Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 17-01746-116

Comprehensive Healthcare Inspection Program Review of the Jonathan M. Wainwright Memorial VA Medical Center, Walla Walla, Washington

March 1, 2018

Washington, DC 20420

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Glossary

CBOC	community based outpatient clinic
CHIP	Comprehensive Healthcare Inspection Program
CNH	community nursing home
EHR	electronic health record
EOC	environment of care
facility	Jonathan M. Wainwright Memorial VA Medical Center
FY	fiscal year
MH	mental health
NA	not applicable
Nurse Executive	Associate Director for Patient Care Services
OIG	Office of Inspector General
PC	primary care
QSV	quality, safety, and value
RRTP	residential rehabilitation treatment program
RCAs	root cause analyses
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 Jonathan M. Wainwright Memorial VA Medical Center (facility). The review covers key clinical and administrative processes that are associated with promoting quality care.

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

1. Leadership and Organizational Risks
2. Quality, Safety, and Value
3. Medication Management
4. Coordination of Care[1]
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 September 18, 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 Jonathan M. Wainwright Memorial VA Medical Center, the leadership team consists of the Facility Director, Chief of Staff, Associate Director for Patient Care Services (Nurse Executive), and Associate Director.

Organizational communication is carried out through a committee reporting structure with the Quality Council having oversight for leadership groups such as the Organizational Culture, Enterprise Risk and Management, Business Planning, and Clinical Executive Boards. The executive leaders are members of the Quality Council.

[1] The Inter-Facility Transfers special focus area did not apply for the Jonathan M. Wainwright Memorial VA Medical Center because the facility did not have an Emergency Department, an urgent care center, or inpatient beds.

At the time of our review, two of the four leaders were in their permanent positions for less than 1 year. The Nurse Executive, acting since October 24, 2016, was permanently assigned on January 18, 2017. The Associate Director, acting since April 9, 2017, was permanently assigned on August 6, 2017. Facility leaders were also proactively recruiting for a new Chief of Staff in anticipation of a January 2018 retirement.

The facility and its leaders are in a state of transition and face a challenging task of improving the organizational culture. Leaders acknowledged past leadership and organizational missteps and ongoing efforts to rebuild workforce and patient trust and engagement, boost employee and patient satisfaction, achieve leadership stability, and improve organizational performance.

In the review of selected employee and patient survey results regarding facility senior leadership, OIG noted satisfaction scores below the VHA average. Additionally, OIG reviewed accreditation agency findings, sentinel events, disclosures of adverse patient events, and Strategic Analytics for Improvement and Learning (SAIL) data and did not identify any substantial organizational risk factors. However, OIG recognizes that the SAIL model has limitations for identifying all areas of clinical risk but is "a way to understand the similarities and differences between the top and bottom performers" within the Veterans Health Administration (VHA).[2]

Although the senior leadership team was knowledgeable about selected SAIL metrics, the leaders should continue to take actions to improve performance of the Quality of Care and Efficiency metrics likely contributing to the current 1-star SAIL rating. In the review of key care processes, OIG issued 10 recommendations that are attributable to the Facility Director, Chief of Staff, Nurse Executive, and Associate Director. Of the six areas of clinical operations reviewed, OIG noted findings in four. These are briefly described below.

Quality, Safety, and Value. OIG found general compliance with requirements for protected peer review and credentialing and privileging processes. However, OIG identified deficiencies in the senior-level committee responsible for quality, safety, and value functions and patient safety.

Medication Management. OIG found that local anticoagulation therapy management policies and processes had been established, and risk minimalization efforts for dosing errors were in place. However, OIG identified deficiencies with the review of quality

[2] 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.

assurance data, evidence of patient education specific to newly prescribed anticoagulants, requirements for laboratory tests prior to initiating anticoagulant medications, and competency assessments for employees actively involved in the anticoagulant program.

Environment of Care. OIG found compliance with the general safety, infection prevention, and privacy measures at the parent facility and in Radiology Service and with overall safety and cleanliness at the Richland community based outpatient clinic. However, OIG identified deficiencies with conducting environment of care rounds and with attendance on rounds.

Long-Term Care Related to Community Nursing Home Oversight. OIG found compliance with the requirements for community nursing home annual reviews. However, OIG identified deficiencies in the Community Nursing Home Oversight Committee attendance and clinical visits for patients residing in community nursing homes.

Summary

In the review of key care processes, OIG issued 10 recommendations that are attributable to the Facility Director, Chief of Staff, Nurse Executive, and Associate Director. The number of recommendations should not be used as a gauge for the overall quality provided at this facility. The intent is for facility leadership to use these recommendations as a "road map" to help improve operations and clinical care. The recommendations address systems issues as well as other less-critical findings that, if left unattended, may eventually interfere with the delivery of quality health care.

Comments

The Veterans Integrated Service Network Director and Acting Facility Director agreed with the CHIP review findings and recommendations and provided acceptable improvement plans. (See Appendixes G and H, pages 45–46, and the responses within the body of the report for the full text of the Directors' comments.). OIG will follow up on the planned actions for the open recommendations until they are completed.

JOHN D. DAIGH, JR., M.D.
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 Jonathan M. Wainwright Memorial VA Medical Center's (facility) 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 Inter-Facility Transfers special focus area did not apply for Jonathan M. Wainwright Memorial VA Medical Center because the facility did not have an Emergency Department, an urgent care center, or inpatient beds. Thus, OIG focused on the remaining five areas of clinical operations and one additional program with relevance to the facility—Mental Health (MH) Residential Rehabilitation Treatment Program (RRTP).

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

Source: VA OIG.

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

Methodology

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

The review covered operations for April 21, 2014[5] through September 18, 2017, the date when an unannounced week-long site visit commenced. OIG presented crime awareness briefings to 92 of the facility's 618 employees on October 11 and 12, 2017. These briefings covered procedures for reporting suspected criminal activity to OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

[3] Appendix C lists policies that had expired recertification dates but were considered in effect as they had not been superseded by more recent policy or guidance.
[4] OIG did not review VHA's internal survey results but focused on OIG inspections and external surveys that affect facility accreditation status.
[5] This is the date of the last Combined Assessment Program and/or Community Based Outpatient Clinic and Primary Care Clinic reviews.

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

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

Results and Recommendations

Leadership and Organizational Risks

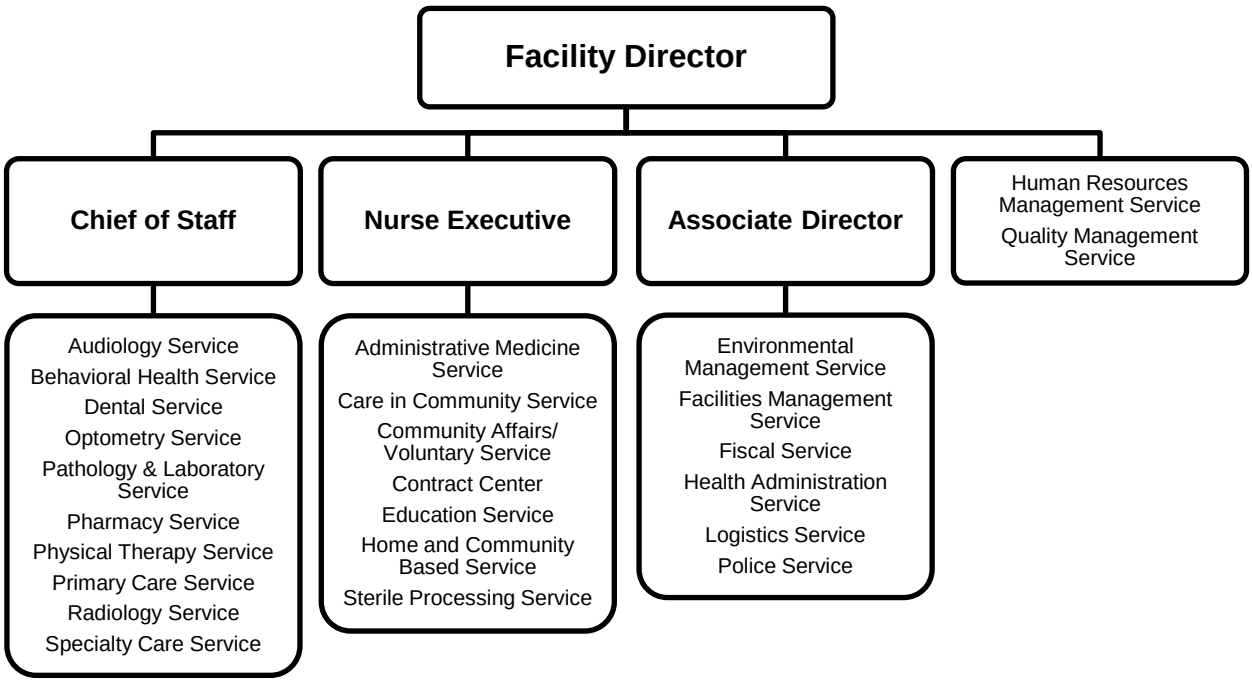
Stable and effective leadership is critical to improving care and sustaining meaningful change. Leadership and organizational risk issues can impact the facility's ability to provide care in all of the selected clinical areas of focus. The factors OIG considered in assessing the facility's risks and 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, the Chief of Staff, the Associate Director for Patient Care Services (Nurse Executive), and Associate Director.

At the time of our review, two of the four executive leaders were new to the facility, having served in their permanent positions for less than 1 year. The Nurse Executive, acting since October 24, 2016, was permanently assigned on January 18, 2017. The Associate Director, acting since April 9, 2017, was permanently assigned on August 6, 2017. Senior leaders also informed OIG that they were proactively recruiting for a new Chief of Staff in anticipation of a January 2018 retirement.

Figure 2. Facility Organizational Chart



Source: Jonathan M. Wainwright Memorial VA Medical Center (received September 18, 2017).

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

Facility leaders openly discussed employee perceptions of past leadership and organizational failures that contributed to the facility's culture that leaders described as "toxic." Each leader clearly articulated substantial ongoing efforts and commitment to restore employee and patient trust and engagement. Each also described significant staffing shortages as a contributing factor to lower employee and veteran satisfaction and poor performance on key quality and efficiency metrics; Human Resource Management Service provided a list of more than 200 vacant positions. In September 2017, the facility launched a major hiring initiative to actively recruit 94 critical positions. Concurrently, facility leaders were building an infrastructure (programs, committees, and processes) to support and sustain organizational transformation and improvements.

Leaders also recognized and acknowledged that the facility did not have an effective executive level oversight committee for QSV functions. Prior to the OIG visit, leaders created the Office of Innovation and Excellence for QSV oversight. Leaders found the office ineffective and dissolved it in June 2017. At the time of the OIG review, facility

leaders had started to develop and implement a plan to re-establish an infrastructure that included staffing key positions; establishing committees and work-groups to review and improve quality measures; and developing formal processes to track, trend, and monitor QSV data. See Figure 3 for the facility committee reporting structure.

Figure 3. Facility Committee Reporting Structure

Source: Jonathan M. Wainwright Memorial VA Medical Center (received September 18, 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 during the period of October 1, 2015 through September 30, 2016. Although OIG recognizes that employee satisfaction and patient experience survey data are subjective, the information can be a starting point for discussions and indicate areas for further inquiry, to 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. Although the selected employee survey results for the Director's office were similar to or above the VHA average, the facility's results (Facility Average) were below VHA average.[6] Further, the two outpatient survey results reflected lower care ratings compared to the VHA average. In all, employees and patients appear generally less than satisfied with leadership and care provided. These scores support the challenges expressed by facility leaders.

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

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	3.0	3.8
All Employee Survey Servant Leader Index Composite	0–100 where HIGHER scores are more favorable	66.7	63.0	66.1
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): I felt like a valued customer.	The response average is the percent of "Agree" and "Strongly Agree" responses.	73.2	67.9	
Survey of Healthcare Experiences of Patients (outpatient specialty care): I felt like a valued customer.		73.8	69.6	

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.

[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.
[9] TJC conducts for-cause unannounced surveys in response to serious incidents relating to the health and/or safety of patients or staff or reported complaints. The outcomes of these types of activities may affect the current accreditation status of an organization.
[10] A closed status indicates that the facility has implemented corrective actions and improvements to address findings and recommendations, not by self-certification, but as determined by accreditation organization or inspecting agency.
[11] The Commission on Accreditation of Rehabilitation Facilities provides an international, independent, peer review system of accreditation that is widely recognized by Federal agencies. VHA's commitment is supported through a system-wide, long-term joint collaboration with the Commission on Accreditation of Rehabilitation Facilities to achieve and maintain national accreditation for all appropriate VHA rehabilitation programs.
[12] For 70 years, the College of American Pathologists has fostered excellence in laboratories and advanced the practice of pathology and laboratory science. In accordance with VHA Handbook 1106.01, VHA laboratories must meet the requirements of the College of American Pathologists.

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

Accreditation or Inspecting Agency	Date of Visit	Number of Findings	Number of Recommendations Remaining Open
VA OIG (*Combined Assessment Program Review of the Jonathan M. Wainwright Memorial VA Medical Center, Walla Walla, Washington, November 24, 2014)*	August 2014	14	0
VA OIG (*Community Based Outpatient Clinic and Primary Care Clinic Reviews at Jonathan M. Wainwright Memorial VA Medical Center, Walla Walla, Washington, July 7, 2014)*	April 2014	9	0
TJC[13] • Ambulatory Health Care Accreditation • Behavioral Health Care Accreditation • Home Care Accreditation	March 2016	 8 7 2	 0 0 0

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

Indicators for Possible Lapses in Care. Within the health care field, the primary organizational risk is the potential for patient harm. Many factors impact the risk for patient harm within a system, including unsafe environmental conditions, sterile processing deficiencies, and infection control practices. Leaders must be able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms. Table 3 summarizes key indicators of risk since OIG's previous August 2014 Combined Assessment Program and April 2014 Community Based Outpatient Clinic (CBOC) and Primary Care (PC) review inspections through the week of September 18, 2017.

Table 3. Summary of Selected Organizational Risk Factors[14] (April 2014 to September 18, 2017)

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

Patient Safety Indicators developed by the Agency for Healthcare Research and Quality within the U.S. Department of Health and Human Services provide information on potential in-hospital complications and adverse events following surgeries and procedures.[18] This data is not applicable since inpatient care is not provided at the facility.

Veterans Health Administration Performance Data. The VA Office of Operational Analytics and Reporting adapted the SAIL Value Model to help define performance expectations within VA.[19] This model includes measures on health care quality, employee satisfaction, access to care, and efficiency, but the model has noted limitations for identifying all areas of clinical risk. The data are presented as one "way to

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

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

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

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

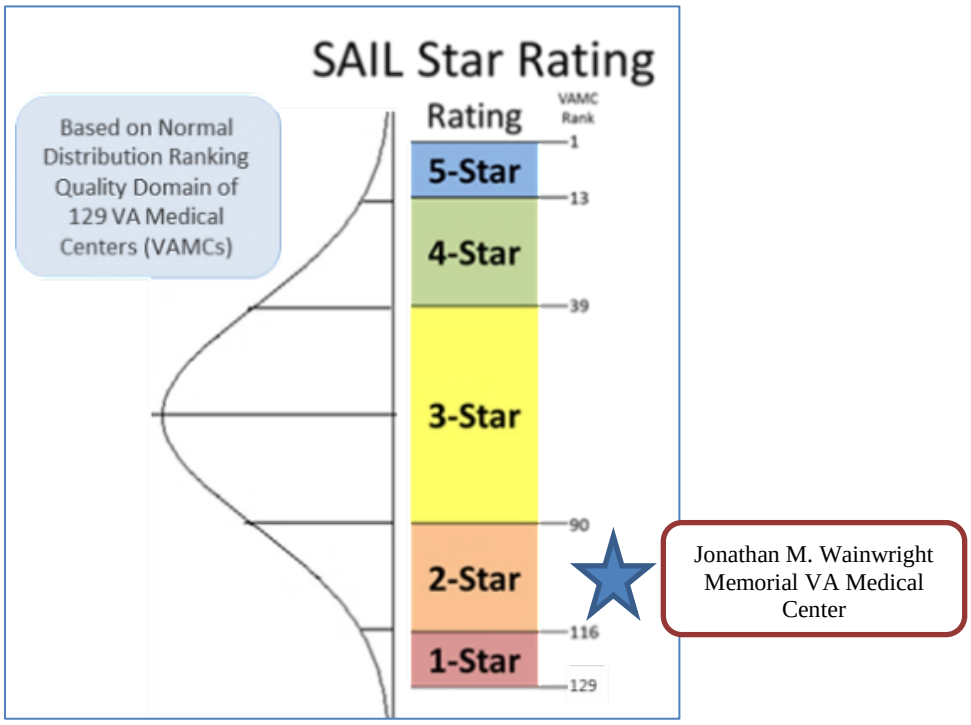
[18] Agency for Healthcare Research and Quality website, https://www.qualityindicators.ahrq.gov/, accessed March 8, 2017.

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

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

VA also uses a star-rating system that is designed to make model results more accessible for the average user. Facilities with a 5-star rating are performing within the top 10 percent of facilities, whereas 1-star facilities are performing within the bottom 10 percent of facilities. Figure 4 describes the distribution of facilities by star rating. As of September 30, 2016, the Jonathan M. Wainwright Memorial VA Medical Center received an interim rating of 2 stars for overall quality. This means the facility is in the 4th quintile (70–90 percent range). Updated data as of June 30, 2017, indicates that the facility has declined to a 1 star for overall quality.

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

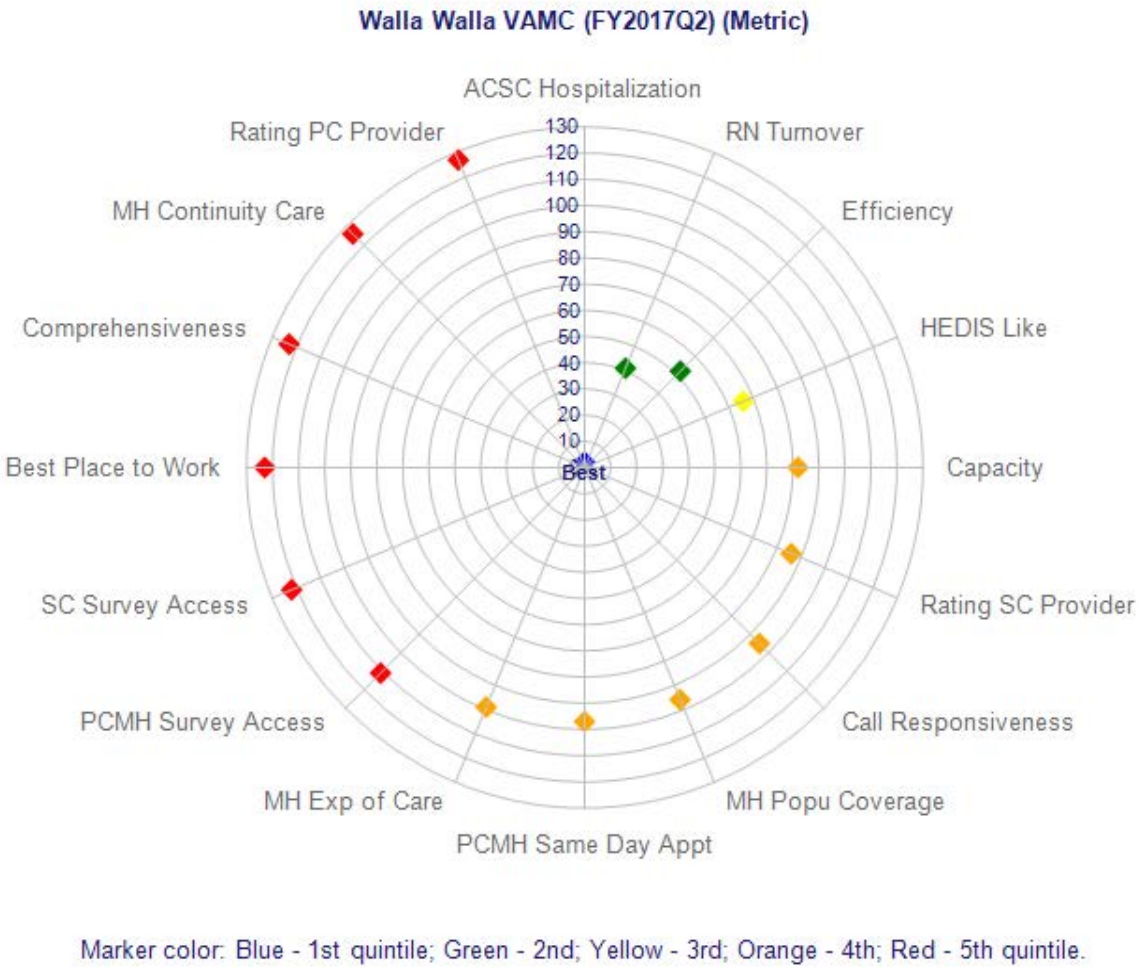


Source: VA Office of Informatics and Analytics' Office of Operational Analytics and Reporting.

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

Figure 5 illustrates the facility's Quality of Care and Efficiency metric rankings and performance compared to other VA facilities as of March 31, 2017. Of note, Figure 5 shows three data points in the top quintiles (blue and green) that show high performance (Ambulatory Care Sensitive Conditions [ACSC] Hospitalization, Registered Nurse [RN] Turnover, and Efficiency). Many metrics are in the bottom quintiles and reflect areas that need improvement and are denoted in orange and red (for example, Best Place to Work, MH Continuity [of] Care, and Rating [of] Primary Care [PC] Provider).

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



Source: VHA Support Service Center.

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

Conclusions. Due to past leadership and organizational failures, the facility and its leaders are in a state of transition and face a challenging task of improving the organizational culture. The leaders spoke enthusiastically of ongoing efforts to rebuild workforce and patient trust and engagement, boost employee and patient satisfaction, achieve leadership stability, and improve organizational performance. These actions included actively engaging with and involving employees at all levels and developing an infrastructure with key personnel that will support and sustain organizational transformation. The leadership team communicated a shared vision of where the facility is, where it needs to be, and what it will take to get there. To ensure success, it will be critical for the leadership team to make decisions and demonstrate behaviors consistent with their vision of a patient-centered integrated health care, an organization where people choose to work, and an active community partner.

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.[21] VHA requires that 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[22] of clinical care
3. Credentialing and privileging
4. Utilization management (UM) reviews[23]
5. Patient safety incident reporting and root cause analyses (RCAs)

OIG interviewed senior managers and key QSV employees and evaluated meeting minutes, licensed independent practitioners' profiles, protected peer reviews, RCAs, 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

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

- Credentialing and privileging processes
  - Considered frequency for Ongoing Professional Practice Evaluation[24] data review
  - Indicated a Focused Professional Practice Evaluation[25]
- Patient safety personnel
  - Entered all reported patient incidents into the WEBSPOT database
  - Completed the required minimum of eight RCAs
  - Reported root cause analysis findings to reporting employees
  - Submitted an annual patient safety report

The performance indicators below did not apply to this facility as the facility did not have inpatient beds.

- 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

Conclusions. OIG found general compliance with requirements for protected peer reviews and credentialing and privileging processes. OIG identified the following deficiencies in the senior-level committee responsible for key QSV functions and patient safety that warranted recommendations for improvement.

Senior-level Committee Responsible for QSV functions. VHA requires facilities to establish a senior-level committee responsible for reviewing data and information and for ensuring regular discussion and integration of key QSV functions. This committee must be chaired or co-chaired by the Facility Director to ensure facility leaders' support in developing prioritized recommendations, chartering improvement teams, and initiating strategies to improve veteran outcomes. At the time of OIG's visit, the facility did not have a committee overseeing QSV functions. Leaders identified the Quality Council and the Clinical Executive Board as the facility committees overseeing QSV functions; however, there was no evidence of QSV-related functions documented in either committee's minutes. Lack of oversight and ineffective leadership contributed to the facility's noncompliance to this requirement. Facility leaders stated that they had already initiated a plan to ensure that a senior-level committee, chaired or co-chaired by the Facility Director, is established to oversee QSV functions.

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

Recommendation

1. The Facility Director ensures that a senior-level committee is established and responsible for key Quality, Safety, and Value functions.

Facility concurred.

Target date for completion: May 30, 2018

Facility response: Will charter an interdisciplinary Quality, Safety, and Value (QSV) Board responsible for reviewing quality metrics, to include patient safety data and processes to ensuring regular discussion and integration of key QSV functions as required in VHA Directive 1026 (Enterprise Framework for Quality, Safety, and Value). This will include data analysis to identify trends and issues, create action items, and following action items to completion. This Board will be co-chaired by the Facility Director and the Quality Manager. The Board will meet monthly to ensure facility leader support in developing prioritized recommendations and initiating strategies to improve veteran outcomes. Meeting minutes will record attendance and track issues/action items to resolution.

The first meeting will be conducted in March 2018.

Demonstrate three consecutive monthly meetings of compliance.

Patient Safety. VHA requires facilities to complete a minimum of eight RCAs during each fiscal year to identify and prevent future adverse events. The process of root cause analysis is integral to promoting patient safety and a just culture, where errors are explored in order to make systematic adjustments to processes or procedures that improve safety and health care quality. The facility completed eight RCAs for FY 2016; however, from October 2016 through August 2017 (11 months), the facility completed only one of the eight required RCAs for FY 2017. Facility staff stated that seven additional RCAs had not been completed because the facility did not have a permanent Patient Safety Manager for 10 months in FY 2017.

Recommendation

2. The Facility Director ensures the Patient Safety Manager completes the required minimum of eight root cause analyses each fiscal year and monitors the manager's compliance.

Facility concurred.

Target date for completion: September 30, 2018

Facility response: The Patient Safety Manager will complete at a minimum:
2 RCA FY18 1st Quarter – (already completed)
2 RCA no later than FY18 2nd Quarter (1 in-progress)
2 RCA no later than FY18 3rd Quarter

2 RCA no later than FY18 4th Quarter
To meet the requirement of the VHA National Patient Safety Improvement Handbook and Cornerstone Category compliance levels.

The VISN20 Patient Safety Office conducted RCA during the week of October 23, 2017.

The National Center for Patient Safety conducted facility wide RCA & Just Culture training during the week of December 18, 2017.

Quarterly progress reports towards compliance will be made to the Quality, Safety, and Value Board in addition to the VISN20 Quality, Safety, and Value Board via the Patient Safety Officer Report to the VISN Leadership.

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,[26] 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 four 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

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

Conclusions. OIG noted local anticoagulation therapy management practices policies and processes had been established, and risk minimalization efforts for dosing errors were in place. However, OIG identified the following deficiencies that warranted recommendations for improvement.

Quality Assurance. VHA requires an ongoing quality assurance plan to be in place to evaluate the anticoagulation management program. This evaluation provides the opportunity to identify practice improvements, ensures appropriate action is taken to improve the practice, and measures the effectiveness of those actions on a regular basis. The plan must include reviewing quality assurance data through the Pharmacy and Therapeutic Committee (or appropriate facility governing body). Although facility policy addressed a quality assurance plan and data collection, OIG found no evidence in the Pharmacy and Therapeutics Committee meeting minutes that the data had been analyzed or reported to the committee. Facility managers stated that lack of staff resulted in noncompliance.

Recommendation

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

Facility concurred.

Target date for completion: April 30, 2018

Facility Response: The anticoagulation program manager presented quality assurance data from (September 9, 2017 through December 31, 2017) at the Pharmacy and Therapeutics Committee meeting held on January 29, 2018. Quality assurance data analyzed and reported includes: major and minor bleeding complications, time-in-therapeutic range, number of anticoagulant consults completed, and average time to completion of anticoagulant consults. The Chief of Pharmacy will track compliance with reporting of anticoagulation program quality assurance data.

The anticoagulation program manager is now scheduled to report quarterly at Pharmacy and Therapeutics Committee.

Demonstrate a minimum of two consecutive quarters of compliance.

Patient Education. VHA requires clinicians deliver initial and ongoing patient and family education for newly prescribed anticoagulant medications that includes elements such as the importance of follow-up monitoring, compliance issues, dietary restrictions, and potential for adverse drug reactions and interactions. Due to the high risk of adverse events, patient and/or family member education is essential to decrease the potential occurrence of bleeding, drug interactions, or other delayed pharmacological effects. OIG did not find evidence that 13 of the 25 patients received education prior to starting the newly prescribed anticoagulant. Anticoagulation clinic managers reported that they

had 30 days to respond to consults and that PC providers are responsible for anticoagulation management, including patient education, during the first 30 days of anticoagulation therapy.

Recommendation

4. 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: May 15, 2018

Facility response: Effective December 18, 2017, the WWVA Anticoagulation Clinic has revised the anticoagulation consultation policy, requiring patient education and completion of the anticoagulation consult within two business days. This includes initial education specific to patients starting newly prescribed anticoagulation medication within two business days from the submission of the anticoagulant consults. Chief of Pharmacy or designee will monitor compliance via patient record reviews conducting monthly audits. Thirty or 100% (whichever is greater) randomly selected consults each month, starting in January until 90% compliance is maintained for three consecutive months.

Laboratory Tests. VHA requires clinicians to obtain required laboratory tests, such as complete blood count, prothrombin time, international normalized ratio, and estimated glomerular filtration rate prior to initiating patients on anticoagulant medications. This ensures patients do not have an underlying medical condition that needs to be addressed prior to receiving the anticoagulant and helps monitor patients while on the anticoagulant. In 7 of the 13 patients initiated on warfarin, clinicians did not obtain the required baseline laboratory tests. For 2 of the 6 patients on rivaroxaban, one patient had a test result outside the acceptable range, and the second patient did not have a current baseline test. For both patients, clinicians did not obtain or document appropriate baseline test results prior to therapy initiation. Additionally, when laboratory tests were completed by non-VA providers, clinicians did not document completed tests prior to initiating anticoagulant medications. Clinical managers were aware of the requirements; however, anticoagulation clinic managers reported that they had 30 days to respond to consults and that PC providers are responsible for anticoagulation management, including obtaining required laboratory tests, during the first 30 days of anticoagulation therapy. As a result, anticoagulation clinic staff were not aware that required tests had not been obtained prior to therapy initiation.

Recommendation

5. The Chief of Staff ensures clinicians consistently obtain and document all required laboratory tests prior to initiating anticoagulant medications and monitors clinicians' compliance.

Facility concurred.

Target date for completion: May 15, 2018

Facility response: Effective December 18, 2017, the WWVA Anticoagulation Clinic has revised the anticoagulation consultation policy, requiring baseline laboratory tests prior to prescribing anticoagulants and completion of the anticoagulation consult within two business days. Education will be given to the General Medical Staff regarding this requirement prior to February 27, 2018. Chief of Pharmacy or designee will monitor compliance via patient record reviews conducting monthly audits. Thirty or 100% (whichever is greater) randomly selected consults each month, starting in January until 90% compliance is maintained for three consecutive months.

Competency. VHA requires that competencies specific to anticoagulation management be established for anticoagulation providers and clinical staff directly involved in caring for patients receiving anticoagulation therapy. Competencies must include knowledge of standard terminology, pharmacology of anticoagulants, monitoring requirements, dose calculations, common side effects, nutrient interactions, and drug-to-drug interactions associated with anticoagulation therapy. This ensures clinicians have sufficient aptitude, knowledge, skills, and abilities to fulfill the duties and responsibilities of the assigned position. None of the four clinicians actively involved in the anticoagulation program had competency assessments completed. Anticoagulation program managers believed the clinicians' Ongoing Professional Practice Evaluations met requirements; however, the evaluations did not include competencies specific to anticoagulation management.

Recommendation

6. The Chief of Staff ensures all required elements specific to anticoagulation management are included in competency assessments for employees actively involved in the anticoagulant program and monitors compliance.

Facility concurred.

Target date for completion: February 28, 2018

Facility response: The Chief of Pharmacy and the Anticoagulation Program Manager have created an annual anticoagulation competency checklist.

Competency reviews for employees in the anticoagulation program will be completed by February 28, 2018.

Henceforth, reviews will continue to be completed on an annual basis.

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.[c]

Fluoroscopic imaging equipment produces x-rays for the diagnosis, localization, and guidance of interventional procedures.[27] 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.[28] The inpatient locked MH unit must provide a healing, recovery-oriented environment as well as be a safe place for patients and employees. VHA developed the MH EOC Checklist to reduce environmental factors that contribute to inpatient suicides, suicide attempts, and other self-injurious behaviors and factors that reduce employee safety on MH units.

OIG inspected seven outpatient clinics (primary care, dermatology/podiatry, optometry, dental, women's, audiology, and MH) and the Radiology Service. OIG also inspected the Richland CBOC. Additionally, OIG reviewed relevant documents and interviewed key employees and managers. The list below shows the location-specific performance indicators selected to examine the risk areas specific to particular settings.

Parent Facility

- EOC Deficiency Tracking
- EOC Rounds
- General safety
- Infection prevention
- Environmental cleanliness
- Exam room privacy
- Availability of feminine hygiene products
- Availability of medical equipment and supplies

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

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

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

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

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

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

Parent Facility: Environment of Care Rounds Frequency. VHA requires EOC rounds to be conducted at a minimum of once per FY in non-patient areas and twice per FY in patient care areas. Further, the Comprehensive EOC Assessment and Compliance Tool is to be used to collect all data associated with EOC rounds within facilities. EOC rounds assist in identifying potential patient safety risks and deficiencies. OIG reviewed the facility's Comprehensive EOC Assessment and Compliance Tool for FY 2017 and found that 5 of the 11 clinical areas were not inspected at the required frequency. Further, while onsite, facility managers were unable to provide evidence of EOC rounds. Facility managers were aware of the requirements but reported that data entry errors,

lack of staff, competing priorities, and the driving distance to rural CBOCs resulted in noncompliance.

Recommendation

7. The Associate Director ensures environment of care inspections are conducted at the required frequency and monitors compliance.

Facility concurred

Target date for completion: June 15, 2018

Facility response: Facility has created an updated Environment of Care (EOC) Rounds calendar for FY18 which includes all occupied buildings on the main campus and the remote clinics at the frequency stipulated in VHA Directive 1608, Comprehensive Environment of Care Program, and the VHA EOC Assessment and Compliance Guide. Rounds are pre-scheduled a minimum of three months in advance. Review of rounds will be performed by the EOC Rounds Committee and reported to the newly chartered Environment of Care Board, chaired by the Associate Director. This action plan will be considered complete after 90% or greater inspections conducted for six consecutive months; however, regular reports to the EOC committee and board will be an ongoing requirement.

VISN20 Safety Manager reports compliance of this performance metrics to the VISN20 Quality, Safety, and Value Board and VISN20 Administrative Services Board that is chaired by the Deputy Network Director on a quarterly basis.

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.[29] OIG reviewed October 1, 2016 through August 17, 2017 Comprehensive EOC Assessment and Compliance Tool records and noted that 9 of 13 core team members did not consistently attend EOC rounds. Facility managers were aware of the inconsistent attendance but reasons cited for noncompliance included two core members located at clinics away from the facility, lack of staff, competing priorities, and scheduling conflicts.

[29] 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

8. The Associate Director ensures core team members consistently participate in environment of care rounds and monitors compliance.

Facility concurred.

Target date for completion: June 15, 2018

Facility Response: Memo for record was issued to designate primary and secondary team members to ensure all areas are inspected by a staff member possessing expertise in the core areas of the Environment of Care (EOC) rounds. Inspections of remote sites by team members completed within 60 days prior to the scheduled inspection can be sent for inclusion into the scheduled rounds. Review of attendance will be performed by the EOC Rounds Committee and reported to the Environment of Care Board chaired by the Associate Director. This action plan will be considered complete after 90% or greater attendance for six consecutive months; however, reports to the EOC Rounds Committee and Environment of Care Board will be an ongoing requirement.

VISN20 Safety Manager reports compliance of this performance metric to the VISN20 Quality, Safety, and Value Board and VISN20 Administrative Services Board that is chaired by the Deputy Network Director on a quarterly basis.

High Risk Processes: Moderate Sedation

OIG's special focus within high-risk processes for the facility was moderate sedation, which is a drug-induced depression of consciousness during which patients can still respond purposefully to verbal comments.[30] Non-anesthesiologists administer sedatives and analgesics to relieve anxiety and increase patient comfort during invasive procedures and usually do not have to provide interventions to maintain a patient's airway, spontaneous ventilations, or cardiovascular function. The administration of moderate sedation could lead to a range of serious adverse events, including cardiac and respiratory depression, brain damage due to low oxygen levels, cardiac arrest, or death.[31]

Properly credentialed providers and trained clinical staff must provide safe care while sedating patients for invasive procedures. Additionally, facility leaders must monitor moderate sedation adverse events, report and trend the use of reversal agents, and systematically aggregate and analyze the data to enhance patient safety and employee performance.[32] During calendar year 2016, VHA clinicians performed more than 600,000 moderate sedation procedures, of which more than half were gastroenterology-related endoscopies.[33] To minimize risks, VHA and TJC have issued requirements and standards for moderate sedation care.

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

OIG reviewed relevant documents and interviewed key employees. Additionally, OIG reviewed the EHRs of 47 randomly selected patients who underwent an invasive procedure involving moderate sedation from July 1, 2015 through June 30, 2016, and the training records of all three clinical employees who performed or assisted during these procedures. Moderate sedation procedures are no longer performed at this facility; therefore, physical inspections were not conducted. The list below shows the performance indicators OIG reviewed.

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

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

- Performance of timeout[34] prior to the moderate sedation procedure
- Post-procedure documentation
- Discharge practices
- Clinician training for moderate sedation

The performance indicator below did not apply to this facility as the facility no longer performed invasive procedures involving moderate sedation as of June 30, 2017.

- Availability of equipment and medications in moderate sedation procedure areas

Conclusions. The facility generally met requirements with the above performance indicators. OIG made no recommendations.

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

Long Term: 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.[35] 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 26 randomly selected patients who received CNH care for more than 3 months during the timeframe July 1, 2015 through June 30, 2016. The list below shows the performance indicators OIG reviewed.

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

The performance indicator below did not apply to this facility because none of the records reviewed had patients placed outside of the catchment area.

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

Conclusions. OIG noted compliance with requirements for annual reviews. OIG identified the following deficiencies with CNH Oversight Committee attendance and clinical visits that warranted recommendations for improvement.

Oversight Committee. VHA requires the CNH Oversight Committee to include multidisciplinary management-level representation from social work, nursing, quality management, acquisitions, and the medical staff. Committee oversight functions include verifying completeness of the CNH Review Teams' initial, annual, and problem-focused CNH evaluations. This multidisciplinary review and perspective helps to ensure that VHA contracted nursing homes provide quality care in a safe environment. The facility's CNH Oversight Committee meeting minutes from October

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

2016 through September 2017, did not contain evidence of attendance by representatives from quality management and medical staff. Program managers reported quality management and medical staff representatives were aware of this requirement but did not attend. A lack of facility leadership oversight resulted in noncompliance.

Recommendation

9. The Chief of Staff and the Nurse Executive ensure that the Community Nursing Home Oversight Committee includes representation by all required disciplines and monitor compliance

Facility concurred.

Target date for completion: April 30, 2018

Facility Response: The charter for the Community Nursing Home Oversight Committee has representation by all required disciplines. Quality Manager is now attending Community Nursing Home (CNH) Oversight Committee meetings. Will continue to work with Chief of Staff (COS) and Nurse Executive to assure that the COS or other medical staff designee is present at CNH Oversight Committee meetings. Non-compliant attendance will be reported to the Clinical Executive Board (CEB) monthly to ensure compliance.

CEB minutes will be given to Quality Manager until three consecutive months of 100% attendance by required disciplines is documented.

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 that allow an exception are met). Social workers and registered nurses must alternate monthly visits, unless otherwise indicated by the patient's treatment plan. This interdisciplinary monitoring ensures vulnerable nursing home patients consistently receive quality care and necessary follow-up services. Fifteen of the 26 patients' EHRs did not contain evidence of social worker cyclical clinical visits with the frequency required by VHA policy. Managers and staff were aware of the requirements but stated staff vacancies contributed to noncompliance with VHA policy.

Recommendation

10. The Nurse Executive ensures social workers conduct cyclical clinical visits with the frequency required by Veterans Health Administration policy and monitors social workers' compliance.

Facility concurred.

Target date for completion: June 15, 2018

Facility Response: Social workers and registered nurses will alternate monthly visits to each Veteran under contract in a nursing home, unless otherwise indicated by the patient's treatment plan. CNH Program Coordinator will conduct monthly audits.

100% of Veterans in the CNH program will be reviewed for documentation of appropriate cyclical clinical visits each month, starting with January until 90% compliance is maintained for three consecutive months.

Mental Health Residential Rehabilitation Treatment Program

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

MH RRTPs provide 24-hour residential rehabilitative and clinical care in a therapeutic setting to eligible veterans who have multiple and severe medical conditions, mental illness, addiction, or psychosocial deficits. They provide the least intensive level of VA inpatient care and differ from acute inpatient and nursing home care as veterans in MH RRTPs are generally capable of self-care. MH RRTPs address rehabilitation, recovery, health maintenance, improved quality of life, and community integration in addition to specifically treating medical conditions, mental illnesses, and addictive disorders. Facility leaders must provide a safe, well-maintained, and appropriately-furnished residential environment that supports and enhances recovery efforts.[36]

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

OIG reviewed relevant documents, inspected the MH RRTP, and interviewed key employees and managers. The list below shows the performance indicators OIG reviewed.

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

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

- Keyless entry or door locks to women veterans' rooms
- Medications secured in residents' rooms

Conclusions. The facility met requirements with the above performance indicators. OIG made no recommendations.

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	Ten OIG recommendations, ranging from documentation issues to deficiencies that can lead to patient and staff safety issues or adverse events, are attributable to the Facility Director, Chief of Staff, Nurse Executive, and Associate Director. See details below.	
Healthcare Processes	**Performance Indicators**	**Critical Recommendations[37] 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 • Patient safety incident reporting and root cause analyses	None	• A senior level committee is established and responsible for QSV functions. • The Patient Safety Manager completes the required minimum of eight RCAs each FY.
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. • Clinicians consistently obtain and document all required laboratory tests prior to initiating anticoagulant medications.	• Anticoagulation management program quality assurance data are analyzed and reported to the Pharmacy and Therapeutics Committee. • All required elements specific to anticoagulation management are included in competency assessments for employees actively involved in the anticoagulation program.

[37] 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
Environment of Care	• Parent facility o EOC deficiency tracking and rounds o General Safety o Infection prevention o Environmental cleanliness o Exam room privacy o Availability of feminine hygiene products and medical equipment and supplies • CBOC o General safety o Infection prevention o Environmental cleanliness o Medication safety and security o Privacy o Availability of feminine hygiene products and medical equipment and supplies o IT network room security • Radiology o Safe use of fluoroscopy equipment o Environmental safety o Infection prevention o Medication safety and security o Radiology equipment inspection o Availability of medical equipment and supplies o Maintenance of radiological equipment • Inpatient MH o MH EOC inspections o Environmental suicide hazard identification o Employee training o Environmental safety o Infection prevention • Availability of medical equipment and supplies	None	• Parent Facility o EOC inspections are conducted at the required frequency. o Core team members consistently participate in EOC rounds.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
High-Risk and Problem-Prone Processes: Moderate Sedation	• Outcomes reporting • Patient safety and documentation o Prior to procedure o After procedure • Staff training and competency • Monitoring equipment and emergency management	None	None
Long Term Care: Contract Nursing Home Oversight	• CNH Oversight Committee and CNH Program Integration • EHR documentation o Patient hand-off o Clinical Visits • CNH annual reviews	• Social workers conduct cyclical clinical visits with the frequency required by VHA policy.	• The CNH Oversight Committee includes representation by all required disciplines.
Mental Health Residential Rehabilitation Program	• Environmental cleanliness and fire safety • Policies/procedures o Safe medication management o Contraband detection • Monthly self-inspections • Contraband and unsecured medication inspections • Locked and alarmed entries • Closed circuit television monitors with recording capability in public areas • Process for responding to behavioral health and medical emergencies	None	None

Facility Profile

The table below provides general background information for this low complexity (3)[38] non-affiliated[39] facility reporting to VISN 20.

Table 4. Facility Profile for Walla Walla (687) for October 1, 2013 through September 30, 2016

Profile Element	Facility Data FY 2014[40]	Facility Data FY 2015[41]	Facility Data FY 2016[42]
Total Medical Care Budget in Millions	$89.1	$95.2	$100.8
Number of:			
• **Unique Patients**	18,822	18,725	19,424
• **Outpatient Visits**	206,428	190,141	184,873
• **Unique Employees**[43]	372	431	470
Type and Number of Operating Beds:			
• **Acute**	n/a	n/a	n/a
• **Mental Health**	n/a	n/a	n/a
• **Community Living Center**	n/a	n/a	n/a
• **Domiciliary**	36	36	36
Average Daily Census:			
• **Acute**	n/a	n/a	n/a
• **Mental Health**	n/a	n/a	n/a
• **Community Living Center**	n/a	n/a	n/a
• **Domiciliary**	27	23	27

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.

n/a = Not applicable

[38] 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
[39] Associated with a medical residency program.
[40] October 1, 2013 through September 30, 2014.
[41] October 1, 2014 through September 30, 2015.
[42] October 1, 2015 through September 30, 2016.
[43] Unique employees involved in direct medical care (cost center 8200).

VA Outpatient Clinic Profiles[44]

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 5. VA Outpatient Clinic Workload/Encounters[45] 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[46] Provided	Diagnostic Services[47] Provided	Ancillary Services[48] Provided
Richland, WA	687GA	7,398	3,117	Cardiology Neurology Dermatology Poly-Trauma Eye	n/a	Nutrition Pharmacy Social Work Weight Management
Lewiston, ID	687GB	8,355	1,992	Cardiology Neurology Pulmonary/ Respiratory Disease Dermatology Endocrinology Eye Anesthesia	n/a	Nutrition Pharmacy Weight Management
La Grande, OR	687GC	2,944	1,001	Cardiology Neurology Dermatology Eye	n/a	Nutrition Pharmacy Social Work Weight Management
Yakima, WA	687HA	8,117	2,554	Cardiology Neurology Pulmonary/ Respiratory Disease Dermatology Eye Anesthesia	n/a	Pharmacy

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

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

n/a – not applicable

[44] Includes all outpatient clinics in the community that were in operation before February 15, 2017. We have omitted Grangeville, ID (687QA); Boardman, OR (687QB); and Enterprise, OR (687QC), as no workload/encounters or services were reported.
[45] An encounter is a professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition.
[46] Specialty care services refer to non-primary care and non-MH services provided by a physician.
[47] Diagnostic services include EKG, EMG, laboratory, nuclear medicine, radiology, and vascular lab services.
[48] Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

VHA Policies Beyond Recertification Dates

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

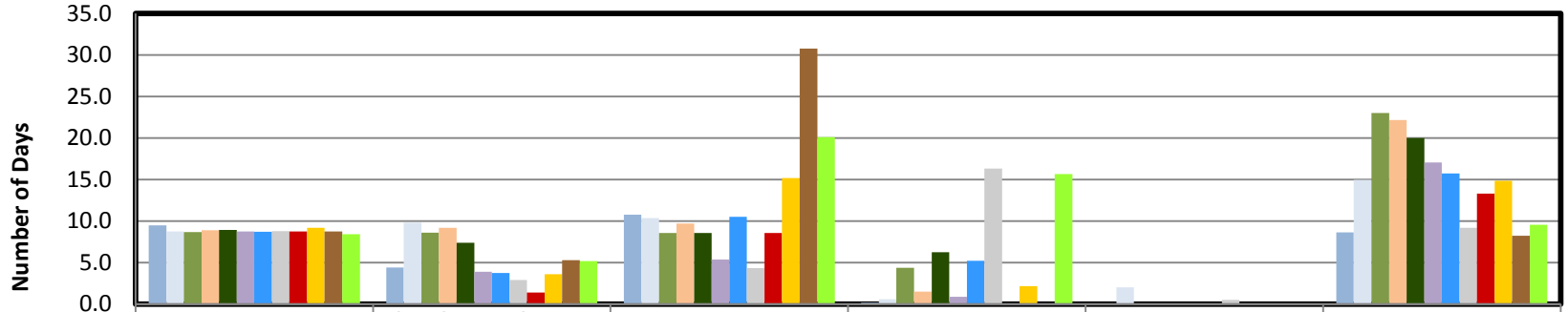
1. VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010 (recertification due date June 30, 2015).
2. VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011 (recertification due date February 29, 2016).
3. VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012 (recertification due date September 30, 2017).
4. VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011 (recertification due date March 31, 2016).
5. VHA Handbook 1004.01, *Informed Consent for Clinical Treatments and Procedures*, August 14, 2009 (recertification due date August 31, 2014), revised May 22, 2017.
6. VHA Handbook 1105.04, *Fluoroscopy Safety*, July 6, 2012 (recertification due date July 31, 2017).
7. VHA Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures*, June 4, 2004 (recertification due date January 31, 2009).
8. VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010 (recertification due date December 31, 2015).

OIG considered these policies to be in effect, as they had not been superseded by more recent policy or guidance. In a June 29, 2016, memorandum to supplement policy provided by VHA Directive 6330(1),[49] 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."[50] 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."[51]

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

Patient Aligned Care Team Compass Metrics

Quarterly New PC Patient Average Wait Time in Days



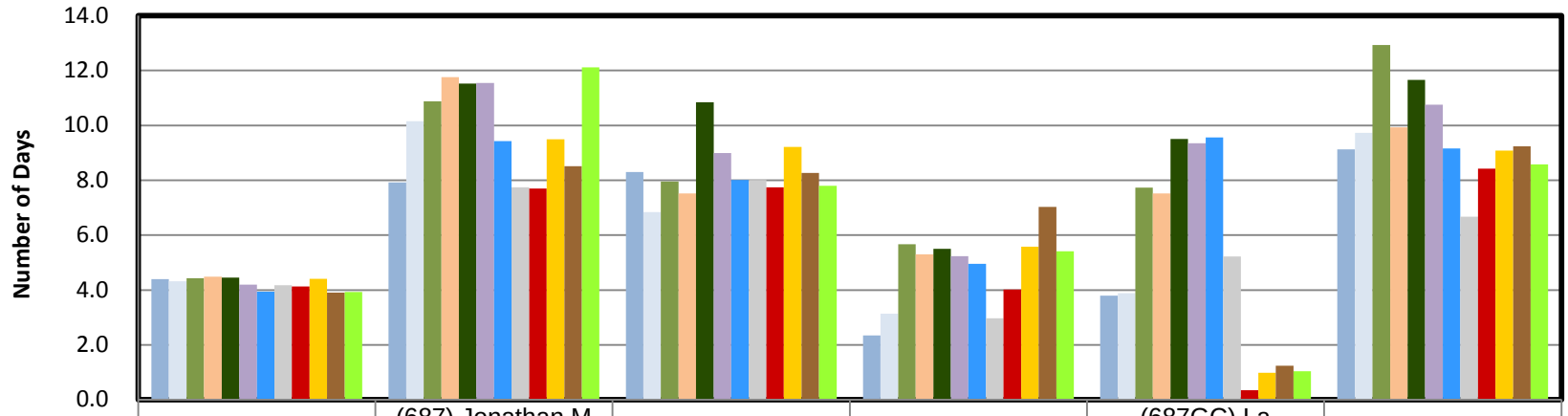
	VHA Total	(687) Jonathan M Wainwright VAMC	(687GA) Richland	(687GB) Lewiston	(687GC) La Grande	(687HA) Yakima
APR-FY16	9.5	4.4	10.8	0.2	0.0	8.6
MAY-FY16	8.7	9.8	10.4	0.6	2.0	15.0
JUN-FY16	8.7	8.6	8.5	4.4	0.0	23.0
JUL-FY16	8.9	9.2	9.7	1.5	0.0	22.2
AUG-FY16	8.9	7.4	8.5	6.3	0.0	20.0
SEP-FY16	8.7	3.9	5.4	0.9	0.0	17.1
OCT-FY17	8.7	3.7	10.5	5.2	0.0	15.7
NOV-FY17	8.8	2.9	4.3	16.3	0.5	9.2
DEC-FY17	8.8	1.4	8.6	0.0	0.0	13.3
JAN-FY17	9.2	3.6	15.2	2.1	0.0	14.8
FEB-FY17	8.7	5.3	30.8	0.0	0.0	8.2
MAR-FY17	8.4	5.2	20.1	15.7	n/a	9.5

Source: VHA Support Service Center.

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

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

Quarterly Established PC Patient Average Wait Time in Days

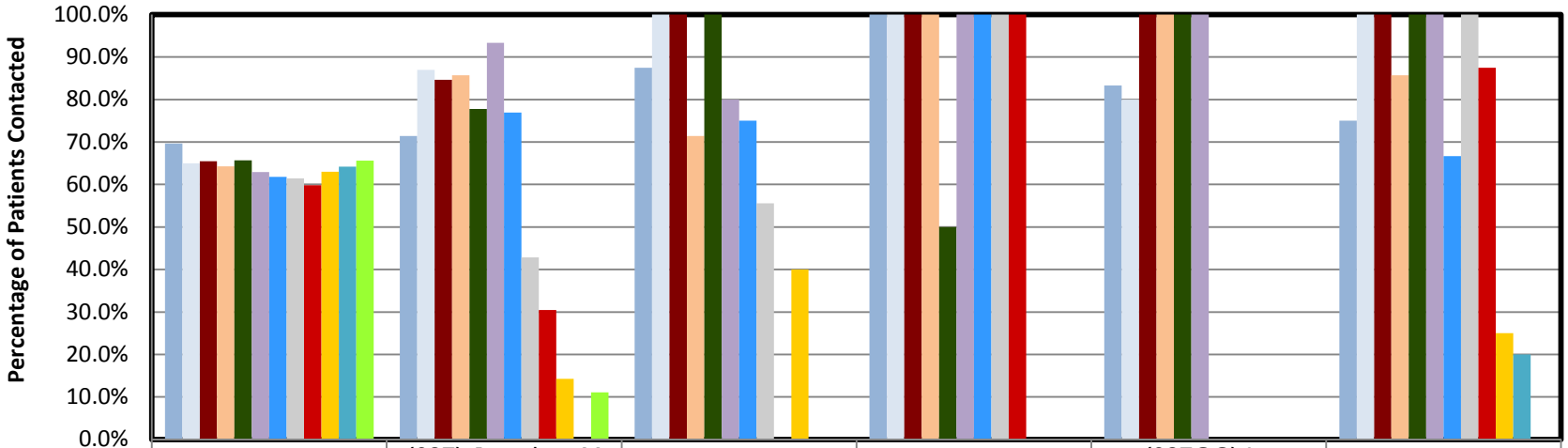


	VHA Total	(687) Jonathan M Wainwright VAMC	(687GA) Richland	(687GB) Lewiston	(687GC) La Grande	(687HA) Yakima
APR-FY16	4.4	7.9	8.3	2.3	3.8	9.1
MAY-FY16	4.3	10.2	6.8	3.1	3.9	9.7
JUN-FY16	4.4	10.9	8.0	5.7	7.7	12.9
JUL-FY16	4.5	11.8	7.5	5.3	7.5	9.9
AUG-FY16	4.5	11.5	10.8	5.5	9.5	11.7
SEP-FY16	4.2	11.5	9.0	5.2	9.3	10.8
OCT-FY17	3.9	9.4	8.0	5.0	9.6	9.2
NOV-FY17	4.2	7.7	8.0	3.0	5.2	6.7
DEC-FY17	4.1	7.7	7.7	4.0	0.3	8.4
JAN-FY17	4.4	9.5	9.2	5.6	1.0	9.1
FEB-FY17	3.9	8.5	8.3	7.0	1.2	9.2
MAR-FY17	3.9	12.1	7.8	5.4	1.0	8.6

Source: VHA Support Service Center.

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

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



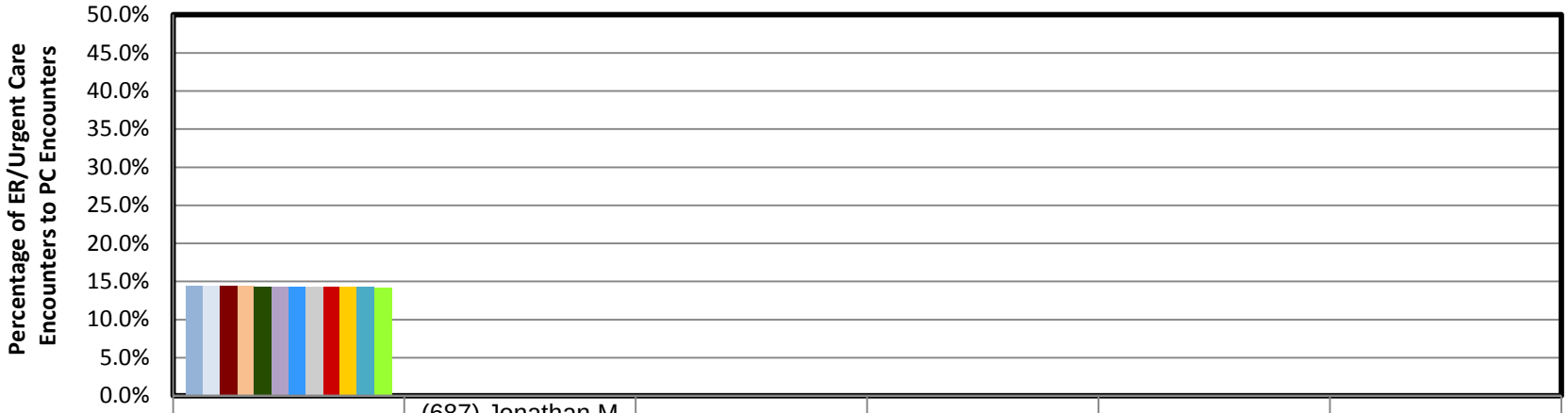
	VHA Total	(687) Jonathan M Wainwright VAMC	(687GA) Richland	(687GB) Lewiston	(687GC) La Grande	(687HA) Yakima
APR-FY16	69.7%	71.4%	87.5%	100.0%	83.3%	75.0%
MAY-FY16	65.0%	87.0%	100.0%	100.0%	80.0%	100.0%
JUN-FY16	65.5%	84.6%	100.0%	100.0%	100.0%	100.0%
JUL-FY16	64.3%	85.7%	71.4%	100.0%	100.0%	85.7%
AUG-FY16	65.7%	77.8%	100.0%	50.0%	100.0%	100.0%
SEP-FY16	62.9%	93.3%	80.0%	100.0%	100.0%	100.0%
OCT-FY17	61.8%	76.9%	75.0%	100.0%	0.0%	66.7%
NOV-FY17	61.4%	42.9%	55.6%	100.0%	n/a	100.0%
DEC-FY17	59.8%	30.4%	0.0%	100.0%	0.0%	87.5%
JAN-FY17	63.0%	14.3%	40.0%	n/a	0.0%	25.0%
FEB-FY17	64.2%	0.0%	0.0%	0.0%	n/a	20.0%
MAR-FY17	65.6%	11.1%	0.0%	0.0%	0.0%	0.0%

Source: VHA Support Service Center.

Note: We 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." The absence of reported data is indicated by "n/a."

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



	VHA Total	(687) Jonathan M Wainwright VAMC	(687GA) Richland	(5V20)	(687GC) La Grande	(5V20) (687HA) Yakima
APR-FY16	14.4%	0.0%	0.0%	0.0%	0.0%	0.0%
MAY-FY16	14.4%	0.0%	0.0%	0.0%	0.0%	0.0%
JUN-FY16	14.4%	0.0%	0.0%	0.0%	0.0%	0.0%
JUL-FY16	14.4%	0.0%	0.0%	0.0%	0.0%	0.0%
AUG-FY16	14.3%	0.0%	0.0%	0.0%	0.0%	0.0%
SEP-FY16	14.2%	0.0%	0.0%	0.0%	0.0%	0.0%
OCT-FY17	14.3%	0.0%	0.0%	0.0%	0.0%	0.0%
NOV-FY17	14.3%	0.0%	0.0%	0.0%	0.0%	0.0%
DEC-FY17	14.2%	0.0%	0.0%	0.0%	0.0%	0.0%
JAN-FY17	14.3%	0.0%	0.0%	0.0%	0.0%	0.0%
FEB-FY17	14.3%	0.0%	0.0%	0.0%	0.0%	0.0%
MAR-FY17	14.2%	0.0%	0.0%	0.0%	0.0%	0.0%

Source: VHA Support Service Center.

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

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

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

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

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

Source: VHA Support Service Center.

Relevant OIG Reports

July 1, 2014 through February 1, 2018[52]

Combined Assessment Program Review of the Jonathan M. Wainwright Memorial VA Medical Center, Walla Walla WA.

11/24/2014 | 14-2078-38 | Summary | Report

Community Based Outpatient Clinics and Primary Care Reviews at the Jonathan M. Wainwright Memorial VA Medical Center, Walla Walla WA.

7/7/2014 | 14-00910-205| Summary | Report

[52] 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: February 5, 2018

From: Director, Northwest Network (10N20)

Subject: **CHIP Review of the Jonathan M. Wainwright Memorial VA Medical Center, Walla Walla, WA**

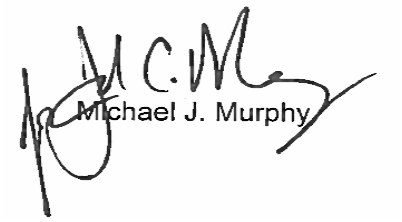
To: Director, Los Angeles Office of Healthcare Inspections (54LA)

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

1. Thank you for the opportunity to provide a status report on the findings from the CHIP Review of the Jonathan M. Wainwright Memorial VA Medical Center, Walla Walla, WA.

2. Attached please find the facility concurrence and response to the findings from the review.

3. I concur with the findings, recommendations, and submitted action plans.



Acting Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: February 7, 2018

From: Acting Director, Jonathan M. Wainwright Memorial VA Medical Center (687/00)

Subject: **CHIP Review of the Jonathan M. Wainwright Memorial VA Medical Center, Walla Walla, WA**

To: Director, Northwest Network (10N20)

1. On behalf of the Jonathan M. Wainwright Memorial VA Medical Center (VAWW), I would like to express my appreciation to the Office of Inspector General (OIG) survey team for their Comprehensive Healthcare Inspection Program (CHIP) Review conducted during the week of September 18, 2017.

2. We have reviewed the findings in the report and agree with all the OIG recommendations. VAWW responses addressing each recommendation are outlined in enclosed CHIP Review Implementation Plan.

3. We appreciate the opportunity to participate in the CHIP Review and to use this implementation plan as way to improve the quality and safety of care we provide to Veterans.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact OIG at (202) 461-4720.
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U.S. House of Representatives: Suzanne Bonamici, Jaime Herrera Beutler, Earl Blumenauer, Peter A. DeFazio, Suzan DelBene, Danny Heck, Pramila Jayapal, Derek Kilmer, Raul R. Labrador, Rick Larsen, Dan Newhouse, David Reichert, Cathy McMorris Rodgers, Kurt Schrader, Mike Simpson, Adam Smith, Greg Walden

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

Endnotes

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

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

[c] The references used for EOC included:
- VHA Handbook 1006.1, *Planning and Activating Community-Based Outpatient Clinics*, May 19, 2004.
- VHA Directive 1014, *Safe Medication Injection Practices*, July 1, 2015.
- VHA Handbook 1105.04, *Fluoroscopy Safety*, July 6, 2012.
- VHA Directive 1116(2), *Sterile Processing Services (SPS)*, March 23, 2016.
- VHA Directive 1131, *Management of Infectious Diseases and Infection Prevention and Control Programs*, November 7, 2017.
- VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013.
- VHA Directive 1330.01, *Health Care Services for Women Veterans*, February 15, 2017.
- VHA Directive 1608, *Comprehensive Environment of Care (CEOC) Program*, February 1, 2016.
- VHA Directive 1761(1), *Supply Chain Inventory Management*, October 24, 2016.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012.
- VA Handbook 6500, *Risk Management Framework for VA Information Systems – Tier 3: VA Information Security Program*, March 10, 2015.
- VHA Radiology Online Guide, http://vaww.infoshare.va.gov/sites/diagnosticservices/NRP/Mammography/Radiology%20Shared%20Files/Radiology_Service_Online_Guide_2016.docx, November 3, 2016.
- MH EOC Checklist, VA National Center for Patient Safety, http://vaww.ncps.med.va.gov/guidelines.html#mhc, accessed December 8, 2016.
- Various requirements of TJC, Association for the Advancement of Medical Instrumentation/Association for the Advancement of Medical Instrumentation, Occupational Safety and Health Administration, International Association of Healthcare Central Service Materiel Management, National Fire Protection Association.

[d] The references used for Moderate Sedation included:
- VHA Handbook 1004.01, *Informed Consent for Clinical Treatments and Procedures*, August 14, 2009.
- VHA Directive1039, *Ensuring Correct Surgery and Invasive Procedures*, July 26, 2013.
- VHA Directive 1073, *Moderate Sedation by Non-Anesthesia Providers*, December 30, 2014.
- VHA Directive 1177; *Cardiopulmonary Resuscitation, Basic Life Support, and Advanced Cardiac Life Support Training for Staff*; November 6, 2014.
- VA National Center for Patient Safety. *Facilitator's Guide for Moderate Sedation Toolkit for Non-Anesthesiologists*. March 29, 2011.
- American Society of Anesthesiologists. Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists. *Anesthesiology*. 2002; 96:1004–17.
- TJC. Hospital Standards. January 2016. PC.03.01.01, EP1 and MS.06.01.03 EP6.

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

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