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Clinical Assessment Program Review of the White River Junction VA Medical Center White River Junction, Vermont

June 20, 2017

Washington, DC 20420

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Glossary

CAP	Clinical Assessment Program
CNH	community nursing home
HER	electronic health record
EOC	environment of care
facility	White River Junction 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

Table of Contents

Executive Summary

Purpose and Objectives: The review provided an evaluation of the quality of care delivered in the inpatient and outpatient settings of the White River Junction 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.

Results: We conducted the review during the week of December 5, 2016, and identified certain system weaknesses in the quality, safety, and value program; anticoagulation policies and processes; transfer documentation; moderate sedation care; community nursing home oversight; and management of disruptive and violent behavior.

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

1. Facility leadership is involved in high-level oversight and decision-making by the Quality Management Board.
2. Clinical managers review Ongoing Professional Practice Evaluation data to monitor trends in practice and patient outcomes.
3. The facility maintains effective oversight of utilization management processes.
4. The facility prioritizes patient safety improvement by consistently conducting root cause analyses as required.
5. Clinical employees and leadership provide safe anticoagulation care.
6. Clinicians provide informed consent and communicate important information to other health care team members through the electronic health record when they transfer patients from the facility.
7. Providers and other clinical employees provide safe moderate sedation care.
8. The facility monitors the community nursing home program and assures the effective oversight of care of patients in these settings.
9. The facility has processes and procedures in place to prevent, reduce, and manage disruptive/violent behavior.

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

Quality, Safety, and Value – Ensure that:
- The Quality Management Board is chaired or co-chaired by the Facility Director and routinely reviews aggregated data.
- Facility clinical managers consistently review Ongoing Professional Practice Evaluation data every 6 months.
- At least 75 percent of all utilization management reviews are completed.
- An interdisciplinary group reviews utilization management data.
- The Patient Safety Manager ensures completion of eight root cause analyses each fiscal year.

Medication Management: Anticoagulation Therapy – Ensure that:
- The facility collects quality assurance data for the anticoagulation management program and that the Medication Use and Evaluation Committee reviews the data annually.
- Anticoagulation clinicians consistently obtain all required laboratory tests prior to initiating warfarin treatment.

Coordination of Care: Inter-Facility Transfers – Ensure that for patients transferred out of the facility:
- Providers consistently include date of transfer and patient or surrogate informed consent in transfer documentation.
- Acceptable designees document staff/attending physician approval as evidenced by the presence of the approving staff/attending physician countersignature in transfer notes.
- Sending nurses document transfer assessments/notes.

Moderate Sedation – Ensure that:
- Providers include all required elements in the history and physical and the pre-sedation assessment.
- Clinical employees document post-procedure assessments of patients' pain levels.
- Clinical employees discharge moderate sedation outpatients in the company of a responsible adult.
- Clinical employees who perform or assist with moderate sedation procedures have current training for the provision of moderate sedation care and that training is documented.
- Clinical teams keep resuscitation equipment in moderate sedation procedure rooms/areas.

Community Nursing Home Oversight – Ensure that:
- The Community Nursing Home Oversight Committee includes representation by all required clinical disciplines.
- Social workers and registered nurses conduct and document cyclical clinical visits with the frequency required by Veterans Health Administration policy for community nursing home oversight.

Management of Disruptive/Violent Behavior – Ensure that:

- The facility implements an Employee Threat Assessment Team or an alternate group that addresses employee-related disruptive behavior and a disruptive behavior reporting and tracking system.
- The facility collects and analyzes data from disruptive or violent behavior incidents.
- Clinicians inform patients about Patient Record Flags and the right to request to amend/appeal flag placement.
- Clinicians review the continuing need for Patient Record Flags every 2 years and document the review.
- Appropriate individuals conduct debriefings after incidents of disruptive or violent behavior.
- 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.

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 39–48, for the full text of the Directors' comments.) We consider recommendations 1, 4, 5, 9, 10, 13, and 22 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 an evaluation of the quality of care delivered in the inpatient and outpatient settings of the facility.

Objectives

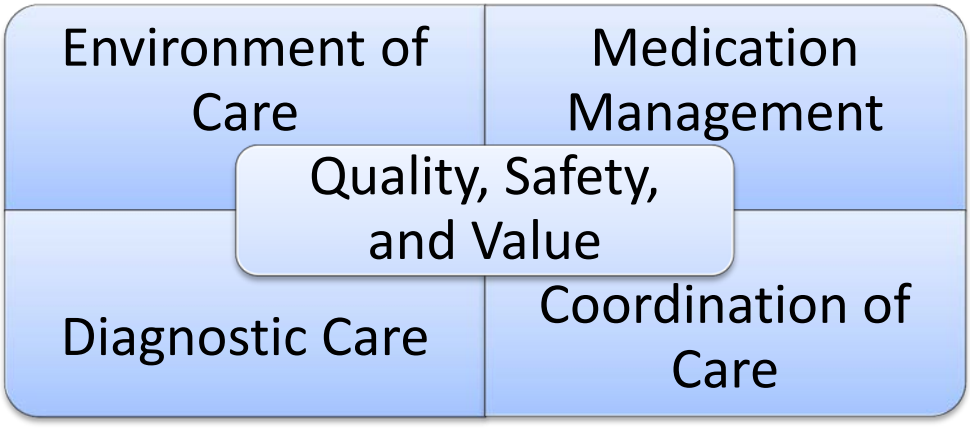
CAP reviews are one element of OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The reviews include cyclical evaluations of key clinical and administrative processes that affect patient care outcomes. Areas of focus include QSV, EOC, Medication Management,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

OIG also evaluates processes that are high risk and problem-prone—Moderate Sedation, CNH Oversight, and Management of Disruptive/Violent Behavior—and follows 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 (now the National Academy 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 who enter 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 (now the National Academy 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]

In a 2001 report entitled "Crossing the Quality Chasm: A New Health System for the 21st Century," the Institute of Medicine (now the National Academy of Medicine) noted that, "Because of the special vulnerability that accompanies illness or injury, coordination of care takes on special importance. Many patients depend on those who provide care to coordinate services—whether tests, consultations, or procedures—to ensure that accurate and timely information reaches those who need it at the appropriate time." Health care providers and organizations need to work together to coordinate their efforts to provide safe, quality care.[8]

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

Diagnostic Care

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

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

High-Risk and Problem-Prone Health Care Processes

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

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

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

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

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

Scope

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

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

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

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

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

We list the review criteria for each of the review areas in the topic checklists.

The review covered operations for FY 2015, FY 2016, and FY 2017 through December 5, 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 White River Junction VA Medical Center, White River Junction, Vermont,* Report No. 13-04240-60, February 6, 2014) and community based outpatient clinic report (*Community Based Outpatient Clinic and Primary Care Clinic Reviews at White River Junction VA Medical Center, White River Junction, Vermont,* Report No. 13-03421-49, January 22, 2014).

We presented crime awareness briefings for 154 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 256 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. Prior to our site visit, issues and concerns came to our attention and were resolved by the time of this CAP review.

Reported Accomplishments

Educational Expansion

Resident and fellow training has expanded at the facility due to the combined efforts of VA site directors and coordinators and close collaboration with university affiliates at Dartmouth-Hitchcock Medical Center and the University of Vermont Medical Center. The facility currently has 42 full-time employee equivalents with the two university affiliations, which has increased veteran access to care. New resident and fellow positons at the facility include cardiology, nephrology, otolaryngology, and orthopedics. The Burlington, VT, outpatient clinic has added resident and fellow positons for PC, psychiatry, sleep medicine, and dermatology. Adding these positions also allowed the

facility to successfully compete for $400,000 in supplemental educational funding. The funds helped redesign and renovate the learning and clinical space used by residents and fellows and provided them with dormitory space to ensure their availability to patients at clinical sites.

Rural Health Outreach

The facility invested in its ability to reach veterans throughout its highly rural catchment area to ensure delivery of high-quality services at the right time to meet veterans' needs. Interdisciplinary MH teams have been added to PC services in facility clinics throughout Vermont as well as western and northern New Hampshire. Combined with an open-access MH program, this initiative ensures same-day MH services for veterans when needed and services within 30 days for 99 percent of all other veterans. To further support the rural population, the facility successfully secured VHA Office of Rural Health grant funding to increase access to clinical pharmacy specialist providers. The grant also allowed expansion of the Medical Foster Home Program, the State Veterans Homes Telehealth Initiative, and home-based PC in rural areas.

Results and Recommendations

Quality, Safety, and Value

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

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

We interviewed senior managers and key QSV employees, and we evaluated meeting minutes, 25 licensed independent practitioners' profiles, 10 protected peer reviews, 5 root cause analyses, and other relevant documents. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement.

Checklist 1. QSV Areas Reviewed, Findings, and Recommendations

NM	Areas Reviewed	Findings	Recommendations
X	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.	For the timeframe June 1–November 30, 2016: • The Quality Management Board was not chaired or co-chaired by the Facility Director. • The Quality Management Board did not routinely review aggregated data to identify trends and take actions when necessary.	**1.** We recommended that the Quality Management Board is chaired or co-chaired by the Facility Director. **2.** We recommended that the Quality Management Board routinely review aggregated data.

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Credentialing and privileging processes met selected requirements: • Facility policy/by-laws specified a frequency for clinical managers to review practitioners' Ongoing Professional Practice Evaluation data. • Facility clinical managers reviewed Ongoing Professional Practice Evaluation data at the frequency specified in the policy/by-laws. • The facility set triggers for when a Focused Professional Practice Evaluation for cause would be indicated.	• Fourteen profiles did not contain evidence that clinical managers reviewed Ongoing Professional Practice Evaluation data every 6 months.	**3.** We recommended that facility clinical managers consistently review Ongoing Professional Practice Evaluation data every 6 months and that facility managers monitor compliance.
	Protected peer reviews met selected requirements: • Peer reviewers documented their use of important aspects of care in their review, such as appropriate and timely ordering of diagnostic tests, timely treatment, and appropriate documentation. • When the Peer Review Committee recommended individual improvement actions, clinical managers implemented the actions.		
X	Utilization management met selected requirements: • The facility completed at least 75 percent of all required inpatient reviews. • Physician Utilization Management Advisors documented their decisions in the National Utilization Management Integration database. • An interdisciplinary group reviewed utilization management data.	• For the timeframe October 1, 2015–September 30, 2016, the facility completed only 71 percent of all required reviews. • For the timeframe July 1, 2015–March 30, 2016, an interdisciplinary group did not review utilization management data.	**4.** We recommended that facility clinical managers ensure completion of at least 75 percent of all utilization management reviews and that facility managers monitor compliance. **5.** We recommended that facility clinical managers ensure an interdisciplinary group reviews utilization management data and that facility managers monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
X	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.	• During FY 2016, the facility only completed six root cause analyses.	**6.** We recommended that the Patient Safety Manager ensures completion of eight root cause analyses each fiscal year and that facility managers monitor compliance.
	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 women's health and two PC clinics; the intensive care, two medical/surgical, and the behavioral health inpatient units; the Emergency Department; SPS; and the community based outpatient clinic in Newport, VT. Additionally, we reviewed relevant documents and eight employee training records, and we 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		
	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 on the hemodialysis unit.		
NA	The facility met infection prevention requirements on the hemodialysis unit.		
NA	The facility met medication safety and security requirements on the hemodialysis unit.		
NA	The facility met privacy requirements on 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 FY 2016, more than 482,000 veterans received an anticoagulant. Anticoagulants (commonly called blood thinners) are a class of drugs that work to prevent the coagulation or clotting of blood. For this review, we evaluated warfarin (Coumadin®) and direct-acting oral anticoagulants. Clinicians use anticoagulants for both the treatment and prevention of cardiac disease, cerebrovascular accident (stroke), and thromboembolism[19] in both the inpatient and outpatient setting. Although these medications offer substantial benefits, their use or misuse carries a significant potential for patient harm. A dose less than the required amount for therapeutic effect can increase the risk of thromboembolic complications while a dose administered at levels greater than required for treatment can increase the risk of bleeding complications. The Joint Commission's National Patient Safety Goal 3.05.01 focuses on improving anticoagulation safety to reduce patient harm and states, "…anticoagulation medications are more likely than others to cause harm due to complex dosing, insufficient monitoring, and inconsistent patient compliance."

We reviewed relevant documents and the competency assessment records of five employees actively involved in the anticoagulant program, and we interviewed key employees. Additionally, we reviewed the EHRs of 37 randomly selected patients who were prescribed new anticoagulant medications from July 1, 2015 through June 30, 2016. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement.

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

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

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

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility provided patients with a direct telephone number for anticoagulation-related calls during normal business hours and defined a process for patient anticoagulation-related calls outside normal business hours.		
	The facility designated a physician as the anticoagulation program champion.		
	The facility defined ways to minimize the risk of incorrect tablet strength dosing errors.		
X	The facility routinely reviewed quality assurance data for the anticoagulation management program at the facility's required frequency at an appropriate committee.	• The facility did not collect quality assurance data for the Medication Use and Evaluation Committee to review annually as required by facility policy.	**7.** We recommended that the facility collect quality assurance data for the anticoagulation management program, that the Medication Use and Evaluation Committee annually review the data, and that facility managers monitor compliance.
	Clinicians provided transition follow-up for inpatients with newly prescribed anticoagulant medications and education specific to the new anticoagulant to both inpatients and outpatients.		
X	Clinicians obtained required laboratory tests: • Prior to initiating anticoagulant medications. • During anticoagulation treatment at the frequency required by local policy.	• In 5 of 22 EHRs, anticoagulation clinicians did not obtain all required laboratory tests prior to initiating warfarin treatment.	**8.** We recommended that facility managers ensure anticoagulation clinicians consistently obtain all required laboratory tests prior to initiating warfarin treatment.
	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 45 randomly selected patients who were transferred acutely out of facility inpatient beds or the Emergency Department/urgent care center to another VHA facility or non-VA facility from July 1, 2015 through June 30, 2016. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement.

Checklist 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.		
X	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	• Provider transfer documentation did not include: o Date of transfer in 28 of 44 applicable EHRs (64 percent) o Documentation of patient or surrogate informed consent in 15 of 44 applicable EHRs (34 percent) involving non-emergent transfers.	**9.** We recommended that for patients transferred out of the facility, providers consistently include date of transfer and patient or surrogate informed consent in transfer documentation and that facility managers monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
X	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	• In 15 of 32 applicable EHRs (47 percent), transfer notes written by acceptable designees did not document staff/attending physician approval. • In 17 of 32 applicable EHRs (53 percent), transfer notes written by acceptable designees did not contain the approving staff/attending physician countersignature.	**10.** We recommended that for inter-facility transfers, facility managers ensure acceptable designees document staff/attending physician approval as evidenced by the presence of the approving staff/attending physician countersignature and monitor compliance.
X	When the facility transferred patients out, sending nurses documented transfer assessments/notes.	• Five of the 45 EHRs (11 percent) did not contain sending nurses' transfer assessments/notes.	**11.** We recommended that for patients transferred out of the facility, sending nurses document transfer assessments/notes and that facility managers monitor compliance.
	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 prothrombin time.

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

We reviewed relevant documents, the EHRs of 50 randomly selected inpatients and outpatients who underwent POCT for blood glucose from July 1, 2015 through June 30, 2016, and the annual competency assessments of 42 clinicians who performed the glucose testing. 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 5. Diagnostic Care: POCT Areas Reviewed, Findings, and Recommendations

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

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

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

Moderate Sedation

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

We reviewed relevant documents; interviewed key employees; and inspected the gastroenterology, interventional radiology, intensive care unit, Emergency Department, and post-anesthesia care unit procedure rooms/areas to assess whether required equipment and sedation medications were available. Additionally, we reviewed the EHRs of 47 randomly selected outpatients who underwent an invasive procedure involving moderate sedation from 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 areas marked as NM did not meet applicable requirements and needed improvement.

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

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

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

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Providers performed history and physical examinations within 30 calendar days prior to the moderate sedation procedure, and the history and physical and the pre-sedation assessment in combination included required elements to ensure patients receive appropriate care.	• In 45 of 46 EHRs (98 percent), providers did not include one or more of the eight required elements in the history and physical and the pre-sedation assessment.	**12.** We recommended that providers include all the required elements in the history and physical and the pre-sedation assessment and that clinical managers monitor compliance.
	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.		
X	Post-procedure documentation included assessments of patient mental status and pain level.	• In 7 of the 47 EHRs (15 percent), the clinical team did not document post-procedure assessments of patient' pain levels.	**13.** We recommended that clinical employees document post-procedure assessments of patients' pain levels and that clinical managers monitor compliance.
	Clinical employees discharged outpatients from the recovery area with orders from the provider who performed the procedure or according to criteria approved by moderate sedation clinical leaders.		
X	Clinical employees discharged moderate sedation outpatients in the company of a responsible adult.	• In 10 of the 47 EHRs (21 percent), there was no evidence that clinical employees discharged moderate sedation outpatients in the company of a responsible adult.	**14.** We recommended that clinical employees discharge moderate sedation outpatients in the company of a responsible adult and that clinical managers monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Selected clinical employees had current training for moderate sedation.	• Four employees' training records did not contain evidence of current training for moderate sedation as required by VHA.	**15.** We recommended that clinical managers ensure that clinical employees who perform or assist with moderate sedation procedures have current training for the provision of moderate sedation care, that training is documented, and that clinical managers monitor compliance.
X	The clinical team kept monitoring and resuscitation equipment and reversal agents in the general areas where moderate sedation was administered.	• We did not find resuscitation equipment in one of five areas where moderate sedation was administered.	**16.** We recommended that clinical teams keep resuscitation equipment in moderate sedation procedure rooms/areas and that clinical managers monitor compliance.
	To minimize risk, clinical employees did not store anesthetic agents in procedure rooms/areas where only moderate sedation procedures were performed by licensed independent practitioners who do not have the training and ability to rescue a patient from general anesthesia.		

Community Nursing Home Oversight

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

We reviewed relevant documents, the EHRs of 37 randomly selected patients who received CNH care for more than 3 months during the timeframe July 1, 2015 through June 30, 2016, and the results from CNH annual reviews completed July 5, 2015 through June 30, 2016. Additionally, we interviewed key employees. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement.

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

NM	Areas Reviewed	Findings	Recommendations
X	The facility had a CNH Oversight Committee that met at least quarterly and included representation by the required disciplines.	• The facility's CNH Oversight Committee did not include a representative from quality management, acquisition, and the medical staff.	**17.** We recommended that facility managers ensure the Community Nursing Home Oversight Committee includes representation by all required clinical 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.		
	The CNH Review Team completed CNH annual reviews.		
	When CNH annual reviews noted four or more exclusionary criteria, facility managers completed exclusion review documentation.		

[23] 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.	• Twenty-three of the 32 applicable EHRs (72 percent) did not contain documentation of social worker and/or registered nurse cyclical clinical visits with the frequency required by VHA policy. One or more of these 23 patients resided in 12 of the 13 CNHs in our review.	**18.** 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 for community nursing home oversight and monitor compliance.

Management of Disruptive/Violent Behavior

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

We reviewed relevant documents, the EHRs of 14 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 areas marked as NM did not meet applicable requirements and needed improvement.

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

NM	Areas Reviewed	Findings	Recommendations
	The facility had a policy, procedure, or guideline on preventing and managing disruptive or violent behavior.		
	The facility conducted an annual Workplace Behavioral Risk Assessment.		
X	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 had not implemented an Employee Threat Assessment Team or acceptable alternate group or a disruptive behavior reporting and tracking system.	**19.** We recommended that the facility implement an Employee Threat Assessment Team or an alternate group that addresses employee-related disruptive behavior and a disruptive behavior reporting and tracking system.
X	The facility collected and analyzed disruptive or violent behavior incidents data.	• Although there were instances of disruptive and violent behavior, the facility did not collect or analyze data from these incidents in the effort to determine ways to provide a safer workplace and EOC.	**20.** We recommended that the facility collect and analyze data from disruptive or violent behavior incidents.

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility assessed physical security and included and tested equipment in accordance with the local physical security assessment.		
X	Clinical managers reviewed patients' disruptive or violent behavior and took appropriate actions, including: • Ensuring discussion by the Disruptive Behavior Committee/Board and entry of a progress note by a clinician committee/board member • Informing patients about Patient Record Flag placement and the right to request to amend/appeal the flag placement • Ensuring Chief of Staff or designee approval of an Order of Behavioral Restriction	• Neither of the two applicable EHRs contained evidence that clinicians informed the patients about the Patient Record Flags and the right to request to amend/appeal Patient Record Flag placement.	**21.** We recommended that facility clinical managers ensure clinicians inform patients about the Patient Record Flags and the right to request to amend/appeal Patient Record Flag placement.
X	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.	• In three of the five applicable EHRs, there was no evidence that clinicians reviewed the continuing need for Patient Record Flags within the past 2 years.	**22.** We recommended that facility clinical managers ensure clinicians review the continuing need for Patient Record Flags every 2 years and document the review.
X	The facility managed selected non-patient related disruptive or violent incidents appropriately according to VHA and local policy.	• For three incidents, there was no evidence that the facility conducted a debriefing.	**23.** We recommended that facility managers ensure appropriate individuals conduct debriefings after incidents of disruptive or violent behavior and monitor compliance.
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. • Six employee training records did not contain documentation of the training required for their assigned risk area within 90 days of hire.	**24.** 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.

Facility Profile

Table 1 below provides general background information for this facility.

Table 1. Facility Profile for White River Junction (405) for FY 2016

Profile Element	Facility Data
Veterans Integrated Service Network Number	1
Complexity Level	2-Medium complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$223.7
Number of:	
• **Unique Patients**	26,245
• **Outpatient Visits**	300,840
• **Unique Employees**[24]	1,047
Type and Number of Operating Beds:	
• **Acute**	50
• **MH**	10
• **Community Living Center**	NA
• **Domiciliary**	14
Average Daily Census:	
• **Acute**	30
• **MH**	7
• **Community Living Center**	NA
• **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.

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

VA Outpatient Clinic Profiles[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
Bennington, VT	405GA	1,524	399	Cardiology Dermatology Endocrinology Neurology Anesthesia ENT Podiatry Urology	EKG	Nutrition Pharmacy Weight Management
Brattleboro, VT	405GC	785	197	Cardiology Dermatology Endocrinology Neurology Anesthesia Podiatry Urology	NA	Nutrition Pharmacy Weight Management
Burlington, VT	405HA	4,256	917	Cardiology Dermatology Endocrinology Neurology Anesthesia Eye Podiatry Urology	EKG	Nutrition Pharmacy Weight Management
Littleton, NH	405HC	2,208	306	Cardiology Dermatology Endocrinology Neurology Anesthesia Podiatry Urology	EKG	Nutrition Pharmacy Weight Management

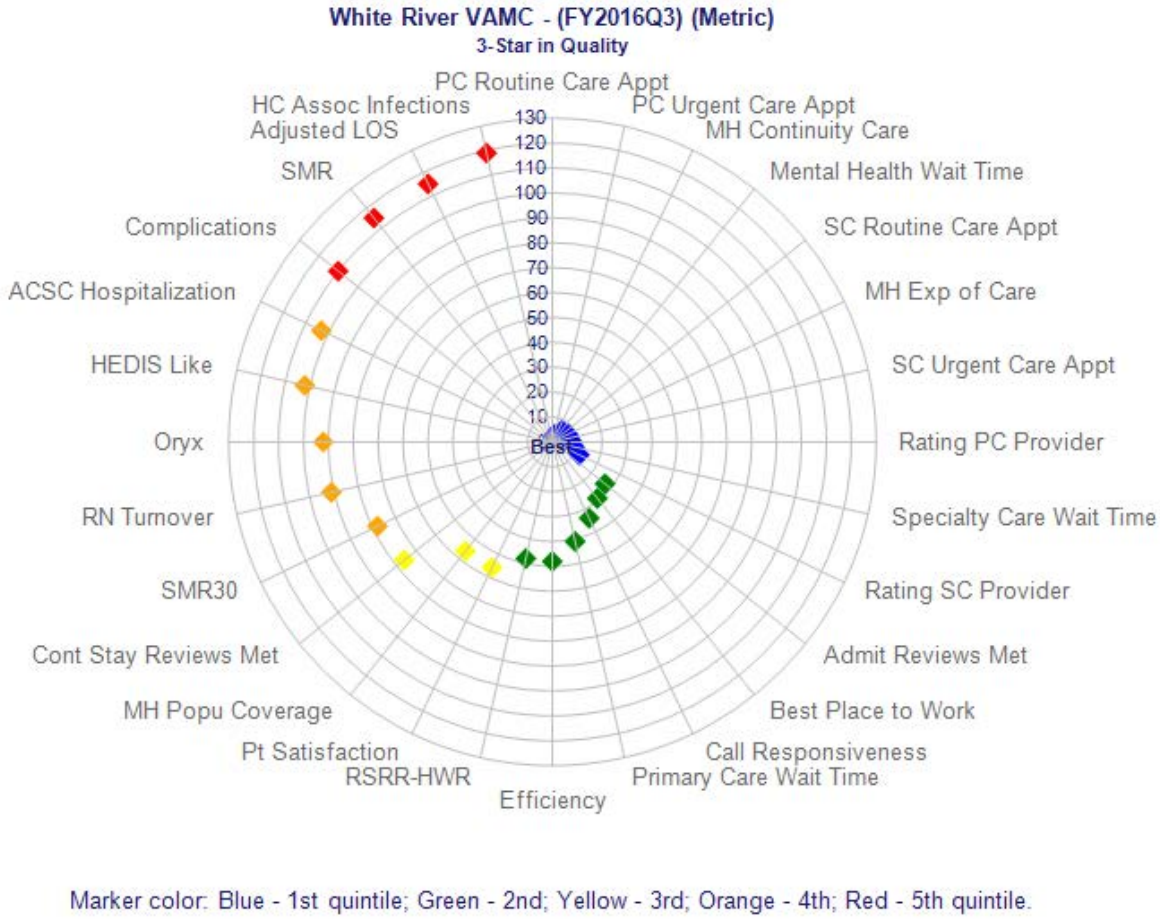
[25] Includes all outpatient clinics in the community that were in operation before February 15, 2016. We have omitted St. Johnsbury, VT (405QA) and Newport, VT (405QB), as no workload/encounters or services were reported.
[26] An encounter is a professional contact between a patient and a practitioner 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.

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Keene, NH	405HE	992	174	Cardiology Endocrinology Neurology Anesthesia Podiatry Urology	EKG	Nutrition Pharmacy Weight Management
Rutland, VT	405HF	1,589	370	Cardiology Dermatology Endocrinology Neurology Anesthesia Podiatry Urology	EKG	Nutrition Pharmacy Weight Management

Source: VHA Support Service Center and VA Corporate Data Warehouse

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

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

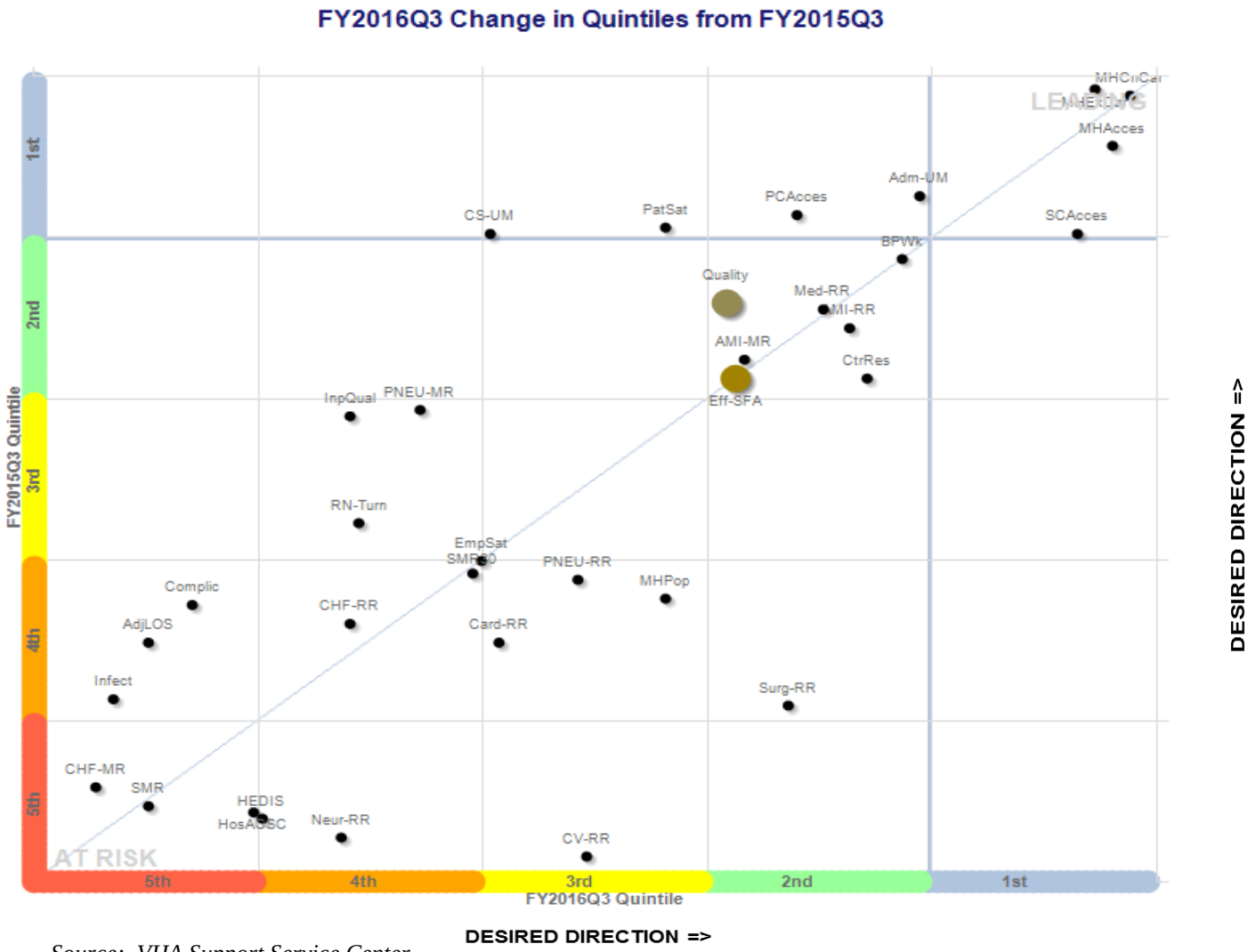


Source: VHA Support Service Center

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

[30] Metric definitions follow the graphs.

Scatter Chart



NOTE

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

Source: VHA Support Service Center

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

Metric Definitions[i]

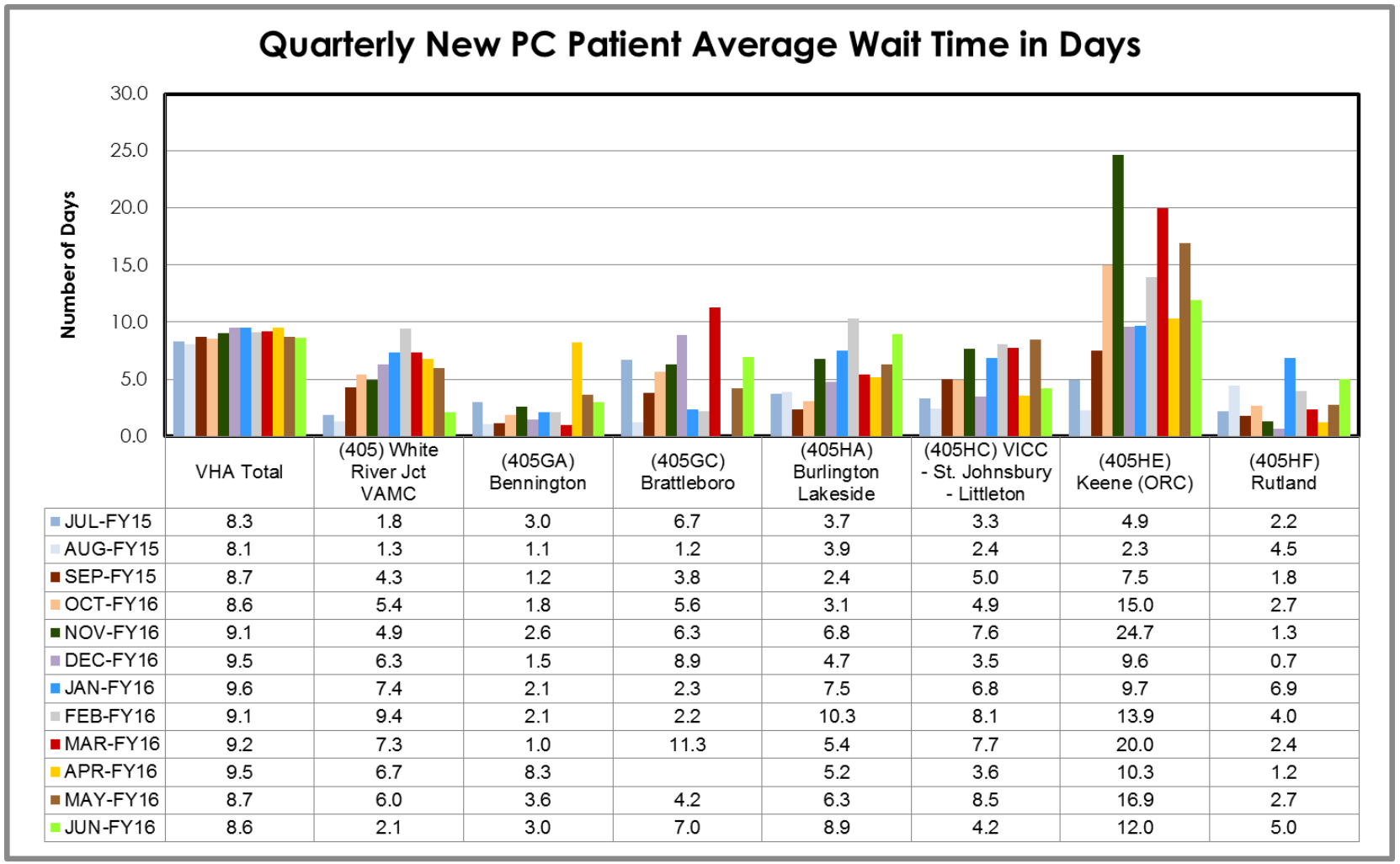
Measure	Definition	Desired Direction
ACSC Hospitalization	Ambulatory care sensitive condition hospitalizations (observed to expected ratio)	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Admit Reviews Met	%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

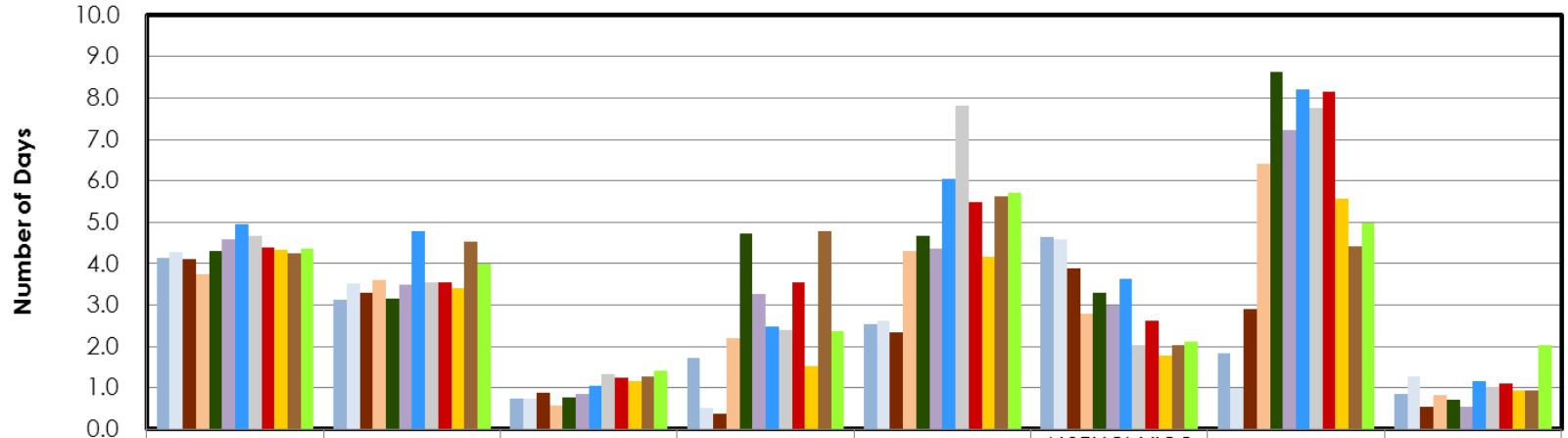


	VHA Total	(405) White River Jct VAMC	(405GA) Bennington	(405GC) Brattleboro	(405HA) Burlington Lakeside	(405HC) VICC - St. Johnsbury - Littleton	(405HE) Keene (ORC)	(405HF) Rutland
JUL-FY15	8.3	1.8	3.0	6.7	3.7	3.3	4.9	2.2
AUG-FY15	8.1	1.3	1.1	1.2	3.9	2.4	2.3	4.5
SEP-FY15	8.7	4.3	1.2	3.8	2.4	5.0	7.5	1.8
OCT-FY16	8.6	5.4	1.8	5.6	3.1	4.9	15.0	2.7
NOV-FY16	9.1	4.9	2.6	6.3	6.8	7.6	24.7	1.3
DEC-FY16	9.5	6.3	1.5	8.9	4.7	3.5	9.6	0.7
JAN-FY16	9.6	7.4	2.1	2.3	7.5	6.8	9.7	6.9
FEB-FY16	9.1	9.4	2.1	2.2	10.3	8.1	13.9	4.0
MAR-FY16	9.2	7.3	1.0	11.3	5.4	7.7	20.0	2.4
APR-FY16	9.5	6.7	8.3		5.2	3.6	10.3	1.2
MAY-FY16	8.7	6.0	3.6	4.2	6.3	8.5	16.9	2.7
JUN-FY16	8.6	2.1	3.0	7.0	8.9	4.2	12.0	5.0

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.* Blank cells indicate the absence of reported data.

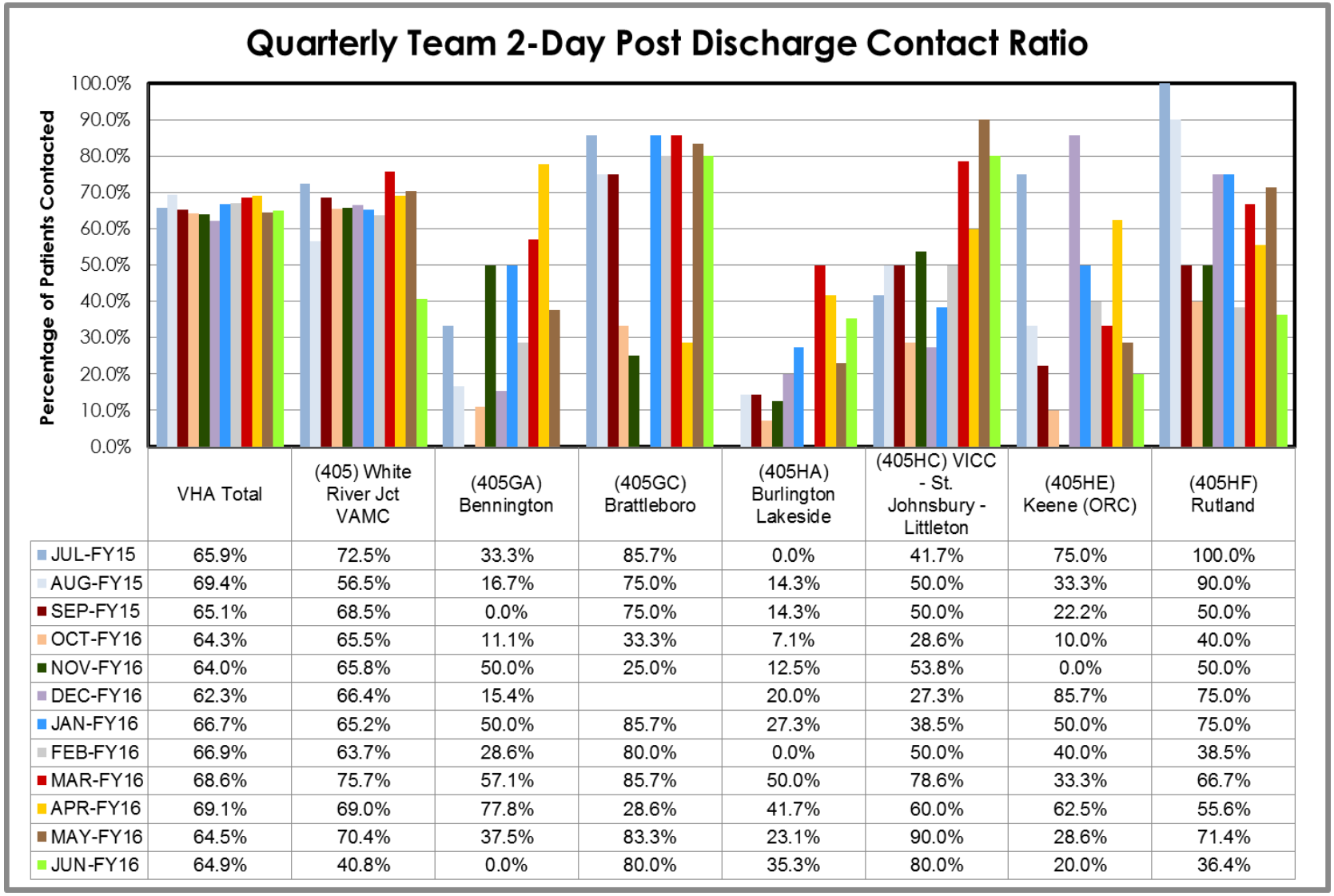


	VHA Total	(405) White River Jct VAMC	(405GA) Bennington	(405GC) Brattleboro	(405HA) Burlington Lakeside	(405HC) VICC - St. Johnsbury - Littleton	(405HE) Keene (ORC)	(405HF) Rutland
JUL-FY15	4.1	3.1	0.7	1.7	2.5	4.7	1.8	0.9
AUG-FY15	4.3	3.5	0.7	0.5	2.6	4.6	1.0	1.3
SEP-FY15	4.1	3.3	0.9	0.4	2.3	3.9	2.9	0.6
OCT-FY16	3.8	3.6	0.6	2.2	4.3	2.8	6.4	0.8
NOV-FY16	4.3	3.1	0.8	4.7	4.7	3.3	8.6	0.7
DEC-FY16	4.6	3.5	0.9	3.3	4.4	3.0	7.2	0.6
JAN-FY16	4.9	4.8	1.1	2.5	6.1	3.6	8.2	1.2
FEB-FY16	4.7	3.6	1.3	2.4	7.8	2.0	7.7	1.0
MAR-FY16	4.4	3.6	1.2	3.5	5.5	2.6	8.1	1.1
APR-FY16	4.3	3.4	1.2	1.5	4.2	1.8	5.6	0.9
MAY-FY16	4.3	4.5	1.3	4.8	5.6	2.0	4.4	0.9
JUN-FY16	4.4	4.0	1.4	2.4	5.7	2.1	5.0	2.0

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.

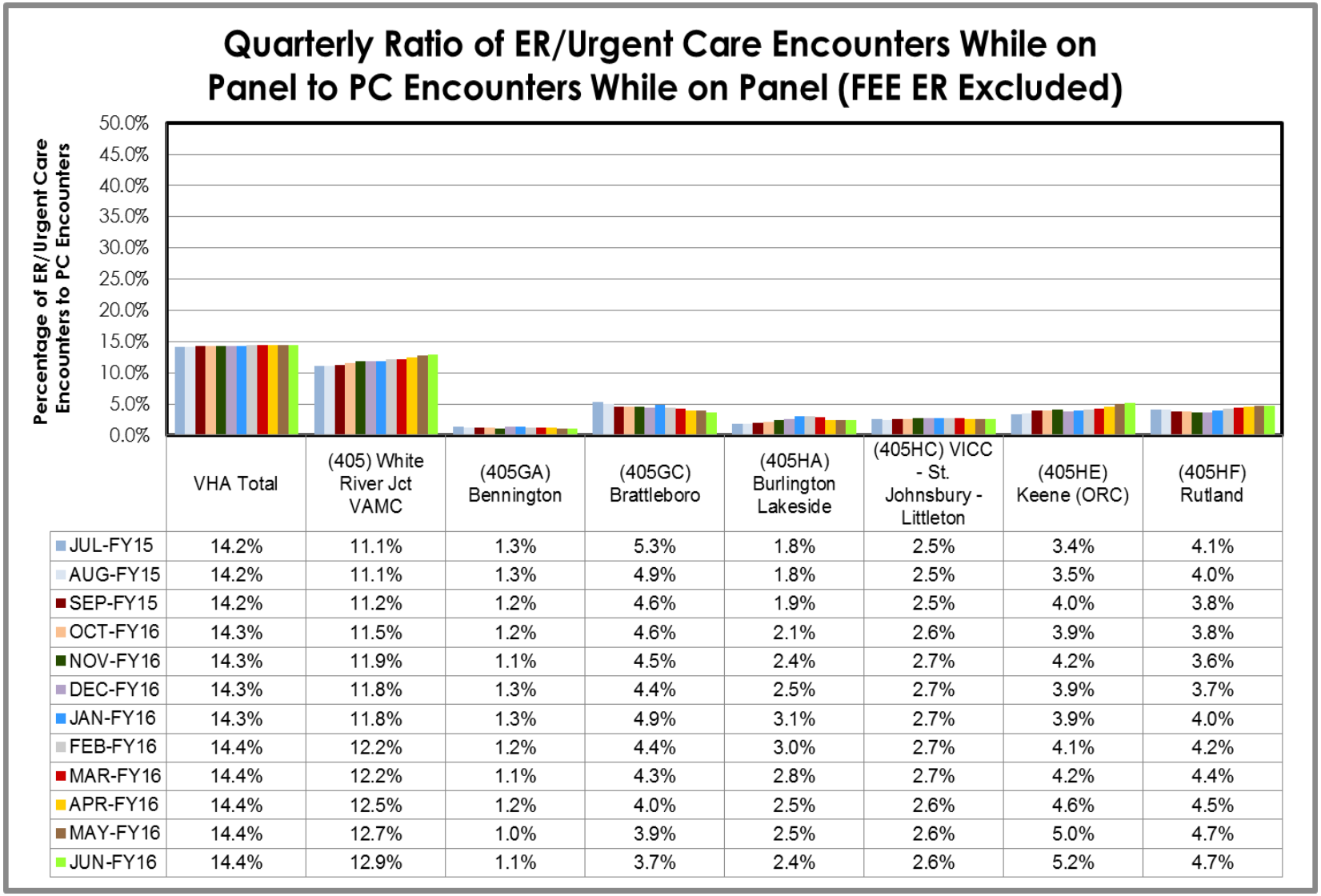


	VHA Total	(405) White River Jct VAMC	(405GA) Bennington	(405GC) Brattleboro	(405HA) Burlington Lakeside	(405HC) VICC - St. Johnsbury - Littleton	(405HE) Keene (ORC)	(405HF) Rutland
JUL-FY15	65.9%	72.5%	33.3%	85.7%	0.0%	41.7%	75.0%	100.0%
AUG-FY15	69.4%	56.5%	16.7%	75.0%	14.3%	50.0%	33.3%	90.0%
SEP-FY15	65.1%	68.5%	0.0%	75.0%	14.3%	50.0%	22.2%	50.0%
OCT-FY16	64.3%	65.5%	11.1%	33.3%	7.1%	28.6%	10.0%	40.0%
NOV-FY16	64.0%	65.8%	50.0%	25.0%	12.5%	53.8%	0.0%	50.0%
DEC-FY16	62.3%	66.4%	15.4%		20.0%	27.3%	85.7%	75.0%
JAN-FY16	66.7%	65.2%	50.0%	85.7%	27.3%	38.5%	50.0%	75.0%
FEB-FY16	66.9%	63.7%	28.6%	80.0%	0.0%	50.0%	40.0%	38.5%
MAR-FY16	68.6%	75.7%	57.1%	85.7%	50.0%	78.6%	33.3%	66.7%
APR-FY16	69.1%	69.0%	77.8%	28.6%	41.7%	60.0%	62.5%	55.6%
MAY-FY16	64.5%	70.4%	37.5%	83.3%	23.1%	90.0%	28.6%	71.4%
JUN-FY16	64.9%	40.8%	0.0%	80.0%	35.3%	80.0%	20.0%	36.4%

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. Blank cells indicate the absence of reported data.



	VHA Total	(405) White River Jct VAMC	(405GA) Bennington	(405GC) Brattleboro	(405HA) Burlington Lakeside	(405HC) VICC - St. Johnsbury - Littleton	(405HE) Keene (ORC)	(405HF) Rutland
JUL-FY15	14.2%	11.1%	1.3%	5.3%	1.8%	2.5%	3.4%	4.1%
AUG-FY15	14.2%	11.1%	1.3%	4.9%	1.8%	2.5%	3.5%	4.0%
SEP-FY15	14.2%	11.2%	1.2%	4.6%	1.9%	2.5%	4.0%	3.8%
OCT-FY16	14.3%	11.5%	1.2%	4.6%	2.1%	2.6%	3.9%	3.8%
NOV-FY16	14.3%	11.9%	1.1%	4.5%	2.4%	2.7%	4.2%	3.6%
DEC-FY16	14.3%	11.8%	1.3%	4.4%	2.5%	2.7%	3.9%	3.7%
JAN-FY16	14.3%	11.8%	1.3%	4.9%	3.1%	2.7%	3.9%	4.0%
FEB-FY16	14.4%	12.2%	1.2%	4.4%	3.0%	2.7%	4.1%	4.2%
MAR-FY16	14.4%	12.2%	1.1%	4.3%	2.8%	2.7%	4.2%	4.4%
APR-FY16	14.4%	12.5%	1.2%	4.0%	2.5%	2.6%	4.6%	4.5%
MAY-FY16	14.4%	12.7%	1.0%	3.9%	2.5%	2.6%	5.0%	4.7%
JUN-FY16	14.4%	12.9%	1.1%	3.7%	2.4%	2.6%	5.2%	4.7%

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
[December 1, 2013 through December 1, 2016]

Facility Reports

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

Appendix E

Veterans Integrated Service Network Director Comments

Department of Veterans Affairs

Memorandum

Date: April 21, 2017

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

Subject: **CAP Review of the White River Junction VA Medical Center, White River Junction, VT**

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

Director, Management Review Service (VHA 10E1D MRS Action)

I have reviewed and concur with the action plans regarding the Draft Report – Combined Assessment Program Review of the White River Junction VA Medical Center, White River Junction, Vermont (Draft Report) issued April 7, 2017.

Michael F. Mayo-Smith, MD, MPH
Director, VA New England Healthcare System (10N1)

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: April 24, 2017

From: Director, White River Junction VA Medical Center (405/00)

Subject: **CAP Review of the White River Junction VA Medical Center, White River Junction, VT**

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

Thank you for the opportunity to respond to the Office of Inspector General Combined Assessment Program Review of the White River Junction VA Medical Center.

I have reviewed and concur with the recommendations in this report. The facility has addressed all recommendations. Corrective action plans are submitted in the attached report.

Alfred A. Montoya, Jr., MHA, VHA-CM
Director, White River Junction VA Medical Center (405/00)

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that the Quality Management Board is chaired or co-chaired by the Facility Director.

Concur

Target date for completion: March 8, 2017

Facility response: White River Junction VAMC self-identified non-compliance during an internal self-assessment. Facility Director had been an active member of Quality Management Board and was named as Co-Chair of Quality Management Board effective October 2016. Updated Center Memorandum includes Facility Director as co-chair of Quality Management Board.

Recommendation 2. We recommended that the Quality Management Board routinely review aggregated data.

Concur

Target date for completion: July 31, 2017

Facility response: Effective December 2016, aggregated data review added as a standing agenda item to Quality Management Board [QMB] meeting minutes. Effective May 2017, a scorecard indicating topic, area, and frequency of aggregated data review will be added to QMB minutes to further demonstrate full and sustained compliance.

Recommendation 3. We recommended that facility clinical managers consistently review Ongoing Professional Practice Evaluation data every 6 months and that facility managers monitor compliance.

Concur

Target date for completion: December 31, 2017

Facility response: The Chief of Staff via Professional Standards Board (PSB) and Clinical Executive Board has approved a revised and expanded Ongoing Professional Practice Evaluation (OPPE) review form, which includes the required 6 month frequency. Service Line Chiefs/Managers are responsible for monitoring and maintaining OPPE review frequency which will be reported to Professional Standards Board monthly beginning June 2017. Quality Management will monitor compliance via Professional Standards Board.

Recommendation 4. We recommended that facility clinical managers ensure completion of at least 75 percent of all utilization management reviews and that facility managers monitor compliance.

Concur

Target date for completion: March 31, 2017

Facility response: White River Junction VAMC self-identified this area of non-compliance during an internal self-assessment. Facility Leadership and the Utilization Management (UM) team leaders identified areas for improvement and enhanced process for reviews. Staff education completed October, 2016. Two quarters UM reviews demonstrate 99% compliance, well above the targeted goal of 75%. Monitoring and sustainability of this process is achieved through weekly reporting to senior leadership at Clinical Friday report morning report.

Recommendation 5. We recommended that facility clinical managers ensure an interdisciplinary group reviews utilization management data and that facility managers monitor compliance.

Concur

Target date for completion: January 31, 2017

Facility response: Facility Leadership conducted a process improvement project focused on National Utilization Management Integration (NUMI). Specifically we expanded and strengthened the Interdisciplinary Rounds process. Membership of committee has been revised to include a comprehensive interdisciplinary membership, including an executive team member. Ongoing compliance is monitored with quarterly reporting through the Clinical Executive Board.

Recommendation 6. We recommended that the Patient Safety Manager ensures completion of eight root cause analyses each fiscal year and that facility managers monitor compliance.

Concur

Target date for completion: June 30, 2017

Facility response: To date in FY 2017, Patient Safety Manager has completed 6 of required 8 root cause analyses (RCA). Two additional root cause analyses are in process and on track for completion by June 30, 2017. Patient Safety Manager reports status of root cause analyses completion rate at Quality Management Board via root cause analyses tracking form in the Quarterly Patient Safety Report.

Recommendation 7. We recommended that the facility collect quality assurance data for the anticoagulation management program, that the Medication Use and Evaluation Committee annually review the data, and that facility managers monitor compliance.

Concur

Target date for completion: July 31, 2017

Facility response: The anticoagulation clinic manager will now report regularly on "Thrombotic and embolic complications" and "Incident, error and close calls," meeting all quality assurance data required.

All required quality assurance data will be included in the anticoagulation report beginning July, 2017 and annually thereafter.

Recommendation 8. We recommended that facility managers ensure anticoagulation clinicians consistently obtain all required laboratory tests prior to initiating warfarin treatment.

Concur

Target date for completion: December 31, 2017

Facility response: The VISN 1 Anticoagulation group clarified that the Algorithm for Initiation of Warfarin should state that a baseline INR should be obtained within 7 days of the initial warfarin order. This change was effective 2/10/2017.

The anticoagulation program implemented these requirements and Medication Use Committee is responsible for communicating with all WRJ ordering prescribers.

Upon receipt of an initial anticoagulant order pharmacy service will review the medical record for required baseline lab test results prior to verifying and/or dispensing the first dose of anticoagulant. If appropriate lab test results are not available the pharmacist will contact the prescriber and document the action in the medical record. The anticoagulant order will not be verified or dispensed by Pharmacy service until the necessary lab test results are available for review. Monitoring for compliance and sustainability of these measures will occur monthly and reported to the Medication Use and Evaluation Committee on a quarterly basis for 2 quarters, beginning July, 2017 and then annually via the Anticoagulation yearly report.

Recommendation 9. We recommended that for patients transferred out of the facility, providers consistently include date of transfer and patient or surrogate informed consent in transfer documentation and that facility managers monitor compliance.

Concur

Target date for completion: January 31, 2017

Facility response: Improved note template placed in Computerized Patient Record System (CPRS) 01/13/2017 and practitioner education completed 01/31/2017. The inter-facility Physician Transfer Form template now forces documentation in these areas:

1. "the date of this transfer is _____."
2. "Patient consent to transfer completed in iMed and signed _____."

Recommendation 10. We recommended that for inter-facility transfers, facility managers ensure acceptable designees document staff/attending physician approval as evidenced by the presence of the approving staff/attending physician countersignature and monitor compliance.

Concur

Target date for completion: January 31, 2017

Facility response: An improved note template placed in CPRS 01/13/2017, Practitioner education completed 1/31/17. The Inter-facility Physician Transfer Form note template now includes a statement that "the attending physician has been contacted and approves of this transfer." Additionally, this improved note will force co-signature by the attending physician when it is written by an intern, resident or any clinician with limited privileges.

Recommendation 11. We recommended that for patients transferred out of the facility, sending nurses document transfer assessments/notes and that facility managers monitor compliance.

Concur

Target date for completion: December 31, 2017

Facility response: Education to staff provided January 2017. Early chart reviews indicate improvement in process and revealed further areas for development. Additional interventions implemented April, 2017, and chart audits for full compliance will continue monthly and be reported quarterly to Nurse Executive Board beginning June 2017 and continue for two quarters to monitor compliance.

Recommendation 12. We recommended that providers include all the required elements in the history and physical and the pre-sedation assessment and that clinical managers monitor compliance.

Concur

Target date for completion: November 30, 2017

Facility response: The pre-sedation assessment templates are being revised to include all necessary and required History and Physical elements. Clinicians with moderate

sedation privileges will receive education on the updated templates. Compliance with History and Physical documentation will be monitored beginning June, 2017 and reported quarterly to Operative and Invasive Committee and to Quality Management for two quarters to demonstrate sustainably of improvement process.

Recommendation 13. We recommended that clinical employees document post-procedure assessments of patients' pain levels and that clinical managers monitor compliance.

Concur

Target date for completion: March 31, 2017

Facility response: Improved/revised documentation form adopted and staff education provided. Managers performing monthly chart review audits to monitor for sustained improvement, reporting monthly to the Associate Chief of Nursing, for review with Quality management.

Recommendation 14. We recommended that clinical employees discharge moderate sedation outpatients in the company of a responsible adult and that clinical managers monitor compliance.

Concur

Target date for completion: December 31, 2017

Facility response: We have created a multi-disciplinary team to review the data to identify causes and barriers for Veterans who are not able to be discharged home in the company of a responsible adult post moderate sedation procedure. We are working to create robust process where the facility will confirm and verify the availably of a responsible accompanying adult at the time of scheduling and also reconfirm at the pre-procedure call to patient. Compliance and sustainability will be monitored monthly beginning July, 2017 and reported to Quality Management Board quarterly beginning fiscal year 2018.

Recommendation 15. We recommended that clinical managers ensure that clinical employees who perform or assist with moderate sedation procedures have current training for the provision of moderate sedation care, that training is documented, and that clinical managers monitor compliance.

Concur

Target date for completion: December 31, 2017

Facility response: Service Line Chiefs with clinicians who perform procedures under moderate sedation in collaboration with the Chief of Education have identified a process improvement which will allow timely assignment of appropriate education modules in coordination with Credentialing and Privileging team. This will ensure that all providers

performing moderate sedation have completed required TMS modules 90 days prior to recredentialing for specific clinical privileges, per VHA Directive. Monitoring for sustained compliance will begin monthly, effective July 2017 and reported quarterly to the Operative and Invasive committee for two quarters to demonstrate sustained compliance.

Recommendation 16. We recommended that clinical teams keep resuscitation equipment in moderate sedation procedure rooms/areas and that clinical managers monitor compliance.

Concur

Target date for completion: June 30, 2017

Facility response: Center Memorandum "Management of Medical Emergencies" (CM 002-17-11) revised February 2017, to include the addition of code cart in Gastroenterology (GI) suite. Code cart requested via Equipment Committee and approved. Purchase and installation of code cart in the GI suite will be completed by June 30, 2017.

Recommendation 17. We recommended that facility managers ensure the Community Nursing Home Oversight Committee includes representation by all required clinical disciplines.

Concur

Target date for completion: August 31, 2017

Facility response: All required clinical disciplines added to essential membership of Community Nursing Home (CNH) Oversight Committee, effective February, 2017. Monitoring for compliance will be quarterly through CNH Oversight Committee meeting minutes through August 31, 2017.

Recommendation 18. 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 for community nursing home oversight and monitor compliance.

Concur

Target date for completion: October 31, 2017

Facility response: Cyclic visits to all Community Nursing homes will be improved to include rotating visits between Social work and Nursing disciplines effective May 1, 2017. Monitoring for compliance will be monthly and reported quarterly through Community Nursing Home oversight committee meeting minutes and up to the Quality Management Board through October, 2017.

Recommendation 19. We recommended that the facility implement an Employee Threat Assessment Team or an alternate group that addresses employee-related disruptive behavior and a disruptive behavior reporting and tracking system.

Concur

Target date for completion: September 30, 2017

Facility response: Effective May 2017 Disruptive Behavior Committee (DBC) will formally identify and implement an Employee Threat Assessment Team (ETAT), per VHA Directive. The Education service will provide Facility wide education on use of the newly implemented Disruptive Behavior Reporting System (DBRS) system to begin June 2017, and continue through September 2017.

Recommendation 20. We recommended that the facility collect and analyze data from disruptive or violent behavior incidents.

Concur

Target date for completion: March 30, 2018

Facility response: Data from the Disruptive Behavior Reporting System (DBRS) will be collected monthly beginning August, 2017 and analyzed quarterly at DBC beginning October, 2017. Analysis will include identification of topics, trends, and outliers with the goal to improve workplace safety. Analysis of data will be reported up through Clinical Executive Board quarterly beginning October, 2017 and continue for 2 quarters to demonstrate sustainability.

Recommendation 21. We recommended that facility clinical managers ensure clinicians inform patients about the Patient Record Flags and the right to request to amend/appeal Patient Record Flag placement.

Concur

Target date for completion: May 30, 2017

Facility response: Effective May 30, 2017, The Disruptive Behavior Committee (DBC) will adopt an improved letter format to notify patients of Behavioral record flag which will include all required elements per VHA Directive.

Recommendation 22. We recommended that facility clinical managers ensure clinicians review the continuing need for Patient Record Flags every 2 years and document the review.

Concur

Target date for completion: March 20, 2017

Facility response: White River Junction VAMC self-identified non-compliance during an internal self-assessment. Effective October 2016, The Management of Disruptive Behavior committee has maintained a spreadsheet of all active patient record flags with date for reviews. This is evaluated monthly as standing agenda item "review of patient flags." Robust sustainability of this process has been demonstrated with 6 months of meeting minutes.

Recommendation 23. We recommended that facility managers ensure appropriate individuals conduct debriefings after incidents of disruptive or violent behavior and monitor compliance.

Concur

Target date for completion: December 31, 2017

Facility response: The facility managers, in coordination with the Disruptive Behavior Committee will conduct timely de-briefings with impacted staff and other appropriate individuals after reported disruptive behavior incidents and 'Code Green' events. This will be reported quarterly to Clinical Executive Board beginning July 2017 and for two quarters to monitor compliance.

Recommendation 24. 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 30, 2018

Facility response: Higher levels of appropriate PMBD level trainings have been assigned in Talent Management System. The Prevention and Management of Disruptive Behavior Coordinator will schedule and arrange appropriate training for employees to occur in coordination with New Employee Orientation. PMBD coordinator has created a training completion and deficiency report, and monitoring will begin June 2017. Tracking and reporting will continue monthly and be reported quarterly to Clinical Executive Board for beginning October, 2017 for 2 quarters to display sustainment of improvement process.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact OIG at (202) 461-4720.
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U.S. House of Representatives: Ann McLane Kuster, Carol Shea-Porter, Peter Welch

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

Endnotes

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

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

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

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

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

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

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

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

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

[i] The reference used for 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: July 28, 2016.