



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

Office of Healthcare Inspections

Report No. 16-00555-337

**Clinical Assessment Program
Review of the
James E. Van Zandt VA Medical Center
Altoona, Pennsylvania**

August 15, 2017

Washington, DC 20420

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Glossary

CAP	Clinical Assessment Program
CNH	community nursing home
EHR	electronic health record
EOC	environment of care
facility	James E. Van Zandt 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
PTSD	post-traumatic stress disorder
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 James E. Van Zandt 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; Community Nursing Home Oversight; Management of Disruptive/Violent Behavior; and Post-Traumatic Stress Disorder Care. 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 March 20, 2017, and identified certain system weaknesses in taking actions for issues identified by quality, safety, and value reviews; medical staff membership; general safety and security of personally identifiable information at the Huntingdon County VA Clinic; the anticoagulation management program; inter-facility transfer data collection and reporting; point-of-care testing follow-up; community nursing home oversight and clinical visits; and Prevention and Management of Disruptive Behavior training.

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

1. The facility takes actions for weaknesses identified in peer review and Focused Professional Practice Evaluations.
2. Facility leadership is able to perform appropriate oversight of all members of the medical staff.
3. The access log for the Huntingdon County VA Clinic information technology network room contains required elements.
4. Patients' personally identifiable information is secured at the Huntingdon County VA Clinic.
5. The facility involves a physician in the anticoagulation management program.
6. The facility uses data to improve inter-facility transfers.
7. Clinicians document facility required actions in response to glucose point-of-care testing results.
8. The facility effectively oversees the community nursing home program and monitors and assures the safe care of patients in the program.
9. Facility employees are trained to reduce and prevent disruptive behaviors.

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

Quality, Safety, and Value – Ensure that:

- The facility consistently takes action when data analyses indicate problems or opportunities for improvement in peer review and Focused Professional Practice Evaluations and evaluates the actions for effectiveness.
- All required practitioners are designated as members of the medical staff.

Environment of Care – Ensure that:

- The information technology network room access log at the Huntingdon County VA Clinic includes all required elements.
- Facility managers implement a process to protect personally identifiable information on laboratory specimens at the Huntingdon County VA Clinic.

Medication Management: Anticoagulation Therapy – Ensure that:

- The facility designates a physician anticoagulation program champion.

Coordination of Care: Inter-Facility Transfers – Ensure that:

- Facility managers collect and report data on patient transfers out of the facility.

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.
- A VA physician orders or approves all therapies that are at VA expense.

Management of Disruptive/Violent Behavior – Ensure that:

- 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 42–48, for the full text of the Directors' comments.) We consider recommendations 3 and 4 closed. We will follow up on the planned actions for the open recommendations until they are completed.



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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—CNH Oversight, Management of Disruptive/Violent Behavior, and PTSD Care—and follows up on recommendations from the previous Combined Assessment Program and Community Based Outpatient Clinic 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

Quality, Safety, and Value

According to the Institute of Medicine (now the National Academy 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

One of VA's strategies is to deliver high quality, veteran-centered care that compares favorably to the best of the private sector in measured outcomes, value, efficiency, and patient experience.²

Environment of Care

All facilities face environmental risks, 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 Institute of Medicine (now the National Academy 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

In a 2001 report entitled "Crossing the Quality Chasm: A New Health System for the 21st Century," the Institute of Medicine (now the National Academy of Medicine) noted 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

As of October 2016, VHA has contracts with more than 1,800 CNHs where more than 9,500 veteran patients reside.¹³ These CNHs may be either in 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 oversight involves annual reviews and monthly patient visits unless otherwise specified.¹⁴

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. Many of these assaults and violent

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 VA Corporate Data Warehouse. Accessed October 31, 2016.

¹⁴ VHA Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures*, June 4, 2004.

acts are perpetrated by patients.¹⁵ 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 policies, programs, and initiatives for reducing and preventing disruptive behaviors and other defined acts that threaten public safety.¹⁶ VHA released 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. Unfortunately, employee training deadlines related to this directive have been postponed several times.¹⁷

PTSD is a disorder that may occur "...following exposure to an extreme traumatic stressor involving direct personal experience."¹⁸ In FYs 2010 through 2015, more than one million patients with a primary or secondary diagnosis of PTSD received MH care at VA medical centers and clinics. During FY 2016, VA MH clinicians diagnosed and treated more than 100,000 additional patients who had not been previously diagnosed with PTSD.¹⁹ Because of the risks involved if this condition is not diagnosed and treated, clinical employees need to screen patients for PTSD, in accordance with requirements, when they present for care.

Scope

To evaluate 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 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.

¹⁶ VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012.

¹⁷ VHA Chief Learning Officer Memorandum: VHA Approval to Temporarily Suspend Talent Management System (TMS) Required Training Assignments, March 21, 2016.

¹⁸ VHA Handbook 1160.03, *Programs for Veterans with Post-Traumatic Stress Disorder (PTSD)*, March 12, 2010.

¹⁹ VA Corporate Data Warehouse. Accessed November 1, 2016.

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

- Community Nursing Home Oversight
- Management of Disruptive/Violent Behavior
- Post-Traumatic Stress Disorder Care

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

The review covered operations for FY 2015, FY 2016, and FY 2017 through March 24, 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 James E. Van Zandt VA Medical Center, Altoona, Pennsylvania, Report No. 13-03626-73, February 14, 2014*) and community based outpatient clinic report (*Community Based Outpatient Clinic and Primary Care Clinic Reviews at James E. Van Zandt VA Medical Center, Altoona, Pennsylvania, Report No. 14-00236-153, May 13, 2014*).

We presented crime awareness briefings to 50 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 166 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. When issues and concerns outside the scope of this CAP review come to our attention, they can be referred for further review separate from this report.

Reported Accomplishment

Physical and Occupational Therapy Telehealth Project

The facility's Physical Medicine and Rehabilitation Service received a grant from the VA Office of Rural Health to implement a physical and occupational therapy telehealth program. All five of the facility's community based outpatient clinics participated in the project. During the project, 2,240 patients were seen via telehealth. The facility showed a cost avoidance of \$46,772 for the 112,652 miles not traveled.

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. 		
	<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. 		
	<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. 		

NM	Areas Reviewed (continued)	Findings	Recommendations
	<p>Patient safety met selected requirements:</p> <ul style="list-style-type: none"> • 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. 		
X	<p>Overall, if QSV reviews identified significant issues, the facility took actions and evaluated them for effectiveness.</p>	<ul style="list-style-type: none"> • The facility did not consistently take actions and evaluate them for effectiveness in peer review and Focused Professional Practice Evaluations. 	<p>1. We recommended that the facility consistently take action when data analyses indicated problems or opportunities for improvement and evaluate the actions for effectiveness in peer review and Focused Professional Practice Evaluations and that facility managers monitor compliance.</p>
	<p>Overall, senior managers actively participated in QSV activities.</p>		
X	<p>The facility complied with VHA Handbook 1100.19 requiring that audiologists, clinical pharmacists, and licensed clinical social workers be designated as members of the medical staff.</p>	<ul style="list-style-type: none"> • Audiologists, clinical pharmacists, and licensed clinical social workers were not members of the medical staff. 	<p>2. We recommended that the facility Chief of Staff ensure that all required practitioners are designated as members of the medical staff.</p>

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.^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 urgent care clinic, two community living centers, the medical unit, radiology, a PC clinic, and the Huntingdon County VA Clinic. Additionally, we reviewed relevant documents, 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. Items that did not apply to this facility are marked NA.

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 community based outpatient clinics.		
	The facility conducted an infection prevention risk assessment.		
	Infection Prevention/Control Committee minutes documented discussion of identified high-risk areas, actions implemented to address those areas, and follow-up on implemented actions and included analysis of surveillance activities and data.		

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.		
X	The facility met general safety requirements.	<ul style="list-style-type: none"> Although the Huntingdon County VA Clinic information technology network room contained a log to document access and monitor security of the IT systems, the log did not include all required elements, such as purpose of visit. 	<p>3. We recommended that facility managers ensure the access log for the Huntingdon County VA Clinic information technology network room includes all required elements to document access and that facility managers monitor compliance.</p>
	The facility met environmental cleanliness requirements.		
X	The facility complied with requirements to protect individually identifiable health information.	<ul style="list-style-type: none"> At the Huntingdon County VA Clinic, we observed unsecured laboratory specimens with labels displaying personally identifiable information in a laboratory specimen return window in a public area. 	<p>4. We recommended that facility managers implement a process to protect personally identifiable information on laboratory specimens at the Huntingdon County VA Clinic and that facility managers monitor compliance.</p>
Areas Reviewed for SPS			
NA	The facility had a policy for cleaning, disinfecting, and sterilizing RME.		
NA	The facility's standard operating procedures for selected RME were current and consistent with the manufacturers' instructions for use.		

NM	Areas Reviewed for SPS (continued)	Findings	Recommendations
NA	The facility performed quality control testing on selected RME with the frequency required by local policy and took appropriate action on positive results.		
NA	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 		
NA	The facility met infection prevention requirements in SPS areas.		
NA	Standard operating procedures for selected RME were located in the area where reprocessing occurred.		
NA	SPS employees checked eyewash stations in SPS areas weekly.		
NA	SPS employees had access to Safety Data Sheets in areas where they used hazardous chemicals.		
Areas Reviewed for the Hemodialysis Unit			
NA	The facility had a policy or procedure for preventive maintenance of hemodialysis machines and performed maintenance at the frequency required by local policy.		
NA	Selected hemodialysis unit employees had evidence of bloodborne pathogens training within the past 12 months.		
NA	The facility met environmental safety requirements on the hemodialysis unit.		
NA	The facility met infection prevention requirements on the hemodialysis unit.		

NM	Areas Reviewed for the Hemodialysis Unit (continued)	Findings	Recommendations
NA	The facility met medication safety and security requirements on the hemodialysis unit.		
NA	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 FY 2016, more than 482,000 veterans received an anticoagulant. 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 thromboembolism²⁰ 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 five employees actively involved in the anticoagulant program, and we interviewed key employees. Additionally, we reviewed the EHRs of 31 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 area 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 		

²⁰ 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.		
X	The facility designated a physician as the anticoagulation program champion.	<ul style="list-style-type: none"> • The facility did not have an anticoagulation program champion. 	<p>5. We recommended that the facility designate a physician anticoagulation program champion.</p>
	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.		
	Clinicians provided transition follow-up for inpatients with newly prescribed anticoagulant medications and education specific to the new anticoagulant to both inpatients and outpatients.		
	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 		
	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 patients and comply with applicable standards.

We reviewed relevant documents and interviewed key employees. Additionally, we reviewed the EHRs of 49 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 area 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.	<ul style="list-style-type: none"> • There was no evidence the facility collected and reported data about transfers out of the facility. 	6. We recommended that the facility collect and report data on patient 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 prothrombin 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.²¹

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 10 clinicians who performed the glucose testing. Additionally, we interviewed key employees and conducted onsite glucometer inspections of PC, the urgent care clinic, the medical unit, a community living center, and the Huntingdon County VA Clinic 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.		

²¹ 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.	<ul style="list-style-type: none"> In 6 of the 50 EHRs (12 percent), clinicians did not document all the actions required by the facility in response to test results; thus indicating that interventions may not have been taken as required. 	<p>7. We recommended that clinicians take and document all actions required by the facility in response to test results and that clinical managers monitor compliance.</p>
	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.		

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.^f 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.²² Local oversight of CNHs is achieved through annual reviews and monthly visits.

We reviewed relevant documents, the EHRs of 12 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 areas marked as NM did not meet applicable requirements and needed improvement.

Checklist 6. CNH Oversight Areas Reviewed, Findings, and Recommendations

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.	<ul style="list-style-type: none"> The facility's CNH Oversight Committee did not include a representative from acquisition or the medical staff. 	8. 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.	<ul style="list-style-type: none"> The minutes of the executive-level committee that evaluates quality improvement data did not contain evidence of CNH program integration. 	9. We recommended that the facility ensure integration of the community nursing home 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.		

²² VHA Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures*, June 4, 2004.

NM	Areas Reviewed (continued)	Findings	Recommendations
	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.	<ul style="list-style-type: none"> • Nine of 11 applicable EHRs did not contain documentation of social worker and/or registered nurse cyclical clinical visits with the frequency required by VHA policy. One or more of the nine patients resided in each of the seven CNHs in our review. 	<p>10. 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 that facility managers monitor compliance.</p>
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.	<ul style="list-style-type: none"> • Three of the 12 EHRs had therapies at VA expense authorized by the licensed clinical social worker rather than a VA physician. 	<p>11. We recommended that a VA physician order or approve all therapies that are at VA expense.</p>

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

Checklist 7. 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.		
	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 		
	The facility collected and analyzed disruptive or violent behavior incidents data.		
	The facility assessed physical security and included and tested equipment in accordance with the local physical security assessment.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	<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 request to amend/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>		
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"> • Three of the 20 employee training records did not contain documentation of Level 1 training within 90 days of hire. • Eleven of the applicable 13 employee training records 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 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.</p>

Post-Traumatic Stress Disorder Care

The purpose of this review was to assess whether the facility complied with selected VHA requirements for PTSD follow-up in the outpatient setting.^h PTSD is a disorder that may occur "...following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury; other threat to one's physical integrity; witnessing an event that involves death, injury or threat to the physical integrity of another person; learning about unexpected or violent death, serious harm, threat of death or injury experienced by a family member or other close associate."²³

The PTSD screen is performed through a required national clinical reminder and is triggered for completion when the patient has his or her first visit at a VHA medical facility. The reminder typically remains active until it is completed. For veterans, the most common traumatic stressor contributing to a PTSD diagnosis is war-zone related stress. VHA requires that:

- Every new patient receive PTSD screening that is then repeated every year for the first 5 years post-separation and every 5 years thereafter unless there is a clinical need to screen earlier.
- If a patient's PTSD screen is positive, an acceptable provider evaluates treatment needs and assesses for suicide risk.
- If the provider determines a need for treatment, there is evidence of referral and coordination of care.

We reviewed relevant documents and the EHRs of 42 randomly selected outpatients who had a positive PTSD screen July 1, 2015 through June 30, 2016. We also interviewed key employees and managers. The table below shows the areas reviewed for this topic. The facility generally met requirements. We made no recommendations.

Checklist 8. PTSD Care Areas Reviewed, Findings, and Recommendations

NM	Areas Reviewed	Findings	Recommendations
	Each patient with a positive PTSD screen received a suicide risk assessment.		
	Suicide risk assessments for patients with positive PTSD screens were completed by acceptable providers.		
	Acceptable providers established plans of care and disposition for patients with positive PTSD screens.		

²³ VHA Handbook 1160.03, *Programs for Veterans with Post-Traumatic Stress Disorder (PTSD)*, March 12, 2010, p. 2.

NM	Areas Reviewed (continued)	Findings	Recommendations
	Acceptable providers offered further diagnostic evaluations to patients with positive PTSD screens.		
	Providers completed diagnostic evaluations for patients with positive PTSD screens.		
	Patients received MH treatment when applicable.		

Facility Profile

Table 1 below provides general background information for this facility.

Table 1. Facility Profile Altoona (503) for FY 2016

Profile Element	Facility Data
VISN Number	4
Complexity Level	3-Low complexity
Affiliated/Non-Affiliated	Non-Affiliated
Total Medical Care Budget in Millions	\$139.8
Number of:	
• Unique Patients	26,162
• Outpatient Visits	231,341
• Unique Employees²⁴	496
Type and Number of Operating Beds:	
• Acute	11
• MH	NA
• Community Living Center	40
• Domiciliary	NA
Average Daily Census:	
• Acute	3
• MH	NA
• Community Living Center	39
• 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 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/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
Johnstown, PA	503GA	7,430	4,202	Cardiology Dermatology Endocrinology Hematology/ Oncology Rheumatology Surgery Eye Podiatry	EKG Laboratory & Pathology	Nutrition Pharmacy Social Work Weight Management
DuBois, PA	503GB	8,839	2,837	Dermatology Endocrinology Rheumatology Surgery Eye Podiatry	EKG Laboratory & Pathology	Nutrition Pharmacy Social Work Weight Management
State College, PA	503GC	7,557	2,184	Cardiology Dermatology Endocrinology Neurology Rheumatology Surgery Eye Podiatry	EKG Laboratory & Pathology Radiology	Nutrition Pharmacy Social Work Weight Management
Mapleton Depot, PA	503GD	2,505	355	Dermatology Endocrinology Rheumatology	EKG Laboratory & Pathology	Nutrition Pharmacy Social Work Weight Management

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.

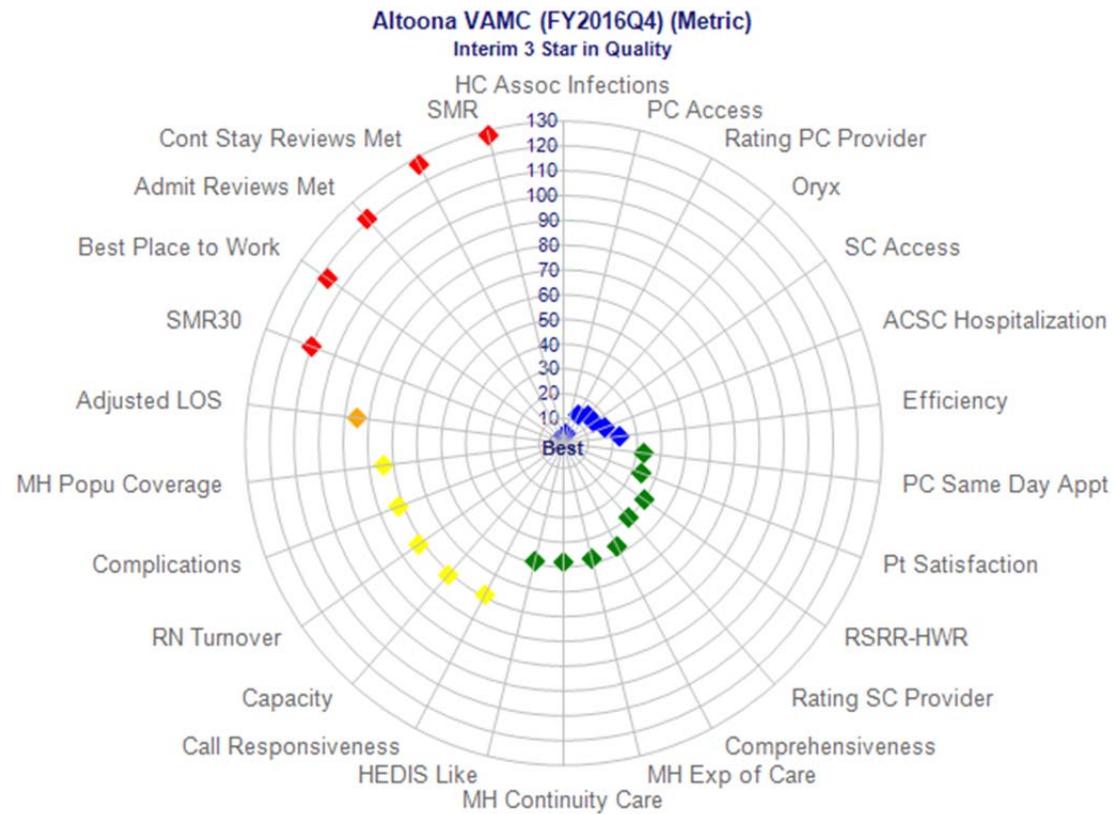
²⁹ Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Indiana, PA	503GE	2,732	619	Dermatology Endocrinology Nephrology Rheumatology	EKG Laboratory & Pathology	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.

Strategic Analytics for Improvement and Learning (SAIL)³⁰



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

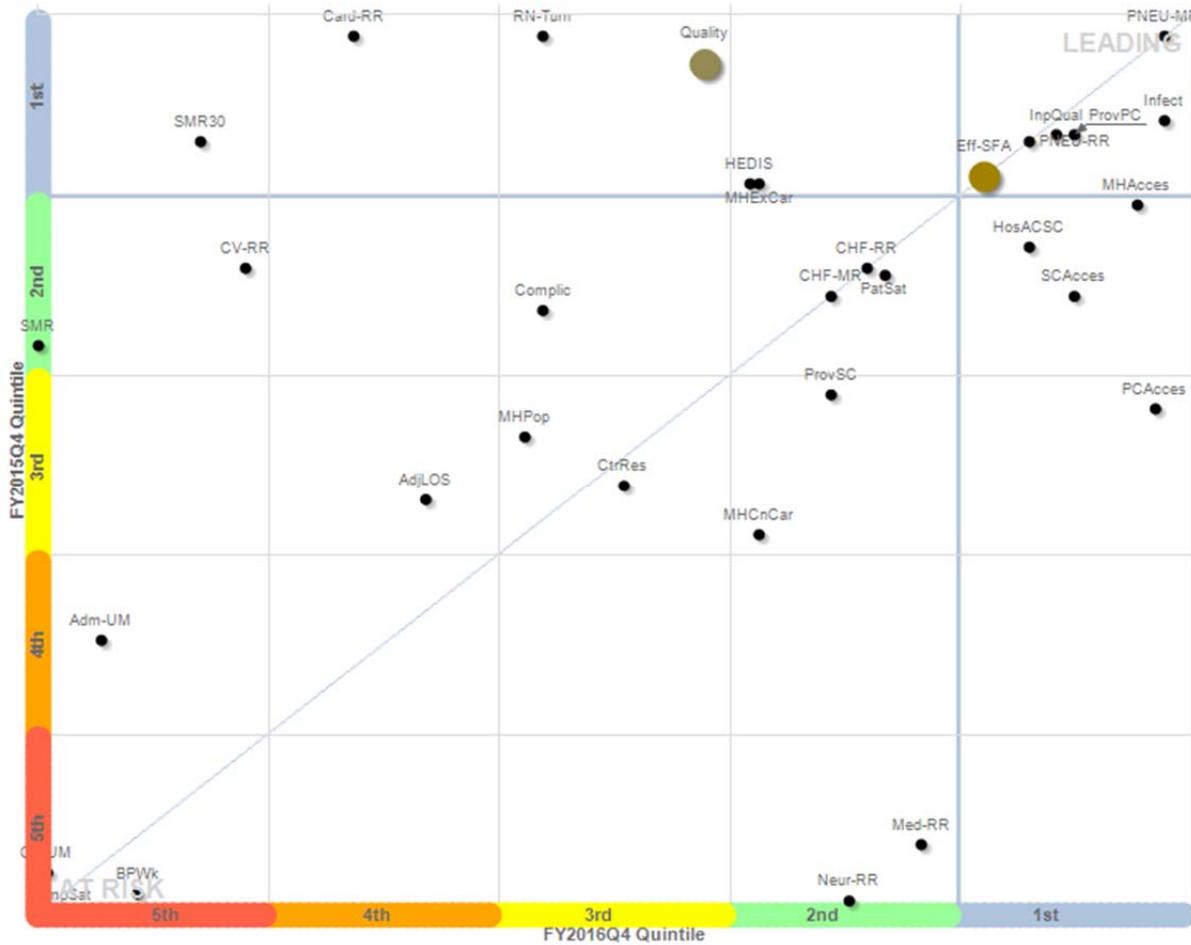
Source: VHA Support Service Center

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

³⁰ Metric definitions follow the graphs.

Scatter Chart

FY2016Q4 Change in Quintiles from FY2015Q4



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

DESIRED DIRECTION ==>

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

Metric Definitionsⁱ

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

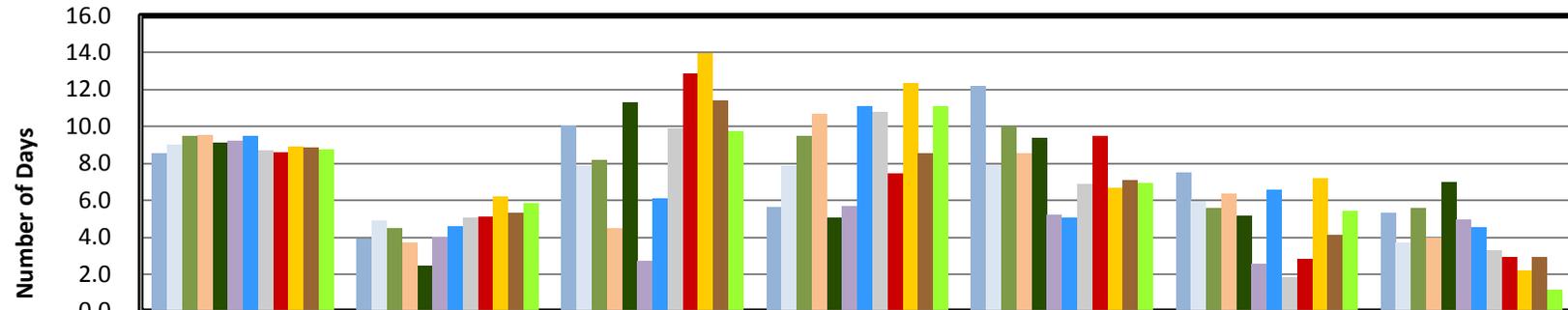
Measure	Definition	Desired Direction
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized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



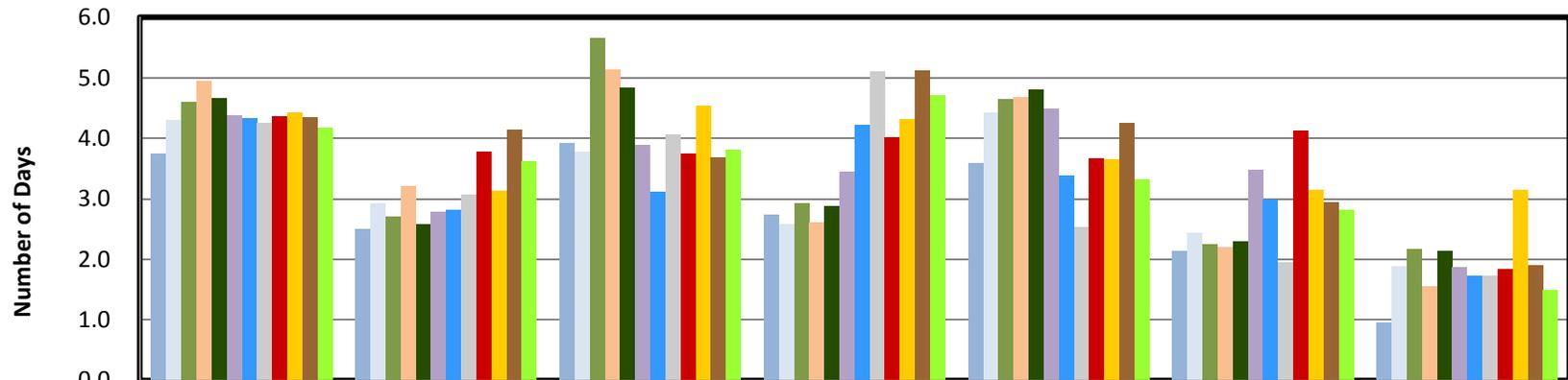
	VHA Total	(503) James E. Van Zandt VAMC	(503GA) Johnstown	(503GB) DuBois (Clearfield)	(503GC) State College (Centre County)	(503GD) Huntingdon County	(503GE) Indiana County
■ OCT-FY16	8.6	3.9	10.1	5.7	12.2	7.5	5.3
■ NOV-FY16	9.1	4.9	7.9	7.9	7.9	5.9	3.7
■ DEC-FY16	9.5	4.5	8.2	9.5	10.0	5.6	5.6
■ JAN-FY16	9.6	3.7	4.5	10.7	8.6	6.4	4.0
■ FEB-FY16	9.1	2.5	11.3	5.1	9.4	5.2	7.0
■ MAR-FY16	9.2	4.0	2.7	5.7	5.2	2.6	5.0
■ APR-FY16	9.5	4.6	6.1	11.1	5.1	6.6	4.6
■ MAY-FY16	8.7	5.1	9.9	10.8	6.9	1.8	3.3
■ JUN-FY16	8.6	5.1	12.9	7.5	9.5	2.8	2.9
■ JUL-FY16	8.9	6.2	14.0	12.3	6.7	7.2	2.2
■ AUG-FY16	8.9	5.4	11.4	8.6	7.1	4.1	3.0
■ SEP-FY16	8.8	5.9	9.7	11.1	6.9	5.4	1.2

Source: VHA Support Service Center

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

Data Definition¹: 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.*

FY 2016 Established PC Patient Average Wait Time in Days



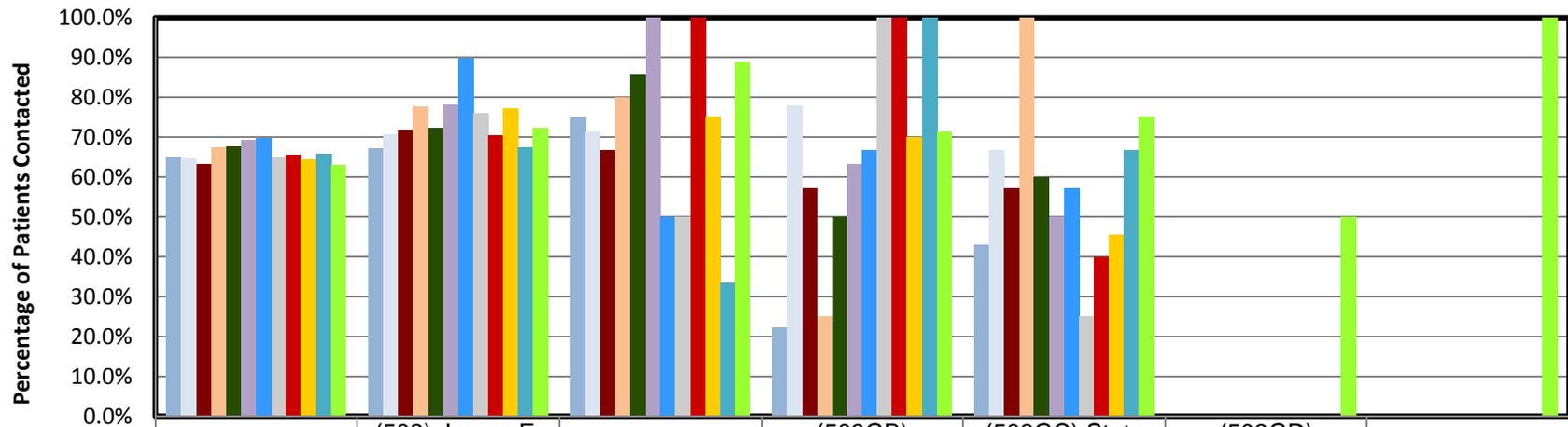
	VHA Total	(503) James E. Van Zandt VAMC	(503GA) Johnstown	(503GB) DuBois (Clearfield)	(503GC) State College (Centre County)	(503GD) Huntingdon County	(503GE) Indiana County
■ OCT-FY16	3.8	2.5	3.9	2.7	3.6	2.1	1.0
■ NOV-FY16	4.3	2.9	3.8	2.6	4.4	2.4	1.9
■ DEC-FY16	4.6	2.7	5.7	2.9	4.6	2.2	2.2
■ JAN-FY16	4.9	3.2	5.1	2.6	4.7	2.2	1.6
■ FEB-FY16	4.7	2.6	4.8	2.9	4.8	2.3	2.1
■ MAR-FY16	4.4	2.8	3.9	3.5	4.5	3.5	1.9
■ APR-FY16	4.3	2.8	3.1	4.2	3.4	3.0	1.7
■ MAY-FY16	4.3	3.1	4.1	5.1	2.5	2.0	1.7
■ JUN-FY16	4.4	3.8	3.8	4.0	3.7	4.1	1.8
■ JUL-FY16	4.4	3.1	4.5	4.3	3.7	3.2	3.2
■ AUG-FY16	4.3	4.1	3.7	5.1	4.3	2.9	1.9
■ SEP-FY16	4.2	3.6	3.8	4.7	3.3	2.8	1.5

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.

FY 2016 Team 2-Day Post Discharge Contact Ratio



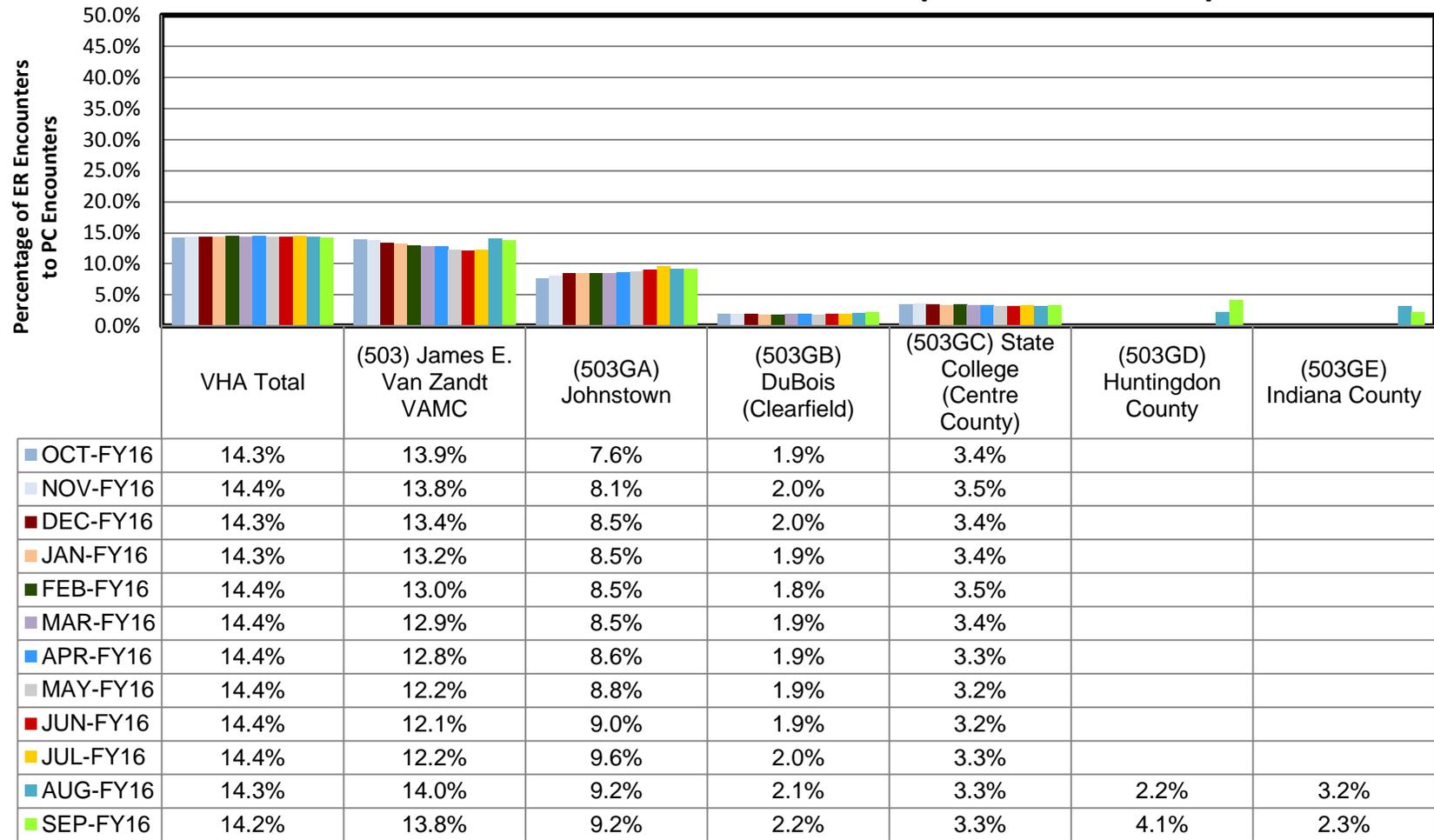
	VHA Total	(503) James E. Van Zandt VAMC	(503GA) Johnstown	(503GB) DuBois (Clearfield)	(503GC) State College (Centre County)	(503GD) Huntingdon County	(503GE) Indiana County
■ OCT-FY16	65.2%	67.3%	75.0%	22.2%	42.9%		
■ NOV-FY16	64.9%	70.7%	71.4%	77.8%	66.7%		
■ DEC-FY16	63.2%	71.7%	66.7%	57.1%	57.1%		
■ JAN-FY16	67.5%	77.6%	80.0%	25.0%	100.0%		
■ FEB-FY16	67.6%	72.2%	85.7%	50.0%	60.0%		
■ MAR-FY16	69.2%	78.1%	100.0%	63.2%	50.0%		
■ APR-FY16	69.7%	89.9%	50.0%	66.7%	57.1%		
■ MAY-FY16	65.0%	76.0%	50.0%	100.0%	25.0%		
■ JUN-FY16	65.5%	70.4%	100.0%	100.0%	40.0%		
■ JUL-FY16	64.3%	77.3%	75.0%	70.0%	45.5%		
■ AUG-FY16	65.7%	67.5%	33.3%	100.0%	66.7%		
■ SEP-FY16	62.9%	72.2%	88.9%	71.4%	75.0%	50.0%	100.0%

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.

FY 2016 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. Blank cells indicate the absence of reported data.

Prior OIG Reports
August 1, 2013 through May 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 – Prevention of Legionnaires’ Disease in VHA Facilities

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

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: June 19, 2017

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

Subject: **CAP Review of the James E. Van Zandt, VA Medical Center,
Altoona, PA**

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

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

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

(original signed by:)
Michael D. Adelman, M.D.

Attachment

Interim Facility Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: June 13, 2017

From: Interim Director, James E. Van Zandt VA Medical Center (503/00)

Subject: **CAP Review of the James E. Van Zandt VA Medical Center,
Altoona, PA**

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

1. I have reviewed and concur with the findings and recommendations in the draft report of the Office of Inspector General Combined Assessment Program Review conducted in the week of March 20, 2017.
2. Corrective action plans have been established with target completion dates, as detailed in the attached report.



Charles R. Thilges
Interim Director

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 the facility consistently take action when data analyses indicated problems or opportunities for improvement and evaluate the actions for effectiveness in peer review and Focused Professional Practice Evaluations and that facility managers monitor compliance.

Concur

Target date for completion: September 30, 2017

Facility response: Peer Review Committee agenda has been modified to include a standing agenda item for discussion of system issues when identified by the initial peer reviewer. Beginning in July, monitoring will begin. The numerator is the number of minutes meeting criteria and the denominator is the total number of minutes reviewed. Goal is 100%. The Peer Review Committee minutes have been modified to include a standing agenda item for documentation of the discussion when there is a level change from the initial peer review. Beginning in July monitoring will begin. The numerator is number of minutes meeting criteria and the denominator is the total number of minutes reviewed. Goal is 100%. The service chief will consistently review the FPPE [Focused Professional Practice Evaluation] data monthly beginning in July, to evaluate for effectiveness, communicate and educate the practitioner, and monitor actions for improvement to ensure compliance with FPPE goals. Numerator is the number of FPPE meeting criteria and the denominator is the total number of FPPE's reviewed. Goal is 100%. This will be reported to Credentialing Committee and Medical Staff Executive Committee.

Recommendation 2. We recommended that the facility Chief of Staff ensure that all required practitioners are designated as members of the medical staff.

Concur

Target date for completion: July 31, 2017

Facility response: The Medical Staff Bylaws will be updated with the March 2017 National Bylaw template to include all required practitioners and Clinical Pharmacists.

Recommendation 3. We recommended that facility managers ensure the access log for the Huntingdon County VA Clinic information technology network room includes all required elements to document access and that facility managers monitor compliance.

Concur

Target date for completion: March 23, 2017 (Completed)

Facility response: On March 23, 2017, the Contracting Officer Representative (COR) provided the Huntingdon Community Based Outpatient Clinic (CBOC) with an Information Technology (IT) log sheet that has all the required elements required to document access. The Regional Manager placed the updated log sheet in the IT Room on March 23, 2017 as requested. The Facility Manager has verified sustained compliance that the correct IT log sheet has remained in place.

Recommendation 4. We recommended that facility managers implement a process to protect personally identifiable information on laboratory specimens at the Huntingdon County VA Clinic and that facility managers monitor compliance.

Concur

Target date for completion: March 22, 2017 (Completed)

Facility response: On March 22, 2017 the process for lab specimens was changed per the OIG recommendation. The patient will no longer place the specimen in the pass through window. The pass through window has been sealed shut by the building maintenance staff and a sign was hung instructing the patient to hand the specimen directly to the Lab Technician. The Facility Manager has verified sustained compliance as the pass through window remains sealed and the process of the patient handing of specimens directly to the Lab Technician remains intact since March 22, 2017. Future sustainment will be evaluated through the ongoing Medical Center's Environment of Care rounds.

Recommendation 5. We recommended that the facility designate a physician anticoagulation program champion.

Concur

Target date for completion: July 1, 2017

Facility response: Primary Care Physician will be appointed as the anticoagulation program champion. This will be evidenced by a memorandum appointing the practitioner.

Recommendation 6. We recommended that the facility collect and report data on patient transfers out of the facility.

Concur

Target date for completion: September 30, 2017

Facility response: Data has been collected on transfers out of the facility and will be reported monthly to the Special Care Units Committee beginning this month (June). Transfers Data has been added as a standing item to the Special Care Units Committee agenda. The numerator is the number of minutes meeting criteria and the denominator is the total number of minutes reviewed. Goal is 100%. Beginning in June, the data will be monitored and submitted to Quality Management Service until 3 consecutive months of data compliance, and then at 6 months and 12 months follow up for sustainment.

Recommendation 7. 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: September 30, 2017

Facility response: The nursing staff (RNs/LPNs) on the Community Living Center and Medical Unit 4 will receive face-to-face education by the respective nurse manager/designee. A training course record will be completed. The training will include the process for completing and reporting point of care testing (AccuCheks) to include review of medical center policies MCM 11L-04 *Ancillary Testing* and MCM 11-18 *Communicating Test Results to Practitioners & Patients*. The target completion date for the staff education is June 30, 2017. Monitoring will be conducted monthly beginning in July 2017. Patient/Nursing Services will report to Quality Management Service monthly until three (3) consecutive months of achievement are received and then at the six (6) month (March 2018) and 12 month (September 2018) intervals to ensure staff are sustaining compliance. There will be two metrics with a goal of 90% compliance. First metric is the number of critical values/AccuChecks completed correctly over the number of critical values/AccuCheck results. The second metric is the number of "Nursing Notification of AccuCheck Results Progress Notes" Completed over the number of "Nursing Notification of AccuCheck Results Progress Notes" Required.

Recommendation 8. We recommended that facility managers ensure the Community Nursing Home Oversight Committee includes representation by all required clinical disciplines.

Concur

Target date for completion: June 30, 2017

Facility response: Contracting Officer was added as a member of the committee as of the meeting held on May 4, 2017. The Chief, Geriatrics & Extended Care is the medical staff representative on the committee. Committee attendance will be monitored. The numerator is the number of meetings attended by the contracting officer and the Chief, Geriatrics & Extended Care and the denominator is the total number of meetings held. Goal is 90%.

Recommendation 9. We recommended that facility managers ensure integration of the community nursing home program into its quality improvement program.

Concur

Target date for completion: October 2017

Facility response: Community Nursing Home Program Integration will be added as a line item and will begin being reported monthly at the Long Term Care Committee in June 2016. Minutes of the June Long Term Care Committee will be reviewed and discussed at the Clinical Management Committee in July 2017. July 2017 minutes of the Clinical Management Committee will be reviewed and discussed at the Leadership Staff Council in August 2017. Future sustainment will be evaluated monthly through review of Clinical Management Committee minutes at Leadership Staff Council. Data monitoring will be submitted to Quality Management Service until there is three consecutive months of compliance. Then data will be submitted to Quality Management Service at six months and twelve months to show sustainment.

Recommendation 10. 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 that facility managers monitor compliance.

Concur

Target date for completion: September 30, 2017

Facility response: Positions have been approved for a dedicated LCSW Contract Nursing Home Coordinator and a registered nurse. Recruitment is pending for these positions. Monthly monitoring will occur to ensure visits are conducted within the required frequency. The numerator is the number of visits conducted within the required frequency and the denominator is the number of Veterans in the program. This will be reported to the Long Term Care (LTC) Committee beginning in June. The LTC committee reports through the committee structure to the Clinical Management Committee and Leadership Staff Council. The goal is 90%. Data will be monitored and submitted to Quality Management Service until 3 consecutive months of data compliance, and then at 6 months and 12 months follow up for sustainment.

Recommendation 11. We recommended that a VA physician order or approve all therapies that are at VA expense.

Concur

Target date for completion: September 30, 2017

Facility response: The physician has begun entering orders for therapy and a template is in place for the physician's orders. The LCSW was educated on the process and will not enter orders for therapy. Beginning in July, data will be reported to the Long Term Care Committee. The numerator is the number of orders written by a physician and the denominator is the total number of orders written. Goal is 100%. Data will be monitored and submitted to Quality Management Service until 3 consecutive months of data compliance, and then at 6 months and 12 months follow up for sustainment.

Recommendation 12. 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.

Concur

Target date for completion: February 1, 2018

Facility response: The occupational health physician will work with Education Service to ensure that Level 1 training is completed during the New Employee Orientation (NEO). The occupational health physician will work with all services to ensure employees in Low and Moderate Risk (Level II and III respectively) received the training within 90 days. This will be achieved by increasing the number of trainers (expanded from 5 to 13 trainers in the past 3 months), achieving a diverse trainer population (trainers now include Nurses and Supervisor), training 2nd and 3rd tour staff by collaborating with the Chief of Acute and Extended Care, and training CBOC staff (currently have 2 trainers at the CBOC's). The following are the measurable goals. By October 1, 2017, 100% of all new employees will have Level I within the 1st week of employment. By November 1, 2017, 100% of "Low Risk" (Level II) new employees will have the required training scheduled. By November 1, 2017, 100% of "Moderate Risk" (Level III) new employees will have required training scheduled. By December 1, 2017, 100% of incumbent "Low" and "Moderate Risk" will have the training completed. Full compliance by February 1, 2018.

OIG Contact and Staff Acknowledgments

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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 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).

^g 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.

^h The references used for PTSD Care included:

- VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.
- VHA Handbook 1160.03, *Programs for Veterans with Post-Traumatic Stress Disorder (PTSD)*, March 12, 2010.
- VA Memorandum, *Information Bulletin: Clarification of Posttraumatic Stress Disorder Screening Requirements*, August 2015.
- *VA/DoD Clinical Practice Guideline for Management of Post-Traumatic Stress*, Version 2.0, October 2010.
- *VHA Technical Manual – PTSD*, VA Measurement Manual PTSD-51.

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: December 19, 2016.