DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection Program Review of the VA Sierra Nevada Health Care System

Reno, Nevada

CHIP REPORT | REPORT #18-00605-174 | MAY 17, 2018

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Figure 1. *VA Sierra Nevada Health Care System, Reno, Nevada*
(Source: https://vaww.va.gov/directory/. Accessed on April 23, 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 VA Sierra Nevada Health Care System (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 consists of the Director, Chief of Staff, Associate Director for Patient Care Services (AD-PCS), and Associate Director. Organizational communication and accountability are carried out through a committee reporting structure with the Quality, Safety, and Value Executive Leadership Board having oversight for leadership groups such as the Environment of Care (EOC), Nursing Executive, Medical Executive, and Quality Executive Councils. The executive leaders are members of the Quality, Safety and Value Executive Leadership Board; it is through this governance structure that they track, trend, and monitor quality of care and patient outcomes.

The Director and Associate Director had been working together since June 2016, but the AD-PCS and Chief of Staff had been in their positions since February and August 2017, respectively. Although the leaders had worked together as a team for less than one year, the OIG noted that they functioned collaboratively, communicated common goals and priorities, and emphasized a transparent and inclusive leadership philosophy and practice. The OIG also noted that Facility leaders implemented processes and plans to develop and maintain a committed workforce and positive patient experiences as evidenced by satisfaction scores.

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 Quality of Care and Efficiency metrics likely contributing to the current "3-Star" rating.

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

Of the eight areas of clinical operations reviewed, the OIG noted findings in five and issued eight recommendations that are attributable to the Director, Chief of Staff, Associate Director for Patient Care Services (AD-PCS), 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.

Quality, Safety, and Value

The OIG found general compliance with requirements for protected peer reviews and utilization management processes.[2] However, the OIG identified a deficiency with annual completions of the required minimum of eight root cause analyses in fiscal year 2017.

Credentialing and Privileging

The OIG found general compliance with credentialing, privileging, and Focused Professional Practice Evaluations. However, the OIG noted a lack of service-specific criteria for Ongoing Professional Practice Evaluations.

Environment of Care

The OIG noted a safe and clean environment of care at both the parent Facility and the representative community based outpatient clinic. The OIG did not note any issues with the availability of medical equipment and supplies. However, the OIG identified deficiencies with EOC rounds and Nutrition and Food Services processes.

Mental Health Care

The OIG noted compliance with providers offering, referring, and completing mental health diagnostic evaluations for patients with positive post-traumatic stress disorder screens. However, the OIG identified a deficiency with the completion of suicide risk assessments by the end of the next business day.

High-Risk Processes

The OIG noted that the Facility had evidence of routine discussions of CLABSI data and prevention measures in committee meeting minutes and tracked and analyzed healthcare-associated bloodstream infections due to central lines. However, the OIG identified a deficiency with staff education.

Summary

In the review of key care processes, the OIG issued eight recommendations that are attributable to the Director, Chief of Staff, AD-PCS, 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

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

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 Acting Veterans Integrated Service Network Director and Acting Facility Director agreed with the CHIP review findings and recommendations and provided acceptable improvement plans. (See Appendixes E and F, pages 53–54, and the responses within the body of the report for the full text of the Acting Directors' comments.) The OIG will follow up on the planned actions until they are completed.

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

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Purpose and Scope

Purpose

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

Scope

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

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

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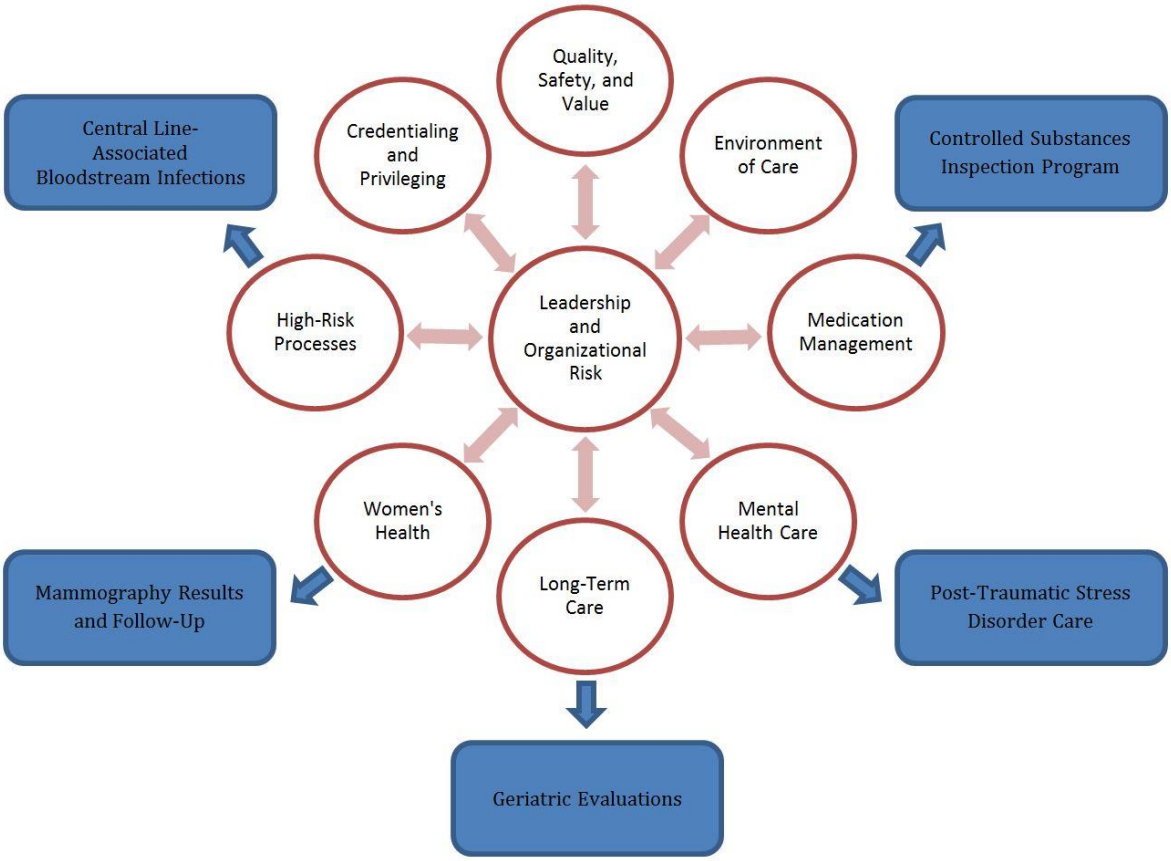
[3] Carol Stephenson, "The role of leadership in managing risk," *Ivey Business Journal*, November/December 2010. https://iveybusinessjournal.com/publication/the-role-of-leadership-in-managing-risk/. (Website accessed on March 1, 2018.)

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

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

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

Figure 2. FY 2018 Comprehensive Healthcare Inspection Program Review of Healthcare Operations and Services



Source: VA OIG

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

Methodology

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

The review covered operations for March 23, 2015,[8] through January 22, 2018, the date when an unannounced week-long site visit commenced. On January 30, 2018, the OIG presented crime awareness briefings to 169 of the Facility's 1,648 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

This report's recommendations for improvement target problems that can impact the quality of patient care significantly enough to warrant OIG follow-up until the Facility completes corrective actions. The 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.

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

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

Results and Recommendations

Leadership and Organizational Risks

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

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

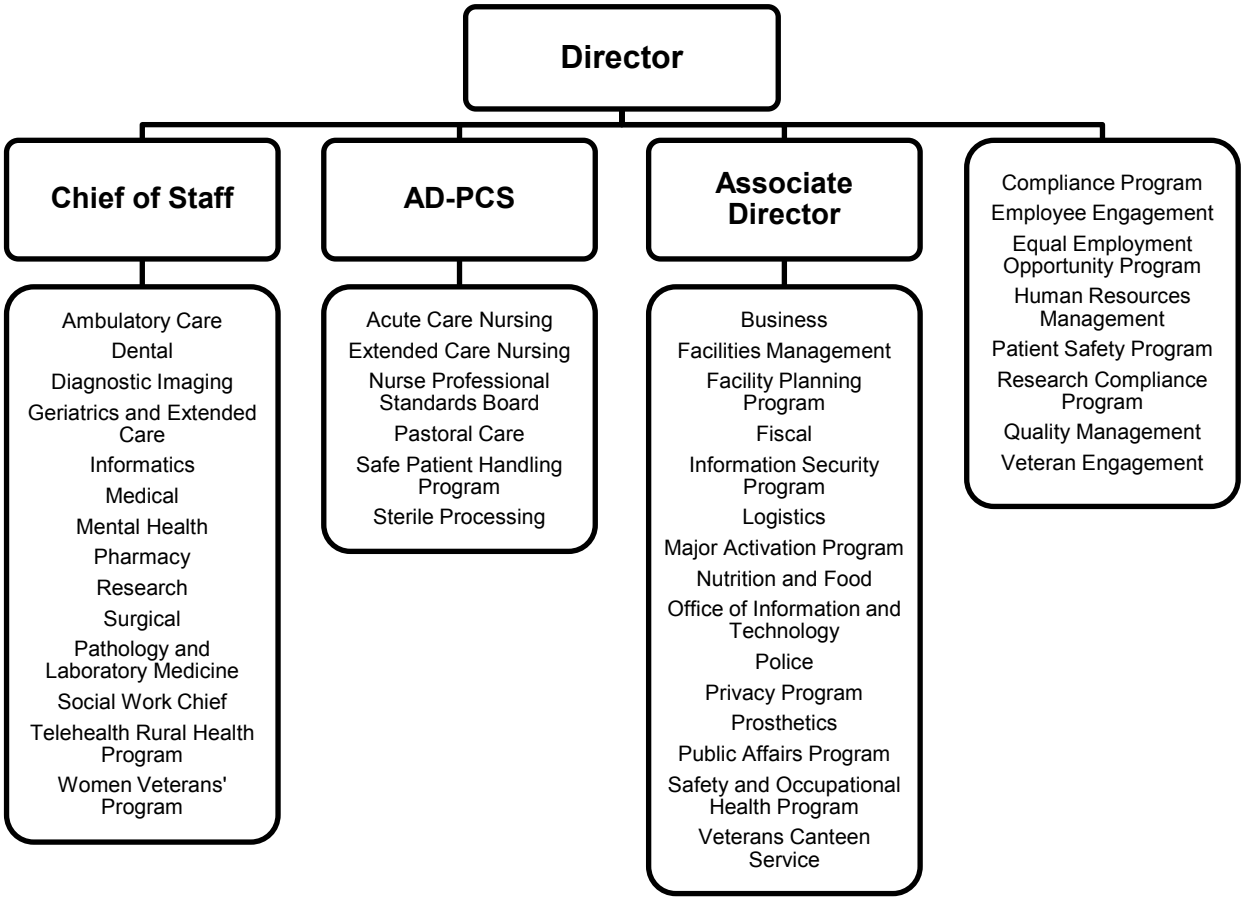
Executive Leadership Stability and Engagement

Because each VA facility organizes its leadership to address the needs and expectations of the local veteran population that it serves, organizational charts may differ among facilities. Figure 3 illustrates the Facility's reported organizational structure. The Facility has a leadership team consisting of the Director, Chief of Staff, Associate Director for Patient Care Services (AD-PCS), and Associate Director. The Chief of Staff and AD-PCS are responsible for overseeing patient care and services.

At the time of OIG visit, the AD-PCS and the Chief of Staff had been in their positions since February and August 2017, respectively. The Director and Associate Director had been working together as executive leaders since June 2016. Although these leaders had worked together as a team for less than one year, the OIG noted the leadership team functioned collaboratively, communicated common goals and priorities, and emphasized a transparent and inclusive leadership philosophy and practice.

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

Figure 3. Facility Organizational Chart



Source: VA Sierra Nevada Health Care System (received January 22, 2018)

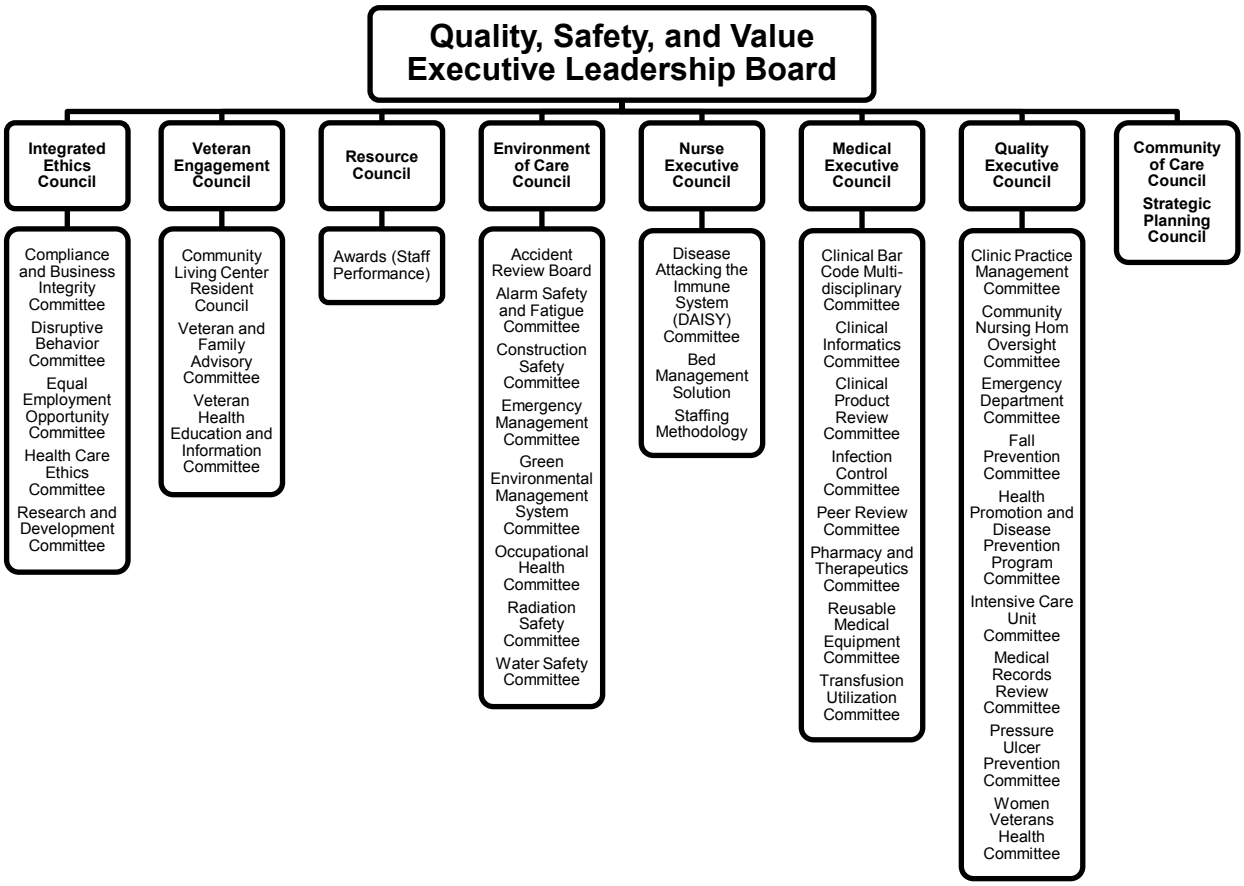
To help assess engagement of Facility executive leadership, the OIG interviewed the Director, Chief of Staff, AD-PCS, and Associate Director regarding their knowledge of various performance metrics and their involvement and support of actions to improve or sustain performance.

In individual interviews, these executive leadership team members spoke knowledgeably about actions taken during the previous 12 months in order to 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 Quality, Safety, and Value Executive Leadership Board, 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 Quality, Safety,

and Value Executive Leadership Board also oversees various working committees, such as the EOC, Nursing Executive, Medical Executive, and Quality Executive Councils. See Figure 4.

Figure 4. Facility Committee Reporting Structure



Source: VA Sierra Nevada Health Care System (received January 23, 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 on VA culture and organizational health. To assess employee and patient attitudes toward Facility leaders, the OIG reviewed employee satisfaction survey results that relate to the period of October 1, 2016, through September 30, 2017, and patient experience survey results that 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.[10] In all, both employees and patients appear generally satisfied with the leadership and care provided.

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

Questions/Survey Items	Scoring	VHA Average	Facility Average	Director's Office Average[11]
All Employee Survey Q59. *How satisfied are you with the job being done by the executive leadership where you work?*	1 (Very Dissatisfied)–5 (Very Satisfied)	3.3	3.5	4.9
All Employee Survey: *Servant Leader Index Composite*	0–100 where HIGHER scores are more favorable	67.7	67.6	93.3

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.

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 higher care ratings than the VHA average.

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

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

Table 2. Survey Results on Patient Attitudes toward Facility Leadership (October 1, 2016, through 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	68.7
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	86.9
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	76.0
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	76.6

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

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

To further assess Leadership and Organizational Risks, the OIG reviewed recommendations from previous inspections by oversight and accrediting agencies to gauge how well leaders respond to identified problems. Table 3 summarizes the relevant Facility inspections most recently performed by the OIG and The Joint Commission (TJC). Indicative of effective leadership, the Facility has closed all recommendations for improvement as listed in Table 3.[13]

[12] The Joint Commission (TJC) conducts for-cause unannounced surveys in response to serious incidents relating to the health and/or safety of patients or staff or reported complaints. The outcomes of these types of activities may affect the current accreditation status of an organization.

[13] A closed status indicates that the Facility has implemented corrective actions and improvements to address findings and recommendations, not by self-certification, but as determined by accreditation organization or inspecting agency.

The OIG also noted the Facility's current accreditation status with the Commission on Accreditation of Rehabilitation Facilities[14] and College of American Pathologists,[15] which demonstrates the Facility leaders' commitment to quality care and services. Additionally, the Long Term Care Institute conducted an inspection of the Facility's Community Living Center.

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

Accreditation or Inspecting Agency	Date of Visit	Number of Findings	Number of Recommendations Remaining Open
OIG (Combined Assessment Program Review of the VA Sierra Nevada Health Care System, Reno, Nevada, June 2, 2015)	March 2015	18	0
OIG (Review of Community Based Outpatient Clinics and Other Outpatient Clinics of) VA Sierra Nevada Health Care System, Reno, Nevada, June 4, 2015	March 2015	5	0
TJC[16]			
• Regular	March 2016		
○ Hospital Accreditation		26	0
○ Nursing Care Center Accreditation		5	0
○ Behavioral Health Care Accreditation		1	0
○ Home Care Accreditation		9	0
• Special Unannounced Event[17]	May 2015	3	0

Sources: OIG and TJC (Inspection/survey results verified with the Director on January 25, 2018)

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

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

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

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.[18]

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

Factor	Number of Occurrences
Sentinel Events[19]	13
Institutional Disclosures[20]	8
Large-Scale Disclosures[21]	0

Source: VA Sierra Nevada Health Care System'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.[22] The rates presented are specifically applicable for this Facility, and lower rates

[18] 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 VA Sierra Nevada Health Care System is a mid-high complexity (1c) affiliated Facility as described in Appendix B.)

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

[20] 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.

[21] 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.

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

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 21	Facility
Pressure ulcers	0.60	0.43	0
Death among surgical inpatients with serious treatable conditions	100.97	62.11	55.56
Iatrogenic pneumothorax	0.19	0.13	0
Central venous catheter-related bloodstream infection	0.15	0.04	0
In-hospital fall with hip fracture	0.08	0.06	0
Perioperative hemorrhage or hematoma	1.94	1.76	0
Postoperative acute kidney injury requiring dialysis	0.88	0.98	0
Postoperative respiratory failure	5.55	4.11	4.40
Perioperative pulmonary embolism or deep vein thrombosis	3.29	4.96	2.01
Postoperative sepsis	4.00	3.30	0
Postoperative wound dehiscence	0.52	0	0
Unrecognized abdominopelvic accidental puncture/laceration	0.53	0.19	0

Source: VHA Support Service Center

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

None of the Patient Safety Indicator measures show an observed rate in excess of the observed rates for VHA.

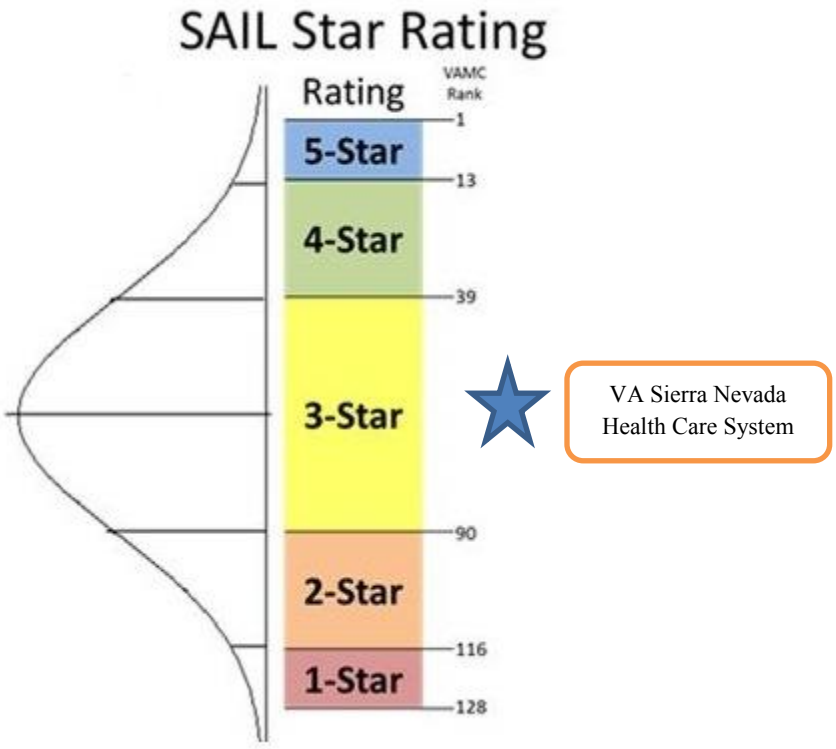
Veterans Health Administration Performance Data

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.[23] As of June 30, 2017, the Facility received a "3-Star" rating for overall quality.

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

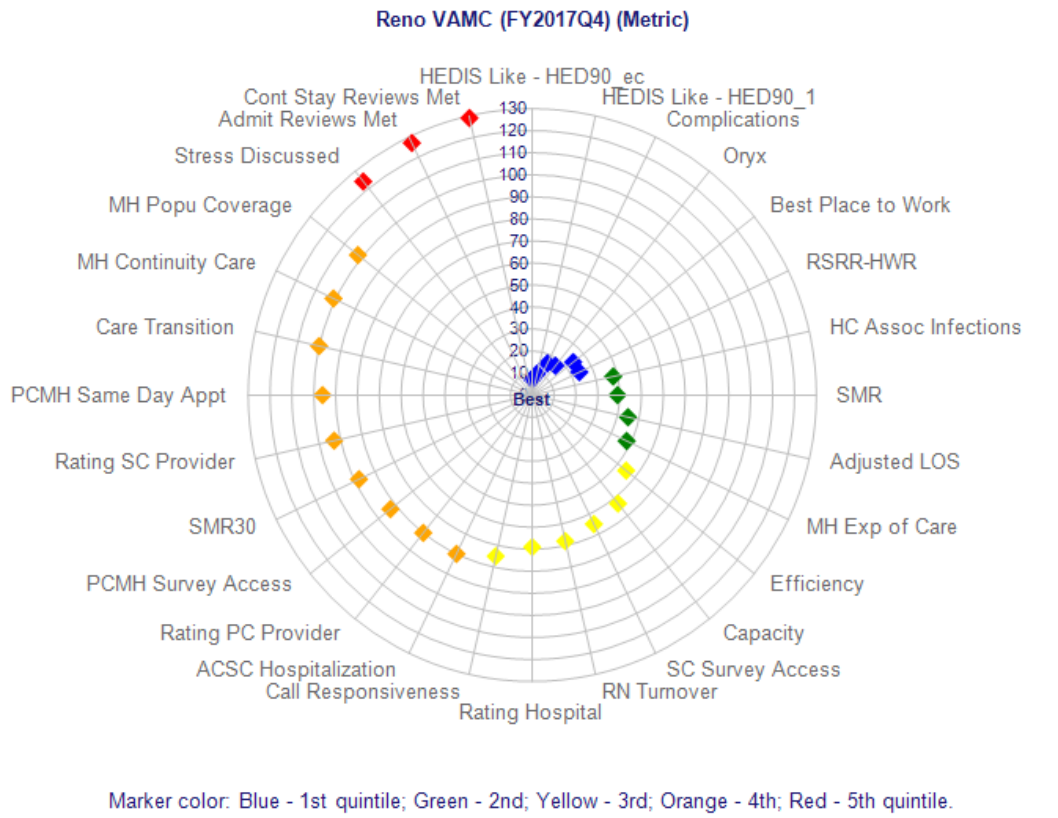


Source: VA Office of Informatics and Analytics' Office of Operational Analytics and Reporting (accessed December 22, 2017)

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, Best Place to Work, and Adjusted Length of Stay [LOS]).[24] Metrics that need improvement are denoted in orange and red (for example, Call Responsiveness, Care Transition, and Continued [Cont] Stay Reviews Met).

[23] Based on normal distribution ranking quality domain of 128 VA Medical Centers.
[24] 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 leaders had worked together as a team for less than one year. However, the OIG noted that the leaders functioned collaboratively, communicated common goals and priorities, and emphasized a transparent and inclusive leadership philosophy and practice. The OIG noted that Facility leaders implemented processes and plans to develop and maintain a committed workforce and positive patient experiences. OIG's review of accreditation organization findings, sentinel events, disclosures, Patient Safety Indicator data, and SAIL results did not identify any substantial organizational risk factors. Although the senior leadership team was knowledgeable about selected SAIL metrics, the leaders should continue to take actions to improve care and performance of selected Quality of Care and Efficiency metrics likely contributing to the "3-Star" ranking.

Quality, Safety, and Value

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

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

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

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

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

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

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

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

[30] VHA Handbook 1050.01.

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

- Protected peer reviews
  - 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[32]
  - Annual completion of a minimum of eight RCAs[33]
  - 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 and UM. However, the OIG identified a deficiency in the completion of root cause analyses that warranted a recommendation for improvement.

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

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

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

Patient Safety

VHA requires facilities to complete at least four individual RCAs and four additional aggregated reviews or individual RCAs during each fiscal year to help identify and mitigate vulnerabilities in their systems of care and to also avoid future occurrences.[34] For FY 2017, the Facility completed five of the eight required root cause analyses, limiting opportunities for the Facility to identify and improve system vulnerabilities. For 11 months[35] in FY 2017, the Patient Safety Manager was also the Acting Chief of Quality Management Service and, due to competing demands, did not identify the deficiency and believed that Facility efforts met requirements.

Recommendation 1

1. The Facility Director requires the Patient Safety Manager to ensure completion of the required minimum of eight root cause analyses each fiscal year and monitors the Patient Safety Manager's compliance.

Facility Concurred.

Target date for completion: 9/30/2018

Facility response: A full-time Patient Safety manager was hired on October 30, 2017. Upon hire, the Patient Safety manager was familiarized with VHA Handbook 1050.01 CHA National Patient Safety Improvement Handbook and the requirement to complete 8 Root Cause Analyses during the fiscal year. Since this date, the Patient Safety manager has already completed 4 root Cause analyses (2 aggregate reviews, and 2 individual analyses).

FY18 Q1: 1 aggregate review completed

FY18 Q2: 1 aggregate review, 1 individual root cause analysis completed

FY18 Q3: 1 root cause analysis currently in progress, at least one root cause analysis, and one aggregate review yet to be completed no later than end of quarter

FY18 Q4: 2 root cause analyses to be completed no later than end of quarter

Quarterly compliance reports will be included in the quarterly Patient Safety report presented to the Quality Executive Council, which is attended by the Director, Associate Director, Chief of Staff, Chief Nurse Exec and Service Chiefs.

[34] VHA Handbook 1050.01.

[35] November 2, 2016, through September 30, 2017.

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).[36]

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.[37]

Clinical privileging is the process by which an LIP is permitted by law and the facility to provide medical care services within the scope of the individual's license. Clinical privileges need to be specific, based on the individual's clinical competence, recommended by service chiefs and the Medical Staff Executive Committee, and approved by the Director. Clinical privileges are granted for a period not to exceed two years, and LIPs must undergo re-privileging prior to the expiration of the held privileges.[38]

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,[39] and 20 LIPs who were re-privileged within 12 months prior to the visit.[40] The OIG evaluated the following performance indicators:

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

[36] VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (Due for recertification October 31, 2017, but has not been updated.)
[37] VHA Handbook 1100.19.
[38] VHA Handbook 1100.19.
[39] The 18-month period was from July 22, 2016, through January 22, 2018.
[40] The 12-month review period was from January 22, 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 selected requirements for credentialing, privileging, and Focused Professional Practice Evaluations. However, the OIG identified a deficiency for Ongoing Professional Practice Evaluations that warranted a recommendation for improvement.

Ongoing Professional Practice Evaluation

VHA requires that at the time of reprivileging, Service Chiefs consider relevant, service- and practitioner-specific data utilizing defined criteria when recommending the continuation of licensed independent practitioners' privileges to the Executive Committee of the Medical Staff.[41] Such data is maintained as part of the practitioner's provider profile and may include direct

[41] VHA Handbook 1100.19.

observations, clinical discussions, and clinical record reviews. This OPPE process is essential to confirm the quality of care delivered and allows the Facility to identify professional practice trends that impact the quality of care and patient safety.

For 17 of 18 applicable provider profiles, there was no evidence of service-specific data collection. As a result, service chiefs used inadequate data to support the decisions to grant clinical privileges to these LIPs. The Credentialing and Privileging Manager and the Chief of Staff reported that they recently identified that some service chiefs had not individualized the service-specific criteria section of the standardized data collection worksheet used for provider evaluation. A lack of attention to detail contributed to this noncompliance.

Recommendation 2

2. The Chief of Staff ensures that service chiefs include service-specific performance data for Ongoing Professional Practice Evaluations and monitors compliance.

Facility Concurred.

Target date for completion: 1/16/2019

Facility response: In accordance with VHA Handbook 1100.19, services perform routine evaluations of each practitioner's clinical care. This occurs every 6-month and at the time of re-credentialing via the Ongoing Professional Practice Evaluation (OPPE) process. At the time of the CHIP survey, some services were using clinical pertinence and OPPE forms that did not specifically identify service-specific performance data.

The Chief of Staff/designee is working with clinical services to ensure all OPPE forms are updated to include service-specific performance data. The updated forms will be presented to the Medical Executive Council for discussion and approval prior to 5/15/2018. The service specific performance OPPE form will be used for all OPPE reviews done after 5/15/2018.

At the next 6-month OPPE review cycle, the Chief of Staff/designee will review random audits of all services' clinical pertinence review forms to assure compliance with VHA Handbook 1100.19. By 1/16/2019, all providers will have one OPPE review done using the service specific performance OPPE form.

Environment of Care

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

The purpose of the OIG review was to determine whether the Facility maintained a clean and safe healthcare environment in accordance with applicable requirements.[43] The OIG also determined whether the Facility met requirements in selected areas that are often associated with higher risks of harm to patients, in this case, with a special emphasis on construction safety[44] and Nutrition and Food Services processes.[45]

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

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

In all, the OIG team inspected six inpatient units (MH B6, critical care, post-anesthesia care, Community Living Center, and medical/surgical units B4 and B5), the Emergency Department, a primary care clinic, and NFS. The team also inspected the Diamond View Outpatient Clinic.[48] There were no applicable active construction projects at the time of the OIG on-site inspection. Additionally, the OIG reviewed the most recent Infection Prevention Risk Assessment, Infection

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

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

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

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

[46] VHA Directive 7715.

[47] VHA Handbook 1109.04.

[48] Each outpatient site selected for physical inspection was randomized from all 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.

Prevention/Control Committee minutes for the past six months, 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
- 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

The performance indicators below did not apply since the Facility had no active construction projects.

- 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[49]

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. However, the OIG identified the following deficiencies with EOC rounds and NFS 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.[50,51] From October 1, 2016, through September 30, 2017, 10 of 13 required members did not consistently participate in EOC rounds. Lack of consistent attendance of subject matter experts increases the risk of missing deficiencies and areas of improvement, which could cause harm to patients, visitors, and staff. Facility managers were aware of requirements but stated that competing priorities and staffing issues contributed to inconsistent participation.

Recommendation 3

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

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

[50] VHA Directive 1608.

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

Facility concurred.

Target date for completion: 1/16/2019

Facility response: All employees responsible for participation in the EOC rounds have been instructed regarding the importance of attendance and participation; this was discussed at the 2/15/2018 Environment of Care Council meeting. Participation is being tracked in the Performance Logic database. To help improve attendance rates, beginning in December 2017, the CBOC Environment of Care inspections were scheduled in conjunction with Leadership CBOC visits.

Monitoring for compliance, as evidenced by attendance records with core team attendance, will be reported at the Quality Executive Council meeting, which is attended by the Director, Associate Director, Chief of Staff, Chief Nurse Exec and Service Chiefs.

This action plan will be considered complete after 90% or greater attendance for two consecutive quarters. Reporting to the Quality Executive Council will be an ongoing requirement; reporting intervals may be modified as 90% or greater compliance is maintained.

Annual Hazard Analysis Critical Control Point Food Safety System Plan

VHA requires that facilities have a Food Safety plan[52] to systematically identify, evaluate, and control food safety hazards. The Facility did not have a Food Safety Plan in place, which compromises the Facility's ability to identify and address safety hazards. The previous NFS Chief did not address the deficiency, and a lack of program oversight resulted in noncompliance. The newly assigned NFS Chief identified the deficiency and was developing a draft plan at the time of the OIG site visit.

Recommendation 4

4. The Associate Director requires the Nutrition and Food Services Chief to develop and implement a Hazard Analysis Critical Control Point Food Safety plan and monitors the Chief's compliance.

Facility concurred.

Target date for completion: 7/12/2018

Facility response: As noted at the CHIP Review, the newly assigned NFS Chief was developing a draft Hazard Analysis Critical Control Point (HACCP) Food Safety Plan at the time of the OIG site visit. The facility Nutrition and Food Services Hazard Analysis Critical Control Point

[52]VHA Handbook 1109.04.

(HACCP) Food Safety Plan containing all required elements will be completed by the Chief, Nutrition and Food Service by 6/22/2018. Upon the plans completion, Food Service staff will receive education on the plan between 6/25/2018 and 7/11/2018 via huddles and one-to-one education. The plan will reside on the Nutrition and Food Service SharePoint for easy access 24/7 by any Nutrition and Food Service staff.

Food Services Inspections

VHA requires that facilities establish a food service-focused inspection process that will be conducted at no less than quarterly intervals.[53] Lack of inspections impedes the Facility's ability to identify and address food safety hazards. There was no evidence that inspections were conducted. A lack of program oversight resulted in noncompliance; however, the newly assigned NFS Chief was in the process of implementing an action plan to address this deficiency.

Recommendation 5

5. The Associate Director requires the Nutrition and Food Services Chief to establish a food service-focused inspection process to occur at no less than quarterly intervals and monitors compliance.

Facility concurred.

Target date for completion: 11/30/2018

Facility response: As documented in the CHIP Report, the newly assigned Nutrition and Food Service (NFS) Chief was in the process of implementing an action plan to address the Food Service-focused inspection process, to be conducted at no less than quarterly intervals. Following the OIG survey, a Food Service inspection was conducted by facility NFS staff on 1/25/2018. As required by VHA Memorandum: Kitchen and Food Production Areas, June 20, 2016, the formal quarterly Food Service-focused inspection process will begin in April 2018.

Monitoring for compliance, as evidenced by at least quarterly Food Service-Focused inspections, will be reported at the Quality Executive Council meeting, which is attended by the Director, Associate Director, Chief of Staff, Chief Nurse Exec and Service Chiefs.

This action plan will be considered complete after three consecutive Food Service-focused inspections have been completed at not less than quarterly intervals. Reporting to the Quality Executive Council will be an ongoing requirement; reporting intervals may be modified after compliance has been demonstrated for three consecutive inspections.

[53] VHA Memorandum, Kitchen and Food Production Areas, June 20, 2016.

Storage Areas

VHA requires that food items are clearly labeled with either the expiration date or date of receipt[54] to optimize food safety and quality. In the food preparation area, the OIG found unlabeled food stored in clear plastic bins. Staff identified that a lack of attention to detail resulted in noncompliance.

Recommendation 6

6. The Associate Director requires the Nutrition and Food Services Chief to ensure that food items are properly labeled and monitors compliance.

Facility concurred.

Target date for completion: 1/16/2019

Facility response: Expiration labeling of the clear plastic bins containing food in the food preparation area was completed on 1/25/2018, to maintain compliance with VHA Handbook 1109.04, Food Service Management Program, October 11, 2013. Nutrition and Food Service (NFS) staff received training on 1/25/2018 in a huddle during the time the OIG was on site. In addition, the Nutrition and Food Service Manager conducted training with the Head Cook, Inventory Specialist and the interim Assistant Inventory Specialist on this labeling process to include the changes in the process of NFS inventory, correct labeling of "use by dates", and First In, First Out (FIO) stocking. A new local policy, "Corrugated Cardboard Cartons and Labeling", document number FS 3.2, was completed on 3/19/2018, based on the VA Nutrition and Food Service FSB (Food Service Board) guidance to the field.

Monitoring for compliance of proper labeling will be done by the new Food Systems Manager, who begins employment 4/15/2018. Weekly spot checks will be done to validate food labels and expiration dates of food items in the plastic bins.

This action plan will be considered complete after 90% or greater compliance for two consecutive quarters. Reporting to the Quality Executive Council, which is attended by the Director, Associate Director, Chief of Staff, Chief Nurse Exec and Service Chiefs will be an ongoing requirement; reporting intervals may be modified as 90% or greater compliance is maintained.

[54]VHA Handbook 1109.04.

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.[55] 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.[56]

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.[57] 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.[58] The OIG team interviewed key managers and reviewed CS inspection reports for the prior two completed quarters;[59] monthly summaries of findings, including discrepancies, provided to the Director for the prior 12 months;[60] CS inspection quarterly trend reports for the prior four quarters;[61] 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

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

[56] 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.)

[57] 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.

[58] 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.

[59] The review period was July through December 2017.

[60] The review period was January through December 2017.

[61] The four quarters were from January 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[62]
- 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

The OIG found general compliance with the above performance indicators. The OIG made no recommendations.

[62] 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."[63] For veterans, the most common traumatic stressor contributing to a PTSD diagnosis is war-zone related stress. Non-war zone military experiences, such as the crash of a military aircraft, may also contribute to the development of PTSD.[64]

The PTSD screen is performed through a required national clinical reminder and is triggered for completion when the patient has his or her first visit at a VHA medical facility. The reminder typically remains active until it is completed.[65] VHA requires that

1. PTSD screening is performed for every new patient and then is repeated every year for the first five years post-separation and every five years thereafter, unless there is a clinical need to re-screen earlier;
2. If the patient's PTSD screen is positive, an acceptable provider must evaluate treatment needs and assess for suicide risk; and
3. If the provider determines a need for treatment, there is evidence of referral and coordination of care.[66]

To assess whether the Facility complied with the requirements related to PTSD screening, diagnostic evaluation, and referral to specialty care, the OIG team reviewed relevant documents and interviewed key employees and managers. Additionally, the OIG reviewed the electronic health records (EHR) of 42 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

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

[64] VHA Handbook 1160.03.

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

[66] VHA Handbook 1160.03.

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

Conclusion

Generally, the OIG noted providers' compliance in offering, referring, and completing MH diagnostic evaluations for patients with positive PTSD screens. However, the OIG identified a deficiency with completion of suicide risk assessment that warranted a recommendation for improvement.

Suicide Risk Assessment

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.[67] The OIG estimated that providers completed suicide risk assessments by the end of the next business day in 69 percent of the EHRs reviewed.[68] The majority of the noncompliant records were found in primary care clinics where the initial PTSD screen and suicide risk assessment were completed by two different staff members. Clinical managers attributed this noncompliance to initiating staff members' inconsistent notification of primary care providers of the patients' positive screens.

Recommendation 7

7. The Chief of Staff ensures that providers complete suicide risk assessments, within the required timeframe, for patients with positive post-traumatic stress disorder screens and monitors the providers' compliance.

Facility concurred.

Target date for completion: 1/16/2019

Facility response: By June 1, 2018, Mental Health Service staff will re-educate Primary Care providers and Transitional Care Management team members on the requirements for completion of a suicide risk assessment for all Veterans with positive PTSD screens. Associate Chief of Staff (ACOS) for Ambulatory Care Service and Deputy ACOS for Ambulatory Care Service will be responsible for continued education for all new providers.

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

[68] The OIG is 95 percent confident that the true rate is somewhere between 54.8 and 81.0 percent, which the OIG determined is statistically significantly below the 90 percent benchmark.

Beginning July 1, 2018, Mental Health Service staff will be responsible for auditing of random chart notes to reflect compliance, as evidenced by completion of the suicide risk assessment for Veterans with positive PTSD screens. The audit results will be reported at the Quality Executive Council meeting, which is attended by the Director, Associate Director, Chief of Staff, Chief Nurse Exec and Service Chiefs.

This action plan will be considered complete after 90% or greater compliance for two consecutive quarters. Reporting to the Quality Executive Council will be an ongoing requirement; reporting intervals may be modified as 90% or greater compliance is maintained.

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.[69] 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.[70] 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.[71]

In 1999, the Veterans Millennium Benefits and Healthcare Act mandated that the veterans' standard benefits package include access to GE.[72] 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.[73] Facility leaders must also evaluate the GE through a review of program objectives, procedures for monitoring care processes and outcomes, and analyses of findings.[74]

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 41 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

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

[70] VHA Directive 1140.04.

[71] 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.

[72] Public Law 106-117.

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

[74] VHA Directive 1140.04.

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

Conclusion

The OIG found general compliance with the above performance indicators. The OIG made no recommendations.

Women's Health: Mammography Results and Follow-Up

In 2017, an estimated 252,710 new cases of invasive breast cancer and 40,610 breast cancer deaths were expected to occur among US women.[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 48 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

[75] U.S. Breast Cancer Statistics. http://www.BreastCancer.org. (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[79]

Conclusion

The OIG found general compliance with the above performance indicators. The OIG made no recommendations.

[79] This performance indicator did not apply to this Facility.

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.[80] 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,"[81] 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.[82]

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 ~~i~~nfection (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."[83]

Infections occurring on or after the third calendar day following admission to an inpatient location are considered "healthcare-associated."[84] 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.[85]

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 16 registered nurses 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

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

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

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

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

[84] 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.

[85] 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

The OIG noted that the Facility had evidence of routine discussions of CLABSI data and prevention measures in committee meeting minutes. The Facility also tracked healthcare-associated bloodstream infections due to central lines and experienced a low incidence of infection. However, the OIG identified a deficiency with staff education that warranted a recommendation for improvement.

Staff Education

TJC requires that staff involved in managing (insertion and maintenance) central lines receive CLABSI and infection prevention education upon hire or granting of initial privileges and periodically thereafter.[86] This ensures that involved staff are aware of what is necessary to prevent central line infections. Failure to educate staff may result in increased incidence of CLABSI. For 2 of 16 registered nurses, there was no evidence of the required training. Clinical leaders were aware of the requirement, but a lack of oversight resulted in noncompliance.

Recommendation 8

8. The Associate Director for Patient Care Services ensures that nursing staff involved in managing central lines receive the required central line-associated bloodstream infection prevention education and monitors staff compliance.

Facility concurred.

Target date for completion: 1/16/2019

Facility Response: Infection Control, Nursing Education, Medicine Service Clinical Administrative Nurse and the Clinical Application Coordinators (CACs) are implementing a

[86]TJC. National Patient Safety Goals (NPSG). NPSG.07.04.01, EP 1, January 2018.

CLABSI prevention education process to ensure nursing staff involved in inserting or maintaining central lines receive the required central line-associated bloodstream infection prevention education and this is monitored for compliance.

The facility Talent Management System (TMS) training module entitled "Infection Control Basics" is being updated to include more in-depth CLABSI training, and then assigned to all clinical personnel who insert or maintain central lines. The module updates have been completed and facility is awaiting TMS to be updated; revised TMS training is anticipated to be available by 5/10/2018.

Monitoring for compliance, as evidenced by TMS training compliance for all nursing staff involved in managing central lines (insertion and maintenance) will be reported monthly by the Chief Nurse Executive/designee at the Quality Executive Council meeting, which is attended by the Director, Associate Director, Chief of Staff, Chief Nurse Executive and Service Chiefs.

This action plan will be considered complete after 90% or greater compliance with TMS training for two consecutive quarters. Reporting to the Quality Executive Council will be an ongoing requirement; reporting intervals may be modified as 90% or greater compliance is maintained.

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 Director, Chief of Staff, AD-PCS, 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	• A minimum of eight RCAs are completed each fiscal year.
Credentialing and Privileging	• Medical licenses • Privileges • FPPEs • OPPEs	• OPPEs include service-specific criteria.	• None

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Environment of Care	• Parent Facility ○ EOC rounds and deficiency tracking ○ Infection prevention ○ General safety ○ Environmental cleanliness ○ General and exam room privacy ○ Availability of medical equipment and supplies • CBOC ○ General safety ○ Medication safety and security ○ Infection prevention ○ Environmental cleanliness ○ General and exam room privacy ○ Availability of medical equipment and supplies • Construction Safety ○ Infection control risk assessment ○ Infection Prevention/ Infection Control Committee discussions ○ Dust control ○ Safety/security ○ Selected requirements based on project type and class • Nutrition and Food Services ○ Annual Hazard Analysis Critical control Point Food Safety System plan ○ Food Services inspections ○ Safe transportation of prepared food ○ Environmental safety ○ Infection prevention ○ Storage areas	• None	• Required team members consistently participate in EOC rounds. • The Nutrition and Food Services Chief develops and implements a Hazard Analysis Critical Control Point Food Safety plan. • The Nutrition and Food Services Chief establishes a food service-focused inspection process to occur at no less than quarterly intervals. • The Nutrition and Food Services Chief ensures food items are properly labeled.

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 post-traumatic stress disorder screens.	• None
Long-Term Care: Geriatric Evaluations	• Program oversight and evaluation • Provision of clinical care • Geriatric management	• None	• None
Women's Health: Mammography Results and Follow-Up	• Result linking • Report scanning and content • Communication of results and recommended actions • Follow-up mammograms and studies	• None	• None
High-Risk Processes: Central Line-Associated Bloodstream Infections	• Policy and infection prevention risk assessment • Committee discussion • Infection incidence data • Education and educational materials • Checklist	• None	• All nursing staff involved in managing central lines receive CLABSI prevention education.

Appendix B: Facility Profile and VA Outpatient Clinic Profiles

Facility Profile

The table below provides general background information for this mid-high-complexity (1c)[87] affiliated[88] Facility reporting to VISN 21.

Table 6. Facility Profile for Reno (654)
(October 1, 2014, through September 30, 2017)

Profile Element	Facility Data FY 2015[89]	Facility Data FY 2016[90]	Facility Data FY 2017[91]
Total Medical Care Budget in Millions	$265.7	$276.4	$286.9
Number of:			
• Unique Patients	32,224	32,806	32,810
• Outpatient Visits	448,715	432,402	421,858
• Unique Employees[92]	1,161	1,248	1,296
Type and Number of Operating Beds:			
• Acute	50	50	50
• Mental Health	14	14	14
• Community Living Center	60	60	60
• Domiciliary	n/a	n/a	n/a
Average Daily Census:			
• Acute	37	36	35
• Mental Health	12	13	12
• Community Living Center	57	55	58
• Domiciliary	n/a	n/a	n/a

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.
n/a = not applicable

[87] 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.
[88] Associated with a medical residency program.
[89] October 1, 2014, through September 30, 2015.
[90] October 1, 2015, through September 30, 2016.
[91] October 1, 2016, through September 30, 2017.
[92] Unique employees involved in direct medical care (cost center 8200).

VA Outpatient Clinic Profiles[93]

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[94] 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[95] Provided	Diagnostic Services[96] Provided	Ancillary Services[97] Provided
Auburn, CA	654GA	7,906	2,334	Dermatology Endocrinology Hematology/ Oncology Neurology Pulmonary/ Respiratory Disease General Surgery Neurosurgery Orthopedics Podiatry Urology	EKG Laboratory & Pathology	Nutrition Pharmacy Prosthetics Weight Management

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

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

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

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

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

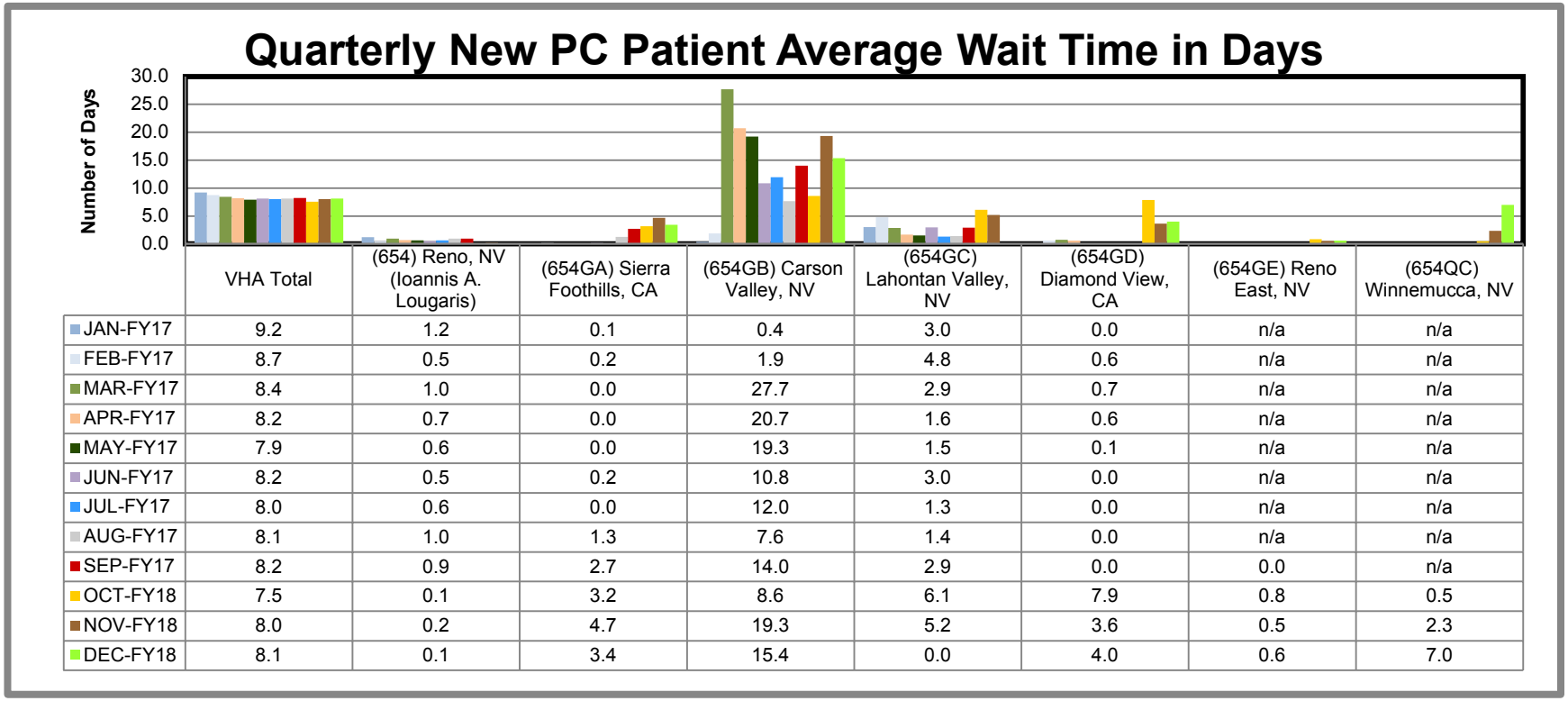
Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services[95] Provided	Diagnostic Services[96] Provided	Ancillary Services[97] Provided
Gardnerville, NV	654GB	6,151	1,544	Dermatology Hematology/ Oncology Pulmonary/ Respiratory Disease Urology	n/a	Pharmacy Weight Management Nutrition
Fallon, NV	654GC	6,970	1,103	Endocrinology Hematology/ Oncology Pulmonary/ Respiratory Disease General Surgery Urology	n/a	Nutrition Pharmacy Weight Management
Susanville, CA	654GD	2,648	660	Dermatology Infectious Disease General Surgery Urology	n/a	Nutrition Pharmacy Weight Management
Reno East, NV	654GE	18	1	n/a	n/a	n/a

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[98]



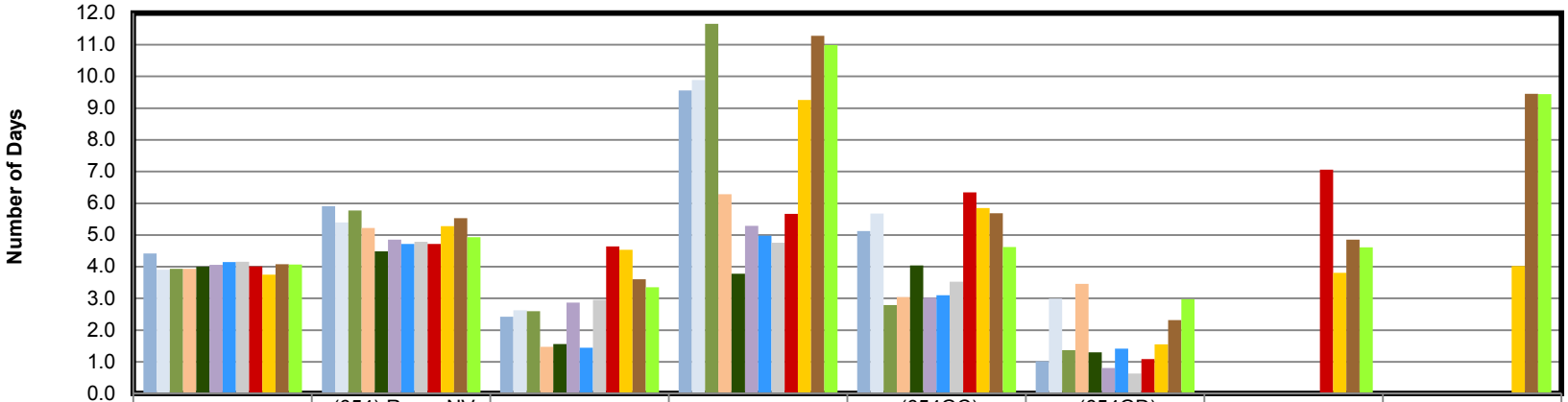
	VHA Total	(654) Reno, NV (Ioannis A. Lougaris)	(654GA) Sierra Foothills, CA	(654GB) Carson Valley, NV	(654GC) Lahontan Valley, NV	(654GD) Diamond View, CA	(654GE) Reno East, NV	(654QC) Winnemucca, NV
JAN-FY17	9.2	1.2	0.1	0.4	3.0	0.0	n/a	n/a
FEB-FY17	8.7	0.5	0.2	1.9	4.8	0.6	n/a	n/a
MAR-FY17	8.4	1.0	0.0	27.7	2.9	0.7	n/a	n/a
APR-FY17	8.2	0.7	0.0	20.7	1.6	0.6	n/a	n/a
MAY-FY17	7.9	0.6	0.0	19.3	1.5	0.1	n/a	n/a
JUN-FY17	8.2	0.5	0.2	10.8	3.0	0.0	n/a	n/a
JUL-FY17	8.0	0.6	0.0	12.0	1.3	0.0	n/a	n/a
AUG-FY17	8.1	1.0	1.3	7.6	1.4	0.0	n/a	n/a
SEP-FY17	8.2	0.9	2.7	14.0	2.9	0.0	0.0	n/a
OCT-FY18	7.5	0.1	3.2	8.6	6.1	7.9	0.8	0.5
NOV-FY18	8.0	0.2	4.7	19.3	5.2	3.6	0.5	2.3
DEC-FY18	8.1	0.1	3.4	15.4	0.0	4.0	0.6	7.0

Source: VHA Support Service Center.

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

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

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

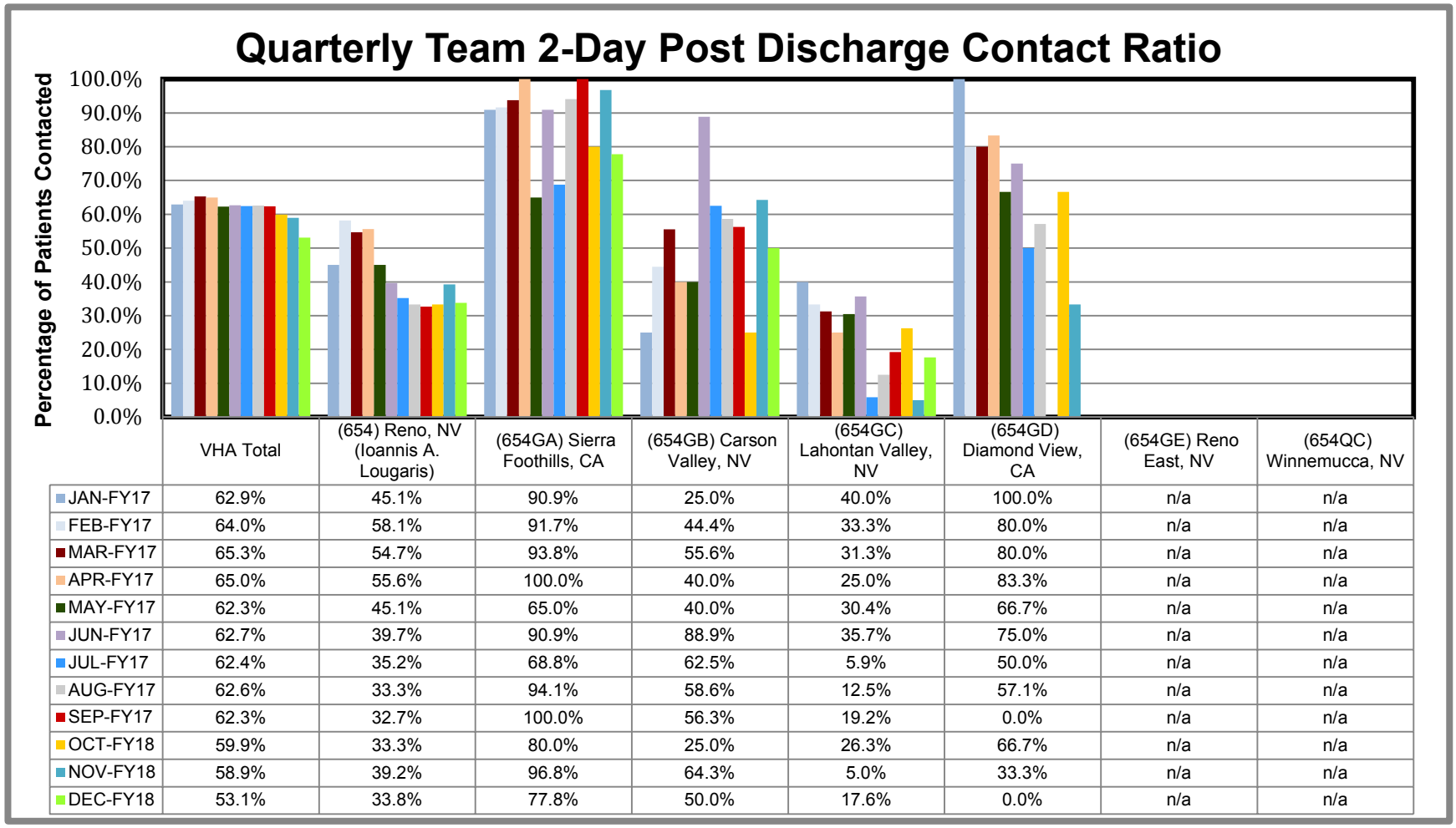


	VHA Total	(654) Reno, NV (Ioannis A. Lougaris)	(654GA) Sierra Foothills, CA	(654GB) Carson Valley, NV	(654GC) Lahontan Valley, NV	(654GD) Diamond View, CA	(654GE) Reno East, NV	(654QC) Winnemucca, NV
JAN-FY17	4.4	5.9	2.4	9.6	5.1	1.0	n/a	n/a
FEB-FY17	3.9	5.4	2.6	9.9	5.7	3.0	n/a	n/a
MAR-FY17	3.9	5.8	2.6	11.7	2.8	1.4	n/a	n/a
APR-FY17	3.9	5.2	1.5	6.3	3.0	3.5	n/a	n/a
MAY-FY17	4.0	4.5	1.6	3.8	4.0	1.3	n/a	n/a
JUN-FY17	4.1	4.9	2.9	5.3	3.0	0.8	n/a	n/a
JUL-FY17	4.1	4.7	1.4	5.0	3.1	1.4	n/a	n/a
AUG-FY17	4.2	4.8	3.0	4.8	3.5	0.6	n/a	n/a
SEP-FY17	4.0	4.7	4.6	5.7	6.3	1.1	7.1	n/a
OCT-FY18	3.7	5.3	4.5	9.3	5.9	1.6	3.8	4.0
NOV-FY18	4.1	5.5	3.6	11.3	5.7	2.3	4.9	9.4
DEC-FY18	4.1	4.9	3.4	11.0	4.6	3.0	4.6	9.4

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. The absence of reported data is indicated by "n/a."*

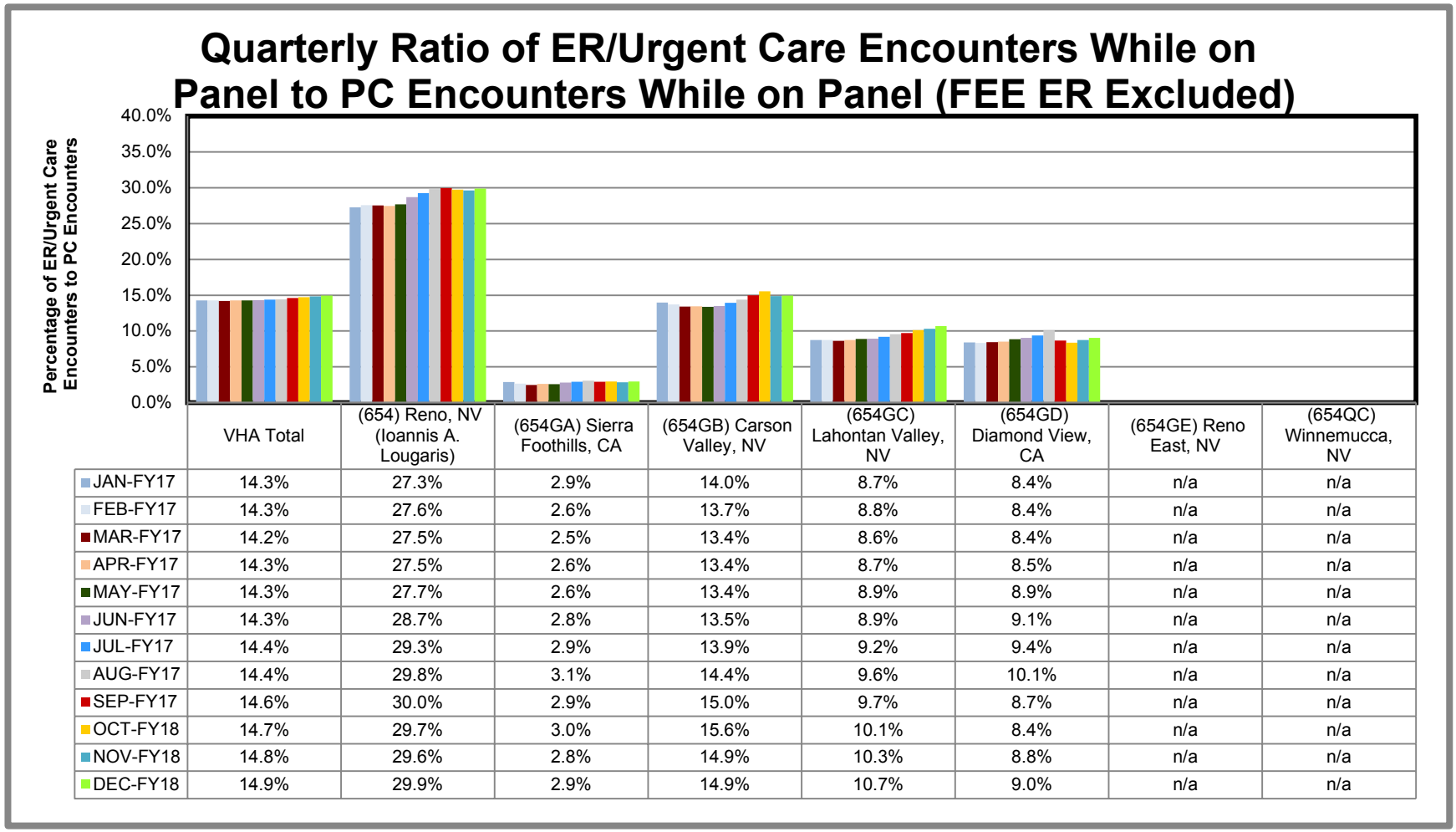


	VHA Total	(654) Reno, NV (Ioannis A. Lougaris)	(654GA) Sierra Foothills, CA	(654GB) Carson Valley, NV	(654GC) Lahontan Valley, NV	(654GD) Diamond View, CA	(654GE) Reno East, NV	(654QC) Winnemucca, NV
JAN-FY17	62.9%	45.1%	90.9%	25.0%	40.0%	100.0%	n/a	n/a
FEB-FY17	64.0%	58.1%	91.7%	44.4%	33.3%	80.0%	n/a	n/a
MAR-FY17	65.3%	54.7%	93.8%	55.6%	31.3%	80.0%	n/a	n/a
APR-FY17	65.0%	55.6%	100.0%	40.0%	25.0%	83.3%	n/a	n/a
MAY-FY17	62.3%	45.1%	65.0%	40.0%	30.4%	66.7%	n/a	n/a
JUN-FY17	62.7%	39.7%	90.9%	88.9%	35.7%	75.0%	n/a	n/a
JUL-FY17	62.4%	35.2%	68.8%	62.5%	5.9%	50.0%	n/a	n/a
AUG-FY17	62.6%	33.3%	94.1%	58.6%	12.5%	57.1%	n/a	n/a
SEP-FY17	62.3%	32.7%	100.0%	56.3%	19.2%	0.0%	n/a	n/a
OCT-FY18	59.9%	33.3%	80.0%	25.0%	26.3%	66.7%	n/a	n/a
NOV-FY18	58.9%	39.2%	96.8%	64.3%	5.0%	33.3%	n/a	n/a
DEC-FY18	53.1%	33.8%	77.8%	50.0%	17.6%	0.0%	n/a	n/a

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." The absence of reported data is indicated by "n/a."*



	VHA Total	(654) Reno, NV (Ioannis A. Lougaris)	(654GA) Sierra Foothills, CA	(654GB) Carson Valley, NV	(654GC) Lahontan Valley, NV	(654GD) Diamond View, CA	(654GE) Reno East, NV	(654QC) Winnemucca, NV
JAN-FY17	14.3%	27.3%	2.9%	14.0%	8.7%	8.4%	n/a	n/a
FEB-FY17	14.3%	27.6%	2.6%	13.7%	8.8%	8.4%	n/a	n/a
MAR-FY17	14.2%	27.5%	2.5%	13.4%	8.6%	8.4%	n/a	n/a
APR-FY17	14.3%	27.5%	2.6%	13.4%	8.7%	8.5%	n/a	n/a
MAY-FY17	14.3%	27.7%	2.6%	13.4%	8.9%	8.9%	n/a	n/a
JUN-FY17	14.3%	28.7%	2.8%	13.5%	8.9%	9.1%	n/a	n/a
JUL-FY17	14.4%	29.3%	2.9%	13.9%	9.2%	9.4%	n/a	n/a
AUG-FY17	14.4%	29.8%	3.1%	14.4%	9.6%	10.1%	n/a	n/a
SEP-FY17	14.6%	30.0%	2.9%	15.0%	9.7%	8.7%	n/a	n/a
OCT-FY18	14.7%	29.7%	3.0%	15.6%	10.1%	8.4%	n/a	n/a
NOV-FY18	14.8%	29.6%	2.8%	14.9%	10.3%	8.8%	n/a	n/a
DEC-FY18	14.9%	29.9%	2.9%	14.9%	10.7%	9.0%	n/a	n/a

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. The absence of reported data is indicated by "n/a."*

Appendix D: Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions[99]

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

[99] 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: Acting VISN Director Comments

Department of Veterans Affairs Memorandum

Date: April 12, 2018

From: Acting Director, Sierra Pacific Network (10N21)

Subj: CHIP Review of the VA Sierra Nevada Health Care System, Reno, NV

To: Director, Los Angeles Office of Healthcare Inspections (54LA)

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

1. Thank you for the opportunity to review the draft report from the Reno facility CHIP review. I concur with the recommendations and responses attached.

2. The VISN will work with the facility to ensure the recommendations are completed and sustained.

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

Appendix F: Acting Facility Director Comments

Department of Veterans Affairs Memorandum

Date: April 11, 2018

From: Acting Director, VA Sierra Nevada Health Care System (654/00)

Subj: CHIP Review of the VA Sierra Nevada Health Care System, Reno, NV

To: Director, Sierra Pacific Network (10N21)

1. We appreciate the opportunity to review the draft report of recommendations for the OIG CHIP Review conducted at the VA Sierra Nevada Health Care System January 22-26, 2018.

2. Please find the attached response to each recommendation included in the report. We are in the process of completing actions to resolve these issues.

Charles Benninger, MN, MHA, CFAAMA
Acting Director

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

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Inspection/Audit/Review Team	Carol Lukasewicz, RN, BSN, Team Leader Stacy DePriest, LCSW, MSW Meredith Magner-Perlin, MPH Laura Owen, LCSW, MSW Simonette Reyes, RN, BSN Erin Stott, RN, MSN Gregory Phelan, Resident Agent in Charge, Office of Investigations
Other Contributors	Limin Clegg, PhD Justin Hanlon, BS Henry Harvey, MS LaFonda Henry, RN-BC, MSN Scott McGrath, BS Jackelinne Melendez, MPA Larry Ross, Jr., MS Marilyn Stones, BS Mary Toy, RN, MSN Robert Wallace, MPH, ScD

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