DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection Program Review of the Cincinnati VA Medical Center

Cincinnati, Ohio

OIG MISSION

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Figure 1. *Cincinnati VA Medical Center, Cincinnati, Ohio
(Source: https://vaww.va.gov/directory/guide/. Accessed on April 25, 2018.)*

Abbreviations

CBOC	community based outpatient clinic
CHIP	Comprehensive Healthcare Inspection Program
CLABSI	central line-associated bloodstream infection
CS	controlled substances
CSC	controlled substances coordinator
CSI	controlled substances inspector
EHR	electronic health record
EOC	environment of care
FPPE	Focused Professional Practice Evaluation
GE	geriatric evaluation
LIP	licensed independent practitioner
MH	mental health
OPPE	Ongoing Professional Practice Evaluation
PC	primary care
PTSD	post-traumatic stress disorder
QSV	quality, safety, and value
RCA	root cause analysis
SAIL	Strategic Analytics for Improvement and Learning
TJC	The Joint Commission
UM	utilization management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

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 Cincinnati VA Medical Center (the 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 healthcare services. The reviews are performed approximately every three years for each facility. The OIG selects and evaluates specific areas of focus on a rotating basis each year.

The OIG's current areas of focus are

1. Leadership and Organizational Risks;

2. Quality, Safety, and Value;

3. Credentialing and Privileging;

4. Environment of Care;

5. Medication Management;

6. Mental Health Care;

7. Long-Term Care;

8. Women's Health; and

9. High-Risk Processes.

This review was conducted during an unannounced visit made during the week of October 16, 2017. The OIG conducted interviews and reviewed clinical and administrative processes related to areas of focus that affect patient care outcomes. Although the 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, could improve patient safety and healthcare quality.

Results and Review Impact

Leadership and Organizational Risks

At the Facility, the leadership team consists of the Director, Chief of Staff, Associate Director for Patient Care Services (AD-PCS), 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 Administrative Executive Board, Clinical Executive Board, and Management Systems Redesign. The leaders are members of the Quality, Safety, and Value Council, through which they track, trend, and monitor quality of care and patient outcomes.

At the time of OIG site visit, the Associate Director position had been vacant since January 2017. This position was filled effective February 2018. With that exception, the executive leadership team has worked together since October 2016. In the review of selected employee and patient survey results regarding facility senior leadership, the OIG noted employees appear generally satisfied with the leadership, and patients appear generally satisfied with care provided.

Additionally, the OIG reviewed accreditation agency findings, sentinel events, disclosures of adverse patient events, and Patient Safety Indicator data, and did not identify any substantial organizational risk factors.

The OIG recognizes that the SAIL model has limitations for identifying all areas of clinical risk but is "a way to understand the similarities and differences between the top and bottom performers" within the Veterans Health Administration (VHA).[1] Although the senior leadership team was knowledgeable about selected SAIL metrics, the leaders should continue to take actions to improve care and performance of the Quality of Care and Efficiency metrics likely contributing to the current "4-Star" rating.

In the review of key care processes, the OIG issued seven recommendations that are attributable to the Director, Chief of Staff, and Associate Director. Of the eight areas of clinical operations reviewed, the OIG noted findings in four. These are briefly described below.

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[1] VHA's Office of Operational Analytics and Reporting developed the SAIL 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.

Quality, Safety, and Value

The OIG found general compliance with requirements for utilization management,[2] completion of root cause analyses, and submission of annual patient safety report. The OIG noted deficiencies with entering all applicable FY 2017 patient incidents into the VHA Patient Safety Information System that warranted a recommendation for improvement.

Credentialing and Privileging

The OIG found compliance with credentialing and privileging requirements, establishing criteria for professional practice evaluations, and processes for approving clinical privileges. However, the OIG identified deficiencies with initiation and defined timeframes of focused professional practice evaluations (FPPEs), and ongoing professional practice evaluation (OPPE) data collection.

Environment of Care

The OIG noted a safe and clean environment of care. General safety, infection prevention, and privacy measures were in place at the facility and representative CBOC. The OIG did not note any issues with the availability of medical equipment and supplies. However, the OIG identified deficiencies with designated team members' attendance for environment of care rounds and the lack of solid bottom shelves in supply storerooms.

Medication Management

The OIG noted general compliance with many of the performance indicators evaluated, including monthly and quarterly Controlled Substances Coordinator (CSC) reports, annual physical security surveys, and program coordinators and inspectors having no conflicts of interest and completing required training. However, the OIG identified deficiencies in the position description of one of the Alternate CSCs and completion of physical inventory of the controlled substance storage area on the day initiated.

Summary

In the review of key care processes, the OIG issued seven recommendations that are attributable to the 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

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[2] VHA Directive 1117, *Utilization Management Program*, July 9, 2014 (amended January 18, 2018). Utilization management involves the forward-looking evaluation of the appropriateness, medical need, and efficiency of health care services according to evidence-based criteria.

care. The recommendations address systems issues as well as other less-critical findings that, if left unattended, may eventually interfere with the delivery of quality health care.

Comments

The Veterans Integrated Service Network Director and Facility Director agreed with the CHIP review findings and recommendations and provided acceptable improvement plans. (See Appendixes E and F, pages 54–55, and the responses within the body of the report for the full text of the Directors' comments.) The OIG considers recommendations one and six closed. The OIG will follow up on the planned actions until they are completed.

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

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Purpose and Scope

Purpose

This Comprehensive Healthcare Inspection Program (CHIP) review was conducted to provide a focused evaluation of the quality of care delivered in the Cincinnati VA Medical Center's (the 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 healthcare services to veterans and to share findings with Facility leaders so that informed decisions can be made to improve care.

Scope

Good leadership makes a difference in managing organizational risks by establishing goals, strategies, and priorities to improve care; setting the quality agenda; and promoting a quality improvement culture to sustain positive change.[3,4] Investment in a culture of safety and quality improvement with robust communication and leadership is more likely to result in positive patient outcomes in healthcare organizations.[5] As noted in Figure 2, leadership and organizational risks can positively or negatively affect processes used to deliver care to veterans.

To examine risks to patients and the organization when these processes are not performed well, the OIG focused on the following nine areas of clinical care and administrative operations that support quality care—Leadership and Organizational Risks; Quality, Safety, and Value (QSV); Credentialing and Privileging; Environment of Care (EOC); Medication Management: Controlled Substances (CS) Inspection Program; Mental Health: Post-Traumatic Stress Disorder (PTSD) Care; Long-Term Care: Geriatric Evaluations; Women's Health: Mammography Results and Follow-up; and High-Risk Processes: Central Line-Associated Bloodstream Infections (CLABSI) (see Figure 2).[6]

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[3] Carol Stephenson, "The role of leadership in managing risk," *Ivey Business Journal*, November/December 2010., https://iveybusinessjournal.com/publication/the-role-of-leadership-in-managing-risk/. (Website accessed on March 1, 2018.)

[4] Anam Parand, Sue Dopson, Anna Renz, and Charles Vincent, "The role of hospital managers in quality and patient safety: a systematic review," *British Medical Journal*, 4, no. 9 (September 5, 2014): e005055. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4158193/. (Website accessed on March 1, 2018.)

[5] Institute for Healthcare Improvement, "How risk management and patient safety intersect: Strategies to help make it happen", March 24, 2015. http://www.npsf.org/blogpost/1158873/211982/How-Risk-Management-and-Patient-Safety-Intersect-Strategies-to-Help-Make-It-Happen. (Website accessed March 1, 2018.)

[6] CHIP reviews address these processes during fiscal year (FY) 2018 (October 1, 2017, through September 30, 2018).

**Figure 2. FY 2018 Comprehensive Healthcare Inspection Program
Review of Healthcare Operations and Services**
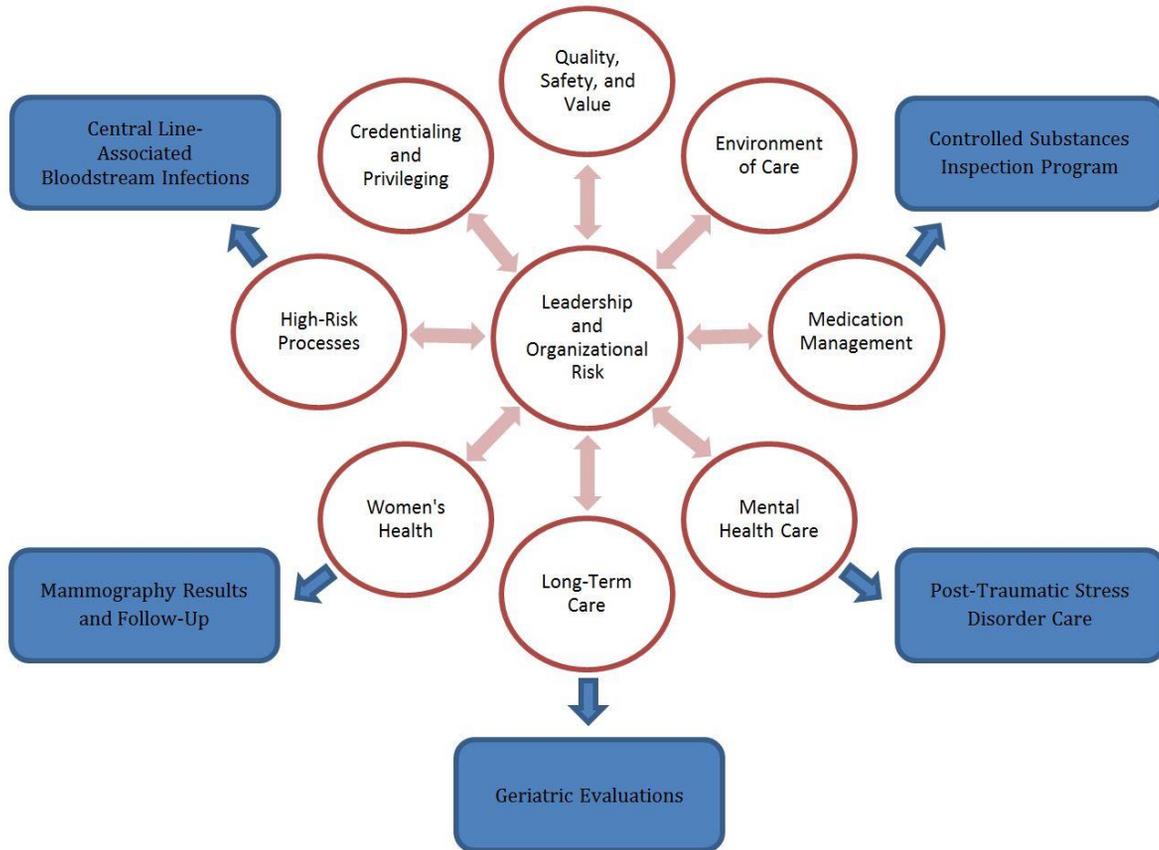
Source: VA OIG

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

Methodology

To determine compliance with the Veterans Health Administration (VHA) requirements related to patient care quality, clinical functions, and the EOC, the OIG physically inspected selected areas; reviewed clinical records, administrative and performance measure data, and accreditation survey reports;[7] and discussed processes and validated findings with managers and employees. The OIG interviewed applicable managers and members of the executive leadership team.

The review covered operations for October 1, 2014,[8] through October 16, 2017, the date when an unannounced week-long site visit commenced. On October 25, 2017, the OIG presented crime awareness briefings to 111 of the Facility's 2,546 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.

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

While onsite, the OIG referred issues and concerns beyond the scope of the CHIP review to our Hotline management team for further evaluation.

The 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.

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

[8] This is the date of the last Combined Assessment Program and/or Community Based Outpatient Clinic and Other Outpatient Clinic reviews.

Results and Recommendations

Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change. Leadership and organizational risks can impact the Facility's ability to provide care in all of the selected clinical areas of focus.[9] To assess the Facility's risks, the OIG considered the following organizational elements

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, and

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 among facilities. Figure 3 illustrates the Facility's reported organizational structure. The Facility has a leadership team consisting of the Director, Chief of Staff, Associate Director of Patient Care Services (AD-PCS), and Associate Director. The Chief of Staff and AD-PCS are responsible for overseeing patient care and program and practice managers.

At the time of the OIG site visit, the Associate Director position had been vacant since January 2017, and there had been two acting Associate Directors covering this position. The position was filled in February 2018. Except for the Associate Director, the leaders have worked together since October 2016.

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[9] L. Botwinick, M. Bisognano, and C. Haraden. "Leadership Guide to Patient Safety," *Institute for Healthcare Improvement*, Innovation Series White Paper. 2006. http://www.ihi.org/resources/Pages/IHIWhitePapers/LeadershipGuidetoPatientSafetyWhitePaper.aspx. (Website accessed February 2, 2017.)

Figure 3. Facility Organizational Chart

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                              Director
        ┌──────────┬────────────┬──────────────┬──────────────┐
   Chief of Staff     AD-PCS     Associate      Compliance Officer
                                 Director       Equal Employment
                                                Opportunity Manager
                                                New Veterans Services
                                                Public Affairs Office
                                                Quality Management
                                                Research Compliance Officer
                                                Systems Redesign
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Chief of Staff	AD-PCS	Associate Director
Chaplain	Clinical Informatics	Engineering
Dental	Community Living Center	Environmental Management Service
Education Service	Medical/Surgical Nursing	Fiscal
Medical Service	Nursing Education	Human Resources
Mental Health Care Line	Nursing Service	Industrial Hygiene and Safety
Neurology	Sterile Processing Service/Reusable Medical Equipment	Logistics
Pathology and Laboratory Medicine	Nursing Standards and Policy	Nutrition and Food Service
Primary Care		Patient Business Service
Radiology		Pharmacy
Rehab Care Line		Police
Research		Prosthetics
Social Work		Voluntary Service
Surgical Service		
Telehealth		
Women Veterans Program Manager		

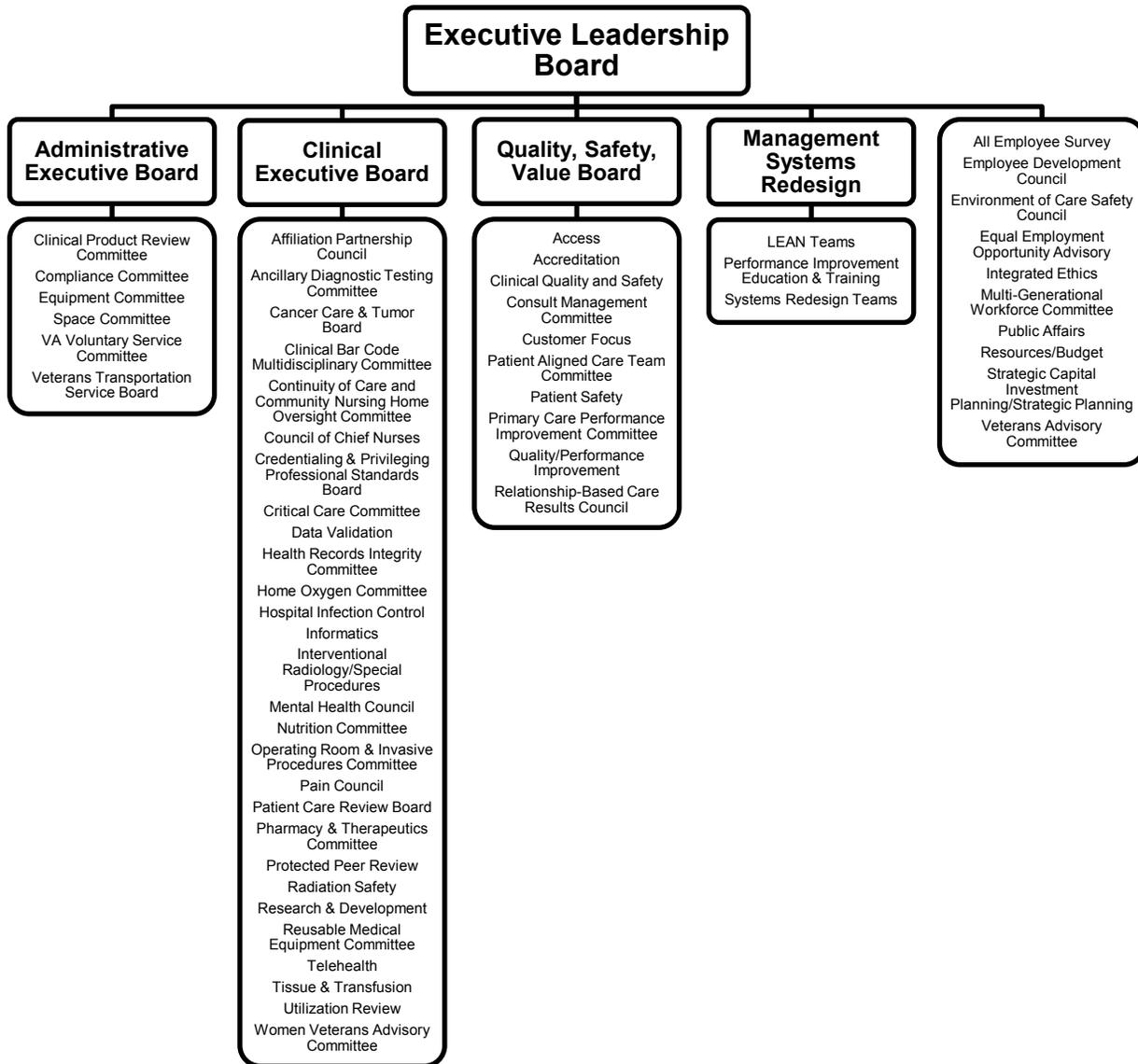*Source: Cincinnati VA Medical Center (received October 18, 2017).*

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

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

The leaders are also engaged in monitoring patient safety and care through formal mechanisms. They are members of the facility's Executive Leadership Board (ELB) which is responsible for all clinical and administrative oversight of care and service delivery at the organization. The 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 ELB oversees various working committees, such as the Administrative Executive Board, Clinical Executive Board, and Management Systems Redesign. In May 2017, the Director separated the QSV Board from the ELB and established the QSV Council. The Director serves as

co-chair of this council, where quality of care and patient outcomes are now reported. Although the reporting structure was in place, the OIG noted that QSV data and actions for improvement were not consistently reported or identified in the QSV Council meeting minutes reviewed. See Figure 4.

Figure 4. Facility Committee Reporting Structure

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                          ┌─────────────────────┐
                          │ Executive Leadership│
                          │        Board        │
                          └─────────────────────┘
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Administrative Executive Board	Clinical Executive Board	Quality, Safety, Value Board	Management Systems Redesign	
Clinical Product Review Committee	Affiliation Partnership Council	Access	LEAN Teams	All Employee Survey
Compliance Committee	Ancillary Diagnostic Testing Committee	Accreditation	Performance Improvement Education & Training	Employee Development Council
Equipment Committee	Cancer Care & Tumor Board	Clinical Quality and Safety	Systems Redesign Teams	Environment of Care Safety Council
Space Committee	Clinical Bar Code Multidisciplinary Committee	Consult Management Committee		Equal Employment Opportunity Advisory
VA Voluntary Service Committee	Continuity of Care and Community Nursing Home Oversight Committee	Customer Focus		Integrated Ethics
Veterans Transportation Service Board	Council of Chief Nurses	Patient Aligned Care Team Committee		Multi-Generational Workforce Committee
	Credentialing & Privileging Professional Standards Board	Patient Safety		Public Affairs
	Critical Care Committee	Primary Care Performance Improvement Committee		Resources/Budget
	Data Validation	Quality/Performance Improvement		Strategic Capital Investment Planning/Strategic Planning
	Health Records Integrity Committee	Relationship-Based Care Results Council		Veterans Advisory Committee
	Home Oxygen Committee			
	Hospital Infection Control			
	Informatics			
	Interventional Radiology/Special Procedures			
	Mental Health Council			
	Nutrition Committee			
	Operating Room & Invasive Procedures Committee			
	Pain Council			
	Patient Care Review Board			
	Pharmacy & Therapeutics Committee			
	Protected Peer Review			
	Radiation Safety			
	Research & Development			
	Reusable Medical Equipment Committee			
	Telehealth			
	Tissue & Transfusion			
	Utilization Review			
	Women Veterans Advisory Committee			

Source: Cincinnati VA Medical Center (October 18, 2017).

Employee Satisfaction and Patient Experience

To assess employee and patient attitudes toward facility senior leadership, the OIG reviewed employee satisfaction survey results that relate to the period of October 1, 2016 through September 30, 2017, and patient experience survey results that related to the period of October 1, 2016 through June 30, 2017.

Although the 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. Tables 1 and 2 provide relevant survey results for VHA and the facility. The facility leaders' results (Director's office average) were rated similarly to the facility and VHA average.[10] In all, both employees and patients appear generally satisfied with the leadership and care provided.

Table 1. Survey Results on Employee Attitudes toward Facility Leadership (October 1, 2016, through September 30, 2017)

Questions/Survey Items	Scoring	VHA Average	Facility Average	Director's Office Average[11]
All Employee Survey Q59. *How satisfied are you with the job being done by the executive leadership where you work?*	1 (Very Dissatisfied)–5 (Very Satisfied)	3.3	3.3	3.2
All Employee Survey: *Servant Leader Index Composite*	0–100 where HIGHER scores are more favorable	67.7	65.3	67.0

Source: VA All Employee Survey (accessed October 4, 2017).

VHA's Patient Experiences Survey Reports provide results from surveys administered by the Survey of Healthcare Experience of Patients (SHEP) program. VHA utilizes industry standard surveys from the Consumer Assessment of Healthcare Providers and Systems program to evaluate patients' experiences of their health care and to support the goal of benchmarking its performance against the private sector.

VHA collects SHEP survey data from Patient-Centered Medical Home, Specialty Care, and Inpatient Surveys. From these, the OIG selected four survey items that reflect patient attitudes towards Facility leaders. For this Facility, the four selected patient survey results reflected higher or similar care ratings compared to the VHA average.

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[10] The OIG makes no comment on the adequacy of the VHA average for each selected survey element. The VHA average is used for comparison purposes only.

[11] Rating is based on responses by employees who report to or are aligned under the Director.

**Table 2. Survey Results on Patient Attitudes toward Facility Leadership
(October 1, 2016, through June 30, 2017)**

Questions	Scoring	VHA Average	Facility Average
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.	66.9	63.3
Survey of Healthcare Experiences of Patients (inpatient): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	83.3	82.8
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	74.6	77.4
Survey of Healthcare Experiences of Patients (outpatient specialty care): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	75.0	80.1

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed October 4, 2017).

Accreditation/For-Cause Surveys[12] and Oversight Inspections

To further assess Leadership and Organizational Risks, the OIG reviewed recommendations from previous inspections by oversight and accrediting agencies to gauge how well leaders respond to identified problems. Table 3 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[13] all recommendations for improvement as listed in Table 3. The OIG noted the Facility's current accreditation status with the Commission on Accreditation

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[12] The Joint Commission (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.

[13] 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.

of Rehabilitation Facilities[14] and the College of American Pathologists,[15] which demonstrates the Facility leaders' commitment to quality care and services. Additionally, the Long Term Care Institute conducted an inspection of the Facility's Community Living Center.[16]

Table 3. Office of Inspector General Inspections/Joint Commission Survey

Accreditation or Inspecting Agency	Date of Visit	Number of Findings	Number of Recommendations Remaining Open
OIG (Combined Assessment Program Review of the Cincinnati VA Medical Center, Cincinnati, Ohio, February 4, 2015)	October 2014	9	0
OIG (Review of Community Based Outpatient Clinic and Other Outpatient Clinics of Cincinnati VA Medical Center, Cincinnati, Ohio, February 19, 2015)	October 2014	7	0
OIG (Healthcare Inspection – Alleged Urology Consult Scheduling Delays, Cincinnati VA Medical Center, Cincinnati, Ohio, June 21, 2017)	n/a	0	n/a
OIG (Healthcare Inspection – Environment of Care and Other Quality Concerns, Cincinnati VA Medical Center, Cincinnati, Ohio, May 3, 2017)	March 2016	1	0

TJC[17]
 • For Cause
 • Regular
    o Hospital Accreditation
    o Nursing Care Center Accreditation
	January 2017
	 August 2016
		0
		
		 23
		 3
			n/a
			
			 0
			 0

[14] The Commission on Accreditation of Rehabilitation Facilities provides an international, independent, peer review system of accreditation that is widely-recognized by Federal agencies. VHA's commitment is supported through a system-wide, long-term joint collaboration with the Commission on Accreditation of Rehabilitation Facilities to achieve and maintain national accreditation for all appropriate VHA rehabilitation programs.

[15] For 70 years, the College of American Pathologists has fostered excellence in laboratories and advanced the practice of pathology and laboratory science. In accordance with VHA Handbook 1106.01, VHA laboratories must meet the requirements of the College of American Pathologists.

[16] Since 1999, the Long Term Care Institute has been to over 3,500 healthcare 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.

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

Accreditation or Inspecting Agency	Date of Visit	Number of Findings	Number of Recommendations Remaining Open
o Behavioral Health Care Accreditation		3	0
o Home Care Accreditation		1	0
• For Cause	April 2016	2	0
• Opiate Substitution Services – Substance Dependence Program (SUDEP)	August 2015	0	n/a
• Special Unannounced Event[18]	November 2014	0	n/a

Sources: OIG and TJC (Inspection/survey results verified with the Director on October 17, 2017).

n/a - not applicable

Indicators for Possible Lapses in Care

Within the healthcare 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 4 summarizes key indicators of risk since the OIG's previous October 2014 Combined Assessment Program and Community Based Outpatient Clinic (CBOC) and Other Outpatient Clinics review inspections through the week of October 16, 2017.[19]

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[18] TJC conducted special focused surveys of VHA organizations and selected CBOCs from October 2014 to September 2015 at VHA's request in response to whistleblower accounts of improprieties and delays in patient care at the Phoenix VA Health Care System. The Cincinnati VA Medical Center was surveyed as part of this VHA review.

[19] 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 Cincinnati VA Medical Center is a high complexity (1b) affiliated Facility as described in Appendix B.)

**Table 4. Summary of Selected Organizational Risk Factors
(October 2014 to October 16, 2017)**

Factor	Number of Occurrences
Sentinel Events[20]	5
Institutional Disclosures[21]	16
Large-Scale Disclosures[22]	0

*Source: Cincinnati VA Medical Center's Acting Chief Quality Management
(received October 18, 2017).*

The 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.[23] The rates presented are specifically applicable for this Facility, and lower rates indicate lower risks. Table 5 summarizes Patient Safety Indicator data from October 1, 2015, through June 30, 2017.

**Table 5. Patient Safety Indicator Data
(October 1, 2015, through June 30, 2017)**

Measure	Reported Rate per 1,000 Hospital Discharges		
	VHA	VISN 10	Facility
Pressure ulcers	0.60	0.32	0.49
Death among surgical inpatients with serious treatable conditions	103.19	140.35	80.0
Iatrogenic pneumothorax	0.18	0.23	0.74
Central venous catheter-related bloodstream infection	0.14	0.15	0.00
In-hospital fall with hip fracture	0.08	0.08	0.00

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[20] A sentinel event is an incident or condition that results in patient death, permanent harm, severe temporary harm, or intervention required to sustain life.

[21] 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 his or her personal representative that an adverse event has occurred during the course of 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.

[22] 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.

[23] Agency for Healthcare Research and Quality website. https://www.qualityindicators.ahrq.gov/. (Website accessed on March 8, 2017.)

Measure	Reported Rate per 1,000 Hospital Discharges		
	VHA	VISN 10	Facility
Perioperative hemorrhage or hematoma	2.00	3.59	2.56
Postoperative acute kidney injury requiring dialysis	0.98	1.11	0.99
Postoperative respiratory failure	5.98	8.86	3.13
Perioperative pulmonary embolism or deep vein thrombosis	3.33	2.75	3.66
Postoperative sepsis	4.04	3.93	3.09
Postoperative wound dehiscence	0.50	1.50	2.57
Unrecognized abdominopelvic accidental puncture/laceration	0.53	0.29	0.92

Source: VHA Support Service Center

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

Seven of the 12 Patient Safety Indicators (pressure ulcers, iatrogenic pneumothorax, perioperative hemorrhage or hematoma, postoperative acute kidney injury requiring dialysis, perioperative pulmonary embolism or deep vein thrombosis, postoperative wound dehiscence, and unrecognized abdominopelvic accidental puncture/laceration) show an observed rate in excess of the observed rates for Veterans Integrated Service Network (VISN) 10 and/or VHA.

Two patients met criteria for inclusion in the pressure ulcers indicator. The facility reported that both patients had very small ulcers in the oral cavity and had shown improvement by discharge. The last occurrence of this measure was in January 2016, and the facility did not consider it to be an issue.

Of the six patients included in the iatrogenic pneumothorax indicator, four patients met exclusionary criteria (two patients had pacemaker insertions, one patient had an existing pleural effusion, and one patient had a lung biopsy). The two patients that met criteria were discharged after the pneumothorax was resolved without further issues.

There were four patients included in the perioperative hemorrhage or hematoma indicator that met inclusion criteria. All patients recovered from the hematomas without incidence.

One patient included in the postoperative acute kidney injury requiring dialysis indicator met criteria for inclusion and this was a single event. The patient developed complications following surgery resulting in the need for dialysis.

All six patients included in the perioperative pulmonary embolism or deep vein thrombosis indicator met inclusion criteria. All patients had specific anticoagulation plans based upon their prior medical history and/or surgical procedure.

One patient met inclusion criteria for unrecognized abdominopelvic accidental puncture/laceration indicator. This case was reviewed using the facility's internal review process, and no further actions were recommended because this was a single event in the past three years.

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

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 June 30, 2017, the facility was rated "4 Stars" for overall quality.

Figure 5. Strategic Analytics for Improvement and Learning Star Rating Distribution (as of June 30, 2017)
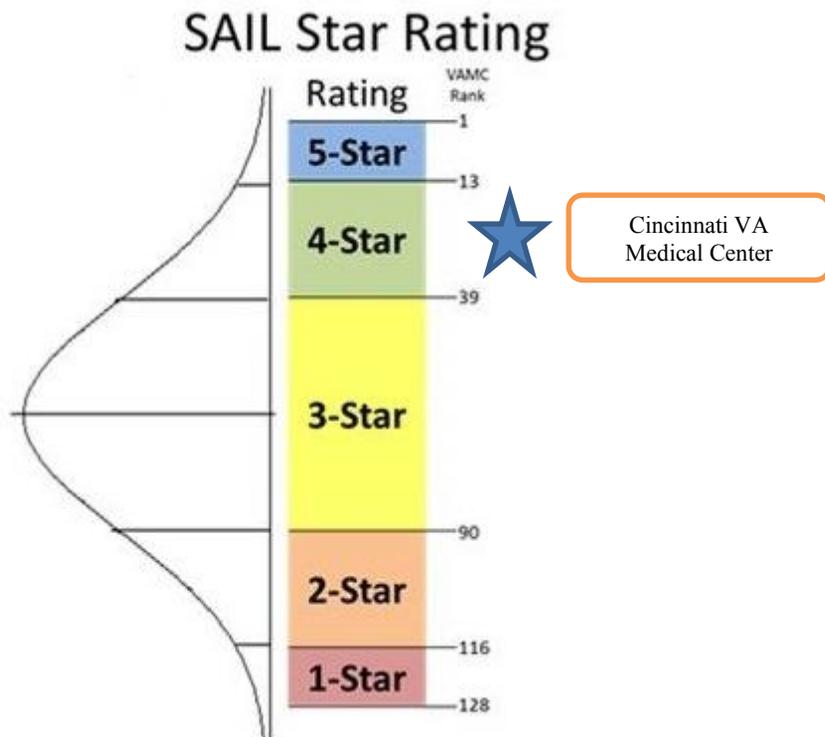
Source: VA Office of Informatics and Analytics' Office of Operational Analytics and Reporting (accessed October 4, 2017).

Figure 6 illustrates the Facility's Quality of Care and Efficiency metric rankings and performance compared with other VA facilities as of June 30, 2017. Of note, Figure 6 uses blue and green data points to indicate high performance (for example, Adjusted Length of Stay [LOS], Capacity, Complications, and Rating [of] Specialty Care [SC] Provider).[24] Metrics that need improvement are denoted in orange and red (for example, Rating [of] Hospital, Healthcare [HC] Associated Infections, and 30-day Risk Standardized Readmission Rate for Hospital Wide Readmissions [RSRR-HWR]).

**Figure 6. Facility Quality of Care and Efficiency Metric Rankings
(as of June 30, 2017)**
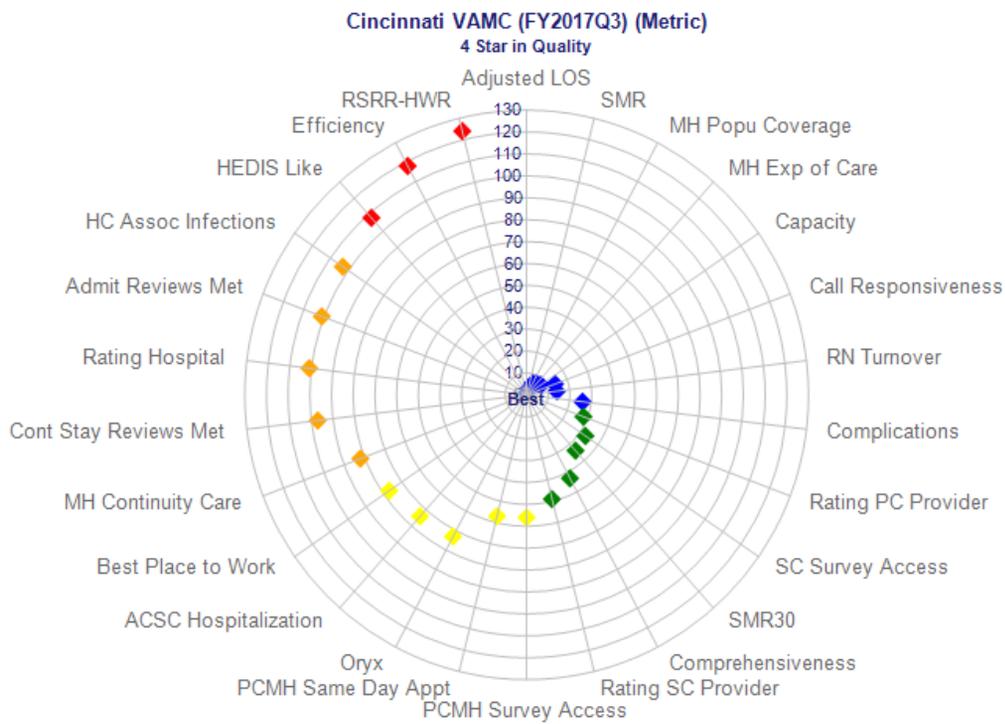
Source: VHA Support Service Center

Note: The OIG did not assess VA's data for accuracy or completeness. Also see Appendix C 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 D.

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[24] For data definitions of acronyms in the SAIL metrics, please see Appendix D.

Conclusion

The Facility has generally stable executive leadership. The OIG noted that Facility leaders were actively engaged with employees and patients to continually improve satisfaction scores by supporting patient safety, quality care, and other positive outcomes such as implementing processes and plans to improve perceptions of the Facility through active stakeholder engagement. OIG's review of accreditation organization findings, sentinel events, disclosures, Patient Safety Indicator data, and SAIL results did not identify any substantial organizational risk factors. The senior leadership team was knowledgeable about selected SAIL metrics but should continue to take actions to improve care and performance of selected Quality of Care and Efficiency metrics likely contributing to the "4-Star" ranking.

Quality, Safety, and Value

VHA's goal is to serve as the nation's leader in delivering high-quality, safe, reliable, and veteran-centered care using a coordinated care continuum. To meet this goal, VHA must foster a culture of integrity and accountability that is vigilant and mindful, proactively risk aware, and predictable, while seeking continuous improvement.[25] VHA also strives to provide healthcare services that compare favorably to the best of the private sector in measured outcomes, value, and efficiency.[26]

VHA requires that its facilities operate a Quality, Safety, and Value (QSV) program to monitor the quality of patient care and performance improvement activities. The purpose of the OIG review was to determine whether the Facility implemented and incorporated selected key functions of VHA's Enterprise Framework for QSV into local activities. To assess this area of focus, the OIG evaluated the following: protected peer reviews of clinical care,[27] utilization management (UM) reviews,[28] and patient safety incident reporting with related root cause analyses (RCAs).[29]

VHA has implemented approaches to improving patient safety, including the reporting of patient safety incidents to its National Center of Patient Safety. Incident reporting helps VHA learn about system vulnerabilities and how to address them. Required RCAs help to more accurately identify and rapidly communicate potential and actual causes of harm to patients throughout the organization.[30]

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[25] VHA Directive 1026; *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013.

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

[27] According to VHA Directive 2010-025 (June 3, 2010), this is a peer evaluation of the care provided by individual providers within a selected episode of care. This also involves a determination of the necessity of specific actions, and confidential communication is given to the providers who were peer reviewed regarding the results and any recommended actions to improve performance. The process may also result in identification of systems and process issues that require special consideration, investigation, and possibly administrative action by facility staff. (Due for recertification June 30, 2015, but has not been updated.)

[28] According to VHA Directive 1117, UM reviews evaluate the appropriateness, medical need, and efficiency of healthcare services according to evidence-based criteria.

[29] According to VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011, VHA has implemented approaches to improve patient safety, including the reporting of patient safety incidents to VHA National Center of Patient Safety, in order for VHA to learn about system vulnerabilities and how to address them as well as the requirement to implement root cause analysis (a widely-used methodology for dealing with safety-related issues) to allow for more accurate and rapid communication throughout an organization of potential and actual causes of harm to patients.

[30] VHA Handbook 1050.01.

The OIG interviewed senior managers and key QSV employees and evaluated meeting minutes, protected peer reviews, RCAs, the annual patient safety report, and other relevant documents. Specifically, OIG inspectors evaluated the following performance indicators:[31]

- Protected peer reviews

    o Examination of important aspects of care (for example, appropriate and timely ordering of diagnostic tests, prompt treatment, and appropriate documentation)

    o Implementation of improvement actions recommended by the Peer Review Committee

- UM

    o Completion of at least 75 percent of all required inpatient reviews

    o Documentation of at least 75 percent of Physician UM Advisors' decisions in National UM Integration database

    o Interdisciplinary review of UM data

- Patient safety

    o Entry of all reported patient incidents into WebSPOT[32]

    o Annual completion of a minimum of eight RCAs[33]

    o Provision of feedback about root cause analysis actions to reporting employees

    o Submission of annual patient safety report

Conclusion

The OIG found general compliance with requirements for UM, completion of root cause analyses, and submission of annual patient safety report. The OIG noted that 2 of 10 selected peer reviews did not include one of the important aspects of care; however, the Facility addressed this finding prior to our site visit. The OIG noted deficiencies with entering all applicable FY 2017 patient incidents into the VHA Patient Safety Information System that warranted a recommendation for improvement.

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[31] For CHIP reviews, the OIG selects performance indicators based on VHA or regulatory requirements or accreditation standards and evaluates these for compliance.

[32] WebSPOT is the software application used for reporting and documenting adverse events in the VHA (National Center for Patient Safety) Patient Safety Information System database.

[33] According to VHA Handbook 1050.01, March 4, 2011, the requirement for a total of eight RCAs and aggregated reviews is a minimum number, as the total number of RCAs is driven by the events that occur and the Safety Assessment Code (SAC) score assigned to them. At least four analyses per fiscal year must be individual RCAs with the balance being aggregated reviews or additional individual RCAs.

Patient Safety Events

VHA requires that reported patient safety events be reported and documented in the VHA Patient Safety Information System.[34] This process provides data that is used to track and trend patient safety incidents across VHA. For 2017, there was a total of 1,142 electronic patient incidents reported; however, only 941 incidents (82 percent) were entered into the VHA Patient Safety Information System. This resulted in incomplete data for VHA tracking, trending, and analysis. The Facility managers cited lack of sufficient staff oversight as the reason for noncompliance.

Recommendation 1

1. The Facility Director ensures all patient incidents are entered into the VHA Patient Safety Information System and monitors compliance.

Facility Concurred.

Target date for completion: November 27, 2017

Facility response: The backlog was resolved on November 27, 2017 with all EPER events being entered into WebSPOT. Following resolution of the backlog, EPER entry into WebSPOT was maintained concurrently. As of March 23, 2018, the EPER system was replaced with the Joint Patient Safety Reporting (JPRS) system at the facility for reporting of patient safety events; it is the only patient safety event reporting system in use.

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[34] VHA Handbook 1050.01.

Credentialing and Privileging

VHA has defined procedures for the credentialing and privileging of all healthcare professionals who are permitted by law and the facility to practice independently—without supervision or direction, within the scope of the individual's license, and in accordance with individually-granted clinical privileges. These healthcare professionals are also referred to as licensed independent practitioners (LIP).[35]

Credentialing refers to the systematic process of screening and evaluating qualifications. Credentialing involves ensuring an applicant has the required education, training, experience, and mental and physical health. This systematic process also ensures that the applicant has the skill to fulfill the requirements of the position and to support the requested clinical privileges.[36]

Clinical privileging is the process by which an LIP is permitted by law and the facility to provide medical care services within the scope of the individual's license. Clinical privileges need to be specific, based on the individual's clinical competence, recommended by service chiefs and the Medical Staff Executive Committee, and approved by the Director. Clinical privileges are granted for a period not to exceed two years, and LIPs must undergo re-privileging prior to the expiration of the held privileges.[37]

The purpose of the OIG review was to determine whether the Facility complied with selected requirements for credentialing and privileging of selected members of the medical staff. The OIG team interviewed key managers and reviewed the credentialing and privileging folders of 13 LIPs who were hired within the previous 6 to 18 months prior to the on-site visit,[38] and 17 LIPs who were re-privileged within 12 months prior to the visit.[39] The OIG evaluated the following performance indicators:

- Credentialing
  - Current licensure
  - Primary source verification
- Privileging
  - Verification of clinical privileges
  - Requested privileges

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[35] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (Due for recertification October 31, 2017, but has not been updated.)

[36] VHA Handbook 1100.19.

[37] VHA Handbook 1100.19.

[38] The 18-month period was from April 1, 2016, through March 30, 2017.

[39] The 12-month review period was from October 1, 2016, through September 30, 2017.

- - Facility-specific

  - Service-specific

  - Provider-specific

  o Service chief recommendation of approval for requested privileges

  o Medical Staff Executive Committee decision to recommend requested privileges

  o Approval of privileges for a period of less than, or equal to, two years

- Focused Professional Practice Evaluation (FPPE)

  o Evaluation initiated

    - Timeframe clearly documented

    - Criteria developed

    - Evaluation by another provider with similar training and privileges

    - Medical Staff Executive Committee decision to recommend continuing initially-granted privileges based on results

- Ongoing Professional Practice Evaluation (OPPE)

  o Determination to continue privileges

    - Criteria specific to the service or section

    - Evaluation by another provider with similar training and privileges

    - Medical Staff Executive Committee decision to recommend continuing privileges

Conclusion

The OIG found general compliance with the indicators for the credentialing and privileging requirements. However, the OIG identified deficiencies with Focused Professional Practice Evaluations (FPPEs) and Ongoing Professional Practice Evaluations (OPPEs).

Focused Professional Practice Evaluations

VHA requires that all LIPs new to the facility have FPPEs completed and documented in the practitioner's provider profile and reported to an appropriate committee of the Medical Staff.[40] The process uses objective criteria and involves the evaluation of privilege-specific competence of the practitioner who has not had documented evidence of competently performing the

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[40] VHA Handbook 1100.19.

requested privileges. FPPEs may include periodic chart review, direct observation, monitoring of diagnostic and treatment techniques, or discussion with other individuals involved in the care of patients. VHA also requires that FPPEs be time-limited. Time-limitations help to ensure an efficient process by preventing undefined or indefinite evaluation of providers.[41]

Clinical managers did not initiate FPPEs for 2 of 13 LIPs or clearly delineate the timeframe for 3 of the 11 initiated FPPEs. This resulted in providers continuing to deliver care without a thorough evaluation of their practice. The Facility managers cited lack of attention to detail and lack of training of administrative staff as reasons for noncompliance.

Recommendation 2

2. The Chief of Staff ensures clinical managers initiate Focused Professional Practice Evaluations that include clearly delineated timeframes and monitors compliance.

> Facility Concurred.
>
> Target date for completion: September 30, 2018
>
> Facility response: A Focused Professional Practice Evaluation (FPPE) audit tracking form, signed by the Service Chief, will be included in each provider's evaluation folder which will be used by the service to validate that each FPPE submitted includes clearly delineated timelines and is complete. The provider's evaluation folder will be reviewed and audit tracking form signed by the Chief of Staff, prior to submission to the Clinical Executive Board (CEB), to validate completeness. This process will be reviewed after a six-month period to ensure 100% compliance and/or any re-evaluation of processes.

Ongoing Professional Practice Evaluations

VHA requires that at the time of reprivileging, Service Chiefs consider relevant service- and practitioner-specific data utilizing defined criteria when recommending the continuation of licensed independent practitioners' privileges to the Executive Committee of the Medical Staff. Such data is maintained as part of the practitioner's provider profile and may include direct observations, clinical discussions, and clinical record reviews. The OPPE process is essential to confirm the quality of care delivered and allows the facility to identify professional practice trends that impact the quality of care and patient safety. For 3 of the 17 provider profiles used to support the renewal of practitioners' privileges, there was no evidence of complete service-specific data collection, resulting in providers continuing to deliver care without a thorough evaluation of their practice. The Facility managers cited lack of attention to detail as the reason for noncompliance.

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[41] VHA Handbook 1100.19.

Recommendation 3

3. The Chief of Staff ensures clinical managers consistently collect and review Ongoing Professional Practice Evaluation data and monitors compliance.

Facility Concurred.

Target date for completion: September 30, 2018

Facility response: An Ongoing Professional Practice Evaluation (OPPE) audit tracking form, signed by the Chief of the specific service with time/date, will be included in each provider's evaluation folder. The form will be used by the specific service to validate that each OPPE submitted is timely, thorough, and complete. The provider's evaluation folder will then be reviewed and the audit tracking form signed and dated by the Chief of Staff, prior to submission to the Clinical Executive Board (CEB), to validate completeness. This process will be reviewed after a six-month period to ensure 100% compliance and/or any re-evaluation of processes.

Environment of Care

Any medical center, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires managers to conduct EOC inspection rounds and resolve issues in a timely manner. The goal of the EOC program is to reduce and control environmental hazards and risks; prevent accidents and injuries; and maintain safe conditions for patients, visitors, and staff. The physical environment of a healthcare organization must not only be functional but should also promote healing.[42]

The purpose of the OIG review was to determine whether the Facility maintained a clean and safe healthcare environment in accordance with applicable requirements.[43] The 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 construction safety[44] and Nutrition and Food Services processes.[45]

VHA requires a safe and healthy worksite for staff, patients, and the general public during construction and renovation-related activities. The implementation of a proactive and comprehensive construction safety program reduces the potential for injury, illness, accidents, or exposures.[46]

The Nutrition and Food Services Program must provide quality meals that meet the regulatory requirements for food safety in accordance with the U.S. Food and Drug Administration's Food Code and VHA's food safety program. Facilities must have annual hazard analysis critical control point food safety plan, food services inspections, food service emergency operations plan, and safe food transportation and storage practices.[47]

In all, the OIG inspected six inpatient units (Medical Intensive Care, Surgical Intensive Care, 6N Medical, 6 South Surgical, post anesthesia care, and community living center), three outpatient clinics (Women's Health, Specialty, and MH), the Emergency Department, and Nutrition and Food Services. The OIG also inspected two construction sites and the Claremont CBOC.[48]

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[42] VHA Directive 1608, *Comprehensive Environment of Care*, February 1, 2016.

[43] Applicable requirements include various VHA Directives, Joint Commission hospital accreditation standards, Occupational Safety and Health Administration, American National Standards Institute (ANSI)/Association for the Advancement of Medical Instrumentation (AAMI), and National Fire Protection Association (NFPA).

[44] VHA Directive 7715, *Safety and Health during Construction*, April 6, 2017.

[45] VHA Handbook 1109.04, *Food Service Management Program*, October 11, 2013.

[46] VHA Directive 7715.

[47] VHA Handbook 1109.04.

[48] Each outpatient site selected for physical inspection was randomized from all PC CBOCs, multi-specialty CBOCs, and health care centers reporting to the parent facility and was operational and classified as such in VA's Site Tracking Database by August 15, 2017.

Additionally, the OIG reviewed the most recent Infection Prevention Risk Assessment, Infection Prevention Committee minutes for the past six months, and other relevant documents and interviewed key employees and managers. The list below shows the location-specific performance indicators selected to examine the risk areas specific to particular settings.

- Parent Facility

  o EOC rounds

  o EOC deficiency tracking

  o Infection prevention

  o General safety

  o Environmental cleanliness

  o General privacy

  o Women veterans' exam room privacy

  o Availability of medical equipment and supplies

- Community Based Outpatient Clinic

  o General safety

  o Medication safety and security

  o Infection prevention

  o Environmental cleanliness

  o General privacy

  o Exam room privacy

  o Availability of medical equipment and supplies

- Construction Safety

  o Completion of infection control risk assessment for all sites

  o Infection Prevention/Infection Control Committee discussions on construction activities

  o Dust control

  o Safety and security

- o Selected requirements based on project type and class[49]
- Nutrition and Food Services
  - o Annual Hazard Analysis Critical Control Point Food Safety System plan
  - o Food Services inspections
  - o Emergency operations plan for food service
  - o Safe transportation of prepared food
  - o Environmental safety
  - o Infection prevention
  - o Storage areas

Conclusion

General safety, infection prevention, and privacy measures were in place at the parent Facility and representative CBOC areas. The OIG did not note any issues with the availability of medical equipment and supplies. However, the OIG identified deficiencies with designated team members' attendance for environment of care rounds and the lack of solid bottom shelves in supply storerooms.

Environment of Care Rounds Attendance

VHA requires facilities to perform comprehensive EOC rounds with a designated team that includes specific membership to ensure a safe, clean, and high-quality care environment.[50] From October 1, 2016, through September 30, 2017, 5 of 13 required members did not consistently attend EOC rounds. This resulted in a lack of subject matter experts on EOC rounds. Facility managers were aware of noncompliance but, due to other priorities or lack of staff, failed to take actions to ensure compliance.

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[49] VA Master Construction Specifications, Section 01-35-26, Sub-Section 1.12. The Type assigned to construction work ranges from Type A (non-invasive activities) to Type D (major demolition and construction). Type C construction involves work that generated a moderate to high level of dust or requires demolition or removal of any fixed building components or assemblies. The Class assigned to construction work ranges from Class I (low-risk groups affected) to Class IV (highest risk groups affected). Class III construction projects affect patients in high-risk areas such as the Emergency Department, inpatient medical and surgical units, and the pharmacy.

[50] According to VHA, core membership is composed of representatives from programmatic areas such as nursing, infection control, patient safety, and medical equipment management to ensure adherence to various program requirements.

Recommendation 4

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

Facility concurred.

Target date for completion: October 1, 2018.

Facility response: The facility safety officer has provided education to the members of the Environment of Care (EOC) rounds regarding required attendance. The attendance will be reported to the EOC Committee meeting quarterly to ensure compliance. This will be monitored for two quarters in the EOC Committee with 85 percent compliance.

Equipment Storage Area Shelving

VHA requires that bottom shelves in equipment storage areas must be solid or have an impervious shelf liner to prevent contamination of stored items.[51] This ensures that clean and sterile supplies do not fall to the floor where the cleanliness of supplies may be compromised. The OIG observed that in seven of nine equipment storage areas, the bottom shelves were not solid and did not have impervious shelf liners. The Facility managers cited lack of sufficient oversight as the reason for noncompliance.

Recommendation 5

5. The Associate Director ensures bottom shelves in equipment storage areas are solid or have impervious shelf liners and monitors compliance.

Facility concurred.

Target date for completion: July 31, 2018

Facility response: A monthly checklist has been implemented in the Supply Chain Service which incorporates checking multiple items within each supply areas. Within the checklist, an item was included to ensure that a solid bottom shelf was present and if not, then instructions to notify the supervisor immediately are included. This process will be monitored monthly to ensure a compliance rate of 90% within six months of implementation of the checklist.

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[51] VHA Directive 1116, *Sterile Processing Services*, March 23, 2016.

Medication Management: Controlled Substances Inspection Program

The Controlled Substances (CS) Act divides controlled drugs into five categories based on whether they have a currently accepted medical treatment use in the United States, their relative abuse potential, and likelihood of causing dependence when abused.[52] Diversion by healthcare workers—the transfer of a legally-prescribed CS from the prescribed individual to another person for illicit use—remains a serious problem that can increase serious patient safety issues, causes harm to the diverter, and elevates the liability risk to healthcare organizations.[53]

VHA requires that facility managers implement and maintain a CS inspection program to minimize the risk for loss and diversion and to enhance patient safety.[54] Requirements include the appointment of CS Coordinator(s) (CSC) and CS inspectors (CSI), procedures for inventory control, and the inspection of the pharmacy and clinical areas with CS.

The OIG review of these issues was conducted to determine whether the Facility complied with requirements related to CS security and inspections and to follow up on recommendations from the 2014 report.[55] The OIG team interviewed key managers and reviewed CS inspection reports for the prior two completed quarters;[56] monthly summaries of findings, including discrepancies, provided to the Director for the prior 12 months;[57] CS inspection quarterly trend reports for the prior four quarters;[58] and other relevant documents. The OIG evaluated the following performance indicators:

- CSC reports
    - Monthly summary of findings to the Director
    - Quarterly trend report to the Director
    - Actions taken to resolve identified problems

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[52] Drug Enforcement Agency Controlled Substance Schedules. https://www.deadiversion.usdoj.gov/schedules/. (Website accessed on August 21, 2017.)

[53] American Society of Health-System Pharmacists, "ASHP Publishes Controlled Substances Diversion Prevention Guidelines," October 2016. https://www.ashp.org/news/2017/03/10/19/22/ashp-publishes-controlled-substances-diversion-prevention-guidelines. (Website accessed on August 21, 2017.)

[54] VHA Handbook 1108.01, *Controlled Substances (Pharmacy Stock)*, November 16, 2010. (*Due for recertification November 30, 2015, but has not been updated*); VA Office of Inspector General, *Combined Assessment Program Summary Report – Evaluation of the Controlled Substances Inspection Program at Veterans Health Administration Facilities*, Report No. 14-01785-184, June 10, 2014.

[55] VA Office of Inspector General, *Combined Assessment Program Summary Report – Evaluation of the Controlled Substances Inspection Program at Veterans Health Administration Facilities*, Report No. 14-01785-184, June 10, 2014.

[56] The review period was April 1, 2017, through September 30, 2017.

[57] The review period was October 1, 2016, through September 30, 2017.

[58] The four quarters were from October 1, 2016, through September 30, 2017.

- Pharmacy operations

    o Annual physical security survey of the pharmacy/pharmacies by VA Police

    o CS ordering processes

    o Inventory completion during Chief of Pharmacy transition

    o Staff restrictions for monthly review of balance adjustments

- Requirements for CSCs

    o Free from conflicts of interest

    o CSC duties included in position description or functional statement

    o Completion of required CSC orientation training course

- Requirements for CSIs

    o Free from conflicts of interest

    o Appointed in writing by the Director for a term not to exceed three years

    o Hiatus of one year between any reappointment

    o Completion of required CSI certification course

    o Completion of required annual updates and/or refresher training

- CS area inspections

    o Monthly inspections

    o Rotations of CSIs

    o Patterns of inspections

    o Completion of inspections on day initiated

    o Reconciliation of dispensing between pharmacy and each dispensing area

    o Verification of CS orders

    o CS inspections performed by CSIs

- Pharmacy inspections

    o Monthly physical counts of the CS in the pharmacy by CSIs

    o Completion of inspections on day initiated

    o   Security and documentation of drugs held for destruction[59]

    o   Accountability for all prescription pads in pharmacy

    o   Verification of hard copy outpatient pharmacy CS prescriptions

    o   Verification of 72-hour inventories of the main vault

    o   Quarterly inspections of emergency drugs

    o   Monthly CSI checks of locks and verification of lock numbers

Conclusion

The OIG noted general compliance with requirements for most of the performance indicators evaluated, including monthly and quarterly CSC reports, annual physical security surveys, and training requirements for both CSCs and CSIs. However, the OIG identified the following deficiencies in an Alternate CSC's position description and completion of physical inventory of the controlled substance storage area on the day initiated that warranted recommendations for improvement.

Controlled Substance Coordinator Duties

VHA requires that the CSC and Alternate CSC duties must be included in the employee's position description or functional statement.[60] These duties may be added as an addendum to the job description.[61] The OIG found that the Alternate CSC's position description did not include duties related to the CSC program as required. The CSC was not aware that the CSC duties had not been added to the Alternate CSC's job description, and this resulted in potentially unclear communication of duties and expectations. Facility managers informed us that a miscommunication between the CSC and the administrative officer was the reason for noncompliance.

Recommendation 6

6. The Director ensures that the Alternate Control Substance Coordinator's position description or functional statement includes an addendum for the Control Substance Coordinator's duties and monitors compliance.

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[59] The "Destructions File Holding Report" lists all drugs awaiting local destruction or turn-over to a reverse distributor. CSIs must verify there is a corresponding sealed evidence bag containing drug(s) for each destruction holding number on the report.

[60] VHA Directive 1108.02, *Inspection of Controlled Substances*, November 28, 2016 (amended March 6, 2017).

[61] VHA Directive 1108.02.

Facility concurred.

Target date for completion: April 2, 2018

Facility response: The Alternate Controlled Substance Coordinator's (ACSC) position description was amended to include the ACSC duties on October 20, 2017. The ACSC role was assigned to a new staff person on March 10, 2018 and that staff person's functional statement was amended to include the ACSC duties on that date. The Controlled Substance Coordinator reviewed the ACSC's functional statement on April 2, 2018 and noted compliance with the inclusion of the ACSC duties. The Controlled Substance Coordinator will monitor the designated facility ACSC's functional statement or position description annually (and upon designation of any new ACSC) to ensure the duties of the position are included.

Controlled Substance Storage Area Inspections

VHA requires that the physical inventory of the CS storage areas be completed on the day initiated.[62] This helps to ensure accountability for all CS. For 3 of 10 areas, the OIG did not find evidence that monthly inspections were completed on the day the inspection was initiated. This resulted in the potential lack of accountability for all controlled substances. The CSC acknowledged the lack of oversight as the reason for noncompliance.

Recommendation 7

7. The Director ensures that all Controlled Substance Inspectors complete the physical inventory of the controlled substance storage areas on the same day initiated and monitors compliance.

Facility concurred.

Target date for completion: August 1, 2018

Facility response: The physical inventory inspection form was updated to include a signature and date line. The Controlled Substance Coordinator (CSC) provided education to the Controlled Substance Inspectors regarding the need to complete the physical inventory of the controlled substance storage area on the day it is initiated. The CSC will check all reports as they are returned to ensure compliance. The CSC will annotate the compliance on the monthly report. The Quality, Safety and Value Committee will monitor monthly for 95 percent compliance.

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[62] VHA Directive 1108.02, *Inspection of Controlled Substance*, November 28, 2016.

Mental Health Care: Post-Traumatic Stress Disorder Care

Post-Traumatic Stress Disorder (PTSD) 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."[63] For veterans, the most common traumatic stressor contributing to a PTSD diagnosis is war-zone related stress. Non-war zone military experiences, such as the crash of a military aircraft, may also contribute to the development of PTSD.[64]

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.[65] VHA requires that

1. PTSD screening is performed for every new patient and then is repeated every year for the first five years post-separation and every five years thereafter, unless there is a clinical need to re-screen earlier;

2. If the patient's PTSD screen is positive, an acceptable provider must evaluate treatment needs and assess for suicide risk; and

3. If the provider determines a need for treatment, there is evidence of referral and coordination of care.[66]

To assess whether the Facility complied with the requirements related to PTSD screening, diagnostic evaluation, and referral to specialty care, the OIG team reviewed relevant documents and interviewed key employees and managers. Additionally, the OIG reviewed the electronic health records (EHR) of 45 randomly selected outpatients who had a positive PTSD screen from July 1, 2016, through June 30, 2017. The OIG evaluated the following performance indicators:

- Completion of suicide risk assessment by acceptable provider within required timeframe

- Offer to patient of further diagnostic evaluation

- Referral for diagnostic evaluation

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[63] VHA Handbook 1160.03, *Programs for Veterans with Post-Traumatic Stress Disorder (PTSD)*, March 12, 2010. (Due for recertification March 31, 2015, and revised December 8, 2015, but has not been updated.)

[64] VHA Handbook 1160.03.

[65] A PTSD screen is not required if the patient received a PTSD diagnosis in outpatient setting in the past year; has a life expectancy of 6 months or less; has severe cognitive impairment, including dementia; is enrolled in a VHA or community-based hospice program; or has a diagnosis of cancer of the liver, pancreas, or esophagus.

[66] VHA Handbook 1160.03.

- Completion of diagnostic evaluation within required timeframe

Conclusion

Generally, the Facility met requirements with the above performance indicators. The OIG made no recommendations.

Long-term Care: Geriatric Evaluations

More than nine million veterans of all ages are enrolled with VA, and 46 percent of these veterans are age 65 and over.[67] As a group, veterans experience more chronic disease and disability than their non-veteran peers. VA must plan for the growing health demands by aging veterans and to have mechanisms in place for delivering those services in an appropriate and cost-effective manner.[68] Participants in geriatric evaluation (GE) programs have been shown to be significantly less likely to lose functional ability, experience health-related restrictions in their daily activities, or use home healthcare services.[69]

In 1999, the Veterans Millennium Benefits and Healthcare Act mandated that the veterans' standard benefits package include access to GE.[70] This includes a comprehensive, multidimensional assessment and the development of an interdisciplinary plan of care. The healthcare team would then manage the patient with treatment, rehabilitation, health promotion, and social service interventions necessary for fulfillment of the plan of care by key personnel.[71] Facility leaders must also evaluate the GE program through a review of program objectives, procedures for monitoring care processes and outcomes, and analyses of findings.[72]

In determining whether the Facility provided an effective geriatric evaluation, OIG staff reviewed relevant documents and interviewed key employees and managers. Additionally, the team reviewed the EHRs of 35 randomly selected patients who received a GE from July 1, 2016, through June 30, 2017. The OIG evaluated the following performance indicators:

- Program oversight and evaluation
    - Evidence of GE program evaluation
    - Evidence of performance improvement activities through leadership board
- Provision of clinical care
    - Medical evaluation by GE provider
    - Assessment by GE nurse

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[67] VHA Directive 1140.04, *Geriatric Evaluation*, November 28, 2017.

[68] VHA Directive 1140.04.

[69] Chad Boult, Lisa B. Boult, Lynne Morishita, Bryan Dowd, Robert L. Kane, and Cristina F. Urdangarin, "A randomized clinical trial of outpatient geriatric evaluation and management," *Journal of the American Geriatrics Society* 49, no. 4 (April 2001): 351–359.

[70] Public Law 106-117.

[71] VHA Directive 1140.11, *Uniform Geriatrics and Extended Care Services in VA Medical Centers and Clinics*, October 11, 2016.

[72] VHA Directive 1140.04.

- o Comprehensive psychosocial assessment by GE social worker

- o Patient or family education

- o Plan of care based on GE

- Geriatric management

- o Implementation of interventions noted in plan of care

Conclusion

Generally, the Facility met requirements with the above performance indicators. The OIG made no recommendations.

Women's Health: Mammography Results and Follow-Up

In 2017, an estimated 252,710 new cases of invasive breast cancer and 40,610 breast cancer deaths were expected to occur among US women.[73] Timely screening, diagnosis, notification, and treatment are essential to early detection and optimal patient outcomes.

The Veterans Health Care Amendments of 1983 mandated VA provide veterans with preventive care, including breast cancer screening.[74] The Veterans Health Care Act of 1992 also authorized VA to provide gender-specific services, including mammography services to eligible women veterans.[75]

VHA has established timeframes for clinicians to notify ordering providers and patients of mammography results. "Incomplete" and "probably benign" results must be communicated to the ordering provider within 30 days of the procedure and to the patient within 14 calendar days from the date the results are available to the ordering provider. "Suspicious" and "highly suggestive of malignancy" results must be communicated to the ordering provider within three business days of the procedure, and the recommended course of action should be communicated to the patient as soon as possible, with seven calendar days representing the outer acceptable limit. Verbal communication with patients must be documented.[76]

The OIG team examined whether the Facility complied with selected VHA requirements for the reporting of mammography results by again reviewing relevant documents and interviewing relevant employees and managers. The team also reviewed the EHRs of 50 randomly selected women veteran patients who received a mammogram from July 1, 2016, through June 30, 2017. The OIG evaluated the following performance indicators:

- Electronic linking of mammogram results to radiology order

- Scanning of hard copy mammography reports, if outsourced

- Inclusion of required components in mammography reports

- Communication of results and any recommended course of action to ordering provider

- Communication of results and any recommended course of action to patient

- Performance of follow-up mammogram if indicated

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[73] U.S. Breast Cancer Statistics. http://www.BreastCancer.org. (Website accessed on May 18, 2017.)

[74] Veterans Health Care Amendments of 1983, Pub. L. 98-160 (1983).

[75] Veterans Health Care Act of 1992, Title I, Pub. L. 102-585 (1992).

[76] VHA Directive 1330.01, *Health Care Services for Women Veterans*, February 15, 2017 (amended September 8, 2017); VHA Handbook 1105.03, *Mammography Program Procedures and Standards*, April 28, 2011. (Due for recertification April 30, 2016, but has not been updated.)

- Performance of follow-up study if indicated

Conclusion

Generally, the Facility met requirements with the above performance indicators. The OIG made no recommendations.

High-Risk Processes: Central Line-Associated Bloodstream Infections

TJC requires facilities to establish systematic infection prevention and control programs to reduce the risk of acquiring and transmitting infections.[77] Central lines "refer to a broad category of intravascular (within blood vessels) devices used to administer fluids, medications, blood and blood products, and parenteral nutrition. Unlike the short, temporary catheters inserted into the peripheral vasculature,"[78] central lines are threaded through a vein in the arm, chest, neck, or groin and advanced so that the furthest tip terminates at or close to the heart or in one of the great vessels.[79]

The use of central lines has greatly facilitated the care provided to patients; however, they are not without their risks. The Centers for Disease Control and Prevention defines a central line-associated bloodstream infection (CLABSI) as a "primary bloodstream infection that develops in a patient with a central line in place. This type of infection occurs within the 48 hours of insertion and is not related to infection at another site."[80]

Infections occurring on or after the third calendar day following admission to an inpatient location are considered "healthcare-associated."[81] The patient's age, underlying conditions, and gender are basic risk factors, but external risk factors such as prolonged hospitalization, multi-lumen central lines, and central line duration far outnumber the basic ones. External factors are associated with a 2.27-fold increased risk for mortality and increased healthcare costs.[82]

The OIG's review of these issues examined whether the Facility established and maintained programs to reduce the incidence of healthcare-associated bloodstream infections in intensive care unit patients with indwelling central lines. In addition to conducting manager and staff interviews, the OIG team reviewed committee minutes, the Infection Prevention/Control Risk Assessment, and other relevant documents. The team also reviewed the training records of seven clinical employees involved in inserting and/or managing central lines. The OIG evaluated the following performance indicators:

- Presence of Facility policy on the use and care of central lines

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[77] TJC. Infection Control and National Patient Safety Goals: IC.01.03.01, EP 4, 5, July 2017.

[78] Association for Professionals in Infection Control and Epidemiology, *Guide to Preventing Central Line-Associated Bloodstream Infections*, 2015.

[79] These are vessels that enter and leave the heart—superior and inferior vena cava, pulmonary artery, pulmonary vein, aorta.

[80] The Centers for Disease Control and Prevention, *Guidelines for the Prevention of Intravascular Catheter-Related Infections*, 2011.

[81] The Centers for Disease Control and Prevention National Healthcare Safety Network, *Bloodstream Infection Event: Central Line-Associated Bloodstream Infection and non-central line-associated Bloodstream Infection*, January 2017.

[82] Association for Professionals in Infection Control and Epidemiology, 2015.

- Performance of annual infection prevention risk assessment

- Evidence of routine discussion of CLABSI data and prevention outcome measures in committee minutes

- Provision of infection incidence data on CLABSI

- Education on reducing the risk of CLABSI for staff involved in inserting and/or managing central lines

- Educational materials about CLABSI prevention for patients and families

- Use of a checklist for central line insertion and maintenance

Conclusion

Generally, the Facility met requirements with the above performance indicators. The OIG made no recommendations.

Appendix A: 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	Seven OIG recommendations, ranging from documentation issues to deficiencies that can lead to patient and staff safety issues or adverse events, are attributable to the Director, Chief of Staff, and Associate Director. See details below.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	- Protected peer review of clinical care - UM reviews - Patient safety incident reporting and RCAs	None	All patient incidents are entered into the VHA Patient Safety Information System.
Credentialing and Privileging	- Medical licenses - Privileges - FPPEs - OPPEs	- Clinical managers initiate Focused Professional Practice Evaluations that include clearly delineated timeframes. - Clinical managers consistently collect and review Ongoing Professional Practice Evaluation data.	None

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement

Environment of Care	• Parent Facility
	   ○ EOC rounds and deficiency tracking
	   ○ Infection prevention
	   ○ General safety
	   ○ Environmental cleanliness
	   ○ General and exam room privacy
	   ○ Availability of medical equipment and supplies
	• CBOC
	   ○ General safety
	   ○ Medication safety and security
	   ○ Infection prevention
	   ○ Environmental cleanliness
	   ○ General and exam room privacy
	   ○ Availability of medical equipment and supplies
	• Construction Safety
	   ○ Infection control risk assessment
	   ○ Infection Prevention/ Infection Control Committee discussions
	   ○ Dust control
	   ○ Safety/security
	   ○ Selected requirements based on project type and class
	• Nutrition and Food Services
	   • Annual Hazard Analysis Critical control Point Food Safety System plan
	   • Food Services inspections
	   • Safe transportation of prepared food
	   • Environmental safety
	   • Infection prevention
	   • Storage areas
		• None	• Required team members participate on EOC rounds.
			• Bottom shelves in all equipment storage areas are solid or have impervious shelf liners.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Medication Management	• CSC reports • Pharmacy operations • Annual physical security survey • CS ordering processes • Inventory completion during Chief of Pharmacy transition • Review of balance adjustments • CSC requirements • CSI requirements • CS area inspections • Pharmacy inspections	• The physical inventory for the CS storage areas are completed on the same day initiated.	• The Alternate CSC's position description or functional statement includes an addendum for the CSC's duties.
Mental Health Care: Post-Traumatic Stress Disorder Care	• Suicide risk assessment • Offer of further diagnostic evaluation • Referral for diagnostic evaluation • Completion of diagnostic evaluation	• None	• None
Long-Term Care: Geriatric Evaluations	• Program oversight and evaluation • Provision of clinical care • Geriatric management	• None	• None
Women's Health: Mammography Results and Follow-Up	• Result linking • Report scanning and content • Communication of results and recommended actions • Follow-up mammograms and studies	• None	• None
High-Risk Processes: Central Line-Associated Bloodstream Infections	• Policy and infection prevention risk assessment • Committee discussion • Infection incidence data • Education and educational materials • Checklist	• None	• None

Appendix B: Facility Profile and VA Outpatient Clinic Profiles

Facility Profile

The table below provides general background information for this high-complexity (1b)[83] affiliated[84] Facility reporting to VISN 10.

Table 6. Facility Profile for Cincinnati (539)
(October 1, 2014, through September 30, 2017)

Profile Element	Facility Data FY 2015[85]	Facility Data FY 2016[86]	Facility Data FY 2017[87]
Total Medical Care Budget in Millions	$388.4	$428.7	$435.6
Number of:			
• Unique Patients	42,904	42,366	42,100
• Outpatient Visits	588,598	580,788	583,495
• Unique Employees[88]	1,921	2,003	2,045
Type and Number of Operating Beds:			
• Community Living Center	64	64	64
• Domiciliary	107	107	107
• Medicine	62	62	62
• Mental Health	24	24	24
• Neurology	2	2	2
• Surgery	29	29	29
Average Daily Census:			
• Community Living Center	50	46	46
• Domiciliary	90	70	84
• Medicine	49	43	43

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[83] The VHA medical centers are classified according to a facility complexity model; 1b designation indicates a Facility with medium-high volume, high-risk patients, many complex clinical programs, and medium-large research and teaching programs.

[84] Associated with a medical residency program.

[85] October 1, 2014, through September 30, 2015.

[86] October 1, 2015, through September 30, 2016.

[87] October 1, 2016, through September 30, 2017.

[88] Unique employees involved in direct medical care (cost center 8200).

Profile Element	Facility Data FY 2015[85]	Facility Data FY 2016[86]	Facility Data FY 2017[87]
• Mental Health	16	17	15
• Neurology	1	1	2
• Surgery	11	11	9

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

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

VA Outpatient Clinic Profiles[89]

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 7 provides information relative to each of the clinics.

**Table 7. VA Outpatient Clinic Workload/Encounters[90] and
Specialty Care, Diagnostic, and Ancillary Services Provided
(October 1, 2016, through September 30, 2017)**

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services[91] Provided	Diagnostic Services[92] Provided	Ancillary Services[93] Provided
Bellevue, KY	539GA	6,336	2,506	Dermatology	EKG	Pharmacy Social Work Weight Management Nutrition
Cincinnati, OH	539GB	12,026	7,252	Dermatology Eye Podiatry	EKG	Pharmacy Social Work Weight Management Nutrition

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[89] Includes all outpatient clinics in the community that were in operation as of August 15, 2017.

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

[91] Specialty care services refer to non-PC and non-MH services provided by a physician.

[92] Diagnostic services include EKG, EMG, laboratory, nuclear medicine, radiology, and vascular lab services.

[93] 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[91] Provided	Diagnostic Services[92] Provided	Ancillary Services[93] Provided
Greendale, IN	539GC	6,234	3,706	Dermatology Infectious Disease Eye Podiatry	EKG	Pharmacy Social Work Weight Management Nutrition
Florence, KY	539GD	7,192	3,271	Dermatology Eye Podiatry	EKG	Pharmacy Social Work Weight Management Nutrition
Hamilton, OH	539GE	7,469	3,395	Dermatology Pulmonary/ Respiratory Disease Poly-Trauma Eye Podiatry	EKG	Pharmacy Social Work Weight Management Nutrition
Georgetown, OH	539GF	3,473	458	n/a	EKG	Pharmacy Nutrition

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

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

n/a = not applicable

Appendix C: Patient Aligned Care Team Compass Metrics[94]

New PC Patient Average Wait Time in Days

	VHA Total	(539) Cincinnati, OH	(539GA) Bellevue, KY	(539GB) Clermont County, OH	(539GC) Dearborn, IN	(539GD) Florence, KY	(539GE) Hamilton, OH	(539GF) Georgetown, OH
OCT-FY17	8.7	4.0	6.5	3.5	1.2	4.1	1.5	9.6
NOV-FY17	8.8	5.6	4.6	3.3	1.9	5.6	4.0	6.4
DEC-FY17	8.8	4.3	4.2	1.2	0.1	1.6	3.3	4.7
JAN-FY17	9.2	8.2	3.9	2.0	1.4	5.5	2.4	5.8
FEB-FY17	8.7	7.1	5.4	1.6	1.6	4.2	2.8	8.2
MAR-FY17	8.4	7.5	9.4	3.2	2.0	3.5	2.8	5.9
APR-FY17	8.2	7.0	6.6	2.1	3.5	5.9	4.8	14.6
MAY-FY17	7.9	7.9	7.7	2.9	8.0	5.5	3.4	15.3
JUN-FY17	8.2	7.9	6.9	3.6	4.2	10.1	1.8	14.2
JUL-FY17	8.0	8.3	4.3	2.6	4.1	4.7	1.5	18.6
AUG-FY17	8.1	7.4	4.7	1.5	4.5	6.5	4.0	19.5
SEP-FY17	8.2	6.7	2.5	5.8	4.0	5.9	3.7	16.1

Source: VHA Support Service Center.

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

Data Definition: *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.*

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[94] Department of Veterans' Affairs, Patient Aligned Care Teams Compass Data Definitions, accessed October 19, 2017.

Established PC Patient Average Wait Time in Days

	VHA Total	(539) Cincinnati, OH	(539GA) Bellevue, KY	(539GB) Clermont County, OH	(539GC) Dearborn, IN	(539GD) Florence, KY	(539GE) Hamilton, OH	(539GF) Georgetown, OH
OCT-FY17	3.9	3.2	3.0	1.7	0.8	1.8	0.6	3.8
NOV-FY17	4.2	3.6	2.1	1.5	0.9	2.5	0.8	3.6
DEC-FY17	4.1	3.5	1.7	1.6	0.7	2.4	0.8	2.6
JAN-FY17	4.4	4.4	1.9	1.5	1.0	2.5	0.9	3.9
FEB-FY17	3.9	4.0	2.3	1.4	1.0	2.1	0.8	4.0
MAR-FY17	3.9	3.6	2.4	1.6	1.8	2.2	1.2	3.1
APR-FY17	3.9	3.9	2.2	1.4	2.5	1.7	1.0	4.2
MAY-FY17	4.0	3.5	1.9	1.2	2.6	1.9	0.8	4.3
JUN-FY17	4.1	4.3	2.6	1.4	2.4	2.2	0.9	4.3
JUL-FY17	4.1	3.9	2.9	1.2	2.3	2.7	1.2	4.5
AUG-FY17	4.2	4.2	1.8	1.8	2.2	3.0	1.5	4.1
SEP-FY17	4.0	4.0	2.0	1.6	2.1	2.5	1.8	3.9

Source: VHA Support Service Center.

Note: The 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.*

Team 2-Day Post Discharge Contact Ratio

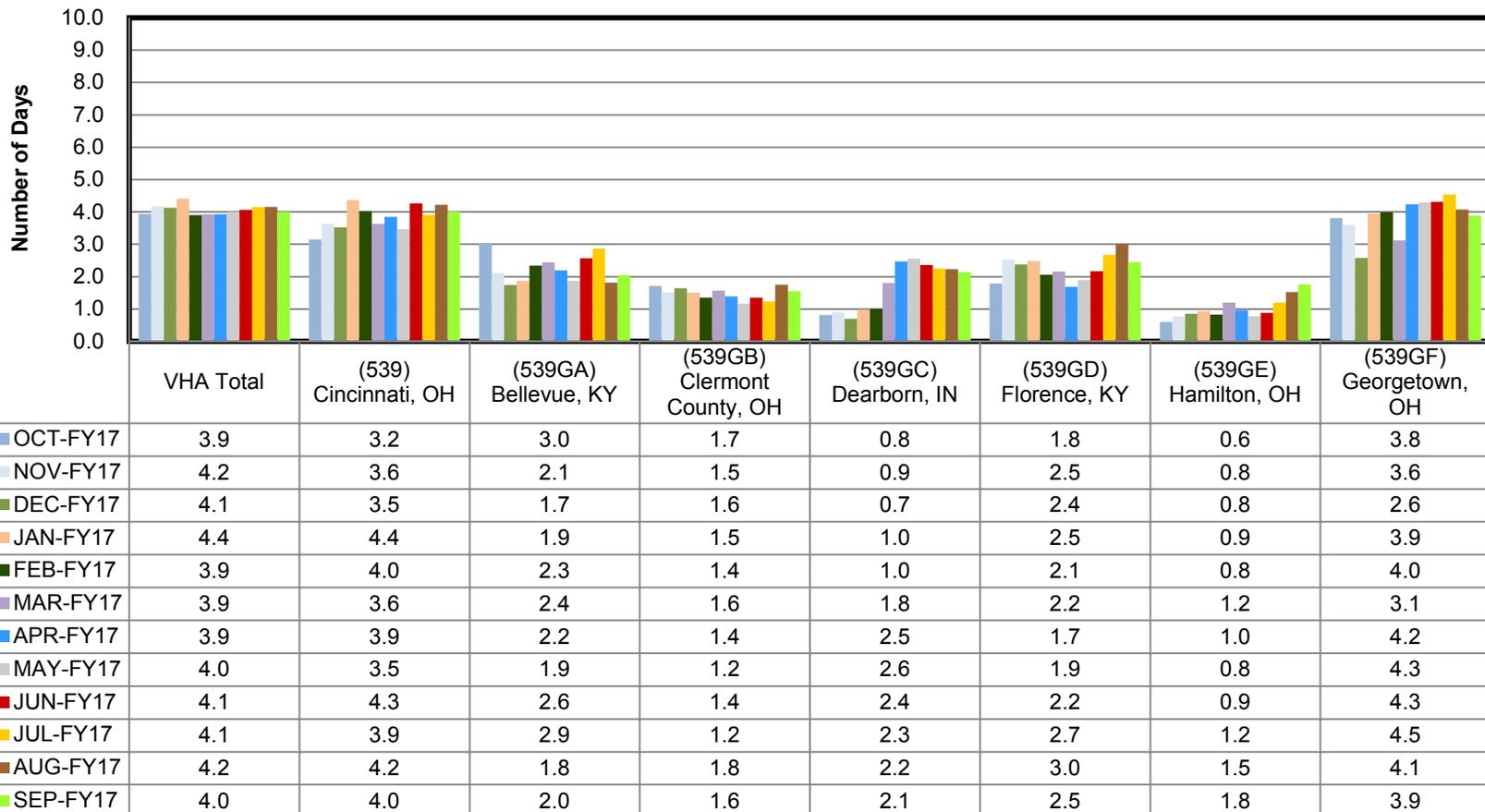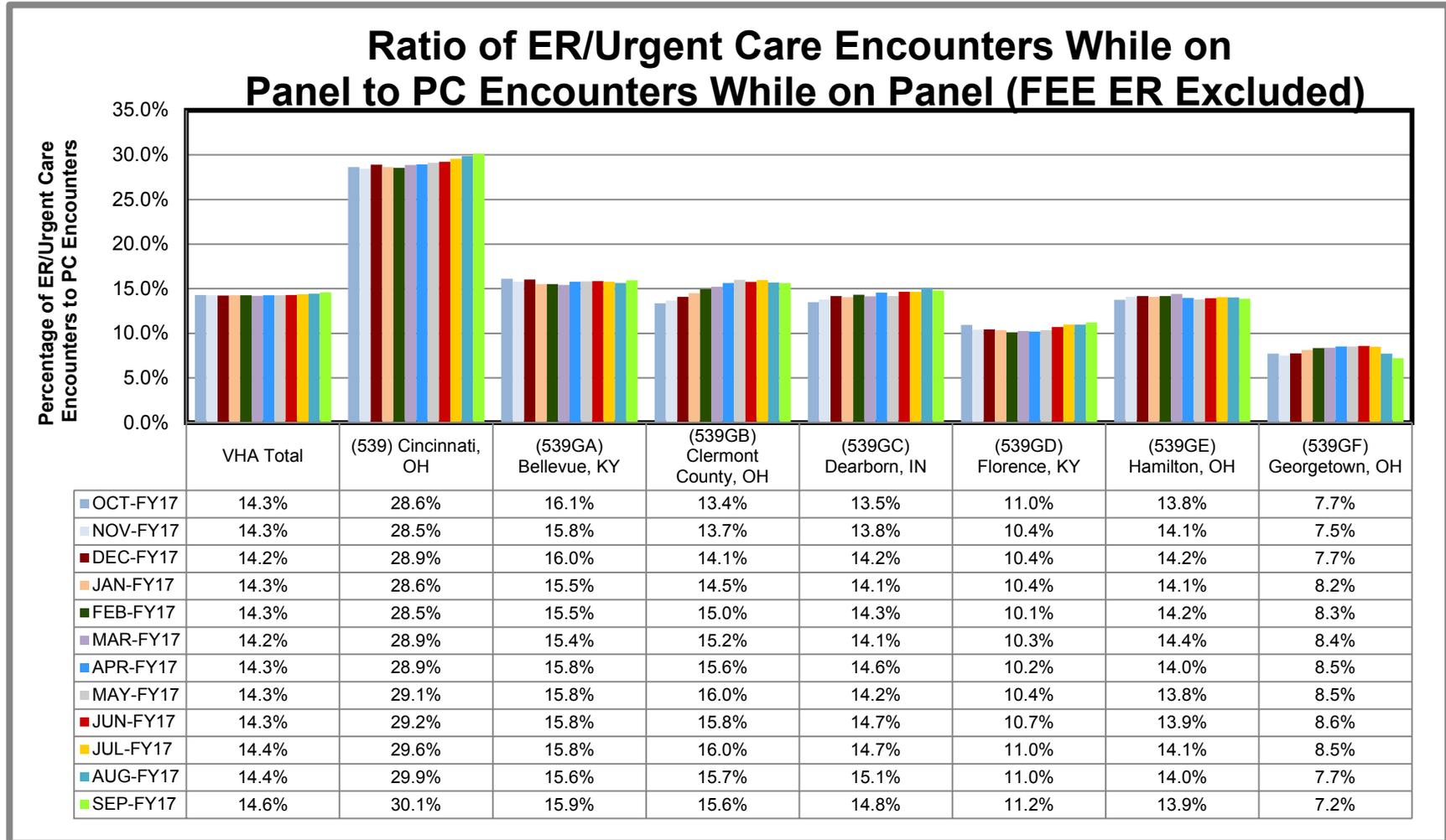|	All VHA	(539) Cincinnati, OH	(539GA) Bellevue, KY	(539GB) Clermont County, OH	(539GC) Dearborn, IN	(539GD) Florence, KY	(539GE) Hamilton, OH	(539GF) Georgetown, OH
OCT-FY17	61.8%	47.0%	51.7%	63.3%	52.9%	62.5%	52.0%	100.0%
NOV-FY17	61.4%	44.4%	52.9%	62.9%	34.4%	81.8%	62.2%	50.0%
DEC-FY17	59.7%	44.1%	44.1%	63.3%	36.4%	58.1%	48.5%	71.4%
JAN-FY17	62.9%	47.3%	72.2%	59.7%	64.5%	74.2%	57.1%	53.3%
FEB-FY17	64.0%	52.1%	76.6%	35.3%	51.4%	24.3%	61.8%	75.0%
MAR-FY17	65.3%	48.9%	67.5%	48.3%	69.6%	72.0%	68.4%	90.9%
APR-FY17	65.0%	53.1%	67.6%	39.3%	83.9%	68.6%	66.7%	76.9%
MAY-FY17	62.3%	46.7%	62.5%	37.5%	72.4%	75.0%	38.1%	93.8%
JUN-FY17	62.7%	43.1%	72.0%	45.5%	57.6%	74.3%	81.0%	57.1%
JUL-FY17	62.4%	38.3%	74.3%	40.5%	53.3%	48.3%	60.6%	66.7%
AUG-FY17	62.6%	36.4%	75.8%	58.3%	64.5%	70.3%	64.7%	33.3%
SEP-FY17	62.3%	45.9%	73.8%	64.6%	62.1%	53.1%	76.9%	80.0%
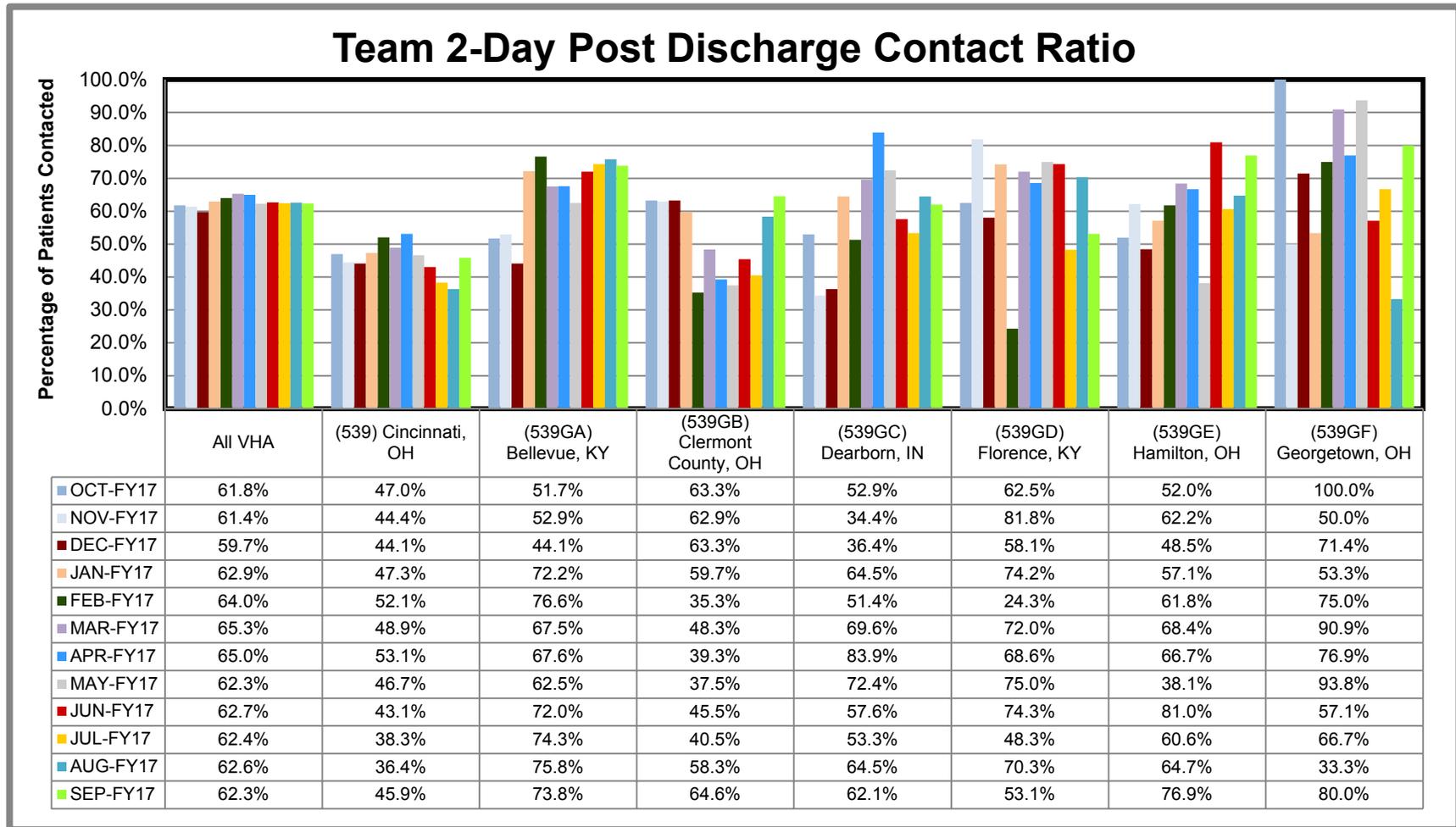
Source: VHA Support Service Center.

Note: The 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."*

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

	VHA Total	(539) Cincinnati, OH	(539GA) Bellevue, KY	(539GB) Clermont County, OH	(539GC) Dearborn, IN	(539GD) Florence, KY	(539GE) Hamilton, OH	(539GF) Georgetown, OH
OCT-FY17	14.3%	28.6%	16.1%	13.4%	13.5%	11.0%	13.8%	7.7%
NOV-FY17	14.3%	28.5%	15.8%	13.7%	13.8%	10.4%	14.1%	7.5%
DEC-FY17	14.2%	28.9%	16.0%	14.1%	14.2%	10.4%	14.2%	7.7%
JAN-FY17	14.3%	28.6%	15.5%	14.5%	14.1%	10.4%	14.1%	8.2%
FEB-FY17	14.3%	28.5%	15.5%	15.0%	14.3%	10.1%	14.2%	8.3%
MAR-FY17	14.2%	28.9%	15.4%	15.2%	14.1%	10.3%	14.4%	8.4%
APR-FY17	14.3%	28.9%	15.8%	15.6%	14.6%	10.2%	14.0%	8.5%
MAY-FY17	14.3%	29.1%	15.8%	16.0%	14.2%	10.4%	13.8%	8.5%
JUN-FY17	14.3%	29.2%	15.8%	15.8%	14.7%	10.7%	13.9%	8.6%
JUL-FY17	14.4%	29.6%	15.8%	16.0%	14.7%	11.0%	14.1%	8.5%
AUG-FY17	14.4%	29.9%	15.6%	15.7%	15.1%	11.0%	14.0%	7.7%
SEP-FY17	14.6%	30.1%	15.9%	15.6%	14.8%	11.2%	13.9%	7.2%

Source: VHA Support Service Center.

Note: The 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 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.*

Appendix D: Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions[95]

Measure	Definition	Desired Direction
ACSC Hospitalization	Ambulatory Care Sensitive Conditions hospitalizations	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	All Employee Survey Best Places to Work score	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
Capacity	Physician Capacity	A lower value is better than a higher value
Care Transition	Care Transition (Inpatient)	A higher value is better than a lower value
Complications	Acute care risk adjusted complication ratio (observed to expected ratio)	A lower value is better than a higher value
Comprehensiveness	Comprehensiveness (PCMH)	A higher value is better than a lower 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
Efficiency/Capacity	Efficiency and Physician Capacity	A higher value is better than a lower value

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[95] VHA Support Service Center (VSSC), Strategic Analytics for Improvement and Learning (SAIL), accessed: February 14, 2018.

Measure	Definition	Desired Direction
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value
HC Assoc Infections	Healthcare 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
HEDIS Like – HED90_1	HEDIS-EPRP Based PRV TOB BHS	A higher value is better than a lower value
HEDIS Like – HED90_ec	HEDIS-eOM Based DM IHD	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
PCMH Same Day Appt	Days waited for appointment when needed care right away (PCMH)	A higher value is better than a lower value
PCMH Survey Access	Timely Appointment, care and information (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
Rating Hospital	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value

Measure	Definition	Desired Direction
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)	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-COPD	30-day risk standardized mortality rate for COPD	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-COPD	30-day risk standardized readmission rate for COPD	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

Measure	Definition	Desired Direction
SC Survey Access	Timely Appointment, care and information (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
Stress Discussed	Stress Discussed (PCMH Q40)	A higher value is better than a lower value

Source: VHA Support Service Center.

Appendix E: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: April 9, 2018

From: Director, VA Healthcare System (10N10)

Subj: CHIP Review of the Cincinnati VA Medical Center, Cincinnati, OH

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

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

1. Please find attached the comments and actions to be taken in response to the CHIP Review of the Cincinnati VA Medical Center, Cincinnati, OH.

2. I concur with the facility's response and appreciate the opportunity to respond to this report.

Robert McDivitt, FACHE

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Americans with Disabilities Act.

Appendix F: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: April 3, 2018

From: Director, Cincinnati VA Medical Center (539/00)

Subj: CHIP Review of the Cincinnati VA Medical Center, Cincinnati, OH

To: Director, VA Healthcare System (10N10)

I concur with the recommendations listed in the Office of Inspector General's report, Comprehensive Healthcare Inspection Program of the Cincinnati VA Medical Center, Cincinnati, OH.

Vivian T. Hutson, FACHE

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Americans with Disabilities Act.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection/Audit/Review Team	Miquita Hill-McCree, RN, MSN Bruce Barnes Patricia Calvin, RN, MBA Wachita Haywood, RN, MSN/NED Thea Sullivan, RN, MBA Sandra Vassell, RN, MBA Gavin T. McClaren, Resident Agent in Charge, Office of Investigations
Other Contributors	Limin Clegg, PhD Justin Hanlon, BS Henry Harvey, MS LaFonda Henry, RN-BC, MSN Scott McGrath, BS Anita Pendleton, AAS Larry Ross, Jr., MS Marilyn Stones, BS Mary Toy, RN, MSN Robert Wallace, MPH, ScD Sonia Whig, LDN, MS

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