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Clinical Assessment Program Review of the Overton Brooks VA Medical Center Shreveport, Louisiana

February 16, 2017

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Glossary

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

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Executive Summary

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

Results: We conducted the review during the week of October 24, 2016, and identified certain system weaknesses in utilization management; general safety; environmental cleanliness; anticoagulation processes; transfer documentation and data collection; history and physical examinations for moderate sedation procedures; community nursing home annual reviews and clinical visits; processes, procedures, and training related to the management of disruptive and violent behavior; and treatment of alcohol use disorder.

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

1. Utilization management decisions are made with physician advisors' input.
2. Patients receive care in a safe and clean environment.
3. Anticoagulation patients can contact clinical employees with safety concerns after business hours.
4. Clinicians use laboratory tests to safely initiate and monitor anticoagulation therapy and provide transition follow-up for patients discharged on newly prescribed anticoagulants.
5. The facility safely transfers patients to another facility and uses patient transfer data to improve care and processes.
6. Providers consistently assess patients prior to moderate sedation procedures.
7. Employees provide ongoing monitoring and follow-up of community nursing home patients.
8. The facility takes necessary steps to prevent or reduce disruptive behaviors.
9. Clinicians notify patients of their rights related to flags placed in their medical records.
10. Clinicians consistently offer further treatment to patients diagnosed with alcohol dependence.

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

Quality, Safety, and Value – Ensure that:
- Physician Utilization Management Advisors consistently document their decisions in the National Utilization Management Integration database.

Environment of Care – Ensure that:
- Environment of Care Committee meeting minutes consistently document corrective actions taken to address rounds deficiencies and consistently track actions taken in response to identified deficiencies to closure.
- Ventilation grills and floors in patient care areas are clean.
- Rusted equipment in patient care areas is repaired or removed from service.
- Sinks in patient nourishment kitchens are clean.
- Hemodialysis unit sinks and floors are clean.
- Clean and dirty items are stored separately on the hemodialysis unit.

Medication Management: Anticoagulation Therapy – Ensure that:
- The facility defines a process for patient anticoagulation-related calls outside normal business hours.
- Clinicians consistently provide transition follow-up to inpatients with newly prescribed anticoagulant medications in accordance with local policy.
- Clinicians consistently obtain all required laboratory tests prior to initiating anticoagulant medications and obtain required laboratory tests during warfarin treatment at the frequency required by local policy.

Coordination of Care: Inter-Facility Transfers – Ensure that:
- The facility collects and reports data on patient transfers out of the facility as required by local policy.
- Transfer notes are written by a staff/attending physician or are written by an acceptable designee and contain a staff/attending physician countersignature.

Moderate Sedation – Ensure that:
- Providers include the evaluation of previous adverse events with anesthesia in the history and physical and pre-sedation assessment.

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 and registered nurses conduct and document cyclical clinical visits with the frequency required by Veterans Health Administration policy.

Management of Disruptive/Violent Behavior – Ensure that:

- The facility implements an Employee Threat Assessment Team and that the VA Police Officer and Risk Manager consistently attend Disruptive Behavior Committee meetings.
- Clinicians inform patients about the Patient Record Flags and the right to appeal flag placement.
- Appropriate individuals conduct debriefings after incidents of disruptive or violent behavior.
- All employees receive Level 1 training and additional training as required for their assigned risk area within 90 days of hire and that the training is documented in employee training records.

We also made the following repeat recommendation.

Alcohol Use Disorder – Ensure that:

- Community based outpatient clinic/primary care clinic employees consistently document the offer of further treatment to patients diagnosed with alcohol dependence.

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 41–48, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

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Purpose and Objectives

Purpose

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

Objectives

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

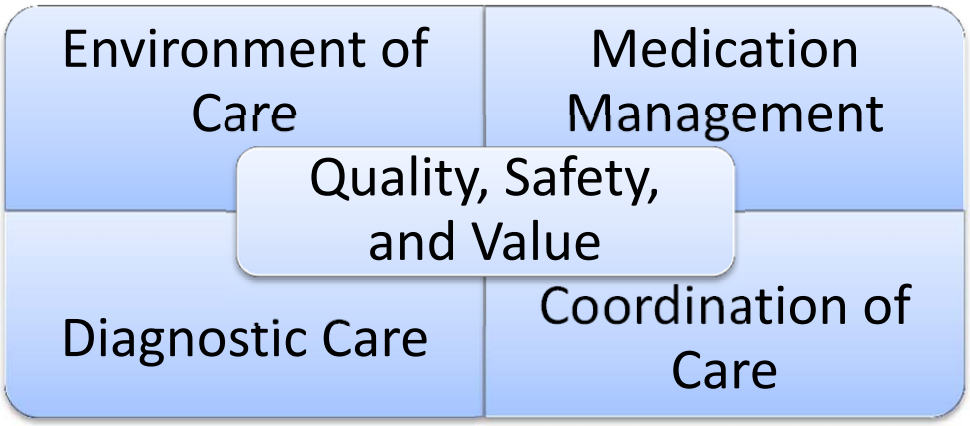
OIG also evaluates processes that are high risk and problem-prone. During this cycle, Moderate Sedation, CNH Oversight, and Management of Disruptive/Violent Behavior are processes that are high risk and problem-prone. We also followed up on recommendations from the previous Combined Assessment Program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

Additionally, OIG provides crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Background

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

Figure 1. Comprehensive Coverage of Continuum of Care



Source: VA OIG

QSV

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

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

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

EOC

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

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

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

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

Medication Management

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

Coordination of Care

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

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

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

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

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

- Moderate Sedation
- CNH Oversight
- Management of Disruptive/Violent Behavior

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

The review covered operations for FY 2015, FY 2016, and FY 2017 through October 24, 2016, and inspectors conducted the reviews in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide the status on the recommendations we made in our previous Combined Assessment Program report (*Combined Assessment Program Review of the Overton Brooks VA Medical Center, Shreveport, Louisiana,* Report No. 14-00308-105, March 31, 2014) and CBOC report (*Community Based Outpatient Clinic and Primary Care Clinic Reviews at Overton Brooks VA Medical Center, Shreveport, Louisiana,* Report No. 14-00228-94, March 14, 2014). We made a repeat recommendation in Alcohol Use Disorder. (See page 29.)

We presented crime awareness briefings for 411 employees. These briefings covered procedures for reporting suspected criminal activity to the 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 243 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 the OIG to monitor until the facility implements corrective actions. Issues and concerns that come to our attention but are outside the scope of this CAP review will be considered for further review separate from the CAP process and may be referred accordingly.

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

Checklist 1. QSV Areas Reviewed, Findings, and Recommendations

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

NM	Areas Reviewed (continued)	Findings	Recommendations
	Credentialing and privileging processes met selected requirements: • Facility policy/by-laws specified a frequency for clinical managers to review practitioners' Ongoing Professional Practice Evaluation data. • Facility clinical managers reviewed Ongoing Professional Practice Evaluation data at the frequency specified in the policy/by-laws. • The facility set triggers for when a Focused Professional Practice Evaluation for cause would be indicated.		
	Protected peer reviews met selected requirements: • Peer reviewers documented their use of important aspects of care in their review, such as appropriate and timely ordering of diagnostic tests, timely treatment, and appropriate documentation. • When the Peer Review Committee recommended individual improvement actions, clinical managers implemented the actions.		
X	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.	• For 63 of the 202 cases (31 percent) referred to Physician Utilization Management Advisors August 15–October 15, 2016, there was no evidence that advisors documented their decisions in the National Utilization Management Integration database.	**1.** We recommended that Physician Utilization Management Advisors consistently document their decisions in the National Utilization Management Integration database and that facility managers monitor compliance.

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

Environment of Care

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

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

We inspected two medical/surgical, the acute inpatient MH, the critical care, and the hemodialysis units; the Emergency Department; SPS; two PC outpatient clinics; the women's clinic; and Knight Street VA Clinic. Additionally, we reviewed relevant documents and 13 employee training records, and we interviewed key employees and managers. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement.

Checklist 2. EOC Areas Reviewed, Findings, and Recommendations

NM	Areas Reviewed for General EOC	Findings	Recommendations
X	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure for the facility and the CBOCs.	Nine months of EOC Committee meeting minutes reviewed: • Minutes did not consistently document corrective actions taken to address rounds deficiencies and did not consistently track corrective actions to closure.	**2.** We recommended that Environment of Care Committee meeting minutes consistently document corrective actions taken to address rounds deficiencies and consistently track actions taken in response to identified deficiencies to closure.
	The facility conducted an infection prevention risk assessment.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
	Infection Prevention/Control Committee minutes documented discussion of identified high-risk areas, actions implemented to address those areas, and follow-up on implemented actions and included analysis of surveillance activities and data.		
	The facility had established a procedure for cleaning equipment between patients.		
	The facility conducted required fire drills in buildings designated for health care occupancy and documented drill critiques.		
	The facility had a policy/procedure/guideline for identification of individuals entering the facility, and units/areas complied with requirements.		
	The facility met general safety requirements.		
X	The facility met environmental cleanliness requirements.	• In four of nine patient care areas, ventilation grills were dusty, and floors were dirty. • In four of nine patient care areas, rusted equipment was present. • In three of four applicable patient care areas, sinks in patient nourishment kitchens were not clean.	**3.** We recommended that facility managers ensure ventilation grills and floors in patient care areas are clean and monitor compliance. **4.** We recommended that the facility repair rusted equipment in patient care areas or remove it from service. **5.** We recommended that facility managers ensure sinks in patient nourishment kitchens are clean and monitor compliance.
	Areas Reviewed for SPS		
	The facility had a policy for cleaning, disinfecting, and sterilizing RME.		
	The facility's standard operating procedures for selected RME were current and consistent with the manufacturers' instructions for use.		

NM	Areas Reviewed for SPS (continued)	Findings	Recommendations
	The facility performed quality control testing on selected RME with the frequency required by local policy and took appropriate action on positive results.		
	Selected SPS employees had evidence of the following for selected RME: • 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		
	The facility had a policy or procedure for preventive maintenance of hemodialysis machines and performed maintenance at the frequency required by local policy.		
	Selected hemodialysis unit employees had evidence of bloodborne pathogens training within the past 12 months.		
X	The facility met environmental safety requirements in the hemodialysis unit.	• Sinks and floors were dirty.	**6.** We recommended that the hemodialysis unit manager ensure sinks and floors are clean and monitor compliance.

NM	Areas Reviewed for the Hemodialysis Unit (continued)	Findings	Recommendations
X	The facility met infection prevention requirements in the hemodialysis unit.	• Clean and dirty items were not stored separately.	**7.** We recommended that the hemodialysis unit manager ensure clean and dirty items are stored separately and monitor compliance.
	The facility met medication safety and security requirements in the hemodialysis unit.		
	The facility met privacy requirements in the hemodialysis unit.		

Medication Management: Anticoagulation Therapy

The purpose of this review was to determine whether facility clinicians appropriately managed and provided education to patients with new orders for anticoagulant medication.[c] During calendar year 2014, an estimated 445,000 veterans were on anticoagulant therapy. Anticoagulants (commonly called blood thinners) are a class of drugs that work to prevent the coagulation or clotting of blood. For this review, we evaluated warfarin (Coumadin®) and direct-acting oral anticoagulants. Clinicians use anticoagulants for both the treatment and prevention of cardiac disease, cerebrovascular accident (stroke), and 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 three employees actively involved in the anticoagulant program, and we interviewed key employees. Additionally, we reviewed the EHRs of 30 patients who were prescribed new anticoagulant medications July 1, 2015 through June 30, 2016. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement.

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

NM	Areas Reviewed	Findings	Recommendations
	The facility had policies and processes for anticoagulation management that included required content.		
	The facility used algorithms, protocols or standardized care processes for the: • 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 had not defined a process for patient anticoagulation-related calls outside normal business hours.	**8.** We recommended that the facility define a process for patient anticoagulation-related calls outside normal business hours.
	The facility designated a physician as the anticoagulation program champion.		
	The facility defined ways to minimize the risk of incorrect tablet strength dosing errors.		
	The facility routinely reviewed quality assurance data for the anticoagulation management program at the facility's required frequency at an appropriate committee.		
X	For inpatients with newly prescribed anticoagulant medications, clinicians provided transition follow-up and education specific to the new anticoagulant.	• Two of the 16 inpatient EHRs did not contain evidence that patients received transition follow-up.	**9.** 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.
X	Clinicians obtained required laboratory tests: • Prior to initiating anticoagulant medications • During anticoagulation treatment at the frequency required by local policy	• In 10 of 28 EHRs, clinicians did not obtain all required laboratory tests prior to initiating warfarin treatment. • Nine of 28 EHRs did not contain evidence that clinicians obtained required laboratory tests during warfarin treatment at the frequency required by local policy.	**10.** We recommended that facility managers ensure clinicians consistently obtain all required laboratory tests prior to initiating anticoagulant medications and obtain required laboratory tests during warfarin treatment at the frequency required by local policy.
	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 39 patients who were transferred acutely out of facility inpatient beds or the Emergency Department/urgent care center to another VHA facility or non-VA facility July 1, 2015 through June 30, 2016. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

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

NM	Areas Reviewed	Findings	Recommendations
	The facility had a policy that addressed patient transfers and included required content.		
	The facility collected and reported data about transfers out of the facility.		
	Transferring providers completed VA Form 10-2649A and/or transfer/progress notes prior to or within a few hours after the transfer that included the following elements: • 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		

NM	Areas Reviewed (continued)	Findings	Recommendations
X	The facility complied with local policy regarding monitoring of transfer data and staff/attending physician oversight of transfers.	Local policy requires monitoring the number of transfers, analysis of outcomes, analysis of appropriateness for transfer, and time between decision and transfer. • There was no evidence the facility collected and reported all required data regarding transfers out of the facility. Local policy does not allow post-graduate trainees to act as designees and requires physician countersignature of transfer documents completed by non-physician designees. • In 19 of the 39 EHRs (49 percent), transfer notes were not written by a staff/attending physician or were written by acceptable designees but did not contain a staff/attending physician countersignature.	**11.** We recommended that the facility collect and report data on patient transfers out of the facility as required by local policy. **12.** We recommended that facility managers ensure transfer notes are written by a staff/attending physician or are written by an acceptable designee and contain a staff/attending physician countersignature.

Diagnostic Care: Point-of-Care Testing

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

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

We reviewed relevant documents, the EHRs of 48 inpatients and outpatients who underwent POCT for blood glucose July 1, 2015 through June 30, 2016, and the annual competency assessments of 45 clinicians who performed the glucose testing. Additionally, we interviewed key employees and conducted onsite glucometer inspections of the two medical/surgical units, the acute inpatient MH unit, the critical care unit, and the Emergency Department to assess compliance with manufacturers' maintenance and solution/reagent storage requirements. The table below shows the areas reviewed for this topic. The facility generally met requirements. We made no recommendations.

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.		
	Clinicians initiated appropriate clinical action and follow-up for test results.		
	The facility had POCT procedure manuals readily available to employees.		
	Quality control testing solutions/reagents and glucose test strips were current (not expired).		
	The facility managed and performed quality control in accordance with its policy/standard operating procedure and manufacturer's recommendations.		
	Glucometers were clean.		

Moderate Sedation

The purpose of this review was to evaluate selected aspects of care to determine whether the facility complied with applicable policies in the provision of moderate sedation.[f] During calendar year 2015, VHA clinicians performed more than 152,000 moderate sedation procedures of which approximately 60,000 were gastroenterology-related endoscopies.[21] Moderate sedation is a drug-induced depression of consciousness during which patients are able to respond to verbal commands. Non-anesthesiologists administer sedatives and analgesics to relieve anxiety and increase patient comfort during invasive procedures and usually do not have to provide interventions to maintain a patent airway, spontaneous ventilations, or cardiovascular function.[22] However, serious adverse events can occur, including cardiac and respiratory depression, brain damage due to low oxygen levels, cardiac arrest, or death. To minimize risks, VHA and The Joint Commission have issued requirements and standards for moderate sedation care.

We reviewed relevant documents, interviewed key employees, and inspected the gastroenterology, cardiology, pulmonology, interventional radiology, and Emergency Department procedure rooms/areas to assess whether required equipment and sedation medications were available. Additionally, we reviewed the EHRs of 44 patients who underwent an invasive procedure involving moderate sedation July 1, 2015 through June 30, 2016, and the training records of 15 clinical employees who performed or assisted during these procedures. The table below shows the areas reviewed for this topic. The area 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
	The facility reported and trended the use of reversal agents in moderate sedation cases, processed adverse events/complications in a similar manner as operating room anesthesia adverse events, and noted the absence of adverse events in Moderate Sedation Committee reports.		

[21] Per VA Corporate Data Warehouse data pull on July 28, 2016.
[22] American Society of Anesthesiologists. Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists. *Anesthesiology*. 2002; 96:1004.

NM	Areas Reviewed (continued)	Findings	Recommendations
X	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.	• In 35 EHRs (80 percent), providers did not include the evaluation of previous adverse events with anesthesia in the history and physical and pre-sedation assessment.	**13.** We recommended that providers include the evaluation of previous adverse events with anesthesia in the history and physical and pre-sedation assessment and that facility managers monitor compliance.
	Providers re-evaluated patients immediately before moderate sedation for changes since the prior assessment.		
	Providers documented informed consent prior to moderate sedation procedures, and the name of provider listed on the consent was the same as the provider who performed the procedure, or the patient was notified of the change.		
	The clinical team, including the provider performing the procedure, conducted and documented a timeout prior to the moderate sedation procedure.		
	Post-procedure documentation included assessments of patient mental status and pain level.		
	Clinical employees discharged outpatients from the recovery area with orders from the provider who performed the procedure or according to criteria approved by moderate sedation clinical leaders.		
	Clinical employees discharged moderate sedation outpatients in the company of a responsible adult.		
	Selected clinical employees had current training for moderate sedation.		

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

Community Nursing Home Oversight

The purpose of this review was to assess whether the facility complied with applicable requirements regarding the monitoring of veterans in contracted CNHs.[9] Since 1965, VHA has provided nursing home care under contracts. 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 46 patients who received CNH care for more than 3 months during the timeframe July 1, 2015 through June 30, 2016, and the results from CNH annual reviews completed July 5, 2015 through June 30, 2016. Additionally, we interviewed key employees. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement.

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

NM	Areas Reviewed	Findings	Recommendations
	The facility had a CNH Oversight Committee that met at least quarterly and included representation by the required disciplines.		
	The facility integrated the CNH Program into its quality improvement program.		
	The facility documented a hand-off for patients placed in CNHs outside of its catchment area.		
	The CNH Review Team completed CNH annual reviews.		
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 a CNH that met four or more VA exclusionary criteria and provided long-term care to six reviewed patients.	**14.** We recommended that facility managers complete exclusion review documentation when community nursing home annual reviews note four or more exclusionary criteria.

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

NM	Areas Reviewed (continued)	Findings	Recommendations
X	Social workers and registered nurses documented clinical visits that alternated on a cyclical basis.	• Five EHRs (11 percent) did not contain documentation of social worker and registered nurse cyclical clinical visits with the frequency required by VHA policy.	**15.** We recommended that facility managers ensure social workers and registered nurses conduct and document cyclical clinical visits with the frequency required by Veterans Health Administration policy 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 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 35 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 August 1, 2015 through September 30, 2016, and the training records of 15 recently hired employees who worked in areas at low, moderate, or high risk for violence. Additionally, we interviewed key employees. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement.

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

NM	Areas Reviewed	Findings	Recommendations
	The facility had a policy, procedure, or guideline on preventing and managing disruptive or violent behavior.		
	The facility conducted an annual Workplace Behavioral Risk Assessment.		
X	The facility had implemented: • 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 had not implemented an Employee Threat Assessment Team. • The VA Police Officer and Risk Manager did not consistently attend Disruptive Behavior Committee meetings.	**16.** We recommended that the facility implement an Employee Threat Assessment Team and that the VA Police Officer and Risk Manager consistently attend Disruptive Behavior Committee meetings.
	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	• In 7 of the 26 applicable EHRs, there was no evidence that clinicians informed the patients about the Patient Record Flags. • In 24 of the 26 applicable EHRs, there was no evidence that clinicians informed the patients about the right to appeal Patient Record Flag placement.	**17.** We recommended that facility clinical managers ensure clinicians inform patients about the Patient Record Flags and the right to appeal Patient Record Flag placement.
	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.		
X	The facility managed selected non-patient related disruptive or violent incidents appropriately according to VHA and local policy.	• For two incidents, there was no evidence that the facility conducted a debriefing.	**18.** We recommended that facility managers ensure appropriate individuals conduct debriefings after incidents of disruptive or violent behavior and monitor compliance.
X	The facility had a security training plan for employees at all risk levels. • All employees received Level 1 training within 90 days of hire. • All employees received additional training as required for the assigned risk area within 90 days of hire.	• Four employee training records did not contain documentation of Level 1 training within 90 days of hire. • Thirteen employee training records did not contain documentation of the training required for their assigned risk area within 90 days of hire.	**19.** We recommended that facility managers ensure all employees receive Level 1 training and additional training as required for their assigned risk area within 90 days of hire and that the training is documented in employee training records.

Review Activity with Previous Community Based Outpatient Clinic and Primary Care Clinic Recommendations

Alcohol Use Disorder

As a follow-up to a recommendation from our prior CAP review, we reassessed facility compliance with CBOC/PC clinic employees' documentation of the offer of further treatment to patients diagnosed with alcohol dependence.[l]

Documentation of Further Treatment. VHA requires that documentation reflect the offer of further treatment for patients diagnosed with alcohol dependence. During our previous CBOC review, we did not find documentation of the offer of further treatment for 2 of 13 patients diagnosed with alcohol dependence. For our current CAP review, the facility provided FY 2016 data showing that documentation of the offer of further treatment for patients diagnosed with alcohol dependence did not occur for 24 of 43 patients (56 percent).

Recommendation

20. We recommended that community based outpatient clinic/primary care clinic employees consistently document the offer of further treatment to patients diagnosed with alcohol dependence.

Facility Profile

Table 1 below provides general background information for this facility.

Table 1. Facility Profile for Shreveport (667) for FY 2016

Profile Element	Facility Data
Veterans Integrated Service Network Number	16
Complexity Level	1c-High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$307.6
Number of:	
• **Unique Patients**	39,760
• **Outpatient Visits**	452,694
• **Unique Employees**[24]	1,334
Type and Number of Operating Beds:	
• **Acute**	84
• **MH**	19
• **Community Living Center**	NA
• **Domiciliary**	NA
Average Daily Census:	
• **Acute**	59
• **MH**	12
• **Community Living Center**	NA
• **Domiciliary**	NA

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

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

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

VA Outpatient Clinic Profiles[25]

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

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

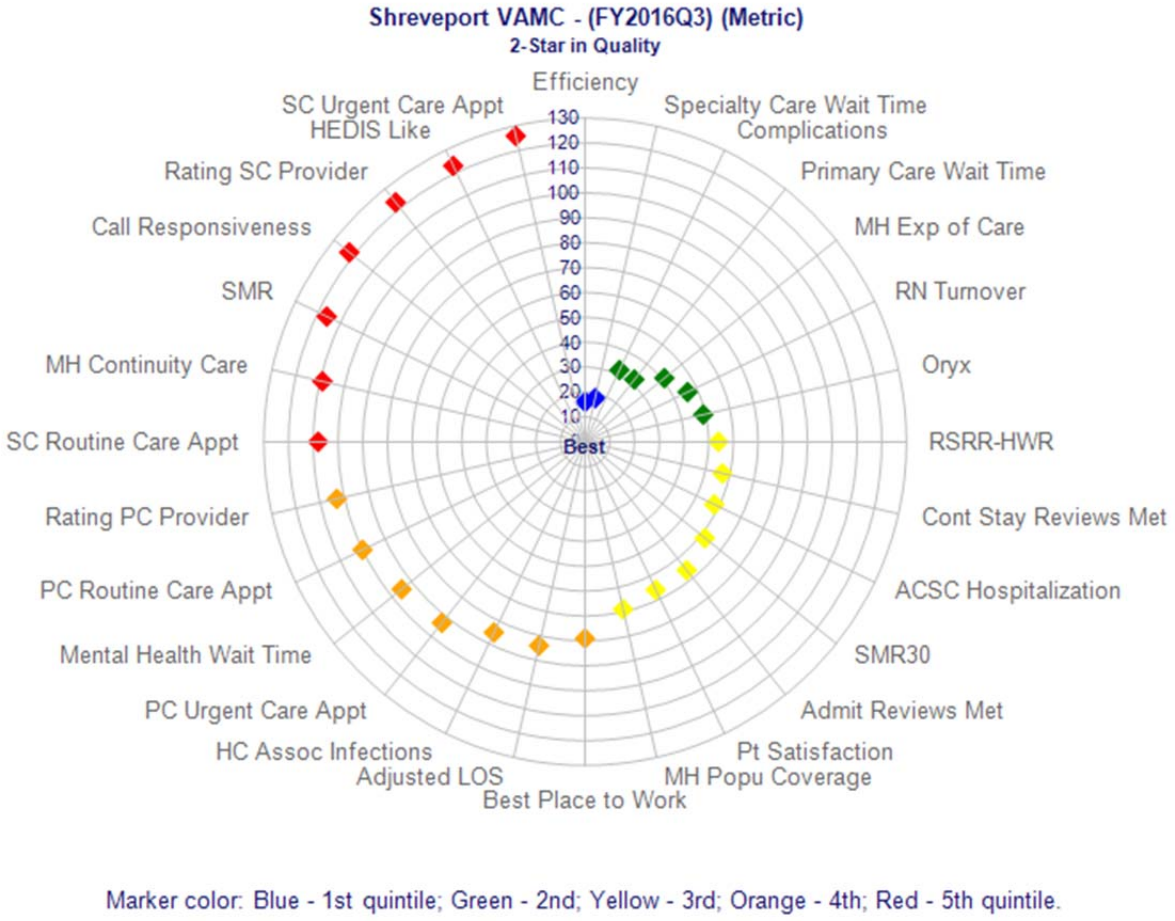
Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services[27] Provided	Diagnostic Services[28] Provided	Ancillary Services[29] Provided
Texarkana, AR	667GA	13,327	3,806	Gastroenterology Hematology/ Oncology Neurology Poly-Trauma Eye Podiatry	NA	Nutrition Social Work Weight Management
Monroe, LA	667GB	13,764	4,500	Gastroenterology Hematology/ Oncology Neurology Poly-Trauma Eye Podiatry	NA	Social Work Weight Management
Longview, TX	667GC	10,932	5,331	Gastroenterology Hematology/ Oncology Neurology Poly-Trauma Eye Podiatry	NA	Social Work Weight Management

Source: VHA Support Service Center and VA Corporate Data Warehouse

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

[25] Includes all outpatient clinics in the community that were in operation before February 15, 2016. We have omitted Shreveport, LA (667QA), 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.

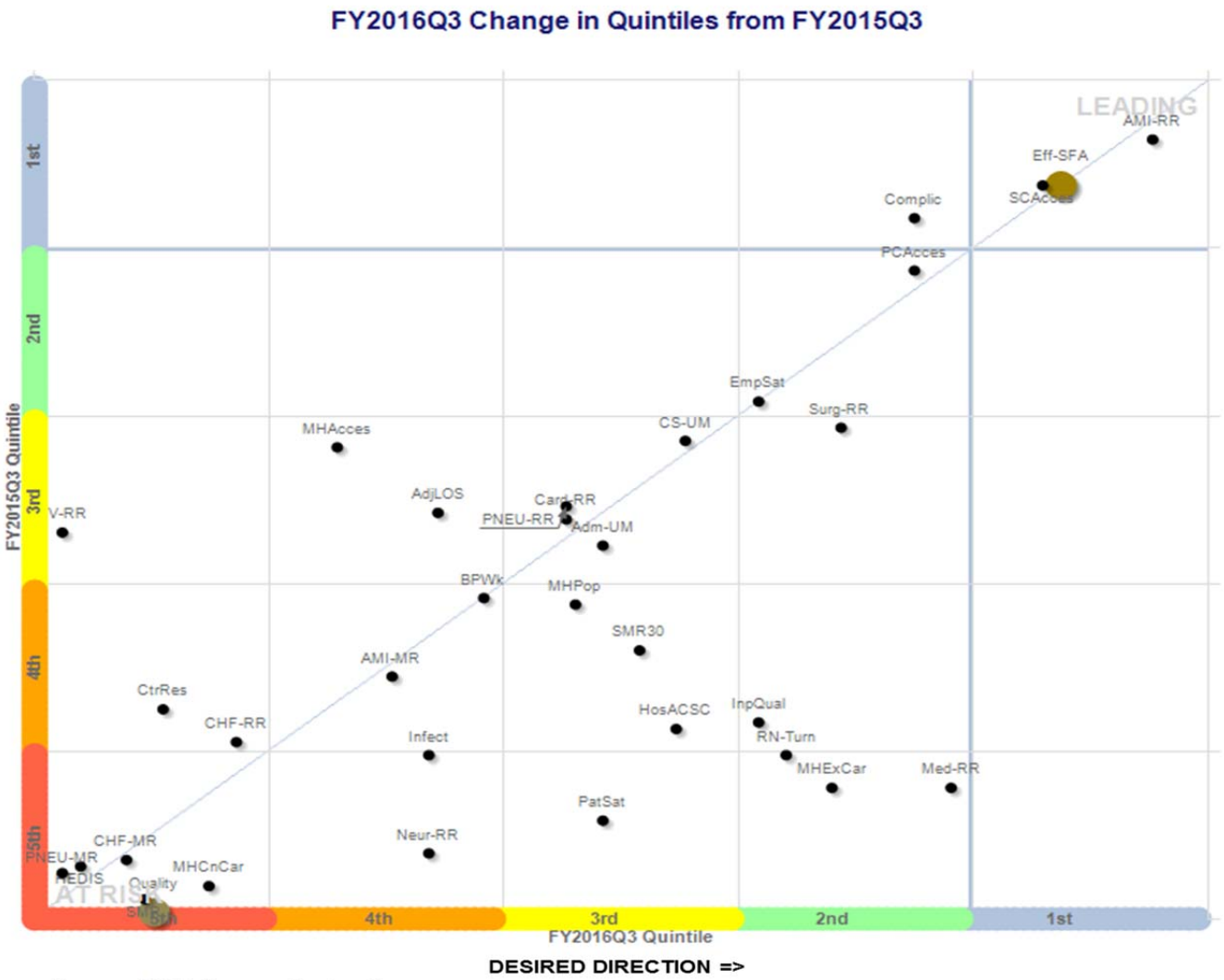
Strategic Analytics for Improvement and Learning (SAIL)[30]



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[j]

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

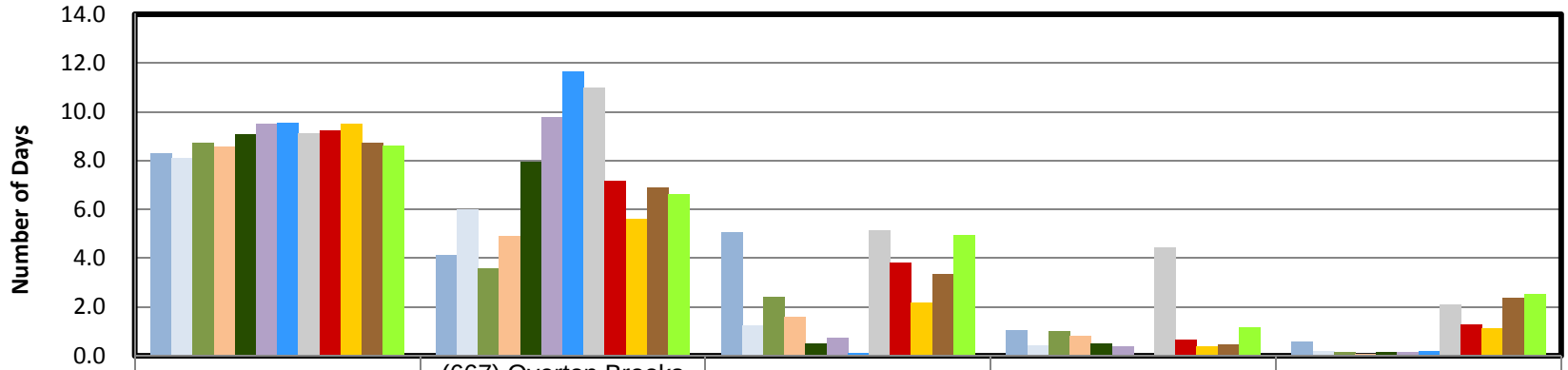
Measure	Definition	Desired Direction
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized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

Source: VHA Support Service Center

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

Patient Aligned Care Team Compass Metrics

Quarterly New PC Patient Average Wait Time in Days

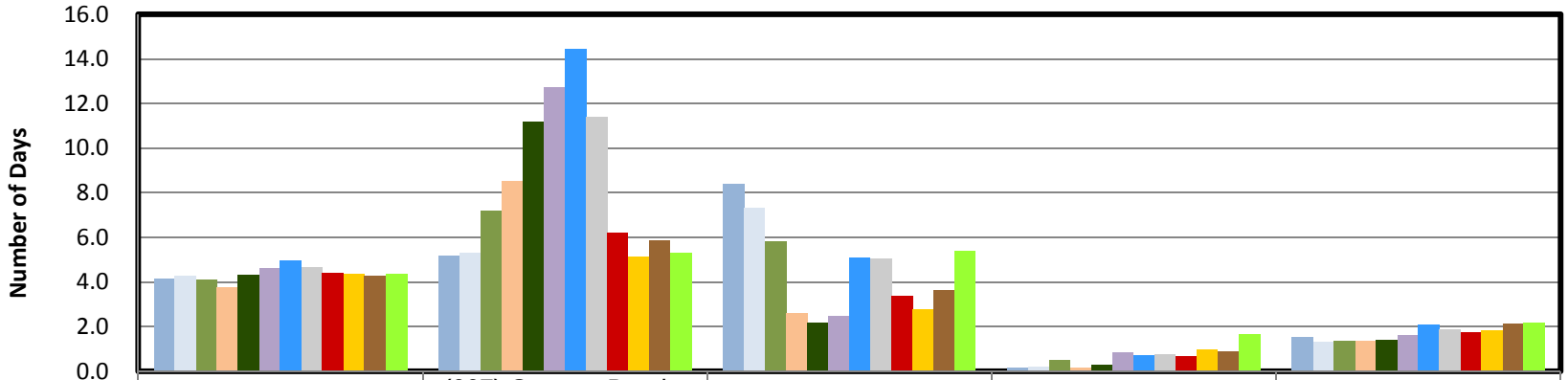


	VHA Total	(667) Overton Brooks VAMC	(667GA) Texarkana	(667GB) Monroe	(667GC) Longview
JUL-FY15	8.3	4.1	5.1	1.0	0.6
AUG-FY15	8.1	6.0	1.2	0.4	0.2
SEP-FY15	8.7	3.6	2.4	1.0	0.1
OCT-FY16	8.6	4.9	1.6	0.8	0.1
NOV-FY16	9.1	7.9	0.5	0.5	0.2
DEC-FY16	9.5	9.8	0.7	0.4	0.1
JAN-FY16	9.6	11.6	0.1	0.0	0.2
FEB-FY16	9.1	11.0	5.1	4.4	2.1
MAR-FY16	9.2	7.1	3.8	0.7	1.3
APR-FY16	9.5	5.6	2.2	0.4	1.1
MAY-FY16	8.7	6.9	3.3	0.4	2.4
JUN-FY16	8.6	6.6	4.9	1.1	2.5

Source: VHA Support Service Center

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

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

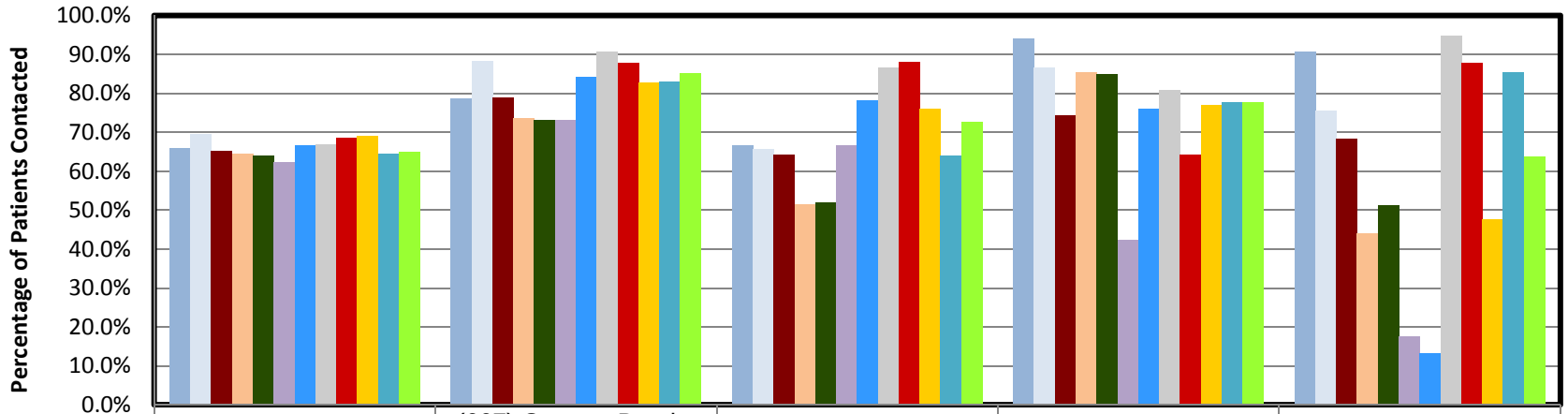


	VHA Total	(667) Overton Brooks VAMC	(667GA) Texarkana	(667GB) Monroe	(667GC) Longview
JUL-FY15	4.1	5.2	8.4	0.2	1.5
AUG-FY15	4.3	5.3	7.3	0.2	1.3
SEP-FY15	4.1	7.2	5.8	0.5	1.4
OCT-FY16	3.8	8.5	2.6	0.2	1.4
NOV-FY16	4.3	11.2	2.2	0.3	1.4
DEC-FY16	4.6	12.7	2.5	0.8	1.6
JAN-FY16	4.9	14.4	5.1	0.7	2.1
FEB-FY16	4.7	11.4	5.0	0.8	1.9
MAR-FY16	4.4	6.2	3.4	0.7	1.7
APR-FY16	4.3	5.1	2.8	1.0	1.8
MAY-FY16	4.3	5.9	3.6	0.9	2.1
JUN-FY16	4.4	5.3	5.4	1.6	2.2

Source: VHA Support Service Center

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

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

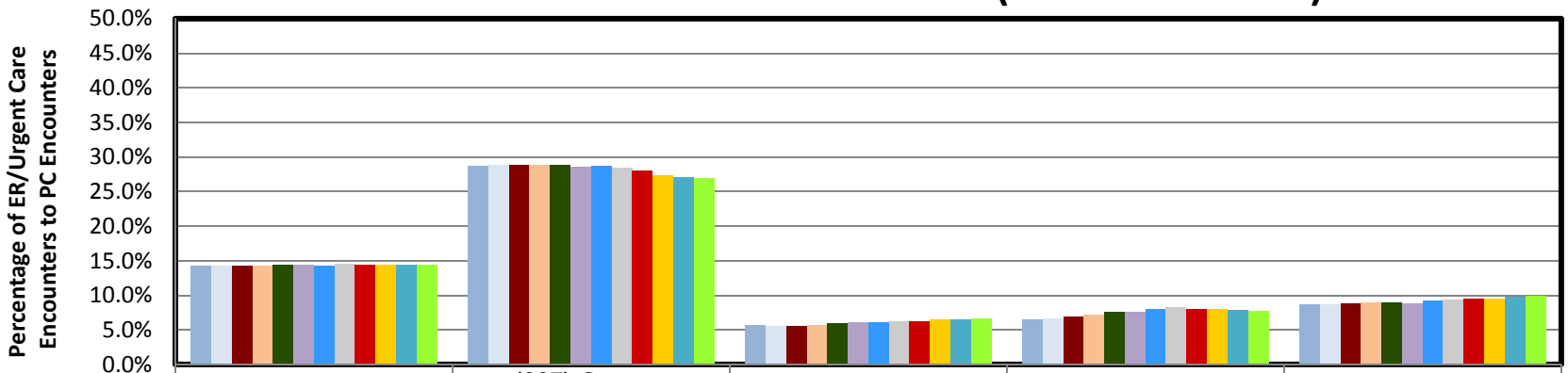


	VHA Total	(667) Overton Brooks VAMC	(667GA) Texarkana	(667GB) Monroe	(667GC) Longview
JUL-FY15	65.9%	78.7%	66.7%	93.9%	90.7%
AUG-FY15	69.4%	88.3%	65.7%	86.7%	75.6%
SEP-FY15	65.1%	78.8%	64.3%	74.3%	68.2%
OCT-FY16	64.3%	73.6%	51.4%	85.4%	43.9%
NOV-FY16	64.0%	73.0%	52.0%	84.8%	51.2%
DEC-FY16	62.3%	73.2%	66.7%	42.3%	17.5%
JAN-FY16	66.7%	84.3%	78.3%	76.0%	13.2%
FEB-FY16	66.9%	90.7%	86.7%	80.9%	94.7%
MAR-FY16	68.6%	87.7%	88.0%	64.3%	87.9%
APR-FY16	69.1%	82.8%	76.0%	76.9%	47.6%
MAY-FY16	64.5%	83.1%	64.0%	77.8%	85.3%
JUN-FY16	64.9%	85.1%	72.7%	77.8%	63.6%

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.



	VHA Total	(667) Overton Brooks VAMC	(667GA) Texarkana	(667GB) Monroe	(667GC) Longview
JUL-FY15	14.2%	28.7%	5.7%	6.5%	8.7%
AUG-FY15	14.2%	28.8%	5.5%	6.7%	8.7%
SEP-FY15	14.2%	28.8%	5.5%	6.9%	8.7%
OCT-FY16	14.3%	28.8%	5.6%	7.2%	8.9%
NOV-FY16	14.3%	28.8%	5.9%	7.5%	8.9%
DEC-FY16	14.3%	28.6%	6.0%	7.5%	8.8%
JAN-FY16	14.3%	28.6%	6.1%	8.0%	9.2%
FEB-FY16	14.4%	28.4%	6.2%	8.2%	9.3%
MAR-FY16	14.4%	28.0%	6.2%	8.0%	9.4%
APR-FY16	14.4%	27.4%	6.5%	8.0%	9.5%
MAY-FY16	14.4%	27.0%	6.5%	7.9%	9.8%
JUN-FY16	14.4%	26.9%	6.6%	7.7%	9.9%

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.

Prior OIG Reports
[December 1, 2013 through December 1, 2016]

Facility Reports

Healthcare Inspection – Patient Care Deficiencies and Mental Health Therapy Availability, Overton Brooks VA Medical Center, Shreveport, Louisiana

1/7/2016 | 14-05075-447 | Summary | Report

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

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

Appendix E

Veterans Integrated Service Network Director Comments

Department of Veterans Affairs

Memorandum

Date: January 18, 2017

From: Director, South Central VA Health Care Network (10N16)

Subject: **CAP Review of the Overton Brooks VA Medical Center, Shreveport, LA**

To: Director, Dallas Office of Healthcare Inspections (54DA)

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

1. The South Central VA Health Care Network (VISN 16) has reviewed and concurs with the response submitted by the Overton Brooks VA Medical Center, Shreveport, LA, regarding the Clinical Assessment Program Draft Report. The facility has already begun to put processes in place to address the recommendations. The Network Office will provide assistance and guidance to ensure recommendations are appropriately addressed and actions are implemented timely.

2. If you have questions regarding the information submitted, please contact Reba T. Moore, VISN 16 Accreditation Specialist at 601.206.7022.

Skye McDougall, PhD
Director, South Central VA Health Care Network (10N16)

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: January 18, 2017

From: Director, Overton Brooks VA Medical Center (667/00)

Subject: **CAP Review of the Overton Brooks VA Medical Center, Shreveport, LA**

To: Director, South Central VA Health Care Network (10N16)

1. Thank you for the opportunity to review the Office of Inspector General draft report: Clinical Assessment Program Review of the Overton Brooks VA Medical Center, Shreveport, LA. I concur with the findings in the draft report and provide the actions associated with each recommendation requested for closure.

2. If you have any questions, please contact Mr. Todd Moore, Chief, Quality, Safety & Value at (318) 990-5905.

Toby T. Mathew
Director, Overton Brooks VA Medical Center (667/00)

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

Concur

Target date for completion: February 28, 2017

Facility response: Physician Utilization Management Advisors (PUMA) document their medical decisions in the National Utilization Management Integration (NUMI) database. Monitoring of compliance is achieved through submission of monthly compliance reports to the Quality, Safety & Value Board. During the months of November and December 2016, compliance rates of 98.2 percent of completion of PUMA reviews were entered into the NUMI database.

Recommendation 2. We recommended that Environment of Care Committee meeting minutes consistently document corrective actions taken to address rounds deficiencies and consistently track actions taken in response to identified deficiencies to closure.

Concur

Target date for completion: March 31, 2017

Facility response: A review of the Environment of Care Board (EOCB) minutes identified opportunities to consistently document the identified deficiencies from Environment of Care rounds to closure. Training was provided in November 2016 to the recorder of the EOCB to document identified deficiencies with corrective actions to closure within the minutes. Additionally, in December 2016, the Facility Safety Officer reviewed all minutes from fiscal year 2016 to specifically monitor open items until closure.

Recommendation 3. We recommended that facility managers ensure ventilation grills and floors in patient care areas are clean and monitor compliance.

Concur

Target date for completion: February 28, 2017

Facility response: A standardized cleaning schedule has been shared with Environmental Management Service leadership. All EMS staff and supervisors have

been provided refresher training with special emphasis of cleaning ventilation grills and floor care. To monitor compliance, the Assistant Chief, EMS will provide an inspection report to the EMS supervisors and review findings with the Chief of EMS.

Recommendation 4. We recommended that the facility repair rusted equipment in patient care areas or remove it from service.

Concur

Target date for completion: March 31, 2017

Facility response: Nursing Service and EMS completed a detailed walk-through of patient care areas in November 2016. A list of the identified items was approved for procurement in December 2016. On January 12, 2017, Contracting provided the Logistics Service a Notice of Award for procurement and delivery of the items identified for removal.

Recommendation 5. We recommended that facility managers ensure sinks in patient nourishment kitchens are clean and monitor compliance.

Concur

Target date for completion: February 28, 2017

Facility response: Sinks in patient nourishment kitchens are a part of the daily EMS standardized cleaning schedule. Monitoring of compliance is achieved by EMS audits conducted by the Assistant Chief, EMS.

Recommendation 6. We recommended that the hemodialysis unit manager ensure sinks and floors are clean and monitor compliance.

Concur

Target date for completion: March 31, 2017

Facility response: Sinks and floors are cleaned daily in the Hemodialysis Unit. The Assistant Chief, EMS is conducting rounds regularly in the hemodialysis unit to monitor for cleanliness. Due to age, a new sink is being purchased and will be installed in the dirty utility room in the hemodialysis unit.

Recommendation 7. We recommended that the hemodialysis unit manager ensure clean and dirty items are stored separately and monitor compliance.

Concur

Target date for completion: April 30, 2017

Facility response: Clean and dirty items are now stored in separated locations. Room 4E20G, located across from the dialysis unit contains dirty items only. Clean items are now stored in Room 4E14.

Recommendation 8. We recommended that the facility define a process for patient anticoagulation-related calls outside normal business hours.

Concur

Target date for completion: February 28, 2017

Facility response: A letter change has been completed by the Business Office that includes contact information to reach the Anticoagulation Clinic, allowing patients to communicate with a pharmacy staff member 24 hours per day.

Recommendation 9. 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: February 28, 2017

Facility response: The Chief of Pharmacy Service reviewed the medical records of patients either currently taking or have newly prescribed anticoagulation medications. In addition, on October 28, 2016, an electronic message was sent to all pharmacists requesting that they remove 30-day refills on any Warfarin prescriptions written at discharge for patients entering all long-term non-VA facilities. The results of these actions are as follows:

All patients prescribed warfarin are followed by the Anticoagulation Clinic and reported to the Pharmacy and Therapeutics (P&T) Committee for monitoring of compliance.

Recommendation 10. We recommended that facility managers ensure clinicians consistently obtain all required laboratory tests prior to initiating anticoagulant medications and obtain required laboratory tests during warfarin treatment at the frequency required by local policy.

Concur

Target date for completion: February 28, 2017

Facility response: An electronic message was sent on October 28, 2016, to providers and pharmacists requesting they order a CBC and INR before initiating Warfarin therapy. Follow-up requirements were reinforced with the Anticoagulation Clinic staff.

Recommendation 11. We recommended that the facility collect and report data on patient transfers out of the facility as required by local policy.

Concur

Target date for completion: April 30, 2017

Facility response: The Clinical Transfer Coordinator has reformatted the data collection spreadsheet to capture all the required data on patients being transferred out of the facility as required by our local policy. The compliance data will be reported monthly to the Quality, Safety & Value Board (QSV) as well as the Medical Executive Board (MEB).

Recommendation 12. We recommended that facility managers ensure transfer notes are written by a staff/attending physician or are written by an acceptable designee and contain a staff/attending physician countersignature.

Concur

Target date for completion: March 31, 2017

Facility response: A template change was made to the discharge instruction progress notes to include transfer form 10-2649B as well requiring a co-signature from the staff/attending physician. Chart audits of all patients transferred are being conducted to ensure compliance. The compliance data will be reported to the Quality, Safety & Value Board as well as the Medical Executive Board (MEB).

Recommendation 13. We recommended that providers include the evaluation of previous adverse events with anesthesia in the history and physical and pre-sedation assessment and that facility managers monitor compliance.

Concur

Target date for completion: March 31, 2017

Facility response: A template change has been made to the Sedation Assessment template note to include the evaluations of previous adverse events related to previous anesthesia and/or sedation.

Chart audits have been completed for the months of November and December 2016. Current review of January 2016 is currently in progress. The monitoring of compliance will be reported to Medical Executive Board through the Operative and Invasive Committee.

Recommendation 14. 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: January 31, 2017

Facility response: The Community Nursing Home (CNH) Program Coordinator has a standardized process for completing all Exclusionary Reviews annually. These evaluations are document-based using Centers for Medicare and Medicaid Services (CMS) data system. If the nursing home fails more than four Categories on the Exclusionary Review, the Request for Exclusionary Form will be completed.

Recommendation 15. We recommended that facility managers ensure social workers and registered nurses conduct and document cyclical clinical visits with the frequency required by Veterans Health Administration policy and monitor compliance.

Concur

Target date for completion: March 31, 2017

Facility response: Chief of Social Work Services initiated a clinical chart review on all Veterans in the Contract Nursing Home Program to ensure social workers and registered nurses conduct and document cyclical clinical visits as required. Compliance will be reported to the Geriatrics and Extended Care Committee (GEC) until compliance is achieved at 90 percent or greater.

Recommendation 16. We recommended that the facility implement an Employee Threat Assessment Team and that the VA Police Officer and Risk Manager consistently attend Disruptive Behavior Committee meetings.

Concur

Target date for completion: February 28, 2017

Facility response: The facility does have interim processes in place to address the functions of ETAT and is finalizing a formal charter for the ETAT. A VA Police Officer and the facility Risk Manager will attend regularly scheduled meetings of the DBC and compliance of the attendees will be tracked by the DBC Committee.

Recommendation 17. We recommended that facility clinical managers ensure clinicians inform patients about the Patient Record Flags and the right to appeal Patient Record Flag placement.

Concur

Target date for completion: April 30, 2017

Facility response: An information sheet on Patient Rights was created to inform patients about the right to appeal Patient Record Flag placement. The information sheet is being included in the notifications to patients that receive a Patient Record Flag in their record. The DBC will monitor and report compliance to the Medical Executive Board.

Recommendation 18. We recommended that facility managers ensure appropriate individuals conduct debriefings after incidents of disruptive or violent behavior and monitor compliance.

Concur

Target date for completion: April 30, 2017

Facility response: The facility is currently researching the development of a debriefing template or SOP that describes the process the facility will follow, and this will be a part of the Incident Reporting system. Monitoring of the compliance with debriefings will be conducted by Patient Safety and DBC.

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

Concur

Target date for completion: January 6, 2017

Facility response: The Talent Management System (TMS) monitors and tracks employee training on security with the deficiency report for all levels, including Level 1, is sent weekly by Education and Training staff to the Service Chiefs for their review and to ensure completion of the assigned training.

Recommendation 20. We recommended that community based outpatient clinic/primary care clinic employees consistently document the offer of further treatment to patients diagnosed with alcohol dependence.

Concur

Target date for completion: April 30, 2017

Facility response: Data has been collected on patients with alcohol dependent screening for the months of November and December 2016. In an effort to meet this recommendation, the facility initiated a review of patients diagnosed with alcohol dependence in all community-based outpatient clinics (including the Knight Street location) and outpatient clinics. The facility has instructed employees at these clinics to offer a referral for patients with alcohol dependence based on screening. We will continue to monitor records to ensure compliance for this measure is being met at 90 percent or greater.

OIG Contact and Staff Acknowledgments

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

Endnotes

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

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

[c] The references used for Medication Management: Anticoagulation Therapy included:
- VHA Directive 1026; *VHA Enterprise Framework for Quality, Safety, and Value*; August 2, 2013.
- VHA Directive 1033, *Anticoagulation Therapy Management*, July 29, 2015.
- VHA Directive 1088, *Communicating Test Results to Providers and Patients*, October 7, 2015.

[d] The references used for Coordination of Care: Inter-Facility Transfers included:
- VHA Directive 2007-015, *Inter-Facility Transfer Policy*, May 7, 2007.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.
- VHA Handbook 1400.01, *Resident Supervision*, December 19, 2012.
- Overton Brooks VA Medical Center Memorandum No. 11-53, *Inter-Facility Transfer of Veterans*, May 12, 2015.

[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.
- Acting Deputy Under Secretary for Health for Operations and Management. "Meeting New Mandatory Safety Training Requirements using Veterans Health Administration's Prevention and Management of Disruptive Behavior (PMDB) Curriculum." memorandum. November 7, 2013.

[i] The reference used for Alcohol Use Disorder was:

- VHA Handbook 1120.02, *Health Promotion and Disease Prevention Core Program Requirements*, July 5, 2012.

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

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

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

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