Department of Veterans Affairs
Office of Inspector General

Office of Healthcare Inspections

Report No. 15-04698-99

Combined Assessment Program Review of the VA Western New York Healthcare System Buffalo, New York

January 28, 2016

Washington, DC 20420

To Report Suspected Wrongdoing in VA Programs and Operations
Telephone: 1-800-488-8244
E-Mail: vaoighotline@va.gov
(Hotline Information: www.va.gov/oig/hotline)

Glossary

AD	advance directive
CAP	Combined Assessment Program
CSP	compounded sterile product
CT	computed tomography
EHR	electronic health record
EOC	environment of care
facility	VA Western New York Healthcare System
FY	fiscal year
MH	mental health
NA	not applicable
NM	not met
OIG	Office of Inspector General
OR	operating room
QSV	quality, safety, and value
VHA	Veterans Health Administration

Table of Contents

Executive Summary

Review Purpose: The purpose of the review was to evaluate selected health care facility operations, focusing on patient care quality and the environment of care, and to provide crime awareness briefings. We conducted the review the week of November 2, 2015.

Review Results: The review covered seven activities. We made no recommendations in the following three activities:

- Coordination of Care
- Computed Tomography Radiation Monitoring
- Suicide Prevention Program

The facility's reported accomplishments were establishing the Homeless Veterans Primary Care Clinic and implementing the new clinical modalities of robotic surgery and cochlear implants.

Recommendations: We made recommendations in the following four activities:

Quality, Safety, and Value: Review Ongoing Professional Practice Evaluation data every 6 months. Complete at least 75 percent of all utilization management reviews. Ensure Physician Utilization Management Advisors consistently document their decisions in the National Utilization Management Integration database. Complete eight root cause analyses each fiscal year. Ensure the Patient Safety Manager consistently provides feedback about root cause analysis findings to the individual or department who reported the incident.

Environment of Care: Ensure floors in patient care areas are clean and free of mold, and store clean and dirty items separately.

Medication Management: Ensure competency assessment for employees who prepare compounded sterile products includes a written test and gloved fingertip sampling. Fully implement the newly revised compounded sterile products safety/competency assessment checklist that includes all required elements. Remove packaging from items before transfer to the buffer room, and clean and sanitize items transferred to the buffer room.

Advance Directives: Correctly post patients' advance directives status. Ask inpatients whether they would like to discuss creating, changing, and/or revoking advance directives.

Comments

The Interim Veterans Integrated Service Network Director and Facility Director agreed with the Combined Assessment Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes C and D, pages 25–30, for the full text of the Directors' comments.) We will follow up on the planned actions until they are completed.

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

Objectives and Scope

Objectives

CAP reviews are one element of the OIG's efforts to ensure that our Nation's veterans receive high quality VA health care services. The objectives of the CAP review are to:

- Conduct recurring evaluations of selected health care facility operations, focusing on patient care quality and the EOC.
- Provide crime awareness briefings to increase employee understanding of the potential for program fraud and the requirement to refer suspected criminal activity to the OIG.

Scope

The scope of the CAP review is limited. Serious issues that come to our attention that are outside the scope will be considered for further review separate from the CAP process and may be referred accordingly.

For this review, we examined selected clinical and administrative activities to determine whether facility performance met requirements related to patient care quality and the EOC. In performing the review, we inspected selected areas, conversed with managers and employees, and reviewed clinical and administrative records. The review covered the following seven activities:

- QSV
- EOC
- Medication Management
- Coordination of Care
- CT Radiation Monitoring
- ADs
- Suicide Prevention Program

We have listed the general information reviewed for each of these activities. Some of the items listed may not have been applicable to this facility because of a difference in size, function, or frequency of occurrence.

The review covered facility operations for FY 2015 and FY 2016 through November 2, 2015, and inspectors conducted the review in accordance with OIG standard operating procedures for CAP reviews. We also asked the facility to provide

the status on the recommendations we made in our previous CAP report (*Combined Assessment Program Review of the VA Western New York Healthcare System, Buffalo, New York,* Report No. 13-00897-242, July 15, 2013).

During this review, we presented crime awareness briefings for 198 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

Additionally, we surveyed employees regarding patient safety and quality of care at the facility. We distributed an electronic survey to all facility employees and received 316 responses. We shared summarized results with facility managers.

In this report, we make recommendations for improvement. Recommendations pertain to issues that are significant enough for the OIG to monitor until the facility implements corrective actions.

Reported Accomplishments

Health Care for Homeless Veterans Primary Care Clinic

Beginning April 2015, the Health Care for Homeless Veterans Program began providing health care to homeless veterans through a conveniently located clinic. A nurse, social worker, and primary care physician provide outreach and case management services. The program has a drop-in center, which offers veterans laundry services, shower and lavatory facilities, computer stations, clothing, and toiletries. The addition of a physician improves chronic disease monitoring, management, and outcomes; facilitates entry into substance abuse treatment programs; and decreases Emergency Department visits. Since the start of the pilot program, Emergency Department visits by the homeless veteran population served have decreased 67 percent. In the 6 months prior to establishing the Homeless Veterans Primary Care Clinic, homeless veterans in the local urban area accessed Emergency Department services 34 times. Since the introduction of the clinic, the same patients have used the Emergency Department 11 times.

New Clinical Modalities

The facility implemented robotic surgery in FY 2014. During FY 2015, providers performed 41 robotic procedures in five different specialty areas—gastroenterology, general surgery, gynecology, thoracic surgery, and urology. There are plans to add vascular specialty cases in the near future.

In addition, the facility is approved as a cochlear implant center and is currently accepting referrals for veterans in Veterans Integrated Service Network 2 and the northeast.

Results and Recommendations

QSV

The purpose of this review was to determine whether the facility complied with selected QSV program requirements.[a]

We conversed with senior managers and key QSV employees, and we evaluated meeting minutes, 20 licensed independent practitioners' profiles, 10 protected peer reviews, 5 root cause analyses, and other relevant documents. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	There was a senior-level committee responsible for key QSV functions that met at least quarterly and was chaired or co-chaired by the Facility Director. • The committee routinely reviewed aggregated data.		
X	Credentialing and privileging processes met selected requirements: • Facility policy/by-laws addressed a frequency for clinical managers to review practitioners' Ongoing Professional Practice Evaluation data. • Facility clinical managers reviewed Ongoing Professional Practice Evaluation data at the frequency specified in the policy/by-laws. • The facility set triggers for when a Focused Professional Practice Evaluation for cause would be indicated. • The facility followed its policy when employees' licenses expired.	• Two profiles did not contain evidence that clinical managers reviewed Ongoing Professional Practice Evaluation data every 6 months.	**1.** We recommended that facility clinical managers consistently review Ongoing Professional Practice Evaluation data every 6 months and that facility managers monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
	Protected peer reviews met selected requirements: • Peer reviewers documented their use of important aspects of care in their review such as appropriate and timely ordering of diagnostic tests, timely treatment, and appropriate documentation. • When the Peer Review Committee recommended individual improvement actions, clinical managers implemented the actions.		
X	Utilization management met selected requirements: • The facility completed at least 75 percent of all required inpatient reviews. • Physician Utilization Management Advisors documented their decisions in the National Utilization Management Integration database. • The facility had designated an interdisciplinary group to review utilization management data.	• For the timeframe October 1, 2014–September 30, 2015, the facility completed only 49 percent of all required reviews. • For 139 of the 614 cases (22 percent) referred to Physician Utilization Management Advisors September 1–October 31, 2015, there was no evidence that advisors documented their decisions in the National Utilization Management Integration database.	**2.** We recommended that facility clinical managers ensure completion of at least 75 percent of all utilization management reviews and that facility managers monitor compliance. **3.** We recommended that Physician Utilization Management Advisors consistently document their decisions in the National Utilization Management Integration database and that facility managers monitor compliance.
X	Patient safety met selected requirements: • The Patient Safety Manager entered all reported patient incidents into the WEBSPOT database. • The facility completed the required minimum of eight root cause analyses. • The facility provided feedback about the root cause analysis findings to the individual or department who reported the incident. • At the completion of FY 2014, the Patient Safety Manager submitted an annual patient safety report to facility leaders.	• During FY 2015, the facility only completed six root cause analyses. • For four root cause analyses, the Patient Safety Manager did not provide feedback about the findings to the individual or department who reported the incident.	**4.** We recommended that the Patient Safety Manager ensure completion of eight root cause analyses each fiscal year and that facility managers monitor compliance. **5.** We recommended that the Patient Safety Manager consistently provide feedback about root cause analysis findings to the individual or department who reported the incident and that facility managers monitor compliance.

NM	Areas Reviewed (continued)	Findings	Recommendations
	Overall, if QSV reviews identified significant issues, the facility took actions and evaluated them for effectiveness.		
	Overall, senior managers actively participated in QSV activities.		
	The facility met any additional elements required by VHA or local policy.		

EOC

The purpose of this review was to determine whether the facility maintained a clean and safe health care environment in accordance with applicable requirements. We also determined whether the facility met selected requirements in the dental clinic and the OR.[b]

At the Buffalo campus, we inspected the medical/surgical intensive care unit, the step-down/progressive care unit, three acute medical units, the community living center, and the acute psychiatry inpatient unit. We also inspected the Emergency Department; the OR; the dental, spinal cord injury, hemodialysis, and women's wellness clinics; and two primary care clinics. At the Batavia campus, we inspected the ambulatory care and dental clinics and two community living centers. Additionally, we reviewed relevant documents and 16 employee training records, and we conversed with key employees and managers. The table below shows the areas reviewed for this topic. The area marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed for General EOC	Findings	Recommendations
	EOC Committee minutes reflected sufficient detail regarding identified deficiencies, corrective actions taken, and tracking of corrective actions to closure for the facility and the community based outpatient clinics.		
	The facility conducted an infection prevention risk assessment.		
	Infection Prevention/Control Committee minutes documented discussion of identified high-risk areas, actions implemented to address those areas, and follow-up on implemented actions and included analysis of surveillance activities and data.		
	The facility had established a process for cleaning equipment between patients.		
	The facility conducted required fire drills in buildings designated for health care occupancy and documented drill critiques.		

NM	Areas Reviewed for General EOC (continued)	Findings	Recommendations
	The facility had a policy/procedure/guideline for identification of individuals entering the facility, and units/areas complied with requirements.		
	The facility met fire safety requirements.		
	The facility met environmental safety requirements.		
X	The facility met infection prevention requirements.	• In 7 of 16 patient care areas, floors were visibly soiled, which included what appeared to be moldy tile grout in congregate showers and restrooms in 2 of those areas. • In 4 of 16 patient care areas, we found soiled housekeeping equipment (floor buffers, mops, buckets) in storerooms used for clean patient equipment and supplies.	**6.** We recommended that facility managers ensure floors in patient care areas are clean and free of mold and monitor compliance. **7.** We recommended that employees store clean and dirty items separately and that facility managers monitor compliance.
	The facility met medication safety and security requirements.		
	The facility met privacy requirements.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for Dental Clinic		
	Dental clinic employees completed bloodborne pathogens training within the past 12 months.		
	Dental clinic employees received hazard communication training on chemical classification, labeling, and safety data sheets.		

NM	Areas Reviewed for Dental Clinic (continued)	Findings	Recommendations
	Designated dental clinic employees received laser safety training in accordance with local policy.		
	The facility tested dental water lines in accordance with local policy.		
X	The facility met environmental safety and infection prevention requirements in the dental clinic.	• At the Buffalo dental clinic, we found soiled housekeeping equipment (floor buffers, mops, buckets) in a storeroom used for patient equipment and supplies.	See recommendation 7.
	The facility met laser safety requirements in the dental clinic.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		
	Areas Reviewed for the OR		
	The facility had emergency fire policy/procedures for the OR that included alarm activation, evacuation, and equipment shutdown with responsibility for turning off room or zone oxygen.		
	The facility had cleaning policy/procedures for the OR and adjunctive areas that included a written cleaning schedule and methods of decontamination.		
	OR housekeepers received training on OR cleaning/disinfection in accordance with local policy.		
	The facility monitored OR temperature, humidity, and positive pressure.		
	The facility met fire safety requirements in the OR.		
	The facility met environmental safety requirements in the OR.		

NM	Areas Reviewed for the OR (continued)	Findings	Recommendations
	The facility met infection prevention requirements in the OR.		
	The facility met medication safety and security requirements in the OR.		
	The facility met laser safety requirements in the OR.		
	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.		

Medication Management

The purpose of this review was to determine whether the facility complied with selected requirements for the safe preparation of CSPs.[c]

We reviewed relevant documents and the competency assessment/testing records of 10 pharmacy employees who routinely compound sterile products. Additionally, we inspected one area where sterile products are compounded. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	The facility had a policy on preparation of CSPs that included required components: • Pharmacist CSP preparation or supervision of preparation except in urgent situations • Hazardous CSP preparation in an area separate from routine CSP preparation or in a compounding aseptic containment isolator • Environmental quality and control of ante and buffer areas • Hood certification initially and every 6 months thereafter • Cleaning procedures for all surfaces in the ante and buffer areas		
X	The facility established competency assessment requirements for employees who prepare CSPs that included required elements, and facility managers assessed employee competency at the required frequency based on the facility's risk level.	• Facility competency assessment for employees who prepare CSPs did not include a written test and gloved fingertip sampling.	**8.** We recommended that facility managers ensure competency assessment for employees who prepare compounded sterile products includes a written test and gloved fingertip sampling.

NM	Areas Reviewed (continued)	Findings	Recommendations
NA	If the facility used an outsourcing facility for CSPs, it had a policy/guidelines/a plan that included required components for the outsourcing facility: • Food and Drug Administration registration • Current Drug Enforcement Agency registration if compounding controlled substances		
X	The facility had a safety/competency assessment checklist for preparation of CSPs that included required steps in the proper order to maintain sterility.	• The facility's CSP safety/competency assessment checklist did not include all the elements required by the United States Pharmacopeia <797>. In September 2015, the facility revised its checklist to include these elements.	**9.** We recommended that the facility fully implement the newly revised compounded sterile products safety/competency assessment checklist that includes all required elements.
	All International Organization for Standardization classified areas had documented evidence of periodic surface sampling, and the facility completed required actions when it identified positive cultures.		
	The facility had a process to track and report CSP medication errors, including near misses.		
	The facility met design and environmental safety controls in compounding areas.		
	The facility used a laminar airflow hood or compounding aseptic isolator for preparing non-hazardous intravenous admixtures and any sterile products.		
	The facility used a biological safety cabinet in a physically separated negative pressure area or a compounding aseptic containment isolator for hazardous medication compounding and had sterile chemotherapy type gloves available for compounding these medications.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	If the facility prepared hazardous CSPs, a drug spill kit was available in the compounding area and during transport of the medication to patient care areas.		
	Hazardous CSPs were physically separated or placed in specially identified segregated containers from other inventory to prevent contamination or personnel exposure.		
	An eyewash station was readily accessible near hazardous medication compounding areas, and there was documented evidence of weekly testing.		
	The facility documented cleaning of compounding areas, and employees completed cleaning at required frequencies.		
	During the past 12 months, the facility initially certified new hoods and recertified all hoods minimally every 6 months.		
	Prepared CSPs had labels with required information prior to delivery to the patient care areas: • Patient identifier • Date prepared • Admixture components • Preparer and checker identifiers • Beyond use date		
X	The facility complied with any additional elements required by VHA, local policy, or other regulatory standards.	Facility policy reviewed, which required that only cleaned, sanitized, and non-shedding paper-related products be brought into the buffer room. • Materials brought into the buffer room were not cleaned and sanitized and included paper products that could shed particulates.	**10.** We recommended that facility managers ensure pharmacy staff remove packaging from items before transfer to the buffer room and clean and sanitize items transferred to the buffer room.

Coordination of Care

The purpose of this review was to evaluate selected aspects of the facility's patient flow process over the inpatient continuum (admission through discharge).[d]

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 35 randomly selected patients who had an acute care inpatient stay of at least 3 days from July 1, 2014, through June 30, 2015. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings	Recommendations
	The facility had a policy that addressed patient discharge and scheduling discharges early in the day.		
	The facility had a policy that addressed temporary bed locations, and it included: • Priority placement for inpatient beds given to patients in temporary bed locations • Upholding the standard of care while patients are in temporary bed locations • Medication administration • Meal provision		
	The Facility Director had appointed a Bed Flow Coordinator with a clinical background.		
	Physicians or acceptable designees completed a history and physical exam within 1 day of the patient's admission or referenced a history and physical exam completed within 30 days prior to admission. • When resident physicians completed the history and physical exams, the attending physicians provided a separate admission note or addendum within 1 day of the admission.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	• When the facility policy and/or scopes of practice allowed for physician assistants or nurse practitioners to complete history and physical exams, they were properly documented.		
	Nurses completed admission assessments within 1 day of the patient's admission.		
	When patients were transferred during the inpatient stay, physicians or acceptable designees documented transfer notes within 1 day of the transfer. • When resident physicians wrote the transfer notes, attending physicians documented adequate supervision. • Receiving physicians documented transfers.		
	When patients were transferred during the inpatient stay, sending and receiving nurses completed transfer notes.		
	Physicians or acceptable designees documented discharge progress notes or instructions that included patient diagnoses, discharge medications, and follow-up activity levels. • When resident physicians completed the discharge notes/instructions, attending physicians documented adequate supervision. • When facility policy and/or scopes of practice allowed for physician assistants or nurse practitioners to complete discharge notes/instructions, they were properly documented.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Clinicians provided discharge instructions to patients and/or caregivers and documented patients and/or caregiver understanding.		
	The facility complied with any additional elements required by VHA or local policy.		

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CT Radiation Monitoring

The purpose of this review was to determine whether the facility complied with selected VHA radiation safety requirements and to follow up on recommendations regarding monitoring and documenting radiation dose from a 2011 report, *Healthcare Inspection – Radiation Safety in Veterans Health Administration Facilities*, Report No. 10-02178-120, March 10, 2011.[e]

We reviewed relevant documents, including qualifications and dosimetry monitoring for 11 CT technologists and CT scanner inspection reports, and conversed with key managers and employees. We also reviewed the EHRs of 50 randomly selected patients who had a CT scan January 1–December 31, 2014. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

NM	Areas Reviewed	Findings	Recommendations
	The facility had a designated Radiation Safety Officer responsible for oversight of the radiation safety program.		
	The facility had a CT/imaging/radiation safety policy or procedure that included: • A CT quality control program with program monitoring by a medical physicist at least annually, image quality monitoring, and CT scanner maintenance • CT protocol monitoring to ensure doses were as low as reasonably achievable and a method for identifying and reporting excessive CT patient doses to the Radiation Safety Officer • A process for managing/reviewing CT protocols and procedures to follow when revising protocols • Radiologist review of appropriateness of CT orders and specification of protocol prior to scans		

NM	Areas Reviewed (continued)	Findings	Recommendations
	A radiologist and technologist expert in CT reviewed all CT protocols revised during the past 12 months.		
	A medical physicist tested a sample of CT protocols at least annually.		
	A medical physicist performed and documented CT scanner annual inspections, an initial inspection after acquisition, and follow-up inspections after repairs or modifications affecting dose or image quality prior to the scanner's return to clinical service.		
	If required by local policy, radiologists included patient radiation dose in the CT report available for clinician review and documented the dose in the required application(s), and any summary reports provided by teleradiology included dose information.		
	CT technologists had required certifications or written affirmation of competency if "grandfathered in" prior to January 1987, and technologists hired after July 1, 2014, had CT certification.		
	There was documented evidence that CT technologists had annual radiation safety training and dosimetry monitoring.		
	If required by local policy, CT technologists had documented training on dose reduction/optimization techniques and safe procedures for operating the types of CT equipment they used.		
	The facility complied with any additional elements required by VHA or local policy.		

ADs

The purpose of this review was to determine whether the facility complied with selected requirements for ADs for patients.[f]

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 35 randomly selected patients who had an acute care admission July 1, 2014–June 30, 2015. The table below shows the areas reviewed for this topic. The areas marked as NM did not meet applicable requirements and needed improvement. Any items that did not apply to this facility are marked NA.

NM	Areas Reviewed	Findings	Recommendations
	The facility had an AD policy that addressed: • AD notification, screening, and discussions • Proper use of AD note titles		
	Employees screened inpatients to determine whether they had ADs and used appropriate note titles to document screening.		
X	When patients provided copies of their current ADs, employees had scanned them into the EHR. • Employees correctly posted patients' AD status.	• For 13 of the 34 applicable EHRs (38 percent), employees did not correctly post patients' AD status.	**11.** We recommended that employees consistently correctly post patients' advance directives status and that facility managers monitor compliance.
X	Employees asked inpatients if they would like to discuss creating, changing, and/or revoking ADs. • When inpatients requested a discussion, employees documented the discussion and used the required AD note titles.	• Thirty-one of the 34 applicable EHRs (91 percent) did not contain documentation that employees asked inpatients whether they wished to discuss creating, changing, and/or revoking ADs.	**12.** We recommended that employees ask inpatients whether they would like to discuss creating, changing, and/or revoking advance directives and that facility managers monitor compliance.
	The facility met any additional elements required by VHA or local policy.		

Suicide Prevention Program

The purpose of this review was to evaluate the extent the facility's MH providers consistently complied with selected suicide prevention program requirements.[g]

We reviewed relevant documents and conversed with key employees. Additionally, we reviewed the EHRs of 40 patients assessed to be at risk for suicide during the period July 1, 2014–June 30, 2015, plus those who died from suicide during this same timeframe. We also reviewed the training records of 15 new employees. The table below shows the areas reviewed for this topic. Any items that did not apply to this facility are marked NA. The facility generally met requirements. We made no recommendations.

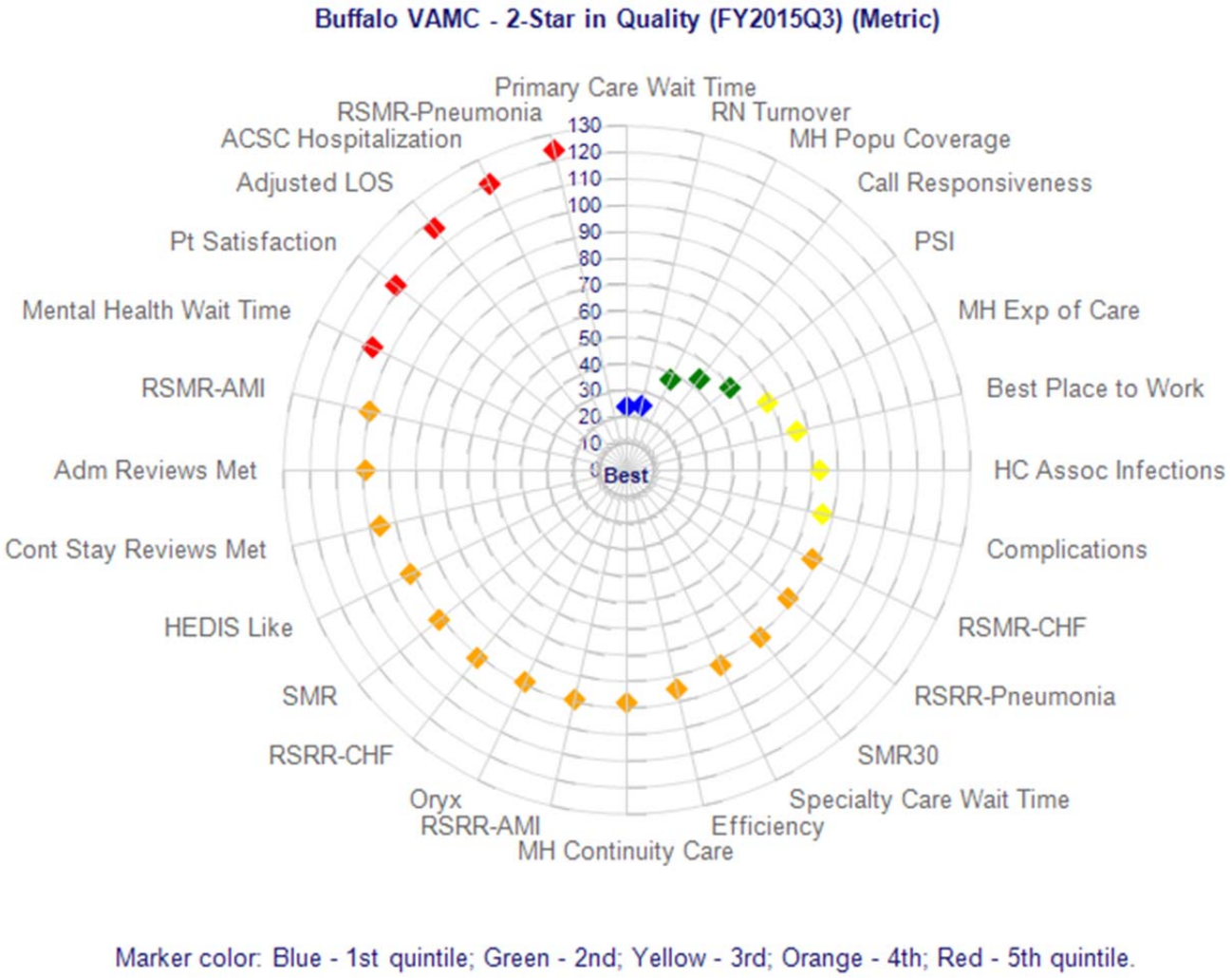
NM	Areas Reviewed	Findings	Recommendations
	The facility had a full-time Suicide Prevention Coordinator.		
	The facility had a process for responding to referrals from the Veterans Crisis Line and for tracking patients who are at high risk for suicide.		
	The facility had a process to follow up on high-risk patients who missed MH appointments.		
	The facility provided training within required timeframes: • Suicide prevention training to new employees • Suicide risk management training to new clinical employees		
	The facility provided at least five suicide prevention outreach activities to community organizations each month.		
	The facility completed required reports and reviews regarding patients who attempted or completed suicide.		
	Clinicians assessed patients for suicide risk at the time of admission.		

NM	Areas Reviewed (continued)	Findings	Recommendations
	Clinicians appropriately placed Patient Record Flags: • High-risk patients received Patient Record Flags. • Moderate- and low-risk patients did not receive Patient Record Flags.		
	Clinicians documented Suicide Prevention Safety Plans that contained the following required elements: • Identification of warning signs • Identification of internal coping strategies • Identification of contact numbers of family or friends for support • Identification of professional agencies • Assessment of available lethal means and how to keep the environment safe		
	Clinicians documented that they gave patients and/or caregivers a copy of the safety plan.		
	The treatment team evaluated patients as follows: • At least four times during the first 30 days after discharge. • Every 90 days to review Patient Record Flags.		
	The facility complied with any additional elements required by VHA or local policy.		

Facility Profile (Buffalo/528) FY 2016 through November 2015[1]	
Type of Organization	Tertiary
Complexity Level	1c - High complexity
Affiliated/Non-Affiliated	Affiliated
Total Medical Care Budget in Millions	$81.4
Number (as of December 7, 2015) of:	
• **Unique Patients**	26,737
• **Outpatient Visits**	91,973
• **Unique Employees**[2]	6,126
Type and Number of Operating Beds:	
• **Hospital**	130
• **Community Living Center**	120
• **MH**	52
Average Daily Census:	
• **Hospital**	72
• **Community Living Center**	77
• **MH**	27
Number of Community Based Outpatient Clinics	6
Location(s)/Station Number(s)	Jamestown/528GB Dunkirk/528GC Niagara Falls/528GD Lockport/528GK Lackawanna/528GQ Olean/528GR
Veterans Integrated Service Network Number	2

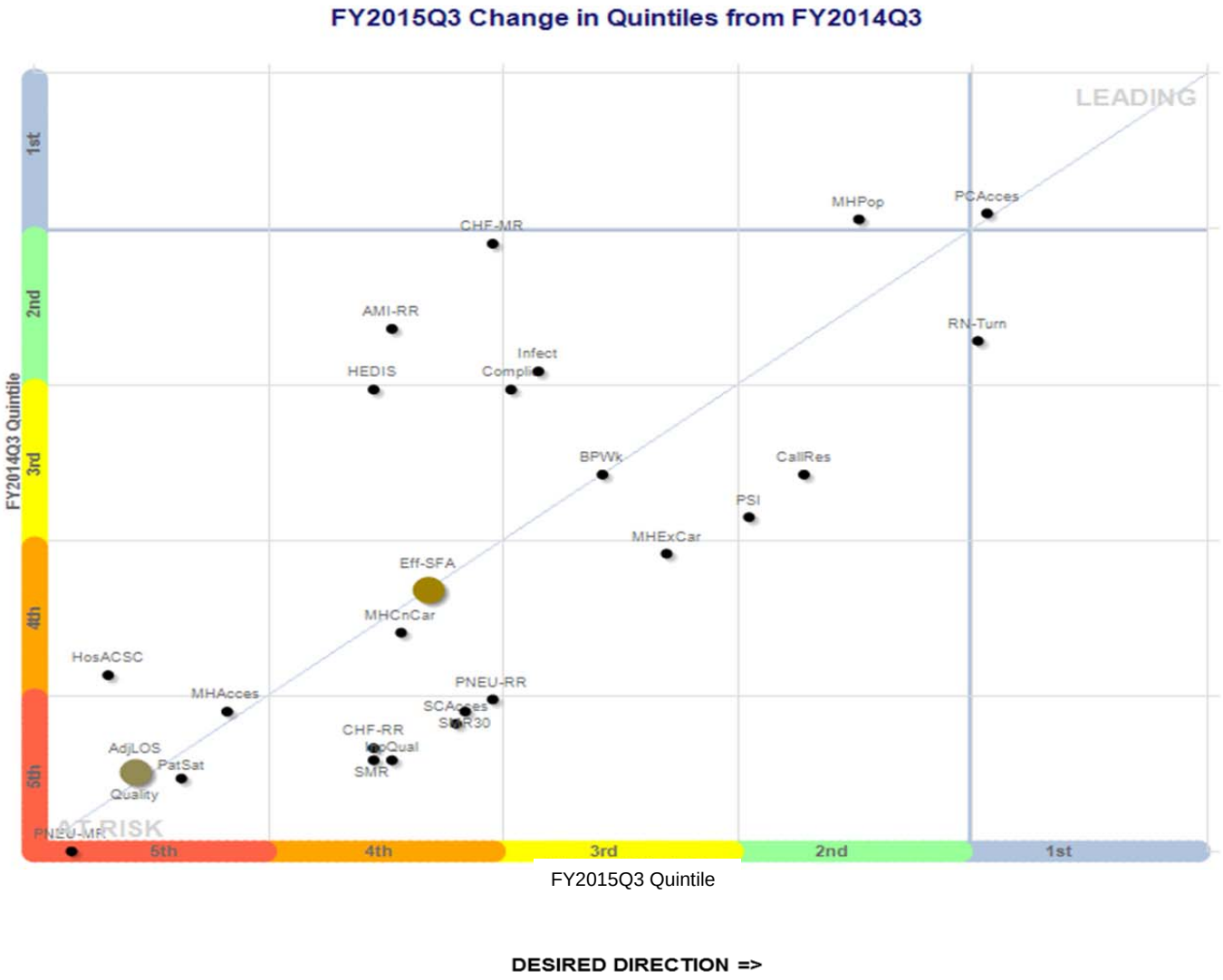
[1] All data is for FY 2016 through November 2015 except where noted.
[2] Unique employees involved in direct medical care (cost center 8200).

Strategic Analytics for Improvement and Learning (SAIL)[3]



[3] Metric definitions follow the graphs.

Scatter Chart



NOTE

Quintiles are derived from facility ranking on z-score of a metric among 128 facilities. Lower quintile is more favorable.

Metric Definitions

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
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
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	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
MH Wait Time	MH wait time for new and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value
MH Continuity Care	MH continuity of care (FY14Q3 and later)	MH Continuity Care
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
Primary Care Wait Time	Primary care wait time for new and established patients (top 50 clinics; FY13 and later)	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
RN Turnover	Registered nurse turnover rate	A lower value is better than a higher value
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-CHF	30-day risk standardized readmission rate for congestive heart failure	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
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 and established patients (top 50 clinics; FY13 and later)	A higher value is better than a lower value

Appendix C

Interim Veterans Integrated Service Network Director Comments

Department of Veterans Affairs

Memorandum

Date: December 31, 2015

From: Interim Director, VA Health Care Upstate New York (10N2)

Subject: **CAP Review of the VA Western New York Healthcare System, Buffalo, NY**

To: Director, Bedford Office of Healthcare Inspections (54BN)

Director, Management Review Service (VHA 10AR MRS OIG CAP CBOC)

1. I concur with the conclusions and recommendations presented by the Office of Healthcare Inspections and present to you a plan of action to correct those areas with findings and recommendations.

2. If you have any questions, please contact Kathryn Varkonda, RN, MSN, Performance Manager, VA Western New York Healthcare System at 716-862-6380.

Signed//
for Darlene A. DeLancey, MS
Interim Network Director

Facility Director Comments

Department of Veterans Affairs

Memorandum

Date: December 31, 2015

From: Director, VA Western New York Healthcare System (528/00)

Subject: **CAP Review of the VA Western New York Healthcare System, Buffalo, NY**

To: Interim Director, VA Health Care Upstate New York (10N2)

1. Thank you for the opportunity to review and respond to the subject report.

2. I concur with the conclusions and recommendations presented by the Office of Healthcare Inspections and present to you a plan of action designed to correct those areas with findings and recommendations.

3. If you have any questions or need further information, please contact Kathryn Varkonda, RN, MSN, VA Western New York Healthcare System Performance Manager, at 716-862-6380.

Brian G. Stiller
BRIAN G. STILLER
Medical Center Director

Comments to OIG's Report

The following Director's comments are submitted in response to the recommendations in the OIG report:

OIG Recommendations

Recommendation 1. We recommended that facility clinical managers consistently review Ongoing Professional Practice Evaluation data every 6 months and that facility managers monitor compliance.

Concur

Target date for completion: April 30, 2016

Facility response: All pending Ongoing Professional Practice Evaluations will be completed by January 15, 2016 and randomly reviewed for completion monthly for 4 months. Monitoring of a 10% random sampling of all Licensed Independent Providers will continue every 6 months to ensure continued compliance.

Recommendation 2. We recommended that facility clinical managers ensure completion of at least 75 percent of all utilization management reviews and that facility managers monitor compliance.

Concur

Target date for completion: April 30, 2016

Facility response: VAWNYHS has hired 2 Utilization Management (UM) Specialists. Since approximately mid-November, 75% of admissions, continued stay and observation reviews have been assigned on a daily basis. The goal for UM staff reviewers is to progress from 49% to 75% minimally completed for admission, continued stay and observation reviews by March 31, 2016.

Recommendation 3. We recommended that Physician Utilization Management Advisors consistently document their decisions in the National Utilization Management Integration database and that facility managers monitor compliance.

Concur

Target date for completion: April 30, 2016

Facility response: The Utilization Management reviewers have generated an educational/ informational email to the Physician Utilization Management Advisors (PUMA) informing them of the need for PUMA response improvement as a result of the OIG findings. The report of cases not meeting the standardized criteria will be reviewed on a weekly basis beginning on January 1, 2016 to monitor PUMA response rates. The

results of this review will be shared with the Chief of Staff for review/follow-up of incomplete PUMA reviews. Additionally, these results will be provided to OIG for 4 months to show sustained improvement in PUMA reviews.

Recommendation 4. We recommended that the Patient Safety Manager ensure completion of eight root cause analyses each fiscal year and that facility managers monitor compliance.

Concur

Target date for completion: April 30, 2016

Facility response: The Patient Safety Manager will ensure that a minimum of eight root cause analyses (RCA) (individual RCAs and Aggregated RCA reviews) are completed each fiscal year. Patient Safety Manager will monitor compliance on a monthly basis. A quarterly patient safety report will be submitted to the Local Leadership Committee that will include number of RCAs completed and numbers of RCAs in progress in order to ensure minimum compliance of analyses are met. For first quarter FY 2016, three RCAs have been completed and three are in the process of being chartered.

Recommendation 5. We recommended that the Patient Safety Manager consistently provide feedback about root cause analysis findings to the individual or department who reported the incident and that facility managers monitor compliance.

Concur

Target date for completion: April 30, 2016

Facility response: A standardized format has been developed and will be implemented to consistently document feedback about RCA findings and actions to staff member or departments submitting close call and adverse event reports that result in a RCA. Compliance will be tracked and monitored using the RCA tracking grid.

Recommendation 6. We recommended that facility managers ensure floors in patient care areas are clean and free of mold and monitor compliance.

Concur

Target date for completion: April 30, 2016

Facility response: Environmental Management Service (EMS) has written a new detailed floor care plan and training that will be rolled out to housekeepers with training completed by January 31, 2016. The training will focus on stripping and waxing, floor maintenance after the waxing process and floor cleanliness. This will be a “hands on” training using the more experienced housekeepers training the less experienced housekeepers. Training will be documented and signed by trainers and housekeepers. Housekeeping supervisors will monitor the training process and follow up on progress

with documented inspections, using the daily job sheet to include restrooms and shower areas for mold.

Recommendation 7. We recommended that employees store clean and dirty items separately and that facility managers monitor compliance.

Concur

Target date for completion: April 30, 2016

Facility response: EMS has created an inspection spreadsheet that divides the medical center into parts for the supervisors to inspect. Supervisors will check clean and soiled utility rooms, storage rooms, closets and where items are stored. This will be done by ward and clinic twice weekly, documented on the spreadsheet, and signed by the supervisor. This process will be put in place at the beginning January 1, 2016.

Recommendation 8. We recommended that facility managers ensure competency assessment for employees who prepare compounded sterile products includes a written test and gloved fingertip sampling.

Concur

Target date for completion: March 1, 2016

Facility response: All pharmacy staff assigned duties in the Sterile Products Compounding Program have completed the required annual TMS training module as of December 29, 2015. Supervisors will require this mandatory annually, dating from the date of the last test. The requirement has been added to the Annual Employee Competency position specific requirements and the employee's supervisor will ensure the requirement is up-to-date at the annual competency assessment.

Gloved fingertip testing of all pharmacy staff commenced November 3, 2015 and is ongoing. All pharmacy staff assigned duties in the sterile products compounding program are expected to be compliant with this requirement by March 1, 2016. The requirement has been added to the Annual Employee Competency position specific requirements and the employee's supervisor will ensure the annual requirement is up-to-date at the annual competency assessment.

Recommendation 9. We recommended that the facility fully implement the newly revised compounded sterile products safety/competency assessment checklist that includes all required elements.

Concur

Target date for completion: March 1, 2016

Facility response: Implementation of the checklist is ongoing and all pharmacy staff assigned duties in the sterile products compounding program are expected to be

compliant with this requirement by March 1, 2016. The requirement has been added to the Annual Employee Competency position specific requirements and the employee's supervisor will ensure the annual requirement is up-to-date at the annual competency assessment.

Recommendation 10. We recommended that facility managers ensure pharmacy staff remove packaging from items before transfer to the buffer room and clean and sanitize items transferred to the buffer room.

Concur

Target date for completion: March 1, 2016

Facility response: Initial education occurred in November and staff will be re-educated regarding the requirement listed at a staff meeting January 5, 2016. Weekly, the Inpatient Pharmacy Supervisor will observe a minimum of 10 unique staff during normal operations to determine compliance with the requirement.

Recommendation 11. We recommended that employees consistently correctly post patients' advance directives status and that facility managers monitor compliance.

Concur

Target date for completion: June 30, 2016

Facility response: Education regarding posting patient's advance directives in CPRS is being developed and will be assigned to appropriate staff upon completion. Training completion by February 29, 2016 and advanced directive postings will be monitored for completion and compliance for 4 months.

Recommendation 12. We recommended that employees ask inpatients whether they would like to discuss creating, changing, and/or revoking advance directives and that facility managers monitor compliance.

Concur

Target date for completion: June 1, 2016

Facility response: To ensure that inpatients are provided the opportunity to discuss creating, changing, and/or revoking an advanced directive, the following list of templates is being reviewed and updated; inpatient admission assessment, inpatient discharge summary, ambulatory surgery assessment, initial mental health intake assessment, initial primary care intake assessment, and VA home care admission assessment

Employees will be educated regarding the changes to the above templated notes. Compliance will be monitored to ensure that patients are given to opportunity to participate in managing care and treatment options related to advance directives.

Office of Inspector General
Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the OIG at (202) 461-4720.
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U.S. House of Representatives: Chris Collins, John Katko, Tom Reed, Louise Slaughter

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

Endnotes

[a] References used for this topic 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] References used for this topic included:
- VHA Directive 2005-037, *Planning for Fire Response*, September 2, 2005.
- VHA Directive 2009-026; *Location, Selection, Installation, Maintenance, and Testing of Emergency Eyewash and Shower Equipment*; May 13, 2009.
- Various requirements of The Joint Commission, the Occupational Safety and Health Administration, the International Association of Healthcare Central Service Materiel Management, the Health Insurance Portability and Accountability Act, National Fire Protection Association, Association of periOperative Registered Nurses, U.S. Pharmacopeial Convention, American National Standards Institute.

[c] References used for this topic included:
- VHA Handbook 1108.06, *Inpatient Pharmacy Services*, June 27, 2006.
- VHA Handbook 1108.07, *Pharmacy General Requirements*, April 17, 2008.
- Various requirements of VA Pharmacy Benefits Management Services, The Joint Commission, the United States Pharmacopeial Convention, the American Society of Health-System Pharmacists, the Institute for Safe Medication Practices, the Food and Drug Administration, and the American National Standards Institute.

[d] The references used for this topic included:
- VHA Directive 1009, *Standards for Addressing the Needs of Patients Held in Temporary Bed Locations*, August 28, 2013.
- VHA Directive 1063, *Utilization of Physician Assistants (PA)*, December 24, 2013.
- VHA Handbook 1400.01, *Resident Supervision*, December 19, 2012.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, March 19, 2015.

[e] References used for this topic included:
- VHA Directive 1129, *Radiation Protection for Machine Sources of Ionizing Radiation*, February 5, 2015.
- VHA Handbook 1105.02, *Nuclear Medicine and Radiation Safety Service*, December 10, 2010.
- VHA Handbook 5005/77, *Staffing*, Part II, Appendix G25, Diagnostic Radiologic Technologist Qualifications Standard GS-647, June 26, 2014.
- The Joint Commission, "Radiation risks of diagnostic imaging," Sentinel Event Alert, Issue 47, August 24, 2011.
- VA Radiology, "Online Guide," updated October 4, 2011.
- The American College of Radiology, "ACR–AAPM TECHNICAL STANDARD FOR DIAGNOSTIC MEDICAL PHYSICS PERFORMANCE MONITORING OF COMPUTED TOMOGRAPHY (CT) EQUIPMENT, Revised 2012.

[f] The references used for this topic included:
- VHA Handbook 1004.02, *Advance Care Planning and Management of Advance Directives*, December 24, 2013.
- VHA Handbook 1907.01, *Health Information Management and Health Records*, July 22, 2014.

[g] References used for this topic included:
- VHA Directive 2010-025, *Peer Review for Quality Management*, June 3, 2010.
- VHA Directive 2010-053, *Patient Record Flags*, December 3, 2010 (corrected 2/3/11).
- VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011.
- VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008.
- VHA Handbook 1160.06, *Inpatient Health Services*, September 16, 2013.
- Various Deputy Under Secretary for Health for Operations and Management memorandums and guides.
- *VA Suicide Prevention Coordinator Manual*, August 2014.
- Various requirements of The Joint Commission.