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Office of Healthcare Inspections

Report No. 17-01751-25

Comprehensive Healthcare Inspection Program Review of the James J. Peters VA Medical Center Bronx, New York

November 29, 2017

Washington, DC 20420

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Glossary

CBOC	community based outpatient clinic
CHIP	Comprehensive Healthcare Inspection Program
EHR	electronic health record
EOC	environment of care
facility	James J. Peters VA Medical Center
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
QSV	quality, safety, and value
SAIL	Strategic Analytics for Improvement and Learning
TJC	The Joint Commission
UM	utilization management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Report Overview

This Comprehensive Healthcare Inspection Program (CHIP) review provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the James J. Peters VA Medical Center (facility). The review covers key clinical and administrative processes that are associated with promoting quality care.

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

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

This review was conducted during an unannounced visit made during the week of April 24, 2017. OIG conducted interviews and reviewed clinical and administrative processes related to areas of focus that affect patient care outcomes. Although OIG reviewed a spectrum of clinical and administrative processes, the sheer complexity of VA medical centers limits the ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of facility performance within the identified focus areas at the time of the OIG visit. Although it is difficult to quantify the risk of patient harm, the findings in this report may help facilities identify areas of vulnerability or conditions that, if properly addressed, will potentially improve patient safety and health care quality.

Results and Review Impact

Leadership and Organizational Risks. At the James J. Peters VA Medical Center, the leadership team consists of the Facility Director, Chief of Staff, Associate Director for Clinical Operations, Associate Director for Patient Care Services (Nurse Executive), and Associate Director (for Business Office, Clinical Engineering, and other operations). Organizational communication and accountability are carried out through a committee reporting structure with the Quality Executive Board having oversight for leadership groups such as the Performance Improvement Council, Medical Executive Committee, Nursing Interpractice Council, and Environment of Care Committee. The leaders are

[1] The Community Nursing Home Oversight special focus area did not apply for the James J. Peters VA Medical Center because the facility did not provide long-term care for greater than 90 days through contracts.

members of the Quality Executive Board through which they track, trend, and monitor quality of care and patient outcomes through this governance structure.

Except for one Associate Director who had been acting since January 2017, OIG found that the executive leaders had been working together as a team since July 2015. In the review of selected employee and patient survey results regarding facility senior leadership, OIG noted high satisfaction scores that reflected active engagement with employees and patients. OIG also noted that facility leaders implemented processes and plans to maintain a committed workforce and positive patient experiences.

Additionally, OIG reviewed accreditation agency findings, sentinel events, disclosures of adverse patient events, Patient Safety Indicator data, and Strategic Analytics for Improvement and Learning (SAIL) data and did not identify any substantial organizational risk factors. OIG recognizes that the SAIL model has limitations for identifying all areas of clinical risk but is "a way to understand the similarities and differences between the top and bottom performers" within the Veterans Health Administration (VHA).[2]

Although the senior leadership team was knowledgeable about selected SAIL metrics, the leaders should continue to take actions to improve performance of the Quality of Care and Efficiency metrics (such as Mental Health [MH] Continuity [of] Care and Healthcare-Associated [HC Assoc] Infections) likely contributing to the current 3-star rating. In the review of key care processes, OIG issued 15 recommendations that are attributable to the Facility Director, Chief of Staff, and Associate Director. OIG noted findings in all five areas of clinical operations reviewed. These are briefly described below.

Quality, Safety, and Value. OIG found that senior managers were engaged with quality, safety, and value activities. When opportunities for improvement were identified, they supported clinical leaders' implementation of corrective actions and monitoring of effectiveness. However, OIG noted deficiencies with the frequency of Quality Executive Board meetings, review of credentialing and privileging data, and utilization management reviews and documentation.[3]

Medication Management. OIG found safe anticoagulation therapy management practices. However, OIG identified a deficiency in the use of quality assurance data to ensure strong ongoing anticoagulation program practices.

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

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

Coordination of Care. OIG noted safe inter-facility patient transfer practices but identified deficiencies with transfer data reporting and analysis and documentation for acute patient transfers to other facilities.

Environment of Care. OIG noted a safe and clean environment of care with the exception of two inpatient units that had stained ceiling tiles, three inpatient units that had dusty ventilation grills, and lax information technology closet security at the White Plains community based outpatient clinic. OIG identified issues with environment of care rounds attendance, panic alarm and security surveillance television system testing, and Interdisciplinary Safety Inspection Team training.

High-Risk Processes Related to Moderate Sedation. OIG found compliance with informed consent documentation, post-procedure assessments, and discharge practices. However, during inspections of procedure areas, OIG observed 10 vials of propofol, an anesthetic agent used only by appropriately trained providers, in one of the two gastroenterology suites. The presence of propofol in the procedure area increases the risk of inadvertent administration of an anesthetic agent for moderate sedation. OIG identified deficiencies in monitoring moderate sedation outcome data, performing history and physical examinations and pre-sedation assessments, and training of clinical staff.

Summary

In the review of key care processes, OIG issued 15 recommendations that are attributable to the Facility Director, Chief of Staff, and Associate Director. The number of recommendations should not be used as a gauge for the overall quality provided at this facility. The intent is for facility leadership to use these recommendations as a "road map" to help improve operations and clinical care. The recommendations address systems issues as well as other less-critical findings that, if left unattended, may eventually interfere with the delivery of quality health care.

Comments

The Veterans Integrated Service Network Director and Facility Director agreed with the CHIP review findings and recommendations and provided acceptable improvement plans. (See Appendixes G and H, pages 46–47, and the responses within the body of the report for the full text of the Directors' comments.) We consider recommendation 12 closed. We will follow up on the planned actions for the open recommendations until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for
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Purpose and Scope

Purpose

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

Scope

The current seven areas of focus for facility reviews are: (1) Leadership and Organizational Risks; (2) Quality, Safety, and Value (QSV); (3) Medication Management; (4) Coordination of Care; (5) Environment of Care (EOC); (6) High-Risk Processes; and (7) Long-Term Care. These were selected because of risks to patients and the organization when care is not performed well. Within four of the fiscal year (FY) 2017 focus areas, the Office of Inspector General (OIG) selected processes for special consideration—Anticoagulation Therapy Management, Inter-Facility Transfers, Moderate Sedation, and Community Nursing Home Oversight (see Figure 1). However, the Community Nursing Home Oversight special focus area did not apply for the James J. Peters VA Medical Center because the facility did not provide long-term care for greater than 90 days through contracts. Thus, OIG focused on the remaining six areas.

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

Source: VA OIG

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

Methodology

To determine compliance with Veterans Health Administration (VHA) requirements[4] related to patient care quality, clinical functions, and the EOC, OIG physically inspected selected areas; reviewed clinical records, administrative and performance measure data, and accreditation survey reports;[5] and discussed processes and validated findings with managers and employees. OIG interviewed applicable managers and members of the executive leadership team.

The review covered operations for May 5, 2014[6] through April 24, 2017, the date when an unannounced week-long site visit commenced. On May 3, 2017, OIG presented crime awareness briefings to 162 of the facility's 2,104 employees. These briefings covered procedures for reporting suspected criminal activity to OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

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

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

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

Results and Recommendations

Leadership and Organizational Risks

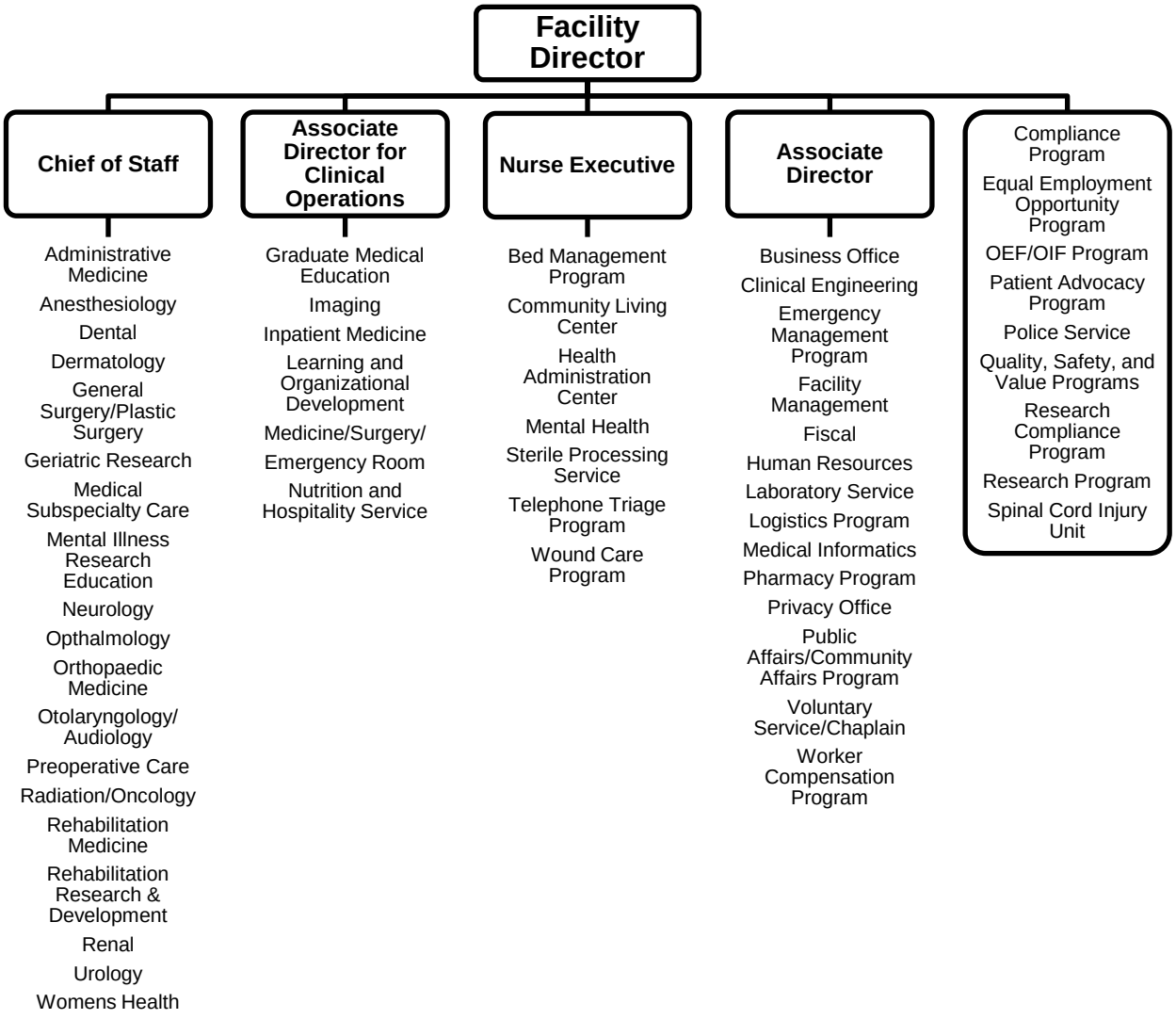
Stable and effective leadership is critical to improving care and sustaining meaningful change. Leadership and organizational risk issues can impact the facility's ability to provide care in all of the selected clinical areas of focus. The factors OIG considered in assessing the facility's risks and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

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

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

It is important to note that the acting Associate Director (for Business Office, Clinical Engineering, and other operations) was not permanently assigned to that position and had been acting since April 3, 2017. With that one exception, the executive leaders had been working together as a team since July 2015.

Figure 2. Facility Organizational Chart



Source: James J. Peters VA Medical Center (received April 24, 2017).

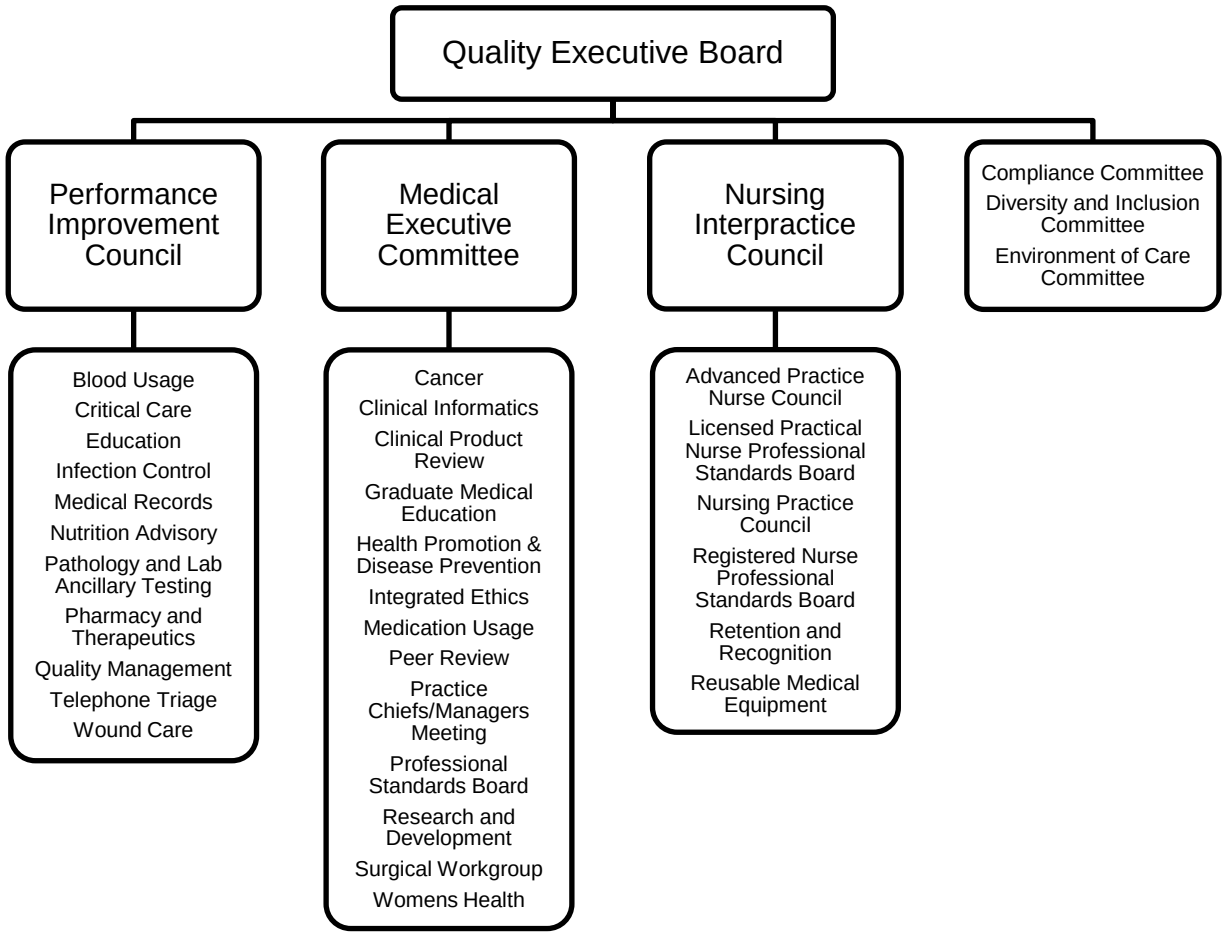
OEF/OIF = Operation Enduring Freedom/Operation Iraqi Freedom.

To help assess engagement of facility executive leadership, OIG interviewed the Facility Director, Chief of Staff, Associate Director for Clinical Operations, and Nurse Executive 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, all of which 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 Quality Executive 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 Quality Executive Board also oversees various working committees such as the Performance Improvement Council, Medical Executive Committee, Nursing Interpractice Council, and EOC Committee. See Figure 3 for the facility committee reporting structure.

Figure 3. Facility Committee Reporting Structure



Source: James J. Peters VA Medical Center (received July 10, 2017).

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

Table 1. Survey Results on Employee and Patient Attitudes toward Facility Leadership (October 1, 2015 through September 30, 2016)

Questions	Scoring	VHA Average	Facility Average	Director's Office Average[8]
All Employee Survey[9] Q59. How satisfied are you with the job being done by the executive leadership where you work?	1 (Very Dissatisfied) – 5 (Very Satisfied)	3.3	3.4	3.7
All Employee Survey Servant Leader Index Composite	0–100 where HIGHER scores are more favorable	66.7	65.7	73.1
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	66.5	
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	79.8	
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): I felt like a valued customer.		73.2	76.6	
Survey of Healthcare Experiences of Patients (outpatient specialty care): I felt like a valued customer.		73.8	78.5	

Accreditation/For-Cause[10] Surveys and Oversight Inspections. To further assess Leadership and Organizational Risks, OIG reviewed recommendations from previous inspections by oversight and accrediting agencies to gauge how well leaders respond to identified problems. Table 2 summarizes the relevant facility inspections most recently

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

performed by the VA OIG and The Joint Commission (TJC). Indicative of effective leadership, the facility has closed[11] all recommendations for improvement as listed in Table 2.

OIG also noted the facility's current accreditation status with the Commission on Accreditation of Rehabilitation Facilities[12] and College of American Pathologists,[13] which demonstrates the facility leaders' commitment to quality care and services. Additionally, the Long Term Care Institute[14] conducted an inspection of the facility's Community Living Center, and the Paralyzed Veterans of America conducted an inspection of the facility's spinal cord injury/disease unit and related services.[15]

Table 2. Office of Inspector General Inspections/Joint Commission Survey

Accreditation or Inspecting Agency	Date of Visit	Number of Findings	Number of Recommendations Remaining Open
VA OIG (*Combined Assessment Program Review of the James J. Peters VA Medical Center, Bronx, New York, August 5, 2014)*	May 2014	18	0
VA OIG (*Community Based Outpatient Clinic and Primary Care Clinic Reviews at James J. Peters VA Medical Center, Bronx, New York, July 2, 2014)*	May 2014	9	0
TJC[16]	May 2015		
• Hospital Accreditation		15	0
• Nursing Care Center Accreditation		2	0
• Behavioral Health Care Accreditation		2	0
• Home Care Accreditation		3	0

[11] A closed status indicates that the facility has implemented corrective actions and improvements to address findings and recommendations, not by self-certification, but as determined by accreditation organization or inspecting agency.
[12] The Commission on Accreditation of Rehabilitation Facilities provides an international, independent, peer review system of accreditation that is widely recognized by Federal agencies. VHA's commitment is supported through a system-wide, long-term joint collaboration with the Commission on Accreditation of Rehabilitation Facilities to achieve and maintain national accreditation for all appropriate VHA rehabilitation programs.
[13] For 70 years, the College of American Pathologists has fostered excellence in laboratories and advanced the practice of pathology and laboratory science. In accordance with VHA Handbook 1106.01, VHA laboratories must meet the requirements of the College of American Pathologists.
[14] Since 1999, the Long Term Care Institute has been to over 3,500 health care facilities conducting quality reviews and external regulatory surveys. The Long Term Care Institute is a leading organization focused on long-term care quality and performance improvement; compliance program development; and review in long-term care, hospice, and other residential care settings.
[15] The Paralyzed Veterans of America inspection took place January 11–12, 2017. This Veteran Service Organization review does not result in accreditation status.
[16] TJC is an internationally accepted external validation that an organization has systems and processes in place to provide safe and quality oriented health care. TJC has been accrediting VHA facilities for more than 30 years. Compliance with TJC standards facilitates risk reduction and performance improvement.

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

Table 3. Summary of Selected Organizational Risk Factors[17] (May 2014 to April 24, 2017)

Factor	Number of Occurrences
Sentinel Events[18]	1
Institutional Disclosures[19]	3
Large-Scale Disclosures[20]	0

OIG also reviewed Patient Safety Indicators developed by the Agency for Healthcare Research and Quality within the U.S. Department of Health and Human Services. These provide information on potential in-hospital complications and adverse events following surgeries and procedures.[21] The rates presented are specifically applicable for this facility, and lower rates indicate lower risks. Table 4 summarizes Patient Safety Indicator data from October 1, 2015 through September 30, 2016.

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

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

Measure	Reported Rate per 1,000 Hospital Discharges		
	VHA	VISN 2	Facility
Pressure Ulcers	0.55	0.90	1.27
Death among surgical inpatients with serious treatable conditions	103.31	115.11	0
Iatrogenic Pneumothorax	0.20	0.49	0
Central Venous Catheter-Related Bloodstream Infection	0.12	0.15	0
In Hospital Fall with Hip Fracture	0.08	0.05	0
Perioperative Hemorrhage or Hematoma	2.59	3.64	0
Postoperative Acute Kidney Injury Requiring Dialysis	1.20	0.87	0
Postoperative Respiratory Failure	6.31	8.19	0
Perioperative Pulmonary Embolism or Deep Vein Thrombosis	3.29	3.67	0
Postoperative Sepsis	4.45	5.98	0
Postoperative Wound Dehiscence	0.65	0	0
Unrecognized Abdominopelvic Accidental Puncture/Laceration	0.67	1.69	0

Source: VHA Support Service Center

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

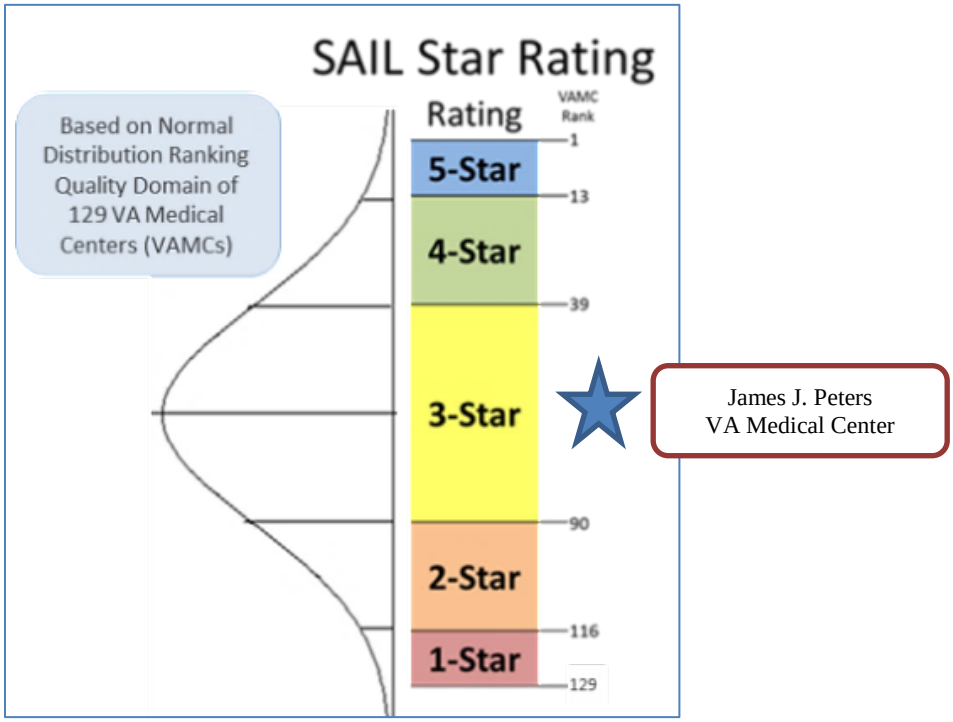
One of the Patient Safety Indicator measures (pressure ulcers) shows an observed rate of 1.27 per 1,000 hospital discharges (2 patients out of a total of 1,574 discharges), in excess of the observed rates for Veterans Integrated Service Network (VISN) 2 and VHA. Although the numerator for this measure is small, the facility leaders reported taking action to increase awareness and knowledge of pressure ulcer prevention and management among nursing staff. Leaders also identified pressure ulcer "champions" to help lead improvement efforts, and since April 2016, they have noted a downward trend in pressure ulcer rates in line with that of VISN 2.

Veterans Health Administration Performance Data. The VA Office of Operational Analytics and Reporting adapted the SAIL Value Model to help define performance expectations within VA.[22] This model includes measures on health care quality, employee satisfaction, access to care, and efficiency but 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.[23]

[22] The model is derived from the Thomson Reuters Top Health Systems Study.
[23] VHA Support Service Center (VSSC). The Strategic Analytics for Improvement and Learning (SAIL) Value Model Documentation Manual. Accessed on April 16, 2017: http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=2146

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 James J. Peters VA Medical Center received an interim rating of 3 stars for overall quality. This means the facility is in the 3rd quintile (30–70 percent range). Updated data as of June 30, 2017, indicates that the facility has remained at 3 stars for overall quality.

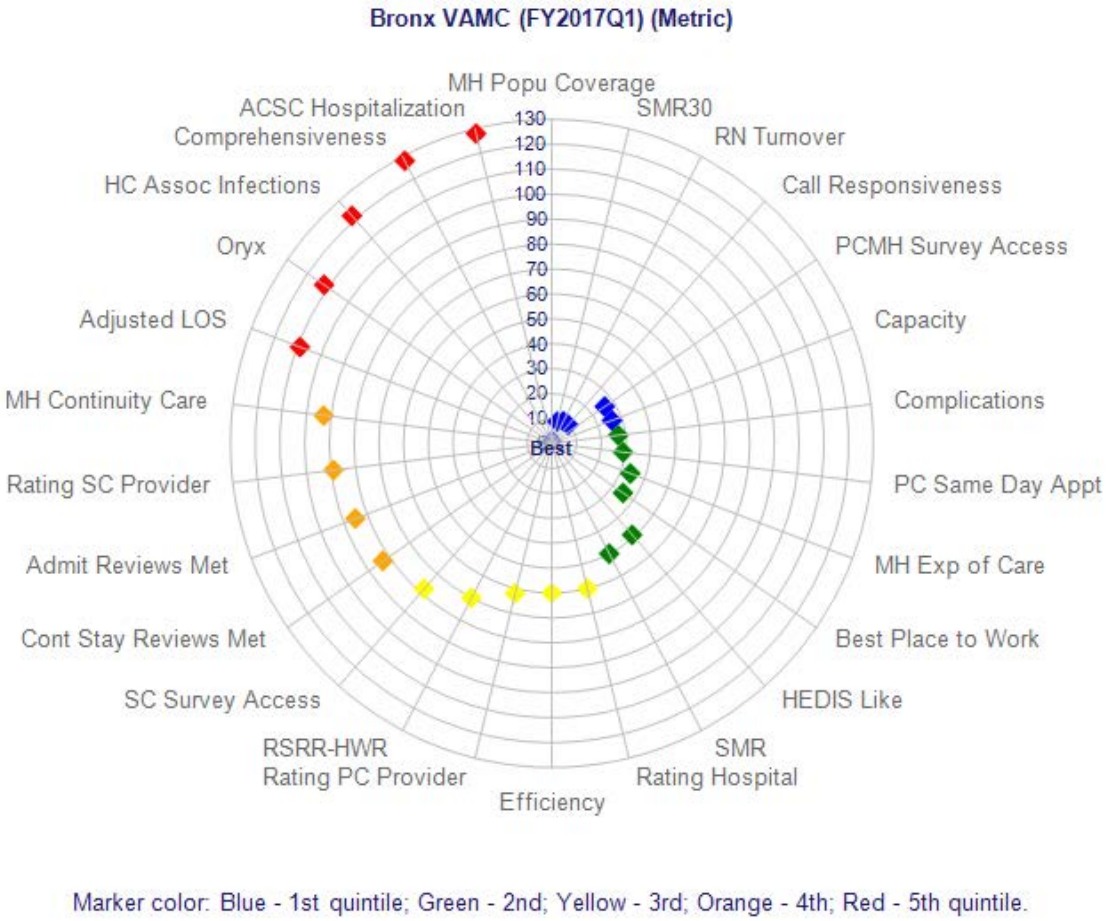
Figure 4. Strategic Analytics for Improvement and Learning Star Rating Distribution (as of September 30, 2016)



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, Registered Nurse [RN] Turnover, Capacity, and Best Place to Work). Metrics in the bottom quintiles reflect areas that need improvement and are denoted in orange and red (for example, Continued [Cont] Stay Reviews, Mental Health [MH] Continuity [of] Care, and Healthcare-Associated [HC Assoc] Infections).

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



Source: VHA Support Service Center

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

Conclusions. The facility has generally stable executive leadership and active engagement with employees and patients to maintain high satisfaction scores. Organizational leaders supports patient safety, quality care, and other positive outcomes (such as initiating processes and plans to maintain positive perceptions of the facility through active stakeholder engagement). OIG's review of accreditation organization findings, sentinel events, disclosures, Patient Safety Indicator data, and SAIL results did not identify any substantial organizational risk factors.[24] The senior leadership team was knowledgeable about selected SAIL metrics but should continue to take actions to improve care and performance, particularly Quality of Care and Efficiency metrics likely contributing to the current 3-star rating.

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

Quality, Safety, and Value

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

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

1. Senior-level involvement in QSV/performance improvement committee
2. Protected peer review[26] of clinical care
3. Credentialing and privileging
4. Utilization management (UM) reviews[27]
5. Patient safety incident reporting and root cause analyses

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

- Senior-level committee responsible for key QSV functions
  - Met at least quarterly
  - Chaired or co-chaired by the Facility Director
  - Reviewed aggregated data routinely
- Protected peer reviews
  - Examined important aspects of care (appropriate and timely ordering of diagnostic tests, timely treatment, and appropriate documentation)
  - Resulted in implementation of Peer Review Committee recommended improvement actions
- Credentialing and privileging processes
  - Considered frequency for Ongoing Professional Practice Evaluation (OPPE)[28] data review
  - Indicated a Focused Professional Practice Evaluation[29]

[25] Department of Veterans Affairs, Veterans Health Administration. *Blueprint for Excellence*. September 2014.
[26] According to VHA Directive 2010-025 (June 3, 2010), this is a peer evaluation of the care provided by individual providers within a selected episode of care. This also involves a determination of the necessity of specific actions, and confidential communication is given to the providers who were peer reviewed regarding the results and any recommended actions to improve performance. The process may also result in identification of systems and process issues that require special consideration, investigation, and possibly administrative action by facility staff.
[27] According to VHA Directive 1117 (July 9, 2014), UM reviews evaluate the appropriateness, medical need, and efficiency of health care services according to evidence-based criteria.
[28] OPPE is the ongoing monitoring of privileged practitioners to identify professional practice trends that impact the quality of care and patient safety.

- UM personnel
  - Completed at least 75 percent of all required inpatient reviews
  - Documented Physician UM Advisors' decisions in the National UM Integration database
  - Reviewed UM data using an interdisciplinary group
- Patient safety personnel
  - Entered all reported patient incidents into the WEBSPOT database
  - Completed the required minimum of eight root cause analyses
  - Reported root cause analysis findings to reporting employees
  - Submitted an annual patient safety report

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

Quality Executive Board. VHA requires that the senior-level committee responsible for key QSV functions meet at least quarterly. This ensures that important QSV policies and practices are routinely discussed and integrated. Facility policy was even stricter, requiring that the Quality Executive Board meet monthly. In practice, the board only met three times in the prior 12 months (April 2016 through March 2017) because of the Facility Director's travel schedule.

Recommendation

1. The Facility Director ensures the Quality Executive Board meets monthly as required by facility policy, or facility leaders revise the local policy to be consistent with Veterans Health Administration quarterly meeting requirements, and the Facility Director monitors compliance.

Facility concurred.

Target date for completion: January 31, 2018

Facility response: Quality Executive Board policy was amended to reflect minimal number of meetings per year to four. Current number of meetings for fiscal year 2017 is five, starting with: October 5, 2016; January 5, 2017; May 12, 2017, July 26, 2017; and September 27, 2017.

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

Credentialing and Privileging. Facility policy requires clinical managers to review OPPE data twice a year. 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. Sixteen of the 25 profiles did not contain evidence that service chiefs reviewed OPPE data twice a year for these licensed independent practitioners. The administrative assistant reported that service chief OPPEs were not completed because he neglected to include those evaluation responsibilities in the Chief of Staff's workload. Some service chiefs reported not completing OPPEs because they lacked staff to collect needed data and did not perceive this as a high priority. One acting service chief was not comfortable with the requirement, as he had not received orientation to this duty.

Recommendation

2. The Chief of Staff ensures clinical managers consistently review Ongoing Professional Practice Evaluation data twice per year and monitors the managers' compliance.

Facility concurred.

Target date for completion: January 31, 2018

Facility Response: A program analyst was detailed to the Chief of Staff office to assist with the Ongoing Professional Practice Evaluation data gathering and reporting. A mandatory meeting was held on May 8, 2017 with all clinical service chiefs, including newly identified and acting chiefs, describing requirements for Ongoing Professional Practice Evaluations. Requirements for Ongoing Professional Practice Evaluations were again reiterated at the May 22, 2017 Medical Executive Committee meeting. The Ongoing Professional Practice Evaluation format was revised to assure that the emphasis was on minimum standards and meaningful triggers by service. The revised format was approved by the Professional Standards Board on June 14, 2017 and the Medical Executive Committee on June 26, 2017.

An electronic process was developed from April 2017 to October 2017 to create a tracking system for Ongoing Professional Practice Evaluation completion. This online dashboard houses the standardized forms with specialty-specific patient care measures and standardized access to data for productivity measures. Practice and Service Chiefs will have access to the dashboard. The plan is to have Practice Managers for the different services complete the dashboard with all required data in a timely fashion. Training is scheduled to be completed by November 30, 2017. The Chief of Staff will host a retreat for all clinical services in December 2017 that will include a detailed review of the Ongoing Professional Practice Evaluation process including hands on demonstration.

Service chiefs acknowledge that they have reviewed the data for each provider by signing the Ongoing Professional Practice Evaluation forms. The signed forms are returned to the Chief of Staff's office for validation and tracking.

Ongoing Professional Practice Evaluation compliance data is presented at the Professional Standards Board meetings quarterly. Chief of Staff office will use the newly developed dashboard to monitor manager's compliance.

Utilization Management: Inpatient Reviews. VHA requires facilities to complete at least 75 percent of all required inpatient UM reviews.[30] These reviews ensure that patients receive health care services at the appropriate level of care when that care is needed. From April 1, 2016 through March 31, 2017, the facility completed 58 percent of all required reviews—falling short of the required 75-percent mark. Reasons provided through interviews for not performing more inpatient UM reviews included that UM staff focused on training newly assigned physicians to conduct reviews. Staff also focused on reviewing whether patients met admission requirements rather than evaluating patients on continued stay criteria.

Recommendation

3. The Facility Director ensures clinical managers complete at least 75 percent of all required inpatient utilization management reviews and monitors the managers' compliance.

Facility concurred.

Target date for completion: January 31, 2018

Facility Response: The utilization management nurses have been notified of the need to complete all required reviews in a timely fashion. This will be monitored daily using the enhanced report. The facility will continue to monitor data monthly, and report quarterly to the Performance Improvement Committee.

Utilization Management: Documentation of Decisions. VHA requires that Physician UM Advisors document their decisions regarding appropriateness of patient admission and continued stays in the National UM Integration database. This allows for the systematic reporting of UM data so that benchmarks, trends, actions, outcomes, and opportunities to improve efficiency can be identified.

In 8 of 10 cases referred to the physician advisors from April 1 through April 25, 2017, there was no evidence that advisors documented their decisions in the database. When asked why documentation was lacking, UM staff reported that one of the Physician UM Advisors disagreed with the criteria, and two other Physician UM Advisors were recently trained and did not yet have the experience or time to document their decisions in the database.

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

Recommendation

4. The Facility Director ensures Physician Utilization Management Advisors consistently document their decisions in the National Utilization Management Integration database and monitors the advisors' compliance.

Facility Concurred.

Target date for completion: January 31, 2018

Facility Response: The Physician Utilization Management advisors were informed on September 27, 2017 of the need for responding to queries related to admissions not met as well as continued stays not met. A review of the current Physician Utilization Management Advisors list was also conducted to ensure the appropriate providers are on the list. Some areas need a coverage provider in order to assist in the reviews during absences and leave. Data collection will include: percentage of record reviews completed; number of records that did not meet criteria; number of records sent to physician utilization management advisors for review; and number of record reviews completed by physician utilization management advisors. Monthly data collection will begin November 1, 2017 and report monthly for the first two months, then quarterly to the Performance Improvement Committee.

Utilization Management: Review of Data. VHA requires that an interdisciplinary facility group review UM data. This group should include, but not be limited to, representatives from UM, medicine, nursing, social work, case management, MH, and Chief Business Office revenue utilization review. This ensures that a comprehensive approach is taken when reviewing UM data to identify areas for improvement throughout a facility. From April 1, 2016 through March 31, 2017, an interdisciplinary group did not review UM data. The reason provided for not meeting the requirement was that the facility had not identified an interdisciplinary group or committee to conduct these data reviews.

Recommendation

5. The Chief of Staff ensures identification of an interdisciplinary group or committee, ensures review of utilization management data on an ongoing basis, and monitors the group's compliance with data review policies.

Facility concurred.

Target date for completion: January 31, 2018

Facility Response: A committee charter has been developed to address the need of data review by an interdisciplinary team. The committee will meet on a quarterly basis and it will include data collection from daily huddles. The committee will report to the Performance Improvement Committee as the improvement forum discussion quarterly. The first meeting will be scheduled on November 22, 2017.

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 five employees actively involved in the anticoagulant program and interviewed key employees. Additionally, OIG reviewed the electronic health records (EHRs) of 36 randomly selected patients who were prescribed new anticoagulant medications from July 1, 2015 through June 30, 2016. The list below shows the performance indicators examined.

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

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

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

Quality Assurance. VHA requires an ongoing quality assurance plan to evaluate the anticoagulation management program. This evaluation provides the opportunity to identify necessary practice improvements, ensures appropriate action is taken to improve the practice, and measures the effectiveness of those actions on a regular basis. Although the facility had a policy addressing a quality assurance plan, anticoagulation management data were not collected, analyzed, or reported biannually to the Pharmacy and Therapeutics Committee. Facility managers stated they did not fully implement the plan because they did not have the data readily available to them. They were unaware that they could obtain data from the computer program used for anticoagulation therapy documentation.

Recommendation

6. The Facility Director ensures all required anticoagulation management program quality assurance data are collected, analyzed, and reported biannually at Pharmacy and Therapeutics Committee meetings and monitors compliance.

Facility concurred.

Target date for completion: January 31, 2018

Facility response: The anticoagulation quality assurance data was reported at the May 17, 2017 Pharmacy and Therapeutics Committee meeting and will continue biannually as a standing agenda item. Data reported to the Pharmacy and Therapeutics Committee was last reported in May 2017 and minutes reflected the Anticoagulant Quality Assurance Analysis.

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

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

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

Data Reporting. VHA requires facilities to collect and report data for patient inter-facility transfers, such as date of transfer, documentation of informed consent and medical or behavioral stability, and identification of transferring and receiving provider, as part of VHA's quality management program. The collection and reporting of data allows the facility to analyze and improve the inter-facility transfer process to maximize patient safety. Although the facility collected inter-facility transfer data, the data were not analyzed or reported to a quality oversight committee. This requirement was overlooked because no committee was assigned the responsibility of reviewing the transfer data.

Recommendation

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

Facility concurred.

Target date for completion: January 31, 2018

Facility Response: Providers and weekend, holiday, evening and night tour administrators were in-serviced on the required documentation for all inter-facility transfers. The inter-facility transfer data will be reported quarterly to the Performance Improvement Committee.

Transfer Documentation. VHA requires that transferring providers document patient or surrogate informed consent and identify the receiving provider on VA Form 10-2649A and/or in transfer/progress notes. This ensures that patients are part of the decision-making process and that receiving providers are aware of patients' needs and the required level of care after transfer. Five of the 34 patients' EHRs (15 percent) did not include documentation of patient or surrogate informed consent, and 4 of the 34 patients' EHRs (12 percent) did not identify the receiving provider. Noncompliance with the requirements was confined to MH providers who were aware of the requirements but chose not to use the required form that conformed to VHA policy.

Recommendation

8. The Chief of Staff ensures mental health providers consistently document patient or surrogate informed consent and identify the receiving provider when patients are transferred out of the facility and monitors the providers' compliance.

Facility concurred.

Target date for completion: January 31, 2018

Facility Response: Mental Health will establish a process to document inter-facility transfers and monitor compliance. Mental Health staff will be in-serviced on the new process and staff will collect and analyze data on all mental health inter-facility transfers. Data will include consent, provider to provider contact, and inter-facility note documentation. Monthly data collection will begin November 2017 and will be included in the Mental Health report to the Performance Improvement Committee, monthly for the first two months, then quarterly.

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 five inpatient units (critical care, 7C-medical/surgical, 6B-inpatient MH, post-anesthesia care, community living center) and Radiology Service. OIG also inspected the White Plains CBOC. Additionally, OIG reviewed relevant documents and 15 employee training records and interviewed key employees and managers. The list below shows the location-specific performance indicators selected to examine the risk areas specific to particular settings.

<u>Parent Facility</u>

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

[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 at the parent facility, representative CBOC, and radiology areas. The locked MH unit had environmental inspection and suicide prevention processes in place. Although the locked MH unit met many requirements, it did not have all required documentation. OIG did not note any issues with the availability of medical equipment and supplies. However, two inpatient units had stained ceiling tiles, three inpatient units had dusty ventilation grills, and the White Plains CBOC information technology closet lacked documentation of authorized access. OIG identified the following deficiencies that warranted recommendations for improvement.

Parent Facility: Environment of Care Rounds Attendance. VHA requires facilities to perform comprehensive EOC rounds with a designated team that includes specific membership to ensure a safe, clean, and high-quality care environment.[34] From October 1, 2016 through April 6, 2017, participation in EOC rounds for 6 of 13 required

[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.

members ranged from 39 percent to 82 percent. Facility managers did not monitor the attendance of team members on EOC rounds and were not aware that team attendance could be tracked and trended with their current Performance Logic software.

Recommendation

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

Facility concurred.

Target date for completion: January 31, 2018

Facility Response: The current Environment of Care team members list was updated to identify primary and secondary team members. All members have been notified of their responsibilities to attend the rounds. A list of dates and location of rounds were also distributed to the group. New members of the Environment of Care team will be trained on the checklist and given access to the performance logic software to document rounding data. The next scheduled Environment of Care rounds will take place on October 20, 2017. The Environment of Care Rounds Coordinator will maintain attendance records for each rounds and data reported to the Environment of Care Committee quarterly.

Locked Mental Health Unit: Panic Alarm Testing. VHA requires that facilities ensure rapid response by VA Police to panic alarm activation within locked inpatient MH units to preserve both patient and staff safety. Panic alarm testing for locked inpatient MH units is required to be documented in a log that includes VA Police response time. Although the facility performed panic alarm testing, VA Police response time was not documented. Facility staff used forms that did not require documentation of VA Police response time for panic alarm testing on locked inpatient MH units.

Recommendation

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

Facility concurred.

Target date for completion: December 31, 2017

Facility Response: Panic alarm testing done by 6B staff was initiated October 16, 2017, and will continue monthly. A tracking sheet was created and staff was in-serviced on how to conduct and document testing. Data will be included in the Mental Health annual report to the Performance Improvement Committee.

Locked Mental Health Unit: Environmental Safety. VHA requires the facility to ensure that appropriate physical security precautions and equipment are implemented, used, and regularly tested as determined by the facility's risk assessment in order to provide a safe environment for patients, visitors, and employees. While VA Police included the locked MH unit in their annual physical security assessment, the unit's security surveillance television was not included. The security surveillance television was not added to the annual physical security assessment because it is a stand-alone system that is not monitored or maintained by VA Police, and they were not aware of the system's existence.

Recommendation

11. The Associate Director ensures the locked mental health unit's security surveillance television system is included in the annual physical security assessment and is regularly tested and monitors compliance.

Facility concurred.

Target date for completion: April 30, 2018.

Facility Response: The inpatient mental health unit security surveillance television system is included in the annual physical security assessment and is tested bi-annually. The camera in the locked isolation room is used for view only and is monitored by the unit staff. The next annual test will take place in March 2018. The report will include the isolation room camera and the report will be signed by the Unit Manager as the responsible person for that equipment functionality and continuous monitoring. Mental Health 6B unit security surveillance television system testing will be attached to the annual physical security assessment conducted by VA Police.

Locked Mental Health Unit: Interdisciplinary Safety Inspection Team Training. VHA requires that facility members of the Interdisciplinary Safety Inspection Team receive training on the identification and correction of environmental hazards, including the proper use of the MH EOC Checklist, so they can effectively inspect inpatient MH units to ensure patient safety. Eight of 11 applicable team members did not complete the required training within the prior 12 months (April 2016 through March 2017). The facility's leaders did not assign a responsible individual to monitor completion of training.

Recommendation

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

Facility concurred.

Target date for completion: Closed

Facility Response: 100 percent of the Mental Health Interdisciplinary Team has completed the required training. Education created an assignment profile in the Talent Management System to capture and track employees training compliance as well as, send reminders 90 days prior to due date to alert employees to complete the course. The Patient Safety Officer will maintain training compliance records and data will be included in the Mental Health reported to Performance Improvement Committee quarterly.

High Risk Processes: Moderate Sedation

OIG's special focus within high-risk processes for the facility was moderate sedation, which is a drug-induced depression of consciousness during which patients can still respond purposefully to verbal comments.[35] Non-anesthesiologists administer sedatives and analgesics to relieve anxiety and increase patient comfort during invasive procedures and usually do not have to provide interventions to maintain a patient's airway, spontaneous ventilations, or cardiovascular function. The administration of moderate sedation could lead to a range of serious adverse events, including cardiac and respiratory depression, brain damage due to low oxygen levels, cardiac arrest, or death.[36]

Properly credentialed providers and trained clinical staff must provide safe care while sedating patients for invasive procedures. Additionally, facility leaders must monitor moderate sedation adverse events, report and trend the use of reversal agents, and systematically aggregate and analyze the data to enhance patient safety and employee performance.[37] During calendar year 2016, VHA clinicians performed more than 600,000 moderate sedation procedures, of which more than half were gastroenterology-related endoscopies.[38] To minimize risks, VHA and TJC have issued requirements and standards for moderate sedation care.

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

OIG reviewed relevant documents, interviewed key employees, and inspected the gastroenterology, cardiology, interventional radiology, intensive care unit, Emergency Department, and dental procedure areas to assess whether required equipment and sedation medications were available. Additionally, OIG reviewed the EHRs of 42 randomly selected patients who underwent an invasive procedure involving moderate sedation from July 1, 2015 through June 30, 2016, and the training records of 15 clinical employees who performed or assisted during these procedures. The list below shows the performance indicators OIG reviewed.

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

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

- Performance of timeout[39] prior to the moderate sedation procedure
- Post-procedure documentation
- Discharge practices
- Clinician training for moderate sedation
- Availability of equipment and medications in moderate sedation procedure areas

Conclusions. Generally, OIG found compliance with informed consent documentation, post-procedure assessments, and discharge practices. However, during inspections of procedure areas, OIG observed 10 vials of propofol, an anesthetic agent used only by appropriately trained providers, in one of the two gastroenterology suites. The presence of propofol in the procedure area increases the risk of inadvertent administration of an anesthetic agent for moderate sedation.[40] Gastroenterology staff stated they were unaware of this anesthetic agent despite its immediate availability in this procedure area. OIG also identified the following deficiencies that warranted recommendations for improvement.

*Reporting and Trending of Reversal Agents and Adverse Events***.** VHA requires facilities to monitor moderate sedation outcomes, including reporting, trending, and analyzing the use of reversal agents and other adverse events or documenting the absence of adverse events for the reporting period. These data are used to assist with decision-making efforts to reduce risks and enhance patient safety. Facility policy required adverse events to be reviewed by the Performance Improvement Committee but did not specifically address monitoring and reporting the use of reversal agents. Performance Improvement Committee meeting minutes dated from January 2016 through February 2017 did not include the presence or absence of adverse events. Clinical managers and quality management staff were not aware that moderate sedation data was to be reported to the Performance Improvement Committee or that facility policy did not address all reporting requirements.

Recommendation

13. The Facility Director ensures that the use of reversal agents in moderate sedation cases and the presence or absence of adverse events are reported to and trended by the Performance Improvement Committee and monitors compliance.

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

[40] According to VHA Directive 1073, for purposes of moderate sedation, drugs that are anesthetic agents (for example, propofol, thiopental, methohexital, ketamine, and etomidate) must be administered by an anesthesiologist, nurse anesthetist, or a licensed independent practitioner with the training and ability to rescue a patient from general anesthesia.

Facility concurred.

Target date for completion: January 31, 2018

Facility Response: The facility monitors reversal agent use in moderate sedation cases. A representative sample is selected randomly, a total of ten records from each service, if less than ten records are available for the quarter, then 100 percent of records reviews are done. Moderate sedation data is tracked, trended, and reported to the Surgical Work Group quarterly. Moderate sedation providers are current members of this committee.

History and Physical Exams and/or Pre-Sedation Assessments. VHA requires that an appropriate history and physical is updated or completed within 30 days of the procedure for which moderate sedation will be administered and that the history and physical and/or the pre-sedation assessment include required elements. This ensures providers are aware of relevant patient information and assessments that may affect the patient's response to moderate sedation.

For 11 of the 42 patients (26 percent), providers did not document or update a history and physical within 30 days of the procedure. For 10 of the 42 patients (24 percent), providers did not provide a complete review of abnormalities of major organ systems. For 27 of the 42 patients (64 percent), providers did not document an airway assessment. Staff members told us that they thought the pre-sedation assessment would suffice for the history and physical requirement if one had not been done. However, the facility's pre-sedation assessment template did not contain all required pre-procedure elements, and this was not recognized by providers or identified through internal chart reviews.

Recommendation

14. The Chief of Staff ensures providers perform history and physical exams within 30 days prior to the moderate sedation procedure and include all required elements in the history and physical exams and/or pre-sedation assessments and monitors providers' compliance.

Facility concurred.

Target date for completion: January 31, 2018

Facility Response: A representative sample of pre-sedation notes are selected randomly, and a total of ten records from each service are reviewed. If less than ten records, then 100 percent of records reviews are conducted. Moderate sedation providers have been in-serviced on the required elements of the pre-sedation note, including completion of Mallampati Score. The pre-sedation template was updated to include a prompt to complete the Mallampati Score. The facility will continue random monitoring of moderate sedation records for the presence of all required elements for the pre-sedation note until compliance of 90 percent is met and sustained; results will be tracked, trended, and presented to the Surgical Work Group quarterly. The facility completes a history and physical within 30 days of moderate sedation procedures and the note includes all the required elements. The facility updated the pre-sedation template to include an option for providers to complete history and physical with required elements on the day of procedure. This has improved compliance with history and physical for moderate sedation procedures. Results will be tracked, trended, and reported to the Surgical Work Group quarterly.

Moderate Sedation Training. VHA requires that an individual who administers, monitors, or supervises moderate sedation must demonstrate successful completion of Talent Management System moderate sedation training and current Advanced Cardiac Life Support and Basic Life Support training. This ensures staff have demonstrated sufficient knowledge to care and respond to an adverse event for a patient receiving moderate sedation.

OIG reviewed 15 training records (7 for physicians and 8 for registered nurses) to spot-check compliance. Three training records did not contain evidence of current Basic Life Support training. Five physician training records did not contain evidence of current Talent Management System moderate sedation training. There was no process in place to ensure providers performing moderate sedation had the appropriate education and training.

Recommendation

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

Facility concurred.

Target date for completion: January 31, 2018

Facility Response: Basic Life Support Certification is monitored by the Education Department for individuals who perform, assist, or supervise moderate sedation procedures. For those who do not have their current Basic Life Support Certification updated within the established time frame, the privilege will be removed. The Cardiopulmonary Resuscitation Committee will report data to the Performance Improvement Committee quarterly. Moderate sedation training will be monitored by the Chief of Anesthesia.

Summary Table of Comprehensive Healthcare Inspection Program Review Findings

Healthcare Processes	Performance Indicators	Conclusion	
Leadership and Organizational Risks	• Executive leadership stability and engagement • Employee satisfaction and patient experience • Accreditation/for-cause surveys and oversight inspections • Indicators for possible lapses in care • VHA performance data	Fifteen OIG recommendations, ranging from documentation issues to deficiencies that can lead to patient and staff safety issues or adverse events, are attributable to the Facility Director, Chief of Staff, and Associate Director. See details below.	
Healthcare Processes	**Performance Indicators**	**Critical Recommendations[41] for Improvement**	**Recommendations for Improvement**
Quality, Safety, and Value	• Senior-level involvement in QSV/performance improvement committee • Protected peer review of clinical care • Credentialing and privileging • UM reviews • Patient safety incident reporting and root cause analyses	• Clinical managers consistently review OPPE data twice per year.	• The Quality Executive Board meets monthly, or facility leaders revise local policy. • Clinical managers complete at least 75 percent of all required inpatient UM reviews. • Physician UM Advisors consistently document their decisions in the National UM Integration database. • An interdisciplinary group or committee is identified and reviews UM data.
Medication Management	• Anticoagulation management policies and procedures • Management of patients receiving new orders for anticoagulants o Prior to treatment o During treatment • Ongoing evaluation of the anticoagulation program • Competency assessment	None	• Anticoagulation management program quality assurance data are collected, analyzed, and reported biannually at Pharmacy and Therapeutics Committee meetings.

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

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Coordination of Care	• Transfer policies and procedures • Oversight of transfer process • EHR documentation o Non-emergent transfers o Emergent transfers	• MH providers consistently document patient or surrogate informed consent and identify the receiving provider when patients are transferred out of the facility.	• Inter-facility patient transfer data are analyzed and reported to an identified quality oversight committee assigned these responsibilities.
Environment of Care	• Parent facility o EOC deficiency tracking and rounds o General Safety o Infection prevention o Environmental cleanliness o Exam room privacy o Availability of feminine hygiene products and medical equipment and supplies • CBOC o General safety o Infection prevention o Environmental cleanliness o Medication safety and security o Privacy o Availability of feminine hygiene products and medical equipment and supplies o IT network room security • Radiology o Safe use of fluoroscopy equipment o Environmental safety o Infection prevention o Medication safety and security o Radiology equipment inspection o Availability of medical equipment and supplies o Maintenance of radiological equipment • Inpatient MH o MH EOC inspections o Environmental suicide hazard identification o Employee training o Environmental safety o Infection prevention o Availability of medical equipment and supplies	• The locked MH unit's security surveillance television system is included in the annual physical security assessment and is regularly tested.	• Required team members participate on EOC rounds. • Locked MH unit panic alarm testing documentation includes VA Police response time. • All members of the Interdisciplinary Safety Inspection Team complete the required training on how to identify and correct environmental hazards, including the proper use of the MH EOC Checklist.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
High-Risk and Problem-Prone Processes: Moderate Sedation	• Outcomes reporting • Patient safety and documentation o Prior to procedure o After procedure • Staff training and competency • Monitoring equipment and emergency management	• Providers perform history and physical exams within 30 days prior to the moderate sedation procedure and include all required elements in the history and physical exams and/or pre-sedation assessments. • Clinical employees who perform, assist with, or supervise moderate sedation procedures have current Basic Life Support certification and moderate sedation training.	• The use of reversal agents in moderate sedation cases and the presence or absence of adverse events are reported to and trended by the Performance Improvement Committee.

Facility Profile

The table below provides general background information for this high-complexity (1b)[42] affiliated[43] facility reporting to VISN 2.

Table 5. Facility Profile for Bronx (526) for October 1, 2013 through September 30, 2016

Profile Element	Facility Data FY 2014[44]	Facility Data FY 2015[45]	Facility Data FY 2016[46]
Total Medical Care Budget in Millions	$278.2	$302.5	$317.7
Number of:			
• **Unique Patients**	26,052	26,038	26,184
• **Outpatient Visits**	352,698	357,965	364,752
• **Unique Employees**[47]	1,500	1,542	1,570
Type and Number of Operating Beds:			
• **Acute**	215	215	215
• **Mental Health**	30	30	30
• **Community Living Center**	80	80	80
• **Domiciliary**	NA	NA	NA
Average Daily Census:			
• **Acute**	80	77	75
• **Mental Health**	21	20	18
• **Community Living Center**	63	54	51
• **Domiciliary**	NA	NA	NA

Source: VA Office of Academic Affiliations, VHA Support Service Center, and VA Corporate Data Warehouse

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

NA = Not applicable

[42] VHA medical centers are classified according to a facilities complexity model; 1b designation indicates a facility with medium-high volume, high-risk patients, many complex clinical programs, and medium-large 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.
[43] Associated with a medical residency program.
[44] October 1, 2013 through September 30, 2014.
[45] October 1, 2014 through September 30, 2015.
[46] October 1, 2015 through September 30, 2016.
[47] Unique employees involved in direct medical care (cost center 8200).

VA Outpatient Clinic Profiles[48]

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

Table 6. VA Outpatient Clinic Workload/Encounters[49] and Specialty Care, Diagnostic, and Ancillary Services Provided[50] for October 1, 2015 through September 30, 2016

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services[51] Provided	Diagnostic Services[52] Provided	Ancillary Services[53] Provided
White Plains, NY	526GA	2,470	1,548	Gastroenterology Hematology/ Oncology Neurology Rheumatology Eye Gynecology	NA	Nutrition Pharmacy Weight Management
Yonkers, NY	526GB	1,863	985	Gastroenterology Neurology Rheumatology	NA	Nutrition Pharmacy Social Work Weight Management
Sunnyside, NY	526GD	1,400	60	Endocrinology	NA	Nutrition Pharmacy Weight Management

Source: VHA Support Service Center and VA Corporate Data Warehouse

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

NA = Not applicable

[48] Includes all outpatient clinics in the community that were in operation as of February 15, 2017.
[49] An encounter is a professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition.
[50] The denoted specialty care and ancillary services are limited to primary clinic stops with a count ≥ 100 encounters for October 1, 2015 through September 30, 2016, timeframe at the specified CBOC.
[51] Specialty care services refer to non-PC and non-MH services provided by a physician.
[52] Diagnostic services include EKG, EMG, laboratory, nuclear medicine, radiology, and vascular lab services.
[53] Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

VHA Policies Beyond Recertification Dates

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

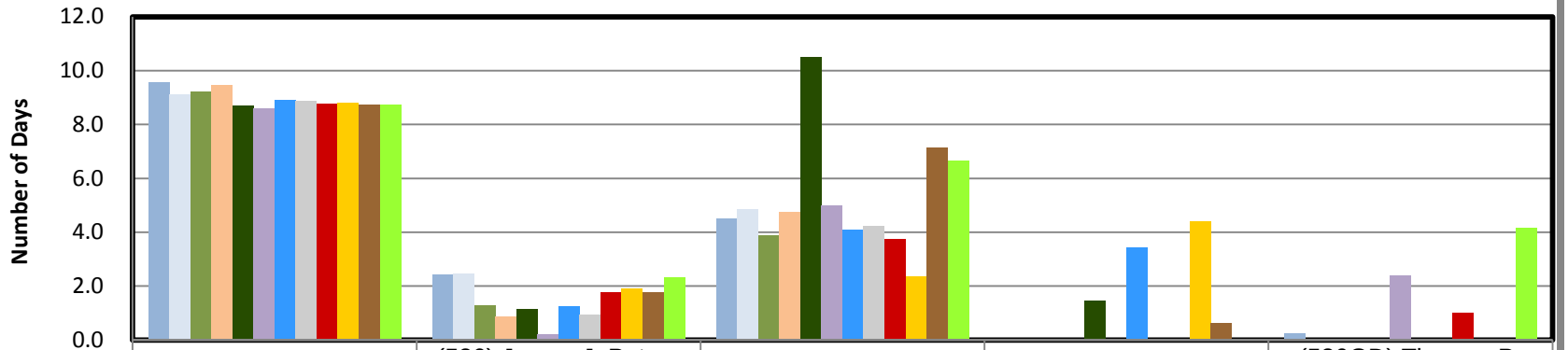
1. VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010 (recertification due date June 30, 2015).
2. VHA Directive 2011-007, Required Hand Hygiene Practices, February 16, 2011 (recertification due date February 29, 2016).
3. VHA Directive 2012-026, Sexual Assaults and Other Defined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

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),[54] 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."[55] 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."[56]

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

Patient Aligned Care Team Compass Metrics

VHA Quarterly New PC Patient Average Wait Time in Days

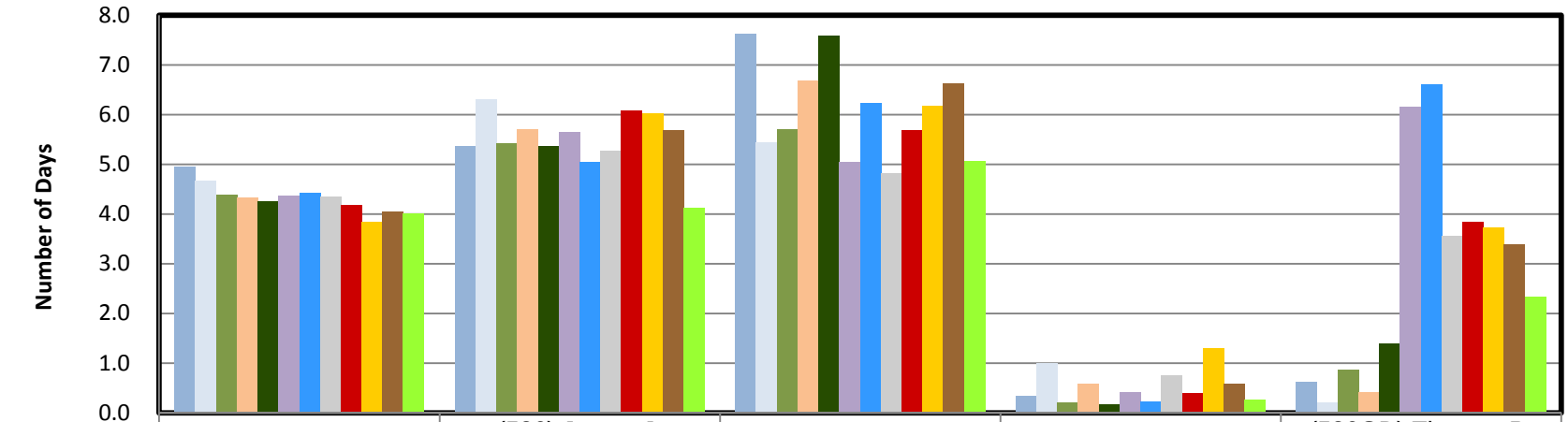


	VHA Total	(526) James J. Peters VAMC	(526GA) White Plains	(526GB) Yonkers	(526GD) Thomas P. Noonan Jr. VA OPC
JAN-FY16	9.6	2.4	4.5	0.0	0.3
FEB-FY16	9.1	2.5	4.9	0.0	0.0
MAR-FY16	9.2	1.3	3.9	0.0	0.0
APR-FY16	9.5	0.9	4.8	0.0	0.0
MAY-FY16	8.7	1.2	10.5	1.5	0.0
JUN-FY16	8.6	0.2	5.0	0.0	2.4
JUL-FY16	8.9	1.3	4.1	3.4	0.0
AUG-FY16	8.9	0.9	4.2	0.0	0.0
SEP-FY16	8.8	1.8	3.7	0.0	1.0
OCT-FY17	8.8	1.9	2.4	4.4	0.0
NOV-FY17	8.7	1.8	7.1	0.6	0.0
DEC-FY17	8.7	2.3	6.7	0.0	4.2

Source: VHA Support Service Center

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

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

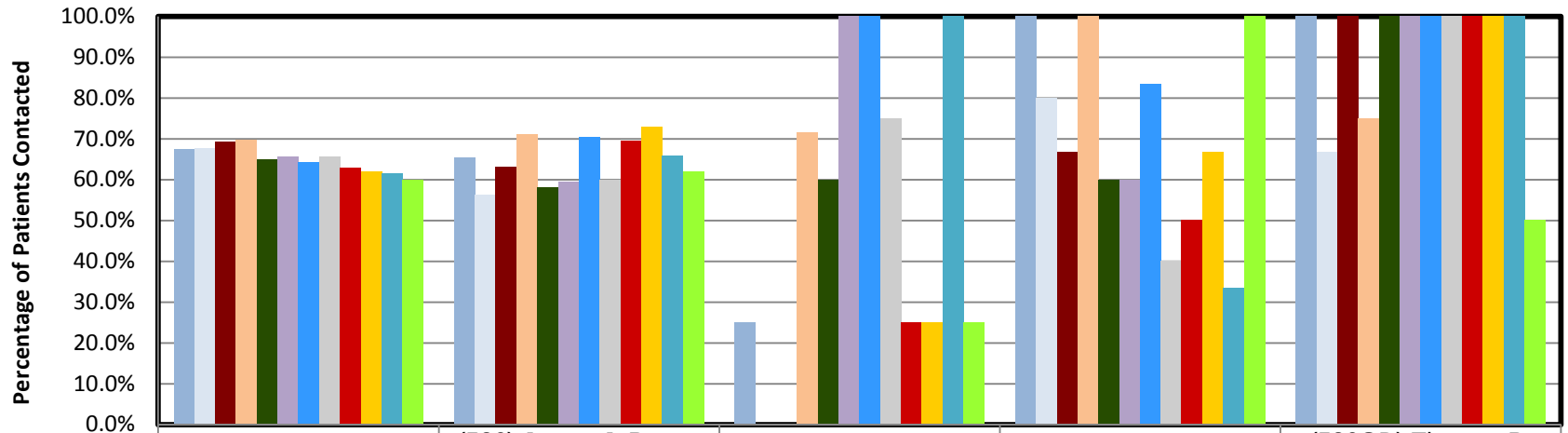


	VHA Total	(526) James J. Peters VAMC	(526GA) White Plains	(526GB) Yonkers	(526GD) Thomas P. Noonan Jr. VA OPC
JAN-FY16	4.9	5.4	7.6	0.3	0.6
FEB-FY16	4.7	6.3	5.4	1.0	0.2
MAR-FY16	4.4	5.4	5.7	0.2	0.9
APR-FY16	4.3	5.7	6.7	0.6	0.4
MAY-FY16	4.3	5.4	7.6	0.2	1.4
JUN-FY16	4.4	5.7	5.0	0.4	6.1
JUL-FY16	4.4	5.0	6.2	0.2	6.6
AUG-FY16	4.3	5.3	4.8	0.7	3.6
SEP-FY16	4.2	6.1	5.7	0.4	3.8
OCT-FY17	3.8	6.0	6.2	1.3	3.7
NOV-FY17	4.0	5.7	6.6	0.6	3.4
DEC-FY17	4.0	4.1	5.1	0.3	2.3

Source: VHA Support Service Center

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

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

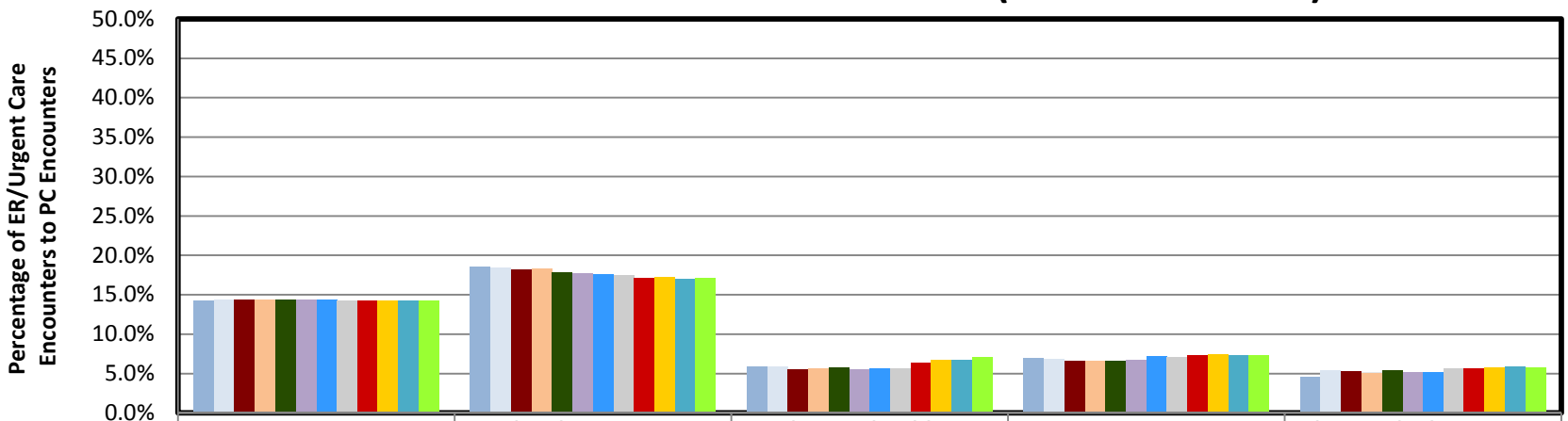


	VHA Total	(526) James J. Peters VAMC	(526GA) White Plains	(526GB) Yonkers	(526GD) Thomas P. Noonan Jr. VA OPC
JAN-FY16	67.5%	65.3%	25.0%	100.0%	100.0%
FEB-FY16	67.6%	56.3%	0.0%	80.0%	66.7%
MAR-FY16	69.2%	63.0%	0.0%	66.7%	100.0%
APR-FY16	69.7%	71.2%	71.4%	100.0%	75.0%
MAY-FY16	65.0%	58.1%	60.0%	60.0%	100.0%
JUN-FY16	65.5%	59.3%	100.0%	60.0%	100.0%
JUL-FY16	64.3%	70.3%	100.0%	83.3%	100.0%
AUG-FY16	65.7%	59.9%	75.0%	40.0%	100.0%
SEP-FY16	62.9%	69.5%	25.0%	50.0%	100.0%
OCT-FY17	62.0%	72.9%	25.0%	66.7%	100.0%
NOV-FY17	61.6%	65.8%	100.0%	33.3%	100.0%
DEC-FY17	59.9%	61.9%	25.0%	100.0%	50.0%

Source: VHA Support Service Center

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

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



	VHA Total	(526) James J. Peters VAMC	(526GA) White Plains	(526GB) Yonkers	(526GD) Thomas P. Noonan Jr. VA OPC
JAN-FY16	14.3%	18.5%	5.9%	7.0%	4.5%
FEB-FY16	14.4%	18.4%	6.0%	6.8%	5.4%
MAR-FY16	14.4%	18.2%	5.6%	6.6%	5.2%
APR-FY16	14.4%	18.3%	5.6%	6.6%	5.1%
MAY-FY16	14.4%	17.9%	5.7%	6.7%	5.4%
JUN-FY16	14.4%	17.8%	5.5%	6.7%	5.1%
JUL-FY16	14.4%	17.6%	5.6%	7.2%	5.1%
AUG-FY16	14.3%	17.5%	5.7%	7.1%	5.6%
SEP-FY16	14.2%	17.2%	6.3%	7.3%	5.7%
OCT-FY17	14.3%	17.3%	6.7%	7.4%	5.8%
NOV-FY17	14.3%	17.0%	6.7%	7.3%	5.9%
DEC-FY17	14.2%	17.1%	7.1%	7.4%	5.8%

Source: VHA Support Service Center

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

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

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

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

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

Source: VHA Support Service Center

Relevant OIG Reports

May 1, 2014 through September 1, 2017[57]

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

6/18/2015 | *15-01297-368* | *Summary* | *Report*

Combined Assessment Program Review of the James J. Peters VA Medical Center, Bronx, New York

8/5/2014 | *14-01289-227* | *Summary* | *Report*

Community Based Outpatient Clinic and Primary Care Clinic Reviews at James J. Peters VA Medical Center, Bronx, New York

7/2/2014 | *14-00932-200* | *Summary* | *Report*

Audit of VHA's Mobile Medical Units

5/14/2014 | *13-03213-152* | *Summary* | *Report*

[57] 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: October 18, 2017

From: Director, New York/New Jersey VA Health Care Network (10N2)

Subject: **CHIP Review of the James J. Peters VA Medical Center, Bronx, NY**

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

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

Thank you for the opportunity to review this report for the James J. Peters VAMC CHIP conducted April 24-27, 2017. I concur with recommendations 1–11 and 13–15. I support the James J. Peters Medical Director's request to close recommendation 12 based on the evidence submitted.

Thank you,

Joan E. McInerney, MD, MBA, MA, FACEP
VISN 2 NETWORK DIRECTOR

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: October 18, 2017

From: Director, James J. Peters VA Medical Center (526/00)

Subject: **CHIP Review of the James J. Peters VA Medical Center, Bronx, NY**

To: Director, New York/New Jersey VA Health Care Network (10N2)

The facility concurs with recommendations 1–11 and 13–15 of James J. Peters CHIP review conducted April 24–27, 2017. We recommend closure of number 12.

Thank you,

Erik Langhoff, MD

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact OIG at (202) 461-4720.
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U.S. House of Representatives: Joseph Crowley, Eliot Engel, Adriano Espaillat, Nita Lowey, Carolyn B. Maloney, Jerrold Nadler, José E. Serrano

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

Endnotes

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

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

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

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

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

[f] The reference used for PACT Compass data graphs was:
- Department of Veterans' Affairs, Patient Aligned Care Teams Compass Data Definitions, accessed: February 14, 2017.

[g] The reference used for the Strategic Analytics for Improvement and Learning (SAIL) metric definitions was:
- VHA Support Service Center (VSSC), Strategic Analytics for Improvement and Learning (SAIL), accessed: October 3, 2016.