



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

Office of Healthcare Inspections

Report No. 16-00550-145

**Clinical Assessment Program
Review of the
Harry S. Truman Memorial
Veterans' Hospital
Columbia, Missouri**

March 8, 2017

Washington, DC 20420

In addition to general privacy laws that govern release of medical information, disclosure of certain veteran health or other private information may be prohibited by various Federal statutes including, but not limited to, 38 U.S.C. §§ 5701, 5705, and 7332, absent an exemption or other specified circumstances. As mandated by law, OIG adheres to privacy and confidentiality laws and regulations protecting veteran health or other private information in this report.

To Report Suspected Wrongdoing in VA Programs and Operations

Telephone: 1-800-488-8244

E-Mail: vaoighotline@va.gov

(Hotline Information: www.va.gov/oig/hotline)

Glossary

CAP	Clinical Assessment Program
CBOC	community based outpatient clinic
CNH	community nursing home
EHR	electronic health record
EOC	environment of care
facility	Harry S. Truman Memorial Veterans' Hospital
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

Table of Contents

	Page
Executive Summary	i
Purpose and Objectives	1
Purpose	1
Objectives	1
Background	1
Scope	5
Reported Accomplishments	6
Results and Recommendations	8
Quality, Safety, and Value	8
Environment of Care	11
Medication Management: Anticoagulation Therapy	14
Coordination of Care: Inter-Facility Transfers	17
Diagnostic Care: Point-of-Care Testing	19
Moderate Sedation.....	21
Community Nursing Home Oversight.....	24
Management of Disruptive/Violent Behavior	25
Review Activity with Previous Combined Assessment Program Review	
Recommendations	28
Quality Management.....	28
Appendixes	
A. Facility Profile and VA Outpatient Clinic Profiles	29
B. Strategic Analytics for Improvement and Learning (SAIL)	31
C. Patient Aligned Care Team Compass Metrics	35
D. Prior OIG Reports	39
E. Veterans Integrated Service Network Director Comments	40
F. Facility Director Comments.....	41
G. OIG Contact and Staff Acknowledgments	47
H. Report Distribution	48
I. Endnotes	49

Executive Summary

Purpose and Objectives: The review provided a focused evaluation of the quality of care provided in the inpatient and outpatient settings of the Harry S. Truman Memorial Veterans' Hospital. 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 October 24, 2016, and identified certain system weaknesses in peer review and utilization management processes; environmental cleanliness; anticoagulation policies and processes; employee competencies for point-of-care testing; documentation of actions for clinically significant point-of-care testing results; processes, procedures, and training related to the management of disruptive and violent behavior; and screening of clinical issues after codes.

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

1. The facility's Peer Review Committee effectively tracks individual improvement action outcomes.
2. Physician advisors provide input for utilization management decisions.
3. Cardiopulmonary Resuscitation Committee reviews assist clinical leaders to plan interventions that may prevent further patient deterioration.
4. Patient nourishment areas are clean.
5. Anticoagulation patients are always able to contact facility employees with safety concerns.
6. Facility employees use quality assurance data to improve care for anticoagulation patients.
7. Clinicians consistently obtain all required laboratory tests prior to initiating anticoagulant medications and effectively monitor patients receiving anticoagulation therapy.
8. The facility maintains competencies for employees who perform point-of-care glucometer testing.
9. Clinicians take action for clinically significant test results.
10. The facility effectively manages potential and actual disruptive or violent behaviors.

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

Quality, Safety, and Value – Ensure that:

- Facility clinical managers consistently implement individual improvement actions recommended by the Peer Review Committee.
- Physician Utilization Management Advisors consistently document their decisions in the National Utilization Management Integration database.

Environment of Care – Ensure that:

- Ice machines and refrigerators in patient nourishment kitchens are clean.

Medication Management: Anticoagulation Therapy – Ensure that:

- The facility defines a process for patient anticoagulation-related calls outside normal business hours.
- The facility reviews designated quality assurance data for the anticoagulation management program quarterly.
- Clinicians consistently obtain all required laboratory tests prior to initiating anticoagulant medications and obtain required laboratory tests during warfarin treatment at the frequency required by local policy.

Diagnostic Care: Point-of-Care Testing – Ensure that:

- Employees who perform glucose testing at the point of care have annual competencies for glucometers.
- Clinicians take and document all actions required by the facility in response to test results.

Management of Disruptive/Violent Behavior – Ensure that:

- The facility implements an Employee Threat Assessment Team or alternate group that addresses employee-related disruptive behavior.
- VA Police officer, Patient Safety Manager, and Patient Advocate attendance is consistently documented at Disruptive Behavior Committee meetings.
- The facility includes and tests slow scan/closed circuit televisions, computer-based panic alarm systems, and electronic personal panic alarms in accordance with the local physical security assessment.
- All employees receive Level 1 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.

We also made the following repeat recommendation.

Quality Management – Ensure that:

- Cardiopulmonary Resuscitation Committee code reviews include screening for clinical issues prior to code that may have contributed to the occurrence of the code.

Comments

The Veterans Integrated Service Network Director and Facility Director agreed with the Clinical Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes E and F, pages 40–46, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.



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

Purpose and Objectives

Purpose

This CAP review provided a focused evaluation of the quality of care provided 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.

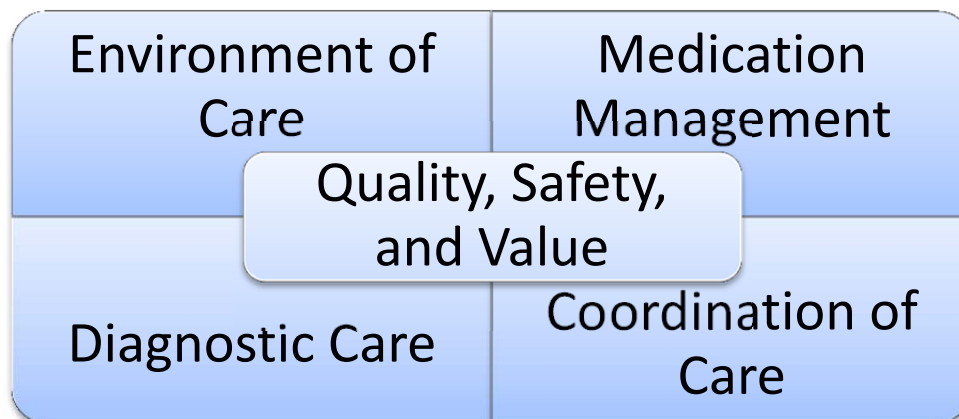
OIG also evaluates processes that are high risk and problem-prone. During this cycle, Moderate Sedation, CNH Oversight, and Management of Disruptive/Violent Behavior are processes that are high risk and problem-prone. We also followed up on recommendations from the previous Combined Assessment Program and CBOC and PC Clinic 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

QSV

According to 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

EOC

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, patients, and anyone else who enters 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 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's 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. 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. 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. 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/diagnosticervices.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.

- QSV
- EOC
- Medication Management: Anticoagulation Therapy
- Coordination of Care: Inter-Facility Transfers
- Diagnostic Care: POCT

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
- CNH Oversight
- Management of Disruptive/Violent Behavior

We list the review criteria for each of the review areas in the topic checklists. Some of the items listed may not have been applicable because of a difference in size, function, or frequency of occurrence.

The review covered operations for FY 2016 and FY 2017 through October 28, 2016, 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 Harry S. Truman Memorial Veterans' Hospital, Columbia, Missouri*, Report No. 13-03650-53, January 29, 2014) and CBOC report (*Community Based Outpatient Clinic and Primary Care Clinic Reviews at Harry S. Truman Memorial Veterans' Hospital, Columbia, Missouri*, Report No. 13-03424-74, February 27, 2014). We made a repeat recommendation in Quality Management.

We presented crime awareness briefings for 155 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 162 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. Serious issues that come to our attention that are outside the scope will be considered for further review separate from the CAP process and may be referred accordingly.

Reported Accomplishments

Hospital of the Future Project – “Blueprint for Excellence” Focuses on High Reliability

The Facility Director has partnered with the National Center for Patient Safety in a project to create a high-reliability hospital or Hospital of the Future. Through this Hospital of the Future project, the Facility Director and Patient Safety Manager are making pioneering moves toward a high reliability organization. In 2015, the Facility

Director dedicated the Patient Safety Manager full time to the Hospital of the Future project and brought on a new Patient Safety Manager to replace the original one. In March 2015, the facility and the National Center for Patient Safety signed a project charter, and after a series of site reviews and consultation and planning calls, the facility formally embarked on a 3-year course for transformation into high reliability. As of January 2016, the facility is now fully engaged in a multi-faceted implementation plan that includes the following initiatives:

1. Clinical team training
2. Just Culture training
3. Leadership Walk Rounds
4. Root cause analysis training for frontline staff
5. leadership safety forums
6. High fidelity simulation
7. National Center for Patient Safety safety reviews
8. Care process improvements

Nursing Pillars

Patient Services has implemented four pillars of excellence—quality, customer service, efficiency, and staff engagement. The pillar groups are led by the associate chief nurses and the Nurse Executive with nurse managers and bedside employees as participating/contributing members of these groups. Each group looked at data in their respective areas to decide which projects to take on. An example for the customer service pillar was to improve on the patient satisfaction survey. A laminated yellow dry erase board was placed in every patient room to specifically address pain. This board allows the patient and family to visually see when the last pain medication was given and what time the next dose of pain medicine can be given. It also lets patients know to call the nurse if pain medication is not working.

Upon admission, employees give patients/families “Invitation to Care” cards that explain the unit the patients are on and cover frequently asked questions. The card invites patients/families to be partners in care and to speak up. The unit nurse manager, house supervisor, and patient advocate numbers are on the back of each card. Patients have voiced appreciation of “being involved.”

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 areas marked as NM did not meet applicable requirements and needed improvement.

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. <ul style="list-style-type: none"> • The committee routinely reviewed aggregated data. 		

NM	Areas Reviewed (continued)	Findings	Recommendations
	<p>Credentialing and privileging processes met selected requirements:</p> <ul style="list-style-type: none"> • 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. 		
X	<p>Protected peer reviews met selected requirements:</p> <ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • In two cases, there was no evidence that clinical managers implemented individual improvement actions recommended by the Peer Review Committee. 	<p>1. We recommended that facility clinical managers consistently implement individual improvement actions recommended by the Peer Review Committee and that facility managers monitor compliance.</p>
X	<p>Utilization management met selected requirements:</p> <ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • For 36 of the 71 cases (51 percent) referred to Physician Utilization Management Advisors August 25–October 25, 2016, there was no evidence that advisors documented their decisions in the National Utilization Management Integration database. 	<p>2. We recommended that Physician Utilization Management Advisors consistently document their decisions in the National Utilization Management Integration database and that facility managers monitor compliance.</p>

NM	Areas Reviewed (continued)	Findings	Recommendations
	Patient safety met selected requirements: <ul style="list-style-type: none"> • The Patient Safety Manager entered all reported patient incidents into the WEBSPOOT 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, the intensive care unit, inpatient units (medical, MH, and surgical), the hemodialysis unit, PC and specialty care clinics, the Saint James VA Clinic (CBOC), and SPS. Additionally, we reviewed relevant documents and 19 employee training records, and we interviewed key employees and managers. The table below shows the areas reviewed for this topic. The area 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
	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.		
	The facility conducted an infection prevention risk assessment.		
	Infection Prevention/Control Committee minutes documented discussion of identified high-risk areas, actions implemented to address those areas, and follow-up on implemented actions and included analysis of surveillance activities and data.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
	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.		
	The facility met general safety requirements.		
X	The facility met environmental cleanliness requirements.	<ul style="list-style-type: none"> • In three of eight applicable patient care areas, ice machines in patient nourishment kitchens were not clean. • In four of eight applicable patient care areas, refrigerators in nourishment kitchens were not clean. 	<p>3. We recommended that facility managers ensure ice machines and refrigerators in patient nourishment kitchens are clean and monitor compliance.</p>
Areas Reviewed for SPS			
	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.		
	Selected SPS employees had evidence of the following for selected RME: <ul style="list-style-type: none"> • 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 		

NM	Areas Reviewed for SPS (continued)	Findings	Recommendations
	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.		
	Selected hemodialysis unit employees had evidence of bloodborne pathogens training within the past 12 months.		
	The facility met environmental safety requirements in the hemodialysis unit.		
	The facility met infection prevention requirements in the hemodialysis unit.		
	The facility met medication safety and security requirements in the hemodialysis unit.		
	The facility met privacy requirements in 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 thromboembolism¹⁹ 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 34 patients who were prescribed new anticoagulant medications 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: <ul style="list-style-type: none"> • 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
X	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.	<ul style="list-style-type: none"> The facility had not defined a process for patient anticoagulation-related calls outside normal business hours. 	<p>4. We recommended that the facility define a process for patient anticoagulation-related calls outside normal business hours.</p>
	The facility designated a physician as the anticoagulation program champion.		
	The facility defined ways to minimize the risk of incorrect tablet strength dosing errors.		
X	The facility routinely reviewed quality assurance data for the anticoagulation management program at the facility's required frequency at an appropriate committee.	<ul style="list-style-type: none"> The facility did not review designated quality assurance data for the anticoagulation management program quarterly. 	<p>5. We recommended that the facility review designated quality assurance data for the anticoagulation management program quarterly and that facility managers monitor compliance.</p>
	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: <ul style="list-style-type: none"> Prior to initiating anticoagulant medications During anticoagulation treatment at the frequency required by local policy 	<ul style="list-style-type: none"> In two EHRs, clinicians did not obtain all required laboratory tests prior to initiating anticoagulant medications. Three of 26 EHRs did not contain evidence that clinicians obtained required laboratory tests during warfarin treatment at the frequency required by local policy. 	<p>6. We recommended that facility managers ensure clinicians consistently obtain all required laboratory tests prior to initiating anticoagulant medications and obtain required laboratory tests during warfarin treatment at the frequency required by local policy.</p>
	When laboratory values did not meet selected criteria, clinicians documented a justification/rationale for prescribing the anticoagulant.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	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.		

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 patient, and comply with applicable standards.

We reviewed relevant documents and interviewed key employees. Additionally, we reviewed the EHRs of 37 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 July 1, 2015 through June 30, 2016. The table below shows the areas reviewed for this topic. The facility generally met requirements. We made no recommendations.

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.		
	The facility collected and reported data about transfers out of the facility.		
	Transferring providers 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: <ul style="list-style-type: none"> • 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 		

NM	Areas Reviewed (continued)	Findings	Recommendations
	When staff/attending physicians did not write transfer notes, acceptable designees: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • Patient stability for transfer • Provision of all medical care within the facility's capacity 		
	Communication with the accepting facility or documentation sent included: <ul style="list-style-type: none"> • 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 49 inpatients and outpatients who underwent POCT for blood glucose July 1, 2015 through June 30, 2016, and the annual competency assessments of 47 clinicians who performed the glucose testing. Additionally, we interviewed key employees conducted onsite glucometer inspections of the community living center, the Emergency Department, PC, the medical inpatient unit, and the Saint James VA Clinic (CBOC) to assess compliance with manufacturers' maintenance and solution/reagent storage requirements. The table below shows the areas reviewed for this topic. The areas 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
X	The facility had a process to ensure employee competency for POCT with glucometers and evaluated competencies at least annually.	<ul style="list-style-type: none"> Eight of 38 employees (21 percent) who performed point-of-care glucose testing did not have annual competency assessments. 	7. We recommended that the laboratory director ensure employees who perform glucose testing at the point of care have annual competencies for glucometers and that facility managers monitor compliance.
	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.	<ul style="list-style-type: none"> In 19 of 49 EHRs (39 percent), clinicians did not document all the actions required by the facility in response to test results. 	8. 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 2015, VHA clinicians performed more than 152,000 moderate sedation procedures of which approximately 60,000 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, cardiology, interventional radiology, 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 48 patients who underwent an invasive procedure involving moderate sedation July 1, 2015 through June 30, 2016, and the training records of 15 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 July 28, 2016.

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 both 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.		
	The clinical team kept monitoring and resuscitation equipment and reversal agents in the general areas where moderate sedation was administered.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	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.⁹ 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 42 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 July 5, 2015 through June 30, 2016. Additionally, we interviewed key employees. The table below shows the areas reviewed for this topic. The facility generally met requirements. We made no recommendations.

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

NM	Areas Reviewed	Findings	Recommendations
	The facility had a CNH Oversight Committee that met at least quarterly and included representation by the required disciplines.		
	The facility integrated the CNH Program into its Quality Improvement Program.		
	The facility documented a hand-off for patients placed in CNHs outside of its catchment area.		
	The CNH Review Team completed CNH annual reviews.		
	When CNH annual reviews noted four or more exclusionary criteria, facility managers completed exclusion review documentation.		
	Social workers and registered nurses documented clinical visits that alternated on a cyclical basis.		

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

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 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 42 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 July 1, 2015 through June 30, 2016, and the training records of 30 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
	The facility had a policy, procedure, or guideline on preventing and managing disruptive or violent behavior.		
	The facility conducted an annual Workplace Behavioral Risk Assessment.		
X	The facility had implemented: <ul style="list-style-type: none"> • An Employee Threat Assessment Team or acceptable alternate group • A Disruptive Behavior Committee/Board with appropriate membership • A disruptive behavior reporting and tracking system 	<ul style="list-style-type: none"> • The facility had not implemented an Employee Threat Assessment Team. • VA Police officer, Patient Safety Manager, and Patient Advocate attendance was not consistently documented at Disruptive Behavior Committee meetings. 	<p>9. We recommended that the facility implement an Employee Threat Assessment Team or an alternate group that addresses employee-related disruptive behavior.</p> <p>10. We recommended that VA Police officer, Patient Safety Manager, and Patient Advocate attendance is consistently documented at Disruptive Behavior Committee meetings.</p>
	The facility collected and analyzed disruptive or violent behavior incidents data.		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	<p>The facility assessed physical security and included and tested equipment in accordance with the local physical security assessment.</p>	<ul style="list-style-type: none"> The facility did not include slow scan/closed circuit televisions, computer-based panic alarm systems, and electronic personal panic alarms in accordance with the physical security assessment. 	<p>11. We recommended that the facility include and test slow scan/closed circuit televisions, computer-based panic alarm systems, and electronic personal panic alarms in accordance with the local physical security assessment.</p>
	<p>Clinical managers reviewed patients' disruptive or violent behavior and took appropriate actions, including:</p> <ul style="list-style-type: none"> 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 appeal the flag placement Ensuring Chief of Staff or designee approval of an Order of Behavioral Restriction 		
	<p>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.</p>		
	<p>The facility managed selected non-patient related disruptive or violent incidents appropriately according to VHA and local policy.</p>		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	<p>The facility had a security training plan for employees at all risk levels.</p> <ul style="list-style-type: none"> • 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. 	<ul style="list-style-type: none"> • Seven employee training records (23 percent) did not contain documentation of Level 1 training within 90 days of hire. • Fifteen employee training records (50 percent) did not contain documentation of the training required for their assigned risk area within 90 days of hire. 	<p>12. We recommended that facility managers ensure all employees receive Level 1 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.</p>

Review Activity with Previous Combined Assessment Program Review Recommendations

Quality Management

As a follow-up to a recommendation from our prior Combined Assessment Program review, we reassessed facility compliance with review of resuscitation events.¹

Committee Minutes Quality Review. VHA requires that review of resuscitation events include screening for clinical issues prior to events that may have contributed to the occurrence of the code. During our previous Combined Assessment Program review, we found no evidence that code reviews included screening for clinical issues prior to code that may have contributed to the occurrence of the code. During this review, we looked at 5 months of Cardiopulmonary Resuscitation Committee meeting minutes. There was no evidence that code reviews included screening for clinical issues prior to code that may have contributed to the occurrence of the code.

Recommendation

13. We recommended that Cardiopulmonary Resuscitation Committee code reviews include screening for clinical issues prior to code that may have contributed to the occurrence of the code.

Facility Profile

Table 1 below provides general background information for this facility.

Table 1. Facility Profile for Columbia (589A4) for FY 2016

Profile Element	Facility Data
Veterans Integrated Service Network Number	15
Complexity Level	1c-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	\$333
Number of:	
• Unique Patients	38,390
• Outpatient Visits	431,752
• Unique Employees²⁴	1,150
Type and Number of Operating Beds:	
• Acute	50
• MH	11
• Community Living Center	41
• Domiciliary	NA
Average Daily Census:	
• Acute	42
• MH	7
• Community Living Center	32
• 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 Profiles²⁵

The VA outpatient clinics in communities within the catchment area of the facility provide PC integrated with women’s health, MH, and telehealth services. Some also provide specialty care, diagnostic, and ancillary services. Table 2 below provides information relative to each of the clinics.

Table 2. VA Outpatient Clinic Workload/Encounters²⁶ 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
Jefferson City, MO	589G8	7,851	1,382	Cardiology Dermatology Gastroenterology Podiatry	NA	Weight Management
Kirksville, MO	589GE	4,916	741	Dermatology Gastroenterology Neurology Anesthesia	NA	Weight Management
Waynesville, MO	589GF	5,612	3,354	Cardiology Dermatology Gastroenterology Neurology Anesthesia	NA	Weight Management
Osage Beach, MO	589GH	5,749	1,947	Cardiology Dermatology Gastroenterology Urology	NA	Weight Management
Mexico, MO	589GX	4,805	1,304	Dermatology Gastroenterology	NA	Weight Management
St. James, MO	589GY	3,334	1,481	NA	NA	NA
Sedalia, MO	589JA	5,409	1,280	Cardiology Dermatology Gastroenterology Neurology	NA	Weight Management
Marshfield, MO	589JD	3,658	1,015	Cardiology Dermatology Gastroenterology Eye	NA	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.

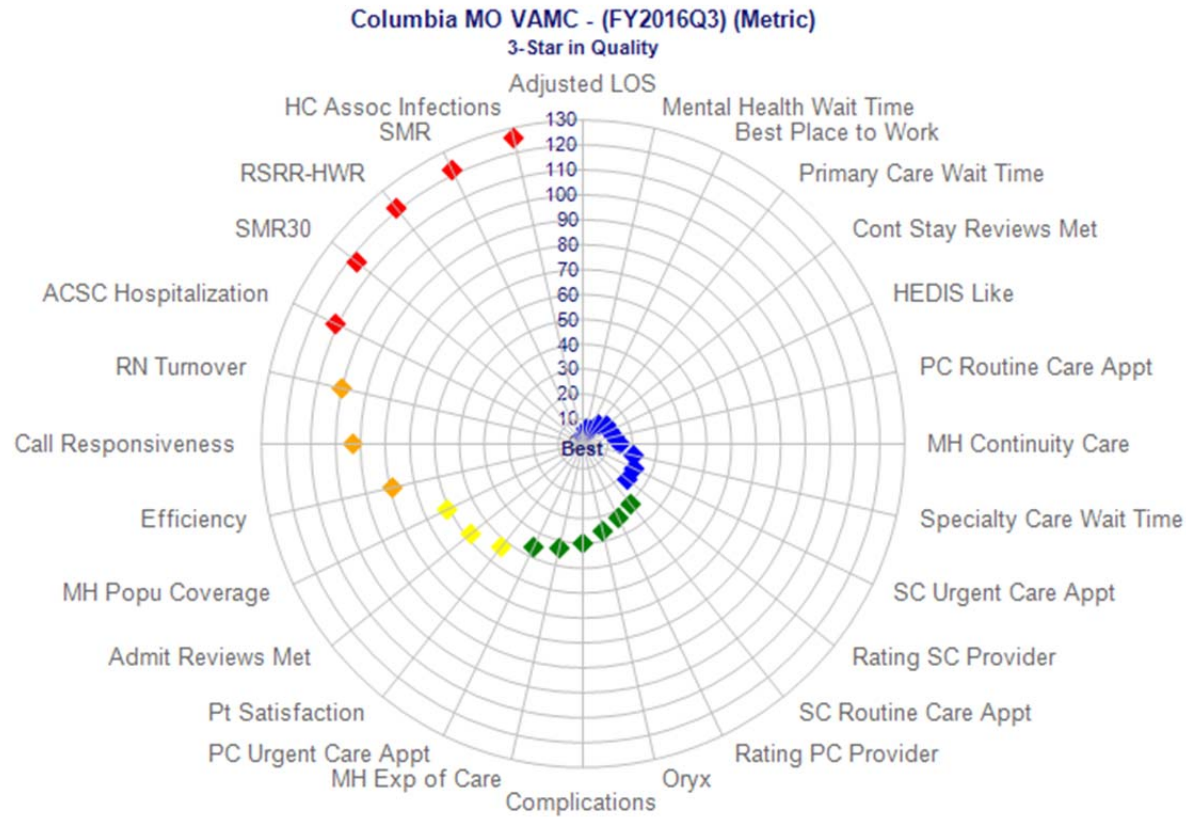
²⁶ An encounter is a professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient’s condition.

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



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

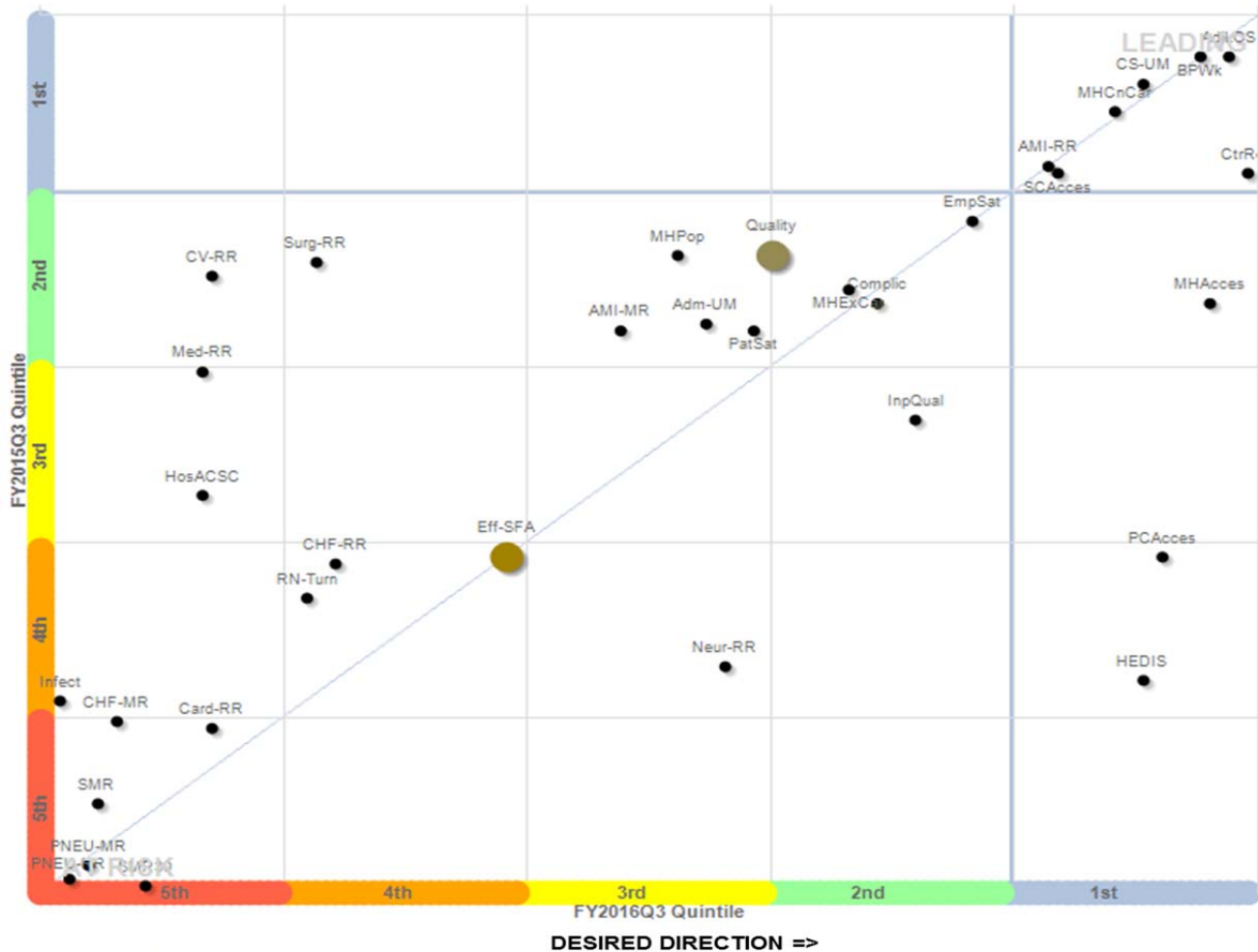
Source: VHA Support Service Center

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

³⁰ Metric definitions follow the graphs.

Scatter Chart

FY2016Q3 Change in Quintiles from FY2015Q3



NOTE

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

DESIRED DIRECTION ==>

Source: VHA Support Service Center

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

Metric Definitions^j

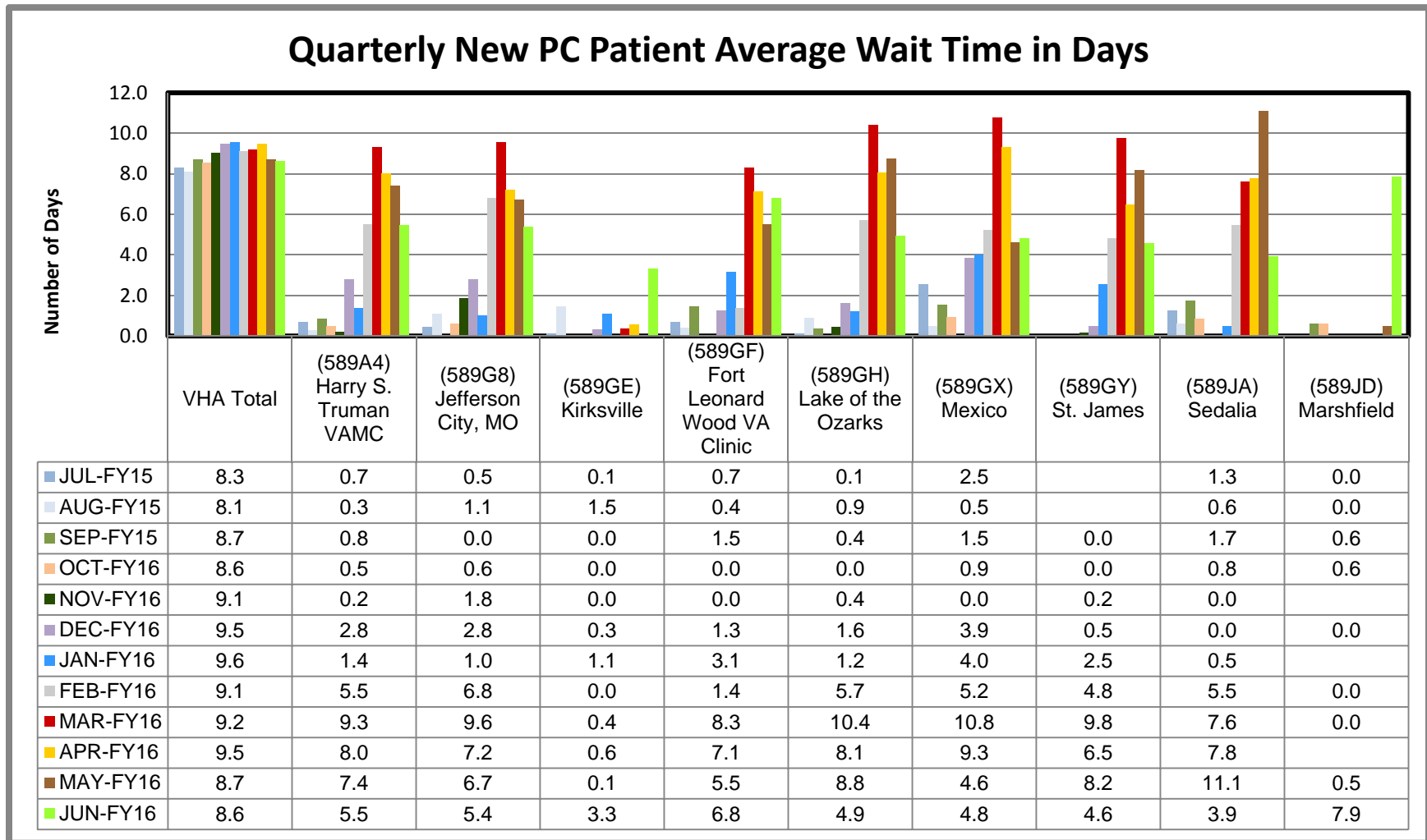
Measure	Definition	Desired Direction
ACSC Hospitalization	Ambulatory care sensitive condition hospitalizations (observed to expected ratio)	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Admit Reviews Met	% 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

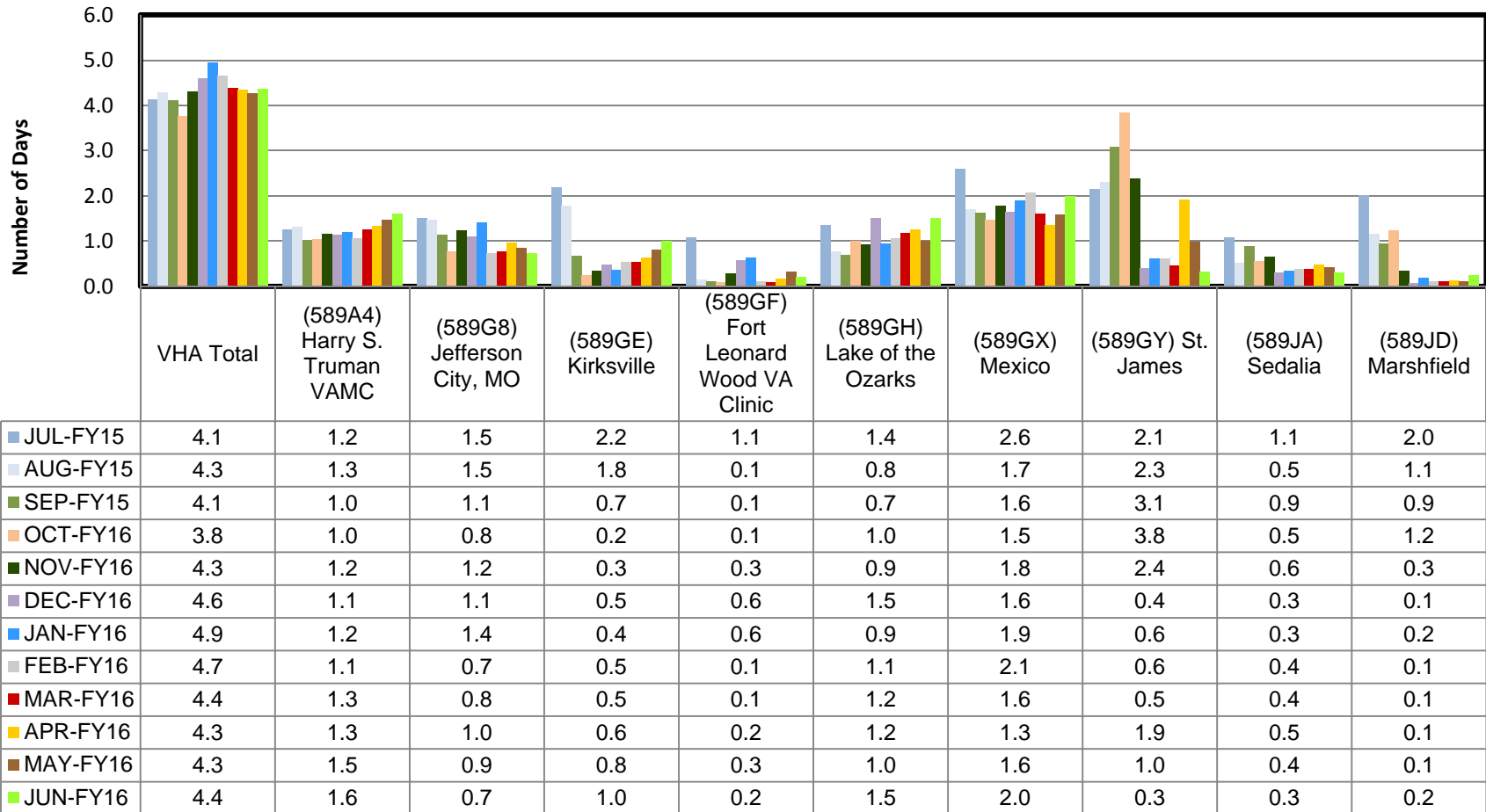


Source: VHA Support Service Center

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

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

Quarterly Established PC Patient Average Wait Time in Days

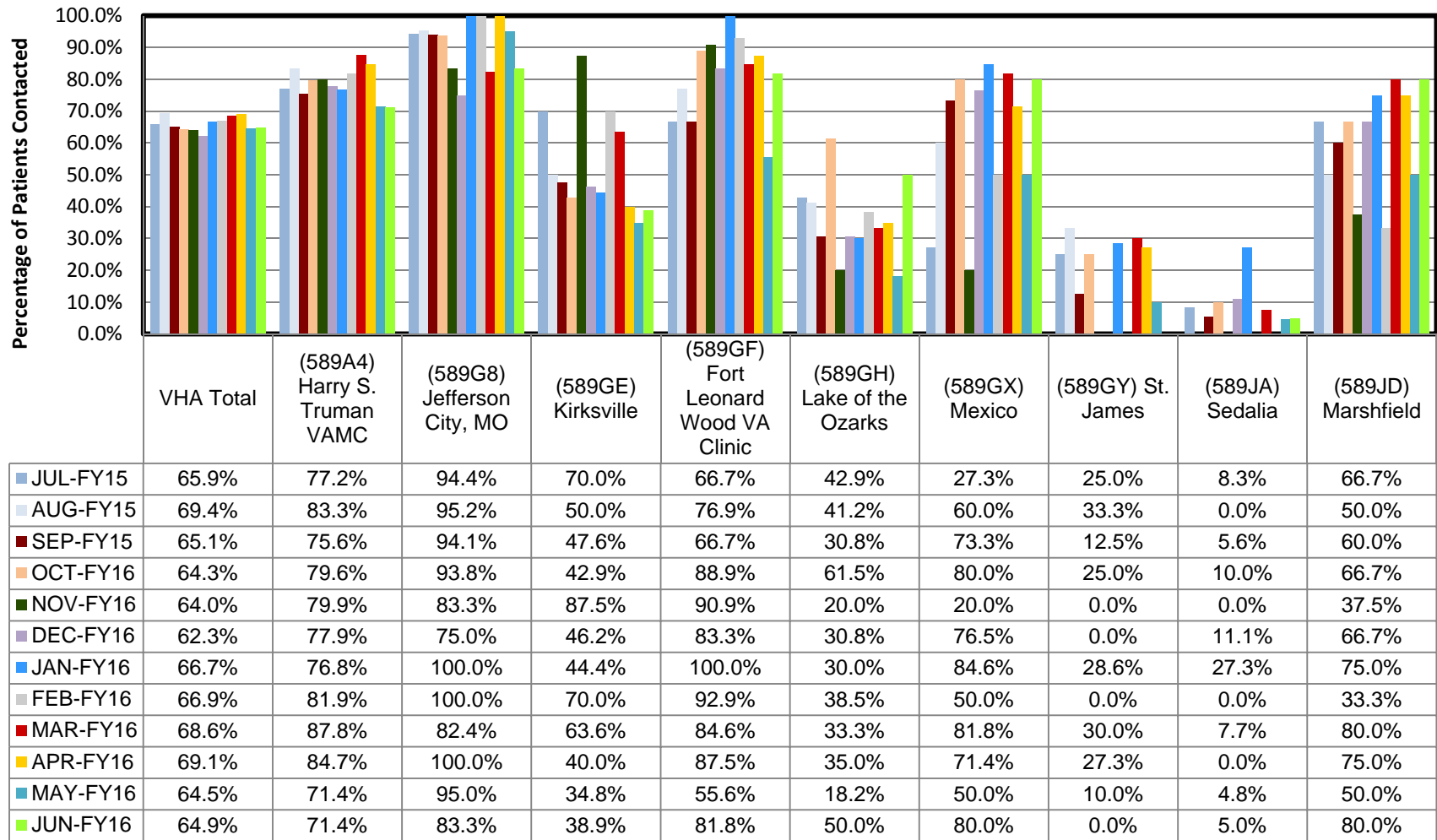


Source: VHA Support Service Center

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.

Quarterly Team 2-Day Post Discharge Contact Ratio

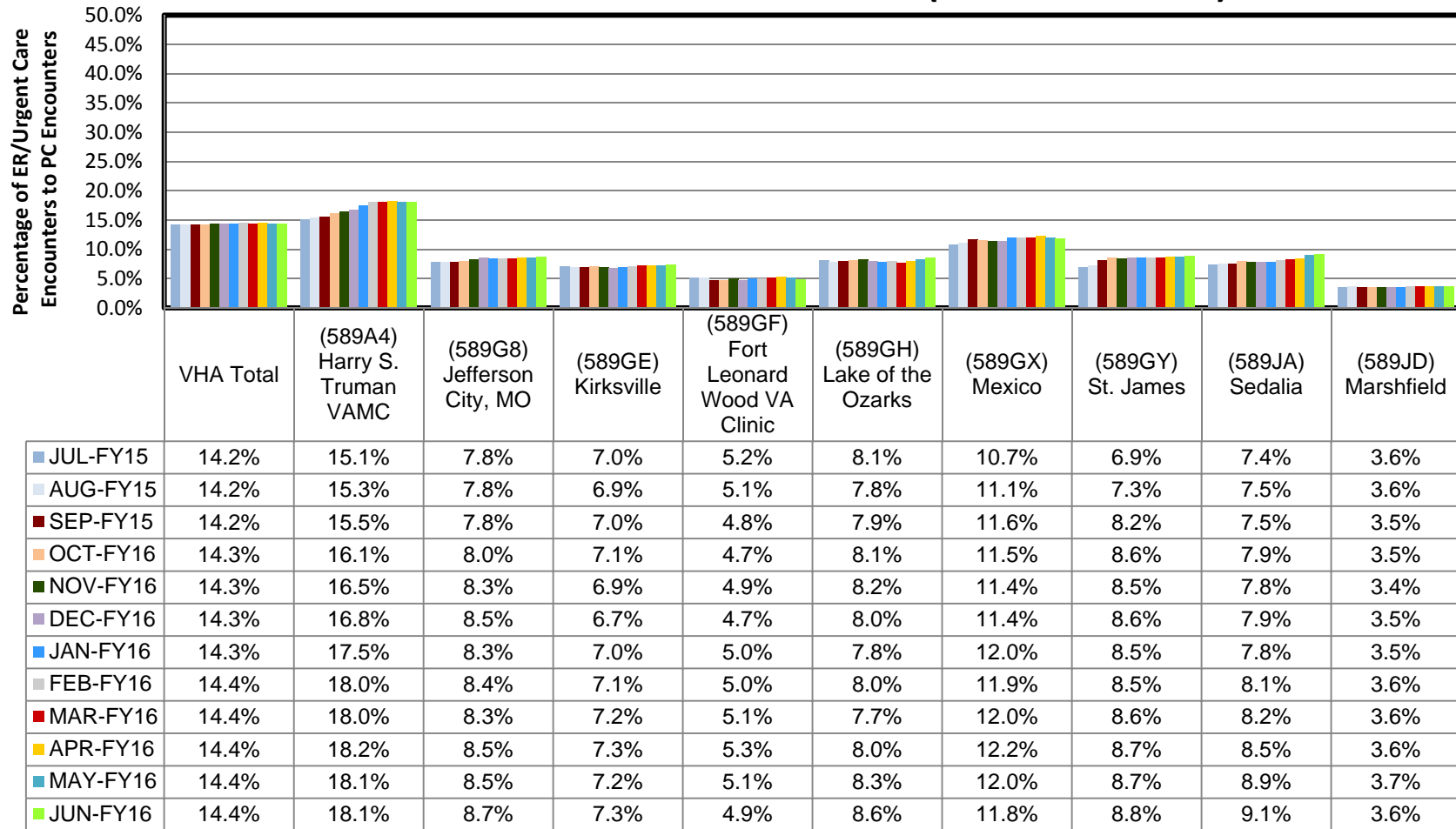


Source: VHA Support Service Center

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.

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



Source: VHA Support Service Center

Note: 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
December 1, 2013 Through December 1, 2016**

Facility Reports

Healthcare Inspection – Quality and Coordination of Care Concerns at Two Veterans Integrated Service Network 15 Facilities

6/25/2015 | 14-04547-401 | [Summary](#) | [Report](#)

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

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

Healthcare Inspection – Review of Solo Physicians' Professional Practice Evaluations in Veterans Health Administration Facilities

6/3/2015 | 15-00911-362 | [Summary](#) | [Report](#)

Healthcare Inspection – Prevention of Legionnaires' Disease in VHA Facilities

8/1/2013 | 13-01189-267 | [Summary](#) | [Report](#)

Healthcare Inspection - Evaluation of Cataract Surgeries and Outcomes in VHA Facilities

3/28/2013 | 11-02487-158 | [Summary](#) | [Report](#)

Veterans Integrated Service Network Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: December 15, 2016

From: Director, VA Heartland Network (10N15)

Subject: **CAP Review of the Harry S. Truman Memorial Veterans' Hospital, Columbia, MO**

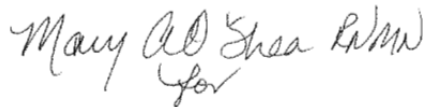
To: Director, Kansas City Office of Healthcare Inspections (54KC)

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

Attached, please find response for the Combined Assessment Program Review for the Harry S. Truman Memorial Veterans' Hospital, Columbia, MO.

I have reviewed and concur with the Medical Center Director's response. Thank you for this opportunity of review focused toward continuous performance improvement.

For additional questions please feel free to contact [REDACTED], VISN 15 Quality Management Officer at [REDACTED].



Mary A. O'Shea, RN, MN
On behalf of Dr. William P. Patterson, MD, MSS
Network Director
VA Heartland Network (VISN 15)

Facility Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: December 12, 2016

From: Director, Harry S. Truman Memorial Veterans' Hospital (589A4/00)

Subject: **CAP Review of the Harry S. Truman Memorial Veterans' Hospital, Columbia, MO**

To: Director, VA Heartland Network (10N15)

1. Thank you for the opportunity to review and respond to the Clinical Assessment Program Review of the Harry S. Truman Memorial Veterans' Hospital.
2. I have reviewed and concur with the recommendations in the report. Corrective action plans have been developed or implemented and are outlined in the attached report.
3. If you have any questions, please contact [REDACTED], Chief, Quality Management.



DAVID ISAACKS, FACHE
Medical Center Director
VAMC Columbia MO

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that facility clinical managers consistently implement individual improvement actions recommended by the Peer Review Committee and that facility managers monitor compliance.

Concur

Target date for completion: April 1, 2017

Facility response: Staff turnover of the Peer Review Board (PRB) facilitator resulted in a lack of supervisory follow-up on two peer review cases as recommended by the PRB. Instruction was provided to the acting PRB facilitator regarding the need to send a memo to supervisors for staff follow-up when required by the PRB, and the two cases missing follow-up at the time of survey have been corrected. The Chief of Quality Management will review PRB minutes for 3 months to monitor compliance with supervisory follow-up with staff as recommended by the PRB.

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

Concur

Target date for completion: March 31, 2017

Facility response: An additional PUMA [Physician Utilization Management Advisor] was appointed to aid in reviewing cases and documenting decisions in the NUMI [National Utilization Management Integration] database. The Chief of Quality Management will monitor compliance with PUMAs documenting their decisions in NUMI until 90% compliance is achieved for three months.

Recommendation 3. We recommended that facility managers ensure ice machines and refrigerators in patient nourishment kitchens are clean and monitor compliance.

Concur

Target date for completion: April 1, 2017

Facility response: The housekeepers have been instructed to complete weekly cleaning of the refrigerators and ice machines used for patient care. Housekeeping supervisors will conduct monthly inspections to ensure cleanliness. Monthly inspection data will be

reviewed and reported to Environment of Care Committee until 3 months of 90% compliance is achieved with ice machines and refrigerators in patient nourishment kitchens being clean.

Recommendation 4. We recommended that the facility define a process for patient anticoagulation-related calls outside normal business hours.

Concur

Target date for completion: February 28, 2017

Facility response: The Anticoagulation Clinic will update patient education literature, phone messages, and business cards to include instructions for patients to do the following: (1) dial 911 for anticoagulation related emergencies; (2) phone the after-hours care line for non-emergent questions that cannot wait to be answered during clinic business hours; and (3) leave a message for the Anticoagulation Clinic staff for non-emergent questions.

Recommendation 5. We recommended that the facility review designated quality assurance data for the anticoagulation management program quarterly and that facility managers monitor compliance.

Concur

Target date for completion: June 1, 2017

Facility response: Anticoagulation Program Quality Assurance Data will be added as a standing agenda item for the Pharmacy and Therapeutics Committee where it will be reviewed no less than quarterly. The Chief of Quality Management will monitor reporting of Anticoagulation Program Quality Assurance data in the Pharmacy and Therapeutics Committee minutes to ensure data is reviewed at least quarterly.

Recommendation 6. We recommended that facility managers ensure clinicians consistently obtain all required laboratory tests prior to initiating anticoagulant medications and obtain required laboratory tests during warfarin treatment at the frequency required by local policy.

Concur

Target date for completion: June 1, 2017

Facility response: The Anticoagulation Management Program policy will be updated to reflect the requirements and frequency for obtaining routine laboratory tests both prior to initiating anticoagulant medication treatment and during ongoing treatment. The Chief of Pharmacy Services will monitor compliance with obtaining required laboratory tests until 3 months of 90% compliance is achieved.

Recommendation 7. We recommended that the laboratory director ensure employees who perform glucose testing at the point of care have annual competencies for glucometers and that facility managers monitor compliance.

Concur

Target date for completion: April 3, 2017

Facility response: In December 2016 the Ancillary Testing Coordinators (ACT) were added to the monthly competency fair held by the Learning Organization each month to facilitate staff completing required competencies. Patient Services is responsible for ensuring that nursing staff on all shifts are scheduled a month to participate in the competencies. Staff that do point-of-care testing will have quality control checks completed and will complete a glucose competency test at that time. Training will be documented in Talent Management System (TMS). Staff will be removed from being able to operate the glucometer if they are not compliant with requirements for point-of-care testing. The Ancillary Testing Coordinators will monitor compliance with glucose competency testing for staff scheduled to complete their annual competencies each month. Results from this monitor will be reported to the Performance Improvement Board for three months.

Recommendation 8. 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: May 1, 2017

Facility response: Nursing staff will be re-educated at staff meetings and via e-mail regarding the requirement to document notification to the provider of critical results using the CO-CRITICAL GLUCOSE POC TEST RESULT template as required by local policy. Compliance with nursing staff using the required CPRS [Computerized Patient Record System] template to document provider notification of critical test results will be monitored monthly until 90% is achieved for 3 months.

Recommendation 9. We recommended that the facility implement an Employee Threat Assessment Team or an alternate group that addresses employee-related disruptive behavior.

Concur

Target date for completion: April 3, 2017

Facility response: An Employee Threat Assessment Team (ETAT) will be implemented by April 2017.

Recommendation 10. We recommended that VA Police officer, Patient Safety Manager, and Patient Advocate attendance is consistently documented at Disruptive Behavior Committee meetings.

Concur

Target date for completion: December 30, 2016

Facility response: In August 2016 the Chair of the Disruptive Behavior Committee (DBC) revised the meeting minutes format to include a member attendance log. A review of DBC meeting minutes for August 2016 through November 2016 shows that documentation of member attendance is now occurring. The facility will use the DBC attendance log to document attendance of all members, including VA Police, the Patient Safety Manager and the Patient Advocate.

Recommendation 11. We recommended that the facility include and test slow scan/closed circuit televisions, computer-based panic alarm systems, and electronic personal panic alarms in accordance with the local physical security assessment.

Concur

Target date for completion: June 1, 2017

Facility response: The October 2016 annual Physical Security Assessments included the slow scan/closed circuit televisions, computer-based panic alarm systems, and electronic personal panic alarms and will continue to be included in future assessments. Monthly testing of the personal panic alarms and closed circuit televisions has been implemented, and testing of the computer based panic alarm system is expected to be instituted by February 2017. Monthly testing data will be reported to Performance Improvement Board until 3 months of 90% compliance is achieved.

Recommendation 12. We recommended that facility managers ensure all employees receive Level 1 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: May 1, 2017

Facility response: The Learning Organization has created an assignment profile in TMS to automatically assign the appropriate PMDB [Prevention and Management of Disruptive Behavior] levels to all new employees. All PMDB training levels will be recorded in TMS [Talent Management System]. The PMDB Coordinator will provide monthly compliance reports to service chiefs to track and resolve any deficiencies. The Chief of Quality Management will review monthly PMDB training reports to ensure that all new employees received PMDB Level 1 training and additional training, as required, within 90 days of hire.

Recommendation 13. We recommended that Cardiopulmonary Resuscitation Committee code reviews include screening for clinical issues prior to code that may have contributed to the occurrence of the code.

Concur

Target date for completion: June 1, 2017

Facility response: The spreadsheet used by the Chair of the Cardiopulmonary Resuscitation (CPR) Committee to document review of the various aspects of the code has been revised to include screening for clinical issues prior to the code that may have contributed to the occurrence of the code. This information will be reviewed at the quarterly CPR Committee meeting and documented in the minutes. The Chief of Quality Management will review CPR Committee minutes for 2 quarters to ensure compliance.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Inspection Team	Larry Selzler, MSPT, Team Leader Stephanie Hensel, RN, JD Eileen Keenan, RN, MSN James Seitz, RN, MBA Greg Billingsley, Resident Agent in Charge, Office of Investigations
Other Contributors	Elizabeth Bullock Lin Clegg, PhD Jennifer Reed, RN, MSHI Larry Ross, Jr., MS Marilyn Stones, BS Mary Toy, RN, MSN Julie Watrous, RN, MS

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, Heartland VA Network (10N15)
Director, Harry S. Truman Memorial Veterans' Hospital (589A4/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Roy Blunt, Tammy Duckworth, Richard J. Durbin, Claire McCaskill
U.S. House of Representatives: Mike Bost; William "Lacy" Clay, Jr.; Emmanuel Cleaver; Rodney Davis; Sam Graves; Vicky Hartzler; Adam Kinzinger; Darin LaHood; Billy Long; Blaine Luetkemeyer; Jason Smith; Ann Wagner

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 Directive 1039, *Ensuring Correct Surgery and Invasive Procedures*, July 26, 2013.
- VHA Directive 1073, *Moderate Sedation by Non-Anesthesia Providers*, December 30, 2014.
- VHA Directive 1177; *Cardiopulmonary Resuscitation, Basic Life Support, and Advanced Cardiac Life Support Training for Staff*; November 6, 2014.
- VA National Center for Patient Safety. *Facilitator's Guide for Moderate Sedation Toolkit for Non-Anesthesiologists*. March 29, 2011.
- American Society of Anesthesiologists. Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists. *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.
- 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 Quality Management was:

- VHA Directive 2008-063, *Oversight and Monitoring of Cardiopulmonary Resuscitative Events and Facility Cardiopulmonary Resuscitation Committees*, October 17, 2008.

^j 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.

^k The reference used for PACT Compass data graphs was:

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