

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

VA



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

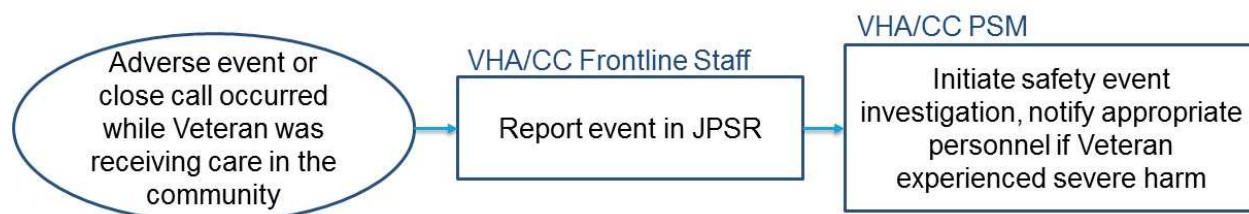
## Evaluating Implementation of the Office of Community Care (OCC) Patient Safety Guidebook

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

## Ensuring Timely, High-Quality Care for Veterans

As Veterans' use of **Community Care (CC)** expands under the **2018 MISSION Act**, it is important to understand whether care delivered in the community is safe. In late 2018, the VA mandated implementation of safety processes—outlined in "**The Patient Safety Events in Community Care: Reporting, Investigation, and Improvement Guidebook**" released by VHA OCC and NCPS—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 continue to increase CC use.

### HIGH-LEVEL CC SAFETY EVENT REPORTING PROCESS FLOW



**VIPs-CC QUERI will work closely with operational partners OCC and NCPS to improve adoption and implementation of Guidebook processes by VA facilities.** Evidence generated from this project will help to refine and improve the Guidebook as an implementation blueprint for our partners.



Safer Systems • Safer Care



# Enhancing the Uptake of Safety Processes

---

Our evaluation goals, 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, 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.

## Identifying Factors Affecting Implementation

---

**Organizational readiness to change** may be an important organizational factor associated with implementation effectiveness.

- 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.

**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 culture, 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, and external policies and incentives.

For more information, check out:  
<https://www.queri.research.va.gov>

If you would like to learn more or partner with us,  
please contact Jeffrey Chan, at [jeffrey.chan@va.gov](mailto:jeffrey.chan@va.gov).

**Principal Investigator:**  
Amy K. Rosen, PhD  
Center for Healthcare Organization and  
Implementation Research (CHOIR)  
VA Boston Healthcare System