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in the 21st Century

# VHA Facility Quality and Safety Report Fiscal Year 2012 Data

Department of Veterans Affairs  
Veterans Health Administration  
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## Executive Summary

The Veterans Health Administration (VHA) is committed to providing the highest quality and safest health care for Veterans, and to being unmatched among health care systems in its transparency to Veterans and the American people about its performance. VHA has established an unparalleled array of programs to measure, analyze, improve, and report on all aspects of health care quality and safety. This report of VHA's quality and safety data presents information related to the care provided in outpatient and hospital settings for Fiscal Year (FY) 2012. This information has been compiled from multiple sources throughout VHA, and provides information for all the six domains that the Institute of Medicine established for defining quality in health care: Effective, Equitable, Safe, Timely, Patient-Centered, and Efficient.

Highlights of the report include the following:

### *Section 1: Services, Utilization, Staffing and Accreditation:*

- We provide new information about the availability and utilization of urgent care, domiciliary care; outpatient visits in both primary and specialty care; cardiac catheterizations; Community Living Centers (CLC) Average Daily Census and Unique Residents; and CLC services for both short stay and long stay residents.
- All VA medical centers have achieved full accreditation from The Joint Commission, and, based on performance in 2012, 32 have been recognized as Joint Commission Top Performers. This program recognizes Joint Commission-accredited hospitals for a significant achievement in accountability and performance measures.

### *Section 2: Effective Care Measures*

- In 2011 and 2012, VHA out-performed the private sector on several widely accepted measures of effective and safe care.
- VHA has established Patient Aligned Care Teams (PACTs) at all sites of care and the number of Veterans seen in VHA primary care settings has increased by over 8% since 2010. Despite increased service volume and patient load, access to primary care has improved and continuity is even better than before.
- Coincident with implementation of better care coordination and follow-up contact within 2 days after hospital discharge, VA is seeing fewer Veteran admissions to the hospital. These early findings suggest PACT is having a positive impact.

### *Section 3: Equitable Care*

- VHA is singular in examining all quality metrics by gender. Women Veterans seen in VA are more likely to obtain effective care than in the private sector, based on both gender-specific measures (e.g., screening for cervical and breast cancer) and gender-neutral measures (e.g., management of hypertension and diabetes, treatment of elevated cholesterol, and screening for colorectal cancer). Overall, men and women Veterans receive similar technical quality of care, and gaps between men and women Veterans in the management of cardiovascular risk factors such as elevated cholesterol have been narrowing.

- Comparisons of the quality of outpatient care for different age groups indicate that Veterans aged 65 or older receive slightly higher levels of recommended services than Veterans younger than 65, particularly for preventive health services.
- Measures of technical quality are comparable for rural and urban Veterans across the vast majority of Veterans Integrated Service Networks. There are few differences in patient experience among rural and urban Veterans regardless of where they reside.

#### *Section 4: Safe Care*

- This expanded section includes Health Care Associated Infections (HAI) including Ventilator Associated Pneumonia (VAP), Central Line Associated Bacteremia (CLAB), and Methicillin-resistant Staphylococcus aureus (MRSA), as well as non-infectious complications such as insulin-induced hypoglycemia, risk-adjusted length of stay in the Intensive Care Unit (ICU) and Hospital-Acquired Pressure Ulcer (HAPU).
- Standardized national reporting of health care complications is not in place across the U.S., so overall comparisons between VHA and private sector hospitals are not made. Additionally, facility-specific rates are often based on small denominators, so even a few events can lead to a high rate which is subject to a large margin of statistical error.
- Overall VA rates of VAP and CLAB compare favorably with rates of events voluntarily reported to the National Health Safety Network (NHSN). Additionally, between 2007 and 2012, rates of MRSA HAIs decreased 72 percent in ICUs and 66 percent in the non-ICU settings.

#### *Section 5: Timely Care*

This section reports percent of new and established primary care and specialty care appointments completed within 14 days of desired date. Subsequent year reports will report a new, more stringent standard that was found to be more reliable and better correlated with patient experience.

#### *Section 6: Patient Centered Domain Metrics*

- Patients at VA facilities reported comparable satisfaction with VA services to those in non-VA facilities and were even more likely to recommend treatment at a VA facility than those treated at non-VA facilities.

#### *Section 7: Efficient Care*

- VHA monitors rates of hospitalization for Ambulatory Care Sensitive Conditions (ACSCs) such as pneumonia and heart failure in order to track the effectiveness of primary care. ACSC's are defined as medical problems that are potentially preventable if appropriate care is provided outside of a hospital. Studies show that effective primary care is associated with fewer ACSC-related hospitalizations, and that more effective primary care ultimately leads to lower health care costs. For this reason, VHA tracks the rate of ACSC hospitalizations as an indicator of Efficient Care.

## Introduction

VHA is the largest integrated health care system in the United States (U.S.). In FY 2012, VHA delivered clinical services to approximately 6 million Veterans out of 8.8 million enrolled Veterans with a budget of \$53.9 billion, according to the President's FY 2012 Budget Submission. VHA operated a wide range of facilities and programs including 152 hospitals, 821 community based outpatient clinics. This report summarizes performance data for clinical quality and patient safety for all VA medical facilities. Where two or more hospital divisions operate as an integrated health care system under a single leadership team, those facilities are combined, resulting in a total of 141 separate facilities listed in this report.<sup>1</sup>

Facilities are categorized according to complexity level which is determined on the basis of the characteristics of the patient population, clinical services offered, educational and research missions and administrative complexity. Facilities are classified into three levels with Level 1 representing the most complex facilities, Level 2 moderately complex facilities, and Level 3 the least complex facilities. Level 1 is further subdivided into categories 1a - 1c.

*Facilities are categorized according to complexity level, which is determined on the basis of the characteristics of the patient population, clinical services offered, educational and research missions and administrative complexity.*

The first section of the report describes the infrastructure of VHA facilities and locally available services across the continuum of Veteran care needs.

The next six sections are organized around the Institute of Medicine's (IOM) six dimensions defining health care quality. According to the IOM,<sup>2</sup> health care should be:

- *Effective*—providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit (avoiding underuse and overuse).
- *Equitable*—providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

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<sup>1</sup> The following hospitals are reported with their parent facility [designated in brackets]: Brockton/West Roxbury [VA Boston Health Care System (HCS)], Castle Point [VA Hudson Valley HCS], Lincoln [Nebraska/Western Iowa HCS], Lyons [VA New Jersey HCS], Miles City [VA Montana HCS], Murfreesboro [VA Tennessee Valley HCS], Sepulveda [VA Greater Los Angeles HCS], Tuskegee [Central Alabama Veterans HCS], Leavenworth [VA Eastern Kansas HCS], Los Angeles OPC [VA Greater Los Angeles HCS], Grand Island [Nebraska/W. Iowa HCS], Lake City [N. Florida/ S. Georgia HCS], and Knoxville [VA Central Iowa HCS]. The Manila VAMC reports no quality data.

<sup>2</sup> Institute of Medicine. *Crossing the Quality Chasm*. National Academy Press: Washington, DC, 2001.

- *Safe*—avoiding injuries to patients from the care that is intended to help them.
- *Timely*—reducing waits and sometimes harmful delays for both those who receive and those who give care.
- *Patient-Centered*—providing care that is respectful of and responsive to individual patient preferences, needs, and values; and ensuring that patient values guide all clinical decisions.
- *Efficient*—avoiding waste of equipment, supplies, ideas, and energy.

## Part 1. VHA Facility Quality and Safety Data

Part 1 references the data tables displayed in Part 3 of this report. The data are organized by data elements defined in columns and facilities defined in rows. The columns referenced in this narrative correspond to the data elements found in the data tables.

### **Section 1: Services, Staffing, Treatment Volumes and Accreditation**

#### **Services Available in VA Facilities:**

Eighty-nine percent of VHA facilities provide in-house acute medical and surgical services, and 80 percent provide acute inpatient psychiatric services. Eighty-two percent (114 of 139) have intensive care units (ICU), 83 percent have emergency departments, and 83 percent have CLCs, formerly designated as Nursing Home Care Units (NHCUs).<sup>3</sup>

*Eighty-nine percent of VHA facilities provide in-house acute medical and surgical services, and 80 percent provide acute inpatient psychiatric services. Eighty-two percent have intensive care units, 83 percent have emergency departments and 83 percent have Community Living Centers.<sup>4</sup>*

In 2004, Public Law (P.L.) 108-422 and P. L. 108-447 directed VA to establish specialized interdisciplinary rehabilitation programs to handle the complex medical, psychological, rehabilitation, and prosthetic needs of Veterans with complex trauma associated with combat injury. The changing nature of combat (e.g., increased prevalence of blast-related as opposed to gunshot-related injury) as well as improved battlefield casualty care has resulted in a growing proportion of

Veterans who have polytrauma, a combination of injuries that include brain injury, limb loss, impaired vision, hearing loss, and psychological sequelae, including post-traumatic stress injury. VA implemented the requirements of these public laws by developing a Polytrauma System of Care (PSC) for severely injured Veterans. The components of the PSC include:

- Five regional Polytrauma/Traumatic Brain Injury (TBI) Rehabilitation Centers (PRC) provide acute comprehensive medical and rehabilitation care for complex and severe polytraumatic injuries. They maintain a full staff of dedicated rehabilitation professionals and consultants from other specialties related to polytrauma. The PRCs serve as resources for other facilities in the PSC, develop research and educational programs and provide system-wide consultation to assist implementation of best practice models of care.
- The 21 Polytrauma Rehabilitation Network Sites (PNS) have dedicated interdisciplinary teams to manage the post-acute sequelae of polytrauma and to coordinate life-long rehabilitation services for patients within each Veterans Integrated Service Network

<sup>3</sup> VA provides institutional long-term care services through three mechanisms: 134 VA owned and operated Community Living Centers (CLC), services purchased under contract with over 2,500 Community Nursing Homes, and 122 State Veterans Homes located in 48 states and Puerto Rico.

(VISN). These sites provide a high level of expert care, a full range of clinical and ancillary services, and serve as resources for other facilities within their network which manage Veterans with severe and lasting injuries that return to their VISN area.

- The 87 Polytrauma Support Clinic Teams (PSCT) are local teams of providers with rehabilitation expertise that deliver follow up services in consultation with regional and network specialists. They assist in management of stable polytrauma sequelae through direct care, consultation, and the use of tele-rehabilitation technologies, as needed. The PSCT also provides second-level comprehensive evaluation of patients who screen positive for possible TBI.
- The remaining 39 VA facilities that do not have the necessary services to provide specialized care have a designated Polytrauma Point of Contact (PPOC) who is knowledgeable about the PSC, and ensures that patients are referred to a facility capable of providing the level of services required. They commonly refer to the PNS and PSCT within their VISN, and may also utilize fee-basis contracting to local civilian rehabilitation resources.

***Up from the previous year, nine more VA facilities that do not have services to provide specialized care now have a designated Polytrauma Point of Contact (PPOC).***

## Utilization of Health Care Services

***In FY 2012, VA provided health care services to 5,911,885 unique patients.***

***Unique Patients:*** This is the total number of unique patients at the national or facility level who received care from VA in a VA or Non-VA setting (VA Care, Non-VA Care, Home Dialysis, Observation Beds, and Pharmacy Only file sources) during FY 2012. In FY 2012, VA

provided health care services to 5,911,885 unique patients. Please note that the numbers of unique patients in this section is based upon care provided in a VA or Non VA setting (VA Care, Non-VA Care, Home Dialysis, Observation Beds, and Pharmacy Only file sources).

***Acute Inpatient: Medical/Surgical.*** VA had a total of 492,506 Acute Inpatient Medical/Surgical hospital discharges in FY 2012 with an average system-wide length of stay of 5.2 days. The rate of discharges per 1,000 facility unique patients was 83.3 and the rate of bed days of care per 1,000 unique patients was 433.7.

***Acute Inpatient: Mental Health.*** VA had a total of 87,124 Acute Inpatient Psychiatry hospital discharges in FY 2012 with an average system-wide length of stay of 9.0 days. The rate of discharges per 1,000 unique patients was 14.7 and the rate of bed days of care per 1,000 unique patients was 124.7.

***Outpatient Visits:*** VA had a total of 12,680,472 primary care outpatient visits and 37,926,203 specialty care outpatient visits in FY 2012.

*Medical Procedures:* In FY 2012, VA performed 453,295 outpatient endoscopy procedures in-house. Of the 5 endoscopy procedure types reported, 51 percent (234,265) were colonoscopies, 26 percent (113,853) upper GI procedures, 17 percent (79,383) ENT endoscopies, three percent (12,587) sigmoidoscopies and three percent (11,744) bronchoscopies. Facilities using the VA Cardiovascular Assessment, Reporting and Tracking System for Cardiac Catheterization Laboratories (CART-CL)<sup>4</sup> reported a total of 40,031 coronary angiographies and 13,207 percutaneous coronary interventions.

*In-house Radiology:* In FY 2012, VA performed 1,289,231 CT, 562,500 MRI, and 159,153 Mammography procedures in-house. It should be noted that VA outsources the great majority of our Mammography; the reported figures reflect only procedures done within VA facilities.

## **Community Living Centers (CLC)**

VA operates 134 CLCs. All CLCs must be fully accredited by The Joint Commission (TJC). VA's CLC program includes an array of short-stay and long-stay services for Veterans who are medically and psychiatrically stable and require the unique services provided in this setting. Additionally, the primary type of service (reason for admission), anticipated length of stay, and anticipated discharge destination must be documented. It is VA policy that CLC admissions must be categorized into short-stay services or long-stay services, placed in the appropriate treating specialty.

These service categories and treating specialty codes are:

- (1) Short Stay (90 days or less)
  - (a) Rehabilitation (64)
  - (b) Skilled Nursing (95)
  - (c) Restorative Care (66)
  - (d) Continuing Care (67)
  - (e) Mental Health Recovery (68)
  - (f) Dementia Care (69)
  - (g) Geriatric Evaluation and Management (GEM) (81)
  - (h) Hospice (may exceed 90 days) (96)
  - (i) Respite Care (47)
- (2) Long Stay (91 days or more)
  - (a) Dementia Care (42)
  - (b) Continuing Care (44)
  - (c) Mental Health Recovery (45)
  - (d) Spinal Cord Injury and Disorders (46)

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<sup>4</sup> [www.hsrd.research.va.gov/for\\_managers/stories/cart-cl.cfm](http://www.hsrd.research.va.gov/for_managers/stories/cart-cl.cfm) In FY 2012, all VA cardiac catheterization laboratories had implemented CART-CL.

## Hospital Accreditation Status

*Thirty-two VA medical centers from across the nation were recently recognized as “top performers” by The Joint Commission.*

The Joint Commission (TJC): In 2012, VA required that all VA hospital and ambulatory care facilities utilized for the diagnosis, treatment and prevention of disease in patients meet or exceed the standards of TJC. The formal review and accreditation process by TJC demonstrates that VA medical facilities are committed to quality and performance improvement.

All VA facilities undergo a triennial onsite survey that includes hospital, ambulatory, CLCs, home care and behavioral health programs. The onsite inspection examines all processes and outcomes of the medical care delivery system to include, but not limited to:

- Environment of Care
- Emergency Management
- Human Resources
- Infection Prevention and Control
- Information Management
- Leadership
- Life Safety
- Medication Management
- Medical Staff
- National Patient Safety Goals
- Nursing
- Provision of Care, Treatment and Services
- Performance Improvement
- Record of Care, Treatment, and Services
- Rights and Responsibility of the Individual
- Transplant Safety
- Waived Testing

*All VA hospital and ambulatory care facilities were fully accredited by the Joint Commission. In addition, rehabilitation programs are accredited by the Commission on Accreditation of Rehabilitation Facilities.*

In 2012, all VA hospital and ambulatory care facilities were fully accredited by TJC.

Commission on Accreditation of Rehabilitation Facilities (CARF): VA is committed to providing specialized treatment and quality rehabilitation care to Veterans with disabilities. These populations include Veterans with spinal cord injuries and disorders (SCI/D), blindness or severely visually impaired, TBI, amputation, serious mental illnesses, and those who are homeless. This commitment is supported through a system-wide, long-term joint collaboration with CARF to achieve and maintain national accreditation for all appropriate VA rehabilitation programs. All VA facilities that applied for CARF accreditation in 2012 have achieved CARF accreditation. The VA facilities listed in this report had their rehabilitation programs accredited by CARF as applicable.

Accreditation Program for VA Clinical Laboratories: VA requires that all laboratory testing performed at VHA medical laboratories, both within medical centers or community based laboratories, utilized for the diagnosis, treatment and prevention of disease in patients, meet or

exceed the requirements of the Clinical Laboratory Improvement Amendments (CLIA) of 1988. All laboratory testing, regardless of location, is subject to onsite inspection and accreditation by a nationally recognized accreditation body, such as the College of American Pathologists (CAP), the Commission on Office Laboratory Accreditation (COLA), or TJC. These accrediting bodies perform a comprehensive review which involves a biennial onsite examination of processes and outcomes of medical laboratory operations including:

- Patient Test Management
- Leadership
- Personnel Standards
- Quality Assurance
- Quality Control
- Proficiency Testing
- Safety

### **Medical Center Staffing**

VHA employed 14,201 full-time and 3,133 part-time physicians Full-Time Employee Equivalents (FTEE) in FY 2012. Nationally, there were 2.9 staff physician FTEE per 1,000 unique patients.<sup>5</sup>

Hours Per Patient Day (HPPD) data (also known as NHPPD - Nursing Hours per Patient Day) are an industry standard that measures the average hours of direct nursing care that patients receive per inpatient day. Data in this report are estimates that are derived from employment files and VHA's Decision Support System (DSS) report DSS Nursing Hours / Costs by Ward and Ward Day of Care Report. This report depends upon accurate mapping of labor to specific patient wards. Although comparative data are available from external sources (Labor Management Institute and National Database Nursing Quality Indicators), it is important to note that VHA data includes **all** worked hours mapped to a ward – e.g. both direct and indirect care.

The facility total loss rate reflects any loss, retirement, death, termination, voluntary separation or transfer that removes an employee from the selected facility. This report gives the facility total loss rate for:

- Registered Nurse (occupation code 0610)
- Practical Nurse (LPN) (occupation code 0620)
- Nursing Assistant (occupation code 0621)

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<sup>5</sup> This number excludes medical residents and other trainees, physicians who provide occasional services without compensation, and contracted physicians.

## Section 2: Effective Care Measures

### Inpatient Core Quality Measures (ORYX)

Of the 141 facilities listed in this report, 129 hospitals offer inpatient acute care services and thus report hospital processes of care using The Joint Commission ORYX<sup>®</sup> measures of inpatient quality.<sup>6</sup> Within VHA, there are four applicable core measurement sets: Acute Myocardial Infarction, Congestive Heart Failure (CHF), Community Acquired Pneumonia and the Surgical Care Improvement Project (SCIP).<sup>7</sup> Summary scores in the form of composite metrics are created by combining the individual measures within each core set using the “opportunities model” approach.<sup>8</sup>

- Acute Myocardial Infarction (AMI). The percent of AMI patients:
  - Without aspirin contraindications who received aspirin within 24 hours of arriving at the hospital.
  - Without aspirin contraindications who are prescribed aspirin at hospital discharge.
  - With left ventricular systolic dysfunction and without both Angiotensin Converting Enzyme Inhibitor (ACEI) and Angiotensin Receptor Blocker (ARB) contraindications who are prescribed an ACEI or ARB at hospital discharge.
  - Without beta blocker contraindications who are prescribed a beta blocker at hospital discharge.
  - Receiving thrombolytic therapy during the hospital stay and having a time from hospital arrival to thrombolysis of 30 minutes or less.
  - Receiving primary Percutaneous Coronary Intervention (PCI) during the hospital stay with a time from hospital arrival to PCI of 90 minutes or less.
  - With elevated low-density lipoprotein cholesterol (LDL-C  $\geq$  130 mg/dL or narrative equivalent) who are prescribed a lipid-lowering medication at hospital discharge.
  
- Heart Failure (HF). The percent of HF patients:
  - Discharged home with written discharge instructions or educational material given to patient or caregiver at discharge or during the hospital stay addressing all of the following: activity level, diet, discharge medications, follow-up appointment, weight monitoring, and what to do if symptoms worsen.
  - With documentation in the hospital record that Left Ventricular Function (LVF) was assessed before arrival, during hospitalization, or is planned for after discharge.

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The following facilities do not offer acute care inpatient services: Honolulu, Anchorage, Bedford, Butler, Canandaigua, Manchester, New Orleans, Northampton, St. Cloud, Orlando, Tuscaloosa, Walla Walla, White City, El Paso, and Columbus.

<sup>7</sup> <http://www.jointcommission.org/accreditationprograms/hospitals/oryx/>.

<sup>8</sup> The opportunities model assumes that each Veteran needs and has the opportunity to receive one or more processes of care, but not all Veterans need the same care. Composite measures that use this model summarize the proportion of appropriate care that is delivered. The denominator for an opportunities model composite is the sum of opportunities (across all Veterans) to receive appropriate care across a set of individual process measures. The numerator is the sum of the components of appropriate care that are actually delivered.

- With Left Ventricular Systolic Dysfunction (LVSD) and without both ACEI and ARB contraindications who are prescribed an ACEI or ARB at hospital discharge.
- Pneumonia. The percent of Pneumonia patients:
  - Transferred or admitted to the ICU within 24 hours of hospital arrival, who had blood cultures performed within 24 hours prior to or 24 hours after hospital arrival.
  - Whose initial emergency room blood culture specimen was collected prior to first hospital dose of antibiotics.
  - Who were immunocompetent and received their initial antibiotic during the first 24 hours that is consistent with current guidelines.
  - Who were immunocompetent ICU patients who receive an initial antibiotic regimen during the first 24 hours that is consistent with current guidelines.
  - Who were immunocompetent non-ICU patients who receive an initial antibiotic regimen during the first 24 hours that is consistent with current guidelines.
- Surgical Care Improvement Project (SCIP):
  - Surgical patients who received prophylactic antibiotics within one hour prior to surgical incision.
  - Prophylactic antibiotic selection for surgical patients.
  - Surgical patients whose prophylactic antibiotics were discontinued within 24 hours after surgery end time. (48 hours for CABG and other cardiac surgery)
  - Cardiac surgery patients with controlled blood glucose at 6 a.m. on the morning following surgery.
  - Surgery patients with appropriate hair removal.
  - Surgery patients with peri-operative temperature management.
  - Patients on beta-blocker therapy prior to admission who received a beta-blocker during the peri-operative period.
  - Surgery patients with recommended venous thromboembolism prophylaxis ordered.
  - Surgery patients who received appropriate venous thromboembolism prophylaxis within 24 hours prior to surgery to 24 hours after surgery.
  - Surgery patients with timely removal of urinary catheter

VHA performance on core hospital measures is reported on the Center for Medicare and Medicaid Service's (CMS) Hospital Compare Web site, <http://www.hospitalcompare.hhs.gov/>. The performance of VHA facilities can be compared with that of private hospitals at this site, although results may differ from this report because of differences in reporting period. Additionally, based on measured performance in 2012, 32 VA facilities were recognized as Top Performers by The Joint Commission<sup>9</sup>

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<sup>9</sup> [http://www.jointcommission.org/accreditation/top\\_performers.aspx](http://www.jointcommission.org/accreditation/top_performers.aspx)

### **30 day Risk Adjusted Disease Mortality**

Hospital-specific, risk-standardized rates of mortality within 30 days of discharge are reported for patients hospitalized with a principal diagnosis of heart attack, heart failure, and Pneumonia. For each condition, the risk-standardized (also known as "adjusted" or "risk-adjusted") hospital mortality rates are calculated using mathematical models that use administrative data to adjust for differences in patient characteristics that affect expected mortality rates.<sup>10</sup> With risk adjustment, mortality rates can be used to compare performance among hospitals. The mortality measures for heart attack, heart failure, and Pneumonia have been endorsed by the National Quality Forum (NQF).<sup>11</sup>

### **30 day Risk Adjusted Readmission Rates**

Hospital-specific, risk-standardized rates of readmission within 30 days of discharge are reported for patients hospitalized with a principal diagnosis of heart attack, heart failure, and Pneumonia. For each condition, the risk-standardized hospital readmission rates are calculated using mathematical models that use administrative data to adjust for differences in patient characteristics that affect expected readmission rates. With risk adjustment, readmission rates can be used to compare performance among hospitals.

### **Surgical Quality**

VA's Surgical Quality Improvement Program (VASQIP) monitors major surgical procedures performed at VHA facilities and tracks risk adjusted surgical complications (morbidity) and mortality rates. The following patient data is collected at each facility by a specially trained nurse and entered into the VA's electronic health record: detailed preoperative patient characteristics including chart-abstracted medical conditions, functional status, recent laboratory tests, information about the surgical procedure performed, and 30-day outcomes data. A surgical procedure is classified as major if the health of the patient and the risk of the surgical procedure create any significant morbidity or mortality within 30 days after the surgical procedure.

The VASQIP program analyzes this patient data using mathematical models to predict an individual patient's expected outcome based on the patient's preoperative characteristics and the type and nature of the surgical procedure. Overall patient outcomes for major surgical procedures are expressed by comparing observed rates of mortality and morbidity to the expected rates for those patients undergoing the procedure as observed-to-expected (O/E) ratios. For example, if, based on patient characteristics, a facility expected five deaths following major surgery, but only four patients died, the O/E ratio would be reported as 0.8.

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<sup>10</sup> Ross J, et al. Use of administrative claims models to assess 30 day mortality among Veterans Health Administration hospitals. *Medical Care* 2010; 48: 652-658.

<sup>11</sup> <http://www.qualityforum.org/Home.aspx>

Listed in columns CM and CN are VA medical centers performing more than 400 major surgical procedures in FY 2012 and the associated O/E ratios for morbidity and mortality. As reference for this period, VASQIP analyzed 127,853 major surgical procedures performed at 132 VA medical centers. The overall 30-day unadjusted mortality and morbidity rates were 1.04 percent and 7.45 percent, respectively.

## Outpatient Quality

*Care Composites:* The National Committee on Quality Assurance (NCQA) publishes the Healthcare Effectiveness Data and Information Set (HEDIS), a recognized tool used by the majority of U.S. health plans to measure performance on important evidence-based dimensions of care and service. VHA uses a subset of measures applicable to the VA population from the HEDIS measures, and collects data on performance using a random sample of patient records that are analyzed and abstracted by trained personnel as part of VHA's External Peer Review Program (EPRP). In this section, quality performance is reported by dimensions of care (diabetes; prevention and screening for cancer; cardiovascular care; immunization; and smoking cessation) with composite scores for each dimension calculated using an "opportunities model" approach described previously. Comparisons between facilities using these metrics should be interpreted cautiously as many factors can account for variations in scores such as differences across facilities in Veterans' clinical and socio-economic conditions. In 2011 and 2012, VHA outperformed the private sector on several widely accepted measures of effective care

- Diabetes Mellitus: The percentage of patients 18 to 75 years of age with diabetes (type 1 and type 2) who had each of the following:
  - HbA1c testing.
  - Poorly controlled HbA1c >9.
  - LDL-C screening.
  - LDL-C controlled to less than 100 mg/dL.
  - Patients receiving any retinal screening during the report period, or a documented refusal of a diabetic eye exam.
  - Patients who have received nephropathy screening.
  - Diabetic blood pressure <140/90: the percentage of hypertensive adults ages 18 to 85 whose blood pressure was controlled to or below 140/90 mmHg during the past year. Both systolic and diastolic pressure readings must be at or under this threshold for blood pressure to be considered controlled.
  
- Prevention And Screening For Cancer:
  - Breast Cancer Screening: The percentage of women between 50 and 69 years old who had at least one mammogram in the past two years.
  - Cervical Cancer Screening: The percentage of women aged 21 to 64 enrolled in a health plan that had at least one pap test in the past 3 years.
  - Colorectal Cancer Screening: The percentage of adults 51 to 75 years of age who have had appropriate screening for colorectal cancer.

- Cardiovascular Care:
  - Cholesterol Management: The percentage of patients 18 to 75 years of age with a diagnosis of Ischemic Vascular Disease (IVD) who received LDL-C screening and whose LDL-C concentration was controlled to <100mg/dL.
  - Blood Pressure: The percentage of hypertensive adults ages 18 to 85 whose blood pressure was controlled to less than 140/90 mmHg during the past year. Both systolic and diastolic pressure readings must be at or under this threshold for blood pressure to be considered controlled.
- Immunizations:
  - Influenza: The percentage of adults 50 years of age or older who received an influenza vaccination during the most recent flu season.
- Smoking Cessation Measures:
  - The percentage of current smokers 18 or older who received advice to quit smoking from their practitioner within the past year.
  - The percentage of current smokers 18 or older whose practitioner discussed or recommended smoking cessation medications with them over the past year.
  - The percentage of current smokers 18 or older whose practitioner discussed or recommended smoking cessation methods or strategies with them over the past year.

Table 1.2, External Comparisons, displays comparative system level information about outpatient performance on individual HEDIS metrics. In making comparisons, caution is warranted due to significant differences in the way VHA abstracts clinical data and defines eligible patients. Due to population differences and methodology variations, not all HEDIS measures are comparable to VA measures; therefore, this is not a comprehensive list of indicators, but this comparison does contain those indicators that are closely aligned in content and methodology. 1) VA comparison data are obtained by abstracting medical record data using similar methodologies to matched HEDIS methodologies. 2) HEDIS Data were obtained from the "State of Health Care Quality Report" available on the NCQA Web site: [www.ncqa.org](http://www.ncqa.org). 3) HEDIS is obtained by survey; VA data is obtained by medical record abstraction. 4) Behavioral Risk Factor Surveillance System (BRFSS) reports are available on the CDC Web site: [www.cdc.gov](http://www.cdc.gov). 5) BRFSS survey scores are median scores. VA Scores are averages obtained by medical record abstraction. 6) Data were obtained from Quality Compass, a tool available through NCQA ([www.ncqa.org](http://www.ncqa.org)). 7) HEDIS HMO comparative data are used. 8) Scores calculated by using Electronic Briefing Book (EBB) standards. Scores calculated out to four decimal places, rounded at two, displayed as an integer.

**Table 1.2: External Comparisons: VHA vs. HEDIS 2010-2012**

Clinical Indicator	VA Average Percent <sup>(1)</sup>			HEDIS 2011 <sup>(1)</sup>		
	VA Average Percent 2012 <sup>(6)</sup>	VA Average Percent 2011 <sup>(6)</sup>	VA Average Percent 2010 <sup>(6)</sup>	HEDIS Commercial 2011 <sup>(7)</sup>	HEDIS Medicare 2011 <sup>(7)</sup>	HEDIS Medicaid 2011 <sup>(7)</sup>
Breast Cancer Screening	87	85	87	71	69	50
Cervical Cancer Screening	93	93	94	77	n/a	67
Cholesterol Management for Patients with Cardiovascular Conditions: LDL-C Control (<100 mg/dL)	70	71	69	59	57	42
Cholesterol Management for Patients with Cardiovascular Conditions: LDL-C Screening	96	96	96	88	89	82
Colorectal Cancer Screening	82	82	82	62	60	n/a
Comprehensive Diabetes Care - Blood Pressure Control (<140/90)	80	81	82	66	63	61
Comprehensive Diabetes Care - Eye Exams	90	90	91	57	66	53
Comprehensive Diabetes Care - HbA1c Testing	99	98	99	90	91	83
Comprehensive Diabetes Care - LDL-C Controlled (LDL-C<100 mg/dL)	68	69	70	48	53	35
Comprehensive Diabetes Care - LDL-C Screening	97	97	97	85	88	75
Comprehensive Diabetes Care - Medical Attention for Nephropathy	95	95	96	84	90	78
Comprehensive Diabetes Care - Poor HbA1c Control (8)	19	17	15	28	27	43
Controlling High Blood Pressure - Total	77	78	79	65	64	57
Medical Assistance with Smoking Cessation - Advising Smokers To Quit <sup>3</sup>	96	97	97	77	n/a	76
Medical Assistance with Smoking Cessation - Discussing Medications <sup>3</sup>	94	94	94	53	n/a	44
Medical Assistance with Smoking Cessation - Discussing Strategies <sup>3</sup>	96	97	97	48	n/a	40
Flu Shots for Adults (50-64) <sup>3</sup>	65	65	71	53	n/a	n/a
Flu Shots for Adults (65 and older) <sup>3, 4, 5</sup>	76	79	82	n/a	69	n/a
Immunizations: Pneumococcal <sup>3,4, 5</sup>	93	94	95	n/a	69	n/a

SOURCE: Office of Analytics and Business Intelligence Updated 11/28/2012

**Due to population differences, and methodology variations not all HEDIS measures are comparable to VA measures - therefore this comparison includes only indicators closely aligned in content and methodology to other health plans and systems.**

- 1) VA comparison data is obtained by abstracting medical record data using similar methodologies to matched HEDIS methodologies.
- 2) HEDIS Data was obtained from the 2012 "State of Health Care Quality Report" available on the NCQA Web site: [www.ncqa.org](http://www.ncqa.org)
- 3) HEDIS is obtained by survey, VA is obtained by medical record abstraction
- 4) BRFSS reports are available on the CDC Web site: [www.cdc.gov](http://www.cdc.gov)
- 5) BRFSS (survey) scores are median scores. VA Scores are averages obtained by medical record abstraction
- 6) VA data is provided based on fiscal year. HEDIS and BRFSS data is calendar year.
- 7) Comparison based on HMO data
- 8) Lower is better

## Patient Aligned Care Teams (PACT) Metrics:

Patient Aligned Care Teams (PACT) represent VHA's approach to implementing the Patient-Centered Medical Home (PCMH), a delivery model designed to improve the provision of coordinated and continuous care throughout a Veteran's lifetime<sup>12</sup>. VHA's metrics for PACTs are designed to track progress in achieving three major aspects of team-based, patient-centered care: access, continuity, and coordination of care. Currently, 84% of Veterans using VHA services are assigned to a PACT team.

*PACT patients should expect that when they make an appointment it will be within seven days of when they want or need it, and they will be able to see their own providers the same day. In addition, 20 percent of the time visits can be handled over the phone. Once discharged, someone from the patient's PACT will check on the patient within two days.*

In the interest of fostering a patient-centered approach to care, it is useful to state the measures from the patient's perspective.

PACT patients should expect that:

- They are receiving care from an adequately staffed PACT reflected in the primary care (PC) staffing ratio of 3 support staff per each full time primary care provider.
- They have access to home telehealth technologies that enhance their self- management and interaction with their PACT team. When they make an appointment it will be within seven days of when they want or need it.
- They can see their assigned primary care provider when they wish to be seen today.
- They will see their own primary care provider when they need to see a provider.
- Not all their needs require an individual face-to-face visit and the PACT will work with the patient's preference for alternative care modalities such as group visits, telephonic checks, or secure electronic messaging. If they are discharged from a VA hospital, someone from their PACT will check on them within 2 days of discharge.

The corresponding metrics and targets are:

- PC Staffing Ratio: The number of support staff assigned to a primary care provider regulated by VHA PCMM Handbook 1101.02. (Target 3.0)
- All PC patients seen in 7 days of Desired Date (Target: 92 percent)
- PC patients enrolled in Home Telehealth reflects the number of primary care patients enrolled in Care Coordination Home Telehealth (CCHT) program at the end of the reporting month, based on enrollment data received from the CCHT vendor databases. (Target: 1.6 percent)
- Same-day appointments with the assigned primary care provider (Target: 70 percent)

<sup>12</sup> [http://www.acponline.org/running\\_practice/delivery\\_and\\_payment\\_models/pcmh/](http://www.acponline.org/running_practice/delivery_and_payment_models/pcmh/)

- Continuity with assigned primary care provider (PCP) Percentage of appointments with the assigned PCP vs. appointments with other primary care providers or Emergency Department visits (Target: 77 percent)
- Ratio of Non-Traditional Appointments (shared medical appointments, telephone encounters, and volume of inbound and outbound secure messages) per the assigned panel. (Target: 20 percent)
- Contact by primary care within 2 business days of discharge from a VHA hospital (Target: 75 percent)

VHA level PACT Metric Achievements as of July 2013 reflect substantial progress towards implementing the requirements of continuous, coordinated, patient-centered care:

- PC Staffing Ratio: 3.1 support staff per primary care provider (Target: 3.0)
- PC patients enrolled in Home Telehealth: 1.6 percent (Target: 1.6 percent)
- Ratio of Non-Traditional Encounters: 19.2 percent (Target: 20 percent)
- All patients seen in PC within 7 days of desired date: 91.2 percent (Target: 92 percent)
- Same day appoints with assigned primary care provider ratio: 65.7 percent (Target: 70 percent).
- Continuity with assigned primary care provider: 77.7 percent (Target: 77 percent)
- Contact made 2 days Post-Discharge (VHA discharges): 73.0 percent (Target: 75 percent)

Implementation of the Patient-Centered Medical Home is a multi-year journey, and evidence of its effectiveness in other health care delivery systems has been slow to accumulate.<sup>13</sup> A comprehensive evaluation of VHA PACT effectiveness is currently underway. The table depicted below highlights early achievements from July 2010 to July 2013. Salient findings include:

- Number of Veterans seen in VHA primary care settings has increased by over 8 percent, while provider staff has risen by only 0.4 percent.
- This increased productivity and efficiency of clinical staff has been made possible by increasing support staffing levels.
- Clinical encounters have increased, primarily through non-face to face and group visits.
- Despite increased service volume and patient load, access to primary care has improved and continuity is even better than before.
- As a result of better coordination of care, including a marked increase in follow-up contact within 2 days after hospital discharge, fewer Veterans have the need to use urgent care, and fewer are getting admitted to the hospital.

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<sup>13</sup> Jackson GL et al. The patient centered medical home: a systematic review. *Ann Intern Med* 2013; 158:169-78.

Primary Care Uniques	↑ 8%	PACT patients enrolled in Home Telehealth	↑ 93%
PACT Provider Staff	↑ 0.4%	PACT Group Visits	↑ 74%
PACT Support Staff	↑ 36%	PACT Telephone Visits	↑ 1073%
Average Panel Size	↑ 5%	PACT patients seen on desired date	↑ 13%
Primary Care Capacity	↑ 6%	PACT patients seen within 7 days of desired date	↑ 6%
PACT Encounters per 1000 unique patients	↑ 49%	3rd Next Available Appointment in PACT clinics	↓ 14%
Continuity	↑ 5%	Same day appointments with PCP	↑ 50%
VHA Acute Admissions per 1000 unique PC patients	↓ 12%	Patients contacted within 2 days after discharge	↑ 1150%
VHA ED Visits per 1000 unique PC patients	↑ 5%		
VHA Urgent Care Visits per 1000 unique PC patients	↓ 33%		

### Section 3: Equitable Care

#### Outpatient Composites: Gender

This section compares the outpatient care received by men and women Veterans using HEDIS outpatient composites across VHA facilities. Currently, seven percent of the users of the VHA health care system are women, but this number is projected to grow to eight percent by 2016 and nine percent by 2020.<sup>14</sup> Although the External Peer Review Program (EPRP) uses a special augmented sample of 30,000 women ages 40 to 69 to increase the precision of the estimates of each quality measure, small sample sizes may limit the ability to compare scores for men and women for some VHA sites. Facility results are only reported if there are 100 or more women in the composite denominator.

The quality of care provided to women Veterans has been considerably higher in VA than for care in the private sector, based on both gender-specific measures (e.g., screening for cervical and breast cancer) and for gender-neutral measures (e.g., management of hypertension and diabetes, treatment of elevated cholesterol, and screening for colorectal cancer). These cross-sectional results indicate that men and women generally are receiving similar technical quality of care. Notwithstanding these positive results, there are also some persistent gaps in care that are opportunities for targeted quality improvement. For example, LDL cholesterol control continues to compare less favorably for female Veterans than for male Veterans. However, taking into account the use of moderate dose statins, which lower

<sup>14</sup> VHA Office of Enrollment and Forecasting (2012 EHCPM (By2011) Sep 30, 2012 Enrollment File)

cardiovascular risk regardless of measured LDL-C level, significantly reduces the apparent gender difference in cholesterol control.<sup>15</sup>

VHA continues to pursue opportunities to identify and reduce variation in care delivery and address areas of care and service delivery that impacts the quality of care provided to female Veterans.

### **Outpatient Composites: Age**

This section compares patients age 65 and older to patients age 65 and under on the outpatient HEDIS composites. Comparisons of the quality of outpatient care for different age groups indicates that Veterans aged 65 or older receive slightly higher levels of recommended services than Veterans younger than 65, particularly for preventive health services.

### **Satisfaction with Care by Race/Ethnicity**

This section provides a comparison of patient experiences according to self-reported race/ethnicity. Adjusted facility scores were calculated for Overall Rating of health care and Overall Rating of hospital (see Section 6 for more details on statistical adjustments). Differences were minor and not consistent across networks.

### **Urban vs. Rural (See Tables 1.3 and 1.4)**

The special needs of Veterans who live in rural areas and those Veterans that have to travel further to receive health care are top priorities for VHA. In this section, determination of Urban versus Rural residence was based on the Veteran's reported home address. Urban areas were defined by U.S. Census Bureau as urbanized areas; rural areas are all other areas excluded in U.S. Census Bureau defined as urbanized areas. Clinical data were obtained from EPRP outpatient samples in FY 2012. National and VISN weighted scores were calculated for the outpatient quality of care clinical composites (See Table 1.3). Facility level scores were not calculated because some facilities serve significant numbers of both urban and rural patients, therefore cannot be classified as simply urban or rural. Differences of +/- five points are viewed as clinically significant. No adjustments were made for patient characteristics. Measures of technical quality are comparable for rural and urban Veterans across all Veterans Integrated Service Networks.

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<sup>15</sup> [http://www.womenshealth.va.gov/WOMENSHEALTH/docs/OIA-BRCO\\_GenderHealthCareReport.pdf](http://www.womenshealth.va.gov/WOMENSHEALTH/docs/OIA-BRCO_GenderHealthCareReport.pdf)

**Table 1.3: Outpatient Care Composites in Percentages, Urban vs. Rural**

Populations	Outpatient Care Composites									
	Urban					Rural				
	Diabetes Mellitus	Prevention	Ischemic Heart Dz	Tobacco	Behavioral Health Screening	Diabetes Mellitus	Prevention	Ischemic Heart Dz	Tobacco	Behavioral Health Screening
Column Designator	Pct	Pct	Pct	Pct	Pct	Pct	Pct	Pct	Pct	Pct
<b>National</b>	90	87	84	95	96	90	87	85	96	97
VA New England Health Care System - VISN 1	91	89	87	95	97	90	87	85	96	97
VA Healthcare Network Upstate New York - VISN 2	89	86	84	97	97	90	86	85	99	97
VA NY/NJ Veterans Healthcare Network - VISN 3	90	87	85	97	98	89	86	86	98	96
VA Healthcare - VISN 4	90	86	86	96	97	91	87	87	93	98
VA Capitol Health Care Network - VISN 5	91	87	85	94	96	90	85	87	92	97
VA Mid-Atlantic Health Care Network - VISN 6	88	89	80	95	95	90	89	84	95	97
VA Southeast Network - VISN 7	91	88	84	96	96	91	89	85	97	96
VA Sunshine Healthcare Network - VISN 8	89	87	86	97	96	91	89	86	98	97
VA Mid South Healthcare Network - VISN 9	90	86	82	95	97	89	87	85	93	97
VA Health Care System of Ohio - VISN 10	91	87	85	96	96	92	87	85	97	97
Veterans In Partnership - VISN 11	90	87	84	95	98	91	87	88	95	98
The Great Lakes Health Care System - VISN 12	91	85	87	94	96	89	89	87	97	97
VA Heartland Network - VISN 15	90	88	84	93	96	88	88	83	97	97
South Central VA Health Care Network - VISN 16	90	88	83	96	97	89	88	84	96	97
VA Heart of Texas Health Care Network - VISN 17	89	87	82	93	96	89	88	87	95	96
VA Southwest Health Care Network - VISN 18	89	87	80	93	95	89	86	82	95	97
Rocky Mountain Network - VISN 19	90	89	83	96	96	91	88	82	96	97
Northwest Network - VISN 20	88	88	81	93	97	89	87	81	94	96
Sierra Pacific Network - VISN 21	90	87	83	96	96	91	87	85	95	97
Desert Pacific Healthcare Network - VISN 22	89	85	84	95	96	90	81	85	96	95
VA Midwest Health Care Network - VISN 23	91	89	84	97	97	91	88	86	97	97

**Notes**

Data source: External Peer Review Program (EPRP) outpatient samples in FY 2012; includes ami, women, diabetes oversamples.

Urban/Rural/Highly Rural designation is based on the "geo-coding" of a patient's address. The data is obtained from the Office of the Assistant Deputy Under Secretary for Health for Policy & Planning (ADUSH – 10P1). Urban are areas defined by U.S. Census Bureau as urbanized areas; rural areas are all other areas excluded in U.S. Census Bureau defined as urbanized areas; and highly rural is any rural area within a county with less than 7 civilians per square mile. Rural data includes highly rural.

Scores are weighted.

Diabetes Composite: Diabetes measure HbA1 GT 9 or not done (poor control) in past year (DMG23H) is reversed to reflect higher performance is better.

**Table 1.4: FY 2012 Outpatient SHEP Scores, Urban vs. Rural**

Outpatient Measures	Rural		Urban		Urban-Rural
	N	Score	N	Score	Difference
How Well Doctors/Nurses Communicate	86,505	70	103,528	70	0
Overall Rating of Personal Doctor/Nurse	87,653	72	104,919	72	0
Getting Needed Care	86,023	51	101,882	51	0
Overall Rating of health care	100,856	59	117,134	58	-1
Getting Care Quickly	78,219	49	94,770	49	0
Shared Decision Making (Outpatient)	49,573	61	58,947	61	0
Overall Rating of Specialist	50,513	68	64,573	67	-1

Scores are adjusted for age, education, self-reported health status, gender, race, and facility characteristics

Survey of Healthcare Experiences of Patients (SHEP) outpatient results found in Table 1.4 are based on a case-mix adjustment model that adjusts for differences among facilities in factors known to influence a patient's experience with care including age, education, self-reported health status, and facility characteristics. As a result of this case-mix adjustment, SHEP scores for VISNs and VA facilities can be more fairly compared with each other. However, because private sector facilities do not utilize the same standardized methodology for case-mix adjustment, external comparisons will not be valid.

The outpatient data presented here use "Top-Box" scoring. The "Top-Box" is the most positive response to CAHPS survey questions. The "Top-Box" response is "Always" for five CAHPS composites (How Well Doctors/Nurses Communicate, Getting Needed Care, Getting Care Quickly) and "'9' or '10' (high)" for the three global ratings (Overall Hospital Rating of Health Care, Overall Rating of Personal Doctor/Nurse, Overall Rating of VA Specialist).

Both rural and urban-dwelling Veterans report satisfaction with outpatient care that is equivalent, and the quality of outpatient care remains high regardless of where Veterans reside. There are essentially no meaningful differences (five points or more) at the national or network level in the scores for any of the outpatient CAHPS composites and reporting measures for patients residing in rural or urban areas. However, ratings for Doctor/Nurse Communication and Overall Rating of personal provider favored urban patients in VISN 3, and Shared Decision Making in VISN 8. Overall Rating of health care and Overall Rating of personal provider favored rural patients in VISN 17, and Shared Decision Making in VISN 22.

## **Section 4: Safe Care**

### **Health Care-Associated Infections**

The rates of health care-associated occurrences for Ventilator Associated Pneumonia (VAP), Central Line Associated Bacteremia (CLAB) and Methicillin-resistant *Staphylococcus aureus* (MRSA) in VA hospitals are tracked and reported regularly, as these are costly and potentially preventable complications of hospitalization.

The rates of VAP in VA ranged from 0 to 16.9 per 1,000 days of mechanical ventilation with pooled mean of 1.8 for medical/surgical intensive care units (ICU). We note that facilities at the upper range had a small denominator of ventilator days and a small number of events, making these rate estimates subject to a large margin of statistical error. Fifty-one facilities had no VAP rate during FY 2012.

The rates of CLAB in VA hospitals ranged from zero to 6.2 per 1,000 days of line placement with an overall mean rate of 1.1. Forty-eight facilities had no central line associated bloodstream infections in 2012. By way of comparison, the National Healthcare Safety Network (NHSN) reported that infection rates in 2009 ranged from

zero (10<sup>th</sup> percentile) to 3.8 (90<sup>th</sup> percentile) per 1000 line days with a pooled mean of 1.7.

**Since undertaking a major MRSA Prevention Initiative, rates across VA have fallen by 72 percent in the ICU setting and 66 percent in the non-ICU setting.**

VA undertook large-scale implementation of a MRSA Prevention Initiative which includes active surveillance screening on hospital admission, transfer, and discharge as well as other interventions to reduce the risk of spread of resistant bacteria<sup>16</sup>.

VA reports MRSA health care associated infection (HAI) rates in both ICU and non-ICU acute care settings and assesses rates of compliance with recommended screening practices. From the time of full implementation of the MRSA Initiative in October 2007 through June 2012, monthly rates of MRSA HAIs decreased 72 percent in ICUs and declined 66 percent in the non-ICUs. The mean rates for FY 2012 for ICU MRSA HAIs was 0.37/1,000 bed days of care and for non-ICUs 0.15/1,000 bed days of care. From the beginning of the Initiative, there has been a 37.6 percent increase nationwide in the number of VHA facilities achieving zero MRSA HAIs each month. MRSA HAIs declined 81 percent in the 22 acute care Spinal Cord Injury Units, and MRSA HAIs declined 36 percent in the CLCs nationwide.

## Patient Safety Measures

**ICU Risk Adjusted Length of Stay.** To assist in tracking the appropriate length of treatment in the ICU, VHA calculates an Observed Minus Expected Length of Stay (OMELOS), which is a risk adjusted measure of appropriate ICU utilization that accounts for characteristics of the individual patient such as age, diagnoses, and laboratory values that determine need for more intensive treatment. An OMELOS less than zero indicates that on average, Veterans in that ICU stay for a period that is shorter than what is expected based on their risk, while an OMELOS greater than zero indicates the opposite. Values for OMELOS across the VHA system ranged from -1.90 to 1.42, with a VA overall of -0.01.

**Insulin Induced Hypoglycemia.** The parameters for optimal glucose control have been studied in literature for several years. Recent studies in the critical care population identified severe hypoglycemia (low blood glucose) as a significant risk of intensive glucose control. VA reports the proportion of patient days which include a measured blood glucose concentration <45mg/dl for Veterans receiving hypoglycemic agents. The VA mean for patient day with a glucose <45mg/dl is 1.3.

<sup>16</sup> Jain R, et al. Veterans Affairs Initiative to Prevent Methicillin-resistant Staphylococcus aureus Infections. N Engl J Med 2012; 364:1419-30.

*Hospital Acquired Pressure Ulcers.* Pressure ulcer prevention is an important patient safety goal. VA reports the incidence of hospital acquired pressure ulcers (HAPU) that are Stage II or greater. Stage II pressure ulcers are when the skin breaks open, wears away, or forms an ulcer which may or may not be tender and painful. Even with appropriate medical and nursing care, sometimes pressure ulcers are unavoidable due to patient-specific factors. As a result, some VA facilities with a high proportion of very old or debilitated patients may have higher HAPU rates.

The Institute for Healthcare Improvement (IHI) Mentor Hospital Registry lists HAPU incidence rates ranging from 1.14 percent to 5.07 percent. The VA National Average pressure ulcer incidence rates (as reported in the ASPIRE report) :

FY 12: 2.36

FY 11: 3.09

FY 10: 3.16

When reviewing comparative data, it is important to ensure that the incidence rate is reviewed (many health care facilities use prevalence as a measure for HAPUs).<sup>17</sup>

## **Section 5: Timely Care**

### **Access to Care**

Delivery of primary care is critical to preventative health care and timely disease identification and management. A visit to a primary health care provider is generally also a patient's point of entry for specialty care. As such, timely access to primary health care services is critical to providing high-quality care to Veterans.

Because of VHA's scheduling software design, waiting times cannot be automatically measured or compared to other health care systems. Instead, waiting times rely on information entered by scheduling staff. In FY 2012, VHA measured the percent of new and established primary care and specialty care appointments completed within 14 days of desired date. The desired appointment date is the date recorded by the scheduler that reflects when the patient or provider wants the patient to be seen. Training and audits are used to assure accuracy of the data. VHA managers use these measures and other clinic operational indicators together to understand and to improve clinic function. At the national level, VA drives improvement by identifying high performers and sharing their best practices with others.

It should be noted that, beginning in FY 2013, VHA began reporting separately the percent of new primary care, specialty care, and mental health appointments completed within 14 days of the create date for an appointment. This more stringent standard was selected based on research showing this method was more reliable and better reflected

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<sup>17</sup> [http://www.ihl.org/IHI/Programs/Campaign/mentor\\_registry\\_pu.htm](http://www.ihl.org/IHI/Programs/Campaign/mentor_registry_pu.htm)

patient experience. Subsequent VHA Facility Reports will reflect the new measurement approach.

### **Section 6: Patient-Centered Domain Metrics**

Accurate assessment of Veteran experience requires scientifically valid tools that allow for comparisons across different health providers and systems, including private-sector benchmarks. In 2009, the SHEP program transitioned to questionnaires based on the family of Consumer Assessment of Healthcare Providers and Systems (CAHPS) surveys. The CAHPS family of surveys used by VHA was developed by the Centers for Medicare & Medicaid Services (CMS) and the Agency for Healthcare Research and Quality (AHRQ), and is considered the “industry standard.” VHA administers the mail-only mode of the inpatient and outpatient survey instruments.

**Table 1.5**

Inpatient Composite and Reporting Measures	Outpatient Composite and Reporting Measures
<ul style="list-style-type: none"> <li>• Communication with Nurses</li> <li>• Communication with Doctors</li> <li>• Responsiveness of Hospital Staff</li> <li>• Pain Management</li> <li>• Communication about Medication</li> <li>• Cleanliness of the Hospital Environment</li> <li>• Quietness of the Hospital Environment</li> <li>• Discharge Information</li> <li>• Overall Rating of Hospital</li> <li>• Willingness to recommend Hospital</li> </ul>	<ul style="list-style-type: none"> <li>• How Well Doctors/Nurses Communicate</li> <li>• Overall Rating of Personal Doctor/Nurse</li> <li>• Getting Needed Care</li> <li>• Overall Rating of Health Care</li> <li>• Getting Care Quickly</li> <li>• Overall Rating of VA Specialist</li> <li>• Provider Wait Time 20 minutes or less</li> </ul>

Composites and reporting scores are calculated as the weighted percentages of survey responses. Inpatient results use population weights to reflect the numbers of patients at each facility, bed sections and other categories such as age and gender. Inpatient scores as reported here exclude responses from patients who were hospitalized in psychiatry bed sections, because the CAHPS instrument was not designed for such settings. Outpatient results use scores from all patients seeking outpatient services, and are adjusted using population weights that reflect the numbers of patients at each facility or clinic and other categories such as age.

*Overall, VA inpatient experiences were similar to those reported by CMS on their Hospital Compare website. The only clinically meaningful area was pain management, which may reflect the high prevalence of pain conditions among Veterans.*

The inpatient survey follows the guidelines described in the “HCAHPS Quality Assurance Guidelines” published by CMS for the mail only mode of survey administration. The data presented here use “Top-Box” scoring. The “Top-Box” is the most positive response to HCAHPS survey questions. The “Top-Box” response is “Always” for five

HCAHPS composites (Communication with Nurses, Communication with Doctors, Responsiveness of Hospital Staff, Pain Management, and Communication about Medicines) and two individual items (Cleanliness of Hospital Environment and Quietness of Hospital Environment), "Yes" for the sixth composite, Discharge Information, "'9' or '10' (high)" for the Overall Hospital Rating item, and "Would definitely recommend" for the Recommend the Hospital item.

To ensure that differences in HCAHPS results reflect differences in perceived hospital quality only, HCAHPS survey results were adjusted for factors beyond the control of the facility such as: service line (medical, surgical, or maternity care), categorical age, self-reported education, self-reported health status, language other than English spoken at home, age by service-line interactions, and percentile response order, also known as "relative lag time," which is based on the time between discharge and survey completion. In addition, facility characteristics such as size and nurse turnover rate were also included in the model. It should be noted that the inpatient scores used the same patient-mix adjustment model as adopted by Medicare, which would allow VA hospitals to be directly compared to those private hospitals contributing HCAHPS data to CMS<sup>18</sup>.

### External Comparators

External HCAHPS composite scores for non-VA hospitals are published on the CMS Hospital Compare Web site. Because VA strictly adheres to the HCAHPS survey protocol, valid and fair comparisons are possible after the data are adjusted for patient case-mix (see Methods above) using the CMS-HCAHPS model. Note that the VA scores specially created for external comparison, differ from those scores that are reported and trended internally, because of the lag in CMS reporting (as many as 15 months), and how the adjustment methods are applied.

Table 1.6 reports percentile scores for all VA inpatient hospitals (FY 2012 data) and approximately 9,900 hospitals publically reporting on Hospital Compare for discharges occurring between April 2011 and March 2012. Overall performance across the majority of composite measures is very similar between VA and non-VA hospitals and this pattern holds for all composites. Based on VA 50<sup>th</sup> and 75<sup>th</sup> percentile scores, the most favorable comparisons with non-VA hospitals (higher or similar scores) are for the Overall Rating of Hospital, and for Willingness to Recommend, Cleanliness of Hospital Environment, Communication about Medications, Responsiveness of Hospital staff, and Discharge Information. Less favorable dimensions of care (VA 50<sup>th</sup> and 75<sup>th</sup> percentile scores 4 or more points lower) are for Communication with Doctor, Communication with Nurses, Pain Management, and Quietness of Hospital Environment.

We should note that these comparisons are not adjusted for hospital characteristics such as bed size, teaching status, or complexity of services, and it is well recognized

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<sup>18</sup> See <http://www.medicare.gov/hospitalcompare/search.html?AspxAutoDetectCookieSupport>

that larger, more complex, and highly academic facilities may perform less favorably on these dimensions. Nonetheless, VA has made an extensive investment in reporting systems to provide feedback to facilities, and in quality improvement tools to address these aspects of patient-centered care.

Table 1.6

**FY 2012 Patient Mixed Adjusted Inpatient HCAHPS Composites & Reporting Measures  
 Top-Box\* Percentile Scores, SHEP Inpatient Percentiles**

Composites / Reporting Measures	Hospital Percentile <sup>1</sup>						
	5 <sup>th</sup>	10 <sup>th</sup>	25 <sup>th</sup>	50 <sup>th</sup>	75 <sup>th</sup>	90 <sup>th</sup>	95 <sup>th</sup>
Cleanliness of Hospital Environment	62	65	69	74	77	83	86
Communication about Medications	55	57	61	64	67	70	72
Communication with Doctors	70	71	74	77	79	81	82
Communication with Nurses	66	68	70	74	77	79	81
Discharge Information	80	82	84	86	88	89	91
Overall Rating of Hospital	55	59	64	68	72	77	78
Pain Management	56	57	62	64	67	68	69
Quietness of Hospital Environment	42	45	48	54	59	62	64
Responsiveness of Hospital Staff	50	52	57	62	68	70	71
Willingness to Recommend Hospital	58	61	68	72	76	80	81

**HCAHPS Percentiles (December 2012)**

Composites / Reporting Measures	Hospital Percentile <sup>2</sup>						
	5 <sup>th</sup>	10 <sup>th</sup>	25 <sup>th</sup>	50 <sup>th</sup>	75 <sup>th</sup>	90 <sup>th</sup>	95 <sup>th</sup>
Cleanliness of Hospital Environment	61	63	67	72	77	83	86
Communication about Medications	53	55	59	62	66	71	74
Communication with Doctors	73	75	78	81	84	88	90
Communication with Nurses	68	71	75	78	81	85	87
Discharge Information	76	78	81	84	87	89	90
Overall Rating of Hospital	55	59	64	69	75	80	84
Pain Management	62	64	67	70	73	77	80
Quietness of Hospital Environment	44	47	52	59	66	73	78
Responsiveness of Hospital Staff	53	56	60	65	71	78	83
Willingness to Recommend Hospital	54	58	64	71	77	82	86

\* The "Top-box" is the most positive response (i.e. "Always" or a rating of "9 or 10") to HCAHPS survey items.

<sup>1</sup> Percentiles for "top-box" scores of the 122 VA hospitals with at least 30 responders for the fiscal year. Surveys are from patients discharged (excluding Psychiatry DRGs) between October 2011 and September 2012. Scores have been adjusted for patient-mix using HCAHPS December 2012 patient-mix coefficients.

<sup>2</sup> Percentiles for "top-box" scores of the 3,892 hospitals publicly reported on Hospital Compare in December 2012. Surveys are from patients discharged between April 2011 and March 2012. Scores have been adjusted for survey mode and patient-mix.

Outpatient results are case-mix adjusted based on a VA model that accounts for factors known to influence patients' experience with care including age, education, self-reported health status, and facility characteristics. Outpatient scores for VISNs and facilities will *NOT* be directly comparable to the private sector as there is no universally recognized adjustment methodology.

### Facility Variation with Outpatient Scores

In order to control for variation between facilities that may be attributed to patient characteristics, metrics were assessed using a model similar to the one employed by HCAHPS, but adapted to the outpatient setting, and also takes advantage of key VA administrative data.

There is ample variation in FY 2012 scores across the 140 VA outpatient facilities but the spread is not as marked as observed in the inpatient scores. Again, variability was examined using inter-quartile range (IQR).

The narrowest spreads were found for Overall Rating of Specialist (IQR=4.1), and Shared Decision Making (IQR=4.7). Greatest variation in performance is found for the items Getting Care Quickly (IQR= 8.1) and Getting Needed Care (IQR=7.6). These are the two composites having shown a 2-point decline since FY 2011, and have the lowest adjusted mean scores in FY 2012. We note that these measures of perceived access have been shown to correlate with Overall Rating of Outpatient Care, and therefore have prompted VA to expand its internal tracking of the various dimensions of access and to embark on significant efforts to understand Veteran needs and expand access through both face-to-face and virtual (e.g., telehealth) encounters.

**Table 1.7**

### **FY 2012 SHEP Measures - Outpatient Facility Variation with VA Patient-Mix Adjustments**

<b>Composites/Reporting Measures</b>	<b>N</b>	<b>Mean</b>	<b>Min</b>	<b>Max</b>	<b>IQR</b>
Getting Care Quickly	140	50.2	35.5	64.0	8.1
Getting Needed Care	140	51.6	38.9	63.9	7.6
How Well Doctors/Nurses Communicate	140	70.7	61.0	79.9	5.0
Overall Rating of health care	140	59.6	43.4	69.0	6.5
Overall Rating of Personal Doctor/Nurse	140	73.1	60.9	84.5	5.4
Overall Rating of Specialists	140	68.1	59.8	77.3	4.1
Shared Decision Making	140	61.5	52.9	69.5	4.7

Notes:

- Results are adjusted for age, education, health status and other variables known to affect patient reports of health care

- Results for composites Getting Needed Care, Getting Care Quickly, and How Well Doctors/Nurses Communicate are based on Always responses
- Results for Rating Personal Doctor/Nurse, Rating of Specialist, and Rating of health care are based on a rating of 9 or 10 (using a 0 to 10 scale, where 0 is the worst possible and 10 is the best possible)
- Includes facilities with at least 30 responders

## Section 7: Efficient Care

### Ambulatory Care Sensitive Conditions Hospitalizations (Columns GB-GD)

VHA monitors rates of hospitalization for Ambulatory Care Sensitive Conditions (ACSCs) such as pneumonia and heart failure in order to track the effectiveness of primary care. ACSC's are defined as medical problems that are potentially preventable if appropriate care is provided outside of a hospital. Studies show that effective primary care is associated with fewer ACSC-related hospitalizations, and that more effective primary care ultimately leads to lower health care costs. For this reason, VHA tracks the rate of ACSC hospitalizations as an indicator of efficient Care.

*VHA monitors rates of Ambulatory Care Sensitive Conditions such as pneumonia and heart failure in order to track the effectiveness of primary care. Over half of VHA facilities have hospitalization rates that are lower than would be expected based on patient risk factors.*

The utility of ACSC hospitalizations as an indicator of effective primary care and overall efficient care is widely recognized by other entities:

- Agency for Health care Research and Quality (AHRQ) maintains an algorithm that models ACSC hospitalizations as Preventive Quality Indicators (PQI)  
[http://www.qualityindicators.ahrq.gov/modules/pqi\\_resources.aspx](http://www.qualityindicators.ahrq.gov/modules/pqi_resources.aspx)

- CMS has conducted studies evaluating ACSC hospitalizations among Medicare Fee-for-Service Beneficiaries
- Institute of Medicine recommends that avoidable hospitalizations be used to monitor access to health care services
- Peer-reviewed literature on ACSC hospitalizations is extensive.

The 12 ACSC Conditions include:

- Diabetes, short-term complications
- Perforated appendix
- Diabetes, long-term complications
- Chronic Obstructive Pulmonary Disease (COPD)
- Hypertension
- Congestive Heart Failure
- Dehydration
- Bacterial Pneumonia
- Urinary Tract Infection
- Angina without an in-hospital procedure
- Uncontrolled Diabetes
- Adult Asthma

(ICD-9 diagnosis code details associated with the above 12 ACSC conditions are available at [http://www.qualityindicators.ahrq.gov/modules/PQI\\_TechSpec.aspx](http://www.qualityindicators.ahrq.gov/modules/PQI_TechSpec.aspx))

*All ACSC Conditions: Hospitalizations per 1000 ACSC Patients:* For each VA Medical Center (VAMC), hospitalizations due to the ACSCs previously listed are counted as the numerator for this measure. For each VAMC all patients with ACSCs are identified as the denominator for this measure. Risk standardized hospitalization rates derived by multivariate regression are reported for FY 2012. This metric permits the facility to understand their risk adjusted performance relative to that of the National System Average. This calculation is the facility O/E (observed over expected admissions) times the national ACSC hospitalization rate per 1000 which was 29.9 in FY 2012 (improved from 30.9 in FY 2011).

*Congestive Heart Failure (CHF): Hospitalizations per 1000 CHF ACSC Patients:* For each VAMC, hospitalizations due to CHF, one of the ACSCs, are counted as the numerator for this measure. For each VAMC all patients with CHF are identified as the denominator for this measure. Risk standardized CHF hospitalization rates derived by multivariate regression are reported for FY 2012. This metric permits the facility to understand their risk adjusted performance relative to that of the National System Average. This calculation is the facility O/E (observed over expected CHF admissions) times the national CHF hospitalization rate per 1000 which was 117.9 in FY 2012 (improved from 118.1 in FY 2011).

*Pneumonia: Hospitalizations per 1000 Pneumonia ACSC Patients:* For each VAMC, hospitalizations due to Pneumonia, one of the ACSCs, are counted as the numerator for this measure. For each VAMC all patients with Pneumonia are identified as the denominator for this measure. Risk standardized hospitalization rates derived by multivariate regression are reported for FY 2012. This metric permits the facility to understand their risk adjusted performance relative to that of the National System Average. This calculation is the facility O/E (observed over expected Pneumonia admissions) times the national Pneumonia hospitalization rate per 1000 which was 214.4 in FY 2012 (improved from 225.0 in FY 2011).

*Note: ACSC hospitalizations with “admission source” equal to “research” and all ACSC hospitalizations resulting in death are excluded from the count of hospitalizations in the reported ACSC rates.*

When benchmarking to other organizations, it is important to understand the definition of population used in the denominator. For many organizations, calculating the population (i.e. Heart Failure, Pneumonia, etc.) is difficult, if not impossible and, therefore, they will frequently utilize the total population in the denominator. The use of the total population in the denominator will produce lower hospitalization rates than those included in the VHA analysis. Additionally, the lack of Medicare, Medicaid, and/or Private Insurance diagnosis and hospitalization data (numerator and denominator) may not provide an accurate accounting of ACSC rates in patients who may rely on both VHA and Medicare for their health care.

## Results

Please Note: Unique Patients in this section includes care provided in a VA or Non-VA setting (VA Care, Non-VA Care, Home Dialysis, Observation Beds, and Pharmacy Only file sources).

*All 12 Ambulatory Care Sensitive Conditions (ACSC):* VHA provided health care to 5,911,885 unique patients in FY 2012. Of these patients, 55 percent (3,246,305 of 5,911,885) were identified as having one or more of the ACSC conditions. Hospitalizations in the ACSC population represented 13 percent (97,139 of 737,520) of the total hospital admissions to a VA or Non-VA facility (FY 2012). The average number of ACSC admissions was 699 with a range of 56 (Coatesville, PA) to 2,348 (Gainesville, FL). The system-wide rate of ACSC Admissions per 1,000 ACSC Patients was 29.9. The observed hospitalization rates per 1,000 ACSC Patients for the 139 individual VHA facilities varied substantially from 6.2 (Coatesville, PA) to 56.9 (Bronx, NY). Risk standardized hospitalization rates ranged from 12.9 (Columbus, OH) to 74.8 (Anchorage, AK).

*Congestive Heart Failure (CHF):* VHA provided health care to 5,911,885 unique patients in FY 2012. Of these patients, four percent (210,723 of 5,911,885) were identified as having a CHF condition. Hospitalizations in the CHF population represented three percent (24,839 of 737,520) of the total hospital admissions to a VA or Non-VA facility (FY 2012). The average number of CHF admissions was 179 with a range of 11 (Coatesville, PA) to 682 (Dallas, TX). The system-wide rate of CHF Admissions per 1,000 CHF patients was 117.9. The observed hospitalization rates per 1,000 CHF Patients for the 139 individual VHA facilities varied greatly from 18.6 (Coatesville, PA) to 231.5 (Anchorage, AK). Risk standardized hospitalization rates ranged from 56.75 (Canandaigua, NY) to 294.75 (Big Spring, TX / Butler, PA / Coatesville, PA / El Paso, TX / Grand Junction, CO / Sheridan, WY). When VHA data were adjusted for patient risk and other variables, 48 percent (67 of 139) of VHA facilities were found to have higher than expected CHF admission rates and 52 percent (72 of 139) lower than expected rates.

*Pneumonia:* VHA provided health care to 5,911,885 unique patients in FY 2012. Of these patients, 1.3 percent (79,675 of 5,911,885) were identified as having a Pneumonia condition. Hospitalizations in the Pneumonia population represented 2.3 percent (17,079 of 737,520) of the total hospital admissions to a VA or Non-VA facility (FY 2012). The average number of Pneumonia admissions was 123 with a range of 12 (Tuscaloosa, AL) to 381 (Gainesville, FL). The system-wide rate of Pneumonia Admissions per 1000 Pneumonia patients was 214.4. The observed hospitalization rates per 1000 Pneumonia patients for the 139 individual VHA facilities varied greatly from 92.7 (New Orleans, LA) to 357.8 (Beckley, WV). Risk standardized hospitalization rates ranged from 108.2 (Memphis, TN) to 536.0 (Coatesville, PA). When VHA data were adjusted for patient risk and other variables, 45 percent (63 of 139) of VHA facilities were found to have higher than expected Pneumonia admission rates and 55 percent (76 of 139) lower than expected rates.

## Part 2: VHA Facility Quality & Safety Data Tables

*The following sections are available on the VA Quality of Care Web Site using the following link:*

<http://www.va.gov/qualityofcare/reports/vha-quality-safety-data-tables-2013.xlsx>

Section 1: Services, Staffing, Treatment Volumes and Accreditation

Section 2: Effective Care

Section 3: Equitable Care

Section 4: Safe Care

Section 5: Timely Care

Section 6: Patient-Centered Care

### Part 3: Data Definitions - Frequently Used Acronyms:

VA	– Department of Veterans Affairs
VHA	– Veterans Health Administration
VAMC	– VA Medical Center
VISN	– Veterans Integrated Service Network
CLC	– Community Living Centers
PACT	– Patient Aligned Service Team
CARF	– Commission on Accreditation of Rehabilitation Facilities
CLIA	– Clinical Laboratory Improvement Amendments
COLA	– Commission on Office Laboratory Accreditation
TJC	– The Joint Commission
HPPD	– Hours Per Patient Day
DSS	– Decision Support System
AMI	– Acute Myocardial Infarction
ACEI	– Angiotensin Converting Enzyme Inhibitor
ARB	– Angiotensin Receptor Blocker
HF	– Heart Failure
ICU	– Intensive Care Unit
SCIP	– Surgical Care Improvement Project
CMS	– Centers for Medicare and Medicaid Services
NQF	– National Quality Forum
VASQIP	– VA’s Surgical Quality Improvement Program
NCQA	– National Center for Quality Assurance
EPRP	– External Peer Review Program
HEDIS	– Healthcare Effectiveness Data and Information Set
SHEP	– Survey of Healthcare Experiences of Patients
VAP	– Ventilator Associated Pneumonia
MRSA	– Methicillin-resistant Staphylococcus aureus
CLAB	– Central Line Associated Bacteremia
OMELOS	– Observed Minus Expected Length of Stay
HAPU	– Hospital Acquired Pressure Ulcer Rate
IHI	– Institute for Healthcare Improvement
VistA	– Veterans Information System and Technology Architecture
HCAHPS	– Hospital Consumer Assessment of Healthcare Providers and Systems
CAHPS	– Consumer Assessment of Healthcare Providers and Systems
ACSCs	– Ambulatory Care Sensitive Conditions
AHRQ	– Agency for Health care Research and Quality
PQI	– Preventive Quality Indicators
CHF	– Congestive Heart Failure
NCPS	– National Center for Patient Safety
RCAs	– Root Cause Analysis
ARs	– Aggregated Reviews
SAC	– Safety Assessment Code
PAC	– Primary Analysis and Categorization

## Definitions      Section 1: Infrastructure

COL	Metric	Description of the Data Element
<b>SECTION 1: Services, Utilization, Staffing and Accreditation</b>		
<b>Available Hospital Services</b>		
A	Acute Medical/Surgical Services	Acute Inpatient: Medical/Surgical: A facility is designated as having acute medicine or surgery in-house services available if the number of discharges from acute medicine or surgery discharging bed sections in a VA hospital setting is greater than ten. Note: A facility is designated as “No” if they have acute medicine discharges and no acute surgery discharges; however, a facility with acute medicine discharges, average length of stay, and bed day of care measures are reported under the acute inpatient Medical/Surgery Utilization section of the report.
B	Acute Mental Health Services	Acute Inpatient Mental Health: A facility is designated as having acute mental health in-house services available if the number of discharges from acute psychiatry discharging bed sections in a VA Hospital setting is greater than ten.
C	Intensive Care Unit	Intensive Care Unit: A facility is designated as having an intensive care unit based on the national VA ICU survey. Medical centers and VISNs need to meet established ICU criteria that would establish their level of care from Highly complex (level 1) to Basic (level 4). Updates to the level of ICU care can be made anytime during the year in collaboration with the National Program Director for Pulmonary/Critical Care. (ICU Levels: 1-Complex, 2-Complex, 3-Moderate or 4-Basic based on the results of the FY 2007-2008 HAIG ICU Level Survey and on-going updates through the Inpatient Evaluation Center ( IPEC).
D	Emergency Dept	Emergency Room Department: A facility is designated as having an emergency department available if there is outpatient encounter workload recorded using primary or secondary Decision Support System (DSS - VA’s Managerial Cost Accounting System) Identifier of 130-Emergency Department.
E	Urgent Care clinics	Urgent Care Clinics: A facility is designated as having an urgent care unit available if there is outpatient encounter workload recorded using primary or secondary Decision Support System (DSS) (VA’s Managerial Cost Accounting System) Identifier of 131-Urgent Care Unit.
F	Community Living Center	Community Living Centers (CLC): A facility is designated as having a CLC if the CLC is accredited under TJC long term care standards and provides nursing home level of care. Most VA CLCs are

		co-located on a VA Medical Center campus although several are free standing on VA property.
G	Spinal Cord Injury/Disorders (SCI/D) Unit	A facility is designated as having a specialty spinal cord injury and disorders unit if they have a dedicated unit that provides rehabilitation, ongoing medical care, and long term care for Veterans with spinal cord injuries and disorders
H	Polytrauma Services	Polytrauma/Traumatic Brain Injury (TBI) Rehabilitation Centers that provide acute comprehensive medical and rehabilitation care for complex and severe polytraumatic injuries. <b>PNS:</b> Polytrauma Rehabilitation Network Sites have dedicated interdisciplinary teams to manage the post-acute sequelae of polytrauma and to coordinate life-long rehabilitation services for patients within their VISN. <b>PSCT:</b> Polytrauma Support Clinic Teams are local teams of providers with rehabilitation expertise who deliver follow up services in consultation with regional and network specialists. <b>PPOC:</b> Polytrauma Point of Contact facilities do not provide specialized care but have a designated PPOC who is knowledgeable of the PSC, and ensures that patients are referred to a facility capable of providing the level of services required.
I	Domiciliary care	Domiciliary Care: A facility is designated as having VA domiciliary care available if there are bed days of care in the non-acute domiciliary care unit treating specialties in a VA Domiciliary care setting.
<b>Utilization</b>		
<b>Acute Inpatient- Medical/Surgical</b>		
J	Medical/Surgical Hospital Discharges	Med Surg Hospital Discharges: These data are the number of hospital discharges from the acute medicine or surgery discharging bed section specialties in a VA Inpatient setting. It does not include patients discharged from a medicine or surgery observation stay.
K	Med Surg Hospital Discharges per 1,000 Uniques	Med Surg Hospital Discharges per 1,000 Unique Pts: The rate of acute medicine and surgery VA hospital discharges per 1000 unique patients is calculated for comparative purposes. Total facility unique patients include patients treated in both VA and Non-VA settings (VA Care, Non-VA Care, Home Dialysis, Observation Beds, and Pharmacy Only file sources).
L	Medical/Surgical LOS	Med Surg LOS: These data are the VA hospital average length of stay for patients who were discharged from acute medicine or surgery bed sections. It does not include patients discharged from observation beds.
M	Bed Days of Care (BDOC)	Med Surg Bed Days of Care Per 1,000 Uniques: These data are the VA hospital total length of stay (bed days of care) for patients who were discharged from an acute medicine or surgery bed section (excluding observation patients). The rate of acute medicine and surgery VA

		hospital bed days of care per 1000 unique patients is calculated for comparative purposes. Total facility uniques includes patients treated in both VA and Non-VA settings (VA Care, Non-VA Care, Home Dialysis, Observation Beds, and Pharmacy Only file sources).
N	# Facility Unique Patients	Unique Patients: This is the total number of unique patients at the national and facility level who received care in a VA or Non VA setting (VA Care, Non-VA Care, Home Dialysis, Observation Beds, and Pharmacy Only file sources) during the reported timeframe.
<b>Acute Inpatient- Mental Health</b>		
O	Mental Health Hospital Discharges	Mental Health Hospital Discharges: These data are the number of hospital discharges from the acute psychiatry discharging bed section specialties in a VA Inpatient setting. It does not include patients who were discharged from psychiatry observation.
P	Unique Mental Health Hospital Discharges (per 1,000 Unique Patients)	Mental Health Hospital Discharges per 1,000 Uniques: The rate of acute mental health VA hospital discharges per 1000 unique patients is calculated for comparative purposes. Total facility uniques includes patients treated in both VA and Non-VA settings (VA Care, Non-VA Care, Home Dialysis, Observation Beds, and Pharmacy Only file sources).
Q	Mental Health LOS	Mental Health ALOS: These data are the VA hospital average length of stay for patients who were discharged from an acute psychiatry bed section. It does not include patients discharged from an observation bed.
R	MH Bed Days of Care	Mental Health Bed Days of Care Per 1,000 Uniques: These data are the VA hospital total length of stay (bed days of care) for patients who were discharged from an acute psychiatry bed section (excluding observation patients). The rate of acute psychiatry VA hospital bed days of care per 1000 unique patients is calculated for comparative purposes. Total facility uniques includes patients treated in both VA and Non-VA settings (VA Care, Non-VA Care, Home Dialysis, Observation Beds, and Pharmacy Only file sources).
<b>Outpatient Visits</b>		
S	Primary Care Outpatient Visits	Primary Care Outpatient Visits: These data are the VHA unduplicated encounters for outpatients who were seen in a primary care Clinic Stop 323 (also includes patients seen for comprehensive women's primary care (322) and geriatric primary care (350)). VHA primary care gives eligible veterans easy access to health care professionals familiar with their needs. It provides long-term patient-provider relationships, coordinates care across a spectrum of health services, educates, and offers disease prevention programs. Primary care now serves as the foundation of VHA health care and has become the first point of contact with the health care

		system for veterans enrolled in VHA.
T	Specialty Care Outpatient Visits	Specialty Care Outpatient Visits: These data are the VHA unduplicated encounters for outpatients who were seen in a VHA facility for a broad array of Geriatric, Medicine, Mental Health, Physical Medicine & Rehabilitation, or Surgical Specialty Care services. Specialty Care is a critical component of the comprehensive medical benefits package of health care services provided directly by the VHA and/or arranged for outside of VHA to meet the needs of our Veterans. (Examples of medicine and surgical specialty care include Allergen Services, Anesthesia Services, Cardiology, Critical and Pulmonary Care, Diabetes and Endocrinology, Dermatology, Emergency Medicine, Gastroenterology, Infectious Diseases, Neurology Services, Nephrology, Oncology, Ophthalmology, Optometry, Pain Management, Podiatry, and Rheumatology)
<b>Outpatient Medical Procedures</b>		
U	Upper GI endoscopy	Data was obtained from the National Patient Care Database (NPCD) outpatient encounter file. All encounters containing a CPT procedure code for one of these types of endoscopies were included in the counts [list of CPT codes used available upon request]. This data displays the counts for five types of endoscopic procedures performed at VA facilities during the reporting period. These procedures were performed by VA salaried, fee and contract providers on VA premises. Procedures paid for by VA but performed offsite (community fee) are not included in these counts. Data is only limited by the accuracy of the CPT codes provided on the encounter record.
V	Colonoscopy	
W	Sigmoidoscopy	
X	Bronchoscopy	
Y	ENT endoscopy	
Z	Coronary angiography	The number coronary angiography and percutaneous coronary intervention/PCI procedures performed. The source of these data is the VA CART Program. There are local variances in procedure coding, these numbers may be different than codes for these procedures in Austin
AA	Percutaneous coronary intervention	
<b>Medical Imaging Services</b>		
AB	CT scans	A computed tomography (CT) scan is an imaging method that uses x-rays to create cross-sectional pictures of the body.
AC	MRI scans	Magnetic resonance imaging (MRI) is an imaging method that uses a magnetic field and pulses of radio wave energy to make pictures of organs and structures inside the body.
AD	Mammography	Mammography is a radiographic technique that uses low-dose x-ray to exam the breast for cancer.
<b>Community Living Centers</b>		
AE	Average Daily Census (ADC)	Average number of residents receiving care each day during a given time period.

AF	Unique Residents	This is the total number of newly admitted residents who received care in a VA community living center during the reported timeframe.
AG	Long Stay Dementia Care (42)	Although dementia specific care may be delivered in any nursing home environment where the safety of the resident is protected, the environment is appropriately stimulating, and staff competencies are evident, dementia specific care considers the functional deficits associated with long-term, chronic cognitive deficits. The primary resources for care include recreation therapy, KT, social work, and nursing. This population may also benefit from supportive or episodic rehabilitation as indicated with at least one therapy intervention such as PT, OT, KT, and SLP based on identified changes in functional status as documented in the MDS and/or progress notes.
AH	Long Stay Continuing Care (44)	The goal of care is maintaining the highest practicable level of well-being and function and preventions of further decline. Examples of long stay continuing care may include but not limited to care for Veterans: (a) With long-standing chronic functional disabilities for whom active rehabilitation is no longer an option; (b) Who require assistance with basic activities of daily living, medication administration, and general supervision and who do not require direct skilled nursing services; or (c) who require skilled nursing interventions that extend beyond the short-stay limit of 90 days. For instance, Veterans who continue to require skilled nursing interventions, such as complex wound care or ventilator care, will convert from a short-stay treating specialty to long-stay continuing care until the skilled nursing services are no longer needed.
AI	Long Stay Mental Health Recovery (45)	Differentiated from acute long term psychiatric care and dementia care, veterans admitted have chronic stable mental illness coupled with geriatric or other syndromes that render them less able to function in non-institutional settings. The home environment and ambiance in a program specifically-designed for caring for this population, utilizes active, recovery-oriented, evidence-based psychological and psychopharmacological treatment service approaches, and therapeutic recreation ; has a structured and creative approach to activities of daily routines; providing meaningful use of time, create opportunities for socialization to enhance psychological functioning, promote quality of life, and prevent behavioral exacerbations or psychological emergencies.
AJ	Long Stay Spinal Cord Injury and Disorders (46)	Emphasis of care is on Veterans who have a primary diagnosis of SCI/D and CLC care due to the level of assistance required and functional impairments that do not allow for independent

		living in the community. This population may also benefit from supportive or episodic rehabilitation as indicated with at least one therapy intervention such as PT, OT, KT, and SLP based on identified changes in functional status as documented in the MDS and/or progress notes. A home environment and recovery setting provides the Veteran with resources to achieve the highest level of well-being and function. The CLC needs to contact the closest SCI/D Center for consultation in the care of Veterans with SCI/D. These Veterans must be offered annual evaluations in a SCI Center each year.
AK	Respite Care (47)	Respite care is a distinct VA program with the unique purpose of providing temporary relief for unpaid caregivers from routine care giving tasks, thus supporting caregivers in maintaining the chronically ill veteran in the home. Respite Care when the VA CLC is coded under treating specialty 47. Respite care services may include various VA and non-VA programs or contracts. In all cases, respite care remains distinct from usual Geriatrics and Extended Care (GEC) services in that the focus and purpose of respite care is providing relief for the caregiver.
AL	Short Stay Rehabilitation (64)	Time-limited, goal-directed care for the purpose of returning the Veteran to functioning as independently as possible. Care and Services are provided in a home environment that enhances preparation for discharge and readies the Veteran to function in a non-institutional environment The program may be accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF). Services are rendered and goals achieved by an interdisciplinary effort to improve function. The primary resources for care are physical therapy (PT), occupational therapy (OT), kinesiotherapy (KT), speech and language pathology (SLP), or a combination of all four. Therapy minutes are clearly documented and the resident's Minimum Data Set (MDS) generates one of the subgroups in the Rehabilitation Resource Utilization Groups (RUG). Outcomes are measured by Functional Independence Measure (FIM) scores. Levels of care are: high-, medium-, or low-intensity inpatient care, depending on the Veteran's needs and goals for rehabilitation.
AM	Short Stay Restorative Care (66)	Time-limited care with the purpose of providing short term restorative interventions, such as bowel and bladder training and toileting; restorative dining; ambulation, etc. The purpose of the admission is to provide a transition from the hospital through short-term restorative care prior to discharge. The primary resources for care include: restorative aides, nurses, KT, and recreation therapy. This population may also benefit from supportive or low-intensity rehabilitation as indicated, with at least one therapy intervention such as PT, OT, KT, and SLP

		based on identified changes in functional status as documented in the MDS and/or progress notes.
AN	Short Continuing Care (67)	Time-limited care for those awaiting alternative placement, such as to a community nursing home or state veterans home. The goal of care is to achieve the highest practicable level of well-being, function, and prevention of premature decline. The primary resources for care include social work, nursing, and therapeutic recreation or KT. This population may also benefit from supportive or episodic rehabilitation as indicated with at least one therapy intervention such as PT, OT, KT, and SLP based on identified changes in functional status as documented in the MDS and/or progress notes.
AO	Short Mental Health Recovery (68)	Time-limited recovery centered care with the purpose of providing evaluation and management, such as medication adjustment and/or evidence-based psychosocial behavioral interventions for veterans with exacerbation of medical and or behavioral symptoms that be managed in a non-psychiatric setting. These veterans are expected to return to their previous living arrangements upon discharge. In this recovery oriented program, active, evidence based psychological and psychopharmacological treatment and services are the focus of care. The primary resources for care include: recreation therapy, social work, nursing, and psychology and/or psychiatry. This population may also benefit from supportive or episodic rehabilitation as indicated with at least one therapy intervention such as PT, OT, KT, and SLP based on identified changes in functional status as documented in the MDS and/or progress notes.
AP	Short Stay Dementia Care (69)	Time-limited, goal-directed care with the purpose of stabilizing symptoms and developing a plan of care to meet ongoing needs within the secure environment of an existing dementia program. The household environment provides cues for resident behavior management and functional improvements. The family or significant other need to be involved in learning about safe and effective care practices in the home, resources for continued support, access to home Telehealth, and other services that support the Veteran and assist the care-giver to continue to care for the Veteran at home. This program may offer family or significant other behavior management skills and opportunities to practice skills while the Veteran is in the CLC. Staff competencies are essential. Dementia-specific care focuses on respectful management of challenging behaviors, functional and cognitive improvement, meaningful use of time, and Veteran and care giver education.
AQ	Geriatric Evaluation and Management	Short-stay skilled nursing care is available for Veterans admitted to the Geriatrics Evaluation

	(GEMI)- (81)	and Management (GEM) program where a Veteran is assessed by a multidisciplinary team. The multidisciplinary team provides comprehensive evaluation of the Veteran’s health status, management of chronic stable conditions including, but not limited to: a thorough assessment of function, medication management, and support services. The program recommends interventions and prepares the Veteran to be able to continue to live in the community. The goal of care is to enhance the ability of the Veteran to achieve the highest practicable level of well-being and to remain in the community.
AR	Short Stay Skilled Nursing Care (95)	Short-stay skilled nursing care is time-limited, goal-directed care for specific conditions or interventions that require the involvement of a Registered Nurse (RN) or a licensed nurse (Licensed Practical Nurse (LPN) or Licensed Vocational Nurse (LVN)) on a daily basis. Care and services are provided in a home environment that enhances preparation for discharge and readies the Veteran to function in a non-institutional setting. Mental health providers (psychology and psychiatry), required to be fully integrated into the CLC pursuant to VHA Handbook 1160.01, must be available as needed.
AS	Hospice (may exceed 90 days) (96)	Hospice is the final stage of the palliative care continuum in which the primary goal of treatment is comfort rather than cure for patients with advanced disease that is life-limiting and refractory to disease-modifying treatment. Life expectancy is determined by a VA physician to be 6 months or less if the disease runs its normal course, consistent with the prognosis component of the Medicare hospice criteria.
<b>CLC Metrics</b>		
AZ	Artifact of culture change metric - Total Score	Self-reported measure to assess implementation of person-centered care in a community living center. Consists of 79 questions broken down into 6 categories: Care practices, Environment, Family Community, Leadership, Workplace, and Outcomes. There are a total of 580 points possible and a higher score is better.
BA	Artifact of culture change metric – Percent Change	Self-reported measure to assess implementation of person-centered care in a community living center. Percent change is the percentage change from FY 2011 quarter one to FY 2011 quarter two. The goal is a 2percent increase in score each quarter, with an overall yearly increase of 8 percent.
BB	Unannounced survey outcomes # of A-G findings	Results of unannounced surveys. The survey follows CMS nursing home survey process applying Joint Commission Standards. Findings are rated on the CMS Scope and Severity Grid. A-G level These findings are less severe in that there is no actual harm or represent isolated

		incidents with no actual harm.
BC	Unannounced survey outcomes # of H-L findings	Results of unannounced surveys. The survey follows CMS nursing home survey process applying Joint Commission Standards. Findings are rated on the CMS Scope and Severity Grid. Findings H-L are have either the potential for actual harm to residents, or immediate jeopardy to residents' health and safety.
BD	IV infections- Central Line Associated Blood Stream Infection	Self-reported measure. Expresses the number of CLAB infections in community living centers in a given month in a standardized rate of number of CLAB infections per 1000 central line days. The definition to determine CLABSI is from the CDC.
BE	UTI infections- Catheter Associated Urinary Tract Infection (symptomatic)	Self-reported measure. Expresses the number of CAUTI infections in community living center in a given month in a standardized rate of number of CAUTI per 1000 catheter days. The definition of a symptomatic CAUTI is from the CDC.
BF	Consistent Assignment –Long Stay (Monthly)	The consistent assignment metric measures whether each resident has no more than 12 direct caregivers in a one month period.* *As applicable to LOS.
BG	Consistent Assignment - Short Stay (Every 2 weeks)	
<b>Hospital Accreditation</b>		
BH	TJC Acute care (Hospital)	The Joint Commission (TJC) Full Accreditation surveys occur on a 3-year cycle which includes a review of multiple applicable programs: e.g., Long Term Care, Hospital, Ambulatory, Behavioral Health, and Home Care programs. The Data is compiled from The Joint Commission Survey reports and reflect the accreditation status as of 2010.
BI	TJC Behavioral Health	
BJ	TJC Long term care	
BK	TJC Ambulatory care	
BL	TJC Home care	
BM	CARF Accreditation	Commission on Accreditation of Rehabilitation Facilities (CARF): VHA is committed to providing specialized treatment and quality rehabilitation care to Veterans with disabilities. These populations include Veterans with spinal cord injuries and disorders (SCI/D), blindness or severely visually impaired, traumatic brain injury, amputation, serious mental illnesses, and those who are homeless. This commitment is supported through a system-wide, long-term joint collaboration with CARF to achieve and maintain national accreditation for all appropriate VHA rehabilitation programs.
BN	Laboratory Accreditation	Report from Pathology & Laboratory Medicine Service, FY 2010. Approximately 250 VA laboratories are accredited by the College of American Pathologists (CAP), The Joint Commission (TJC) or COLA.

Medical Center Staffing		
BO	Physician Full-time FTEE	MD Full-time FTEE: This is the staffing of full-time physician FTEE (Full Time Employee Equivalent) in VA budget object code 1081(Physicians-Full Time). This does not include medical residents, trainees, physicians in a without compensation status, or contract physicians.
BP	Physician Part-time FTEE	MD Part-time FTEE: This is the staffing of part-time physician FTEE (Full Time Employee Equivalent) in VA budget object code 1082(Physicians-Part Time). This does not include medical residents, trainees, physicians in a without compensation status, or contract physicians.
BQ	Physician FTEE	MD FTEE per 1,000 Uniques: This is the staffing rate of full and part-time physician FTEE (Full Time Employee Equivalent) in VA budget object code 1081(Physicians-Full Time) and 1082 (Physicians-Part Time) per 1,000 total facility unique patients. This does not include medical residents, trainees, physicians in a without compensation status, or contract physicians.
HPPD (Hours per patient day) data		<p>The HPPD data is obtained from the DSS Nursing Hours/Costs by Ward and Ward Day of Care report. Total Ward Days: the Source data is the DSS NDE WARD and the DSS ALB NDE PAID file. The Ward Hours of Care include the admission and discharge days in the report. Total Patient Ward Hours: The total Hours of actual occupancy time of patients on the selected ward. For example: a patient is on WARD X from 3am until 8am they are credited with 5 ward hours of care on WARD x. if same patient transferred at 8 am to WARD Z and remains there until midnight they will be credited with 19 ward hours on WARD Z. Total Patient Ward Hours: The total Hours of actual occupancy time of patients on the selected ward. For example: a patient is on WARD X from 3am until 8am they are credited with 5 ward hours of care on WARD x. if same patient transferred at 8 am to WARD Z and remains there until midnight they will be credited with 19 ward hours on WARD Z. Total Ward Days: Calculation = Total Patient Ward Hours/24. The admission day is counted; the discharge day is counted.If a patient is admitted and discharged in the same day, then the ward hours of care (which is the actual time the patient spent on the unit) is in the ward hours count.Patients with Ward Hours of Care assigned to a MAS observation beds on a regular inpatient ward will be included in the report.</p> <p>***The HPPD data has not been manipulated or changed from what appears in the DSS HPPD report. Facilities with data that appears significantly skewed (high or low) have been notified and advised to review the data with their local DSS Manager(s) to ensure that labor mapping and ward mapping (“C-Ward tables”) is correct. Additional report definitions and information</p>

		may be viewed by accessing the DSS report. <a href="https://vssc.med.va.gov/dss_ssl/NURSEINP.asp">https://vssc.med.va.gov/dss_ssl/NURSEINP.asp</a> Total Hours per Ward Day: Calculation = Total Nursing Hours/Total Ward Days. RN: Calculation = RN Total Nursing Hours/Total Ward Days. LPN: Calculation = LPN Total Nursing Hours/Total Ward Days. NA: Calculation = NA Total Nursing Hours/Total Ward Days.
BR	Critical Care Units: Registered Nurses	Clusters: E8 - Med/Surg ICU Combined; E6 - Cardiac Care Unit; E5 - Neuro ICU; E4 - Medical ICU 2; E3 - Medical ICU 1; E2 - Telemetry ICU; E1 - Surg ICU
BS	Critical Care Units: LPNs	
BT	Critical Care Units: Nursing Assistants	
BV	Medical Units: Registered Nurses	FT - Ward Neuro; FN - Wards Mixed Med/Int. Med 2; FM - Wards Mixed Med/Int. Med 1; ES - Ward Gen Med/Acute 4; EP - Wards - Infectious Disease; EO - Wards Rheumatology/Dermatology; EN - Wards Oncology; EM - Ward Gen Med/Acute 3; EL - Ward Gen Med/Acute 2; EK - Ward Gen Med/Acute 1
BW	Medical Units: LPNs	
BX	Medical Units: Nursing Assistants	
BZ	Surgical Units: Registered Nurses	
CA	Surgical Units: LPNs	F5 - Ward Neuro/Neuro Surgery; F4 - Wards Neurosurgery; F3 - Wards - Surgery 3; F2 - Wards - Surgery 2; F1 - Wards - Surgery 1
CB	Surgical Units: Nursing Assistants	
CD	Mixed Med/Surg: Registered Nurses	FL - Ward Mixed Med/Surg/Int. Med 2; FK - Ward Mixed Med/Surg/Int. Med 1; FJ - Wards Mixed Med/Surg/PSI 2; FI - Wards Mixed Med/Surg/PSI 1; FH - Wards Mixed Med/Surg 4; FG - Wards Mixed Med/Surg 3; FF - Wards Mixed Med/Surg 2; FE - Wards Mixed Med/Surg 1
CE	Mixed Med/Surg: LPNs	
CF	Mixed Med/Surg: Nursing Assistants	
CH	Acute Mental Health: RNs	HM - Wards Psychiatry Acute 4; HL - Wards Psychiatry Acute 3; H6 - Wards Psychiatry Acute 2; H5 - Wards Psychiatry Acute 1; H4 - Wards Psychiatry Mixed Detox 2; H3 - Wards Psychiatry Mixed Detox 1
CI	Acute Mental Health: LPNs	
CJ	Acute Mental Health: Nursing Assistants	
CP	CLCs: Registered Nurses	G8 - Wards - NHCU Ventilator 2; G7 - Wards - NHCU Ventilator 1; G6 - Wards - Routine NHCU 6; G5 - Wards - Routine NHCU 5; G4 - Wards - Routine NHCU 4; G3 - Wards - Routine NHCU 3; G2 - Wards - Routine NHCU 2; G1 - Wards - Routine NHCU 1
CQ	CLCs: LPNs	
CR	CLCs: Nursing Assistants	
CT	RN Turnover	The report reflects the Facility total loss rate for Registered Nurse (occupation code 0610) Practical Nurse (LPN/LVN - occupation code 0620) and Nursing Assistant (occupation code 0621) Facility Total Loss Rate – Any loss, retirement, death, termination, voluntary separation or transfer that removes employee from the selected Facility.
CU	LPN Turnover	
CV	Nursing Assistant Turnover	
CX	<u>Total FTE/1000 VA Unique Patients</u>	<b>FTE:</b> FMS - Total Medical Care FTE <b>Effective 8/21/03:</b> Program code of .30 included that will be reflected in both current and prior year. This will only be reflected if you run the report using FY 2003 as your fiscal year. Prior year runs were not updated.

		<p><b>For FY 2003 and later</b>, BOCs greater than or equal to 3000 and less than or equal to 3999 are excluded. Prior to this change, capital expenses set up with A1 (would be picked up in the measure) vs capital expenses for 02 being set up with B1 (not captured in the measure), therefore, making this measure incomparable between FY's.</p> <p><b>Effective 5/13/04:</b> Funds beginning with 0162 and 0152 added beginning with FY 2004 data.</p> <p><b>VA Unique Patients:</b> VA hospital Inpatients, Outpatients, NHCU and Doms</p>
<b>Section 2: Effectiveness Measures</b>		
<b>ORYX Inpatient Composites</b>		
CY	Acute Myocardial Infarction	AMI - Inpatient -ASA w/i 24 hours of admission; AMI - Tobacco - Inpatient Counseling – AMI; AMI - Inpatient –timely reperfusion (VA Measure); AMI - Inpatient -LVEF LT 40 on ACEI or ARB at discharge; AMI - Inpatient -Beta blockers w/i 24 hrs after admission; AMI - Inpatient - LDL - Cholesterol Assessment; AMI - Inpatient - Lipid Lowering Therapy f/ at Risk Pts GE 130; AMI - Inpatient -ASA at discharge; AMI - Inpatient -Beta blockers at discharge
CZ	Congestive Heart Failure	HF - Inpatient - LVF assessed or planned at discharge; HF - Inpatient - LVEF LT 40 on ACEI or ARB specific at discharge; HF - Inpatient -Tobacco - Inpatient Counseling – HF; HF - Inpatient - Discharge instructions f/ diet/wt/meds
DA	Community Acquired Pneumonia	CAP - Inpatient - O2 Assess in 24 Hours of Arrival; CAP - Inpatient - Appropriate initial antibiotic f/ immunocompromised pt in ICU; CAP - Inpatient - Appropriate initial antibiotic f/ immunocompromised pt Non-ICU; CAP - Inpatient - Influenza vaccination; CAP - Inpatient - Blood Cultures w/in 24 hrs of arrival - Inpatient ICU; CAP - Inpatient - Blood cultures perform in ED prior to 1st antibiotic; CAP - Inpatient - Initial antibiotic w/in 6 hrs of arrival; CAP - Inpatient - pneumococcal screen & or vaccination; CAP –Inpatient- Tobacco - Inpatient Counseling
DB	SCIP(Surgical Care Improvement Project)	SIP - Inpatient - Correct Antibiotic (All); SIP - Inpatient - Hair removal by acceptable method; SIP - Inpatient - Beta Blocker Therapy Perioperatively; SIP - Inpatient - VTE Prophylaxis Ordered; SIP - Inpatient - VTE Prophylaxis Received w/in 24 hrs; SIP - Inpatient - Prophylactic antibiotics started timely; SIP - Inpatient - Prophylactic antibiotics dc-end timely; SIP - Inpatient - Glucose levels within range - Cardiac Surgery
<b>30 day Risk Adjusted Disease Mortality</b>		
DC	Adjusted Mortality Pneumonia	The ratio of predicted 30-day mortality (death within 30 days of hospital admission) to expected 30-day mortality for patients with a primary diagnosis of pneumonia, multiplied by

		<p>the national VA unadjusted 30-day mortality rate for these patients. Calculated as: <math>(\text{Numerator} / \text{Denominator}) \times \text{Rate}</math>; as percent. Numerator: The mean predicted 30-day mortality of patients who had a primary diagnosis of pneumonia, (anticipated mortality of the specific patients at the specific hospital). Predicted 30-day mortality is estimated by using a multivariate hierarchical logistic regression model that has as predictors: age, gender, 1-year history of coronary artery bypass graft, 1-year history of percutaneous coronary intervention, and 1-year history of co-morbidities, with site as a random effect. Denominator: The mean expected 30-day mortality of patients who had a primary diagnosis of heart failure (anticipated mortality of the specific patients at an average hospital). Expected 30-day mortality is computed from the model described above, using the outcome of each specific patient at the average hospital (i.e., predicted mortality minus the site effect). Rate: The number of patients with a primary diagnosis of pneumonia who die within 30 days of hospital admission divided by the total number of patients with a primary diagnosis of pneumonia x 100.</p>
DD	Adjusted Mortality AMI	<p>The ratio of predicted 30-day mortality (death within 30 days of hospital admission) to expected 30-day mortality for patients with a primary diagnosis of acute myocardial infarction, multiplied by the national VA unadjusted 30-day mortality rate for these patients. Calculated as: <math>(\text{Numerator} / \text{Denominator}) \times \text{Rate}</math>; as percent. Numerator: The mean predicted 30-day mortality of patients who had a primary diagnosis of acute myocardial infarction (anticipated mortality of the specific patients at the specific hospital). Predicted 30-day mortality is estimated by using a multivariate hierarchical logistic regression model that has as predictors: age, gender, 1-year history of coronary artery bypass graft, 1-year history of percutaneous coronary intervention, and 1-year history of co-morbidities, with site as a random effect. Denominator: The mean expected 30-day mortality of patients who had a primary diagnosis of acute myocardial infarction (anticipated mortality of the specific patients at an average hospital). Expected 30-day mortality is computed from the model described above, using the outcome of each specific patient at the average hospital (i.e., predicted mortality minus the site effect). Rate: The number of patients with a primary diagnosis of acute myocardial infarction who die within 30 days of hospital admission divided by the total number of patients with a primary diagnosis of acute myocardial infarction x 100.</p>
DE	Adjusted Mortality CHF	<p>The ratio of predicted 30-day mortality (death within 30 days of hospital admission) to expected 30-day mortality for patients with a primary diagnosis of heart failure, multiplied by</p>

		<p>the national VA unadjusted 30-day mortality rate for these patients. Calculated as: <math>(\text{Numerator} / \text{Denominator}) \times \text{Rate}</math>; as percent. Numerator: The mean predicted 30-day mortality of patients who had a primary diagnosis of heart failure (anticipated mortality of the specific patients at the specific hospital). Predicted 30-day mortality is estimated by using a multivariate hierarchical logistic regression model that has as predictors: age, gender, 1-year history of coronary artery bypass graft, 1-year history of percutaneous coronary intervention, and 1-year history of co-morbidities, with site as a random effect. Denominator: The mean expected 30-day mortality of patients who had a primary diagnosis of heart failure (anticipated mortality of the specific patients at an average hospital). Expected 30-day mortality is computed from the model described above, using the outcome of each specific patient at the average hospital (i.e., predicted mortality minus the site effect). Rate: The number of patients with a primary diagnosis of heart failure who die within 30 days of hospital admission divided by the total number of patients with a primary diagnosis of heart failure x 100.</p>
<p><b>Risk Adjusted Readmission Rates</b></p>		
<p>DF</p>	<p>Acute Myocardial Infarction (AMI)- Facility</p>	<p>The ratio of predicted 30-day readmission (readmission within 30 days of hospital admission) to expected 30-day readmission for patients with a primary diagnosis of acute myocardial infarction, multiplied by the national VA unadjusted 30-day readmission rate for these patients. Calculated as: <math>(\text{Numerator} / \text{Denominator}) \times \text{Rate}</math>; as percent. Numerator: The mean predicted 30-day readmission of patients who had a primary diagnosis of acute myocardial infarction (anticipated readmission of the specific patients at the specific hospital). Predicted 30-day readmission is estimated by using a multivariate hierarchical logistic regression model that has as predictors: age, gender, 1-year history of coronary artery bypass graft, 1-year history of percutaneous coronary intervention, and 1-year history of co-morbidities, with site as a random effect. Denominator: The mean expected 30-day readmission of patients who had a primary diagnosis of acute myocardial infarction (anticipated readmission of the specific patients at an average hospital). Expected 30-day readmission is computed from the model described above, using the outcome of each specific patient at the average hospital (i.e., predicted readmission minus the site effect). Rate: The number of patients with a primary diagnosis of acute myocardial infarction who are readmitted within 30 days of hospital admission divided by the total number of patients with a primary diagnosis of acute myocardial infarction x 100.</p>

DG	Acute Myocardial Infarction (AMI)- HRR	Hospital referral regions (HRRs) are regional market areas for tertiary medical care. Each HRR contains at least one hospital that performs major cardiovascular procedures and neurosurgery
DH	Congestive Heart Failure (CHF)- Facility	The ratio of predicted 30-day readmission (readmission within 30 days of hospital admission) to expected 30-day mortality for patients with a primary diagnosis of heart failure, multiplied by the national VA unadjusted 30-day readmission rate for these patients. Calculated as: (Numerator / Denominator) x Rate; as percent. Numerator: The mean predicted 30-day readmission of patients who had a primary diagnosis of heart failure (anticipated readmission of the specific patients at the specific hospital). Predicted 30-day readmission is estimated by using a multivariate hierarchical logistic regression model that has as predictors: age, gender, 1-year history of coronary artery bypass graft, 1-year history of percutaneous coronary intervention, and 1-year history of co-morbidities, with site as a random effect. Denominator: The mean expected 30-day readmission of patients who had a primary diagnosis of heart failure (anticipated readmission of the specific patients at an average hospital). Expected 30-day readmission is computed from the model described above, using the outcome of each specific patient at the average hospital (i.e., predicted readmission minus the site effect). Rate: The number of patients with a primary diagnosis of heart failure who are readmitted within 30 days of hospital admission divided by the total number of patients with a primary diagnosis of heart failure x 100.
DI	Congestive Heart Failure (CHF)- HRR	Hospital referral regions (HRRs) are regional market areas for tertiary medical care. Each HRR contains at least one hospital that performs major cardiovascular procedures and neurosurgery
DJ	Pneumonia- Facility	The ratio of predicted 30-day readmission (readmission within 30 days of hospital admission) to expected 30-day readmission for patients with a primary diagnosis of pneumonia, multiplied by the national VA unadjusted 30-day mortality rate for these patients. Calculated as: (Numerator /Denominator) x Rate; as percent. Numerator: The mean predicted 30-day readmission of patients who had a primary diagnosis of pneumonia, (anticipated readmission of the specific patients at the specific hospital). Predicted 30-day readmission is estimated by using a multivariate hierarchical logistic regression model that has as predictors: age, gender, 1-year history of coronary artery bypass graft, 1-year history of percutaneous coronary intervention, and 1-year history of co-morbidities, with site as a random effect. Denominator: The mean expected 30-day readmission of patients who had a primary diagnosis of heart failure (anticipated readmission of the specific patients at an average hospital). Expected 30-day

		readmission is computed from the model described above, using the outcome of each specific patient at the average hospital (i.e., predicted mortality minus the site effect). Rate: The number of patients with a primary diagnosis of pneumonia who are readmitted within 30 days of hospital admission divided by the total number of patients with a primary diagnosis of pneumonia x 100.
DK	Pneumonia- HRR	Hospital referral regions (HRRs) are regional market areas for tertiary medical care. Each HRR contains at least one hospital that performs major cardiovascular procedures and neurosurgery
<b>VASQIP Outcome measures</b>		
DL	Surgical Mortality	The VASQIP program analyzes patient data using mathematical models to predict an individual patient’s expected outcome based on the patient’s preoperative characteristics and the type and nature of the surgical procedure. Overall patient outcomes for major surgical procedures are expressed by comparing observed rates of mortality and morbidity to the expected rates for those patients undergoing the procedure as observed-to-expected (O/E) ratios. For example, if, based on patient characteristics, a facility expected 5 deaths following major surgery, but only 4 patients died, the O/E ratio would be reported as 0.8.
DM	Surgical Morbidity	
<b>Outpatient Composites</b>		
DN	Diabetes Mellitus	Measures in the Diabetic Composite: DM - Outpatients - HbA1 > 9 or not done (poor control) in past year (HEDIS); DM - Outpatients - LDL-C < 100 (HEDIS); DM - Outpatients - BP LE 140/90; DM - Outpatients - Retinal exam, timely by disease (HEDIS); DM - Outpatients - LDL-C measured (HEDIS) w/ 1 yr review; DM - Outpatients - Renal Testing (HEDIS); DM - Outpatients - HbA1c Annual
DO	Prevention	CA - Women age 50-69 screened for Breast Cancer (HEDIS); CA - Women age 21-64 screened for Cervical Cancer in the past 3 yrs (HEDIS); CA - Pts receiving appropriate Colorectal Cancer Screening (HEDIS); P-Immunizations - Pneumococcal Outpatients – Nexus; Immunizations - Outpatients - Influenza ages 50-64 - Nexus Clinics (HEDIS); Immunizations - Outpatients - Influenza ages GE 65 (HEDIS); Mov- Outpatients screened for Obesity
DP	Ischemic Heart Disease	HTN - Outpatients diagnosis HTN & BP LT 140/90 (HEDIS); AMI - Outpatients LDL-C measured (HEDIS); AMI - Outpatients LDL-C LT 100 (HEDIS)
DQ	Tobacco	Tobacco - Outpatients - Pts using tobacco in past year who have been offered meds; Tobacco - Outpatients - Pts using tobacco in past year provided w/ counseling on how to quit; Tobacco - Outpatients - Pts using tobacco in past year offered referral to cessation program

DR	Behavioral Health Screening (BHS)	SUD- Outpatients screened annually for Alcohol Misuse; PTSD- Outpatients screened at required intervals for PTSD using the PC-PTSD; MDD- Outpatients screened annually for depression ; SUD - Outpt - Pts scrn f/ alcohol misuse w/ score GE 5 w/ timely counsel; Combined scores for timely suicide evals if pos ptsd or mdd scrn
<b>Patient Aligned Care Team (PACT) Metrics</b>		
DS	Percent of same day appointments with assigned provider	This measures the percent of requested same day appointments (desire date = create date or walk-ins) in PC Clinics 322, 323 and 350 for PC assigned patients where the patient was seen by their Primary Care and/or Associate Provider within 1 day of the desired date. Note this metric does include walk-in appointments if entered in the appointment package.
DT	Percent of encounters by telephone	The ratio of encounters in the reporting month for primary care assigned patients where the encounter has one of the following telephone stop codes (103, 147,148,169,178,181,182,199, 216,221,229, 324,325, 326, 424,425,428,527,528,530,536,537,542,545,546,579,584,597,611,686) in combination with any of these stop codes (322,323,348,350,531,704,534) <u>and</u> any encounters where stop code 338 is in the primary position on the encounter, divided by the total encounters for assigned primary care patients in the reporting month where the encounter has one of the following primary care stop codes (322,323,338,348,350,531,704,534,539) in the primary or secondary position on the encounter. Note that this measure looks at encounter activity across all VHA facilities for the assigned primary care patients.
DU	Completed appointments within 7 days (primary care)	The percent of New and Established Patient Appointments for Primary Care (clinic stops 322, 323, and 350), excluding C&P appointments, where the patient appointment was within 7 days (between 0 and 7 days) of the patient's desired date.
DV	Percent of visits with assigned provider (Continuity)	This is a measure of where the patient receives his primary care and by whom. A high percentage is better. The formula is the number of Primary Care Encounters WOP with the patient's assigned primary care (or associate) provider <i>divided by</i> the number of Primary Care Encounters WOP with the patient's assigned primary care (or associate) provider <b>plus</b> the total VHA ER/Urgent Care WOP <b>plus</b> the number of Primary Care Encounters WOP with a provider other than the patient's PCP/AP.
DW	Post-discharge contact by assigned provider within 2 days	The percent of discharges (VHA and FEE inpatient discharges) for the reporting timeframe for assigned primary care patients where the patient was contacted by primary care within <b>2 business days</b> post discharge. Discharges resulting in death and discharges where a patient is

		readmitted within 2 days of discharge are excluded from this metric.
<b>Section 3: Equitable</b>		
<b>Outpatient composites: Gender</b>		
DX	Diabetes Mellitus- Male	Data source: External Peer Review Program (EPRP) outpatient samples in FY 2012; includes women oversamples. Scores are weighted. Diabetes Composite: Diabetes measure HbA1 GT 9 or not done (poor control) in past year (DMG23H) is reversed to reflect higher performance is better. Results for composites with less than 100 cases are not shown. Stratified results are not shown if at least one of the Gender categories has less than 100 cases for a given composite. Prevention Composite excludes preventive measures specific to women (Breast Cancer and Cervical Cancer screenings).
DY	Diabetes Mellitus- Female	
DZ	Diabetes Mellitus- Gender Difference	
EA	Prevention- Male	
EB	Prevention- Female	
EC	Prevention- Gender Difference	
ED	Ischemic Heart Disease- Male	
EE	Ischemic Heart Disease- Female	
EF	Ischemic Heart Disease- Gender Diff.	
EG	Tobacco- Male	
EH	Tobacco- Female	
EI	Tobacco- Gender Difference	
EJ	Behavioral Health Screening- Male	
EK	Behavioral Health Screening- Female	
EL	Behavioral Health Screening- Gender Diff.	
<b>Outpatient composites: Age</b>		
EM	Diabetes Mellitus- <65yo	Data source: External Peer Review Program (EPRP) outpatient samples in FY 2012. Scores are weighted. Diabetes Composite: Diabetes measure HbA1 GT 9 or not done (poor control) in past year (DMG23H) is reversed to reflect higher performance is better. Results for composites with less than 100 cases are not shown. Stratified results are not shown if a least one of the Age categories has less than 100 cases for a given composite. Prevention Composite excludes age-specific preventive measure (women age 21-64 screened for cervical cancer)
EN	Diabetes Mellitus- 65+yo	
EO	Diabetes Mellitus- Age Difference	
EP	Prevention- <65yo	
EQ	Prevention- 65+yo	
ER	Prevention- Age Difference	
ES	Ischemic Heart Disease- <65yo	
ET	Ischemic Heart Disease- 65+yo	
EU	Ischemic Heart Disease- Age Difference	
EV	Tobacco- <65yo	

EW	Tobacco- 65+yo	
EX	Tobacco- Age Difference	
EY	Behavioral Health Screening- <65yo	
EZ	Behavioral Health Screening- 65+yo	
FA	Behavioral Health Screening- Age Diff.	
<b>Patient Satisfaction: Ethnic breakout</b>		
FB	Satisfaction w/Inpatient Care- White	Number of patients responding to the Inpatient SHEP survey Question 21: Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay?
FC	Satisfaction w/Inpatient Care- White	Percentage of patients responding with 9 or 10 to the Inpatient SHEP survey Question 21: Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay?
FD	Satisfaction w/Inpatient Care- Other	Number of patients responding to the Inpatient SHEP survey Question 21: Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay?
FE	Satisfaction w/Inpatient Care- Other	Percentage of patients responding with 9 or 10 to the Inpatient SHEP survey Question 21: Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay?
FF	Satisfaction w/Outpatient Care- White	Number of patients responding to the Outpatient SHEP survey Question 10: Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your VA health care in the last 12 months?
FG	Satisfaction w/Outpatient Care- White	Percentage of patients responding with 9 or 10 to the Outpatient SHEP survey Question 10: Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your VA health care in the last 12 months?
FH	Satisfaction w/Outpatient Care- Other	Number of patients responding to the Outpatient SHEP survey Question 10: Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your VA health care in the last 12 months?
FI	Satisfaction w/Outpatient Care- Other	Percentage of patients responding with 9 or 10 to the Outpatient SHEP survey Question 10: Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your VA health care in the last 12

		months?
<b>SECTION 4: Safe</b>		
<b>Health care Associated Infections</b>		
FJ	Ventilator Associated Pneumonia	Ventilator Associated Pneumonia (VAP) Infection Rate = (numerator/denominator) x 1000 Numerator: The number of VAP infections (ICU). Denominator: The number of ventilator days.
FK	Number of Ventilator days	Total number of days of exposure to ventilators by all patients in the ICU. The count is performed at the same time each day.
FL	CLAB	Central Line Associated Bloodstream (CLAB) Infection Rate = (numerator/denominator) x 1000 Numerator: The number of central line infections. Denominator: The number of central line days.
FM	Number of Central line days	Total number of days a central line is in place for patients in certain hospital unit. The count is performed at the same time each day. Each patient with one or more central lines at the time the count is performed is counted as one central line day.
FN	ICU MRSA	MRSA Infection Rate (Intensive Care Units (ICU) Only)= (numerator/denominator) x 1000 Numerator: Total number of MRSA infections (culture positive). Denominator: Bed days of care.
FO	ICU MRSA Screening Rate	MRSA Composite Screening Rate (ICU only)= (numerator/denominator) x 100 Numerator: Total number of indicated nasal screens for MRSA performed timely. Denominator: 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.
FP	Acute Care MRSA	MRSA Infection Rate (Acute care ward)= (numerator/denominator) x 1000 Numerator: Total number of MRSA infections (culture positive). Denominator: Bed days of care.
FQ	Acute Care MRSA Screening Rate	MRSA Composite Screening Rate (Acute care wards)= (numerator/denominator) x 100 Numerator: Total number of indicated nasal screens for MRSA performed timely. Denominator: 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.
<b>Patient Safety Measures</b>		

FR	ICU risk adjusted Length of Stay	ICU Risk Adjusted Length of Stay (OMELOS): OMELOS is “observed minus expected length of stay” and is risk adjusted by the IPEC. The average observed patient-level unit length of stay minus expected patient-level unit length of stay for ICU stays at a given facility. If the OMELOS is less than zero, then observed unit length of stay is less than expected. If the OMELOS is greater than zero, then the observed unit length of stay is greater than expected.
FS	Insulin induced hypoglycemia	Insulin Induced Hypoglycemia BS<45 mg/dl: The percentage of patient-days in the ICU, for patients with orders written for insulin or other hypoglycemic agents, with any glucose measurements less than or equal to 45 mg/dL. Calculated as (numerator / denominator) x 100; as percent. Numerator: The total number of ICU patient-days, for patients with orders written for insulin or other hypoglycemic agents (VA Drug Class HS501 or HS502) between 8 hours before hospital admission (e.g., orders written in the ED) and unit discharge, with any glucose measurements less than or equal to 45 mg/dL. Denominator: The total number of ICU patient-days for patients with orders written for insulin or other hypoglycemic agents (VA Drug Class HS501 or HS502) between 8 hours before hospital admission (e.g., orders written in the ED) and unit discharge.
FT	Hospital acquired pressure ulcers	<p>Pressure ulcer prevention is an important patient safety goal. VA reports the incidence of hospital acquired pressure ulcers (HAPU) that are Stage II or greater. Stage II pressure ulcers are when the skin breaks open, wears away, or forms an ulcer which may or may not be tender and painful. Even with appropriate medical and nursing care, sometimes pressure ulcers are unavoidable due to patient-specific factors. As a result, some VA facilities with a high proportion of very old or debilitated patients may have higher HAPU rates</p> <p>The Institute for Healthcare Improvement (IHI) Mentor Hospital Registry lists hospital acquired pressure ulcer <u>incidence</u> rates ranging from 1.14 percent to 5.07 percent. When reviewing comparative data, it is important to ensure that the incidence rate is reviewed (many health care facilities use prevalence as a measure for hospital acquired pressure ulcers).<sup>[1]</sup></p>

<sup>[1]</sup> [http://www.ihl.org/IHI/Programs/Campaign/mentor\\_registry\\_pu.htm](http://www.ihl.org/IHI/Programs/Campaign/mentor_registry_pu.htm)

		<p>Data Definitions for FY 2012 data.</p> <p>Hospital Acquired Pressure Ulcer (HAPU) for FY 2012 includes data reported in the VANOD Skin Risk cube for the following nursing unit types: Critical Care, Medical, Acute Mental Health, Acute Mixed Medical Surgical, Step-down, SCI Acute and Rehab, and Surgical. The rate is calculated based upon the number of patients discharged from the included unit types who had a HAPU documented over the total ward days of care. In FY 2012, the report logic was updated to EXCLUDE HAPU's documented on the day of discharge when a patient was admitted immediately to a CLC. This was done to alleviate confusion resulting from the MDS wound classification and HAPU assessments. In addition, the files used to identify patients was changed from the National Patient Care Database to the Nursing Unit Mapping Application (NUMA) tool and the change from patient days (based upon midnight census) to ward days of care (that calculates a ward day based upon the exact amount of time a patient spends on a ward).</p> <p>Data is reported as the rate, calculated as: Hospital Acquired Pressure Ulcer (HAPU) Rate = (numerator / denominator) x 1000 <b>Numerator (HAPU 2 plus Count):</b> The number of discharged Acute Care patients who develop Hospital-Acquired Pressure Ulcers Stage II or greater as documented in the VANOD templates with a length of stay 48 hours or longer. <b>Denominator:</b> Discharge date minus admission date for all discharged Acute Care patients with a length of stay 48 hours or longer. **It should be noted that Data are only captured if the VANOD skin templates have been used properly. If a facility is not using all of the VANOD templates as intended, the HAPU rate may be incorrectly reflected. Additional documentation and definitions are available on the VANOD products page:  <a href="http://vssc.med.va.gov/products.asp">http://vssc.med.va.gov/products.asp</a></p>
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**SECTION 5: Timely**

FU	Primary Care patients seen within 14 days	Measurement segments all primary care patients into two groups; those that are new (not seen in the clinic group in the past 24 months) and all others, or "established" patients. Wait times for new and established patients are calculated from the appointment desired date. The desired appointment date is the date on which the patient or provider wants the patient to be seen. The goal is to see patients (complete appointments) within 14 days from the desired date
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		for all appointments.
FV	Specialty care patients seen within 14 days	Measurement segments all specialty care patients into two groups; those that are new (not seen in the clinic group in the past 24 months) and all others, or “established” patients. Wait times for new and established patients are calculated from the appointment desired date. The desired appointment date is the date on which the patient or provider wants the patient to be seen. The goal is to see patients (complete appointments) within 14 days from the desired date for all appointments.
<b>SECTION 6: Patient-Centered</b>		
<b>Satisfaction with Inpatient Care</b>		
FW	Communication with Nurses Number of surveys returned	Question 1. During this hospital stay, how often did nurses treat you with courtesy and respect?
FX	Communication with Nurses Score	Question 2. During this hospital stay, how often did nurses listen carefully to you? Question 3. During this hospital stay, how often did nurses explain things in a way you could understand? Questions 1, 2, and 3 have the following response scale: Never, Sometimes, Usually, Always. The score on each item is calculated as the percentage of responses that fall in the top category (Always). Communication with Nurses is then calculated as the average of the site's scores on the three items.
FY	Communication with Doctors Number of surveys returned	Question 5. During this hospital stay, how often did doctors treat you with courtesy and respect?
FZ	Communication with Doctors Score	Question 6. During this hospital stay, how often did doctors listen carefully to you? Question 7. During this hospital stay, how often did doctors explain things in a way you could understand? Questions 5, 6, and 7 have the following response scale: Never, Sometimes, Usually, Always. The score on each item is calculated as the percentage of responses that fall in the top category (Always). Communication with Doctors is then calculated as the average of the site's scores on the three items.
GA	Responsiveness of Hospital Staff Number of surveys returned	Question 4. During this hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it?

GBF I	Responsiveness of Hospital Staff Score	<p>Question 11. How often did you get help in getting to the bathroom or in using a bedpan as soon as you wanted? Filter: Question 10. During this hospital stay, did you need help from nurses or other hospital staff in getting to the bathroom or in using a bedpan? [Response options: Yes, No] Question 4 has the following response scale: Never, Sometimes, Usually, Always, I never pressed the call button. The score on Question 4 is calculated as the percentage of responses that fall in the top category (Always); responses of 'I never pressed the call button' are excluded from the denominator in the calculation of this percentage. Question 11 has the following response scale: Never, Sometimes, Usually, Always. The score on Question 11 is calculated as the percentage of responses that fall in the top two categories (Usually, Always). "Responsiveness" is then calculated as the average of the site's scores on the two items.</p>
GC	Pain Management Number of surveys returned	<p>Question 13. During this hospital stay, how often was your pain well controlled? Question 14. During this hospital stay, how often did the hospital staff do everything they could to help you with your pain?</p>
GD	Pain Management Score	<p>Filter: Question 12. During this hospital stay, did you need medicine for pain? [Response options: Yes, No] Questions 13 and 14 have the following response scale: Never, Sometimes, Usually, Always. The score on each item is calculated as the percentage of responses that fall in the top two categories (Usually, Always). Pain Control is then calculated as the average of the site's scores on the two items.</p>
GE	Communication about medication Number of surveys returned	<p>Question 16. Before giving you any new medicine, how often did hospital staff tell you what the medicine was for?</p>
GF	Communication about medication Score	<p>Question 17. Before giving you any new medicine, how often did hospital staff describe possible side effects in a way you could understand? Filter: Question 15. During this hospital stay, were you given any medicine that you had not taken before?</p>

		<p>Questions 16 and 17 have the following response scale: Never, Sometimes, Usually, Always. The score on each item is calculated as the percentage of responses that fall in the top category (Always). Communication about Medication is then calculated as the average of the site's scores on the two items.</p>
GG	Cleanliness of the hospital environment Number of surveys returned	<p>Question 8. During this hospital stay, how often were your room and bathroom kept clean? Question 8 has the following response scale: Never, Sometimes, Usually, Always. The reporting measure is calculated as the percentage of responses that fall in the top two categories (Usually, Always).</p>
GH	Cleanliness of the hospital environment Score	
GI	Quietness of the hospital environment Number of surveys returned	<p>Question 9. During this hospital stay, how often was the area around your room quiet at night? Question 9 has the following response scale: Never, Sometimes, Usually, Always. The reporting measure is calculated as the percentage of responses that fall in the top two categories (Usually, Always).</p>
GJ	Quietness of the hospital environment Score	
GK	Discharge information Number of surveys returned	<p>Question 19. During this hospital stay, did doctors, nurses or other hospital staff talk with you about whether you would have the help you needed when you left the hospital? Question 20. During this hospital stay, did you get information in writing about what symptoms or health problems to look out for after you left the hospital? Filter: Question 18. After you left the hospital, did you go directly to your own home, to someone else's home, or to another health facility? Questions 19 and 20 have the following response scale: Yes, No. The score on each item is calculated as the percentage of 'Yes' responses. Discharge Information is then calculated as the average of the site's scores on the two items.</p>
GL	Discharge information Score	
GM	Overall rating of hospital Number of surveys returned	<p>Question 21. Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay? Question 21 has the following response scale: 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10. The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).</p>
GN	Overall rating of hospital Score	
GO	Willingness to recommend Number of surveys returned	<p>Question 22. Would you recommend this hospital to your friends and family? Question 22 has the following response scale: Definitely no, Probably no, Probably yes,</p>

GP	Willingness to recommend Score	Definitely yes. The reporting measure is calculated as the percentage of responses in the top category (Definitely yes).
<b>Satisfaction with Outpatient Care</b>		
GQ	How Well Doctors/Nurses Communicate Number of surveys returned	Question 15. In the last 12 months, how often did your personal VA doctor or nurse explain things in a way that was easy to understand? Question 16. In the last 12 months, how often did your personal VA doctor or nurse listen carefully to you?
GR	How Well Doctors/Nurses Communicate Score	Question 18. In the last 12 months, how often did your personal VA doctor or nurse show respect for what you had to say? Question 19. In the last 12 months, how often did your personal VA doctor or nurse spend enough time with you? Filters: Question 13. A personal doctor or nurse is the one you would see if you need a checkup, want advice about a health problem or get sick or hurt. Do you have a personal VA doctor or nurse? [Response options: Yes, No] Question 14. In the last 12 months, how many times did you visit your personal VA doctor or nurse to get care for yourself? [Response options: None, 1, 2, 3, 4, 5 to 9, 10 or more] Responses to Questions 15, 16, 18, and 19 were used only if response to Question 13 was 'yes' or blank and response to Question 14 was not 'None.' Questions 15, 16, 18, and 19 have the following response scale: Never, Sometimes, Usually, Always. The score on each item is calculated as the percentage of responses that fall in the top category (Always). How Well Doctors/Nurses Communicate is then calculated as the average of the site's scores on the four items.
GS	Rating of Personal Doctor/Nurse Number of surveys returned	Question 20. Using any number from 0 to 10, where 0 is the worst personal doctor/nurse possible and 10 is the best personal doctor/nurse possible, what number would you use to rate your personal VA doctor/nurse?
GT	Rating of Personal Doctor/Nurse Score	Filter: Question 13. A personal doctor or nurse is the one you would see if you need a checkup, want

		<p>advice about a health problem or get sick or hurt. Do you have a personal VA doctor or nurse? [Response options: Yes, No]</p> <p>Responses to Question 20 were used only if response to Question 13 was 'yes' or blank.</p> <p>Question 20 has the following response scale: 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10.</p> <p>The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).</p>
GU	Getting Needed Care Number of surveys returned	<p>Question 12. In the past 12 months, how often was it easy to get the care, tests or treatment you thought you needed through VA?</p>
GV	Getting Needed Care Score	<p>Filter: Question 11. In the past 12 months, did you try to get any care, tests or treatment through VA? [Response options: Yes, No]</p> <p>Response to Question 12 was used only if response to Question 11 was 'yes' or blank.</p> <p>Question 22. In the last 12 months, how often was it easy to get appointments with VA specialists?</p> <p>Filter: Question 21. Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. In the last 12 months, did you try to make any appointments to see a VA specialist? [Response options: Yes, No]</p> <p>Response to Question 22 was used only if response to Question 21 was 'yes' or blank.</p> <p>Questions 12 and 22 have the following response scale: Never, Sometimes, Usually, Always.</p> <p>The score on each item is calculated as the percentage of responses that fall in the top category (Always).</p> <p>Getting Needed Care is then calculated as the average of the site's scores on the two items.</p>
GW	Overall Rating of VA Health Care Number of surveys returned	<p>Question 10. Using any number from 0 to 10, where 0 is the worst health care possible and 10 is the best health care possible, what number would you use to rate all your VA health care in the last 12 months?</p>
GX	Overall Rating of VA Health Care Score	<p>Question 10 has the following response scale: 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10.</p> <p>The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).</p>
GY	Getting Care Quickly Number of surveys returned	<p>Question 2. In the last 12 months, when you needed care right away, how often did you get care as soon as you thought you needed?</p>
GZ	Getting Care Quickly Score	<p>Filter: Question 1. In the last 12 months, did you have an illness, injury, or condition that needed care right away in a clinic, emergency room, or doctor's office? [Response options: Yes,</p>

		<p>No]</p> <p>Response to Question 2 was used only if response to Question 1 was 'yes' or blank.</p> <p>Question 4. In the past 12 months, not counting the times you needed care right away, how often did you get an appointment as soon as you thought you needed?</p> <p>Filter: Question 3. In the last 12 months, not counting the times you needed care right away, did you make any appointments for your health care at a doctor's office or clinic? [Response options: Yes, No]</p> <p>Response to Question 4 was used only if response to Question 3 was 'yes' or blank.</p> <p>Questions 2 and 4 have the following response scale: Never, Sometimes, Usually, Always.</p> <p>The score on each item is calculated as the percentage of responses that fall in the top category (Always).</p> <p>Getting Care Quickly is then calculated as the average of the site's scores on the two items.</p>
HA	Overall Rating of VA Specialist Number of surveys returned	<p>Question 24. We want to know your rating of the VA specialist you saw most often in the last 12 months. Using any number from 0 to 10, where 0 is the worst specialist possible and 10 is the best specialist possible, what number would you use to rate that VA specialist?</p> <p>Filters:</p> <p>Question 21. Specialists are doctors like surgeons, heart doctors, allergy doctors, skin doctors, and other doctors who specialize in one area of health care. In the last 12 months, did you try to make any appointments to see a VA Specialist? [Response options: Yes, No]</p> <p>Question 23. How many VA specialists have you seen in the last 12 months? [Response options: None, 1 VA specialist, 2, 3, 4, 5 or more VA specialists]</p> <p>Response to Question 24 was used only if response to Question 21 was 'yes' or blank and response to Question 23 was not 'None'.</p> <p>Question 24 has the following response scale: 0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10.</p> <p>The reporting measure is calculated as the percentage of responses that fall in the top two categories (9, 10).</p>
HB	Overall Rating of VA Specialist Score	
HC	Provider Wait Time 20 min or less Number of surveys returned	Outpatient Question 32: Percentage reporting a wait time of 20 minutes or less
HD	Provider Wait Time 20 min or less Score	
<b>SECTION 7: Efficient</b>		

Ambulatory Care Sensitive Conditions		
HE	All 12	All 12 ACSC Conditions: Hospitalizations per 1000 ACSC Patients: This is the risk standardized admission rate of ACSC hospitalizations per 1000 unique ACSC patients during the Fiscal Year reporting period. A total of 130 ICD-9 diagnosis codes associated with the 12 ACSCs listed previously were used to identify all patients with any of the ACSCs (see code detail at <a href="http://www.qualityindicators.ahrq.gov/pqi_download.htm">http://www.qualityindicators.ahrq.gov/pqi_download.htm</a> ) in any position in the inpatient, outpatient, and Fee/Contract files. Avoidable or ACSC hospitalizations were identified by matching these 130 ICD-9 codes to the principal diagnosis in the inpatient main files (certain CHF and pneumonia admissions are excluded according to AHRQ's algorithm). ACSC patients and hospitalizations were then assigned to facilities by their assignment to an associated primary care provider (PCP).
HF	CHF	Congestive Heart Failure (CHF): Hospitalizations per 1000 CHF ACSC Patients: This is the risk standardized admission rate of CHF ACSC hospitalizations per 1000 unique CHF ACSC patients during the Fiscal Year reporting period. A total of 25 ICD-9 diagnosis codes associated with the CHF ACSCs were used to identify all patients with any of the ACSCs (see code detail at <a href="http://www.qualityindicators.ahrq.gov/pqi_download.htm">http://www.qualityindicators.ahrq.gov/pqi_download.htm</a> ) in any position in the inpatient, outpatient, and Fee/Contract files. Avoidable or ACSC hospitalizations were identified by matching these 25 ICD-9 codes to the principal diagnosis in the inpatient main files (certain CHF admissions are excluded according to AHRQ's algorithm). CHF ACSC patients and hospitalizations were then assigned to facilities by their assignment to an associated Primary Care Provider (PCP).
HG	Pneumonia	Pneumonia: Hospitalizations per 1000 Pneumonia ACSC Patients: This is the risk standardized admission rate of bacterial pneumonia ACSC hospitalizations per 1000 unique bacterial pneumonia ACSC patients during the Fiscal Year reporting period. A total of 12 ICD-9 diagnosis codes associated with the bacterial pneumonia ACSCs were used to identify all patients with any of the ACSCs (see code detail at <a href="http://www.qualityindicators.ahrq.gov/pqi_download.htm">http://www.qualityindicators.ahrq.gov/pqi_download.htm</a> ) in any position in the inpatient, outpatient, and Fee/Contract files. Avoidable or ACSC hospitalizations were identified by matching these 12 ICD-9 codes to the principal diagnosis in the inpatient main files (certain pneumonia admissions are excluded according to the AHRQ's algorithm). Bacterial Pneumonia ACSC patients and hospitalizations were then assigned to facilities by their assignment to an

		associated primary care provider (PCP).
	Acute Care Admissions not meeting InterQual Clinical Appropriateness Criteria- level of care too high	
	Post-Admission Bed Days not meeting Clinical Appropriateness Criteria-level of care too low	
	Post-Admission Bed Days not meeting Clinical Appropriateness Criteria-level of care too high	