DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection Program Review of the William Jennings Bryan Dorn VA Medical Center

Columbia, South Carolina

CHIP REPORT | REPORT #18-00412-173 | MAY, 17 2018

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Figure 1. *William Jennings Bryan Dorn VA Medical Center, Columbia, South Carolina*
(Source: https://vaww.va.gov/directory/. Accessed on April 19, 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 William Jennings Bryan Dorn 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 January 22, 2018. 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 consisted of the Director, Chief of Staff, Associate Director for Patient Care Services (AD-PCS), Associate Director, and Acting Assistant Director. Organizational communication and accountability were carried out through a committee reporting structure, with the Executive Leadership Committee having oversight for leadership groups such as the Nurse Executive, Medical Executive, Quality Improvement, and Environment of Care (EOC) Board. The leaders are members of the Executive Leadership Committee, through which they track, trend, and monitor quality of care and patient outcomes.

Except for the Acting Assistant Director, who had been in the position since November 2017, the OIG found that the executive leaders had been working together as a leadership team since July 2017. In the review of selected employee and patient survey results regarding Facility leaders, the OIG noted high satisfaction scores that reflected active engagement with employees. The leadership was also actively engaged with improving patient satisfaction and had implemented several processes to engage patients regarding their experience.

The OIG recognizes that the Strategic Analytics for Improvement and Learning (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 VHA.[1] Although the leadership team was knowledgeable about selected SAIL metrics, the leaders should continue to take actions to improve performance of the Mental Health metrics likely contributing to the current "2-Star" rating.

Additionally, the OIG reviewed accreditation agency findings, sentinel events, disclosures of adverse patient events, and Patient Safety Indicator data.

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

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

Credentialing and Privileging

The OIG found general compliance with requirements for credentialing and privileging. However, the OIG identified deficiencies in Focused Professional Practice Evaluation and Ongoing Professional Practice Evaluation processes.

Environment of Care

The OIG noted that general safety, infection prevention, and privacy measures were in place at the parent Facility and representative CBOC. The OIG did not note any issues with the availability of medical equipment and supplies. The OIG identified deficiencies in EOC rounds, environmental cleanliness, and medical equipment safety.

Mental Health Care

The OIG noted compliance with provider documentation of further diagnostic evaluation being offered, referred, and completed. However, the OIG identified a deficiency in timely completion of suicide risk assessments.

Long-term Care

The OIG noted compliance with access to geriatric evaluation. However, the OIG identified deficiencies in program oversight and implementation of geriatric plans of care.

Summary

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

Comments

The Veterans Integrated Service Network Director and Facility Director agreed with the CHIP review findings and recommendations and provided acceptable improvement plans. (See Appendixes E and F, pages 56–57, and the responses within the body of the report for the full

text of the Directors' comments.) The OIG will follow up on the planned actions until they are completed.

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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 inpatient and outpatient settings of the William Jennings Bryan Dorn VA Medical Center (the Facility) 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.[2,3] 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.[4] 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).[5]

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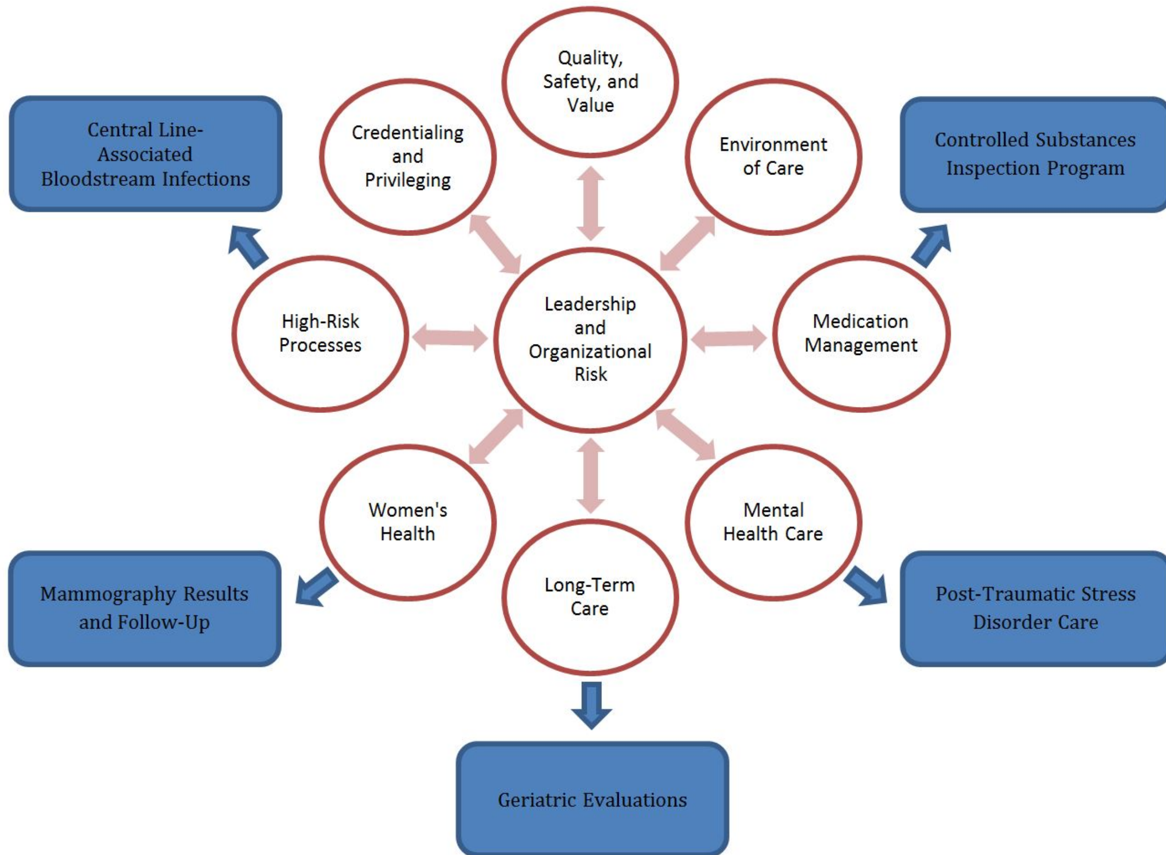
[2] Carol Stephenson, "The role of leadership in managing risk," *Ivey Business Journal*, November/December 2010. https://iveybusinessjournal.com/publication/the-role-of-leadership-in-managing-risk/. (Website accessed on March 1, 2018.)

[3] 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.)

[4] 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.)

[5] 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, 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;[6] 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 March 16, 2015,[7] through January 22, 2018, the date when an unannounced week-long site visit commenced. On January 19, 2018, the OIG presented crime awareness briefings to nine of the Facility's 2,915 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 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 on site, the OIG did not receive any concerns beyond the scope of the CHIP review. The OIG conducted the inspection in accordance with OIG standard operating procedures for CHIP reviews and Q*uality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

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

[7] 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.[8] 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.

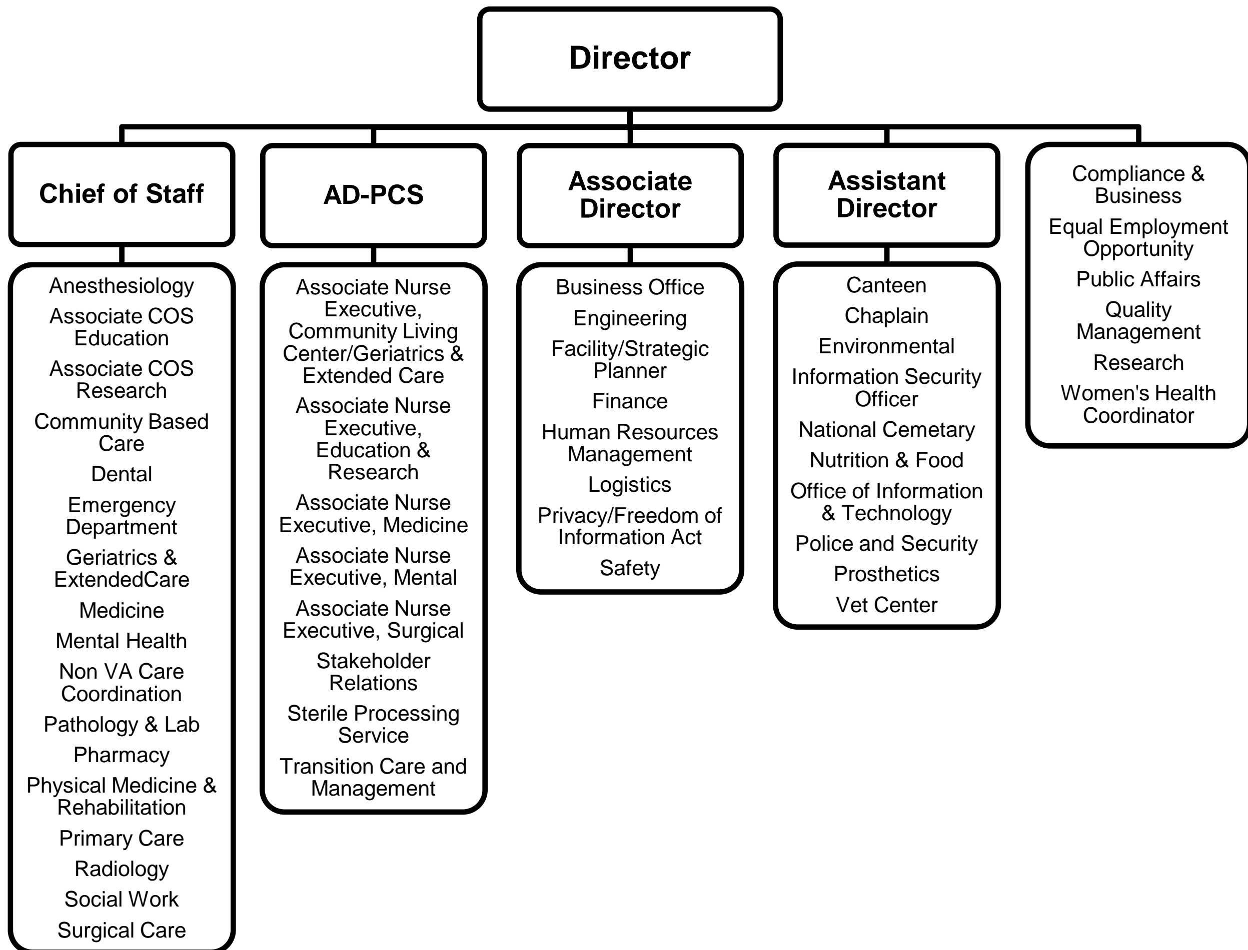
Executive Leadership Stability and Engagement

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 for Patient Care Services (AD-PCS), Associate Director, and Acting Assistant Director. The Chief of Staff and AD-PCS are responsible for overseeing patient care and program and practice chiefs.

The current Director was appointed in March 2017, served as the Acting Director from July 2016 to March 2017, and was the Associate Director prior to appointment as the Acting Director. The Chief of Staff has been in the role since January 2014. The AD-PCS has been at the Facility for 40 years and in the role since November 1999. The Associate Director previously served as the Chief of Logistics since August 2012 prior to assuming the role of Associate Director in July 2017. The Acting Assistant Director has been in the position since November 2017. With the exception of the Acting Assistant Director, the executive leaders had been working together as a leadership team since July 2017.

[8] 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



Source: William Jennings Bryan Dorn VA Medical Center (received January 22, 2018)

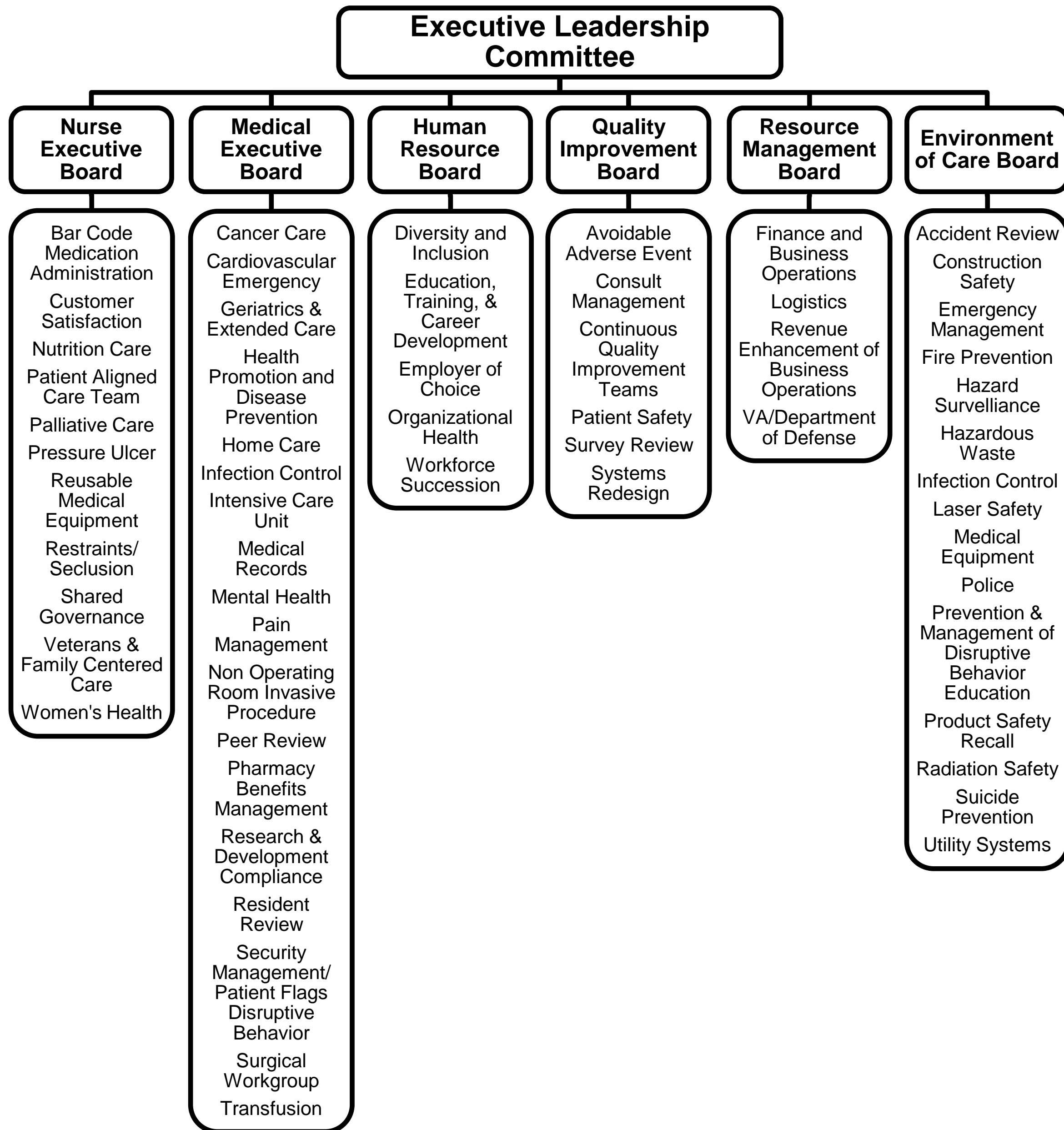
To help assess engagement of Facility executive leadership, the OIG interviewed the Chief of Staff, AD-PCS, Associate Director, and Acting Assistant Director regarding their knowledge of various metrics and their involvement and support of actions to improve or sustain performance. The Director was attending required training, and the Associate Director was acting during the Director's absence.

In individual interviews, these executive leaders were generally 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 Committee, which tracks, trends, and monitors quality of care and patient outcomes. 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 Executive Leadership Committee oversees various working committees, such as the Nurse Executive, Medical Executive, Quality Improvement, and EOC Boards. See Figure 4.

Figure 4. Facility Committee Reporting Structure



Source: William Jennings Bryan Dorn VA Medical Center (received January 22, 2018)

Employee Satisfaction and Patient Experience

The All Employee Survey is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential. Since 2001, the instrument has been refined at several points in response to VA leadership inquiries about VA culture and organizational health. To assess employee and patient attitudes toward Facility leaders, the OIG reviewed employee satisfaction and patient experience survey results that relate to the period of October 1, 2016, through September 30, 2017.

Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on Facility leadership. Tables 1 and 2 provide relevant survey results for VHA and the Facility. As Table 1 indicates, the Facility leaders' results (Director's office average) were rated markedly above the VHA and Facility average.[9] In all, employees appear generally satisfied with the leadership while opportunities exist to continue to improve both inpatient and outpatient experiences.

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[10]
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	3.4	4.6
All Employee Survey: *Servant Leader Index Composite*	0–100 where HIGHER scores are more favorable	67.7	67.7	87.7

Source: VA All Employee Survey (accessed December 22, 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.

[9] 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.

[10] Rating is based on responses by employees who report to the Director.

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, all four patient survey results reflected lower care ratings than the VHA average. The Facility leaders are actively engaged with improving patient satisfaction and had implemented several processes to engage patients regarding their experience, including patient panels, patient satisfaction surveys, and phone polling surveys.

Table 2. Survey Results on Patient Attitudes toward Facility Leadership (October 1, 2016, through September 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.	66.7	60.9
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.	83.4	80.4
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.	74.9	66.9
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.	75.2	71.0

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed December 22, 2017)

Accreditation/For-Cause Surveys[11] 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

[11] 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.

respond to identified problems. Table 3 summarizes the relevant Facility inspections most recently performed by the OIG and The Joint Commission (TJC). Indicative of effective leadership, the Facility has closed all recommendations for improvement as listed in Table 3.[12]

The OIG also noted the Facility's current accreditation status with the Commission on Accreditation of Rehabilitation Facilities[13] and College of American Pathologists,[14] 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.[15]

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 (Healthcare Inspection – Pulmonary Medicine Clinic Appointment Cancellations, William Jennings Bryan Dorn VA Medical Center, Columbia, South Carolina, January 6, 2016)	n/a	0	n/a
OIG *(Healthcare Inspection – Credentialing and Privileging Concerns, William Jennings Bryan Dorn VA Medical Center, Columbia, South Carolina, June 24, 2015)*	n/a	1	0
OIG (*Combined Assessment Program Review of the William Jennings Bryan Dorn VA Medical Center, May 21, 2015)*	March 2015	20	0
OIG (*Review of Community Based Outpatient Clinics and Other Outpatient Clinics of William Jennings Bryan Dorn VA Medical Center, June 5, 2015)*	March 2015	5	0

[12] 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.

[13] 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.

[14] 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.

[15] 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.

Accreditation or Inspecting Agency	Date of Visit	Number of Findings	Number of Recommendations Remaining Open
TJC[16]			
• Regular	January 2016		
o Hospital Accreditation		23	0
o Nursing Care Center Accreditation		0	n/a
o Behavioral Health Care Accreditation		0	n/a
o Home Care Accreditation		5	0
• For Cause	July 2017	0	n/a

Sources: OIG and TJC (Inspection/survey results verified with the Facility Quality Manager on January 23, 2018)

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 March 2015 Combined Assessment Program and Community Based Outpatient Clinic (CBOC) and Other Outpatient Clinics review inspections through the week of January 22, 2018.[17] The Facility leaders reported that cases that led to the 19 identified institutional disclosures were reviewed and appropriate actions were taken to prevent reoccurrence.

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

[17] It is difficult to quantify an acceptable number of occurrences because one occurrence is one too many. Efforts should focus on prevention. Sentinel events and those that lead to disclosure can occur in either inpatient or outpatient settings and should be viewed within the context of the complexity of the Facility. (Note that the William Jennings Bryan Dorn VA Medical Center is a mid-high complexity (1c) affiliated Facility as described in Appendix B.)

Table 4. Summary of Selected Organizational Risk Factors (March 2015 to January 22, 2018)

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

Source: William Jennings Bryan Dorn VA Medical Center's Patient Safety Manager (received January 24, 2018)

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.[21] 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 September 30, 2017.

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

Measure	Reported Rate per 1,000 Hospital Discharges		
	VHA	VISN 7	Facility
Pressure ulcers	0.60	0.32	0.30
Death among surgical inpatients with serious treatable conditions	100.97	71.73	0.00
Iatrogenic pneumothorax	0.19	0.09	0.00
Central venous catheter-related bloodstream infection	0.15	0.23	0.00
In-hospital fall with hip fracture	0.08	0.08	0.38

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

[19] Institutional disclosure of adverse events (sometimes referred to as "administrative disclosure") is a formal process by which facility leaders together with clinicians and others, as appropriate, inform the patient or 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.

[20] Large-scale disclosure of adverse events (sometimes referred to as "notification") is a formal process by which VHA officials assist with coordinating the notification to multiple patients (or their personal representatives) that they may have been affected by an adverse event resulting from a systems issue.

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

Measure	Reported Rate per 1,000 Hospital Discharges		
	VHA	VISN 7	Facility
Perioperative hemorrhage or hematoma	1.94	1.59	0.00
Postoperative acute kidney injury requiring dialysis	0.88	0.75	1.90
Postoperative respiratory failure	5.55	4.94	6.96
Perioperative pulmonary embolism or deep vein thrombosis	3.29	3.05	0.00
Postoperative sepsis	4.00	2.74	0.00
Postoperative wound dehiscence	0.52	0.57	0.00
Unrecognized abdominopelvic accidental puncture/laceration	0.53	0.21	0.00

Source: VHA Support Service Center (accessed December 8, 2017)

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

The Patient Safety Indicator measure for in-hospital fall with hip fracture, postoperative acute kidney injury requiring dialysis, and postoperative respiratory failure showed a higher observed rate than Veterans Integrated Service Network (VISN) 7 and VHA. The Facility had an active process for oversight of adverse events through the establishment of an interdisciplinary Avoidable Adverse Event Committee. This committee reviews all patient safety indicator data to identify, monitor, and trend all adverse events and reports directly to the Quality Improvement Board.

Two patients sustained a hip fracture after an inpatient fall. For both cases, Facility staff conducted a root cause analysis and took actions to prevent reoccurrences.

A single patient developed an acute injury postoperatively that required dialysis, and three patients developed postoperative respiratory failure. The Avoidable Adverse Event Committee reviewed the four cases and determined that there were no opportunities for improvement.

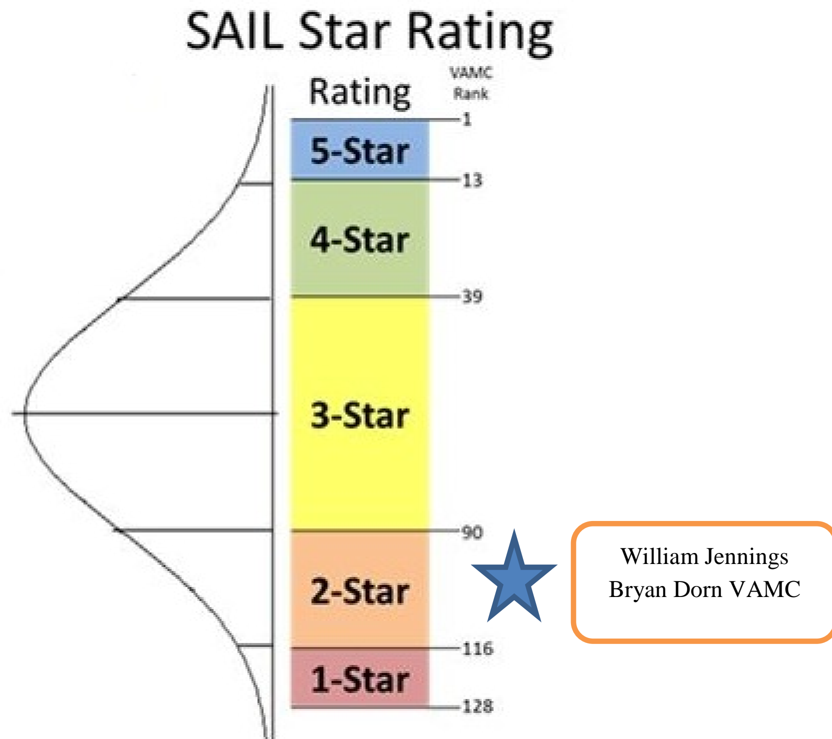
Veterans Health Administration Performance Data

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 healthcare 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 where facilities with a "5-Star" rating are performing within the top 10 percent of facilities and "1-Star" facilities are performing within the bottom 10 percent

of facilities. Figure 5 describes the distribution of facilities by star rating.[22] As of June 30, 2017, the Facility was rated at "2-Star" for overall quality.

Figure 5. Strategic Analytics for Improvement and Learning Star Rating Distribution (as of June 30, 2017)



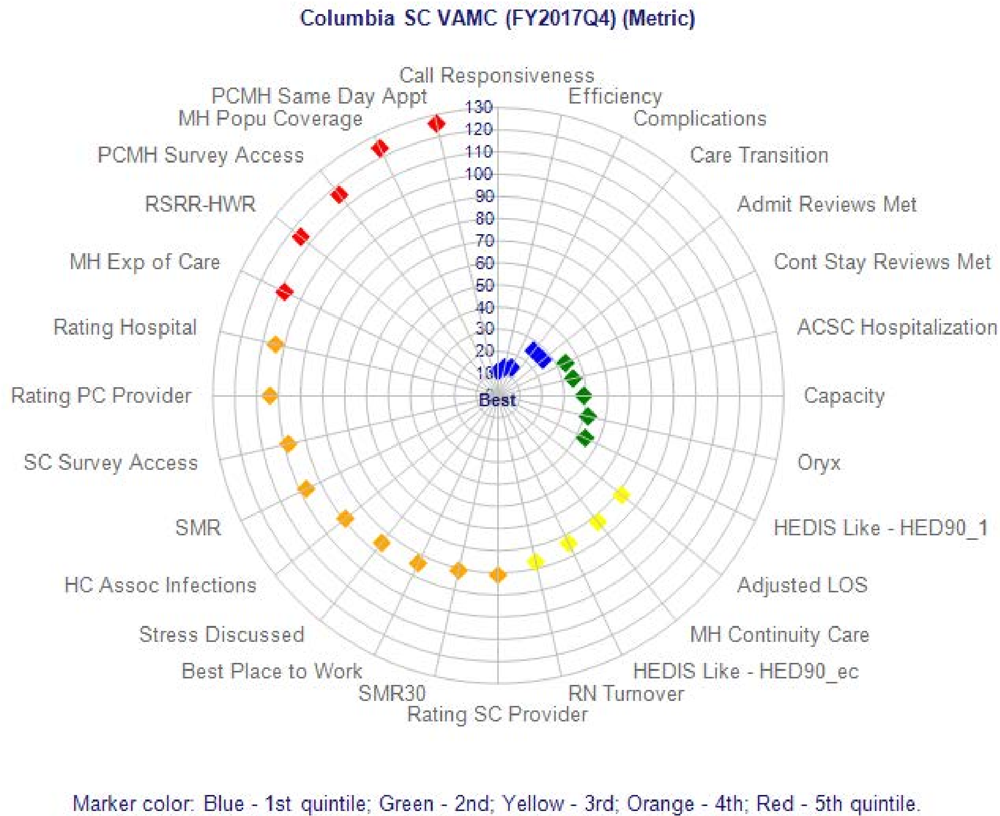
Source: VA Office of Informatics and Analytics' Office of Operational Analytics and Reporting (accessed December 22, 2017)

Figure 6 illustrates the Facility's Quality of Care and Efficiency metric rankings and performance compared with other VA facilities as of September 30, 2017. Of note, Figure 6 uses blue and green data points to indicate high performance (for example in the areas of Complications, Care Transition, and Capacity).[23] Metrics that need improvement are denoted in orange and red (for example, Rating (of) Specialty Care (SC) Provider, Standardized Mortality Ratio (SMR), and Mental Health (MH) Population (Popu) Coverage).

[22] Based on normal distribution ranking quality domain of 128 VA Medical Centers.

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

Figure 6. Facility Quality of Care and Efficiency Metric Rankings (as of September 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.

Conclusion

The Facility has stable executive leadership and active engagement with employees as evidenced by high satisfaction scores. The leaders appear actively engaged with improving patient satisfaction and had implemented several processes to engage patients regarding their experience, including patient panels, patient satisfaction surveys, and phone polling surveys. Organizational leaders support patient safety, quality care, and other positive outcomes (such as initiating processes and plans to maintain positive perceptions of the Facility through active stakeholder engagement). OIG's review of accreditation organization findings, sentinel events, Patient Safety Indicator data, and SAIL results did not identify any substantial organizational risk factors. The senior leadership team was actively engaged and knowledgeable about selected

SAIL metrics but should continue to take actions to improve care and performance of selected Quality of Care and Efficiency metrics that are likely contributing to the "2-Star" rating.

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.[24] VHA also strives to provide healthcare services that compare favorably to the best of the private sector in measured outcomes, value, and efficiency.[25]

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,[26] utilization management (UM) reviews,[27] and patient safety incident reporting with related root cause analyses (RCAs).[28]

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.[29]

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

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

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

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

[28] 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.

[29] 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:[30]

- Protected peer reviews
  - Examination of important aspects of care (for example, appropriate and timely ordering of diagnostic tests, prompt treatment, and appropriate documentation)
  - Implementation of improvement actions recommended by the Peer Review Committee
- UM
  - Completion of at least 75 percent of all required inpatient reviews
  - Documentation of at least 75 percent of Physician UM Advisors' decisions in National UM Integration database
  - Interdisciplinary review of UM data
- Patient safety
  - Entry of all reported patient incidents into WebSPOT[31]
  - Annual completion of a minimum of eight RCAs[32]
  - Provision of feedback about root cause analysis actions to reporting employees
  - Submission of annual patient safety report

Conclusion

The OIG found general compliance with requirements for protected peer reviews, utilization management, and patient safety. The OIG made no recommendations.

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

[31] 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.

[32] 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.

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).[33]

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.[34]

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 Facility 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.[35]

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 10 LIPs who were hired within 18 months prior to the on-site visit,[36] and 20 LIPs who were re-privileged within 12 months prior to the visit.[37] The OIG evaluated the following performance indicators:

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

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

[34] VHA Handbook 1100.19.

[35] VHA Handbook 1100.19.

[36] The 18-month period was from July 22, 2016, through January 22, 2017.

[37] The 12-month review period was from January 23, 2017, through January 22, 2018.

        - Facility-specific
        - Service-specific
        - Provider-specific
    - Service chief recommendation of approval for requested privileges
    - Medical Staff Executive Committee decision to recommend requested privileges
    - Approval of privileges for a period of less than, or equal to, two years
- Focused Professional Practice Evaluation (FPPE)
    - 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)
    - 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 requirements for credentialing and privileging. However, the OIG identified the following deficiencies in Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) processes that warranted recommendations for improvement.

Focused Professional Practice Evaluations

VHA requires that all LIPs new to the Facility have FPPEs completed, documented in the provider's profile, and reported to an appropriate committee of the Medical Staff.[38] The process involves the evaluation of privilege-specific competence of the provider who has no documented

[38] VHA Handbook 1100.19.

evidence of competently performing the requested privileges. This may include periodic chart review, direct observation, monitoring of diagnostic and treatment techniques, or discussion with other individuals involved in the care of patients.[39]

For 4 of 10 LIPs, FPPEs were not completed or reviewed as required. EHR reviews were incomplete for one of the providers; however, the Medical Executive Board recommended continuation of initially granted privileges for this provider. The FPPEs of the three remaining providers were not presented to the Medical Executive Board in the timeframe required by the Facility. This resulted in providers continuing to deliver care without a thorough evaluation of their practice. The Chief of Staff and Service Chiefs stated the reasons for not completing the required reviews were due to competing patient care priorities and not having a tracking mechanism for review due dates.

Recommendation 1

1. The Chief of Staff ensures Service Chiefs complete required elements of Focused Professional Practice Evaluations for review by the Medical Executive Board and monitors compliance.

Facility Concurred.

Target date for completion: July 2, 2018

Facility response: Effective February 6, 2018, the Medical Executive Board (MEB) for Credentialing and Privileging (C&P) revised the agenda to establish continuous monthly monitoring of Focused Professional Practice Evaluations (FPPEs). The agenda now includes the following four (4) topics:

-Past Due Focused Professional Practice Evaluations (FPPEs)

-Past Due Ongoing Professional Practice Evaluations (OPPEs)

-FPPEs due in one month

-OPPEs due in one month

These four topics are now at the top of every agenda for MEB for C&P. The FPPEs and OPPEs are listed by service and provider and include review period. The services with FPPEs and OPPEs that do not include the required number of electronic health record reviews (EHR) will not be accepted and remain outstanding until completed as defined in the Medical Staff Bylaws. PRIVplus, the web-based credentialing and privileging software for healthcare providers, will be utilized to identify pending OPPEs and FPPEs and monitor those past due. Compliance monitoring for this recommendation will be through PRIVplus. The numerator will be the

[39] VHA Handbook 1100.19.

number of current FPPEs. The denominator will be the number of current appointments in PRIVplus. As of March 9, 2018, 610 FPPEs for 615 providers are current with a 99.12 percent compliance rate. In addition to remaining as a standing, recurring agenda topic in MEB for C&P, compliance monitoring will be reported quarterly to the Quality Improvement Board. Reporting will begin April 2018 continuing monthly until compliance is sustained at greater than 90 percent at which time monitoring will transition to quarterly.

Specialty Care Professional Practice Evaluations

VHA requires FPPE and OPPE criteria to be specific to the specialty and has identified minimum-required specialty criteria for gastroenterology, pathology and laboratory medicine, nuclear medicine, and radiation oncology.[40] This ensures a consistent approach to evaluating providers in these specialties and is essential to confirming the quality of care delivered.

For OPPEs of five LIPs, there was no evidence of the use of minimum-required specialty criteria for competency evaluation. As a result, providers continued to deliver care without a thorough evaluation of their practice. Service chiefs reported a lack of understanding of the requirements and did not include minimum required evaluation criteria in the OPPE process.

Recommendation 2

2. The Chief of Staff ensures that Service Chiefs include all required elements for Ongoing Professional Practice Evaluations and monitors compliance.

Facility Concurred.

Target date for completion: April 20, 2018

Facility response: The OPPE forms for specialty care providers in gastroenterology, pathology and laboratory medicine, and nuclear medicine were reviewed and revised to include the use of minimum-required specialty criteria for competency evaluation presented to MEB for C&P on March 20, 2018. Once approved, the revised forms will be implemented for the identified specialty providers. The Chief, QM reviewed the OPPE forms for compliance with Directive requirements prior to their submission to MEB for C&P for approval. Ongoing compliance will be monitored annually as part of the review required for MEB for C&P. The Chief, QM, in collaboration with the Medical Staff Office, will monitor OPPE forms submitted for compliance with current guidance.

[40] Acting DUSHOM Memo, Requirements for Peer Review of Solo Practitioners, August 29, 2016.

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.[41]

The purpose of the OIG review was to determine whether the Facility maintained a clean and safe healthcare environment in accordance with applicable requirements.[42] 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[43] and Nutrition and Food Services processes.[44]

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.[45]

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.[46]

In all, the OIG team inspected six inpatient units (critical care–4 East, community living center-103A, medical–4 West, mental health-recovery east, post-anesthesia care, surgical–2 West), the Emergency Department, Outpatient-Freedom Clinic, Nutrition and Food Services, and a construction site. The OIG also inspected the Orangeburg CBOC.[47] Additionally, the OIG reviewed the most recent Infection Prevention Risk Assessment, Infection Prevention/Control

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

[42] 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).

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

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

[45] VHA Directive 7715.

[46] VHA Handbook 1109.04.

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

Committee minutes for the past six months, construction activities, and other relevant documents, and interviewed key employees and managers. The OIG evaluated the following location-specific performance indicators:

- Parent Facility
  - EOC rounds
  - EOC deficiency tracking
  - Infection prevention
  - General safety
  - Environmental cleanliness
  - General privacy
  - Women veterans' exam room privacy
  - Availability of medical equipment and supplies
- Community Based Outpatient Clinic
  - General safety
  - Medication safety and security
  - Infection prevention
  - Environmental cleanliness
  - General privacy
  - Exam room privacy
  - Availability of medical equipment and supplies
- Construction Safety
  - Completion of infection control risk assessment for all sites
  - Infection Prevention/Infection Control Committee discussions on construction activities
  - Dust control
  - Safety and security

  - Selected requirements based on project type and class[48]
- Nutrition and Food Services
  - Annual Hazard Analysis Critical Control Point Food Safety System plan
  - Food Services inspections
  - Emergency operations plan for food service
  - Safe transportation of prepared food
  - Environmental safety
  - Infection prevention
  - Storage areas

Conclusion

General safety, infection prevention, and privacy measures were in place at the parent Facility and representative CBOC. The OIG did not note any issues with the availability of medical equipment and supplies. One ongoing construction project met all construction safety requirements, and Nutrition and Food Services met the performance indicators reviewed. The OIG identified the following deficiencies in EOC rounds, environmental cleanliness, and medical equipment safety that warranted recommendations for improvement.

Parent Facility's 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.[49] From October 1, 2016, through September 30, 2017, 5 of 13 required EOC team members did not attend rounds consistently. This resulted in lack of subject matter experts on EOC rounds. Facility managers were not monitoring attendance to ensure adequate representation during EOC rounds.

[48] 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.

[49] VHA Directive 1608. According to the Directive, 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 3

3. The Associate Director ensures all required team members consistently participate on environment of care rounds and monitor compliance.

Facility concurred.

Target date for completion: July 2, 2018

Facility response: The Environment of Care (EOC) inspector noted that prior to the inspection here at Dorn, he had never seen anyone take the initiative to correct a flawed system. The process of evaluating each area to confirm which areas are required to be inspected took several months to reformat because the entire Facility had to be surveyed for correct ownership of each area and then the database rebuilt and a new schedule formatted. The switch to the new schedule and database was made for the first inspection in October 2017. The EOC Rounds schedule was reformatted for Fiscal Year (FY) 2018 to provide for better attendance from all disciplines.

Progress to Date:

The current attendance rates for FY18 are:

Columbia (544)	93.5 percent Overall
Engineering	100 percent
EMS	100 percent
HIPPA Privacy Rules	100 percent
Infection Control	100 percent
Information Security	45.8 percent*
Logistics	73.9 percent**
Medical Equipment	100 percent
Nursing	100 percent
Patient Safety	100 percent
Safety	100 percent
Security	95.8 percent
Senior Leadership	100 percent
VCS	100 percent
Vets Privacy/Dignity	100 percent

The Information Security Officer Inspections are now being performed by VISN 7 personnel and began late October of this fiscal year. Attendance for 1st quarter was 35.7 percent, attendance

improved so far for the 2nd quarter at 60 percent. The Chief of Logistics has added additional personnel to ensure coverage with FY18 first quarter compliance at 61.5 percent and 2nd quarter compliance at 90 percent. To insure improved attendance Service Chiefs will be notified by email prior to each inspection and will be notified immediately after EOC Inspection rounds if the appointed team member does not attend. The schedule for EOC Rounds will continue to be sent to inspectors and Service Chiefs. The EOC Inspection attendance will continue to be tracked monthly and reported to the Environment of Care Board and Executive Leadership Council with an expectation of greater than 90 percent compliance for each identified area. Monitoring and reporting have been incorporated as standing agenda items and will continue indefinitely.

Parent Facility: Facility Cleanliness

TJC requires hospitals to identify environmental deficiencies, hazards, and unsafe practices; and to keep furnishings and equipment safe and in good repair. This ensures a clean and safe health care environment.[50] The OIG noted problems with cleanliness and maintenance of overhead structures throughout the parent Facility. Six of eight patient care areas had dirty ventilation grills; three areas had stained, dusty, cracked, or broken ceiling tiles; two areas had privacy curtains needing maintenance or replacement; and three areas had dusty fire sprinkler heads. Environmental Management Service (EMS) housekeeping staff were not following room cleaning procedures, and these deficiencies were not addressed by EMS supervisors or consistently identified during Facility EOC rounds.

Recommendation 4

4. The Associate Director ensures that Facility managers maintain a safe and clean environment throughout the Facility and monitors compliance.

Facility concurred.

Target date for completion: April 30, 2018

Facility response: Findings from OIG visit were reviewed with EMS Supervisory and Housekeeping Staff in January and February meetings. Privacy curtain issues were corrected immediately. Increased emphasis has been placed on checking vents and sprinklers during EOC rounds as well as daily and weekly QA rounds. EMS has recently filled a position (2/2018) to have a dedicated QA/Training position. Ongoing compliance monitoring has been incorporated into EMS Supervisory quality assurance rounds and routine Environment of Care Rounds.

[50] TJC. Environment of Care standard EC.02.06.01, EP20. July 2017.

Orangeburg CBOC: Medical Equipment Safety Inspection

VHA Center for Engineering and Occupational Safety and Health (CEOSH) requires facilities to have a mechanism or method in place for equipment users to be confident that the equipment they are using is safe and functional.[51] The Facility uses dated stickers as a visual tool to communicate that equipment has been checked for safety. Two of eight examination tables at the Orangeburg CBOC lacked inspection stickers. This resulted in equipment in service without visual evidence that it was safe to use. Facility staff were unable to identify why the stickers were missing from this recently placed equipment, and clinical staff could not state what actions to take to ensure safe equipment.

Recommendation 5

5. The Associate Director ensures all medical equipment is identified as safe for patient use and monitors compliance.

Facility concurred.

Target date for completion: April 30, 2018

Facility response: Technicians will review original incoming inspection reports for these devices. After review is complete and inspection reports are confirmed, Biomed will affix new inspection indicator stickers to the exam tables. Healthcare Technology Management technicians will re-educate area staff on the meaning of inspection stickers present on their medical devices and what the proper response should be. Ongoing compliance monitoring current medical equipment inspection stickers with an expectation of greater than 90 percent compliance will occur during environment of care rounds.

[51] Environment of Care Guidebook, VHA Center for Engineering & Occupational Safety and health (CEOSH), June 2017.

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 June 2017 through December 2017.

[57] The review period was December 2016 through December 2017.

[58] The four quarters were from December 2016 through December 2017.

- Pharmacy operations
  - Annual physical security survey of the pharmacy/pharmacies by VA Police
  - CS ordering processes
  - Inventory completion during Chief of Pharmacy transition
  - Staff restrictions for monthly review of balance adjustments
- Requirements for CSCs
  - Free from conflicts of interest
  - CSC duties included in position description or functional statement
  - Completion of required CSC orientation training course
- Requirements for CSIs
  - Free from conflicts of interest
  - Appointed in writing by the Director for a term not to exceed three years
  - Hiatus of one year between any reappointment
  - Completion of required CSI certification course
  - Completion of required annual updates and/or refresher training
- CS area inspections
  - Monthly inspections
  - Rotations of CSIs
  - Patterns of inspections
  - Completion of inspections on day initiated
  - Reconciliation of dispensing between pharmacy and each dispensing area
  - Verification of CS orders
  - CS inspections performed by CSIs
- Pharmacy inspections
  - Monthly physical counts of the CS in the pharmacy by CSIs
  - Completion of inspections on day initiated

- Security and documentation of drugs held for destruction[59]
- Accountability for all prescription pads in pharmacy
- Verification of hard copy outpatient pharmacy CS prescriptions
- Verification of 72-hour inventories of the main vault
- Quarterly inspections of emergency drugs
- Monthly CSI checks of locks and verification of lock numbers

Conclusion

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

[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.

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."[60] 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.[61]

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.[62] 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.[63]

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 30 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

[60] 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.)

[61] VHA Handbook 1160.03.

[62] 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.

[63] VHA Handbook 1160.03.

- Referral for diagnostic evaluation
- Completion of diagnostic evaluation within required timeframe

Conclusion

Generally, the OIG noted compliance with provider documentation of further diagnostic evaluation being offered, referred, and completed. However, the OIG identified a deficiency in timely completion of suicide risk assessment that warranted a recommendation for improvement.

Suicide Risk Assessment Completed by Next Business Day

VHA requires an appropriate provider assess patients with a positive PTSD screen by the end of the next business day to ensure immediate safety risks are identified and addressed.[64] The OIG estimated that providers completed suicide risk assessments by the next business day in 53 percent of the EHRs reviewed.[65] Clinical staff reported that because the EHR system allows multiple providers to access the patient record simultaneously, alerts may not be visible to providers until they re-access the record, and the Facility did not have a process for timely person-to-person communication of positive PTSD screens.

Recommendation 6

6. The Chief of Staff ensures providers complete suicide risk assessments, within the required timeframe, for patients with positive Post-Traumatic Stress Disorder screens and monitors providers' compliance.

Facility concurred.

Target date for completion: October 1, 2018

Facility response: In 2017, the Facility self-identified, the need for improvement in the timely completion of the Suicide Risk Evaluation (SRE) after a positive Post Traumatic Stress Disorder (PTSD) or Major Depressive Disorder (MDD) screen. The Facility has since implemented actions to improve performance. It is important to note that the audit period of the electronic health records (EHR) for this OIG CHIP Review was from July 1, 2016 through June 30, 2017. The Facility implemented corrective actions beginning July 2017, thus no improvements would be noted through the course of the OIG CHIP Review.

[64] Department of Veterans Affairs Memorandum, Information Bulletin: Clarification of Posttraumatic Stress Disorder Screening Requirements, August 2015.

[65] OIG is 95 percent confident that the true rate is somewhere between 36.8–70.1 percent, which OIG determined is statistically significantly below the 90 percent benchmark.

July 27, 2017, Primary Care (PC) pulled a list of patients with a positive PTSD screen who did not have the necessary SRE completed and the list was sent to each provider for action. The list was reviewed by PC leadership to identify teams that had frequent fallouts and focus on them for more in-depth education and process improvement strategies. This practice allowed immediate emphasis on and education of the SRE reminder and enabled rapid performance improvement across teamlets.

During this time, the providers identified a possible issue with the print name of the clinical reminder associated with SRE. In the reminder due folder, the SRE reminder displayed as F/U Pos Dep/PTSD/PS Screening. The providers recognized that this title does not accurately reflect the nature of the reminder or the urgency needed for completion. On February 2, 2018, the print name for this reminder was changed to Suicide Risk Evaluation.

A comprehensive Patient Aligned Care Team (PACT) training was developed and held for all PACT teamlet members March 7-9, 2018. During this training PACT providers, Registered Nurses (RNs), and Licensed Practical Nurses (LPNs) were educated regarding the requirement for an SRE to be done if there is a positive PTSD screen. Education included the requirement for a warm handoff to an appropriately trained provider when a PTSD screen is positive; this includes education regarding the potential need to refresh patient information so that the follow up reminder appears on the stated provider’s desktop. PACT training not only defined team roles and responsibilities in general but especially as it related to reminder completion; a key component of this training was an emphasis on the importance of daily HUDDLES to improve workflow and teamlet communication, especially as it relates to warm hand-offs and assurance of required task completion during the visit.

Ongoing education/training has been incorporated in PC staff meetings. A second comprehensive PACT training is scheduled for August 13-17, 2018.

Mental Health and OIF/OEF/OND Nurse Case Managers were trained to be able to complete the SRE in addition to Licensed Independent Providers. An algorithm was developed to give Clinical Associates and other members of the health care team guidance as to the appropriate use of Primary Care Mental Health Integration (PCMH-I) providers, where available, to assist with completion of the SRE upon determination of a positive PTSD screen.

The Facility External Peer Review Program (EPRP) Coordinator has developed an in-depth EPRP training at each site including Dorn and the CBOCs. This training will involve all PC staff and will focus on SRE as well as the other Healthcare Effectiveness Data and Information Set (HEDIS) metrics. Four trainings have been completed to date at Orangeburg, Greenville, Rock Hill and Dorn. All trainings will be completed by May 4, 2018. The goal is to educate direct patient care staff regarding HEDIS measures and their outcomes on important dimensions of outpatient care.

Compliance will be monitored via Quality Management chart review of 15 records each month that trigger for a suicide risk assessment. The numerator will be the number of cases with timely completion of the suicide risk assessment and the denominator will be the number of cases that triggered for a suicide risk assessment. Our goal is to demonstrate sustained compliance at or above 90 percent.

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.[66] 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.[67] 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.[68]

In 1999, the Veterans Millennium Benefits and Healthcare Act mandated that the veterans' standard benefits package include access to GE.[69] 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.[70] Facility leaders must also evaluate the GE through a review of program objectives, procedures for monitoring care processes and outcomes, and analyses of findings.[71]

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 47 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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[66] VHA Directive 1140.04, *Geriatric Evaluation*, November 28, 2017.

[67] VHA Directive 1140.04.

[68] 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.

[69] Public Law 106-117.

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

[71] VHA Directive 1140.04.

  - Comprehensive psychosocial assessment by GE social worker
  - Patient or family education
  - Plan of care based on geriatric evaluation
- Geriatric management
  - Implementation of interventions noted in plan of care

Conclusion

Generally, the OIG noted compliance with access to GE. However, the OIG identified the following deficiencies in program oversight and geriatric plan of care implementation that warranted recommendations for improvement.

Program Oversight and Evaluation

VHA requires Facility leaders to assess the GE program and oversee performance improvement activities.[72] This provides the opportunity to identify practice improvements, ensures appropriate actions were taken, and measures the effectiveness of actions on a regular basis. The results of performance improvement activities for the Geriatrics and Extended Care Program were reported at other Facility committees but not to the appropriate leadership committee (Medical Executive Board) due to lack of understanding of performance improvement reporting requirements.

Recommendation 7

7. The Chief of Staff ensures that geriatric evaluation program performance improvement activities are presented to an appropriate leadership board and monitors compliance.

Facility concurred.

Target date for completion: June 4, 2018

Facility response: The Chief, GEC and Associate Nurse Executive (ANE), GEC will review VHA Directive 1140.04 requirements for program evaluation and performance improvement and the reporting structure for current performance improvement activities. Based on existing reports and areas for review they identify, the Chief, GEC and ANE, GEC will develop a process for monitoring and reporting to the Medical Executive Board (MEB). The first GEC Performance Improvement Report has been added to the agenda for the May 24, 2018 MEB meeting. GEC PI reporting has been added as a recurring agenda item to the Medical Executive Board (MEB) and compliance will be monitored via reporting to MEB and review of MEB minutes.

[72] VHA Directive 1140.04.

Plan of Care Implementation

VHA requires that geriatric evaluations include development and implementation of an interdisciplinary plan of care to ensure that facilities provide a comprehensive approach towards meeting collaborative care goals for patients.[73] The OIG estimated that care plan actions were implemented in 58 percent of the EHRs reviewed.[74] Staff reported that the care plan template included multiple interventions that could not be edited or customized for each patient, and this resulted in the appearance that patients had unimplemented actions.

Recommendation 8

8. The Chief of Staff ensures that clinicians accurately identify and implement the Geriatric Evaluation plan of care interventions and monitors compliance.

Facility concurred.

Target date for completion: August 31, 2018

Facility response: The ANE, GEC Service has identified eight (8) separate care plan templates for review and revision. On March 23, 2018, the ANE, GEC Service met with the Home Based Primary Care (HBPC) team leads and assigned review and revision for each of the care plans.

The care plans will be revised to incorporate text box entry and allow for individualization of the care plan based on the specific needs of the patient. Revisions will be reviewed by the ANE, GEC and submitted to the Clinical Application Coordinator to build new Nursing Visit and Team Meeting templates. HBPC staff will be educated on the revisions to the care plans and expectations for completion.

By April 9, 2018, the revised Nurse Visit and Team Meeting templates will be implemented. The ANE, GEC will complete random audits to review for care plan action implementation. Our goal is to demonstrate sustained compliance of 90 percent with monthly audits beginning May 2018.

[73] VHA Directive 1140.04.

[74] The OIG is 95 percent confident that the true rate is somewhere between 42.5–70.1 percent, which the OIG determined is statistically significantly below the 90 percent benchmark.

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.[75] 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.[76] The Veterans Health Care Act of 1992 also authorized VA to provide gender-specific services, including mammography services to eligible women veterans.[77]

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.[78]

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 49 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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[75] U.S. Breast Cancer Statistics. http://www.BreastCancer.org website. (Website accessed on May 18, 2017.)

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

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

[78] 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

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.[79] 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,"[80] 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.[81]

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."[82]

Infections occurring on or after the third calendar day following admission to an inpatient location are considered "healthcare-associated."[83] 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.[84]

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 26 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

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

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

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

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

[83] 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.

[84] 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	Eight OIG recommendations, ranging from documentation issues to deficiencies that can lead to patient and staff safety issues or adverse events, are attributable to the Chief of Staff and Associate Director. See details below.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• Protected peer review of clinical care • UM reviews • Patient safety incident reporting and RCAs	• None	• None
Credentialing and Privileging	• Medical licenses • Privileges • FPPEs • OPPEs	• Service Chiefs complete required elements of Focused Professional Practice Evaluations for review by the Medical Executive Board.	• Service Chiefs include all required elements for Ongoing Professional Practice Evaluations.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement

Environment of Care	• Parent Facility
	  o EOC rounds and deficiency tracking
	  o Infection prevention
	  o General safety
	  o Environmental cleanliness
	  o General and exam room privacy
	  o Availability of medical equipment and supplies
	• CBOC
	  o General safety
	  o Medication safety and security
	  o Infection prevention
	  o Environmental cleanliness
	  o General and exam room privacy
	  o Availability of medical equipment and supplies
	• Construction Safety
	  o Infection control risk assessment
	  o Infection Prevention/ Infection Control Committee discussions
	  o Dust control
	  o Safety/security
	  o Selected requirements based on project type and class
	• Nutrition and Food Services
	  o Annual Hazard Analysis Critical control Point Food Safety System plan
	  o Food Services inspections
	  o Safe transportation of prepared food
	  o Environmental safety
	  o Infection prevention
	  o Storage areas
		• None	• Parent Facility:
			  o Required team members consistently participate on EOC rounds.
			  o Facility managers maintain a safe and clean environment throughout the Facility.
			  o Medical equipment is identified as safe for patient use.

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	• None	• None
Mental Health Care: Post-Traumatic Stress Disorder Care	• Suicide risk assessment • Offer of further diagnostic evaluation • Referral for diagnostic evaluation • Completion of diagnostic evaluation	• Providers complete suicide risk assessments, within the required timeframe, for patients with positive PTSD screens.	• None
Long-Term Care: Geriatric Evaluations	• Program oversight and evaluation • Provision of clinical care • Geriatric management	• Clinicians accurately identify and implement the Geriatric Evaluation plan of care interventions.	• Geriatric evaluation program performance improvement activities are presented to an appropriate leadership board.
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 mid-high-complexity (1c)[85] affiliated[86] Facility reporting to VISN 7.

Table 6. Facility Profile for Columbia (544)
(October 1, 2014, through September 30, 2017)

Profile Element	Facility Data FY 2015[87]	Facility Data FY 2016[88]	Facility Data FY 2017[89]
Total Medical Care Budget in Millions	$448.8	$490.8	$532.7
Number of: • Unique Patients	80,498	81,577	82,475
• Outpatient Visits	1,012,797	1,050,891	1,078,839
• Unique Employees[90]	2,102	2,103	2,239
Type and Number of Operating Beds: • Community Living Center	94	94	94
• Medicine	72	72	72
• Mental Health	17	17	17
• Surgery	23	23	23
Average Daily Census: • Community Living Center	60	55	62
• Medicine	46	37	39
• Mental Health	15	13	16
• Surgery	6	9	8

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.

[85] The VHA medical centers are classified according to a Facility complexity model; 1c designation indicates a Facility with medium-high volume, medium-risk patients, some complex clinical programs, and medium-sized research and teaching programs.

[86] Associated with a medical residency program.

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

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

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

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

VA Outpatient Clinic Profiles[91]

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[92] 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[93] Provided	Diagnostic Services[94] Provided	Ancillary Services[95] Provided
Greenville, SC	544BZ	29,782	11,877	Cardiology Gastroenterology Infectious Disease Pulmonary/ Respiratory Disease Blind Rehab Poly-Trauma Spinal Cord Injury Eye	Radiology	Nutrition Pharmacy Weight Management Dental

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

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

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

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

[95] Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

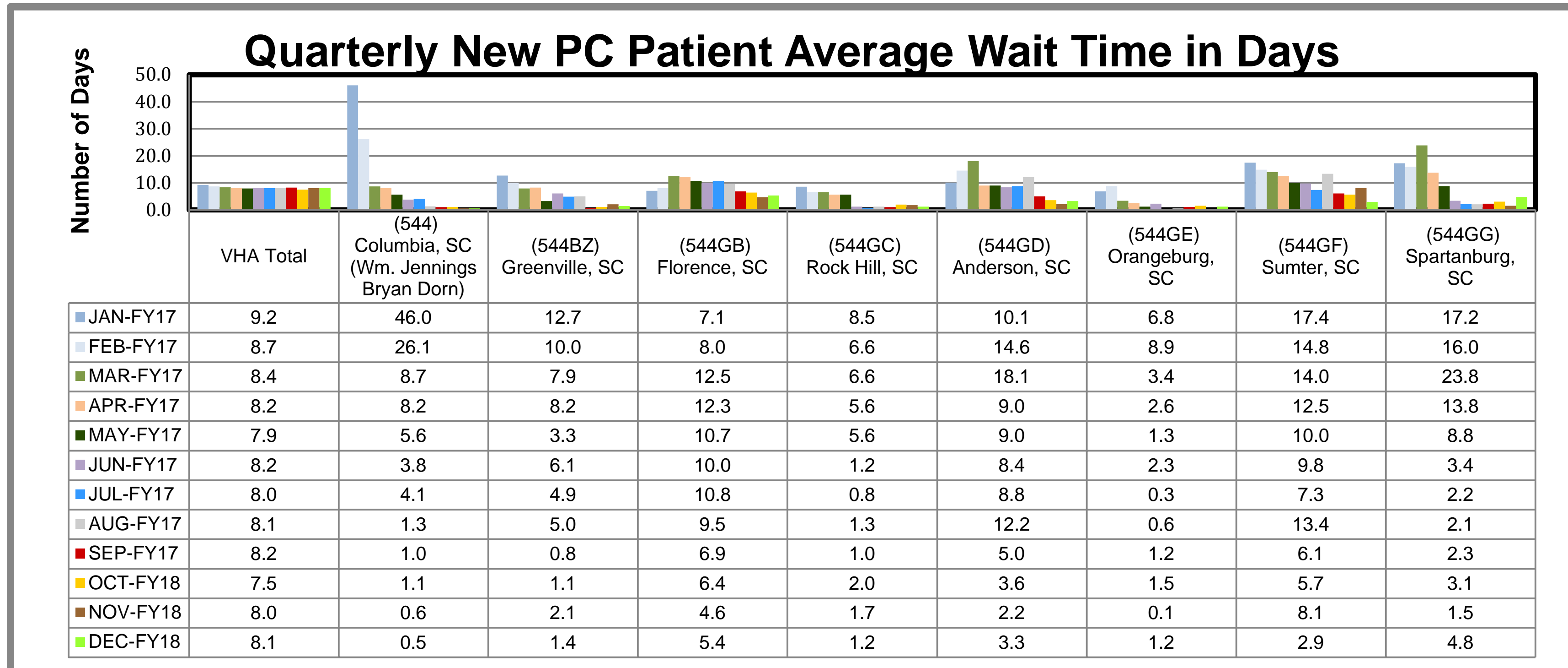
Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services[93] Provided	Diagnostic Services[94] Provided	Ancillary Services[95] Provided
Florence, SC	554GB	17,555	5,787	Nephrology Poly-Trauma Eye	n/a	Nutrition Pharmacy Social Work Weight Management
Rock Hill, SC	554GB	15,325	11,707	Nephrology	n/a	Pharmacy
Anderson, SC	554GB	13,261	4,946	Nephrology Podiatry Eye	n/a	Nutrition Pharmacy Weight Management
Orangeburg, SC	554GB	7,821	2,955	n/a	n/a	Nutrition Pharmacy Social Work
Sumter, SC	554GB	10,484	4,970	n/a	n/a	Nutrition Pharmacy
Spartanburg, SC	554GB	12,738	6,599	Dermatology Eye	n/a	Nutrition Pharmacy

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[96]



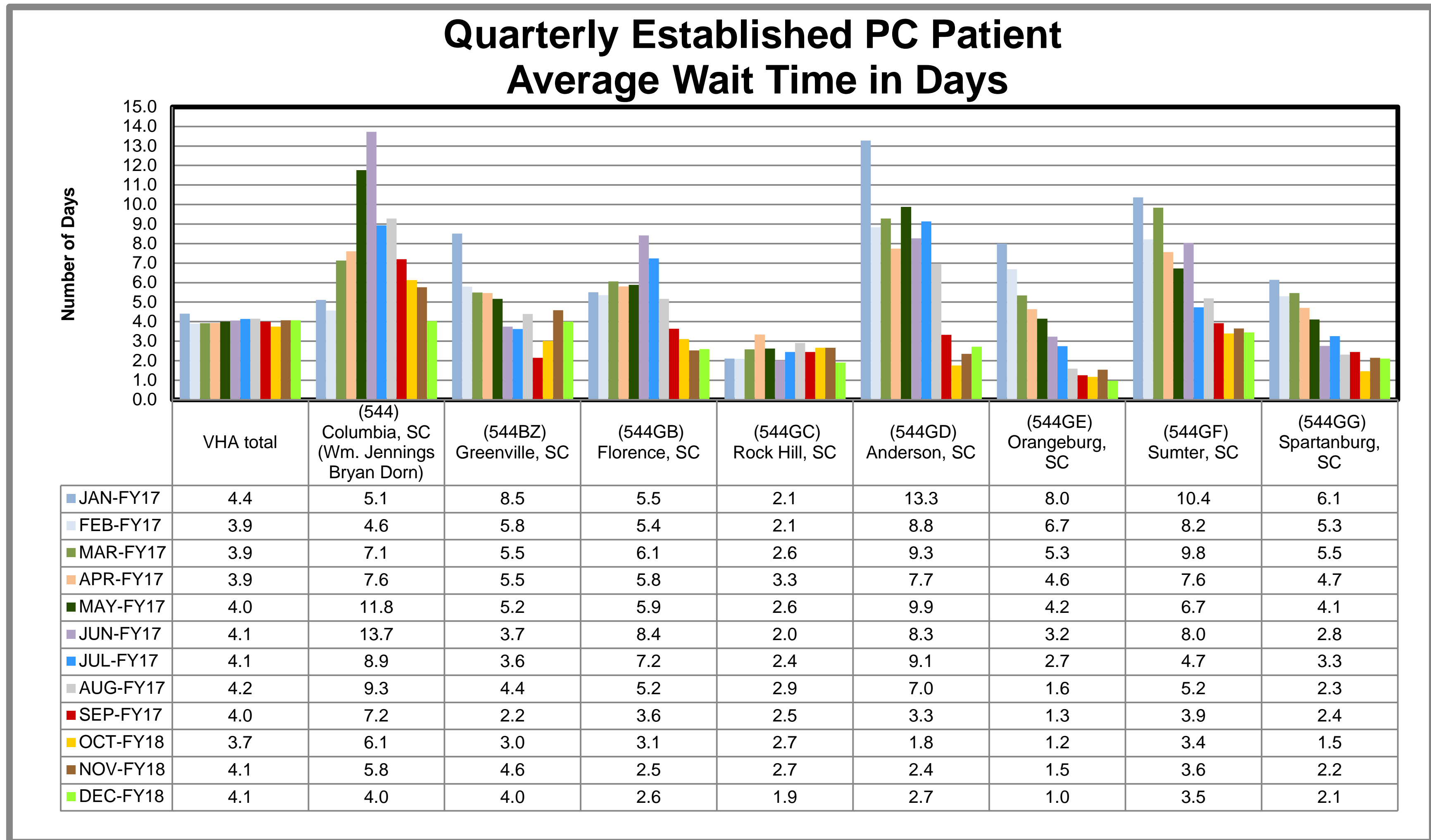
	VHA Total	(544) Columbia, SC (Wm. Jennings Bryan Dorn)	(544BZ) Greenville, SC	(544GB) Florence, SC	(544GC) Rock Hill, SC	(544GD) Anderson, SC	(544GE) Orangeburg, SC	(544GF) Sumter, SC	(544GG) Spartanburg, SC
JAN-FY17	9.2	46.0	12.7	7.1	8.5	10.1	6.8	17.4	17.2
FEB-FY17	8.7	26.1	10.0	8.0	6.6	14.6	8.9	14.8	16.0
MAR-FY17	8.4	8.7	7.9	12.5	6.6	18.1	3.4	14.0	23.8
APR-FY17	8.2	8.2	8.2	12.3	5.6	9.0	2.6	12.5	13.8
MAY-FY17	7.9	5.6	3.3	10.7	5.6	9.0	1.3	10.0	8.8
JUN-FY17	8.2	3.8	6.1	10.0	1.2	8.4	2.3	9.8	3.4
JUL-FY17	8.0	4.1	4.9	10.8	0.8	8.8	0.3	7.3	2.2
AUG-FY17	8.1	1.3	5.0	9.5	1.3	12.2	0.6	13.4	2.1
SEP-FY17	8.2	1.0	0.8	6.9	1.0	5.0	1.2	6.1	2.3
OCT-FY18	7.5	1.1	1.1	6.4	2.0	3.6	1.5	5.7	3.1
NOV-FY18	8.0	0.6	2.1	4.6	1.7	2.2	0.1	8.1	1.5
DEC-FY18	8.1	0.5	1.4	5.4	1.2	3.3	1.2	2.9	4.8

Source: VHA Support Service Center.

Note: The OIG did not assess VA's data for accuracy or completeness. We have on file the Facility's explanation for the increased wait times for the parent Facility.

***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.*

[96] Department of Veterans' Affairs, Patient Aligned Care Teams Compass Data Definitions, accessed January 17, 2018.

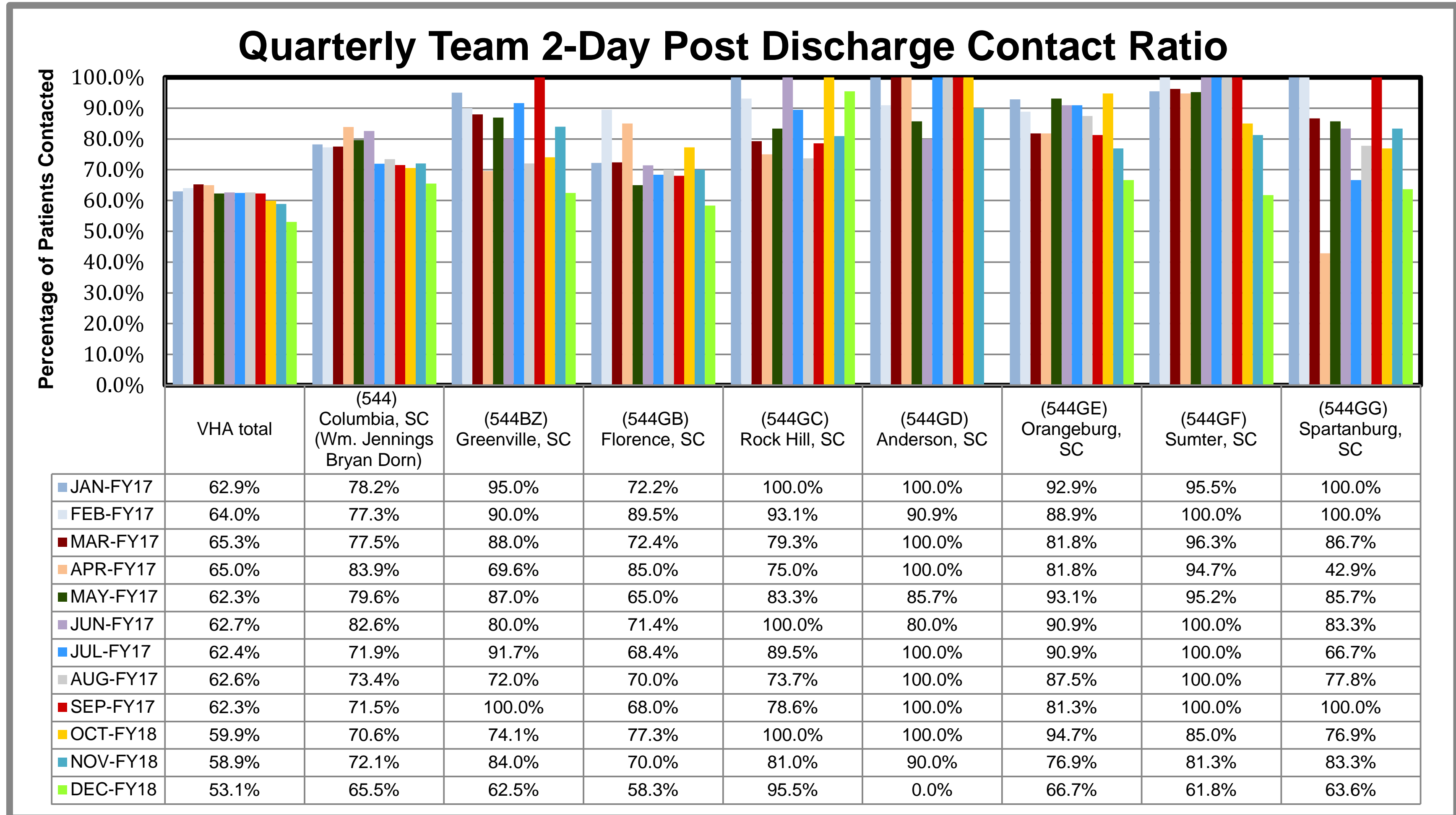


	VHA total	(544) Columbia, SC (Wm. Jennings Bryan Dorn)	(544BZ) Greenville, SC	(544GB) Florence, SC	(544GC) Rock Hill, SC	(544GD) Anderson, SC	(544GE) Orangeburg, SC	(544GF) Sumter, SC	(544GG) Spartanburg, SC
JAN-FY17	4.4	5.1	8.5	5.5	2.1	13.3	8.0	10.4	6.1
FEB-FY17	3.9	4.6	5.8	5.4	2.1	8.8	6.7	8.2	5.3
MAR-FY17	3.9	7.1	5.5	6.1	2.6	9.3	5.3	9.8	5.5
APR-FY17	3.9	7.6	5.5	5.8	3.3	7.7	4.6	7.6	4.7
MAY-FY17	4.0	11.8	5.2	5.9	2.6	9.9	4.2	6.7	4.1
JUN-FY17	4.1	13.7	3.7	8.4	2.0	8.3	3.2	8.0	2.8
JUL-FY17	4.1	8.9	3.6	7.2	2.4	9.1	2.7	4.7	3.3
AUG-FY17	4.2	9.3	4.4	5.2	2.9	7.0	1.6	5.2	2.3
SEP-FY17	4.0	7.2	2.2	3.6	2.5	3.3	1.3	3.9	2.4
OCT-FY18	3.7	6.1	3.0	3.1	2.7	1.8	1.2	3.4	1.5
NOV-FY18	4.1	5.8	4.6	2.5	2.7	2.4	1.5	3.6	2.2
DEC-FY18	4.1	4.0	4.0	2.6	1.9	2.7	1.0	3.5	2.1

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

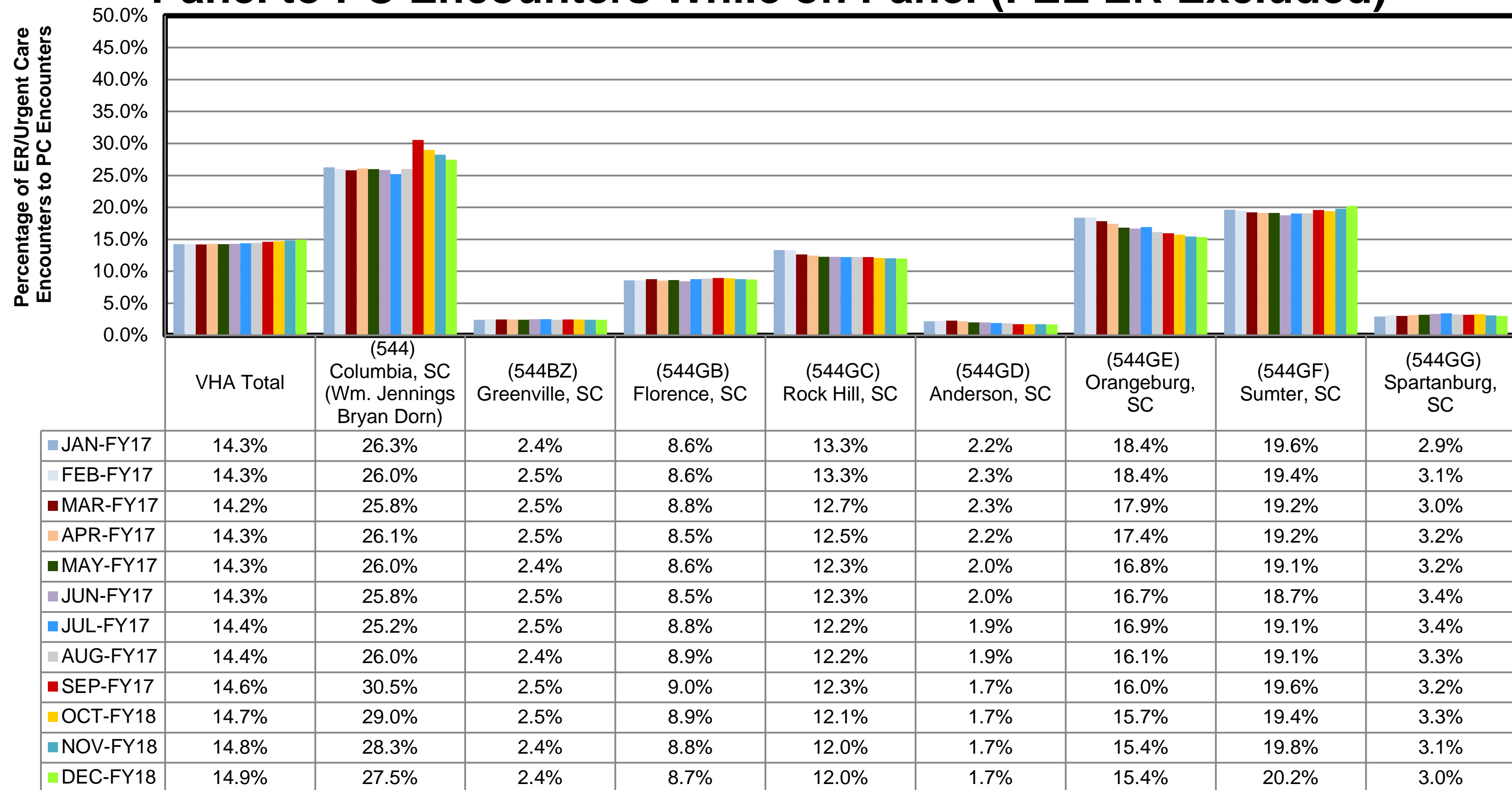


	VHA total	(544) Columbia, SC (Wm. Jennings Bryan Dorn)	(544BZ) Greenville, SC	(544GB) Florence, SC	(544GC) Rock Hill, SC	(544GD) Anderson, SC	(544GE) Orangeburg, SC	(544GF) Sumter, SC	(544GG) Spartanburg, SC
JAN-FY17	62.9%	78.2%	95.0%	72.2%	100.0%	100.0%	92.9%	95.5%	100.0%
FEB-FY17	64.0%	77.3%	90.0%	89.5%	93.1%	90.9%	88.9%	100.0%	100.0%
MAR-FY17	65.3%	77.5%	88.0%	72.4%	79.3%	100.0%	81.8%	96.3%	86.7%
APR-FY17	65.0%	83.9%	69.6%	85.0%	75.0%	100.0%	81.8%	94.7%	42.9%
MAY-FY17	62.3%	79.6%	87.0%	65.0%	83.3%	85.7%	93.1%	95.2%	85.7%
JUN-FY17	62.7%	82.6%	80.0%	71.4%	100.0%	80.0%	90.9%	100.0%	83.3%
JUL-FY17	62.4%	71.9%	91.7%	68.4%	89.5%	100.0%	90.9%	100.0%	66.7%
AUG-FY17	62.6%	73.4%	72.0%	70.0%	73.7%	100.0%	87.5%	100.0%	77.8%
SEP-FY17	62.3%	71.5%	100.0%	68.0%	78.6%	100.0%	81.3%	100.0%	100.0%
OCT-FY18	59.9%	70.6%	74.1%	77.3%	100.0%	100.0%	94.7%	85.0%	76.9%
NOV-FY18	58.9%	72.1%	84.0%	70.0%	81.0%	90.0%	76.9%	81.3%	83.3%
DEC-FY18	53.1%	65.5%	62.5%	58.3%	95.5%	0.0%	66.7%	61.8%	63.6%

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."*



	VHA Total	(544) Columbia, SC (Wm. Jennings Bryan Dorn)	(544BZ) Greenville, SC	(544GB) Florence, SC	(544GC) Rock Hill, SC	(544GD) Anderson, SC	(544GE) Orangeburg, SC	(544GF) Sumter, SC	(544GG) Spartanburg, SC
JAN-FY17	14.3%	26.3%	2.4%	8.6%	13.3%	2.2%	18.4%	19.6%	2.9%
FEB-FY17	14.3%	26.0%	2.5%	8.6%	13.3%	2.3%	18.4%	19.4%	3.1%
MAR-FY17	14.2%	25.8%	2.5%	8.8%	12.7%	2.3%	17.9%	19.2%	3.0%
APR-FY17	14.3%	26.1%	2.5%	8.5%	12.5%	2.2%	17.4%	19.2%	3.2%
MAY-FY17	14.3%	26.0%	2.4%	8.6%	12.3%	2.0%	16.8%	19.1%	3.2%
JUN-FY17	14.3%	25.8%	2.5%	8.5%	12.3%	2.0%	16.7%	18.7%	3.4%
JUL-FY17	14.4%	25.2%	2.5%	8.8%	12.2%	1.9%	16.9%	19.1%	3.4%
AUG-FY17	14.4%	26.0%	2.4%	8.9%	12.2%	1.9%	16.1%	19.1%	3.3%
SEP-FY17	14.6%	30.5%	2.5%	9.0%	12.3%	1.7%	16.0%	19.6%	3.2%
OCT-FY18	14.7%	29.0%	2.5%	8.9%	12.1%	1.7%	15.7%	19.4%	3.3%
NOV-FY18	14.8%	28.3%	2.4%	8.8%	12.0%	1.7%	15.4%	19.8%	3.1%
DEC-FY18	14.9%	27.5%	2.4%	8.7%	12.0%	1.7%	15.4%	20.2%	3.0%

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[97]

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

[97] 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: March 21, 2018

From: Deputy Director, VA Southeast Network (10N7)

Subj: CHIP Review of the William Jennings Bryan Dorn VA Medical Center, Columbia, SC

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

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

1. I have had the opportunity to review the Comprehensive Healthcare Inspection Program (CHIP) review of the William Jennings Bryan Dorn VA Medical Center, Columbia, SC.
2. William Jennings Bryan Dorn VA Medical Center submits the attached draft report concurring with recommendations 1-8. I concur with the Draft Report CHIP Review of the Wm. Jennings Bryan Dorn VAMC, Columbia, SC.
3. I appreciate the opportunity for this review as part of a continuing process to improve the care of our veterans.

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: March 15, 2018

From: Director, William Jennings Bryan Dorn VA Medical Center (544/00)

Subj: CHIP Review of the William Jennings Bryan Dorn VA Medical Center, Columbia, SC

To: Director, VA Southeast Network (10N7)

William Jennings Bryan Dorn VA Medical Center would like to thank the Office of the Inspector General Team for the recommendations based on their assessment during the Comprehensive Healthcare Inspections Program Review. I reviewed the response and concur with the facility's findings, recommendations, and submitted action plans.

DAVID L. OMURA, DPT, MHA, MS
MEDICAL CENTER DIRECTOR

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

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