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Office of Healthcare Inspections

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Comprehensive Healthcare Inspection Program Review of the Grand Junction Veterans Health Care System Grand Junction, Colorado

January 18, 2018

Washington, DC 20420

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Glossary

Chief Nurse Executive	Associate Director for Patient Care Services
CHIP	Comprehensive Healthcare Inspection Program
EHR	electronic health record
EOC	environment of care
facility	Grand Junction Veterans Health Care System
FY	fiscal year
MH	mental health
OIG	Office of Inspector General
PC	primary care
PTSD	post-traumatic stress disorder
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 Grand Junction Veterans 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[1]
7. Long-Term Care[2]

This review was conducted during an unannounced visit made during the week of July 17, 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 Grand Junction Veterans Health Care System (facility), the leadership team consists of the Facility Director, Chief of Staff, Associate Director for Patient Care Services (Chief Nurse Executive), and Associate Director. Organizational communication and accountability are carried out through a committee reporting structure with the Executive Quality Council having oversight for committees and governing boards, such as the Integrated Ethics Board; Quality, Safety, and Value Board, Clinical Executive Board, and Administrative Leadership Board. The

[1] The Moderate Sedation special focus area did not apply for the Grand Junction Veterans Health Care System because the facility did not perform procedures using moderate sedation.
[2] The Community Nursing Home Oversight special focus area did not apply for the Grand Junction Veterans Health Care System because the facility did not provide long-term care for greater than 90 days through contracts.

leaders are members of the Executive Quality Council through which they track, trend, and monitor quality of care and patient outcomes.

The facility did not have a permanently assigned leadership team until April 17, 2017, when the Facility Director was appointed. In the review of selected employee and patient survey results regarding the facility's leaders, OIG noted positive satisfaction scores that reflected active engagement with employees and patients.

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 and did not identify any substantial organizational risk factors. OIG recognizes that the SAIL model has limitations for identifying all areas of clinical risk but is "a way to understand the similarities and differences between the top and bottom performers" within the Veterans Health Administration (VHA).[3]

The leadership team was knowledgeable about selected SAIL metrics and had taken actions to improve performance of the Quality of Care and Efficiency metrics likely contributing to the current 4-star SAIL rating. In the review of key care processes, OIG issued nine recommendations that are attributable to the Facility Director, Chief of Staff, and Associate Director. Of the five areas of clinical operations reviewed, OIG noted findings in four. 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 noted general compliance with requirements for protected peer reviews and credentialing and privileging processes. However, OIG noted deficiencies in Physician Utilization Management Advisors' documentation of their decisions and Patient Safety Manager feedback to employees who submitted reports.[4]

Medication Management. OIG found safe anticoagulation therapy management practices. The facility had developed and implemented anticoagulation management policies with accompanying algorithms, protocols, and standardized care processes. The facility also met many of the other performance indicators OIG evaluated. However, OIG identified deficiencies with having a process to address

[3] 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.

[4] 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.

anticoagulation-related calls outside normal business hours and reviewing all required anticoagulation data.

Coordination of Care. OIG noted safe inter-facility patient transfer practices. The facility had developed and implemented a patient transfer policy and collected data about inter-facility transfers and met many of the other performance indicators evaluated. However, OIG identified deficiencies with reporting inter-facility transfer data to an oversight committee, documenting patient consent for transfer, and sending or communicating pertinent patient information to the accepting medical facility.

Environment of Care. OIG noted a generally safe and clean environment of care. The parent facility, the representative community based outpatient clinic inspected, Radiology Service, and the locked mental health unit met most of the performance indicators OIG evaluated. However, OIG identified deficiencies with environment of care rounds attendance and mental health unit employee and Interdisciplinary Safety Inspection Team training.

Summary

In the review of key care processes, OIG issued nine recommendations that are attributable to the Facility Director, Chief of Staff, and Associate 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 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 44–45, and the responses within the body of the report for the full text of the Directors' comments.) OIG will follow up on the planned actions until they are completed.

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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 Grand Junction Veterans 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 Oversight (see Figure 1).

However, the Moderate Sedation special focus area did not apply for the Grand Junction Veterans Health Care System because the facility did not perform procedures using moderate sedation, and the Community Nursing Home Oversight special focus area did not apply because the facility did not provide long-term care for greater than 90 days through contracts. Thus, OIG focused on the remaining five areas of clinical operations and one additional program with relevance to the facility—Post-Traumatic Stress Disorder (PTSD) Care.

Additionally, OIG staff provided 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.

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

Source: VA OIG.

Methodology

To determine compliance with Veterans Health Administration (VHA) requirements[5] 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;[6] 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 April 28, 2014[7] through July 17, 2017, the date when an unannounced week-long site visit commenced. On July 26 and 27, 2017, OIG presented crime awareness briefings to 104 of the facility's 731 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

[5] 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.
[6] OIG did not review VHA's internal survey results but focused on OIG inspections and external surveys that affect facility accreditation status.
[7] This is the date of the last Community Based Outpatient Clinic and Primary Care Clinic reviews.

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 did not receive any concerns beyond the scope of the CHIP Review. 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.

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:

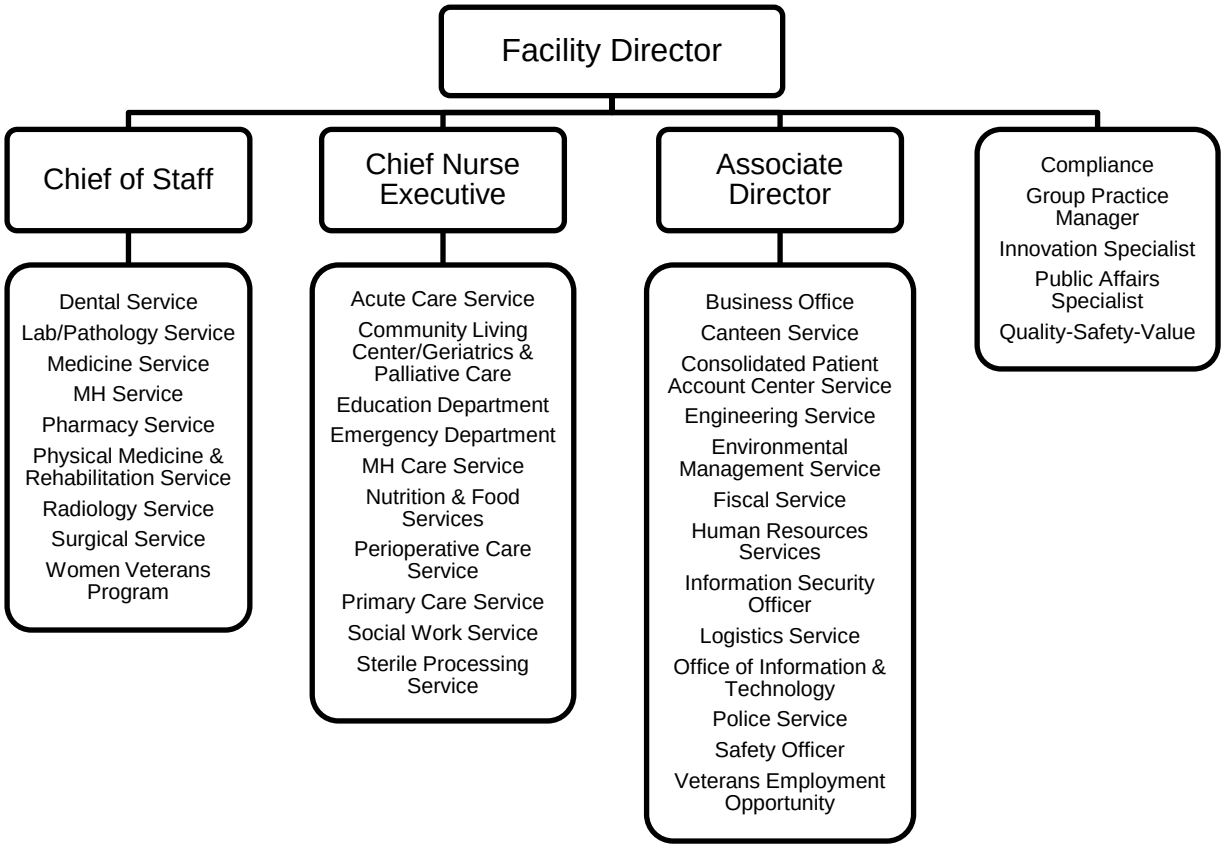
1. Executive leadership stability and engagement
2. Employee satisfaction and patient experience
3. Accreditation/for-cause surveys and oversight inspections
4. Indicators for possible lapses in care
5. VHA performance data

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 Facility Director, Chief of Staff, Associate Director for Patient Care Services (Chief Nurse Executive), and Associate Director. The Chief of Staff and Chief Nurse Executive are responsible for overseeing program and service chiefs.

The facility did not have a complete, permanently assigned leadership team until April 2017, when the Facility Director was appointed.

In an effort to improve effectiveness and speed of communication, the Facility Director established the Daily Management System. The system is designed to identify and address problems/issues quickly at several levels—department, senior executive, and facility wide. It empowers front-line employees to resolve problems at their levels and escalate those that require higher authority to managers who create action plans in a timely manner. Facility staff shared favorable outlook for the facility and expressed that the facility's culture is changing and allowing more transparent and effective communication between leaders and employees. OIG noted that the Daily Management System is a positive effort by the leadership team to improve accountability and communication.

Figure 2. Facility Organizational Chart



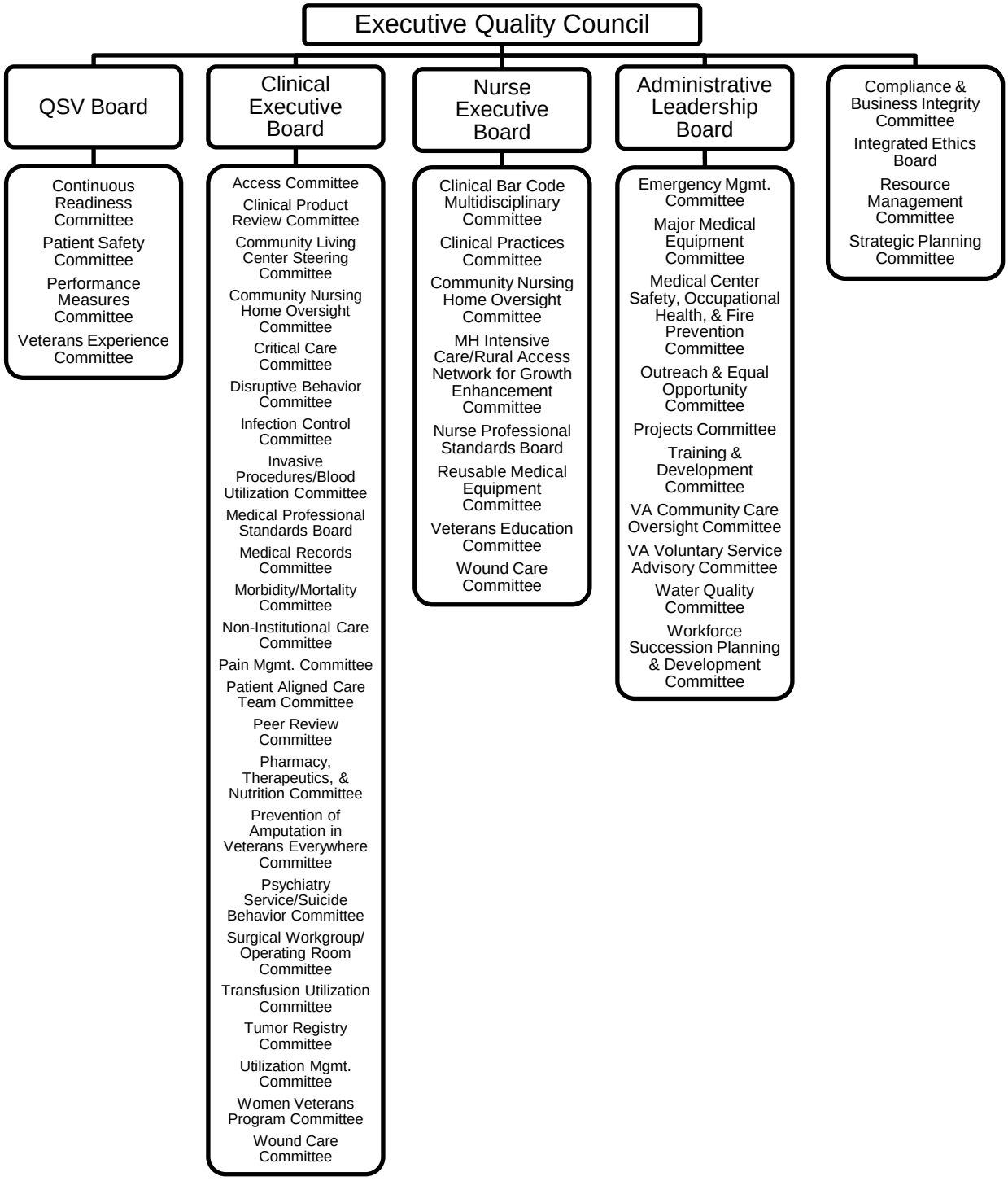
Source: Grand Junction Veterans Health Care System (received July 24, 2017).

To assess engagement of facility executive leadership, OIG interviewed the Facility Director, Chief of Staff, Chief Nurse Executive, and Associate 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 Executive Quality Council, 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 Executive Quality Council also oversees various working committees and governing boards, such as the Integrated Ethics Board, QSV Board, Clinical Executive Board, and Administrative Leadership Board. See Figure 3.

Figure 3. Facility Committee Reporting Structure



Source: Grand Junction Veterans Health Care System (received 10/25/17).

Employee Satisfaction and Patient Experience. To assess employee and patient attitudes toward facility executive leaders, 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 above the facility average, and the Servant Leader Index Composite was rated above the VHA average.[8] All four patient survey results reflected higher care ratings than the VHA average. In all, both employees and patients appear generally satisfied with the leadership and care provided.

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[9]
All Employee Survey[10] 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	2.8	3.2
All Employee Survey Servant Leader Index Composite	0–100 where HIGHER scores are more favorable	66.7	67.1	70.1
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	71.3	
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	86.6	
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): I felt like a valued customer.		73.2	78.9	
Survey of Healthcare Experiences of Patients (outpatient specialty care): I felt like a valued customer.		73.8	76.6	

[8] 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.
[9] Rating is based on responses by employees who report to the Director.
[10] 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[11] 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[12] all recommendations for improvement as listed in Table 2.

OIG also noted the facility's current accreditation status with the Commission on Accreditation of Rehabilitation Facilities[13] and College of American Pathologists,[14] which demonstrates the facility leaders' commitment to quality care and services. Additionally, the Long Term Care Institute[15] conducted an inspection of the facility's Community Living Center.

[11] 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.
[12] 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.
[13] 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.
[14] 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.
[15] 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.

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 –Quality of Care Concerns in the Management of Hepatitis C Patient, Grand Junction, Colorado, May 11, 2016)*	February 2015	1	0
VA OIG (*Combined Assessment Program Review of the Grand Junction VA Medical Center, Grand Junction, Colorado, September 2, 2014)*	July 2014	16	0
VA OIG (*Community Based Outpatient Clinic and Primary Care Clinic Reviews at Grand Junction VA Medical Center, Grand Junction, Colorado, July 16, 2014)*	April 2014	4	0
TJC[16] • Hospital Accreditation • Nursing Care Center Accreditation • Behavioral Health Care Accreditation • Home Care Accreditation	March 2016	 15 0 0 1	 0 0 0 0

[16] 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 more than 30 years. Compliance with TJC standards facilitates risk reduction and performance improvement.

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 July 2014 Combined Assessment Program inspection through the week of July 17, 2017.

Table 3. Summary of Selected Organizational Risk Factors[17] (July 2014 to July 17, 2017)

Factor	Number of Occurrences
Sentinel Events[18]	7
Institutional Disclosures[19]	11
Large-Scale Disclosures[20]	0

[17] 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 Grand Junction Veterans Health Care System is a medium-complexity (2) affiliated facility as described in Appendix B.)

[18] 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.

[19] 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.

[20] 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.

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.[21] The rates presented are specifically applicable for this facility, and lower rates indicate lower risks. Table 4 summarizes Patient Safety Indicator data from October 1, 2015 through September 30, 2016.

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

Measure	Reported Rate per 1,000 Hospital Discharges		
	VHA	VISN 19	Facility
Pressure Ulcers	0.55	0.50	2.38
Death among surgical inpatients with serious treatable conditions	103.31	78.26	NA
Iatrogenic Pneumothorax	0.20	0.21	0
Central Venous Catheter-Related Bloodstream Infection	0.12	0.25	0
In Hospital Fall with Hip Fracture	0.08	0.13	0
Perioperative Hemorrhage or Hematoma	2.59	1.89	0
Postoperative Acute Kidney Injury Requiring Dialysis	1.20	0.87	0
Postoperative Respiratory Failure	6.31	8.98	0
Perioperative Pulmonary Embolism or Deep Vein Thrombosis	3.29	3.33	0
Postoperative Sepsis	4.45	7.27	0
Postoperative Wound Dehiscence	0.65	1.28	0
Unrecognized Abdominopelvic Accidental Puncture/Laceration	0.67	0.49	0

Source: VHA Support Service Center.

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

NA = Not applicable

The Patient Safety Indicator measure for pressure ulcers shows an observed rate of 2.38 per 1,000 hospital discharges, in excess of the observed rates for Veterans Integrated Service Network (VISN) 19 and VHA. The observed rate is the result of one patient who had pressure ulcers at the time of admission. Program managers stated that the patient was inaccurately documented as having hospital-acquired pressure ulcers and that this reporting error was being addressed at the national level.

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.[22] 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

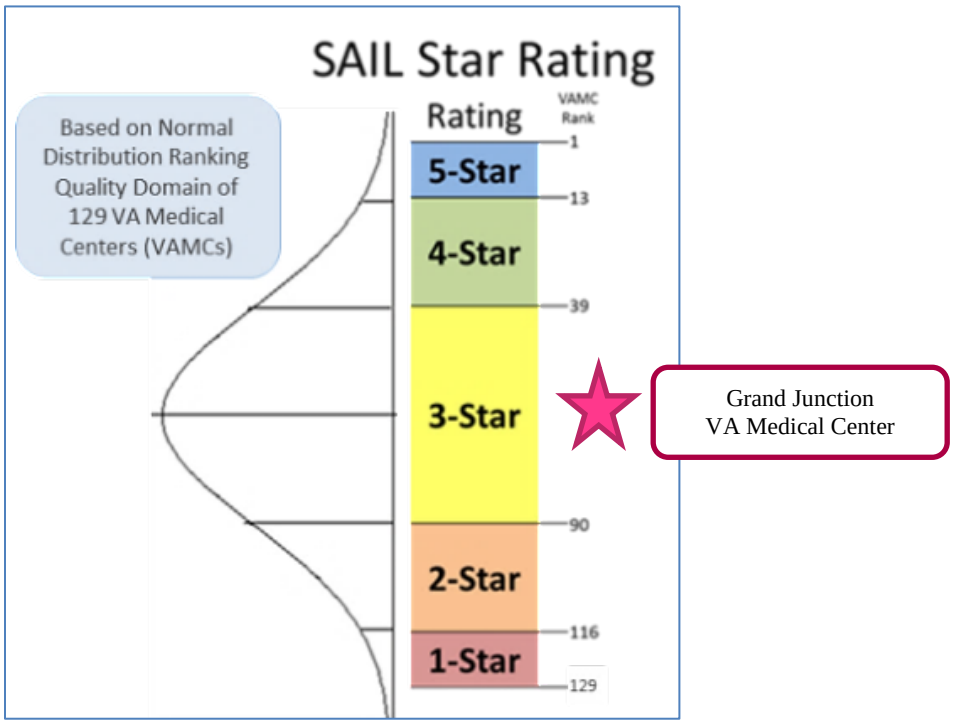
[21] Agency for Healthcare Research and Quality website, https://www.qualityindicators.ahrq.gov/, accessed March 8, 2017.

[22] 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.[23]

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 Grand Junction Veterans Health Care System received an interim rating of 3 stars for overall quality. This means the facility was in the 3rd quintile (30–70 percent range). Updated data as of June 30, 2017, indicates that the facility has improved to 4 stars for overall quality.

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

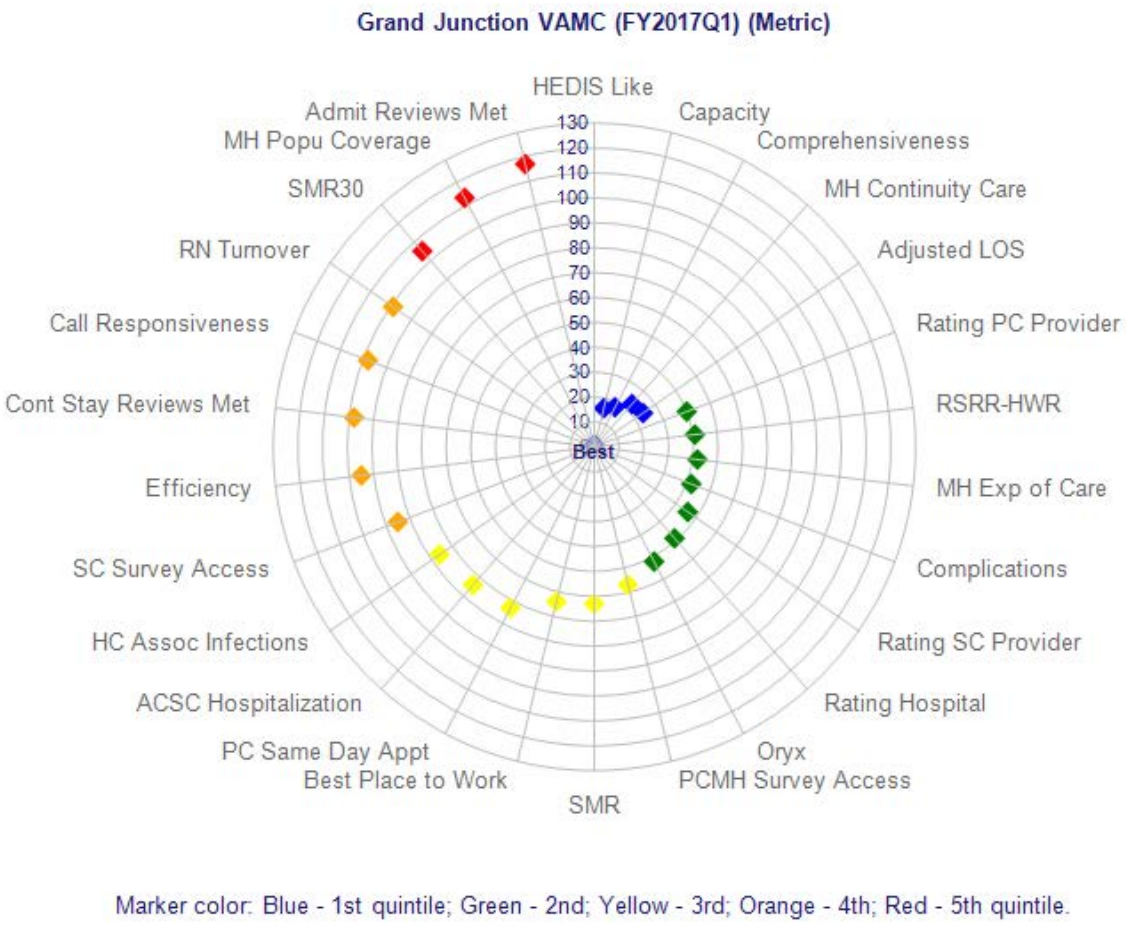


Source: VA Office of Informatics and Analytics' Office of Operational Analytics and Reporting.

[23] 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

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 blue and green data points in the top quintiles that show high performance (for example, Capacity, Mental Health [MH] Continuity [of] Care, and Complications). Metrics in the bottom quintiles reflect areas that need improvement and are denoted in orange and red (for example, Efficiency, Registered Nurse [RN] Turnover, and Acute Care 30-Day Standardized Mortality Ratio [SMR30]).

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. With the appointment of the Facility Director in April 2017, the facility now has the opportunity to maintain the stability of executive leadership, and the current leaders have active engagement with employees and patients as evidenced by positive satisfaction scores. Further, the Daily Management System has improved the effectiveness and speed of communication, and organizational leaders support patient safety, quality care, and other positive outcomes. OIG's review of accreditation organization findings, sentinel events, disclosures, Patient Safety Indicator data, and SAIL results did not identify any substantial organizational risk factors.[24] The senior leadership team was knowledgeable about selected SAIL metrics and had taken actions to improve performance of selected SAIL metrics, particularly Quality of Care and Efficiency metrics, likely contributing to the current 4-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
- Credentialing and privileging processes
  - Considered frequency for Ongoing Professional Practice Evaluation[28] data review
  - Indicated a Focused Professional Practice Evaluation[29]

[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.
[28] Ongoing Professional Practice Evaluation is the ongoing monitoring of privileged practitioners to identify professional practice trends that impact the quality of care and patient safety.

- 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 found general compliance with requirements for protected peer reviews and credentialing and privileging processes. However, OIG identified the following deficiencies in UM and patient safety that warranted recommendations for improvement.

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. For 16 of 76 cases (21 percent) referred to the physician advisors from January 1 to March 31, 2017, the physician advisors did not document their decisions in the database. Program managers were aware of the requirements and reported that an insufficient number of physician advisors resulted in inconsistent documentation of their decisions in the database.

Recommendation

1. The Chief of Staff ensures Physician Utilization Management Advisors consistently document their decisions in the National Utilization Management Integration database and monitors the advisors' compliance.

[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: May 31, 2018

Facility Response: Additional Physician Utilization Management Advisors (PUMAs) for Medicine, Psychiatry, and Surgery services will be identified, trained, and provided with access to the National Utilization Management Integration (NUMI) database. The facility UM coordinator will provide a weekly update on PUMA review compliance to the Chief of Staff along with a list of any outstanding reviews. PUMA review completion rates will also be discussed by the Chief of Quality, Safety, and Value, at their weekly operational update to the Executive Leadership Team. This data element is discussed at the standing utilization management committee and will be added as a monthly agenda item, for oversight purposes, and reported at the Clinical Executive Board (CEB) meeting until closed by the OIG. Full implementation of processes is anticipated no later than January 2018 with full compliance being demonstrated by a PUMA review completion rate of 90% or greater for 3 consecutive months.

Patient Safety: Reporting. VHA requires the Patient Safety Manager or designee to provide feedback about root cause analysis[30] actions to the individuals or departments who reported the incidents. This establishes trust in the system and demonstrates the seriousness and commitment on the part of the facility to the importance of the reporting effort. For three of the five applicable root cause analyses, there was no documented evidence that the Patient Safety Manager provided feedback. The Patient Safety Manager believed that providing personal verbal feedback to the reporters was sufficient.

Recommendation

2. The Facility Director ensures the Patient Safety Manager consistently provides feedback to employees or departments who submit close call and adverse event reports that result in a root cause analysis and monitors the manager's compliance.

[30] A root cause analysis is a structured method used to analyze serious adverse events.

Facility concurred

Target date for completion: March 30, 2018

Facility Response: The Patient Safety Manager will continue to ensure that feedback on the findings/actions taken, is provided to employees or departments who submit reports that result in a root cause analysis (RCA) being performed. Beginning with the 11/30/17 quarterly Patient Safety Committee meeting, a permanent, standing agenda item will be added, for reporting the method and date that feedback about RCA actions was provided to the individuals or departments who reported the incident. The Patient Safety Manager will prepare a summary of this discussion in the committee meeting minutes which will be forwarded to the Executive Quality Council for monitoring. Compliance with the above actions will be demonstrated after 2 quarters of meeting minutes and reports are available.

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,[31] 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 seven employees actively involved in the anticoagulant program and interviewed key employees. Additionally, OIG reviewed the electronic health records (EHRs) of 34 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

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

Conclusions. Generally, OIG noted safe anticoagulation therapy management practices. The facility had developed and implemented anticoagulation management policies and had algorithms, protocols, or standardized care processes. Additionally, the facility met many of the other performance indicators listed above. However, OIG identified deficiencies for anticoagulation management and quality assurance that warranted recommendations for improvement.

Anticoagulation Management Outside Normal Business Hours. VHA requires facilities to have a defined process for addressing anticoagulation-related calls in a timely manner outside of normal business hours. This ensures continuity of care and safety for patients on anticoagulant medications. There was no documented evidence that the facility's anticoagulation program had a defined process to address anticoagulation-related calls outside normal business hours. Program managers were aware of the requirement and believed that informing patients to call the facility's main phone number was sufficient.

Recommendation

3. The Chief of Staff ensures anticoagulation program managers establish a defined process for anticoagulation-related calls outside normal business hours and monitors compliance with the process.

Facility concurred.

Target date for completion: March 30, 2018

Facility Response: Current facility policy states that the Medical Officer of the Day (MOD) will provide afterhours coverage for the Pharmacy Anticoagulation Clinic (PAC). The current PAC afterhours phone message directs patients to call the main facility for any emergent issues or concerns. The PAC will create a business card with appropriate numbers to call afterhours. The card will be given to all current patients in their next PAC monthly mailing. New patients will receive the business card during New Patient Orientation. The Chief of Pharmacy will be responsible for ensuring the creation of the new cards. Completion of these actions will be reported by the PAC Coordinator during their quarterly reports to the Pharmacy and Therapeutics Committee. Monitoring of compliance for previous patients and new starts will be reported in P&TC for two quarters with an expected compliance rate of 100%.

Quality Assurance. VHA requires an ongoing quality assurance plan to evaluate the anticoagulation management program. The plan should include reports that assess the quality of care provided, such as time in therapeutic range or proportion of patients on warfarin who have not had an international normalized ratio[32] in the last 42 days; proportion of patients with pathologic bleeding events and patients with thromboembolic

[32] The international normalized ratio is a calculation based on results of a prothrombin time (test to help diagnose the cause of unexplained bleeding) and is used to monitor individuals who are being treated with warfarin anticoagulant.

events; and patient incidents associated with an anticoagulant. This 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. Although anticoagulation data was presented to the Pharmacy and Therapeutics Committee, two of the three sets of quarterly committee minutes reviewed reflected very brief reporting of data with no discussion or no reporting of data. Program managers were aware of the requirement and perceived that they were compliant by submitting pharmacy generated anticoagulation data to the committee.

Recommendation

4. The Chief of Staff ensures the Pharmacy and Therapeutics Committee reviews anticoagulation data quarterly and monitors the committee's compliance.

Facility concurred.

Target date for completion: April 30, 2018

Facility Response: Anticoagulation data is generated and is reported quarterly at the facility's Pharmacy and Therapeutics Committee (P&TC), with a summary report provided to the Clinical Executive Board (CEB). To ensure robust discussion, a Clinical Pharmacy Specialist from the Pharmacy Anticoagulation Clinic (PAC) will attend P&TC to present the quarterly data and answer any questions. The Administrative Assistant to the Associate Chief of Staff for Primary Care will be responsible for documenting P&TC minutes to include a more detailed capture of the committee's discussion of PAC data. A summary of this discussion will be included in the report to the CEB. The Quality of these minutes will be monitored over two quarters by the Chief of Staff and Chief of Pharmacy.

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 48 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 and collected data about transfers out. Additionally, the facility met the performance indicators evaluated for resident supervision, nurse documentation of transfer assessments/notes, provider documentation for emergent transfers, and

communication with the accepting facility. However, OIG identified the following deficiencies for data reporting and transfer documentation 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 reported to a quality oversight committee. Managers were aware of the requirement and stated that transfer data were reported in daily management briefings. The recently assigned facility transfer coordinator plans to monitor inter-facility transfers and report transfer data to a quality oversight committee.

Recommendation

5. The Facility Director ensures inter-facility patient transfer data are reported to a quality oversight committee and monitors compliance.

Facility concurred.

Target date for completion: February 28, 2018

Facility Response: The facility Patient Transfer Policy was updated at the time of the OIG-CHIP site visit to include the requirement to report transfer data to an oversight committee. The Transfer Coordinator had been gathering transfer related information but began organizing it in a structured template after the OIG-CHIP site visit. Through CPRS view alerts, the Transfer Coordinator is notified of every patient transferred out of the GJVHCS. The following data points are compiled for monitoring and review: date of transfer, diagnosis, point of origin (ED, inpatient, clinic, etc.), destination hospital, whether a non-VA care consult was placed, patient consent for transfer, interfacility transfer form, discharge summary or ED progress note, clinical information sent with patient, nursing discharge/progress note, and reason for transfer.

Beginning with the September 2017 UM committee meeting, transfer data was added as an ongoing/standing agenda item. The Transfer Coordinator is responsible for presenting and summarizing the quarterly transfer data and preparing a written report. A summary of transfer data is included in the committee report that is sent to the Clinical Executive Board for oversight purposes. Compliance with the above actions will be demonstrated after 2 quarters of meeting minutes and reports are available for review.

Transfer Documentation. VHA requires that transferring providers document patient or surrogate informed consent on VA Form 10-2649A and/or in transfer/progress notes. This ensures patients are part of the decision-making process. VHA also 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. Twelve of the 45 applicable patients' EHRs (27 percent) did not include documentation of patient or surrogate informed consent. Managers stated that the staff's lack of attention to detail when completing templated notes that included documentation of informed consent resulted in noncompliance. Additionally, in 8 of the 42 applicable patients' EHRs (19 percent), clinicians did not document that they sent or communicated pertinent patient information. Program managers stated that administrative employees did not consistently scan transfer documents in a timely manner due to other priorities.

Recommendation

6. The Chief of Staff ensures that for patients transferred out of the facility, clinicians consistently include in transfer documentation patient or surrogate informed consent and monitors the clinicians' compliance.

Facility concurred.

Target date for completion: April 30, 2018

Facility Response: Consents are being obtained for transfers out of the facility but not consistently scanned, in a timely manner, into the medical record. The facility is procuring a scanner for the Administrative Officer of the Day (AOD) to directly scan the patient consent form into the electronic medical record (EMR), as an addendum to the Interfacility Transfer Form. The Chief, MAS is currently in the process of procuring the scanner and will train the AODs on the scanning process once it is in place.

The Patient Transfer Coordinator has been monitoring for the presence of the informed consent for transfer form and started reporting this data in their report to the UM committee in September 2017. The Transfer Coordinator will continue to report this as a standing agenda item and will monitor adherence with this action plan to ensure demonstrated evidence of sustained compliance with a scanning completion rate of 90% or better for 2 quarters.

Recommendation

7. The Chief of Staff ensures that for patients transferred out of the facility, clinicians consistently document sending or communicating pertinent patient information to the receiving facility and monitors the clinicians' compliance.

Facility concurred.

Target date for completion: April 30, 2018

Facility Response: The interfacility transfer note template does currently contain a section for documentation of the pertinent clinical information that is sent with the patient to the receiving facility. The Transfer Coordinator began monitoring this data point after feedback from the OIG-CHIP team during their site visit, and started including this data in their report to the UM committee in September 2017. The Transfer Coordinator will continue to monitor and report this element on an ongoing basis and include this, along with the other data elements that are tracked, in the committee report to the Clinical Executive Board. Sustained compliance with this recommendation will be demonstrated by a quarterly completion rate (documentation of pertinent information sent to the receiving facility) of better than 90% over 2 quarters.

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.[33] 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.[34] 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 (critical care, locked MH, two medical-surgical [3rd and 5th floor units], post-anesthesia care, community living center), four outpatient clinics (PC, dental, MH, and women's health), the Emergency Department, and Radiology Service. OIG also inspected the Montrose Outpatient PC Clinic. 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.

Parent Facility

- 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

[33] VHA Handbook 1105.04, *Fluoroscopy Safety*, July 6, 2012.
[34] 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. The parent facility tracked EOC deficiencies and met the performance indicators evaluated for general safety, infection prevention, cleanliness, and privacy. The representative community based outpatient clinic and Radiology Service generally met the performance indicators OIG examined for those areas. The locked MH unit had MH EOC inspection and environmental suicide hazard identification and abatement processes in place and met the infection prevention indicators evaluated. OIG did not note any issues with the availability of medical equipment and supplies. However, OIG identified the following deficiencies for EOC rounds and employee training that warranted recommendations for improvement.

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.[35] Five of 13 core team members did not consistently attend EOC rounds. Managers were aware

[35] 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.

of the deficiency but had competing priorities and challenging clinic assignments, which resulted in noncompliance.

Recommendation

8. The Associate Director ensures core team members consistently attend environment of care rounds and monitors compliance.

Facility concurred.

Target date for completion: April 30, 2018

Facility Response: The applicable facility policy was revised to ensure that all Comprehensive Environment of Care Inspections (CEOC) team members/subject matter experts are clearly designated to attend CEOC rounds in accordance with VHA Directive 1608. CEOC attendance is tracked and reported to the facility Safety Committee with supporting documentation included in the minutes for review by Senior Leadership. The CEOC Coordinator will track weekly attendance, report compliance monthly at the Safety Committee and provide data for the first 2 quarters of FY18 with sustained compliance being demonstrated by an attendance rate of 90% or better over that interval.

Locked Mental Health Unit: Employee and Inspection Team Training. VHA requires that locked MH unit employees and Interdisciplinary Safety Inspection Team members receive training on the identification and correction of environmental hazards, including the proper use of the MH EOC Checklist. This ensures staff possess the necessary knowledge and skills to perform inspections of the locked MH unit in order to assure the safety of patients, staff, and visitors. From June 2016 to July 2017, 2 of 10 locked MH unit employees and 2 of 6 Interdisciplinary Safety Inspection Team members did not complete the required training. EOC leaders and managers were aware of the specific training requirement but did not monitor training completion.

Recommendation

9. The Associate Director ensures all locked mental health 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 Mental Health Environment of Care Checklist, and monitors employees' and team members' compliance.

Facility concurred.

Target date for completion: March 31, 2018

Facility Response: Required Mental Health Comprehensive Environment of Care Inspections (CEOC) training was assigned in TMS to Non-Clinical and Clinical staff whose responsibilities include conducting CEOC rounds on the locked mental health unit. Training was also assigned to all current staff of the facility's locked Mental Health ward (5P). This training compliance is tracked through the Education Department.

As of 12/6/17 all active mental health unit employees have completed the training, except for a newly hired employee. The EOC team and the Safety Committee leadership reviewed the MH EOC member list comparing it to the VHA Directive. They identified two additional personnel who should be added to the list of those required to have the appropriate training. The training was assigned to these additional personnel with a due date established. The CEOC Coordinator will monitor for completion of training by these additional personnel (through monthly reports from the Education Department) and will include this in their report to the Safety Committee. Once this is completed, 100% of required personnel will have completed the assigned training.

Annual training compliance will be monitored and reported monthly by the Safety Department and reported on an ongoing basis at the Safety Committee for oversight purposes.

Post-Traumatic Stress Disorder Care

For this facility, OIG also evaluated PTSD, a disorder that may occur "…following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury; other threat to one's physical integrity; witnessing an event that involves death, injury or threat to the physical integrity of another person; learning about unexpected or violent death, serious harm, threat of death or injury experienced by a family member or other close associate."[36]

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

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

The purpose of this review was to assess whether the facility complied with selected VHA requirements for PTSD follow-up in the outpatient setting.[e]

OIG reviewed relevant documents and interviewed key employees and managers. Additionally, OIG reviewed the EHRs of 50 randomly selected patients who had a positive PTSD screen from April 1, 2016 through March 31, 2017. The list below shows the performance indicators OIG reviewed.

- Completion of a suicide risk assessment by acceptable providers
- Establishment of plan of care and disposition
- Offer of further diagnostic evaluations
- Completion of diagnostic evaluations
- Receipt of MH treatment when applicable

Conclusion. Generally, the facility met requirements with the above performance indicators. OIG made no recommendations.

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

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	Nine 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, and Associate Director. See details below.	
Healthcare Processes	**Performance Indicators**	**Critical Recommendations[37] 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	None	• Physician UM Advisors consistently document their decisions in the National UM Integration database. • The Patient Safety Manager consistently provides feedback to employees or departments who submit close call and adverse event reports that result in a root cause analysis.
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	• Anticoagulation program managers establish a defined process for anticoagulation-related calls outside normal business hours.	• The Pharmacy and Therapeutics Committee reviews all required anticoagulation data quarterly.

[37] 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: • Clinicians consistently include patient or surrogate informed consent in transfer documentation. • Clinicians consistently document sending or communicating to the receiving facility pertinent patient information.	• Inter-facility patient transfer data are reported to a quality oversight committee.
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 • Community Based Outpatient Clinic 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		• Core team members consistently attend EOC rounds. • 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.)
Post-Traumatic Stress Disorder Care	• Completion of a suicide risk assessment by acceptable providers • Established plan of care and disposition • Offer of further diagnostic evaluations • Completion of diagnostic evaluations • Receipt of MH treatment when applicable	None	None

Facility Profile

The table below provides general background information for this medium-complexity (2)[38] affiliated[39] facility reporting to VISN 19.

Table 5. Facility Profile for Grand Junction (575) for October 1, 2013 through September 30, 2016

Profile Element	Facility Data FY 2014[40]	Facility Data FY 2015[41]	Facility Data FY 2016[42]
Total Medical Care Budget in Millions	$105.1	$137.6	$123.1
Number of:			
• **Unique Patients**	13,778	14,321	14,584
• **Outpatient Visits**	180,310	180,288	180,497
• **Unique Employees**[43]	492	523	551
Type and Number of Operating Beds:			
• **Acute**	23	23	23
• **Mental Health**	8	8	8
• **Community Living Center**	30	30	30
• **Domiciliary**	NA	NA	NA
Average Daily Census:			
• **Acute**	13	11	10
• **Mental Health**	3	3	3
• **Community Living Center**	25	26	22
• **Domiciliary**	NA	NA	NA

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

[38] VHA medical centers are classified according to a facilities complexity model; 2 designation indicates a facility with medium volume, low-risk patients, few complex clinical programs, and small or no research and teaching programs. Retrieved September 10, 2017, from http://opes.vssc.med.va.gov/FacilityComplexityLevels/Facility%20Complexity%20Levels%20Document%20Library/Facility%20Complexity%20Level%20Model%20Fact%20Sheet.docx.
[39] Associated with a medical residency program.
[40] October 1, 2013 through September 30, 2014.
[41] October 1, 2014 through September 30, 2015.
[42] October 1, 2015 through September 30, 2016.
[43] Unique employees involved in direct medical care (cost center 8200).

VA Outpatient Clinic Profiles[44]

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[45] and Specialty Care, Diagnostic, and Ancillary Services Provided for October 1, 2015 through September 30, 2016

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services[46] Provided	Diagnostic Services[47] Provided	Ancillary Services[48] Provided
Montrose, CO	575GA	3,970	306	Dermatology Endocrinology Gastroenterology Nephrology Pulmonary/ Respiratory Disease Blind Rehab Eye Anesthesia General Surgery Podiatry	NA	Nutrition Pharmacy Weight Management
Craig, CO	575GB	674	117	Dermatology Endocrinology Gastroenterology Blind Rehab Eye Anesthesia General Surgery Podiatry	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.

NA = Not applicable

[44] Includes all outpatient clinics in the community that were in operation as of February 15, 2017. We have omitted Glenwood Springs, CO (575QA) and Moab, UT (575QB), as no workload/encounters or services were reported.
[45] An encounter is a professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition.
[46] Specialty care services refer to non-PC and non-MH services provided by a physician.
[47] Diagnostic services include EKG, EMG, laboratory, nuclear medicine, radiology, and vascular lab services.
[48] 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:

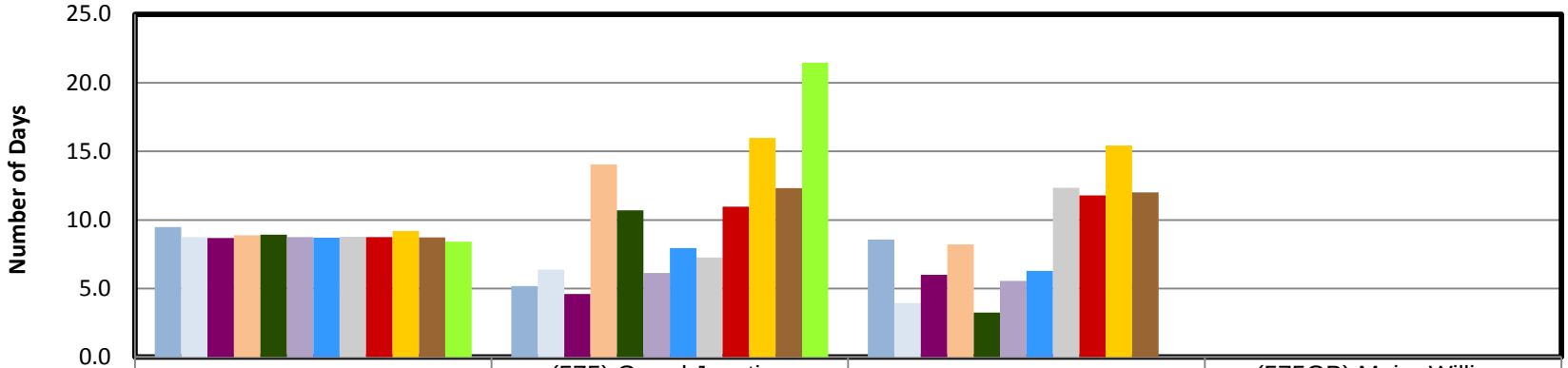
1. VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010 (recertification due date June 30, 2015).
2. VHA Directive 2011-007, Required Hand Hygiene Practices, February 16, 2011 (recertification due date February 29, 2016).
3. VHA Directive 2012-026, Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities, September 27, 2012 (recertification due date September 30, 2017).
4. VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011 (recertification due date March 31, 2016).
5. VHA Handbook 1105.04, *Fluoroscopy Safety*, July 6, 2012 (recertification due date July 31, 2017).
6. VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008 (recertification due date September 30, 2013), amended November 16, 2015.
7. VHA Handbook 1160.03, *Programs for Veterans with Post-Traumatic Stress Disorder (PTSD)*, March 12, 2010 (recertification due date March 31, 2015) revised December 8, 2015.[49]

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),[50] 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."[51] 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."[52]

[49] [49] This handbook was in effect during the review period for this report; it was rescinded and replaced by VHA Directive 1160.03, *Programs for Veterans with Post-Traumatic Stress Disorder (PTSD)*, November 16, 2017.
[50] VHA Directive 6330(1), *Controlled National Policy/Directives Management System*, June 24, 2016, amended January 11, 2017.
[51] VA Under Secretary for Health. "Validity of VHA Policy Document." Memorandum. June 29, 2016.
[52] Ibid.

Patient Aligned Care Team Compass Metrics

Quarterly New PC Patient Average Wait Time in Days

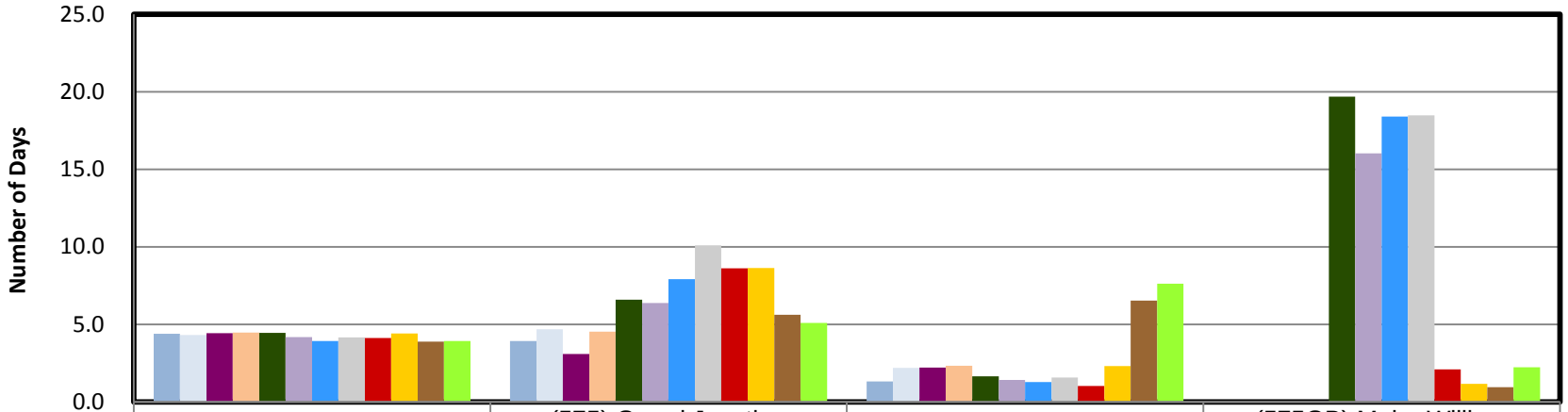


	VHA Total	(575) Grand Junction VAMC	(575GA) Montrose	(575GB) Major William Edward Adams VA Clinic
APR-FY16	9.5	5.2	8.6	
MAY-FY16	8.7	6.4	3.9	
JUN-FY16	8.7	4.6	6.0	
JUL-FY16	8.9	14.0	8.2	
AUG-FY16	8.9	10.7	3.3	
SEP-FY16	8.7	6.1	5.6	
OCT-FY17	8.7	7.9	6.3	
NOV-FY17	8.8	7.3	12.3	
DEC-FY17	8.8	11.0	11.8	
JAN-FY17	9.2	16.0	15.4	
FEB-FY17	8.7	12.3	12.0	
MAR-FY17	8.4	21.5	0.0	0.0

Source: VHA Support Service Center.

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

Data Definition[f]: 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.

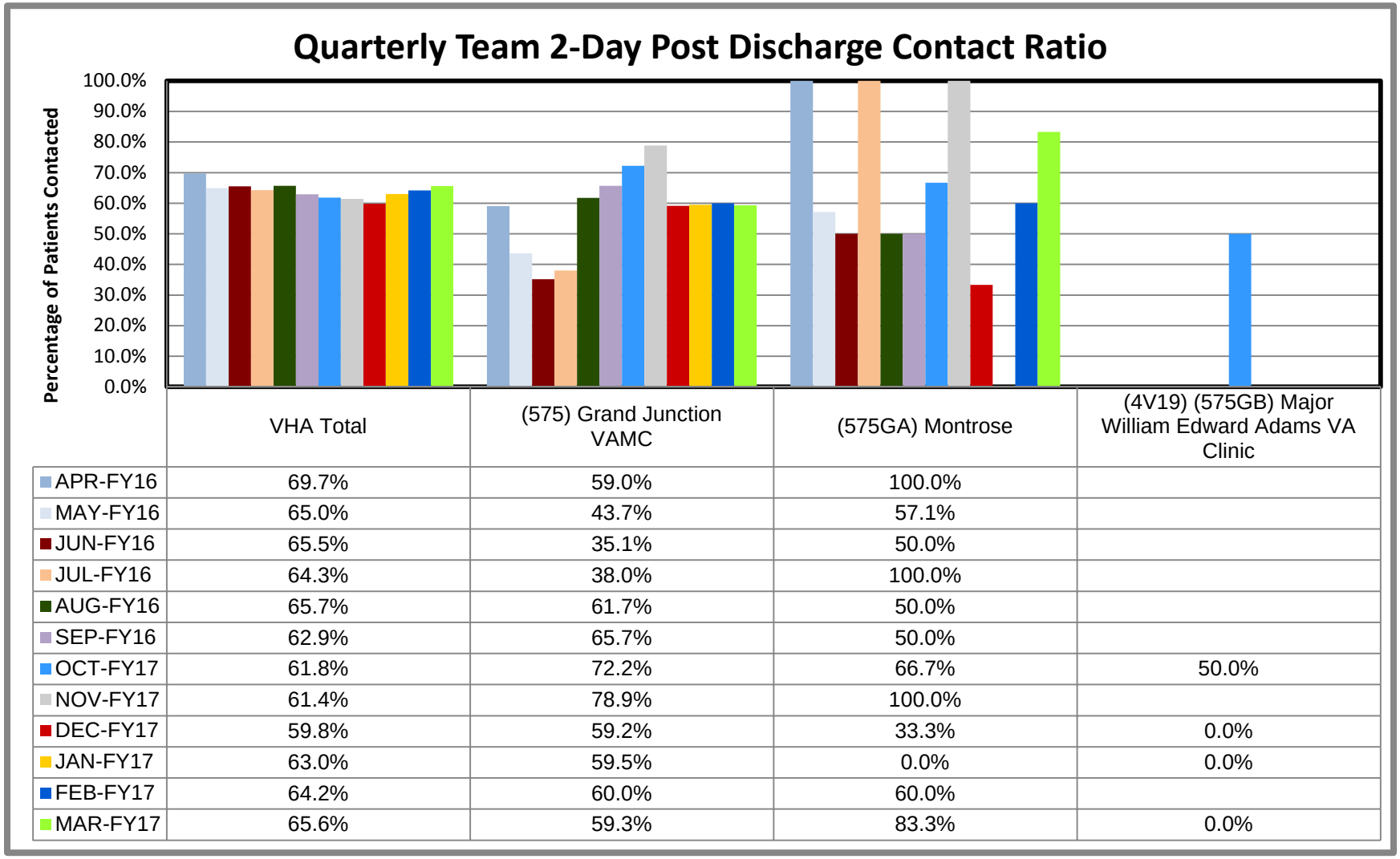


	VHA Total	(575) Grand Junction VAMC	(575GA) Montrose	(575GB) Major William Edward Adams VA Clinic
APR-FY16	4.4	3.9	1.3	0.0
MAY-FY16	4.3	4.7	2.2	0.0
JUN-FY16	4.4	3.1	2.2	0.0
JUL-FY16	4.5	4.5	2.3	0.0
AUG-FY16	4.5	6.6	1.7	19.7
SEP-FY16	4.2	6.4	1.4	16.0
OCT-FY17	3.9	7.9	1.3	18.4
NOV-FY17	4.2	10.1	1.6	18.5
DEC-FY17	4.1	8.6	1.0	2.1
JAN-FY17	4.4	8.6	2.3	1.2
FEB-FY17	3.9	5.6	6.5	1.0
MAR-FY17	3.9	5.1	7.6	2.2

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.

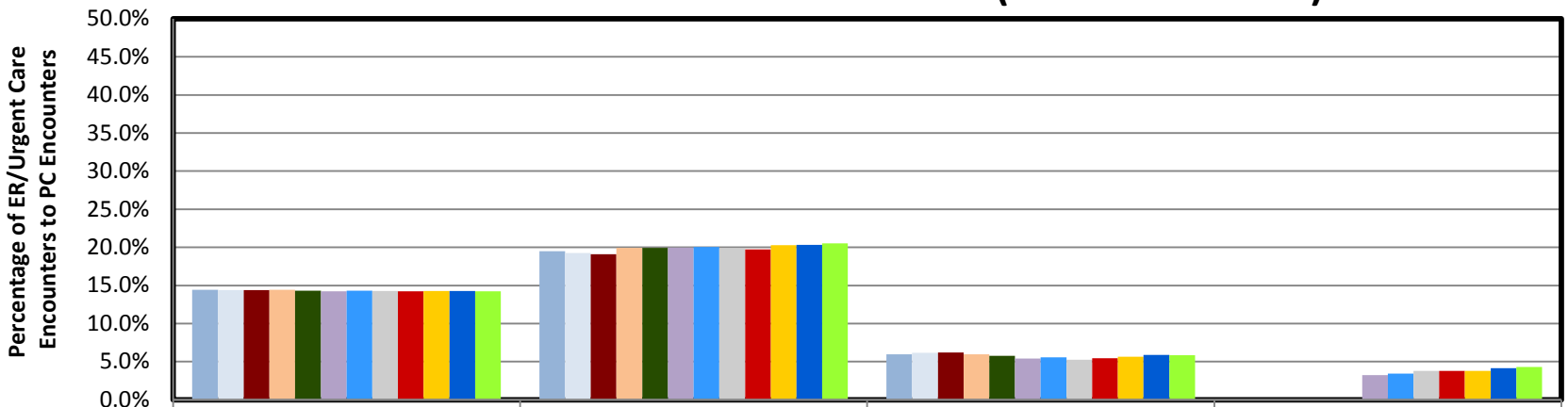


	VHA Total	(575) Grand Junction VAMC	(575GA) Montrose	(4V19) (575GB) Major William Edward Adams VA Clinic
APR-FY16	69.7%	59.0%	100.0%	
MAY-FY16	65.0%	43.7%	57.1%	
JUN-FY16	65.5%	35.1%	50.0%	
JUL-FY16	64.3%	38.0%	100.0%	
AUG-FY16	65.7%	61.7%	50.0%	
SEP-FY16	62.9%	65.7%	50.0%	
OCT-FY17	61.8%	72.2%	66.7%	50.0%
NOV-FY17	61.4%	78.9%	100.0%	
DEC-FY17	59.8%	59.2%	33.3%	0.0%
JAN-FY17	63.0%	59.5%	0.0%	0.0%
FEB-FY17	64.2%	60.0%	60.0%	
MAR-FY17	65.6%	59.3%	83.3%	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	(575) Grand Junction VAMC	(575GA) Montrose	(575GB) Major William Edward Adams VA Clinic
APR-FY16	14.4%	19.5%	5.9%	
MAY-FY16	14.4%	19.3%	6.2%	
JUN-FY16	14.4%	19.1%	6.2%	
JUL-FY16	14.4%	19.9%	6.0%	
AUG-FY16	14.3%	19.9%	5.8%	
SEP-FY16	14.2%	20.0%	5.4%	3.2%
OCT-FY17	14.3%	20.0%	5.5%	3.4%
NOV-FY17	14.3%	19.9%	5.2%	3.8%
DEC-FY17	14.2%	19.7%	5.5%	3.8%
JAN-FY17	14.3%	20.3%	5.6%	3.8%
FEB-FY17	14.3%	20.3%	5.9%	4.1%
MAR-FY17	14.2%	20.5%	5.8%	4.3%

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[g]

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

April 28, 2014 through December 1, 2017[53]

Healthcare Inspection – Unexpected Death of a Patient: Alleged Methadone Overdose, Grand Junction VA Health Care System, Grand Junction, Colorado

11/30/2017 | *16-04208-30* | *Summary* | *Report*

Healthcare Inspection – Quality of Care Concerns in the Management of a Hepatitis C Patient, Grand Junction Veterans Health Care System, Grand Junction, Colorado

5/11/2016 | *15-01599-289* | *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*

Combined Assessment Program Review of the Grand Junction VA Medical Center, Grand Junction, Colorado

9/2/2014 | *14-02068-264* | *Summary* | *Report*

Community Based Outpatient Clinic and Primary Care Clinic Reviews at Grand Junction VA Medical Center, Grand Junction, Colorado

7/16/2014 | *14-00918-204* | *Summary* | *Report*

[53] 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 20, 2017

From: Director, Rocky Mountain Network (10N19)

Subject: CHIP Review of the Grand Junction Veterans Health Care System, Grand Junction, CO

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

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

1. Thank you for the opportunity to review and respond to the OIG-CHIP report.

2. I have reviewed and concur with the facility responses and action plans.

Ralph T. Gigliotti, FACHE
Director, VA Rocky Mountain Network (10N19)

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: December 20, 2017

From: Director, Grand Junction Veterans Health Care System (575/00)

Subject: CHIP Review of the Grand Junction Veterans Health Care System, Grand Junction, CO

To: Director, Rocky Mountain Network (10N19)

1. Thank you for the opportunity to submit responses and provide comment to this report.

2. I have reviewed and concur with the nine (9) findings and recommendations presented in the report from the Office of the Inspector General, for the Comprehensive Healthcare Inspection Program (CHIP) review conducted the week of July 17, 2017.

3. Corrective action plans and compliance monitoring have been established and target dates have been set for the recommendations as detailed in the attached report.

4. Please contact our facility for any additional questions or if further information is required.

M. T. Kilmer
Michael T. Kilmer
Director

OIG Contact and Staff Acknowledgments

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This report is available at www.va.gov/oig.

Endnotes

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

[b] The references used for 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 Directive 1761(1), *Supply Chain Inventory Management*, October 24, 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 PTSD Care included:
- VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.
- VHA Handbook 1160.03, *Programs for Veterans with Post-Traumatic Stress Disorder (PTSD)*, March 12, 2010.
- VA Memorandum, *Information Bulletin: Clarification of Posttraumatic Stress Disorder Screening Requirements*, August 2015.
- *VA/DoD Clinical Practice Guideline for Management of Post-Traumatic Stress*, Version 2.0, October 2010.
- *VHA Technical Manual – PTSD*, VA Measurement Manual PTSD-51.

[f] The reference used for PACT Compass data graphs was:
- Department of Veterans' Affairs, Patient Aligned Care Teams Compass Data Definitions, accessed: April 28, 2017.

[g] 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.