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Office of Inspector General

Office of Healthcare Inspections

Report No. 17-01760-85

Comprehensive Healthcare Inspection Program Review of the Huntington VA Medical Center Huntington, West Virginia

January 31, 2018

Washington, DC 20420

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Glossary

CBOC	community based outpatient clinic
CHIP	Comprehensive Healthcare Inspection Program
EHR	electronic health record
EOC	environment of care
facility	Huntington VA Medical Center
FY	fiscal year
IT	Information technology
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 Huntington VA Medical Center (facility). The review covers key clinical and administrative processes that are associated with promoting quality care.

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

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

This review was conducted during an unannounced visit made during the week of August 7, 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 Huntington VA Medical Center, the leadership team consists of the Facility Director, Chief of Staff, Associate Director for Patient Care Services (Nurse Executive), and Acting Associate Director. 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 Resource Management; Medical Staff; and Quality, Safety, and Value Councils. The leaders are members of the Executive Leadership Board through which they track, trend, and monitor quality of care and patient outcomes.

The Associate Director position has been vacant since April 2017, and two employees have served in an acting capacity. The Nurse Executive was permanently assigned in July 2017 but had served in an acting capacity since December 2016. The Director and

Chief of Staff have been working together as a team since February 2014. In the review of selected employee and patient survey results regarding facility senior leadership, OIG noted high satisfaction scores that reflected active engagement with employees and patients. OIG also noted that facility leaders implemented processes and plans to maintain a committed workforce and positive patient experiences.

Additionally, OIG reviewed accreditation agency findings, sentinel events, disclosures of adverse patient events, Patient Safety Indicator data, and Strategic Analytics for Improvement and Learning (SAIL) data and did not identify any substantial organizational risk factors. OIG recognizes that the SAIL model has limitations for identifying all areas of clinical risk but is "a way to understand the similarities and differences between the top and bottom performers" within the Veterans Health Administration (VHA).[1]

Although the senior leadership team was knowledgeable about selected SAIL metrics, the leaders should continue to take actions to improve performance of the Quality of Care and Efficiency metrics likely contributing to the current 4-star SAIL rating. In the review of key care processes, OIG issued seven recommendations that are attributable to the Facility Director, Chief of Staff, Nurse Executive, and Associate Director. Of the six areas of clinical operations reviewed, OIG noted findings in four. These are briefly described below.

Quality, Safety, and Value. Generally, OIG found that senior managers were engaged with quality, safety, and value activities. OIG found compliance with requirements for protected peer reviews, credentialing and privileging, utilization management,[2] and patient safety. However, OIG identified a deficiency with the senior-level committee responsible for key quality, safety, and value functions.

Coordination of Care. OIG noted that the facility developed and implemented a patient transfer policy and collected and reported data about transfers out of the facility. Generally, OIG found compliance with providers' and acceptable designees' documentation for emergent transfers. However, OIG identified deficiencies in nursing transfer documentation and communication with the accepting facility.

Environment of Care. The parent facility generally met deficiency tracking, general safety, infection prevention, and privacy requirements. The representative community based outpatient clinic generally met requirements for cleanliness, medication safety

[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.

and security, and privacy. OIG did not identify any deficiencies in the performance indicators evaluated for Radiology Service or note any issues with the availability of medical equipment and supplies. However, several patient care areas had dusty ventilation grills, and the Gallipolis CBOC's women's public restroom lacked feminine hygiene products and disposal bins. OIG identified deficiencies with environment of care rounds attendance and with general safety and infection prevention at the representative community based outpatient clinic.

Long-Term Care: Community Nursing Home Oversight. Generally, OIG noted compliance with requirements for community nursing home program integration, documentation, and annual reviews. However, OIG identified a deficiency with Community Nursing Home Oversight Committee membership.

Summary

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

Comments

The Veterans Integrated Service Network Director and Facility Director agreed with the CHIP review findings and recommendations and provided acceptable improvement plans. OIG considers recommendation 1 closed. (See Appendixes G and H, pages 43–44, 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 for the open recommendations until they are completed.

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Purpose and Scope

Purpose

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

Scope

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

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 from April 2, 2014[5] through August 7, 2017, the date when an unannounced week-long site visit commenced. OIG also presented crime awareness briefings to 108 of the facility's 1,439 employees on August 14 and 15, 2017. 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 a CHIP review. We conducted the inspection in accordance with 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

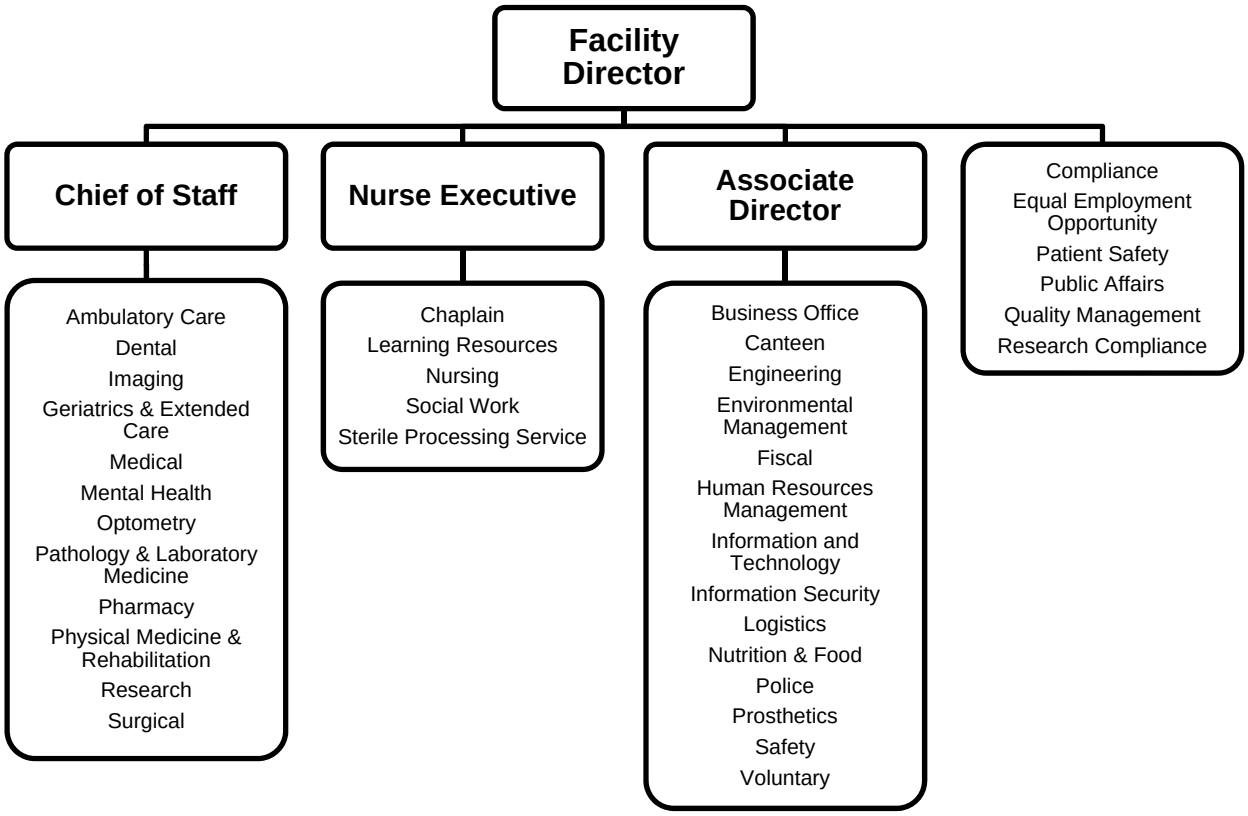
Stable and effective leadership is critical to improving care and sustaining meaningful change. Leadership and organizational risk issues can impact the facility's ability to provide care in all of the selected clinical areas of focus. The factors OIG considered in assessing the facility's risks and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

It is important to note that the Associate Director was not permanently assigned. A Veterans Benefits Administration employee was detailed to the position from April 1, 2017 to August 1, 2017, as part of the Director's initiative to integrate the facility with other VA divisions. The subsequent Acting Associate Director assumed the role on August 7, 2017 (the first day of the OIG onsite visit), is in a VHA leadership program, and has been assigned to the position for a limited time. The Nurse Executive was permanently assigned in July 2017 but had served as acting in the position since December 2016. The Director and Chief of Staff had been working together as a team since February 2014.

Figure 2. Facility Organizational Chart



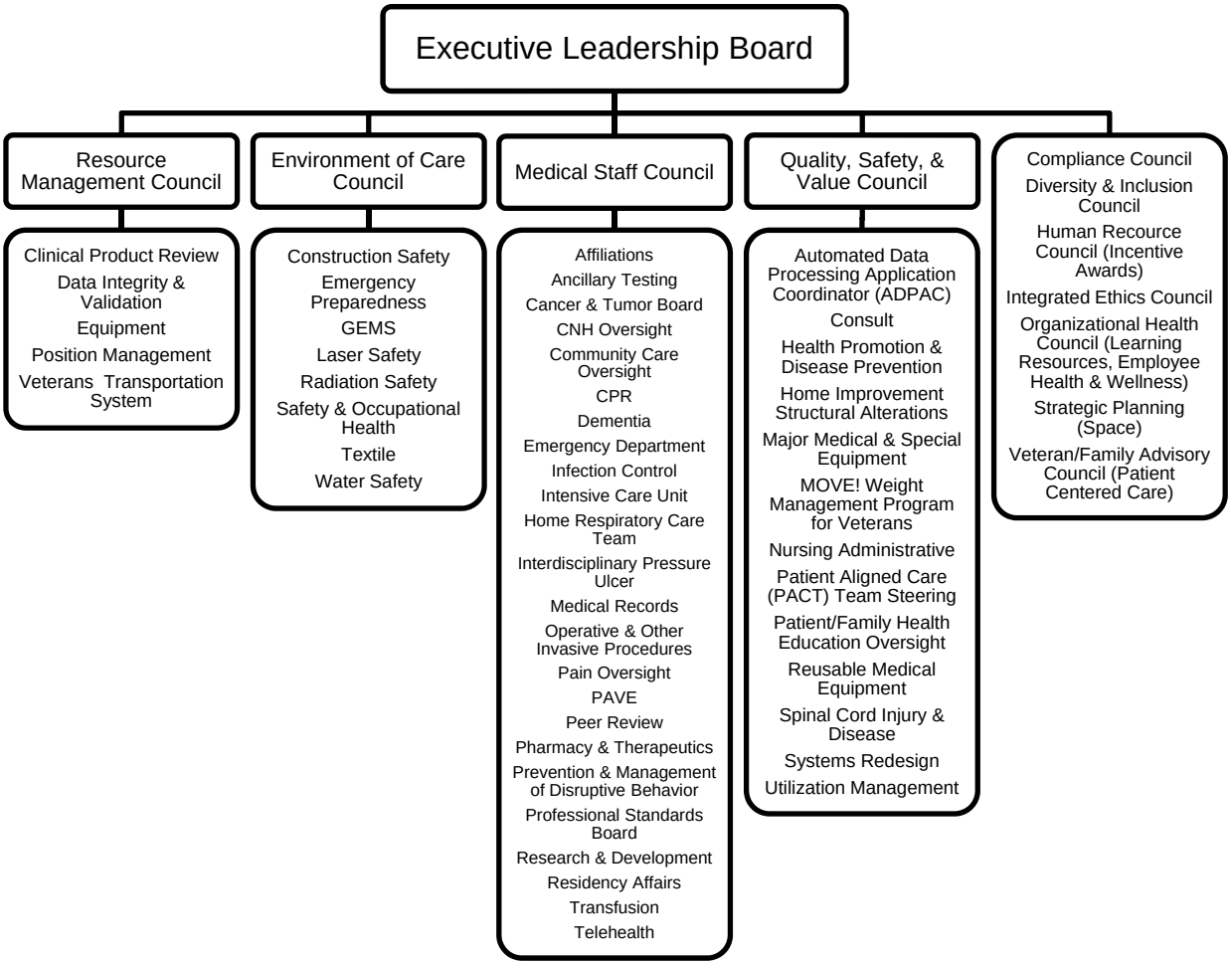
Source: Huntington VA Medical Center (received August 14, 2017).

To help assess engagement of facility executive leadership, OIG interviewed the Facility Director, Chief of Staff, and Nurse Executive 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 Resource Management, Medical Staff, and QSV Councils. See Figure 3.

Figure 3. Facility Committee Reporting Structure



Source: Huntington VA Medical Center (received August 10, 2017).

CNH = Contract Nursing Home

CPR = cardiopulmonary resuscitation

PAVE = Prevention of Amputation in Veterans Everywhere

Employee Satisfaction and Patient Experience. To assess employee and patient attitudes toward facility senior leadership, OIG reviewed employee satisfaction and patient experience survey results that relate to the period of October 1, 2015 through September 30, 2016. Although OIG recognizes that employee satisfaction and patient experience survey data are subjective, they can be a starting point for discussions and indicate areas for further inquiry, which can be considered along with other information on facility leadership. Table 1 provides relevant survey results for VHA and the facility for the 12-month period. The facility leaders' results (Director's office average) were rated markedly above the VHA and facility average.[6] All four patient survey results reflected similar or 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)	3.3	3.8	4.2
All Employee Survey Servant Leader Index Composite	0–100 where HIGHER scores are more favorable	66.7	71.0	85.6
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	66.2	
Survey of Healthcare Experiences of Patients (inpatient): I felt like a valued customer.	The response average is the percent of "Agree" and "Strongly Agree" responses.	82.8	84.8	
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): I felt like a valued customer.		73.2	76.9	
Survey of Healthcare Experiences of Patients (outpatient specialty care): I felt like a valued customer.		73.8	79.0	

[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). Indicative of effective leadership, the facility has closed[10] all recommendations for improvement as listed in Table 2. OIG also noted the facility's current accreditation status with the Commission on Accreditation of Rehabilitation Facilities[11] and College of American Pathologists,[12] which demonstrates the facility leaders' commitment to quality care and services.

[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.

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

Accreditation or Inspecting Agency	Date of Visit	Number of Findings	Number of Recommendations Remaining Open
VA OIG (*Healthcare Inspection – Alleged Improper Maintenance of Reprocessing Equipment Huntington VA Medical Center, Huntington, West Virginia, June 25, 2015)*	August 2014	0	NA
VA OIG (*Healthcare Inspection – Peer Review for Quality Management Concerns Huntington VA Medical Center, Huntington, West Virginia, April 11, 2017)*	May 2015	6	0
VA OIG (*Combined Assessment Program Review of the Huntington VA Medical Center, Huntington, West Virginia, October 27, 2014)*	August 2014	17	0
VA OIG *(Community Based Outpatient Clinic and Primary Care Clinic Reviews at the Huntington VA Medical Center, Huntington, West Virginia, June 10, 2014)*	April 2014	6	0
TJC[13] • Hospital Accreditation • Behavioral Health Care Accreditation • Home Care Accreditation	July 2016	 13 2 4	 0 0 0

NA = Not applicable

[13] TJC is an internationally accepted external validation that an organization has systems and processes in place to provide safe and quality oriented health care. TJC has been accrediting VHA facilities for more than 30 years. Compliance with TJC standards facilitates risk reduction and performance improvement.

Indicators for Possible Lapses in Care. Within the health care field, the primary organizational risk is the potential for patient harm. Many factors impact the risk for patient harm within a system, including unsafe environmental conditions, sterile processing deficiencies, and infection control practices. Leaders must be able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms. Table 3 summarizes key indicators of risk since OIG's previous April 2014 Combined Assessment Program and Community Based Outpatient Clinic (CBOC) and Primary Care (PC) review inspections through the week of August 7, 2017.

Table 3. Summary of Selected Organizational Risk Factors[14] (April 2014 to August 7, 2017)

Factor	Number of Occurrences
Sentinel Events[15]	3
Institutional Disclosures[16]	5
Large-Scale Disclosures[17]	0

[14] 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 Huntington VA Medical Center is a mid-high complexity (1c) affiliated facility as described in Appendix B.)
[15] 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.
[16] 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.
[17] 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.

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.[18] 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.

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

Measure	Reported Rate per 1,000 Hospital Discharges		
	VHA	VISN 5	Facility
Pressure Ulcers	0.55	0.85	0.64
Death among surgical inpatients with serious treatable conditions	103.31	130.95	71.43
Iatrogenic Pneumothorax	0.20	0.11	0
Central Venous Catheter-Related Bloodstream Infection	0.12	0	0
In Hospital Fall with Hip Fracture	0.08	0.07	0
Perioperative Hemorrhage or Hematoma	2.59	2.49	3.55
Postoperative Acute Kidney Injury Requiring Dialysis	1.20	1.21	2.61
Postoperative Respiratory Failure	6.31	3.40	3.27
Perioperative Pulmonary Embolism or Deep Vein Thrombosis	3.29	5.38	1.74
Postoperative Sepsis	4.45	2.50	0
Postoperative Wound Dehiscence	0.65	0	0
Unrecognized Abdominopelvic Accidental Puncture/Laceration	0.67	0	0

Source: VHA Support Service Center.

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

The Patient Safety Indicator measures for pressure ulcers, perioperative hemorrhage or hematoma, and postoperative acute kidney injury requiring dialysis show an observed rate in excess of the observed rates for Veterans Integrated Service Network (VISN) 5 and/or VHA. Facility managers reported that the increase in pressure ulcer rates was related to one patient and that the patient's care had been reviewed and was appropriate, resulting in complete healing of the patient's pressure ulcers. Two patients experienced perioperative hemorrhage or hematoma, and an additional patient had postoperative acute kidney injury requiring dialysis. The facility reviewed all three surgical cases, and care was deemed appropriate.

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.[19] This model includes measures on health care quality, employee satisfaction, access to care, and efficiency, but the model has noted limitations for identifying all areas of clinical risk. The data are presented as one "way to

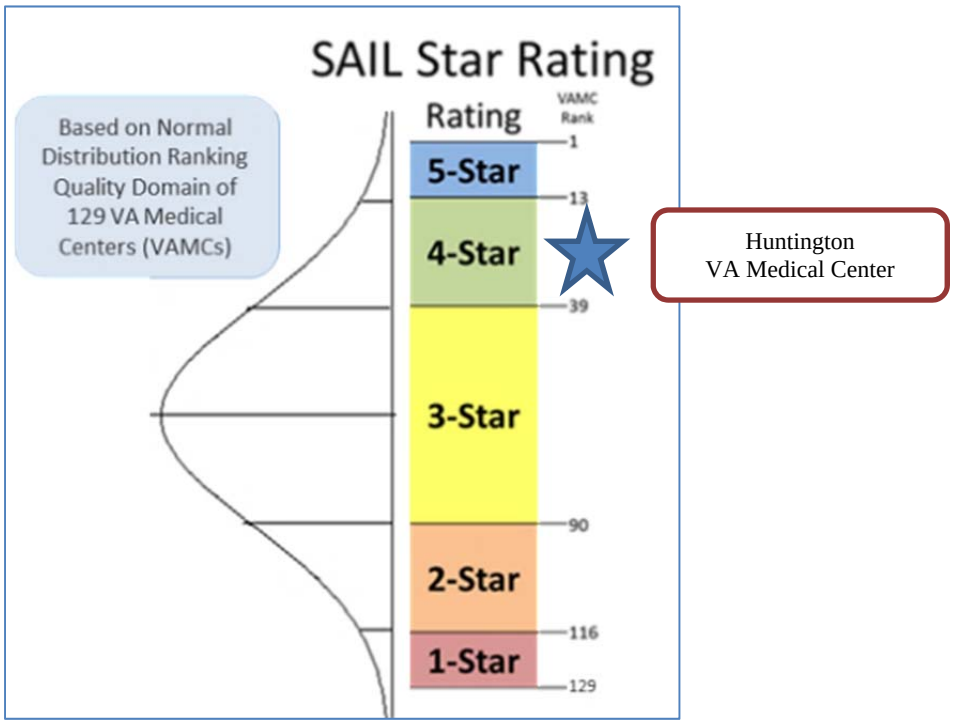
[18] Agency for Healthcare Research and Quality website, https://www.qualityindicators.ahrq.gov/, accessed March 8, 2017.

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

understand the similarities and differences between the top and bottom performers" within VHA.[20]

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 Huntington VA Medical Center received an interim rating of 4 stars for overall quality. This means the facility is in the 2nd quintile (10–30 percent range). Updated data as of June 30, 2017, indicates that the facility has remained at 4 stars for overall quality.

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

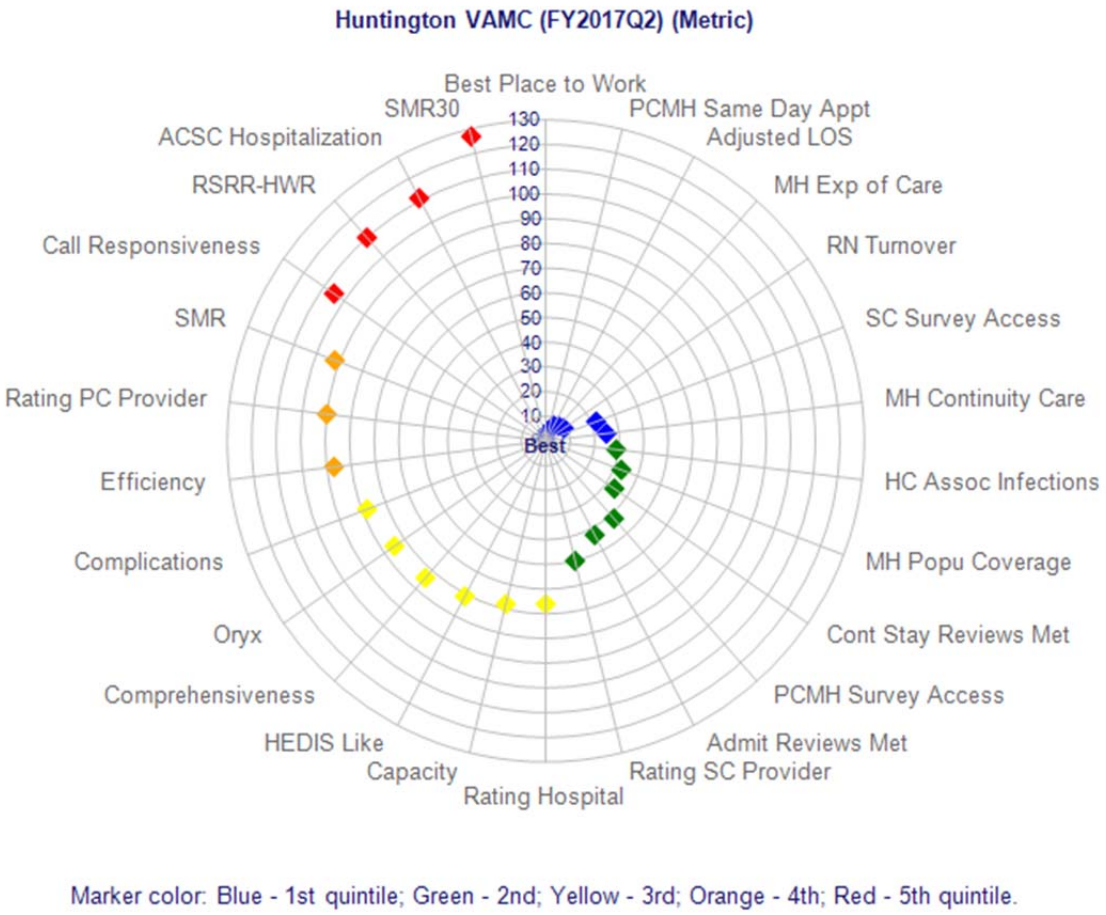


Source: VA Office of Informatics and Analytics' Office of Operational Analytics and Reporting.

[20] VHA Support Service Center (VSSC). The Strategic Analytics for Improvement and Learning (SAIL) Value Model Documentation Manual. Accessed on April 16, 2017: http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=2146

Figure 5 illustrates the facility's Quality of Care and Efficiency metric rankings and performance compared to other VA facilities as of March 31, 2017. 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), Mental Health (MH) Continuity [of] Care, and Registered Nurse (RN) Turnover). Metrics in the bottom quintiles reflect areas that need improvement and are denoted in orange and red (for example, Rating of PC Provider, Call Responsiveness, and Acute Care 30-day Standardized Mortality Ratio [SMR30]).

Figure 5. Facility Quality of Care and Efficiency Metric Rankings (as of March 31, 2017)



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 current leaders have active engagement with employees and patients and are maintaining high satisfaction scores. Organizational leaders support 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). 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.[21] The senior leadership team was knowledgeable of SAIL metrics but should continue to take actions to improve care and performance of selected SAIL metrics, particularly Quality of Care and Efficiency metrics likely contributing to the current 4-star rating.

[21] 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.[22] 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[23] of clinical care
3. Credentialing and privileging
4. Utilization management (UM) reviews[24]
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

[22] Department of Veterans Affairs, Veterans Health Administration. *Blueprint for Excellence*. September 2014.
[23] 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.
[24] According to VHA Directive 1117 (July 9, 2014), UM reviews evaluate the appropriateness, medical need, and efficiency of health care services according to evidence-based criteria.

- Credentialing and privileging processes
  - Considered frequency for Ongoing Professional Practice Evaluation[25] data review
  - Indicated a Focused Professional Practice Evaluation[26]
- 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. OIG found general compliance with requirements for protected peer reviews, credentialing and privileging, UM, and patient safety. However, OIG identified a deficiency with the senior-level committee responsible for key QSV functions that warranted a recommendation for improvement.

Quality, Safety, and Value Council. VHA requires the facility's senior-level committee responsible for key QSV functions to review and analyze data, identify opportunities for improvement, implement corrective actions, and monitor the actions implemented for effectiveness. This committee must also document meeting minutes produced in the process of conducting systematic health care reviews for the purpose of improving the quality of health care or the utilization of health care resources in VHA facilities. This ensures that key QSV functions are discussed and integrated on a regular basis under an organizational structure that promotes the exchange and flow of quality information. OIG requested minutes for the QSV Council for the timeframe March 2016 to March 2017. The facility did not have minutes for this timeframe; therefore, OIG was not able to evaluate whether the QSV Council performed the required functions. The staff member responsible for drafting the minutes left employment in November 2015, and no arrangements were made for documentation of QSV Council activities. On July 23, 2017, the facility filled the position responsible for drafting QSV Council minutes.

[25] Ongoing Professional Practice Evaluation is the ongoing monitoring of privileged practitioners to identify professional practice trends that impact the quality of care and patient safety.
[26] 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.

Recommendation

1. The Facility Director requires the Quality, Safety, and Value Council to document meeting minutes that include evidence of the review and analysis of aggregated data, identification of opportunities for improvement, implementation of corrective actions, and evaluation of effectiveness of the actions and monitors the Quality, Safety, and Value Council's compliance.

Facility Concurred.

Target date for completion: Closed

Facility response: The Quality, Safety, Value Council meets monthly. Meetings minutes were provided for May 3rd, June 7th, July 5th, August 2nd, September 6th, October 4th, November 1st, and December 6, 2017. Each set of minutes reflects meeting attendance, tracking of action items from one meeting to the next, service level performance improvement projects, Quality Management reports (including Risk Management, Peer Review, Infection Prevention and Control, VA Surgical Quality Improvement Program, SAIL, IPEC, and other performance measures), Patient Safety, Controlled Substance Program, and Committee reports. The minutes reflect active discussion and communication between senior leadership and the services/programs of the organization, in addition to review and analysis of aggregated data, identification of opportunities for improvement, implementation of corrective actions, and evaluation of effectiveness of the actions.

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,[27] or a blood thinner, which is a drug that works to prevent the coagulation or clotting of blood. TJC's National Patient Safety Goal (3.05.01) focuses on improving anticoagulation safety to reduce patient harm and states, "…anticoagulation medications are more likely than others to cause harm due to complex dosing, insufficient monitoring, and inconsistent patient compliance."

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

OIG reviewed relevant documents and the competency assessment records of 11 employees actively involved in the anticoagulant program and interviewed key employees. Additionally, OIG reviewed the electronic health records (EHRs) of 29 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

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

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

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 45 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 developed and implemented a patient transfer policy and collected and reported data about transfers out. Generally, OIG found compliance with acceptable designees' documentation and provider documentation for emergent transfers. However, OIG identified the following deficiencies in transfer

documentation and communication with the accepting facility that warranted recommendations for improvement.

Transfer Documentation. When patients are transferred out of the facility, TJC requires sending nurses to document transfer assessments/notes for the receiving nurses. This communication of relevant information ensures continuity of care for patients transferred to other facilities. Five of the 45 patients' EHRs (11 percent) did not contain sending nurses' transfer assessments/notes. The reason given for noncompliance was a lack of attention to detail when completing documentation for patients transferred during weekends and holidays.

Recommendation

2. The Associate Director for Patient Care Services ensures that for patients transferred out of the facility, sending nurses document transfer assessments/notes and monitors the nurses' compliance.

Facility Concurred.

Target date for completion: March 31, 2018

Facility Response: The Discharge-Patient/Family Education progress note template was revised. If the nurse selects that the patient is being discharged to a nursing home, another VA facility, or a non-VA facility, the "Nursing report called to" is triggered as a mandatory field that must be completed. Once the mandatory field is triggered, the nurse then documents who the report was called to. Monitoring was initiated in October 2017. Full compliance will be considered 90 percent, or greater, compliance for six 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 communicate or send pertinent patient information for 10 of the 33 applicable patients (30 percent) transferred from the Emergency Department. The reasons for noncompliance were that residents completing transfer documentation lacked knowledge of required elements or attention to detail and that providers either did not use an available template that contained all the required elements or did not complete the template in its entirety.

Recommendation

3. The Chief of Staff ensures that for patients transferred out of the facility, providers communicate with or send to the accepting facility pertinent patient information and monitors providers' compliance.

Facility Concurred.

Target date for completion: June 30, 2018

Facility Response: Providers are aware of the need to communicate with and/or the need to send to the accepting facility pertinent patient information. Monitoring of providers' compliance will be conducted monthly and feedback will be provided to the service chiefs for non-compliance. Additional instruction will be provided to non-compliant providers on a case by case basis. Full compliance will be considered 90 percent, or greater, compliance for six (6) 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.[d]

Fluoroscopic imaging equipment produces x-rays for the diagnosis, localization, and guidance of interventional procedures.[28] 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.[29] The inpatient locked MH unit must provide a healing, recovery-oriented environment as well as be a safe place for patients and employees. VHA developed the MH EOC Checklist to reduce environmental factors that contribute to inpatient suicides, suicide attempts, and other self-injurious behaviors and factors that reduce employee safety on MH units.

In all, OIG inspected the medical intensive care unit (4B), Emergency Department, medical unit (5B), surgical/telemetry unit (4B), and Radiology Service. OIG also inspected the Gallipolis CBOC. Additionally, OIG reviewed relevant documents and interviewed key employees and managers. The list below shows the location-specific performance indicators selected to examine the risk areas specific to particular settings.

<u>Parent Facility</u>

- EOC deficiency tracking
- EOC rounds
- General safety
- Infection prevention
- Environmental cleanliness
- Exam room privacy
- Availability of feminine hygiene products
- Availability of medical equipment and supplies

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

Community Based Outpatient Clinic

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

Radiology

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

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

Locked Mental Health Unit

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

Conclusions. The parent facility generally met deficiency tracking, general safety, infection prevention, and privacy requirements. The representative CBOC generally met requirements for cleanliness, medication safety and security, and privacy. OIG did not identify any deficiencies in the performance indicators evaluated for Radiology Service. Additionally, OIG did not note any issues with the availability of medical equipment and supplies. However, several patient care areas[30] had dusty ventilation grills, and the Gallipolis CBOC's women's public restroom lacked feminine hygiene products and disposal bins. OIG identified the following deficiencies that warranted recommendations for improvement.

[30] The Emergency Department and medical intensive care (4B), medical (5B), and surgical/telemetry (4B) units.

Parent Facility: Environment of Care Rounds Attendance. VHA requires facilities to perform comprehensive EOC rounds with a designated team that includes specific membership to ensure a safe, clean, and high-quality care environment.[31] Additionally, VHA requires 90 percent participation by designated team members on EOC rounds. Participation from October 1, 2016 to July 5, 2017 ranged from 45 percent to 77 percent for 3 of 13 EOC rounds team members. Facility managers attributed low attendance to poor coordination with alternate attendees covering vacancies for the infection control nurse, facility Information Security Officer, and facility Privacy Officer.

Recommendation

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

Facility Response: Facility Concurred.

Target date for completion: March 31, 2018

Facility Response: All employees responsible for participation in the Environment of Care (EOC) rounds have been instructed regarding the importance of attendance and participation. Participation is recorded in the VISN 5 Performance Logic database. Attendance has been 100 percent for all required participants for a 3-month time frame (September through November 2017). Full compliance will be considered 95-100 percent compliance with attendance for six (6) consecutive months

Community Based Outpatient Clinic: General Safety. VHA requires that access to sterile supply rooms is restricted to prevent access to sterile and/or contaminated materials. At the Gallipolis CBOC, sterile supplies were not stored in a secured location. The supply room used for storage of sterile supplies could not be locked and was accessible to patients. CBOC staff were unaware of this requirement.

Recommendation

5. The Associate Director ensures access to sterile supplies at the Gallipolis community based outpatient clinic is restricted and monitors compliance.

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

Facility Concurred.

Target date for completion. April 30, 2018

Facility Response: A punch key lock will be installed on the door to the supply storage room at the Gallipolis outpatient clinic. Following installation of the punch key lock, a Registered Nurse (RN) working at the Gallipolis clinic will check the door a minimum of once weekly to ensure that the door is closed/secured and will report compliance to the Primary Care Nurse Manager weekly. Compliance will be determined as 1) installation of the punch key lock, and 2) reports of satisfactory weekly compliance for two months.

Community Based Outpatient Clinic: Infection Prevention. TJC requires that hospitals minimize risk of infection when storing and disposing of infectious waste. Securing this waste helps prevent the spread of potentially infectious pathogens. At the Gallipolis CBOC, medical (biohazardous) waste stored for pick-up was not in a secured location. CBOC staff were unaware of this requirement.

Recommendation

6. The Associate Director ensures medical (biohazardous) waste stored for pick-up at the Gallipolis community based outpatient clinic is secured and monitors compliance.

Facility Concurred.

Target date for completion. April 30, 2018

Facility Response: A punch key lock will be installed on the door to the medical (biohazardous) waste storage room at the Gallipolis outpatient clinic. Following installation of the punch key lock, a Registered Nurse (RN) working at the Gallipolis clinic will check the door a minimum of once weekly to ensure that the door is closed/secured and will report compliance to the Primary Care Nurse Manager weekly. Compliance will be determined as 1) installation of the punch key lock, and 2) reports of satisfactory weekly compliance for two months.

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.[32] 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.[33]

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.[34] During calendar year 2016, VHA clinicians performed more than 600,000 moderate sedation procedures, of which more than half were gastroenterology-related endoscopies.[35] 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, and intensive care unit procedure areas to assess whether required equipment and sedation medications were available. Additionally, OIG reviewed the EHRs of 44 randomly selected patients who underwent an invasive procedure involving moderate sedation from July 1, 2015 through June 30, 2016, and the training records of 17 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

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

- Performance of timeout[36] 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

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

[36] 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.

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, Associate Director for Patient Care Services, or the equivalent) and includes multidisciplinary management-level representatives from social work, nursing, quality management, acquisition, and the medical staff. The CNH Oversight Committee must meet at least quarterly.[37] 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 36 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
- Completion of CNH annual reviews by CNH Review Team
- Documentation of social worker and registered nurse cyclical clinical visits

The performance indicators below did not apply to this facility as the facility did not have patients placed in CNHs outside the catchment area or CNH annual reviews with four or more exclusionary criteria.

- Documentation of hand-off for patients placed in CNHs outside catchment area
- Completion of exclusion review documentation when CNH annual reviews noted four or more exclusionary criteria

Conclusions. Generally, OIG noted compliance with requirements for CNH program integration, documentation, and annual reviews. OIG identified the following deficiency that warranted a recommendation for improvement.

Oversight Committee. VHA requires the CNH Oversight Committee to include multidisciplinary management-level representation from social work, nursing, quality management, acquisitions, and the medical staff. Committee oversight functions include verifying completeness of the CNH Review Teams initial, annual, and problem focused CNH evaluations. This multidisciplinary review and perspective helps to ensure that VHA contracted nursing homes provide quality care in a safe environment. The facility's CNH Oversight Committee did not include a representative from acquisitions.

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

A member of Social Work Service who performed collateral duty as a Contracting Officer's Representative attended committee meetings, and multiple members of the committee believed this met the requirements of the directive.

Recommendation

7. The Chief of Staff ensures the Community Nursing Home Oversight Committee includes a representative from acquisitions.

Facility Concurred.

Target date for completion: April 30, 2018

Facility Response: A staff member from Acquisitions service will be appointed to the Community Nursing Home (CNH) Oversight Committee. The charter of the Community Nursing Home (CNH) Oversight Committee will be revised to include a staff member from Acquisitions service. The revised charter will be sent to the Medical Staff Council for approval and will have signature approval from the Chief of Staff and Medical Center Director. The minutes from the Community Nursing Home (CNH) Oversight Committee during the 2nd quarter of FY2018 will reflect attendance of the newly appointed member from Acquisitions service.

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	Seven 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, Associate Director for Patient Care Services, and Associate Director. See details below.	
Healthcare Processes	**Performance Indicators**	**Critical Recommendations[38] for Improvement**	**Recommendations for Improvement**
Quality, Safety, and Value	• Senior-level involvement in QSV/performance improvement committee • Protected peer review of clinical care • Credentialing and privileging • UM reviews • Patient safety incident reporting and root cause analyses	None	• The QSV Council documents meeting minutes that include evidence of the review and analysis of aggregated data, identification of opportunities for improvement, implementation of corrective actions, and evaluation of effectiveness of the actions.
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	None

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

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Coordination of Care	• Transfer policies and procedures • Oversight of transfer process • EHR documentation o Non-emergent transfers o Emergent transfers	For patients transferred out of the facility: • Sending nurses document transfer assessments/notes. • Providers communicate with or send to the accepting facility pertinent patient information.	None
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	None	• Required team members consistently participate on EOC rounds. • Access to sterile supplies at the Gallipolis CBOC is restricted. • Medical (biohazardous) waste stored for pick-up at the Gallipolis CBOC is secured.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Environment of Care (continued)	• 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	NA	NA
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	None	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	None	• The CNH Oversight Committee includes a representative from acquisitions.

NA = Not applicable

Facility Profile

The table below provides general background information for this mid-high complexity (1c)[39] affiliated[40] facility reporting to VISN 5.

Table 5. Facility Profile for Huntington (581) for October 1, 2013 through September 30, 2016

Profile Element	Facility Data FY 2014[41]	Facility Data FY 2015[42]	Facility Data FY 2016[43]
Total Medical Care Budget in Millions	$221.1	$246.0	$253.2
Number of:			
• **Unique Patients**	28,737	27,900	28,539
• **Outpatient Visits**	362,766	380,736	399,771
• **Unique Employees**[44]	986	1,058	1,074
Type and Number of Operating Beds:			
• **Acute**	80	80	80
• **Mental Health**	NA	NA	NA
• **Community Living Center**	NA	NA	NA
• **Domiciliary**	NA	NA	NA
Average Daily Census:			
• **Acute**	39	39	33
• **Mental Health**	NA	NA	NA
• **Community Living Center**	NA	NA	NA
• **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

[39] VHA medical centers are classified according to a facilities complexity model; 1c designation indicates a facility with medium-high volume, medium-risk patients, some complex clinical programs, and medium sized research and teaching programs. Retrieved September 10, 2017, from http://opes.vssc.med.va.gov/FacilityComplexityLevels/Pages/default.aspx
[40] Associated with a medical residency program.
[41] October 1, 2013 through September 30, 2014.
[42] October 1, 2014 through September 30, 2015.
[43] October 1, 2015 through September 30, 2016.
[44] Unique employees involved in direct medical care (cost center 8200).

VA Outpatient Clinic Profiles[45]

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

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

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services[47] Provided	Diagnostic Services[48] Provided	Ancillary Services[49] Provided
Prestonsburg, KY	581GA	11,820	4,145	Cardiology Endocrinology Infectious Disease Nephrology Neurology Eye Podiatry	NA	Nutrition Pharmacy Social Work Weight Management
South Charleston, WV	581GB	16,794	5,077	Cardiology Endocrinology Infectious Disease Nephrology Neurology Eye	NA	Nutrition Pharmacy Social Work Weight Management

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

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

NA = Not applicable

[45] Includes all outpatient clinics in the community that were in operation as of February 15, 2017. We have omitted Gallipolis, OH (581GG); Williamson, WV (581GH); and Huntington, WV (581QA), as no workload/encounters or services were reported.
[46] An encounter is a professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition.
[47] Specialty care services refer to non-PC and non-MH services provided by a physician.
[48] Diagnostic services include EKG, EMG, laboratory, nuclear medicine, radiology, and vascular lab services.
[49] Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

VHA Policies Beyond Recertification Dates

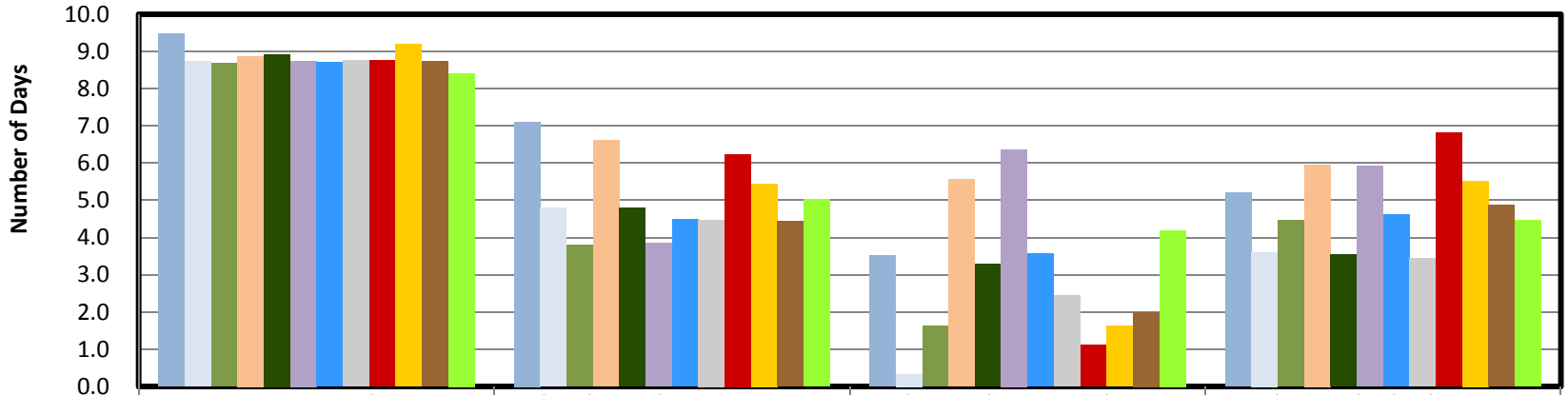
In this report, OIG cited three policies that were beyond the recertification date:

1. VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010 (recertification due date June 30, 2015).
2. VHA Handbook 1105.04, *Fluoroscopy Safety*, July 6, 2012 (recertification due date July 31, 2017).
3. 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),[50] 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."[51] 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."[52]

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

Patient Aligned Care Team Compass Metrics

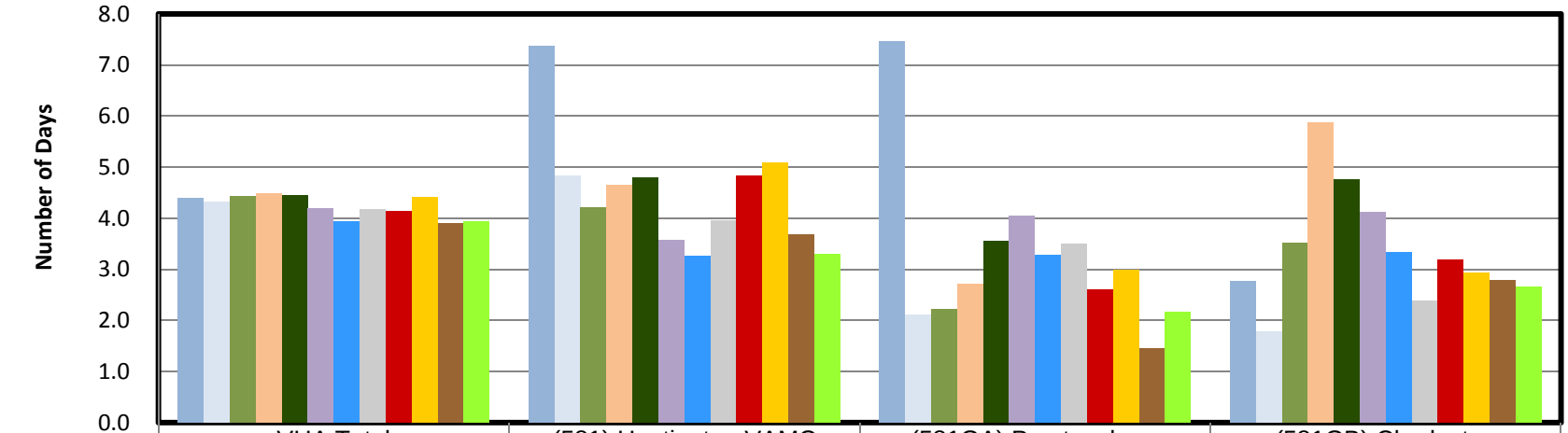


	VHA Total	(581) Huntington VAMC	(581GA) Prestonsburg	(581GB) Charleston
APR-FY16	9.5	7.1	3.5	5.2
MAY-FY16	8.7	4.8	0.3	3.6
JUN-FY16	8.7	3.8	1.6	4.5
JUL-FY16	8.9	6.6	5.6	6.0
AUG-FY16	8.9	4.8	3.3	3.5
SEP-FY16	8.7	3.9	6.4	5.9
OCT-FY17	8.7	4.5	3.6	4.6
NOV-FY17	8.8	4.5	2.4	3.4
DEC-FY17	8.8	6.2	1.1	6.8
JAN-FY17	9.2	5.4	1.6	5.5
FEB-FY17	8.7	4.4	2.0	4.9
MAR-FY17	8.4	5.0	4.2	4.5

Source: VHA Support Service Center.

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

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

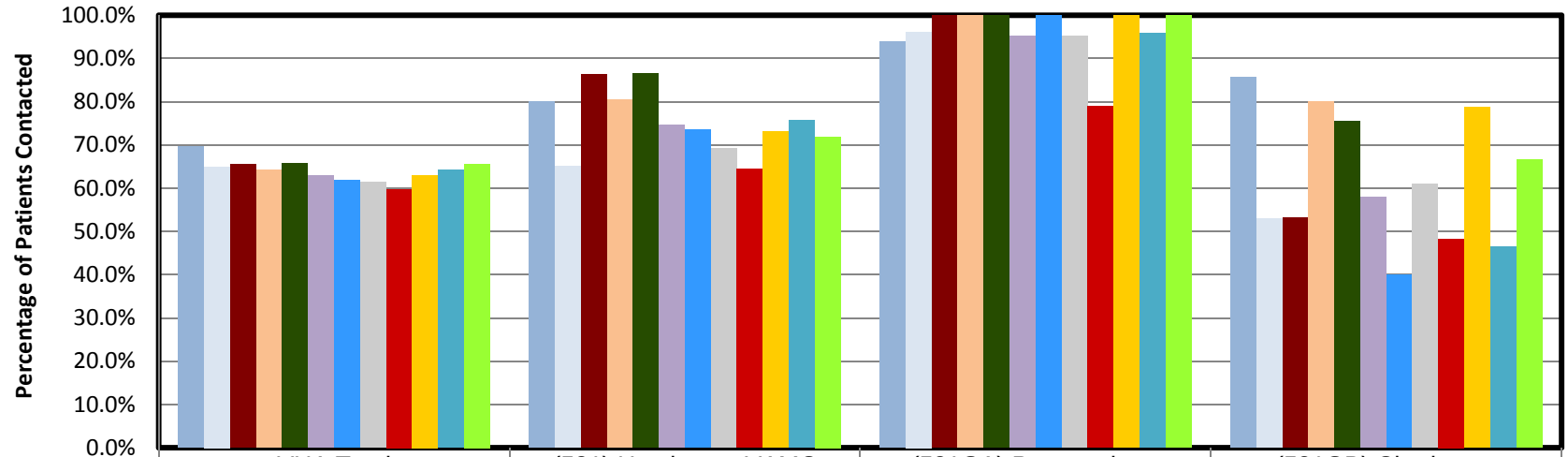


	VHA Total	(581) Huntington VAMC	(581GA) Prestonsburg	(581GB) Charleston
APR-FY16	4.4	7.4	7.5	2.8
MAY-FY16	4.3	4.8	2.1	1.8
JUN-FY16	4.4	4.2	2.2	3.5
JUL-FY16	4.5	4.7	2.7	5.9
AUG-FY16	4.5	4.8	3.5	4.8
SEP-FY16	4.2	3.6	4.1	4.1
OCT-FY17	3.9	3.3	3.3	3.3
NOV-FY17	4.2	3.9	3.5	2.4
DEC-FY17	4.1	4.8	2.6	3.2
JAN-FY17	4.4	5.1	3.0	2.9
FEB-FY17	3.9	3.7	1.5	2.8
MAR-FY17	3.9	3.3	2.2	2.7

Source: VHA Support Service Center.

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

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

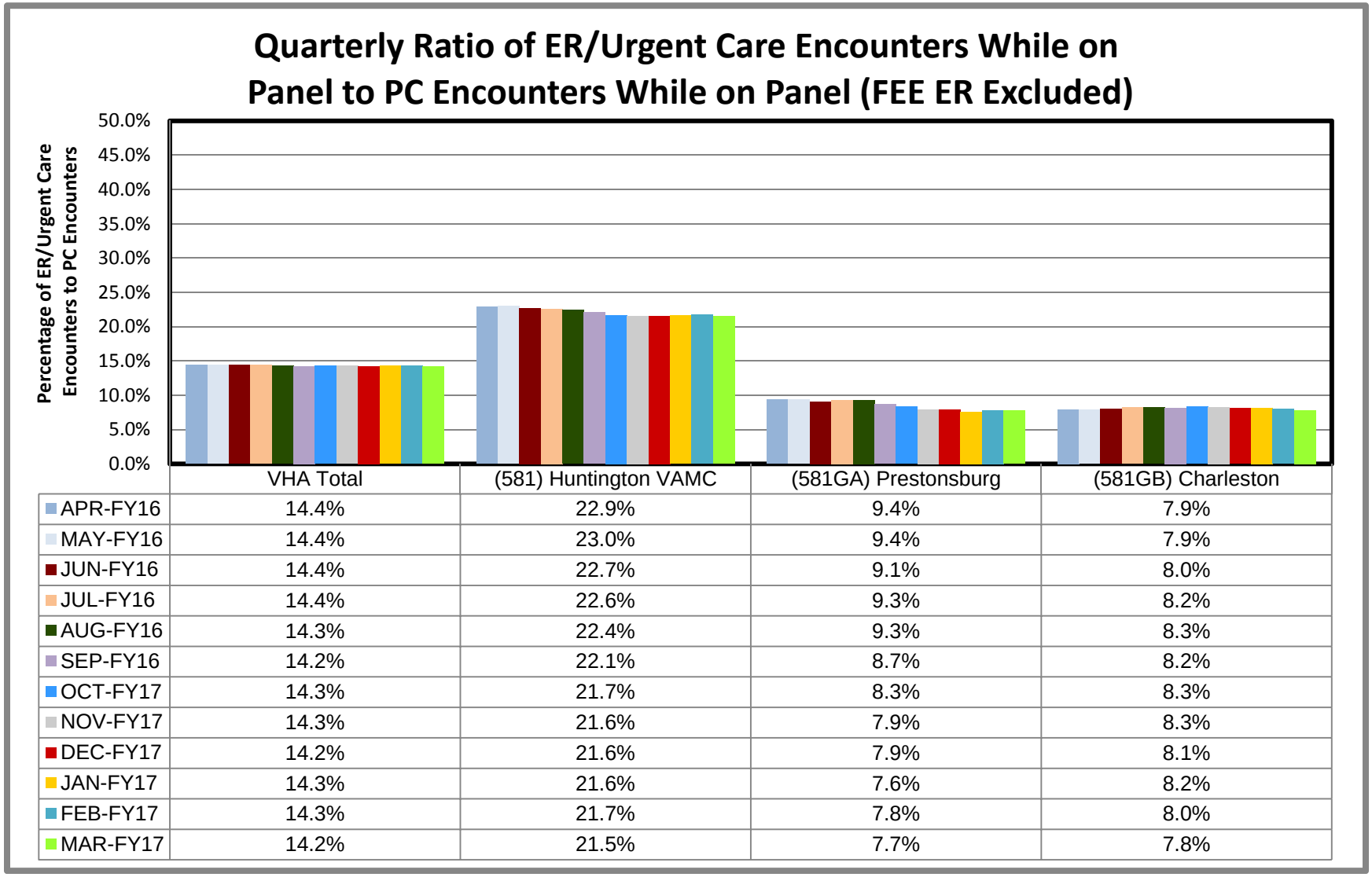


	VHA Total	(581) Huntington VAMC	(581GA) Prestonsburg	(581GB) Charleston
APR-FY16	69.7%	80.1%	93.9%	85.7%
MAY-FY16	65.0%	65.1%	96.2%	52.9%
JUN-FY16	65.5%	86.3%	100.0%	53.1%
JUL-FY16	64.3%	80.5%	100.0%	80.0%
AUG-FY16	65.7%	86.5%	100.0%	75.6%
SEP-FY16	62.9%	74.7%	95.2%	58.0%
OCT-FY17	61.8%	73.5%	100.0%	40.0%
NOV-FY17	61.4%	69.1%	95.2%	61.0%
DEC-FY17	59.8%	64.4%	78.9%	48.3%
JAN-FY17	63.0%	73.1%	100.0%	78.8%
FEB-FY17	64.2%	75.7%	95.8%	46.4%
MAR-FY17	65.6%	71.9%	100.0%	66.7%

Source: VHA Support Service Center.

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

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



	VHA Total	(581) Huntington VAMC	(581GA) Prestonsburg	(581GB) Charleston
APR-FY16	14.4%	22.9%	9.4%	7.9%
MAY-FY16	14.4%	23.0%	9.4%	7.9%
JUN-FY16	14.4%	22.7%	9.1%	8.0%
JUL-FY16	14.4%	22.6%	9.3%	8.2%
AUG-FY16	14.3%	22.4%	9.3%	8.3%
SEP-FY16	14.2%	22.1%	8.7%	8.2%
OCT-FY17	14.3%	21.7%	8.3%	8.3%
NOV-FY17	14.3%	21.6%	7.9%	8.3%
DEC-FY17	14.2%	21.6%	7.9%	8.1%
JAN-FY17	14.3%	21.6%	7.6%	8.2%
FEB-FY17	14.3%	21.7%	7.8%	8.0%
MAR-FY17	14.2%	21.5%	7.7%	7.8%

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

April 2, 2014 through January 1, 2018[53]

Review of VHA Care and Privacy Standards for Women Veterans
6/19/2017 | 15-03303-206 | Summary | Report

Healthcare Inspection – Peer Review for Quality Management Concerns, Huntington VA Medical Center, Huntington, West Virginia
4/11/2017 | 15-00223-196 | Summary | Report

Healthcare Inspection – Alleged Improper Maintenance of Reprocessing Equipment, Huntington VA Medical Center, Huntington, West Virginia
6/25/2015 | 14-02634-397 | 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 Huntington VA Medical Center, Huntington, West Virginia
10/27/2014 | 14-02074-06 | Summary | Report

Community Based Outpatient Clinic and Primary Care Clinic Reviews at Huntington VA Medical Center, Huntington, West Virginia
6/10/2014 | 14-00905-182 | Summary | Report

[53] 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: January 5, 2018

From: Director, VA Capitol Health Care Network (10N5)

Subject: **CHIP Review of the Huntington VA Medical Center, Huntington, WV**

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

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

1. I would like to express my appreciation to the Office of Inspector General (OIG) Healthcare Inspection Team for their professional and comprehensive review of the Huntingtin VA Medical Center, Huntington, WV. I have reviewed the draft report and concur with the findings and recommendations.

2. I have reviewed and concur with the submitted responses and action plans from the Huntington VA Medical Center.

3. Please express my thanks to the Team for their professionalism and assistance to us in our continuing efforts to improve the care we provide to our Veterans.

MD CMO

FOR AND IN THE ABSENCE

Joseph A. Williams, Jr.
Director, VA Capitol Health Care Network, VISN 5

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: January 4, 2018

From: Director, Huntington VA Medical Center (581/00)

Subject: **CHIP Review of the Huntington VA Medical Center, Huntington, WV**

To: Director, VA Capitol Health Care Network (10N5)

1. I wish to extend my thanks to the Office of Inspector General (OIG) Healthcare Inspection Team for the professional review of the organization that was completed. I have reviewed the draft report and concur with the findings and recommendations.

2. Attached are the facility responses to the seven (7) recommendations, including actions that are in progress to correct the identified opportunities for improvement.

J. Brian Nimmo, MS, FACHE
Medical Center Director

OIG Contact and Staff Acknowledgments

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U.S. Senate: Sherrod Brown, Shelley Moore Capito, Joe Manchin III, Mitch McConnell, Rand Paul, Rob Portman
U.S. House of Representatives: Evan Jenkins, Bill Johnson, Thomas Massie, David B. McKinley, Alex Mooney, Harold Rogers, Steve Stivers, Brad Wenstrup

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 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.
- 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 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: April 28, 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.