Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 17-01745-96

Comprehensive Healthcare Inspection Program Review of the VA Black Hills Health Care System Fort Meade, South Dakota

February 8, 2018

Washington, DC 20420

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Glossary

CBOC	community based outpatient clinic
CHIP	Comprehensive Healthcare Inspection Program
EHR	electronic health record
EOC	environment of care
facility	VA Black Hills Health Care System
FY	fiscal year
MH	mental health
NA	not applicable
Nurse Executive	Associate Director for Patient Care Services
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 VA Black Hills Health Care System (facility). The review covers key clinical and administrative processes that are associated with promoting quality care.

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

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

This review was conducted during an unannounced visit during the week of August 28, 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 VA Black Hills Health Care System, the leadership team consists of the Facility Director, Chief of Staff, Associate Director for Patient Care Services (Nurse Executive), and Associate Director. Organizational communication and accountability are carried out through a committee reporting structure with the Executive Leadership Board having oversight for leadership groups such as the Administrative Executive Council, Clinical Executive Council, Clinical Operations Council, Customer Service Council, and Workforce Development Council. The executive leaders are members of the Executive Leadership Board, which is

[1] The Community Nursing Home Oversight special focus area did not apply for the VA Black Hills Health Care System because the facility did not provide long-term care for greater than 90 days through contracts.

chaired by the Facility Director. The Executive Leadership Board tracks, trends, and monitors quality of care and patient outcomes.

It is important to note that two of the four leadership team members had been in their positions less than 6 months at the time of our review. The Chief of Staff, permanently assigned in 2011, was temporarily detailed to another VA facility, and another physician had been acting since March 2017. The Nurse Executive was permanently assigned in March 2017. The Facility Director was assigned in August 2015, and the Associate Director was assigned in October 2012.

In the review of selected employee and patient survey results regarding facility senior leadership, OIG noted opportunities to improve employee satisfaction, while patient satisfaction scores reflected higher care ratings than the Veterans Health Administration (VHA) average. OIG also noted that facility leaders implemented processes and plans to maintain a committed workforce and positive patient experiences.

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 VHA.[2]

Although the senior leadership team was knowledgeable about selected SAIL metrics, the leaders should continue to take 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 six recommendations that are attributable to the Facility Director, Chief of Staff, and Associate Director. Of the six areas of clinical operations reviewed, OIG noted findings in three. These are briefly described below.

Coordination of Care. OIG noted safe inter-facility patient transfer practices. However, OIG identified a deficiency with transfer data reporting and evaluation.

Environment of Care. OIG noted a generally safe and clean environment of care at the facility's two campuses, representative CBOC, and radiology areas. OIG identified deficiencies with environment of care rounds attendance, locked mental health unit environmental safety, and locked mental health unit employee and Interdisciplinary Safety Inspection Team training.

[2] 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.

High-Risk Processes Related to Moderate Sedation. OIG found compliance with informed consent documentation, post-procedure assessments, and discharge practices. However, OIG identified deficiencies with pre-sedation assessments and the timeout procedure prior to moderate sedation.

Summary

In the review of key care processes, OIG issued six 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 43–44, 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 VA Black Hills 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). The Community Nursing Home Oversight special focus area did not apply for the VA Black Hills Health Care System because the facility did not provide long-term (greater than 90 days) contracted care. Thus, OIG focused on the remaining five areas of clinical operations and a program relevant to the facility—Post-Traumatic Stress Disorder Care.

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

Source: VA OIG.

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.

Methodology

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

The review covered operations for April 21, 2014[5] through August 28, 2017, the date when an unannounced week-long site visit commenced. On September 6, 2017, OIG presented crime awareness briefings to 151 of the facility's 1,234 employees. These briefings covered procedures for reporting suspected criminal activity to OIG and

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

included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

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

While onsite, OIG referred issues and concerns beyond the scope of the CHIP review to our Hotline management team for further evaluation. OIG conducted the inspection in accordance with OIG standard operating procedures for CHIP reviews and *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

Results and Recommendations

Leadership and Organizational Risks

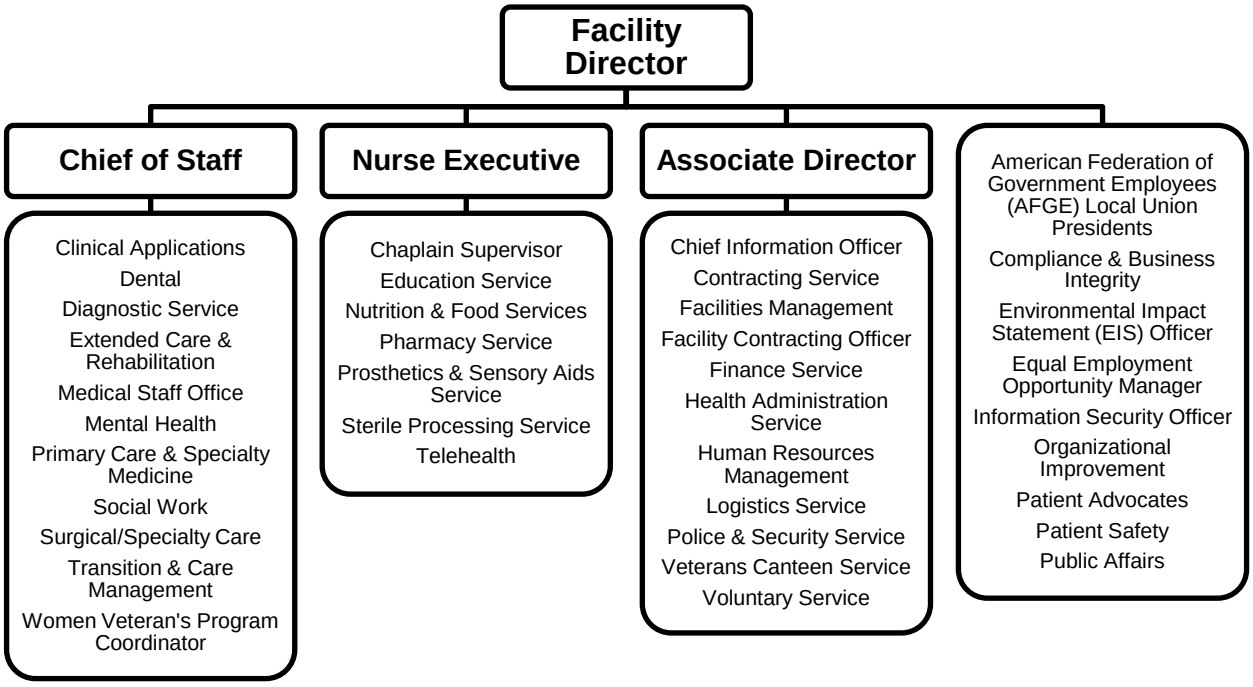
Stable and effective leadership is critical to improving care and sustaining meaningful change. Leadership and organizational risk issues can impact the facility's ability to provide care in all of the selected clinical areas of focus. The factors OIG considered in assessing the facility's risks and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

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

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

It is important to note that two of the four leadership team members had been in their positions less than 6 months at the time of our review. The Chief of Staff, permanently assigned in 2011, was temporarily detailed to another VA facility and another physician had been acting since March 2017. The Nurse Executive was permanently appointed in March 2017. The Facility Director was assigned in August 2015, and the Associate Director was assigned in October 2012. The executive leaders had been working together since March 2017.

Figure 2. Facility Organizational Chart



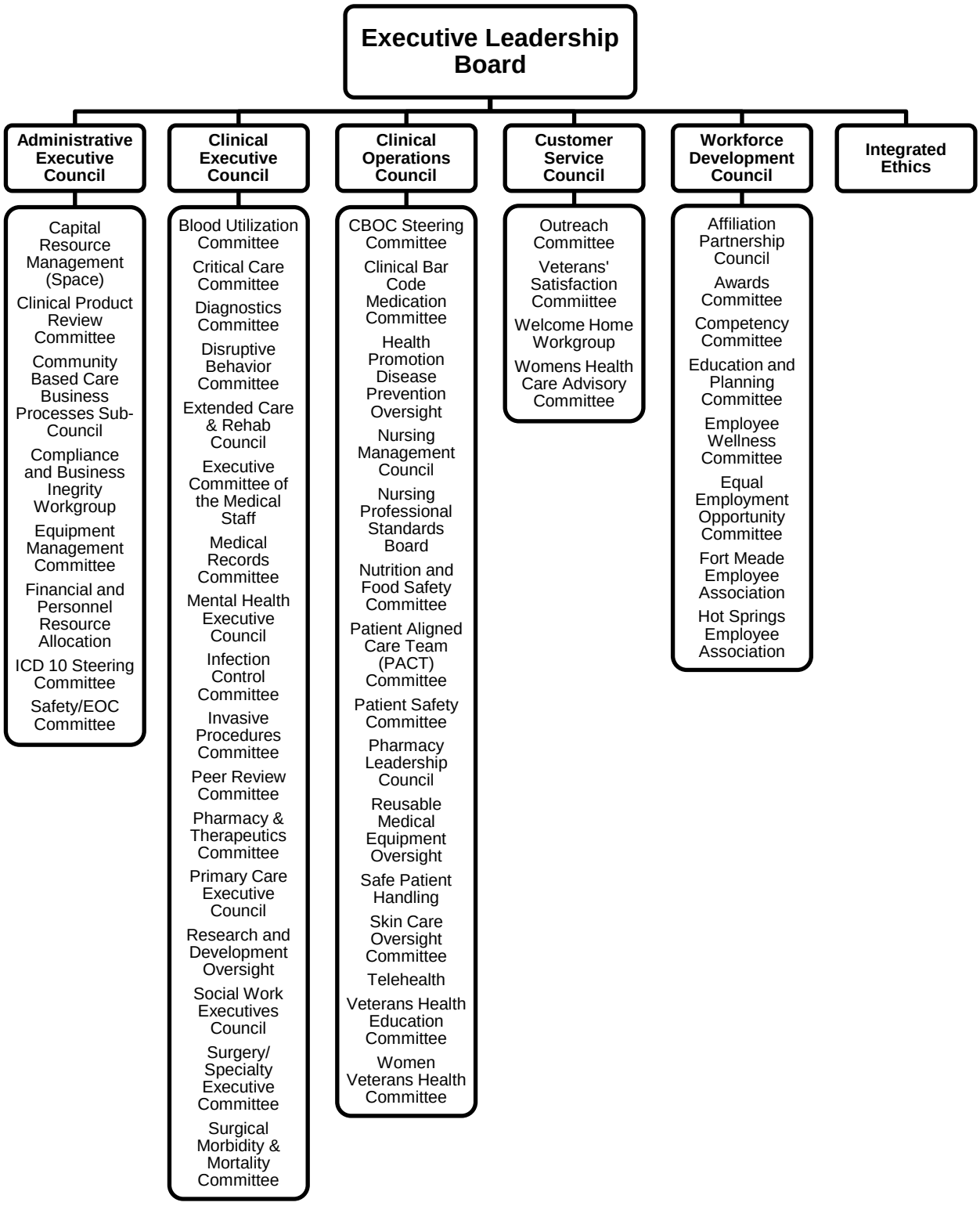
Source: VA Black Hills Health Care System (received August 28, 2017).

To help assess engagement of facility executive leadership, OIG interviewed the Facility Director, Acting Chief of Staff, 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 Leadership Board, which tracks, trends, and monitors quality of care and patient outcomes. The Facility Director serves as the Chairperson, with the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. The Executive Leadership Board also oversees various working councils and committees, such as the Administrative Executive Council, Clinical Executive Council, Clinical Operations Council, Customer Service Council, and Workforce Development Council. See Figure 3 for the facility committee reporting structure.

Figure 3. Facility Committee Reporting Structure



Source: VA Black Hills Health Care System (received August 28, 2017).

ICD = International Statistical Classification of Diseases and Related Health Problems

Employee Satisfaction and Patient Experience. To assess employee and patient attitudes toward facility senior leadership, OIG reviewed employee satisfaction and patient experience survey results that relate to the period of October 1, 2015 through September 30, 2016. Although OIG recognizes that employee satisfaction and patient experience survey data are subjective, they can be a starting point for discussions and indicate areas for further inquiry, which can be considered along with other information on facility leadership. Table 1 provides relevant survey results for VHA and the facility for the 12-month period. The facility leaders' results (Director's office average) were rated above the VHA and facility average; however, the facility averages were below the VHA average.[6] All four patient survey results reflected higher care ratings than the VHA average. In all, opportunities exist to improve employee satisfaction, while 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[7]
All Employee Survey[8] Q59. How satisfied are you with the job being done by the executive leadership where you work?	1 (Very Dissatisfied) – 5 (Very Satisfied)	3.3	2.9	3.9
All Employee Survey Servant Leader Index Composite	0–100 where HIGHER scores are more favorable	66.7	62.2	76.8
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	77.0	
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	87.4	
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): I felt like a valued customer.		73.2	76.8	
Survey of Healthcare Experiences of Patients (outpatient specialty care): I felt like a valued customer.		73.8	84.4	

Accreditation/For-Cause[9] Surveys and Oversight Inspections. To further assess Leadership and Organizational Risks, OIG reviewed recommendations from previous inspections by oversight and accrediting agencies to gauge how well leaders respond to

[6] OIG makes no comment on the adequacy of the VHA average for each selected survey element. The VHA average is used for comparison purposes only.
[7] Rating is based on responses by employees who report to the Director.
[8] The All Employee Survey is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential. The instrument has been refined at several points since 2001 in response to operational inquiries by VA leadership on organizational health relationships and VA culture.
[9] TJC conducts for-cause unannounced surveys in response to serious incidents relating to the health and/or safety of patients or staff or reported complaints. The outcomes of these types of activities may affect the current accreditation status of an organization.

identified problems. Table 2 summarizes the relevant facility inspections most recently performed by the VA OIG and The Joint Commission (TJC). Indicative of effective leadership, the facility has closed[10] all 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[11] and College of American Pathologists,[12] which demonstrates the facility leaders' commitment to quality care and services. Additionally, the Long Term Care Institute[13] conducted inspections of the facility's Community Living Center.

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 (*Combined Assessment Program Review of the VA Black Hills Health Care System, Fort Meade, South Dakota, July 25, 2014)*	May 2014	16	0
VA OIG (*Community Based Outpatient Clinic and Primary Care Clinic Reviews at VA Black Hills Health Care System, Fort Meade, South Dakota, July 2, 2014)*	April 2014	7	0
TJC[14]			
• Hospital Accreditation	September 2016	17	0
• Nursing Care Center Accreditation		1	0
• Behavioral Health Care Accreditation		4	0
• Home Care Accreditation		4	0

[10] A closed status indicates that the facility has implemented corrective actions and improvements to address findings and recommendations, not by self-certification, but as determined by accreditation organization or inspecting agency.
[11] The Commission on Accreditation of Rehabilitation Facilities provides an international, independent, peer review system of accreditation that is widely recognized by Federal agencies. VHA's commitment is supported through a system-wide, long-term joint collaboration with the Commission on Accreditation of Rehabilitation Facilities to achieve and maintain national accreditation for all appropriate VHA rehabilitation programs.
[12] For 70 years, the College of American Pathologists has fostered excellence in laboratories and advanced the practice of pathology and laboratory science. In accordance with VHA Handbook 1106.01, VHA laboratories must meet the requirements of the College of American Pathologists.
[13] Since 1999, the Long Term Care Institute has been to over 3,500 health care facilities conducting quality reviews and external regulatory surveys. The Long Term Care Institute is a leading organization focused on long-term care quality and performance improvement; compliance program development; and review in long-term care, hospice, and other residential care settings.
[14] 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 May 2014 Combined Assessment Program and April 2014 Community Based Outpatient Clinic (CBOC) and Primary Care (PC) review inspections through the week of August 28, 2017.

Table 3. Summary of Selected Organizational Risk Factors[15] (April 2014 to August 28, 2017)

Factor	Number of Occurrences
Sentinel Events[16]	0
Institutional Disclosures[17]	4
Large-Scale Disclosures[18]	0

[15] 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 VA Black Hills Health Care System is a medium complexity (2) affiliated facility as described in Appendix B.)
[16] 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.
[17] 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.
[18] 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.[19] 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 23	Fort Meade	Hot Springs
Pressure Ulcers	0.55	0.79	0.00	0.00
Death among surgical inpatients with serious treatable conditions	103.31	92.20	0.00	NA
Iatrogenic Pneumothorax	0.20	0.28	0.00	0.00
Central Venous Catheter-Related Bloodstream Infection	0.12	0.17	0.00	0.00
In Hospital Fall with Hip Fracture	0.08	0.14	0.00	0.00
Perioperative Hemorrhage or Hematoma	2.59	2.63	0.00	NA
Postoperative Acute Kidney Injury Requiring Dialysis	1.20	1.22	0.00	NA
Postoperative Respiratory Failure	6.31	5.96	0.00	NA
Perioperative Pulmonary Embolism or Deep Vein Thrombosis	3.29	2.48	13.51	NA
Postoperative Sepsis	4.45	4.18	0.00	NA
Postoperative Wound Dehiscence	0.65	1.13	0.00	0.00
Unrecognized Abdominopelvic Accidental Puncture/Laceration	0.67	1.23	0.00	0.00

Source: VHA Support Service Center.

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

The Patient Safety Indicator for perioperative pulmonary embolism or deep vein thrombosis shows an observed rate of 13.51 per 1,000 hospital discharges for the Fort Meade Division in excess of the observed rates for VISN 23 and VHA. Although the numerator for this measure is one patient, the facility reported providing appropriate care pre- and post-operatively to the patient who had been on long-term anticoagulant therapy.

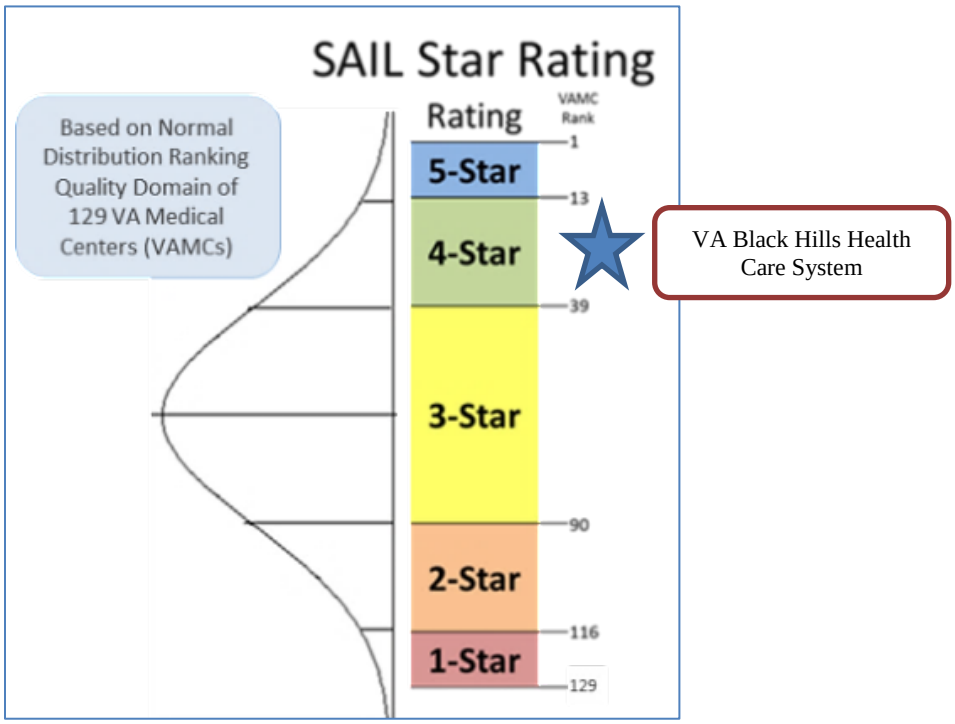
Veterans Health Administration Performance Data. The VA Office of Operational Analytics and Reporting adapted the SAIL Value Model to help define performance expectations within VA.[20] This model includes measures on health care quality, employee satisfaction, access to care, and efficiency, but the model has noted limitations for identifying all areas of clinical risk. The data are presented as one "way to

[19] Agency for Healthcare Research and Quality website, https://www.qualityindicators.ahrq.gov/, accessed March 8, 2017.
[20] 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.[21]

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 VA Black Hills Health Care System received an interim rating of 4 stars for overall quality. This means the facility is in the 2nd quintile (10–30 percent range). Updated data as of June 30, 2017, indicates that the facility has remained at 4 stars for overall quality.

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

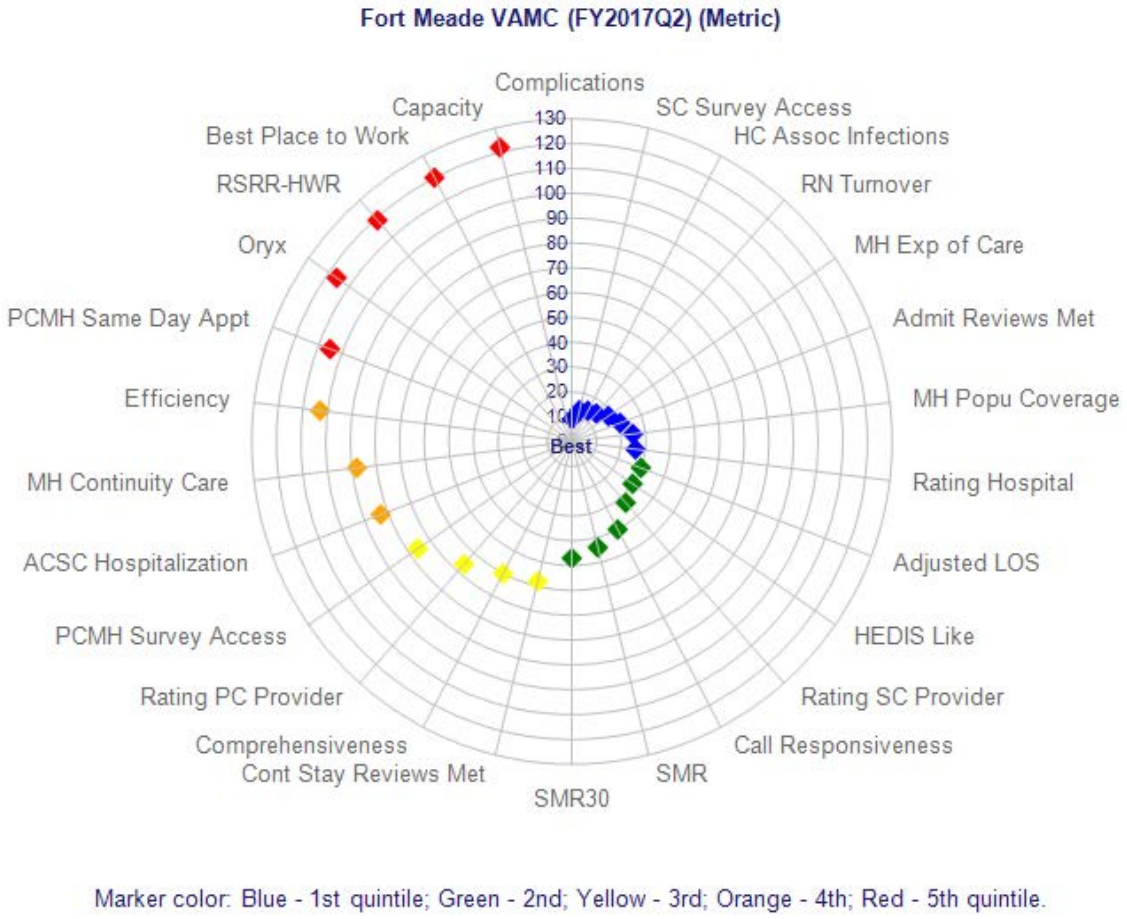


Source: VA Office of Informatics and Analytics' Office of Operational Analytics and Reporting.

[21] 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 by quintile as of March 31, 2017. Of note, Figure 5 shows blue and green data points in the top quintiles that are performed well (for example, Complications, RN [Registered Nurse] Turnover, and Call Responsiveness). Metrics in the bottom quintiles and needing improvement are denoted in orange and red (for example, Mental Health [MH] Continuity [of] Care, Best Place to Work, and Capacity).

Figure 5. Facility Quality of Care and Efficiency Metric Rankings (as of March 31, 2017)



Source: VHA Support Service Center.

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

Conclusions. The facility has opportunities to improve employee satisfaction. However, organizational leadership supports patient safety, quality care, and other positive outcomes (such as initiating processes and plans to maintain positive perceptions of the facility through active stakeholder engagement). 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.[22] The senior leadership team was knowledgeable about selected SAIL metrics but should continue to take actions to improve care and performance, particularly Quality of Care and Efficiency metrics likely contributing to the current 4-star rating.

[22] 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.[23] 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[24] of clinical care
3. Credentialing and privileging
4. Utilization management (UM) reviews[25]
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 (OPPE)[26] data review
  - Indicated a Focused Professional Practice Evaluation[27]

[23] Department of Veterans Affairs, Veterans Health Administration. *Blueprint for Excellence*. September 2014.
[24] 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.
[25] 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.
[26] OPPE 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, the facility met requirements with the above performance indicators. OIG made no recommendations.

[27] 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.

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,[28] or a blood thinner, which is a drug that works to prevent the coagulation or clotting of blood. JC'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 17 employees actively involved in the anticoagulant program and interviewed key employees. Additionally, OIG reviewed the electronic health records (EHRs) of 41 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

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

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

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 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 44 randomly selected patients who were transferred out of facility inpatient beds or the Emergency Department 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 documented patient transfers. However, OIG identified the following deficiency with data reporting for patient inter-facility transfers.

Data Reporting and Evaluation. 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 the facility'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 leaders received transfer data during morning reports, they were unaware of the requirement to analyze and report transfer data to a quality oversight committee as part of the facility's quality management program.

Recommendation

1. The Facility Director ensures inter-facility patient transfer data are analyzed and reported to a quality oversight committee as part of the facility's quality management program and monitors compliance.

Facility concurred.

Target date for completion: July 30, 2018

Facility Response: The ACOS Primary Care and Specialty Medicine is responsible for the audits, analysis and reporting of inter-facility transfer data. 100% of interfacility transfers will be audited for compliance with documentation requirements. This data will be analyzed and reported monthly for at least 6 months to facility leadership through the Facility Quality, Safety and Value Committee or until the recommendation is closed. Reporting of interfacility transfer data and analysis will then be reported quarterly to Primary Care Executive Committee and Clinical Executive Committee.

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.[29] 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.[30] 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 two facility campuses and a CBOC involving 17 patient care areas. At the Fort Meade campus, OIG inspected the Emergency Department, three inpatient units (intensive care, medical surgical, and the locked MH), community living center unit G, two outpatient clinics (PC and women's health), and Radiology Service. At the Hot Springs campus, OIG inspected the medical/surgical inpatient unit, community living center, urgent care center, four outpatient clinics (behavioral health, PC, eye and dental), and Radiology Service. OIG also inspected the Pine Ridge CBOC. Additionally, OIG reviewed relevant documents and 16 employee training records, and interviewed key employees and managers. The list below shows the location-specific performance indicators selected to examine the risk areas specific to particular settings.

<u>Parent Facility</u>

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

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

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

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

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

Conclusions. General safety, infection prevention, and privacy measures were in place at the two campuses, representative CBOC, and radiology areas. At the Hot Springs campus, OIG received concerns regarding timely delivery of sterile instruments to the Dental and Eye clinics. OIG reviewed the issue and learned that clinic managers had already initiated corrective actions with Sterile Processing Service to ensure timely delivery of sterile equipment. OIG noted that the locked MH unit met many requirements evaluated. OIG identified the following deficiencies 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. From October 1, 2016 through June 30, 2017, participation in EOC rounds for 7 of the 13 required members ranged from 63 to 86 percent. Facility managers were aware of the requirement but stated that competing priorities, staff availability, and travel logistics to rural CBOCs resulted in noncompliance.

Recommendation

2. The Associate Director ensures required team members participate in environment of care rounds and monitors compliance.

Facility concurred.

Target date for completion: March 31, 2018

Facility Response: The Associate Director with the support of the VA BHHCS Environment of Care Safety Committee is responsible for compliance with EOC Rounds Attendance. Designated EOC Rounds members are aware of attendance requirements and are required to attend scheduled rounds.

Environment of Care Rounds (EOC) Attendance has been added to the VA BHHCS FY18 Organizational Improvement Strategic Initiatives and added to the monthly agenda item at the Environment of Care Safety Committee meetings held the first Thursday of each month. Attendance will be monitored through the VA BHHCS FY18 Organizational Improvement's strategic Initiatives and reported to the facility EOC Safety Committee. VA BHHCS requires 90% of EOC Rounds be attended by all 13 multidisciplinary team members or their representative. Environment of Care Rounds attendance is tracked through the Performance Logic Software Program and attendance is reported as a standing monthly agenda item at the Environment of Care Safety Committee meetings held the first Thursday of each month. The VA BHHCS EOC Rounds Coordinator will audit EOC Rounds Attendance prior to the monthly EOC Safety Meeting and report the prior month's performance. The facility EOC Safety Committee will monitor for at least 6 months of compliance of 90% or greater of EOC rounding attendance. In addition, this information will be reported included in the ongoing EOC Safety Committee report to facility leadership through the Administrative Executive Committee.

Compliance Monitoring: N= numerator; D= denominator

- October 2017: N=78 D=86: 90.7% compliant
- November 2017: N=84 D=89: 94.4% compliant
- December 2017: N=49 D=53: 92.5% compliant

Locked Mental Health Unit: Environmental Safety. VHA requires inpatient locked MH unit seclusion rooms to comply with the MH EOC Checklist and be free of furniture other than a box type bed secured to the floor to ensure patient safety. The bed in the seclusion room was not secured to the floor. EOC leaders and managers were aware of the requirement and believed that the facility was compliant because the bed was heavy.

Recommendation

3. The Associate Director ensures the locked mental health unit's seclusion room bed is secured to the floor.

Facility concurred.

Target date for completion: May 30, 2018

Facility Response: The Associate Director with support from the Mental Health Environment of Care (MH EOC) Committee is responsible to ensure that appropriate beds are secured to the floor on the locked mental health unit's seclusion room.

The following steps were taken to address the recommendation:
- 11/6/2017 the recommendation was brought to MH EOC Committee to review and investigate bed options
- 12/4/2017 MH EOC Committee decided to do a risk assessment of the seclusion room until final decisions for bed options are made
  -- Risk assessment completed on 01/04/2018
  -- Findings show low risk due to the following mitigating factors.
    --- Cameras in place with continuous staff monitoring 24/7.
    --- Every 15 minute physical rounds.
    --- Doors to the rooms open outward and beds can't block doorways.
    --- No patient events related to non-secured beds have occurred to date.
- MH EOC Committee will explore bed options.
- Resolution of this issue will occur by 5/30/2018.

The MH EOC committee will monitor the progress on the placement of secure beds in mental health inpatient seclusion rooms until beds are installed and secured to the floor. In addition, monthly reports to facility leadership will be made through Quality, Safety and Value Committee.

Locked Mental Health Unit: Annual Training. VHA requires that locked MH unit employees and facility members of the Interdisciplinary Safety Inspection Team receive training on the identification and correction of environmental hazards, including the proper use of the MH EOC Checklist, so they can effectively inspect inpatient MH units to ensure patient, visitor, and staff safety. Eight of 10 locked MH unit employees and 2 of 6 Interdisciplinary Safety Inspection Team members did not complete the required training within the prior 12 months (August 2016 through July 2017). EOC leaders and managers were aware of the specific training requirement but did not assign a responsible individual to monitor completion of training.

Recommendation

4. The Associate Director ensures that locked mental health unit employees and members of the Interdisciplinary Safety Inspection Team complete the required training for the identification and correction of environmental hazards, including the proper use

of the Mental Health Environment of Care Checklist, and the Associate Director monitors compliance.

Facility concurred.

Target date for completion: June 30, 2018

Facility Response: The Nurse Manager of the locked inpatient mental health unit is responsible for facilitating and monitoring completion of the required training for the identification and correction of environmental hazards. The "MH EOC TMS" module is the means utilized to provide the annual training.

The following actions have been taken to address the recommendation:

- 9/17/17 sent a request to TMS coordinator to have the MH EOC TMS module added to locked unit nursing staff mandatory training list annually. As of 1-4-2018, 100% of the inpatient mental health nursing staff have completed the TMS.
- 9/17/17 Inpatient Mental Health Nurse Manager spoke with MH Secretary/ ADPAC that new staff receiving keys to the locked inpatient unit needs to complete MH EOC for non-clinical/ clinical staff. As of 1/4/2018, 100% of the staff with keys to the locked inpatient unit have completed the TMS.
- 11/17/17 Lab supervisor has been notified to ensure all lab staff would have MH EOC TMS training prior to coming onto the unit.
- 12/29/17 Lab, Housekeeping, and MSA service lines will have MH EOC added to their employee's to-do list in TMS no later than the end of January 2018.

Beginning 1/4/2018, the TMS Coordinator is providing monthly MH EOC TMS module deficiency reports to Locked Inpatient Nurse Manager. Nurse Manager will analyze compliance, address non-compliance and provide reports regarding training compliance. These reports will be provided monthly to the Facility Quality, Safety and Value Committee until there is 6 months of greater than 90% compliance. When the recommendation is closed, ongoing reports regarding MH EOC annual training will be evaluated through the MH EOC Committee.

Compliance Monitoring: N= numerator; D= denominator

- January 2018: N=202 D=215: 93.95% compliant

High Risk Processes: Moderate Sedation

OIG's special focus within high-risk processes for the facility was moderate sedation, which is a drug-induced depression of consciousness during which patients can still respond purposefully to verbal comments.[31] Non-anesthesiologists administer sedatives and analgesics to relieve anxiety and increase patient comfort during invasive procedures and usually do not have to provide interventions to maintain a patient's airway, spontaneous ventilations, or cardiovascular function. The administration of moderate sedation could lead to a range of serious adverse events, including cardiac and respiratory depression, brain damage due to low oxygen levels, cardiac arrest, or death.[32]

Properly credentialed providers and trained clinical staff must provide safe care while sedating patients for invasive procedures. Additionally, facility leaders must monitor moderate sedation adverse events, report and trend the use of reversal agents, and systematically aggregate and analyze the data to enhance patient safety and employee performance.[33] During calendar year 2016, VHA clinicians performed more than 600,000 moderate sedation procedures, of which more than half were gastroenterology-related endoscopies.[34] To minimize risks, VHA and TJC have issued requirements and standards for moderate sedation care.

The purpose of this review was to evaluate selected aspects of care to determine whether the facility complied with applicable policies in the provision of moderate sedation.[e]

OIG reviewed relevant documents, interviewed key employees, and inspected the outpatient, intensive care unit, and Emergency Department procedure areas to assess whether required equipment and sedation medications were available. Additionally, OIG reviewed the EHRs of 25 randomly selected patients who underwent an invasive procedure involving moderate sedation from July 1, 2015 through June 30, 2016, and the training records of 15 clinical employees who performed or assisted during these procedures. The list below shows the performance indicators OIG reviewed.

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

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

- Performance of timeout[35] prior to the moderate sedation procedure
- Post-procedure documentation
- Discharge practices
- Clinician training for moderate sedation
- Availability of equipment and medications in moderate sedation procedure areas

Conclusions. Generally, OIG found compliance with informed consent documentation, post-procedure assessments, and discharge practices. However, OIG identified the following deficiencies that warranted recommendations for improvement.

Pre-sedation Assessment. VHA requires that providers perform a pre-sedation assessment prior to conducting a moderate sedation procedure. This ensures providers are aware of relevant patient information and assessments that may affect the patient's response to moderate sedation. For 3 of the 25 patients, OIG did not find evidence that providers assessed the patients' previous experience with sedation or anesthesia. Lack of attention to detail resulted in noncompliance.

Recommendation

5. The Chief of Staff ensures that providers assess for patients' previous adverse experiences with sedation or anesthesia prior to performing moderate sedation procedures and monitors compliance.

Facility concurred.

Target date for completion: June 30, 2018

Facility Response: ACOS for Primary Care and Specialty Medicine is responsible for re-educating the Patient Aligned Care Team (PACT) providers on documentation requirements related to the required assessment of patient's previous experience with sedation or anesthesia at the PACT meeting January 31, 2018. He will also provide the same education to the hospitalist by February 25, 2018.

The Administrative Officers for Primary Care and Specialty Medicine are responsible for monthly audits of all procedures where moderate sedation is used. These audits for completion of documentation of assessment of the patient's prior experience with sedation or anesthesia will occur until there is 6 months of greater than 90% compliance. The data will be reported monthly to the Facility Leadership through the Quality Safety and Value Committee.

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

Timeout Checklist. VHA requires a timeout be facilitated by a checklist and occur immediately prior to the start of the procedure. This ensures that the clinical team members involved in the procedure are in agreement that they consistently have the correct patient, procedure, and site and also proper equipment, medications, and supplies prior to starting any aspect of the procedure. For all 25 patients' EHRs reviewed, there was no evidence that clinicians performed timeouts using a checklist. Additionally, during physical inspection of the three moderate procedure areas, OIG did not find posted timeout checklists in the Emergency Department and intensive care unit. Unit managers perceived the facility met requirements because when certified registered nurse anesthetists participated in moderate sedation procedures, they used the checklist. However, managers were unaware that non-anesthesia staff performing moderate sedation procedures did not use the checklist.

Recommendation

6. The Chief of Staff ensures that clinical team members conduct timeouts using a checklist with all the required elements prior to performing moderate sedation procedures and monitors compliance.

Facility concurred.

Target date for completion: July 30, 2018

Facility Response: The facility will address the recommendation as follows:

- Nurse Manager laminated "Time Out Checklists" and place them in every room in Emergency Department and Intensive Care Unit. Action completed November 15, 2017.

- The use of the Non-OR Procedure Note will be mandatory for any procedure done in these areas – Estimated completion date is February 15, 2018.

- ACOS Primary Care and Specialty Medicine will provide education to the providers on completion of "Time out" prior to performing moderate sedation and the associated documentation requirements – Estimated completion date is February 15, 2018.

- Associate Chief Nurse prior to performing moderate sedation – Assigned staff and Nurse Managers will educate nurses on documentation requirements related to completion of "Time-out"- Estimated completion date is February 15, 2018.

The Administrative Officer for Primary Care and Specialty Medicine is responsible for monthly audits of all procedures completed in ICU and Emergency Department. These audits for completion of "Time Out" prior to the procedure will occur until there is 6 months of greater than 90% compliance. The data will be reported monthly to the Facility Leadership through the Quality Safety and Value Committee.

Post-Traumatic Stress Disorder Care

For this facility, OIG also evaluated post-traumatic stress disorder (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.[f]

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

- 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

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	Six 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	None
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	None	None
Coordination of Care	• Transfer policies and procedures • Oversight of transfer process • EHR documentation o Non-emergent transfers • Emergent transfers	None	• Inter-facility patient transfer data are analyzed and reported to a quality oversight committee as part of the facility's quality management program.

[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[38] for Improvement	Recommendations for Improvement
Environment of Care	• Parent facility o EOC deficiency tracking and rounds o General Safety o Infection prevention o Environmental cleanliness o Exam room privacy o Availability of feminine hygiene products and medical equipment and supplies • CBOC o General safety o Infection prevention o Environmental cleanliness o Medication safety and security o Privacy o Availability of feminine hygiene products and medical equipment and supplies o IT network room security • Radiology o Safe use of fluoroscopy equipment o Environmental safety o Infection prevention o Medication safety and security o Radiology equipment inspection o Availability of medical equipment and supplies o Maintenance of radiological equipment • Inpatient MH o MH EOC inspections o Environmental suicide hazard identification o Employee training o Environmental safety o Infection prevention • Availability of medical equipment and supplies	• Inpatient MH: o The locked MH unit's seclusion room bed is secured to the floor.	• Parent facility: o Required team members participate in EOC rounds. • Inpatient MH: o Inpatient locked MH unit employees and all members of the Interdisciplinary Safety Inspection Team complete the required training for the identification and correction of environmental hazards, including the proper use of the MH EOC Checklist.

[38] 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[39] for Improvement	Recommendations for Improvement

High-Risk and Problem-Prone Processes: Moderate Sedation	• Outcomes reporting
	• Patient safety and documentation
	  o Prior to procedure
	  o After procedure
	• Staff training and competency
	• Monitoring equipment and emergency management
		• Providers assess for patients' previous adverse experiences with sedation or anesthesia prior to performing moderate sedation procedures.
		• Prior to performing moderate sedation procedures, clinical team members conduct timeouts using a checklist.
			None

Post-Traumatic Stress Disorder Care	• 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.	None	None

[39] 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.

Facility Profile

The table below provides general background information for this medium-complexity (2)[40] affiliated[41] facility reporting to VISN 23.

Table 5. Facility Profile for Fort Meade (568) for October 1, 2013 through September 30, 2016

Profile Element	Facility Data FY 2014[42]	Facility Data FY 2015[43]	Facility Data FY 2016[44]
Total Medical Care Budget in Millions	$181.5	$226.3	$187.4
Number of:			
• **Unique Patients**	20,316	20,550	20,537
• **Outpatient Visits**	250,530	261,111	252,844
• **Unique Employees**[45]	807	852	863
Type and Number of Operating Beds:			
• **Acute**	34	34	34
• **Mental Health**	10	10	10
• **Community Living Center**	104	104	104
• **Domiciliary**	112	112	112
Average Daily Census:			
• **Acute**	14	14	12
• **Mental Health**	5	4	4
• **Community Living Center**	56	52	53
• **Domiciliary**	88	87	73

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.

[40] 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 7, 2017 from http://opes.vssc.med.va.gov/FacilityComplexityLevels/Pages/default.aspx
[41] Associated with a medical residency program.
[42] October 1, 2013 through September 30, 2014.
[43] October 1, 2014 through September 30, 2015.
[44] October 1, 2015 through September 30, 2016.
[45] Unique employees involved in direct medical care (cost center 8200).

VA Outpatient Clinic Profiles[46]

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[47] 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[48] Provided	Diagnostic Services[49] Provided	Ancillary Services[50] Provided
Rapid City, SD	568GA	9,954	6,706	Cardiology Endocrinology Gastroenterology Infectious Disease Neurology Pulmonary/ Respiratory Disease General Surgery Gynecology	NA	Nutrition Pharmacy Social Work Weight Management
Pierre, SD	568GB	2,114	334	Cardiology Endocrinology Hematology/ Oncology Infectious Disease Podiatry	Laboratory and Pathology	Nutrition Pharmacy Weight Management
Newcastle, WY	568HA	101	36	NA	NA	NA
Gordon, NE	568HB	206	118	NA	NA	NA
Pine Ridge, SD	568HF	97	108	Endocrinology	NA	NA
Scottsbluff, NE	568HH	3,512	1,102	Endocrinology Poly-Trauma Anesthesia	NA	Nutrition Pharmacy Social Weight Management
Mission, SD	568HJ	368	NA	NA	NA	NA
McLaughlin, SD	568HK	NA	130	NA	NA	Nutrition

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

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

[46] Includes all outpatient clinics in the community that were in operation before February 15, 2017.
[47] An encounter is a professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition.
[48] Specialty care services refer to non-primary care and non-MH services provided by a physician.
[49] Diagnostic services include EKG, EMG, laboratory, nuclear medicine, radiology, and vascular lab services.
[50] Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services[51] Provided	Diagnostic Services[52] Provided	Ancillary Services[53] Provided
Eagle Butte, SD	568HM	620	91	Endocrinology	NA	Nutrition Social Work
Winner, SD	568HP	1,492	110	Cardiology Amputation Follow-up	Laboratory and Pathology	Nutrition Social Work

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

VHA Policies Beyond Recertification Dates

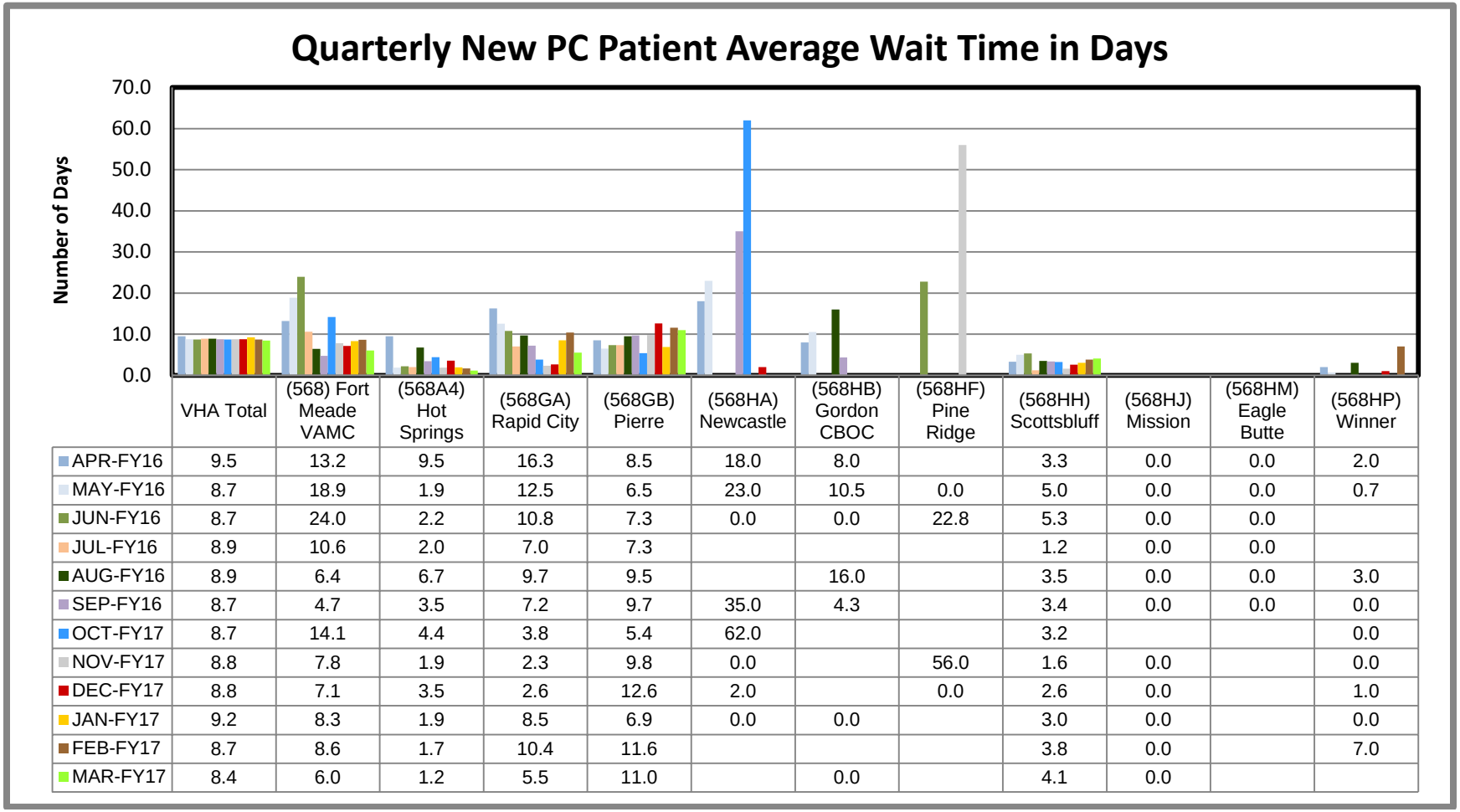
In this report, OIG cited three policies that were beyond the recertification date:

1. VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010 (recertification due date June 30, 2015).
2. VHA Handbook 1105.04, *Fluoroscopy Safety*, July 6, 2012 (recertification due date July 31, 2017).
3. 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.[54]

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),[55] 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."[56] 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."[57]

[54] 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.
[55] VHA Directive 6330(1), *Controlled National Policy/Directives Management System*, June 24, 2016, amended January 11, 2017.
[56] VA Under Secretary for Health. "Validity of VHA Policy Document." Memorandum. June 29, 2016.
[57] Ibid.

Patient Aligned Care Team Compass Metrics

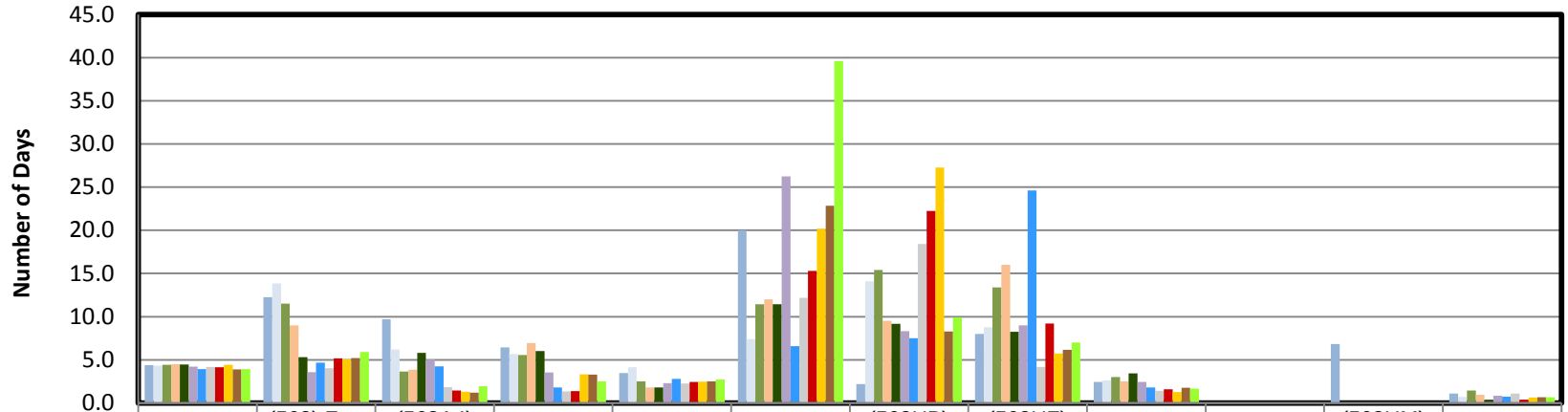


	VHA Total	(568) Fort Meade VAMC	(568A4) Hot Springs	(568GA) Rapid City	(568GB) Pierre	(568HA) Newcastle	(568HB) Gordon CBOC	(568HF) Pine Ridge	(568HH) Scottsbluff	(568HJ) Mission	(568HM) Eagle Butte	(568HP) Winner
APR-FY16	9.5	13.2	9.5	16.3	8.5	18.0	8.0		3.3	0.0	0.0	2.0
MAY-FY16	8.7	18.9	1.9	12.5	6.5	23.0	10.5	0.0	5.0	0.0	0.0	0.7
JUN-FY16	8.7	24.0	2.2	10.8	7.3	0.0	0.0	22.8	5.3	0.0	0.0	
JUL-FY16	8.9	10.6	2.0	7.0	7.3				1.2	0.0	0.0	
AUG-FY16	8.9	6.4	6.7	9.7	9.5		16.0		3.5	0.0	0.0	3.0
SEP-FY16	8.7	4.7	3.5	7.2	9.7	35.0	4.3		3.4	0.0	0.0	0.0
OCT-FY17	8.7	14.1	4.4	3.8	5.4	62.0			3.2			0.0
NOV-FY17	8.8	7.8	1.9	2.3	9.8	0.0		56.0	1.6	0.0		0.0
DEC-FY17	8.8	7.1	3.5	2.6	12.6	2.0		0.0	2.6	0.0		1.0
JAN-FY17	9.2	8.3	1.9	8.5	6.9	0.0	0.0		3.0	0.0		0.0
FEB-FY17	8.7	8.6	1.7	10.4	11.6				3.8	0.0		7.0
MAR-FY17	8.4	6.0	1.2	5.5	11.0		0.0		4.1	0.0		

Source: VHA Support Service Center.

Note: We did not assess VA's data for accuracy or completeness. We have on file the facility's explanation for the increased wait times for Newcastle and Pine Ridge.

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

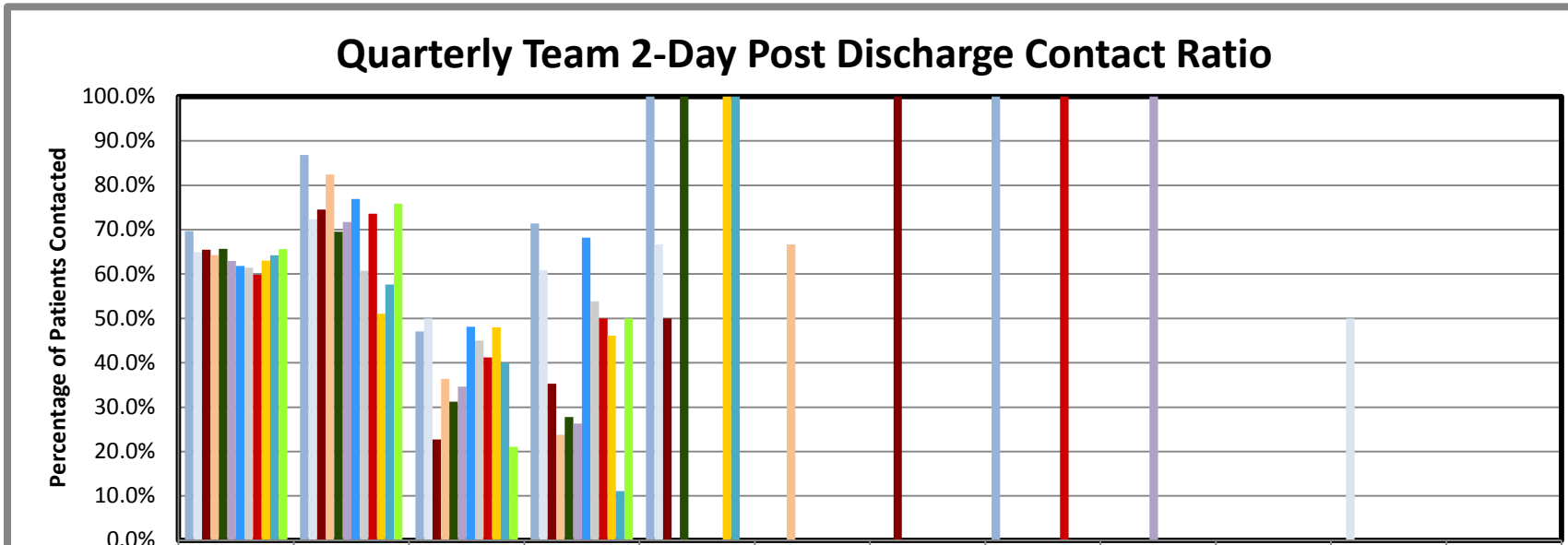


	VHA Total	(568) Fort Meade VAMC	(568A4) Hot Springs	(568GA) Rapid City	(568GB) Pierre	(568HA) Newcastle	(568HB) Gordon CBOC	(568HF) Pine Ridge	(568HH) Scottsbluff	(568HJ) Mission	(568HM) Eagle Butte	(568HP) Winner
APR-FY16	4.4	12.2	9.7	6.4	3.5	20.0	2.2	8.0	2.4	0.0	6.8	1.1
MAY-FY16	4.3	13.8	6.2	5.7	4.2	7.4	14.1	8.8	2.6	0.0	0.0	0.7
JUN-FY16	4.4	11.5	3.7	5.6	2.5	11.4	15.4	13.4	3.0	0.0	0.0	1.5
JUL-FY16	4.5	9.0	3.9	6.9	1.8	12.0	9.5	16.0	2.5	0.0	0.0	0.9
AUG-FY16	4.5	5.3	5.8	6.0	1.8	11.5	9.2	8.3	3.4	0.0	0.0	0.4
SEP-FY16	4.2	3.6	5.0	3.5	2.3	26.3	8.3	9.0	2.4	0.0	0.0	0.8
OCT-FY17	3.9	4.7	4.2	1.8	2.8	6.6	7.5	24.6	1.8	0.0		0.7
NOV-FY17	4.2	4.0	1.8	1.3	2.3	12.2	18.4	4.2	1.4	0.0		1.1
DEC-FY17	4.1	5.1	1.4	1.4	2.4	15.3	22.3	9.2	1.6	0.0		0.4
JAN-FY17	4.4	5.0	1.3	3.3	2.5	20.2	27.3	5.7	1.3	0.0		0.6
FEB-FY17	3.9	5.2	1.2	3.3	2.5	22.9	8.3	6.2	1.7	0.0		0.7
MAR-FY17	3.9	5.9	2.0	2.5	2.7	39.6	9.9	7.0	1.7	0.0		0.7

Source: VHA Support Service Center.

Note: We did not assess VA's data for accuracy or completeness. We have on file the facility's explanation for the increased wait times for Newcastle, Gordon, and Pine Ridge.

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

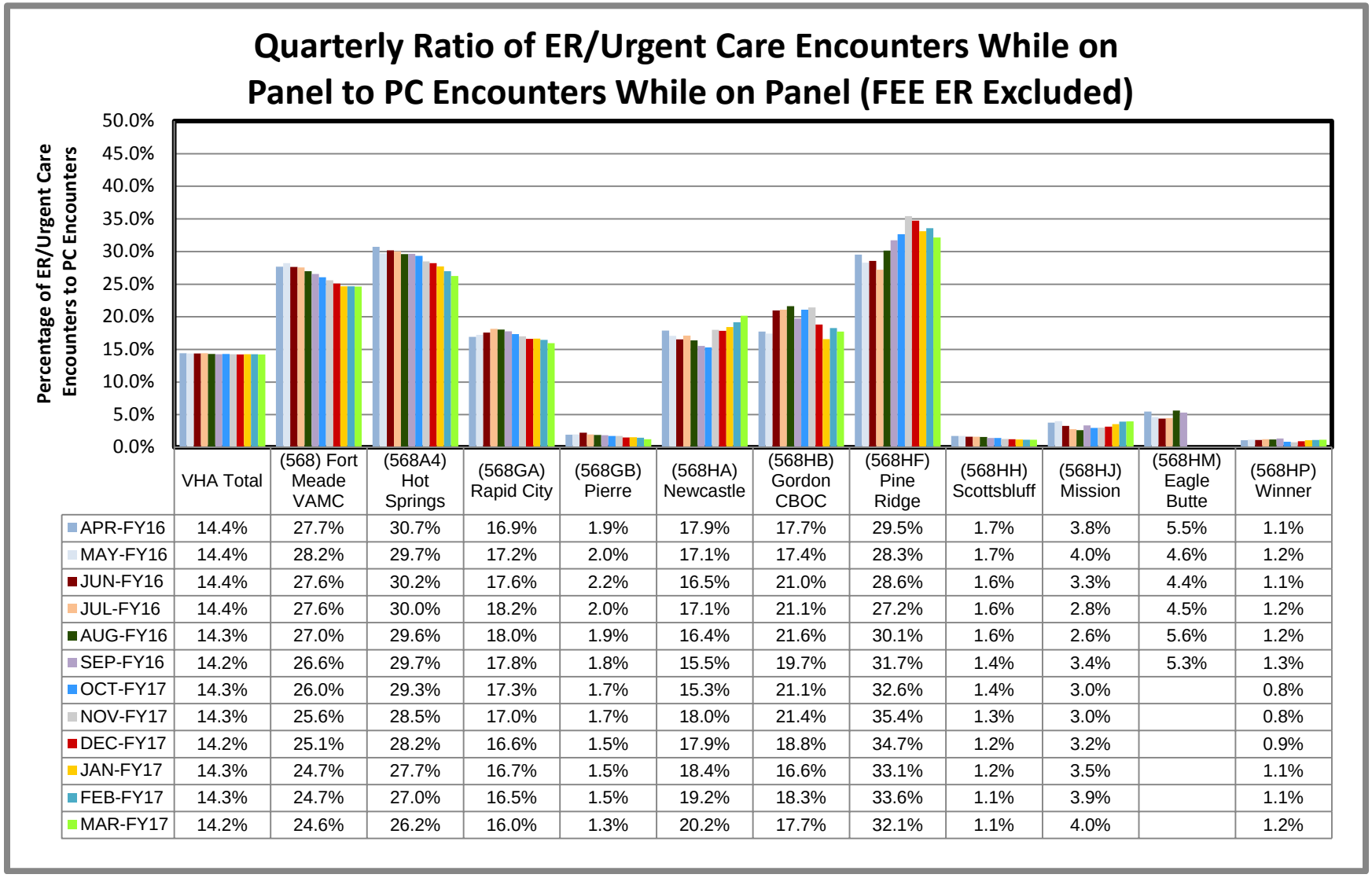


	VHA Total	(568) Fort Meade VAMC	(568A4) Hot Springs	(568GA) Rapid City	(568GB) Pierre	(568HA) Newcastle	(568HB) Gordon CBOC	(568HF) Pine Ridge	(568HH) Scottsbluff	(568HJ) Mission	(568HM) Eagle Butte	(568HP) Winner
APR-FY16	69.7%	86.8%	47.1%	71.4%	100.0%		0.0%	100.0%	0.0%	0.0%	0.0%	0.0%
MAY-FY16	65.0%	72.3%	50.0%	60.9%	66.7%	0.0%			0.0%		50.0%	0.0%
JUN-FY16	65.5%	74.5%	22.7%	35.3%	50.0%		100.0%			0.0%	0.0%	
JUL-FY16	64.3%	82.5%	36.4%	23.8%		66.7%	0.0%	0.0%			0.0%	0.0%
AUG-FY16	65.7%	69.6%	31.3%	27.8%	100.0%		0.0%	0.0%	0.0%	0.0%	0.0%	
SEP-FY16	62.9%	71.7%	34.6%	26.3%	0.0%			0.0%	100.0%		0.0%	0.0%
OCT-FY17	61.8%	76.9%	48.1%	68.2%		0.0%	0.0%					
NOV-FY17	61.4%	60.8%	45.0%	53.8%		0.0%		0.0%	0.0%			
DEC-FY17	59.8%	73.6%	41.2%	50.0%				100.0%				0.0%
JAN-FY17	63.0%	51.0%	48.0%	46.2%	100.0%	0.0%				0.0%		0.0%
FEB-FY17	64.2%	57.6%	40.0%	11.1%	100.0%				0.0%	0.0%		
MAR-FY17	65.6%	75.9%	21.1%	50.0%				0.0%	0.0%	0.0%		0.0%

Source: VHA Support Service Center.

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

Data Definition: The percent of assigned PC patients discharged from any VA facility who have been contacted by a PC team member within 2 business days during the reporting period. Patients are excluded if they are discharged from an observation specialty and/or readmitted within 2 business days to any VA facility. Team members must have been assigned to the patient's team at the time of the patient's discharge. 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	(568) Fort Meade VAMC	(568A4) Hot Springs	(568GA) Rapid City	(568GB) Pierre	(568HA) Newcastle	(568HB) Gordon CBOC	(568HF) Pine Ridge	(568HH) Scottsbluff	(568HJ) Mission	(568HM) Eagle Butte	(568HP) Winner
APR-FY16	14.4%	27.7%	30.7%	16.9%	1.9%	17.9%	17.7%	29.5%	1.7%	3.8%	5.5%	1.1%
MAY-FY16	14.4%	28.2%	29.7%	17.2%	2.0%	17.1%	17.4%	28.3%	1.7%	4.0%	4.6%	1.2%
JUN-FY16	14.4%	27.6%	30.2%	17.6%	2.2%	16.5%	21.0%	28.6%	1.6%	3.3%	4.4%	1.1%
JUL-FY16	14.4%	27.6%	30.0%	18.2%	2.0%	17.1%	21.1%	27.2%	1.6%	2.8%	4.5%	1.2%
AUG-FY16	14.3%	27.0%	29.6%	18.0%	1.9%	16.4%	21.6%	30.1%	1.6%	2.6%	5.6%	1.2%
SEP-FY16	14.2%	26.6%	29.7%	17.8%	1.8%	15.5%	19.7%	31.7%	1.4%	3.4%	5.3%	1.3%
OCT-FY17	14.3%	26.0%	29.3%	17.3%	1.7%	15.3%	21.1%	32.6%	1.4%	3.0%		0.8%
NOV-FY17	14.3%	25.6%	28.5%	17.0%	1.7%	18.0%	21.4%	35.4%	1.3%	3.0%		0.8%
DEC-FY17	14.2%	25.1%	28.2%	16.6%	1.5%	17.9%	18.8%	34.7%	1.2%	3.2%		0.9%
JAN-FY17	14.3%	24.7%	27.7%	16.7%	1.5%	18.4%	16.6%	33.1%	1.2%	3.5%		1.1%
FEB-FY17	14.3%	24.7%	27.0%	16.5%	1.5%	19.2%	18.3%	33.6%	1.1%	3.9%		1.1%
MAR-FY17	14.2%	24.6%	26.2%	16.0%	1.3%	20.2%	17.7%	32.1%	1.1%	4.0%		1.2%

Source: VHA Support Service Center.

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

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

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

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

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

Source: VHA Support Service Center.

Relevant OIG Reports

July 1, 2014 through January 1, 2018[58]

Healthcare Inspection – Communication and Quality of Care Concerns, VA Black Hills Health Care System, Fort Meade, South Dakota
7/8/2015 | *14-04491-394* | *Summary* | *Report*

Healthcare Inspection – Coordination and Delivery of Medical Care Concerns, VA Black Hills Health Care System, Fort Meade, South Dakota
8/20/2014 | *14-01467-256* | *Summary* | *Report*

Combined Assessment Program Review of the VA Black Hills Health Care System, Fort Meade, South Dakota
7/25/2014 | *14-01294-224* | *Summary* | *Report*

Community Based Outpatient Clinic and Primary Care Clinic Reviews at VA Black Hills Health Care System, Fort Meade, South Dakota
7/2/2014 | *14-00909-191* | *Summary* | *Report*

[58] 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: January 10, 2018

From: Director, VA Midwest Health Care Network (10N23)

Subject: **CHIP Review of the VA Black Hills Health Care System, Fort Meade, SD**

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

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

I have reviewed the draft report of the Office of Inspector General (OIG) and I concur with the recommendations from the CHIP review the week of August 27, 2017. The Health Care System has developed action plans to address the recommendations which are included in the attached comments.

Sincerely,

Janet P. Murphy, MBA

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: January 9, 2018

From: Director, VA Black Hills HCS, Fort Meade, SD (568/00)

Subject: **CHIP Review of the VA Black Hills Health Care System, Fort Meade, SD**

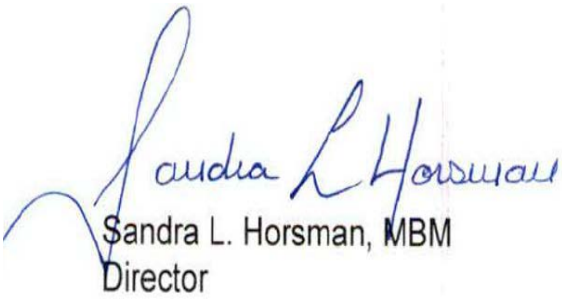
To: Director, VA Midwest Health Care Network (10N23)

I have reviewed the draft report of the Office of Inspector General (OIG) and I concur with the recommendations from the CHIP review the week of August 27, 2017. The Health Care System has developed action plans to address the recommendations which are included in the attached comments.

Thank you to the OIG Survey Team for the consultative visit. The recommendations will assists us in strengthening our processes to deliver consistent quality care to our Veterans.

Please contact me if you have additional questions or comments.

Sincerely,



Sandra L. Horsman, MBM
Director

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Other Contributors	Daisy Arugay-Rittenberg, MT Elizabeth Bullock Limin Clegg, PhD Stacy DePriest, LCSW; MSW LaFonda Henry, MSN, RN-BC Carol Lukasewicz, RN, BSN Jackelinne Melendez, MPH Larry Ross, Jr., MS Marilyn Stones, BS Mary Toy, MSN, RN

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U.S. House of Representatives: Don Bacon, Liz Cheney, Kevin Cramer, Jeff Fortenberry, Kristi Noem, Adrian Smith

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 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 Handbook 1006.1, *Planning and Activating Community-Based Outpatient Clinics*, May 19, 2004.
- 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 Directive 1131, *Management of Infectious Diseases and Infection Prevention and Control Programs*, November 7, 2017.
- VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013.
- VHA Directive 1330.01, *Health Care Services for Women Veterans*, February 15, 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.
- VA Handbook 6500, *Risk Management Framework for VA Information Systems – Tier 3: VA Information Security Program*, March 10, 2015.
- VHA Radiology Online Guide, http://vaww.infoshare.va.gov/sites/diagnosticservices/NRP/Mammography/Radiology%20Shared%20Files/Radiology_Service_Online_Guide_2016.docx, November 3, 2016.
- MH EOC Checklist, VA National Center for Patient Safety, http://vaww.ncps.med.va.gov/guidelines.html#mhc, accessed December 8, 2016.
- Various requirements of TJC, Association for the Advancement of Medical Instrumentation/Association for the Advancement of Medical Instrumentation, Occupational Safety and Health Administration, International Association of Healthcare Central Service Materiel Management, National Fire Protection Association.

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

[f] The references used for PTSD Care included:

- 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.

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

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

[h] The reference used for the SAIL metric definitions was:

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