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Office of Inspector General

Office of Healthcare Inspections

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Comprehensive Healthcare Inspection Program Review of the Fayetteville VA Medical Center Fayetteville, North Carolina

March 28, 2018

Washington, DC 20420

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Glossary

CBOC	community based outpatient clinic
CHIP	Comprehensive Healthcare Inspection Program
EHR	electronic health record
EOC	environment of care
facility	Fayetteville 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
PTSD	post-traumatic stress disorder
QSV	quality, safety, and value
SAIL	Strategic Analytics for Improvement and Learning
TJC	The Joint Commission
UM	utilization management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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Report Overview

This Comprehensive Healthcare Inspection Program (CHIP) review provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Fayetteville 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 August 14, 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 Fayetteville VA Medical Center, the leadership team consists of the Facility Interim Director, Chief of Staff, Associate Director for Patient Care Services (Nurse Executive), and Associate Director. Organizational communication and accountability are carried out through a committee reporting structure with the Executive Leadership Board having oversight for leadership groups such as the Medical Executive Board, Nursing Executive Council, and EOC Council. The leaders are members of the Executive Leadership Board through which they track, trend, and monitor quality of care and patient outcomes.

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

Current leadership has been stable with the most recent assignment of the Associate Director in February 2017. In the review of selected employee and patient survey results regarding facility senior leadership, OIG noted opportunities to improve both patient experiences and employee attitudes toward leadership.

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 likely contributing to the current 2-star SAIL rating. In the review of key care processes, OIG issued 10 recommendations that are attributable to the Facility Interim Director, Chief of Staff, and Associate Director. Of the six areas of clinical operations reviewed, OIG noted findings in five. These are briefly described below.

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

Medication Management. OIG found safe anticoagulation therapy management practices and compliance with many of the performance indicators evaluated such as policy content, risk minimization of dosing errors, and routing review of quality assurance data. However, OIG identified a deficiency with consistently obtaining all required laboratory tests prior to initiating patients on anticoagulant medications.

Coordination of Care. OIG noted that the facility developed and implemented a patient transfer policy. However, OIG identified deficiencies with transfer documentation and communication with accepting facilities.

[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.

Environment of Care. OIG noted a generally safe and clean environment of care at the parent facility. OIG did not identify any issues with the representative community based outpatient clinic and Radiology Service performance indicators reviewed. The locked mental health unit performed required inspections, had processes in place for suicide hazard identification and abatement, and met infection prevention requirements. However, OIG identified a deficiency with Interdisciplinary Safety Inspection Team training on the locked mental health unit that warranted a recommendation for improvement.

Post-Traumatic Stress Disorder Care. OIG noted the facility generally established plans of care and disposition for patients with positive post-traumatic stress disorder screens. However, OIG identified deficiencies in completing suicide risk assessments and diagnostic evaluations that warranted recommendations for improvement.

Summary

In the review of key care processes, OIG issued 10 recommendations that are attributable to the Facility Interim 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 Interim 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.) OIG considers recommendation four 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
Healthcare Inspections

Purpose and Scope

Purpose

This Comprehensive Healthcare Inspection Program (CHIP) review was conducted to provide a focused evaluation of the quality of care delivered in the Fayetteville 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 Fayetteville 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 five areas of clinical operations and one additional program with relevance to the facility—Post Traumatic Stress Disorder Care.

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

Source: VA OIG

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

Methodology

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

The review covered operations for June 23, 2014[5] through August 14, 2017, the date when an unannounced week-long site visit commenced. OIG also presented crime awareness briefings to 236 of the facility's 2,083 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.

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

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

Results and Recommendations

Leadership and Organizational Risks

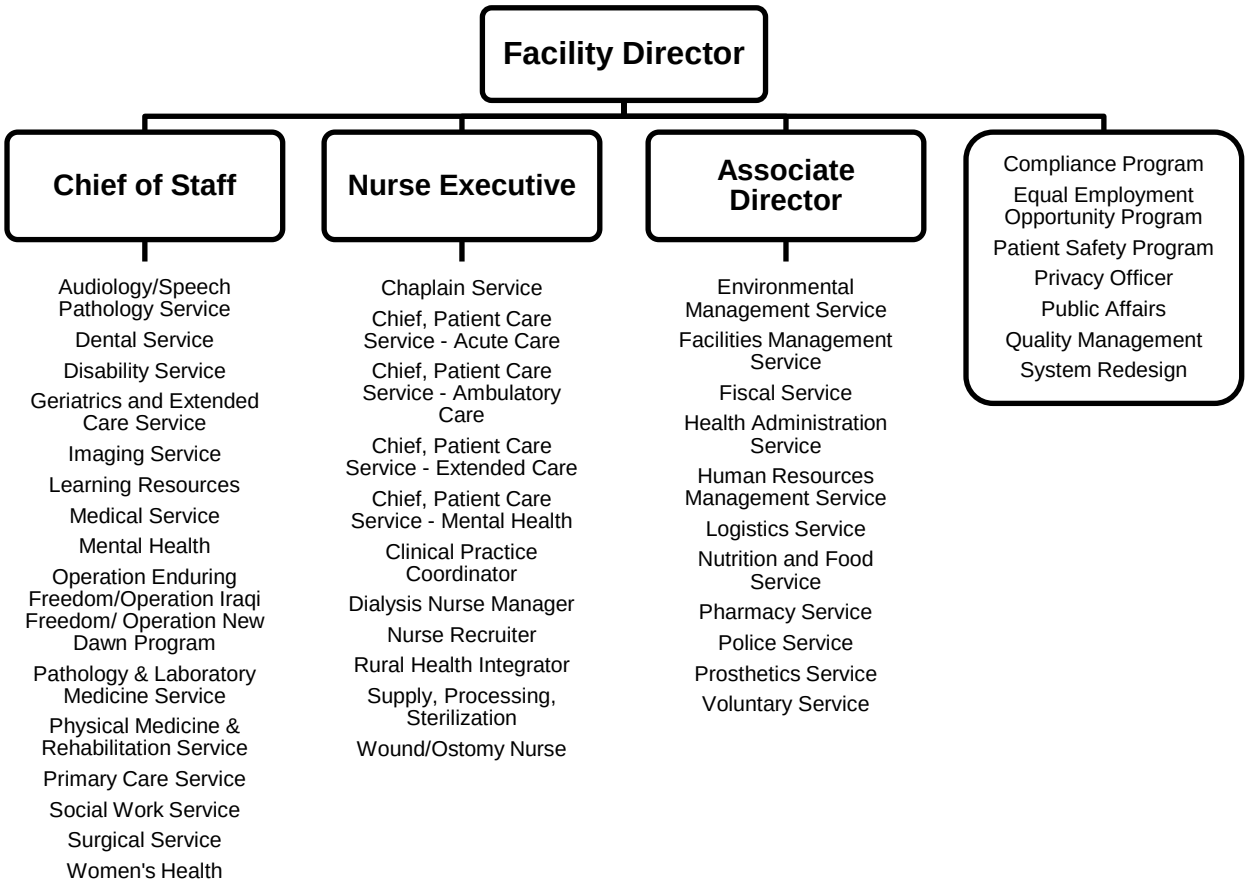
Stable and effective leadership is critical to improving care and sustaining meaningful change. Leadership and organizational risk issues can impact the facility's ability to provide care in all of the selected clinical areas of focus. The factors OIG considered in assessing the facility's risks and 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 Interim Director, Chief of Staff, Associate Director for Patient Care Services (Nurse Executive), and Associate Director. At the time of our site visit, the facility did not have an Assistant Director; however, the request to establish the position was approved in November 2017. The Chief of Staff, Nurse Executive, and Associate Director are responsible for overseeing patient care and service and program chiefs.

It is important to note that all current members of the executive leadership team are permanently assigned. The most recent member to join the team was the Associate Director, who assumed the position in February 2017.

Figure 2. Facility Organizational Chart



Source: Fayetteville VA Medical Center (received August 28, 2017).

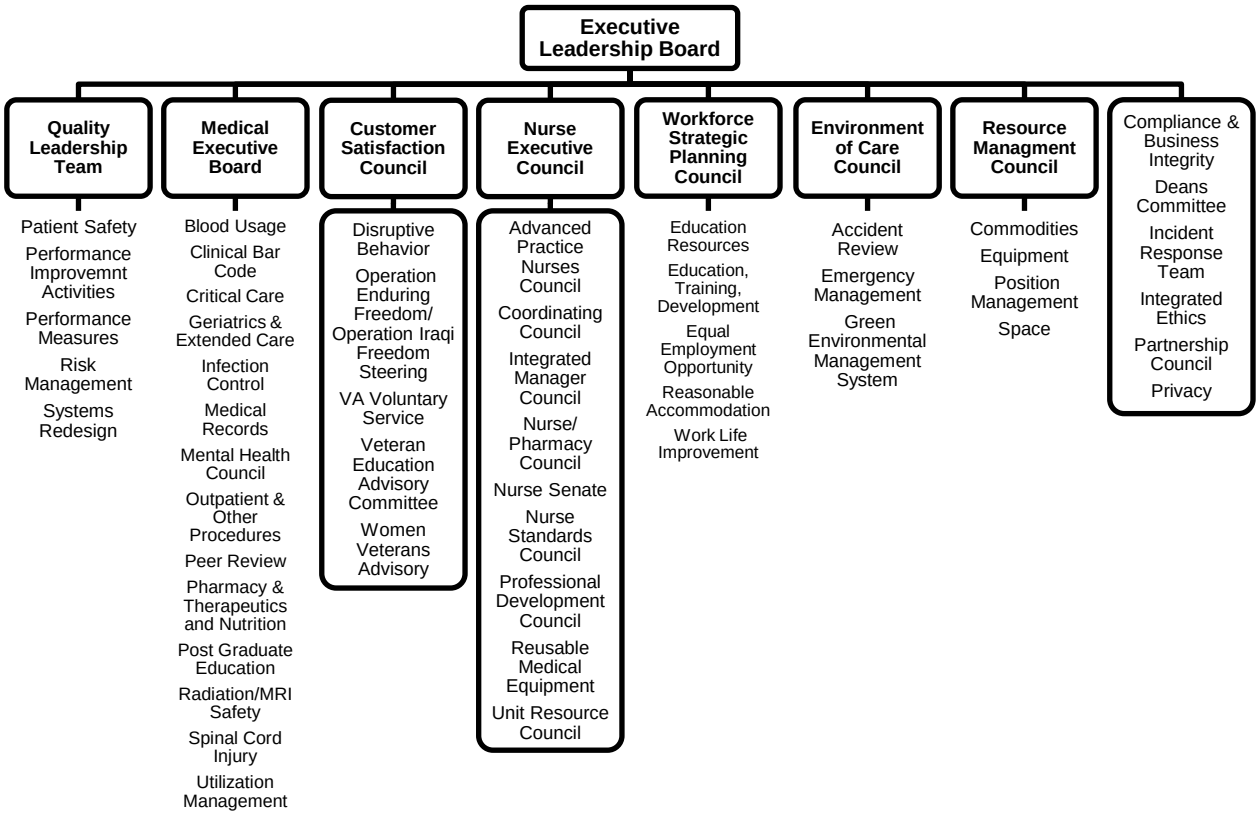
To help assess engagement of facility executive leadership, OIG interviewed the Facility Interim Director, Chief of Staff, Chief Nurse Executive, and Associate Director regarding their knowledge of various metrics and their involvement and support of actions to improve or sustain performance.

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

The leaders are also engaged in monitoring patient safety and care through formal mechanisms. They are members of the Executive Leadership Board, which tracks, trends, and monitors quality of care and patient outcomes. The Facility Interim Director serves as the Chairperson with the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic

planning. The Executive Leadership Board also oversees various working committees, such as the Medical Executive Board, Nursing Executive Council, and EOC Council. See Figure 3.

Figure 3. Facility Committee Reporting Structure



Source: Fayetteville VA Medical Center (received August 28, 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. While the facility leaders' results (Director's office average) were rated above the VHA and facility average, the facility average for both selected employee survey questions were below the VHA average.[6] Further, all patient survey results reflected lower care ratings than the VHA average. In all, opportunities exist to improve both patient experiences and employee attitudes toward leadership.

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

Questions	Scoring	VHA Average	Facility Average	Director's Office Average[7]
All Employee Survey[8] Q59. How satisfied are you with the job being done by the executive leadership where you work?	1 (Very Dissatisfied) – 5 (Very Satisfied)	3.3	3.1	4.0
All Employee Survey Servant Leader Index Composite	0–100 where HIGHER scores are more favorable	66.7	61.6	76.6
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	46.2	
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	77.2	
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): I felt like a valued customer.		73.2	59.6	
Survey of Healthcare Experiences of Patients (outpatient specialty care): I felt like a valued customer.		73.8	63.1	

[6] OIG makes no comment on the adequacy of the VHA average for each selected survey element. The VHA average is used for comparison purposes only.
[7] Rating is based on responses by employees who report to the Director.
[8] The All Employee Survey is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential. The instrument has been refined at several points since 2001 in response to operational inquiries by VA leadership on organizational health relationships and VA culture.

Accreditation/For-Cause[9] Surveys and Oversight Inspections. To further assess Leadership and Organizational Risks, OIG reviewed recommendations from previous inspections by oversight and accrediting agencies to gauge how well leaders respond to identified problems. Table 2 summarizes the relevant facility inspections most recently performed by the VA OIG and The Joint Commission (TJC). Indicative of effective leadership, the facility has closed[10] all but two recommendations for improvement as listed in Table 2. Recommendations remained open for the OIG report published in September 2016 because facility improvement actions were in progress at the time of the site visit. Updated data as of September 2017 indicates that facility actions continue to be in progress for one remaining recommendation.

OIG also noted the facility's current accreditation status with the Commission on Accreditation of Rehabilitation Facilities[11] and College of American Pathologists,[12] which demonstrates the facility leaders' commitment to quality care and services. Additionally, the Long Term Care Institute[13] conducted an inspection of the facility's Community Living Center.

[9] TJC conducts for-cause unannounced surveys in response to serious incidents relating to the health and/or safety of patients or staff or reported complaints. The outcomes of these types of activities may affect the current accreditation status of an organization.
[10] A closed status indicates that the facility has implemented corrective actions and improvements to address findings and recommendations, not by self-certification, but as determined by accreditation organization or inspecting agency.
[11] The Commission on Accreditation of Rehabilitation Facilities provides an international, independent, peer review system of accreditation that is widely recognized by Federal agencies. VHA's commitment is supported through a system-wide, long-term joint collaboration with the Commission on Accreditation of Rehabilitation Facilities to achieve and maintain national accreditation for all appropriate VHA rehabilitation programs.
[12] For 70 years, the College of American Pathologists has fostered excellence in laboratories and advanced the practice of pathology and laboratory science. In accordance with VHA Handbook 1106.01, VHA laboratories must meet the requirements of the College of American Pathologists.
[13] Since 1999, the Long Term Care Institute has been to over 3,500 health care facilities conducting quality reviews and external regulatory surveys. The Long Term Care Institute is a leading organization focused on long-term care quality and performance improvement; compliance program development; and review in long-term care, hospice, and other residential care settings.

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 (Healthcare Inspection – Surgical Service Concerns, Fayetteville VA Medical Center, Fayetteville, North Carolina, September 30, 2016)	February 2015	6	2
VA OIG (Healthcare Inspection – Alleged Improper Management of Dermatology Requests, Fayetteville VA Medical Center, Fayetteville, North Carolina, May 3, 2016)	NA	2	0
VA OIG (*Combined Assessment Program Review of the Fayetteville VA Medical Center, Fayetteville, North Carolina, August 19, 2014)*	June 2014	18	0
VA OIG (*Community Based Outpatient Clinic and Primary Care Clinic Reviews at Fayetteville VA Medical Center, Fayetteville, North Carolina, August 18, 2014)*	June 2014	6	0
TJC[14] • Hospital Accreditation • Behavioral Health Care Accreditation • Home Care Accreditation	January 2017	 24 9 2	 0 0 0

Indicators for Possible Lapses in Care. Within the health care field, the primary organizational risk is the potential for patient harm. Many factors impact the risk for patient harm within a system, including unsafe environmental conditions, sterile processing deficiencies, and infection control practices. Leaders must be able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms. Table 3 summarizes key indicators of risk since OIG's previous June 2014 Combined Assessment Program and Community Based Outpatient Clinic (CBOC) and Primary Care (PC) review inspections through the week of August 14, 2017.

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

Table 3. Summary of Selected Organizational Risk Factors[15] (June 2014 to August 18, 2017)

Factor	Number of Occurrences
Sentinel Events[16]	0
Institutional Disclosures[17]	5
Large-Scale Disclosures[18]	1

OIG also reviewed Patient Safety Indicators developed by the Agency for Healthcare Research and Quality within the U.S. Department of Health and Human Services. These provide information on potential in-hospital complications and adverse events following surgeries and procedures.[19] The rates presented are specifically applicable for this facility, and lower rates indicate lower risks. Table 4 summarizes Patient Safety Indicator data from October 1, 2015 through September 30, 2016.

[15] It is difficult to quantify an acceptable number of occurrences because one occurrence is one too many. Efforts should focus on prevention. Sentinel events and those that lead to disclosure can occur in either inpatient or outpatient settings and should be viewed within the context of the complexity of the facility. (Note that the Fayetteville VA Medical Center is a medium complexity (2) affiliated facility as described in Appendix B. As of October 1, 2017, the Fayetteville VA Medical Center is now designated as a high-complexity (1c) affiliated facility.)
[16] A sentinel event is a patient safety event that involves a patient and results in death, permanent harm, or severe temporary harm and intervention required to sustain life.
[17] Institutional disclosure of adverse events (sometimes referred to as "administrative disclosure") is a formal process by which facility leaders together with clinicians and others, as appropriate, inform the patient or the patient's personal representative that an adverse event has occurred during the patient's care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse.
[18] Large-scale disclosure of adverse events (sometimes referred to as "notification") is a formal process by which VHA officials assist with coordinating the notification to multiple patients (or their personal representatives) that they may have been affected by an adverse event resulting from a systems issue.
[19] 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 6	Facility
Pressure Ulcers	0.55	0.61	0
Death among surgical inpatients with serious treatable conditions	103.31	68.49	NA
Iatrogenic Pneumothorax	0.20	0.36	0
Central Venous Catheter-Related Bloodstream Infection	0.12	0.07	0
In Hospital Fall with Hip Fracture	0.08	0.16	0.96
Perioperative Hemorrhage or Hematoma	2.59	2.33	0
Postoperative Acute Kidney Injury Requiring Dialysis	1.20	0.91	0
Postoperative Respiratory Failure	6.31	4.41	0
Perioperative Pulmonary Embolism or Deep Vein Thrombosis	3.29	2.23	0
Postoperative Sepsis	4.45	4.74	NA
Postoperative Wound Dehiscence	0.65	1.14	0
Unrecognized Abdominopelvic Accidental Puncture/Laceration	0.67	1.63	0

Source: VHA Support Service Center.

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

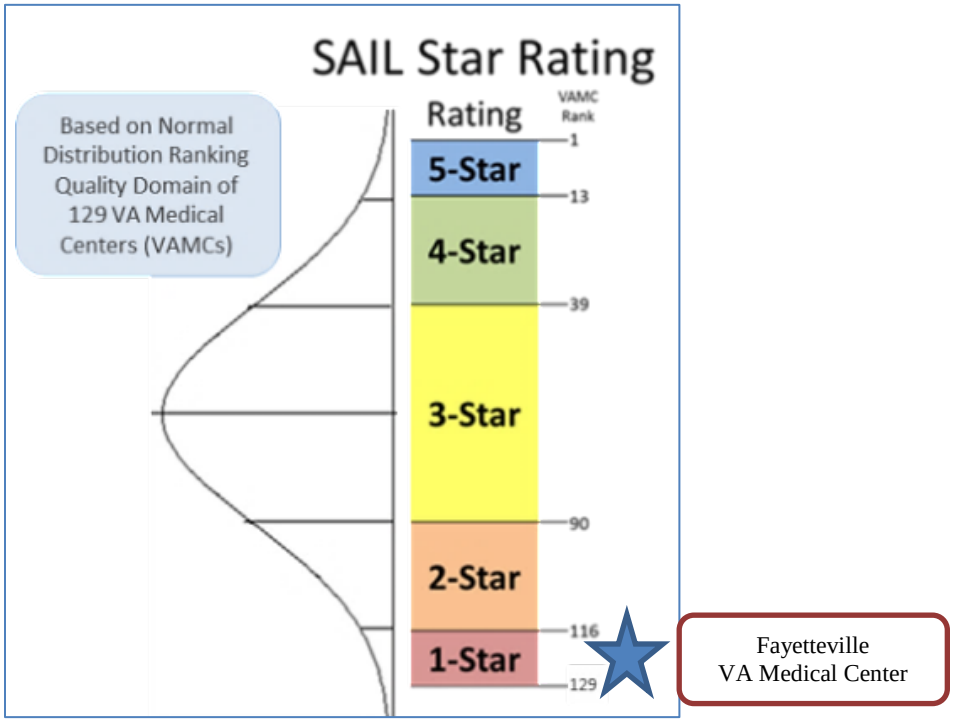
One of the applicable Patient Safety Indicator measures (in hospital fall with hip fracture) shows an observed rate in excess of the observed rates for VISN 6 and VHA. The facility leaders reported this observation was due to one patient who suffered an unobserved fall while exiting his bed. The facility leaders reportedly investigated this incident, found that the patient received appropriate treatment planning and care, and implemented process/practice improvements to help prevent hospital falls.

Veterans Health Administration Performance Data. The VA Office of Operational Analytics and Reporting adapted the SAIL Value Model to help define performance expectations within VA.[20] This model includes measures on health care quality, employee satisfaction, access to care, and efficiency, but the model has noted limitations for identifying all areas of clinical risk. The data are presented as one "way to understand the similarities and differences between the top and bottom performers" within VHA.[21]

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

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 Fayetteville VA Medical Center received an interim rating of 1 star for overall quality. This means the facility is in the 5th quintile (bottom 10 percent range). Updated data as of June 30, 2017, indicates that the facility has increased to a 2-star rating for overall quality.

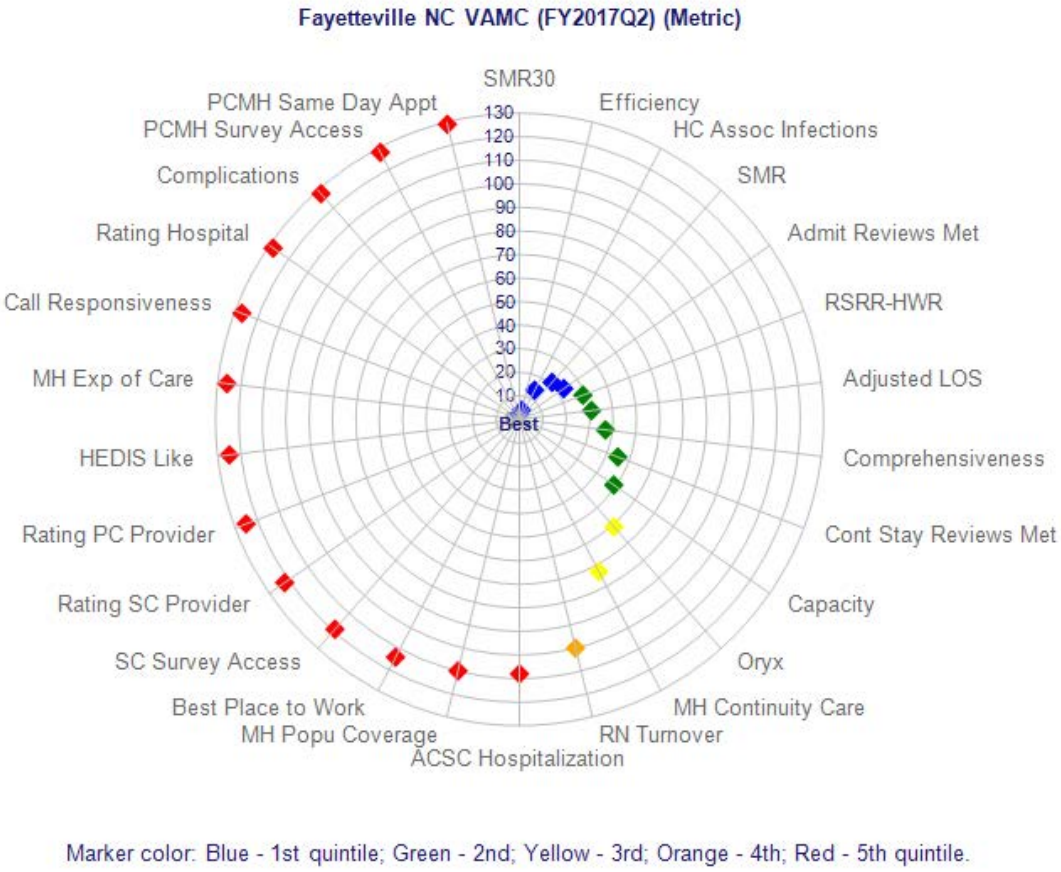
Figure 4. Strategic Analytics for Improvement and Learning Star Rating Distribution (as of September 30, 2016)



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 March 31, 2017. Of note, Figure 5 shows blue and green data points in the top quintiles that show high performance (for example, Acute Care 30-Day Standardized Mortality Ratio [SMR30], Healthcare-Associated [HC Assoc] Infections, and Adjusted Length of Stay [LOS]). Metrics in the bottom quintiles reflect areas that need improvement and are denoted in orange and red (for example, Rating [of] PC Provider, Complications, and Patient Centered Medical Home [PCMH] Same Day Appointment.

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



Source: VHA Support Service Center.

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

Conclusions. The facility has generally stable executive leadership with a newly approved Assistant Director position to support patient safety, quality care, and other positive outcomes. However, opportunities exist for leadership to improve both employee and patient perceptions of the facility. OIG's review of accreditation organization findings, sentinel events, disclosures, and Patient Safety Indicator data did not identify any substantial organizational risk factors. The senior leadership team seemed knowledgeable about selected SAIL metrics but should continue to take actions to improve care and performance of selected SAIL metrics, particularly Quality of Care and Efficiency metrics likely contributing to the current 2-star rating.[22]

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

Quality, Safety, and Value

One of VA's strategies is to deliver high-quality, veteran-centered care that compares favorably to the best of the private sector in measured outcomes, value, and efficiency.[23] VHA requires that its facilities operate a QSV program to monitor patient care quality and performance improvement activities.

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

1. Senior-level involvement in QSV/performance improvement committee
2. Protected peer review[24] of clinical care
3. Credentialing and privileging
4. Utilization management (UM) reviews[25]
5. Patient safety incident reporting and root cause analyses

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

- Senior-level committee responsible for key QSV functions
  - Met at least quarterly
  - Chaired or co-chaired by the Facility Director
  - Reviewed aggregated data routinely
- Protected peer reviews
  - Examined important aspects of care (appropriate and timely ordering of diagnostic tests, timely treatment, and appropriate documentation)
  - Resulted in implementation of Peer Review Committee recommended improvement actions
- Credentialing and privileging processes
  - Considered frequency for Ongoing Professional Practice Evaluation (OPPE)[26] data review
  - Indicated a Focused Professional Practice Evaluation[27]

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

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

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

Credentialing and Privileging. Facility policy requires clinical managers to review OPPE data every 6 months. The ongoing monitoring of privileged practitioners is essential to confirm the quality of care delivered and allows the facility to identify professional practice trends that impact patient safety. Ten of the 25 profiles did not contain evidence that service chiefs reviewed OPPE data every 6 months for these licensed independent practitioners. Managers stated noncompliance was attributed to inattention to detail, lack of awareness, and breakdown of processes due to staffing shortages.

Recommendation

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

Facility concurred.

Target date for completion: September 30, 2018

Facility response: The Chief of Staff will ensure Clinical Service Chiefs present OPPE data every six months for the providers of their respective service. Compliance with this process will be monitored every month at the Medical Executive Board that is chaired by the Chief of Staff. Target 95% compliance.

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

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.[28] This allows for national level UM data to be available for review by an interdisciplinary group to set benchmarks; identify trends, actions, and opportunities to improve efficiency; and monitor outcomes. In 43 of 91 cases (47 percent) referred to the physician advisors from May 1 through July 30, 2017, there was no evidence that advisors documented their decisions in the database. Managers reported that some providers were transitioning into their new roles as Physician UM Advisors and that there was lack of adequate oversight over the Physician UM Advisor functions.

Recommendation

2. The Chief of Staff 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: September 30, 2018

Facility response: Physician Utilization Management Advisors (PUMA) decisions are documented in the National Utilization Management Integration (NUMI) database. This is a metric of the Utilization Management (UM) report. Compliance with this requirement is presented and discussed quarterly at the Medical Executive Board that is chaired by the Chief of Staff. Target 80% compliance.

Utilization Management: Review of Data. VHA requires that an interdisciplinary facility group review UM data. This group must 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 December 1, 2015 through May 25, 2017, required interdisciplinary staff did not consistently attend meetings. Senior managers knew the requirements, but observed issues of noncompliance occurred as a result of limited administrative support staff needed to coordinate the interdisciplinary meetings.

Recommendation

3. The Facility Interim Director ensures that required representatives of the interdisciplinary group consistently attend meetings and review utilization management data, and monitors the group's compliance.

[28] National Utilization Management Integration is a computer program that supports Utilization Management staff in their functions in the review and documentation of clinical care activities for the appropriate use of resources. VHA Directive 1117, *Utilization Management Program*, July 9, 2014

Facility concurred.

Target date for completion: September 30, 2018

Facility response: The UM Committee Chair records attendance at every committee meeting. Tracking of committee attendance will be included in quarterly UM reports. Compliance with this report will be presented and discussed at the Medical Executive Board that is chaired by the Chief of Staff. Target 90% compliance.

Patient Safety: Annual Report. VHA requires the Patient Safety Manager to submit to facility leadership an annual patient safety report that provides an overview of the patient safety program status, relevant data and trends, program successes, and areas for improvement. The annual report serves to keep facility leaders apprised of patient safety activities and required program functions. There was no annual report for FY 2016. Facility managers reported that from November 2016 to August 2017, the facility's Patient Safety Manager position was vacant; a designated acting Patient Safety Manager was not assigned until approximately May 2017. However, managers emphasized that during this period, appropriate QSV staff addressed all identified patient safety concerns.

Recommendation

4. The Facility Interim Director ensures that the Patient Safety Manager submits an annual patient safety report to facility leaders at the completion of each fiscal year and monitors compliance.

Facility concurred.

Target date for completion: Completed

Facility response: The 2017 Annual Patient Safety reported was signed by the Interim Director on November 17, 2017. The report was presented and discussed at the Executive Leadership Board on November 21, 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,[29] or a blood thinner, which is a drug that works to prevent the coagulation or clotting of blood. TJC's National Patient Safety Goal (3.05.01) focuses on improving anticoagulation safety to reduce patient harm and states, "…anticoagulation medications are more likely than others to cause harm due to complex dosing, insufficient monitoring, and inconsistent patient compliance."

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

OIG reviewed relevant documents and the competency assessment records of 10 employees actively involved in the anticoagulant program and interviewed key employees. Additionally, OIG reviewed the electronic health records (EHRs) of 25 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

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

Conclusions. Generally, OIG noted safe anticoagulation therapy management practices and compliance with many of the performance indicators listed above such as policy content, risk minimization of dosing errors, and routine review of quality assurance data. However, OIG identified the following deficiencies that warranted recommendations for improvement.

Laboratory Tests. VHA requires clinicians to obtain baseline laboratory tests, such as complete blood count and prothrombin time, prior to initiating patients on anticoagulant medications. This ensures that patients do not have an underlying medical condition which needs to be addressed prior to receiving the anticoagulant and helps monitor patients while on the anticoagulant. In 3 of the 16 applicable patients, clinicians did not obtain all required laboratory tests prior to initiating warfarin. Clinicians were unaware of all required tests, and clinical managers failed to provide oversight to ensure compliance.

Recommendation

5. The Chief of Staff ensures clinicians consistently obtain all required laboratory tests prior to initiating patients on anticoagulant medications and monitors clinicians' compliance.

Facility concurred.

Target date for completion: September 30, 2018

Facility Response: The anticoagulation coordinator will provide the appropriate education to prescribers by March 16, 2018. Medications will be restricted to ordering via an order set by March 30, 2018. Data related to all new patients started on anticoagulants will be collected monthly and reported quarterly to the Pharmacy & Therapeutics/Nutrition Committee. Target 90% compliance.

Coordination of Care: Inter-Facility Transfers

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

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

OIG reviewed relevant policies and facility data and interviewed key employees. Additionally, OIG reviewed the EHRs of 46 randomly selected patients who were transferred out of facility inpatient beds or the urgent care center to another VHA facility or non-VA facility from July 1, 2015 through June 30, 2016. The list below shows the performance indicators OIG examined.

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

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

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 level of care after transfer. For 21 of the 46 non-emergent transfer patients (46 percent), documentation did not include patient or surrogate informed consent; and for 32 of the 46 patients (70 percent), transfer documentation did not include identification of the transferring and receiving provider or designee. Staff confirmed that noncompliance was due to outdated facility policies and procedures that were inconsistent with VHA requirements.

Recommendation

6. The Chief of Staff ensures providers consistently document patient or surrogate informed consent and identify the receiving provider for patients transferred out of the facility and monitors the providers' compliance.

Facility concurred.

Target date for completion: September 30, 2018

Facility Response: By June 1, 2018, a template will be available in the electronic medical record to document patient transfers. This template will include a place for providers to consistently document patient and or surrogate informed consent, identify the receiving provider and document pertinent patient information to be communicated to the receiving facility when patients are transferred out. Providers will be educated on the use of this template by June 30, 2018. Oversight and compliance with this process will be reported monthly at the Medical Executive Board that is chaired by the Chief of Staff. Target 90% compliance.

Communication with Accepting Facility. VHA requires that for inter-facility transfers, communication occurs between the sending and accepting facilities or the sending facility provides pertinent medical information when they transfer the patient. Clinicians did not document that they sent or communicated pertinent patient information to the receiving facility for 41 of 42 applicable patients (98 percent). Staff acknowledged that noncompliance was due to outdated facility policies and procedures that were inconsistent with VHA requirements.

Recommendation

7. The Chief of Staff ensures that clinicians consistently communicate pertinent patient information to the receiving facility when patients are transferred out of the facility and monitors the clinicians' compliance.

Facility concurred.

Target date for completion: September 30, 2018

Facility Response: By June 1, 2018, a template will be available in the electronic medical record to document patient transfers. This template will include a place for providers to consistently document patient and or surrogate informed consent, identify the receiving provider and document pertinent patient information to be communicated to the receiving facility when patients are transferred out. Providers will be educated on the use of this template by June 30, 2018. Oversight and compliance with this process will be reported monthly at the Medical Executive Board that is chaired by the Chief of Staff. Target 90% compliance.

Environment of Care

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

Fluoroscopic imaging equipment produces x-rays for the diagnosis, localization, and guidance of interventional procedures.[30] 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.[31] 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 the inpatient medical/surgical unit (3C); the locked MH unit; Radiology at the main campus and at the Fayetteville Health Care Center; community living center (3A); women's health clinics (1 and 2); primary care clinics (Modules 1, 2, and 3); and the urgent care clinic. OIG also inspected the Jacksonville CBOC. Additionally, OIG reviewed relevant documents and 16 employee training records and interviewed key employees and managers. The list below shows the location-specific performance indicators selected to examine the risk areas specific to particular settings.

<u>Parent Facility</u>

- EOC deficiency tracking
- EOC rounds
- General safety
- Infection prevention
- Environmental cleanliness
- Exam room privacy
- Availability of feminine hygiene products
- Availability of medical equipment and supplies

[30] VHA Handbook 1105.04, *Fluoroscopy Safety*, July 6, 2012.
[31] 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. The parent facility generally met the performance indicators evaluated for general safety and infection prevention. OIG did not identify any issues with the representative CBOC and Radiology Service performance indicators reviewed. The locked MH unit performed required inspections, had processes in place for suicide hazard identification and abatement, and met infection prevention requirements. OIG did not note any issues with the availability of medical equipment and supplies. However, OIG identified the following deficiency that warranted a recommendation for improvement.

Locked Mental Health Unit: Interdisciplinary Safety Inspection Team Training. VHA requires that MH unit staff and Interdisciplinary Safety Inspection Team members receive annual training on the identification and correction of environmental hazards, including the proper use of the MH EOC Checklist, so they can effectively inspect inpatient MH units to ensure staff, visitor, and patient safety. The facility was unable to provide current training records for three of the six Interdisciplinary Safety Inspection Team members. Managers/staff knew the requirements but were unaware of the noncompliance.

Recommendation

8. The Associate Director ensures that 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. September 30, 2018

Facility Response: A list of committee members has been reviewed. These members have been assigned the required Talent Management System (TMS) course as designated by their role to comply with the annual educational requirement on how to identify and correct environmental hazards, including the proper use of the Mental Health Environment of Care Checklist. The Associate Director, in collaboration with the Chief, MHSL, will review TMS reports and record results quarterly at the Environment of Care committee that is chaired by the Associate Director. Target 90% compliance.

High Risk Processes: Moderate Sedation

OIG's special focus within high-risk processes for the facility was moderate sedation, which is a drug-induced depression of consciousness during which patients can still respond purposefully to verbal comments.[32] 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.[33]

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.[34] During calendar year 2016, VHA clinicians performed more than 600,000 moderate sedation procedures, of which more than half were gastroenterology-related endoscopies.[35] 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 ambulatory surgical unit and the gastroenterology procedure area at the Fayetteville Health Care Center to assess whether required equipment and sedation medications were available. Additionally, OIG reviewed the EHRs of 44 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

[32] American Society of Anesthesiologists (ASA), Practice Guidelines for Sedation and Analgesia by Non-Anesthesiologists, 2002. Anesthesiology 2002; 96:1004-17.
[33] 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.
[34] VHA Directive 1073, *Moderate Sedation by Non-Anesthesiology Providers*, December 30, 2014.
[35] Per VA Corporate Data Warehouse data pull on February 22, 2017.

- Performance of timeout[36] 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, the facility met requirements with the above performance indicators. OIG made no recommendations.

[36] 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.

Post-Traumatic Stress Disorder Care

For this facility, OIG also evaluated post-traumatic stress disorder (PTSD), a disorder that may occur "…following exposure to an extreme traumatic stressor involving direct personal experience of an event that involves actual or threatened death or serious injury; other threat to one's physical integrity; witnessing an event that involves death, injury or threat to the physical integrity of another person; learning about unexpected or violent death, serious harm, threat of death or injury experienced by a family member or other close associate."[37]

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

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

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

OIG reviewed relevant documents and interviewed key employees and managers. Additionally, OIG reviewed the EHRs of 37 randomly selected patients who had a positive PTSD screen from April 1, 2016 through March 31, 2017. The list below shows the performance indicators OIG reviewed.

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

Conclusions. Generally, OIG found compliance with establishing plans of care and disposition. However, OIG identified the following deficiencies that warranted recommendations for improvement.

Suicide Risk Assessment and Diagnostic Evaluation. VHA requires that each patient with a positive PTSD screen receive a suicide risk assessment and an offer for referral

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

for further diagnostic evaluation. If referred for the further diagnostic evaluation, VHA requires providers to complete the evaluations within 30 days. This ensures early identification and management of stress-related disorders.[38] Four of 37 patients with positive PTSD screens (11 percent) did not receive a suicide risk assessment, and providers did not complete diagnostic evaluations within 30 days for 3 of 19 patients. Managers/staff knew the requirements but were unaware of the noncompliance.

Recommendations

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

Facility concurred.

Target date for completion. September 30, 2018

Facility Response: By March 1, 2018 it is anticipated that Mental Health and Primary Care providers will be re-educated on the requirements for completion of a suicide risk assessment for all patients with positive PTSD screen. MHSL providers will be added to the clinical reminder report titled "Follow Up PTSD/Depression". The Primary Care Mental Health Integration (PCMHI) Coordinator will review results monthly and present compliance results quarterly at the Medical Executive Board that is chaired by the Chief of Staff. Target 90% compliance.

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

Facility concurred.

Target date for completion. September 30, 2018

Facility Response: By March 1, 2018 it is anticipated that appropriate providers will be re-educated on the requirements for completion of diagnostic evaluation for patients with positive post-traumatic stress disorder screens within 30 days of the referral. The supervisory psychologist will review data associated with this process monthly and present compliance results quarterly at the Medical Executive Board that is chaired by the Chief of Staff. Target 90% compliance.

[38] VHA Handbook 1160.03, *Programs for Veterans with Post-Traumatic Stress Disorder (PTSD)*, March 12, 2010, revised December 8, 2015.

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	Ten OIG recommendations, ranging from documentation issues to deficiencies that can lead to patient and staff safety issues or adverse events, are attributable to the Facility Interim Director, Chief of Staff, and Associate Director. See details below.	
Healthcare Processes	**Performance Indicators**	**Critical Recommendations[39] for Improvement**	**Recommendations for Improvement**
Quality, Safety, and Value	• Senior-level involvement in QSV/performance improvement committee • Protected peer review of clinical care • Credentialing and privileging • UM reviews • Patient safety incident reporting and root cause analyses	• Clinical managers consistently review OPPE data every 6 months.	• Physician UM Advisors consistently document their decisions in the National UM Integration database. • Required representatives of the interdisciplinary group consistently attend meetings and review UM data. • The Patient Safety Manager submits an annual patient safety report to facility leaders at the completion of each FY.
Medication Management	• Anticoagulation management policies and procedures • Management of patients receiving new orders for anticoagulants o Prior to treatment o During treatment • Ongoing evaluation of the anticoagulation program • Competency assessment	• Clinicians consistently obtain all required laboratory tests prior to initiating patients on anticoagulant medications.	None

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

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	• Providers consistently document patient or surrogate informed consent and identify the receiving provider for patients transferred out of the facility. • Clinicians consistently communicate pertinent patient information to the receiving facility when patients are transferred out of the facility.	None

Healthcare Processes	Performance Indicators	Critical Recommendations[40] for Improvement	Recommendations for Improvement
Environment of Care	• Parent facility o EOC deficiency tracking and rounds o General Safety o Infection prevention o Environmental cleanliness o Exam room privacy o Availability of feminine hygiene products and medical equipment and supplies • CBOC o General safety o Infection prevention o Environmental cleanliness o Medication safety and security o Privacy o Availability of feminine hygiene products and medical equipment and supplies o IT network room security • Radiology o Safe use of fluoroscopy equipment o Environmental safety o Infection prevention o Medication safety and security o Radiology equipment inspection o Availability of medical equipment and supplies o Maintenance of radiological equipment • Inpatient MH • MH EOC inspections • Environmental suicide hazard identification • Employee training • Environmental safety • Infection prevention • Availability of medical equipment and supplies	None	• The Interdisciplinary Safety Inspection Team completes the required training on how to identify and correct environmental hazards, including the proper use of the MH EOC Checklist.

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

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement

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
		None	None

High-Risk and Problem-Prone Processes: Post-Traumatic Stress Disorder Care	• Completion of a suicide risk assessment by acceptable providers • Established plan of care and disposition • Offer of further diagnostic evaluations • Completion of diagnostic evaluations • Receipt of MH treatment when applicable	• Acceptable providers perform suicide risk assessments for all patients with positive PTSD screens. • Acceptable providers complete diagnostic evaluations for patients with positive PTSD screens within 30 days of the referral.	None

Facility Profile

The table below provides general background information for this medium-complexity (2)[41,42] affiliated[43] facility reporting to VISN 6.

Table 5. Facility Profile for Fayetteville (565) 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	$298.5	$331.5	$360.0
Number of:			
• **Unique Patients**	61,236	65,414	69,249
• **Outpatient Visits**	579,110	557,586	698,680
• **Unique Employees**[47]	1,254	1,454	1,647
Type and Number of Operating Beds:			
• **Acute**	40	40	40
• **Mental Health**	20	20	20
• **Community Living Center**	69	69	69
• **Domiciliary**	n/a	n/a	n/a
Average Daily Census:			
• **Acute**	14	14	12
• **Mental Health**	16	17	17
• **Community Living Center**	51	50	34
• **Domiciliary**	n/a	n/a	n/a

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.

n/a = not applicable.

[41] VHA medical centers are classified according to a facilities complexity model; 2 designation indicates a facility with medium volume, low-risk patients, few complex clinical programs, and small or no research and teaching programs. Retrieved September 10, 2017, from http://opes.vssc.med.va.gov/FacilityComplexityLevels/Pages/default.aspx
[42] As of October 1, 2017, the Fayetteville VA Medical Center is now designated as a high-complexity (1c) affiliated facility.
[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 for October 1, 2015 through September 30, 2016

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services[50] Provided	Diagnostic Services[51] Provided	Ancillary Services[52] Provided
Jacksonville, NC	565GA	17,654	7,827	Dermatology Eye Gynecology Podiatry	Laboratory and Pathology	Nutrition Pharmacy Social Work Weight Management
Wilmington, NC	565GC	23,643	14,786	Cardiology Dermatology Gastroenterology Infectious Disease Rehab Physician Eye General Surgery Gynecology Podiatry Urology	Laboratory and Pathology Radiology	Dental Nutrition Pharmacy Social Work Weight Management
Hamlet, NC	565GD	3,929	2,938	Endocrinology Eye Anesthesia Gynecology	n/a	Nutrition Pharmacy Weight Management
Pembroke, NC	565GE	7,721	3,295	Endocrinology Eye Gynecology	n/a	Nutrition Pharmacy Weight Management

[48] Includes all outpatient clinics in the community that were in operation as of February 15, 2017. We have omitted Supply, NC (565GH); Jacksonville, NC (565GJ); and Fayetteville, NC (565QA), as no workload/encounters or services were reported.
[49] An encounter is a professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition.
[50] Specialty care services refer to non-primary care and non-MH services provided by a physician.
[51] Diagnostic services include EKG, EMG, laboratory, nuclear medicine, radiology, and vascular lab services.
[52] Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services[53] Provided	Diagnostic Services[54] Provided	Ancillary Services[55] Provided
Goldsboro, NC	565GF	6,643	4,042	Dermatology Endocrinology Hematology/ Oncology Eye Gynecology	n/a	Nutrition Pharmacy Weight Management
Sanford, NC	565GG	2,308	237	n/a	n/a	Nutrition Pharmacy Weight Management
Fayetteville, NC	565GL	65,560	7,461	Cardiology Endocrinology Gastroenterology Hematology/ Oncology Infectious Disease Nephrology Neurology Pulmonary/ Respiratory Disease Blind Rehab Eye General Surgery Anesthesia ENT Gynecology Orthopedics Podiatry Urology	EKG Radiology	Nutrition Pharmacy Prosthetics Social Work Weight Management

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

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

n/a = not applicable.

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

VHA Policies Beyond Recertification Dates

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

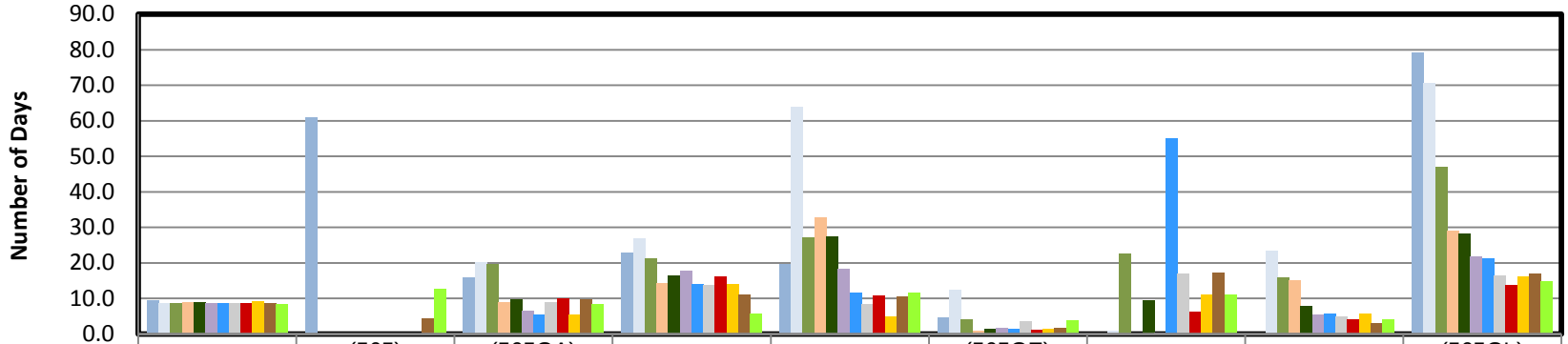
1. VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010 (recertification due date June 30, 2015).
2. VHA Directive 2011-007, Required Hand Hygiene Practices, February 16, 2011 (recertification due date February 29, 2016).
3. VHA Directive 2012-026, Sexual Assaults and Other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities, September 27, 2012 (recertification due date September 30, 2017).
4. VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011 (recertification due date March 31, 2016).
5. VHA Handbook 1004.01, *Informed Consent for Clinical Treatments and Procedures*, August 14, 2009 (recertification due date August 31, 2014), revised May 22, 2017.
6. VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008 (recertification due date September 30, 2013), amended November 16, 2015.
7. VHA Handbook 1160.03, *Programs for Veterans with Post-Traumatic Stress Disorder (PTSD)*, March 12, 2010 (recertification due date March 31, 2015) revised December 8, 2015.

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),[56] 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."[57] 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."[58]

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

Patient Aligned Care Team Compass Metrics

Quarterly New PC Patient Average Wait Time in Days



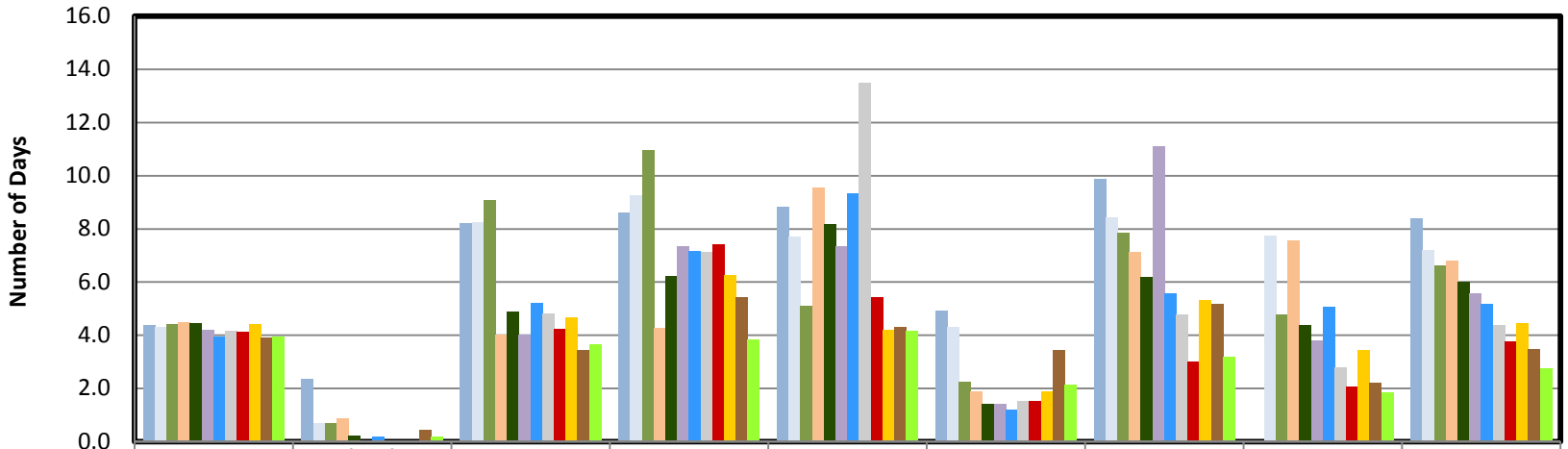
	VHA Total	(565) Fayetteville VAMC	(565GA) Jacksonville VA Clinic	(565GC) Wilmington	(565GD) Hamlet	(565GE) Robeson County	(565GF) Goldsboro	(565GG) Lee County	(565GL) Cumberland County
APR-FY16	9.5	60.9	16.0	23.0	19.8	4.8	n/a	n/a	79.1
MAY-FY16	8.7	0.0	20.3	27.0	64.0	12.5	1.0	23.5	70.5
JUN-FY16	8.7	0.0	19.8	21.5	27.1	4.3	22.8	15.9	47.1
JUL-FY16	8.9	n/a	9.0	14.4	32.9	1.0	0.0	15.3	29.1
AUG-FY16	8.9	n/a	9.8	16.5	27.5	1.5	9.5	7.8	28.2
SEP-FY16	8.7	n/a	6.7	17.9	18.3	1.6	0.5	5.5	21.8
OCT-FY17	8.7	n/a	5.6	14.0	11.7	1.5	55.1	5.8	21.3
NOV-FY17	8.8	n/a	8.9	13.9	8.6	3.7	16.9	5.0	16.5
DEC-FY17	8.8	n/a	10.1	16.2	10.8	1.2	6.2	4.1	13.8
JAN-FY17	9.2	n/a	5.6	14.1	4.9	1.4	11.1	5.7	16.2
FEB-FY17	8.7	4.4	9.7	11.0	10.5	1.6	17.4	3.1	17.0
MAR-FY17	8.4	12.7	8.3	5.6	11.8	3.7	11.0	4.2	14.9

Source: VHA Support Service Center.

Note: OIG did not assess VA's data for accuracy or completeness. We have on file the facility's explanation for the increasing wait times for the Fayetteville VAMC, Hamlet VA Clinic, Goldsboro VA Clinic, and Cumberland County VA Clinic.

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

Quarterly Established PC Patient Average Wait Time in Days

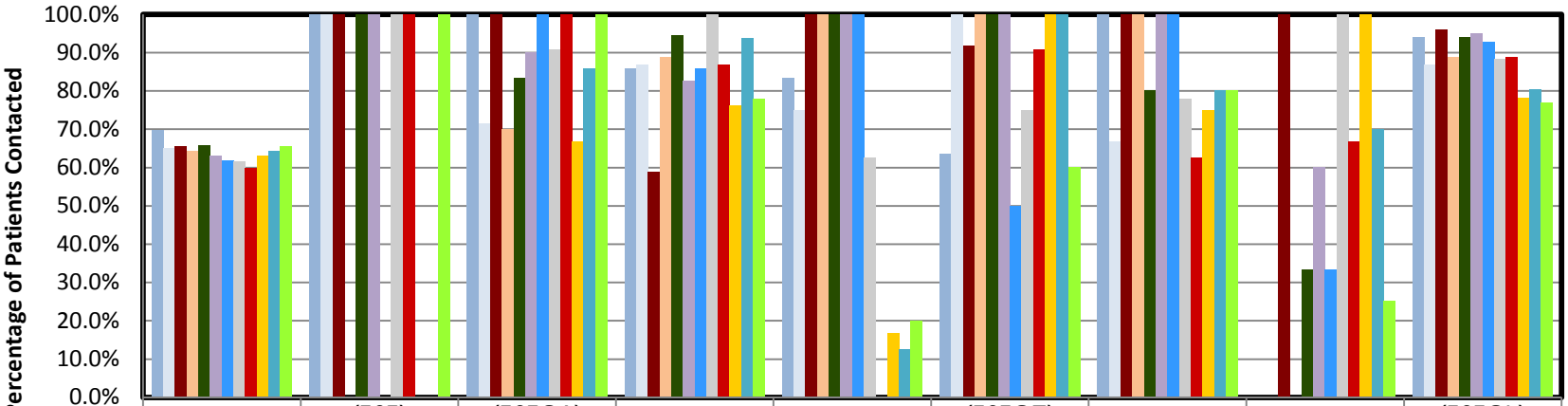


	VHA Total	(565) Fayetteville VAMC	(565GA) Jacksonville VA Clinic	(565GC) Wilmington	(565GD) Hamlet	(565GE) Robeson County	(565GF) Goldsboro	(565GG) Lee County	(565GL) Cumberland County
APR-FY16	4.4	2.4	8.2	8.6	8.8	4.9	9.9	n/a	8.4
MAY-FY16	4.3	0.7	8.2	9.3	7.7	4.3	8.4	7.7	7.2
JUN-FY16	4.4	0.7	9.1	10.9	5.1	2.2	7.9	4.8	6.6
JUL-FY16	4.5	0.9	4.0	4.3	9.6	1.9	7.1	7.6	6.8
AUG-FY16	4.5	0.2	4.9	6.2	8.2	1.4	6.2	4.4	6.0
SEP-FY16	4.2	n/a	4.0	7.3	7.4	1.4	11.1	3.8	5.6
OCT-FY17	3.9	0.2	5.2	7.2	9.3	1.2	5.6	5.1	5.2
NOV-FY17	4.2	0.0	4.8	7.1	13.5	1.5	4.8	2.8	4.4
DEC-FY17	4.1	0.1	4.2	7.4	5.4	1.5	3.0	2.1	3.8
JAN-FY17	4.4	0.0	4.7	6.3	4.2	1.9	5.3	3.4	4.5
FEB-FY17	3.9	0.4	3.5	5.4	4.3	3.4	5.2	2.2	3.5
MAR-FY17	3.9	0.2	3.7	3.8	4.2	2.1	3.2	1.9	2.8

Source: VHA Support Service Center.

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

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

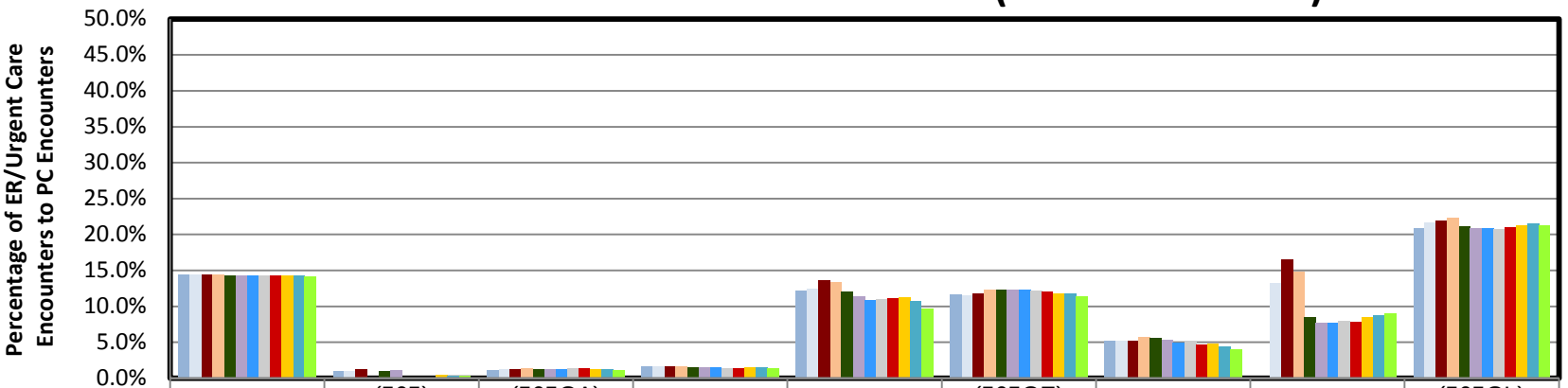


	VHA Total	(565) Fayetteville VAMC	(565GA) Jacksonville VA Clinic	(565GC) Wilmington	(565GD) Hamlet	(565GE) Robeson County	(565GF) Goldsboro	(565GG) Lee County	(565GL) Cumberland County
APR-FY16	69.7%	100.0%	100.0%	85.7%	83.3%	63.6%	100.0%	n/a	94.0%
MAY-FY16	65.0%	100.0%	71.4%	86.7%	75.0%	100.0%	66.7%	n/a	86.7%
JUN-FY16	65.5%	100.0%	100.0%	58.8%	100.0%	91.7%	100.0%	100.0%	95.9%
JUL-FY16	64.3%	n/a	70.0%	88.9%	100.0%	100.0%	100.0%	n/a	88.7%
AUG-FY16	65.7%	100.0%	83.3%	94.4%	100.0%	100.0%	80.0%	33.3%	94.1%
SEP-FY16	62.9%	100.0%	90.0%	82.6%	100.0%	100.0%	100.0%	60.0%	95.0%
OCT-FY17	61.8%	n/a	100.0%	85.7%	100.0%	50.0%	100.0%	33.3%	92.9%
NOV-FY17	61.4%	100.0%	90.9%	100.0%	62.5%	75.0%	77.8%	100.0%	88.2%
DEC-FY17	59.8%	100.0%	100.0%	86.7%	0.0%	90.9%	62.5%	66.7%	88.8%
JAN-FY17	63.0%	n/a	66.7%	76.2%	16.7%	100.0%	75.0%	100.0%	78.1%
FEB-FY17	64.2%	n/a	85.7%	93.8%	12.5%	100.0%	80.0%	70.0%	80.3%
MAR-FY17	65.6%	100.0%	100.0%	77.8%	20.0%	60.0%	80.0%	25.0%	76.9%

Source: VHA Support Service Center.

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

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



	VHA Total	(565) Fayetteville VAMC	(565GA) Jacksonville VA Clinic	(565GC) Wilmington	(565GD) Hamlet	(565GE) Robeson County	(565GF) Goldsboro	(565GG) Lee County	(565GL) Cumberland County
APR-FY16	14.4%	1.1%	1.2%	1.7%	12.1%	11.6%	5.2%	n/a	20.9%
MAY-FY16	14.4%	1.0%	1.2%	1.6%	12.5%	11.5%	5.3%	13.2%	21.7%
JUN-FY16	14.4%	1.3%	1.2%	1.6%	13.6%	11.9%	5.2%	16.5%	21.9%
JUL-FY16	14.4%	n/a	1.4%	1.6%	13.4%	12.4%	5.7%	14.8%	22.3%
AUG-FY16	14.3%	0.9%	1.3%	1.5%	12.1%	12.3%	5.5%	8.5%	21.1%
SEP-FY16	14.2%	1.1%	1.3%	1.5%	11.3%	12.3%	5.4%	7.7%	20.8%
OCT-FY17	14.3%	0.0%	1.3%	1.5%	10.8%	12.2%	4.9%	7.7%	20.8%
NOV-FY17	14.3%	0.0%	1.3%	1.4%	11.0%	12.2%	5.2%	8.0%	20.8%
DEC-FY17	14.2%	0.1%	1.4%	1.4%	11.1%	12.1%	4.7%	7.9%	20.9%
JAN-FY17	14.3%	0.5%	1.3%	1.5%	11.3%	11.8%	4.8%	8.4%	21.3%
FEB-FY17	14.3%	0.4%	1.3%	1.5%	10.7%	11.8%	4.4%	8.7%	21.5%
MAR-FY17	14.2%	0.3%	1.2%	1.4%	9.7%	11.3%	4.1%	9.1%	21.3%

Source: VHA Support Service Center.

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

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

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

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

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

Source: VHA Support Service Center.

Relevant OIG Reports

June 23, 2014 through March 1, 2018[59]

Healthcare Inspection – Surgical Service Concerns, Fayetteville VA Medical Center, Fayetteville, North Carolina
9/30/2016 | 15-00084-370 | *Summary | Report*

Healthcare Inspection – Alleged Improper Management of Dermatology Requests, Fayetteville VA Medical Center, Fayetteville, North Carolina
5/3/2016 | 14-02890-286 | *Summary* | *Report*

Combined Assessment Program Review of the Fayetteville VA Medical Center, Fayetteville, North Carolina
8/19/2014 | 14-02067-253 | *Summary | Report*

Community Based Outpatient Clinic and Primary Care Clinic Reviews at Fayetteville VA Medical Center, Fayetteville, North Carolina
8/18/2014 | 14-00924-247 | *Summary | Report*

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

VISN Director Comments

Department of Veterans Affairs

Memorandum

Date: February 16, 2018

From: Network Director, VA Mid-Atlantic Health Care Network (10N6)

Subject: **CHIP Review of the Fayetteville VA Medical Center, Fayetteville, NC**

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

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

1. The attached subject report is forwarded for your review and further action. I reviewed the response of the Fayetteville VA Medical Center (VAMC), Fayetteville, NC and concur with the facility's findings, recommendations and submitted action plans.

DEANNE M. SEEKINS 261197
Digitally signed by DEANNE M. SEEKINS 261197
Date: 2018.01.31 16:49:59 -05'00'

DEANNE M. SEEKINS, MBA, VHA-CM
Mid-Atlantic Network Director, VISN 6

Facility Interim Director Comments

Department of Veterans Affairs

Memorandum

Date: February 16, 2018

From: Interim Director, Fayetteville VA Medical Center (565/00)

Subject: **CHIP Review of the Fayetteville VA Medical Center, Fayetteville, NC**

To: Director, VA Mid-Atlantic Health Care Network (10N6)

1. Fayetteville VA Medical Center concurs with the findings brought forth in this report. Specific corrective actions have been provided for the recommendations.

MARK E. SHELHORSE, MD
Interim Director

OIG Contact and Staff Acknowledgments

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National Veterans Service Organizations
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Office of Management and Budget
U.S. Senate: Richard Burr, Thom Tillis
U.S. House of Representatives: Alma Adams; Ted Budd; G.K. Butterfield; Virginia Foxx; George Holding; Richard L. Hudson, Jr.; Walter B. Jones; Patrick McHenry; Mark Meadows; Robert Pittenger; David E. Price; David Rouzer; Mark Walker

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

Endnotes

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

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

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

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

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

[f] The references used for PTSD Care included:

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

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

- Department of Veterans' Affairs, Patient Aligned Care Teams Compass Data Definitions, accessed: April 28, 2017.

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

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