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Clinical Assessment Program Review of the Montana VA Health Care System Fort Harrison, Montana

July 26, 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
facility	Montana VA Health Care System
FY	fiscal year
MH	mental health
NA	not applicable
NM	not met
OIG	Office of Inspector General
PC	primary care
POCT	point-of-care testing
QSV	quality, safety, and value
RME	reusable medical equipment
SPS	Sterile Processing Service
VHA	Veterans Health Administration

Table of Contents

Executive Summary

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

Results: We conducted the review during the week of March 6, 2017, and identified certain system weaknesses in environmental cleanliness; reusable medical equipment processes; anticoagulation processes; transfer data collection; point-of-care testing; moderate sedation policy, processes, and training; community nursing home annual reviews and clinical visits; disruptive/violent behavior management policy and processes; the surgical death review process; pressure ulcer documentation; and medication reconciliation and patient education related to fluoroquinolones.

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

1. Patient care areas do not have stained or missing ceiling tiles.
2. The facility has established effective processes for reusable medical equipment reprocessing.
3. The facility has a comprehensive anticoagulation therapy management program.
4. The facility uses patient transfer data to improve care and processes.
5. Clinicians appropriately manage critical point-of-care test values.
6. The facility has effective processes to report adverse events and ensure training is in place related to moderate sedation.
7. The facility completes required documentation for exclusion reviews and consistently performs required cyclical reviews of patient care provided through the community nursing home program.
8. The facility effectively manages disruptive/violent behavior incidents.
9. The facility tracks and reviews surgical deaths.
10. Employees consistently document required elements related to pressure ulcers.
11. Clinicians include fluoroquinolones in medication reconciliation and medication counseling and evaluate patient understanding of the education provided.

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

Environment of Care – Ensure that:
- Missing and stained ceiling tiles in patient care areas are replaced.
- Standard operating procedures for colonoscopes and endoscopes for esophagogastroduodenoscopy and endoscopic retrograde cholangiopancreatography are consistent with the manufacturers' instructions for use.
- Sterile Processing Service employees document positive quality control testing results for colonoscopes and endoscopes for esophagogastroduodenoscopy and endoscopic retrograde cholangiopancreatography in a manner that allows tracking of actions taken.

Medication Management: Anticoagulation Therapy – Ensure that:
- The facility provides patients with a direct telephone number for anticoagulation-related calls during normal business hours and defines a process for anticoagulation calls outside normal business hours.
- A physician anticoagulation program champion is designated.
- Clinicians consistently provide transition follow-up to inpatients with newly prescribed anticoagulant medications in accordance with local policy.

Coordination of Care: Inter-Facility Transfers – Ensure that:
- Data on patient transfers out of the facility are collected and reported.

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

Moderate Sedation – Ensure that:
- Adverse events/complications are processed in a similar manner as operating room anesthesia adverse events.
- The absence of adverse events is noted in Operative and Invasive Procedure Committee reports.
- Clinical employees who perform or assist with moderate sedation procedures have current Talent Management System training for the provision of moderate sedation care and that training is documented.
- The policy on ensuring correct surgery and invasive procedures is revised to include all elements of the timeout checklist required by Veterans Health Administration Directive 1039.

Community Nursing Home Oversight – Ensure that:
- Facility managers complete exclusion review documentation when community nursing home annual reviews note four or more exclusionary criteria.
- Social workers conduct and document cyclical clinical visits with the frequency required by Veterans Health Administration policy.

Management of Disruptive/Violent Behavior – Ensure that:

- The facility revises the workplace violence prevention policy to include required membership for the Disruptive Behavior Committee.
- A clinician member of the Disruptive Behavior Committee enters Patient Record Flags into the electronic health records.

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

Quality Management – Ensure that:

- A process is implemented to ensure all surgical deaths are tracked and reviewed by appropriate clinical employees.

Pressure Ulcer Prevention and Management – Ensure that:

- Acute care employees accurately document location, stage, risk scale score, and date pressure ulcer acquired for all patients with pressure ulcers.

Medication Management – Ensure that:

- Clinic employees document in patients' electronic health records medication reconciliation that includes the newly prescribed fluoroquinolone, patient counseling/education that includes the fluoroquinolone, and evaluation of the patients' level of understanding of the education.

Comments

The Veterans Integrated Service Network Director and Facility Director agreed with the Clinical Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes E and F, pages 44–52, for the full text of the Directors' comments.) We consider recommendations 1, 2, 4, 5, and 12 closed. We will follow up on the planned actions for the open recommendations until they are completed.

JOHN D. DAIGH, JR., M.D.
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Purpose and Objectives

Purpose

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

Objectives

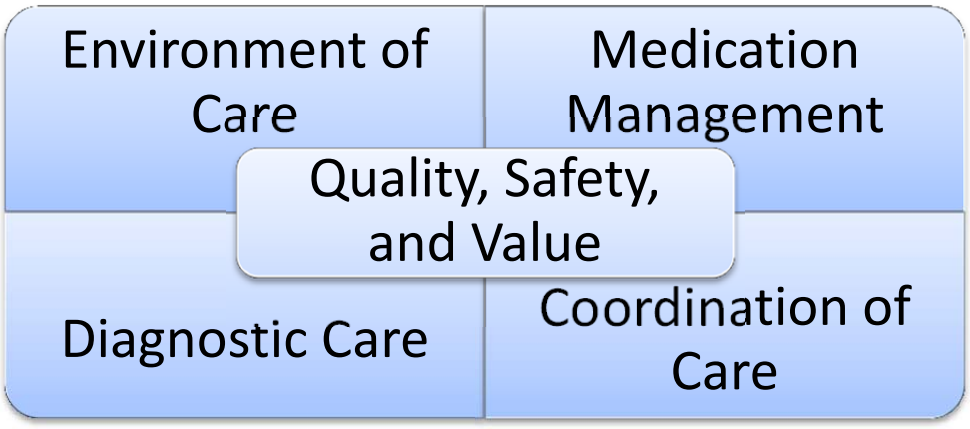
CAP reviews are one element of OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The reviews include cyclical evaluations of key clinical and administrative processes that affect patient care outcomes. Areas of focus include QSV, EOC, Medication Management,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

OIG also evaluates processes that are high risk and problem-prone—Moderate Sedation, CNH Oversight, and Management of Disruptive/Violent Behavior—and follows up on recommendations from the previous Combined Assessment Program and CBOC and PC 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—health care-associated infections, medication safety, and falls. Because health care-associated infections are transmitted through air, water, and contact with contaminated surfaces, the physical environment plays a key role in preventing the spread of infections in health care settings. Medication safety is markedly influenced by physical environmental conditions, including light levels and workspace organization. Environmental features, such as the

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

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

Medication Management

Comprehensive medication management is defined as the standard of care that ensures clinicians individually assess each patient's medications to determine that each is appropriate for the patient, effective for the medical condition, safe given the comorbidities and other medications prescribed, and able to be taken by the patient as intended. Medications are involved in 80 percent of all treatments and impact every aspect of a patient's life. Drug therapy problems occur every day. The Institute of Medicine (now the National Academy of Medicine) noted that while medications account for only 10 percent of total health care costs, their ability to control disease and impact overall costs, morbidity, and productivity—when appropriately used—is enormous. The components of the medication management process include procuring, storing, securing, prescribing or ordering, transcribing, preparing, dispensing, and administering.[5,6]

Coordination of Care

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

In a 2001 report entitled "Crossing the Quality Chasm: A New Health System for the 21st Century," the Institute of Medicine (now the National Academy of Medicine) noted that, "Because of the special vulnerability that accompanies illness or injury, coordination of care takes on special importance. Many patients depend on those who provide care to coordinate services whether tests, consultations, or procedures to ensure that accurate and timely information reaches those who need it at the appropriate time." Health care providers and organizations need to work together to coordinate their efforts to provide safe, quality care.[8]

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

Diagnostic Care

The diagnostic process is a complex, patient-centered, collaborative activity that involves information gathering and clinical reasoning with the goal of determining a patient's health problem. Diagnostic testing may occur in successive rounds of information gathering, integration, and interpretation, with each round refining the working diagnosis. In many cases, diagnostic testing can identify a condition before it is clinically apparent; for example, an imaging study indicating the presence of coronary artery blockage can identify coronary artery disease even in the absence of symptoms. PC clinicians order laboratory tests in slightly less than one third of patient visits, and direct-to-patient testing is becoming increasingly prevalent.[9]

Medical imaging also plays a critical role in establishing the diagnoses for many conditions. The advancement of imaging technologies has improved the ability of clinicians to detect, diagnose, and treat conditions while also allowing patients to avoid more invasive procedures. Performed appropriately, diagnostic care facilitates the provision of timely, cost-effective, and high quality medical care.[10]

High-Risk and Problem-Prone Health Care Processes

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

Moderate sedation is a drug-induced depression of consciousness during which patients respond purposefully to verbal comments.[13] Properly credentialed providers and trained clinical staff must provide safe care while sedating patients for invasive procedures. Additionally, facility leaders must monitor moderate sedation adverse events, report and trend the use of reversal agents, and systematically aggregate and analyze the data to enhance patient safety and performance.[14]

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

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

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

Scope

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

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

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

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

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

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

The review covered operations for FY 2015, FY 2016, and FY 2017 through March 10, 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 VA Montana Health Care System, Fort Harrison, Montana,* Report No. 14-00685-156, May 19, 2014) and CBOC report (*Community Based Outpatient Clinic and Primary Care Clinic Reviews at VA Montana Health Care System, Fort Harrison, Montana,* Report No. 13-03416-56, February 5, 2014). In this report, we are making repeat recommendations in Quality Management, Pressure Ulcer Prevention and Management, and Medication Management. (See pages 29–30.)

We presented crime awareness briefings for 82 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 288 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 the CAP review came to our attention and were referred for further review separate from this report.

Reported Accomplishment

Telephone Triage Nurse Advice Line

Being a highly rural state, access to health care for all Montana veterans is limited. In order to better serve veterans, in October 2016, the facility implemented a 24/7, 365 days a year telephone triage nurse advice line. Trained clinical employees provide Montana and Sheridan, WY, veterans with telephone access to health care advice and information.

Since implementation, the facility's telephone nurse advice line has handled calls from veterans with an average speed of response of 14 seconds. Since becoming fully staffed in December of 2016, the nurse advice line has realized an abandoned call rate of only 4 percent. Veterans are receiving improved customer service by interacting with a "live" person in real time and, in many cases, issues are resolved on the first call.

Results and Recommendations

Quality, Safety, and Value

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

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

We interviewed senior managers and key QSV employees, and we evaluated meeting minutes, 25 licensed independent practitioners' profiles, 10 protected peer reviews, 5 root cause analyses, and other relevant documents. The table below shows the areas reviewed for this topic. The facility generally met requirements. We made no recommendations.

Checklist 1. QSV Areas Reviewed, Findings, and Recommendations

NM	Areas Reviewed	Findings	Recommendations
	There was a senior-level committee responsible for key QSV functions that met at least quarterly and was chaired or co-chaired by the Facility Director. • The committee routinely reviewed aggregated data.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Credentialing and privileging processes met selected requirements: • Facility policy/by-laws addressed a frequency for clinical managers to review practitioners' Ongoing Professional Practice Evaluation data. • Facility clinical managers reviewed Ongoing Professional Practice Evaluation data at the frequency specified in the policy/by-laws. • The facility set triggers for when a Focused Professional Practice Evaluation for cause would be indicated.		
	Protected peer reviews met selected requirements: • Peer reviewers documented their use of important aspects of care in their review, such as appropriate and timely ordering of diagnostic tests, timely treatment, and appropriate documentation. • When the Peer Review Committee recommended individual improvement actions, clinical managers implemented the actions.		
	Utilization management met selected requirements: • The facility completed at least 75 percent of all required inpatient reviews. • Physician Utilization Management Advisors documented their decisions in the National Utilization Management Integration database. • An interdisciplinary group reviewed utilization management data.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Patient safety met selected requirements: • The Patient Safety Manager entered all reported patient incidents into the WEBSPOT database. • The facility completed the required minimum of eight root cause analyses. • The facility provided feedback about the root cause analysis findings to the individual or department who reported the incident. • At the completion of FY 2016, the Patient Safety Manager submitted an annual patient safety report to facility leaders.		
	Overall, if QSV reviews identified significant issues, the facility took actions and evaluated them for effectiveness.		
	Overall, senior managers actively participated in QSV activities.		

Environment of Care

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

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

We inspected two medical/surgical units, the intensive care unit, the Emergency Department, a PC clinic, SPS, and the community living center at the facility and the PC and specialty clinics and SPS at the Billings CBOC. Additionally, we reviewed relevant documents and nine 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. Any items that did not apply to this facility are marked NA.

Checklist 2. EOC Areas Reviewed, Findings, and Recommendations

NM	Areas Reviewed for General EOC	Findings	Recommendations
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure for the facility and the CBOCs.		
	The facility conducted an infection prevention risk assessment.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
	Infection Prevention/Control Committee minutes documented discussion of identified high-risk areas, actions implemented to address those areas, and follow-up on implemented actions and included analysis of surveillance activities and data.		
	The facility had established a procedure for cleaning equipment between patients.		
	The facility conducted required fire drills in buildings designated for health care occupancy and documented drill critiques.		
	The facility had a policy/procedure/guideline for identification of individuals entering the facility, and units/areas complied with requirements.		
	The facility met general safety requirements.		
X	The facility met environmental cleanliness requirements.	• Two of eight patient care areas had missing and/or stained ceiling tiles.	**1.** We recommended that the facility replace missing and stained ceiling tiles in patient care areas and that facility managers monitor compliance.
	Areas Reviewed for SPS		
	The facility had a policy for cleaning, disinfecting, and sterilizing RME.		
X	The facility's standard operating procedures for selected RME were current and consistent with the manufacturers' instructions for use.	• Standard operating procedures for the colonoscope and endoscopes for esophagogastroduodenoscopy and endoscopic retrograde cholangiopancreatography were not consistent with the manufacturers' instructions for use.	**2.** We recommended that facility managers ensure standard operating procedures for colonoscopes and endoscopes for esophagogastroduodenoscopy and endoscopic retrograde cholangiopancreatography are consistent with the manufacturers' instructions for use.

NM	Areas Reviewed for SPS (continued)	Findings	Recommendations
X	The facility performed quality control testing on selected RME with the frequency required by local policy and took appropriate action on positive results.	• SPS employees were not documenting positive quality control testing results for colonoscopes and endoscopes for esophagogastroduodenoscopy and endoscopic retrograde cholangiopancreatography in a manner that allowed tracking of actions taken.	**3.** We recommended that Sterile Processing Service employees document positive quality control testing results for colonoscopes and endoscopes for esophagogastroduodenoscopy and endoscopic retrograde cholangiopancreatography in a manner that allows tracking of actions taken and that facility managers monitor compliance.
	Selected SPS employees had evidence of the following for selected RME: • Training and competencies at orientation if employed less than or equal to 1 year • Competencies within the past 12 months or with the frequency required by local policy if employed more than 1 year		
	The facility met infection prevention requirements in SPS areas.		
	Standard operating procedures for selected RME were located in the area where reprocessing occurred.		
	SPS employees checked eyewash stations in SPS areas weekly.		
	SPS employees had access to Safety Data Sheets in areas where they used hazardous chemicals.		
	Areas Reviewed for the Hemodialysis Unit		
NA	The facility had a policy or procedure for preventive maintenance of hemodialysis machines and performed maintenance at the frequency required by local policy.		
NA	Selected hemodialysis unit employees had evidence of bloodborne pathogens training within the past 12 months.		

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

Medication Management: Anticoagulation Therapy

The purpose of this review was to determine whether facility clinicians appropriately managed and provided education to patients with new orders for anticoagulant medication.[c] During FY 2016, more than 482,000 veterans received an anticoagulant. Anticoagulants (commonly called blood thinners) are a class of drugs that work to prevent the coagulation or clotting of blood. For this review, we evaluated warfarin (Coumadin®) and direct-acting oral anticoagulants. Clinicians use anticoagulants for both the treatment and prevention of cardiac disease, cerebrovascular accident (stroke), and thromboembolism[19] in both the inpatient and outpatient setting. Although these medications offer substantial benefits, their use or misuse carries a significant potential for patient harm. A dose less than the required amount for therapeutic effect can increase the risk of thromboembolic complications while a dose administered at levels greater than required for treatment can increase the risk of bleeding complications. The Joint Commission's National Patient Safety Goal 3.05.01 focuses on improving anticoagulation safety to reduce patient harm and states, "…anticoagulation medications are more likely than others to cause harm due to complex dosing, insufficient monitoring, and inconsistent patient compliance."

We reviewed relevant documents and the competency assessment records of 10 employees actively involved in the anticoagulant program, and we interviewed key employees. Additionally, we reviewed the EHRs of 39 randomly selected patients who were prescribed new anticoagulant medications from July 1, 2015 through June 30, 2016. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement.

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

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

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

NM	Areas Reviewed (continued)	Findings	Recommendations
X	The facility provided patients with a direct telephone number for anticoagulation-related calls during normal business hours and defined a process for patient anticoagulation-related calls outside normal business hours.	• The facility did not provide patients with a direct telephone number for anticoagulation-related calls during normal business hours. • The facility had not defined a process for patient anticoagulation-related calls outside normal business hours.	**4.** We recommended that the facility provide patients with a direct telephone number for anticoagulation-related calls during normal business hours and define a process for anticoagulation calls outside normal business hours.
X	The facility designated a physician as the anticoagulation program champion.	• The facility did not have an anticoagulation program champion.	**5.** 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	Clinicians provided transition follow-up for inpatients with newly prescribed anticoagulant medications and education specific to the new anticoagulant to both inpatients and outpatients.	• Four of the 13 inpatient EHRs did not contain evidence that patients received transition follow-up.	**6.** We recommended that clinicians consistently provide transition follow-up to inpatients with newly prescribed anticoagulant medications in accordance with local policy and that facility managers monitor compliance.
	Clinicians obtained required laboratory tests: • 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 45 randomly selected patients who were transferred acutely out of facility inpatient beds or the Emergency Department/urgent care center to another VHA facility or non-VA facility from July 1, 2015 through June 30, 2016. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement.

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

NM	Areas Reviewed	Findings	Recommendations
	The facility had a policy that addressed patient transfers and included required content.		
X	The facility collected and reported data about transfers out of the facility.	• There was no evidence the facility collected and reported data about transfers out of the facility.	**7.** We recommended that the facility collect and report data on patient transfers out of the facility.
	Transferring providers completed VA Form 10-2649A and/or transfer/progress notes prior to or within a few hours after the transfer that included the following elements: • Date of transfer • Documentation of patient or surrogate informed consent • Medical and/or behavioral stability • Identification of transferring and receiving provider or designee • Details of the reason for transfer or proposed level of care needed		

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

Diagnostic Care: Point-of-Care Testing

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

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

We reviewed relevant documents, the EHRs of 50 randomly selected inpatients and outpatients who underwent POCT for blood glucose from July 1, 2015 through June 30, 2016, and the annual competency assessments of 36 clinicians who performed the glucose testing. Additionally, we interviewed key employees and conducted onsite glucometer inspections of the Emergency Department, a PC clinic, the physical therapy clinic, an acute inpatient medical unit, and the Billings 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.		
	The Chief of Pathology and Laboratory Medicine Service approved all tests performed outside the main laboratory.		

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

NM	Areas Reviewed (continued)	Findings	Recommendations
	The facility had a process to ensure employee competency for POCT with glucometers and evaluated competencies at least annually.		
	The facility required documentation of POCT results in the EHR.		
	A regulatory agency accredited the facility's POCT program.		
	Clinicians documented test results in the EHR.		
X	Clinicians initiated appropriate clinical action and follow-up for test results.	• In 17 EHRs (34 percent), clinicians did not document all the actions required by the facility in response to test results.	**8.** We recommended that clinicians take and document all actions required by the facility in response to test results and that clinical managers monitor compliance.
	The facility had POCT procedure manuals readily available to employees.		
	Quality control testing solutions/reagents and glucose test strips were current (not expired).		
	The facility managed and performed quality control in accordance with its policy/standard operating procedure and manufacturer's recommendations.		
	Glucometers were clean.		

Moderate Sedation

The purpose of this review was to evaluate selected aspects of care to determine whether the facility complied with applicable policies in the provision of moderate sedation.[f] During calendar year 2016, VHA clinicians performed more than 600,000 moderate sedation procedures of which more than half were gastroenterology-related endoscopies.[21] Moderate sedation is a drug-induced depression of consciousness during which patients are able to respond to verbal commands. Non-anesthesiologists administer sedatives and analgesics to relieve anxiety and increase patient comfort during invasive procedures and usually do not have to provide interventions to maintain a patent airway, spontaneous ventilations, or cardiovascular function.[22] However, serious adverse events can occur, including cardiac and respiratory depression, brain damage due to low oxygen levels, cardiac arrest, or death. To minimize risks, VHA and The Joint Commission have issued requirements and standards for moderate sedation care.

We reviewed relevant documents; interviewed key employees; and inspected the interventional radiology, intensive care unit, Emergency Department, and gastroenterology (Helena and Billings CBOC) procedure rooms/areas to assess whether required equipment and sedation medications were available. Additionally, we reviewed the EHRs of 46 randomly selected patients who underwent an invasive procedure involving moderate sedation from July 1, 2015 through June 30, 2016, and the training records of 14 clinical employees who performed or assisted during these procedures. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement.

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

NM	Areas Reviewed	Findings	Recommendations
X	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.	• The facility did not process adverse events/complications in a similar manner as operating room anesthesia adverse events. • The facility did not note the absence of adverse events in Operative and Invasive Procedure Committee reports.	**9.** We recommended that the facility process adverse events/complications in a similar manner as operating room anesthesia adverse events and that facility managers monitor compliance. **10.** We recommended that the facility note the absence of adverse events in Operative and Invasive Procedure Committee reports and that facility managers monitor compliance.

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

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

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Selected clinical employees had current training for moderate sedation.	• Seven of the 14 employees' training records did not contain evidence of current Talent Management System training for moderate sedation.	**11.** We recommended that clinical managers ensure clinical employees who perform or assist with moderate sedation procedures have current Talent Management System training for the provision of moderate sedation care, ensure the training is documented, and monitor compliance.
	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.		
X	The facility's policy for ensuring correct surgery and invasive procedures complied with VHA requirements.	• The facility's policy did not include all elements in the timeout checklist required by VHA Directive 1039. Missing elements were: o Patient position o Correct medical implant(s) available if applicable o Appropriate antibiotic prophylaxis o Appropriate deep vein thrombosis prophylaxis o Blood availability if applicable o Special equipment available if applicable	**12.** We recommended that the facility revise the policy on ensuring correct surgery and invasive procedures to include all elements of the timeout checklist required by Veterans Health Administration Directive 1039.

Community Nursing Home Oversight

The purpose of this review was to assess whether the facility complied with applicable requirements regarding the monitoring of veterans in contracted CNHs.[9] Since 1965, VHA has provided nursing home care under contracts. VHA facilities must integrate the CNH program into their quality improvement programs. The Facility Director establishes the CNH Oversight Committee, which reports to the chief clinical officer (Chief of Staff, Associate Director for Patient Care Services, or the equivalent) and includes multidisciplinary management-level representatives from social work, nursing, quality management, acquisition, and the medical staff. The CNH Oversight Committee must meet at least quarterly.[23] Local oversight of CNHs is achieved through annual reviews and monthly visits.

We reviewed relevant documents, the EHRs of 39 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 areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

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.		
NA	The facility documented a hand-off for patients placed in CNHs outside of its catchment area.		
	The CNH Review Team completed CNH annual reviews.		

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

NM	Areas Reviewed (continued)	Findings	Recommendations
X	When CNH annual reviews noted four or more exclusionary criteria, facility managers completed exclusion review documentation.	• Facility managers did not complete exclusion review documentation for two CNHs that met four or more VA exclusionary criteria, affecting two patients in our review.	**13.** We recommended that facility managers complete exclusion review documentation when community nursing home annual reviews note four or more exclusionary criteria.
X	Social workers and registered nurses documented clinical visits that alternated on a cyclical basis.	• Thirty-seven of the 39 EHRs (95 percent) did not contain documentation of social worker cyclical clinical visits with the frequency required by VHA policy. One or more of these 37 patients resided in each of 18 of the 19 CNHs in our review.	**14.** We recommended that facility managers ensure social workers conduct and document cyclical clinical visits with the frequency required by Veterans Health Administration policy for community nursing home oversight and monitor compliance.

Management of Disruptive/Violent Behavior

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

We reviewed relevant documents, the EHRs of 42 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 July 1, 2015 through June 30, 2016, and the training records of 15 recently hired employees who worked in areas at low and minimal risk for violence. Additionally, we interviewed key employees. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement.

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

NM	Areas Reviewed	Findings	Recommendations
X	The facility had a policy, procedure, or guideline on preventing and managing disruptive or violent behavior.	• The facility's policy did not define required membership for the Disruptive Behavior Committee in accordance with VHA Directive 2010-053.	**15.** We recommended that the facility revise the workplace violence prevention policy to include required membership for the Disruptive Behavior Committee.
	The facility conducted an annual Workplace Behavioral Risk Assessment.		
	The facility had implemented: • An Employee Threat Assessment Team or acceptable alternate group • A Disruptive Behavior Committee/Board with appropriate membership • A disruptive behavior reporting and tracking system		
	The 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	Clinical managers reviewed patients' disruptive or violent behavior and took appropriate actions, including: • Ensuring discussion by the Disruptive Behavior Committee/Board and entry of a progress note by a clinician committee/board member • Informing patients about Patient Record Flag placement and the right to request to amend/appeal the flag placement • Ensuring Chief of Staff or designee approval of an Order of Behavioral Restriction	• For seven EHRs, Disruptive Behavior Committee discussion recommended placement of a Patient Record Flag. However, flags were not entered into the EHRs.	**16.** We recommended that facility clinical managers ensure a clinician member of the Disruptive Behavior Committee enters Patient Record Flags into the electronic health records.
	When a Patient Record Flag was placed for an incident of disruptive behavior in the past, a clinician reviewed the continuing need for the flag within the past 2 years.		
	The facility managed selected non-patient related disruptive or violent incidents appropriately according to VHA and local policy.		
	The facility had a security training plan for employees at all risk levels. • All employees received Level 1 training within 90 days of hire. • All employees received additional training as required for the assigned risk area within 90 days of hire.		

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

Quality Management

As a follow-up to a recommendation from our prior Combined Assessment Program review, we reassessed facility compliance with selected requirements for surgical death reviews.[i]

Surgical Death Reviews. VHA requires the facility Surgical Work Group to review surgical deaths monthly. During our previous Combined Assessment Program review, we found that the facility's review process did not ensure all surgical deaths were tracked and reviewed by appropriate clinical employees. During this review, we looked at 6 months of Surgical Work Group meeting minutes. There was no evidence the facility had a process to ensure that all surgical deaths were tracked and reviewed by appropriate clinical employees.

Recommendation

17. We recommended that the facility implement a process to ensure all surgical deaths are tracked and reviewed by appropriate clinical employees.

Pressure Ulcer Prevention and Management

As a follow-up to a recommendation from our prior Combined Assessment Program review, we reassessed facility compliance with documenting pressure ulcers.[j]

Pressure Ulcer Documentation. VHA requires employees to document the location, stage, risk scale score, and date acquired for each identified pressure ulcer. During our previous Combined Assessment Program review, we found that employees did not consistently document these elements. During this review, we looked at 8 quarters of medical record audits and found that employees did not consistently document the location, stage, risk scale score, and/or date the pressure ulcer was acquired.

Recommendation

18. We recommended that acute care employees accurately document location, stage, risk scale score, and date pressure ulcer acquired for all patients with pressure ulcers and that facility managers monitor compliance.

Medication Management

As a follow-up to recommendations from our prior CBOC and PC Clinic review, we reassessed facility compliance with requirements for clinical oversight and education for outpatients prescribed oral fluoroquinolone antibiotics.[k]

Fluoroquinolone Oversight and Education. VHA requires that medication reconciliation occur at every episode of care where medications are administered, prescribed, and modified or may influence the care given. In addition, clinicians are to document the education provided to the patient regarding the fluoroquinolone and the patients understanding of that education. During our previous CBOC and PC Clinic review, we did not find documentation that medication reconciliation and medication counseling included the newly prescribed fluoroquinolone and that clinicians evaluated each patient's understanding of the education provided. During this review, we looked at 9 months of medical record audits. Clinicians did not consistently document that medication reconciliation and medication counseling included the newly prescribed fluoroquinolone or that they evaluated each patient's understanding of the education provided.

Recommendation

19. We recommended that clinic employees document in patients' electronic health records medication reconciliation that includes the newly prescribed fluoroquinolone, patient counseling/education that includes the fluoroquinolone, and evaluation of the patients' level of understanding of the education.

Facility Profile

Table 1 below provides general background information for this facility.

Table 1. Facility Profile for Fort Harrison (436) for FY 2016

Profile Element	Facility Data
Veterans Integrated Service Network Number	19
Complexity Level	2-Medium complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$272.7
Number of:	
• **Unique Patients**	38,318
• **Outpatient Visits**	405,185
• **Unique Employees**[24]	978
Type and Number of Operating Beds:	
• **Acute**	26
• **MH**	NA
• **Community Living Center**	30
• **Domiciliary**	24
Average Daily Census:	
• **Acute**	15
• **MH**	NA
• **Community Living Center**	21
• **Domiciliary**	17

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

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

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

VA Outpatient Clinic Profiles[25]

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

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

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services[27] Provided	Diagnostic Services[28] Provided	Ancillary Services[29] Provided
Anaconda, MT	436GA	2,066	221	Dermatology Endocrinology Eye Neurology Pulmonary/ Respiratory Disease	EKG	Nutrition Weight Management
Great Falls, MT	436GB	11,393	2,956	Cardiology Dermatology Endocrinology Eye Neurology Pulmonary/ Respiratory Disease Rheumatology Anesthesia Blind Rehab Poly-Trauma	EKG	Nutrition Pharmacy Weight Management
Missoula, MT	436GC	16,686	4,829	Cardiology Dermatology Endocrinology Neurology Pulmonary/ Respiratory Disease Rheumatology Blind Rehab Poly-Trauma Anesthesia Amputation Follow-up Eye General Surgery Urology	EKG	Nutrition Pharmacy Prosthetics Weight Management

[25] Includes all outpatient clinics in the community that were in operation before February 15, 2016. We have omitted Hamilton, MT (436QA); Plentywood, MT (436QB); and Helena, MT (436QC), as no workload/encounters or services were reported.
[26] An encounter is a professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition.
[27] Specialty care services refer to non-PC and non-MH services provided by a physician.
[28] Diagnostic services include EKG, EMG, laboratory, nuclear medicine, radiology, and vascular lab services.
[29] Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

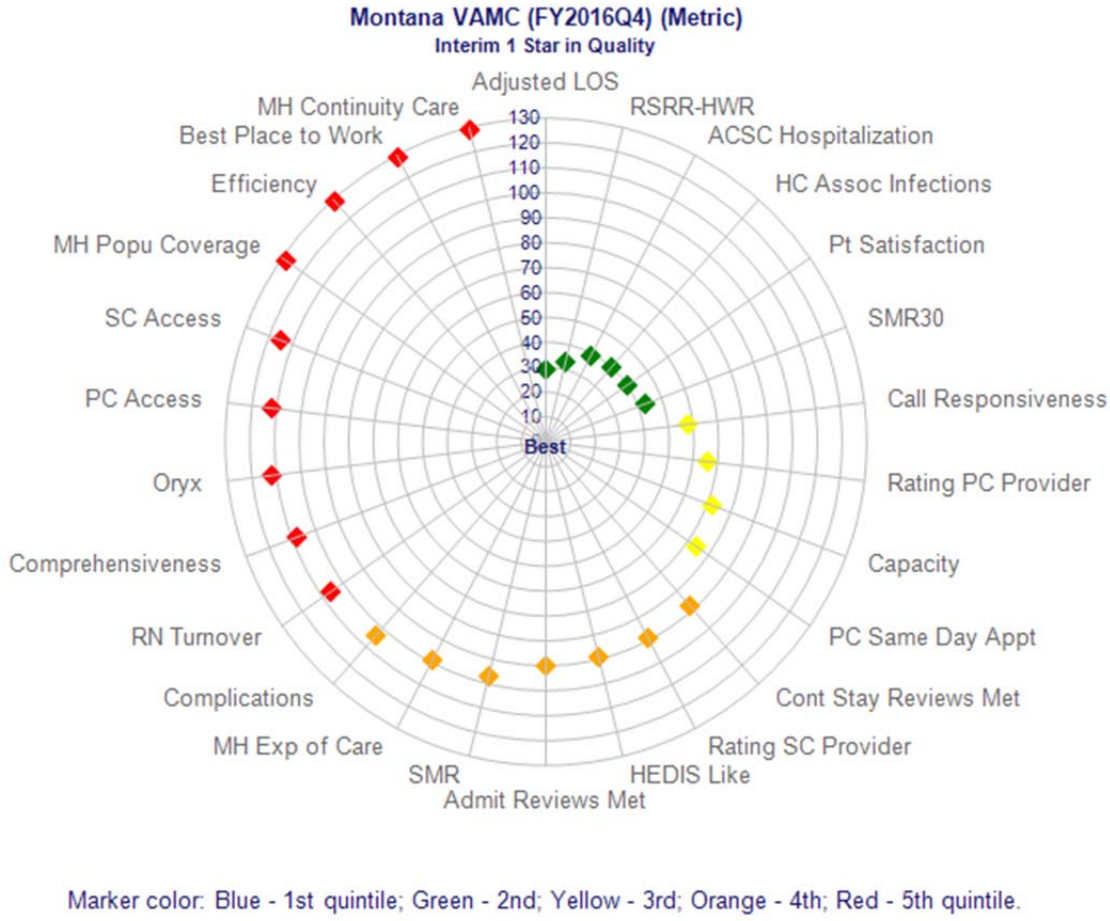
Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Bozeman, MT	436GD	6,222	2,076	Cardiology Dermatology Endocrinology Neurology Rheumatology Blind Rehab Poly-Trauma Pulmonary/ Respiratory Disease Anesthesia Eye	EKG	Nutrition Weight Management
Kalispell, MT	436GF	14,178	3,149	Cardiology Dermatology Endocrinology Neurology Pulmonary/ Respiratory Disease Rheumatology Blind Rehab Poly-Trauma Anesthesia ENT Eye Orthopedics Vascular	EKG	Nutrition Pharmacy Weight Management
Billings, MT	436GH	18,500	3,420	Cardiology Dermatology Endocrinology Gastroenterology Neurology Rheumatology Blind Rehab Poly-Trauma Anesthesia Amputation Follow-up Eye General Surgery Gynecology Hematology/ Oncology Orthopedics Podiatry Urology	EKG Laboratory & Pathology Radiology	Nutrition Dental Pharmacy Weight Management
Glasgow, MT	436GI	1,323	61	Dermatology Endocrinology Eye Neurology Rheumatology Anesthesia	EKG	Nutrition Weight Management

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Miles City, MT	436GJ	2,816	106	Dermatology Endocrinology Amputation Follow-up Blind Rehab Eye	EKG	Nutrition Pharmacy Social Work Weight Management
Glendive, MT	436GK	1,566	638	Dermatology Endocrinology Eye Neurology Anesthesia Vascular	EKG	Nutrition Weight Management
Cut Bank, MT	436GL	2,096	125	Dermatology Endocrinology Eye Neurology Rheumatology Blind Rehab Poly-Trauma	EKG	Nutrition Weight Management
Lewistown, MT	436GM	2,291	114	Dermatology Endocrinology Eye Neurology Blind Rehab Anesthesia	EKG	Nutrition Weight Management
Havre, MT	436HC	2,199	496	Dermatology Endocrinology Neurology	EKG	Nutrition

Source: VHA Support Service Center and VA Corporate Data Warehouse

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

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

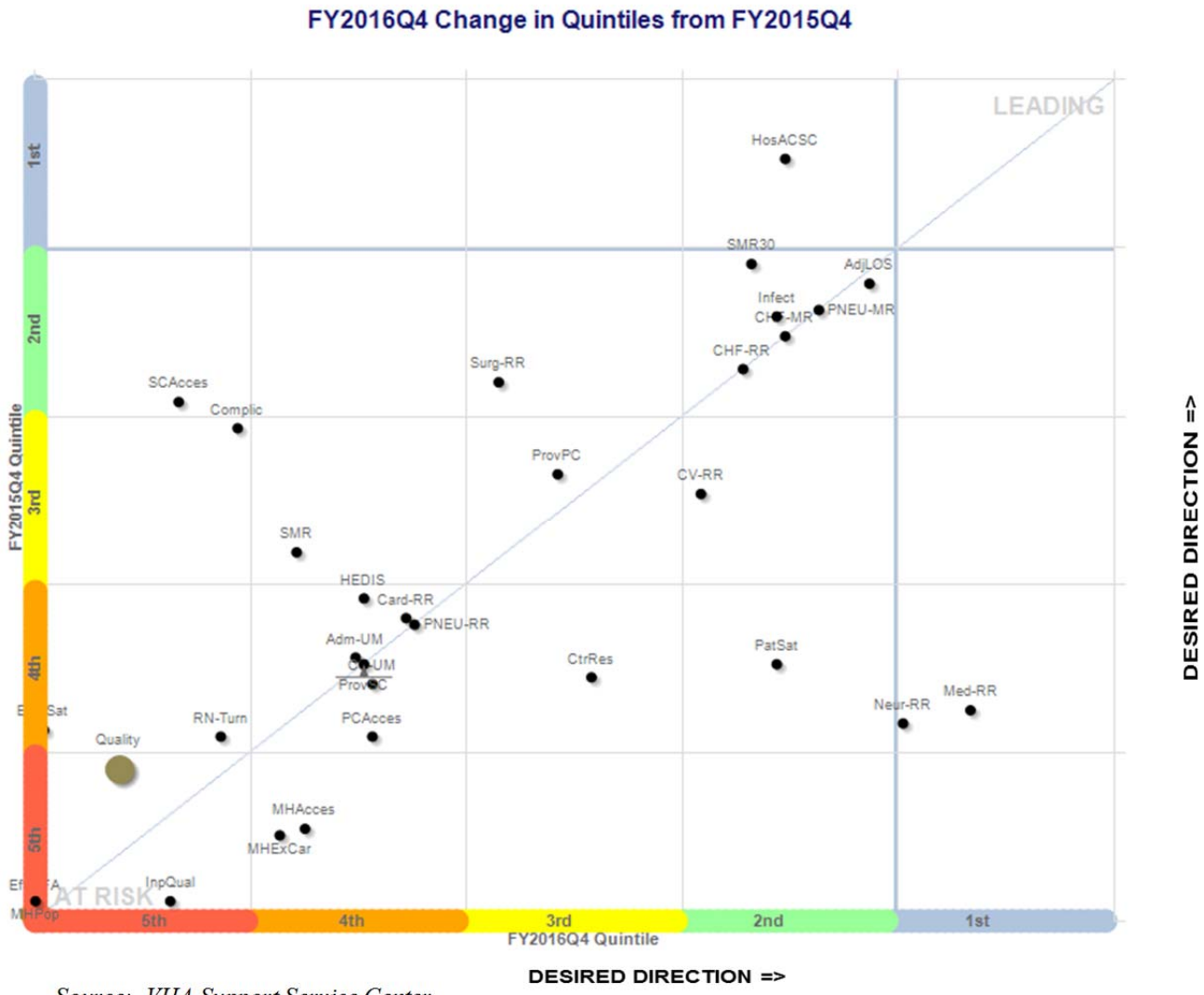


Source: VHA Support Service Center

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

[30] Metric definitions follow the graphs.

Scatter Chart



NOTE

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

Source: VHA Support Service Center

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

Metric Definitions[I]

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

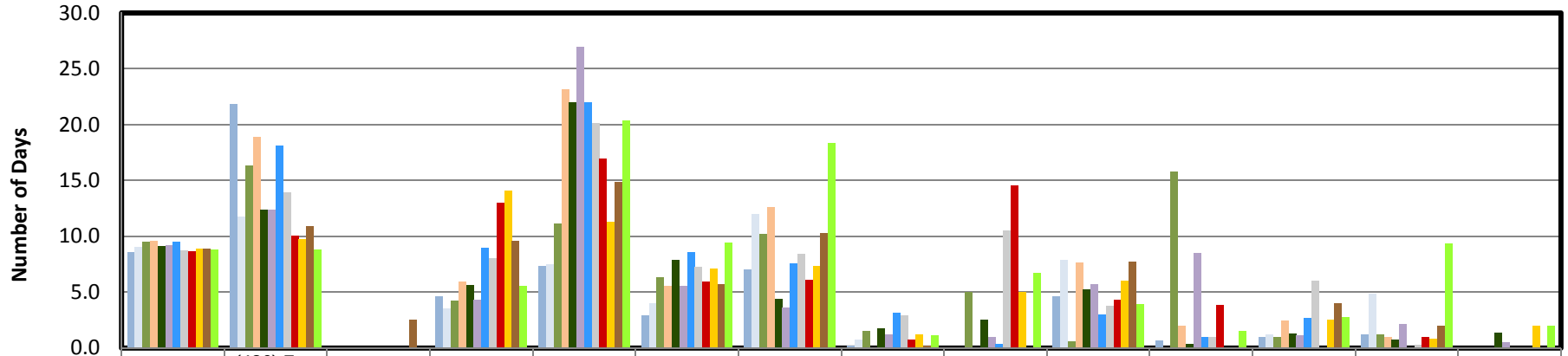
Measure	Definition	Desired Direction
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-Cardio	30-day risk standardized readmission rate for cardiorespiratory patient cohort	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-CV	30-day risk standardized readmission rate for cardiovascular patient cohort	A lower value is better than a higher value
RSRR-HWR	Hospital wide readmission	A lower value is better than a higher value
RSRR-Med	30-day risk standardized readmission rate for medicine patient cohort	A lower value is better than a higher value
RSRR-Neuro	30-day risk standardized readmission rate for neurology patient cohort	A lower value is better than a higher value
RSRR-Pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
RSRR-Surg	30-day risk standardized readmission rate for surgery patient cohort	A lower value is better than a higher value
SC Routine Care Appt	Timeliness in getting a SC routine care appointment (Specialty Care)	A higher value is better than a lower value
SC Urgent Care Appt	Timeliness in getting a SC urgent care appointment (Specialty Care)	A higher value is better than a lower value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Specialty Care Wait Time	Specialty care wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value

Source: VHA Support Service Center

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

Patient Aligned Care Team Compass Metrics

FY 2016 New PC Patient Average Wait Time in Days

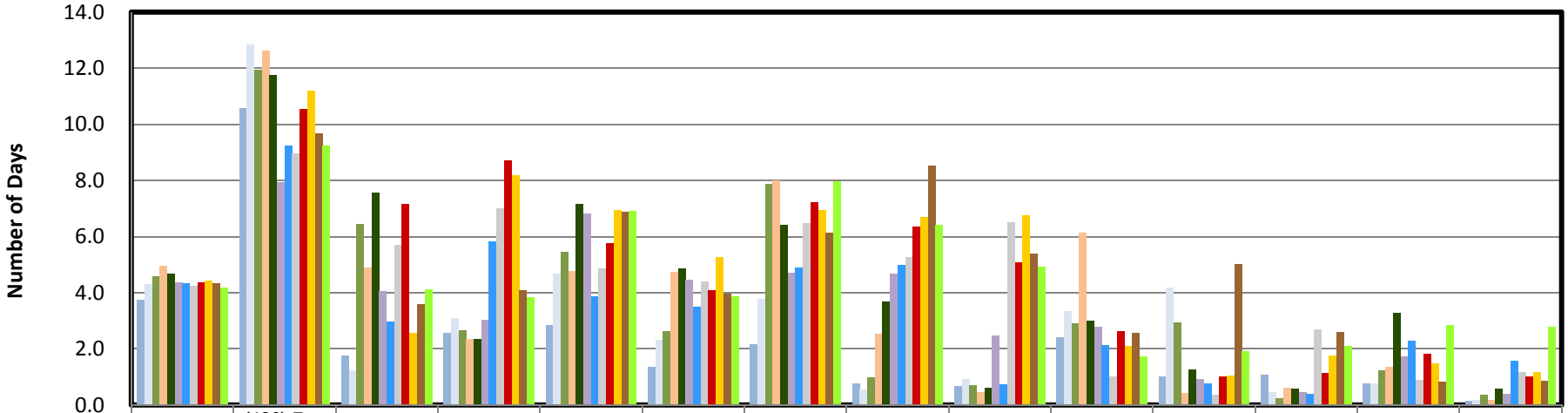


	VHA Total	(436) Fort Harrison VA Medical Center	(436GA) Anaconda	(436GB) Great Falls	(436GC) Missoula	(436GD) Bozeman	(436GF) Kalispell	(436GH) Billings	(436GI) Glasgow	(436GJ) Miles City VA Clinic	(436GK) Glendive	(436GL) Cut Bank	(436GM) Lewistown	(436HC) Merril Lundman VA OPC
OCT-FY16	8.6	21.9	0.0	4.6	7.3	2.9	7.0	0.2	0.0	4.6	0.7	1.0	1.2	0.0
NOV-FY16	9.1	11.7		3.5	7.5	4.0	12.0	0.8	0.0	7.9	0.0	1.2	4.9	0.0
DEC-FY16	9.5	16.3		4.2	11.1	6.3	10.2	1.5	5.0	0.6	15.8	1.0	1.2	0.0
JAN-FY16	9.6	18.9		5.9	23.2	5.5	12.6	0.0	0.0	7.7	2.0	2.4	1.0	0.0
FEB-FY16	9.1	12.3		5.6	22.0	7.9	4.4	1.7	2.5	5.3	0.3	1.3	0.8	1.3
MAR-FY16	9.2	12.4		4.3	26.9	5.5	3.6	1.2	1.0	5.7	8.5	1.1	2.2	0.5
APR-FY16	9.5	18.1		8.9	22.0	8.5	7.5	3.1	0.3	3.0	1.0	2.7	0.0	0.0
MAY-FY16	8.7	14.0		8.0	20.1	7.2	8.4	2.9	10.5	3.8	1.0	6.0	0.3	0.0
JUN-FY16	8.6	10.0		13.0	16.9	5.9	6.1	0.7	14.6	4.3	3.8	0.0	1.0	0.0
JUL-FY16	8.9	9.8	0.0	14.1	11.3	7.1	7.3	1.2	5.0	6.0		2.6	0.8	2.0
AUG-FY16	8.9	10.9	2.5	9.6	14.9	5.7	10.3	0.2	0.0	7.8	0.0	4.0	2.0	0.0
SEP-FY16	8.8	8.8	0.0	5.5	20.3	9.4	18.3	1.2	6.7	3.9	1.5	2.8	9.3	2.0

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.* Blank cells indicate the absence of reported data.

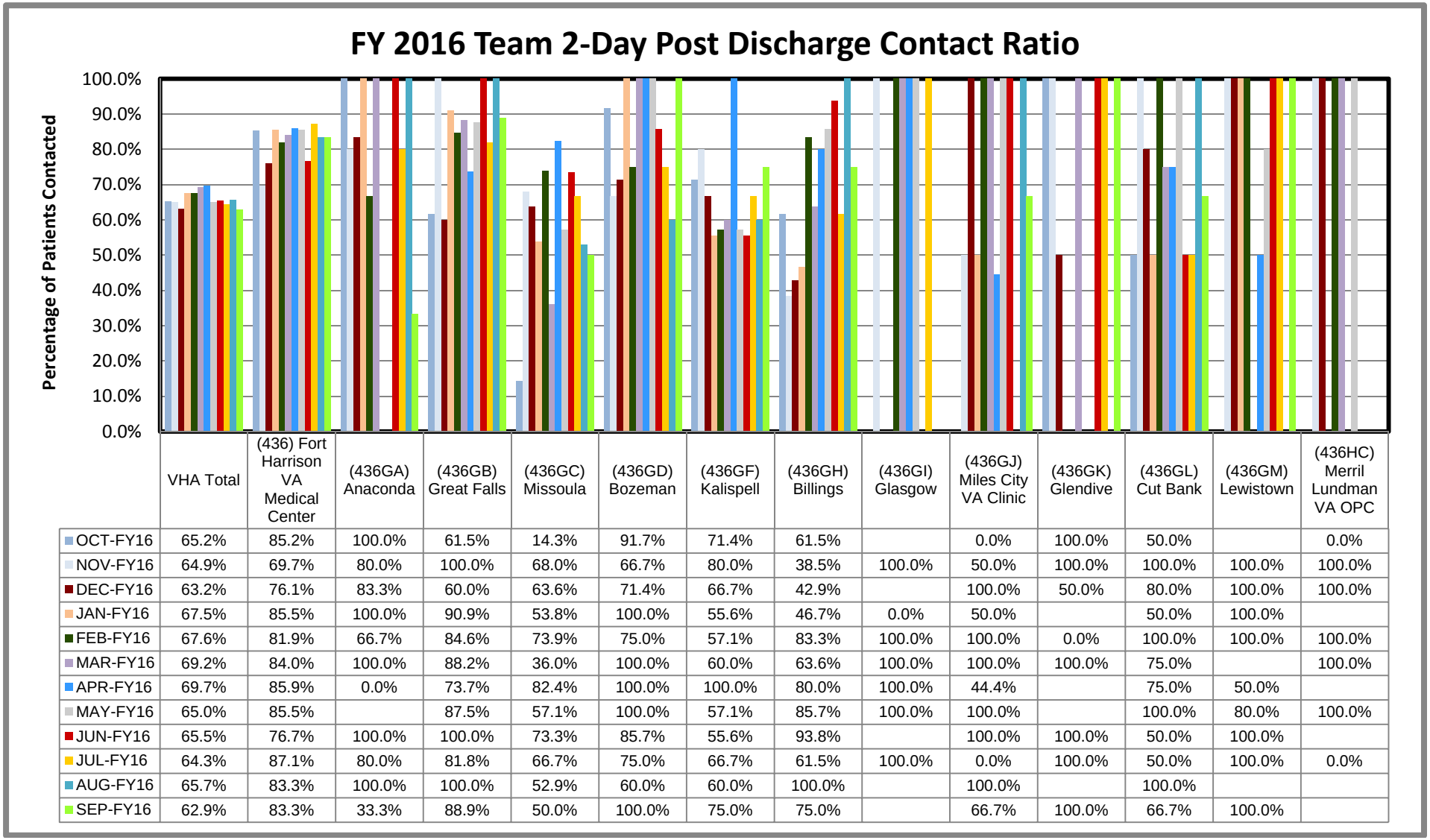


	VHA Total	(436) Fort Harrison VA Medical Center	(436GA) Anaconda	(436GB) Great Falls	(436GC) Missoula	(436GD) Bozeman	(436GF) Kalispell	(436GH) Billings	(436GI) Glasgow	(436GJ) Miles City VA Clinic	(436GK) Glendive	(436GL) Cut Bank	(436GM) Lewistown	(436HC) Merril Lundman VA OPC
OCT-FY16	3.8	10.6	1.8	2.5	2.9	1.4	2.2	0.8	0.7	2.4	1.0	1.1	0.8	0.1
NOV-FY16	4.3	12.8	1.2	3.1	4.7	2.3	3.8	0.5	0.9	3.3	4.2	0.4	0.8	0.2
DEC-FY16	4.6	11.9	6.4	2.6	5.4	2.6	7.9	1.0	0.7	2.9	2.9	0.2	1.2	0.3
JAN-FY16	4.9	12.6	4.9	2.3	4.8	4.7	8.0	2.5	0.4	6.1	0.4	0.6	1.3	0.2
FEB-FY16	4.7	11.8	7.6	2.4	7.2	4.9	6.4	3.7	0.6	3.0	1.3	0.6	3.3	0.6
MAR-FY16	4.4	7.9	4.0	3.0	6.8	4.5	4.7	4.7	2.5	2.8	0.9	0.4	1.7	0.4
APR-FY16	4.3	9.2	3.0	5.8	3.9	3.5	4.9	5.0	0.7	2.1	0.8	0.4	2.3	1.6
MAY-FY16	4.3	9.0	5.7	7.0	4.9	4.4	6.5	5.3	6.5	1.0	0.3	2.7	0.9	1.2
JUN-FY16	4.4	10.5	7.2	8.7	5.8	4.1	7.2	6.4	5.1	2.6	1.0	1.2	1.8	1.0
JUL-FY16	4.4	11.2	2.6	8.2	6.9	5.3	6.9	6.7	6.8	2.1	1.0	1.8	1.5	1.2
AUG-FY16	4.3	9.7	3.6	4.1	6.9	4.0	6.1	8.5	5.4	2.6	5.0	2.6	0.8	0.9
SEP-FY16	4.2	9.2	4.1	3.8	6.9	3.9	8.0	6.4	4.9	1.7	1.9	2.1	2.8	2.8

Source: VHA Support Service Center

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

Data Definition: The average number of calendar days between an established patient's PC completed appointment (clinic stops 322, 323, and 350, excluding Compensation and Pension appointments) and the earliest of three possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date.

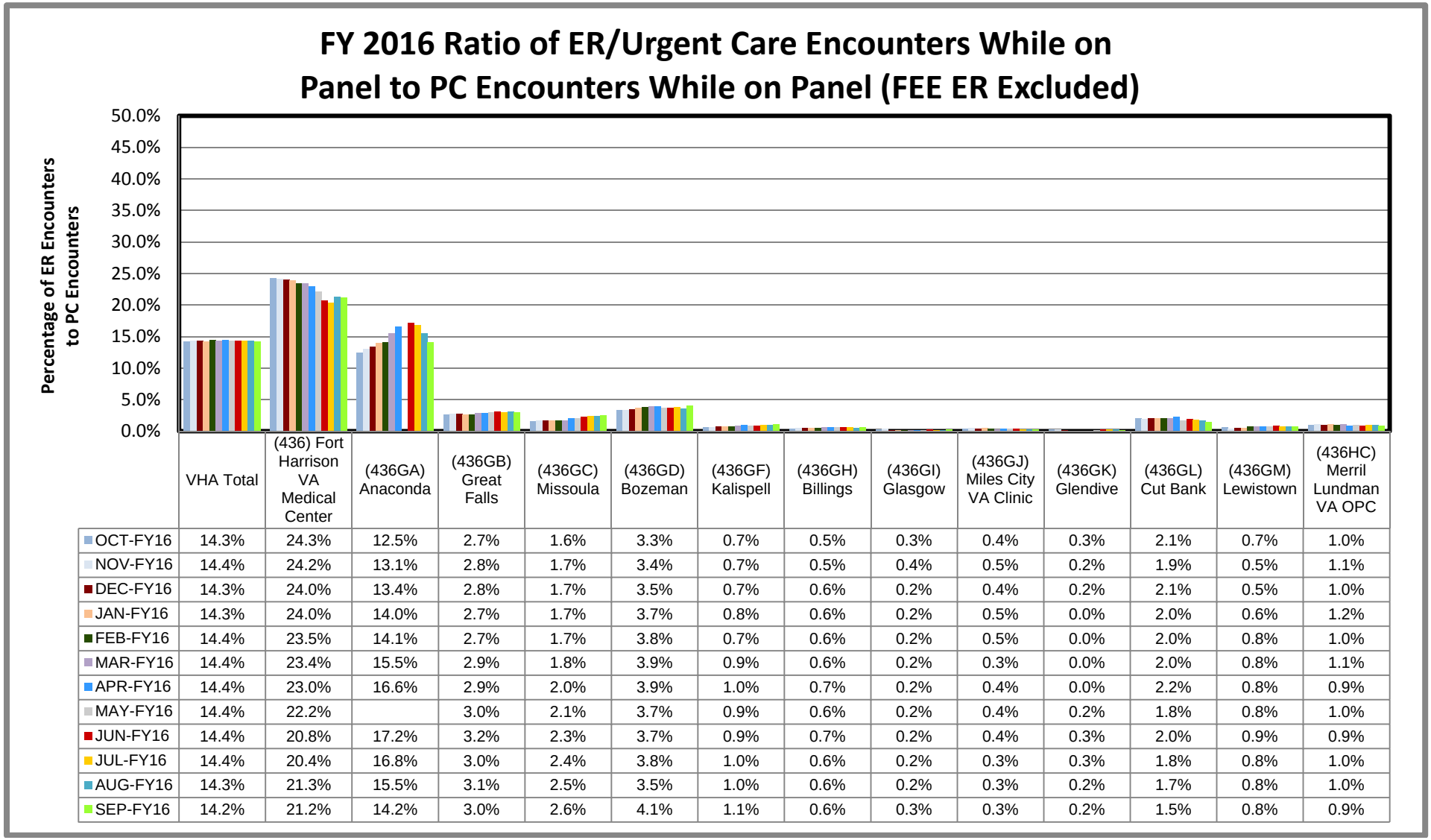


	VHA Total	(436) Fort Harrison VA Medical Center	(436GA) Anaconda	(436GB) Great Falls	(436GC) Missoula	(436GD) Bozeman	(436GF) Kalispell	(436GH) Billings	(436GI) Glasgow	(436GJ) Miles City VA Clinic	(436GK) Glendive	(436GL) Cut Bank	(436GM) Lewistown	(436HC) Merril Lundman VA OPC
OCT-FY16	65.2%	85.2%	100.0%	61.5%	14.3%	91.7%	71.4%	61.5%		0.0%	100.0%	50.0%		0.0%
NOV-FY16	64.9%	69.7%	80.0%	100.0%	68.0%	66.7%	80.0%	38.5%	100.0%	50.0%	100.0%	100.0%	100.0%	100.0%
DEC-FY16	63.2%	76.1%	83.3%	60.0%	63.6%	71.4%	66.7%	42.9%		100.0%	50.0%	80.0%	100.0%	100.0%
JAN-FY16	67.5%	85.5%	100.0%	90.9%	53.8%	100.0%	55.6%	46.7%	0.0%	50.0%		50.0%	100.0%	
FEB-FY16	67.6%	81.9%	66.7%	84.6%	73.9%	75.0%	57.1%	83.3%	100.0%	100.0%	0.0%	100.0%	100.0%	100.0%
MAR-FY16	69.2%	84.0%	100.0%	88.2%	36.0%	100.0%	60.0%	63.6%	100.0%	100.0%	100.0%	75.0%		100.0%
APR-FY16	69.7%	85.9%	0.0%	73.7%	82.4%	100.0%	100.0%	80.0%	100.0%	44.4%		75.0%	50.0%	
MAY-FY16	65.0%	85.5%		87.5%	57.1%	100.0%	57.1%	85.7%	100.0%	100.0%		100.0%	80.0%	100.0%
JUN-FY16	65.5%	76.7%	100.0%	100.0%	73.3%	85.7%	55.6%	93.8%		100.0%	100.0%	50.0%	100.0%	
JUL-FY16	64.3%	87.1%	80.0%	81.8%	66.7%	75.0%	66.7%	61.5%	100.0%	0.0%	100.0%	50.0%	100.0%	0.0%
AUG-FY16	65.7%	83.3%	100.0%	100.0%	52.9%	60.0%	60.0%	100.0%		100.0%		100.0%		
SEP-FY16	62.9%	83.3%	33.3%	88.9%	50.0%	100.0%	75.0%	75.0%		66.7%	100.0%	66.7%	100.0%	

Source: VHA Support Service Center

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

Data Definition: The percent of assigned PC patients discharged from any VA facility who have been contacted by a PC team member within 2 business days during the reporting period. Patients are excluded if they are discharged from an observation specialty and/or readmitted within 2 business days to any VA facility. Team members must have been assigned to the patient's team at the time of the patient's discharge. Blank cells indicate the absence of reported data.



	VHA Total	(436) Fort Harrison VA Medical Center	(436GA) Anaconda	(436GB) Great Falls	(436GC) Missoula	(436GD) Bozeman	(436GF) Kalispell	(436GH) Billings	(436GI) Glasgow	(436GJ) Miles City VA Clinic	(436GK) Glendive	(436GL) Cut Bank	(436GM) Lewistown	(436HC) Merril Lundman VA OPC
OCT-FY16	14.3%	24.3%	12.5%	2.7%	1.6%	3.3%	0.7%	0.5%	0.3%	0.4%	0.3%	2.1%	0.7%	1.0%
NOV-FY16	14.4%	24.2%	13.1%	2.8%	1.7%	3.4%	0.7%	0.5%	0.4%	0.5%	0.2%	1.9%	0.5%	1.1%
DEC-FY16	14.3%	24.0%	13.4%	2.8%	1.7%	3.5%	0.7%	0.6%	0.2%	0.4%	0.2%	2.1%	0.5%	1.0%
JAN-FY16	14.3%	24.0%	14.0%	2.7%	1.7%	3.7%	0.8%	0.6%	0.2%	0.5%	0.0%	2.0%	0.6%	1.2%
FEB-FY16	14.4%	23.5%	14.1%	2.7%	1.7%	3.8%	0.7%	0.6%	0.2%	0.5%	0.0%	2.0%	0.8%	1.0%
MAR-FY16	14.4%	23.4%	15.5%	2.9%	1.8%	3.9%	0.9%	0.6%	0.2%	0.3%	0.0%	2.0%	0.8%	1.1%
APR-FY16	14.4%	23.0%	16.6%	2.9%	2.0%	3.9%	1.0%	0.7%	0.2%	0.4%	0.0%	2.2%	0.8%	0.9%
MAY-FY16	14.4%	22.2%		3.0%	2.1%	3.7%	0.9%	0.6%	0.2%	0.4%	0.2%	1.8%	0.8%	1.0%
JUN-FY16	14.4%	20.8%	17.2%	3.2%	2.3%	3.7%	0.9%	0.7%	0.2%	0.4%	0.3%	2.0%	0.9%	0.9%
JUL-FY16	14.4%	20.4%	16.8%	3.0%	2.4%	3.8%	1.0%	0.6%	0.2%	0.3%	0.3%	1.8%	0.8%	1.0%
AUG-FY16	14.3%	21.3%	15.5%	3.1%	2.5%	3.5%	1.0%	0.6%	0.2%	0.3%	0.2%	1.7%	0.8%	1.0%
SEP-FY16	14.2%	21.2%	14.2%	3.0%	2.6%	4.1%	1.1%	0.6%	0.3%	0.3%	0.2%	1.5%	0.8%	0.9%

Source: VHA Support Service Center

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

Data Definition: This is a measure of where the patient receives his PC and by whom. A low percentage is better. The formula is the total VHA ER/Urgent Care Encounters While on Team (WOT) with a Licensed Independent Practitioner (LIP) *divided by* the number of PC Team Encounters WOT with an LIP **plus** the total number of VHA ER/Urgent Care Encounters WOT with an LIP. Blank cells indicate the absence of reported data.

Prior OIG Reports
August 1, 2013 through March 1, 2017

Facility Reports

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

6/18/2015 | 15-01297-368 | Summary | Report

Healthcare Inspection – Prevention of Legionnaires' Disease in VHA Facilities

8/1/2013 | 13-01189-267 | Summary | Report

Appendix E

Veterans Integrated Service Network Director Comments

Department of Veterans Affairs

Memorandum

Date: May 25, 2017

From: Director, Rocky Mountain Network (10N19)

Subject: **CAP Review of the Montana VA Health Care System, Fort Harrison, MT**

To: Director, Seattle Office of Healthcare Inspections (54SE)

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

I have reviewed and concur with the responses from the Montana VAHCS to the Combined Assessment Program review of their facility.

(original signed by:)
Ralph T. Gigliotti, FACHE
Director, VA Rocky Mountain Network (10N19)

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: May 23, 2017

From: Director, Montana VA Health Care System (436/00)

Subject: **CAP Review of the Montana VA Health Care System, Fort Harrison, MT**

To: Director, Rocky Mountain Network (10N19)

1. On behalf of the Montana VA Health Care System, I want to express my appreciation to the Office of Inspector General (OIG) Office of Healthcare Inspections for the Combined Assessment Program review of the Montana VA Health Care System, conducted March 6–10, 2017.

2. The attached documents provide comment to the reported findings and outlines the actions taken by the staff of the Montana VA Health Care System in response to the OIG recommendations.

(original signed by:)
Kathy W. Berger
Director, Montana VA Health Care System

Comments to OIG's Report

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

OIG Recommendations

Recommendation 1. We recommended that the facility replace missing and stained ceiling tiles in patient care areas and that facility managers monitor compliance.

Concur

Target date for completion: May 2017

Facility response: The stained ceiling tiles in the two patient care areas found during the environment of care inspection have been replaced by the Facility Management Service. Ongoing compliance will be monitored during facility EOC rounds.

Recommendation 2. We recommended that facility managers ensure standard operating procedures for colonoscopes and endoscopes for esophagogastroduodenoscopy and endoscopic retrograde cholangiopancreatography are consistent with the manufacturers' instructions for use.

Concur

Target date for completion: May 2017

Facility response: The standard operating procedures (SOPs) in place for the colonoscopes and endoscopes at the time of the OIG review were missing sections from the manufacturer's instructions. These SOPs now have the complete manufacturer's instructions.

Recommendation 3. We recommended that Sterile Processing Service employees document positive quality control testing results for colonoscopes and endoscopes for esophagogastroduodenoscopy and endoscopic retrograde cholangiopancreatography in a manner that allows tracking of actions taken and that facility managers monitor compliance.

Concur

Target date for completion: September 2017

Facility response: The quality control testing results documentation spreadsheet has been revised to document the positive quality control results and the actions taken. Facility managers will monitor compliance for 3 consecutive months with an expected compliance rate of 90%.

Recommendation 4. We recommended that the facility provide patients with a direct telephone number for anticoagulation-related calls during normal business hours and define a process for anticoagulation calls outside normal business hours.

Concur

Target date for completion: May 2017

Facility response: The letter sent to patients following each anticoagulation clinic visit includes phone numbers for day time and after-hours access for anticoagulation related concerns. The voice mail message for the anticoagulation clinic was updated to include a number to call for anticoagulation related questions outside normal business hours. This process has been included in the Pharmacist Anticoagulation Clinic Monitoring and Treatment Protocol of the Medical Center Memorandum Anticoagulation Management Program.

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

Concur

Target date for completion: April 2017

Facility response: The Chief of Staff has designated a staff physician to be the anticoagulation program champion. The Medical Center Memorandum Anticoagulation Management Program outlines the functions and responsibilities of the anticoagulation program champion.

Recommendation 6. We recommended that clinicians consistently provide transition follow-up to inpatients with newly prescribed anticoagulant medications in accordance with local policy and that facility managers monitor compliance.

Concur

Target date for completion: August 2017

Facility response: Local policy did not exclude post-operative orthopedic inpatients on short term anticoagulation that remain under the care of the surgeon from transition follow-up. The Medical Center Memorandum Anticoagulation Management Program was updated to clarify that patients receiving short term treatment with a DOAC in the post-operative setting (generally 30 days or less) will remain under the care of the surgeon for the duration of DOAC use. Pharmacy will monitor transition follow-up for inpatients with newly prescribed anticoagulant medications for 3 consecutive months with an expected compliance rate of 90%.

Recommendation 7. We recommended that the facility collect and report data on patient transfers out of the facility.

Concur

Target date for completion: June 2017

Facility response: Data collection on inter-facility transfers began in fourth quarter FY 2016 and is being reported quarterly to the Health Care Quality Safety and Value Executive Committee. Monitoring will occur for 3 consecutive quarters with an expected compliance rate of 90%.

Recommendation 8. We recommended that clinicians take and document all actions required by the facility in response to test results and that clinical managers monitor compliance.

Concur

Target date for completion: September 2017

Facility response: Facility policy states that glucometer critical test results will be documented utilizing the progress note title "Finger Stick Glucose Critical Notification/Readback." The Laboratory Ancillary Testing Coordinator reviewed the requirements and processes for documenting all actions in response to test results with the clinical Nurse Managers. The documentation requirements were then communicated to nursing staff during unit/clinic staff meetings. Clinical managers will monitor compliance for 3 consecutive months with an expected compliance rate of 90%.

Recommendation 9. We recommended that the facility process adverse events/complications in a similar manner as operating room anesthesia adverse events and that facility managers monitor compliance.

Concur

Target date for completion: September 2017

Facility response: Criteria for monitoring adverse events/complications for moderate sedation have been established and approved by the Associate Chief of Staff, Surgery and Perioperative Care. Clinical managers will monitor compliance for 3 consecutive months or meeting minutes include the information with an expected compliance rate of 90%.

Recommendation 10. We recommended that the facility note the absence of adverse events in Operative and Invasive Procedure Committee reports and that facility managers monitor compliance.

Concur

Target date for completion: September 2017

Facility response: Adverse events/complications will be reported to the Invasive Procedures Committee. Negative reports will be included. Clinical managers will monitor compliance for 3 consecutive months with an expected compliance rate of 90%.

Recommendation 11. We recommended that clinical managers ensure clinical employees who perform or assist with moderate sedation procedures have current Talent Management System training for the provision of moderate sedation care, ensure the training is documented, and monitor compliance.

Concur

Target date for completion: July 2017

Facility response: As noted during the on-site review, moderate sedation has only been utilized at the Billings Health Care Center (HCC) in the endoscopy suite for the past 12 months. All providers and nurses who are involved in the use of moderate sedation at this site have completed the TMS training as required. Facility leadership is currently reviewing the Medical Center Memorandum "Moderate Sedation by Non-Anesthesia Personnel" to evaluate approved sites for moderate sedation use. If Fort Harrison is to remain on the approved list for moderate sedation, leadership will ensure privileged providers and nurses complete the required TMS training prior to moderate sedation use.

Recommendation 12. We recommended that the facility revise the policy on ensuring correct surgery and invasive procedures to include all elements of the timeout checklist required by Veterans Health Administration Directive 1039.

Concur

Target date for completion: April 2017

Facility response: The Medical Center Memorandum "Ensuring Correct Surgery and Invasive Procedures" contained a condensed version of the time out checklist for out of OR procedures. The Medical Center Memorandum "Ensuring Correct Surgery and Invasive Procedures" has been updated to include the full timeout checklist required by the Veterans Health Administration Directive 1039 for out of OR procedures.

Recommendation 13. We recommended that facility managers complete exclusion review documentation when community nursing home annual reviews note four or more exclusionary criteria.

Concur

Target date for completion: October 2017

Facility response: The exclusion review documentation was lacking the VISN [Veterans Integrated Service Network] and Central Office reviewer's signatures. Facility managers have completed the exclusion review documentation for the community nursing homes whose annual review noted four or more exclusionary criteria. Ongoing monitoring will be done through the CNH/NIC committee for three consecutive months with an expected compliance rate of 90%.

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

Concur

Target date for completion: September 2017

Facility response: The recommendation was a result of social work staffing shortages in the Community Nursing Home program. This shortage has been corrected and nurses and social workers are now documenting the cyclical clinical visits as required by policy. Facility mangers will monitor the frequency of reviews for 3 consecutive months with an expected compliance rate of 90%. Ongoing monitoring will be through the CNH/NIC committee.

Recommendation 15. We recommended that the facility revise the workplace violence prevention policy to include required membership for the Disruptive Behavior Committee.

Concur

Target date for completion: July 2017

Facility response: Clinical management has determined that a separate Disruptive Patient Behavior and Patient Records Flag policy would be appropriate for meeting the requirements of the Veterans Health Administration Directive 2010-053. The new policy includes the required membership for the Disruptive Behavior Committee. This policy is currently in the concurrence process.

Recommendation 16. We recommended that facility clinical managers ensure a clinician member of the Disruptive Behavior Committee enters Patient Record Flags into the electronic health records.

Concur

Target date for completion: October 2017

Facility response: The Disruptive Patient Behavior and Patient Records Flag policy outlines the responsibility of a clinician member of the Disruptive Behavior Committee to enter Patient Record Flags into the electronic health record. This policy is presently in the concurrence process for publication. Facility clinical managers will monitor compliance for 3 consecutive months with an expected compliance rate of 90%.

Recommendation 17. We recommended that the facility implement a process to ensure all surgical deaths are tracked and reviewed by appropriate clinical employees.

Concur

Target date for completion: September 2017

Facility response: M&M reviews are being completed on all surgical deaths. However, the Surgical Work Group minutes have not documented the discussion of the group for trending and analysis of findings. M&M reviews will continue on all surgical deaths. The Surgical Work Group will document discussion regarding the M&M reviews including trending and analysis of findings. The Surgical Work Group will complete a monthly review of surgical deaths within 30 days of the procedure and document findings and discussions for all surgical deaths for the next 6 months; the goal is 100 percent compliance.

Recommendation 18. We recommended that acute care employees accurately document location, stage, risk scale score, and date pressure ulcer acquired for all patients with pressure ulcers and that facility managers monitor compliance.

Concur

Target date for completion: October 2017

Facility response: Acute care employees have been re-educated to accurately document location, stage, risk scale score, and date acquired for all hospital acquired pressure ulcers. The medical record audits have been updated to accurately capture the documentation in the EHR for location, stage, risk scale score, and date acquired for all hospital acquired pressure ulcers. There were no hospital acquired pressure ulcers for second quarter fiscal year 2017. Facility managers will monitor compliance for 3 consecutive quarters with an expected compliance rate of 90%.

Recommendation 19. We recommended that clinic employees document in patients' electronic health records medication reconciliation that includes the newly prescribed fluoroquinolone, patient counseling/education that includes the fluoroquinolone, and evaluation of the patients' level of understanding of the education.

Concur

Target date for completion: October 2017

Facility response: Primary Care providers have consistently documented the requirements for patient education and medication reconciliation in relation to fluoroquinolone prescribing. Fluoroquinolones are prescribed for short-term prophylaxis prior to urology procedures. The patient education and medication reconciliation has not been consistently documented for these patients. The urologists have been educated on the need for patient education and medication reconciliation when ordering fluoroquinolones even for short-term prophylaxis use. Monitoring for compliance will be documented for 3 consecutive months with an expected compliance rate of 90%.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
Inspection Team	Craig Byer, MS, RRA, Team Leader Carol Lukasewicz, RN, BSN Sarah Mainzer, BSN, JD Monika Spinks, RN, BSN Susan Tostenrude, MS Michelle Wilt, MBA, BSN Robert Sproull, Resident Agent in Charge, Office of Investigations
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U.S. Senate: Steve Daines, Jon Tester
U.S. House of Representatives: Greg Gianforte

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 Directive1039, *Ensuring Correct Surgery and Invasive Procedures*, July 26, 2013.
- VHA Directive 1073, *Moderate Sedation by Non-Anesthesia Providers*, December 30, 2014.
- VHA Directive 1177; *Cardiopulmonary Resuscitation, Basic Life Support, and Advanced Cardiac Life Support Training for Staff*; November 6, 2014.
- VA National Center for Patient Safety. *Facilitator's Guide for Moderate Sedation Toolkit for Non-Anesthesiologists*. March 29, 2011.
- American Society of Anesthesiologists. Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists. *Anesthesiology*. 2002; 96:1004–17.
- The Joint Commission. Hospital Standards. January 2016. PC.03.01.01, EP1 and MS.06.01.03 EP6.

[g] The references used for CNH Oversight included:
- VHA Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures*, June 4, 2004.
- 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.
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[j] The reference used for Pressure Ulcer Prevention and Management was:

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[k] The references used for Medication Management included:

- VHA Directive 2011-012, *Medication Reconciliation,* March 9, 2011.
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[l] The reference used for the Strategic Analytics for Improvement and Learning (SAIL) metric definitions was:

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[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.