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Office of Healthcare Inspections

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Comprehensive Healthcare Inspection Program Review of the New Mexico VA Health Care System Albuquerque, New Mexico

January 4, 2018

Washington, DC 20420

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Glossary

CBOC	community based outpatient clinic
CHIP	Comprehensive Healthcare Inspection Program
CNH	community nursing home
EHR	electronic health record
EOC	environment of care
facility	New Mexico VA Health Care System
FY	fiscal year
MH	mental health
Nurse Executive	Associate Director for Patient Care Services
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
PC	primary care
QSV	quality, safety, and value
SAIL	Strategic Analytics for Improvement and Learning
TJC	The Joint Commission
UM	utilization management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Report Overview

This Comprehensive Healthcare Inspection Program (CHIP) review provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the New Mexico VA Health Care System (facility). The review covers key clinical and administrative processes that are associated with promoting quality care.

CHIP reviews are one element of the Office of Inspector General's (OIG) overall efforts to ensure that our nation's veterans receive high-quality and timely VA health care services. The reviews are performed approximately every 3 years for each facility. OIG selects and evaluates specific areas of focus on a rotating basis each year. OIG's current areas of focus are:

1. Leadership and Organizational Risks
2. Quality, Safety, and Value
3. Medication Management
4. Coordination of Care
5. Environment of Care
6. High-Risk Processes
7. Long-Term Care

This review was conducted during an unannounced visit made during the week of May 15, 2017. OIG conducted interviews and reviewed clinical and administrative processes related to areas of focus that affect patient care outcomes. Although OIG reviewed a spectrum of clinical and administrative processes, the sheer complexity of VA medical centers limits the ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of facility performance within the identified focus areas at the time of the OIG visit. Although it is difficult to quantify the risk of patient harm, the findings in this report may help facilities identify areas of vulnerability or conditions that, if properly addressed, will potentially improve patient safety and health care quality.

Results and Review Impact

Leadership and Organizational Risks. At the New Mexico VA Health Care System, the leadership team consists of the Facility Director, Chief of Staff, Associate Director for Patient Care Services (Nurse Executive), Associate Director, and Assistant Director. Organizational communication and accountability are carried out through a committee reporting structure with the Quality Executive Board having oversight for leadership groups such as the Quality Board, Administrative Executive Board, and Executive Committee of the Medical Staff. The facility leaders are members of the Quality Executive Board through which they track, trend, and monitor quality of care and patient outcomes.

The Facility Director and Assistant Director were permanently assigned in 2014 (December and January, respectively), and the Nurse Executive was permanently

assigned in January 2016. The Chief of Staff was permanently assigned in August 2016 and had previously served in that position on an interim basis for approximately 6 months when the position was vacant. The Associate Director position has been vacant for more than 2 years, and four employees have served as Interim Associate Director. The Director made a selection of an Associate Director from three prior announcements. Two selectees did not meet pre-employment requirements, and the third declined for financial reasons. Recruitment efforts for an Associate Director were ongoing during the OIG site visit.

In the review of selected employee and patient survey results regarding facility senior leadership, OIG noted satisfaction scores similar to or below the VHA average.

Additionally, OIG reviewed accreditation agency findings, sentinel events, disclosures of adverse patient events, Patient Safety Indicator data, and Strategic Analytics for Improvement and Learning (SAIL) data. OIG recognizes that the SAIL model has limitations for identifying all areas of clinical risk, but it is "a way to understand the similarities and differences between the top and bottom performers" within the Veterans Health Administration (VHA).[1]

The senior leadership team was knowledgeable about selected SAIL metrics but should continue to take actions to improve performance of the Quality of Care and Efficiency metrics likely contributing to the facility's current 2-star SAIL rating. Further, the presence of organization risk factors, as evidenced by sentinel events, disclosures, and Patient Safety Indicator data, may contribute to future issues of noncompliance and/or lapses in patient safety unless corrective processes are implemented and continuously monitored.

In the review of key care processes, OIG issued 20 recommendations that are attributable to the Chief of Staff, Nurse Executive, Associate Director, and Assistant Director. Of the seven areas of clinical operations reviewed, OIG noted findings in six. These are briefly described below.

Quality, Safety, and Value. OIG found that senior managers were engaged with quality, safety, and value activities. When opportunities for improvement were identified, they supported clinical leaders' implementation of corrective actions and monitoring of effectiveness. OIG found general compliance with requirements for

[1] VHA Support Service Center (VSSC). The Strategic Analytics for Improvement and Learning (SAIL) Value Model Documentation Manual. Accessed on April 16, 2017: http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=2146. VHA's Office of Operational Analytics and Reporting developed a model for understanding a facility's performance in relation to nine quality domains and one efficiency domain. The domains within SAIL are made up of multiple composite measures, and the resulting scores permit comparison of facilities within a Veterans Integrated Service Network or across VHA. The SAIL model uses a "star" ranking system to designate a facility's performance in individual measures, domains, and overall quality.

protected peer review and patient safety. However, OIG noted deficiencies in credentialing and privileging and utilization management processes.[2]

Medication Management. OIG found that local anticoagulation therapy management policies and processes had been established, and risk minimalization efforts for dosing errors were in place. However, OIG identified deficiencies with use of quality assurance data to ensure strong ongoing anticoagulation program practices, evidence of education specific to newly prescribed direct-acting oral anticoagulants, requirements for laboratory tests prior to initiating anticoagulant medications, and competency assessments for employees actively involved in the anticoagulant program.

Coordination of Care. OIG noted that the facility developed and implemented a patient transfer policy. However, OIG identified deficiencies with data reporting, transfer documentation, and communication with the accepting facility.

Environment of Care. OIG noted compliance with requirements for general safety and privacy at the parent facility, representative community based outpatient clinic, and radiology areas. Additionally, the locked mental health unit met most of the performance indicators examined. However, OIG identified deficiencies with environment of care rounds frequency and attendance, cleanliness and damaged furnishings at the parent facility, outdated supplies at the selected community based outpatient clinic, the physical security assessment on the locked mental health unit, and mental health unit employee and Interdisciplinary Safety Inspection Team training.

High-Risk Processes Related to Moderate Sedation. OIG found compliance with reporting and trending the use of reversal agents in moderate sedation cases, discharge practices, and clinician training. However, OIG identified deficiencies with informed consent and timeout processes and procedures.

Long-Term Care: Community Nursing Home Oversight. OIG noted compliance with requirements for program integration and annual reviews. However, OIG identified deficiencies with Community Nursing Home Oversight Committee meeting attendance and conducting and documenting monthly cyclical clinical visits for patients residing in community nursing homes.

Summary

In the review of key care processes, OIG issued 20 recommendations that are attributable to the Facility Director, Chief of Staff, Nurse Executive, Associate Director, and Assistant Director. The number of recommendations should not be used as a gauge for the overall quality provided at this facility. The intent is for facility leadership to use these recommendations as a "road map" to help improve operations and clinical care. The recommendations address systems issues as well as other less-critical

[2] According to VHA Directive 1117 (July 9, 2014), utilization management involves the forward-looking evaluation of the appropriateness, medical need, and efficiency of health care services according to evidence-based criteria.

findings that, if left unattended, may eventually interfere with the delivery of quality health care.

Comments

The Veterans Integrated Service Network Director and Facility Director agreed with the CHIP review findings and recommendations and provided acceptable improvement plans. (See Appendixes G and H, pages 53–54, and the responses within the body of the report for the full text of the Directors' comments.) OIG considers recommendations 3, 6, 14, and 19 closed. OIG 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 Scope

Purpose

This Comprehensive Healthcare Inspection Program (CHIP) review was conducted to provide a focused evaluation of the quality of care delivered in the New Mexico VA Health Care System's (facility) inpatient and outpatient settings through a broad overview of key clinical and administrative processes that are associated with quality care and positive patient outcomes. The purpose of the review was to provide oversight of health care services to veterans and to share findings with facility leaders so that informed decisions can be made to improve care.

Scope

The current seven areas of focus for facility reviews are: (1) Leadership and Organizational Risks; (2) Quality, Safety, and Value (QSV); (3) Medication Management; (4) Coordination of Care; (5) Environment of Care (EOC); (6) High-Risk Processes; and (7) Long-Term Care. These were selected because of risks to patients and the organization when care is not performed well. Within four of the fiscal year (FY) 2017 focus areas, the Office of Inspector General (OIG) selected processes for special consideration—Anticoagulation Therapy Management, Inter-Facility Transfers, Moderate Sedation, and Community Nursing Home (CNH) Oversight (see Figure 1).

Figure 1. Fiscal Year 2017 Comprehensive Healthcare Inspection Program Review of Health Care Operations and Services

Source: VA OIG.

Additionally, OIG staff provide crime awareness briefings to increase facility employees' understanding of the potential for VA program fraud and the requirement to report suspected criminal activity to OIG.

Methodology

To determine compliance with Veterans Health Administration (VHA) requirements[3] related to patient care quality, clinical functions, and the EOC, OIG physically inspected selected areas; reviewed clinical records, administrative and performance measure data, and accreditation survey reports;[4] and discussed processes and validated findings with managers and employees. OIG interviewed applicable managers and members of the executive leadership team.

The review covered operations for June 2, 2014[5] through May 15, 2017, the date when the unannounced week-long site visit commenced. On May 23, 2017, OIG presented crime awareness briefings to 33 of the facility's 2,849 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.

Recommendations for improvement in this report target problems that can impact the quality of patient care significantly enough to warrant OIG follow-up until the facility completes corrective actions. The Facility Director's comments submitted in response to the recommendations in this report appear within each topic area.

While onsite, OIG received reports of delayed operating room procedures because sterile equipment was not available at the time of the surgery. OIG also learned of Sterile Processing Service staffing concerns resulting in issues with the availability of sterile equipment for surgeries. These issues and concerns beyond the scope of the CHIP review were referred to the OIG Hotline management team for further evaluation.

OIG conducted the inspection in accordance with OIG standard operating procedures for CHIP reviews and *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

[3] Appendix C lists policies that had expired recertification dates but were considered in effect as they had not been superseded by more recent policy or guidance.
[4] OIG did not review VHA's internal survey results but focused on OIG inspections and external surveys that affect facility accreditation status.
[5] This is the date of the last Combined Assessment Program and/or Community Based Outpatient Clinic and Primary Care Clinic reviews.

Results and Recommendations

Leadership and Organizational Risks

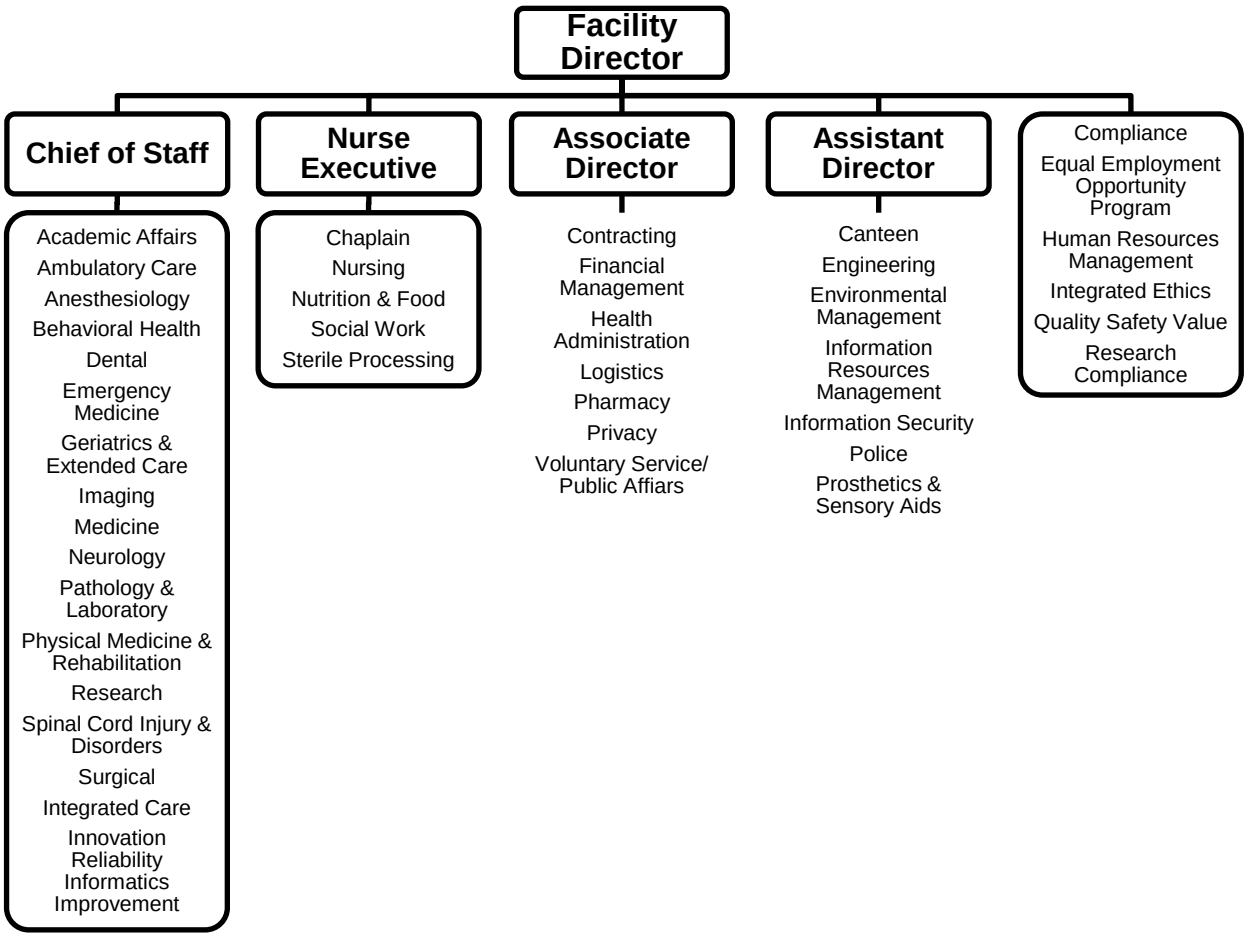
Stable and effective leadership is critical to improving care and sustaining meaningful change. Leadership and organizational risk issues can impact the facility's ability to provide care in all of the selected clinical areas of focus. The factors OIG considered in assessing the facility's risks and strengths were:

1. Executive leadership stability and engagement
2. Employee satisfaction and patient experience
3. Accreditation/for-cause surveys and oversight inspections
4. Indicators for possible lapses in care
5. VHA performance data

Executive Leadership Stability and Engagement. Because each VA facility organizes its leadership to address the needs and expectations of the local veteran population that it serves, organizational charts may differ between facilities. Figure 2 illustrates this facility's reported organizational structure. The facility has a leadership team consisting of the Director, Chief of Staff, Associate Director for Patient Care Services (Nurse Executive), Associate Director, and Assistant Director. The Chief of Staff and Associate Directors are responsible for overseeing patient care and service and program chiefs.

The Facility Director and Assistant Director were permanently assigned in 2014 (December and January, respectively), and the Nurse Executive was permanently assigned in January 2016. The Chief of Staff was permanently assigned in August 2016 and had previously served in that position on an interim basis for approximately 6 months when the position was vacant. The Associate Director position has been vacant for more than 2 years during which time four employees have served as Interim Associate Director. The Director made a selection of an Associate Director from three prior announcements. Two selectees did not meet pre-employment requirements, and the third declined for financial reasons. Recruitment efforts for an Associate Director were ongoing during OIG's site visit.

Figure 2. Facility Organizational Chart



Source: New Mexico VA Health Care System (received July 13, 2017).

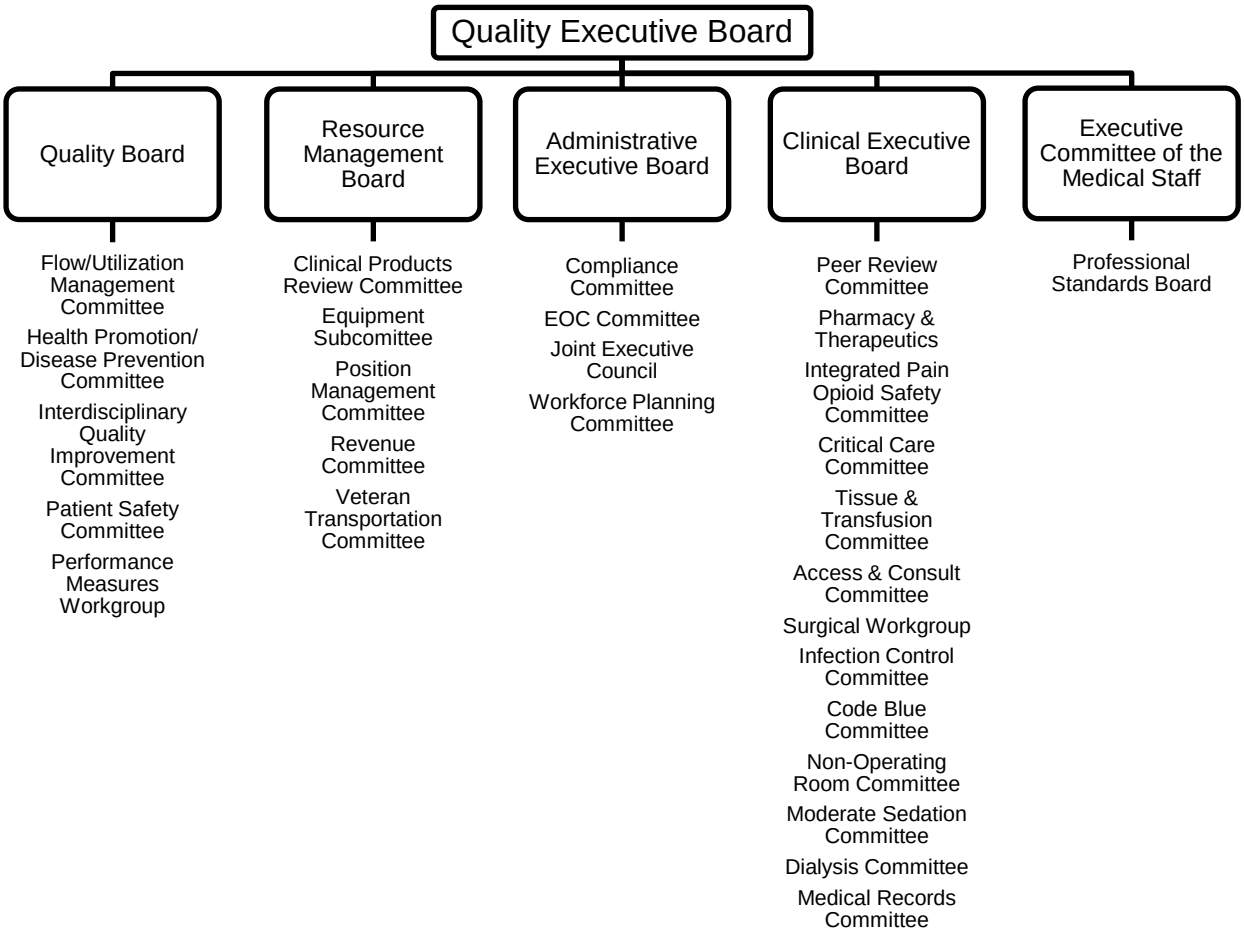
To help assess engagement of facility executive leadership, OIG interviewed the Facility Director, Chief of Staff, Nurse Executive, Interim Associate Director, and Assistant Director regarding their knowledge of various metrics and their involvement and support of actions to improve or sustain performance.

In individual interviews, these executive leaders generally were able to speak knowledgeably about actions taken during the previous 12 months in order to maintain or improve performance, employee and patient survey results, and selected Strategic Analytics for Improvement and Learning (SAIL) metrics. These are discussed more fully below.

The leaders are also engaged in monitoring patient safety and care through formal mechanisms. They are members of the facility's Quality Executive Board, which tracks, trends, and monitors quality of care and patient outcomes. The Facility Director serves as the Chairperson with the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning.

The Quality Executive Board also oversees various working committees, such as the Quality Board, Resource Management Board, and Executive Committee of the Medical Staff. See Figure 3.

Figure 3. Facility Committee Reporting Structure



Source: New Mexico VA Health Care System (received July 13, 2017).

Employee Satisfaction and Patient Experience. To assess employee and patient attitudes toward facility senior leadership, OIG reviewed employee satisfaction and patient experience survey results that relate to the period of October 1, 2015 through September 30, 2016. Although OIG recognizes that employee satisfaction and patient experience survey data are subjective, they can be a starting point for discussions and indicate areas for further inquiry, which can be considered along with other information on facility leadership. Table 1 provides relevant survey results for VHA and the facility for the 12-month period. The facility leaders' results (Director's office average) were rated similarly to the facility average, and the facility's performance for both of the selected employee survey results were below the VHA average.[6] Employee attitudes were generally satisfied with leadership. Although inpatients were satisfied with their care, three of the four patient survey results reflected lower ratings than the VHA average. Facility leaders expressed that longer wait times for hard-to-recruit specialists such as dermatologists and orthopedists remain a challenge when competing for scarce resources in a rural area such as New Mexico and affected the outpatient specialty care results.

Table 1. Survey Results on Employee and Patient Attitudes toward Facility Leadership (October 1, 2015 through September 30, 2016)

Questions	Scoring	VHA Average	Facility Average	Director's Office Average[7]
All Employee Survey[8] Q59. How satisfied are you with the job being done by the executive leadership where you work?	1 (Very Dissatisfied) – 5 (Very Satisfied)	3.3	3.2	3.5
All Employee Survey Servant Leader Index Composite	0–100 where HIGHER scores are more favorable	66.7	65.8	65.9
Survey of Healthcare Experiences of Patients (inpatient): Would you recommend this hospital to your friends and family?	The response average is the percent of "Definitely Yes" responses.	65.8	74.4	
Survey of Healthcare Experiences of Patients (inpatient): I felt like a valued customer.	The response average is the percent of "Agree" and "Strongly Agree" responses.	82.8	81.7	
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): I felt like a valued customer.		73.2	70.4	
Survey of Healthcare Experiences of Patients (outpatient specialty care): I felt like a valued customer.		73.8	67.8	

[6] OIG makes no comment on the adequacy of the VHA average for each selected survey element. The VHA average is used for comparison purposes only.
[7] Rating is based on responses by employees who report to the Director.
[8] The All Employee Survey is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential. The instrument has been refined at several points since 2001 in response to operational inquiries by VA leadership on organizational health relationships and VA culture.

Accreditation/For-Cause[9] Surveys and Oversight Inspections. To further assess Leadership and Organizational Risks, OIG reviewed recommendations from previous inspections by oversight and accrediting agencies to gauge how well leaders respond to identified problems. Table 2 summarizes the relevant facility inspections most recently performed by the VA OIG and The Joint Commission (TJC). Indicative of effective leadership, the facility has closed[10] all OIG recommendations for improvement as listed in Table 2. Recommendations remain open for the TJC accreditation inspection. The facility reported that insufficient time has elapsed for it to close the recommendations.

OIG also noted the facility's current accreditation status with the Commission on Accreditation of Rehabilitation Facilities[11] and College of American Pathologists,[12] which demonstrates the facility leaders' commitment to quality care and services. Additionally, the Long Term Care Institute[13] conducted an inspection of the facility's Community Living Center, and the Paralyzed Veterans of America conducted an inspection of the facility's spinal cord injury/disease unit and related services.[14]

[9] TJC conducts for-cause unannounced surveys in response to serious incidents relating to the health and/or safety of patients or staff or reported complaints. The outcomes of these types of activities may affect the current accreditation status of an organization.
[10] A closed status indicates that the facility has implemented corrective actions and improvements to address findings and recommendations, not by self-certification, but as determined by accreditation organization or inspecting agency.
[11] The Commission on Accreditation of Rehabilitation Facilities provides an international, independent, peer review system of accreditation that is widely recognized by Federal agencies. VHA's commitment is supported through a system-wide, long-term joint collaboration with the Commission on Accreditation of Rehabilitation Facilities to achieve and maintain national accreditation for all appropriate VHA rehabilitation programs.
[12] For 70 years, the College of American Pathologists has fostered excellence in laboratories and advanced the practice of pathology and laboratory science. In accordance with VHA Handbook 1106.01, VHA laboratories must meet the requirements of the College of American Pathologists.
[13] Since 1999, the Long Term Care Institute has been to over 3,500 health care facilities conducting quality reviews and external regulatory surveys. The Long Term Care Institute is a leading organization focused on long-term care quality and performance improvement; compliance program development; and review in long-term care, hospice, and other residential care settings.
[14] The Paralyzed Veterans of America inspection took place November 30–December 1, 2016. This Veteran Service Organization review does not result in accreditation status.

Table 2. Office of Inspector General Inspections/Joint Commission Survey

Accreditation or Inspecting Agency	Date of Visit	Number of Findings	Number of Recommendations Remaining Open
VA OIG (*Healthcare Inspection – Lack of Follow-Up Care for Positive Colorectal Cancer Screening, New Mexico VA Health Care System, Albuquerque, New Mexico, September 27, 2016)*	February 2015	4	0
VA OIG *(Combined Assessment Program Review of the New Mexico VA Health Care System, Albuquerque, New Mexico, July 31, 2014)*	June 2014	9	0
VA OIG *(Community Based Outpatient Clinic and Primary Care Clinic Reviews at New Mexico VA Health Care System, Albuquerque, New Mexico, August 1, 2014)*	June 2014	8	0
TJC[15] • Hospital Accreditation • Nursing Care Center Accreditation • Behavioral Health Care Accreditation • Home Care Accreditation	March 2017	 27 0 4 9	 27 0 4 9

[15] TJC is an internationally accepted external validation that an organization has systems and processes in place to provide safe and quality oriented health care. TJC has been accrediting VHA facilities for over 30 years. Compliance with Joint Commission standards and accreditation processes facilitates risk reduction and performance improvement by standardizing critical procedures and processes.

Indicators for Possible Lapses in Care. Within the health care field, the primary organizational risk is the potential for patient harm. Many factors impact the risk for patient harm within a system, including unsafe environmental conditions, sterile processing deficiencies, and infection control practices. Leaders must be able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms. Table 3 summarizes key indicators of risk since OIG's previous June 2014 Combined Assessment Program and Community Based Outpatient Clinic (CBOC) and Primary Care (PC) review inspections through the week of May 15, 2017.

Table 3. Summary of Selected Organizational Risk Factors[16] (June 2014 to May 15, 2017)

Factor	Number of Occurrences
Sentinel Events[17]	4
Institutional Disclosures[18]	11
Large-Scale Disclosures[19]	0

OIG also reviewed Patient Safety Indicators developed by the Agency for Healthcare Research and Quality within the U.S. Department of Health and Human Services. These provide information on potential in-hospital complications and adverse events following surgeries and procedures.[20] The rates presented are specifically applicable for this facility, and lower rates indicate lower risks. Table 4 summarizes the Patient Safety Indicator data from October 1, 2015 through September 30, 2016.

[16] It is difficult to quantify an acceptable number of occurrences because one occurrence is one too many. Efforts should focus on prevention. Sentinel events and those that lead to disclosure can occur in either inpatient or outpatient settings and should be viewed within the context of the complexity of the facility. (Note that the New Mexico VA Health Care System is a high complexity (1a) affiliated facility as described in Appendix B.)
[17] A sentinel event is a patient safety event that involves a patient and results in death, permanent harm, or severe temporary harm and intervention required to sustain life.
[18] Institutional disclosure of adverse events (sometimes referred to as "administrative disclosure") is a formal process by which facility leaders together with clinicians and others, as appropriate, inform the patient or the patient's personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse.
[19] Large-scale disclosure of adverse events (sometimes referred to as "notification") is a formal process by which VHA officials assist with coordinating the notification to multiple patients (or their personal representatives) that they may have been affected by an adverse event resulting from a systems issue.
[20] Agency for Healthcare Research and Quality website, https://www.qualityindicators.ahrq.gov/, accessed March 8, 2017.

Table 4. October 1, 2015 through September 30, 2016, Patient Safety Indicator Data

Measure	Reported Rate per 1,000 Hospital Discharges		
	VHA	VISN 22	Facility
Pressure Ulcers	0.55	0.67	0.79
Death among surgical inpatients with serious treatable conditions	103.31	156.25	171.43
Iatrogenic Pneumothorax	0.20	0.13	0.00
Central Venous Catheter-Related Bloodstream Infection	0.12	0.00	0.00
In Hospital Fall with Hip Fracture	0.08	0.08	0.00
Perioperative Hemorrhage or Hematoma	2.59	2.26	2.83
Postoperative Acute Kidney Injury Requiring Dialysis	1.20	1.81	0.00
Postoperative Respiratory Failure	6.31	7.50	9.82
Perioperative Pulmonary Embolism or Deep Vein Thrombosis	3.29	4.78	6.29
Postoperative Sepsis	4.45	6.09	10.92
Postoperative Wound Dehiscence	0.65	1.34	5.29
Unrecognized Abdominopelvic Accidental Puncture/Laceration	0.67	0.00	0.00

Source: VHA Support Service Center.

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

Seven of the 12 Patient Safety Indicator measures show facility-level observed rates per 1,000 hospital discharges in excess of the observed rates for Veterans Integrated Service Network (VISN) 22 and VHA. Facility managers reported incorrect case classification, coding inaccuracies, and poor documentation as contributing factors to the higher observed rates. For example, the facility's review of reported cases for death among surgical inpatients with serious treatable conditions measure included palliative/hospice cases, where the goal was not curative, because of coding and classification errors. Facility managers stated that if palliative/hospice cases were removed, the facility rate would have been comparable to VHA. Additionally, for the postoperative sepsis measure, the facility also identified coding and documentation issues; however, facility managers acknowledged that the facility's observed rate remains in excess of the observed rate for VHA. The facility plans to conduct further analysis through the Sepsis Committee to determine whether sepsis prevention activities have been missed and to address improvement opportunities.

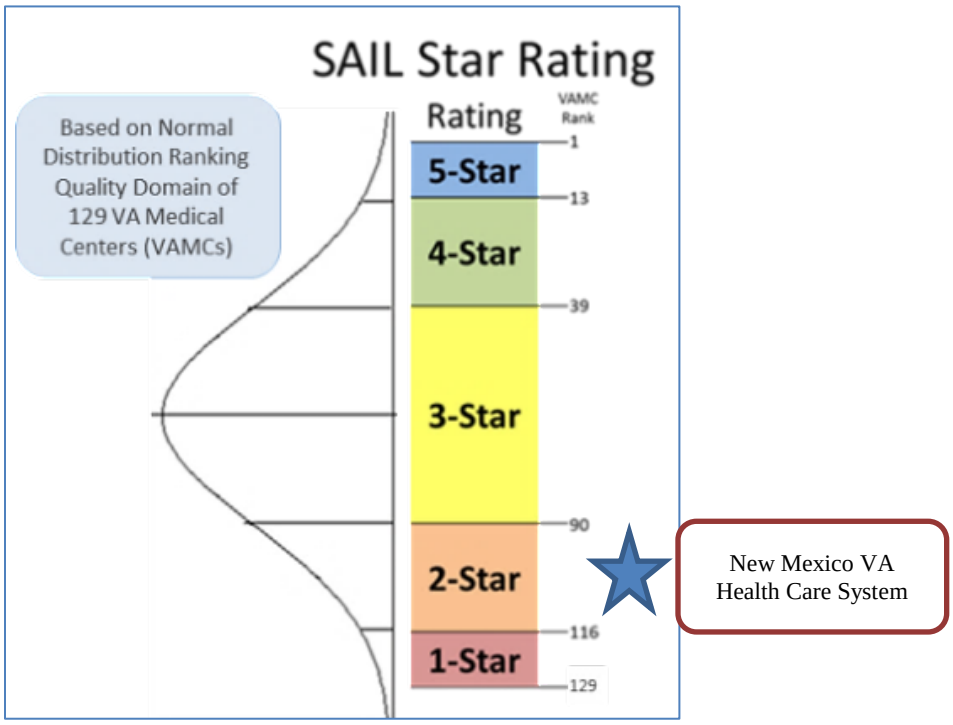
Veterans Health Administration Performance Data. The VA Office of Operational Analytics and Reporting adapted the SAIL Value Model to help define performance expectations within VA.[21] This model includes measures on health care quality, employee satisfaction, access to care, and efficiency, but the model has noted limitations for identifying all areas of clinical risk. The data are presented as one "way to

[21] The model is derived from the Thomson Reuters Top Health Systems Study.

understand the similarities and differences between the top and bottom performers" within VHA.[22]

VA also uses a star-rating system that is designed to make model results more accessible for the average user. Facilities with a 5-star rating are performing within the top 10 percent of facilities, whereas 1-star facilities are performing within the bottom 10 percent of facilities. Figure 4 describes the distribution of facilities by star rating. As of September 30, 2016, the New Mexico VA Health Care System received an interim[23] rating of 2 stars for overall quality. This means the facility was in the 4th quintile (80–90 percent range). Updated data as of June 30, 2017, indicates that the facility has remained at 2 stars for overall quality.

Figure 4. Strategic Analytics for Improvement and Learning Star Rating Distribution (as of September 30, 2016)



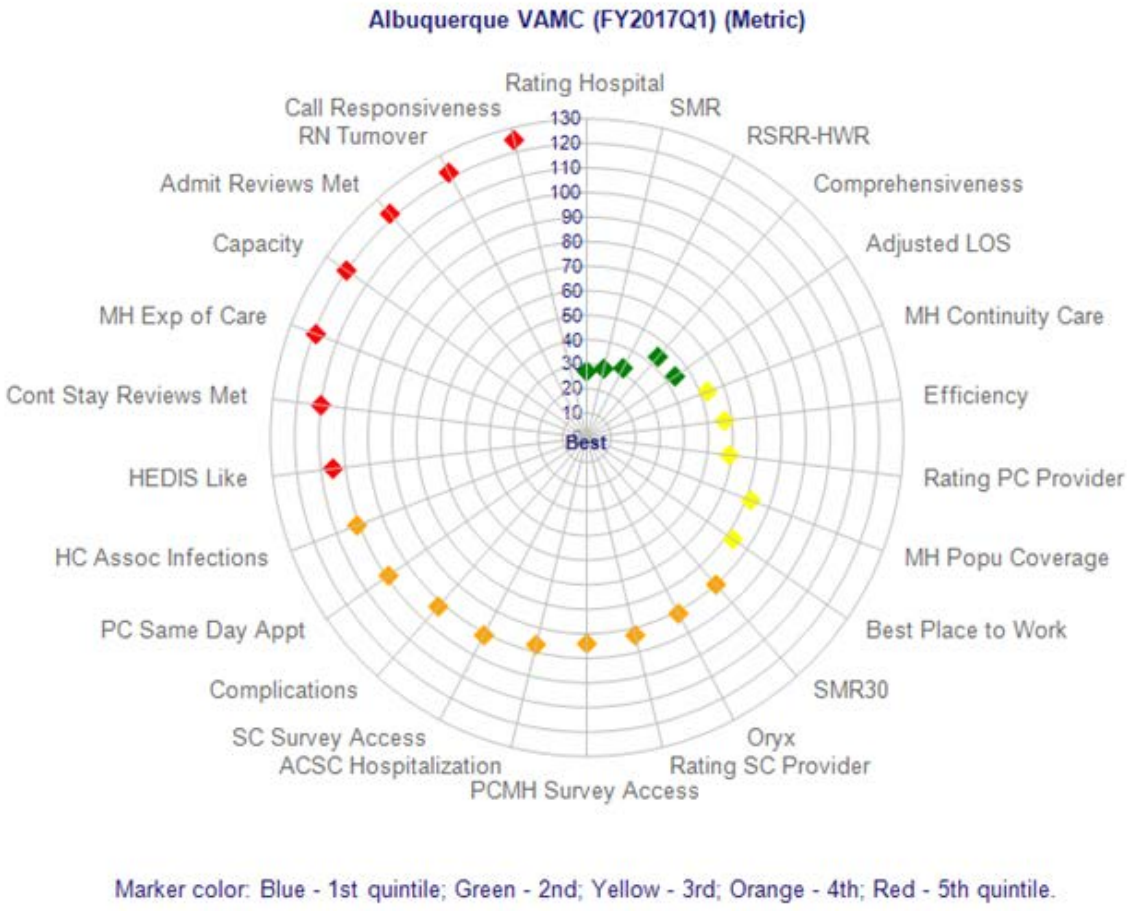
Source: VA Office of Informatics and Analytics' Office of Operational Analytics and Reporting.

[22] VHA Support Service Center (VSSC). The Strategic Analytics for Improvement and Learning (SAIL) Value Model Documentation Manual. Accessed on April 16, 2017: http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=2146

[23] Star rating was labeled "interim" for fiscal quarters prior to end of year appraisal to align with VA's public reporting of SAIL star rating at end of year.

Figure 5 illustrates the facility's Quality of Care and Efficiency metric rankings and performance compared to other VA facilities as of December 31, 2016. Of note, Figure 5 shows no metric in the top 10 percent quintile (blue); however, the green data points in the top quintiles show high performance (for example, Rating [of] Hospital, Acute Care in Hospital Standardized Mortality Ratio [SMR], and Hospital-Wide Readmission [RSRR-HWR]). Metrics in the bottom quintiles reflect areas that need improvement and are denoted in orange and red (for example, Mental Health [MH] Experience of Care, Capacity, and Registered Nurse [RN] Turnover).

Figure 5. Facility Quality of Care and Efficiency Metric Rankings (as of December 31, 2016)



Source: VHA Support Service Center.

Note: OIG did not assess VA's data for accuracy or completeness. Also see Appendix D for sample outpatient performance measures that feed into these data points (such as wait times, discharge contacts, and where patient care is received). For data definitions, see Appendix E.

Conclusions. The facility has generally stable executive leadership and active engagement with employees and patients as evidenced by high satisfaction scores. Organizational leaders support patient safety, quality care, and other positive outcomes (such as initiating processes and plans to improve perceptions of the facility through active stakeholder engagement). However, the presence of organization risk factors, as evidenced by sentinel events, disclosures, and Patient Safety Indicator data, may contribute to future issues of noncompliance and/or lapses in patient safety unless corrective processes are implemented and continuously monitored. Further, although the senior leadership team was knowledgeable about selected SAIL metrics,[24] the team should continue to take actions to improve care and performance, particularly Quality of Care and Efficiency metrics likely contributing to the current 2-star rating.

[24] OIG recognizes that the SAIL model has limitations for identifying all areas of clinical risk. OIG is using it as "a way to understand the similarities and differences between the top and bottom performers" within the VHA system.

Quality, Safety, and Value

One of VA's strategies is to deliver high-quality, veteran-centered care that compares favorably to the best of the private sector in measured outcomes, value, and efficiency.[25] VHA requires that its facilities operate a QSV program to monitor patient care quality and performance improvement activities.

The purpose of this review was to determine whether the facility complied with key QSV program requirements.[a] To assess this area of focus, OIG evaluated the following:

1. Senior-level involvement in QSV/performance improvement committee
2. Protected peer review[26] of clinical care
3. Credentialing and privileging
4. Utilization management (UM) reviews[27]
5. Patient safety incident reporting and root cause analyses

OIG interviewed senior managers and key QSV employees and evaluated meeting minutes, licensed independent practitioners' profiles, protected peer reviews, root cause analyses, and other relevant documents. The list below shows the performance indicators for each of the following QSV program activities.

- Senior-level committee responsible for key QSV functions
  - Met at least quarterly
  - Chaired or co-chaired by the Facility Director
  - Reviewed aggregated data routinely
- Protected peer reviews
  - Examined important aspects of care (appropriate and timely ordering of diagnostic tests, timely treatment, and appropriate documentation)
  - Resulted in implementation of Peer Review Committee recommended improvement actions

[25] Department of Veterans Affairs, Veterans Health Administration. *Blueprint for Excellence*. September 2014.
[26] According to VHA Directive 2010-025 (June 3, 2010), this is a peer evaluation of the care provided by individual providers within a selected episode of care. This also involves a determination of the necessity of specific actions, and confidential communication is given to the providers who were peer reviewed regarding the results and any recommended actions to improve performance. The process may also result in identification of systems and process issues that require special consideration, investigation, and possibly administrative action by facility staff.
[27] According to VHA Directive 1117 (July 9, 2014), UM reviews evaluate the appropriateness, medical need, and efficiency of health care services according to evidence-based criteria.

- Credentialing and privileging processes
  - Considered frequency for Ongoing Professional Practice Evaluation (OPPE)[28] data review
  - Indicated a Focused Professional Practice Evaluation[29]
- UM personnel
  - Completed at least 75 percent of all required inpatient reviews
  - Documented Physician UM Advisors' decisions in the National UM Integration database
  - Reviewed UM data using an interdisciplinary group
- Patient safety personnel
  - Entered all reported patient incidents into the WEBSPOT database
  - Completed the required minimum of eight root cause analyses
  - Reported root cause analysis findings to reporting employees
  - Submitted an annual patient safety report

Conclusions. Generally, OIG found that senior managers were engaged with QSV activities, and when opportunities for improvement were identified, they supported clinical leaders' implementation of corrective actions and monitoring for effectiveness. OIG also found general compliance with requirements for protected peer review and patient safety. However, OIG identified the following deficiencies in the remaining areas that warranted recommendations for improvement.

Credentialing and Privileging. Facility medical staff bylaws require clinical managers to review OPPEs quarterly. The ongoing monitoring of privileged practitioners is essential to confirm the quality of care delivered and allows the facility to identify professional practice trends that impact patient safety. Thirteen of the 25 licensed independent practitioners' profiles did not contain evidence that service chiefs reviewed OPPE data quarterly for medicine, behavioral health, neurology, physical medicine and rehabilitation, or spinal cord injury and disability. Managers indicated that evaluations are completed every 2 years in accordance with the facility's Peer Review Committee policy; however, managers were unaware of the quarterly review requirement for OPPEs.

Recommendation

1. The Chief of Staff ensures clinical managers consistently review Ongoing Professional Practice Evaluation data quarterly and monitors the managers' compliance.

[28] OPPE is the ongoing monitoring of privileged practitioners to identify professional practice trends that impact the quality of care and patient safety.
[29] Focused Professional Practice Evaluation is a process whereby the facility evaluates the privilege-specific competence of the practitioner who does not have documented evidence of competently performing the requested privileges of the facility. It typically occurs at the time of initial appointment to the medical staff or the granting of new, additional privileges. The Focused Professional Practice Evaluation may be used when a question arises regarding a currently privileged practitioner's ability to provide safe, high-quality patient care.

Facility concurred.

Target date for completion: July 2018

Facility Response: Quarterly OPPE reviews will be completed by all clinical services. The Ongoing Professional Practice Evaluation form will be modified to include a signature from the clinical managers and managers will be instructed as necessary. Medical Office staff will report compliance by service and overall to the Professional Standards Board until 90% compliance is noted with sustained improvement over 6 consecutive months.

Utilization Management: Documentation of Decisions. VHA requires that Physician UM Advisors document their decisions regarding appropriateness of patient admission and continued stays in the National UM Integration database. This allows for national level UM data to be available for review by an interdisciplinary group to set benchmarks; identify trends, actions, and opportunities to improve efficiency; and monitor outcomes. In 12 of 42 cases (29 percent) referred to the physician advisors from March through April 30, 2017, there was no evidence that advisors documented their decisions in the database. UM staff reported that physician advisors lacked oversight for their activities and therefore did not consistently review and document referred cases. At the time of OIG's visit, a responsible person for oversight of the Physician UM Advisors was named and functioning in this role.

Recommendation

2. The Associate Director for Patient Care Services ensures Physician Utilization Management Advisors consistently document their decisions in the National Utilization Management Integration database and monitors the advisors' compliance.

Facility concurred.

Target date for completion: March 2018

Facility Response: All Physician Utilization Management Advisors (PUMAs) will be trained on the requirement for documenting their decisions in the National Utilization Management Integration (NUMI) database. A formal procedure has been developed for communication between the Utilization Management (UM) reviewers and the PUMA to improve awareness of pending reviews as well as to assist in tracking response times. PUMA compliance will be reported to the Flow Committee monthly. The Flow Committee will include compliance data in their report to the Quality Board. The process will be monitored until 90% compliance is noted with sustained improvement over 6 months.

Medication Management: Anticoagulation Therapy

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. From October 1, 2015 through September 30, 2016, more than 482,000 veterans received an anticoagulant,[30] or a blood thinner, which is a drug that works to prevent the coagulation or clotting of blood. TJC'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."

Within medication management, OIG selected a special focus on anticoagulation therapy given its risk and common usage among veterans. The purpose of this review was to determine whether facility clinicians appropriately managed and provided education to patients with new orders for anticoagulant medication.[b]

OIG reviewed relevant documents and the competency assessment records of four employees actively involved in the anticoagulant program and interviewed key employees. Additionally, OIG reviewed the electronic health records (EHRs) of 35 randomly selected patients who were prescribed new anticoagulant medications from July 1, 2015 through June 30, 2016. The list below shows the performance indicators examined.

- Development and implementation of anticoagulation management policies
- Algorithms, protocols, or standardized care processes
  - Initiation and maintenance of warfarin
  - Management of anticoagulants before, during, and after procedures
  - Use of weight-based, unfractionated heparin
- Provision of a direct telephone number for patient anticoagulation-related calls
- Designation of a physician anticoagulation program champion
- Risk minimization of dosing errors
- Routine review of quality assurance data
- Provision of transition follow-up and education for patients with newly prescribed anticoagulant medications
- Laboratory testing
  - Prior to initiating anticoagulant medications
  - During anticoagulation treatment
- Documentation of justification/rationale for prescribing the anticoagulant when laboratory values did not meet selected criteria
- Competency assessments for employees actively involved in the anticoagulant program

[30] Managerial Cost Accounting Pharmacy Cube, Corporate Data Warehouse data pull on March 23, 2017.

Conclusions. Generally, OIG noted that local policies and processes had been established and that risk minimalization efforts for dosing errors were in place. However, OIG identified the following deficiencies that warranted recommendations for improvement.

Quality Assurance. VHA requires an ongoing quality assurance plan to evaluate the anticoagulation management program. This evaluation provides the opportunity to identify practice improvements, ensures appropriate action is taken to improve the practice, and measures the effectiveness of those actions on a regular basis. Clinic managers stated that, as required by facility policy, quality assurance data for the anticoagulation management program was submitted quarterly to the Pharmacy and Therapeutics Committee. However, for the timeframe of October 2016 to April 2017, only the April 2017 committee minutes documented discussions of all required anticoagulation data. Clinical managers were aware of the requirements and believed that submitting collected anticoagulation data to the Pharmacy and Therapeutics Committee met requirements.

Recommendation

3. The Associate Director ensures quality assurance data for the anticoagulation management program are reviewed at the Pharmacy and Therapeutics Committee and monitors compliance.

Facility concurred.

Target date for completion: Completed. August 2017

Facility Response: Quality Assurance data related to the anticoagulation management program to include, Time in Therapeutic Range (TTR), percentage of patients with 7-day follow-up for sub therapeutic or supratherapeutic International Normalized Ratio (INR), percentage of patients with follow-up INR in the last 42 days, proportion of patients with thrombolytic events, patient events, close calls, near misses with anticoagulation treatment and adverse drug events will be reported to the Pharmacy and Therapeutics (P&T) Committee. Quality assurance data for a 6 month period were reported in the April and August, 2017 P&T Committee meetings. The facility requests closure of this recommendation based on the meeting minutes provided.

Patient Education. VHA requires clinicians to deliver initial and ongoing patient and family education for newly prescribed anticoagulant medications that includes the importance of follow-up monitoring, compliance issues, dietary restrictions, and potential for adverse drug reactions and interactions. Due to the high risk of adverse events, patient and/or family member education is essential to decrease the potential occurrence of bleeding, drug interactions, or other delayed pharmacological effects. Of the 35 EHRs reviewed, OIG noted compliance with patient education for all 25 patients initiated on warfarin. For the 10 patients newly prescribed direct-acting oral anticoagulants, eight EHRs did not contain evidence that patients received education. Clinical managers cited that patients receiving direct-acting oral anticoagulants were not

followed by the anticoagulation clinic, and this lack of oversight contributed to noncompliance.

Recommendation

4. The Chief of Staff ensures clinicians provide specific education to patients with newly prescribed anticoagulant medications and monitors clinicians' compliance.

Facility concurred.

Target date for completion: July 2018

Facility Response: Ordering templates in CPRS [Computerized Patient Record System] for direct-acting oral anticoagulants (DOAC) will be revised to prompt providing appropriate education to the patient and to document the education. Compliance will be monitored by anticoagulation management program staff and will be reported to the Pharmacy and Therapeutics Committee until 90% compliance is noted with sustained improvement over 6 consecutive months.

Laboratory Tests. VHA requires clinicians to obtain baseline laboratory tests, such as complete blood count, prothrombin time, and international normalized ratio, prior to initiating patients on anticoagulant medications. This ensures patients do not have an underlying medical condition which needs to be addressed prior to receiving the anticoagulant and helps monitor patients while on the anticoagulant. For 5 of the 25 applicable patients, clinicians did not obtain all required laboratory tests prior to initiating warfarin treatment. Anticoagulation clinic providers did not consistently document baseline laboratory tests for patients newly initiated on anticoagulants through orders or prescriptions by non-VA providers, and a lack of attention to detail and oversight resulted in noncompliance.

Recommendation

5. The Chief of Staff ensures clinicians obtain required laboratory tests prior to initiating anticoagulant medications and monitors the clinicians' compliance.

Facility concurred.

Target date for completion: July 2018

Facility Response: Ordering templates in CPRS for DOAC's will be revised to ensure appropriate labs are ordered and documented. Anticoagulation clinic staff were educated in May 2017 regarding completeness of documentation of outside baseline INR for patients on warfarin. Compliance will be monitored by anticoagulation management program staff and will be reported to the Pharmacy and Therapeutics Committee until 90% compliance is noted with sustained improvement over 6 consecutive months.

Competency. VHA requires competencies specific to anticoagulation management be established for anticoagulation providers and clinical staff directly involved in caring for patients receiving anticoagulation therapy. Competencies must include knowledge of standard terminology, pharmacology of anticoagulants, monitoring requirements, dose calculations, common side effects, nutrient interactions, and drug-to-drug interactions associated with anticoagulation therapy. This ensures providers have sufficient aptitude, knowledge, skill, and abilities to fulfill the duties and responsibilities of the assigned position. The facility uses OPPEs to assess competency. For the four clinicians actively involved in the anticoagulant program, competency assessments did not include dose calculations, common side effects, nutrient interactions, and drug-to-drug interactions associated with anticoagulants. Anticoagulation program managers believed the general pharmacology competencies included in OPPEs met requirements and were unaware of the specific anticoagulation competencies required for the clinical staff involved in the management of patients receiving anticoagulants.

Recommendation

6. The Associate Director ensures all required elements specific to anticoagulation management are included in competency assessments for all employees actively involved in the anticoagulant program and monitors compliance.

Facility concurred.

Target date for completion: Completed. July 2017

Facility Response: Pharmacy updated the competency requirements to include dose calculations, common side effects, nutrient interactions, and drug-to-drug interactions associated with anticoagulants. The Anticoagulation Management Program competency now includes a document review and a written competency exam for employees actively involved in the program. The Competency Exams were completed by existing Anticoagulation Management Program employees in April 2017, and upon hire in July 2017 for a new staff member. The Competency Assessment Checklists (one for Clinical Pharmacists and one for Clinical Pharmacy Technicians) were updated accordingly, and each staff member has an updated checklist in their Personnel Folder. The facility requests closure of this recommendation based on evidence of competencies provided.

Coordination of Care: Inter-Facility Transfers

Coordination of care is the process of ensuring continuity of care, treatment, or services provided by a facility, which includes referring individuals to appropriate community resources to meet ongoing identified needs. Effective coordination of care also involves implementing a plan of care and avoiding unnecessary duplication of services. OIG selected a special focus on inter-facility transfers because they are frequently necessary to provide patients with access to specific providers or services. 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.

The purpose of this review was to evaluate selected aspects of the facility's patient transfer process, specifically transfers out of the facility.[c]

OIG reviewed relevant policies and facility data and interviewed key employees. Additionally, OIG reviewed the EHRs of 37 randomly selected patients who were transferred 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 list below shows the performance indicators OIG examined.

- Development and implementation of patient transfer policy
- Collection and reporting of data about transfers out of the facility
- Completion of VA Form 10-2649A and/or transfer/progress notes prior to or within a few hours after the transfer
  - Date of transfer
  - 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
- Documentation by acceptable designees in the absence of staff/attending physicians
  - Staff/attending physician approval
  - Staff/attending physician countersignature on the transfer note
- Nurse documentation of transfer assessments/notes
- Provider documentation for emergent transfers
  - Patient stability for transfer
  - Provision of all medical care within the facility's capacity
- Communication with the accepting facility
  - Available history
  - Observations, signs, symptoms, and preliminary diagnoses
  - Results of diagnostic studies and tests

Conclusions. OIG noted that the facility developed and implemented a patient transfer policy. However, OIG identified the following deficiencies with data reporting, transfer documentation, and communication with the accepting facility that warranted recommendations for improvement.

Data Reporting. VHA requires facilities to collect and report data for patient inter-facility transfers, such as date of transfer, documentation of informed consent and medical or behavioral stability, and identification of transferring and receiving provider, as part of VHA's quality management program. The collection and reporting of data allows the facility to analyze and improve the inter-facility transfer process to maximize patient safety. Although the facility collected inter-facility transfer data, the data were not analyzed or reported to a quality oversight committee. Facility managers stated they informally report transfer data during daily morning reports; however, they were unaware of the requirement to collect, analyze, and formally report transfer data as part of the facility's quality management program.

Recommendation

7. The Facility Director ensures inter-facility patient transfer data are analyzed and reported to an identified quality oversight committee assigned these responsibilities and monitors compliance.

Facility concurred.

Target date for completion: July 2018

Facility Response: The Flow committee has been identified as the primary oversight committee for ensuring inter-facility transfer data are analyzed and reported. All transfer data will be collected by the Transfer Coordinators who will be responsible for trending, analysis and reporting. The Flow Committee will include compliance data in their report to the Quality Board until 90% compliance is noted with sustained improvement over 6 consecutive months.

Transfer Documentation. VHA requires that transferring providers document patient or surrogate informed consent and identify the receiving provider on VA Form 10-2649A and/or in transfer/progress notes. This ensures that patients are part of the decision-making process and that receiving providers are aware of patients' needs and level of care after transfer. Ten of the 37 patients' EHRs (27 percent) did not document patient or surrogate informed consent, 5 of the 37 patients' EHRs (14 percent) did not document patients' medical and behavioral stability, and 7 of the 37 patients' EHRs (19 percent) did not identify the transferring provider or designee. The facility cited the lack of a permanent transfer coordinator to manage and monitor transfers as the primary reason for noncompliance with VHA documentation requirements.

Recommendation

8. The Associate Director for Patient Care Services ensures providers consistently document patient or surrogate informed consent and patient medical and behavioral stability and identify transferring providers or designees for patients transferred out of the facility and monitors providers' compliance.

Facility concurred.

Target date for completion: July 2018

Facility Response: A data collection sheet has been developed to prompt collection of all required information related to inter-facility transfers. Processes have been standardized to ensure that the Transfer Coordinator receive information timely on all inter-facility transfers. Requirements for informed consent, documentation of medical and behavioral health stability and identification of the transferring provider has been reviewed with all involved staff. Medical Support Assistants have been trained to check for all required elements prior to transfer and provide feedback to the transferring provider. The Transfer Coordinators will also check each transfer for completeness and will provide feedback to the transferring provider.

The Transfer Coordinators will track and report compliance to the Flow Committee monthly. The Flow Committee will include compliance data in their report to the Quality Board until 90% compliance is noted with sustained improvement over 6 consecutive months.

Communication with Accepting Facility. VHA requires that for inter-facility transfers, communication occurs between the sending and accepting facilities or the sending facility provides pertinent patient information when they transfer the patient. Communication of relevant information ensures continuity of care for patients transferred out of VHA facilities. Providers did not send or communicate pertinent patient information for 13 of the 37 patients (35 percent). Interviews with staff indicated that communication between facilities occurred and that staff believed this met requirements; however, this communication was not documented.

Recommendation

9. The Associate Director for Patient Care Services ensures that, for inter-facility transfers, providers document sending or communicating to the accepting facility pertinent patient information and monitors compliance.

Facility concurred.

Target date for completion: July 2018

Facility Response: A data collection sheet has been developed to prompt collection of all required information related to inter-facility transfers. Processes have been standardized to ensure that the Transfer Coordinator receive information timely on all inter-facility transfers. Requirements for documenting communication to the accepting facility on all pertinent patient information has been reviewed with all involved staff. Medical Support Assistants have been trained to check for all required elements prior to transfer and provide feedback to the transferring provider. The Transfer Coordinators will also check each transfer for completeness and will provide feedback to the transferring provider.

The Transfer Coordinators will track and report compliance to the Flow Committee monthly. The Flow Committee will include compliance data in their report to the Quality Board until 90% compliance is noted with sustained improvement over 6 consecutive months.

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. OIG also determined whether the facility met requirements in selected areas that are often associated with higher risks of harm to patients, in this case, with a special emphasis on Radiology Service and the locked MH unit.[d]

Fluoroscopic imaging equipment produces x-rays for the diagnosis, localization, and guidance of interventional procedures.[31] Although an integral part of health care, fluoroscopic imaging can deliver large doses of radiation to patients and employees. Large doses of radiation are known to increase the incidence of cancer and can cause fetal abnormalities.

VHA provides various MH services to patients with acute and severe emotional and/or behavioral symptoms. These services are often provided in an inpatient setting.[32] The inpatient locked MH unit must provide a healing, recovery-oriented environment as well as be a safe place for patients and employees. VHA developed the MH EOC Checklist to reduce environmental factors that contribute to inpatient suicides, suicide attempts, and other self-injurious behaviors and factors that reduce employee safety on MH units.

In all, OIG inspected six inpatient units (surgical intensive care, medical/surgical 5A and 5D, spinal cord injury, Community Living Center, and locked geriatric MH), two outpatient clinics (PC Module E and women's health), the Emergency Department, and Radiology Service. OIG also inspected the Santa Fe VA Clinic (randomly selected CBOC). Additionally, OIG reviewed relevant documents and 16 employee training records and interviewed key employees and managers. The list below shows the location-specific performance indicators selected to examine the risk areas specific to particular settings.

<u>Parent Facility</u>

- EOC Deficiency Tracking
- EOC Rounds
- General safety
- Infection prevention
- Environmental cleanliness
- Exam room privacy
- Availability of feminine hygiene products
- Availability of medical equipment and supplies

[31] VHA Handbook 1105.04, *Fluoroscopy Safety*, July 6, 2012.
[32] VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013.

Community Based Outpatient Clinic
- General safety
- Infection prevention
- Environmental cleanliness
- Medication safety and security
- Exam room privacy
- General privacy
- Availability of feminine hygiene products
- IT network room security
- Availability of medical equipment and supplies

Radiology
- Safe use of fluoroscopy equipment
- Environmental safety
- Infection prevention
- Medication safety and security
- Radiology equipment inspection
- Availability of medical equipment and supplies
- Maintenance of radiological equipment

Locked Mental Health Unit
- MH EOC inspections
- Environmental suicide hazard identification and abatement
- Environmental safety
- Infection prevention
- Employee training on MH environmental hazards
- Availability of medical equipment and supplies

Conclusions. General safety and privacy measures were in place at the parent facility, representative CBOC, and radiology areas. However, OIG noted a lack of feminine hygiene products and disposal bins in the Santa Fe VA Clinic. The locked MH unit met most of the performance indicators examined. OIG identified the following deficiencies that warranted recommendations for improvement.

Parent Facility: Environment of Care Rounds Frequency. VHA requires EOC rounds to be conducted at a minimum of once per FY in non-patient areas and twice per FY in patient care areas. Further, the Comprehensive EOC Assessment and Compliance Tool is to be used to collect all data associated with EOC rounds within facilities. EOC rounds assist in identifying potential patient safety risks and deficiencies.

OIG reviewed Comprehensive EOC Assessment and Compliance Tool data for FY 2016[33] and found the facility's 13 CBOCs were not inspected at the required frequency. Members of the EOC interdisciplinary team stated that rounds were completed; however, the rounds were not documented in the Comprehensive EOC Assessment and Compliance Tool. Facility managers believed they were meeting the requirements and were unaware of the noncompliance, but they were unable to produce evidence that demonstrated compliance.

Recommendation

10. The Assistant Director ensures environment of care inspections are conducted at the required frequency and documented in the Comprehensive Environment of Care Assessment and Compliance Tool and monitors compliance.

Facility concurred.

Target date for completion: April 2018

Facility Response: All Environment of Care (EOC) Team Members completing semi-annual EOC inspections were identified and were provided access to the Comprehensive EOC Assessment and Compliance Tool (e.g. Performance Logic Software). To ensure all required aspects of the inspections are completed, alternate staff, with comparable experience and specialty, were identified and were also provided access to the tool.

A schedule for the first half of FY 2018 was developed where all required disciplines are scheduled to visit each of the 13 CBOCs between October and March 2018. All disciplines do not attend at the same time to avoid overwhelming or disrupting these small clinics. The dates for each visit are entered into the tool in the month prior to the visit and team members/alternates are instructed to log their visit and their findings in the software. Compliance with completing visits to all CBOCs will be tracked and reported to the EOC Committee monthly. Compliance will also be monitored in the Quality Board until 90% compliance is noted with sustained improvement over 6 consecutive months.

Parent Facility: Environment of Care Rounds Attendance. VHA requires facilities to perform comprehensive EOC rounds with a designated team that includes specific membership to ensure a safe, clean, and high-quality care environment.[34] OIG noted that 7 of 13 core team members' participation ranged from 0 to 67 percent, with 4 members attending less than 50 percent of the rounds conducted from

[33] October 1, 2015 through September 30, 2016.
[34] According to VHA, core membership is composed of representatives from programmatic areas, such as nursing, infection control, patient safety, and medical equipment management, to ensure adherence to various program requirements.

October 1, 2016 to April 20, 2017. Identified reasons for noncompliance included core members not assigned to be present during all required rounds, inadequate recording of attendance in the Comprehensive EOC Assessment and Compliance Tool, and facility managers failing to provide oversight to ensure compliance.

Recommendation

11. The Assistant Director ensures core team members consistently participate in environment of care rounds and attendance is documented in the Comprehensive Environment of Care Assessment and Compliance Tool and monitors compliance.

Facility concurred. Target date for completion: March 2018 Facility Response: Team members and their alternates participating in environment of care (EOC) rounds have all been instructed on the need to log their attendance in Performance Logic Software Tool even when no discrepancies were found. Compliance will be tracked and reported monthly in the EOC Committee. Compliance will also be monitored in the Quality Board until 90% compliance is noted with sustained improvement over 6 consecutive months.

Parent Facility: Cleanliness. TJC requires hospitals to maintain a clean environment, continually monitor environmental conditions, and remediate conditions not meeting this requirement. This ensures a clean and safe health care environment to minimize the spread of infection and reduce or eliminate potential safety hazards.

Four of eight patient care areas[35] had dirty floors and dirty patient rolling equipment (such as stretchers and bed frames), and three patient care areas[36] had damaged furnishings (chair armrests or torn seat cushions). Four of eight patient nourishment kitchens[37] had ice machines with dirty trays and racks. Managers stated that floors and ice machines were cleaned daily and believed this met cleanliness requirements. Managers also stated that when cleaning beds and gurneys, the focus was on the mattress and bed rails; consequently, the horizontal bases were missed due to a lack of attention to detail. Managers had not placed work orders to repair or remove damaged furnishings because they were either unaware of the issue or did not think that the damage warranted repair or removal from service.

Recommendation

12. The Assistant Director ensures that in patient care areas, floors and rolling equipment are clean, nourishment kitchen ice machines are clean, and damaged furniture is repaired or removed from service and monitors compliance.

[35] Emergency Department, medical/surgical unit 5A, medical/surgical unit 5D, and surgical intensive care unit.
[36] Emergency Department, medical/surgical unit 5A, and medical/surgical unit 5D.
[37] Emergency Department, medical/surgical unit 5A, and medical/surgical unit 5D.

Facility concurred.

Target date for completion: July 2018

Facility Response: Environmental Management Service (EMS), in collaboration with Nursing Service, developed a quarterly cleaning schedule for 'Clean,' 'Soiled,' and 'Equipment' storage rooms. The Clean Storage process includes the dusting of rolling equipment for stretchers and IV poles. Nurse Managers are responsible for the daily dusting of horizontal surfaces on stretchers and bed frames located in their area. Compliance by managers at the point of use will be monitored during EOC rounds and the EMS schedule will be tracked and reported to the EOC Committee. Compliance will also be monitored in the Quality Board until 90% compliance is noted with sustained improvement over 6 consecutive months.

EMS implemented weekly external cleaning and inspections of facility wide ice machines. If hard water deposits prevent the cleaning of the trays/grate, a work order for replacement is entered by EMS. Weekly checks and tray/grate replacement will be tracked and reported to the EOC Committee. Compliance will also be monitored in the Quality Board until 90% compliance is noted with sustained improvement over 6 consecutive months.

EMS developed a laminated instruction document titled "When it's Broken." This document provides specifics on reporting damaged or broken items. These instructions were also published on the Nurse Share Drive and Nurse newsletter. Furniture inspection will be a priority focus in EOC rounds with inspections completed, findings and actions taken reported in the EOC Committee. Compliance will also be monitored in the Quality Board until 90% compliance is noted with sustained improvement over 6 consecutive months.

Community Based Outpatient Clinic: Expiration Dates on Supplies. VHA requires facilities to adhere to expiration dates on clinic supplies and products. The expiration date or shelf life is the period of time which a product remains suitable for its intended use. It reflects product usability or stability rather than sterility of the contents. Outdated items must be removed from the care area as these items may not function as intended. Ten items (scalpels and urinary catheters) in the Santa Fe VA Clinic's automated dispensing unit had expired. Although the dispensing unit could be programmed to automatically track expiration dates as items are stocked, the nurses were manually checking expiration dates. A lack of attention to detail resulted in outdated items not being removed from the automated dispensing unit/clinic.

Recommendation

13. The Assistant Director ensures outdated supplies are removed from the Santa Fe VA Clinic and monitors compliance.

Facility concurred.

Target date for completion: March 2018

Facility Response: Logistics conducted extensive Omnicell research for producing the Expired Items Report. It was determined that it is not practical to use the expiration monitor report as it will alert all 150 machines (inpatient and all clinics) regarding the expiration of one item.

The Santa Fe Community Based Outpatient Clinic (CBOC) staff have conducted weekly manual supply inventories. Items within one month of expiration are returned to the main facility for redistribution to an area where they will be used quickly. Compliance with completing the inventories and data on items returned to Logistics will be tracked by the clinic and will be reported to EOC Committee. Compliance will also be monitored in the Quality Board until 90% compliance is noted with sustained improvement over 6 consecutive months.

Locked Mental Health Unit: Physical Security Risk Assessment. VHA requires VA Police to perform physical security risk assessments annually to ensure that appropriate physical security precautions are being taken and that equipment is regularly tested in order to provide a safe environment for patients, visitors, and employees. The locked geriatric MH unit was under construction during the FY 2017 risk assessment and was not included in the review, nor was a risk assessment completed prior to the unit's activation in February 2017. Facility managers reported that several Interdisciplinary Safety Inspection Team members walked through the unit to assess risk and believed this met the requirement. Facility managers and VA Police were unable to provide documentation that the assessment for the locked geriatric MH unit was completed.

Recommendation

14. The Assistant Director ensures facility managers complete a physical security assessment for the locked geriatric mental health unit.

Facility concurred.

Target date for completion: Completed. May 2017

Facility Response: The Physical Security Survey of Building 41, 6th floor C-Quad Geriatric Psychiatric Unit was conducted on May 19, 2017. The facility requests closure of this recommendation based on physical security surveys conducted by VA Police of the acute and geriatric MH units on May 19, 2017.

Locked Mental Health Unit: Annual Training. VHA requires that locked MH unit employees and the facility's Interdisciplinary Safety Inspection Team members receive training on the identification and correction of environmental hazards, including the proper use of the MH EOC Checklist so they can effectively inspect inpatient MH units to ensure patient, visitor, and staff safety. Eight of 10 locked MH unit employees and three of six Interdisciplinary Safety Inspection Team members did not complete the required training within the past 12 months. EOC leaders and managers were unaware of the specific training requirement.

Recommendation

15. The Assistant Director ensures all locked mental health unit employees and Interdisciplinary Safety Inspection Team members receive annual training on how to identify and correct environmental hazards, to include the proper use of the Mental Health Environment of Care Checklist, and monitors compliance.

Facility concurred.

Target date for completion: December 2017

Facility Response: The Mental Health Environment of Care Checklist training was assigned to all staff as it is difficult to identify individual staff that may need to work on one of the locked mental health units at some time. Services were allowed to request a waiver for specific employees that do not ever need to work in those environments. Compliance with training will be tracked and reported to the EOC Committee for Behavioral Health staff assigned to work on the locked mental health units, staff identified on the Interdisciplinary Safety Inspection Team and assigned staff at large. Compliance will also be monitored in the Quality Board until 90% compliance is noted with sustained improvement over 6 consecutive months.

High Risk Processes: Moderate Sedation

OIG's special focus within high-risk processes for the facility was moderate sedation, which is a drug-induced depression of consciousness during which patients can still respond purposefully to verbal comments.[38] 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 patient's airway, spontaneous ventilations, or cardiovascular function. The administration of moderate sedation could lead to a range of serious adverse events, including cardiac and respiratory depression, brain damage due to low oxygen levels, cardiac arrest, or death.[39]

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 employee performance.[40] During calendar year 2016, VHA clinicians performed more than 600,000 moderate sedation procedures, of which more than half were gastroenterology-related endoscopies.[41] To minimize risks, VHA and TJC have issued requirements and standards for moderate sedation care.

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.[e]

OIG reviewed relevant documents; interviewed key employees; and inspected the gastroenterology, cardiology, pulmonology, interventional radiology, pain clinic, medical intensive care unit, and Emergency Department procedure areas to assess whether required equipment and sedation medications were available. Additionally, OIG reviewed the EHRs of 47 randomly selected patients who underwent an invasive procedure involving moderate sedation from July 1, 2015 through June 30, 2016, and the training records of 15 clinical employees who performed or assisted during these procedures. The list below shows the performance indicators OIG reviewed.

- Reporting and trending the use of reversal agents in moderate sedation cases
- Performance of history and physical examinations and pre-sedation assessment within 30 calendar days prior to the moderate sedation procedure
- Re-evaluation of patients immediately before administration of moderate sedation
- Documentation of informed consent prior to the moderate sedation procedure

[38] American Society of Anesthesiologists (ASA), Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists, 2002. Anesthesiology 2002; 96:1004-17.
[39] VA National Center for Patient Safety. March 2015. Moderate Sedation Toolkit for Non-Anesthesiologists: Facilitator's Guide, Retrieved March 20, 2017 from: https://www.patientsafety.va.gov/docs/modSedationtoolkit/FacilitatorGuide.pdf.
[40] VHA Directive 1073, *Moderate Sedation by Non-Anesthesiology Providers*, December 30, 2014.
[41] Per VA Corporate Data Warehouse data pull on February 22, 2017.

- Performance of timeout[42] prior to the moderate sedation procedure
- Post-procedure documentation
- Discharge practices
- Clinician training for moderate sedation
- Availability of equipment and medications in moderate sedation procedure areas

Conclusions. Generally, OIG found compliance with reporting and trending the use of reversal agents in moderate sedation cases, discharge practices, and training of clinical staff. OIG identified the following deficiencies that warranted recommendations for improvement.

Informed Consent. VHA requires that providers obtain and document informed consent prior to moderate sedation procedures. The informed consent must identify, by name and profession, the practitioner who has primary responsibility for the relevant aspect of the patient's care and the name and profession of any other individuals responsible for authorizing or performing the treatment or procedure. In addition, VHA requires that when it becomes necessary for a substitute practitioner to perform the procedure, the patient must be informed of the change, and the discussion and patient approval must be documented in the patient's EHR. This ensures the patient has been given the right to accept or refuse the substitute practitioner.

For 7 of the 47 patients (15 percent), the name of the provider listed on the informed consent did not match that of the provider who performed the procedure, and there was no documentation the provider informed the patient of the change. The facility program manager reported that residents and fellows[43] selected incorrect attending practitioner names from a pre-populated drop-down menu. Lack of attention to detail in selecting the correct attending practitioner resulted in noncompliance with the requirements.

Recommendation

16. The Chief of Staff ensures that providers include the accurate name of the provider performing the procedure on the informed consent and monitors providers' compliance.

Facility concurred.

Target date for completion: March 2018

Facility Response: The CPRS Non-OR [Operating Room] Procedure Note was augmented to include required provider/consent/procedure information and the master audit sheet was updated to track compliance with including the name of the provider(s) completing the procedure. Compliance is tracked and reported to the Moderate Sedation Committee. Compliance will also be monitored in the Quality Board until 90% compliance is noted with sustained improvement over 6 consecutive months.

[42] A time out is the process of verifying correct patient, procedure, and procedure site/side. The procedure team (physician, nurses, and other support staff) also verifies that the patient has given consent for the procedure and that any specialty equipment needed is available. This is performed prior to the start of the procedure.
[43] A physician who has completed residency training and is pursuing additional specialty training.

Timeout Procedure. VHA and TJC require the clinical team, including the provider performing the procedure, to conduct and document a timeout immediately prior to performing a moderate sedation procedure. The timeout process ensures that the clinical team members and the privileged provider are in agreement that they have the correct patient, procedure, and site on the patient and that they have proper equipment, medications, and supplies prior to starting any aspect of the procedure. Thirty-two of the 46 applicable patients' EHRs (70 percent) did not contain evidence that the provider participated in the timeout for gastroenterology procedures. Gastroenterology-privileged providers and managers were unaware of the requirement and thought they were in compliance when the fellows (not privileged at this facility) represented the privileged provider during the timeout.

Recommendation

17. The Chief of Staff ensures the privileged providers performing the procedure participate in the timeout process prior to moderate sedation procedures and monitors providers' compliance.

Facility concurred.

Target date for completion: March 2018

Facility Response: Providers and RNs participating in moderate sedation were provided refresher education including elements of the time-out process. The CPRS Non-OR Procedure Note was augmented to include required time out elements and the master audit sheet was updated to track compliance with documenting that the attending provider was present for the time-out. Compliance is tracked and reported to the Moderate Sedation Committee. Compliance will also be monitored in the Quality Board until 90% compliance is noted with sustained improvement over 6 consecutive months.

Timeout Checklist. VHA requires a timeout must be facilitated by a checklist and occur immediately prior to the start of the procedure. The VHA "Out of OR [Operating Room] Time Out" checklist requires patient identity, consent form, procedure, side/site, imaging (if applicable), and specialty or unit specific element. This ensures that the clinical team members involved in the procedure are in agreement that they have the correct patient, procedure, and site and also proper equipment, medications, and supplies prior to starting any aspect of the procedure. For 44 of the 46 applicable patients' EHRs (96 percent), a checklist of the items embedded in an EHR note template did not contain all required timeout elements. Senior clinicians and managers who developed related policies and procedures were unaware that the timeout and checklist requirements were not understood or implemented at the service level.

Recommendation

18. The Chief of Staff ensures clinical teams use a checklist that includes all required elements to conduct and document timeouts prior to moderate sedation procedures and monitors compliance.

Facility concurred.

Target date for completion: March 2018

Facility Response: Providers and RNs participating in moderate sedation were provided refresher education including elements of the time-out process. Laminated checklists were re-distributed to all Non-OR Surgical Procedure Sites. The CPRS Non-OR Procedure Note was augmented to include required time out elements. Compliance with all required elements is tracked and reported to the Moderate Sedation Committee. Compliance will also be monitored in the Quality Board until 90% compliance is noted with sustained improvement over 6 consecutive months.

Long-Term Care: Community Nursing Home Oversight

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.[44] Local oversight of CNHs is achieved through annual reviews and monthly visits.

The purpose of this review was to assess whether the facility complied with applicable requirements regarding the monitoring of veterans in contracted CNHs.[f]

OIG interviewed key employees and reviewed relevant documents and the results from CNH annual reviews completed July 5, 2015 through June 30, 2016. Additionally, OIG reviewed the EHRs of 38 randomly selected patients who received CNH care for more than 3 months during the timeframe July 1, 2015 through June 30, 2016. The list below shows the performance indicators OIG reviewed.

- Implementation of a CNH Oversight Committee with representation by required disciplines and meetings at least quarterly
- Integration of CNH program into quality improvement program
- Documentation of hand-off for patients placed in CNHs outside catchment area
- Completion of CNH annual reviews by CNH Review Team
- Completion of exclusion review documentation when CNH annual reviews noted four or more exclusionary criteria
- Documentation of social worker and registered nurse cyclical clinical visits

Conclusions. Generally, OIG noted compliance with requirements for program integration and annual reviews. OIG identified the following deficiencies that warranted recommendations for improvement.

Oversight Committee. VHA requires the CNH Oversight Committee to include representation from social work, nursing, quality management, acquisitions, and the medical staff. Committee oversight functions include verifying completeness of the CNH Review Teams' initial, annual, and problem-focused CNH evaluations. This multidisciplinary review and perspective helps to ensure patients in the CNH program receive high-quality care in a safe environment. From July 2016 to April 2017, CNH Oversight Committee meeting minutes did not contain evidence of medical staff representative attendance. Managers and staff knew about the requirements; however, they stated that staff vacancies and availability contributed to noncompliance with VHA policy.

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

Recommendation

19. The Chief of Staff ensures the Community Nursing Home Oversight Committee includes consistent representation by all required disciplines and monitors compliance.

Facility concurred.

Target date for completion: Completed. October 2017

Facility Response: The Medical staff representative was identified and informed of the need to attend the community nursing home quarterly oversight committee. The medical staff representative attendance has been 100% since OIG CHIP visit. The facility requests closure of this recommendation based on meeting minutes provided. Attendance will continue to be monitored and will be reported to the Clinical Executive Board.

Clinical Visits. VHA requires that every patient under contract in a nursing home must be visited by a social worker or registered nurse at least every 30 days (unless specific criteria that allow an exception are met). Social workers and registered nurses must alternate monthly visits (unless otherwise indicated by the patient's treatment plan). This interdisciplinary monitoring ensures vulnerable nursing home patients consistently receive quality care and necessary follow-up services. Twenty-three of the 38 patients' EHRs (61 percent) did not contain evidence of social worker and/or registered nurse cyclical clinical visits with the frequency required by VHA policy. Managers and staff knew about the requirements but stated staff vacancies contributed to noncompliance with VHA policy.

Recommendation

20. The Chief of Staff ensures the social workers and registered nurses conduct monthly cyclical clinical visits and monitors compliance.

Facility concurred.

Target date for completion: March 2018

Facility Response: Additional Community Nursing Home Oversight staff have been hired to permit Social Work (SW) and Registered Nurse (RN) visits to alternate each month as required. Compliance with monthly visits alternating between the SW or RN will be tracked and reported to the Community Nursing Home Oversight Committee and roll-up to the Clinical Executive Board. Compliance will also be monitored in the Quality Board until 90% compliance is noted with sustained improvement over 6 consecutive months.

Summary Table of Comprehensive Healthcare Inspection Program Review Findings

Healthcare Processes	Performance Indicators	Conclusion	
Leadership and Organizational Risks	• Executive leadership stability and engagement • Employee satisfaction and patient experience • Accreditation/for-cause surveys and oversight inspections • Indicators for possible lapses in care • VHA performance data	Twenty OIG recommendations, ranging from documentation issues to deficiencies that can lead to patient and staff safety issues or adverse events, are attributable to the Facility Director, Chief of Staff, Nurse Executive, Associate Director, and Assistant Director. See details below.	
Healthcare Processes	**Performance Indicators**	**Critical Recommendations[45] for Improvement**	**Recommendations for Improvement**
Quality, Safety, and Value	• Senior-level involvement in QSV/performance improvement committee • Protected peer review of clinical care • Credentialing and privileging • UM reviews • Patient safety incident reporting and root cause analyses	• Clinical managers consistently review OPPE data quarterly.	• Physician UM Advisors consistently document their decisions in the National UM Integration database.
Medication Management	• Anticoagulation management policies and procedures • Management of patients receiving new orders for anticoagulants o Prior to treatment o During treatment • Ongoing evaluation of the anticoagulation program • Competency assessment	• Clinicians provide specific education to patients with newly prescribed anticoagulant medications. • Clinicians obtain required laboratory tests prior to initiating anticoagulant medications.	• Quality assurance data for the anticoagulation management program are reviewed at the Pharmacy and Therapeutics Committee. • All required elements specific to anticoagulation management are included in competency assessments for all employees actively involved in the anticoagulant program.

[45] OIG defines "critical recommendations" as those that rise above others and address vulnerabilities and risks that could cause exceptionally grave health care outcomes and/or significant impact to quality of care.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Coordination of Care	• Transfer policies and procedures • Oversight of transfer process • EHR documentation o Non-emergent transfers o Emergent transfers	For patients transferred out of the facility: • Providers consistently document patient or surrogate informed consent and patient medical and behavioral stability and identify transferring providers or designees. • Providers document sending or communicating to the accepting facility pertinent patient information.	• Inter-facility patient transfer data are analyzed and reported to an identified quality oversight committee assigned these responsibilities.
Environment of Care	• Parent facility o EOC deficiency tracking and rounds o General Safety o Infection prevention o Environmental cleanliness o Exam room privacy o Availability of feminine hygiene products and medical equipment and supplies • CBOC o General safety o Infection prevention o Environmental cleanliness o Medication safety and security o Privacy o Availability of feminine hygiene products and medical equipment and supplies o IT network room security • Radiology o Safe use of fluoroscopy equipment o Environmental safety o Infection prevention o Medication safety and security o Radiology equipment inspection o Availability of medical equipment and supplies o Maintenance of radiological equipment	• EOC inspections are conducted at the required frequency and documented in the Comprehensive EOC Assessment and Compliance Tool. • Locked MH unit o A physical security assessment is completed for the locked geriatric MH unit.	• Core team members consistently participate in EOC rounds, and attendance is documented in the Comprehensive EOC Assessment and Compliance Tool. • Parent Facility o In patient care areas, floors and rolling equipment are clean, nourishment kitchen ice machines are clean, and damaged furniture in is repaired or removed from service. • CBOC o Outdated supplies are removed from the clinic. • Locked MH unit o All locked MH unit employees and Interdisciplinary Safety Inspection Team members complete the required training on how to identify and correct environmental hazards, including the proper use of the MH EOC Checklist.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Environment of Care (continued)	• Inpatient MH o MH EOC inspections o Environmental suicide hazard identification o Employee training o Environmental safety o Infection prevention o Availability of medical equipment and supplies	(See previous page.)	(See previous page.)
High-Risk and Problem-Prone Processes: Moderate Sedation	• Outcomes reporting • Patient safety and documentation o Prior to procedure o After procedure • Staff training and competency • Monitoring equipment and emergency management	• For moderate sedation procedures, providers include the accurate name of the provider performing the procedure on the informed consent. • The privileged provider performing the moderate sedation procedure participates in the timeout process. • Prior to moderate sedation procedures, clinical teams use a checklist that includes all required elements to conduct and document timeouts.	None
Long-Term Care: Community Nursing Home Oversight	• CNH Oversight Committee and CNH program integration • EHR documentation o Patient hand-off o Clinical visits • CNH annual reviews	• Social workers and registered nurses conduct monthly cyclical clinical visits.	• The CNH Oversight Committee includes consistent representation by all required disciplines.

Facility Profile

The table below provides general background information for this high-complexity (1a)[46] affiliated[47] facility reporting to VISN 22.

Table 5. Facility Profile for Albuquerque (501) for October 1, 2013 through September 30, 2016

Profile Element	Facility Data FY 2014[48]	Facility Data FY 2015[49]	Facility Data FY 2016[50]
Total Medical Care Budget in Millions	$425.2	$481.1	$490.4
Number of:			
• **Unique Patients**	65,390	65,230	65,654
• **Outpatient Visits**	660,959	685,375	685,814
• **Unique Employees**[51]	2,031	2,175	2,204
Type and Number of Operating Beds:			
• **Acute**	131	131	131
• **Mental Health**	36	36	36
• **Community Living Center**	36	36	36
• **Domiciliary**	90	90	90
Average Daily Census:			
• **Acute**	80	68	68
• **Mental Health**	20	18	24
• **Community Living Center**	23	18	15
• **Domiciliary**	71	65	62

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

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

NA = Not applicable

[46] VHA medical centers are classified according to a facilities complexity model; 1a designation indicates a facility with high volume, high-risk patients, most complex clinical programs, and large research and teaching programs. Retrieved September 7, 2017 from http://opes.vssc.med.va.gov/FacilityComplexityLevels/Facility%20Complexity%20Levels%20Document%20Library/Facility%20Complexity%20Level%20Model%20Fact%20Sheet.docx.
[47] Associated with a medical residency program.
[48] October 1, 2013 through September 30, 2014.
[49] October 1, 2014 through September 30, 2015.
[50] October 1, 2015 through September 30, 2016.
[51] Unique employees involved in direct medical care (cost center 8200).

VA Outpatient Clinic Profiles[52]

The VA outpatient clinics in communities within the catchment area of the facility provide PC integrated with women's health, MH, and telehealth services. Some also provide specialty care, diagnostic, and ancillary services. Table 6 provides information relative to each of the clinics.

Table 6. VA Outpatient Clinic Workload/Encounters[53] and Specialty Care, Diagnostic, and Ancillary Services Provided[54] for October 1, 2015 through September 30, 2016

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services[55] Provided	Diagnostic Services[56] Provided	Ancillary Services[57] Provided
Las Vegas, NM	501G2	6,327	2,122	Dermatology Endocrinology Gastroenterology Neurology Amputation Follow-up Poly-Trauma Eye	NA	Nutrition Pharmacy Social Work Weight Management
Artesia, NM	501GA	6,163	1,035	Endocrinology Gastroenterology Neurology Amputation Follow-up Poly-Trauma Rehab Physician Eye Anesthesia	NA	Nutrition Pharmacy Weight Management
Farmington, NM	501GB	6,963	1,941	Endocrinology Gastroenterology Neurology Pulmonary/ Respiratory Disease Amputation Follow-up Poly-Trauma Rehab Physician Eye Anesthesia	NA	Nutrition Pharmacy Weight Management

[52] Includes all outpatient clinics in the community that were in operation as of February 15, 2017.
[53] An encounter is a professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition.
[54] The denoted specialty care and ancillary services are limited to primary clinic stops with a count ≥ 100 encounters for October 1, 2015 through September 30, 2016, timeframe at the specified CBOC.
[55] Specialty care services refer to non-PC and non-MH services provided by a physician.
[56] Diagnostic services include EKG, EMG, laboratory, nuclear medicine, radiology, and vascular lab services.
[57] 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[58] Provided	Diagnostic Services[59] Provided	Ancillary Services[60] Provided
Silver City, NM	501GC	4,722	809	Dermatology Endocrinology Gastroenterology Neurology Amputation Follow-up Poly-Trauma Rehab Physician Eye Anesthesia ENT	NA	Nutrition Pharmacy Social Work Weight Management
Gallup, NM	501GD	4,071	781	Dermatology Endocrinology Gastroenterology Neurology Amputation Follow-up Poly-Trauma Eye Anesthesia	NA	Nutrition Pharmacy Weight Management
Espanola, NM	501GE	2,657	631	Dermatology Endocrinology Neurology Amputation Follow-up Eye	NA	Nutrition Pharmacy Social Work Weight Management
Truth or Consequences, NM	501GH	4,111	444	NA	NA	Social Work
Alamogordo, NM	501GI	5,539	425	Dermatology Endocrinology Gastroenterology Neurology Amputation Follow-up Poly-Trauma Rehab Physician Eye Anesthesia	NA	Nutrition Pharmacy Weight Management

[58] Specialty care services refer to non-primary care and non-MH services provided by a physician.
[59] Diagnostic services include EKG, EMG, laboratory, nuclear medicine, radiology, and vascular lab services.
[60] 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[61] Provided	Diagnostic Services[62] Provided	Ancillary Services[63] Provided
Durango, CO	501GJ	4,896	2,433	Endocrinology Neurology Amputation Follow-up Poly-Trauma Rehab Physician Eye Anesthesia ENT	NA	Nutrition Pharmacy Social Work Weight Management
Santa Fe, NM	501GK	5,260	2,747	Endocrinology Gastroenterology Neurology Amputation Follow-up Eye Anesthesia	NA	Nutrition Pharmacy Social Work Weight Management
Rio Rancho, NM	501GM	10,435	4,334	Dermatology Endocrinology Neurology Eye Anesthesia	NA	Dental Nutrition Pharmacy Weight Management
Taos, NM	501GN	1	NA	NA	NA	NA
Raton, NM	501HB	4,718	459	Endocrinology Neurology Eye Anesthesia	NA	Nutrition Pharmacy Weight Management

Source: VHA Support Service Center and VA Corporate Data Warehouse.

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

[61] Specialty care services refer to non-primary care and non-MH services provided by a physician.
[62] Diagnostic services include EKG, EMG, laboratory, nuclear medicine, radiology, and vascular lab services.
[63] Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

VHA Policies Beyond Recertification Dates

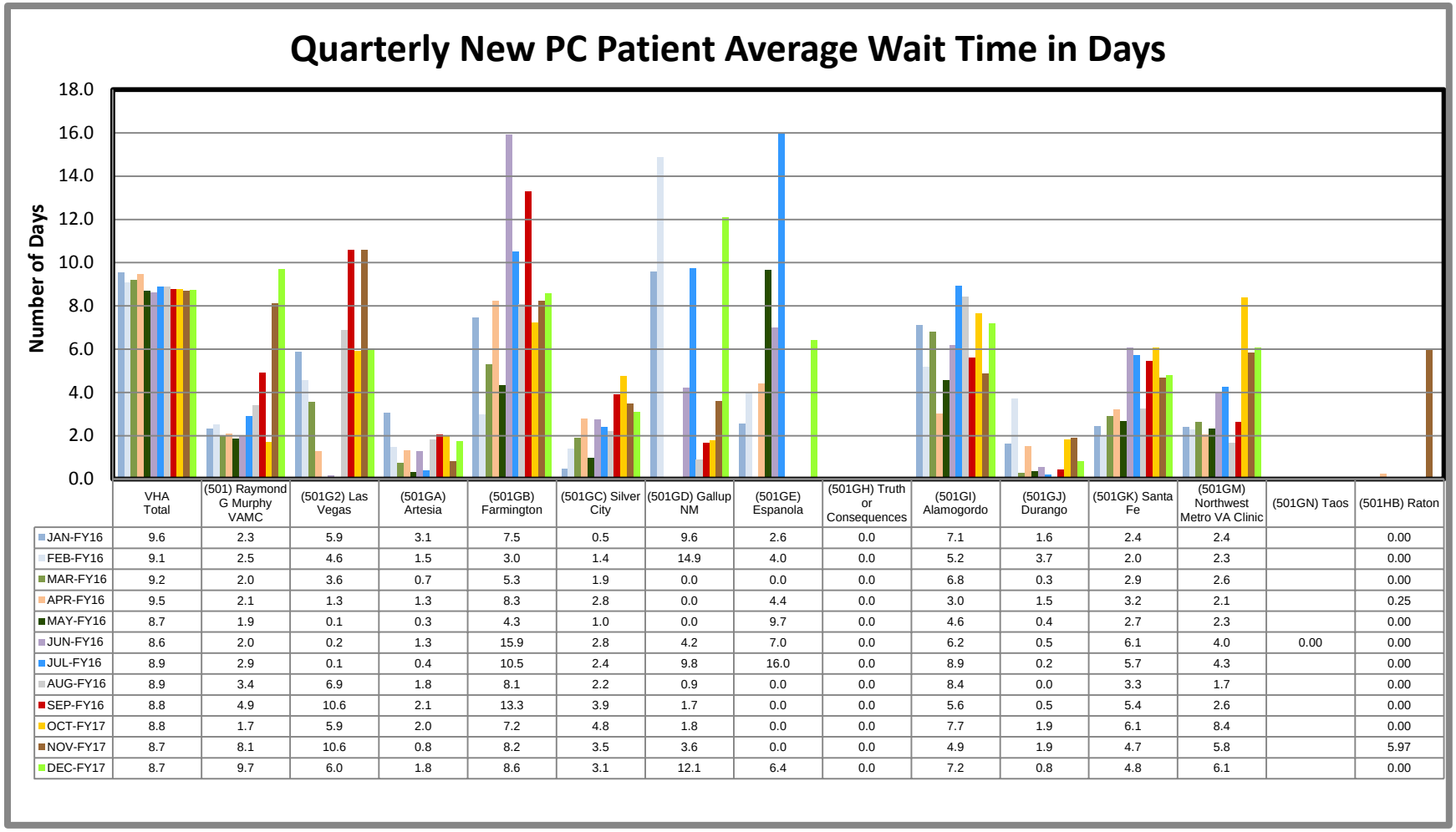
In this report, OIG cited seven policies that were beyond the recertification date:

1. VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010 (recertification due date June 30, 2015).
2. VHA Directive 2011-007, Required Hand Hygiene Practices, February 16, 2011 (recertification due date February 29, 2016).
3. VHA Directive 2012-026, Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities, September 27, 2012 (recertification due date September 30, 2017).
4. VHA Handbook 1004.01, *Informed Consent for Clinical Treatments and Procedures*, August 14, 2009 (recertification due date August 31, 2014), revised May 22, 2017.
5. VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011 (recertification due date March 31, 2016).
6. VHA Handbook 1105.04, *Fluoroscopy Safety*, July 6, 2012 (recertification due date July 31, 2017).
7. VHA Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures*, June 4, 2004 (recertification due date January 31, 2009).

OIG considered these policies to be in effect, as they had not been superseded by more recent policy or guidance. In a June 29, 2016, memorandum to supplement policy provided by VHA Directive 6330(1),[64] the VA Under Secretary for Health mandated the "…continued use of and adherence to VHA policy documents beyond their recertification date until the policy is rescinded, recertified, or superseded by a more recent policy or guidance."[65] The Under Secretary for Health also tasked the Principal Deputy Under Secretary for Health and Deputy Under Secretaries for Health with ensuring "…the timely rescission or recertification of policy documents over which their program offices have primary responsibility."[66]

[64] VHA Directive 6330(1), *Controlled National Policy/Directives Management System*, June 24, 2016, amended January 11, 2017.
[65] VA Under Secretary for Health. "Validity of VHA Policy Document." Memorandum. June 29, 2016.
[66] Ibid.

Patient Aligned Care Team Compass Metrics

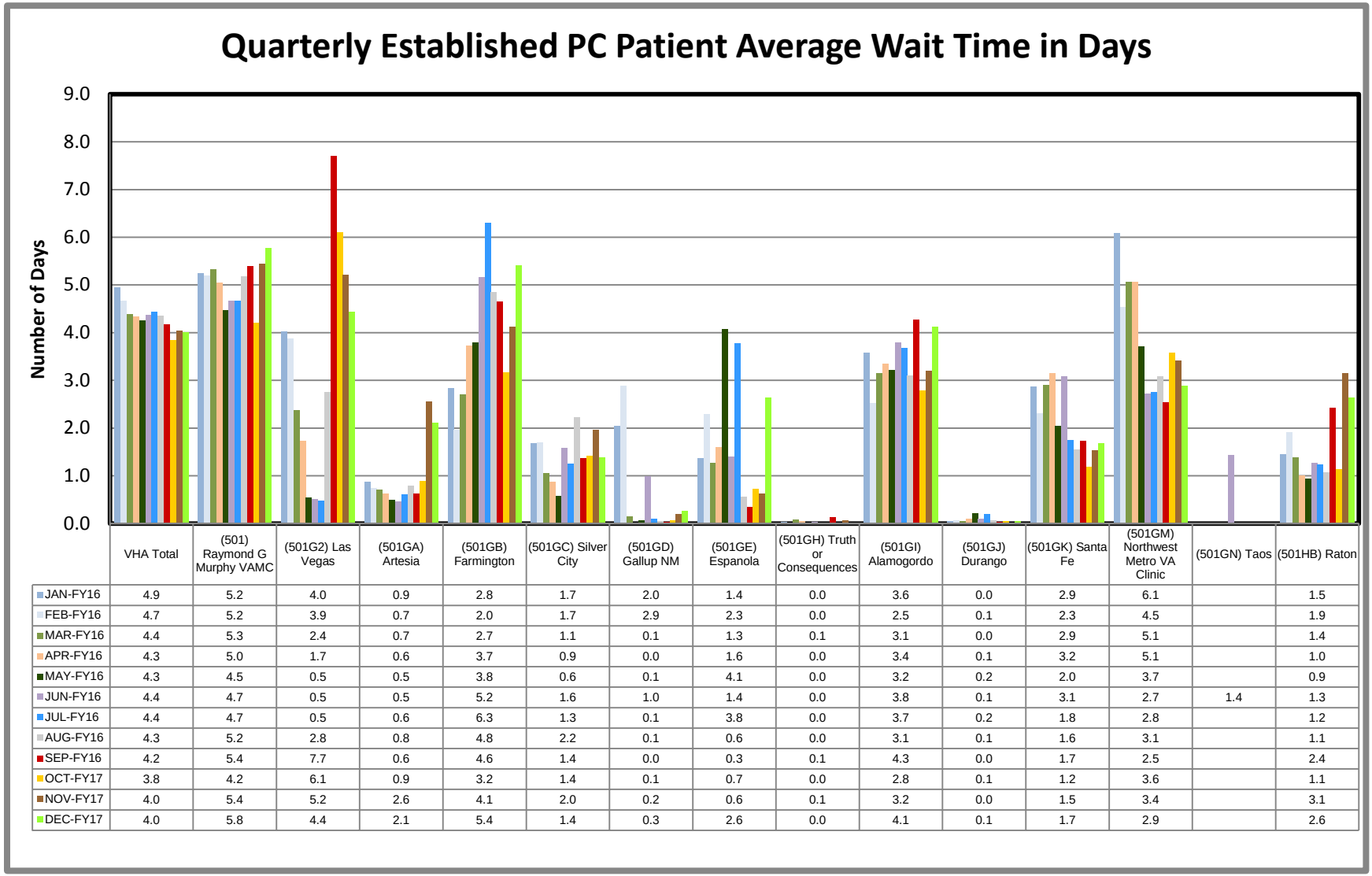


	VHA Total	(501) Raymond G Murphy VAMC	(501G2) Las Vegas	(501GA) Artesia	(501GB) Farmington	(501GC) Silver City	(501GD) Gallup NM	(501GE) Espanola	(501GH) Truth or Consequences	(501GI) Alamogordo	(501GJ) Durango	(501GK) Santa Fe	(501GM) Northwest Metro VA Clinic	(501GN) Taos	(501HB) Raton
JAN-FY16	9.6	2.3	5.9	3.1	7.5	0.5	9.6	2.6	0.0	7.1	1.6	2.4	2.4		0.00
FEB-FY16	9.1	2.5	4.6	1.5	3.0	1.4	14.9	4.0	0.0	5.2	3.7	2.0	2.3		0.00
MAR-FY16	9.2	2.0	3.6	0.7	5.3	1.9	0.0	0.0	0.0	6.8	0.3	2.9	2.6		0.00
APR-FY16	9.5	2.1	1.3	1.3	8.3	2.8	0.0	4.4	0.0	3.0	1.5	3.2	2.1		0.25
MAY-FY16	8.7	1.9	0.1	0.3	4.3	1.0	0.0	9.7	0.0	4.6	0.4	2.7	2.3		0.00
JUN-FY16	8.6	2.0	0.2	1.3	15.9	2.8	4.2	7.0	0.0	6.2	0.5	6.1	4.0	0.00	0.00
JUL-FY16	8.9	2.9	0.1	0.4	10.5	2.4	9.8	16.0	0.0	8.9	0.2	5.7	4.3		0.00
AUG-FY16	8.9	3.4	6.9	1.8	8.1	2.2	0.9	0.0	0.0	8.4	0.0	3.3	1.7		0.00
SEP-FY16	8.8	4.9	10.6	2.1	13.3	3.9	1.7	0.0	0.0	5.6	0.5	5.4	2.6		0.00
OCT-FY17	8.8	1.7	5.9	2.0	7.2	4.8	1.8	0.0	0.0	7.7	1.9	6.1	8.4		0.00
NOV-FY17	8.7	8.1	10.6	0.8	8.2	3.5	3.6	0.0	0.0	4.9	1.9	4.7	5.8		5.97
DEC-FY17	8.7	9.7	6.0	1.8	8.6	3.1	12.1	6.4	0.0	7.2	0.8	4.8	6.1		0.00

Source: VHA Support Service Center.

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

Data Definition[g]: 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.

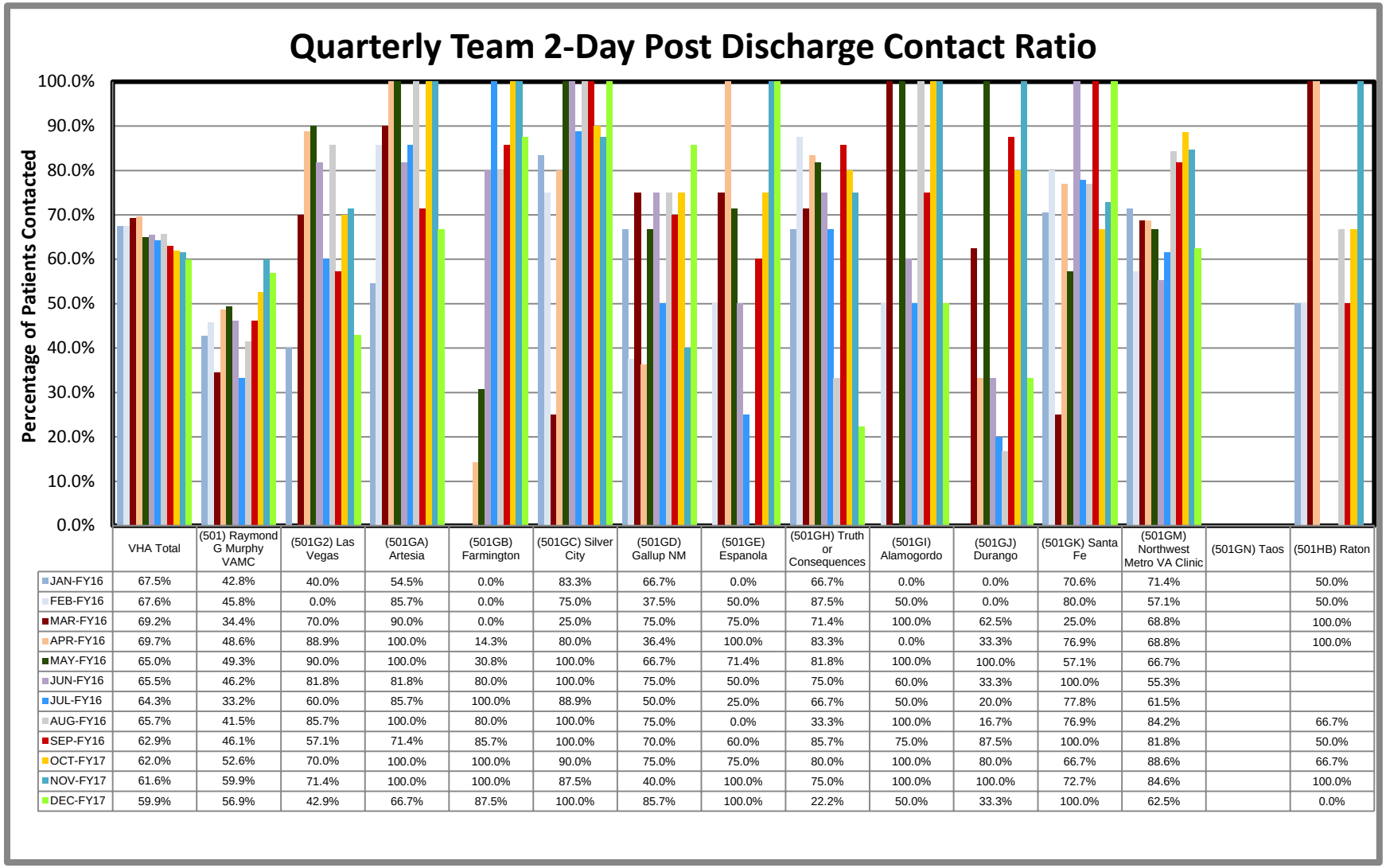


	VHA Total	(501) Raymond G Murphy VAMC	(501G2) Las Vegas	(501GA) Artesia	(501GB) Farmington	(501GC) Silver City	(501GD) Gallup NM	(501GE) Espanola	(501GH) Truth or Consequences	(501GI) Alamogordo	(501GJ) Durango	(501GK) Santa Fe	(501GM) Northwest Metro VA Clinic	(501GN) Taos	(501HB) Raton
JAN-FY16	4.9	5.2	4.0	0.9	2.8	1.7	2.0	1.4	0.0	3.6	0.0	2.9	6.1		1.5
FEB-FY16	4.7	5.2	3.9	0.7	2.0	1.7	2.9	2.3	0.0	2.5	0.1	2.3	4.5		1.9
MAR-FY16	4.4	5.3	2.4	0.7	2.7	1.1	0.1	1.3	0.1	3.1	0.0	2.9	5.1		1.4
APR-FY16	4.3	5.0	1.7	0.6	3.7	0.9	0.0	1.6	0.0	3.4	0.1	3.2	5.1		1.0
MAY-FY16	4.3	4.5	0.5	0.5	3.8	0.6	0.1	4.1	0.0	3.2	0.2	2.0	3.7		0.9
JUN-FY16	4.4	4.7	0.5	0.5	5.2	1.6	1.0	1.4	0.0	3.8	0.1	3.1	2.7	1.4	1.3
JUL-FY16	4.4	4.7	0.5	0.6	6.3	1.3	0.1	3.8	0.0	3.7	0.2	1.8	2.8		1.2
AUG-FY16	4.3	5.2	2.8	0.8	4.8	2.2	0.1	0.6	0.0	3.1	0.1	1.6	3.1		1.1
SEP-FY16	4.2	5.4	7.7	0.6	4.6	1.4	0.0	0.3	0.1	4.3	0.0	1.7	2.5		2.4
OCT-FY17	3.8	4.2	6.1	0.9	3.2	1.4	0.1	0.7	0.0	2.8	0.1	1.2	3.6		1.1
NOV-FY17	4.0	5.4	5.2	2.6	4.1	2.0	0.2	0.6	0.1	3.2	0.0	1.5	3.4		3.1
DEC-FY17	4.0	5.8	4.4	2.1	5.4	1.4	0.3	2.6	0.0	4.1	0.1	1.7	2.9		2.6

Source: VHA Support Service Center.

Note: OIG 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. Blank cells indicate the absence of reported data.

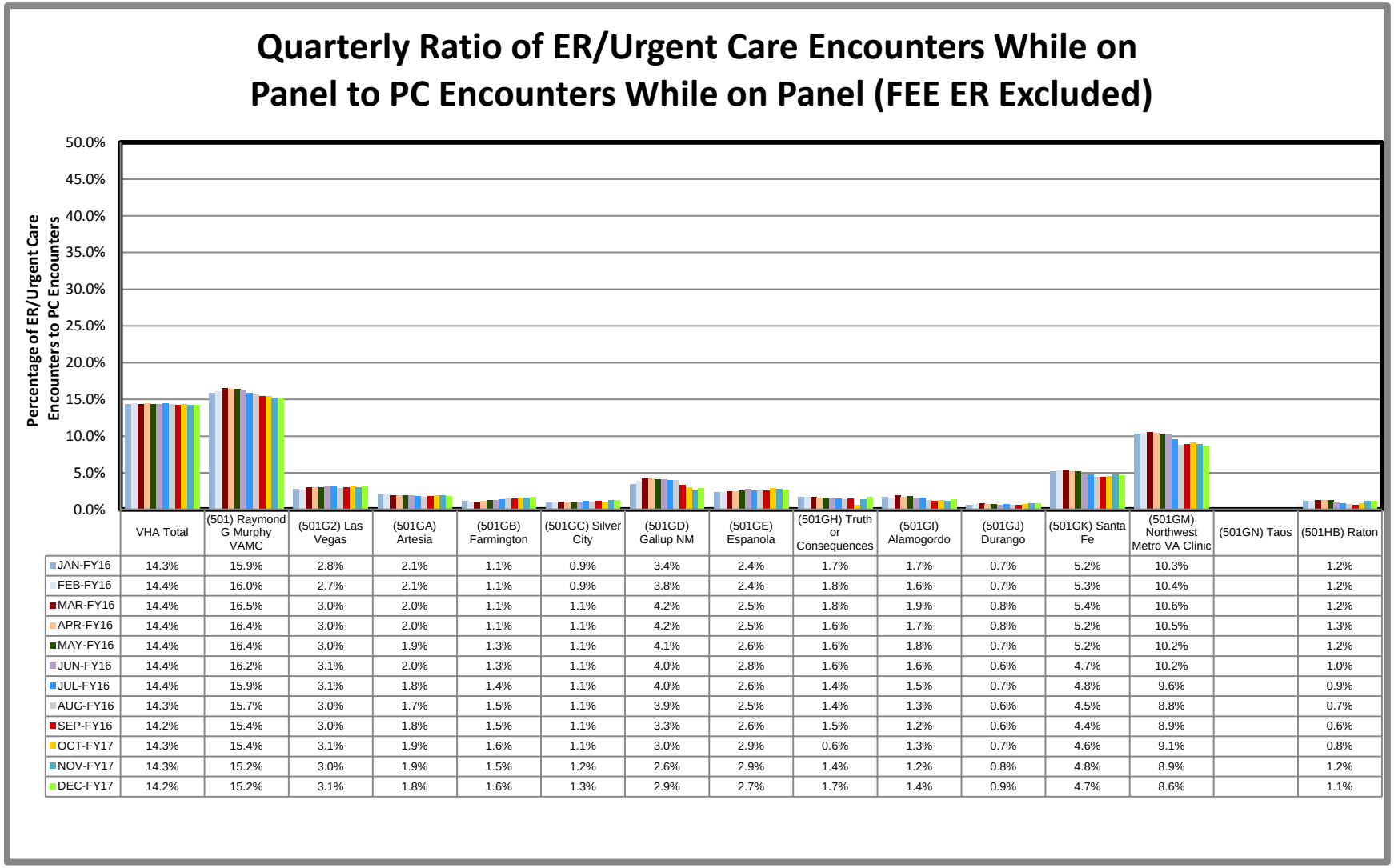


	VHA Total	(501) Raymond G Murphy VAMC	(501G2) Las Vegas	(501GA) Artesia	(501GB) Farmington	(501GC) Silver City	(501GD) Gallup NM	(501GE) Espanola	(501GH) Truth or Consequences	(501GI) Alamogordo	(501GJ) Durango	(501GK) Santa Fe	(501GM) Northwest Metro VA Clinic	(501GN) Taos	(501HB) Raton
JAN-FY16	67.5%	42.8%	40.0%	54.5%	0.0%	83.3%	66.7%	0.0%	66.7%	0.0%	0.0%	70.6%	71.4%		50.0%
FEB-FY16	67.6%	45.8%	0.0%	85.7%	0.0%	75.0%	37.5%	50.0%	87.5%	50.0%	0.0%	80.0%	57.1%		50.0%
MAR-FY16	69.2%	34.4%	70.0%	90.0%	0.0%	25.0%	75.0%	75.0%	71.4%	100.0%	62.5%	25.0%	68.8%		100.0%
APR-FY16	69.7%	48.6%	88.9%	100.0%	14.3%	80.0%	36.4%	100.0%	83.3%	0.0%	33.3%	76.9%	68.8%		100.0%
MAY-FY16	65.0%	49.3%	90.0%	100.0%	30.8%	100.0%	66.7%	71.4%	81.8%	100.0%	100.0%	57.1%	66.7%		
JUN-FY16	65.5%	46.2%	81.8%	81.8%	80.0%	100.0%	75.0%	50.0%	75.0%	60.0%	33.3%	100.0%	55.3%		
JUL-FY16	64.3%	33.2%	60.0%	85.7%	100.0%	88.9%	50.0%	25.0%	66.7%	50.0%	20.0%	77.8%	61.5%		
AUG-FY16	65.7%	41.5%	85.7%	100.0%	80.0%	100.0%	75.0%	0.0%	33.3%	100.0%	16.7%	76.9%	84.2%		66.7%
SEP-FY16	62.9%	46.1%	57.1%	71.4%	85.7%	100.0%	70.0%	60.0%	85.7%	75.0%	87.5%	100.0%	81.8%		50.0%
OCT-FY17	62.0%	52.6%	70.0%	100.0%	100.0%	90.0%	75.0%	75.0%	80.0%	100.0%	80.0%	66.7%	88.6%		66.7%
NOV-FY17	61.6%	59.9%	71.4%	100.0%	100.0%	87.5%	40.0%	100.0%	75.0%	100.0%	100.0%	72.7%	84.6%		100.0%
DEC-FY17	59.9%	56.9%	42.9%	66.7%	87.5%	100.0%	85.7%	100.0%	22.2%	50.0%	33.3%	100.0%	62.5%		0.0%

Source: VHA Support Service Center.

Note: OIG 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. Team member identification is based on the primary provider on the encounter. Performance measure mnemonic "PACT17." Blank cells indicate the absence of reported data.



	VHA Total	(501) Raymond G Murphy VAMC	(501G2) Las Vegas	(501GA) Artesia	(501GB) Farmington	(501GC) Silver City	(501GD) Gallup NM	(501GE) Espanola	(501GH) Truth or Consequences	(501GI) Alamogordo	(501GJ) Durango	(501GK) Santa Fe	(501GM) Northwest Metro VA Clinic	(501GN) Taos	(501HB) Raton
JAN-FY16	14.3%	15.9%	2.8%	2.1%	1.1%	0.9%	3.4%	2.4%	1.7%	1.7%	0.7%	5.2%	10.3%		1.2%
FEB-FY16	14.4%	16.0%	2.7%	2.1%	1.1%	0.9%	3.8%	2.4%	1.8%	1.6%	0.7%	5.3%	10.4%		1.2%
MAR-FY16	14.4%	16.5%	3.0%	2.0%	1.1%	1.1%	4.2%	2.5%	1.8%	1.9%	0.8%	5.4%	10.6%		1.2%
APR-FY16	14.4%	16.4%	3.0%	2.0%	1.1%	1.1%	4.2%	2.5%	1.6%	1.7%	0.8%	5.2%	10.5%		1.3%
MAY-FY16	14.4%	16.4%	3.0%	1.9%	1.3%	1.1%	4.1%	2.6%	1.6%	1.8%	0.7%	5.2%	10.2%		1.2%
JUN-FY16	14.4%	16.2%	3.1%	2.0%	1.3%	1.1%	4.0%	2.8%	1.6%	1.6%	0.6%	4.7%	10.2%		1.0%
JUL-FY16	14.4%	15.9%	3.1%	1.8%	1.4%	1.1%	4.0%	2.6%	1.4%	1.5%	0.7%	4.8%	9.6%		0.9%
AUG-FY16	14.3%	15.7%	3.0%	1.7%	1.5%	1.1%	3.9%	2.5%	1.4%	1.3%	0.6%	4.5%	8.8%		0.7%
SEP-FY16	14.2%	15.4%	3.0%	1.8%	1.5%	1.1%	3.3%	2.6%	1.5%	1.2%	0.6%	4.4%	8.9%		0.6%
OCT-FY17	14.3%	15.4%	3.1%	1.9%	1.6%	1.1%	3.0%	2.9%	0.6%	1.3%	0.7%	4.6%	9.1%		0.8%
NOV-FY17	14.3%	15.2%	3.0%	1.9%	1.5%	1.2%	2.6%	2.9%	1.4%	1.2%	0.8%	4.8%	8.9%		1.2%
DEC-FY17	14.2%	15.2%	3.1%	1.8%	1.6%	1.3%	2.9%	2.7%	1.7%	1.4%	0.9%	4.7%	8.6%		1.1%

Source: VHA Support Service Center.

Note: OIG 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.

Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions[h]

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

Measure	Definition	Desired Direction
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
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.

Relevant OIG Reports

June 1, 2014 through December 1, 2017[67]

Healthcare Inspection – Lack of Follow-Up Care for Positive Colorectal Cancer Screening, New Mexico VA Health Care System, Albuquerque, New Mexico
9/27/2016 | *15-00018-349* | *Summary* | *Report*

Healthcare Inspection – Review of the Operations and Effectiveness of VHA Residential Substance Use Treatment Programs
7/30/2015 | *15-01579-457* | *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*

Community Based Outpatient Clinic and Primary Care Clinic Reviews at New Mexico VA Health Care System, Albuquerque, New Mexico
8/1/2014 | *10-00919-228* | *Summary* | *Report*

Combined Assessment Program Review of the New Mexico VA Health Care System, Albuquerque, New Mexico
7/31/2014 | *14-02063-231* | *Summary* | *Report*

[67] These are relevant reports that focused on the facility as well as national-level evaluations of which the facility was a component of the review.

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: December 1, 2017

From: Director, Desert Pacific Healthcare Network (10N22)

Subject: **CHIP Review of the New Mexico VA Health Care System, Albuquerque, NM**

To: Director, Los Angeles Office of Healthcare Inspections (54LA)

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

I concur with the New Mexico's VA Health Care System's response and action plans as detailed within the report.

Marie L. Weldon, FACHE
Network Director, VISN 22

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: November 28, 2017

From: Director, New Mexico VA Health Care System (501/00)

Subject: **CHIP Review of the New Mexico VA Health Care System, Albuquerque, NM**

To: Director, Desert Pacific Healthcare Network (10N22)

I concur with the findings and recommendations in the report of the Comprehensive Healthcare Inspection Program (CHIP) Review of the New Mexico VA Health Care System, Albuquerque, New Mexico.

Please find responses and actions for the recommendations.

Andrew M. Welch, MHA, FACHE
Director

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National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Michael F. Bennet, Cory Gardner, Martin Heinrich, Tom Udall
U.S. House of Representatives: Michelle Lujan Grisham, Ben R. Lujan, Steve Pearce, Scott Tipton

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 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.

[c] The references used for Coordination of Care: Inter-Facility Transfers included:
- VHA Directive 2007-015, *Inter-Facility Transfer Policy*, May 7, 2007. This directive was in effect during the timeframe of OIG's review but has been rescinded and replaced with VHA Directive 1094, *Inter-Facility Transfer Policy*, January 11, 2017.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.
- VHA Handbook 1400.01, *Resident Supervision*, December 19, 2012.

[d] The references used for EOC included:
- VHA Directive 1014, *Safe Medication Injection Practices*, July 1, 2015.
- VHA Handbook 1105.04, *Fluoroscopy Safety*, July 6, 2012.
- VHA Directive 1116(2), *Sterile Processing Services (SPS)*, March 23, 2016.
- VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013.
- VHA Directive 1229, *Planning and Operating Outpatient Sites of Care*, July 7, 2017.
- VHA Directive 1330.01(1), Health Care Services for Women Veterans, February 15, 2017 (amended September 8, 2017).
- VHA Directive 1608, *Comprehensive Environment of Care (CEOC) Program*, February 1, 2016.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012.
- VA Handbook 6500, *Risk Management Framework for VA Information Systems – Tier 3: VA Information Security Program*, March 10, 2015.
- VHA Radiology Online Guide, http://vaww.infoshare.va.gov/sites/diagnosticservices/NRP/Mammography/Radiology%20Shared%20Files/Radiology_Service_Online_Guide_2016.docx, November 3, 2016.
- MH EOC Checklist, VA National Center for Patient Safety, http://vaww.ncps.med.va.gov/guidelines.html#mhc, accessed December 8, 2016.
- Various requirements of TJC, Association for the Advancement of Medical Instrumentation/Association for the Advancement of Medical Instrumentation, Occupational Safety and Health Administration, International Association of Healthcare Central Service Materiel Management, National Fire Protection Association.

[e] 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.
- TJC. Hospital Standards. January 2016. PC.03.01.01, EP1 and MS.06.01.03 EP6.

[f] The references used for CNH Oversight included:

- VHA Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures*, June 4, 2004.
- VA OIG report, *Healthcare Inspection – Evaluation of the Veterans Health Administration's Contact Community Nursing Home Program*, (Report No. 05-00266-39, December 13, 2007).

[g] The reference used for PACT Compass data graphs was:

- Department of Veterans' Affairs, Patient Aligned Care Teams Compass Data Definitions, accessed: February 14, 2017.

[h] 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.