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Clinical Assessment Program Review of the Southeast Louisiana Veterans Health Care System New Orleans, Louisiana

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Glossary

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

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Executive Summary

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

Results: We conducted the review during the week of March 6, 2017, and identified certain system weaknesses in the Quality, Safety, and Value Committee; credentialing and privileging; protected peer review; patient safety; environmental cleanliness; anticoagulation processes and employee competency assessments; community nursing home clinical visits; the disruptive behavior program; documentation of mammogram orders; and tetanus vaccination screening and documentation.

Review Impact: As a result of the findings, we could not gain reasonable assurance that the Southeast Louisiana Veterans Health Care System:

1. Has effective leadership and oversight for the review of data, information, and risk intelligence and integration of quality, safety, and value on a regular basis
2. Reviews Ongoing Professional Practice Evaluation data as required
3. Implements improvement actions recommended by the Peer Review Committee
4. Records patient incidents into the required database for tracking and trending
5. Provides feedback about root cause analysis findings to appropriate parties
6. Maintains clean floors and carpets in the pain clinic, outpatient mental health clinic, and Baton Rouge Outpatient Clinic
7. Has a comprehensive anticoagulation therapy management program
8. Provides effective oversight of veterans in the community nursing home program through cyclical visits
9. Effectively manages disruptive/violent behavior incidents
10. Documents orders for all mammograms in patients' electronic health records
11. Consistently screens patients for tetanus vaccinations and documents all required elements for administered vaccines

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

Quality, Safety, and Value – Ensure that:

- The Quality, Safety, and Value Committee is consistently chaired or co-chaired by the Facility Director.
- Facility clinical managers consistently review Ongoing Professional Practice Evaluation data every 6 months and consistently implement individual improvement actions recommended by the Peer Review Committee.
- The Patient Safety Manager consistently enters all reported patient incidents into the WEBSPOT database and consistently provides feedback about root cause analysis findings to the individual or department who reported the incident.

Environment of Care – Ensure that:

- Carpets and tile floors in patient care areas are clean.

Medication Management: Anticoagulation Therapy – Ensure that:

- Clinicians consistently provide specific education to patients with newly prescribed anticoagulant medications and consistently obtain all required laboratory tests prior to initiating anticoagulants.
- Patients newly prescribed warfarin have an international normalized ratio measurement taken within 7 days of warfarin initiation.
- For employees actively involved in the anticoagulant program, clinical managers include in competency assessments drug-to-drug interactions associated with anticoagulation therapy.

Community Nursing Home Oversight – Ensure that:

- 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 Committee/Board.
- Clinicians inform patients about the 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.
- All employees receive Level 1 Prevention and Management of Disruptive Behavior training and additional training as required for their assigned risk area within 90 days of hire and that the training is documented in employee training records.

We also made the following repeat recommendations from the previous Combined Assessment Program review.

Women's Health – Ensure that:

- Clinicians enter orders for mammograms in the Computerized Patient Record System.

Medication Management – Ensure that:

- Clinicians screen patients for tetanus vaccinations at clinic visits and document all required vaccine administration elements.

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 41–49, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

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Purpose and Objectives

Purpose

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

Objectives

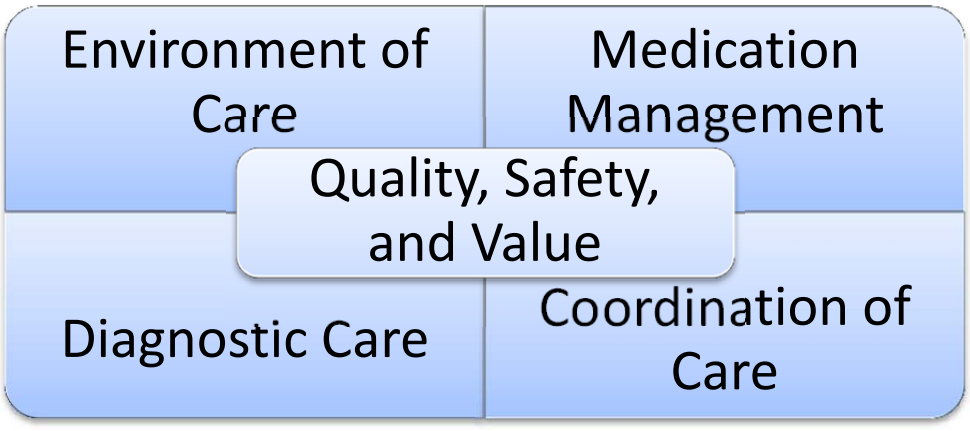
CAP reviews are one element of OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The reviews include cyclical evaluations of key clinical and administrative processes that affect patient care outcomes. Areas of focus include QSV, EOC, Medication Management, 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 oversight 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 March 6, 2017, 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 Southeast Louisiana Veterans Health Care System, New Orleans, Louisiana,* Report No. 13-04242-61, February 11, 2014) and community based outpatient clinic report (*Community Based Outpatient Clinic and Primary Care Clinic Reviews at Southeast Louisiana Veterans Health Care System, New Orleans, Louisiana*, Report No. 13-03423-55, February 4, 2014). We made repeat recommendations in Women's Health and Medication Management. (See pages 27–28.)

We presented crime awareness briefings for 81 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 285 responses. We shared summarized results with facility managers.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough for OIG to monitor until the facility implements corrective actions. Issues and concerns outside the scope of the CAP review came to our attention and were referred for further review.

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. Any items that did not apply to this facility are marked NA.

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.	• The Quality, Safety, and Value Committee was not consistently chaired or co-chaired by the Facility Director.	**1.** We recommended that the Quality, Safety, and Value Committee be consistently chaired or co-chaired by the Facility Director.

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.	• Nine profiles did not contain evidence that clinical managers reviewed Ongoing Professional Practice Evaluation data every 6 months.	**2.** We recommended that facility clinical managers consistently review Ongoing Professional Practice Evaluation data every 6 months and that facility managers monitor compliance.
X	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.	• In four cases, there was no evidence that clinical managers implemented individual improvement actions recommended by the Peer Review Committee.	**3.** We recommended that facility clinical managers consistently implement individual improvement actions recommended by the Peer Review Committee and that facility managers monitor compliance.
NA	Utilization management met selected requirements: • The facility completed at least 75 percent of all required inpatient reviews. • Physician Utilization Management Advisors documented their decisions in the National Utilization Management Integration database. • An interdisciplinary group reviewed utilization management data.		

NM	Areas Reviewed (continued)	Findings	Recommendations
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.	• The Patient Safety Manager did not enter 276 patient incidents reported in FY 2016 into the WEBSPOT database. • For four of five applicable root cause analyses, the Patient Safety Manager did not provide feedback about the findings to the individual or department who reported the incident.	**4.** We recommended that the Patient Safety Manager consistently enter all reported patient incidents into the WEBSPOT database and that facility managers monitor compliance. **5.** We recommended that the Patient Safety Manager consistently provide feedback about root cause analysis findings to the individual or department who reported the incident 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 two outpatient PC clinics, two outpatient MH clinics, the dental clinic, the urgent care center, the pain clinic, the women's clinic, SPS, and the Baton Rouge Outpatient Clinic. Additionally, we reviewed relevant documents and 10 SPS employee training records, and we interviewed key employees and managers. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

Checklist 2. EOC Areas Reviewed, Findings, and Recommendations

NM	Areas Reviewed for General EOC	Findings	Recommendations
	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.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
	Infection Prevention/Control Committee minutes documented discussion of identified high-risk areas, actions implemented to address those areas, and follow-up on implemented actions and included analysis of surveillance activities and data.		
	The facility had established a procedure for cleaning equipment between patients.		
	The facility conducted required fire drills in buildings designated for health care occupancy and documented drill critiques.		
	The facility had a policy/procedure/guideline for identification of individuals entering the facility, and units/areas complied with requirements.		
	The facility met general safety requirements.		
X	The facility met environmental cleanliness requirements.	• In three of nine patient care areas, the carpet and tile floors were dirty.	**6.** We recommended that facility managers ensure carpets and tile floors in patient care areas are clean and monitor compliance.
	Areas Reviewed for SPS		
	The facility had a policy for cleaning, disinfecting, and sterilizing RME.		
	The facility's standard operating procedures for selected RME were current and consistent with the manufacturers' instructions for use.		
	The facility performed quality control testing on selected RME with the frequency required by local policy and took appropriate action on positive results.		

NM	Areas Reviewed for SPS (continued)	Findings	Recommendations
	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.		
	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 three employees actively involved in the anticoagulant program, and we interviewed key employees. Additionally, we reviewed the EHRs of 25 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.		
	The facility routinely reviewed quality assurance data for the anticoagulation management program at the facility's required frequency at an appropriate committee.		
X	For patients with newly prescribed anticoagulant medications, clinicians provided transition follow-up and education specific to the new anticoagulant.	• Five of 17 EHRs did not contain evidence that patients received education specific to the newly prescribed anticoagulant.	**7.** We recommended that clinicians consistently provide specific education to patients with newly prescribed anticoagulant medications and that facility managers monitor compliance.
X	Clinicians obtained required laboratory tests: • Prior to initiating anticoagulant medications. • During anticoagulation treatment at the frequency required by local policy.	• In 6 of 17 EHRs, clinicians did not obtain all required laboratory tests prior to initiating warfarin treatment. • Four of 17 EHRs did not contain documentation that patients had an international normalized ratio measurement taken within 7 days of warfarin initiation.	**8.** We recommended that facility managers ensure clinicians consistently obtain all required laboratory tests prior to initiating anticoagulant medications. **9.** We recommended that clinicians ensure patients newly prescribed warfarin have an international normalized ratio measurement taken within 7 days of warfarin initiation and that facility managers monitor compliance.
	When laboratory values did not meet selected criteria, clinicians documented a justification/rationale for prescribing the anticoagulant.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	The facility required competency assessments for employees actively involved in the anticoagulant program, and clinical managers completed competency assessments that included required content at the frequency required by local policy.	• For all three employees actively involved in the anticoagulant program, competency assessments did not include drug-to-drug interactions associated with anticoagulation therapy.	**10.** We recommended that for employees actively involved in the anticoagulant program, clinical managers include in competency assessments drug-to-drug interactions associated with anticoagulation therapy and that facility managers monitor compliance.

Coordination of Care: Inter-Facility Transfers

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

We reviewed relevant documents and interviewed key employees. Additionally, we reviewed the EHRs of 48 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 facility generally met requirements. We made no recommendations.

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

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

NM	Areas Reviewed (continued)	Findings	Recommendations
	When staff/attending physicians did not write transfer notes, acceptable designees: • Obtained and documented staff/attending physician approval • Obtained staff/attending physician countersignature on the transfer note		
	When the facility transferred patients out, sending nurses documented transfer assessments/notes.		
	In emergent transfers, providers documented: • Patient stability for transfer • Provision of all medical care within the facility's capacity		
	Communication with the accepting facility or documentation sent included: • Available history • Observations, signs, symptoms, and preliminary diagnoses • Results of diagnostic studies and tests		

Diagnostic Care: Point-of-Care Testing

The purpose of this review was to evaluate the facility's glucometer POCT program compliance with applicable laboratory regulatory standards and quality testing practices as required by VHA, the College of American Pathologists, and The Joint Commission.[e] The majority of laboratory testing is performed in the main laboratory. However, with newer technologies, testing has emerged from the laboratory to the patient's bedside, the patient's home, and other non-laboratory sites. This is called POCT (also known as ancillary or waived testing) and can include tests for blood glucose, fecal occult blood, hemoglobin, and 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 35 clinicians who performed the glucose testing. Additionally, we interviewed key employees and conducted onsite glucometer inspections of the urgent care center, two PC clinics, the pain clinic, and the Baton Rouge Outpatient Clinic to assess compliance with manufacturers' maintenance and solution/reagent storage requirements. The table below shows the areas reviewed for this topic. The facility generally met requirements. We made no recommendations.

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

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

[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 Chief of Pathology and Laboratory Medicine Service approved all tests performed outside the main laboratory.		
	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 procedure rooms/areas to assess whether required equipment and sedation medications were available. Additionally, we reviewed the EHRs of 43 randomly selected patients who underwent an invasive procedure involving moderate sedation from July 1, 2015 through June 30, 2016, and the training records of nine clinical employees who performed or assisted during these procedures. The table below shows the areas reviewed for this topic. The facility generally met requirements. We made no recommendations.

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

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

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

NM	Areas Reviewed (continued)	Findings	Recommendations
	Providers performed history and physical examinations within 30 calendar days prior to the moderate sedation procedure, and the history and physical and the pre-sedation assessment in combination included required elements.		
	Providers re-evaluated patients immediately before moderate sedation for changes since the prior assessment.		
	Providers documented informed consent prior to moderate sedation procedures, and the name of provider listed on the consent was the same as the provider who performed the procedure, or the patient was notified of the change.		
	The clinical team, including the provider performing the procedure, conducted and documented a timeout prior to the moderate sedation procedure.		
	Post-procedure documentation included assessments of patient mental status and pain level.		
	Clinical employees discharged outpatients from the recovery area with orders from the provider who performed the procedure or according to criteria approved by moderate sedation clinical leaders.		
	Clinical employees discharged moderate sedation outpatients in the company of a responsible adult.		
	Selected clinical employees had current training for moderate sedation.		

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

Community Nursing Home Oversight

The purpose of this review was to assess whether the facility complied with applicable requirements regarding the monitoring of veterans in contracted CNHs.[g] 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 40 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 area 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
	The facility had a CNH Oversight Committee that met at least quarterly and included representation by the required disciplines.		
	The facility integrated the CNH Program into its quality improvement program.		
	The facility documented a hand-off for patients placed in CNHs outside of its catchment area.		
	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.	• Thirteen of the 40 EHRs (33 percent) did not contain documentation of social worker and registered nurse cyclical clinical visits with the frequency required by VHA policy. The affected patients resided in five CNHs as detailed below. o One resided in Chateau D'Ville House and Rehab in Donaldsville, LA. o One resided in Forest Manor Nursing Home in Covington, LA. o Four resided in Jefferson Manor Nursing Home in Baton Rouge, LA. o Two resided in the John Hainkel Rehab and Nursing Home in New Orleans, LA. o Five resided in the Northridge Care Center in Baker, LA.	**11.** 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 13 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 30 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 and had not implemented a Disruptive Behavior Committee/Board.	**12.** 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 Committee/Board.
	The facility collected and analyzed disruptive or violent behavior incidents data.		
	The facility assessed physical security and included and tested equipment in accordance with the local physical security assessment.		

NM	Areas Reviewed (continued)	Findings	Recommendations
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	• In two of the three applicable EHRs, there was no evidence that clinicians informed the patients about the Patient Record Flags and/or the right to request to amend/appeal Patient Record Flag placement.	**13.** 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 two of the three applicable EHRs, there was no evidence that clinicians reviewed the continuing need for Patient Record Flags within the past 2 years.	**14.** We recommended that facility clinical managers ensure clinicians review the continuing need for Patient Record Flags every 2 years and document the review.
	The facility managed selected non-patient related disruptive or violent incidents appropriately according to VHA and local policy.		
X	The facility had a security training plan for employees at all risk levels. • All employees received Level 1 training within 90 days of hire. • All employees received additional training as required for the assigned risk area within 90 days of hire.	• Twelve employee training records (40 percent) did not contain documentation of Level 1 training within 90 days of hire. • Seventeen of the 20 applicable employee training records did not contain documentation of the training required for their assigned risk area within 90 days of hire.	**15.** We recommended that facility managers ensure all employees receive Level 1 Prevention and Management of Disruptive Behavior training and additional training as required for their assigned risk area within 90 days of hire and that the training is documented in employee training records.

Review Activities with Previous Combined Assessment Program Review Recommendations

As a follow-up to recommendations from our prior Combined Assessment Program review, we reassessed facility compliance with orders for mammograms and tetanus vaccination screening and documentation.

Women's Health

Mammogram Orders. VHA requires that requests for screening and diagnostic mammograms must be initiated via a Computerized Patient Record System radiology order or Veterans Information Systems and Technology Architecture Radiology package order.[i] This order must be entered regardless of where the veteran will obtain the mammogram—onsite or via contract or non-VA care. Orders through VA Care in the Community, including non-VA care or Choice, must be electronically entered as Computerized Patient Record System radiology orders or Veterans Information Systems and Technology Architecture Radiology package orders and also as non-VA Care or VA Care in the Community consult requests.

During our previous Combined Assessment Program review, 29 of 33 EHRs (88 percent) did not contain a documented Computerized Patient Record System order for the mammogram. The facility provided FY 2016 data on breast cancer screenings for 1,348 patients. We found that 239 of these patients' EHRs (18 percent) did not contain a documented Computerized Patient Record System order for the mammogram.

Recommendation

16. We recommended that clinicians enter orders for mammograms in the Computerized Patient Record System and that clinical managers monitor compliance.

Medication Management

Tetanus Vaccination Screening and Documentation. VHA requires facilities to provide clinical preventive services, including immunizations.[j] Contraindications to the vaccine or patient declinations to receive the vaccine must be clearly documented in the patient's EHR; any patient EHR lacking such documentation is considered a missed vaccination opportunity, which is documented and evaluated through the organization's quality improvement process.

During our previous Combined Assessment Program review, 17 of 30 EHRs (57 percent) lacked documentation of tetanus vaccination screening. Additionally, none of the three patients who received tetanus vaccinations had the edition date of the Vaccine Information Statement documented in his or her EHR. For FY 2016, the facility reported a total compliance rate of 70 percent for screening patients for tetanus vaccinations at clinic visits and for documenting all required vaccine administration elements.

Recommendations

17. We recommended that clinicians screen patients for tetanus vaccinations at clinic visits and that clinical managers monitor compliance.

18. We recommended that clinicians document all required vaccine administration elements and that clinical managers monitor compliance.

Facility Profile

Table 1 below provides general background information for this facility.

Table 1. Facility Profile for New Orleans (629) for FY 2016

Profile Element	Facility Data
VISN Number	16
Complexity Level	1b-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$457.8
Number of:	
• **Unique Patients**	43,149
• **Outpatient Visits**	553,821
• **Unique Employees**[24]	1,039
Type and Number of Operating Beds:	
• **Acute**	NA
• **MH**	NA
• **Community Living Center**	NA
• **Domiciliary**	NA
Average Daily Census:	
• **Acute**	NA
• **MH**	NA
• **Community Living Center**	NA
• **Domiciliary**	NA

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
Baton Rouge, LA	629BY	22,383	13,611	Cardiology Dermatology Endocrinology Gastroenterology Neurology Amputation Follow-up Pulmonary/ Respiratory Disease Poly-Trauma Rehab Physician Anesthesia Eye Podiatry	EKG Laboratory and Pathology Radiology	Dental Nutrition Prosthetics Social Work Weight Management
Houma, LA	629GA	5,349	3,693	Anesthesia Cardiology Dermatology Eye Gastroenterology Poly-Trauma	Radiology	Nutrition Weight Management
Hammond, LA	629GB	7,821	5,644	Blind Rehab Cardiology Dermatology Gastroenterology Poly-Trauma Rehab Physician Anesthesia Eye Gynecology Neurology Podiatry	NA	Nutrition Social Work Weight Management

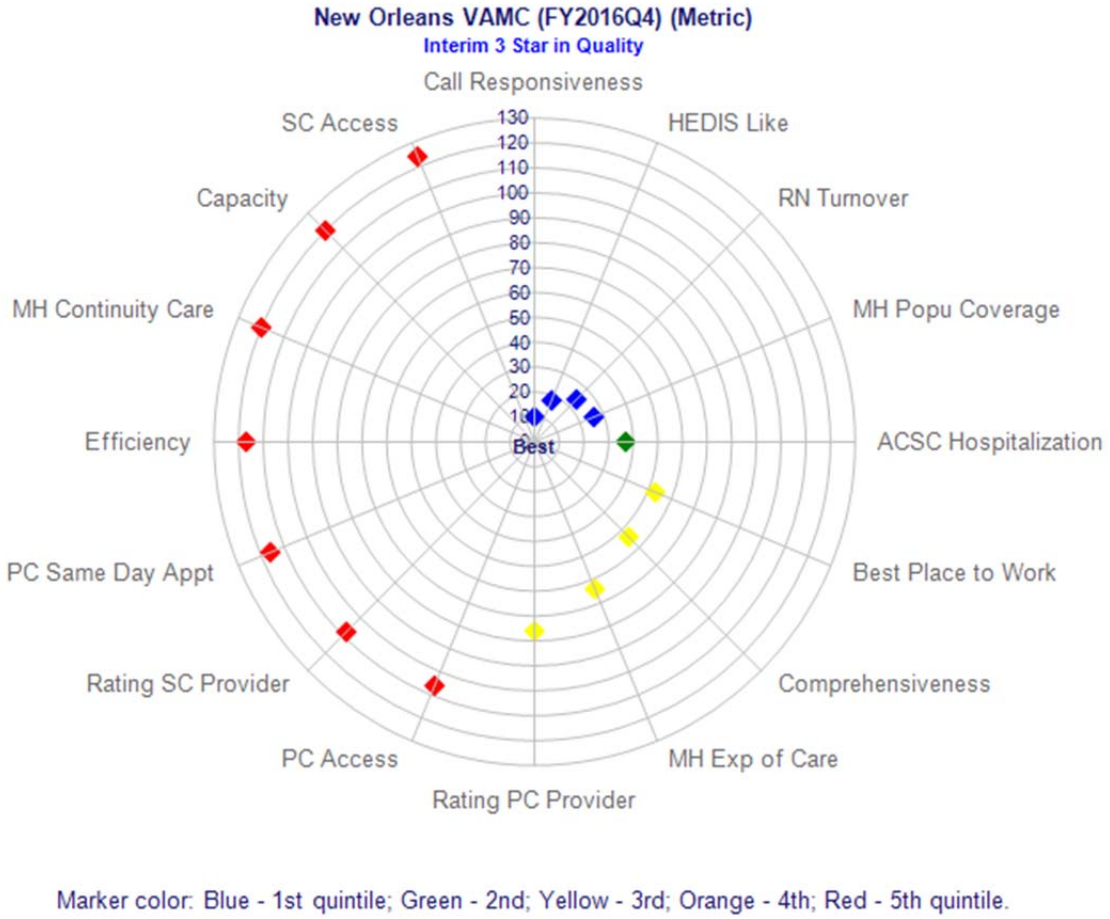
[25] Includes all outpatient clinics in the community that were in operation before February 15, 2016. We have omitted Baton Rouge, LA (629QA), as no workload/encounters or services were reported.
[26] An encounter is a professional contact between a patient and a practitioner vested with responsibility 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
Slidell, LA	629GC	6,289	2,549	Blind Rehab Dermatology Gastroenterology Poly-Trauma Rehab Physician Anesthesia Eye Gynecology	NA	Nutrition Social Work Weight Management
Reserve, LA	629GD	3,672	2,113	Anesthesia Cardiology Dermatology Eye Gastroenterology	NA	Nutrition Social Work Weight Management
Franklin, LA	629GE	1,239	869	Anesthesia Cardiology Dermatology Eye Gastroenterology	NA	NA
Bogalusa, LA	629GF	1,684	1,423	Anesthesia Cardiology Dermatology Eye Gastroenterology	NA	NA

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]

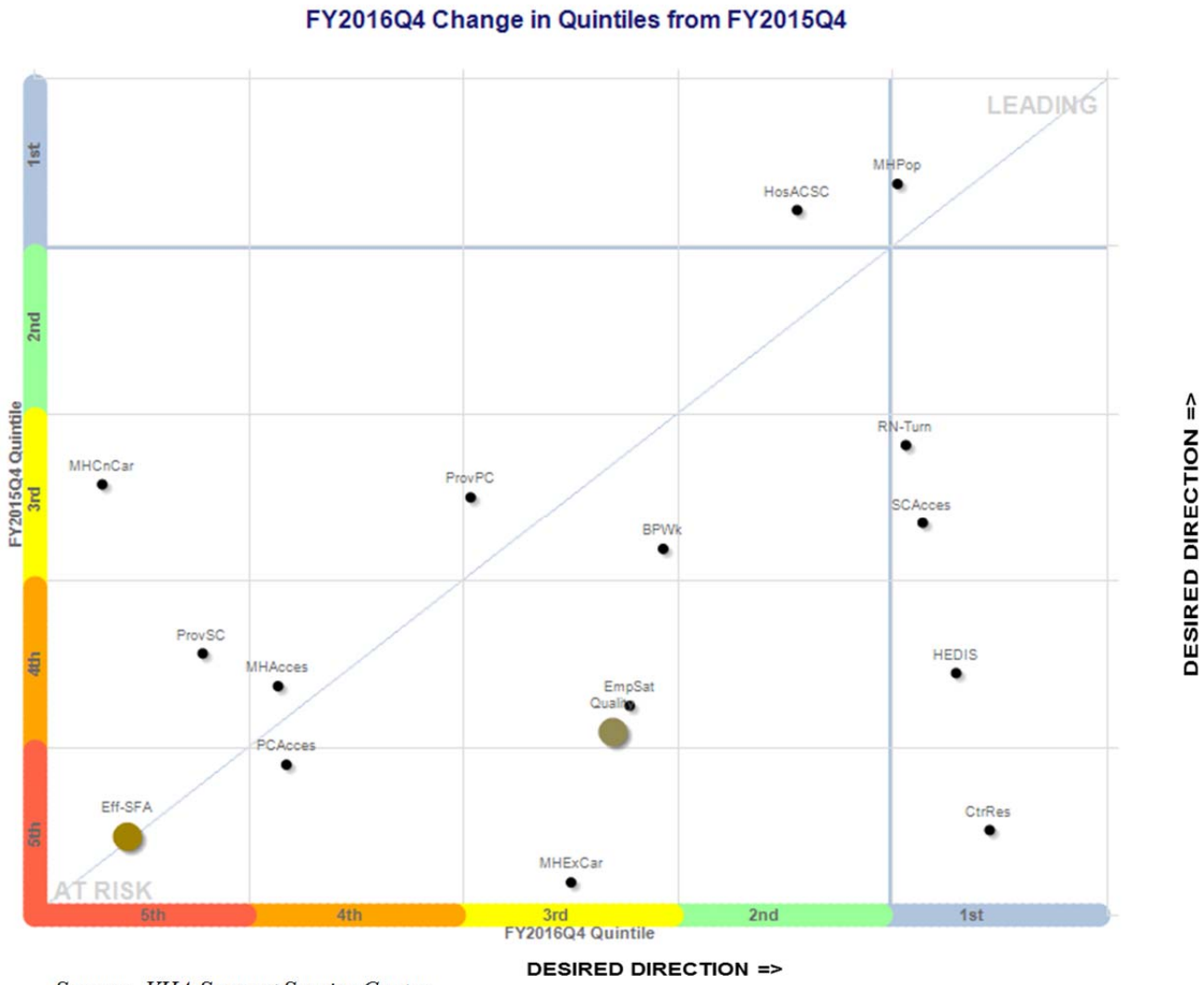


Source: VHA Support Service Center

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[k]

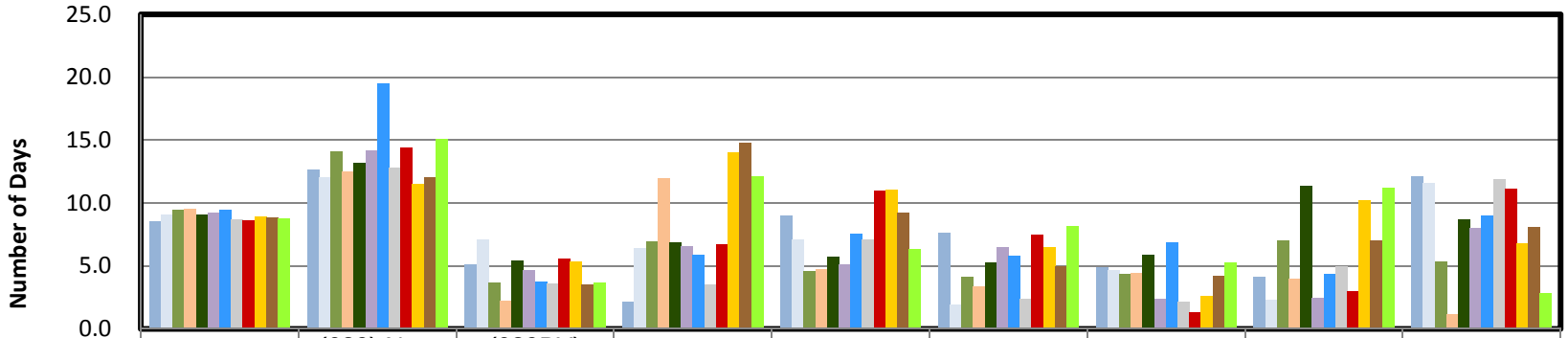
Measure	Definition	Desired Direction
ACSC Hospitalization	Ambulatory care sensitive condition hospitalizations (observed to expected ratio)	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Admit Reviews Met	%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



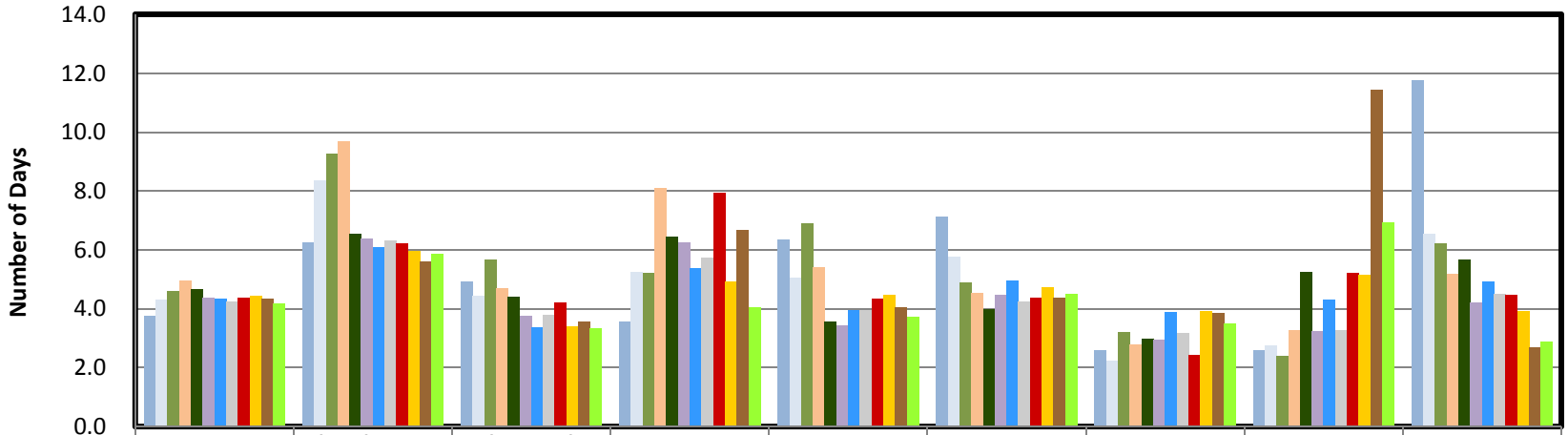
	VHA Total	(629) New Orleans VAMC	(629BY) Baton Rouge	(629GA) Houma	(629GB) Hammond	(629GC) Slidell	(629GD) St. John	(629GE) Franklin	(629GF) Bogalusa
OCT-FY16	8.6	12.7	5.2	2.2	9.0	7.7	4.9	4.2	12.1
NOV-FY16	9.1	12.1	7.1	6.4	7.1	2.0	4.7	2.3	11.6
DEC-FY16	9.5	14.1	3.7	6.9	4.6	4.1	4.4	7.0	5.3
JAN-FY16	9.6	12.5	2.2	12.0	4.7	3.4	4.4	4.0	1.2
FEB-FY16	9.1	13.2	5.5	6.9	5.8	5.3	5.9	11.3	8.7
MAR-FY16	9.2	14.2	4.6	6.6	5.1	6.5	2.4	2.5	8.0
APR-FY16	9.5	19.5	3.7	5.9	7.6	5.8	6.9	4.3	9.0
MAY-FY16	8.7	12.8	3.6	3.5	7.1	2.4	2.2	5.0	11.9
JUN-FY16	8.6	14.4	5.6	6.7	11.0	7.5	1.3	3.0	11.2
JUL-FY16	8.9	11.5	5.3	14.1	11.0	6.5	2.6	10.2	6.8
AUG-FY16	8.9	12.0	3.5	14.8	9.3	5.0	4.2	7.0	8.1
SEP-FY16	8.8	15.1	3.7	12.1	6.3	8.2	5.3	11.2	2.9

Source: VHA Support Service Center

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

Data Definition[l]: 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.*

FY 2016 Established PC Patient Average Wait Time in Days

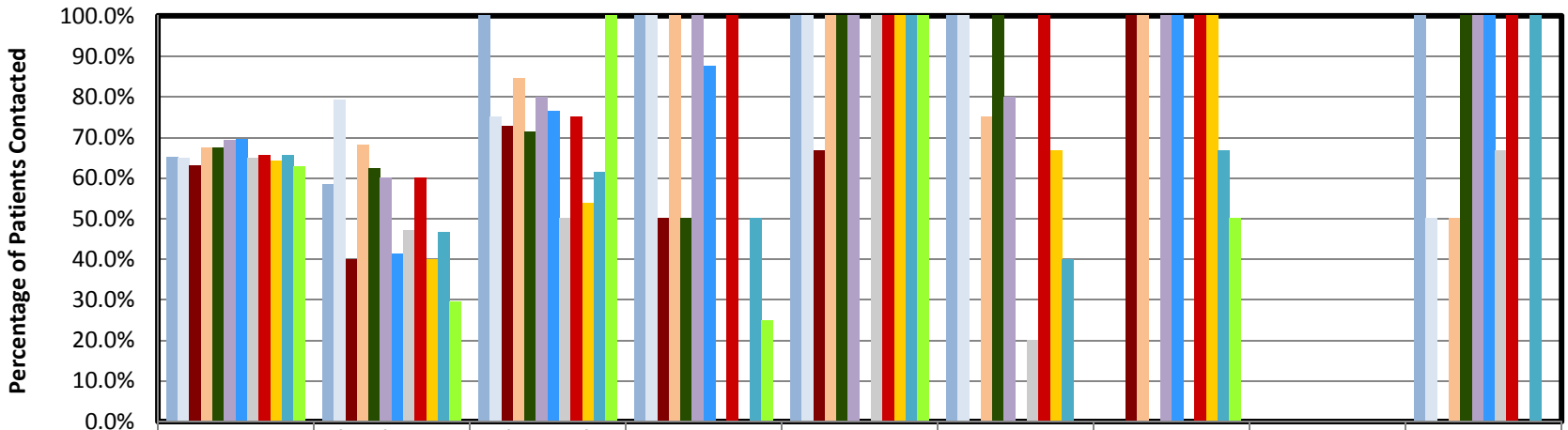


	VHA Total	(629) New Orleans VAMC	(629BY) Baton Rouge	(629GA) Houma	(629GB) Hammond	(629GC) Slidell	(629GD) St. John	(629GE) Franklin	(629GF) Bogalusa
OCT-FY16	3.8	6.2	4.9	3.6	6.4	7.1	2.6	2.6	11.8
NOV-FY16	4.3	8.3	4.4	5.2	5.0	5.8	2.2	2.7	6.5
DEC-FY16	4.6	9.3	5.7	5.2	6.9	4.9	3.2	2.4	6.2
JAN-FY16	4.9	9.7	4.7	8.1	5.4	4.5	2.8	3.3	5.2
FEB-FY16	4.7	6.5	4.4	6.5	3.6	4.0	3.0	5.3	5.7
MAR-FY16	4.4	6.4	3.8	6.2	3.4	4.5	2.9	3.2	4.2
APR-FY16	4.3	6.1	3.4	5.4	3.9	5.0	3.9	4.3	4.9
MAY-FY16	4.3	6.3	3.8	5.7	4.0	4.2	3.2	3.3	4.5
JUN-FY16	4.4	6.2	4.2	7.9	4.3	4.4	2.4	5.2	4.5
JUL-FY16	4.4	6.0	3.4	4.9	4.5	4.7	3.9	5.1	3.9
AUG-FY16	4.3	5.6	3.6	6.7	4.0	4.4	3.9	11.4	2.7
SEP-FY16	4.2	5.9	3.3	4.0	3.7	4.5	3.5	6.9	2.9

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.

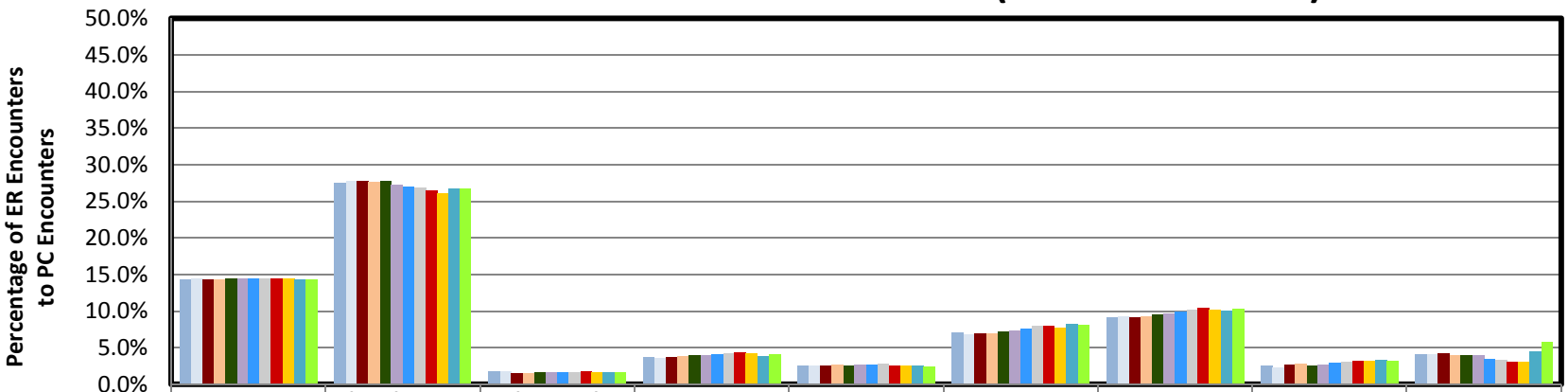


	VHA Total	(629) New Orleans VAMC	(629BY) Baton Rouge	(629GA) Houma	(629GB) Hammond	(629GC) Slidell	(629GD) St. John	(629GE) Franklin	(629GF) Bogalusa
OCT-FY16	65.2%	58.3%	100.0%	100.0%	100.0%	100.0%			100.0%
NOV-FY16	64.9%	79.2%	75.0%	100.0%	100.0%	100.0%		0.0%	50.0%
DEC-FY16	63.2%	40.0%	72.7%	50.0%	66.7%		100.0%		0.0%
JAN-FY16	67.5%	68.2%	84.6%	100.0%	100.0%	75.0%	100.0%	0.0%	50.0%
FEB-FY16	67.6%	62.5%	71.4%	50.0%	100.0%	100.0%	0.0%		100.0%
MAR-FY16	69.2%	60.0%	80.0%	100.0%	100.0%	80.0%	100.0%	0.0%	100.0%
APR-FY16	69.7%	41.4%	76.5%	87.5%			100.0%		100.0%
MAY-FY16	65.0%	47.1%	50.0%	0.0%	100.0%	20.0%	0.0%		66.7%
JUN-FY16	65.5%	60.0%	75.0%	100.0%	100.0%	100.0%	100.0%		100.0%
JUL-FY16	64.3%	40.0%	53.8%	0.0%	100.0%	66.7%	100.0%		
AUG-FY16	65.7%	46.7%	61.5%	50.0%	100.0%	40.0%	66.7%		100.0%
SEP-FY16	62.9%	29.4%	100.0%	25.0%	100.0%	0.0%	50.0%		0.0%

Source: VHA Support Service Center

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

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



	VHA Total	(629) New Orleans VAMC	(629BY) Baton Rouge	(629GA) Houma	(629GB) Hammond	(629GC) Slidell	(629GD) St. John	(629GE) Franklin	(629GF) Bogalusa
OCT-FY16	14.3%	27.4%	1.8%	3.7%	2.5%	7.1%	9.2%	2.5%	4.0%
NOV-FY16	14.4%	27.8%	1.7%	3.6%	2.4%	6.9%	9.2%	2.3%	4.1%
DEC-FY16	14.3%	27.7%	1.5%	3.7%	2.6%	6.9%	9.1%	2.6%	4.2%
JAN-FY16	14.3%	27.6%	1.5%	3.8%	2.7%	6.9%	9.2%	2.7%	3.9%
FEB-FY16	14.4%	27.8%	1.6%	3.9%	2.5%	7.1%	9.5%	2.5%	4.0%
MAR-FY16	14.4%	27.2%	1.6%	3.9%	2.7%	7.4%	9.7%	2.6%	4.0%
APR-FY16	14.4%	27.0%	1.6%	4.0%	2.7%	7.6%	9.9%	2.9%	3.5%
MAY-FY16	14.4%	26.8%	1.7%	4.2%	2.7%	8.0%	10.2%	3.0%	3.3%
JUN-FY16	14.4%	26.5%	1.8%	4.3%	2.6%	7.9%	10.4%	3.1%	3.1%
JUL-FY16	14.4%	26.0%	1.6%	4.2%	2.5%	7.7%	10.1%	3.2%	3.0%
AUG-FY16	14.3%	26.7%	1.6%	3.8%	2.5%	8.2%	10.0%	3.3%	4.5%
SEP-FY16	14.2%	26.7%	1.7%	4.0%	2.3%	8.1%	10.3%	3.1%	5.7%

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
April 1, 2014 through April 1, 2017

Facility Reports

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

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: May 23, 2017

From: Director, South Central VA Health Care Network (10N16)

Subject: **CAP Review of the Southeast Louisiana Veterans Health Care System, New Orleans, LA**

To: Director, Dallas Office of Healthcare Inspections (54DA)

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

1. The South Central VA Health Care Network (VISN 16) has reviewed and concurs with the findings, recommendations and action plans submitted by the Southeast Louisiana Veterans Health Care System, New Orleans, LA in response to the draft CAP Report.

Skye McDougall, PhD
Director, South Central VA Health Care Network (10N16)

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: May 22, 2017

From: Director, Southeast Louisiana Veterans Health Care System (629/00)

Subject: **CAP Review of the Southeast Louisiana Veterans Health Care System, New Orleans, LA**

To: Director, South Central VA Health Care Network (10N16)

Thank you for your thoughtful review of our Southeast Louisiana Veterans Health Care System's outpatient activities. We are grateful for the external eyes that help us identify areas where we can improve our service to our Veterans, especially during this time of transition as we move into and activate our new facility.

We concur with the recommendations made as a result of your review. Contained in this document, you will find our responses, action plans and progress to date for these recommendations.

Fernando O. Rivera, FACHE
SLVHCS Medical Center Director

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that the Quality, Safety, and Value Committee be consistently chaired or co-chaired by the Facility Director.

Concur

Target date for completion: 1 October 2017

Facility response: The Southeast Louisiana Veterans Health Care System's Leadership Council is established as the Quality, Safety and Value Committee for the health care system and serves as the integrating/leadership body for all committees in the governance structure. The Leadership Council serves as the highest level of governance within the healthcare system and is therefore the most senior-level committee. Leadership Council policy was revised to reflect designation of the Medical Center Director as the chairperson of the Council. Additionally, this station policy includes designation of a meeting schedule policy of monthly frequency which exceeds the quarterly requirement of VHA Directive 1026, VHA Enterprise Framework for Quality, Safety and Value. Leadership Council policy has been developed in accordance with specifications of VHA Directive 1026 to ensure the required components of an enterprise-wide, integrated framework for quality, safety and value are established as a multidisciplinary, standing committee. The Leadership Council has met and continues to meet monthly for the last two years. Signed minutes will be the validation method and a copy of the signed Leadership Council Policy as well as meeting minutes will be provided in future progress updates.

To track compliance with the established action plan, the Quality Manager will track Leadership Council meeting frequency and verify Medical Center Director as chairperson via review of the Leadership Council meeting minutes and provide report of these to Quality Council for a period of 6 consecutive months or as advised by the OIG Office.

Recommendation 2. 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: 1 November 2017

Facility response: The Chief of Staff has tasked the Medical Staff office to randomly audit 10% of all Licensed Independent Practitioners on a monthly basis to assure compliance with VHA OPPE [Ongoing Professional Practice Evaluation] requirements.

The results of each month's audit will be reported monthly to PSB [Professional Standards Board] and Quality Council to track compliance.

Recommendation 3. We recommended that facility clinical managers consistently implement individual improvement actions recommended by the Peer Review Committee and that facility managers monitor compliance.

Concur

Target date for completion: 1 October 2017

Facility response: A new Risk Manager was selected in December 2016 and immediately established a tracking process within the Peer Review Committee agenda and standing agenda items to ensure completion of committee recommendations of improvement actions and provide a system of tracking recommendations and corresponding actions until closure. During the OIG-CAP inspection, the inspector commented favorably on this newly established practice and recommended continuation of the following plan: 1) recommendations from the Peer Review Committee for cases scored as level 2 or 3 are addressed by the Service Chief and/or clinical supervisor for individual practice improvement actions, 2) peer review documents will reflect evidence that the Service Chief and/or clinical supervisor met with the involved practitioner and completed actions to improve care, 3) summary of completed action(s) will be retained with the peer review documents, 4) actions taken by the Service Chief and/or clinical supervisor will be provided to the Peer Review Committee and documented in the Peer Review Committee minutes and 5) a standing agenda item was added under old business to track actions until closed by the Committee. Since the OIG CAP inspection in March 6, 2017, Peer Review meeting minutes contain documentation that identified improvement actions that were addressed and tracked to closure. As an additional measure to ensure management monitors compliance, 6 consecutive months of Peer Review Committee meeting minutes will be presented by the Risk Manager to the Quality Council.

Recommendation 4. We recommended that the Patient Safety Manager consistently enter all reported patient incidents into the WEBSPOT database and that facility managers monitor compliance.

Concur

Target date for completion: 1 May 2017

Facility response: This recommendation was made as a result of 2015 data review. Beginning in FY17 we initiated new processes to ensure that we had clear processes to enter all of the ePERS [electronic patient event reports] into Web SPOT. By using a spread sheet with tabs for each step of the process we track all ePERs at every stage. With this tracking system in place currently 300/303 ePERs have been entered into the Web Spot database. Eighty four are aggregate logs and 216 are safety reports (total: 300). The calculated percentage of entered ePERs is 99%.

We consider the eight (8) months of data to be of sufficient strength to demonstrate compliance.

Recommendation 5. We recommended that the Patient Safety Manager consistently provide feedback about root cause analysis findings to the individual or department who reported the incident and that facility managers monitor compliance.

Concur

Target date for completion: 1 May 2017

Facility response: This recommendation was based on data from 2015. Beginning in FY17 we changed our processes to ensure that feedback to the reporter has been documented for RCAs [root cause analyses]. For aggregate reviews, the reporter feedback is found in question #12. For individual RCAs, the reporter feedback is in question #17. In FY17 RCAs which are closed, we have documented the reporter feedback under the follow up section (root cause #1) outcome measure #1 to ensure consistency and that the information is easily accessible.

We consider this process to be of sufficient strength to demonstrate compliance since 1 October 2016.

Recommendation 6. We recommended that facility managers ensure carpets and tile floors in patient care areas are clean and monitor compliance.

Concur

Target date for completion: 1 December 2017

Facility response: Environmental Management Service will continue to manage through daily cleaning and maintenance of these areas. The service will manage quality checks through weekly EOC rounds and daily supervisor checks. We have added scheduled semi-annual planned maintenance ticket into MAXIMO for general maintenance to all floors for all CBOCs [community based outpatient clinics]. The PM [preventive maintenance] checks in MAXIMO allow the service to track when scheduled maintenance was completed and foresee any major concerns. The data from quality checks and EOC rounds will be reported monthly through Quality Council for tracking and compliance.

Recommendation 7. We recommended that clinicians consistently provide specific education to patients with newly prescribed anticoagulant medications and that facility managers monitor compliance.

Concur

Target date for completion: 1 October 2017

Facility response: We have begun to review 100% of the charts for new starts weekly for compliance and if documentation is not present will make every effort to contact

the Veteran before the end of the 7 day period. All attempts to contact the veteran will be documented and anticoagulation prescribers will document in CPRS [Computerized Patient Record System] whenever patients cannot be reached within 7 days along with the planned action as a result of the inability to contact. This data will be reported monthly to Quality Council for tracking and compliance.

Recommendation 8. We recommended that facility managers ensure clinicians consistently obtain all required laboratory tests prior to initiating anticoagulant medications.

Concur

Target date for completion: 1 October 2017

Facility response: We are reviewing 100% charts per month for compliance. We have developed an order menu to assure that labs are ordered at the time of initiation of new anticoagulants. The Pharmacy will not dispense new orders for anticoagulation unless baseline labs have been drawn. The data from the 100% chart review will be reported to Quality Council monthly for tracking and compliance.

Recommendation 9. We recommended that clinicians ensure patients newly prescribed warfarin have an international normalized ratio measurement taken within 7 days of warfarin initiation and that facility managers monitor compliance.

Concur

Target date for completion: 1 October 2017

Facility response: We are reviewing 100% of the charts for new starts weekly for compliance. Anticoagulation Providers will document in CPRS whenever patients cannot be reached within 7 days and will alert the Treating Provider that follow-up lab could not be obtained within the necessary time period. The data from the 100% chart review of new starts will be reported to the Quality Council for tracking and compliance.

Recommendation 10. We recommended that for employees actively involved in the anticoagulant program, clinical managers include in competency assessments, drug-to-drug interactions associated with anticoagulation therapy and that facility managers monitor compliance.

Concur

Target date for completion: 1 April 2017

Facility response: The Anticoagulation Policy has been amended to include the requirement of initial and annual competencies and the Initial and Annual Competency Forms have been updated to include drug-drug interactions. Drug-to-Drug Interaction competencies for all anticoagulation prescribers have been assessed for the current fiscal year. We believe the actions provided have satisfied this recommendation.

Recommendation 11. 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: 1 October 2017

Facility response: The facility policy for Community Nursing Home Care has been rewritten and is in the policy approval process. 100% of the total charts for patients in community nursing home care will be audited monthly and documentation of quarterly visits will be tracked and reported to Quality Council on a monthly basis.

Recommendation 12. 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 Committee/Board.

Concur

Target date for completion: 1 August 2017

Facility response: SLVHCS [Southeast Louisiana Veterans Health Care System] has an active Disruptive Behavior Committee that meets monthly. SLVHCS is in the process of creating a Employee Threat Assessment Team Policy in accordance with "Employee Threat Assessment Team (ETAT): A Guidebook for Managing Risks Posed by the Disruptive and Threatening Employee" published by the VHA Center for Engineering and Occupational Safety and Health (CEOSH). With the publishing of the policy the facility ETAT will activate.

Recommendation 13. 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: 1 May 2017

Facility response: Since November of 2016 SLVHCS DBC [Disruptive Behavior Committee] has been sending by certified and first class mail a letter to Veterans who have had their case reviewed and substantiated by DBC. The letters to Veterans who have had a Patient Record Flag placed also include a description of their appeal rights and the processes by which to do so. We have created a note title "Record Flag Patient Notification" which is to be used for electronic medical record documentation of the signed letter and the use of certified mail and the letter and mail receipt will be scanned into the record attached to the note title. Each month an electronic report of the above note title will be generated and compared with the minutes of DBC to assure that all patients have been appropriately notified.

Recommendation 14. 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: 1 August 2017

Facility response: Since October 2016 the PMDB [prevention and management of disruptive behavior] coordinator has run a monthly report on current flags to ensure all flags needing a review are placed on the DBC agenda. The committee is currently working through the backlog to assure that all flags have been reviewed. Current process has the DBC Chair update all reviewed patient Record Flags in VISTA [Veterans Information Systems and Technology Architecture] within 5 business days of their review and document the review in the electronic medical record.

Recommendation 15. 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: 1 July 2017

Facility response: Beginning in January 2017 all employees beginning employment have had TMS [Talent Management System] Level 1 Prevention and Management of Disruptive Behavior training assigned and been provided as a part of New Employee Orientation, the additional training required for their assigned risk area. This process meets the requirement of training within 90 days of hire. This training is documented in employee training records. For employees who have entered onto duty and not completed the Level 1 training in TMS, the Prevention and Management of Disruptive Behavior Coordinator works directly with the employee's supervisor to accomplish. Each month a TMS report is run that documents training assigned and training completed.

Recommendation 16. We recommended that clinicians enter orders for mammograms in the Computerized Patient Record System and that clinical managers monitor compliance.

Concur

Target date for completion: 1 November 2017

Facility response: 1. The newly hired Women's Program Nurse Navigator has been approved to order past due mammograms (work down backlog). This process of ordering mammograms was finalized as of May 8, 2017.

2. WH [women's health] Program staff are working directly with PACTs [Patient Aligned Care Teams] using new list of mammograms due every 2 weeks (keeping current with newly due screenings). PACT providers review both screening and diagnostic mammograms.

3. We have developed a protocol to allow PACT RN [registered nurse] Care Managers to order mammograms when due (consistent with a Best Practice for ordering screening mammograms used by Oklahoma City VAMC [VA medical center]).

4. We will audit the process monthly through the clinical reminder completion report. We will report our data to Quality Council monthly for tracking.

Recommendation 17. We recommended that clinicians screen patients for tetanus vaccinations at clinic visits and that clinical managers monitor compliance.

Concur

Target date for completion: 1 October 2017

Facility response: The Tdap (diphtheria, tetanus and pertussis) vaccine screening requirement and successful completion of the Tdap clinical reminder has been communicated to all nursing staff in NEXUS clinics. All nursing staff and provider staff in these clinics are required to complete the reminder at the time of the appointment for all Veterans receiving services in these NEXUS clinics. Each month clinical Informatics team runs a report tracking completion of the reminders that have been due to track and monitor compliance. A SOP [standard operating procedure] is in development that requires nursing staff to complete this action at check-in for the Veteran.

Recommendation 18. We recommended that clinicians document all required vaccine administration elements and that clinical managers monitor compliance.

Concur

Target date for completion: 1 October 2017

Facility response: The clinical reminder is created to include all of the necessary elements for documentation at the time the reminder is completed. The Tdap screening requirement and successful completion of the Tdap clinical reminder has been communicated to all nursing staff in NEXUS clinics. All nursing staff and provider staff in these clinics are required to complete the reminder at the time of the appointment for all Veterans receiving services in these NEXUS clinics. Each month the clinical informatics team runs a report tracking completion of the reminders that have been due to track and monitor compliance. A SOP is in development that requires nursing staff to complete this action at check-in for the Veteran.

OIG Contact and Staff Acknowledgments

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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 Women's Health was:

- VHA Handbook 1330.01, *Health Care Services for Women Veterans*, February 17, 2017.

[j] The reference used for Medication Management was:

- VHA Handbook 1120.05, *Coordination and Development of Clinical Preventive Services Guidance*, July 29, 2015.

[k] 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.

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

- Department of Veterans' Affairs, Patient Aligned Care Teams Compass Data Definitions, accessed: December 19, 2016.