

QUERI Partnered Evaluation Initiative

June 2019

Corresponding Principal Investigator: Amy Rosen, PhD

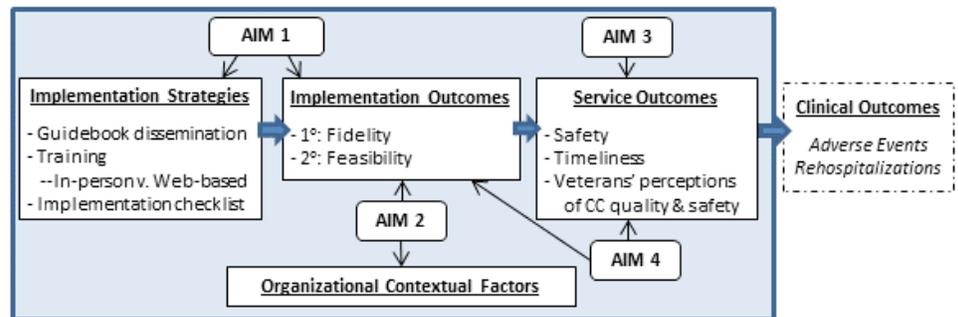
Amy.Rosen2@va.gov

Evaluating the Implementation of Patient Safety Practices to Ensure Timely, High-Quality Community Care

Boston, MA

Overview

There is a lack of information on the types and frequency of safety events that Veterans experience through community care, as well as the timeliness of care that Veterans receive. The passage of the 2018 VA MISSION Act—with a key goal being to increase access to community care for Veterans—makes it critical to evaluate the quality and safety of that care. The VA Office of Community Care (OCC) recently identified several important safety-related gaps associated with reporting, investigation, and improvement that occur when Veterans receive community care. To address these gaps, OCC, in partnership with VA's National Center for Patient Safety (NCPS), developed a VA OCC Patient Safety Guidebook for sites to use to improve delivery of safe care. In brief, the Guidebook contains the specific processes for reporting, investigating, and improvement that should be implemented across the two settings of care: the VA healthcare system and community care settings.



Objectives and Methodology

The primary objective of the Evaluating the Implementation of Patient Safety Practices to Ensure Timely, High-Quality QUERI initiative is to evaluate the implementation of safety processes and provide useful and timely information to its partners on ways in which they could enhance uptake and spread of the implementation. Specifically, QUERI investigators will:

- Assess variation across VISNs and facilities in the implementation of Guidebook processes used for patient safety reporting, investigation, and improvement;
- Identify the organizational contextual factors that influence implementation for sites with high vs. low fidelity to Guidebook safety processes;
- Describe variation across VISNs and sites in service outcomes, such as safety events, timeliness, and Veterans' perceptions of CC quality and safety; and
- Identify implementation strategies and organizational factors that distinguish high- vs. low-performing sites on their implementation and service outcomes.

Anticipated Impacts

Guidebook safety processes have been rolled-out nationally across all VISNs through a VA mandate. This roll-out will also impact all VA facilities. QUERI investigators will interview VA and community care staff at 18 facilities across VA (nine from those VISNs that were early implementers and nine from VISNs where implementation was delayed). This evaluation has the potential to integrate and improve the delivery of quality and safety of care to Veterans regardless of where they receive care, whether it be in VA or community care settings.

Operations Partners

VA's Office of Community Care and National Center of Patient Safety.



U.S. Department of Veterans Affairs
Veterans Health Administration
Quality Enhancement Research Initiative

www.queri.research.va.gov