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Office of Healthcare Inspections

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Comprehensive Healthcare Inspection Program Review of the Minneapolis VA Health Care System Minneapolis, Minnesota

January 11, 2018

Washington, DC 20420

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Glossary

CBOC	community based outpatient clinic
CHIP	Comprehensive Healthcare Inspection Program
CNH	community nursing home
EHR	electronic health record
EOC	environment of care
facility	Minneapolis VA Health Care System
FY	fiscal year
MH	mental health
Nurse Executive	Associate Director for Patient Care Services
OIG	Office of Inspector General
PC	primary care
QSV	quality, safety, and value
SAIL	Strategic Analytics for Improvement and Learning
TJC	The Joint Commission
UM	utilization management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Report Overview

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

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

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

This review was conducted during an unannounced visit made during the week of May 22, 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 Minneapolis VA Health Care System, the leadership team consists of the Facility Director, Chief of Staff, Associate Director for Patient Care Services (Nurse Executive), Associate Director for Operations, and Associate Director/Chief Experience Officer. Organizational communication and accountability are carried out through a committee reporting structure with the Executive Leadership Board having oversight for leadership groups such as the Executive Committee of the Medical Staff, Quality Management Council, and Executive Council of the Nursing Staff. The leaders are members of the Executive Leadership Board through which they track, trend, and monitor quality of care and patient outcomes.

The acting Associate Director/Chief Experience Officer was not permanently assigned to that position and had been acting since April 3, 2017. With one exception, the executive leaders had been working together as a team since January 2015.

In the review of selected employee and patient survey results regarding facility senior leadership, OIG noted employee attitudes were generally satisfied, and surveyed patients generally expressed higher satisfaction toward the facility compared to the Veterans Health Administration (VHA) average.

Additionally, OIG reviewed accreditation agency findings, sentinel events, disclosures of adverse patient events, Patient Safety Indicator data, and Strategic Analytics for Improvement and Learning (SAIL) data and did not identify any substantial organizational risk factors. OIG recognizes that the SAIL model has limitations for identifying all areas of clinical risk but is "a way to understand the similarities and differences between the top and bottom performers" within VHA.[1] Although the senior leadership team should continue to take actions to make improvements, the team was knowledgeable about selected SAIL metrics; and, as of June 30, 2017, the facility continued to be rated at 5 stars for overall quality.

In the review of the six remaining key care processes, OIG issued 18 recommendations that are attributable to the Facility Director, Chief of Staff, Nurse Executive, and Associate Director for Operations. These are briefly described below.

Quality, Safety, and Value. OIG found that senior managers were engaged with quality, safety, and value activities. When opportunities for improvement were identified, they supported clinical leaders' implementation of corrective actions and monitoring of effectiveness. However, OIG noted deficiencies in peer review, utilization management,[2] patient safety, and committee meeting minutes.

Medication Management. OIG found safe anticoagulation therapy management practices for many of the performance indicators evaluated, including risk minimization of dosing errors, provision of transition follow-up, and education for patients with newly prescribed anticoagulant medications. However, OIG identified deficiencies in addressing the transition between the inpatient and outpatient care settings and an anticoagulation quality assurance program in facility policy; ensuring quality assurance data are collected, analyzed, and reported; and completing annual competency

[1] 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.

[2] 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.

assessments for all employees actively involved in the anticoagulation management program.

Coordination of Care. OIG noted that the facility collected and reported data about transfers out of the facility but identified deficiencies with the transfer policy, transfer documentation, and communication with the accepting facility.

Environment of Care. OIG found compliance with general safety and infection prevention at the parent facility, in Radiology Service, and at the representative community based outpatient clinic. OIG identified issues with conducting environment of care rounds and attendance of required team members. Additionally, OIG noted deficiencies with training of locked mental health unit employees and Interdisciplinary Safety Inspection Team members on the identification and correction of environmental hazards.

High-Risk Processes Related to Moderate Sedation. Generally, OIG found compliance with reporting and trending the use of reversal agents in moderate sedation cases, post-procedure assessments, and discharge practices. OIG identified deficiencies with history and physical examinations and/or pre-sedation assessments, informed consent, and pre-procedural timeouts.

Long-Term Care Related to Community Nursing Home Oversight. OIG noted compliance with requirements for community nursing home program integration and annual reviews. However, OIG identified deficiencies with documenting attendance in Community Nursing Home Oversight Committee minutes and conducting monthly cyclical clinical visits for patients residing in community nursing homes.

Summary

In the review of key care processes, OIG issued 18 recommendations that are attributable to the Facility Director, Chief of Staff, Nurse Executive, and Associate Director for Operations. 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 54–55, and the responses within the body of the report for the full text of the Directors' comments.) OIG will follow up on the planned actions until they are completed.

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Assistant Inspector General for
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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 Minneapolis VA Health Care System's (facility) inpatient and outpatient settings through a broad overview of key clinical and administrative processes that are associated with quality care and positive patient outcomes. The purpose of the review was to provide oversight of health care services to veterans and to share findings with facility leaders so that informed decisions can be made to improve care.

Scope

The current seven areas of focus for facility reviews are: (1) Leadership and Organizational Risks; (2) Quality, Safety, and Value (QSV); (3) Medication Management; (4) Coordination of Care; (5) Environment of Care (EOC); (6) High-Risk Processes; and (7) Long-Term Care. These were selected because of risks to patients and the organization when care is not performed well. Within four of the fiscal year (FY) 2017 focus areas, the Office of Inspector General (OIG) selected processes for special consideration—Anticoagulation Therapy Management, Inter-Facility Transfers, Moderate Sedation, and Community Nursing Home (CNH) Oversight (see Figure 1).

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[3] 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;[4] 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 September 22, 2014[5] through May 22, 2017, the date when an unannounced week-long site visit commenced. On June 1, 2017, OIG presented crime awareness briefings to 26 of the facility's 4,534 employees. These briefings covered procedures for reporting suspected criminal activity to OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

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 the 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.

[3] 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.
[4] OIG did not review VHA's internal survey results but focused on OIG inspections and external surveys that affect facility accreditation status.
[5] This is the date of the last Combined Assessment Program and/or Community Based Outpatient Clinic and Primary Care Clinic reviews.

Results and Recommendations

Leadership and Organizational Risks

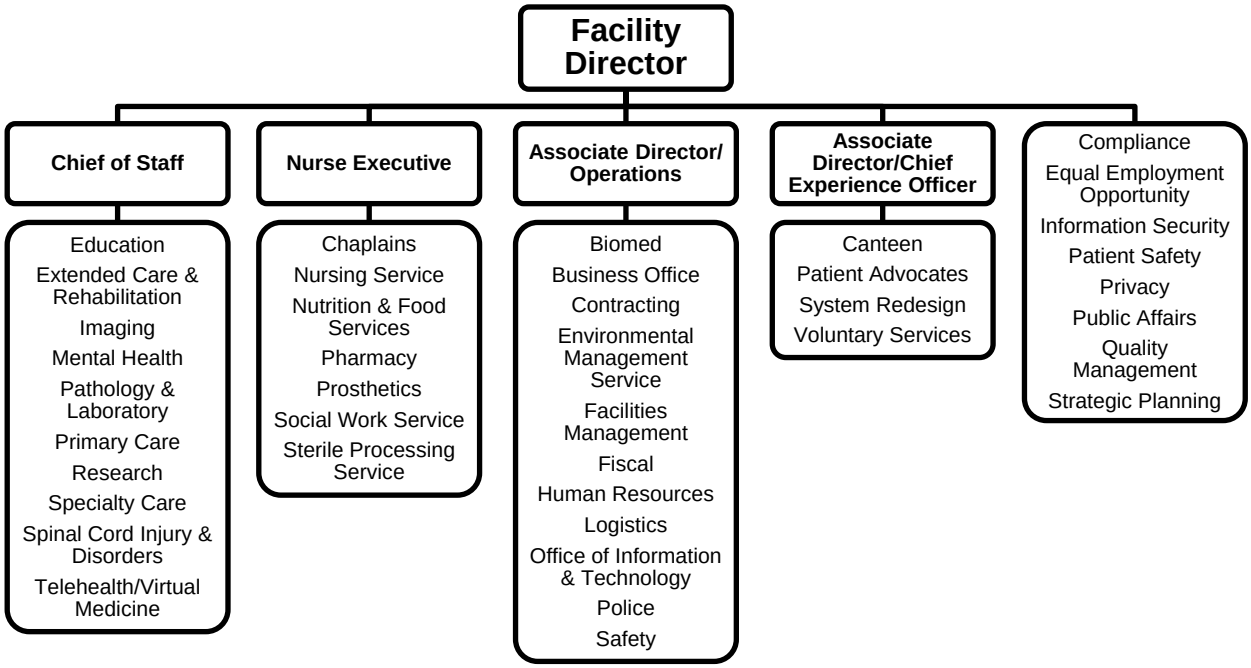
Stable and effective leadership is critical to improving care and sustaining meaningful change. Leadership and organizational risk issues can impact the facility's ability to provide care in all of the selected clinical areas of focus. The factors OIG considered in assessing the facility's risks and 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), Associate Director for Operations, and Associate Director/Chief Experience Officer. The Chief of Staff, Nurse Executive, and Associate Directors are responsible for overseeing patient care service lines and program chiefs.

It is important to note that the acting Associate Director/Chief Experience Officer was not permanently assigned to that position and had been acting since April 3, 2017. With that one exception, the executive leaders had been working together as a team since January 2015.

Figure 2. Facility Organizational Chart



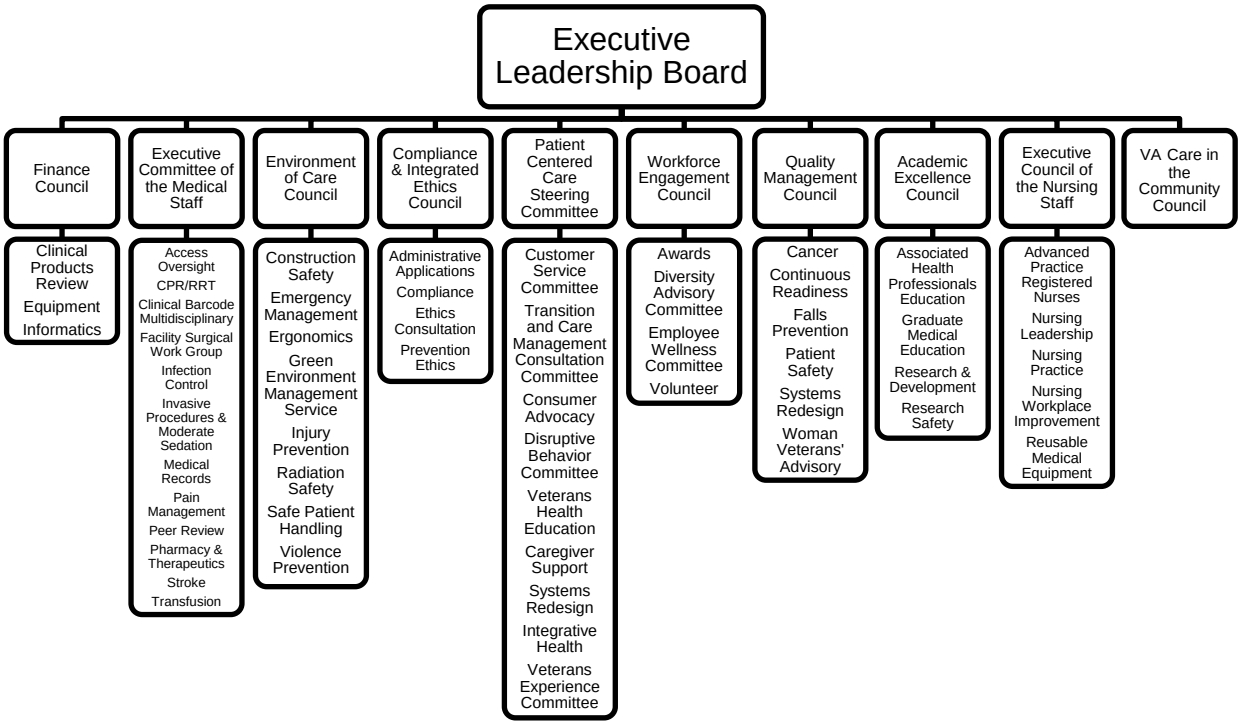
Source: Minneapolis VA Health Care System (received April 24, 2017).

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

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

The leaders are also engaged in monitoring patient safety and care through formal mechanisms. They are members of the facility's Executive Leadership Board, which tracks, trends, and monitors quality of care and patient outcomes. The Facility Director serves as the Chairperson with the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. The Executive Leadership Board also oversees various working committees, such as the Executive Committee of the Medical Staff, Quality Management Council, and Executive Council of the Nursing Staff. See Figure 3.

Figure 3. Facility Committee Reporting Structure



Source: Minneapolis VA Health Care System website (retrieved October 10, 2017 from https://vaww.visn23.portal.va.gov/min/SiteDirectory/ELB1/SitePages/Executive%20Leadership%20Board%20Map.aspx*).*

CPR/RRT = Cardiopulmonary Resuscitation/Rapid Response Team

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 average) were rated above the VHA average, and the results based upon employees who report to the facility director (Director's office average) were markedly higher than the facility and VHA averages.[6] All of the patient survey results reflected higher care ratings than the VHA average. In all, both employees and patients appear generally satisfied with the leadership and care provided.

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

Questions	Scoring	VHA Average	Facility Average	Director's Office Average[7]
All Employee Survey[8] Q59. How satisfied are you with the job being done by the executive leadership where you work?	1 (Very Dissatisfied) – 5 (Very Satisfied)	3.31	3.42	4.3
All Employee Survey Servant Leader Index Composite	0–100 where HIGHER scores are more favorable	66.68	67.44	88.09
Survey of Healthcare Experiences of Patients (inpatient): Would you recommend this hospital to your friends and family?	The response average is the percent of "Definitely Yes" responses.	65.8	73.41	
Survey of Healthcare Experiences of Patients (inpatient): I felt like a valued customer.	The response average is the percent of "Agree" and "Strongly Agree" responses.	82.75	88.48	
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): I felt like a valued customer.		73.21	78.21	
Survey of Healthcare Experiences of Patients (outpatient specialty care): I felt like a valued customer.		73.79	81.9	

[6] 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.
[7] Rating is based on responses by employees who report to the Director.
[8] 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.

Accreditation/For-Cause[9] 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). One recommendation remains open for TJC's inspection. It was reported that the reason the recommendation remains open is that TJC granted a time-limited waiver for physical modifications to pharmacy areas. The target date for completion is December 31, 2017. Indicative of effective leadership, the facility has closed[10] the remaining 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[11] and College of American Pathologists,[12] which demonstrates the facility leaders' commitment to quality care and services. Additionally, the Long Term Care Institute[13] conducted an inspection of the facility's Community Living Center, and the Paralyzed Veterans of America conducted an inspection of the facility's spinal cord injury/disease unit and related services.[14]

[9] 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.
[10] 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.
[11] 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.
[12] 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.
[13] Since 1999, the Long Term Care Institute has been to over 3,500 health care facilities conducting quality reviews and external regulatory surveys. The Long Term Care Institute is a leading organization focused on long-term care quality and performance improvement; compliance program development; and review in long-term care, hospice, and other residential care settings.
[14] The Paralyzed Veterans of America inspection took place April 11–12, 2017. This Veteran Service Organization review does not result in accreditation status.

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 – Access and Quality of Care Concerns, Phoenix VA Health Care System, Phoenix, Arizona and Delayed Test Result Notification, Minneapolis VA Health Care System, Minneapolis, Minnesota*, June 23, 2016)	June 2015	1	0
VA OIG (*Healthcare Inspection – Psychiatry Partial Hospitalization Program and Management Concerns, Minneapolis VA Health Care System, Minneapolis, Minnesota*, August 11, 2016*)*	September 2014	0	NA
VA OIG (*Combined Assessment Program Review of the Minneapolis VA Health Care System Minneapolis, Minnesota, November 18, 2014)*	September 2014	5	0
VA OIG (*Community Based Outpatient Clinic and Primary Care Clinic Reviews at Minneapolis VA Health Care System, Minneapolis, Minnesota*, September 8, 2014)	July 2014	8	0
TJC[15] • Hospital Accreditation • Behavioral Health Care Accreditation • Home Care Accreditation	October 2016	 31 1 2	 1 0 0

[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 September 2014 Combined Assessment Program review inspections through the week of May 22, 2017.

Table 3. Summary of Selected Organizational Risk Factors[16] (September 2014 to May 22, 2017)

Factor	Number of Occurrences
Sentinel Events[17]	7
Institutional Disclosures[18]	9
Large-Scale Disclosures[19]	1

OIG also reviewed Patient Safety Indicators developed by the Agency for Healthcare Research and Quality within the U.S. Department of Health and Human Services. These provide information on potential in-hospital complications and adverse events following surgeries and procedures.[20] The rates presented are specifically applicable for this facility, and lower rates indicate lower risks. Table 4 summarizes Patient Safety Indicator data from October 1, 2015 through September 30, 2016.

[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 Minneapolis VA Health Care System is a high complexity (1a) 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.

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

Measure	Reported Rate per 1,000 Hospital Discharges		
	VHA	VISN 23	Facility
Pressure Ulcers	0.55	0.79	1.43
Death among surgical inpatients with serious treatable conditions	103.31	92.20	94.59
Iatrogenic Pneumothorax	0.20	0.28	0.31
Central Venous Catheter-Related Bloodstream Infection	0.12	0.17	0.49
In Hospital Fall with Hip Fracture	0.08	0.14	0
Perioperative Hemorrhage or Hematoma	2.59	2.63	2.71
Postoperative Acute Kidney Injury Requiring Dialysis	1.20	1.22	2.38
Postoperative Respiratory Failure	6.31	5.96	2.85
Perioperative Pulmonary Embolism or Deep Vein Thrombosis	3.29	2.48	2.91
Postoperative Sepsis	4.45	4.18	4.41
Postoperative Wound Dehiscence	0.65	1.13	2.55
Unrecognized Abdominopelvic Accidental Puncture/Laceration	0.67	1.23	0.99

Source: VHA Support Service Center.

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

Seven of the Patient Safety Indicator measures show an observed rate per 1,000 hospital discharges in excess of the observed rates for Veterans Integrated Service Network (VISN) 23 and/or VHA. For pressure ulcers, facility leadership reported patients were incorrectly included (patients had a pressure ulcer, but it was not hospital acquired).

One patient had an iatrogenic pneumothorax, but it occurred prior to admission to the facility and should not have been included in the report. No other trends for pneumothorax were identified.

Multiple attempts have been made in the last year to understand the factors leading to central line infections, and practices known to decrease central line infection rates have been put into place and have had a measurable impact.

Only one of the six patients identified as having a perioperative hemorrhage actually had a significant bleeding event. Furthermore, the event could not have been prevented.

Facility leadership identified four patients who had acute kidney injury requiring postoperative dialysis. All of the patients were high-risk cardiac surgery patients. Actions taken to decrease renal failure in these patients included improved medical management and consideration for less invasive surgical interventions.

There was a single patient with wound dehiscence (a surgical complication in which a wound ruptures along a surgical incision). This rare postoperative complication was reviewed by the facility.

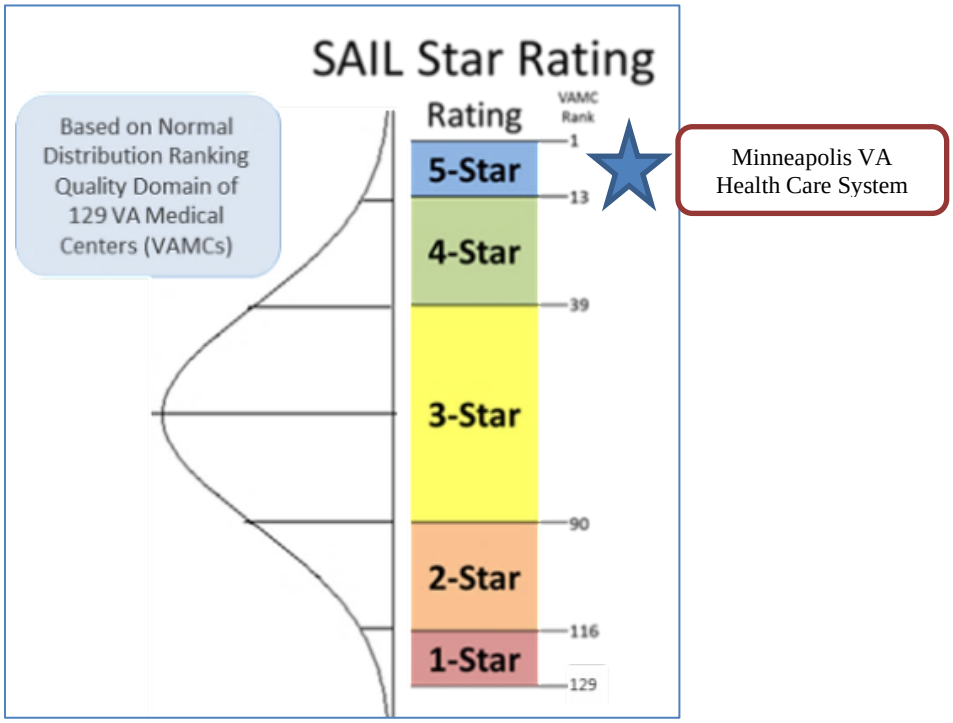
There was a single patient identified as having an unrecognized accidental abdominopelvic puncture/laceration; however, this was a coding error as there was no evidence of this injury in the patient's electronic health record (EHR). Education was provided to the staff that assigns diagnostic codes to EHRs.

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 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 Minneapolis VA Health Care System received an interim rating of 5 stars for overall quality. This means the facility was in the 1st quintile (top 10 percent range). Updated data as of June 30, 2017, indicates that the facility has remained at 5 stars for overall quality.

[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

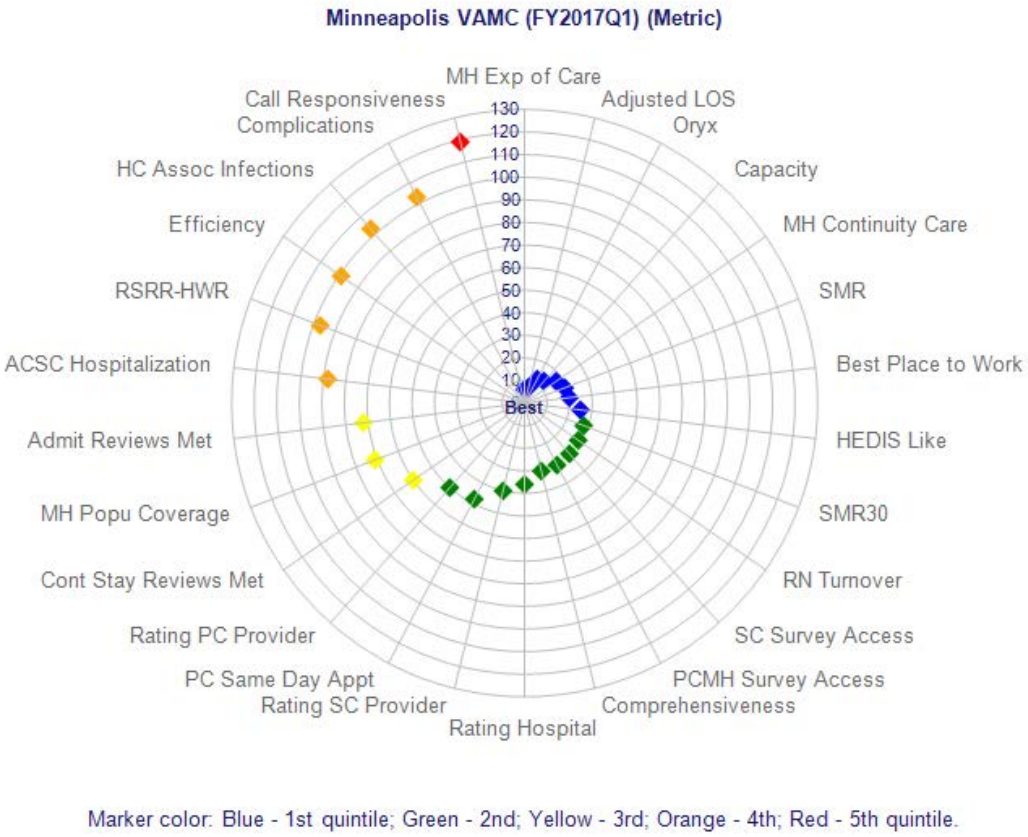
Figure 4. Strategic Analytics for Improvement and Learning Star Rating Distribution (as of September 30, 2016)



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

Figure 5 illustrates the facility's Quality of Care and Efficiency metric rankings and performance compared to other VA facilities as of December 31, 2016. Of note, Figure 5 shows blue and green data points in the top quintiles that show high performance (for example, Adjusted Length of Stay [LOS], Capacity, and Best Place to Work). Metrics in the bottom quintiles reflect areas that need improvement and are denoted in orange and red (for example, Healthcare-Associated [HC Assoc] Infections, Complications, and Call Responsiveness).

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



Source: VHA Support Service Center.

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

Conclusions. The facility has generally stable executive leadership and active engagement with employees and patients to maintain high satisfaction scores. Organizational leadership supports patient safety, quality care, and other positive outcomes (such as initiating processes and plans to maintain positive perceptions of the facility through active stakeholder engagement). The senior leadership team was knowledgeable of insightful and important metrics that reflect upon their leadership qualities and activities taken to improve or sustain performance of selected metrics.

OIG's review of accreditation organization findings, sentinel events, disclosures, Patient Safety Indicator data, and SAIL results did not identify any substantial organizational risk factors.[23] Although the facility had opportunities for improvement in Quality of Care metrics (see Figure 5), as of June 30, 2017, the facility continues to be rated as 5 stars for overall quality.

[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 (OPPE)[27] data review
  - Indicated a Focused Professional Practice Evaluation[28]

[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] OPPE 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 also found general compliance with requirements for credentialing and privileging. However, OIG identified the following deficiencies in peer review, UM, and patient safety that warranted recommendations for improvement.

Peer Review. VHA requires that when the Peer Review Committee recommends individual improvement actions, clinical managers implement the actions. Peer review can result in both immediate and long-term improvements in patient care by revealing areas for improvement in the practice of one or multiple providers. In two of six applicable peer reviews conducted, there was no evidence that clinical managers implemented individual improvement actions. OIG determined that noncompliance was due to lack of oversight by the Peer Review Committee to ensure that actions taken were appropriately documented.

Recommendation

1. The Chief of Staff ensures clinical managers consistently implement and document actions recommended by the Peer Review Committee and monitors compliance.

Facility concurred.

Target date for completion: February 1, 2018

Facility response: Closure of all items was incorporated into Peer Review Minutes beginning July, 2017. 100 percent of Final Level 2 and 3 peer review cases had Service Chief documented evidence of closure. 100 percent compliance was achieved for three consecutive months.

[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.

Utilization Management: Inpatient Reviews. VHA requires facilities to complete at least 75 percent of all required inpatient UM reviews. These reviews ensure patients receive health care services at the appropriate level of care when that care is needed. For the timeframe April 1, 2016 through March 31, 2017, the facility completed only 69 percent of all required reviews. The UM program lacked experienced staff during this time period to perform the reviews and input data. The facility stated that the UM program is now fully staffed and that staff are trained.

Recommendation

2. The Chief of Staff ensures completion of at least 75 percent of all required inpatient utilization management reviews and monitors compliance.

Facility concurred.

Target date for completion: March 1, 2018

Facility response: The UM Department was fully staffed as of November 20, 2017 and overtime and/or comp time will be offered to ensure the 75 percent review completion rate is met. Compliance will be monitored monthly until 75 percent completion is achieved for three consecutive months.

Physician Utilization Management Advisor Reviews. VHA requires that Physician UM Advisors document their decisions regarding appropriateness of patient admission and continued stays in the National UM Integration database. This ensures national level UM data is available for review by an interdisciplinary group to set benchmarks; identify trends, actions, and opportunities to improve efficiency; and monitor outcomes.

In 33 of 222 cases (15 percent) referred to the advisors March 1–April 30, 2017, there was no evidence that advisors documented decisions in the database. Seventeen of the 33 cases (52 percent) were from Medicine Service, which rotated physician reviewers, and the reviews were not being completed. As of April 1, 2017, Medicine Service appointed one provider to complete the reviews. For the other cases, a shortage of UM staff prevented timely entry of information into the UM database for physician review. The UM manager told OIG that data entry should now be timely because the vacancies have since been filled. The Emergency Department has also recently made changes in staffing to improve compliance with data entry.

Recommendation

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

Facility concurred.

Target date for completion: April 1, 2018

Facility response: The PUMAs [Physician Utilization Management Advisors] check for reviews frequently and the UM nurses will follow-up for every review sent. PUMA reviews are sent timely by the UM nurses to the PUMAs to allow more PUMA review time. If the patient has been discharged, a PUMA review will not be sent. When multiple continued stay days are not met and the reason is the same for each day, the UM nurse will only send one review to the PUMA to decrease duplication. The Mental Health Patient Service Line has now designated one main PUMA instead of having rotating PUMAs to decrease confusion. Compliance will be monitored monthly until greater than 90 percent compliance is achieved for three consecutive months.

Patient Safety. VHA and TJC require the Patient Safety Manager to submit to facility leadership an annual patient safety report that provides an overview of the patient safety program status, relevant data and trends, program successes, and areas for improvement. The annual report serves to keep facility leaders apprised of patient safety activities and required program functions. Although the Patient Safety Manager completed and submitted quarterly reports, the Patient Safety Manager did not submit an annual report to facility leadership for FY 2016. The Patient Safety Manager was unaware of the requirement for an annual report and was under the impression that quarterly reports would suffice.

Recommendation

4. The Facility Director ensures the Patient Safety Manager submits an annual patient safety report to facility leaders at the completion of each fiscal year and monitors compliance.

Facility concurred.

Target date for completion: January 1, 2018

Facility response: The FY 2017 annual patient safety report draft was completed on June 30, 2017. The final draft of the annual report will be finished by December 1, 2017 to allow for analysis of fourth quarter's data. The report will be submitted to the Patient Safety Committee, Quality Management Council, and the Executive Leadership Board by December 21, 2017. The Patient Safety report is included as an annual agenda item to ensure compliance in each FY.

Committee Meeting Minutes. VHA requires that when QSV activities identify significant issues, the facility takes actions and tracks issues to closure. This ensures there is a process for continuous measurement and improvement of facility operations. Executive Leadership Board and Peer Review Committee meeting minutes from April 2016 through April 2017 did not accurately reflect the status of action items. Items that required actions were closed in committee meeting minutes; however, documentation

reflected that actions were ongoing. Facility staff stated that the items were closed out of habit; minutes were reviewed and approved without consideration for ongoing improvement efforts.

Recommendation

5. The Facility Director and Chief of Staff ensure that Executive Leadership Board and Peer Review Committee meeting minutes accurately reflect action status and that items are tracked to closure and monitor compliance.

Facility concurred.

Target date for completion: March 1, 2018

Facility response: At the July 27, 2017 meeting, the ELB [Executive Leadership Board] approved that the meeting minutes will accurately reflect action status by including a grid on ELB Executive Summaries, which allows for the status of open items tracked to closure and compliance is monitored. Training on the new process of tracking action status was provided to all Council Chairs in September, 2017.

Peer Review Committee: Action status of all items was incorporated into Peer Review Minutes starting in August, 2017.

All items will be tracked to closure and compliance will be monitored until greater than 90 percent compliance is achieved for three consecutive months.

Medication Management: Anticoagulation Therapy

Comprehensive medication management is defined as the standard of care that ensures clinicians individually assess each patient's medications to determine that each is appropriate for the patient, effective for the medical condition, safe given the comorbidities and other medications prescribed, and able to be taken by the patient as intended. From October 1, 2015 through September 30, 2016, more than 482,000 veterans received an anticoagulant,[29] 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 interviewed key employees. OIG requested the competency assessment records of 17 employees actively involved in the anticoagulant program and received records for 14 key employees. Additionally, OIG reviewed the EHRs of 28 randomly selected patients who were prescribed new anticoagulant medications from July 1, 2015 through June 30, 2016. The 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

[29] 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, including risk minimization of dosing errors, provision of transition follow-up, and education for patients with newly prescribed anticoagulant medications. However, OIG identified the following deficiencies for policy and processes, quality assurance data, and staff competency that warranted recommendations for improvement.

Anticoagulation Program Management: Policy and Processes. VHA requires facilities to maintain a well-organized anticoagulation management program with processes and policies that address required elements. This ensures clinicians are providing high-quality, evidence-based management of anticoagulants to reduce the likelihood of patient harm. Facility policy did not address the transition of patients between the inpatient and outpatient care settings or an anticoagulation quality management plan. The Anticoagulation Program Manager has been in the role less than 2 years and had competing priorities while working towards a compliant program.

Recommendation

6. The Associate Director for Patient Care Services ensures the anticoagulation management program policy is revised to include the transition of patients between the inpatient and outpatient care settings and an anticoagulation quality assurance program.

Facility concurred.

Target date for completion: June 1, 2018

Facility response: A new facility anticoagulation management program policy that includes transition of patients between the inpatient and outpatient care settings has been drafted and is in the approval process. The new policy defines the anticoagulation quality assurance program.

Quality Assurance Data. VHA requires an ongoing quality assurance plan be in place to identify practice improvements, ensure appropriate action is taken to improve practice, and measure the effectiveness of those actions on a regular basis. Although anticoagulation quality assurance data was presented to Pharmacy and Therapeutics Committee in March 2017, it had not been collected, analyzed, or reported biannually as required by facility policy. Further, facility pharmacists monitored and adjusted anticoagulation medications for patients of the facility and VA-staffed community based outpatient clinics (CBOC); however, the facility provided no anticoagulation management oversight for six contract CBOCs. The anticoagulation program manager and acting Chief of Pharmacy stated that they were told they were not responsible for overseeing the program at the contract CBOCs. The Anticoagulation Program Manager has been in the role less than 2 years and had competing priorities while working towards a compliant program. Additionally, Pharmacy Service has had acting chiefs since May 2016.

Recommendation

7. The Chief of Staff and Associate Director for Patient Care Services ensure that anticoagulation management program quality assurance data from all sites of care are collected, analyzed, and reported biannually to the Pharmacy and Therapeutics Committee and monitor compliance.

Facility concurred.

Target date for completion: April 1, 2018

Facility response: Anticoagulation management program quality assurance data from all sites of care, including contract CBOCs, will be collected, analyzed, and reported biannually to the Pharmacy and Therapeutics Committee and compliance will be monitored.

Competency. VHA requires facilities assess the competency of staff actively involved in the anticoagulation management program. This ensures clinicians are current in their knowledge and skills to provide high-quality, evidence-based management of anticoagulants to reduce the likelihood of patient harm. Competency assessments must include required content and be completed at the frequency required by facility policy. The facility requires annual assessments.

Facility pharmacy staff manage the anticoagulation management program for the facility and for the six non-contract CBOCs. Staff of the other six CBOCs, which are contract, were not VA employees but were required to follow VHA policy. All 11 facility pharmacy staff had competency assessments that included required content and were completed at the required frequency. OIG requested six competency assessments for staff from the contract CBOCs; OIG received and reviewed three. None of the three competency assessments met VHA requirements for content or were completed annually. Again, the anticoagulation program manager and acting Chief of Pharmacy stated that they were told they were not responsible for overseeing the program at the contract CBOCs.

Recommendation

8. The Associate Director for Patient Care Services ensures that annual anticoagulation management program competency assessments include all required content and that employees assigned to this program complete competency assessments as required and monitors compliance.

Facility concurred.

Target date for completion: April 1, 2018

Facility response: All anticoagulation management program employees assigned to this program will have completed competency assessments, which includes all required content. Compliance will be monitored monthly until greater than 90 percent compliance is met for three consecutive months.

Coordination of Care: Inter-Facility Transfers

Coordination of care is the process of ensuring continuity of care, treatment, or services provided by a facility, which includes referring individuals to appropriate community resources to meet ongoing identified needs. Effective coordination of care also involves implementing a plan of care and avoiding unnecessary duplication of services. OIG selected a special focus on inter-facility transfers because they are frequently necessary to provide patients with access to specific providers or services. VHA has the responsibility to ensure that transfers into and out of its medical facilities are carried out appropriately under circumstances that provide maximum safety for patients and comply with applicable standards.

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

OIG reviewed relevant policies and facility data and interviewed key employees. Additionally, OIG reviewed the EHRs of 27 randomly selected patients who were transferred out of facility inpatient beds or the Emergency Department/urgent care center to another VHA facility or non-VA facility from July 1, 2015 through June 30, 2016. The list below shows the performance indicators OIG examined.

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

Conclusions. OIG noted that the facility collected and reported data about transfers out of the facility. However, OIG identified the following deficiencies with the facility's transfer policy, transfer documentation, and communication with accepting facility that warranted recommendations for improvement.

Inter-Facility Transfer Policy. VHA requires facilities to have a written inter-facility transfer policy that includes required content. This is to ensure that transfers into and out of the facility are carried out appropriately to provide maximum safety for patients. The facility's policy did not include all required elements, including patient or surrogate informed consent, medical or behavioral stability, and identification of transferring and receiving provider or designee. Facility staff told OIG they were aware that the policy required revision, but they believed they were following the VHA directive. They told OIG they purposely waited until the new directive was published (January 11, 2017) and then established a team to revise the facility's policy. They anticipate completion and approval of the updated policy by August 1, 2017.

Recommendation

9. The Facility Director ensures the facility's revised inter-facility transfer policy includes all required elements.

Facility concurred. Target date for completion: June 1, 2018 Facility response: Inter-Facility Transfer policy, in alignment with VHA Directive 1094, has been written to include all required elements and is in the approval process.

Inter-Facility Transfer Documentation. VHA requires transferring clinicians to complete VA Form 10-2649A and/or transfer/progress notes that include all required elements prior to or within a few hours after the transfer. This ensures the safe transfer of patients out of VHA facilities. Clinicians did not document patient or surrogate informed consent in 11 of 22 applicable EHRs, medical or behavioral stability in 7 of 27 EHRs, or identification of transferring and receiving provider or designee in 12 of 27 EHRs. The facility's inter-facility transfer policy and processes did not require documentation of these elements. Additionally, although a template that included all required elements was available, facility staff told OIG that some clinical areas did not use the template.

Recommendation

10. The Chief of Staff ensures that for patients transferred out of the facility, providers consistently document patient or surrogate informed consent, medical and behavioral stability, and identification of transferring and receiving provider or designee and monitors providers' compliance.

Facility concurred.

Target date for completion: April 1, 2018

Facility response: Provider will complete the patient or surrogate iMED consent form (Physician Certification and Patient Consent to Transfer – VA Form 1026-49B); medical and behavioral stability; and identification of transferring and receiving provider or designee are all included in the newly revised order sets for each service line. Compliance will be monitored monthly until greater than 90 percent compliance is achieved for three consecutive months.

Communication with Accepting Facility. VHA requires that for inter-facility transfers, communication occurs between the sending and accepting facilities or the sending facility provides pertinent patient information when they transfer the patient. Communication of relevant information ensures continuity of care for patients transferred out of VHA facilities. Providers did not send or communicate pertinent patient information for 3 of the 18 applicable patients. The facility's inter-facility transfer policy and processes were not compliant with VHA policy requirements and did not require staff to communicate these elements when transferring patients.

Recommendation

11. The Chief of Staff ensures that for patients transferred out of the facility, providers document sending or communicating to the accepting facility pertinent patient information and monitors compliance.

Facility concurred.

Target date for completion: April 1, 2018

Facility response: The provider will complete the Interfacility Transfer Form 10-2649A and Non-VA Care Consult. If inpatients transfer out, provider will complete discharge summary prior to transfer. All required elements are included in the newly revised order sets for each service line. Compliance will be monitored monthly until greater than 90 percent compliance is achieved for three consecutive months.

Environment of Care

The purpose of this review was to determine whether the facility maintained a clean and safe health care environment in accordance with applicable requirements. OIG also determined whether the facility met requirements in selected areas that are often associated with higher risks of harm to patients, in this case, with a special emphasis on Radiology Service and the locked mental health (MH) unit.[d]

Fluoroscopic imaging equipment produces x-rays for the diagnosis, localization, and guidance of interventional procedures.[30] 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.[31] The inpatient locked MH unit must provide a healing, recovery-oriented environment as well as be a safe place for patients and employees. VHA developed the MH EOC Checklist to reduce environmental factors that contribute to inpatient suicides, suicide attempts, and other self-injurious behaviors and factors that reduce employee safety on MH units.

In all, OIG inspected six inpatient units (the intensive care, medical 3E, MH, post-anesthesia care, and Community Living Center 1E and 1F), Radiology Service, and the Emergency Department. OIG also inspected the Rice Lake CBOC. Additionally, OIG reviewed relevant documents and 16 employee training records and interviewed key employees and managers. The list below shows the location-specific performance indicators selected to examine the risk areas specific to particular settings.

<u>Parent Facility</u>

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

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

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. OIG found compliance with general safety and infection prevention at the parent facility, in Radiology Service, and at the representative CBOC. Additionally, the locked MH unit had environmental suicide hazard identification and abatement processes in place. OIG did not note any issues with the availability of medical equipment and supplies. However, four inpatient units[32] had stained ceiling tiles and three inpatient units[33] had dusty ventilation grills. OIG identified the following deficiencies with EOC rounds and for the locked MH unit that warranted recommendations for improvement.

Environment of Care Rounds. VHA requires facilities to perform comprehensive EOC rounds in clinical and nonclinical areas at a prescribed frequency with a designated team that includes specific membership to ensure a safe, clean, and high quality care environment and to identify unsafe and/or untoward conditions. Further, the Comprehensive EOC Assessment and Compliance Tool is to be used to collect all data

[32] Intensive care, Community Living Center 1E and 1F, and the post-anesthesia care units.
[33] Intensive care and Community Living Center 1E and 1F units.

associated with EOC rounds within facilities. The facility did not conduct EOC rounds for 24 of the 140 areas (17 percent) requiring EOC rounds. Additionally, team member attendance was not tracked or reported to the EOC Committee. Facility managers were unaware that attendance could be tracked and trended with the Performance Logic software used for EOC rounds.

Recommendation

12. The Associate Director for Operations ensures designated team members conduct environment of care rounds in clinical and nonclinical areas as required and monitors compliance.

Facility concurred.

Target date for completion: February 1, 2018

Facility response: The EOC Committee ensures all clinical and non-clinical areas have rounds conducted as required and that compliance is monitored. Additionally, the EOC Committee tracks attendance in Performance Logic appropriately for all areas of rounding. All members have a back-up identified in the event of absence. When an individual or their back-up is absent from rounds, the Committee escalates as necessary to leadership. EOC Committee minutes reflect monitoring and actions taken for absentee members for the last three consecutive months. Compliance was monitored and tracked in Performance Logic to ensure environment of care rounds in clinical and nonclinical areas were completed as required. Compliance was achieved for September 90.5 percent, October 91.4 percent and November 100 percent.

Locked Mental Health Unit: Employee and Interdisciplinary Safety Inspection Team Training. VHA requires that locked MH unit employees and members of the facility's Interdisciplinary Safety Inspection Team receive training every 12 months on the identification and correction of environmental hazards, including the proper use of the MH EOC Checklist, so they can identify environmental hazards that present a threat to suicidal patients. Three of 10 locked MH unit employees and three of six Interdisciplinary Safety Inspection Team members did not complete the required training within the past 12 months. Facility managers tracked training completion but were not enforcing compliance with the requirement.

Recommendation

13. The Associate Director for Operations ensures all locked mental health unit employees and Interdisciplinary Safety Inspection Team members receive annual training on how to identify and correct environmental hazards, including the proper use of the Mental Health Environment of Care Checklist, and monitors compliance.

Facility concurred.

Target date for completion. February 1, 2018

Facility response: Training was formally assigned in TMS for staff members that had not completed the required training. One staff member listed as non-compliant was in the process of leaving the VA, that individual was removed from the MH Inspection Team list. All training was completed by June 30, 2017. Training records will be reviewed on an annual basis to demonstrate compliance. A compliance rate of 100 percent has been achieved and maintained.

High Risk Processes: Moderate Sedation

OIG's special focus within high-risk processes for the facility was moderate sedation, which is a drug-induced depression of consciousness during which patients can still respond purposefully to verbal comments.[34] Non-anesthesiologists administer sedatives and analgesics to relieve anxiety and increase patient comfort during invasive procedures and usually do not have to provide interventions to maintain a patient's airway, spontaneous ventilations, or cardiovascular function. The administration of moderate sedation could lead to a range of serious adverse events, including cardiac and respiratory depression, brain damage due to low oxygen levels, cardiac arrest, or death.[35]

Properly credentialed providers and trained clinical staff must provide safe care while sedating patients for invasive procedures. Additionally, facility leaders must monitor moderate sedation adverse events, report and trend the use of reversal agents, and systematically aggregate and analyze the data to enhance patient safety and employee performance.[36] During calendar year 2016, VHA clinicians performed more than 600,000 moderate sedation procedures, of which more than half were gastroenterology-related endoscopies.[37] To minimize risks, VHA and TJC have issued requirements and standards for moderate sedation care.

The purpose of this review was to evaluate selected aspects of care to determine whether the facility complied with applicable policies in the provision of moderate sedation.[e]

OIG reviewed relevant documents, interviewed key employees, and inspected the gastroenterology, cardiology, pulmonology, interventional radiology, intensive care unit, Emergency Department, and dental procedure areas to assess whether required equipment and sedation medications were available. Additionally, OIG reviewed the EHRs of 42 randomly selected patients who underwent an invasive procedure involving moderate sedation from July 1, 2015 through June 30, 2016, and the training records of 16 clinical employees who performed or assisted during these procedures. The list below shows the performance indicators OIG reviewed.

- Reporting and trending the use of reversal agents in moderate sedation cases
- Performance of history and physical examinations and pre-sedation assessment within 30 calendar days prior to the moderate sedation procedure
- Re-evaluation of patients immediately before administration of moderate sedation
- Documentation of informed consent prior to the moderate sedation procedure

[34] American Society of Anesthesiologists (ASA), Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists, 2002. Anesthesiology 2002; 96:1004-17.
[35] VA National Center for Patient Safety. Moderate Sedation Toolkit for Non-Anesthesiologists: Facilitator's Guide. March 2015. Retrieved March 20, 2017 from: https://www.patientsafety.va.gov/docs/modSedationtoolkit/FacilitatorGuide.pdf.
[36] VHA Directive 1073, *Moderate Sedation by Non-Anesthesiology Providers*, December 30, 2014.
[37] Per VA Corporate Data Warehouse data pull on February 22, 2017.

- Performance of timeout[38] prior to the moderate sedation procedure
- Post-procedure documentation
- Discharge practices
- Clinician training for moderate sedation
- Availability of equipment and medications in moderate sedation procedure areas

Conclusions. Generally, OIG found compliance with reporting and trending the use of reversal agents in moderate sedation cases, post-procedure assessments, and discharge practices. OIG identified the following deficiencies for history and physical exams and/or pre-sedation assessments, informed consent, and timeouts that warranted recommendations for improvement.

*History and Physical Exams and/or Pre-Sedation Assessments***.** VHA requires that providers perform a history and physical and/or pre-sedation assessment that includes required elements within 30 calendar days prior to the moderate sedation procedure. This ensures providers are aware of relevant patient information that may affect the patient's response to moderate sedation. Pre-sedation airway assessments include mouth opening, Mallampati score (relative tongue/palate size), neck extension, and chin size. To provide safe care, the providers also need to be aware of the patient's history of previous adverse experience(s) with sedation or anesthesia.[39]

For 12 of 42 patients (29 percent), providers did not complete an airway assessment. During the timeframe for our review, providers documented their airway assessments as "within normal limits," which was not adequate. Facility managers made a change in provider pre-sedation assessment templates in June 2016 to prompt for and improve documentation of airway assessments, resulting in improved compliance.

For 6 of 42 patients (14 percent), providers did not document patient history of previous adverse experience with sedation or anesthesia. Although templates included this element, OIG was told that lack of attention to detail by providers was the reason this part of the template was not completed.

Recommendation

14. The Chief of Staff ensures that providers include an airway assessment and history of previous adverse experience with sedation or anesthesia in the history and physical exam and/or pre-sedation assessment and monitors the providers' compliance.

[38] A time out is the process of verifying correct patient, procedure, and procedure site/side. The procedure team (physician, nurses, and other support staff) also verifies that the patient has given consent for the procedure and that any specialty equipment needed is available. This is performed prior to the start of the procedure.
[39] VA National Center for Patient Safety.

Facility concurred.

Target date for completion: February 1, 2018

Facility response: Standardized airway assessment was implemented for all sedation procedures in July, 2016. All staff in areas performing Moderate Sedation were educated on standardized Mallampati airway assessment. CPRS documentation included this as a hard stop for the provider to complete. All pre-moderate sedation templates were reviewed to ensure previous adverse experience with sedation or anesthesia was included as part of the history and physical exam and/or pre-sedation assessment. All departments that perform moderate sedation audited for both the Mallampati airway assessment and previous adverse experience with sedation or anesthesia, and compliance was achieved for August 98.9 percent, September 98.6 percent, and October 100 percent.

Informed Consent. VHA requires that providers provide and document informed consent prior to moderate sedation procedures. This ensures that patients have been given the right to accept or refuse any medical treatment or procedure recommended to them. According to the times entered for consents, 8 of 42 patients (19 percent) signed the informed consent after the start of the procedure. According to the Chief of Gastrointestinal Services, providers obtain consent immediately before the start of procedures and administration of sedation. However, facility staff had not recognized that the times automatically entered by the electronic consent program were not consistent with real time, thus causing a disparity with the medication administration and procedure start times entered into the EHR by the staff.

Recommendation

15. The Chief of Staff ensures that providers provide and document informed consent prior to moderate sedation administration and monitors providers' compliance.

Facility concurred.

Target date for completion: February 1, 2018

Facility response: All providers in areas performing moderate sedation were educated on the informed consent policy. All departments conducted monthly audits to ensure informed consent was obtained prior to moderate sedation procedure and compliance was achieved for August 97.8 percent, September 100 percent, and October 97.8 percent.

Timeouts. VHA and TJC require the clinical team, including the provider performing the procedure, to conduct and document a timeout prior to the moderate sedation procedure. The timeout must include specific required elements, be facilitated by a checklist, and be completed prior to the start of the moderate sedation procedure. This ensures that the clinical team members involved in the procedure are in agreement that they have the correct patient, procedure, and site on the patient and that they have

proper equipment, medications, and supplies prior to starting any aspect of the procedure.

For 27 of 42 patients (64 percent), OIG did not find evidence of a timeout prior to the start of procedures. Of the 15 patients who underwent a timeout, the privileged provider performing the procedure did not participate in five of those timeouts, and the procedure team did not use a checklist for four of these patients. While onsite, OIG observed great variance in how timeouts were performed. All of the gastroenterology procedure areas contained laminated checklists; however, the staff were unaware of them and could not articulate all required items on the checklist.

Recommendation

16. The Chief of Staff ensures clinical teams conduct and document timeouts prior to moderate sedation procedures, the privileged provider participates in the timeout, and staff use a checklist that includes all required elements and monitors compliance.

Facility concurred.

Target date for completion: February 1, 2018

Facility response: All providers in areas performing moderate sedation were educated on facility policy and the time-out process. All departments conducted monthly chart audits and direct procedure observations to ensure that prior to the moderate sedation procedure: timeouts were completed and documented; that the privileged provider participated in the timeout; and that staff used a checklist that includes all required elements. Direct observation compliance for August 100 percent, September 96.7 percent, and October 94.4 percent. Chart audit compliance for August 98.2 percent, September 99.3 percent, and October 98.1 percent.

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.[40] 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.[f]

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 EHRs of 41 randomly selected 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

The performance indicator that did not apply to this facility is listed below:

- The facility documented a hand-off for patients placed in CNHs outside of its catchment area.

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

Oversight Committee. VHA requires the CNH Oversight Committee to include representation from social work, nursing, quality management, acquisitions, and the medical staff. This ensures patients in the CNH program receive high-quality care in a safe environment. OIG reviewed attendance and minutes from the last 12 months of the CNH Oversight Committee and noted that representatives from social work, nursing,

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

quality management, acquisitions, and the medical staff were not present during the meetings. Program managers failed to ensure that the CNH Oversight Committee had appropriate members.

Recommendation

17. The Chief of Staff ensures Community Nursing Home Oversight Committee meetings include participation by all required disciplines and monitors compliance.

Facility concurred.

Target date for completion: February 1, 2018

Facility response: A new format was implemented for meeting minutes to include an attendance column and appointed all required meeting participants. An Outlook calendar appointment was sent to CNH Committee members for quarterly CNH Oversight meetings. Tracked participant attendance was documented in the meeting minutes with three consecutive months of compliance achieved at 100 percent.

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 that allow an exception are met). Social workers and registered nurses must alternate monthly visits (unless indicated by patients' treatment plans). This interdisciplinary monitoring ensures vulnerable nursing home patients consistently receive quality care and necessary follow-up services. Fifteen of 41 patients (37 percent) did not receive monthly clinical visits, and 7 of 41 patients (17 percent) did not receive cyclical clinical visits from social workers and/or registered nurses. Managers and staff knew the requirements, but staff availability, vacancies, and recruitment challenges affected compliance.

Recommendation

18. The Associate Director for Patient Care Services ensures the social workers and registered nurses conduct monthly cyclical clinical visits and monitors compliance.

Facility concurred.

Target date for completion: February 1, 2018

Facility response: An electronic tracking system for Community Nursing Home visits was developed. A CPRS note title was revised that specifies the visit type (visit within the first 30 days versus phone/fax follow-up). A CPRS template revision now includes a follow-up plan for next Registered Nurse/Social Worker visit. Documentation of clinical justification is now included for deviation of required alternating discipline visit. CNH staff were educated on the electronic CNH visit tracking system, revised templates and note titles. Three consecutive months of compliance was achieved in August 95 percent, September 93 percent, and October 99 percent.

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	Eighteen 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, Nurse Executive, and Associate Director for Operations. See details below.	
Healthcare Processes	**Performance Indicators**	**Critical Recommendations[41] 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	• Clinical managers consistently implement and document actions recommended by the Peer Review Committee. • Clinical managers complete at least 75 percent of all required inpatient UM reviews. • Physician UM Advisors consistently document their decisions in the National UM Integration database. • The Patient Safety Manager submits an annual patient safety report to facility leaders at the completion of each FY. • Executive Leadership Board and Peer Review Committee meeting minutes accurately reflect action status, and items are tracked to closure.

[41] 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
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 anticoagulation management program policy is revised to include the transition of patients between the inpatient and outpatient care settings and an anticoagulation quality assurance program. • Anticoagulation management program quality assurance data from all sites of care are collected, analyzed, and reported biannually to the Pharmacy and Therapeutics Committee. • Annual competency assessments that include all required content are completed for all employees actively involved in the anticoagulation management program, including all CBOCs.
Coordination of Care	• Transfer policies and procedures • Oversight of transfer process • EHR documentation o Non-emergent transfers o Emergent transfers	When patients are transferred out of the facility: • Providers consistently document patient or surrogate informed consent, medical and behavioral stability, and identification of transferring and receiving provider or designee. • Providers document sending or communicating to the accepting facility pertinent patient information.	• The facility's revised inter-facility transfer policy includes all required elements.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Environment of Care	• Parent facility o EOC deficiency tracking and rounds o General Safety o Infection prevention o Environmental cleanliness o Exam room privacy o Availability of feminine hygiene products and medical equipment and supplies • CBOC o General safety o Infection prevention o Environmental cleanliness o Medication safety and security o Privacy o Availability of feminine hygiene products and medical equipment and supplies o IT network room security • Radiology o Safe use of fluoroscopy equipment o Environmental safety o Infection prevention o Medication safety and security o Radiology equipment inspection o Availability of medical equipment and supplies o Maintenance of radiological equipment • Inpatient MH o MH EOC inspections o Environmental suicide hazard identification o Employee training o Environmental safety o Infection prevention o Availability of medical equipment and supplies	None	• Designated team members conduct EOC rounds in clinical and nonclinical areas as required. • All locked MH unit employees and Interdisciplinary Safety Inspection Team members receive annual training on how to identify and correct environmental hazards, including the proper use of the MH EOC Checklist.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
High-Risk and Problem-Prone Processes: Moderate Sedation	• Outcomes reporting • Patient safety and documentation o Prior to procedure o After procedure • Staff training and competency • Monitoring equipment and emergency management	• Providers include an airway assessment and history of previous adverse experience with sedation or anesthesia in the history and physical exam and/or pre-sedation assessment. • Providers provide and document informed consent prior to moderate sedation administration. • Clinical teams conduct and document timeouts prior to moderate sedation procedures, the privileged provider participates in the timeout, and staff use a checklist that includes all required elements.	None
Long-Term Care: Community Nursing Home Oversight	• CNH Oversight Committee and CNH program integration • EHR documentation o Patient hand-off o Clinical visits • CNH annual reviews	• Social workers and registered nurses conduct and document monthly cyclical clinical visits.	• CNH Oversight Committee meetings include participation by all required disciplines.

Facility Profile

The table below provides general background information for this high-complexity (1a)[42] affiliated[43] facility reporting to VISN 23.

Table 5. Facility Profile for Minneapolis (618) for October 1, 2013 through September 30, 2016

Profile Element	Facility Data FY 2014[44]	Facility Data FY 2015[45]	Facility Data FY 2016[46]
Total Medical Care Budget in Millions	$768.8	$838.7	$891.3
Number of:			
• **Unique Patients**	100,804	102,385	103,551
• **Outpatient Visits**	868,181	903,280	918,231
• **Unique Employees**[47]	3,296	3,459	3,646
Type and Number of Operating Beds:			
• **Acute**	201	201	205
• **Mental Health**	24	24	24
• **Community Living Center**	80	80	80
• **Domiciliary**	NA	NA	NA
Average Daily Census:			
• **Acute**	123	118	125
• **Mental Health**	11	12	16
• **Community Living Center**	63	69	68
• **Domiciliary**	NA	NA	NA

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

[42] VHA medical centers are classified according to a facilities complexity model; 1a designation indicates a facility with high-volume, high-risk patients, most complex clinical programs, and large research and teaching programs. Retrieved September 14, 2017, from http://opes.vssc.med.va.gov/FacilityComplexityLevels/Facility%20Complexity%20Levels%20Document%20Library/Facility%20Complexity%20Level%20Model%20Fact%20Sheet.docx
[43] Associated with a medical residency program.
[44] October 1, 2013 through September 30, 2014.
[45] October 1, 2014 through September 30, 2015.
[46] October 1, 2015 through September 30, 2016.
[47] Unique employees involved in direct medical care (cost center 8200).

VA Outpatient Clinic Profiles[48]

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

Table 6. VA Outpatient Clinic Workload/Encounters[49] 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[50] Provided	Diagnostic Services[51] Provided	Ancillary Services[52] Provided
Superior, WI	618BY	16,560	6,482	Cardiology Endocrinology Gastroenterology Hematology/ Oncology Infectious Disease Nephrology Neurology Pulmonary/ Respiratory Disease Rheumatology Amputation Follow-up Poly-Trauma Eye General Surgery Neurosurgery Urology Vascular	EKG Laboratory and Pathology	Nutrition Pharmacy Social Work Weight Management
St. James, MN	618GA	8,427	3,120	Cardiology Endocrinology Gastroenterology Hematology/ Oncology Nephrology Neurology Spinal Cord Injury General Surgery Neurosurgery Vascular	EKG	Nutrition Pharmacy Social Work

[48] Includes all outpatient clinics in the community that were in operation as of February 15, 2017. We have omitted Minneapolis, MN (618GL); Rice Lake, WI (618GM); and Mankato, MN (618GN), as no workload/encounters or services were reported.
[49] An encounter is a professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition.
[50] Specialty care services refer to non-PC and non-MH services provided by a physician.
[51] Diagnostic services include EKG, EMG, laboratory, nuclear medicine, radiology, and vascular lab services.
[52] Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Hibbing, MN	618GB	8,183	2,171	Cardiology Endocrinology Gastroenterology Hematology/ Oncology Infectious Disease Nephrology Neurology Pulmonary/ Respiratory Disease Rheumatology Spinal Cord Injury Eye General Surgery Podiatry Urology Vascular	EKG	Nutrition Pharmacy Social Work Weight Management
Maplewood, MN	618GD	9,921	4,559	Allergy Cardiology Endocrinology Hematology/ Oncology Pulmonary/ Respiratory Disease General Surgery Neurosurgery	EKG	Nutrition Pharmacy Social Work Weight Management
Chippewa Falls, WI	618GE	9,451	5,607	Cardiology Endocrinology Gastroenterology Hematology/ Oncology Infectious Disease Nephrology Neurology Pulmonary/ Respiratory Disease Rheumatology Spinal Cord Injury Eye General Surgery Urology Vascular	EKG	Nutrition Pharmacy Social Work Weight Management

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Rochester, MN	618GG	9,839	4,526	Cardiology Endocrinology Gastroenterology Hematology/ Oncology Nephrology Neurology Pulmonary/ Respiratory Disease Rheumatology Eye General Surgery Neurosurgery	EKG	Nutrition Pharmacy Social Work Weight Management
Hayward, WI	618GH	9,440	2,886	Cardiology Endocrinology Gastroenterology Hematology/ Oncology Infectious Disease Nephrology Neurology Pulmonary/ Respiratory Disease Rheumatology Spinal Cord Injury Eye General Surgery Gynecology Urology Vascular	EKG	Nutrition Pharmacy Social Work Weight Management
Ramsey, MN	618GI	12,338	6,113	Cardiology Endocrinology Gastroenterology Hematology/ Oncology Infectious Disease Nephrology Pulmonary/ Respiratory Disease Rheumatology Anesthesia Eye General Surgery	NA	Dental Nutrition Pharmacy Social Work Weight Management

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Shakopee, MN	618GJ	5,104	3,041	Gastroenterology Nephrology Pulmonary/ Respiratory Disease Rheumatology Spinal Cord Injury Eye General Surgery Neurosurgery Podiatry	NA	Nutrition Pharmacy Social Work Weight Management
Albert Lea, MN	618GK	4,543	1,000	Cardiology Hematology/ Oncology Infectious Disease Nephrology Neurology Pulmonary/ Respiratory Disease Rheumatology Eye General Surgery Podiatry Urology	EKG	Nutrition Pharmacy Social Work Weight Management
Fort Snelling, MN	618QA	152	1,714	NA	EKG Radiology	NA

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

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

VHA Policies Beyond Recertification Dates

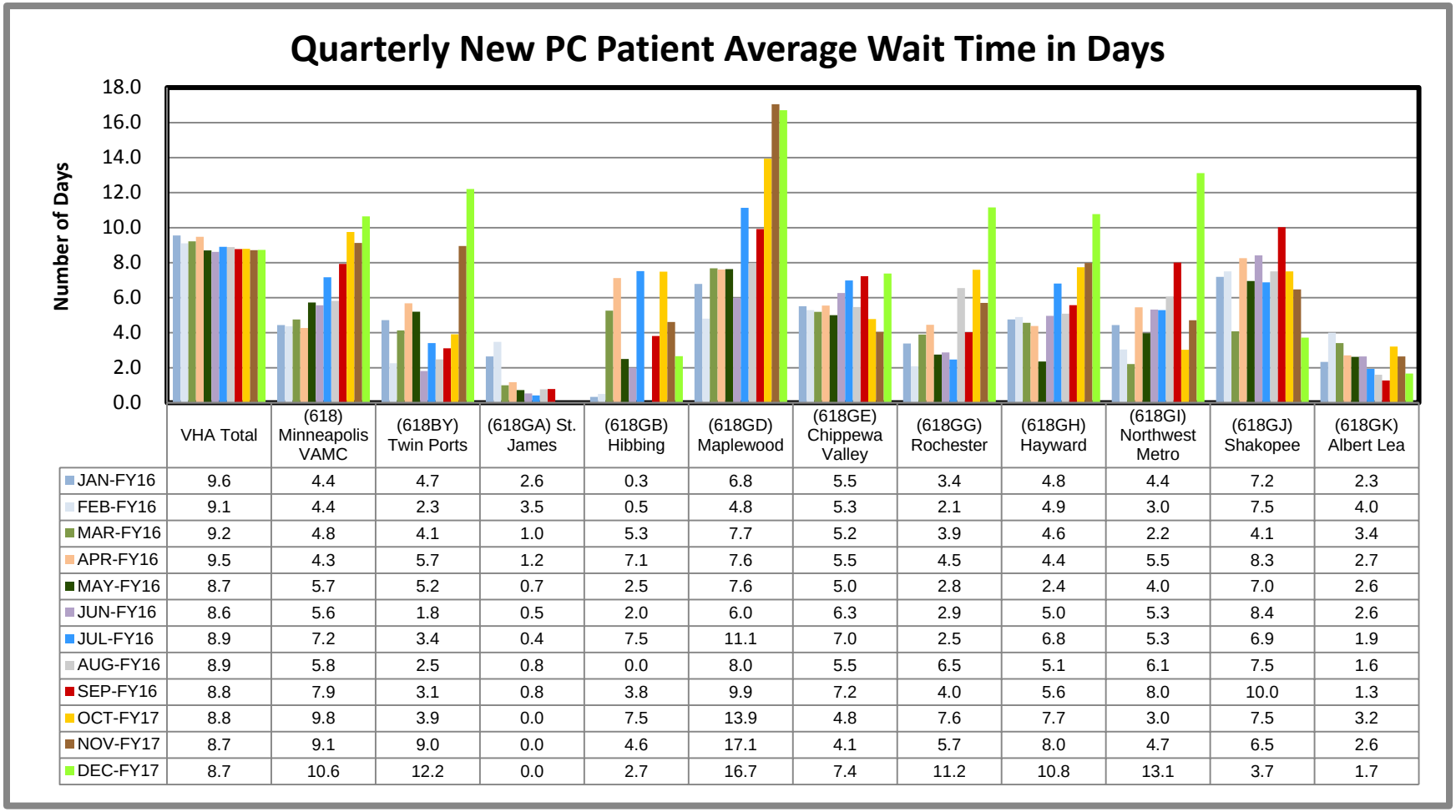
In this report, OIG cited seven policies that were beyond the recertification date:

1. VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010 (recertification due date June 30, 2015).
2. VHA Directive 2011-007, Required Hand Hygiene Practices, February 16, 2011 (recertification due date February 29, 2016).
3. VHA Directive 2012-026, Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities, September 27, 2012 (recertification due date September 30, 2017).
4. VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011 (recertification due date March 31, 2016).
5. VHA Handbook 1004.01, *Informed Consent for Clinical Treatments and Procedures*, August 14, 2009 (recertification due date August 31, 2014), revised May 22, 2017.
6. VHA Handbook 1105.04, *Fluoroscopy Safety*, July 6, 2012 (recertification due date July 31, 2017).
7. VHA Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures*, June 4, 2004 (recertification due date January 31, 2009).

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),[53] 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."[54] 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."[55]

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

Patient Aligned Care Team Compass Metrics

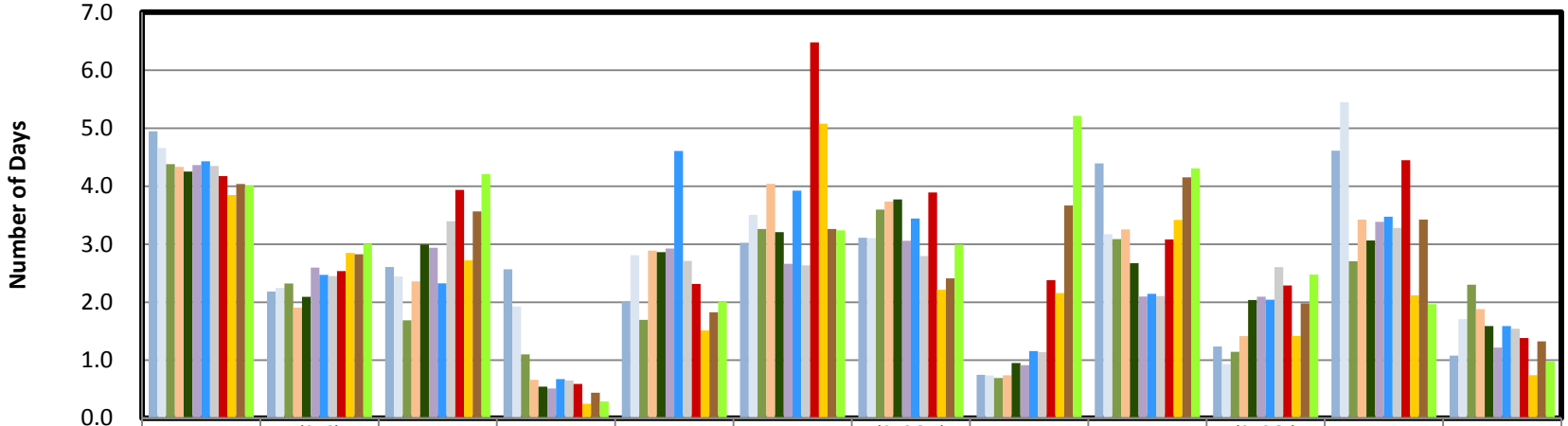


	VHA Total	(618) Minneapolis VAMC	(618BY) Twin Ports	(618GA) St. James	(618GB) Hibbing	(618GD) Maplewood	(618GE) Chippewa Valley	(618GG) Rochester	(618GH) Hayward	(618GI) Northwest Metro	(618GJ) Shakopee	(618GK) Albert Lea
JAN-FY16	9.6	4.4	4.7	2.6	0.3	6.8	5.5	3.4	4.8	4.4	7.2	2.3
FEB-FY16	9.1	4.4	2.3	3.5	0.5	4.8	5.3	2.1	4.9	3.0	7.5	4.0
MAR-FY16	9.2	4.8	4.1	1.0	5.3	7.7	5.2	3.9	4.6	2.2	4.1	3.4
APR-FY16	9.5	4.3	5.7	1.2	7.1	7.6	5.5	4.5	4.4	5.5	8.3	2.7
MAY-FY16	8.7	5.7	5.2	0.7	2.5	7.6	5.0	2.8	2.4	4.0	7.0	2.6
JUN-FY16	8.6	5.6	1.8	0.5	2.0	6.0	6.3	2.9	5.0	5.3	8.4	2.6
JUL-FY16	8.9	7.2	3.4	0.4	7.5	11.1	7.0	2.5	6.8	5.3	6.9	1.9
AUG-FY16	8.9	5.8	2.5	0.8	0.0	8.0	5.5	6.5	5.1	6.1	7.5	1.6
SEP-FY16	8.8	7.9	3.1	0.8	3.8	9.9	7.2	4.0	5.6	8.0	10.0	1.3
OCT-FY17	8.8	9.8	3.9	0.0	7.5	13.9	4.8	7.6	7.7	3.0	7.5	3.2
NOV-FY17	8.7	9.1	9.0	0.0	4.6	17.1	4.1	5.7	8.0	4.7	6.5	2.6
DEC-FY17	8.7	10.6	12.2	0.0	2.7	16.7	7.4	11.2	10.8	13.1	3.7	1.7

Source: VHA Support Service Center.

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

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



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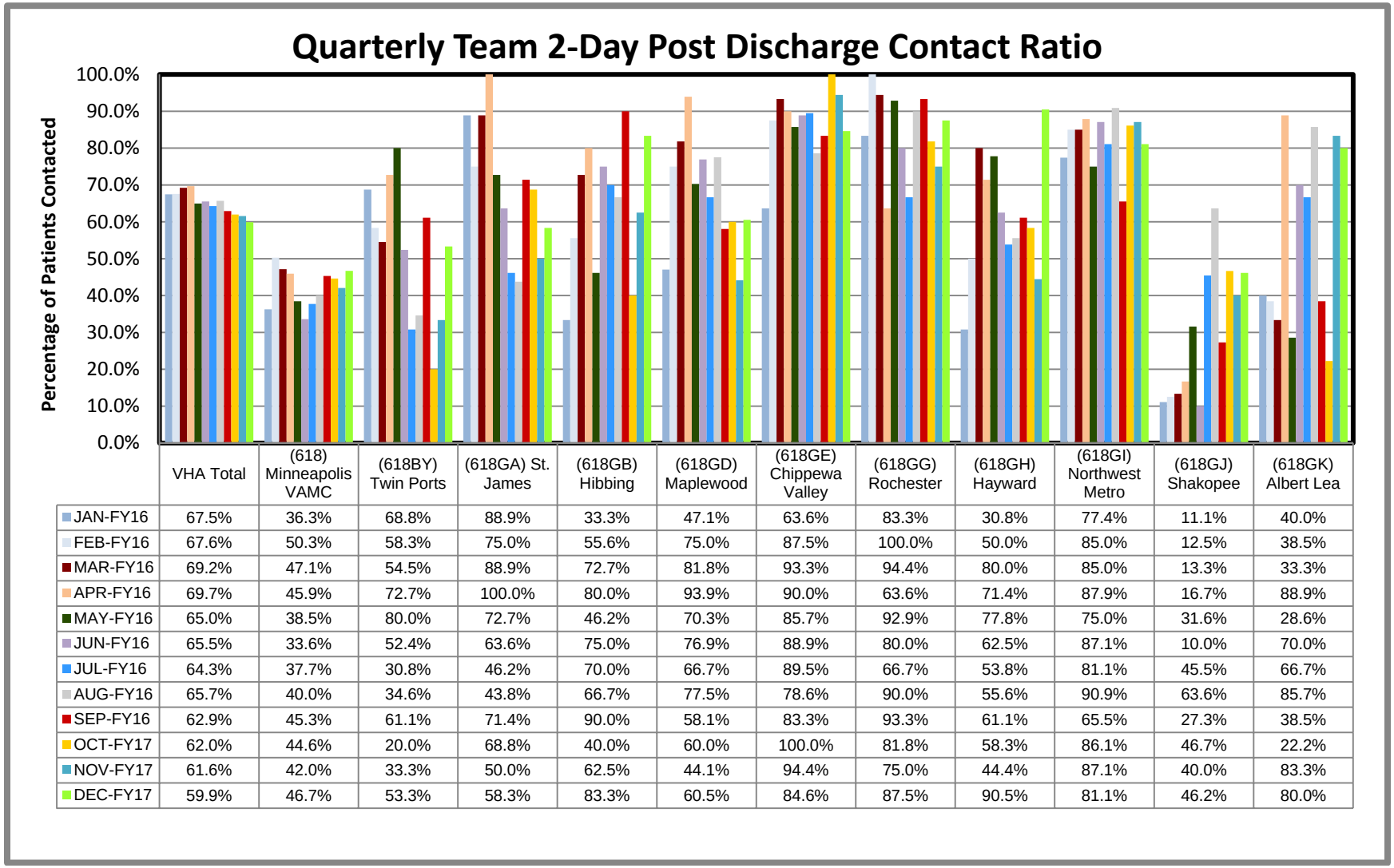
JAN-FY16	4.9	2.2	2.6	2.6	2.0	3.0	3.1	0.7	4.4	1.2	4.6	1.1
FEB-FY16	4.7	2.2	2.4	1.9	2.8	3.5	3.1	0.7	3.2	0.9	5.4	1.7
MAR-FY16	4.4	2.3	1.7	1.1	1.7	3.3	3.6	0.7	3.1	1.1	2.7	2.3
APR-FY16	4.3	1.9	2.4	0.7	2.9	4.0	3.7	0.7	3.3	1.4	3.4	1.9
MAY-FY16	4.3	2.1	3.0	0.5	2.9	3.2	3.8	1.0	2.7	2.0	3.1	1.6
JUN-FY16	4.4	2.6	2.9	0.5	2.9	2.7	3.1	0.9	2.1	2.1	3.4	1.2
JUL-FY16	4.4	2.5	2.3	0.7	4.6	3.9	3.4	1.2	2.1	2.0	3.5	1.6
AUG-FY16	4.3	2.5	3.4	0.7	2.7	2.6	2.8	1.1	2.1	2.6	3.3	1.5
SEP-FY16	4.2	2.5	3.9	0.6	2.3	6.5	3.9	2.4	3.1	2.3	4.4	1.4
OCT-FY17	3.8	2.9	2.7	0.2	1.5	5.1	2.2	2.2	3.4	1.4	2.1	0.7
NOV-FY17	4.0	2.8	3.6	0.4	1.8	3.3	2.4	3.7	4.2	2.0	3.4	1.3
DEC-FY17	4.0	3.0	4.2	0.3	2.0	3.2	3.0	5.2	4.3	2.5	2.0	1.0

Source: VHA Support Service Center.

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

Data Definition: The average number of calendar days between an established patient's PC completed appointment (clinic stops 322, 323, and 350, excluding Compensation and Pension appointments) and the earliest of three possible preferred (desired) dates (Electronic Wait List [EWL], Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date.



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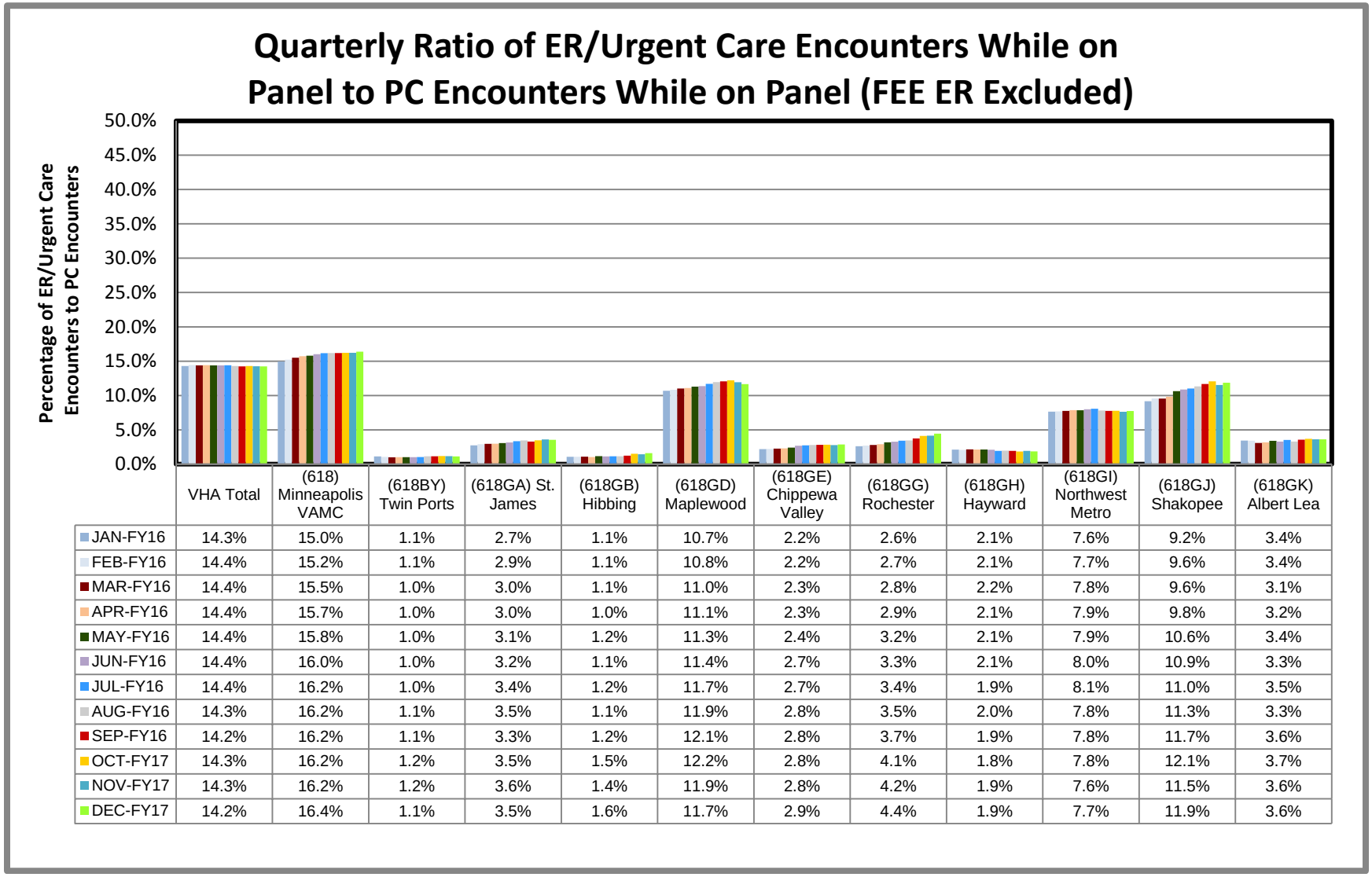
JAN-FY16	67.5%	36.3%	68.8%	88.9%	33.3%	47.1%	63.6%	83.3%	30.8%	77.4%	11.1%	40.0%
FEB-FY16	67.6%	50.3%	58.3%	75.0%	55.6%	75.0%	87.5%	100.0%	50.0%	85.0%	12.5%	38.5%
MAR-FY16	69.2%	47.1%	54.5%	88.9%	72.7%	81.8%	93.3%	94.4%	80.0%	85.0%	13.3%	33.3%
APR-FY16	69.7%	45.9%	72.7%	100.0%	80.0%	93.9%	90.0%	63.6%	71.4%	87.9%	16.7%	88.9%
MAY-FY16	65.0%	38.5%	80.0%	72.7%	46.2%	70.3%	85.7%	92.9%	77.8%	75.0%	31.6%	28.6%
JUN-FY16	65.5%	33.6%	52.4%	63.6%	75.0%	76.9%	88.9%	80.0%	62.5%	87.1%	10.0%	70.0%
JUL-FY16	64.3%	37.7%	30.8%	46.2%	70.0%	66.7%	89.5%	66.7%	53.8%	81.1%	45.5%	66.7%
AUG-FY16	65.7%	40.0%	34.6%	43.8%	66.7%	77.5%	78.6%	90.0%	55.6%	90.9%	63.6%	85.7%
SEP-FY16	62.9%	45.3%	61.1%	71.4%	90.0%	58.1%	83.3%	93.3%	61.1%	65.5%	27.3%	38.5%
OCT-FY17	62.0%	44.6%	20.0%	68.8%	40.0%	60.0%	100.0%	81.8%	58.3%	86.1%	46.7%	22.2%
NOV-FY17	61.6%	42.0%	33.3%	50.0%	62.5%	44.1%	94.4%	75.0%	44.4%	87.1%	40.0%	83.3%
DEC-FY17	59.9%	46.7%	53.3%	58.3%	83.3%	60.5%	84.6%	87.5%	90.5%	81.1%	46.2%	80.0%

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."



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JAN-FY16	14.3%	15.0%	1.1%	2.7%	1.1%	10.7%	2.2%	2.6%	2.1%	7.6%	9.2%	3.4%
FEB-FY16	14.4%	15.2%	1.1%	2.9%	1.1%	10.8%	2.2%	2.7%	2.1%	7.7%	9.6%	3.4%
MAR-FY16	14.4%	15.5%	1.0%	3.0%	1.1%	11.0%	2.3%	2.8%	2.2%	7.8%	9.6%	3.1%
APR-FY16	14.4%	15.7%	1.0%	3.0%	1.0%	11.1%	2.3%	2.9%	2.1%	7.9%	9.8%	3.2%
MAY-FY16	14.4%	15.8%	1.0%	3.1%	1.2%	11.3%	2.4%	3.2%	2.1%	7.9%	10.6%	3.4%
JUN-FY16	14.4%	16.0%	1.0%	3.2%	1.1%	11.4%	2.7%	3.3%	2.1%	8.0%	10.9%	3.3%
JUL-FY16	14.4%	16.2%	1.0%	3.4%	1.2%	11.7%	2.7%	3.4%	1.9%	8.1%	11.0%	3.5%
AUG-FY16	14.3%	16.2%	1.1%	3.5%	1.1%	11.9%	2.8%	3.5%	2.0%	7.8%	11.3%	3.3%
SEP-FY16	14.2%	16.2%	1.1%	3.3%	1.2%	12.1%	2.8%	3.7%	1.9%	7.8%	11.7%	3.6%
OCT-FY17	14.3%	16.2%	1.2%	3.5%	1.5%	12.2%	2.8%	4.1%	1.8%	7.8%	12.1%	3.7%
NOV-FY17	14.3%	16.2%	1.2%	3.6%	1.4%	11.9%	2.8%	4.2%	1.9%	7.6%	11.5%	3.6%
DEC-FY17	14.2%	16.4%	1.1%	3.5%	1.6%	11.7%	2.9%	4.4%	1.9%	7.7%	11.9%	3.6%

Source: VHA Support Service Center.

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

Data Definition: This is a measure of where the patient receives his PC and by whom. A low percentage is better. The formula is the total VHA ER/Urgent Care Encounters While on Team (WOT) with a Licensed Independent Practitioner (LIP) *divided by* the number of PC Team Encounters WOT with an LIP **plus** the total number of VHA ER/Urgent Care Encounters WOT with an LIP.

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

Measure	Definition	Desired Direction
ACSC Hospitalization	Ambulatory care sensitive condition hospitalizations (observed to expected ratio)	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Admit Reviews Met	% Acute Admission Reviews that meet InterQual criteria	A higher value is better than a lower value
Best Place to Work	Overall satisfaction with job	A higher value is better than a lower value
Call Center Responsiveness	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
Call Responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Complications	Acute care risk adjusted complication ratio	A lower value is better than a higher value
Cont Stay Reviews Met	% Acute Continued Stay reviews that meet InterQual criteria	A higher value is better than a lower value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value
HC Assoc Infections	Health care associated infections	A lower value is better than a higher value
HEDIS Like	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
MH Wait Time	MH care wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
MH Continuity Care	MH continuity of care (FY14Q3 and later)	A higher value is better than a lower value
MH Exp of Care	MH experience of care (FY14Q3 and later)	A higher value is better than a lower value
MH Popu Coverage	MH population coverage (FY14Q3 and later)	A higher value is better than a lower value
Oryx	Inpatient performance measure (ORYX)	A higher value is better than a lower value
PC Routine Care Appt	Timeliness in getting a PC routine care appointment (PCMH)	A higher value is better than a lower value
PC Urgent Care Appt	Timeliness in getting a PC urgent care appointment (PCMH)	A higher value is better than a lower value
PC Wait Time	PC wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
PSI	Patient safety indicator (observed to expected ratio)	A lower value is better than a higher value
Pt Satisfaction	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value
Rating PC Provider	Rating of PC providers (PCMH)	A higher value is better than a lower value
Rating SC Provider	Rating of specialty care providers (specialty care module)	A higher value is better than a lower value
RN Turnover	Registered nurse turnover rate	A lower value is better than a higher value

Measure	Definition	Desired Direction
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-Cardio	30-day risk standardized readmission rate for cardiorespiratory patient cohort	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-CV	30-day risk standardized readmission rate for cardiovascular patient cohort	A lower value is better than a higher value
RSRR-HWR	Hospital wide readmission	A lower value is better than a higher value
RSRR-Med	30-day risk standardized readmission rate for medicine patient cohort	A lower value is better than a higher value
RSRR-Neuro	30-day risk standardized readmission rate for neurology patient cohort	A lower value is better than a higher value
RSRR-Pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
RSRR-Surg	30-day risk standardized readmission rate for surgery patient cohort	A lower value is better than a higher value
SC Routine Care Appt	Timeliness in getting a SC routine care appointment (Specialty Care)	A higher value is better than a lower value
SC Urgent Care Appt	Timeliness in getting a SC urgent care appointment (Specialty Care)	A higher value is better than a lower value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Specialty Care Wait Time	Specialty care wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value

Source: VHA Support Service Center.

Relevant OIG Reports

September 1, 2014 through December 1, 2017[56]

Healthcare Inspection – Review of VHA's "Our Doctors" Website Accuracy
6/23/2017 | *16-01436-270* | *Summary* | *Report*

Healthcare Inspection – Review of Primary Care Ghost Panels, Veterans Integrated Service Network 23, Eagan, Minnesota
8/11/2016 | *16-01708-340* | *Summary* | *Report*

Healthcare Inspection – Psychiatry Partial Hospitalization Program and Management Concerns, Minneapolis VA Health Care System, Minneapolis, Minnesota
8/11/2016 | *14-04655-369* | *Summary* | *Report*

Healthcare Inspection – Access and Quality of Care Concerns, Phoenix VA Health Care System, Phoenix, Arizona, and Delayed Test Result Notification, Minneapolis VA Health Care System, Minneapolis, Minnesota
6/23/2016 | *15-03867-287* | *Summary* | *Report*

Audit of VHA's Efforts To Improve Veterans' Access to Outpatient Psychiatrists
8/25/2015 | *13-03917-487* | *Summary* | *Report*

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

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

Combined Assessment Program Review of the Minneapolis VA Health Care System, Minneapolis, Minnesota
11/18/2014 | *14-02083-24* | *Summary* | *Report*

Community Based Outpatient Clinic and Primary Care Clinic Reviews at Minneapolis VA Health Care System, Minneapolis, Minnesota
9/8/2014 | *14-00938-272* | *Summary* | *Report*

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

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: December 5, 2017

From: Director, VA Midwest Health Care Network (10N23)

Subject: **CHIP Review of the Minneapolis VA Health Care System, Minneapolis, MN**

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

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

I have reviewed the concurrence for each recommendation and action plan with measurable goals and target completion dates, for the 2017 CHIP Review at the Minneapolis VA Health Care System.

A. Sanchez, MD for Ms. Murphy

Janet P. Murphy, MBA

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: November 28, 2017

From: Director, Minneapolis VA Health Care System (618/00)

Subject: **CHIP Review of the Minneapolis VA Health Care System, Minneapolis, MN**

To: Director, VA Midwest Health Care Network (10N23)

1. Enclosed is our concurrence for each recommendation and action plan, with measurable goals and target completion dates, for the 2017 CHIP Review at the Minneapolis VA Health Care System. I concur with the action plans and submitted documentation. Thank you for considering our requests.

PATRICK J. KELLY, FACHE

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

Endnotes

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

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

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

[d] The references used for EOC included:
- VHA 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.

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

[f] 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).

[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.