U.S. Department of Veterans Affairs
Veterans Health Administration
Office of Community Care

Veterans Health Administration Office of Community Care

Patient Safety Guidebook

December 2018

EXECUTIVE SUMMARY

The goal of the Veterans Health Administration (VHA) Office of Community Care (OCC) and National Center for Patient Safety (NCPS) is to align quality and patient safety policies across the spectrum of care for Department of Veterans Affairs (VA) beneficiaries, to include both internal VHA (direct) and purchased care. This VHA OCC Patient Safety Guidebook and its associated community care-related patient safety reporting, investigation, and improvement processes were developed to resolve identified gaps in information sharing, reporting structure, and feedback to stakeholders for patient safety events (adverse events and close calls) that occur when Veterans are receiving care on behalf of VA in the community.

The VHA OCC Patient Safety Guidebook, built on existing VHA patient safety reporting and investigation processes, provides the tools and processes to report, disclose, investigate, and improve patient safety for Veterans who receive care in the community and supports VHA's goal of preventing inadvertent harm to Veterans consequent to their medical care. The Guidebook and its associated processes increase communication and collaboration between VHA and its community partners.

Developed in collaboration with VA Medical Center (VAMC) Patient Safety Managers (PSMs), Veterans Integrated Service Network (VISN) Patient Safety Officers (PSOs), and the National Center for Patient Safety (NCPS), the Guidebook is intended to provide clear roles, responsibilities, and procedures to explore vulnerabilities in the community care system and emphasize prevention through collaboration with community partners to mitigate system vulnerabilities and improve patient safety.

A community care patient safety event is defined as an adverse event or close call (see Glossary) impacting a Veteran that occurs at a facility outside VA that is providing care on behalf of VA. While the focus of this Guidebook is on community care events occurring involving third-party administrators (TPAs, contractual relationships established under the Veterans Choice Program [VCP] network, Patient-Centered Community Care [PC3] network, or the Community Care Network [CCN]), VHA is expected to also work with non-TPA community care providers, as able, to investigate events and implement corrective actions.

POLICY

The VHA Handbook 1050.01 directs VA employees on the procedures needed to accomplish the VHA's goal of preventing inadvertent harm to patients consequent to their medical care. Under its Organizational Excellence Program Office, VHA implemented a four- step approach to patient safety and respect for patients based on the principles of a high reliability organization that includes:

1. Understanding the health care continuum as a system, and exploring system vulnerabilities that can result in patient harm
2. Reporting of adverse events and close calls
3. Emphasizing prevention rather than punishment to mitigate system vulnerabilities Disclosure of adverse events to patients

KEY TERMS

For the purposes of the VHA OCC Patient Safety Guidebook, please see the Table of Key Terms below for community care-related terms used throughout the Guidebook. For additional definitions, please refer to the Glossary at the end of the Guidebook.

Table of Key Terms

Key Term	Definition
Community Care	Care that is provided to veterans in the community through regional contracting vehicles, provider agreements, individual authorizations, Veterans Care Agreements, and/or other memorandums of understanding (MOUs).

Key Term	Definition
Third-party Administrator (TPA)	A company that is contracted by VHA to create a regional network of providers that provide care to Veterans. Examples of Veteran programs which incorporate TPAs include: Veterans Choice Program (VCP), Patient-Centered Community Care (PC3), and the Community Care Network (CCN). *TPAs are responsible for ensuring that safe medical care is provided to Veterans by providers in their network. Each TPA is responsible for investigating adverse events and close calls that occur to Veterans who see a provider in their network through the VCP, PC3, or CCN programs and to ensure that appropriate follow up actions are taken when necessary.
TPA Quality and Patient Safety Representative	An assigned representative from the TPA's quality and patient safety team who coordinates with VISN PSOs, PSMs, VAMC community care coordination staff, and VHA OCC for community care-related patient safety issues that occur within the TPA's network
Non-TPA Community Care	All other community care services supported by VHA that are not provided through TPA contracts (examples include care delivered through individual authorizations, provider agreements, Veterans Care Agreements, home health services, dialysis, etc.)
VHA Office of Community Care (OCC) staff	Staff employed by the VHA Program Office supporting the community care program
VAMC community care coordination staff	VAMC staff directly supporting the coordination of care for Veterans receiving care in the community

ROLES AND RESPONSIBILITIES

Roles and responsibilities for community care-related adverse event and close call reporting and investigation processes are outlined in detail in Appendix A. Those roles considered "key" are called out within the matrix in Appendix B, featuring specific community care-related patient safety tasks for these roles.

PROCEDURES FOR PROCESSING COMMUNITY CARE-RELATED PATIENT SAFETY EVENTS

Procedures associated with reporting, investigation, and improvement a community care related patient safety events are outlined here. A process flow providing an overview of these processes is included in Appendix C. Utilization of the Joint Patient Safety Reporting System (JPSR) within this process is paramount to ensuring that patient safety events are properly captured and investigated, and so that records of these events can be utilized in trend analysis focused on reducing such events.

Patient Safety Reporting:

1. For any patient safety event that has occurred in community care, a VAMC staff member identifies the patient safety event and reports it in the Joint Patient Safety Reporting System (JPSR)
    - In JPSR, "contracted care" is selected for location of the event and report is submitted
    - Staff should ensure that full details of the event are provided in the event description area, however do not utilize personal identification of staff or the patient in the event description box
    - Supporting documentation relevant to the patient safety event should be attached in PDF form when submitting the event in JPSR
2. Notification sent by JPSR (once event report submitted) to VA Facility PSM
3. VA Facility PSM reviews event report and determine any immediate action needs, to include clinical needs of the injured Veteran, based on type, severity, and probability of the event, and the notification distribution requirements for the event
    - For administrative issues not classified as a patient safety event (no potential or actual harm occurs to the patient), report the issue through the appropriate venue
    - For adverse events and close calls with the **potential** to be scored with a SAC = 3 or classified high severity/probability (pre-SAC scoring/assessment, based on initial assessment of event), complete notifications and procedures per the table within Appendix D referencing community care-related tasks for events reported by VHA staff

Patient Safety Investigation:

1. Review event and conduct initial investigation

   - VA Facility PSM reviews reported event in JPSR and requests that appropriate VAMC community care coordination staff review case, engage with other VAMC community care coordination staff and/or TPA Quality and Patient Safety Representative if needed, conduct an initial investigation, perform any needed immediate actions, to include addressing clinical needs of the injured Veteran, and provide a summary of findings to the PSM

   - Non-VHA staff (TPA or Non-TPA community care) follow established organizational procedures and contractual requirements to investigate event and perform appropriate follow-up actions

2. Assess event's severity/probability

   - VA Facility PSM scores event using SAC matrix from VHA Handbook 1050.01, enters event data into patient safety event management system, and performs appropriate action based on SAC score per VHA Handbook 1050.01

   - Non-VHA staff perform appropriate action based on organizational procedures, contractual requirements, and this Guidebook

3. Complete procedures are provided in Appendix E for the investigation of adverse events and close calls deemed high severity/probability and/or scored with an actual or potential SAC = 3

Patient Safety Improvement:

1. It is recommended that VISN PSOs and TPA Quality and Patient Safety Representatives brief combined community care event trends, lessons learned, corrective actions, and/or de-identified case studies, when overall care processes may be improved, at VISN PSO-designated meetings on a quarterly basis, at minimum, with recommended attendees including TPA Quality and Patient Safety Representative, NCPS, VHA OCC, and VAMC community care coordination staff (participants at discretion of PSO depending on nature of discussion).

2. For events attributable to a process error(s) on the part of the TPA or a provider in the TPA network, VISN PSOs follow up with their TPA Quality and Patient Safety Representatives to ensure an investigative analysis and/or quality improvement initiative was completed (attestation provided) and corrective actions implemented.

3. For events attributable to a process error(s) on the part of Non-TPA community care facility/provider, VAMC community care coordination staff or PSOs follow up, as appropriate, with the applicable Non-TPA community care facility/provider to ensure an investigative analysis and/or quality improvement initiative was completed (attestation provided) and corrective actions implemented.

4. PSMs or designees (e.g., VAMC community care coordination staff supporting community care patient safety efforts) may brief community care trend reports, lessons learned, and/or corrective actions at VA Community Care Oversight Council meetings, at applicable facilities.

5. TPA Quality and Patient Safety Representatives, or other designated staff, provide patient safety performance metrics (as outlined per contract requirements) to the NCPS and VHA OCC.

6. Non-TPA community care staff provide patient safety performance metrics (as outlined per contract requirements) to the NCPS and VHA OCC.

7. Complete procedures are provided in Appendix F for improvement actions related to adverse events and close calls deemed high severity/probability and/or scored with an actual or potential SAC = 3

Patient Safety Events Scored SAC < 3:

1. Patient safety events which receive a SAC less than 3 should still be entered into JPSR in order to capture the event and for event to be routed to the facility PSM.

2. Decisions on how to address these events will be made amongst the facility PSM and facility leadership.

3. An accumulation of SAC < 3 events indicating a potential trend of patient safety events at a site or functional area within a site should be researched within an aggregate review process to determine areas of improvement and actions items for reducing these events.

GLOSSARY

Source: VHA Handbook 1050.01, VHA NATIONAL PATIENT SAFETY IMPROVEMENT HANDBOOK

(see Appendix G)

Adverse Event: Adverse events that may be candidates for a root cause analysis (RCA) are untoward incidents, therapeutic misadventures, iatrogenic injuries, or other adverse occurrences directly associated with care or services provided to a Veteran in the community on behalf of the VA. Adverse events may result from acts of commission or omission (e.g., administration of the wrong medication, failure to make a timely diagnosis or institute the appropriate therapeutic intervention, adverse reactions or negative outcomes of treatment). Some examples of more common adverse events include: patient falls, adverse drug events, procedural errors or complications, and missing patient events. All adverse events, including those occurring in community care, require reporting and documentation in the patient safety event management system. The type of review required is determined through the SAC Matrix scoring process (see Appendices).

Aggregated Review: The Aggregated Review process is a method of analyzing a group of similar incidents or event types to determine common causes, thereby facilitating coordinated actions to prevent recurrences. Issues and incidents reviewed via Aggregated Reviews are those that do not require individual RCAs. The determination of common causes using Aggregated Reviews provides the opportunity to correct minor issues before they lead to serious adverse events.

Close Call: A close call is an event or situation that could have resulted in an adverse event, but did not, either by chance or through timely intervention. Such events have also been referred to as “near miss” incidents. An example of a close call would be a surgical or other procedure almost performed on the wrong patient due to lapses in verification of patient identification, but caught prior to the procedure. Close calls are opportunities for learning and afford the chance to develop preventive strategies and actions; they receive the same level of scrutiny as adverse events that result in actual injury. They require reporting and documentation in the patient safety event management system. NOTE: Just as for adverse events, the SAC Matrix scoring process and score determines the type of review (see Appendices).

Disclosure of Adverse Events: Disclosure of adverse events refers to the forthright and empathetic discussion of clinically-significant facts between providers or other personnel and patients or their personal representatives about the occurrence of a harmful adverse event, or an adverse event that could result in harm in the foreseeable future directly associated with care or services provided to a Veteran.

Joint Patient Safety Reporting System (JPSR): Patient safety event reporting system utilized by both VA and DoD. JPSR is where all patient safety events related to Community Care should be reported, so that appropriate follow-up actions can be assigned and documented. Patient safety event data captured in

JPSR is a highly important tool to be tracked and utilized in patient safety improvement initiatives by facility and VISN level patient safety managers.

Patient Safety: Patient Safety is ensuring freedom from accidental or inadvertent injury during health care processes.

Patient Safety Event: An adverse event or close call.

Root Cause Analysis: RCA is a process for identifying the basic or contributing causal factors that underlie variations in performance associated with adverse events or close calls. An RCA is a specific type of focused review that is used for all adverse events or close calls requiring analysis. Consistent use of RCAs further refines the implementation and increases the quality and consistency of focused reviews. To avoid confusion, the term RCA is used to denote this type of focused review and must adhere to the procedures provided in the VHA Handbook 1050.01. RCAs must be initiated with a specific charter memorandum, and the term “Root Cause Analysis” must be used in documents so that they are protected and deemed confidential under 38 U.S.C. 5705 and it’s implementing regulations.

APPENDICES

Appendix A. Detailed Roles and Responsibilities

Role	Patient Safety Responsibilities
All VA Staff	○ Report adverse events involving VA care in the community in JPSR
VISN PSO	○ Maintain communication with VAMC PSMs regarding patient safety events ○ Review patient safety event trend reports and brief VISN leadership on trends ○ Develop corrective action plans related to patient safety event trends ○ Communicate with TPA POC, VHA OCC, and NCPS (when necessary)
VAMC PSM	○ Serve as facility POC for patient safety event-related actions and advisory within facility ○ Use SAC matrix to determine what action is required regarding adverse events or close calls ○ Facilitate RCAs at the facility ○ Maintain documentation showing patient safety event-related actions and recommendations which have been developed and completed
VAMC Community Care Staff	○ Report adverse events and close calls ○ Utilize JPSR to report and capture Community Care related patient safety events ○ Conduct initial investigations on Community Care related events ○ Assist in RCAs as applicable
TPA Quality and Patient Safety Representative	○ Collaborate with VISN PSO and VAMC PSMs to perform Joint RCAs as applicable ○ Provide attestation of completion of RCAs for TPA-related patient safety events ○ Conduct lessons learned meetings related to patient safety events, provide patient safety trends reports to VAMC and VISN staff

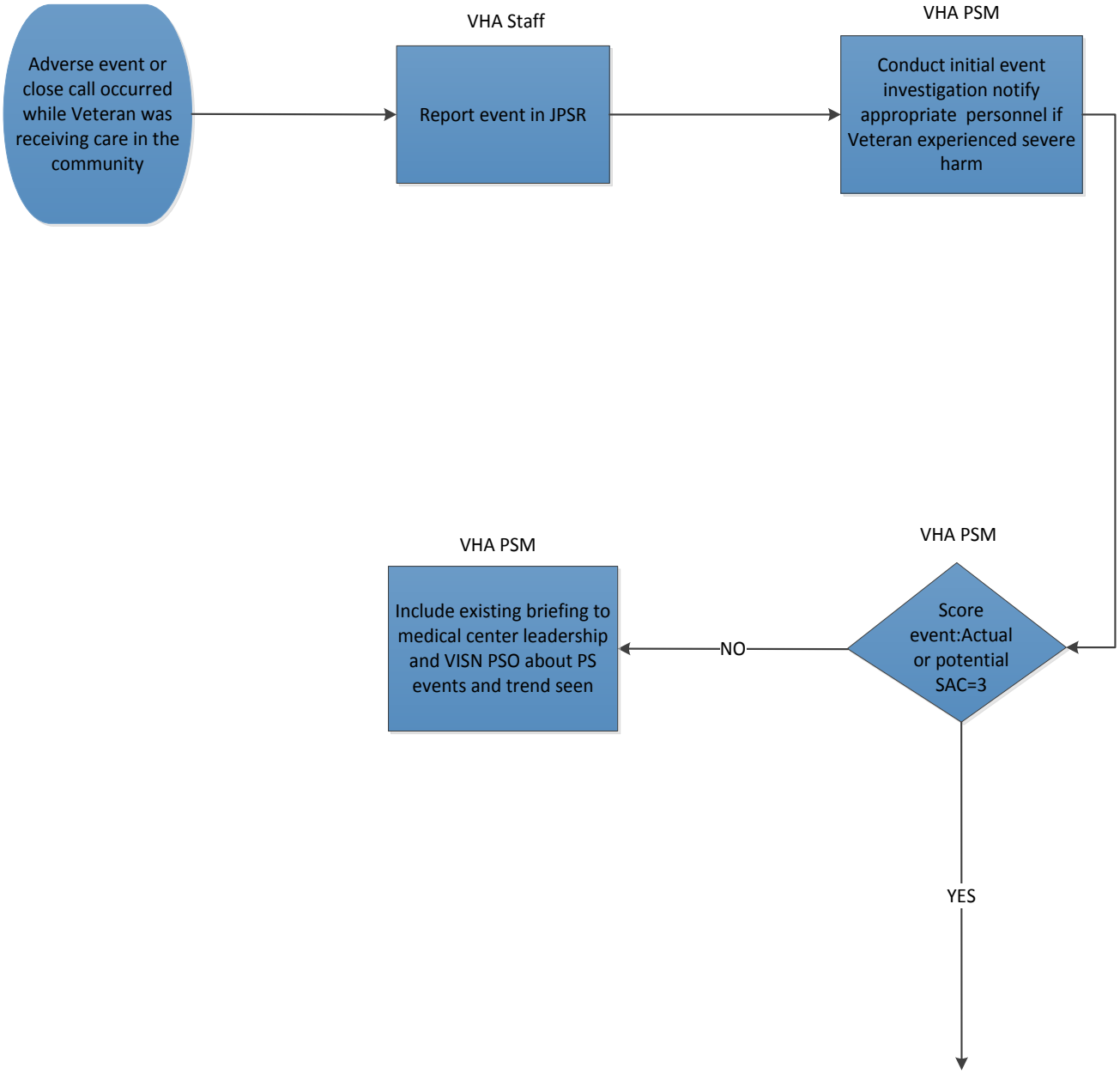
Appendix B. Matrix of Responsible Entities and Community Care-Related Patient Safety Tasks

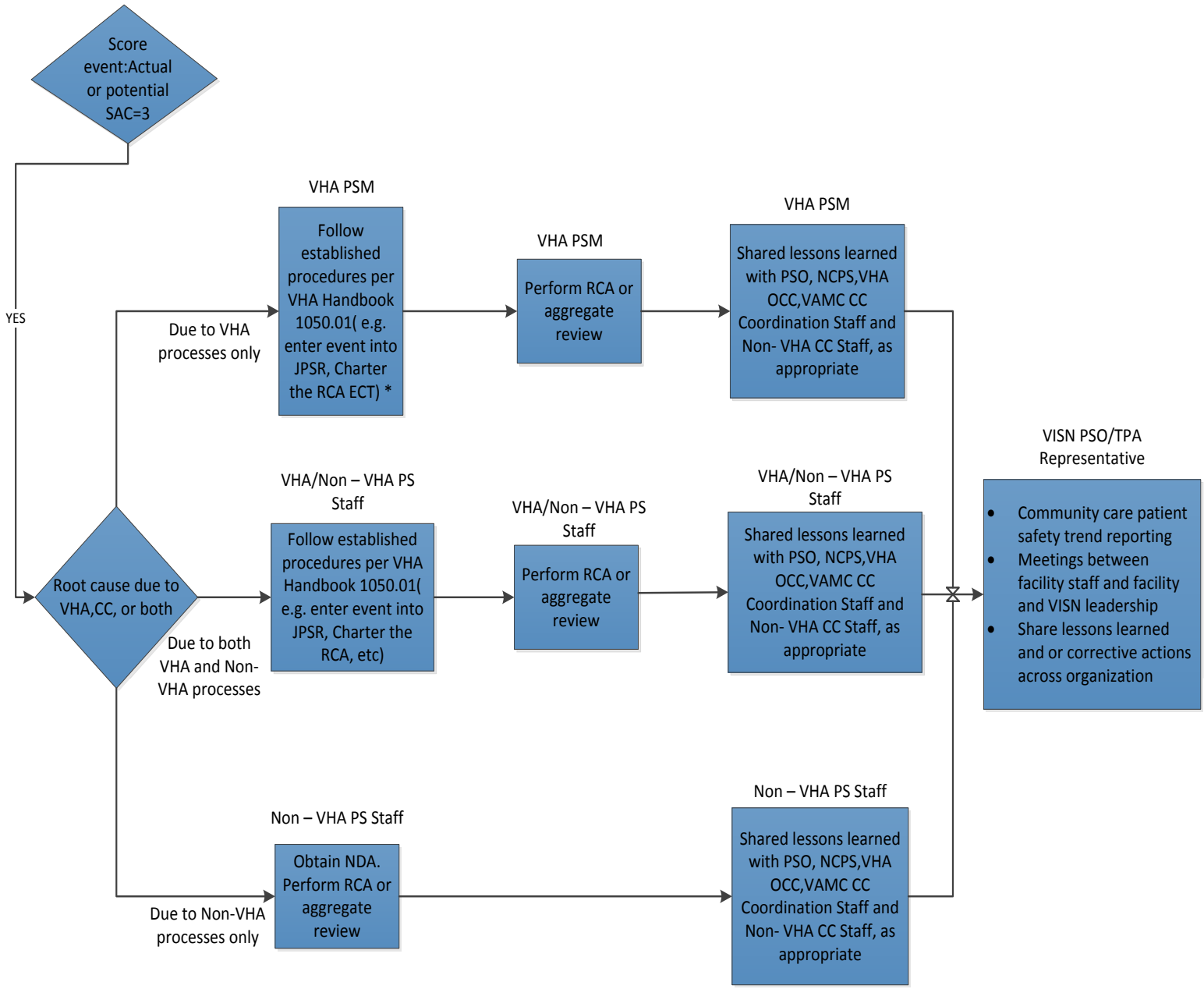
Patient Safety Reporting	**Responsible Entity**			
Community Care-related Patient Safety Tasks	**VISN PSO**	**VAMC PSM**	**VAMC Community Care Coordination Staff**	**Non-VHA Community Care Staff (e.g., TPA Quality and Patient Safety Representative)**
Follow patient safety reporting procedures as outlined in the Guidebook	✓	✓	✓	✓
Initial review of submitted patient safety event reports and completion of any immediate action needs		✓		
For high severity/probability patient safety events (with the potential to be scored a safety assessment code [SAC]= 3), notify appropriate personnel as outlined in the Guidebook	✓	✓	✓	✓
Sign a non-disclosure agreement (NDA)				✓
Follow established procedures per VHA Handbook 1050.01	✓	✓	✓	

Patient Safety Investigation	Responsible Entity			
Community Care-related Patient Safety Tasks	**VISN PSO**	**VAMC PSM**	**VAMC Community Care Coordination Staff**	**Non-VHA Community Care Staff (e.g., TPA Quality and Patient Safety Representative)**
Follow patient safety investigation procedures as outlined in the Guidebook	✓	✓	✓	✓
Conduct initial event investigation for community care-related patient safety events, when applicable	✓	✓	✓	✓
Complete RCA facilitation training (if staff member has not had RCA facilitation training)		✓		
Participate on RCA Teams (when applicable)	✓	✓	✓	✓
Facilitate joint RCAs or Aggregated Reviews (when applicable)				✓
Provide support to VAMC PSMs	✓	✓	✓	

Patient Safety Improvement	Responsible Entity			
Community Care-related Patient Safety Tasks	**VISN PSO**	**VAMC PSM**	**VAMC Community Care Coordination Staff**	**Non-VHA Community Care Staff (e.g., TPA Quality and Patient Safety Representative)**
Follow patient safety improvement procedures as outlined in the Guidebook	✓	✓	✓	✓
Include CC as a standing agenda item at designated meetings (at discretion of VISN PSO) – especially in discussion of TPA related concerns	✓			
Include discussions about CC event reports and lessons learned as part of regular VISN- or VAMC-level patient safety discussions	✓	✓		✓
Provide an attestation of completion of an RCA or quality improvement initiative, when applicable, or explanation of non-completion				✓

Appendix C. VHA CC Patient Safety Event Process Flow




Score event:Actual or potential SAC=3
YES
Root cause due to VHA,CC, or both
Due to VHA processes only
VHA PSM
Follow established procedures per VHA Handbook 1050.01(e.g. enter event into JPSR, Charter the RCA ECT) *
VHA PSM
Perform RCA or aggregate review
VHA PSM
Shared lessons learned with PSO, NCPS,VHA OCC,VAMC CC Coordination Staff and Non- VHA CC Staff, as appropriate
Due to both VHA and Non-VHA processes
VHA/Non – VHA PS Staff
Follow established procedures per VHA Handbook 1050.01(e.g. enter event into JPSR, Charter the RCA, etc)
VHA/Non – VHA PS Staff
Perform RCA or aggregate review
VHA/Non – VHA PS Staff
Shared lessons learned with PSO, NCPS,VHA OCC,VAMC CC Coordination Staff and Non- VHA CC Staff, as appropriate
Due to Non-VHA processes only
Non – VHA PS Staff
Obtain NDA. Perform RCA or aggregate review
Non – VHA PS Staff
Shared lessons learned with PSO, NCPS,VHA OCC,VAMC CC Coordination Staff and Non- VHA CC Staff, as appropriate
VISN PSO/TPA Representative
• Community care patient safety trend reporting
• Meetings between facility staff and facility and VISN leadership
• Share lessons learned and or corrective actions across organization

Appendix D. VHA CC Patient Safety Reporting Tasks for High Severity/Probability (pre-SAC scoring) Events

Patient Safety Reporting **Community Care-related Patient Safety Tasks**	**For adverse events and close calls identified by a VHA staff member, with the potential to be scored with a SAC = 3 (pre-SAC scoring), and potentially resulting from errors and/or systems flaws involving:**				
High Severity/Probability only – expected to be very low in frequency)	**TPA Care Processes Only**	**Processes involving both TPA and VHA**	**Non-TPA Community Care Processes Only**	**Processes involving both Non-TPA Community Care and VHA**	**VHA Processes Only**
PSM notifies VISN PSO of event by telephone or electronically	✓	✓	✓	✓	
PSM notifies VAMC community care coordination staff of event by telephone or electronically	✓	✓	✓	✓	✓
PSM notifies TPA Quality and Patient Safety Representative of event by telephone or electronically	✓	✓			
VAMC community care coordination staff notifies Non- TPA community care staff of event by telephone or electronically			✓	✓	
TPA Quality and Patient Safety Representative or Non-TPA community care staff initiate further action per established organizational procedures and contractual requirements	✓	✓	✓	✓	

Patient Safety Reporting **Community Care-related Patient Safety Tasks**	**For adverse events and close calls identified by a VHA staff member, with the potential to be scored with a SAC = 3 (pre-SAC scoring), and potentially resulting from errors and/or systems flaws involving:**				
High Severity/Probability only – expected to be very low in frequency)	**TPA Care Processes Only**	**Processes involving both TPA and VHA**	**Non-TPA Community Care Processes Only**	**Processes involving both Non-TPA Community Care and VHA**	**VHA Processes Only**
Refer to VHA Handbook 1050.01 for established procedures regarding compensation to injured patients and voluntary reporting of patient safety events to The Joint Commission	✓	✓	✓	✓	✓
Follow established procedures per VHA Handbook 1050.01		✓		✓	✓

Appendix E. VHA CC Patient Safety Investigation Tasks for High Severity/Probability (pre-SAC scoring) Events

Patient Safety Investigation **Community Care-related Patient Safety Tasks**	**For adverse events and close calls identified by a VHA staff member, with the potential to be scored with a SAC = 3 (pre-SAC scoring), and potentially resulting from errors and/or systems flaws involving:**				
SAC = 3 only – expected to be very low in frequency)	**TPA Care Processes Only**	**Processes involving both TPA and VHA**	**Non-TPA Community Care Processes Only**	**Processes involving both Non-TPA Community Care and VHA**	**VHA Processes Only**
Actual SAC=3 *only*: VHA and TPA or Non-TPA community care staff, as applicable, complete a joint (both VHA and non-VHA staff) RCA within 45 days (e.g., delay in care and unclear where process gap occurred)		✓		✓	
Potential SAC=3 *only*: VHA and TPA or Non-TPA community care staff, as applicable, complete a joint (both VHA and non-VHA staff) RCA within 45 days (e.g., delay in care and unclear where process gap occurred) or an Aggregated Review will be completed		✓		✓	
Actual SAC=3 *only*: VHA patient safety staff complete an RCA within 45 days on the VHA components of the process (e.g., wrong provider type consulted)					✓
Potential SAC=3 *only*: VHA patient safety staff complete an RCA within 45 days on the VHA components of the process or an Aggregated Review will be completed					✓

Patient Safety Investigation **Community Care-related Patient Safety Tasks**	**For adverse events and close calls identified by a VHA staff member, with the potential to be scored with a SAC = 3 (pre-SAC scoring), and potentially resulting from errors and/or systems flaws involving:**				
SAC = 3 only – expected to be very low in frequency)	**TPA Care Processes Only**	**Processes involving both TPA and VHA**	**Non-TPA Community Care Processes Only**	**Processes involving both Non-TPA Community Care and VHA**	**VHA Processes Only**
TPA Quality and Patient Safety Representative or Non-TPA community care staff, as applicable, complete an RCA or other quality improvement initiative within 45 days	✓		✓		
TPA Quality and Patient Safety Representative or Non-TPA community care staff, as applicable, provides the PSM, PSO, and VHA OCC with an attestation by e-mail that an investigative analysis and/or quality improvement initiative was completed and appropriate corrective actions taken (see Appendix D). If an analysis/initiative was not completed, a statement of non-completion with an explanation is provided.	✓		✓		
VAMC community care coordination staff serve on the RCA Team, if appropriate		✓	✓	✓	✓

Note: If insufficient Non-TPA community care staff exist to support an investigative analysis and/or quality improvement initiative, the VAMC PSM will review the event to determine the need for an RCA or Aggregated Review, and will facilitate the completion of these processes as applicable. The PSM will provide summary findings, to include corrective actions and lessons learned, to the appropriate PSM, VISN PSO, VHA OCC, and NCPS, as applicable.

Appendix F. VHA CC Patient Safety Improvement Tasks for High Severity/Probability (pre-SAC scoring) Events

Patient Safety Improvement **Community Care-related Patient Safety Tasks**	**For adverse events and close calls identified by a VHA staff member, with the potential to be scored with a SAC = 3 (pre-SAC scoring), and potentially resulting from errors and/or systems flaws involving:**				
SAC = 3 only – expected to be very low in frequency)	**TPA Care Processes Only**	**Processes involving both TPA and VHA**	**Non-TPA Community Care Processes Only**	**Processes involving both Non-TPA Community Care and VHA**	**VHA Processes Only**
VAMC PSM document summary findings from the RCA and communicate findings with VAMC Leadership, VAMC community care staff, and VISN PSO		✓		✓	✓
If overall care processes may be improved by sharing lessons learned and/or corrective actions, the PSM or PSO will share these with the TPA Quality and Patient Safety Representative					✓
TPA Quality and Patient Safety Representative or Non-TPA community care staff, as applicable, shares lessons learned and/or corrective actions with the PSM, PSO, VHA OCC, and VAMC community care coordination staff	✓		✓		
Follow established procedures per VHA Handbook 1050.01		✓		✓	✓

Appendix G. Forms and References (Laws, Standards, Guidance, etc.)

No.	Title	Form/Links
1.	**VHA OCC Patient Safety Non-Disclosure Agreement and Release of VHA Data**	VHA OCC NDA
2.	**Joint Patient Safety Reporting**	JPSR Training – Reporter_MEDVAMC
3.	**Standard RCA Example**	Standard RCA Example-9.24.18.docx

- VHA Handbook 1050.01: VHA NATIONAL PATIENT SAFETY IMPROVEMENT HANDBOOK
- 38 U.S.C. 5705 - Confidentiality of medical quality-assurance records
- Operations and Medical Management: Veterans Safety Event (TriWest)

REVISION HISTORY

The development and maintenance of this document is the responsibility of the VHA OCC. Questions regarding, or proposed changes to this document, including supporting rationale, should be submitted to CC-PatientSafety@va.gov. For additional resources related to patient safety in community care, please go to the VHA OCC Field Guidebook SharePoint Page.

1. Revision: v1
   Date: 6/15/2017
   Description of Changes: Initial Draft
   Requested By: VHA OCC

2. Revision: v2
   Date: 2/21/2018
   Description of Changes: Updated per end-user feedback
   Requested By: VHA OCC

3. Revision: v3
   Date: 12/10/2018
   Description of Changes: Updated per end-user feedback
   Requested By: VHA OCC