

# Patient Topics

## Admission Procedures:

**Emergency medical care will be rendered immediately to anyone, veteran or not, when such care is required.**

Patients who are entitled to care at the VA Nebraska – Western Iowa Health Care System are either receiving treatment for an injury or a disability incurred or aggravated while in active military service (service-connected) or are receiving treatment for non-service-connected conditions provided they are unable to defray the costs of private care. With the exception of care for service-connected disorders, all patients are screened for what is termed “legal and financial entitlement” before being provided care. This entitlement is established by law and the screening is performed by non-medical personnel. If legal eligibility exists, medical care is rendered based on need for medical care in service-connected conditions and based on need for hospitalization for non-service-connected disorders. Determination of need for medical care and hospitalization is made by a physician. During regular working hours, an admitting physician makes these determinations; after hours, the medical officer of the day makes the determination. If it is determined that a patient meets both the legal and medical qualifications for care, the patient is scheduled to receive such care on a priority basis. Both service-connected and non-service-connected veterans receive treatment on an outpatient basis without prior hospitalization through the Ambulatory Care Program. For the latter, the outpatient care is on a resource-available basis. Patients are admitted to the clinical service which is most appropriate for the admission diagnosis. Medical patients are admitted in rotation to clinical teams staffed by faculty and house officers of Creighton University or the University of Nebraska.

All admissions are subject to post-admission utilization review. The hospital uses InterQual criteria for post-admission review. The utilization reviewers provide the work teams with the diagnostic-related group (DRG) average length of stay (ALOS) for each patient’s admission diagnosis. Ward teams are expected to provide appropriate inpatient care within the ALOS guidelines. Ward teams and their staff attendings are expected to participate in multidisciplinary rounds daily on their patients. These rounds facilitate communication between physicians, nurses, and other support staff and improve patient flow.

### **Discharge Procedures:**

Upon completion of necessary inpatient care, patients may be discharged and returned to their personal physician or to non-VA clinics of their choice. In the latter circumstance, no further Veterans Affairs care is offered, and Veterans Affairs services are terminated.

Patients may also be discharged to a VA-based ambulatory status for either service-connected or non-service-connected conditions. Service-connected patients should be discharged to the Outpatient Clinic. For non-service-connected conditions, the patients are discharged to Outpatient Treatment/Non-Service Connected (OPT/NSC) status. This status is intended to provide outpatient follow-up care and adjustment of treatments following hospitalization. Upon stabilization of the patient's condition, the patient may be discharged and returned to the care of a private physician

Irregular discharge, such as against medical advice (AMA) or absent without leave (AWOL), are also employed. Patients who refuse to cooperate or who wish to leave before the physician feels that the course of treatment has been completed are discharged AMA. Patients leaving under these circumstances should be asked to sign a document stating that they are leaving in spite of the fact that they have been advised it would be against their best interest to do so. An AMA template is available in CPRS for use in these instances. A patient leaving the Medical Center without official status (such as without a pass or fails to return from pass at the scheduled time) is considered absent without leave (AWOL) and is so discharged. The following is a tabulation of types of discharge which may be used in dismissing a patient from the Medical Center:

- Outpatient treatment/non-service-connected (OPT/NSC)
- Outpatient treatment/service-connected (OPT/SC)
- Regular
- Irregular (AMA, AWOL, etc.)

## **Advanced Clinic Access: Key Concepts for Providers**

An access problem is a delay problem. The goal of the VHA's Advanced Clinic Access Initiative is to build a system in which patients could see their own providers when they choose. When the resources are managed well, openness or space in the clinic creates "capacity" to schedule or see patients. In an optimal system of "advanced clinic access," an organization provides enough openness or space in the clinic (capacity) for health services to meet the demand of its patient population at the time the demand occurs.

**Advanced Clinic Access (ACA)** is a fundamental shift from the past. Traditionally, health care organizations have viewed the demand for health care as insatiable. Therefore, the typical approach to access was predicated on the false belief that barriers needed to be constructed in order not to be overwhelmed by patient demand. Improving access therefore entailed complex

scheduling systems, a wide variety of appointment types and lengths, long waits to see providers, the transfer of demand to other areas of the health care system such as urgent care or the emergency department, and elaborate triage systems that attempted to distinguish patients who could wait for care from those who could not.

Within the core competencies of a system-based practice, the understanding and demonstration of awareness and of responsiveness to the larger context and system of health care to effectively provide care that is of optimal value is required. In this context, one should gain an understanding of how their individual patient care practices affect other health care professionals, the health care organization, and larger society. Within the system-based practice competency, a provider must also be able to demonstrate the ability to effectively partner with health care managers and providers to assess, coordinate, and improve health care quality and performance, while acting as an advocate for patients. Through an understanding of the system of Advanced Clinic Access, you will gain an understanding of how effective partnering with the health care system not only increases efficiency, but also leads change in a direction that directly benefits patients through improved quality of care and gain insight into how individual practices interact with the health system and decisions you make within the clinic have broad implications.

**Advanced Clinic Access (ACA)** In contrast to traditional methods of dealing with access, ACA seeks not to control the daily patient demand for care, but rather to predict and respond to it. The ACA model is based on the principle that, when supply and demand is in balance (or equilibrium), there is no need for waits in the system. In traditional systems, demand is divided into urgent and routine. Such a division creates a delay by creating separate lines (or queues) for different types of patients. Removing the queues reduces the delay. An ACA system is designed to eliminate waiting times. While all of these principles are used in outpatient practice, some are particularly relevant to continuity clinics.

Three strategies for building a sustainable system for patient access or Advanced Clinic Access are:

### **Shape Demand**

Improving access is all about increasing the ability of the system to predict and absorb demand (patients' requests for care). Reducing the amount of demand makes it easier for the system to absorb current or future levels of demand.

### **Match Supply and Demand**

A clinic with Advanced Clinic Access is one where supply and demand are in alignment. If the demand is greater than supply, there will be a delay in providing care. If the supply is greater than demand, then resources are being wasted. When supply and demand is matched, there is no delay in providing care.

### **Redesign the System to Increase Supply**

One way to increase a clinic's ability to absorb more demand is to make the clinic more efficient. If an appointment now takes 45 minutes, but can be redesigned to take 20 minutes, then more patients can be seen on a given day. Reducing the average visit time doesn't

necessarily mean working faster, but working smarter. Shorter visits don't mean less time with patients; but rather more quality time with patients.

## **Shape the Demand**

### **Work Down the Backlog**

"Backlog" consists of all the appointments that are on the future schedule for a particular clinic. A backlog of appointments clogs clinic schedules, taking up slots that could be used for patients requesting appointments with their providers. It is sometimes useful to think of backlog as a reservoir of unmet demand. Not all appointments on the future schedule are the same. "Good" backlog consists of appointments in the future that need to be there, including:

- Provider discretionary return appointments
  - Patient choice (patients call in today but want to come in tomorrow)
  - Automatic appointments at certain intervals to manage specific types of patient's
- "Bad" backlog consists of appointments for anyone who was deflected into the future who could have been seen today. Avoid bad backlog; it fills appointment slots in the future that could be used to meet patient demand each day.

**Reduce Demand** Improving access is all about increasing the ability of the system to predict and absorb demand (patients' requests for care). Reducing the amount of demand makes it easier for the system to absorb current or future levels of demand. One of the key ways a health care system can improve access is by reducing unnecessary demand for various services so that patients who need a particular service can receive it in a timely way.

### **Maximize activity at each appointment.**

This is often called "max-packing." It means doing as much for patients while they are in the office for any given visit, to reduce future work (in many cases, eliminating the need for extra appointments). Some ways to do this include the following:

- Look for anyone who is on the schedule today who has also booked an appointment in the future and take care of his or her future needs during today's visit.
- Use a checklist of preventive care to anticipate a patient's future needs, and whenever possible, take care of those needs today.
- Do not ignore chronic care issues when a patient is presenting with an acute issue.
- Do as much as possible today to prevent future visits for problems that could have been addressed at this visit.

### **Extend intervals for return appointments.**

The interval for a return appointment depends on the patient's needs and the discretion of the provider. Physicians should consider what is necessary for the management of the patient, rather than "the usual" return visit interval. When medically appropriate, extending intervals for return appointments adds capacity to the system because fewer future appointment slots are filled. Some immediate steps that a physician can take to reduce return intervals include: -

Eliminate automatic return visits at standard intervals (e.g., all patients are no longer automatically told to come back in one month).

-Use evidence-guided principles to determine when a patient should return  
-Stress the concept of when care is needed not if care is needed -Availability in the schedule provides a way for the patient to be seen when an issue arises, not making appointments “just in case”.

### **Create alternatives to traditional face-to-face interactions.**

Several types of interactions between providers and patients can take the place of a traditional one-on-one clinic visit with a physician, including the following: -Physicians can conduct telephone “visits” with patients.

### **Optimize patient involvement in care.**

Clinics that promote patient self-management, particularly for chronic diseases, not only reduce unnecessary demand for visits, but also achieve better overall management of the patient’s condition. For example, patients with COPD who understand how to manage their medications and what to do in an emergency are less likely to utilize the emergency or urgent care clinic for a preventable exacerbation. They are also less likely to use an office visit for something that they can manage on their own.

### **Understand the nature of service agreements between primary and specialty care.**

Service agreements between primary care physicians and specialists define the list of conditions that should be taken care of in primary care and the process for making a prompt referral to specialty care if needed. Primary care physicians are assured that their patients will be treated promptly by a specialist—either by appointment or by an immediate phone consult if more appropriate, while specialists are assured that they will see only those patients who need to be seen by a specialist.

## **Matching Supply and Demand:**

**Understanding Supply and Demand** The experience of many health care organizations that have looked at supply and demand has taught us not only that demand is not insatiable, but also that it is highly predictable. In fact, the demand for any kind of service -appointment, advice, or message to provider - can be predicted accurately based on the population, the scope of provider practice and, over time, the practice style of each provider. Discussing how the demands for services generated by patients in your panel can give you a better understanding how the interaction of those demands with the resources (supply) of the VA System and help you to act as an advocate for them within the health care system.

Consider doing today’s work today. Once you know your true supply and demand, you can determine a course of action. If the overall pattern of demand and supply shows a mismatch (e.g., demand exceeds supply), then steps need to be taken to bring demand and supply into equilibrium.

If the overall pattern of demand and supply (looking at weekly and monthly trends) shows a balance between the two, then clinics have a choice as to how to respond to (or absorb) patient demand daily. They can establish a “carve-out” system or they can “do today’s work today” (Advanced Clinic Access).

A carve-out system holds some appointments each day in anticipation of same-day demand. This may help initially to meet daily demand, but because holding appointments in effect closes slots in the future

(e.g., every afternoon's 3 – 5 PM appointments) it constrains the system by reducing the number of slots available to meet today's demand. This means that with carve-out systems, some demand will still be put off into the future (i.e., patients will be given an appointment on another day).

An Advanced Clinic Access system, unlike a carve-out system, takes care of each day's demand on the day it is generated. In some practices, a given provider availability may translate into doing this week's work this week or a similar concept. In clinics with Advanced Clinic Access, the only appointments that are on the books at the beginning of each day are the return appointments that were generated by physician discretion or patient preference on a previous day. This provides maximum flexibility in the system to absorb daily demand.

**Reduce Appointment Types** Having a lot of appointment types actually increases total delay in the system because each appointment type creates its own differential delay and queue. For example, if a physician only takes physicals on Tuesday afternoons, a patient needing a physical may have to wait several weeks until a Tuesday afternoon slot is available. In a resident clinic, the educational needs of a program also are considered in designing your clinics; however, consideration needs to be given to making sure your patients have access to you or your attending(s) and team of providers. The greater the number sub types of appointments the greater the chance an appointment will not be available.

**Plan for Contingencies** Even if the supply and demand in a clinic are generally in balance, there will be times when there is a surge in demand (demand outstrips supply) that is either expected (e.g., flu season) or unexpected (e.g., a lot of walk-ins on one day). Expected and unexpected variations in supply can also occur (e.g., vacations or emergency sick leaves.) In a traditional system, patients are often made to absorb the consequences of the mismatch between supply and demand (i.e., they have to wait). For clinics with Advanced Clinic Access, contingency plans shift the variation from the demand (patient) side to the supply (provider) side. The clinic in which you participate will have designed systems to account for these issues. Consider that your ICU rotations, Post Call clinics, and Night float months are yet another contingency that needs to be addressed by the clinic and by all members of the staff including the other providers. I.e., whenever you are not present in scheduled clinics, someone else may have to see your assigned patients.

## **Redesign the System**

**Optimize the Care Team** The specific mix of staff (number of physicians, nurses, assistants, technicians, clerks, etc.) will vary from clinic to clinic and determines the extent and type of work that can be driven away from the physician (the constraint). Staff mix is key to maximizing the capacity of the clinic.

The care team composition of each clinic emerges from a discussion of how the clinic (and ultimately the facility) decides to balance its supply and demand. The clinic has to understand the types of services it provides, and then decide who should be involved in the work and how the work should be divided.

### **Synchronize Patient, Provider, and Information**

In a clinic, the major stages revolve around the presence of the patient, the provider, and the medical record, chart, and other information needed for the patient visit.

**Start the first AM and PM appointment on time.**

**Use health prompts to anticipate the full potential of today's need.** Preventive medicine guidelines are one example of prompts that can be imbedded either electronically in CPRS or used manually to generate information that the care team needs on the day of the clinic visit, e.g., the prompt tells the care team that the patient may be due for a sigmoidoscopy, flu shot and pneumococcal vaccine, or a HgbA<sub>1c</sub> test for diabetes. According to the Institute of Medicine reports in 2002, approximately only ½ of the best and most appropriate care is being offered and provided to our patients.

### **Optimize Rooms and Equipment**

Fully utilizing rooms and equipment increases the number of patients that can be seen each day, contributing to increased supply for the clinic and the ability to meet patient demand for appointments.

### **Use open rooming to maximize flexibility.**

Open rooming means that any provider can use any exam room. In some traditional clinics, certain exam rooms are assigned to specific physicians.

## **Advanced Directives/Durable Power of Attorney/Do Not Resuscitate**

Extensive policies dictate the means of institution of “No Code” status and limitations of or withdrawal of care. Initiation of such measures requires the participation and signature of the attending staff physician.

Refer to these health care system policies for further information:

- COS-048 Withholding and Withdrawing Life Sustaining Treatment
- PCS-015 Advance Directives for Health Care
- DIR-014 Notification of Chaplain on Patients Placed on No Code
- QM-001 Patient Rights

## **Autopsies**

VA policy COS-0`17 requires that an autopsy be requested from the next-of-kin for **all deaths** in the Medical Center. It is the responsibility of the physician alone to secure autopsies at the time of death of a patient for whom he/she is responsible. After asking the next-of-kin for the autopsy, **the request and decision** regarding performance of the autopsy must be **recorded in the progress notes** of the deceased patient's medical record. Administrative personnel will not obtain permission from the next-of-kin for post-mortem examinations under any circumstances. Forms for obtaining consent are maintained by ward clerk personnel. If the family requests that they be informed of the results of the autopsy or if promised that they will

receive a report of the findings, it becomes the physician's responsibility to personally provide the information either by telephone or by a letter, working with the Release of Information Clerk. Autopsy results are not required to be included in death summaries which should be performed promptly.

For further information on autopsies, refer to **Health Care System Policy COS-017 "Indications for Post-Mortem Examination."**

## Ethics/End-of-Life Issues

A Medical Ethics/Optimum Care Committee (OCC) has been established to address ethical issues in patient care. This committee can be accessed through the Chairperson or any member. Any staff member involved in the provision of direct patient care may request advice or consideration of potential issues. Patients and their designated representatives may also seek guidance.

For further information, refer to **Health Care System Policy COS-042 "Medical Ethics/Optimum Care Committee."**

If you have questions, contact the Chairperson of the OCC

## A GUIDE TO RELEASE OF INFORMATION FOR PROVIDERS

Omaha Release of Information Office – Hospital Front Lobby Ext. 4166

**DO's 1. At this point in time the following information can be released to the patient without a written consent or involvement of Release of Information personnel:**

You may verbally provide any information the patient needs or wants to know regarding his/her condition and the results of any test or procedures.

You may verbally provide any instructions and/or orders that the patient needs to follow his/her hospitalization or clinic visit. This information can also be shared with a caregiver (such as a wife or nursing home caring for the patient) consistent with good medical-ethical practices.

You may give the patient a copy of a lab test, radiology report, pathology report etc., if it is given during the visit and is part of providing patient education or explaining care to the patient. (For example, a Coumadin Clinic where the provider prints a graph of 6 months' worth

of tests to show the patient how his levels have decreased over a period of time or a follow-up appointment after a stress test to discuss the results and determine future action).

You may also call or send the patient a copy of test results when they become available, even if it is a few days after the visit. You may send letters to the patient regarding his/her medical condition, need for follow-up, etc. A copy should be maintained for the patient's record. If the patient has specified that he has a confidential mailing address any letters must be sent to that address. Send your letters to patients through the Release of Information department so that they can ensure that it is sent to the appropriate address.  You may give the patient any information regarding his condition or treatment over the phone. But if the patient is calling you, **you must be very sure that it is actually the patient that you are speaking with.** The best way to do this is to call the patient back at the home or work phone number listed in his/her records.

You may provide the patient a printout or list of his/her medications such as can be provided using the options RX Information Profile, ACTIVE RX'S DISPLAY [PSZZACT], or the Active Prescriptions under the Reports tab in CPRS.

If you are discussing the patient's treatment in the presence of a third party, you must make sure that you have the consent of the patient to do so. You are strongly encouraged to document this approval in the medical record.

2. The two-part NCR **RETURN TO WORK** form can be used. The patient does sign this copy and this does constitute consent. However, physicians can complete this form and give it to the patient right at the time of the visit. The carbon copy needs to be sent to the Release of Information office so that an accounting can be maintained as required by the Privacy Act.

3. **FORM COMPLETION** --When Release of Information staff requests that a form be completed or an opinion be given, Providers can assume that all necessary consents and disclaimers have been obtained and that the forms must be dealt with. **VHA policy requires that VHA health care providers, when requested, provide descriptive statements and opinions for VA patients with respect to patients' medical condition, employability, and degree of disability.** These forms must be completed as soon as possible and as completely as possible. **The completed forms must be returned to the Release of Information office and not given directly to the patient.** This must be done so that an accounting can be maintained, a disclaimer signed, and a copy of the completed form made for the record, as required by the Privacy Act.

4. **EXAMINATIONS IN ORDER TO PROVIDE OPINIONS**--If a patient requests an examination in order to complete a form or provide an opinion, this must be done. The exception to this rule is exams for the Social Security Administration. **PROVIDERS MAY COMPLETE FORMS, PREPARE LETTERS, OR MAKE STATEMENTS IN THE MEDICAL RECORD FOR THE SOCIAL SECURITY ADMINISTRATION IF THEY CAN DO SO BASED ON THEIR PERSONAL KNOWLEDGE OF THE PATIENT AND/OR A REVIEW OF THE RECORDS. HOWEVER, NO SPECIAL EXAMINATION MAY BE DONE SOLELY TO COMPLETE SOCIAL SECURITY FORMS.**

**5. OPINIONS REGARDING SERVICE CONNECTION**--If requested by a patient, providers are required to provide an opinion in the medical record regarding the relationship of the patient's medical condition as it relates to his/her military service. *A note in the medical record containing a statement such as, "in my medical opinion the currently existing medical condition is 'related to,' 'possibly related to,' or 'at least as likely as not related to' an injury, disease, or event occurring during the veteran's military service" constitutes a sufficient supportive statement. The injury, disease, or event can be something described by the veteran or shown in other records, but should be identified as such by the physician in the physician's statement. A statement to the effect of, "I am unable to determine whether a relationship exists" between the present disability and a described injury, disease, or event occurring during military service, is also acceptable.* NOTE: In all instances involving VA determinations of disability or service connection mentioned in items 3, 4 & 5 above, **the veteran is required to sign a disclaimer** that states: "I understand that the VA health care practitioner's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions." **For this reason, it is essential that no completed form or notes with a medical opinion of disability or service connection be given directly to the veteran. He/she must be sent to the Release of Information office listed above before this information is released.** Security bags are available in each clinic area for the veteran to transport the notes or forms to the Release of Information office.

**6. NON-VA Providers**—You may release verbal information (not including information pertaining to treatment for Drug Abuse, Alcohol Abuse, HIV/AIDS, or Sickle Cell Anemia) to a non-VA health care provider for treatment purposes. You may release records (not including information pertaining to treatment for Drug Abuse, Alcohol Abuse, HIV/AIDS, or Sickle Cell Anemia) to a non-VA health care provider for treatment purposes upon receipt of a written (or FAXED) request. **If you are releasing records a written request from the non-VA provider is required.** Any records released to a non-VA provider do constitute a disclosure. Therefore you need to inform the Release of Information Office and send the written request when you provide records to non-VA providers, so that a record of this disclosure can be maintained as required by HIPAA and the Privacy Act. If you need to release either verbal information or records pertaining to alcohol abuse, drug abuse, sickle cell anemia or HIV/AIDS, contact the Release of Information office before any information is released and they will guide you through the correct processes.

7. Do call Release of Information or the HIMS Supervisor at the numbers listed at the top of this document if you have any questions regarding Release of Information.

8. Do call the Privacy Officer at ext. 3427 if you have questions or concerns regarding Privacy Issues or witness any violations of privacy at our facility.

## **DON'TS**

1. Don't give patients copies of **past** electronic or hard copy medical records that are not required during the patient's current visit as part of providing instruction, education, or determining the course of treatment. This is a violation of the Privacy Act. If patients need copies from their **past** records they should be referred to Release of Information. This includes progress notes, lab, radiology and pathology reports, discharge summaries, operation reports etc.
2. Don't complete a form that the patient brings in and just hand it back to him/her. You may complete the form, but make sure that the patient and the form get to Release of Information so that a consent can be obtained, a copy made for the record, a disclaimer obtained if necessary, and an accounting maintained.
3. Do not refer patients to the Compensation and Pension office if they are requesting a disability evaluation for any purpose that is not related to VA disabilities. Non-VA disability opinions should be provided by the Primary Care physician with referrals to other providers if necessary.
4. DO NOT RESPOND TO ANY SUBPOENA OR COURT ORDER OR LETTER FROM AN ATTORNEY SENT DIRECTLY TO YOU. Take any subpoena or court order or attorney letter you receive to Release of Information IMMEDIATELY. They will check with the Regional Counsel if necessary and provide you with guidance and information on how to proceed.
5. Do not communicate confidential patient information using e-mail systems other than the internal VistA email. You may not communicate confidential patient information in OUTLOOK. This applies to communications with the patients or other providers. E-mail systems other than VistA are not secure.
6. If you call a patient do not leave any medical information other than an appointment date and time on an answering machine or voice mail

## **Reporting Abuse and Neglect**

Abuse and neglect are serious detriments to the health and safety of patients. By law, suspected abuse or neglect must be reported, although the procedures to report abuse are different in all US states and territories. The differing regulations may cause confusion or delays in reporting suspected abuse or neglect. VA facility policies regarding reporting such cases should reflect state law and may slightly differ between VA Medical Centers. Regardless, in all VA Medical Centers, all instances of suspected abuse and neglect must be reported to your local VA Social Work Service. Involve your supervisor in all suspected cases of abuse or neglect. They will evaluate the situation and gather the pertinent information and documentation to present to Social Work Service for follow-up.

Most cases of abuse or neglect are discovered in outpatients who are visiting a clinic, patients arriving in emergency departments, or in newly admitted inpatients. Signs and symptoms of abuse or neglect include:

- vague or inconsistent explanations of injuries (which may be the result of shame or fear of retaliation);
- acute or past chronic injuries such as bruising or broken bones;
- delayed medical care for injuries or illness;
- chronic abdominal pain;
- chronic depression and fatigue;
- poor nutritional status;
- bed sores;
- neglected oral health or dentition;
- inappropriate or soiled clothing; and/or
- poor hygiene.

Because the suspicion or discovery of patient abuse or neglect is a serious matter and may cause embarrassment to the patient or caregiver or may cause further harm to the patient by a caregiver, do not confront the patient or caregiver. Confronting a guilty caregiver may escalate into a dangerous situation. In all circumstances of suspected or overt signs of patient abuse and neglect, notify your supervisor as soon as possible. The observation and reporting of suspected abuse or neglect is very important. You may be responsible for saving a life or preventing continued avoidable pain and suffering by being alert to the signs of possible patient abuse and neglect.

## **Patient Rights & Responsibilities**

***The Veterans Health Administration (VHA) is pleased you have selected us to provide your healthcare. We want to improve your health and well-being. We will make your visit or stay as pleasant for you as possible. As part of our service to you, to other veterans and to the Nation, we are committed to improving healthcare quality. We also train future healthcare professionals, conduct research, and support our country in times of national emergency. In all these activities, our employees will respect and support your rights as a patient. Your basic rights and responsibilities are outlined in this document. Please talk with VA treatment team members or a patient advocate if you have any questions or would like more information about your rights.***

### **I. RESPECT AND NONDISCRIMINATION**

- You will be treated with dignity, compassion, and respect as an individual. Your privacy will be protected. You will receive care in a safe environment. We will seek to honor your personal and religious values.
- You or someone you choose has the right to keep and spend your money. You have the right to receive an accounting of any VA held funds.

- Treatment will respect your personal freedoms. In rare cases, the use of medication and physical restraints may be used if all other efforts to keep you or others free from harm have not worked.
- As an inpatient or nursing home resident, you may wear your own clothes. You may keep personal items. This will depend on your medical condition.
- As an inpatient or nursing home resident, you have the right to social interaction and regular exercise. You will have the opportunity for religious worship and spiritual support. You may decide whether to participate in these activities. You may decide whether to perform tasks in or for the Medical Center.
- As an inpatient or nursing home resident, you have the right to communicate freely and privately. You may have or refuse visitors. You will have access to public telephones. You may participate in civic rights, such as voting and free speech.
- As a nursing home resident, you can organize and take part in resident groups in the facility. Your family also can meet with the families of other residents.
- To provide a safe treatment environment for all patients or residents and staff, you are expected to respect other patients, residents and staff and to follow the facility's rules. Avoid unsafe acts that place others at risk for accidents or injuries. Please immediately report any condition you believe to be unsafe.

## **II. INFORMATION DISCLOSURE AND CONFIDENTIALITY**

- You will be given information about the health benefits you can receive. The information will be provided in a way you can understand.
- You will receive information about the costs of your care, if any, before you are treated. You are responsible for paying your portion of any costs associated with your care.
- Your medical record will be kept confidential. Information about you will not be released without your consent unless authorized by law (an example of this is State public health reporting). You have the right to information in your medical record and may request a copy of your medical records. This will be provided except in rare situations when your VA physician feels the information will be harmful to you. In that case, you have the right to have this discussed with you by your VA provider.
- You will be informed of all outcomes of care, including any potential injuries. You will be informed about how to request compensation for any injuries.

## **III. PARTICIPATION IN TREATMENT DECISIONS**

You, and any persons you choose, will be involved in all decisions about your care. You will be given information you can understand about the benefits and risks of treatment. You will be given other options. You can agree to or refuse treatment. You will be told what is likely to happen to you if you refuse treatment. Refusing treatment will not affect your rights to future care but you take responsibility for the possible results to your health.

- Tell your provider about your current condition, medicines (including over-the-counter and herbals), and medical history. Also, share any other information that affects your health. You should ask questions when you do not understand something about your care. Being

involved is very important for you to get the best possible results.

- You will be given, in writing, the name and title of the provider in charge of your care. As our partner in healthcare, you have the right to be involved in choosing your provider. You also have the right to know the names and titles of those who provide you care. This includes students, residents and trainees. Providers will properly introduce themselves when they take part in your care.
- You will be educated about your role and responsibilities as a patient or resident. This includes your participation in decision making and care at the end of life.
- If you believe you cannot follow the treatment plan, you have a responsibility to notify your provider or treatment team.
- You have the right to have your pain assessed and to receive treatment to manage your pain. You and your treatment team will develop a pain management plan together. You are expected to help the treatment team by telling them if you have pain and if the treatment is working.
- As an inpatient or nursing home resident, you will be provided any transportation necessary for your treatment plan.
- You have the right to choose whether you will participate in any research project. Any research will be clearly identified. Potential risks of the research will be identified and there will be no pressure on you to participate.
- You will be included in resolving any ethical issues about your care. You may consult with the Medical Center's Ethics Consultation Service and/or other staff knowledgeable about healthcare ethics.
- If you or the Medical Center believes that you have been neglected, abused or exploited, you will receive help.

#### **IV. COMPLAINTS**

You are encouraged and expected to seek help from your treatment team or a patient advocate if you have problems or complaints. Any privacy complaints will be addressed by the facility Privacy Officer. You will be given understandable information about the complaint process in your preferred language. You may complain verbally or in writing, without fear of retaliation. If you believe that you or your family member has been neglected, abused or exploited by VA staff, please report this promptly to the treatment team or patient advocate. You will receive help immediately. If you believe the organization has failed to address or satisfy your concerns about health care quality and safety, you may contact the Joint Commission's Office of Quality Monitoring at 1-800-994-6610. If you believe that the organization has failed to address your concerns about suspected criminal activities, fraud, waste, abuse, or mismanagement, you may contact the VA Office of the Inspector General at 1-800-488-8244 or email [vaighotline@va.gov](mailto:vaighotline@va.gov).

# Patient Advocates Concerns & Complaints

Our Patient Advocate program seeks to personally give you and your family the security of knowing someone is available to focus on your individual concerns and rights as a patient. We work directly with all departments on your behalf and can address your questions, problems or special needs. If you, or a Veteran you care for, has not been able to resolve important issues related to VA through other means, please contact one of our highly skilled patient advocates, listed on the reverse, who will be eager to help you with your concern in a timely manner.

## **PATIENT ADVOCATES AND SERVICE LEVEL ADVOCATES:**

- Are a link between you and your medical care provider
- Welcome suggestions for improved care and service.
- If you have a concern, please feel free to talk to us, or any VA employee, for assistance.
- We are here to serve you.

## VA NWIHCS Behavior Standards

The VA NWIHCS I CARE Behavior Standards (next page) were developed by a group of VA employees that wanted meaningful and actionable behaviors to exemplify the VA's core values. I CARE never goes out of style, it's how we fulfill our mission to serve Veterans every day

## The Patient Safety Program

**THE VA NATIONAL CENTER FOR PATIENT SAFETY (NCPS) SERVES AS A RESOURCE FOR HEALTH CARE CENTERS AND IMPLEMENTED A 3 STEP APPROACH TO IMPROVING PATIENT SAFETY:**

- o Understanding that the healthcare continuum is a system and exploring system flaws/vulnerabilities that can result in harm to patients.
- o Encouraging reporting of system flaws/vulnerabilities so that VHA can learn about them and how to prevent them.
- o Emphasizing prevention rather than punishment as the preferred method to prevent system vulnerabilities and reduce adverse events.

**ASSOCIATE CHIEF OF STAFF FOR PATIENT SAFETY**

402-995-3763

**PATIENT SAFETY MANAGER**

402-995-5851

**PATIENT SAFETY NURSE**

308-382-3660 EXT 3277

**VA NATIONAL CENTER FOR PATIENT SAFETY**

[WWW.PATIENTSAFETY.VA.GOV](http://WWW.PATIENTSAFETY.VA.GOV)

**JOINT PATIENT SAFETY REPORTING (JPSR)**

[HTTPS://PSRDEMOTRAINING.CSD.DISA.MIL/INDEX](https://PSRDEMOTRAINING.CSD.DISA.MIL/INDEX)

## **TYPES OF INCIDENTS**

### **Adverse Events:**

Adverse events are untoward incidents, therapeutic misadventures, iatrogenic injuries, or other adverse occurrences directly associated with care or services provided within the jurisdiction of a medical center, outpatient or other VHA facility.

### **Sentinel Events**

Sentinel Events are a type of adverse event. Sentinel events are defined by the Joint Commission as:

- o Death
- o Permanent Injury
- o Severe Temporary Harm

Sentinel events signal the need for immediate investigation and response. The facility Director's office is to notify the network of any Sentinel event. The immediate investigations may be a Root Cause Analysis (RCA), or in the case of an intentionally unsafe act, administrative action.

### **Close Calls**

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 preventative strategies and actions. They receive the same level of scrutiny as adverse events that result in actual injury and require completion of a Patient Incident Report.

# The Joint Patient Safety Reporting (JPSR)

## WHAT HAPPENS WHEN YOU SUBMIT A REPORT IN JPSR?

### Reporter:

Submits a confidential event/incident report using JPSR. Reporter can remain anonymous, if preferred. The link to JPSR will be available on every computer.

### Patient Safety Manager:

Receives event/incident report and assigns to a "Handler/Investigator" for follow-up, if applicable. Patient Safety Manager tracks event from start to finish.

### Handler/Investigator:

Reviews events/reports as assigned, investigates what happens, and documents findings in JPSR. The Handler/Investigator only have access to the events they are assigned. After the investigator completes the report, the report goes back to the Patient Safety Manager for approval and additional action, if needed.

## ENTER AN INCIDENT REPORT:

<https://psrdemotraining.csd.disa.mil/index> Additional Training and information can be found on the Patient Safety SharePoint Site.

# National Patient Safety Goals (NPSG)

## PATIENT IDENTIFICATION

Prior to any care, specimen collected, medication administered the patient MUST be actively involved in the patient identification. You must ask the patient their name and full Social Security Number (SSN).

## COMMUNICATION HAND OFF

NWIHCS has a standard hand off tool that is used with providers that allow consistent communication between caregivers. This tool allows for person to person question and answers to decrease the likelihood of misinformation. There are no verbal orders. You will access a computer on station and submit you orders from that computer. All staff must use the read back method for receiving critical values or test results.

## MEDICATION RECONCILIATION

A process exists for comparing the patient's current medications while under VA care. This standard requires provider initiate the medication reconciliation and documents medication reconciliation with an outside provide when transferring the patient to an non-VA care facility.

## **RAPID RESPONSE TEAM (RRT)**

When you see a patient that appears in distress, you are to call 3333 and tell the dispatcher you need a Rapid Response Team to your location. This will bring a physician, nurse and a respiratory therapist to examine the patient and decide the next course of treatment. You are never wrong in calling an RRT if you really think the patient is not well. (i.e., falls, faints, etc.) These NPSG's, along with other VHA standards of practice, are tracked and reported to various committees throughout NWHCS, VISN, and Central Office. Your cooperation in assuring that you use these goals helps to create the culture of safety that is necessary for patient safety. For any questions, contact the NWHCS Patient Safety Manager.

## **Pain Management**

NWHCS is dedicated to maintaining a safe and comfortable environment for the patients and residents. Pain management is a comprehensive process which involves a multidisciplinary treatment approach. Those experiencing pain are assessed and reassessed at appropriate intervals after implementing various methods in effort to reduce pain or improve ability to function. Appropriate techniques are used to evaluate the patients' and residents' pain level before and after various interventions such as psychosocial interventions, nonpharmacological therapies, specialty procedures (injections, nerve block), pharmacological options when appropriate, etc. The goal is to enhance the comfort of the patients and residents by setting realistic pain expectations.

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## **Stop the Line**

VHA wants all staff to feel empowered to "STOP the Line!" if they believe there is an immediate threat to safety. Staff is encouraged to express their concerns when they identify concerns during the health care process regardless of their position by using three simple steps, known as the 3W's.

- o Say WHAT you see
- o Say WHAT you are concerned about: and,
- o Say WHAT you want to happen to keep things safe

***"I see that this Veteran's blood pressure is elevated and I'm concerned that his medications may need an adjustment. I'd like his discharge to be postponed until his medications are reviewed."***

# Management of Suspected Abuse, Assault, and Neglect

It is the policy of NWHCS to report all suspected cases of adult and child abuse/neglect, maltreatments, assaults etc. to the appropriate authorities following mandatory reporting guidelines for the states of Nebraska and Iowa to the extent that process is consistent with Federal records confidentiality statutes. Please review policy PCS-022.

## High Fall Risk Patients

### HOW DO YOU KNOW IF A PATIENT IS AT RISK FOR FALLING?

- o Yellow start outside of patient's door
- o Yellow socks
- o Yellow wristband
- o Unsteady or using a walker/cane/crutches

If you have any concerns regarding a patient, stay with the patient and use the patient's call light to notify a nurse immediately.

## OPERATION S.A.V.E.

Operation S.A.V.E. will help you act with care and compassion if you encounter a Veteran who is in suicidal crisis. The acronym "S.A.V.E." helps one remember the important steps involved in suicide prevention:

- Signs of suicidal thinking should be recognized
- Ask the most important question of all
- Validate the Veteran's experience
- Encourage treatment and Expedite getting help

### IMPORTANCE OF IDENTIFYING WARNING SIGNS

- Many Veterans may not show any signs of intent to harm themselves before doing so
- There are behaviors which may be signs a Veteran needs help
- Veterans in crisis may show behaviors that indicate a risk of harming themselves

# SIGNS OF SUICIDAL THINKING

## Learn to recognize these warning signs:

- Hopelessness, feeling like there's no way out
- Anxiety, agitation, sleeplessness or mood swings
- Feeling like there is no reason to live
- Rage or anger
- Engaging in risky activities without thinking
- Increasing alcohol or drug abuse
- Withdrawing from family and friends

## The presence of any of the following signs requires immediate attention:

- Thinking about hurting or killing themselves
- Looking for ways to die
- Talking about death, dying or suicide
- Self-destructive or risk-taking behavior, especially when it involves alcohol, drugs or weapons

## Veteran-specific risks

- Frequent deployments
- Deployments to hostile environments
- Exposure to extreme stress
- Physical/sexual assault while in the service (not limited to women)
- Length of deployments
- Service-related injury

## Things to Consider When Talking With a Veteran at Risk for Suicide

- Remain calm
- Listen more than you speak
- Maintain eye contact
- Act with confidence
- Do not argue
- Use open body language
- Limit questions-let the Veteran do the talking
- Use supportive, encouraging comments
- Be honest-there are no quick solutions, but help is available

## ASKING THE QUESTION

Know how to ask the most important question of all. Are you thinking about killing yourself?

- Are you thinking of suicide? Have you had thoughts about taking your own life?
- Are you thinking about killing yourself?
- DO ask the question if you've identified warning signs or symptoms
- DO ask the question in such a way that is natural and flows with the conversation

- DON'T ask the question as though you are looking for a "no" answer "You aren't thinking of killing yourself, are you?"
- DON'T wait to ask the question when he/she is halfway out the door

## **VALIDATE THE VETERAN'S EXPERIENCE**

- Talk openly about suicide. Be willing to listen and allow the Veteran to express his or her feelings.
- Recognize that the situation is serious.
- Do not pass judgment
- Reassure that help is available

## **ENCOURAGE TREATMENT & EXPEDITING GETTING HELP**

### **What Should I Do if I Think Someone is Suicidal?**

- Don't keep the Veteran's suicidal behavior a secret
- Do not leave him or her alone
- Try to get the person to seek immediate help from his or her doctor or the nearest hospital emergency room, or
- Call 911
- Reassure the Veteran that help is available.
- Call the Veterans Crisis Line at 1-800-273-8255, Press 1

### **Safety Issues:**

- Never negotiate with someone who has a gun
- Get to safety and call VA police or security
- If the Veteran has taken pills, cut himself or herself or done harm to himself or herself in some way
- Call VA police or security
- Remember: When a Veteran at risk for suicide leaves your facility, provide suicide prevention information to the Veteran and his or her family

## **RESOURCES**

### **Mental Health**

VHA provides specialty inpatient and outpatient mental health services at its medical centers and community-based outpatient clinics. All mental health care provided by VHA supports recovery, striving to enable a person with mental health problems to live a meaningful life in the community and achieve his or her full potential. For more information on VA Mental Health Services visit [www.mentalhealth.va.gov](http://www.mentalhealth.va.gov).

### **Vet Centers**

Vet Centers are VA community-based centers that provide a range of counseling, outreach, and referral services. For more information about Vet Centers and to find the Vet Center closest to visit [www.vetcenter.va.gov](http://www.vetcenter.va.gov).

## **YOUR SUICIDE PREVENTION CONTACT:**

**MYTH OR REALITY:** Asking about suicide may lead to someone to taking his or her life.

**REALITY:** Asking about suicide does not create suicidal thoughts. The act of asking the question simply gives the veteran permission to talk about his or her thoughts or feelings.

**MYTH OR REALITY:** There are talkers and there are doers.

**REALITY:** Most people who die by suicide have communicated some intent. Someone who talks about suicide gives the guide and/or clinician an opportunity to intervene before suicidal behaviors occur. Almost everyone who dies by suicide or attempts suicide has given some clue or warning. Suicide threats should never be ignored. No matter how casually or jokingly said, statements like “You’ll be sorry when I’m dead,” or “I can’t see any way out” may indicate serious suicidal feelings.

**MYTH OR REALITY:** If somebody really wants to die by suicide, there is nothing you can do about it.

**REALITY:** Most suicidal ideas are associated with treatable disorders. Helping someone find a safe environment for treatment can save a life. The acute risk for suicide is often time limited. If you can help the person survive the immediate crisis and overcome the strong intent to die by suicide, you have gone a long way toward promoting a positive outcome.

**MYTH OR REALITY:** He/she really wouldn’t die by suicide because...

- he just made plans for a vacation
- she has young children at home
- he made a verbal or written promise
- she knows how dearly her family loves her

**REALITY:** The intent to die can override any rational thinking. Someone experiencing suicidal ideation or intent must be taken seriously and referred to a clinical provider who can further evaluate their condition and provide treatment as appropriate.

## **Make the Connection**

MakeTheConnection.net is a one stop resource where Veterans and their families and friends can privately explore information about physical and mental health symptoms, challenging life events, and mental health conditions. On this site, Veterans and their families and friends can learn about available resources and support. Visit [www. MakeTheConnection.net](http://www.MakeTheConnection.net) to learn more.

## **Post-Traumatic Stress Disorder (PTSD)**

Each VA medical center has PTSD specialists who provide treatment for Veterans with PTSD. For more information about PTSD and to locate the VA PTSD program nearest you visit [www.ptsd.va.gov](http://www.ptsd.va.gov)

**PTSD Coach App:** The PTSD Coach application, allows phone users to manage their symptoms, links them with local sources of support, and provides information on PTSD. Visit [www.ptsd.va.gov/public/pages/PTSDCoach.asp](http://www.ptsd.va.gov/public/pages/PTSDCoach.asp).

**Veterans Crisis Line/Chat/Text 1-800-273-8255, Press 1**

<http://www.veteranscrisisline.net/Text> to 838255

**VA Suicide Prevention Coordinators**

Each VA Medical Center has a suicide prevention coordinator to make sure Veterans receive needed counseling and services Resource locator - <http://www.veteranscrisisline.net>

## **FACTS ABOUT VETERAN SUICIDE**

- 20 percent of U.S. deaths from suicide are Veterans (National Violent Death Reporting System)
- As of 2011, Veterans account for 9.1% of the US civilian population (US Census Bureau)
- Veterans are more likely than the general population to use firearms as a means for suicide (National Violent Death Reporting System)
- 950 suicide attempts per month among Veterans receiving VA health care services (VA National Suicide Prevention Coordinator reports, October 1, 2008 – December 31, 2010)
- Decreased suicide rates in Veterans aged 18-29 who use VA health care services (National Violent Death Reporting System and VA Serious Mental Illness Treatment Resource and Evaluation Center)
- 33 percent of recent Veteran suicides have a history of previous attempts (VA National Suicide Prevention Coordinator reports, October 1, 2008 – December 31, 2010)