Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 17-01764-143

Comprehensive Healthcare Inspection Program Review of the Tennessee Valley Healthcare System Nashville, Tennessee

March 27, 2018

Washington, DC 20420

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Glossary

CBOC	community based outpatient clinic
CHIP	Comprehensive Healthcare Inspection Program
CLC	Community Living Center
CNH	community nursing home
EHR	electronic health record
EOC	environment of care
facility	Tennessee Valley Healthcare 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
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 Tennessee Valley Healthcare System (facility). The review covers key clinical and administrative processes that are associated with promoting quality care.

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

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

This review was conducted during an unannounced visit made during the week of October 2, 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 Tennessee Valley Healthcare System, the leadership team consists of the Facility Director, Chief of Staff, Associate Director for Patient Care Services (Nurse Executive), Deputy Director, Associate Director, and Assistant Director. Organizational communication and accountability are carried out through a committee reporting structure with the Health System Governing Council having oversight for leadership groups such as the Medical Executive Board; Nurse Executive Board; and Quality, Safety, and Value Committee. The leaders are members of the Health System Governing Council through which they track, trend, and monitor quality of care and patient outcomes.

Except for the Assistant Director position that has been vacant since June 2016, OIG found that the executive leaders had been working together as a team since

January 2017. In the review of selected employee and patient survey results regarding facility senior leadership, OIG noted low satisfaction scores that reflected a greater need for active engagement with employees and patients. OIG also noted that facility leaders were implementing processes and plans to develop the workforce and improve 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 the Veterans Health Administration (VHA).[1]

Although the senior leadership team was knowledgeable about selected SAIL metrics, the leaders should continue to take significant actions to improve performance of the Quality of Care and Efficiency metrics likely contributing to the current 1-star rating. In the review of key care processes, OIG issued 15 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 five. These are briefly described below.

Quality, Safety, and Value. OIG found that senior managers were engaged with quality, safety, and value activities. When opportunities for improvement were identified, they supported clinical leaders' implementation of corrective actions and monitoring of effectiveness. OIG found general compliance with requirements for protected peer review and patient safety. However, OIG noted deficiencies with credentialing and privileging and utilization management processes.[2]

Medication Management. OIG found safe anticoagulation therapy management practices. However, OIG identified a deficiency in providing patient education specific to newly prescribed anticoagulation medications.

Coordination of Care. OIG noted that the facility developed and implemented a patient transfer policy. However, OIG identified deficiencies with transfer data analysis and reporting, transfer documentation, and staff/attending physician countersignature for acceptable designees.

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

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

Environment of Care. OIG noted compliance with requirements for general safety and privacy at the parent facility, representative community based outpatient clinic, and radiology areas. However, OIG identified issues with environment of care rounds frequency and attendance; parent facility cleanliness; radiology signage; and panic alarm testing and employee training on the locked mental health unit.

High-Risk Processes Related to Moderate Sedation. OIG found compliance with reporting and trending the use of reversal agents, availability of equipment and medications in moderate sedation procedure areas, post-procedure assessment documentation, and discharge practices. OIG identified deficiencies with history and physical examinations and pre-sedation assessment processes, informed consents, and training of clinical staff.

Summary

In the review of key care processes, OIG issued 15 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 48–49, and the responses within the body of the report for the full text of the Directors' comments.) OIG considers recommendation 10 closed. OIG will follow up on the planned actions for the open recommendations until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
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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 Tennessee Valley Healthcare System (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).

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

Source: VA OIG.

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

Methodology

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

The review covered operations for August 11, 2014[5] through October 2, 2017. OIG presented crime awareness briefings to 145 of the facility's 4,537 employees on November 14 and 15, 2017. These briefings covered procedures for reporting suspected criminal activity to OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

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

While onsite, OIG did not receive any concerns beyond the scope of a CHIP review. OIG conducted the inspection in accordance with OIG standard operating procedures for CHIP reviews and Quality Standards for Inspection and Evaluation published by the Council of the Inspectors General on Integrity and Efficiency.

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

Results and Recommendations

Leadership and Organizational Risks

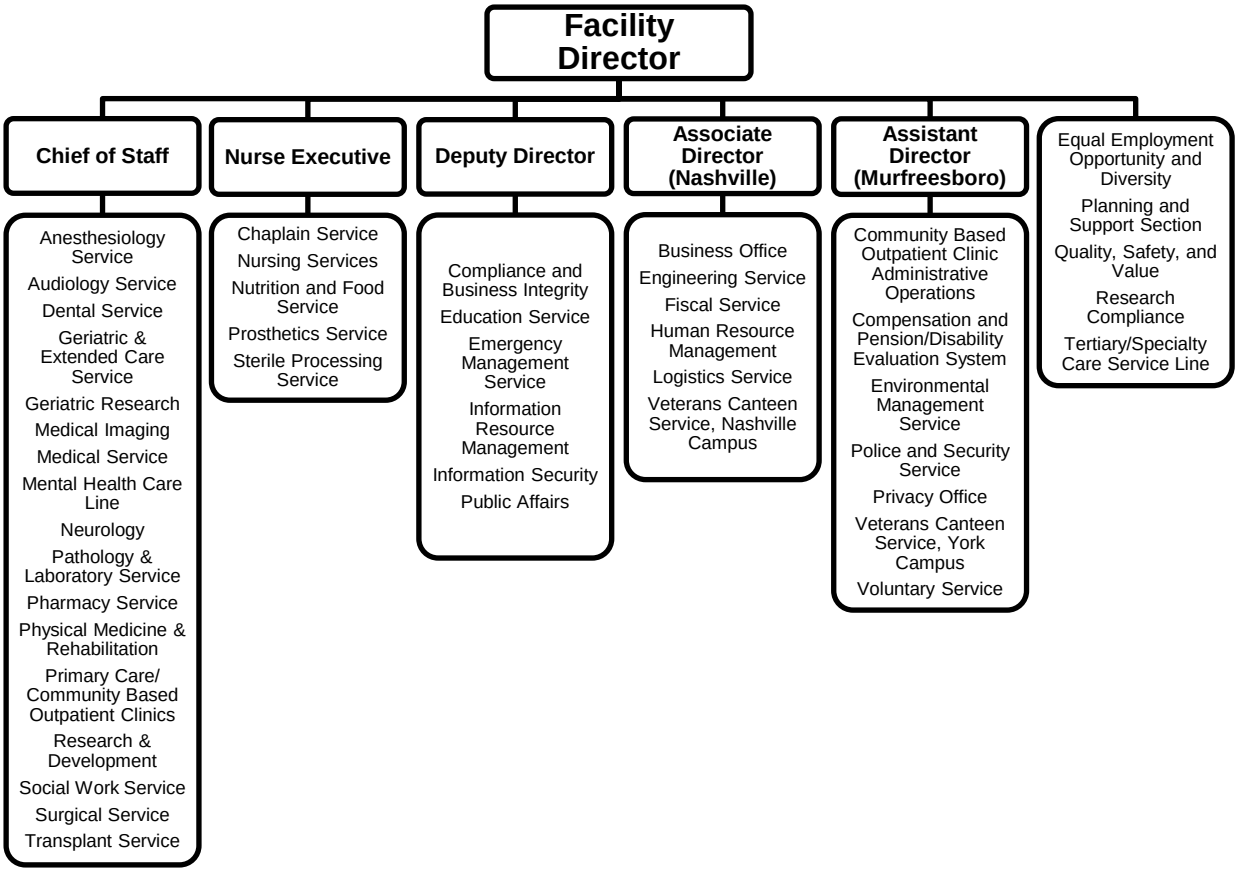
Stable and effective leadership is critical to improving care and sustaining meaningful change. Leadership and organizational risk issues can impact the facility's ability to provide care in all of the selected clinical areas of focus. The factors OIG considered in assessing the facility's risks and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

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

Executive Leadership Stability and Engagement. Because each VA facility organizes its leadership to address the needs and expectations of the local veteran population that it serves, the leadership organizational charts may differ between facilities. Figure 2 illustrates this facility's reported organizational structure. The facility has a leadership team consisting of the Facility Director, Chief of Staff, Associate Director for Patient Care Services (Nurse Executive), Deputy Director, Associate Director, and Assistant 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 the Assistant Director position has been vacant since June 2016, and the facility is currently recruiting for that position. With that one exception, the executive leaders had been working together as a team since January 2017.

Figure 2. Facility Organizational Chart



Source: Tennessee Valley Healthcare System (received October 4, 2017).

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

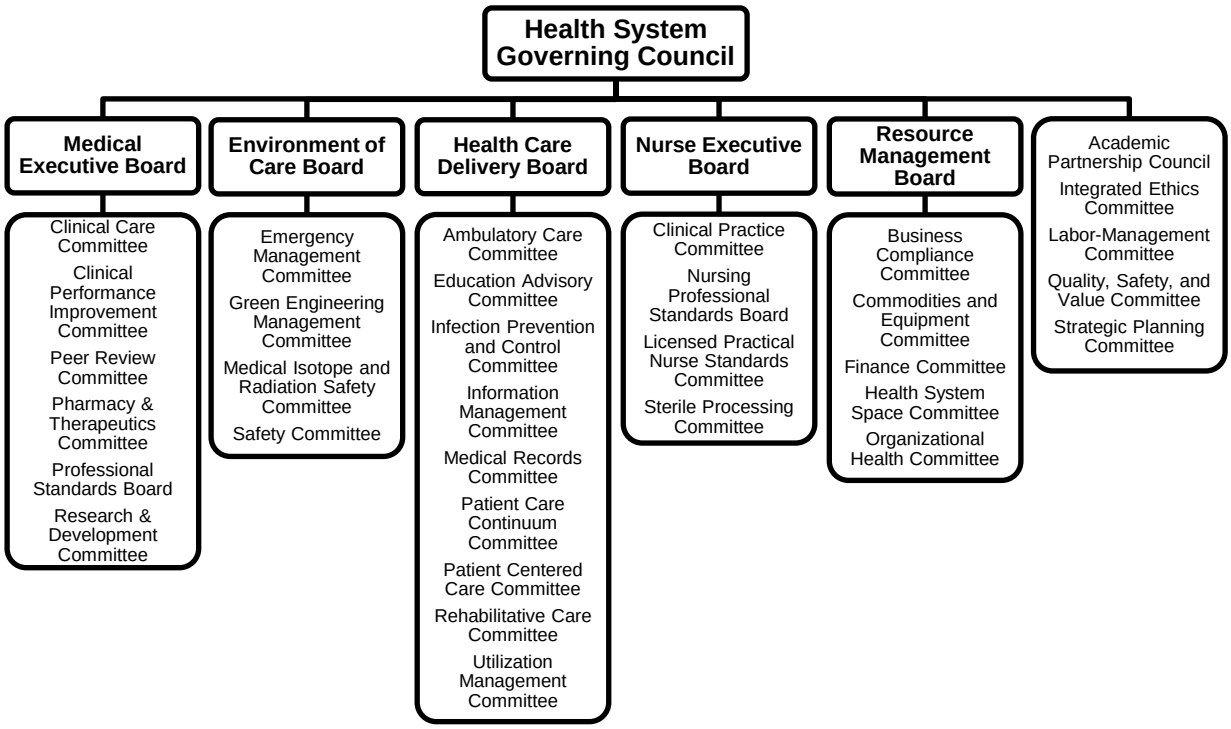
In individual interviews, these executive leaders generally were able to speak knowledgeably about actions taken during the previous 12 months in order to maintain or improve performance, employee and patient survey results, and selected Strategic Analytics for Improvement and Learning (SAIL) metrics. 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 Health System Governing Council[6]

[6] The facility established an updated governance structure on December 5, 2017. The Health System Governing Council was in place at the time of the onsite inspection.

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 Health System Governing Council oversees various working committees such as the Medical Executive Board; Nurse Executive Board; and Quality, Safety, and Value Committee. See Figure 3.

Figure 3. Facility Committee Reporting Structure



Source: Tennessee Valley Healthcare System (received October 4, 2017).

Employee Satisfaction and Patient Experience. To assess employee and patient attitudes toward facility senior leadership, OIG reviewed employee satisfaction and patient experience survey results that relate to the period of October 1, 2015 through September 30, 2016. Although OIG recognizes that employee satisfaction and patient experience survey data are subjective, they can be a starting point for discussions and indicate areas for further inquiry, which can be considered along with other information on facility leadership. Table 1 provides relevant survey results for VHA and the facility for the 12-month period. The facility leaders' results (Director's office average) and the facility average for both selected survey questions were rated below the VHA average.[7] Further, each of the four patient survey results reflected lower care ratings than the VHA

[7] 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.

average. In all, both employees and patients appear generally less satisfied with facility leadership and care provided when compared to that across VHA.

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[8]
All Employee Survey[9] Q59. How satisfied are you with the job being done by the executive leadership where you work?	1 (Very Dissatisfied) – 5 (Very Satisfied)	3.3	3.0	3.1
All Employee Survey Servant Leader Index Composite	0–100 where HIGHER scores are more favorable	66.7	62.4	55.5
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	65.0	
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	82.3	
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): I felt like a valued customer.		73.2	70.6	
Survey of Healthcare Experiences of Patients (outpatient specialty care): I felt like a valued customer.		73.8	67.2	

Accreditation/For-Cause[10] Surveys and Oversight Inspections. To further assess Leadership and Organizational Risks, OIG reviewed recommendations from previous inspections by oversight and accrediting agencies to gauge how well leaders respond to identified problems. Table 2 summarizes the relevant facility inspections most recently performed by the VA OIG and The Joint Commission (TJC). The facility has closed[11] all survey recommendations for improvement as listed in Table 2. OIG also noted the facility's current accreditation status with the Commission on Accreditation of

[8] Rating is based on responses by employees who report to the Director.
[9] 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.
[10] 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.
[11] 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.

Rehabilitation Facilities[12] and College of American Pathologists.[13] Additionally, the Long Term Care Institute[14] conducted an inspection 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 Tennessee Valley Healthcare System, Nashville, Tennessee, October 16, 2014)*	August 2014	20	0
VA OIG (*Community Based Outpatient Clinic and Primary Care Clinic Reviews at Tennessee Valley Healthcare System, Nashville, Tennessee, September 25, 2014)*	August 2014	13	0
TJC[15] • Hospital Accreditation • Behavioral Health Care Accreditation • Home Care Accreditation	October 2016	33 10 4	0 0 0

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 August 2014 Combined Assessment Program and Community Based Outpatient Clinic (CBOC) and Primary Care (PC) review inspections through the week of October 2, 2017.

[12] 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.
[13] 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.
[14] 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.
[15] TJC is an internationally accepted external validation that an organization has systems and processes in place to provide safe and quality oriented health care. TJC has been accrediting VHA facilities for more than 30 years. Compliance with TJC standards facilitates risk reduction and performance improvement.

Table 3. Summary of Selected Organizational Risk Factors[16] (May 2014 to April 24, 2017)

Factor	Number of Occurrences
Sentinel Events[17]	11
Institutional Disclosures[18]	10
Large-Scale Disclosures[19]	0

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

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

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

Measure	Reported Rate per 1,000 Hospital Discharges		
	VHA	VISN 9	Facility
Pressure Ulcers	0.55	0.59	0.58
Death among surgical inpatients with serious treatable conditions	103.31	97.30	42.55
Iatrogenic Pneumothorax	0.20	0.13	0.19
Central Venous Catheter-Related Bloodstream Infection	0.12	0.07	0.32
In Hospital Fall with Hip Fracture	0.08	0.05	0.00
Perioperative Hemorrhage or Hematoma	2.59	4.03	2.88
Postoperative Acute Kidney Injury Requiring Dialysis	1.20	0.00	0.00
Postoperative Respiratory Failure	6.31	6.81	0.00
Perioperative Pulmonary Embolism or Deep Vein Thrombosis	3.29	5.29	1.81
Postoperative Sepsis	4.45	8.44	3.68
Postoperative Wound Dehiscence	0.65	1.09	0.00
Unrecognized Abdominopelvic Accidental Puncture/Laceration	0.67	0.95	2.24

Source: VHA Support Service Center

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

Four of the Patient Safety Indicator measures (pressure ulcers, central venous catheter-related bloodstream infection, perioperative hemorrhage or hematoma, and unrecognized abdominopelvic accidental puncture/laceration) show an observed rate in excess of the observed rates for Veterans Integrated Service Network (VISN) 9 and/or VHA. Although the numerator for these measures are small (one to three patients), the facility reported the reasons for these observations were multifactorial, that care was reviewed for the identified patients, and no deficiencies were found in the care that was provided. Additionally facility leadership offered the following rationales for the excess in the overall observed rates.

- Insufficient training for staff
- Staffing shortages
- Inadequate clinician documentation
- Inaccurate coding
- Patient pre-existing comorbidities and pre-operative high risk status

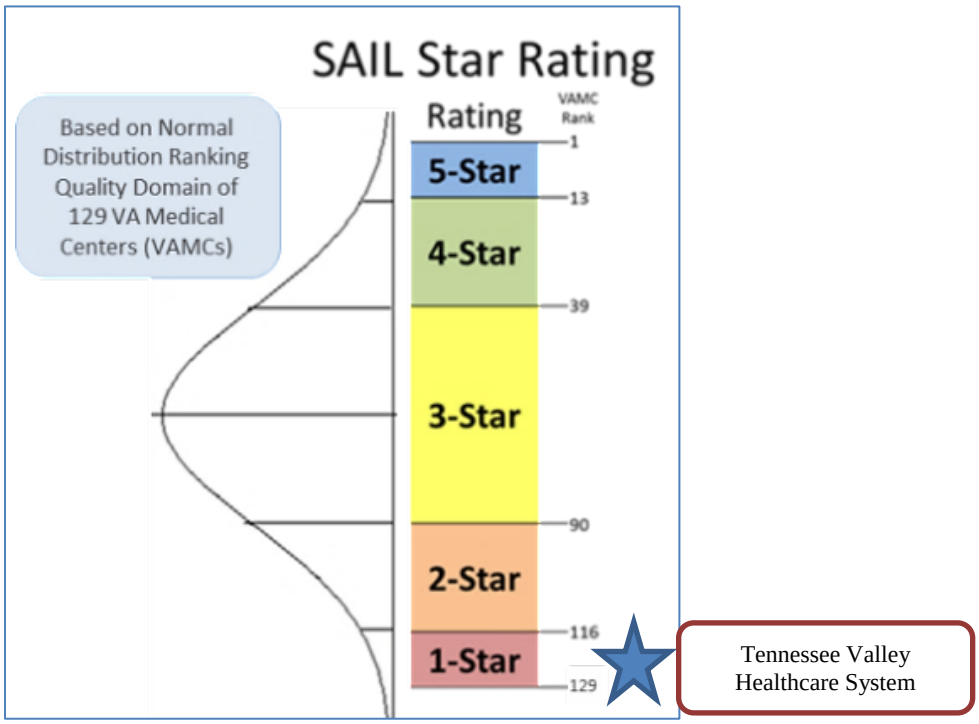
Veterans Health Administration Performance Data. The VA Office of Operational Analytics and Reporting adapted the SAIL Value Model to help define performance expectations within VA.[21] This model includes measures on health care quality, employee satisfaction, access to care, and efficiency, but the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

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

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

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

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



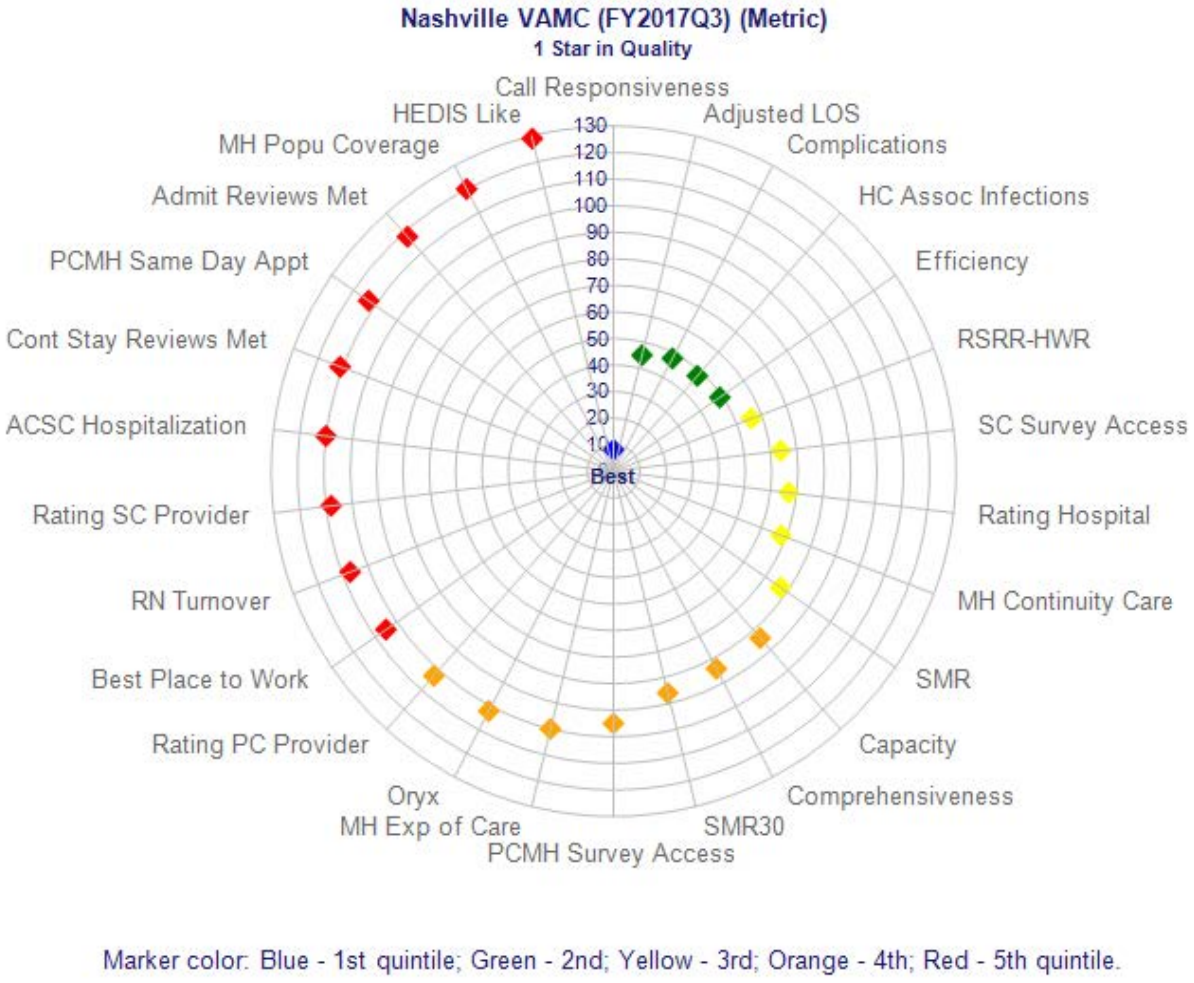
Source: VA Office of Informatics and Analytics' Office of Operational Analytics and Reporting.

Figure 5 illustrates the facility's Quality of Care and Efficiency metric rankings and performance compared to other VA facilities as of June 30, 2017. Of note, Figure 5 shows blue and green data points in the top quintiles that show high performance (for example, Call Responsiveness, Adjusted Length of Stay [LOS], and

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

Healthcare-Associated (HC Assoc) Infections). Metrics in the bottom quintiles reflect areas that need improvement and are denoted in orange and red (for example, Rating of Primary Care [PC] Provider, Continued (Cont) Stay Reviews Met, and Mental Health (MH) Population [Popu] Coverage).

Figure 5. Facility Quality of Care and Efficiency Metric Rankings (as of June 30, 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 a generally stable executive leadership to support patient safety, quality care, and other positive outcomes; however, opportunities exist to improve both patient experiences and employee attitudes towards leadership. 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.[23] The senior leadership team was knowledgeable about selected SAIL metrics but should continue to take significant actions to improve care and performance, particularly Quality of Care and Efficiency metrics likely contributing to the most current 1-star ranking.

[23] 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.[24] 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[25] of clinical care
3. Credentialing and privileging
4. Utilization management (UM) reviews[26]
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

[24] Department of Veterans Affairs, Veterans Health Administration. *Blueprint for Excellence*. September 2014.
[25] 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.
[26] According to VHA Directive 1117 (July 9, 2014), UM reviews evaluate the appropriateness, medical need, and efficiency of health care services according to evidence-based criteria.

- Credentialing and privileging processes
  - Considered frequency for Ongoing Professional Practice Evaluation (OPPE)[27] data review
  - Indicated a Focused Professional Practice Evaluation[28]
- UM personnel
  - Completed at least 75 percent of all required inpatient reviews
  - Documented Physician UM Advisors' decisions in the National UM Integration database
  - Reviewed UM data using an interdisciplinary group
- Patient safety personnel
  - Entered all reported patient incidents into the WEBSPOT database
  - Completed the required minimum of eight root cause analyses
  - Reported root cause analysis findings to reporting employees
  - Submitted an annual patient safety report

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

Credentialing and Privileging. VHA requires clinical managers to review OPPE data at a minimum of every six months.[29] The ongoing monitoring of privileged practitioners is essential to confirm the quality of care delivered and allows the facility to identify professional practice trends that impact patient safety. Nine of the 29 profiles did not contain evidence that service chiefs reviewed OPPE data every 6 months for these licensed independent practitioners. The Chief of Pathology was Acting Chief of Staff at the time of the site visit and was unable to provide reasons for noncompliance.

Recommendation

1. The Chief of Staff ensures clinical managers consistently review Ongoing Professional Practice Evaluation data every 6 months and monitors compliance.

[27] OPPE is the ongoing monitoring of privileged practitioners to identify professional practice trends that impact the quality of care and patient safety.
[28] 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.
[29] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012.

Facility Concurred

Target date for completion: September 29, 2018

To ensure compliance of the required OPPE data monitoring by the Clinical Service Managers, the Medical Staff Office will present OPPE/FPPE reports at every Professional Standards Board meeting. This report will include OPPE/FPPEs that are due for review within the next 90 days. This will allow service chiefs ample time to ensure reports are completed and returned to the Medical Staff Office. To ensure compliance the Medical Staff Office will select 5 random clinical service providers and request proof of up to date and current OPPE/FPPE information. Those services that are delinquent with providing OPPE/FPPE data timely will be reported to the Chief of Staff for further action. This action will be implemented immediately, and will be an ongoing and continuous monitoring program. The Medical Staff Office will provide a report to the Professional Standards Board on February 12, 2018, providing information to service chiefs of delinquent OPPE/FPPE reports. The Medical Staff Office will give service chiefs until May 1, 2018 to submit missing OPPE/FPPE reports. Additional guidance to service level administrative personnel will be provided to ensure proper OPPE/FPPE data is kept in each provider's 6 part folder. Any non-compliance issues will be addressed by the COS and documented in the MEC minutes. This will be monitored for two quarters with a goal of 90 percent compliance.

Utilization Management: Documentation of Decisions. VHA requires that Physician UM Advisors document their decisions regarding appropriateness of patient admission and continued stays in the National UM Integration database. This allows for national level UM data to be available for review by an interdisciplinary group to set benchmarks; identify trends, actions, and opportunities to improve efficiency; and monitor outcomes. The VISN collects and reports the data for Physician UM Advisors for the Nashville campus and the Alvin C. York campus separately and collectively. For 74 of the 107 cases (69 percent) referred to the physician advisors at the Alvin C. York campus from July 21, 2017 to September 20, 2017, there was no evidence that the advisors documented their decisions in the database. Reportedly, one of the Physician UM Advisors disagreed with the criteria and did not complete the reviews, and two other advisors were recently trained and did not yet have the experience or time to independently document their decisions in the database.

Recommendation

2. The Chief of Staff ensures Physician Utilization Management Advisors at the Alvin C. York campus consistently document their decisions in the National Utilization Management Integration database and monitors the advisors' compliance.

Facility Concurred.

Target date for completion: September 29, 2018

Facility response: The Nashville campus is developing a PUMA service for Medicine Service PUMA reviews. PUMA services will be staffed by hospitalists who are trained as PUMAs. PUMAs will complete the Talent Management System (TMS) training. PUMAs are also establishing weekly meetings scheduled with the UM nurses to standardize the language and approach to the PUMA review responses along with the schedule to assign the reviews. The Nashville PUMA service is currently covering the PUMA reviews for the Alvin C. York campus given that the PUMA at the York campus is on leave. The Chief of Staff is currently in the process of appointing a PUMA(s) at the Alvin C. York campus. The PUMA(s) will be completed with all training by February 28, 2018. Once the training is complete, the Alvin C. York PUMA(s) will cover the PUMA reviews for the Alvin C. York campus. The PUMAs at Alvin C. York will attend the weekly PUMA meetings that have been established with the Nashville PUMAs. The UM Committee meets monthly to review the UM data, including the percentage of PUMA reviews completed. The UM Committee will have representation of PUMAs from both the Nashville campus and the AIvin C. York campus. The UM Committee is chaired by the Deputy Chief of Staff. The UM Committee will monitor the percentage of PUMA reviews completed monthly. Any non-compliance issues with PUMA Training or timely decision documentation in the National Utilization Management Integration database will be addressed by the COS and documented in the UM minutes. This will be monitored for two quarters with a goal of 90 percent compliance.

Medication Management: Anticoagulation Therapy

Comprehensive medication management is defined as the standard of care that ensures clinicians individually assess each patient's medications to determine that each is appropriate for the patient, effective for the medical condition, safe given the comorbidities and other medications prescribed, and able to be taken by the patient as intended. From October 1, 2015 through September 30, 2016, more than 482,000 veterans received an anticoagulant,[30] or a blood thinner, which is a drug that works to prevent the coagulation or clotting of blood. TJC's National Patient Safety Goal (3.05.01) focuses on improving anticoagulation safety to reduce patient harm and states, "…anticoagulation medications are more likely than others to cause harm due to complex dosing, insufficient monitoring, and inconsistent patient compliance."

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

OIG reviewed relevant documents and the competency assessment records of seven employees actively involved in the anticoagulant program and interviewed key employees. Additionally, OIG reviewed the electronic health records (EHRs) of 31 randomly selected patients who were prescribed new anticoagulant medications from July 1, 2015 through June 30, 2016. The list below shows the performance indicators examined.

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

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

Conclusions. Generally, OIG noted safe anticoagulation therapy management practices for the many indicators listed above. However, OIG identified the following deficiency that warranted a recommendation for improvement.

Patient Education. VHA requires clinicians to deliver initial and ongoing patient and family education for newly prescribed anticoagulant medications, which includes the importance of follow-up monitoring, compliance issues, dietary restrictions, and potential for adverse drug reactions and interactions. Due to the high risk of adverse events, patient and/or family member education is essential to decrease the potential occurrence of bleeding, drug interactions, or other delayed pharmacological effects. OIG found no evidence of patient education specific to the newly prescribed anticoagulation medication in 10 of 31 EHRs (32 percent). Pharmacy managers were unaware that clinicians did not document patient education.

Recommendation

3. The Facility Director ensures clinicians document patient education for patients receiving anticoagulation medication and monitors compliance.

Facility Concurred.

Target date for completion: September 29, 2018

Facility Response: Inpatient nursing leadership added templated anticoagulation education verbiage with a mandatory checkbox to the nursing discharge note and discussed it in the Nursing Documentation Group on January 30, 2018. This templated section will incorporate all anticoagulants in a drop-down menu with specific education statements. For outpatients, a Direct Oral Anticoagulants (DOAC) stewardship policy was approved at the January 2018 Pharmacy and Therapeutics meeting. A DOAC specific policy for peripheral artery disease is being developed and will be presented at the Forms Committee February 12, 2018 with a go live date not to exceed May 1, 2018. Documentation will be completed as both will be mandatory check boxes and compliance will be reported to the Anticoagulation Subcommittee for both inpatients and outpatients. This will be monitored for two quarters with a goal of 100 percent compliance.

Coordination of Care: Inter-Facility Transfers

Coordination of care is the process of ensuring continuity of care, treatment, or services provided by a facility, which includes referring individuals to appropriate community resources to meet ongoing identified needs. Effective coordination of care also involves implementing a plan of care and avoiding unnecessary duplication of services. OIG selected a special focus on inter-facility transfers because they are frequently necessary to provide patients with access to specific providers or services. VHA has the responsibility to ensure that transfers into and out of its medical facilities are carried out appropriately under circumstances that provide maximum safety for patients and comply with applicable standards.

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

OIG reviewed relevant policies and facility data and interviewed key employees. Additionally, OIG reviewed the EHRs of 38 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. However, OIG identified the following deficiencies with data reporting, transfer documentation, and resident supervision that warranted recommendations for improvement.

Data Reporting. VHA requires facilities to collect and report data for patient inter-facility transfers, such as date of transfer, documentation of informed consent and medical or behavioral stability, and identification of transferring and receiving provider, as part of VHA's quality management program. The collection and reporting of data allows the facility to analyze and improve the inter-facility transfer process to maximize patient safety. Although the facility collected inter-facility transfer data, the data were not analyzed or reported to an identified quality oversight committee. Facility managers were aware of the requirement but failed to ensure that a responsible committee was assigned to analyze the data for quality improvement opportunities.

Recommendation

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

Facility Concurred.

Target date for completion: September 29, 2018

Facility Response: The Care in the Community (CITC) Clinical Program audits transfers monthly for date, informed consent, medical and psychological stability, and referring and accepting provider. We are expecting to maintain a 90 percent accuracy rate. These audits will be sent to the CITC Clinical Program Manager on the 5th of each month. The total number of monthly transfers will be sent to the Clinical Program Manager and SAIL Coordinator. Data will be reported to the Community Care Workgroup, who will monitor accuracy rates. This will be monitored for two quarters with a goal of 90 percent compliance.

Transfer Documentation. VHA requires transferring providers to complete VA Form 10-2649A and/or transfer/progress notes that include all required elements prior to or within a few hours after the transfer. This ensures the safe transfer of patients out of the VHA facilities. Provider transfer documentation did not include certain required elements such as patient or surrogate informed consent in 5 of the 37 applicable EHRs (14 percent). In addition, evaluation of medical or behavioral stability was not documented in 9 of the 38 EHRs (24 percent). Noncompliance with the requirements was attributed to part-time providers who were not fully aware of the VHA requirements for documentation of patient transfers. Clinical managers and transfer coordinators reported that electronic consent forms were not always available and that when hard copy consent forms were used, they were not scanned into the EHR in a timely manner.

Recommendation

5. The Chief of Staff ensures providers consistently document patient or surrogate informed consent and the patient's medical and behavior stability when patients are transferred out of the facility and monitors the providers' compliance.

Facility Concurred.

Target date for completion: September 29, 2018

Facility Response: The form itself was reviewed with all Emergency Department and Urgent Care Center providers to ensure that they were aware of the requirement to complete section 4 ("Condition of the Patient on Transfer"). TVHS will also add this to the orientation for medicine residents as they begin new rotation at TVHS so they will be aware of the required documentation. A recommendation will be made to the Medical Records Committee that different priority levels be established for scanning of documents into the electronic health record. Patient consent documents will be high priority and require scanning within 24 hours. Although nursing and medicine services will be covering the majority of the documentation and clinical work required, we will request that the administrative officer on duty do a final review of each patient packet prior to transfer to ensure that it is complete. A review will be done by QSV of 17 transfer records per month for 4 months. This will be monitored for two quarters with a goal of 90 percent compliance.

Transfer Documentation. VHA requires that when staff/attending physicians do not write transfer notes, acceptable designees obtain and document staff/attending physician approval and obtain countersignature on the notes. This ensures the decision to transfer patients out of VHA facilities was made by a credentialed provider. For four of the eight applicable patients, transfer notes written by acceptable designees did not include a staff/attending physician countersignature. Some providers were unaware of the countersignature requirements while others lacked attention to detail, and facility managers did not provide oversight.

Recommendation

6. The Chief of Staff ensures providers countersign the acceptable designees' transfer/progress notes when patients are transferred out of the facility and monitors compliance.

Facility Concurred.

Target date for completion: September 29, 2018

Facility Response: TVHS Medicine Service educated the Emergency Department and Urgent Care Center staff about the requirement for timely documentation of attending supervision and approval of any transfers. Since there are also transfers from the wards that can occur during off-tour hours, (e.g. 3 AM ST elevation myocardial infarction in a hospitalized patient), the residents will document in the electronic health record their conversation with the ward attending physician indicating approval of the emergent transfer. The Medicine Service will expect co-signature of such notes within twenty-four hours. A focused review will be done by QSV consisting of 17 transfer notes per month for 4 months to ensure timely documentation is achieved. This will be monitored for two quarters with a goal of 90 percent compliance.

Environment of Care

The purpose of this review was to determine whether the facility maintained a clean and safe health care environment in accordance with applicable requirements. OIG also determined whether the facility met requirements in selected areas that are often associated with higher risks of harm to patients, in this case, with a special emphasis on Radiology Service and the locked MH unit.[d]

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

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

OIG inspected two health care campus sites. The Nashville campus inspections included the Emergency Department, Radiology Service, and three inpatient units (medical cardiac care, 2N-medical, and 2G-surgical). The Alvin C. York campus inspections included Radiology Service, 10 inpatient units (medical intensive care, Community Living Center [CLC]-West [Patriot Cove/Patriot Haven], CLC-East [Caribbean Islands], CLC-7A, CLC-8B [long-term care psychiatry], CLC-1B, CLC-hospice, 1A-medical, and 7A and 7B inpatient MH), and the urgent care and women's health clinics. We also inspected the Albion Street CBOC. Additionally, OIG reviewed relevant documents and 16 employee training records and interviewed key employees and managers. The list below shows the performance indicators selected to examine the risk areas specific to particular settings.

<u>Nashville and Alvin C. York Facilities</u>

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

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

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

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

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

Conclusions. General safety, infection prevention, and privacy measures were in place at the parent facility, representative CBOC, and radiology areas. The locked MH unit had suicide prevention processes in place. However, OIG noted a lack of documentation for access by authorized individuals to the information technology closet at the Albion Street CBOC. Additionally, the VHA Women's Veteran Program Office conducted a site inspection at the facility on September 5, 2017, and identified a lack of feminine hygiene products throughout the system. In response to the VHA report, the facility developed an action plan to correct the deficiencies. The deficiencies are tracked within VISN 9 and VHA to completion. OIG did not note any issues with the availability of medical equipment and supplies. OIG identified the following deficiencies that warranted recommendations for improvement.

Parent Facility: Environment of Care Rounds. VHA requires EOC rounds to be conducted at a minimum of once per FY in non-patient care areas and twice per FY in patient care areas. Further, the Comprehensive EOC Assessment and Compliance Tool is used to collect all data associated with EOC rounds within facilities. EOC rounds assist in identifying potential patient safety risks and deficiencies. For FY 2016 and FY 2017 through August 24, 2017, the facility did not complete required inspections for 43 of 101 areas (43 percent) for the Nashville campus and 56 of 117 areas

(48 percent) for the Alvin C York campus. As a result, the facility was unable to ensure all potential patient safety risks and deficiencies were identified. Facility managers lacked proper knowledge on the use of the Comprehensive EOC Assessment and Compliance Tool which led to noncompliance.

Recommendation

7. The Associate Director ensures that environment of care rounds are conducted at the required frequency and correctly documented in the Comprehensive Environment of Care Assessment and Compliance Tool and monitors compliance.

Facility Concurred.

Target date for completion. May 31, 2018

Facility Response: We will continue using our weekly rounds schedule. All inspections will be reported monthly to the Environment of Care Board (EOCB). Make up days are built into the schedule, but ad-hoc inspections can be scheduled as needed. The Performance Logic Database is currently being investigated for obsolete folders. The Engineering Service will report inspection completion to the EOCB monthly. The EOCB will monitor until three sequential months demonstrates 90 percent compliance.

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.[33] From October 2016 through August 2017, 4 of 13 EOC core team members did not consistently attend EOC rounds. Facility managers were not aware that team attendance could be tracked and trended within the Comprehensive EOC Assessment and Compliance Tool and failed to monitor EOC rounds team attendance by alternative means to ensure compliance.

Recommendation

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

[33] According to VHA, core membership is composed of representatives from programmatic areas such as nursing, infection control, patient safety, and medical equipment management to ensure adherence to various program requirements. Further, all patient care areas of the hospital must be reviewed at least twice a year.

Facility Concurred.

Target date for completion. May 31, 2018

Facility Response: For FY18 (beginning October 2017), the EOCB voted to set the standard for all EOC Rounds inspectors at 90 percent attendance. This message was communicated via email and through the EOCB. Additionally, EOC Rounds attendance is now tracked and reviewed monthly on the EOCB Agenda (meets the 4th Tuesday of the month). The Life Safety Manager will collect attendance of EOC rounds, report data to EOCB monthly, and monitor until three sequential months demonstrates 90 percent compliance.

Parent Facility: Cleanliness. TJC requires hospitals to maintain a clean environment, continually monitor environmental conditions, and remediate conditions not meeting this requirement. This ensures a clean and safe health care environment to minimize the spread of infection and reduce or eliminate potential fire safety hazards. All 13 inpatient units across both campuses had dirty ventilation grills; and 8 of 13 inpatient units[34] had stained, dusty, cracked, or broken ceiling tiles. Although the checklist used by the EOC Rounds Interdisciplinary Team included observing ventilation grills and ceiling tiles for cleanliness, the staff touring the facility during OIG's inspection had no explanation why these deficiencies were not identified during rounds and corrected.

Recommendation

9. The Associate Director ensures ventilation grills are clean and ceiling tiles are properly maintained and monitors compliance.

[34] Medical cardiac care and 2G-surgical units at the Nashville campus and the medical intensive care, CLC-West, CLC-East, CLC-1B, CLC-hospice, and medical-1A units at the Alvin C. York campus.

Facility Concurred.

Target date for completion. May 31, 2018

Facility Response: EOC Rounds Inspectors were advised of Recommendation # 9, and advised that ventilation grills and diffusers will be observed on weekly EOC Rounds. Education included discussion of 3 Performance Logic items:

VA-EMT-010, Are vents, lights, and ceiling tiles free from dust, water stains, and mold?

VA-ENG-002, Are ceiling tiles stained or other signs of leaks?

VA-ENG-004, Are ceiling tiles missing/broken?

This effort will be monitored on Environmental Rounds Tracking and Action items (with 14 day closure metrics), where all areas in the hospital are inspected twice a year. Additional monitors will include the Service Quarterly EOC and TJC Checklist (internal checklist), that is required for all services. The ventilation grills and diffusers will be monitored for 4 months for a 90 percent compliance rate based on the percentage of patient care areas reviewed on EOC Rounds. Engineering Service is working with Logistics and Environmental Management Service (EMS) to purchase new equipment (high powered vacuums) for EMS. This product will aid the cleaning of vents and diffusers on ceilings. Estimated time to procure is 90 days, May 31, 2018. This will be monitored until three sequential months demonstrates 90 percent compliance.

Parent Facility: Radiology Signage. The Occupational Safety and Health Administration requires each radiation area to have conspicuously posted signs bearing the radiation caution symbol and warning. This ensures patient, staff, and visitor safety within the Radiology Service area. At the Alvin C. York Radiology Service area, OIG did not find the required signage on four procedure room doors. While knowledgeable of the safety signage requirement, radiology managers and staff failed to ensure required signage was present on the procedure room doors.

Recommendation

10. The Chief of Staff ensures radiation safety signage is posted in each radiation area and monitors compliance.

Facility Concurred.

Target date for completion. Request Closure

Facility Response: The Safety Manager investigated the issue with the Radiology Supervisor on January 30, 2018. Four rooms (G06, G08, G15, G17) all had 'X-ray in Use' signs recently installed.

Locked Mental Health Unit: Panic Alarm Testing. VHA requires that facilities ensure rapid response by VA Police to panic alarm activation within locked inpatient MH units to preserve both patient and staff safety. Panic alarm testing for locked inpatient MH

units is required to be monitored and documented in a log that includes VA Police response time. Although the facility performed panic alarm testing, VA Police response time was not documented. Locked MH unit managers and VA Police were unaware of the requirement.

Recommendation

11. The Associate Director ensures locked mental health unit panic alarm testing documentation includes VA Police response time and monitors compliance.

Facility Concurred.

Target date for completion. May 31, 2018

Facility Response: Nursing Service staff in each MH ward will institute a monthly no-notice panic alarm drill (not announced as a drill) and will document date, time of notification, VA police response time, and other remarks. Discussions will occur quarterly between the Nursing Service and the Police Service management teams to identify problem areas or other areas of concern. The Nursing Service will maintain documentation of monthly panic alarm drills and report all compliance to the Nursing Quality Improvement Committee. Nursing Service will continue to report these issues to the TVHS Nursing Quality Improvement Committee on a monthly basis. This will be monitored until three sequential months demonstrates 90 percent compliance.

Locked Mental Health Unit: Employee Training. VHA requires all staff who work on inpatient mental health units as well as members of the ISIT receive annual 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. For October 2016 through September 2017, OIG did not find evidence that 7 of the 14 Interdisciplinary Safety Inspection Team members completed the required training. Facility managers did not assign a responsible individual to monitor completion of training.

Recommendation

12. The Associate Director ensures all mental health unit employees and Interdisciplinary Safety Inspection Team members complete the required training on how to identify and correct environmental hazards, including the proper use of the Mental Health Environment of Care Checklist, and monitors compliance.

Facility Concurred.

Target date for completion. September 29, 2018

Facility Response: All personnel, clinical and non-clinical, who conduct MH EOC Checklist (MHEOCC) Rounds and provide care on the Mental Health wards will complete the MHEOCC training 1290945 for clinical staff and 1290950 for non-clinical staff, by March 7, 2018, at which time quarterly monitoring will begin, per the VHA Directive. All training rosters will be obtained by the supervisors, updated as staff rosters change, provided to Patient Safety quarterly, maintained in the associated areas for swift retrieval upon request, and reported to the Patient Safety Committee and Quality Safety Value Boards. This will be monitored until two sequential quarters demonstrates 90 percent compliance.

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.[35] 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.[36]

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.[37] During calendar year 2016, VHA clinicians performed more than 600,000 moderate sedation procedures, of which more than half were gastroenterology-related endoscopies.[38] To minimize risks, VHA and TJC have issued requirements and standards for moderate sedation care.

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

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

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

[35] American Society of Anesthesiologists (ASA), Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists, 2002. Anesthesiology 2002; 96:1004-17.
[36] 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.
[37] VHA Directive 1073, *Moderate Sedation by Non-Anesthesiology Providers*, December 30, 2014.
[38] Per VA Corporate Data Warehouse data pull on February 22, 2017.

- Performance of timeout[39] 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 reporting and trending the use of reversal agents, availability of equipment and medications in moderate sedation procedure areas, post-procedure assessment documentation, and discharge practices. OIG also identified the following deficiencies that warranted recommendations for improvement.

History and Physical Exams and/or Pre-Sedation Assessments. VHA requires that an appropriate history and physical is updated or completed within 30 days of the procedure for which moderate sedation will be administered and that the history and physical and/or the pre-sedation assessment include required elements. This ensures providers are aware of relevant patient information and assessments that may affect the patient's response to moderate sedation. In 14 of 47 EHRs (30 percent), providers did not complete a review of abnormalities of major organ systems. OIG noted that the moderate sedation template contained all required elements; however, due to a lack of attention to detail providers were not consistently documenting a review of organ systems relevant to the procedure (for example, respiratory status for a patient about to have sedating medications).

Recommendation

13. The Chief of Staff ensures that providers include review of abnormalities of major organ systems in the history and physical exams and/or pre-sedation assessments and monitors compliance.

Facility Concurred.

Target date for completion: September 29, 2018

Facility Response: We created a new template in the EHR that has all the required fields. Education was provided to all providers in the Gastrointestinal Lab on the new template. The Chief of Anesthesia will track compliance through the Moderate Sedation Workgroup. This will be monitored until two sequential quarters demonstrates 90 percent compliance.

Informed Consents. VHA requires that providers obtain and document informed consent prior to moderate sedation procedures. The informed consent must identify, by name and profession, the practitioner who has primary responsibility for the relevant aspect of the patient's care and the name and profession of any other individuals

[39] 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.

responsible for authorizing or performing the treatment or procedure. In addition, VHA requires that when it becomes necessary for a substitute practitioner to perform the procedure, the patient must be informed of the change, and the discussion and patient approval must be documented in the patient's EHR. This ensures the patient has been given the right to accept or refuse the substitute practitioner. In 6 of 47 EHRs (13 percent), the name of the provider listed on the informed consent did not match that of the provider who performed the procedure, and OIG found no evidence that the patient was informed of a change in provider. The Surgery Service Chief and facility managers reported that consents are usually obtained earlier during a clinic visit, and changes in providers were not caught or corrected during the timeout process prior to initiation of the procedures.

Recommendation

14. The Chief of Staff ensures that providers inform patients when the provider performing a moderate sedation procedure is not the provider listed on the informed consent for the procedure and document the patient's assent to the change and monitors compliance.

Facility Concurred.

Target date for completion: September 29, 2018

Facility Response: Providers are informing patients of all the possible physicians who have privileges and adding their names to the consent form. This will take care of any unforeseen events or coverage issues. It also gives the patient the opportunity to inquire about our physicians and ask any questions they may have. This applies to the procedure proper and the moderate sedation part. The cardiac catheterization laboratory will monitor every consent form prior to every procedure to ensure more than a 90 percent compliance rate (our goal is 100 percent compliance). The data collected will be kept in a spreadsheet on a VA computer and any deviation will be corrected before the procedure, preferably, and catalogued for review. This will be monitored until two sequential quarters demonstrates 90 percent compliance.

Moderate Sedation Training. VHA requires that an individual who administers, monitors, or supervises moderate sedation must demonstrate successful completion of Talent Management System moderate sedation test no more than 90 days before the privileging/re-privileging or scope of practice action. This ensures clinical staff have demonstrated sufficient knowledge to care and respond to an adverse event for a patient receiving moderate sedation. OIG did not find evidence of current Talent Management System moderate sedation training for the five applicable physicians reviewed. The physicians and the Surgical Service Chief were not aware of the training requirement, and there was no process in place to ensure providers performing moderate sedation completed the training.

Recommendation

15. The Chief of Staff ensures clinical employees who perform, assist with, or supervise moderate sedation procedures have current moderate sedation training and monitors their compliance.

Facility Concurred.

Target date for completion: July 31, 2018

Facility Response: Training for moderate sedation will be tracked by the Invasive Procedure Committee and reported up to the Patient Safety Board (PSB) by the chair of the CPR committee. Training statuses will be reported to the PSB on a monthly basis and the measure for compliance will be 100 percent per VHA requirements. Training will be tracked for 100 percent compliance rate. This will be monitored until three sequential months demonstrates 100 percent compliance.

Long-Term Care: Community Nursing Home Oversight

Since 1965, VHA has provided nursing home care under contracts. VHA facilities must integrate the Community Nursing Home (CNH) program into their quality improvement programs. The Facility Director establishes the CNH Oversight Committee, which reports to the chief clinical officer (Chief of Staff, Associate Director for Patient Care Services, or the equivalent) and includes multidisciplinary management-level representatives from social work, nursing, quality management, acquisition, and the medical staff. The CNH Oversight Committee must meet at least quarterly.[40] Local oversight of CNHs is achieved through annual reviews and monthly visits.

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

OIG interviewed key employees, reviewed relevant documents, and the results from CNH annual reviews completed July 5, 2015 through June 30, 2016. Additionally, OIG reviewed the EHRs of 43 randomly selected patients who received CNH care for more than 3 months during the timeframe July 1, 2015 through June 30, 2016. The list below shows the performance indicators OIG reviewed.

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

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

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

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	Fifteen 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[41] for Improvement**	**Recommendations for Improvement**
Quality, Safety, and Value	• Senior-level involvement in QSV/performance improvement committee • Protected peer review of clinical care • Credentialing and privileging • UM reviews • Patient safety incident reporting and root cause analyses	• Clinical managers consistently review OPPE data every 6 months.	• Physician UM Advisors at the Alvin C. York campus consistently document their decisions in the National UM Integration database.
Medication Management	• Anticoagulation management policies and procedures • Management of patients receiving new orders for anticoagulants o Prior to treatment o During treatment • Ongoing evaluation of the anticoagulation program • Competency assessment	• Clinicians document patient education for patients receiving anticoagulation medication.	None

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

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Coordination of Care	• Transfer policies and procedures • Oversight of transfer process • EHR documentation o Non-emergent transfers • Emergent transfers	• Providers consistently document patient or surrogate informed consent and the patient's medical and behavior stability when patients are transferred out of the facility.	• Inter-facility patient transfer data are analyzed and reported to an identified quality oversight committee. • Providers countersign the acceptable designees' transfer/progress notes when patients are transferred out of the facility.

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
	  • 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
		• Radiation safety signage is posted in each radiation area.	• EOC rounds are conducted at the required frequency and correctly documented in the Comprehensive EOC Assessment and Compliance Tool.
			• Required team members participate on EOC rounds.
			• Ventilation grills are clean and ceiling tiles are properly maintained.
			• Locked MH unit panic alarm testing documentation includes VA Police response time.
			• All MH unit employees and Interdisciplinary Safety Inspection Team members complete the required training on how to identify and correct environmental hazards, including the proper use of the MH EOC Checklist.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Environment of Care (continued)	• Inpatient MH o MH EOC inspections o Environmental suicide hazard identification o Employee training o Environmental safety o Infection prevention o Availability of medical equipment and supplies	(See previous page)	(See previous page)
High-Risk and Problem-Prone Processes: Moderate Sedation	• Outcomes reporting • Patient safety and documentation o Prior to procedure o After procedure • Staff training and competency o Monitoring equipment and emergency management	• Providers include review of abnormalities of major organ systems in the history and physical exams and/or pre-sedation assessments. • Providers inform patients when the provider performing a moderate sedation procedure is not the provider listed on the informed consent for the procedure and document the patient's assent to the change.	• Clinical employees who perform, assist with, or supervise moderate sedation procedures have current moderate sedation training.
Long-Term Care: Community Nursing Home Oversight	• CNH Oversight Committee and CNH program integration • EHR documentation o Patient hand-off o Clinical visits • CNH annual reviews	None	None

Facility Profile

The table below provides general background information for this high-complexity (1a)[42] affiliated[43] facility reporting to VISN 9.

Table 5. Facility Profile for Nashville (626) for October 1, 2013 through September 30, 2016

Profile Element	Facility Data FY 2014[44]	Facility Data FY 2015[45]	Facility Data FY 2016[46]
Total Medical Care Budget in Millions	$657.7	$756.1	$779.8
Number of:			
• **Unique Patients**	92,244	92,733	96,616
• **Outpatient Visits**	1,000,934	1,059,171	1,101,150
• **Unique Employees**[47]	3,320	3,542	3,698
Type and Number of Operating Beds:			
• **Acute**	165	165	165
• **Mental Health**	76	76	76
• **Community Living Center**	178	178	165
• **Domiciliary**	34	34	34
Average Daily Census:			
• **Acute**	132	116	119
• **Mental Health**	55	42	42
• **Community Living Center**	132	120	128
• **Domiciliary**	14	24	25

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.

[42] VHA medical centers are classified according to a facility complexity model; 1a designation indicates a facility with high volume, high-risk patients, most complex clinical programs, and large research and teaching programs. Retrieved September 7, 2017, from http://opes.vssc.med.va.gov/FacilityComplexityLevels/Pages/default.aspx.
[43] Associated with a medical residency program.
[44] October 1, 2013 through September 30, 2014.
[45] October 1, 2014 through September 30, 2015.
[46] October 1, 2015 through September 30, 2016.
[47] Unique employees involved in direct medical care (cost center 8200).

VA Outpatient Clinic Profiles[48]

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 below provides information relative to each of the clinics.

Table 6. VA Outpatient Clinic Workload/Encounters[49] and Specialty Care, Diagnostic, and Ancillary Services Provided for Fiscal Year 2016

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services[50] Provided	Diagnostic Services[51] Provided	Ancillary Services[52] Provided
Dover, TN	626GA	3,548	954	Endocrinology Blind Rehab Anesthesia	n/a	Pharmacy Social Work Weight Management
Bowling Green, KY	626GC	8,613	2,414	Endocrinology Blind Rehab Eye Anesthesia	n/a	Nutrition Pharmacy Social Work Weight Management
Clarksville, TN	626GE	16,638	8,909	Endocrinology Blind Rehab Rehab Physician Eye Anesthesia	EKG Radiology	Dental Nutrition Pharmacy Social Work Weight Management
Chattanooga, TN	626GF	27,779	16,899	Cardiology Endocrinology Gastroenterology Hematology/ Oncology Infectious Disease Neurology Amputation Follow-up Blind Rehab Eye Anesthesia General Surgery Gynecology Orthopedics Podiatry	EKG Laboratory and Pathology Nuclear Medicine Radiology	Dental Nutrition Pharmacy Social Work Weight Management

[48] Includes all outpatient clinics in the community that were in operation before February 15, 2017. We have omitted Nashville, TN (626QA); Nashville, TN (626QB); Chattanooga, TN (626QC); and Murfreesboro, TN (626QD), as no workload/encounters or services were reported.
[49] An encounter is a professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition.
[50] Specialty care services refer to non-primary care and non-MH services provided by a physician.
[51] Diagnostic services include EKG, EMG, laboratory, nuclear medicine, radiology, and vascular lab services.
[52] Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services Provided	Diagnostic Services Provided	Ancillary Services Provided
Arnold Air Force Base, TN	626GG	2,347	594	Endocrinology Blind Rehab Eye	Radiology	Nutrition Pharmacy Social Work
Cookeville, TN	626GH	7,532	3,759	Dermatology Endocrinology Amputation Follow-up Blind Rehab Eye Anesthesia	Laboratory and Pathology	Nutrition Pharmacy Social Work Weight Management
Hopkinsville, KY	626GJ	7,145	6,591	Endocrinology Blind Rehab Rehab Physician Eye Anesthesia General Surgery	n/a	Nutrition Pharmacy Social Work Weight Management
McMinnville, TN	626GK	4,369	1,600	Endocrinology Blind Rehab Eye Anesthesia	n/a	Nutrition Pharmacy Social Work Weight Management
Harriman, TN	626GL	2,353	1,413	Endocrinology Blind Rehab Eye Anesthesia	Laboratory and Pathology	Nutrition Weight Management
Columbia, TN	626GM	5,866	877	Endocrinology Blind Rehab Eye Anesthesia General Surgery	n/a	Nutrition Pharmacy Weight Management
Athens, TN	626GN	3,394	696	Endocrinology Blind Rehab Eye Anesthesia	Laboratory and Pathology	Nutrition Pharmacy Social Work Weight Management
Nashville, TN	626GO	131	6	n/a	n/a	Nutrition Pharmacy

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

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

n/a: Not applicable

VHA Policies Beyond Recertification Dates

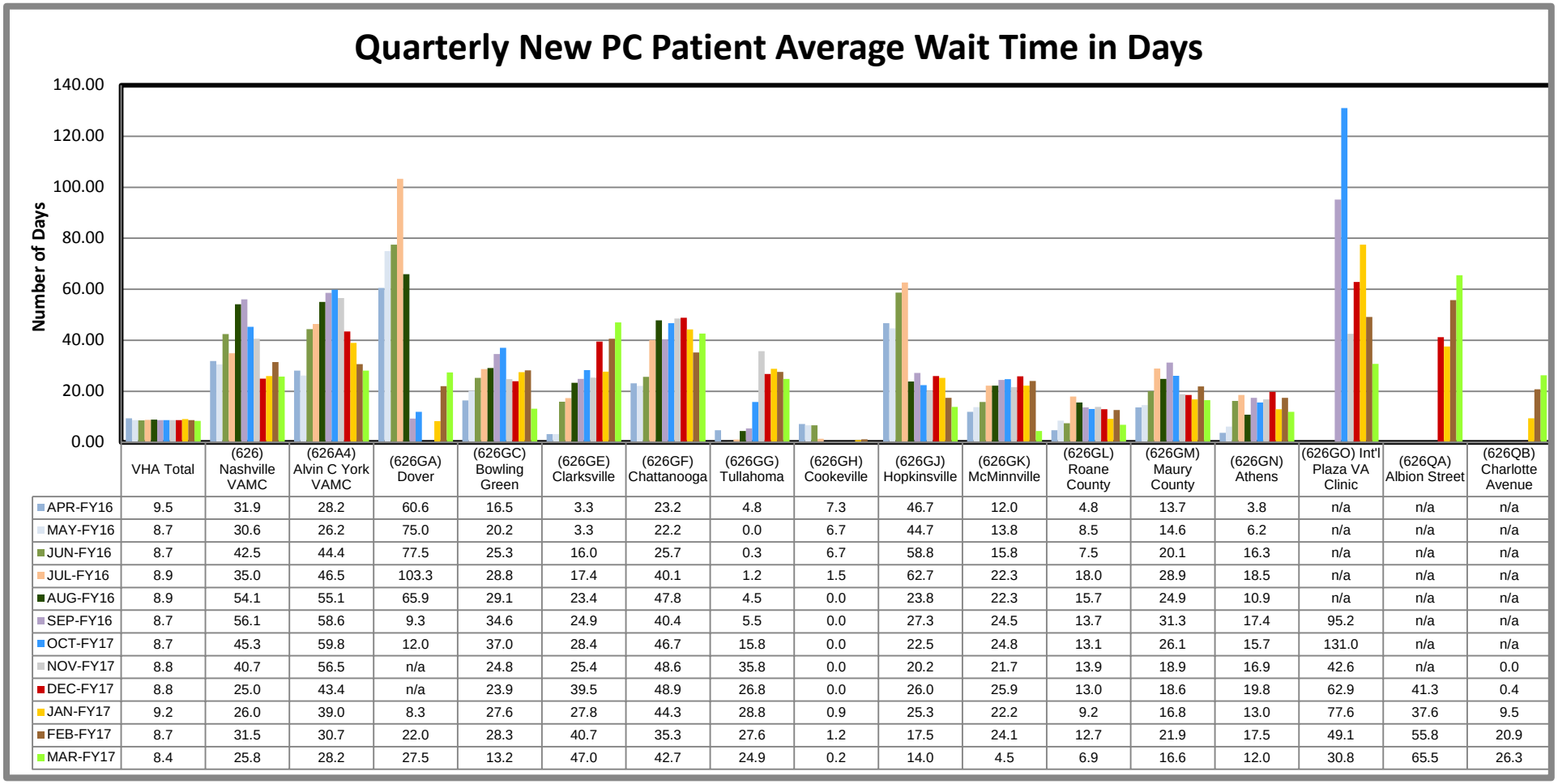
In this report, OIG cited two policies that were beyond the recertification date:

1. VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010 (recertification due date June 30, 2015).
2. VHA Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures*, June 4, 2004 (recertification due date January 31, 2009).

OIG considered these policies to be in effect, as they had not been superseded by more recent policy or guidance. In a June 29, 2016, memorandum to supplement policy provided by VHA Directive 6330(1),[53] 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."[54] 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."[55]

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

Patient Aligned Care Team Compass Metrics

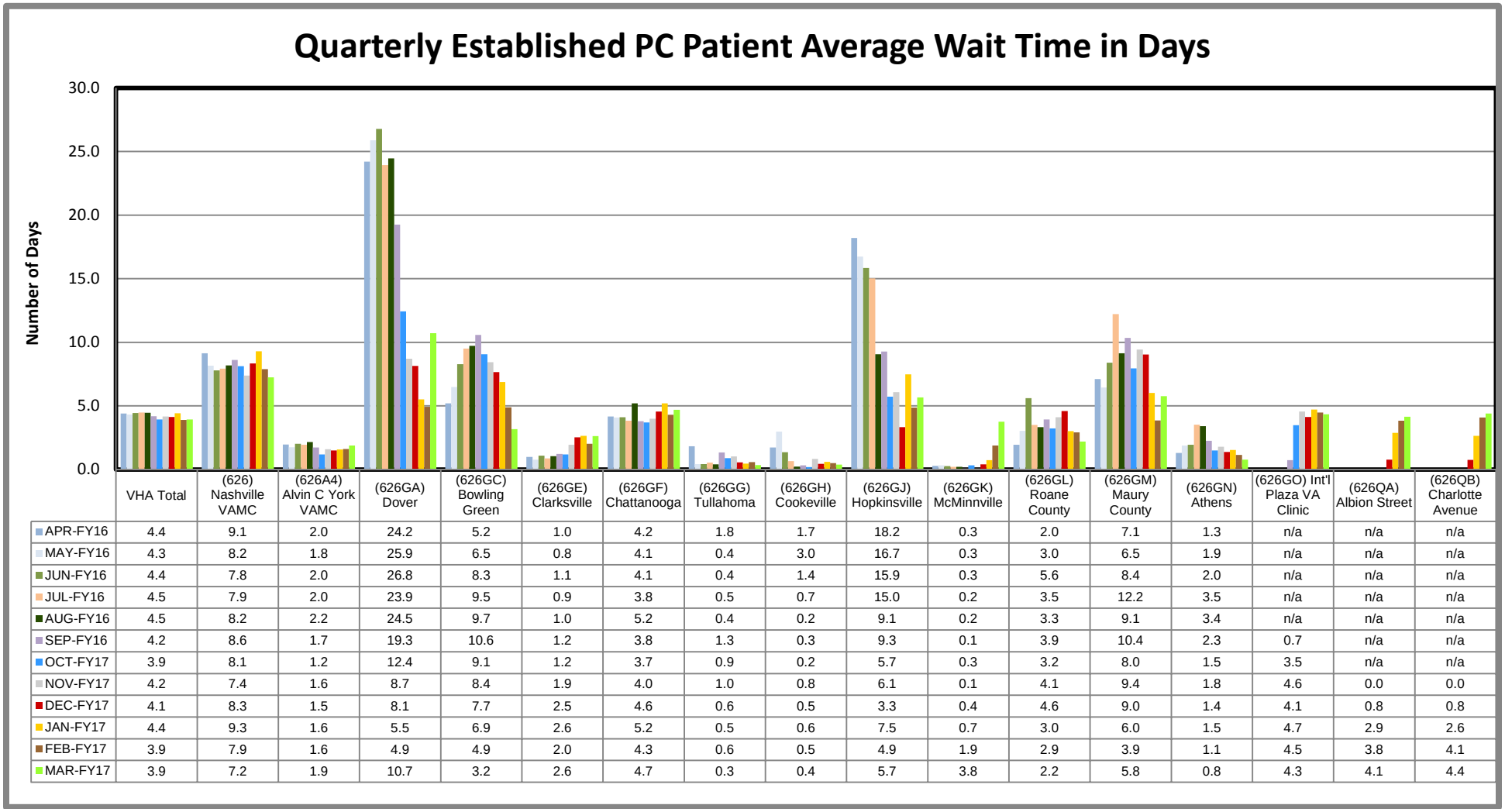


	VHA Total	(626) Nashville VAMC	(626A4) Alvin C York VAMC	(626GA) Dover	(626GC) Bowling Green	(626GE) Clarksville	(626GF) Chattanooga	(626GG) Tullahoma	(626GH) Cookeville	(626GJ) Hopkinsville	(626GK) McMinnville	(626GL) Roane County	(626GM) Maury County	(626GN) Athens	(626GO) Int'l Plaza VA Clinic	(626QA) Albion Street	(626QB) Charlotte Avenue
APR-FY16	9.5	31.9	28.2	60.6	16.5	3.3	23.2	4.8	7.3	46.7	12.0	4.8	13.7	3.8	n/a	n/a	n/a
MAY-FY16	8.7	30.6	26.2	75.0	20.2	3.3	22.2	0.0	6.7	44.7	13.8	8.5	14.6	6.2	n/a	n/a	n/a
JUN-FY16	8.7	42.5	44.4	77.5	25.3	16.0	25.7	0.3	6.7	58.8	15.8	7.5	20.1	16.3	n/a	n/a	n/a
JUL-FY16	8.9	35.0	46.5	103.3	28.8	17.4	40.1	1.2	1.5	62.7	22.3	18.0	28.9	18.5	n/a	n/a	n/a
AUG-FY16	8.9	54.1	55.1	65.9	29.1	23.4	47.8	4.5	0.0	23.8	22.3	15.7	24.9	10.9	n/a	n/a	n/a
SEP-FY16	8.7	56.1	58.6	9.3	34.6	24.9	40.4	5.5	0.0	27.3	24.5	13.7	31.3	17.4	95.2	n/a	n/a
OCT-FY17	8.7	45.3	59.8	12.0	37.0	28.4	46.7	15.8	0.0	22.5	24.8	13.1	26.1	15.7	131.0	n/a	n/a
NOV-FY17	8.8	40.7	56.5	n/a	24.8	25.4	48.6	35.8	0.0	20.2	21.7	13.9	18.9	16.9	42.6	n/a	0.0
DEC-FY17	8.8	25.0	43.4	n/a	23.9	39.5	48.9	26.8	0.0	26.0	25.9	13.0	18.6	19.8	62.9	41.3	0.4
JAN-FY17	9.2	26.0	39.0	8.3	27.6	27.8	44.3	28.8	0.9	25.3	22.2	9.2	16.8	13.0	77.6	37.6	9.5
FEB-FY17	8.7	31.5	30.7	22.0	28.3	40.7	35.3	27.6	1.2	17.5	24.1	12.7	21.9	17.5	49.1	55.8	20.9
MAR-FY17	8.4	25.8	28.2	27.5	13.2	47.0	42.7	24.9	0.2	14.0	4.5	6.9	16.6	12.0	30.8	65.5	26.3

Source: VHA Support Service Center.

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

Data Definition: 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 FY15, this metric was calculated using the earliest possible create date.* The absence of reported data is indicated by "n/a."



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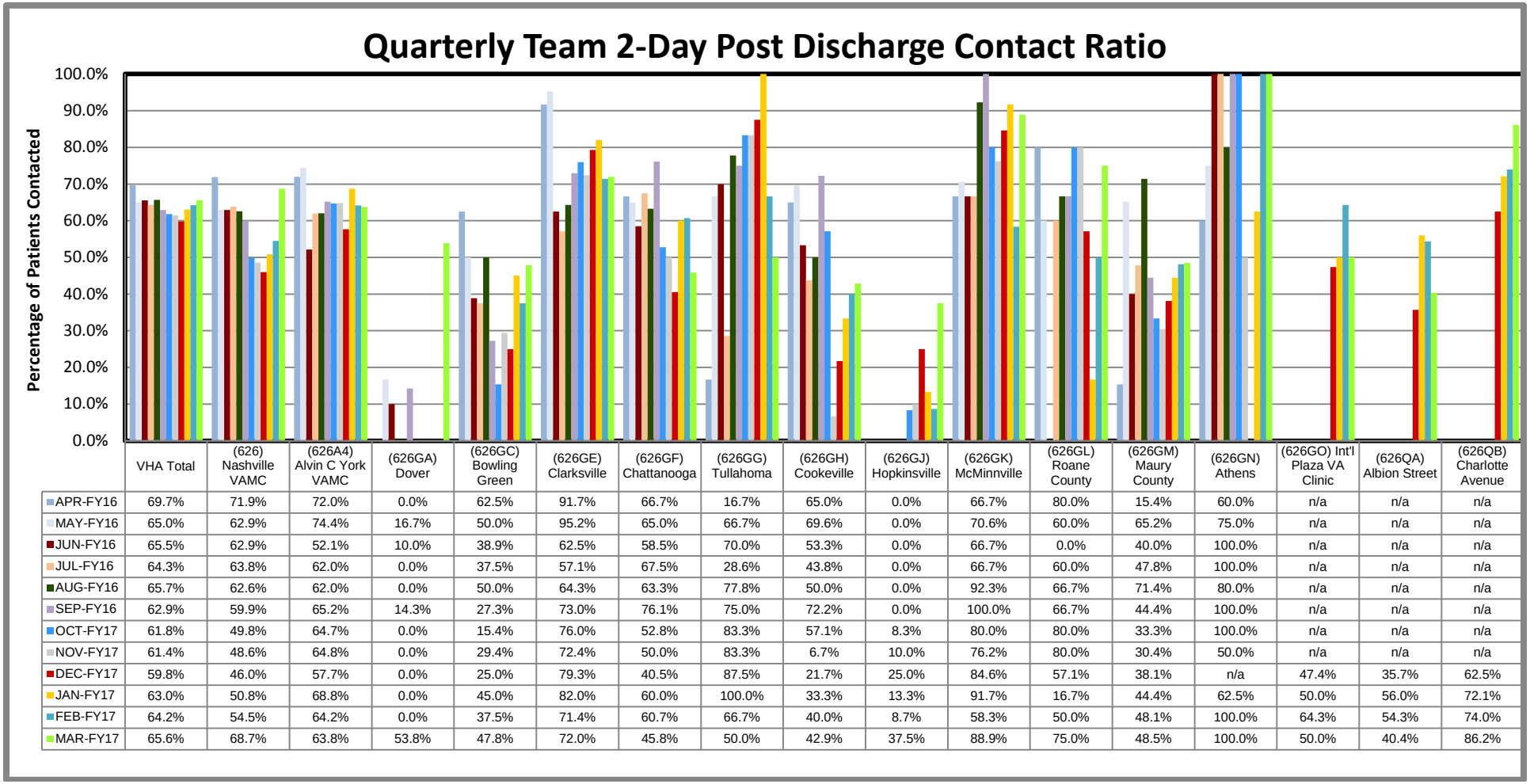
APR-FY16	4.4	9.1	2.0	24.2	5.2	1.0	4.2	1.8	1.7	18.2	0.3	2.0	7.1	1.3	n/a	n/a	n/a
MAY-FY16	4.3	8.2	1.8	25.9	6.5	0.8	4.1	0.4	3.0	16.7	0.3	3.0	6.5	1.9	n/a	n/a	n/a
JUN-FY16	4.4	7.8	2.0	26.8	8.3	1.1	4.1	0.4	1.4	15.9	0.3	5.6	8.4	2.0	n/a	n/a	n/a
JUL-FY16	4.5	7.9	2.0	23.9	9.5	0.9	3.8	0.5	0.7	15.0	0.2	3.5	12.2	3.5	n/a	n/a	n/a
AUG-FY16	4.5	8.2	2.2	24.5	9.7	1.0	5.2	0.4	0.2	9.1	0.2	3.3	9.1	3.4	n/a	n/a	n/a
SEP-FY16	4.2	8.6	1.7	19.3	10.6	1.2	3.8	1.3	0.3	9.3	0.1	3.9	10.4	2.3	0.7	n/a	n/a
OCT-FY17	3.9	8.1	1.2	12.4	9.1	1.2	3.7	0.9	0.2	5.7	0.3	3.2	8.0	1.5	3.5	n/a	n/a
NOV-FY17	4.2	7.4	1.6	8.7	8.4	1.9	4.0	1.0	0.8	6.1	0.1	4.1	9.4	1.8	4.6	0.0	0.0
DEC-FY17	4.1	8.3	1.5	8.1	7.7	2.5	4.6	0.6	0.5	3.3	0.4	4.6	9.0	1.4	4.1	0.8	0.8
JAN-FY17	4.4	9.3	1.6	5.5	6.9	2.6	5.2	0.5	0.6	7.5	0.7	3.0	6.0	1.5	4.7	2.9	2.6
FEB-FY17	3.9	7.9	1.6	4.9	4.9	2.0	4.3	0.6	0.5	4.9	1.9	2.9	3.9	1.1	4.5	3.8	4.1
MAR-FY17	3.9	7.2	1.9	10.7	3.2	2.6	4.7	0.3	0.4	5.7	3.8	2.2	5.8	0.8	4.3	4.1	4.4

Source: VHA Support Service Center.

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

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



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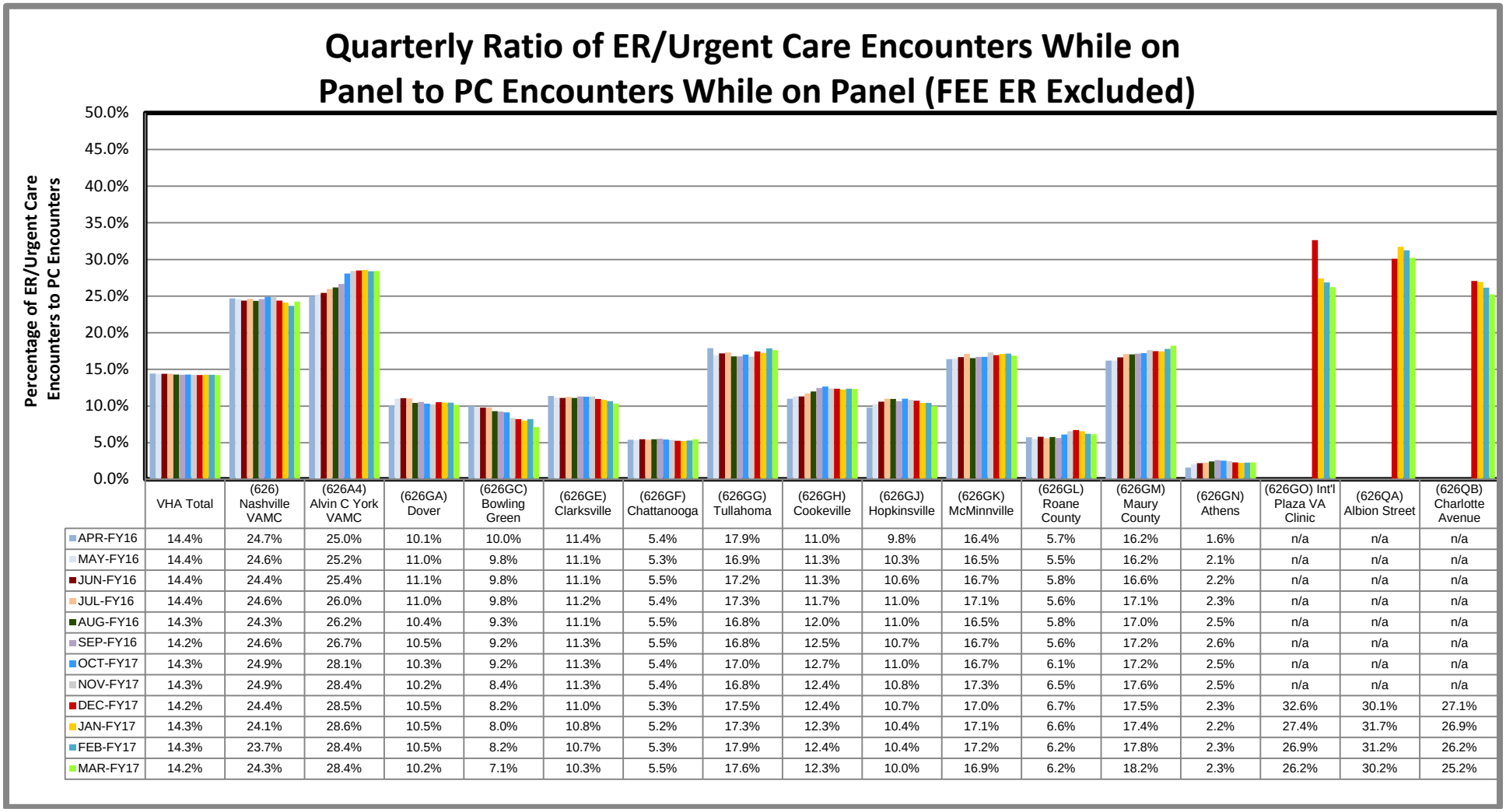
APR-FY16	69.7%	71.9%	72.0%	0.0%	62.5%	91.7%	66.7%	16.7%	65.0%	0.0%	66.7%	80.0%	15.4%	60.0%	n/a	n/a	n/a
MAY-FY16	65.0%	62.9%	74.4%	16.7%	50.0%	95.2%	65.0%	66.7%	69.6%	0.0%	70.6%	60.0%	65.2%	75.0%	n/a	n/a	n/a
JUN-FY16	65.5%	62.9%	52.1%	10.0%	38.9%	62.5%	58.5%	70.0%	53.3%	0.0%	66.7%	0.0%	40.0%	100.0%	n/a	n/a	n/a
JUL-FY16	64.3%	63.8%	62.0%	0.0%	37.5%	57.1%	67.5%	28.6%	43.8%	0.0%	66.7%	60.0%	47.8%	100.0%	n/a	n/a	n/a
AUG-FY16	65.7%	62.6%	62.0%	0.0%	50.0%	64.3%	63.3%	77.8%	50.0%	0.0%	92.3%	66.7%	71.4%	80.0%	n/a	n/a	n/a
SEP-FY16	62.9%	59.9%	65.2%	14.3%	27.3%	73.0%	76.1%	75.0%	72.2%	0.0%	100.0%	66.7%	44.4%	100.0%	n/a	n/a	n/a
OCT-FY17	61.8%	49.8%	64.7%	0.0%	15.4%	76.0%	52.8%	83.3%	57.1%	8.3%	80.0%	80.0%	33.3%	100.0%	n/a	n/a	n/a
NOV-FY17	61.4%	48.6%	64.8%	0.0%	29.4%	72.4%	50.0%	83.3%	6.7%	10.0%	76.2%	80.0%	30.4%	50.0%	n/a	n/a	n/a
DEC-FY17	59.8%	46.0%	57.7%	0.0%	25.0%	79.3%	40.5%	87.5%	21.7%	25.0%	84.6%	57.1%	38.1%	n/a	47.4%	35.7%	62.5%
JAN-FY17	63.0%	50.8%	68.8%	0.0%	45.0%	82.0%	60.0%	100.0%	33.3%	13.3%	91.7%	16.7%	44.4%	62.5%	50.0%	56.0%	72.1%
FEB-FY17	64.2%	54.5%	64.2%	0.0%	37.5%	71.4%	60.7%	66.7%	40.0%	8.7%	58.3%	50.0%	48.1%	100.0%	64.3%	54.3%	74.0%
MAR-FY17	65.6%	68.7%	63.8%	53.8%	47.8%	72.0%	45.8%	50.0%	42.9%	37.5%	88.9%	75.0%	48.5%	100.0%	50.0%	40.4%	86.2%

Source: VHA Support Service Center.

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

Data Definition: The percent of assigned PC patients discharged from any VA facility who have been contacted by a PC team member within 2 business days during the reporting period. Patients are excluded if they are discharged from an observation specialty and/or readmitted within 2 business days to any VA facility. Team members must have been assigned to the patient's team at the time of the patient's discharge. Team member identification is based on the primary provider on the encounter. Performance measure mnemonic "PACT17." The absence of reported data is indicated by "n/a."



	VHA Total	(626) Nashville VAMC	(626A4) Alvin C York VAMC	(626GA) Dover	(626GC) Bowling Green	(626GE) Clarksville	(626GF) Chattanooga	(626GG) Tullahoma	(626GH) Cookeville	(626GJ) Hopkinsville	(626GK) McMinnville	(626GL) Roane County	(626GM) Maury County	(626GN) Athens	(626GO) Int'l Plaza VA Clinic	(626QA) Albion Street	(626QB) Charlotte Avenue
APR-FY16	14.4%	24.7%	25.0%	10.1%	10.0%	11.4%	5.4%	17.9%	11.0%	9.8%	16.4%	5.7%	16.2%	1.6%	n/a	n/a	n/a
MAY-FY16	14.4%	24.6%	25.2%	11.0%	9.8%	11.1%	5.3%	16.9%	11.3%	10.3%	16.5%	5.5%	16.2%	2.1%	n/a	n/a	n/a
JUN-FY16	14.4%	24.4%	25.4%	11.1%	9.8%	11.1%	5.5%	17.2%	11.3%	10.6%	16.7%	5.8%	16.6%	2.2%	n/a	n/a	n/a
JUL-FY16	14.4%	24.6%	26.0%	11.0%	9.8%	11.2%	5.4%	17.3%	11.7%	11.0%	17.1%	5.6%	17.1%	2.3%	n/a	n/a	n/a
AUG-FY16	14.3%	24.3%	26.2%	10.4%	9.3%	11.1%	5.5%	16.8%	12.0%	11.0%	16.5%	5.8%	17.0%	2.5%	n/a	n/a	n/a
SEP-FY16	14.2%	24.6%	26.7%	10.5%	9.2%	11.3%	5.5%	16.8%	12.5%	10.7%	16.7%	5.6%	17.2%	2.6%	n/a	n/a	n/a
OCT-FY17	14.3%	24.9%	28.1%	10.3%	9.2%	11.3%	5.4%	17.0%	12.7%	11.0%	16.7%	6.1%	17.2%	2.5%	n/a	n/a	n/a
NOV-FY17	14.3%	24.9%	28.4%	10.2%	8.4%	11.3%	5.4%	16.8%	12.4%	10.8%	17.3%	6.5%	17.6%	2.5%	n/a	n/a	n/a
DEC-FY17	14.2%	24.4%	28.5%	10.5%	8.2%	11.0%	5.3%	17.5%	12.4%	10.7%	17.0%	6.7%	17.5%	2.3%	32.6%	30.1%	27.1%
JAN-FY17	14.3%	24.1%	28.6%	10.5%	8.0%	10.8%	5.2%	17.3%	12.3%	10.4%	17.1%	6.6%	17.4%	2.2%	27.4%	31.7%	26.9%
FEB-FY17	14.3%	23.7%	28.4%	10.5%	8.2%	10.7%	5.3%	17.9%	12.4%	10.4%	17.2%	6.2%	17.8%	2.3%	26.9%	31.2%	26.2%
MAR-FY17	14.2%	24.3%	28.4%	10.2%	7.1%	10.3%	5.5%	17.6%	12.3%	10.0%	16.9%	6.2%	18.2%	2.3%	26.2%	30.2%	25.2%

Source: VHA Support Service Center.

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

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

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

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

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

Source: VHA Support Service Center.

Relevant OIG Reports

September 1, 2014 through March 1, 2018[56]

Audit of VHA's Consolidated Patient Account Center Controls to Prevent Improper Billings for Service-Connected Conditions
8/9/2017 | *16-00589-264* | *Summary* | *Report*

Audit of VHA's Consolidated Mail Outpatient Pharmacy Program
11/2/2016 | *15-05255-422* | *Summary* | *Report*

Combined Assessment Program Review of the Tennessee Valley Healthcare System, Nashville, Tennessee
10/16/2014 | *14-02077-01* | *Summary* | *Report*

Community Based Outpatient Clinic and Primary Care Clinic Reviews at Tennessee Valley Healthcare System, Nashville, Tennessee
9/25/2014 | *14-00929-287* | *Summary* | *Report*

[56] 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: February 22, 2018

From: Director, MidSouth Healthcare Network (10N9)

Subject: **CHIP Review of the Tennessee Valley Healthcare System, Nashville, TN**

To: Director, Bay Pines Office of Healthcare Inspections (54SP)

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

1. I have reviewed and concur with the findings and recommendations in the CHIP Review of the Tennessee Valley Healthcare System.

2. Corrective action plans have been established with completion dates, as detailed in the attached report.

Cynthia Breyfogle, FACHE

Interim Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: February 22, 2018

From: Interim Director, Tennessee Valley Healthcare System (626/00)

Subject: **CHIP Review of the Tennessee Valley Healthcare System, Nashville, TN**

To: Director, MidSouth Healthcare Network (10N9)

1. I have reviewed and concur with the findings and recommendations in the report of the Tennessee Valley Healthcare System.

2. Corrective action plans have been established with completion dates, as detailed in the attached report.

Jennifer L Vedral.Baron, MN, ARNP, NP-ct, FAANP, FACHE
Health System Director

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

Endnotes

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

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

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

[d] The references used for EOC included:
- VHA 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.
- VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012.
- VA Handbook 6500, *Risk Management Framework for VA Information Systems – Tier 3: VA Information Security Program*, March 10, 2015.
- MH EOC Checklist, VA National Center for Patient Safety, http://vaww.ncps.med.va.gov/guidelines.html#mhc, accessed December 8, 2016.
- Various requirements of TJC, Association for the Advancement of Medical Instrumentation/Association for the Advancement of Medical Instrumentation, Occupational Safety and Health Administration, International Association of Healthcare Central Service Materiel Management, National Fire Protection Association.

[e] The references used for Moderate Sedation included:
- VHA Handbook 1004.01, *Informed Consent for Clinical Treatments and Procedures*, August 14, 2009.
- VHA Directive1039, *Ensuring Correct Surgery and Invasive Procedures*, July 26, 2013.
- VHA Directive 1073, *Moderate Sedation by Non-Anesthesia Providers*, December 30, 2014.
- VHA Directive 1177; *Cardiopulmonary Resuscitation, Basic Life Support, and Advanced Cardiac Life Support Training for Staff*; November 6, 2014.
- VA National Center for Patient Safety. *Facilitator's Guide for Moderate Sedation Toolkit for Non-Anesthesiologists*. March 29, 2011.
- American Society of Anesthesiologists. Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists. *Anesthesiology*. 2002; 96:1004–17.
- TJC. Hospital Standards. January 2016. PC.03.01.01, EP1 and MS.06.01.03 EP6.

[f] The references used for CNH Oversight included:

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

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

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