



**Department of Veterans Affairs
Office of Inspector General**

Office of Healthcare Inspections

Report No. 17-01849-42

**Comprehensive Healthcare
Inspection Program Review
of the
John D. Dingell VA Medical Center
Detroit, Michigan**

December 21, 2017

Washington, DC 20420

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Glossary

CHIP	Comprehensive Healthcare Inspection Program
CNH	community nursing home
EHR	electronic health record
EOC	environment of care
facility	John D. Dingell VA Medical Center
FY	fiscal year
MH	mental health
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
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Table of Contents

	Page
Report Overview	i
Purpose and Scope	1
Purpose	1
Scope.....	1
Methodology	2
Results and Recommendations	3
Leadership and Organizational Risks	3
Quality, Safety, and Value	15
Medication Management: Anticoagulation Therapy	18
Coordination of Care: Inter-Facility Transfers	21
Environment of Care	22
High-Risk Processes: Moderate Sedation	28
Long-Term Care: Community Nursing Home Oversight	30
Appendixes	
A. Summary Table of Comprehensive Healthcare Inspection Program Review Findings.....	32
B. Facility Profile and VA Outpatient Clinic Profiles	35
C. VHA Policies Beyond Recertification Dates.....	37
D. Patient Aligned Care Team Compass Metrics	38
E. Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions.....	42
F. Relevant OIG Reports	44
G. VISN Director Comments	45
H. Facility Director Comments.....	46
I. OIG Contact and Staff Acknowledgments	47
J. Report Distribution	48
K. Endnotes	49

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 John D. Dingell VA Medical Center (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 April 24, 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 John D. Dingell VA Medical Center, the leadership team consists of the Facility Director, Chief of Staff, Associate Director for Patient Care Services (Nurse Executive), and Associate Director. Organizational communication and accountability are carried out through a committee reporting structure with the Leadership Board and Quality Leadership Committee having oversight for leadership groups such as the Organizational Performance Improvement Committee, Clinical Executive Committee, Patient Safety Committee, and Environment of Care/Safety Committee. The leaders are members of the Leadership Board and Quality Leadership Committee through which they track, trend, and monitor quality of care and patient outcomes through these governance structures.

All leadership positions are currently permanently assigned. The most recent addition to the executive leadership team was the Associate Director who assumed the position in April 2017. The other leaders had been working together as a team since May 2014. In the review of selected employee and patient survey results regarding facility senior leadership, OIG noted employee ratings were generally satisfied, and patients appeared generally less than satisfied when compared to the VHA average. OIG also noted that facility leaders implemented processes and plans to improve satisfaction scores and perceptions of the facility.

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 identified multiple 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

The senior leadership team was knowledgeable about selected SAIL metrics but need to continue to take considerable actions to improve performance of selected SAIL metrics, particularly Quality of Care and Efficiency metrics likely contributing to the current 2-star rating. In the review of key care processes, OIG issued 10 recommendations that are attributable to the Chief of Staff, Nurse Executive, and Associate Director. Of the six areas of clinical operations reviewed, OIG noted findings in four. These are briefly described below.

Quality, Safety, and Value. OIG found that senior managers were engaged with quality, safety, and value activities. When opportunities for improvement were identified, they supported clinical leaders’ implementation of corrective actions and monitoring of effectiveness. OIG found general compliance with requirements for protected peer reviews,² utilization management,³ and patient safety. However, OIG noted a deficiency in credentialing and privileging.

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 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.

³ 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.

Medication Management. OIG found safe anticoagulation therapy management practices for many of the performance indicators examined, including development and implementation of anticoagulation management policies, risk minimization of dosing errors, and routine review of quality assurance data. However, OIG identified deficiencies in patient education and employee competency.

Environment of Care. Generally, OIG noted compliance with requirements for cleanliness and privacy at the parent facility and representative community based outpatient clinic inspected. The Radiology Department and locked mental health unit met most of the performance indicators examined. However, OIG identified deficiencies with environment of care rounds attendance, damaged furnishings, panic alarm testing, radiology equipment inspections and testing, and Interdisciplinary Safety Inspection Team training.

Long-Term Care. OIG found compliance with requirements for the Community Nursing Home Oversight Committee, program integration, and annual reviews. However, OIG identified a deficiency in clinical visits for patients residing in community nursing homes.

Summary

In the review of key care processes, OIG issued 10 recommendations that are attributable to the Chief of Staff, Nurse Executive, 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 45–46, and the responses within the body of the report for the full text of the Directors’ comments.) OIG will follow up on the planned actions until they are completed.



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Purpose and Scope

Purpose

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

Scope

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

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



Source: VA OIG.

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

Methodology

To determine compliance with Veterans Health Administration (VHA) requirements⁴ 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;⁵ 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 May 26, 2014⁶ through April 24, 2017, the date when an unannounced week-long site visit commenced. OIG presented crime awareness briefings on April 26, 2017, to 53 of the facility's 2,070 employees. These briefings covered procedures for reporting suspected criminal activity to OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

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

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

⁴ 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.

⁵ OIG did not review VHA's internal survey results but focused on OIG inspections and external surveys that affect facility accreditation status.

⁶ This is the date of the last Combined Assessment Program and/or Community Based Outpatient Clinic and Primary Care Clinic reviews.

Results and Recommendations

Leadership and Organizational Risks

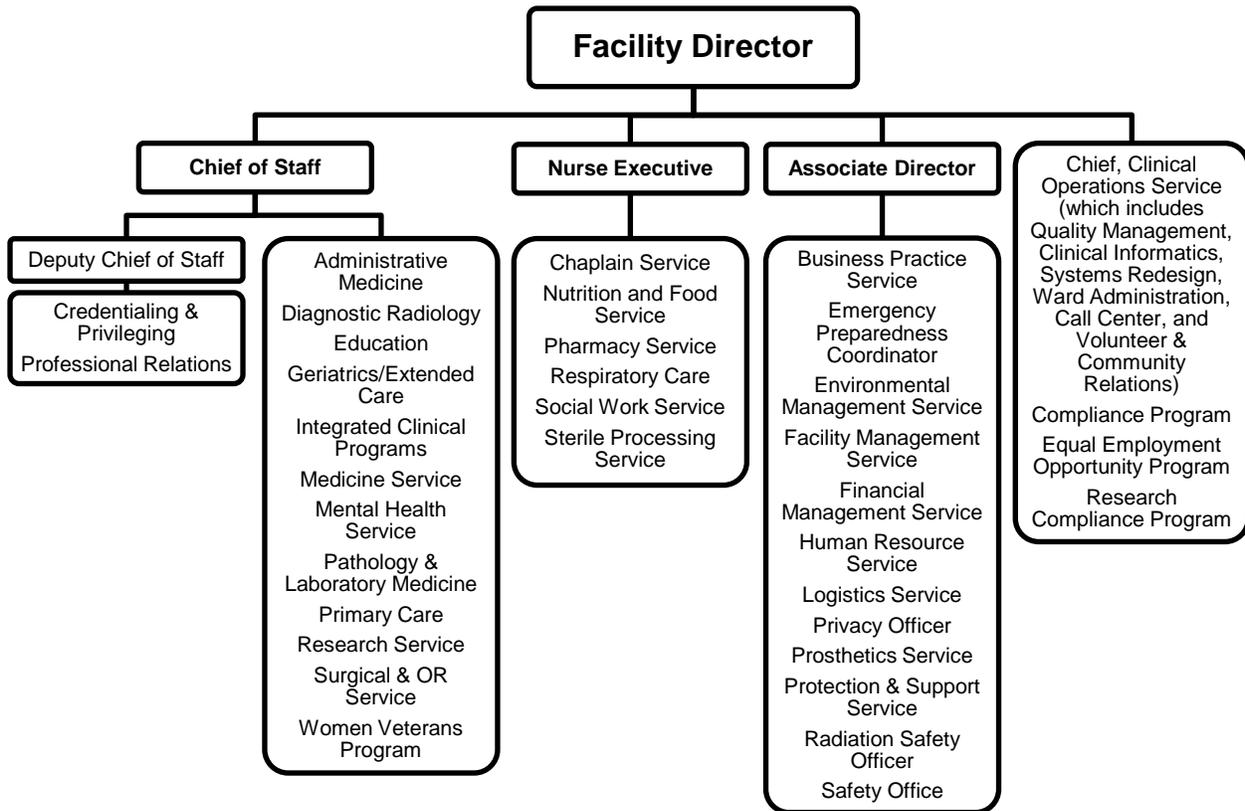
Stable and effective leadership is critical to improving care and sustaining meaningful change. Leadership and organizational risk issues can impact the facility's ability to provide care in all of the selected clinical areas of focus. The factors OIG considered in assessing the facility's risks and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

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

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

All leadership positions are currently permanently assigned. The most recent addition to the executive leadership team was the Associate Director who assumed the position in April 2017. The other leaders had been working together as a team since May 2014.

Figure 2. Facility Organizational Chart



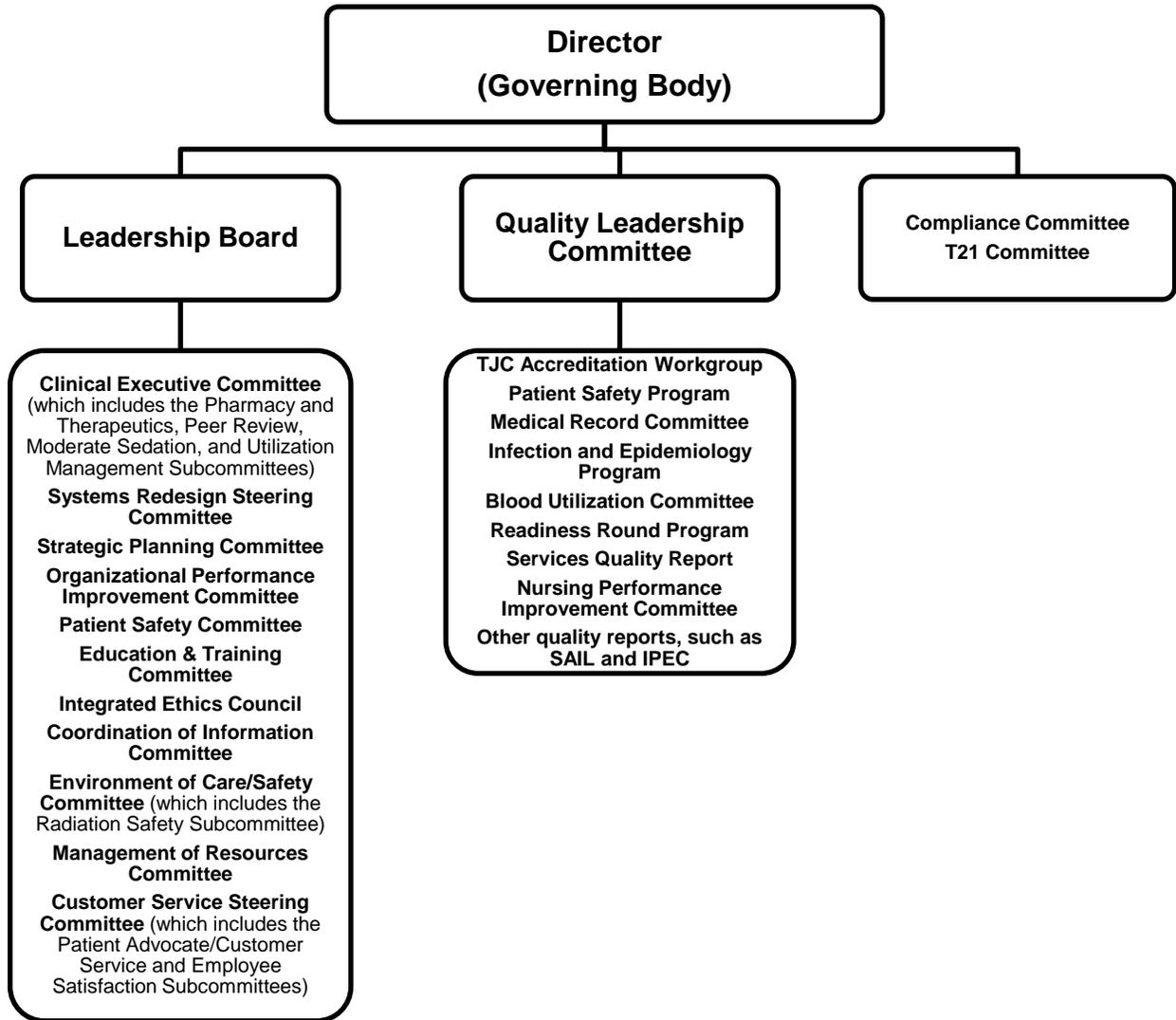
Source: John D. Dingell VA Medical Center (received September 19, 2017).

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

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

The leaders are also engaged in monitoring patient safety and care through formal mechanisms. They are members of the facility’s Leadership Board and Quality Leadership Committee, which track, trend, and monitor 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 Leadership Board also oversees various working committees, such as the Clinical Executive Committee, Organizational Performance Improvement Committee, Patient Safety Committee, and EOC/Safety Committee. See Figure 3.

Figure 3. Facility Committee Reporting Structure



Source: John D. Dingell VA Medical Center (received July 11, 2017).

Employee Satisfaction and Patient Experience. To assess employee and patient attitudes toward facility senior leadership, OIG reviewed employee satisfaction and patient experience survey results that relate to the period of October 1, 2015 through September 30, 2016. Although OIG recognizes that employee satisfaction and patient experience survey data are subjective, they can be a starting point for discussions and indicate areas for further inquiry, which can be considered along with other information on facility leadership. Table 1 provides relevant survey results for VHA and the facility for the 12-month period. The facility leaders’ results (Director’s office average) were rated markedly above the VHA and facility average.⁷ All four patient survey results reflected lower care ratings than the VHA average. In all, employees were generally satisfied in regards to leadership, and patients appeared generally less satisfied when compared to the VHA average.

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	4.0
All Employee Survey Servant Leader Index Composite	0–100 where HIGHER scores are more favorable	66.7	62.8	79.9
Survey of Healthcare Experiences of Patients (inpatient): Would you recommend this hospital to your friends and family?	The response average is the percent of “Definitely Yes” responses.	65.8	56.3	
Survey of Healthcare Experiences of Patients (inpatient): I felt like a valued customer.	The response average is the percent of “Agree” and “Strongly Agree” responses.	82.8	78.7	
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): I felt like a valued customer.		73.2	69.3	
Survey of Healthcare Experiences of Patients (outpatient specialty care): I felt like a valued customer.		73.8	65.5	

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.

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.

Accreditation/For-Cause¹⁰ Surveys and Oversight Inspections. To further assess Leadership and Organizational Risks, OIG reviewed recommendations from previous inspections by oversight and accrediting agencies to gauge how well leaders respond to identified problems. Table 2 summarizes the relevant facility inspections most recently performed by the VA OIG and The Joint Commission (TJC). Indicative of effective leadership, the facility has closed¹¹ all recommendations for improvement for the Combined Assessment Program and Community Based Outpatient Clinic and Primary Care (PC) Clinic reviews as listed in Table 2. However, for the hotline inspections, recommendations remain open, which was expected, because the two hotline reports were recently published, and a follow-up status had not yet been requested. Since that time, the facility has taken actions to improve, and OIG has closed three recommendations made in the June 2017 hotline report and two recommendations made in the February 2017 hotline report.

OIG also noted the facility's current accreditation status with the Commission on Accreditation of Rehabilitation Facilities¹² and College of American Pathologists,¹³ which demonstrates the facility leaders' commitment to quality care and services. Additionally, the Long Term Care Institute¹⁴ conducted an inspection of the facility's Community Living Center.

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.

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.

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 (<i>Healthcare Inspection – Alleged Mismanagement and Quality of Care Issues in Surgical Service, John D. Dingell VA Medical Center, Detroit, Michigan, June 19, 2017</i>)	May 2015 June 2015	8	8
VA OIG (<i>Healthcare Inspection – Documentation of Patient Enrollment Concerns in Home Telehealth at John D. Dingell VA Medical Center, Detroit, Michigan, February 9, 2017</i>)	June 2014	3	3
VA OIG (<i>Combined Assessment Program Review of the John D. Dingell VA Medical Center Detroit, Michigan, September 4, 2014</i>)	July 2014	19	0
VA OIG (<i>Community Based Outpatient Clinic and Primary Care Clinic Reviews at John D. Dingell VA Medical Center, Detroit, Michigan, July 22, 2014</i>)	May 2014	3	0
TJC ¹⁵ <ul style="list-style-type: none"> • Hospital Accreditation • Nursing Care Center Accreditation • Behavioral Health Care Accreditation • Home Care Accreditation 	September 2015	30 2 2 9	0 0 0 0

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.

Indicators for Possible Lapses in Care. Within the health care field, the primary organizational risk is the potential for patient harm. Many factors impact the risk for patient harm within a system, including unsafe environmental conditions, sterile processing deficiencies, and infection control practices. Leaders must be able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms. Table 3 summarizes key indicators of risk since OIG’s previous May 2014 Combined Assessment Program and Community Based Outpatient Clinic and PC review inspections through the week of April 24, 2017.

**Table 3. Summary of Selected Organizational Risk Factors¹⁶
(May 2014 to April 24, 2017)**

Factor	Number of Occurrences
Sentinel Events ¹⁷	5
Institutional Disclosures ¹⁸	8
Large-Scale Disclosures ¹⁹	0

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 John D. Dingell VA Medical Center is a high-complexity (1c) 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.

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 Patient Safety Indicator data from October 1, 2015 through September 30, 2016.

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

Measure	Reported Rate per 1,000 Hospital Discharges		
	VHA	VISN 10	Facility
Pressure Ulcers	0.55	0.34	0.59
Death among surgical inpatients with serious treatable conditions	103.31	100.00	157.89
Iatrogenic Pneumothorax	0.20	0.27	0
Central Venous Catheter-Related Bloodstream Infection	0.12	0.15	0
In Hospital Fall with Hip Fracture	0.08	0.04	0
Perioperative Hemorrhage or Hematoma	2.59	4.78	1.39
Postoperative Acute Kidney Injury Requiring Dialysis	1.20	1.68	0
Postoperative Respiratory Failure	6.31	10.01	13.93
Perioperative Pulmonary Embolism or Deep Vein Thrombosis	3.29	2.42	1.35
Postoperative Sepsis	4.45	4.28	4.52
Postoperative Wound Dehiscence	0.65	2.64	0
Unrecognized Abdominopelvic Accidental Puncture/Laceration	0.67	0	0

Source: VHA Support Service Center.

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

The Patient Safety Indicator measures for pressure ulcers, death among surgical inpatients with serious treatable conditions, postoperative respiratory failure, and postoperative sepsis show an observed rate per 1,000 hospital discharges in excess of the observed rates for Veterans Integrated Service Network (VISN) 10 and VHA. Facility managers informed us that following case reviews and analysis of this data, they found that many of the failing cases in these areas were not actual Patient Safety Indicators but were attributed to documentation errors. An example given was that more than half of the postoperative respiratory failures noted in the Patient Safety Indicator data were actually postoperative patients who required ventilation assistance for airway management and were not respiratory failures.

²⁰ Agency for Healthcare Research and Quality website, <https://www.qualityindicators.ahrq.gov/>, accessed March 8, 2017.

In an effort to reduce the erroneous Patient Safety Indicators, facility managers initiated a daily Patient Safety Indicator coding and trigger review process. Patient events that meet a Patient Safety Indicator trigger are submitted for clinical and coding review to ensure the event was not documented or coded in error. Facility managers acknowledged that if these errors had been corrected prior to the data pull, the facility would have achieved a benchmark score equal to or better than VISN 10 and VHA scores.

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 has noted limitations for identifying all areas of clinical risk. The data are presented as one “way to understand the similarities and differences between the top and bottom performers” within VHA.²²

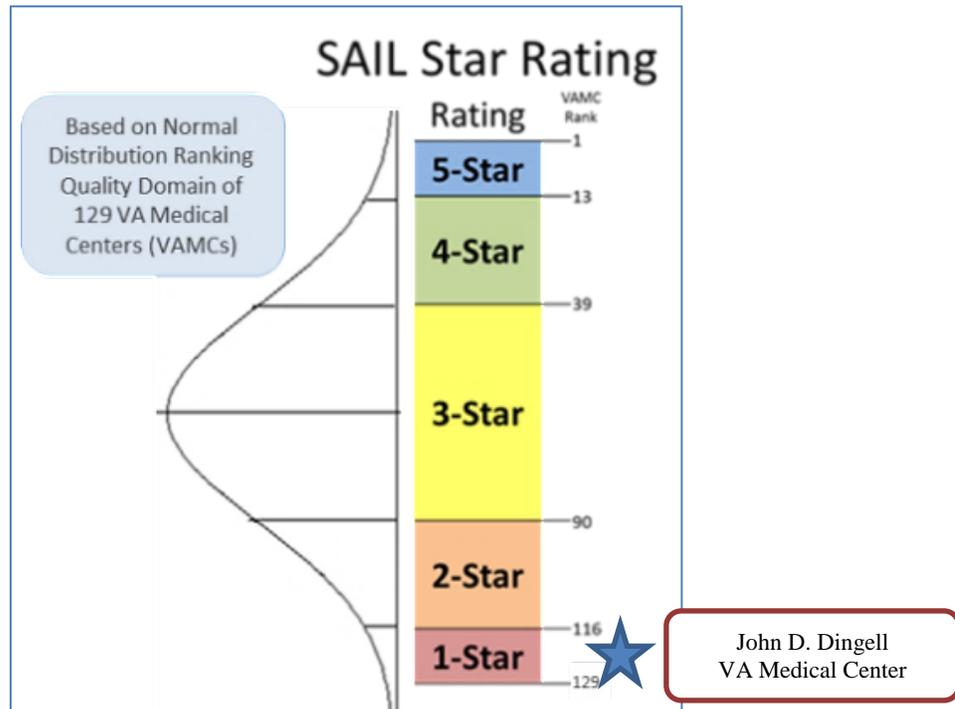
²¹ The model is derived from the Thomson Reuters Top Health Systems Study.

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>

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 John D. Dingell VA Medical Center received an interim²³ rating of 1 star for overall quality. This means the facility was in the 5th quintile (bottom 10 percent). Updated data as of June 30, 2017, indicates that the facility has improved to 2 stars for overall quality.

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

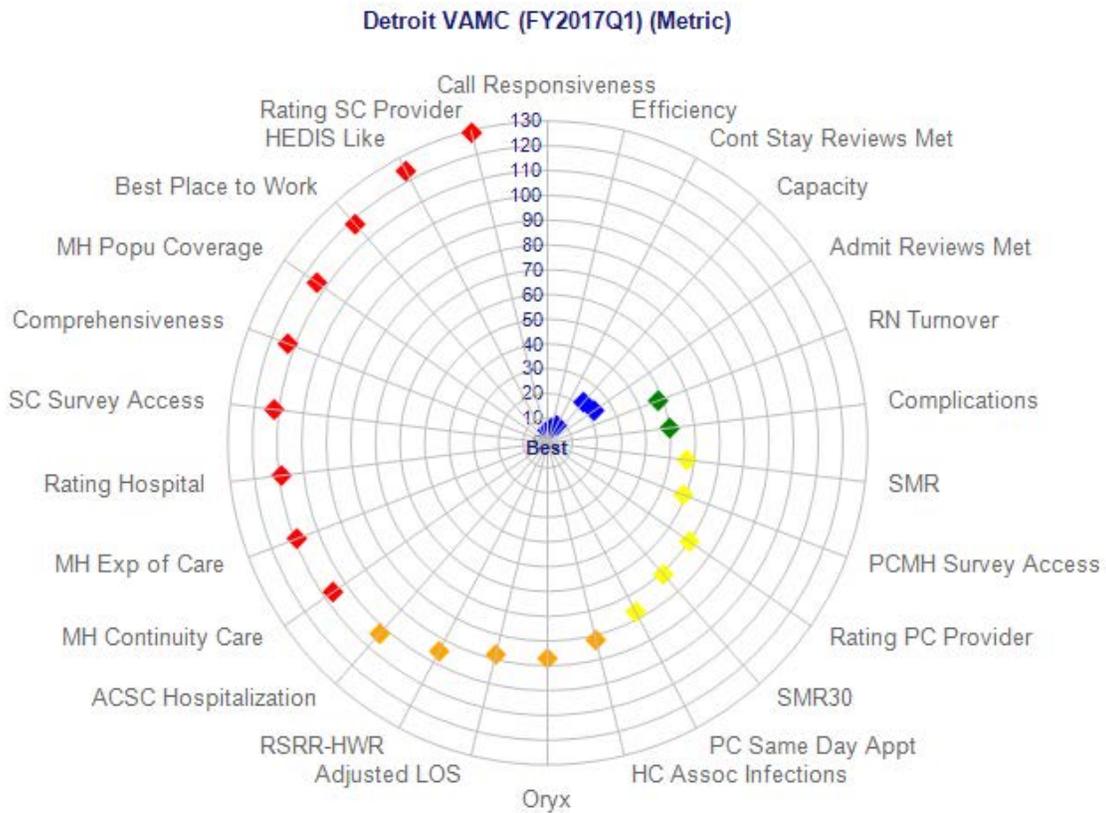


Source: VA Office of Informatics and Analytics' Office of Operational Analytics and Reporting.

²³ Star rating was labeled “interim” for fiscal quarters prior to end of year appraisal to align with VA’s public reporting of SAIL star rating at end of year.

Figure 5 illustrates the facility's Quality of Care and Efficiency metric rankings and performance compared to other VA facilities as of December 31, 2016. Of note, Figure 5 shows blue and green data points in the top quintiles that show high performance (for example, Call Responsiveness, Efficiency, and Registered Nurse [RN] Turnover). Metrics in the bottom quintiles reflect areas that need improvement and are denoted in orange and red (for example, Mental Health [MH] Continuity [of] Care, Comprehensiveness, and Best Place to Work).

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



Marker color: Blue - 1st quintile; Green - 2nd; Yellow - 3rd; Orange - 4th; Red - 5th quintile.

Source: VHA Support Service Center.

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

Conclusions. The facility has generally stable executive leadership and active engagement with employees and patients to improve satisfaction scores. Organizational leaders support patient safety, quality care, and other positive outcomes (such as initiating processes and plans to improve perceptions of the facility through active stakeholder engagement). OIG’s review of accreditation organization findings, sentinel events, disclosures, Patient Safety Indicator data, and SAIL results identified multiple organizational risk factors.²⁴ The senior leadership team was knowledgeable about selected SAIL metrics and should continue to take considerable actions to improve care and performance, particularly Quality of Care and Efficiency metrics likely contributing to the current 2-star rating.

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

Quality, Safety, and Value

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

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

1. Senior-level involvement in QSV/performance improvement committee
2. Protected peer review²⁶ of clinical care
3. Credentialing and privileging
4. Utilization management (UM) reviews²⁷
5. Patient safety incident reporting and root cause analyses

OIG interviewed senior managers and key QSV employees and evaluated meeting minutes, licensed independent practitioners' profiles, protected peer reviews, root cause analyses, and other relevant documents.

The list below shows the performance indicators for each of the following QSV program activities.

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

²⁵ Department of Veterans Affairs, Veterans Health Administration. *Blueprint for Excellence*. September 2014.

²⁶ According to VHA Directive 2010-025 (June 3, 2010), this is a peer evaluation of the care provided by individual providers within a selected episode of care. This also involves a determination of the necessity of specific actions, and confidential communication is given to the providers who were peer reviewed regarding the results and any recommended actions to improve performance. The process may also result in identification of systems and process issues that require special consideration, investigation, and possibly administrative action by facility staff.

²⁷ According to VHA Directive 1117 (July 9, 2014), UM reviews evaluate the appropriateness, medical need, and efficiency of health care services according to evidence-based criteria.

- Credentialing and privileging processes
 - Considered frequency for Ongoing Professional Practice Evaluation²⁸ data review
 - Indicated a Focused Professional Practice Evaluation²⁹
- 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 WEBSPOOT database
 - Completed the required minimum of eight root cause analyses
 - Reported root cause analysis findings to reporting employees
 - Submitted an annual patient safety report

Conclusions. Generally, OIG found that senior managers were engaged with QSV activities, and when opportunities for improvement were identified, they supported clinical leaders' implementation of corrective actions and monitoring for effectiveness. OIG also found general compliance with requirements for protected peer reviews, UM, and patient safety. However, OIG identified the following deficiency with credentialing and privileging processes that warranted a recommendation for improvement.

Credentialing and Privileging. Facility bylaws require clinical managers to review Ongoing Professional Practice Evaluation data every 6 months. 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. Six of the 25 licensed independent practitioners' profiles did not contain evidence that clinical managers reviewed Ongoing Professional Practice Evaluation data every 6 months. The Credentialing Coordinator indicated that the information is requested from the respective service chiefs every 6 months; however, not all service chiefs are compliant with timely responses.

Recommendation

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

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

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

Facility concurred.

Target date for completion: December 29, 2017

Facility response: The Credentialing and Privileging office created a new stratified and structured OPPE database and increased their reach out to each service chief.

Measurable Goals: More than 90% of OPPE's be submitted to the committee for review. Processes were initiated in May 2017; this will be an ongoing monthly report submitted to the Clinical Executive committee.

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 six employees actively involved in the anticoagulant program and interviewed key employees. Additionally, OIG reviewed the electronic health records (EHRs) of 27 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 many of the indicators listed above, including development and implementation of anticoagulation management policies, risk minimization of dosing errors, and routine review of quality assurance data. However, OIG identified the following deficiencies with patient education and employee competency that warranted recommendations for improvement.

Patient Education. The facility's Guidelines for the Use of Anticoagulation Therapy require initial and ongoing education for patients and family members. Education should include elements such as the importance of follow-up monitoring, indication of therapy, dietary restrictions and interactions, and signs and symptoms of bleeding/thromboembolic events. 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. In 9 of the 27 EHRs, patients did not receive initial education on the newly prescribed anticoagulant. Facility managers reported that staff attest to providing patient education; however, staff failed to document the education in the EHRs. Facility managers did not monitor for compliance but since our site visit have developed an anticoagulation education template which prompts staff to document required education.

Recommendation

2. The Chief of Staff and Associate Director for Patient Care Services ensure clinicians consistently provide specific education to patients with newly prescribed anticoagulant medications and monitor clinicians' compliance.

Facility concurred.

Target date for completion: December 29, 2017

Facility Response: Detroit VAMC [VA medical center] re-educated healthcare providers and modified the documentation to include the educational material and prompts needed for anticoagulation. A monthly chart audit was initiated starting since May of 2017.

Measurable Goals: More than 90% of new anticoagulation prescriptions have required education documented timely. This is an ongoing audit, and the results will be reported to the anticoagulation committee, and to the Clinical Executive Committee.

Employee Competency. VHA requires competency assessments that include specific elements for employees actively involved in the anticoagulant program. This ensures that all staff who are involved in the management of anticoagulation therapy patients are knowledgeable of current anticoagulant literature, dosing guidelines, and treatment options. Competency assessments are to be completed at the frequency determined by the facility, which is annually. Maintenance of annual competency validates that providers are capable of managing anticoagulation therapy patients.

The facility requires that all providers and ancillary staff participate in competency assessment by completing Talent Management System education module(s) for anticoagulation education, which does not include all VHA required elements. Consequently, none of the competency assessments for the six employees actively involved in the anticoagulant program included knowledge of standard terminology, pharmacology of anticoagulants, monitoring requirements, dose calculation, common side effects, or nutrient and drug to drug interactions associated with anticoagulation therapy. Facility managers indicated that they were under the impression that the national Talent Management Systems modules would suffice as competency assessment compliance for anticoagulation.

Recommendation

3. The Associate Director for Patient Care Services ensures clinical managers include in competency assessments of employees actively involved in the anticoagulant program knowledge of standard terminology, pharmacology of anticoagulants, monitoring requirements, dose calculation, common side effects, nutrient interactions associated with anticoagulation therapy, and drug to drug interactions associated with anticoagulation therapy, and the Associate Director for Patient Care Services monitors managers' compliance.

Facility concurred.

Target date for completion: January 31, 2018

Facility Response: The facility has implemented a best practice competency exam, to be completed annually on all anticoagulation team members, including pharmacists and Medicine Service providers.

Measurable Goals: More than 90% of all anticoagulation staff complete exam December 2017, and have the exam scheduled as an annual competency. This will be rolled into the OPPE process and report[ed] every 6 months (per provider) to the Credentialing and Privileging Committee.

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 46 randomly selected patients who were transferred out of facility inpatient beds or the Emergency Department/urgent care center to another VHA facility or non-VA facility from July 1, 2015 through June 30, 2016. The list below shows the performance indicators OIG examined.

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

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

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 the Radiology Department and the locked MH unit.^d

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

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

In all, OIG inspected two Community Living Center, the medical/surgical intensive care, the MH, and four inpatient medical/surgical units. OIG also inspected the post-anesthesia care unit, the Emergency and Radiology Departments, the rheumatology/oncology specialty clinic, the PC and women's health clinics, and the Veterans Community Resource and Referral Center (the randomly selected representative community based outpatient clinic). Additionally, OIG reviewed relevant documents and 16 employee training records and interviewed key employees and managers. The list below shows the location-specific performance indicators selected to examine the risk areas specific to particular settings.

Parent Facility

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

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. Generally, OIG noted compliance with requirements for cleanliness and privacy at the parent facility and representative community based outpatient clinic. The Radiology Department and locked MH unit met most of the performance indicators listed above. Additionally, OIG did not note any issues with the availability of medical equipment and supplies. However, OIG identified the following deficiencies that warranted recommendations for improvement.

Parent Facility: Environment of Care Rounds Attendance. VHA requires facilities to perform comprehensive EOC rounds with a team that includes specific membership to ensure a safe, clean, and high-quality care environment.³³ OIG reviewed Comprehensive EOC Assessment and Compliance Tool documentation for October 1, 2015 through September 30, 2016, and observed that nursing, biomedical engineering, women veterans program, VA Police, and logistics representatives did not consistently attend rounds. Managers were aware of noncompliance and failed to take follow-up actions to ensure compliance due to other priorities and lack of staff.

Recommendation

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

Facility concurred.

Target date for completion: February 28, 2018

Facility Response: The Environment of Care attendance log was updated to reflect the most recent directive requirements. A new backup system was established to ensure each required team member had alternatives identified. The EOC attendance will be reported through executive leadership weekly for follow up on deficient attendees.

Measurable Goals: EOC rounds will be attended with greater than 90% compliance monthly, the weekly compliance will be directly reported to the Associate Director, Associate Director of Patient Care Services, and the Chief of staff to ensure weekly feedback on performance.

Parent Facility: Furnishings. TJC requires hospitals to continually monitor environmental issues and to use the results of data analysis to identify opportunities to resolve environmental safety and infection prevention issues. This ensures a clean and safe health care environment. Patient rooms in 9 of 15 patient care areas inspected contained damaged bedside tables with sharp edges, torn armrests on recliner chairs, and damaged delaminated Formica® sink counters with sharp edges. OIG also noted a soiled couch with damaged armrests in the women's health clinic waiting area. These findings posed safety hazards and/or infection prevention issues since the surfaces could not be sanitized. Managers and staff knew about the requirements but were either unaware of the damaged furnishings OIG observed or failed to perceive those items as safety or infection control risks.

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.

Recommendation

5. The Associate Director ensures damaged furnishings in patient care areas are repaired or removed from service.

Facility concurred.

Target date for completion: January 31, 2018

Facility Response: Dis-repair of furnishings was added to multiple ongoing audit checklists including: EOC rounds, Quality Management weekly rounds, and Clinical Nursing Manager. Where the equipment is identified and work orders are placed for management of the furnishing. The team has been instructed to remove the furnishings from use until repaired.

Measurable Goals: Greater than 90% of identified furnishings will be repaired or replaced when recognized by ongoing audit. This will be reported monthly to the interior design committee, and quarterly to the Environment of Care Committee.

Community Based Outpatient Clinic: Panic Alarms. VHA requires facilities to implement, use, and regularly test appropriate physical security precautions and equipment including, but not limited to, panic alarm systems to ensure the safety of patients and staff. During OIG's inspection of the Veterans Community Resource and Referral Center, OIG found no documentation of panic alarm system testing. Managers and staff knew about the requirements but assumed that VA Police were maintaining alarm test records. However, VA Police only maintained records for the parent facility.

Recommendation

6. The Associate Director ensures panic alarms at the Veterans Community Resource and Referral Center are tested and testing is documented and monitors compliance.

Facility concurred.

Target date for completion: December 29, 2017

Facility Response: In June of 2017, the panic alarms at the VCRRC [Veterans Community Resource and Referral Center] were added to the Police and Security Office inspection and documentation schedule, with monthly oversight.

Measurable Goals: Greater than 90% compliance with monthly testing of panic alarms at VCRRC. This will continue to be monitored monthly, and report[ed] to the Quality Leadership Committee and EOC committee monthly.

Radiology: General Safety. VHA and the Occupational Safety and Health Administration require that shields and aprons used for the protection of radiology personnel and patients are well maintained and periodically inspected and tested for integrity. This ensures employees are not exposed to large doses of fluoroscopic radiation. OIG found no evidence that the shields and aprons were inspected or tested.

OIG was informed that an electronic system used to record inspection and test results was non-functional.

Recommendation

7. The Associate Director ensures radiation shields and aprons have evidence of periodic inspection and testing for integrity and monitors compliance.

Facility concurred.

Target date for completion: November 30, 2017

Facility Response: In August 2017, the facility identified all radiation shields. A contractor was called in to inspect the integrity of all shields and completed the inspection.

Measurable Goals: Greater than 90% of lead aprons and shields are inspected annually. This annual audit will report to the radiation safety committee.

Radiology: Equipment Inspections. VHA requires that radiology equipment is tested after installation before first clinical use, annually, and after each repair or modification that may affect patient dose or image quality. Two of 10 pieces of radiology equipment did not have evidence of inspection by a medical physicist within the past 12 months. Managers were aware of noncompliance and failed to take follow-up actions to ensure compliance due to staffing issues and other priorities.

Recommendation

8. The Associate Director ensures radiology equipment consistently receives annual inspection by a medical physicist and monitors compliance.

Facility concurred.

Target date for completion: December 1, 2017

Facility Response: In September 2017, all radiation equipment has been inspected. In addition, all repaired radiology equipment must be inspected by a medical physicist before returning to service.

Measurable Goals: Greater than 90% of radiology equipment will be inspected annually by a medical physicist, and all equipment removed from service for repair will receive an inspection by a medical physicist prior to returning to service. This will report monthly to the Radiation Safety Committee.

Locked Mental Health Unit: Inspection Team Training. VHA requires that Interdisciplinary Safety Inspection Team members receive annual training on the identification and correction of environmental hazards, including the proper use of the MH EOC Checklist. This ensures inspection team members possess the necessary knowledge and skills to perform inspections of the locked MH unit in order to assure the

safety of staff, visitors, and patients. Four of six Interdisciplinary Safety Inspection Team members did not have evidence of training within the past 12 months. Team members knew about the requirements but failed to take follow-up actions to ensure compliance due to other priorities and collateral duties.

Recommendation

9. The Associate Director ensures Interdisciplinary Safety Inspection Team members receive annual training on how to identify and correct environmental hazards, including the proper use of the Mental Health Environment of Care Checklist, and monitors team members' compliance.

Facility concurred.

Target date for completion: December 1, 2017

Facility Response: All MHEOC Members (7 total members) were identified, and all required education was completed prior to the OIG surveyors leaving the facility in April.

Measurable Goals: 100% MHEOC completed education for 2017, 100% of required staff members (MHEOC team members) will complete annual educational requirements. This will be reported to the EOC committee annually.

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.³⁴ 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.³⁵

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.³⁶ During calendar year 2016, VHA clinicians performed more than 600,000 moderate sedation procedures, of which more than half were gastroenterology-related endoscopies.³⁷ 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 cardiac catheterization suite, endoscopy suite (includes gastroenterology and pulmonary), radiology suite, intensive care unit, and Emergency Department procedure areas to assess whether required equipment and sedation medications were available. Additionally, OIG reviewed the EHRs of 42 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

³⁴ American Society of Anesthesiologists (ASA), Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists, 2002. *Anesthesiology* 2002; 96:1004-17.

³⁵ 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>.

³⁶ VHA Directive 1073, *Moderate Sedation by Non-Anesthesiology Providers*, December 30, 2014.

³⁷ Per VA Corporate Data Warehouse data pull on February 22, 2017.

- Performance of timeout³⁸ 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

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

³⁸ 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.

Long-Term Care: Community Nursing Home Oversight

Since 1965, VHA has provided nursing home care under contracts. VHA facilities must integrate the CNH program into their quality improvement programs. The Facility Director establishes the CNH Oversight Committee, which reports to the chief clinical officer (Chief of Staff, Nurse Executive, 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.³⁹ Local oversight of CNHs is achieved through annual reviews and monthly visits.

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

OIG interviewed key employees and reviewed relevant documents and the results from CNH annual reviews completed July 5, 2015 through June 30, 2016. Additionally, OIG reviewed the EHRs of 29 randomly selected patients who received CNH care for more than 3 months during the timeframe July 1, 2015 through June 30, 2016. The list below shows the performance indicators OIG reviewed.

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

Conclusions. Generally, OIG noted compliance with requirements for the CNH Oversight Committee, program integration, and annual reviews. However, OIG identified the following deficiency with clinical visits that warranted a recommendation for improvement.

Clinical Visits. VHA requires that every patient under contract in a nursing home be visited by a social worker or registered nurse at least every 30 days (unless specific criteria allow an exception). Social workers and registered nurses must alternate monthly visits unless otherwise indicated by the patient's visit plan. This interdisciplinary monitoring ensures vulnerable nursing home patients consistently receive quality care and necessary follow-up services. None of the 29 patients received cyclical social worker and registered nurse visits with the frequency required by VHA policy. Managers and staff knew about the requirements, but staff availability and collateral duties prevented compliance.

³⁹ VHA Handbook 1143.2, *VHA Community Nursing Home Oversight Procedures*, June 4, 2004.

Recommendation

10. The Chief of Staff ensures social workers and registered nurses conduct cyclical clinical visits with the frequency required by Veterans Health Administration policy for community nursing home oversight and monitors their compliance.

Facility concurred.

Target date for completion: December 29, 2017

Facility Response: Hire 1 full time RN [registered nurse] for social work department. Create an internal tool for tracking compliance with visitation monthly (alternating visits between social work and nursing). And begin tracking weekly to ensure compliance is noted every 30 days.

Measurable Goals: Greater than 90% of home visitation will occur every 30 days. This will be reported to the Clinical executive committee quarterly.

Summary Table of Comprehensive Healthcare Inspection Program Review Findings			
Healthcare Processes	Performance Indicators	Conclusion	
Leadership and Organizational Risks	<ul style="list-style-type: none"> 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 	Ten OIG recommendations, ranging from documentation issues to deficiencies that can lead to patient and staff safety issues or adverse events, are attributable to the Chief of Staff, Nurse Executive, and Associate Director. See details below.	
Healthcare Processes	Performance Indicators	Critical Recommendations⁴⁰ for Improvement	Recommendations for Improvement
Quality, Safety, and Value	<ul style="list-style-type: none"> 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 	<ul style="list-style-type: none"> Clinical managers consistently collect and review OPPE data every 6 months. 	None
Medication Management	<ul style="list-style-type: none"> Anticoagulation management policies and procedures Management of patients receiving new orders for anticoagulants <ul style="list-style-type: none"> Prior to treatment During treatment Ongoing evaluation of the anticoagulation program Competency assessment 	<ul style="list-style-type: none"> Clinicians consistently provide specific education to patients with newly prescribed anticoagulant medications. 	<ul style="list-style-type: none"> Clinical managers include all required elements in competency assessments of employees actively involved in the anticoagulant program.
Coordination of Care	<ul style="list-style-type: none"> Transfer policies and procedures Oversight of transfer process EHR documentation <ul style="list-style-type: none"> Non-emergent transfers Emergent transfers 	None	None

⁴⁰ 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
<p>Environment of Care</p>	<ul style="list-style-type: none"> • Parent facility <ul style="list-style-type: none"> ○ EOC deficiency tracking and rounds ○ Infection prevention ○ General Safety ○ Environmental cleanliness ○ Exam room privacy ○ Availability of feminine hygiene products and medical equipment and supplies • Community Based Outpatient Clinic <ul style="list-style-type: none"> ○ Infection prevention ○ General safety ○ Environmental cleanliness ○ Medication safety and security ○ Privacy ○ Availability of feminine hygiene products and medical equipment and supplies ○ IT network room security • Radiology <ul style="list-style-type: none"> ○ 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 • Inpatient MH <ul style="list-style-type: none"> ○ MH EOC inspections ○ Environmental suicide hazard identification ○ Employee training ○ Environmental safety ○ Infection prevention ○ Availability of medical equipment and supplies 	<ul style="list-style-type: none"> • Parent facility: <ul style="list-style-type: none"> ○ Damaged furnishings in patient care areas are repaired or removed from service. • Community Based Outpatient Clinic: <ul style="list-style-type: none"> ○ Panic alarms at the Veterans Community Resource and Referral Center are tested, and testing is documented. • Radiology: <ul style="list-style-type: none"> ○ Radiation shields and aprons have evidence of periodic testing and inspection for integrity. ○ Radiology equipment consistently receives annual inspection by a medical physicist. 	<ul style="list-style-type: none"> • Parent facility: <ul style="list-style-type: none"> ○ Core team members consistently attend EOC rounds. • Inpatient MH: <ul style="list-style-type: none"> ○ All members of the Interdisciplinary Safety Inspection Team receive annual 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
High-Risk and Problem-Prone Processes: Moderate Sedation	<ul style="list-style-type: none"> • Outcomes reporting • Patient safety and documentation <ul style="list-style-type: none"> ○ Prior to procedure ○ After procedure • Staff training and competency • Monitoring equipment and emergency management 	None	None
Long-Term Care: Community Nursing Home Oversight	<ul style="list-style-type: none"> • CNH Oversight Committee and CNH program integration • EHR documentation <ul style="list-style-type: none"> ○ Patient hand-off ○ Clinical visits • CNH annual reviews 	<ul style="list-style-type: none"> • Social workers and registered nurses conduct cyclical clinical visits with the frequency required by VHA policy. 	None

Facility Profile

The table below provides general background information for this mid-high complexity (1c)⁴¹ affiliated⁴² facility reporting to VISN 10.

Table 5. Facility Profile for Detroit (553) for October 1, 2013 through September 30, 2016

Profile Element	Facility Data FY 2014 ⁴³	Facility Data FY 2015 ⁴⁴	Facility Data FY 2016 ⁴⁵
Total Medical Care Budget in Millions	\$320.1	\$345.1	\$363.9
Number of:			
• Unique Patients	49,063	52,162	53,898
• Outpatient Visits	504,357	526,500	547,422
• Unique Employees⁴⁶	1,530	1,617	1,560
Type and Number of Operating Beds:			
• Acute	70	75	75
• Mental Health	30	30	30
• Community Living Center	109	109	109
• Domiciliary	50	50	50
Average Daily Census:			
• Acute	48	46	45
• Mental Health	12	13	11
• Community Living Center	69	65	52
• Domiciliary	36	39	37

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.

⁴¹ VHA medical centers are classified according to a facilities complexity model; 1c designation indicates a facility with medium-high volume, medium-risk patients, some complex clinical programs, and medium sized research and teaching programs. Retrieved September 13, 2017, from

<http://opes.vssc.med.va.gov/FacilityComplexityLevels/Facility%20Complexity%20Levels%20Document%20Library/Facility%20Complexity%20Level%20Model%20Fact%20Sheet.docx>.

⁴² Associated with a medical residency program.

⁴³ October 1, 2013 through September 30, 2014.

⁴⁴ October 1, 2014 through September 30, 2015.

⁴⁵ October 1, 2015 through September 30, 2016.

⁴⁶ Unique employees involved in direct medical care (cost center 8200).

VA Outpatient Clinic Profiles⁴⁷

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

Table 6. VA Outpatient Clinic Workload/Encounters⁴⁸ and Specialty Care, Diagnostic, and Ancillary Services Provided⁴⁹ for October 1, 2015 through September 30, 2016

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services ⁵⁰ Provided	Diagnostic Services ⁵¹ Provided	Ancillary Services ⁵² Provided
Yale, MI	553GA	9,445	1,161	Anesthesia Eye	NA	Pharmacy Prosthetics
Pontiac, MI	553GB	6,692	1,277	Dermatology Endocrinology Blind Rehab Anesthesia Eye	NA	Weight Management

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

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

NA = Not applicable

⁴⁷ Includes all outpatient clinics in the community that were in operation as of February 15, 2017. OIG has omitted Detroit, MI (553QA), as no workload/encounters or services were reported.

⁴⁸ An encounter is a professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition.

⁴⁹ The denoted specialty care and ancillary services are limited to primary clinic stops with a count ≥ 100 encounters for October 1, 2015 through September 30, 2016, timeframe at the specified community based outpatient clinic.

⁵⁰ Specialty care services refer to non-PC 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.

VHA Policies Beyond Recertification Dates

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

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

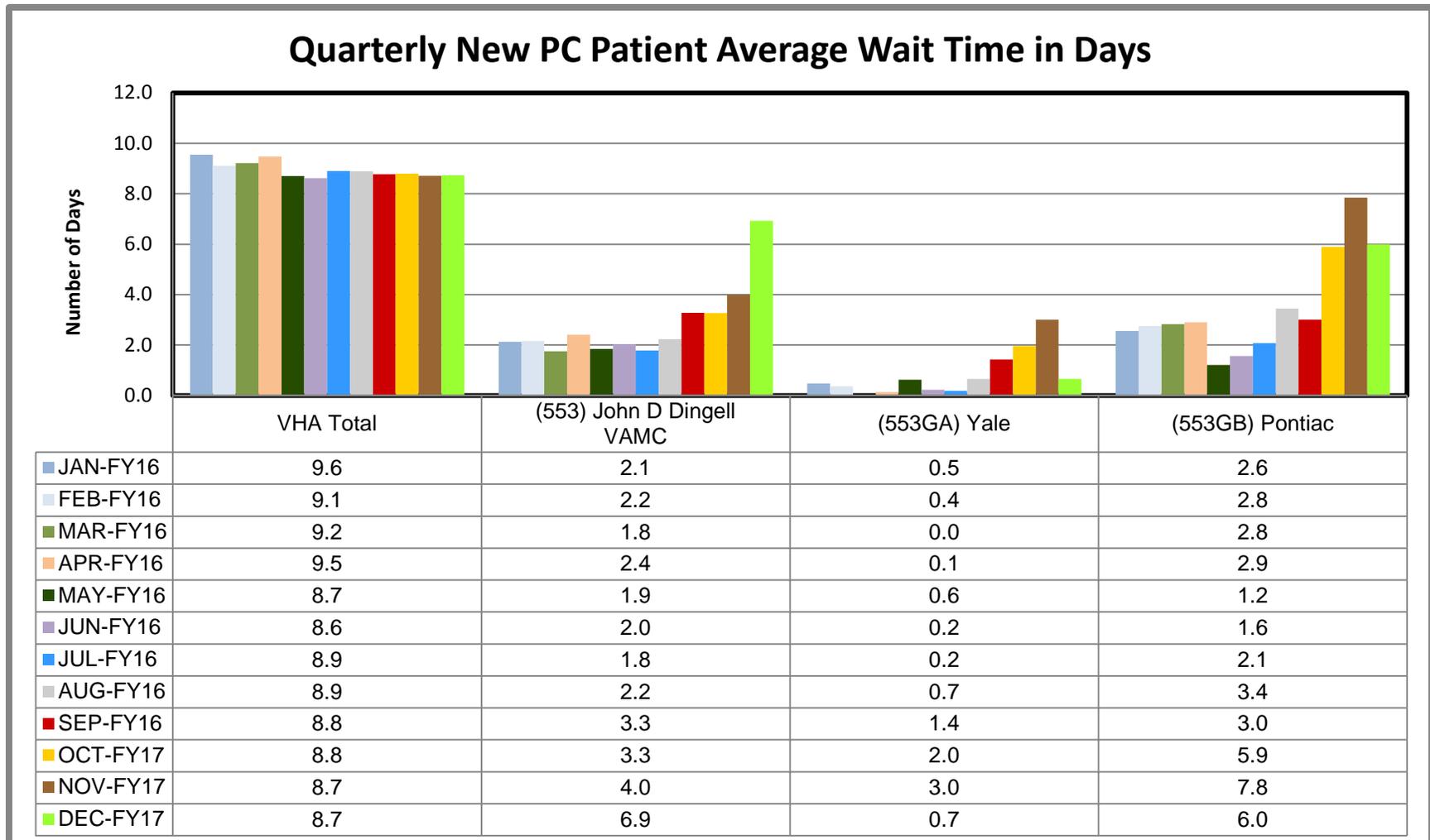
OIG considered these policies to be in effect, as they had not been superseded by more recent policy or guidance. In a June 29, 2016, memorandum to supplement policy provided by VHA Directive 6330(1),⁵³ the VA Under Secretary for Health mandated the "...continued use of and adherence to VHA policy documents 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

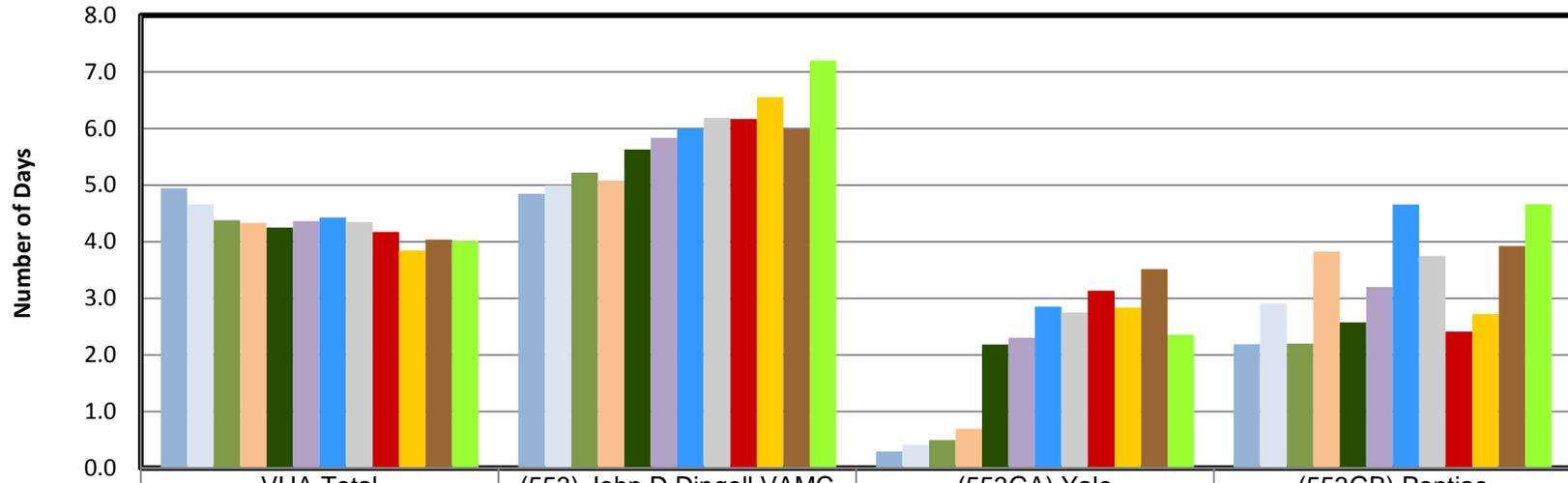


Source: VHA Support Service Center.

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

Data Definition⁶: The average number of calendar days between a new patient’s PC completed appointment (clinic stops 322, 323, and 350, excluding Compensation and Pension appointments) and the earliest of three possible preferred (desired) dates (Electronic Wait List [EWL], Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date. *Note that prior to FY 2015, this metric was calculated using the earliest possible create date.*

Quarterly Established PC Patient Average Wait Time in Days



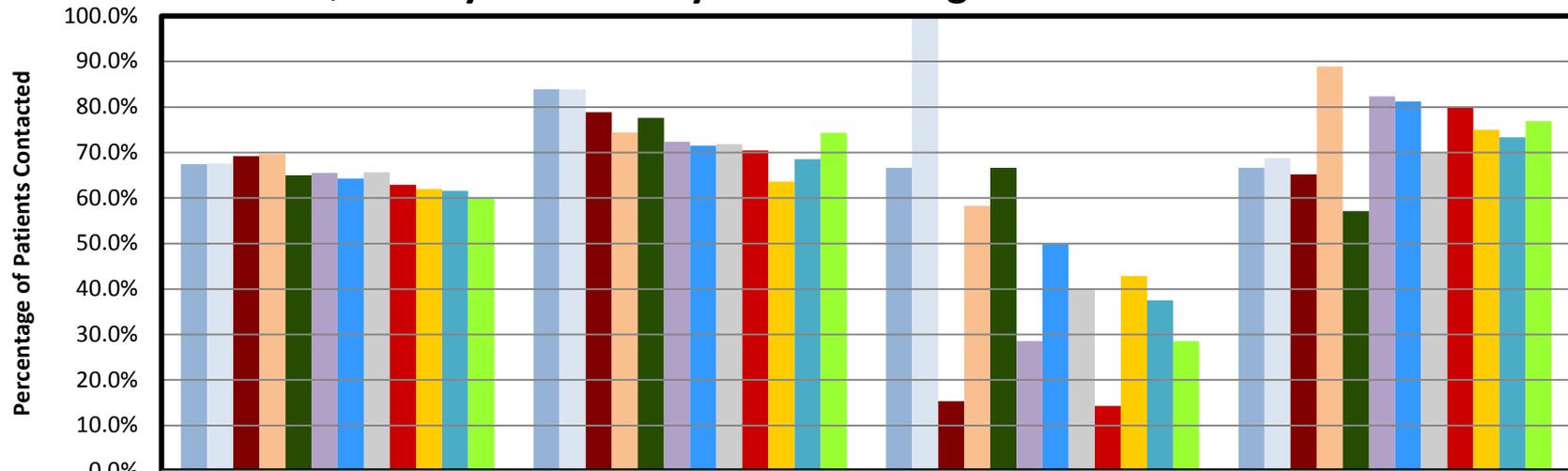
	VHA Total	(553) John D Dingell VAMC	(553GA) Yale	(553GB) Pontiac
JAN-FY16	4.9	4.8	0.3	2.2
FEB-FY16	4.7	5.0	0.4	2.9
MAR-FY16	4.4	5.2	0.5	2.2
APR-FY16	4.3	5.1	0.7	3.8
MAY-FY16	4.3	5.6	2.2	2.6
JUN-FY16	4.4	5.8	2.3	3.2
JUL-FY16	4.4	6.0	2.9	4.7
AUG-FY16	4.3	6.2	2.7	3.7
SEP-FY16	4.2	6.2	3.1	2.4
OCT-FY17	3.8	6.6	2.8	2.7
NOV-FY17	4.0	6.0	3.5	3.9
DEC-FY17	4.0	7.2	2.4	4.7

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.

Quarterly Team 2-Day Post Discharge Contact Ratio



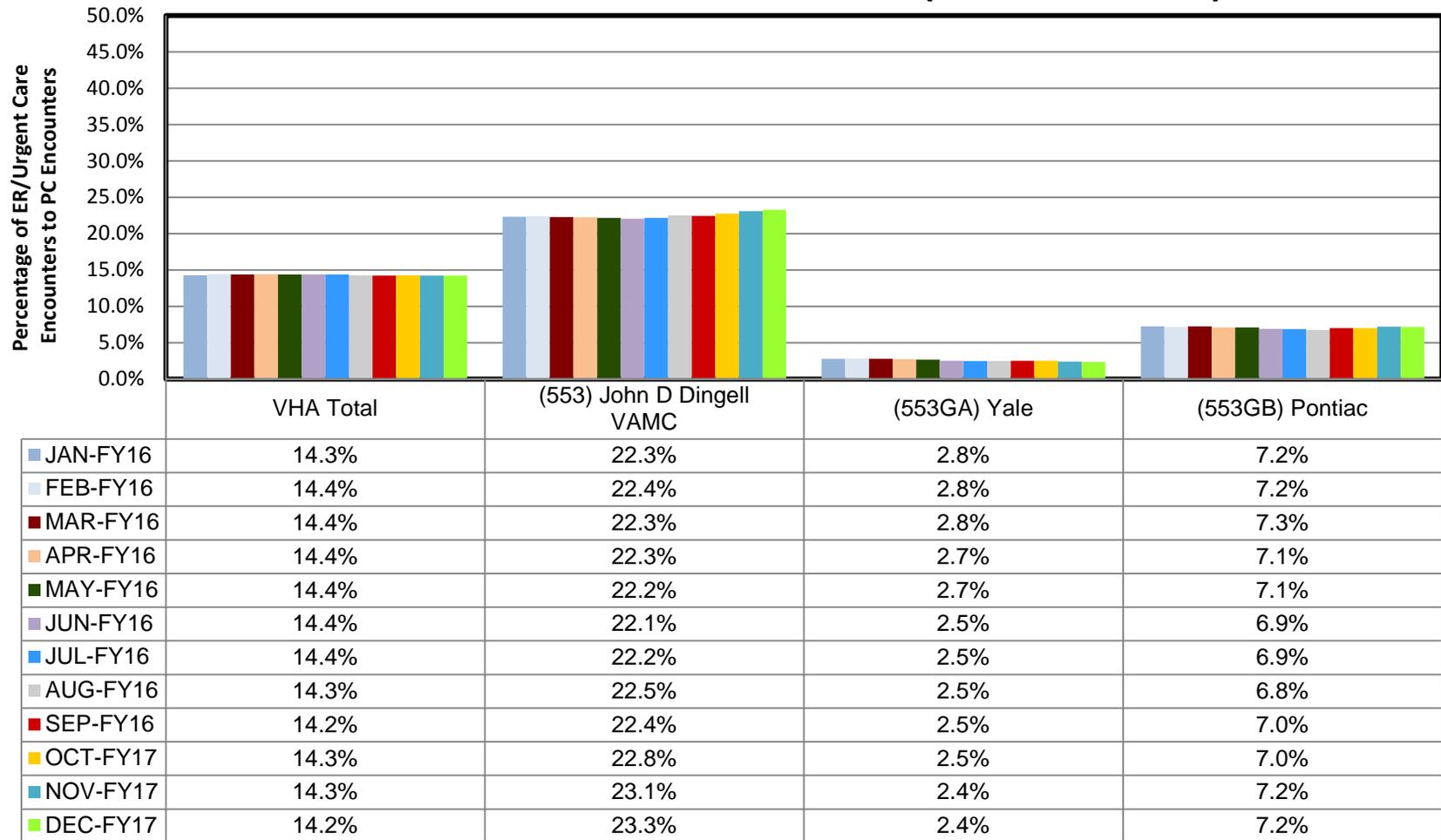
	VHA Total	(553) John D Dingell VAMC	(553GA) Yale	(553GB) Pontiac
JAN-FY16	67.5%	83.9%	66.7%	66.7%
FEB-FY16	67.6%	83.9%	100.0%	68.8%
MAR-FY16	69.2%	78.9%	15.4%	65.2%
APR-FY16	69.7%	74.4%	58.3%	88.9%
MAY-FY16	65.0%	77.6%	66.7%	57.1%
JUN-FY16	65.5%	72.4%	28.6%	82.4%
JUL-FY16	64.3%	71.5%	50.0%	81.3%
AUG-FY16	65.7%	71.8%	40.0%	70.0%
SEP-FY16	62.9%	70.4%	14.3%	80.0%
OCT-FY17	62.0%	63.6%	42.9%	75.0%
NOV-FY17	61.6%	68.5%	37.5%	73.3%
DEC-FY17	59.9%	74.3%	28.6%	76.9%

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.”

Quarterly Ratio of ER/Urgent Care Encounters While on Panel to PC Encounters While on Panel (FEE ER Excluded)



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.

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

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

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

Source: VHA Support Service Center.

Relevant OIG Reports

July 1, 2014 through September 1, 2017

Healthcare Inspection – Alleged Mismanagement and Quality of Care Issues in Surgical Service, John D. Dingell VA Medical Center, Detroit, Michigan

6/19/2017 | 15-02994-269 | [Summary](#) | [Report](#)

Healthcare Inspection – Documentation of Patient Enrollment Concerns in Home Telehealth John D. Dingell VA Medical Center Detroit, Michigan

2/9/2017 | 14-00750-143 | [Summary](#) | [Report](#)

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

6/18/2015 | 15-01297-368 | [Summary](#) | [Report](#)

Combined Assessment Program Review of the John D. Dingell VA Medical Center, Detroit, Michigan

9/4/2014 | 14-02069-268 | [Summary](#) | [Report](#)

Community Based Outpatient Clinic and Primary Care Clinic Reviews at John D. Dingell VA Medical Center, Detroit, Michigan

7/22/2014 | 14-00931-213 | [Summary](#) | [Report](#)

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: November 13, 2017

From: Network Director, VISN 10 (10N10)

Subject: **CHIP Review of the John D. Dingell VA Medical Center, Detroit, MI**

To: Director, Atlanta Office of Healthcare Inspections (54AT)

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

1. Attached please find our corrective action to the CHIP Review of the John D. Dingell VA Medical Center, Detroit, MI.
2. I have reviewed and concur with the response submitted by the Medical Center Director.

(Original signed by:)

Thelma Jane Johnson

For Robert P. McDivitt, FACHE

Attachment

Facility Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: November 11, 2017

From: Director, John D. Dingell VA Medical Center (553/00)

Subject: CAP Review of the John D. Dingell VA Medical Center, Detroit, MI

To: VISN 10/OIG CAP Survey Office

1. Thank you for the opportunity to review the draft of inspector General report on the John D. Dingell VA Medical Center CAP Review. I have reviewed each recommendation and concur with the findings.
2. If you have any questions, or wish to discuss this report, please contact me at (313) 576-1212



Pamela J. Reeves, MD.

OIG Contact and Staff Acknowledgments

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

Endnotes

^a The references used for QSV were:

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

^b The references used for Medication Management: Anticoagulation Therapy included:

- VHA Directive 1026; *VHA Enterprise Framework for Quality, Safety, and Value*; August 2, 2013.
- VHA Directive 1033, *Anticoagulation Therapy Management*, July 29, 2015.
- VHA Directive 1088, *Communicating Test Results to Providers and Patients*, October 7, 2015.

^c The references used for Coordination of Care: Inter-Facility Transfers included:

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

^d The references used for EOC included:

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

^e The references used for Moderate Sedation included:

- VHA Handbook 1004.01, *Informed Consent for Clinical Treatments and Procedures*, August 14, 2009.
- VHA Directive 1039, *Ensuring Correct Surgery and Invasive Procedures*, July 26, 2013.
- VHA Directive 1073, *Moderate Sedation by Non-Anesthesia Providers*, December 30, 2014.
- VHA Directive 1177; *Cardiopulmonary Resuscitation, Basic Life Support, and Advanced Cardiac Life Support Training for Staff*, November 6, 2014.
- VA National Center for Patient Safety. *Facilitator's Guide for Moderate Sedation Toolkit for Non-Anesthesiologists*. March 29, 2011.
- American Society of Anesthesiologists. Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists. *Anesthesiology*. 2002; 96:1004–17.
- TJC. Hospital Standards. January 2016. PC.03.01.01, EP1 and MS.06.01.03 EP6.

^f The references used for CNH Oversight included:

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

^g The reference used for PACT Compass data graphs was:

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

^h The reference used for the Strategic Analytics for Improvement and Learning (SAIL) metric definitions was:

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