VA Implementation of Patient Safety Practices in Community Care (VIPs-CC)

U.S. Department of Veterans Affairs

Evaluating Implementation of the Office of Integrated Veteran Care (IVC) Patient Safety Guidebook

The VIPs-CC QUERI Partnered Evaluation Initiative (PEI) is a collaboration between VHA Office of Integrated Veteran Care (IVC), National Center for Patient Safety (NCPS), and VA researchers at Boston, Bedford, and Indianapolis to evaluate the national implementation of the Patient Safety Guidebook and assess VA's progress towards its transformation into a high-reliability organization (HRO). The PEI aims to provide IVC and NCPS with useful and timely information to enhance uptake and spread of "Guidebook" safety processes.

Ensure Safe, Timely, High-Quality Care for Veterans

As Veterans' use of **Community Care (CC)** continues to expand under the **2018 MISSION Act**, it is increasingly important to understand whether care delivered in the community is safe. Beginning in late 2018, the VA mandated implementation of safety processes utilizing the *Patient Safety Events in Community Care: Reporting, Investigation, and Improvement Guidebook*. The Guidebook—released and continuously updated by VHA IVC and NCPS—seeks to standardize **CC safety event** collection and reporting across VA and CC providers using the **Joint Patient Safety Reporting System (JPSR)**. Ensuring effective implementation of these processes is critical as Veterans use of CC increases.

HIGH-LEVEL CC SAFETY EVENT REPORTING PROCESS FLOW

VIPs-CC QUERI works in a formally chartered group with operational partners IVC and NCPS to revise and improve adoption and implementation of Guidebook processes by VA facilities.
Evidence generated from this project and partnership will help to refine and improve the Guidebook, and related safety and quality processes as an implementation blueprint for our partners.

QUERI VA Quality Enhancement Research Initiative EVIDENCE INTO PRACTICE

NCPS VA National Center for Patient Safety
Safer Systems • Safer Care

VA COMMUNITY CARE

VIPs-CC VA Implementation of Patient Safety Practices in Community Care QUERI Partnered Evaluation Initiative

Assess Effects of Guidebook Safety Process Implementation

The PEI's specific aims, guided by **Proctor's Implementation Outcomes Framework** and the **Consolidated Framework for Implementation Research (CFIR)**, are to:

1. Assess variation across VISNs and facilities in the implementation of standardized Guidebook processes—*cornerstones of an HRO*—used for patient safety reporting, investigation, and improvement.
2. Identify organizational contextual factors (e.g., safety culture, leadership engagement) that influence implementation for sites with high vs. low fidelity to Guidebook safety processes.
3. Describe variation across VISNs and sites in service outcomes: safety events (in both VHA and CC), timeliness, and Veterans' perceptions of CC quality and safety.
4. Identify specific combinations of implementation strategies and organizational factors that distinguish high- vs. low-performing sites on their implementation and service outcomes.

Association of Organizational Readiness with Implementation Effectiveness and Reporting of VA vs. CC Safety Events

Web-based surveys and **interviews** with VISN and facility-level patient safety and quality management staff demonstrate that **organizational readiness to change** may be an important organizational factor associated with implementation effectiveness and measures of hospital safety.

- Sites with higher **Organizational Readiness for Implementing Change (ORIC)** scores report a higher number of CC patient safety events, potentially indicating they had greater organizational commitment to adopting Guidebook safety processes than lower scoring sites. Preliminary findings suggest, at least some slight relationship between a facility's readiness to change and the ratio of CC safety events to CC referrals. Additional analyses comparing VHA and CC safety event/close call reporting suggest that there may be opportunities for improving Guidebook implementation through identification of "best practices" from facilities with larger increases in event/close call reporting over time and/or better patient safety culture.

Other contextual factors may also influence sites' implementation processes and effectiveness.

- **Facilitators**: Networks and communication, use of available resources (e.g., JPSR for event reporting), safety and HRO cultures, and engaging individuals in the implementation process.

- **Barriers**: Planning for implementation, executing the implementation processes without clear definitions and roles, networks and communication, leadership engagement, availability of resources, culture, external policies and incentives, and recently, the COVID pandemic.

Quantitative analyses demonstrate a much larger number of patient safety events reported nationwide in VA than in CC over an approximately a two-year period (FY 2020 - 22): There were 310,703 events reported in VA, compared to 17,772 in CC. However, there was a much greater increase in the percent of safety events reported in CC than in VA over that time period (25.7% vs. 6.8%, respectively). At the facility level, there was greater variation in reporting across CC vs. VA facilities, signaling opportunities at the local level for targeted prevention and/or quality improvement activities. Additionally, differences in safety reporting, particularly across CC facilities, suggest that some barriers to implementation (e.g., leadership commitment, lack of safety training and awareness) exist, and should be remedied in order to improve safety reporting overall.

Building on these findings, the VIPs-CC team is conducting additional exploratory analysis focusing on Adverse Events vs. Close Calls, and Recovery Rate (close calls/[adverse events + close calls]). VIPs-CC is also using Coincidence Analysis (CNA), a new form of configurational analysis, to gain additional insight into potential links between safety event reporting, patient safety culture, and other organizational and patient safety-related factors such as facility-level Networks and Communication, Leadership Engagement, Relative Priority, Implementation Fidelity, Adverse Event/Close Call Ratio, and Patient Safety Indicator (PSI-90) Composite Score. In collaboration with operational partners, presentations have been made at both VA and non-VA conferences (HSR&D and AcademyHealth), and manuscripts are in-preparation to further disseminate findings.

For more information, check out:
https://www.queri.research.va.gov/centers/safety_quality.cfm

If you would like to learn more or partner with us, please contact Jeffrey Chan, at jeffrey.chan@va.gov.

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