it through TJC and HCAHPS. Moreover, there is no evidence that any additional requirements for “measuring quality” would benefit or enlighten the patients.

Future Challenges

The challenges for the future are clear. There will be increased complexity in obtaining medical care. This complexity will be the result of powerful social and economic forces seeking to extend benefits to the uninsured, but, in the process, reconfiguring all of medical care. Insurance companies, highly dependent upon profit from Medicare Advantage programs, will seek to extend those programs to cover more Veterans; it is

unclear whether there will be a path toward payment from such Medicare Advantage programs to VHA medical centers, should the Veteran choose the VHA medical center for “private” health services.

Overall, costs will be the issue, or, rather, preservation of quality in the face of cost pressures will be the issue.

IV. The Modern History of Quality Improvement and Patient Risk Reduction Efforts in Civilian Hospitals

The modern history of efforts to reduce patient safety problems in hospitals (initially inpatient, later outpatient) begins roughly with the Institute of Medicine (IOM) report “To Err is Human” in 1998. The then controversial estimate of 49,000 to 98,000 unnecessary deaths in American hospitals each year was an alarming figure. The Centers for Medicare and Medicaid Services (CMS) in the public sector and a variety of efforts in the private and for-profit sector (The Joint Commission, the Institute for Healthcare Improvement, Leapfrog, Consumer Reports, U.S. News, and others derivative from CMS efforts) focused initially on high profile incidents (“sentinel” and “never” events), later on mathematical indices of quality improvement.

In general, so called high profile investigations of adverse events and hospital safety problems (see, for example, Lavery) do not prompt patients to change providers. Most patients are dependent upon limited (and opaque) sources of information and anecdotal referral, rather than such high profile investigations to alter their habits.

Further, however, the public reporting initiatives in hospital quality from Medicare also appear to have had little impact, for example, on 30 day mortality for myocardial infarction, congestive heart failure and pneumonia. See, for example, Ryan, whose report indicates that hospital reports on quality data under Hospital Compare “led to no reductions in mortality beyond existing trends for heart attack and pneumonia and led to modest reduction in mortality for heart failure.” With no impact on the underlying issues, the public could hardly be expected to respond with changes in patterns of utilization of health resources.

What about report cards? See Sinaiko, for example, whose findings were that public report cards, notwithstanding their proliferation, have proven difficult for consumers to interpret, and have “had little impact on the provider choices consumers are making.” The business of public reporting, therefore, and of the “report cards” and “grades” distributed, is best seen as possibly preliminary, and certainly as commercial, entrepreneurial activities building on the public’s concern, rather than as solutions to the patient safety and unnecessary morbidity/mortality problems outlined in the IOM report.

What is missing? Either better, more effective, more compelling and more robustly aggregated data, or personal involvement and oversight, or both.

In the first of these categories, Luft, Feijter and Levtzion-Korach may be seen as representative of the literature calling for standardization and more comprehensive, more robustly aggregated data. Luft outlines concerns (privacy, funding, potential misuse) in efforts to standardize and aggregate data, and proposes a “public-private data aggregator” to receive payer-based but de-identified information for consumer reporting and research purposes.

Feijter and colleagues illustrate that “single error detection methods are unable to provide a comprehensive picture of patient safety” and include among these deficient mechanisms the voluntary incident reporting systems, retrospective chart reviews and patient complaints. Their work illustrates, for example, in an American academic health center, that incident reporting systems “do not capture all incidents in hospitals and should be combined with complementary information about diagnostic error and delayed treatment from patient complaints and retrospective chart review.” They note that health care facilities having access to a variety of incident detection mechanisms should attempt to harness those in the improvement of patient safety.

Levtzion-Korach and colleagues examine incident reports, patient complaints, risk management, medical malpractice claims, and “executive walkarounds,” to yield information varying in the timing of the reporting, the severity of events, and the background or profession of the reporters. They note that there is little overlap amongst these various systems, with communication problems dominating patient complaints and malpractice claims, walkarounds identifying issues with equipment and supplies, adverse event reporting highlighting identification issues, especially mislabeling of laboratory and other specimens. They also note that while physicians accounted for half of risk management reports, in “adverse event” reporting - - where nurses are the main reporters -- physicians accounted for 2.5% of such reports. Complaints and malpractice claims, of course, came primarily from patients.

Levtzion-Korach concluded that the differing mechanisms that hospitals have available for the identification of patient safety issues may be seen as complementary, and that a more comprehensive picture of problems will develop from this broader approach and synthesis of such individual messages.

The American Legion's "System Worth Saving" Task Force approach would appear to be another tool which is largely absent from the American system, VHA or civilian. While individual hospital boards have evidenced greater interest in the years since 1998 in quality, as have executive staffs, and national reporting of incidents has become more robust since the National Patient Safety Goal effort (2005ff.) of The Joint Commission, there is no analog to the Legion's "board of visitors" approach for hospitals nationally.

These efforts should be seen as both a supplement and a guide for the VHA, including the work of the VHA National Center for Patient Safety (NCPS), the VHA's adoption of and measurement of its compliance with the National Patient Safety Goals of The Joint Commission on the NCPS internet site, (www.patientsafety.gov).

V. Studies of Quality in the VHA System

History of Quality Improvement Activity in the VA

The Department of Veterans Affairs has been engaged in attempts to measure (and promote better) quality for 25 years. There had been both internal and external criticism of VA care in general, and specifically of high VA surgical operative mortality. Public Law 99-166, effective December 1985, began this process. The history is recounted in a special issue of the *Journal of the American College of Surgeons* (see Stremple, “The Historical Evolution of the Department of Veterans Affairs National Surgical Quality Improvement Program.”). This history is brought forward in other reviews of the literature concerning quality improvement activity in the VA system (see, for example, Matula, “Comparisons of Quality of Surgical Care Between the US Department of Veterans Affairs and the Private Sector,” *Journal of the American College of Surgery*, December 2010).

Patient Safety, Private Sector and VHA

Beginning in 2003, the Agency for Healthcare Research and Quality put forward Patient Safety Indicators (PSIs), based on ICD-9-CM codes, designed to prevent adverse events that patients experience in acute care hospitals. Increasingly, the PSIs have been used for public reporting. For example, the National Quality Forum has endorsed ten of the Patient Safety Indicators as standards, and the Centers for Medicare and Medicaid Services will be using several individual PSIs and a composite measure on the Hospital Compare website (see Rosen, “Validating the Patient Safety Indicators in the Veterans Health Administration: Are They Ready for Prime Time?,” *Journal of the American College of Surgeons*, June 2011.)

Studies of Surgery, Chronic Disease, Mental Health

Many of the early studies of quality in the Veterans Administration hospitals focused on surgery, rather than on the (arguably) more difficult quality standards associated with management of chronic disease and with mental health and substance abuse.

Of great import, mental health and substance abuse disorders are prominent among those treated in the VHA System. A recent publication (*Health Affairs*, Oct. 19, 2011, see bibliography) reports that 33% of all VHA cost goes to mental illness and substance abuse, although those treated represent only 15% of the patient population, including nearly half (47%) of the inpatient discharges. This study found the average treatment cost for a Veteran with mental illness and substance abuse to be over \$12,000, or nearly three times the cost for an average Veteran without mental illness and substance abuse conditions. This is the Altarum/Rand report, commissioned in 2006, which examined records of some 837,000 patients from fiscal year 2007, for treatment of schizophrenia, bipolar disorders, post-traumatic stress, major depression and substance abuse. By way of explanation, most of the funds spent caring for this group went for their non-mental health conditions, including diabetes and hypertension. This study represents that the quality of care for Veterans was similar to or better than that given to privately insured patients or those enrolled in Medicare or Medicaid. However, the great challenge was variability, with a “twenty-three percentage point” variation among the regions. Some of the parameters for measurement of quality might be seen as controversial; for example, programs were marked down which did not include pharmacotherapy for alcohol dependence.

Efforts to “increase efficiency while improving quality,” should be examined with at least an objective, if not skeptical, review. The VHA has undertaken mental health initiatives to increase the proportion of Veterans receiving what are referred to as “evidence-based treatments.” Parallel efforts in the private sector indicate that one man’s “evidence-based treatment” is another’s “boot out the door,” (e.g., pharmacotherapy in lieu of more labor intensive efforts in alcoholism). This suggests that, in the middle portion of this study, discussion with patients and former patients should be a part of at least reviewing if not validating the parameters for measuring the quality of “evidence-based programs” in the VHA, given the high degree of complexity of measurement as well as the cultural determinants of mental health and mental illness.

VI. Comparability of Quality Measurement in the VHA and Civilian Hospital Systems

Examination was made of the complete 153 VHA medical center reports for “Hospital Compare,” as utilized in the VHA system. Of these 153 centers, 49 participate in the modified Hospital Compare program.

Of the 153 medical centers, the American Legion task force visited 25 total sites this year, as follows:

Baltimore, MD

Biloxi, MS

Charleston, SC

Chicago, IL

Cincinnati, OH

Columbia, SC

Columbus, OH

Des Moines, IA

Durham, NC

Long Beach, CA

Lyons, NJ

Manhattan, NY

Memphis, TN

Milwaukee, WI

Nashville, TN

New Orleans, LA

Omaha, NE

Sacramento, CA
Salisbury, NC
San Diego, CA
San Francisco, CA
Seattle, WA
St. Louis, MO
Vancouver, WA
Washington, DC

Of these twenty-five, there are eighteen medical centers for which there are “System Worth Saving” site visits, but which have no matching Hospital Compare reports, that is, they do not appear to participate in the CMS program. They are:

VA Long Beach Healthcare System, Long Beach, CA
VA Northern California Health Care System, Sacramento, CA
VA San Diego Healthcare System, San Diego, CA
Jesse Brown VA Medical Center, Chicago, IL
Southeast Louisiana Health Care System, New Orleans, LA
St. Louis Healthcare System, John Cochran Division, St. Louis, MO
VA Gulf Coast Veterans Health Care System, Biloxi, MS
Durham VA Medical Center, Durham, NC
W.G. Hefner VA Medical Center, Salisbury, NC
New York Harbor Healthcare System, Manhattan, NY
Cincinnati VA Medical Center, Cincinnati, OH
Chalmers P. Wylie VA Ambulatory Care Center, Columbus, OH

Wm. Jennings Bryan Dorn Department of Veterans Affairs Medical Center, Columbia, SC

Tennessee Valley Healthcare System, Nashville, TN

VA Puget Sound Healthcare System, Seattle, WA

Vancouver Campus of the Portland VAMC, Vancouver, WA

Finally, there are nine medical centers for which there are *both* “System Worth Saving” site visits and Hospital Compare materials.

These nine are (alphabetical by state):

San Francisco, CA, VA Medical Center;

Washington, DC VA Medical Center;

Central Iowa Health Care System, Des Moines, IA;

Baltimore, MD VA Medical Center;

Omaha, NE;

New Jersey Healthcare System, Lyons, NJ;

Charleston, SC VA Medical Center;

Tennessee Valley Healthcare System, Memphis, TN; and

Clement J. Zablocki Milwaukee, WI VA Medical Center

The exhibit following this section VI. shows (for one VA medical center) a sample of the three most common patient care comparison areas in the CMS Hospital Compare project, namely

(1) “timely & effective care,”

(2) “readmits, complications & deaths,” and

(3) patient satisfaction surveys. (Omitted here are imaging and relative cost measures.)

The complete three-part exhibit for all nine of these medical centers can be found as Exhibit 2 at the end of this report. As part of exhibit 2, comparison is made of results from the VA medical center, results from a comparably sized “index” civilian hospital in the same city as the VA medical center, and results which show the same-state and national averages for the various measures.

However, both the strength and weakness of VA medical center participation in the Hospital Compare project can be seen in the single sample following this page.

On the positive side, such participation is an opportunity for VA medical centers to be compared to a broad national average of hospitals. On the negative side, all of the VA medical centers reported *no results* on the patient survey (presumably participating instead in the “Customer Service Score” alternative, see below). In addition, most of the other (timely & effective care, readmits, complications & death) data were not submitted, either, or, if submitted, were not available.

In other words, 49 of the 153 VA medical centers “participated” in the 2011-2012 Hospital Compare project; however, examination of the 9 VA medical centers which had both (1) Hospital Compare participation and (2) a Legion System Worth Saving survey shows that most of the important information needed for Hospital Compare comparisons was not submitted.

Inexplicably, much of the “reporting” to the Hospital Compare program from the civilian hospitals, as well, consists of “n/a.” That is, the VA medical centers (together with many of the civilian hospital participants) either don’t respond, have submitted information which is insufficiently accurate, or are not having their results reported by CMS.

This may illustrate the difficulty - - noted above - - of having “quality improvement” metrics which are inextricably tied to “revenue reduction” goals. In any event, the “Hospital Compare” project is a work-in-progress.

Still, “Hospital Compare” is one of the two (together with accreditation) national standards we can look to that reveal “comparability” between VA medical centers and civilian hospitals. The exhibit which follows, one of the nine VA medical center hospitals where there is both a “System Worth Saving” survey and a “Hospital Compare” report shows results from the VA center, an “index” hospital, that is, a comparably sized hospital in the same city or vicinity, together with state averages and national averages for the particular measurement.

The entire set of nine comparables (showing “timely and effective care,” “readmits, complications and death,” and “patients surveys,” can be found as Exhibit 2, following this report.

In general, and notwithstanding the absence of data, it is clear that the VA medical centers can “hold their own,” in the Hospital Compare measures, and, in some of these nine jurisdictions, are superior (at least as measured by these categories) to the index hospitals and/or state or national averages.

None of this is definitive - - given the paucity of data and the resulting spotty reports. However, to the extent we have national comparables, the VA medical centers appear at least equivalent to the index hospitals and averages of the states in which they are located. In addition, as noted above, on our other “national standard,” that is, accreditation, 17 of the nation’s 405 top hospitals (per The Joint Commission) are VA medical centers, about right as a proportion of total hospitals in the accreditation pool, or about four percent.

[Sample Hospital Compare exhibit follows.]

Comparison of VHA Medical Centers and Same-City Index Hospitals, Same State Average, Hospital Compare Program, **Timely Effective Care**

Timely & Effective Care	National Average	Memphis VA Medical Center	Baptist Memorial Hospital, Memphis, TN	Tennessee Average
Effective Heart Attack Care				
Heart Attack Patients Given Aspirin at Discharge.	99%	100%	100%	99%
Heart Attack Patients Given a Prescription for a Statin at Discharge.	98%	na	99%	98%
Effective Heart Failure Care				
Heart Failure Patients Given Discharge Instructions.	93%	100%	90%	91%
Heart Failure Patients Given an Evaluation of Left Ventricular Systolic (LVS) Function.	99%	100%	100%	99%
Heart Failure Patients Given ACE Inhibitor or ARB for Left Ventricular Systolic Dysfunction (LVSD).	96%	98%	99%	96%
Effective Pneumonia Care				
Pneumonia Patients Whose Initial Emergency Room Blood Culture Was Performed Prior to the Administration of The First Hospital Dose of Antibiotics.	97%	98%	99%	98%
Pneumonia Patients Given the Most Appropriate Initial Antibiotic(s).	95%	98%	97%	95%
Timely Surgical Care				
Outpatients having surgery who got an antibiotic at the right time - within one hour before surgery. (Higher numbers are better).	96%	na	98%	97%
Surgery patients who were given an antibiotic at the right time (within one hour before surgery) to help prevent infection.	98%	99%	98%	98%
Surgery patients whose preventive antibiotics were stopped at the right time (within 24 hours after surgery).	97%	96%	95%	97%
Patients who got treatment at the right time (within 24 hours before or after their surgery) to help prevent blood clots after certain types of surgery.	97%	100%	97%	97%
Effective Surgical Care				
Outpatients having surgery who got the right kind of antibiotic. (Higher numbers are better).	97%	na	99%	97%
Surgery patients who were taking heart drugs called beta blockers before coming to the hospital, who were kept on the beta blockers during the period just before and after their surgery.	96%	81%	99%	96%
Surgery patients who were given the right kind of antibiotic to help prevent infection.	98%	100%	99%	99%
Heart surgery patients whose blood sugar (blood glucose) is kept under good control in the days right after surgery.	96%	88%	92%	95%
Surgery patients whose urinary catheters were removed on the first or second day after surgery.	95%	96%	82%	94%
Patients having surgery who were actively warmed in the operating room or whose body temperature was near normal by the end of surgery.	100%	na	100%	100%
Surgery patients whose doctors ordered treatments to prevent blood clots after certain types of surgeries.	98%	100%	99%	98%

Comparison of VHA Medical Centers and Same-City Index Hospitals, Same State Average, Hospital Compare Program, Readmits, Complications Death

30-Day Outcomes Readmission and Deaths	National Average	Memphis VA Medical Center	Baptist Memorial Hospital, Memphis, TN
Serious Complications			
Collapsed lung due to medical treatment	.35/1,000 discharges	na	Same as U.S.
Serious blood clots after surgery	4.71/1,000 discharges	na	Same as U.S.
A wound that splits open after surgery on the abdomen or pelvis	.95/1,000 discharges	na	Same as U.S.
Accidental cuts and tears from medical treatment	2.05/1,000 discharges	na	Same as U.S.
Pressure sores (bedsores)	na	na	na
Infections from a large venous catheter	na	na	na
Broken hip from a fall after surgery	na	na	na
Bloodstream infection after surgery	na	na	na
Deaths for Certain Conditions			
Deaths after admission for a broken hip	na	na	na
Deaths after admission for a heart attack	na	na	na
Deaths after admission for congestive heart failure	na	na	na
Deaths after admission for a stroke	na	na	na
Deaths after admission for a gastrointestinal (GI) bleed	na	na	na
Deaths after admission for pneumonia	na	na	na
Other Complications and Deaths			
Deaths among patients with serious treatable complications after surgery	113.43/1,000 discharges	na	Same as U.S.
Breathing failure after surgery	na	na	Worse than U.S.
Death after surgery to repair a weakness in the abdominal aorta	na	na	na
Hospital Acquired Conditions			
Objects accidentally left in the body after surgery	.028/1,000 discharges	na	.000/1,000 discharges
Air bubble in the bloodstream	.003/1,000 discharges	na	.031/1,000 discharges
Mismatched blood types	.001/1,000 discharges	na	.000/1,000 discharges
Severe pressure sores (bed sores)	.136/1,000 discharges	na	.153/1,000 discharges
Falls and injuries	.527/1,000 discharges	na	.427/1,000 discharges
Blood infection from a catheter in a large vein	.372/1,000 discharges	na	.519/1,000 discharges
Infection from a urinary catheter	.358/1,000 discharges	na	5.338/1,000 discharges
Signs of uncontrolled blood sugar	.058/1,000 discharges	na	.092/1,000 discharges
Healthcare Associated Infections			
Central line associated blood stream infections (CLABSI)		na	Same as U.S.

Comparison of VHA Medical Centers and Same-City Index Hospitals, Same State Average, Hospital Compare Program, **Patient Survey Results**

Patient Survey Results	National Average	Memphis VA Medical Center	Baptist Memorial Hospital, Memphis, TN	Tennessee Average
Patients who reported that their nurses "Always" communicated well.	78%	Not Available	77%	79%
Patients who reported that their doctors "Always" communicated well.	81%	Not Available	77%	83%
Patients who reported that they "Always" received help as soon as they wanted.	66%	Not Available	61%	67%
Patients who reported that their pain was "Always" well controlled.	70%	Not Available	69%	71%
Patients who reported that staff "Always" explained about medicines before giving it to them.	63%	Not Available	58%	64%
Patients who reported that their room and bathroom were "Always" clean.	73%	Not Available	73%	72%
Patients who reported that the area around their room was "Always" quiet at night.	60%	Not Available	67%	66%
Patients at each hospital who reported that YES, they were given information about what to do during their recovery at home.	84%	Not Available	80%	83%
Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest).	69%	Not Available	73%	69%
Patients who reported YES, they would definitely recommend the hospital.	70%	Not Available	78%	70%

VII. Qualitative Measurement, the Interview Process, a System Worth Saving Activities:

A key element in the “System Worth Saving” task force activities involves personal interviews with leaders of the VHA medical centers. Through the American Legion reports, the observations and initiatives of VHA medical center leaders become more widely known, and their achievements more widely recognized.

It is well known that public reporting of hospital performance data appears to energize hospitals to focus on higher levels of performance, or at least to devote additional efforts toward such performance. Hafner and others interviewed (through focus groups) administrators, physicians, nurses and others from randomly selected Joint Commission accredited hospitals in the civilian sector. Their findings suggested that, “As the health care industry has moved toward greater transparency and accountability, health care professionals have responded by re-prioritizing hospital quality improvement efforts to address gaps in care.”

Exhibit 4 (below) contains substantial excerpts from the System Worth Saving interview process, valuable both for the student and the practitioner. In addition, the complete text of the pre-survey and the written reports—products of the Legion volunteers and professional staff—will be found at www.vhahospitalqualitystudy.org, developed for this study.

The “personal” content and humane observations in both the pre-survey and the written reports are a different form of “quality assurance,” dependent on interpersonal communication rather than “box-checking.”

Recommendation: Reports from task force members, after review by the individual medical center chief executive, should be offered to the VHA for “posting” online, together with other patient safety and quality reports for the individual centers. The appearance of American Legion-sponsored interviews and conclusions would add “consumer” and “board of visitor”-type credibility to VHA organizational reports. In addition, it might have the same impact as the public reporting (US News, Consumer Reports, Leapfrog and others) in the private sector, namely, rewarding the attention of executives in the VHA system on patient safety and quality assurance.

VIII. SHEP and HCAHPS

The VHA has adopted the Survey of Healthcare Experience of Patients (SHEP), nominally based on the Consumer Assessment of Healthcare Providers and Systems (HCAHPS) used by CMS. However, the potential for comparability is limited.

First, there are a variety of “black box” factors pertinent to comparison of different years. The VHA adopted the use of the SHEP in fiscal year 2009. Explanatory material from the VHA indicates that earlier years of the SHEP program (that is, prior to its rearrangement to emulate the HCAHPS) have “differences in satisfaction metrics and survey administration protocol.”

Second, the inpatient surveys for SHEP and for HCAHPS have similar bases, but there is no analogous outpatient comparability. The outpatient SHEP survey is based on a variety of different types of information, including clinician and group surveys.

Third, both the inpatient and outpatient SHEP surveys have questions not included in HCAHPS.

Fourth, SHEP scoring is somewhat unusual, characterized as “top box” scoring, in which answers to questions that are “usually” and “always” done are combined, and ratings of “9 or 10” on a scale of zero to ten, likewise.

Fifth, both the inpatient and outpatient scores employ “patient mix adjustment” that “accounts for differences in patient characteristics known to influence ratings of health care.” This nominally includes age, education, health status and service line, and otherwise undifferentiated “other patient characteristics.” Notwithstanding, the VHA explanatory material indicates that “the VHA adjusted scores closely approximate what CMS reports to the public on CMS Hospital Compare, and allows VHA hospitals to be compared to non-VHA hospitals.” Exact replication is compromised because of variable lags in reporting periods.

In summary, there are explained and unexplained adjustments to the SHEP (and the HCAHPS) reports. As noted earlier, only a minority of VHA medical center reports in the SHEP/HCAHPS format is available, and comparisons between the two methods yield no significant results.

Helpfully, those VHA medical centers that participate in the HCAHPS program have an opportunity to compare their overall patient satisfaction by quarter with the VHA national average (see Exhibit C, “VA Loma Linda Healthcare System” Customer Service Scores Comparison).

Additional effort would be required to display the civilian hospital system national averages, or those from the appropriate region, but the effort, as discussed elsewhere in this paper, should be made.

Recommendation: That the Legion and VHA leadership encourage VHA medical centers to participate in the HCAHPS reports, given (1) the importance of demonstrating the value of VHA services, (2) the relative numeric weight of over 4,000 hospitals participating in HCAHPS, compared to 153 medical centers participating in SHEP, and (3) the increased information which would inure to the VHA system for internal management purposes.

IX. Quality Measures and Reimbursement

In the VHA system, quality assurance “scores” do not appear to have any direct relationship to financial support for the institution. That is, while deficiencies (for example, in physical plant) may bring increased or specific allocations, there are no financial penalties for “patient safety violations” or other shortcomings in quality assurance.

In the civilian system, to the contrary, patient safety, consumer reports and quality assurance (the triad of categories for the various means of measuring quality in the private sector) appear increasingly to be poised for use in reimbursement limitation.

For example, an important multi-year focus for the Centers for Medicare and Medicaid Services (CMS) has been the reduction of readmissions, that is, the admission of a Medicare beneficiary to a hospital within thirty days of discharge. Common sense would dictate that the cause for many of these readmissions is the press for “productivity” brought about from 1983ff. through Diagnosis Related Group reimbursement. Under DRG reimbursement, a hospital is paid for a case or an admission, not for length of stay. From 1983 to the present the “push” (financially) in civilian hospitals has been to discharge the patient as early as possible. By discharging a patient in, say, five days, rather than, say, six days, a hospital with the same staff complement will increase its productivity, that is, will increase the “throughput” of the patient. Of course, the other consequence of DRG reimbursement has been the extraordinary growth and proliferation of continued stay (long-term acute care), long-term (nursing home and other) and ambulatory care schemas intended to “catch” the patient who has been discharged. What has changed from 1983 forward, in other words, is not the human body - - the recovery process from surgery or from medical diagnoses (the three most avidly followed by CMS are myocardial infarction, congestive heart failure and pneumonia), but rather the financial consequences of treating patients in longer or shorter periods of time.

Now, to repeat, CMS has discovered the readmission problem, in which annually approximately ten million Medicare beneficiaries are readmitted to a hospital within thirty days for any cause, a rate of nearly one in five Medicare discharges.

Is the readmission rate an index of quality? CMS has identified eight hospitals (of more than 4,000 nationally) with worse than average readmissions for all three of the diagnoses mentioned above. These eight include Beth Israel Deaconess Medical Center in Boston, Florida Hospital in Orlando, Florida (the nation's largest), the Henry Ford Hospital in Detroit, the Mount Sinai Hospital in New York, and two VA Medical Centers, San Juan VA Medical Center in San Juan, Puerto Rico, and Tampa VA Medical Center in Tampa, Florida. With regard to Beth Israel and the others in the civilian sector, would any knowledgeable observer of the field judge these to be inferior, quality compromised hospitals? Much of our sense of "good hospitals" and "good doctors" is reputational - - that is, dependent upon what we've learned anecdotally, by word of mouth and from other means through which the reputation of these hospitals are communicated. These are, to the contrary, outstanding hospitals, ones that characteristically rank high in the "reputation" category.

Conversely, ten hospitals in the CMS ranking have better than average readmission rates for all three measures, including, for example, Boca Raton Regional Hospital in Boca Raton, Munson Medical Center in Traverse City, Michigan, etc. There is nothing inferior or deficient in any of these ten hospitals, but none of them - - not one - - would appear on a "Top 50" or "Top 100" list of hospitals by reputation, if only because they are known most prominently in their respective service areas, and not far beyond.

Notwithstanding this paradox - - that the "worst performers" in readmissions are amongst are most highly regarded hospitals, and the "best performers" are known, if at all, locally, CMS proposes to penalize (financially) those hospitals with high readmission rates.

What is the lesson? The VA system, without financial penalties, has every reason to facilitate reporting, whereas the civilian system, with the "box checking" now competing with quality assessment based on institution reputation, does not. Where did the private sector reimbursement penalties come from? They came from the National Quality Forum, a non-profit that evaluates measures on a contract with the government, where less than 20% of the 400 NQF members voted, with a disproportionate number of those representing the health professions voting against these measures.

The point here is a simple one: by “linking” pending reimbursement changes with “quality reports,” CMS risks stifling reporting (and steps which would hopefully follow in remediation of errors), and instead rewarding “failure to report.” Indeed, simultaneously, the Office of Inspector General, in a reported dated July 19, 2012, has concluded that hospital reporting of adverse events to state reporting systems (that is, reporting by hospitals in the civilian sector to one or the other of the 26 states using adverse event reporting), resulted in only an estimated 12% of adverse events nationally that met state requirements for reporting having actually been reported.

So the “circle” of reasoning would appear to be closed in this area, that is, there is no incentive to report, performance indicates that underreporting is rampant, and there will be punishment for reporting in the future, in the linkage of reimbursement to reporting of patient safety or quality assurance shortcomings.

Recommendation: The VA should do everything possible to avoid emulating the adverse consequences of the linkage of “pay for performance” which is the theory behind private sector reporting, and which is proving to have results and consequences the very opposite of those intended.

X. Outpatient Services

A significant disadvantage to the current focus of CMS (in Hospital Compare and related studies) is the limitation to inpatient services. Approximately half of the net revenue of the modern American community non-profit hospital comes from outpatient services. Increasingly, standards associated with patient risk reduction and quality assurance (for example, the National Patient Safety Goals) are applied to “all patient populations,” not only to the inpatient side. Therefore, an assessment of quality is by definition incomplete to the extent it relies on an assessment of only inpatient services.

The VHA system, with 153 medical centers and more than 800 community-based outpatient clinics, shows extensive development in area. Moreover, with increased emphasis on the early discharge of the inpatient (in both the civilian and military populations), outpatient services acquire still greater import.

The “qualitative” assessment of the VHA system (especially by Longman and others), and the qualitative nature of the “System Worth Saving” assessment by the American Legion, obviates this problem. Questions posed by Legion-designated interviewers bring into focus problem areas, for example, those highlighted by area Veterans. No such equivalent is available for the civilian hospital field on a regional or national basis. Again, the closest that this ideal is approached in the civilian hospital world is through the accreditation process (including some community input) overseen by The Joint Commission (and by the American Osteopathic Association and Det Norske Veritas).

In the absence of “metrics” or quality measures which can be used to compare the VA and the non-VA system, academic studies take place. For example, one recent study (see Rose, “Organizational Characteristics of Anti-Coagulation Clinics in the Veterans Health Administration”) looks at a particular area of import in the prevention of adverse events for outpatients, namely anti-coagulation control. Exactly how anti-coagulation clinics or outpatient services are organized (people, space, money, equipment, and, especially, pharmaceutical products) for optimum patient outcome are developing areas for examination. In this study, the variables examined included the qualification of personnel, their supervision, the management and coordination of care, the education of patients, the selection and assessment of patients, the monitoring of the laboratories, the

initiation of the therapy and the maintenance of the therapy. Recommendations were made, “high” and “low” performers were identified, and six characteristics of the “high performers” noted, although none of the features were identified with all of the high performers, but only a few of them with the low performers. This type of study has merit within the VA system, but, again, takes place in the absence of comparison with alternatives methodologies in the civilian hospital system. Moreover, individual studies may reflect the bias, predisposition or preconception of those having a particular interest in such areas.

Recommendation: That the VHA system examine outpatient “metrics” which might be used to compare performance of the VHA outpatient services with those of the civilian hospital population.

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XIII. Exhibits (1-5)

- (1) Listing of VHA medical centers, highlighting those participating in the “Hospital Compare” survey**

- (2) “Hospital Compare,” complete exhibit, (a) Timely & Effective Care, (b) Readmits, Complications & Death, Patient Survey
Results: nine VHA medical centers, same-city index hospitals, same-state averages, national average**

- (3) Sample of one VHA medical center Customer Service Scores, compared to national VHA medical center results**

- (4) American Legion “System Worth Saving” summary of key 2012 survey findings**

- (5) Slides for presentation, American Legion convention, Indianapolis, August 25, 2012**

(1) Listing of VHA medical centers, highlighting those participating in the “Hospital Compare” survey

VA Healthcare System
Medical Center List

Hospital	City	State	Facility ID	Hospital Compare
Alaska VA Healthcare System	Anchorage	AK	463	
Birmingham VA Medical Center	Birmingham	AL	521	Y
Central Alabama Veterans Health Care System East Campus	Tuskegee	AL	619A4	
Central Alabama Veterans Health Care System West Campus	Montgomery	AL	619	
Tuscaloosa VA Medical Center	Tuscaloosa	AL	679	
Central Arkansas Veterans Healthcare System Eugene J. Towbin Healthcare Center	North Little Rock	AR	598	
Central Arkansas Veterans Healthcare System John L. McClellan Memorial Veterans Hospital	Little Rock	AR	598	Y
Veterans Health Care System of the Ozarks	Fayetteville	AR	564	
Northern Arizona VA Health Care System	Prescott	AZ	649	Y
Phoenix VA Health Care System	Phoenix	AZ	644	
Southern Arizona VA Health Care System	Tucson	AZ	678	
Livermore	Livermore	CA	640	
Menlo Park	Menlo Park	CA	640	
San Francisco VA Medical Center	San Francisco	CA	662	Y
VA Central California Health Care System	Fresno	CA	570	
VA Greater Los Angeles Healthcare System (GLA)	Los Angeles	CA	691	
VA Loma Linda Healthcare System	Loma Linda	CA	605	
VA Long Beach Healthcare System	Long Beach	CA	600	
VA Northern California Health Care System	Mather	CA	612	
VA Palo Alto Health Care System	Palo Alto	CA	640	
VA San Diego Healthcare system	San Diego	CA	664	
Grand Junction VA Medical Center	Grand Junction	CO	575	Y
VA Eastern Colorado Health Care System (ECHCS)	Denver	CO	554	
VA Connecticut Healthcare System Newington Campus	Newington	CT	689A4	
VA Connecticut Healthcare System West Haven Campus	West Haven	CT	689	Y
Washington DC VA Medical Center	Washington	DC	688	Y
Wilmington VA Medical Center	Wilmington	DE	460	Y
Bay Pines VA Healthcare System	Bay Pines	FL	516	Y
James A. Haley Veterans' Hospital	Tampa	FL	673	
Lake City VAMC, NF/SGVHS	Lake City	FL	573A4	
Malcom Randall VAMC, NF/SGVHS	Gainesville	FL	573	
Miami VA Healthcare System	Miami	FL	546	
North Florida/South Georgia Veterans Health System	Gainesville	FL	573	
Orlando VA Medical Center	Orlando	FL	675	
West Palm Beach VAMC	West Palm Beach	FL	548	
Atlanta VA Medical Center	Decatur	GA	508	Y
Carl Vinson VA Medical Center	Dublin	GA	557	
Charlie Norwood VA Medical Center	Augusta	GA	509	
VA Pacific Islands Health Care System	Honolulu	HI	459	
Iowa City VA Health Care System	Iowa City	IA	636A8	Y
VA Central Iowa Health Care System	Des Moines	IA	636A6	

VA Healthcare System
Medical Center List

Hospital	City	State	Facility ID	Hospital Compare
Boise VA Medical Center	Boise	ID	531	Y
Captain James A. Lovell Federal Health Care Center	North Chicago	IL	556	Y
Edward Hines Jr. VA Hospital	Hines	IL	578	
Jesse Brown VA Medical Center	Chicago	IL	537	
Marion VA Medical Center	Marion	IL	657A5	
VA Illiana Health Care System	Danville	IL	550	
Richard L. Roudebush VA Medical Center (Indianapolis VA Medical Center)	Indianapolis	IN	583	Y
VA Northern Indiana Health Care System - Marion Campus	Marion	IN	610	
VA Northern Indiana Health Care System - Fort Wayne Campus	Fort Wayne	IN	610A4	
Robert J. Dole Department of Veterans Affairs Medical and Regional Office Center	Wichita	KS	589A7	Y
VA Eastern Kansas Health Care System - Colmery-O'Neil VA Medical Center	Topeka	KS	589A5	
VA Eastern Kansas Health Care System - Dwight D. Eisenhower VA Medical Center	Leavenworth	KS	589A6	
Lexington VA Medical Center	Lexington	KY	596	
Lexington VAMC: Cooper Division	Lexington	KY	596A4	
Lexington VAMC: Leestown Division	Lexington	KY	596	Y
Robley Rex VA Medical Center	Louisville	KY	603	
Alexandria VA Health Care System	Alexandria	LA	502	Y
Overton Brooks VA Medical Center	Shreveport	LA	667	
Southeast Louisiana Veterans Health Care System	New Orleans	LA	629	
Edith Nourse Rogers Memorial Veterans Hospital	Bedford	MA	518	Y
VA Boston Healthcare System, Brockton Campus	Brockton	MA	523A5	
VA Boston Healthcare System, Jamaica Plain Campus	Jamaica Plain	MA	523	
VA Boston Healthcare System, West Roxbury Campus	West Roxbury	MA	523A4	
VA Central Western Massachusetts Healthcare System	Leeds	MA	631	
Baltimore VA Medical Center - VA Maryland Health Care System	Baltimore	MD	512	Y
Loch Raven VA Community Living & Rehabilitation Center	Baltimore	MD	512GB	
Perry Point VA Medical Center - VA Maryland Health Care System	Perryville	MD	512A5	
VA Maryland Health Care System	Baltimore	MD	512	
VA Maine Healthcare System - Togus	Augusta	ME	402	Y
Aleda E. Lutz VA Medical Center	Saginaw	MI	655	Y
Battle Creek VA Medical Center	Battle Creek	MI	515	
John D. Dingell VA Medical Center	Detroit	MI	553	
Oscar G. Johnson VA Medical Center	Iron Mountain	MI	585	
VA Ann Arbor Healthcare System	Ann Arbor	MI	506	
Minneapolis VA Health Care System	Minneapolis	MN	618	Y
St. Cloud VA Health Care System	St. Cloud	MN	656	
Harry S. Truman Memorial	Columbia	MO	589A4	Y
John J. Pershing VA Medical Center	Poplar Bluff	MO	657A4	
Kansas City VA Medical Center	Kansas City	MO	589	
VA St. Louis Health Care System - Jefferson Barracks Division	Saint Louis	MO	657A0	
VA St. Louis Health Care System - John Cochran Division	Saint Louis	MO	657	

VA Healthcare System
Medical Center List

Hospital	City	State	Facility ID	Hospital Compare
G.V. (Sonny) Montgomery VA Medical Center	Jackson	MS	586	Y
VA Gulf Coast Veterans Health Care System	Biloxi	MS	520	
VA Montana Health Care System	Fort Harrison	MT	436	Y
Asheville VA Medical Center	Asheville	NC	637	Y
Durham VA Medical Center	Durham	NC	558	
Fayetteville VA Medical Center	Fayetteville	NC	565	
Salisbury - W.G. (Bill) Hefner VA Medical Center	Salisbury	NC	659	
Fargo VA Healthcare System	Fargo	ND	437	Y
Omaha - VA Nebraska-Western Iowa Health Care System	Omaha	NE	636	Y
Manchester VA Medical Center	Manchester	NH	608	
East Orange Campus of the VA New Jersey Health Care System	East Orange	NJ	561	Y
Lyons Campus of the VA New Jersey Health Care System	Lyons	NJ	561A4	
New Mexico VA Health Care System	Albuquerque	NM	501	Y
VA Sierra Nevada Health Care System	Reno	NV	654	Y
VA Southern Nevada Healthcare System (VASNHS)	Las Vegas	NV	593	
Albany VA Medical Center: Samuel S. Stratton	Albany	NY	528A8	Y
Bath VA Medical Center	Bath	NY	528A6	
Brooklyn Campus of the VA NY Harbor Healthcare System	Brooklyn	NY	630A4	
Canandaigua VA Medical Center	Canandaigua	NY	528A5	
Castle Point Campus of the VA Hudson Valley Health Care System	Castle Point	NY	620A4	
Franklin Delano Roosevelt Campus of the VA Hudson Valley Health Care System (Montrose)	Montrose	NY	620	
James J. Peters VA Medical Center (Bronx, NY)	Bronx	NY	526	
Manhattan Campus of the VA NY Harbor Healthcare System	New York	NY	630	
Northport VA Medical Center	Northport	NY	632	
Syracuse VA Medical Center	Syracuse	NY	528A7	
VA Western New York Healthcare System at Batavia	Batavia	NY	528A4	
VA Western New York Healthcare System at Buffalo	Buffalo	NY	528	
Chalmers P. Wylie Ambulatory Care Center	Columbus	OH	757	
Chillicothe VA Medical Center	Chillicothe	OH	538	Y
Cincinnati VA Medical Center	Cincinnati	OH	539	
Dayton VA Medical Center	Dayton	OH	552	
Louis Stokes VA Medical Center	Cleveland	OH	541	
Jack C. Montgomery VAMC	Muskogee	OK	623	Y
Oklahoma City VA Medical Center	Oklahoma City	OK	635	
Portland VA Medical Center	Portland	OR	648	Y
VA Roseburg Healthcare System	Roseburg	OR	653	
Altoona - James E. Van Zandt VA Medical Center	Altoona	PA	503	Y
Coatesville VA Medical Center	Coatesville	PA	542	
Erie VA Medical Center	Erie	PA	562	
Lebanon VA Medical Center	Lebanon	PA	595	
Philadelphia VA Medical Center	Philadelphia	PA	642	

VA Healthcare System
Medical Center List

Hospital	City	State	Facility ID	Hospital Compare
VA Butler Healthcare	Butler	PA	529	
VA Pittsburgh Healthcare System, H.J. Heinz Campus	Pittsburgh	PA	646A4	
VA Pittsburgh Healthcare System, Highland Drive Campus	Pittsburgh	PA	646A5	
VA Pittsburgh Healthcare System, University Drive Campus	Pittsburgh	PA	646	
Wilkes-Barre VA Medical Center	Wilkes-Barre	PA	693	
VA Caribbean Healthcare System	San Juan	PR	672	Y
Providence VA Medical Center	Providence	RI	650	Y
Ralph H. Johnson VA Medical Center	Charleston	SC	534	Y
Wm. Jennings Bryan Dorn VA Medical Center	Columbia	SC	544	
Sioux Falls VA Health Care System	Sioux Falls	SD	438	Y
VA Black Hills Health Care System - Hot Springs Campus	Hot Springs	SD	568A4	
VA Black Hills Health Care System - Fort Meade Campus	Fort Meade	SD	568	
Memphis VA Medical Center	Memphis	TN	614	Y
Mountain Home VAMC/Johnson City	Mountain Home	TN	621	
Tennessee Valley Healthcare System - Alvin C. York (Murfreesboro) Campus	Murfreesboro	TN	626A4	
Tennessee Valley Healthcare System - Nashville Campus	Nashville	TN	626	
Amarillo VA Health Care System	Amarillo	TX	504	Y
Central Texas Veterans Health Care System	Temple	TX	674	
Central Texas Veterans Health Care System - Waco VA Medical Center	Waco	TX	674A4	
El Paso VA Health Care System	El Paso	TX	756	
Kerrville VA Medical Center	Kerrville	TX	671A4	
Michael E. DeBakey VA Medical Center	Houston	TX	580	
South Texas Veterans Health Care System	San Antonio	TX	671	
VA North Texas Health Care System: Dallas VA Medical Center	Dallas	TX	549	
VA North Texas Health Care System: Sam Rayburn Memorial Veterans Center	Bonham	TX	549A4	
VA Texas Valley Coastal Bend Health Care System	Harlingen	TX	740	
West Texas VA Health Care System	Big Spring	TX	519	
VA Salt Lake City Health Care System	Salt Lake City	UT	660	Y
Hampton VA Medical Center	Hampton	VA	590	Y
Hunter Holmes McGuire VA Medical Center	Richmond	VA	652	
Salem VA Medical Center	Salem	VA	658	
White River Junction VA Medical Center	White River Junction	VT	405	Y
Jonathan M. Wainwright Memorial VA Medical Center	Walla Walla	WA	687	Y
Portland VA Medical Center - Vancouver Campus	Vancouver	WA	648	
Spokane VA Medical Center	Spokane	WA	668	
VA Puget Sound Health Care System - American Lake Division	Lakewood	WA	663A4	
VA Puget Sound Health Care System - Seattle Division	Seattle	WA	663	
Clement J. Zablocki Veterans Affairs Medical Center	Milwaukee	WI	695	Y
Tomah VA Medical Center	Tomah	WI	676	
William S. Middleton Memorial Veterans Hospital	Madison	WI	607	
Beckley VA Medical Center	Beckley	WV	517	Y

VA Healthcare System
Medical Center List

Hospital	City	State	Facility ID	Hospital Compare
Clarksburg - Louis A. Johnson VA Medical Center	Clarksburg	WV	540	
Huntington VA Medical Center	Huntington	WV	581	
Martinsburg VA Medical Center	Martinsburg	WV	613	
Cheyenne VA Medical Sheridan VA Medical Center	Cheyenne	WY	442	Y
Sheridan VA Medical Center	Sheridan	WY	666	

(2) “Hospital Compare,” complete exhibit of nine VA medical centers, nine same-city index hospitals, same-state and national averages, in these categories:

(a) Timely & Effective Care, followed by a blank page, then

(b) Readmits, Complications & Death, followed by a blank page, then by

(c) Patient Survey Results.

Timely & Effective Care	National Average	San Francisco VA Medical Center	San Francisco General Hospital	CA Average
Effective Heart Attack Care				
Heart Attack Patients Given Aspirin at Discharge.	99%	100%	100%	99%
Heart Attack Patients Given a Prescription for a Statin at Discharge.	98%	na	99%	98%
Effective Heart Failure Care				
Heart Failure Patients Given Discharge Instructions.	93%	94%	90%	94%
Heart Failure Patients Given an Evaluation of Left Ventricular Systolic (LVS) Function.	99%	100%	100%	99%
Heart Failure Patients Given ACE Inhibitor or ARB for Left Ventricular Systolic Dysfunction (LVSD).	96%	96%	96%	96%
Effective Pneumonia Care				
Pneumonia Patients Whose Initial Emergency Room Blood Culture Was Performed Prior to the Administration of The First Hospital Dose of Antibiotics.	97%	97%	93%	97%
Pneumonia Patients Given the Most Appropriate Initial Antibiotic(s).	95%	97%	98%	96%
Timely Surgical Care				
Outpatients having surgery who got an antibiotic at the right time - within one hour before surgery. (Higher numbers are better).	96%	na	na	95%
Surgery patients who were given an antibiotic at the right time (within one hour before surgery) to help prevent infection.	98%	99%	97%	98%
Surgery patients whose preventive antibiotics were stopped at the right time (within 24 hours after surgery).	97%	98%	97%	97%
Patients who got treatment at the right time (within 24 hours before or after their surgery) to help prevent blood clots after certain types of surgery.	97%	97%	98%	97%
Effective Surgical Care				
Outpatients having surgery who got the right kind of antibiotic. (Higher numbers are better).	97%	na	99%	96%
Surgery patients who were taking heart drugs called beta blockers before coming to the hospital, who were kept on the beta blockers during the period just before and after their surgery.	96%	100%	94%	96%
Surgery patients who were given the right kind of antibiotic to help prevent infection.	98%	100%	98%	98%
Heart surgery patients whose blood sugar (blood glucose) is kept under good control in the days right after surgery.	96%	97%	na	95%
Surgery patients whose urinary catheters were removed on the first or second day after surgery.	95%	97%	100%	95%
Patients having surgery who were actively warmed in the operating room or whose body temperature was near normal by the end of surgery.	100%	na	100%	100%
Surgery patients whose doctors ordered treatments to prevent blood clots after certain types of surgeries.	98%	97%	98%	97%

Timely & Effective Care	National Average	Washington, DC VA Medical Center	George Washington University Hospital	District of Columbia Average
Effective Heart Attack Care				
Heart Attack Patients Given Aspirin at Discharge.	99%	98%	100%	100%
Heart Attack Patients Given a Prescription for a Statin at Discharge.	98%	na	99%	96%
Effective Heart Failure Care				
Heart Failure Patients Given Discharge Instructions.	93%	99%	100%	82%
Heart Failure Patients Given an Evaluation of Left Ventricular Systolic (LVS) Function.	99%	100%	100%	97%
Heart Failure Patients Given ACE Inhibitor or ARB for Left Ventricular Systolic Dysfunction (LVSD).	96%	95%	96%	91%
Effective Pneumonia Care				
Pneumonia Patients Whose Initial Emergency Room Blood Culture Was Performed Prior to the Administration of The First Hospital Dose of Antibiotics.	97%	95%	94%	92%
Pneumonia Patients Given the Most Appropriate Initial Antibiotic(s).	95%	97%	96%	97%
Timely Surgical Care				
Outpatients having surgery who got an antibiotic at the right time - within one hour before surgery. (Higher numbers are better).	96%	na	95%	92%
Surgery patients who were given an antibiotic at the right time (within one hour before surgery) to help prevent infection.	98%	99%	97%	96%
Surgery patients whose preventive antibiotics were stopped at the right time (within 24 hours after surgery).	97%	94%	94%	95%
Patients who got treatment at the right time (within 24 hours before or after their surgery) to help prevent blood clots after certain types of surgery.	97%	96%	99%	96%
Effective Surgical Care				
Outpatients having surgery who got the right kind of antibiotic. (Higher numbers are better).	97%	na	91%	94%
Surgery patients who were taking heart drugs called beta blockers before coming to the hospital, who were kept on the beta blockers during the period just before and after their surgery.	96%	100%	97%	93%
Surgery patients who were given the right kind of antibiotic to help prevent infection.	98%	100%	98%	98%
Heart surgery patients whose blood sugar (blood glucose) is kept under good control in the days right after surgery.	96%	97%	93%	93%
Surgery patients whose urinary catheters were removed on the first or second day after surgery.	95%	100%	98%	95%
Patients having surgery who were actively warmed in the operating room or whose body temperature was near normal by the end of surgery.	100%	na	100%	99%
Surgery patients whose doctors ordered treatments to prevent blood clots after certain types of surgeries.	98%	98%	100%	97%

Timely & Effective Care	National Average	VA Central Iowa Healthcare System, Des Moines	Iowa Methodist Medical Center, Des Moines	Iowa Average
Effective Heart Attack Care				
Heart Attack Patients Given Aspirin at Discharge.	99%	na	99%	99%
Heart Attack Patients Given a Prescription for a Statin at Discharge.	98%	na	95%	97%
Effective Heart Failure Care				
Heart Failure Patients Given Discharge Instructions.	93%	95%	71%	90%
Heart Failure Patients Given an Evaluation of Left Ventricular Systolic (LVS) Function.	99%	100%	98%	96%
Heart Failure Patients Given ACE Inhibitor or ARB for Left Ventricular Systolic Dysfunction (LVSD).	96%	100%	94%	95%
Effective Pneumonia Care				
Pneumonia Patients Whose Initial Emergency Room Blood Culture Was Performed Prior to the Administration of The First Hospital Dose of Antibiotics.	97%	96%	98%	98%
Pneumonia Patients Given the Most Appropriate Initial Antibiotic(s).	95%	90%	95%	93%
Timely Surgical Care				
Outpatients having surgery who got an antibiotic at the right time - within one hour before surgery. (Higher numbers are better).	96%	na	99%	96%
Surgery patients who were given an antibiotic at the right time (within one hour before surgery) to help prevent infection.	98%	96%	98%	98%
Surgery patients whose preventive antibiotics were stopped at the right time (within 24 hours after surgery).	97%	97%	97%	97%
Patients who got treatment at the right time (within 24 hours before or after their surgery) to help prevent blood clots after certain types of surgery.	97%	94%	97%	97%
Effective Surgical Care				
Outpatients having surgery who got the right kind of antibiotic. (Higher numbers are better).	97%	na	97%	98%
Surgery patients who were taking heart drugs called beta blockers before coming to the hospital, who were kept on the beta blockers during the period just before and after their surgery.	96%	96%	99%	96%
Surgery patients who were given the right kind of antibiotic to help prevent infection.	98%	99%	99%	98%
Heart surgery patients whose blood sugar (blood glucose) is kept under good control in the days right after surgery.	96%	na	82%	94%
Surgery patients whose urinary catheters were removed on the first or second day after surgery.	95%	96%	97%	95%
Patients having surgery who were actively warmed in the operating room or whose body temperature was near normal by the end of surgery.	100%	na	100%	100%
Surgery patients whose doctors ordered treatments to prevent blood clots after certain types of surgeries.	98%	95%	98%	98%

Timely & Effective Care	National Average	VA Maryland Healthcare System, Baltimore	Bon Secours Hospital, Baltimore MD	Maryland Average
Effective Heart Attack Care				
Heart Attack Patients Given Aspirin at Discharge.	99%	100%	na	99%
Heart Attack Patients Given a Prescription for a Statin at Discharge.	98%	na	na	97%
Effective Heart Failure Care				
Heart Failure Patients Given Discharge Instructions.	93%	95%	97%	92%
Heart Failure Patients Given an Evaluation of Left Ventricular Systolic (LVS) Function.	99%	100%	99%	99%
Heart Failure Patients Given ACE Inhibitor or ARB for Left Ventricular Systolic Dysfunction (LVSD).	96%	96%	98%	97%
Effective Pneumonia Care				
Pneumonia Patients Whose Initial Emergency Room Blood Culture Was Performed Prior to the Administration of The First Hospital Dose of Antibiotics.	97%	98%	95%	96%
Pneumonia Patients Given the Most Appropriate Initial Antibiotic(s).	95%	91%	97%	96%
Timely Surgical Care				
Outpatients having surgery who got an antibiotic at the right time - within one hour before surgery. (Higher numbers are better).	96%	na	na	na
Surgery patients who were given an antibiotic at the right time (within one hour before surgery) to help prevent infection.	98%	97%	100%	97%
Surgery patients whose preventive antibiotics were stopped at the right time (within 24 hours after surgery).	97%	96%	97%	97%
Patients who got treatment at the right time (within 24 hours before or after their surgery) to help prevent blood clots after certain types of surgery.	97%	88%	90%	97%
Effective Surgical Care				
Outpatients having surgery who got the right kind of antibiotic. (Higher numbers are better).	97%	na	na	na
Surgery patients who were taking heart drugs called beta blockers before coming to the hospital, who were kept on the beta blockers during the period just before and after their surgery.	96%	100%	89%	96%
Surgery patients who were given the right kind of antibiotic to help prevent infection.	98%	96%	87%	98%
Heart surgery patients whose blood sugar (blood glucose) is kept under good control in the days right after surgery.	96%	na	na	94%
Surgery patients whose urinary catheters were removed on the first or second day after surgery.	95%	85%	96%	95%
Patients having surgery who were actively warmed in the operating room or whose body temperature was near normal by the end of surgery.	100%	na	99%	100%
Surgery patients whose doctors ordered treatments to prevent blood clots after certain types of surgeries.	98%	91%	92%	98%

Timely & Effective Care	National Average	Omaha VA Medical Center (VA Nebraska Western Iowa)	Alegent Creighton Health Medical Center, Omaha, NE	Nebraska Average
Effective Heart Attack Care				
Heart Attack Patients Given Aspirin at Discharge.	99%	na	100%	100%
Heart Attack Patients Given a Prescription for a Statin at Discharge.	98%	na	100%	99%
Effective Heart Failure Care				
Heart Failure Patients Given Discharge Instructions.	93%	88%	97%	92%
Heart Failure Patients Given an Evaluation of Left Ventricular Systolic (LVS) Function.	99%	100%	100%	97%
Heart Failure Patients Given ACE Inhibitor or ARB for Left Ventricular Systolic Dysfunction (LVSD).	96%	100%	99%	95%
Effective Pneumonia Care				
Pneumonia Patients Whose Initial Emergency Room Blood Culture Was Performed Prior to the Administration of The First Hospital Dose of Antibiotics.	97%	100%	100%	98%
Pneumonia Patients Given the Most Appropriate Initial Antibiotic(s).	95%	89%	97%	94%
Timely Surgical Care				
Outpatients having surgery who got an antibiotic at the right time - within one hour before surgery. (Higher numbers are better).	96%	na	100%	96%
Surgery patients who were given an antibiotic at the right time (within one hour before surgery) to help prevent infection.	98%	97%	99%	97%
Surgery patients whose preventive antibiotics were stopped at the right time (within 24 hours after surgery).	97%	97%	99%	97%
Patients who got treatment at the right time (within 24 hours before or after their surgery) to help prevent blood clots after certain types of surgery.	97%	93%	98%	98%
Effective Surgical Care				
Outpatients having surgery who got the right kind of antibiotic. (Higher numbers are better).	97%	na	100%	98%
Surgery patients who were taking heart drugs called beta blockers before coming to the hospital, who were kept on the beta blockers during the period just before and after their surgery.	96%	97%	99%	97%
Surgery patients who were given the right kind of antibiotic to help prevent infection.	98%	97%	98%	99%
Heart surgery patients whose blood sugar (blood glucose) is kept under good control in the days right after surgery.	96%	na	96%	96%
Surgery patients whose urinary catheters were removed on the first or second day after surgery.	95%	95%	99%	93%
Patients having surgery who were actively warmed in the operating room or whose body temperature was near normal by the end of surgery.	100%	na	99%	100%
Surgery patients whose doctors ordered treatments to prevent blood clots after certain types of surgeries.	98%	96%	98%	99%

Timely & Effective Care	National Average	VA New Jersey Health Care System, East Orange	Saint Barnabus Medical Center, Livingston, NJ	New Jersey Average
Effective Heart Attack Care				
Heart Attack Patients Given Aspirin at Discharge.	99%	na	100%	99%
Heart Attack Patients Given a Prescription for a Statin at Discharge.	98%	na	99%	98%
Effective Heart Failure Care				
Heart Failure Patients Given Discharge Instructions.	93%	93%	100%	96%
Heart Failure Patients Given an Evaluation of Left Ventricular Systolic (LVS) Function.	99%	100%	100%	100%
Heart Failure Patients Given ACE Inhibitor or ARB for Left Ventricular Systolic Dysfunction (LVSD).	96%	94%	100%	98%
Effective Pneumonia Care				
Pneumonia Patients Whose Initial Emergency Room Blood Culture Was Performed Prior to the Administration of The First Hospital Dose of Antibiotics.	97%	97%	100%	98%
Pneumonia Patients Given the Most Appropriate Initial Antibiotic(s).	95%	100%	100%	97%
Timely Surgical Care				
Outpatients having surgery who got an antibiotic at the right time - within one hour before surgery. (Higher numbers are better).	96%	na	99%	97%
Surgery patients who were given an antibiotic at the right time (within one hour before surgery) to help prevent infection.	98%	100%	100%	99%
Surgery patients whose preventive antibiotics were stopped at the right time (within 24 hours after surgery).	97%	94%	98%	98%
Patients who got treatment at the right time (within 24 hours before or after their surgery) to help prevent blood clots after certain types of surgery.	97%	97%	97%	98%
Effective Surgical Care				
Outpatients having surgery who got the right kind of antibiotic. (Higher numbers are better).	97%	na	98%	97%
Surgery patients who were taking heart drugs called beta blockers before coming to the hospital, who were kept on the beta blockers during the period just before and after their surgery.	96%	85%	99%	97%
Surgery patients who were given the right kind of antibiotic to help prevent infection.	98%	98%	100%	99%
Heart surgery patients whose blood sugar (blood glucose) is kept under good control in the days right after surgery.	96%	na	100%	97%
Surgery patients whose urinary catheters were removed on the first or second day after surgery.	95%	87%	95%	96%
Patients having surgery who were actively warmed in the operating room or whose body temperature was near normal by the end of surgery.	100%	na	100%	100%
Surgery patients whose doctors ordered treatments to prevent blood clots after certain types of surgeries.	98%	98%	97%	99%

Timely & Effective Care	National Average	Charleston VA Medical Center	MUSC Medical Center, Charleston, SC	South Carolina Average
Effective Heart Attack Care				
Heart Attack Patients Given Aspirin at Discharge.	99%	100%	98%	98%
Heart Attack Patients Given a Prescription for a Statin at Discharge.	98%	na	99%	98%
Effective Heart Failure Care				
Heart Failure Patients Given Discharge Instructions.	93%	100%	94%	93%
Heart Failure Patients Given an Evaluation of Left Ventricular Systolic (LVS) Function.	99%	100%	100%	99%
Heart Failure Patients Given ACE Inhibitor or ARB for Left Ventricular Systolic Dysfunction (LVSD).	96%	100%	99%	97%
Effective Pneumonia Care				
Pneumonia Patients Whose Initial Emergency Room Blood Culture Was Performed Prior to the Administration of The First Hospital Dose of Antibiotics.	97%	97%	95%	98%
Pneumonia Patients Given the Most Appropriate Initial Antibiotic(s).	95%	83%	88%	96%
Timely Surgical Care				
Outpatients having surgery who got an antibiotic at the right time - within one hour before surgery. (Higher numbers are better).	96%	na	95%	98%
Surgery patients who were given an antibiotic at the right time (within one hour before surgery) to help prevent infection.	98%	100%	98%	99%
Surgery patients whose preventive antibiotics were stopped at the right time (within 24 hours after surgery).	97%	99%	98%	98%
Patients who got treatment at the right time (within 24 hours before or after their surgery) to help prevent blood clots after certain types of surgery.	97%	99%	98%	98%
Effective Surgical Care				
Outpatients having surgery who got the right kind of antibiotic. (Higher numbers are better).	97%	na	95%	95%
Surgery patients who were taking heart drugs called beta blockers before coming to the hospital, who were kept on the beta blockers during the period just before and after their surgery.	96%	99%	98%	97%
Surgery patients who were given the right kind of antibiotic to help prevent infection.	98%	100%	98%	99%
Heart surgery patients whose blood sugar (blood glucose) is kept under good control in the days right after surgery.	96%	99%	91%	97%
Surgery patients whose urinary catheters were removed on the first or second day after surgery.	95%	98%	96%	96%
Patients having surgery who were actively warmed in the operating room or whose body temperature was near normal by the end of surgery.	100%	na	100%	100%
Surgery patients whose doctors ordered treatments to prevent blood clots after certain types of surgeries.	98%	99%	99%	98%

Timely & Effective Care	National Average	Memphis VA Medical Center	Baptist Memorial Hospital, Memphis, TN	Tennessee Average
Effective Heart Attack Care				
Heart Attack Patients Given Aspirin at Discharge.	99%	100%	100%	99%
Heart Attack Patients Given a Prescription for a Statin at Discharge.	98%	na	99%	98%
Effective Heart Failure Care				
Heart Failure Patients Given Discharge Instructions.	93%	100%	90%	91%
Heart Failure Patients Given an Evaluation of Left Ventricular Systolic (LVS) Function.	99%	100%	100%	99%
Heart Failure Patients Given ACE Inhibitor or ARB for Left Ventricular Systolic Dysfunction (LVSD).	96%	98%	99%	96%
Effective Pneumonia Care				
Pneumonia Patients Whose Initial Emergency Room Blood Culture Was Performed Prior to the Administration of The First Hospital Dose of Antibiotics.	97%	98%	99%	98%
Pneumonia Patients Given the Most Appropriate Initial Antibiotic(s).	95%	98%	97%	95%
Timely Surgical Care				
Outpatients having surgery who got an antibiotic at the right time - within one hour before surgery. (Higher numbers are better).	96%	na	98%	97%
Surgery patients who were given an antibiotic at the right time (within one hour before surgery) to help prevent infection.	98%	99%	98%	98%
Surgery patients whose preventive antibiotics were stopped at the right time (within 24 hours after surgery).	97%	96%	95%	97%
Patients who got treatment at the right time (within 24 hours before or after their surgery) to help prevent blood clots after certain types of surgery.	97%	100%	97%	97%
Effective Surgical Care				
Outpatients having surgery who got the right kind of antibiotic. (Higher numbers are better).	97%	na	99%	97%
Surgery patients who were taking heart drugs called beta blockers before coming to the hospital, who were kept on the beta blockers during the period just before and after their surgery.	96%	81%	99%	96%
Surgery patients who were given the right kind of antibiotic to help prevent infection.	98%	100%	99%	99%
Heart surgery patients whose blood sugar (blood glucose) is kept under good control in the days right after surgery.	96%	88%	92%	95%
Surgery patients whose urinary catheters were removed on the first or second day after surgery.	95%	96%	82%	94%
Patients having surgery who were actively warmed in the operating room or whose body temperature was near normal by the end of surgery.	100%	na	100%	100%
Surgery patients whose doctors ordered treatments to prevent blood clots after certain types of surgeries.	98%	100%	99%	98%

Timely & Effective Care	National Average	Milwaukee VA Medical Center	Aurora St. Lukes Medical Center, Milwaukee	Wisconsin Average
Effective Heart Attack Care				
Heart Attack Patients Given Aspirin at Discharge.	99%	97%	100%	100%
Heart Attack Patients Given a Prescription for a Statin at Discharge.	98%	na	99%	98%
Effective Heart Failure Care				
Heart Failure Patients Given Discharge Instructions.	93%	100%	91%	92%
Heart Failure Patients Given an Evaluation of Left Ventricular Systolic (LVS) Function.	99%	100%	100%	98%
Heart Failure Patients Given ACE Inhibitor or ARB for Left Ventricular Systolic Dysfunction (LVSD).	96%	94%	97%	96%
Effective Pneumonia Care				
Pneumonia Patients Whose Initial Emergency Room Blood Culture Was Performed Prior to the Administration of The First Hospital Dose of Antibiotics.	97%	100%	99%	98%
Pneumonia Patients Given the Most Appropriate Initial Antibiotic(s).	95%	100%	98%	96%
Timely Surgical Care				
Outpatients having surgery who got an antibiotic at the right time - within one hour before surgery. (Higher numbers are better).	96%	na	93%	96%
Surgery patients who were given an antibiotic at the right time (within one hour before surgery) to help prevent infection.	98%	98%	98%	98%
Surgery patients whose preventive antibiotics were stopped at the right time (within 24 hours after surgery).	97%	98%	99%	98%
Patients who got treatment at the right time (within 24 hours before or after their surgery) to help prevent blood clots after certain types of surgery.	97%	99%	97%	97%
Effective Surgical Care				
Outpatients having surgery who got the right kind of antibiotic. (Higher numbers are better).	97%	na	95%	98%
Surgery patients who were taking heart drugs called beta blockers before coming to the hospital, who were kept on the beta blockers during the period just before and after their surgery.	96%	99%	97%	96%
Surgery patients who were given the right kind of antibiotic to help prevent infection.	98%	100%	99%	99%
Heart surgery patients whose blood sugar (blood glucose) is kept under good control in the days right after surgery.	96%	98%	98%	94%
Surgery patients whose urinary catheters were removed on the first or second day after surgery.	95%	96%	96%	95%
Patients having surgery who were actively warmed in the operating room or whose body temperature was near normal by the end of surgery.	100%	na	100%	100%
Surgery patients whose doctors ordered treatments to prevent blood clots after certain types of surgeries.	98%	100%	98%	98%

30-Day Outcomes Readmission and Deaths	National Average	San Francisco VA Medical Center	San Francisco General Hospital
Serious Complications			
Collapsed lung due to medical treatment	.35/1,000 discharges	na	Same as U.S.
Serious blood clots after surgery	4.71/1,000 discharges	na	Same as U.S.
A wound that splits open after surgery on the abdomen or pelvis	.95/1,000 discharges	na	Same as U.S.
Accidental cuts and tears from medical treatment	2.05/1,000 discharges	na	Same as U.S.
Pressure sores (bedsores)	na	na	na
Infections from a large venous catheter	na	na	na
Broken hip from a fall after surgery	na	na	na
Bloodstream infection after surgery	na	na	na
Deaths for Certain Conditions			
Deaths after admission for a broken hip	na	na	na
Deaths after admission for a heart attack	na	na	na
Deaths after admission for congestive heart failure	na	na	na
Deaths after admission for a stroke	na	na	na
Deaths after admission for a gastrointestinal (GI) bleed	na	na	na
Deaths after admission for pneumonia	na	na	na
Other Complications and Deaths			
Deaths among patients with serious treatable complications after surgery	113.43/1,000 discharges	na	Same as U.S.
Breathing failure after surgery	na	na	na
Death after surgery to repair a weakness in the abdominal aorta	na	na	na
Hospital Acquired Conditions			
Objects accidentally left in the body after surgery	.028/1,000 discharges	na	.209/1,000 discharges
Air bubble in the bloodstream	.003/1,000 discharges	na	.000/1,000 discharges
Mismatched blood types	.001/1,000 discharges	na	.000/1,000 discharges
Severe pressure sores (bed sores)	.136/1,000 discharges	na	.417/1,000 discharges
Falls and injuries	.527/1,000 discharges	na	.626/1,000 discharges
Blood infection from a catheter in a large vein	.372/1,000 discharges	na	.000/1,000 discharges
Infection from a urinary catheter	.358/1,000 discharges	na	.209/1,000 discharges
Signs of uncontrolled blood sugar	.058/1,000 discharges	na	.209/1,000 discharges
Healthcare Associated Infections			
Central line associated blood stream infections (CLABSI)		na	Better than U.S.

30-Day Outcomes Readmission and Deaths	National Average	Washington, DC VA Medical Center	George Washington University Hospital
Serious Complications			
Collapsed lung due to medical treatment	.35/1,000 discharges	na	Same as U.S.
Serious blood clots after surgery	4.71/1,000 discharges	na	Same as U.S.
A wound that splits open after surgery on the abdomen or pelvis	.95/1,000 discharges	na	Same as U.S.
Accidental cuts and tears from medical treatment	2.05/1,000 discharges	na	Same as U.S.
Pressure sores (bedsores)	na	na	na
Infections from a large venous catheter	na	na	na
Broken hip from a fall after surgery	na	na	na
Bloodstream infection after surgery	na	na	na
Deaths for Certain Conditions			
Deaths after admission for a broken hip	na	na	na
Deaths after admission for a heart attack	na	na	na
Deaths after admission for congestive heart failure	na	na	na
Deaths after admission for a stroke	na	na	na
Deaths after admission for a gastrointestinal (GI) bleed	na	na	na
Deaths after admission for pneumonia	na	na	na
Other Complications and Deaths			
Deaths among patients with serious treatable complications after surgery	113.43/1,000 discharges	na	Same as U.S.
Breathing failure after surgery	na	na	Same as U.S.
Death after surgery to repair a weakness in the abdominal aorta	na	na	na
Hospital Acquired Conditions			
Objects accidentally left in the body after surgery	.028/1,000 discharges	na	.445/1,000 discharges
Air bubble in the bloodstream	.003/1,000 discharges	na	.000/1,000 discharges
Mismatched blood types	.001/1,000 discharges	na	.000/1,000 discharges
Severe pressure sores (bed sores)	.136/1,000 discharges	na	.000/1,000 discharges
Falls and injuries	.527/1,000 discharges	na	1.112/1,000 discharges
Blood infection from a catheter in a large vein	.372/1,000 discharges	na	.445/1,000 discharges
Infection from a urinary catheter	.358/1,000 discharges	na	.778/1,000 discharges
Signs of uncontrolled blood sugar	.058/1,000 discharges	na	.111/1,000 discharges
Healthcare Associated Infections			
Central line associated blood stream infections (CLABSI)		na	Same as U.S.

30-Day Outcomes Readmission and Deaths	National Average	VA Central Iowa Healthcare System, Des Moines	Iowa Methodist Medical Center, Des Moines
Serious Complications			
Collapsed lung due to medical treatment	.35/1,000 discharges	na	Same as U.S.
Serious blood clots after surgery	4.71/1,000 discharges	na	Better than U.S.
A wound that splits open after surgery on the abdomen or pelvis	.95/1,000 discharges	na	Same as U.S.
Accidental cuts and tears from medical treatment	2.05/1,000 discharges	na	Better than U.S.
Pressure sores (bedsores)	na	na	na
Infections from a large venous catheter	na	na	na
Broken hip from a fall after surgery	na	na	na
Bloodstream infection after surgery	na	na	na
Deaths for Certain Conditions			
Deaths after admission for a broken hip	na	na	na
Deaths after admission for a heart attack	na	na	na
Deaths after admission for congestive heart failure	na	na	na
Deaths after admission for a stroke	na	na	na
Deaths after admission for a gastrointestinal (GI) bleed	na	na	na
Deaths after admission for pneumonia	na	na	na
Other Complications and Deaths			
Deaths among patients with serious treatable complications after surgery	113.43/1,000 discharges	na	Same as U.S.
Breathing failure after surgery	na	na	Better than U.S.
Death after surgery to repair a weakness in the abdominal aorta	na	na	na
Hospital Acquired Conditions			
Objects accidentally left in the body after surgery	.028/1,000 discharges	na	.112/1,000 discharges
Air bubble in the bloodstream	.003/1,000 discharges	na	.000/1,000 discharges
Mismatched blood types	.001/1,000 discharges	na	.000/1,000 discharges
Severe pressure sores (bed sores)	.136/1,000 discharges	na	.223/1,000 discharges
Falls and injuries	.527/1,000 discharges	na	.669/1,000 discharges
Blood infection from a catheter in a large vein	.372/1,000 discharges	na	.502/1,000 discharges
Infection from a urinary catheter	.358/1,000 discharges	na	1.339/1,000 discharges
Signs of uncontrolled blood sugar	.058/1,000 discharges	na	.335/1,000 discharges
Healthcare Associated Infections			
Central line associated blood stream infections (CLABSI)		na	Better than U.S.

30-Day Outcomes Readmission and Deaths	National Average	VA Maryland Healthcare System, Baltimore	Bon Secours Hospital, Baltimore MD
Serious Complications			
Collapsed lung due to medical treatment	.35/1,000 discharges	na	na
Serious blood clots after surgery	4.71/1,000 discharges	na	na
A wound that splits open after surgery on the abdomen or pelvis	.95/1,000 discharges	na	na
Accidental cuts and tears from medical treatment	2.05/1,000 discharges	na	na
Pressure sores (bedsores)	na	na	na
Infections from a large venous catheter	na	na	na
Broken hip from a fall after surgery	na	na	na
Bloodstream infection after surgery	na	na	na
Deaths for Certain Conditions			
Deaths after admission for a broken hip	na	na	na
Deaths after admission for a heart attack	na	na	na
Deaths after admission for congestive heart failure	na	na	na
Deaths after admission for a stroke	na	na	na
Deaths after admission for a gastrointestinal (GI) bleed	na	na	na
Deaths after admission for pneumonia	na	na	na
Other Complications and Deaths			
Deaths among patients with serious treatable complications after surgery	113.43/1,000 discharges	na	na
Breathing failure after surgery	na	na	na
Death after surgery to repair a weakness in the abdominal aorta	na	na	na
Hospital Acquired Conditions			
Objects accidentally left in the body after surgery	.028/1,000 discharges	na	na
Air bubble in the bloodstream	.003/1,000 discharges	na	na
Mismatched blood types	.001/1,000 discharges	na	na
Severe pressure sores (bed sores)	.136/1,000 discharges	na	na
Falls and injuries	.527/1,000 discharges	na	na
Blood infection from a catheter in a large vein	.372/1,000 discharges	na	na
Infection from a urinary catheter	.358/1,000 discharges	na	na
Signs of uncontrolled blood sugar	.058/1,000 discharges	na	na
Healthcare Associated Infections			
Central line associated blood stream infections (CLABSI)		na	Same as U.S.

30-Day Outcomes Readmission and Deaths

National Average

**Omaha VA Medical Center (VA
Nebraska Western Iowa)**

**Alegent Creighton Health
Medical Center, Omaha, NE**

Serious Complications

Collapsed lung due to medical treatment	.35/1,000 discharges	na	Worse than U.S.
Serious blood clots after surgery	4.71/1,000 discharges	na	Worse than U.S.
A wound that splits open after surgery on the abdomen or pelvis	.95/1,000 discharges	na	Same as U.S.

Accidental cuts and tears from medical treatment	2.05/1,000 discharges	na	Worse than U.S.
Pressure sores (bedsores)	na	na	na
Infections from a large venous catheter	na	na	na
Broken hip from a fall after surgery	na	na	na
Bloodstream infection after surgery	na	na	na

Deaths for Certain Conditions

Deaths after admission for a broken hip	na	na	na
Deaths after admission for a heart attack	na	na	na
Deaths after admission for congestive heart failure	na	na	na
Deaths after admission for a stroke	na	na	na
Deaths after admission for a gastrointestinal (GI) bleed	na	na	na
Deaths after admission for pneumonia	na	na	na

Other Complications and Deaths

Deaths among patients with serious treatable complications after surgery	113.43/1,000 discharges	na	Same as U.S.
Breathing failure after surgery	na	na	na
Death after surgery to repair a weakness in the abdominal aorta	na	na	na

Hospital Acquired Conditions

Objects accidentally left in the body after surgery	.028/1,000 discharges	na	.000/1,000 discharges
Air bubble in the bloodstream	.003/1,000 discharges	na	.000/1,000 discharges
Mismatched blood types	.001/1,000 discharges	na	.000/1,000 discharges
Severe pressure sores (bed sores)	.136/1,000 discharges	na	.000/1,000 discharges
Falls and injuries	.527/1,000 discharges	na	.000/1,000 discharges
Blood infection from a catheter in a large vein	.372/1,000 discharges	na	.539/1,000 discharges
Infection from a urinary catheter	.358/1,000 discharges	na	1.797/1,000 discharges
Signs of uncontrolled blood sugar	.058/1,000 discharges	na	.180/1,000 discharges

Healthcare Associated Infections

Central line associated blood stream infections (CLABSI)		na	Better than U.S.
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30-Day Outcomes Readmission and Deaths	National Average	VA New Jersey Health Care System, East Orange	Saint Barnabus Medical Center, Livingston, NJ
Serious Complications			
Collapsed lung due to medical treatment	.35/1,000 discharges	na	Same as U.S.
Serious blood clots after surgery	4.71/1,000 discharges	na	Worse than U.S.
A wound that splits open after surgery on the abdomen or pelvis	.95/1,000 discharges	na	Same as U.S.
Accidental cuts and tears from medical treatment	2.05/1,000 discharges	na	Worse than U.S.
Pressure sores (bedsores)	na	na	na
Infections from a large venous catheter	na	na	na
Broken hip from a fall after surgery	na	na	na
Bloodstream infection after surgery	na	na	na
Deaths for Certain Conditions			
Deaths after admission for a broken hip	na	na	na
Deaths after admission for a heart attack	na	na	na
Deaths after admission for congestive heart failure	na	na	na
Deaths after admission for a stroke	na	na	na
Deaths after admission for a gastrointestinal (GI) bleed	na	na	na
Deaths after admission for pneumonia	na	na	na
Other Complications and Deaths			
Deaths among patients with serious treatable complications after surgery	113.43/1,000 discharges	na	Same as U.S.
Breathing failure after surgery	na	na	Same as U.S.
Death after surgery to repair a weakness in the abdominal aorta	na	na	na
Hospital Acquired Conditions			
Objects accidentally left in the body after surgery	.028/1,000 discharges	na	.000/1,000 discharges
Air bubble in the bloodstream	.003/1,000 discharges	na	.000/1,000 discharges
Mismatched blood types	.001/1,000 discharges	na	.000/1,000 discharges
Severe pressure sores (bed sores)	.136/1,000 discharges	na	.203/1,000 discharges
Falls and injuries	.527/1,000 discharges	na	.405/1,000 discharges
Blood infection from a catheter in a large vein	.372/1,000 discharges	na	1.419/1,000 discharges
Infection from a urinary catheter	.358/1,000 discharges	na	.558/1,000 discharges
Signs of uncontrolled blood sugar	.058/1,000 discharges	na	.101/1,000 discharges
Healthcare Associated Infections			
Central line associated blood stream infections (CLABSI)		na	Better than U.S.

30-Day Outcomes Readmission and Deaths

National Average

Charleston VA Medical Center

**MUSC Medical Center,
Charleston, SC**

Serious Complications

Collapsed lung due to medical treatment	.35/1,000 discharges	na	Same as U.S.
Serious blood clots after surgery	4.71/1,000 discharges	na	Same as U.S.
A wound that splits open after surgery on the abdomen or pelvis	.95/1,000 discharges	na	Same as U.S.
Accidental cuts and tears from medical treatment	2.05/1,000 discharges	na	Same as U.S.
Pressure sores (bedsores)	na	na	na
Infections from a large venous catheter	na	na	na
Broken hip from a fall after surgery	na	na	na
Bloodstream infection after surgery	na	na	na

Deaths for Certain Conditions

Deaths after admission for a broken hip	na	na	na
Deaths after admission for a heart attack	na	na	na
Deaths after admission for congestive heart failure	na	na	na
Deaths after admission for a stroke	na	na	na
Deaths after admission for a gastrointestinal (GI) bleed	na	na	na
Deaths after admission for pneumonia	na	na	na

Other Complications and Deaths

Deaths among patients with serious treatable complications after surgery	113.43/1,000 discharges	na	Same as U.S.
Breathing failure after surgery	na	na	Same as U.S.
Death after surgery to repair a weakness in the abdominal aorta	na	na	na

Hospital Acquired Conditions

Objects accidentally left in the body after surgery	.028/1,000 discharges	na	.000/1,000 discharges
Air bubble in the bloodstream	.003/1,000 discharges	na	.000/1,000 discharges
Mismatched blood types	.001/1,000 discharges	na	.000/1,000 discharges
Severe pressure sores (bed sores)	.136/1,000 discharges	na	.444/1,000 discharges
Falls and injuries	.527/1,000 discharges	na	.277/1,000 discharges
Blood infection from a catheter in a large vein	.372/1,000 discharges	na	.388/1,000 discharges
Infection from a urinary catheter	.358/1,000 discharges	na	.000/1,000 discharges
Signs of uncontrolled blood sugar	.058/1,000 discharges	na	.000/1,000 discharges

Healthcare Associated Infections

Central line associated blood stream infections (CLABSI)		na	Better than U.S.
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30-Day Outcomes Readmission and Deaths

National Average

Memphis VA Medical Center

**Baptist Memorial Hospital,
Memphis, TN**

Serious Complications

Collapsed lung due to medical treatment	.35/1,000 discharges	na	Same as U.S.
Serious blood clots after surgery	4.71/1,000 discharges	na	Same as U.S.
A wound that splits open after surgery on the abdomen or pelvis	.95/1,000 discharges	na	Same as U.S.
Accidental cuts and tears from medical treatment	2.05/1,000 discharges	na	Same as U.S.
Pressure sores (bedsores)	na	na	na
Infections from a large venous catheter	na	na	na
Broken hip from a fall after surgery	na	na	na
Bloodstream infection after surgery	na	na	na

Deaths for Certain Conditions

Deaths after admission for a broken hip	na	na	na
Deaths after admission for a heart attack	na	na	na
Deaths after admission for congestive heart failure	na	na	na
Deaths after admission for a stroke	na	na	na
Deaths after admission for a gastrointestinal (GI) bleed	na	na	na
Deaths after admission for pneumonia	na	na	na

Other Complications and Deaths

Deaths among patients with serious treatable complications after surgery	113.43/1,000 discharges	na	Same as U.S.
Breathing failure after surgery	na	na	Worse than U.S.
Death after surgery to repair a weakness in the abdominal aorta	na	na	na

Hospital Acquired Conditions

Objects accidentally left in the body after surgery	.028/1,000 discharges	na	.000/1,000 discharges
Air bubble in the bloodstream	.003/1,000 discharges	na	.031/1,000 discharges
Mismatched blood types	.001/1,000 discharges	na	.000/1,000 discharges
Severe pressure sores (bed sores)	.136/1,000 discharges	na	.153/1,000 discharges
Falls and injuries	.527/1,000 discharges	na	.427/1,000 discharges
Blood infection from a catheter in a large vein	.372/1,000 discharges	na	.519/1,000 discharges
Infection from a urinary catheter	.358/1,000 discharges	na	5.338/1,000 discharges
Signs of uncontrolled blood sugar	.058/1,000 discharges	na	.092/1,000 discharges

Healthcare Associated Infections

Central line associated blood stream infections (CLABSI)		na	Same as U.S.
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30-Day Outcomes Readmission and Deaths	National Average	Milwaukee VA Medical Center	Aurora St. Lukes Medical Center, Milwaukee
Serious Complications			
Collapsed lung due to medical treatment	.35/1,000 discharges	na	Same as U.S.
Serious blood clots after surgery	4.71/1,000 discharges	na	Better than U.S.
A wound that splits open after surgery on the abdomen or pelvis	.95/1,000 discharges	na	Same as U.S.
Accidental cuts and tears from medical treatment	2.05/1,000 discharges	na	Same as U.S.
Pressure sores (bedsores)	na	na	na
Infections from a large venous catheter	na	na	na
Broken hip from a fall after surgery	na	na	na
Bloodstream infection after surgery	na	na	na
Deaths for Certain Conditions			
Deaths after admission for a broken hip	na	na	na
Deaths after admission for a heart attack	na	na	na
Deaths after admission for congestive heart failure	na	na	na
Deaths after admission for a stroke	na	na	na
Deaths after admission for a gastrointestinal (GI) bleed	na	na	na
Deaths after admission for pneumonia	na	na	na
Other Complications and Deaths			
Deaths among patients with serious treatable complications after surgery	113.43/1,000 discharges	na	Same as U.S.
Breathing failure after surgery	na	na	Better than U.S.
Death after surgery to repair a weakness in the abdominal aorta	na	na	na
Hospital Acquired Conditions			
Objects accidentally left in the body after surgery	.028/1,000 discharges	na	.000/1,000 discharges
Air bubble in the bloodstream	.003/1,000 discharges	na	.000/1,000 discharges
Mismatched blood types	.001/1,000 discharges	na	.000/1,000 discharges
Severe pressure sores (bed sores)	.136/1,000 discharges	na	.027/1,000 discharges
Falls and injuries	.527/1,000 discharges	na	.466/1,000 discharges
Blood infection from a catheter in a large vein	.372/1,000 discharges	na	1.289/1,000 discharges
Infection from a urinary catheter	.358/1,000 discharges	na	.494/1,000 discharges
Signs of uncontrolled blood sugar	.058/1,000 discharges	na	.000/1,000 discharges
Healthcare Associated Infections			
Central line associated blood stream infections (CLABSI)		na	Same as U.S.

Comparison of VHA Medical Centers and Same-City Index Hospitals, Same State Average, Hospital Compare Program, **Patient Survey Results**

Patient Survey Results	National Average	San Francisco VA Medical Center	San Francisco General Hospital	CA Average
Patients who reported that their nurses "Always" communicated well.	78%	Not Available	67%	73%
Patients who reported that their doctors "Always" communicated well.	81%	Not Available	72%	77%
Patients who reported that they "Always" received help as soon as they wanted.	66%	Not Available	52%	60%
Patients who reported that their pain was "Always" well controlled.	70%	Not Available	59%	68%
Patients who reported that staff "Always" explained about medicines before giving it to them.	63%	Not Available	61%	59%
Patients who reported that their room and bathroom were "Always" clean.	73%	Not Available	66%	70%
Patients who reported that the area around their room was "Always" quiet at night.	60%	Not Available	36%	50%
Patients at each hospital who reported that YES, they were given information about what to do during their recovery at home.	84%	Not Available	81%	82%
Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest).	69%	Not Available	60%	67%
Patients who reported YES, they would definitely recommend the hospital.	70%	Not Available	63%	69%

Comparison of VHA Medical Centers and Same-City Index Hospitals, Same State Average, Hospital Compare Program, **Patient Survey Results**

Patient Survey Results	National Average	Washington, DC VA Medical Center	George Washington University Hospital	District of Columbia Average
Patients who reported that their nurses "Always" communicated well.	78%	Not Available	71%	69%
Patients who reported that their doctors "Always" communicated well.	81%	Not Available	78%	76%
Patients who reported that they "Always" received help as soon as they wanted.	66%	Not Available	52%	52%
Patients who reported that their pain was "Always" well controlled.	70%	Not Available	64%	64%
Patients who reported that staff "Always" explained about medicines before giving it to them.	63%	Not Available	56%	56%
Patients who reported that their room and bathroom were "Always" clean.	73%	Not Available	60%	61%
Patients who reported that the area around their room was "Always" quiet at night.	60%	Not Available	55%	56%
Patients at each hospital who reported that YES, they were given information about what to do during their recovery at home.	84%	Not Available	83%	77%
Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest).	69%	Not Available	64%	58%
Patients who reported YES, they would definitely recommend the hospital.	70%	Not Available	72%	63%

Comparison of VHA Medical Centers and Same-City Index Hospitals, Same State Average, Hospital Compare Program, **Patient Survey Results**

Patient Survey Results	National Average	VA Central Iowa Healthcare System, Des Moines	Iowa Methodist Medical Center, Des Moines	Iowa Average
Patients who reported that their nurses "Always" communicated well.	78%	Not Available	75%	81%
Patients who reported that their doctors "Always" communicated well.	81%	Not Available	77%	84%
Patients who reported that they "Always" received help as soon as they wanted.	66%	Not Available	56%	70%
Patients who reported that their pain was "Always" well controlled.	70%	Not Available	69%	71%
Patients who reported that staff "Always" explained about medicines before giving it to them.	63%	Not Available	63%	65%
Patients who reported that their room and bathroom were "Always" clean.	73%	Not Available	73%	78%
Patients who reported that the area around their room was "Always" quiet at night.	60%	Not Available	63%	63%
Patients at each hospital who reported that YES, they were given information about what to do during their recovery at home.	84%	Not Available	84%	86%
Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest).	69%	Not Available	74%	74%
Patients who reported YES, they would definitely recommend the hospital.	70%	Not Available	79%	75%

Comparison of VHA Medical Centers and Same-City Index Hospitals, Same State Average, Hospital Compare Program, **Patient Survey Results**

Patient Survey Results	National Average	VA Maryland Healthcare System, Baltimore	Bon Secours Hospital, Baltimore MD	Maryland Average
Patients who reported that their nurses "Always" communicated well.	78%	Not available	66%	74%
Patients who reported that their doctors "Always" communicated well.	81%	Not available	76%	78%
Patients who reported that they "Always" received help as soon as they wanted.	66%	Not available	51%	59%
Patients who reported that their pain was "Always" well controlled.	70%	Not available	64%	68%
Patients who reported that staff "Always" explained about medicines before giving it to them.	63%	Not available	50%	58%
Patients who reported that their room and bathroom were "Always" clean.	73%	Not available	66%	65%
Patients who reported that the area around their room was "Always" quiet at night.	60%	Not available	62%	56%
Patients at each hospital who reported that YES, they were given information about what to do during their recovery at home.	84%	Not available	79%	83%
Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest).	69%	Not available	51%	65%
Patients who reported YES, they would definitely recommend the hospital.	70%	Not available	48%	67%

Comparison of VHA Medical Centers and Same-City Index Hospitals, Same State Average, Hospital Compare Program, **Patient Survey Results**

Patient Survey Results	National Average	Omaha VA Medical Center (VA Nebraska Western Iowa)	Alegent Creighton Health Medical Center, Omaha, NE	Nebraska Average
Patients who reported that their nurses "Always" communicated well.	78%	Not Available	80%	81%
Patients who reported that their doctors "Always" communicated well.	81%	Not Available	81%	84%
Patients who reported that they "Always" received help as soon as they wanted.	66%	Not Available	62%	72%
Patients who reported that their pain was "Always" well controlled.	70%	Not Available	72%	72%
Patients who reported that staff "Always" explained about medicines before giving it to them.	63%	Not Available	65%	64%
Patients who reported that their room and bathroom were "Always" clean.	73%	Not Available	68%	78%
Patients who reported that the area around their room was "Always" quiet at night.	60%	Not Available	55%	64%
Patients at each hospital who reported that YES, they were given information about what to do during their recovery at home.	84%	Not Available	88%	87%
Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest).	69%	Not Available	70%	75%
Patients who reported YES, they would definitely recommend the hospital.	70%	Not Available	73%	76%

Comparison of VHA Medical Centers and Same-City Index Hospitals, Same State Average, Hospital Compare Program, **Patient Survey Results**

Patient Survey Results	National Average	VA New Jersey Health Care System, East Orange	Saint Barnabus Medical Center, Livingston, NJ	New Jersey Average
Patients who reported that their nurses "Always" communicated well.	78%	Not Available	72%	75%
Patients who reported that their doctors "Always" communicated well.	81%	Not Available	79%	77%
Patients who reported that they "Always" received help as soon as they wanted.	66%	Not Available	55%	59%
Patients who reported that their pain was "Always" well controlled.	70%	Not Available	69%	67%
Patients who reported that staff "Always" explained about medicines before giving it to them.	63%	Not Available	57%	59%
Patients who reported that their room and bathroom were "Always" clean.	73%	Not Available	67%	68%
Patients who reported that the area around their room was "Always" quiet at night.	60%	Not Available	53%	52%
Patients at each hospital who reported that YES, they were given information about what to do during their recovery at home.	84%	Not Available	78%	80%
Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest).	69%	Not Available	64%	63%
Patients who reported YES, they would definitely recommend the hospital.	70%	Not Available	71%	66%

Comparison of VHA Medical Centers and Same-City Index Hospitals, Same State Average, Hospital Compare Program, **Patient Survey Results**

Patient Survey Results	National Average	Charleston VA Medical Center	MUSC Medical Center, Charleston, SC	South Carolina Average
Patients who reported that their nurses "Always" communicated well.	78%	Not Available	80%	80%
Patients who reported that their doctors "Always" communicated well.	81%	Not Available	81%	84%
Patients who reported that they "Always" received help as soon as they wanted.	66%	Not Available	66%	68%
Patients who reported that their pain was "Always" well controlled.	70%	Not Available	71%	72%
Patients who reported that staff "Always" explained about medicines before giving it to them.	63%	Not Available	64%	66%
Patients who reported that their room and bathroom were "Always" clean.	73%	Not Available	68%	73%
Patients who reported that the area around their room was "Always" quiet at night.	60%	Not Available	65%	68%
Patients at each hospital who reported that YES, they were given information about what to do during their recovery at home.	84%	Not Available	84%	85%
Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest).	69%	Not Available	81%	71%
Patients who reported YES, they would definitely recommend the hospital.	70%	Not Available	85%	71%

Comparison of VHA Medical Centers and Same-City Index Hospitals, Same State Average, Hospital Compare Program, **Patient Survey Results**

Patient Survey Results	National Average	Memphis VA Medical Center	Baptist Memorial Hospital, Memphis, TN	Tennessee Average
Patients who reported that their nurses "Always" communicated well.	78%	Not Available	77%	79%
Patients who reported that their doctors "Always" communicated well.	81%	Not Available	77%	83%
Patients who reported that they "Always" received help as soon as they wanted.	66%	Not Available	61%	67%
Patients who reported that their pain was "Always" well controlled.	70%	Not Available	69%	71%
Patients who reported that staff "Always" explained about medicines before giving it to them.	63%	Not Available	58%	64%
Patients who reported that their room and bathroom were "Always" clean.	73%	Not Available	73%	72%
Patients who reported that the area around their room was "Always" quiet at night.	60%	Not Available	67%	66%
Patients at each hospital who reported that YES, they were given information about what to do during their recovery at home.	84%	Not Available	80%	83%
Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest).	69%	Not Available	73%	69%
Patients who reported YES, they would definitely recommend the hospital.	70%	Not Available	78%	70%

Comparison of VHA Medical Centers and Same-City Index Hospitals, Same State Average, Hospital Compare Program, **Patient Survey Results**

Patient Survey Results	National Average	Milwaukee VA Medical Center	Aurora St. Lukes Medical Center, Milwaukee	Wisconsin Average
Patients who reported that their nurses "Always" communicated well.	78%	Not Available	77%	81%
Patients who reported that their doctors "Always" communicated well.	81%	Not Available	77%	83%
Patients who reported that they "Always" received help as soon as they wanted.	66%	Not Available	58%	71%
Patients who reported that their pain was "Always" well controlled.	70%	Not Available	69%	72%
Patients who reported that staff "Always" explained about medicines before giving it to them.	63%	Not Available	63%	67%
Patients who reported that their room and bathroom were "Always" clean.	73%	Not Available	69%	78%
Patients who reported that the area around their room was "Always" quiet at night.	60%	Not Available	52%	63%
Patients at each hospital who reported that YES, they were given information about what to do during their recovery at home.	84%	Not Available	86%	87%
Patients who gave their hospital a rating of 9 or 10 on a scale from 0 (lowest) to 10 (highest).	69%	Not Available	70%	74%
Patients who reported YES, they would definitely recommend the hospital.	70%	Not Available	72%	74%

(3) Sample of one VHA medical center Customer Service Scores, compared to national VHA medical center results

VA Loma Linda Healthcare System

VA Loma Linda Healthcare
System Home

Available Services

Patient Information

Visitor Information

Our Doctors

Returning Combat
Veterans

Health Care Eligibility

Careers

Volunteer or Give

Emergency Response &
Information

Contact Us

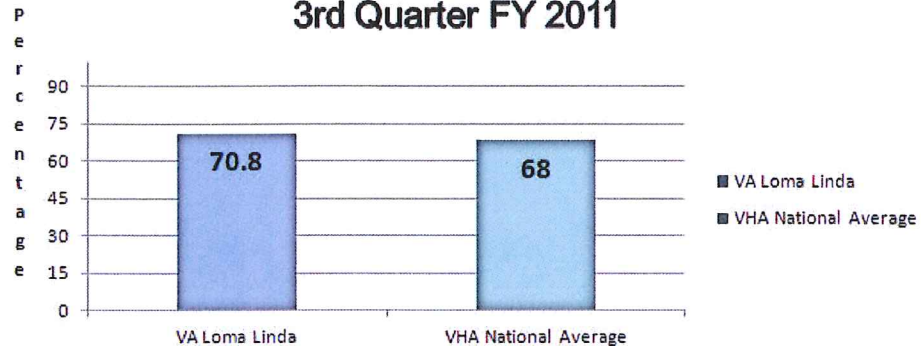
About Us

Site Search

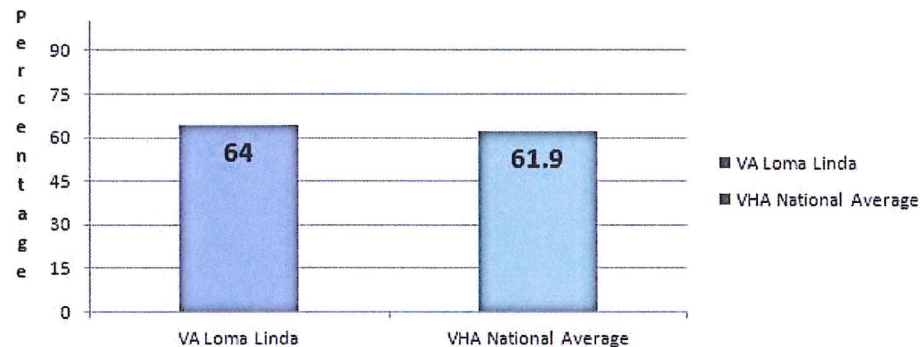
Customer Service Scores

VA Loma Linda Healthcare System participates in the Hospital Consumer Assessment of Health Providers and Systems (HCAHPS) hospital survey to measure what kind of experience patients have at VA Loma Linda Medical Center while receiving care.

Overall Patient Satisfaction at VA Loma Linda Healthcare System with Personal Doctor/Nurse 3rd Quarter FY 2011



Overall Patient Satisfaction at VA Loma Linda Healthcare System with Rating Specialist 3rd Quarter FY 2011



Note:

All HCAHPS scores reported here reflect data gathered over the past 3 months (April-June).

Let us Know What You Think

We value your opinion. If you would like to share with us your experience or would just like to comment on your care at the VA Loma Linda Healthcare System, please contact our Customer Service Office at vhalomvss@va.gov or by phone at (909) 825-7084 ext. 6133.

(4) American Legion “System Worth Saving” summary of key 2012 survey findings

	Baltimore, MD	Biloxi, MS	Charleston, SC	Chicago, IL	Cincinnati, OH
Quality of Care Measures					
FY Budget 2011	\$519,362,965	\$319,487,960	\$286,500,000	\$356,000,000	\$355,510,201
FY Budget 2012	\$500,615,065	\$328,463,067	\$303,500,000	\$368,000,000	\$349,531,855
How is quality measured?	PI Program Plan; External Reviews; OIG Reviews; In-House Monitoring	Performance measures to understand broad overview of healthcare quality and access	The approach is one of 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.	Using a patient satisfaction survey given to and submitted by our veterans; Receiving quality patient care services awards; Joint Commission and OIG Survey Accreditation readiness	Through an assessment of outcomes of care as compared to VA and non-VA facilities, Veteran satisfaction with our care and services, whether any patient incidents would suggest that our processes for providing care should be improved and by assessing the performance of our staff and others involved in the care process.
Accountability and maintenance of quality care	Accreditation through TJC, CARF, AAHRP, CAP, ASHO, ACoS COC, ACR	Performance Measures meeting once a month to discuss current Performance Plan and overall progress	Through performance scorecards, outcomes of team initiatives, actions taken as a result of QM processes, committee reports and meeting minutes; Accreditation through the Joint Commission	Hold every employee, every department, and every administrator accountable for providing the best quality of care here at JBVAMC. If one department fails to provide good care, then every department looks bad as a unit. The matter is quickly addressed from everyone who is involved; The center utilizes a quality improvement measure that involves reviewing the case and then finding the best and most effective way to improve future problems.	The medical center tracks measures of quality required by VA, outside reviewers and the Network, as well as locally developed measures. Some measures are reported externally to Veterans. The CVAMC also does very detailed assessments of its degree of compliance with mandated measures required by The Joint Commission, OIG CAP survey processes, CARF and other reviewers. There is a continual assessment of programs and services, using local as well as VISN and national measures/standards. When an incident occurs, there is systematic access to processes to determine whether improvements are needed to prevent a recurrence. Employees are evaluated for the quality of care or services they provide, and there is active work to improve performance and conduct among staff or take appropriate administrative action.

	Baltimore, MD	Biloxi, MS	Charleston, SC	Chicago, IL	Cincinnati, OH
Quality Manager Position	Responsible for ensuring that a systematic process is in place for monitoring the facility quality data. This individual serves as the performance improvement/quality consultant to VAMHCS leadership, PI teams and employees. Additionally, this individual serves on executive committees and workgroups where quality data and information are reviewed, analyzed, and acted upon. Serves as	Serves as a consultant, facilitator and compliance monitor for health care system processes and programs	The Quality Manager is responsible for the management, coordination, integration, technical support, and daily oversight of the facility's Quality Management Program	The Chief of Performance Improvement has responsibility for leading the Medical Center Quality program. This includes the domains of Survey Readiness, Systems Redesign, Management, and Risk Management. The Quality Manager ensures that the Quality Program meets VHA requirements, and that the facility maintains Joint Commission, OIG, and other survey readiness. The External Peer	Design, implementation, coordination, and evaluation of an integrated Quality Management Program for the Cincinnati VAMC and all components which include direct oversight of Performance Improvement, Risk Management, External Accreditation, VASQIP, and Utilization Management operates under a broadly delegated authority to influence the organizational mission, participates in strategic
1. How are quality care indicators and measurements tracked and managed?	Identify and pursue opportunities for performance improvement; The PI Program Plan provides the structure and guidance for the design, measurement, assessment and improvement of VAMHCS performance. It applies to all settings within the full continuum of the VAMHCS including all outpatient, inpatient, long-term care, behavioral and home care settings; Quality is also measured through the results of external reviews, VHA reviews, OIG reviews and ongoing in-house monitoring using PI SubCouncils at the Clinical Center/Service level and the Executive Performance Improvement Council.	Through the Performance Measures Committee and the Quality & Performance Management Board	The Senior Executive Council is a standing leadership committee to review quality data and ensure that information and key quality components are discussed and that data are reviewed. This Council evaluates effectiveness through the assessment of goal achievement, outcome measures of specific performance measures, and the level of implementation of strategic planning initiatives.	Organizational reporting structure where all noteworthy quality indicators and measurements are presented at the monthly Quality Leadership Council. An annual QLC calendar is available to all applicable Service Chiefs, which includes the functions, monitors, and committee reports to be presented, evaluated, and acted upon for each month. Complete minutes are recorded, and follow-up action items are addressed until closure.	Performance measures and monitors of all types are tracked over time to identify trends as well as compare with internal and external benchmarks for the purpose of identifying opportunities for improvement.
2. How do you measure and manage quality as a healthcare facility?	Committees identify the measures warranting performance improvement or monitoring and the frequency of collection; Collection tracking, and trending and analysis are performed on a monthly, quarterly, semi-annual, or annual basis; Results are reported to one of the Executive Committees for oversight monitoring'	There are a number of consultants that assist service lines, program managers, and administration in developing and maintaining quality programs. Measurement and management are conducted through the Quality & Performance Management Service.	See above answer	Structure of strategic planning framework for collaborative, systematic and continuous performance improvement activities; Measure and manage quality through interdisciplinary committees, chartered improvement teams, services improving outcomes for patients, visitors and staff through a performance improvement approach. Integrated measuring and managing methodologies include A-TAMMCS, Plan-Do-Study-Act (PDSA), Six Sigma, Lean Thinking, Rapid Process Improvement Workshops (RPIW), and Project Charter.	VA Central Office provides a Network Director Performance Plan each fiscal year which is considered high priority. Areas of high risk and patient safety concerns are priority for identifying and improving the quality and safety of healthcare.
Patient Safety Manager Position	Oversight of safety issues involving patients, visitors, and staff within VA Maryland Health Care System	Coordinates and manages an Integrated Patient Safety program for the facility; Consults with clinical services; Manages the National Patient Safety Goals; Tracks data for efficient processes and resource planning	Responsible for implementing a 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	Responsible for overseeing the delivery of patient safety to a culturally diverse veteran population	The Patient Safety Managers support the Root Cause Analysis (RCA) process in response to an unexpected outcome by providing team training, support and developing competencies in team function. The Patient Safety Managers also have programmatic functions such as serving as the facility point of contact for Patient Safety Alerts/Advisories including

	Baltimore, MD	Biloxi, MS	Charleston, SC	Chicago, IL	Cincinnati, OH
Utilization Management Position	Evaluates and determines the coverage and appropriateness of medical services to ensure proper use of resources	Reviews admissions and continued stay for appropriateness; Identifies trends; Compiles report data	Review medical records to determine acuity for admission and continuing length of staff. Patient satisfaction is not a direct responsibility but indirectly serves to promote timely discharge planning.	Ensure quality of care; include completion of reviews for patients admitted to the facility as well as those remaining within the facility to ensure patients are at the appropriate level of care and have timely access to care; Completion of reviews helps to ensure application of evidenced based criteria, effective resource utilization, and increased efficiency.	Utilization Review nurses in the Quality Management department review electronic medical records, attend interdisciplinary rounds daily, collaborate with the Attending and Emergency Room doctors regularly concerning patients and the level of care and the timeliness of care that they receive.
1. How are measurement tools used to improve quality of care and patient satisfaction?	On a facility-wide and clinical center specific basis, the primary UM outcome indicators (e.g. readmission, adm meeting criteria) are sent to committees to assist in the identification of potential gaps in service or care. Further indicators are collected on individual providers to assist them in understanding their practice patterns and identify ways of improving their aggregate care as well as care for individual patients.	National Utilization Management Integration System; McKesson InterQual Criteria assist in identifying a safe and appropriate level of care. IQ criteria are also used to identify over and under utilization of services which can impact quality of care.	Tools serve 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.	Analyzes data retrieved from National Utilization Management Integration (NUMI) and VHA Support Service Center (VSSC) to identify systems issues presenting barriers to patient flow; Monitors data regarding patients not meeting InterQual criteria, including reasons not met and recommended levels of care for those patients not meeting criteria; Data used to help drive change within the facility and improve patient flow, thereby improving quality care, access to care, and ultimately patient satisfaction.	The tools used to improve quality of care and patient satisfaction come from developed computerized software geared to assist the UR nurse in completing reviews in a more efficient manner, and via data-specific tools developed by the UR nurses to accomplish task, such as; tracking and trending data that is unique to the needs of the facility in meeting the National Directives. The data obtained by the UR nurse is used to improve and promote patient flow throughout the facility by addressing issues that hinder and or stifle flow thus increasing patient satisfaction.
Risk Manager Position	Implements a risk management program that includes reporting, sentinel event reporting, and peer review	Ensures that patient care is of the highest quality; Advises the organization if there is a risk to quality of care	Responsibilities include 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.	Collaborates with all services at all levels to ensure quality of care and patient satisfaction	Mitigates risk through proactive identification and management of issues that pose a risk to patients, visitors, the organization and its staff

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1. How are measurement tools used to improve quality of care and patient satisfaction?	A variety of measurement tools are utilized for planning, data collection, and analysis. Some examples include: process mapping to identify critical steps in a process and actual or potential risk areas for analysis; run charts to show levels of performance over time; control charts to identify the type of variation that exists in a process and whether the process is statistically in control.	Data such as patient satisfaction scores, mortality rates and established clinical monitors (e.g., influenza vaccination rate) are used in determining if and where the organization may be at risk for not meeting quality patient care standards. Established monitors and risk management tools allow for the prioritization of risk factors and the determination of multiple or singular risks will impact the organizations. When performance scores fail to meet the expected benchmark, the appropriate service chiefs and program leaders are consulted in an effort to improve operations.	Tools serve 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.	The Risk Manager is part of the Quality Management Team, and participates on Performance Improvement initiatives; Risk Manager is also involved in facilitating corrective actions to improve quality of care and patient satisfaction for issues that may have been discovered in a Risk Management review.	Risk Management trends data to monitor from tort claims and provider reviews to improve the quality of care. Risk management also works with patient advocates regarding Veteran concerns to improve patient satisfaction.
Systems Redesign Manager Position	To redesign the system in a manner that ensures quality of care throughout the facility	Facilitates performance improvement of clinical and administrative practices	Facilitates systems redesign groups facility wide that work to improve quality of care and patient satisfaction	Eliminate waste, improve processes that overlap into providing quality care, and is involved in patient satisfaction	Serve as a consultant to workgroups throughout the Medical Center to analyze performance data related to quality of care and patient satisfaction, identify performance gaps between expected and actual performance, identify process barriers that negatively impact quality of care and patient satisfaction and develop solutions to improve both.
1. How are measurement tools used to improve quality of care and patient satisfaction?	There are formal and informal meetings related to systems redesign (SR) and Access issues relating to miss opportunities. Currently VAMHCS is rolling out Yellow Belt Lean training for all leadership and Management positions to ensure the SR efforts are efficiently and effectively rolled out across the Health Care Delivery system. There is extensive Clinical Center involvement and monthly reporting using the all systems redesign tools.	Use measurement tools including variability analysis, queuing, statistical process controls, and most Lean tools (time studies, environment (spaghetti) diagrams, etc.) to specifically identify areas for process improvement.	Measurement tools in this facility are tracked daily, weekly, monthly and quarterly. They are reported to all employees, clinic management and/or leadership electronically and/or face-to-face. 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.	Routine monitoring of VHA Support Service (VSSC) Data, that identifies areas for improvement; examine access, no shows, clinical utilization statistical summary (CUSS) report, and telephone usage; daily monitoring of electronic wait list and clinic cancellations	Regular monitoring of quality of care indicators and patient satisfaction data and development of improvement projects based on areas that do not meet expected performance measures. In addition to the VA-prescribed performance measures, the facility also designs studies to investigate ongoing issues (e.g. complaints, incident reports, etc.) for opportunities of improvement. SR at this facility is aligned within the Quality Management office and participates in Patient Safety root cause analysis and healthcare failure mode effect analysis.

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Chief Health Medical Information Officer/Clinical Lead for Informatics Position	Manages and processes clinical data, information, and knowledge; stores and retrieves patient information; provides tools for data management; Maintains integrity of computerized data	Ensures patient quality in health information management through coders, release of information management, and scanning	Clinical systems are extremely dependent on information technology networks and systems to operate. This fact clearly defines the critical role that it has in ensuring quality of care and patient satisfaction. As a CIO I have collaborated with my clinical partners to bring projects like home telehealth, telehealth expansion, veterans electronic lifetime record (VLER), DOD/VA partnerships, veterans guest access and most recently Vocera (nurse call enhancement) to improve the quality of care and satisfaction of our nations veterans.	Responsible for oversight of the quality and accuracy of the medical record and all associated clinical documentation, coding, and release of information functions	Responsible for the appropriate use of technology as it applies to clinical settings
1. How are quality of care and patient satisfaction indicators and measurements tracked and managed?	Not answered in Mail out form	Health Information Management Section Receives monthly notification of the Customer Service Standards report from the Patient Advocate. This information is reviewed to determine whether there are any areas that can be corrected and these representative check specifically for Staff courtesy and accessibility in Release of Information.	Through SHEP scores	Data Validation Committee reporting structure ensures that data is analyzed and utilized to improve the quality of care. For Health Information Service, key measures include accuracy and timeliness of coding. Results are reported to the Medical Records Committee.	These are measured through quality department via performance measures and quality indicators. Facility provides support for building of clinical reminders and templates containing health factors to be able to track specific measures. Patient satisfaction is tracked and managed through education. Quality of care and patient satisfaction data is reviewed on a department specific level. The IPEC system is available with statistical analysis capabilities.
2. How do you measure the results of quality of care and patient satisfaction indicators?	Not answered in Mail out form	Health Information Management Section receives monthly notification of the Customer Service Standards report from the Patient Advocate. This information is reviewed to determine whether there are any areas that can be corrected and these representatives specifically check for Staff courtesy and accessibility in Release of Information. They then look at our staffing metric for ROI, to see how we can make adjustments to be of better	Not answered in Mail out form	Through PACT	These are measured through outcomes evaluated through the performance measures mentioned above. Clinical reminders, allow for real time evaluation of key indicators that affect patient care.

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3. How are measurement tools used to improve the quality of care and patient satisfaction?	Not answered in Mail out form	Coding, release of information, and scanning	Not answered on Mail out form	Timeliness of release of information is measured to ensure patients receive requested information in a timely manner. When timeliness exceeds set standards, the systems and processes used are reviewed to improve efficiency.	Reminder reports are run by specific departments, mainly primary care, to measure quality of care and they use this information to make appropriate clinical changes. Patient satisfaction is collected, maintained and addressed through the education department. BCMA reports are run to note trends and improvements in quality of care.
Grant Programs	Bed Management Collaborative; Palliative Care	Specialty Care PACT Pilot Project; Rural Health Mental Health Program	n/a	The Joint Commission is inspecting the facility for quality of care	PTSD programming, Women's Health initiatives, Health Promotion/Disease Prevention Programs for Veterans and their spouses, programming for inpatient mental health, a new initiative to improve health status and quality of life for Veterans with COPD, a collaborative with the community on cancer care, an initiative to improve health status and wellness of employees, the ongoing mobile van outreach initiative funded by Cintas Corporation's Farmer Family Foundation, a grant from Proctor and Gamble to beautify the Ft. Thomas campus and create areas for recreational programs and gardening and rural outreach initiatives.
Staff Positions Responsible for Performance Measures	Performance Measure Coordinator; System Redesign Coordinator	Performance Measures Coordinator; All employees are responsible for meeting performance measures	Medical Center Director	Each Service/Section Chief, Service Line Chief, and Program Director	Chief of Staff

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Patient Satisfaction Measures					
How is patient satisfaction measured?	Surveys/Assessments from patient perspective; Data distributed daily, monthly, quarterly, and annually to clinical areas; VVSC interdisciplinary committee oversees patient satisfaction improvement efforts	Monitoring various data elements, including performance measures and monitors that are reviewed in both the Patient Satisfaction Committee and the Customer Service Board. The data is used to develop plans of action to improve patient and family experiences.	If every veteran is satisfied with their outcome	Through the Jesse Brown VAMC Customer Service Committee. The purpose of the Jesse Brown VAMC Customer Service Committee (CSC) is to discuss issues related to customer service and identify new methods of providing the highest level of service to our Veterans. The council is dedicated to service excellence and meets regularly to develop innovative customer service programs. The JBVAMC CSC has a duty to represent the greater interests for the JBVAMC concerning customer satisfaction issues.	SHEPS Survey and Quickcard Survey
Measurement tools to track patient satisfaction	Survey of Healthcare Experiences of Patients (SHEP); TruthPoint	Ongoing questionnaires, post-discharge calls, Patient Advocate Tracking data and Survey of Healthcare Experiences of Patients reports to guide our improvement plans. Patients are involved in plans by having a Veteran serve as member of the PSC.	Utilization of SHEP scores, ICE machines, IRIS internet inquiries, patient feedback cards from both the inpatients and outpatient; Results are discussed monthly in the Customer Service Committee; The group brainstorms ideas to enhance our Veteran and Family Experience; Live interactive feedback during rounding and the Patient Advocate Tracking System	The council evaluates the results of the National VA Patient Satisfaction Surveys, VISN surveys or other locally administered data collection methods; and identifies opportunities for improvement and benchmark results as applicable against established industry standards. JBVAMC has 3 primary methods of data collection and monitoring. HCAPS, SHEP and Press Ganey. They are all tracked via the CSC.	Survey of Healthcare Experiences of Patients (SHEP); Quickcards; Patient Advocate complaints

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Patient Advocate Position	Resolves issues and concerns of veterans in navigating the health system; Track veteran complaints and compliments by month and service/clinical center	Manages, analyzes, and distributes the Patient Advocate Tracking System complaint/compliment data	Responsible for taking patient issues and concerns and assisting in getting a result for the Veteran and their families when issues arise; Tack and trend data to do process improvement; Utilize tools for patient advocate to ensure any increase or trend is immediately identified; Advocate and educate our Veterans and their families.	Service Recovery, whereby patient complaints are identified, resolved, classified, and utilized to improve overall service to veterans. The Patient Advocacy Program is an important aspect of patient satisfaction and contributes proactively to VHA initiatives to provide world-class customer service.	Serves as the liaison between the Medical Center, patients, staff and the community it serves regarding patients' rights and advocacy
1. How are patient satisfaction indicators and measurements tracked and managed?	Surveys are used to assess the quality of care as seen from the eyes of the patient and family. Data is analyzed and distributed on a daily, monthly, quarterly, and annual basis to all clinical centers and services to assess and develop strategies to meet patients' needs. The Consumer Relations Service Business Manager manages, analyzes, and distributes the SHEP patient satisfaction data. A Patient Advocate manages, analyzes, and distributes the Patient Advocate Tracking System (PATS) complaint/compliment data. The VAMHCS Veterans Satisfaction Committee (VVSC) is an	They are tracked in the Patient Satisfaction Committee and reported into Customer Service Board and Performance Measures Committee.	Through the CSC	Discuss issues related to customer service and identify new methods of providing the highest level of service to our Veterans. The council is dedicated to service excellence and meets regularly to develop innovative customer service programs. The CSC provides advice, counsel and feedback to the Executive Leadership Team regarding plans, initiatives, and service experience(s). The Council also works collaboratively across all services to support and enhance each service's customer satisfaction initiatives. The council evaluates the results of the National VA Patient Satisfaction	Survey of Healthcare Experiences of Patients (SHEP); Quickcards; Patient Advocate reports
Director of Patient Care Services Position	Analyzes and manages data and collaborates with the clinical centers and services to promote patient-centered care, enhance customer service, and improve patient satisfaction	Ensures that services, functions, and committees participate in the PI program and associated activities	Collaborates with senior executive management in making decisions about health care services, settings, and organizational priorities	Direct responsibility is undefined in report	Oversight of Nursing Service including all aspects of patient care, quality of care, safe patient care, compliance with regulatory standards, patient satisfaction, etc.

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1. How are patient satisfaction indicators and measurements tracked and managed?	n/a	Continuous measurement of patient satisfaction by monitoring various data elements that are reviewed in both the Patient Satisfaction Committee and the Customer Service Board. In addition, Patient Satisfaction scores are monitored through our Performance Measures Committee. The data is used to develop plans of action to improve our patients and their family's experiences within our health care system.	They are posted monthly to the National Website and they are placed in an excel sheet, shared with staff and the counsel to address.	Part of facility score care card and tracked by senior leadership when new results are available	Through Customer Service Committee, unit based practice councils, staff meetings, postings
Patient Aligned Care Team Coordinator Position	Oversees implementation of PACT in Primary Care; Develop and implement a quality program to become Veteran-centric	To ensure that all facets of the PACT program are rolled out to the 48 primary care teams of the Gulf Coast. The duties involved range from ensuring phone systems and communication tools are in place, to ensuring Veteran outreach occurs, to the management of the performance metrics and team training for Central Office functions.	The PACT duties and responsibilities consist of oversight of the specific goals of PACT to optimize access 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.	Implementation of PACT is a team effort including primary care, nursing, PAS, social work, nutrition and food services, and pharmacy, among others.	Training and monitoring of PACT teams; facilitate PACT teamlet dynamics; review and interpretation of data and reports; mentor teamlets in the tenets of PACT.
Quality of Care vs. Patient Safety	Quality of care and patient safety are interrelated. Focusing on patient safety provides the organization with the opportunity to mitigate potential adverse events thus improving quality of care. The patient safety program promotes the implementation of knowledge-based actions that can be formulated, tested, and implemented to mitigate system vulnerabilities that can lead to patient harm and negatively effect quality of care.	The goal of VHA's patient safety program is to reduce or eliminate harm to patients as a result of their care. This has a direct relation to quality of care: the degree to which health services increase the likelihood of desired health outcomes and are consistent with current professional knowledge.	Patient safety focuses on direct safety risks and developing processes and systems to prevent repeat occurrences. Safety is, however, an integral component of the QM program.	Under the umbrella of Quality Management, Patient Safety works collaboratively with Performance Improvement, System Redesign and Risk Management. Quality of Care issues can be identified in many venues such as Patient Incident Reports, Occurrence Screens, self reports, medical record reviews, peer reviews etc.	Both are very closely interwoven and at times difficult to separate. However, the actual process of how issues are examined and corrective actions taken may differ. For example, RCA's look at system issues, not necessarily person specific issues. Person specific issues are dealt with via other means such as Peer Review, Administrative Investigations.

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Process for a root cause analysis	The RCA process is a specific type of focused review that is used for all adverse events or close calls requiring analysis utilizing the Safety Assessment Code (SAC) Matrix. An interdisciplinary team approach is utilized to focus primarily on systems and processes rather than individual performance. The result of the analysis identifies changes that could be made in systems and processes through either redesign or development of new processes and systems that would improve performance and reduce risk.	Conducting an RCA is a critical aspect in the process of improving patient safety. The goal of the RCA process is to find out what happened, why it happened, and to determine what can be done to prevent it from happening again.	When an adverse event occurs, the event undergoes an analysis to determine severity. If criteria are met, an 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.	Multidisciplinary teams are formed to investigate adverse events and close calls. Close calls are events that could have resulted in a patient's accident or injury, but didn't — either by chance or timely intervention; RCAs are used to focus on improving and redesigning systems and processes — rather than focus on individual performance, which is seldom the sole reason for an adverse event or close call. A previously unheeded or unnoticed chain of events most often leads to a recurring safety problem, regardless of the personnel involved.	When an event becomes known, the Patient Safety Manager, based on criteria, determines if a RCA needs to be done. The Director charts a team to fully examine the issue and make specific recommendations for organizational improvement. When the project is completed the team reports to leadership and other parties as appropriate. This is treated as a learning opportunity and outcome is communicated to staff in multiple ways.

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Quality of Care Measures					
FY Budget 2011	\$352,166,843	\$174,327,283	\$414,754,866	\$250,658,591	\$371,000,000
FY Budget 2012	\$358,119,974	\$178,738,119	\$349,781,588	\$246,962,878	\$400,000,000
How is quality measured?	Monitoring and tracking of all medical center performance improvement and patient safety activities and issues, recommending actions, tracking the resolutions, and supporting the improvement of processes. Aggregated data review and analysis of key quality indicators helps to determine performance improvement priorities. The data collected for high priority and required areas are used to monitor the stability of existing processes, identify opportunities for improvement, and identify changes that lead to improvement or sustain improvement. Areas for monitoring performance are determined by considering the Veterans' needs, nationally identified high risk areas, sentinel events, and priorities set by leaders at the local, regional, and national level. In addition, the medical center identifies those areas needing improvement and identifies desired changes. Performance measures are used to determine whether the changes result in desired outcomes.	Dimensions include appropriateness of care, efficacy, efficiency, timeliness, accessibility, safety, continuity of care, and environmental safety. Patient safety, infection control, risk control, are an integral part of the Quality Program structure.	Performance measures are determined by VA Central Office, the VISN, and the facility, culminating in an ECF plan for performance for each fiscal year.	Utilizes data resources and tools designed and developed at all three levels within VA's agency structure: VA Central Office, the VISN, and the facility.	Selection of performance monitors/measures to determine if a process/function is performing at expected level. Performance measures are designed by the Medical Center or selected from external measures. Relevant measures are selected that may be compared to similar organizations/ industries, or benchmarked with exceptional performers/organizations. Comparative data are used to determine if there is excessive variability or unacceptable levels of performance, as well as levels that represent superior performance. Data collection and analysis activities are intended to address important Medical Center processes and functions. Statistical tools and techniques are used to analyze and display data.
Accountability and maintenance of quality care	Accountability is maintained through verification of performance via internal and external reviews (The Joint Commission, Office of the Inspector General [OIG], Commission on the Accreditation of Rehabilitation Facilities [CARF], the College of American Pathologists [CAP], and other federal and state regulatory agencies. Healthcare Inspection Reports are available to the public from the OIG website and TJC Accountability Measures are available from the Quality Check website as well as on the U.S. Department of Health & Human Services Hospital Care internet site. The facility openly communicates with state and federal regulatory agencies as well as Veteran Service Organizations and other community partners with the intent of maintaining accountability through transparency. The Medical Center fully engages a comprehensive and proactive Compliance and Business Integrity program promoting an organizational culture and encourages compliance with the laws, regulations, and standards.	Continuous monitoring and reporting of measures, and Establishment of committees, teams, workgroups to report to the governing bodies.	The VA has established a division of Patient-Centered Care and is rolling out educational initiatives nationwide. At VISN 5, Patient Satisfaction/Patient Centered Care is a standing agenda item for daily morning report and the Executive Leadership Committee. This is mirrored in the facilities.	VACIHCS is held accountable for specific performance measures established by VACO, the VISN, and within the facility and is charged with implementing and progressing on strategic goals set at all three organizational levels. Additionally, VACIHCS maintains continuous service readiness and is routinely and regularly visited both by internal VA and external survey, accreditation, and other regulatory bodies. Within the facility, staff is encouraged to identify and address any opportunities for improvement at all levels within the system. Performance and outcomes measured through all of these mechanisms continuously feed focused efforts designed to enhance and improve Veteran-centered quality of care.	Management of quality is overseen through our Medical Center Governance Structure. Through this structure is a series of committees and sub-committees which report up to councils chaired or co-chaired by members of the executive leadership team. Each council and committee is chartered with specific charges and measures of effectiveness. Durham also has a very effective internal tracer program whereby a group of trained tracer team consultants performs internal evaluations of clinical areas to ensure there is a safe environment and that care is being provided in a safe, high quality manner.

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Quality Manager Position	Plans, develops, and maintains a comprehensive program to ensure compliance with the Department of Veterans Affairs (VA) Directives, Joint Commission Standards, and other internal/external regulatory agencies. An integral member of the facility's leadership team, the Quality Manager is responsible for transition to continuous quality improvement as an approach to assess and improve the quality	Support and advise executive leadership, service Chiefs and supervisors in planning, developing, while implementing a key quality program infrastructure. Analyzing and establishing improved models of care while coaching staff and leaders as relevant. Coordinating all accreditation surveys, external and internal (OIG).	Responsible for the implementation of the Quality Management program which includes accreditation & oversight, admissions, risk management, quality & process improvement, and utilization management.	Responsible for ensuring that components of the quality management system and patient safety improvement program are integrated; ensuring a systematic process is in place for monitoring the facility quality data; serving as the quality consultant to the facility leadership, system redesign/performance improvement (SR/PI) teams and employees; serving on executive committees and workgroups where	Responsibility for leading the Medical Center Quality program. This includes the domains of Survey Readiness, Customer Satisfaction, Systems Redesign, Utilization Management, Risk Management, and Credentialing and Privileging. The Quality Manager ensures that the Quality Program meets VHA requirements, and that the facility maintains Joint Commission, OIG, and other survey readiness.
1. How are quality care indicators and measurements tracked and managed?	Executive Leadership and QM review and analyze quality data related to the VHA performance measures, Joint Commission ORYX measures, access data, patient satisfaction data, business and financial measures, Deputy Under Secretary for Health measures, significant patient safety activities, UM data trends, Risk Management data trends, and actions required in response to internal and external reviews. This is accomplished through oversight and integration of service level and committee performance activities and measures.	Multiple electronic data sources are available, including customized reports from the data warehouse. Data comparison is available with our VISN facilities and national comparisons as well. Establish targets, measure and monitor. Research "best practice" and recognized benchmarks. Monthly data monitoring and reporting.	Performance measures dashboard	In conjunction with the Quality Management System, VACIHCS utilizes an abundance of valuable data resources and tools.	Our council structure determines what is reported where, and in conjunction with our Quality Management Plan determines which committees and councils are responsible for which data. The Quality Council and the Executive Committee of the Medical Staff are responsible for overseeing most quality data, and making recommendations to the Durham Leadership Board as needed to follow up on improvement opportunities identified by the data. Each month our facility submits an Operations Report to the VISN.
2. How do you measure and manage quality as a healthcare facility?	Monitoring and tracking of all medical center performance improvement and patient safety activities and issues, recommending actions (as necessary), tracking the resolution of problems addressed, and supporting the improvement of processes. Aggregated data review and analysis of key quality indicators helps to determine performance improvement priorities. The data collected for high priority and required areas are used to monitor the stability of existing processes, identify opportunities for improvement, and identify changes that lead to improvement or sustain improvement. Areas for monitoring performance are determined by considering the Veterans' needs, nationally identified high risk areas, sentinel events, and priorities set by leaders at the local, regional, and national level. In addition, the medical center identifies those areas needing improvement and identifies desired changes. Performance measures are used to determine whether the changes result in desired outcomes.	Multiple electronic data sources are available, including customized reports from the data warehouse. Data comparison is available with our VISN facilities and national comparisons as well. Establish targets, measure and monitor. Research "best practice" and recognized benchmarks. Monthly data monitoring and reporting.	Quality is managed by everyone in the organization from leadership to the front-line employee. Patient care and satisfaction is a top priority for the medical center and is measured via the ECF performance plans.	See above answer	We have a large number of quality of care measures, most of which are a part of the External Peer Review Program (EPRP). The EPRP program consists of hundreds of measures of clinical quality abstracted from patient records by an independent contractor (West Virginia Medical Institute). Each month, data is abstracted and reported on these measures to our clinical and medical center leadership, including the Executive Leadership Team. EPRP measures both inpatient and outpatient care. In addition, the Inpatient Evaluation Center (IPEC) compiles quality metrics for both inpatient and outpatient care. This data is reported by IPEC quarterly and it is carefully analyzed and reported to medical center leadership. Other measures of quality of care mandated by VHA directive, and that data is reported through the council governance structure.
Patient Safety Manager Position	The Medical Center's Patient Safety (PS) Programs an integral part of the overall performance improvement program. The goal of the Patient Safety Program is to create a culture of safety through anonymous incident reporting that is non-punitive. The purpose is to identify opportunities for improvement in patient care monitoring, incident reporting,	Ensures that the VA ACC provides safe care to all eligible Veterans by conducting RCAs or other investigations on concerns brought forward that may prevent the delivery of safe / quality care.	PS compliance & monitoring; Root Cause Analysis; HFMEAs; Risk Assessment	The patient safety manager is responsible for ensuring that components of the Quality Management System and Patient Safety Improvement Program are integrated; implementing a coordinated patient safety improvement program at the facility level that is based on guidance and tools from the NCPS, which meets the needs and priorities identified	The Patient Safety Manager is responsible for ensuring that the Medical Center has a proactive program to improve patient safety. This includes analysis of episodes of care that reveal opportunities to improve, including near misses, with a focus on systems improvement. Patient Safety conducts Root Cause analyses, Healthcare Failure Mode and Effects analyses,

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Utilization Management Position	The Utilization Management (UM) Program provides clinical and administrative recommendations relative to programs, committees, and/ or services relating to patient care and utilization management as an approach to assess and improve the quality of healthcare services, including the utilization of resources. The UM nurse is a collaborative member of the Quality Management team and is involved in performance improvement as an approach to assess and improve the quality of health care services.	Ensures that appropriate care is provided to Veterans in the appropriate setting.	UM coordinators are responsible for the review, assessment, and monitoring of admissions appropriateness and the continued stay for inpatients in meeting defined criteria for best practice. UM coordinators review patient charts daily evaluating care and patient progress towards discharge. They work collaboratively with physicians, Case managers, and Social Workers, identify the appropriate level of care based upon the patient's current condition.	The utilization Manager monitors the appropriate and efficient use of resources and assists in the promotion and maintenance of high-quality care through the analysis, review and evaluation of clinical practices. Through the use of evidence based criteria, the Utilization Management Process to guide the delivery of quality patient care and appropriateness of services at the VACIHCS, ensuring the veteran is provided the right care so that the veteran be discharged and return home quicker.	The Utilization Management nurses review admissions to and continuing stays in inpatient care for appropriateness. InterQual criteria are used, as per VHA mandate. The purpose of UM is to help ensure that resources are used wisely. Cases not meeting criteria are forwarded for Physician Advisor review to determine if the admission or continuing stay is clinically warranted. If not, the Physician Advisor advises the admitting or treating Physician on alternatives to inpatient care. In some cases, systems issues will result in a continuing stays or admissions that don't meet criteria.
1. How are measurement tools used to improve quality of care and patient satisfaction?	1. Daily reports of reviews not meeting IQ criteria go to our Physician Utilization; 2. Biweekly reports go to the bed huddle which the Deputy Nurse Executive resides; 3.A Quarterly Aggregate report goes to the Health Systems Council. This report includes information on readmission rates, Lengths of Stay, percentage of reviews meeting and not meeting, recommended level of care for reviews not meeting and reasons for reviews not meeting. Recommendations to improve patient care are made at the end of this report.	SHEP scores which apply to the facility also apply to The Utilization Management Coordinator. In addition, re-admission rates have been tracked for 4 years (a base year and 3 consecutive years) and these have remained low compared to the base year. Preventing re-admissions is a good indicator of quality health care.	National Utilization Management Information database is the program used for data entry and reporting of performance. Indicators for acute care admissions and stays are produced from this database.		UM analyzes data retrieved from National Utilization Management Integration (NUMI) and VHA Support Service Center (VSSC) to identify systems issues presenting barriers to patient flow. Specifically, UM monitors data regarding patients not meeting InterQual criteria, including reasons not met and recommended levels of care for those patients not meeting criteria. The data is used to help drive change within the facility and improve patient flow, thereby improving quality care, access to care, and ultimately patient satisfaction.
Risk Manager Position	Management Advisors, (PUMA's.) We have one PUMA for Mental Health, one for Surgery and one for Medicine. Each PUMA decides whether to agree or disagree with the primary review and to take action if needed.	Reviews care for peer review to ensure that care delivered is within community standards of care and if not, assesses why.	Medical Risk Management involves monitoring for variations in provider practice and their subsequent impacts upon patient care & outcomes. This monitoring includes review of 16 triggers and 3 occurrence screening daily for peer review and patient safety purposes. In addition, Risk Management is involved with Regional Counsel in the review and management of tort claims. Mortality and complications are two primary interests of risk management, and integrated into the peer review process. In addition, this individual plays a key role in disclosures. The RM is also responsible for VASQIP which is related to tracking complications and deaths within 30	Manage the protected peer review for quality management program. The peer to peer program ensures quality improvement and/or resource utilization purposes relevant to the care provided by individual providers. The peer review program and processes comply and are in accordance with all applicable laws, regulations, current VHA policy, and requirements of relevant accrediting and oversight agencies. Peer reviews include all critical reviews of patient care by a provider that are performed for the purpose of improving the quality of health care and improving the utilization of health care resources. Peer review, conducted for these	The Risk Manager is responsible for developing and managing the Durham VA Medical Center Risk Management Program in accordance with regulatory agencies, VHA, Network and facility requirements. This includes interpreting VA handbooks and directives related to risk management. The incumbent serves as a subject matter expert for risk management. The incumbent provides advice and support to the medical center staff, directs the development and maintenance of programs designed to reduce risk at all levels within the healthcare delivery system, and provides professional management, educational assistance and policy development and implementation guidance in

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1. How are measurement tools used to improve quality of care and patient satisfaction?	The Risk Manager tracks outcomes related to deaths. A mortality report is completed quarterly and reported to the Health Systems Council. Outcome data such as readmissions and adverse events are also reviewed to identify areas of improvement both at the individual provider and system level to identify areas of improvement.	SHEP scores which apply to the facility also apply to The Utilization Management Coordinator. In addition, re-admission rates have been tracked for 4 years (a base year and 3 consecutive years) and these have remained low compared to the base year. Preventing re-admissions is a good indicator of quality health care.	For overall risk management, peer review performance measures, mortality outcomes, and performance measures dashboard are used to monitor quality of care. For surgical risk, the VASQIP program is the measurement tool used and it is based on the observed versus expected ratio for mortality and morbidity. Raw data of complications are provided to attending surgeons on a quarterly basis. This information is used to determine if changes are needed in the care of the surgical patients.	Recommendations for systems improvements impacting quality of care and patient satisfaction are routinely made as a result of the peer review program and individual case reviews. The Peer Review Committee also may recommend independent administrative review, referral to other discipline's peer review processes, and performance improvement initiatives, as well as referral to other components of the quality management system.	There are several sources of data that measure quality of care and patient satisfaction such as: PATS tracks the following Risk Management issues if the Veteran/Representative presents to the patient advocate office or a service level PAL. Veteran can be provided generic information r/t to the TORT claim process by our office. In some cases, these concerns are forwarded to the Risk Manager if indicated.
Systems Redesign Manager Position	Providing process improvement expertise to the facility through the management of Performance Improvement teams and projects with the overall goal of providing Quality, Safety and Value within the services we deliver to our internal and external stakeholders.	Looks at processes involved in care delivery and makes recommendations on how to streamline or improve the process. Manages educational development programs to enhance staff knowledge and application of a continuous improvement environment. SR managers' performance is as both a Coach and /or team leader in evaluating current practices, developing and recommending steps for change, implementing those steps in some cases to lead improvement in multiple areas of focus within an organization.	The Chief of Staff office has the overall responsibility for quality of care provided to patients.	Monitors compliance with the scheduling directive, electronic wait list, and VHA consult policy. The position facilitates various process improvement projects distributed from the VHA System Redesign Office and local identification of improvement needs.	Participate in National, VISN and local teams to eliminate waste, improve processes which all overlaps into providing quality care (timely care by improving access to clinics) and patient satisfaction (improving telephone processes, involve with our local PACT implementation team, i.e. Patient Center Care), in which the Patient/Veteran is at the center or driver of his care. We are part of the National Initiative to Reduce Missed Opportunities (No Shows), main goal to utilize every available slot so that each Veteran can be seen when they would like.
1. How are measurement tools used to improve quality of care and patient satisfaction?	over. An interdisciplinary team discusses each patient and incorporates Utilization Management information into the decision making process on the patient's care.	In the SR program data, direct observation, and individual experience all play a role in modifying process that are currently in place. Data, flow maps, spaghetti diagrams, SIPOC's, Value Stream Maps, and A3's are all tools that serve a defined purpose of translating data into information that can be used to improve or in some case not change activities.	Every morning leads track and follow up on access, wait time, missed opportunity, Secure, messaging, E consult and important clinical quality measures.	The Systems Redesign Coordinator is responsible for monitoring access reports, electronic wait lists, pending reports, and missed opportunity rates among others. The data from all of these directly feed identification of areas that are in need of focused review and/or improvement efforts, which are designed to contribute to enhanced patient-centered care and patient satisfaction.	Routine monitoring of VHA Support Service Center (VSSC) Data, that identifies areas for improvement; VSSC site, we look at Access, No Shows, Clinical Utilization Statistical Summary (CUSS) Report, Telephone; Daily monitoring of Electronic Wait List, Clinic Cancellations. The data is used to identify areas for improvement for Veteran Satisfaction and Teams are formed to implement various Quality Improvement.

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Chief Health Medical Information Officer/Clinical Lead for Informatics Position	Not as involved in ensuring quality of care and patient satisfaction as our Program Specialist is in Quality Management; Involved in acquiring and analyzing data, as well as preparing reports and presentations for facility-wide dissemination as related to performance measures and improvement.	Collaborate with other services in developing and using IT and procedures that impact on patient care; Developing and implementing standards of practice in the field of IT related to patient care delivery.	The VA's comprehensive use of its award-winning electronic medical record (CPRS) is more than just a replacement of a paper record. It's a quality initiative. The 100% availability of the comprehensive record, built-in clinical decision support (clinical reminders), automatic drug interaction checks, and more all have a profound impact on the quality of care delivered. Informatics is responsible for maintaining CPRS and where possible optimizing the record to better ensure quality care delivery	VACIHCS does not have a chief medical information officer and is unaware of an equivalent position.	The Chief of Health Information Management Service is responsible for oversight of the quality and accuracy of the medical record and all associated clinical documentation, coding, and release of information functions.
1. How are quality of care and patient satisfaction indicators and measurements tracked and managed?	The Quality Management Program Specialist tracks and manages measures related to quality of care and patient satisfaction from the Executive Leadership Steering Committee (ELSC), Health Systems Council (HSC), and related Quality management-specific performance improvement initiatives. Job-specific tasks include creating/updating spreadsheets, databases, and SharePoint materials to track, manage, and present quality indicators related to performance improvement from committees, councils, and systems redesign.	The Health Information Team (HIT) is an interdisciplinary Team chartered to provide oversight for the quality of health information documented in hardcopy and/or electronic medical records. The HIT is responsible for making recommendations for content of documentation and evaluating compliance with health information management standards of practice, reimbursement requirements and clinical practice standards. These activities are to ensure that an adequate, permanent medical record is maintained for every patient receiving services at the Chalmers P. Wylie VA Ambulatory Care Center.	Quality of care and patient satisfaction are measured many ways – some quick examples include: Clinical Reminder Reports, Data Warehouse, SHEP scores, EPRP reviews, Truthpoint Surveys.	n/a	Our council structure determines what is reported where, and in conjunction with our Quality Management Plan determines which committees and councils are responsible for which data. The Quality Council and the Executive Committee of the Medical Staff are responsible for overseeing most quality data, and making recommendations to the Durham Leadership Board as needed to follow up on improvement opportunities identified by the data. Each month our facility submits an Operations Report to the VISN. The report contains many measures of clinical quality, which along with the results of our other clinical quality measures, are discussed at monthly Durham Leadership Board meetings
2. How do you measure the results of quality of care and patient satisfaction indicators?	Quality of Care and Patient Satisfaction indicators relate to Performance Measures under the Network Director Performance Plan and the Executive Career Field measure which are tracked and trended at the local level through the ELSC performance measures sub-council. Specific measures related to quality of care and satisfaction is tracked and trended based on national and VISN benchmarks. The facility reviews performance-related measures	See above answer	These results are regularly analyzed and subsequent targeted interventions launched to address areas of potential vulnerability.	n/a	Three workgroups have been created to improve areas of patient centered care (staff, tools, patients)

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3. How are measurement tools used to improve the quality of care and patient satisfaction?	Data reported in the sub-council and during External Peer Review Program (EPRP) EXIT reports provide specific measurements of performance related to quality of care and patient satisfaction. These measurements allow the facility to target areas for Improvement using action plans, Plan-Do-Check-Act cycles, and other service/facility level improvement initiatives as deemed necessary by the ELSC or other committee. Results of action plans and performance initiatives are scored and relayed to the actionable areas for further study or change in process.	Various tools such as Excel, Access and VHA fileman routines are used to collect, organize and display data gathered through VISTA, CPRS, VSSC, DSS.	An excellent example is the VISN5 Data Warehouse, which allows point of care analysis of quality of care data by front-line clinical staff, including individualized reports.	n/a	Timeliness of release of information is measured to ensure patients receive requested information in a timely manner. When timeliness exceeds set standards, the systems and processes used are reviewed to improve efficiency.
Grant Programs	Wellness coaching has been part of the strategy of health and wellness in multiple venues to include: hospitals, corporations, specialty clinics, franchises, schools, fitness centers, the military and others for over 20 years. Research from multiple universities, including Stanford and Duke, continues to show Wellness Coaching is a successful approach to develop and maintain a healthy lifestyle.	A 3 year grant was received for FY 2010 – FY 2012 to reduce hospital readmissions through patient case management. Readmission rates have remained at half the level they were in 2009 before the grant staff were hired.	LiV program, MOVE program, Rural Health, Telehealth, Patient –centered care	Patient-Centered Care. Patient Flow. PACT.	The DVAMC has more than 140 research investigators conducting over 440 research studies.
Staff Positions Responsible for Performance Measures	External Peer Review Program Coordinator	Quality Management Nurse	Clinical Measures: Performance Measures/EPRP Coordinator; Access: SR Coordinator & Nadine Nolan; Aspire/Hospital Compare: R. A. Burris/Pam Rachal	all staff working in programs affecting access, clinical measures, and measures reported through ASPIRE/Hospital Compare are responsible for the outcomes on those measures.	Clinical Consultants for Quality are responsible for reporting clinical measures/ASPIRE/ Hospital Compare results to medical center leadership. They work with Quality Coordinators of the services to ensure that opportunities to improve are identified and remedied.

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Patient Satisfaction Measures					
How is patient satisfaction measured?	National Survey-Survey of Healthcare Experiences of Patients (SHEP); Monthly Patient Panel Discussion; Veteran Town Hall Meeting; Focus Group Meeting; Comment Cards; Speak Up and Speak Out for Patients to voice their concerns/compliment; 48 hours discharge telephone follow up calls; Inpatient Proactive Visits	All data received by the patient advocates is compiled into meaning full graphs and charts with recommendations for actions and presented to the senior management. This data is also reviewed by the Patient Satisfaction Committee with recommendations to the facility.	A measure of the patient's level of contentment with the overall experience at the medical center including quality of care and services received.	Data that is received from the Survey of Healthcare Experiences of Patients (SHEP) and the Patient Advocate Tracking System (PATS) is compiled, trended, analyzed and reviewed both at the facility level and within the specific service areas related to the individualized feedback.	The degree to which our Veteran's regards the health care service, product or the manner in which it is delivered by the provider as safe, high quality, useful, effective, or beneficial all contribute the perception that our patients have concerning their care and whether or not they are satisfied
Measurement tools to track patient satisfaction	Surveys; Patient Advocate Tracking System	SHEP scores, patient advocate tracking system, patient focus groups, comment cards filled out by patients.	SHEP scorecard and ECF dashboard	Survey of Healthcare Experiences of Patients (SHEP) and Patient Advocate Tracking System (PATS)	Durham provides evidence based and metric proven high quality care, our goal for patient satisfaction to mirror the actual high quality care received to the perception of that care.

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Patient Advocate Position	Manage the complaint process, including complaint resolution, data capture and analysis of issues/complaints in order to support the facility in making system improvements. Assists in resolving complaint issues that cannot be resolved at the front line, or point of service working directly with Service Chiefs and Service management to facilitate resolution of problems beyond the scope of front line staff and support the facility in presenting the patient's perspective of the problem and desired resolution to Management. Support patient rights and responsibilities and assists in development of and customer service training initiatives.	Work with the Veterans on a daily basis to address concerns, complaints and help the Veterans feel satisfied with their healthcare experience. Assist the facility in moving towards a Patient Centered Culture. Monitor SHEP and customer comments and recommend new initiatives to the Executive Management.	The primary purpose of the position as Department Chief is to provide the coordination necessary for an effective, comprehensive, and integrated consumer affairs program that supports VHA (Veteran's Health Administration), VISN (Veteran's Integrated Service Network), and DC VA Medical Center goals. Additional responsibilities functioning as the Chief of Service include serving as a change agent while serving on Medical Center and VISN level committee's along with daily duties of ensuring that quality service is provided to veterans, their families, and other internal and external customers.	serves as the veterans voice in addressing concerns with the care the patient is receiving at the medical center. Concerns and issues are tracked through the use of the Patient Advocate Tracking System (PATS) and the Inquiry Routing and Information System (IRIS).	The Patient Advocacy Program was established to ensure that all Veterans and their families, who are served in VHA facilities and clinics, have their complaints addressed in a convenient and timely manner. The Patient Advocacy Program operates under the broader philosophy of
1. How are patient satisfaction indicators and measurements tracked and managed?	Patient satisfaction indicators and measurements are tracked and managed through performance measures.	SHEP scores and Patient Advocate Tracking System data is calculated monthly and reported to the Director.	SHEP survey and Performance Measures dashboard	Every time a veteran contacts or speaks to the Patient Advocate to voice a concern, that concern is entered into the PATS system. The Patient Advocate works closely with all providers; keeping a close working relationship ensuring the conflict resolution process is timely and successful and completed within 7 days. All concerns within the PATS system are tracked and any patterns discovered are distributed to service line staff who then must submit an action plan detailing how the issue will be approached. If the patient advocate is unable to address the veterans concern that veteran has	Service Recovery, whereby patient complaints are identified, resolved, classified, and utilized to improve overall service to veterans. The Patient Advocacy Program is an important aspect of patient satisfaction and contributes proactively to VHA initiatives to provide world-class customer service.
Director of Patient Care Services Position	Serve as chairperson for the Patient and Family Centered Care Committee; Maintain a high standard and quality services for patient; Ensure employees are trained to meet the expectations of patients and family members; Maintain operation budget while maintaining high quality care; Oversee all nursing care, inpatient and outpatient Sterile Processing Services; Voluntary Service; Chaplain Service	The Nurse Executive / Director of Patient Care Services is responsible to the Director, for establishing, maintaining and providing oversight for nursing standards of practice. He/she functions as the senior nurse executive within a decentralized nursing service model with multiple service lines. She/he functions at an advanced level in nursing administration and serves as the principle advisor to the executive management on issues of nursing practice. He/she is responsible for the functions of the Office of the Nurse Executive. The incumbent is an integral member of the senior management team and participates in the strategic planning, executive decision-making and policy determination and implementation strategies.	Senior registered nurse executive directly responsible for nursing clinical quality, education, and care management in inpatient and outpatient settings.	assists the director in leading, organizing, developing, executing and controlling the delivery and coordination of patient care and nursing services and serves as the acting director in the director's absence. Through the collaboration with healthcare system executives, the DPCS creates organizational mission, vision and strategic and tactical plans.	The Associate Director for Patient Care Services is responsible for management and oversight of nursing professional practice, delivery of inpatient nursing care, and sterile processing services.

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1. How are patient satisfaction indicators and measurements tracked and managed?	Surveys; Patient Advocate Tracking System	SHEP scores and Patient Advocate Tracking System data is calculated monthly and reported to the Director.	SHEP scorecard and ECF dashboard	Every time a veteran contacts or speaks to the Patient Advocate to voice a concern, that concern is entered into the PATS system. The Patient Advocate works closely with all providers; keeping a close working relationship ensuring the conflict resolution process is timely and successful and completed within 7 days. All concerns within the PATS system are tracked and any patterns discovered are distributed to service line staff who then must submit an action plan detailing how the issue will be approached. If the patient advocate is unable to address the veterans concern that veteran has the ability to meet with the executive staff, and in certain situations submit a congressional inquiry to their local representatives for assistance.	Durham has 3 primary methods of data collection and monitoring. PATS, SHEP and Press Ganey. They are all tracked via the Customer Satisfaction Council.
Patient Aligned Care Team Coordinator Position	Chair the PACT Steering Committee and have championed the initiative at our VAMC. Managed the budget/funding, prepared action plans, and coordinated education. Participate in monthly calls with the VISN 7 PACT leads.	ensure all PACT teamlets are functioning as a unit. They are also responsible for organizing and leading PACT meetings, generating metrics, and managing CBOC's. The PACT coordinator identifies needs and delivers training based upon the operational needs of a specific area by training managers, supervisors, and staff.	Education of staff about PACT and increasing buy-in, dissemination of data regarding PACT benchmarks, developing action plans on how to achieve benchmarks, weekly PACT meetings with stakeholders, writing minutes for weekly meetings, attending PACT collaborative meetings	Currently the VACIHCS does not have a PACT Coordinator, in its absence is a PACT Core team that meets on a weekly basis and a PACT Steering Committee that meets on a monthly basis.	The PACT Coordinator is charged to ensure the transition of primary care delivery at the Durham VA to the PACT model in order to provide optimal health management through effective teamwork in patient-centered environment.
Quality of Care vs. Patient Safety	Quality of Care covers all areas of care delivered at our facility. Patient Safety is involved in quality of care delivery, but focuses on systems issues to improve on the quality of care.	Those two are intertwined. We strive to provide safe, quality care. No distinction between the two.	Both are focused on quality of the care provided to the patient. The patient safety program assesses continuously for risk factors that relate to near miss and sentinel events related to human, equipment, or supply factors. Quality of care is focused on practice by healthcare providers and clinicians.	Quality of care and patient safety are integrally interrelated. Patient safety directly impacts the quality of care a patient is provided.	Quality of Care is the objective of patient safety. Providing safe quality care is the Medical Center's first key driver and as such the two are linked.

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Process for a root cause analysis	All adverse event reported to Patient Safety are reviewed for level of harm. All events that are scored 3 on a SAC score established by the NCPS are reviewed through the RCA process. A Multidisciplinary team approved by the Director is chartered to review the events, to identify Lessons Learned and establish action plans to prevent future occurrences of the events.	Identify the incident. Score the incident based on guidance provided by the NCPS. Pull together a small team of staff members who are expert in the area being reviewed as well as individuals without knowledge of the area to give the team balance. Focus on the processes around the incident. Develop changes to the process that will prevent the incident from occurring again.	RCA process includes identify an event, reviewing the timeline that led to the event, and assessing for process/system issues or practice variation	Identified in an attachment that was sent with the materials	For the most part RCA result from an evaluation of a patient incident report. However, they do not arise exclusively from reports from one source. Once received, the issue is assigned a Safety Assessment Code (SAC) by the PSM. Depending on the score (actual of 3 or potential of 3 or in the judgment of the PSM, there is a need to conduct an RCA), the PSM obtains team members from the services and ensures there is a multidisciplinary team. A Charter is established through SPOT which is signed by the Director. Once the charter is signed, the team convenes and evaluates all the facts and circumstances surrounding the incident. Within 45 days the team completes its work develops a root cause statement and related actions to correct the systems identified in the RCA and root cause statement. Once the RCA is completed and receive the Director's concurrence with the corrective actions, the actions are tasked out to the process owners for implementation and monitoring.

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Quality of Care Measures					
FY Budget 2011	\$442,000,000.00	\$424,573,187	\$498,296,247	\$340,000,000	\$500,263,163
FY Budget 2012	\$439,000,000.00	\$413,061,723	\$521,045,554	\$340,000,000	\$505,690,324
How is quality measured?	Executive Career Field; Network Directors Performance Plan; External Peer Review Program; Clinical Performance Measures (ORYX, IPEC); Councils/Committees	Quality is measured as part of ongoing monitoring as well as for specific improvement initiatives. Quality is managed through direct problem solving and systematic improvement efforts such as Lean VATAMMCS team projects.	VANYHHS QM program includes systems (reports, dashboards etc.) to monitor VHA performance measures and monitors and Joint Commission performance indicators	Performance measures;; IPEC data;; Joint Commission ORYX measures	Data are collected to monitor the stability of processes, identify opportunities for improvement, identify changes that will lead to improvement, and sustain improvement.. Facilities also determine local priorities such as patient health outcomes, Veteran satisfaction, employee satisfaction and staffing effectiveness. The Joint Commission also has data collection requirement in important aspects of care. If three or more consecutive quarters show data outside of the desired range, improvement initiatives are planned and initiated and appropriate oversight is also arranged.
Accountability and maintenance of quality care	Network Directors Performance Plan; Executive Career Field; External and Internal Surveys and Audits	Accountability for quality is demonstrated through daily oversight by Leadership via Hot Buttons, VISN performance reviews, performance measure results and external site visits such as Joint Commission and the OIG.	VANYHHS demonstrates and maintains accountability for quality of care through our communication and reporting structure. Validation of the quality of care provided is done on an ongoing basis through several site visit reviews such as the Joint Commission, CARF, Office of the Inspector General, etc.	Each quality measure mentioned above is assigned an over site Champion who leads the effort in working with others to ensure the measures are met. The Champion and team members must present their actions and progress to the Medical Center Director in weekly or monthly meetings and monthly to the VISN 9 Network Director.	The Medical Center compares its internally derived data with external comparative databases. These are used to determine if there is excessive variability or unacceptable levels of performance. The Medical Center initiates action plans to resolve undesirable trends. The Medical Center has defined and implemented an ongoing, proactive program for identifying and reducing unanticipated adverse events and safety risks to patients. Actual or potential process breakdowns are identified, prioritized and analyzed. The process and/or underlying systems are then redesigned, tested, implemented and monitored. The Medical Center reports process measures and outcomes measures on the Hospital Compare Website.

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Quality Manager Position	Responsible for overseeing quality and performance improvement programs for the facility.	Oversight for PI, Risk, Utilization, Patient Safety, External Review, System Redesign and Credentialing and Privileging Providers.	Provides oversight, coordination and management of Quality Program for VANYHHS. Ensures Service Chiefs and major committees have data needed for review and action. Shares pertinent information from VHA field offices on annual performance requirements. Ensures ongoing compliance with several accrediting body requirements.	Oversight for the Quality Management Department which includes Risk Management, Systems Redesign, Infection Control; Medical Staff Credentialing and Privileging; Utilization Management; Accreditation; and Performance Measure oversight.	The Quality Manager collaborates with the Medical Center Director, the Top Management Team, the Division/Program Managers, the Patient Safety Managers and all employees to ensure that the Quality Management and Patient Safety Programs are in place and monitored. The Quality Manager oversees various performance improvement initiatives, quality management activities and reviews,
1. How are quality care indicators and measurements tracked and managed?	Data	In a variety of ways. We utilize VSSC reports, IPEC Links reports and local reports.	Full access to VHA performance measure web sites. As data are available they are sent to the appropriate staff and/or Committees.	Numerous methods including the VA's Performance Measure system; HEDIS; Joint Commission ORYX measures; observations, data collection, comparisons and analysis.	Same as above, "How is quality measured?"
2. How do you measure and manage quality as a healthcare facility?	Benchmarking	Same as above	Quality is measured through VHA performance measure data, accreditation survey results, Veteran and employee survey results and other internal controls.	Numerous data systems and outcomes.	Same as above, "How is quality measured?"
Patient Safety Manager Position	responsible for assuring compliance with the National Patient Safety Goals and improving quality processes.	Oversight of Patient Safety Program that includes tracking and trending of adverse events, completion of Root Cause Analyses (RCAs), Healthcare Failure Mode and Effect Analyses (HFMEAs) and NCPS issued Patient Safety Alerts/Advisories. Provide employee education and program representation on medical center committees.	Provides oversight for the patient safety program of VANYHHS that includes ongoing staff education on patient safety initiatives including the Joint Commission patient safety goals, patient disclosure review of close calls and incidents, management of patient safety alerts and recalls, oversight and coordination of root cause analysis teams and reports and the	Oversight for the RCA process and education to staff on safe patient care policies and practices	Responsible for reporting, entering and tracking Safety Reports (patient incident reports), in "SPOT," a VHA national database. Some medical centers have an additional database for tracking incidents to meet local needs for data sorting and analysis. The PSM also ensures that the components of the Quality Management Plan and Patient Safety Improvement Program are

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Utilization Management Position	Responsible for right level of care for inpatients.	UM Manager coordinates the UM Program which seeks to provide clinical care which is evidence-based to insure the best possible patient outcomes in the most cost effective manner.	The UM program ensures the appropriate and efficient use of inpatient resources at VANYHHS.	Oversight for educating the medical staff on criteria for appropriate patient admissions and continued stays in the hospital and reviewing the data to identify opportunities in clinical practice to ensure the criteria are met	Utilization Management (UM) Nurses review 100% of all acute care admissions and continued stay days for appropriate assignment of level of care. When the assigned level of care deviates from the recommended level of care, the case is referred to a Physician UM Advisor (PUMA). Additionally, quality of care issues identified in the review process are referred for further review/action. Referrals can be made to Quality Management or the PUMA.
1. How are measurement tools used to improve quality of care and patient satisfaction?	NUMI software-automates UM assessments and outcomes-utilized for data analysis and reporting quarterly locally and at network level; Improved quality of care results from right care, the right patient, the right time and for the right reason. NUMI uses evidenced based criteria to perform screening.	UM staff conducts admission and continued stay reviews on patients admitted to the acute care units to determine whether this is the correct care setting to meet patient needs based on their presenting medical problem. Progress made to return them to their normal health status is monitored and gauged against whether they are in the correct care setting to meet their care needs. This data is then presented to the Utilization Management Committee and is used to guide improvement initiatives to most effectively and efficiently meet patient care needs.	VHA Has contracted with McKesson to use the InterQual Acute and behavioral health Criteria sets to review each admission and day of care. Patients not meeting criteria are discussed with the treatment team. When the provider concurs, changes to the level of care occur; when the provider disagrees with the finding, the case is discussed with a supervising physician advisor who makes a final determination based on the best interest of the patient or Healthcare proxy. Patients who do not meet criteria but another level of care is not available (such as subacute medical/ nursing home) are placed on alternate level of care status. A list of all such patients is reviewed on a weekly basis with the Chief of Staff who works with Social Work and QM to expedite desired transitions; the list is also reported to Executive Staff on a weekly basis again to expedite desired transitions. UM data is aggregated on a quarterly process, including not only the percentage of patients meeting/not meeting criteria, but also categories of reasons for remaining at the current level of care and recommended levels of care.	No response indicated	Through the application and interpretation of standardized criteria, assessments are completed to determine the most appropriate level of care for each patient. The data gathered in this process is collated and reported in daily, monthly or quarterly reports. Additionally, specific projects are completed to improve quality of care. One such example is the completion of a guardianship process review. The purpose of this study was to improve the timeliness of the guardianship procedure. Another example of a process review was the completion of an analysis of patients who were admitted to observation status. Both of these studies were aimed at improving care and ultimately patient satisfaction.
Risk Manager Position	responsible for Protected Peer Review and Tort Claims.	Manages the Protected Peer Review Program, facilitates action plans that emerge from peer review committee for quality improvement; Coordinates Administrative Investigations in accordance with VHA Directive; Facilitates morbidity and mortality reviews and reporting; Screens deaths against established criteria to determine need for further review; Manages the tort claim process; Collaborates with Chief of Staff in review of malpractice claims on providers; Collaboration with the Patient Safety Officer in reviewing incident reports. Review for need for disclosure, review for need for fact finding and follow-up to prevent further adverse events; collaborate with COS if significant	The risk management program is primarily responsible for the management of the tort claim process providing guidance to providers in claim management and education to avert future claims. Works closely with Regional Counsel and the Office of Medical-Legal Affairs	Oversight of the Peer Review Process and Tort Claim Review	The Risk Manager coordinates the medical center's peer review program, mortality reviews and institutional disclosures, in close collaboration with the Chief of Staff. The Risk Manager also facilitates peer review training. Additional responsibilities include assistance with accreditation activities, frequent collaboration with patient safety managers and others, and analysis of adverse events/prevention planning.

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1. How are measurement tools used to improve quality of care and patient satisfaction?	Analysis of Protected Peer Review data to identify trends (timelines, Identify education & training needs for staff, Review of Disclosure opportunities); Recommendations forwarded to appropriate provider and/or committee for actions	Tracking, trending, and analyzing morbidity, mortality, peer review, disclosure, and tort claims data to identify trends and systems improvements in order to minimize risk to patients and institutional monetary loss.	Analytical tools are used to track, trend, and monitor actual adverse events, close calls, unsafe conditions, corrective actions and their effectiveness	Data is used to trend patterns and predict outcomes.	No response indicated
Systems Redesign Manager Position	Designs and reorganizes facility culture using the principles of system redesign to improve flow and access.	Improving quality of care	Provides oversight of system redesign/lean projects to incorporate the concepts of ongoing, sustainable performance improvement that include the efficient use of resources.	Oversight of SR projects and working with teams to ensure use of improvement tools and lean thinking	Our Systems Redesign Coordinator takes the lead role in coordinating, teaching, and overseeing SRD projects in close collaboration with Medical Center Leadership.
1. How are measurement tools used to improve quality of care and patient satisfaction?	Measurement tools are critical to any type of quality improvement project. Measurement tools allow us to establish a baseline. It also helps us direct our possible solution to the root cause. We measure performance against standards, and then monitor the improvement through the process that was implemented. We utilize control charts to determine trends or shifts. We utilize Lean measurement tools such as value stream mapping to analyze how information and/or service move through a process. This will allow us to identify opportunities to remove delays, errors, and waste. By using a Cause and Effect diagram, we can identify the root cause to the problem. Pareto Charts will allow us to count and categorize frequency of occurrences so it allows us to target the major issues to our problem.	Measures are used to assess / analyze a problem, to track performance and to insure improvements are sustained.	A variety of analytic tools are used to understand and quantify barriers to effective and efficient processes necessary for optimal care. All projects have measureable aims and project-specific metrics including quality of care, access to care and/or patient/family satisfaction. Projects are designed to have changes that are both measureable and sustainable.	Measurement tools are selected based on the needs & scope of a process improvement opportunity to determine the extent of the impact of problems, help sort out what is value-added and what is waste, map the current performance, measure/analyze current process state, determine the standard/desired performance, identify the performance gaps, and control and Sustain Improvements	As a member of the Medical Center's Improvement team, the Systems Redesign Coordinator provides support and guidance in the analysis of current processes and the redesign and implementation of activities and initiatives to improve access and flow, thus helping the Hospital to achieve its goal to improve access to care for all veterans.

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Chief Health Medical Information Officer/Clinical Lead for Informatics Position	Responsible for quality of clinical information.	Availability of resources; working with providers and technical staff to evaluate effectiveness of current systems (software/hardware) and conduct research on potential solutions to assure continuity of care through technology.	to facilitate many of the informatics related projects that drive the medical center. These projects can range from a new documentation system being placed in the OR to the institution of different modalities that involves patients having quicker and easier access to our system.	No position.	Our lead Informatics role is played by the Manager of CLIMET (Clinical Informatics and Medical Technology. This person participates in a wide variety of Medical Center groups and works closely with Medical Center Leadership to coordinate and prioritize Informatics goals and projects. This role also is key in Medical Information.:
1. How are quality of care and patient satisfaction indicators and measurements tracked and managed?	Several ways including monthly datapull of quality of care provided for all outpatients seen during the month and used to create provider profiles and other reports for monitoring and improving quality of the care.	These are tracked by Planetree	Random audits are done on a timely basis to ensure that a lot of our system level initiatives do not impact patient care in a negative way. There are also many formal committees that are in place within NYH such as the Clinical Informatics Committee that tracks and reviews data related to quality of care for patients on a routine basis.	n/a	Patient Satisfaction reports (SHEP/HCAPS, Patient Advocate reports, etc.) are reviewed as they related to eligibility, enrollment, beneficiary travel, purchased care and other MIS departments. We look for trends and adjust processes as needed to better meet veteran expectations.
2. How do you measure the results of quality of care and patient satisfaction indicators?	Opportunities for improving quality are identified for actions and follow-up. For example, our facility needed to improve Mental Health screening and assessments of positive screens for alcohol, depression and PTSD. Tedious templates were created to run monthly reports for that produce lists of patients seen today and still needing screening (or evaluation by provider of positive screen). Nurses reviewed cases and sent encrypted email to	These are measured and tracked by services and programs	Much of the data we receive comes from national reports such as the PACT Compass in VSSC. Depending on what gets reported and how close we are to the threshold, if any of the measures needs improvement then the next step would be to create a focus group of subject matter experts to tackle these issues. The experts ranging from different disciplines such as informatics and quality improvement would meet come up with a plan and implement and	n/a	The Health Information Management program works very closely with members of the medical staff, including PACT members, to assure encounter data and medical record documentation is complete and accurate. A multi-disciplinary team, for example, recently reviewed the practice of "copying and pasting" medical record documents. The team took baseline data, analyzed the data and created business rules and educational plans to assure

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3. How are measurement tools used to improve the quality of care and patient satisfaction?	Clinical reminders support quality at point-of-care. Usually copies of those same reminders are modified to produce reports to measure and monitor that quality.	Both automated and manual measurement tools are used to track indicators of quality.	Proactive measurement tool called clinical reminders to not only focus on quality of care of patients but to prioritize what needs to get done during the point of care. Through the informatics department reports can be generated using clinical reminders and focus on patients that did not have a chance to get seen or those that are due for pertinent screening. The information is shared with the practices in which proper outreach gets done. Another measurement tool available is the Data Warehouse. Reports can be pulled from the local Data Warehouse and available for a majority of the end users to see. After the fact changes can be tracked using the same reports.	n/a	MIS uses the "plan-do-study-act" improvement model to review and improve processes. We also participate in Root Cause Analysis teams and other process review teams reviewing processes to improve patient satisfaction and outcomes. For example, the Beneficiary Travel was the subject of a comprehensive review by the Preventative Ethics team using the ISSUES (Identify, Study, Select, Undertake, Evaluate, Sustain) model.
Grant Programs	Lean Training; Rapid Improvement Events; Flow Collaboratives; Rural Health Initiatives; Telehealth Programs; Clinical Video Programs; Million Veterans Program	Patient-Centered Care (PCC) Center of Innovation; The Department of Veterans Affairs (VA) created a new office to develop personal, patient-centered models of care for Veterans who receive health care services at VA's more than 1,000 points of care across the Nation.	VANYHHS has been funded for two programs focused on improving care and preventing readmissions to CHF patients. These programs are known as VALOR and VICTORY. PROVE – medical education study	VA Innovation Competition Program awarded a \$700,00.00 to the medical center for the purchase of 60 high technology environmental control units and televisions for every patient in the Spinal Cord Injury Unit.	No response indicated
Staff Positions Responsible for Performance Measures	Chief, Primary Care; Chief, Long Term Care; Chief, Inpatient and Healthcare Group; Chief, Office of Data Collection and Analysis	All staff is responsible, appropriate to their areas	PI Manager and Chief of Staff	Over site for each performance measure is assigned to an individual involved in that area of clinical practice or business practice. The level of staff with over site ranges from a Pentad member, Service Chief, physician, to a manager or supervisor.	Both the Informatics section of Clinical Informatics and Medical Technology (CLIMET) and the Quality Management Service have important roles in performance measures.

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Patient Satisfaction Measures					
How is patient satisfaction measured?	The Survey of Healthcare Experiences of Patients (SHEP) is conducted in compliance with the requirements of Executive Order 12862 and VHA Directive 2006-041 (http://vawww.oqp.med.va.gov/oqp_services/veterans_satisfaction/pol_regs.asp). This Executive Order required agencies to publish customer service standards, survey their respective customers and use customer feedback information to manage the agency. Veteran patient satisfaction surveying is designed to promote health care quality assessment and improvement strategies that address patients' needs and concerns as defined by patients. The Office of Quality & Performance (OQP) is the analytical, methodological, and reporting staff for Surveys of the Health Experiences of Patients (SHEP). SHEP Survey Reports are published electronically (http://vawww.oqp.med.va.gov). These reports give VISN, facility, bed section and CBOC level data (where applicable) and comparisons, including statistical variance from the National mean (adjusted for patient characteristics at the reporting unit)	Truth Point: VISN 3 contracted with Truth Point Vertical Systems, Inc. to implement Truth Point, touch screen technology, to capture patient feedback at the point of care in VISN 3 facilities.	Patient Satisfaction is measured through a variety of mechanisms including questionnaires, inpatient interviews, discharge call interviews and patient contacts through the Patient Representative Program. Patient concerns are managed by the Customer Service Committee, the Patient Representative Program, the Post Discharge Call Program, Service Chiefs/Program Managers and all other employees.	VAMC Memphis measures and manages patient satisfaction via our SHEP scores and the Patient Advocate Tracking System (PATS).	The VISN 12 Performance Measures scorecard tracks 20 patient satisfaction indices on a monthly basis. CLIMET monitors this data, analyzes it for changes in trending and outlier data and reports to Medical Center Management monthly.
Measurement tools to track patient satisfaction	Patient Advocate Tracking System-Patient issues are documented, followed, categorized and reported to the Organizational Excellence Board; Focus group reports (OEF/OIF/OND-Conducted by Gallup and Facility (Patients and Staff)-Conducted by Planetree)	SHEP/HCAPS Data for Inpatients and Outpatients; TruthPoint; We're Listening Patient Feedback System	HCAHPS; Post Discharge Interview; TruthPoint; Patient Representative Data; Pharmacy Wait Times	Statistical data from the SHEP surveys and Patient Advocate Tracking System are compiled in reports that are monitored by the Customer Service Department manager, executive leadership and managers and supervisors throughout the organization.	Patient satisfaction measured through a patient satisfaction survey that equates to the private sector satisfaction survey HCAPS. The Customer Service Council reviews the data/results from both the Inpatient and Outpatient populations on a quarterly basis. We attempt to trend those results against what the Patient Advocates illustrate with their reports. We also utilize Customer Service postcards that are available in many clinics; the Veterans provide us feedback

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Patient Advocate Position	Monitoring of all patient satisfaction measures is the responsibility of the VA Long Beach Healthcare System Office of Patient Centered Care.	Serves as an advocate for patients throughout the facility. Receives and listens to complaints and grievances from patients or from individuals on behalf of patients. Contacts members of the hospital staff at all levels concerning any matter or problem relating to patient care which has not been resolved by other services and seeks a resolution, whenever possible, within the full resources of the medical center and VA system. When a problem area or complaint is identified, the incumbent explores all avenues, crossing all lines of authority and responsibility within the medical center, in order to properly identify the nature and scope of the problem and to initiate appropriate action to expedite a resolution. Identifies existing or potential problem areas and suggests solutions or alternatives to existing procedures which contribute to these problems.	Resolving complaints that cannot be resolved at the point of service level and/or across disciplines; Presenting patient issues at various facility meetings and committees; Interpreting patient rights and responsibilities; Management the use of Patient Tracking System (PATS); Providing trends of complaints and satisfaction data at the facility level; Ensuring a process is in place for distribution of the information to appropriate leaders, committees, services and staff; Identifying opportunities for system improvements based on quarterly complaint trending; Ensuring any significant single patient complaint is brought to the attention of appropriate staff to trigger assessment of whether there needs to be a facility system analysis so the problem	Patient Advocates are tasked with implementing service recovery mechanisms in order to assist our veterans in resolving their concerns with the facility.	The Patient Advocacy Program is an important aspect of patient satisfaction and contributes proactively to VHA initiatives to provide world-class customer service. The patient advocates interact with Veterans and their families by providing active listening and assistance. The advocate may assist in gathering information, navigating the medical centers' systems and processes, in resolving any concerns or issues. The patient advocates also actively participate in the medical center's outreach initiatives. The patient advocates enter data into the Patient Advocate Tracking System and refer any serious matters to the appropriate medical center resources. The patient advocates are active members of numerous committees, representing the voice of the patients/families.
1. How are patient satisfaction indicators and measurements tracked and managed?	Not listed on the form	Data from all measurement tools is collated and analyzed for trends and reported daily, monthly and as needed to VISN and VAMC patient satisfaction committees. Data is used to drive decisions that improve patient satisfaction.	Patient Satisfaction is measured through a variety of mechanisms including questionnaires, inpatient interviews, discharge call interviews and patient contacts through the Patient Representative Program	Patient Advocates do not track satisfaction indicators. Advocates document and code all of their patient interactions into the PATS system for the Customer Service Manager who analyzes the data.	The PATS data is tracked through the Quality Management and Safety section. Patient satisfaction data indicator and measurements have been spoken to as answers to other questions in this document.
Director of Patient Care Services Position	As the Associate Director, Patient Care Services/Nurse Executive has overall responsibility for all clinical and operational aspects of planning, coordinating, implementing and evaluating the delivery of patient care in the following Services: Nursing, Social Work, Sterile Processing, Pharmacy, Nutrition and Food, Chaplain, Veterans and Family Assistance, Women's Health, Special Initiatives, Telehealth, and the Caregiver Program.	The Associate Director, Patient Care & Nursing Services is responsible for line supervision of the acute Nursing units, ICUs, OR, CLC & Acute Psychiatric units, Acute Social workers, Nutrition & Food Service, & Sterile Processing Supplies. The position is ultimately accountable for the provision of all nursing care standards.	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 satisfaction is an important metric and is closely watched by all of these disciplines.	Description of responsibilities not included	Responsible for understanding and addressing issues related to patient satisfaction. Processes are in place to ensure proper communication of patient satisfaction data through appropriate hospital committees which perform the functions of monitoring, evaluating, and addressing patient satisfaction indicators, as well as individual patient concerns complaints.

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1. How are patient satisfaction indicators and measurements tracked and managed?	Not listed on the form	Truth Pint, Implementation Schedule at VA NJHCS, Survey Question Highlights, Monthly Tracking: Patient Advocacy Leadership Hot Buttons, Consumer Satisfaction Council and Planetree Steering Committee	Patient concerns are managed by the Customer Service Committee, the Patient Representative Program, the Post Discharge Call Program, Service Chiefs/Program Managers and all other employees.	We are assigned performance measures for the year by VISN leadership. We report monthly to the VISN about our current scores and any action plans we have initiated.	VISN 12 Performance Measures scorecard tracks various patient satisfaction indices on a monthly basis. CLIMET monitors this data, analyzes it for changes in trending and outlier data and reports to Medical Center Management monthly.
Patient Aligned Care Team Coordinator Position	Assure that PACT is implemented by providing opportunities for training, monitoring PACT performance measures, and working closely with VISN staff to continuously improve.	The ACOS Ambulatory Care, Section Chiefs, and the Director of the CBOC's are responsible for implementing and maintaining the Pact Model of Health Care delivery in VANJ. Their duties include, but are not limited to insuring that PACT teams are educated and trained in PACT principles and that education is supported in an effort to provide veterans exceptional health care that improves their well being.	Clinical oversight for PACT implementation and operations; Coordinate staff and resources; Communicate with other services relating to the PACT extended team members (pharmacy, nutrition, social work, psychology); Coordinate PACT staff meetings; Provide bi-weekly progress reports to Senior Management	Coordination of facility PACT Steering Committee; Assist team leaders in each Primary Care area with implementation of PACT; Monitor data on PACT goals and formulate actions plans for target(s) not met; Facilitate Teamlet huddles and intervene with team building efforts, if needed; Interface with Nursing and Business Office service lines to insure staff trained and functioning effectively in PACT role	To implement PACT into the Specialty Care, Spinal Cord care and Mental Health. PACT in Primary Care is implemented.
Quality of Care vs. Patient Safety	Quality doesn't exist without safety.	Patient safety is one dimension or domain of quality.	We don't believe that there is a significant difference between Quality of Care and Patient Safety. The two are closely interrelated. Patients receive safe care in healthcare environments that put a premium on providing the highest quality of care.	Quality of care encompasses the entire health care spectrum of the patient, from admission to discharge, and as an outpatient. Quality of care deals with accessibility to care, timeliness of that care, adequacy of the care, and patient satisfaction. Patient safety focuses on the absence of harm, or possible harm, while the patient is receiving high quality of care.	The goal of VHA's patient safety program is to reduce or eliminate harm to patients as a result of their care. This has a direct relation to quality of care: the degree to which health services increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

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Process for a root cause analysis	As per VHA Patient Safety Improvement Handbook 1050.01	Event reviewed; Team members requested/selected from involved services; Team convened (orientation to RCA process; medical record, VHA Directive, local policy and literature review; Gemba walk of event, if applicable; interviews of key involved staff; expert consultants or contact manufacturer, if indicated; Root Cause(s), actions and measureable outcomes written and presented to management team	Once an incident is brought to Patient Safety/QM's attention, a discussion occurs with Senior Management regarding the details of the incident. A preliminary fact finding session may occur and with senior management's input, it is determined whether an RCA is warranted. Once this has been decided, an Incident Report is completed and submitted to the VISN. Senior Management then chooses members of the RCA team. Patient Safety then facilitates the RCA team providing the necessary resources that the RCA team may need. Once the RCA is completed, the RCA team presents the RCA report which includes the action table (root causes and recommended actions) to SM for approval. Once the actions are approved, Patient Safety works with the various departments to ensure that the actions are implemented.	Close call or sentinel event identified; Decision for RCA made by Leadership; Team Members identified and approved by Leadership; RCA team meets; Root Causes, Actions, and Recommendations identified; Team results presented to Medical Center Director and other Leadership; Actions monitored for completion	Conducting an RCA is a critical aspect in the process of improving patient safety. The goal of the RCA process is to find out what happened, why it happened, and to determine what can be done to prevent it from happening again. Multidisciplinary teams are formed to investigate adverse events and close calls. Close calls are events that could have resulted in a patient's accident or injury, but didn't — either by chance or timely intervention. RCAs are used to focus on improving and redesigning systems and processes — rather than focus on individual performance, which is seldom the sole reason for an adverse event or close call. A previously unheeded or unnoticed chain of events most often leads to a recurring safety problem, regardless of the personnel involved. RCA teams improve patient safety by formulating solutions, testing, implementing, and measuring outcomes. NCPS enters all RCA data into the Patient Safety Information System — an internal, confidential, non-punitive reporting system

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Quality of Care Measures					
FY Budget 2011	\$550,000,000	\$314,000,000	\$343,979,242	\$529,387,493	\$335,000,000
FY Budget 2012	\$550,000,000	\$317,000,000	\$363,821,604	\$518,658,192	\$341,000,000
How is quality measured?	The aim of Quality is to ensure that health care is 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.	Measurement of clinical outcomes, performance measures, voice of the customer, peer review, accreditation reviews and direct observation of National Patient Safety Goal implementation. We manage through self-reporting, root cause analyses, systems redesign, implementation of patient centered care principles, and audit of patient records and continuous data streams.	Evidence based performance measures are monitored throughout the organization. Data is reviewed at provider, team, service, or clinic level. Performance measures are categorized as critical and/or non-critical both in clinical and administrative areas; these measures are included in the performance contract of the appropriate Executive team and Service chief level. Quality Board is the organizational council where all quality measures are reviewed. A variety of tools/mechanisms are utilized to address opportunities as they are identified. Tools utilized include 1) transparency of quality care through the use of N-Tracks SharePoint, 2) use of executive-sponsored daily morning meetings to outline the progress owners have made to ensure all Veterans are receiving evidence-based care, 3) use of a well-defined process improvement model-VA-TAMMCS, and 4) development of executive team books providing an update on quality measures.	Data management and critical analysis are used for each quality and safety component. Use of goals, comparisons of internal and external benchmarks, identification of opportunities for improvement and implementation and evaluation of actions until problems are resolved or improvements are achieved. VHA provides several mechanisms for performance measurement.	Key components include quality assurance, performance improvement, patient safety improvement, internal and external reviews, internal and external customer satisfaction, utilization management, and risk management. Following a systematic process greatly increases the chances for successful systems redesign. Salisbury VAMC utilizes a framework of VA-TAMMCS which stands for Vision, Analysis, Team, Aim, Map, Measure, Change, Sustain and Spread. Quality Management activities are reported via a committee structure with all committees ultimately reporting to the Executive Committee of the Governing Body.
Accountability and maintenance of quality care	Though our National accreditation, certifications, licensure, and VHA oversight.	The Office of the Assistant Deputy Under Secretary for Health for Quality, Safety, and Value (ADUSH QSV) plans, directs, coordinates, and evaluates the VHA's national quality, safety, and value producing programs and approaches. The Secretary's approach to transparency has heightened the visibility of quality indicators and the QQSV displays data from the facility level to the national aggregated level on a website that is available to the entire population. Additionally, the facility holds monthly Quality of Care Committee (QOCC) meetings, concerning itself with issues that require an in-depth discussion of details of clinical processes. Technical aspects of patient care are a major focus of this committee.	Accountability is built into all Executive Team members, Service Chiefs, and Section Chiefs via performance contracts.	In addition to the VA Performance Measure and Monitor Programs, VA Central Office, VISN 21 and NCHCS have an ongoing review processes, which continuously monitor the performance and delivery of care at each facility. NCHCS participates in external audits by agencies such as, Office of Inspector General (OIG), College of American Pathologists (CAP), Commission on Accreditation of Rehabilitation Facilities (CARF), Food and Drug Administration (FDA), Occupational Safety and Health Administration (OSHA), Long Term Care Institute (LTCI) and Joint Commission (JC) just to name a few. Additional internal audits are conducted on a reoccurring basis as well, such as Annual Workplace Evaluations (AWE), Green Environmental Management System (GEMS), VA Surgical Quality Improvement Program (VASQIP), System-wide Ongoing Assessment and Review Strategy (SOARS) and a VISN lead review team (VORP/GORP/HORP). Once the review or survey is completed the QM collaborate with organizational leaders to develop, trace, track, and monitor action plans to closure.	We use the External Peer Review Program as an objective accounting of performance and quality of care. Also, the Physician Pay for Performance Program and the Executive Career Field Performance Appraisal system ensure staff are held accountable for the quality of care provided.

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Quality Manager Position	Directs 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, such that the participants understand their role, responsibilities, and accountability. An organized, systematic approach to planning, delivering, measuring, and improving health care is required to	Ensuring all components of the QMS and patient safety improvement program 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; and Serving on the executive committees and workgroups where quality data is reviewed, analyzed and acted upon; The Quality Manager	Provides oversight of readiness efforts involving regulatory/accreditation surveys; leads/participates in process improvement, and serves as the Director of Midwest Mountain Veteran Engineering Research Center (MWM VERC)	Ensuring that components of the quality management system and patient safety improvement program are integrated; Ensuring a systematic process is in place for monitoring the facility quality data; Serving as the quality consultant to the facility leadership, Quality Improvement (QI) or Performance Improvement (PI) teams, and employees; Serving on executive committees and	Creates an environment that facilitates the integration of continuous improvement into the design of delivery systems, into day-to-day operations, and into the organizational culture through the use of various performance improvement projects.
1. How are quality care indicators and measurements tracked and managed?	Through monthly committee minutes, organizational dashboards, and monthly review with senior leadership.	Data is tracked 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. We trend our data and report it through weekly and monthly benchmark reports in meetings with frontline staff, managers and executive leadership. Selected performance measures are used by the VISN and Central Office to compare our performance with other facilities, VISN and nationwide.	Accountability for quality is built into all employees expectations. Expectations are to access data and work on continual improvement.	NCHCS uses VHA, VISN 21 and local facility indicators to develop performance plans. Data is collected, aggregated and analyzed. Data are aggregated at the frequency appropriate to the activity or process being studied. Statistical tools and techniques are used to analyze and display data. We also utilize a variety of external databases/benchmarks to track and monitor NCHCS performance on identified quality of care indicators and monitors. Data are compared internally over time and externally with other resources such as Joint Commission ORYX performance measures.	Salisbury uses a system of gathering and critically analyzing data relevant to quality and safety, assuring data is valid and reliable, comparing the data analysis results with established goals or internal/external benchmarks, identifying specific opportunities for improvement, and implementing and evaluating actions until problems are resolved or improvements are achieved.
2. How do you measure and manage quality as a healthcare facility?	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, such that the participants understand their role, responsibilities, and accountability. An organized, systematic approach to planning, delivering, measuring, and improving health care is required to effectively link the organizational mission, vision, and core values to the day-to-day operations.	Quality is measured by using national benchmarks established by many organizations through research and reporting of data from large populations.	See above answer	Data management and critical analysis are used for each quality and safety component. Use of goals, comparisons of internal and external benchmarks, identification of opportunities for improvement and implementation and evaluation of actions until problems are resolved or improvements are achieved. VHA provides several mechanisms for performance measurement. including but not limited to access to the national VSSC database (Performance Measurement Dashboards), VA TAMMCS improvement model (Systems Redesign), OCCO ISO 9001 standards for RME (to be exported to other improvement areas within VHA), ASPIRE comparison data and LinkS for summarizing clinical outcomes, VASQIP, IPEC and EPRP data, and SHEP customer satisfaction data	Quality Management activities are reported via a committee structure with all committees ultimately reporting to the Executive Committee of the Governing Body. Quality Management/ Performance Improvement activities are communicated to leadership via committee minutes and reports during the ECGB meeting. Adverse trends, significant outliers, and strong practices of the key components are presented during the monthly meetings and are recorded in the minutes. In addition the Director and other Quad members, along with the Quality Manager, promote quality of care delivery through collaboration and communication with other medical center leaders.
Patient Safety Manager Position	Investigate Adverse Event reports and complete RCAs and HFMEAs as per Directive. As per the Patient Safety Improvement Handbook: AERs, RCAs, HFMEAs, National Patient Safety Goals, staff and patient ongoing education, Patient Safety Alerts and Advisories, database analysis, and improvement of systems and processes to improve patient safety.	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; Provide New Employee Orientation to all new employees relative to the	NWCHCS has best practice of being one of few facilities that employs an ACOS for Patient Safety (physician) as well as Patient Safety manager. The patient safety staff work collaboratively with all services/areas in the HCS (clinical and administrative) to identify opportunities for improvement of patient safety and quality of care. Multiple mechanism are	The Patient Safety Manager leads, coordinates and implements the Dept. of VA Patient Safety Program. She implements the National Patient Safety Goals, developed by the National Center for Patient safety (NCPS) and supports and develops the patient safety process, while promoting a culture of safety throughout the organization. The Patient Safety Managers	Policy development; Educational presentations on all components of the Patient Safety Program; Serve as trainer and consultant and assisting with Root Cause Analysis and Health Care Failure Mode and Effect Analysis; Conduct ongoing risk assessment within the facility; Serve on committees that have influence and impact on Patient Safety within the

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Utilization Management Position	Reviews the clinical data and apply InterQual Criteria to determine if the patient is in the right level of care, for the right reason, and for the right length of time.	Assist with the development of the section's standard operating procedures; interpretation of and compliance with The Joint Commission Standards, VA/VHA policies and procedures/directives, VISN 16 directives, and any federal regulation(s) governing health care to our 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	Works collaboratively with clinical staff to ensure veterans are receiving the appropriate level of care at all levels. This is an evidence based national review system that ensures patients; VA has chosen the InterQual criteria system.	Assuring that the right care at the right time in the right setting for the right reason occurs in the healthcare delivery system.	The Utilization Management Coordinator applies strict evidence-based criteria to determine the appropriateness of care, to promote high quality care, to assure effective resource utilization, and to increase efficiency and improve access to care, which will lead to increased patient satisfaction.
1. How are measurement tools used to improve quality of care and patient satisfaction?	Use the UM data which is gathered by the UM Specialists to identify system wide problems as well as problems with the UM program. By having the proper resources for a robust UM program, we can ensure quality care by monitoring the timeliness of studies, procedures and consults, we can shorten the length of stay thereby increasing patient safety, and enhancing patient satisfaction. Our work is 100% Veteran Centered. We strive to collaborate with the Social Workers toward post discharge needs and placement when necessary. Everyone wants to return home after they leave the hospital, but sometimes this is not possible. Additionally, an effective and efficient UM Program monitors facility resources. Not only the length of stay, but also over utilization or under utilization of tests and services. By managing the flow of our Veterans throughout the hospital course, we will need to utilize Fee less frequently. This can be a large cost savings for the organization.	Measurement tools are used to evaluate the appropriateness, medical need, and efficiency of health care services to our Veterans in accordance with evidence-based criteria. Monitors are created and data collected and reported; trends identified are discussed and recommendations are given when needed for process improvement. Patient surveys are devised and utilized to capture patient satisfaction of services received.	Data is collected from utilization management to determine trends, help develop solutions to patient-flow problems and identify areas of need for patient care and flow.	The NVCC team will be calling Veterans after their non-VA care to ask three quick questions to assess their satisfaction with the NVCC process and the care they received at the non-VA facility. This data will be reviewed and any negative responses will be validated.	The Utilization Management Coordinator collects and analyzes data relating to the percentage of reviews completed, the percentage of reviews meeting criteria, the percentage of reviews not meeting criteria, reasons for days not meeting criteria, the recommended level of care when criteria was not met, length of stay, and an analysis of physician approvals and/or denials are also tracked. The Utilization Management Coordinator communicates the Utilization Management data to the Utilization Management Committee and to leadership. The substantive data generated through the Utilization Management reviews are integrated into performance improvement/systems redesign initiatives with the overall intent to improve operational efficiencies and provide high quality care, which will increase patient satisfaction.
Risk Manager Position	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. It is a traditional organizational function designed to contribute to improving the quality of care and appropriate utilization of health care resources.	Oversees the Risk Management (RM) 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. 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.	Provides oversight of Peer Review Program; tort claim process in collaboration with a quality, regional counsel, and executive team; conducts risk assessments; and coordinates institutional disclosures.	In coordination with other programs such as Patient Safety and Quality, the risk manager systematically identifies, evaluates, reduces and/or eliminates and monitors the occurrence of adverse events arising from operational activities and environmental conditions. As a counterpart of Enterprise Risk Processes, the risk manager examines multiple risk categories and projects how a given risk might have implications for the entire organization.	Reports analysis and development of ways to reduce risk to patients and employees of the VAMC, as well as reporting adverse patient events in conjunction with the Patient Safety Manager.

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1. How are measurement tools used to improve quality of care and patient satisfaction?	Utilize the automated occurrence screening program which reviews all admissions and discharges for readmissions within 10 days of discharge, deaths within 30 days of an operative procedure, returns to surgery during the same admission, admissions within three days of an ambulatory care visit, and all deaths.	The measurement tools used by RM are varied. We compile and track data. We trend data to identify any patterns and/or opportunities for improvement. Risk techniques are evaluated to ensure that 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.	Peer review aggregate data regarding the 11 aspects of care is reported quarterly to the committee, executive committee, the VISN and VA Central Office. Key process indicators have been developed for both the peer review process and the Medical Malpractice Tort Claim process.	Measurement tools are a means to monitor and track our performance, identify trends, analyze risk/gaps, and guide planning/action.	Tracking and trending of data and analysis of date to determine areas of concern for follow-up. The Risk Manager makes recommendations to Medical Center and Service/Service Line Managers based on analysis of Risk Management data. The Risk Manager analyzes data, recognizes trends, uses statistical analysis and recommends solutions to identified problems.
Systems Redesign Manager Position	TVHS' Systems Redesign Program requires all improvement teams to be aligned with overall strategic goals of the facility, VISN and National Office. Therefore, team are requested ensure that patient safety and satisfaction are not sacrificed while improving a process.	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 that can be improved, develop a plan, and monitor results. This function falls under our new Office of Cultural Transformation.	Facilitates all Rapid Process Improvement Workgroups (RPIW) that are formed to complete process improvement work around a specific problem; serves as a resource to NWI staff regarding process improvement methodology and works collaboratively with a variety of workgroups to ensure that VA-TAMMCS is utilized.	The SRD manager seeks to find ways to balance patient care demand with available resources that provide that care; Incorporates other organizational programs and leaders in improving the way we deliver our care.	Peer review data, tort claim data, adverse event data, results from surveys, etc., are all types of information that is trended and analyzed.
1. How are measurement tools used to improve quality of care and patient satisfaction?	Improvement teams are charter to increase efficiencies, decrease cost and maximize resources while maintaining patient safety and satisfaction. All team are required to have a measurement tool to ensure they are improving the selected process, this measurement is also use to monitor sustainability of the improved process. Team progress is monitor by an Executive Sponsor and a reporting Committee structure.	VA has several data bases which allow measurement of many different processes. We use DSS, the data warehouse, and many specially designed reports to measure what we do and patient satisfaction.	Through the use of VA-TAMMCS, there are a variety of tools that are utilized to analyze the area, map the process, measure the process and changes and develop a control plan. These tools include: process flow maps, swim lanes to outline various department responsibilities, use of graphs such as line, Pareto, and dashboards.	Measurement tools are a means to monitor and track our performance, identify trends, analyze risk/gaps, and guide planning/action.	Salisbury VAMC sponsored Systems Redesign/Lean training (Improving Our Work Is Our Work – IOWIOW) in September 2011. Training was planned and coordinated by SR Manager and conducted by a Veterans Engineer Resource Center trainer. VISN 6 sponsored "Leading Organizational Improvement" SR/Lean training in January 2012 for Systems Redesign, Quality, Patient Safety Managers and Facility Leadership that has been followed with regular LOI Team Meetings and overall plan for developing facility capability to lead improvement work by using Lean tools. We are in the process of developing a similar training for middle managers.

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Chief Health Medical Information Officer/Clinical Lead for Informatics Position	Many of our VA patients reside hours away from our main campus. My responsibilities today focus on providing improved access to these patients through building a Telehealth program that allows patients to receive medical care and education near their homes via remote audio/visual technology.	Role is to create, compile, guide the review of every patient's care benchmarked against the VA national set standards every month for all patients. This position works with the clinical staff to improve their performance and deliver better patient care through the use of data and co-chairs the Medical Records Committee that reviews appropriateness, timeliness, and ease of use, for all the clinical reminders, CPRS notes, and templates that are used in our electronic medical record.	Provides oversight for informatics applications for the clinical areas; collaborates with interdisciplinary groups to develop and revise clinical applications to provide better documentation of evidence-based care given; and, coordinates education programs for new users to the electronic medical record.	The Chief Information Officer (CIO) directs the Office of Information & Technology (OI&T) to deliver adaptable, secure and cost effective technology services to the Department of Veterans Affairs (VA) and acts as a steward for all VA's IT assets and resources. The CIO mission is to provide and protect information necessary to enable excellence through client and customer service.	Ensures facility staff receive education as it relates to health information management processes. Generates and interprets a variety of reports impacting quality of care so that staff may improve processes and address deficiencies in the areas of medical documentation and informatics.
1. How are quality of care and patient satisfaction indicators and measurements tracked and managed?	Quality of care is measured by Quality Management by monthly reporting of over 84 clinical metrics, and tracking for informal internal review of over 90 out-patient and 90 in-patient metrics. Patient satisfaction is measured by using the SHEP patient survey of 20 questions.	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. Our site has champions for each quality of care and patient satisfaction indicator and it is their responsibility to lead the organization in constant improvement.	The Patient Satisfaction Oversight Committee and Sub-Committees track patient satisfaction data through SHEP Survey results and Press Ganey results. The Executive Team meets with the Patient Satisfaction Coordinator monthly to review patient satisfaction data. In addition data is tracked and managed through the Compass Database for outpatient clinic performance.	Patient surveys; Clinical performance guideline reports; Internal audits;	Monthly and Quarterly monitors/audits are conducted to review staff compliance with various regulatory indicators. Many of the reports are submitted to the Medical Records Committee for review. Some are submitted to the Compliance Committee. When reported results indicate the Service is not meeting the compliance rating, Action Plans are required to report processes to be utilized in meeting the standards.
2. How do you measure the results of quality of care and patient satisfaction indicators?	Clinical reminders are 'pushed' to clinicians in order to promote quality performance and help ensure that patients are receiving appropriate assessments and quality care.	Quality of care and patient satisfaction indicators are measured internally through a number of different repositories such as the VISN 16 data warehouse and VSSC reporting. Externally, our quality of care indicators are reviewed monthly through the External Peer Review Program. A third party review organization, which is contracted with the VA, is given roughly 125 patients to review their care retrospective every month, against national	Quality of care and satisfaction indicators are reviewed on a regular basis through a variety of committees in NWI. The information is disseminated to staff who participate in quality improvement initiatives. Examples include: Compass Measures set by VISN and monitor continuity of care and same day access. PACT teams use this information as well as performance measure data during monthly huddles to address improvement opportunities.	Patient surveys; Clinical performance guideline reports; Internal audits;	Indicators are measured through various reports such as Coding Compliance Business Integrity Monitors, Medical Record Chart Reviews, Unapproved Abbreviations Reports, Delinquent Chart Reports, Health Administrative Service HIMS Dashboard Reports (Turnaround Time Reports for Release of Information and Scanning Status Reports), and Outpatient Metrics Reports. These reports are reflected in the quality of care provided due to

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3. How are measurement tools used to improve the quality of care and patient satisfaction?	Tracking of quality performance is used to improve or maintain quality performance and patient satisfaction. Opportunities for performance improvement projects, education, additional resources are identified.	Measurement tools are used throughout the organization to improve quality and patient satisfaction. The results are reviewed in a multitude of committees and individuals that analyze the trends of the data and recommend changes to deliver care with the highest level of quality and highest patient satisfaction.	Outpatient Clinics and inpatient wards review patient satisfaction data on a regular basis and identify opportunities for improvement. Each unit and/or clinic manager will implement a small test of change and monitor progress utilizing Press Ganey and SHEP patient satisfaction scores.	Patient surveys; Clinical performance guideline reports; Internal audits;	These measurement tools provide feedback to staff regarding the appropriateness of their part in these processes and in some cases their overall compliance with regulatory guidance. Staff are expected to take this information and make the appropriate corrective actions. When staff have questions regarding any of these report and/or processes, Health Information Management staff are available to assist. The frequency of the reported data allows for analysis of improvement efforts. These efforts will be reflected in the quality of care provided which will result in an improvement in overall patient satisfaction.
Grant Programs	Our GRECC is working on numerous quality improvement studies to include rural health, geriatric health and development of tools to enhance clinical operations.	SLVHCS has received an Inter-facility Capability Grant that has funded systems redesign and the patient centered care and is a funding source for implementing the Office of Cultural Transformation. Multiple staff have attended yellow belt training in preparation for implementation of innovative quality of care programs. Lean methods have been instituted in reducing on hand clinic supplies.	There are two major grants: the MWM VERC and the ICG. The VERC is a resource to multiple VISNs; though having the expertise locally has been a benefit to NWHCS. The aim of the ICG is to address the organizational and operation barriers to create a continuous improvement capability at NWHCS by 1) preparing leaders at all levels of the organization to lead in a continuous improvement (transformational) environment, 2) creating a culture of learning and psychological safety where all workers seek to continuously improve systems through system redesign, and 3) enhancing the critical thinking and analytical capabilities of all staff.	n/a	The Rural Health Program is funded by a grant and provides education and outreach to underserved populations in remote regions of our service area with the ultimate goal of enrolling veterans in health care services. The Director co-funded a \$50,000 pilot funding research grant with the Wake Forest Translational Sciences Institute to fund a start-up project between Wake and Salisbury investigators. This was awarded and project is underway. Data from this research will be used to apply for DoD funding. Additionally, Salisbury was awarded one of the largest grants ever given to a VA hospital in a single year for the rural health physician training program.
Staff Positions Responsible for Performance Measures	All Services are responsible for support of organizational performance measures.	Performance measures are the responsibility of all staff involved. The Performance Improvement Coordinator has responsibility for compiling and disseminating the information.	Every PACT member is responsible for access and clinical measures.	Facility Director, Chief of Staff, Associate Director, Patient Care Services, Associate Directors, Service Chiefs, Program Managers, Site Managers, Quality Manager and other key leaders as well as every employee.	All staff are responsible for performance measures in their respective areas.

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Patient Satisfaction Measures					
How is patient satisfaction measured?	General non-job based answer not provided	Patient satisfaction is measured through weekly comment card reports and Survey of Healthcare Experiences of Patients (SHEP). These results are reported monthly to SLVHCS executive leadership and service chiefs to target trends and possible process improvement initiatives. Concerns from letters, phone contacts, and personal contacts are also tracked and trended through the Patient Advocate Tracking System (PATS), which is also discussed with leadership.	We use two survey products to measure and manage patient satisfaction: the Survey of Healthcare Experiences of Patients (SHEP) and Press Ganey.	We measure patient satisfaction using Survey of Healthcare Experiences of Patients (SHEP) scores (monthly reports) and Patient Advocate Tracking System (PATS) data (compiled monthly). Patient satisfaction is managed by the Customer Service Manager and Assistant Manager, yet a key performance element of each employee's standards.	Salisbury VAMC leadership monitors patient satisfaction measures through analysis of Press Ganey Survey results, Survey of Healthcare Experiences of Patients (SHEP) data and information from the Patient Advocate Tracking System (PATS). Press Ganey and the Survey of Healthcare Experiences of Patients (SHEP) are national companies, contracted through VISN 6 and VHA, which sends random surveys to patients monthly to collect data on the overall satisfaction or clinic visit. We manage patient satisfaction by monitoring the scores in the following areas - Inpatient: Getting Needed Care, Getting Care Quickly, How Well Doctors/Nurses Communicate, Overall Rating of Personal Doctor/Nurse, Overall Rating of Specialist, Overall Rating of Health Care, Pharmacy Mailed, Pharmacy Pickup, Provider Wait Time; Outpatient: Communication with Nurses, Communication with Doctors, Communication about Medication, Responsiveness of Hospital Staff, Discharge Information, Pain Management, Cleanliness of the Hospital, Noise Level in the Room.
Measurement tools to track patient satisfaction	General non-job based answer not provided	SHEP and PATS	We use a number of mail-out survey tools to assess and track patient satisfaction data: the SHEP survey for inpatient and outpatient services, and the Press Ganey survey for inpatient, outpatient and Emergency Department.	Survey of Healthcare Experiences of Patients (SHEP) scores and Patient Advocate Tracking System (PATS) data are our current measurement tools. We also plan on using focus groups for Veterans in FY 2012-2013.	Press Ganey Survey, SHEP, Patient Advocate Tracking System (PATS)

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Patient Advocate Position	Providing assistance to Veterans and their family based on their experiences and perceptions of their health care experience in a thorough and timely manner—providing the right answer.	To facilitate patient concerns and mitigate any road blocks that our Veterans experience in receiving proper and timely care.	The Patient Advocate is responsible for the effective administration of the Patient Advocacy Program at each division of this health care system. The role is to assist veterans, families and advocates with questions about patient care and to provide a mechanism for expeditious resolution of any concerns.	To provide a centralized and convenient means for patients to have their complaints and compliments addressed and processed.	To provide veterans with access to the care they need in a timely manner and to ensure that they have quality outcomes. We will also provide a health care environment where all veterans, their family members, and significant others are treated with courtesy and dignity throughout all aspects of their treatment, care and service. As a result, veterans will express a high degree of satisfaction with the services they receive.
1. How are patient satisfaction indicators and measurements tracked and managed?	Patient Advocate use the Patient Advocate Tracking System PATS are reviewed monthly and distributed to leaders and services for review, action and discussion.	Measured and track through surveys, phone calls, etc. Trends are managed directly within each service area when reported.	Through the Patient Satisfaction Oversight Committee.	Patient complaints are logged into the Patient Advocate Tracking System database which is displayed on the Customer Service SharePoint site (monthly) and reported in monthly leadership forums. Service Chiefs with significant amounts of patient complaints are notified and asked to identify and implement improvements	Salisbury VAMC leadership monitors patient satisfaction measures through analysis of Press Ganey Survey results, Survey of Healthcare Experiences of Patients (SHEP) data and information from the Patient Advocate Tracking System (PATS). Press Ganey and the Survey of Healthcare Experiences of Patients (SHEP) are national companies, contracted through VISN 6 and VHA, which sends random surveys to patients monthly to collect data on the overall satisfaction or clinic visit.
Director of Patient Care Services Position	Oversight for Patient Advocate, Co-Chair for Patient Center Care Committee, Coordinate Patient Centered Care Activities for the Facility.	This position is a member of the PENTAD and participates in the strategic planning as well as day to day functions of the Health Care System. She also functions as the Nurse Executive and provides oversight of the professional standards of clinical services that support patient care - social workers, dietitians.	Responsible for oversight of all clinical programs to include: Primary Care/Spec Med; Surgery; Mental Health; Extended Care & Rehab; Radiology; Lab & Pathology; Research. Is responsible for oversight, via ACOS for Patient Safety, Education, and Quality. Directly supervises all Service Chiefs in clinical programs, chairs Medicine Executive Committee, and is intimately involved in many improvement groups focused on improving patient safety and quality of care.	Role not defined	Responsible for all patient care services including nursing and staff responsible for sterile processing of equipment

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1. How are patient satisfaction indicators and measurements tracked and managed?	They are followed in the Patient Centered Care Committee and in performance measures. The SHEP and PATS scores are sent to leaders monthly for tracking and corrective action plans if necessary.	Patient satisfaction is measured through weekly comment card reports and SHEP surveys. These results are reported on monthly to SLVHCS executive leadership and service chiefs to target trends any possible process improvement initiatives.	Answer identified in an attached document	We measure patient satisfaction using Survey of Healthcare Experiences of Patients (SHEP) scores (monthly reports) and Patient Advocate Tracking System (PATS) data (compiled monthly). Patient satisfaction is managed by the Customer Service Manager and Assistant Manager, yet a key performance element of each employee's standards.	Salisbury VAMC leadership monitors patient satisfaction measures through analysis of Press Ganey Survey results, Survey of Healthcare Experiences of Patients (SHEP) data and information from the Patient Advocate Tracking System (PATS). Press Ganey and the Survey of Healthcare Experiences of Patients (SHEP) are national companies, contracted through VISN 6 and VHA, which sends random surveys to patients monthly to collect data on the overall satisfaction or clinic visit.
Patient Aligned Care Team Coordinator Position	Responsible for the transformation to the PACT system design for the delivery of Primary and Specialty Care; The clear delineation of staff roles and responsibilities; Infrastructure development of MyHealtheVet, Secure Messaging and Telemedicine; Facilitate the education of staff regarding process, function and system design; Facilitate Veteran education regarding the functionality of PACT healthcare system delivery including Patient Centered Care.	The role 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 & training, educating patients, and other internal and external customers. The position requires working hand in-hand with the assistant chief of staff/clinics (ACOS/C), clinic manager, nurse managers, and lead to effectively convert and implement this model. This role includes tracking and trending PACT performance measures at the CBOC level and at the team level. Finally, the role includes preparing briefing reports to the leadership and coordinating local participation in National and VISN Collaborative, etc.	NWI has a PACT Steering committee. The chairs of this committee are responsible for being a liaison for the VISN 23 PACT Steering Committee to provide a clear channel of communication between NWI and the VISN. The NWI PACT coordinator also supports PACTs in their efforts to provide coordinated, quality care to the Veterans and to meet PACT and performance measure metrics.	VANCHCS does not have a designated PACT Coordinator. PACT is administered by a leadership team that includes all of the disciplines involved in PACT.	Dr Dalsania, ACOS of Primary Care, runs the PACT meetings, coordinates the facility data for input to the national coach's reports, and provides feedback to the local PACT Teams on measures of success.
Quality of Care vs. Patient Safety	Quality of Care is broader in its approach and deals with the clinical skills and capabilities of staff as well as utilization management, risk management, and monitoring for compliance with usual practices whereas Patient Safety is focused on improving the systems and processes that exist in the organization rather than on the people involved in an event.	Patient safety and Quality of Care are inter-related. We believe patient safety is the cornerstone for all quality of care. There are many initiatives that carry issues of quality into the organization but always with the understanding that patient safety is the underpinning of quality in all areas.	Quality of care and patient safety are interrelated. Having safety policies in place and continuing to improve processes in patient care, staff education all impact the quality of care a patient is provided.	The goal of VHA's patient safety program is to reduce or eliminate harm to patients as a result of their care. This has a direct relation to quality of care: the degree to which health services increase the likelihood of desired health outcomes and are consistent with current professional knowledge.	The Quality Program at this facility works very much in tandem with Patient Safety. Quality puts a strong focus on adherence to quality criteria set by The Joint Commission. Patient Safety focuses on the National Patient Safety Goals and safety guidelines as outlined by the National Center of Patient Safety.

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Process for a root cause analysis	Systematic process as per direction and format of National Center for Patient Safety.	Based on a Safety Assessment Code, a root cause analysis would be identified by the patient safety manager and recommended to the director for concurrence. A team is selected with service chief and top management input. The team is convened and charged by the chief of staff. The patient safety manager is the advisor to the team and provides just-in-time training and support throughout the process. The team uses a web based computer program to track its work and prepare a final report. The results of the RCA are presented to the director, top management and related service chiefs. The patient safety manager tracks the progress of the action and outcome measures to completion.	The RCA process is explained in the Patient Safety Improvement Program Policy (DIR-024) and in the VHA National Patient Safety Improvement Handbook (VHA HANDBOOK 1050.01. We follow these requirements.	Multidisciplinary teams are formed to investigate adverse events and close calls. Close calls are events that could have resulted in a patient's accident or injury, but didn't — either by chance or timely intervention. RCAs are used to focus on improving and redesigning systems and processes — rather than focus on individual performance, which is seldom the sole reason for an adverse event or close call. A previously unheeded or unnoticed chain of events most often leads to a recurring safety problem, regardless of the personnel involved. RCA teams improve patient safety by formulating solutions, testing, implementing, and measuring outcomes. NCPS enters all RCA data into the Patient Safety Information System — an internal, confidential, non-punitive reporting system. Findings can be shared nationally if there is a clear benefit for multiple facilities; however, RCA reports are considered confidential quality improvement documents and are protected from release.	Once it has been established that an event merits an RCA, a RCA team is convened. This team is multidisciplinary and may include individuals with extensive professional knowledge in a given area or knowledge regarding the logistics of a particular unit or service. Members are usually selected by their service chief or at request of the Patient Safety Manager. Participation is mandatory. The initial meeting provides RCA “Just in Time” training, team expectations, and a review of the incident. Other meetings include a mapping of the incident, interviews, record reviews, journal reviews, and finally development of actions and outcome measures. The actions and outcome measures are presented to leadership for discussion, recommendations and final approval. Each RCA takes about 4 – 6, 90 minute meetings.

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Quality of Care Measures					
FY Budget 2011	\$537,000,000	\$500,000,000	\$472,000,000	\$393,698,897	\$644,000,000
FY Budget 2012	\$550,000,000	\$500,000,000	\$494,000,000	\$393,147,914	\$669,800,000
How is quality measured?	Tracking clinical and administrative performance measures established by VHA as part of the 2012 Executive Career Field (ECF) Performance Plan which also includes VISN 22 specific measures. These measures are incorporated into service chiefs, supervisors and staff's individual performance plans and evaluations; VA Desert Pacific Healthcare Network (VISN 22) FY 2012-2017 Strategic Plan; Performance measures are reviewed monthly. When performance measures (PM) are not met Executive Leadership requests updates on sustainable action plans to meet the underperforming PM. Quarterly, the Network Director and Network Officers come to the facility for a PM update.	Data management and critical analysis is used for each quality and safety component. Also, setting goals, comparisons of internal and external benchmarks, identification of opportunities for improvement and implementation and evaluation of actions until problems are resolved or improvements are achieved form the basis of performance improvement activities. Veterans Health Administration (VHA) provides several mechanisms for performance measurement .	Data management and critical analysis are used for each quality and safety component. Use of goals, comparisons of internal and external benchmarks, identification of opportunities for improvement and implementation and evaluation of actions until problems are resolved or improvements are achieved. VHA provides several mechanisms for performance measurement.	External Peer Review Program to review pneumonia care, heart failure care, acute coronary syndrome care, preventive measures, surgical care, and home care; Internal review; Clinical review; Active Peer Review; Conducting tracers; Monitoring of care processes through performance measures local and national; Conducting Veteran Satisfaction surveys, focus groups, interviews, rounds to identify and address problems and concerns; Conducting interdisciplinary environment of care rounds; Active surveillance for health care acquired infections	ECF indicators; Performance Measure/Monitor indicators includes ORYX, EPRP, IPEC, VANOD, NDQI?, VASQIP; Hospital Wide Committee Monitors; Division/Service Level measures/monitors
Accountability and maintenance of quality care	Each PM has a champion, and each champion is responsible for meeting the measure that is equitable for the Veteran. We strive to make sure that we are meeting the mission of serving Veterans first; we use the PMs as a tool for keeping ourselves accountable. When a PM is not met we take great steps to understand why the PM is not met, and what process changes need to be implemented in order to meet the PM.	The medical center demonstrates and maintains accountability of quality by an Executive Leadership Board, Medical Executive Committee and Peer review Committee that provide oversight to ensure that quality management components, as defined in VHA Directives 2009-043, are implemented and integrated.)	Field Specific Response Required - (Example: There is a Clinical and Medical Executive Leadership (Clinical Executive Board, Quality Executive Board, Medical Executive Council) function that provides oversight to ensure that quality management components, as defined in VHA Directives 2009-043, are implemented and integrated.)	At the Medical Center accountability is demonstrated through our commitment to our Veterans. Internally the Executive Boards including Leadership Performance Advisory Board critically reviews and monitors performance measures and service action plans to improve performance. We compare our performance with other VA facilities as well as local community hospitals performance. Our performance data is publically available.	Respond timely to ECF plan monitors; Respond timely to accreditation findings; Development of improvement teams timely and following action plans to completion; Ongoing monitoring to maintain accountability; Respond to VISN suspenses timely and completely

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Quality Manager Position	Oversight responsibility for performance improvement, risk management, patient safety, External Peer Review Program (EPRP), continuous readiness program, Preventive Ethics and accreditation. The Quality Manager also serves as the Chairperson for the facility's Performance Improvement Council where quality data is presented and tracked. The Quality Manager oversees the clinical	The QM ensures that all components of the quality management system and patient safety improvement program are integrated. The QM has a systematic process in place for monitoring the facility quality data. Also, serves as the quality consultant to the facility leadership, Quality Improvement (QI) or Performance Improvement (PI) teams, and employees. Lastly, the QM serves on executive committees	Ensuring that components of the quality management system and patient safety improvement program are integrated; Ensuring a systematic process is in place for monitoring the facility quality data. Serving as the quality consultant to the facility leadership, Quality Improvement (QI) or Performance Improvement (PI) teams, and employees; Serving on executive committees and	Ensuring that components of the Quality Management System and Patient Safety Improvement Program are integrated; Ensuring a systematic process is in place for monitoring the facility quality data; Serving as the quality consultant to the Facility Leadership, Quality Improvement (QI) teams and employees; Serving on executive committees and workgroups where quality data and information	Oversees accreditation preparation/site visits. Includes Joint commission, OIG CAP, CARF continuous readiness, Risk Management, Performance Measures/Monitors, Cancer Data Center, Credentialing and Privileging OPPE/FPPE data collection, RCA and HFMEA participation with Patient Safety Program, Chart Review data collection for VHA and Joint Commission monitors, Performance Improvement Activities
1. How are quality care indicators and measurements tracked and managed?	The Performance Improvement Management Service provides detailed data analysis on a quarterly basis that includes trended data and information on relevant changes to the clinical performance measures on an ongoing basis to Executive Leadership, Clinical Service Chiefs and the PI teams they work with. They update the facility clinical reminders annually to reflect current changes in the performance measures providing frontline staff with the tools they need to provide timely, quality care.	Site Report is missing	Service lines and departments responsible for quality of care indicators manage and present their status and metrics at the Clinical Executive Board.	Indicator are define monitored and reported through various committees and reports	Ongoing scorecard that is located on Q&P web page; Monthly review with Director and facility leaders; Performance Improvement groups to meet measures/indicators; Hospital Wide Committees report to Hospital Councils and Executive Leadership Board/Executive Quality Board; Division/Service Level Quality meetings report to SBU
2. How do you measure and manage quality as a healthcare facility?	See above response	Site Report is missing	Data management and critical analysis are used for each quality and safety component. Use of goals, comparisons of internal and external benchmarks, identification of opportunities for improvement and implementation and evaluation of actions until problems are resolved or improvements are achieved. VHA provides several mechanisms for performance measurement.	Quality is measured and management through our performance measure system patient safety program, utilization management program, risk management program, ongoing practice monitoring and occurrence screen monitoring	ECF indicators; Performance Measure/Monitor indicators includes ORYX, EPRP, IPEC, VANOD, NDQI?, VASQIP; Hospital Wide Committee Monitors; Division/Service Level measures/monitors
Patient Safety Manager Position	The Patient Safety Manager (PSM) works with staff throughout the facility to develop innovative, evidence-based approaches to establish, enhance, modify, and/or improve patient care with a focus on patient safety. The PSM ensures that the action items and outcome measures from RCAs, Aggregate Reviews and HFMEAs have been successfully implemented,	The Patient Safety Manger ensures that the components of the Quality Management System and Patient Safety Improvement Program are integrated. They also implement and coordinate patient safety improvement programs based on guidance and tools from the National Center for Patient Safety (NCPS) and which meets the needs and priorities identified	Ensuring that components of the Quality Management System and Patient Safety Improvement Program are integrated; Implementing a coordinated patient safety improvement program that is based on guidance and tools from the National Center for Patient Safety (NCPS) and which meets the needs and priorities identified by the Facility	Performing and supporting RCA activities by acting as a Team Member, Advisor, or providing "Just in Time" training to groups tasked to perform RCAs; Performing and supporting general programmatic functions by maintaining statistics on the number of RCAs and Aggregate Reviews performed monthly or by presenting Patient Safety Program overviews to new	The goal of VHA's patient safety program is to reduce or eliminate harm to patients as a result of their care. This has a direct relation to quality of care: the degree to which health services increase the likelihood of desired health outcomes and are consistent with current professional knowledge.

	San Diego, CA	San Francisco, CA	Seattle, WA	St. Louis, MS	Vancouver, WA
Utilization Management Position	The UM manager oversees a program that is involved in placing Veterans in the most appropriate beds. Her staff is involved in transferring Veterans into VASDHS from community and VA facilities. She works closely with VISN 22 facilities, DoD and active duty OEF/OIF and Veterans from across the nation seeking specialty services at VASDHS.	Assuring that the right care at the right time in the right setting for the right reason occurs in the healthcare delivery system	Assuring that the right care at the right time in the right setting for the right reason occurs in the healthcare delivery system.	An integrated program that promotes a culture conducive to the melding of UM into daily patient care management activities; such as, patient flow, care coordination and discharge planning. Assists the facility in improving the efficiency of patient care. Monitors and evaluates the overall appropriateness, efficiency and effectiveness of health care resources; reviews all admissions and continued stay reviews of all acute inpatient admissions.	We use a number of indicators to evaluate the quality of care being provided, including readmission rates, variance data from UM (NUMI) software, time on divert, OMELOS, length of stay, patient satisfaction data, and one day lengths of stay.
1. How are measurement tools used to improve quality of care and patient satisfaction?	UM uses a national data system National Utilization Management Integration (NUMI). From the data gathered on a daily basis we run reports on placements, treatments, diagnosis, lengths of stay and a variety of other issues. From this we provide weekly feedback to the Executive Leadership Team and physicians on the needs of the Veterans seeking care at VASDHS. We do periodic reports to the Performance Improvement Committee and Medical Executive Committee. The data is also used in the systems and process redesign initiatives. Changes made using our data are followed and monitored through access and satisfaction scores.	Site Report is missing	No answer indicated	No response indicated	We use a number of indicators to evaluate the quality of care being provided, including readmission rates, variance data from UM (NUMI) software, time on divert, OMELOS, length of stay, patient satisfaction data, and one day lengths of stay. Using variance data, we are decreasing the number of variance days in Neurology by increasing the neuro checks performed. In the process of this work, we discovered that the neuro checks themselves were not well-defined, and also needed to take into account sleep times for some patients. These adjustments were made for patient satisfactions, as well as improving overall care. Another example was to decrease the number of patients admitted for bowel preps. None of these will meet criteria. Instead, the clinic coordinators identify whether the Vet will be able to manage the bowel prep at home or not. If not, the patient is admitted instead of automatically admitted.
Risk Manager Position	The Risk Manager serves as the subject matter expert on the VHA's Risk Management Program and requirements. The Risk Manager provides advice and support to the medical center staff, directs the development and maintenance of programs designed to reduce risk at all levels within the healthcare delivery system, and provides educational assistance and policy development/implementation guidance in the area of risk management. In addition, the Risk Manager participates in the development of innovative, evidence-based approaches to the establishment, enhancement, modification, and/or improvement of care with a focus on risk management	Site Report is missing	In coordination with other programs such as Patient Safety and Quality, the risk manager systematically identifies, evaluates, reduces and/or eliminates and monitors the occurrence of adverse events arising from operational activities and environmental conditions; Facilitates Protected Peer Review Process; As a counterpart of Enterprise Risk Processes, the risk manager examines multiple risk categories and projects how a given risk might have implications for the entire organization.	Monitors, identifies, evaluated and correct actual or potentially harmful events which adversely impact on the quality of care of our veterans, staff and/or visitors	One thing that we do NOT do (which is commonly done in the private sector) is to manipulate the care in such a way as to get patients to meet the criteria, e.g. adjust IV rates so that the patient meets, make medication adjustments for Psych patients for the sole purpose of meeting criteria, etc.

	San Diego, CA	San Francisco, CA	Seattle, WA	St. Louis, MS	Vancouver, WA
1. How are measurement tools used to improve quality of care and patient satisfaction?	Tracking tools are used to monitor timeliness, quality of reviews, etc.	Site Report is missing	Access databases are used to track the Protected Peer Review process, mortality reviews, Medical Advisory Opinions, and tort claims. Reports are generated to measure the effectiveness of our internal processes.	No response indicated	Risk Management reviews and analyzes morbidity/mortality (M&M) data, Death Reviews, Occurrence data, Protected Peer Reviews, and tort claim events to identify underlying trends.
Systems Redesign Manager Position	The Systems Redesign Manager provides overall direction to systems improvement strategies and initiatives throughout the facility, ensuring that all projects are fully integrated with quality improvement and patient centered care to ultimately enhance quality and access to care.	The medical center does not have a dedicated SR Manager. There is a Patient Centered Redesign committee (PCRC) which manages systems redesign projects throughout the Medical Center.	The SRD manager seeks to find ways to balance patient care demand with available resources that provide that care; Incorporates other organizational programs and leaders in improving the way we deliver our care.	Directs and coordinates the administrative, operational, & planning activities for SR/ACA programs for the Facility. Planning activities for system redesign including advanced access to all clinics and all other related performance improvement activities through the HealthCare System. Ensures the Alignment of SR/ACA plans/objectives with the VISN SR/ACA objectives, as well as nationally.	n/a
1. How are measurement tools used to improve quality of care and patient satisfaction?	Measurement tools are used daily, weekly, and monthly to create reports, evaluate and disseminate information, and implement procedures to improve effectiveness and efficiency of services. Additionally, the tools provide higher management reports to stay abreast of the quality of care provided by the facility.	Site Report is missing	We begin by first of all understanding current processes that result in our quality of care and patient satisfaction. Once we understand those processes through flow mapping, time studies, and using queuing theory if applicable, we are better able to find the constraints and improve upon the timeliness, avoid waste in the eyes of the customer, and provide the patient with quality care the first time each time. The VA provides a plethora of data tools from which to extract data for baseline measurements and then gated studies along the way to process improvement.	No response indicated	n/a

	San Diego, CA	San Francisco, CA	Seattle, WA	St. Louis, MS	Vancouver, WA
Chief Health Medical Information Officer/Clinical Lead for Informatics Position	Collection of data on a monthly basis (VA data repository); Utilize these data to create and validate provider-specific, as well as facility-specific feedback to Leadership; Create automated reports that evaluate patients seen by individual providers in Primary Care. These reports quantify how many of the patients seen by a provider within the selected interval, i.e., monthly, quarterly, etc., had the requirement apply and, of those patients, how many had the requirement satisfied; Similar process is taking place for <u>Inpatient Nursing</u> and Outpatient Nursing areas.	Site Report is missing	The Chief Information Officer (CIO) directs the Office of Information & Technology (OI&T) to deliver adaptable, secure and cost effective technology services to the Department of Veterans Affairs (VA) and acts as a steward for all VA's IT assets and resources. The CIO mission is to provide and protect information necessary to enable excellence through client and customer service.	Ensures the health information systems supports the care and service delivery and facilitates the improvement of care and services through collection and reporting of clinical information	Portland is VA's leading facility for innovation and the use of technology to improve the quality of care. We use technology to ensure quality of care by building decision support tools into our electronic medical record. Computers allow us to guide our clinicians to make decisions based on the best evidence by displaying it to them at key points in the clinical process.
1. How are quality of care and patient satisfaction indicators and measurements tracked and managed?	Monthly Performance Measure Reports (Individual Provider "Report Cards") are sent to the Primary Care Teams POCs; monitoring of staff compliance with satisfying clinical reminders and performance measures; facility "Report Card".	Site Report is missing	There are many quality of care indicators monitored locally, at the VISN level, and nationally. These are regularly reported at both facility performance reviews and in program specific and other forums. Successes, barriers, and best practices are discussed and shared both between service lines and with other VHA facilities.	Indicators and measurements are tracked by QM-we support QM if they have reporting needs. We also work with QM to ensure that the electronic health record reflects the most current performance measures and clinical guidelines.	We research medical literature and other expert sources to identify the tangible measures of quality care. We then set up data streams that tell us how well we are doing in achieving the quality outcomes. A good example of this is a chronic disease like diabetes. With Diabetes, there are a set of quality outcomes such as a blood test called Hemoglobin A1C that is an indicator of good control of blood sugar. Other quality outcomes for diabetes would be control of cholesterol and periodic screening for kidney or eye damage. Once the quality outcomes have been identified, we design processes that our staff follow in their work with the veteran to try to achieve the quality goal. We identify measurable outcomes for all of our clinical and administrative processes and we use this data to drive performance improvement.
2. How do you measure the results of quality of care and patient satisfaction indicators?	Clinical Reminders matching performance measures guidelines were implemented for this purpose. These are tools for tracking Facility and Provider compliance. We can look at overall performance for stop codes or provider panel, or can drill down to a team of patients or clinic. It ensures quality patient care through timely interventions. And we can create reports, charts, and graphs. Patient lists can be created for patient mailings, case managers, etc.	Site Report is missing	National and regional monitors for quality of care indices have been established and are used to indicate program and provider performance toward specified goals. Areas or individuals failing to meet criteria are identified and corrective measures taken and improvement monitored as appropriate. Clinical reminders and decision support software are used real time to help clinicians make better decisions regarding treatment regimens and to identify	Real time tools are available to provide data back to management as quickly as possible.	We use these data streams in a variety of ways. We look at them retrospectively to assess past performance. We display them concurrently so that a doctor or nurse would be reminded that a veteran just now checking in for an appointment is due for an important screening or in need of a medication adjustment. We also use the data streams to look into the future and anticipate when veterans will be in our clinics or hospitals who are in need of an intervention

	San Diego, CA	San Francisco, CA	Seattle, WA	St. Louis, MS	Vancouver, WA
3. How are measurement tools used to improve the quality of care and patient satisfaction?	Clinical Reminders are measurement tools used to prepare Facility-wide performance reports which are disseminated to Supervisors, Management, Executive Leadership, as well as the Network Director. Tracking performance ensures prompt quality patient care and Performance Measures compliance.	Site Report is missing	Results of past and current performance in specific measures are watched and trended in order to allow the facility, programs and individual providers to identify areas for improvement overall as well as to identify specific patients or groups of patients who may require intervention or benefit from program changes or new initiatives in health care delivery practices or modes.	All reports, including those from the data warehouse, are aimed to help the front line staff improve quality, efficiency and safety. For example, there are regular reports regarding BCMA use that are used by Pharmacy, Nursing and Biomedical Engineering staff to make sure that the bar code medication process is functioning properly.	We capture quality outcome data in the course of all of our clinical and administrative processes. We compare ourselves to other VA facilities and to the private sector. We continuously redesign processes in order to improve our ability to achieve quality outcomes. We then design performance improvement initiatives aimed at addressing patient satisfaction issues that were identified in the surveys. We repeat this cycle regularly to stay on top of current issues and to see if our previous performance improvement initiatives were successful.
Grant Programs	VA San Diego received a grant and is currently conducting an innovative quality of care program and research on the use and efficacy of mantra repetition therapy for managing PTSD. Additionally, VA San Diego received a national grant to expand training nationally and continue conducting training locally for marriage/couples relationship training titled "From Warrior to Soul mate".	Site Report is missing	n/a	Participate in Patient Safety program on Reduction of health care acquired central line infections; Received grant for 8 patient centered care projects to improve the environment of care; Selected as VISN site for Surgical Flow improvement project.	Patient Center of Inquiry – From National Patient Safety Office (Med Rec)
Staff Positions Responsible for Performance Measures	The PIMS department and Health Systems Specialist in the Director's Office, System Redesign Staff and several Administrative Officers track performance measures. It is the responsibility of all employees to deliver quality care to Veterans, which ultimately affects the success of performance measures.	Site Report is missing	The Office of Analytics	Director Quality Management in conjunction with other executive team members and service chiefs.	Q&P performance measure/EPRP coordinator facilitates this

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Patient Satisfaction Measures					
How is patient satisfaction measured?	Patient satisfaction is measured through tracking quarterly results of a national survey (SHEP), and quarterly trending of the Top-3 complaint issues which are presented to management at the Veteran Employee Service Council (VESC).	Site Report is missing	SHEP Surveys; Post discharge phone calls to all patients who are discharged from an inpatient stay; rounding the facility and visiting with Veterans; Veterans participate some committees; Patient Advocate Tracking System; Executive Correspondence; and Congressional Correspondence.	SHEP data is provided and discussed at the QEB Committee; The data is graphed, analyzed and use the National % as the benchmark; Internal quick cards are available throughout specifics clinical areas and entered into a database; which is graphed by location and available to all staff members; Patient Advocates meet with assigned services on a quarterly basis to share data related to them.	Patient Advocate Tracking System (PATS) – Director's Morning Meeting (weekly); Survey of Healthcare Experiences of Patients (SHEP) – Patient Satisfaction Committee (quarterly/semi-annually); Press Ganey (new)
Measurement tools to track patient satisfaction	SHEP Survey questions: HCAHPS scores; Reports of patient complaint and compliment with monthly, quarterly and annual trending from the Patient Advocate Tracking System (PATS).	Site Report is missing	See above response	Quick Cards, national SHEP Survey, Executive Staff walk around, patient advocate rounds	See above response

	San Diego, CA	San Francisco, CA	Seattle, WA	St. Louis, MS	Vancouver, WA
Patient Advocate Position	Expediently resolve problems by assisting Veterans, family members, and others, assist to overcome institutional obstacles while working within the existing laws and regulations of the Department of Veterans Affairs (DVA) and VHA (Veterans Health Administration), and work across Service-Boundaries to identify solutions to patient complaints	Site Report is missing	Provide concern resolution, address compliments with Service Lines, provide customer satisfaction training, and make inpatient visits to new patients and provide concern resolution to inpatients.	Being the interface with Veterans and families that have information needs, concerns or compliments.	Resolving complaints that cannot be resolved at the point of service level and /or across disciplines; Presenting patient issues at various facility meetings and committees; Interpreting patient rights and responsibilities; Managing the use of the Patient Advocate Tracking System (PATS); Providing trends of complaints and satisfaction data at the facility level; Ensuring a process is in place for distribution of the information to appropriate leaders, committees, services and staff.
1. How are patient satisfaction indicators and measurements tracked and managed?	Besides the SHEP scores, the hospital also gets patient satisfaction reports from the Patient Advocate Tracking System. Patients and family who contact the Patient Advocate by walk-in, phone, voice-mail, e-mail, letter, and Internet (IRIS), have their concerns recorded in our tracking system where we code the type of complaint according to VA standards for Customer Service. Details are available for review at the patient level, and down to the employee involved level when those names are known.	Site Report is missing	Patient Advocate Tracking System. The facility also reviews SHEP scores for patient satisfaction.	SHEP and PATS reports. Concerns, issues and compliments are recorded in PATS Quarterly reports are generated and Patient Advocate meets with services to review trends in reports and progress on actions.	Patient Advocate Tracking System (PATS) – Director's Morning Meeting (weekly); Survey of Healthcare Experiences of Patients (SHEP) – Patient Satisfaction Committee (quarterly/semi-annually); Press Ganey – New
Director of Patient Care Services Position	Roles and Responsibilities for AD/PCS/Nurse Executive include personnel management, budgeting, best health care practices, strategic planning, and the clinical oversight responsibility for the provision of timely and continuous high quality and safe care delivered to patients throughout the VA San Diego Healthcare System. The disciplines under my responsibility include Nursing, Social Work, Nutrition and Food and the Chaplain service. Clinical competency and adherence to VHA Directives for all programs and services fall within role responsibility in addition to meeting organizational performance measures for quality care.	Site Report is missing	No response indicated	The Associate Director for Patient Care Service provides oversight and direction to ensure that Veteran needs are met to their expectations and in a timely manner. Discharge planning and Veteran education in a manner they are able to understand and engage in their care. Meeting the Veteran and their family at their level to achieve an understanding that improves their health.	I am responsible for the professional practice of 950 nursing staff at the medical center's two campuses and eight Community Based Outpatient Clinics. As Deputy Director, Patient Care Services, I am the executive responsible for Critical-Care, Critical Care Medicine, Medical-Surgical Units, Emergency Department, Emergency Medical Services, Nursing Research, Nursing Professional Services, Escort, IV and PICC Teams, Respiratory Therapy, Utilization Management, Medical Center Education, Pharmacy, Food and Nutrition Services, Imaging, Laboratory Services, Audiology, Speech Pathology, Chaplain and Social Work Services, representing a total of 1100 employees and a budget of \$152M.

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1. How are patient satisfaction indicators and measurements tracked and managed?	Patient satisfaction indicators are tracked by a number of committees and are reviewed by Executive Leadership regularly. Specifically, patient satisfaction information is reviewed during the monthly Veteran Employee Service Council (VESC) and the monthly One VA and UVC (United Veterans Council) meetings. If a measure is not meeting the mark or the Executive Leadership Team identifies an opportunity for improvement the Lead/Champion is tasked with providing an action plan, which is monitored until the measure is met.	Site Report is missing	No response indicated	SHEP and PATS reports. Concerns, issues and compliments are recorded in PATS Quarterly reports are generated and Patient Advocate meets with services to review trends in reports and progress on actions.	Patient Advocate Tracking System (PATS) – Director's Morning Meeting (weekly); Survey of Healthcare Experiences of Patients (SHEP) – Patient Satisfaction Committee (quarterly/semi-annually); Press Ganey – New
Patient Aligned Care Team Coordinator Position	Oversee interdisciplinary primary care operations for VHA clinics (including contract) and implementation of PACT aims; I directly supervise the physicians who work in Primary Care. I also participate as a VISN leader (co-chairing the PC committee) and as a member of the VHA Field Advisory Committee for Primary Care.	Site Report is missing	Oversee the implementation of PACT principles at all 9 Puget Sound Clinic sites.	Acting Associate Chief Nurse Primary Care – Education, management and supervision of nursing staff assigned to PACT.	PVAMC's rollout of the PACT Transformation is being led by Primary Care Division (PCD) leadership and its executive team.
Quality of Care vs. Patient Safety	There is no difference. Quality care and patient safety go hand and hand. The aim is to provide both safe and high quality care to patients.	Site Report is missing	Quality of care and patient safety go hand in hand. Patient safety is the cornerstone of high-quality health care. Many patient safety practices, BCMA, CPRS, CRM (crew resource management), SBAR, Time Out, Hand Hygiene, IV-Pumps, CL catheter bundles, Surgical bundles, other automated and systems with human factors built in are considered strategies to avoid patient safety errors and improve Quality health care. Quality of care and patient safety has some differences in systems of review and follow up to ensure quality and safe care.	There is no difference. They are hand in hand. Patient safety is quality of care and quality of care in impacted by patient safety events.	Quality of care and patient safety go hand in hand. Patient safety is the cornerstone of high-quality health care. Many patient safety practices, BCMA, CPRS, CRM (crew resource management), SBAR, Time Out, Hand Hygiene, IV-Pumps, CL catheter bundles, Surgical bundles, other automated and systems with human factors built in are considered strategies to avoid patient safety errors and improve Quality health care. Quality of care and patient safety has some differences in systems of review and follow up to ensure quality and safe care.

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Process for a root cause analysis	A standardized process for RCAs was developed by the VHA National Center of Patient Safety that all VA facilities are required to utilize. A team is chartered and tasked with reviewing the event and identifying the root cause and/or contributing factors related to the event. Various tools are used throughout the process. Action items and outcome measures are developed. A final report is prepared by the team and presented to Executive Leadership. The RCA team has forty-five days to complete the Root Cause Analysis. Once approved and signed by the Director, the report is transmitted to the NCPS. The action items and outcome measures are tracked to completion	Site Report is missing	Conducting an RCA is a critical aspect in the process of improving patient safety. Multidisciplinary teams are formed to investigate adverse events and close calls. Close calls are events that could have resulted in a patient's accident or injury, but didn't — either by chance or timely intervention. RCAs are used to focus on improving and redesigning systems and processes — rather than focus on individual performance, which is seldom the sole reason for an adverse event or close call. A previously unheeded or unnoticed chain of events most often leads to a recurring safety problem, regardless of the personnel involved. RCA teams improve patient safety by formulating solutions, testing, implementing, and measuring outcomes. NCPS enters all RCA data into the Patient Safety Information System — an internal, confidential, non-punitive reporting system. Findings can be shared nationally if there is a clear benefit for multiple facilities; however, RCA reports are considered confidential.	An event (incident) is reported which after review is been identified to have an RCA team chartered. Team charter is signed by the Medical Center Director. Once the team has completed the process will present findings to the Executive Team.	Conducting an RCA is a critical aspect in the process of improving patient safety. Multidisciplinary teams are formed to investigate adverse events and close calls. Close calls are events that could have resulted in a patient's accident or injury, but didn't — either by chance or timely intervention. RCAs are used to focus on improving and redesigning systems and processes — rather than focus on individual performance, which is seldom the sole reason for an adverse event or close call. A previously unheeded or unnoticed chain of events most often leads to a recurring safety problem, regardless of the personnel involved. RCA teams improve patient safety by formulating solutions, testing, implementing, and measuring outcomes. NCPS enters all RCA data into the Patient Safety Information System — an internal, confidential, non-punitive reporting system. Findings can be shared nationally if there is a clear benefit for multiple facilities; however, RCA reports are considered confidential.

(5) Slides for presentation, American Legion convention, Indianapolis, August 25, 2012

The American Legion 94th National Convention

Indianapolis, Indiana

August 25, 2012



A close-up photograph of a Marine in a dark blue dress uniform. The uniform features red piping along the collar, lapels, and cuffs. Gold buttons and insignia are visible. A yellow ribbon is pinned to the left lapel. A white belt with a gold buckle is worn around the waist. The background is white.

National Veterans Affairs and Rehabilitation Commission Meeting

Measurement of Quality in the VA and Civilian Hospital Systems: Good News for Veterans

Fred Hyde, MD
Clinical Professor
Department of Health Policy and Management
Mailman School of Public Health
Columbia University, New York

**Who has studied the VA
system, to examine quality?**

Who has studied the VA system?

(1) The RAND Corporation

A decorative graphic element in the bottom-left corner of the slide, consisting of overlapping blue and black geometric shapes.

Who has studied the VA system?

- (1) The RAND Corporation
- (2) Phillip Longman (“Best Care Anywhere”)

Who has studied the VA system?

- (1) The RAND Corporation
- (2) Phillip Longman
- (3) Individual quality assurance researchers (see bibliography, more than 75 studies)

Who has studied the VA system?

- (1) The RAND Corporation
 - (2) Phillip Longman
 - (3) Individual quality assurance researchers (see bibliography)
 - (4) The Joint Commission (Joint Commission on Accreditation of Health Care Organizations)
- 

Who has studied the VA system?

- (1) The RAND Corporation
 - (2) Phillip Longman
 - (3) Individual quality assurance researchers (see bibliography)
 - (4) The Joint Commission (Joint Commission on Accreditation of Health Care Organizations)
 - (5) HCAHPS (the CMS program for assessment of “quality” measures)
- 

Who has studied the VA system?

- (1) The RAND Corporation
 - (2) Phillip Longman
 - (3) Individual quality assurance researchers (see bibliography)
 - (4) The Joint Commission (Joint Commission on Accreditation of Health Care Organizations)
 - (5) HCAHPS (the CMS program for assessment of “quality” measures)
 - (6) AHRQ, the Agency for Healthcare Research and Quality
- 

What have they found?

What have they found?

(1) RAND Corporation Findings:

- * VA patients were more likely to receive recommended care than patients in the national sample
 - * Quality of care was better for VA patients on all measures except acute care, on which the two samples were similar
- 

What have they found?

(2) Phillip Longman

- * Three editions of a popular book, subtitled “Why VA Health Care Would Work Better for Everyone”
 - * Popular author, celebrated in business texts, interviews, when published
- 

What have they found?

(3) Other researchers

- * Consistent message—when compared, VA results are superior to those in the general hospital population
 - * In the “insurance” area, VA results are superior to those in Medicare Advantage programs
- 

What have they found?

(4) The Joint Commission:

- * 17 of the top 405 hospitals in the nation are VA Medical Centers

What have they found?

(6) AHRQ:

- * AHRQ is the primary HHS activity involved in quality and value
 - * AHRQ sponsors the Patient Safety Improvement Corps jointly with the VA
 - * Validation of patient safety indicators in the VA, for example, studies on utilization of HER, surgical site infection risk
- 

Challenges for the Future

(1) Complexity in obtaining the medical care –
what guidance will the Veteran receive?

Challenges for the Future

- (1) Complexity in obtaining the medical care – what guidance will the Veteran receive?
- (2) Complexity in health services research: Conflict between commercial and governmental forces

Challenges for the Future

- (1) Complexity in obtaining the medical care – what guidance will the Veteran receive?
 - (2) Complexity in health services research: Conflict between commercial and governmental forces
 - (3) Medicare Advantage benefits
- 

Challenges for the Future

- (1) Complexity in obtaining the medical care – what guidance will the Veteran receive?
 - (2) Complexity in health services research: Conflict between commercial and governmental forces
 - (3) Medicare Advantage
 - (4) Cost of care, results
- 

Conclusions

- ▶ In the modern hospital era of hospitals (1997 – 2013), quality has been an important issue.



Conclusions

- ▶ Quality in the VA Systems shows in all of the studies cited to be at least equal and in many cases superior to that available in the civilian system.



Conclusions

- ▶ Those aspects of quality that are measured in the civilian system do not always pertain to the patient experience; many are aimed at reducing Medicare and Medicaid expenditures.



Conclusions

- ▶ Overlap between the civilian and VA systems takes place in The Joint Commission's accreditation process and, to a lesser extent, in the HCAHPS program.



Conclusions

- ▶ There is not yet enough “overlap” between the VA and the civilian “HCAHPS” measures to be meaningful.



Conclusions

- ▶ There are significant differences between the needs of patients in the VA system and the needs of patients in civilian hospitals



Recommendations

- ▶ The VA should be encouraged to submit its 153 medical centers to common bases of comparison.



Recommendations

- ▶ The “message” concerning quality in the VA System should be consistently and realistically presented to the Veteran.



Recommendations

- ▶ The “System Worth Saving” Task Force is a unique American solution to the challenge posed for Veterans’ medical care – a “board of visitors” operating on a national level, with access to the highest officials in the VA

