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Office of Inspector General

Office of Healthcare Inspections

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Comprehensive Healthcare Inspection Program Review of the Bath VA Medical Center Bath, New York

December 7, 2017

Washington, DC 20420

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Glossary

CBOC	community based outpatient clinic
CHIP	Comprehensive Healthcare Inspection Program
EHR	electronic health record
EOC	environment of care
facility	Bath VA Medical Center
FY	fiscal year
MH	mental health
Nurse Executive	Associate Director for Patient Care Services
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
PC	primary care
PTSD	post-traumatic stress disorder
QSV	quality, safety, and value
RRTP	Residential Rehabilitation Treatment Program
SAIL	Strategic Analytics for Improvement and Learning
TJC	The Joint Commission
UM	utilization management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Report Overview

This Comprehensive Healthcare Inspection Program (CHIP) review provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Bath VA Medical Center (facility). The review covers key clinical and administrative processes that are associated with promoting quality care.

CHIP reviews are one element of the Office of Inspector General's (OIG) overall efforts to ensure that our nation's veterans receive high-quality and timely VA health care services. The reviews are performed approximately every 3 years for each facility. OIG selects and evaluates specific areas of focus on a rotating basis each year. OIG's current areas of focus are:

1. Leadership and Organizational Risks
2. Quality, Safety, and Value
3. Medication Management
4. Coordination of Care
5. Environment of Care
6. High-Risk Processes[1]
7. Long-Term Care[2]

This review was conducted during an unannounced visit made during the week of May 8, 2017. OIG conducted interviews and reviewed clinical and administrative processes related to areas of focus that affect patient care outcomes. Although OIG reviewed a spectrum of clinical and administrative processes, the sheer complexity of VA medical centers limits the ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of facility performance within the identified focus areas at the time of the OIG visit. Although it is difficult to quantify the risk of patient harm, the findings in this report may help facilities identify areas of vulnerability or conditions that, if properly addressed, will potentially improve patient safety and health care quality.

Results and Review Impact

Leadership and Organizational Risks. At the Bath VA Medical Center, the leadership team consists of the Facility Director, Chief of Staff, Associate Director for Patient Care Services (Nurse Executive), and Associate Director. Organizational communication and accountability are carried out through a committee reporting structure with local leadership having oversight of multiple working committees such as the Executive Committee of the Medical Staff, Organizational Improvement Committee, and Resource

[1] The Moderate Sedation focus area did not apply because the facility did not perform procedures using moderate sedation.
[2] The Community Nursing Home Oversight special focus area did not apply because the facility did not provide long-term care for greater than 90 days through contracts.

Board. The quadrad leaders are responsible for the integration, promotion, and flow of information in order to monitor quality of care and patient outcomes.

The Chief of Staff was recently hired in March 2017. The position became vacant in August 2016, and a Chief of Staff from another VA facility served as Acting Chief of Staff for 8 months. The remaining leadership team members (Director, Associate Director, and Nurse Executive) are permanently assigned and have all been at their positions for more than 18 months.

In the review of selected employee and patient survey results regarding facility senior leadership, OIG noted high satisfaction scores that reflected active engagement with employees and patients. OIG also noted that facility leaders implemented processes and plans to maintain positive perceptions of the facility and facility senior leadership.

Additionally, OIG reviewed accreditation agency findings, sentinel events, disclosures of adverse patient events, Patient Safety Indicator data, and Strategic Analytics for Improvement and Learning (SAIL) data and did not identify any substantial organizational risk factors. OIG recognizes that the SAIL model has limitations for identifying all areas of clinical risk but is "a way to understand the similarities and differences between the top and bottom performers" within the Veterans Health Administration (VHA).[3]

The senior leadership team was generally knowledgeable about selected SAIL metrics, employee and patient survey results, and actions taken during the previous 12 months in order to maintain/improve performance likely contributing to the current 5-star rating. In the review of key care processes, OIG issued 11 recommendations that are attributable to the Chief of Staff and Associate Director. Of the six areas of clinical operations reviewed, OIG noted findings in five. These are briefly described below.

Quality, Safety, and Value. OIG found that senior managers were engaged with quality, safety, and value activities. When opportunities for improvement were identified, they supported clinical leaders' implementation of corrective actions and monitoring of effectiveness. OIG found general compliance with requirements for protected peer review and patient safety. However, OIG noted deficiencies in credentialing and privileging and utilization management.[4]

[3] VHA Support Service Center (VSSC). The Strategic Analytics for Improvement and Learning (SAIL) Value Model Documentation Manual. Accessed on April 16, 2017: http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=2146. VHA's Office of Operational Analytics and Reporting developed a model for understanding a facility's performance in relation to nine quality domains and one efficiency domain. The domains within SAIL are made up of multiple composite measures, and the resulting scores permit comparison of facilities within a Veterans Integrated Service Network or across VHA. The SAIL model uses a "star" ranking system to designate a facility's performance in individual measures, domains, and overall quality.

[4] According to VHA Directive 1117 (July 9, 2014), utilization management involves the forward-looking evaluation of the appropriateness, medical need, and efficiency of health care services according to evidence-based criteria.

Medication Management. Generally, OIG noted safe anticoagulation therapy management practices for the many performance indicators evaluated. However, OIG identified a deficiency in providing education to patients with newly prescribed anticoagulant medications.

Coordination of Care. OIG noted that the facility developed and implemented a patient transfer policy and collected and reported data about transfers out of the facility. OIG made no recommendations.

Environment of Care. OIG noted a generally safe and clean environment of care at the parent facility and representative community based outpatient clinic with the exception of information technology network room security at the Wellsboro VA Clinic. However, OIG identified deficiencies with the frequency of environment of care rounds and consistent participation in inspections by core team members. In addition, OIG identified deficiencies at the Wellsboro VA Clinic with having a sufficient supply of oxygen tanks and personal protective equipment and with sterile supply storage.

Mental Health Residential Rehabilitation Treatment Program. OIG found compliance with cleanliness and with having policies/procedures for safe medication management and contraband detection. However, OIG identified deficiencies in monthly self-inspections, weekly contraband inspections, every 2-hour rounds of all public spaces, and daily resident room inspections for unsecured medications and with security at the main point of entry and a non-main entrance door.

Summary

In the review of key care processes, OIG issued 11 recommendations that are attributable to the Chief of Staff and Associate Director. The number of recommendations should not be used as a gauge for the overall quality provided at this facility. The intent is for facility leadership to use these recommendations as a "road map" to help improve operations and clinical care. The recommendations address systems issues as well as other less-critical findings that, if left unattended, may eventually interfere with the delivery of quality health care.

Comments

The Veterans Integrated Service Network Director and Facility Director agreed with the CHIP review findings and recommendations and provided acceptable improvement plans. (See Appendixes G and H, pages 43–44, for the full text of the Directors' comments.) We will follow up on the planned actions for the open recommendations until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

Purpose and Scope

Purpose

This Comprehensive Healthcare Inspection Program (CHIP) review was conducted to provide a focused evaluation of the quality of care delivered in the Bath VA Medical Center's (facility) inpatient and outpatient settings through a broad overview of key clinical and administrative processes that are associated with quality care and positive patient outcomes. The purpose of the review was to provide oversight of health care services to veterans and to share findings with facility leaders so that informed decisions can be made to improve care.

Scope

The current seven areas of focus for facility reviews are: (1) Leadership and Organizational Risks; (2) Quality, Safety, and Value (QSV); (3) Medication Management; (4) Coordination of Care; (5) Environment of Care (EOC); (6) High-Risk Processes; and (7) Long-Term Care. These were selected because of risks to patients and the organization when care is not performed well. Within four of the fiscal year (FY) 2017 focus areas, the Office of Inspector General (OIG) selected processes for special consideration—Anticoagulation Therapy Management, Inter-Facility Transfers, Moderate Sedation, and Community Nursing Home Oversight (see Figure 1). OIG focused on five areas of clinical operations[5] and two additional programs with relevance to the facility—Mental Health Residential Rehabilitation Treatment Program and Post-Traumatic Stress Disorder Care.

[5] The Community Nursing Home Oversight special focus area did not apply for the Bath VA Medical Center because the facility did not provide long-term care for greater than 90 days through contracts, and the Moderate Sedation focus area did not apply because the facility did not perform procedures using moderate sedation.

Figure 1. Fiscal Year 2017 Comprehensive Healthcare Inspection Program Review of Health Care Operations and Services

Source: VA OIG

Additionally, OIG staff provide crime awareness briefings to increase facility employees' understanding of the potential for VA program fraud and the requirement to report suspected criminal activity to OIG.

Methodology

To determine compliance with Veterans Health Administration (VHA) requirements[6] related to patient care quality, clinical functions, and the EOC, OIG physically inspected selected areas; reviewed clinical records, administrative and performance measure data, and accreditation survey reports;[7] and discussed processes and validated findings with managers and employees. OIG interviewed applicable managers and members of the executive leadership team.

The review covered operations for August 1, 2014[8] through May 8, 2017, the date when an unannounced week-long site visit commenced. On May 23, 2017, OIG presented crime awareness briefings to 29 of the facility's 766 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.

[6] Appendix C lists policies that had expired recertification dates but were considered in effect as they had not been superseded by more recent policy or guidance.
[7] OIG did not review VHA's internal survey results but focused on OIG inspections and external surveys that affect facility accreditation status.
[8] This is the date of the last Combined Assessment Program and/or Community Based Outpatient Clinic and Primary Care Clinic reviews.

Recommendations for improvement in this report target problems that can impact the quality of patient care significantly enough to warrant OIG follow-up until the facility completes corrective actions. The Facility Director's comments submitted in response to the recommendations in this report appear within each topic area.

Issues and concerns beyond the scope of a CHIP review are referred to the OIG Hotline management team for further evaluation.

OIG conducted the inspection in accordance with OIG standard operating procedures for CHIP reviews and Quality Standards for Inspection and Evaluation published by the Council of the Inspectors General on Integrity and Efficiency.

Results and Recommendations

Leadership and Organizational Risks

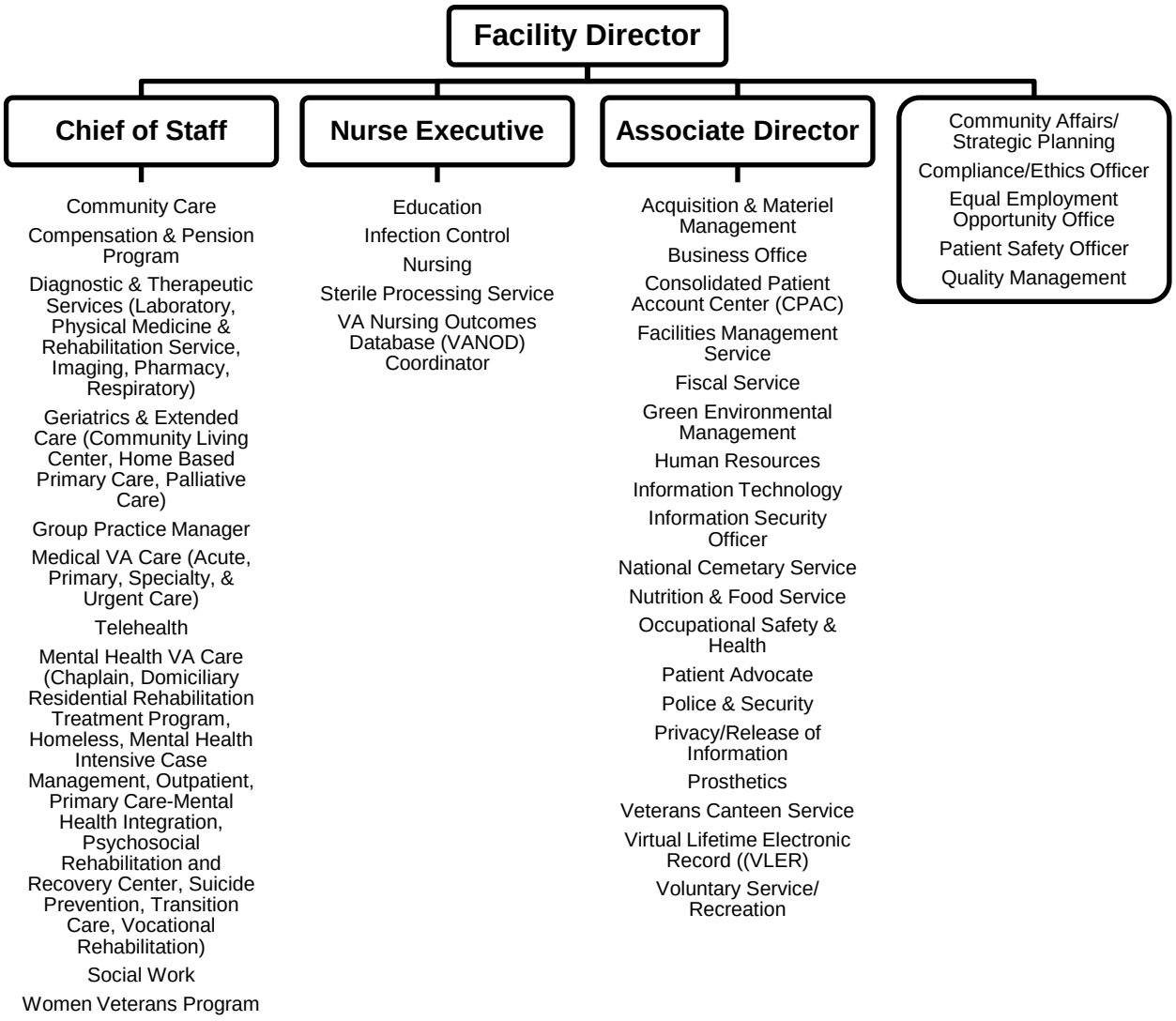
Stable and effective leadership is critical to improving care and sustaining meaningful change. Leadership and organizational risk issues can impact the facility's ability to provide care in all of the selected clinical areas of focus. The factors OIG considered in assessing the facility's risks and strengths were:

1. Executive leadership stability and engagement
2. Employee satisfaction and patient experience
3. Accreditation/for-cause surveys and oversight inspections
4. Indicators for possible lapses in care
5. VHA performance data

Executive Leadership Stability and Engagement. Because each VA facility organizes its leadership to address the needs and expectations of the local veteran population that it serves, organizational charts may differ between facilities. Figure 2 illustrates this facility's reported organizational structure. The facility has a leadership team consisting of the Director, Chief of Staff, Associate Director for Patient Care Services (Nurse Executive), and Associate Director. The Chief of Staff and Nurse Executive are responsible for overseeing patient care and service directors.

It is important to note that the Chief of Staff was hired in March 2017. The position had been vacant since August 2016, and a Chief of Staff from another VA facility served as Acting Chief of Staff for 8 months. The remaining leadership team members (Director, Associate Director, and Nurse Executive) are permanently assigned and have all been at their positions for more than 18 months.

Figure 2. Facility Organizational Chart



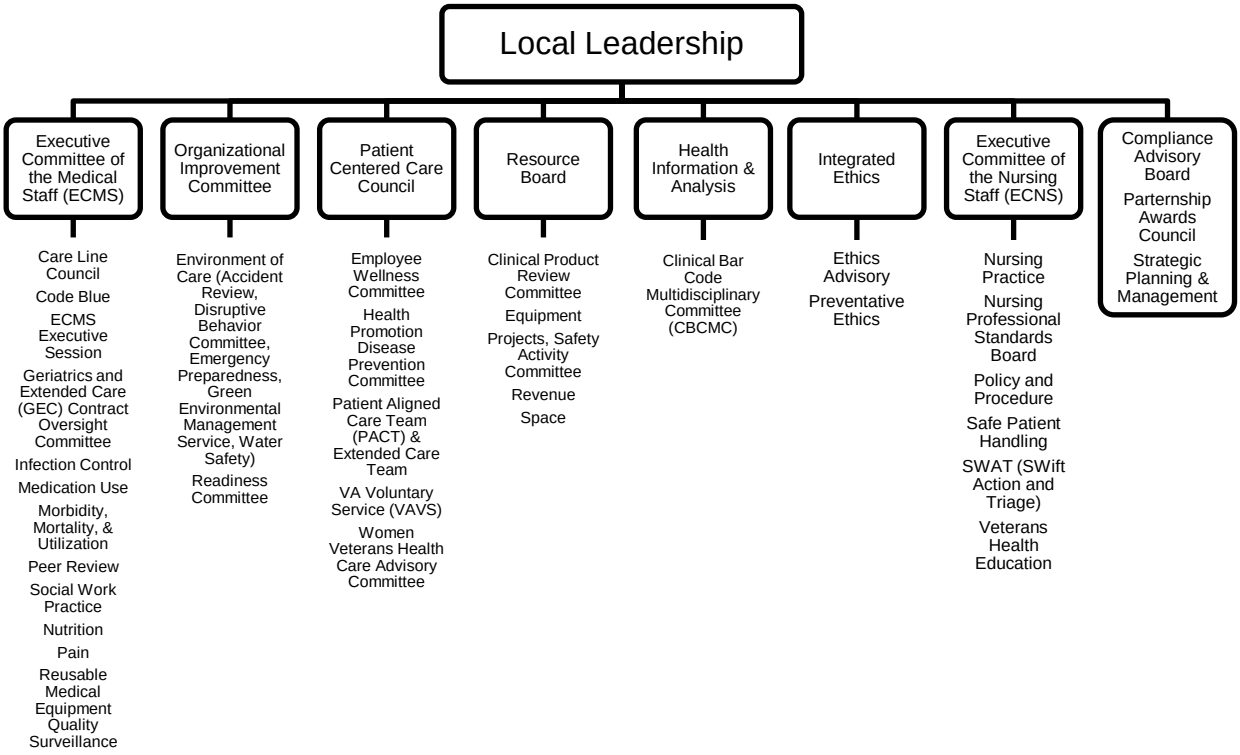
Source: Bath VA Medical Center (received July 19, 2017).

To help assess engagement of facility executive leadership, OIG interviewed the Facility Director, Chief of Staff, Nurse Executive, and Associate Director regarding their knowledge of various metrics and their involvement and support of actions to improve or sustain performance.

In individual interviews, these executive leaders generally were able to speak knowledgeably about actions taken during the previous 12 months in order to maintain or improve performance, employee and patient survey results, and selected Strategic Analytics for Improvement and Learning (SAIL) metrics. These are discussed more fully below.

The leaders are also engaged in monitoring patient safety and care through formal mechanisms. Local leadership, under the direction and authority of the Facility Director, is responsible for the integration, promotion, and flow of information in order to monitor quality of care and patient outcomes. Local leadership oversee multiple working committees, such as the Executive Committee of the Medical Staff, Organizational Improvement Committee, and Resource Board. See Figure 3.

Figure 3. Facility Committee Reporting Structure



Source: Bath VA Medical Center (received July 19, 2017).

Employee Satisfaction and Patient Experience. To assess employee and patient attitudes toward facility senior leadership, OIG reviewed employee satisfaction and patient experience survey results that relate to the period of October 1, 2015 through September 30, 2016. Although OIG recognizes that employee satisfaction and patient experience survey data are subjective, they can be a starting point for discussions and indicate areas for further inquiry, which can be considered along with other information on facility leadership. Table 1 provides relevant survey results for VHA and the facility for the 12-month period. The facility leaders' results (Director's office average) were rated markedly above the VHA and facility average.[9] All of the patient survey results reflected higher care ratings than the VHA average. In all, both employees and patients appear generally satisfied with the leadership and care provided.

Table 1. Survey Results on Employee and Patient Attitudes toward Facility Leadership (October 1, 2015 through September 30, 2016)

Questions	Scoring	VHA Average	Facility Average	Director's Office Average[10]
All Employee Survey[11] Q59. How satisfied are you with the job being done by the executive leadership where you work?	1 (Very Dissatisfied) – 5 (Very Satisfied)	3.3	3.5	4.8
All Employee Survey Servant Leader Index Composite	0–100 where HIGHER scores are more favorable	66.7	66.6	89.1
Survey of Healthcare Experiences of Patients (inpatient): Would you recommend this hospital to your friends and family?	The response average is the percent of "Definitely Yes" responses.	65.8	72.1	
Survey of Healthcare Experiences of Patients (inpatient): I felt like a valued customer.	The response average is the percent of "Agree" and "Strongly Agree" responses.	82.8	89.6	
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): I felt like a valued customer.		73.2	78.6	
Survey of Healthcare Experiences of Patients (outpatient specialty care): I felt like a valued customer.		73.8	80.7	

Accreditation/For-Cause[12] Surveys and Oversight Inspections. To further assess Leadership and Organizational Risks, OIG reviewed recommendations from previous inspections by oversight and accrediting agencies to gauge how well leaders respond to identified problems. Table 2 summarizes the relevant facility inspections most recently

[9] OIG makes no comment on the adequacy of the VHA average for each selected survey element. The VHA average is used for comparison purposes only.
[10] Rating is based on responses by employees who report to the Director.
[11] The All Employee Survey is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential. The instrument has been refined at several points since 2001 in response to operational inquiries by VA leadership on organizational health relationships and VA culture.
[12] TJC conducts for-cause unannounced surveys in response to serious incidents relating to the health and/or safety of patients or staff or reported complaints. The outcomes of these types of activities may affect the current accreditation status of an organization.

performed by the VA OIG and The Joint Commission (TJC). Indicative of effective leadership, the facility has closed[13] all recommendations for improvement as listed in Table 2.

OIG also noted the facility's current accreditation status with the Commission on Accreditation of Rehabilitation Facilities[14] and College of American Pathologists,[15] which demonstrates the facility leaders' commitment to quality care and services. Additionally, the Long Term Care Institute[16] conducted an inspection of the facility's Community Living Center.

Table 2. Office of Inspector General Inspections/Joint Commission Survey

Accreditation or Inspecting Agency	Date of Visit	Number of Findings	Number of Recommendations Remaining Open
VA OIG (*Combined Assessment Program Review of Bath VA Medical Center, Bath, New York, September 29, 2014)*	August 2014	5	0
VA OIG (*Community Based Outpatient Clinic and Primary Care Clinic Reviews at Bath VA Medical Center, Bath, New York, September 29, 2014)*	August 2014	2	0
TJC[17] • Hospital Accreditation • Nursing Care Center Accreditation • Behavioral Health Care Accreditation • Home Care Accreditation	June 2015	 10 2 2 2	 0 0 0 0

[13] A closed status indicates that the facility has implemented corrective actions and improvements to address findings and recommendations, not by self-certification, but as determined by accreditation organization or inspecting agency.

[14] The Commission on Accreditation of Rehabilitation Facilities provides an international, independent, peer review system of accreditation that is widely recognized by Federal agencies, 40 state governments, major insurers, and leading professional groups in rehabilitation as well as by consumer and advocacy organizations throughout the United States and in other countries. VHA's commitment is supported through a system-wide, long-term joint collaboration with the Commission on Accreditation of Rehabilitation Facilities to achieve and maintain national accreditation for all appropriate VHA rehabilitation programs, thereby helping to ensure that quality rehabilitation programs meet the unique needs of these veteran populations and provide a catalyst for improving the quality of life of veterans receiving services.

[15] For 70 years, the College of American Pathologists has fostered excellence in laboratories and advanced the practice of pathology and laboratory science. In accordance with VHA Handbook 1106.01, VHA laboratories must meet the requirements of the College of American Pathologists.

[16] Since 1999, the Long Term Care Institute has been to over 3,500 health care facilities conducting quality reviews and external regulatory surveys. The Long Term Care Institute is a leading organization focused on long-term care quality and performance improvement; compliance program development; and review in long-term care, hospice, and other residential care settings.

[17] TJC is an internationally accepted external validation that an organization has systems and processes in place to provide safe and quality oriented health care. TJC has been accrediting VHA facilities for over 30 years. Compliance with Joint Commission standards and accreditation processes facilitates risk reduction and performance improvement by standardizing critical procedures and processes.

Indicators for Possible Lapses in Care. Within the health care field, the primary organizational risk is the potential for patient harm. Many factors impact the risk for patient harm within a system, including unsafe environmental conditions, sterile processing deficiencies, and infection control practices. Leaders must be able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms. Table 3 summarizes key indicators of risk since OIG's previous August 2014 Combined Assessment Program and Community Based Outpatient Clinic (CBOC) and Primary Care (PC) review inspections through the week of May 8, 2017.

Table 3. Summary of Selected Organizational Risk Factors[18] (August 2014 to May 8, 2017)

Factor	Number of Occurrences
Sentinel Events[19]	0
Institutional Disclosures[20]	3
Large-Scale Disclosures[21]	0

OIG also reviewed Patient Safety Indicators developed by the Agency for Healthcare Research and Quality within the U.S. Department of Health and Human Services. These provide information on potential in-hospital complications and adverse events following surgeries and procedures.[22] Table 4 summarizes Patient Safety Indicator data from October 1, 2015 through September 30, 2016. The rates presented are specifically applicable for this facility, and lower rates indicate lower risks. None of the four applicable Patient Safety Indicator measures show an observed rate per 1,000 hospital discharges in excess of the observed rates for VISN 2 and VHA.

[18] It is difficult to quantify an acceptable number of occurrences because one occurrence is one too many. Efforts should focus on prevention. Sentinel events and those that lead to disclosure can occur in either inpatient or outpatient settings and should be viewed within the context of the complexity of the facility. (Note that the Bath VA Medical Center is a low complexity (3) non-affiliated facility as described in Appendix B.)
[19] A sentinel event is a patient safety event that involves a patient and results in death, permanent harm, or severe temporary harm and intervention required to sustain life.
[20] Institutional disclosure of adverse events (sometimes referred to as "administrative disclosure") is a formal process by which facility leaders together with clinicians and others, as appropriate, inform the patient or the patient's personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse.
[21] Large-scale disclosure of adverse events (sometimes referred to as "notification") is a formal process by which VHA officials assist with coordinating the notification to multiple patients (or their personal representatives) that they may have been affected by an adverse event resulting from a systems issue.
[22] Agency for Healthcare Research and Quality website, https://www.qualityindicators.ahrq.gov/, accessed March 8, 2017.

Table 4. October 1, 2015 through September 30, 2016, Patient Safety Indicator Data

Measure	Reported Rate per 1,000 Hospital Discharges		
	VHA	VISN 2	Facility
Pressure Ulcers	0.55	0.90	0.00
Death among surgical inpatients with serious treatable conditions	103.31	115.11	NA
Iatrogenic Pneumothorax	0.20	0.49	0.00
Central Venous Catheter-Related Bloodstream Infection	0.12	0.15	0.00
In Hospital Fall with Hip Fracture	0.08	0.05	0.00
Perioperative Hemorrhage or Hematoma	2.59	3.64	NA
Postoperative Acute Kidney Injury Requiring Dialysis	1.20	0.87	NA
Postoperative Respiratory Failure	6.31	8.19	NA
Perioperative Pulmonary Embolism or Deep Vein Thrombosis	3.29	3.67	NA
Postoperative Sepsis	4.45	5.98	NA
Postoperative Wound Dehiscence	0.65	0.00	NA
Unrecognized Abdominopelvic Accidental Puncture/Laceration	0.67	1.69	NA

Source: VHA Support Service Center.

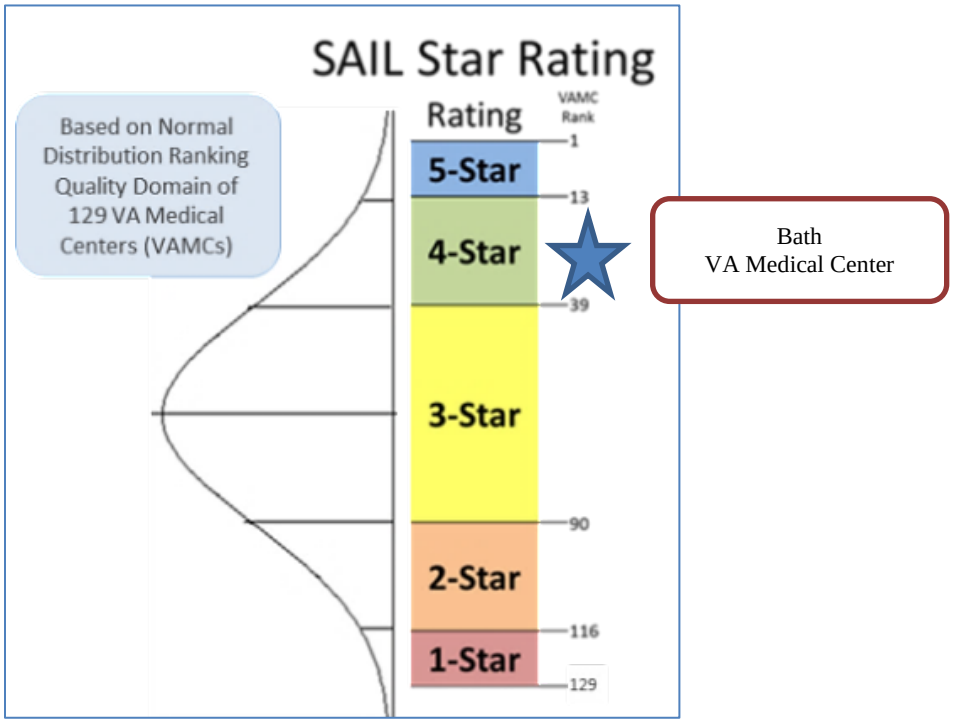
Note: OIG did not assess VA's data for accuracy or completeness.

Veterans Health Administration Performance Data. The VA Office of Operational Analytics and Reporting adapted the SAIL Value Model to help define performance expectations within VA.[23] This model includes measures on health care quality, employee satisfaction, access to care, and efficiency but has noted limitations for identifying all areas of clinical risk. The data are presented as one "way to understand the similarities and differences between the top and bottom performers" within VHA.[24]

VA also uses a star-rating system that is designed to make model results more accessible for the average user. Facilities with a 5-star rating are performing within the top 10 percent of facilities, whereas 1-star facilities are performing within the bottom 10 percent of facilities. Figure 4 describes the distribution of facilities by star rating. As of September 30, 2016, the Bath VA Medical Center received an interim rating of 4 stars for overall quality. This means the facility is in the 2nd quintile (10–30 percent range). Updated data as of June 30, 2017, indicates that the facility has improved to 5 stars for overall quality.

[23] The model is derived from the Thomson Reuters Top Health Systems Study.
[24] VHA Support Service Center (VSSC). The Strategic Analytics for Improvement and Learning (SAIL) Value Model Documentation Manual. Accessed on April 16, 2017: http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=2146

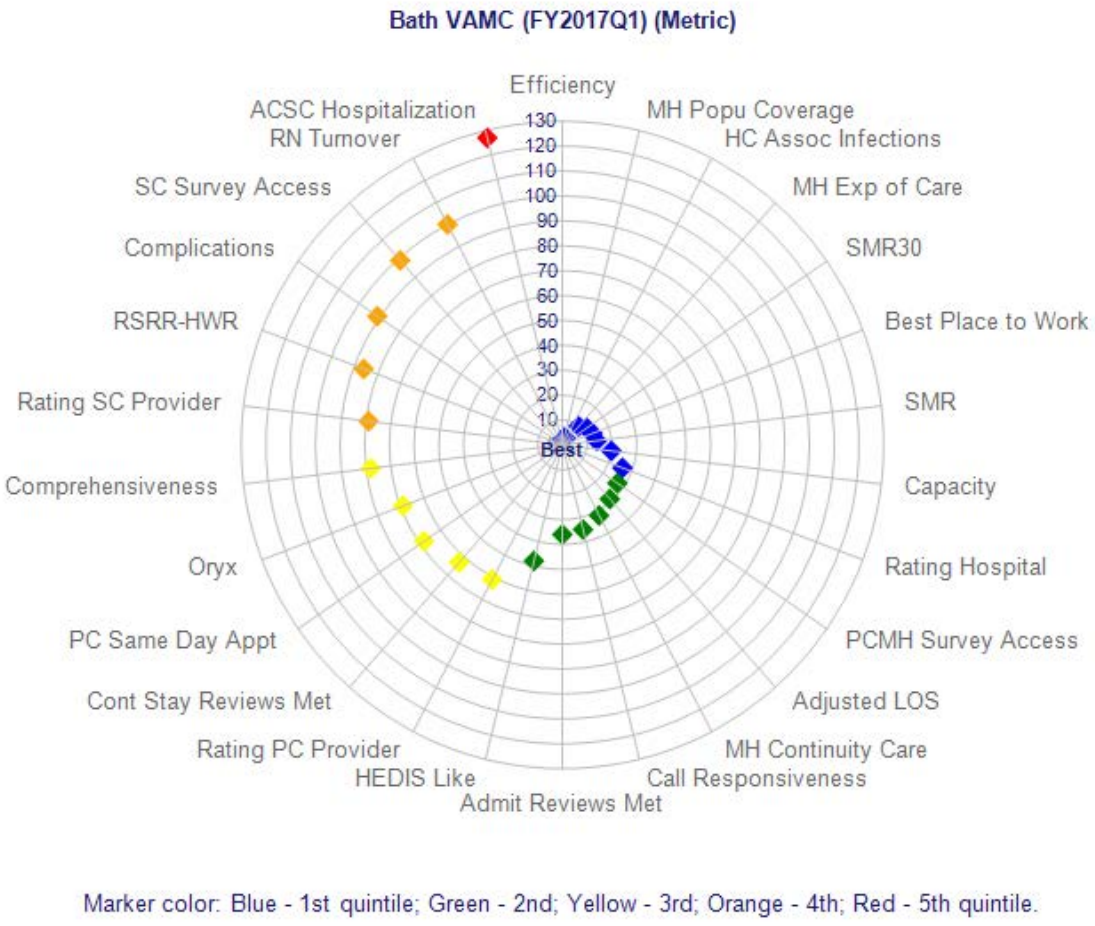
Figure 4. Strategic Analytics for Improvement and Learning Star Rating Distribution (as of September 30, 2016)



Source: VA Office of Informatics and Analytics' Office of Operational Analytics and Reporting.

Figure 5 illustrates the facility's Quality of Care and Efficiency metric rankings and performance compared to other VA facilities as of December 31, 2016. Of note, Figure 5 shows multiple blue and green data points in the top quintiles that show high performance (for example, Efficiency, Mental Health [MH] Population Coverage, and Healthcare-Associated [HC Assoc] Infections). Metrics in the bottom quintiles reflect areas that need improvement and are denoted in orange and red (for example, Complications, Registered Nurse [RN] Turnover, and Ambulatory Care-Sensitive Condition [ACSC] Hospitalization.

Figure 5. Facility Quality of Care and Efficiency Metric Rankings (as of December 31, 2016)



Source: VHA Support Service Center.

Note: OIG did not assess VA's data for accuracy or completeness. Also see Appendix D for sample outpatient performance measures that feed into these data points (such as wait times, discharge contacts, and where patient care is received). For data definitions, see Appendix E.

Conclusions. The facility has generally stable executive leadership and active engagement with employees and patients as evidenced by high satisfaction scores. Organizational leaders support patient safety, quality care, and other positive outcomes (such as active processes and plans to maintain positive perceptions of the facility and facility senior leadership). OIG's review of accreditation organization findings, sentinel events, disclosures, Patient Safety Indicator data, and SAIL results did not identify any substantial organizational risk factors.[25] The senior leadership team was knowledgeable about selected SAIL metrics likely contributing to the interim 4-star rating, and since our site visit, updated data as of June 30, 2017 indicates that the facility has improved to a 5-star rating for overall quality.

[25] OIG recognizes that the SAIL model has limitations for identifying all areas of clinical risk. OIG is using it as "a way to understand the similarities and differences between the top and bottom performers" within the VHA system.

Quality, Safety, and Value

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, and efficiency.[26] VHA requires that its facilities operate a QSV program to monitor patient care quality and performance improvement activities.

The purpose of this review was to determine whether the facility complied with key QSV program requirements.[a] To assess this area of focus, OIG evaluated the following:

1. Senior-level involvement in QSV/performance improvement committee
2. Protected peer review[27] of clinical care
3. Credentialing and privileging
4. Utilization management (UM) reviews[28]
5. Patient safety incident reporting and root cause analyses

OIG interviewed senior managers and key QSV employees and evaluated meeting minutes, licensed independent practitioners' profiles, protected peer reviews, root cause analyses, and other relevant documents.

The list below shows the performance indicators for each of the following QSV program activities.

- Senior-level committee responsible for key QSV functions
  - Met at least quarterly
  - Chaired or co-chaired by the Facility Director
  - Reviewed aggregated data routinely
- Protected peer reviews
  - Examined important aspects of care (appropriate and timely ordering of diagnostic tests, timely treatment, and appropriate documentation)
  - Resulted in implementation of Peer Review Committee recommended improvement actions

[26] Department of Veterans Affairs, Veterans Health Administration. *Blueprint for Excellence*. September 2014.
[27] According to VHA Directive 2010-025 (June 3, 2010), this is a peer evaluation of the care provided by individual providers within a selected episode of care. This also involves a determination of the necessity of specific actions, and confidential communication is given to the providers who were peer reviewed regarding the results and any recommended actions to improve performance. The process may also result in identification of systems and process issues that require special consideration, investigation, and possibly administrative action by facility staff.
[28] According to VHA Directive 1117 (July 9, 2014), UM reviews evaluate the appropriateness, medical need, and efficiency of health care services according to evidence-based criteria.

- Credentialing and privileging processes
  - Considered frequency for Ongoing Professional Practice Evaluation (OPPE)[29] data review
  - Indicated a Focused Professional Practice Evaluation[30]
- UM personnel
  - Completed at least 75 percent of all required inpatient reviews
  - Documented Physician UM Advisors' decisions in the National UM Integration database
  - Reviewed UM data using an interdisciplinary group
- Patient safety personnel
  - Entered all reported patient incidents into the WEBSPOT database
  - Completed the required minimum of eight root cause analyses
  - Reported root cause analysis findings to reporting employees
  - Submitted an annual patient safety report

Conclusions. Generally, OIG found that senior managers were engaged with QSV activities, and when opportunities for improvement were identified, they supported clinical leaders' implementation of corrective actions and monitoring for effectiveness. OIG found general compliance with requirements for protected peer review and patient safety. However, OIG identified the following deficiencies in the remaining areas that warranted recommendations for improvement.

Credentialing and Privileging. Facility policy requires clinical managers to review OPPE data every 6 months. The ongoing monitoring of privileged practitioners is essential to confirm the quality of care delivered and allows the facility to identify professional practice trends that impact patient safety. Twenty-three of the 25 profiles did not contain evidence that service chiefs reviewed OPPE data every 6 months for these licensed independent practitioners. The reasons for noncompliance included staff turnover, intermittently vacant Chief of Staff position, lack of oversight, and knowledge gap in knowing where to send the OPPE packets for the interim OPPE analyst (who had been in the role since May 2016). Additionally, leadership was unaware of the problem.

Recommendation

1. The Chief of Staff ensures clinical managers consistently review Ongoing Professional Practice Evaluation data every 6 months and monitors the managers' compliance.

[29] OPPE is the ongoing monitoring of privileged practitioners to identify professional practice trends that impact the quality of care and patient safety.
[30] Focused Professional Practice Evaluation is a process whereby the facility evaluates the privilege-specific competence of the practitioner who does not have documented evidence of competently performing the requested privileges of the facility. It typically occurs at the time of initial appointment to the medical staff or the granting of new, additional privileges. The Focused Professional Practice Evaluation may be used when a question arises regarding a currently privileged practitioner's ability to provide safe, high-quality patient care.

Facility Concurred.

Target date for completion: April 30, 2018

Facility response: Revisions to the OPPE/FPPE (Focused Professional Practice Evaluation) process were initiated following the OIG site visit including orienting the new Chief of Staff and Associate Chief of Staff to their role in managing the OPPE/FPPE process. Medical Staff received education regarding the FPPE/OPPE process and provider level expectations on September 14, 2017 at the quarterly Medical Staff meeting. Members of the Executive Committee of the Medical Staff (ECMS) – Executive Session for Credentialing created standard work including revisions to the chart review tools and discipline specific OPPE indicators. Management of the FPPE-OPPE files will be transferred from Quality Management to the clinical service areas in FY 18 for review every six months. Secured folders on a shared drive were created to house information and track compliance with timely collection of data (i.e. Chart reviews, CMEs, etc.) Service chiefs will report FPPE/OPPE status to the Care Line Managers. Compliance will be monitored monthly by the facility Quality, Safety and Value committee. Any barriers to completion will be reported to the ECMS- Executive Session for Credentialing for awareness and resolution.

Utilization Management: Documentation of Decisions. VHA requires Physician UM Advisors to document their decisions regarding appropriateness of patient admission and continued stays in the National UM Integration database. This ensures the facility has data to use to set benchmarks; identify trends, actions, and opportunities to improve efficiency; and monitor outcomes. In 36 of 41 cases (88 percent) referred to the Physician UM Advisors for March and April 2017, there was no evidence that advisors documented their decisions in the National UM Integration database. UM staff reported that the Chief of Staff position had been intermittently vacant over the last year. This resulted in a lack of oversight to ensure Physician UM Advisors completed reviews.

Recommendation

2. The Chief of Staff ensures that Physician Utilization Management Advisors consistently document their decisions in the National Utilization Management Integration database and monitors the advisors' compliance.

Facility Concurred.

Target date for completion: January 31, 2018

Facility response: The Utilization Management (UM) Nurse provides the Physician Utilization Management Advisor (PUMA) with a list of any outstanding reviews at the end of each week. Any reviews not completed within 48 hours prior to the 14 day expiration date will be reported to leadership, the Chief of Staff. The UM Nurse will be notified when the PUMA will be out of the office and the name of a surrogate PUMA will be provided.

Compliance with this measure will be tracked monthly at the Executive Committee of the Medical Staff until compliance of 90 percent is achieved for three consecutive months.

Medication Management: Anticoagulation Therapy

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. From October 1, 2015 through September 30, 2016, more than 482,000 veterans received an anticoagulant,[31] or a blood thinner, which is a drug that works to prevent the coagulation or clotting of blood. TJC'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."

Within medication management, OIG selected a special focus on anticoagulation therapy given its risk and common usage among veterans. The purpose of this review was to determine whether facility clinicians appropriately managed and provided education to patients with new orders for anticoagulant medication.[b]

OIG reviewed relevant documents and the competency assessment records of five employees actively involved in the anticoagulant program and interviewed key employees. Additionally, OIG reviewed the electronic health records (EHRs) of 30 randomly selected patients who were prescribed new anticoagulant medications from July 1, 2015 through June 30, 2016. The list below shows the performance indicators examined.

- Development and implementation of anticoagulation management policies
- Algorithms, protocols, or standardized care processes
  - Initiation and maintenance of warfarin
  - Management of anticoagulants before, during, and after procedures
  - Use of weight-based, unfractionated heparin
- Provision of a direct telephone number for patient anticoagulation-related calls
- Designation of a physician anticoagulation program champion
- Risk minimization of dosing errors
- Routine review of quality assurance data
- Provision of transition follow-up and education for patients with newly prescribed anticoagulant medications
- Laboratory testing
  - Prior to initiating anticoagulant medications
  - During anticoagulation treatment
- Documentation of justification/rationale for prescribing the anticoagulant when laboratory values did not meet selected criteria
- Competency assessments for employees actively involved in the anticoagulant program

[31] Managerial Cost Accounting Pharmacy Cube, Corporate Data Warehouse data pull on March 23, 2017.

Conclusions. Generally, OIG noted safe anticoagulation therapy management practices for the many indicators listed above. However, OIG identified the following deficiency that warranted a recommendation for improvement.

Patient Education. VHA requires clinicians to deliver initial and ongoing patient and family education for newly prescribed anticoagulant medications, which includes the importance of follow-up monitoring, compliance issues, dietary restrictions, and potential for adverse reactions and interactions. Due to the high risk of adverse events, patient and/or family member education is essential to decrease the potential occurrence of bleeding, drug interactions, or other delayed pharmacological effects. Four of the 30 patients (13 percent) did not receive education specific to the newly prescribed anticoagulant. Anticoagulant clinicians were aware of requirements, but they were unaware that clinicians from other clinics who also manage anticoagulation therapy did not provide specific education to patients with newly prescribed anticoagulant medications.

Recommendation

3. The Chief of Staff ensures clinicians consistently provide specific education to patients with newly prescribed anticoagulant medications and monitors clinicians' compliance.

Facility Concurred.

Target date for completion: December 31, 2017

Facility Response: Clinical pharmacists ensured staff had access to written education materials for anticoagulation therapy in all clinical areas; completed September 30, 2017. Modifications are being made to the outpatient anticoagulation clinic consult and to the documentation template used by all clinical staff to include basic counseling points for anticoagulation to maximize compliance with delivery of education and documentation of such. The anticipated completion of edits to the consult and note template is December 31, 2017. To monitor compliance, a random sample of 30 percent of patients initiated on anticoagulation therapy will be reviewed for evidence of initial education documentation. This monitor will continue until 90 percent compliance for 3 consecutive months has been achieved.

Coordination of Care: Inter-Facility Transfers

Coordination of care is the process of ensuring continuity of care, treatment, or services provided by a facility, which includes referring individuals to appropriate community resources to meet ongoing identified needs. Effective coordination of care also involves implementing a plan of care and avoiding unnecessary duplication of services. OIG selected a special focus on inter-facility transfers because they are frequently necessary to provide patients with access to specific providers or services. 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.

The purpose of this review was to evaluate selected aspects of the facility's patient transfer process, specifically transfers out of the facility.[c]

OIG reviewed relevant policies and facility data and interviewed key employees. Additionally, OIG reviewed the EHRs of 48 randomly selected patients who were transferred 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 list below shows the performance indicators OIG examined.

- Development and implementation of patient transfer policy
- Collection and reporting of data about transfers out of the facility
- Completion of VA Form 10-2649A and/or transfer/progress notes prior to or within a few hours after the transfer
  - Date of transfer
  - 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
- Documentation by acceptable designees in the absence of staff/attending physicians
  - Staff/attending physician approval
  - Staff/attending physician countersignature on the transfer note
- Nurse documentation of transfer assessments/notes
- Provider documentation for emergent transfers
  - Patient stability for transfer
  - Provision of all medical care within the facility's capacity
- Communication with the accepting facility
  - Available history
  - Observations, signs, symptoms, and preliminary diagnoses
  - Results of diagnostic studies and tests

Conclusions. Generally, the facility met requirements with the above performance indicators. OIG made no recommendations.

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 requirements in selected areas that are often associated with higher risks of harm to patients, in this case, with a special emphasis on Radiology Service and the locked MH unit.[d]

Fluoroscopic imaging equipment produces x-rays for the diagnosis, localization, and guidance of interventional procedures.[32] Although an integral part of health care, fluoroscopic imaging can deliver large doses of radiation to patients and employees. Large doses of radiation are known to increase the incidence of cancer and can cause fetal abnormalities.

VHA provides various MH services to patients with acute and severe emotional and/or behavioral symptoms. These services are often provided in an inpatient setting.[33] The inpatient locked MH unit must provide a healing, recovery-oriented environment as well as be a safe place for patients and employees. VHA developed the MH EOC Checklist to reduce environmental factors that contribute to inpatient suicides, suicide attempts, and other self-injurious behaviors and factors that reduce employee safety on MH units.

In all, OIG inspected the medical/surgical unit, the community living center units (1, 3, 4, and 5), urgent care, Radiology Service, the cardiology clinic, outpatient MH, and the women's clinic. OIG also inspected the Wellsboro VA Clinic. Additionally, OIG reviewed relevant documents and interviewed key employees and managers. The list below shows the location-specific performance indicators selected to examine the risk areas specific to particular settings.

<u>Parent Facility</u>

- EOC Deficiency Tracking
- EOC Rounds
- General safety
- Infection prevention
- Environmental cleanliness
- Exam room privacy
- Availability of feminine hygiene products
- Availability of medical equipment and supplies

[32] VHA Handbook 1105.04, *Fluoroscopy Safety*, July 6, 2012.
[33] VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013.

Community Based Outpatient Clinic
- General safety
- Infection prevention
- Environmental cleanliness
- Medication safety and security
- Exam room privacy
- General privacy
- Availability of feminine hygiene products
- IT network room security
- Availability of medical equipment and supplies

Radiology
- Safe use of fluoroscopy equipment
- Environmental safety
- Infection prevention
- Medication safety and security
- Radiology equipment inspection
- Availability of medical equipment and supplies
- Maintenance of radiological equipment

Performance indicators that did not apply to this facility are listed below.

Locked Mental Health Unit
- MH EOC inspections
- Environmental suicide hazard identification and abatement
- Environmental safety
- Infection prevention
- Employee training on MH environmental hazards
- Availability of medical equipment and supplies

Conclusions. Generally, OIG noted compliance with requirements for cleanliness and safety at the parent facility and representative CBOC. However, the Wellsboro VA Clinic information technology closet lacked documentation of authorized access. Further, OIG identified the following deficiencies that warranted recommendations for improvement.

Parent Facility: Environment of Care Rounds. VHA requires EOC rounds to be conducted at a minimum of once per FY in non-patient care areas and twice per FY in patient care areas. This ensures a safe, clean, and functional health care environment. OIG reviewed FY 2016 facility EOC rounds records and observed that 15 of 96 facility areas (16 percent) were not inspected at the required frequency. Facility managers, believing that they were meeting requirements, failed to maintain appropriate oversight.

Recommendation

4. The Associate Director ensures all areas of the facility are inspected at the required frequency and monitors compliance.

Facility Concurred.

Target date for completion. May 17, 2017

Facility Response: On May 17, 2017 data entered into the Environment of Care national database was changed to reflect individual buildings to ensure all areas were inspected at the required frequency. A process has been developed to review the database annually to accurately reflect the total number of buildings as well as the appropriate patient care/non-patient care designation. Additionally, to improve oversight, a process has been established to create an annual EOC calendar to validate all buildings are being inspected at the required frequency. For FY 17, 95 of the 96 facility areas were inspected at the required frequency. The single outlier, building 34, was inspected for the 2nd time on October 5, 2017; 5 days beyond the end of the FY.

Parent Facility: Environment of Care Rounds Attendance. VHA requires facilities to perform comprehensive EOC rounds with a team that includes specific membership to ensure a safe, clean, and high quality care environment.[34] OIG reviewed Comprehensive EOC Assessment and Compliance Tool documentation for FY 2016 and noted that 5 of 13 EOC core team members did not consistently attend EOC rounds. Facility managers were aware of requirements but did not provide oversight at the service level to ensure compliance.

Recommendation

5. The Associate Director ensures core team members consistently attend environment of care rounds and monitors compliance.

Facility Concurred.

Target date for completion. September 30, 2017

Facility Response: The facility previously recognized this recommendation early in FY 17. All core team members identified an alternate within their subject area. Overall attendance in FY 17 was 99.2 percent of core team members and/or their designee. Attendance continues to be monitored and reported at the Environment of Care meetings quarterly.

Community Based Outpatient Clinic: Patient Care Supplies. JC requires clinic managers to maintain an adequate inventory of patient care supplies, including oxygen

[34] According to VHA, core membership is composed of representatives from programmatic areas such as nursing, infection control, patient safety, and medical equipment management to ensure adherence to various program requirements.

tanks. Having sufficient inventory ensures patients are able to receive care when needed. The Wellsboro VA Clinic had only one oxygen tank on hand, and it was empty. Clinic managers stated that the clinic should have two oxygen tanks, and at least one tank should be full. Oxygen tank inventory was not on the patient care supply list that was routinely checked for reordering purposes.

Recommendation

6. The Associate Director ensures that an inventory of the required number of filled oxygen tanks is maintained at the Wellsboro VA Clinic and monitors compliance.

Facility Concurred.

Target date for completion. December 31, 2017

Facility Response: A full oxygen tank was delivered to the Wellsboro VA clinic during the OIG site visit. New processes were developed to include using a daily oxygen tank room checklist, so nursing staff actively monitor usage of oxygen in the clinic. Additionally, par levels have been established and replacement tanks are ordered timely. The nurse manager monitors completion of the checklist monthly and will report at the facility Environment of Care meeting monthly.

Community Based Outpatient Clinic: Personal Protective Equipment. VHA requires its facilities to maintain an adequate supply of personal protective equipment to contain and prevent the spread of infection. The Wellsboro VA Clinic did not have an adequate supply and assortment of personal protective equipment (masks, gloves, gowns, and goggles) available for employees. Clinic managers did not check supply lists to ensure availability of all personal protective equipment.

Recommendation

7. The Associate Director ensures that an adequate supply of personal protective equipment (masks, gloves, gowns, and goggles) is available for employees at the Wellsboro VA Clinic and monitors compliance.

Facility Concurred.

Target date for completion. June 30, 2017

Facility Response: Personal protective equipment (PPE) was delivered to the Wellsboro VA Clinic on May 17, 2017. PPE cabinets were installed on the wall in the hallway to house easily accessible PPE supplies on June 30, 2017. Par levels are included to allow for adequate delivery time when supplies are low. Staff members maintain the PPE supplies using the monthly Infection Control Liaison checklist.

Community Based Outpatient Clinic: Sterile Supply Storage. VHA requires that clean and sterile supplies stored on the bottom shelf of an open shelf or wired cart have a physical barrier between the bottom shelf, the floor, and any housekeeping activities. This ensures that clean and sterile supplies do not fall to the floor where the cleanliness

of supplies may be compromised. The Wellsboro VA Clinic clean/sterile supply room stored supplies on carts with wire bottom shelves. Clinic managers did not check the clean/sterile supply room to ensure cleanliness and infection prevention policies were followed.

Recommendation

8. The Associate Director ensures that clean and sterile supplies are stored on supply room carts that have solid bottom shelves at the Wellsboro VA Clinic and monitors compliance.

Facility Concurred.

Target date for completion. June 1, 2017

Facility Response: A plastic liner was installed on the bottom shelf of the Wellsboro VA Clinic. This item is included in the Environment of Care checklist and monitored for compliance. In addition, logistics staff is on site monthly to clean and check supplies. The Logistics checklist was modified to include visual validation of a plastic liner on the bottom shelf of all clean/sterile supply shelves managed by the logistics department.

Mental Health Residential Rehabilitation Treatment Program

For this facility, OIG evaluated the MH Residential Rehabilitation Treatment Program (RRTP), more commonly referred to as domiciliary or residential treatment programs. 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.

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 care 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.[35]

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 2005, the Domiciliary RRTP became fully integrated with other residential rehabilitation treatment programs of the Office of MH Services. The MH RRTP bed level of care includes Domiciliary RRTP.[36]

The purpose of the review was to determine whether the facility's Domiciliary RRTP complied with selected EOC requirements.[e] OIG reviewed relevant documents, inspected the Domiciliary RRTP, and interviewed key employees and managers. The list below shows the performance indicators OIG reviewed.

- Environmental cleanliness
- Appropriate fire extinguishers near grease producing cooking devices
- Policies/procedures for safe medication management and contraband detection
- Performance and documentation of monthly self-inspections to include all required elements, work orders for items needing repair, and correction of identified deficiencies
- Performance and documentation of contraband inspections, rounds of all public spaces, daily bed checks, and resident room inspections for unsecured medications
- Written agreements in place acknowledging resident responsibility for medication security
- Keyless entry to MH RRTP main point(s) of entry, closed circuit television monitoring, and all other doors locked to outside and alarmed

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

- Closed circuit television monitors with recording capability in public areas but no in treatment areas or private spaces with signage alerting veterans and visitors of recording
- Process for employees to respond and articulate behavioral health and medical emergencies
- Keyless entry or door locks to women veterans' rooms
- Medications secured in residents' rooms

Conclusions. Generally, OIG found compliance with cleanliness and with having policies/procedures for safe medication management and contraband detection. However, OIG identified the following deficiencies that warranted recommendations for improvement.

*Inspections***.** VHA requires MH RRTP employees to conduct and document monthly self-inspections, weekly contraband inspections, daily patient room inspections, and rounds of public spaces every 2 hours. MH RRTP employees are also to document findings in order to identify deficiencies related to safety, security, and privacy. OIG reviewed self-inspection documentation from November 2016 through April 2017 and documentation of weekly contraband inspections conducted during April 2017. OIG noted that Domiciliary RRTP employees did not conduct and document the monthly self-inspection for November 2016 and the weekly contraband inspection for the last week of April 2017. Additionally, Domiciliary RRTP employees did not consistently conduct and document every 2-hour rounds of all public spaces from April 23, 2017 through May 6, 2017, and daily resident room inspections for unsecured medications from April 23, 2017 through May 6, 2017. Program managers believed employees were conducting all required inspections and were unaware of noncompliance until OIG's onsite review of the inspection data.

Recommendation

9. The Chief of Staff ensures that Domiciliary Residential Rehabilitation Treatment Program employees conduct and document monthly self-inspections, weekly contraband inspections, every 2-hour rounds of all public spaces, and daily resident room inspections for unsecured medications and monitors employees' compliance.

Facility Concurred.

Target date for completion: January 31, 2018

Facility Response: The 2-hour rounding tool and the daily resident room inspection sheets were revised and staff members were trained regarding use of the inspection sheets in July 2017. Staff compliance in completing the inspection sheets is being monitored. Documentation of monthly inspections was 100 percent compliant in August, September and October 2017.

*Environmental Safety***.** VHA requires that MH RRTP main points of entry have a keyless system. This ensures that the unit is secured against unauthorized staff, veteran, or visitor access. The Domiciliary RRTP main point of entry did not have a keyless system. Program managers were new to the position and were unaware of the requirement.

Recommendation

10. The Chief of Staff ensures that Domiciliary Residential Rehabilitation Treatment Program managers ensure the main point of entry has a keyless system and monitors compliance.

Facility Concurred.

Target date for completion: March 31, 2018

Facility Response: A contract was awarded on November 2, 2017 for a project proposal to secure the main door with a keyless entry system to monitor access to the DRRTP (Domiciliary Residential Rehabilitation Treatment Program) 24 hours a day, 7 days a week. This area is currently monitored continuously by cameras that are monitored in two locations; the Police Dispatch center, and the main desk at the DRRTP. In addition, after 9pm the main point of entry is secured (locked from the outside).

*Staff and Patient Safety***.** VHA requires that MH RRTP doors not considered main entrances be locked to prevent unauthorized entry and alarmed at all times. This facilitates staff and patient safety and would alert staff of unauthorized exits. One of 10 Domiciliary RRTP unit non-main entrance doors was locked for unauthorized entry but not alarmed. Program managers were new to the position and unaware of requirements.

Recommendation

11. The Chief of Staff ensures that Domiciliary Residential Rehabilitation Treatment Program managers ensure all non-main entrance doors are locked to prevent unauthorized entry and alarmed at all times and monitors compliance.

Facility Concurred.

Target date for completion: June 9, 2017

Facility Response: All non-main entrance doors to the DRRTP are locked and now alarmed. The final door was alarmed on June 9, 2017 following construction project completion.

Post-Traumatic Stress Disorder Care

For this facility, OIG also evaluated post-traumatic stress disorder (PTSD), a disorder that may occur "…following exposure to an extreme traumatic stressor involving direct personal experience that involves actual or threatened death or serious injury; other threat to one's physical integrity; witnessing an event that involves death, injury or threat to the physical integrity of another person; learning about unexpected or violent death, serious harm, threat of death or injury experienced by a family member or other close associate."[37]

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

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

The purpose of this review was to assess whether the facility complied with selected VHA requirements for PTSD follow-up in the outpatient setting.[f]

OIG reviewed relevant documents and interviewed key employees and managers. Additionally, OIG reviewed the EHRs of 32 randomly selected patients who had a positive PTSD screen from April 1, 2016 through March 30, 2017. The list below shows the performance indicators OIG reviewed.

- Completion of a suicide risk assessment by acceptable providers
- Established plan of care and disposition
- Offer of further diagnostic evaluations
- Completion of diagnostic evaluations
- Receipt of MH treatment when applicable

Conclusion. Generally, the facility met requirements with the above performance indicators. OIG made no recommendations.

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

Summary Table of Comprehensive Healthcare Inspection Program Review Findings

Healthcare Processes	Performance Indicators	Conclusion	
Leadership and Organizational Risks	• Executive leadership stability and engagement • Employee satisfaction and patient experience • Accreditation/for-cause surveys and oversight inspections • Indicators for possible lapses in care • VHA performance data	Eleven OIG recommendations, ranging from documentation issues to deficiencies that can lead to patient and staff safety issues or adverse events, are attributable to the Chief of Staff and Associate Director. See details below.	
Healthcare Processes	**Performance Indicators**	**Critical Recommendations[38] for Improvement**	**Recommendations for Improvement**
Quality, Safety, and Value	• Senior-level involvement in QSV/performance improvement committee • Protected peer review of clinical care • Credentialing and privileging • UM reviews • Patient safety incident reporting and root cause analyses	• Clinical managers consistently review OPPE data every 6 months.	• Physician UM Advisors consistently document their decisions in the National UM Integration database.
Medication Management	• Anticoagulation management policies and procedures • Management of patients receiving new orders for anticoagulants o Prior to treatment o During treatment • Ongoing evaluation of the anticoagulation program • Competency assessment	• Clinicians consistently provide specific education to patients with newly prescribed anticoagulant medications.	None
Coordination of Care	• Transfer policies and procedures • Oversight of transfer process • EHR documentation o Non-emergent transfers o Emergent transfers	None	None

[38] OIG defines "critical recommendations" as those that rise above others and address vulnerabilities and risks that could cause exceptionally grave health care outcomes and/or significant impact to quality of care.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Environment of Care	• Parent facility o EOC deficiency tracking and rounds o General Safety o Infection prevention o Environmental cleanliness o Exam room privacy o Availability of feminine hygiene products and medical equipment and supplies • CBOC o General safety o Infection prevention o Environmental cleanliness o Medication safety and security o Privacy o Availability of feminine hygiene products and medical equipment and supplies o IT network room security • Radiology o Safe use of fluoroscopy equipment o Environmental safety o Infection prevention o Medication safety and security o Radiology equipment inspection o Availability of medical equipment and supplies o Maintenance of radiological equipment • Inpatient MH o MH EOC inspections o Environmental suicide hazard identification o Employee training o Environmental safety o Infection prevention o Availability of medical equipment and supplies	• CBOC o An inventory of the required number of filled oxygen tanks is maintained at the Wellsboro VA Clinic. o An adequate supply of personal protective equipment (masks, gowns, gloves, and goggles) is available for employees at the Wellsboro VA Clinic.	• Parent Facility o All areas of the facility are inspected at the required frequency. o Core team members consistently attend EOC rounds. • CBOC o Clean and sterile supplies are stored on supply room carts that have solid bottom shelves at the Wellsboro VA Clinic..

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Mental Health Residential Rehabilitation Treatment Program	• Environmental cleanliness and fire safety • Policies/procedures o Safe medication management o Contraband detection • Monthly self-inspections • Contraband and unsecured medication inspections • Locked and alarmed entries • Closed circuit television monitors with recording capability in public areas • Process for responding to behavioral health and medical emergencies	• Employees conduct and document monthly self-inspections, weekly contraband inspections, every 2-hour rounds of all public spaces, and daily resident room inspections for unsecured medications. • The main point of entry for the Domiciliary RRTP has a keyless system. • All non-main entrance doors at the Domiciliary RRTP are locked to prevent unauthorized entry and alarmed at all times.	None
Post-Traumatic Stress Disorder Care	• Completion of a suicide risk assessment by acceptable providers • Established plan of care and disposition • Offer of further diagnostic evaluations • Completion of diagnostic evaluations • Receipt of MH treatment when applicable	None	None

Facility Profile

The table below provides general background information for this low-complexity (3)[39] non-affiliated[40] facility reporting to VISN 2.

Table 5. Facility Profile for Bath (528A6) for October 1, 2013 through September 30, 2016

Profile Element	Facility Data FY 2014[41]	Facility Data FY 2015[42]	Facility Data FY 2016[43]
Total Medical Care Budget in Millions	$103.0	$102.9	$103.6
Number of:			
• **Unique Patients**	12,365	12,927	13,156
• **Outpatient Visits**	168,562	174,088	171,185
• **Unique Employees**[44]	787	777	773
Type and Number of Operating Beds:			
• **Acute**	15	10	10
• **Mental Health**	0	0	0
• **Community Living Center**	160	160	91
• **Domiciliary**	187	187	170
Average Daily Census:			
• **Acute**	4	5	5
• **Mental Health**	NA	NA	NA
• **Community Living Center**	72	72	57
• **Domiciliary**	168	159	151

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.

NA = Not applicable

[39] VHA medical centers are classified according to a facilities complexity model; a low complexity (3) designation indicates a facility with low volume, low risk patients, few or no complex clinical programs, and small or no research and teaching programs. Retrieved September 7, 2017 from http://opes.vssc.med.va.gov/FacilityComplexityLevels/Facility%20Complexity%20Levels%20Document%20Library/Facility%20Complexity%20Level%20Model%20Fact%20Sheet.docx.
[40] Associated with a medical residency program.
[41] October 1, 2013 through September 30, 2014.
[42] October 1, 2014 through September 30, 2015.
[43] October 1, 2015 through September 30, 2016.
[44] Unique employees involved in direct medical care (cost center 8200).

VA Outpatient Clinic Profiles[45]

The VA outpatient clinics in communities within the catchment area of the facility provide PC integrated with women's health, MH, and telehealth services. Some also provide specialty care, diagnostic, and ancillary services. Table 6 provides information relative to each of the clinics.

Table 6. VA Outpatient Clinic Workload/Encounters[46] and Specialty Care, Diagnostic, and Ancillary Services Provided[47] for October 1, 2015 through September 30, 2016

Location	Station No.	PC Workload/Encounters	MH Workload/Encounters	Specialty Care Services[48] Provided	Diagnostic Services[49] Provided	Ancillary Services[50] Provided
Elmira, NY	528G4	5,953	2,019	Allergy Dermatology Endocrinology Gastroenterology Hematology/ Oncology Infectious Disease Neurology Rheumatology Poly-Trauma Anesthesia Eye General Surgery Podiatry Urology	NA	Nutrition Pharmacy Prosthetics Social Work Weight Management
Wellsville, NY	528G8	3,411	1,167	Allergy Dermatology Endocrinology Gastroenterology Infectious Disease Neurology Rheumatology Blind Rehab Poly-Trauma Anesthesia ENT Eye General Surgery	NA	Nutrition Weight Management

Source: VHA Support Service Center and VA Corporate Data Warehouse.

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

NA = Not applicable

[45] Includes all outpatient clinics in the community that were in operation as of February 15, 2017. We have omitted Coudersport, PA (528QE); and Wellsboro, PA (528QF), as no workload/encounters or services were reported.
[46] An encounter is a professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition.
[47] The denoted specialty care and ancillary services are limited to primary clinic stops with a count ≥ 100 encounters for October 1, 2015 through September 30, 2016, timeframe at the specified CBOC.
[48] Specialty care services refer to non-PC and non-MH services provided by a physician.
[49] Diagnostic services include EKG, EMG, laboratory, nuclear medicine, radiology, and vascular lab services.
[50] Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

VHA Policies Beyond Recertification Dates

In this report, OIG cited seven policies that were beyond the recertification date:

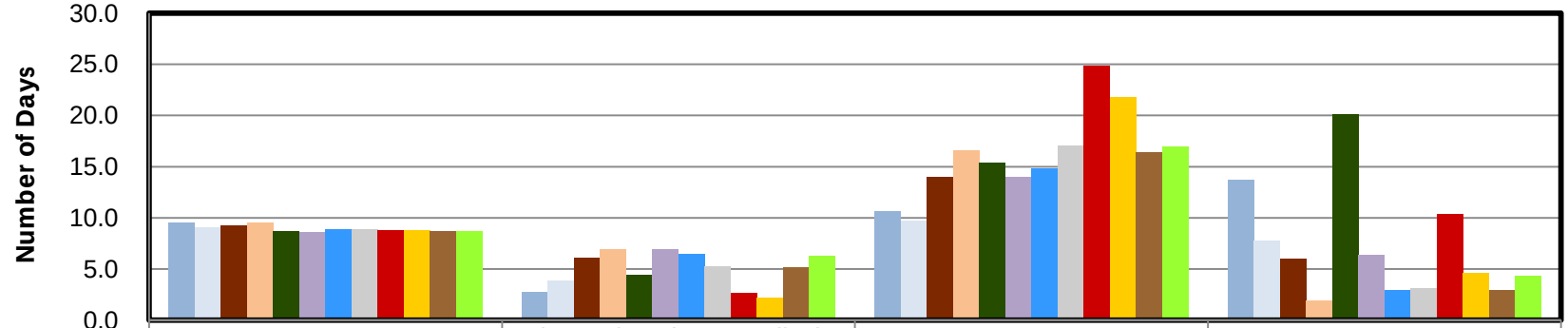
1. VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010 (recertification due date June 30, 2015).
2. VHA Directive 2011-007, Required Hand Hygiene Practices, February 16, 2011 (recertification due date February 29, 2016).
3. VHA Directive 2012-026, Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities, September 27, 2012 (recertification due date September 30, 2017).
4. VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011 (recertification due date March 31, 2016).
5. VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008 (recertification due date September 30, 2013), amended November 16, 2015.
6. VHA Handbook 1160.03, *Programs for Veterans with Post-Traumatic Stress Disorder (PTSD)*, March 12, 2010 (recertification due date March 31, 2015), revised December 8, 2015.
7. VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010 (recertification due date December 31, 2015).

OIG considered these policies to be in effect, as they had not been superseded by more recent policy or guidance. In a June 29, 2016, memorandum to supplement policy provided by VHA Directive 6330(1),[51] the VA Under Secretary for Health mandated the "…continued use of and adherence to VHA policy documents beyond their recertification date until the policy is rescinded, recertified, or superseded by a more recent policy or guidance."[52] The Under Secretary for Health also tasked the Principal Deputy Under Secretary for Health and Deputy Under Secretaries for Health with ensuring "…the timely rescission or recertification of policy documents over which their program offices have primary responsibility."[53]

[51] VHA Directive 6330(1), *Controlled National Policy/Directives Management System*, June 24, 2016, amended January 11, 2017.
[52] VA Under Secretary for Health. "Validity of VHA Policy Document." Memorandum. June 29, 2016.
[53] Ibid.

Patient Aligned Care Team Compass Metrics

Quarterly New PC Patient Average Wait Time in Days

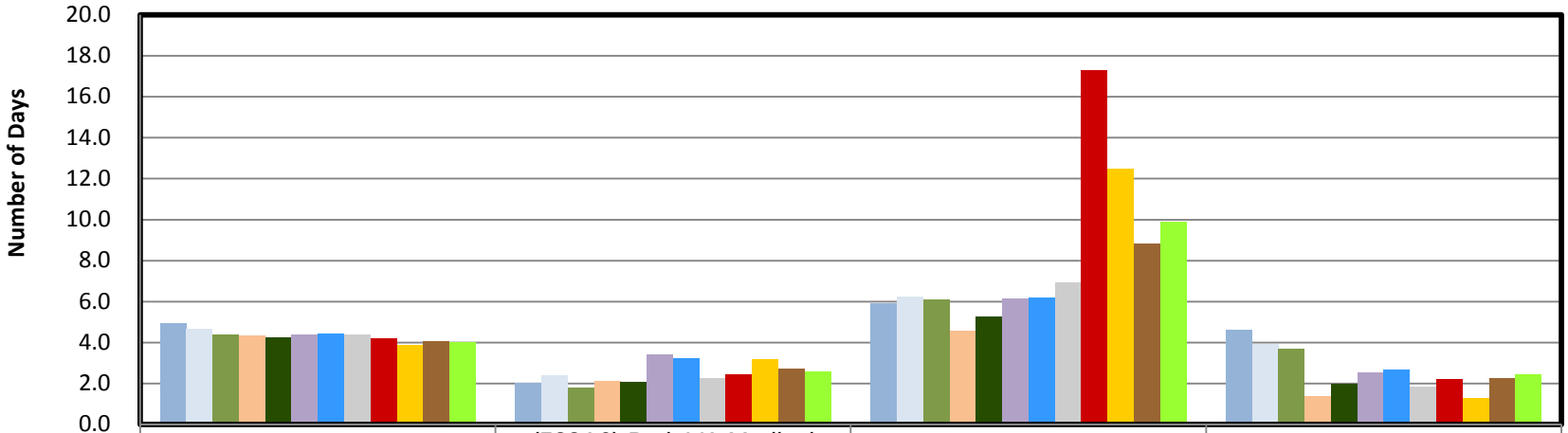


	VHA Total	(528A6) Bath VA Medical Center	(528G4) Elmira	(528G8) Wellsville
JAN-FY16	9.6	2.8	10.7	13.7
FEB-FY16	9.1	3.8	9.7	7.7
MAR-FY16	9.2	6.1	13.9	6.0
APR-FY16	9.5	7.0	16.6	1.9
MAY-FY16	8.7	4.4	15.4	20.1
JUN-FY16	8.6	6.9	14.0	6.4
JUL-FY16	8.9	6.5	14.8	2.9
AUG-FY16	8.9	5.3	17.1	3.2
SEP-FY16	8.8	2.7	24.9	10.3
OCT-FY17	8.8	2.2	21.8	4.6
NOV-FY17	8.7	5.2	16.4	2.9
DEC-FY17	8.7	6.3	16.9	4.3

Source: VHA Support Service Center.

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

Data Definition[g]: The average number of calendar days between a new patient's PC completed appointment (clinic stops 322, 323, and 350, excluding Compensation and Pension appointments) and the earliest of three possible preferred (desired) dates (Electronic Wait List [EWL], Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date. *Note that prior to FY 2015, this metric was calculated using the earliest possible create date.*

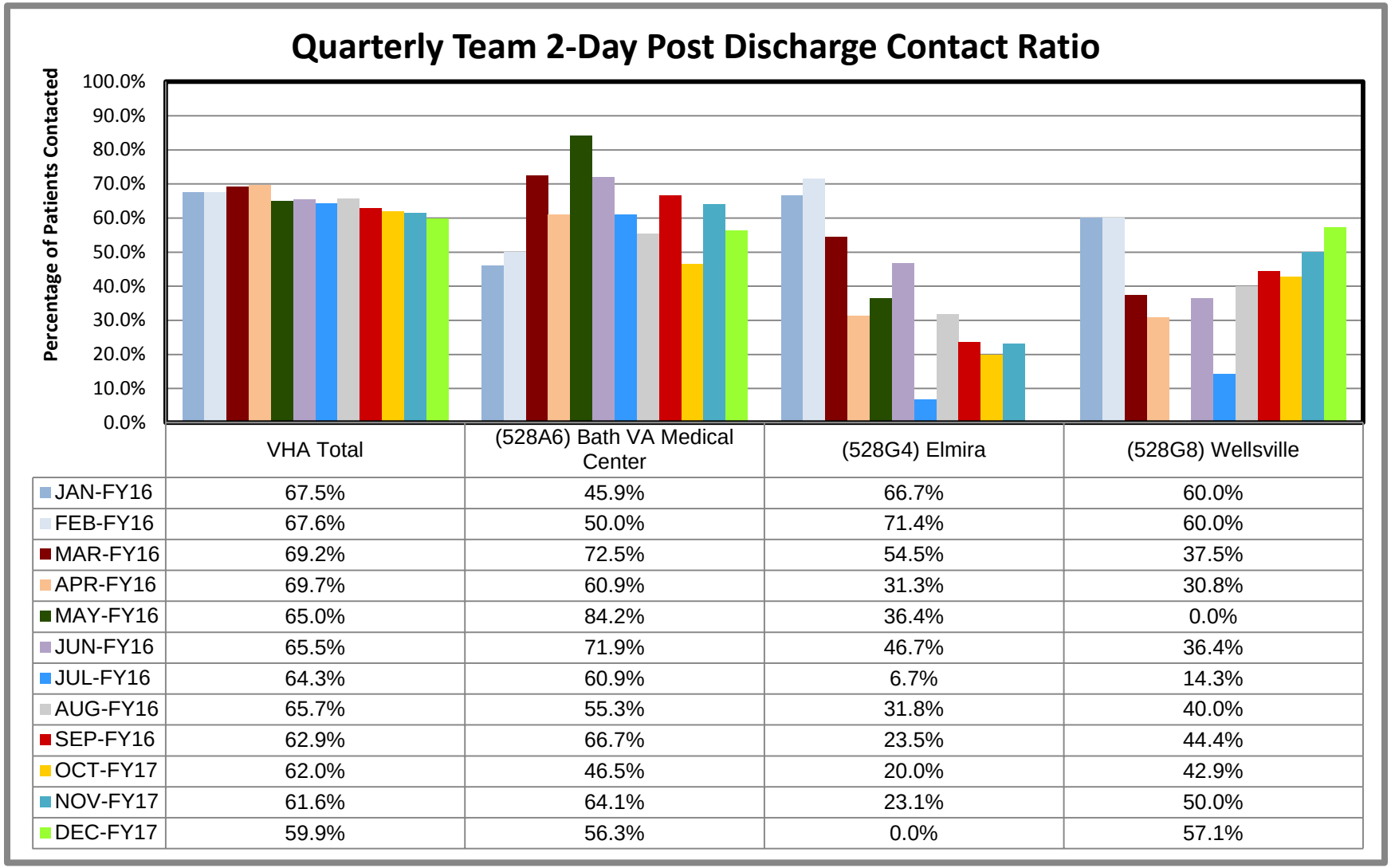


	VHA Total	(528A6) Bath VA Medical Center	(528G4) Elmira	(528G8) Wellsville
JAN-FY16	4.9	2.0	5.9	4.6
FEB-FY16	4.7	2.4	6.2	3.9
MAR-FY16	4.4	1.8	6.1	3.7
APR-FY16	4.3	2.1	4.6	1.4
MAY-FY16	4.3	2.1	5.3	2.0
JUN-FY16	4.4	3.4	6.1	2.5
JUL-FY16	4.4	3.2	6.2	2.7
AUG-FY16	4.3	2.2	6.9	1.8
SEP-FY16	4.2	2.4	17.3	2.2
OCT-FY17	3.8	3.2	12.4	1.3
NOV-FY17	4.0	2.7	8.8	2.2
DEC-FY17	4.0	2.6	9.9	2.4

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.

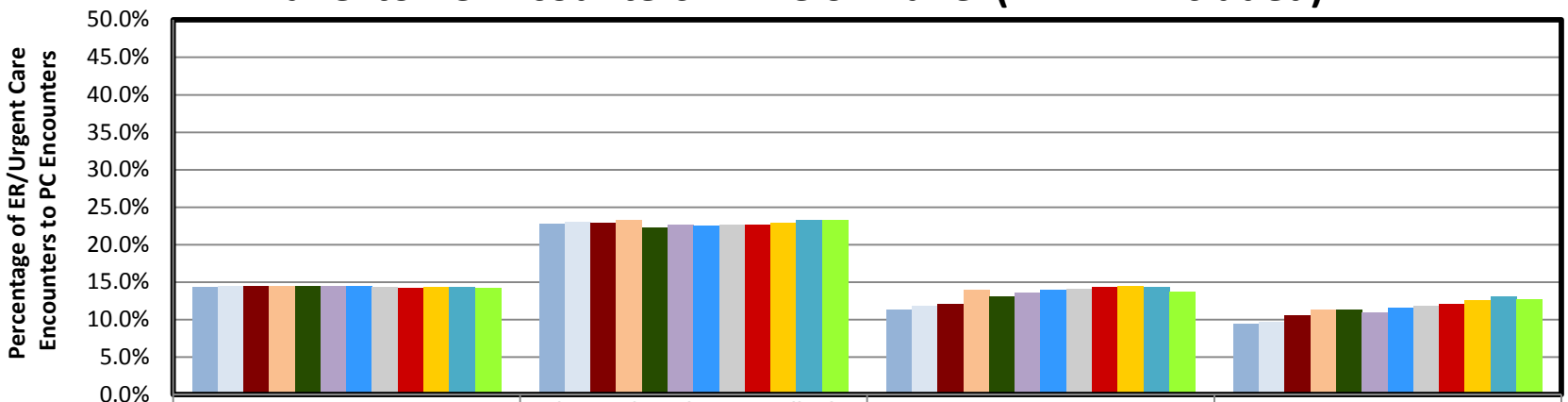


	VHA Total	(528A6) Bath VA Medical Center	(528G4) Elmira	(528G8) Wellsville
JAN-FY16	67.5%	45.9%	66.7%	60.0%
FEB-FY16	67.6%	50.0%	71.4%	60.0%
MAR-FY16	69.2%	72.5%	54.5%	37.5%
APR-FY16	69.7%	60.9%	31.3%	30.8%
MAY-FY16	65.0%	84.2%	36.4%	0.0%
JUN-FY16	65.5%	71.9%	46.7%	36.4%
JUL-FY16	64.3%	60.9%	6.7%	14.3%
AUG-FY16	65.7%	55.3%	31.8%	40.0%
SEP-FY16	62.9%	66.7%	23.5%	44.4%
OCT-FY17	62.0%	46.5%	20.0%	42.9%
NOV-FY17	61.6%	64.1%	23.1%	50.0%
DEC-FY17	59.9%	56.3%	0.0%	57.1%

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. Team member identification is based on the primary provider on the encounter. Performance measure mnemonic "PACT17."



	VHA Total	(528A6) Bath VA Medical Center	(528G4) Elmira	(528G8) Wellsville
JAN-FY16	14.3%	22.8%	11.3%	9.4%
FEB-FY16	14.4%	23.1%	11.8%	9.7%
MAR-FY16	14.4%	22.9%	12.1%	10.6%
APR-FY16	14.4%	23.3%	13.9%	11.3%
MAY-FY16	14.4%	22.3%	13.0%	11.3%
JUN-FY16	14.4%	22.6%	13.5%	10.9%
JUL-FY16	14.4%	22.6%	14.0%	11.5%
AUG-FY16	14.3%	22.6%	14.1%	11.8%
SEP-FY16	14.2%	22.7%	14.3%	12.1%
OCT-FY17	14.3%	23.0%	14.4%	12.5%
NOV-FY17	14.3%	23.2%	14.3%	13.1%
DEC-FY17	14.2%	23.3%	13.7%	12.6%

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.

Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions[h]

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

Measure	Definition	Desired Direction
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
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

Relevant OIG Reports

August 1, 2014 through September 1, 2017[54]

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*

Combined Assessment Program Review of the Bath VA Medical Center, Bath, New York

9/29/2014 | *14-02075-292* | *Summary* | *Report*

Community Based Outpatient Clinic and Primary Care Clinic Reviews at Bath VA Medical Center, Bath, New York

9/29/2014 | *14-00928-291* | *Summary* | *Report*

[54] These are relevant reports that focused on the facility as well as national-level evaluations of which the facility was a component of the review.

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: November 6, 2017

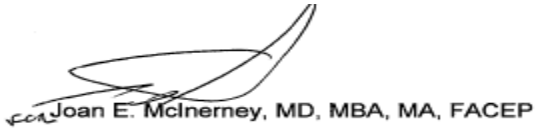
From: Director, New York/New Jersey VA Health Care Network (10N2)

Subject: **CHIP Review of the Bath VA Medical Center, Bath, NY**

To: Associate Director, Bay Pines Office of Healthcare Inspections (54SP)

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

I concur with the conclusions and recommendations presented by the Office of Healthcare Inspections and present to you an action plan to correct those areas with recommendations.



Thomas Sharpe, Acting Deputy Network Director

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: November 3, 2017

From: Director, Bath VA Medical Center (528A6/00)

Subject: **CHIP Review of the Bath VA Medical Center, Bath, NY**

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

I have reviewed the draft report of the Office of Inspector General (OIG) and I concur with the recommendations from the CHIP review on May 8-12th. The Medical Center has developed action plans to address the eleven recommendations which are included in the attached comments.

I would like to thank the OIG Survey Team for the consultative visit. The recommendations will strengthen our processes to deliver consistent quality care to our Veterans.

Please contact me if you have additional questions or comments.

Michael J. Swartz, FACHE
Medical Center Director

OIG Contact and Staff Acknowledgments

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U.S. Senate: Robert P. Casey, Jr.; Kirsten E. Gillibrand; Charles E. Schumer; Patrick J. Toomey
U.S. House of Representatives: Chris Collins, John Faso, Brian Higgins, John Katko, Mike Kelly, Tom Marino, Tom Reed, Louise Slaughter, Claudia Tenney, Glenn W. Thompson

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 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.

[c] The references used for Coordination of Care: Inter-Facility Transfers included:
- VHA Directive 2007-015, *Inter-Facility Transfer Policy*, May 7, 2007. This directive was in effect during the timeframe of OIG's review but has been rescinded and replaced with VHA Directive 1094, *Inter-Facility Transfer Policy*, January 11, 2017.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.
- VHA Handbook 1400.01, *Resident Supervision*, December 19, 2012.

[d] The references used for EOC included:
- VHA Handbook 1006.1, *Planning and Activating Community-Based Outpatient Clinics*, May 19, 2004.
- VHA Directive 1014, *Safe Medication Injection Practices*, July 1, 2015.
- VHA Handbook 1105.04, *Fluoroscopy Safety*, July 6, 2012.
- VHA Directive 1116(2), *Sterile Processing Services (SPS)*, March 23, 2016.
- VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013.
- VHA Directive 1330.01, *Health Care Services for Women Veterans*, February 15, 2017.
- VHA Directive 1608, *Comprehensive Environment of Care (CEOC) Program*, February 1, 2016.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012.
- VA Handbook 6500, *Risk Management Framework for VA Information Systems – Tier 3: VA Information Security Program*, March 10, 2015.
- MH EOC Checklist, VA National Center for Patient Safety, http://vaww.ncps.med.va.gov/guidelines.html#mhc, accessed December 8, 2016.
- Various requirements of TJC, Association for the Advancement of Medical Instrumentation/Association for the Advancement of Medical Instrumentation, Occupational Safety and Health Administration, International Association of Healthcare Central Service Materiel Management, National Fire Protection Association.

[e] 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*, February 15, 2017 (amended September 8, 2017).
- Requirements of the VHA Center for Engineering and Occupational Safety and Health and the National Fire Protection Association.

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

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

- Department of Veterans' Affairs, Patient Aligned Care Teams Compass Data Definitions, accessed: February 14, 2017.

[h] 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.