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**Clinical Assessment Program
Review of the
Atlanta VA Medical Center
Decatur, Georgia**

June 8, 2017

Washington, DC 20420

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Glossary

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

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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 Atlanta VA Medical Center. We reviewed clinical and administrative processes that affect patient care outcomes—Quality, Safety, and Value; Environment of Care; Medication Management; Coordination of Care; Diagnostic Care; Moderate Sedation; Community Nursing Home Oversight; Management of Disruptive/Violent Behavior; and the Mental Health Residential Rehabilitation Treatment Program. We also followed up on recommendations from the previous Combined Assessment Program and Community Based Outpatient Clinic and Primary Care Clinic reviews and provided crime awareness briefings.

Results: We conducted the review during the week of January 23, 2017, and identified certain system weaknesses in credentialing and privileging, peer review, utilization management, Environment of Care Committee documentation, general safety, environmental cleanliness, anticoagulation policies and processes, transfer documentation, point-of-care testing, processes and training related to the management of disruptive or violent behavior, pressure ulcer management, and care for patients with a positive alcohol screen.

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

1. Clinical managers effectively monitor the professional competency of providers, peer reviewers assess important aspects of care, and physician advisors' input is considered when making utilization management decisions.
2. Facility leaders address environmental deficiencies and maintain a clean and safe environment in patient care areas.
3. The facility has a comprehensive anticoagulation therapy management program.
4. Clinicians always safely transfer patients from the facility.
5. Glucometers are always clean.
6. The facility has an effective program to prevent and manage disruptive/violent behavior.
7. Facility leadership implemented and maintained processes to ensure care for patients with pressure ulcers and positive alcohol screens.

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

Quality, Safety, and Value – Ensure that:

- Clinical managers consistently review Ongoing Professional Practice Evaluation data semi-annually.
- Peer reviewers consistently document their evaluation of at least one of the important aspects of care such as appropriate and timely ordering of diagnostic tests, timely treatment, and appropriate documentation.
- Physician Utilization Management Advisors consistently document their decisions in the National Utilization Management Integration database.

Environment of Care – Ensure that:

- Environment of Care Committee meeting minutes document discussion of environment of care deficiencies, include actions taken to address deficiencies, and track actions taken to closure.
- Information technology network room logs contain all required information to document visitors' access.
- Ventilation grills and floors in patient care areas are clean.
- Damaged furniture in patient care areas is repaired or removed from service.
- Ice machines in patient nourishment kitchens are clean.

Medication Management: Anticoagulation Therapy – Ensure that:

- The facility develops and implements a policy that addresses anticoagulation management.
- The facility designates a physician anticoagulation program champion.
- Clinicians consistently provide specific education to patients with newly prescribed anticoagulant medications.

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

- Providers complete transfer documentation for patients transferred out of the facility.
- Providers consistently include documentation of patient or surrogate informed consent in transfer documentation.
- Transfer notes written by acceptable designees document staff/attending physician approval and contain a staff/attending physician countersignature.

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

- Glucometers are clean before and after use.

Management of Disruptive/Violent Behavior – Ensure that:

- The facility implements an Employee Threat Assessment Team or an alternate group that addresses employee-related disruptive behavior.
- The Patient Safety Manager and/or Risk Manager and Patient Advocate consistently attend Disruptive Behavior Committee meetings.
- Clinicians inform patients about the Patient Record Flags and the right to request to amend/appeal flag placement.
- 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.

We also made the following repeat recommendations from the previous Combined Assessment Program and Community Based Outpatient Clinic and Primary Care Clinic reviews.

Pressure Ulcer Prevention and Management – Ensure that:

- All patients discharged with pressure ulcers have wound care follow-up plans and receive dressing supplies prior to being discharged.

Alcohol Use Disorder – Ensure that:

- Employees consistently complete diagnostic assessments for patients with a positive alcohol screen.

Comments

The Acting 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 43–51, for the full text of the Directors' comments.) The facility considers recommendations 2, 3, 7, 9, 10, 12–14, and 17–19 completed; however, we consider all recommendations open until we receive and review written documentation of the facility's completion of the proposed actions.



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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.

We also evaluated the high-risk processes of Moderate Sedation, CNH Oversight, Management of Disruptive/Violent Behavior, and MH RRTP. We followed up with facility managers 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

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

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

Environment of Care

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

The physical environment shapes every patient experience and all health care delivery, including those episodes of care that result in patient harm. Three patient safety areas are markedly influenced by the environment—healthcare-associated infections, medication safety, and falls. Because healthcare-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 healthcare settings. Medication safety is markedly influenced by physical environmental conditions, including lighting and workspace organization. Environmental features, such as the placement of

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).

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 being treated, 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 safe 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 testing at the point of care 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 showing 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. Of all of their responsibilities, one of the most important is 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 adverse events involving moderate sedation, 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.

MH RRTPs provide 24-hour residential rehabilitative and clinical care in a therapeutic setting to eligible veterans who have multiple and severe medical conditions, mental illness, addiction, or psychosocial deficits. They provide the least intensive level of VA inpatient care and differ from acute inpatient and nursing home beds as veterans in MH RRTPs are generally capable of self-care. MH RRTPs address rehabilitation, recovery, health maintenance, improved quality of life, and community integration in addition to specifically treating medical conditions, mental illnesses, and addictive disorders. Facility leaders must provide a safe, well-maintained, and appropriately-furnished residential environment that supports and enhances recovery efforts.¹⁹

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.

¹⁹ VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010.

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. Our 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

We also evaluated four additional processes because of their inherent risks and potential vulnerabilities.

- Moderate Sedation
- Community Nursing Home Oversight
- Management of Disruptive/Violent Behavior
- Mental Health Residential Rehabilitation Treatment Program

We list the review criteria for each process in the topic checklists.

The review covered operations for FY 2015, FY 2016, and FY 2017 through January 27, 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 Atlanta VA Medical Center, Decatur, Georgia*, Report No. 13-03653-91, March 12, 2014) and CBOC report (*Community Based Outpatient Clinic and Primary Care Clinic Reviews at Atlanta VA Medical Center, Decatur, Georgia*, Report No. 13-03419-90, March 17, 2014). We made repeat recommendations in Pressure Ulcer Prevention and Management and Alcohol Use Disorder. (See page 30.)

We presented crime awareness briefings for 344 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 508 responses. We shared summarized results with facility managers.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough for OIG to monitor until the facility implements corrective actions. Issues and concerns outside the scope of this CAP review came to our attention, and we referred them for further review separate from this report.

Reported Accomplishments

Magnet Recognition Program®

On October 20, 2015, the facility received Magnet Recognition Program® redesignation for excellence in nursing service from the American Nurses Credentialing Center. The facility is one of four VA medical centers currently recognized as a Magnet facility and one of six Georgia hospitals, a status that is held by less than 7 percent of health care organizations in the United States and is the gold standard for nursing excellence.

Pilot Site for VA Center for Innovation

The facility was selected as one of eight pilot sites for the VA Center for Innovation to establish a VA Innovators Network that empowers front line employees to innovate. Facility employees submitted 36 applications to be considered to receive Spark-Seed-Spread Innovation grant funding to apply towards their innovation ideas. Eight employee projects were selected for national grant funding. In addition, 30 employees attended the Office of Personnel Management Innovation Lab's Human-Centered Design training in February 2016. Two of the funded projects, Technology-Based Eye Care Screening and Care in the Community Tool, have been recognized as providing a return on investment that exceeds the entire cost of the Innovators Network Program and eight pilot sites for FY 2016. The facility has been nationally recognized for four innovations—Technology-Based Eye Care Services, The Ambassador Program, the Non-VA Care Coordination Tool, and Consult Tracking in the Computerized Patient Record System (CPRS). Facility employees also participated in a Georgia Institute of Technology pitch workshop in October 2016. During the workshop, facility employees proposed a project to improve operating room logistics, which was accepted by the Industrial Design Department of Georgia Institute of Technology for a semester long masters-level class. The facility has received a second year of funding as a pilot site to cover the Innovations Specialist position and access to grant funding for a second year.

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
X	<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. 	<ul style="list-style-type: none"> • Six profiles did not contain evidence that clinical managers reviewed Ongoing Professional Practice Evaluation data semi-annually. 	<p>1. We recommended that facility clinical managers consistently review Ongoing Professional Practice Evaluation data semi-annually and that facility managers monitor compliance.</p>
X	<p>Protected peer reviews met selected requirements:</p> <ul style="list-style-type: none"> • Peer reviewers documented their evaluation 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 three cases, peer reviewers did not document their evaluation of at least one of the important aspects of care, such as appropriate and timely ordering of diagnostic tests, timely treatment, and appropriate documentation. 	<p>2. We recommended that facility clinical managers ensure peer reviewers consistently document their evaluation of at least one of the important aspects of care and that facility managers monitor compliance.</p>

NM	Areas Reviewed (continued)	Findings	Recommendations
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 236 of the 772 cases (31 percent) referred to Physician Utilization Management Advisors from November 23, 2016 to January 23, 2017, lacked evidence that advisors documented their decisions in the National Utilization Management Integration database. This resulted in less data for the facility to use to set benchmarks; identify trends, actions, and opportunities to improve efficiency; and monitor outcomes. 	<p>3. 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>
	<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. 		
	<p>Overall, if QSV reviews identified significant issues, the facility took actions and evaluated them for effectiveness.</p>		
	<p>Overall, senior managers actively participated in QSV activities.</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. We also determined whether the facility met selected requirements in SPS and the hemodialysis unit.^b

VHA must manage environmental hazards in order to promote a safe, functional, and supportive healthcare environment. Further, VHA must establish a systematic infection prevention and control program to reduce the risk of patients and/or healthcare providers 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, inpatient areas (7th floor medicine, 8th floor medicine, surgery, MH, the medical intensive care unit, the surgical intensive care unit, PC (Gold Clinic), specialty care (surgical), SPS, the hemodialysis unit, and the Newnan CBOC. Additionally, we reviewed relevant documents and 20 employee training records, and we interviewed key employees and managers. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement.

Checklist 2. EOC Areas Reviewed, Findings, and Recommendations

NM	Areas Reviewed for General EOC	Findings	Recommendations
X	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure for the facility and the CBOCs.	Six months of EOC Committee meeting minutes reviewed: <ul style="list-style-type: none"> • Minutes did not include consistent discussion of EOC rounds deficiencies. • Minutes did not include corrective actions taken to address rounds deficiencies or track corrective actions to closure. 	4. We recommended that Environment of Care Committee meeting minutes document discussion of environment of care rounds deficiencies, include corrective actions taken to address rounds deficiencies, and track actions taken in response to identified deficiencies to closure.

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
	The facility conducted an infection prevention risk assessment.		
	Infection Prevention/Control Committee minutes documented discussion of identified high-risk areas, actions implemented to address those areas, and follow-up on implemented actions and included analysis of surveillance activities and data.		
	The facility had established a 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"> • In nine patient care areas, information technology network room logs did not contain all required information to document access. 	<p>5. We recommended that facility managers ensure information technology network room logs for visitors contain all required information to document access and monitor compliance.</p>
X	The facility met environmental cleanliness requirements.	<ul style="list-style-type: none"> • In 4 of 11 patient care areas, ventilation grills were dirty. • In 7 of 11 patient care areas, floors were dirty. • Seven of 11 patient care areas contained damaged furniture. • In five of nine applicable patient care areas, ice machines in patient nourishment kitchens were not clean. 	<p>6. We recommended that facility managers ensure ventilation grills and floors in patient care areas are clean and monitor compliance.</p> <p>7. We recommended that the facility repair damaged furniture in patient care areas or remove it from service.</p> <p>8. We recommended that facility managers ensure ice machines in patient nourishment kitchens are clean and monitor compliance.</p>

NM	Areas Reviewed for SPS	Findings	Recommendations
	The facility had a policy for cleaning, disinfecting, and sterilizing RME.		
	The facility's standard operating procedures for selected RME were current and consistent with the manufacturers' instructions for use.		
	The facility performed quality control testing on selected RME with the frequency required by local policy and took appropriate action on positive results.		
	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 		
X	The facility met infection prevention requirements in SPS areas.	<ul style="list-style-type: none"> • The medivator room floor was dirty. 	See recommendation 6.
	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.		

NM	Areas Reviewed for the Hemodialysis Unit	Findings	Recommendations
	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 on the hemodialysis unit.		
	The facility met infection prevention requirements on the hemodialysis unit.		
	The facility met medication safety and security requirements on the hemodialysis unit.		
	The facility met privacy requirements on the hemodialysis unit.		

Medication Management: Anticoagulation Therapy

The purpose of this review was to determine whether facility clinicians appropriately managed and provided education to patients with new orders for anticoagulant medication.^c During 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 10 employees actively involved in the anticoagulant program, and we interviewed key employees. Additionally, we reviewed the EHRs of 28 randomly selected patients who were prescribed new anticoagulant medications from July 1, 2015 through June 30, 2016. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement.

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

NM	Areas Reviewed	Findings	Recommendations
X	The facility had policies and processes for anticoagulation management that included required content.	<ul style="list-style-type: none"> The facility did not have a policy that addressed anticoagulation management. 	9. We recommended that the facility develop and implement a policy that addresses anticoagulation management.
	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. 	10. We recommended that the facility designate a physician anticoagulation program champion.
	The facility defined ways to minimize the risk of incorrect tablet strength dosing errors.		
	The facility routinely reviewed quality assurance data for the anticoagulation management program at the facility's required frequency at an appropriate committee.		
X	For inpatients with newly prescribed anticoagulant medications, clinicians provided transition follow-up and education specific to the new anticoagulant.	<ul style="list-style-type: none"> Three of the 28 EHRs did not contain evidence that patients received education specific to the newly prescribed anticoagulant. 	11. We recommended that clinicians consistently provide specific education to patients with newly prescribed anticoagulant medications and that facility managers monitor compliance.
	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 43 randomly selected patients who were transferred acutely out of facility inpatient beds or the Emergency Department/urgent care center to another VHA facility or non-VA facility from July 1, 2015 through June 30, 2016. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement.

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

NM	Areas Reviewed	Findings	Recommendations
	The facility had a policy that addressed patient transfers and included required content.		
	The facility collected and reported data about transfers out of the facility.		
X	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 	<ul style="list-style-type: none"> • Transferring providers did not complete a VA Form 10-2649A or transfer/progress note in 23 of the 43 EHRs (53 percent). • Provider transfer documentation did not include documentation of patient or surrogate informed consent in 9 of 29 EHRs. 	<p>12. We recommended that providers complete transfer documentation for patients transferred out of the facility and that facility managers monitor compliance.</p> <p>13. We recommended that for patients transferred out of the facility, providers consistently include documentation of patient or surrogate informed consent in transfer documentation and that facility managers monitor compliance.</p>

NM	Areas Reviewed (continued)	Findings	Recommendations
X	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 	<ul style="list-style-type: none"> • In two of the five applicable EHRs, transfer notes written by acceptable designees did not document staff/attending physician approval or contain a staff/attending physician countersignature. 	14. We recommended that facility managers ensure transfer notes written by acceptable designees document staff/attending physician approval and contain a staff/attending physician countersignature and monitor compliance.
	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, sophisticated blood and stool testing has moved 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.²¹

We reviewed relevant documents, the EHRs of 49 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 42 clinicians who performed the glucose testing. Additionally, we interviewed key employees and conducted onsite glucometer inspections of the Emergency Department, 7th floor medicine, surgery, specialty care (surgical), and the Newnan CBOC 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.		

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 Chief of Pathology and Laboratory Medicine Service approved all tests performed outside the main laboratory.		
	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.		
	Clinicians initiated appropriate clinical action and follow-up for test results.		
	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.		
X	Glucometers were clean.	<ul style="list-style-type: none"> We found dirty glucometers in two of five areas. 	15. We recommended that employees ensure glucometers are clean before and after use and that clinical managers monitor compliance.

Moderate Sedation

The purpose of this review was to evaluate selected aspects of care to determine whether the facility complied with applicable policies in the provision of moderate sedation.^f During calendar year 2016, VHA clinicians performed more than 600,000 moderate sedation procedures of which more than half were gastroenterology-related endoscopies.²² 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.²³ 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 38 randomly selected patients who underwent an invasive procedure involving moderate sedation from 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.		

²² Per VA Corporate Data Warehouse data pull on February 22, 2017.

²³ American Society of Anesthesiologists. Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists. *Anesthesiology*. 2002; 96:1004.

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

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

Community Nursing Home Oversight

The purpose of this review was to assess whether the facility complied with applicable requirements regarding the monitoring of veterans in contracted CNHs.⁹ Since 1965, VHA has provided nursing home care under contracts with private institutions. 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.²⁴ Local oversight of CNHs is achieved through annual reviews and monthly visits.

We reviewed relevant documents, the EHRs of 40 randomly selected 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.		

²⁴ 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 reflects 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 44 randomly selected 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 October 1, 2015 through September 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 or acceptable alternate group. • The Patient Safety Manager and/or Risk Manager did not attend any Disruptive Behavior Committee meetings, and the Patient Advocate only attended 2 of 11 meetings. 	<p>16. We recommended that the facility implement an Employee Threat Assessment Team or an alternate group that addresses employee-related disruptive behavior.</p> <p>17. We recommended that the Patient Safety Manager and/or Risk Manager and Patient Advocate consistently attend Disruptive Behavior Committee meetings.</p>
	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
X	<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 	<ul style="list-style-type: none"> • None of the applicable 11 EHRs contained evidence that clinicians informed the patients about the Patient Record Flags and the right to request to amend/appeal Patient Record Flag placement. 	<p>18. We recommended that facility clinical managers ensure clinicians inform patients about the Patient Record Flags and the right to request to amend/appeal Patient Record Flag placement.</p>
	<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"> • Eight employee training records (27 percent) did not contain documentation of Level 1 training within 90 days of hire. • Nine employee training records (30 percent) did not contain documentation of the training required for their assigned risk area within 90 days of hire. 	<p>19. We recommended that facility managers ensure all employees receive Level 1 Prevention and Management of Disruptive Behavior training and additional training as required for their assigned risk area within 90 days of hire and that the training is documented in employee training records.</p>

Mental Health Residential Rehabilitation Treatment Program

The purpose of this review was to determine whether the facility’s MH RRTPs (more commonly referred to as domiciliary or residential treatment programs) complied with selected EOC requirements. The Domiciliary Care for Homeless Veterans Program was established through legislation in the late 1860s with the purpose of providing a home for disabled volunteer soldiers of the Civil War. In 1995, VA established the Psychosocial RRTP bed level of care. This distinct level of MH residential care is appropriate for veterans with mental illnesses or addictive disorders who require structure and support to address psychosocial deficits, including homelessness and unemployment. In 2005, the Domiciliary RRTP became fully integrated with other RRTPs of the Office of MH Services.ⁱ

We reviewed relevant documents, inspected the Fort McPherson Program, and interviewed key employees. The table below shows the areas reviewed for this topic. The facility generally met requirements. We made no recommendations.

Checklist 9. MH RRTP Areas Reviewed, Findings, and Recommendations

NM	Areas Reviewed	Findings	Recommendations
	The residential environment was clean and in good repair.		
	Appropriate fire extinguishers were available near grease producing cooking devices.		
	There were policies/procedures that addressed safe medication management and contraband detection.		
	MH RRTP employees conducted and documented monthly self-inspections that included all required elements, submitted work orders for items needing repair, and ensured correction of any identified deficiencies.		
	MH RRTP employees conducted and documented contraband inspections, rounds of all public spaces, daily bed checks, and resident room inspections for unsecured medications.		
	The MH RRTP had written agreements in place acknowledging resident responsibility for medication security.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	The MH RRTP main point(s) of entry had keyless entry and closed circuit television monitoring, and all other doors were locked to the outside and alarmed.		
	The MH RRTP had closed circuit television monitors with recording capability in public areas but not in treatment areas or private spaces and had signage alerting veterans and visitors of recording.		
	There was a process for responding to behavioral health and medical emergencies, and MH RRTP employees could articulate the process.		
	In mixed gender MH RRTP units, women veterans' rooms had keyless entry or door locks.		
	Residents secured medications in their rooms.		

Review Activities with Previous Combined Assessment Program and Community Based Outpatient Clinic and Primary Care Clinic Review Recommendations

Pressure Ulcer Prevention and Management

As a follow-up to a recommendation from our prior Combined Assessment Program review, we reassessed facility compliance with wound care follow-up plans and dressing supplies for patients with hospital-acquired pressure ulcers.^j

Hospital-Acquired Pressure Ulcers. The Joint Commission requires that prior to discharge, the facility arrange or assist in arranging the services required by the patient after discharge in order to meet his or her ongoing needs for care and services. During our previous Combined Assessment Program review, we found that EHRs did not contain evidence of wound care follow-up plans at discharge or evidence of patient receipt of dressing supplies prior to discharge. During this review, we looked at FY 2016 pressure ulcer data supplied by the facility. We found 45 percent compliance with wound care follow-up plans and dressing supplies ordered at discharge.

Recommendation

20. We recommended that facility clinical managers ensure that all patients discharged with pressure ulcers have wound care follow-up plans and receive dressing supplies prior to being discharged and that facility managers monitor compliance.

Alcohol Use Disorder

As a follow-up to a recommendation from our prior CBOC and PC Clinic reviews, we reassessed facility compliance with diagnostic assessments for patients with positive alcohol screens.^k

Diagnostic Assessments. VHA requires that patients with a positive alcohol screen receive a diagnostic assessment. During our previous CBOC and PC Clinic reviews we found that employees did not complete diagnostic assessments for patients who had positive alcohol use screens. During this review, we looked at FY 2016 Brief Alcohol Counseling data supplied by the facility. We found 59 percent compliance with diagnostic assessments for patients with a positive alcohol screen.

Recommendation

21. We recommended that employees consistently complete diagnostic assessments for patients with a positive alcohol screen and that facility managers monitor compliance.

Facility Profile

Table 1 below provides general background information for this facility.

Table 1. Facility Profile for Decatur (508) for FY 2016

Profile Element	Facility Data
Veterans Integrated Service Network Number	7
Complexity Level	1a-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	\$798.2
Number of:	
• Unique Patients	109,077
• Outpatient Visits	1,377,353
• Unique Employees²⁵	3,942
Type and Number of Operating Beds:	
• Acute	152
• MH	40
• Community Living Center	107
• Domiciliary	61
Average Daily Census:	
• Acute	94
• MH	31
• Community Living Center	90
• Domiciliary	33

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.

²⁵ Unique employees involved in direct medical care (cost center 8200).

VA Outpatient Clinic Profiles²⁶

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/Encounters²⁷ and Specialty Care, Diagnostic, and Ancillary Services Provided for FY 2016

Location	Station No.	PC Workload/Encounters	MH Workload/Encounters	Specialty Care Services ²⁸ Provided	Diagnostic Services ²⁹ Provided	Ancillary Services ³⁰ Provided
Atlanta, GA	508GA	21,124	12,303	Dermatology Infectious Disease Nephrology Anesthesia Vascular	NA	Nutrition Dental Pharmacy Weight Management
Flowery Branch, GA	508GE	14,950	8,418	Dermatology Neurology Rheumatology Poly-Trauma Podiatry Vascular Eye	NA	Nutrition Dental Pharmacy
Austell, GA	508GF	14,791	7,492	Dermatology	NA	Nutrition Pharmacy
Stockbridge, GA	508GG	12,944	6,168	Dermatology Gastroenterology Vascular	NA	Nutrition Pharmacy Weight Management
Lawrenceville, GA	508GH	14,968	7,332	Dermatology Infectious Disease Vascular Eye	NA	Nutrition Pharmacy Weight Management
Newnan, GA	508GI	12,409	5,052	Dermatology Vascular Eye	NA	Nutrition Pharmacy Weight Management

²⁶ Includes all outpatient clinics in the community that were in operation before February 15, 2016. We have omitted Rome, GA (508GL); East Point, GA (508QB); Atlanta, GA (508QC); East Point, GA (508QD); and Lawrenceville, GA (508QE), as no workload/encounters or services were reported.

²⁷ An encounter is a professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition.

²⁸ Specialty care services refer to non-primary care and non-MH services provided by a physician.

²⁹ Diagnostic services include EKG, EMG, laboratory, nuclear medicine, radiology, and vascular lab services.

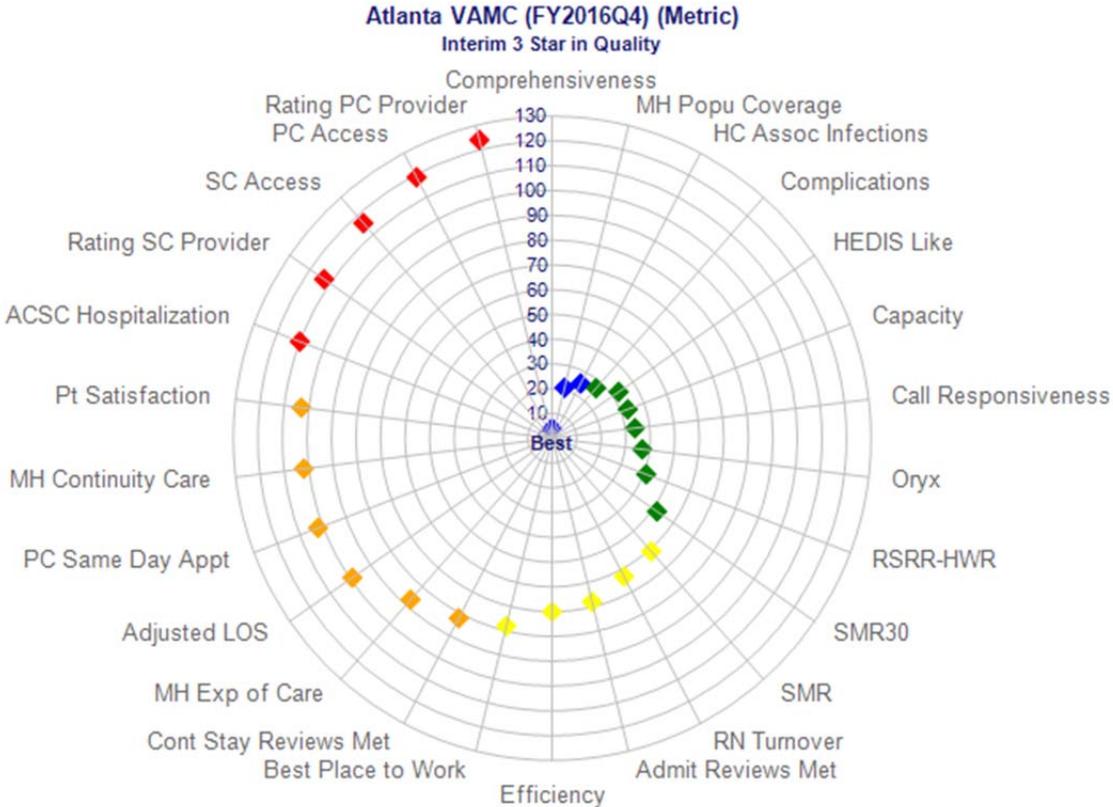
³⁰ Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Blairsville, GA	508GJ	6,344	3,312	Dermatology Hematology/ Oncology Infectious Disease Neurology Vascular Eye	NA	Nutrition Pharmacy Weight Management
Carrollton, GA	508GK	9,152	5,581	Dermatology Endocrinology Infectious Disease Orthopedics Podiatry Vascular Eye	NA	Nutrition Dental Pharmacy Weight Management Social Work
Decatur, GA	508QF	32,860	19,426	Dermatology Rheumatology Poly-Trauma Anesthesia	NA	Nutrition Dental Pharmacy

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)³¹



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

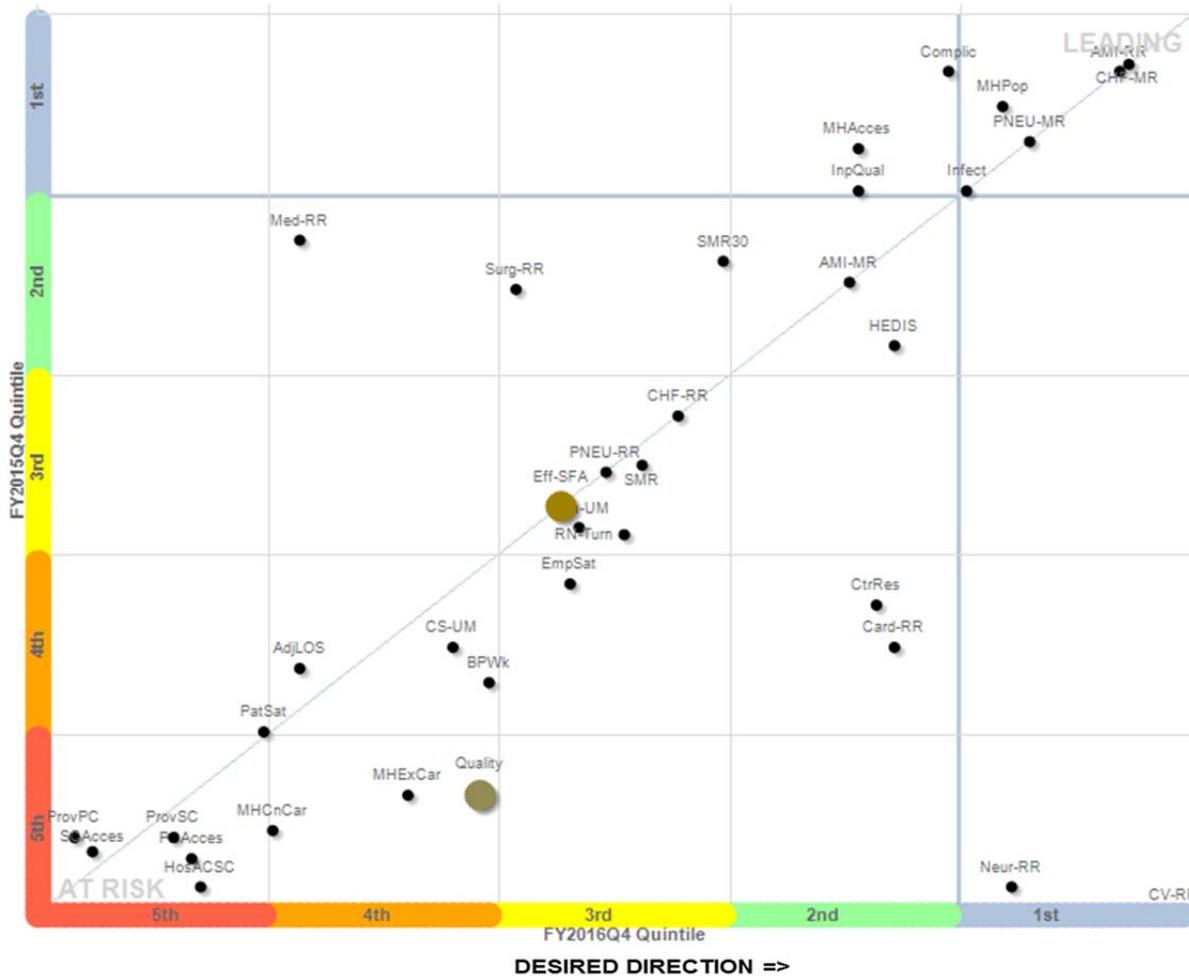
Source: VHA Support Service Center

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

³¹ 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.

DESIRED DIRECTION ==>

Source: VHA Support Service Center

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

Metric Definitions¹

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

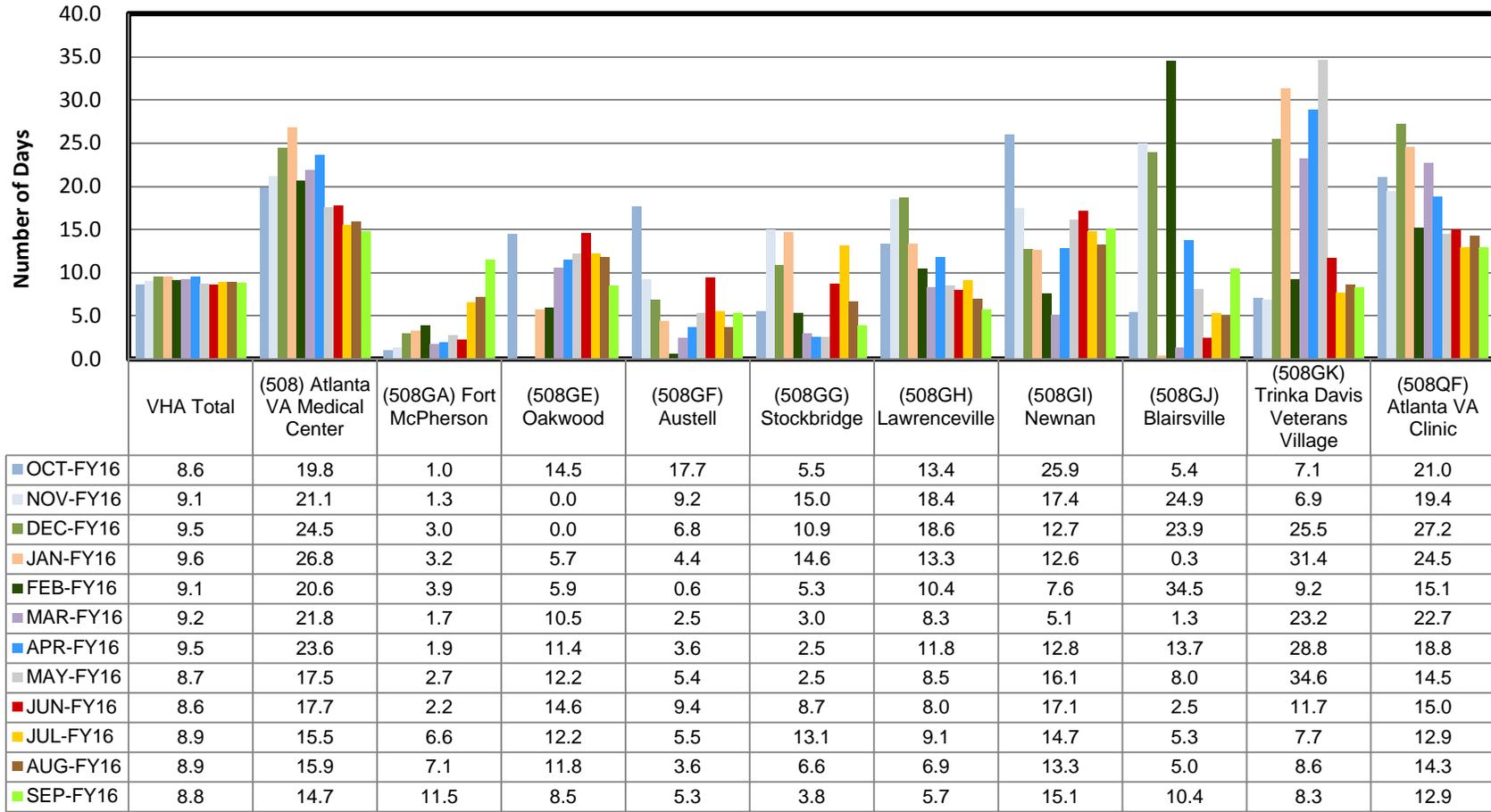
Measure	Definition	Desired Direction
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized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

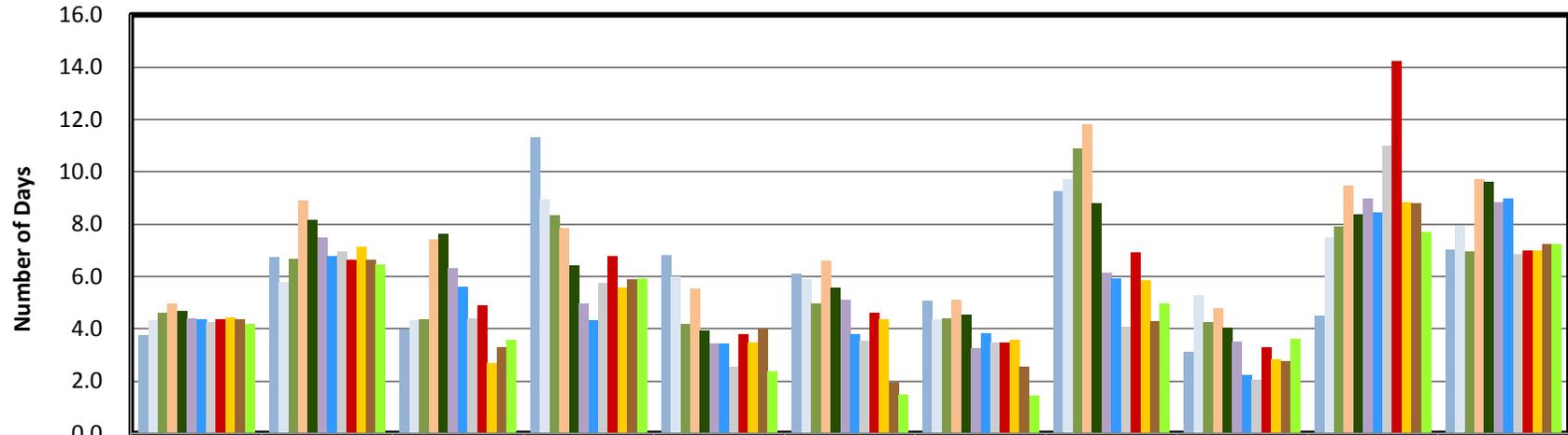


Source: VHA Support Service Center

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

Data Definition^m: 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



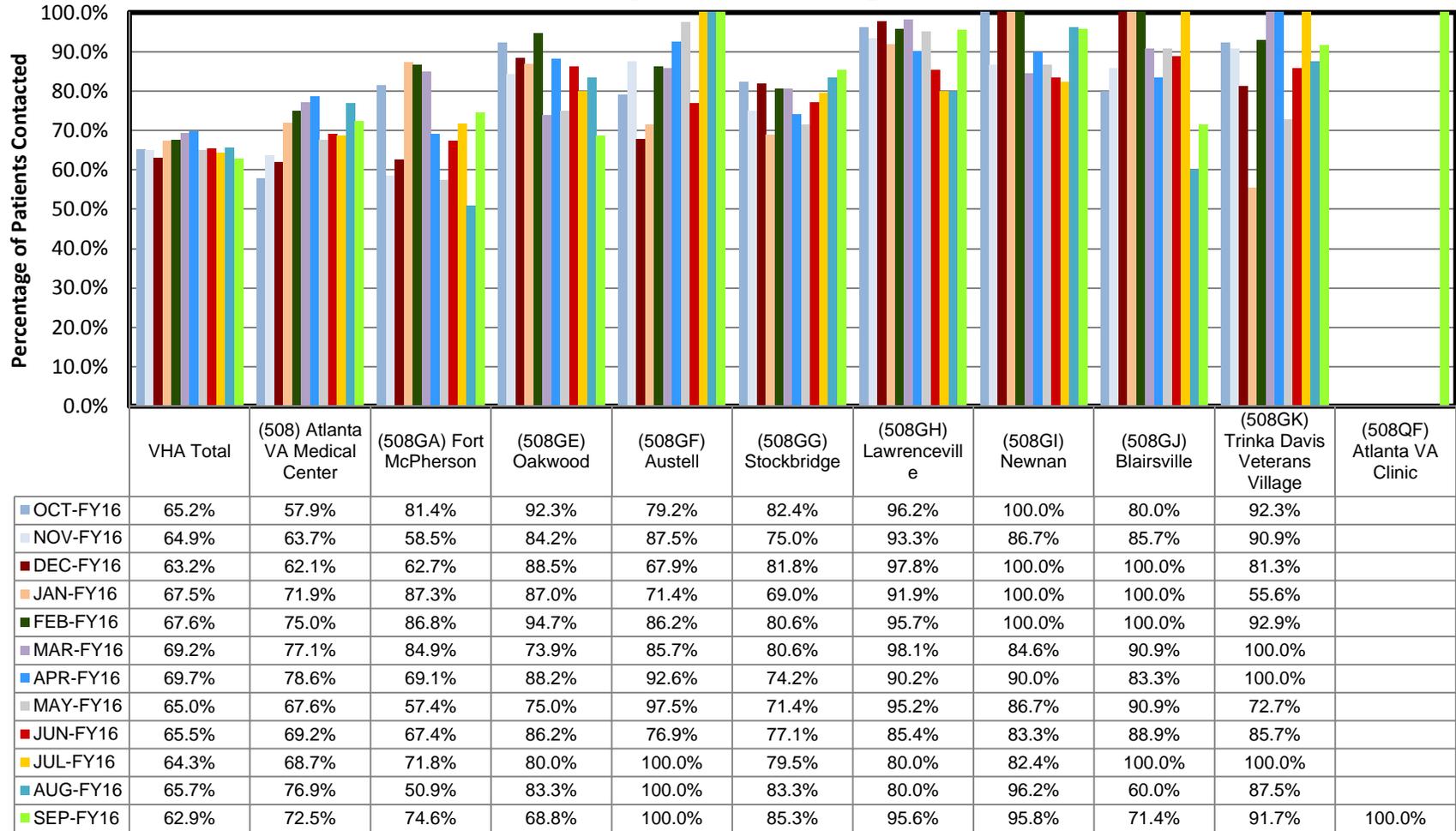
	VHA Total	(508) Atlanta VA Medical Center	(508GA) Fort McPherson	(508GE) Oakwood	(508GF) Austell	(508GG) Stockbridge	(508GH) Lawrenceville	(508GI) Newnan	(508GJ) Blairsville	(508GK) Trink Davis Veterans Village	(508QF) Atlanta VA Clinic
OCT-FY16	3.8	6.7	4.0	11.3	6.8	6.1	5.0	9.3	3.1	4.5	7.0
NOV-FY16	4.3	5.8	4.3	8.9	6.0	5.9	4.4	9.7	5.3	7.5	7.9
DEC-FY16	4.6	6.7	4.3	8.3	4.2	5.0	4.4	10.9	4.2	7.9	6.9
JAN-FY16	4.9	8.9	7.4	7.8	5.5	6.6	5.1	11.8	4.8	9.5	9.7
FEB-FY16	4.7	8.1	7.6	6.4	3.9	5.6	4.5	8.8	4.0	8.4	9.6
MAR-FY16	4.4	7.5	6.3	5.0	3.4	5.1	3.3	6.1	3.5	9.0	8.8
APR-FY16	4.3	6.8	5.6	4.3	3.4	3.8	3.8	5.9	2.2	8.4	9.0
MAY-FY16	4.3	7.0	4.4	5.7	2.6	3.5	3.5	4.1	2.0	11.0	6.8
JUN-FY16	4.4	6.6	4.9	6.7	3.8	4.6	3.5	6.9	3.3	14.2	7.0
JUL-FY16	4.4	7.1	2.7	5.6	3.5	4.3	3.6	5.8	2.8	8.8	7.0
AUG-FY16	4.3	6.6	3.3	5.9	4.0	1.9	2.5	4.3	2.8	8.8	7.2
SEP-FY16	4.2	6.5	3.6	5.9	2.4	1.5	1.4	4.9	3.6	7.7	7.2

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

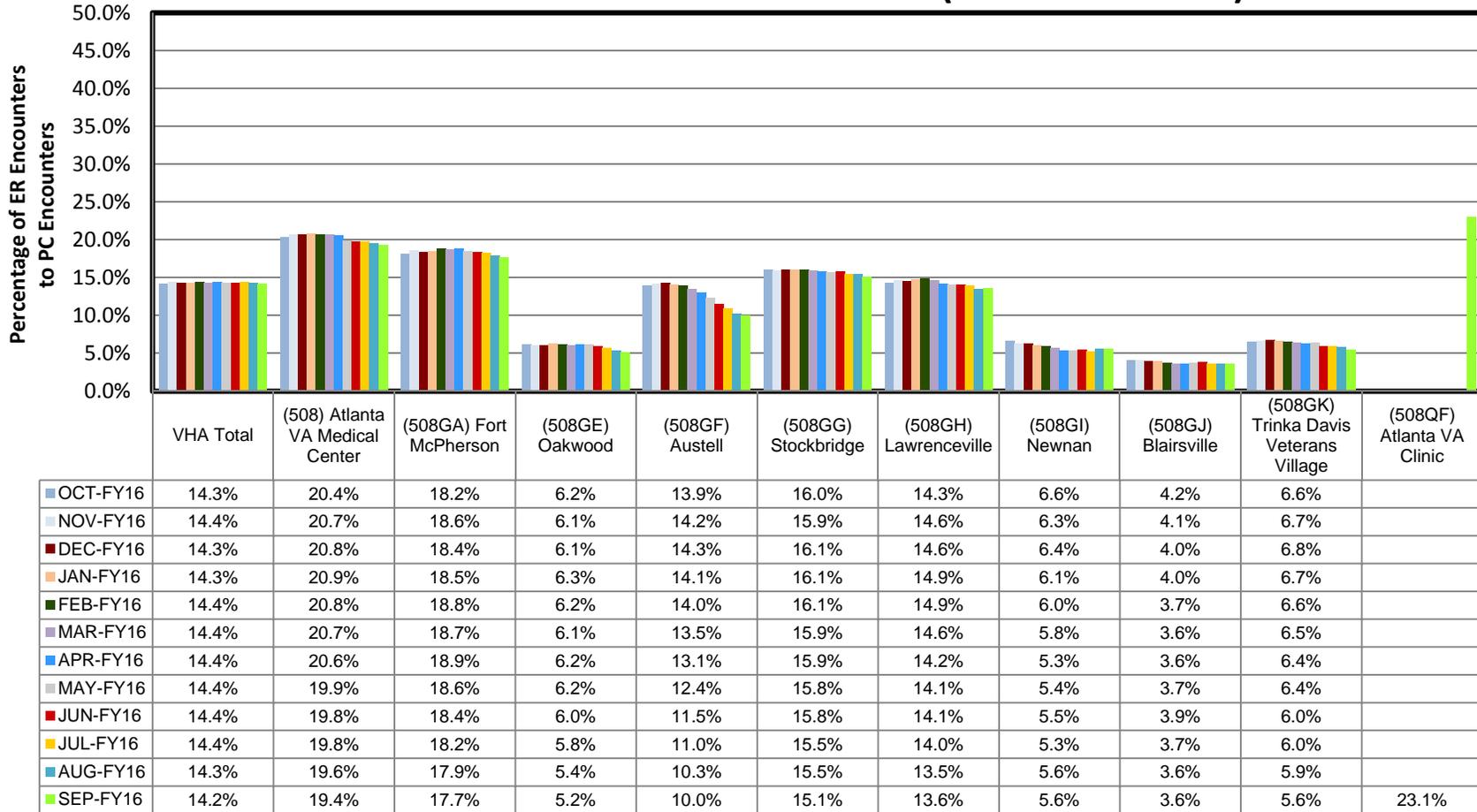


Source: VHA Support Service Center

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
[February 1, 2014 through February 1, 2017]

Facility Reports

Review of the Implementation of the Veterans Choice Program

1/30/2017 | 15-04673-333 | [Summary](#) | [Report](#)

Healthcare Inspection – Evaluation of a Patient’s Care and Disclosure of Protected Information, Atlanta VA Medical Center, Decatur, Georgia

6/23/2015 | 15-02276-391 | [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 – Alleged Medication Cart Deficiencies and Unsafe Medication Administration Practices, Atlanta VA Medical Center, Decatur, Georgia

7/16/2014 | 14-02396-212 | [Summary](#) | [Report](#)

Healthcare Inspection – Follow-Up of Mental Health Inpatient Unit and Outpatient Contract Programs, Atlanta VA Medical Center, Decatur, Georgia

6/19/2014 | 12-03869-187 | [Summary](#) | [Report](#)

Acting Veterans Integrated Service Network Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: May 12, 2017

From: Acting Director, VA Southeast Network (10N7)

Subject: **CAP Draft Review of the Atlanta VA Medical Center, Decatur, GA**

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

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

1. I have reviewed and concur with the recommendations of the draft report for the OIG Clinical Assessment Program (CAP) Review for the Atlanta VA Medical Center, conducted January 23–27, 2017.



Robert R. Norvel Jr., MD
Acting Director, VA Southeast Network

Facility Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: April 20, 2017

From: Director, Atlanta VA Medical Center (508/00)

Subject: **CAP Review of the Atlanta VA Medical Center, Decatur, GA**

To: Director, VA Southeast Network (10N7)

I have reviewed and concur with the recommendations of the draft report for the OIG Clinical Assessment Program (CAP) Review of the Atlanta VA Medical Center, conducted January 23–27, 2017. Thank you for the opportunity to review our processes to ensure we continue to provide excellent care to our Veterans. Corrective action plans have been developed and target dates established as detailed in the attached report.



Annette P. Walker
Director, Atlanta VA Medical Center

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that facility clinical managers consistently review Ongoing Professional Practice Evaluation data semi-annually and that facility managers monitor compliance.

Concur

Target date for completion: October 31, 2017

Facility response: Processes were strengthened to ensure Ongoing Professional Practice Evaluations are completed semi-annually as specified in the facility's policy. A tracking sheet has been developed for service line use and will be submitted annually to the medical center Professional Standards Board to monitor compliance.

Recommendation 2. We recommended that facility clinical managers ensure peer reviewers consistently document their evaluation of at least one of the important aspects of care and that facility managers monitor compliance.

Concur

Target date for completion: March 31, 2017 (Completed)

Facility response: The Peer Review Committee (PRC) minutes template was modified in January 2017 to ensure consistent documentation of the aspects of care, if indicated, for each case during peer review evaluations. The PRC minutes have been monitored for aspects of care documentation for three consecutive months and compliance has been sustained.

Recommendation 3. 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 28, 2017 (Completed)

Facility response: The Physician Utilization Management Advisors (PUMAs) were educated on the importance of completing National Utilization Management Integration (NUMI) reviews and signed up for the PUMA Pending Review email. The PUMA decision documentation is presented at the Utilization Management Committee meetings. The Utilization Management Committee minutes have been monitored for

documentation of PUMA decision for three consecutive months and compliance has been sustained.

Recommendation 4. We recommended that Environment of Care Committee meeting minutes document discussion of environment of care rounds deficiencies, include corrective actions taken to address rounds deficiencies, and track actions taken in response to identified deficiencies to closure.

Concur

Target date for completion: July 31, 2017

Facility response: The Environment of Care (EOC) Committee agenda and reporting structure was modified to include quarterly discussions of deficiencies identified during EOC rounds with implemented corrective actions and tracking to closure in the EOC minutes. The process was implemented in April 2017 and will be tracked for three consecutive months for demonstrated compliance.

Recommendation 5. We recommended that facility managers ensure information technology network room logs for visitors contain all required information to document access and monitor compliance.

Concur

Target date for completion: July 31, 2017

Facility response: The Visitor Access Log with required elements for documentation and monitoring in all IT closets per VHA Handbook 6500 was implemented April 2017. The Chief, Office of Information Technology will use a quarterly validation/redundancy procedure for three consecutive months to ensure access logs are reviewed and monitored for sustained compliance.

Recommendation 6. We recommended that facility managers ensure ventilation grills and floors in patient care areas are clean and monitor compliance.

Concur

Target date for completion: July 31, 2017

Facility response: The Environmental Management Services leadership has increased surveillance through systematic evaluations across shifts as of January 2017 to ensure ventilation grills and floors in patient care areas are clean. Continuous compliance has been monitored with implementation of real time corrective actions for sustainment.

Recommendation 7. We recommended that the facility repair damaged furniture in patient care areas or remove it from service.

Concur

Target date for completion: March 14, 2017 (Completed)

Facility response: All damaged furniture identified during inspection was removed from service and replaced. A walk-through of the facility was conducted by Environmental Management Service (EMS) staff and all task, guest and waiting room furniture that was ripped, torn or broken was replaced. Condition of furniture is part of the standard checklist used by the Environment of Care Team during weekly rounds.

Recommendation 8. We recommended that facility managers ensure ice machines in patient nourishment kitchens are clean and monitor compliance.

Concur

Target date for completion: July 31, 2017

Facility response: The Preventive Maintenance List for ice machines in patient nourishment kitchens was modified for concurrence with manufacturer's weekly maintenance recommendations. Preventive maintenance checks and services are performed by Engineering Service and compliance will be monitored for three consecutive months.

Recommendation 9. We recommended that the facility develop and implement a policy that addresses anticoagulation management.

Concur

Target date for completion: February 1, 2017 (Completed)

Facility response: The facility's Pharmacy Anticoagulation policies have been updated to be consistent with VHA Directive 1033: Anticoagulation Therapy Management, dated July 29, 2015.

Recommendation 10. We recommended that the facility designate a physician anticoagulation program champion.

Concur

Target date for completion: January 3, 2017 (Completed)

Facility response: A Physician Anticoagulation Program Champion has been appointed via Memorandum signed by the Chief of Staff.

Recommendation 11. We recommended that clinicians consistently provide specific education to patients with newly prescribed anticoagulant medications and that facility managers monitor compliance.

Concur

Target date for completion: July 31, 2017

Facility response: The Pharmacy Anticoagulation Consult template and the Medication Use Evaluation for Direct Oral Anticoagulants template have been modified to include a mandatory field which requires providers to document that patients have been educated on their prescribed anticoagulants. Compliance will be monitored for three consecutive months.

Recommendation 12. We recommended that providers complete transfer documentation for patients transferred out of the facility and that facility managers monitor compliance.

Concur

Target date for completion: March 28, 2017 (Completed)

Facility response: Utilization Management monitors electronic health records for completion of form 10-2649a and a process has been implemented to provide clinicians with compliance outcomes. Completion of form 10-2649a has been included in the inter-facility transfer metrics and is monitored for compliance in the Utilization Management Committee as of January 2017. The Utilization Management Committee has monitored this metric for three consecutive months and compliance has been sustained.

Recommendation 13. We recommended that for patients transferred out of the facility, providers consistently include documentation of patient or surrogate informed consent in transfer documentation and that facility managers monitor compliance.

Concur

Target date for completion: March 28, 2017 (Completed)

Facility response: Utilization Management monitors electronic health records for documentation of informed consent for Inter-facility transfers and have implemented a process to provide clinicians with compliance outcomes. Completion of consent to transfer has been included in the inter-facility transfer metrics which is monitored for compliance in the Utilization Management Committee as of January 2017. The Utilization Management Committee has monitored this metric for three consecutive months and compliance has been sustained.

Recommendation 14. We recommended that facility managers ensure transfer notes written by acceptable designees document staff/attending physician approval and contain a staff/attending physician countersignature and monitor compliance.

Concur

Target date for completion: March 28, 2017 (Completed)

Facility response: Utilization Management monitors electronic health records for documentation of attending physician approval and co-signature on the transfer notes. A process has been implemented to provide clinicians with feedback when a missing attending co-signature is identified. Transfer notes written by acceptable designees or attending physician with appropriate countersignature has been included in the inter-facility transfer metrics which is monitored for compliance in the Utilization Management Committee as of January 2017. The Utilization Management Committee has monitored this metric for three consecutive months and compliance has been sustained.

Recommendation 15. We recommended that employees ensure glucometers are clean before and after use and that clinical managers monitor compliance.

Concur

Target date for completion: July 31, 2017

Facility response: The Point of Care Whole Blood Glucose Testing Procedure is located at approved ancillary glucose testing locations and online for end user reference regarding glucometer cleaning, use of acceptable cleaning solutions and documentation of cleaning. Operators are required to review the Blood Glucose testing policy as part of annual competency certification. The Ancillary Testing Coordinator performs audits of testing locations to ensure meters are cleaned per policy. Compliance will be monitored for three consecutive months for process sustainment.

Recommendation 16. 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: July 31, 2017

Facility response: A facility Employee Threat Assessment Team (ETAT) had not been established prior to the Acting Deputy Under Secretary for Health for Operations and Management memorandum, dated March 13, 2014, which stated that facilities without a previously established ETAT were to cease developing and implementing such team. In lieu of a formal ETAT, employee-generated disruptive behavior and/or threats are routed to the facility's Department of Human Resources/Employee Relations (ER) Specialist who assists management in fact-finding and coordination of follow-on actions. Management reviews the facts with the ER Specialist and makes a recommendation for

actions. The Medical Center Memorandum 00-72 “Civility in the Workplace” is being revised to incorporate this process.

Recommendation 17. We recommended that the Patient Safety Manager and/or Risk Manager and Patient Advocate consistently attend Disruptive Behavior Committee meetings.

Concur

Target date for completion: January 26, 2017 (Completed)

Facility response: Representatives from Patient Safety and Veteran Experience Office [Patient Advocate] were added as mandatory members of the Disruptive Behavior Committee per Medical Center Memorandum 11-72 “Management and Coordination of Care for the Difficult Patient; Disruptive Behavior Committee/Patient Record Flag Advisories” which was revised to reflect membership composition February 2017. Committee member attendance is monitored and included in the minutes.

Recommendation 18. We recommended that facility clinical managers ensure clinicians inform patients about the Patient Record Flags and the right to request to amend/appeal Patient Record Flag placement.

Concur

Target date for completion: January 26, 2017 (Completed)

Facility response: Veterans receive a notification letter from the Chief of Staff (COS) that a patient record flag has been placed on his/her medical record in accordance with Medical Center Memorandum 11-72 “Management and Coordination of Care for the Difficult Patient; Disruptive Behavior Committee/Patient Record Flag Advisories.” The signed Order of Behavioral Restriction letter outlines the behaviors of concern, the restrictions in care, and the method for appeal.

Recommendation 19. We recommended that facility managers ensure all employees receive Level 1 Prevention and Management of Disruptive Behavior training and additional training as required for their assigned risk area within 90 days of hire and that the training is documented in employee training records.

Concur

Target date for completion: March 31, 2017 (Completed)

Facility response: All new employees are assigned Prevention and Management of Disruptive Behavior (PMDB) training upon hire based on their assigned work area designations per the facility Workplace Behavioral Risk Assessment (WBRA). The Education Department monitors the status of the 90 day training requirement and has implemented a notification escalation process for employees and managers to facilitate compliance.

Recommendation 20. We recommended that facility clinical managers ensure that all patients discharged with pressure ulcers have wound care follow-up plans and receive dressing supplies prior to being discharged and that facility managers monitor compliance.

Concur

Target date for completion: July 31, 2017

Facility response: The facility has developed a scope of practice and standard of practice for the wound care registered nurses to include the ability to prescribe wound care supplies for patients being discharged with pressure ulcers. The template for the nursing discharge assessment will be amended to include wound care follow-up plans. Chart audits will be conducted for three consecutive months for process sustainment.

Recommendation 21. We recommended that employees consistently complete diagnostic assessments for patients with a positive alcohol screen and that facility managers monitor compliance.

Concur

Target date for completion: July 31, 2017

Facility response. The Clinical Reminder report is used to identify patients for alcohol use screening. Providers complete diagnostic assessments and brief alcohol counseling for any patient with a positive alcohol use screen. Compliance monitoring for patients with a positive alcohol screen are conducted and any patient that did not receive alcohol counseling will be called by the provider to complete the counseling. Compliance will be monitored for three consecutive months for process sustainment.

OIG Contact and Staff Acknowledgments

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

Endnotes

^a The references used for QSV included:

- 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 References used for MH RRTP were:

- VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010.
- VHA Handbook 1330.01, *Health Care Services for Women Veterans*, May 21, 2010.
- Requirements of the VHA Center for Engineering and Occupational Safety and Health and the National Fire Protection Association.

^j The references used for Pressure Ulcer Prevention and Management included:

- VHA Handbook 1180.02, *Prevention of Pressure Ulcers*, July 1, 2011 (corrected copy).
- Various requirements of The Joint Commission.
- Agency for Healthcare Research and Quality Guidelines.
- National Pressure Ulcer Advisory Panel Guidelines.
- The New York State Department of Health, et al., *Gold STAMP Program Pressure Ulcer Resource Guide*, November 2012.

^k The references used for the Alcohol Use Disorder included:

- National Center for Health Promotion and Disease Prevention (NCP), Veteran Health Education and Information (NVEI) Program, *Patient Education: TEACH for Success*. Retrieved from http://www.prevention.va.gov/Publications/Newsletters/2013/HealthPOWER_Prevention_News_Winter_2012_2013_FY12_TEACH_MI_Facilitator_Training.asp on January 17, 2014.
- VHA Handbook 1120.02, *Health Promotion Disease Prevention (HPDP) Program*, July 5, 2012.
- VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.

^l 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.

^m 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.