Department of Veterans Affairs
Office of Inspector General

Comprehensive Healthcare Inspection Program Review of the Alexandria VA Health Care System Pineville, Louisiana

February 1, 2018

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Glossary

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

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Report Overview

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

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

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

This review was conducted during an unannounced visit made during the week of 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 Alexandria VA Health Care System, the leadership team consists of the Facility Director, Chief of Staff, Associate Director for Patient Care Services (Nurse Executive), and Associate Director. Organizational communication and accountability are carried out through a committee reporting structure, with the Joint Advisory Governing Board having oversight for leadership groups such as the Joint Partnership Council, Veterans Health Council, and Executive Committee of the Medical Staff. The leaders are members of the Joint Advisory Governing Board, through which they track, trend, and monitor quality of care and patient outcomes.

All leadership positions are currently permanently assigned. The most recent addition to the Executive Leadership Team was the Nurse Executive, who assumed this position

in August 2016. In the review of selected employee and patient survey results regarding facility senior leadership, OIG noted employee satisfaction scores above or similar to the VHA averages and patient survey scores that reflected less satisfaction compared to the VHA average. However, OIG also noted that facility leaders implemented processes to improve positive patient experiences.

Additionally, OIG reviewed accreditation agency findings, sentinel events, disclosures of adverse patient events, and Patient Safety Indicator data and did not identify any substantial organizational risk factors.

OIG recognizes that the Strategic Analytics for Improvement and Learning (SAIL) model has limitations for identifying all areas of clinical risk but is "a way to understand the similarities and differences between the top and bottom performers" within the Veterans Health Administration (VHA).[1] Although the senior leadership team was knowledgeable about selected SAIL metrics, the leaders should make significant efforts to improve performance of the Quality of Care and Efficiency metrics likely contributing to the current 2-star SAIL rating.

In the review of key care processes, OIG issued nine recommendations that are attributable to the Chief of Staff and Associate Director. Of the six 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. However, OIG noted deficiencies in the credentialing and privileging process.

Medication Management. Generally, OIG noted safe anticoagulation therapy management practices, including compliance with the requirements for obtaining required laboratory tests and competency assessments for employees actively involved in the program. However, OIG identified a deficiency in providing education specific to patients with newly prescribed anticoagulant medications.

Environment of Care. OIG noted compliance with general safety and privacy measures at the parent facility and representative community based outpatient clinic and in radiology areas. However, OIG identified deficiencies with environment of care rounds, safety and infection prevention, and employee training on mental health environmental hazards.

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[1] VHA Support Service Center (VSSC). The Strategic Analytics for Improvement and Learning (SAIL) Value Model Documentation Manual. Accessed on April 16, 2017:
http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=2146.
VHA's Office of Operational Analytics and Reporting developed a model for understanding a facility's performance in relation to nine quality domains and one efficiency domain. The domains within SAIL are made up of multiple composite measures, and the resulting scores permit comparison of facilities within a Veterans Integrated Service Network or across VHA. The SAIL model uses a "star" ranking system to designate a facility's performance in individual measures, domains, and overall quality.

Long-Term Care: Community Nursing Home Oversight. OIG found compliance with requirements for integration of the community nursing home program, patient hand-offs, and community nursing home annual reviews. However, OIG identified deficiencies with the Community Nursing Home Oversight Committee and cyclical clinical visits.

Post-Traumatic Stress Disorder Care. OIG did not find compliance with requirements for post-traumatic stress disorder care and identified deficiencies with the completion of suicide risk assessments and the offer of further diagnostic evaluations.

Summary

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

Comments

The Veterans Integrated Service Network Director and Facility Director agreed with the CHIP review findings and recommendations and provided acceptable improvement plans. (See Appendixes G and H, pages 42–43, and the responses within the body of the report for the full text of the Directors' comments.) OIG will follow up on the planned actions until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

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

Scope

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

However, the Moderate Sedation special focus area did not apply for the Alexandria VA Health Care System because the facility did not perform procedures using moderate sedation. Thus, OIG focused on the remaining five areas of clinical operations and one additional program with relevance to the facility—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[2] 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;[3] 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 August 4, 2014[4] through June 19, 2017, the date when an unannounced week-long site visit commenced. On June 8, 2017, OIG also presented crime awareness briefings to 105 of the facility's 1,289 employees. These briefings covered procedures for reporting suspected criminal activity to OIG and

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[2] 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.

[3] OIG did not review VHA's internal survey results but focused on OIG inspections and external surveys that affect facility accreditation status.

[4] 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, OIG referred issues and concerns beyond the scope of the CHIP review to the OIG Hotline management team for further evaluation. OIG conducted the inspection in accordance with OIG standard operating procedures for CHIP reviews and *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Results and Recommendations

Leadership and Organizational Risks

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

1. Executive leadership stability and engagement

2. Employee satisfaction and patient experience

3. Accreditation/for-cause surveys and oversight inspections

4. Indicators for possible lapses in care

5. VHA performance data

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

It is important to note that all leadership positions are currently permanently assigned. The most recent addition to the Executive Leadership Team was the Nurse Executive, who assumed this position in August 2016.

To help assess engagement of facility executive leadership, OIG interviewed the Facility Director, Chief of Staff, Nurse Executive, and Associate Director regarding their knowledge of various metrics and their involvement and support of actions to improve or sustain performance. In individual interviews, these executive leaders generally were able to speak knowledgeably about actions taken during the previous 12 months in order to maintain or improve performance, employee and patient survey results, and selected Strategic Analytics for Improvement and Learning (SAIL) metrics. These are discussed more fully below.

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

Figure 2. Facility Organizational Chart

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                        ┌──────────────────────┐
                        │   Facility Director   │
                        └──────────────────────┘
            ┌────────────────────┼────────────────────┐
   ┌────────────────┐  ┌────────────────┐  ┌────────────────┐
   │  Chief of Staff │  │ Nurse Executive │  │Associate Director│
   └────────────────┘  └────────────────┘  └────────────────┘
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Chief of Staff

Dental Service
Education
Imaging Service
Library Service
Medical Service/Geriatrics & Extended Care
Mental Health
Pathology & Laboratory
Pharmacy Service
Physical Medicine & Rehabilitation
Primary Care/Community Based Outpatient Clinics
Specialty Care

Nurse Executive

Chaplain Service
Nursing Service
Nutrition and Food Service
Sterile Processing Service

Associate Director

Decision Support Service
Engineering Service
Environmental Management Service
Fiscal Service
Human Resource Management
Logistics
Medical Administration Service
Office of Information and Technology
Police Service
Prosthetics & Sensory Aids
Safety
Veteran Canteen Service

Source: Alexandria VA Health Care System (received July 12, 2017).

Figure 3. Facility Committee Reporting Structure

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                  ┌──────────────────────────┐
                  │  Joint Advisory Governing  │
                  │          Board            │
                  └──────────────────────────┘
       ┌──────────────────────┼──────────────────────┐
┌──────────────┐  ┌──────────────────────┐  ┌──────────────┐
│Joint Partnership│  │                      │  │Veterans Health│
│   Council      │  │                      │  │   Council     │
└──────────────┘  └──────────────────────┘  └──────────────┘
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Joint Partnership Council

Executive Committee of the Medical Staff
Healthcare Resources Committee
Quality, Safety, & Value Committee
Strategic Directions Committee
Veterans Experience Committee
Workforce Committee

Veterans Health Council

Source: Alexandria VA Health Care System (received July 12, 2017).

Employee Satisfaction and Patient Experience. To assess employee and patient attitudes toward facility senior leadership, OIG reviewed employee satisfaction and patient experience survey results that relate to the period of October 1, 2015 through September 30, 2016. Although OIG recognizes that employee satisfaction and patient experience survey data are subjective, they can be a starting point for discussions and indicate areas for further inquiry, which can be considered along with other information on facility leadership. Table 1 provides relevant survey results for VHA and the facility for the 12-month period. The facility leaders' results (Director's office average) were rated markedly above the VHA and facility average.[5] The facility's performance (facility average) for the two selected survey results was similar to the VHA average.[6] Employee attitudes were generally satisfied. However, three of the four patient survey results reflected lower care ratings compared to the VHA average, and patients appear generally less satisfied with the leadership and care provided.

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

Questions	Scoring	VHA Average	Facility Average	Director's Office Average[7]
All Employee Survey[8] Q59. How satisfied are you with the job being done by the executive leadership where you work?	1 (Very Dissatisfied) – 5 (Very Satisfied)	3.3	3.3	4.5
All Employee Survey Servant Leader Index Composite	0–100 where HIGHER scores are more favorable	66.7	67.1	84.0
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	61.0	
Survey of Healthcare Experiences of Patients (inpatient): I felt like a valued customer.	The response average is the percent of "Agree" and "Strongly Agree" responses.	82.8	83.3	
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): I felt like a valued customer.		73.2	69.1	
Survey of Healthcare Experiences of Patients (outpatient specialty care): I felt like a valued customer.		73.8	63.7	

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[5] 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.

[6] We make no comment on the adequacy of the VHA average for each selected survey element. The VHA average is used for comparison purposes only.

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

[8] The All Employee Survey is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential. The instrument has been refined at several points since 2001 in response to operational inquiries by VA leadership on organizational health relationships and VA culture.

To address patient satisfaction scores, facility leadership required employees to attend Military Experience Training "MIL X Training" developed by the Office of Patient Centered Care and provided by local facilitators. This training is designed to provide an appreciation for what veterans have experienced during their years of service. The goal is to allow and/or improve the connection employees have with the population they serve. Leadership has also focused efforts on hiring additional primary care (PC), mental health (MH), and specialty providers to improve access and continuity of care, which may be contributing to the lower survey results for outpatient care.

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

OIG also noted the facility's current accreditation status with the Commission on Accreditation of Rehabilitation Facilities[11] and College of American Pathologists,[12] which demonstrates the facility leaders' commitment to quality care and services. Additionally, the Long Term Care Institute[13] conducted inspections of the facility's community living center.

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[9] TJC conducts for-cause unannounced surveys in response to serious incidents relating to the health and/or safety of patients or staff or reported complaints. The outcomes of these types of activities may affect the current accreditation status of an organization.

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

[11] The Commission on Accreditation of Rehabilitation Facilities provides an international, independent, peer review system of accreditation that is widely recognized by Federal agencies. VHA's commitment is supported through a system-wide, long-term joint collaboration with the Commission on Accreditation of Rehabilitation Facilities to achieve and maintain national accreditation for all appropriate VHA rehabilitation programs.

[12] For 70 years, the College of American Pathologists has fostered excellence in laboratories and advanced the practice of pathology and laboratory science. In accordance with VHA Handbook 1106.01, VHA laboratories must meet the requirements of the College of American Pathologists.

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

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

Accreditation or Inspecting Agency	Date of Visit	Number of Findings	Number of Recommendations Remaining Open
VA OIG (Combined Assessment Program Review of the Alexandria VA Health Care System, Pineville, Louisiana, October 16, 2014)	August 2014	18	0
VA OIG (Community Based Outpatient Clinic and Primary Care Clinic Reviews at Alexandria VA Health Care System, Pineville, Louisiana, September 16, 2014)	August 2014	5	0

TJC[14]
  • Regular
    o Hospital Accreditation
    o Nursing Care Center Accreditation
    o Behavioral Health Care Accreditation
    o Home Care Accreditation
  • For-Cause
	September 2014
	
	January 2015
		
		8
		4
		1
		
		2
		5
			0
			
			0

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

Indicators for Possible Lapses in Care. Within the health care field, the primary organizational risk is the potential for patient harm. Many factors impact the risk for patient harm within a system, including unsafe environmental conditions, sterile processing deficiencies, and infection control practices. Leaders must be able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms. Table 3 summarizes key indicators of risk since OIG's previous August 2014 Combined Assessment Program and Community Based Outpatient Clinic and PC review inspections through the week of June 19, 2017.

Table 3. Summary of Selected Organizational Risk Factors[15]
(August 2014 to June 19, 2017)

Factor	Number of Occurrences
Sentinel Events[16]	6
Institutional Disclosures[17]	0
Large-Scale Disclosures[18]	0

[15] It is difficult to quantify an acceptable number of occurrences because one occurrence is one too many. Efforts should focus on prevention. Sentinel events and those that lead to disclosure can occur in either inpatient or outpatient settings and should be viewed within the context of the complexity of the facility. (Note that the Alexandria VA Health Care System is a low complexity (3) affiliated facility as described in Appendix B.)

[16] A sentinel event is a patient safety event that involves a patient and results in death, permanent harm, or severe temporary harm and intervention required to sustain life.

[17] Institutional disclosure of adverse events (sometimes referred to as "administrative disclosure") is a formal process by which facility leaders together with clinicians and others, as appropriate, inform the patient or the patient's personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse.

[18] Large-scale disclosure of adverse events (sometimes referred to as "notification") is a formal process by which VHA officials assist with coordinating the notification to multiple patients (or their personal representatives) that they may have been affected by an adverse event resulting from a systems issue.

OIG also reviewed Patient Safety Indicators developed by the Agency for Healthcare Research and Quality within the U.S. Department of Health and Human Services. These provide information on potential in-hospital complications and adverse events following surgeries and procedures.[19] The rates presented are specifically applicable for this facility, and lower rates indicate lower risks. Table 4 summarizes Patient Safety Indicator data from October 1, 2015 through September 30, 2016.

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

Measure	Reported Rate per 1,000 Hospital Discharges		
	VHA	VISN 16	Facility
Pressure Ulcers	0.55	0.60	0
Death among surgical inpatients with serious treatable conditions	103.31	94.44	NA
Iatrogenic Pneumothorax	0.20	0.08	0
Central Venous Catheter-Related Bloodstream Infection	0.12	0.07	0
In Hospital Fall with Hip Fracture	0.08	0.05	0
Perioperative Hemorrhage or Hematoma	2.59	2.27	0
Postoperative Acute Kidney Injury Requiring Dialysis	1.20	1.94	0
Postoperative Respiratory Failure	6.31	3.33	0
Perioperative Pulmonary Embolism or Deep Vein Thrombosis	3.29	3.80	0
Postoperative Sepsis	4.45	4.03	0
Postoperative Wound Dehiscence	0.65	0	0
Unrecognized Abdominopelvic Accidental Puncture/Laceration	0.67	1.22	0

Source: VHA Support Service Center.

NA = Not Applicable

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

None of the 11 applicable PSI measures show an observed rate per 1,000 hospital discharges in excess of the observed rates for Veterans Integrated Service Network (VISN) 16 and VHA.

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

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

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

Figure 4. Strategic Analytics for Improvement and Learning Star Rating Distribution (as of September 30, 2016)
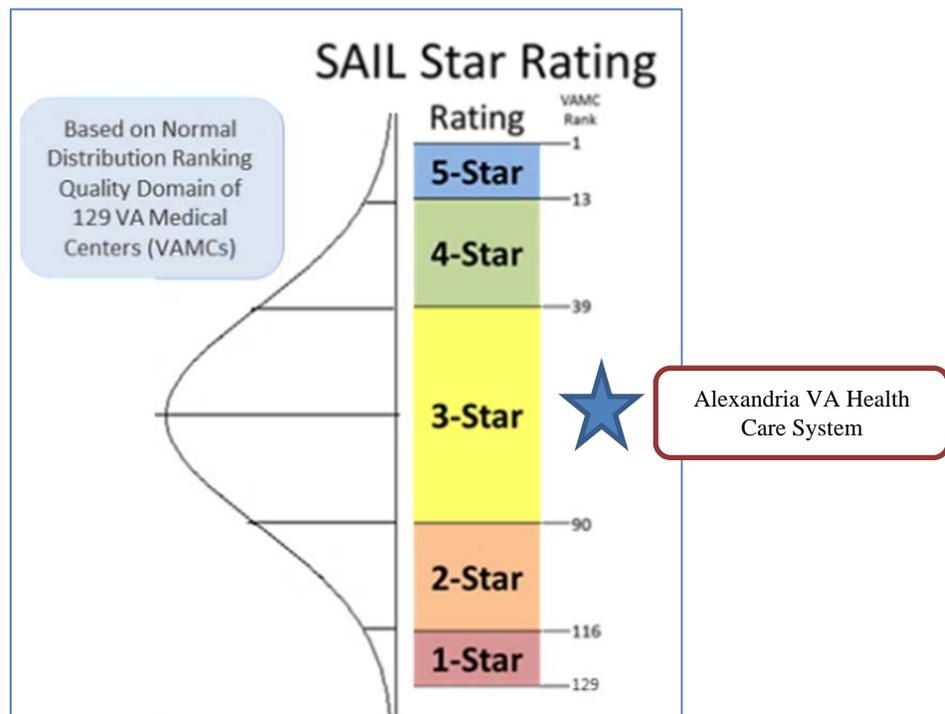
Source: VA Office of Informatics and Analytics' Office of Operational Analytics and Reporting.

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

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

Figure 5 illustrates the facility's Quality of Care and Efficiency metric rankings and performance compared to other VA facilities as of December 31, 2016. Of note, Figure 5 shows blue and green data points in the top quintiles that show high performance (for example, Healthcare-Associated [HC Assoc] Infections, Ambulatory Care Sensitive Condition [ACSC] Hospitalization, and Registered Nurse [RN] Turnover). Metrics in the bottom quintiles reflect areas that need improvement and are denoted in orange and red (for example, Comprehensiveness, MH Continuity [of] Care, and Complications).

Figure 5. Facility Quality of Care and Efficiency Metric Rankings
(as of December 31, 2016)
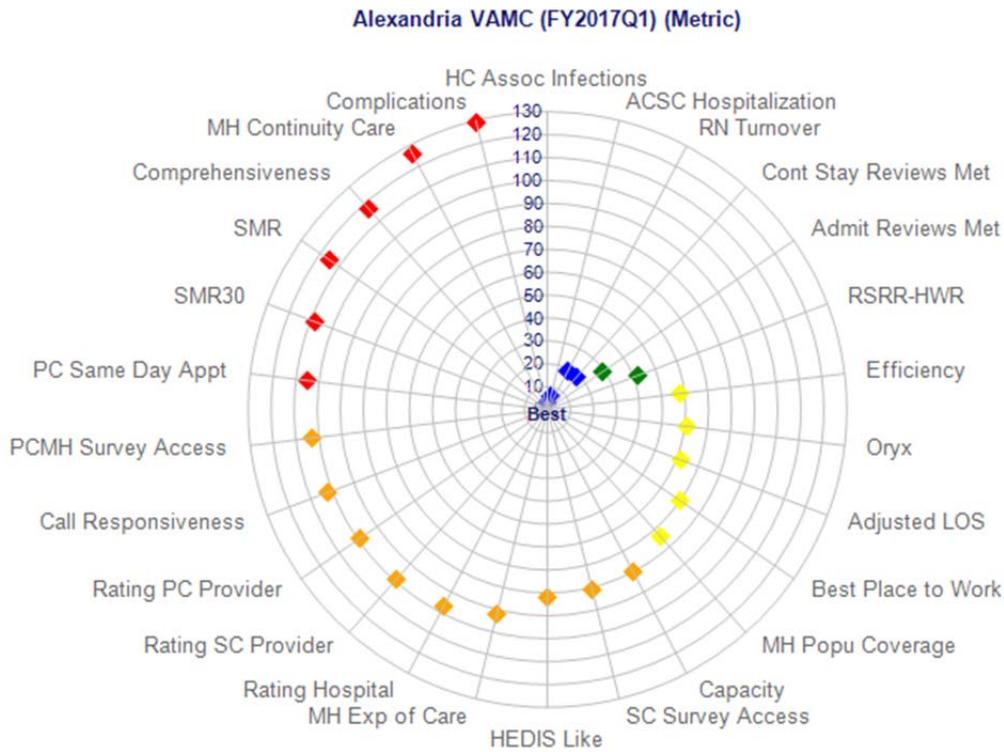
Source: VHA Support Service Center.

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

Conclusions. The facility has stable executive leadership and active engagement with employees but needs to continue efforts to improve patient experience scores. Organizational leaders support patient safety, quality care, and other positive outcomes. OIG's review of accreditation organization findings, sentinel events, disclosures, and Patient Safety Indicator data did not identify any substantial organizational risk factors.[22] The senior leaders seemed knowledgeable about selected SAIL metrics but should make significant efforts to improve care and performance, particularly Quality of Care and Efficiency metrics likely contributing to the current 2-star ranking.

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[22] OIG recognizes that the SAIL model has limitations for identifying all areas of clinical risk. OIG is using it as "a way to understand the similarities and differences between the top and bottom performers" within the VHA system.

Quality, Safety, and Value

One of VA's strategies is to deliver high-quality, veteran-centered care that compares favorably to the best of the private sector in measured outcomes, value, and efficiency.[23] VHA requires that its facilities operate a QSV program to monitor patient care quality and performance improvement activities.

The purpose of this review was to determine whether the facility complied with key QSV program requirements.[a] To assess this area of focus, OIG evaluated the following:

1. Senior-level involvement in QSV/performance improvement committee
2. Protected peer review[24] of clinical care
3. Credentialing and privileging
4. Utilization management (UM) reviews[25]
5. Patient safety incident reporting and root cause analyses

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

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

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

[24] According to VHA Directive 2010-025 (June 3, 2010), this is a peer evaluation of the care provided by individual providers within a selected episode of care. This also involves a determination of the necessity of specific actions, and confidential communication is given to the providers who were peer reviewed regarding the results and any recommended actions to improve performance. The process may also result in identification of systems and process issues that require special consideration, investigation, and possibly administrative action by facility staff.

[25] According to VHA Directive 1117 (July 9, 2014), UM reviews evaluate the appropriateness, medical need, and efficiency of health care services according to evidence-based criteria.

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

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

Conclusions. Generally, OIG found that senior managers were engaged with QSV activities, and, when opportunities for improvement were identified, they supported clinical leaders' implementation of corrective actions and monitoring for effectiveness. OIG found general compliance with requirements for protected peer review and patient safety.   However, OIG identified the following deficiency that warranted a recommendation for improvement.

Credentialing and Privileging. VHA requires the review of OPPE data on a regular basis and at a minimum of every 6 months. The ongoing monitoring of privileged practitioners is essential to confirm the quality of care delivered and allows the facility to identify professional practice trends that impact patient safety. Thirteen of the 25 profiles did not contain evidence that clinical managers reviewed OPPE data every 6 months for these licensed independent practitioners. The Credentialing Coordinator indicated that the reasons OPPEs were not completed timely were the lack of consistent leadership in many areas and conflicting priorities (patient care) of the acting staff assigned to those areas.

Recommendation

1. The Chief of Staff ensures that clinical managers consistently review Ongoing Professional Practice Evaluation data at least every 6 months and monitors managers' compliance.

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

Facility concurred.

Target date for completion: June 30, 2018

Facility Response: Clinical Service Chiefs completed an evaluation of their current review periods for OPPE. Each service has established a 6-month review cycle. Monitoring of the monthly schedule of OPPE's is an agenda item for the monthly Credentialing and Privileging Committee. The Clinical Service Chiefs report the rate of completion for OPPE monthly to the Chief of Staff at the Credentialing and Privileging Committee meeting. OPPE reviews are measured as the number of OPPEs completed each month over the number of OPPEs due each month. Target 90% compliance.

Medication Management: Anticoagulation Therapy

Comprehensive medication management is defined as the standard of care that ensures clinicians individually assess each patient's medications to determine that each is appropriate for the patient, effective for the medical condition, safe given the comorbidities and other medications prescribed, and able to be taken by the patient as intended. From October 1, 2015 through September 30, 2016, more than 482,000 veterans received an anticoagulant,[28] or a blood thinner, which is a drug that works to prevent the coagulation or clotting of blood. TJC's National Patient Safety Goal (3.05.01) focuses on improving anticoagulation safety to reduce patient harm and states, "…anticoagulation medications are more likely than others to cause harm due to complex dosing, insufficient monitoring, and inconsistent patient compliance."

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

OIG reviewed relevant documents and the competency assessment records of three employees actively involved in the anticoagulant program and interviewed key employees. Additionally, OIG reviewed the electronic health records (EHRs) of 25 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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[28] Managerial Cost Accounting Pharmacy Cube, Corporate Data Warehouse data pull on March 23, 2017.

Conclusions. Generally, OIG noted safe anticoagulation therapy management practices for most of the performance indicators above, including compliance with the requirements for obtaining required laboratory tests and competency assessments for employees actively involved in the program. However, OIG identified the following deficiency that warranted a recommendation for improvement.

Patient Education. VHA requires clinicians to provide initial and ongoing education to all patients who are newly prescribed with anticoagulant medications. This education should include elements such as the importance of follow-up monitoring, indication for therapy, dietary restrictions and interactions, and signs and symptoms of bleeding/thromboembolic events. Due to the high risk of adverse events, patient education is essential to decrease the potential occurrence of bleeding, drug interactions, or other delayed pharmacological effects. Four of the 25 EHRs did not contain evidence that patients received initial education specific to the newly prescribed anticoagulant. Facility managers indicated that clinicians' lack of knowledge related to the documentation requirements for education at initiation of anticoagulation therapy contributed to noncompliance.

Recommendation

2. The Chief of Staff ensures clinicians consistently provide specific education to patients with newly prescribed anticoagulant medications and monitors clinicians' compliance.

Facility concurred.

Target date for completion: June 30, 2018

Facility Response: Chief of Pharmacy Service completed an update of the Criteria for Use Order template to require documentation that appropriate education was provided prior to prescribing anticoagulants. Quarterly reports, indicating requirements that are still active, are reported to the Chief of Staff through the Pharmacy & Therapeutics Committee. Staff education is measured by the number of unique patients receiving education to the number of unique patients with newly prescribed anticoagulant medications orders. Target 90% compliance.

Coordination of Care: Inter-Facility Transfers

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

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

OIG reviewed relevant policies and facility data and interviewed key employees. Additionally, OIG reviewed the EHRs of 50 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. Generally, the facility met requirements with the above performance indicators. OIG made no recommendations.

Environment of Care

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

Fluoroscopic imaging equipment produces x-rays for the diagnosis, localization, and guidance of interventional procedures.[29] Although an integral part of health care, fluoroscopic imaging can deliver large doses of radiation to patients and employees. Large doses of radiation are known to increase the incidence of cancer and can cause fetal abnormalities.

VHA provides various MH services to patients with acute and severe emotional and/or behavioral symptoms. These services are often provided in an inpatient setting.[30] The inpatient locked MH unit must provide a healing, recovery-oriented environment as well as be a safe place for patients and employees. VHA developed the MH EOC Checklist to reduce environmental factors that contribute to inpatient suicides, suicide attempts, and other self-injurious behaviors and factors that reduce employee safety on MH units.

In all, OIG inspected five inpatient units (medical/surgical, locked MH, post-anesthesia care, and community living centers 1 and 2), the urgent care clinic, a PC clinic, a specialty clinic, and Radiology Service. OIG also inspected the Lake Charles outpatient clinic. 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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[29] VHA Handbook 1105.04, *Fluoroscopy Safety*, July 6, 2012.
[30] VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013.

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

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

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

Conclusions. General safety and privacy measures were in place at the parent facility, representative community based outpatient clinic, and radiology areas. OIG did not note any issues with the availability of medical equipment and supplies. However, OIG identified the following deficiencies that warranted recommendations for improvement.

Parent Facility: Environment of Care Rounds Attendance. VHA requires facilities to perform comprehensive EOC rounds with a designated team that includes specific membership to ensure a safe, clean, and high-quality care environment.[31] OIG reviewed Comprehensive EOC Assessment and Compliance Tool documentation for FY 2016 and did not find evidence that the information security officer and representatives from nursing, biomedical engineering, privacy/facility information management, the women veterans program, and VA Police consistently attended rounds. Managers were aware of noncompliance, but due to other priorities or lack of staff, failed to take follow-up actions to ensure compliance.

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[31] According to VHA, core membership is composed of representatives from programmatic areas such as nursing, infection control, patient safety, and medical equipment management to ensure adherence to various program requirements. Further, all patient care areas of the hospital must be reviewed at least twice a year.

Recommendation

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

Facility concurred.

Target date for completion: June 30, 2018

Facility Response: The information security officer and representatives from nursing, biomedical engineering, privacy/facility information management, the women veterans program, and VA Police received notice of required attendance from the Associate Director. Team participation is monitored at the monthly Environment of Care (EOC) Committee. The Safety Officer contacts the deficient services prior to the initiation of the rounds to ensure participation by required disciplines. The Associate Director will issue a memorandum to the supervisor of staff that are deficient in attendance to ensure staff attendance on the EOC rounds. Staff attendance will be measured by the number of rounds attended to the number of rounds that were conducted. Target 90% compliance.

Parent Facility Safety and Infection Prevention. The TJC requires that hospitals continually monitor environmental conditions. This ensures a clean and safe health care environment and minimizes the spread of infection and reduces or eliminates potential safety hazards. Seven of 10 patient care areas[32] inspected contained damaged furnishings or environmental surfaces, such as walls or counter tops, which posed safety hazards and/or infection prevention issues since the surfaces could not be sanitized. Managers and staff knew the safety and infection prevention requirements but were unaware of the damaged furnishings and environmental surfaces.

Recommendation

4. The Associate Director ensures that facility managers maintain a safe and clean environment in all patient care areas and monitors the managers' compliance.

Facility concurred.

Target date for completion: June 30, 2018

Facility Response: The 7 areas with identified deficiencies have been corrected. Patient care areas are being monitored on EOC rounds weekly and deficiencies that are entered pertaining to damaged furnishings and environmental surfaces are monitored to closure at the EOC Committee monthly. Target 90% compliance.

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[32] Medical/Surgical, Locked MH, post anesthesia care, community living center 1 and 2 units and the urgent care and specialty care clinics.

Locked Mental Health Unit: Employee and Inspection Team Training. VHA requires that locked MH unit employees and Interdisciplinary Safety Inspection Team members receive annual 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 10 locked MH unit employees and all six Interdisciplinary Safety Inspection Team members did not have evidence of the required training within the past 12 months (June 2016 to June 2017). MH unit employees knew the requirements but did not take the training due to other priorities and collateral duties. Interdisciplinary Safety Inspection Team members did not complete the available online training. Managers described just-in-time training conducted for team members; however, they could not produce evidence of training for the noncompliant team members.

Recommendation

5. The Associate Director ensures locked mental health unit employees and Interdisciplinary Safety Inspection Team members 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 monitors compliance.

Facility concurred.

Target date for completion: June 30, 2018

Facility Response: All locked mental health unit employees and Interdisciplinary Safety Inspection Team (IDST) members have completed required training in TMS [Talent Management System]. In addition, the Education Coordinator assigned the IDST this required training in TMS. Training compliance is reported to the Associate Director and will be tracked at the EOC Committee quarterly. The Associate Director will issue a memorandum to the supervisor of staff that are out of compliance. The memorandum will direct the supervisors to ensure staff complete the training. Training compliance is measured by the number of staff completing the training to the number of staff assigned the training. Target 90% compliance.

Long-Term Care: Community Nursing Home Oversight

Since 1965, VHA has provided nursing home care under contracts. VHA facilities must integrate the CNH program into their Quality Improvement Programs. The Facility Director establishes the CNH Oversight Committee, which reports to the chief clinical officer (Chief of Staff, Nurse Executive, or the equivalent) and includes multidisciplinary management-level representatives from social work, nursing, quality management, acquisition, and the medical staff. The CNH Oversight Committee must meet at least quarterly.[33] Local oversight of CNHs is achieved through annual reviews and monthly visits.

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

OIG interviewed key employees and reviewed relevant documents and the results from CNH annual reviews completed July 5, 2015 through June 30, 2016. Additionally, OIG reviewed the EHRs of 48 randomly selected patients who received CNH care for more than 3 months during the timeframe July 1, 2015 through June 30, 2016. The list below shows the performance indicators OIG reviewed.

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

Conclusions. Generally, OIG noted compliance with requirements for the integration of the CNH Oversight Committee processes into the facility's quality improvement program, patient hand-offs, and CNH annual reviews. OIG identified the following deficiencies that warranted recommendations for improvement.

Oversight Committee. VHA requires the CNH Oversight Committee to include management-level representation from social work, nursing, quality management, acquisitions, and the medical staff. Committee oversight functions include verifying completeness of the CNH Review Teams initial, annual, and problem-focused CNH evaluations. Multidisciplinary review and perspective helps to ensure VHA contracted nursing homes provide quality care in a safe environment. Neither of the two medical staff members of the CNH Oversight Committee attended meetings for the timeframe January 2016 through April 2017. Managers and staff were aware of noncompliance with the requirements, but staffing issues and other priorities prevented compliance.

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

Recommendation

6. The Chief of Staff ensures the Community Nursing Home Oversight Committee includes consistent representation by the medical staff and monitors compliance.

Facility concurred.

Target date for completion: June 30, 2018

Facility Response: CNH Coordinator established attendance tracking for medical staff members. Lack of attendance at CNH Oversight Committee discussed with medical staff. Reminder email is sent one week prior to meeting, and again the day before. The CNH Oversight Committee monthly minutes will reflect medical staff attendance. The Chief of Staff will issue a memorandum to the medical staff supervisor directing the attendance by the assigned staff to the committee meetings. Staff attendance is measured by the number of times the medical staff attend the meeting to the number of meetings that are held. Target 90% compliance.

Clinical Visits. VHA requires that every patient under contract in a nursing home must be visited by a social worker or registered nurse at least every 30 days (unless specific criteria allow an exception). Social workers and registered nurses must alternate monthly visits unless otherwise indicated by the patient's visit plan. This interdisciplinary monitoring ensures vulnerable nursing home patients consistently receive quality care and necessary follow-up services. None of the 48 EHRs contained documentation of social worker and/or registered nurse cyclical clinical visits with the frequency required by VHA policy. Forty seven of the 48 EHRs (98 percent) did not contain documentation that social workers and registered nurses alternated monthly visits as required by VHA policy; some patients were visited exclusively by one discipline or the other. Managers and staff knew about the requirements, but facility managers stated that staff availability and collateral duties contributed to noncompliance with VHA policy.

Recommendation

7. The Chief of Staff ensures social workers and registered nurses conduct alternating, cyclical clinical visits with the required frequency and monitors their compliance.

Facility concurred.

Target date for completion: June 30, 2018

Facility Response: CNH Coordinator developed a monthly schedule that ensures alternating cyclical clinical visits by the Social Worker and RN, and reports to the CNH Oversight Committee. The Chief of Staff will issue a memorandum to the supervisor of the Social Worker or RN that is not adhering to the cyclical visit schedule to ensure that staff adhere to the visit schedule. Adherence to the visit schedule will be measured by the number of cyclical clinical visits conducted by the appropriate discipline to the number of clinical visits that occurred each month. Target 100% compliance.

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."[34]

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 receives 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.[f]

OIG reviewed relevant documents and interviewed key employees and managers. Additionally, OIG reviewed the EHRs of 42 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

Conclusions. OIG identified deficiencies with the completion of suicide risk assessments and the offer of further diagnostic evaluations. Because these elements of care were not performed, the remaining performance indicators were not applicable.

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[34] VHA Handbook 1160.03, *Programs for Veterans with Post-Traumatic Stress Disorder (PTSD)*, March 12, 2010.

Suicide Risk Assessment. VHA requires that each patient with a positive PTSD screen receive a suicide risk assessment. The provider performing the assessment could be pivotal in connecting patients at risk for suicide to an MH professional, supporting a decrease in the likelihood of suicidal behavior. Fifteen of the 42 patients (36 percent) did not receive a suicide risk assessment. Managers told us that lack of warm-handoffs (direct communication between clinicians to "hand-off" the patient) between nursing staff and PC providers, PC providers overlooking follow-up positive PTSD/Depression screen clinical reminders, and lack of education on clinical reminders for newer providers could have contributed to noncompliance.

Recommendation

8. The Chief of Staff ensures acceptable providers perform and document suicide risk assessments for all patients with positive post-traumatic stress disorder screens and monitors providers' compliance.

Facility concurred.

Target date for completion: June 30, 2018

Facility Response: Chief of Primary Care educated primary care providers on suicide risk assessments for all patients with positive post-traumatic stress disorder screens. Reinforcement of warm-handoffs occur at every Primary Care Provider meeting and during PACT meetings. New provider orientation includes a 2-hour live CPRS [Computerized Patient Record System] training with the Clinical Applications Coordinators who review the process for completing clinical reminders, in addition to the required TMS training. Primary Care began monitoring follow-up for positive depression and PTSD screenings in July with results communicated to PACT [Patient Aligned Care Team] providers and reporting to ECMS [Executive Committee of the Medical Staff] monthly. Results are measured by the number of patients with a positive post-traumatic stress disorder screen receiving a suicide risk assessment by acceptable providers. Target 90% compliance.

Diagnostic Evaluation. VHA requires that an acceptable provider offer further evaluation to patients with a positive PTSD screen. Referral for further diagnostic evaluations allows the patient to receive specialized MH treatment if indicated. Eight of the 42 EHRs (19 percent) did not contain evidence that acceptable providers offered patients referrals for diagnostic evaluations. Managers told us that providers did not complete the clinical reminder prompt and may have lacked education on reminder completion.

Recommendation

9. The Chief of Staff ensures that acceptable providers offer further diagnostic evaluations to patients with positive post-traumatic stress disorder screens and monitors providers' compliance.

Facility concurred.

Target date for completion: June 30, 2018

Facility Response: Chief of Primary Care educated primary care providers on offering further diagnostic evaluations for all patients with positive post-traumatic stress disorder screens. Reinforcement of warm-handoffs occur at every Primary Care Provider meeting and during PACT meetings. New provider orientation includes a 2-hour live CPRS training with the Clinical Applications Coordinators to review the process for documenting when providers offered further diagnostic evaluations. Primary Care began monitoring when providers offered further diagnostic evaluations in December 2017 with results communicated back to PACT providers. Results will be reported to ECMS beginning January 2018. Providers offering further diagnostic evaluations will be measured by the number of patients with a positive post-traumatic stress disorder screen who were offered further diagnostic evaluation. Target 90% compliance.

Summary Table of Comprehensive Healthcare Inspection Program Review Findings		
Healthcare Processes	**Performance Indicators**	**Conclusion**
Leadership and Organizational Risks	• Executive leadership stability and engagement • Employee satisfaction and patient experience • Accreditation/for-cause surveys and oversight inspections • Indicators for possible lapses in care • VHA performance data	Nine OIG recommendations, ranging from documentation issues to deficiencies that can lead to patient and staff safety issues or adverse events, are attributable to the Chief of Staff and Associate Director. See details below.

Healthcare Processes	**Performance Indicators**	**Critical Recommendations[35] for Improvement**	**Recommendations for Improvement**
Quality, Safety, and Value	• Senior-level involvement in QSV/performance improvement committee • Protected peer review of clinical care • Credentialing and privileging • UM reviews • Patient safety incident reporting and root cause analyses	• Clinical managers consistently review OPPE data at least every 6 months.	None

Medication Management	• Anticoagulation management policies and procedures
	• Management of patients receiving new orders for anticoagulants
	  o Prior to treatment
	  o During treatment
	• Ongoing evaluation of the anticoagulation program
	• Competency assessment
		• Clinicians consistently provide specific education to patients with newly prescribed anticoagulant medications.	None

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

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Coordination of Care	• Transfer policies and procedures • Oversight of transfer process • EHR documentation o Non-emergent transfers o Emergent transfers	None	None
Environment of Care	• Parent facility o EOC deficiency tracking and rounds o General Safety o Infection prevention o Environmental cleanliness o Exam room privacy o Availability of feminine hygiene products and medical equipment and supplies • Community Based Outpatient Clinic o General safety o Infection prevention o Environmental cleanliness o Medication safety and security o Privacy o Availability of feminine hygiene products and medical equipment and supplies o IT network room security • Radiology o Safe use of fluoroscopy equipment o Environmental safety o Infection prevention o Medication safety and security o Radiology equipment inspection o Availability of medical equipment and supplies o Maintenance of radiological equipment • Inpatient MH o MH EOC inspections o Environmental suicide hazard identification o Employee training o Environmental safety o Infection prevention o Availability of medical equipment and supplies	None	• Required team members consistently participate on EOC rounds. • Facility managers maintain a safe and clean environment in all patient care areas. • Locked MH unit employees and Interdisciplinary Safety Inspection Team members complete the required training on how to identify and correct environmental hazards, including the proper use of the MH EOC Checklist.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement

Long-Term Care: Community Nursing Home Oversight	• CNH Oversight Committee and CNH program integration
	• EHR documentation
	  ○ Patient hand-off
	  ○ Clinical visits
	• CNH annual reviews
		• Social workers and registered nurses conduct alternating, cyclical clinical visits with the required frequency.	• The CNH Oversight Committee includes consistent representation by the medical staff.

Post-Traumatic Stress Disorder Care	• Completion of a suicide risk assessment by acceptable providers • Established plan of care and disposition • Offer of further diagnostic evaluations • Completion of diagnostic evaluations • Receipt of MH treatment when applicable	• Acceptable providers perform and document suicide risk assessments for all patients with positive PTSD screens. • Acceptable providers offer further diagnostic evaluations to patients with positive PTSD screens.	None

Facility Profile

The table below provides general background information for this low-complexity (3)[36] affiliated[37] facility reporting to VISN 16.

Table 5. Facility Profile for Pineville (502) for October 1, 2013 through September 30, 2016

Profile Element	Facility Data FY 2014[38]	Facility Data FY 2015[39]	Facility Data FY 2016[40]
Total Medical Care Budget in Millions	$201.2	$224.5	$229.8
Number of:			
• **Unique Patients**	31,418	31,998	32,478
• **Outpatient Visits**	310,249	312,381	315,159
• **Unique Employees**[41]	1,003	996	932
Type and Number of Operating Beds:			
• **Acute**	40	40	40
• **Mental Health**	65	65	65
• **Community Living Center**	154	154	154
• **Domiciliary**	NA	NA	NA
Average Daily Census:			
• **Acute**	22	14	9
• **Mental Health**	34	33	28
• **Community Living Center**	73	81	85
• **Domiciliary**	NA	NA	NA

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

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

NA = Not applicable

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[36] VHA medical centers are classified according to a facilities complexity model; 3 designation indicates a facility with low volume, low-risk patients, few or no complex clinical programs, and small or no research and teaching programs. Retrieved November 8, 2017, from http://opes.vssc.med.va.gov/FacilityComplexityLevels/Pages/default.aspx

[37] Associated with a medical residency program.

[38] October 1, 2013 through September 30, 2014.

[39] October 1, 2014 through September 30, 2015.

[40] October 1, 2015 through September 30, 2016.

[41] Unique employees involved in direct medical care (cost center 8200).

VA Outpatient Clinic Profiles[42]

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[43] 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[44] Provided	Diagnostic Services[45] Provided	Ancillary Services[46] Provided
Jennings, LA	502GA	7,248	4,634	Dermatology Pulmonary/ Respiratory Disease Spinal Cord Injury Anesthesia Eye General Surgery	NA	Nutrition Pharmacy Social Work Weight Management
Lafayette, LA	502GB	17,504	8,565	Cardiology Dermatology Endocrinology Anesthesia Eye Podiatry	NA	Nutrition Pharmacy Prosthetics Social Work Weight Management
Lake Charles, LA	502GE	2,749	NA	NA	NA	NA
Leesville, LA	502GF	7,273	3,658	Dermatology Blind Rehab Rehab Physician Eye	NA	Nutrition Pharmacy Prosthetics Social Work Weight Management
Natchitoches, LA	502GG	2,319	2,605	Dermatology Eye	NA	Nutrition Pharmacy Social Work Weight Management

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

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

NA = Not applicable

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[42] Includes all outpatient clinics in the community that were in operation as of February 15, 2017. OIG has omitted Lafayette, LA (502QB), as no workload/encounters or services were reported.

[43] An encounter is a professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition.

[44] Specialty care services refer to non-PC and non-MH services provided by a physician.

[45] Diagnostic services include EKG, EMG, laboratory, nuclear medicine, radiology, and vascular lab services.

[46] Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

VHA Policies Beyond Recertification Dates

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

1. VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010 (recertification due date June 30, 2015).

2. VHA Handbook 1105.04, *Fluoroscopy Safety*, July 6, 2012 (recertification due date July 31, 2017).

3. VHA Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures*, June 4, 2004 (recertification due date January 31, 2009)

4. VHA Handbook 1160.03, *Programs for Veterans with Post-Traumatic Stress Disorder (PTSD)*, March 12, 2010 (recertification due date March 31, 2015) revised December 8, 2015.[47]

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),[48] the VA Under Secretary for Health mandated the "…continued use of and adherence to VHA policy documents beyond their recertification date until the policy is rescinded, recertified, or superseded by a more recent policy or guidance."[49] 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."[50]

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[47] 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.

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

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

[50] Ibid.

Patient Aligned Care Team Compass Metrics
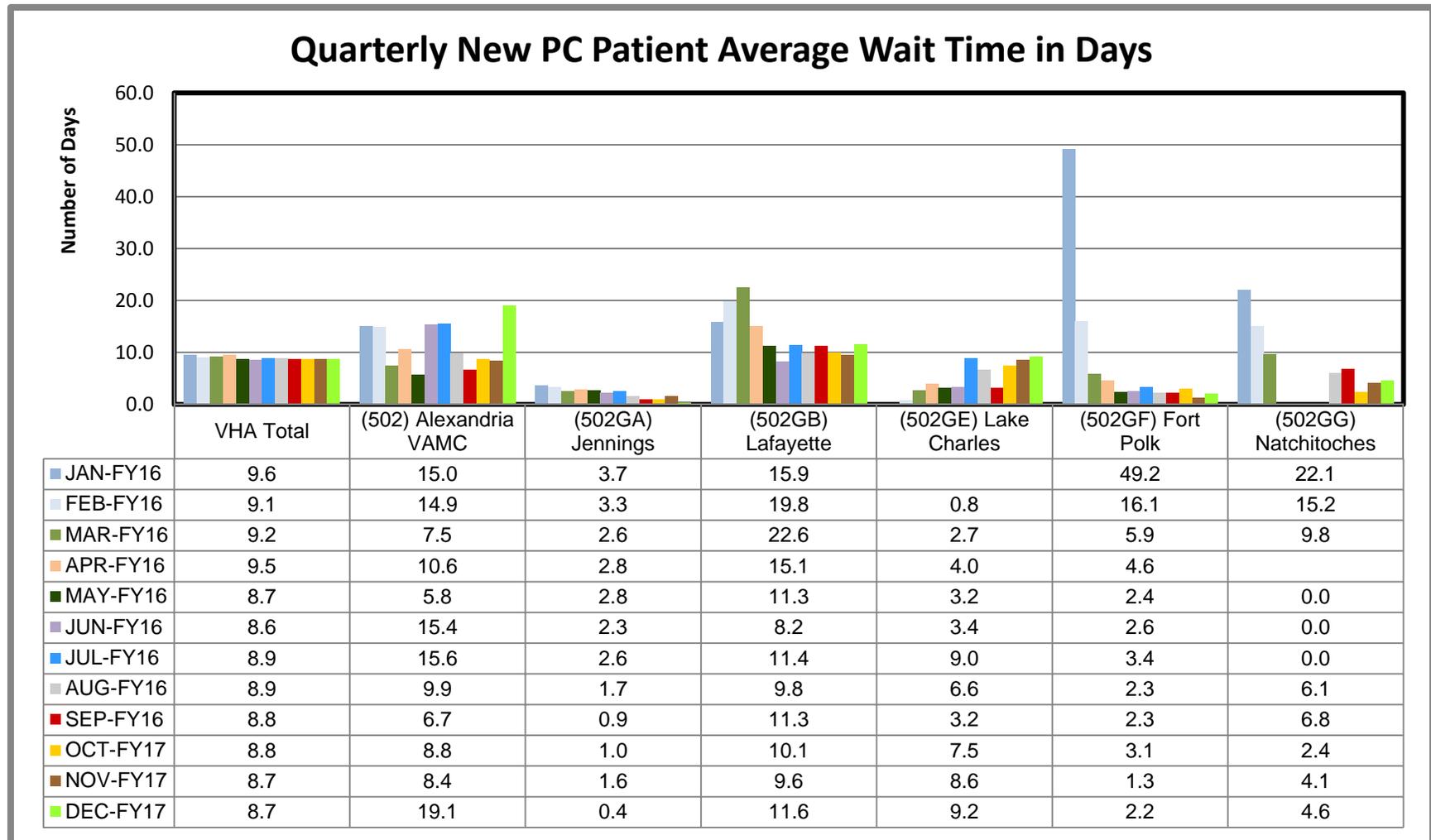
Quarterly New PC Patient Average Wait Time in Days

	VHA Total	(502) Alexandria VAMC	(502GA) Jennings	(502GB) Lafayette	(502GE) Lake Charles	(502GF) Fort Polk	(502GG) Natchitoches
■ JAN-FY16	9.6	15.0	3.7	15.9		49.2	22.1
■ FEB-FY16	9.1	14.9	3.3	19.8	0.8	16.1	15.2
■ MAR-FY16	9.2	7.5	2.6	22.6	2.7	5.9	9.8
■ APR-FY16	9.5	10.6	2.8	15.1	4.0	4.6	
■ MAY-FY16	8.7	5.8	2.8	11.3	3.2	2.4	0.0
■ JUN-FY16	8.6	15.4	2.3	8.2	3.4	2.6	0.0
■ JUL-FY16	8.9	15.6	2.6	11.4	9.0	3.4	0.0
■ AUG-FY16	8.9	9.9	1.7	9.8	6.6	2.3	6.1
■ SEP-FY16	8.8	6.7	0.9	11.3	3.2	2.3	6.8
■ OCT-FY17	8.8	8.8	1.0	10.1	7.5	3.1	2.4
■ NOV-FY17	8.7	8.4	1.6	9.6	8.6	1.3	4.1
■ DEC-FY17	8.7	19.1	0.4	11.6	9.2	2.2	4.6

Source: VHA Support Service Center.

Note: OIG did not assess VA's data for accuracy or completeness. OIG has on file the facility's explanation for the January 2016 data point for Fort Polk.

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

Quarterly Established PC Patient Average Wait Time in Days
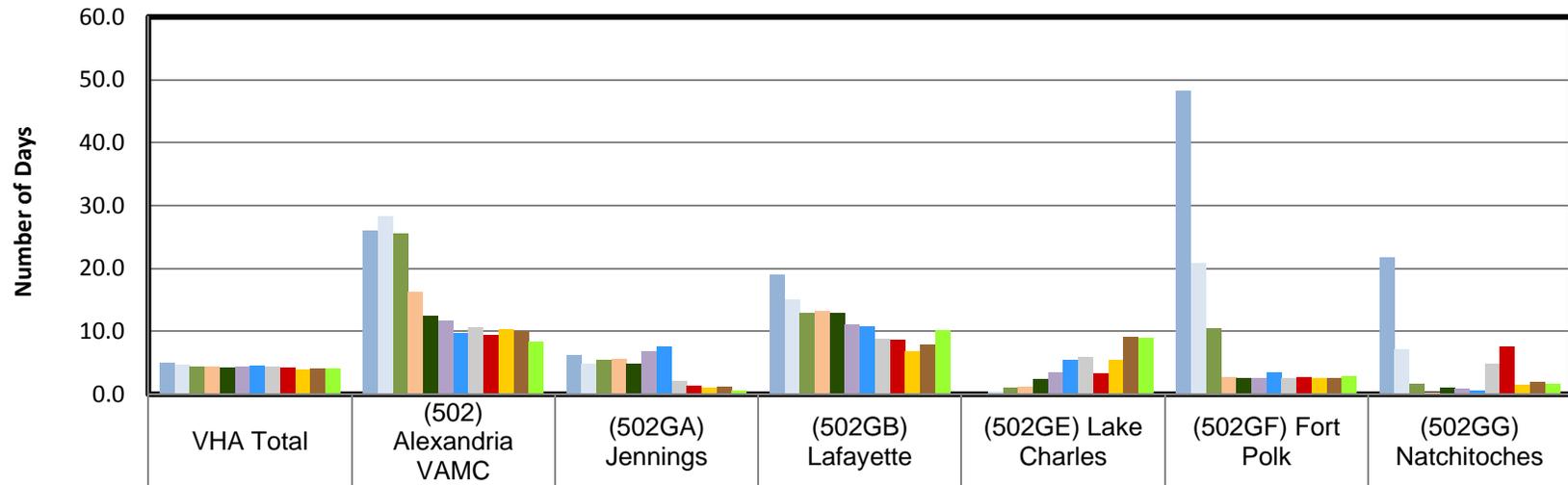
	VHA Total	(502) Alexandria VAMC	(502GA) Jennings	(502GB) Lafayette	(502GE) Lake Charles	(502GF) Fort Polk	(502GG) Natchitoches
JAN-FY16	4.9	26.0	6.2	19.0		48.2	21.7
FEB-FY16	4.7	28.2	4.8	15.0	0.4	20.8	7.1
MAR-FY16	4.4	25.6	5.4	12.9	1.0	10.5	1.6
APR-FY16	4.3	16.2	5.6	13.2	1.2	2.7	0.2
MAY-FY16	4.3	12.4	4.7	12.9	2.3	2.6	0.9
JUN-FY16	4.4	11.7	6.7	11.1	3.4	2.6	0.9
JUL-FY16	4.4	9.8	7.6	10.7	5.4	3.4	0.5
AUG-FY16	4.3	10.6	2.1	8.7	5.9	2.5	4.7
SEP-FY16	4.2	9.4	1.3	8.6	3.3	2.7	7.6
OCT-FY17	3.8	10.4	1.1	6.9	5.5	2.6	1.5
NOV-FY17	4.0	10.0	1.2	7.8	9.0	2.5	2.0
DEC-FY17	4.0	8.3	0.6	10.2	8.9	2.8	1.6

Source: VHA Support Service Center.

Note: OIG did not assess VA's data for accuracy or completeness. OIG has on file the facility's explanation for the January 2016 data point for Fort Polk.

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
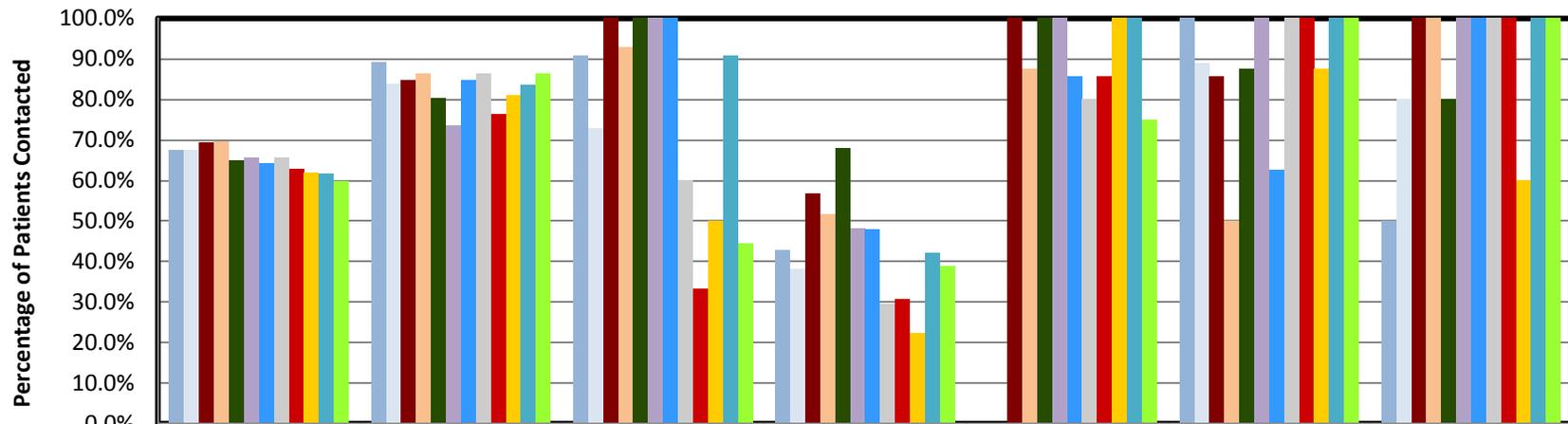
	VHA Total	(502) Alexandria VAMC	(502GA) Jennings	(502GB) Lafayette	(502GE) Lake Charles	(502GF) Fort Polk	(502GG) Natchitoches
JAN-FY16	67.5%	89.2%	90.9%	42.9%		100.0%	50.0%
FEB-FY16	67.6%	83.8%	72.7%	38.1%	0.0%	88.9%	80.0%
MAR-FY16	69.2%	84.7%	100.0%	56.7%	100.0%	85.7%	100.0%
APR-FY16	69.7%	86.3%	92.9%	51.6%	87.5%	50.0%	100.0%
MAY-FY16	65.0%	80.3%	100.0%	68.0%	100.0%	87.5%	80.0%
JUN-FY16	65.5%	73.6%	100.0%	48.3%	100.0%	100.0%	100.0%
JUL-FY16	64.3%	84.6%	100.0%	48.0%	85.7%	62.5%	100.0%
AUG-FY16	65.7%	86.4%	60.0%	29.6%	80.0%	100.0%	100.0%
SEP-FY16	62.9%	76.3%	33.3%	30.8%	85.7%	100.0%	100.0%
OCT-FY17	62.0%	81.0%	50.0%	22.2%	100.0%	87.5%	60.0%
NOV-FY17	61.6%	83.6%	90.9%	42.1%	100.0%	100.0%	100.0%
DEC-FY17	59.9%	86.4%	44.4%	38.9%	75.0%	100.0%	100.0%

Source: VHA Support Service Center.

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

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

	VHA Total	(502) Alexandria VAMC	(502GA) Jennings	(502GB) Lafayette	(502GE) Lake Charles	(502GF) Fort Polk	(502GG) Natchitoches
JAN-FY16	14.3%	24.3%	3.9%	5.2%		6.1%	16.0%
FEB-FY16	14.4%	24.2%	3.9%	5.2%	1.8%	6.0%	14.6%
MAR-FY16	14.4%	23.7%	3.6%	5.3%	6.2%	5.4%	15.5%
APR-FY16	14.4%	23.4%	3.2%	5.4%	5.6%	5.5%	16.3%
MAY-FY16	14.4%	22.8%	3.0%	5.2%	5.2%	5.5%	15.9%
JUN-FY16	14.4%	23.3%	3.6%	5.4%	4.8%	5.4%	17.0%
JUL-FY16	14.4%	22.6%	3.3%	5.2%	4.2%	5.4%	17.0%
AUG-FY16	14.3%	22.3%	3.3%	5.4%	3.9%	5.3%	16.9%
SEP-FY16	14.2%	22.6%	3.5%	5.3%	3.7%	5.2%	16.8%
OCT-FY17	14.3%	22.3%	3.5%	5.0%	3.7%	5.1%	16.9%
NOV-FY17	14.3%	22.3%	3.5%	5.0%	3.6%	5.1%	16.0%
DEC-FY17	14.2%	22.3%	3.4%	4.8%	3.6%	5.1%	16.6%

Source: VHA Support Service Center.

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

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

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

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

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

Source: VHA Support Service Center.

Relevant OIG Reports

August 4, 2014 through January 1, 2018[51]

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 Alexandria VA Health Care System, Pineville, Louisiana
10/16/2014 | 14-02070-305 | Summary | Report

Community Based Outpatient Clinic and Primary Care Clinic Reviews at Alexandria VA Health Care System, Pineville, Louisiana
9/16/2014 | 14-00926-281 | Summary | Report

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[51] 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 28, 2017

From: Director, South Central VA Health Care Network (10N16)

Subject: **CHIP Review of the Alexandria VA Health Care System, Pineville,
LA**

To: Director, Atlanta Office of Healthcare Inspections (54AT)

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

1. The South Central VA Health Care Network (VISN16) has reviewed and concurs with the findings, recommendations, and action plans submitted by the Alexandria VA Health Care System, Pineville, LA, in response to the Draft CHIP report.
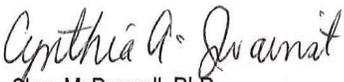
Skye McDougall, PhD
Director, South Central VA Health Care Network (10N16)

Facility Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: December 28, 2017

From: Director, Alexandria VA Health Care System (502/00)

Subject: **CHIP Review of the Alexandria VA Health Care System, Pineville, LA**

To: Director, South Central VA Health Care Network (10N16)

1. I concur with the recommendations presented in the OIG CHIP review of the Alexandria VA Health Care System. Actions taken as a result of the recommendations can be found in the following pages.
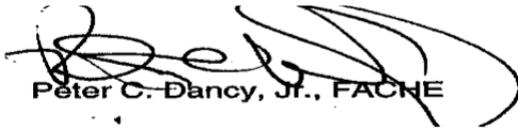
Peter C. Dancy, Jr., FACHE

Attachment

OIG Contact and Staff Acknowledgments

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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: Bill Cassidy, John Kennedy
U.S. House of Representatives: Ralph Abraham, Garret Graves, Clay Higgins,
    Mike Johnson, Cedric Richmond, Steve Scalise

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

Endnotes

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

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

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

[d] The references used for EOC included:
- VHA Directive 1014, *Safe Medication Injection Practices*, July 1, 2015.
- VHA Handbook 1105.04, *Fluoroscopy Safety*, July 6, 2012.
- VHA Directive 1116(2), *Sterile Processing Services (SPS)*, March 23, 2016.
- VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013.
- VHA Directive 1229, *Planning and Operating Outpatient Sites of Care*, July 7, 2017.
- VHA Directive 1330.01(1), Health Care Services for Women Veterans, February 15, 2017 (amended September 8, 2017).
- VHA Directive 1608, *Comprehensive Environment of Care (CEOC) Program*, February 1, 2016.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.
- VA Handbook 6500, *Risk Management Framework for VA Information Systems – Tier 3: VA Information Security Program*, March 10, 2015.
- VHA Radiology Online Guide, http://vaww.infoshare.va.gov/sites/diagnosticservices/NRP/Mammography/Radiology%20Shared%20Files/Radiology_Service_Online_Guide_2016.docx, November 3, 2016.
- MH EOC Checklist, VA National Center for Patient Safety, http://vaww.ncps.med.va.gov/guidelines.html#mhc, accessed December 8, 2016.
- Various requirements of TJC, Association for the Advancement of Medical Instrumentation/Association for the Advancement of Medical Instrumentation, Occupational Safety and Health Administration, International Association of Healthcare Central Service Materiel Management, National Fire Protection Association.

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

[f] 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.

[g] The reference used for PACT Compass data graphs was:
- Department of Veterans' Affairs, Patient Aligned Care Teams Compass Data Definitions, accessed: February 14, 2017.

[h] The reference used for the Strategic Analytics for Improvement and Learning (SAIL) metric definitions was:
- VHA Support Service Center (VSSC), Strategic Analytics for Improvement and Learning (SAIL), accessed: October 3, 2016.