



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

**Office of Healthcare Inspections**

**Report No. 17-01762-88**

**Comprehensive Healthcare  
Inspection Program Review  
of the  
VA New York Harbor  
Healthcare System  
New York, New York**

**February 7, 2018**

**Washington, DC 20420**

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## Glossary

CBOC	community based outpatient clinic
CEB	Clinical Executive Board
Chief Nurse Executive	Associate Director for Patient Care Services
CHIP	Comprehensive Healthcare Inspection Program
EHR	electronic health record
EOC	environment of care
facility	VA New York Harbor Healthcare System
FY	fiscal year
MH	mental health
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
PC	primary care
P&T	Pharmacy and Therapeutics
PTSD	post-traumatic stress disorder
QM	Quality Management
QSV	quality, safety, and value
RRTP	residential rehabilitation treatment program
SAIL	Strategic Analytics for Improvement and Learning
SPOT	Surgical, Procedural, Operative, and Therapeutics
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 VA New York Harbor Healthcare System (facility). The review covers key clinical and administrative processes that are associated with promoting quality care.

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

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

This review was conducted during an unannounced visit made during the week of June 19, 2017. OIG conducted interviews and reviewed clinical and administrative processes related to areas of focus that affect patient care outcomes. Although OIG reviewed a spectrum of clinical and administrative processes, the sheer complexity of VA medical centers limits the ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of facility performance within the identified focus areas at the time of the OIG visit. Although it is difficult to quantify the risk of patient harm, the findings in this report may help facilities identify areas of vulnerability or conditions that, if properly addressed, will potentially improve patient safety and health care quality.

### Results and Review Impact

**Leadership and Organizational Risks.** At the VA New York Harbor Healthcare System, the leadership team consists of the Facility Director, Chief of Staff, Associate Director for Patient Care Services (Chief Nurse Executive), Associate Director for Facilities and Human Resources, and Associate Director for Finance and Information Management. Organizational communication and accountability are carried out through a committee reporting structure, with the Executive Council having oversight for leadership groups such as the Clinical Executive Board, Environment of Care Committee, Patient Services Management Staff, and Performance Improvement

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<sup>1</sup> The Community Nursing Home Oversight special focus area did not apply for the VA New York Harbor Healthcare System because the facility only provided limited long-term care to patients for greater than 90 days through contracts.

Leadership Team. The leaders are members of the Executive Council, through which they track, trend, and monitor quality of care and patient outcomes.

Members of the leadership team are all permanent and have been in their positions from 6 months to 13 years. Their tenure as VA employees ranges from 6 to 35 years. In the review of selected employee and patient survey results regarding facility senior leadership, OIG noted generally high satisfaction scores that reflected active engagement with employees and patients. OIG also noted that facility leaders implemented processes and plans to maintain a committed workforce and positive patient experiences.

Additionally, OIG reviewed accreditation agency findings, sentinel events, disclosures of adverse patient events, Patient Safety Indicator data, and Strategic Analytics for Improvement and Learning (SAIL) data and did not identify any substantial organizational risk factors. OIG recognizes that the SAIL model has limitations for identifying all areas of clinical risk but is “a way to understand the similarities and differences between the top and bottom performers” within the Veterans Health Administration (VHA).<sup>2</sup>

Although the senior leadership team had a methodical approach to regularly review data and actions taken for 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 SAIL rating (for example, Healthcare-Associated Infections, Capacity, and Complications). In the review of key care processes, OIG issued 14 recommendations that are attributable to the Facility Director, Associate Director, and Chief of Staff. Of the seven areas of clinical operations reviewed, OIG noted findings in five. 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. OIG found general compliance with requirements for protected peer reviews, utilization management,<sup>3</sup> and patient safety. However, OIG noted a deficiency with credentialing and privileging processes.

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<sup>2</sup> 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.

<sup>3</sup> 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.

**Medication Management.** OIG found safe anticoagulation therapy management practices and compliance with policy content, transition follow-up for inpatients, and laboratory testing. However, OIG identified deficiencies with quality assurance data, patient education, and competencies.

**Coordination of Care.** OIG noted compliance with transfer policy content, resident supervision, and nurses' assessments/notes but identified deficiencies with data analysis and reporting, transfer documentation, and communication with the accepting facility.

**Environment of Care.** OIG noted a generally safe and clean environment of care, with the exception of multiple inpatient units that had dusty ceiling tiles, ventilation grills, and dirty bases on patient rolling equipment (vital sign machine, computer on wheels, and intravenous pole). The parent facility met most of the performance indicators evaluated, and OIG did not note any issues with the performance indicators examined for the representative community based outpatient clinic or for radiology. However, OIG identified deficiencies with environment of care rounds attendance, panic alarm, bed safety on a locked mental health unit, and Interdisciplinary Safety Inspection Team training.

**High-Risk Processes Related to Moderate Sedation.** OIG found compliance with timeouts, discharge practices, and employee training. However, OIG identified deficiencies with reporting and trending the use of reversal agents, history and physical examinations and pre-sedation assessments, and informed consent.

## Summary

In the review of key care processes, OIG issued 14 recommendations that are attributable to the Facility Director, Chief of Staff, and Associate Directors. The number of recommendations should not be used as a gauge for the overall quality provided at this facility. The intent is for facility leadership to use these recommendations as a "road map" to help improve operations and clinical care. The recommendations address systems issues as well as other less-critical findings that, if left unattended, may eventually interfere with the delivery of quality health care.

## Comments

The Veterans Integrated Service Network Director and Facility Director agreed with the CHIP review findings and recommendations and provided acceptable improvement plans. (See Appendixes G and H, pages 53–54, 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.



JOHN D. DAIGH, JR., M.D.  
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## Purpose and Scope

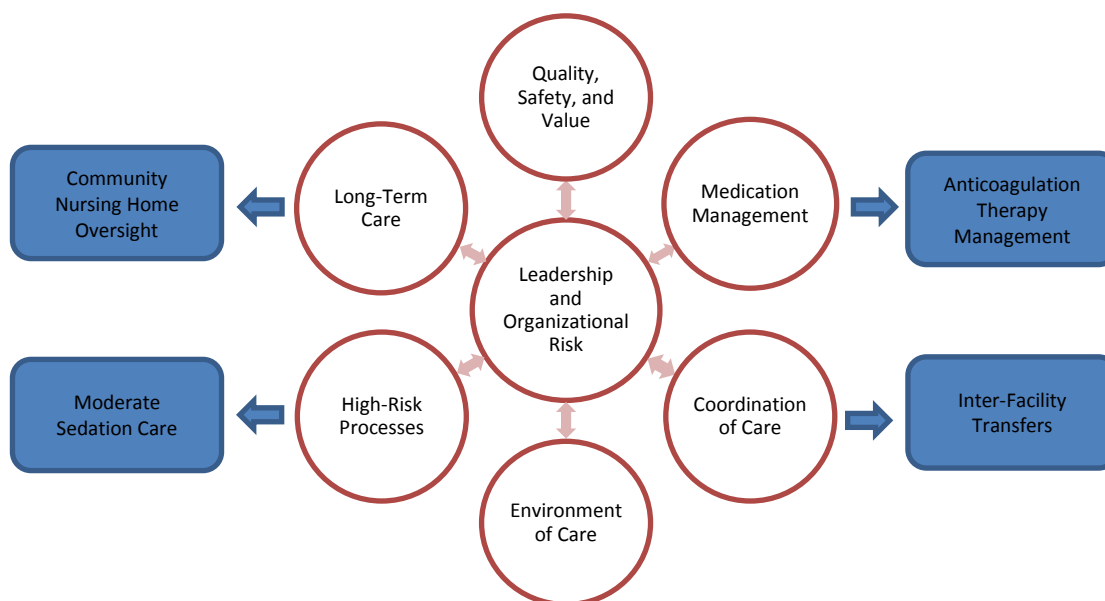
### Purpose

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

### Scope

The current seven areas of focus for facility reviews are: (1) Leadership and Organizational Risks; (2) Quality, Safety, and Value (QSV); (3) Medication Management; (4) Coordination of Care; (5) Environment of Care (EOC); (6) High-Risk Processes; and (7) Long-Term Care. These were selected because of risks to patients and the organization when care is not performed well. Within four of the fiscal year (FY) 2017 focus areas, the Office of Inspector General (OIG) selected processes for special consideration—Anticoagulation Therapy Management, Inter-Facility Transfers, Moderate Sedation, and Community Nursing Home Oversight (see Figure 1). However, the Community Nursing Home Oversight special focus area did not apply for the VA New York Harbor Healthcare System because the facility only provided limited long-term care to patients for greater than 90 days through contracts. Thus, OIG focused on the remaining five areas of clinical operations and two additional programs with relevance to the facility—Mental Health (MH) Residential Rehabilitation Treatment Program (RRTP) and Post-Traumatic Stress Disorder (PTSD) Care.

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



Source: VA OIG.

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

## Methodology

To determine compliance with Veterans Health Administration (VHA) requirements<sup>4</sup> 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;<sup>5</sup> 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 June 9, 2014<sup>6</sup> through June 19, 2017, the date when an unannounced week-long site visit commenced. OIG also presented crime awareness briefings to 135 of the facility's 4,097 employees on June 29, 2017. These briefings covered procedures for reporting suspected criminal activity to OIG and

<sup>4</sup> 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.

<sup>5</sup> OIG did not review VHA's internal survey results but focused on OIG inspections and external surveys that affect facility accreditation status.

<sup>6</sup> This is the date of the last Combined Assessment Program and/or Community Based Outpatient Clinic and Primary Care Clinic reviews.

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

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

While onsite, the OIG did not receive any concerns beyond the scope of the CHIP review. We conducted the inspection in accordance with OIG standard operating procedures for CHIP reviews and *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

## Results and Recommendations

### Leadership and Organizational Risks

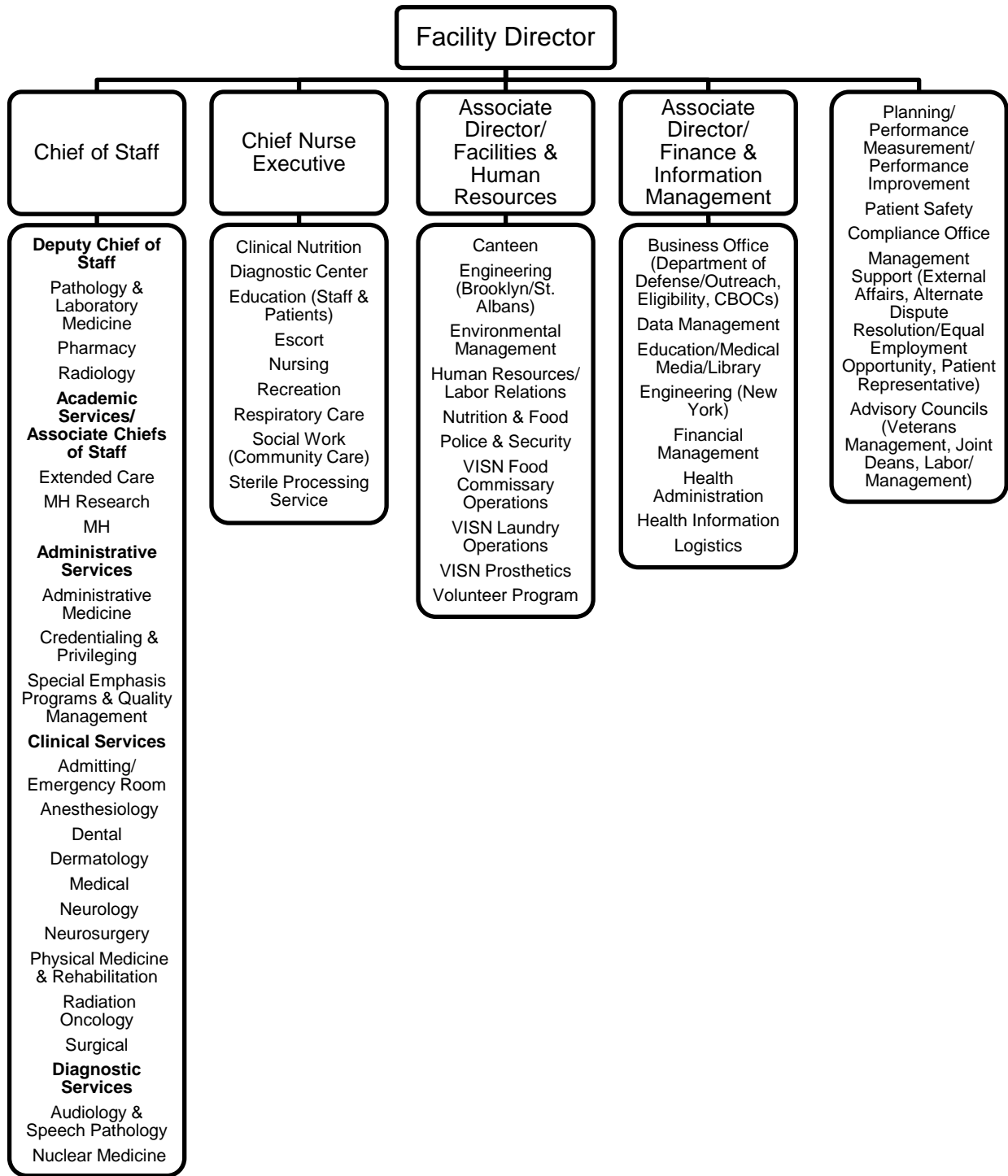
Stable and effective leadership is critical to improving care and sustaining meaningful change. Leadership and organizational risk issues can impact the facility's ability to provide care in all of the selected clinical areas of focus. The factors OIG considered in assessing the facility's risks and strengths were:

1. Executive leadership stability and engagement
2. Employee satisfaction and patient experience
3. Accreditation/for-cause surveys and oversight inspections
4. Indicators for possible lapses in care
5. VHA performance data

**Executive Leadership Stability and Engagement.** Because each VA facility organizes its leadership to address the needs and expectations of the local veteran population that it serves, organizational charts may differ between facilities. Figure 2 illustrates this facility's reported organizational structure. The facility has a leadership team consisting of the Director, Chief of Staff, Associate Director for Patient Care Services (Chief Nurse Executive), Associate Director for Facilities and Human Resources, and Associate Director for Finance and Information Management. The Chief of Staff and Chief Nurse Executive are responsible for overseeing patient care and service and program chiefs.

The facility leadership team have been in their positions from 6 months to 13 years. Their tenure as VA employees ranges from 6 to 35 years. It is important to note that all members of the leadership team are permanently assigned and have been working together since January 2017 when the Chief of Staff assumed the position.

**Figure 2. Facility Organizational Chart**



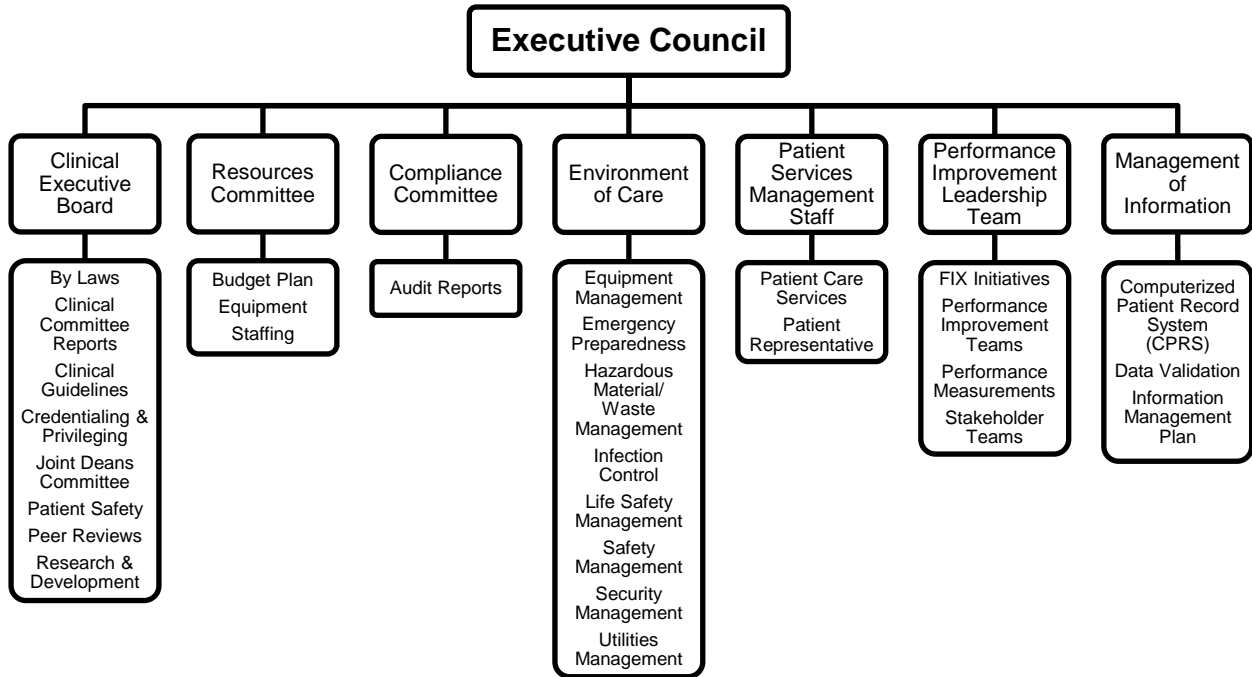
Source: VA New York Harbor Healthcare System (received July 11, 2017).

To help assess engagement of facility executive leadership, OIG interviewed the Facility Director, Associate Director for Finance and Information Management, Associate Director for Facilities and Human Resources, Chief Nurse Executive, and Chief of Staff 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, all of which 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 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 Council also oversees various working committees, such as the Clinical Executive Board (CEB), Resources Committee, Environment of Care Committee, and Performance Improvement Leadership Team. See Figure 3.

**Figure 3. Facility Committee Reporting Structure**



Source: VA New York Harbor Healthcare System (received July 11, 2017).

FIX = Flow Improvement Inpatient Initiatives

**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.<sup>7</sup> Facility employee responses (Facility average) were similar to those expressed across VHA (VHA average). The two inpatient survey results reflected lower care ratings than the VHA average while the two outpatient survey results reflected higher care ratings. In all, both employees and patients appear generally satisfied with the leadership and care provided.

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

Questions	Scoring	VHA Average	Facility Average	Director’s Office Average <sup>8</sup>
All Employee Survey <sup>9</sup> 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	3.3	4.1
All Employee Survey Servant Leader Index Composite	0–100 where HIGHER scores are more favorable	66.7	63.3	80.22
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	59.5	
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	81.6	
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): I felt like a valued customer.		73.2	80.0	
Survey of Healthcare Experiences of Patients (outpatient specialty care): I felt like a valued customer.		73.8	76.9	

<sup>7</sup> 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.

<sup>8</sup> Rating is based on responses by employees who report to the Director.

<sup>9</sup> 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<sup>10</sup> Surveys and Oversight Inspections.** To further assess Leadership and Organizational Risks, OIG reviewed recommendations from previous inspections by oversight and accrediting agencies to gauge how well leaders respond to identified problems. Table 2 summarizes the relevant facility inspections most recently performed by the VA OIG and The Joint Commission (TJC). Indicative of effective leadership, the facility has closed<sup>11</sup> all recommendations for improvement as listed in Table 2.

OIG also noted the facility's current accreditation status with the Commission on Accreditation of Rehabilitation Facilities<sup>12</sup> and College of American Pathologists,<sup>13</sup> which demonstrates the facility leaders' commitment to quality care and services. Additionally, the Long Term Care Institute<sup>14</sup> conducted an inspection of the facility's St. Alban's Division Community Living Center.

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<sup>10</sup> 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.

<sup>11</sup> A closed status indicates that the facility has implemented corrective actions and improvements to address findings and recommendations, not by self-certification, but as determined by accreditation organization or inspecting agency.

<sup>12</sup> 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.

<sup>13</sup> 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.

<sup>14</sup> Since 1999, the Long Term Care Institute has been to over 3,500 health care facilities conducting quality reviews and external regulatory surveys. The Long Term Care Institute is a leading organization focused on long-term care quality and performance improvement; compliance program development; and review in long-term care, hospice, and other residential care settings.

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

Accreditation or Inspecting Agency	Date of Visit	Number of Findings	Number of Recommendations Remaining Open
VA OIG ( <i>Healthcare Inspection – Operating Room Reusable Medical Equipment and Sterile Processing Service Concerns, VA New York Harbor Healthcare System, New York, New York, September 29, 2016</i> )	April 2015; October 2015	8	0
VA OIG ( <i>Combined Assessment Program Review of the VA New York Harbor Healthcare System, New York, New York, August 14, 2014</i> )	June 2014	16	0
VA OIG ( <i>Community Based Outpatient Clinic and Primary Care Clinic Reviews at VA New York Harbor Healthcare System, New York, New York, August 1, 2014</i> )	June 2014	7	0
TJC <sup>15</sup> <ul style="list-style-type: none"> <li>• Hospital Accreditation</li> <li>• Nursing Care Center Accreditation</li> <li>• Behavioral Health Care Accreditation</li> <li>• Home Care Accreditation</li> </ul>	March 2015	25 3 1 4	0 0 0 0

<sup>15</sup> 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 June 2014 Combined Assessment Program and Community Based Outpatient Clinic (CBOC) and Primary Care (PC) review inspections through the week of June 19, 2017.

**Table 3. Summary of Selected Organizational Risk Factors<sup>16</sup>  
(June 2014 to June 19, 2017)**

Factor	Number of Occurrences
Sentinel Events <sup>17</sup>	4
Institutional Disclosures <sup>18</sup>	8
Large-Scale Disclosures <sup>19</sup>	0

<sup>16</sup> It is difficult to quantify an acceptable number of occurrences because one occurrence is one too many. Efforts should focus on prevention. Sentinel events and those that lead to disclosure can occur in either inpatient or outpatient settings and should be viewed within the context of the complexity of the facility. (Note that the VA New York Harbor Healthcare System is a high-complexity (1a) affiliated facility as described in Appendix B.)

<sup>17</sup> 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.

<sup>18</sup> 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.

<sup>19</sup> 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.<sup>20</sup> 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 2	New York	Brooklyn
Pressure Ulcers	0.55	0.90	2.95	1.70
Death among surgical inpatients with serious treatable conditions	103.31	115.11	151.52	150.00
Iatrogenic Pneumothorax	0.20	0.49	0.60	0.53
Central Venous Catheter-Related Bloodstream Infection	0.12	0.15	0.50	0.00
In Hospital Fall with Hip Fracture	0.08	0.05	0.00	0.00
Perioperative Hemorrhage or Hematoma	2.59	3.64	10.09	0.00
Postoperative Acute Kidney Injury Requiring Dialysis	1.20	0.87	0.00	0.00
Postoperative Respiratory Failure	6.31	8.19	3.16	32.00
Perioperative Pulmonary Embolism or Deep Vein Thrombosis	3.29	3.67	4.70	5.15
Postoperative Sepsis	4.45	5.98	8.20	18.52
Postoperative Wound Dehiscence	0.65	0	0.00	0.00
Unrecognized Abdominopelvic Accidental Puncture/Laceration	0.67	1.69	5.52	0.00

Source: VHA Support Service Center.

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

Nine of the 12 Patient Safety Indicator measures show an observed rate per 1,000 hospital discharges in excess of the observed rates for Veterans Integrated Service Network (VISN) 2 and VHA for the New York and/or Brooklyn Divisions.

The facility began intensive efforts to improve specific Patient Safety Indicator measures in FY 2016.<sup>21</sup> Efforts to reduce the incidence of pressure ulcers, including staff education, improved practices, and mandatory consults to wound care specialists are ongoing. Data related to the prevalence of pressure ulcers is now trended and reviewed quarterly.

The facility completed a review of death among surgical inpatients. The review found that all of the cases were urgent or emergent with little opportunity for pre-operative optimization of the patients' other serious conditions. The facility put in place an action

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

<sup>21</sup> October 1, 2015 through September 30, 2016.

plan to address identified concerns, which was reviewed and approved by the VHA Surgical Office.

The facility found that increased incidences of iatrogenic pneumothorax<sup>22</sup> were related to procedures where a pneumothorax was unavoidable or a known risk. Insufficient communication between infectious disease and intensive care unit staff was identified as the reason for the higher rates for central venous catheter related blood stream infections and postoperative respiratory failure. Of note is that there has not been a central catheter related infection or ventilator associated respiratory condition at the Brooklyn campus since October 2016.

The facility reviewed all perioperative deep vein thrombosis cases and focused efforts on ensuring appropriately timed implementation of prophylactic treatments to prevent thrombosis. For postoperative sepsis, the facility identified opportunities for better communication with treatment teams and miscoding.

Facility program managers initiated an educational call with Inpatient Evaluation Center staff to better understand the metrics used for abdominopelvic accidental puncture or laceration and other measures. Plans are also in place to move all high-risk, complex surgeries to the New York campus.

**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.<sup>23</sup> This model includes measures on health care quality, employee satisfaction, access to care, and efficiency, but the model has noted limitations for identifying all areas of clinical risk. The data are presented as one “way to understand the similarities and differences between the top and bottom performers” within VHA.<sup>24</sup>

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<sup>22</sup> Iatrogenic pneumothorax is the presence of air or gas in the cavity between the lungs and the chest wall, causing collapse of the lung, which is caused by a medical procedure.

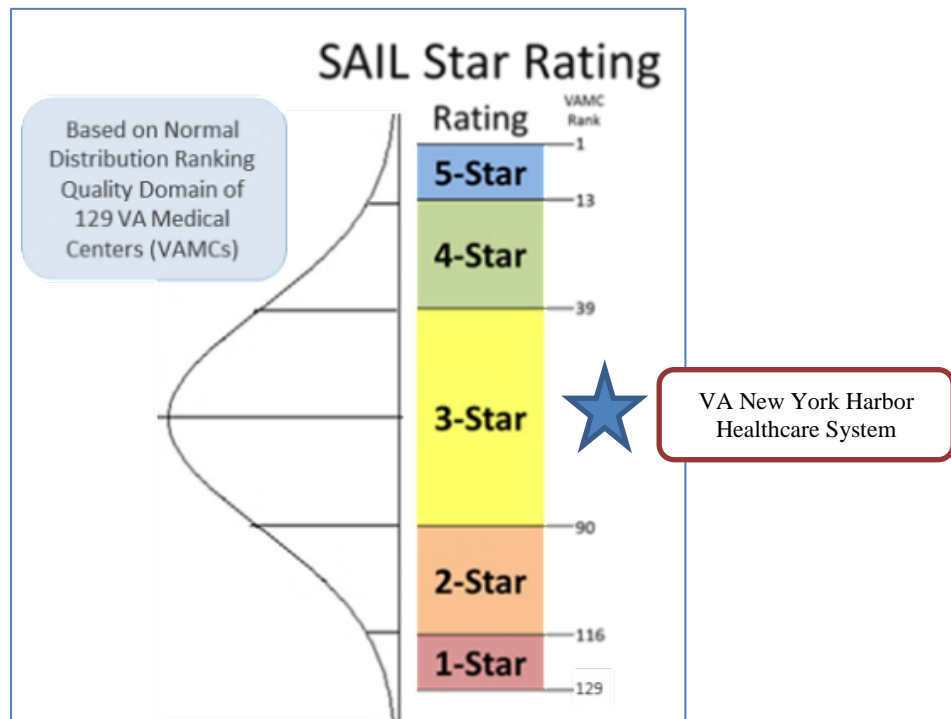
<sup>23</sup> The model is derived from the Thomson Reuters Top Health Systems Study.

<sup>24</sup> 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>

VA also uses a star-rating system that is designed to make model results more accessible for the average user. Facilities with a 5-star rating are performing within the top 10 percent of facilities, whereas 1-star facilities are performing within the bottom 10 percent of facilities. Figure 4 describes the distribution of facilities by star rating. As of September 30, 2016, the VA New York Harbor Healthcare System received an interim rating of 3 stars for overall quality. This means the facility was in the 3<sup>rd</sup> quintile (30–70 percent range). Updated data as of June 30, 2017, indicates that the facility has declined to 2 stars for overall quality.

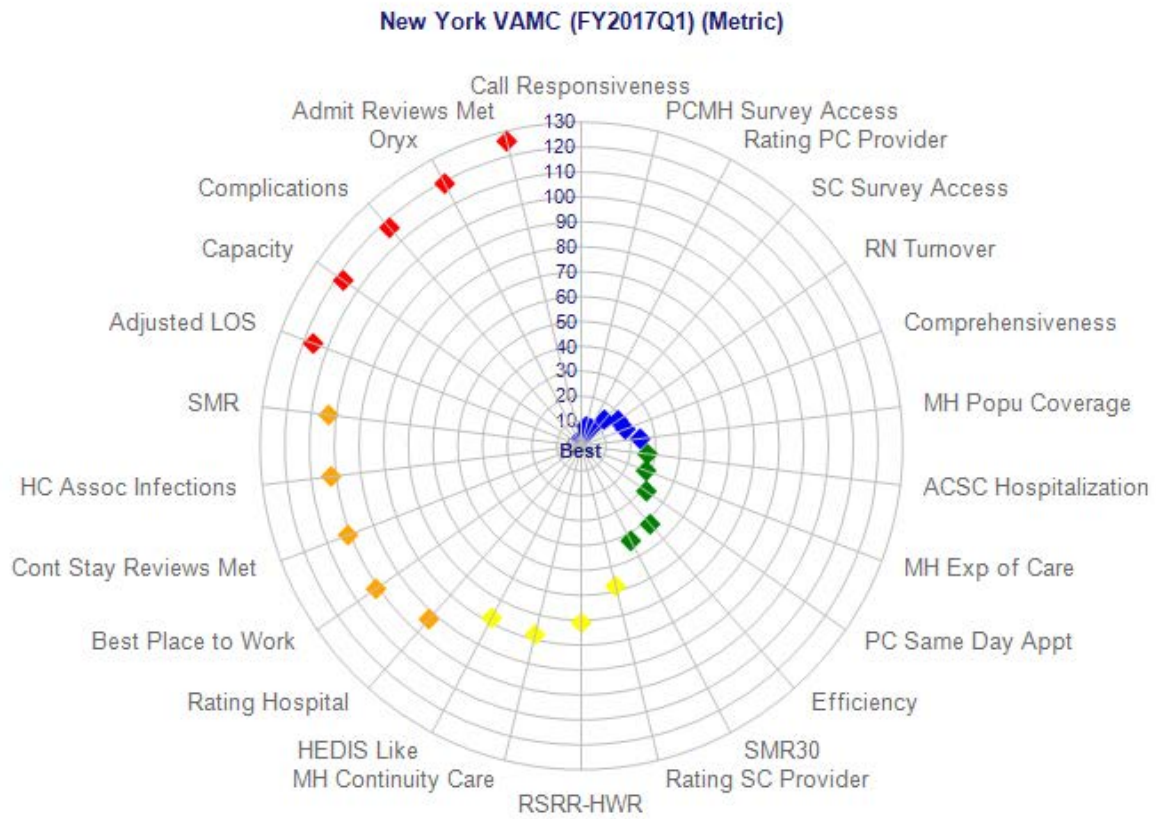
**Figure 4. Strategic Analytics for Improvement and Learning Star Rating Distribution (as of September 30, 2016)**



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

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, Rating [of] PC Provider, Registered Nurse [RN] Turnover, and MH Experience [Exp] of Care). Metrics in the bottom quintiles reflect areas that need improvement and are denoted in orange and red (for example, Best Place to Work, Healthcare-Associated [HC Assoc] Infections, Capacity, and Complications).

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



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

Source: VHA Support Service Center.

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

**Conclusions.** The facility has generally stable executive leadership with demonstrated cohesiveness and active engagement with employees and patients to maintain satisfaction scores. Organizational leaders support patient safety, quality care, and other positive outcomes. 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.<sup>25</sup> The leadership team had a methodical approach (through daily meetings) to regularly review data and actions taken for selected performance improvement, SAIL, and patient safety metrics to improve those metrics and care to veterans and should continue to take actions to improve the metrics likely contributing to the current 2-star rating.

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<sup>25</sup> 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.<sup>26</sup> 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.<sup>a</sup> To assess this area of focus, OIG evaluated the following:

1. Senior-level involvement in QSV/performance improvement committee
2. Protected peer review<sup>27</sup> of clinical care
3. Credentialing and privileging
4. Utilization management (UM) reviews<sup>28</sup>
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)<sup>29</sup> data review
  - Indicated a Focused Professional Practice Evaluation<sup>30</sup>

<sup>26</sup> Department of Veterans Affairs, Veterans Health Administration. *Blueprint for Excellence*. September 2014.

<sup>27</sup> 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.

<sup>28</sup> 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.

<sup>29</sup> 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 protected peer reviews, UM, and patient safety. However, OIG identified the following deficiency with credentialing and privileging processes that warranted a recommendation for improvement.

*Credentialing and Privileging.* VHA requires facilities to have an ongoing monitoring process for privileged practitioners. Ongoing monitoring is essential to confirm that quality care is delivered and allows the facility to identify professional practice trends that impact quality of care and patient safety. Facility policy required service chiefs to review OPPE data semiannually. Three of the 25 profiles, all from Medicine Service, did not contain evidence that clinical managers reviewed OPPE data every 6 months. The reason for delays was related to the loss of the administrative officer who had primary responsibility for data collection and left employment in January 2017. The facility could not fill the position due to the January 2017 hiring freeze. At the time of the onsite visit, the position was vacant and on the hiring priority list.

### *Recommendation*

1. The Chief of Staff ensures Medicine Service clinical managers consistently review Ongoing Professional Practice Evaluation data every 6 months and monitors the managers' compliance.

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<sup>30</sup> 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: November 30, 2018

Facility response: Medical Service has since remedied the issue with completion of OPPEs for the medical specialties. The OPPE reporting cycle (10/16-3/17) due at the April 2017 meeting were included in the most recent OPPE cycle (4/17–9/17) and reported at the October 2017 Professional Standard and Credentialing Board Meeting. Professional Standard and Credentialing Board will measure consistent completion of OPPE's for two cycles (a full year). Full compliance will be considered 100 percent compliance with meeting the deadlines for the two cycles of reporting. Additional administrative support for Medical Service is expected in January 2018.

## 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,<sup>31</sup> 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.<sup>b</sup>

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 (EHR) of 34 randomly selected patients who were prescribed new anticoagulant medications from July 1, 2015 through June 30, 2016. The list below shows the performance indicators examined.

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

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<sup>31</sup> 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 policy content, transition follow-up for inpatients, and laboratory testing. However, OIG identified the following deficiencies in quality assurance data, patient education, and competencies that warranted recommendations for improvement.

*Quality Assurance.* VHA requires an ongoing quality assurance plan to evaluate the anticoagulation management program. This provides the opportunity to identify practice improvements, ensures appropriate action is taken to improve the practice, and measures the effectiveness of those actions on a regular basis. Patient incidents, close calls, near misses, and adverse drug events involving anticoagulants should be assessed and analyzed by the facility Pharmacy and Therapeutics (P&T) Committee. Although the facility had a policy addressing a quality assurance plan, anticoagulation management data was not collected, analyzed, or reported quarterly to the P&T Committee as required by facility policy. Facility managers stated they did not fully implement the plan because they did not have processes in place to obtain the data for analysis. Facility anticoagulation staff began addressing VHA requirements for anticoagulation program management in September 2015. Initial actions included creation of a policy (dated November 2016), documentation templates, and a tracking report for the quality assurance plan. This process took longer than expected. At the time of OIG's visit, clinical staff were using documentation templates, and program managers were able to obtain data regarding anticoagulation therapy.

### *Recommendation*

2. The Chief of Staff ensures quality assurance data for the anticoagulation management program are collected, analyzed, and reported quarterly at Pharmacy and Therapeutics Committee meetings and monitors compliance.

Facility concurred.

Target date for completion: June 30, 2018

Facility Response: Anticoagulation management data is reported to the P&T Committee. The P&T Committee informed the anticoagulation management clinical champions of the need to report on a quarterly basis to the P&T Committee. The anticoagulation clinical champions will collect and analyze quality assurance data. As per the Healthcare System Policy 111-04, the assurance data reviewed will include elevated INRs, bleeding events, thromboembolic events, sub-therapeutic INRs, and patient incidents and close calls/near misses associated with anticoagulant medications. Anticoagulation data was reported at the September 2017 P&T Committee and the December 2017 P&T Committee. The Clinical Champions were provided a quarterly reporting schedule to ensure ongoing compliance with reporting to the P&T Committee. The measure of success is to ensure that the Anti-coagulation clinical champions continue to report quarterly to the P&T Committee. Specifically, the measure of success will ensure that the quarterly reports scheduled for March and June are

reported to the P&T Committee (100 percent compliance with reporting at the March and June meeting).

*Patient Education.* VHA requires clinicians to provide initial and ongoing patient and family education for newly prescribed anticoagulant medications that includes the importance of follow-up monitoring, compliance issues, dietary restrictions, and potential for adverse reactions and interactions. This is to ensure that patients receive information about side effects, drug interactions, and symptoms of bleeding to reduce the likelihood of patient harm. OIG did not find evidence that 7 of the 34 patients (21 percent) received education specific to the newly prescribed anticoagulant. Facility policy stated that direct-acting oral anticoagulants can be initiated by providers and patients are to be referred to the anticoagulation clinic for ongoing management. All seven patients had direct-acting oral anticoagulants initiated and managed by PC and cardiology providers. The PC and Medicine Service chiefs verbalized their belief that initial education was occurring, but they did not ensure that patients were referred to the anticoagulation clinic. Anticoagulation program managers were also unaware the patients were not referred to or seen in the anticoagulation clinic.

#### *Recommendation*

3. The Chief of Staff ensures clinicians consistently provide specific education to patients with newly prescribed anticoagulant medications and refer patients prescribed direct-acting oral anticoagulants to the anticoagulation clinic and monitors clinicians' compliance.

Facility concurred.

Target date for completion: June 30, 2018

Facility Response: The Chairperson of the P&T Committee is developing an ordering template that will prompt the provider to provide the required education for any patient newly prescribed anticoagulant medications. The P&T Committee will monitor compliance once the template is developed and implemented. Monitoring will consist of reviewing a representative sample of medical record documentation of patients newly prescribed anticoagulant medications to ensure that the required education was documented. Compliance will be considered 90 percent sustained for 3 months.

*Competencies.* VHA requires that facilities have processes to assess competencies specific to anticoagulation management for providers and clinical staff directly involved in caring for patients receiving anticoagulation therapy. 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. Competencies must include knowledge of standard terminology, pharmacology of anticoagulants, monitoring requirements, dose calculations, common side effects, nutrient interactions, and drug to drug interactions associated with anticoagulation therapy. None of the competency assessments for the 10 anticoagulation program staff (five nurses and five pharmacists) included all required elements. The nurse manager providing

oversight of the anticoagulation clinic nurses was unaware of the VHA competency assessment requirements. Prior to our visit, pharmacy staff identified this deficit and were in the process of revising the competencies to reflect the necessary requirements.

*Recommendation*

4. The Chief of Staff requires that clinical managers include in the competency assessments of employees actively involved in the anticoagulant program knowledge of standard terminology, pharmacology of anticoagulants, monitoring requirements, dose calculation, common side effects, nutrient interactions associated with anticoagulation therapy, and drug to drug interactions associated with anticoagulation therapy, and the Chief of Staff monitors clinical managers' compliance.

Facility concurred.

Target date for completion: November 30, 2018

Competency forms have been revised for Pharmacy and Nursing Service staff who work in the Anti-Coagulation clinic either full time or temporarily to include all required elements. The staff will also be provided with information about the updated competency requirements. All staff will have completed competency assessments using the updated forms by the end of FY 2018. Nursing and Pharmacy Service will perform an audit of competency records of appropriate staff to ensure the new competency forms were used and all competencies were completed.

## 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.<sup>c</sup>

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 compliance with policy content, resident supervision, and nurses' assessments/notes. However, OIG identified the following deficiencies for data analysis and reporting, transfer documentation, and communication with the accepting facility that warranted recommendations for improvement.



*Transfer Data.* VHA requires facilities to collect, analyze, and report data for patient inter-facility transfers as part of VHA's quality management program. Collecting, analyzing, and reporting this data allows the facility to analyze and improve the inter-facility transfer process to maximize patient safety. Although the facility collected transfer data, OIG found no evidence that the data were analyzed or reported. The transfer coordinator told OIG that she was unaware of this responsibility. Facility leaders had recently taken action to address needed process improvements for inter-facility transfers. The Chief of the Emergency Department was appointed clinical champion, and the transfer coordinator is now under his supervision.

### *Recommendation*

5. The Chief of Staff ensures inter-facility patient transfer data are analyzed and reported and monitors compliance.

Facility concurred.

Target date for completion: July 31, 2018

Facility Response: The facility Inter-Facility Transfer policy was revised and will be presented for approval to the December CEB meeting scheduled for December 21, 2017. A quarterly report will be presented to the CEB starting with the January 2018 meeting scheduled for January 18, 2018. The measure of success is the reporting of the quarterly data to CEB. Sustained improvement will be considered submission of the quarterly report for 2 quarters. Reports are due to the CEB in January 2018 and March 2018.

*Transfer Documentation.* VHA requires transferring providers to complete VA Form 10-2649A and/or transfer/progress notes that contain all required elements, including patient or surrogate informed consent, prior to or within a few hours after the transfer. This is to ensure that transfers out of the facility are carried out appropriately and under circumstances to provide maximum safety for patients and that patients are part of the decision-making process. The facility relies on the VISN 3 inter-facility transfer policy, issued January 31, 2009, which requires the use of VA inter-facility transfer Form 10-2649A and informed consent Form 10-2649B. Twenty-six of the 44 patients' EHRs (59 percent) did not include VA Form 10-2649A. Six of the 41 applicable patients' EHRs (15 percent) did not include VA Form 10-2649B, documentation of patient or surrogate informed consent. Facility staff stated that due to a lack of attention to detail, the requirement to use VA Forms 10-2649A and 10-2649B was not monitored.

### *Recommendation*

6. The Chief of Staff ensures that for patients transferred out of the facility, providers consistently complete VA Forms 10-2649A and 10-2649B as required by Veterans Integrated Service Network policy and monitors providers' compliance.

Facility concurred.

Target date for completion: July 31, 2018

Facility Response: A process was developed whereby the Travel Office will not process the travel request without the approval of the Inter-facility Transfer Coordinator or designee. The Inter-facility Transfer Coordinator will review CPRS to ensure forms 10-2649A and B are completed. Documentation compliance will be part of the report to the CEB. Compliance will be considered 90 percent compliance with documentation requirements. Sustained success will be monitored for 6 months.

*Communication with Accepting Facility.* VHA requires that for inter-facility transfers, communication occurs between the sending and accepting facilities or the sending facility provides pertinent patient information when they transfer the patient. Communication of relevant information ensures continuity of care for patients transferred out of VHA facilities. Providers did not communicate or send pertinent patient information for two of the six applicable patients transferred from the Emergency Department. The Chief of the Emergency Department was new to the role and had not yet implemented an ongoing review of transfer documentation compliance.

#### *Recommendation*

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

Facility concurred.

Target date for completion: July 31, 2018

Facility Response: The revised policy includes the process for hand off communication. This process will be part of the monitoring system and reported quarterly to CEB. Compliance will be considered 90 percent compliance with documentation requirements. Sustained success will be monitored for 6 months.

## Environment of Care

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

Fluoroscopic imaging equipment produces x-rays for the diagnosis, localization, and guidance of interventional procedures.<sup>32</sup> 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.<sup>33</sup> The inpatient locked MH unit must provide a healing, recovery-oriented environment as well as be a safe place for patients and employees. VHA developed the MH EOC Checklist to reduce environmental factors that contribute to inpatient suicides, suicide attempts, and other self-injurious behaviors and factors that reduce employee safety on MH units.

In all, OIG inspected four facility sites during this review involving 20 separate patient care areas. At the Manhattan campus, OIG inspected Radiology Service and the Emergency Department, surgical intensive care unit, 13 North medical unit, 17 North and South inpatient MH units, and post-anesthesia care unit. At the Brooklyn campus, OIG inspected Radiology Service and the Emergency Department, post-anesthesia care unit, 11 East critical care unit, 11 West medical/surgical unit, and 15 East inpatient MH unit. At the St. Albans campus, OIG inspected seven Community Living Center units (A4, A5, B2, B3, C2, C3, and D3). OIG also inspected the Staten Island CBOC. Additionally, OIG reviewed relevant documents and 16 employee training records and interviewed key employees and managers. The list below shows the location-specific performance indicators selected to examine the risk areas specific to particular settings.

### Parent Facility

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

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<sup>32</sup> VHA Handbook 1105.04, *Fluoroscopy Safety*, July 6, 2012.

<sup>33</sup> 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.** Generally, OIG noted a safe and clean EOC, with the exception of multiple inpatient units that had dusty ceiling tiles, ventilation grills, and dirty bases on patient rolling equipment (vital sign machine, computer on wheels, and intravenous pole). The parent facility met most of the performance indicators evaluated. OIG did not note any issues with the performance indicators examined for the representative CBOC or for radiology and did not identify any issues with the availability of medical equipment and supplies. However, OIG identified the following deficiencies at the parent facility and for the locked MH units that warranted recommendations for improvement.

*Parent Facility: Environment of Care Rounds Attendance.* VHA requires facilities to perform comprehensive EOC rounds with a designated team that includes specific membership to ensure a safe, clean, and high-quality care environment.<sup>34</sup> In FY 2017 (October 2016 to June 2017), the VA Police Service, which covers all

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<sup>34</sup> 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.

three campuses, attended only 28 percent of the required EOC rounds. The VA Police Service was excused from rounds on the Manhattan campus contrary to VHA requirements. Facility managers were not aware that full team attendance was mandatory and could be tracked and trended with the Comprehensive EOC Assessment and Compliance Tool software, and the EOC Committee was not reviewing EOC rounds team attendance.

### *Recommendation*

8. The Associate Director for Facilities and Human Resources ensures the VA Police Service consistently participates on environment of care rounds and monitors compliance.

Facility concurred.

Target date for completion. June 30, 2018

Facility Response: The Chief of VA Police Service was notified by the Associate Director for Facilities and Human Resources of the requirement that VA Police Service consistently participate on EOC rounds. A new dashboard was developed to track attendance on EOC rounds. This dashboard will be reviewed monthly by the EOC Committee. Services not attending rounds will be contacted by the Associate Director for Facilities and Human Resources for corrective action. The measure of success will include the monthly reporting of the dashboard to the EOC Committee that documents 90 percent compliance with VA Police Service attendance on EOC rounds. Compliance will be considered sustained with 90 percent attendance for 6 months.

*Locked Mental Health Unit: Panic Alarm Testing.* VHA requires that the facility ensure rapid response by VA Police to panic alarm activation within locked inpatient MH units to preserve patient, visitor, and staff safety. Panic alarm testing for locked inpatient MH units is required to be documented in a log that includes VA Police response time. Although the facility performed panic alarm testing, VA Police response time was not documented. The forms the facility used for panic alarm testing results for locked inpatient MH units did not include response time.

### *Recommendation*

9. The Associate Director for Facilities and Human Resources ensures locked mental health unit panic alarm testing documentation includes VA Police Service response time and monitors compliance.

Facility concurred.

Target date for completion. June 30, 2018

Facility Response: The process and documentation to track VA Police and Security Service response times was modified after the OIG CHIP visit to include response times. This change was effective in August 2017. A review of the documentation from August through November 2017 shows continued compliance. As the measure of success, Police Service will continue to ensure that the documentation of the testing of panic alarms contains the Police response time. Compliance will be considered sustained with 90 percent documentation of response time for 6 months.

*Locked Mental Health Unit: Mechanical Beds.* To ensure patient safety, VHA requires that if electrical or mechanical hospital beds are used on locked MH units, patients should be watched when the beds are occupied, and the room should be locked when not occupied. Further, the MH EOC Checklist states that when patients are in one of these beds, a risk assessment should be conducted frequently to determine potential level of suicide risk. On the Manhattan campus' 17 South locked MH unit, the room with a mechanical bed was unlocked, and the cranks on the bed were not secured. The room was unlocked because a patient was allowed to use it temporarily. Facility MH managers were unable to provide a risk assessment associated with the use of this bed and stated that allowing the patient to use this room was an error.

#### *Recommendation*

10. The Associate Director for Patient Care Services ensures that a risk assessment is completed when a locked mental health unit patient is using an electrical or mechanical hospital bed and that the room containing the bed is locked when not in use, and the Associate Director for Patient Care Services monitors compliance.

Facility concurred.

Target date for completion. June 30, 2018

Facility Response: The Mental Health Care Line Manager and Deputy Patient Safety Manager completed a risk assessment on December 27, 2017. It is common practice for the room to be locked when not in use. This will be monitored as part of the regular rounds on the locked psych units. The results of the rounds will be reviewed monthly by the unit Nurse Managers. The measure of success will be the documentation of the check that the door was found locked during rounds. Compliance will be considered sustained with 100 percent documentation of the door locked for 6 months.

*Locked Mental Health Unit: Interdisciplinary Safety Inspection Team Training.* VHA requires that facility members of the Interdisciplinary Safety Inspection Team receive training on the identification and correction of environmental hazards, including the proper use of the MH EOC Checklist, so they can effectively inspect inpatient MH units to ensure patient, visitor, and staff safety. Two of six Interdisciplinary Safety Inspection Team members did not complete the required training within the previous 12 months

(May 2016 through May 2017). Training completion oversight was delegated to individual services that were not aware of the requirement.

*Recommendation*

11. The Facility Director ensures all members of the Interdisciplinary Safety Inspection Team complete the required training on how to identify and correct environmental hazards, including the proper use of the Mental Health Environment of Care Checklist, and the Facility Director monitors compliance.

Facility concurred.

Target date for completion. July 31, 2018

Facility Response: As recommended during the OIG CHIP visit, the Deputy Patient Safety Manager ensured that all members of the MH EOC rounds completed the required training. A training report will be reviewed by the Patient Safety Manager prior to the scheduling of the biannual EOC rounds to monitor and ensure that all staff are trained. As per VHA, the next MH EOC rounds need to be completed by January 15, 2018. Prior to performing these rounds, the Deputy Patient Manager will verify that the team has completed the necessary training. The training records will be reviewed again during the biannual EOC rounds that are required to be completed in July 2018.

## 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.<sup>35</sup> 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.<sup>36</sup>

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.<sup>37</sup> During calendar year 2016, VHA clinicians performed more than 600,000 moderate sedation procedures, of which more than half were gastroenterology-related endoscopies.<sup>38</sup> 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.<sup>e</sup>

OIG reviewed relevant documents, interviewed key employees, and inspected the gastroenterology, cardiology, interventional radiology, medical and surgical intensive care unit, the Emergency Department procedure areas at the Manhattan campus, and the interventional radiology procedure area at the Brooklyn campus to assess whether required equipment and sedation medications were available. Additionally, OIG reviewed the EHRs of 34 randomly selected patients who underwent an invasive procedure involving moderate sedation from July 1, 2015 through June 30, 2016, and the training records of 15 clinical employees who performed or assisted during these procedures. The list below shows the performance indicators OIG reviewed.

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

<sup>35</sup> American Society of Anesthesiologists (ASA), Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists, 2002. *Anesthesiology* 2002; 96:1004-17.

<sup>36</sup> 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>.

<sup>37</sup> VHA Directive 1073, *Moderate Sedation by Non-Anesthesiology Providers*, December 30, 2014.

<sup>38</sup> Per VA Corporate Data Warehouse data pull on February 22, 2017.



- Performance of timeout<sup>39</sup> 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 timeouts, discharge practices, and employee training. However, OIG identified deficiencies with reporting and trending the use of reversal agents, history and physical examinations and pre-sedation assessments, and informed consent that warranted recommendations for improvement.

*Reporting and Trending of Reversal Agents and Adverse Events.* VHA requires facilities to monitor moderate sedation outcomes, including reporting and trending the use of reversal agents and analyzing adverse events or documenting the absence of adverse events for the reporting period. These data are used to assist with decision-making efforts to reduce risks and enhance patient safety. Surgical, Procedural, Operative, and Therapeutic Committee meeting minutes dated from April 2016 through April 2017 did not include trending of the use of reversal agents or the presence or absence of adverse events in all reports. Staff from moderate sedation areas did not report required data to the committee during the timeframe reviewed. The committee chair told us that a standard format for reporting had not yet been implemented.

### *Recommendation*

12. The Chief of Staff ensures that the use of reversal agents in moderate sedation cases and the presence or absence of adverse events for all areas administering moderate sedation are reported to and trended by the Surgical, Procedural, Operative, and Therapeutic Committee and monitors compliance.

Facility concurred.

Target date for completion: September 30, 2018

Facility Response: The Performance Improvement Manager will work with the Chairperson of the Surgical, Procedural, Operative and Therapeutic (SPOT) Committee to develop a standardized reporting format for the trending and reporting of sedation outcomes, including the use of reversal agents and adverse events. A reporting schedule will be developed and communicated to the appropriate clinical areas where sedation is used. These clinical areas will be reporting using the standardized report format to ensure that they are reporting on the trending of reversal agents and adverse events related to sedation. The SPOT Committee will ensure compliance with the reporting schedule and standardized reporting format for the procedural areas as the

<sup>39</sup> 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.

measure of success (100 percent of all areas scheduled to report). Compliance will be considered sustained with a review of reports to the SPOT Committee for 6 months that conform to the revised reporting format.

*History and Physical Exams and/or Pre-Sedation Assessments.* VHA requires that providers perform a history and physical and/or pre-sedation assessment that includes required elements within 30 calendar days prior to a procedure for which moderate sedation will be administered. This ensures providers are aware of relevant patient information and assessments that may affect the patient's response to moderate sedation. OIG did not find evidence that providers reviewed abnormalities of major organ systems for 4 of 34 patients (12 percent) or alcohol, tobacco, or substance use or abuse for 5 of 34 patients (15 percent). OIG also did not find evidence that providers performed airway assessments for 5 of 34 patients (15 percent). Noncompliance was observed mainly for patients having cardiology procedures. A cardiology provider stated that the airway assessment and alcohol, tobacco, and substance use or abuse is included in their CART-CL<sup>40</sup> documentation, and that they only complete focused assessments based on the procedure being performed and not a review of all major organ systems. OIG noted that the cardiology providers did not consistently document the required elements in either the CART-CL program or EHR, and that the chart review tool used by quality management did not include all required areas.

### *Recommendation*

13. The Chief of Staff ensures providers include a review of abnormalities of major organ systems; an airway assessment; and a review of alcohol, tobacco, or substance use or abuse in the history and physical exams and/or pre-sedation assessments and monitors providers' compliance.

Facility concurred.

Target date for completion: September 30, 2018

Facility Response: QM is currently performing a review with Clinical Informatics of all CPRS templates used in the procedural areas to ensure that the templates include the required documentation elements. A review of documentation will be completed quarterly by QM and reported to the SPOT Committee. A representative sample of records will be reviewed. The measure of success will be 90 percent compliance with the documentation requirements of a review of abnormalities of major organ systems; an airway assessment; and a review of alcohol, tobacco, or substance use or abuse in the history and physical exams and or pre-sedation assessments at 90 percent for 6 months.

*Informed Consent.* VHA requires that the name of the provider listed on the informed consent for a moderate sedation procedure is the same as the provider who performs

<sup>40</sup> CART-CL stands for Cardiovascular Assessment, Reporting, and Tracking System for Catheterization Laboratories.

the procedure or that the patient is notified of the change. This ensures that patients have consented to the change. For 7 of the 34 patients (21 percent), the name of the provider listed on the informed consent did not match the privileged provider who performed the procedure, and there was no documentation that the provider informed the patient of the change. Noncompliance was observed mainly for patients having gastroenterology procedures. According to the Chief of Gastrointestinal Services at the Manhattan campus, the reason for this disparity was that at the time of patient consent, it was not always known who would be the attending for the procedure. Attending providers were not aware that they needed to document patient assent if they were not listed on the consent.

### *Recommendation*

14. The Chief of Staff ensures providers notify patients of changes in who is performing the moderate sedation procedure and document this in the electronic health record and monitors providers' compliance.

Facility concurred.

Target date for completion: June 2018

Facility Response: CPRS templates will be revised to include a prompt to document that the patient was informed of changes in who is performing the procedure (when applicable). A review of documentation will be completed quarterly by QM and reported to the SPOT Committee. A representative sample of procedure notes will be reviewed. For those cases where the provider performing the procedure is not the provider who is listed on the informed consent, QM will ensure that the patient was notified and that this notification is documented in the medical record. Measure of success will be 90 percent compliance of documentation for 6 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.<sup>41</sup>

The purpose of the review was to determine whether the facility's MH RRTPs complied with selected EOC requirements.<sup>f</sup>

OIG reviewed relevant documents, inspected the 15 West domiciliary substance abuse unit at the Brooklyn campus and the Psychosocial RRTP at the St. Albans campus, 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 recording

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<sup>41</sup> 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

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

## Post-Traumatic Stress Disorder Care

For this facility, OIG also evaluated PTSD, a disorder that may occur "...following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury; other threat to one's physical integrity; witnessing an event that involves death, injury or threat to the physical integrity of another person; learning about unexpected or violent death, serious harm, threat of death or injury experienced by a family member or other close associate."<sup>42</sup>

The PTSD screen is performed through a required national clinical reminder and is triggered for completion when the patient has his or her first visit at a VHA medical facility. The reminder typically remains active until it is completed. For veterans, the most common traumatic stressor contributing to a PTSD diagnosis is war-zone related stress. VHA requires that:

- Every new patient receive PTSD screening that is then repeated every year for the first 5 years post-separation and every 5 years thereafter, unless there is a clinical need to screen earlier.
- If a patient's PTSD screen is positive, an acceptable provider evaluates treatment needs and assesses for suicide risk.
- If the provider determines a need for treatment, there is evidence of referral and coordination of care.

The purpose of this review was to assess whether the facility complied with selected VHA requirements for PTSD follow-up in the outpatient setting.<sup>9</sup>

OIG reviewed relevant documents and interviewed key employees and managers. Additionally, OIG reviewed the EHRs of 34 randomly selected patients who had a positive PTSD screen from April 1, 2016 through March 31, 2017. The list below shows the performance indicators OIG reviewed.

- Completion of a suicide risk assessment by acceptable providers
- Establishment of plan of care and disposition
- Offer of further diagnostic evaluations
- Completion of diagnostic evaluations
- Receipt of MH treatment when applicable

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

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<sup>42</sup> VHA Handbook 1160.03, *Programs for Veterans with Post-Traumatic Stress Disorder (PTSD)*, March 12, 2010.

<b>Summary Table of Comprehensive Healthcare Inspection Program Review Findings</b>			
<b>Healthcare Processes</b>	<b>Performance Indicators</b>	<b>Conclusion</b>	
<b>Leadership and Organizational Risks</b>	<ul style="list-style-type: none"> <li>• Executive leadership stability and engagement</li> <li>• Employee satisfaction and patient experience</li> <li>• Accreditation/for-cause surveys and oversight inspections</li> <li>• Indicators for possible lapses in care</li> <li>• VHA performance data</li> </ul>	Fourteen OIG recommendations, ranging from documentation issues to deficiencies that can lead to patient and staff safety issues or adverse events, are attributable to the Facility Director, Chief of Staff, and Associate Directors. See details below.	
<b>Healthcare Processes</b>	<b>Performance Indicators</b>	<b>Critical Recommendations<sup>43</sup> for Improvement</b>	<b>Recommendations for Improvement</b>
<b>Quality, Safety, and Value</b>	<ul style="list-style-type: none"> <li>• Senior-level involvement in QSV/performance improvement committee</li> <li>• Protected peer review of clinical care</li> <li>• Credentialing and privileging</li> <li>• UM reviews</li> <li>• Patient safety incident reporting and root cause analyses</li> </ul>	<ul style="list-style-type: none"> <li>• Clinical managers consistently review OPPE data every 6 months.</li> </ul>	None
<b>Medication Management</b>	<ul style="list-style-type: none"> <li>• Anticoagulation management policies and procedures</li> <li>• Management of patients receiving new orders for anticoagulants <ul style="list-style-type: none"> <li>○ Prior to treatment</li> <li>○ During treatment</li> </ul> </li> <li>• Ongoing evaluation of the anticoagulation program</li> <li>• Competency assessment</li> </ul>	<ul style="list-style-type: none"> <li>• Clinicians consistently provide specific education to patients with newly prescribed anticoagulant medications and refer patients prescribed direct-acting oral anticoagulants to the anticoagulation clinic.</li> </ul>	<ul style="list-style-type: none"> <li>• Anticoagulation management program quality assurance data are collected, analyzed, and reported quarterly at Pharmacy and Therapeutics Committee meetings.</li> <li>• Clinical managers include required elements in the competency assessments of employees actively involved in the anticoagulant program.</li> </ul>

<sup>43</sup> 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
<p><b>Coordination of Care</b></p>	<ul style="list-style-type: none"> <li>• Transfer policies and procedures</li> <li>• Oversight of transfer process</li> <li>• EHR documentation                             <ul style="list-style-type: none"> <li>○ Non-emergent transfers</li> <li>○ Emergent transfers</li> </ul> </li> </ul>	<p>For patients transferred out of the facility:</p> <ul style="list-style-type: none"> <li>• Providers consistently complete VA Forms 10-2649A and 10-2649B.</li> <li>• Providers communicate or send required information to the accepting facility.</li> </ul>	<ul style="list-style-type: none"> <li>• Inter-facility patient transfer data are analyzed and reported.</li> </ul>
<p><b>Environment of Care</b></p>	<ul style="list-style-type: none"> <li>• Parent facility                             <ul style="list-style-type: none"> <li>○ EOC deficiency tracking and rounds</li> <li>○ General Safety</li> <li>○ Infection prevention</li> <li>○ Environmental cleanliness</li> <li>○ Exam room privacy</li> <li>○ Availability of feminine hygiene products and medical equipment and supplies</li> </ul> </li> <li>• CBOC                             <ul style="list-style-type: none"> <li>○ General safety</li> <li>○ Infection prevention</li> <li>○ Environmental cleanliness</li> <li>○ Medication safety and security</li> <li>○ Privacy</li> <li>○ Availability of feminine hygiene products and medical equipment and supplies</li> <li>○ IT network room security</li> </ul> </li> <li>• Radiology                             <ul style="list-style-type: none"> <li>○ Safe use of fluoroscopy equipment</li> <li>○ Environmental safety</li> <li>○ Infection prevention</li> <li>○ Medication safety and security</li> <li>○ Radiology equipment inspection</li> <li>○ Availability of medical equipment and supplies</li> <li>○ Maintenance of radiological equipment</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• A risk assessment is completed when a locked MH unit patient is using an electrical or mechanical hospital bed, and the room containing the bed is locked when not in use.</li> </ul>	<ul style="list-style-type: none"> <li>• The VA Police Service consistently participates on EOC rounds.</li> <li>• Locked MH unit panic alarm testing documentation includes VA Police Service response time.</li> <li>• All members of the Interdisciplinary Safety Inspection Team complete the required training on how to identify and correct environmental hazards, including the proper use of the MH EOC Checklist.</li> </ul>



Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
<b>Environment of Care (continued)</b>	<ul style="list-style-type: none"> <li>• Inpatient MH                             <ul style="list-style-type: none"> <li>○ MH EOC inspections</li> <li>○ Environmental suicide hazard identification</li> <li>○ Employee training</li> <li>○ Environmental safety</li> <li>○ Infection prevention</li> <li>○ Availability of medical equipment and supplies</li> </ul> </li> </ul>	(See previous page.)	(See previous page.)
<b>High-Risk and Problem-Prone Processes: Moderate Sedation</b>	<ul style="list-style-type: none"> <li>• Outcomes reporting</li> <li>• Patient safety and documentation                             <ul style="list-style-type: none"> <li>○ Prior to procedure</li> <li>○ After procedure</li> </ul> </li> <li>• Staff training and competency</li> <li>• Monitoring equipment and emergency management</li> </ul>	<ul style="list-style-type: none"> <li>• Providers include required elements in the history and physical exams and/or pre-sedation assessments.</li> <li>• Providers notify patients of changes in who is performing the moderate sedation procedure and document this in the EHR.</li> </ul>	<ul style="list-style-type: none"> <li>• The use of reversal agents in moderate sedation cases and the presence or absence of adverse events for all areas administering moderate sedation are reported to and trended by the Surgical, Procedural, Operative, and Therapeutic Committee.</li> </ul>
<b>High-Risk and Problem-Prone Processes: Mental Health Residential Rehabilitation Treatment Program</b>	<ul style="list-style-type: none"> <li>• Environmental cleanliness and fire safety</li> <li>• Policies/procedures                             <ul style="list-style-type: none"> <li>○ Safe medication management</li> <li>○ Contraband detection</li> </ul> </li> <li>• Monthly self-inspections</li> <li>• Contraband and unsecured medication inspections</li> <li>• Locked and alarmed entries</li> <li>• Closed circuit television monitors with recording capability in public areas</li> <li>• Process for responding to behavioral health and medical emergencies</li> </ul>	None	None
<b>High-Risk and Problem-Prone Processes: Post-Traumatic Stress Disorder Care</b>	<ul style="list-style-type: none"> <li>• Completion of a suicide risk assessment by acceptable providers</li> <li>• Established plan of care and disposition</li> <li>• Offer of further diagnostic evaluations</li> <li>• Completion of diagnostic evaluations</li> <li>• Receipt of MH treatment when applicable</li> </ul>	None	None

## Facility Profile

The table below provides general background information for this high-complexity (1a)<sup>44</sup> affiliated<sup>45</sup> facility reporting to VISN 2.

**Table 5. Facility Profile for New York (630) for October 1, 2013 through September 30, 2016**

Profile Element	Facility Data FY 2014 <sup>46</sup>	Facility Data FY 2015 <sup>47</sup>	Facility Data FY 2016 <sup>48</sup>
<b>Total Medical Care Budget in Millions</b>	\$709.9	\$747.8	\$777.4
<b>Number of:</b>			
• <b>Unique Patients</b>	47,969	48,086	48,033
• <b>Outpatient Visits</b>	772,408	769,390	759,056
• <b>Unique Employees<sup>49</sup></b>	3,185	3,167	3,088
<b>Type and Number of Operating Beds:</b>			
• <b>Acute</b>	210	185	185
• <b>Mental Health</b>	52	50	50
• <b>Community Living Center</b>	179	179	179
• <b>Domiciliary</b>	76	76	66
<b>Average Daily Census:</b>			
• <b>Acute</b>	138	131	112
• <b>Mental Health</b>	38	37	34
• <b>Community Living Center</b>	130	134	132
• <b>Domiciliary</b>	51	62	55

Source: VA Office of Academic Affiliations, VHA Support Service Center, and VA Corporate Data Warehouse.

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

NA = Not applicable

<sup>44</sup> VHA medical centers are classified according to a facilities complexity model; 1a designation indicates a facility with high volume, high-risk patients, most complex clinical programs, and large research and teaching programs. Retrieved September 10, 2017, from <http://opes.vssc.med.va.gov/FacilityComplexityLevels/Pages/default.aspx>

<sup>45</sup> Associated with a medical residency program.

<sup>46</sup> October 1, 2013 through September 30, 2014.

<sup>47</sup> October 1, 2014 through September 30, 2015.

<sup>48</sup> October 1, 2015 through September 30, 2016.

<sup>49</sup> Unique employees involved in direct medical care (cost center 8200).

## VA Outpatient Clinic Profiles<sup>50</sup>

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<sup>51</sup> 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 <sup>52</sup> Provided	Diagnostic Services <sup>53</sup> Provided	Ancillary Services <sup>54</sup> Provided
New York, NY	630GA	943	538	NA	NA	Pharmacy Social Work Weight Management
Staten Island, NY	630GB	3,505	2,415	Endocrinology Neurology Anesthesia Eye Podiatry	NA	Nutrition Pharmacy Social Work Weight Management
Brooklyn, NY	630GC	483	1,022	NA	Radiology	Pharmacy Weight Management

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

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

NA = Not applicable

<sup>50</sup> Includes all outpatient clinics in the community that were in operation as of February 15, 2017. We have displayed Brooklyn, NY (630GC); however, the CBOC was deactivated on June 30, 2016.

<sup>51</sup> An encounter is a professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition.

<sup>52</sup> Specialty care services refer to non-PC and non-MH services provided by a physician.

<sup>53</sup> Diagnostic services include EKG, EMG, laboratory, nuclear medicine, radiology, and vascular lab services.

<sup>54</sup> 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 1160.03, *Programs for Veterans with Post-Traumatic Stress Disorder (PTSD)*, March 12, 2010 (recertification due date March 31, 2015) revised December 8, 2015.<sup>55</sup>
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),<sup>56</sup> 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

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<sup>55</sup> This handbook was in effect during the review period for this report; it was rescinded and replaced by VHA Directive 1160.03, *Programs for Veterans with Post-Traumatic Stress Disorder (PTSD)*, November 16, 2017.

<sup>56</sup> VHA Directive 6330(1), *Controlled National Policy/Directives Management System*, June 24, 2016, amended January 11, 2017.

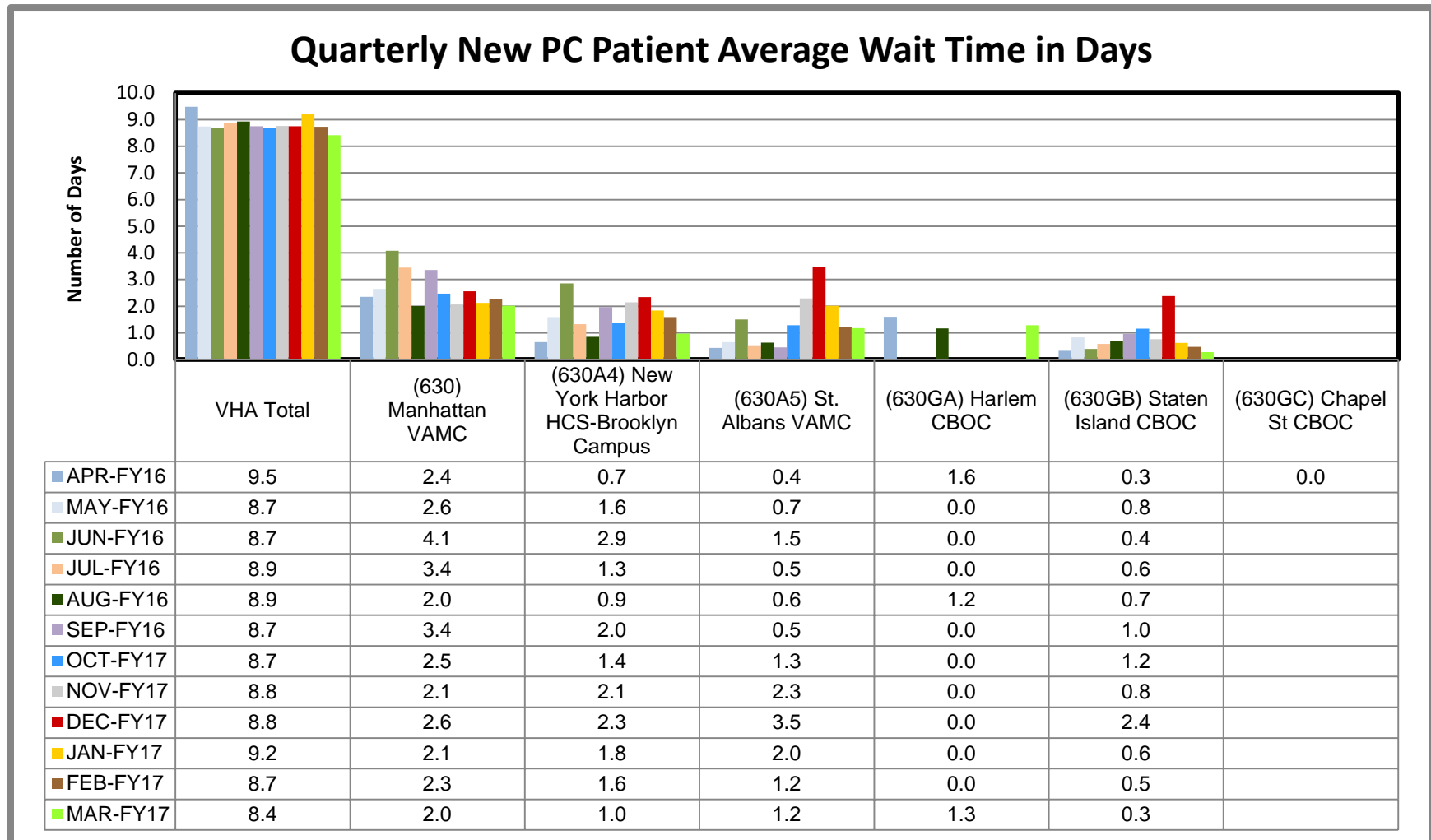
recent policy or guidance.”<sup>57</sup> The Under Secretary for Health also tasked the Principal Deputy Under Secretary for Health and Deputy Under Secretaries for Health with ensuring “...the timely rescission or recertification of policy documents over which their program offices have primary responsibility.”<sup>58</sup>

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<sup>57</sup> VA Under Secretary for Health. “Validity of VHA Policy Document.” Memorandum. June 29, 2016.

<sup>58</sup> Ibid.

### Patient Aligned Care Team Compass Metrics

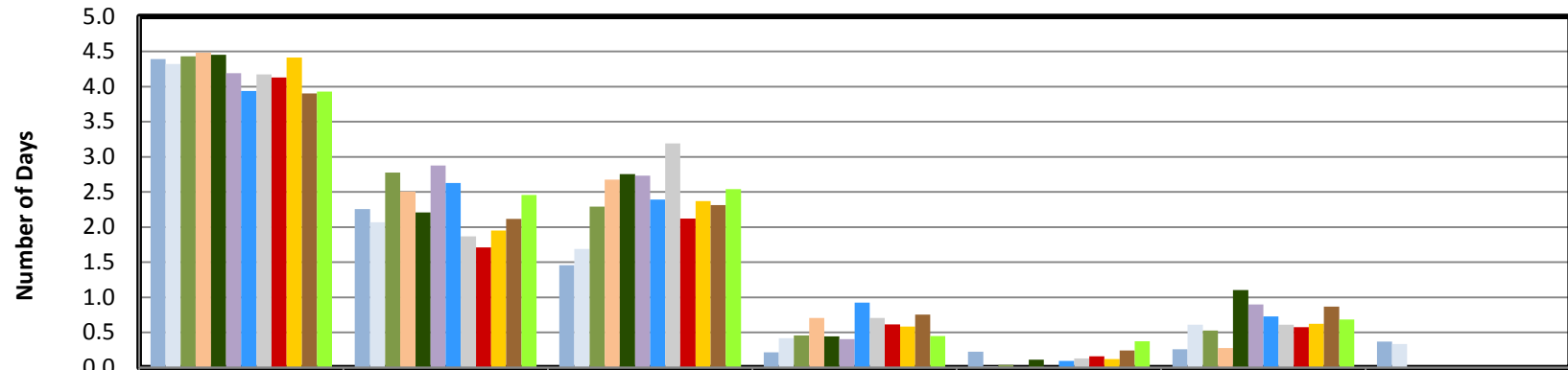


Source: VHA Support Service Center.

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

**Data Definition<sup>h</sup>:** 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.* Blank cells indicate the absence of reported data.

### Quarterly Established PC Patient Average Wait Time in Days



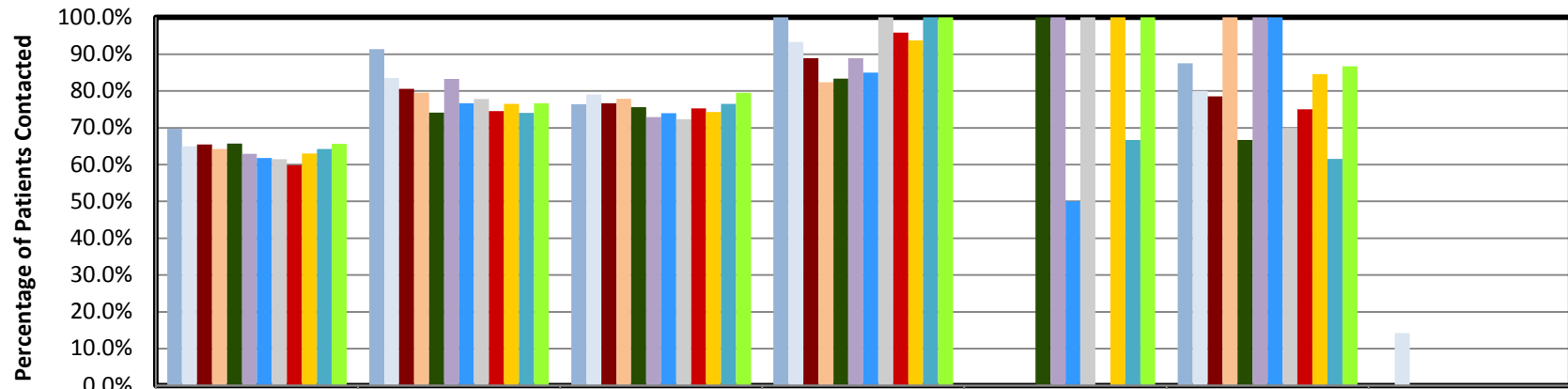
	VHA Total	(630) Manhattan VAMC	(630A4) New York Harbor HCS-Brooklyn Campus	(630A5) St. Albans VAMC	(630GA) Harlem CBOC	(630GB) Staten Island CBOC	(630GC) Chapel St CBOC
■ APR-FY16	4.4	2.3	1.5	0.2	0.2	0.3	0.4
■ MAY-FY16	4.3	2.1	1.7	0.4	0.0	0.6	0.3
■ JUN-FY16	4.4	2.8	2.3	0.5	0.0	0.5	
■ JUL-FY16	4.5	2.5	2.7	0.7	0.0	0.3	
■ AUG-FY16	4.5	2.2	2.8	0.4	0.1	1.1	
■ SEP-FY16	4.2	2.9	2.7	0.4	0.0	0.9	
■ OCT-FY17	3.9	2.6	2.4	0.9	0.1	0.7	
■ NOV-FY17	4.2	1.9	3.2	0.7	0.1	0.6	
■ DEC-FY17	4.1	1.7	2.1	0.6	0.2	0.6	
■ JAN-FY17	4.4	1.9	2.4	0.6	0.1	0.6	
■ FEB-FY17	3.9	2.1	2.3	0.8	0.2	0.9	
■ MAR-FY17	3.9	2.5	2.5	0.4	0.4	0.7	

Source: VHA Support Service Center.

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

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

### Quarterly Team 2-Day Post Discharge Contact Ratio



	VHA Total	(630) Manhattan VAMC	(630A4) New York Harbor HCS-Brooklyn Campus	(630A5) St. Albans VAMC	(630GA) Harlem CBOC	(630GB) Staten Island CBOC	(630GC) Chapel St CBOC
■ APR-FY16	69.7%	91.4%	76.4%	100.0%		87.5%	0.0%
■ MAY-FY16	65.0%	83.5%	79.0%	93.3%	0.0%	80.0%	14.3%
■ JUN-FY16	65.5%	80.6%	76.7%	88.9%		78.6%	0.0%
■ JUL-FY16	64.3%	79.6%	77.9%	82.4%		100.0%	0.0%
■ AUG-FY16	65.7%	74.2%	75.6%	83.3%	100.0%	66.7%	0.0%
■ SEP-FY16	62.9%	83.2%	72.9%	88.9%	100.0%	100.0%	
■ OCT-FY17	61.8%	76.7%	74.0%	85.0%	50.0%	100.0%	
■ NOV-FY17	61.4%	77.8%	72.3%	100.0%	100.0%	70.0%	
■ DEC-FY17	59.8%	74.6%	75.3%	95.8%		75.0%	
■ JAN-FY17	63.0%	76.5%	74.3%	93.8%	100.0%	84.6%	
■ FEB-FY17	64.2%	74.1%	76.5%	100.0%	66.7%	61.5%	
■ MAR-FY17	65.6%	76.7%	79.5%	100.0%	100.0%	86.7%	

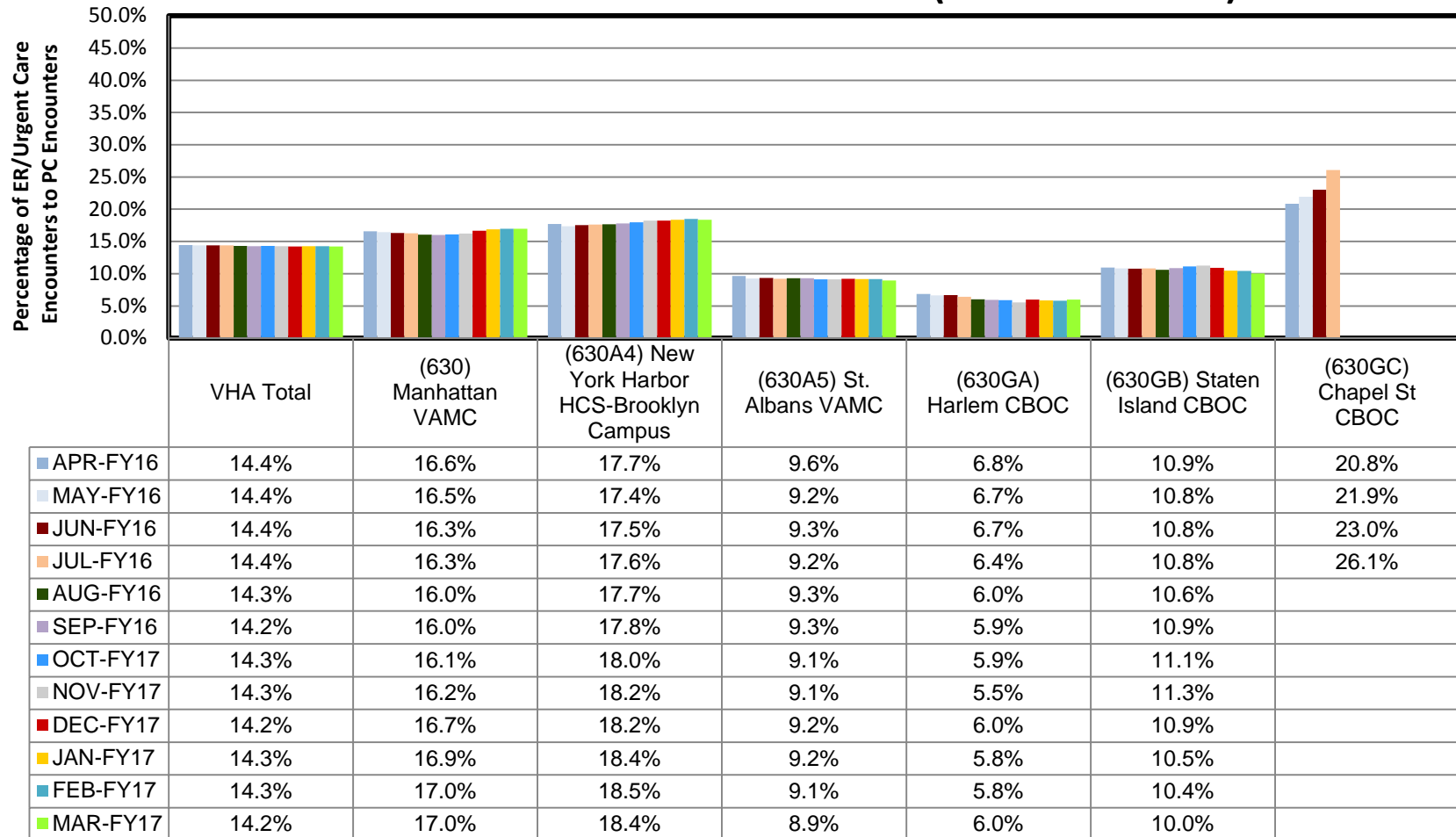
Source: VHA Support Service Center.

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

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



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



Source: VHA Support Service Center.

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

**Data Definition:** This is a measure of where the patient receives 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. Blank cells indicate the absence of reported data.

## Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions<sup>i</sup>

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

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

Source: VHA Support Service Center.

## Relevant OIG Reports

**June 9, 2014 through January 1, 2018<sup>59</sup>**

**Healthcare Inspection – Pressure Ulcer Prevention and Management, VA New York Harbor Healthcare System, New York, New York**

8/17/2017 | 16-02998-345 | [Summary](#) | [Report](#)

**Healthcare Inspection – Operating Room Reusable Medical Equipment and Sterile Processing Service Concerns, VA New York Harbor Healthcare System, New York, New York**

9/29/2016 | 14-04274-418 | [Summary](#) | [Report](#)

**Review of Alleged Mismanagement of the Ambulette Services at the New York Harbor Healthcare System**

8/18/2016 | 15-04945-331 | [Summary](#) | [Report](#)

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

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

**Combined Assessment Program Review of the VA New York Harbor Healthcare System, New York, New York**

8/14/2014 | 14-01293-243 | [Summary](#) | [Report](#)

**Community Based Outpatient Clinic and Primary Care Clinic Reviews at VA New York Harbor Healthcare System, New York, New York**

8/1/2014 | 14-00934-221 | [Summary](#) | [Report](#)

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<sup>59</sup> These are relevant reports that focused on the facility as well as national-level evaluations of which the facility was a component of the review.

## VISN Director Comments

**Department of  
Veterans Affairs**

# Memorandum

**Date:** December 22, 2017

**From:** Director, New York/New Jersey VA Health Care Network (10N2)

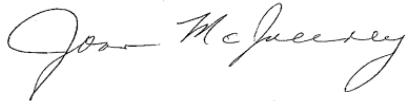
**Subject: CHIP Review of the VA New York Harbor Healthcare System,  
New York, NY**

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

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

Please find the initial status response for the OIG CHIP review of the VA New York Harbor Healthcare System conducted the week of June 19, 2017.

I have reviewed and concur with the Director's response. Thank you for this opportunity to focus on continuous performance improvement.



Joan E. McInerney, MD, MBA, MA, FA CEP  
VISN 2 Network Director

## Facility Director Comments

**Department of  
Veterans Affairs**

# Memorandum

**Date:** December 21, 2017

**From:** Director, VA New York Harbor Healthcare System (630/00)

**Subject: CHIP Review of the VA New York Harbor Healthcare System New York, NY**

**To:** Director, New York/New Jersey VA Health Care Network (10N2)

I have reviewed the draft report of the Office of the Inspector General (OIG) and I concur with the recommendations of the OIG CHIP review of the week of June 19, 2017. The Healthcare System has developed action plans to address the 14 recommendations.

I would like to thank the OIG team for the consultative visit. The recommendations will strengthen our processes to deliver consistent quality care to our Veterans.

Please contact me if you have any questions or comments.



Martina A. Parauda  
Director

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## OIG Contact and Staff Acknowledgments

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<b>Contact</b>	For more information about this report, please contact OIG at (202) 461-4720.
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<b>Other Contributors</b>	Elizabeth Bullock Limin Clegg, PhD LaFonda Henry, RN-BC, MSN Larry Ross, Jr., MS Marilyn Stones, BS April Terenzi, BS, BA Mary Toy, RN, MSN

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## Report Distribution

### **VA Distribution**

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Director, New York/New Jersey VA Health Care Network (10N2)  
Director, VA New York Harbor Healthcare System (630/00)

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Senate Committee on Homeland Security and Governmental Affairs  
National Veterans Service Organizations  
Government Accountability Office  
Office of Management and Budget  
U.S. Senate: Kirsten E. Gillibrand, Charles E. Schumer  
U.S. House of Representatives: Yvette D. Clarke, Joseph Crowley, Daniel Donovan, Eliot Engel, Adriano Espaillat, Hakeem Jeffries, Carolyn B. Maloney, Gregory W. Meeks, Grace Meng, Jerrold Nadler, Jose Serrano, Nydia M. Velázquez

This report is available at [www.va.gov/oig](http://www.va.gov/oig).



## Endnotes

<sup>a</sup> The references used for QSV were:

- VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013.
- VHA Directive 1117, *Utilization Management Program*, July 9, 2014.
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.

<sup>b</sup> 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.

<sup>c</sup> 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.

<sup>d</sup> The references used for EOC included:

- VHA Directive 1014, *Safe Medication Injection Practices*, July 1, 2015.
- VHA Handbook 1105.04, *Fluoroscopy Safety*, July 6, 2012.
- VHA Directive 1116(2), *Sterile Processing Services (SPS)*, March 23, 2016.
- VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013.
- VHA Directive 1229, *Planning and Operating Outpatient Sites of Care*, July 7, 2017.
- VHA Directive 1330.01(1), *Health Care Services for Women Veterans*, February 15, 2017 (amended September 8, 2017).
- VHA Directive 1608, *Comprehensive Environment of Care (CEOC) Program*, February 1, 2016.
- VHA Directive 1761(1), *Supply Chain Inventory Management*, October 24, 2016.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.
- VA Handbook 6500, *Risk Management Framework for VA Information Systems – Tier 3: VA Information Security Program*, March 10, 2015.
- VHA Radiology Online Guide, [http://vaww.infoshare.va.gov/sites/diagnosticervices/NRP/Mammography/Radiology%20Shared%20Files/Radiology\\_Service\\_Online\\_Guide\\_2016.docx](http://vaww.infoshare.va.gov/sites/diagnosticervices/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.

<sup>e</sup> The references used for Moderate Sedation included:

- VHA Directive 1039, *Ensuring Correct Surgery and Invasive Procedures*, July 26, 2013.
- VHA Directive 1073, *Moderate Sedation by Non-Anesthesia Providers*, December 30, 2014.
- VHA Directive 1177; *Cardiopulmonary Resuscitation, Basic Life Support, and Advanced Cardiac Life Support Training for Staff*, November 6, 2014.
- VA National Center for Patient Safety. *Facilitator's Guide for Moderate Sedation Toolkit for Non-Anesthesiologists*. March 29, 2011.
- American Society of Anesthesiologists. *Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists*. 2002; 96:1004–17.
- TJC. *Hospital Standards*. January 2016. PC.03.01.01, EP1 and MS.06.01.03 EP6.

<sup>f</sup> 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.

<sup>g</sup> The references used for PTSD Care included:

- VHA Handbook 1160.03, *Programs for Veterans with Post-Traumatic Stress Disorder (PTSD)*, March 12, 2010.
- VA Memorandum, *Information Bulletin: Clarification of Posttraumatic Stress Disorder Screening Requirements*, August 2015.
- *VA/DoD Clinical Practice Guideline for Management of Post-Traumatic Stress*, Version 2.0, October 2010.
- *VHA Technical Manual – PTSD*, VA Measurement Manual PTSD-51.

<sup>h</sup> The reference used for PACT Compass data graphs was:

- Department of Veterans' Affairs, Patient Aligned Care Teams Compass Data Definitions, accessed: February 14, 2017.

<sup>i</sup> 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.