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Clinical Assessment Program Review of the Canandaigua VA Medical Center Canandaigua, New York

March 27, 2017

Washington, DC 20420

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Glossary

CAP	Clinical Assessment Program
CNH	community nursing home
EHR	electronic health record
EOC	environment of care
facility	Canandaigua 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
PTSD	post-traumatic stress disorder
QSV	quality, safety, and value
RME	reusable medical equipment
RRTP	residential rehabilitation treatment program
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 Canandaigua VA Medical Center. We reviewed clinical and administrative processes that affect patient care outcomes—Quality, Safety, and Value; Environment of Care; Medication Management; Diagnostic Care; Community Nursing Home Oversight; Management of Disruptive/Violent Behavior; Mental Health Residential Rehabilitation Treatment Program; and Post-Traumatic Stress Disorder Care. 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 competency assessments for employees assigned to the anticoagulation management program; documentation of critical glucose values from point-of-care testing; Community Nursing Home Oversight Committee, annual reviews, and clinical visits; employee training in managing disruptive or violent behavior; and post-traumatic stress disorder suicide risk assessments and referrals.

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

1. The facility maintains competencies for employees directly involved in the management of anticoagulation therapy.
2. Nursing documentation of critical point-of-care glucose testing results is communicated effectively with other nurses and members of the health care team.
3. Facility leaders have effective oversight of the Community Nursing Home Program and assure the safe and effective care of patients in these remote facilities.
4. The facility effectively trains employees to manage disruptive or violent behavior.
5. The facility mitigates risk for those who screen positive for post-traumatic stress disorder through the completion of a suicide risk assessment or the offer of referrals for further diagnostic evaluation. This assessment found that about 44 percent of the patients with a positive post-traumatic stress disorder screen did not have a suicide risk assessment.

Recommendations: We made recommendations in the following five review areas.

Medication Management: Anticoagulation Therapy – Ensure that:

- Employees actively involved in the anticoagulant program complete competency assessments annually.

Diagnostic Care: Point-of-Care Testing – Ensure that:

- Clinicians document interventions and provider communication for glucometer critical values with the required template.

Community Nursing Home Oversight – Ensure that:

- The facility establishes a Community Nursing Home Oversight Committee.
- The facility integrates the Community Nursing Home Program into its quality improvement program.
- Social workers and registered nurses 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.

Post-Traumatic Stress Disorder Care – Ensure that acceptable providers:

- Perform and document suicide risk assessments for all patients with positive post-traumatic stress disorder screens.
- Offer further diagnostic evaluations to patients with positive post-traumatic stress disorder screens.

Comments

The Veterans Integrated Service Network Director and Facility Director agreed with the Clinical Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes E and F, pages 37–42, for the full text of the Directors' comments.) We consider recommendation 1 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.

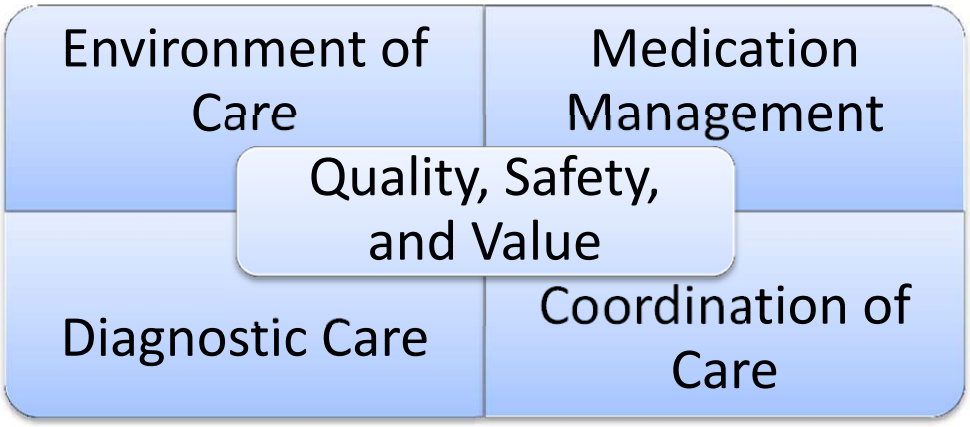
During this cycle, CNH Oversight, Management of Disruptive/Violent Behavior, MH RRTP, and PTSD Care are processes that are high risk and problem-prone. We also followed up on recommendations from the previous Combined Assessment Program and Community Based Outpatient Clinic and PC Clinic Reviews.

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]

As of October 2016, VHA has contracts with more than 1,800 CNHs where more than 9,500 veteran patients reside.[13] 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.[14]

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

[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] VA Corporate Data Warehouse. Accessed October 31, 2016.
[14] VHA Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures*, June 4, 2004.

acts are perpetrated by patients.[15] 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.[16] 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.

MH RRTPs provide 24-hour residential rehabilitative and clinical care in a therapeutic setting to eligible veterans who have multiple and severe medical conditions, mental illness, addiction, or psychosocial deficits. They provide the least intensive level of VA inpatient care and differ from acute inpatient and nursing home beds as veterans in MH RRTPs are generally capable of self-care. MH RRTPs address rehabilitation, recovery, health maintenance, improved quality of life, and community integration in addition to specifically treating medical conditions, mental illnesses, and addictive disorders. Facility leaders must provide a safe, well-maintained, and appropriately-furnished residential environment that supports and enhances recovery efforts.[17]

PTSD is a disorder that may occur "…following exposure to an extreme traumatic stressor involving direct personal experience."[18] FYs 2010 through 2015, more than 1 million patients with a primary or secondary diagnosis of PTSD received MH care at VA medical centers and clinics. During FY 2016, VA MH clinicians diagnosed and treated more than 100,000 additional patients who had not been previously diagnosed with PTSD.[19] Because of the risks involved if this condition is not diagnosed and treated, clinical employees need to screen patients for PTSD, in accordance with requirements, when they present for care.

[15] 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.
[16] VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012.
[17] VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010.
[18] VHA Handbook 1160.03, *Programs for Veterans with Post-Traumatic Stress Disorder (PTSD)*, March 12, 2010.
[19] VA Corporate Data Warehouse. Accessed November 1, 2016.

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 four aspects of clinical care.

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

We did not perform the Coordination of Care: Inter-Facility Transfers topic due to the lack of a sufficient number of patients meeting criteria for the review.

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

- Community Nursing Home Oversight
- Management of Disruptive/Violent Behavior
- Mental Health Residential Rehabilitation Treatment Program
- Post-Traumatic Stress Disorder

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 Canandaigua VA Medical Center, Canandaigua, New York,* Report No. 14-00688-162, May 14, 2014) and Community Based Outpatient Clinic report (*Community Based Outpatient Clinic and Primary Care Clinic Reviews at Canandaigua VA Medical Center, Canandaigua, New York,* Report No. 14-00244-147, May 22, 2014).

We presented crime awareness briefings for 151 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 176 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

Outpatient Care

PC created a committee that champions improvement in Healthcare Effectiveness Data and Information Set measures. Through this committee, PC has been able to shift their Strategic Analytics for Improvement and Learning score from the 5th quintile to the 4th quintile in less than a year. The facility saw steady improvement in many areas of Healthcare Effectiveness Data and Information Set measures. For example the Alcohol Use Disorders Identification Test (Audit-C) measure score for the final FY 2016 External Peer Review Program was 100 percent.

Geriatrics and Extended Care

Through extensive efforts and focus on three primary elements—clinical care and skills, strategic leadership/engagement, and environmental modifications—the care line was successful in reducing the FY 2016 fall rate for residents of the community living centers by more than 25 percent. In addition, the care line successfully implemented direct scheduling in audiology during FY 2016 as indicated by a 15 percent increase in the percentage of appointments without consults, which improved care for veterans in need of audiological services.

Mental Health

The outpatient behavioral health clinics instituted a new process for appointment management, and as a result, exceeded the 85 percent implementation target for completion of return to clinic orders. Completion of return to clinic orders improves customer service to veterans by ensuring they always have an appointment prior to leaving the clinic.

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. Any items that did not apply to this facility are marked NA. 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.		
NA	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.[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 four community living center inpatient units, two PC clinics, the podiatry clinic, the physical therapy department, and the Clinton Crossings specialty clinic in Rochester, NY. Additionally, we reviewed relevant documents and interviewed key employees and managers. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

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 community based outpatient clinics.		
	The facility conducted an infection prevention risk assessment.		
	Infection Prevention/Control Committee minutes documented discussion of identified high-risk areas, actions implemented to address those areas, and follow-up on implemented actions and included analysis of surveillance activities and data.		

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		
NA	The facility had a policy for cleaning, disinfecting, and sterilizing RME.		
NA	The facility's standard operating procedures for selected RME were current and consistent with the manufacturers' instructions for use.		
NA	The facility performed quality control testing on selected RME with the frequency required by local policy and took appropriate action on positive results.		
NA	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		
NA	The facility met infection prevention requirements in SPS areas.		

NM	Areas Reviewed for SPS (continued)	Findings	Recommendations
NA	Standard operating procedures for selected RME were located in the area where reprocessing occurred.		
NA	SPS employees checked eyewash stations in SPS areas weekly.		
NA	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[20] 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 36 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 area 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		

[20] 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.		
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.	• Six of 10 employees actively involved in the anticoagulant program did not have competency assessments completed annually.	**1.** We recommended that employees actively involved in the anticoagulant program complete competency assessments annually and that clinical 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.[d] 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.[21]

We reviewed relevant documents, the EHRs of 45 inpatients and outpatients who underwent POCT for blood glucose July 1, 2015 through June 30, 2016, and the annual competency assessments of 31 clinicians who performed the glucose testing. Additionally, we interviewed key employees and conducted onsite glucometer inspections of a PC clinic and four CLC units to assess compliance with manufacturers' maintenance and solution/reagent storage requirements. 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. 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.		

[21] 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.		
X	The facility complied with local nursing standard operating procedure, which requires employees to document interventions and provider communication with the appropriate template for glucometer critical values.	• None of the 10 applicable EHRs contained the required template.	**2.** We recommended that clinicians document interventions and provider communication for glucometer critical values with the required template and that clinical managers monitor compliance.

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.[e] 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.[22] Local oversight of CNHs is achieved through annual reviews and monthly visits.

We reviewed relevant documents, the EHRs of 17 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 5. 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 did not have a CNH Oversight Committee.	**3.** We recommended that the facility establish a Community Nursing Home Oversight Committee.
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.	**4.** 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.		
	The CNH Review Team completed CNH annual reviews.		
	When CNH annual reviews noted four or more exclusionary criteria, facility managers completed exclusion review documentation.		

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

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Social workers and registered nurses documented clinical visits that alternated on a cyclical basis.	• None of the EHRs contained documentation of social worker and 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.[f] 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 25 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 or moderate 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 6. 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.		
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.	• Two employee training records did not contain documentation of Level 1 training within 90 days of hire. • Three of the applicable seven employee training records did not contain documentation of the training required for their assigned risk area within 90 days of hire.	**6.** 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.

Mental Health Residential Rehabilitation Treatment Program

The purpose of this review was to determine whether the facility's MH RRTP (more commonly referred to as domiciliary or residential treatment programs) complied with selected EOC requirements. The Domiciliary Care for Homeless Veterans Program was established through legislation in the late 1860s with the purpose of providing a home for disabled volunteer soldiers of the Civil War. In 1995, VA established the Psychosocial RRTP bed level of care. This distinct level of MH residential care is appropriate for veterans with mental illnesses or addictive disorders who require structure and support to address psychosocial deficits, including homelessness and unemployment. In 2005, the Domiciliary RRTP became fully integrated with other RRTPs of the Office of MH Services.[g]

We reviewed relevant documents, inspected the Psychosocial RRTP, and interviewed key employees. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

Checklist 7. MH RRTP Areas Reviewed, Findings, and Recommendations

NM	Areas Reviewed	Findings	Recommendations
	The residential environment was clean and in good repair.		
NA	Appropriate fire extinguishers were available near grease producing cooking devices.		
	There were policies/procedures that addressed safe medication management and contraband detection.		
	MH RRTP employees conducted and documented monthly self-inspections that included all required elements, submitted work orders for items needing repair, and ensured correction of any identified deficiencies.		
	MH RRTP employees conducted and documented contraband inspections, rounds of all public spaces, daily bed checks, and resident room inspections for unsecured medications.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The MH RRTP had written agreements in place acknowledging resident responsibility for medication security.		
	The MH RRTP main point(s) of entry had keyless entry and closed circuit television monitoring, and all other doors were locked to the outside and alarmed.		
	The MH RRTP had closed circuit television monitors with recording capability in public areas but not in treatment areas or private spaces and had signage alerting veterans and visitors of recording.		
	There was a process for responding to behavioral health and medical emergencies, and MH RRTP employees could articulate the process.		
	In mixed gender MH RRTP units, women veterans' rooms had keyless entry or door locks.		
	Residents secured medications in their rooms.		

Post-Traumatic Stress Disorder Care

The purpose of this review was to assess whether the facility complied with selected VHA requirements for PTSD follow-up in the outpatient setting.[h] PTSD is a disorder that may occur "…following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury; other threat to one's physical integrity; witnessing an event that involves death, injury or threat to the physical integrity of another person; learning about unexpected or violent death, serious harm, threat of death or injury experienced by a family member or other close associate."[23]

The PTSD screen is performed through a required national clinical reminder and is triggered for completion when the patient has his or her first visit at a VHA medical facility. The reminder typically remains active until it is completed. For veterans, the most common traumatic stressor contributing to a PTSD diagnosis is war-zone related stress. VHA requires that:

- Every new patient receive PTSD screening that is then repeated every year for the first 5 years post-separation and every 5 years thereafter unless there is a clinical need to screen earlier.
- If a patient's PTSD screen is positive, an acceptable provider evaluates treatment needs and assesses for suicide risk.
- If the provider determines a need for treatment, there is evidence of referral and coordination of care.

We reviewed relevant documents and the EHRs of 39 outpatients who had a positive PTSD screen July 1, 2015 through June 30, 2016. We also 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 8. PTSD Care Areas Reviewed, Findings, and Recommendations

NM	Areas Reviewed	Findings	Recommendations
X	Each patient with a positive PTSD screen received a suicide risk assessment.	• Seventeen of the 39 patients (44 percent) did not receive a suicide risk assessment.	**7.** We recommended that acceptable providers perform and document suicide risk assessments for all patients with positive post-traumatic stress disorder screens.
	Suicide risk assessments for patients with positive PTSD screens were completed by acceptable providers.		

[23] VHA Handbook 1160.03, *Programs for Veterans with Post-Traumatic Stress Disorder (PTSD)*, March 12, 2010.

NM	Areas Reviewed (continued)	Findings	Recommendations
	Acceptable providers established plans of care and disposition for patients with positive PTSD screens.		
X	Acceptable providers offered further diagnostic evaluations to patients with positive PTSD screens.	• Acceptable providers did not offer patients referrals for diagnostic evaluations in 10 of the 39 EHRs (26 percent).	**8.** We recommended that acceptable providers offer further diagnostic evaluations to patients with positive post-traumatic stress disorder screens.
	Providers completed diagnostic evaluations for patients with positive PTSD screens.		
	Patients received MH treatment when applicable.		

Facility Profile

Table 1 below provides general background information for this facility.

Table 1. Facility Profile for Canandaigua (528A5) for FY 2016

Profile Element	Facility Data
Veterans Integrated Service Network Number	2
Complexity Level	3-Low complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$176
Number of:	
• **Unique Patients**	20,361
• **Outpatient Visits**	242,624
• **Unique Employees**[24]	970
Type and Number of Operating Beds:	
• **Acute**	NA
• **MH**	NA
• **Community Living Center**	138
• **Domiciliary**	48
Average Daily Census:	
• **Acute**	NA
• **MH**	NA
• **Community Living Center**	83
• **Domiciliary**	33

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 Profile[25]

The VA outpatient clinics in the 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[26] and Specialty Care, Diagnostic, and Ancillary Services Provided for FY 2016

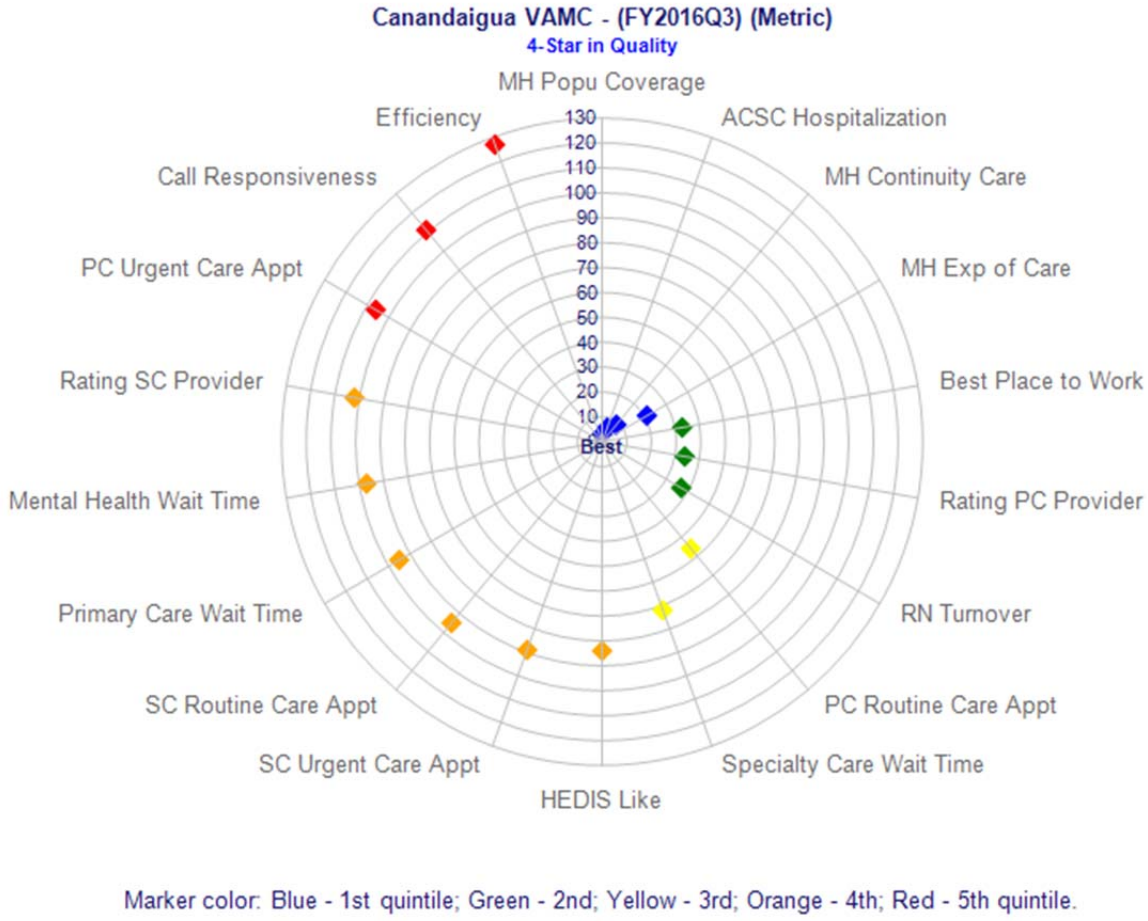
Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services[27] Provided	Diagnostic Services[28] Provided	Ancillary Services[29] Provided
Rochester, NY	528GE	22,492	15,346	Allergy Cardiology Dermatology Endocrinology Gastroenterology Infectious Disease Rheumatology Poly-Trauma Rehab Physician ENT Eye General Surgery Orthopedics Podiatry Urology	EKG Laboratory and Pathology Radiology	Pharmacy Prosthetics Weight Management Dental Nutrition

Source: VHA Support Service Center and VA Corporate Data Warehouse

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

[25] Includes all outpatient clinics in the community that were in operation before February 15, 2016. We have omitted Rochester, NY (528QC) and Rochester, NY (528QD), as no workload/encounters or services were reported.
[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.

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

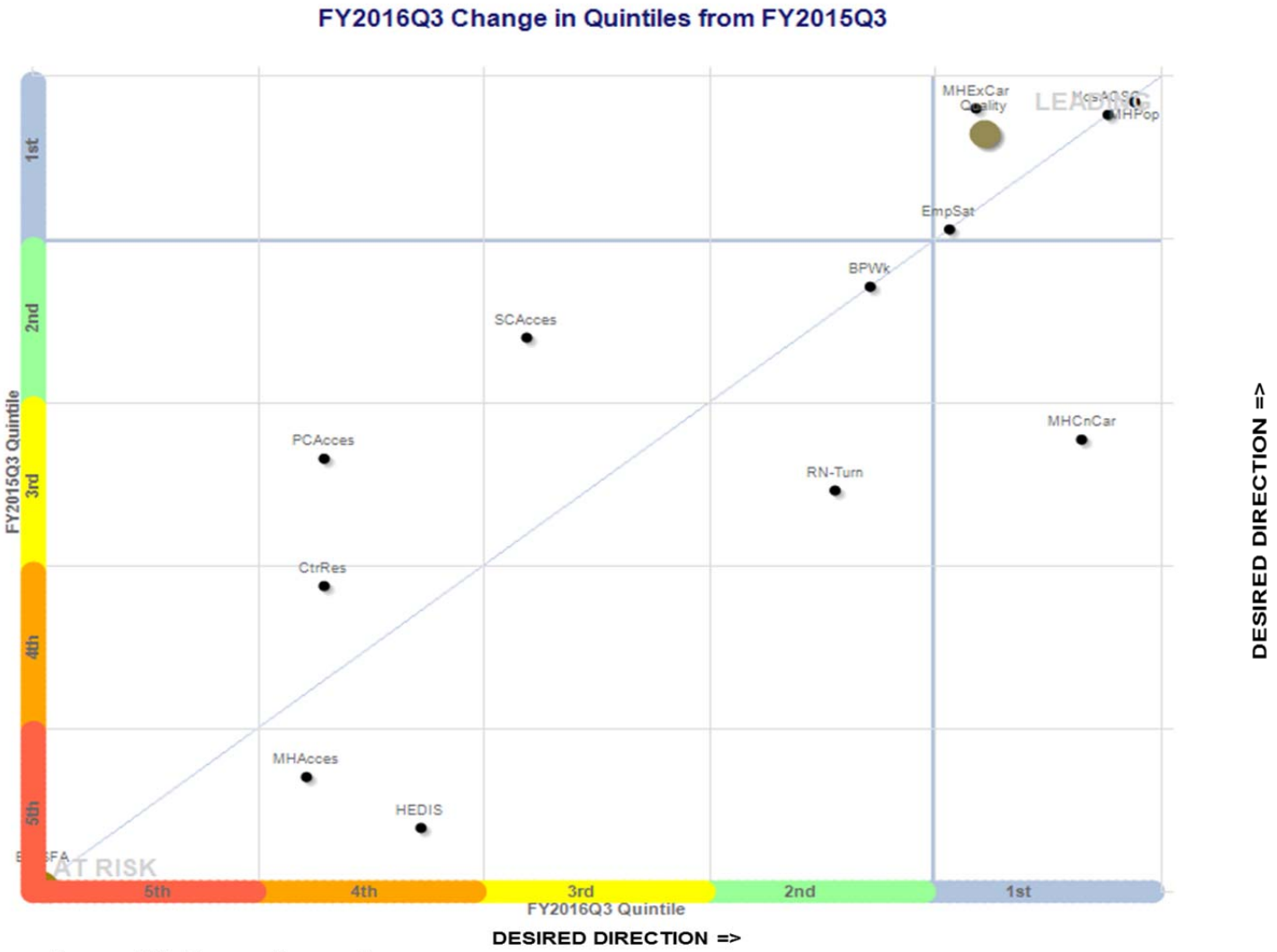


Source: VHA Support Service Center

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[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

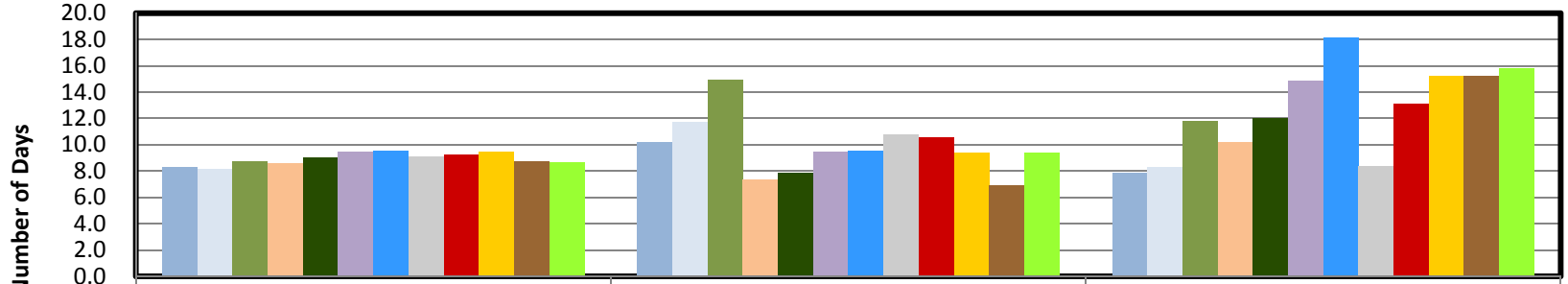
Measure	Definition	Desired Direction
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized 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

Quarterly New PC Patient Average Wait Time in Days

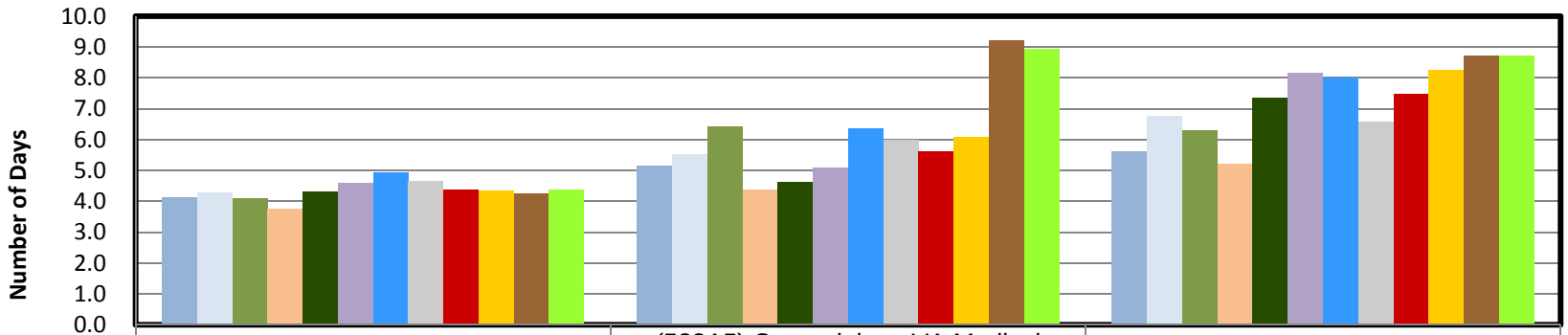


	VHA Total	(528A5) Canandaigua VA Medical Center	(528GE) Rochester
JUL-FY15	8.3	10.2	7.8
AUG-FY15	8.1	11.7	8.3
SEP-FY15	8.7	14.9	11.8
OCT-FY16	8.6	7.3	10.2
NOV-FY16	9.1	7.8	12.0
DEC-FY16	9.5	9.5	14.8
JAN-FY16	9.6	9.6	18.1
FEB-FY16	9.1	10.8	8.3
MAR-FY16	9.2	10.6	13.1
APR-FY16	9.5	9.4	15.2
MAY-FY16	8.7	6.9	15.2
JUN-FY16	8.6	9.4	15.8

Source: VHA Support Service Center

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

Data Definition[j]: 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.*

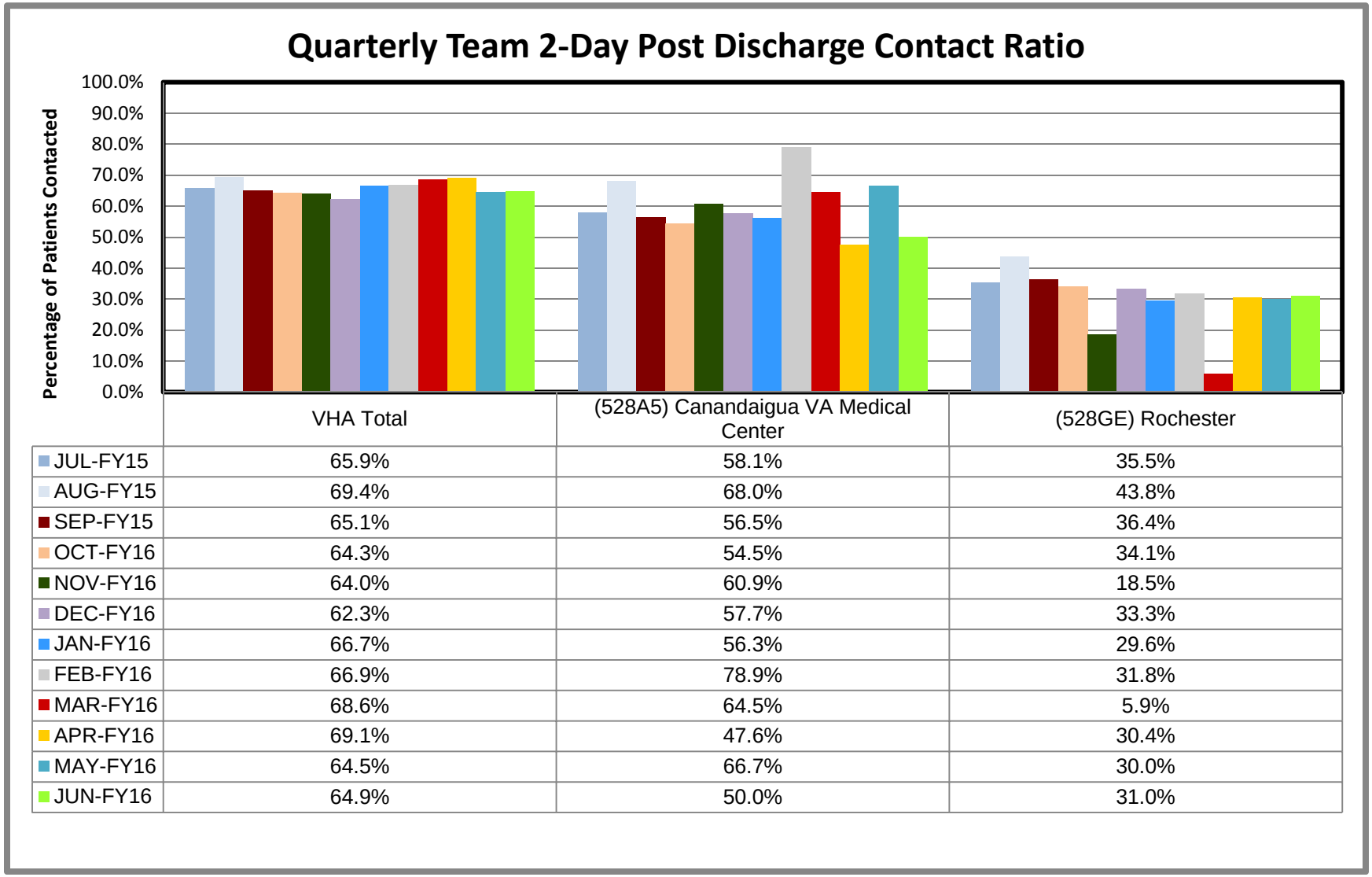


	VHA Total	(528A5) Canandaigua VA Medical Center	(528GE) Rochester
JUL-FY15	4.1	5.1	5.6
AUG-FY15	4.3	5.5	6.8
SEP-FY15	4.1	6.4	6.3
OCT-FY16	3.8	4.4	5.2
NOV-FY16	4.3	4.6	7.4
DEC-FY16	4.6	5.1	8.2
JAN-FY16	4.9	6.4	8.0
FEB-FY16	4.7	6.0	6.6
MAR-FY16	4.4	5.6	7.5
APR-FY16	4.3	6.1	8.2
MAY-FY16	4.3	9.2	8.7
JUN-FY16	4.4	8.9	8.7

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.

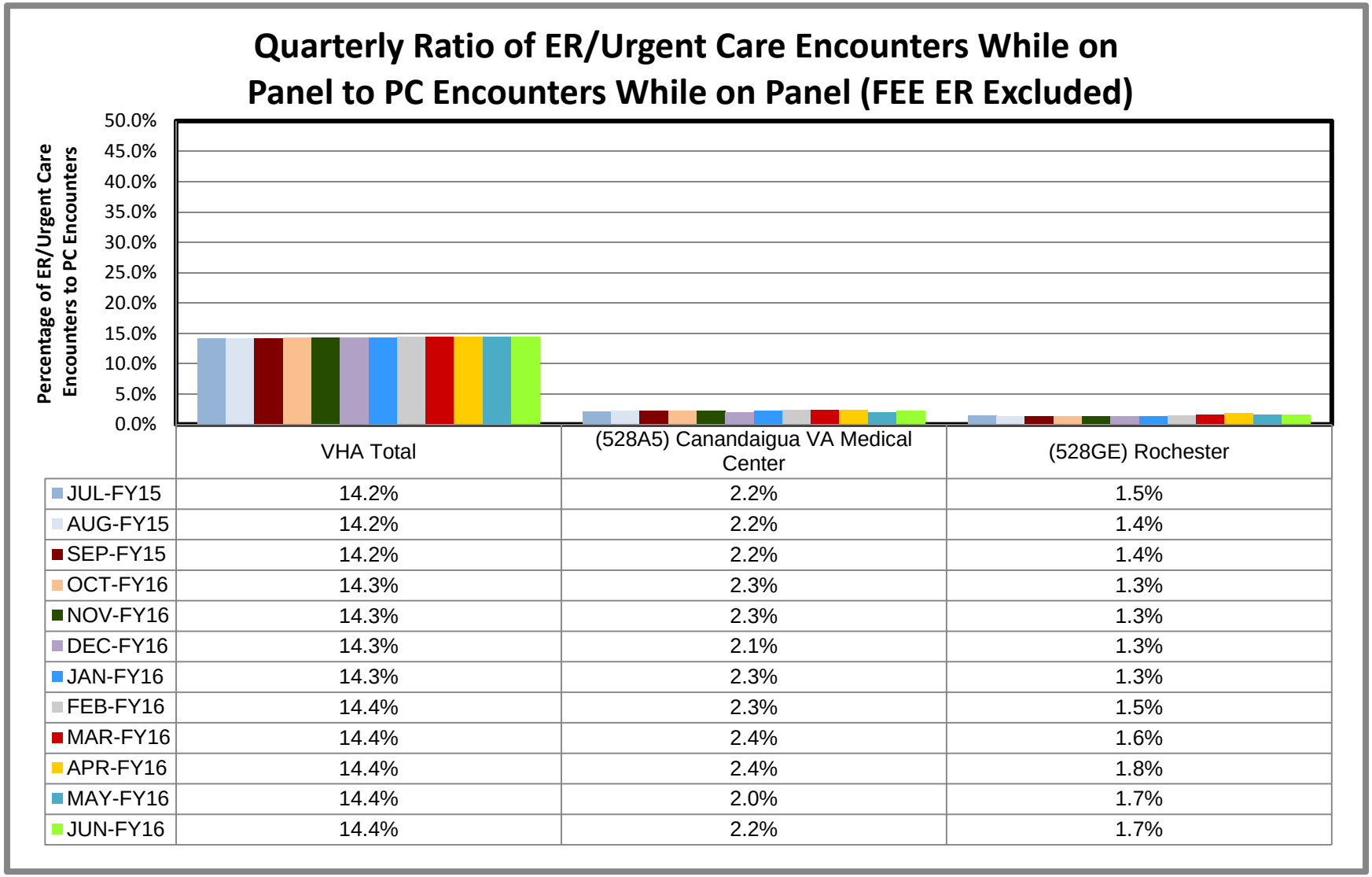


	VHA Total	(528A5) Canandaigua VA Medical Center	(528GE) Rochester
JUL-FY15	65.9%	58.1%	35.5%
AUG-FY15	69.4%	68.0%	43.8%
SEP-FY15	65.1%	56.5%	36.4%
OCT-FY16	64.3%	54.5%	34.1%
NOV-FY16	64.0%	60.9%	18.5%
DEC-FY16	62.3%	57.7%	33.3%
JAN-FY16	66.7%	56.3%	29.6%
FEB-FY16	66.9%	78.9%	31.8%
MAR-FY16	68.6%	64.5%	5.9%
APR-FY16	69.1%	47.6%	30.4%
MAY-FY16	64.5%	66.7%	30.0%
JUN-FY16	64.9%	50.0%	31.0%

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	(528A5) Canandaigua VA Medical Center	(528GE) Rochester
JUL-FY15	14.2%	2.2%	1.5%
AUG-FY15	14.2%	2.2%	1.4%
SEP-FY15	14.2%	2.2%	1.4%
OCT-FY16	14.3%	2.3%	1.3%
NOV-FY16	14.3%	2.3%	1.3%
DEC-FY16	14.3%	2.1%	1.3%
JAN-FY16	14.3%	2.3%	1.3%
FEB-FY16	14.4%	2.3%	1.5%
MAR-FY16	14.4%	2.4%	1.6%
APR-FY16	14.4%	2.4%	1.8%
MAY-FY16	14.4%	2.0%	1.7%
JUN-FY16	14.4%	2.2%	1.7%

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 1, 2016]

Facility Reports[31]

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

[31] Two other reports related to programs located in Canandaigua, NY, are not listed here because they are not part of the Canandaigua VA Medical Center: *Healthcare Inspection – Veterans Crisis Line Caller Response* and *Quality Assurance Concerns, Canandaigua, New York*, Report No. 14-03540-123, February 11, 2016, and *Audit of VHA's National Call Center for Homeless Veterans*, Report No. 13-01859-42, December 3, 2014.

Appendix E

Veterans Integrated Service Network Director Comments

Department of Veterans Affairs

Memorandum

Date: December 15, 2016

From: Director, VA New York/New Jersey Health Care Network (10N2)

Subject: **CAP Review of the Canandaigua VA Medical Center, Canandaigua, NY**

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

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

1. We are submitting written comments in response to the CAP Review of the Canandaigua VA Medical Center completed October 17–20, 2016, in Canandaigua, N.Y.

2. In reviewing the draft report, the facility addressed all identified deficiencies and has a plan to resolve all non-compliant areas cited in the report. Network 2 concurs with the report.

Joan E. McInerney, MD, MBA, MA, FACEP

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: December 14, 2016

From: Director, Canandaigua VA Medical Center (528A5/00)

Subject: **CAP Review of the Canandaigua VA Medical Center, Canandaigua, NY**

To: Director, VA New York/New Jersey Health Care Network (10N2)

1. We are submitting written comments in response to the CAP Review of the Canandaigua VA Medical Center completed October 17–20, 2016, in Canandaigua, N.Y.

2. In reviewing the draft report, the facility has addressed all identified deficiencies and has a plan to resolve all non-compliant areas cited in the report. I concur with the report.

Michael Swartz, FACHE

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 employees actively involved in the anticoagulant program complete competency assessments annually and that clinical managers monitor compliance.

Concur

Target date for completion: Completed

Facility response: The Advanced Anticoagulation Talent Management System (TMS) module is assigned annually as a provider competency. We are 100 percent complaint. We have assigned a TMS lead from pharmacy to monitor for continued compliance.

Recommendation 2. We recommended that clinicians document interventions and provider communication for glucometer critical values with the required template and that clinical managers monitor compliance.

Concur

Target date for completion: March 31, 2017

Facility response: The Critical Value Nurse Note template will be used to document interventions and provider communication for glucometer critical values. Clinical nurse managers will monitor compliance monthly. The measure for success is greater than 90 percent compliant for three consecutive months to achieve sustainability.

Recommendation 3. We recommended that the facility establish a Community Nursing Home Oversight Committee.

Concur

Target date for completion: March 1, 2017

Facility response: Leadership of Geriatric Extended Care (GEC) and Rehabilitation Operations will establish a Community Nursing Home (CNH) Oversight Committee. The committee includes Social Work, Nursing, Quality Management, and additional staff as indicated, and will convene on a monthly basis. The CNH Oversight Committee focus will include ongoing monitoring of Veteran census and problem focused reviews of CNH facilities. This committee will review VHA standards regarding the provisions of care for Veterans involved in the CNH program and monitor compliance with those standards. This committee will report all findings to the facility's Contract Oversight Committee on a

monthly basis. The measure for success is greater than 90 percent compliant for three consecutive months to achieve sustainability.

Recommendation 4. We recommended that the facility ensure integration of the Community Nursing Home Program into its quality improvement program.

Concur

Target date for completion: May 1, 2017

Facility response: Senior Executive Medical Staff (ECMS) is responsible for establishing a CNH Oversight Committee. The CNH Oversight Committee is responsible for the integration of the CHN program into the quality improvement program. Leadership of GEC and Rehabilitation Operations will report the measure of success of each CNH directly to the ECMS quarterly. ECMS includes Chief of Staff (COS) and Associate Director for Patient Nursing Services (ADPNS). The measure of success will include ongoing (annual) review of CNH quality Measures and inspections from Nursing Home (NH) Compare (www.medicare.gov/nursinghomecompare) and use of the Minimum Data Set (MDS) Quality Measures for each resident and facility during scheduled visits. The quality measures include deficiency measures from NH Compare, indicators from MDS QI Profile and, are not limited to sentinel events. This information will be reviewed with the CNH Oversight Committee and will be utilized by staff to suggest individual resident, program, and/or clinical improvements on a quarterly basis. The measure for success is greater than 90 percent compliant for three consecutive months to achieve sustainability. GEC leadership will report the measure of success to ECMS.

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: March 1, 2017

Facility response: The GEC and Rehabilitation Operations Manager will establish a structured schedule of cyclical clinical visits for the CNH team as defined by VHA Handbook 1143.2. The GEC and Rehabilitation Operations Manager will directly monitor the scheduled clinical visits to ensure compliance per VHA standard. GEC leadership will report the measure of success to ECMS. The measure for success is greater than 90 percent compliant for three consecutive months to achieve sustainability.

Recommendation 6. 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: March 31, 2017

Facility response: Prevention and Management of Disruptive Behavior (PMDB) training has been incorporated within new employee orientation. Training occurs twice a month in alignment with week one of new employee orientation. Training completion is documented in TMS. Education will review all past new employees to ensure they have received the required level of PMDB training within 90 days of hire. The PMDB Coordinator will monitor employee TMS compliance/deficiency reports to ensure required PMDB training levels are completed within 90 days of hire. This will be monitored monthly and reported to the Quality, Safety and Value Oversight Committee quarterly to ensure compliance. The measure for success is greater than 90 percent compliance for three consecutive months to achieve sustainability.

Recommendation 7. We recommended that acceptable providers perform and document suicide risk assessments for all patients with positive post-traumatic stress disorder screens.

Concur

Target date for completion: March 31, 2017

Facility response: When a registered nurse completes a post-traumatic stress disorder (PTSD) screen, and if it is positive, the psychiatrist or nurse practitioner will complete the suicide risk assessment. The registered nurse and providers will include the nurse manager and clinic manager as co-signers to the positive PTSD and the suicide risk assessment for a 60-day period to ensure compliance. We will use the monthly External Peer Review Program (EPRP) to track measure of success for positive Primary Care-PTSD screen with timely suicide evaluation. The measure for success is greater than 90 percent compliant for three consecutive months to achieve sustainability.

Recommendation 8. We recommended that acceptable providers offer further diagnostic evaluations to patients with positive post-traumatic stress disorder screens.

Concur

Target date for completion: March 31, 2017

Facility response: When a Veteran has a positive PTSD screen, the psychiatrist, nurse practitioner, social worker, psychologist, and or the licensed mental health counselor will offer further diagnostic evaluation to determine if post-traumatic treatment is clinically indicated. We will use the monthly EPRP to track measure of success for screening for PTSD at required intervals with primary care PTSD. The measure for success is greater than 90 percent compliant for three consecutive months to achieve sustainability.

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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:
- 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 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.

[e] 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).

[f] 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.

[g] The references used for MH RRTP were:
- VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010.
- VHA Handbook 1330.01, *Health Care Services for Women Veterans*, May 21, 2010.
- Requirements of the VHA Center for Engineering and Occupational Safety and Health and the National Fire Protection Association.

[h] The references used for PTSD Care included:

- VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.
- VHA Handbook 1160.03, *Programs for Veterans with Post-Traumatic Stress Disorder (PTSD)*, March 12, 2010.
- VA Memorandum, *Information Bulletin: Clarification of Posttraumatic Stress Disorder Screening Requirements*, August 2015.
- *VA/DoD Clinical Practice Guideline for Management of Post-Traumatic Stress*, Version 2.0, October 2010.
- *VHA Technical Manual – PTSD*, VA Measurement Manual PTSD-51.

[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 Patient Aligned Care Team Compass data graphs was:

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