



**Department of Veterans Affairs
Office of Inspector General**

Office of Healthcare Inspections

Report No. 17-01748-82

**Comprehensive Healthcare
Inspection Program Review
of the
Robert J. Dole VA Medical Center
Wichita, Kansas**

February 6, 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	Robert J. Dole VA Medical Center
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 Robert J. Dole 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 July 31, 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 Robert J. Dole VA Medical Center, the leadership team consists of the Facility Director, Chief of Staff, Associate Director for Patient Care Services (Nurse Executive), Associate Director, and Assistant Director. Organizational communication and accountability are carried out through a committee reporting structure with the Quality, Safety, and Value Board having oversight for leadership groups such as the Executive Compliance Council, Quality Performance Council, and Organizational Health Council. The leaders are members of the Quality, Safety, and Value Board through which they track, trend, and monitor quality of care and patient outcomes.

The executive leaders had been working together as a team since December 2016. In the review of selected employee and patient survey results regarding facility senior

leadership, OIG noted generally high patient satisfaction scores but noted opportunities to improve overall employee satisfaction.

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 was generally 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 3-star SAIL rating. In the review of key care processes, OIG issued 14 recommendations that are attributable to the Facility Director, Chief of Staff, Nurse Executive, and Associate Director. OIG noted findings in the six areas of clinical operations reviewed. These are briefly described below.

Quality, Safety, and Value. OIG noted compliance with requirements for protected peer review, credentialing and privileging processes, and patient safety reporting. However, OIG identified deficiencies with specifying the senior-level committee responsible for key quality, safety, and value functions and with Physician Utilization Management Advisors’ documentation of their decisions.²

Medication Management. OIG found safe anticoagulation therapy management practices. The facility had developed and implemented anticoagulation management policies and met many of the other performance indicators evaluated, such as designating a physician anticoagulation program champion, minimizing risk of dosing errors, and performing laboratory testing. However, OIG identified deficiencies with the facility’s quality assurance plan, collecting and reporting of anticoagulation data, and employee competencies.

Coordination of Care. OIG noted that the facility developed and implemented a patient transfer policy and met most of the performance indicators evaluated for transfer documentation. However, OIG identified deficiencies with collecting, reporting, and analyzing inter-facility patient transfer data and with supervision of residents.

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.

Environment of Care. OIG found that the parent facility tracked environmental deficiencies and met general safety, infection prevention, and privacy performance indicators. The Salina community based outpatient clinic met the measures reviewed for infection prevention, cleanliness, medication safety and security, and information technology network room security. Radiology Service generally met the performance indicators evaluated. However, OIG identified deficiencies with environment of care rounds attendance and cleanliness of rolling equipment at the parent facility, and panic alarm testing and inadequate exit signage at the Salina community based outpatient clinic.

High-Risk Processes Related to Moderate Sedation. OIG found compliance with reporting and trending the use of reversal agents in moderate sedation cases and having equipment and medications available in moderate sedation procedure areas. OIG also noted that the facility generally re-evaluated patients before moderate sedation procedures, documented informed consent, performed time-outs, discharged patients appropriately, and trained clinicians. However, OIG identified deficiencies with assessing patients' airways before procedures and patients' pain levels after procedures.

Long-Term Care: Community Nursing Home Oversight. OIG noted compliance with documenting hand-offs for patients placed in community nursing homes outside the facility's catchment area. However, OIG identified deficiencies with the Community Nursing Home Oversight Committee's meeting frequency, integration of the program into the facility's quality improvement program, annual reviews of community nursing homes, and the frequency of visits to patients residing in these homes.

Summary

In the review of key care processes, OIG issued 14 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. (See Appendixes G and H, pages 47–48, and the responses within the body of the report for the full text of the Directors' comments.) OIG considers recommendations 9, 10, 13, and 14 closed. OIG will follow up on the planned actions for the open recommendations until they are completed.



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Purpose and Scope

Purpose

This Comprehensive Healthcare Inspection Program (CHIP) review was conducted to provide a focused evaluation of the quality of care delivered in the Robert J. Dole 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 (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) requirements³ 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 May 5, 2014⁵ through July 31, 2017, the date when an unannounced week-long site visit commenced. OIG also presented crime awareness briefings to 96 of the facility's 1,050 employees on August 16, 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. 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

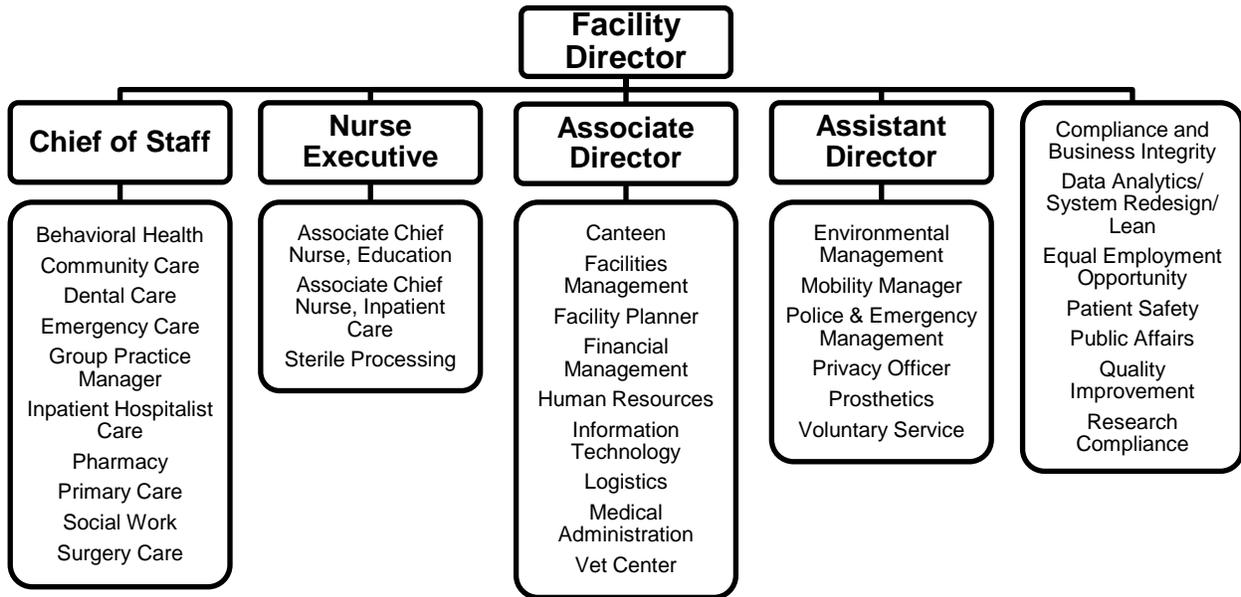
Stable and effective leadership is critical to improving care and sustaining meaningful change. Leadership and organizational risk issues can impact the facility's ability to provide care in all of the selected clinical areas of focus. The factors OIG considered in assessing the facility's risks and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

The Associate Director was temporarily assigned to Veterans Integrated Service Network (VISN) 15 in April 2017, and the Assistant Director served as the Acting Associate Director. The executive leaders in place at the time of the OIG site visit had been working together as a team since December 2016.

Figure 2. Facility Organizational Chart.



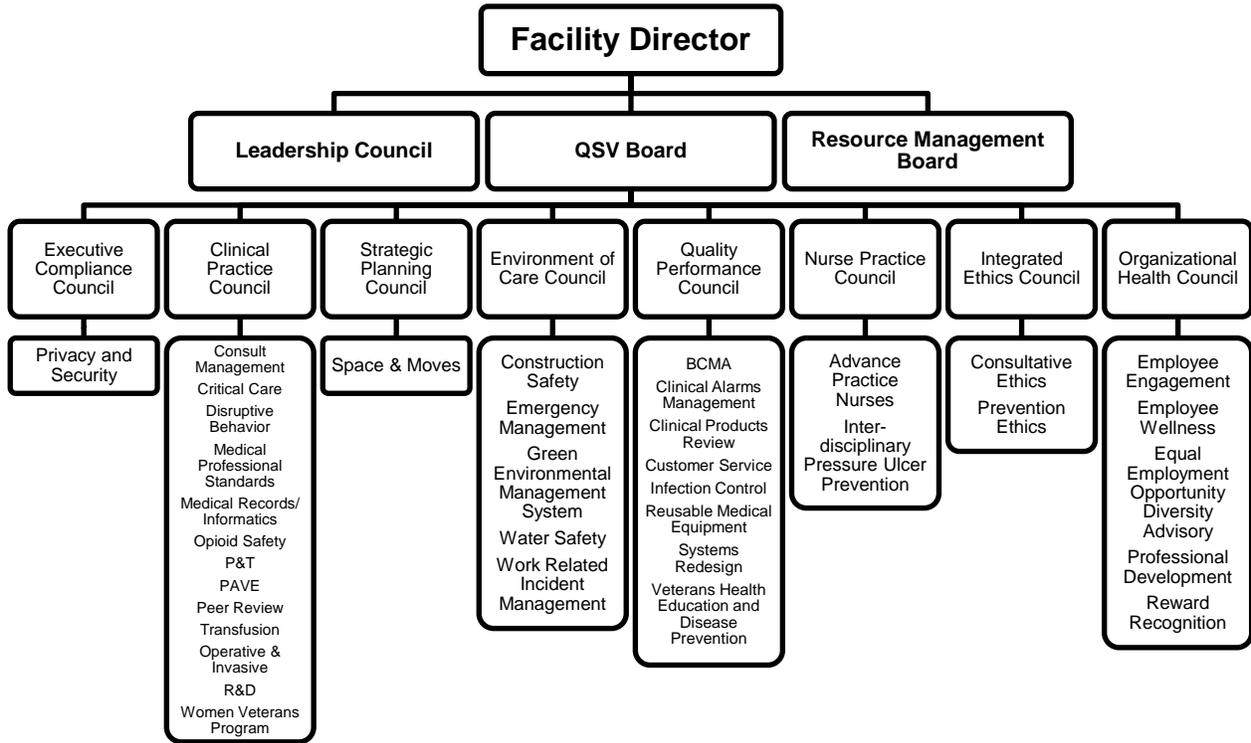
Source: Robert J. Dole VA Medical Center (received July 31, 2017).

To help assess engagement of facility executive leadership, OIG interviewed the Facility Director, Chief of Staff, Nurse Executive, and Acting Associate Director regarding their knowledge of various metrics and their involvement in 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 Quality, Safety, and Value (QSV) 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 QSV Board also oversees various working groups, such as the Executive Compliance Council, Quality Performance Council, and Organizational Health Council. See Figure 3.

Figure 3. Facility Committee Reporting Structure.



Source: Robert J. Dole VA Medical Center (received July 31, 2017).

BCMA = Bar Code Medication Administration

P&T = Pharmacy & Therapeutics

PAVE = Preservation of Amputation in Veterans Everywhere

R&D = Research and Development

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. For employee satisfaction, the facility rated below VHA’s average score; however, facility leaders’ results (Director’s office average) were above the VHA average.⁶ This is an indication that leadership needs to continue efforts to

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.

improve overall employee satisfaction. OIG also noted that all four patient experience survey results reflected similar or higher care ratings compared to the VHA averages.

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	2.9	4.1
All Employee Survey Servant Leader Index Composite	0–100 where HIGHER scores are more favorable	66.7	63.8	81.5
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	65.2	
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	85.9	
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): I felt like a valued customer.		73.2	77.5	
Survey of Healthcare Experiences of Patients (outpatient specialty care): I felt like a valued customer.		73.8	74.3	

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-Cause⁹ 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 closed¹⁰ 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 Facilities¹¹ and College of American Pathologists,¹² which demonstrates the facility leaders' commitment to quality care and services. Additionally, the Long Term Care Institute¹³ conducted an inspection of the facility's Community Living Center.

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.

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 (<i>Healthcare Inspection – Quality of Care and Other Concerns, Robert J. Dole VA Medical Center, Wichita, Kansas, July 19, 2017</i>)	July 2015	6	0
VA OIG (<i>Combined Assessment Program Review of the Robert J. Dole VA Medical Center, Wichita, Kansas, November 3, 2014</i>)	August 2014	25	0
VA OIG (<i>Community Based Outpatient Clinic and Primary Care Clinic Reviews at Robert J. Dole VA Medical Center, Wichita, Kansas, July 8, 2014</i>)	May 2014	17	0
TJC ¹⁴			
<ul style="list-style-type: none"> • Hospital Accreditation • Behavioral Health Care Accreditation • Home Care Accreditation 	October 2016	11 1 4	0 0 0

¹⁴ 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 May 2014 Combined Assessment Program and August 2014 Community Based Outpatient Clinic (CBOC) and Primary Care (PC) review inspections through the week of July 31, 2017.

**Table 3. Summary of Selected Organizational Risk Factors¹⁵
(May 2014 to July 31, 2017)**

Factor	Number of Occurrences
Sentinel Events ¹⁶	0
Institutional Disclosures ¹⁷	7
Large-Scale Disclosures ¹⁸	0

¹⁵ 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 Robert J. Dole VA Medical Center is a mid-high complexity (1c) affiliated facility as described in Appendix B.)

¹⁶ 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.

¹⁷ 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.

¹⁸ 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.¹⁹ 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 15	Facility
Pressure Ulcers	0.55	0.28	0.00
Death among surgical inpatients with serious treatable conditions	103.31	95.24	0.00
Iatrogenic Pneumothorax	0.20	0.05	0.00
Central Venous Catheter-Related Bloodstream Infection	0.12	0.08	0.00
In Hospital Fall with Hip Fracture	0.08	0.12	0.00
Perioperative Hemorrhage or Hematoma	2.59	1.11	2.16
Postoperative Acute Kidney Injury Requiring Dialysis	1.20	2.48	0.00
Postoperative Respiratory Failure	6.31	8.91	12.86
Perioperative Pulmonary Embolism or Deep Vein Thrombosis	3.29	1.03	0.00
Postoperative Sepsis	4.45	7.54	8.82
Postoperative Wound Dehiscence	0.65	0.00	0.00
Unrecognized Abdominopelvic Accidental Puncture/Laceration	0.67	0.44	0.00

Source: VHA Support Service Center.

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

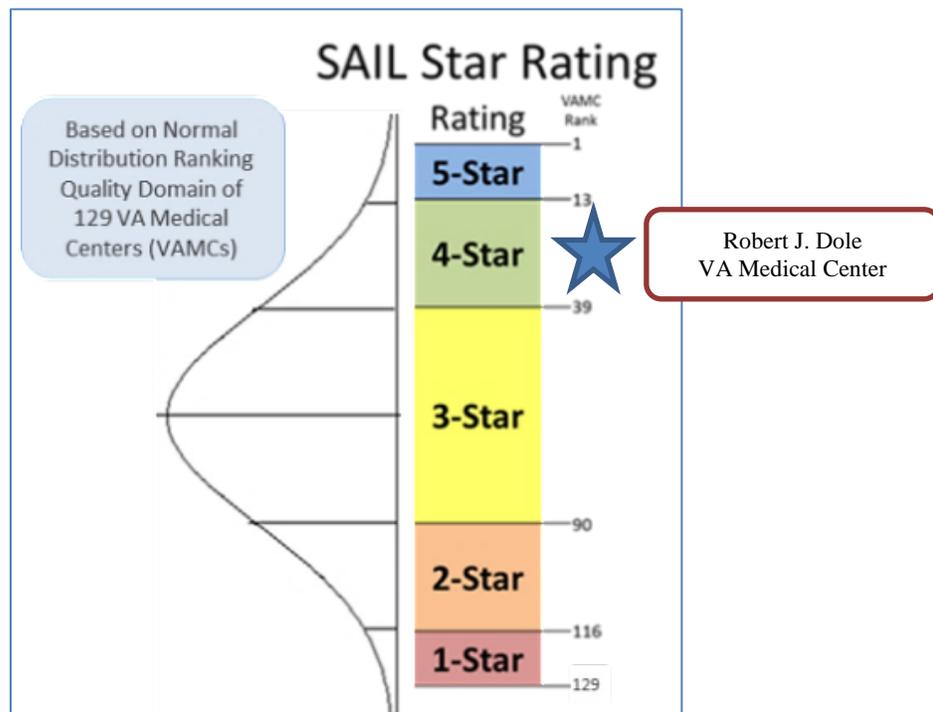
Two of the Patient Safety Indicator measures (postoperative respiratory failure and postoperative sepsis) show observed rates in excess of the observed rates for VISN 15 and VHA, and one measure (perioperative hemorrhage or hematoma) exceeds the observed rate for VISN 15. Facility managers reported that the perioperative hemorrhage or hematoma rate resulted from one veteran who developed a hematoma after a vascular surgery. Managers also stated that documentation and/or coding errors resulted in higher rates for postoperative respiratory failure and postoperative sepsis. For example, three of the four veterans who had postoperative respiratory failure had significant underlying chronic pulmonary disease that staff either did not document or incorrectly coded during admission, and two of the three veterans who had postoperative sepsis had underlying sepsis during admission, which staff inaccurately coded.

¹⁹ Agency for Healthcare Research and Quality website, <https://www.qualityindicators.ahrq.gov/>, accessed March 8, 2017.

Veterans Health Administration Performance Data. The VA Office of Operational Analytics and Reporting adapted the SAIL Value Model to help define performance expectations within VA.²⁰ This model includes measures on health care quality, employee satisfaction, access to care, and efficiency, but the model has noted limitations for identifying all areas of clinical risk. The data are presented as one “way to understand the similarities and differences between the top and bottom performers” within VHA.²¹

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 Robert J. Dole VA Medical Center received an interim rating of 4 stars for overall quality. This means the facility was in the 2nd quintile (13–39 percent range). Updated data as of June 30, 2017, indicates that the facility has declined to 3 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.

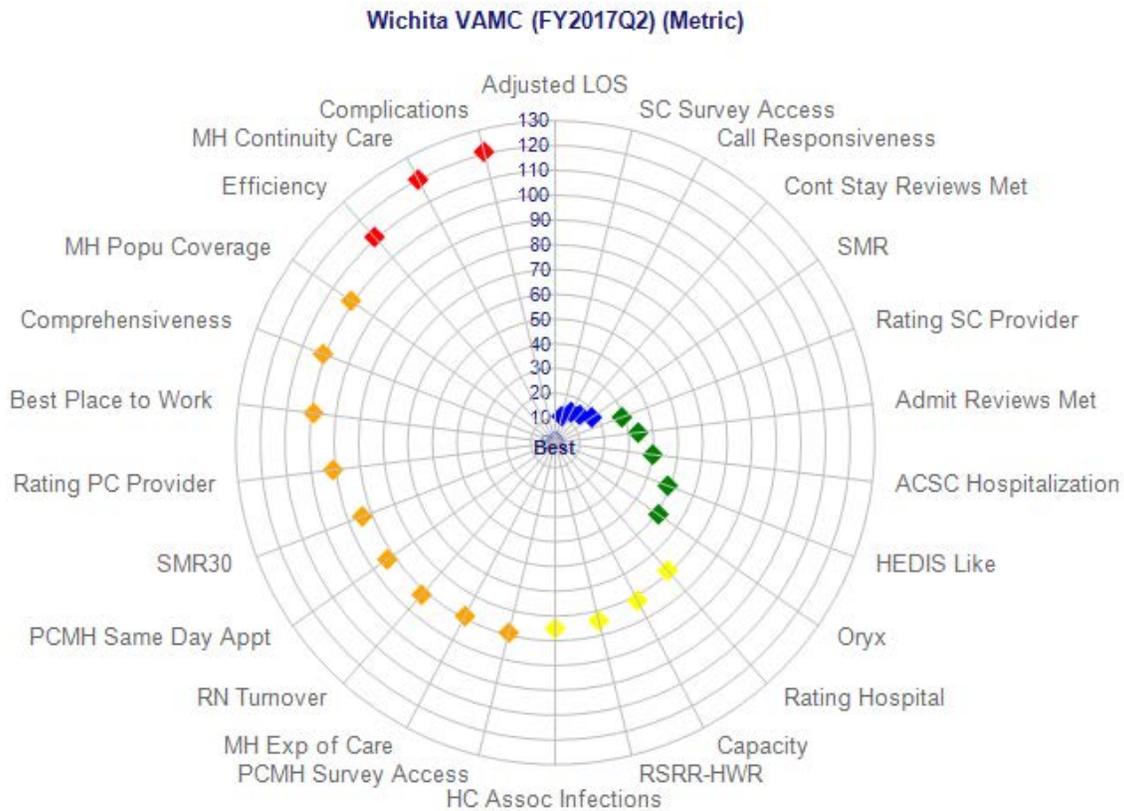
²⁰ The model is derived from the Thomson Reuters Top Health Systems Study.

²¹ 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, Call Responsiveness, Acute Care In-Hospital Standardized Mortality Ratio [SMR], and Ambulatory Care Sensitive Condition Hospitalizations [ACSC Hospitalization]). Metrics in the bottom quintiles reflect areas that need improvement and are denoted in orange and red (for example, Acute Care 30-Day Standardized Mortality Ratio [SMR30], MH Continuity of Care, and Complications).

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



Marker color: Blue - 1st quintile; Green - 2nd; Yellow - 3rd; Orange - 4th; Red - 5th quintile.

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 to support patient safety and quality care. 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.²² The senior leadership team was knowledgeable about selected SAIL metrics but should continue to take actions to improve care, overall employee satisfaction, and performance, particularly Quality of Care and Efficiency metrics likely contributing to the current 3-star ranking.

²² 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.²³ 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 review²⁴ of clinical care
3. Credentialing and privileging
4. Utilization management (UM) reviews²⁵
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 Evaluation²⁶ data review
 - Indicated a Focused Professional Practice Evaluation²⁷

²³ Department of Veterans Affairs, Veterans Health Administration. *Blueprint for Excellence*. September 2014.

²⁴ 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.

²⁵ 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.

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

- UM personnel
 - Completed at least 75 percent of all required inpatient reviews
 - Documented Physician UM Advisors' decisions in the National UM Integration database
 - Reviewed UM data using an interdisciplinary group
- Patient safety personnel
 - Entered all reported patient incidents into the WEBSPOOT 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. OIG found general compliance with requirements for protected peer review, credentialing and privileging processes, and patient safety reporting. However, OIG identified the following deficiencies regarding the senior-level committee responsible for QSV and UM that warranted recommendations for improvement.

Senior-Level Committee Responsible for Quality, Safety, and Value Functions. VHA requires facilities to establish a senior-level committee responsible for reviewing data and information and for ensuring regular discussion and integration of key QSV functions. This committee must be chaired or co-chaired by the Facility Director to ensure facility leaders' support in developing prioritized recommendations, chartering improvement teams, and initiating strategies to improve veteran outcomes. Facility policy identified the QSV Board as the senior-level committee responsible for QSV functions. However, although the Facility Director chaired the QSV Board, no QSV-specific data were discussed at this committee. Instead, the facility's Quality and Performance Council provided oversight of quality data collection and analysis and resulting actions, and the Facility Director did not chair or co-chair this committee. Facility leaders misunderstood VHA requirements specific to the senior-level QSV committee and stated that the Facility Director will co-chair the Quality and Performance Council.

Recommendation

1. The Facility Director ensures revision of local policy to specify the Quality and Performance Council as the senior-level committee responsible for key quality, safety, and value functions and co-chairs this committee.

²⁷ Focused Professional Practice Evaluation is a process whereby the facility evaluates the privilege-specific competence of the practitioner who does not have documented evidence of competently performing the requested privileges of the facility. It typically occurs at the time of initial appointment to the medical staff or the granting of new, additional privileges. The Focused Professional Practice Evaluation may be used when a question arises regarding a currently privileged practitioner's ability to provide safe, high-quality patient care.

Facility concurred.

Target date for completion: January 2018

Facility response: The Medical Center Director has been added as Co-chair to the Quality Performance Council. The Quality Performance Council charter is currently under revision. The Council charter and three consecutive months of meeting minutes will be provided as evidence of compliance.

Utilization Management: Documentation of Decisions. VHA requires Physician UM Advisors to document their decisions regarding appropriateness of patient admission and continued stays in the National UM Integration database. This allows for national level UM data to be available for review by an interdisciplinary group to set benchmarks; identify trends, actions, and opportunities to improve efficiency; and monitor outcomes. In 24 of the 36 cases (67 percent) referred to physician advisors June 1–July 31, 2017, there was no evidence that advisors documented their decisions in the database. UM staff reported that untimely and inconsistent physician advisor response for referred cases not meeting criteria, poor communication regarding alternate coverage when primary physician advisors are unavailable, and technical problems with the National UM Integration database resulted in noncompliance.

Recommendation

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

Facility concurred.

Target date for completion: January 2018

Facility response: The facility Chief of Staff has appointed a back-up for the Physician Utilization Management Advisor Champion and seven additional Physician Utilization Management Advisors were selected. An audit of Physician Utilization Management Advisor reviews in the National Utilization Management Integration database from August 2017 through October 2017 shows compliance with the national directive. As evidence of compliance, reports are submitted to the Clinical Practice Council to demonstrate six consecutive months of 90% compliance.

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,²⁸ 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 seven employees actively involved in the anticoagulant program and interviewed key employees. Additionally, OIG reviewed the electronic health records (EHRs) of 32 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

²⁸ Managerial Cost Accounting Pharmacy Cube, Corporate Data Warehouse data pull on March 23, 2017.

Conclusions. Generally, OIG noted safe anticoagulation therapy management practices. The facility had developed and implemented anticoagulation management policies, algorithms, protocols, and standardized care processes. Additionally, the facility met many of the other performance indicators evaluated, such as designating a physician anticoagulation program champion, minimizing risk of dosing errors, and performing laboratory testing. However, OIG identified the following deficiencies for quality assurance and employee competency assessments that warranted recommendations for improvement.

Quality Assurance. VHA requires an ongoing quality assurance plan to be in place to evaluate the anticoagulation management program. This evaluation provides the opportunity to identify practice improvements, ensures appropriate action is taken to improve the practice, and measures the effectiveness of those actions on a regular basis. Although facility policy described a quality assurance plan, anticoagulation management data were not analyzed or reported quarterly to the Pharmacy and Therapeutics Committee. Elements involving patient incidents, close calls, and adverse drug events were discussed but were not specific to anticoagulants. Managers believed that facility efforts met requirements.

Recommendation

3. The Chief of Staff ensures that anticoagulation management program quality assurance data are collected, analyzed, and reported quarterly at the Pharmacy and Therapeutics Committee and monitors program managers' compliance.

Facility concurred.

Target date for completion: June 2018

Facility Response: The Chief of Staff has ensured that the agenda for the quarterly meetings of the Pharmacy and Therapeutics Committee was expanded to include all the elements related to anticoagulant monitoring. As evidence of compliance, the minutes are submitted to the Clinical Practice Council for review, and monitoring will continue until two quarters of 90% compliance is noted.

Competency Assessments. VHA requires the facility to establish competencies specific to anticoagulation management for providers and clinical staff directly involved in caring for patients receiving anticoagulation therapy. Competencies must include knowledge of standard terminology, pharmacology of anticoagulants, monitoring requirements, dose calculations, common side effects, nutrient interactions, and drug to drug interactions associated with anticoagulation therapy. This ensures providers have sufficient aptitude, knowledge, skills, and abilities to fulfill the duties and responsibilities of the assigned position. Although all seven employees had competencies established for general pharmacology, none had competencies specific to anticoagulation management. All seven employees completed anticoagulation training in VHA's Talent Management System (online training system), and managers believed this training alone met the competency requirement.

Recommendation

4. The Chief of Staff ensures clinical managers include anticoagulation-specific elements in competency assessments for employees actively involved in the anticoagulant program and monitors managers' compliance.

Facility concurred.

Target date for completion: January 2018

Facility Response: The Chief of Staff ensured that the competency assessments for the Clinical Pharmacy Staff actively involved in the anticoagulant management program were updated to include all required anticoagulation-specific elements. An audit of competency assessments was completed in November 2017 by the Clinical Pharmacist Supervisor with 100% compliance and reported to the Clinical Practice Council. As evidence of compliance, the list of employees actively involved in the anticoagulant program will be submitted as well as the competency assessment form.

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 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. Additionally, providers and nurses carried out and documented care coordination elements, including informed consent and communications with the accepting facility, required in the patient transfer process. However, OIG identified the following deficiencies with data collection and reporting and with resident supervision that warranted recommendations for improvement.

Data Collection and Reporting. VHA requires facilities to collect, report, and analyze data for patient inter-facility transfers, such as date of transfer, documentation of informed consent and medical or behavioral stability, and identification of transferring and receiving provider, as part of the facility's quality management program. Data monitoring allows the facility to identify trends that could affect the safe transfer of patients out of the facility. There was no evidence the facility collected and reported data about inter-facility transfers. Facility managers acknowledged they were unaware of this requirement and initiated action plans to collect and report inter-facility transfer data during OIG's onsite inspection.

Recommendation

5. The Facility Director ensures inter-facility patient transfer data are collected, reported, and analyzed as part of the facility's quality management program and monitors compliance.

Facility concurred.

Target date for completion: June 2018

Facility Response: The Facility Director ensures that patient transfer data will be collected, reported, and analyzed within the Patient Flow Committee, chaired by the Nurse Executive, that was established in 2017. The minutes are submitted to Quality Performance Council for review and six months of compliance will be submitted as evidence of compliance.

Resident Supervision. VHA requires that when staff/attending physicians do not write transfer notes, acceptable designees obtain and document staff/attending physician approval and obtain countersignature on the note. This ensures the decision to transfer patients out of VHA facilities was made by a credentialed provider. For 6 of the 12 applicable patients, transfer notes written by acceptable designees did not include a staff/attending physician countersignature. Facility managers were unaware of the requirement and believed the facility was in compliance.

Recommendation

6. The Chief of Staff ensures transfer notes written by acceptable designees include a staff/attending physician countersignature and monitors acceptable designees' compliance.

Facility concurred.

Target date for completion: June 2018

Facility Response: The Chief of Staff will ensure that all patients that transfer out of the facility have a transfer note with an attending physician countersignature. The interfacility transfer note was revised to include a reminder for resident physicians to add their attending physician as a cosigner. Compliance will be monitored and reported to the Clinical Practice Council until four consecutive months at 90% compliance is achieved.

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.²⁹ 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 mental health (MH) services to patients with acute and severe emotional and/or behavioral symptoms. These services are often provided in an inpatient setting.³⁰ 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 three inpatient areas (critical care, medical/surgical, and community living center), four outpatient areas (dental, spinal cord injury, specialty, and PC), the Emergency Department, and Radiology Service. OIG also inspected the Salina 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.

Parent Facility

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

²⁹ VHA Handbook 1105.04, *Fluoroscopy Safety*, July 6, 2012.

³⁰ 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
- Information technology 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 tracked EOC deficiencies and met the performance indicators evaluated for general safety, infection prevention, and privacy. However, OIG noted dusty rolling patient equipment (stretchers and bed frames) in the three inpatient units inspected as well as in the Emergency Department and spinal cord injury clinic. The Salina CBOC met the infection prevention, cleanliness, medication safety and security, and information technology network room security measures reviewed. However, OIG noted one corridor at the CBOC where the exit sign was not readily visible. Radiology Service generally met the performance indicators evaluated. OIG did not note any issues with the availability of medical equipment and supplies. OIG identified the following deficiencies with EOC rounds participation and with general safety at the Salina CBOC that warranted recommendations for improvement.

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 From October 2015 through June 2017, 8 of 13 members did not consistently participate in EOC rounds. Facility leadership identified staffing issues, lack of back-up members, and accountability concerns as reasons for noncompliance.

Recommendation

7. The Associate Director ensures required team members consistently participate in environment of care rounds and monitors team members' compliance.

Facility concurred.

Target date for completion. June 2018

Facility Response: The Associate Director ensures consistent participation of membership by increasing the number of back-up staff assigned to the Environment of Care Rounds Team. As evidence of compliance, attendance will be reported monthly to the Environment of Care Committee until 90% compliance is achieved for four consecutive months.

Community Based Outpatient Clinic: General Safety – Panic Alarm Testing. VHA requires facilities to regularly test appropriate physical security precautions and equipment, including panic alarm systems. Testing alarms in high-risk outpatient areas ensures rapid response by police to panic alarm activation, which preserves both patient and staff safety. At the Salina CBOC, clinic staff have access to individual panic alarms (on-person which do not alert personnel outside the immediate clinic area) as well as system-wide panic alarms located on the computer desktops (which alert VA Police). OIG found no evidence that the system-wide panic alarms available at the CBOC were tested by VA Police. VA Police were aware of the requirements but could not provide evidence that testing was performed.

Recommendation

8. The Associate Director ensures that VA Police perform and document system-wide panic alarm testing at the Salina community based outpatient clinic 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 2018

Facility Response: The Associate Director ensures that panic alarm testing will be completed monthly at the Salina Community Based Outpatient Clinic and reported to the Environment of Care Committee. As evidence of compliance, monitoring will be continued until 90% compliance is achieved for four consecutive 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 cardiology, interventional radiology, gastroenterology, ambulatory surgery, and Emergency Department procedure areas to assess whether required equipment and sedation medications were available. Additionally, OIG reviewed the EHRs of 37 randomly selected patients who underwent an invasive procedure involving moderate sedation from July 1, 2015 through June 30, 2016, and the training records of 15 clinical employees who performed or assisted during these procedures. The 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

³²American 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 timeout³⁶ 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. The facility reported and trended the use of reversal agents in moderate sedation cases and had equipment and medications available in moderate sedation procedure areas. Additionally, the facility met the performance indicators examined for re-evaluating patients before moderate sedation procedures, documenting informed consent, performing time-outs, discharging patients, and training clinicians. However, OIG identified deficiencies with pre- and post-procedure documentation.

Pre-Sedation Documentation. VHA requires that providers complete a history and physical examination and pre-sedation assessment prior to performing a moderate sedation procedure. The history and physical and pre-sedation assessment in combination must include required elements. This ensures providers are aware of relevant patient information and assessments that may affect the patient's response to moderate sedation. Five of the 37 patients' EHRs (14 percent) did not contain evidence of airway assessments. Clinical managers were unaware that some pre-sedation templates did not include all required elements, such as airway assessment prior to moderate sedation procedure, resulting in noncompliance for this element.

Recommendation

9. The Chief of Staff ensures providers include an airway assessment in the history and physical examination and/or pre-sedation assessment and monitors providers' compliance.

Facility concurred.

Target date for completion: Completed - Request closure

Facility Response: Documentation templates were revised so that the Chief of Staff can ensure airway assessments are completed. As evidence of compliance, monitoring demonstrates 90% compliance has been achieved for four consecutive months and has been uploaded to the share point site for OIG Inspector review. Facility requests closure of this recommendation based on evidence provided.

Post-Procedure Documentation. VHA and TJC require the clinical team to monitor and document the patient's mental status and pain level following a moderate sedation procedure. The assessment must be at a level consistent with the status of the patient

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.

and the potential effect of the procedure or sedation. Post-procedure monitoring ensures patients are recovering as clinically indicated and is part of the criteria used to determine readiness for discharge. In 23 of the 37 patients' EHRs (62 percent), OIG did not find evidence that clinicians assessed post-procedure pain level. This requirement is also delineated in facility policy; clinical managers were unaware of noncompliance until an internal review revealed only one procedure area consistently monitored and/or documented patients' post-procedure pain level.

Recommendation

10. The Chief of Staff ensures clinicians perform post-procedure assessments of patient pain level and monitors clinicians' compliance.

Facility concurred.

Target date for completion: Completed - Request closure

Facility Response: The Chief of Staff and Nurse Executive ensure clinicians perform post-procedure assessments of patient pain levels by revising templates. As evidence of compliance, monitoring demonstrates 90% compliance has been achieved for four consecutive months and has been uploaded to the share point site for OIG Inspector review. Facility requests closure of this recommendation based on evidence provided.

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 31 patients who received CNH care for more than 3 months during the timeframe July 1, 2015 through June 30, 2016. The list below shows the performance indicators OIG reviewed.

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

Conclusions. Generally, OIG noted compliance with documentation of hand-off for patients placed in CNHs outside the facility's catchment area. However, OIG identified the following deficiencies with the CNH Oversight Committee, program integration, annual reviews, and clinical visits that warranted recommendations for improvement.

Oversight Committee. VHA requires the Facility Director to establish a CNH Oversight Committee that reports to the Chief of Staff or designee and meets at least quarterly. The CNH Oversight Committee verifies completeness of the CNH Review Teams' initial, annual, and problem focused evaluations to ensure VHA contracted nursing homes provide quality care in a safe environment. The facility did not establish a CNH Oversight Committee until December 2016 when the new CNH Program Coordinator was assigned. OIG found evidence of quarterly committee meetings since it was established. Managers and staff were aware of these requirements, but did not assign a responsible person to ensure compliance prior to the appointment of the new CNH Program Coordinator.

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

Recommendation

11. The Facility Director ensures the Community Nursing Home Oversight Committee continues to meet at least quarterly and monitors compliance.

Facility concurred.

Target date for completion: March 2018

Facility Response: The Facility Director ensured that the Community Nursing Home Oversight Committee was re-established in December 2016 and met monthly for 5 months. Since April 2017 they have been meeting quarterly with meetings in July and October 2017. As evidence of compliance, minutes will be provided to the Clinical Practice Council for two consecutive quarters.

Community Nursing Home Program Quality Improvement Integration. VHA requires that facilities integrate the CNH program into their quality improvement program. Monitoring and incorporating CNH findings into the quality improvement program supports overall CNH program goals to improve patient outcomes and optimize function and quality of life. The minutes of the facility executive-level committee that evaluates quality improvement data did not contain evidence of CNH program integration. Managers and staff believed that reporting CNH related data to the Home Care Oversight Committee in place of the facility executive-level committee met VHA requirements.

Recommendation

12. The Facility Director ensures that the community nursing home program is integrated into the facility quality improvement program.

Facility concurred.

Target date for completion: March 2018

Facility Response: The Facility Director ensures that the Community Nursing Home Program is integrated into the facility quality improvement program by reporting quarterly to the Clinical Practice Council. As evidence of compliance, minutes will be provided to the Clinical Practice Council for two consecutive quarters.

Community Nursing Home Annual Reviews. VHA requires the CNH Review Team to complete annual reviews of all CNHs under VA contract. The annual review must include an analysis of the deficiencies, staffing ratios, and quality measure information from the most recent state survey. When supplemented by the facility's experience with the CNH and patient and family feedback, the information provides an overall picture of the CNH's quality of patient care and environmental safety. The results of the review determine whether the team recommends renewal of a CNH contract. The facility's CNH Review Team did not complete any of the seven annual reviews during OIG's

review period. Managers and staff were aware of the requirements, but the lack of a responsible individual to provide program oversight resulted in noncompliance.

Recommendation

13. The Chief of Staff ensures the Community Nursing Home Review Team completes required annual reviews and monitors the team's compliance.

Facility concurred.

Target date for completion: Completed - Request closure

Facility Response: The Chief of Staff ensured that the Community Nursing Home Program completed annual reviews for fiscal year 2017 and ensures the annual reviews for fiscal year 2018 have begun. Tracking of the reviews is occurring and reported to Clinical Practice Council. As evidence of compliance, six consecutive months of reviews were uploaded to the share point site for OIG Inspector review, demonstrating 100% compliance. Facility requests closure based on evidence provided.

Clinical Visits. VHA requires that every patient under contract in a nursing home must be visited by a social worker or registered nurse at least every 30 days (unless specific criteria allow an exception). Social workers and nurses alternate monthly visits, unless otherwise indicated by the patient's individualized visitation plan. This interdisciplinary monitoring ensures vulnerable nursing home patients consistently receive quality care and necessary follow-up services. Twenty-eight of the 31 patients' EHRs (90 percent) did not contain documentation of social worker and registered nurse cyclical clinical visits with the frequency required by VHA policy. Managers and staff were aware of the requirements, but staff vacancies resulted in noncompliance. The facility reported increased compliance with the recruitment of the CNH Program Coordinator in December 2016.

Recommendation

14. The Chief of Staff and Associate Director for Patient Care Services ensure social workers and registered nurses conduct and document cyclical clinical visits with the frequency required by Veterans Health Administration policy for community nursing home oversight and monitor social workers' and registered nurses' compliance.

Facility concurred.

Target date for completion: Completed - Request closure

Facility Response: The Chief of Staff and Nurse Executive ensure Social Workers and Registered Nurses conduct and document that cyclical clinical visits are occurring. As evidence of compliance, four consecutive months of reviews were uploaded to the share point site for OIG Inspector review, demonstrating full compliance. Facility requests closure based on evidence provided.

Summary Table of Comprehensive Healthcare Inspection Program Review Findings			
Healthcare Processes	Performance Indicators	Conclusion	
Leadership and Organizational Risks	<ul style="list-style-type: none"> • 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 	Fourteen 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 Recommendations³⁸ for Improvement	Recommendations for Improvement
Quality, Safety, and Value	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • Facility Director ensures revision of local policy to specify the Quality and Performance Council as the senior-level committee responsible for QSV functions and co-chairs this committee. • Physician UM Advisors consistently document their decisions in the National UM Integration database.
Medication Management	<ul style="list-style-type: none"> • Anticoagulation management policies and procedures • Management of patients receiving new orders for anticoagulants <ul style="list-style-type: none"> ○ Prior to treatment ○ During treatment • Ongoing evaluation of the anticoagulation program • Competency assessment 	<ul style="list-style-type: none"> • Clinical managers include anticoagulation-specific elements in competency assessments for employees actively involved in the anticoagulant program. 	<ul style="list-style-type: none"> • Anticoagulation management program quality assurance data are collected, analyzed, and reported quarterly at the Pharmacy and Therapeutics Committee.

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	<ul style="list-style-type: none"> • Transfer policies and procedures • Oversight of transfer process • EHR documentation <ul style="list-style-type: none"> ○ Non-emergent transfers ○ Emergent transfers 	<ul style="list-style-type: none"> • Transfer notes written by acceptable designees include a staff/attending physician countersignature 	<ul style="list-style-type: none"> • Inter-facility patient transfer data are collected, reported, and analyzed as part of the facility's quality improvement program.
Environment of Care	<ul style="list-style-type: none"> • Parent facility <ul style="list-style-type: none"> ○ EOC deficiency tracking and rounds ○ General Safety ○ Infection prevention ○ Environmental cleanliness ○ Exam room privacy ○ Availability of feminine hygiene products and medical equipment and supplies • CBOC <ul style="list-style-type: none"> ○ General safety ○ Infection prevention ○ Environmental cleanliness ○ Medication safety and security ○ Privacy ○ Availability of feminine hygiene products and medical equipment and supplies ○ IT network room security • Radiology <ul style="list-style-type: none"> ○ 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 	<ul style="list-style-type: none"> • CBOC: <ul style="list-style-type: none"> ○ VA Police perform and document system-wide panic alarm testing at the Salina CBOC. 	<ul style="list-style-type: none"> • Parent facility: <ul style="list-style-type: none"> ○ Required team members consistently participate in EOC rounds.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Environment of Care (continued)	<ul style="list-style-type: none"> • Inpatient MH <ul style="list-style-type: none"> ○ MH EOC inspections ○ Environmental suicide hazard identification ○ Employee training ○ Environmental safety ○ Infection prevention ○ Availability of medical equipment and supplies 	Not Applicable	Not Applicable
High-Risk and Problem-Prone Processes: Moderate Sedation	<ul style="list-style-type: none"> • Outcomes reporting • Patient safety and documentation <ul style="list-style-type: none"> ○ Prior to procedure ○ After procedure • Staff training and competency • Monitoring equipment and emergency management 	<ul style="list-style-type: none"> • Providers include an airway assessment in the history and physical examination and/or pre-sedation assessment. • Clinicians performs post-procedure assessments of patient pain level. 	None
Long-Term Care: Community Nursing Home Oversight	<ul style="list-style-type: none"> • CNH Oversight Committee and CNH program integration • EHR documentation <ul style="list-style-type: none"> ○ Patient hand-off ○ Clinical visits • CNH annual reviews 	<ul style="list-style-type: none"> • The CNH Review Team completes required annual reviews. • Social workers and registered nurses conduct and document cyclical clinical visits with the frequency required by VHA policy for CNH oversight. 	<ul style="list-style-type: none"> • The CNH Oversight Committee continues to meet at least quarterly. • The CNH program is integrated into the facility quality improvement program.

Facility Profile

The table below provides general background information for this mid-high complexity (1c)^{39, 40} affiliated⁴¹ facility reporting to VISN 15.

Table 5. Facility Profile for Wichita (589A7) for October 1, 2013 through September 30, 2016

Profile Element	Facility Data FY 2014 ⁴²	Facility Data FY 2015 ⁴³	Facility Data FY 2016 ⁴⁴
Total Medical Care Budget in Millions	\$196.0	\$199.3	\$222.5
Number of:			
• Unique Patients	27,891	27,784	27,886
• Outpatient Visits	316,605	307,253	310,380
• Unique Employees⁴⁵	834	885	897
Type and Number of Operating Beds:			
• Acute	41	41	41
• Mental Health	NA	NA	NA
• Community Living Center	40	40	40
• Domiciliary	NA	NA	NA
Average Daily Census:			
• Acute	23	22	22
• Mental Health	NA	NA	NA
• Community Living Center	32	28	25
• 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 Updated data as of October 1, 2017, reflects that the facility is designated as a complexity model 2, indicating medium volume, low risk patients, few complex clinical programs, and small or no research and teaching programs.

⁴¹ Associated with a medical residency program.

⁴² October 1, 2013 through September 30, 2014.

⁴³ October 1, 2014 through September 30, 2015.

⁴⁴ October 1, 2015 through September 30, 2016.

⁴⁵ Unique employees involved in direct medical care (cost center 8200).

VA Outpatient Clinic Profiles⁴⁶

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/Encounters⁴⁷ 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 ⁴⁸ Provided	Diagnostic Services ⁴⁹ Provided	Ancillary Services ⁵⁰ Provided
Dodge City, KS	589G2	2,262	576	Endocrinology Hematology/ Oncology Podiatry	EKG	Nutrition Weight Management
Liberal, KS	589G3	517	130	Endocrinology Hematology/ Oncology Neurology Podiatry	EKG	Weight Management
Hays, KS	589G4	3,211	1,677	Hematology/ Oncology Neurology Eye Podiatry	EKG	Nutrition Prosthetics Social Work Weight Management
Parsons, KS	589G5	2,392	1,539	Endocrinology Hematology/ Oncology Nephrology Neurology Eye Podiatry	EKG	Nutrition Social Work Weight Management
Hutchinson, KS	589G7	3,576	1,439	Endocrinology Hematology/ Oncology Eye Podiatry	EKG	Nutrition Social Work Weight Management

⁴⁶ Includes all outpatient clinics in the community that were in operation as of February 15, 2017. We have omitted Wichita, KS (589QB) and Wichita, KS (589QC), as no workload/encounters or services were reported.

⁴⁷ An encounter is a professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient’s condition.

⁴⁸ Specialty care services refer to non-PC and non-MH services provided by a physician.

⁴⁹ Diagnostic services include EKG, EMG, laboratory, nuclear medicine, radiology, and vascular lab services.

⁵⁰ Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Salina, KS	589GW	4,970	1,771	Endocrinology Hematology/ Oncology Blind Rehab Eye Podiatry	EKG	Nutrition 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.

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).

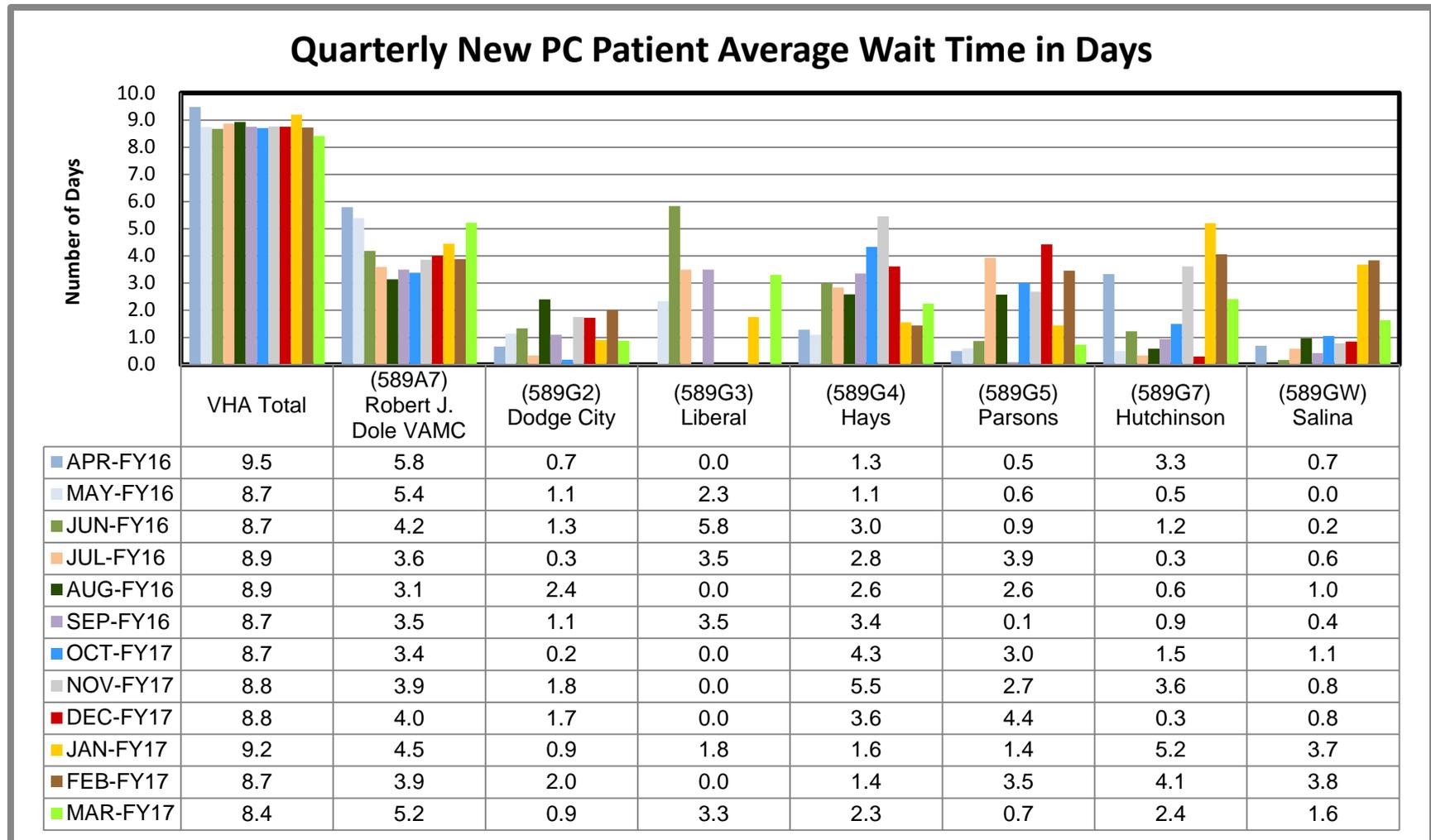
OIG considered these policies to be in effect, as they had not been superseded by more recent policy or guidance. In a June 29, 2016, memorandum to supplement policy provided by VHA Directive 6330(1),⁵¹ the VA Under Secretary for Health mandated the "...continued use of and adherence to VHA policy documents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

⁵¹ VHA Directive 6330(1), *Controlled National Policy/Directives Management System*, June 24, 2016, amended January 11, 2017.

⁵² VA Under Secretary for Health. "Validity of VHA Policy Document." Memorandum. June 29, 2016.

⁵³ Ibid.

Patient Aligned Care Team Compass Metrics

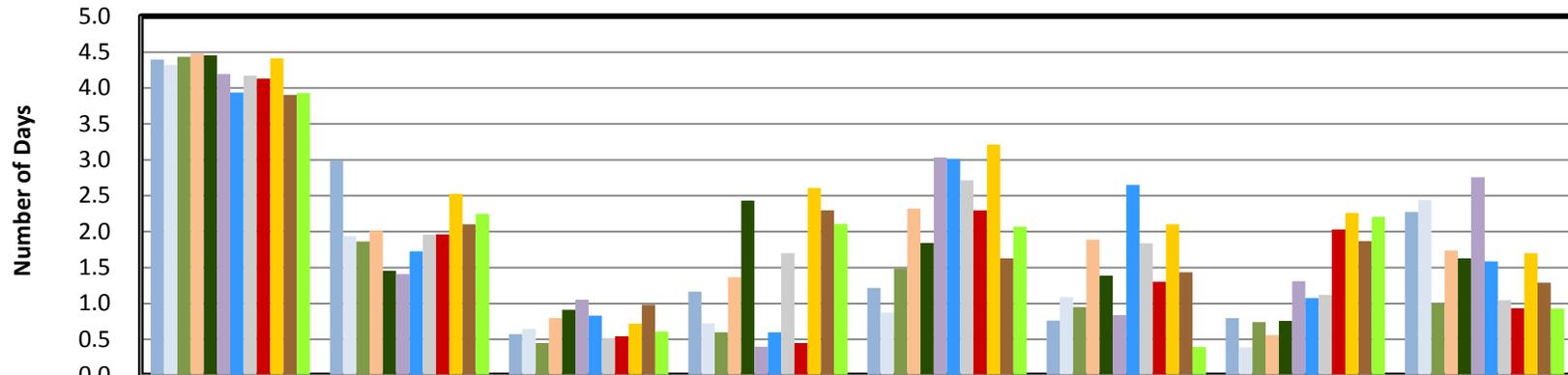


Source: VHA Support Service Center.

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

Data Definition⁶: The average number of calendar days between a new patient’s PC completed appointment (clinic stops 322, 323, and 350, excluding Compensation and Pension appointments) and the earliest of three possible preferred (desired) dates (Electronic Wait List [EWL], Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date. *Note that prior to FY 2015, this metric was calculated using the earliest possible create date.*

Quarterly Established PC Patient Average Wait Time in Days



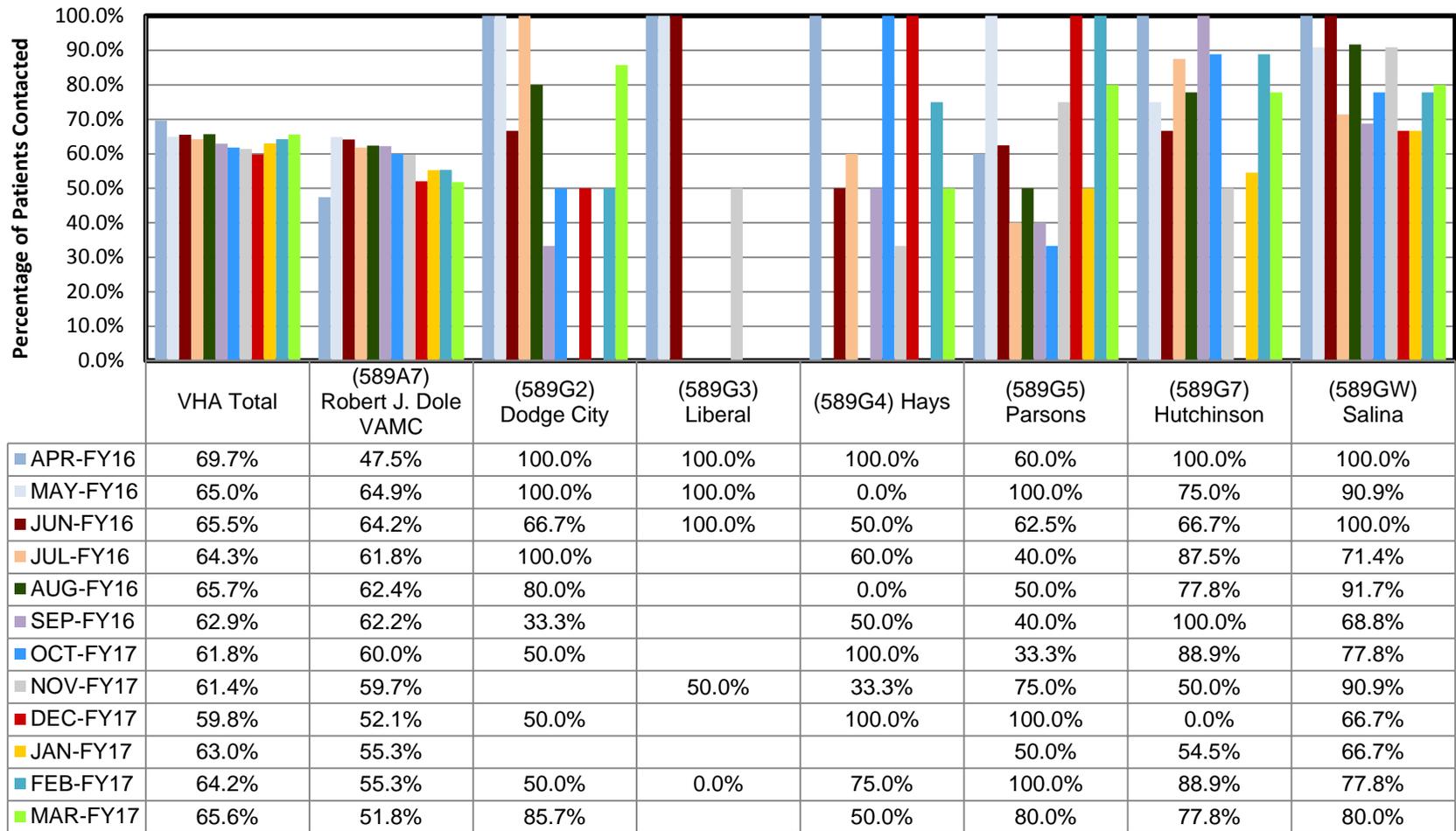
	VHA Total	(589A7) Robert J. Dole VAMC	(589G2) Dodge City	(589G3) Liberal	(589G4) Hays	(589G5) Parsons	(589G7) Hutchinson	(589GW) Salina
■ APR-FY16	4.4	3.0	0.6	1.2	1.2	0.8	0.8	2.3
■ MAY-FY16	4.3	1.9	0.6	0.7	0.9	1.1	0.4	2.4
■ JUN-FY16	4.4	1.9	0.4	0.6	1.5	0.9	0.7	1.0
■ JUL-FY16	4.5	2.0	0.8	1.4	2.3	1.9	0.6	1.7
■ AUG-FY16	4.5	1.5	0.9	2.4	1.8	1.4	0.8	1.6
■ SEP-FY16	4.2	1.4	1.1	0.4	3.0	0.8	1.3	2.8
■ OCT-FY17	3.9	1.7	0.8	0.6	3.0	2.7	1.1	1.6
■ NOV-FY17	4.2	2.0	0.5	1.7	2.7	1.8	1.1	1.0
■ DEC-FY17	4.1	2.0	0.5	0.5	2.3	1.3	2.0	0.9
■ JAN-FY17	4.4	2.5	0.7	2.6	3.2	2.1	2.3	1.7
■ FEB-FY17	3.9	2.1	1.0	2.3	1.6	1.4	1.9	1.3
■ MAR-FY17	3.9	2.2	0.6	2.1	2.1	0.4	2.2	0.9

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.

Quarterly Team 2-Day Post Discharge Contact Ratio

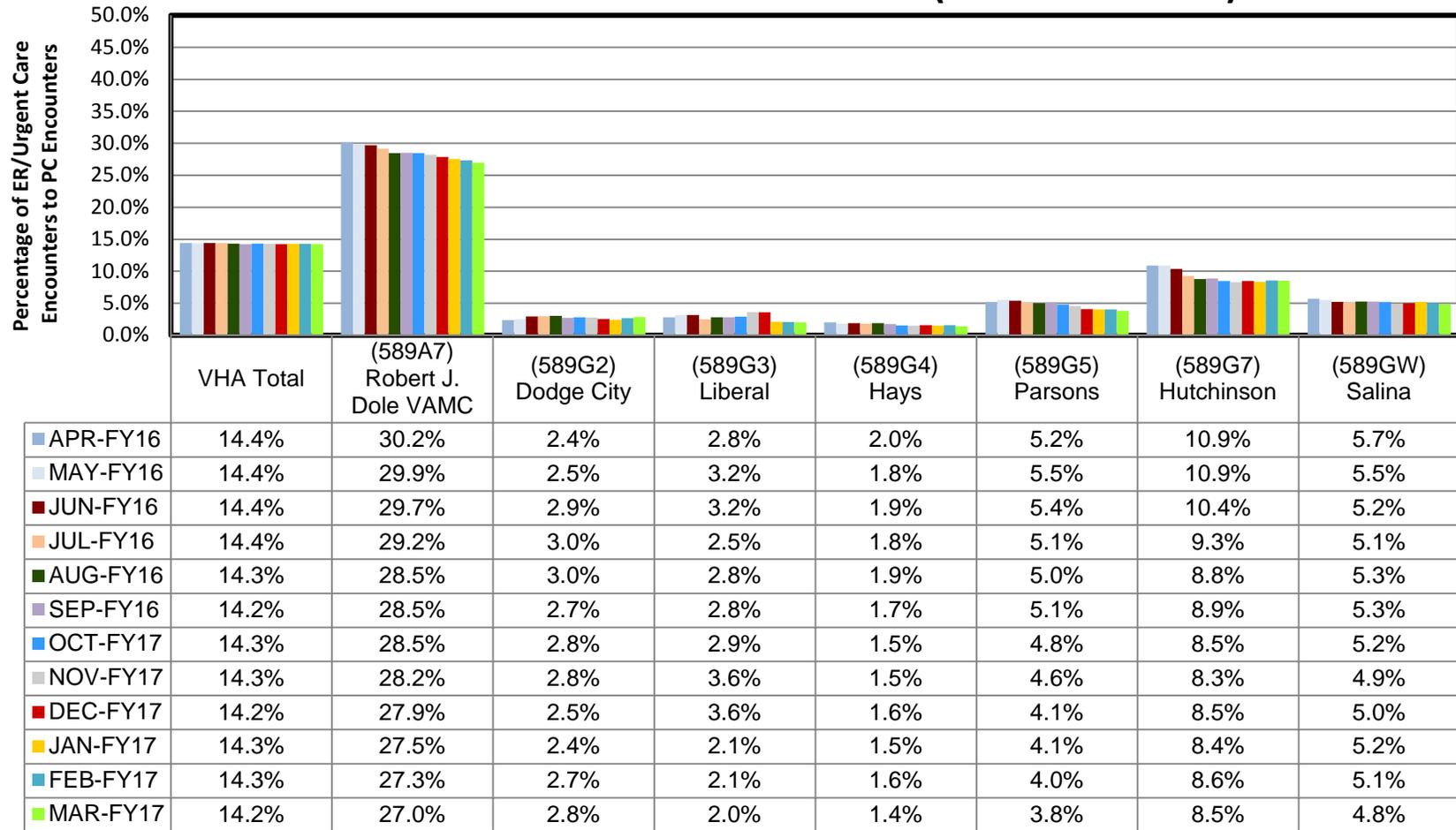


Source: VHA Support Service Center.

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

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

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



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

July 1, 2014 through January 1, 2018⁵⁴

Healthcare Inspection – Quality of Care and Other Concerns Robert J. Dole VA Medical Center, Wichita, Kansas

7/19/2017 | 15-04641-304 | [Summary](#) | [Report](#)

Review of VHA Care and Privacy Standards for Women Veterans

6/19/2017 | 15-03303-206 | [Summary](#) | [Report](#) |

Community Based Outpatient Clinics Summary Report – Evaluation of Medication Oversight and Education at Community Based Outpatient Clinics and Other Outpatient Clinics

6/18/2015 | 15-01297-368 | [Summary](#) | [Report](#)

Healthcare Inspection – Review of Solo Physicians’ Professional Practice Evaluations in Veterans Health Administration Facilities

6/3/2015 | 15-00911-362 | [Summary](#) | [Report](#) |

Combined Assessment Program Review of the Robert J. Dole VA Medical Center, Wichita, Kansas

11/3/2014 | 14-02076-13 | [Summary](#) | [Report](#)

Community Based Outpatient Clinic and Primary Care Clinic Reviews at Robert J. Dole VA Medical Center, Wichita, Kansas

7/8/2014 | 14-00915-206 | [Summary](#) | [Report](#)

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

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: December 18, 2017

From: Director, VA Heartland Network (10N15)

Subject: CHIP Review of the Robert J. Dole VA Medical Center, Wichita, KS

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

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

Attached, please find the initial status response for the Comprehensive Healthcare Inspection Program Review of the Robert J. Dole VA Medical Center, Wichita, KS (Conducted the week of July 31, 2017).

I have reviewed and concur with the Medical Center Director's response.

Thank you for this opportunity to focus on continuous performance improvement.

Mary O'Shea MN, RN

Mary O'Shea, MN, RN for

William P. Patterson, MD, MSS

Network Director

VA Heartland Network (VISN 15)

Facility Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: December 18, 2017

From: Director, Robert J. Dole VA Medical Center (589A7/00)

Subject: **CHIP Review of the Robert J. Dole VA Medical Center, Wichita,
KS**

To: Director, VA Heartland Network (10N15)

1. I have reviewed the findings and concur with the recommendations.
2. Attached are the corrective actions with target completion dates.



Rick Ament, MSA, FACHE

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact OIG at (202) 461-4720.
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National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Jerry Moran, Pat Roberts
U.S. House of Representatives: Ron Estes, Lynn Jenkins, Roger Marshall, Kevin Yoder

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/diagnosticsservices/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 Directive 1039, *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.