VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection Program Review of the Phoenix VA Health Care System

Phoenix, Arizona

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Figure 1. *Phoenix VA Health Care System, Phoenix, Arizona*
(Source: https://vaww.va.gov/directory/. Accessed on April 5, 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 Phoenix VA Health Care System (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 February 5, 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), Deputy Director, and Associate Director. Organizational

communication and accountability are carried out through a committee reporting structure, with a Governing Council having oversight for groups such as the Administrative Executive, Clinical Executive, Nursing Executive, and Quality Executive Boards. The leaders are members of the Governing Council through which they track, trend, and monitor quality of care and patient outcomes.

In 2014, the Facility became the focus of VA-wide demands to improve veterans' access to care and wait times. After six Interim Directors, a permanent Director was assigned in October 2016, along with a permanent Chief of Staff. The AD-PCS was permanently assigned in 2015. The Associate and Deputy Directors were assigned in March and April 2017, respectively. Since April 2017, the Facility has had a generally stable executive leadership team.

Facility leaders support patient safety, quality care, and other positive outcomes (such as initiating processes and plans to maintain positive perceptions of the Facility through active stakeholder engagement); however, leaders continue to face a challenging task of rebuilding patient and public trust while improving organizational performance. In the review of selected employee and patient survey results regarding Facility leaders, the OIG noted generally satisfied employees, while opportunities appear to exist to improve patient experiences. The leadership team appears to be committed to efforts to "turn things around."

The OIG did not identify any substantial organizational risk factors from sentinel events and institutional disclosures; however, the OIG is concerned with the number of potential in-hospital complications and adverse events following surgeries and procedures that may contribute to lapses in patient safety unless corrective actions are implemented and continuously monitored.

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] The senior leadership team was knowledgeable about selected SAIL metrics. The leaders recognize that more work is required and that exceptional efforts and actions from committed clinicians are critical to improve care and performance of selected Quality of Care and Efficiency metrics likely contributing to the current "1-Star" rating.

Of the eight areas of clinical operations reviewed, the OIG noted findings in five and issued 13 recommendations that are attributable to the Director, Deputy Director, Chief of Staff, and Associate Director. These are briefly described below.

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[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. However, the OIG identified deficiencies with utilization management and patient safety processes.[2]

Environment of Care

The OIG noted privacy measures were in place at the parent Facility and representative CBOC. The OIG did not identify any issues with the availability of medical equipment and supplies or with construction safety. However, the OIG identified deficiencies with core member participation in EOC rounds, personal protective equipment, and environmental cleanliness. Additionally, the OIG identified deficiencies with environmental safety, proper labeling of stored food items, and temperature monitoring in the dry food storage area in Nutrition and Food Services.

Medication Management

The OIG found general compliance with quarterly reports, annual physical security surveys, ordering procedures, and program coordinators and inspectors having no conflicts of interest and completing required training. However, the OIG identified deficiencies with monthly inspections, inspection patterns, and reconciliation of return to pharmacy stock requirements.

Mental Health Care

The OIG noted compliance with timely completion of suicide risk assessments for patients with positive post-traumatic stress disorder screens. However, the OIG identified a deficiency with providers offering further diagnostic evaluation.

Long-term Care

The OIG noted general compliance with access to geriatric evaluations, program oversight, and program management requirements. The OIG identified a deficiency with the completion of medical evaluations by geriatric evaluation providers.

Summary

In the review of key care processes, the OIG issued 13 recommendations that are attributable to the Director, Chief of Staff, Deputy Director, and Associate Director. The number of recommendations should not be used as a gauge for the overall quality provided at this facility. The intent is for Facility leaders to use these recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues as well as other less-

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

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 Facility Director agreed with the Comprehensive Healthcare Inspection Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes E and F, pages 60–61, and the responses within the body of the report for the full text of the Directors' comments.) The Facility considers recommendations 6 and 8 completed; however, OIG considers all recommendations open until the OIG receives and reviews written documentation of the Facility's completion of the proposed actions. The OIG will follow up on the planned actions until they are completed.

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Assistant Inspector General
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Purpose and Scope

Purpose

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

Scope

Good leadership makes a difference in managing organizational risks by establishing goals, strategies, and priorities to improve care; setting the quality agenda; and promoting a quality improvement culture to sustain positive change.[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**
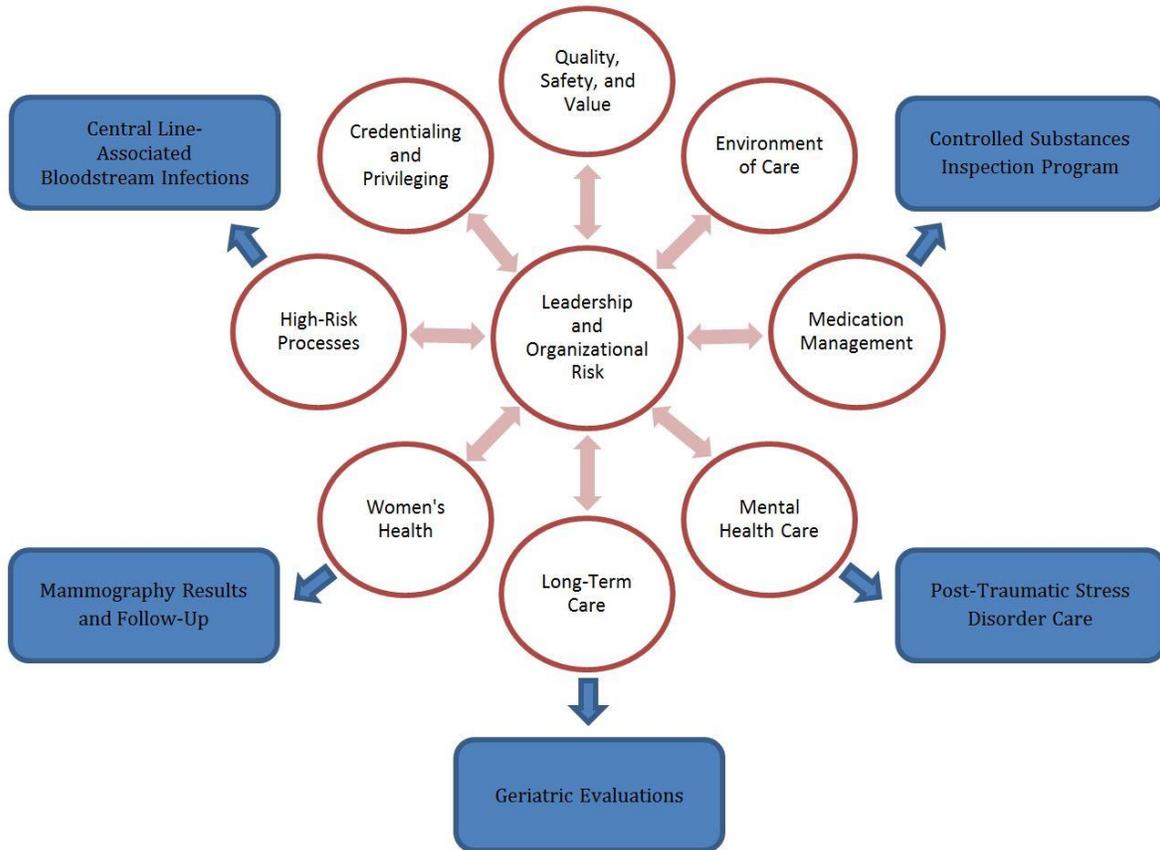
Source: VA OIG

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 9 2015,[8] through February 5, 2018, the date when an unannounced week-long site visit commenced. On March 20–23, 2018, the OIG presented crime awareness briefings to 156 of the Facility's 3,748 employees. These briefings covered procedures for reporting suspected criminal activity to the OIG and included case-specific examples illustrating procurement fraud, conflicts of interest, and bribery.

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

While on site, the OIG did not receive any complaints beyond the scope of the CHIP review. The OIG conducted the inspection in accordance with OIG standard operating procedures for CHIP reviews and *Quality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

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

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

Results and Recommendations

Leadership and Organizational Risks

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

1. Executive leadership stability and engagement,

2. Employee satisfaction and patient experience,

3. Accreditation/for-cause surveys and oversight inspections,

4. Indicators for possible lapses in care, and

5. VHA performance data.

Executive Leadership Stability and Engagement

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

In 2014, allegations of Facility veterans dying while waiting for care sparked a demand for reform VA wide with calls to improve veterans' access to care and wait times.[10] After six Interim Directors in less than three years, a permanent Director and Chief of Staff were assigned in October 2016. The AD-PCS was permanently assigned in 2015. The Associate and Deputy Directors were assigned in March and April 2017, respectively. The leaders have worked together as a team since April 2017.

Facility leaders reported making progress since 2014; however, the Facility continues to struggle to gain patients' and public trust, as evidenced by low patient satisfaction survey results. Despite

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

[10] VA Office of Inspector General, "*Review of Alleged Patient Deaths, Patient Wait Times, and Scheduling Practices at the Phoenix VA Health Care System*," Report No. 14-02603-267, August 26, 2014.

staff comments of continued broken administrative processes, the leadership team appears to be optimistic and committed to "turn things around."

Figure 3. Facility Organizational Chart

Director				
Chief of Staff	**AD-PCS**	**Deputy Director**	**Associate Director**	Compliance Equal Employment Opportunity Quality Safety and Improvement Research Compliance
Audiology & Speech Pathology Clinical Informatics Compensation and Pension Dental Deputy Chief of Staff Education Geriatrics Group Practice Manager Medicine Pathology and Lab Pharmacy Physical Medicine and Rehabilitation Primary Care Psychiatry Psychology Radiology and Nuclear Medicine Research Surgery Women Veterans Program	Chaplain Deputy Nurse Executive Nursing Social Work Sterile Processing	Communications Department Community Managed Care Engineering Fiscal Human Resources Logistics and Contracting Planning Scheduling and Call Center	Business Operations Canteen Environmental Management Information Security Nutrition Office of Information and Technology Patient Advocates Police Privacy Prosthetics Radiation Safety Voluntary	

Source: Phoenix VA Health Care System (February 5, 2018)

To help assess engagement of Facility executive leadership, the OIG interviewed the Director, Chief of Staff, AD-PCS, Deputy Director, 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 generally were able to speak knowledgeably about actions taken during the previous 12 months in order to maintain or improve performance, employee and patient survey results, and selected Strategic Analytics for Improvement and Learning (SAIL) metrics. These are discussed more fully below.

The leaders are also engaged in monitoring patient safety and care through formal mechanisms. They are members of the Facility's Governing Council, 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 Governing Council also oversees various working committees, such as the Administrative Executive, Clinical Executive, Nursing Executive, Quality Executive, and Medical Executive Boards. See Figure 4.

Figure 4. Facility Committee Reporting Structure
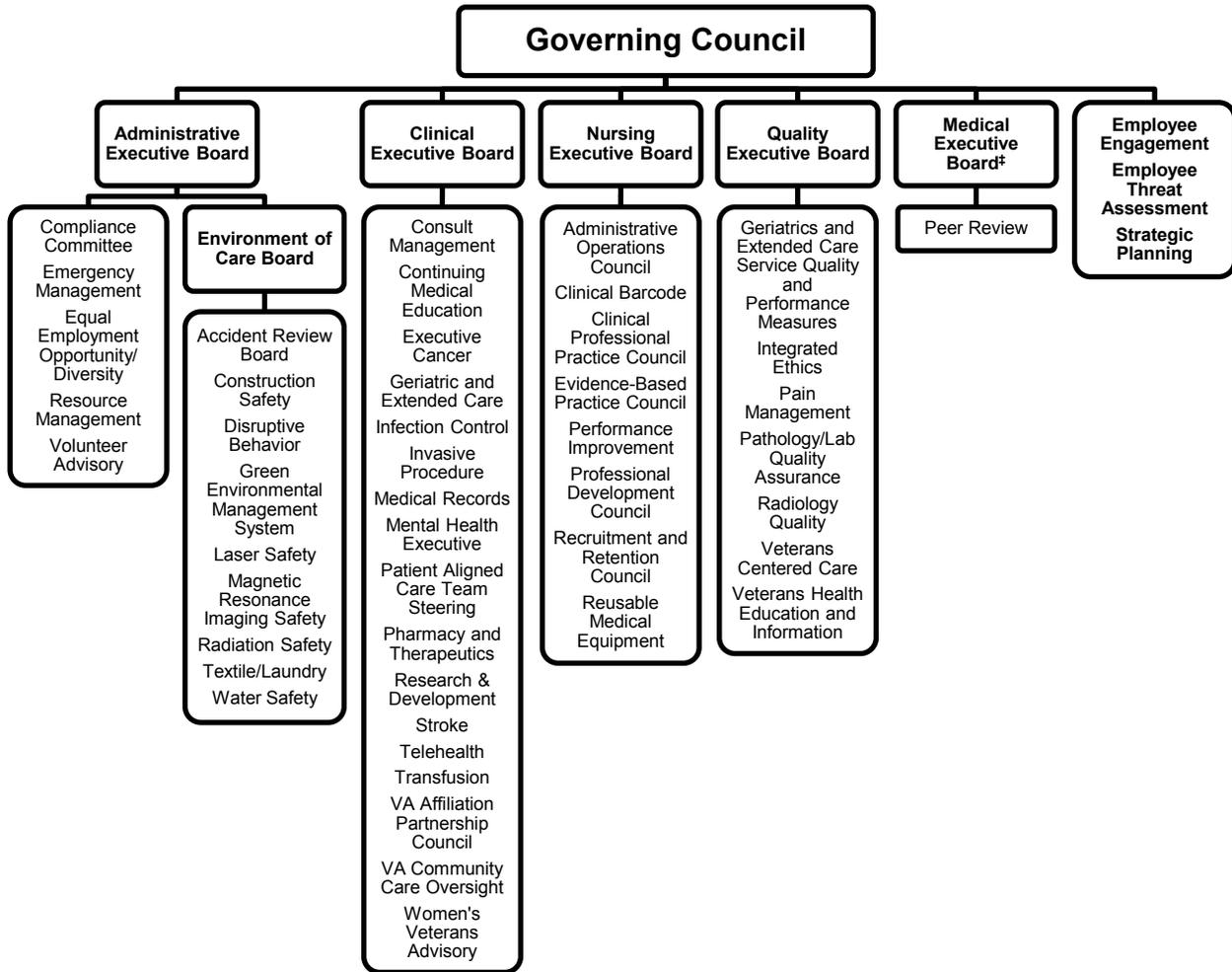
Source: Phoenix VA Health Care System (received January 5, 2018)

‡ *The Medical Executive Board reports to the Director.*

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.[11] In all, employees appear generally satisfied with the leadership, while opportunities exist to continue to improve both inpatient and outpatient experiences.

Table 1. Survey Results on Employee Attitudes toward Facility Leadership[12] (October 1, 2016, through September 30, 2017)

Questions/Survey Items	Scoring	VHA Average	Facility Average	Director's Office Average[13]
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	3.2	4.2
All Employee Survey: *Servant Leader Index Composite*	0–100 where HIGHER scores are more favorable	67.7	66.4	80.5

Source: VA All Employee Survey (accessed January 4, 2018)

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.

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[11] 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.

[12] The All Employee Survey is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential. The instrument has been refined at several points since 2001 in response to operational inquiries by VA leadership on organizational health relationships and VA culture.

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

VHA collects SHEP survey data from Patient-Centered Medical Home, Specialty Care, and Inpatient Surveys. From these, the OIG selected four survey items that reflect patient attitudes toward Facility leaders. For this Facility, all four patient survey results reflected lower care ratings than the VHA average. Although the OIG noted improvements in three of the four patient survey results when compared to the previous year's survey results,[14] multiple opportunities continue to exist to improve patient satisfaction with care provided.

Table 2. Survey Results on Patient Attitudes toward Facility Leadership[15] (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	55.2
Survey of Healthcare Experiences of Patients (inpatient): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	83.4	74.4
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	74.9	66.8
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	63.1

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed January 4, 2018)

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[14] Improvements were noted when comparing patient survey results from fiscal years 2016 (October 1, 2015, through September 30, 2016) and 2017 (October 1, 2016, through September 30, 2017).

[15] VHA's Patient Experiences Survey Reports provide results from surveys administered by the Survey of Healthcare Experience of Patients (SHEP) program. Industry standard surveys from the Consumer Assessment of Healthcare Providers and Systems program are utilized to evaluate patients' experiences of their health care and to support the goal of benchmarking VHA performance against the private sector. VHA collects SHEP survey data from Patient-Centered Medical Home, Specialty Care, and Inpatient Surveys.

Accreditation/For-Cause Surveys[16] 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). The Facility has closed all recommendations for improvement as listed in Table 3.[17]

The OIG also noted the Facility's current accreditation status with the Commission on Accreditation of Rehabilitation Facilities[18] and College of American Pathologists,[19] 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.[20]

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 Phoenix VA Health Care System, Phoenix, Arizona, June 4, 2015*)	March 2015	11	0
OIG (*Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Phoenix VA Health Care System, Phoenix, Arizona, June 4, 2015*)	March 2015	11	0
OIG (*Healthcare Inspection – Access to Urology Service, Phoenix VA Health Care System, Phoenix, Arizona, October 15,*	August 2014 January 2015	3	0

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[16] 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.

[17] 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.

[18] 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.

[19] 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.

[20] Since 1999, the Long Term Care Institute has been to over 3,500 healthcare facilities conducting quality reviews and external regulatory surveys. The Long Term Care Institute is a leading organization focused on long-term care quality and performance improvement; compliance program development; and review in long-term care, hospice, and other residential care settings.

Accreditation or Inspecting Agency	Date of Visit	Number of Findings	Number of Recommendations Remaining Open
2015)			
OIG (*Healthcare Inspection – Access and Quality of Care Concerns, Phoenix VA Health Care System, Phoenix, Arizona and Delayed Test Result Notification, Minneapolis VA Health Care System, Minneapolis, Minnesota, June 23, 2016*)	June–July 2015	7[21]	0
OIG (*Healthcare Inspection – Delay in Care of a Lung Cancer Patient, Phoenix VA Health Care System, Phoenix, Arizona, September 30, 2015*)	April 2015	7	0
OIG (*Healthcare Inspection – Follow-Up Review, Access to Urology Service, Phoenix VA Health Care System, Phoenix, Arizona, August 14, 2017*)	n/a	0	n/a
TJC[22]			
• Regular	December 2017		
o Hospital Accreditation		43	0
o Behavioral Health Care Accreditation		6	0
o Home Care Accreditation		7	0
• Follow Up	March 2018	0	n/a

Sources: OIG and TJC (Inspection/survey results verified with the Director on February 6, 2018)

n/a – not applicable

Indicators for Possible Lapses in Care

Within the healthcare field, the primary organizational risk is the potential for patient harm. Many factors impact the risk for patient harm within a system, including unsafe environmental conditions, sterile processing deficiencies, and infection control practices. Leaders must be able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms. Table 4 summarizes key indicators of risk since the OIG's previous

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[21] Recommendations 3–9 were directed to the Phoenix VA Health Care System.

[22] 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.

March 2015 Combined Assessment Program and Community Based Outpatient Clinic (CBOC) and Other Outpatient Clinics review inspections through the week of February 5, 2018.[23]

Table 4. Summary of Selected Organizational Risk Factors (March 2015 to February 5, 2018)

Factor	Number of Occurrences
Sentinel Events[24]	4
Institutional Disclosures[25]	12
Large-Scale Disclosures[26]	0

Source: Phoenix VA Health Care System's Patient Safety Manager (received February 7, 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.[27] The rates presented are specifically applicable for this Facility, and lower rates indicate lower risks. Table 5 summarizes Patient Safety Indicator data from October 1, 2015, through September 30, 2017.

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[23] 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 Phoenix VA Health Care System is a high complexity (1b) affiliated Facility as described in Appendix B.)

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

[25] 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.

[26] 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.

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

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

Measure	Reported Rate per 1,000 Hospital Discharges		
	VHA	VISN 22	Facility
Pressure ulcers	0.60	0.57	1.46
Death among surgical inpatients with serious treatable conditions	100.97	98.20	113.21
Iatrogenic pneumothorax	0.19	0.17	0.21
Central venous catheter-related bloodstream infection	0.15	0.04	0.00
In-hospital fall with hip fracture	0.08	0.05	0.13
Perioperative hemorrhage or hematoma	1.94	1.17	0.55
Postoperative acute kidney injury requiring dialysis	0.88	0.88	1.81
Postoperative respiratory failure	5.55	5.20	6.47
Perioperative pulmonary embolism or deep vein thrombosis	3.29	3.09	4.67
Postoperative sepsis	4.00	4.25	2.03
Postoperative wound dehiscence	0.52	0.30	0.00
Unrecognized abdominopelvic accidental puncture/laceration	0.53	0.21	0.00

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

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

Seven of the 12 Patient Safety Indicator measures (pressure ulcers, death among surgical inpatients with serious treatable conditions, iatrogenic pneumothorax, in hospital fall with hip fracture, postoperative acute kidney injury requiring dialysis, postoperative respiratory failure, and postoperative sepsis) show observed rates in excess of the observed rates for Veterans Integrated Service Network (VISN) 22 and VHA. The OIG is concerned with the number of measures above VHA and VISN observed rates because the presence of these risk factors may contribute to future lapses in patient safety unless corrective processes are implemented and continuously monitored.

At the time of the OIG visit, the Facility had not implemented a routine review of the Patient Safety Indicator measures because of competing priorities and limited resources. The QSV Chief stated that the Facility routinely reviews patient safety such as patient incidents, the VA Surgical Quality Improvement Program database, and quality measures from external accrediting

agencies (National Committee for Quality Assurance[28] and TJC). Beginning in April 2018, Facility leaders plan to implement a quarterly review of Patient Safety Indicators and report the results of the review to the Quality Executive Board.

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.[29] 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.[30] As of June 30, 2017, the Facility was rated at "1-Star"for overall quality.

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[28] An independent, non-profit organization in the U.S that works to improve health care quality through the administration of evidence-based standards, measures, programs, and accreditation. http://www.ncqa.org/HomePage.aspx. (Website accessed on March 8, 2018.)

[29] The model is derived from the Thomson Reuters Top Health Systems Study.

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

**Figure 5. Strategic Analytics for Improvement and
Learning Star Rating Distribution (as of June 30, 2017)**
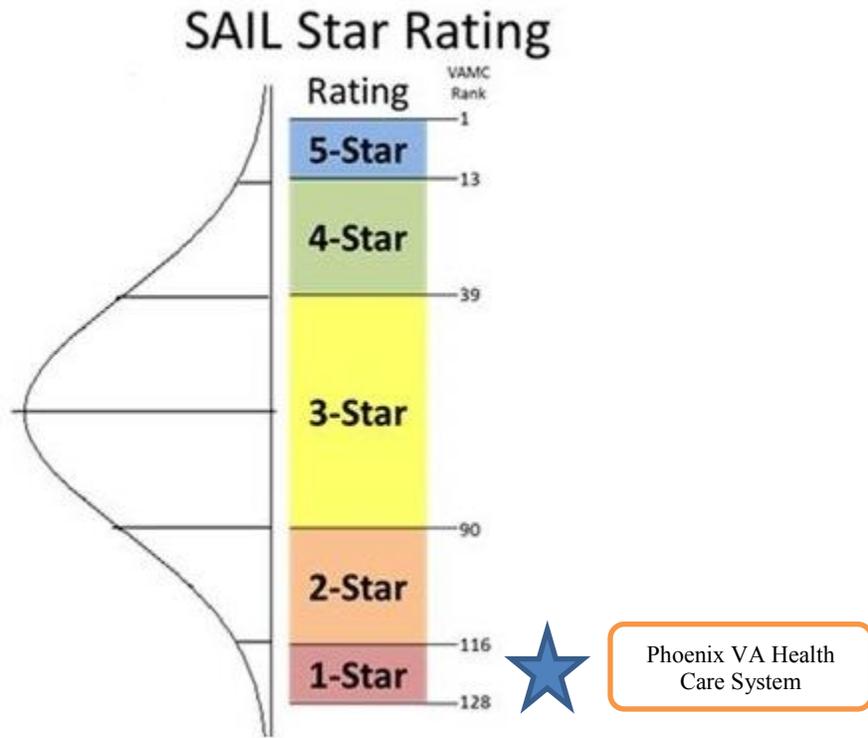
*Source: VA Office of Informatics and Analytics' Office of
Operational Analytics and Reporting (accessed January
4, 2018)*

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 Oryx [inpatient performance measures], Registered Nurse (RN) Turnover, and Ambulatory Care Sensitive Conditions (ASCS) Hospitalization).[31] Metrics that need improvement are denoted in orange and red (for example, Healthcare (HC) Associated (Assoc) Infections, Best Place to Work, Rating (of) Hospital, and Rating (of) Specialty Care (SC) Provider).

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[31] 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)**
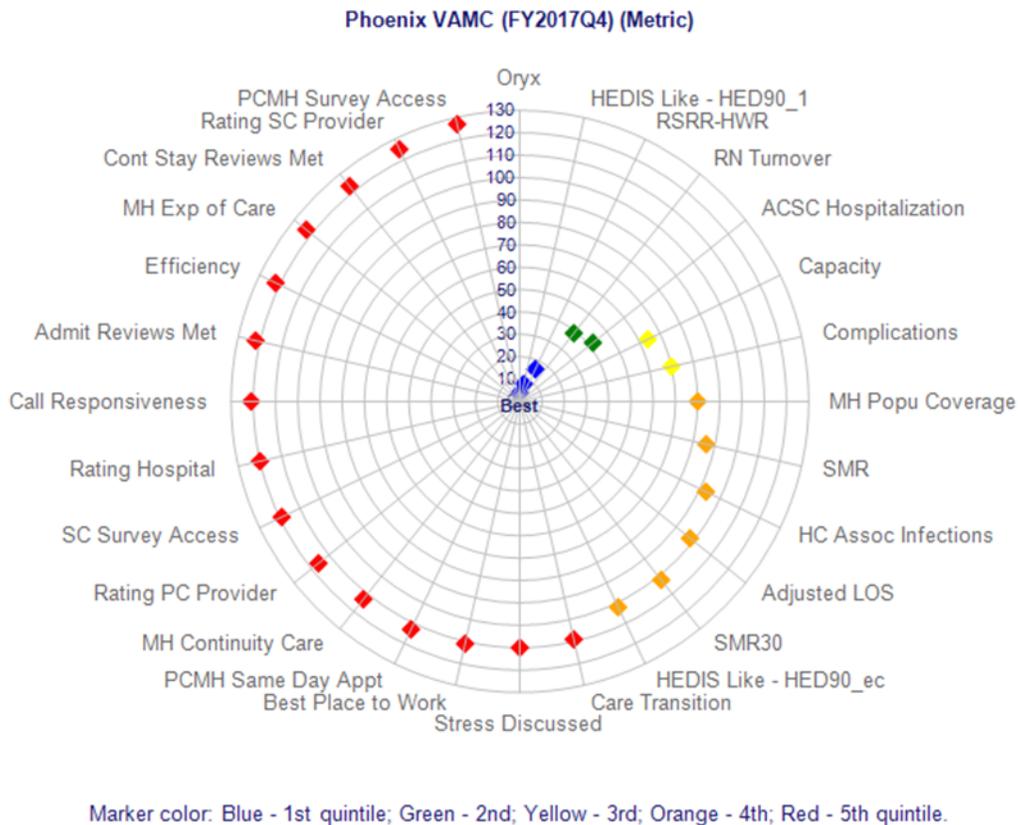
Marker color: Blue - 1st quintile; Green - 2nd; Yellow - 3rd; Orange - 4th; Red - 5th quintile.

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

In 2014, the Facility became the focus of VA-wide demands to improve veterans' access to care and wait times. After six Interim Directors, a permanent Director was assigned in October 2016, along with a permanent Chief of Staff. The AD-PCS was permanently assigned in 2015. The Associate and Deputy Directors were assigned in March and April 2017, respectively.

Facility leaders support patient safety, quality care, and other positive outcomes (such as initiating processes and plans to maintain positive perceptions of the Facility through active stakeholder engagement); however, leaders are aware that they face a challenging task of rebuilding patient and public trust while improving organizational performance. The leadership team appears to be committed to "turn things around."

The leadership team appeared knowledgeable about selected SAIL metrics and acknowledged that ongoing efforts, commitment, and actions are critical to improve care and performance of selected Quality of Care and Efficiency metrics likely contributing to the "1-Star" ranking.

The OIG did not identify any substantial organizational risk factors from sentinel events and institutional disclosures; however, the OIG is concerned with the low patient survey results with care provided and high rates of in-hospital complications and adverse events (Table 5) following surgeries and procedures. Unless corrective processes are implemented and continuously monitored, these may contribute to future issues of lapses in patient safety.

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.[32] VHA also strives to provide healthcare services that compare favorably to the best of the private sector in measured outcomes, value, and efficiency.[33]

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,[34] utilization management (UM) reviews,[35] and patient safety incident reporting with related root cause analyses (RCAs).[36]

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.[37]

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

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

[34] 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.)

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

[36] 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.

[37] 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:[38]

- Protected peer reviews

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

  o Implementation of improvement actions recommended by the Peer Review Committee

- UM

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

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

  o Interdisciplinary review of UM data

- Patient safety

  o Entry of all reported patient incidents into WebSPOT[39]

  o Annual completion of a minimum of eight RCAs[40]

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

  o Submission of annual patient safety report

Conclusions

The OIG found general compliance with requirements for protected peer reviews. However, the OIG identified deficiencies with UM documentation and patient safety, which warranted recommendations for improvement.

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

[39] 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.

[40] 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.

Utilization Management: Documentation of Decisions

VHA requires that Physician UM Advisors document their decisions in the National UM Integration database regarding appropriateness of patient admissions and continued stays.[41] This allows for national level UM data to be available for review by an interdisciplinary group to set benchmarks; identify trends, actions, and opportunities to improve efficiency; and monitor outcomes. In 366 of the 462 cases (79 percent) referred to the physician advisors from November 15, 2017, through January 15, 2018, there was no evidence that advisors documented their decisions in the database. Facility staff stated that position vacancies, clinical responsibilities, and the lack of permanently assigned Physician UM Advisors contributed to the noncompliance.

Recommendation 1

1. The Facility Director ensures Physician Utilization Management Advisors consistently document their decisions in the National Utilization Management Integration database and monitors the advisors' compliance.

Facility Concurred.

Target date for completion: August 30, 2018

Facility response: The PUMA position was filled and continues to complete required reviews. A marked improvement in NUMI documentation, with an increase to 84% as of February 2018 was recognized. The target compliance rate is 80%. NUMI documentation and metrics will be monitored and reported monthly to Clinical Executive Board (CEB) to ensure target goal is sustained.

Patient Safety Events

VHA requires that patient safety events be reported and documented in WebSPOT.[42] This process provides data that is used to track and trend patient safety incidents across VHA. For FY 2017, a total of 1,177 electronic patient incidents were reported; however, only 792 (67 percent) were entered into WebSPOT. This resulted in incomplete data for VHA tracking, trending, and analysis. Facility staff reported that the patient safety manager vacancies made it difficult to maintain compliance with this requirement; however, in July and August 2017, the Facility leaders hired two full-time patient safety managers whose responsibilities include maintenance of accurate patient incident data in the WebSPOT database.

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[41] VHA Directive 1117.

[42] VHA Handbook 1050.01.

Recommendation 2

2. The Facility Director ensures all patient incidents are entered into WebSPOT and monitors compliance.

Facility concurred.

Target date for completion: July 1, 2018

Facility response: Patient Safety managers will close and enter all pertinent WEBSPOT patient safety events from October 1, 2017, to March 31, 2018, by July 1, 2018. Patient Safety will close all new events within 7 days. PVAHCS received 937 ePERS in FY2018. Patient Safety Managers have 82 ePERS left to enter to meet the requirements of this recommendation.

Electronic Patient Safety Events (ePER) transitioned to Joint Patient Safety Reporting (JPSR) permanently beginning April 1, 2018. National Center for Patient Safety (NCPS) has stated the ePER system will close permanently July 1, 2018. JPSR directly links all completed events to the WEBSPOT; therefore, the entry into WEBSPOT will be automated starting April 1, 2018.

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).[43]

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.[44]

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.[45]

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,[46] and 20 LIPs who were re-privileged within 12 months prior to the visit.[47] The OIG evaluated the following performance indicators:

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

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

[44] VHA Handbook 1100.19.

[45] VHA Handbook 1100.19.

[46] The 18-month period was from August 5, 2016, through February 5, 2018.

[47] The 12-month review period was from February 5, 2017, through February 5, 2018.

- - Facility-specific

  - Service-specific

  - Provider-specific

  o Service chief recommendation of approval for requested privileges

  o Medical Staff Executive Committee decision to recommend requested privileges

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

- Focused Professional Practice Evaluation (FPPE)

  o Evaluation initiated

    - Timeframe clearly documented

    - Criteria developed

    - Evaluation by another provider with similar training and privileges

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

- Ongoing Professional Practice Evaluation (OPPE)

  o Determination to continue privileges

    - Criteria specific to the service or section

    - Evaluation by another provider with similar training and privileges

    - Medical Staff Executive Committee decision to recommend continuing privileges

Conclusion

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

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.[48]

The purpose of the OIG review was to determine whether the Facility maintained a clean and safe healthcare environment in accordance with applicable requirements.[49] 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[50] and Nutrition and Food Services processes.[51]

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.[52]

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.[53]

In all, the OIG team inspected six inpatient units (medical/surgical 2B and 3C, critical care, pre-operative and post-anesthesia care, locked MH, and Community Living Center), the Emergency Department, the primary care Emerald clinic, and a surgical specialty clinic. The OIG also inspected the Nutrition/Food Service, five construction sites, and the Thunderbird CBOC.[54] The OIG reviewed the most recent Infection Prevention Risk Assessment, Infection

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

[49] 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).

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

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

[52] VHA Directive 7715.

[53] VHA Handbook 1109.04.

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

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

    o EOC rounds

    o EOC deficiency tracking

    o Infection prevention

    o General safety

    o Environmental cleanliness

    o General privacy

    o Women veterans' exam room privacy

    o Availability of medical equipment and supplies

- Community Based Outpatient Clinic

    o General safety

    o Medication safety and security

    o Infection prevention

    o Environmental cleanliness

    o General privacy

    o Exam room privacy

    o Availability of medical equipment and supplies

- Construction Safety

    o Completion of infection control risk assessment for all sites

    o Infection Prevention/Infection Control Committee discussions on construction activities

    o Dust control

    o Safety and security

- o Selected requirements based on project type and class[55]
- Nutrition and Food Services
  - o Annual Hazard Analysis Critical Control Point Food Safety System plan
  - o Food Services inspections
  - o Emergency operations plan for food service
  - o Safe transportation of prepared food
  - o Environmental safety
  - o Infection prevention
  - o Storage areas

Conclusions

Privacy measures were in place at the parent Facility and representative CBOC. The OIG did not identify any issues with the availability of medical equipment and supplies, and Construction Safety met the performance indicators reviewed. However, the OIG noted deficiencies with EOC rounds attendance, general cleanliness, and personal protective equipment availability. The OIG also noted Nutrition and Food Services did not meet requirements for environmental safety, proper labeling of stored food items, and temperature monitoring in the dry food storage area.

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 of care environment.[56] From October 1, 2016, through September 30, 2017, 6 of 13 required members did not consistently attend rounds, resulting in a lack of subject matter experts on EOC rounds. Facility managers were aware of the requirements, but vacancies and competing priorities prevented compliance.

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[55] 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.

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

Recommendation 3

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

Facility concurred.

Target date for completion: July 31, 2018

Facility response: On April 12, 2018, PVAHCS changed its environment of care (EOC) rounding participation roster to ensure compliance with VHA Directive 1608. PVAHCS mandates that each of the 13 core EOC rounding members achieve 85% or greater participation as noted in the VHA Directive.

The EOC Committee (EOCC) dashboard, which includes EOC rounding participation, is reported to EOCC monthly, which in turn report the dashboard monthly to the Administrative Executive Board (AEB). The AEB will ensure attendance and participation in environment of care rounds and identify the appropriate Pentad leader to resolve attendance issues as they arise.

Parent Facility and Community Based Outpatient Clinic General Safety: Personal Protective Equipment

Occupational Safety and Health Administration requires employers to ensure appropriate personal protective equipment is readily accessible at the worksite.[57] This prevents exposure to, and possible infection from, bloodborne pathogens and other potentially infectious materials. For nine patient care areas inspected,[58] the Facility did not provide readily accessible employee gowns. Clinical managers believed that gowns stored in a locked clean supply room met requirements.

Recommendation 4

4. The Deputy Director and Associate Director ensure personal protective equipment is readily accessible and monitor compliance.

Facility concurred.

Target date for completion: June 30, 2018

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[57] 29 CFR 1910, Occupational Safety and Health Standards.
https://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=STANDARDS&p_id=10051. (Website accessed on February 15, 2018.)

[58] Medical/surgical 2C and 3B, critical care, pre-operative and post-anesthesia care, and Community Living Center units; a surgical specialty and primary care Emerald clinics; the Emergency Department; and the Thunderbird CBOC.

Facility response: The Deputy Medical Center Director will ensure that a review of all clinical areas is completed with assessment of personal protective equipment (PPE) and adequate accessibility in all work areas.

Parent Facility's Environmental Cleanliness

TJC requires hospitals to maintain and continually monitor the environment and remediate conditions to ensure a clean and safe environment.[59] The OIG noted that five of nine patient care areas[60] had dirty floors and/or debris present. Facility leaders were aware of the deficiencies and failed to take necessary actions to ensure compliance.

Recommendation 5

5. The Associate Director ensures that a clean environment is maintained throughout the Facility and monitors compliance.

Facility concurred.

Target date for completion: July 31, 2018

Facility response: Medical Center Executive Leadership has developed and implemented a three-prong approach of: 1) Implementation of the "Keep it Clean, Keep it Safe" program; 2) Leadership Rounding; and, 3) Ensuring adequate Environmental Management Service (EMS) staffing levels. Environmental cleanliness will be monitored frequently through regularly scheduled EOC and Leadership rounds and daily Associate Director and EMS Chief rounds. Issues identified will be communicated to appropriate Service Chiefs and addressed. Results of EOC and Leadership rounds will be reported to the EOC Committee and ELC respectively.

Nutrition and Food Services: Environmental Safety

VHA requires that storage areas for refuse (waste or trash), recyclables, and returnables be stored separate from food preparation areas.[61] VHA also requires garbage cans to be kept covered with tight-fitting lids to ensure sanitary conditions are maintained.[62] The OIG found uncovered garbage receptacles in the food preparation area. Facility managers and staff were unaware of the requirements.

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

[60] Medical/surgical 3B, critical care, and Community Living Center units; the primary care Emerald clinic; and the Emergency Department.

[61] VHA Handbook 1109.04 *Food Services Management Program*, October 11, 2013.

[62] VHA Handbook 1109.04.

Recommendation 6

6. The Associate Director requires Nutrition and Food Service managers ensure garbage receptacles are stored separately from food preparation areas and properly covered with tight-fitting lids and monitors managers' compliance.

Facility concurred.

Target date for completion: Completed. February 20, 2018

Facility response: PVAHCS purchased garbage receptacles with properly covered, tight-fitting lids and installed them in the food preparation areas. Monitoring and tracking for compliance will be maintained through quarterly facility-level Environment of Care Rounds and monthly service-level Environment of Care rounds to ensure sustained compliance.

Nutrition and Food Services: Storage Areas

VHA requires that all food items are properly labeled and indicate the expiration date, as appropriate, upon receipt. This process ensures that the food served is safe for consumption.[63] The OIG noted that food items in the dry storage area and freezer had no expiration date labels. Facility managers were aware of the requirements; however, a lack of oversight and attention to detail led to noncompliance.

Recommendation 7

7. The Associate Director requires Nutrition and Food Services managers ensure all food items are properly labeled with expiration dates, as appropriate, and monitors managers' compliance.

Facility concurred.

Target date for completion: September 30, 2018

Facility response: The Chief of Nutrition Health and Food Service (NHFS) completed the revision of process and staff in-service training on labeling and dating food items on March 26, 2018. NHFS employees also received in-service training on Sanitation and Inspection, Storage of Food, and Supplies.

On February 26, 2018, food service supervisors started conducting daily inspections of food items in all storage areas and reviewed corrective actions with employees at tray line huddles. On March 1, 2018, NHFS implemented a new food labeling process.

Monitoring and tracking for compliance will be maintained through quarterly facility-level Environment of Care Rounds and monthly service-level Environment of Care rounds to ensure

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[63] VHA Handbook 1109.04.

sustained compliance. Compliance will be reported monthly to the Administrative Executive Board.

Nutrition and Food Services: Temperature Monitoring

VHA requires facilities monitor the temperature levels in dry food storage areas to optimize food safety and quality.[64] The Facility did not monitor temperature levels in the dry storage area, which resulted in the inability to be assured that food was safely stored. Nutrition and Food Services managers were unaware of this requirement.

Recommendation 8

8. The Associate Director requires Nutrition and Food Services managers ensure temperature monitoring occurs in the dry food storage area and monitors managers' compliance.

Facility concurred.

Target date for completion: Completed. February 27, 2018

Facility response: On February 27, 2018, Engineering installed a thermostat in the Ingredient Control Room Dry Storage to monitor temperatures continuously. The Ingredient Control Room Dry Storage thermostat is aligned with the building management temperature system. If the thermostats reads > 70 degrees, an alarm will sound and the boiler plant will be notified for immediate action. Building Management Temperature System electronic logs are maintained for review of compliance with temperature requirements. All events that trigger an alarm are reported daily in morning briefing and any actions required. Since the installation of this thermostat with centralized scheduling, no alarms have triggered requiring reporting. The facility will continue to monitor to ensure sustained compliance.

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[64] 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.[65] 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.[66]

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.[67,68] 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.[69] The OIG team interviewed key managers and reviewed CS inspection reports for the prior two completed quarters;[70] monthly summaries of findings, including discrepancies, provided to the Director for the prior 12 months;[71] CS inspection quarterly trend reports for the prior four quarters;[72] 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

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

[66] 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.)

[67] 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.

[68] VHA Directive 1108.02, *Inspection of Controlled Substances*, November 28, 2016.

[69] 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.

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

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

[72] The four quarters were from October 2016 through September 2017.

- o Actions taken to resolve identified problems

- Pharmacy operations

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

  - o CS ordering processes

  - o Inventory completion during Chief of Pharmacy transition

  - o Staff restrictions for monthly review of balance adjustments

- Requirements for CSCs

  - o Free from conflicts of interest

  - o CSC duties included in position description or functional statement

  - o Completion of required CSC orientation training course

- Requirements for CSIs

  - o Free from conflicts of interest

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

  - o Hiatus of one year between any reappointment

  - o Completion of required CSI certification course

  - o Completion of required annual updates and/or refresher training

- CS area inspections

  - o Monthly inspections

  - o Rotations of CSIs

  - o Patterns of inspections

  - o Completion of inspections on day initiated

  - o Reconciliation of dispensing between pharmacy and each dispensing area

  - o Verification of CS orders

  - o CS inspections performed by CSIs

- Pharmacy inspections

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

  - o Completion of inspections on day initiated

o Security and documentation of drugs held for destruction[73]

o Accountability for all prescription pads in pharmacy

o Verification of hard copy outpatient pharmacy CS prescriptions

o Verification of 72-hour inventories of the main vault

o Quarterly inspections of emergency drugs

o Monthly CSI checks of locks and verification of lock numbers

Conclusions

The OIG found general compliance with requirements for most of the performance indicators evaluated, including CSC reports, annual physical security surveys, ordering procedures, and the CSC and CSIs having no conflicts of interest and completing required training. However, the OIG identified deficiencies with CS area inspections that warranted recommendations for improvement.

Controlled Substances Area Inspections: Monthly Inspections

VHA requires CSIs to conduct monthly inspections of CS storage areas and for CSCs to refrain from conducting these routine inspections.[74] The OIG noted that the CSCs conducted frequent monthly inspections in 5 of the 10 areas selected for review. For example, four out of five months in an operating room area and three out of six months in four procedure areas (cardiac catheterization, gastroenterology, bronchoscopy, and interventional radiology). The CSCs were aware of the requirement and stated they conducted the inspections because the assigned CSIs did not complete their assignments due to competing priorities and that the program had an insufficient number of CSIs to provide back-up coverage.

Recommendation 9

9. The Facility Director ensures that Controlled Substances Inspectors complete routine monthly controlled substances inspections and monitors compliance.

Facility concurred.

Target date for completion: July 1, 2018

Facility response: Education of all Controlled Substance Inspectors regarding the need to complete 100% of controlled substance inspections was completed via email and face to face on

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[73] 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.

[74] VHA Directive 1108.02(1).

March 30, 2018. The Controlled Substance Coordinator (CSC) and the Alternate CSC will track weekly completion of Controlled Substance Inspections by the Controlled Substance Inspectors, which the CSC will report monthly to Quality Executive Board. The CSC and the Alternate CSC are responsible for the corrective action and overall and ongoing compliance. PVAHCS Policy 00-22, *Inspection of Controlled Substances,* was revised to include the updated requirements.

Controlled Substances Area Inspections: Patterns of Inspections

VHA requires that inspections be scheduled randomly and not scheduled consistently the same day and week each month to ensure the element of surprise.[75] For eight of 10 areas selected, from July to December 2017, the OIG noted that CSIs conducted inspections during the last five days of the month. Conducting CS inspections consistently around the same day each month removes the element of surprise. The CSC stated that CSIs planned random visits each month; however, due to CSIs' primary duties and competing priorities, inspections were conducted during the last few days of the month.

Recommendation 10

10. The Facility Director ensures that controlled substances inspections are randomly performed to ensure the element of surprise and monitors compliance.

Facility concurred.

Target date for completion: July 1, 2018

Facility response: The CSC and the alternate CSC will ensure that controlled substances inspections are randomly performed to ensure the element of surprise. The CSC will develop an audit tool that will be reported monthly to Quality Executive Board to ensure sustained compliance.

Controlled Substances Area Inspections: Reconciliation of Dispensing and Return of Stock for One Random Day

VHA requires CS program staff to reconcile the distribution (restocking/refilling) of CS to every automated dispensing cabinet and one random day's return of expired or overstock of CS to pharmacy.[76] The reconciliation provides the opportunity to identify potential drug diversion activities and any discrepancies with refilling or returning CS.

The OIG found that reconciliations of the returns to pharmacy stock were not conducted in any of the 10 CS areas for the six months of inspection reports reviewed. The OIG noted that the

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[75] VHA Directive 1108.02(1).
[76] VHA Directive 1108.02(1).

CSCs were not aware that the report used to reconcile expired or overstocked CS from dispensing areas to pharmacy did not include returns from every automated dispensing cabinet.

Recommendation 11

11. The Facility Director ensures that reconciliation of controlled substances returns to pharmacy stock is performed during controlled substances inspections and monitors compliance.

Facility concurred.

Target date for completion: July 1, 2018

Facility response: The Associate Chief Pharmacy Operations will ensure monthly CSI Inspections will include the tracking of narcotic returns from Drug Dispensing Automation (Acudose, Omnicell) in the field to the Inpatient Pharmacy Vault as part of the routine monthly CSI audit. Monitoring and compliance will be reported monthly to the Clinical Executive Board to ensure sustained compliance.

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."[77] 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.[78]

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.[79] 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.[80]

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

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

- Offer to patient of further diagnostic evaluation

- Referral for diagnostic evaluation

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[77] 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.)

[78] VHA Handbook 1160.03.

[79] 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.

[80] VHA Handbook 1160.03.

- Completion of diagnostic evaluation within required timeframe

Conclusions

The OIG found general compliance with providers completing suicide risk assessments within the required timeframe. The OIG identified a deficiency with providers offering further diagnostic evaluations.

Offer of Diagnostic Evaluation

VHA requires that an appropriate provider offers further diagnostic evaluation to patients with positive PTSD screens.[81] This ensures early identification and management of stress-related disorders. The OIG estimated that providers documented offers of further diagnostic evaluations in 78 percent of the EHRs reviewed.[82] Program managers reported that clinic staff notified providers of the need for medical follow-up through clinical reminders; however, clinic staff did not use the same process to alert providers of patients with positive PTSD screens. The lack of a consistent process for notifying providers of positive PTSD screens resulted in noncompliance.

Recommendation 12

12. The Chief of Staff ensures that acceptable providers offer further diagnostic evaluations to patients with positive post-traumatic stress disorder screens and monitors providers' compliance.

Facility concurred.

Target date for completion: August 30, 2018

Facility response: Monthly monitoring utilizing 30 chart audits of Primary Care Veterans receiving a new positive reminder for PTSD for completion of PTSD post diagnostic treatment will be implemented. Compliance with the process will be addressed as needed with individual providers until a target compliance rate of 90% is sustained. Audit data review during monthly Ambulatory Care Service meeting will be conducted to determine areas of focus and action. Monthly data will be reported to Clinical Executive Board.

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

[82] The OIG is 95 percent confident that the true rate is somewhere between 64.4 and 88.8 percent, which the OIG determined is statistically significantly below the 90 percent benchmark.

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.[83] 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.[84] 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.[85]

In 1999, the Veterans Millennium Benefits and Healthcare Act mandated that the veterans' standard benefits package include access to GE.[86] 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.[87] Facility leaders must also evaluate the GE program through a review of program objectives, procedures for monitoring care processes and outcomes, and analyses of findings.[88]

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 48 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

  o Evidence of GE program evaluation

  o Evidence of performance improvement activities through leadership board

- Provision of clinical care

  o Medical evaluation by GE provider

  o Assessment by GE nurse

  o Comprehensive psychosocial assessment by GE social worker

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

[84] VHA Directive 1140.04.

[85] 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.

[86] Public Law 106-117.

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

[88] VHA Directive 1140.04.

- o Patient or family education

- o Plan of care based on GE

- Geriatric management

- o Implementation of interventions noted in plan of care

Conclusions

Generally, the OIG noted compliance with program oversight, nursing and social worker assessments, patient education, plan of care development, and interventions implementation when indicated. However, the OIG identified a deficiency with medical evaluation that warranted a recommendation.

Medical Evaluation

VHA requires GE providers to directly perform or supervise medical evaluation and care of patients in the program. This ensures that veterans receive comprehensive, multidimensional, and interdisciplinary assessments of their physical and mental health, and functional and socioeconomic status.[89] The OIG estimated that GE providers evaluated patients in 77 percent of the EHRs reviewed.[90] The lack of a medical evaluation delays the development of a plan of care and the provision of optimal care. Program managers reported that provider staffing issues affected their ability to accommodate the increasing number of patients admitted to the program.

Recommendation 13

13. The Chief of Staff ensures that geriatric evaluation providers complete a medical evaluation of patients admitted to the program and monitors providers' compliance.

Facility concurred.

Target date for completion: June 30, 2018

Facility response: Associate Chief of Service for Geriatric Extended Care Services provided Home Based Primary Care (HBPC) providers education regarding HBPC Policy and Procedure, including medical evaluation of patients admitted to the program. Chart audits will be conducted of 100% HBPC admissions to determine if the provider's initial assessment is documented in CPRS. Monitoring will continue until 90% compliance is achieved for 3 consecutive months and sustained. Compliance will be reported monthly to Quality Executive Board.

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[89] VHA Directive 1140.04.

[90] The OIG is 95 percent confident that the true rate is somewhere between 64.6 to 87.5 percent, which the OIG determined is statistically significantly below the 90 percent benchmark.

Women's Health: Mammography Results and Follow-Up

In 2017, an estimated 252,710 new cases of invasive breast cancer and 40,610 breast cancer deaths were expected to occur among US women.[91] 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.[92] The Veterans Health Care Act of 1992 also authorized VA to provide gender-specific services, including mammography services to eligible women veterans.[93]

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.[94]

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

- Electronic linking of mammogram results to radiology order

- Scanning of hard copy mammography reports, if outsourced

- Inclusion of required components in mammography reports

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

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

- Performance of follow-up mammogram if indicated

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

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

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

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

- Performance of follow-up study

Conclusion

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

High-Risk Processes: Central Line-Associated Bloodstream Infections

TJC requires facilities to establish systematic infection prevention and control programs to reduce the risk of acquiring and transmitting infections.[95] 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,"[96] 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.[97]

The use of central lines has greatly facilitated the care provided to patients; however, they are not without their risks. The Centers for Disease Control and Prevention defines a central line-associated bloodstream infection (CLABSI) as a "primary bloodstream infection that develops in a patient with a central line in place. This type of infection occurs within the 48 hours of insertion and is not related to infection at another site."[98]

Infections occurring on or after the third calendar day following admission to an inpatient location are considered "healthcare-associated."[99] 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.[100]

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 18 clinical employees involved in inserting and/or managing central lines. The OIG evaluated the following performance indicators:

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

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

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

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

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

[99] 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.

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

- Performance of annual infection prevention risk assessment

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

- Provision of infection incidence data on CLABSI

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

- Educational materials about CLABSI prevention for patients and families

- Use of a checklist for central line insertion and maintenance

Conclusion

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

Appendix A: Summary Table of Comprehensive Healthcare Inspection Program Review Findings

Healthcare Processes	Performance Indicators	Conclusion
Leadership and Organizational Risks	- Executive leadership stability and engagement - Employee satisfaction and patient experience - Accreditation/for-cause surveys and oversight inspections - Indicators for possible lapses in care - VHA performance data	Thirteen 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, Deputy Director Chief of Staff, and Associate Director. See details below.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement[101]	Recommendations for Improvement
Quality, Safety, and Value	- Protected peer review of clinical care - UM reviews - Patient safety incident reporting and RCAs	None	- Physician Utilization Management Advisors consistently document their decisions in the National Utilization Management Integration database. - All patient incidents are entered into WebSPOT.
Credentialing and Privileging	- Medical licenses - Privileges - FPPEs - OPPEs	None	None

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

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement

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
		• Personal protective gowns are readily accessible for employees.	• Required team members consistently participate on EOC rounds.
			• A clean environment is maintained throughout the Facility.
			• Garbage receptacles are stored separate from food preparation areas and are kept covered with tight fitting lids.
			• Food items are properly labeled with expiration dates.
			• Temperature monitoring occurs in the dry food storage area.

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	• CSIs complete required monthly inspections. • CS inspections are randomly performed. • Reconciliation of returns to pharmacy stock is performed during CS inspections.
Mental Health Care: Post-Traumatic Stress Disorder Care	• Suicide risk assessment • Offer of further diagnostic evaluation • Referral for diagnostic evaluation • Completion of diagnostic evaluation	• Acceptable providers offer further diagnostic evaluations to patients with positive post-traumatic stress disorder screens.	• None
Long-Term Care: Geriatric Evaluations	• Program oversight and evaluation • Provision of clinical care • Geriatric management	• GE providers complete a medical evaluation of patients admitted to the program.	• None
Women's Health: Mammography Results and Follow-Up	• Result linking • Report scanning and content • Communication of results and recommended actions • Follow-up mammograms and studies	• None	• None
High-Risk Processes: Central Line-Associated Bloodstream Infections	• Policy and infection prevention risk assessment • Committee discussion • Infection incidence data • Education and educational materials • Checklist	• None	• None

Appendix B: Facility Profile and VA Outpatient Clinic Profiles

Facility Profile

The table below provides general background information for this high-complexity (1b)[102] affiliated[103] Facility reporting to VISN 22.

Table 6. Facility Profile for Phoenix (644)
(October 1, 2014, through September 30, 2017)

Profile Element	Facility Data FY 2015[104]	Facility Data FY 2016[105]	Facility Data FY 2017[106]
Total Medical Care Budget in Millions	$677.7	$663.2	$681.2
Number of:			
• Unique Patients	85,195	89,207	91,424
• Outpatient Visits	957,019	1,027,022	1,078,556
• Unique Employees[107]	2,718	2,871	3,059
Type and Number of Operating Beds:			
• Community Living Center	104	104	104
• Domiciliary	24	24	24
• Medicine	82	82	82
• Mental Health	48	48	48
• Surgery	36	36	36
Average Daily Census:			
• Community Living Center	34	35	34
• Domiciliary	19	20	21
• Medicine	46	59	57
• Mental Health	38	41	36

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

[103] Associated with a medical residency program.

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

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

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

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

Profile Element	Facility Data FY 2015[104]	Facility Data FY 2016[105]	Facility Data FY 2017[106]
• Surgery	15	15	16

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

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

VA Outpatient Clinic Profiles[108]

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[109] 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[110] Provided	Diagnostic Services[111] Provided	Ancillary Services[112] Provided
Southeast-Gilbert, AZ	644BY	41,095	19,699	Dermatology Rehab Physician Anesthesia Podiatry	Radiology	Nutrition Pharmacy Social Work Weight Management Dental

[108] Includes all outpatient clinics in the community that were in operation as of August 15, 2017. The Phoenix, AZ (644QA) was omitted, as no workload/encounters or services were reported.

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

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

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

[112] 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[110] Provided	Diagnostic Services[111] Provided	Ancillary Services[112] Provided
Northwest-Surprise, AZ	644GA	23,214	9,494	Dermatology Endocrinology Anesthesia Podiatry	Radiology	Nutrition Pharmacy Social Work Weight Management Dental
Show Low, AZ	644GB	7,646	3,651	Dermatology Endocrinology Anesthesia Podiatry	n/a	Nutrition Pharmacy Social Work Weight Management
Southwest-Buckeye, AZ	644GC	5,062	1,397	Dermatology Endocrinology Anesthesia	n/a	Nutrition Pharmacy Weight Management
Payson, AZ	644GD	3,303	391	Dermatology Endocrinology Anesthesia	n/a	Nutrition
Thunderbird-Phoenix, AZ	644GE	8,912	4,282	Dermatology Gastroenterology Nephrology Anesthesia Podiatry	n/a	Alternative Nutrition Pharmacy Social Work Weight Management
Globe, AZ	644GF	2,392	497	Dermatology Endocrinology Anesthesia Vascular	n/a	Nutrition Pharmacy Social Work Weight Management

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services[110] Provided	Diagnostic Services[111] Provided	Ancillary Services[112] Provided
Northeast-Scottsdale, AZ	644GG	4,087	2,918	Dermatology Anesthesia	n/a	Nutrition Pharmacy Social Work Weight Management
Midtown-Phoenix, AZ	644GH	17,602	4,916	Dermatology Endocrinology	n/a	Nutrition Pharmacy Weight Management

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[113]

Quarterly New PC Patient Average Wait Time in Days

	VHA Total	(644) Phoenix, AZ (Carl T. Hayden)	(644BY) Southeast, AZ	(644GA) Northwest, AZ	(644GB) Show Low, AZ	(644GC) Southwest, AZ	(644GD) Payson, AZ	(644GE) Thunderbird, AZ	(644GF) Globe, AZ	(644GG) Northeast Phoenix-Via Linda Road, AZ	(644GH) Phoenix Midtown, AZ	(644QA) Phoenix-East Thomas Road, AZ
JAN-FY17	9.2	9.5	16.2	15.9	2.2	0.3	1.0	21.2	9.0	28.2	n/a	n/a
FEB-FY17	8.7	6.4	13.6	10.2	3.9	6.3	4.8	8.2	2.0	3.2	7.0	n/a
MAR-FY17	8.4	4.7	14.0	13.3	1.6	8.7	2.1	7.8	3.8	7.3	11.6	n/a
APR-FY17	8.2	6.2	18.7	12.2	1.1	14.3	1.9	18.9	4.3	11.6	12.6	n/a
MAY-FY17	7.9	7.2	13.6	11.3	1.0	15.1	2.5	9.8	5.0	10.5	14.5	n/a
JUN-FY17	8.2	3.9	15.0	9.2	2.4	14.5	2.0	8.6	2.9	8.8	13.3	n/a
JUL-FY17	8.0	5.2	16.3	16.8	3.5	14.0	2.0	14.7	3.7	13.0	24.0	n/a
AUG-FY17	8.1	7.6	22.7	21.2	3.3	24.7	1.7	22.0	2.2	15.1	21.2	n/a
SEP-FY17	8.2	3.5	19.1	16.2	4.8	22.0	0.7	18.5	8.8	16.1	20.3	n/a
OCT-FY18	7.5	2.1	18.8	6.6	7.8	18.8	0.0	9.0	0.9	17.9	27.7	n/a
NOV-FY18	8.0	3.6	19.3	12.0	5.3	25.6	0.0	18.7	3.0	17.1	28.7	n/a
DEC-FY18	8.1	5.4	18.0	16.7	2.9	14.4	0.0	23.4	1.3	24.1	28.9	n/a

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."*

[113] Department of Veterans' Affairs, Patient Aligned Care Teams Compass Data Definitions, accessed January 19, 2018.

Quarterly Established PC Patient
Average Wait Time in Days

	VHA Total	(644) Phoenix, AZ (Carl T. Hayden)	(644BY) Southeast, AZ	(644GA) Northwest, AZ	(644GB) Show Low, AZ	(644GC) Southwest, AZ	(644GD) Payson, AZ	(644GE) Thunderbird, AZ	(644GF) Globe, AZ	(644GG) Northeast Phoenix-Via Linda Road, AZ	(644GH) Phoenix Midtown, AZ	(644QA) Phoenix-East Thomas Road, AZ
JAN-FY17	4.4	7.5	5.9	2.3	2.9	2.2	2.4	5.1	2.8	4.2	0.0	n/a
FEB-FY17	3.9	4.9	6.2	2.2	3.1	3.3	7.9	5.7	1.9	3.8	5.3	n/a
MAR-FY17	3.9	5.5	7.2	2.6	2.1	7.4	1.4	4.3	1.3	4.3	10.6	n/a
APR-FY17	3.9	5.4	6.8	2.7	1.7	9.7	1.4	5.2	1.4	4.9	10.2	n/a
MAY-FY17	4.0	5.5	7.4	3.6	2.0	9.5	1.5	4.4	1.8	4.0	10.8	n/a
JUN-FY17	4.1	5.3	6.9	2.9	3.1	9.3	1.6	5.5	1.5	3.6	10.8	n/a
JUL-FY17	4.1	4.7	6.6	2.2	3.4	8.2	1.7	6.9	3.5	5.7	11.7	n/a
AUG-FY17	4.2	6.2	9.0	3.4	3.7	9.3	1.5	3.2	2.2	5.5	11.9	n/a
SEP-FY17	4.0	2.5	6.9	1.7	2.8	10.0	1.0	4.2	1.7	6.4	10.6	n/a
OCT-FY18	3.7	1.6	5.7	2.7	4.0	6.3	0.2	3.3	2.0	6.1	9.4	n/a
NOV-FY18	4.1	3.1	6.5	3.9	4.4	7.7	0.3	3.8	1.9	7.2	9.8	n/a
DEC-FY18	4.1	3.7	6.8	3.9	4.4	8.3	0.1	7.5	1.0	9.1	10.2	n/a

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."

Quarterly Team 2-Day Post Discharge Contact Ratio

|	VHA Total	(644) Phoenix, AZ (Carl T. Hayden)	(644BY) Southeast, AZ	(644GA) Northwest, AZ	(644GB) Show Low, AZ	(644GC) Southwest, AZ	(644GD) Payson, AZ	(644GE) Thunderbird, AZ	(644GF) Globe, AZ	(644GG) Northeast Phoenix-Via Linda Road, AZ	(644GH) Phoenix Midtown, AZ	(644QA) Phoenix-East Thomas Road, AZ
JAN-FY17	62.9%	61.3%	68.0%	37.2%	100.0%	55.6%	0.0%	65.4%	100.0%	50.0%	38.5%	n/a
FEB-FY17	64.0%	74.7%	72.2%	60.0%	42.9%	66.7%	14.3%	86.7%	100.0%	30.0%	58.9%	n/a
MAR-FY17	65.3%	74.1%	82.1%	52.5%	100.0%	92.6%	0.0%	77.8%	100.0%	57.1%	60.9%	n/a
APR-FY17	65.0%	76.0%	88.0%	51.1%	33.3%	88.2%	0.0%	61.8%	100.0%	37.5%	79.3%	n/a
MAY-FY17	62.3%	70.2%	86.3%	60.0%	87.5%	81.3%	0.0%	71.1%	50.0%	45.5%	68.2%	n/a
JUN-FY17	62.7%	74.2%	86.9%	48.8%	85.7%	83.8%	0.0%	75.8%	100.0%	68.8%	69.3%	n/a
JUL-FY17	62.4%	69.1%	83.3%	56.8%	75.0%	83.3%	0.0%	69.6%	50.0%	71.4%	67.1%	n/a
AUG-FY17	62.6%	72.8%	81.6%	71.8%	50.0%	83.3%	n/a	90.6%	80.0%	60.0%	68.7%	n/a
SEP-FY17	62.3%	55.8%	80.4%	63.9%	100.0%	82.4%	0.0%	79.1%	0.0%	71.4%	62.6%	n/a
OCT-FY18	59.9%	69.2%	77.1%	67.4%	60.0%	70.8%	0.0%	81.1%	n/a	57.1%	69.7%	n/a
NOV-FY18	58.9%	73.0%	80.9%	76.5%	66.7%	75.0%	0.0%	80.0%	100.0%	66.7%	70.8%	n/a
DEC-FY18	53.1%	75.2%	63.5%	64.9%	42.9%	79.2%	0.0%	84.6%	N/A	76.5%	67.5%	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."*

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

	VHA Total	(644) Phoenix, AZ (Carl T. Hayden)	(644BY) Southeast, AZ	(644GA) Northwest, AZ	(644GB) Show Low, AZ	(644GC) Southwest, AZ	(644GD) Payson, AZ	(644GE) Thunderbird, AZ	(644GF) Globe, AZ	(644GG) Northeast Phoenix-Via Linda Road, AZ	(644GH) Phoenix Midtown, AZ	(644QA) Phoenix-East Thomas Road, AZ
JAN-FY17	14.3%	27.1%	11.9%	13.2%	1.8%	21.6%	2.9%	21.1%	2.9%	15.0%	70.8%	n/a
FEB-FY17	14.3%	27.3%	11.8%	12.7%	1.9%	20.4%	2.7%	20.7%	3.3%	15.3%	37.0%	n/a
MAR-FY17	14.2%	27.4%	11.9%	12.0%	1.8%	21.3%	2.6%	20.8%	3.2%	15.4%	34.3%	n/a
APR-FY17	14.3%	28.0%	12.0%	12.2%	1.8%	23.1%	2.4%	20.7%	3.0%	15.0%	32.8%	n/a
MAY-FY17	14.3%	28.4%	12.1%	12.4%	1.7%	23.6%	2.2%	20.9%	2.7%	15.4%	32.8%	n/a
JUN-FY17	14.3%	28.6%	12.2%	12.4%	1.6%	23.7%	1.8%	21.6%	2.5%	16.1%	32.2%	n/a
JUL-FY17	14.4%	29.6%	12.5%	12.5%	1.5%	24.3%	1.6%	21.6%	2.5%	16.3%	32.4%	n/a
AUG-FY17	14.4%	29.1%	12.8%	12.4%	1.5%	24.2%	1.5%	22.1%	2.4%	16.1%	31.8%	n/a
SEP-FY17	14.6%	28.3%	13.2%	12.4%	1.6%	24.1%	1.5%	22.6%	2.3%	16.4%	31.1%	n/a
OCT-FY18	14.7%	28.1%	13.5%	12.2%	1.7%	23.9%	1.6%	22.8%	2.3%	16.7%	30.6%	n/a
NOV-FY18	14.8%	27.8%	13.7%	12.3%	1.9%	23.7%	1.7%	23.6%	2.3%	17.2%	30.2%	n/a
DEC-FY18	14.9%	27.5%	14.1%	12.0%	1.9%	23.1%	1.9%	23.9%	2.2%	18.0%	30.6%	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[114]

Measure	Definition	Desired Direction
ACSC Hospitalization	Ambulatory Care Sensitive Conditions hospitalizations	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Admit Reviews Met	% Acute Admission Reviews that meet InterQual criteria	A higher value is better than a lower value
Best Place to Work	All Employee Survey Best Places to Work score	A higher value is better than a lower value
Call Center Responsiveness	Average speed of call center responded to calls in seconds	A lower value is better than a higher value
Call Responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Capacity	Physician Capacity	A lower value is better than a higher value
Care Transition	Care Transition (Inpatient)	A higher value is better than a lower value
Complications	Acute care risk adjusted complication ratio (observed to expected ratio)	A lower value is better than a higher value
Comprehensiveness	Comprehensiveness (PCMH)	A higher value is better than a lower value
Cont Stay Reviews Met	% Acute Continued Stay reviews that meet InterQual criteria	A higher value is better than a lower value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Efficiency/Capacity	Efficiency and Physician Capacity	A higher value is better than a lower value

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

Measure	Definition	Desired Direction
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value
HC Assoc Infections	Healthcare associated infections	A lower value is better than a higher value
HEDIS Like	Outpatient performance measure (HEDIS)	A higher value is better than a lower value
HEDIS Like – HED90_1	HEDIS-EPRP Based PRV TOB BHS	A higher value is better than a lower value
HEDIS Like – HED90_ec	HEDIS-eOM Based DM IHD	A higher value is better than a lower value
MH Wait Time	MH care wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
MH Continuity Care	MH continuity of care (FY14Q3 and later)	A higher value is better than a lower value
MH Exp of Care	MH experience of care (FY14Q3 and later)	A higher value is better than a lower value
MH Popu Coverage	MH population coverage (FY14Q3 and later)	A higher value is better than a lower value
Oryx	Inpatient performance measure (ORYX)	A higher value is better than a lower value
PC Routine Care Appt	Timeliness in getting a PC routine care appointment (PCMH)	A higher value is better than a lower value
PC Urgent Care Appt	Timeliness in getting a PC urgent care appointment (PCMH)	A higher value is better than a lower value
PCMH Same Day Appt	Days waited for appointment when needed care right away (PCMH)	A higher value is better than a lower value
PCMH Survey Access	Timely Appointment, care and information (PCMH)	A higher value is better than a lower value
PC Wait Time	PC wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
PSI	Patient safety indicator (observed to expected ratio)	A lower value is better than a higher value
Rating Hospital	Overall rating of hospital stay (inpatient only)	A higher value is better than a lower value

Measure	Definition	Desired Direction
Rating PC Provider	Rating of PC providers (PCMH)	A higher value is better than a lower value
Rating SC Provider	Rating of specialty care providers (specialty care)	A higher value is better than a lower value
RN Turnover	Registered nurse turnover rate	A lower value is better than a higher value
RSMR-AMI	30-day risk standardized mortality rate for acute myocardial infarction	A lower value is better than a higher value
RSMR-CHF	30-day risk standardized mortality rate for congestive heart failure	A lower value is better than a higher value
RSMR-COPD	30-day risk standardized mortality rate for COPD	A lower value is better than a higher value
RSMR-Pneumonia	30-day risk standardized mortality rate for pneumonia	A lower value is better than a higher value
RSRR-AMI	30-day risk standardized readmission rate for acute myocardial infarction	A lower value is better than a higher value
RSRR-Cardio	30-day risk standardized readmission rate for cardiorespiratory patient cohort	A lower value is better than a higher value
RSRR-CHF	30-day risk standardized readmission rate for congestive heart failure	A lower value is better than a higher value
RSRR-COPD	30-day risk standardized readmission rate for COPD	A lower value is better than a higher value
RSRR-CV	30-day risk standardized readmission rate for cardiovascular patient cohort	A lower value is better than a higher value
RSRR-HWR	Hospital wide readmission	A lower value is better than a higher value
RSRR-Med	30-day risk standardized readmission rate for medicine patient cohort	A lower value is better than a higher value
RSRR-Neuro	30-day risk standardized readmission rate for neurology patient cohort	A lower value is better than a higher value
RSRR-Pneumonia	30-day risk standardized readmission rate for pneumonia	A lower value is better than a higher value
RSRR-Surg	30-day risk standardized readmission rate for surgery patient cohort	A lower value is better than a higher value
SC Routine Care Appt	Timeliness in getting a SC routine care appointment (Specialty Care)	A higher value is better than a lower value

Measure	Definition	Desired Direction
SC Survey Access	Timely Appointment, care and information (Specialty Care)	A higher value is better than a lower value
SC Urgent Care Appt	Timeliness in getting a SC urgent care appointment (Specialty Care)	A higher value is better than a lower value
SMR	Acute care in-hospital standardized mortality ratio	A lower value is better than a higher value
SMR30	Acute care 30-day standardized mortality ratio	A lower value is better than a higher value
Specialty Care Wait Time	Specialty care wait time for new patient completed appointments within 30 days of preferred date	A higher value is better than a lower value
Stress Discussed	Stress Discussed (PCMH Q40)	A higher value is better than a lower value

Source: VHA Support Service Center

Appendix E: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: April 25, 2018]

From: Acting Director, Desert Pacific Healthcare Network (10N22)

Subj: CHIP Review of the Phoenix VA Health Care System, Phoenix, AZ

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

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

I concur with the findings, recommendations and action plans in the Draft CHIP Review of the VA Phoenix Health Care System, Phoenix, Arizona, dated April 6, 2018, for recommendations 1-13.

(Original signed by:)

Randy Quinton, Deputy Network Director for

_____

Robert M. Smith, MD, Acting Network Director

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

Appendix F: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: April 23, 2018

From: Director, Phoenix VA Health Care System (644/00)

Subj: CHIP Review of the Phoenix VA Health Care System, Phoenix, AZ

To: Acting Director, Desert Pacific Healthcare Network (10N22)

1. Thank you for the opportunity to review and comment on the draft report, Comprehensive Healthcare Inspection Program Review of the Phoenix VA Healthcare System (PVAHCS). I concur with the13 recommendations and have included our facility response to each of the recommendations that were identified in the review conducted the week of February 5, 2018.

2. If you have any additional questions, please contact me at (602) 604-3914.

(Original signed by:)

Rimaann O. Nelson, Medical Center Director

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

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