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Clinical Assessment Program Review of the Wilmington VA Medical Center Wilmington, Delaware

September 20, 2017

Washington, DC 20420

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Glossary

CAP	Clinical Assessment Program
CBOC	community based outpatient clinic
CNH	community nursing home
EHR	electronic health record
EOC	environment of care
ER	emergency room
facility	Wilmington VA Medical Center
FY	fiscal year
MH	mental health
NA	not applicable
NM	not met
OIG	Office of Inspector General
PC	primary care
POCT	point-of-care testing
QSV	quality, safety, and value
RME	reusable medical equipment
SPS	Sterile Processing Service
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Executive Summary

Purpose and Objectives: The review provided an evaluation of the quality of care delivered in the inpatient and outpatient settings of the Wilmington VA Medical Center. We reviewed clinical and administrative processes that affect patient care outcomes—Quality, Safety, and Value; Environment of Care; Medication Management; Coordination of Care; Diagnostic Care; Moderate Sedation; Community Nursing Home Oversight; and Management of Disruptive/Violent Behavior. We also followed up on recommendations from the previous Combined Assessment Program and Community Based Outpatient Clinic and Primary Care Clinic reviews and provided crime awareness briefings.

Results: We conducted the review during the week of January 30, 2017, and identified certain system weaknesses in Environment of Care Committee meeting minutes; general safety; Sterile Processing Service employee competencies; hemodialysis unit infection prevention; anticoagulation processes and employee competencies; transfer data and documentation; point-of-care testing actions; community nursing home oversight, clinical visits, and policies; and management of disruptive/violent behavior policy, committee representation, and employee training.

Review Impact: As a result of the findings, we could not gain reasonable assurance that:

1. Environment of Care minutes track actions taken in response to identified deficiencies until closed.
2. Community based outpatient clinic fire extinguishers are inspected monthly, and community based outpatient clinic information technology network room logs contain access documentation.
3. Sterile Processing Service employees complete annual competencies for the types of reusable medical equipment they reprocess.
4. All hemodialysis unit employees wear gloves when handling patient equipment.
5. Clinicians obtain all required laboratory testing prior to the initiation of anticoagulants.
6. Clinicians have documented competency to manage anticoagulation therapy patients.
7. The facility collects and reports data on transfers out and includes required elements in patient transfer documentation.
8. The facility takes and documents all required actions in response to glucose point-of-care testing results.

9. The facility effectively oversees the community nursing home program and consistently performs required cyclical reviews of patient care provided through the program.
10. The facility's management of disruptive behavior policy reflects current practice, members consistently attend Disruptive Behavior Committee meetings, and employees are trained to reduce and prevent disruptive behaviors.

Recommendations: We made recommendations in the following six review areas.

Environment of Care – Ensure that:
- Environment of Care Committee meeting minutes track actions taken in response to identified deficiencies to closure.
- All fire extinguishers are inspected monthly and marked with the correct inspection date.
- Employees document when they access information technology network rooms by using the visitor logs.
- Sterile Processing Service employees receive annual competencies for the types of reusable medical equipment they reprocess.
- Hemodialysis unit employees wear gloves when handling patient equipment.

Medication Management: Anticoagulation Therapy – Ensure that:
- Clinicians consistently obtain all required laboratory tests prior to initiating warfarin treatment.
- Clinical managers include in the competency assessments of employees actively involved in the anticoagulant program knowledge of drug to drug interactions associated with anticoagulation therapy.
- Clinical managers complete competency assessments annually for employees actively involved in the anticoagulant program.

Coordination of Care: Inter-Facility Transfers – Ensure that:
- Facility managers collect and report data on patient transfers out of the facility.
- For patients transferred out of the facility, clinicians consistently include in transfer documentation patient or surrogate informed consent and medical and behavioral stability.

Diagnostic Care: Point-of-Care Testing – Ensure that:
- Clinicians take and document all actions required by the facility in response to test results.

Community Nursing Home Oversight – Ensure that:

- The Community Nursing Home Oversight Committee includes representation by all required clinical disciplines.
- The community nursing home program is integrated into the facility's quality improvement program.
- Social workers and registered nurses conduct and document cyclical clinical visits with the frequency required by Veterans Health Administration policy.
- Facility managers update the policy on the community nursing home program to include all elements required by Veterans Health Administration policy.
- A VA physician orders or approves all therapies that are at VA expense.
- The community nursing home program office scans existing paper health records into electronic health records and develops a process to scan new records as they are received.

Management of Disruptive/Violent Behavior – Ensure that:

- Facility managers update the policy on preventing and managing disruptive and violent behavior.
- The VA Police Officer and the Patient Advocate consistently attend Disruptive Behavior Committee meetings.
- All employees receive Level 1 Prevention and Management of Disruptive Behavior training and additional training as required for their assigned risk area within 90 days of hire and that the training is documented in employee training records.

Comments

The Veterans Integrated Service Network Director and Interim Facility Director agreed with the Clinical Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes E and F, pages 41–49, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

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Assistant Inspector General for
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Purpose and Objectives

Purpose

This CAP review provided an evaluation of the quality of care delivered in the inpatient and outpatient settings of the facility.

Objectives

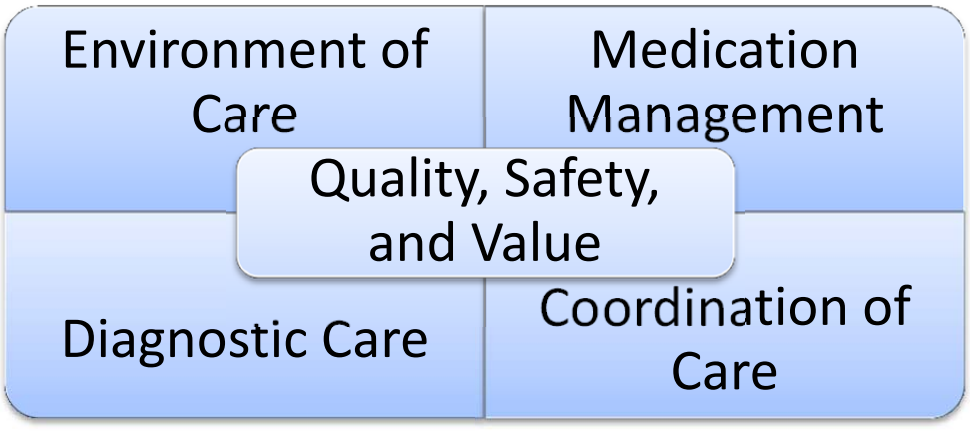
CAP reviews are one element of OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The reviews include cyclical evaluations of key clinical and administrative processes that affect patient care outcomes. Areas of focus include QSV, EOC, Medication Management, Coordination of Care, and Diagnostic Care.

OIG also evaluates processes that are high risk and problem-prone—Moderate Sedation, CNH Oversight, and Management of Disruptive/Violent Behavior—and follows up on recommendations from the previous Combined Assessment Program and CBOC and PC reviews. Additionally, OIG provides crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to OIG.

Background

We evaluate key aspects of clinical care delivery in a variety of primary/specialty care and inpatient/outpatient settings. These aspects include QSV, EOC, Medication Management, Coordination of Care, and Diagnostic Care (see Figure 1 below).

Figure 1. Comprehensive Coverage of Continuum of Care



Source: VA OIG

Quality, Safety, and Value

According to the National Academy of Medicine (formerly the Institute of Medicine), there are six important components of a health care system that provides high quality care to individuals. The system:

1. Is safe (free from accidental injury) for all patients, in all processes, all the time.
2. Provides care that is effective (care that, wherever possible, is based on the use of systematically obtained evidence to make determinations regarding whether a preventive service, diagnostic test, therapy, or no intervention would produce the best outcome).
3. Is patient-centered. This concept includes respect for patients' values and preferences; coordination and integration of care; information, communication, and education; physical comfort; and involvement of family and friends.
4. Delivers care in a timely manner (without long waits that are wasteful and often anxiety-provoking).
5. Is efficient (uses resources to obtain the best value for the money spent).
6. Is equitable (bases care on an individual's needs and not on personal characteristics—such as gender, race, or insurance status—that are unrelated to the patient's condition or to the reason for seeking care).[1]

VA states that one of its strategies is to deliver high quality, veteran-centered care that compares favorably to the best of the private sector in measured outcomes, value, efficiency, and patient experience.[2]

Environment of Care

All facilities face risks in the environment, including those associated with safety and security, fire, hazardous materials and waste, medical equipment, and utility systems. The EOC is made up of three basic elements: (1) the building or space; (2) equipment used to support patient care; and (3) people who enter the environment.[3]

The physical environment shapes every patient experience and all health care delivery, including those episodes of care that result in patient harm. Three patient safety areas are markedly influenced by the environment—health care-associated infections, medication safety, and falls. Because health care-associated infections are transmitted through air, water, and contact with contaminated surfaces, the physical environment plays a key role in preventing the spread of infections in health care settings. Medication safety is markedly influenced by physical environmental conditions, including light levels and workspace organization. Environmental features, such as the

[1] Teleki SS, Damberg, CL, Reville RT. *Quality of Health Care: What Is It, Why Is It Important, and How Can It Be Improved in California's Workers Compensation Programs?* Santa Monica: RAND Corporation; May 2003 Quality and Workers' Compensation Working Draft.
[2] Department of Veterans Affairs, Veterans Health Administration. *Blueprint for Excellence*. September 2014.
[3] The Joint Commission. *Comprehensive Accreditation Manual for Hospitals: E-dition*®: Joint Commission Resources; July 2016: Environment of Care (EC).

placement of doorways, flooring type, and the location of furniture, can contribute to patient falls and associated injuries.[4]

Medication Management

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. Medications are involved in 80 percent of all treatments and impact every aspect of a patient's life. Drug therapy problems occur every day. The National Academy of Medicine (formerly the Institute of Medicine) noted that while medications account for only 10 percent of total health care costs, their ability to control disease and impact overall costs, morbidity, and productivity—when appropriately used—is enormous. The components of the medication management process include procuring, storing, securing, prescribing or ordering, transcribing, preparing, dispensing, and administering.[5,6]

Coordination of Care

Coordination of care is the process of coordinating care, treatment, or services provided by a facility, including referring individuals to appropriate community resources to meet ongoing identified needs, implementing the plan of care, and avoiding unnecessary duplication of services. Coordination of care is recognized as a major challenge in the safe delivery of care. The rise of chronic illness means that a patient's care, treatment, and services likely will involve an array of providers in a variety of health care settings, including the patient's home.[7]

The Institute of Medicine (now the National Academy of Medicine) report "Crossing the Quality Chasm: A New Health System for the 21st Century" notes that, "Because of the special vulnerability that accompanies illness or injury, coordination of care takes on special importance. Many patients depend on those who provide care to coordinate services whether tests, consultations, or procedures to ensure that accurate and timely information reaches those who need it at the appropriate time." Health care providers and organizations need to work together to coordinate their efforts to provide safe, quality care.[8]

[4] Joseph A, Malone EB. *The Physical Environment: An Often Unconsidered Patient Safety Tool*. Agency for Healthcare Research and Quality. Patient Safety Network; October 2012.
[5] Patient-Centered Primary Care Collaborative. *The Patient-Centered Medical Home: Integrating Comprehensive Medication Management to Optimize Patient Outcomes, Resource Guide*. 2nd ed; June 2012.
[6] The Joint Commission. *Comprehensive Accreditation Manual for Hospitals: E-dition*®: Joint Commission Resources; July 2016: Medication Management (MM).
[7] The Joint Commission. *Comprehensive Accreditation Manual for Hospitals: E-dition*®: Joint Commission Resources; July 2016: Provision of Care, Treatment, and Services (PC).
[8] Institute of Medicine. *Crossing the Quality Chasm: A New Health System for the 21st Century*. The National Academies Press; March 2001.

Diagnostic Care

The diagnostic process is a complex, patient-centered, collaborative activity that involves information gathering and clinical reasoning with the goal of determining a patient's health problem. Diagnostic testing may occur in successive rounds of information gathering, integration, and interpretation, with each round refining the working diagnosis. PC clinicians order laboratory tests in slightly less than one third of patient visits, and direct-to-patient testing is becoming increasingly prevalent.[9]

Medical imaging also plays a critical role in establishing the diagnoses for many conditions. The advancement of imaging technologies has improved the ability of clinicians to detect, diagnose, and treat conditions while also allowing patients to avoid more invasive procedures. In many cases, diagnostic testing can identify a condition before it is clinically apparent; for example, an imaging study indicating the presence of coronary artery blockage can identify coronary artery disease even in the absence of symptoms. Performed appropriately, diagnostic care facilitates the provision of timely, cost-effective, and high quality medical care.[10]

High-Risk and Problem-Prone Health Care Processes

Health care leaders must give priority to high-volume, high-risk, or problem-prone processes for performance improvement activities.[11] "Specifically, they are responsible for identifying high-risk areas that could cause harm to patients, visitors, and employees; implementing programs to avert risks; and managing a robust reporting process for adverse events that do occur. But of all of their responsibilities, one of the most important is focusing on improving patient safety."[12]

Moderate sedation is a drug-induced depression of consciousness during which patients respond purposefully to verbal comments.[13] 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 performance.[14]

[9] Committee on Diagnostic Error in Health Care. Balogh EP, Miller BT, Ball JR, eds. *Improving Diagnosis in Health Care*. Washington, DC: The National Academies Press; 2015: Chap. 2.
[10] Department of Veterans Affairs. Patient Care Services. Diagnostic Services. http://www.patientcare.va.gov/diagnosticservices.asp. Accessed September 21, 2016.
[11] The Joint Commission. *Comprehensive Accreditation Manual for Hospitals: E-dition*®: Joint Commission Resources; July 2016: Leadership (LD) Accreditation Requirements, LD.04.04.01, EP2.
[12] Bickmore, AM. Streamlining the Risk Management Process in Healthcare to Improve Workflow and Increase Patient Safety, *HealthCatalyst*, https://www.healthcatalyst.com/streamlining-risk-management-process-healthcare.
[13] American Society of Anesthesiologists (ASA), Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists, 2002. Anesthesiology 2002; 96:1004-17.
[14] VHA Directive 1073, *Moderate Sedation by Non-Anesthesiology Providers*, December 30, 2014.

As of October 2016, VHA has contracts with more than 1,800 CNHs where more than 9,500 veteran patients reside.[15] These CNHs may be within close proximity to a VA facility or located hundreds of miles away. VHA requires local oversight of CNHs, which includes monitoring and follow-up services for patients who choose to reside in nursing homes in the community. This involves annual reviews and monthly patient visits unless otherwise specified.[16]

According to the U.S. Bureau of Labor Statistics, health care workers are nearly five times more likely to be victims of nonfatal assaults or violent acts in their work places than average workers in all industries combined, and many of these assaults and violent acts are perpetrated by patients.[17] Management of disruptive/violent behavior is the process of reducing and preventing disruptive behaviors and other defined acts that threaten public safety through the development of policy, programs, and initiatives aimed at patient, visitor, and employee safety.[18] VHA has a directive that addresses the management of all individuals in VHA facilities whose behavior could jeopardize the health or safety of others, undermine a culture of safety in VHA, or otherwise interfere with the delivery of health care at a facility; however, staff training deadlines have been postponed several times.

Scope

To evaluate for compliance with requirements related to patient care quality, clinical functions, and the EOC, we physically inspected selected areas, discussed processes and validated findings with managers and employees, and reviewed clinical and administrative records. The review covered the following five aspects of clinical care.

- Quality, Safety, and Value
- Environment of Care
- Medication Management: Anticoagulation Therapy
- Coordination of Care: Inter-Facility Transfers
- Diagnostic Care: Point-of-Care Testing

[15] VA Corporate Data Warehouse. Accessed October 31, 2016.
[16] VHA Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures*, June 4, 2004.
[17] U.S. Bureau of Labor Statistics. Janocha JA, Smith RT. *Workplace Safety and Health in the Health Care and Social Assistance Industry, 2003–07*. http://www.bls.gov/opub/mlr/cwc/workplace-safety-and-health-in-the-health-care-and-social-assistance-industry-2003-07.pdf. August 30, 2010. Accessed October 28, 2016.
[18] VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012.

We also evaluated three additional review areas because of inherent risks and potential vulnerabilities.

- Moderate Sedation
- Community Nursing Home Oversight
- Management of Disruptive/Violent Behavior

We list the review criteria for each of the review areas in the topic checklists.

The review covered operations for FYs 2015 and 2016 and for FY 2017 through February 3, 2017, and inspectors conducted the reviews 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 Combined Assessment Program report (*Combined Assessment Program Review of the Wilmington VA Medical Center, Wilmington*, *Delawar*e, Report No. 13-04243-151, May 20, 2014) and CBOC report (*Community Based Outpatient Clinic and Primary Care Clinic Reviews at Wilmington VA Medical Center, Wilmington, Delaware,* Report No. 14-00235-195, June 26, 2014).

We presented crime awareness briefings for 84 employees. These briefings covered procedures for reporting suspected criminal activity to OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

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 126 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 OIG to monitor until the facility implements corrective actions. Issues and concerns that come to our attention but are outside the scope of this CAP review will be considered for further review separate from the CAP process and may be referred accordingly.

Reported Accomplishments

Outpatient Detoxification Program

VHA asked facility managers to evaluate the cost of inpatient versus outpatient detoxification protocols both in the VA and in the non-VA setting. From this study, facility managers estimated that development of an outpatient detoxification program could save the VA $3,000 to $5,000 per patient. Based on these findings, in July 2016, the facility opened an outpatient detoxification program. Patients who previously would have been in inpatient programs can now safely and effectively stop alcohol use through the facility's outpatient program.

Hands-On Simulation Training for Personal Protective Equipment

An external survey of facility infection prevention identified that clinical and ancillary employees were not appropriately using personal protective equipment. The infection prevention team developed hands-on simulation training to actively engage clinical and ancillary employees in completing competencies and understanding the importance of proper use of personal protective equipment. Facility managers presented this program to the VA National Long-Term Care Group in November 2016.

Results and Recommendations

Quality, Safety, and Value

The purpose of this review was to determine whether the facility complied with selected QSV program requirements.[a] VHA requires that its facilities operate a QSV program to monitor patient care quality and performance improvement activities. Many QSV activities are required by VHA directives, accreditation standards, and Federal regulations. Public Law 100-322 mandates VA's OIG to oversee VHA quality improvement programs at every level. This review focuses on the following program areas.

- Senior-level committee or group with responsibility for QSV/performance improvement
- Protected peer review
- Credentialing and privileging
- Utilization management
- Patient safety

We interviewed senior managers and key QSV employees, and we evaluated meeting minutes, 25 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 facility generally met requirements. We made no recommendations.

Checklist 1. QSV Areas Reviewed, Findings, and Recommendations

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.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Credentialing and privileging processes met selected requirements: • Facility policy/by-laws specified 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.		
	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.		
	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. • An interdisciplinary group reviewed utilization management data.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	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 2016, the Patient Safety Manager submitted an annual patient safety report to facility leaders.		
	Overall, if QSV reviews identified significant issues, the facility took actions and evaluated them for effectiveness.		
	Overall, senior managers actively participated in QSV activities.		

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. We also determined whether the facility met selected requirements in SPS and the hemodialysis unit.[b]

VHA must manage risks in the environment in order to promote a safe, functional, and supportive environment. Further, VHA must establish a systematic infection prevention and control program to reduce the possibility of acquiring and transmitting infections. We selected the hemodialysis unit and SPS as special emphasis areas due to the increased potential for exposure to infectious agents inherent to hemodialysis and procedures using RME. Hemodialysis patients are at higher risk for infections for various reasons, including that hemodialysis requires vascular access for prolonged periods of time and that opportunities exist for transmission of infectious agents when multiple patients receive dialysis concurrently. RME is intended for repeated use on different patients after being reprocessed through cleaning, disinfection, and/or sterilization. Patients undergoing procedures using RME are at higher risk of exposure to infectious agents if RME is not properly reprocessed.

We inspected the community living center, the Emergency Department, a medical-surgical inpatient unit, the intensive care unit, the hemodialysis unit, the hematology/oncology clinic, SPS, and the Cumberland County CBOC. Additionally, we reviewed relevant documents and 29 employee training records, and we interviewed 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.

Checklist 2. EOC Areas Reviewed, Findings, and Recommendations

NM	Areas Reviewed for General EOC	Findings	Recommendations
X	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure for the facility and the CBOCs.	Seven months of EOC Committee meeting minutes reviewed: • Minutes did not track corrective actions to closure.	**1.** We recommended that Environment of Care Committee meeting minutes track actions taken in response to identified deficiencies to closure.
	The facility conducted an infection prevention risk assessment.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
	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 procedure 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.		
X	The facility met general safety requirements.	• Although we conducted our site visit in January 2017, the CBOC fire extinguishers were marked as having been inspected on February 28, 2017. • Although the CBOC information technology network room contained logs to document access, there were no entries for the past year. CBOC employees told us that individuals had accessed the room during the timeframe for which there were no entries.	**2.** We recommended that facility managers ensure all fire extinguishers are inspected monthly and marked with the correct date and monitor compliance. **3.** We recommended that employees document when they access information technology network rooms by using the visitor logs and that facility managers monitor compliance.
	The facility met environmental cleanliness requirements.		

NM	Areas Reviewed for SPS	Findings	Recommendations
	The facility had a policy for cleaning, disinfecting, and sterilizing RME.		
	The facility's standard operating procedures for selected RME were current and consistent with the manufacturers' instructions for use.		
	The facility performed quality control testing on selected RME with the frequency required by local policy and took appropriate action on positive results.		
X	Selected SPS employees had evidence of the following for selected RME: • Training and competencies at orientation if employed less than or equal to 1 year • Competencies within the past 12 months or with the frequency required by local policy if employed more than 1 year	• Three of 10 applicable employees did not have documentation of competencies within the past 12 months for selected RME.	**4.** We recommended that Sterile Processing Service managers ensure Sterile Processing Service employees receive annual competencies for the types of reusable medical equipment they reprocess.
	The facility met infection prevention requirements in SPS areas.		
	Standard operating procedures for selected RME were located in the area where reprocessing occurred.		
	SPS employees checked eyewash stations in SPS areas weekly.		
	SPS employees had access to Safety Data Sheets in areas where they used hazardous chemicals.		
	Areas Reviewed for the Hemodialysis Unit		
	The facility had a policy or procedure for preventive maintenance of hemodialysis machines and performed maintenance at the frequency required by local policy.		

NM	Areas Reviewed for the Hemodialysis Unit (continued)	Findings	Recommendations
	Selected hemodialysis unit employees had evidence of bloodborne pathogens training within the past 12 months.		
	The facility met environmental safety requirements on the hemodialysis unit.		
X	The facility met infection prevention requirements on the hemodialysis unit.	• We observed employees handling patient equipment without wearing gloves	**5.** We recommended that hemodialysis unit employees wear gloves when handling patient equipment and that the hemodialysis unit manager monitors compliance.
	The facility met medication safety and security requirements on the hemodialysis unit.		
	The facility met privacy requirements on the hemodialysis unit.		

Medication Management: Anticoagulation Therapy

The purpose of this review was to determine whether facility clinicians appropriately managed and provided education to patients with new orders for anticoagulant medication.[c] During calendar year 2014, an estimated 445,000 veterans were on anticoagulant therapy. Anticoagulants (commonly called blood thinners) are a class of drugs that work to prevent the coagulation or clotting of blood. For this review, we evaluated warfarin (Coumadin®) and direct-acting oral anticoagulants. Clinicians use anticoagulants for both the treatment and prevention of cardiac disease, cerebrovascular accident (stroke), and thromboembolism[19] in both the inpatient and outpatient setting. Although these medications offer substantial benefits, their use or misuse carries a significant potential for patient harm. A dose less than the required amount for therapeutic effect can increase the risk of thromboembolic complications while a dose administered at levels greater than required for treatment can increase the risk of bleeding complications. The Joint Commission'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."

We reviewed relevant documents and the competency assessment records of 10 employees actively involved in the anticoagulant program, and we interviewed key employees. Additionally, we reviewed the EHRs of 27 randomly selected patients who were prescribed new anticoagulant medications from July 1, 2015 through June 30, 2016. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement.

Checklist 3. Medication Management: Anticoagulation Therapy Areas Reviewed, Findings, and Recommendations

NM	Areas Reviewed	Findings	Recommendations
	The facility had policies and processes for anticoagulation management that included required content.		
	The facility used algorithms, protocols or standardized care processes for the: • Initiation and maintenance of warfarin • Management of anticoagulants before, during, and after procedures • Use of weight-based, unfractionated heparin		

[19] Thromboembolism is the obstruction of a blood vessel by a blood clot that has become dislodged from another site in the circulation.

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility provided patients with a direct telephone number for anticoagulation-related calls during normal business hours and defined a process for patient anticoagulation-related calls outside normal business hours.		
	The facility designated a physician as the anticoagulation program champion.		
	The facility defined ways to minimize the risk of incorrect tablet strength dosing errors.		
	The facility routinely reviewed quality assurance data for the anticoagulation management program at the facility's required frequency at an appropriate committee.		
	For patients newly prescribed anticoagulant medications, clinicians provided inpatients with transition follow-up in accordance with local policy and all patients with education specific to the new anticoagulant.		
X	Clinicians obtained required laboratory tests: • Prior to initiating anticoagulant medications • During anticoagulation treatment at the frequency required by local policy	• In two of nine EHRs, clinicians did not obtain all required laboratory tests prior to initiating warfarin treatment.	**6.** We recommended that facility managers ensure clinicians consistently obtain all required laboratory tests prior to initiating warfarin treatment.
	When laboratory values did not meet selected criteria, clinicians documented a justification/rationale for prescribing the anticoagulant.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	The facility required competency assessments for employees actively involved in the anticoagulant program, and clinical managers completed competency assessments that included required content at the frequency required by local policy.	• For 6 of 10 employees actively involved in the anticoagulant program, there was no documentation that competency assessments included drug to drug interactions associated with anticoagulation therapy. • For 6 of 10 employees actively involved in the anticoagulant program, there was no documentation that competency assessments were conducted annually as required by facility policy.	**7.** We recommended that for employees actively involved in the anticoagulant program, clinical managers include in the competency assessments drug to drug interactions associated with anticoagulation therapy and that facility managers monitor compliance. **8.** We recommended that for employees actively involved in the anticoagulant program, clinical managers complete competency assessments annually and that facility managers monitor compliance.

Coordination of Care: Inter-Facility Transfers

The purpose of this review was to evaluate selected aspects of the facility's patient transfer process, specifically transfers out of the facility.[d] Inter-facility transfers are frequently necessary to provide patients with access to specific providers or services. The movement of an acutely ill person from one institution to another exposes the patient to risks, while in some cases, failing to transfer a patient may be equally risky. VHA has the responsibility to ensure that transfers into and out of its medical facilities are carried out appropriately, under circumstances that provide maximum safety for patients, and comply with applicable standards.

We reviewed relevant documents and interviewed key employees. Additionally, we reviewed the EHRs of 48 randomly selected patients who were transferred acutely out of facility inpatient beds or the Emergency Department/urgent care center to another VHA facility or non-VA facility from July 1, 2015 through June 30, 2016. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement.

Checklist 4. Coordination of Care: Inter-Facility Transfers Areas Reviewed, Findings, and Recommendations

NM	Areas Reviewed	Findings	Recommendations
	The facility had a policy that addressed patient transfers and included required content.		
X	The facility collected and reported data about transfers out of the facility.	• There was no evidence the facility collected and reported data about transfers out of the facility.	**9.** We recommended that the facility collect and report data on patient transfers out of the facility and that facility managers monitor compliance.
X	Transferring clinicians completed VA Form 10-2649A and/or transfer/progress notes prior to or within a few hours after the transfer that included the following elements: • Date of transfer • Documentation of patient or surrogate informed consent • Medical and/or behavioral stability • Identification of transferring and receiving provider or designee • Details of the reason for transfer or proposed level of care needed	• Clinician transfer documentation did not include: o Documentation of patient or surrogate informed consent in 17 of the 48 EHRs (35 percent) o Documentation of medical and behavioral stability in 10 of the 48 EHRs (21percent)	**10.** We recommended that for patients transferred out of the facility, clinicians consistently include documentation of patient or surrogate informed consent and of medical and behavioral stability in transfer documentation and that facility managers monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
	When staff/attending physicians did not write transfer notes, acceptable designees: • Obtained and documented staff/attending physician approval • Obtained staff/attending physician countersignature on the transfer note		
	When the facility transferred patients out, sending nurses documented transfer assessments/notes.		
	In emergent transfers, providers documented: • Patient stability for transfer • Provision of all medical care within the facility capacity		
	Communication with the accepting facility or documentation sent included: • Available history • Observations, signs, symptoms, and preliminary diagnoses • Results of diagnostic studies and tests		

Diagnostic Care: Point-of-Care Testing

The purpose of this review was to evaluate the facility's glucometer POCT program compliance with applicable laboratory regulatory standards and quality testing practices as required by VHA, the College of American Pathologists, and The Joint Commission.[e] The majority of laboratory testing is performed in the main laboratory. However, with newer technologies, testing has emerged from the laboratory to the patient's bedside, the patient's home, and other non-laboratory sites. This is called POCT (also known as ancillary or waived testing) and can include tests for blood glucose, fecal occult blood, hemoglobin, and pro-thrombin time.

All laboratory testing performed in VHA facilities must adhere to quality testing practices. These practices include annual competency assessment and quality control testing. Failure to implement and comply with regulatory standards and quality testing practices can jeopardize patient safety and place VHA facilities at risk. Erroneous results can lead to inaccurate diagnoses, inappropriate medical treatment, and poor patient outcomes.[20]

We reviewed relevant documents, the EHRs of 50 randomly selected inpatients and outpatients who underwent POCT for blood glucose from July 1, 2015 through June 30, 2016, and the annual competency assessments of 35 clinicians who performed the glucose testing. Additionally, we interviewed key employees and conducted onsite glucometer inspections of the community living center, a specialty clinic, the hemodialysis unit, the medical intensive care unit, and the Emergency Department to assess compliance with manufacturers' maintenance and solution/reagent storage requirements. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement.

Checklist 5. Diagnostic Care: POCT Areas Reviewed, Findings, and Recommendations

NM	Areas Reviewed	Findings	Recommendations
	The facility had a policy delineating requirements for the POCT program and required oversight by the Chief of Pathology and Laboratory Medicine Service.		
	The facility had a designated POCT/Ancillary Testing Coordinator.		
	The Chief of Pathology and Laboratory Medicine Service approved all tests performed outside the main laboratory.		

[20] The Joint Commission. *Comprehensive Accreditation Manual for Laboratories and Point-of-Care Testing*. Update 2. September 2010.

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility had a process to ensure employee competency for POCT with glucometers and evaluated competencies at least annually.		
	The facility required documentation of POCT results in the EHR.		
	A regulatory agency accredited the facility's POCT program.		
	Clinicians documented test results in the EHR.		
X	Clinicians initiated appropriate clinical action and follow-up for test results.	• In 6 of the 50 EHRs (12 percent), clinicians did not document all the actions required by the facility in response to test results.	**11.** We recommended that clinicians take and document all actions required by the facility in response to test results and that clinical managers monitor compliance.
	The facility had POCT procedure manuals readily available to employees.		
	Quality control testing solutions/reagents and glucose test strips were current (not expired).		
	The facility managed and performed quality control in accordance with its policy/standard operating procedure and manufacturer's recommendations.		
	Glucometers were clean.		

Moderate Sedation

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.[f] During calendar year 2016, VHA clinicians performed more than 600,000 moderate sedation procedures of which more than half were gastroenterology-related endoscopies.[21] Moderate sedation is a drug-induced depression of consciousness during which patients are able to respond to verbal commands. 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 patent airway, spontaneous ventilations, or cardiovascular function.[22] However, serious adverse events can occur, including cardiac and respiratory depression, brain damage due to low oxygen levels, cardiac arrest, or death. To minimize risks, VHA and The Joint Commission have issued requirements and standards for moderate sedation care.

We reviewed relevant documents, interviewed key employees, and inspected the gastroenterology, pulmonology, intensive care unit, and Emergency Department procedure rooms/areas to assess whether required equipment and sedation medications were available. Additionally, we reviewed the EHRs of 28 randomly selected patients who underwent an invasive procedure involving moderate sedation from July 1, 2015 through June 30, 2016, and the training records of 17 clinical employees who performed or assisted during these procedures. The table below shows the areas reviewed for this topic. The facility generally met requirements. We made no recommendations.

Checklist 6. Moderate Sedation Areas Reviewed, Findings, and Recommendations

NM	Areas Reviewed	Findings	Recommendations
	The facility reported and trended the use of reversal agents in moderate sedation cases, processed adverse events/complications in a similar manner as operating room anesthesia adverse events, and noted the absence of adverse events in Moderate Sedation Committee reports.		

[21] Per VA Corporate Data Warehouse data pull on February 22, 2017.
[22] American Society of Anesthesiologists. Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists. *Anesthesiology*. 2002; 96:1004.

NM	Areas Reviewed (continued)	Findings	Recommendations
	Providers performed history and physical examinations within 30 calendar days prior to the moderate sedation procedure, and the history and physical and the pre-sedation assessment in combination included required elements.		
	Providers re-evaluated patients immediately before moderate sedation for changes since the prior assessment.		
	Providers documented informed consent prior to moderate sedation procedures, and the name of provider listed on the consent was the same as the provider who performed the procedure, or the patient was notified of the change.		
	The clinical team, including the provider performing the procedure, conducted and documented a timeout prior to the moderate sedation procedure.		
	Post-procedure documentation included assessments of patient mental status and pain level.		
	Clinical employees discharged outpatients from the recovery area with orders from the provider who performed the procedure or according to criteria approved by moderate sedation clinical leaders.		
	Clinical employees discharged moderate sedation outpatients in the company of a responsible adult.		
	Selected clinical employees had current training for moderate sedation.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The clinical team kept monitoring and resuscitation equipment and reversal agents in the general areas where moderate sedation was administered.		
	To minimize risk, clinical employees did not store anesthetic agents in procedure rooms/areas where only moderate sedation procedures were performed by licensed independent practitioners who do not have the training and ability to rescue a patient from general anesthesia.		

Community Nursing Home Oversight

The purpose of this review was to assess whether the facility complied with applicable requirements regarding the monitoring of veterans in contracted CNHs.[g] 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, Associate Director for Patient Care Services, 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.[23] Local oversight of CNHs is achieved through annual reviews and monthly visits.

We reviewed relevant documents, the EHRs of eight patients who received CNH care for more than 3 months during the timeframe July 1, 2015 through June 30, 2016, and the results from CNH annual reviews completed from July 5, 2015 through June 30, 2016. Additionally, we interviewed key employees. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. The items that did not apply to this facility are marked NA.

Checklist 7. CNH Oversight Areas Reviewed, Findings, and Recommendation

NM	Areas Reviewed	Findings	Recommendations
X	The facility had a CNH Oversight Committee that met at least quarterly and included representation by the required disciplines.	• The facility's CNH Oversight Committee did not include a representative from quality management or acquisition.	**12.** We recommended that facility managers ensure the Community Nursing Home Oversight Committee includes representation by all required clinical disciplines.
X	The facility integrated the CNH program into its quality improvement program.	• The minutes of the executive-level committee that evaluates quality improvement data did not contain evidence of CNH program integration.	**13.** We recommended that the facility ensure integration of the community nursing home program into its quality improvement program.
NA	The facility documented a hand-off for patients placed in CNHs outside of its catchment area.		
	The CNH Review Team completed CNH annual reviews.		

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

NM	Areas Reviewed (continued)	Findings	Recommendations
NA	When CNH annual reviews noted four or more exclusionary criteria, facility managers completed exclusion review documentation.		
X	Social workers and registered nurses documented clinical visits that alternated on a cyclical basis.	• None of the eight EHRs contained documentation of social worker and/or registered nurse cyclical clinical visits with the frequency required by VHA policy. Four of the patients resided in Regal Heights, three resided in Harbor Healthcare, and one resided in Cadia Rehabilitation Broadmeadow.	**14.** We recommended that facility managers ensure social workers and registered nurses conduct and document cyclical clinical visits with the frequency required by Veterans Health Administration policy for community nursing home oversight and monitor compliance.
X	Local policy met the requirements of VHA policy.	• Local policy MCM 460-118.20, *CNH Program*, did not include the following elements required by VHA Handbook 1143.2. o Requirements for requesting an exception when the CNH fails the exclusionary criteria and requirements for requesting an exception o Guidelines for frequency and types of visits and the need for cyclical visits to alternate between registered nurses and social workers. o Membership and responsibilities of the committee tasked with CNH oversight o Monthly CNH visit guidelines regarding the type of information required to be gathered during the visit	**15.** We recommended that the facility update its policy on the community nursing home program to include all elements required by Veterans Health Administration policy.

NM	Areas Reviewed (continued)	Findings	Recommendations
X	The facility complied with VHA policy, which requires that for patients receiving rehabilitation therapies at VA expense, a VA physician must order the therapy(ies) or approve the nursing home's plan for therapy for a specific period of time.	• Three of the eight EHRs had therapies at VA expense authorized by the Associate Clinical Nurse Supervisor.	**16.** We recommended that a VA physician order or approve all therapies that are at VA expense.
X	The facility complied with VHA and local policy requirements for scanning paper health records.	• The CNH program office keeps paper health records rather than scanning them into the EHR as required by VHA Handbook 1907.01 and local policy MCM 460-136.53, *Health Information Management Documentation and Procedures*.	**17.** We recommended that facility managers ensure the community nursing home program office scans existing paper health records into electronic health records and develops a process to scan new records as they are received.

Management of Disruptive/Violent Behavior

The purpose of this review was to determine the extent to which the facility complied with selected requirements in the management of disruptive and violent behavior.[h] VHA policy states a commitment to reducing and preventing disruptive behaviors and other defined acts that threaten public safety through the development of policy, programs, and initiatives aimed at patient, visitor, and employee safety. In addition, Public Law 112-154, section 106 directed VA to develop and implement a comprehensive policy on the reporting and tracking of public safety incidents that occur at each medical facility.

We reviewed relevant documents, the EHRs of 19 patients who exhibited disruptive or violent behavior, 3 Reports of Contact from violent/disruptive patient/employee/other (visitor) incidents that occurred during the 12-month period from July 1, 2015 through June 30, 2016, and the training records of 20 recently hired employees who worked in areas at low, moderate, or high risk for violence. Additionally, we interviewed key employees. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement.

Checklist 8. Management of Disruptive/Violent Behavior Areas Reviewed, Findings, and Recommendations

NM	Areas Reviewed	Findings	Recommendations
X	The facility had a policy, procedure, or guideline on preventing and managing disruptive or violent behavior.	• Facility policy was not consistent with the current practice of calling for assistance with disruptive or violent behavior incidents.	**18.** We recommended that the facility update its policy on preventing and managing disruptive and violent behavior.
	The facility conducted an annual Workplace Behavioral Risk Assessment.		
X	The facility had implemented: • An Employee Threat Assessment Team or acceptable alternate group • A Disruptive Behavior Committee/Board with appropriate membership • A disruptive behavior reporting and tracking system	• The VA Police Officer and Patient Advocate did not consistently attend Disruptive Behavior Committee meetings.	**19.** We recommended that the VA Police Officer and the Patient Advocate consistently attend Disruptive Behavior Committee meetings.
	The facility collected and analyzed disruptive or violent behavior incidents data.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility assessed physical security and included and tested equipment in accordance with the local physical security assessment.		
	Clinical managers reviewed patients' disruptive or violent behavior and took appropriate actions, including: • Ensuring discussion by the Disruptive Behavior Committee/Board and entry of a progress note by a clinician committee/board member • Informing patients about Patient Record Flag placement and the right to request to amend/appeal the flag placement • Ensuring Chief of Staff or designee approval of an Order of Behavioral Restriction		
	When a Patient Record Flag was placed for an incident of disruptive behavior in the past, a clinician reviewed the continuing need for the flag within the past 2 years.		
	The facility managed selected non-patient related disruptive or violent incidents appropriately according to VHA and local policy.		
X	The facility had a security training plan for employees at all risk levels. • All employees received Level 1 training within 90 days of hire. • All employees received additional training as required for the assigned risk area within 90 days of hire.	• Three employee training records did not contain documentation of Level 1 training within 90 days of hire. • Ten employee training records did not contain documentation of the training required for their assigned risk area within 90 days of hire.	**20.** We recommended that facility managers ensure all employees receive Level 1 Prevention and Management of Disruptive Behavior training and additional training as required for their assigned risk area within 90 days of hire and that training is documented in employee training records.

Facility Profile

Table 1 below provides general background information for this facility.

Table 1. Facility Profile for Wilmington (460) for FY 2016

Profile Element	Facility Data
VISN Number	4
Complexity Level	2-Medium complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$214.4
Number of:	
• **Unique Patients**	29,917
• **Outpatient Visits**	297,750
• **Unique Employees**[24]	794
Type and Number of Operating Beds:	
• **Acute**	60
• **MH**	NA
• **Community Living Center**	60
• **Domiciliary**	NA
Average Daily Census:	
• **Acute**	15
• **MH**	NA
• **Community Living Center**	41
• **Domiciliary**	NA

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

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

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

VA Outpatient Clinic Profiles[25]

The VA outpatient clinics in the 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 2 below provides information relative to each of the clinics.

Table 2. VA Outpatient Clinic Workload/Encounters[26] and Specialty Care, Diagnostic, and Ancillary Services Provided for FY 2016

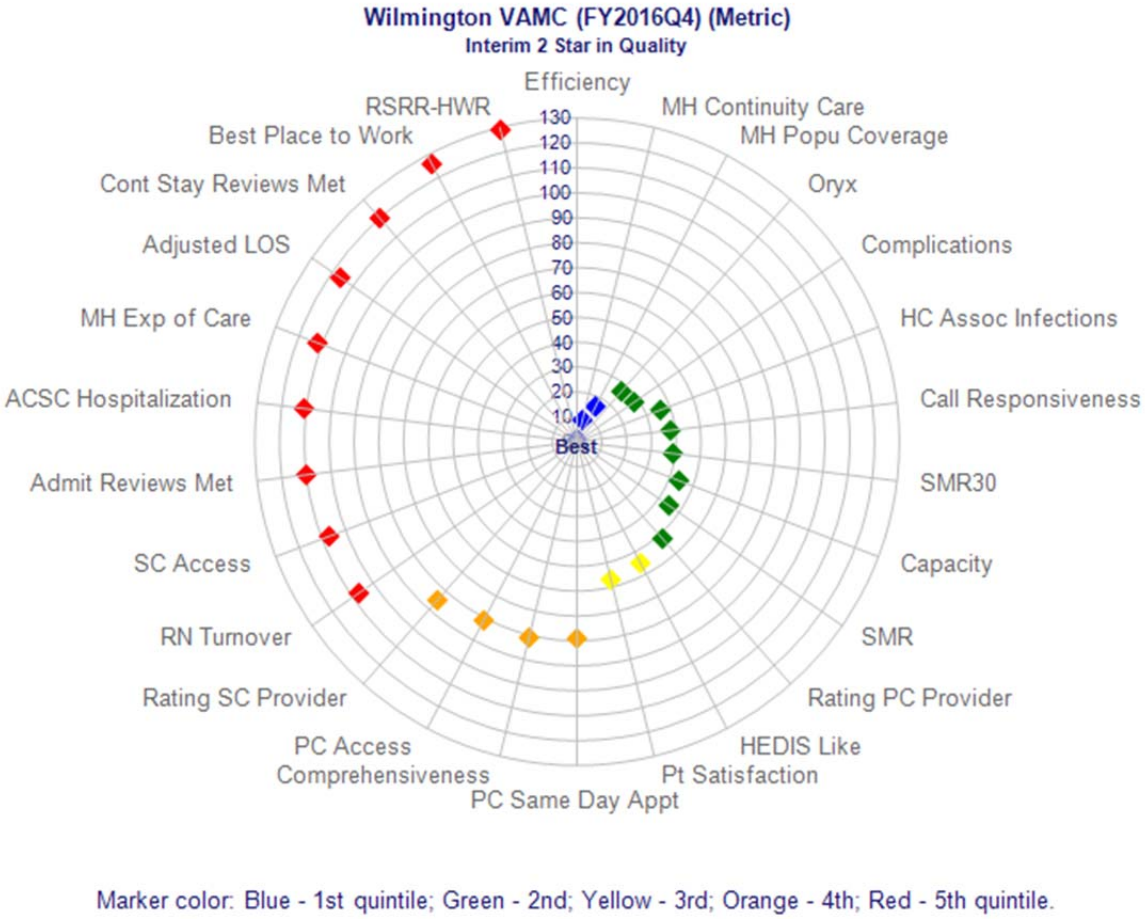
Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services[27] Provided	Diagnostic Services[28] Provided	Ancillary Services[29] Provided
Georgetown, DE	460GA	8,280	2,611	Dermatology Endocrinology Eye General Surgery Podiatry	NA	Nutrition Pharmacy Social Work
Dover, DE	460GC	10,161	6,559	Dermatology Endocrinology Eye General Surgery Rheumatology Podiatry	NA	Nutrition Pharmacy Social Work Weight Management
Cape May, NJ	460GD	2,564	1,156	Blind Rehab Dermatology Endocrinology Eye Neurology Podiatry	NA	Social Work
Northfield, NJ	460HE	5,673	3,935	Dermatology Endocrinology Eye General Surgery Podiatry	NA	Nutrition Social Work
Vineland, NJ	460HG	7,028	2,772	Dermatology Endocrinology Eye General Surgery Podiatry	NA	Nutrition Pharmacy Social Work Weight Management

Source: VHA Support Service Center and VA Corporate Data Warehouse

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

[25] Includes all outpatient clinics in the community that were in operation before February 15, 2016.
[26] An encounter is a professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition.
[27] Specialty care services refer to non-PC and non-MH services provided by a physician.
[28] Diagnostic services include EKG, EMG, laboratory, nuclear medicine, radiology, and vascular lab services.
[29] Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

Strategic Analytics for Improvement and Learning (SAIL)[30]

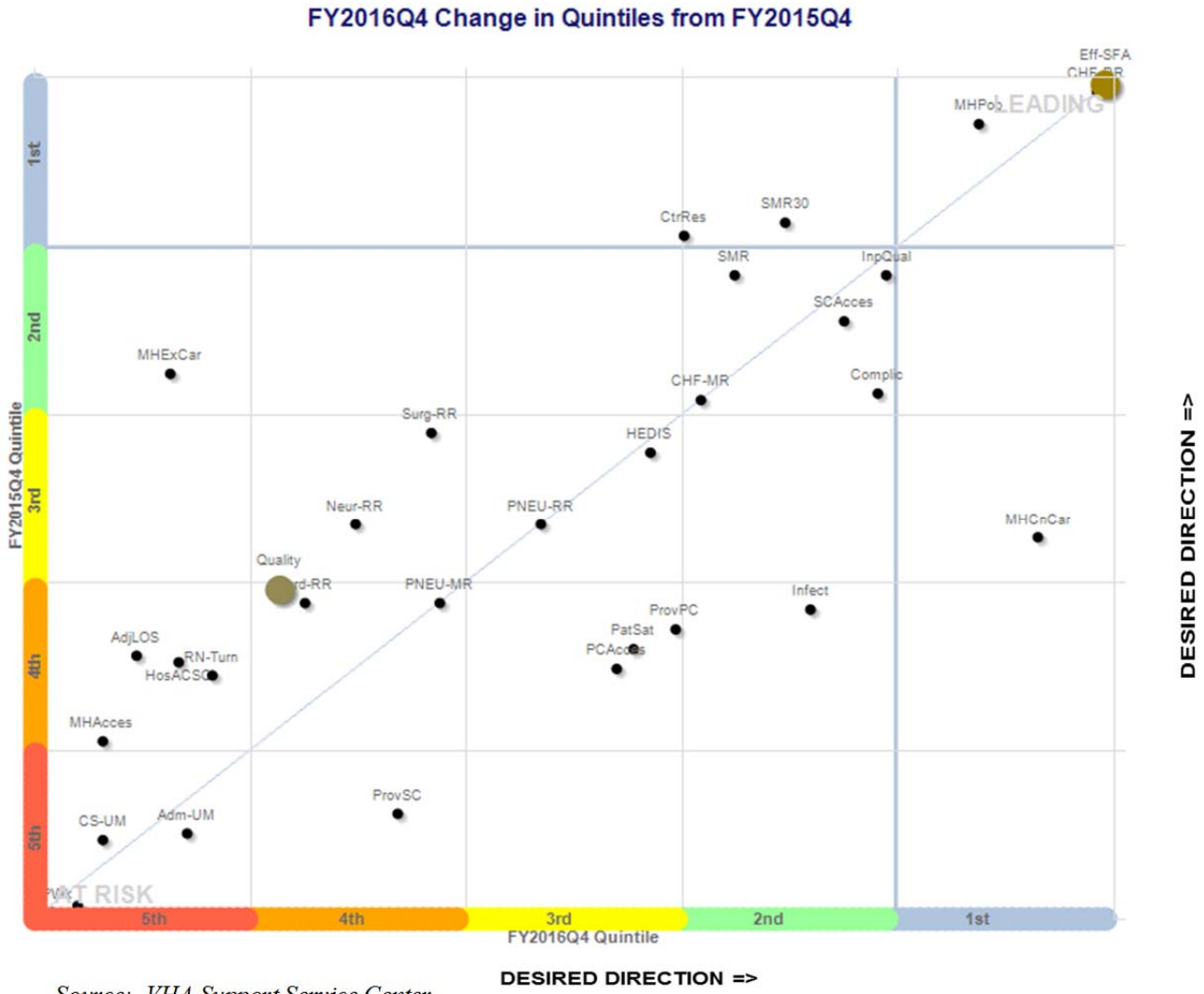


Source: VHA Support Service Center

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

[30] 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.

Source: VHA Support Service Center

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

Metric Definitions[i]

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

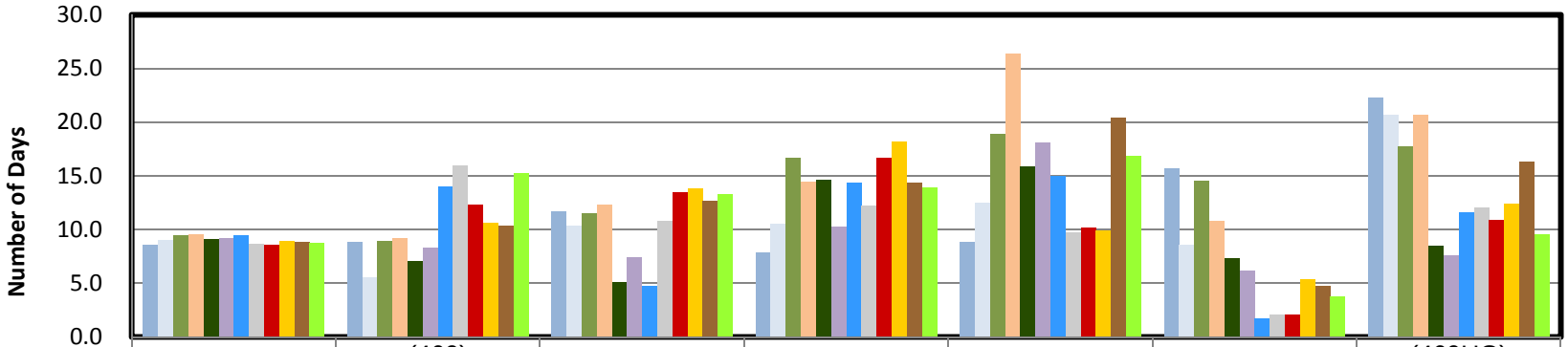
Measure	Definition	Desired Direction
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized 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

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

Patient Aligned Care Team Compass Metrics

FY 2016 New PC Patient Average Wait Time in Days

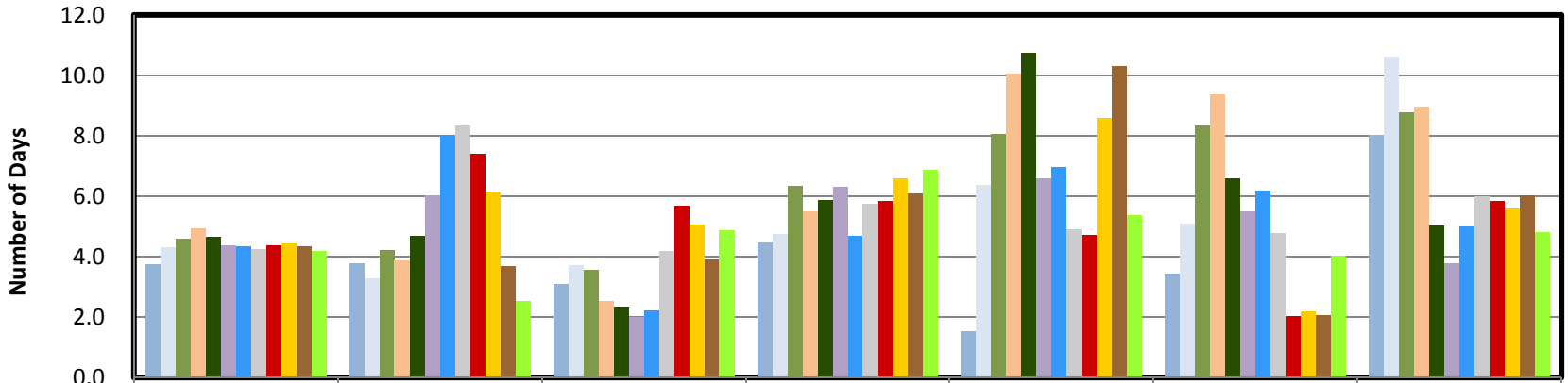


	VHA Total	(460) Wilmington VAMC	(460GA) Sussex County	(460GC) Kent County	(460GD) Cape May USCG	(460HE) Atlantic County	(460HG) Cumberland County
OCT-FY16	8.6	8.8	11.7	7.9	8.9	15.7	22.3
NOV-FY16	9.1	5.6	10.4	10.5	12.5	8.6	20.7
DEC-FY16	9.5	9.0	11.5	16.7	18.9	14.5	17.8
JAN-FY16	9.6	9.2	12.3	14.4	26.4	10.8	20.7
FEB-FY16	9.1	7.1	5.1	14.7	15.9	7.4	8.5
MAR-FY16	9.2	8.3	7.4	10.3	18.1	6.2	7.6
APR-FY16	9.5	14.0	4.8	14.4	15.0	1.7	11.6
MAY-FY16	8.7	16.0	10.8	12.3	9.7	2.1	12.1
JUN-FY16	8.6	12.4	13.4	16.7	10.2	2.1	10.9
JUL-FY16	8.9	10.6	13.8	18.2	9.9	5.4	12.4
AUG-FY16	8.9	10.4	12.7	14.4	20.5	4.7	16.4
SEP-FY16	8.8	15.3	13.3	13.9	16.8	3.8	9.6

Source: VHA Support Service Center

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

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

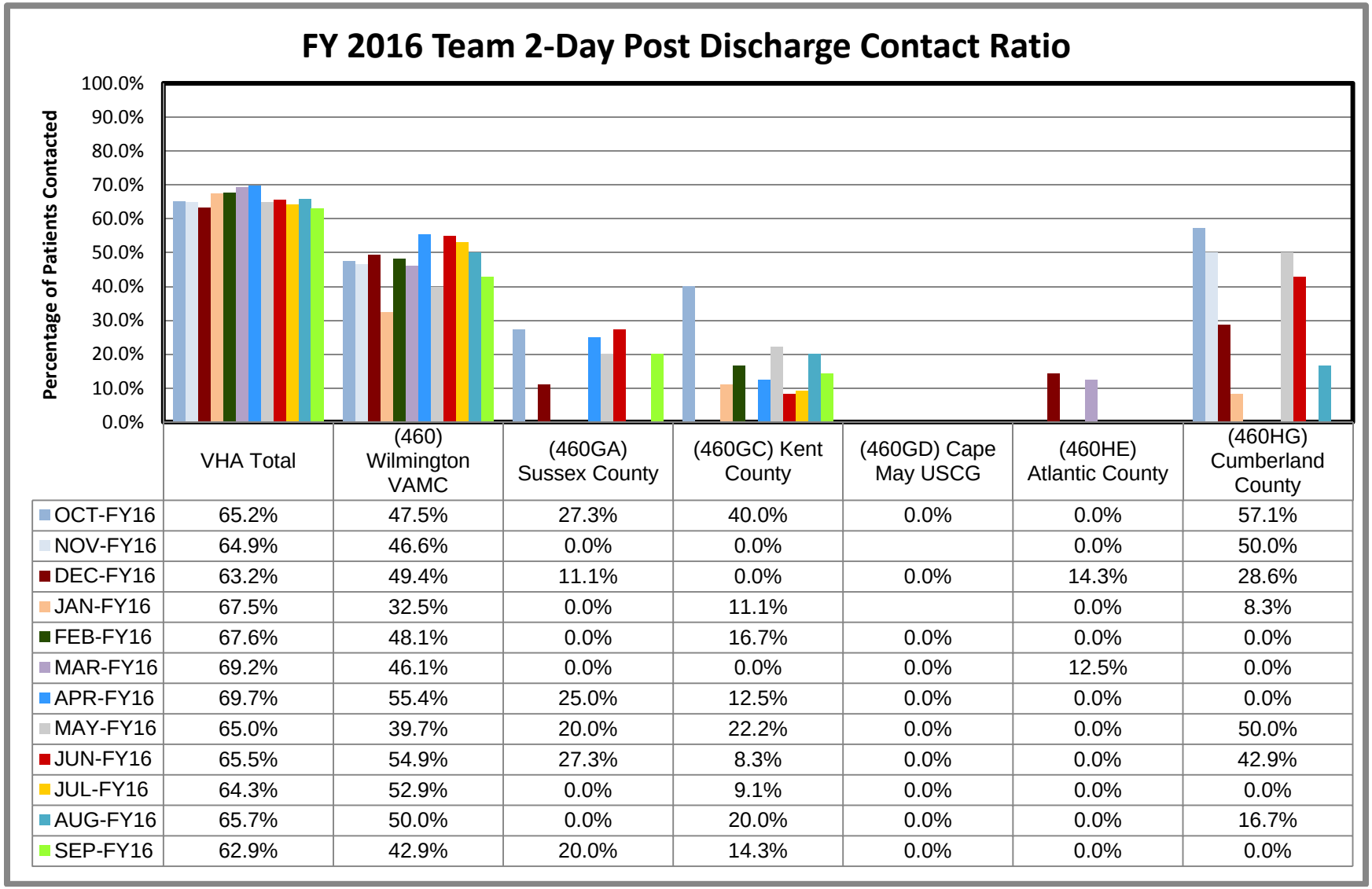


	VHA Total	(460) Wilmington VAMC	(460GA) Sussex County	(460GC) Kent County	(460GD) Cape May USCG	(460HE) Atlantic County	(460HG) Cumberland County
OCT-FY16	3.8	3.8	3.1	4.5	1.5	3.4	8.0
NOV-FY16	4.3	3.3	3.7	4.8	6.4	5.1	10.6
DEC-FY16	4.6	4.2	3.6	6.3	8.1	8.4	8.8
JAN-FY16	4.9	3.9	2.5	5.5	10.1	9.4	9.0
FEB-FY16	4.7	4.7	2.3	5.9	10.7	6.6	5.0
MAR-FY16	4.4	6.0	2.0	6.3	6.6	5.5	3.8
APR-FY16	4.3	8.0	2.2	4.7	7.0	6.2	5.0
MAY-FY16	4.3	8.3	4.2	5.8	4.9	4.8	6.0
JUN-FY16	4.4	7.4	5.7	5.8	4.7	2.0	5.8
JUL-FY16	4.4	6.1	5.1	6.6	8.6	2.2	5.6
AUG-FY16	4.3	3.7	3.9	6.1	10.3	2.1	6.0
SEP-FY16	4.2	2.5	4.9	6.9	5.4	4.0	4.8

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.

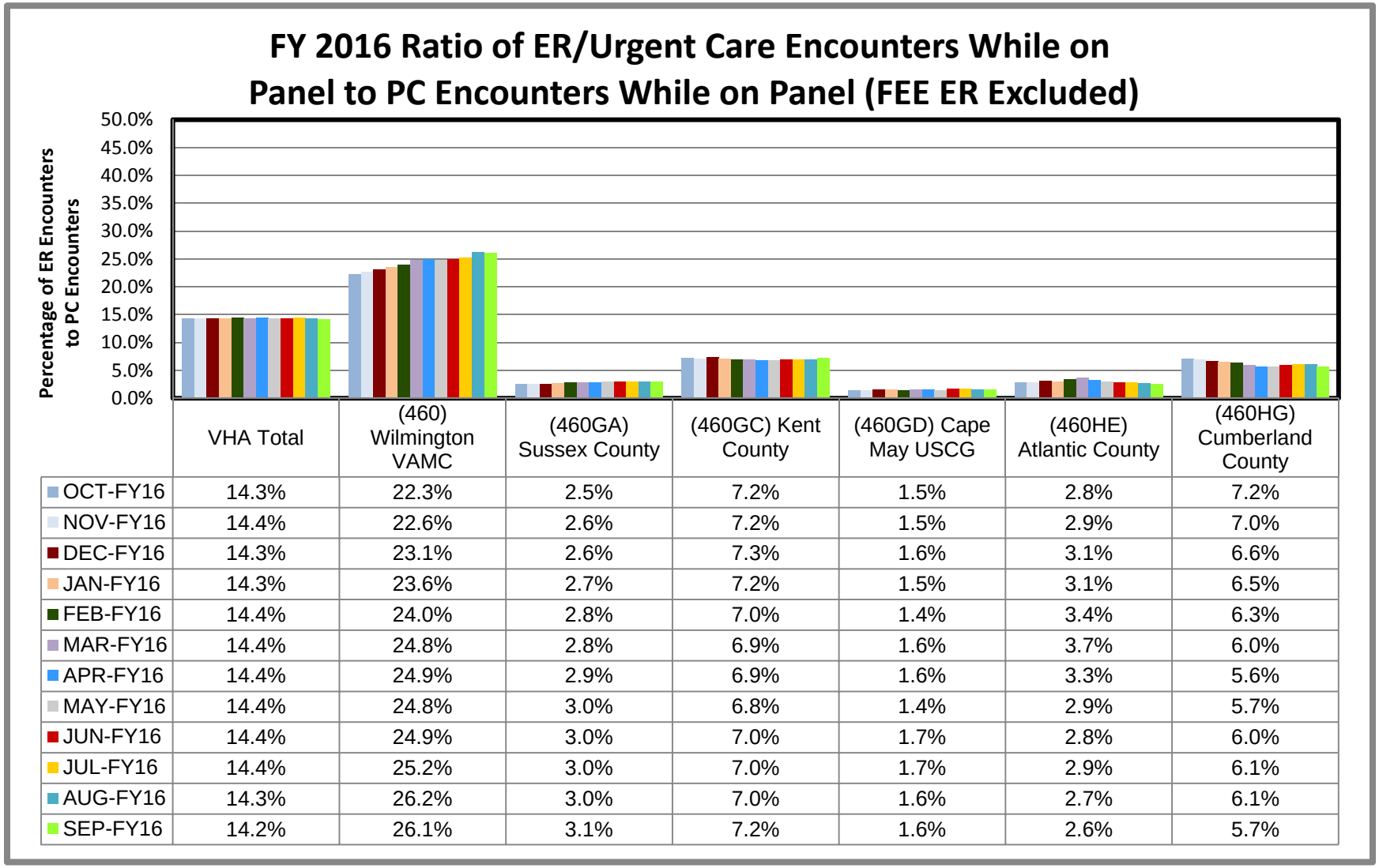


	VHA Total	(460) Wilmington VAMC	(460GA) Sussex County	(460GC) Kent County	(460GD) Cape May USCG	(460HE) Atlantic County	(460HG) Cumberland County
OCT-FY16	65.2%	47.5%	27.3%	40.0%	0.0%	0.0%	57.1%
NOV-FY16	64.9%	46.6%	0.0%	0.0%		0.0%	50.0%
DEC-FY16	63.2%	49.4%	11.1%	0.0%	0.0%	14.3%	28.6%
JAN-FY16	67.5%	32.5%	0.0%	11.1%		0.0%	8.3%
FEB-FY16	67.6%	48.1%	0.0%	16.7%	0.0%	0.0%	0.0%
MAR-FY16	69.2%	46.1%	0.0%	0.0%	0.0%	12.5%	0.0%
APR-FY16	69.7%	55.4%	25.0%	12.5%	0.0%	0.0%	0.0%
MAY-FY16	65.0%	39.7%	20.0%	22.2%	0.0%	0.0%	50.0%
JUN-FY16	65.5%	54.9%	27.3%	8.3%	0.0%	0.0%	42.9%
JUL-FY16	64.3%	52.9%	0.0%	9.1%	0.0%	0.0%	0.0%
AUG-FY16	65.7%	50.0%	0.0%	20.0%	0.0%	0.0%	16.7%
SEP-FY16	62.9%	42.9%	20.0%	14.3%	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. Blank cells indicate the absence of reported data.



	VHA Total	(460) Wilmington VAMC	(460GA) Sussex County	(460GC) Kent County	(460GD) Cape May USCG	(460HE) Atlantic County	(460HG) Cumberland County
OCT-FY16	14.3%	22.3%	2.5%	7.2%	1.5%	2.8%	7.2%
NOV-FY16	14.4%	22.6%	2.6%	7.2%	1.5%	2.9%	7.0%
DEC-FY16	14.3%	23.1%	2.6%	7.3%	1.6%	3.1%	6.6%
JAN-FY16	14.3%	23.6%	2.7%	7.2%	1.5%	3.1%	6.5%
FEB-FY16	14.4%	24.0%	2.8%	7.0%	1.4%	3.4%	6.3%
MAR-FY16	14.4%	24.8%	2.8%	6.9%	1.6%	3.7%	6.0%
APR-FY16	14.4%	24.9%	2.9%	6.9%	1.6%	3.3%	5.6%
MAY-FY16	14.4%	24.8%	3.0%	6.8%	1.4%	2.9%	5.7%
JUN-FY16	14.4%	24.9%	3.0%	7.0%	1.7%	2.8%	6.0%
JUL-FY16	14.4%	25.2%	3.0%	7.0%	1.7%	2.9%	6.1%
AUG-FY16	14.3%	26.2%	3.0%	7.0%	1.6%	2.7%	6.1%
SEP-FY16	14.2%	26.1%	3.1%	7.2%	1.6%	2.6%	5.7%

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.

Prior OIG Reports
March 1, 2014 through March 1, 2017

Facility Reports

Community Based Outpatient Clinics Summary Report – Evaluation of Medication Oversight and Education at Community Based Outpatient Clinics and Other Outpatient Clinics
6/18/2015 | 15-01297-368 | Summary | Report

Healthcare Inspection – Review of Solo Physicians' Professional Practice Evaluations in Veterans Health Administration Facilities
6/3/2015 | 15-00911-362 | Summary | Report

Audit of VHA's Mobile Medical Units
5/14/2014 | 13-03213-152 | Summary | Report

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: July 12, 2017

From: Director, VA Healthcare – VISN 4 (10N4)

Subject: **CAP Review of the Wilmington VA Medical Center, Wilmington, DE**

To: Acting Director, Washington, DC, Office of Healthcare Inspections (54DC)

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

I have reviewed the responses provided by the Wilmington VAMC, Wilmington, DE, and I am submitting to your office as requested. I concur with their responses.

(*original signed by*:)
MICHAEL D. ADELMAN, M.D.

Interim Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: July 12, 2017

From: Interim Director, Wilmington VA Medical Center (460/00)

Subject: **CAP Review of the Wilmington VA Medical Center, Wilmington, DE**

To: Director, VA Healthcare – VISN 4 (10N4)

1. I have reviewed and concur with 20 of 20 recommendations made during the Office of Inspector General's (OIG) Healthcare Inspections' Clinical Assessment Program (CAP) Review conducted January 30, 2017 through February 2, 2017. The medical center has been developing and updating action plans to improve upon processes in accordance with the recommendations.

2. I would like to thank the OIG Survey team for providing a thorough report and for the consultation they provided during the survey process. Your input greatly enhanced the medical center's ability to strengthen processes and further improve the care we provide to our Veterans.

(*original signed by:)*
Vincent Kane

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 Environment of Care Committee meeting minutes track actions taken in response to identified deficiencies to closure.

Concur

Target date for completion: July 31, 2017

Facility response: Identified issues/deficiencies are recorded and tracked through completion and monitored for compliance by the Environment of Care and Safety Council Score Card. The committee will track compliance until the facility achieves 90% compliance for 3 consecutive months. Compliance oversight will be reported to the Administrative Leadership Board. **Recommendation 2.** We recommended that facility managers ensure all fire extinguishers are inspected monthly and marked with the correct date and monitor compliance.

Concur

Target date for completion: August 31, 2017

Facility response: Staff responsible for inspecting fire extinguishers will be provided additional training to ensure appropriate procedures are followed. Facilities Management Service staff will inspect fire extinguishers monthly until 100% compliance is achieved and maintained for 3 consecutive months.

Recommendation 3. We recommended that employees document when they access information technology network rooms by using the visitor logs and that facility managers monitor compliance.

Concur

Target date for completion: September 30, 2017

Facility response: The Medical Center has a process to ensure tracking of entry to the network closets by employees (visitors) is documented. CBOCs will report room access to Facility Chief Information Officer for 90 days for 90% compliance for 3 consecutive months. Any non-compliance will be reported to the Associate Director for Operations. Environment of care rounds will continue to report any findings to EOC committee for corrective actions.

Recommendation 4. We recommended that Sterile Processing Service managers ensure Sterile Processing Service employees receive annual competencies for the types of reusable medical equipment they reprocess.

Concur

Target date for completion: November 30, 2017

Facility response: All SPS staff competencies will be posted to the SPS SharePoint for leadership review the first Wednesday of each month. Any competencies due within 30 days will be reviewed with and signed by the staff member; updated competencies will be reposted to the SPS SharePoint. The results of this monitor will be reported to the Reusable Medical Equipment/SPS Council monthly and tracked on the Council Score Card until 100% compliance is achieved and maintained for 3 consecutive months. Any deficiencies will be reported to the Executive Leadership Board (ELB).

Recommendation 5. We recommended that hemodialysis unit employees wear gloves when handling patient equipment and that the hemodialysis unit manager monitors compliance.

Concur

Target date for completion: November 30, 2017

Facility response: Hemodialysis nurse manager will provide education for all hemodialysis staff on proper use of gloves when handling patient equipment. 30 observations will be completed each month to evaluate effectiveness of training until 90% compliance is met for 3 consecutive months. This information will be added to the Dialysis Committee score card for compliance monitoring. Identified issues and non-compliance will be reported to the Clinical Leadership Board (CLB)

Recommendation 6. We recommended that facility managers ensure clinicians consistently obtain all required laboratory tests prior to initiating warfarin treatment.

Concur

Target date for completion: November 30, 2017

Facility response: Anticoagulation Therapy Laboratory Testing/Monitoring Training will be provided to 100% of providers managing anticoagulation patients. This training will be monitored in TMS. Pharmacy will audit compliance with laboratory test ordering of 10% of anticoagulation patients until 90% compliance is met for 3 consecutive months. Results of monitoring and education requirements will be reported to Pharmacy and Therapeutics (P&T) Council. Identified issues and compliance will be reported to the Medical Executive Board (MEB).

Recommendation 7. We recommended that for employees actively involved in the anticoagulant program, clinical managers include in the competency assessments drug to drug interactions associated with anticoagulation therapy and that facility managers monitor compliance.

Concur

Target date for completion: November 30, 2017

Facility response: All employees actively involved in the anticoagulation program will complete training/education regarding anticoagulation therapy including drug to drug interactions annually tracked in TMS. Associate Chiefs of Staff and Facility Education will perform random monthly audits until 90% compliance is met and maintained for 3 consecutive months. Results of audits will be reported to P&T. Results of monitoring and education will be reported to Pharmacy and Therapeutics (P&T) Council. Identified issues and compliance will be reported to Medical Executive Board (MEB).

Recommendation 8. We recommended that for employees actively involved in the anticoagulant program, clinical managers complete competency assessments annually and that facility managers monitor compliance.

Concur

Target date for completion: November 30, 2017

Facility response: All employees actively involved in the anticoagulation program will complete annual training/education regarding anticoagulation therapy. Associate Chiefs of Staff and Facility Education will perform random monthly audits until 90% compliance is met and maintained for 3 consecutive months. Results of monitoring and education requirements will be reported to Pharmacy and Therapeutics (P&T) Council. Identified issues and compliance will be reported to Medical Executive Board (MEB).

Recommendation 9. We recommended that the facility collect and report data on patient transfers out of the facility and that facility managers monitor compliance.

Concur

Target date for completion: December 10, 2017

Facility response: Patient transfer and consent data will be collected through medical record audits. Results will be reported to the Medical Executive Board (MEB) through the Medical Records Committee. Compliance will be monitored for 90 days until 90% compliance is achieved for 3 consecutive months.

Recommendation 10. We recommended that for patients transferred out of the facility, clinicians consistently include documentation of patient or surrogate informed consent and of medical and behavioral stability in transfer documentation and that facility managers monitor compliance.

Concur

Target date for completion: August 10, 2017

Facility response: The medical center inter-facility transfer note will be updated to reflect the requirements of VA Form 10-2649A 'Inter-Facility Transfer Form'. 100% clinicians with privileges/scopes of practice to transfer and/or accept transfers will receive education on correct documentation of patient transfers. 90% of transfers reviewed will have evidence of complete documentation. Results of monitoring and education will be reported to the Medical Records Committee. Identified issues will be reported to the Medical Executive Board (MEB).

Recommendation 11. We recommended that clinicians take and document all actions required by the facility in response to test results and that clinical managers monitor compliance.

Concur

Target date for completion: November 30, 2017

Facility response: Facility Education will provide education on the procedures and required documentation of POC blood glucose testing to 100% of staff performing POC blood glucose testing. The Laboratory POC testing coordinator will provide monthly reports to the Associate Chief Nurses for all critical POC glucose critical results that do not have complete documentation. Results of the monitoring will be reported to the Clinical Leadership Board (CLB) and will continue until 90% compliance is met and maintained for 3 consecutive months.

Recommendation 12. We recommended that facility managers ensure the Community Nursing Home Oversight Committee includes representation by all required clinical disciplines.

Concur

Target date for completion: November 30, 2017

Facility response: The Community Nursing Home Oversight Committee will be incorporated with the Extended Care Council. Membership was expanded to meet VHA Handbook 1143.2 Community Nursing Home Oversight. Membership attendance will be monitored monthly by the ECC [Extended Care Council] chair and reported to Clinical Leadership Board (CLB) until 90% reached by member/designee.

Recommendation 13. We recommended that the facility ensure integration of the community nursing home program into its quality improvement program.

Concur

Target date for completion: November 30, 2017

Facility response: A monthly summary report of the CNH program (to include: nursing home reviews, financial availability, evaluation and monitoring of the care quality) will be presented monthly at ECC. The ACNS [Associate Clinical Nurse Supervisor] will monitor compliance of the CNH report submission to Clinical Leadership Board for 3 consecutive months.

Recommendation 14. We recommended that facility managers ensure social workers and registered nurses conduct and document cyclical clinical visits with the frequency required by Veterans Health Administration policy for community nursing home oversight and monitor compliance.

Concur

Target date for completion: November 30, 2017

Facility response: The Community Nursing Home Coordinator, in collaboration with Social Work will establish a cyclical, rotating clinical visit schedule in accordance with VHA Handbook 1143.2 Community Nursing Home Oversight Procedures and document the visits in CPRS [Computerized Patient Record System]. An audit of 10% of the monthly clinical visits will be conducted to evaluate appropriate visitation and completion of required documentation each month until 90% compliance is met and maintained for 3 consecutive months. These audits will be tracked in the Extended Care Council monthly, identified issues and compliance will be reported to Clinical Leadership Board (CLB)

Recommendation 15. We recommended that the facility updates its policy on the community nursing home program to include all elements required by Veterans Health Administration policy.

Concur

Target date for completion: August 30, 2017

Facility response: The Community Nursing Home Program Center Memorandum 460-118.20 was revised and is under review for approval.

Recommendation 16. We recommended that a VA physician order or approve all therapies that are at VA expense.

Concur

Target date for completion: November 30, 2017

Facility response: The medical center will designate a physician to approve all rehabilitation therapies for Veterans residing at Contract Nursing Homes. Record audits of 100% Veterans at Contract Nursing Homes at VA expense requiring rehabilitative services will be audited to ensure services have been approved by the designated VA Physician until 100% compliance is met and maintained for 3 consecutive months. Results of these audits will be reported to Extended Care Council; identified issues will be reported to Clinical Leadership Board (CLB).

Recommendation 17. We recommended that facility managers ensure the community nursing home program office scans existing paper health records into electronic health records and develops a process to scan new records as they are received.

Concur

Target date for completion: November 30, 2017

Facility response: All paper records maintained by the Community Nursing Home Coordinator will be submitted to Medical Records for scanning. The Community Nursing Home Coordinator will audit 4 random charts each month to validate the scanned paper records are available in CPRS until 100% compliance is met and maintained for 3 consecutive months.

Recommendation 18. We recommended that the facility update its policy on preventing and managing disruptive and violent behavior.

Concur

Target date for completion: June 30, 2017

Facility response: The Prevention and Management of Disruptive Behavior (PMDB) policy has been updated and is under review for approval.

Recommendation 19. We recommended that the VA Police Officer and the Patient Advocate consistently attend Disruptive Behavior Committee meetings.

Concur

Target date for completion: September 30, 2017

Facility response: The Chief of VA Police will be assigned as co-chair of the Disruptive Behavior Committee. A patient advocate will be appointed as a member of the

Disruptive Behavior Committee. All members of the Disruptive Behavior Committee or their designee will attend no less than 90% of scheduled meetings. Attendance will be monitored and reported to the Behavioral Health Council until compliance is met and maintained for 3 consecutive months.

Recommendation 20. We recommended that facility managers ensure all employees receive Level 1 Prevention and Management of Disruptive Behavior training and additional training as required for their assigned risk area within 90 days of hire and that the training is documented in employee training records.

Concur

Target date for completion: November 30, 2017

Facility response: All new employees will be assigned PMDB Level 1 training in TMS [Talent Management System]. During New Employee Orientation (NEO), additional PMDB training requirements will be identified based on the assigned risk area within the first 3 days of employment and the PMDB Coordinator will register the employee for training. Training compliance will be monitored the first Friday of each month by the PMDB Coordinator; any issues of non-compliance will be reported to the supervisor and to the Disruptive Behavior Council monthly. Staff identified to be non-compliant within 30 days of the required time frame will be reported to the medical center director. 90% of staff will be compliant completing the assigned level of PMDB training for three consecutive months.

OIG Contact and Staff Acknowledgments

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

Endnotes

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

[b] The references used for EOC included:
- VA Handbook 6500, *Risk Management Framework for VA Information Systems – Tier 3: VA Information Security Program*, March 10, 2015.
- VHA Directive 1116(2), *Sterile Processing Services (SPS)*, March 23, 2016.
- VHA Directive 7704(1); *Location, Selection, Installation, Maintenance, and Testing of Emergency Eyewash and Shower Equipment*; February 16, 2016.
- Various requirements of The Joint Commission, Centers for Disease Control and Prevention, Occupational Safety and Health Administration, International Association of Healthcare Central Service Materiel Management, Health Insurance Portability and Accountability Act, National Fire Protection Association.

[c] 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.

[d] The references used for Coordination of Care: Inter-Facility Transfers included:
- VHA Directive 2007-015, *Inter-Facility Transfer Policy*, May 7, 2007.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.
- VHA Handbook 1400.01, *Resident Supervision*, December 19, 2012.

[e] The references used for Diagnostic Care: POCT included:
- VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service Procedures*, October 6, 2008.
- VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service (P&LMS) Procedures*, January 29, 2016.
- VHA Directive 1088, *Communicating Test Results to Providers and Patients*, October 7, 2015.
- The Joint Commission. *Comprehensive Accreditation Manual for Laboratories and Point-of-Care Testing*. Update 2. September 2010.
- Boaz M, Landau Z, Wainstein J. Analysis of Institutional Blood Glucose Surveillance. *Journal of Diabetes Science and Technology*. 2010;4(6):1,514–15. Accessed July 18, 2016.

[f] 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.
- The Joint Commission. Hospital Standards. January 2016. PC.03.01.01, EP1 and MS.06.01.03 EP6.

[g] The references used for CNH Oversight included:
- VHA Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures*, June 4, 2004.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.
- 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).

[h] The references used for Management of Disruptive/Violent Behavior included:

- VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012.
- Public Law 112-154. Honoring America's Veterans and Caring for Camp Lejeune Families Act of 2012. August 6, 2012. 126 Stat. 1165. Sec. 106.
- Acting Deputy Under Secretary for Health for Operations and Management. "Meeting New Mandatory Safety Training Requirements using Veterans Health Administration's Prevention and Management of Disruptive Behavior (PMDB) Curriculum." memorandum. November 7, 2013.

[i] The reference used for the Strategic Analytics for Improvement and Learning (SAIL) metric definitions was:

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

[j] The reference used for Patient Aligned Care Team Compass data graphs was:

- Department of Veterans' Affairs, Patient Aligned Care Teams Compass Data Definitions, accessed: February 25, 2016.