Department of Veterans Affairs
Office of Inspector General

Report No. 17-01740-62

Comprehensive Healthcare Inspection Program Review of the VA Southern Oregon Rehabilitation Center and Clinics White City, Oregon

January 11, 2018

Washington, DC 20420

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Glossary

CCTV	closed circuit television
CHIP	Comprehensive Healthcare Inspection Program
EOC	environment of care
facility	VA Southern Oregon Rehabilitation Center and Clinics
FY	fiscal year
MH	mental health
Nurse Executive	Associate Director for Patient Care Services
OIG	Office of Inspector General
PC	primary care
PTSD	post-traumatic stress disorder
QSV	quality, safety, and value
SAIL	Strategic Analytics for Improvement and Learning
TJC	The Joint Commission
UM	utilization management
VHA	Veterans Health Administration

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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 VA Southern Oregon Rehabilitation Center and Clinics (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[1]
5. Environment of Care
6. High-Risk Processes[2]
7. Long-Term Care

This review was conducted during an unannounced visit made during the week of June 5, 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 VA Southern Oregon Rehabilitation Center and Clinics, 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 facility leaders having oversight for leadership groups such as the Quality Leadership Governance Board, Medical Executive Committee, Nursing Professional Committee, and Environment of Care Committee. The Quality Leadership

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[1] The Inter-Facility Transfers special focus area did not apply for the VA Southern Oregon Rehabilitation Center and Clinics because the facility did not have an Emergency Department, an urgent care center, or inpatient beds.
[2] The Moderate Sedation special focus area did not apply for the VA Southern Oregon Rehabilitation Center and Clinics because the facility did not perform procedures using moderate sedation.

Governance Board, co-chaired by the Facility Director, tracks, trends, and monitors quality of care and patient outcomes. The leadership team are members of the Quality Leadership Governance Board.

The Nurse Executive and Associate Director were not permanently assigned, and recruiting efforts were ongoing during OIG's site visit. The Facility Director and Chief of Staff had been working together as a team since October 2015. In the review of selected employee survey results regarding facility senior leadership, OIG noted satisfaction scores that reflected active engagement with employees. Patient survey results indicated that patients were generally less than satisfied, and facility leaders had opportunities to improve patient experiences.

Additionally, OIG reviewed accreditation agency findings, sentinel events, disclosures of adverse patient events, 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, but these leaders should continue to take actions to improve care and performance of the Quality of Care and Efficiency metrics likely contributing to the current 1-star SAIL rating.

In the review of key care processes, OIG issued eight recommendations that are attributable to the Facility Director, 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. Generally, 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 for effectiveness. OIG found general compliance with requirements for protected peer reviews, credentialing and privileging processes, and utilization management.[4] However, OIG noted a deficiency in completing the required number of root cause analyses.

Medication Management. OIG found safe anticoagulation therapy management practices for many of the indicators and compliance with requirements for obtaining

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[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.

required laboratory tests and competency assessments for employees actively involved in the program. However, OIG identified a deficiency in the review of quality assurance data.

Environment of Care. OIG noted a safe and clean environment of care. The parent facility met most of the performance indicators evaluated. OIG did not identify any reportable deficiencies for the representative community based outpatient clinic or for radiology. However, OIG identified a deficiency with environment of care rounds attendance.

Long-Term Care: Community Nursing Home Oversight. OIG noted compliance with integration of the community nursing home program, patient hand-offs, and community nursing home annual reviews. However, OIG identified deficiencies with Community Nursing Home Oversight Committee representation and clinical visits for patients residing in community nursing homes.

Mental Health Residential Rehabilitation Treatment Program. OIG generally noted a clean environment and compliance with having required policies/procedures in place, conducting and documenting monthly self-inspections, having written medication agreements in place, and ensuring medication security. However, OIG identified deficiencies with weekly contraband inspections, closed circuit television surveillance systems, and signage alerting patients and visitors of recording.

Summary

In the review of key care processes, OIG issued eight recommendations that are attributable to the Facility Director, 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 42–43, and the responses within the body of the report, for the full text of the Directors' comments.) OIG considers recommendations 1, 7, and 8 closed. OIG will follow up on the planned actions for the open recommendations until they are completed.

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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 VA Southern Oregon Rehabilitation Center and Clinics' (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).

The Inter-Facility Transfers special focus area did not apply for the VA Southern Oregon Rehabilitation Center and Clinics because the facility did not have an Emergency Department, an urgent care center, or inpatient beds, and the Moderate Sedation special focus area did not apply because the facility did not perform procedures using moderate sedation. Thus, OIG focused on the remaining four areas of clinical operations and two additional programs with relevance to the facility—Mental Health (MH) Residential Rehabilitation Treatment Program (RRTP) and Post-Traumatic Stress Disorder (PTSD) Care.

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[5] 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;[6] 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 April 21, 2014[7] through June 5, 2017, the date when an unannounced week-long site visit commenced. On June 27 and 28, 2017, OIG presented crime awareness briefings to 64 of the facility's 707 employees. These briefings covered procedures for reporting suspected criminal activity to OIG and

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[5] 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.

[6] OIG did not review VHA's internal survey results but focused on OIG inspections and external surveys that affect facility accreditation status.

[7] This is the date of the last Combined Assessment Program and/or Community Based Outpatient Clinic and Primary Care Clinic reviews.

included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

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.

While onsite, OIG did not receive any concerns beyond the scope of a CHIP review. 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 program and service chiefs and service line directors.

It is important to note that the Nurse Executive and Associate Director were not permanently assigned. At the time of OIG's onsite visit, the Nurse Executive position had been vacant for 2 months (since April 2017), and one employee had served as Interim Nurse Executive since the position became vacant. The Associate Director position had been vacant for 3 months (since March 2017), and an employee from another VA facility had served as the Interim Associate Director. The Facility Director and Chief of Staff had been working together as a team since October 2015.

Figure 2. Facility Organizational Chart

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                           │  Facility Director  │
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│  Chief of Staff │ │ Nurse Executive │ │Associate Director│ │     Facility Planner    │
└─────────────────┘ └─────────────────┘ └──────────────────┘ │    Equal Employment     │
                                                              │ Opportunity & Compliance│
                                                              │    Quality Management   │
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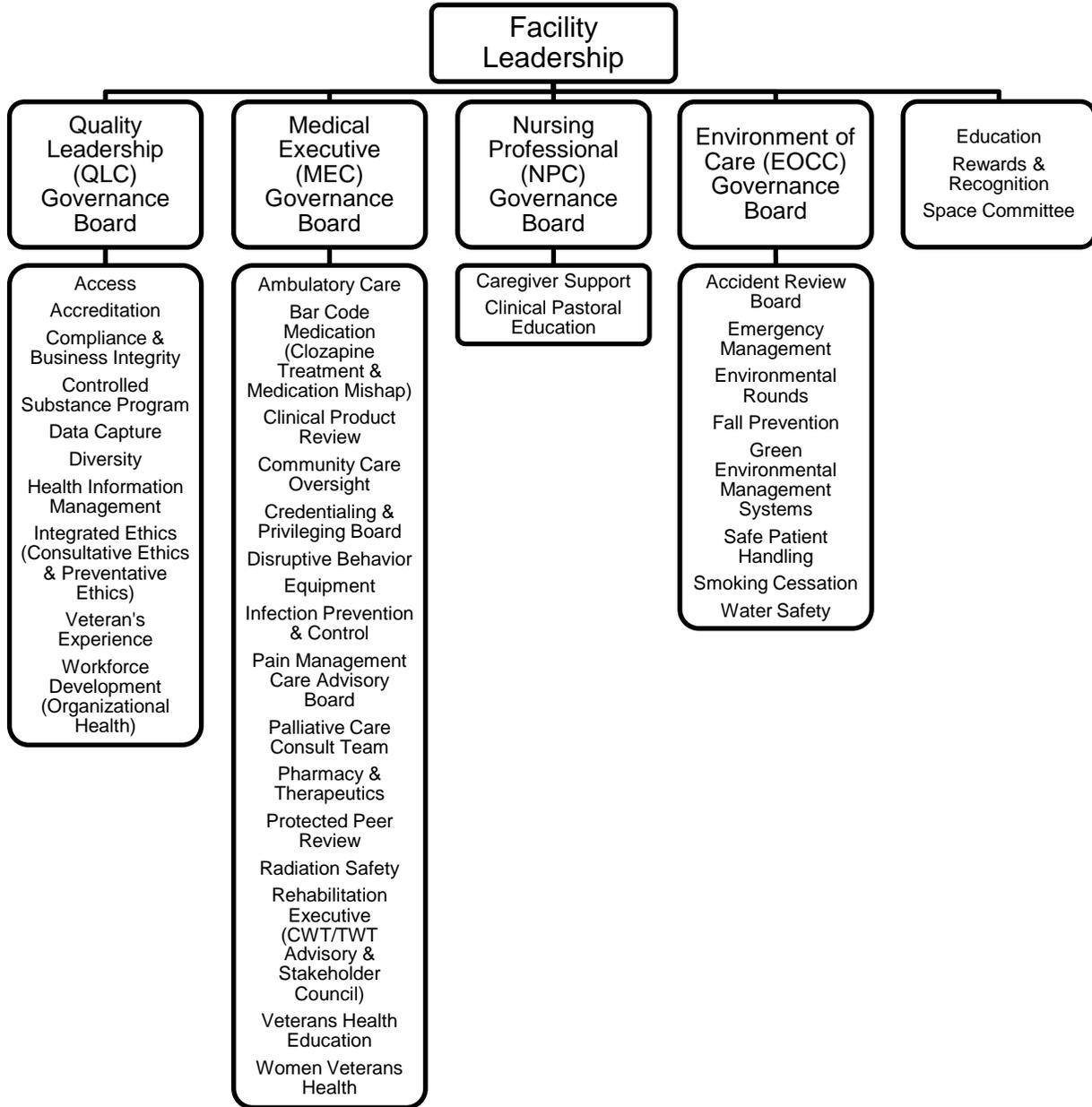| Chief of Staff	Nurse Executive	Associate Director
Associate Chief of Staff Mental Health	Chaplain	Business Office
Associate Chief Nurse Executive	Education	Canteen
Psychiatry	Laboratory	Facilities Management
Psychology	Nutrition & Food	Finance
Residential Rehabilitation Treatment Program	Sterile Processing	Human Resources
Social Work	Telehealth	Information & Technology
Vocational Rehabilitation	Veterans Experience	Logistics
Associate Chief of Staff Primary Care		Police
Dermatology		Privacy Officer
Primary Care		Prosthetics
Orthopedics		
Associate Chief of Staff Specialty Care		
Audiology		
Compensation & Pension		
Dental		
Optometry		
Physical Medicine & Rehabilitation		
Radiology		
Designated Education Officer		
Geriatrics & Extended Care		
Pharmacy		
Recruiter		
Women's Health		

Source: VA Southern Oregon Rehabilitation Center and Clinics (received July 26, 2017).

To help assess engagement of facility executive leadership, OIG interviewed the Facility Director, Acting Chief of Staff, Nurse Executive, and Acting 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 executive leaders are also engaged in monitoring patient safety and care through formal mechanisms. They are members of the facility's Quality Leadership Governance Board, which tracks, trends, and monitors quality of care and patient outcomes. The Facility Director serves as Co-Chairperson with the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. The executive leaders oversee various working committees, such as the Medical Executive Committee, Nursing Professional Committee, and EOC Committee. See Figure 3.

Figure 3. Facility Committee Reporting Structure

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                        Facility
                        Leadership
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Quality Leadership (QLC) Governance Board	Medical Executive (MEC) Governance Board	Nursing Professional (NPC) Governance Board	Environment of Care (EOCC) Governance Board	Education / Rewards & Recognition / Space Committee
Access Accreditation Compliance & Business Integrity Controlled Substance Program Data Capture Diversity Health Information Management Integrated Ethics (Consultative Ethics & Preventative Ethics) Veteran's Experience Workforce Development (Organizational Health)	Ambulatory Care Bar Code Medication (Clozapine Treatment & Medication Mishap) Clinical Product Review Community Care Oversight Credentialing & Privileging Board Disruptive Behavior Equipment Infection Prevention & Control Pain Management Care Advisory Board Palliative Care Consult Team Pharmacy & Therapeutics Protected Peer Review Radiation Safety Rehabilitation Executive (CWT/TWT Advisory & Stakeholder Council) Veterans Health Education Women Veterans Health	Caregiver Support Clinical Pastoral Education	Accident Review Board Emergency Management Environmental Rounds Fall Prevention Green Environmental Management Systems Safe Patient Handling Smoking Cessation Water Safety	

Source: VA Southern Oregon Rehabilitation Center and Clinics (received July 26, 2017).

CWT/TWT = Compensated Work Therapy/Transitional Work Therapy

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 (Facility and Director's office averages) were rated above the VHA average,[8] and employees appear generally satisfied. Both patient survey results reflected lower care ratings than the VHA average, and patients appear generally less than 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[9]
All Employee Survey[10] 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	3.4	3.7
All Employee Survey Servant Leader Index Composite	0–100 where HIGHER scores are more favorable	66.7	68.3	67.3
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): I felt like a valued customer.	The response average is the percent of "Agree" and "Strongly Agree" responses.	73.2	66.6	
Survey of Healthcare Experiences of Patients (outpatient specialty care): I felt like a valued customer.		73.8	68.9	

Accreditation/For-Cause[11] 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 performed by the VA OIG and The Joint Commission (TJC). Indicative of effective

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[8] 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.

[9] Rating is based on responses by employees who report to the Director.

[10] 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.

[11] 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.

leadership, the facility has closed[12] 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[13] and College of American Pathologists,[14] which demonstrates the facility leaders' commitment to quality care and services.

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 (*Healthcare Inspection – Alleged Program Mismanagement and other Concerns at the VA Southern Oregon Rehabilitation Center and Clinics, White City, Oregon, May 17, 2017*)	February 2015	0	NA
VA OIG (*Combined Assessment Program Review of the VA Southern Oregon Rehabilitation Center and Clinics, White City, Oregon, September 11, 2014*)	July 2014	12	0
VA OIG (*Community Based Outpatient Clinic and Primary Care Clinic Reviews at the VA Southern Oregon Rehabilitation Center and Clinics, White City, Oregon, June 26, 2014*)	April 2014	6	0
TJC[15] • Ambulatory Health Care Accreditation • Behavioral Health Care Accreditation • Home Care Accreditation	September 2016	1 2 2	0

NA= Not applicable

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[12] 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.

[13] The Commission on Accreditation of Rehabilitation Facilities provides an international, independent, peer review system of accreditation that is widely recognized by Federal agencies. 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.

[14] 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.

[15] 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 more than 30 years. Compliance with TJC standards facilitates risk reduction and performance improvement.

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 April 2014 Combined Assessment Program and Community Based Outpatient Clinic and Primary Care (PC) review inspections through the week of June 5, 2017.

Table 3. Summary of Selected Organizational Risk Factors[16]
(April 2014 to June 5, 2017)

Factor	Number of Occurrences
Sentinel Events[17]	3
Institutional Disclosures[18]	7
Large-Scale Disclosures[19]	0

The Agency for Healthcare Research and Quality within the U.S. Department of Health and Human Services has developed Patient Safety Indicators to provide information on potential in-hospital complications and adverse events following surgeries and procedures.[20] Since the facility does not provide inpatient care, there is no Patient Safety Indicator data.

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[16] 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 VA Southern Oregon Rehabilitation Center and Clinics is a low-complexity (3) affiliated facility as described in Appendix B.)

[17] 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.

[18] 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.

[19] 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.

[20] Agency for Healthcare Research and Quality website, https://www.qualityindicators.ahrq.gov/, accessed March 8, 2017.

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.[21] This model includes measures on health care quality, employee satisfaction, access to care, and efficiency, but the model 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.[22]

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 VA Southern Oregon Rehabilitation Center and Clinics received an interim rating of 1 star for overall quality. This means the facility was in the 5th quintile (bottom 10 percent). Updated data as of June 30, 2017, indicates that the facility has remained at 1 star for overall quality.

Figure 4. Strategic Analytics for Improvement and Learning Star Rating Distribution (as of September 30, 2016)
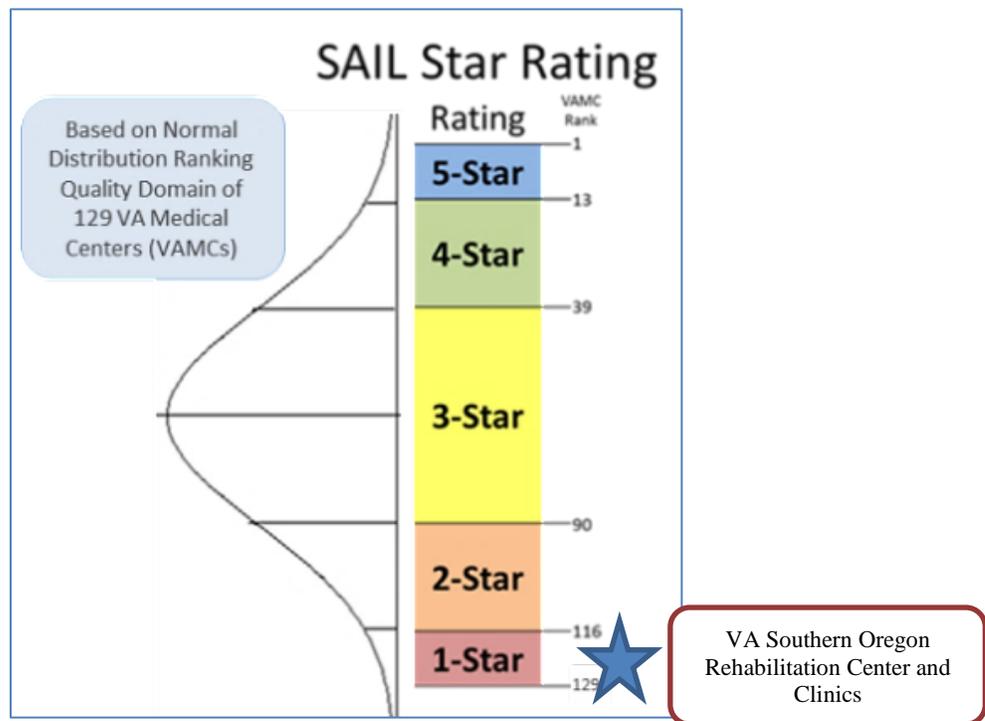
*Source: VA Office of Informatics and Analytics' Office of Operational Analytics and Reporting.*

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[21] The model is derived from the Thomson Reuters Top Health Systems Study.

[22] 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 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 blue data points in the top quintile that show high performance (for example, Ambulatory Care Sensitive Conditions [ACSC] Hospitalization and MH Population [Popu] Coverage). Metrics in the bottom quintiles reflect areas that need improvement and are denoted in orange and red (for example, Call Responsiveness, Registered Nurse [RN] Turnover, and Rating [of] Specialty Care [SC] Provider).

Figure 5. Facility Quality of Care and Efficiency Metric Rankings
(as of December 31, 2016)
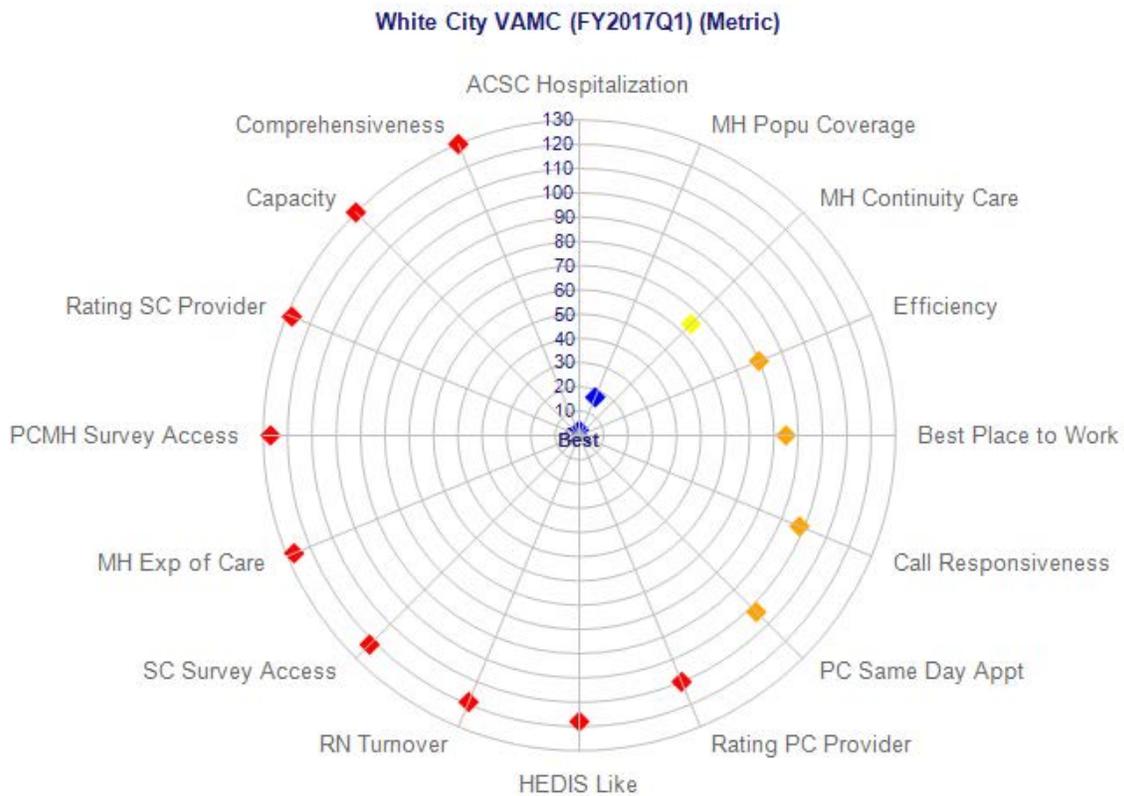
Source: VHA Support Service Center.

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 opportunities to improve the stability of executive leadership and patient satisfaction. Organizational leadership supports patient safety, quality care, and other positive outcomes. OIG's review of accreditation organization findings, sentinel events, disclosures, and SAIL results did not identify any substantial organizational risk factors.[23] The senior leadership team was generally knowledgeable about selected SAIL metrics but should continue to take actions to improve care and performance, particularly Quality of Care and Efficiency metrics likely contributing to the current 1-star rating.

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[23] 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.[24] 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[25] of clinical care

3. Credentialing and privileging

4. Utilization management (UM) reviews[26]

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
- Credentialing and privileging processes
  - Considered frequency for Ongoing Professional Practice Evaluation[27] data review
  - Indicated a Focused Professional Practice Evaluation[28]

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[24] Department of Veterans Affairs, Veterans Health Administration. *Blueprint for Excellence*. September 2014.

[25] 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.

[26] 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.

[27] Ongoing Professional Practice Evaluation is the ongoing monitoring of privileged practitioners to identify professional practice trends that impact the quality of care and patient safety.

- 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 reviews, credentialing and privileging processes, and UM. However, OIG identified the following deficiency in patient safety that warranted a recommendation for improvement.

Patient Safety. VHA requires facilities to complete a minimum of eight root cause analyses during each FY to help identify the cause and effect of the adverse event to avoid future occurrence. The eight root cause analyses must include four events involving individual patients and four from aggregate data for patient falls, missing patients, or adverse medication events experienced by patients. For FY 2016,[29] the facility performed six of the eight required root cause analyses. The Patient Safety Manager stated that two additional root cause analyses were not completed because employees did not report a sufficient number of incidents that met review criteria, and no replacement was considered.

Recommendation

1. The Facility Director requires the Patient Safety Manager to ensure completion of the required minimum of eight root cause analyses each fiscal year.

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[28] 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.

[29] October 1, 2015 through September 30, 2016.

Facility concurred.

Target date for completion: December 7, 2017

Facility response: During FY17 the VA SORCC [Southern Oregon Rehabilitation Center and Clinics] completed the required 8 root cause analyses. Ongoing root cause analysis progress is reported quarterly to Quality Leadership Committee (QLC). The minutes and meeting summary submitted support that 7 of the required 8 RCAs were completed for FY17, with the 8th completed RCA reported at the December 7, 2017 meeting. Additionally, a NCPS [National Center for Patient Safety] SPOT Database shows 7 of the required, aggregated and individual RCAs are completed. In FY17 NCPS required that the aggregated missing person RCA is completed as a PSAT [Patient Safety Assessment Tool] for Wandering and Missing Patients. The Director approved the completed PSAT, for total of 8.

Request closure based on the evidence provided.

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,[30] 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 four employees actively involved in the anticoagulant program and interviewed key employees. Additionally, OIG reviewed the electronic health records of 35 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

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

Conclusions. Generally, OIG noted safe anticoagulation therapy management practices for many of the indicators listed above and compliance with requirements for obtaining required laboratory tests and competency assessments for employees actively involved in the program. However, OIG identified a deficiency in the review of quality assurance data that warranted a recommendation for improvement.

Quality Assurance. VHA requires review of anticoagulation management program quality assurance data by the Pharmacy and Therapeutics Committee and the Executive Committee of the Medical Staff, as appropriate. This provides the opportunity to identify practice improvements, ensure appropriate action is taken to improve the practice, and measure the effectiveness of those actions on a regular basis. The facility collected and submitted anticoagulation data to the Pharmacy and Therapeutics Committee. However, for the period October 2016 to April 2017, OIG found no evidence of review of all anticoagulation data. For example, minutes did not contain information for bleeding and thromboembolic (clot formation) events specific to anticoagulation therapy. Clinical managers were aware of the requirements but thought that submitting anticoagulation data to the Pharmacy and Therapeutics Committee alone was sufficient to meet requirements.

Recommendation

2. The Chief of Staff requires the Pharmacy and Therapeutics Committee to review all quality assurance data for the anticoagulation management program and monitors the committee's compliance.

Facility concurred.

Target date for completion: May 18, 2018

Facility Response: The committee minutes (August and October 2017) submitted demonstrate the Anticoagulation Clinic quality assurance data are reported separately to the P & T [Pharmacy and Therapeutics] Committee. This collected data is monitored and reported to the Medical Executive Committee (MEC) by the Chief of Pharmacy. Due to the change of reporting process, the October FY18 P&T minutes support the reporting change. Ongoing monitoring by the Chief of Pharmacy and reporting will continue through the MEC.

Due to a change in reporting, this recommendation is open until compliance is met.

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.[c]

Fluoroscopic imaging equipment produces x-rays for the diagnosis, localization, and guidance of interventional procedures.[31] 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.[32] 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.

OIG inspected eight outpatient clinics (one each of audiology, dental, dermatology, eye, and MH and three PC), Radiology Service, and the Klamath Falls community based outpatient 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.

Parent Facility
- 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

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[31] VHA Handbook 1105.04, *Fluoroscopy Safety*, July 6, 2012.
[32] 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

The performance indicators below did not apply to this facility as the facility did not have a locked MH unit.

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 a safe and clean EOC and did not identify any reportable deficiencies for the representative community based outpatient clinic or for radiology. Additionally, OIG did not note any issues with the availability of medical equipment and supplies. OIG identified the following deficiency with EOC rounds that warranted a recommendation for improvement.

Parent Facility: Environment of Care Rounds Attendance. VHA requires facilities to conduct comprehensive EOC rounds with a designated team that includes specific core members in order to ensure a clean and high quality care environment and to identify unsafe and/or untoward conditions.[33] EOC rounds participation for October 1, 2015 through September 30, 2016 ranged from 67 percent to 85 percent for 3 of 12 core

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[33] 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.

members. Senior leaders were aware of the requirements but due to lack of staff did not assign designees to attend or participate in EOC rounds when core team members were unavailable.

Recommendation

3. The Associate Director ensures required team members consistently participate on environment of care rounds and monitors compliance.

Facility concurred.

Target date for completion: March 2018

Facility Response: This has been remedied through the onboarding of an Administrative Officer (AO). The AO is the direct backup to the Chief Supply Chain Officer on attending weekly Environment of Care rounding. This expectation has been communicated and the incumbent in this role will attend in tandem with the Chief Supply Chain Officer through an orientation process. Additionally, through cascaded performance elements this will be added to the Chief Supply Chain Officers performance appraisal beginning FY18. The Women's Program Manager has been informed of attendance expectations, either attending or sending a representative.

Attendance to the environment of care rounding is monitored by the Chairperson of the Environment of Care Committee (EOCC) and documented in the environment of care national data base, as well as reported monthly to the EOCC. The overall attendance of EOCC rounding for FY17 has reached 94.4%. Leadership attendance has shown a continuous improvement of participation and/or sending a replacement, reaching 92% for the Q4 [quarter 4]. Individual and overall attendance will continue to be monitored and reported monthly to the EOCC. The Chair of the EOCC will monitor attendance monthly and report to the EOCC until attendance is 90% or greater for all members for three consecutive quarters.

This recommendation is open until compliance is met.

Long-Term Care: Community Nursing Home Oversight

Since 1965, VHA has provided nursing home care under contracts. VHA facilities must integrate the CNH program into their Quality Improvement Programs. The Facility Director establishes the CNH Oversight Committee, which reports to the chief clinical officer (Chief of Staff, Nurse Executive, or the equivalent) and includes multidisciplinary management-level representatives from social work, nursing, quality management, acquisition, and the medical staff. The CNH Oversight Committee must meet at least quarterly.[34] Local oversight of CNHs is achieved through annual reviews and monthly visits.

The purpose of this review was to assess whether the facility complied with applicable requirements regarding the monitoring of veterans in contracted CNHs.[d]

OIG interviewed key employees and reviewed relevant documents and the results from CNH annual reviews completed July 5, 2015 through June 30, 2016. Additionally, OIG reviewed the electronic health records of 21 patients who received CNH care for more than 3 months during the timeframe July 1, 2015 through June 30, 2016. The list below shows the performance indicators OIG reviewed.

- Implementation of a CNH Oversight Committee with representation by required disciplines and meetings at least quarterly
- Integration of CNH program into quality improvement program
- Documentation of hand-off for patients placed in CNHs outside catchment area
- Completion of CNH annual reviews by CNH Review Team
- Completion of exclusion review documentation when CNH annual reviews noted four or more exclusionary criteria
- Documentation of social worker and registered nurse cyclical clinical visits

Conclusions. Generally, OIG noted compliance with integration of the CNH program, patient hand-offs, and CNH annual reviews. OIG identified the following deficiencies with the oversight committee and clinical visits that warranted recommendations for improvement.

Oversight Committee. VHA requires the CNH Oversight Committee to include multidisciplinary management-level representation from social work, nursing, quality management, acquisitions, and the medical staff. Committee oversight functions include verifying completeness of the CNH review teams' initial, annual, and problem focused CNH evaluations. This multidisciplinary review and approach helps to ensure that VHA contracted nursing homes provide quality care in a safe environment. The facility's CNH Oversight Committee did not include consistent management-level representation (attendance was less than or equal to 50 percent) from nursing, social work, acquisitions, and the medical staff/physicians. Managers and employees were aware of the requirements; FY 2017[35] committee meeting minutes documented

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[34] VHA Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures,* June 4, 2004.
[35] October 1, 2016 through September 30, 2017.

discussions of the required disciplines, actions taken, and the need for increased attendance by all members. Managers stated that competing priorities and staffing shortages resulted in limited committee attendance.

Recommendation

4. The Chief of Staff ensures management-level representatives from all required disciplines consistently attend Community Nursing Home Oversight Committee meetings and monitors their compliance.

Facility concurred.

Target date for completion: April 25, 2018

Facility Response: Initiated a meeting sign-in sheet to track who attends the meeting. The sign-in sheet has added a safety representative, contracting staff (acquisitions/logistics), nurse manager, Medical staff of HBPC/GEC [Home Based PC/Geriatrics and Extended Care], to meet the requirements of 1143.2 (2004). All required staff except Contracting, have attended Qtr. 3 & 4 of 2017 per VHA Handbook 1143.2 paragraph 4e. The Chair of the Contracted Nursing Home Oversight Committee will monitor attendance quarterly (this committee meets quarterly) and report to the MEC [Medical Executive Committee] until attendance is 90% or greater for all members for three consecutive quarters.

This recommendation is open until compliance is met.

Clinical Visits. VHA requires that every patient under contract in a nursing home must be visited by a social worker or registered nurse at least every 30 days (unless specific criteria allow an exception). Social workers and nurses alternate monthly visits, unless otherwise indicated by the patient's individualized visitation plan. This interdisciplinary monitoring ensures vulnerable nursing home patients consistently receive quality care and necessary follow-up services. Nine of the 21 patients did not receive social worker cyclical clinical visits with the frequency required by VHA policy. The facility reported and meeting minutes documented that limited funding prevented the program from hiring a CNH social worker. As a collateral duty, PC social workers were designated to perform CNH visits, but workload demands prevented them from consistently conducting monthly visits.

Recommendation

5. The Chief of Staff ensures social workers conduct cyclical clinical visits with the required frequency and monitors the social workers' compliance.

Facility concurred.

Target date for completion: January 24, 2018

Facility Response: For cyclical clinical visits, VA SORCC achieved 95% compliance for FY17 Qtr. 3 and 100% compliance for FY17 Qtr. 4. All community nursing home visits are monitored through chart audits for compliance with this requirement. The CCOC [Community Care Oversight Committee] minutes support the 3rd & 4th quarters (6 months) reporting. Audits and reporting to CCOC are ongoing. Due to the CCOC meeting quarterly, FY18 Q1 will not be reported until 01/24/17.

This recommendation is open until compliance of 90% or greater is achieved for three consecutive months.

Mental Health Residential Rehabilitation Treatment Program

For this facility, OIG evaluated the MH 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.[36]

The purpose of the review was to determine whether the facility's MH RRTPs complied with selected EOC requirements.[e]

OIG reviewed relevant documents, inspected six residential units (204, 205, 206, 215, 216, and 217) housing patients within one of four residential programs (Domiciliary Care for Homeless Veterans Program, Supported Transitional Program, Substance Abuse RRTP, and women's Domiciliary Care for Homeless Veterans Program), 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 (CCTV) monitoring, and all other doors locked to outside and alarmed
- CCTV monitors with recording capability in public areas but not in treatment areas or private spaces

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

- Signage alerting veterans and visitors of recording
- Process for employees to respond to and articulate behavioral health and medical emergencies
- Keyless entry or door locks to women veterans' rooms
- Medications secured in residents' rooms

Conclusions. Generally, OIG noted a clean environment and compliance with establishing required policies/procedures and medication agreements, conducting and documenting monthly self-inspections, and ensuring medication security. However, OIG identified the following deficiencies for contraband inspections, CCTV surveillance, and signage that warranted recommendations for improvement.

Weekly Contraband Inspections. VHA requires MH RRTP employees to conduct random, weekly contraband inspections in a minimum of 10 percent of resident rooms, lockers, and drawers. Contraband refers to goods that are prohibited on the unit including, but not limited to, weapons, illegal drugs, and alcohol. Weekly contraband inspections ensure the safety of the residents, staff, and visitors. OIG did not find evidence of weekly inspections for units 215, 216, and 217. Program managers believed weekly inspections were performed but could not provide evidence that these occurred.

Recommendation

6. The Chief of Staff ensures Mental Health Residential Rehabilitation Treatment Program employees perform and document weekly contraband inspections and monitors employees' compliance.

Facility concurred.

Target date for completion: March 30, 2018

Facility Response: After this review, all residents were relocated from Bldgs. 215, 216 and 217, to Bldgs. 203A, 204A & 205A. Section staff inspect for contraband during Daily Rounds, Daily Bed Checks and Weekly Medication Locker Inspections. Space has been added to the rounding/check forms use by staff, to include documentation [of] a check for contraband. Residential Rehabilitation Treatment Program (RRTP) Chief will monitor monthly for daily/weekly contraband check compliance/documentation and report quarterly to the Rehabilitation Executive Committee (REC) until compliance of greater than 90% per month is reached and maintained for three consecutive months.

Due to a change in documentation, this recommendation is open until compliance is met.

Closed Circuit Television Surveillance. VHA requires MH RRTPs to maintain a single point of access utilizing keyless entry and CCTV monitoring. Public areas, including access points, hallways, and stairwells, must have CCTV systems with recording capability to ensure a safe environment. The main points of entry for units 215, 216, and 217 had CCTV systems, but the monitors were inoperable. Additionally, units 204,

205, and 206 had CCTV systems monitoring entry points but not monitoring public areas. VA Police were unaware that monitors were not functioning and/or not monitoring public areas because of a lack of communication between VA Police and MH RRTP employees. OIG was told that the facility plans to install new CCTV systems in the upcoming months to meet requirements.

Recommendation

7. The Associate Director ensures that closed circuit television surveillance systems are repaired or replaced for all required areas in the Mental Health Residential Rehabilitation Treatment Program units.

Facility concurred.

Target date for completion: September 1, 2017

Facility Response: Closed circuit monitors in B215/B216 were replaced with new units and system brought back on line. Since the time of the review, all residents have been relocated out of those buildings (including B217). Main points of entrance for B204, 205 have been changed. All new entrance points are monitored via CCTV security cameras. B206 has been torn down and is being replaced.

Additional cameras have been installed to cover changes to RRTP plans for main points of entrance.

Request closure based on the evidence provided.

Signage. VHA requires MH RRTPs to display signage alerting patients and visitors that they are being recorded. This ensures patient and visitor awareness. None of the MH RRTP units had such signage. Program employees stated that they had notified facility managers of this requirement a year ago, and leadership failed to take actions to ensure compliance.

Recommendation

8. The Chief of Staff ensures the Mental Health Residential Rehabilitation Treatment Program units have signage alerting patients and visitors of closed circuit television recording.

Facility concurred.

Target date for completion: November 22, 2017

Facility Response: Signage has been installed to notify Veterans and Visitors of closed circuit television recording.

Request closure based on the evidence provided.

Post-Traumatic Stress Disorder Care

For this facility, OIG also evaluated PTSD, a disorder that may occur "…following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury; other threat to one's physical integrity; witnessing an event that involves death, injury or threat to the physical integrity of another person; learning about unexpected or violent death, serious harm, threat of death or injury experienced by a family member or other close associate."[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 electronic health records of 49 randomly selected outpatients 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
- Establishment of 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.

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[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	Eight OIG recommendations, ranging from documentation issues to deficiencies that can lead to patient and staff safety issues or adverse events, are attributable to the Facility Director, 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	None	• The Patient Safety Manager ensures completion of the required minimum of eight root cause analyses each FY.

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
		None	• The Pharmacy and Therapeutics Committee reviews all quality assurance data for the anticoagulation management program.

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[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 　○ EOC deficiency tracking and rounds 　○ General Safety 　○ Infection prevention 　○ Environmental cleanliness 　○ Exam room privacy 　○ Availability of feminine hygiene products and medical equipment and supplies • Community Based Outpatient Clinic 　○ General safety 　○ Infection prevention 　○ Environmental cleanliness 　○ Medication safety and security 　○ Privacy 　○ Availability of feminine hygiene products and medical equipment and supplies 　○ IT network room security • 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 • Inpatient MH 　○ MH EOC inspections 　○ Environmental suicide hazard identification 　○ Employee training 　○ Environmental safety 　○ Infection prevention 　○ Availability of medical equipment and supplies	None	• Required team members consistently participate on EOC rounds.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement

Long-Term Care: Community Nursing Home Oversight	• CNH Oversight Committee and CNH program integration
	• Electronic health record documentation
	  o Patient hand-off
	  o Clinical visits
	• CNH annual reviews
		• Social workers conduct cyclical clinical visits with the required frequency.	• Management-level representatives from all required disciplines consistently attend CNH Oversight Committee meetings.

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
	• CCTV monitors with recording capability in public areas
	• Process for responding to behavioral health and medical emergencies
		• MH RRTP employees perform and document weekly contraband inspections.
		• CCTV surveillance systems are repaired or replaced for all required areas in the MH RRTP units.
			• The MH RRTP units have signage alerting patients and visitors of CCTV recording.

Post-Traumatic Stress Disorder Care	• Completion of a suicide risk assessment by acceptable providers • Establishment of 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] affiliated[40] facility reporting to Veterans Integrated Service Network 20.

Table 4. Facility Profile for White City (692) 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	$100.5	$122.0	$138.0
Number of:			
• **Unique Patients**	17,731	17,304	17,397
• **Outpatient Visits**	228,681	223,166	216,134
• **Unique Employees**[44]	512	578	549
Type and Number of Operating Beds:			
• **Acute**	NA	NA	NA
• **Mental Health**	NA	NA	NA
• **Community Living Center**	NA	NA	NA
• **Domiciliary**	525	525	525
Average Daily Census:			
• **Acute**	NA	NA	NA
• **Mental Health**	NA	NA	NA
• **Community Living Center**	NA	NA	NA
• **Domiciliary**	440	444	365

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

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[39] VHA medical centers are classified according to a facilities complexity model; 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 10, 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 5 provides information relative to each of the clinics.

Table 5. VA Outpatient Clinic Workload/Encounters[46] and Specialty Care, Diagnostic, and Ancillary Services Provided for October 1, 2015 through September 30, 2016

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services[47] Provided	Diagnostic Services[48] Provided	Ancillary Services[49] Provided
Klamath Falls, OR	692GA	6,422	1,415	Cardiology Dermatology Endocrinology Amputation Follow-Up Blind Rehab Eye General Surgery	Laboratory and Pathology	Nutrition Pharmacy Weight Management
Grants Pass, OR	692GB	5,264	911	Cardiology Dermatology Endocrinology	NA	Nutrition Pharmacy 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

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[45] Includes all outpatient clinics in the community that were in operation as of February 15, 2017.

[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] Specialty care services refer to non-PC and non-MH services provided by a physician.

[48] Diagnostic services include EKG, EMG, laboratory, nuclear medicine, radiology, and vascular lab services.

[49] Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

VHA Policies Beyond Recertification Dates

In this report, OIG cited nine 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 1105.04, *Fluoroscopy Safety*, July 6, 2012 (recertification due date July 31, 2017).

6. VHA Handbook 1143.2, VHA Community Nursing Home Oversight Procedures, June 4, 2004 (recertification due date January 31, 2009).

7. 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.

8. 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.[50]

9. 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]

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[50] This handbook was in effect during the review period for this report; it was rescinded and replaced by VHA Directive 1160.03, *Programs for Veterans with Post-Traumatic Stress Disorder (PTSD)*, November 16, 2017.

[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
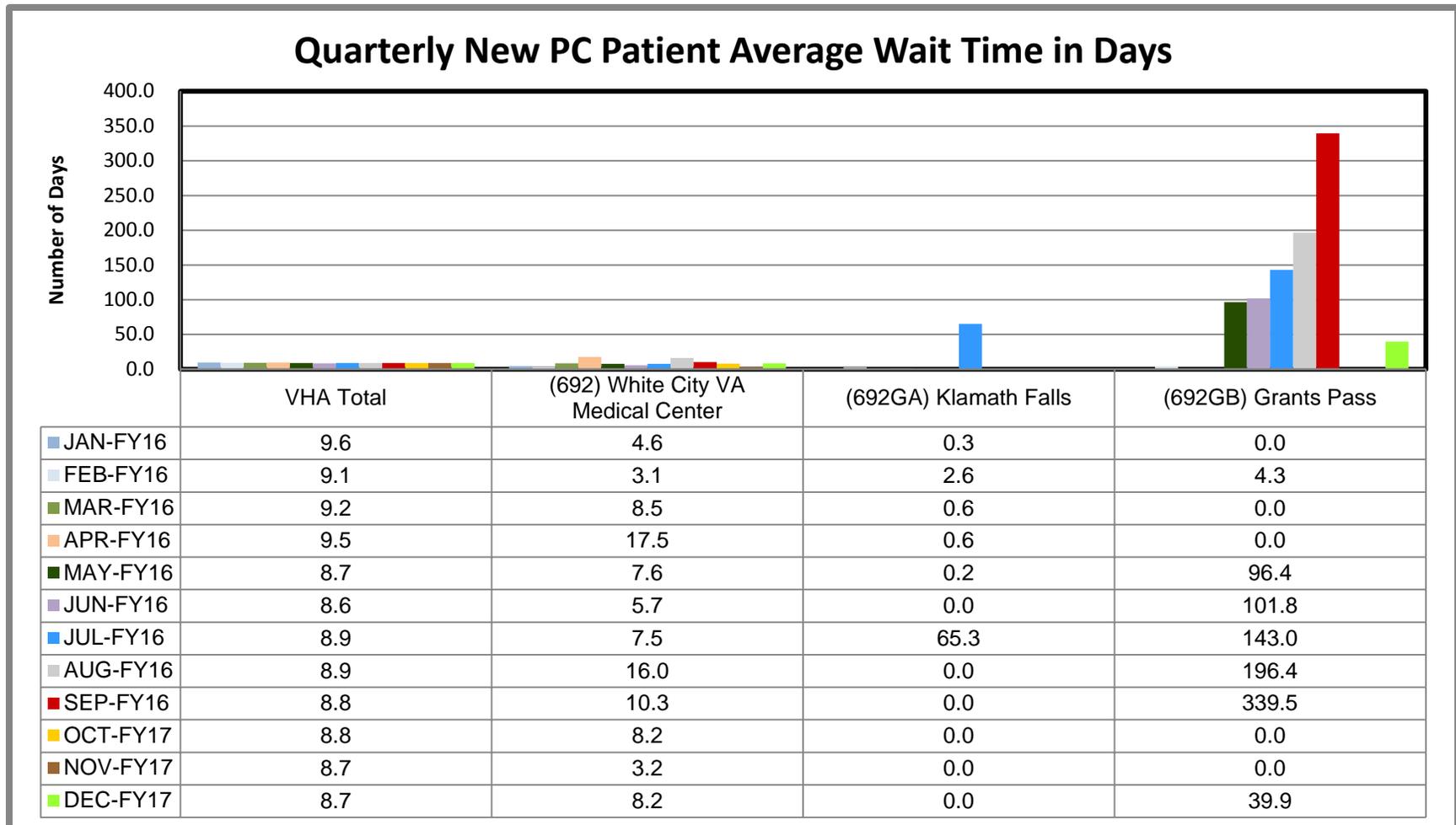
Quarterly New PC Patient Average Wait Time in Days

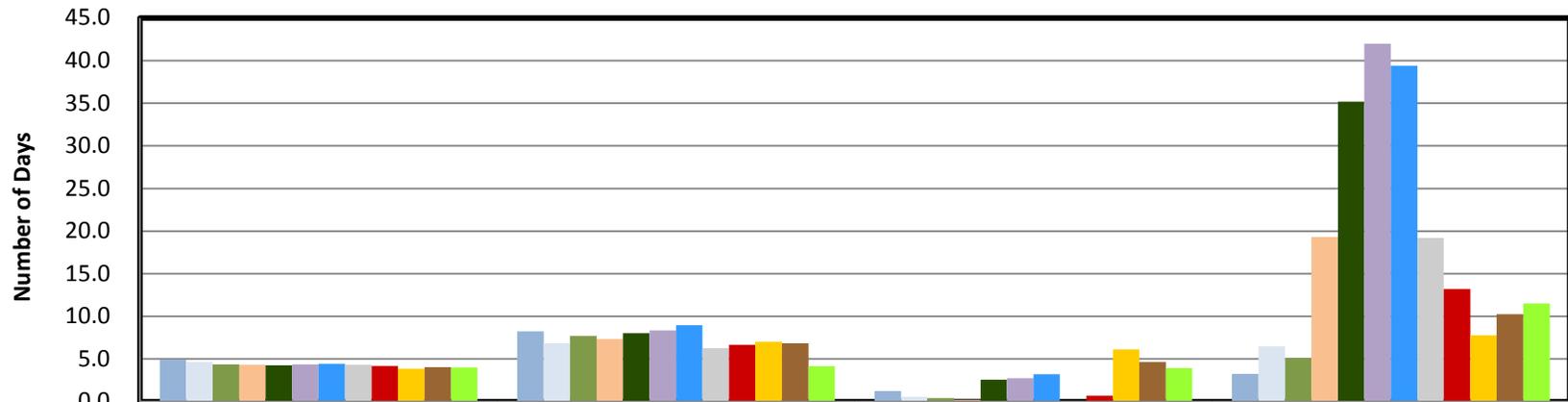|	VHA Total	(692) White City VA Medical Center	(692GA) Klamath Falls	(692GB) Grants Pass
JAN-FY16	9.6	4.6	0.3	0.0
FEB-FY16	9.1	3.1	2.6	4.3
MAR-FY16	9.2	8.5	0.6	0.0
APR-FY16	9.5	17.5	0.6	0.0
MAY-FY16	8.7	7.6	0.2	96.4
JUN-FY16	8.6	5.7	0.0	101.8
JUL-FY16	8.9	7.5	65.3	143.0
AUG-FY16	8.9	16.0	0.0	196.4
SEP-FY16	8.8	10.3	0.0	339.5
OCT-FY17	8.8	8.2	0.0	0.0
NOV-FY17	8.7	3.2	0.0	0.0
DEC-FY17	8.7	8.2	0.0	39.9

Source: VHA Support Service Center.

Note: OIG did not assess VA's data for accuracy or completeness. OIG has on file the facility's explanation for the July 2016 data point for Klamath Falls and May–September 2016 data points for Grants Pass.

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.*

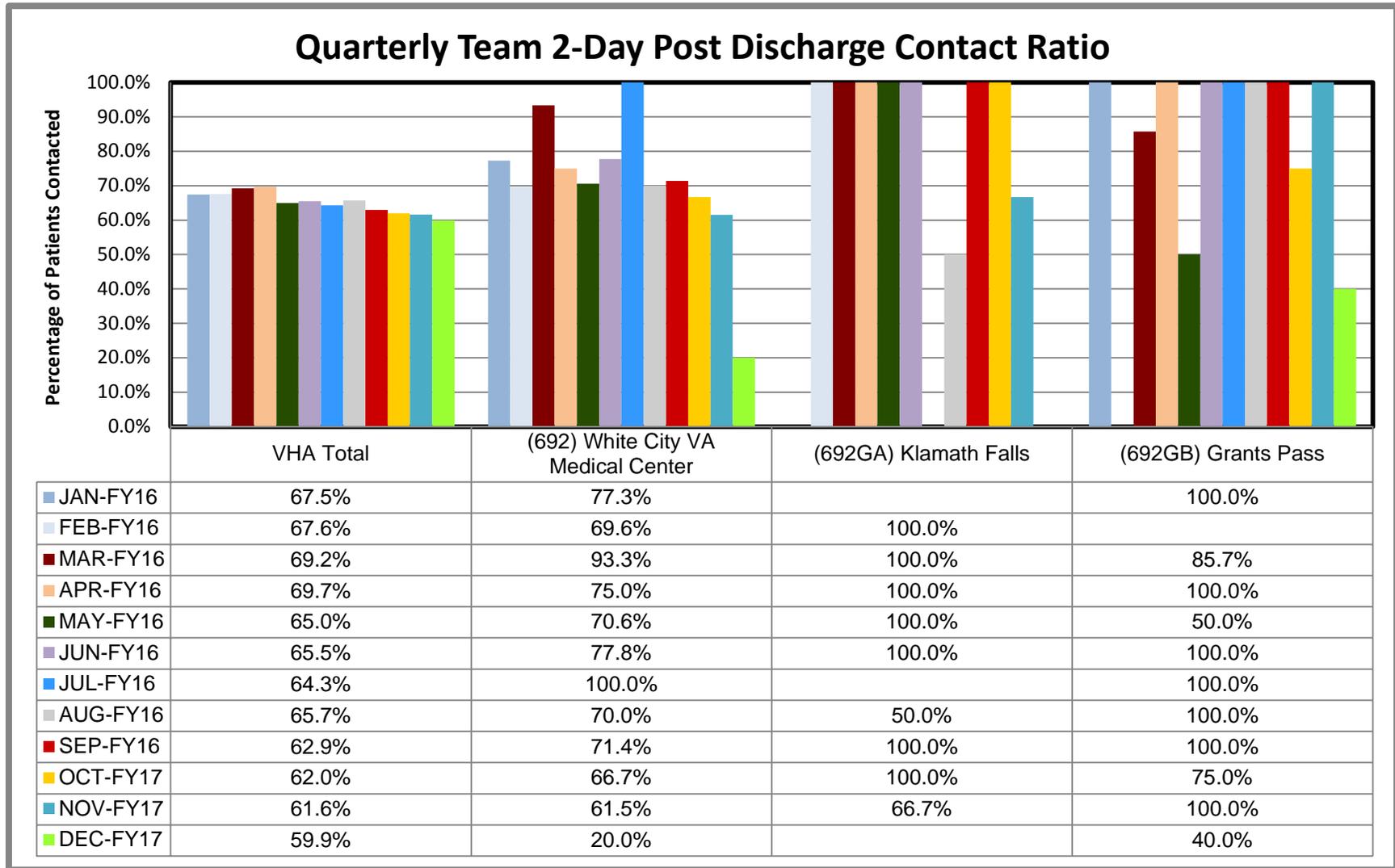## Quarterly Established PC Patient Average Wait Time in Days

	VHA Total	(692) White City VA Medical Center	(692GA) Klamath Falls	(692GB) Grants Pass
JAN-FY16	4.9	8.2	1.2	3.2
FEB-FY16	4.7	6.8	0.6	6.5
MAR-FY16	4.4	7.7	0.4	5.1
APR-FY16	4.3	7.3	0.2	19.3
MAY-FY16	4.3	8.0	2.6	35.2
JUN-FY16	4.4	8.4	2.8	42.0
JUL-FY16	4.4	9.0	3.2	39.4
AUG-FY16	4.3	6.3	0.1	19.2
SEP-FY16	4.2	6.7	0.7	13.2
OCT-FY17	3.8	7.0	6.1	7.8
NOV-FY17	4.0	6.8	4.6	10.2
DEC-FY17	4.0	4.1	3.9	11.5

Source: VHA Support Service Center.

Note: OIG did not assess VA's data for accuracy or completeness. We have on file the facility's explanation for the May–July 2016 data points for Grants Pass.

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.
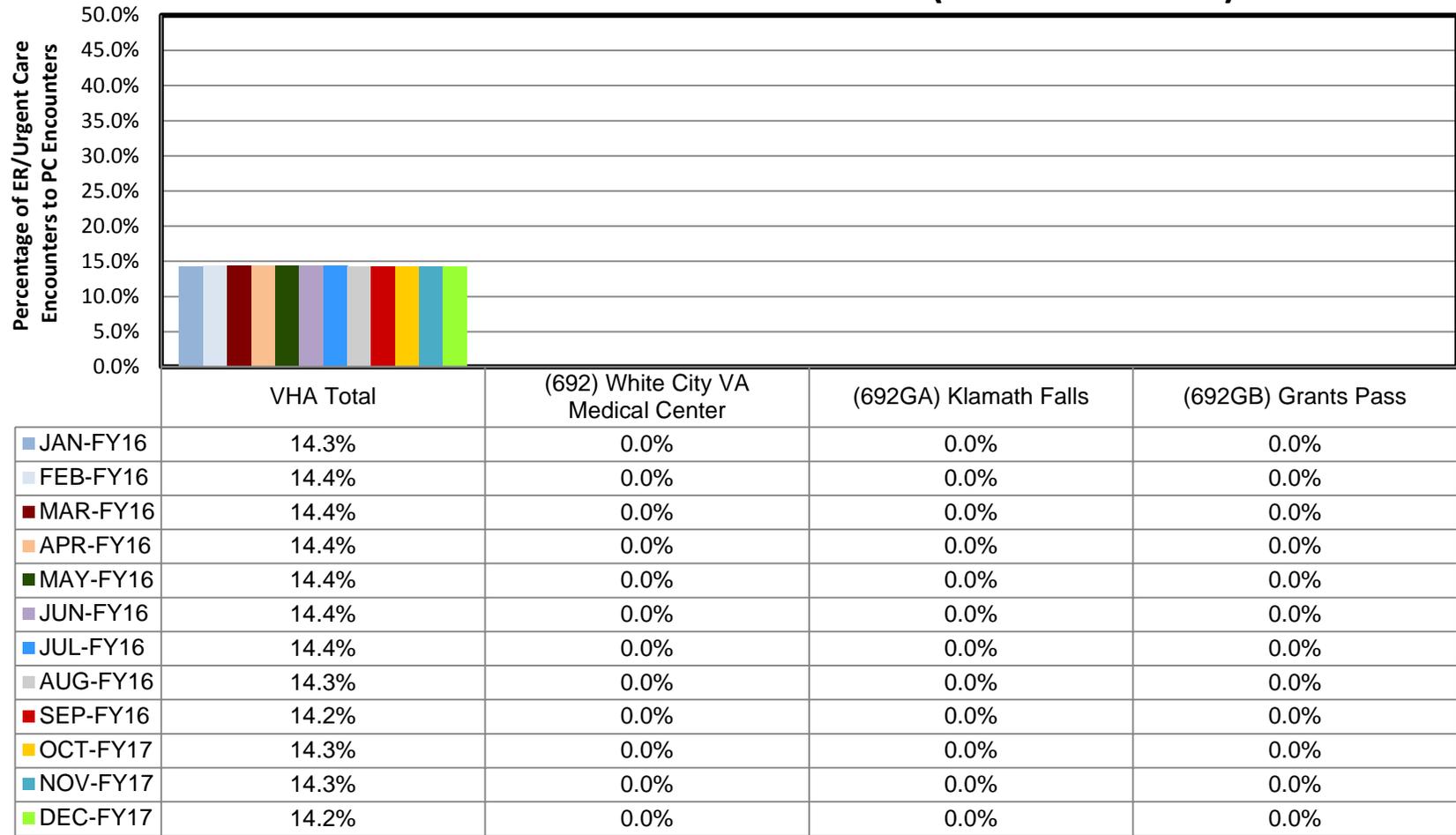
Quarterly Team 2-Day Post Discharge Contact Ratio

	VHA Total	(692) White City VA Medical Center	(692GA) Klamath Falls	(692GB) Grants Pass
JAN-FY16	67.5%	77.3%		100.0%
FEB-FY16	67.6%	69.6%	100.0%	
MAR-FY16	69.2%	93.3%	100.0%	85.7%
APR-FY16	69.7%	75.0%	100.0%	100.0%
MAY-FY16	65.0%	70.6%	100.0%	50.0%
JUN-FY16	65.5%	77.8%	100.0%	100.0%
JUL-FY16	64.3%	100.0%		100.0%
AUG-FY16	65.7%	70.0%	50.0%	100.0%
SEP-FY16	62.9%	71.4%	100.0%	100.0%
OCT-FY17	62.0%	66.7%	100.0%	75.0%
NOV-FY17	61.6%	61.5%	66.7%	100.0%
DEC-FY17	59.9%	20.0%		40.0%

Source: VHA Support Service Center.

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

Data Definition: The percent of assigned PC patients discharged from any VA facility who have been contacted by a PC team member within 2 business days during the reporting period. Patients are excluded if they are discharged from an observation specialty and/or readmitted within 2 business days to any VA facility. Team members must have been assigned to the patient's team at the time of the patient's discharge. Team member identification is based on the primary provider on the encounter. Performance measure mnemonic "PACT17." Blank cells indicate the absence of reported data.

Quarterly Ratio of ER/Urgent Care Encounters While on Panel to PC Encounters While on Panel (FEE ER Excluded)

	VHA Total	(692) White City VA Medical Center	(692GA) Klamath Falls	(692GB) Grants Pass
JAN-FY16	14.3%	0.0%	0.0%	0.0%
FEB-FY16	14.4%	0.0%	0.0%	0.0%
MAR-FY16	14.4%	0.0%	0.0%	0.0%
APR-FY16	14.4%	0.0%	0.0%	0.0%
MAY-FY16	14.4%	0.0%	0.0%	0.0%
JUN-FY16	14.4%	0.0%	0.0%	0.0%
JUL-FY16	14.4%	0.0%	0.0%	0.0%
AUG-FY16	14.3%	0.0%	0.0%	0.0%
SEP-FY16	14.2%	0.0%	0.0%	0.0%
OCT-FY17	14.3%	0.0%	0.0%	0.0%
NOV-FY17	14.3%	0.0%	0.0%	0.0%
DEC-FY17	14.2%	0.0%	0.0%	0.0%

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

June 1, 2014 through October 1, 2017[54]

Healthcare Inspection – Alleged Program Mismanagement and Other Concerns at the VA Southern Oregon Rehabilitation Center and Clinics, White City, Oregon
5/17/2017 | 15-01653-226 | Summary | Report

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

Combined Assessment Program Review of the VA Southern Oregon Rehabilitation Center and Clinics, White City, Oregon
9/11/2014 | 14-02072-283 | Summary | Report

Community Based Outpatient Clinic and Primary Care Clinic Reviews at VA Southern Oregon Rehabilitation Center and Clinics, White City, Oregon
6/26/2014 | 14-00911-193 | Summary | Report

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[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.

Veterans Integrated Service Network Director Comments

<table>
<tr><td>Department of
Veterans Affairs</td><td>**Memorandum**</td></tr>
</table>

Date: December 19, 2017

From: Director, Northwest Network (10N20)

Subject: **CHIP Review of the Southern Oregon Rehabilitation Center and Clinics, White City, OR**

To: Director, Los Angeles Office of Healthcare Inspections (54LA)

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

1. Thank you for the opportunity to provide a status report on the findings from the CHIP Review of the Southern Oregon Rehabilitation Center and Clinics, White City, Oregon.

2. Attached please find the facility concurrence and response to the findings from the review.

3. I concur with the findings, recommendations, and submitted action plans.

Michael J. Murphy

Facility Director Comments

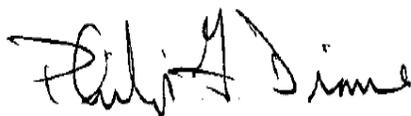**Department of
Veterans Affairs**

Memorandum

Date: December 5, 2017

From: Director, VA Southern Oregon Rehabilitation Center and Clinics (692/00)

Subject: **CHIP Review of the Southern Oregon Rehabilitation Center and Clinics, White City, OR**

To: Director, Northwest Network (10N20)

1. On behalf of the VA SORCC, I would like to express my appreciation to the Office of Inspector General (OIG) Survey Team for their professional and Comprehensive Healthcare Inspection Program (CHIP) review conducted on June 5–8, 2017.

2. We have reviewed the findings in the report and agree with all of the OIG recommendations. VA SORCC's responses addressing each recommendation are included, as well as actions in progress that we have/are implementing. We request several recommendations to be closed.

3. We appreciate the opportunity for the review as a continuing process to improve the care we provide for our Veterans.

Philip G. Dionne

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact OIG at (202) 461-4720.
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U.S. House of Representatives: Suzanne Bonamici, Earl Blumenauer, Peter DeFazio,
   John Garamendi, Jared Huffman, Doug LaMalfa, Kurt Schrader, Greg Walden

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 EOC included:
- 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 1229, *Planning and Operating Outpatient Sites of Care*, July 7, 2017.
- VHA Directive 1330.01(1), Health Care Services for Women Veterans, February 15, 2017 (amended September 8, 2017).
- VHA Directive 1608, *Comprehensive Environment of Care (CEOC) Program*, February 1, 2016.
- VHA Directive 1761(1), *Supply Chain Inventory Management*, October 24, 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.
- VHA Radiology Online Guide, http://vaww.infoshare.va.gov/sites/diagnosticservices/NRP/Mammography/Radiology%20Shared%20Files/Radiology_Service_Online_Guide_2016.docx, November 3, 2016.
- 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.

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

[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.