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Clinical Assessment Program Review of the VA Eastern Colorado Health Care System Denver, Colorado

September 29, 2017

Washington, DC 20420

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Glossary

CAP	Clinical Assessment Program
CBOC	community based outpatient clinic
CNH	community nursing home
EHR	electronic health record
EOC	environment of care
ER	emergency room
facility	VA Eastern Colorado Health Care System
FY	fiscal year
IAC	Interdisciplinary Anticoagulation Committee
MH	mental health
NA	not applicable
NM	not met
OIG	Office of Inspector General
PC	primary care
POCT	point-of-care testing
PTSD	post-traumatic stress disorder
QSV	quality, safety, and value
RME	reusable medical equipment
RRTP	residential rehabilitation treatment program
SPS	Sterile Processing Service
VHA	Veterans Health Administration
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 VA Eastern Colorado Health Care System. OIG 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; Management of Disruptive/Violent Behavior; and Mental Health Residential Rehabilitation Treatment Program. OIG 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: OIG conducted the review during the week of February 27, 2017 and identified certain system weaknesses in the Quality, Safety, and Value Committee; credentialing and privileging; utilization management; patient safety; general safety; environmental cleanliness; reusable medical equipment processes; anticoagulation policies and processes; transfer processes and documentation; point-of-care testing follow-up; moderate sedation data collection and reporting; management of disruptive or violent behavior; residential rehabilitation treatment program security; and nurse staffing methodology.

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

1. The facility has effective quality, safety, and value program oversight, policies, and practices.
2. The facility maintains a safe environment by consistently conducting fire drills.
3. The facility maintains clean horizontal surfaces, ventilation grills, and floors in patient care areas and clean patient nourishment kitchens.
4. The facility reprocesses reusable medical equipment according to manufacturer instructions and ensures employees have documented competencies to do so.
5. The facility has a comprehensive anticoagulation therapy management program.
6. The facility has a safe inter-facility transfer process.
7. Clinicians take action in response to glucose point-of-care testing results.
8. The facility uses data to improve moderate sedation care.
9. The facility has a comprehensive program for the management of disruptive/violent behavior incidents.
10. The facility maintains a secure Mental Health Residential Rehabilitation Treatment Program.
11. The facility uses the nurse staffing methodology and conducts annual reassessments.

Recommendations: OIG made recommendations in the following eight review areas.

Quality, Safety, and Value – Ensure that:
- The designated quality, safety, and value committee meets quarterly and is chaired or co-chaired by the Facility Director.
- Policy/by-laws are revised to comply with VHA requirements for clinical managers to review practitioners' Ongoing Professional Practice Evaluation data every 6 months.
- Clinical managers consistently review Ongoing Professional Practice Evaluation data.
- An interdisciplinary group reviews utilization management data.
- The Patient Safety Manager consistently enters all reported patient incidents into the WEBSPOT database.
- The facility consistently evaluates actions for effectiveness in the Clinical Executive Committee and Performance Improvement Board.

Environment of Care – Ensure that:
- All health care occupancy buildings have at least one fire drill per shift per quarter.
- Horizontal surfaces, ventilation grills, and floors in patient care areas are clean.
- Ice machines and refrigerators in patient nourishment kitchens are clean.
- The standard operating procedure for the retrograde cholangiopancreatography endoscope is consistent with the manufacturer's instructions for use.
- Sterile Processing Service employees receive competencies at orientation and annually for the types of reusable medical equipment they reprocess.

Medication Management: Anticoagulation Therapy – Ensure that:
- The policy for anticoagulation management is revised to include required elements including addressing no shows, patient noncompliance and minimizing loss to follow-up.
- The facility defines a process for patient anticoagulation-related calls outside normal business hours.
- Managers complete competency assessments semiannually for employees actively involved in anticoagulant program.

Coordination of Care: Inter-Facility Transfers – Ensure that:
- The facility collects and reports data on patient transfers out of the facility.
- For patients transferred out of the facility, providers consistently include required elements in transfer documentation.
- For emergent transfers, provider transfer notes document patient stability for transfer.
- For patients transferred out of the facility, providers document sending or communicating required elements to the accepting facility.

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

- Clinicians take and document all actions required by the facility in response to test results.

Moderate Sedation – Ensure that:

- The facility reports and trends the use of reversal agents in moderate sedation cases and processes adverse events and complications in a similar manner as operating room anesthesia adverse events.

Management of Disruptive/Violent Behavior – Ensure that:

- The VA Police Officer, Patient Safety Manager and/or Risk Manager, and Patient Advocate consistently attend Disruptive Behavior Committee meetings.
- The facility collects and analyzes data from disruptive or violent behavior incidents.
- A clinician member of the Disruptive Behavior Committee enters progress notes regarding Patient Record Flags.
- Clinicians inform patients about the Patient Record Flags and the right to request to amend/appeal flag placement.
- All employees receive Level 1 Prevention and Management of Disruptive Behavior training and additional training as required for their assigned risk area within 90 days of hire and that the training is documented in employee training records.

Mental Health Residential Rehabilitation Treatment Program – Ensure that:

- All doors other than the main point of entry are locked and alarmed.

OIG also made the following repeat recommendation from the previous Combined Assessment Program review.

Nurse Staffing – Ensure that:

- The facility fully implements the nurse staffing methodology and conducts annual reassessments.

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 44–54, for the full text of the Directors' comments.) OIG considers recommendation 24 closed. The facility considers recommendations 1, 4, 7, 9, 10, 12, 13, and 23 completed; however, OIG considers these recommendations open until OIG receives and reviews written documentation of the facility's completion of the proposed actions. OIG will follow up on the planned actions for the open recommendations until they are completed.

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Purpose and Objectives

Purpose

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

Objectives

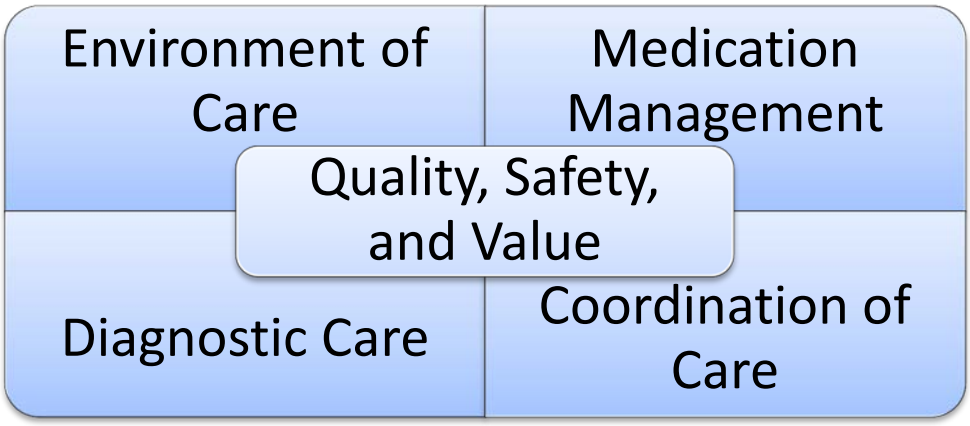
CAP reviews are one element of OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The reviews include cyclical evaluations of key clinical and administrative processes that affect patient care outcomes. Areas of focus include QSV, EOC, Medication Management,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

OIG also evaluates processes that are high risk and problem-prone—Moderate Sedation, CNH Oversight, Management of Disruptive/Violent Behavior, and MH RRTP—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

OIG evaluates 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]

One of VA's 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 environmental risks, 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 factors, 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. 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. 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. 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 harm patients, visitors, and employees; implementing programs to avert risks; and managing a robust reporting process for adverse events that 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 can still 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 employee 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 either in close proximity to a VA facility or located hundreds of miles away. VHA requires local oversight of CNHs, which includes monitoring and follow-up services for patients who choose to reside in nursing homes in the community. This involves annual reviews and monthly patient visits unless otherwise specified.[16]

According to the U.S. Bureau of Labor Statistics, health care workers are nearly five times more likely to be victims of nonfatal assaults or violent acts in their work places than average workers in all industries combined. Many of these assaults and violent acts are perpetrated by patients.[17] Management of disruptive/violent behavior involves the development of policy, programs, and initiatives for reducing and preventing disruptive behaviors and other defined acts that threaten public safety.[18] VHA released 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. Unfortunately, employee training deadlines related to this directive have been postponed several times.

MH RRTPs provide 24-hour residential rehabilitative and clinical care in a therapeutic setting to eligible veterans who have multiple and severe medical conditions, mental illness, addiction, or psychosocial deficits. They provide the least intensive level of VA inpatient care and differ from acute inpatient and nursing home beds as veterans in MH RRTPs are generally capable of self-care. MH RRTPs address rehabilitation, recovery, health maintenance, improved quality of life, and community integration in addition to specifically treating medical conditions, mental illnesses, and addictive disorders. Facility leaders must provide a safe, well-maintained, and appropriately-furnished residential environment that supports and enhances recovery efforts.[19]

[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.
[19] VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010.

Scope

To determine compliance with requirements related to patient care quality, clinical functions, and the EOC, OIG 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

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

- Moderate Sedation
- Community Nursing Home Oversight
- Management of Disruptive/Violent Behavior
- Mental Health Residential Rehabilitation Treatment Program

OIG lists 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 February 27, 2017, and inspectors conducted the reviews in accordance with OIG standard operating procedures for CAP reviews. OIG also asked the facility to provide the status on the recommendations OIG made in our previous Combined Assessment Program report (*Combined Assessment Program Review of the VA Eastern Colorado Health Care System, Denver, Colorado,* Report No. 14-00306-95, March 19, 2014) and CBOC report (*Community Based Outpatient Clinic and Primary Care Clinic Reviews at VA Eastern Colorado Health Care System, Denver, Colorado,* Report No. 14-002230-93, March 18, 2014). OIG made a repeat recommendation in Nurse Staffing. (See page 32.)

OIG presented crime awareness briefings to 138 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, OIG surveyed employees regarding patient safety and quality of care at the facility. OIG distributed an electronic survey to all facility employees and received 457 responses. We shared summarized results with facility managers.

In this report, OIG makes recommendations for improvement. Recommendations pertain to issues that are significant enough for OIG to monitor until the facility implements corrective actions. When issues and concerns outside the scope of this CHIP review come to our attention, they can be referred for further review separate from this report.

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

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

Checklist 1. QSV Areas Reviewed, Findings, and Recommendations

NM	Areas Reviewed	Findings	Recommendations
X	There was a senior-level committee responsible for key QSV functions that met at least quarterly and was chaired or co-chaired by the Facility Director. • The committee routinely reviewed aggregated data.	• The designated QSV committee did not meet quarterly and was not chaired or co-chaired by the Facility Director.	**1.** We recommended that the facility ensure the designated quality, safety, and value committee meets quarterly and is 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.	• Facility policy/by-laws did not comply with VHA's required frequency for clinical managers to review practitioners' Ongoing Professional Practice Evaluation data every 6 months. • Seven profiles did not contain evidence that clinical managers reviewed Ongoing Professional Practice Evaluation data.	**2.** We recommended that the facility revise the policy/by-laws to specify a frequency for clinical managers to review practitioners' Ongoing Professional Practice Evaluation data every 6 months. **3.** We recommended that facility clinical managers consistently review Ongoing Professional Practice Evaluation data and that facility managers monitor compliance.
	Protected peer reviews met selected requirements: • Peer reviewers documented their use of important aspects of care in their review, such as appropriate and timely ordering of diagnostic tests, timely treatment, and appropriate documentation. • When the Peer Review Committee recommended individual improvement actions, clinical managers implemented the actions.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Utilization management met selected requirements: • The facility completed at least 75 percent of all required inpatient reviews. • Physician Utilization Management Advisors documented their decisions in the National Utilization Management Integration database. • An interdisciplinary group reviewed utilization management data.	• For the timeframe January 1, 2016 through December 31, 2016, an interdisciplinary group did not review utilization management data.	**4.** We recommended that facility clinical managers ensure an interdisciplinary group reviews utilization management data and that facility managers monitor compliance.
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 19 patient incidents reported in FY 2016 into the WEBSPOT database.	**5.** We recommended that the Patient Safety Manager consistently enter all reported patient incidents into the WEBSPOT database and that facility managers monitor compliance.
X	Overall, if QSV reviews identified significant issues, the facility took actions and evaluated them for effectiveness.	• The facility did not consistently evaluate actions for effectiveness in the Clinical Executive Committee and Performance Improvement Board.	**6.** We recommended that the facility consistently evaluate actions for effectiveness in the Clinical Executive Committee and Performance Improvement Board and that facility managers monitor compliance.
	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. OIG also determined whether the facility met selected requirements in SPS and the hemodialysis unit.[b]

VHA must manage risks in the environment in order to promote a safe, functional, and supportive environment. Further, VHA must establish a systematic infection prevention and control program to reduce the possibility of acquiring and transmitting infections. OIG 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.

OIG inspected the Alamosa CBOC, the Emergency Department, inpatient units (medicine, community living center, 7 North MH, medicine intensive care, surgical intensive care, and surgical/telemetry), PC, the specialty clinic, hemodialysis, and SPS. Additionally, OIG reviewed relevant documents and 20 employee training records, and OIG interviewed key employees and managers. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement.

Checklist 2. EOC Areas Reviewed, Findings, and Recommendations

NM	Areas Reviewed for General EOC	Findings	Recommendations
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure for the facility and the CBOCs.		
	The facility conducted an infection prevention risk assessment.		

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.		
X	The facility conducted required fire drills in buildings designated for health care occupancy and documented drill critiques.	Past 2 quarters of fire drill documentation for health care occupancy buildings reviewed: • All applicable buildings did not have at least one fire drill per shift per quarter.	**7.** We recommended that facility managers ensure all health care occupancy buildings have at least one fire drill per shift per quarter and monitor compliance.
	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 8 of 10 patient care areas, horizontal surfaces were dusty, ventilation grills were dusty, or floors were dirty. • In five of eight applicable patient care areas, ice machines or refrigerators in patient nourishment kitchens were not clean.	**8.** We recommended that facility managers ensure horizontal surfaces, ventilation grills, and floors in patient care areas are clean and monitor compliance. **9.** We recommended that facility managers ensure ice machines and refrigerators in patient nourishment kitchens are clean and monitor compliance.
	Areas Reviewed for SPS		
	The facility had a policy for cleaning, disinfecting, and sterilizing RME.		
X	The facility's standard operating procedures for selected RME were current and consistent with the manufacturers' instructions for use.	• The standard operating procedure for the retrograde cholangiopancreatography endoscope was not consistent with the manufacturer's instructions for use.	**10.** We recommended that facility managers ensure the standard operating procedure for the retrograde cholangiopancreatography endoscope is consistent with the manufacturer's instructions for use.

NM	Areas Reviewed for SPS (continued)	Findings	Recommendations
	The facility performed quality control testing on selected RME with the frequency required by local policy and took appropriate action on positive results.		
X	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	• Four of five applicable employees had no documentation of competencies at orientation for selected RME. • None of four applicable employees had documentation of competencies within the past 12 months for selected RME.	**11.** We recommended that Sterile Processing Service managers ensure Sterile Processing Service employees receive competencies at orientation and annually for the types of reusable medical equipment they reprocess.
X	The facility met infection prevention requirements in SPS areas.	• In two SPS areas, floors were dirty.	See recommendation 8.
	Standard operating procedures for selected RME were located in the area where reprocessing occurred.		
	SPS employees checked eyewash stations in SPS areas weekly.		
	SPS employees had access to Safety Data Sheets in areas where they used hazardous chemicals.		
	Areas Reviewed for the Hemodialysis Unit		
	The facility had a policy or procedure for preventive maintenance of hemodialysis machines and performed maintenance at the frequency required by local policy.		
	Selected hemodialysis unit employees had evidence of bloodborne pathogens training within the past 12 months.		
	The facility met environmental safety requirements on the hemodialysis unit.		
	The facility met infection prevention requirements on the hemodialysis unit.		

NM	Areas Reviewed for the Hemodialysis Unit (continued)	Findings	Recommendations
	The facility met medication safety and security requirements on the hemodialysis unit.		
	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, OIG evaluated warfarin (Coumadin®) and direct-acting oral anticoagulants. Clinicians use anticoagulants for both the treatment and prevention of cardiac disease, cerebrovascular accident (stroke), and thromboembolism[20] in both the inpatient and outpatient setting. Although these medications offer substantial benefits, their use or misuse carries a significant potential for patient harm. A dose less than the required amount for therapeutic effect can increase the risk of thromboembolic complications while a dose administered at levels greater than required for treatment can increase the risk of bleeding complications. The Joint Commission's National Patient Safety Goal 3.05.01 focuses on improving anticoagulation safety to reduce patient harm and states, "…anticoagulation medications are more likely than others to cause harm due to complex dosing, insufficient monitoring, and inconsistent patient compliance."

OIG reviewed relevant documents and the competency assessment records of 10 employees actively involved in the anticoagulant program, and OIG interviewed key employees. Additionally, OIG reviewed the EHRs of 28 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
X	The facility had policies and processes for anticoagulation management that included required content.	• Facility policies and processes were incomplete in several areas. o Process for addressing no-shows not incorporated into written policy o Process for addressing patient noncompliance not incorporated into written policy o Process for minimizing loss to follow-up not incorporated into written policy	**12.** We recommended that the facility revise the policy for anticoagulation management to include addressing no shows and patient noncompliance and minimizing loss to follow-up.

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

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility 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		
X	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 did not have a defined process for patient anticoagulation-related calls outside normal business hours.	**13.** We recommended that the facility define a process for patient anticoagulation-related calls outside normal business hours.
	The facility designated a physician as the anticoagulation program champion.		
	The facility defined ways to minimize the risk of incorrect tablet strength dosing errors.		
	The facility routinely reviewed quality assurance data for the anticoagulation management program at the facility's required frequency at an appropriate committee.		
	For inpatients with newly prescribed anticoagulant medications, clinicians provided transition follow-up and education specific to the new anticoagulant.		
	Clinicians obtained required laboratory tests: • Prior to initiating anticoagulant medications • During anticoagulation treatment at the frequency required by local policy		

NM	Areas Reviewed (continued)	Findings	Recommendations
	When laboratory values did not meet selected criteria, clinicians documented a justification/rationale for prescribing the anticoagulant.		
X	The facility required competency assessments for employees actively involved in the anticoagulant program, and clinical managers completed competency assessments that included required content at the frequency required by local policy.	• Nine of 10 employees actively involved in the anticoagulant program did not have competency assessments completed semiannually as required in the local scope of practice.	**14.** We recommended that clinical managers complete semiannual competency assessments for employees actively involved in the anticoagulant program 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.

OIG reviewed relevant documents and interviewed key employees. Additionally, OIG reviewed the EHRs of 47 randomly selected patients who were transferred acutely out of facility inpatient beds or the Emergency Department/urgent care center to another VHA facility or non-VA facility from July 1, 2015 through June 30, 2016. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement.

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

NM	Areas Reviewed	Findings	Recommendations
	The facility had a policy that addressed patient transfers and included required content.		
X	The facility collected and reported data about transfers out of the facility.	• There was no evidence the facility collected and reported data about transfers out of the facility.	**15.** We recommended that the facility collect and report data on patient transfers out of the facility.
X	Transferring providers completed VA Form 10-2649A and/or transfer/progress notes prior to or within a few hours after the transfer that included the following elements: • Date of transfer • Documentation of patient or surrogate informed consent • Medical and/or behavioral stability • Identification of transferring and receiving provider or designee • Details of the reason for transfer or proposed level of care needed	• Provider transfer documentation did not include: o Documentation of patient or surrogate informed consent in 39 of the 47 EHRs (83 percent), all of which involved non-emergent transfers o Documentation of medical and behavioral stability in 32 of the 47 EHRs (68 percent) o Identification of transferring and receiving provider or designee in 21 of the 47 EHRs (45 percent) o Details of the reason for transfer or proposed level of care needed in 11 of the 47 EHRs (23 percent)	**16.** We recommended that for patients transferred out of the facility, providers consistently include documentation of patient or surrogate informed consent, documentation of medical and behavioral stability, identification of transferring and receiving provider or designee, and details of the reason for transfer or proposed level of care needed in transfer documentation and that facility managers monitor compliance.

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.		
X	In emergent transfers, providers documented: • Patient stability for transfer • Provision of all medical care within the facility's capacity	• In 24 of the 46 EHRs (52 percent), provider transfer notes did not document patient stability for transfer.	**17.** We recommended that facility managers ensure that for emergent transfers, provider transfer notes include patient stability for transfer and monitor compliance.
X	Communication with the accepting facility or documentation sent included: • Available history • Observations, signs, symptoms, and preliminary diagnoses • Results of diagnostic studies and tests	• Providers did not document that they sent or communicated the following information to the receiving facility: o Available history in 45 of 46 EHRs (98 percent) o Observations, signs, symptoms, and preliminary diagnoses in 45 of 46 EHRs (98 percent) o Results of diagnostic studies and tests in any of the applicable 42 EHRs	**18.** We recommended that for patients transferred out of the facility, providers document sending or communicating to the accepting facility available history; observations, signs, symptoms, and preliminary diagnoses; and results of diagnostic studies and tests and that facility managers monitor compliance.

Diagnostic Care: Point-of Care Testing

The purpose of this review was to evaluate the facility's glucometer POCT program compliance with applicable laboratory regulatory standards and quality testing practices as required by VHA, the College of American Pathologists, and The Joint Commission.[e] The majority of laboratory testing is performed in the main laboratory. However, with newer technologies, testing has emerged from the laboratory to the patient's bedside, the patient's home, and other non-laboratory sites. This is called POCT (also known as ancillary or waived testing) and can include tests for blood glucose, fecal occult blood, hemoglobin, and 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.[21]

OIG 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 44 clinicians who performed the glucose testing. Additionally, OIG interviewed key employees and conducted onsite glucometer inspections of the Emergency Department, a PC clinic, two medical/surgical inpatient units, and the community living center to assess compliance with manufacturer's maintenance and solution/reagent storage requirements. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement.

Checklist 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.		

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

NM	Areas Reviewed (continued)	Findings	Recommendations
	The 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.		
X	Clinicians initiated appropriate clinical action and follow-up for test results.	• In 13 EHRs (26 percent), clinicians did not document all the actions required by the facility in response to test results.	**19.** We recommended that clinicians take and document all actions required by the facility in response to test results and that clinical managers monitor compliance.
	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.[22] 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.[23] 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.

OIG reviewed relevant documents, interviewed key employees, and inspected the gastroenterology, cardiology, interventional radiology, Emergency Department, and dental procedure rooms/areas to assess whether required equipment and sedation medications were available. Additionally, OIG reviewed the EHRs of 38 randomly selected patients who underwent an invasive procedure involving moderate sedation from July 1, 2015 through June 30, 2016, and the training records of 15 clinical employees who performed or assisted during these procedures. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement.

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

NM	Areas Reviewed	Findings	Recommendations
X	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.	• The facility did not report and trend the use of reversal agents in moderate sedation cases. • The facility did not process adverse events/complications in a similar manner as operating room anesthesia adverse events.	**20.** We recommended that the facility report and trend the use of reversal agents in moderate sedation cases and process adverse events/complications in a similar manner as operating room anesthesia adverse events and that facility managers monitor compliance.

[22] Per VA Corporate Data Warehouse data pull on February 22, 2017.
[23] 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.		

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

Community Nursing Home Oversight

The purpose of this review was to assess whether the facility complied with applicable requirements regarding the monitoring of veterans in contracted CNHs.[9] Since 1965, VHA has provided nursing home care under contracts. VHA facilities must integrate the CNH program into their quality improvement programs. The Facility Director establishes the CNH Oversight Committee, which reports to the chief clinical officer (Chief of Staff, Associate Director for Patient Care Services, or the equivalent) and includes multidisciplinary management-level representatives from social work, nursing, quality management, acquisition, and the medical staff. The CNH Oversight Committee must meet at least quarterly.[24] Local oversight of CNHs is achieved through annual reviews and monthly visits.

OIG reviewed relevant documents, the EHRs of 47 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, OIG interviewed key employees. The table below shows the areas reviewed for this topic. The facility generally met requirements. OIG made no recommendations.

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.		
	Social workers and registered nurses documented clinical visits that alternated on a cyclical basis.		

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

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.

OIG reviewed relevant documents, the EHRs of 44 randomly selected patients who exhibited disruptive or violent behavior, 3 Reports of Contact from violent/disruptive patient/employee/other (visitor) incidents that occurred during the 12-month period January 1, 2016 through December 31, 2016, and the training records of 30 recently hired employees who worked in areas at low, moderate, or high risk for violence. Additionally, OIG 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 VA Police Officer, Patient Safety Manager and/or Risk Manager, and Patient Advocate did not consistently attend Disruptive Behavior Committee meetings.	**21.** We recommended that the VA Police Officer, Patient Safety Manager and/or Risk Manager, and Patient Advocate consistently attend Disruptive Behavior Committee meetings.
X	The facility collected and analyzed disruptive or violent behavior incidents data.	• There was no evidence of disruptive or violent behavior incidents data collection and analysis.	**22.** We recommended that the facility collect and analyze data from disruptive or violent behavior incidents.

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility assessed physical security and included and tested equipment in accordance with the local physical security assessment.		
X	Clinical managers reviewed patients' disruptive or violent behavior and took appropriate actions, including: • Ensuring discussion by the Disruptive Behavior Committee/Board and entry of a progress note by a clinician committee/board member • Informing patients about Patient Record Flag placement and the right to request to amend/appeal the flag placement • Ensuring Chief of Staff or designee approval of an Order of Behavioral Restriction	• None of the five applicable EHRs contained a progress note entered by a Disruptive Behavior Committee member. • Two of the five applicable EHRs lacked evidence that clinicians informed the patients about the Patient Record Flags. • The five applicable EHRs lacked evidence that clinicians informed the patients about the right to request to amend/appeal Patient Record Flag placement.	**23.** We recommended that facility clinical managers ensure a clinician member of the Disruptive Behavior Committee enters progress notes regarding Patient Record Flags. **24.** 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.
	When a Patient Record Flag was placed for an incident of disruptive behavior in the past, a clinician reviewed the continuing need for the flag within the past 2 years.		
	The facility managed selected non-patient related disruptive or violent incidents appropriately according to VHA and local policy.		
X	The facility had a security training plan for employees at all risk levels. • All employees received Level 1 training within 90 days of hire. • All employees received additional training as required for the assigned risk area within 90 days of hire.	• Fifteen employee training records (50 percent) did not contain documentation of Level 1 training within 90 days of hire. • None of the 30 employee training records contained documentation of the training required for their assigned risk area within 90 days of hire.	**25.** We recommended that facility managers ensure all employees receive Level 1 Prevention and Management of Disruptive Behavior training and additional training as required for their assigned risk area within 90 days of hire and that the training is documented in employee training records.

Mental Health Residential Rehabilitation Treatment Program

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

OIG reviewed relevant documents, inspected the Domiciliary Care for Homeless Veterans Program and PTSD-RRTP units, and 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. Any items that did not apply to this facility are marked NA.

Checklist 9. MH RRTP Areas Reviewed, Findings, and Recommendations

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

NM	Areas Reviewed (continued)	Findings	Recommendations
	The MH RRTP had written agreements in place acknowledging resident responsibility for medication security.		
X	The MH RRTP main point(s) of entry had keyless entry and closed circuit television monitoring, and all other doors were locked to the outside and alarmed.	• Two doors on the Domiciliary Care for Homeless Veterans Program unit were not locked and alarmed.	**26.** We recommended that all doors on the Domiciliary Care for Homeless Veterans Program unit other than the main point of entry be locked and alarmed.
	The MH RRTP had closed circuit television monitors with recording capability in public areas but not in treatment areas or private spaces and had signage alerting veterans and visitors of recording.		
	There was a process for responding to behavioral health and medical emergencies, and MH RRTP employees could articulate the process.		
	In mixed gender MH RRTP units, women veterans' rooms had keyless entry or door locks.		
	Residents secured medications in their rooms.		

Review Activity with Previous Combined Assessment Program Review Recommendations

Nurse Staffing

As a follow-up to a recommendation from our prior Combined Assessment Program review, OIG reassessed facility compliance with implementation of the nurse staffing methodology.[j]

Nurse Staffing Methodology. VHA requires application of a nationally standardized methodology process to determine staffing for VA nursing personnel for all inpatient points of care. Once implemented, each facility must do annual reassessments, repeating the steps required for initial implementation. During OIG's previous Combined Assessment Program review, OIG found that the staffing methodology process had not been fully implemented. During this review, OIG looked for implementation of unit-based and facility expert panels and reassessment for FY 2016 and were unable to find either for the previous year.

Recommendation

27. We recommended that the facility fully implement the nurse staffing methodology and conduct annual reassessments.

Facility Profile

Table 1 below provides general background information for this facility.

Table 1. Facility Profile for Denver (554) for FY 2016

Profile Element	Facility Data
VISN Number	19
Complexity Level	1a-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$734.5
Number of:	
• **Unique Patients**	91,923
• **Outpatient Visits**	998,311
• **Unique Employees**[25]	2,787
Type and Number of Operating Beds:	
• **Acute**	93
• **MH**	38
• **Community Living Center**	100
• **Domiciliary**	59
Average Daily Census:	
• **Acute**	70
• **MH**	35
• **Community Living Center**	64
• **Domiciliary**	50

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

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

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

VA Outpatient Clinic Profiles[26]

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[27] and Specialty Care, Diagnostic, and Ancillary Services Provided for FY 2016

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services[28] Provided	Diagnostic Services[29] Provided	Ancillary Services[30] Provided
Aurora, CO	554GB	18,449	3,504	Dermatology Eye	NA	Nutrition Pharmacy
Golden, CO	554GC	23,272	16,483	Dermatology Endocrinology Poly-Trauma Rehab Physician Anesthesia Eye Gynecology	Radiology	Pharmacy Weight Management
Pueblo, CO	554GD	15,900	13,325	Cardiology Dermatology Endocrinology Gastroenterology Hematology/ Oncology Nephrology Pulmonary/ Respiratory Disease Poly-Trauma Anesthesia Blind Rehab Eye General Surgery Podiatry	Radiology	Nutrition Pharmacy Weight Management Dental

[26] Includes all outpatient clinics in the community that were in operation before February 15, 2016. OIG has omitted Denver, CO (554QA); Aurora, CO (554QB); and Salida, CO (554QC), as no workload/encounters or services were reported.
[27] An encounter is a professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition.
[28] Specialty care services refer to non-primary care and non-MH services provided by a physician.
[29] Diagnostic services include EKG, EMG, laboratory, nuclear medicine, radiology, and vascular lab services.
[30] Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

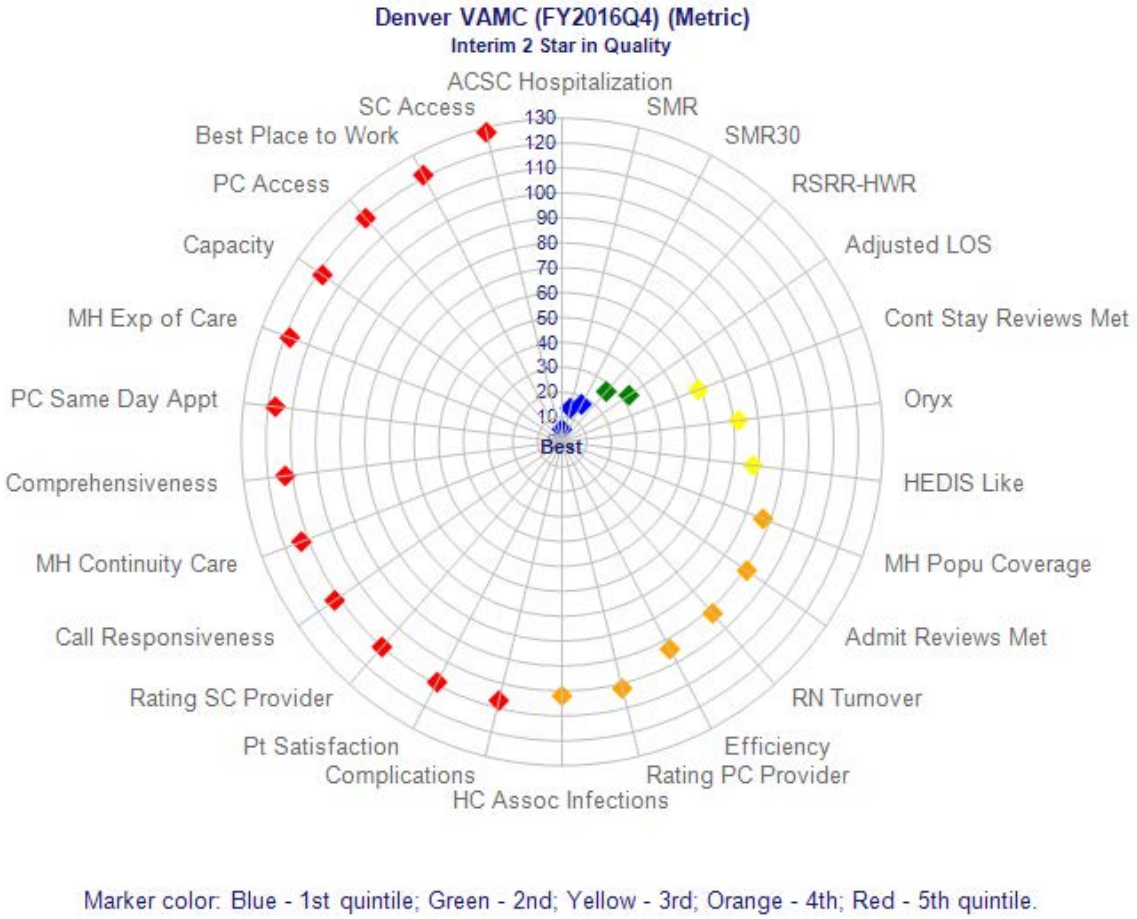
Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Colorado Springs, CO	554GE	42,502	37,464	Dermatology Endocrinology Gastroenterology Nephrology Pulmonary/ Respiratory Disease Poly-Trauma Rehab Physician Amputation Follow-up Anesthesia Blind Rehab Eye General Surgery Gynecology Orthopedics Podiatry	Radiology	Nutrition Pharmacy Prosthetics Social Work Weight Management Dental
Alamosa, CO	554GF	3,321	1,919	Dermatology Endocrinology Gastroenterology Nephrology Pulmonary/ Respiratory Disease Anesthesia Blind Rehab Eye General Surgery Gynecology	NA	Weight Management
La Junta, CO	554GG	2,516	1,464	Dermatology Endocrinology Gastroenterology Nephrology Pulmonary/ Respiratory Disease Anesthesia Eye Podiatry	NA	Weight Management
Lamar, CO	554GH	1,656	245	Anesthesia Dermatology Endocrinology Gastroenterology Nephrology Pulmonary/ Respiratory Disease Blind Rehab Eye	NA	Pharmacy Weight Management

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Burlington, CO	554GI	927	321	Dermatology Endocrinology Gastroenterology Pulmonary/ Respiratory Disease Blind Rehab Eye Anesthesia	NA	Weight Management

Source: VHA Support Service Center and VA Corporate Data Warehouse

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

Strategic Analytics for Improvement and Learning (SAIL)[31]

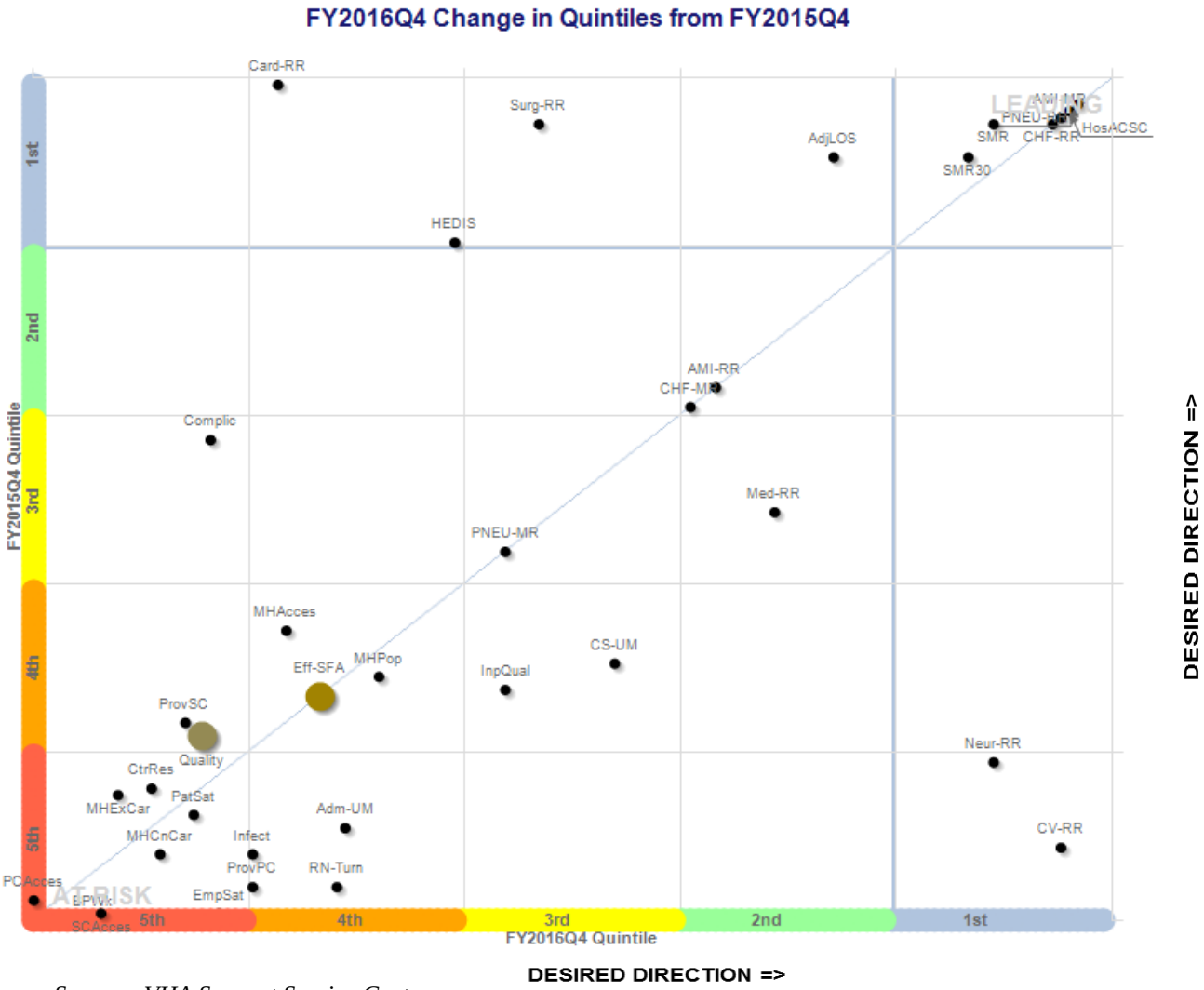


Source: VHA Support Service Center

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

[31] 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: OIG did not assess VA's data for accuracy or completeness.

Metric Definitions[k]

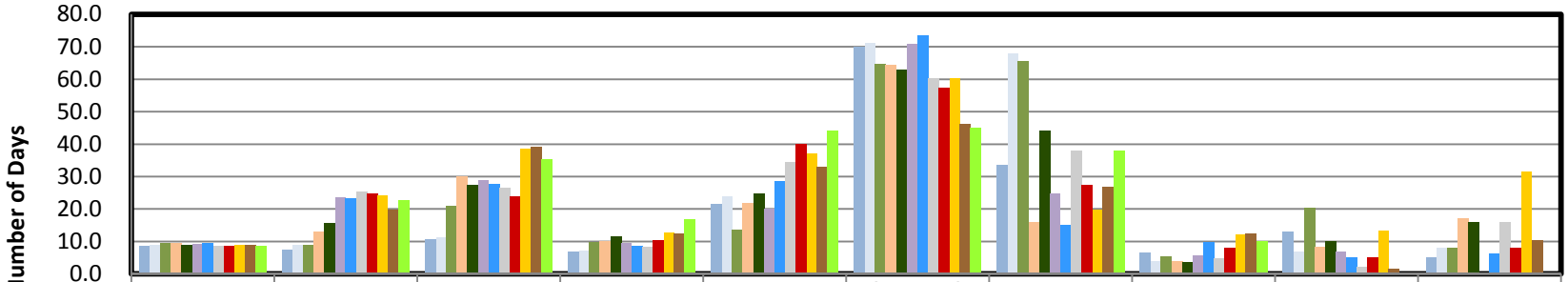
Measure	Definition	Desired Direction
ACSC Hospitalization	Ambulatory care sensitive condition hospitalizations (observed to expected ratio)	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Admit Reviews Met	% 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: OIG did not assess VA's data for accuracy or completeness.

Patient Aligned Care Team Compass Metrics



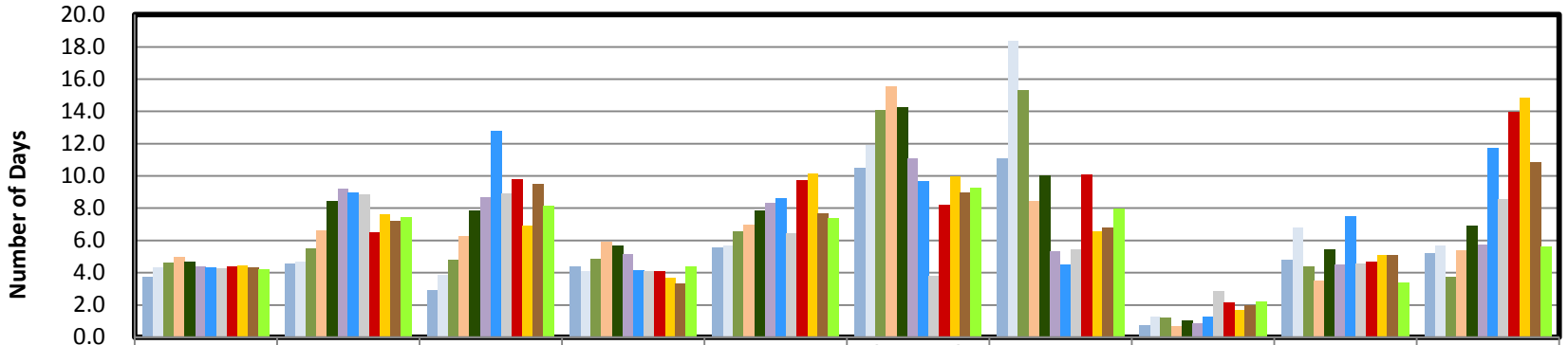
	VHA Total	(554) Denver VA Medical Center	(554GB) Aurora	(554GC) Golden	(554GD) Pueblo	(554GE) PFC Floyd K Lindstrom VA Clinic	(554GF) Alamosa	(554GG) La Junta	(554GH) Lamar	(554GI) Burlington
OCT-FY16	8.6	7.4	10.8	6.8	21.5	70.0	33.8	6.8	13.0	5.0
NOV-FY16	9.1	9.0	11.2	7.3	24.0	71.1	68.0	3.9	6.8	8.2
DEC-FY16	9.5	8.8	20.9	9.8	13.8	64.7	65.5	5.4	20.4	8.3
JAN-FY16	9.6	13.1	30.0	10.2	21.9	64.4	16.1	4.0	8.3	17.0
FEB-FY16	9.1	15.8	27.5	11.6	25.0	63.1	44.2	3.8	10.0	16.0
MAR-FY16	9.2	23.7	29.1	9.5	20.1	71.0	24.9	5.9	6.8	0.5
APR-FY16	9.5	23.2	27.7	8.7	28.5	73.6	15.1	9.7	5.2	6.3
MAY-FY16	8.7	25.3	26.5	8.5	34.6	60.3	38.0	4.8	2.3	15.9
JUN-FY16	8.6	24.9	24.0	10.6	40.2	57.4	27.4	8.0	5.0	8.0
JUL-FY16	8.9	24.1	38.7	12.7	37.1	60.4	20.0	12.2	13.5	31.5
AUG-FY16	8.9	20.0	39.2	12.3	32.9	46.2	26.8	12.6	1.7	10.5
SEP-FY16	8.8	22.8	35.4	17.0	44.0	45.0	37.9	10.0	0.0	0.0

Source: VHA Support Service Center

Note: OIG 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



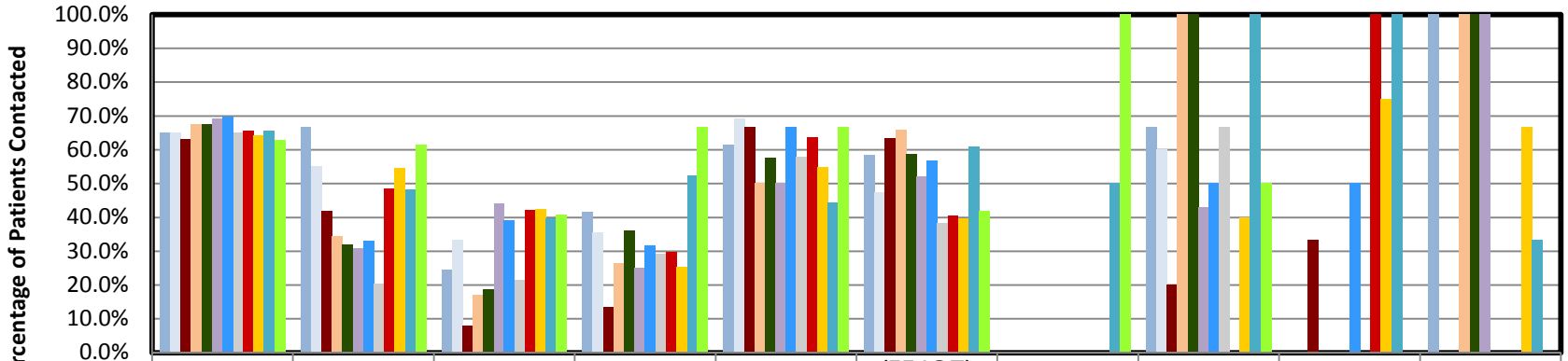
	VHA Total	(554) Denver VA Medical Center	(554GB) Aurora	(554GC) Golden	(554GD) Pueblo	(554GE) PFC Floyd K Lindstrom VA Clinic	(554GF) Alamosa	(554GG) La Junta	(554GH) Lamar	(554GI) Burlington
OCT-FY16	3.8	4.6	2.9	4.4	5.5	10.5	11.1	0.8	4.8	5.2
NOV-FY16	4.3	4.7	3.8	4.1	5.7	11.9	18.4	1.3	6.8	5.7
DEC-FY16	4.6	5.5	4.8	4.9	6.6	14.1	15.3	1.2	4.4	3.8
JAN-FY16	4.9	6.6	6.2	5.9	7.0	15.5	8.5	0.7	3.5	5.4
FEB-FY16	4.7	8.4	7.8	5.7	7.9	14.2	10.0	1.0	5.4	6.9
MAR-FY16	4.4	9.2	8.6	5.1	8.3	11.1	5.3	0.8	4.5	5.7
APR-FY16	4.3	9.0	12.8	4.2	8.6	9.7	4.5	1.2	7.5	11.8
MAY-FY16	4.3	8.9	8.9	4.1	6.4	3.8	5.4	2.9	4.6	8.5
JUN-FY16	4.4	6.5	9.8	4.1	9.7	8.2	10.1	2.1	4.7	14.0
JUL-FY16	4.4	7.6	6.9	3.7	10.1	10.0	6.5	1.7	5.1	14.9
AUG-FY16	4.3	7.2	9.5	3.3	7.7	9.0	6.8	2.0	5.1	10.8
SEP-FY16	4.2	7.4	8.1	4.4	7.4	9.2	8.0	2.2	3.4	5.6

Source: VHA Support Service Center

Note: OIG 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.

FY 2016 Team 2-Day Post Discharge Contact Ratio

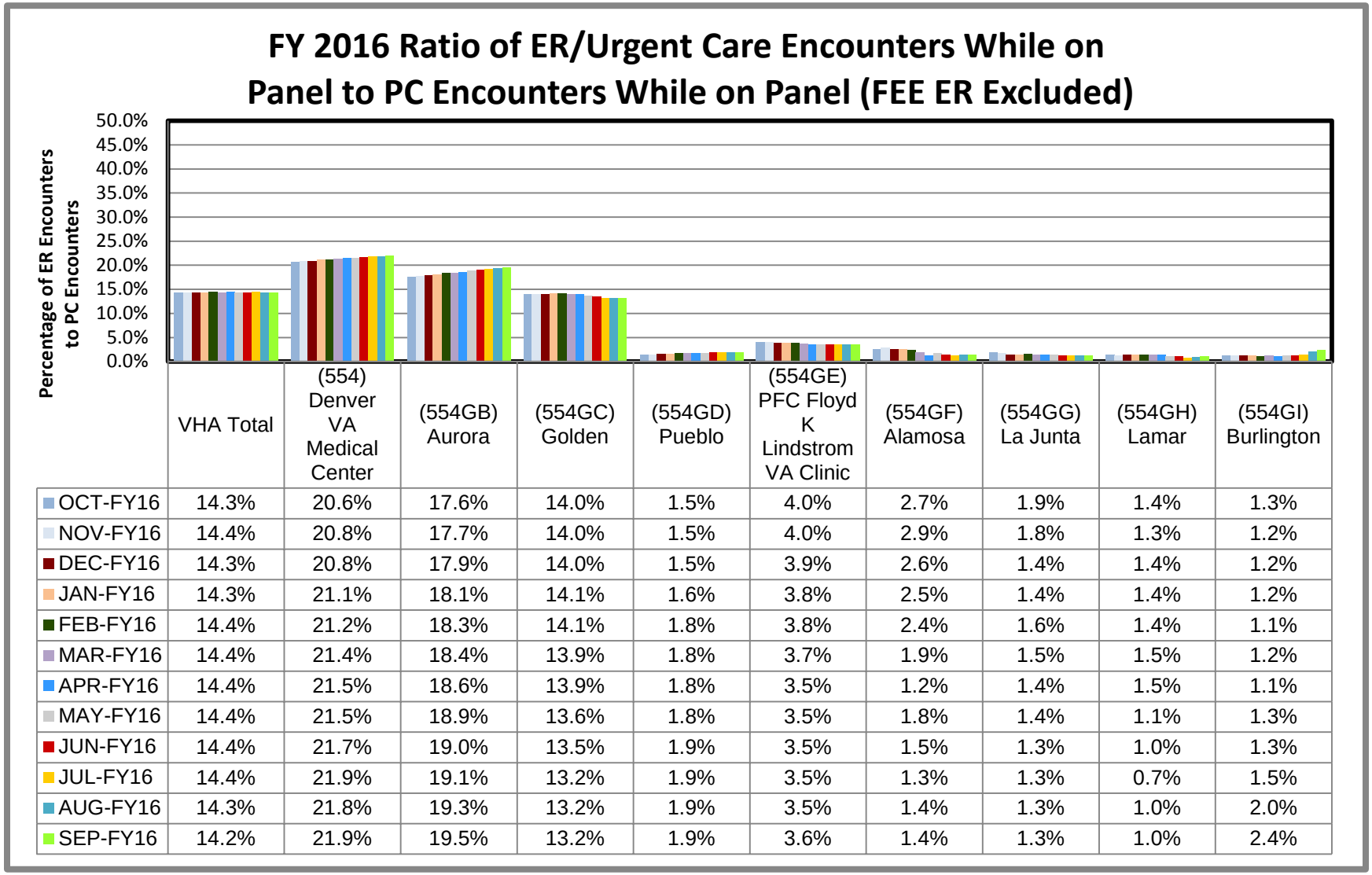


	VHA Total	(554) Denver VA Medical Center	(554GB) Aurora	(554GC) Golden	(554GD) Pueblo	(554GE) PFC Floyd K Lindstrom VA Clinic	(554GF) Alamosa	(554GG) La Junta	(554GH) Lamar	(554GI) Burlington
OCT-FY16	65.2%	66.7%	24.5%	41.5%	61.5%	58.5%	0.0%	66.7%		100.0%
NOV-FY16	64.9%	55.2%	33.3%	35.6%	69.2%	47.5%	0.0%	60.0%	0.0%	
DEC-FY16	63.2%	42.0%	7.9%	13.6%	66.7%	63.4%	0.0%	20.0%	33.3%	0.0%
JAN-FY16	67.5%	34.3%	17.0%	26.4%	50.0%	66.0%	0.0%	100.0%	0.0%	100.0%
FEB-FY16	67.6%	31.9%	18.8%	36.2%	57.7%	58.7%	0.0%	100.0%		100.0%
MAR-FY16	69.2%	30.8%	44.1%	25.0%	50.0%	52.0%		42.9%		100.0%
APR-FY16	69.7%	33.2%	39.0%	31.8%	66.7%	56.9%	0.0%	50.0%	50.0%	
MAY-FY16	65.0%	20.3%	21.3%	29.2%	57.9%	38.2%	0.0%	66.7%		
JUN-FY16	65.5%	48.6%	42.1%	29.6%	63.6%	40.4%	0.0%	0.0%	100.0%	
JUL-FY16	64.3%	54.5%	42.3%	25.4%	55.0%	39.6%	0.0%	40.0%	75.0%	66.7%
AUG-FY16	65.7%	48.3%	39.7%	52.4%	44.4%	60.9%	50.0%	100.0%	100.0%	33.3%
SEP-FY16	62.9%	61.5%	40.7%	66.7%	66.7%	41.9%	100.0%	50.0%		0.0%

Source: VHA Support Service Center

Note: OIG 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	(554) Denver VA Medical Center	(554GB) Aurora	(554GC) Golden	(554GD) Pueblo	(554GE) PFC Floyd K Lindstrom VA Clinic	(554GF) Alamosa	(554GG) La Junta	(554GH) Lamar	(554GI) Burlington
OCT-FY16	14.3%	20.6%	17.6%	14.0%	1.5%	4.0%	2.7%	1.9%	1.4%	1.3%
NOV-FY16	14.4%	20.8%	17.7%	14.0%	1.5%	4.0%	2.9%	1.8%	1.3%	1.2%
DEC-FY16	14.3%	20.8%	17.9%	14.0%	1.5%	3.9%	2.6%	1.4%	1.4%	1.2%
JAN-FY16	14.3%	21.1%	18.1%	14.1%	1.6%	3.8%	2.5%	1.4%	1.4%	1.2%
FEB-FY16	14.4%	21.2%	18.3%	14.1%	1.8%	3.8%	2.4%	1.6%	1.4%	1.1%
MAR-FY16	14.4%	21.4%	18.4%	13.9%	1.8%	3.7%	1.9%	1.5%	1.5%	1.2%
APR-FY16	14.4%	21.5%	18.6%	13.9%	1.8%	3.5%	1.2%	1.4%	1.5%	1.1%
MAY-FY16	14.4%	21.5%	18.9%	13.6%	1.8%	3.5%	1.8%	1.4%	1.1%	1.3%
JUN-FY16	14.4%	21.7%	19.0%	13.5%	1.9%	3.5%	1.5%	1.3%	1.0%	1.3%
JUL-FY16	14.4%	21.9%	19.1%	13.2%	1.9%	3.5%	1.3%	1.3%	0.7%	1.5%
AUG-FY16	14.3%	21.8%	19.3%	13.2%	1.9%	3.5%	1.4%	1.3%	1.0%	2.0%
SEP-FY16	14.2%	21.9%	19.5%	13.2%	1.9%	3.6%	1.4%	1.3%	1.0%	2.4%

Source: VHA Support Service Center

Note: OIG 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

Review of the Replacement of the Denver Medical Center, Eastern Colorado Health Care System
9/21/2016–15-03706-330–Summary–Report

Review of Alleged Untimely Care at VHA's Community Based Outpatient Clinic Colorado Springs, CO
2/4/2016 | 15-02472-46 | Summary | Report

Healthcare Inspection – Alleged Substandard Prostate Cancer Screening, VA Eastern Colorado Health Care System, Denver, CO
9/3/2015–14-03833-385—Summary–Report

Healthcare Inspection – Alleged Consult Processing Delay Resulting in Patient Death, VA Eastern Colorado Health Care System, Denver, Colorado
7/7/2015–14-04049-379–Summary–Report

Review of Alleged Delays in Care Caused by Patient-Centered Community Care (PC3) Issues
7/1/2015 | 14-04116-408 | Summary | Report

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

Healthcare Inspection-Alleged Quality of Care and Courtesy Issues at the Alamosa Community Based Outpatient Clinic, Alamosa, Colorado
1/13/2015–14-00615-61–Summary–Report

Audit of VHA's Mobile Medical Units
5/14/2014–13-03213-152–Summary–Report

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: August 21, 2016

From: Director, Rocky Mountain Network (10N19)

Subject: **CAP Review of the VA Eastern Colorado Health Care System, Denver, CO**

To: Director, Denver Office of Healthcare Inspections (54DV)

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

I have reviewed and concur with the responses from the Eastern Colorado HCS to the Combined Assessment Program review of their facility.

(original signed by:)
Ralph T. Gigliotti, FACHE
Director, VA Rocky Mountain Network (10N19)

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: August 21, 2017

From: Director, VA Eastern Colorado Health Care System, Denver, CO (554/00)

Subject: **CAP Review of the VA Eastern Colorado Health Care System, Denver, CO**

To: Director, Rocky Mountain Network (10N19)

1. We are submitting written comments in response to the Combined Assessment Program Review completed February 27–March 2, 2017, at the VA Eastern Colorado Health Care System (ECHCS).

2. In reviewing the draft report, the facility has addressed all identified deficiencies and has either already resolved and/or a plan to resolve all remaining non-compliant areas cited in the report. I concur with all remaining findings, recommendations, and submitted action plans.

Sallie A. Houser-Hanfelder, FACHE

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that the facility ensure the designated quality, safety, and value committee meets quarterly and is chaired or co-chaired by the Facility Director.

Concur

Target date for completion: Completed 5/31/17

Facility response: The new Quality, Safety, Value Executive Council (QSVEC), co-chaired by the Facility Director was initiated in FY16 Q4 and began meeting monthly starting in FY17Q1 (prior to the OIG inspection). The previous quality oversight meeting (Performance Improvement Board) is now the Performance Improvement Committee, which feeds into QSVEC. This concern has already been remedied, and we are requesting closure.

Recommendation 2. We recommended that the facility revise the policy/by-laws to specify a frequency for clinical managers to review practitioners' Ongoing Professional Practice Evaluation data every 6 months.

Concur

Target date for completion: 8/31/17

Facility response: The facility by-laws are currently being updated using the VACO template to incorporate specific VHA language regarding frequency of OPPE.

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

Concur

Target date for completion: 11/30/17

Facility response: A new OPPE initiative was already underway when the OIG inspection occurred; new standardized OPPE forms were approved by the Professional Standards Board and Clinical Executive Council on 2/13/17. Service-specific OPPE templates have been uploaded onto the MSO website for all providers and service chiefs to use. Data will be monitored until 2 consecutive OPPE sessions with 90% compliance has been achieved.

Recommendation 4. We recommended that facility clinical managers ensure an interdisciplinary group reviews utilization management data and that facility managers monitor compliance.

Concur

Target date for completion: Completed 4/13/17

Facility response: Since prior to 2015, an interdisciplinary group and executives have reviewed utilization management (UM) data daily (report available for review); unfortunately, this exchange was not captured in any facility meeting minutes. As of FY17 Q2, this information is presented and discussed at both the SAIL meetings and the Performance Improvement Committee and will continued to be reported quarterly. We are requesting closure of this item.

Recommendation 5. 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: 10/31/17

Facility response: All 1,689 reports were addressed appropriately, and 99% were input into WEBSPOT. In order to mitigate the current problem of having to do dual-entry into two separate systems, the facility will be implementing the new Patient Safety reporting tool (JPSR). The Patient Safety Manager will receive training on the new system on 8/31/17, and additional staff training will commence thereafter.

Recommendation 6. We recommended that the facility consistently evaluate actions for effectiveness in the Clinical Executive Committee and Performance Improvement Board and that facility managers monitor compliance.

Concur

Target date for completion: 10/31/17

Facility response: In early FY17 QSVEC started and Performance Improvement Board was re-engineered to Performance Improvement Committee with new charter/chair/recorder. QM staff trained new recorders on proper minutes' documentation, and minutes for both CEC and PIC are being reviewed for compliance.

Recommendation 7. We recommended that facility managers ensure all health care occupancy buildings have at least one fire drill per shift per quarter and monitor compliance.

Concur

Target date for completion: Completed 4/11/2017

Facility response: The CLC has an early 8-hr shift from 6a–2:30p that FMS was not aware of. We were combining 1st and 2nd shift into one drill to reduce patient disturbance. As we were conducting the drills at 2:30p to capture both shifts, it was found this 8-hr shift was not provided the drill. This was rectified immediately (upon awareness). The CLC closed May 2017. The facility is compliant with performing at least one fire drill per shift per quarter. We request closure of this item.

Recommendation 8. We recommended that facility managers ensure horizontal surfaces, ventilation grills, and floors in patient care areas are clean and monitor compliance.

Concur

Target date for completion: 10/31/17

Facility response: The following changes were implemented after the inspection: stripping and waxing of all inpatient wards; equipment purchased and provided to staff specifically for high and low dusting; modified terminal room cleaning procedure, including emphasis on high dusting and floor cleaning; implementation of weekly EMS EOC rounding; and modified inspection sheet to include high dust, low dust, patient refrigerators, patient ice machines, and patient nutrition room. Target date includes monitoring time to ensure sustainment.

Recommendation 9. We recommended that facility managers ensure ice machines and refrigerators in patient nourishment kitchens are clean and monitor compliance.

Concur

Target date for completion: Completed 10/31/17

Facility response: The action plan for this item was included in the changes described above (recommendation 8). Target date includes monitoring time to ensure sustainment.

Recommendation 10. We recommended that facility managers ensure the standard operating procedure for the retrograde cholangiopancreatography endoscope is consistent with the manufacturer's instructions for use.

Concur

Target date for completion: Completed 5/31/2017

Facility response: Upon pre-inspection OIG review, it was found that the ERCP SOP was missing one line item (out of 185 line items/41 pages) for use. This was corrected immediately upon notification, and all employees were given real-time training with hands-on return demonstrations completed. We request closure of this item.

Recommendation 11. We recommended that Sterile Processing Service managers ensure Sterile Processing Service employees receive competencies at orientation and annually for the types of reusable medical equipment they reprocess.

Concur

Target date for completion: 10/3/17

Facility response: New employee competency forms have been revised to correspond with current VHA requirements. Additionally, the master training spreadsheet has been updated to provide alerts for annual competency requirements. The target date for completion includes monitoring time to ensure sustainment.

Recommendation 12. We recommended that the facility revise the policy for anticoagulation management to include addressing no shows and patient noncompliance and minimizing loss to follow-up.

Concur

Target date for completion: Completed 6/30/17

Facility response: The ECHCS anticoagulation clinic utilizes the Anticoagulation Management Tool (AMT) which is a VA nationally developed database to minimize patient loss to follow-up and to address patient no-shows, and noncompliance with the treatment plan. ECHCS utilizes this tool daily to ensure patients are not lost to follow up. This tool is also used weekly to determine patients that have no-showed. Appropriate action is taken to contact these patients. We have added the process to current medical center policy and request closure.

Recommendation 13. We recommended that the facility define a process for patient anticoagulation related calls outside normal business hours.

Concur

Target date for completion: Completed 6/30/17

Facility Response: VA ECHCS has a defined after-hours process for patient anticoagulation-related calls. Patients can leave a message on the anticoagulation clinic voicemail if non-urgent or contact the 24/7 Nurse Line for urgent needs. This information is contained in the new patient information packet. We have added the process to a medical center policy and request closure.

Recommendation 14. We recommended that clinical managers complete semiannual competency assessments for employees actively involved in the anticoagulant program and that facility managers monitor compliance.

Concur

Target date for completion: 11/30/17

Facility response: Ongoing Professional Peer Evaluations (OPPE) are documented biannually (following FYQ2 and FYQ4) for every pharmacist with a scope of practice at the facility. We have updated the standardized Clinical Care Review assessment questions and created a new pharmacist OPPE form, using the new OPPE template that was approved by PSB/CEC on 2/13/17. We will monitor until 2 consecutive OPPE sessions have been completed (FY17 Q2 and Q4).

Recommendation 15. We recommended that the facility collect and report data on patient transfers out of the facility.

Concur

Target date for completion: 8/30/2017

Facility response: Patient transfer information was previously discussed daily by an interdisciplinary team and leadership; however, the data was not formally collected and reported at a committee. Transfer data is now reported, discussed, and documented in the Access to Care Committee minutes.

Recommendation 16. We recommended that for patients transferred out of the facility, providers consistently include documentation of patient or surrogate informed consent, documentation of medical and behavioral stability, identification of transferring and receiving provider or designee, and details of the reason for transfer or proposed level of care needed in transfer documentation and that facility managers monitor compliance.

Concur

Target date for completion: 10/31/17

Facility response: A new CPRS template, incorporating all VA Form 10-2649A requirements, has been completed, and staff have been educated about the mandatory use of the template for patient transfers and the use of i-Med consent. Data will be monitored until 3 consecutive months of 90% compliance has been achieved.

Recommendation 17. We recommended that facility managers ensure that for emergent transfers, provider transfer notes include patient stability for transfer and monitor compliance.

Concur

Target date for completion: 10/31/17

Facility Response: A new CPRS template, incorporating all VA Form 10-2649A requirements, has been completed, and staff have been educated about the mandatory use of the template for patient transfers. Data will be monitored until 3 consecutive months of 90% compliance has been achieved.

Recommendation 18. We recommended that for patients transferred out of the facility, providers' document sending or communicating to the accepting facility available history; observations, signs, symptoms, and preliminary diagnoses; and results of diagnostic studies and tests and that facility managers monitor compliance.

Concur

Target date for completion: 10/31/17

Facility response: A new CPRS template, incorporating all VA Form 10-2649A requirements, has been completed, and staff have been educated about the mandatory use of the template for patient transfers. Data will be monitored until 3 consecutive months of 90% compliance has been achieved.

Recommendation 19. We recommended that clinicians take and document all actions required by the facility in response to test results and that clinical managers monitor compliance.

Concur

Target date for completion: 10/31/17

Facility response: Nursing staff has been re-educated on the documentation requirements and the mandatory use of the available standardized template. Nursing orientation has been revised to include this information as well. Data will be monitored until 3 consecutive months of 90% compliance has been achieved.

Recommendation 20. We recommended that the facility report and trend the use of reversal agents in moderate sedation cases and process adverse events/complications in a similar manner as operating room anesthesia adverse events and that facility managers monitor compliance.

Concur

Target date for completion: 1/31/18

Facility response: We chartered a new "Out of OR Invasive Procedures Committee" to centralize oversight of all procedural services outside the OR, and moderate sedation reports are now reported to OOIPC. Additionally, a new standardized CPRS template is in development for use by all Moderate Sedation areas to standardize capture of adverse events and complications. The OOIPC minutes will be monitored for compliance.

Recommendation 21. We recommended that the VA Police Officer, Patient Safety Manager and/or Risk Manager, and Patient Advocate consistently attend Disruptive Behavior Committee meetings.

Concur

Target date for completion: 10/31/17

Facility response: A charter was developed and disseminated for the Disruptive Behavior Committee, to include required attendees. Minutes will be monitored until 3 consecutive months of 90% compliance has been achieved.

Recommendation 22. We recommended that the facility collect and analyze data from disruptive or violent behavior incidents.

Concur

Target date for completion: 12/31/17

Facility response: The DBC will collect and analyze data from disruptive or violent behavior incidents. Minutes will be monitored until 3 consecutive months of tracking and trending of data has been achieved.

Recommendation 23. We recommended that facility clinical managers ensure a clinician member of the Disruptive Behavior Committee enters progress notes regarding Patient Record Flags.

Concur

Target date for completion: Completed 8/31/2017

Facility response: As of February 2017, the Chair of the DBC assumed responsibility for entering progress notes for all patients on which a PRF is required. We request closure of this item.

Recommendation 24. 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: Completed 5/31/2017

Facility response: Veterans are sent notification letters when their Behavioral Flags contain Orders of Behavioral Restriction. Notification letters have been updated to include verbiage regarding patients' appeal rights. All letters sent since 2/28/17 contain the required verbiage and are sent Certified Mail.

Recommendation 25. 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: 12/31/17

Facility response: Assignment profiles are used that automatically assign the required level of training to employees and send automated reminders about required training. Additional classes have been added, and a new educator is being trained in PMDB. Reoccurring training reports will be generated and distributed to leadership to increase the awareness and support for required training. Data will be monitored until 3 consecutive months of 90% compliance has been achieved.

Recommendation 26. We recommended that all doors on the Domiciliary Care for Homeless Veterans Program unit other than the main point of entry be locked and alarmed.

Concur

Target date for completion: 10/31/17

Facility response: To remedy the program immediately, all exterior doors were locked, making them permanent egress-only doors thus making the program fully compliant with the "single ingress rule." An on-site evaluation has been conducted for door alarms, and a proposal submitted to the Contracting Department. Additionally, nursing staff check each egress-only door as part of their environment of care rounds every two hours.

Recommendation 27. We recommended that the facility fully implement the nurse staffing methodology and conduct annual reassessments.

Concur

Target date for completion: 10/31/17

Facility response: Nurse Staffing Methodology was fully implemented after the 2014 OIG inspection and led to major positive changes, but vacancies in key leadership and clinical positions during FY15-16 caused major disruption in the process. The process was reinvigorated for FY17, and all steps are anticipated to be completed by late summer.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
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Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Michael F. Bennet, Cory Gardner
U.S. House of Representatives: Ken Buck, Mike Coffman, Diana DeGette, Doug Lamborn, Ed Perlmutter, Jared Polis, Scott Tipton

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 references used for MH RRTP were:

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

[j] The reference used for Nurse Staffing was:

- VHA Directive 2010-034, *Staffing Methodology for VHA Nursing Personnel*, July 19, 2010.
- VHA. "Staffing Methodology for Nursing Personnel." August 30, 2011.

[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 20, 2016.