Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-00620-548

Combined Assessment Program Review of the Manchester VA Medical Center Manchester, New Hampshire

September 30, 2015

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
Telephone: 1-800-488-8244
E-Mail: vaoighotline@va.gov
(Hotline Information: www.va.gov/oig/hotline)

Glossary

CAP	Combined Assessment Program
CT	computed tomography
EAM	emergency airway management
EHR	electronic health record
EOC	environment of care
facility	Manchester VA Medical Center
FY	fiscal year
MH	mental health
NA	not applicable
NM	not met
OIG	Office of Inspector General
QM	quality management
SCI	spinal cord injury
VCP	Veterans Choice Program
VHA	Veterans Health Administration

Table of Contents

Executive Summary

Review Purpose: The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the week of August 10, 2015.

Review Results: The review covered eight activities. We made no recommendations in the following six activities:

- Environment of Care
- Medication Management
- Coordination of Care
- Computed Tomography Radiation Monitoring
- Emergency Airway Management
- Continuity of Care

The facility's reported accomplishments were the establishment of the Veterans Choice Program Support Office and the Nurse First Clinic.

Recommendations: We made recommendations in the following two activities:

Quality Management: Ensure that when cases receive initial Level 2 or 3 ratings, the Peer Review Committee consistently invites involved providers to submit comments to and/or appear before the committee prior to final level assignment. Review privilege forms annually, and document the review. Ensure licensed independent practitioners' folders do not contain non-allowed information. Require the Code Committee to review each code episode. Ensure the Safe Patient Handling Committee meets monthly and provides oversight of the safe patient handling program. Include all required elements in the quality control policy for scanning.

Suicide Prevention Program: Assign the Suicide Prevention Coordinator full time to suicide prevention activities. Ensure new employees receive suicide prevention training.

Comments

The Veterans Integrated Service Network Director and Acting Facility Director agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 24–28, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Objectives and Scope

Objectives

CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care quality and the EOC.
- Provide crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope

The scope of the CAP review is limited. Serious issues that come to our attention that are outside the scope will be considered for further review separate from the CAP process and may be referred accordingly.

For this review, we examined selected clinical and administrative activities to determine whether facility performance met requirements related to patient care quality and the EOC. In performing the review, we inspected selected areas, conversed with managers and employees, and reviewed clinical and administrative records. The review covered the following eight activities:

- QM
- EOC
- Medication Management
- Coordination of Care
- CT Radiation Monitoring
- EAM
- Continuity of Care
- Suicide Prevention Program

We have listed the general information reviewed for each of these activities. Some of the items listed may not have been applicable to this facility because of a difference in size, function, or frequency of occurrence.

The review covered facility operations for FY 2013, FY 2014, and FY 2015 through August 10, 2015, and inspectors conducted the review in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide the status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the Manchester VA Medical Center, Manchester, New Hampshire,* Report No. 13-00374-174, April 12, 2013). We made a repeat recommendation in QM.

During this review, we presented crime awareness briefings for 38 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

Additionally, we surveyed employees regarding patient safety and quality of care at the facility. We distributed an electronic survey to all facility employees and received 284 responses. We shared summarized results with facility managers.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough for the OIG to monitor until the facility implements corrective actions.

Reported Accomplishments

VCP

In April 2015, the facility established one of the nation's first VCP Support Offices. The VCP Support Office consists of four dedicated VCP champions. For patient convenience, Veterans Benefits Administration benefits and eligibility representatives cohabitate office space to facilitate ease in problem solving with a wrap-around service approach. The VCP Support Office also supports warm hand-offs with Health Net and helps to increase community provider involvement.

Nurse First Clinic

The facility initiated and opened a Nurse First Clinic in late 2014. This program, staffed by registered nurses, assists patients with minor health concerns not requiring urgent care. This enhanced triage helps to streamline services and make urgent care clinic providers available to patients who require more acute care.

Results and Recommendations

QM

The purpose of this review was to determine whether facility senior managers actively supported and appropriately responded to QM efforts and whether the facility met selected requirements within its QM program.[a]

We conversed with senior managers and key QM employees, and we evaluated meeting minutes, 10 credentialing and privileging folders, and other relevant documents. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	There was a senior-level committee responsible for key quality, safety, and value functions that met at least quarterly and was chaired or co-chaired by the Facility Director. • The committee routinely reviewed aggregated data. • QM, patient safety, and systems redesign appeared to be integrated.		
X	Peer reviewed deaths met selected requirements: • Peers completed reviews within specified timeframes. • The Peer Review Committee reviewed cases receiving initial Level 2 or 3 ratings. • Involved providers were invited to provide input prior to the final Peer Review Committee determination.	For the 12-month period May 1, 2013, through April 30, 2014: • For several death cases that received initial Level 2 or 3 ratings, the Peer Review Committee did not invite involved providers to provide input prior to the final determination.	**1.** We recommended that when cases receive initial Level 2 or 3 ratings, the Peer Review Committee consistently invite involved providers to submit comments to and/or appear before the committee prior to the final level assignment.

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Credentialing and privileging processes met selected requirements: • Facility managers reviewed privilege forms annually and ensured proper approval of revised forms. • Facility managers ensured appropriate privileges for licensed independent practitioners. • Facility managers removed licensed independent practitioners' access to patients' EHRs upon separation. • Facility managers properly maintained licensed independent practitioners' folders.	• Facility managers did not review privilege forms annually. • Seven of the 10 licensed independent practitioners' folders contained non-allowed information.	**2.** We recommended that facility managers review privilege forms annually and document the review. **3.** We recommended that the facility ensure that licensed independent practitioners' folders do not contain non-allowed information.
	Observation bed use met selected requirements: • The facility gathered data regarding appropriateness of observation bed usage. • The facility reassessed observation criteria and/or utilization if conversions to acute admissions were consistently 25–30 percent or more.		
X	The process to review resuscitation events met selected requirements: • An interdisciplinary committee reviewed episodes of care where resuscitation was attempted. • Resuscitation event reviews included screening for clinical issues prior to events that may have contributed to the occurrence of the code. • The facility collected data that measured performance in responding to events.	Twelve months of Code Committee meeting minutes reviewed: • The committee did not review each episode. This is a repeat finding from the previous CAP review.	**4.** We recommended that the Code Committee review each code episode.

NM	Areas Reviewed (continued)	Findings	Recommendations
NA	The surgical review process met selected requirements: • An interdisciplinary committee with appropriate leadership and clinical membership met monthly to review surgical processes and outcomes. • The Surgical Work Group reviewed surgical deaths with identified problems or opportunities for improvement. • The Surgical Work Group reviewed additional data elements.		
	Clinicians appropriately reported critical incidents.		
X	The safe patient handling program met selected requirements: • A committee provided program oversight. • The committee gathered, tracked, and shared patient handling injury data.	• The Safe Patient Handling Committee did not meet during the review period and did not provide oversight of the safe patient handling program.	**5.** We recommended that the Safe Patient Handling Committee meet monthly and provide oversight of the safe patient handling program.
	The process to review the quality of entries in the EHR met selected requirements: • A committee reviewed EHR quality. • A committee analyzed data at least quarterly. • Reviews included data from most services and program areas.		
X	The policy for scanning internal forms into EHRs included the following required items: • Quality of the source document and an alternative means of capturing data when the quality of the document is inadequate. • A correction process if scanned items have errors.	• The scanning policy/process did not include the quality of the source document, an alternative means of capturing data when the quality of the source document does not meet image quality controls, a correction process if scanned items have errors, and a complete review of scanned documents to ensure readability and retrievability.	**6.** We recommended that the quality control policy for scanning include the quality of the source document, an alternative means of capturing data when the quality of the source document does not meet image quality controls, a correction process if scanned items have errors, and a complete review of scanned documents to ensure readability and retrievability.

NM	Areas Reviewed (continued)	Findings	Recommendations
	• A complete review of scanned documents to ensure readability and retrievability of the record and quality assurance reviews on a sample of the scanned documents.		
	Overall, if QM reviews identified significant issues, the facility took actions and evaluated them for effectiveness.		
	Overall, senior managers actively participated in performance improvement over the past 12 months.		
	Overall, the facility had a comprehensive, effective QM program over the past 12 months.		
	The facility met any additional elements required by VHA or local policy.		

EOC

The purpose of this review was to determine whether the facility maintained a clean and safe health care environment in accordance with applicable requirements. We also determined whether the facility met selected requirements in emergency management.[b]

We inspected the community living center; the same day surgery suite; and the urgent care, primary care, and cardiology clinics. Additionally, we reviewed relevant documents and conversed with key employees and managers. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed for General EOC	Findings	Recommendations
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure for the facility and the community based outpatient clinics.		
	The facility conducted an infection prevention risk assessment.		
	Infection Prevention/Control Committee minutes documented discussion of identified high-risk areas, actions implemented to address those areas, and follow-up on implemented actions and included analysis of surveillance activities and data.		
	The facility had established a process for cleaning equipment.		
	The facility conducted required fire drills in buildings designated for health care occupancy and documented drill critiques.		
	The facility had a policy/procedure/guideline for identification of individuals entering the facility, and units/areas complied with requirements.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
	The facility met fire safety requirements.		
	The facility met environmental safety requirements.		
	The facility met infection prevention requirements.		
	The facility met medication safety and security requirements.		
	The facility met patient privacy requirements.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for SCI Center		
NA	The facility completed and documented required inspection checklists of all ceiling mounted patient lifts.		
NA	The facility met fire safety requirements in the SCI Center.		
NA	The facility met environmental safety requirements in the SCI Center.		
NA	The facility met infection prevention requirements in the SCI Center.		
NA	The facility met medication safety and security requirements in the SCI Center.		
NA	The facility met patient privacy requirements in the SCI Center.		
NA	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for Emergency Management		
	The facility had a documented Hazard Vulnerability Assessment and reviewed the assessment annually.		

NM	Areas Reviewed for Emergency Management (continued)	Findings	Recommendations
	The facility maintained a list of resources and assets it may need during an emergency.		
	The facility had a written Emergency Operations Plan that addressed key components.		
	The facility had a written description of how it will respond to an influx of potentially infectious patients and a plan for managing them over an extended period of time.		
	Employees received training and competency assessment on use of emergency evacuation devices.		
	Evacuation devices were immediately accessible and in good repair.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for Construction Safety		
NA	The facility met selected dust control, temporary barrier, storage, and security requirements for the construction site perimeter.		
NA	The facility complied with any additional elements required by VHA or local policy, or other regulatory standards.		

Medication Management

The purpose of this review was to determine whether the facility had established safe medication storage practices in accordance with VHA policy and Joint Commission standards.[c]

We reviewed relevant documents, the training records of 20 nursing employees, and pharmacy monthly medication storage area inspection documentation for the past 6 months. Additionally, we inspected the community living center, post-anesthesia care unit, operating room, and the urgent care clinic and for these areas reviewed documentation of narcotic wastage from automated dispensing machines and inspected crash carts containing emergency medications. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings	Recommendations
	Facility policy addressed medication receipt in patient care areas, storage procedures until administration, and staff authorized to have access to medications and areas used to store them.		
	The facility required two signatures on controlled substances partial dose wasting.		
	The facility defined those medications and supplies needed for emergencies and procedures for crash cart checks, checks included all required elements, and the facility conducted checks with the frequency required by local policy.		
	The facility prohibited storage of potassium chloride vials in patient care areas.		
NA	If the facility stocked heparin in concentrations of more than 5,000 units per milliliter in patient care areas, the Chief of Pharmacy approved it.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility maintained a list of the look-alike and sound-alike medications it stores, dispenses, and administers; reviewed this list annually and ensured it was available for staff reference; and had labeling/storage processes to prevent errors.		
	The facility identified in writing its high-alert and hazardous medications, ensured the high-alert list was available for staff reference, and had processes to manage these medications.		
	The facility conducted and documented inspections of all medication storage areas at least monthly, fully implemented corrective actions, and monitored the changes.		
	The facility/Pharmacy Service had a written policy for safe use of automated dispensing machines that included oversight of overrides and employee training and minimum competency requirements for users, and employees received training or competency assessment in accordance with local policy.		
	The facility employed practices to prevent wrong-route drug errors.		
	Medications prepared but not immediately administered contained labels with all required elements.		
	The facility removed medications awaiting destruction or stored them separately from medications available for administration.		
	The facility met multi-dose insulin pen requirements.		
	The facility complied with any additional elements required by VHA or local policy.		

Coordination of Care

The purpose of this review was to evaluate the consult management process and the completion of inpatient clinical consults.[d]

We reviewed relevant documents, and we conversed with key employees. Additionally, we reviewed the EHRs of 32 randomly selected patients who had a consult requested during an acute care admission from January 1 through June 30, 2014. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings	Recommendations
	A committee oversaw the facility's consult management processes.		
	Major bed services had designated employees to: • Provide training in the use of the computerized consult package • Review and manage consults		
	Consult requests met selected requirements: • Requestors included the reason for the consult. • Requestors selected the proper consult title. • Consultants appropriately changed consult statuses, linked responses to the requests, and completed consults within the specified timeframe.		
	The facility met any additional elements required by VHA or local policy.		

CT Radiation Monitoring

The purpose of this review was to determine whether the facility complied with selected VHA radiation safety requirements and to follow up on recommendations regarding monitoring and documenting radiation dose from a 2011 report, *Healthcare Inspection – Radiation Safety in Veterans Health Administration Facilities*, Report No. 10-02178-120, March 10, 2011.[e]

We reviewed relevant documents, including qualifications and dosimetry monitoring for five CT technologists and CT scanner inspection reports, and conversed with key managers and employees. We also reviewed the EHRs of 50 randomly selected patients who had a CT scan January 1–December 31, 2014. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings	Recommendations
	The facility had a designated Radiation Safety Officer responsible for oversight of the radiation safety program.		
	The facility had a CT/imaging/radiation safety policy or procedure that included: • A CT quality control program with program monitoring by a medical physicist at least annually, image quality monitoring, and CT scanner maintenance • CT protocol monitoring to ensure doses were as low as reasonably achievable and a method for identifying and reporting excessive CT patient doses to the Radiation Safety Officer • A process for managing/reviewing CT protocols and procedures to follow when revising protocols • Radiologist review of appropriateness of CT orders and specification of protocol prior to scans		
	A radiologist and technologist expert in CT reviewed all CT protocols revised during the past 12 months.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	A medical physicist tested a sample of CT protocols at least annually.		
	A medical physicist performed and documented CT scanner annual inspections, an initial inspection after acquisition, and follow-up inspections after repairs or modifications affecting dose or image quality prior to the scanner's return to clinical service.		
	If required by local policy, radiologists included patient radiation dose in the CT report available for clinician review and documented the dose in the required application(s), and any summary reports provided by teleradiology included dose information.		
	CT technologists had required certifications or written affirmation of competency if "grandfathered in" prior to January 1987, and technologists hired after July 1, 2014, had CT certification.		
	There was documented evidence that CT technologists had annual radiation safety training and dosimetry monitoring.		
	If required by local policy, CT technologists had documented training on dose reduction/optimization techniques and safe procedures for operating the types of CT equipment they used.		
	The facility complied with any additional elements required by VHA or local policy.		

EAM

The purpose of this review was to determine whether the facility complied with selected VHA out of operating room airway management requirements.[f]

We reviewed relevant documents, including the EAM coverage schedule for 30 selected dates from January 1 through June 30, 2014, and we conversed with key managers and employees. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings	Recommendations
	The facility had a local EAM policy or had a documented exemption.		
NA	If the facility had an exemption, it did not have employees privileged to perform procedures using moderate or deep sedation that might lead to airway compromise.		
	Facility policy designated a clinical subject matter expert, such as the Chief of Staff or Chief of Anesthesia, to oversee EAM.		
	Facility policy addressed key VHA requirements, including: • Competency assessment and reassessment processes • Use of equipment to confirm proper placement of breathing tubes • A plan for managing a difficult airway		
	Initial competency assessment for EAM included: • Subject matter content elements and completion of a written test • Successful demonstration of procedural skills on airway simulators or mannequins • Successful demonstration of procedural skills on patients		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Reassessments for continued EAM competency were completed at the time of renewal of privileges or scope of practice and included: • Review of clinician-specific EAM data • Subject matter content elements and completion of a written test • Successful demonstration of procedural skills on airway simulators or mannequins • At least one occurrence of successful airway management and intubation in the preceding 2 years, written certification of competency by the supervisor, or successful demonstration of skills to the subject matter expert • A statement related to EAM if the clinician was not a licensed independent practitioner		
	The facility had a clinician with EAM privileges or scope of practice or an anesthesiology staff member available during all hours the facility provided patient care.		
	Video equipment to confirm proper placement of breathing tubes was available for immediate clinician use.		
	The facility complied with any additional elements required by VHA or local policy.		

Continuity of Care

The purpose of this review was to evaluate whether clinical information from patients' community hospitalizations at VA expense was scanned and available to facility providers and whether providers documented acknowledgement of it. [g]

We reviewed relevant documents and the EHRs of 30 patients who had been hospitalized at VA expense in the local community from February 2014 to March 2015. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings	Recommendations
	Clinical information was consistently available to the primary care team for the clinic visit subsequent to the non-VA hospitalization.		
	Members of the patients' primary care teams documented that they were aware of the patients' non-VA hospitalization.		
	The facility complied with any additional elements required by VHA or local policy.		

Suicide Prevention Program

The purpose of this review was to evaluate the extent the facility's MH providers consistently complied with selected suicide prevention program requirements.[h]

We reviewed relevant documents and conversed with key employees. We also reviewed the EHRs of 27 patients assessed to be at high risk for suicide and the training records of 15 new employees. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

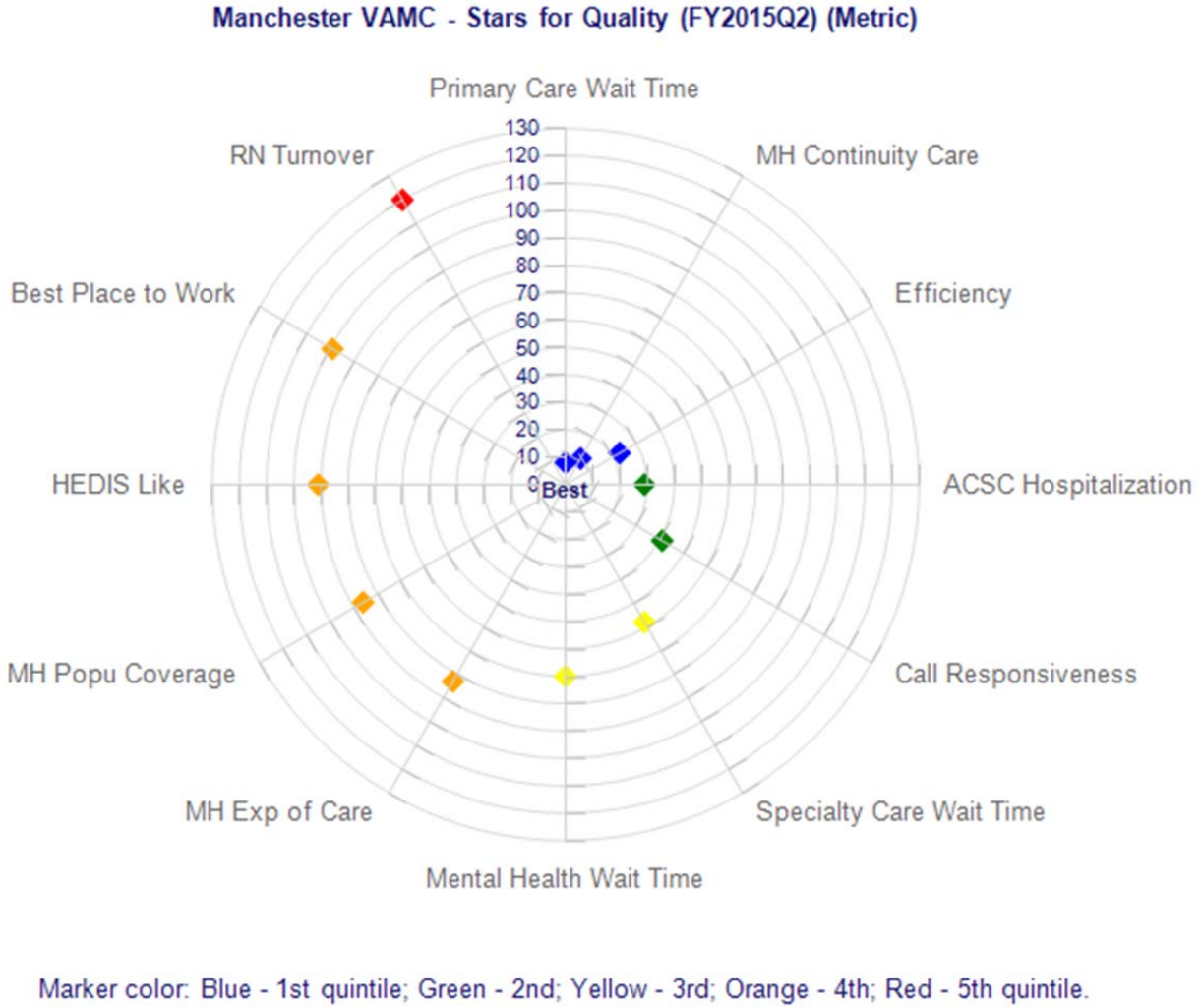
NM	Areas Reviewed	Findings	Recommendations
X	The facility had a full-time Suicide Prevention Coordinator and a plan for back-up.	• The facility's Suicide Prevention Coordinator was not dedicated full time to suicide prevention activities.	**7.** We recommended that the facility assign the Suicide Prevention Coordinator full time to suicide prevention activities.
	The facility had a process for responding to referrals from the Veterans Crisis Line and for identifying and tracking patients who are at high risk for suicide.		
X	The facility provided suicide prevention training to new employees and community organizations.	• Three employee training records contained no evidence of suicide prevention training.	**8.** We recommended that the facility ensure new employees receive suicide prevention training and that facility managers monitor compliance.
	The facility issued required reports regarding any patients who attempted or completed suicide within the past 12 months.		
	The facility had a process to follow up on patients who missed MH appointments.		
	Patients had documented safety plans that specifically addressed suicidality.		
	Patients and/or their families participated in safety plan development.		
	Clinicians documented safety plans that contained all required elements.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Clinicians documented that the patients and/or their families received a copy of the safety plan.		
	Clinicians placed flags in the EHRs for high-risk patients.		
	The facility complied with any additional elements required by VHA or local policy.		

Facility Profile (Manchester/608) FY 2015 through July 2015[1]	
Type of Organization	Secondary
Complexity Level	3-Low complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$147.4
Number of:	
• **Unique Patients**	22,849
• **Outpatient Visits**	212,710
• **Unique Employees**[2]	607
Type and Number of Operating Beds:	
• **Hospital**	NA
• **Community Living Center**	112
• **MH**	NA
Average Daily Census:	
• **Hospital**	NA
• **Community Living Center**	34
• **MH**	NA
Number of Community Based Outpatient Clinics	4
Location(s)/Station Number(s)	Portsmouth/608GA Somersworth/608GC Conway/608GD Tilton/608HA
Veterans Integrated Service Network Number	1

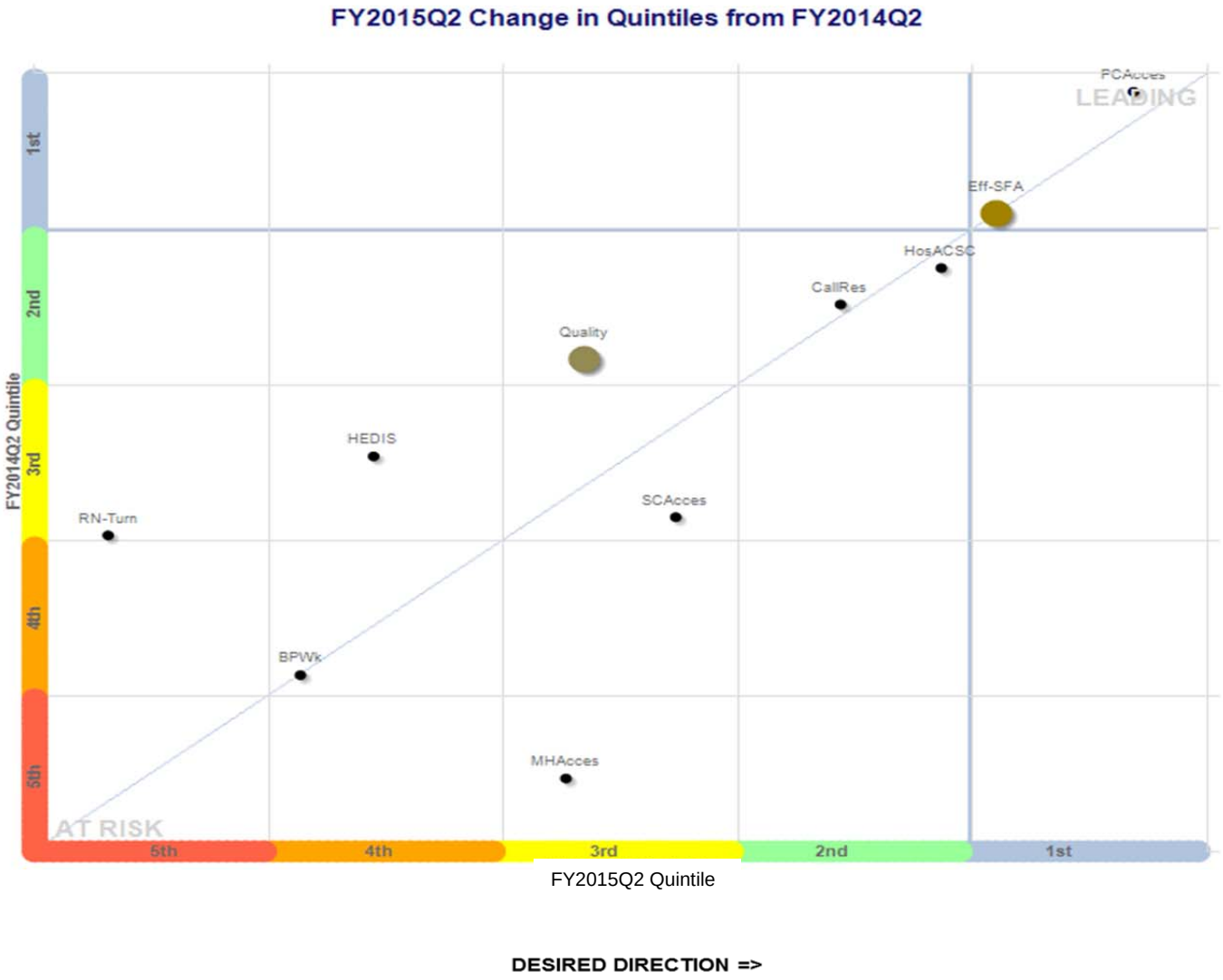
[1] All data is for FY 2015 through July 2015 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200).

Strategic Analytics for Improvement and Learning (SAIL)[3]



[3] Metric definitions follow the graphs.

Scatter Chart



NOTE

Quintiles are derived from facility ranking on z-score of a metric among 128 facilities. Lower quintile is more favorable.

Metric Definitions

Measure	Definition	Desired direction
ACSC Hospitalization	Ambulatory care sensitive condition hospitalizations (observed to expected ratio)	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Best Place to Work	Overall satisfaction with job	A higher value is better than a lower value
Call Center Responsiveness	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
Call Responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Complications	Acute care risk adjusted complication ratio	A lower value is better than a higher value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value
HC Assoc Infections	Health care associated infections	A lower value is better than a higher value
HEDIS	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
MH Wait Time	MH wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value
MH Continuity Care	MH continuity of care (FY14Q3 and later)	MH Continuity Care
MH Exp of Care	MH experience of care (FY14Q3 and later)	A higher value is better than a lower value
MH Popu Coverage	MH population coverage (FY14Q3 and later)	A higher value is better than a lower value
Oryx	Inpatient performance measure (ORYX)	A higher value is better than a lower value
Primary Care Wait Time	Primary care wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value
PSI	Patient safety indicator (observed to expected ratio)	A lower value is better than a higher value
Pt Satisfaction	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
RN Turnover	Registered nurse turnover rate	A lower value is better than a higher value
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-Pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Specialty Care Wait Time	Specialty care wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value

Appendix C

Veterans Integrated Service Network Director Comments

Department of Veterans Affairs

Memorandum

Date: September 17, 2015

From: Director, VA New England Healthcare System (10N1)

Subject: **CAP Review of the Manchester VA Medical Center, Manchester, NH**

To: Director, Bedford Office of Healthcare Inspections (54BN)

Director, Management Review Service (VHA 10AR MRS OIG CAP CBOC)

I have reviewed and concur with the action plans regarding the Combined Assessment Program (CAP) Review of the Manchester VA Medical Center, Manchester, NH.

Sincerely,

Michael Mayo-Smith, MD, MPH
Network Director, VISN 1

Acting Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: September 14, 2015

From: Acting Director, Manchester VA Medical Center (608/00)

Subject: **CAP Review of the Manchester VA Medical Center, Manchester, NH**

To: Director, VA New England Healthcare System (10N1)

1. We appreciate the opportunity to review the draft report of recommendations for the OIG CAP Review conducted at the Manchester VA Medical Center from August 10–14, 2015.

2. Please find the attached response to each recommendation included in the report. We have completed, or are in the process of completing actions to resolve these issues.

Danielle Ocker, RN, BSN, MBA
Acting Medical Center Director

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that when cases receive initial Level 2 or 3 ratings, the Peer Review Committee consistently invite involved providers to submit comments to and/or appear before the committee prior to the final level assignment.

Concur

Target date for completion: November 30, 2015

Facility response: Per medical center policy, providers whose care is under review (Level 2 and Level 3) by the Peer Review Committee are invited to appear before the Peer Review Committee before a final Committee decision is reached. The Peer Review Committee minutes will reflect these invitations to appear, and discussions held with the provider.

Recommendation 2. We recommended that facility managers review privilege forms annually and document the review.

Concur

Target date for completion: November 30, 2015

Facility response: The Medical Staff Office has initiated a process to ensure annual review of all privilege forms. Reviews will be documented by the Medical Staff Office.

Recommendation 3. We recommended that the facility ensure that licensed independent practitioners' folders do not contain non-allowed information.

Concur

Target date for completion: October 30, 2015

Facility response: The Medical Staff Office has begun review of all practitioner credentialing folders, and has removed all non-allowed information. The process will be maintained by the Credentialing and Privileging Coordinator.

Recommendation 4. We recommended that the Code Committee review each code episode.

Concur

Target date for completion: December 31, 2015

Facility response: The Code Committee reviews each code episode, and will include a comprehensive review in the minutes of the committee meetings.

Recommendation 5. We recommended that the Safe Patient Handling Committee meet monthly and provide oversight of the safe patient handling program.

Concur

Target date for completion: November 30, 2015

Facility response: The facility has assigned the duties of Safe Patient Handling Coordinator to provide oversight to the Safe Patient Handling Program and conduct monthly meetings.

Recommendation 6. We recommended that the quality control policy for scanning include the quality of the source document, an alternative means of capturing data when the quality of the source document does not meet image quality controls, a correction process if scanned items have errors, and a complete review of scanned documents to ensure readability and retrievability.

Concur

Target date for completion: December 31, 2015

Facility response: The Health Information Management Service Chief has initiated a policy and an audited peer review monitoring process to assure document quality, accuracy and integrity of scanned information.

Recommendation 7. We recommended that the facility assign the Suicide Prevention Coordinator full time to suicide prevention activities.

Concur

Target date for completion: February 28, 2016

Facility response: The facility employs a full-time Suicide Prevention Coordinator who is currently carrying a small patient panel. A plan is in place for the Suicide Prevention Coordinator to transition these patients to other providers, and devote full-time to Suicide Prevention activities. Transition activities are Veteran-centered, and will be completed based on the individual needs and safety of the Veteran.

Recommendation 8. We recommended that the facility ensure new employees receive suicide prevention training and that facility managers monitor compliance.

Concur

Target date for completion: December 31, 2015

Facility response: All new employees are assigned Suicide Prevention training in the Talent Management System. Additionally, the Suicide Prevention Coordinator offers monthly training sessions for all new employees, and 1:1 sessions are available. Compliance to course completion will be monitored by Service Chiefs and/or Supervisors.

Office of Inspector General
Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Inspection Team	Clarissa Reynolds, CNHA, MBA, Team Leader Elaine Kahigian, RN, JD Frank Keslof, EMT, MHA Jeanne Martin, PharmD Emorfia Valkanos, RPh Matthew Kidd, Special Agent, Office of Investigations
Other Contributors	Elizabeth Bullock Shirley Carlile, BA Paula Chapman, CTRS Roneisha Charles, BS Lin Clegg, PhD Marnette Dhooghe, MS Julie Watrous, RN, MS Jarvis Yu, MS

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, VA New England Healthcare System (10N1)
Acting Director, Manchester VA Medical Center (608/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Kelly Ayotte, Jeanne Shaheen
U.S. House of Representatives: Frank Guinta, Ann McLane Kuster

This report is available at www.va.gov/oig.

Endnotes

[a] References used for this topic included:
- VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-032, *Safe Patient Handling Program and Facility Design*, June 28, 2010.
- VHA Directive 1036, *Standards for Observation in VA Medical Facilities*, February 6, 2014.
- VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.
- VHA Handbook 1102.01, *National Surgery Office*, January 30, 2013.
- VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, July 22, 2014.

[b] References used for this topic included:
- VHA Directive 2008-052, *Smoke-Free Policy for VA Health Care Facilities*, August 26, 2008.
- VHA Directive 2010-032, *Safe Patient Handling Program and Facility Design*, June 28, 2010.
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- VA National Center for Patient Safety, "Issues continue to occur due to improper ceiling mounted patient lift installation, maintenance and inspection," Addendum to Patient Safety Alert 14-07, September 3, 2014.
- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, the International Association of Healthcare Central Service Materiel Management, the Health Insurance Portability and Accountability Act, Underwriters Laboratories, VA Master Specifications.

[c] References used for this topic included:
- VHA Directive 2008-027, *The Availability of Potassium Chloride for Injection Concentrate USP*, May 13, 2008.
- VHA Directive 2010-020, *Anticoagulation Therapy Management*, May 14, 2010.
- VHA Handbook 1108.01, *Controlled Substances (Pharmacy Stock)*, November 16, 2010.
- VHA Handbook 1108.05, *Outpatient Pharmacy Services*, May 30, 2006.
- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- VHA Handbook 1108.07, *Pharmacy General Requirements*, April 17, 2008.
- Various requirements of The Joint Commission.

[d] The reference used for this topic was:
- Under Secretary for Health, "Consult Business Rule Implementation," memorandum, May 23, 2013.

[e] References used for this topic included:
- VHA Directive 1129, *Radiation Protection for Machine Sources of Ionizing Radiation*, February 5, 2015.
- VHA Handbook 1105.02, *Nuclear Medicine and Radiation Safety Service*, December 10, 2010.
- VHA Handbook 5005/77, *Staffing*, Part II, Appendix G25, Diagnostic Radiologic Technologist Qualifications Standard GS-647, June 26, 2014.
- The Joint Commission, "Radiation risks of diagnostic imaging," Sentinel Event Alert, Issue 47, August 24, 2011.
- VA Radiology, "Online Guide," updated October 4, 2011.
- The American College of Radiology, "ACR–AAPM TECHNICAL STANDARD FOR DIAGNOSTIC MEDICAL PHYSICS PERFORMANCE MONITORING OF COMPUTED TOMOGRAPHY (CT) EQUIPMENT, Revised 2012.

[f] References used for this topic included:
- VHA Directive 2012-032, *Out of Operating Room Airway Management*, October 26, 2012.
- VHA Handbook 1101.04, *Medical Officer of the Day*, August 30, 2010.

[g] The references used for this topic were:
- VHA Handbook 1907.01, *Health Information Management and Health Records*, September 19, 2012.
- Various requirements of the Joint Commission.

[h] References used for this topic included:
- VHA Directive 2008-036, *Use of Patient Record Flags to Identify Patients at High Risk for Suicide*, July 18, 2008.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.
- Deputy Under Secretary for Health for Operations and Management, "Patients at High Risk for Suicide," memorandum, April 24, 2008.
- Various requirements of The Joint Commission.