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Clinical Assessment Program Review of the Boise VA Medical Center Boise, Idaho

March 8, 2017

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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
ER	emergency room
facility	Boise VA Medical Center
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 Boise VA Medical Center. 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 24, 2016, and identified certain system weaknesses in Environment of Care Committee documentation of environment of care deficiencies, the facility's policy for ensuring correct surgery and invasive procedures, Community Nursing Home Oversight Committee meeting frequency and representation, Community Nursing Home Review Team annual reviews, and community nursing home cyclical visits.

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

1. Facility documentation of deficiencies noted during environment of care rounds consistently includes a comprehensive analysis of the findings.
2. Facility policy for ensuring correct surgery and invasive procedures includes all Veterans Health Administration required elements for the timeout checklist.
3. There is effective oversight and management of the community nursing home program.

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

Environment of Care – Ensure that:

- Environment of Care Committee meeting minutes consistently include discussion and analysis of environment of care rounds deficiencies.

Moderate Sedation – Ensure that:

- Facility policy for ensuring correct surgery and invasive procedures is revised to include all elements of the timeout checklist required by the Veterans Health Administration.

Community Nursing Home Oversight – Ensure that:

- The Community Nursing Home Oversight Committee meets at least quarterly and includes representation by all required disciplines.
- The Community Nursing Home Review Team completes required annual reviews that include analysis of the latest state survey.
- Social workers and registered nurses conduct and document cyclical clinical visits with the frequency required by Veterans Health Administration policy.

Comments

The Veterans Integrated Service Network Director and Acting Facility Director agreed with the Clinical Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes E and F, pages 37–40, for the full text of the Directors' comments.) We consider recommendation 2 closed. We will follow up on the planned actions for the open recommendations 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. The reviews 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.

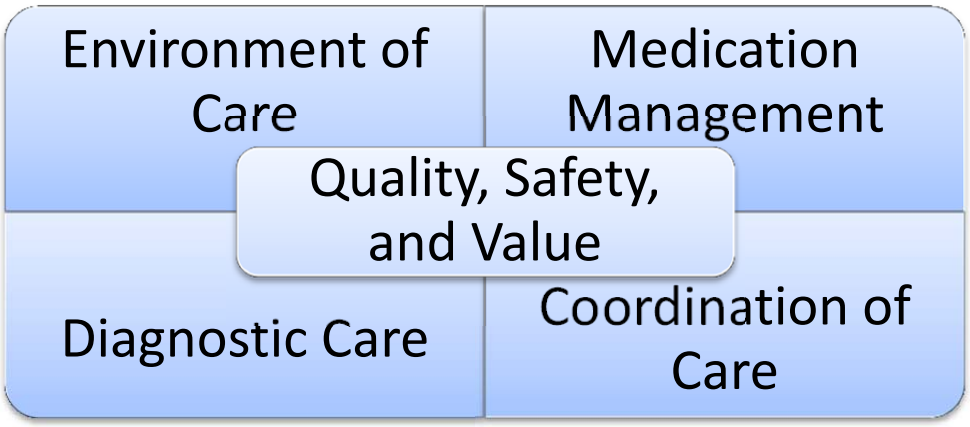
OIG also evaluates processes that are high risk and problem-prone. During this cycle, Moderate Sedation, CNH Oversight, and Management of Disruptive/Violent Behavior are processes that are high risk and problem-prone. We also followed up on recommendations from the previous Combined Assessment Program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

QSV

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]

EOC

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 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]

As of October 2016, VHA has contracts with more than 1,800 CNHs where more than 9,500 veteran patients reside. These CNHs may be within close proximity to a VA

[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.

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.

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. 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. 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.

- QSV
- EOC
- Medication Management: Anticoagulation Therapy
- Coordination of Care: Inter-Facility Transfers
- Diagnostic Care: POCT

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

- Moderate Sedation
- CNH 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 2016 and FY 2017 through October 28, 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 Boise VA Medical Center, Boise, Idaho*, Report No. 13-04241-78, February 25, 2014) and CBOC report (*Community Based Outpatient Clinic and Primary Care Clinic Reviews at Boise VA Medical Center, Boise, Idaho*, Report No. 13-04331-63, February 13, 2014).

We presented crime awareness briefings for 119 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 155 responses. We shared summarized results with the Acting Facility Director.

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. 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.

Reported Accomplishments

Biomedical Research Center of Excellence Grant

In June 2016, the National Institutes of Health, National Institute of General Medical Sciences awarded Dr. Dennis Stevens, a facility infectious disease clinician/scientist, a 5-year, $7 million Centers of Biomedical Research Excellence grant. The facility will establish a multi-disciplinary Biomedical Research Center of Excellence in emerging/reemerging infectious diseases to prevent; diagnose; and treat severe, life-threatening infections.

Antimicrobial Prescribing Best Practice Award

Facility pharmacists, pharmacy residents, physicians, and Idaho State University faculty, received the 2016 Best Practices Award from the American Society of Health-System Pharmacists. The award was the result of developing and implementing an antimicrobial prescribing improvement project for patients with acute respiratory infections that focused on pharmacist intervention in the ambulatory care setting.

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 facility generally met requirements. We made no recommendations.

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.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Credentialing and privileging processes met selected requirements: • Facility policy/by-laws addressed 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.		
	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.		

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.[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 Emergency Department, the CLC, the intensive care unit, the inpatient medical/surgical and MH units, the PC and women's health clinics, SPS, and the Burns Outreach Clinic. Additionally, we reviewed relevant documents and 10 employee training records, and we interviewed key employees and managers. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

Checklist 2. EOC Areas Reviewed, Findings, and Recommendations

NM	Areas Reviewed for General EOC	Findings	Recommendations
X	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.	Six months of EOC Committee meeting minutes reviewed: • Minutes did not include consistent discussion and analysis of EOC rounds deficiencies.	**1.** We recommended that Environment of Care Committee meeting minutes consistently include discussion and analysis of environment of care rounds deficiencies.
	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.		
	The facility met environmental cleanliness requirements.		
	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		
	The facility met infection prevention requirements in SPS areas.		

NM	Areas Reviewed for SPS (continued)	Findings	Recommendations
	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		
NA	The facility had a policy or procedure for preventive maintenance of hemodialysis machines and performed maintenance at the frequency required by local policy.		
NA	Selected hemodialysis unit employees had evidence of bloodborne pathogens training within the past 12 months.		
NA	The facility met environmental safety requirements in the hemodialysis unit.		
NA	The facility met infection prevention requirements in the hemodialysis unit.		
NA	The facility met medication safety and security requirements in the hemodialysis unit.		
NA	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[15] 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 10 employees actively involved in the anticoagulant program, and we interviewed key employees. Additionally, we reviewed the EHRs of 50 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 facility generally met requirements. We made no recommendations.

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		

[15] 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.		
	Clinicians obtained required laboratory tests: • Prior to initiating anticoagulant medications • During anticoagulation treatment at the frequency required by local policy		
	When laboratory values did not meet selected criteria, clinicians documented a justification/rationale for prescribing the anticoagulant.		
	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.		

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 31 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 facility generally met requirements. We made no recommendations.

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		
	Communication with the accepting facility or documentation sent included: • Available history • Observations, signs, symptoms, and preliminary diagnoses • Results of diagnostic studies and tests		

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.[16]

We reviewed relevant documents, the EHRs of 50 inpatients and outpatients who underwent POCT for blood glucose July 1, 2015 through June 30, 2016, and the annual competency assessments of 39 clinicians who performed the glucose testing. Additionally, we interviewed key employees and conducted onsite glucometer inspections of the intensive care unit, Emergency Department, Blue Team PC clinic, Women's Health Clinic; and Burns Oregon Outreach Clinic 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.		

[16] 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 2015, VHA clinicians performed more than 152,000 moderate sedation procedures of which approximately 60,000 were gastroenterology-related endoscopies.[17] 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.[18] 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, radiology, intensive care unit, and Emergency Department procedure areas to assess whether required equipment and sedation medications were available. Additionally, we reviewed the EHRs of 48 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.		

[17] Per VA Corporate Data Warehouse data pull on July 28, 2016.
[18] 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 both the history and physical and the pre-sedation assessment included required elements.		
	Providers re-evaluated patients immediately before moderate sedation for changes since the prior assessment.		
	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.		
	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.		
	Selected clinical employees had current training for moderate sedation.		
	The clinical team kept monitoring and resuscitation equipment and reversal agents in the general areas where moderate sedation was administered.		
	To minimize risk, clinical staff 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.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	The facility's local policy for "Ensuring Correct Surgery and Invasive Procedures" meets VHA requirements.	The facility's policy, Ensuring Correct Surgery and Invasive Procedures, did not include the following timeout checklist elements: • Site has been marked appropriately, and the site of the mark is visible after preparatory draping. • Appropriate antibiotic prophylaxis.	**2.** We recommended that the facility revise the Ensuring Correct Surgery and Invasive Procedures policy to include all elements of the timeout checklist required by the Veterans Health Administration.

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.[19] Local oversight of CNHs is achieved through annual reviews and monthly visits.

We reviewed relevant documents, the EHRs of 39 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 meet quarterly. • The facility's CNH Oversight Committee did not include a representative from quality management, acquisition, and the medical staff.	**3.** We recommended that facility managers ensure the Community Nursing Home Oversight Committee meets at least quarterly and includes representation by all required disciplines.
	The facility integrated the CNH Program into its Quality Improvement Program.		
	The facility documented a hand-off for patients placed in CNHs outside of its catchment area.		

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

NM	Areas Reviewed (continued)	Findings	Recommendations
X	The CNH Review Team completed CNH annual reviews.	• The CNH Review Team did not complete 3 of 11 CNH annual reviews. • None of the eight CNH annual reviews conducted included analysis of the latest state survey.	**4.** We recommended that facility managers ensure the Community Nursing Home Review Team completes required annual reviews that include analysis of the latest state survey and monitor compliance.
	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.	• None of the 39 EHRs contained documentation of social worker and/or registered nurse cyclical clinical visits with the frequency required by VHA policy.	**5.** We recommended that facility managers ensure social workers and registered nurses 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 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 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 15 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 facility generally met requirements. We made no recommendations.

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 or acceptable alternate group • 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 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.		
	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.		

Facility Profile

Table 1 below provides general background information for this facility.

Table 1. Facility Profile for Boise (531) for FY 2016

Profile Element	Facility Data
Veterans Integrated Service Network Number	20
Complexity Level	2-Medium complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$239
Number of:	
• **Unique Patients**	35,473
• **Outpatient Visits**	365,896
• **Unique Employees**[20]	1,111
Type and Number of Operating Beds:	
• **Acute**	29
• **MH**	8
• **Community Living Center**	28
• **Domiciliary**	14
Average Daily Census:	
• **Acute**	22
• **MH**	3
• **Community Living Center**	22
• **Domiciliary**	11

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.

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

VA Outpatient Clinic Profiles[21]

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, diagnostic, and ancillary services. Table 2 below provides information relative to each of the clinics.

Table 2. VA Outpatient Clinic Workload/Encounters[22] and Specialty Care, Diagnostic, and Ancillary Services Provided[23] for FY 2016

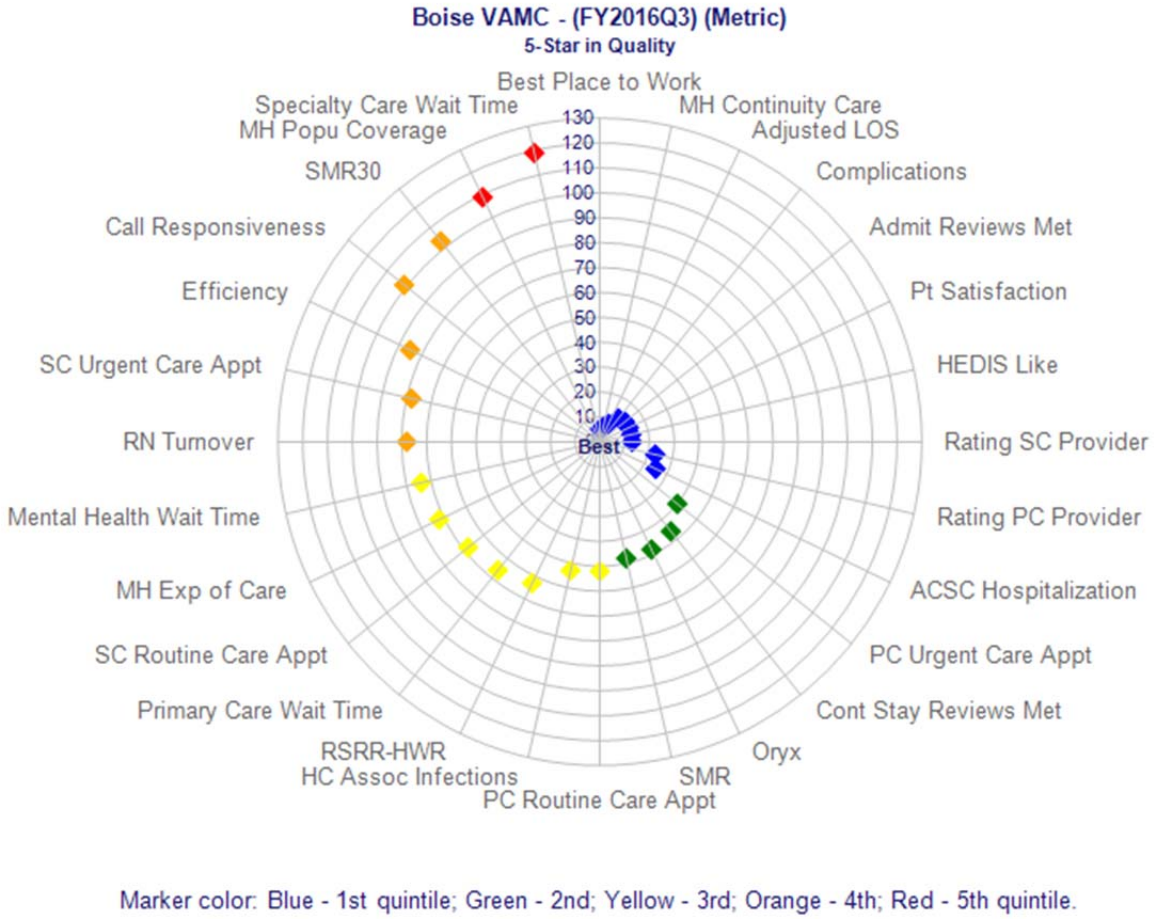
Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services[24] Provided	Diagnostic Services[25] Provided	Ancillary Services[26] Provided
Twin Falls, ID	531GE	9,577	2,939	Dermatology Pulmonary/ Respiratory Disease Podiatry	NA	Nutrition Pharmacy Weight Management
Caldwell, ID	531GG	10,768	3,414	Dermatology Blind Rehab Rehab Physician Anesthesia Eye Podiatry	NA	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.

[21] Includes all outpatient clinics in the community that were in operation before February 15, 2016. We have omitted Burns, OR (531GH); Mountain Home, ID (531GI); and Salmon, ID (531GJ), as no workload/encounters or services were reported.
[22] An encounter is a professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition.
[23] The denoted specialty care and ancillary services are limited to primary clinic stops with a count ≥ 100 encounters for October 1, 2015 through September 30, 2016, timeframe at the specified CBOC.
[24] Specialty care services refer to non-PC and non-MH services provided by a physician.
[25] Diagnostic services include EKG, EMG, laboratory, nuclear medicine, radiology, and vascular lab services.
[26] Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

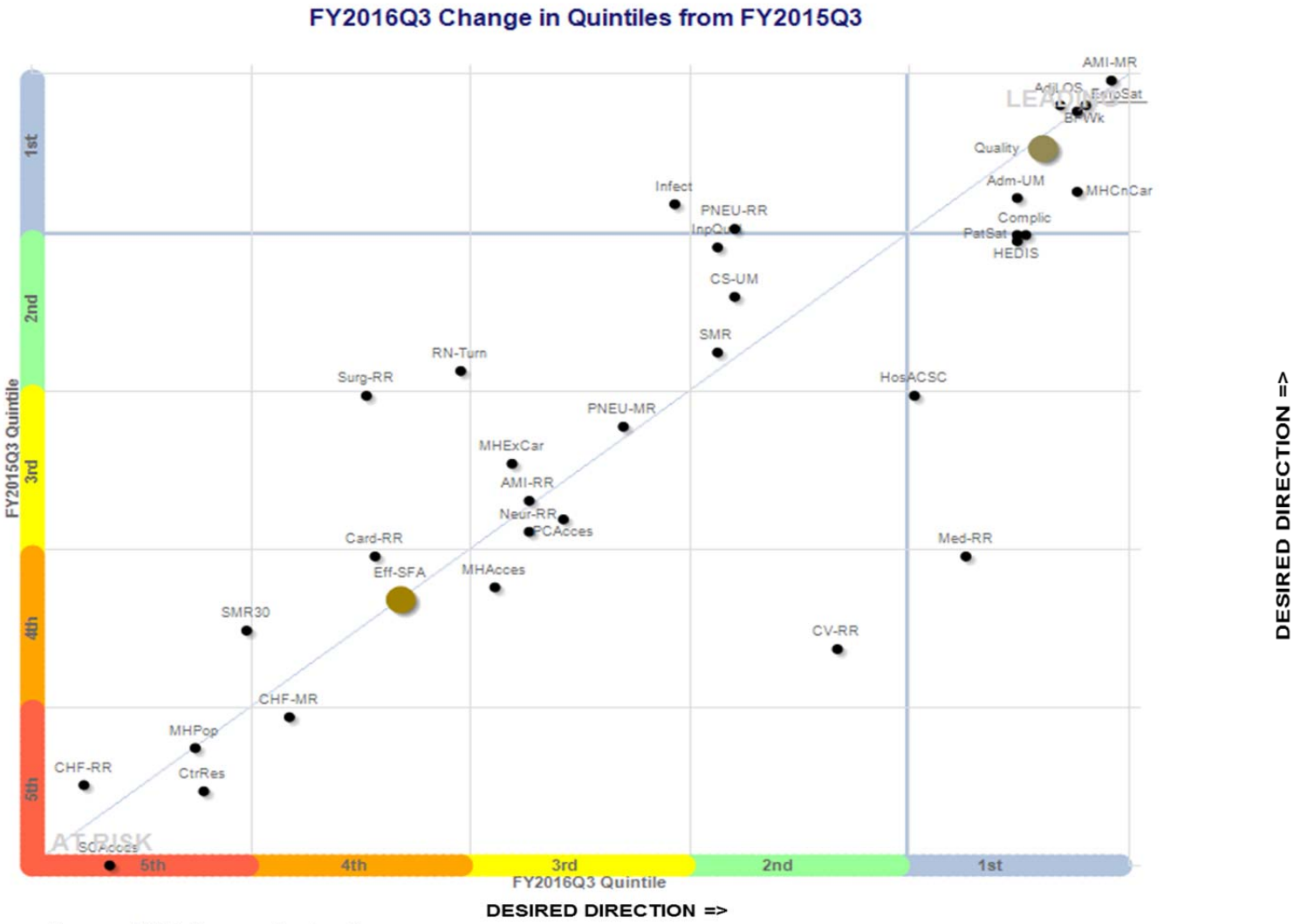
Strategic Analytics for Improvement and Learning (SAIL)[27]



Source: VHA Support Service Center
Note: We did not assess VA's data for accuracy or completeness.

[27] 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[i]

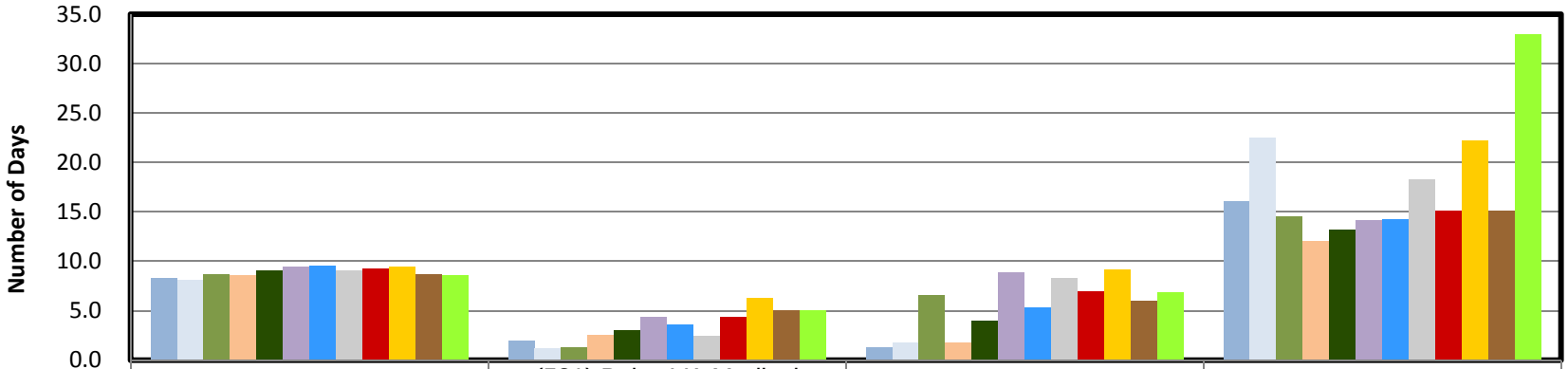
Measure	Definition	Desired Direction
ACSC Hospitalization	Ambulatory care sensitive condition hospitalizations (observed to expected ratio)	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Admit Reviews Met	% 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

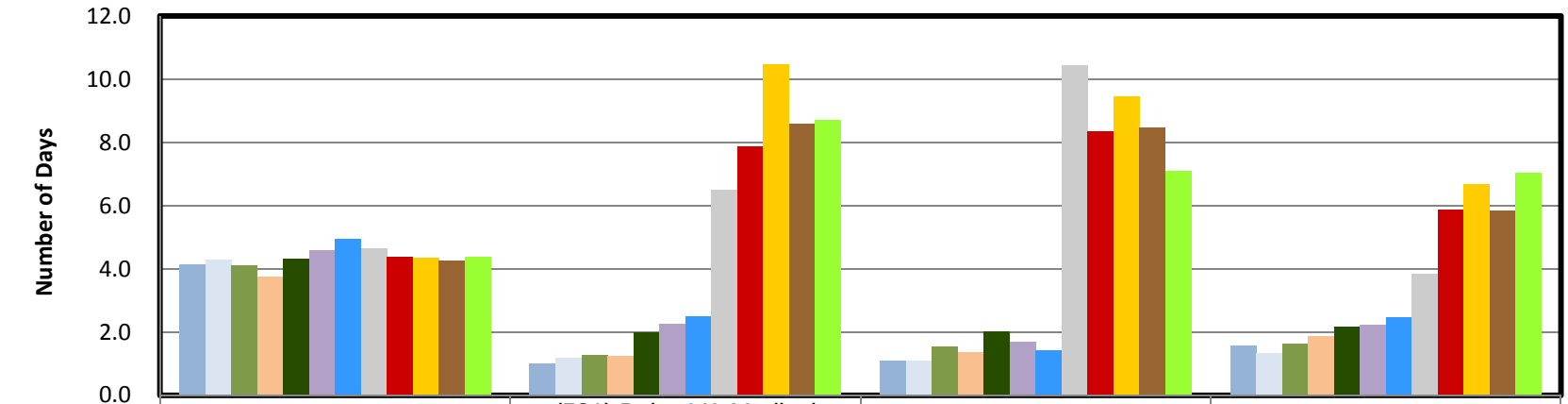


	VHA Total	(531) Boise VA Medical Center	(531GE) Twin Falls	(531GG) Caldwell
JUL-FY15	8.3	2.0	1.3	16.1
AUG-FY15	8.1	1.2	1.7	22.5
SEP-FY15	8.7	1.3	6.6	14.5
OCT-FY16	8.6	2.5	1.8	12.1
NOV-FY16	9.1	3.0	3.9	13.2
DEC-FY16	9.5	4.4	8.9	14.2
JAN-FY16	9.6	3.6	5.3	14.3
FEB-FY16	9.1	2.4	8.3	18.3
MAR-FY16	9.2	4.4	7.0	15.1
APR-FY16	9.5	6.3	9.1	22.2
MAY-FY16	8.7	5.0	6.0	15.1
JUN-FY16	8.6	5.1	6.8	33.0

Source: VHA Support Service Center

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

Data Definition[i]: 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.*

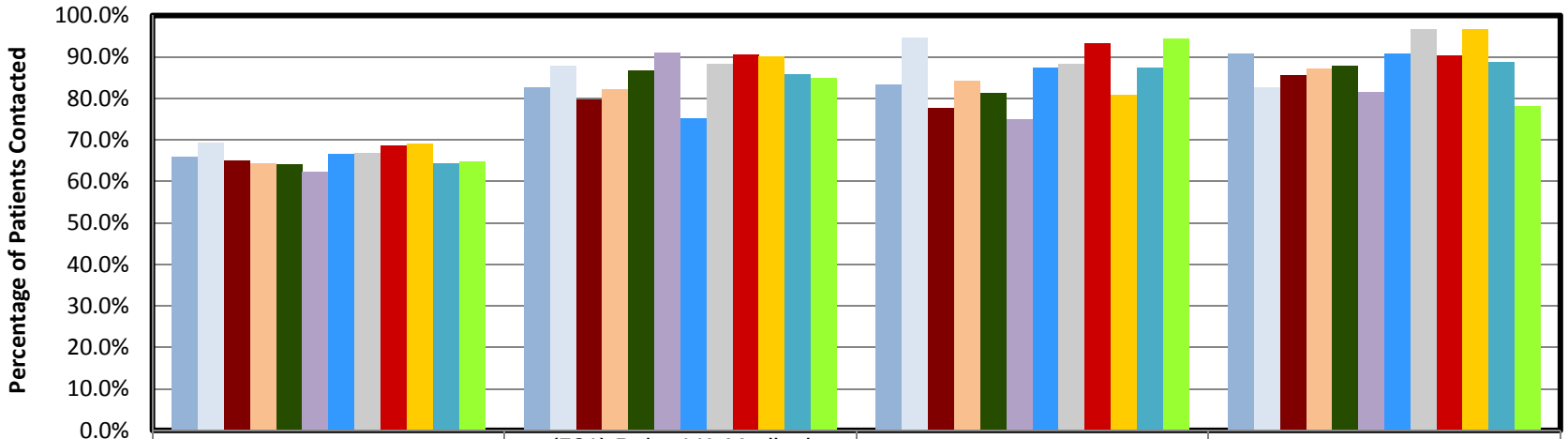


	VHA Total	(531) Boise VA Medical Center	(531GE) Twin Falls	(531GG) Caldwell
JUL-FY15	4.1	1.0	1.1	1.6
AUG-FY15	4.3	1.2	1.1	1.3
SEP-FY15	4.1	1.3	1.5	1.6
OCT-FY16	3.8	1.2	1.4	1.9
NOV-FY16	4.3	2.0	2.0	2.2
DEC-FY16	4.6	2.3	1.7	2.2
JAN-FY16	4.9	2.5	1.4	2.5
FEB-FY16	4.7	6.5	10.4	3.8
MAR-FY16	4.4	7.9	8.4	5.9
APR-FY16	4.3	10.5	9.5	6.7
MAY-FY16	4.3	8.6	8.5	5.8
JUN-FY16	4.4	8.7	7.1	7.0

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.

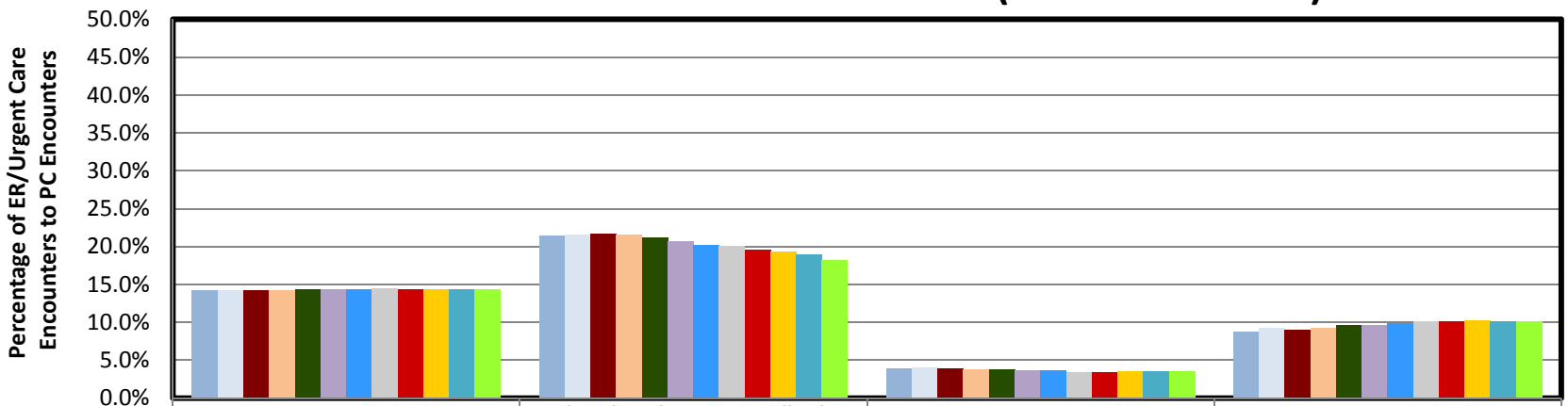


	VHA Total	(531) Boise VA Medical Center	(531GE) Twin Falls	(531GG) Caldwell
JUL-FY15	65.9%	82.7%	83.3%	90.9%
AUG-FY15	69.4%	88.0%	94.7%	82.6%
SEP-FY15	65.1%	79.8%	77.8%	85.7%
OCT-FY16	64.3%	82.3%	84.2%	87.1%
NOV-FY16	64.0%	86.8%	81.3%	87.9%
DEC-FY16	62.3%	91.0%	75.0%	81.6%
JAN-FY16	66.7%	75.3%	87.5%	90.9%
FEB-FY16	66.9%	88.3%	88.2%	96.8%
MAR-FY16	68.6%	90.7%	93.3%	90.3%
APR-FY16	69.1%	90.2%	80.8%	96.7%
MAY-FY16	64.5%	85.9%	87.5%	88.9%
JUN-FY16	64.9%	85.1%	94.4%	78.1%

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	(531) Boise VA Medical Center	(531GE) Twin Falls	(531GG) Caldwell
JUL-FY15	14.2%	21.4%	3.9%	8.8%
AUG-FY15	14.2%	21.5%	4.0%	9.3%
SEP-FY15	14.2%	21.7%	3.9%	9.0%
OCT-FY16	14.3%	21.6%	3.8%	9.3%
NOV-FY16	14.3%	21.2%	3.7%	9.6%
DEC-FY16	14.3%	20.7%	3.7%	9.7%
JAN-FY16	14.3%	20.2%	3.7%	9.9%
FEB-FY16	14.4%	20.1%	3.5%	10.1%
MAR-FY16	14.4%	19.6%	3.4%	10.2%
APR-FY16	14.4%	19.4%	3.6%	10.2%
MAY-FY16	14.4%	19.0%	3.6%	10.1%
JUN-FY16	14.4%	18.3%	3.6%	10.2%

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
[December 1, 2013 through December 1, 2016]

Facility Reports

VA's Federal Information Security Modernization Act Audit for Fiscal Year 2015
3/15/2016 | 15-01957-100 | 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

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

Veterans Integrated Service Network Director Comments

Department of Veterans Affairs

Memorandum

Date: December 21, 2016

From: Director, Northwest Network (10N20)

Subject: **CAP Review of the Boise VA Medical Center, Boise, ID**

To: Acting Director, Seattle Office of Healthcare Inspections (54SE)

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

1. Thank you for the opportunity to respond to the proposed recommendations from the Clinical Assessment Program Review of the Boise VA Medical Center, Boise, Idaho.

2. Attached please find the facility concurrences and responses to each of the findings from the review.

3. If you have additional questions or need further information, please contact [redacted], Deputy Quality Management Officer at [redacted].

(Original signed by:)
Michael J. Murphy

Acting Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: December 15, 2016

From: Acting Director, Boise VA Medical Center (531/00)

Subject: **CAP Review of the Boise VA Medical Center, Boise, ID**

To: Director, Northwest Network (10N20)

1. Thank you for the opportunity to review the report on the Office of the Inspector General Clinical Assessment Program Review of the Boise VA Medical Center during the week of October 24, 2016. We concur with the findings and recommendations and will ensure that actions to correct them are completed as described.

2. Please find attached our facility responses to each recommendation, including the status of the corrective action plans.

3. If you have any additional questions or need further information, please contact Dr. [redacted], Chief, Quality and Performance Improvement at [redacted].

(Original signed by:)
Grant Ragsdale
Acting Director, Boise VA Medical Center

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that Environment of Care Committee meeting minutes consistently include discussion and analysis of environment of care rounds deficiencies.

Concur

Target date for completion: April 30, 2017

Facility response: A standardized tool was developed to guide and document Environment of Care (EOC) Committee members' discussion and analysis of EOC rounds deficiencies in accordance with VHA and The Joint Commission requirements. EOC Committee processes for discussion, analysis, and documentation of EOC round deficiencies were revised and implemented. EOC committee members were educated about the updated processes and tool.

Compliance with documentation of discussion and analysis of EOC rounds deficiencies in EOC committee meeting minutes will be monitored monthly. Monthly audit results will be reported to the Quality Executive Board.

Recommendation 2. We recommended that the facility revise the Ensuring Correct Surgery and Invasive Procedures policy to include all elements of the timeout checklist required by the Veterans Health Administration.

Concur

Target date for completion: November 30, 2016

Facility response: The Ensuring Correct Surgery and Invasive Procedures policy was revised to be fully compliant with VHA guidance, including all required timeout checklist elements.

We request closure of this recommendation based on the evidence provided.

Recommendation 3. We recommended that facility managers ensure the Community Nursing Home Oversight Committee meets at least quarterly and includes representation by all required disciplines.

Concur

Target date for completion: July 31, 2017

Facility response: The Community Nursing Home Oversight Committee (CNHOC) membership was updated to include all members required by VHA guidance. The committee has been scheduled to meet every 2–3 months (quarterly at the least).

Compliance with requirements for quarterly CNHOC meetings, including representation by all required disciplines, will be monitored quarterly. Quarterly audit results will be reported to the Quality Executive Board.

Recommendation 4. We recommended that facility managers ensure the Community Nursing Home Review Team completes required annual reviews including the analysis of the latest state survey and monitor compliance.

Concur

Target date for completion: July 31, 2017

Facility response: Processes were revised and implemented to ensure that community nursing home (CNH) site visits by program staff are scheduled and completed on time. Processes were revised and implemented to ensure that annual CNH reviews include analysis of the latest state survey results. The Community Nursing Home Review Team is scheduled to meet every 2–3 months (quarterly at the least) to complete annual CNH reviews.

Compliance with requirements for the Community Nursing Home Review Team to complete annual reviews, including analysis of the latest state survey, will be monitored quarterly. Quarterly audit results will be reported to the Quality Executive Board.

Recommendation 5. We recommended that facility managers ensure social workers and registered nurses conduct and document cyclical clinical visits with the frequency required by Veterans Health Administration policy and monitor compliance.

Concur

Target date for completion: July 31, 2017

Facility response: A tool was developed to strengthen CNH cyclic clinical visit scheduling and tracking by program staff. Processes were revised and implemented to ensure that cyclical clinical visits by program social workers and registered nurses are scheduled, completed, and documented on time, in compliance with VHA requirements.

Compliance with requirements for the CNH social workers and registered nurses to conduct and document cyclical clinical visits with the frequency required by VHA policy will be monitored quarterly. Quarterly audit results will be reported to the Quality Executive Board.

OIG Contact and Staff Acknowledgments

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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:
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- 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.
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[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 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.

[j] The reference used for PACT Compass data graphs was:

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