



VHA DEPUTY UNDERSECRETARY
FOR HEALTH FOR OPERATIONS
AND MANAGEMENT
FY2009
MONITORS and GUIDELINES

October 6, 2008

**Deputy Under Secretary for Health for Operations and Management
Monitors and Guidelines for FY 2009
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VSSC DUSHOM Web Reporting Link: <http://vssc.med.va.gov/DUSHOM/>

**VHA Deputy Under Secretary for Health for Operations and Management
2009 Monitors – Contacts**

MONITOR	POINT OF CONTACT
DOMAIN: QUALITY	
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2. “Fresh Eyes on Service” Program	Joan Van Riper National Pt. Advocate Prgm 518-626-5673
3. Community Living Centers - Cultural Transformation	Christa Hojlo, PhD Director VA & SVH Nursing Home Care 202-461-6779
4. Fluoride Treatment for Patients at High Risk for Dental Caries (NEW)	Gretchen Gibson, DDS, MPH Dental Field Coordinator for Oral Health Quality Group 479-444-5042
5. Colorectal Cancer Treatment and Surveillance (NEW)	Michael Davies, MD National Director Systems Redesign 605-720-7174
6. Methicillin-Resistant Staphylococcus Aureus (MRSA) Screening, Acute Care (NEW)	Rajiv Jain, MD MRSA Program Office 412-688-6102
7. Supply Processing and Distribution (SPD): Self Evaluation (NEW)	Gary Roselle, MD Infectious Disease 513-475-6317, ext 6398
8. Community Living Centers – Bedfast Residents (NEW)	Christa Hojlo, MD Director VA Community Living Centers 202-461-6779
DOMAIN: ACCESS	
1. Comprehensive Oral Evaluation for Eligible Veterans	Timothy Ward DDS Ass't USH for Dentistry Office of Dentistry 202-461-6954

MONITOR	POINT OF CONTACT
2. Care for the Medically Compelling Dental Patient (NEW)	Timothy Ward DDS Ass't USH for Dentistry Office of Dentistry 202-461-6954
3. Wait Times - Outpatient Imaging Procedures	Charles Anderson, MD Director, VHA Radiology Program 919-383-7874 x 260
4. Examine the Impact of Hospital Flow on Emergency Department (ED) Operations	Gary Tyndall, MD Emergency Dept. Medical Director 315-425-4400 x 54417
5. Using Discharge Appointments to Balance Discharges Within the Day and Across the Day of Week	Fabiane Erb Systems Redesign Office 716-862-8522
6. Colonoscopy Follow-up of Positive Fecal Occult Blood Tests (FOBT)	Dede Ordin, MD, MPH Director, Quality Improvement, OQP 202-266-4519
7. Compensation and Pension Timeliness	Debbie Leek Program Specialist 615-340-4079
8. Operating Room/Surgical Flow Systems Redesign (NEW)	Fabiane Erb Systems Redesign Office 716-862-8522
9. Care Coordination: Tele-Mental Health Expansion (NEW)	John Peters Program Analyst – Office of Care Coord 202-461-6946
10. Ensure Timely Access for ALL New Veterans Who Need Mental Health Care	Tim Cuerdon Health Systems Specialist 202-461-7351
11. Mental Health Care Transitions Follow Up to Inpatient Mental Health Hospitalization Monitor Documentation	Tim Cuerdon Health Systems Specialist 202-461-7351
12. Follow-up for High Risk Hospitalized Mental Health Patients	Tim Cuerdon Health Systems Specialist 202-461-7351
13. Mental Health – HUD VASH	Tim Cuerdon Health Systems Specialist 202-461-7351
DOMAIN: COST	
1. Prosthetics Home Respiratory Care Program	Robert Baum Program Analyst 202-254-0440
2. Care Coordination/Home Tele-health Utilization Reduction	Ellen Edmonson Director of Operations Office of Care Coordination 202-461-6972
3. Construction Projects (3) a. NRM Project Obligations by End of FY b. NRM Maintenance Project Obligations by June 30, 2009 c. NRM Project Obligations for Facility Condition Assessment Projects d. Minor Construction Obligations	Brandi Fate Director – CAMPS 202-266-4671

MONITOR	POINT OF CONTACT
4. Logistics (5) a. Unauthorized Commitment and Ratification b. Federal Procurement Data System Entry c. Logistics Purchase Card Program <i>(NEW)</i> d. Inventory Management e. Equipment Inventory	Garth Glenn Inventory Management Specialist 202-679-7952
5. Prosthetics a. Consults Pending b. Surgical Implant Serial Numbers <i>(NEW)</i>	Robert Baum Program Analyst 202-254-0440
6. Administrative Systems Redesign	Fabiane Erb Systems Redesign Office 716-862-8522
DOMAIN: BUILDING HEALTHY COMMUNITIES	
1. Employee Seasonal Influenza Vaccination	Pamela Hirsch Occupational Health Nurse 202-461-8493
2. Safe Patient Movement and Handling <i>(NEW)</i>	Kevin Grant Program Analyst 202-461-8495
3. Workers Compensation Job Offers Performance <i>(NEW)</i>	Eileen Coyne Workers' Compensation Program Mgr. 512-326-6557
4. Timely Submission Worker's Compensation Request to the Department of Labor	Eileen Coyne Workers' Compensation Program Mgr. 512-326-6557
DOMAIN: AREAS OF SPECIAL EMPHASIS	
1. Post Deployment - OEF/OIF Screening	Bryan Volpp, MD – Technical 925-370-4169 Dr. Kenneth Hyams – Clinical 202-273-8579 Dr. Laurent Lehmann – Clinical 202-461-7364
2. Vehicle Fleet Management <i>(NEW)</i>	John D. Stenger Dir. Health Care Engineering 202-266-4604
3. Energy / Sustainability <i>(NEW)</i>	John D. Stenger Dir. Health Care Engineering 202-266-4604

DOMAIN: QUALITY

1. Electronic Support for Patient Decisions: iMedConsent™

Informed consent for treatments and procedures is essential to high quality patient care. Implementation of national standards for the informed consent process will help ensure that veterans across the country receive the information they need to make informed decisions about their health care.

ACTIONS: Use of iMedConsent™ to electronically generate, sign and store consent forms for clinical treatments and procedures is mandatory. Network Directors are responsible for ensuring that facility leaders have the support and resources they need to implement iMedConsent™ in all clinical settings. Facility Directors, CMOs, and QMOs are responsible for seeing that their practitioners use the program to document consent for clinical treatments and procedures that require signature consent.

DEFINITIONS/OBJECTIVES: The iMedConsent™ software program is a useful tool that promotes a standardized approach to the process and documentation of informed consent. The FY2009 Performance Monitor is designed to ensure regular and routine usage of iMedConsent™.

DATA SOURCE: iMedConsent™ usage data is collected in chart reviews performed for the Surgical Care Improvement Project (SCIP). SCIP data is accessible online at: <http://vaww.pdw.med.va.gov/pdwframe.asp>. The supporting indicator SIC2 calculates the percentage of consent forms generated using iMedConsent™ based on a sampling of surgical chart reviews in the following specialties: Cardiothoracic Surgery, General Surgery, Neurosurgery, OB/GYN Surgery, Orthopedic Surgery, Urologic Surgery, and Vascular Surgery. In addition, total iMedConsent™ usage data for each clinical specialty (surgical and non-surgical) at each facility is included in the monitor report. This data is pulled from the iMedConsent™ servers at each facility.

No data need be submitted by facilities or VISNs for this monitor. The National Center for Ethics in Health Care will submit quarterly progress reports to the DUSHOM. These reports will be posted on the initiative website: http://vaww.patientdecisions.va.gov/links_docs.asp upon submission to the DUSHOM.

TARGET: The FY 2009 target for achievement at the facility level for iMedConsent™ usage is 85% (cumulative of all monitored surgical specialties, over the final two quarters [Q3 + Q4] of the fiscal year). However, a Network cumulative score will also be calculated. The Network cumulative score is the percentage of iMedConsent™ usage in the VISN calculated over the final two quarters of FY 2009 (Q3 + Q4). Facilities will achieve a fully-satisfactory rating if their individual score is 85% or better and the cumulative Network score is 80% or greater. Facilities will achieve an exceptional rating if their individual score is 95% or greater and the Network cumulative score is 80% or greater. (Note: If the Network cumulative score is less than 80% all facilities in the Network fail the monitor irrespective of individual facility performance.) Network Directors are expected to continue evaluating the overall iMedConsent™ usage data to ensure that the program is being used in all applicable specialties at each facility.

CONTACT: Raymond Frazier, Program Analyst, National Center for Ethics in Health Care @ 202-461-4028 or ray.frazier@va.gov.

2. “Fresh Eyes on Service” Program

VHA's Fresh Eyes on Service Program is a process designed to sample the customer service behaviors and services at VA Medical Centers and large CBOCs (over 1500 unique patients). This process is conducted by trained VHA employees or VSOs who make on-site visits and, as necessary, supplemental telephone calls. The main goal of the program is to identify and share successful practices observed. This program also allows opportunities for improvement to be observed. Because the program's emphasis is on systems improvement and the veteran's experience, rather than on individual staff

members, only trended data from the Fresh Eyes on Service Program will be rolled up nationally. Specific data from a "Fresh Eyes" visit will remain at the local Medical Center level.

DEFINITION: The Veterans "Fresh Eyes on Service Program" consists of in-person visits by trained VHA employees or Veterans Service Organization (VSO) representatives to observe customer service provided to veterans at Medical Centers and large Community Based Outpatient Clinics (CBOC). Visits may be augmented by telephone calls.

ACTIONS: Each VISN will report trended data on the results of "Fresh Eyes" visits during FY09 on the template on the 10NC Share Point site.

DATA SOURCE: "Fresh Eyes" visits/phone calls within the VISN.

TARGET: By the end of Quarter 4 FY09, 100% of each VISN's Medical Centers and/or large CBOCs will have had a "Fresh Eyes" visit with trended results reported. This target is cumulative data reported from FY08 and 09. **Met = 100%**

REPORTING:

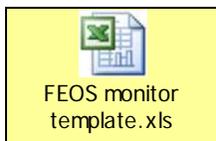
a.) **Monthly** - The Fresh Eyes on Service monitor will be posted to the 10NC Share Point site: <https://vaww.portal.vhaco.va.gov/sites/dushom/10NC/Fresh%20Eyes%20on%20Service%20Site%20Vi%20Tracking/Forms/AllItems.aspx>.

The following information should be reported monthly on the 10NC Share Point site. This data will be reviewed monthly by the National Fresh Eyes Committee to assure that visits are being completed to meet the FY09 performance goal.

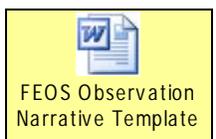
- Total number of "Fresh Eyes" visits during FY09 (and names of sites visited)
- Total number of Medical Centers and large CBOCs in the VISN
- Percent of VISN sites visited in FY09.
- Number of VA employees who actively participated as "Fresh Eyes" observers.
- Number of VSOs who actively participated as "Fresh Eyes" observers.

b.) **2nd and 4th Quarters**, the following information should also be reported to the 10NC Share Point site: Observations – positives and opportunities for improvement (general trends, not specific details) from the "Fresh Eyes" visits during FY09 via the template provided. Observation narrative reports should be saved as a Microsoft Word document to the folder on the 10NC Share Point site labeled "VISN Summaries". Each VISN will have a specified folder within the main "VISN Summaries" folder..

c.) **4th quarter:** The National Veteran Service and Advocacy Program will submit the final report findings to the DUSHOM web profile.



Document: FEOS monitor template



Document: FEOS observation narrative template

CONTACT: Joan Van Riper, Director, National Patient Advocate Program @ 518-626-5673 or e-mail: Joan.VanRiper@va.gov

The information below will be populated **monthly** on the 10NC Share Point site.

FEOS VISN Site Visit Summary Data								
VISN	Total # VAMCs visited Q1 Y09	Total # CBOCs visited Q1 FY09	Total # FEOS visits Q1 FY09	% of VISN sites visited QTR1 FY09 (cumulative)	# of VISN VAMCs visited using telephone contact (supplemental approach)	# of VISN CBOCs visited using telephone contact (supplemental approach)	# trained individuals who participated as FEOS observers	
							VA Employees	VSO
VISN								

The information below will be submitted **2nd** and **4th** quarter to the 10NC Share Point site.

VISN #:	Narrative Report Template for Quarters 2 & 4, FY09
Contact Name:	
Contact Phone Number:	
Contact E-mail:	
Please list the site ID and name of facilities visited since last reporting period:	
Observations summary: positives and opportunities for improvement; general trends as noted from individual site reports, not specific details; complete in applicable sections below. Additional pages may be added, as needed.	
Brief description of exemplary service observed/experienced:	
Brief description of opportunities for improvement in service observed/experienced:	

3. Community Living Centers - Cultural Transformation

The purpose of the monitor is to promote the cultural transformation in VHA Community Living Centers (CLC). This applies to all Community Living Centers including short stay and long stay. The “Artifact” Tool will allow the facility to perform a self assessment first quarter, choose areas for improvement to make changes and move forward with cultural transformation, and to reassess and measure improvement in third quarter.

RATIONALE: Cultural transformation of our VA CLCs means transforming the way we think about how we deliver care to our veterans in our VA CLC facilities. The purpose of cultural transformation is to transform our CLCs from the institutional care model where loneliness, hopelessness and boredom are present to vibrant communities where the focus is on resident centered care and a homelike environment. Cultural Transformation needs to take place in the areas of Care Practices, Work Practices, and the Environment. The Artifact Tool lists specific action items that can be undertaken to move an organization forward to achieve Cultural Transformation and provides a means to measure progress.

ACTIONS:

- a.) **First Quarter:** Each facility Director will be responsible for performing a self assessment of Cultural Transformation progress using the Artifact tool and will select areas to work on for improvement. The self assessment results will be submitted on the FY09 Q1 DUSHOM report via the VISN Office.
- b.) **Third Quarter:** The facility Director will be responsible for performing a self reassessment using the Artifact tool and the score will be posted on the DUSHOM report via the VISN Office.

It is suggested that the facility cultural transformation interdisciplinary team along with the facility's leadership complete the self assessment together and reach a consensus. The percent change from first quarter to third quarter will be calculated to measure progress in implementing cultural transformation at the facility.

DATA SOURCE: Self Assessments using Artifact Tool performed by applicable facilities.

TARGET: The % change in scores in self assessment from first quarter to third quarter will increase.

Fully successful = 5% increase from first quarter to third quarter in at least 2 categories or overall self assessment scores.

Exceptional = 10% increase from first quarter to third quarter in at least 2 categories or overall self assessment scores.

REPORTING: VISNs will submit the Assessment Reports for each of their applicable facilities directly to the DUSHOM report using the following template. There will be no data submitted for second and fourth quarter. The Office of Geriatrics and Extended Care will calculate the percent change from first quarter to third quarter.

Template for Submitting Self Assessment Scores

Artifacts Sections	Potential Points	1 st QTR	3 rd QTR	% change
Care Practices	45			
Environment	180			
Family and Community	30			
Leadership	25			
Workplace practice	55			
Outcomes	20			
Artifacts of Culture Change- Grand Total	355			

CONTACT: Christa Hojlo, PhD, Director, VA Community Living Centers and Director, State Veterans Home Clinical and Survey Oversight at 202-461-6779



Document: Artifacts of Cultural Transformation

4. Fluoride Treatment for Patients at High Risk for Dental Caries (NEW)

The majority of VA Dental patients are more medically and dentally compromised than the general population. One of the most common chronic infections is dental caries; incorporating a medical model of dental care we can initiate preventive strategies to help reduce this chronic infection. Using a systematic review of the literature, the VA Oral Health Quality Group concluded that appropriate application of various types of fluoride in high caries risk populations could reduce the number of new carious lesions.

Initial data have identified wide variability in the use of fluoride among VISNs and stations. In FY07, only about 45% of all veterans receiving comprehensive VA dental care would have met the target for this monitor.

With this knowledge, the Office of Dentistry proposed a multifaceted approach to increase the use of this preventive strategy:

1. Formulation of an information letter (IL) regarding the findings from the systematic literature review of fluoride use in the medical management of dental caries along with recommendations based on this review.
2. Application for the addition of the recommended fluoride products to the national formulary, based upon the scientific recommendations, allowing VA dentists wide accessibility to these products.
3. Office of Dentistry Education Group will utilize Web Based Training to educate dental providers and teams on the IL findings and its recommendations.
4. Establish the Fluoride Treatment for Patients at High Risk for Dental Caries monitor to assess improvement in the addition of this preventive strategy in patient care.

GOAL: The goal of this monitor is to increase the use of fluoride products for veterans at high risk for dental caries. To accomplish this, veterans eligible for comprehensive and repeat dental care (i.e. classifications I, IIC and IV) and identified as having a high risk for future caries will be provided either a professional application of or pharmacy prescription for fluoride.

This monitor will track the provision of one aspect of preventive dental care within the VA as we move toward a more medically based dental caries strategy.

ACTION: Dental professionals will identify patients who are at high risk for future dental caries, as evidenced by at least two dental carious lesions within a 12 month time period. They will then be responsible for determining and administering the appropriate mode(s) of fluoride. Professionally applied fluoride can be administered as an adjunct during most dental appointments. Often this is performed during either the dental examination or dental hygiene appointments. Based upon the patient's needs, the dentist may also prescribe a fluoride to be used at home. To successfully meet the requirement of the monitor, either or both of these strategies must be performed within 12 months prior to the first dental restoration to 6 months after the second restoration.

DEFINITIONS:

Comprehensive Care Veteran Dental Patients: Veteran patients treated in VA facilities eligible for continuing and comprehensive care in dental classifications I, IIC or IV.

High Caries Risk: Those veterans who received at least two restorative procedures within a 12 month time period (see Table 1).

Dental restoration or restorative procedures: Provision of restorative procedures as noted by the capture in Dental Record Manager (DRM) as any of the restorative procedure codes listed in Table 1 to include amalgam, composite, gold foil, inlay, onlay or permanent crowns and excluding veneers and temporary crowns.

Professional fluoride intervention: Application of a professional strength fluoride or fabrication of a fluoride gel carrier by a dental professional as noted by the capture in DRM of procedure codes listed in Table 2 **OR** dispensing of a prescription fluoride to the patient through a pharmacy prescription as noted in Decision Support Services Pharmacy Database.

Monitored Period: The monitored period is the 12 month interval ending six months prior to the reporting date. For example, the monitored period for the quarter ending September 30, 2008 is April 1, 2007 to March 31, 2008. If a Veteran received two dental restorations during that time period and also had

professional fluoride within the above timeframes relative to their restorative care, the monitor was met. As a rolling monitor, the monitored period will advance three months every fiscal quarter reporting period.

DATA SOURCE: This data is accessible through the Dental Encounter System and the Decision Support Services Pharmacy data.

REPORTING: The Office of Dentistry will consolidate the information quarterly and provide the necessary data transfer through the agreed methodology to the VSSC for inclusion in the comprehensive quarterly monitor reporting provided by the VSSC. FCDM sites will also be able to view facility specific information as part of the consolidated Dental Performance Scorecard on the Dental Reporting and Analytics System (DRAS) intranet site.

TARGET:

Fully Successful: A minimum of 60% of all veterans at each facility eligible for comprehensive dental care who are at high risk for dental caries will receive either a professional application of or pharmacy prescription for fluoride.

Exceptional: A minimum of 75% of all veterans at each facility eligible for comprehensive dental care who are at high risk for dental caries will receive either a professional application of or pharmacy prescription for fluoride.

- *Numerator:* All comprehensive care veteran dental patients that are classified high caries risk within the monitored period **AND** have been provided a professional fluoride intervention within 12 months prior to their first restoration and 6 months following their second restoration.

- *Denominator:* All comprehensive care veteran dental patients that are classified high caries risk within the monitored period.

CONTACT: Gretchen Gibson, DDS, MPH, Dental Field Coordinator for Oral Health Quality Group, Office of Dentistry @ 479-444-5042 or gretchen.gibson@va.gov

TABLE 1 DRM Codes Used to Identify Restorative Intervention

Restorative Category	Eligible Codes
Amalgam	D2140, D2150, D2160, D2161
Composite (anterior and posterior)	D2330, D2331, D2332, D2335, D2391, D2392, D2393, D2394
Gold foil	D2410, D2420, D2430
Inlay/Onlay (metallic, porcelain/ceramic, resin)	D2510, D2520, D2530, D2542, D2543, D2544, D2610, D2620, D2630, D2642, D2643, D2644, D2650, D2651, D2652, D2662, D2663, D2664,
Permanent Crown (resin, porcelain/ceramic, porcelain fused to metal, cast metal)	D2390, D2710, D2712, D2720, D2721, D2722, D2740, D2750, D2751, D2752, D2780, D2781, D2782, D2783, D2790, D2791, D2792, D2794

TABLE 2 DRM Codes Used to Identify Professional Fluoride Intervention

Fluoride Treatment	Eligible Codes
Topical application of fluoride (in office)	D1201, D1203, D1204, D1205
Topical application of fluoride varnish: therapeutic application for moderate to high caries risk patients	D1206
Fluoride gel carrier	D5986

5. Colorectal Cancer Treatment and Surveillance (NEW)

DEFINITION: This monitor is designed to track improvement in reliability (guideline concordance), and timeliness in the treatment and surveillance process of colorectal cancer (CRC). In this first year, medical centers will be required to submit data in two main categories:

- By the **end of 2nd quarter FY2009**, each Medical Center will submit electronically a process flow chart which will describe their facility's current CRC treatment process.
- **During the 3rd and 4th quarters FY2009**, each Medical Center will submit information on plans (3rd quarter) and accomplishments to date (4th quarter) for at least one targeted improvement area in the CRC treatment process.

RATIONALE: For several years, medical centers have been working to improvement timeliness of CRC **diagnosis**. However, preliminary work, documented in studies both inside and external to the VHA, indicates that there are also opportunities to improve the **treatment and surveillance** process in CRC. A CRC Treatment Improvement Collaborative funded by the Office of Quality and Performance during FY 07 – 08 identified opportunities and strategies for improvement. This is an early step in development of a national cancer care improvement strategy that addresses treatment and survivorship as well as diagnosis.

ACTIONS:

- By the **end of 2nd quarter FY2009**, each Medical Center will identify colorectal cancer process team members, set an aim to improve colorectal cancer timelines and reliability and complete a flow chart of its current process of colorectal cancer treatment (following initial diagnosis). *Resources for completing this flowchart, including a short interview for patients and front line staff to gather their perspectives about the process, are available under **Improvement Resources** below.* The flowchart will be submitted electronically to the **VISN Systems Redesign Point of Contact**, who will provide feedback and will also upload to the Systems Redesign Website.
- By the **end of the 3rd quarter FY2009**, each medical center will decide upon at least one step in the process of CRC treatment and/or surveillance to be targeted for improvement. Each center will describe one or more measures to be used to track improvement. *Measures potentially useful for initial assessment and ongoing tracking of steps in the CRC diagnosis and surveillances process are available under **Improvement Resources** below.* Examples of potential targets include pre-operative CEA and CT scans, resection of 12 or more lymph nodes and documentation of clear margins in curative-intent surgery, and surveillance colonoscopy within 12 months of curative-intent surgery. The required information will be submitted electronically in a standardized format to the **VISN Systems Redesign Point of Contact**, who will provide feedback and will also upload to the Systems Redesign Website.
- By the **end of the 4th quarter FY2009**, each medical center will report on its progress in making further improvements using a structured format to be provided in Q3 FY2009. The information will be entered into a VSSC template.

DATA SOURCE: Data will be collected by each facility. Data from fiscal years 2006 – present may be used. Data may be collected prospectively or retrospectively through chart review and/or locally-developed electronic tools. A Colorectal Cancer Improvement Registry (see **Improvement Resources** below) has been developed for optional use in this project.

TARGETS:

- Fully Satisfactory:** Submission of the required information in the required timeframe.
Exceptional: n/a.

REPORTING: National Director of Systems Redesign will report VISN Results to the DUSHOM for the 2, 3, and 4 Quarters.

Improvement Resources

- **Flow chart instructions and patient/staff interview forms.**
 - [Flow Charting Basics](#) and [Simplified Treatment Flow Chart](#) (with change concepts)
 - [Patient Interview questions](#) and [Staff Interview questions](#)
- **Measurement:**
 - **Suggested measures:** [Improvement Indicators](#)
 - **Data collection/tracking:** A Colorectal Cancer Improvement Registry has been developed to quickly track key dates and data points necessary for generating several quality indicators and can also be used by clinicians for tracking surveillance. This is an access database, and a blank template can be accessed through the Treatment and Surveillance document library of the [Colorectal Cancer](#) page on the Systems Redesign Website under the subject heading *Data Tool V2* and includes [Data Tool V2 Instructions](#) for use. This improvement registry is for local use and does not automatically transmit data outside the facility. Additional tools developed by facilities will be shared as they are identified.
- **Aims, team membership:** [Leadership in Systems Redesign](#)
- **Improvement resources** have been developed by the National CRC Treatment Improvement Project and are available through the Treatment and Surveillance document library of the [Colorectal Cancer](#) page on the Systems Redesign Website.
- Resources include:
 - A [High Impact Changes Presentation](#) that highlights the advances made by the CRC collaborative and includes links to valuable resources. Included in this document are examples of clinical reminders, templates, and quick orders that can improve accuracy of surgical work-up, reporting and surveillance.
 - Stories of successful projects and information for contacting successful teams.
 - NCCN [Colon](#) and [Rectal](#) Cancer Guide.
 - Links to other useful sites such as [ASCO C3 Colorectal Cancer Coalition website](#), [Lance Armstrong Cancer Information website](#) and the [Cancer Information Service](#).

CONTACT: Mike Davies, MD, National Director of Systems Redesign, 605-720-7174

6. Methicillin-resistant Staphylococcus Aureus (MRSA) Screening, Acute Care

Staphylococcal infections, including MRSA, occur most frequently among the elderly, persons with weakened immune systems and those in frequent contact with the healthcare system. An estimated one-third of patients acquiring MRSA will develop an infection. The consequences of MRSA are increased morbidity/mortality, increased length of stay, and increased hospital costs. MRSA identification is necessary for appropriate management and improved outcomes for patients with MRSA and to prevent the spread of MRSA to other patients.

GOAL: Identify MRSA in patients as a critical step to break the chain of transmission.

ACTION: All patients admitted to an acute inpatient unit must be swabbed for MRSA upon admission to the facility, regardless of prior MRSA history. Nasal screening must be performed within 24 hours of admission to the facility. Subsequent unit (based on unit-to-unit) admissions/transfers also require a nasal screen with the following parameters: no more than 24 hrs prior to arrival on the unit or no more than 24 hrs after arrival to the unit in order to be considered in compliance. Discharge nasal screens will be completed on exit from the unit, where or when indicated as per the MRSA Data Reporting User Manual. Please note that the goal is to obtain a nasal screening as soon as the patient is admitted to the unit to decrease chances for transmission. As a way to improve compliance, staff should be encouraged to obtain nasal screens immediately upon admission.

Patients may be admitted to the facility or a unit multiple times during the reporting month. Every admission and exit should be counted separately.

DATA SOURCE: Reports will be generated from VHA MRSA Databases housed within the Inpatient Evaluation Center (IPEC) reporting structure. These databases contain self-reported, facility-specific information regarding the MRSA Prevention Initiative from VA medical centers nationwide.

DATA ORIGIN/EXTRACTION: Data will be extracted quarterly from the IPEC MRSA Data Management System by the VHA MRSA Program Office and submitted to the Office of the DUSHOM to be posted on the Web Profile.

This is not a sample. All nasal screening opportunities at admission, transfer and exit for the facility's acute care units for the calendar month will be included.

DEFINITIONS:

Indicator Statement:

Percent of indicated nasal screens for MRSA performed timely

- *Numerator Statements: Total number of indicated nasal screens for MRSA performed timely*
- *Denominator Statement: Total number of indicated nasal screens for MRSA*

Timely Swab: Nasal screening must be completed within 24 hours upon admission or transfer in to the unit (24 hours reflects prior to or after arrival on the unit) AND on exit from the unit.

TIME FRAMES:

- Reporting is based upon data entry into the IPEC Data Management website for MRSA Reporting.
- Data is submitted to the website by the **15th of each month** for two months prior. There is a 45 day lag for data entry based on the need to obtain all data for reporting purposes.
- **Quarterly** reports will be generated by the MRSA Program Office from the IPEC MRSA Databases and provided to the DUSHOM in accordance with DUSHOM reporting requirements.
- Baseline will consist of July and August 08 data.
- **Quarterly** data will be consistent with DUSHOM reporting quarters.
- FY 09 score will be a cumulative Swabbing Rate obtained from the period of care October 1, 2008 thru June 30, 2009 (due to reporting lag and requirement to have FY 09 data submitted NLT Sept 1, 2009).

CALCULATION AND SCORING:

Facility Wide Admission Swabbing Rate

Calculated automatically within the IPEC Data Management site using data submitted from facilities into the MRSA Facility Wide Reporting Portal (line 5 of Facility Wide reporting format).

Unit-Specific Admission Swabbing Rate

Calculated automatically within the IPEC Data Management site using data submitted from facilities into the MRSA Unit-Specific Reporting Portal (line 6 of Unit-Specific reporting format)

Unit-Specific Discharge Swabbing Rate

Calculated automatically within the IPEC Data Management site using data submitted from facilities into the MRSA Unit-Specific Reporting Portal (line 15 of Unit-Specific reporting format)

The numerators and denominators will be aggregated at the Facility and the VISN level and scored at the facility and the VISN level by IPEC

TARGETS:

- The target will be set at **90%** swabbing effectiveness on admission/transfer in and discharge/transfer out. The rate will be calculated using data extracted from the MRSA Data portion of the Inpatient Evaluation Center (IPEC) Data Management website for admission to the facility (see attached data entry screen).

- o To pass, **the VISN** must achieve a swabbing compliance rate of 90% or higher on admission and exit, **and each facility** within the VISN must achieve a swabbing compliance rate of 85% or higher on admission and exit.

CONTACTS:

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Facility Wide MRSA Reporting Portal format (submitted to IPEC):

MRSA PREVALENCE MEASURES (FACILITY WIDE)	
	(1) Number of admissions to the facility for the month.
	(2) Number of (1) who received MRSA nasal screening upon admission to facility.
	(3) Number of (1) positive for MRSA based on nasal screening upon admission to facility. *
	(4) Number of (1) positive for MRSA based on clinical cultures upon admission to facility.
	(5) % Effectiveness of MRSA nasal screening upon admission to facility (Admission Swabbing Rate).
	(6) % Prevalence rate of MRSA based on nasal screening upon admission to facility.
	(7) % Prevalence rate of MRSA based on clinical cultures upon admission to facility.
	(8) % Total prevalence rate of MRSA upon admission to facility.

Unit-Specific MRSA Reporting Portal format (submitted to IPEC):

MRSA PREVALENCE MEASURES (UNIT SPECIFIC)	
	(1) Number of admissions (admissions + transfers in) to the unit for the month.
	(2) Number of (1) for whom nasal screening was indicated.
	(3) Number of (2) who received MRSA nasal screening upon admission to unit (within 24 hours).
	(4) Number of (1) positive for MRSA based on nasal screening upon admission to unit. *
	(5) Number of (1) positive for MRSA based on clinical cultures upon admission to unit.
	(6) % Effectiveness of MRSA nasal screening upon admission to unit (Admission Swabbing Rate).
	(7) % Prevalence rate of MRSA based on nasal screening upon admission to unit.
	(8) % Prevalence rate of MRSA based on clinical cultures upon admission to unit.
	(9) % Total prevalence rate of MRSA upon admission to unit.
MRSA TRANSMISSION MEASURES (UNIT SPECIFIC)	
	(10) Number of bed days of care for the unit for the month.
	(11) Number of exits (discharges + deaths + transfer out) from the unit.
	(12) Number of (11) for whom a discharge/transfer swab was indicated.
	(13) Number of (12) who received MRSA nasal screening upon exit from unit.
	(14) Number of MRSA transmissions on unit based on MRSA nasal screenings or clinical cultures.
	(15) % Effectiveness of MRSA nasal screening upon exit from unit (Discharge Swabbing Rate).
	(16) Rate of MRSA transmissions on unit per 1,000 bed days of care.

ADDITIONAL ITEMS:

For additional information please refer to the MRSA Data Reporting User Manual: (<http://vaww.teamshare.va.gov/getting2zero/default.aspx>).

REFERENCE/RESOURCES:

- VHA Directive 2007-002 MRSA Initiative: http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1525
- VHA MRSA Program Office: http://vaww.va.gov/pittsburgh/mrsa/mrsa_home.htm
- Centers for Disease Control: http://www.cdc.gov/ncidod/dhqp/ar_mrsa.html
- Institute for Health Improvement (IHI): <http://www.ihl.org/IHI/Programs/InnovationCommunities/IMPACTICReducingHospital-AcquiredInfections.htm>

7. Supply Processing and Distribution (SPD) Self Evaluation

Supply, Processing, and Distribution (SPD) is a section of the medical center that is dedicated to the receiving, storage, and distribution of medical supplies and the decontamination and sterilization of reusable medical supplies and equipment.

Operations vary greatly from facility to facility; however, program emphasis should be directed toward a total SPD support concept, enabling medical practitioners to administer the highest standard of healthcare with the resources available.

SPD optimizes its support of the medical facility by providing integrated material management and ensuring a continuous flow of processed sterile and non-sterile supplies, instruments, and equipment to all points of use. Similarly, return of reusable soiled items to SPD is handled in a manner conducive to economical and efficient processing for future use.

The objectives of SPD will be to provide centralized total supply support of the medical center's patient care programs, while assuring appropriate aseptic conditions, economy of operation, and consistency in processing, storing, and distribution, all under strictly controlled conditions. The major goal of SPD is to allow the professional medical staff every opportunity to concentrate on direct patient care.

GOAL: Promote quality and consistency in SPD operations

ACTION: Every SPD must complete the SPD Self Evaluation in accordance with the guidance contained in the Self Evaluation Guide. This guide is to be used to evaluate the overall performance of the Supply, Processing, and Distribution (SPD) section. The Evaluation is to be completed by someone outside of the SPD section. The guide is divided into five sections, including some of which may not apply to every SPD area. If a section does not apply, a full explanation as to why the support is not being provided and who is performing the function should be given for that section of the guide to be completed. The findings of this evaluation should be shared with the infection control official and other appropriate officials at the medical center.



Embedded Document – SPD Inspection Guide



SPD Certification
Sept 08.doc ...

Embedded Document – VISN Director Certification

DEFINITIONS:

Monitor Statements: Timely completion of Supply Processing and Distribution (SPD) Self Evaluation

- *Numerator Statements:* SPD Self Evaluation completed every six months
- *Denominator Statement:* NA

Timely Evaluation: An evaluation must be completed within the first 6 months of the start of the fiscal year (October – March) and within the next five months (April – August), resulting in no less than two evaluations in any given fiscal year with each evaluation 6 months apart from the other, (additional evaluations may be performed if the facility wishes).

DATA SOURCE and REPORTING: Certification of completion of the SPD Self Evaluation will be submitted by each facility to their respective VISN Office. Each VISN Director will attest that SPD evaluations have been completed at each of their facilities and will submit the signed certification through 10N to Patient Care Services (PCS) by **March 30th and August 30th, 2009** via the 10NC Share Point Link: https://vaww.portal.vhaco.va.gov/sites/dushom/10NC/FY09_Monitor_SPD_Self_Evaluation/Forms/AllItems.aspx.

PCS Office of Infectious Disease will review and aggregate and submit a report the results to 10N and OQP on **April 10 and September 10, 2009**. The SPD Self Evaluation must be completed in accordance with the requirements/guidance contained in the SPD Self Evaluation Guide. PCS will establish a reporting process (in collaboration with 10N) to receive the certifications from the facilities and VISN Offices. The Self Evaluation Guide and Template has been used in the field since 1996.

TIMEFRAME: Each facility will submit certification of two completed evaluations (six months apart) to their respective VISN Office with the VISN Office submitting a consolidated report of certification for all of its facilities through 10N to Patient Care Services. (The template for VISN Director Certification is provided.) Two evaluations must be completed between October 1, 2008 and August 30, 2009 (six months apart) and certification reported as described above.

TARGETS: Two certifications of the completion of the evaluations in a timely manner (as noted above), from each facility, obtained and submitted by each VISN Office in a consolidated report for all of its facilities through 10N to the Patient Care Services Office via 10NC Share Point Link above.

CONTACTS:

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ADDITIONAL ITEMS:

- Handbook 7176, Supply, Processing, and Distribution (SPD) Operating Requirements
Supply Processing and Distribution Self Evaluation Guide
<http://www1.va.gov/vasafety/docs/SPDHandbook7176.pdf>
- 10NC Share Point Site for Reporting SPD Certifications:
https://vaww.portal.vhaco.va.gov/sites/dushom/10NC/FY09_Monitor_SPD_Self_Evaluation/Forms/AllItems.aspx.

8. Community Living Centers - Bedfast Residents **(NEW)**

A decline in physical activity may come with age due to muscle loss, joint stiffness, fear of injury, worsening illness, or depression. Prevalence of community living center residents who are bedfast is estimated to be approximately 5%. Being bedfast can result in decreased social and physical activities, pressure ulcers/skin breakdown, and decreased muscle tone with increased contractures, increased depression, cardiovascular and respiratory problems, metabolic issues, and gastrointestinal problems. Care of the bedfast resident focuses on preventing problems. Community Living Center (CLC) staff should encourage residents to take part in physical activities and stay as active as possible. Even when residents develop limited mobility due to their medical conditions, residents can benefit from being moved out of their bed and room.

GOAL: The goal of the monitor is to promote physical activity and socialization among Community Living Center residents who spent most of their time in bed or in a chair in their room during the 7-day assessment period.

ACTIONS: Each CLC will strive to decrease the number of residents who meet the definition of bedfast through actions to decrease the amount of time residents are confined to their beds and/or rooms (social isolation).

DATA SOURCE: CLC Quality Measure/Quality Indicator data is provided by Corporate Data Center Operations - Austin (CDCO-Austin) who aggregates and calculates the information from Resident Assessment Instrument/ Minimum Data Set (RAI/MDS) assessments electronically submitted from all VHA Community Living Centers. Dataset owner is GEC.

DEFINITIONS:

Monitor: Percent of residents who spent 22 hours or more per day in bed or in a recliner in own room for at least 4 of the 7 days during the assessment period.

- *Numerator:* Percent of residents who are bedfast (*G6a is checked*) on target (eligible) assessment
- *Denominator:* All residents with a valid eligible assessment

Exclusions:

- The eligible assessment is an admission assessment
- Bedfast status is unknown on the eligible assessment
- Resident is comatose or status is unknown on the eligible assessment

MDS Assessments Used: Most recent Omnibus Budget Reconciliation Act (OBRA) eligible assessment with an assessment reference date (A3a) within the calculated report period. Eligible assessments may include OBRA Full (AA8a = 02, 03, or 04) or Quarterly Assessments (AA8a = 05 or 10).

TARGET:

Exceptional = less than 6% Bedfast for the VISN AND every CLC in VISN must be less than or equal to 8%

Fully successful = between 6-8% Bedfast for the VISN AND every CLC in VISN must be less than or equal to 10%

REPORTING: The Office of Geriatrics and Extended Care will submit reports to DUSHOM quarterly.

ATTACHMENT: FY 2008 Data

Facility nhc4	Q1 Num	Q1 Denom	Q1 PCT	Q2 Num	Q2 Denom	Q2 PCT	YTD Num	YTD Denom	YTD Pct
VISN 1	32	517	6	33	533	6	33	533	6
VISN 2	10	355	3	8	376	2	8	376	2
VISN 3	25	697	4	37	727	5	37	727	5
VISN 4	44	780	6	62	818	8	62	818	8
VISN 5	13	458	3	16	478	3	16	478	3
VISN 6	63	577	11	73	598	12	73	598	12
VISN 7	60	607	10	63	640	10	63	640	10
VISN 8	41	644	6	45	667	7	45	667	7
VISN 9	23	308	7	30	329	9	30	329	9
VISN 10	46	418	11	40	461	9	40	461	9
VISN 11	37	447	8	38	475	8	38	475	8
VISN 12	19	511	4	27	557	5	27	557	5
VISN 15	11	212	5	12	231	5	12	231	5
VISN 16	43	481	9	50	495	10	50	495	10
VISN 17	36	399	9	37	432	9	37	432	9
VISN 18	17	273	6	19	280	7	19	280	7
VISN 19	11	203	5	14	214	7	14	214	7
VISN 20	15	185	8	14	207	7	14	207	7
VISN 21	21	527	4	24	548	4	24	548	4
VISN 22	16	261	6	22	292	8	22	292	8
VISN 23	18	424	4	11	465	2	11	465	2
National	601	9284	6	675	9823	7	675	9823	7

REFERENCES:

- o Resident Assessment Instrument (RAI) Minimum Data Set (MDS) Directive
http://www1.va.gov/vhapublications/ViewPublication.asp?pub_ID=1648
- o [RAI-MDS 2.0 homepage](#) - This is the version currently used by CMS and the VA.

CONTACT: Christa Hojlo, PhD, Director VA Community Living Centers and Director State Veterans Home Clinical and Survey Oversight at 202-461-6779 or christa.hojlo@va.gov

DOMAIN: ACCESS

a. Comprehensive Oral Evaluation for Eligible Veterans

This monitor is designed to improve surveillance for oral disease and malignancies in veterans. Potential Benefits include:

- Early detection and treatment of oral disease and malignancies thereby reducing morbidity and mortality.

- Fosters a culture of wellness and disease prevention within the population of veterans eligible for oral health care.
- A more preventive or medicine based rather than surgical approach to dental treatment resulting in increased cost effectiveness.
- Support Veterans' efforts to maintain a natural dentition longer

Initial data have identified wide variability among VISNs in the percentage of eligible patients that are provided with a comprehensive evaluation at least once every two years. This indicator is expected to narrow the variability gap and increase the number of veterans who receive this type of evaluation.

Historically, VA has provided dental care to approximately 10% of all veterans seeking medical care. This has declined in the past decade to approximately 7% as the capacity to provide dental care has diminished. It is anticipated that a greater percentage of veterans will receive care as the focus is shifted to preventive treatment.

GOAL: Eligible Veterans will have a comprehensive oral evaluation at least once in any 24 month period.

ACTIONS: Clinic locations must assure that patients being seen for a comprehensive exam are tracked and scheduled for return appointments no further in the future than 24 months following the most recent exam. Clinics will need to identify patients who were already seen prior to the implementation of this monitor and who are approaching their 24 month return date, and contact/schedule these patients for the return visit prior to the arrival of their 24 month deadline.

DEFINITIONS:

Eligible Veteran: An eligible veteran has been rated as Dental Class I, IIC or IV. These veterans are eligible for ongoing, repeat and comprehensive dental care.

Indicator Inclusion Criteria: Eligible Veterans must have sought care through VA and had a comprehensive oral evaluation within the preceding 36 months to be included in either the denominator, or numerator of this indicator as documented in the Dental Record Manager (DRM) module of the Computerized Patient Record System (CPRS) or the VistA Fee application for non-VA care.

Comprehensive Evaluation: This is defined as an oral evaluation that includes a comprehensive soft and hard tissue assessment. It is identified during data collection by capturing a completed dental procedure code (D0120, D0150 or D0180) in the dental database.

- *Numerator:* Eligible Veterans who have had an initial comprehensive oral evaluation and then a subsequent comprehensive oral evaluation within the subsequent 24 month period
- *Denominator:* All eligible Veterans who had an initial comprehensive oral evaluation during the twelve month period ending twenty-four months prior to the quarter being reported.

DATA SOURCE: Data is accessible through the Dental Encounter System and will be generated quarterly by the Office of Dentistry.

TARGET: A minimum of 75% of eligible Veterans will have a comprehensive oral evaluation at least once in any 24 month period.

REPORTING: Findings will be calculated quarterly and will be reported as part of the quarterly VSSC monitor dashboard report to leadership. Facilities are not expected to self report as this monitor requires evaluation of national data. Included in the report will be **numerators, denominators and percentages** for both FCDM parent stations and VISNs.

Formula for calculation of compliance: Eligible veterans who received a follow-up comprehensive assessment within 24 months of their previous comprehensive evaluation divided by all eligible veterans who received a comprehensive evaluation during the twelve month period ending twenty-four

months prior to the quarter being reported. *(The denominator for the quarterly report for October 2008 would include all eligible veterans from the time period 10/1/2005 through 9/30/2006 receiving a comprehensive oral-evaluation. The numerator will contain those veterans in the denominator who received a subsequent evaluation within twenty-four months following the initial examination.)*

CONTACT: Timothy Ward, MA, DDS, Assistant Under Secretary for Health for Dentistry Office of Dentistry @ 202-461-6954 or timothy.ward@va.gov

2. Care for the Medically Compelling Dental Patient *(NEW)*

In the past eight years, veterans' dental care to the medically compelling dental patient, where poor health is negatively impacting a systemic illness, has been reduced by half. These patients include poorly controlled diabetic patients, head and neck cancer patients, organ transplant patients and others. In 2000, approximately 21% of all unique patients receiving dental care by the VA Healthcare System were medically compelling patients in classification categories III and VI. By 2008 this figure has been reduced to 12%, largely a result of the significant increases in dental care provided to the growing populations of OEF/OIF veterans and those with 100% service connection.

This monitor would require that a minimum of 10% of patients receiving dental care at each facility are Dental Classification III and VI patients. A 10% floor, while still less than previous years, would give dental administrators the guidance and incentive needed to focus their efforts on caring for the most medically necessary and needy veterans. Approximately 70 facilities would need to increase the number of patients in these classifications by a total of 8,490 unique patients, to achieve a national 10% minimum. The remaining facilities are currently meeting or exceeding the 10% target.

ACTIONS: The clinics will need to assess their current percentage of Classification III and VI patients. The clinics will need to concentrate on facilitating consultation processes with their medical center providers to assure identification of patients with medical conditions that are being complicated and or aggravated by dental conditions. It will be necessary for clinic locations to manage scheduling to assure that appointment slots are available for patients with Classification III and or VI needs and that these patients are attentively considered when scheduling appointments and or contracting for care.

DATA SOURCE: This data is currently accessible through the Dental Encounter System and existing Non-VA Care/Vista Fee data transfers from the VSSC to the Dental Reporting and Analytics System (DRAS).

REPORTING: The Office of Dentistry will consolidate the information quarterly and provide the necessary data transfer through the agreed upon methodology to the VSSC. FCDM sites will also be able to view facility specific information as part of the consolidated Dental Performance Scorecard on the DRAS Reporting Services intranet site.

TARGET: 10% of all patients receiving dental care (unique patient count) will be Classification III and or VI veterans.

DEFINITIONS:

Monitor Goal Statement: Veterans with medically compelling dental conditions will constitute no less than 10% of the unique dental patients seen each year.

- *Numerator:* Total number of unique Dental Classification III or VI patients receiving dental care during the previous 12 months.
- *Denominator:* Total number of all unique patients receiving dental care during the previous 12 months.

Inclusion Criteria:

- The numerator will consist of all veterans (uniques) seen at a given facility who receive contract (fee) or VHA dental care as either a Classification III or Classification VI patient during the preceding four (4) quarters (same quarters as the denominator).
- The denominator will consist of all veterans (uniques) receiving contract (fee) or VHA dental care within the preceding four (4) quarters (same quarters as the numerator).

Terminology:

- Dental Classification III: The dental care classification comprising those patients eligible for dental care to satisfactorily resolve the problem which is aggravating the service connected condition. Eligibility is determined for each episode of dental care and must be predicated on medical referral and application, followed by dental evaluation.
- Dental Classification VI: The dental care classification comprising those patients scheduled for admission or who are receiving outpatient care under 38 U.S.C. who have been clinically determined to have a dental condition that is complicating a non-service connected medical condition for which they are currently being treated. Eligibility is determined for each episode of dental care and must be predicated on referral and application, followed by evaluation. This category includes homeless veterans.

Methodology/Formula for Calculation of Compliance:

Data is collected weekly by the Office of Dentistry through the Dental Encounter System and VSSC data transfers of Non-VA Care dental activity. The calculation will consist of:

Number of Classification III and or VI dental uniques treated in 12 month period (same rolling 12 month period as denominator)

All dental uniques treated within the 12 month period (same rolling 12 month period as numerator)

CONTACT: Timothy Ward, MA, DDS Assistant Under Secretary for Health for Dentistry Office of Dentistry, 810 Vermont Avenue (112D), Washington, DC 20420, 202-461-6954 timothy.ward@va.gov

3. Waiting Times - Outpatient Imaging Procedures:

This monitor measures waiting times for six outpatient radiology procedure types by computing the time in days between the date the patient was registered in the VistA Radiology Software (date/time entered at the "Imaging Exam Date/Time:" prompt) backwards to the Date Desired for the ordered procedure ("Request Date:" prompt). Data collection will occur at the end of each quarter of FY 2009. The six outpatient radiology procedure types are as follows:

- Computed Tomography
- Diagnostic Mammography
- Ultrasound
- Nuclear Medicine
- Magnetic Resonance Imaging
- The imaging portion of Nuclear Stress Tests

In addition two radiology procedure types will be reported but not used for performance monitoring:

- General Radiology and Interventional Procedures

CONSIDERATIONS: Ordering physicians need to be educated that the “Date Desired” should not be entered as Today if the study is intended to be done in the future. Failure to enter this date correctly will distort the wait times.

Business processes that circumvent the process of the ordering provider entering the radiology order with the Request Date. For example, clinicians enter a consult in lieu of a radiology order and then radiology service enters the order on the day the patient is registered. In this case all waiting times will appear as zero because the procedure is always performed on the day the order is entered. *Outpatient Imaging:* Fee and outside contract procedures will not be included

DATA SOURCE: Sites will run the VistA Outpatient Procedure Wait Time Report and report the percentage performed within 30 days for each of the eight radiology procedure types. VSSC website: <http://klfmenu.med.va.gov>

- *Numerator:* Number of outpatient radiology procedures performed in the quarter, of each radiology procedure type, where the waiting time is less than or equal to 30 days:
- *Denominator:* Total number of outpatient radiology procedures performed in the quarter, of each radiology procedure type.
- *Exclusions:* Cancelled, “No Credit”, inpatient cases, fee or outside contract procedures that are entered in non-counting locations.

TARGET:

Successful = 90% of procedures performed no more than 30 days after desired date

Exceptional = 95% of procedures performed no more than 30 days after desired date

REPORTING: Data is submitted quarterly (**beginning 2nd Q**) by each site to the VISN office and input by the VISN for each site using the DUSHOM Web Profile.

CONTACT: Charles Anderson, MD, Director VHA Radiology Program @ 919 383-7874 x260 or Charles.Anderson2@va.gov

4. Examine the Impact of Hospital Flow on Emergency Department (ED) Operations

ED crowding is not a problem isolated to the ED, but rather is more often a symptom of inpatient flow problems. A number of issues can contribute to this, including but not limited to: lack of available hospital beds, long waits for necessary clinical data (i.e. lab, radiology), lack of timely access to key consultative services, as well as to understaffing and process or physical inadequacies in the ED itself.

It is vital that VHA maintain its commitment to providing high quality patient care, including delivery of emergent and urgent care when and where needed. To do so necessitates a better understanding of ED operations, but also must consider hospital flow and all the downstream processes that impact ED operations. These three measures are designed to reflect issues that impact the delivery of emergency care in VHA.

GOALS:

- a. Stays in ED exceeding 6 hours.

The metric is the proportion of *patients remaining in the ED beyond 6 hours* during the quarter, excluding patients assigned to a Clinical Decision Protocol. Time in the ED begins at the first contact with ED staff, (i.e. reception clerk, triage nurse,) to the time the patient physically leaves the ED either to home, transfer to another facility, or admission to a hospital unit. ED stays exceeding six hours are considered excessive.

The total time a patient spends in the ED is felt to be the best assessment of the sum of ED throughput and a reflection of overall system performance. Delays frequently occur for reasons such as the time it takes to triage and then perform the initial evaluation to obtain clinical data needed for key decision making (i.e. lab, x-ray), availability of appropriate consultation, or the logistics of moving the patient out of the ED. Of particular concern is the holding of patients in the ED after a decision to admit has been made, especially when this involves admission to an ICU bed.

TARGET:

Exceptional = less than 5% of all ED stays exceed 6 hours in length

Fully Satisfactory = less than 10% of all ED stays exceed 6 hours in length

b.) Time on Diversion: The metrics for this are:

- Total number of days during the quarter the ED is on diversion to ambulance arrivals or to inter-facility transfers during any part of the day and;
- Total number of hours during the quarter the ED is on diversion to ambulance arrivals or to inter-facility transfers

One consequence of the failure to effectively manage EDs or hospital operations, or of a sheer and unanticipated increase in volume (natural variability) is ED crowding. This can lead to unsafe conditions and in rare instances it may be necessary to close the facility to new arrivals via ambulance and to inter-facility transfers in order to avoid compromising patient safety. It is good practice to document reasons for diversion (i.e. ED overcrowding, no ICU beds, no floor beds, etc.).

TARGET:

Exceptional = less than 50 hours/quarter and less than 10 days with any diversion during the quarter

Fully Satisfactory = less than 200 hours/quarter and between 10 days and 14 days with any diversion during the quarter

c.) Emergency Department Missed Opportunities: The metric is the proportion of patients presenting in ED during the quarter that leave prematurely by:

- Leaving without being seen or;
- Leaving against medical advice (AMA) or;
- Before their workup has been initiated/completed

Long waits and delays for emergency care lead to patient frustration and engender a loss of confidence in the system. Leaving prematurely has been associated with worse outcomes, a high frequency of ED revisits and patient dissatisfaction.

TARGET:

Exceptional = less than 3% of the patients left prematurely during the quarter

Fully Satisfactory = less than 10% of the patients left prematurely during the quarter

REPORTING: Data will be reported by VISNs on the DUSHOM Web Profile.

Note: Facilities that do not have an Emergency Department are exempt from reporting.

ACTIONS: At the **end of first, second, third and fourth quarter FY2009**, each Medical Center **with an ED** will submit the following information identified in the table below.

A Monitor: ED stays over 6 hours		Response	Comments
1	Total number of ED visits during this quarter. (Enter number of ED visits, not unique patients.)		
2	Total number of ED visits longer than 6 hours. Total number of ED visits where time from first patient contact with ED staff, (i.e. reception clerk, triage nurse), to time the patient physically leaves the ED, (either to home, transfer to another facility, or admission to a hospital unit), was greater than six hours. Exclude patients assigned to an ED-based Clinical Decision Protocol (see below). (Enter number of ED visits, not unique patients.)		
3	Calculate percent (%) of ED visits exceeding 6 hours (A2 / A1 x 100) (Enter the percent calculated.)		
B Monitor: Diversions During the Quarter		Response	Comments
1	The total number of days during the quarter the ED was on diversion for any part of the day should be reported. (Enter number of days.) Comment as needed to clarify.		
2	Total number of hours of ED diversion during the quarter. Diversion is defined as those periods when the ED is closed to EMS arrivals. (Enter number of hours.) Comment as needed to clarify		
C Monitor: ED Missed Opportunity rates During the Quarter		Response	Comments
1	Number of instances when a patient left the ED before being evaluated by a healthcare professional, (left without being seen, before workup initiated). (Enter number of instances.)		
2	Number of instances when a patient left the ED prematurely, either against medical advice or before having their workup completed . (Enter number of instances.)		
3	Calculate missed opportunity rate = Numerator Is (C1+C2) / A1		

Note: A **Clinical Decision Protocol** is a pre-defined unit based protocol implemented for specific clinical conditions in order to provide additional information as to whether a patient may be discharged or must be admitted. Often called "Observation Units", or "Clinical Decision Units" (CDUs), these processes are limited to a few select conditions where the clinical status is initially unclear, but where additional testing and/or treatment may abrogate the need for hospital admission if specific metrics are met. In general these are limited to stays from 8-24 hours, during which the decision to discharge or admit is made based on progress through a detailed clinical protocol. (Centers for Medicare and Medicaid Services {CMS} presently limits payment for "observation care" to Chest Pain, Asthma and Congestive Heart Failure.) This exclusion is limited to use of an **ED-based CDU**, where unit specific policies and procedures are in place, and where tracking data for each disease or symptom-specific protocol is aggregated.

CONTACT: Gary Tyndall, MD, Emergency Department Medical Director @ 315-425-4400 Ext. 54417 or Gary.tyndall@va.gov

5. Using Discharge Appointments to Balance Discharges Within the Day and Across the Day of Week

VHA's Flow Improvement Inpatient Initiative is designed to systematically analyze the barriers to the smooth flow of patients through the continuum of care. Its goal is to improve patient throughput and access to care while improving or controlling quality of care. This initiative is composed of health service

teams that will understand, analyze, implement and measure processes that will smooth any unnecessary delay in the patient journey.

DEFINITION: Discharge appointments are used to synchronize the work of the care team by:

- involving patient and family in decisions about the time of day for the discharge to occur
- enabling the health care team to self-organize around the agreed upon discharge appointment time
- reducing or eliminating “batching” of discharges during particular times of day, and during particular days of the week
- assisting with making beds available for admissions.

Typically, a nurse makes the “appointment” (in coordination with the care team) as a target time for the discharge to happen.

ACTIONS: Each facility will continue the use of Discharge Appointments for acute care and Community Living Center discharges to smooth discharges across different times of day and days of the week to minimize batching. (These are not outpatient clinic appointments but appointments for discharge from an in-patient unit.) No more than 20% of the average number of discharges per day should be scheduled for a particular discharge time/ hour of the day.

DATA SOURCE: Discharge Appointments data is tracked locally using standardized methodology (non-count clinic in Scheduling package for discharge appointments; Fileman extract and report).

TARGET:

Fully Successful: By the end of Quarter 4, FY09, 55% of aggregated discharges* from acute care** and Community Living Center (CLC) will have a discharge appointment. 65% of those discharges will leave within 1 hour of the discharge appointment time****.

Exceptional: By the end of Quarter 4, FY09, 65% of aggregated discharges* from acute care** and Community Living Center (CLC) will have a discharge appointment; 75% leave within 1 hour of discharge appointment time****.

* excludes discharges due to death or irregular discharges or emergent transfers to higher level of inpatient care in another VA or non-VA hospital

** acute care = acute medicine, surgery and psychiatry bed-sections

**** with-in 1 hour of the discharge appointment time means the timeframe from 1 hour before through 1 hour after the appointment time.

REPORTING: The Discharge Appointment data will be self reported via the template format included below, on the DUSHOM website at the end of the **2nd and 4th Quarter, FY09.**

By the end of 2nd and 4th quarter, each medical center will submit the following information

- a.) Total cumulative **number of Discharges** from acute and Community Living Center (CLC) during quarters (Qtr 1 & 2 at end of Qtr 2; Qtr 3 & 4 at end of Qtr 4).
- b.) Total cumulative number of Discharges during the quarters for which there was a scheduled **discharge appointment** created prior to discharge (Qtr 1 & 2 at end of Qtr 2; Qtr 3 & 4 at end of Qtr 4).
- c.) Total cumulative number of Discharges during the quarter for which there was a scheduled discharge appointment created prior to discharge and the patient **left within one hour** of the scheduled discharge appointment (Qtr 1 & 2 at end of Qtr 2; Qtr 3 & 4 at end of Qtr 4).

Monitor: Inpatient Flow: Using Discharge Appointments to Balance Discharges					
VISN #:		Facility:			
Quarter 2 FY09 Discharge Appt. Report			Quarter 4 FY09 Discharge Appt. Report		
Cumulative # Discharges, excluding deaths, irregular & emergent transfers to a higher level of care, from acute care and CLC during Qtrs 1&2, appropriate for Discharge Appt.	Cumulative Number of Discharges with Discharge Appt. during Qtrs 1 & 2	Cumulative Number of Discharges during Qtrs 1 & 2 which left within one hour of Discharge Appt.	Cumulative Number of Discharges excluding deaths, irregular & emergent transfers to a higher level of care, from acute care and CLC during Qtrs 3& 4, appropriate for Discharge Appt.	Cumulative Number of Discharges with Discharge Appt. during Qtrs 3 & 4 (FS level: 55%; Ex level: 65%)	Cumulative Number of Discharges during Qtrs 3 & 4 which left within one hour of Discharge Appt. (Targets - FS level: 65%; Ex level: 75%)

CONTACT: Fabiane Erb @ Fabiane.Erb@va.gov or 716-862-8522.

OTHER: The FIX Subcommittee will be reviewing data on facility “smoothing” of discharges across the times of the day and across the days of the week and sharing that data and their observations and providing instructions for how to obtain & assess this performance data with VA facilities during FY2009. The plan is to move toward a focus on outcome measures of discharge smoothing with targets for improvements in “smoothing” in FY2010.

6. Colonoscopy Follow-up of Positive Fecal Occult Blood Tests (FOBTs)

Delays in diagnosis of CRC have been documented throughout VHA. These delays are potentially costly in terms of patient morbidity and mortality and are also a major contributor to tort claims. VHA Directive 2007-004, dated January 2007 established timeframes for patient notification and follow-up testing for positive screening tests, stating that if a follow-up diagnostic colonoscopy is indicated, it must be performed within 60 days of the positive screening test. In a FY07 monitor, facilities were required to flow map their CRC diagnostic process, measure the timeliness of follow-up of FOBTs, and provide a report on their improvement efforts. The FY08 monitor definition was a refinement of the FY07 monitor based on lessons learned during facilities’ FY07 data collection. The FY09 monitor continues refinement of the monitor in an attempt to better understand the extent of and reasons for delays in follow-up colonoscopy and to provide more meaningful data to medical centers.

The optional measures will provide information on the number of patients with rapid follow-up (within 30 days, which many facilities have set as their goal), as well as the number of patients with significant (≥ 90 days) delay in follow-up.

This monitor is designed to track improvement in timeliness of diagnosis of colorectal cancer (CRC) and compliance with VHA Directive timeframe of 60-day colonoscopic follow-up of a positive FOBT screening test. Facilities will report data that will generate the following information:

- **Core Monitor:** Proportion of patients with a positive colorectal cancer (CRC) screening FOBT who have diagnostic colonoscopy ≤ 60 days after the positive screening FOBT.
 - **Numerator:** Those in denominator who had complete diagnostic colonoscopy ≤ 60 days after a positive CRC screening FOBT (data element 5 below)
 - **Denominator:** Number of patients with a positive CRC screening FOBT in the measurement month

Exclusions:

- Patients who refuse follow-up colonoscopy (data element 2 below)
- Patients who choose to have follow-up colonoscopy outside (i.e., neither performed nor paid for by) the VA (data element 3 below)
- Patients determined to be clinically “inappropriate” for colonoscopy (data element 4 below)
- Patients who have had a previous positive FOBT in the FY09
- Patients whose FOBT was not performed as a CRC screening FOBT.

THERE ARE NO OTHER EXCLUSIONS (Do NOT exclude patient cancellations, no shows, or patients who are appropriate for a VA colonoscopy but did not have a consult for colonoscopy submitted by primary care)

Number of patients: Facilities are encouraged to track all patients with positive screening FOBTs. However, medical centers with greater than 30 FOBT-positive patients in a measurement month may track a random sample of at least 30 FOBT-positive patients in the measurement month. Facilities will be asked to record whether they are using 100% or a sample of their FOBT-positive patients

CRC screening FOBT: Patient was provided a three-card FOBT (either guiac or immunochemical) for purposes of CRC screening. Positive FOBTs performed for diagnostic purposes (e.g., evaluation of symptoms or iron-deficiency anemia) are NOT included in the denominator.

Positive CRC screening FOBT: At least one of the CRC screening FOBT cards was positive (regardless of how many cards were received by the lab);

Measurement month: Month of first positive FOBT. (The month is defined by the date of the lab report.)

Follow-up colonoscopy outside the VA: Colonoscopy neither performed nor paid for by the VA.

Clinically “inappropriate” for colonoscopy: It is determined by a medical center clinician(s) that for clinical reasons patient is not a candidate for follow-up colonoscopy.

- **Optional Monitors** : Proportion of patients with a positive colorectal cancer (CRC) screening FOBT who have a diagnostic colonoscopy \leq 30/90 days after the positive screening FOBT.
 - *Numerator:* Those in denominator who complete diagnostic colonoscopy \leq 30/90 days after a positive CRC screening FOBT (data element 4 below)
 - *Denominator:* Same as Core Monitor Denominator above.

ACTIONS:

Core Monitor and Optional Monitors: Beginning at the end of Q2 FY09, medical centers will report **quarterly** on the following data **for each month in the preceding quarter** in a VSSC monitor report template (e.g., Q2 FY09 report would include positive FOBTs from Q1 FY09; the delayed reporting is designed to accommodate the 60-day and optional 90 day follow-up periods). The monitors will be using the following information provided by the medical center (and all of which may be tracked by the medical center in the CRC FOBT Follow-Up Tracking Tool described below):

- **Data element 1 (required):** Number of patients with a positive CRC screening FOBT in the measurement month, excluding:
 - Patients who refuse follow-up colonoscopy (data element 2 below)
 - Patients who choose to have follow-up colonoscopy outside (i.e., neither performed nor paid for by) the VA (data element 3 below)

- Patients determined to be clinically “inappropriate” for colonoscopy (data element 4 below)
 - Patients who have had a previous positive FOBT in the FY09
 - Patients whose FOBT was not performed as a CRC screening FOBT
- Data element 1a (required if applicable): If you were unable to calculate Data element 1 using the definition provided above, describe how the number that you provided was calculated.
 - Data element 2 (required): Number of patients in with a positive CRC screening FOBT in the measurement month who refuse follow-up diagnostic colonoscopy.
 - Data element 3 (required): Number of patients with a positive CRC screening FOBT in the measurement month who choose to have follow-up colonoscopy outside (i.e., neither performed nor paid for by) the VA.
 - Data element 4 (required): Number of patients with a positive CRC screening FOBT in the measurement month for whom it is determined by medical center clinician(s) that follow-up colonoscopy is “inappropriate”. The reason why the follow-up colonoscopy is “inappropriate” should be documented in the medical record. Reasons may include co-morbidities, recent normal colonoscopy, or other situations as determined by medical center clinicians. It is recommended that guidelines for determining “inappropriateness” be incorporated into medical center pathways/reminder systems. (Some possible reasons for “inappropriateness” have been incorporated into the FOBT Tracking Tool included below under Improvement Resources.)
 - Data element 5 (required): Number of patients in data element 1 who underwent colonoscopy \leq 60 days after the date of the first positive CRC screening FOBT in the measurement period.
 - Data element 6 (optional): Number of patients in data element 1 who underwent colonoscopy \leq 30 days after the date of the first positive CRC screening FOBT.
 - Data element 7 (optional): Number of patients in data element 1 who underwent colonoscopy \leq 90 days after the date of the first positive CRC screening FOBT.

DATA SOURCES:

Data elements 1-7: Collected by each facility.

Data element 1: A list of positive FOBTs is available in a laboratory report that can be generated at each medical center. The National Laboratory Testing Code for the three-card set is 82270.0000, but each facility will need to verify that this is the test code used by its lab. Facilities using immunologic-based tests for fecal occult blood should also make sure that results of these tests (which may be coded differently from guaiac-based FOBTs) are also captured in Data element 1. In reviewing positive results, medical centers may wish to verify that each three-card test was truly ordered for purposes of CRC screening; Tests that were NOT performed for purposes of CRC screening should be EXCLUDED from this data element. When entering data for measurement month, medical centers will need to review previous quarters' positive CRC screening FOBTs to identify (and exclude) cases with a previous positive CRC screening FOBT in FY09.

There are at present no nationally-standardized reports addressing data elements 1-6.

An Excel CRC FOBT Follow-Up Tracking tool has been developed for optional use by facilities to assist in collection of the reported data. (See [Improvement Resources](#) below.) The tool has been updated to provide the information reported for this monitor. The data for reporting are included on the FY09 Monitor Data tab in the spreadsheet.

TARGETS:

Fully Satisfactory:

- Quarterly data submitted Q2-Q4 for Core Monitor for FOBT measurement months October 2008-June 2009.
- Core Monitor is equal to or greater than 55%

Exceptional:

- Quarterly data submitted Q2-Q4 for Core Monitor and Optional Monitors for FOBT measurement months October 2008-June 2009.
- Core Monitor is equal to or greater than 75%

CONTACT: Dede Ordin, MD, MPH, Director, Quality Improvement, Office of Quality and Performance @ 202-266-4519 or Diana.ordin@va.gov

Improvement Resources

- CRC FOBT Follow-Up Tracking Tool - In "Diagnosis Improvement" section of Systems Redesign Webpage [VHA Systems Redesign - Colorectal](#)
- A CRC diagnosis improvement List Serve ([CRC DIAGNOSIS Listserve](#))
- Monthly national phone calls sponsored by the Systems Redesign GI Community of Practice (3rd Wednesday, access code 34199)
- Systems Redesign webpage ([VHA Systems Redesign - Colorectal](#)). Aggregate data from this monitor will be posted on this site quarterly.
- CRC Diagnosis Improvement Guide ([CRC Diagnosis Improvement Guide 2007](#))

7. Compensation and Pension Timeliness

Timely processing of C&P exams is important in providing quality care and benefits to veterans.

GOAL: High quality C&P exams will be completed and returned to VBA with cumulative average processing days of 30 days or less.

ACTIONS: Each facility will report and transmit their VWM (AMIS) 290 data during the **first fourteen (14) calendar days** of each month, which includes the average processing days.

- *Numerator:* Sum of the products of average processing days and number of exams returned as completed by facility for each month within the time period being assessed.
- *Denominator:* Number of exams returned as completed by facility within the time period being assessed.

Example for calculation of cumulative average processing days:

Month	APD*	Exams Completed
October	20	100
November	30	200

$$\text{Cumulative APD} = \frac{(20 \times 100) + (30 \times 200)}{(100 + 200)} = 27$$

*APD – Average Processing Days

DATA SOURCE AND METHODOLOGY: Data source: VWM (AMIS) 290 data (<http://vaww.frs.aac.va.gov/>). Extraction: VWM 290 data will be extracted monthly from the AAC FRS database by the Compensation and Pension Examination Program (CPEP) Office.

REPORTING: Facilities are responsible for ensuring their monthly VWM (AMIS) 290 data is transmitted accurately and promptly to the Austin Automation Center (AAC) between the **1st and 14th calendar day** of each month and verifying that their data was successfully updated in the AAC database. Transmissions are done using the MAS Code Sheet User Menu in Vista.

- **Monthly:** Average processing days will continue to be reported for facilities and VISNs via the usual processes (national C&P Timeliness Reports to 10N and VISN Network Directors).
- **Quarterly:** Quarterly cumulative average processing days and FYTD cumulative average processing days will be calculated as shown in the above example.
- **Missing Data:** Facilities and VISNs with missing data will be classified as "incomplete" and cumulative average processing days will not be calculated.
- Pending exam counts will be reviewed to provide an early warning of potentially excessive future average processing days.

TIME FRAME: Reporting will be quarterly, beginning with the 1st Quarter FY 2009, as follows:

- 1st Quarter: October – December 2008
- 2nd Quarter: January – March 2009
- 3rd Quarter: April – June 2009
- 4th Quarter: July – September 2009

TARGET:

Met = Facilities and VISNs with cumulative average processing days less than or equal to 30 days at the end of FY 09 will have met the performance monitor.

Not Met = Facilities and VISNs with cumulative average processing days greater than 30 days at the end of FY 09 will have **not** met the performance monitor.

Not Met = Facilities and VISNs with missing monthly data at the end of FY 09 will have **not** met the performance monitor.

SPECIAL CONSIDERATIONS: Facilities that have an abnormally high portion of pending exams in September 2009 may be asked to provide an explanation prior to being classified as meeting this performance monitor.

CONTACT: Debbie Leek, Program Specialist, CPEP Office, @ Debbie.Leek@va.gov or 615-340-4079.

8. Operating Room/Surgical Flow Systems Redesign *(NEW)*

VHA's FIX/Inpatient Flow Subcommittee recognizes that surgical flow, especially scheduling of patients for operating room surgeries, has a significant impact on Medical Center overall flow. In FY2007/2008, during the Tri-VISN Surgical Flow Pilot Collaboratives, key metric identification was an integral part of this improvement work. In Surgical Flow, experience taught that most facilities benefited from focusing effort on improving first case on-time starts. Surgery services learned that if the first case started on time, there was greater likelihood of smooth flow during the remainder of the day including better patient experience and less over time use. Three metrics are at play: Scheduled Time, Patient in-room time, and Incision Time. In some facilities scheduled time means patient in-room time and in other facilities it means incision time. Facilities will need to review their understanding of these terms. Because most avoidable delay occurs prior to entering the OR, the most appropriate monitor is "in room time". (These avoidable delays might include lack of proper consent, missing equipment, missing lab work, missing personnel. Once in the OR, delays are more likely unavoidable, such as difficulty placing a urinary catheter, difficulty placing an arterial line, or time needed to establish unusual monitoring). As VHA knowledge about Surgical Flow improvement improves, the FIX Subcommittee anticipates metrics that further focus on Surgical Flow improvement will be proposed in future years.

DEFINE: This Monitor supports VHA Surgical Flow improvement, by focusing on a key metric, first case on-time starts. This Monitor includes local facility measurement of first case on-time starts, identification of barriers to first case on-time starts and actions taken by the facility to address those barriers and improve Surgical Flow.

ACTIONS: Each facility which has Surgery / Operating Room(s) is asked to collect the following:

- **By the end of Qtr 1, FY09:** The facility will establish processes to begin tracking first case on-time starts, using the Surgery package and the definitions noted below. Tracking for reporting in this monitor will begin at the start of Qtr 2, FY09.
- **By the end of Qtr 2, FY09:** Performance data for the 2nd Qtr for first case on-time starts, and a list of barriers to starting on time
- **By the end of Qtr 3, FY09:** Performance data for the 3rd Qtr for first case on-time starts
- **By the end of Qtr 4, FY09:** Performance data for the 4th Qtr for first case on-time starts and a description of actions underway to address barriers and improve performance

DATA SOURCE: Facilities with Surgery/OR(s) will collect data daily for Quarters 2, 3 and 4 for first cases: Scheduled start time (Surgery package, field 10), which equals “scheduled time” for this monitor, and Time Pat In OR (Surgery package, field .205), which equals “start time” for this monitor.

TARGET: *Fully Satisfactory level:*

- **By the end of Quarter 2 FY09:** each VA Medical Center with Surgery/OR(s) will report data for the entire quarter on the scheduled first case time, and the actual first case start time, for each day; the Medical Center will also provide a list of barriers to on-time starts that have been identified.
- **By the end of Quarter 3 FY09:** each VA Medical Center with Surgery/OR(s) will report data for the entire quarter on the scheduled first case time, and the actual first case start time, for each day.
- **By the end of Quarter 4, FY09,** each VA Medical Center with Surgery/OR(s) will report data for the entire quarter on the scheduled first case time, and the actual first case start time, for each day; the Medical Center will also provide a brief narrative description of actions underway to address barriers and improve performance.

REPORTING: This Monitor will be self reported via the template format included below, on the DUSHOM Web Profile at the end of 2nd, 3rd and 4th Quarter, FY09.

Monitor: Operating Room/Surgical Flow Systems Redesign					
VISN #:		Facility:			
Quarter 2 FY09 Report					
For the entire Quarter	# of first cases which started no later than the “scheduled time”	# of first cases for which the interval between “scheduled time” and “start time” is equal to or less than 15 minutes	# of first cases for which the interval between “scheduled time” and “start time” is greater than 15 minutes but less than or equal to 30 minutes	# of first cases for which the interval between “scheduled time” and “start time” is greater than 30 minutes but less than or equal to 60 minutes	# of first cases for which the interval between “scheduled time” and “start time” is greater than 60 minutes
Provide a brief list of barriers to first case on-time starts that have been identified:					

Monitor: Operating Room/Surgical Flow Systems Redesign					
VISN #:		Facility:			
Quarter 3 FY09 Report					
For the entire Quarter	# of first cases which started no later than the "scheduled time"	# of first cases for which the interval between "scheduled time" and "start time" is equal to or less than 15 minutes	# of first cases for which the interval between "scheduled time" and "start time" is greater than 15 minutes but less than or equal to 30 minutes	# of first cases for which the interval between "scheduled time" and "start time" is greater than 30 minutes but less than or equal to 60 minutes	# of first cases for which the interval between "scheduled time" and "start time" is greater than 60 minutes

Monitor: Operating Room/Surgical Flow Systems Redesign					
VISN #:		Facility:			
Quarter 4 FY09 Report					
For the entire Quarter	# of first cases which started no later than the "scheduled time"	# of first cases for which the interval between "scheduled time" and "start time" is equal to or less than 15 minutes	# of first cases for which the interval between "scheduled time" and "start time" is greater than 15 minutes but less than or equal to 30 minutes	# of first cases for which the interval between "scheduled time" and "start time" is greater than 30 minutes but less than or equal to 60 minutes	# of first cases for which the interval between "scheduled time" and "start time" is greater than 60 minutes
Provide a brief list of actions underway to address barriers to first case on-time starts that were identified.					

CONTACT: Fabiane Erb @ Fabiane.Erb@va.gov or 716-862-8522.

9. Care Coordination: Tele-mental Health Expansion (NEW)

Every VISN received funding during FY06 and FY07 to expand telemental health services to veteran patients. Funding was made available to VISNs contingent upon their meeting agreed targets and this monitor requires VISNs to demonstrate that they are meeting the VISN specified targets as pre-conditions for receiving this funding. Telemental Health Staffing and Equipment funding Memorandums of May 18, 2006 and June 1, 2007 were agreed between the Deputy Under Secretary for Health for Operations and Management (10N) and each VISN established targets for the number of veteran patients receiving mental health services through telemental health programs as well as for the number of encounters through telemental health programs in clinics, and for participating VISNs for specialty telemental health clinics (i.e. substance abuse and PTSD) and Care Coordination Home Telehealth (CCHT) for mental health populations.

RATIONALE: Telemental Health equipment and staffing funds were provided to increase access to mental health services for veteran patients. Funding was made available to VISNs contingent upon their meeting agreed targets. This monitor verifies that the agreed level of patient encounters has occurred and the agreed number of veteran patients are receiving access to mental health care via telehealth.

ACTIONS: The mechanisms to achieve this are in place already. Most importantly, VISNs must ensure that telemental health clinics in all new and existing sites are properly coded so the data will be fed from the Austin Automation Center to DSS.

DATA SOURCE: Data sets that DSS routinely provides for the Office of Care Coordination Services (CCS). These data can be accessed by the VISN Telemental Health (TMH) Leads and TMH Program Support Assistants at: https://klfmenu.med.va.gov/dss_ssl/TeleHealth.asp and for CCHT for mental health populations at <http://vssc.med.va.gov/products.asp?PgmArea=13> The VISN can follow the number of unique patients treated on the databases that DSS provides the Office of Care Coordination. Actual report will be based on DSS data through September 30th, 2009. Reporting will be done directly by the Office of Care Coordination Services per VISN from the DSS web site. These data will be discussed with the VISN Telemental Health Leads quarterly during the year.

REPORTING: No report need be submitted by facilities or VISNs for this monitor. CCS will submit quarterly reports to 10N via Office of Mental Health Services (OMHS) for each VISN. This report will be based on data taken directly from the DSS and VSSC databases (links above). Progress will be discussed with the VISN TMH Leads quarterly during the year.

TARGETS: Satisfactory accomplishment will be the number of unique patients having accessed mental health services through the number of telemental health encounters by September 30, 2009 based on agreed targets for each as outlined in the 2 memorandums cited above. Excellence will be 10% additional unique patients accessing mental health services through telemental health.

CONTACT PERSON: John Peters, Program Analyst, Office of Care Coordination @ 202-461-6946 or John.Peters@va.gov

10. Ensure Timely Access for All New Veterans Who Need Mental Health Care (NEW)

This monitor establishes expectations for timely access to MH specialty care and further serves to validate system-wide implementation of these expectations. Enhancing the capacity of mental health services, and facilitating access to high quality services are major goals of the VHA Comprehensive Mental Health Strategic Plan. Recently, these priorities were re-emphasized by the Secretary in a 12 Point Plan which required an initial contact with mental health within 24 hours of presenting for care. If the initial evaluation did not identify any more urgent needs, there will be follow-up within a maximum of 14 days to allow for a more extensive evaluation and the initiation of appropriate care.

VA's data show that the proportion of new veterans seeking VA care who have a possible mental health problem has increased over the past two years. For example, the proportion of OIF/OEF veterans with possible mental health problems at the end of FY 2005 was 31 percent, compared to nearly 38 percent in the most recent report released in April, 2007. PTSD diagnoses during this same timeframe went from 13 percent to almost 18 percent.

OBJECTIVE: Veterans defined as new to mental health will have further evaluation and the initiation of Mental Health Care within 15 days of trigger encounter (walk in or direct access to mental health clinic) or a referral to mental health service from either primary care provider or other specialty care provider.

DEFINITIONS:

New Patient: A new patient to mental health is defined as no treatment encounters in any mental health 500 stop code series in the past 24 months at that facility. This definition specifically includes 500 series stop codes for substance use disorder services, as well as primary care based mental health. If referred from primary care and was never seen in mental health then the veteran would be counted as new to mental health

A patient receiving mental health care under the 534 code (primary care based mental health) or substance abuse code (e.g., 523 for methadone), who is referred to specialty mental health care is NOT considered a new patient (i.e.: he/she had an encounter in the 523 or 534 stop code in the prior 24 months).

Trigger Encounter: New Patient encounter in any clinic (excludes lab, radiology, etc) stop code except C&P (in either primary or secondary position) for a MH diagnosis (primary or secondary).

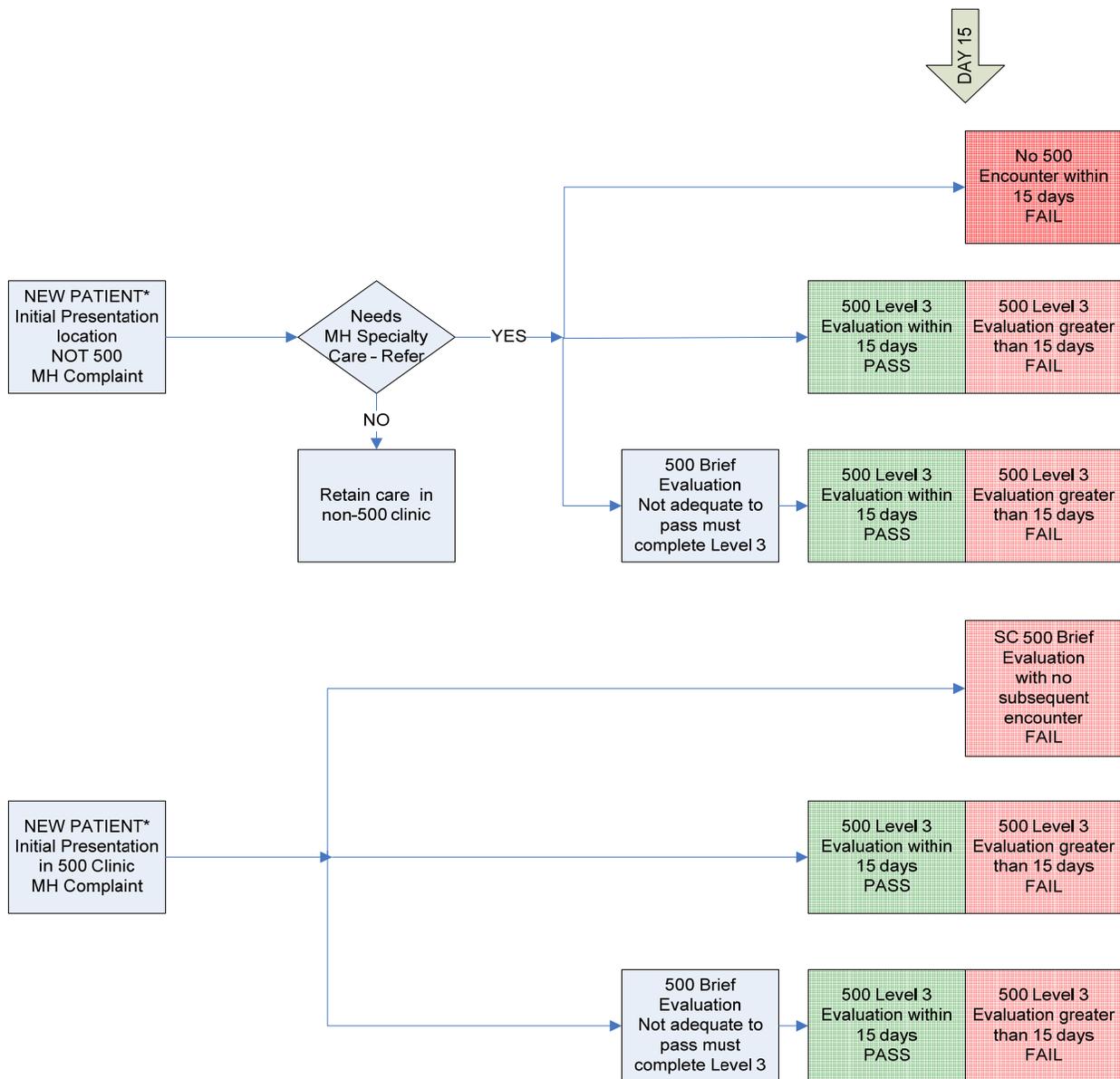
Timely Specialty MH Care: Within 15 days of trigger encounter or referral there must be an inpatient, residential rehabilitation or MH encounter, with a level 3 CPT code that denote further evaluation and the initiation of treatment. This requirement may be satisfied (encounter containing the level 3 CPT code) at the initial encounter OR a subsequent encounter as long as the level 3 CPT encounter occurs within the 15 day window. (See timeline chart)

Setting for Initiation of Treatment: Initiation of treatment can be performed face-to-face, by telemedicine, or by telephone as long as the provider – patient exchange is performed by an acceptable provider, and is documented in the medical record with associated coding that accurately reflects contact/encounter.

Acceptable provider: For a “provider” to be deemed acceptable he/she must be an MD, NP, DO, PhD or PsyD Psychologist, LCSW, APN, PA, (or a trainee with appropriate co-signature) or other allied healthcare professional who by virtue of educational background AND privileging and or scope of practice has been determined by the facility to be capable of evaluating and treating mental illness. Examples of this include RNs providing follow-up in the integrated mental health and primary care or substance use counselors providing evaluation and treatment in our substance use disorder programs.

ACTIONS: Veterans presenting with a request for specialty mental health services or those who referred for specialty mental health services will be seen by MH professionals qualified to provide specialty MH within 15 days of their trigger encounter/referral.

- *Numerator:* Veterans with encounter in 500 series except for 531 (encounter indicative of extensive MH evaluation) < 15 days from date of initial trigger encounter/referral
- *Denominator:* Veterans with encounter in any stop code except C&P, for a MH dx/problem AND no prior encounters in 500 series in the previous 24 months. Veterans with a mental health diagnosis who are treated in Primary Care and not referred to Mental Health are not in this monitor. The monitor is for new veterans who require further evaluation and treatment in Mental Health.



***New Patient:** A new patient to mental health is defined as no treatment encounters in any mental health 500 stop code series in the past 24 months at that facility. This definition specifically includes 500 series stop codes for substance use disorder services, as well as primary care based mental health. If referred from primary care and was never seen in mental health then the veteran would be counted as new to mental health. A patient receiving mental health care under the 534 code (primary care based mental health) or substance abuse code (e.g., 523 for methadone), who is referred to specialty mental health care is NOT considered a new patient (i.e.: he/she had an encounter in the 523 or 534 stop code in the prior 24 months).

TARGET: The target for this monitor will be **90%** for all medical centers. Although it is the expectation that all patients receive the timeliness referenced in the monitor, it is understood that the electronic capture of the data limits the level of granularity necessary to establish a higher target.

DATA SOURCE: VISN Support Service Center (VSSC)

REPORTING: The VSSC will report data monthly by facility and by VISN in accordance with usual VSSC reporting cycle.

NOTE: This monitor is **NOT** reported via the DUSHOM web link.

Limitations in the electronic data include:

- No show rates for mental health both inside and outside of the VA are notoriously high. VA study showed that only 50% of patients show to specialty MH care, 34% for alcohol dependent or problem drinking
- Inability to identify patients presenting with MH concerns who were NOT referred to MH (e.g., treatment managed in PC = absence 500 stop code)
- Fee basis referrals will not be identified, so they will appear to be a fail when in fact they may have been seen at a fee basis contactors site within the time period required
- Coding variability, inaccuracies (validation studies pending)

CONTACT: Tim Cuerdon (Timothy.Cuerdon@va.gov) (202) 461-7351)

11. Mental Health Care Transitions Follow Up to Inpatient Mental Health Hospitalization Monitor Documentation (NEW)

The risk for suicide is high in most mental disorders, with estimates of risk generally suggest a 5 to 15 fold increase. High rates of suicide are particularly associated with acute episodes of illness, recent hospital discharge, social factors such as living alone, and features of clinical history such as substance misuse and non-fatal self harm. A study (Appleby et al., 1999) looked at data on over 2,000 suicides by patients who had had contact with mental health services in the year before their death. A quarter of these occurred within 3 months of discharge, with the highest number occurring in the first week of discharge.

A new FY09 monitor has been developed by the Office of Quality and Performance, Patient Care Services, and Mental Health Services. Veterans being discharged from an inpatient mental health program must be followed-up by an outpatient treatment program within 7 days of the date of discharge. The initial contact can be face to face, telephonic or telemental health. If the contact is telephonic, a face to face appointment must take place within 14 days of the date of discharge from the inpatient program.

DEFINE: This monitor establishes expectations for continuity of care to MH specialty care and further serves to validate system-wide implementation of these expectations. Facilitating engagement and promoting continuity of care to high quality services are major goals of the VHA Comprehensive Mental Health Strategic Plan. These priorities are re-emphasized in the Uniform Mental Health Services in VA Medical Centers & Clinics Handbook.

GOAL: Facilities must ensure continuity of care during transitions from Inpatient Mental Health to outpatient care. When veterans are discharged from inpatient mental health care settings, they must receive follow-up mental health evaluations within 7 calendar days of discharge. The initial follow-up for veterans discharged may be by telephone, if a face to face or telemental health follow up occurs within 14 days. Any indications of clinical deterioration, non-adherence with treatment, or danger to the veteran or others must trigger appropriate and timely interventions.

COMPANION REPORT: A Mental Health Initiative Report, a report services product, is available and provides aggregated and patient detailed information on this monitor. The report can display data in both tabular and graphic form and at the VHA, VISN or parent facility levels. The report allows drill down to patient SSN for users with real SSN workload access (functional task code 110TT02 for station, 110TT05 for VISN and 110TT01 for national). In addition, the data can be exported to a variety of media including Power Point and Excel.

DEFINITION: Percent of inpatient discharges, which include at least bed day of care in a mental health bed-section of care, in which the patient received timely outpatient mental health services after a discharge.

- *Numerator:* Mental Health discharges with a face-to-face, telehealth or telephone encounter in a mental health stop code (see Appendix A.) during the 7 days after discharge. The initial follow up encounter can not be on the same day as the discharge from inpatient. If initial follow-up contact is by telephone within 7 days, a face to face follow up must occur within 14 days.
- *Denominator:* VA inpatient discharges in which the patient had at least one bed day of care on a mental health service (see Appendix B.).
- *Exclusions:* Patients discharged or transferred from inpatient mental health to a medical/surgical/nursing home service or Mental Health Residential Rehabilitation Treatment Program bed sections (see Appendix C.). Patients who expired as an inpatient are also excluded from the measure. Please note that regular and irregular discharges are included in this measure.

TARGET:

Fully Successful = 85%

Exceptional = 90%

DATA SOURCES: National Patient Care Database (NPCD) Outpatient and Inpatient Workload files. Data will be updated every 2 weeks.

Resource for Data:

<https://reports.vssc.med.va.gov/Reports/Pages/Report.aspx?ItemPath=%2fMHInitiatives%2fMental+Health+Initiative+Report>

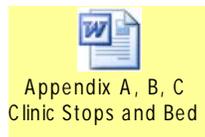
REPORT: Report will be provided to 10N on a quarterly basis by MH Services and OMHS will roll up quarterly and submit to 10N for posting on the DUSHOM web site. In addition, reports are available on the VSSC website and updated every two weeks. *Note: “Companion Report” section on this guidelines and view sample VSSC report in attachment below.*

CONTACT: Tim Cuerdon @ timothy.cuerdon@va.gov or 202-461-7351

VSSC Report:



Appendix A, B, C Clinic Stops and Bed Sections



Resource - Help Desk at: http://vssc.med.va.gov/FAQ/HD_request.asp

12. Follow-up for High Risk Hospitalized Mental Health Patients (NEW)

High rates of suicide are particularly associated with acute episodes of illness, recent hospital discharge, social factors such as living alone, and features of clinical history such as substance misuse and non-fatal self harm. A study (Appleby et al., 1999) looked at data on over 2,000 suicides by patients who had had contact with mental health services in the year before their death. A quarter of these occurred within 3 months of discharge, with the highest number occurring in the first week following discharge. Pilot testing at VA sites, ongoing for the past six months, has already demonstrated the value of Category II Patient “flags” in veterans electronic medical records for helping providers to identify those at high risk for suicide, and to increase the awareness of all facility staff of the presence of suicide warning signs. Additionally,

ready access to mental health services and being engaged in a therapeutic relationship are identified as strong preventative factors for reducing suicidal behaviors.

OBJECTIVE: Suicide prevention is a VA priority. VA's overall strategy is based on the principle that suicide prevention requires ready access to high quality mental health services as well as clinical and public health-oriented programs that directly target suicide prevention.

ACTION: VA is establishing a performance monitor requiring that patients admitted for acute psychiatric hospitalization and who report or demonstrate actual suicidal behavior or report serious ideations of suicidal behavior must be "flagged" and placed on a facility high risk list and kept on the list for a period of at least 3 months after discharge.

- Their level of danger for suicidality and other psychiatric symptoms must be evaluated at least weekly during the first 30 days after discharge.
- Follow up evaluations need to be done by an approved mental health provider, and
- All of these contacts should be face to face unless patient needs and desires dictate otherwise.

DEFINITION: Veterans may be determined to be at high risk for suicide for a variety of reasons. This is always a clinical judgment made after an evaluation for risk factors, protective factors, and the presence or absence of warning signs. Core criteria for designating a patient as high risk for suicide clearly include reports by the patient or others that he/she is having serious suicidal ideation and or observations or reports that the veteran has demonstrated suicidal behaviors such as planning attempts, obtaining the means to kill himself/herself, and attempting to die by suicide. Identified risk factors that clinicians need to consider when identifying veterans for placement on the high risk list and subsequent "flagging" include:

- demonstration of new or a history of aggressive and or impulsive behaviors,
- history of trauma or abuse,
- active substance abuse,
- family history of suicide,
- easy access to lethal means,
- recent loss of a loved one
- recent financial loss,
- relational distress, separation and/or divorce,
- lack of social supports and/or a sense of isolation.

When patients who have been determined to be chronically at risk for suicide experience loss, new or additional stressors, or other life changes they should be evaluated for a potential change in their level of risk and also placed on the high risk list if appropriate.

Veterans who are hospitalized as a result of a suicide attempt or a determination that they are at high risk for suicide must be placed on the high risk list, flagged, and kept on the list for a period of at least 3 months after discharge. They must be evaluated at least weekly during the first 30 days after discharge.

A key element of their discharge plan and these subsequent visits must include the development and monitoring of a Safety Plan.

DATA SOURCE: VISN Support Service Center (VSSC) uses the NPCD Outpatient and Inpatient Workload files

REPORTING: The VSSC will report data monthly by facility and by VISN in accordance with usual VSSC reporting cycle and OMHS will roll up quarterly and submit to 10N for posting on the DUSHOM web site.

MONITOR: Patients who are admitted for hospitalization as a result of a suicide attempt or a determination that they are at high risk for suicide must be "flagged", placed on the high risk list, and kept on the list for a period of at least 3 months after discharge. They must be evaluated at least weekly during the first 30 days after discharge. Follow up needs to be with an approved mental health provider. These visits should be face to face unless patient needs dictate otherwise.

- *Numerator*: All patients in the denominator who have evidence in VISTA of four weekly follow-up evaluations during the first 30 days after discharge. (Follow-up evaluations may occur within regularly scheduled therapeutic appointments – the follow-up evaluations do not require a separate, stand alone appointment)
- *Denominator*: All patients discharged from an inpatient mental health service between October 1, 2008 and September 30, 2009, who were admitted as a result of a suicide attempt or a determination that they were at high risk for suicide.

EXCLUSIONS: Patients discharged to RRTP or other inpatient care setting

TARGET:

Fully Successful = 85%
Outstanding = 90%

CONTACT: Tim Cuerdon, 202-461-7351, tim.cuerdon@va.gov,

13. HUD – VASH (NEW)

In Fiscal Year (FY) 2008, more than 10,000 Housing Choice vouchers were authorized and funding was made available to hire and retain case manager(s) for veterans in the HUD-VASH program. Funding for implementation was sent to participating VA medical facilities in March 2008 to recruit and hire case managers. The hiring was expected to be finalized within 90 days and programs were to be operational by the end of July 2008.

OBJECTIVE: Ending homelessness among our nation’s veterans is a very high priority for VA. To that end, VHA entered into the HUD-VASH Program which is a collaborative partnership between the Department of Housing and Urban Development (HUD) and the Department of Veterans Affairs (VA) Supported Housing (VASH) to form the HUD VASH program. In this partnership, HUD provides permanent housing to homeless veterans with Housing Choice Section 8 vouchers, while VA provides veterans with case management and supportive services to promote and maintain recovery and independence in community-based housing. The HUD-VASH Program is an essential and critical part of VHA, as it provides case management, supportive services, and safe permanent housing for homeless veterans. Although the program began in 1992, the number of operational programs began growing dramatically beginning in 2008, requiring conformity of oversight procedures and the need to monitor timely access to permanent housing for homeless veterans.

ACTION: To support timely implementation of HUD VASH, a performance monitor will be implemented in FY 2009 requiring that permanent staff be hired, that case management services be provided and that a percent of the awarded vouchers be made by the Public Housing Authority (PHA) to appropriate participating HUD-VASH veterans as follows:

- a. 25 percent of vouchers be awarded by November 1, 2008
- b. 50 percent of awarded vouchers by end of 1st Quarter, FY 2009
- c. 75 percent of awarded vouchers by the end of the 2nd Quarter, FY 2009
- d. 90 percent of awarded vouchers by the end of the 3rd Quarter, FY 2009.

DEFINITION: HUD-VASH Case Manager is an individual with the VA health care aspect of the HUD-VASH program who provides case management services for veterans and who administers the program locally. The goal of case management is to promote and maintain recovery, and support the veteran in securing and maintaining safe, permanent housing.

DATA SOURCE: VISN Dashboard and NEPEC Program evaluation data

REPORTING: HUD VASH data (# VA case managers hired, # veterans referred to local Public Housing Authority (PHA) and % of vouchers issued to homeless veterans) is reported to the OMHS on a monthly basis. The report is due on the 5th day of each month. OMHS will roll up quarterly and submit to 10N for posting on the DUSHOM web site.

GOAL: Timely issuing of Housing Choice vouchers to homeless veterans

- o *Numerator:* The number of homeless veterans at each medical center who were entered into VA HUD-VASH Case Management, referred to the local Public Housing Authority and received a housing voucher.
- o *Denominator:* The number of HUD-VASH vouchers received by each medical center to provide permanent housing opportunities to eligible homeless veterans.
- o *Exclusions:* Medical centers that did not receive funding for Case Management or the Housing Choice vouchers from HUD

TARGETS:

- o 25 percent of vouchers be awarded by November 1, 2008
- o 50 percent of awarded vouchers by end of 1st Quarter, FY 2009
- o 75 percent of awarded vouchers by the end of the 2nd Quarter, FY 2009
- o 90 percent of awarded vouchers by the end of the 3rd Quarter, FY 2009

CONTACT: Office of Mental Health Services

Paul Smits, paul.smits@va.gov (202) 461-7348

Teresa Pittman, teresa.pittman@va.gov (202) 461-7308

DOMAIN: COST

1. Prosthetics Home Respiratory Care Program

An audit of VHA's Home Respiratory Care Program (HRCP) was conducted by the Inspector General's Office to determine whether medical facilities are complying with VHA's HRCP policy and administering the program effectively. The audit was also conducted to determine whether medical facilities are effectively administering the HRCP durable medical equipment contracts and paying the correct amounts for purchased equipment and services.

ACTION: The VISN Prosthetic Representatives will self-report the status of the following to the Prosthetics and Clinical Logistics Program Office:

- a.) The HRCT at each facility will review medical records of all new Home Oxygen patients for appropriate and complete medical documentation and prescription criteria in accordance with the CPR.
- b.) The HRCT at each facility will monitor and maintain appropriate home oxygen prescription renewal dates in accordance to the CPR. The prosthetics software module will be updated accordingly.
- c.) The HRCT at each facility will audit 5% of the total number of home oxygen patients' invoices for a 90 day period in order to ensure appropriate equipment delivery and accuracy of vendor billing of purchased supplies or services.
- d.) A minimum of sixteen (16) random home oxygen visits will be conducted by the PSAS representative and/or clinical representative on a yearly basis. A minimum of four (4) visits will be performed per quarter.

REPORTING:

- a.) The HRCT will report the percentage of new patients with appropriate/complete documentation to all new patients, in their meeting minutes.
- b.) The HRCT will report the percentage of patients with current and appropriate renewal dates, in the prosthetic software package, to all prescriptions, in their meeting minutes.
- c.) The HRCT will report the percentage of correct/consistent invoices to all audited invoices, in their meeting minutes.
- d.) Four (4) visits per quarter must be documented in meeting minutes and reported compliant to the DUSHOM web-site.

Quarterly, the VISN reports compliance for **a, b, c and d** for each facility on the DUSHOM web site.

TARGET: Success rate for a, b, and c will be measured at 95%. Success rate for d will be at 100%.

CONTACT: Robert Baum, Chief Operating Officer @ 202-254-0440 or Robert.Baum@va.gov

2. Care Coordination: Home Telehealth (CCHT) Utilization Reduction Monitor

CCHT is predicated on just-in-time care for appropriate patients. Monitoring appropriately selected patients on an ongoing basis has been shown to reduce utilization. This monitor verifies that the patient selection and CCHT clinical care processes are functioning as intended.

DEFINE: For each VISN, CCHT patients enrolled for non-institutional care (NIC) and chronic care management (CCM) must show a minimum 30% reduction in bed days of care (BDOC) and a 20% reduction in emergency room visits.

ACTION: The mechanisms to achieve this are in place already. Care Coordinators should continue to evaluate patients for enrollment in CCHT based on national guidance and VISN policy (i.e. clinical history and past utilization patterns). Patients enrolled as NIC must have a Continuum of Care assessment completed initially and at least every 6 months.

DATA SOURCE: The data source will be the Office of Care Coordination Services (CCS) Outcomes Data Cube. These data are updated approximately every 2 weeks and are readily available to the VISN CCHT staff at: <http://klfmenu.med.va.gov/products.asp?PgmArea=13>.

REPORTING: CCS will pull data per VISN directly from the data cube and report to the DUSHOM for input into the DUSHOM Web site on a **quarterly** basis. This data will also be shared with the VISNs and progress will be discussed with the VISN CCHT Leads quarterly during the year.

The actual measure will be assessed based on available data as of **September 25th, 2009**.

TARGET: Satisfactory and Exceptional targets are outlined in the table below. The measure will compare the cohort of patients enrolled into the CCHT program during the last 6 months of FY08 (April – September 2008) and review their utilization while enrolled in CCHT at the end of FY09 (12 months enrollment) compared to their pre-enrollment utilization.

	Satisfactory	Exceptional
BDOC	30%	40%
Emergency Visits	20%	30%

CONTACT: Ellen Edmonson, Director of Operations, Office of Care Coordination Services @ 202-461-6972 or ellen.edmonson@va.gov

3. Construction Projects: (Three components)

a.) Non-Recurring Maintenance (NRM) Project Obligations by end of FY: Ratio of NRM obligations towards NRM allocation

RATIONALE: Ensures that 100% of the NRM allocation based on the VISN's VERA allocation and mark-up apportionment is obligated towards NRM projects.

ACTIONS: VHA's Finance Office will provide the NRM allocation total to VISN CFOs; VHA's CAMPS will ensure at least 100% of NRM projects are planned to obligate towards NRMs; VHA's Finance will then provide NRM obligation data to show the results. VHA's Finance Office in conjunction with VHA's CAMPS will put processes in place to ensure NRM obligations are made within the fiscal year.

DATA SOURCE: Financial Management System (FMS)

TARGETS:

- o *Exceptional* = 100% of the NRM allocation is obligated towards NRMs
- o *Outstanding* = 85-100% of the NRM allocation is obligated towards
- o *Fully Satisfactory* = 70-85% of the NRM allocation is obligated towards NRMs

CONTACTS:

Brandi Fate, Director – CAMPS @ 202-266-4671 or brandi.fate@va.gov
Paul Kearns, VHA Chief Financial Officer @ 202-461 or paul.kearns@va.gov

b.) Non-Recurring Maintenance (NRM) Project Obligations by June 30, 2009: Ratio of NRM obligations towards NRM allocation

RATIONALE: Ensures that 80% of the NRM allocation is obligated towards NRM projects within the first three quarters of the fiscal year.

ACTIONS: VHA's Finance Office will provide the NRM allocation total to VISN CFOs; VHA's CAMPS will ensure at least 80% of NRM projects are planned to be obligated by June 30, 2009; VHA's Finance will then provide NRM obligation data to show the results. VHA's Finance Office in conjunction with VHA's CAMPS will put processes in place to ensure NRM obligations are made by June 30, 2009.

DATA SOURCE: Financial Management System (FMS)

TARGETS:

- o *Exceptional* = 80-100% of the NRM allocation is obligated towards NRMs by June 30, 2009
- o *Outstanding* = 65-80% of the NRM allocation is obligated towards NRMs by June 30, 2009
- o *Fully Satisfactory* = 50-65% of the NRM allocation is obligated towards NRMs by June 30, 2009

CONTACTS:

Brandi Fate, Director – CAMPS @ 202-266-4671 or brandi.fate@va.gov
Paul Kearns, VHA Chief Financial Officer @ 202-461 or paul.kearns@va.gov

c.) Non-Recurring Maintenance (NRM) Project Obligations for Facility Condition Assessment (FCA) projects: Ratio of FCA NRMs towards NRM allocation

RATIONALE: Ensures that 40% of the NRM allocation is obligated towards NRM projects correcting FCA deficiencies

ACTIONS: VHA's Finance Office will provide the NRM allocation total to VISN CFOs; VHA's CAMPS will ensure at least 40% of NRM projects are planned to obligate towards correcting FCA deficiencies; VHA's

Finance will then provide NRM obligation data to show the results. VHA's Finance Office in conjunction with VHA's CAMPS will put processes in place to ensure NRM obligations are made within the fiscal year.

DATA SOURCE: Financial Management System (FMS)

TARGETS:

- *Exceptional* = 75-100% of the NRM allocation is obligated towards NRMs for FCA deficiency corrections
- *Outstanding* = 60-75% of the NRM allocation is obligated towards NRMs for FCA deficiency corrections
- *Fully Satisfactory* = 40-60% of the NRM allocation is obligated towards NRMs for FCA deficiency corrections

CONTACTS:

Brandi Fate, Director – CAMPS @ 202-266-4671 or brandi.fate@va.gov
Paul Kearns, VHA Chief Financial Officer @ 202-461 or paul.kearns@va.gov

d.) Minor Construction Obligations: Ratio of actual Minor Construction Projects to Planned minor construction projects

RATIONALE: Ensures that the carry-over for Minor Construction dollars is minimized.

ACTIONS: VHA's CAMPS provides the planned list of Minor Construction projects (FY2009 Minor Operating Plan) to 004; 004 approves the Operating Plan and accepts as the planned obligations; OAEM provides the actual obligations for Minor projects; CAMPS compares actual obligations towards planned obligations and provides details if obligations are not met.

DATA SOURCE: Financial Management System (FMS)

TARGETS:

- Exceptional* = 100% of planned Minor obligations are obligated within the VISN
- Fully Satisfactory* = 80% of planned Minor obligations are obligated within the VISN

REPORTING for a, b, c and d above: Data will be collected through FMS and reported monthly with a cumulative report presented to the DUSHOM at the end of the FY2009 cycle by Brandi Fate

CONTACT: Brandi Fate, Director – CAMPS @ 202-266-4671 or brandi.fate@va.gov

4. Logistics (Five components):

a.) Unauthorized Commitment and Ratification

All procurements are to be made in accordance with Federal Acquisition Regulations which state that only a warranted contracting official can commit the government for products or services. VHA is working to ensure no procurements are done without official authorization.

DEFINITION: Unauthorized Commitment is an individual other than a warranted contracting officer commits the government to products or services without proper authority. Ratification is the processes were an unauthorized commitment is approved for payment of the product or service.

ACTIONS: Reports are prepared on a monthly basis. Collated reports will be shared with the field and upper management.

DATA SOURCE: Data is collected from field sites through an error report from the FMS system and sent to the field facilities which in turn are forwarded to the national level.

REPORTING: Information will be collected from field facilities on a monthly basis by the P&CLO office and analyzed. A report will be prepared quarterly and sent to the DUSHOM with a copy sent to all Network Directors. **NOTE:** *This monitor is NOT reported via the DUSHOM web link*

TARGETS: Zero unauthorized commitments for VHA. For the report any network with 9 or less unauthorized commitments will be color coded green, 10 to 19 is color coded yellow, and 19 and above is color coded red

SPECIAL CONSIDERATIONS: VULNERABILITIES OF THE REPORT/LIMITATIONS

This report is based upon transfer of information from field facilities to the national office. Reports are not nationally based.

b.) Federal Procurement Data System Entry

VHA, as required by Federal Acquisition Regulations (FAR) 4.6, must report all procurements over \$3,000 dollars to the Federal Procurement Data System-Next Generation. VHA has in previous years underreported the dollars to the FPDS system.

DEFINITION: All dollars reported are broken down into either large business or the following socioeconomic categories which include: Small Businesses, Small Disadvantaged Businesses, 8(a) Businesses, Women Owned Businesses, Veteran-Owned Small Businesses, Service-Disabled Veteran-Owned Small Businesses and HUB Zone Businesses.

ACTIONS: Reports to compare FPDS data with NLD and FMS data are being developed. Reports will be ready by the end of first quarter FY08. Reports will be prepared by P&CLO office and shared with the field and upper management.

DATA SOURCE: Data will be from both the Federal Procurement Next Generation database as well as information obtained from the National Logistics Database. This information will be collected and analyzed by the P&CLO data team either in Washington D.C. or Hines IL.

REPORTING: Information will be collected from FPDS, NLD and FMS data sets on a quarterly basis. A report will be prepared quarterly and sent to the DUSHOM with a copy sent to all Network Directors. **NOTE:** *This monitor is NOT reported via the DUSHOM web link.*

TARGET: 100 % of all procurements over micro-purchase threshold \$3,000 are to be reported into the FPDS-NG system.

SPECIAL CONSIDERATIONS: VULNERABILITIES OF THE REPORT/LIMITATIONS

Report is based upon comparison of two multiple data sources. The first data source used will be FPDS-NG which is the final repository for all spend according to the federal government. The second is the National Logistics Database which captures procurement information from all VHA VISTA IFCAP systems. The third will be the FMS financial system that is the system of record for all financial information.

c.) Logistics Purchase Card Program (NEW)

Combined Assessment Program reviews conducted by the Office of Inspector General (OIG) are conducted regularly at individual Veterans Affairs Medical Centers to determine whether medical facilities are complying with VHA's Government Purchase Card policy and administering the program effectively.

ACTION: VISN Purchase Card (PC) Program Managers will self-report the status of the following to the Office of Prosthetics and Clinical Logistics:

- The Facility Director must perform an annual review of the Purchase Card Program. The review shall be performed by a team of knowledgeable individuals to include, but not limited to, the HCA or Logistics Manager, Financial Quality Assurance Manager (FQAM), VISN PC Manager, and a Fiscal representative.
- Approximately 25 percent of cardholder accounts are reviewed each calendar quarter. Results of these internal reviews must be documented and recommended corrective actions monitored to ensure effectiveness.
- The Facility Director will certify annually that the facility Purchase Card Program complies with the requirements of VHA Handbook 1730.1. Circumstances of noncompliance must be annotated along with the recommended corrective action. The annual certification of compliance will be submitted to the Network Director by the **30th of June**.
- The Facility Director must request an annual certification by Human Resources Management Service (HRMS) indicating that all cardholders, approving officials, and alternate approving official, facility A/OPC, DO, and alternates have the corresponding duties integrated into their position descriptions and performance plans. This annual certification of compliance will be submitted to the Network Director by the **30th of June**.

REPORTING:

- Facility PC Coordinator (A/OPC) is to submit to the VISN HCA a copy of the Quarterly Purchase Card Program Certification Report. The VISN HCA maintains the quarterly reports, which requires certification of accurate training documentation and program statistics by the facilities Fiscal Officers, Logistics Officers, and A/OPCs.
- Network Director ensures that an annual certification/review process is in place to ensure that all VHA program participants follow the procedures of VHA Directive and Handbook 1730.1, Use and Management of the Government Purchase Card Program

TARGET: The Facility Director will certify annually that the facility Purchase Card Program complies with the requirements of VHA Handbook 1730.1. Circumstances of noncompliance must be annotated along with the recommended corrective action. The annual certification of compliance will be submitted to the Network Director by the **30th of June**. Success equals 100% of facilities certifying total compliance with VHA Directive and Handbook 1730.1.

d.) Inventory Management:

The OIG Audit March 1999 projected \$68 million in excess inventory. The USH agreed with the OIG recommendations to:

- Eliminate excess inventories over 30 days on hand
- Establish inventory management programs.
- Establish goals and procedures to monitor progress in reducing inventories levels.
- Dollar Value of Stock on Hand
- Dollar Value of Inactive Supplies
- % of Inactive Supply on Hand
- Dollar Value of Long Supply Items
- % of Long Supply Items
- Turnover Rate

DEFINITIONS:

Dollar Value of Stock on Hand: Dollar value of supplies in the inventory primaries as recorded in the Generic Inventory Package (GIP)

Dollar Value of Inactive Supplies: Dollar amount of items with no consumption over 90 days.

Percent of Inactive Supply on Hand: Percent of inactive items versus all stock on hand

Turnover Rate: is the average number of times a facility is replacing its entire inventory in the respective inventory point.

DATA SOURCE: The Generic Inventory Package (GIP) is used as the source document for the evaluating Inventory Management Benchmarks. Reports are generated automatically on the first day of each month in GIP by a routine in IFCAP at each station. Information is stored nationally in a database which will generate needed reports for the stations and networks. Data is extracted monthly from all VA IFCAP systems nationally.

REPORTING: A **quarterly** report is sent from the National Office of Logistics to the Deputy Under Secretary of Health for Operations and Management and then sent to the field. **NOTE:** *This monitor is NOT reported via the DUSHOM web link.*

TARGETS: Dollar Value indicators are informational only and show trends of official inventories. The target is established for the percentages of inactive and long supply as follows:

Category	% Inactive >90 Days	% Long Supply >90 Days	Turnover Rate
Medical Surgical/Supply Processing and Distribution (SPD) and Total Supply Support (TSS)	20%	30%	10
Radiology	20%	30%	8
Laboratory	25%	35%	8
Dental	30%	40%	8
Environmental Management (EMS)	15%	20%	10
	% Inactive >90 Days	% Long Supply >270 Days	
Engineering	n/a	50%	4

Special Considerations: VULNERABILITIES OF THE REPORT/LIMITATIONS. Automatic retrieval of data still has to be categorized into the six general areas to prepare reports. Communication between field and the Prosthetics and Clinical Logistics Office will still be required if new inventories are added or inventories are deleted.

CONTACT for a –d above: Garth Glenn, Inventory Management Specialist @ 202-679-7952 or garth.glenn@va.gov

e.) Equipment Inventory Listing:

A United States Government Accountability Office report from July 2004 found that VHA lacked reliable property control records. To ensure better control of VHA property an annual inventory of all equipment will be accomplished by Equipment Inventory Listing account.

DEFINITION: Equipment Inventory Listings (EIL) are a record of all equipment owned by the medical center considered non-expendable. Each medical center is required by VA Directive/Handbook 7127 to annually inventory every EIL. The monitor baseline will be established by medical center informing the Prosthetics and Clinical Logistics Office (CLO) the number of scheduled inventories by quarter that equal the total number of EILs in the facility. Additional inventories may be required if the initial EIL annual inventory falls below 95%. This would require a follow-up inventory in six months which will be included in the baseline as the year progresses.

ACTIONS: Data will be collated by each medical facility manually and sent to the respective CLO offices in each VISN on a quarterly basis. VISN offices will send data to the Prosthetics and Clinical Logistics Office by the 10th working day at the end of each quarter.

TARGETS: Percentage of completed inventories based upon the number of scheduled cumulative inventories by quarter of 100% is the expected standard. Also included will be dollar value of discrepancies reported and number of Report of Surveys (ROS) done by the Medical Centers. (Revised)

REPORTING: Reports are sent from the medical centers to the Prosthetic & Clinical Logistics Office (PCLO). The PCLO prepares a consolidated report and sends to the Deputy Under Secretary of Health for Operations & Management. **NOTE:** *This monitor is NOT reported via the DUSHOM web link.*

CONSIDERATIONS: VULNERABILITIES OF THE REPORT/LIMITATIONS

This report is based upon manual processes including when EIL inventories are scheduled and the report sent by each network after collation of data from their facilities.

CONTACT: Garth Glenn, Inventory Management Specialist @ 202-679-7952 or garth.glenn@va.gov

6. Prosthetics (Two components):

a.) Consults Pending Report:

The Suspense package tracks all consults in CPRS. After initial action, If a consult is unable to be completed, it is placed in a pending status in accordance with the Business Practice Guidelines for Prosthetic Consults Management. VHA, VSOs and the congressional staff may utilize this report as a means to assess the timely provision of prosthetic devices to disabled veterans.

GOAL: To ensure all patients receive all items / services requested in a timely manner.

DATA SOURCE: Suspense package tracks all consults in CPRS.

REPORTING: The Consults Pending report is extracted from the Suspense Package. The report *is* monitored **monthly** by Prosthetic & Clinical Logistics Office (PCLO). Pending orders will be measured from the date the order was placed in pending status. A monthly report is sent to the Deputy Under Secretary of Health for Operations and Management and then sent to the field. **NOTE:** VISN do NOT report this monitor via the DUSHOM web link.

TARGET: The goal is 0% for consults pending greater than 15 days.

b.) Surgical Implant Serial Numbers (NEW)

All purchase orders and stock issues have a prompt for serial numbers. Entering the serial number at this prompt will result in the data entry on the patient's 2319 for recall purposes.

GOAL: Surgical implants with serial numbers will be recorded on the patient's 2319 by the appropriate Prosthetic Staff to ensure patient safety in the event of a recall.

DATA SOURCE: Data will be pulled from the National Patient Prosthetics Database (NPPD) by the Hines Data Extraction Group.

REPORTING: This report will be monitored monthly by PCLO with quarterly reports to the Deputy Under Secretary of Health for Operations and Management. **NOTE:** This monitor is **NOT** reported via the DUSHOM web link.

TARGET: The goal is 100% for entry of serial numbers for all surgical implants.

CONTACT for a and b above: Robert Baum, Chief Operating Officer @ (202) 254- 0440 or Robert.Baum@va.gov

7. Administrative Systems Redesign Monitor **(NEW)**

VHA's Administrative Systems Redesign Subcommittee recognizes that there is an intersection between Management Analysis/Business Process Reengineering (MA/BPR) and some areas of application of Systems Redesign principles in Administrative/Business processes. This Monitor is intended to highlight that intersection and encourage facilities to use Systems Redesign principles to improve these processes and to avoid unnecessary duplication of effort.

DEFINITION: This Monitor connects requirements of Management Analysis/Business Process Reengineering (MA/BPR) program for FY2009 for Plant Operations with the application of Systems Redesign principles in the Administrative/Business Processes of Non-Recurring Maintenance (NRM) and Work Orders.

ACTIONS: Each facility will continue to participate in MA/BPR as required. For FY2009, there is a specific intersection between Administrative Systems Redesign focused processes of Non-Recurring Maintenance (NRM) and Work Orders, and MA/BPR's Plant Operations. The expectation is that each facility will use System Redesign principles to study NRM and Work Orders as options within the MABPR study of Plant Operations.

DATA SOURCE: Facilities will report data as required by MA/BPR, and will document the application of systems redesign principles for improvements and reduction in delays in NRM and Work Orders. Systems Redesign improvement principles may include: balancing demand and supply, carrying out several Plan-Do-Study-Act cycles, reducing cycle times & delays in these processes, applying Lean Thinking, Theory of Constraints, and/or Six Sigma methods to improve these processes.

TARGET:

Fully Satisfactory: By the end of Quarter 4, FY09, each VA Medical Center will provide a self report on their work on NRM and Work Orders, demonstrating evidence of intersection between MA/BPR and application of Systems Redesign principles.

REPORTING: This will be **self reported via the template format** included below, on the DUSHOM SharePoint at the end of the **4th Quarter, FY09**.

Monitor: Administrative Systems Redesign	
VISN #:	Facility:
Quarter 4 FY09 Report	
Provide a brief narrative summary which demonstrates evidence of use of Systems Redesign in the MA/BPR required Plant Operations topic, for Work Order and NRM processes.	

CONTACT: Fabiane Erb, Systems Redesign Program Office @ Fabiane.Erb@va.gov or 716-862-8522.

DOMAIN: BUILDING HEALTHY COMMUNITIES

1. Employee Seasonal Influenza Vaccination

Influenza is a contagious respiratory illness caused by influenza viruses. It can cause mild to severe illness, and at times can lead to death. Approximately 36,000 people die from influenza each year. Influenza transmission between patients and employees represents a serious problem in health care. Vaccination represents the most effective prevention strategy. Low health care worker immunization rates substantially increase employee absenteeism and health care costs. Despite long-standing recommendations, less than 40% of health care workers nationally are vaccinated against influenza each year. In FY08 65% of VHA employees were vaccinated against seasonal influenza.

The Joint Commission promulgated an influenza vaccination standard. The Healthcare Infection Control Practices Advisory Committee (HICPAC) has recommended that Health Care Worker influenza vaccination coverage be used as a health-care quality measure in those states that mandate public reporting of health-care-associated infections. The FY09 Flu Kit contains detailed instructions on benefits and effective development of influenza campaigns.

VHA established target influenza vaccination goal of 80% penetration by the end of FY11. VHA exceeded the target for FY08 with 65% of VHA employees vaccinated against seasonal influenza.

DEFINE: Facilities shall develop a systematic, sustained campaign on seasonal influenza vaccination to achieve a 80% penetration rate for employees by the end of FY11. For FY09, acceptable penetration (vaccination prevalence) levels for employees are 68% met and exceeds 73%.

RESOURCES:

Joint Commission Standards: IC 4.15 Immunization against influenza is offered to all staff and licensed independent practitioners.

http://vaww.ogp.med.va.gov/ogp_services/accreditation/uploads/JCAHO2007/Manuals/Apr%20HAP2007.pdf

MMWR July 13, 2007 / Vol. 56 / No. RR-6. Prevention and control of Influenza. Recommendations of the Advisory Committee on Immunization Practices (ACIP) 2007.

<http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5606a1.htm>

GOAL: VISNs shall develop a systematic, sustained campaign on influenza vaccination to achieve 80% penetration by the end of FY11. For FY09, acceptable penetration (vaccination prevalence) levels for employees are 65% met and exceeds 70%.

DATA SOURCE: Occupational Health staff will develop a method for tracking employee, volunteer and others who are vaccinated against seasonal influenza.

ACTION- By the end of Quarter 3, FY09:

1. Facilities will submit a report on the number of employees, volunteers and other personnel who were vaccinated against influenza during the 2008-2009 season utilizing the spreadsheet below to their VISN.
2. VISNs will submit facility level information, aggregated by VISN, using the attached document to Pamela Hirsch.
3. Calculation of vaccination rates will be done by Pamela Hirsch utilizing data from the VSSC Employee Report.

TARGETS - Quarter 3:

Employee vaccination rate of **68%** will be considered "met" and 73% "exceeded". Volunteers and other personnel e.g. academic affiliates, residents, students, agency personnel, contractors, and others

working on site etc. will not be included in calculating the vaccination rate for the performance monitor, but number of those individuals vaccinated must be reported.



- Embedded Document

CONTACT: Questions or requests for additional information may be directed to Pamela Hirsch @ Pamela.Hirsch@va.gov or 202- 461-8493

2. **Safe Patient Movement and Handling** *(NEW)*

VHA is currently rolling out a Safe Patient Handling Program with a likely overall cost of \$205,000,000; the first \$61,000,000 were released to the field in June 2008. A roll-out conference occurred in September 2008 to support implementation. Critical milestones and steps will be maintained and tracked on the 10NC Share-Point site: https://vaww.portal.vhaco.va.gov/sites/dushom/10NC/Safe_Patient_Movement_Handling_Monitor/Forms/AllItems.aspx.

The milestones and steps include a detailed equipment inventory and facility risk assessment to guide equipment selection and construction funds needs. Facility champions were identified in August 2008, and funding for a 0.5 FTE is included in the FY2009 budget. In addition to the equipment selection, they will also coordinate other elements, such as the development of an injury prevention program/ peer leaders on each unit, equipment maintenance and storage, and implementation in nursing practices and an appropriate strategic plan. The timing of these latter steps will depend on equipment availability, construction, and other local factors. Critical elements of this plan must be reported to 10NC on a Share-Point site. Field visits will occur twice per year to one hospital in each VISN to conduct on-site reviews

Separate from the performance monitor, VHA has tasked the VISN 8 Patient Safety Center of Inquiry to evaluate the formal program rollout. A baseline set of data collection instruments (Activation Survey, Milestone Questionnaire, and the Program Status Report) and quarterly summaries (Milestone Questionnaire and the Program Status Report) will go to each facility champion to determine the status of implementation.

GOAL: The Veterans Health Administration is implementing a system-wide Safe Patient Handling Program. Each station must have a facility champion leading implementation of the Safe Patient Handling program that will provide detailed reports on implementation at their facility to their VISN Quality Manager for tracking.

ACTION:

- Each facility shall appoint a champion to manage the program
- Each quarter facility champions will report progress on the planned steps outlined in the attached spread sheet mounted to the VISN Quality Manager for entry on the 10NC Share-Point site.
- Each quarter facility champions will complete the program evaluation instruments from the VISN 8 Patient Safety Center of Inquiry.

TARGETS: Facilities who submit all required data identified on the attachment according to the dates identified will have "met" the performance monitor. Ongoing funding for the Safe Patient Handling program is dependent on meeting project milestones

REPORTING: The Safe Patient Handling Program will provide quarterly findings for the DUSHOM Profile



Embedded Document: Reporting Sheet for Safe Patient Movement and Handling

SPH Perf
Monitors_MM_9-29.xls

DATA SOURCE: Quarterly queries through 10N to Facility Champions

CONTACT: Questions or requests for additional information may be directed to Kevin Grant at Kevin.grant2@va.gov or 202-461-8495.

3. Workers Compensation Job Offers Performance (NEW)

BACKGROUND:

Workers' Compensation costs for VHA were about \$165 Million for Chargeback Year 2008. In response to an OIG mandate, VA has been conducting a systematic Workers' Compensation Case Review, as agreed upon across Administrations. This review of all cases is now expanded to all cases that generate chargeback costs beyond 2005 to include cases through 2008. It relies on the VHA copy of the Workers' Compensation file. The records held at the OWCP District Offices are not included. Results of each individual case review are entered into the Workers' Compensation Management Information System (WCMIS) in the case review screens. The goal of the case review is to identify work capacity where it exists and to extend meaningful job offers to those claimants who could return to gainful employment.

Although the date of next review is completed for the majority of CB2005 cases, many of the pertinent fields remain empty. In the absence of adequate documentation, i.e., completion of the date of return to work, VHA is unable to determine whether claimants have really returned to work. VHA will use these data to work with DOL on customer service standards. Where no recent (one to three years) documentation of work capacity exists in the VA record, facilities will document their current information request by date to the Department of Labor, with the first date representing a written request to the claims examiner, a second date (from a higher-level request) to the senior (supervisory) claims examiner, and a third request through the VISN coordinator that this be elevated to the OWCP District Director.

Data are accessible through WCMIS, and those reports will identify work capacity and job offers on a chargeback (Chargeback Year is July 1 through June 30) year quarterly basis including and up through CB 2008.

ACTION: Claimants in a PR and PN status on the Periodic Rolls through Chargeback Year 2008 are included in this monitor. Where work capacity is documented in the record, the facility shall extend meaningful job offers. Facilities shall enter the date of the job offer, the date of the employee's response, and the actual date of return to work.

Satisfactory is considered **50%**, while **60%** is considered exceptional.

CONTACT: Eileen Coyne, National Workers' Compensation Program Manager at 512-326-6557.

4. Timely Submission of Workers' Compensation Requests to Department of Labor

Over the last six years, VHA has committed substantial resources to developing an infrastructure to eliminate, or at least minimize, frequency and cost of injuries. The Safety Programs in VHA report to the Office of the Deputy Under Secretary for Health for Operations and Management (10N) to provide senior management support to the program and performance monitors on critical items ensure top management, and in-house data systems support injury tracking and compliance assurance. These actions have led to unprecedented improvement, a successful alliance with OSHA, and markedly improved employee safety and health status.

In parallel, VHA is mandated by the Department of Labor and the White House to improve the timeliness of claims filing, defined as submitting lost time workers compensation claims. The Federal Employees' Compensation Act requires workers' compensation forms (CA-1s and CA-2s) be submitted to the Department of Labor within 14 calendar (10 work days) after an employee submits these forms to his/her

supervisor. Facilities that use VHA's in-house injury reporting and management system (ASISTS) have achieved on average in excess of 85% timeliness, with some facilities achieving over a 95% compliance with the two-week criterion.

DEFINE: Timely submission of Workers' Compensation claims is an important measure of the effectiveness of the Workers' Compensation and safety program at VHA facilities. The Department of Labor has identified 90% timeliness as part of its SHARE (Safety, Health, and Return to Employment) initiative. Claims for work-related injuries and illnesses must be submitted within 10 days of an employee's notice to file such a claim

ACTION: Facilities shall submit claims for work-related injury (CA-1) electronically through ASISTS to meet the Federal timeliness mandates.

DATA SOURCE: Timeliness of submissions will be monitored through the WC/MIS System at the Austin Automation System.

TARGETS: A 95% submission within 10 business days will be deemed "met".

REPORTS: The VHA National Worker's Compensation Office will submit a roll-up report **quarterly** for the DUSHOM.

CONTACT: Eileen Coyne @ Eileen.Coyne@va.gov or 512-326-6557.

DOMAIN: AREAS OF SPECIAL EMPHASIS

1. Post-Deployment Screening – OEF/OIF:

Screening for alcohol abuse, depression, PTSD and other illnesses after recent deployment is critical for returning OEF/OIF Veterans.

TARGET: FY 2009: Met = 95% and Exceeds = 98% The targets were derived from a sample survey of the completion of this screening performed in August 2008 evaluating overall completion rates for this reminder at a set of test sites. There were a considerable number of facilities that have already achieved the 98% rate. Screening for alcohol abuse, depression, PTSD and other illnesses after recent deployment is critical for these returning Veterans

DEFINITIONS:

- *Numerator:* Patients as described above who have had the OEF/OIF Post-Deployment Screening reminder completed more recently than the last service separation date.
- *Denominator:* Patients with a last service separation date of later than 9/11/01 who do not have an entry of NO IRAQ/AFGHAN service and who have had at least one visit in the past year and 2 visits since service separation to a clinic with a stop code as defined in the location list VA-NEXUS CLINICS WITH OEF/OIF EXCLUSIONS which is similar but not identical to the NEXUS clinic definition. Patient with severe cognitive impairment are removed from the denominator.

Patients who refuse alcohol, PTSD or depression screening will have to be re-screened using the individual reminders for these screenings if the refusal is over a year old and the patient is seen again in a designated clinic.

(Note: per the instructions which have been updated from FY08, please enter the number of patients not screened (a.k.a. "Due") into the DUSHOM report, matching the data returned by the reminders-due report. Denominator is the applicable number. The number of total patients that the report was run on will

be the number of unique patients seen at the facility in the past 1 year. The numerator as defined above is the Applicable patient minus the Due patients).

DATA SOURCE: Sites will need to run a Clinical Reminder report each month in order to generate the data that will be used for this report until such time that a national reminder extract is available for this purpose Report (facility level) monthly data on the 10NC Share Point Web Link (below).

REPORTING: Facility level data will be reported **Monthly (10th)** on 10NC Share Point Web Link:

<https://vaww.portal.vhaco.va.gov/sites/dushom/10NC/default.aspx>

CONTACTS: Technical: Bryan Volpp, MD @ 925-370-4169 or Bryan.Volpp@va.gov
Clinical: Dr. Kenneth Hyams @ 202- 273-8579 or Dr. Laurent Lehmann 202-461-7364



Embedded Document – Monitor Instructions

2. Vehicle Fleet Management (NEW)

Order 13423 of January 26, 2007, requires the measure to be implemented in accordance with policy. Reduction in petroleum costs makes additional funds available for other activities that can positively influence patient care.

GOALS:

- a. VISN's will ensure reduction of total consumption of petroleum products by 2 percent annually for vehicle fleets.
- b. Federal Automotive Statistical Tool (FAST); Comprehensive Automobile Reporting System (CARS)

ACTION:

- a. Vehicle fleet managers within the VISN must enter vehicle fleet data into FAST, and VISN vehicle fleet coordinators must validate the completeness and accuracy of the data submitted.
- b. Through effective leadership and enforcement of existing policies and the implementation of strong vehicle fleet management practices (such as proper utilization) consonant with the vehicle fleet management guidebook. In addition, VISNs should review the Alternate Fueling Plans submitted during FY 2007 and 2008, and acquire alternate fuel vehicles as appropriate.
- c. FAST opens October 1st for entry of prior fiscal year vehicle fleet data. Each vehicle fleet within the VISN must enter the following data into FAST:
 - i. Vehicle inventory by vehicle type
 - ii. Vehicle Acquisitions and Disposals
 - iii. Operating Cost and Mileage by vehicle type
 - iv. Fuel Cost and Quantity by fuel type

DATA SOURCES:

- a. Comprehensive Automobile Reporting System (CARS): Federal Automotive Statistical Tool (FAST)
- b. Vehicle Fleet managers at the medical center and VISN level as well as vehicle operators and vehicle operator supervisors at all levels

- c. FAST can be found at the following address: <https://fastweb.inel.gov/index.shtml> CARS can be found at the following address: http://vaww.ceosh.med.va.gov/facility_engineering/cars.shtml
- d. Recorded and documented on a monthly basis in CARS and reported annually in the FAST database
- e. FAST and CARS, see item 6.c. for web links

DEFINITIONS:

- o *Numerator:* Annual total consumption of petroleum products (VA owned and commercially leased vehicles) in FY 2008 less the annual total consumption of petroleum products (VA owned and commercially leased vehicles) in FY 2009.
- o *Denominator:* Annual total consumption of petroleum products (VA owned and commercially leased vehicles) in FY 2008.

TARGETS:

Fully Successful: VISN reduces total consumption of petroleum products by a minimum of 2 percent and Medical Centers who submit all required data in FAST according to the dates identified by 10NB will have “met” this portion of the performance monitor

REPORTING:

By utilizing CARS, each VISN will determine its petroleum consumption for VA owned and commercially leased vehicles in FY09 and submit a report to 10NB by 10/30/09 indicating the percentage reduction from previous fiscal year consumption.

By utilizing FAST, 10NB will generate a completion status report at the end of FY08 FAST open season.

Quarterly reports will be prepared by the VACO Office of Healthcare Engineering with findings shared with VISNs and the DUSHOM to be entered into the Web Profile.

CONTACT: John D. Stenger @ 202.266.4604

3. Energy/Sustainability *(NEW)*

These reductions in energy consumption are required by the Energy Independence and Security Act (EISA) of 2007. Reduction in energy and utility costs makes additional funds available for other activities that can positively influence patient care

GOAL: VISNs will reduce annual energy usage by 3% annually through the end of fiscal year 2015 relative to baseline for fiscal year 2003. There will be a measureable reduction in energy consumption reported in VSSC Database of at least 3% for FY 2009 over FY 2008.

ACTION:

- a. Medical Center Energy Managers/Engineers are responsible to enter energy consumption data into the VSSC Database. VISN Energy Managers/Engineers are responsible to verify and validate the data entered.
- b. Through effective leadership and enforcement of existing policies and the implementation of strong energy management practices by Medical Center and VISN Leaders.
- c. Medical Center energy consumption data is required to be entered into the VSSC database on a quarterly basis.

DATA SOURCE:

- a. VISN Service Support Center (VSSC) Database Facility and VISN Energy Engineers
- b. The VSSC database can be found at this link: <http://vssc.med.va.gov/>
- c. Recorded and documented on a monthly basis and reported quarterly in the VSSC database
- d. VSSC Database at <http://vssc.med.va.gov/>

DEFINITION:

- o *Numerator:* Annual total consumption of energy (BTUs/1000 sf) in FY 2008 less the annual total consumption of energy (BTUs/1000 sf) in FY 2009.
- o *Denominator:* Annual total consumption of energy (BTUs/1000 sf) in FY 2008.

TARGETS:

Fully Successful: VISN reduces total energy consumption by a minimum of 3 percent

REPORTING:

The VSSC will generate and submit to 10 NB quarterly roll up reports by VISN showing progress in meeting this monitor by the last business day of the month following the close of each quarter. In addition, an annual summary report for VHA will be submitted to 10NB by 10/30/2009.

Quarterly reports will be prepared by the VACO Office of Healthcare Engineering with findings shared with VISNs and the DUSHOM to be entered into the Web Profile.

CONTACT: John D. Stenger @ 202.266.4604