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Clinical Assessment Program Review of the Southern Arizona VA Health Care System Tucson, Arizona

March 13, 2017

Washington, DC 20420

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Glossary

CAP	Clinical Assessment Program
CBOC	community based outpatient clinic
CNH	community nursing home
EHR	electronic health record
EOC	environment of care
facility	Southern Arizona VA Health Care System
FY	fiscal year
MH	mental health
NA	not applicable
NM	not met
OIG	Office of Inspector General
PC	primary care
POCT	point-of-care testing
QSV	quality, safety, and value
RME	reusable medical equipment
SPS	Sterile Processing Service
VHA	Veterans Health Administration

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Executive Summary

Purpose and Objectives: The review provided a focused evaluation of the quality of care provided in the inpatient and outpatient settings of the Southern Arizona VA Health Care System. We reviewed clinical and administrative processes that affect patient care outcomes—Quality, Safety, and Value; Environment of Care; Medication Management; Coordination of Care; Diagnostic Care; Moderate Sedation; Community Nursing Home Oversight; and Management of Disruptive/Violent Behavior. We also followed up on recommendations from the previous Combined Assessment Program and Community Based Outpatient Clinic and Primary Care Clinic Reviews and provided crime awareness briefings.

Results: We conducted the review during the week of October 17, 2016, and identified certain system weaknesses in Quality, Safety, and Value Committee oversight; utilization management; environmental cleanliness; general safety; anticoagulation processes and competency assessment; transfer documentation; informed consent for moderate sedation procedures; community nursing home program oversight, annual reviews, and clinical visits; and training related to the management of disruptive and violent behavior.

Review Impact: As a result of the findings, we could not gain reasonable assurance that:

1. Aggregate quality of care data is available for facility leaders to review.
2. Utilization management data is reviewed to optimize operational efficiency.
3. Medical (biohazardous) waste stored for pick-up and chemicals stored in the hemodialysis unit are secured to provide a safe work and patient care environment.
4. Clinicians consistently use laboratory tests to safely initiate anticoagulation therapy and have documented competency to manage anticoagulation therapy.
5. Providers safely transfer patients from the facility.
6. Providers consistently notify patients when the provider performing the moderate sedation procedure changes.
7. Facility leaders monitor the Community Nursing Home Program and assure the safe care of patients in those homes.
8. Facility employees are trained to reduce and prevent disruptive behaviors.
9. Patients with identified learning barriers receive accommodations to ensure medication counseling is understood.

Recommendations: We made recommendations in the following seven review areas:

Quality, Safety, and Value – Ensure that:
- The Quality, Safety, and Value Executive Committee routinely review aggregated data and document the reviews.
- An interdisciplinary group reviews utilization management data.

Environment of Care – Ensure that:
- Medical (biohazardous) waste stored for pick-up is secured.
- Hemodialysis unit employees secure chemicals when not in use.

Medication Management: Anticoagulation Therapy – Ensure that:
- Clinicians consistently obtain all required laboratory tests prior to initiating anticoagulant medications.
- For employees actively involved in the anticoagulant program, clinical managers complete competency assessments annually.

Coordination of Care: Inter-Facility Transfers – Ensure that:
- For patients transferred out of the facility, providers document sending or communicating to the accepting facility available history; observations, signs, symptoms, and preliminary diagnoses; and results of diagnostic studies and tests.

Moderate Sedation – Ensure that:
- Providers notify patients of changes in who is performing the moderate sedation procedure and document this in the electronic health record.

Community Nursing Home Oversight – Ensure that:
- The Community Nursing Home Oversight Committee includes representation by all required clinical disciplines.
- The Community Nursing Home Program is integrated into the facility's quality improvement program.
- The Community Nursing Home Review Team completes required annual reviews.
- Social workers conduct and document cyclical clinical visits with the frequency required by Veterans Health Administration policy.

Management of Disruptive/Violent Behavior – Ensure that:
- All employees receive Level 1 Prevention and Management of Disruptive Behavior training and additional training as required for their assigned risk area within 90 days of hire and that the training is documented in employee training records.

We also made the following repeat recommendation.

Follow-Up on Medication Management – Ensure that:
- Clinicians conducting medication education accommodate identified learning barriers and document the accommodations made to address those barriers.

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 E and F, pages 40–46, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

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Purpose and Objectives

Purpose

This CAP review provided a focused evaluation of the quality of care provided in the inpatient and outpatient settings of the facility.

Objectives

CAP reviews are one element of OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services and include cyclical evaluations of key clinical and administrative processes that affect patient care outcomes. Areas of focus include QSV, EOC, Medication Management, Coordination of Care, and Diagnostic Care.

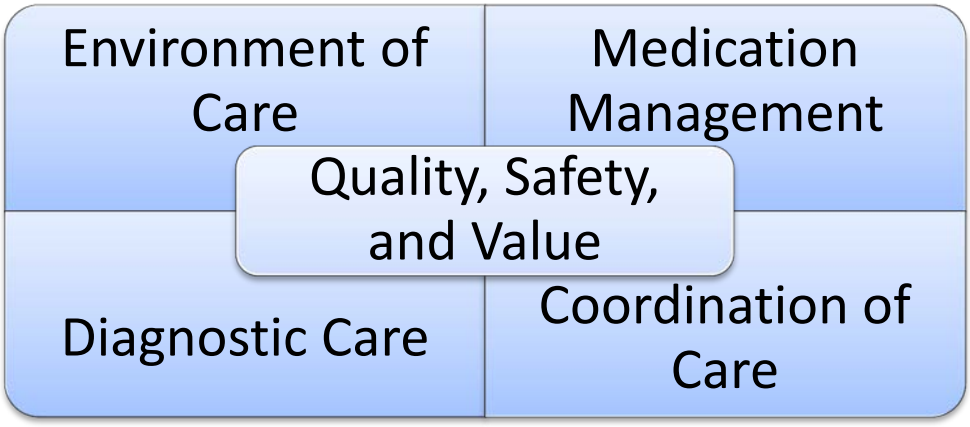
OIG also evaluates processes that are high risk and problem-prone. During this cycle, Moderate Sedation, CNH Oversight, and Management of Disruptive/Violent Behavior are processes that are high risk and problem-prone. We also followed up on recommendations from the previous Combined Assessment Program and CBOC and PC Clinic Reviews.

Additionally, OIG provides crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to OIG.

Background

We evaluate key aspects of clinical care delivery in a variety of primary/specialty care and inpatient/outpatient settings. These aspects include QSV, EOC, Medication Management; Coordination of Care; and Diagnostic Care (see Figure 1 below).

Figure 1. Comprehensive Coverage of Continuum of Care



Source: VA OIG

Quality, Safety, and Value

According to the Institute of Medicine, there are six important components of a health care system that provides high quality care to individuals. The system:

1. Is safe (free from accidental injury) for all patients, in all processes, all the time.
2. Provides care that is effective (care that, wherever possible, is based on the use of systematically obtained evidence to make determinations regarding whether a preventive service, diagnostic test, therapy, or no intervention would produce the best outcome).
3. Is patient-centered. This concept includes respect for patients' values and preferences; coordination and integration of care; information, communication, and education; physical comfort; and involvement of family and friends.
4. Delivers care in a timely manner (without long waits that are wasteful and often anxiety-provoking).
5. Is efficient (uses resources to obtain the best value for the money spent).
6. Is equitable (bases care on an individual's needs and not on personal characteristics—such as gender, race, or insurance status—that are unrelated to the patient's condition or to the reason for seeking care).[1]

VA states that one of its strategies is to deliver high quality, veteran-centered care that compares favorably to the best of the private sector in measured outcomes, value, efficiency, and patient experience.[2]

Environment of Care

All facilities face risks in the environment, including those associated with safety and security, fire, hazardous materials and waste, medical equipment, and utility systems. The EOC is made up of three basic elements: (1) the building or space; (2) equipment used to support patient care; and (3) people, patients, and anyone else who enters the environment.[3]

The physical environment shapes every patient experience and all health care delivery, including those episodes of care that result in patient harm. Three patient safety areas are markedly influenced by the environment—health care-associated infections, medication safety, and falls. Because health care-associated infections are transmitted through air, water, and contact with contaminated surfaces, the physical environment plays a key role in preventing the spread of infections in health care settings. Medication safety is markedly influenced by physical environmental conditions, including light levels and workspace organization. Environmental features, such as the

[1] Teleki SS, Damberg, CL, Reville RT. *Quality of Health Care: What Is It, Why Is It Important, and How Can It Be Improved in California's Workers Compensation Programs?* Santa Monica: RAND Corporation; May 2003 Quality and Workers' Compensation Working Draft.
[2] Department of Veterans Affairs, Veterans Health Administration. *Blueprint for Excellence*. September 2014.
[3] The Joint Commission. *Comprehensive Accreditation Manual for Hospitals: E-dition*®: Joint Commission Resources; July 2016: Environment of Care (EC).

placement of doorways, flooring type, and the location of furniture, can contribute to patient falls and associated injuries.[4]

Medication Management

Comprehensive medication management is defined as the standard of care that ensures clinicians individually assess each patient's medications to determine that each is appropriate for the patient, effective for the medical condition, safe given the comorbidities and other medications prescribed, and able to be taken by the patient as intended. Medications are involved in 80 percent of all treatments and impact every aspect of a patient's life. Drug therapy problems occur every day. The Institute of Medicine noted that while medications account for only 10 percent of total health care costs, their ability to control disease and impact overall costs, morbidity, and productivity—when appropriately used—is enormous. The components of the medication management process include procuring, storing, securing, prescribing or ordering, transcribing, preparing, dispensing, and administering.[5,6]

Coordination of Care

Coordination of care is the process of coordinating care, treatment, or services provided by a facility, including referring individuals to appropriate community resources to meet ongoing identified needs, implementing the plan of care, and avoiding unnecessary duplication of services. Coordination of care is recognized as a major challenge in the safe delivery of care. The rise of chronic illness means that a patient's care, treatment, and services likely will involve an array of providers in a variety of health care settings, including the patient's home.[7]

The Institute of Medicine's report "Crossing the Quality Chasm: A New Health System for the 21st Century" notes that, "Because of the special vulnerability that accompanies illness or injury, coordination of care takes on special importance. Many patients depend on those who provide care to coordinate services whether tests, consultations, or procedures to ensure that accurate and timely information reaches those who need it at the appropriate time." Health care providers and organizations need to work together to coordinate their efforts to provide safe, quality care.[8]

[4] Joseph A, Malone EB. *The Physical Environment: An Often Unconsidered Patient Safety Tool*. Agency for Healthcare Research and Quality. Patient Safety Network; October 2012.
[5] Patient-Centered Primary Care Collaborative. *The Patient-Centered Medical Home: Integrating Comprehensive Medication Management to Optimize Patient Outcomes, Resource Guide*. 2nd ed; June 2012.
[6] The Joint Commission. *Comprehensive Accreditation Manual for Hospitals: E-dition*®: Joint Commission Resources; July 2016: Medication Management (MM).
[7] The Joint Commission. *Comprehensive Accreditation Manual for Hospitals: E-dition*®: Joint Commission Resources; July 2016: Provision of Care, Treatment, and Services (PC).
[8] Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. The National Academies Press; March 2001.

Diagnostic Care

The diagnostic process is a complex, patient-centered, collaborative activity that involves information gathering and clinical reasoning with the goal of determining a patient's health problem. Diagnostic testing may occur in successive rounds of information gathering, integration, and interpretation, with each round refining the working diagnosis. In many cases, diagnostic testing can identify a condition before it is clinically apparent; for example, an imaging study indicating the presence of coronary artery blockage can identify coronary artery disease even in the absence of symptoms. PC clinicians order laboratory tests in slightly less than one third of patient visits, and direct-to-patient testing is becoming increasingly prevalent.[9]

Medical imaging also plays a critical role in establishing the diagnoses for many conditions. The advancement of imaging technologies has improved the ability of clinicians to detect, diagnose, and treat conditions while also allowing patients to avoid more invasive procedures. Performed appropriately, diagnostic care facilitates the provision of timely, cost-effective, and high quality medical care.[10]

High-Risk and Problem-Prone Health Care Processes

Health care leaders must give priority to high-volume, high-risk, or problem-prone processes for performance improvement activities.[11] Specifically, they are responsible for identifying high-risk areas that could cause harm to patients, visitors, and employees; implementing programs to avert risks; and managing a robust reporting process for adverse events that do occur. But of all of their responsibilities, one of the most important is focusing on improving patient safety.[12]

Moderate sedation is a drug-induced depression of consciousness during which patients respond purposefully to verbal comments.[13] Properly credentialed providers and trained clinical staff must provide safe care while sedating patients for invasive procedures. Additionally, facility leaders must monitor moderate sedation adverse events, report and trend the use of reversal agents, and systematically aggregate and analyze the data to enhance patient safety and performance.[14]

[9] Committee on Diagnostic Error in Health Care. Balogh EP, Miller BT, Ball JR, eds. *Improving Diagnosis in Health Care*. Washington, DC: The National Academies Press; 2015: Chap. 2.
[10] Department of Veterans Affairs. Patient Care Services. Diagnostic Services. http://www.patientcare.va.gov/diagnosticservices.asp. Accessed September 21, 2016.
[11] The Joint Commission. *Comprehensive Accreditation Manual for Hospitals: E-dition*®: Joint Commission Resources; July 2016: Leadership (LD) Accreditation Requirements, LD.04.04.01, EP2.
[12] Bickmore, AM. Streamlining the Risk Management Process in Healthcare to Improve Workflow and Increase Patient Safety, *HealthCatalyst*, https://www.healthcatalyst.com/streamlining-risk-management-process-healthcare.
[13] American Society of Anesthesiologists (ASA), Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists, 2002. Anesthesiology 2002; 96:1004-17.
[14] VHA Directive 1073, *Moderate Sedation by Non-Anesthesiology Providers*, December 30, 2014.

As of October 2016, VHA has contracts with more than 1,800 CNHs where more than 9,500 veteran patients reside.[15] These CNHs may be within close proximity to a VA facility or located hundreds of miles away. VHA requires local oversight of CNHs, which includes monitoring and follow-up services for patients who choose to reside in nursing homes in the community. This involves annual reviews and monthly patient visits unless otherwise specified.[16]

According to the U.S. Bureau of Labor Statistics, health care workers are nearly five times more likely to be victims of nonfatal assaults or violent acts in their work places than average workers in all industries combined, and many of these assaults and violent acts are perpetrated by patients.[17] Management of disruptive/violent behavior is the process of reducing and preventing disruptive behaviors and other defined acts that threaten public safety through the development of policy, programs, and initiatives aimed at patient, visitor, and employee safety.[18] VHA has a directive that addresses the management of all individuals in VHA facilities whose behavior could jeopardize the health or safety of others, undermine a culture of safety in VHA, or otherwise interfere with the delivery of health care at a facility; however, staff training deadlines have been postponed several times.

Scope

To evaluate for compliance with requirements related to patient care quality, clinical functions, and the EOC, we physically inspected selected areas, discussed processes and validated findings with managers and employees, and reviewed clinical and administrative records. The review covered the following five aspects of clinical care.

- Quality, Safety, and Value
- Environment of Care
- Medication Management: Anticoagulation Therapy
- Coordination of Care: Inter-Facility Transfers
- Diagnostic Care: Point-of-Care Testing

[15] VA Corporate Data Warehouse. Accessed October 31, 2016.
[16] VHA Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures,* June 4, 2004.
[17] U.S. Bureau of Labor Statistics. Janocha JA, Smith RT. *Workplace Safety and Health in the Health Care and Social Assistance Industry, 2003–07*. http://www.bls.gov/opub/mlr/cwc/workplace-safety-and-health-in-the-health-care-and-social-assistance-industry-2003-07.pdf. August 30, 2010. Accessed October 28, 2016.
[18] VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities,* September 27, 2012.

We also evaluated three additional review areas because of inherent risks and potential vulnerabilities.

- Moderate Sedation
- Community Nursing Home Oversight
- Management of Disruptive/Violent Behavior

We list the review criteria for each of the review areas in the topic checklists. Some of the items listed may not have been applicable because of a difference in size, function, or frequency of occurrence.

The review covered operations for FY 2015, FY 2016, and FY 2017 through October 17, 2016, and inspectors conducted the reviews 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 Combined Assessment Program report (*Combined Assessment Program Review of the Southern Arizona VA Health Care System, Tucson, Arizona,* Report No. 14-00305-123, April 14, 2014) and CBOC report (*Community Based Outpatient Clinic and Primary Care Clinic Reviews at Southern Arizona VA Health Care System, Tucson, Arizona,* Report No. 14-00240-129, April 28, 2014). We made a repeat recommendation in Medication Management. (See page 27.)

We presented crime awareness briefings for 74 employees. These briefings covered procedures for reporting suspected criminal activity to 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 570 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 OIG to monitor until the facility implements corrective actions. Issues and concerns that come to our attention but are outside the scope of this CAP review will be considered for further review separate from the CAP process and may be referred accordingly.

Reported Accomplishments

Clinical Surveillance Unit

In October 2015, the facility formed a Clinical Surveillance Unit to serve as the foundation for a reliable and efficient system to identify and track unsuspected radiologic findings for timely follow-up studies. Unsuspected radiologic findings on chest images are frequently clinically significant, and delays in follow-up studies lead to delays in diagnoses and poor outcomes. To date, the Clinical Surveillance Unit team

has reviewed over 10,000 cases and facilitated enhanced or expedited care for more than 550 cases.

Targeting Reduced Surgical Cancellation Rates

Historically, patient-related issues accounted for the highest frequency reason for operating room cancellations. Targeted Lean improvement work resulted in the implementation of a Pre-Admission Testing team and the development of a pre-operative tool that leverages data in real time. From October 1, 2015 to December 31, 2015, operating room cancellation rates decreased by 9.5 percent and were well below the national average. During FY 2016, the facility continued to sustain low operating room cancellation rates.

Results and Recommendations

Quality, Safety, and Value

The purpose of this review was to determine whether the facility complied with selected QSV program requirements.[a] VHA requires that its facilities operate a QSV program to monitor patient care quality and performance improvement activities. Many QSV activities are required by VHA directives, accreditation standards, and Federal regulations. Public Law 100-322 mandates VA's OIG to oversee VHA quality improvement programs at every level. This review focuses on the following program areas.

- Senior-level committee or group with responsibility for QSV/performance improvement
- Protected peer review
- Credentialing and privileging
- Utilization management
- Patient safety

We interviewed senior managers and key QSV employees, and we evaluated meeting minutes, 25 licensed independent practitioners' profiles, 10 protected peer reviews, 5 root cause analyses, 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.

Checklist 1. QSV Areas Reviewed, Findings, and Recommendations

NM	Areas Reviewed	Findings	Recommendations
	There was a senior-level committee responsible for key QSV functions that met at least quarterly and was chaired or co-chaired by the Facility Director. • The committee routinely reviewed aggregated data.	Two quarters of QSV Executive Committee meeting minutes reviewed: • The committee did not routinely review aggregated data.	**1.** We recommended that the Facility Director ensure that the Quality, Safety, and Value Executive Committee routinely reviews aggregated data and documents the reviews.

NM	Areas Reviewed (continued)	Findings	Recommendations
	Credentialing and privileging processes met selected requirements: • Facility policy/by-laws specified a frequency for clinical managers to review practitioners' Ongoing Professional Practice Evaluation data. • Facility clinical managers reviewed Ongoing Professional Practice Evaluation data at the frequency specified in the policy/by-laws. • The facility set triggers for when a Focused Professional Practice Evaluation for cause would be indicated.		
	Protected peer reviews met selected requirements: • Peer reviewers documented their use of important aspects of care in their review, such as appropriate and timely ordering of diagnostic tests, timely treatment, and appropriate documentation. • When the Peer Review Committee recommended individual improvement actions, clinical managers implemented the actions.		
X	Utilization management met selected requirements: • The facility completed at least 75 percent of all required inpatient reviews. • Physician Utilization Management Advisors documented their decisions in the National Utilization Management Integration database. • An interdisciplinary group reviewed utilization management data.	• For the timeframe July 1, 2015–June 30, 2016, an interdisciplinary group did not review utilization management data.	**2.** We recommended that facility clinical managers ensure an interdisciplinary group reviews utilization management data and that facility managers monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
	Patient safety met selected requirements: • The Patient Safety Manager entered all reported patient incidents into the WEBSPOT database. • The facility completed the required minimum of eight root cause analyses. • The facility provided feedback about the root cause analysis findings to the individual or department who reported the incident. • At the completion of FY 2016, the Patient Safety Manager submitted an annual patient safety report to facility leaders.		
	Overall, if QSV reviews identified significant issues, the facility took actions and evaluated them for effectiveness.		
	Overall, senior managers actively participated in QSV activities.		

Environment of Care

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 SPS and the hemodialysis unit.[b]

VHA must manage risks in the environment in order to promote a safe, functional, and supportive environment. Further, VHA must establish a systematic infection prevention and control program to reduce the possibility of acquiring and transmitting infections. We selected the hemodialysis unit and SPS as special emphasis areas due to the increased potential for exposure to infectious agents inherent to hemodialysis and procedures using RME. Hemodialysis patients are at higher risk for infections for various reasons, including that hemodialysis requires vascular access for prolonged periods of time and that opportunities exist for transmission of infectious agents when multiple patients receive dialysis concurrently. RME is intended for repeated use on different patients after being reprocessed through cleaning, disinfection, and/or sterilization. Patients undergoing procedures using RME are at higher risk of exposure to infectious agents if RME is not properly reprocessed.

We inspected the inpatient medical, surgical, intensive care, hemodialysis, and MH units; the community living center; the Emergency Department; the Octillo Clinic; SPS; and the Casa Grande CBOC. Additionally, we reviewed relevant documents and 20 employee training records, and we interviewed key employees and managers. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement.

Checklist 2. EOC Areas Reviewed, Findings, and 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 CBOCs.		
	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.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
	The facility had established a procedure for cleaning equipment between patients.		
	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.		
	The facility met general safety requirements.		
X	The facility met environmental cleanliness requirements.	• In four of seven patient care areas, medical (biohazardous) waste stored for pick-up was not in a secured location to prevent spread of potentially infectious pathogens.	**3.** We recommended that facility managers ensure medical (biohazardous) waste stored for pick-up is secured and monitor compliance.
	Areas Reviewed for SPS		
	The facility had a policy for cleaning, disinfecting, and sterilizing RME.		
	The facility's standard operating procedures for selected RME were current and consistent with the manufacturers' instructions for use.		
	The facility performed quality control testing on selected RME with the frequency required by local policy and took appropriate action on positive results.		
	Selected SPS employees had evidence of the following for selected RME: • Training and competencies at orientation if employed less than or equal to 1 year • Competencies within the past 12 months or with the frequency required by local policy if employed more than 1 year		

NM	Areas Reviewed for SPS (continued)	Findings	Recommendations
	The facility met infection prevention requirements in SPS areas.		
	Standard operating procedures for selected RME were located in the area where reprocessing occurred.		
	SPS employees checked eyewash stations in SPS areas weekly.		
	SPS employees had access to Safety Data Sheets in areas where they used hazardous chemicals.		
	Areas Reviewed for the Hemodialysis Unit		
	The facility had a policy or procedure for preventive maintenance of hemodialysis machines and performed maintenance at the frequency required by local policy.		
	Selected hemodialysis unit employees had evidence of bloodborne pathogens training within the past 12 months.		
X	The facility met environmental safety requirements on the hemodialysis unit.	• We observed chemicals stored in an unlocked cabinet in an area accessible to patients.	**4.** We recommended that hemodialysis unit employees secure chemicals when not in use and that the hemodialysis unit manager monitors compliance.
	The facility met infection prevention requirements on the hemodialysis unit.		
	The facility met medication safety and security requirements on the hemodialysis unit.		
	The facility met privacy requirements in the hemodialysis unit.		

Medication Management: Anticoagulation Therapy

The purpose of this review was to determine whether facility clinicians appropriately managed and provided education to patients with new orders for anticoagulant medication.[c] During calendar year 2014, an estimated 445,000 veterans were on anticoagulant therapy. Anticoagulants (commonly called blood thinners) are a class of drugs that work to prevent the coagulation or clotting of blood. For this review, we evaluated warfarin (Coumadin®) and direct-acting oral anticoagulants. Clinicians use anticoagulants for both the treatment and prevention of cardiac disease, cerebrovascular accident (stroke), and thromboembolism[19] in both the inpatient and outpatient setting. Although these medications offer substantial benefits, their use or misuse carries a significant potential for patient harm. A dose less than the required amount for therapeutic effect can increase the risk of thromboembolic complications while a dose administered at levels greater than required for treatment can increase the risk of bleeding complications. The Joint Commission's National Patient Safety Goal 3.05.01 focuses on improving anticoagulation safety to reduce patient harm and states, "…anticoagulation medications are more likely than others to cause harm due to complex dosing, insufficient monitoring, and inconsistent patient compliance."

We reviewed relevant documents and the competency assessment records of nine employees actively involved in the anticoagulant program, and we interviewed key employees. Additionally, we reviewed the EHRs of 28 randomly selected patients who were prescribed new anticoagulant medications July 1, 2015 through June 30, 2016. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement.

Checklist 3. Medication Management: Anticoagulation Therapy Areas Reviewed, Findings, and Recommendations

NM	Areas Reviewed	Findings	Recommendations
	The facility had policies and processes for anticoagulation management that included required content.		
	The facility used algorithms, protocols or standardized care processes for the: • Initiation and maintenance of warfarin • Management of anticoagulants before, during, and after procedures • Use of weight-based, unfractionated heparin		

[19] Thromboembolism is the obstruction of a blood vessel by a blood clot that has become dislodged from another site in the circulation.

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility provided patients with a direct telephone number for anticoagulation-related calls during normal business hours and defined a process for patient anticoagulation-related calls outside normal business hours.		
	The facility designated a physician as the anticoagulation program champion.		
	The facility defined ways to minimize the risk of incorrect tablet strength dosing errors.		
	The facility routinely reviewed quality assurance data for the anticoagulation management program at the facility's required frequency at an appropriate committee.		
	For patients newly prescribed anticoagulant medications, clinicians provided inpatients with transition follow-up in accordance with local policy and all patients with education specific to the new anticoagulant.		
X	Clinicians obtained required laboratory tests: • Prior to initiating anticoagulant medications • During anticoagulation treatment at the frequency required by local policy	• In 3 of 17 EHRs, clinicians did not obtain all required laboratory tests prior to initiating warfarin treatment.	**5.** We recommended that facility managers ensure clinicians consistently obtain all required laboratory tests prior to initiating anticoagulant medications.
	When laboratory values did not meet selected criteria, clinicians documented a justification/rationale for prescribing the anticoagulant.		
X	The facility required competency assessments for employees actively involved in the anticoagulant program, and clinical managers completed competency assessments that included required content at the frequency required by local policy.	• Two of nine employees actively involved in the anticoagulant program did not have competency assessments completed annually.	**6.** We recommended that for employees actively involved in the anticoagulant program, clinical managers complete competency assessments annually and that facility managers monitor compliance.

Coordination of Care: Inter-Facility Transfers

The purpose of this review was to evaluate selected aspects of the facility's patient transfer process, specifically transfers out of the facility.[d] Inter-facility transfers are frequently necessary to provide patients with access to specific providers or services. The movement of an acutely ill person from one institution to another exposes the patient to risks, while in some cases, failing to transfer a patient may be equally risky. VHA has the responsibility to ensure that transfers into and out of its medical facilities are carried out appropriately, under circumstances that provide maximum safety for patients, and comply with applicable standards.

We reviewed relevant documents and interviewed key employees. Additionally, we reviewed the EHRs of 35 randomly selected patients who were transferred acutely out of facility inpatient beds or the Emergency Department/urgent care center to another VHA facility or non-VA facility July 1, 2015 through June 30, 2016. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement.

Checklist 4. Coordination of Care: Inter-Facility Transfers Areas Reviewed, Findings, and Recommendations

NM	Areas Reviewed	Findings	Recommendations
	The facility had a policy that addressed patient transfers and included required content.		
	The facility collected and reported data about transfers out of the facility.		
	Transferring providers completed VA Form 10-2649A and/or transfer/progress notes prior to or within a few hours after the transfer that included the following elements: • Date of transfer • Documentation of patient or surrogate informed consent • Medical and/or behavioral stability • Identification of transferring and receiving provider or designee • Details of the reason for transfer or proposed level of care needed		

NM	Areas Reviewed (continued)	Findings	Recommendations
	When staff/attending physicians did not write transfer notes, acceptable designees: • Obtained and documented staff/attending physician approval • Obtained staff/attending physician countersignature on the transfer note		
	When the facility transferred patients out, sending nurses documented transfer assessments/notes.		
	In emergent transfers, providers documented: • Patient stability for transfer • Provision of all medical care within the facility's capacity		
X	Communication with the accepting facility or documentation sent included: • Available history • Observations, signs, symptoms, and preliminary diagnoses • Results of diagnostic studies and tests	• Providers did not document that they sent the following information to the receiving facility: o Available history; observations, signs, symptoms, and preliminary diagnoses; and results of diagnostic studies and tests in 31 of 33 (94 percent) applicable EHRs.	**7.** We recommended that for patients transferred out of the facility, providers document sending or communicating to the accepting facility available history; observations, signs, symptoms, and preliminary diagnoses; and results of diagnostic studies and tests and that facility managers monitor compliance.

Diagnostic Care: Point-of-Care Testing

The purpose of this review was to evaluate the facility's glucometer POCT program compliance with applicable laboratory regulatory standards and quality testing practices as required by VHA, the College of American Pathologists, and The Joint Commission.[e] The majority of laboratory testing is performed in the main laboratory. However, with newer technologies, testing has emerged from the laboratory to the patient's bedside, the patient's home, and other non-laboratory sites. This is called POCT (also known as ancillary or waived testing) and can include tests for blood glucose, fecal occult blood, hemoglobin, and pro-thrombin time.

All laboratory testing performed in VHA facilities must adhere to quality testing practices. These practices include annual competency assessment and quality control testing. Failure to implement and comply with regulatory standards and quality testing practices can jeopardize patient safety and place VHA facilities at risk. Erroneous results can lead to inaccurate diagnoses, inappropriate medical treatment, and poor patient outcomes.[20]

We reviewed relevant documents, the EHRs of 49 randomly selected inpatients and outpatients who underwent POCT for blood glucose July 1, 2015 through June 30, 2016, and the annual competency assessments of 10 clinicians who performed the glucose testing. Additionally, we interviewed key employees and conducted onsite glucometer inspections of the Emergency Department; medical, surgical, intensive care, and MH units; and the Casa Grande CBOC to assess compliance with manufacturers' maintenance and solution/reagent storage requirements. The table below shows the areas reviewed for this topic. The facility generally met requirements. We made no recommendations.

Checklist 5. Diagnostic Care: POCT Areas Reviewed, Findings, and Recommendations

NM	Areas Reviewed	Findings	Recommendations
	The facility had a policy delineating requirements for the POCT program and required oversight by the Chief of Pathology and Laboratory Medicine Service.		
	The facility had a designated POCT/Ancillary Testing Coordinator.		
	The Chief of Pathology and Laboratory Medicine Service approved all tests performed outside the main laboratory.		

[20] The Joint Commission. *Comprehensive Accreditation Manual for Laboratories and Point-of-Care Testing*. Update 2. September 2010.

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility had a process to ensure employee competency for POCT with glucometers and evaluated competencies at least annually.		
	The facility required documentation of POCT results in the EHR.		
	A regulatory agency accredited the facility's POCT program.		
	Clinicians documented test results in the EHR.		
	Clinicians initiated appropriate clinical action and follow-up for test results.		
	The facility had POCT procedure manuals readily available to employees.		
	Quality control testing solutions/reagents and glucose test strips were current (not expired).		
	The facility managed and performed quality control in accordance with its policy/standard operating procedure and manufacturer's recommendations.		
	Glucometers were clean.		

Moderate Sedation

The purpose of this review was to evaluate selected aspects of care to determine whether the facility complied with applicable policies in the provision of moderate sedation.[f] During calendar year 2016, VHA clinicians performed more than 600,000 moderate sedation procedures of which more than half were gastroenterology-related endoscopies.[21] Moderate sedation is a drug-induced depression of consciousness during which patients are able to respond to verbal commands. Non-anesthesiologists administer sedatives and analgesics to relieve anxiety and increase patient comfort during invasive procedures and usually do not have to provide interventions to maintain a patent airway, spontaneous ventilations, or cardiovascular function.[22] However, serious adverse events can occur, including cardiac and respiratory depression, brain damage due to low oxygen levels, cardiac arrest, or death. To minimize risks, VHA and The Joint Commission have issued requirements and standards for moderate sedation care.

We reviewed relevant documents, interviewed key employees, and inspected the gastroenterology laboratory, pulmonary/bronchoscopy laboratory, post-anesthesia care unit, Emergency Department, and intensive care unit procedure rooms/areas to assess whether required equipment and sedation medications were available. Additionally, we reviewed the EHRs of 45 randomly selected patients who underwent an invasive procedure involving moderate sedation July 1, 2015 through June 30, 2016, and the training records of 15 clinical employees who performed or assisted during these procedures. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement.

Checklist 6. Moderate Sedation Areas Reviewed, Findings, and Recommendations

NM	Areas Reviewed	Findings	Recommendations
	The facility reported and trended the use of reversal agents in moderate sedation cases, processed adverse events/complications in a similar manner as operating room anesthesia adverse events, and noted the absence of adverse events in Moderate Sedation Committee reports.		

[21] Per VA Corporate Data Warehouse data pull on February 22, 2017.
[22] American Society of Anesthesiologists. Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists. *Anesthesiology*. 2002; 96:1004.

NM	Areas Reviewed (continued)	Findings	Recommendations
	Providers performed history and physical examinations within 30 calendar days prior to the moderate sedation procedure, and the history and physical and the pre-sedation assessment in combination included required elements.		
	Providers re-evaluated patients immediately before moderate sedation for changes since the prior assessment.		
X	Providers documented informed consent prior to moderate sedation procedures, and the name of provider listed on the consent was the same as the provider who performed the procedure, or the patient was notified of the change.	• In two of the three EHRs where the name of the provider listed on the informed consent did not match that of the provider who performed the procedure, there was no documentation that the provider informed the patient of the change.	**8.** We recommended that providers notify patients of changes in who is performing the moderate sedation procedure and document this in the electronic health record and that facility managers monitor compliance.
	The clinical team, including the provider performing the procedure, conducted and documented a timeout prior to the moderate sedation procedure.		
	Post-procedure documentation included assessments of patient mental status and pain level.		
	Clinical employees discharged outpatients from the recovery area with orders from the provider who performed the procedure or according to criteria approved by moderate sedation clinical leaders.		
	Clinical employees discharged moderate sedation patients in the company of a responsible adult.		
	Selected clinical employees had current training for moderate sedation.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The clinical team kept monitoring and resuscitation equipment and reversal agents in the general areas where moderate sedation was administered.		
	To minimize risk, clinical employees did not store anesthetic agents in procedure rooms/areas where only moderate sedation procedures were performed by licensed independent practitioners who do not have the training and ability to rescue a patient from general anesthesia.		

Community Nursing Home Oversight

The purpose of this review was to assess whether the facility complied with applicable requirements regarding the monitoring of veterans in contracted CNHs.[9] Since 1965, VHA has provided nursing home care under contracts. VHA facilities must integrate the CNH program into their quality improvement programs. The Facility Director establishes the CNH Oversight Committee, which reports to the chief clinical officer (Chief of Staff, Associate Director for Patient Care Services, or the equivalent) and includes multidisciplinary management-level representatives from social work, nursing, quality management, acquisition, and the medical staff. The CNH Oversight Committee must meet at least quarterly.[23] Local oversight of CNHs is achieved through annual reviews and monthly visits.

We reviewed relevant documents, the EHRs of 35 patients who received CNH care for more than 3 months during the timeframe July 1, 2015 through June 30, 2016, and the results from CNH annual reviews completed July 5, 2015 through June 30, 2016. Additionally, we interviewed key employees. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement.

Checklist 7. CNH Oversight Areas Reviewed, Findings, and Recommendations

NM	Areas Reviewed	Findings	Recommendations
X	The facility had a CNH Oversight Committee that met at least quarterly and included representation by the required disciplines.	• The facility's CNH Oversight Committee did not include a representative from the medical staff.	**9.** We recommended that facility managers ensure the Community Nursing Home Oversight Committee includes representation by all required clinical disciplines.
X	The facility integrated the CNH Program into its quality improvement program.	• The minutes of the executive-level committee that evaluates quality improvement data did not contain evidence of CNH Program integration.	**10.** We recommended that the facility ensure integration of the Community Nursing Home Program into its quality improvement program.
	The facility documented a hand-off for patients placed in CNHs outside of its catchment area.		
X	The CNH Review Team completed CNH annual reviews.	• The CNH Review Team did not complete two of eight CNH annual reviews involving 8 of 35 patients (23 percent) in our review.	**11.** We recommended that facility managers ensure the Community Nursing Home Review Team completes required annual reviews and monitor compliance.

[23] VHA Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures*, June 4, 2004.

NM	Areas Reviewed (continued)	Findings	Recommendations
	When CNH annual reviews noted four or more exclusionary criteria, facility managers completed exclusion review documentation.		
X	Social workers and registered nurses documented clinical visits that alternated on a cyclical basis.	• Eight of 35 EHRs (23 percent) did not contain documentation of social worker cyclical clinical visits with the frequency required by VHA policy.	**12.** We recommended that facility managers ensure social workers conduct and document cyclical clinical visits with the frequency required by Veterans Health Administration policy and monitor compliance.

Management of Disruptive/Violent Behavior

The purpose of this review was to determine the extent to which the facility complied with selected requirements in the management of disruptive and violent behavior.[h] VHA policy states a commitment to reducing and preventing disruptive behaviors and other defined acts that threaten public safety through the development of policy, programs, and initiatives aimed at patient, visitor, and employee safety. In addition, Public Law 112-154, section 106 directed VA to develop and implement a comprehensive policy on the reporting and tracking of public safety incidents that occur at each medical facility.

We reviewed relevant documents, the EHRs of 44 randomly selected patients who exhibited disruptive or violent behavior, 3 Reports of Contact from violent/disruptive patient/employee/other (visitor) incidents that occurred during the 12-month period July 1, 2015 through June 30, 2016, and the training records of 23 recently hired employees who worked in areas at low, moderate, or high risk for violence. Additionally, we interviewed key employees. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement.

Checklist 8. Management of Disruptive/Violent Behavior Areas Reviewed, Findings, and Recommendations

NM	Areas Reviewed	Findings	Recommendations
	The facility had a policy, procedure, or guideline on preventing and managing disruptive or violent behavior.		
	The facility conducted an annual Workplace Behavioral Risk Assessment.		
	The facility had implemented: • An Employee Threat Assessment Team • A Disruptive Behavior Committee/Board with appropriate membership • A disruptive behavior reporting and tracking system		
	The facility collected and analyzed disruptive or violent behavior incidents data.		
	The facility assessed physical security and included and tested equipment in accordance with the local physical security assessment.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Clinical managers reviewed patients' disruptive or violent behavior and took appropriate actions, including: • Ensuring discussion by the Disruptive Behavior Committee/Board and entry of a progress note by a clinician committee/board member • Informing patients about Patient Record Flag placement and the right to request to amend/appeal the flag placement • Ensuring Chief of Staff or designee approval of an Order of Behavioral Restriction		
	When a Patient Record Flag was placed for an incident of disruptive behavior in the past, a clinician reviewed the continuing need for the flag within the past 2 years.		
	The facility managed selected non-patient related disruptive or violent incidents appropriately according to VHA and local policy.		
X	The facility had a security training plan for employees at all risk levels. • All employees received Level 1 training within 90 days of hire. • All employees received additional training as required for the assigned risk area within 90 days of hire.	• Five employee training records did not contain documentation of Level 1 training within 90 days of hire. • Fourteen of the applicable 23 employee training records did not contain documentation of the training required for their assigned risk area within 90 days of hire.	**13.** We recommended that facility managers ensure all employees receive Level 1 Prevention and Management of Disruptive Behavior training and additional training as required for their assigned risk area within 90 days of hire and that the training is documented in employee training records.

Review Activity with Previous Combined Assessment Program Review Recommendations

Follow-Up on Medication Management

As a follow-up to a recommendation from our prior Combined Assessment Program review, we reassessed facility compliance with medication education for patients discharged with orders for fluoroquinolone oral antibiotics.[i]

Medication Education. VHA requires that if providers identified learning barriers as part of the learning assessment, they adjusted medication counseling to accommodate the barriers. During our previous CAP review, we found that for patients with identified learning barriers, EHR documentation did not consistently reflect medication counseling accommodation to address the barriers. During this review, facility leaders indicated that they did not consistently meet relevant requirements for documentation of medication counseling accommodations made to address identified learning barriers. Compliance was documented as 73, 67, and 87 percent for February, March, and May 2016, respectively.

Recommendation

14. We recommended that clinicians conducting medication education accommodate identified learning barriers and document the accommodations made to address those barriers and that facility managers monitor compliance.

Facility Profile

Table 1 below provides general background information for this facility.

Table 1. Facility Profile for Tucson (678) for FY 2016

Profile Element	Facility Data
Veterans Integrated Service Network Number	22
Complexity Level	1a-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$483.2
Number of:	
• **Unique Patients**	55,149
• **Outpatient Visits**	691,261
• **Unique Employees**[24]	2,276
Type and Number of Operating Beds:	
• **Acute**	143
• **MH**	28
• **Community Living Center**	90
• **Domiciliary**	18
Average Daily Census:	
• **Acute**	124
• **MH**	15
• **Community Living Center**	76
• **Domiciliary**	12

Source: VA Office of Academic Affiliations, VHA Support Service Center, and VA Corporate Data Warehouse

Note: We did not assess VA's data for accuracy or completeness.

[24] Unique employees involved in direct medical care (cost center 8200).

VA Outpatient Clinic Profiles[25]

The VA outpatient clinics in communities within the catchment area of the facility provide PC integrated with women's health, MH, and telehealth services. Some also provide specialty care and ancillary services. Table 2 below provides information relative to each of the clinics.

Table 2. VA Outpatient Clinic Workload/Encounters[26] and Specialty Care, Diagnostic, and Ancillary Services Provided for FY 2016

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services[27] Provided	Diagnostic Services[28] Provided	Ancillary Services[29] Provided
Sierra Vista, AZ	678GA	11,560	2,908	Cardiology Dermatology Endocrinology Rheumatology Rehab Poly-Trauma Anesthesia Eye Gynecology Podiatry Urology	Radiology	Nutrition Pharmacy Social Work Weight Management
Yuma, AZ	678GB	8,327	2,897	Cardiology Dermatology Endocrinology Infectious Disease Nephrology Rehab Poly-Trauma Anesthesia Eye Urology Vascular	Laboratory and Pathology Radiology	Nutrition Pharmacy Social Work Weight Management
Casa Grande, AZ	678GC	8,039	3,088	Cardiology Dermatology Endocrinology Infectious Diseases Pulmonary/ Respiratory Disease Rheumatology Rehab Anesthesia Eye Podiatry Urology	Radiology	Nutrition Pharmacy Weight Management

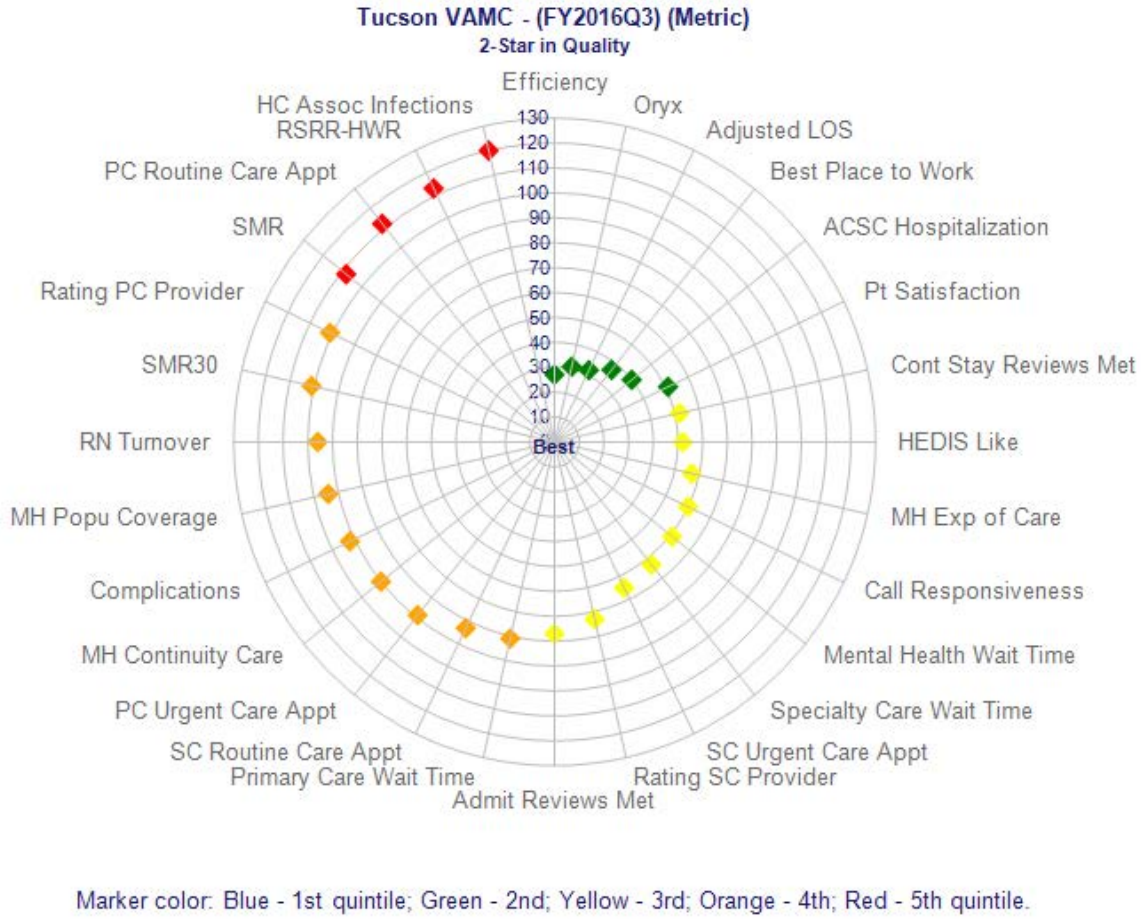
[25] Includes all outpatient clinics in the community that were in operation before February 15, 2016.
[26] An encounter is a professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition.
[27] Specialty care services refer to non-PC and non-MH services provided by a physician.
[28] Diagnostic services include EKG, EMG, laboratory, nuclear medicine, radiology, and vascular lab services.
[29] Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Safford, AZ	678GD	2,695	511	Cardiology Dermatology Endocrinology Infectious Disease Rehab Anesthesia	NA	Nutrition Pharmacy Weight Management
Green Valley, AZ	678GE	4,048	443	Cardiology Dermatology Endocrinology Anesthesia	NA	Nutrition Pharmacy Weight Management
Tucson, AZ	678GF	10,505	1,928	Dermatology Endocrinology Rehab Anesthesia Eye	Radiology	Nutrition Pharmacy Weight Management
Tucson, AZ	678GG	7,466	2,196	Dermatology Endocrinology Rehab Anesthesia Eye	Radiology	Nutrition Pharmacy Weight Management

Source: VHA Support Service Center and VA Corporate Data Warehouse

Note: We did not assess VA's data for accuracy or completeness.

Strategic Analytics for Improvement and Learning (SAIL)[30]

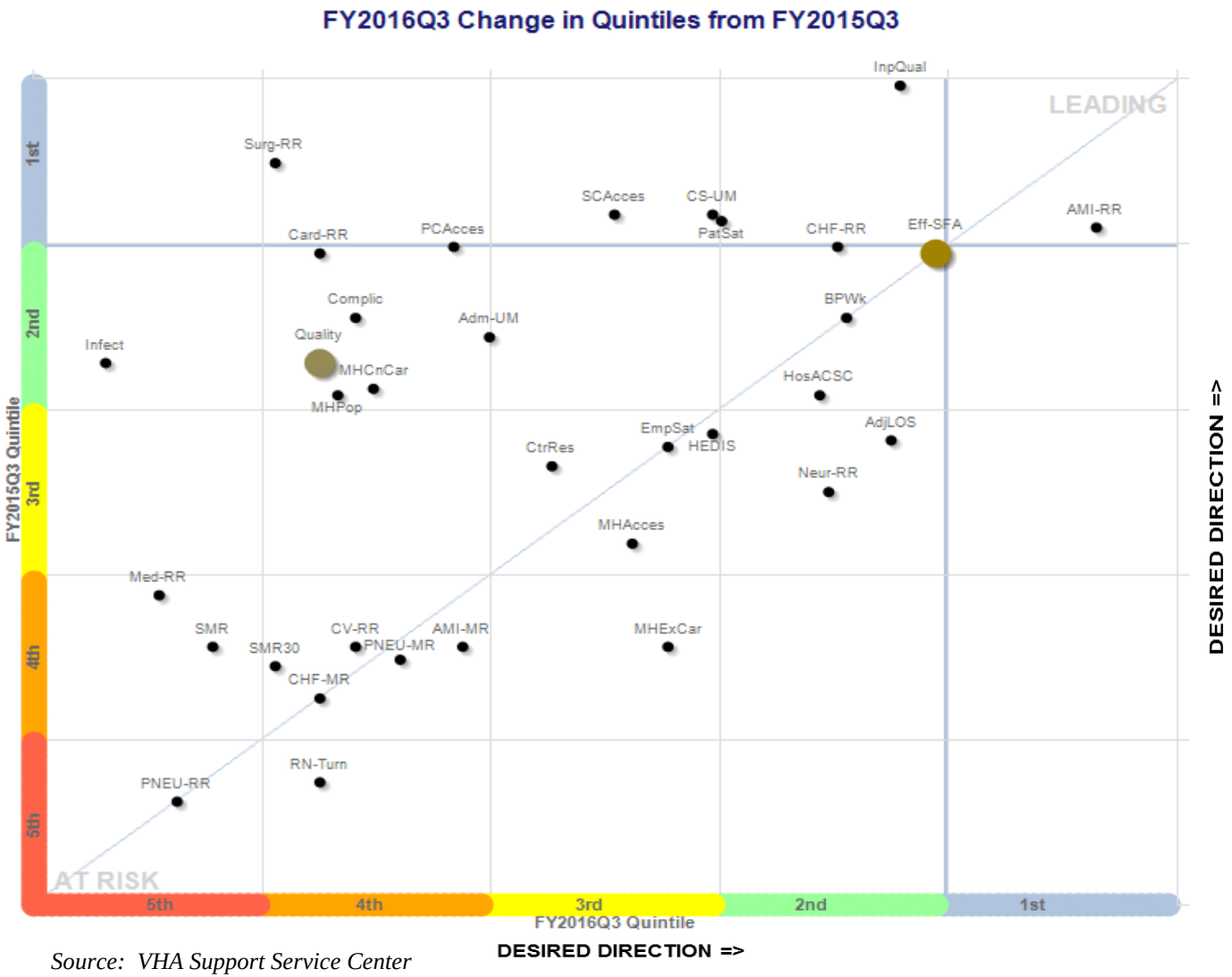


Source: VHA Support Service Center

Note: We did not assess VA's data for accuracy or completeness.

[30] 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.

Source: VHA Support Service Center

Note: We did not assess VA's data for accuracy or completeness.

Metric Definitions[j]

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
Admit Reviews Met	% Acute Admission Reviews that meet InterQual criteria	A higher value is better than a lower 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
Cont Stay Reviews Met	% Acute Continued Stay reviews that meet InterQual criteria	A higher value is better than a lower 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 Like	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
MH Wait Time	MH care wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
MH Continuity Care	MH continuity of care (FY14Q3 and later)	A higher value is better than a lower value
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
PC Routine Care Appt	Timeliness in getting a PC routine care appointment (PCMH)	A higher value is better than a lower value
PC Urgent Care Appt	Timeliness in getting a PC urgent care appointment (PCMH)	A higher value is better than a lower value
PC Wait Time	PC wait time for new patient completed appointments within 30 days of preferred date	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
Rating PC Provider	Rating of PC providers (PCMH)	A higher value is better than a lower value
Rating SC Provider	Rating of specialty care providers (specialty care module)	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

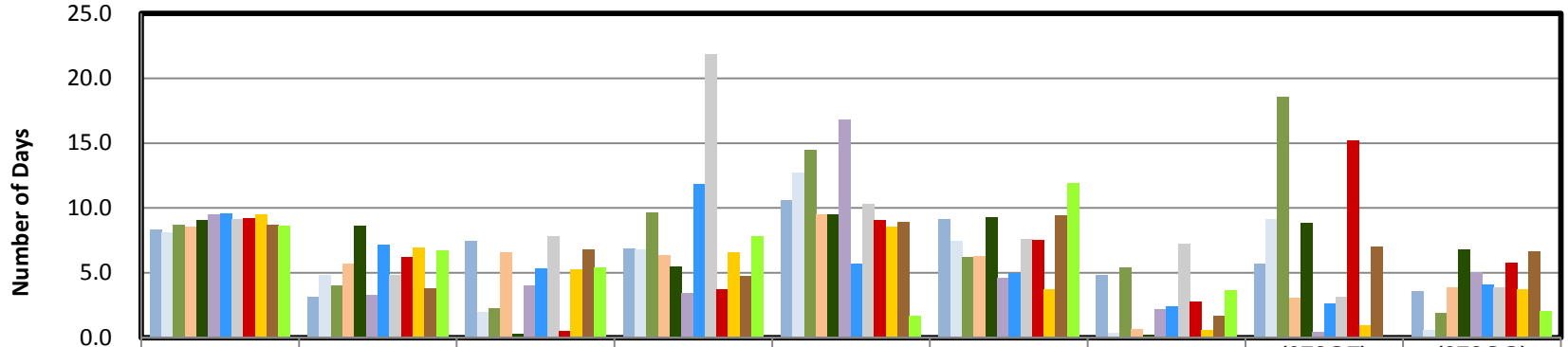
Measure	Definition	Desired Direction
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-Cardio	30-day risk standardized readmission rate for cardiorespiratory patient cohort	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-CV	30-day risk standardized readmission rate for cardiovascular patient cohort	A lower value is better than a higher value
RSRR-HWR	Hospital wide readmission	A lower value is better than a higher value
RSRR-Med	30-day risk standardized readmission rate for medicine patient cohort	A lower value is better than a higher value
RSRR-Neuro	30-day risk standardized readmission rate for neurology patient cohort	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
RSRR-Surg	30-day risk standardized readmission rate for surgery patient cohort	A lower value is better than a higher value
SC Routine Care Appt	Timeliness in getting a SC routine care appointment (Specialty Care)	A higher value is better than a lower value
SC Urgent Care Appt	Timeliness in getting a SC urgent care appointment (Specialty Care)	A higher value is better than a lower 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 patient completed appointments within 30 days of preferred date	A higher value is better than a lower value

Source: VHA Support Service Center

Note: We did not assess VA's data for accuracy or completeness.

Patient Aligned Care Team Compass Metrics

Quarterly New PC Patient Average Wait Time in Days

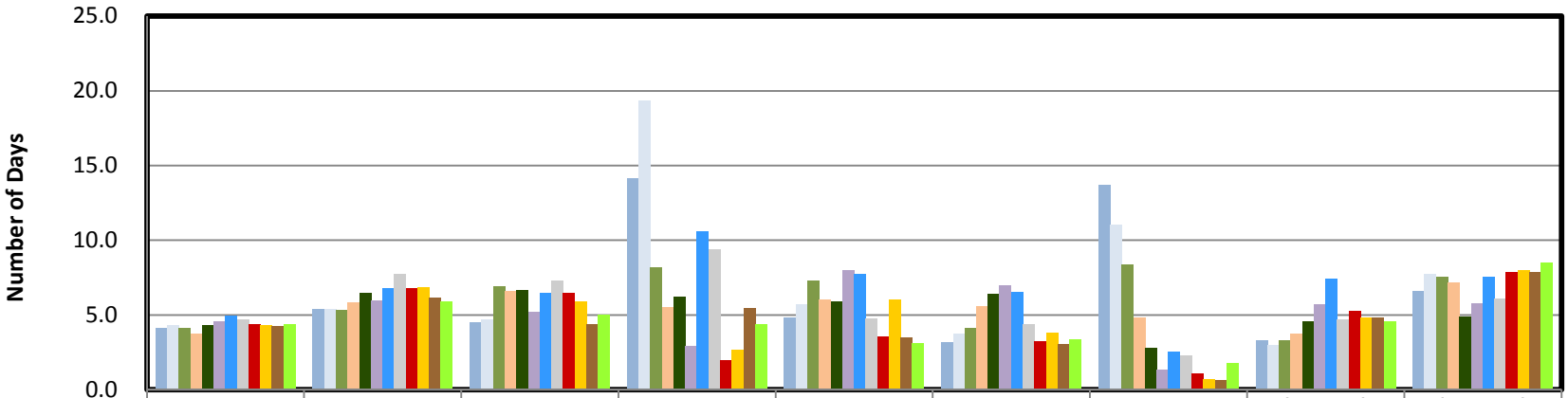


	VHA Total	(678) Tucson VAMC	(678GA) Sierra Vista	(678GB) Yuma	(678GC) Casa Grande	(678GD) Safford	(678GE) Green Valley	(678GF) Northwest Tucson VA Clinic	(678GG) Southeast Tucson VA Clinic
JUL-FY15	8.3	3.2	7.4	6.9	10.6	9.2	4.8	5.7	3.6
AUG-FY15	8.1	4.8	1.9	6.8	12.7	7.4	0.4	9.1	0.6
SEP-FY15	8.7	4.0	2.3	9.7	14.5	6.3	5.4	18.6	1.9
OCT-FY16	8.6	5.7	6.5	6.4	9.5	6.3	0.7	3.1	3.9
NOV-FY16	9.1	8.6	0.3	5.4	9.5	9.3	0.2	8.9	6.8
DEC-FY16	9.5	3.3	4.0	3.4	16.8	4.6	2.2	0.4	5.0
JAN-FY16	9.6	7.1	5.4	11.8	5.7	4.9	2.4	2.6	4.1
FEB-FY16	9.1	4.8	7.8	21.8	10.3	7.6	7.2	3.1	3.8
MAR-FY16	9.2	6.2	0.5	3.7	9.0	7.5	2.8	15.2	5.8
APR-FY16	9.5	7.0	5.3	6.6	8.5	3.8	0.6	1.0	3.7
MAY-FY16	8.7	3.8	6.8	4.7	8.9	9.4	1.7	7.0	6.7
JUN-FY16	8.6	6.7	5.4	7.8	1.7	11.9	3.6	0.0	2.0

Source: VHA Support Service Center

Note: We did not assess VA's data for accuracy or completeness.

Data Definition[k]: The average number of calendar days between a new patient's PC completed appointment (clinic stops 322, 323, and 350, excluding Compensation and Pension appointments) and the earliest of three possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date. *Note that prior to FY 2015, this metric was calculated using the earliest possible create date.*

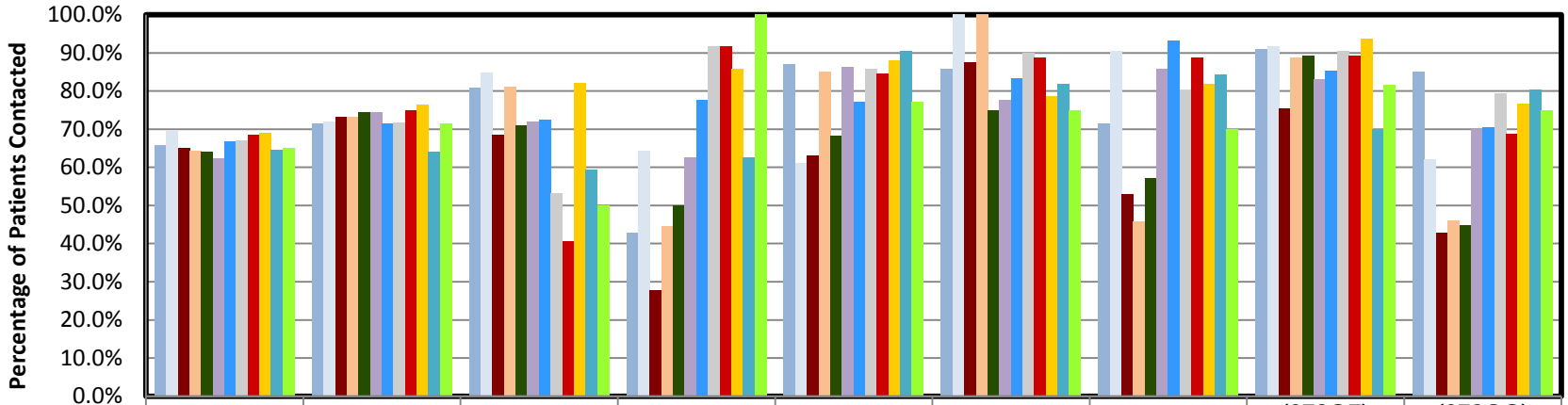


	VHA Total	(678) Tucson VAMC	(678GA) Sierra Vista	(678GB) Yuma	(678GC) Casa Grande	(678GD) Safford	(678GE) Green Valley	(678GF) Northwest Tucson VA Clinic	(678GG) Southeast Tucson VA Clinic
JUL-FY15	4.1	5.4	4.5	14.2	4.8	3.2	13.7	3.3	6.6
AUG-FY15	4.3	5.3	4.7	19.4	5.7	3.7	11.0	3.0	7.7
SEP-FY15	4.1	5.3	6.9	8.2	7.3	4.1	8.4	3.3	7.6
OCT-FY16	3.8	5.8	6.6	5.5	6.0	5.6	4.8	3.7	7.1
NOV-FY16	4.3	6.5	6.6	6.2	5.9	6.4	2.8	4.6	4.9
DEC-FY16	4.6	5.9	5.2	2.9	8.0	7.0	1.3	5.7	5.8
JAN-FY16	4.9	6.8	6.5	10.6	7.7	6.5	2.5	7.4	7.6
FEB-FY16	4.7	7.7	7.3	9.4	4.7	4.4	2.3	4.7	6.1
MAR-FY16	4.4	6.8	6.5	2.0	3.6	3.2	1.1	5.2	7.9
APR-FY16	4.3	6.9	5.9	2.7	6.0	3.8	0.7	4.8	8.0
MAY-FY16	4.3	6.2	4.4	5.5	3.5	3.0	0.6	4.8	7.8
JUN-FY16	4.4	5.9	5.0	4.4	3.1	3.4	1.8	4.6	8.5

Source: VHA Support Service Center

Note: We did not assess VA's data for accuracy or completeness.

Data Definition: The average number of calendar days between an established patient's PC completed appointment (clinic stops 322, 323, and 350, excluding Compensation and Pension appointments) and the earliest of three possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date.

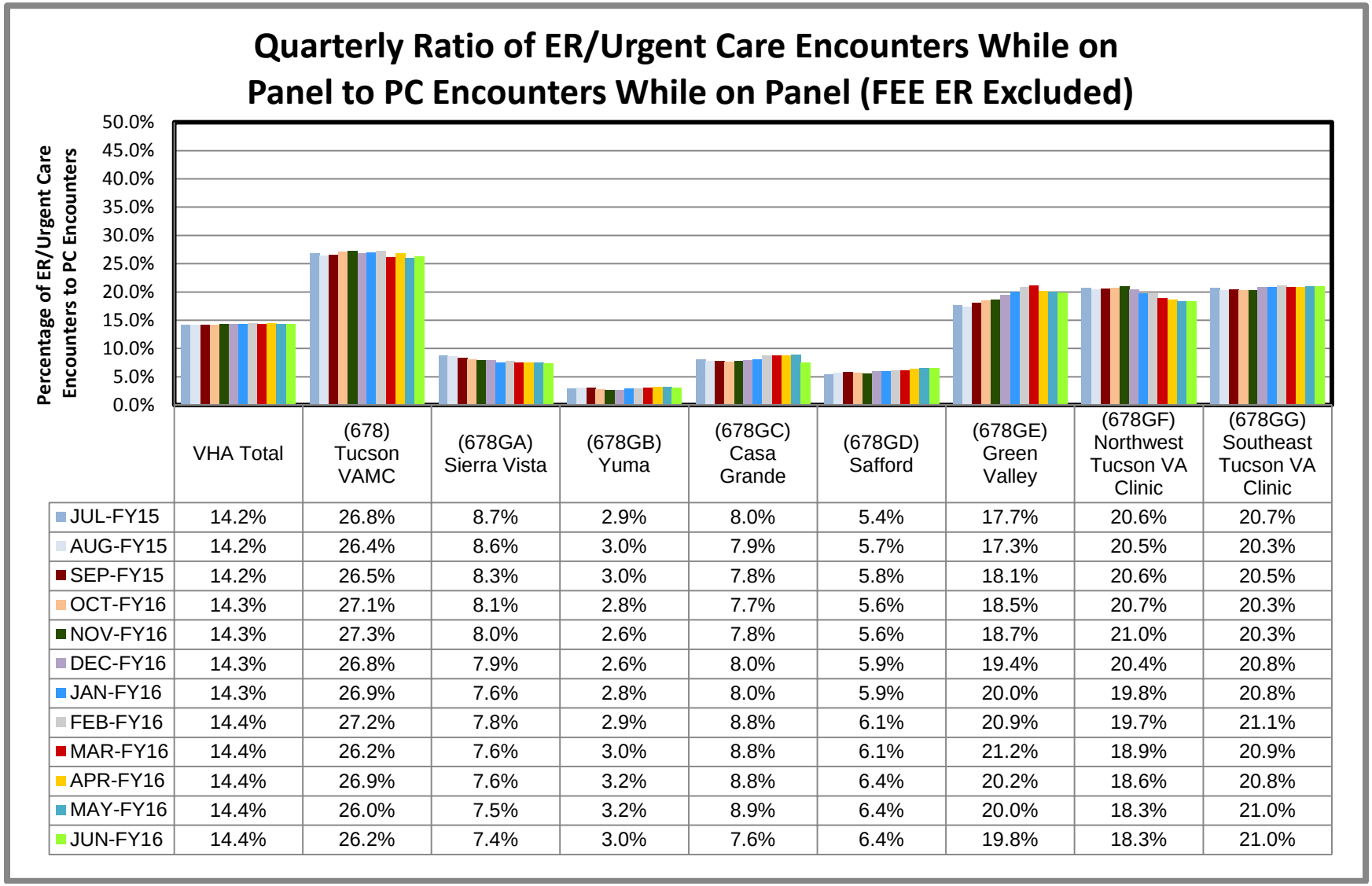


	VHA Total	(678) Tucson VAMC	(678GA) Sierra Vista	(678GB) Yuma	(678GC) Casa Grande	(678GD) Safford	(678GE) Green Valley	(678GF) Northwest Tucson VA Clinic	(678GG) Southeast Tucson VA Clinic
JUL-FY15	65.9%	71.4%	81.0%	42.9%	87.0%	85.7%	71.4%	90.9%	85.2%
AUG-FY15	69.4%	72.0%	84.8%	64.3%	61.1%	100.0%	90.5%	91.7%	62.2%
SEP-FY15	65.1%	73.3%	68.4%	27.8%	63.2%	87.5%	52.9%	75.4%	42.9%
OCT-FY16	64.3%	73.3%	81.1%	44.4%	85.2%	100.0%	45.8%	88.7%	45.9%
NOV-FY16	64.0%	74.4%	71.1%	50.0%	68.2%	75.0%	57.1%	89.3%	44.8%
DEC-FY16	62.3%	74.4%	72.0%	62.5%	86.4%	77.8%	85.7%	83.0%	70.0%
JAN-FY16	66.7%	71.5%	72.4%	77.8%	77.3%	83.3%	93.3%	85.4%	70.5%
FEB-FY16	66.9%	71.8%	53.1%	91.7%	85.7%	90.0%	80.0%	90.6%	79.5%
MAR-FY16	68.6%	74.9%	40.6%	91.7%	84.6%	88.9%	88.9%	89.3%	68.6%
APR-FY16	69.1%	76.4%	82.1%	85.7%	88.0%	78.6%	81.8%	93.6%	76.7%
MAY-FY16	64.5%	64.1%	59.4%	62.5%	90.5%	81.8%	84.2%	70.0%	80.4%
JUN-FY16	64.9%	71.5%	50.0%	100.0%	77.3%	75.0%	70.0%	81.6%	75.0%

Source: VHA Support Service Center

Note: We did not assess VA's data for accuracy or completeness.

Data Definition: The percent of assigned PC patients discharged from any VA facility who have been contacted by a PC team member within 2 business days during the reporting period. Patients are excluded if they are discharged from an observation specialty and/or readmitted within 2 business days to any VA facility. Team members must have been assigned to the patient's team at the time of the patient's discharge.



	VHA Total	(678) Tucson VAMC	(678GA) Sierra Vista	(678GB) Yuma	(678GC) Casa Grande	(678GD) Safford	(678GE) Green Valley	(678GF) Northwest Tucson VA Clinic	(678GG) Southeast Tucson VA Clinic
JUL-FY15	14.2%	26.8%	8.7%	2.9%	8.0%	5.4%	17.7%	20.6%	20.7%
AUG-FY15	14.2%	26.4%	8.6%	3.0%	7.9%	5.7%	17.3%	20.5%	20.3%
SEP-FY15	14.2%	26.5%	8.3%	3.0%	7.8%	5.8%	18.1%	20.6%	20.5%
OCT-FY16	14.3%	27.1%	8.1%	2.8%	7.7%	5.6%	18.5%	20.7%	20.3%
NOV-FY16	14.3%	27.3%	8.0%	2.6%	7.8%	5.6%	18.7%	21.0%	20.3%
DEC-FY16	14.3%	26.8%	7.9%	2.6%	8.0%	5.9%	19.4%	20.4%	20.8%
JAN-FY16	14.3%	26.9%	7.6%	2.8%	8.0%	5.9%	20.0%	19.8%	20.8%
FEB-FY16	14.4%	27.2%	7.8%	2.9%	8.8%	6.1%	20.9%	19.7%	21.1%
MAR-FY16	14.4%	26.2%	7.6%	3.0%	8.8%	6.1%	21.2%	18.9%	20.9%
APR-FY16	14.4%	26.9%	7.6%	3.2%	8.8%	6.4%	20.2%	18.6%	20.8%
MAY-FY16	14.4%	26.0%	7.5%	3.2%	8.9%	6.4%	20.0%	18.3%	21.0%
JUN-FY16	14.4%	26.2%	7.4%	3.0%	7.6%	6.4%	19.8%	18.3%	21.0%

Source: VHA Support Service Center

Note: We did not assess VA's data for accuracy or completeness.

Data Definition: This is a measure of where the patient receives his PC and by whom. A low percentage is better. The formula is the total VHA ER/Urgent Care Encounters While on Team (WOT) with a Licensed Independent Practitioner (LIP) *divided by* the number of PC Team Encounters WOT with an LIP **plus** the total number of VHA ER/Urgent Care Encounters WOT with an LIP.

Prior OIG Reports
[November 1, 2013 through November 30, 2016]

Facility Reports

Healthcare Inspection – Review of Robotic Assisted General Surgery, Southern Arizona Health Care System, Tucson, Arizona
11/14/2016 | 15-04651-81 | Summary | Report

Review of Alleged Wait-Time Manipulation at the Southern Arizona VA Health Care System
11/9/2016 | 14-02890-72 | Summary | Report

Audit of VHA's Consolidated Mail Outpatient Pharmacy Program
11/2/2016 | 15-05255-422 | Summary | Report

Review of Alleged Wasted Funds in VHA's Southern Arizona VA Health Care System
2/18/2016 | 15-02413-55 | Summary | Report

Healthcare Inspection – Review of the Operations and Effectiveness of VHA Residential Substance Use Treatment Programs
7/30/2015 | 15-01579-457 | Summary | Report

Healthcare Inspection – Alleged Quality of Care Issues at the Community Based Outpatient Clinic, Casa Grande, AZ
7/7/2015 | 14-04260-395 | Summary | Report

Community Based Outpatient Clinics Summary Report – Evaluation of Medication Oversight and Education at Community Based Outpatient Clinics and Other Outpatient Clinics
6/18/2015 | 15-01297-368 | Summary | Report

Audit of the Non-Recurring Maintenance Program
5/7/2014 | 13-00589-137 | Summary | Report

Audit of VA's Hearing Aid Services
2/20/2014 | 12-02910-80 | Summary | Report

Veterans Integrated Service Network Director Comments

Department of Veterans Affairs

Memorandum

Date: January 11, 2017

From: Director, Desert Pacific Healthcare Network (10N22)

Subject: **CAP Review of the Southern Arizona VA Health Care System, Tucson, AZ**

To: Director, San Diego Office of Healthcare Inspections (54SD)

Director, Management Review Service (VHA 10E1D MRS OIG CAP CBOC)

1. I concur with the findings and recommendations in the Combined Assessment Program Review of Southern Arizona VA Health Care System.

2. If you have any questions or concerns, please contact [redacted], VISN 22 Deputy Quality Management Officer, at [redacted].

Marie L Weldon

MARIE L. WELDON, FACHE
Network Director, VISN 22 (10N22)

Acting Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: January 4, 2017

From: Acting Director, Southern Arizona VA Health Care System (678/00)

Subject: **CAP Review of the Southern Arizona VA Health Care System, Tucson, AZ**

To: Director, Desert Pacific Healthcare Network (10N22)

1. I concur with the findings and recommendations of the Office of Inspector General Combined Assessment Program Review of the Southern Arizona VA Health Care System, Tucson, Arizona.

2. Attached are the facility actions taken as a result of these findings. If you have questions or require additional information, please contact [redacted], Clinical Director, Performance Management at [redacted].

Jennifer S. Gutowski, MHA, FACHE
Acting 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 the Facility Director ensure that the Quality, Safety, and Value Executive Committee routinely reviews aggregated data and documents the reviews.

Concur

Target date for completion: June 30, 2017

Facility response: The Quality, Safety, and Value (QSV) Committee meeting on December 20, 2016 added aggregated data and document reviews as a standing agenda item. Compliance will be monitored for the next six (6) months by reviewing the agenda/minutes of each meeting.

Recommendation 2. We recommended that facility clinical managers ensure an interdisciplinary group reviews utilization management data and that facility managers monitor compliance.

Concur

Target date for completion: June 30, 2017

Facility response: In September 12, 2016, the facility established an interdisciplinary Utilization Management (UM) Committee which meets monthly. The UM Committee will monitor compliance monthly.

Starting January 2017, the Chair of the UM Committee will present the utilization management data and findings to the Medical Executive Board and the QSV Committee. Compliance will be monitored for the next six (6) months by reviewing the agenda/minutes of each UM Committee meeting.

Recommendation 3. We recommended that facility managers ensure medical (biohazardous) waste stored for pick-up is secured and monitor compliance.

Concur

Target date for completion: June 30, 2017

Facility response: Medical biohazardous waste is collected by Environmental Management Service (EMS) on the units daily, as needed, and is temporarily contained in the unit's soiled utilities closet for pick-up twice daily by EMS. The soiled utility

closets are not considered "storage," they are temporary holding areas. However, the soiled utility closets have locks on the doors, so are considered secured. The locked doors will be monitored for compliance by the Clinical Nurse Managers on a monthly basis and findings reported quarterly to the Patient Safety Committee.

Recommendation 4. We recommended that hemodialysis unit employees secure chemicals when not in use and that the hemodialysis unit manager monitors compliance.

Concur

Target date for completion: June 30, 2017

Facility response: On December 23, 2016 facilities replaced the existing lock with a "storeroom" lock (defined as "always locked and always needs a key") so that it cannot be unlocked. Compliance will be monitored by the manager of the hemodialysis unit monthly and findings reported quarterly to the Patient Safety Committee.

Recommendation 5. We recommended that facility managers ensure clinicians consistently obtain all required laboratory tests prior to initiating anticoagulant medications.

Concur

Target date for completion: June 30, 2017

Facility response: As of December 21, 2016, Pharmacists will not process a prescription for a new start anticoagulant without a baseline PT/INR. Compliance will be monitored monthly and reported quarterly in the Anticoagulation Subcommittee with findings reported to the Pharmacy and Therapeutics Committee.

Recommendation 6. We recommended that for employees actively involved in the anticoagulant program, clinical managers complete competency assessments annually and that facility managers monitor compliance.

Concur

Target date for completion: June 30, 2017

Facility response: The TMS anti-coagulation webcourse (basic and advanced) is assigned to providers, nurses, pharmacists, and dieticians who manage anti-coagulated patients as an annual requirement. Three providers during the OIG visit in October 2016 had not completed this training, but have since completed.

The completion of the TMS anti-coagulation webcourse will be monitored by the Designated Learning Officer (DLO) and reported to the MEB on a monthly basis.

Recommendation 7. We recommended that for patients transferred out of the facility, providers document sending or communicating to the accepting facility available history; observations, signs, symptoms, and preliminary diagnoses; and results of diagnostic studies and tests and that facility managers monitor compliance.

Concur

Target date for completion: May 31, 2017

Facility response: Beginning December 1, 2016, the revised *Interfacility Transfer Note and Non VA Care Coordination Note* templates were implemented, which include a new check box for each document sent with the veteran, a check box for confirmation of signed patient transfer document sent, and a requirement for the sending provider to co-sign the notes. These new items have been added to the existing monthly transfer audit, which is completed by the Care in the Community Program Manager and reported to the Medical Records Committee monthly.

Recommendation 8. We recommended that providers notify patients of changes in who is performing the moderate sedation procedure and document this in the electronic health record and that facility managers monitor compliance.

Concur

Target date for completion: June 30, 2017

Facility response: Effective January 1, 2017, the informed consent will be reviewed at the procedure "time out" to confirm the provider listed on the consent is the provider performing the consent. If the provider listed on the consent is different than the provider performing the procedure, this will be discussed with the patient and documented. EHR audits will be performed monthly to ensure documentation with compliance and reported quarterly to the Invasive Procedure Committee.

Recommendation 9. We recommended that facility managers ensure the Community Nursing Home Oversight Committee includes representation by all required clinical disciplines.

Concur

Target date for completion: June 30, 2017

Facility response: On October 25, 2016, the Rehabilitation & Transitional Care line (RTCL) Medical Director was added to the Home and Community Programs (H&CP) Workgroup which serves as the CNH Oversight Committee. Compliance will be monitored for the next six months by reviewing the minutes and the attendance record for each meeting.

Recommendation 10. We recommended that the facility ensure integration of the Community Nursing Home Program into its quality improvement program.

Concur

Target date for completion: June 30, 2017

Facility response: Community Nursing Home Program (CNHP) Program reports to the Home & Community Programs (H&CP) Workgroup. Effective Aug 8, 2016, the H&CP Workgroup Chair reports monthly to the RTCL Quality Management Committee.

Effective December 20, 2016, the RTCL QM Committee was added as a standing agenda item to the QSV Committee. Compliance will be monitored for the next six (6) months by reviewing the agenda/minutes of each meeting.

Recommendation 11. We recommended that facility managers ensure the Community Nursing Home Review Team completes required annual reviews and monitor compliance.

Concur

Target date for completion: June 30, 2017

Facility response: Effective January 24, 2017, the CNH Program will report to the H&CP Workgroup on CNH Annual Review due dates and scheduled reviews. Compliance with the annual reviews requirement is also monitored by the Chief of RTCL.

Recommendation 12. We recommended that facility managers ensure social workers conduct and document cyclical clinical visits with the frequency required by Veterans Health Administration policy and monitor compliance.

Concur

Target date for completion: June 30, 2017

Facility response: As of November 7, 2016, two additional social workers were trained to complete the CNH social work visits to ensure no future missed visits. Compliance with the Veterans Health Administration policy requirement is monitored by the Chief of RTCL through quarterly H&CP Workgroup Meetings which report to the RTCL QM Committee. The first report to the H&CP Workgroup will take place at their next meeting in January 2017.

Recommendation 13. We recommended that facility managers ensure all employees receive Level 1 Prevention and Management of Disruptive Behavior training and additional training as required for their assigned risk area within 90 days of hire and that the training is documented in employee training records.

Concur

Target date for completion: June 30, 2017

Facility response: The Level I training module is part of the "New employee Orientation." Additional training will occur as required for assigned risk areas within 90 days of hire and will be documented in TMS. Compliance is monitored by the Clinical Director, Education, Training and Development and will be reported monthly at the Learning Organization Committee beginning January 2017.

Recommendation 14. We recommended that clinicians conducting medication education accommodate identified learning barriers and document the accommodations made to address those barriers and that facility managers monitor compliance.

Concur

Target date for completion: June 30, 2017

Facility response: On December 22, 2016, the Critical Care Shift Assessment Note, Admission Note, and the Inpatient Nursing Note had a hard stop placed mandating an *accommodation* if a barrier is noted. The Patient Education Coordinator will conduct monthly EHR audits to ensure compliance with the documentation, and present all audit information monthly to the Quality, Safety, Value (QSV) Committee.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Inspection Team	Katrina Young, RN, BSN, MSHL, Team Leader Patricia Calvin, RN, BSN, MBA Lindsay Gold, LCSW Deborah Howard, RN, MSN Jennifer Tinsley, LCSW Judy Montano, MS Alicia Pineda, Special Agent, Office of Investigations
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U.S. House of Representatives: Raul Grijalva, Martha McSally, Tom O'Halleran

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

Endnotes

[a] The references used for QSV were:
- VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013.
- VHA Directive 1117, *Utilization Management Program*, July 9, 2014.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.

[b] The references used for EOC included:
- VA Handbook 6500, *Risk Management Framework for VA Information Systems – Tier 3: VA Information Security Program*, March 10, 2015.
- VHA Directive 1116(2), *Sterile Processing Services (SPS)*, March 23, 2016.
- VHA Directive 7704(1); *Location, Selection, Installation, Maintenance, and Testing of Emergency Eyewash and Shower Equipment*; February 16, 2016.
- Various requirements of The Joint Commission, Centers for Disease Control and Prevention, Occupational Safety and Health Administration, International Association of Healthcare Central Service Materiel Management, Health Insurance Portability and Accountability Act, National Fire Protection Association.

[c] The references used for Medication Management: Anticoagulation Therapy included:
- VHA Directive 1026; *VHA Enterprise Framework for Quality, Safety, and Value*; August 2, 2013.
- VHA Directive 1033, *Anticoagulation Therapy Management*, July 29, 2015.
- VHA Directive 1088, *Communicating Test Results to Providers and Patients*, October 7, 2015.

[d] The references used for Coordination of Care: Inter-Facility Transfers included:
- VHA Directive 2007-015, *Inter-Facility Transfer Policy*, May 7, 2007.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.
- VHA Handbook 1400.01, *Resident Supervision*, December 19, 2012.

[e] The references used for Diagnostic Care: POCT included:
- VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service Procedures*, October 6, 2008.
- VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service (P&LMS) Procedures*, January 29, 2016.
- VHA Directive 1088, *Communicating Test Results to Providers and Patients*, October 7, 2015.
- The Joint Commission. *Comprehensive Accreditation Manual for Laboratories and Point-of-Care Testing*. Update 2. September 2010.
- Boaz M, Landau Z, Wainstein J. Analysis of Institutional Blood Glucose Surveillance. *Journal of Diabetes Science and Technology*. 2010;4(6):1,514–15. Accessed July 18, 2016.

[f] The references used for Moderate Sedation included:
- VHA Handbook 1004.01, *Informed Consent for Clinical Treatments and Procedures*, August 14, 2009.
- VHA Directive1039, *Ensuring Correct Surgery and Invasive Procedures*, July 26, 2013.
- VHA Directive 1073, *Moderate Sedation by Non-Anesthesia Providers*, December 30, 2014.
- VHA Directive 1177; *Cardiopulmonary Resuscitation, Basic Life Support, and Advanced Cardiac Life Support Training for Staff*; November 6, 2014.
- VA National Center for Patient Safety. *Facilitator's Guide for Moderate Sedation Toolkit for Non-Anesthesiologists*. March 29, 2011.
- American Society of Anesthesiologists. Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists. *Anesthesiology*. 2002; 96:1004–17.
- The Joint Commission. Hospital Standards. January 2016. PC.03.01.01, EP1 and MS.06.01.03 EP6.

[g] The references used for CNH Oversight included:
- VHA Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures*, June 4, 2004.
- VA OIG report, *Healthcare Inspection – Evaluation of the Veterans Health Administration's Contact Community Nursing Home Program*, (Report No. 05-00266-39, December 13, 2007).

[h] The references used for Management of Disruptive/Violent Behavior included:

- VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012.
- Public Law 112-154. Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012. August 6, 2012. 126 Stat. 1165. Sec. 106.
- Acting Deputy Under Secretary for Health for Operations and Management. "Meeting New Mandatory Safety Training Requirements using Veterans Health Administration's Prevention and Management of Disruptive Behavior (PMDB) Curriculum." memorandum. November 7, 2013.

[i] The reference used for Medication Management was:

- VHA Directive 1907.01, *Health Information management and Health Records,* March 19, 2015.
- The Joint Commission. Hospital Standards. January 2016. PC.02.03.01, EP1.

[j] The reference used for the Strategic Analytics for Improvement and Learning (SAIL) metric definitions was:

- VHA Support Service Center (VSSC), Strategic Analytics for Improvement and Learning (SAIL), accessed: October 3, 2016.

[k] The reference used for Patient Aligned Care Team Compass data graphs was:

- Department of Veterans' Affairs, Patient Aligned Care Teams Compass Data Definitions, accessed: February 25, 2016.