



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

Office of Healthcare Inspections

Report No. 17-01851-72

**Comprehensive Healthcare
Inspection Program Review
of the Central Alabama
Veterans Health Care System
Montgomery, Alabama**

February 6, 2018

Washington, DC 20420

In addition to general privacy laws that govern release of medical information, disclosure of certain veteran health or other private information may be prohibited by various Federal statutes including, but not limited to, 38 U.S.C. §§ 5701, 5705, and 7332, absent an exemption or other specified circumstances. As mandated by law, OIG adheres to privacy and confidentiality laws and regulations protecting veteran health or other private information in this report.

**To Report Suspected Wrongdoing in VA Programs and Operations
Telephone: 1-800-488-8244
Web site: www.va.gov/oig**

Glossary

CBOC	community based outpatient clinic
CHIP	Comprehensive Healthcare Inspection Program
HER	electronic health record
EOC	environment of care
facility	Central Alabama Veterans Health Care System
FY	fiscal year
MH	mental health
Nurse Executive	Associate Director for Patient Care Services
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
PC	primary care
PTSD	post-traumatic stress disorder
QSV	quality, safety, and value
RRTP	Residential Rehabilitation Treatment Program
SAIL	Strategic Analytics for Improvement and Learning
TJC	The Joint Commission
UM	utilization management
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	4
Leadership and Organizational Risks	4
Quality, Safety, and Value	14
Medication Management: Anticoagulation Therapy	17
Coordination of Care: Inter-Facility Transfers	19
Environment of Care.....	21
Mental Health Residential Rehabilitation Treatment Program	25
Post-Traumatic Stress Disorder Care	27
Appendixes	
A. Summary Table of Comprehensive Healthcare Inspection Program Review Findings.....	30
B. Facility Profile and VA Outpatient Clinic Profiles	33
C. VHA Policies Beyond Recertification Dates.....	35
D. Patient Aligned Care Team Compass Metrics	36
E. Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions.....	40
F. Relevant OIG Reports	42
G. VISN Director Comments	43
H. Facility Director Comments.....	44
I. OIG Contact and Staff Acknowledgments	45
J. Report Distribution	46
K. Endnotes	47

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 Central Alabama Veterans Health Care System (facility). The review covers key clinical and administrative processes that are associated with promoting quality care.

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

1. Leadership and Organizational Risks
2. Quality, Safety, and Value
3. Medication Management
4. Coordination of Care
5. Environment of Care
6. High-Risk Processes¹
7. Long-Term Care²

This review was conducted during an unannounced visit made during the week of June 5, 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 Central Alabama Veterans Health Care System, the leadership team consists of the Facility Director, Chief of Staff, Associate Director for Patient Care Services (Nurse Executive), Deputy Director, and Associate Director. Organizational communication and accountability are carried out through a committee reporting structure with the Medical Center Governing Board having oversight for leadership groups such as the Medical Executive Council; Quality, Safety

¹ The high risk focus area of Moderate Sedation was not reviewed during this site visit because the facility does not perform invasive procedures using moderate sedation.

² The Community Nursing Home Oversight special focus area was not performed for the Central Alabama Veterans Health Care System because the facility provided long-term care to patients for greater than 90 days through a very limited number of contracts.

and Value Council; and Operations and Planning Council. The leaders are members of the Medical Executive Governing Board through which they track, trend, and monitor quality of care and patient outcomes.

Except for the Deputy Director position, which was vacant at the time of the review, OIG found that the remaining executive leaders had been working together as a team since February 2017. In the review of selected employee and patient survey results regarding facility senior leadership, OIG noted that there were opportunities to improve patients' experiences and that facility leaders implemented processes and plans to improve both employee and patient satisfaction.

Additionally, OIG reviewed accreditation agency findings, sentinel events, disclosures of adverse patient events, Patient Safety Indicator data, and Strategic Analytics for Improvement and Learning (SAIL) data and did not identify any substantial organizational risk factors. OIG recognizes that the SAIL model has limitations for identifying all areas of clinical risk but is "a way to understand the similarities and differences between the top and bottom performers" within the Veterans Health Administration (VHA).³

Although the senior leadership team was knowledgeable about selected SAIL metrics, the leaders should continue to take actions to improve performance of the Quality of Care and Efficiency metrics likely contributing to the current 3-star SAIL rating. In the review of key care processes, OIG issued seven recommendations that are attributable to the Chief of Staff 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 general compliance with requirements for protected peer review, utilization management,⁴ and patient safety reporting and found 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. However, OIG noted a deficiency in credentialing and privileging processes.

Coordination of Care. OIG noted that the facility developed and implemented a patient transfer policy but identified a deficiency with transfer documentation when patients are transferred to other facilities.

³ VHA Support Service Center (VSSC). The Strategic Analytics for Improvement and Learning (SAIL) Value Model Documentation Manual. Accessed on April 16, 2017:

<http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=2146>.

VHA's Office of Operational Analytics and Reporting developed a model for understanding a facility's performance in relation to nine quality domains and one efficiency domain. The domains within SAIL are made up of multiple composite measures, and the resulting scores permit comparison of facilities within a Veterans Integrated Service Network or across VHA. The SAIL model uses a "star" ranking system to designate a facility's performance in individual measures, domains, and overall quality.

⁴ According to VHA Directive 1117 (July 9, 2014), utilization management involves the forward-looking evaluation of the appropriateness, medical need, and efficiency of health care services according to evidence-based criteria.

Environment of Care. OIG noted a safe and clean environment of care. The parent facility met most of the performance indicators evaluated. OIG did not identify any reportable deficiencies for the representative community based outpatient clinic or for radiology. However, OIG identified deficiencies with environment of care rounds attendance and Interdisciplinary Safety Inspection Team training.

Post-Traumatic Stress Disorder Care. OIG identified deficiencies with providers performing suicide risk assessments, offering further diagnostic evaluations, and completing diagnostic evaluations within 30 days of referral for all patients with a positive post-traumatic stress disorder screen.

Summary

In the review of key care processes, OIG issued seven recommendations that are attributable to the Chief of Staff and Associate Director. The number of recommendations should not be used as a gauge for the overall quality provided at this facility. The intent is for facility leadership to use these recommendations as a “road map” to help improve operations and clinical care. The recommendations address systems issues as well as other less-critical findings that, if left unattended, may eventually interfere with the delivery of quality health care.

Comments

The Veterans Integrated Service Network Director and Facility Director agreed with the CHIP review findings and recommendations and provided acceptable improvement plans. (See Appendixes G and H, pages 43–44, and the responses within the body of the report for the full text of the Directors’ comments.) OIG will follow up on the planned actions until they are completed.



JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
Healthcare Inspections

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 Central Alabama Veterans Health Care System's (facility) inpatient and outpatient settings through a broad overview of key clinical and administrative processes that are associated with quality care and positive patient outcomes. The purpose of the review was to provide oversight of health care services to veterans and to share findings with facility leaders so that informed decisions can be made to improve care.

Scope

The current seven areas of focus for facility reviews are: (1) Leadership and Organizational Risks; (2) Quality, Safety, and Value (QSV); (3) Medication Management; (4) Coordination of Care; (5) Environment of Care (EOC); (6) High-Risk Processes; and (7) Long-Term Care. These were selected because of risks to patients and the organization when care is not performed well. Within four of the fiscal year (FY) 2017 focus areas, the Office of Inspector General (OIG) selected processes for special consideration—Anticoagulation Therapy Management, Inter-Facility Transfers, Moderate Sedation, and Community Nursing Home Oversight (see Figure 1). OIG focused on four areas of clinical operations⁵ and two additional programs with relevance to the facility—Mental Health (MH) Residential Rehabilitation Treatment Program (RRTP) and Post-Traumatic Stress Disorder (PTSD) Care.

⁵ The Community Nursing Home Oversight special focus area did not apply for the Central Alabama Veterans Health Care System because the facility provided long-term care to patients for greater than 90 days through a very limited number of contracts, and the Moderate Sedation focus area did not apply because the facility did not perform procedures using moderate sedation.

**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) requirements⁶ 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;⁷ and discussed processes and validated findings with managers and employees. OIG also considered the multiple locations through which the facility's clinical teams provide care and interviewed executive leaders.⁸

⁶ 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.

⁷ OIG did not review VHA's internal survey results but focused on OIG inspections and external surveys that affect facility accreditation status.

⁸ OIG notes additional challenges for facility leaders when responsibilities span across multiple campuses. Our review methodology also involved assessment of aggregate data for the healthcare care system and, therefore, may not detect measurable differences in care results of the various care locations.

The review covered operations for August 25, 2014⁹ through June 5, 2017, the date when an unannounced week-long site visit commenced. July 11–12, 2017, OIG presented crime awareness briefings to 194 of the facility's 1,595 employees. These briefings covered procedures for reporting suspected criminal activity to OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

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

While onsite, OIG referred issues and concerns beyond the scope of the CHIP review to OIG's 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.

⁹ 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

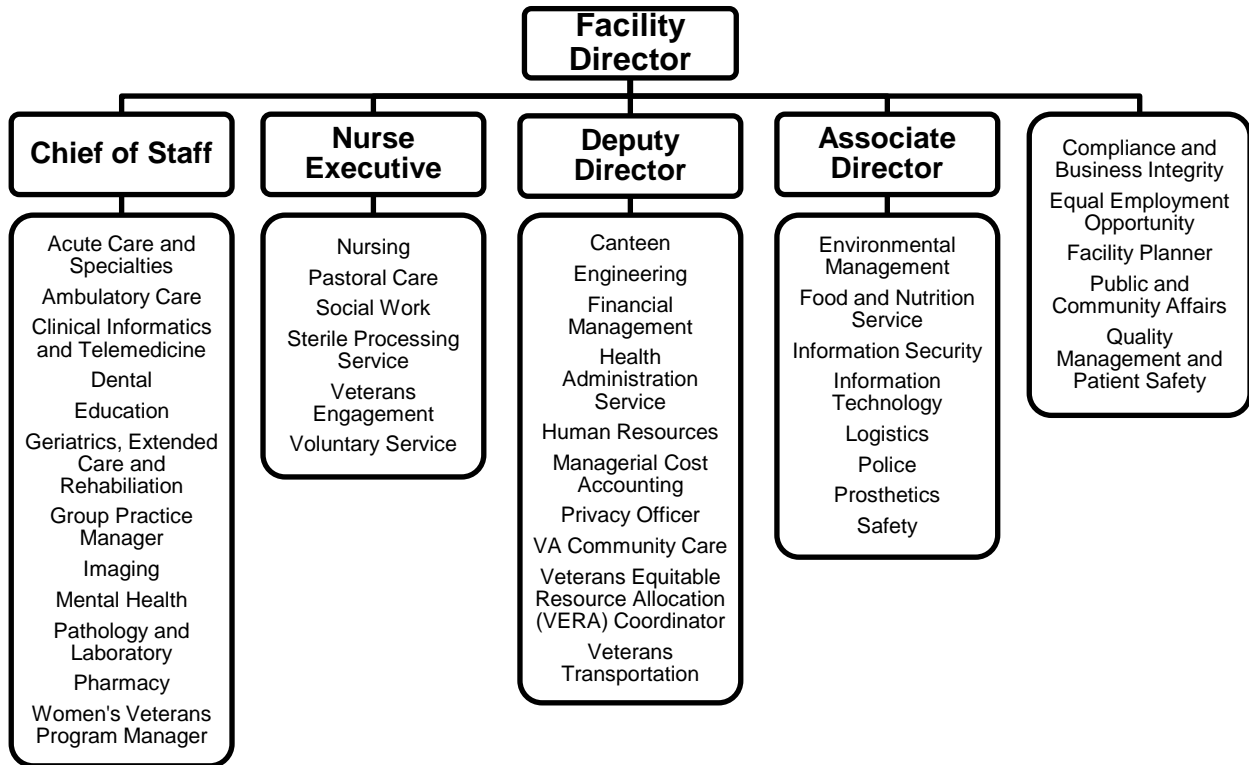
Stable and effective leadership is critical to improving care and sustaining meaningful change. Leadership and organizational risk issues can impact the facility's ability to provide care in all of the selected clinical areas of focus. The factors OIG considered in assessing the facility's risks and 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), Deputy Director, and Associate Director. The Chief of Staff, Nurse Executive, and Associate Director are responsible for overseeing patient care through program chiefs across all facility care locations.

It is important to note that the Facility Director and the Nurse Executive assumed their positions in November 2016 and February 2017, respectively. In addition, the position of Associate Director for Operations was converted to a Deputy Director position in December 2016. This vacancy was announced on May 2, 2017. The selected candidate was submitted to the Veterans Integrated Service Network (VISN) Director for approval on August 4, 2017, and to VHA Executive Recruitment for final approval on September 6, 2017. At the time of OIG's visit, this position was not confirmed with an identified entrance on duty date.

Figure 2. Facility Organizational Chart



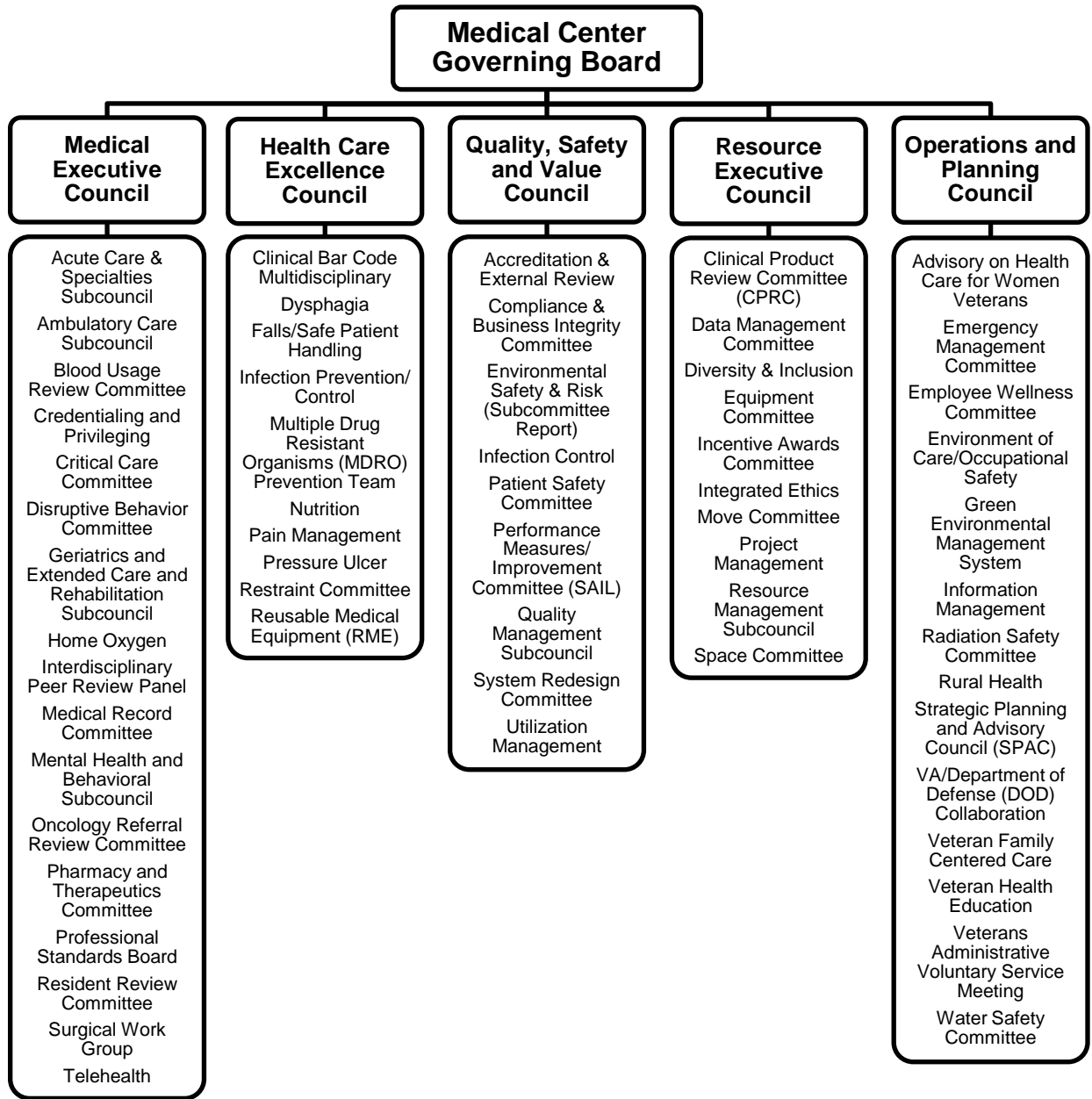
Source: Central Alabama Veterans Health Care System (received June 8, 2017).

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 Medical Center Governing Board, which tracks, trends, and monitors quality of care and patient outcomes. The Facility Director serves as the Chairperson with the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. The Medical Center Governing Board also oversees various working committees, such as the Medical Executive Council; Quality, Safety and Value Council; and Operations and Planning Council. See Figure 3.

Figure 3. Facility Committee Reporting Structure



Source: Central Alabama Veterans Health Care System (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’s performance for both of the selected employee survey results was similar to or lower than the VHA average. The facility leaders’ results (Director’s office average) were rated above the VHA and facility average.¹⁰ All of the patient survey results reflected lower care ratings than the VHA average. In all, while employees appear generally satisfied with the leadership, patients appear less satisfied.

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 ¹¹
All Employee Survey ¹² 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	3.3	3.5
All Employee Survey Servant Leader Index Composite	0–100 where HIGHER scores are more favorable	66.7	65.9	68.1
Survey of Healthcare Experiences of Patients (inpatient): Would you recommend this hospital to your friends and family?	The response average is the percent of “Definitely Yes” responses.	65.8	50.8	
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	72.2	
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): I felt like a valued customer.		73.2	60.1	
Survey of Healthcare Experiences of Patients (outpatient specialty care): I felt like a valued customer.		73.8	63.4	

The facility’s leadership team implemented several initiatives to assist with improving both employee and patient scores. To address employee scores, the Facility Director implemented a monthly communication program to provide updates and respond to

¹⁰ 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.

¹¹ Rating is based on responses by employees who report to the Director.

¹² 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.

questions and concerns. Additionally, a monthly newsletter highlighting facility and employee accomplishments is distributed to all employees, and facility leaders re-established the “Employee of the Month/Quarter/Year” and “Supervisor of the Month/Quarter/Year.”

To address patient scores, the Veterans’ Voice Advisory Committee created an online veterans satisfaction tool to obtain real-time satisfaction data. In addition, the Chief of Staff and the Group Practice Manager hold weekly meetings with service chiefs to review access and establish actions for improvement. In February 2017, facility call center staff completed a Rapid Process Improvement Workshop, and the call center is currently hiring six additional employees. In an effort to decrease primary care (PC) wait times, facility managers are aggressively recruiting PC providers. Also, beginning June 17, 2017, PC providers began scheduling patients for Saturday clinics in three of the facility’s highest volume areas—the main campus at Montgomery; the Tuskegee, AL, campus; and the Columbus, GA, community based outpatient clinic (CBOC).

Accreditation/For-Cause¹³ 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).

OIG also noted the facility’s current accreditation status with the Commission on Accreditation of Rehabilitation Facilities¹⁴ and College of American Pathologists,¹⁵ which demonstrates the facility leaders’ commitment to quality care and services. Additionally, the Long Term Care Institute¹⁶ conducted an inspection of the facility’s Community Living Center.

¹³ 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.

¹⁴ 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.

¹⁵ 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.

¹⁶ 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
<i>VA OIG (Healthcare Inspection – Alleged Manipulation of Outpatient Appointments, Central Alabama VA Health Care System, Montgomery, Alabama, September 21, 2016)</i>	Not Applicable	0	Not Applicable
<i>VA OIG (Healthcare Inspection – Emergency Department Concerns, Central Alabama VA Health Care System, Montgomery, Alabama, January 14, 2016)</i>	August 2014 September 2014 November 2014	3	0
<i>VA OIG (Healthcare Inspection – Mental Health-Related Deficiencies and Inadequate Leadership Responsiveness, Central Alabama VA Health Care System, Montgomery, Alabama, July 29, 2015)</i>	August 2014 September 2014 November 2014	17	2
<i>VA OIG (Healthcare Inspection – Deficient Consult Management, Contractor, and Administrative Practices, Central Alabama Veterans Health Care System, Montgomery, Alabama, July 29, 2015)</i>	August 2014 September 2014 November 2014	7	1
<i>VA OIG (Combined Assessment Program Review of the Central Alabama Veterans Health Care System, Montgomery, Alabama, November 25, 2014)</i>	August 2014	22	0
<i>VA OIG (Community Based Outpatient Clinic and Primary Care Clinic Reviews at Central Alabama Veterans Health Care System, Montgomery, Alabama, December 4, 2014)</i>	August 2014	19	0
TJC ¹⁷ <ul style="list-style-type: none"> • Hospital Accreditation • Nursing Care Center Accreditation • Behavioral Health Care Accreditation • Home Care Accreditation 	January 2016	24 4 0 1	0 0 Not Applicable 0

At the time of OIG’s site visit, the facility had three open recommendations from two previously published hotline reports. However, at the time of this report’s publication, only one recommendation remains open from the hotline report involving deficient consult management, contractor, and administrative practices. This recommendation requires direct monitoring and annual assessment of effectiveness of actions taken to remedy all deficiencies identified in this report by the Under Secretary for Health’s Office for a period of 3 years. To date, in conjunction with the Under Secretary for Health, the Deputy Under Secretary for Health for Operations and Management continues to

¹⁷ 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.

monitor the facility’s action plan quarterly with the VISN and facility leadership. According to facility managers, the target completion date for this recommendation will be July 2018.

While onsite OIG also noted and reviewed documentation for two open recommendations from the previously published CBOC report. Based on the evidence provided, OIG closed one of the recommendations while onsite. The other recommendation was closed following the onsite visit during a final OIG status follow-up on September 19, 2017.

Indicators for Possible Lapses in Care. Within the health care field, the primary organizational risk is the potential for patient harm. Many factors impact the risk for patient harm within a system, including unsafe environmental conditions, sterile processing deficiencies, and infection control practices. Leaders must be able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms. Table 3 summarizes key indicators of risk since OIG’s previous August 2014 Combined Assessment Program and CBOC and PC review inspections through the week of June 5, 2017.

**Table 3. Summary of Selected Organizational Risk Factors¹⁸
(August 2014 to June 5, 2017)**

Factor	Number of Occurrences
Sentinel Events ¹⁹	3
Institutional Disclosures ²⁰	4
Large-Scale Disclosures ²¹	0

¹⁸ 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 Central Alabama Veterans Health Care System is a medium complexity (2) affiliated facility as described in Appendix B.)

¹⁹ 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.

²⁰ 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.

²¹ 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.²² 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 7	Facility
Pressure Ulcers	0.55	0.16	0
Death among surgical inpatients with serious treatable conditions	103.31	42.37	NA
Iatrogenic Pneumothorax	0.20	0.04	0
Central Venous Catheter-Related Bloodstream Infection	0.12	0.15	0
In Hospital Fall with Hip Fracture	0.08	0.11	0
Perioperative Hemorrhage or Hematoma	2.59	0.85	0
Postoperative Acute Kidney Injury Requiring Dialysis	1.20	1.03	0
Postoperative Respiratory Failure	6.31	3.62	0
Perioperative Pulmonary Embolism or Deep Vein Thrombosis	3.29	2.46	0
Postoperative Sepsis	4.45	2.50	0
Postoperative Wound Dehiscence	0.65	0	0
Unrecognized Abdominopelvic Accidental Puncture/Laceration	0.67	0.39	0

Source: VHA Support Service Center.

NA = Not Applicable

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

None of the 11 applicable PSI measures show an observed rate per 1,000 hospital discharges in excess of the observed rates for VISN 7 and VHA.

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.²³ This model includes measures on health care quality, employee satisfaction, access to care, and efficiency, but the model has noted limitations for identifying all areas of clinical risk. The data are presented as one “way to understand the similarities and differences between the top and bottom performers” within VHA.²⁴

²² Agency for Healthcare Research and Quality website, <https://www.qualityindicators.ahrq.gov/>, accessed March 8, 2017.

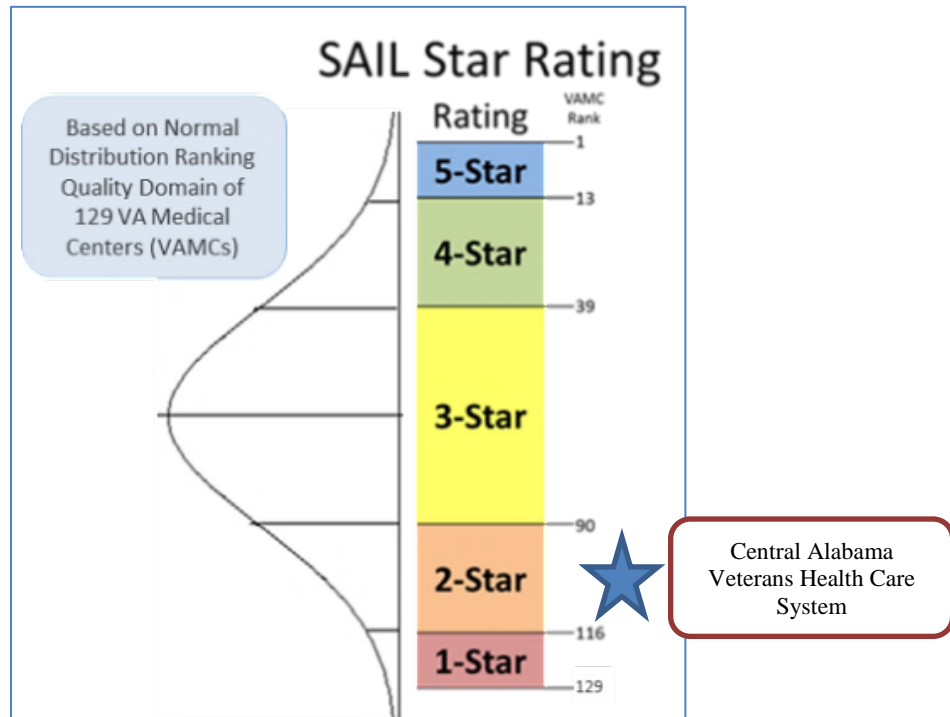
²³ The model is derived from the Thomson Reuters Top Health Systems Study.

²⁴ 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 Central Alabama Veterans Health Care System received an interim rating of 2 stars for overall quality. This means the facility was in the 4th quintile (70–90 percent range). Updated data as of June 30, 2017, indicates that the facility has improved to 3 stars for overall quality.

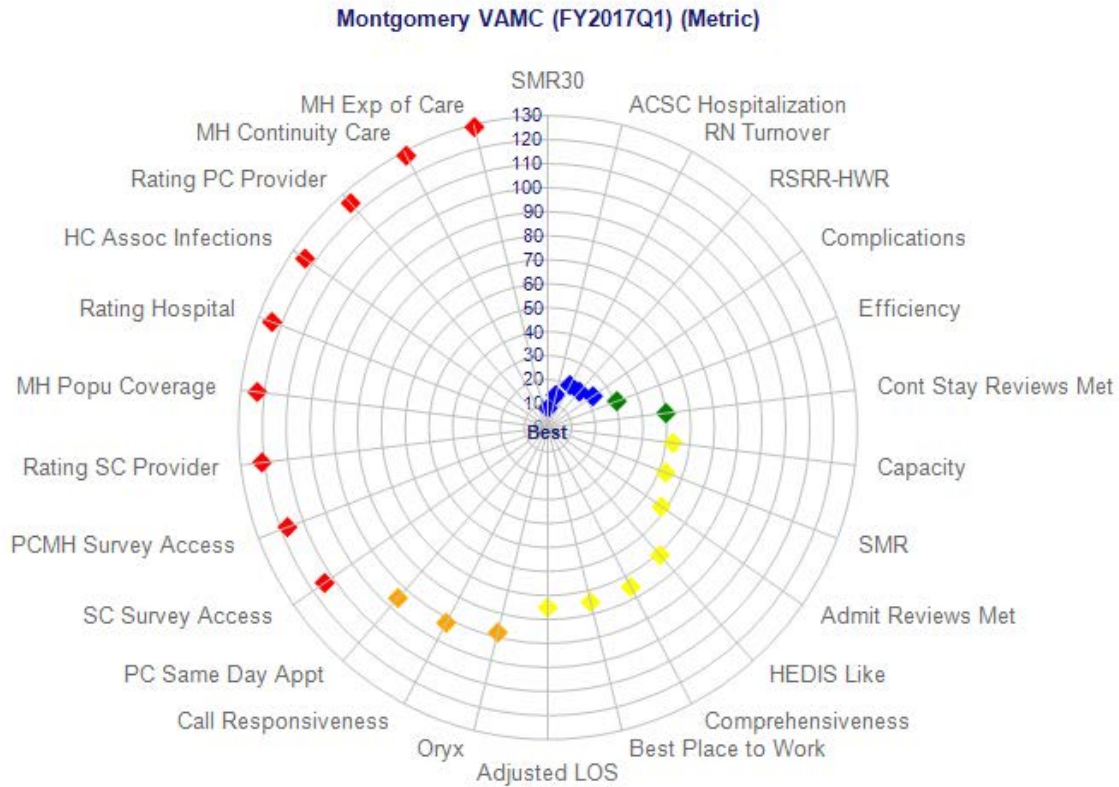
Figure 4. Strategic Analytics for Improvement and Learning Star Rating Distribution (as of September 30, 2016)



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

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, Acute-Care 30-day Standardized Mortality Ratio [SMR30], Registered Nurse [RN] Turnover, and Complications). Metrics in the bottom quintiles reflect areas that need improvement and are denoted in orange and red (for example, Specialty Care [SC] Survey Access, Healthcare-Associated [HC Assoc] Infections, and MH Continuity [of] Care).

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 ongoing processes to improve employee and patient satisfaction. The facility leadership team has selected a candidate for the Deputy Director position; however, at the time of OIG’s visit, the entrance on duty date had not been determined for this candidate. OIG’s review of accreditation organization findings, sentinel events, disclosures, Patient Safety Indicator data, and SAIL results did not identify any substantial organizational risk factors.²⁵ The senior leadership team was knowledgeable about selected SAIL metrics but should continue to take actions to improve care and performance of selected SAIL metrics, particularly Quality of Care and Efficiency metrics likely contributing to the current 3-star rating.

²⁵ 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.²⁶ 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 review²⁷ of clinical care
3. Credentialing and privileging
4. Utilization management (UM) reviews²⁸
5. Patient safety incident reporting and root cause analyses

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

- Senior-level committee responsible for key QSV functions
 - Met at least quarterly
 - Chaired or co-chaired by the Facility Director
 - Reviewed aggregated data routinely
- Protected peer reviews
 - Examined important aspects of care (appropriate and timely ordering of diagnostic tests, timely treatment, and appropriate documentation)
 - Resulted in implementation of Peer Review Committee recommended improvement actions
- Credentialing and privileging processes
 - Considered frequency for Ongoing Professional Practice Evaluation (OPPE)²⁹ data review
 - Indicated a Focused Professional Practice Evaluation³⁰

²⁶ Department of Veterans Affairs, Veterans Health Administration. *Blueprint for Excellence*. September 2014.

²⁷ 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.

²⁸ 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.

²⁹ OPPE is the ongoing monitoring of privileged practitioners to identify professional practice trends that impact the quality of care and patient safety.

- UM personnel
 - Completed at least 75 percent of all required inpatient reviews
 - Documented Physician UM Advisors' decisions in the National UM Integration database
 - Reviewed UM data using an interdisciplinary group
- Patient safety personnel
 - Entered all reported patient incidents into the 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 found general compliance with requirements for protected peer review, UM, and patient safety reporting. However, OIG identified the following deficiency in the credentialing and privileging processes that warranted a recommendation for improvement.

Credentialing and Privileging. VHA requires clinical managers to review OPPE 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. Nineteen of the 25 profiles did not contain evidence that service chiefs reviewed OPPE data every 6 months. Credentialing and privileging staff could not clearly articulate facility requirements for frequency of OPPE review. Service line managers cited inadequate training of clinical managers in administrative processes such as credentialing and privileging and providers' lack of awareness of OPPE requirements.

Recommendation

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

³⁰ 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: June 30, 2018

Facility Response: The Chief of Staff with the Medical Service Line Chiefs discussed the requirements and expectations for Ongoing Professional Practice Evaluation (OPPE). A process was established to ensure that OPPEs are conducted timely. Service Line Chiefs are responsible for monitoring and maintaining the OPPEs and compliance data will be reviewed quarterly in each service. The Chief of Staff Office will monitor the process until sustained compliance is achieved for six consecutive months. Monitoring reports will be presented quarterly to the Medical Staff Executive Committee.

Target compliance is 90%.

Medication Management: Anticoagulation Therapy

Comprehensive medication management is defined as the standard of care that ensures clinicians individually assess each patient's medications to determine that each is appropriate for the patient, effective for the medical condition, safe given the comorbidities and other medications prescribed, and able to be taken by the patient as intended. From October 1, 2015 through September 30, 2016, more than 482,000 veterans received an anticoagulant,³¹ or a blood thinner, which is a drug that works to prevent the coagulation or clotting of blood. TJC's National Patient Safety Goal (3.05.01) focuses on improving anticoagulation safety to reduce patient harm and states, "...anticoagulation medications are more likely than others to cause harm due to complex dosing, insufficient monitoring, and inconsistent patient compliance."

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

OIG reviewed relevant documents and the competency assessment records of 10 employees actively involved in the anticoagulant program and interviewed key employees. Additionally, OIG reviewed the electronic health records (EHRs) of 30 randomly selected patients who were prescribed new anticoagulant medications from July 1, 2015 through June 30, 2016. The list below shows the performance indicators examined.

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

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

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

Coordination of Care: Inter-Facility Transfers

Coordination of care is the process of ensuring continuity of care, treatment, or services provided by a facility, which includes referring individuals to appropriate community resources to meet ongoing identified needs. Effective coordination of care 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 44 randomly selected patients who were transferred out of facility inpatient beds or the Emergency Department to another VHA facility or non-VA facility from July 1, 2015 through June 30, 2016. The list below shows the performance indicators OIG examined.

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

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

Transfer Documentation. VHA requires transferring providers to complete VA Form 10-2649A and/or transfer/progress notes that include all required elements prior to or within a few hours after the transfer. This ensures that patients are part of the decision-making process and that they are assessed for stability prior to transfer. Six of the 44 EHRs (14 percent) did not include documentation of patient or surrogate informed consent, 7 of the 44 EHRs (16 percent) did not include medical and/or behavioral stability, and 16 of the 44 EHRs (36 percent) did not identify the transferring and/or receiving provider or designee. Managers monitored for the presence of VA Form 10-2649A but were unaware of the lack of compliance with the required elements and documentation within the form.

Recommendation

2. The Chief of Staff ensures that for patients transferred out of the facility, providers consistently include patient or surrogate informed consent, medical and/or behavioral stability, and identification of transferring and receiving provider or designee in transfer documentation and monitors providers' compliance.

Facility concurred.

Target date for completion: June 30, 2018

Facility Response: Providers will complete transfer documentation for patients transferred out of the facility. The Chief of Staff has instructed the providers to complete documentation requirements for patient transfers. Bed Management staff monitors the compliance of transfer documentation and reports the results to the Utilization Management Committee and Medical Staff Executive Council for leadership oversight. Quality Management will conduct a monthly chart audit of the provider's transfer documentation until sustained compliance is achieved.

Target compliance is 90%.

Environment of Care

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

Fluoroscopic imaging equipment produces x-rays for the diagnosis, localization, and guidance of interventional procedures.³² 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.³³ 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 three inpatient units (intensive care, medical/surgical, and post-anesthesia care), the Emergency Department, and Radiology Service at the Montgomery campus; the community living center, the community living center-dementia unit, the high-intensity psychiatric unit, and Radiology Service at the Tuskegee campus; and the Dothan CBOC. Additionally, OIG reviewed relevant documents and 16 employee training records and interviewed key employees and managers. The list below shows the location-specific performance indicators selected to examine the risk areas specific to particular settings.

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

³² VHA Handbook 1105.04, *Fluoroscopy Safety*, July 6, 2012.

³³ VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013.

Community Based Outpatient Clinic

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

Radiology

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

Locked Mental Health Unit

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

Conclusions. General safety, infection prevention, and privacy measures were in place. OIG did not note any issues with the availability of medical equipment and supplies. However, OIG identified the deficiencies with EOC rounds and locked MH unit inspection team training that warranted recommendations for improvement.

Parent Facility: Environment of Care Rounds Attendance. VHA requires facilities to perform comprehensive EOC rounds with a designated team that includes specific membership to ensure a safe, clean, and high-quality care environment.³⁴ Each VA medical facility director is responsible for ensuring that the Comprehensive EOC Assessment and Compliance Tool is used to collect data associated with comprehensive EOC rounds at his or her facility.³⁵ OIG reviewed attendance records and found that 11 of 13 required members did not consistently attend EOC rounds. Additionally, the facility did not consistently use the Comprehensive EOC Assessment

³⁴ According to VHA, core membership is composed of representatives from programmatic areas such as nursing, infection control, patient safety, and medical equipment management to ensure adherence to various program requirements. Further, all patient care areas of the hospital must be reviewed at least twice a year.

³⁵ VHA Directive 1608, Comprehensive Environment of Care (CEOC) Program, February 1, 2016.

and Compliance Tool to record participation in EOC rounds. Facility managers and staff were aware of requirements, but staff vacancies, recruitment challenges, and collateral duties contributed to noncompliance. The employee responsible for the Comprehensive EOC Assessment and Compliance Tool was newly appointed and still in training at the time of OIG's review.

Recommendation

3. The Associate Director ensures the team members responsible for comprehensive EOC rounds consistently participate and use the Comprehensive Environment of Care Assessment and Compliance Tool to document results of those rounds and monitors compliance.

Facility concurred.

Target date for completion: June 30, 2018

Facility Response: The facility Environmental Management Services (EMS) Acting Chief sent a memo to the Service Chiefs to identify required membership and designee to EOC Rounds. Training on EOC rounds was conducted in August 2017 to include logging attendance in performance logic. All members have been notified of their responsibilities to attend the rounds. EMS is tracking EOC attendance rounds compliance and reports quarterly to the Environment of Care Committee.

Target compliance is 90%.

Locked Mental Health Unit: Inspection Team Training. VHA requires that facility members of the Interdisciplinary Safety Inspection Team receive training every 12 months on the identification and correction of environmental hazards, including the proper use of the MH EOC Checklist, so they can effectively inspect inpatient MH units to ensure the safety of patients, visitors, and staff.³⁶ Four of the six Interdisciplinary Safety Inspection Team members did not have evidence of completing the required training within the past 12 months. Facility managers and staff were aware of requirements; however, some staff were not compliant due to collateral duties and other priorities, and managers failed to provide oversight to ensure compliance.

Recommendation

4. 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 compliance.

³⁶ VHA National Center for Patient Safety, Mental Health Environment of Care Checklist – Checklist General Instructions, December 8, 2016.

Facility concurred.

Target date for completion: March 30, 2018

Facility Response: The Mental Health Safety Interdisciplinary team is responsible for completing the annual training including the proper use of the Mental Health Environment of Care Checklist. The team members were assigned the annual mandatory training. The course is offered in the Talent Management System which also sends the reminders 90 days prior to due date to alert employees to complete the course. The Patient Safety Manager monitors and maintains the training compliance records and reports the results biannually to the Environment of Care Committee.

Target compliance is 90%.

Mental Health Residential Rehabilitation Treatment Program

For this facility, OIG evaluated the MH RRTP, more commonly referred to as domiciliary or residential treatment programs. This distinct level of MH residential care is appropriate for veterans with mental illnesses or addictive disorders who require structure and support to address psychosocial deficits, including homelessness and unemployment.

MH RRTPs provide 24-hour residential rehabilitative and clinical care in a therapeutic setting to eligible veterans who have multiple and severe medical conditions, mental illness, addiction, or psychosocial deficits. They provide the least intensive level of VA inpatient care and differ from acute inpatient and nursing home care as veterans in MH RRTPs are generally capable of self-care. MH RRTPs address rehabilitation, recovery, health maintenance, improved quality of life, and community integration in addition to specifically treating medical conditions, mental illnesses, and addictive disorders. Facility leaders must provide a safe, well-maintained, and appropriately-furnished residential environment that supports and enhances recovery efforts.³⁷

The purpose of the review was to determine whether the facility's MH RRTPs complied with selected EOC requirements.^e

OIG reviewed relevant documents, inspected the MH RRTP areas, and interviewed key employees and managers. The list below shows the performance indicators OIG reviewed.

- Environmental cleanliness
- Appropriate fire extinguishers near grease producing cooking devices³⁸
- Policies/procedures for safe medication management and contraband detection
- Performance and documentation of monthly self-inspections to include all required elements, work orders for items needing repair, and correction of identified deficiencies
- Performance and documentation of contraband inspections, rounds of all public spaces, daily bed checks, and resident room inspections for unsecured medications
- Written agreements in place acknowledging resident responsibility for medication security
- Keyless entry to MH RRTP main point(s) of entry, closed circuit television monitoring, and all other doors locked to outside and alarmed
- Closed circuit television (CCTV) monitors with recording capability in public areas but not in treatment areas or private spaces
- Signage alerting veterans and visitors of CCTV recording

³⁷ VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010.

³⁸ This performance indicator did not apply to this facility and thus, was not reviewed.

- Process for employees to respond and articulate behavioral health and medical emergencies
- Keyless entry or door locks to women veterans' rooms
- Medications secured in residents' rooms

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

Post-Traumatic Stress Disorder Care

For this facility, OIG also evaluated PTSD, a disorder that may occur “...following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury; other threat to one’s physical integrity; witnessing an event that involves death, injury or threat to the physical integrity of another person; learning about unexpected or violent death, serious harm, threat of death or injury experienced by a family member or other close associate.”³⁹

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

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

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

OIG reviewed relevant documents and interviewed key employees and managers. Additionally, OIG reviewed the EHRs of 35 randomly selected patients who had a positive PTSD screen from April 1, 2016 through March 31, 2017. The list below shows the performance indicators OIG reviewed.

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

Conclusions. Generally, OIG found that providers did not consistently complete suicide risk assessments or offer and/or complete further diagnostic evaluations. OIG identified the following deficiencies that warranted recommendations for improvement.

Suicide Risk Assessment and Diagnostic Evaluation. VHA requires that each patient with a positive PTSD screen receive a suicide risk assessment and an offer for referral for further diagnostic evaluation. If referred for the further diagnostic evaluation, VHA

³⁹ VHA Handbook 1160.03, *Programs for Veterans with Post-Traumatic Stress Disorder (PTSD)*, March 12, 2010.

requires providers to complete the evaluations within 30 days. This ensures early identification and management of stress-related disorders. OIG found that 9 of 35 patients (26 percent) did not receive a suicide risk assessment, and acceptable providers did not offer 6 of the 35 patients (17 percent) referrals for diagnostic evaluations. Additionally, providers did not complete clinical diagnostic evaluations within 30 days for 5 of 13 applicable patients. Program managers were aware of the requirements, but inadequate MH staffing levels and frequent turnover prevented compliance in meeting the requirements for PTSD care.

Recommendations

5. The Chief of Staff ensures that acceptable providers perform suicide risk assessments for all patients with positive post-traumatic stress disorder screens and monitors providers' compliance.

Facility concurred.

Target date for completion: June 30, 2018

Facility Response: The updated/revised Mental Health clinical reminders was installed which includes the follow-up suicide risk assessment for all patients with positive PTSD screens. Providers were provided training materials about the updated reminders. Quality Management will monitor the compliance monthly on the documentation of suicide risk assessments for all patients with positive PTSD screens and report the results to the Medical Staff Executive Council for leadership oversight.

Target compliance is 90%.

6. The Chief of Staff ensures that acceptable providers offer further diagnostic evaluations to patients with positive post-traumatic stress disorder screens and monitors providers' compliance.

Facility concurred.

Target date for completion: June 30, 2018

Facility Response: The updated/revised Mental Health clinical reminders was installed which includes the documentation of offered diagnostic evaluation/treatment for all patients with positive PTSD screens. Providers were provided training materials about the updated reminders. Quality Management will monitor the compliance monthly on the documentation of further diagnostic evaluations to patients with positive PTSD screens and reports the results to the Medical Staff Executive Council for leadership oversight.

Target compliance is 90%.

7. The Chief of Staff ensures that providers complete diagnostic evaluations for patients with positive post-traumatic stress disorder screens within 30 days of the referral and monitors providers' compliance.

Facility concurred.

Target date for completion: June 30, 2018

Facility Response: The updated/revised Mental Health clinical reminders was installed which includes completion of diagnostic evaluations for patients with positive PTSD screens. Quality Management will monitor the compliance on documentation of diagnostic evaluations for patients with positive PTSD screens within 30 days of the referral and reports the results to the Medical Staff Executive Council for leadership oversight.

Target compliance is 90%.

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 	Seven 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 and Associate Director. See details below.	
Healthcare Processes	Performance Indicators	Critical Recommendations ⁴⁰ 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 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 	None	None
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 	<ul style="list-style-type: none"> Providers consistently include patient or surrogate informed consent, medical and/or behavioral stability, and identification of transferring and receiving provider for patients transferred out of the facility. 	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 ○ General Safety ○ Infection prevention ○ Environmental cleanliness ○ Exam room privacy ○ Availability of feminine hygiene products and medical equipment and supplies • CBOC <ul style="list-style-type: none"> ○ General safety ○ Infection prevention ○ 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 	<p>None</p>	<ul style="list-style-type: none"> • Team members responsible for comprehensive EOC rounds consistently participate and use the Comprehensive EOC Assessment and Compliance Tool to document results of those rounds. • Interdisciplinary Safety Inspection Team members 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
Mental Health Residential Rehabilitation Treatment Program	<ul style="list-style-type: none"> • Environmental cleanliness and fire safety • Policies/procedures <ul style="list-style-type: none"> ○ Safe medication management ○ Contraband detection • Monthly self-inspections • Contraband and unsecured medication inspections • Locked and alarmed entries • Closed circuit television monitors with recording capability in public areas • Process for responding to behavioral health and medical emergencies 	None	None
Post-Traumatic Stress Disorder Care	<ul style="list-style-type: none"> • Completion of a suicide risk assessment by acceptable providers • Established plan of care and disposition • Offer of further diagnostic evaluations • Completion of diagnostic evaluations • Receipt of MH treatment when applicable 	<ul style="list-style-type: none"> • Acceptable providers perform suicide risk assessments for all patients with positive PTSD screens. • Acceptable providers offer further diagnostic evaluations to patients with positive PTSD screens. • Providers complete diagnostic evaluations for patients with positive PTSD screens within 30 days of the referral. 	

Facility Profile

The table below provides general background information for this medium-complexity (2)⁴¹ affiliated⁴² facility with multiple campuses reporting to VISN 7.

Table 5. Facility Profile for Montgomery (619) 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	\$238.0	\$300.2	\$290.3
Number of:			
• Unique Patients	46,817	48,302	49,101
• Outpatient Visits	439,137	475,949	502,151
• Unique Employees⁴⁶	1,129	1,222	1,396
Type and Number of Operating Beds:			
• Acute	41	41	41
• Mental Health	30	30	30
• Community Living Center	160	160	160
• Domiciliary	73	73	73
Average Daily Census:			
• Acute	15	13	11
• Mental Health	26	21	19
• Community Living Center	81	74	70
• Domiciliary	69	62	61

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; 2 designation indicates a facility with medium volume, low-risk patients, few complex clinical programs, and small or no research and teaching programs. Retrieved September 7, 2017, from <http://opes.vssc.med.va.gov/FacilityComplexityLevels/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 Provided for October 1, 2015 through September 30, 2016

Location	Station No.	PC Workload/Encounters	MH Workload/Encounters	Specialty Care Services ⁴⁹ Provided	Diagnostic Services ⁵⁰ Provided	Ancillary Services ⁵¹ Provided
Columbus, GA	619GA	5,534	8,403	Endocrinology Neurology Eye	NA	Nutrition Pharmacy Social Work Weight Management
Dothan, AL	619GB	9,773	6,754	NA	NA	NA
Fort Rucker, AL	619GD	10,117	4,699	Endocrinology Neurology Blind Rehab Eye	NA	Dental Nutrition Pharmacy Social Work Weight Management
Monroeville, AL	619GE	4,221	1,538	NA	NA	Social Work Weight Management
Montgomery, AL	619GF	17,673	471	Neurology Spinal Cord Injury Eye	Radiology	Dental Nutrition Pharmacy Social Work
Fort Benning, GA	619QB	20,560	1,245	Eye	NA	Nutrition Pharmacy Social Work

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 Dothan, AL (619QA), 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 Specialty care services refer to non-PC and non-MH services provided by a physician.

⁵⁰ Diagnostic services include EKG, EMG, laboratory, nuclear medicine, radiology, and vascular lab services.

⁵¹ Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

VHA Policies Beyond Recertification Dates

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

1. VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010 (recertification due date June 30, 2015).
2. VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011 (recertification due date February 29, 2016).
3. VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012 (recertification due date September 30, 2017).
4. VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011 (recertification due date March 31, 2016).
5. VHA Handbook 1105.04, *Fluoroscopy Safety*, July 6, 2012 (recertification due date July 31, 2017).
6. VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008 (recertification due date September 30, 2013), amended November 16, 2015.
7. VHA Handbook 1160.03, *Programs for Veterans with Post-Traumatic Stress Disorder (PTSD)*, March 12, 2010 (recertification due date March 31, 2015), revised December 8, 2015.⁵²
8. VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010 (recertification due date December 31, 2015).

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

⁵² This handbook was in effect during the review period for this report; it was rescinded and replaced by VHA Directive 1160.03, *Programs for Veterans with Post-Traumatic Stress Disorder (PTSD)*, November 16, 2017.

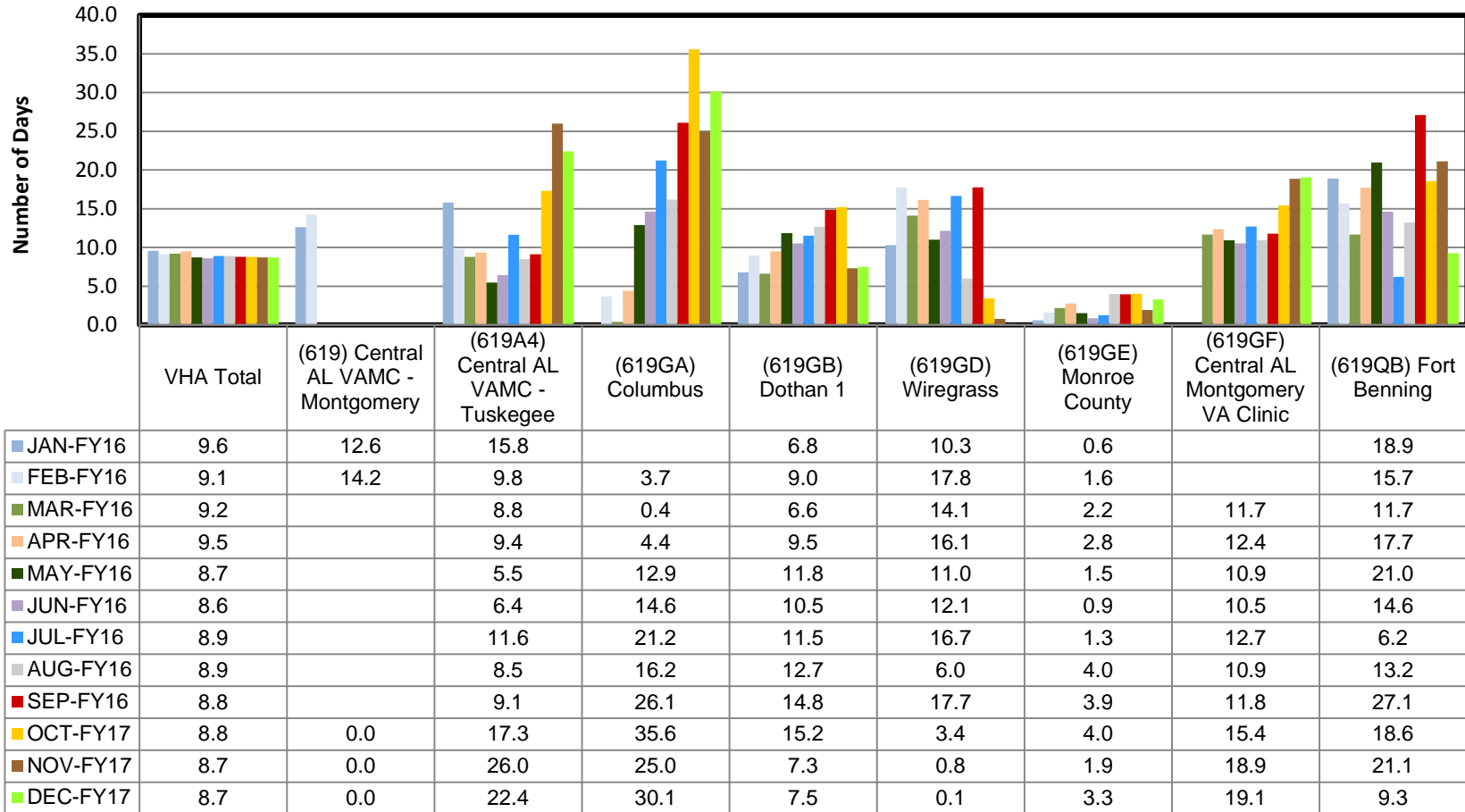
⁵³ VHA Directive 6330(1), *Controlled National Policy/Directives Management System*, June 24, 2016, amended January 11, 2017.

⁵⁴ VA Under Secretary for Health. "Validity of VHA Policy Document." Memorandum. June 29, 2016.

⁵⁵ Ibid.

Patient Aligned Care Team Compass Metrics

Quarterly New PC Patient Average Wait Time in Days

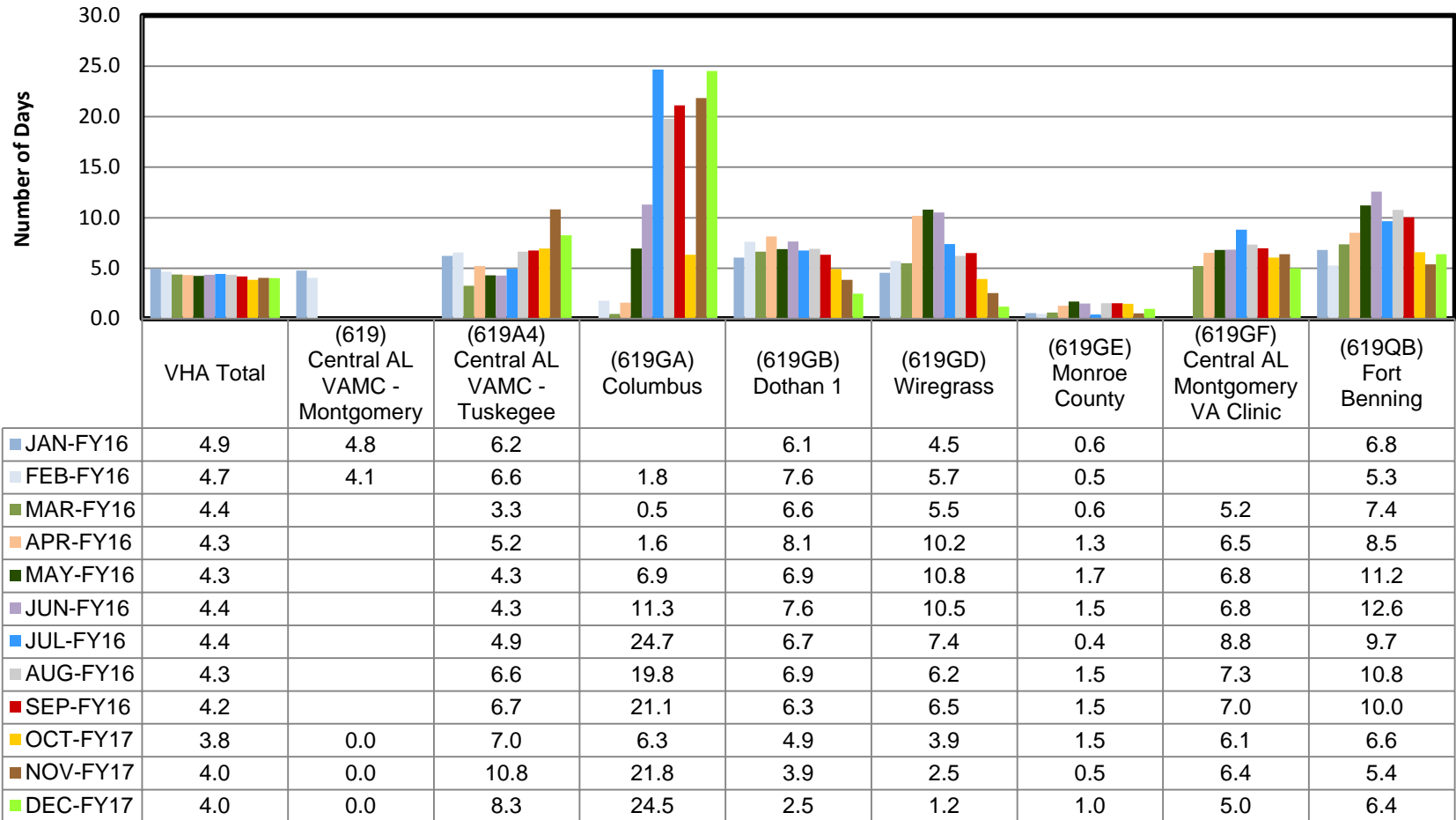


Source: VHA Support Service Center.

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.* Blank cells indicate the absence of reported data.

Quarterly Established PC Patient Average Wait Time in Days

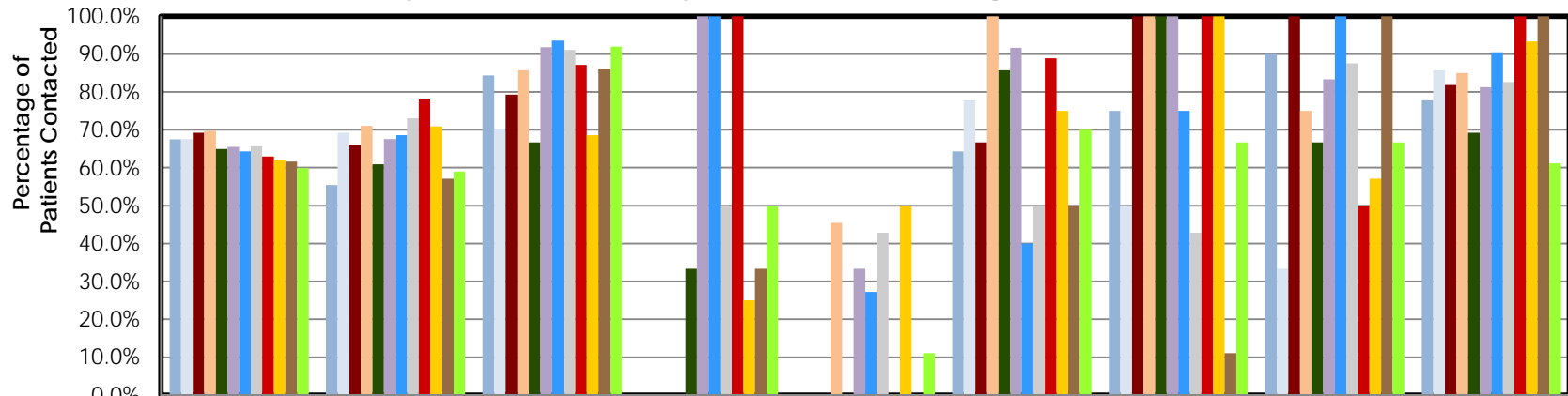


Source: VHA Support Service Center.

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

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

Quarterly Team 2-Day Post Discharge Contact Ratio



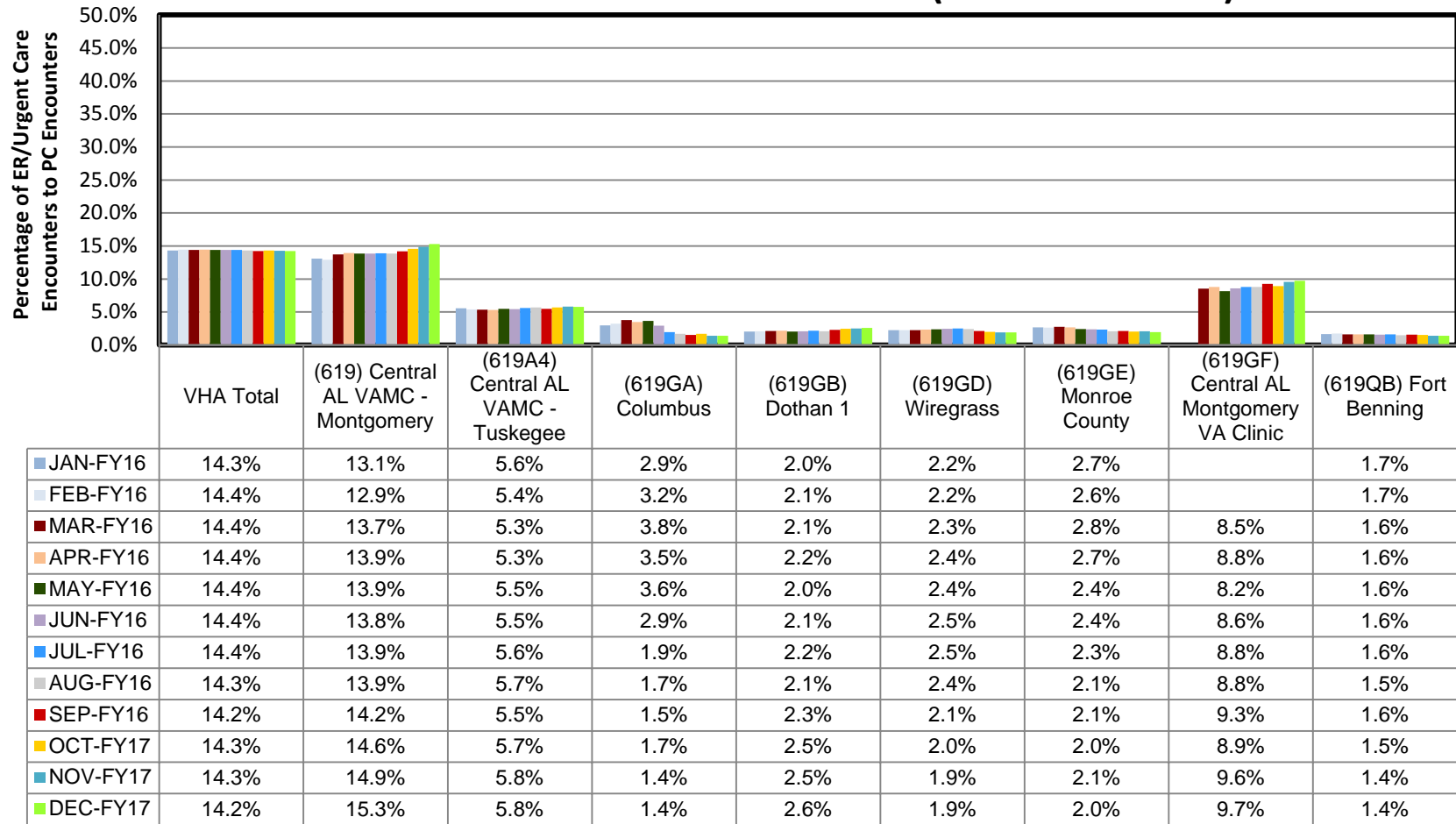
	VHA Total	(619) Central AL VAMC - Montgomery	(619A4) Central AL VAMC - Tuskegee	(619GA) Columbus	(619GB) Dothan 1	(619GD) Wiregrass	(619GE) Monroe County	(619GF) Central AL Montgomery VA Clinic	(619QB) Fort Benning
JAN-FY16	67.5%	55.4%	84.4%	0.0%	0.0%	64.3%	75.0%	90.0%	77.8%
FEB-FY16	67.6%	69.2%	70.4%	0.0%	0.0%	77.8%	50.0%	33.3%	85.7%
MAR-FY16	69.2%	65.9%	79.3%	0.0%	0.0%	66.7%	100.0%	100.0%	81.8%
APR-FY16	69.7%	71.1%	85.7%	0.0%	45.5%	100.0%	100.0%	75.0%	85.0%
MAY-FY16	65.0%	60.9%	66.7%	33.3%	0.0%	85.7%	100.0%	66.7%	69.2%
JUN-FY16	65.5%	67.6%	91.8%	100.0%	33.3%	91.7%	100.0%	83.3%	81.3%
JUL-FY16	64.3%	68.6%	93.5%	100.0%	27.3%	40.0%	75.0%	100.0%	90.5%
AUG-FY16	65.7%	73.0%	91.1%	50.0%	42.9%	50.0%	42.9%	87.5%	82.6%
SEP-FY16	62.9%	78.3%	87.1%	100.0%	0.0%	88.9%	100.0%	50.0%	100.0%
OCT-FY17	62.0%	70.9%	68.6%	25.0%	50.0%	75.0%	100.0%	57.1%	93.3%
NOV-FY17	61.6%	57.1%	86.2%	33.3%	0.0%	50.0%	11.1%	100.0%	100.0%
DEC-FY17	59.9%	59.0%	92.0%	50.0%	11.1%	70.0%	66.7%	66.7%	61.1%

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. Blank cells indicate the absence of reported data.

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

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

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

Source: VHA Support Service Center.

Relevant OIG Reports

August 25, 2014 through November 1, 2017⁵⁶

Healthcare Inspection – Alleged Manipulation of Outpatient Appointments, Central Alabama VA Health Care System, Montgomery, Alabama

9/21/2016 | 15-03942-392 | [Summary](#) | [Report](#)

Healthcare Inspection – Emergency Department Concerns, Central Alabama VA Health Care System, Montgomery, Alabama

1/14/2016 | 14-04530-41 | [Summary](#) | [Report](#)

Healthcare Inspection – Mental Health-Related Deficiencies and Inadequate Leadership Responsiveness, Central Alabama VA Health Care System, Montgomery, Alabama

7/29/2015 | 14-04530-414 | [Summary](#) | [Report](#)

Healthcare Inspection – Deficient Consult Management, Contractor, and Administrative Practices, Central Alabama VA Health Care System, Montgomery, Alabama

7/29/2015 | 14-04530-452 | [Summary](#) | [Report](#)

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

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

Community Based Outpatient Clinic and Primary Care Clinic Reviews at Central Alabama Veterans Health Care System, Montgomery, Alabama

12/4/2014 | 14-00930-14 | [Summary](#) | [Report](#)

Combined Assessment Program Review of the Central Alabama Veterans Health Care System, Montgomery, Alabama

11/25/2014 | 14-02079-10 | [Summary](#) | [Report](#)

⁵⁶ These are relevant reports that focused on the facility as well as national-level evaluations of which the facility was a component of the review.

VISN Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: December 26, 2017

From: Director, VA Southeast Network (10N7)

Subject: **CHIP Review of the Central Alabama Veterans Health Care System, Montgomery, AL**

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

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

1. I have had the opportunity to review the Draft Report Comprehensive Healthcare Inspection Program review of the Central Alabama Veterans HCS, Montgomery, AL.
2. Central Alabama VA Healthcare System submits the attached draft report concurring with recommendations 1–7. I concur with the Draft Report Comprehensive Healthcare Inspection Program review of the Central Alabama HCS, Montgomery, AL.
3. I appreciate the opportunity for this review as part of the continuing process to improve the care of our Veterans.
4. If you have any questions or require further information, please contact the VISN 7 Quality Management Officer.


Robin E. Jackson, PhD, LCSW

Facility Director Comments

**Department of
Veterans Affairs**

Memorandum

Date: December 19, 2017

From: Director, Central Alabama Veterans Health Care System (619/00)

Subject: CHIP Review of the Central Alabama Veterans Health Care System, Montgomery, AL

To: Director, VA Southeast Network (10N7)

1. I have reviewed and concur with the findings and recommendations in the OIG report, Comprehensive Healthcare Inspection Program Review of the Central Alabama Veterans Healthcare System, Montgomery, Alabama.
2. Thank you for the support as we continue to improve the services and processes at CAVHCS for the best outcomes for our Veterans.

Boyle,
Linda L.
Linda L. Boyle, DM, RN
Director

Digitally signed
by Boyle, Linda L .
Date: 2017.12.20
18:49:03 -06'00'

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact OIG at (202) 461-4720.
Inspection Team	Sonia Whig, LDN, MS, Team Leader Bruce Barnes LaFonda Henry, RN-BC, MSN Wachita Haywood, RN, MSN/NED Kendrick Stoudmire, Special Agent, Office of Investigations
Other Contributors	Elizabeth Bullock Limin Clegg, PhD LaFonda Henry, RN-BC, MSN Anita Pendleton, AAS Larry Ross, Jr., MS Marilyn Stones, BS Mary Toy, RN, MSN

Report Distribution

VA Distribution

Office of the Secretary
Veterans Health Administration
Assistant Secretaries
General Counsel
Director, VA Southeast Network (10N7)
Director, Central Alabama Veterans Health Care System (619/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Johnny Isakson, Doug Jones, David Perdue, Richard C. Shelby
U.S. House of Representatives: Robert Aderholt, Sanford D. Bishop, Jr., Mo Brooks; Bradley Byrne; A. Drew Ferguson; Gary Palmer; Martha Roby; Mike Rogers; Austin Scott; David Scott; Terri A. Sewell

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:

- VA Handbook 0730, *Security and Law Enforcement*, August 11, 2000.
- VHA Directive 1014, *Safe Medication Injection Practices*, July 1, 2015.
- VHA Handbook 1105.04, *Fluoroscopy Safety*, July 6, 2012.
- VHA Directive 1116(2), *Sterile Processing Services (SPS)*, March 23, 2016.
- VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013.
- VHA Directive 1229, *Planning and Operating Outpatient Sites of Care*, July 7, 2017.
- VHA Directive 1330.01(1), *Health Care Services for Women Veterans*, February 15, 2017 (amended September 8, 2017).
- VHA Directive 1608, *Comprehensive Environment of Care (CEOC) Program*, February 1, 2016.
- VHA Directive 1761(1), *Supply Chain Inventory Management*, October 24, 2016.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.
- VHA Directive 2011-007, *Required Hand Hygiene Practices*, February 16, 2011.
- VHA Directive 2012-026, *Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012.
- VA Handbook 6500, *Risk Management Framework for VA Information Systems – Tier 3: VA Information Security Program*, March 10, 2015.
- VHA Radiology Online Guide, http://vaww.infoshare.va.gov/sites/diagnosticservices/NRP/Mammography/Radiology%20Shared%20Files/Radiology_Service_Online_Guide_2016.docx, November 3, 2016.
- MH EOC Checklist, VA National Center for Patient Safety, <http://vaww.ncps.med.va.gov/guidelines.html#mhc>, accessed December 8, 2016.
- Various requirements of TJC, Association for the Advancement of Medical Instrumentation/Association for the Advancement of Medical Instrumentation, Occupational Safety and Health Administration, International Association of Healthcare Central Service Materiel Management, National Fire Protection Association.

^e The references used for MH RRTP were:

- VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Program (MH RRTP)*, December 22, 2010.
- VHA Handbook 1330.01, *Health Care Services for Women Veterans*, February 15, 2017 (amended September 8, 2017).
- Requirements of the VHA Center for Engineering and Occupational Safety and Health and the National Fire Protection Association.

^f The references used for PTSD Care included:

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

^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.