Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 16-00116-323

Combined Assessment Program Review of the VA Connecticut Healthcare System West Haven, Connecticut

June 23, 2016

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
Telephone: 1-800-488-8244
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Glossary

AD	advance directive
CAP	Combined Assessment Program
CSP	compounded sterile product
CT	computed tomography
EHR	electronic health record
EOC	environment of care
facility	VA Connecticut Healthcare System
FY	fiscal year
MH	mental health
NA	not applicable
NM	not met
OIG	Office of Inspector General
OR	operating room
QSV	quality, safety, and value
VHA	Veterans Health Administration

Table of Contents

Executive Summary

Review Purpose: The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the week of March 21, 2016.

Review Results: The review covered seven activities and a follow-up review area from the previous Combined Assessment Program review. We made no recommendations in the following two activities:

- Coordination of Care
- Computed Tomography Radiation Monitoring

The facility's reported accomplishments were the Outstanding Achievement Award from the American College of Surgeons Commission on Cancer and the Homeless Team's successes.

Recommendations: We made recommendations in the following five activities and follow-up review area:

Quality, Safety, and Value: Consistently review Ongoing Professional Practice Evaluation data every 6 months. Ensure Physician Utilization Management Advisors consistently document their decisions in the National Utilization Management Integration database. Require the Patient Safety Manager to consistently enter all reported patient incidents into the WEBSPOT database.

Environment of Care: Repair damaged furniture in patient care areas, or remove it from service. Ensure employees follow facility policy for disinfecting exam tables after each patient use.

Medication Management: Ensure annual competency assessment for pharmacy employees who prepare compounded sterile products includes a written test.

Advance Directives: Ask inpatients whether they would like to discuss creating, changing, and/or revoking advance directives.

Suicide Prevention Program: Ensure the Suicide Prevention Coordinators consistently provide at least five community outreach activities every month.

Follow-Up on Nurse Staffing: Accurately monitor the nurse staffing methodology implemented in March 2013, and use the standard nursing hours per patient day calculation to assess nurse staffing adequacy for all units.

Comments

The Veterans Integrated Service Network and Facility Directors agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 25–30, for the full text of the Directors' comments.) We consider recommendation 6 closed. We 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

Objectives and Scope

Objectives

CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care quality and the EOC.
- Provide crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope

The scope of the CAP review is limited. Serious issues that come to our attention that are outside the scope will be considered for further review separate from the CAP process and may be referred accordingly.

For this review, we examined selected clinical and administrative activities to determine whether facility performance met requirements related to patient care quality and the EOC. In performing the review, we inspected selected areas, conversed with managers and employees, and reviewed clinical and administrative records. The review covered the following seven activities and follow-up review area from the previous CAP review:

- QSV
- EOC
- Medication Management
- Coordination of Care
- CT Radiation Monitoring
- ADs
- Suicide Prevention Program
- Follow-Up on Nurse Staffing

We have listed the general information reviewed for each of these activities. Some of the items listed may not have been applicable to this facility because of a difference in size, function, or frequency of occurrence.

The review covered facility operations for FYs 2014 and 2015 and FY 2016 through March 21, 2016, and inspectors conducted the review in accordance with OIG standard

operating procedures for CAP reviews. We also asked the facility to provide the status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the VA Connecticut Healthcare System, West Haven, Connecticut,* Report No. 13-01976-312, September 12, 2013). We made a repeat recommendation in Nurse Staffing.

During this review, we presented crime awareness briefings for 275 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

Additionally, we surveyed employees regarding patient safety and quality of care at the facility. We distributed an electronic survey to all facility employees and received 517 responses. We shared summarized results with facility managers.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough for the OIG to monitor until the facility implements corrective actions.

Reported Accomplishments

Cancer Care Center Team and Program Awards

In 2014, the American College of Surgeons Commission on Cancer granted the facility an Outstanding Achievement Award. The committee awarded the facility's Cancer Care Program commendations in each of the areas reviewed, including preventive screening programs, innovative treatment, research, palliative and hospice care, and educating the next generation of health care leaders. The facility was the only VA facility to receive this recognition. In July 2015, the Veterans Integrated Service Network 1 Director presented the Comprehensive Cancer Care Center Team with the ICARE (Integrity, Commitment, Advocacy, Respect, and Excellence) Award in recognition of the accomplishment.

Homeless Team Successes

The facility's homeless team supports veterans in meeting immediate housing needs and long-term stability while living in the community. Based at the facility's Errera Community Care Center, the unique collaboration of state, federal, and community partners creates a statewide system to identify and prevent homelessness among veterans and ensures that when episodes of homelessness do occur, they are brief, safe, and non-recurring. In addition to community partners, the VHA Homeless Hotline also identifies homeless veterans and refers them to the facility. The homeless team reviews each referral and provides appropriate housing resources and services. The unique partnership rapidly provides homeless veterans with interim housing, placing them into permanent housing with the appropriate support within 90 days. According to facility and state data, in 2015, the homeless team assisted in providing permanent housing to 766 veterans within an average of 78 days.

Results and Recommendations

QSV

The purpose of this review was to determine whether the facility complied with selected QSV program requirements.[a]

We conversed with senior managers and key QSV employees, and we evaluated meeting minutes, 20 licensed independent practitioners' profiles, 10 protected peer reviews, 5 root cause analyses, and other relevant documents. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	There was a senior-level committee responsible for key QSV functions that met at least quarterly and was chaired or co-chaired by the Facility Director. • The committee routinely reviewed aggregated data.		
X	Credentialing and privileging processes met selected requirements: • Facility policy/by-laws addressed a frequency for clinical managers to review practitioners' Ongoing Professional Practice Evaluation data. • Facility clinical managers reviewed Ongoing Professional Practice Evaluation data at the frequency specified in the policy/by-laws. • The facility set triggers for when a Focused Professional Practice Evaluation for cause would be indicated. • The facility followed its policy when employees' licenses expired.	• Eight provider profiles did not contain evidence that clinical managers reviewed Ongoing Professional Practice Evaluation data every 6 months.	**1.** We recommended that facility clinical managers consistently review Ongoing Professional Practice Evaluation data every 6 months and that facility managers monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
	Protected peer reviews met selected requirements: • Peer reviewers documented their use of important aspects of care in their review such as appropriate and timely ordering of diagnostic tests, timely treatment, and appropriate documentation. • When the Peer Review Committee recommended individual improvement actions, clinical managers implemented the actions.		
X	Utilization management met selected requirements: • The facility completed at least 75 percent of all required inpatient reviews. • Physician Utilization Management Advisors documented their decisions in the National Utilization Management Integration database. • The facility had designated an interdisciplinary group to review utilization management data.	• For 8 of the 27 cases referred to Physician Utilization Management Advisors January 1–March 21, 2016, there was no evidence that advisors documented their decisions in the National Utilization Management Integration database.	**2.** We recommended that Physician Utilization Management Advisors consistently document their decisions in the National Utilization Management Integration database and that facility managers monitor compliance.
X	Patient safety met selected requirements: • The Patient Safety Manager entered all reported patient incidents into the WEBSPOT database. • The facility completed the required minimum of eight root cause analyses. • The facility provided feedback about the root cause analysis findings to the individual or department who reported the incident. • At the completion of FY 2015, the Patient Safety Manager submitted an annual patient safety report to facility leaders.	• The Patient Safety Manager did not enter 599 patient incidents reported in FY 2015 into the WEBSPOT database.	**3.** We recommended that the Patient Safety Manager consistently enter all reported patient incidents into the WEBSPOT database and that facility managers monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
	Overall, if QSV reviews identified significant issues, the facility took actions and evaluated them for effectiveness.		
	Overall, senior managers actively participated in QSV activities.		
	The facility met any additional elements required by VHA or local policy.		

EOC

The purpose of this review was to determine whether the facility maintained a clean and safe health care environment in accordance with applicable requirements. We also determined whether the facility met selected requirements in the dental clinic and the OR.[b]

At the West Haven campus, we inspected the community living center; one medical/surgical unit; the telemetry/step-down, behavioral health, surgical intensive care, and medical intensive care inpatient units; the OR; the Emergency Department; the dental clinic; and two primary care clinics. At the Newington campus, we inspected the urgent care and dental clinics and two primary care clinics. Additionally, we reviewed relevant documents and 40 employee training records, and we conversed with key employees and managers. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed for General EOC	Findings	Recommendations
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure for the facility and the community based outpatient clinics.		
	The facility conducted an infection prevention risk assessment.		
	Infection Prevention/Control Committee minutes documented discussion of identified high-risk areas, actions implemented to address those areas, and follow-up on implemented actions and included analysis of surveillance activities and data.		
	The facility had established a process for cleaning equipment between patients.		
	The facility conducted required fire drills in buildings designated for health care occupancy and documented drill critiques.		
	The facility had a policy/procedure/guideline for identification of individuals entering the facility, and units/areas complied with requirements.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
	The facility met fire safety requirements.		
X	The facility met environmental safety requirements.	• Six of 12 patient care areas contained damaged furniture.	**4.** We recommended that the facility repair damaged furniture in patient care areas or remove it from service.
	The facility met infection prevention requirements.		
	The facility met medication safety and security requirements.		
	The facility met privacy requirements.		
X	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	Local policy requires cleaning exam tables after each use with an appropriate disinfection agent. • In each of the four primary care clinics, we observed that employees did not consistently disinfect exam tables after each patient use.	**5.** We recommended that facility managers ensure employees follow facility policy for disinfecting exam tables after each patient use and monitor compliance.
	Areas Reviewed for Dental Clinic		
	Dental clinic employees completed bloodborne pathogens training within the past 12 months.		
	Dental clinic employees received hazard communication training on chemical classification, labeling, and safety data sheets.		
NA	Designated dental clinic employees received laser safety training in accordance with local policy.		
	The facility tested dental water lines in accordance with local policy.		
	The facility met environmental safety and infection prevention requirements in the dental clinic.		

NM	Areas Reviewed for Dental Clinic (continued)	Findings	Recommendations
NA	The facility met laser safety requirements in the dental clinic.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for the OR		
	The facility had emergency fire policy/procedures for the OR that included alarm activation, evacuation, and equipment shutdown with responsibility for turning off room or zone oxygen.		
	The facility had cleaning policy/procedures for the OR and adjunctive areas that included a written cleaning schedule and methods of decontamination.		
	OR housekeepers received training on OR cleaning/disinfection in accordance with local policy.		
	The facility monitored OR temperature, humidity, and positive pressure.		
	The facility met fire safety requirements in the OR.		
	The facility met environmental safety requirements in the OR.		
	The facility met infection prevention requirements in the OR.		
	The facility met medication safety and security requirements in the OR.		
	The facility met laser safety requirements in the OR.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		

Medication Management

The purpose of this review was to determine whether the facility complied with selected requirements for the safe preparation of CSPs.[c]

We reviewed relevant documents and the competency assessment/testing records of 10 pharmacy employees, (6 pharmacists, 2 pharmacy technicians, 1 pharmacy student intern, and 1 pharmacy student technician). Additionally, we inspected three areas where sterile products are compounded. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	The facility had a policy on preparation of CSPs that included required components: • Pharmacist CSP preparation or supervision of preparation except in urgent situations • Hazardous CSP preparation in an area separate from routine CSP preparation or in a compounding aseptic containment isolator • Environmental quality and control of ante and buffer areas • Hood certification initially and every 6 months thereafter • Cleaning procedures for all surfaces in the ante and buffer areas		
X	The facility established competency assessment requirements for employees who prepare CSPs that included required elements, and facility managers assessed employee competency at the required frequency based on the facility's risk level.	• Three pharmacy employees who prepare CSPs did not complete an annual written test.	**6.** We recommended that facility managers ensure annual competency assessment for pharmacy employees who prepare compounded sterile products includes a written test and monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
	If the facility used an outsourcing facility for CSPs, it had a policy/guidelines/a plan that included required components for the outsourcing facility: • Food and Drug Administration registration • Current Drug Enforcement Agency registration if compounding controlled substances		
	The facility had a safety/competency assessment checklist for preparation of CSPs that included required steps in the proper order to maintain sterility.		
	All International Organization for Standardization classified areas had documented evidence of periodic surface sampling, and the facility completed required actions when it identified positive cultures.		
	The facility had a process to track and report CSP medication errors, including near misses.		
	The facility met design and environmental safety controls in compounding areas.		
	The facility used a laminar airflow hood or compounding aseptic isolator for preparing non-hazardous intravenous admixtures and any sterile products.		
	The facility used a biological safety cabinet in a physically separated negative pressure area or a compounding aseptic containment isolator for hazardous medication compounding and had sterile chemotherapy type gloves available for compounding these medications.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	If the facility prepared hazardous CSPs, a drug spill kit was available in the compounding area and during transport of the medication to patient care areas.		
	Hazardous CSPs were physically separated or placed in specially identified segregated containers from other inventory to prevent contamination or personnel exposure.		
	An eyewash station was readily accessible near hazardous medication compounding areas, and there was documented evidence of weekly testing.		
	The facility documented cleaning of compounding areas, and employees completed cleaning at required frequencies.		
	During the past 12 months, the facility initially certified new hoods and recertified all hoods minimally every 6 months.		
	Prepared CSPs had labels with required information prior to delivery to the patient care areas: • Patient identifier • Date prepared • Admixture components • Preparer and checker identifiers • Beyond use date		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		

Coordination of Care

The purpose of this review was to evaluate selected aspects of the facility's patient flow process over the inpatient continuum (admission through discharge).[d]

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 35 randomly selected patients who had an acute care inpatient stay of at least 3 days from July 1, 2014, through June 30, 2015. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings	Recommendations
	The facility had a policy that addressed patient discharge and scheduling discharges early in the day.		
	The facility had a policy that addressed temporary bed locations, and it included: • Priority placement for inpatient beds given to patients in temporary bed locations • Upholding the standard of care while patients are in temporary bed locations • Medication administration • Meal provision		
	The Facility Director had appointed a Bed Flow Coordinator with a clinical background.		
	Physicians or acceptable designees completed a history and physical exam within 1 day of the patient's admission or referenced a history and physical exam completed within 30 days prior to admission. • When resident physicians completed the history and physical exams, the attending physicians provided a separate admission note or addendum within 1 day of the admission.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	• When the facility policy and/or scopes of practice allowed for physician assistants or nurse practitioners to complete history and physical exams, they were properly documented.		
	Nurses completed admission assessments within 1 day of the patient's admission.		
	When patients were transferred during the inpatient stay, physicians or acceptable designees documented transfer notes within 1 day of the transfer. • When resident physicians wrote the transfer notes, attending physicians documented adequate supervision. • Receiving physicians documented transfers.		
	When patients were transferred during the inpatient stay, sending and receiving nurses completed transfer notes.		
	Physicians or acceptable designees documented discharge progress notes or instructions that included patient diagnoses, discharge medications, and follow-up activity levels. • When resident physicians completed the discharge notes/instructions, attending physicians documented adequate supervision. • When facility policy and/or scopes of practice allowed for physician assistants or nurse practitioners to complete discharge notes/instructions, they were properly documented.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Clinicians provided discharge instructions to patients and/or caregivers and documented patients and/or caregiver understanding.		
	The facility complied with any additional elements required by VHA or local policy.		

CT Radiation Monitoring

The purpose of this review was to determine whether the facility complied with selected VHA radiation safety requirements and to follow up on recommendations regarding monitoring and documenting radiation dose from a 2011 report, *Healthcare Inspection – Radiation Safety in Veterans Health Administration Facilities*, Report No. 10-02178-120, March 10, 2011.[e]

We reviewed relevant documents, including qualifications and dosimetry monitoring for 12 CT technologists and CT scanner inspection reports, and conversed with key managers and employees. We also reviewed the EHRs of 46 randomly selected patients who had a CT scan January 1–December 31, 2014. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings	Recommendations
	The facility had a designated Radiation Safety Officer responsible for oversight of the radiation safety program.		
	The facility had a CT/imaging/radiation safety policy or procedure that included: • A CT quality control program with program monitoring by a medical physicist at least annually, image quality monitoring, and CT scanner maintenance • CT protocol monitoring to ensure doses were as low as reasonably achievable and a method for identifying and reporting excessive CT patient doses to the Radiation Safety Officer • A process for managing/reviewing CT protocols and procedures to follow when revising protocols • Radiologist review of appropriateness of CT orders and specification of protocol prior to scans		

NM	Areas Reviewed (continued)	Findings	Recommendations
	A radiologist and technologist expert in CT reviewed all CT protocols revised during the past 12 months.		
	A medical physicist tested a sample of CT protocols at least annually.		
	A medical physicist performed and documented CT scanner annual inspections, an initial inspection after acquisition, and follow-up inspections after repairs or modifications affecting dose or image quality prior to the scanner's return to clinical service.		
	If required by local policy, radiologists included patient radiation dose in the CT report available for clinician review and documented the dose in the required application(s), and any summary reports provided by teleradiology included dose information.		
	CT technologists had required certifications or written affirmation of competency if "grandfathered in" prior to January 1987, and technologists hired after July 1, 2014, had CT certification.		
	There was documented evidence that CT technologists had annual radiation safety training and dosimetry monitoring.		
	If required by local policy, CT technologists had documented training on dose reduction/optimization techniques and safe procedures for operating the types of CT equipment they used.		
	The facility complied with any additional elements required by VHA or local policy.		

ADs

The purpose of this review was to determine whether the facility complied with selected requirements for ADs for patients.[f]

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 35 randomly selected patients who had an acute care admission July 1, 2014–June 30, 2015. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	The facility had an AD policy that addressed: • AD notification, screening, and discussions • Proper use of AD note titles		
	Employees screened inpatients to determine whether they had ADs and used appropriate note titles to document screening.		
	When patients provided copies of their current ADs, employees had scanned them into the EHR. • Employees correctly posted patients' AD status.		
X	Employees asked inpatients if they would like to discuss creating, changing, and/or revoking ADs. • When inpatients requested a discussion, employees documented the discussion and used the required AD note titles.	• Six EHRs (17 percent) did not contain documentation that employees asked inpatients whether they wished to discuss creating, changing, and/or revoking ADs.	**7.** We recommended that employees ask inpatients whether they would like to discuss creating, changing, and/or revoking advance directives and that facility managers monitor compliance.
	The facility met any additional elements required by VHA or local policy.		

Suicide Prevention Program

The purpose of this review was to evaluate the extent the facility's MH providers consistently complied with selected suicide prevention program requirements.[g]

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 39 patients assessed to be at risk for suicide during the period October 1, 2014–September 30, 2015, plus those who died from suicide during this same timeframe. We also reviewed the training records of 15 new employees. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	The facility had a full-time Suicide Prevention Coordinator.		
	The facility had a process for responding to referrals from the Veterans Crisis Line and for tracking patients who are at high risk for suicide.		
	The facility had a process to follow up on high-risk patients who missed MH appointments.		
	The facility provided training within required timeframes: • Suicide prevention training to new employees • Suicide risk management training to new clinical employees		
X	The facility provided at least five suicide prevention outreach activities to community organizations each month.	• In the 3 months prior to the site visit, the Suicide Prevention Coordinators provided evidence of only three outreach activities for 1 month and two outreach activities for another month.	**8.** We recommended that the Suicide Prevention Coordinators consistently provide at least five community outreach activities every month and that facility managers monitor compliance.
	The facility completed required reports and reviews regarding patients who attempted or completed suicide.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Clinicians assessed patients for suicide risk at the time of admission.		
	Clinicians appropriately placed Patient Record Flags: • High-risk patients received Patient Record Flags. • Moderate- and low-risk patients did not receive Patient Record Flags.		
	Clinicians documented Suicide Prevention Safety Plans that contained the following required elements: • Identification of warning signs • Identification of internal coping strategies • Identification of contact numbers of family or friends for support • Identification of professional agencies • Assessment of available lethal means and how to keep the environment safe		
	Clinicians documented that they gave patients and/or caregivers a copy of the safety plan.		
	The treatment team evaluated patients as follows: • At least four times during the first 30 days after discharge • Every 90 days to review Patient Record Flags		
	The facility complied with any additional elements required by VHA or local policy.		

Review Activity With Previous CAP Recommendations

Follow-Up on Nurse Staffing

As a follow-up to recommendations from our prior CAP review, we reassessed facility compliance with monitoring the nurse staffing methodology implemented in March 2013.[h]

Nurse Staffing Methodology Reassessment and Nursing Hours per Patient Day. VHA requires facility managers to complete annual reassessments of the facility nurse staffing methodology to assess effectiveness. During our previous CAP review, we recommended that nursing managers monitor the newly implemented staffing methodology. During this review, we found no documented evidence that nursing managers had accurately monitored the nurse staffing methodology over the past 12 months. VHA also requires the use of a standard nursing hours per patient day calculation for use in assessing nurse staffing adequacy. We had previously recommended that the facility reassess the target nursing hours per patient day for the medical intensive care unit to more accurately plan for staffing and evaluate the actual staffing provided. During this review, we found multiple methods of nursing hours per patient day calculation and record keeping for all units, not just the medical intensive care unit.

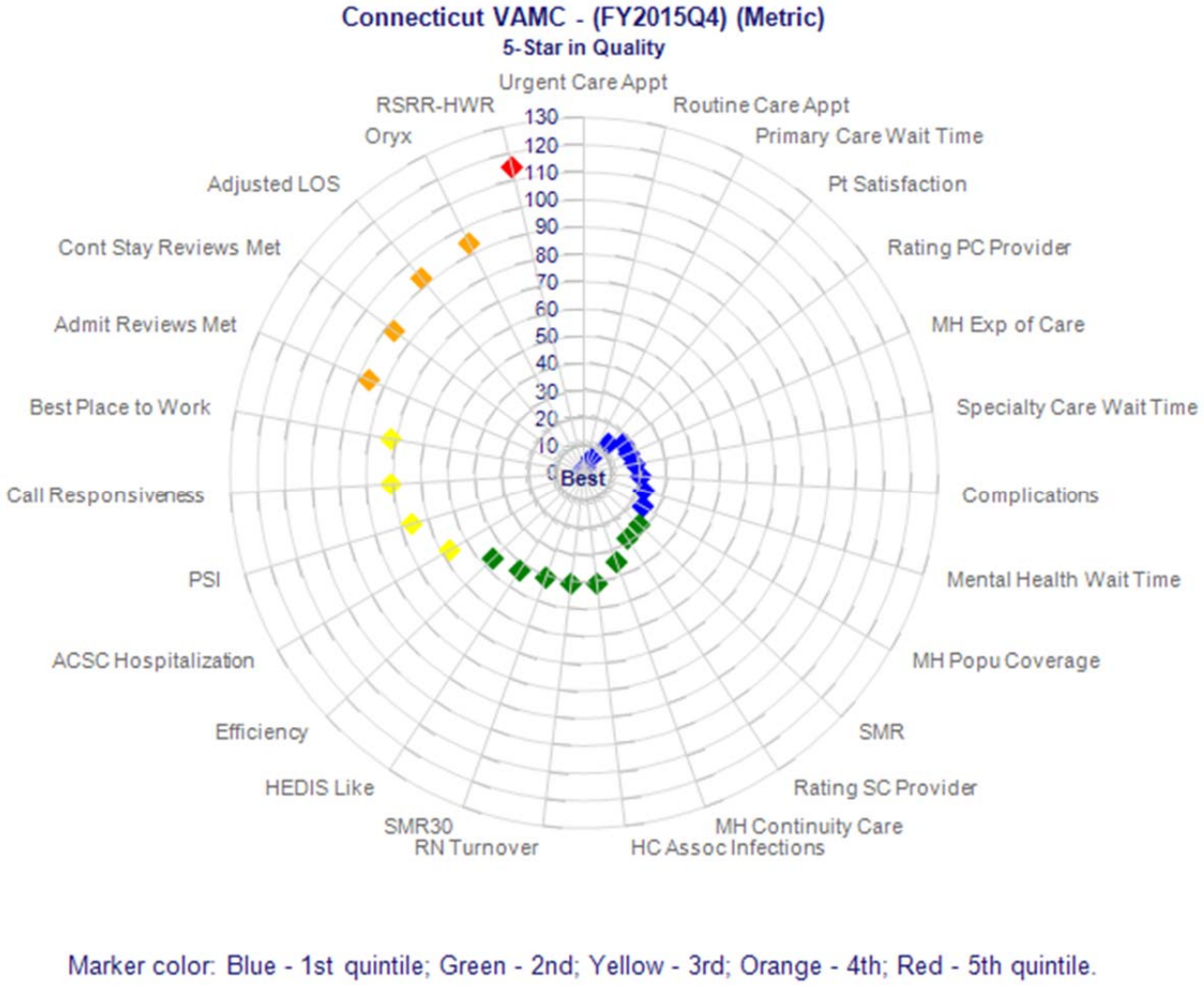
Recommendation

9. We recommended that nurse managers accurately monitor the nurse staffing methodology implemented in March 2013 and use the standard nursing hours per patient day calculation to assess nurse staffing adequacy for all units.

Facility Profile (West Haven/689) FY 2016 through March 2016[1]	
Type of Organization	Tertiary
Complexity Level	1a-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$523.5
Number of:	
• **Unique Patients**	45,624
• **Outpatient Visits**	339,399
• **Unique Employees**[2]	2,478
Type and Number of Operating Beds (as of February 2016):	
• **Hospital**	113
• **Community Living Center**	40
• **Domiciliary**	32
Average Daily Census (as of February 2016):	
• **Hospital**	75
• **Community Living Center**	23
• **Domiciliary**	21
Number of Community Based Outpatient Clinics	6[3]
Location(s)/Station Number(s)	Waterbury/689GA Stamford/689GB Willimantic/689GC Winsted/689GD Danbury/689GE New London/689HC
Veterans Integrated Service Network Number	1

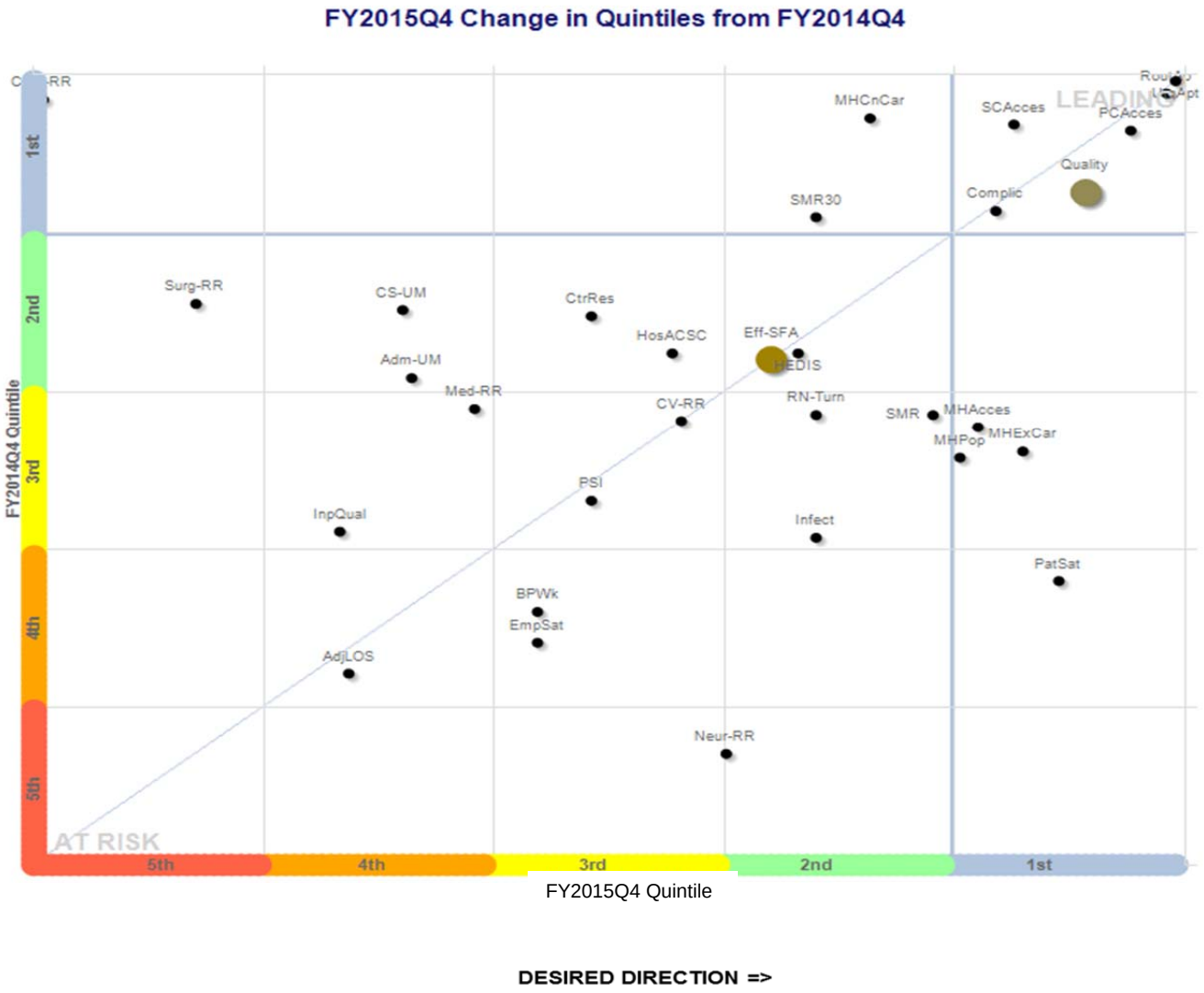
[1] All data is for FY 2016 through March 2016 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200).
[3] We have omitted West Haven (689QA) as no workload was reported.

Strategic Analytics for Improvement and Learning (SAIL)[4]



[4] Metric definitions follow the graphs.

Scatter Chart



NOTE

Quintiles are derived from facility ranking on z-score of a metric among 128 facilities. Lower quintile is more favorable.

Metric Definitions

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
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
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	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
MH Wait Time	MH wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value
MH Continuity Care	MH continuity of care (FY14Q3 and later)	MH Continuity Care
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
Primary Care Wait Time	Primary care wait time for new and established patients (top 50 clinics; FY13 and later)	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
RN Turnover	Registered nurse turnover rate	A lower value is better than a higher value
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-CHF	30-day risk standardized readmission rate for congestive heart failure	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
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 and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value

Appendix C

Veterans Integrated Service Network Director Comments

Department of Veterans Affairs

Memorandum

Date: May 19, 2016

From: Director, VA New England Healthcare System (10N1)

Subject: **CAP Review of the VA Connecticut Healthcare System, West Haven, CT**

To: Director, Bedford Office of Healthcare Inspections (54BN)

Director, Management Review Service (VHA 10E1D MRS OIG CAP CBOC)

I have reviewed and concur with the action plans regarding the CAP review of the VA Connecticut Healthcare System, West Haven, CT.

Sincerely,

Michael F. Mayo-Smith, MD, MPH
Director, VA New England Healthcare System (10N1)

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: May 18, 2016

From: Director, VA Connecticut Healthcare System (689/00)

Subject: **CAP Review of the VA Connecticut Healthcare System, West Haven, CT**

To: Director, VA New England Healthcare System (10N1)

1. Thank you for the opportunity to review the draft report of the CAP Review of the VA Connecticut Healthcare System, West Haven, CT.
2. I concur with the action plans set forth in this report.
3. If you have additional questions or need further information, please contact me at (203) 932-5711 ext. 2800.

Gerald Culliton
Director, VA Connecticut Healthcare System (689/00)

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that facility clinical managers consistently review Ongoing Professional Practice Evaluation data every 6 months and that facility managers monitor compliance.

Concur

Target date for completion: August 31, 2016

Facility response: VA Connecticut Healthcare System (VACT) convened stakeholders from Credentialing and the Chief of Staff (COS) office to review the current Ongoing Professional Practice Evaluation (OPPE) process. The Medical Staff By-Laws and facility policy were reviewed with the Medical Staff Executive Committee (MSEC). Moving forward the process to maintain compliance will be:

1. Each year the services are required to self-identify the critical elements for evaluation of each practitioner's professional practice for each area of general competence. There is a requirement for annual review of the Standard Form used by each service for OPPE. Copies of the current forms will be sent to the Associate COS for review annually each May.

2. It is a requirement that OPPE be collected on a semi-annual basis and we have defined semi-annual as January–June and July–December cycle. Tracking will be submitted to the Credentialing Committee and reported to MSEC and the results be formally entered into the privileging process. OPPE folders will then be maintained in their respective service with oversight by the Chief of Staff.

3. Any further changes or updates to this process will be routed through MSEC.

Recommendation 2. We recommended that Physician Utilization Management Advisors consistently document their decisions in the National Utilization Management Integration database and that facility managers monitor compliance.

Concur

Target date for completion: August 31, 2016

Facility response: VACT immediately convened the group of utilization management (UM) stakeholders to include the COS, Physician Utilization Management Advisors (PUMA) and the UM nurses to develop an action plan. The UM nurse will send an email to the PUMA once a review request has been entered in NUMI [National Utilization Management Integration]. If no response has been received in 48–72 hours,

the UM nurse will send a second email reminder. The UM lead will send bi-monthly PUMA response results to all PUMAs, UM nurses and COS. PUMA response results reported quarterly to Medical Staff Executive Committee/CQI Committee with UM and Flow report. Additional "backup" PUMAs will be recruited as able with COS assistance.

Recommendation 3. We recommended that the Patient Safety Manager consistently enter all reported patient incidents into the WEBSPOT database and that facility managers monitor compliance.

Concur

Target date for completion: July 31, 2016

Facility response: VACT continued to move forward with entering all patient incidents into WEBSPOT. Approximately one quarter of the deficit has now been entered with the goal of all back log entered by the end of July 2016. The data entry technician is providing a daily update to the Chief of Quality Management and Patient Safety Manager. Moving forward, all incident reports will be entered by the end of the following month with a goal of 90 percent or greater. This will be reported out quarterly to the Patient Safety Committee.

Recommendation 4. We recommended that the facility repair damaged furniture in patient care areas or remove it from service.

Concur

Target date for completion: August 31, 2016

Facility response: VACT immediately convened stakeholders from facilities management, environmental management and interior design develop a plan to repair or replace furnishings noted during OIG CAP survey. The team plans to do an extended walk through of all patient care areas to further identify any additional furniture in need of repair or replacement. Checking furniture for damage has also been added to environment of care rounds and will be reported with rounds report at each EOC committee meeting beginning in June 2016.

Recommendation 5. We recommended that facility managers ensure employees follow facility policy for disinfecting exam tables after each patient use and monitor compliance.

Concur

Target date for completion: August 31, 2016

Facility response: VACT stakeholders including primary and specialty care managers reviewed the health system policy for the cleaning of non-critical reusable medical equipment (RME) and reeducated clinic staff that exam tables should be disinfected after each patient use. At this time our VACT policy exceeds the Centers for Disease Control and Prevention recommendations. This will be monitored for no less than

3 months by clinic nurse managers and compliance reported to Quality Management. The RME coordinator Nursing Director, Primary care will further research Centers for Disease Control and Prevention expectation of cleaning and work with Infection Prevention to make any needed policy changes in the future.

Recommendation 6. We recommended that facility managers ensure annual competency assessment for pharmacy employees who prepare compounded sterile products includes a written test and monitor compliance.

Concur

Target date for completion: April 30, 2016

Facility response: VACT pharmacy managers immediately addressed this by requiring all staff to complete Critical Point (software that we use as our initial and then annual written competencies). The Inpatient Pharmacy Supervisor is finalizing with the Critical Point team details to send all employees electronic reminders to complete annual competencies when they become due. The Pharmacy Management Team has made a requirement that all staff turn in documentation of their Critical Point transcript by April of each year moving forward. All pharmacy staff who prepare CSPs are in compliance at this time.

Recommendation 7. We recommended that employees ask inpatients whether they would like to discuss creating, changing, and/or revoking advance directives and that facility managers monitor compliance.

Concur

Target date for completion: August 31, 2016

Facility response: VACT recognized this vulnerability prior to the OIG CAP review and immediately updated templates used for all inpatient admissions to include creating, changing and or revoking advance directives during that stay. All inpatients are now asked upon admission if they would like to discuss creating, changing and or revoking advance directives and if so, they are referred to social work service. Quality Management will review 50 inpatient records per month for no less than 3 months with the expectation of 90% compliance or greater. A random sample review for May 2016 showed 100% compliance with all patients being asked the appropriate questions. Quality Management will share these results monthly with the Associate Director, Patient Care Services for dissemination to clinical staff.

Recommendation 8. We recommended that the Suicide Prevention Coordinators consistently provide at least five community outreach activities every month and that facility managers monitor compliance.

Concur

Target date for completion: May 31, 2016

Facility response: The Suicide Prevention Program (SPP) team has implemented the following processes to ensure the outreach goal of five outreach events is consistently met. Suicide Prevention has met or exceeded five outreach events per month for February to April 2016 and is on target for May 2016. The SPP team has:

1. Increased participation in VACT's Outreach Committee.
    a. Doing so has afforded the opportunity of join efforts with other programs.

2. Identified and will continue to seek community organizations where Veterans and their families may frequent/receive services.
    a. Will strategically provide mailings of Veterans Crisis Line materials
    b. Offer Suicide Prevention training/Veterans Crisis Line presentations as requested
        i. Examples of this include participation in college "Fresh Check Days," Veterans Awareness motorcycle rides, and presentations at Veterans organizations (American Legion, Disabled American Veterans) statewide.

3. Initiated a weekly process wherein the Program Support Assistant identifies, schedules and tracks outreach efforts that occur through the month, coordinating efforts and availability with the Suicide Prevention Coordinators.

4. Monthly data will be reported to Quality Management for no less than 3 months from the OIG CAP survey.

Recommendation 9. We recommended that nurse managers accurately monitor the nurse staffing methodology implemented in March 2013 and use the standard nursing hours per patient day calculation to assess nurse staffing adequacy for all units.

Concur

Target date for completion: August 31, 2016

Facility response: Nurse Managers will accurately monitor the nurse staffing methodology as implemented in March 2013. The nurse managers will monitor staffing data daily and provide documentation within the tracking tool if there is a discrepancy. Monthly meetings with the unit panels will be held to address issues for over or under shooting target ranges, and quarterly meetings with minutes will be held with the unit managers and the nursing directors. Minutes of the quarterly meetings will be submitted to the Associate Director, Patient Care Services for review and validation. The expert panel will meet annually for year-end roll up, benchmark review and planning for next calendar year.

Office of Inspector General
Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
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U.S. House of Representatives: Joe Courtney, Rosa L. DeLauro, Elizabeth Esty, Jim Himes, John B. Larson

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

Endnotes

[a] The references used for this topic 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 this topic included:
- VHA Directive 2005-037, *Planning for Fire Response*, September 2, 2005.
- VHA Directive 2009-026; *Location, Selection, Installation, Maintenance, and Testing of Emergency Eyewash and Shower Equipment*; May 13, 2009.
- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, the International Association of Healthcare Central Service Materiel Management, the Health Insurance Portability and Accountability Act, National Fire Protection Association, Association of periOperative Registered Nurses, U.S. Pharmacopeial Convention, American National Standards Institute.

[c] The references used for this topic included:
- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- VHA Handbook 1108.07, *Pharmacy General Requirements*, April 17, 2008.
- Various requirements of VA Pharmacy Benefits Management Services, The Joint Commission, the United States Pharmacopeial Convention, the American Society of Health-System Pharmacists, the Institute for Safe Medication Practices, the Food and Drug Administration, and the American National Standards Institute.

[d] The references used for this topic included:
- VHA Directive 1009, *Standards for Addressing the Needs of Patients Held in Temporary Bed Locations*, August 28, 2013.
- VHA Directive 1063, *Utilization of Physician Assistants (PA)*, December 24, 2013.
- VHA Handbook 1400.01, *Resident Supervision*, December 19, 2012.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.

[e] The references used for this topic included:
- VHA Directive 1129, *Radiation Protection for Machine Sources of Ionizing Radiation*, February 5, 2015.
- VHA Handbook 1105.02, *Nuclear Medicine and Radiation Safety Service*, December 10, 2010.
- VHA Handbook 5005/77, *Staffing*, Part II, Appendix G25, Diagnostic Radiologic Technologist Qualifications Standard GS-647, June 26, 2014.
- The Joint Commission, "Radiation risks of diagnostic imaging," Sentinel Event Alert, Issue 47, August 24, 2011.
- VA Radiology, "Online Guide," updated October 4, 2011.
- The American College of Radiology, "ACR–AAPM TECHNICAL STANDARD FOR DIAGNOSTIC MEDICAL PHYSICS PERFORMANCE MONITORING OF COMPUTED TOMOGRAPHY (CT) EQUIPMENT, Revised 2012.

[f] The references used for this topic included:
- VHA Handbook 1004.02, *Advance Care Planning and Management of Advance Directives*, December 24, 2013.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, July 22, 2014.

[g] The references used for this topic included:
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-053, *Patient Record Flags*, December 3, 2010 (corrected 2/3/11).
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.
- VHA Handbook 1160.06, *Inpatient Health Services*, September 16, 2013.
- Various Deputy Under Secretary for Health for Operations and Management memorandums and guides.
- *VA Suicide Prevention Coordinator Manual*, August 2014.
- Various requirements of The Joint Commission.

[h] The references used for this topic were:
- VHA Directive 2010-034, *Staffing Methodology for VHA Nursing Personnel*, July 19, 2010.
- VHA "Staffing Methodology for Nursing Personnel," August 30, 2011.