Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 17-01758-104

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

February 28, 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	Hampton VA Medical Center
FY	fiscal year
MH	mental health
Nurse Executive	Associate Director for Patient Care Services
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
PC	primary care
QSV	quality, safety, and value
RRTP	residential rehabilitation treatment program
SAIL	Strategic Analytics for Improvement and Learning
TJC	The Joint Commission
UM	utilization management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Report Overview

This Comprehensive Healthcare Inspection Program (CHIP) review provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Hampton 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 10, 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 Hampton VA Medical Center, the leadership team consists of the Facility Director, Chief of Staff, Associate Director for Patient Care Services (Nurse Executive), and Associate Director. Organizational communication and accountability are carried out through a committee reporting structure with the Executive Leadership Council having oversight for leadership groups such as the Administrative Executive Board, Quality Safety Value Board, Patient Care Services Board, and Medical Executive Board. The leaders are members of the Executive Leadership Council through which they track, trend, and monitor quality of care and patient outcomes.

All members of the leadership team were permanently assigned. However, the Director and Nurse Executive had been in their respective positions for less than 1 year at the

time of OIG's onsite visit. In the review of selected employee and patient survey results regarding facility senior leadership, OIG noted generally positive satisfaction scores that reflected active engagement with employees and patients. OIG also noted that facility leaders implemented processes and plans to maintain a committed workforce and positive patient experiences.

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

Although the senior leadership team was knowledgeable about selected SAIL metrics, the leaders should continue to take actions to improve performance of the Quality of Care and Efficiency metrics likely contributing to the current 2-star rating (for example, Best Place to Work and Capacity). In the review of key care processes, OIG issued 19 recommendations that are attributable to the Facility Director, Chief of Staff, and Associate Director. OIG noted findings in all seven areas of clinical operations reviewed. These are briefly described below.

Quality, Safety, and Value. OIG found that senior managers were engaged with quality, safety, and value activities. When opportunities for improvement were identified, they supported clinical leaders' implementation of corrective actions and monitoring of effectiveness. Additionally, OIG found general compliance with the utilization management and patient safety requirements evaluated.[2] However, OIG noted deficiencies in peer review and credentialing and privileging processes.

Medication Management. OIG found safe anticoagulation therapy management practices and compliance with many of the performance indicators evaluated such as policy content, risk minimization of dosing errors, and transition follow-up and education for patients with newly prescribed anticoagulant medications. However, OIG identified deficiencies with laboratory testing and competencies.

Coordination of Care. OIG noted that the facility developed and implemented a patient transfer policy and collected and reported data about transfers out of the facility.

[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.

In addition, the facility met the performance indicators evaluated for resident supervision, nurse documentation of transfer assessments/notes, provider documentation for emergent transfers, and communication with the accepting facility. However, OIG identified a deficiency with inter-facility transfer documentation.

Environment of Care. OIG noted a generally safe and clean environment of care with the exception of lax security of the information technology closet at the Chesapeake Community Based Outpatient Clinic and its use for storing equipment and supplies. Additionally, OIG did not identify any issues with the performance indicators evaluated for Radiology Service. However, OIG identified deficiencies with environment of care rounds; exam room panic alarms and storage of clean and sterile supplies at the representative community based outpatient clinic; and panic alarm testing, the security surveillance television system, and employee and Interdisciplinary Safety Inspection Team training on the locked mental health unit.

High-Risk Processes Related to Moderate Sedation. OIG found compliance with reporting and trending the use of reversal agents, re-evaluating patients before moderate sedation, informed consent documentation and time-outs, post-procedure assessments, and discharge practices. However, OIG identified deficiencies with history and physical examinations and/or pre-sedation assessments and physician training.

Long-Term Care: Community Nursing Home Oversight. OIG identified deficiencies with the Community Nursing Home Oversight Committee, community nursing home program integration, annual reviews, and clinical visits.

Mental Health Residential Rehabilitation Treatment Program. OIG found that the program had policies/procedures for safe medication management and contraband detection and that employees knew the processes for behavioral health and medical emergencies. Additionally, OIG noted compliance with the performance indicators evaluated for cleanliness, fire safety, contraband inspections, rounds of all public spaces, daily bed checks, medication security, and women veterans' security. However, OIG identified deficiencies with medication inspections and the closed circuit surveillance television system.

Summary

In the review of key care processes, OIG issued 19 recommendations that are attributable to the Facility Director, Associate Director, and Chief of Staff. 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 Comprehensive Healthcare Inspection Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes G and H, pages 51–52, and the responses within the body of the report for the full text of the Directors' comments.) OIG will follow up on the planned actions for the open recommendations until they are completed.

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Purpose and Scope

Purpose

This Comprehensive Healthcare Inspection Program (CHIP) review was conducted to provide a focused evaluation of the quality of care delivered in the Hampton 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). OIG also evaluated an additional program with relevance to the facility—the Mental Health (MH) Residential Rehabilitation Treatment Program (RRTP).

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

Source: VA OIG.

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

Methodology

To determine compliance with Veterans Health Administration (VHA) requirements[3] related to patient care quality, clinical functions, and the EOC, OIG physically inspected selected areas; reviewed clinical records, administrative and performance measure data, and accreditation survey reports;[4] and discussed processes and validated findings with managers and employees. OIG interviewed applicable managers and members of the executive leadership team.

The review covered operations for April 1, 2014[5] through July 10, 2017, the date when an unannounced week-long site visit commenced. On August 1, 2017, OIG presented crime awareness briefings to 197 of the facility's 1,787 employees. These briefings covered procedures for reporting suspected criminal activity to OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

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

While onsite, OIG did not receive any concerns beyond the scope of 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

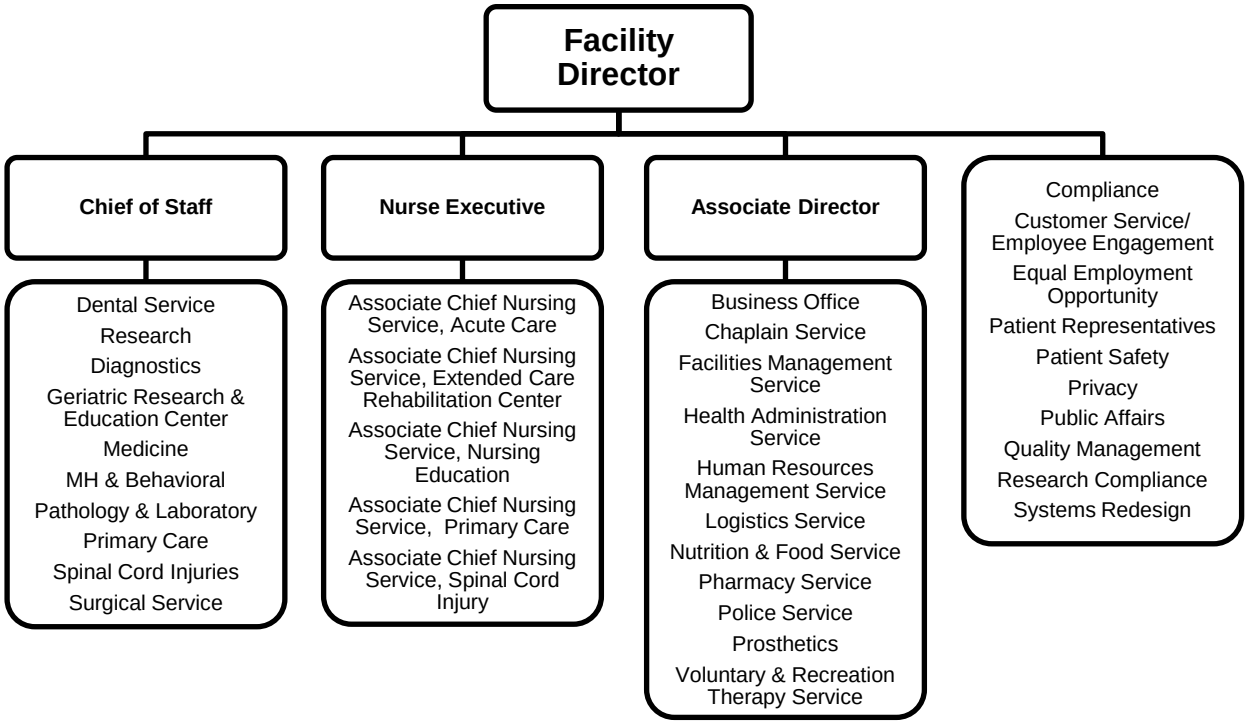
Stable and effective leadership is critical to improving care and sustaining meaningful change. Leadership and organizational risk issues can impact the facility's ability to provide care in all of the selected clinical areas of focus. The factors OIG considered in assessing the facility's risks and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

It is important to note that the all members of the leadership team are permanently assigned. However, the Director had only been in the position since June 2017, and the Chief of Staff and Nurse Executive had been in their respective positions since August 2016.

Figure 2. Facility Organizational Chart



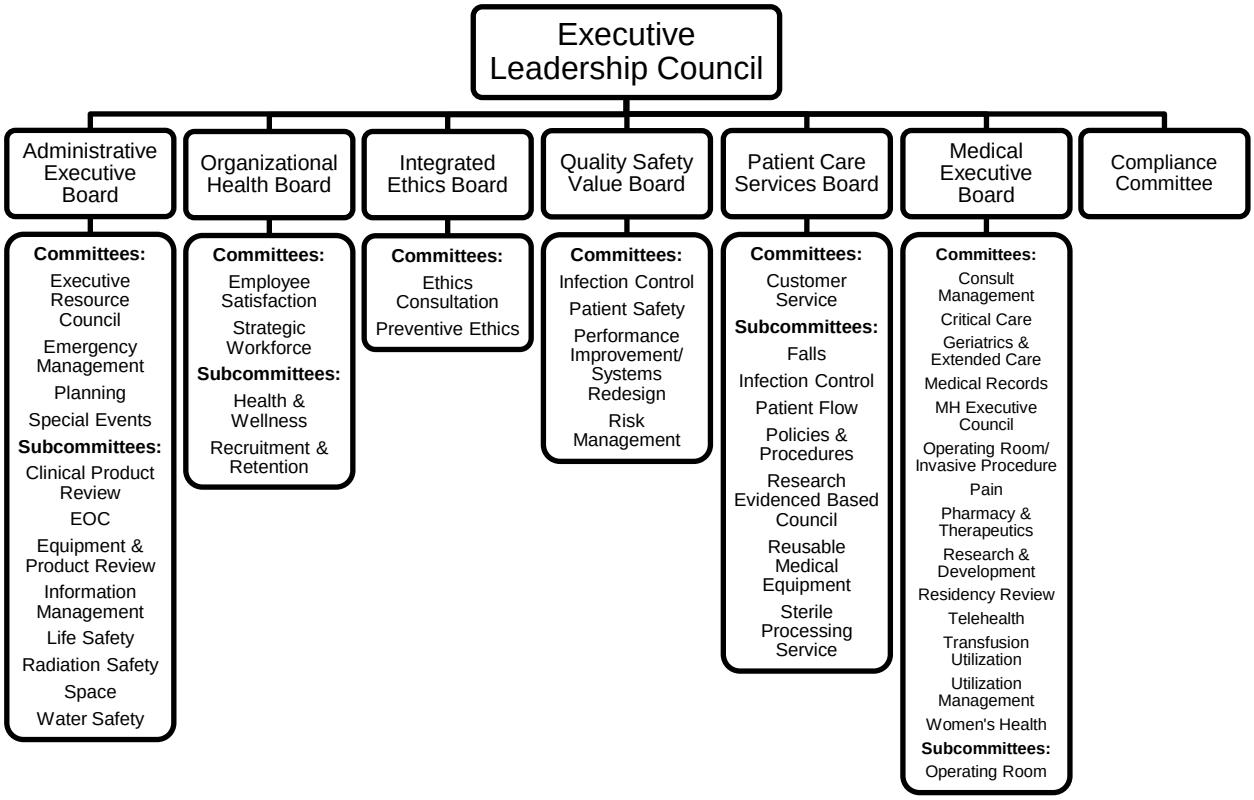
Source: Hampton VA Medical Center (received July 19, 2017).

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

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

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

Figure 3. Facility Committee Reporting Structure



Source: Hampton VA Medical Center (received July 20, 2017).

Employee Satisfaction and Patient Experience. To assess employee and patient attitudes toward facility senior leadership, OIG reviewed employee satisfaction and patient experience survey results that relate to the period of October 1, 2015 through September 30, 2016. Although OIG recognizes that employee satisfaction and patient experience survey data are subjective, they can be a starting point for discussions and indicate areas for further inquiry, which can be considered along with other information on facility leadership. Table 1 provides relevant survey results for VHA and the facility for the 12-month period. The facility leaders' results (Director's office average) were rated markedly above the VHA and facility average.[6] One of the four patient survey results reflected higher care ratings than the VHA average, while the other three reflected lower ratings. In all, employees appear more satisfied than patients with the leadership and care provided.

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

Questions	Scoring	VHA Average	Facility Average	Director's Office Average[7]
All Employee Survey[8] Q59. How satisfied are you with the job being done by the executive leadership where you work?	1 (Very Dissatisfied) – 5 (Very Satisfied)	3.3	3.2	4.1
All Employee Survey Servant Leader Index Composite	0–100 where HIGHER scores are more favorable	66.7	62.0	77.1
Survey of Healthcare Experiences of Patients (inpatient): Would you recommend this hospital to your friends and family?	The response average is the percent of "Definitely Yes" responses.	65.8	55.0	
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	83.2	
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): I felt like a valued customer.		73.2	60.6	
Survey of Healthcare Experiences of Patients (outpatient specialty care): I felt like a valued customer.		73.8	65.7	

[6] OIG makes no comment on the adequacy of the VHA average for each selected survey element. The VHA average is used for comparison purposes only.
[7] Rating is based on responses by employees who report to the Director.
[8] The All Employee Survey is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential. The instrument has been refined at several points since 2001 in response to operational inquiries by VA leadership on organizational health relationships and VA culture.

Accreditation/For-Cause[9] Surveys and Oversight Inspections. To further assess Leadership and Organizational Risks, OIG reviewed recommendations from previous inspections by oversight and accrediting agencies to gauge how well leaders respond to identified problems. Table 2 summarizes the relevant facility inspections most recently performed by the VA OIG and The Joint Commission (TJC).

OIG also noted the facility's current accreditation status with the Commission on Accreditation of Rehabilitation Facilities,[10] College of American Pathologists,[11] and Long Term Care Institute,[12] which demonstrates the facility leaders' commitment to quality care and services. Additionally, the Paralyzed Veterans of America conducted an inspection of the facility's spinal cord injury/disease unit and related services.[13]

[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] 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.
[11] 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.
[12] 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.
[13] The Paralyzed Veterans of America inspection took place March 16–17, 2017. This Veteran Service Organization review does not result in accreditation status.

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

Accreditation or Inspecting Agency	Date of Visit	Number of Findings	Number of Recommendations Remaining Open
VA OIG (*Healthcare Inspection – Patient Care Concerns at the Community Living Center, Hampton VA Medical Center, Hampton, Virginia, May 11, 2017.)*	June 2015	4	4
VA OIG (*Healthcare Inspection – Suicide Risk and Alleged Medical Management Issues, Hampton VA Medical Center Hampton, Virginia, March 30, 2015*.)	August 2014	2	0
VA OIG (*Combined Assessment Program Review of the Hampton VA Medical Center, Hampton, Virginia, January 20, 2015.)*	September 2014	15	0
VA OIG (*Community Based Outpatient Clinic and Primary Care Clinic Reviews at Hampton VA Medical Center, Hampton, Virginia, June 30, 2014.)*	April 2014	8	0
TJC[14] • Hospital Accreditation • Nursing Care Center Accreditation • Behavioral Health Care Accreditation Home Care Accreditation	August 2014	17 1 0 1	0

At the time of our site visit, the facility had four open recommendations from a previously published hotline report related to the facility's community living center. However, at the time of report publication, all recommendations had been closed.

[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 September 2014 Combined Assessment Program inspection through the week of July 10, 2017.

Table 3. Summary of Selected Organizational Risk Factors[15] (September 2014 to July 10, 2017)

Factor	Number of Occurrences
Sentinel Events[16]	2
Institutional Disclosures[17]	11
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 Hampton 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 6	Facility
Pressure Ulcers	0.55	0.61	0
Death among surgical inpatients with serious treatable conditions	103.31	68.49	333.33
Iatrogenic Pneumothorax	0.20	0.36	0
Central Venous Catheter-Related Bloodstream Infection	0.12	0.07	0
In Hospital Fall with Hip Fracture	0.08	0.16	0
Perioperative Hemorrhage or Hematoma	2.59	2.33	0
Postoperative Acute Kidney Injury Requiring Dialysis	1.20	0.91	0
Postoperative Respiratory Failure	6.31	4.41	0
Perioperative Pulmonary Embolism or Deep Vein Thrombosis	3.29	2.23	0
Postoperative Sepsis	4.45	4.47	0
Postoperative Wound Dehiscence	0.65	1.14	0
Unrecognized Abdominopelvic Accidental Puncture/Laceration	0.67	1.63	0

Source: VHA Support Service Center.

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

The Patient Safety Indicator measure for death among surgical inpatients with serious treatable conditions shows an observed rate in excess of the observed rates for Veterans Integrated Service Network (VISN) 6 and VHA. Facility managers reported that the three surgical cases meeting criteria for this performance measure involved patients with multiple pre-existing comorbidities and pre-operative risks for complications.

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 has noted limitations for

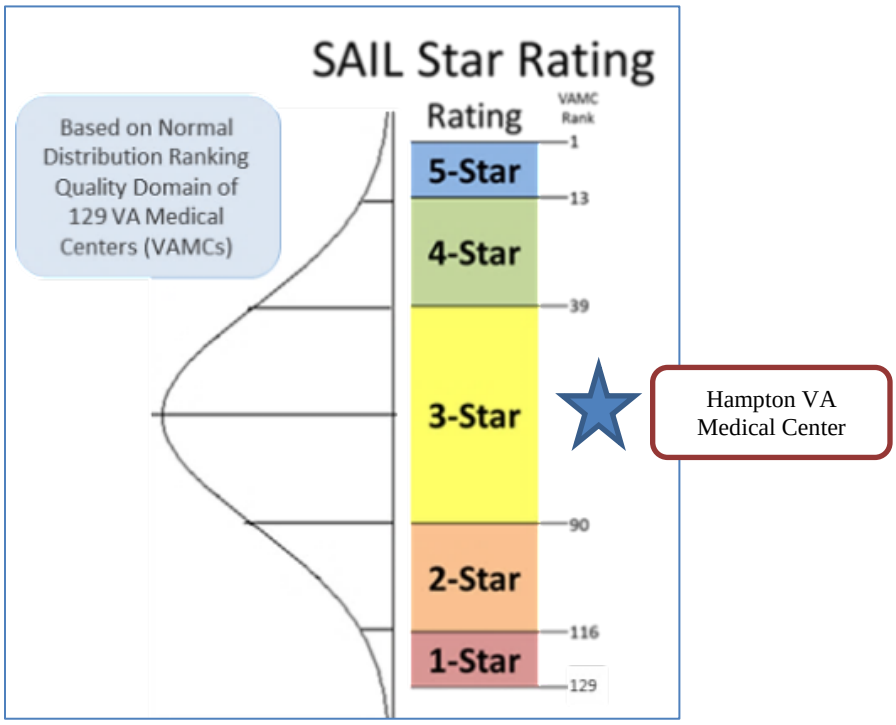
[19] Agency for Healthcare Research and Quality website, https://www.qualityindicators.ahrq.gov/, accessed March 8, 2017.

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

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 Hampton VA Medical Center received an interim rating of 3 stars for overall quality. This means the facility is in the 3rd quintile (30–70 percent range). Updated data as of June 30, 2017, indicates that the facility has declined to 2 stars for overall quality.

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

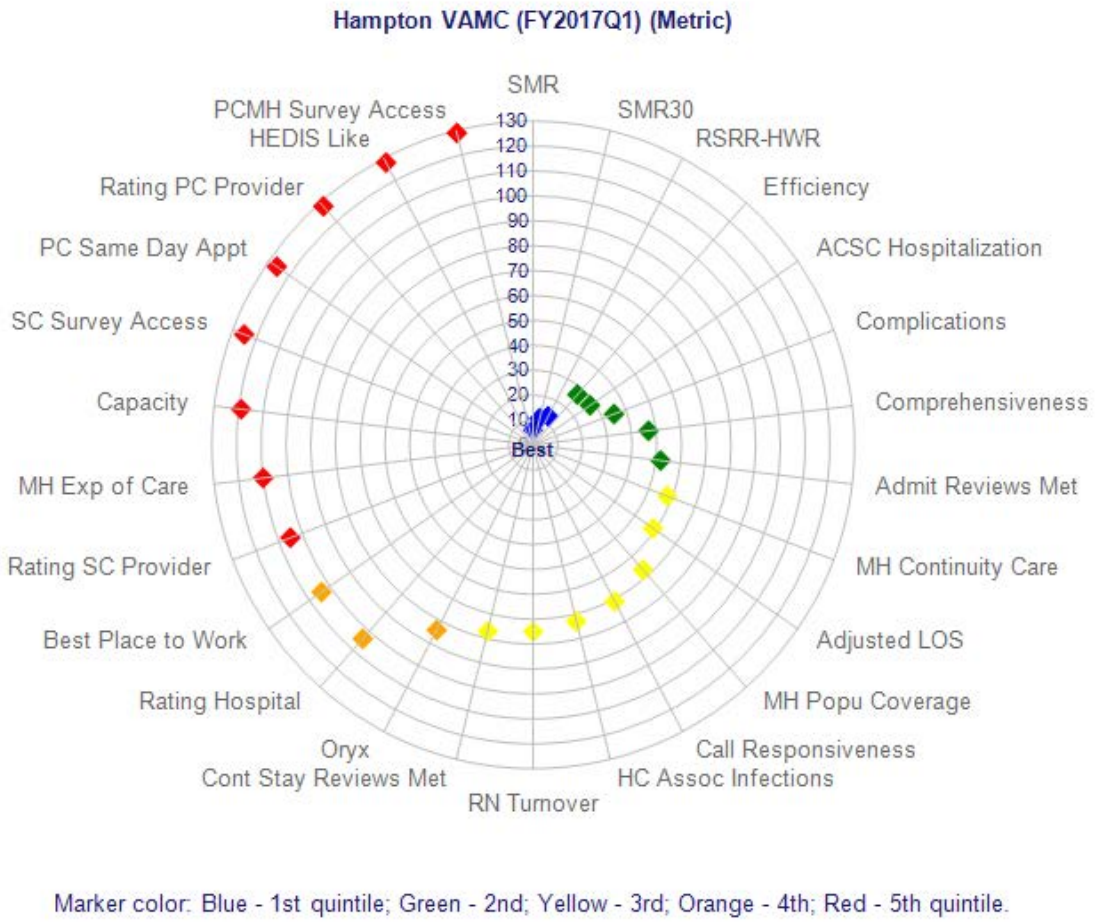


Source: VA Office of Informatics and Analytics' Office of Operational Analytics and Reporting.

[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 December 31, 2016. Of note, Figure 5 shows blue and green data points in the top quintiles that show high performance (for example, Standardized Mortality Ration [SMR], Hospital-Wide Readmissions [RSRR-HWR], and Complications). Metrics in the bottom quintiles reflect areas that need improvement and are denoted in orange and red (for example, Best Place to Work, Capacity, and PC Same Day Appointment [Appt]).

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



Source: VHA Support Service Center.

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

Conclusions. The facility has a newer executive leadership team that appears stable and actively engaged with employees. The executive leaders seemed to support patient safety, quality care, and other positive outcomes, and 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 leaders were also knowledgeable about selected SAIL metrics; however, OIG noted that opportunities exist to improve care and performance of selected metrics, particularly Quality of Care and Efficiency, likely contributing to the current 2-star rating. Opportunities also exist for these leaders to improve patient satisfaction, especially with outpatient care.

[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 review[24] of clinical care
3. Credentialing and privileging
4. Utilization management (UM) reviews[25]
5. Patient safety incident reporting and root cause analyses

OIG interviewed senior managers and key QSV employees and evaluated meeting minutes, licensed independent practitioners' profiles, protected peer reviews, root cause analyses, and other relevant documents. The list below shows the performance indicators for each of the following QSV program activities.

- Senior-level committee responsible for key QSV functions
  - Met at least quarterly
  - Chaired or co-chaired by the Facility Director
  - Reviewed aggregated data routinely
- Protected peer reviews
  - Examined important aspects of care (appropriate and timely ordering of diagnostic tests, timely treatment, and appropriate documentation)
  - Resulted in implementation of Peer Review Committee recommended improvement actions
- Credentialing and privileging processes
  - Considered frequency for Ongoing Professional Practice Evaluation (OPPE)[26] data review
  - Indicated a Focused Professional Practice Evaluation[27]

[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] OPPE is the ongoing monitoring of privileged practitioners to identify professional practice trends that impact the quality of care and patient safety.

- UM personnel
  - Completed at least 75 percent of all required inpatient reviews
  - Documented Physician UM Advisors' decisions in the National UM Integration database
  - Reviewed UM data using an interdisciplinary group
- Patient safety personnel
  - Entered all reported patient incidents into the WEBSPOT database
  - Completed the required minimum of eight root cause analyses
  - Reported root cause analysis findings to reporting employees
  - Submitted an annual patient safety report

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

Peer Review. VHA requires that when the Peer Review Committee recommends individual improvement actions as a result of peer review, clinical managers implement the actions. Peer review can result in both immediate and long-term improvements in patient care by revealing areas for improvement in the practice of one or multiple providers. For the eight peer reviews where the Peer Review Committee documented a need for individual improvement actions, there was no evidence that clinical managers or service chiefs implemented the actions. OIG found that the peer review coordinators failed to communicate necessary actions with service chiefs and ensure implementation of improvement actions.

Recommendation

1. The Chief of Staff ensures that clinical managers communicate to the Peer Review Committee all completions of individual improvement actions and monitors managers' compliance.

[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: May 31, 2018

Facility Response: A Protected Peer Review Follow-Up Action Form will be completed on all Level 2 and 3 reviews. The Risk Manager is responsible for documenting the Peer Review Committee's recommendations for improvement on the form and sending to the provider's Service Chief. The Service Chief is responsible for updating the provider on the Peer Review Committee's recommendations and the form is signed by both the Service Chief and provider. The Service Chief is responsible for monitoring compliance and will report compliance to the Peer Review Committee monthly until there is documented 90 percent or greater compliance for three consecutive months. Compliance with improvement action plans will be included in the Peer Review Committee's quarterly report to the Medical Executive Board.

Credentialing and Privileging. VHA requires that credentialing and privileging includes review of OPPE data on a regular basis as defined by local policy, which, at this facility, requires clinical managers to review OPPE data quarterly. The ongoing monitoring of privileged practitioners is essential to confirm the quality of care delivered and allows the facility to identify professional practice trends that impact patient safety. Thirteen of the 27 profiles OIG reviewed did not contain evidence that service chiefs reviewed OPPE data quarterly. Managers stated that PC administrative staff positions were not filled, so clerical steps in the process were not completed.

Recommendation

2. The Chief of Staff ensures clinical managers consistently review Ongoing Professional Practice Evaluation data with the frequency required by facility policy and monitors the managers' compliance.

Facility Concurred.

Target date for completion: July 31, 2018

Facility response: With revision of the Medical Staff Bylaws, OPPE data is now reported to the MEB every six months for each service as assigned. All supporting documentation, including chart reviews and files, will be maintained by the Medical Staff Coordinator. Compliance will be reported in the Medical Executive Board meeting minutes. Based on the newly established reporting grid, the Chief of Staff will monitor the process until 90 percent compliance is noted with sustained improvement over six months.

Medication Management: Anticoagulation Therapy

Comprehensive medication management is defined as the standard of care that ensures clinicians individually assess each patient's medications to determine that each is appropriate for the patient, effective for the medical condition, safe given the comorbidities and other medications prescribed, and able to be taken by the patient as intended. From October 1, 2015 through September 30, 2016, more than 482,000 veterans received an anticoagulant,[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 10 employees actively involved in the anticoagulant program and interviewed key employees. Additionally, OIG reviewed the electronic health records (EHRs) of 28 randomly selected patients who were prescribed new anticoagulant medications from July 1, 2015 through June 30, 2016. The list below shows the performance indicators examined.

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

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

Conclusions. Generally, OIG noted safe anticoagulation therapy management practices and compliance with many of the performance indicators listed above such as policy content, risk minimization of dosing errors, and transition follow-up and education for patients with newly prescribed anticoagulant medications. However, OIG identified deficiencies with laboratory testing and competencies that warranted recommendations for improvement.

Laboratory Testing. VHA requires clinicians to obtain international normalized ratio (INR) measurements within 7 days for all patients initiated of warfarin. This allows clinicians to monitor patients while receiving the anticoagulant and ensure that any underlying medical conditions are addressed. Two of 13 applicable patients had an INR measurement taken later than the required 7 day period. Clinicians lacked awareness of required timing for the INR tests, and clinical managers failed to provide oversight.

Recommendation

3. The Chief of Staff requires clinicians to ensure patients with newly prescribed warfarin have international normalized ratio measurements taken within 7 days of warfarin initiation, and monitor compliance.

Facility Concurred.

Target date for completion: June 1, 2018

Facility Response: Medical Center Memorandum 119-40, Anticoagulation Program, as updated, sets the standard for newly initiated patients on anticoagulation therapy to be seen within 7 days of initiation of therapy or hospital discharge. Ongoing evaluation of this item will be incorporated into the OPPE effective January 15, 2018. There will be monthly monitoring on all records of patients started on new anticoagulation medications by the Chief of Pharmacy on compliance for each provider until there is 90 percent compliance for three consecutive months. Compliance is reported to the Medical Executive Board.

Competencies. VHA requires that competencies specific to anticoagulant therapy management are included in the competency plans for employees who provide care for patients receiving anticoagulation therapy. The facility also requires annual assessment of these competencies. This is to ensure clinicians are current in their knowledge and practice to provide high-quality, evidence-based management of anticoagulants to reduce the likelihood of patient harm. Seven of the 10 employees did not have anticoagulation therapy competency assessments completed annually. Program managers were aware of requirements but lacked attention to detail and failed to monitor the program efficiently.

Recommendation

4. The Chief of Staff requires clinical managers to complete competency assessments annually for employees actively involved in the anticoagulant program and monitors managers' compliance.

Facility Concurred.

Target date for completion: March 31, 2018

Facility Response: Anticoagulant therapy management competencies will be assessed annually for employees actively involved in the anticoagulant program. There will be monthly monitoring by the Chief of Pharmacy of compliance for each provider until there is 90 percent compliance for three consecutive months. Compliance is reported to the Medical Executive Board.

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 44 randomly selected patients who were transferred out of facility inpatient beds or the Emergency Department/urgent care center to another VHA facility or non-VA facility from July 1, 2015 through June 30, 2016. The list below shows the performance indicators OIG examined.

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

Conclusions. OIG noted that the facility developed and implemented a patient transfer policy and collected and reported data about transfers out. The facility also met the performance indicators evaluated for resident supervision, nurse documentation of transfer assessments/notes, provider documentation for emergent transfers, and

communication with the accepting facility. However, OIG identified a deficiency in the identification of a licensed independent provider at the receiving facility that warranted a recommendation for improvement.

Transfer Documentation. VHA requires that transferring clinicians identify the receiving provider on VA Form 10-2649A and/or in transfer/progress notes. This ensures receiving providers are aware of patients' needs and level of care after transfer. For 5 of 44 patients (11 percent), transfer documentation did not include identification of the receiving provider. The clinicians involved in these transfers lacked knowledge of and/or training specific to VHA transfer policy requirements.

Recommendation

5. The Chief of Staff ensures clinicians consistently include identification of the receiving provider in transfer documentation and monitors the clinicians' compliance.

Facility Concurred.

Target date for completion: April 30, 2018

Facility Response: The electronic VA Interfacility Transfer Form 10-2649A was updated to make the entry of the name of the transferring and receiving physician or designee a required field in the template. Medical record audits are being performed by the Nurse Manager, Flow Depot, to validate that the VA Form 10-2649A is being completed, including the name of the transferring and receiving physician or designee. Monthly audits will continue on all records of patients transferred out until there is 90 percent compliance for three consecutive months. Results of the monthly audits are reported to the Patient Flow Committee who subsequently reports to Medical Executive Board quarterly.

Environment of Care

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

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

OIG inspected the medical/surgical, hospice, the intensive care, the spinal cord, same day surgery/post-anesthesia care, and the locked MH units; the Community Living Center; Radiology Service; the Emergency Department; and the women's clinic. OIG also inspected the Chesapeake CBOC. Additionally, OIG reviewed relevant documents and 19 employee training records and interviewed key employees and managers. The list below shows the location-specific performance indicators selected to examine the risk areas specific to particular settings.

<u>Parent Facility</u>

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

[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
- IT network room security
- Availability of medical equipment and supplies

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

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

Conclusions. The parent facility met the performance indicators evaluated for general safety, infection prevention, cleanliness, and privacy. The representative CBOC generally met requirements for infection prevention, cleanliness, medication safety and security, and privacy. OIG did not identify any issues with the Radiology Service performance indicators reviewed. The locked MH unit performed required inspections, had processes in place for suicide hazard identification and abatement, and met infection prevention requirements. OIG did not note any issues with the availability of medical equipment and supplies. However, OIG identified the following deficiencies at the parent facility, at the representative CBOC, and on the locked MH unit that warranted recommendations for improvement.

Parent Facility: Environment of Care Rounds Frequency. VHA requires EOC rounds to be conducted at a minimum of once per FY in non-patient care areas and twice per FY in patient care areas. This ensures a safe, clean, and functional health care environment. OIG reviewed FY 2016[31] facility EOC rounds records and observed that 6 of 46 (13 percent) patient care areas were not inspected at the required frequency.

[31] October 2015 through September 2016.

Facility managers were unaware of the requirement that EOC rounds are to be conducted on a FY basis rather than on a calendar year cycle.

Recommendation

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

Facility Concurred.

Target date for completion: June 30, 2018

Facility Response: The EOC inspection schedules were updated to reflect biannual visits for clinical areas and annual for all other areas. The Associate Director will monitor compliance with assigned rounding schedules until there is 90 percent or higher compliance for three consecutive months and report results to the Administrative Executive Board.

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.[32] OIG reviewed Comprehensive EOC Assessment and Compliance Tool documentation for FY 2016[33] and observed that 9 of 13 EOC core team members did not consistently attend EOC rounds. Facility managers were aware of requirements but due to conflicting priorities or emergent situations, they were unable to attend rounds as scheduled.

Recommendation

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

Facility Concurred.

Target date for completion: June 30, 2018

Facility Response: Medical Center Memorandum 590-001-09, Environment of Care Survey Program, is updated to reflect that attendance for EOC rounds is mandatory for required members. Primary team members are required to have at least one staff member designated as an alternate to participate in the EOC rounds in the absence of the primary member. The Associate Director will monitor attendance compliance until there is 90 percent compliance for three consecutive months. Compliance is reported to Administrative Executive Board.

[32] 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.
[33] October 2015 through September 2016.

Community Based Outpatient Clinic: Exam Room Panic Alarms. VHA requires facilities to ensure that appropriate physical security precautions and equipment are implemented, used, and tested. This ensures the safety of patients and staff. At the Chesapeake CBOC, OIG found no evidence of panic alarm testing during the months of February and May 2017. Managers were aware of noncompliance and failed to take follow-up action due to staffing issues.

Recommendation

8. The Associate Director ensures the Chesapeake community based outpatient clinic panic alarms are tested monthly and monitors compliance.

Facility Concurred.

Target date for completion: June 30, 2018

Facility Response: The VA police performed a physical security survey of the Chesapeake CBOC on December 14, 2017. All panic alarms were tested and all were fully functional. The Associated Director will monitor compliance with monthly testing until 90 percent compliance is obtained for three consecutive months. Compliance for performing the monthly panic alarm testing is reported to the EOC Committee.

Community Based Outpatient Clinic: Logistics. VHA requires that clean and sterile supplies stored on the bottom shelf of an open shelf cart have a physical barrier between the shelf and traffic or housekeeping activities to prevent contamination of stored supplies. At the Chesapeake CBOC, OIG found clean supplies stored on an open shelf cart without a solid bottom. Senior managers knew the requirements; however, inadequate oversight and staff's lack of awareness of requirements contributed to noncompliance.

Recommendation

9. The Associate Director ensures storage carts and shelves at the Chesapeake Community Based Outpatient Clinic have solid bottom shelves and monitors compliance.

Facility Concurred.

Target date for completion: June 30, 2018

Facility Response: A solid plastic bottom was added to each supply bin on the bottom shelf of the supply shelving units at the Chesapeake CBOC. Monthly checks of storage carts to validate solid bottom shelves will be done by the Charge Nurse and reported to the EOC Committee until there is 90 percent compliance for three consecutive months.

Locked Mental Health Unit: Panic Alarm Testing. VHA requires that facilities ensure rapid response by VA Police to panic alarm activation within locked inpatient MH units to provide immediate support to staff, patients, and visitors to secure a safe environment. Panic alarm testing for locked inpatient MH units is required to be

documented in a log that includes VA Police response time. Although panic alarm testing was conducted on the locked MH unit for the months of May and June 2017, VA Police response time was not documented. VA Police Service employees were unaware of the requirement.

Recommendation

10. The Associate Director ensures locked mental health unit panic alarm testing includes documentation of VA Police response time and monitors compliance.

Facility Concurred.

Target date for completion: June 30, 2018

Facility Response: VA police response time is now documented with monthly panic alarm testing in the locked mental health unit. The Associate Director will monitor compliance until 90 percent compliance is obtained for three consecutive months. Compliance for performing the monthly panic alarm testing is reported to the EOC Committee.

Locked Mental Health Unit: Security Surveillance Television System. VA requires that when surveillance television systems are in use, performance checks should be conducted daily and substitute coverage be provided during maintenance or breakdown periods. Seven of the 32 (22 percent) cameras located on the locked MH unit were non-functional. VA Police Service employees told OIG that the cameras located on the locked MH unit are part of three separate systems that cannot be upgraded. The facility is expecting to have a new surveillance system in place within the next 1 or 2 years.

Recommendation

11. The Associate Director ensures that adequate security surveillance is provided through functional and regularly tested equipment and monitors compliance.

Facility Concurred.

Target date for completion: June 30, 2018

Facility Response: A Risk Assessment was performed during the week of December 18, 2017 with a physical security survey of the locked mental health unit. Until the new surveillance system is in place, the locked mental health unit staff are performing patient rounding every fifteen minutes, entrance and exit doors are locked, and two staff members are present whenever a patient is utilizing the outside courtyard. Two of the observation/seclusion rooms that were identified as having non-functional cameras are not in use. Compliance with rounding will be documented on the Charge Nurse Shift Report and monitored by the Chief Nurse, Mental Health, until there is 90 percent compliance for three months. Compliance will be reported to the EOC Committee and subsequently the Administrative Executive Board.

Locked Mental Health Unit: Employee and Interdisciplinary Safety Inspection Team Training. VHA requires that staff assigned to work on the locked MH unit and Interdisciplinary Safety Inspection Team members receive training on the identification and correction of environmental hazards, including the proper use of the MH EOC Checklist. This ensures they possess the necessary knowledge and skills to perform inspections of the locked MH unit in order to assure staff, patient, and visitor safety. The 12 locked MH unit employees and 4 of 7 Interdisciplinary Safety Inspection Team members did not complete the training within the past 12 months (June 2016 to July 2017). Facility managers did not have a clear understanding of which staff members were required to complete the online training through the VA Talent Management System and as a result, had not assigned the training.

Recommendation

12. The Associate Director ensures locked mental health unit employees and Interdisciplinary Safety Inspection Team members receive annual training for identification and correction of environmental hazards and proper use of the Mental Health Environment of Care Checklist and monitors compliance.

Facility Concurred.

Target date for completion: June 30, 2018

Facility Response: The Patient Safety Manager will ensure Interdisciplinary Safety Inspection Team members and locked Mental Health unit employees complete required Talent Management System (TMS) training for identification and correction of environmental hazards and proper use of the Mental Health EOC Checklist prior to conducting inspections. Completion of this training requirement has also been added to the mental health unit employee orientation checklist. This required training will be completed by Staff on the locked Mental Health unit by the target date of June 30, 2018. Compliance will be monitored monthly by the Patient Safety Manager until there is 90 percent compliance for three consecutive months. Compliance will be reported to the EOC Committee.

High Risk Processes: Moderate Sedation

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

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

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

OIG reviewed relevant documents, interviewed key employees, and inspected the intensive care unit, same day surgery/post-anesthesia care unit, endoscopy, and operating room procedure areas to assess whether required equipment and sedation medications were available. Additionally, OIG reviewed the EHRs of 49 randomly selected patients who underwent an invasive procedure involving moderate sedation from July 1, 2015 through June 30, 2016, and the training records of 12 clinical employees (nine nursing staff and three physicians) who performed or assisted during these procedures. The list below shows the performance indicators OIG reviewed.

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

[34] American Society of Anesthesiologists (ASA), Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists, 2002. Anesthesiology 2002; 96:1004-17.
[35] VA National Center for Patient Safety. 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.
[36] VHA Directive 1073, *Moderate Sedation by Non-Anesthesiology Providers*, December 30, 2014.
[37] Per VA Corporate Data Warehouse data pull on February 22, 2017.

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

Conclusions. Generally, OIG found compliance with reporting and trending the use of reversal agents, re-evaluating patients before moderate sedation, informed consent documentation and time-outs, post-procedure assessments, and discharge practices. OIG identified deficiencies with history and physical examinations and/or pre-sedation assessments and physician training that warranted recommendations for improvement.

History and Physical Exams and/or Pre-Sedation Assessments. VHA requires that providers perform a history and physical within 30 calendar days prior to the moderate sedation procedure and/or a pre-sedation assessment. The combination of the patient's history and physical and pre-sedation assessment must include required elements such as review of abnormalities of major organ systems, assessment of the airway, and a history of any previous adverse experience with sedation and anesthesia. This ensures providers are aware of relevant patient information and assessments that may affect the patient's response to moderate sedation. For 38 of the 49 patients (78 percent), providers did not document whether the patient had a history of previous adverse experience with sedation and anesthesia in the history and physical and/or pre-sedation assessment. Surgery and Medicine Service staff were unaware of this requirement.

Recommendation

13. The Chief of Staff ensures providers include a history of previous adverse experience with sedation and anesthesia in the history and physical and/or pre-sedation assessment and monitors providers' compliance.

Facility Concurred.

Target date for completion: May 31, 2018

Facility Response: The Pre-Procedure/History and Physical Computerized Patient Record System (CPRS) templates were revised to include questions regarding previous general anesthesia and previous complications from anesthesia. These new questions are a required field in the template. Providers were educated on the new template. The Chief of Staff will monitor compliance with required documentation by review of a random sample of 30 cases per month, until there is 90 percent or greater compliance for three consecutive months. Results will be reported monthly to the Medical Executive Board and reflected in the minutes.

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

Moderate Sedation Training for Physicians. VHA requires that an individual who administers, monitors, or supervises moderate sedation must demonstrate sufficient knowledge to care for a patient receiving moderate sedation through successful completion of VA Talent Management System moderate sedation training prior to re-privileging. This promotes patient safety and quality of care. Two of the three physicians reviewed who had already been re-privileged completed the training during the week OIG was onsite. Surgery and Medicine Service staff believed physician training was up to date and were not aware of the specific moderate sedation training requirements.

Recommendation

14. The Chief of Staff ensures that physicians who perform or assist with moderate sedation procedures receive training for the provision of moderate sedation care prior to being re-privileged and that training is documented and monitors compliance with training and documentation.

Facility Concurred.

Target date for completion: March 31, 2018

Facility Response: All physicians with privileges for moderate sedation have completed the moderate sedation training module. The Initial Privileging Request and Reappraisal Request Checklists have been updated to include the question "Requesting Moderate Sedation" (Yes or No) and the TMS Moderate Sedation training module completion date. These checklists are completed by the provider prior to the initial privileging and reappraisal processes to validate that the Moderate Sedation training module has been completed within 90 days of the initial privileging or re-privileging process. These checklists are reviewed during the Medical Executive Board Credentialing and Privileging meeting. Chief of Staff will monitor compliance monthly until 100 percent compliance with completed provider training.

Long-Term Care: Community Nursing Home Oversight

Since 1965, VHA has provided nursing home care under contracts. VHA facilities must integrate the CNH program into their Quality Improvement Programs. The Facility Director establishes the CNH Oversight Committee, which reports to the chief clinical officer (Chief of Staff, Nurse Executive, or the equivalent) and includes multidisciplinary management-level representatives from social work, nursing, quality management, acquisition, and the medical staff. The CNH Oversight Committee must meet at least quarterly.[39] Local oversight of CNHs is achieved through annual reviews and monthly visits.

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

OIG interviewed key employees and reviewed relevant documents and the results from CNH annual reviews completed July 5, 2015 through June 30, 2016. Additionally, OIG reviewed the EHRs of 41 randomly selected patients who received CNH care for more than 3 months during the timeframe July 1, 2015 through June 30, 2016. The list below shows the performance indicators OIG reviewed.

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

The performance indicator below did not apply to this facility.

- Documentation of hand-off for patients placed in CNHs outside catchment area

Conclusions. OIG identified deficiencies with the CNH Oversight Committee and program integration, annual reviews, and clinical visits that warranted recommendations for improvement.

Oversight Committee. VHA requires the CNH Oversight Committee to meet at least quarterly and to include representation from social work, nursing, quality management, acquisitions, and the medical staff. Committee oversight functions include verifying completeness of the CNH Review Teams initial, annual, and problem focused CNH evaluations. This multidisciplinary review and perspective helps to ensure that VHA contracted nursing homes provide quality care in a safe environment. VHA also 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

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

function and quality of life. The facility's CNH Oversight Committee did not meet quarterly, include representatives from quality management and acquisitions, or integrate the CNH program into the facility's quality improvement program. The CNH Oversight Committee chair did not conduct sufficient committee and program oversight and was unaware of meeting frequency and multidisciplinary requirements.

Recommendation

15. The Facility Director ensures that the Community Nursing Home Oversight Committee meets at least quarterly, includes representatives from all required disciplines, and integrates processes into the facility's quality improvement program with documentation of these processes in the facility's executive-level committee meeting minutes and monitors compliance.

Facility Concurred.

Target date for completion: July 31, 2018

Facility Response: The Community Nursing Home Oversight Subcommittee will meet quarterly. Membership was expanded to include Quality Management and Acquisition representatives to meet membership requirements as outlined in VHA Handbook 1143.02, Community Nursing Home Oversight Procedures. The Home and Community Care Manager will monitor compliance of meeting frequency, integrate processes into the facility's quality improvement program, and inclusion of required attendance until there is 90 percent compliance for six consecutive months. Compliance will be reported quarterly to the Geriatrics and Extended Care Committee, which reports to the Medical Executive Board.

Annual Reviews. VHA requires CNH Review Teams to complete annual reviews of all CNHs under VA contract. These reviews must include an analysis of the most recent state survey to ensure CNHs meet all state licensing requirements and are safe for veteran patients. VHA also requires that when CNH annual reviews note four or more exclusionary criteria, facility managers complete exclusion review documentation. This ensures the Contracting Officer has the information necessary to determine whether or not to continue the contract with the CNH.

The facility's CNH Review Team did not complete 3 of 13 CNH annual reviews within the review period of July 5, 2015 to June 30, 2016. Additionally, facility managers did not complete requests for exclusionary criteria exemptions for one CNH that met the criteria of four or more deficiencies where three patients resided. Members of the team did not have a process in place to ensure that reviews were completed as required. Senior managers did not provide required oversight of the CNH Review Team to ensure the team conducted annual reviews within the required timeframe and submitted requests for exclusionary criteria exemptions.

Recommendation

16. The Chief of Staff ensures the Community Nursing Home Review Team completes annual reviews within the required timeframe and submits exclusionary criteria exemption requests when a community nursing home meets the threshold of four or more deficiencies and monitors the team's compliance.

Facility Concurred.

Target date for completion: July 31, 2018

Facility Response: The Community Nursing Home Review Team completes and documents the required annual reviews in VHA's National Tracking Tool. If a community nursing home exceeds the threshold of four or more deficiencies, then those deficiencies are addressed accordingly. The Home and Community Care Manager ensures completion of the reviews and tracks any identified deficiencies, and subsequently reports to the Geriatrics and Extended Care Committee. The Chief of Staff will monitor reporting compliance until there is 90 percent compliance for six consecutive months and results will be reported in the MEB minutes.

Monthly 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 registered nurses must alternate monthly visits unless otherwise indicated by the patient's visit plan. This interdisciplinary monitoring ensures vulnerable nursing home patients consistently receive quality care and necessary follow-up services. Forty of 41 patients' EHRs (98 percent), did not contain evidence of social worker and/or registered nurse cyclical clinical visits with the frequency required by VHA policy. CNH nursing and social work managers knew about the requirements and were assigned to conduct monthly visits, but failed to ensure that visits were completed as required.

Recommendation

17. The Chief of Staff ensures 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 monitors social workers' and registered nurses' compliance.

Facility Concurred.

Target date for completion: October 31, 2018

Facility Response: The Home and Community Care Manager, in collaboration with the Social Worker and Registered Nurse, established a monthly alternating clinical visit schedule in accordance with VHA Handbook 1143.02, Community Nursing Home Oversight Procedures. The monthly patient visits are documented in the CPRS and are tracked via patient spreadsheet. An audit of a representative sample of monthly clinical visits is conducted to validate that clinical visits are completed and documented in CPRS. The results of these audits are reported to the Geriatrics and Extended Care Committee who subsequently report results to the Medical Executive Board. The Chief of Staff will monitor compliance until there is 90 percent compliance for six consecutive months.

Mental Health Residential Rehabilitation Treatment Program

For this facility, OIG evaluated the MH RRTP, more commonly referred to as domiciliary or residential treatment programs. This distinct level of MH residential care is appropriate for veterans with mental illnesses or addictive disorders who require structure and support to address psychosocial deficits, including homelessness and unemployment.

MH RRTPs provide 24-hour residential rehabilitative and clinical care in a therapeutic setting to eligible veterans who have multiple and severe medical conditions, mental illness, addiction, or psychosocial deficits. They provide the least intensive level of VA inpatient care and differ from acute inpatient and nursing home care as veterans in MH RRTPs are generally capable of self-care. MH RRTPs address rehabilitation, recovery, health maintenance, improved quality of life, and community integration in addition to specifically treating medical conditions, mental illnesses, and addictive disorders. Facility leaders must provide a safe, well-maintained, and appropriately-furnished residential environment that supports and enhances recovery efforts.[40]

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

OIG reviewed relevant documents; inspected the Domiciliary Care for Homeless Veterans Program, the general domiciliary, and the Substance Abuse and Post-Traumatic Stress Disorder RRTPs; and interviewed key employees and managers. The list below shows the performance indicators OIG reviewed.

- Environmental cleanliness
- Appropriate fire extinguishers near grease producing cooking devices
- Policies/procedures for safe medication management and contraband detection
- Performance and documentation of monthly self-inspections to include all required elements, work orders for items needing repair, and correction of identified deficiencies
- Performance and documentation of contraband inspections, rounds of all public spaces, daily bed checks, and resident room inspections for unsecured medications
- Written agreements in place acknowledging resident responsibility for medication security
- Keyless entry to MH RRTP main point(s) of entry, closed circuit television monitoring, and all other doors locked to outside and alarmed
- Closed circuit television (CCTV) monitors with recording capability in public areas but not in treatment areas or private spaces
- Signage alerting veterans and visitors of CCTV recording

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

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

Conclusions. Generally, OIG found compliance with cleanliness, fire safety, policies/procedures for safe medication management and contraband detection, most required inspections, medication security, employees' knowledge of processes for behavioral health and medical emergencies, and women veterans' security. However, OIG identified deficiencies with medication inspections and the security surveillance television system that warranted recommendations for improvement.

*Medication Inspections***.** VHA requires MH RRTP employees to conduct and document daily inspections of all resident's rooms to detect unsecured medications. This ensures a safe environment and promotes a sense of well-being for all the residents. For the 13-day period June 25 through July 7, 2017, MH RRTP employees did not consistently conduct and document daily resident room inspections for unsecured medications. The Domiciliary Care for Homeless Veterans Program and the general domiciliary missed inspections for 4 of the 13 days. The Substance Abuse and Post-Traumatic Stress Disorder RRTPs missed inspections for 2 of the 13 days. Program managers and staff were aware of the requirements; noncompliance was due to lack of program managers' oversight.

Recommendation

18. The Associate Director ensures that Domiciliary Care for Homeless Veterans Program, general domiciliary, and Substance Abuse and Post-Traumatic Stress Disorder Residential Rehabilitation Treatment Program employees conduct and document daily resident room inspections for unsecured medications and monitors employees' compliance.

Facility Concurred.

Target date for completion: May 31, 2018

Facility Response: The MHRRTP daily rounds sheet has been updated to include a checklist for validating that resident's medications are secured. Any instances of non-compliance are reported to the Chief, MHRRTP for their immediate action. Compliance for residents securing their medications is reported to the Mental Health Executive Committee who subsequently reports results to the Medical Executive Board. The Chief, MHRRTP will monitor daily rounding sheets monthly until there is 90 percent compliance for three consecutive months.

*Closed Circuit Surveillance Television System***.** VHA requires a functional closed circuit surveillance television system with recording capability to be located at the main point(s) of entry and in public areas of MH RRTP units to ensure the safety of staff, patients, and visitors. Twelve of the 48 cameras in the MH RRTPs (25 percent) were non-functional. Managers stated that the facility has three different surveillance systems in place and

the cameras located in the MH RRTPs are part of an obsolete system and expect the facility to have a new surveillance system in place within the next 1 or 2 years.

Recommendation

19. The Associate Director ensures that adequate security surveillance is provided through functional and regularly tested equipment and monitors compliance.

Facility Concurred.

Target date for completion: April 30, 2018

Facility Response: A Risk Assessment was performed during the week of December 18, 2017 with a physical security survey of the MHRRTP unit. Until the new surveillance system is in place, VA police are conducting security rounds at least twice a shift and documenting in the VA Police Daily Observation Journal and the MHRRTP staff are performing hourly rounding on the unit. Contract security guards are in place at the two entrances to the MHRRTP unit 24 hours-a-day, 7 days-a-week for enhanced security of residents, visitors and staff. Compliance will be reported to the EOC Committee and subsequently the Administrative Executive Board. The Chief, VA Police will monitor police rounding compliance monthly until they're in 90 percent or greater compliance for three consecutive months. The Chief, MHRRTP will monitor daily rounding sheets monthly until there is 90 percent compliance for three consecutive months.

Summary Table of Comprehensive Healthcare Inspection Program Review Findings

Healthcare Processes	Performance Indicators	Conclusion	
Leadership and Organizational Risks	• Executive leadership stability and engagement • Employee satisfaction and patient experience • Accreditation/for-cause surveys and oversight inspections • Indicators for possible lapses in care • VHA performance data	Nineteen OIG recommendations, ranging from documentation issues to deficiencies that can lead to patient and staff safety issues or adverse events, are attributable to the Facility Director, Chief of Staff, and Associate Director. See details below.	
Healthcare Processes	**Performance Indicators**	**Critical Recommendations[41] for Improvement**	**Recommendations for Improvement**
Quality, Safety, and Value	• Senior-level involvement in QSV/performance improvement committee • Protected peer review of clinical care • Credentialing and privileging • UM reviews • Patient safety incident reporting and root cause analyses	• Clinical managers consistently review OPPE data with the frequency required by facility policy.	• Clinical managers communicate to the Peer Review Committee all completions of individual improvement actions.
Medication Management	• Anticoagulation management policies and procedures • Management of patients receiving new orders for anticoagulants o Prior to treatment o During treatment • Ongoing evaluation of the anticoagulation program • Competency assessment	• Clinicians ensure patients newly prescribed warfarin have an international normalized ratio measurement taken within 7 days of warfarin initiation.	• Clinical managers complete competency assessments annually for employees actively involved in the anticoagulant program.

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

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Coordination of Care	• Transfer policies and procedures • Oversight of transfer process • EHR documentation o Non-emergent transfers o Emergent transfers	• Clinicians consistently include identification of the receiving provider in transfer documentation.	• None
Environment of Care	• Parent facility o EOC deficiency tracking and rounds o General Safety o Infection prevention o Environmental cleanliness o Exam room privacy o Availability of feminine hygiene products and medical equipment and supplies • CBOC o General safety o Infection prevention o Environmental cleanliness o Medication safety and security o Privacy o Availability of feminine hygiene products and medical equipment and supplies o IT network room security • Radiology o Safe use of fluoroscopy equipment o Environmental safety o Infection prevention o Medication safety and security o Radiology equipment inspection o Availability of medical equipment and supplies o Maintenance of radiological equipment • Inpatient MH o MH EOC inspections o Environmental suicide hazard identification o Employee training o Environmental safety o Infection prevention o Availability of medical equipment and supplies	• Panic alarms in the Chesapeake CBOC are tested monthly. • Adequate security surveillance is provided through functional and regularly tested equipment.	• All areas of the facility are inspected at the required frequency. • Core team members consistently attend EOC rounds. • Storage carts and shelves at the Chesapeake CBOC have solid bottom shelves. • Locked MH unit panic alarm testing includes documentation of VA Police response time. • Locked MH unit employees and Interdisciplinary Safety Inspection Team members receive annual training for identification and correction of environmental hazards and proper use of the Mental Health Environment of Care Checklist

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
High-Risk and Problem-Prone Processes: Moderate Sedation	• Outcomes reporting • Patient safety and documentation o Prior to procedure o After procedure • Staff training and competency • Monitoring equipment and emergency management	• Providers include a history of previous adverse experience with sedation and anesthesia in the history and physical and/or pre-sedation assessment.	• Physicians who perform or assist with moderate sedation procedures receive moderate sedation training prior to being re-privileged.
Long-Term Care: Community Nursing Home Oversight	• CNH Oversight Committee and CNH program integration • EHR documentation o Patient hand-off o Clinical visits • CNH annual reviews	• The CNH Review Team completes annual reviews within the required timeframe and submits exclusionary criteria exemption requests when a CNH meets the threshold of four or more deficiencies. • Social workers and registered nurses conduct and document cyclical clinical visits with the frequency required by VHA policy.	• The CNH Oversight Committee meets at least quarterly, includes representatives from all required disciplines, and integrates processes into the facility's quality management program with documentation of these processes in the facility's executive-level committee meeting minutes.
Mental Health Residential Rehabilitation Treatment Program	• Environmental cleanliness and fire safety • Policies/procedures o Safe medication management o Contraband detection • Monthly self-inspections • Contraband and unsecured medication inspections • Locked and alarmed entries • Closed circuit television monitors with recording capability in public areas • Process for responding to behavioral health and medical emergencies	• MH RRTP employees conduct and document daily resident room inspections for unsecured medications. • Adequate security surveillance is provided through functional and regularly tested equipment.	• None

Facility Profile

The table below provides general background information for this mid-high complexity (1c)[42] affiliated[43] facility reporting to VISN 6.

Table 5. Facility Profile for Hampton (590) for October 1, 2013 through September 30, 2016

Profile Element	Facility Data FY 2014[44]	Facility Data FY 2015[45]	Facility Data FY 2016[46]
Total Medical Care Budget in Millions	$284.3	$319.5	$356.8
Number of:			
• **Unique Patients**	48,385	48,996	50,546
• **Outpatient Visits**	499,011	513,185	527,841
• **Unique Employees**[47]	1,419	1,477	1,587
Type and Number of Operating Beds:			
• **Acute**	106	87	87
• **Mental Health**	40	40	40
• **Community Living Center**	122	122	122
• **Domiciliary**	169	169	169
Average Daily Census:			
• **Acute**	51	50	57
• **Mental Health**	28	31	27
• **Community Living Center**	65	70	72
• **Domiciliary**	143	143	128

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.

[42] 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
[43] Associated with a medical residency program.
[44] October 1, 2013 through September 30, 2014.
[45] October 1, 2014 through September 30, 2015.
[46] October 1, 2015 through September 30, 2016.
[47] Unique employees involved in direct medical care (cost center 8200).

VA Outpatient Clinic Profiles[48]

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

Table 6. VA Outpatient Clinic Workload/Encounters[49] and Specialty Care, Diagnostic, and Ancillary Services Provided for October 1, 2015 through September 30, 2016

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services[50] Provided	Diagnostic Services[51] Provided	Ancillary Services[52] Provided
Virginia Beach, VA	590GB	11,536	7,702	Dermatology Endocrinology Eye	NA	Nutrition Pharmacy Weight Management
Elizabeth City, NC	590GC	5,147	4,005	Dermatology Eye General Surgery	NA	Nutrition Pharmacy Weight Management
Chesapeake, VA	590GD	12,458	3,394	Endocrinology	NA	NA

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

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

NA = Not applicable

[48] Includes all outpatient clinics in the community that were in operation as of February 15, 2017.
[49] An encounter is a professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition.
[50] Specialty care services refer to non-PC and non-MH services provided by a physician.
[51] Diagnostic services include EKG, EMG, laboratory, nuclear medicine, radiology, and vascular lab services.
[52] Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

VHA Policies Beyond Recertification Dates

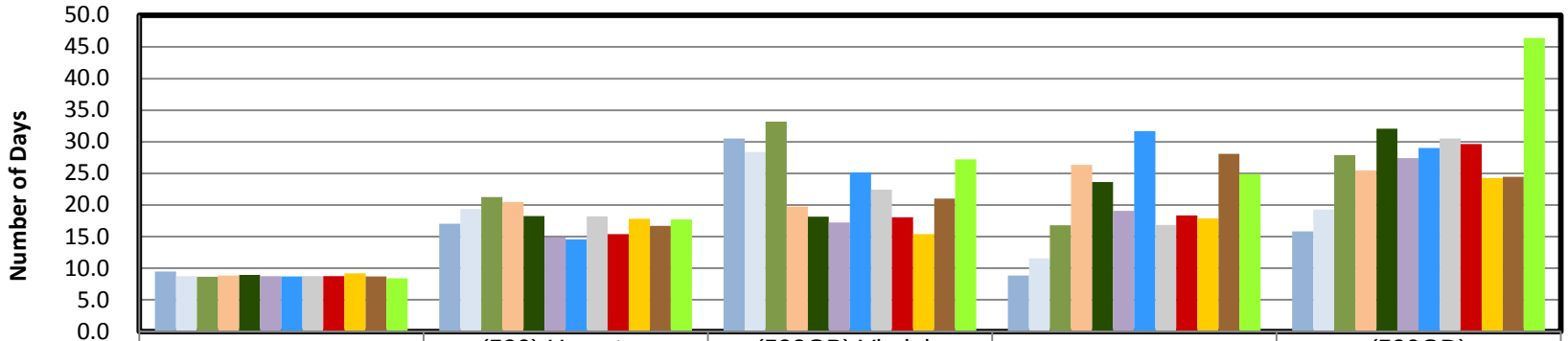
In this report, OIG cited four policies that were beyond the recertification date:

1. VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010 (recertification due date June 30, 2015).
2. VHA Handbook 1105.04, *Fluoroscopy Safety*, July 6, 2012 (recertification due date July 31, 2017).
3. VHA Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures*, June 4, 2004 (recertification due date January 31, 2009).
4. VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010 (recertification due date December 31, 2015).

OIG considered these policies to be in effect, as they had not been superseded by more recent policy or guidance. In a June 29, 2016, memorandum to supplement policy provided by VHA Directive 6330(1),[53] the VA Under Secretary for Health mandated the "…continued use of and adherence to VHA policy documents beyond their recertification date until the policy is rescinded, recertified, or superseded by a more recent policy or guidance."[54] The Under Secretary for Health also tasked the Principal Deputy Under Secretary for Health and Deputy Under Secretaries for Health with ensuring "…the timely rescission or recertification of policy documents over which their program offices have primary responsibility."[55]

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

Patient Aligned Care Team Compass Metrics

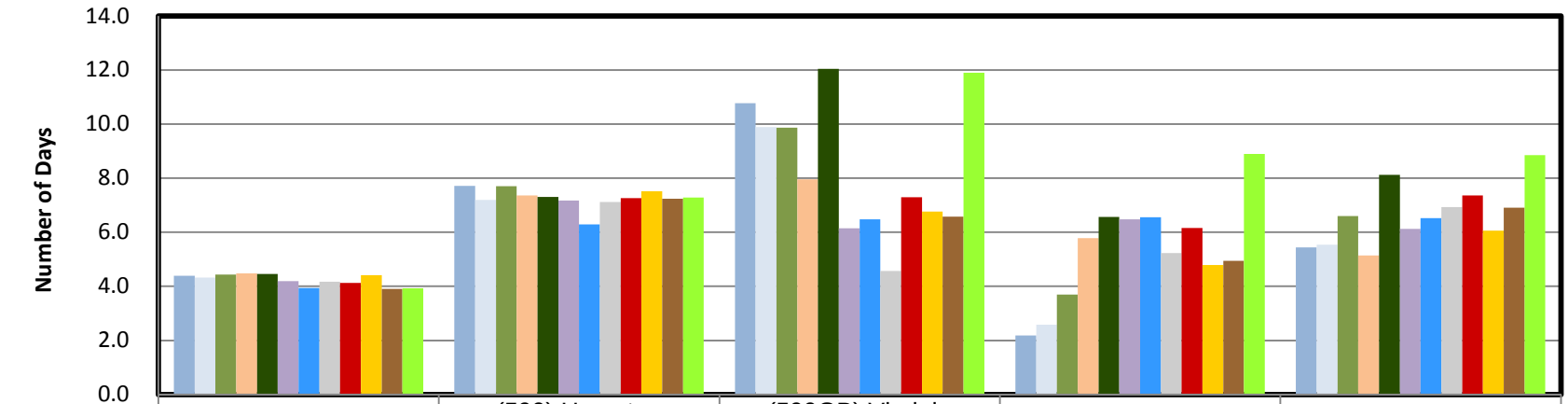


	VHA Total	(590) Hampton VAMC	(590GB) Virginia Beach	(590GC) Albemarle	(590GD) Chesapeake
APR-FY16	9.5	17.1	30.5	8.9	15.8
MAY-FY16	8.7	19.4	28.4	11.6	19.3
JUN-FY16	8.7	21.3	33.2	16.8	27.9
JUL-FY16	8.9	20.5	19.8	26.3	25.5
AUG-FY16	8.9	18.2	18.1	23.7	32.1
SEP-FY16	8.7	14.8	17.2	19.1	27.4
OCT-FY17	8.7	14.6	25.2	31.7	29.0
NOV-FY17	8.8	18.2	22.4	16.9	30.5
DEC-FY17	8.8	15.4	18.1	18.4	29.6
JAN-FY17	9.2	17.8	15.4	17.9	24.3
FEB-FY17	8.7	16.7	21.0	28.1	24.5
MAR-FY17	8.4	17.7	27.2	24.9	46.4

Source: VHA Support Service Center.

Note: OIG did not assess VA's data for accuracy or completeness. We have on file the facility's explanation for the increase in wait times for the Virginia Beach, Albemarle, and Chesapeake Outpatient Clinics.

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

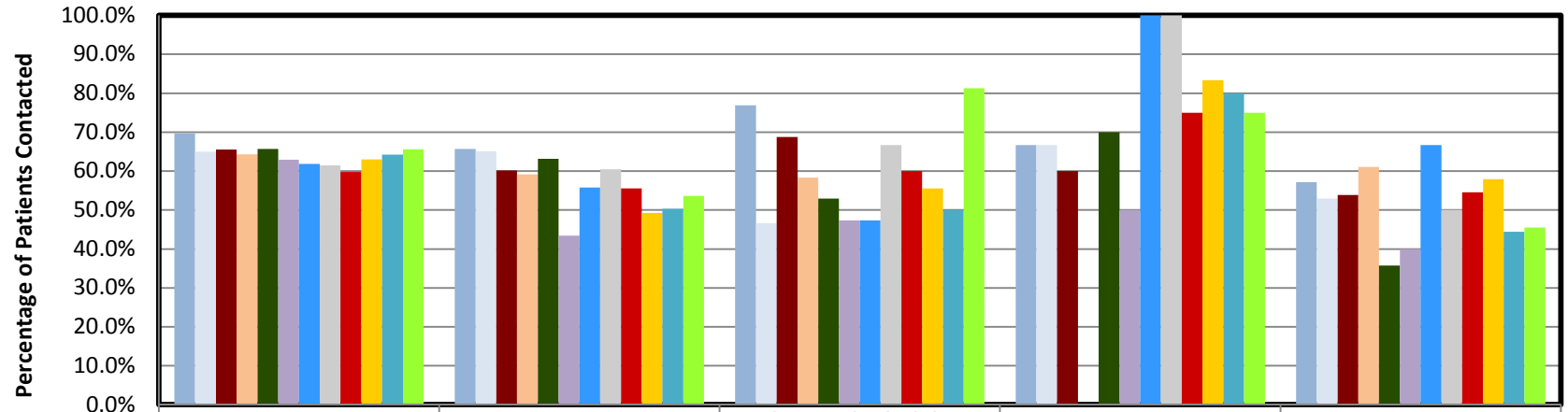


	VHA Total	(590) Hampton VAMC	(590GB) Virginia Beach	(590GC) Albemarle	(590GD) Chesapeake
APR-FY16	4.4	7.7	10.8	2.2	5.4
MAY-FY16	4.3	7.2	9.9	2.6	5.5
JUN-FY16	4.4	7.7	9.9	3.7	6.6
JUL-FY16	4.5	7.4	8.0	5.8	5.1
AUG-FY16	4.5	7.3	12.0	6.6	8.1
SEP-FY16	4.2	7.2	6.2	6.5	6.1
OCT-FY17	3.9	6.3	6.5	6.6	6.5
NOV-FY17	4.2	7.1	4.6	5.2	6.9
DEC-FY17	4.1	7.3	7.3	6.2	7.4
JAN-FY17	4.4	7.5	6.8	4.8	6.1
FEB-FY17	3.9	7.2	6.6	4.9	6.9
MAR-FY17	3.9	7.3	11.9	8.9	8.8

Source: VHA Support Service Center.

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

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

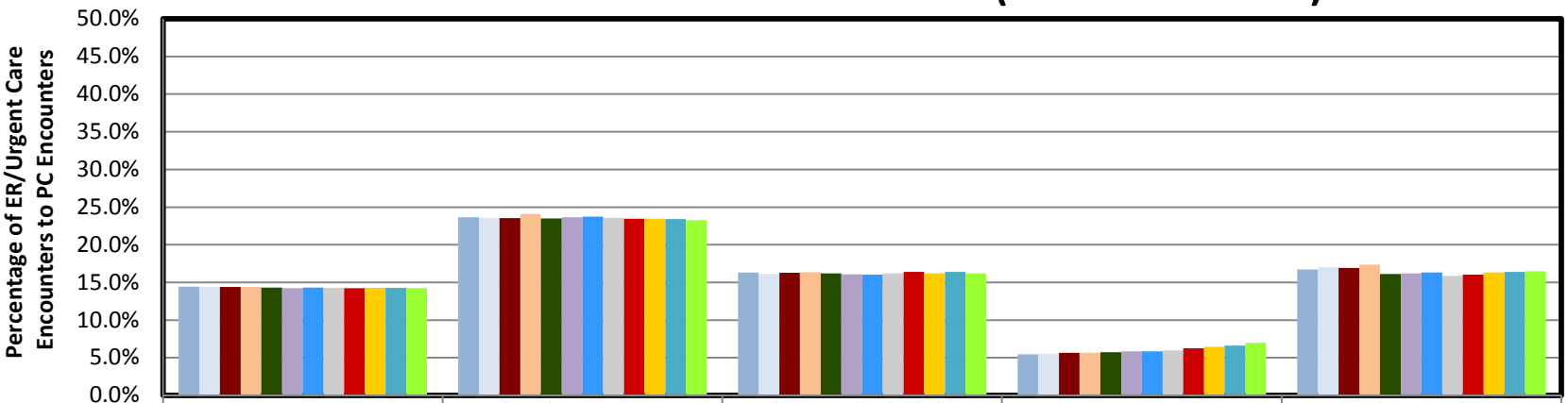


	VHA Total	(590) Hampton VAMC	(590GB) Virginia Beach	(590GC) Albemarle	(590GD) Chesapeake
APR-FY16	69.7%	65.7%	76.9%	66.7%	57.1%
MAY-FY16	65.0%	65.1%	46.7%	66.7%	52.9%
JUN-FY16	65.5%	60.1%	68.8%	60.0%	53.8%
JUL-FY16	64.3%	59.2%	58.3%	0.0%	61.1%
AUG-FY16	65.7%	63.1%	52.9%	70.0%	35.7%
SEP-FY16	62.9%	43.4%	47.4%	50.0%	40.0%
OCT-FY17	61.8%	55.8%	47.4%	100.0%	66.7%
NOV-FY17	61.4%	60.4%	66.7%	100.0%	50.0%
DEC-FY17	59.8%	55.6%	60.0%	75.0%	54.5%
JAN-FY17	63.0%	49.2%	55.6%	83.3%	57.9%
FEB-FY17	64.2%	50.3%	50.0%	80.0%	44.4%
MAR-FY17	65.6%	53.6%	81.3%	75.0%	45.5%

Source: VHA Support Service Center.

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

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



	VHA Total	(590) Hampton VAMC	(590GB) Virginia Beach	(590GC) Albemarle	(590GD) Chesapeake
APR-FY16	14.4%	23.7%	16.3%	5.4%	16.7%
MAY-FY16	14.4%	23.6%	16.1%	5.5%	17.0%
JUN-FY16	14.4%	23.6%	16.3%	5.6%	16.9%
JUL-FY16	14.4%	24.1%	16.3%	5.7%	17.4%
AUG-FY16	14.3%	23.5%	16.2%	5.7%	16.1%
SEP-FY16	14.2%	23.6%	16.1%	5.8%	16.2%
OCT-FY17	14.3%	23.7%	16.0%	5.9%	16.3%
NOV-FY17	14.3%	23.6%	16.2%	6.0%	15.9%
DEC-FY17	14.2%	23.5%	16.4%	6.3%	16.0%
JAN-FY17	14.3%	23.5%	16.2%	6.5%	16.3%
FEB-FY17	14.3%	23.4%	16.4%	6.6%	16.4%
MAR-FY17	14.2%	23.3%	16.2%	7.0%	16.5%

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[i]

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

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

Source: VHA Support Service Center.

Relevant OIG Reports

April 1, 2014 through February 1, 2018[56]

Healthcare Inspection – Patient Care Concerns at the Community Living Center, Hampton VA Medical Center, Hampton, Virginia
5/11/2017 | *15-02009-227* | *Summary* | *Report*

Audit of Veteran Wait Time Data, Choice Access, and Consult Management in VISN 6
3/2/2017 | *16-02618-424* | *Summary* | *Report*

Healthcare Inspection – Review of the Operations and Effectiveness of VHA Residential Substance Use Treatment Programs
7/30/2015 | *15-01579-457* | *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*

Healthcare Inspection – Suicide Risk and Alleged Medical Management Issues, Hampton VA Medical Center, Hampton, Virginia
3/30/2015 | *14-02139-156* | *Summary* | *Report*

Combined Assessment Program Review of the Hampton VA Medical Center, Hampton, Virginia
1/20/2015 | *14-02082-82* | *Summary* | *Report*

Healthcare Inspection – Alleged Nursing Deficiencies Led to Patient's Death, Hampton VA Medical Center, Hampton, Virginia
11/5/2014 | *13-02527-23* | *Summary* | *Report*

Community Based Outpatient Clinic and Primary Care Clinic Reviews at Hampton VA Medical Center, Hampton, Virginia
6/30/2014 | *14-00908-194* | *Summary* | *Report*

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

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: January 9, 2018

From: Acting Director, VA Mid-Atlantic Health Care Network (10N6)

Subject: **CHIP Review of the Hampton VA Medical Center, Hampton, VA**

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

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

The attached subject report is forwarded for your review and further action. I reviewed the response of the Hampton VA Medical Center (VAMC), Hampton, VA and concur with the facility's findings, recommendations, and submitted action plans.

DEANNE M. SEEKINS 261197 Digitally signed by DEANNE M. SEEKINS 261197 Date: 2018.01.10 07:29:14 -05'00'

Deanne M. Seekins, MBA, VHA-CM
Mid-Atlantic Network Director, VISN 6

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: January 3, 2018

From: Director, Hampton VA Medical Center, Hampton, VA (590/00)

Subject: **CHIP Review of the Hampton VA Medical Center, Hampton, VA**

To: Director, VA Mid-Atlantic Health Care Network (10N6)

I have reviewed and concur with the recommendations in the draft report for the OIG Comprehensive Healthcare Inspection Program Review of the Hampton VA Medical Center. Thank you for the opportunity to review our processes to ensure we continue to provide excellent care to our Veterans. Corrective action plans and target dates for completion have been established and detailed in the attached report.

J. Ronald Johnson, FACHE
Director, Hampton VA Medical Center

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact OIG at (202) 461-4720.
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This report is available at www.va.gov/oig.

Endnotes

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

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

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

[d] The references used for EOC included:
- VA Handbook 0730, *Security and Law Enforcement*, August 11, 2000.
- 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 Directive 1131, *Management of Infectious Diseases and Infection Prevention and Control Programs*, November 7, 2017.
- VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013.
- VHA Directive 1229, *Planning and Operating Outpatient Sites of Care*, July 7, 2017.
- VHA Directive 1330.01(1), Health Care Services for Women Veterans, February 15, 2017 (amended September 8, 2017).
- VHA Directive 1608, *Comprehensive Environment of Care (CEOC) Program*, February 1, 2016.
- VHA Directive 1761(1), *Supply Chain Inventory Management*, October 24, 2016.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012.
- VA Handbook 6500, *Risk Management Framework for VA Information Systems – Tier 3: VA Information Security Program*, March 10, 2015.
- VHA Radiology Online Guide, http://vaww.infoshare.va.gov/sites/diagnosticservices/NRP/Mammography/Radiology%20Shared%20Files/Radiology_Service_Online_Guide_2016.docx, November 3, 2016.
- MH EOC Checklist, VA National Center for Patient Safety, http://vaww.ncps.med.va.gov/guidelines.html#mhc, accessed December 8, 2016.
- Various requirements of TJC, Association for the Advancement of Medical Instrumentation/Association for the Advancement of Medical Instrumentation, Occupational Safety and Health Administration, International Association of Healthcare Central Service Materiel Management, National Fire Protection Association.

[e] The references used for Moderate Sedation included:
- VHA Handbook 1004.01, *Informed Consent for Clinical Treatments and Procedures*, August 14, 2009.
- VHA Directive1039, *Ensuring Correct Surgery and Invasive Procedures*, July 26, 2013.
- VHA Directive 1073, *Moderate Sedation by Non-Anesthesia Providers*, December 30, 2014.
- VHA Directive 1177; *Cardiopulmonary Resuscitation, Basic Life Support, and Advanced Cardiac Life Support Training for Staff*; November 6, 2014.
- VA National Center for Patient Safety. *Facilitator's Guide for Moderate Sedation Toolkit for Non-Anesthesiologists*. March 29, 2011.

- American Society of Anesthesiologists. Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists. *Anesthesiology*. 2002; 96:1004–17.
- TJC. Hospital Standards. January 2016. PC.03.01.01, EP1 and MS.06.01.03 EP6.

[f] The references used for CNH Oversight included:

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

[g] The references used for MH RRTP were:

- VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010.
- VHA Handbook 1330.01, *Health Care Services for Women Veterans*, February 15, 2017 (amended September 8, 2017).
- Requirements of the VHA Center for Engineering and Occupational Safety and Health and the National Fire Protection Association.

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

- Department of Veterans' Affairs, Patient Aligned Care Teams Compass Data Definitions, accessed: April 28, 2017.

[i] 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.