DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection Program Review of the VA Palo Alto Health Care System

California

CHIP REPORT | REPORT #18-00617-227 | JULY 31, 2018

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***Figure 1**: VA Palo Alto Health Care System, Palo Alto, CA*
(Source: https://vaww.va.gov/directory/guide/, accessed on May 22, 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
OIG	Office of Inspector General
PC	primary care
PTSD	post-traumatic stress disorder
RCA	root cause analysis
QSV	quality, safety, and value
SAIL	Strategic Analytics for Improvement and Learning
TJC	The Joint Commission
UM	utilization management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Report Overview

This Comprehensive Healthcare Inspection Program (CHIP) review provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the VA Palo Alto 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 overall efforts of the Office of Inspector General (OIG) 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 March 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 (ADPCS), Acting Deputy Director, and Associate Director. The Chief of Staff and ADPCS are responsible for overseeing patient care and service and the program chiefs.

The Deputy Director position had been vacant for seven months before an Acting Deputy Director was appointed February 1, 2018. The Associate Director was permanently assigned October 29, 2017. With those two exceptions, the executive leaders had been working together as a team since June 2017, the date the Director was permanently assigned after serving more than four years as Deputy Director.

In the review of selected employee satisfaction survey results regarding Facility leaders, the OIG noted high satisfaction scores that reflected active engagement with employees. In the review of selected patient experience survey results regarding Facility leaders, the OIG noted that the Facility's scores were above the Veterans Health Administration (VHA) average and that Facility leaders had implemented processes and plans to maintain a committed workforce and positive patient experiences.

Organizational communication and accountability are carried out through a committee reporting structure with the Strategic Planning Leadership Board having oversight for leadership groups such as the Clinical Planning, Quality, Safety and Value, and Capital Steering Councils. The Facility leaders are members of the Strategic Planning Leadership Board through which they are responsible for tracking, trending, and monitoring quality of care and patient outcomes.

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 Facility made minor improvements in their SAIL ratings over the past two years. Although the leadership team was knowledgeable about selected SAIL metrics, the leaders should continue to take actions to improve performance of the Quality of Care and Efficiency metrics likely contributing to the current "2-Star" rating.

[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. http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=2146. (Website accessed on April 16, 2017.)

Additionally, the OIG reviewed accreditation agency findings, sentinel events,[2] disclosures of adverse patient events, and Patient Safety Indicator data and did not identify any substantial organizational risk factors. However, the OIG noted that the Facility needed to establish a more accurate and reliable system for tracking, documenting, and timely reporting of Patient Safety Indicator data.

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

Quality, Safety, and Value

The OIG found general compliance with requirements for protected peer reviews. However, the OIG identified deficiencies with utilization management[3] and patient safety processes.

Environment of Care

The OIG noted general safety, infection prevention, and privacy measures were in place at the parent Facility in Palo Alto and at the Menlo Park and Livermore campuses. However, the OIG identified deficiencies with environment of care rounds attendance at the parent Facility and with panic alarm testing at the representative community based outpatient clinic.

Medication Management

The OIG found general compliance with requirements for controlled substances (CS) inspection program reports, annual physical security surveys, CS coordinators and inspectors having no conflict of interest and completing required training, and pharmacy operations. However, the OIG identified deficiencies with the completion of monthly inspections and the one day's reconciliation of CS returns to pharmacy stock.

Long-term Care

The OIG noted general compliance with access to geriatric evaluation, provider and nursing evaluations, patient education, development of plan of care, and implementation of interventions when indicated; however, the OIG identified a deficiency with program oversight.

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

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

Summary

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

Comments

The Acting Veterans Integrated Service Network Director and Facility Director agreed with the CHIP review findings and recommendations and provided acceptable improvement plans. (See Appendixes E and F, pages 58–59, and the responses within the body of the report for the full text of the Directors' comments.) The OIG considers Recommendations 1 and 5 closed. We will follow up on the planned actions for the open recommendations until they are completed.

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

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Purpose and Scope

Purpose

This Comprehensive Healthcare Inspection Program (CHIP) review was conducted to provide a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the VA Palo Alto 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.[4,5] 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.[6] Figure 2 shows the direct relationship leadership and organizational risks have with the processes used to deliver health 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).[7]

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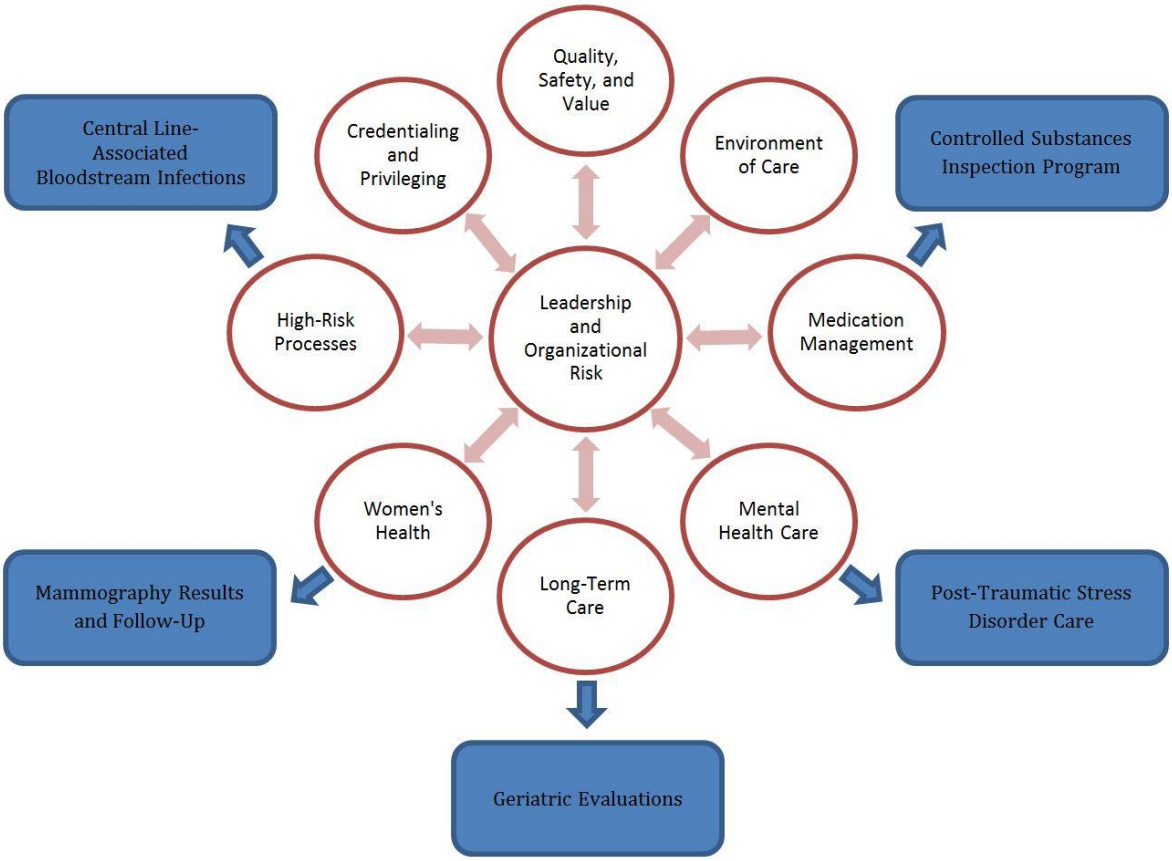
[4] Carol Stephenson, "The role of leadership in managing risk," *Ivey Business Journal*, November/December 2010. https://iveybusinessjournal.com/publication/the-role-of-leadership-in-managing-risk/. (Website accessed on March 1, 2018.)

[5] 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.)

[6] 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.)

[7] 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;[8] 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 February 23, 2015,[9] through March 5, 2018, the date when an unannounced week-long site visit commenced. On April 10 and 11, 2018, the OIG presented crime awareness briefings to 317 of the Facility's 5,408 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.

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

[9] 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 selected clinical areas of focus.[10] 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.

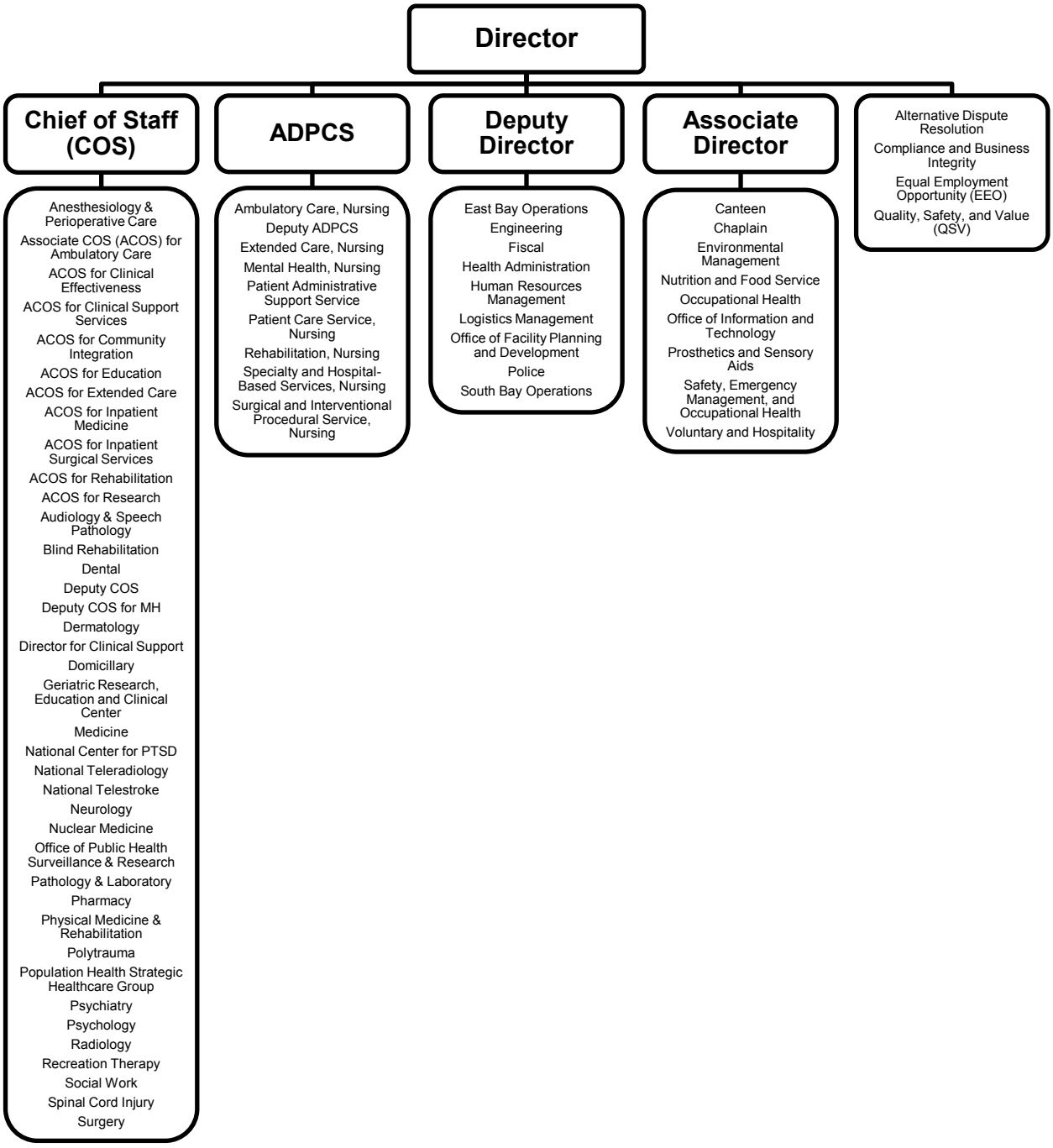
Executive Leadership Stability and Engagement

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 (ADPCS), Acting Deputy Director, and Associate Director. The Chief of Staff and ADPCS are responsible for overseeing patient care and service and program chiefs.

The Deputy Director position had been vacant for seven months before an Acting Deputy Director was appointed in an interim capacity February 1, 2018. The Associate Director was permanently assigned October 29, 2017. With those two exceptions, the executive leaders had been working together as a team since June 2017, the date the Director was permanently assigned after more than four years as Deputy Director.

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

Figure 3. Facility Organizational Chart



Source: VA Palo Alto Health Care System (March 5, 2018)

To help assess engagement of Facility executive leadership, the OIG interviewed the Director, Chief of Staff, ADPCS, 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 Strategic Planning Leadership Board, which tracks, trends, and monitors quality of care and patient outcomes. The Director serves as the chairperson with the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. The Strategic Planning Leadership Board also oversees various working committees, such as the Clinical Planning, Quality, Safety and Value, and Capital Steering Councils. The OIG noted that the Strategic Planning Leadership Board had no documented evidence of its activities and interactions with the Councils. The Director confirmed the OIG's observation and stated that the Facility had already initiated a plan to document the Strategic Planning Leadership Board's activities through meeting minutes. The Director also reported that the leadership team meets daily to discuss SAIL metrics and develop and monitor improvement activities. See Figure 4.

Figure 4. Facility Committee Reporting Structure

Source: VA Palo Alto Health Care System (received March 6, 2018)

Employee Satisfaction and Patient Experience

The All Employee Survey is an annual, voluntary, census survey of VA workforce experiences. The results 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.

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.

To assess employee and patient attitudes toward Facility leaders, the OIG reviewed employee satisfaction and patient experience survey results that relate to the period of October 1, 2016, through September 30, 2017. 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 above the VHA and Facility averages.[11] Employees appear generally satisfied with Facility leaders.

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

Questions/Survey Items	Scoring	VHA Average	Facility Average	Director's Office Average[12]
All Employee Survey Q59. *How satisfied are you with the job being done by the executive leadership where you work?*	1 (Very Dissatisfied)–5 (Very Satisfied)	3.3	3.4	3.9
All Employee Survey: *Servant Leader Index Composite*	0–100 where HIGHER scores are more favorable	67.7	69.9	74.9

Source: VA All Employee Survey (accessed February 9, 2018)

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

VHA collects SHEP survey data from Patient-Centered Medical Home, Specialty Care, and Inpatient Surveys. From these, the OIG selected four survey items that reflect patient attitudes toward Facility leaders (see Table 2). For this Facility, all four patient survey results reflected higher care ratings than the VHA average. Patients appear to be satisfied with the leadership and care provided.

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

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

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

Questions	Scoring	VHA Average	Facility Average
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	66.7	84.7
Survey of Healthcare Experiences of Patients (inpatient): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	83.4	90.2
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	82.5
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	79.7

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

Accreditation/For-Cause Surveys[13] 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

[13] 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.

recently performed by the OIG and The Joint Commission (TJC).[14] Indicative of effective leadership, the Facility has closed[15] all but one recommendation as listed in Table 3.

The OIG also noted the Facility's current accreditation status with the Commission on Accreditation of Rehabilitation Facilities[16] and College of American Pathologists,[17] which demonstrates the Facility leaders' commitment to quality care and services. Additionally, the Long Term Care Institute conducted inspections of the Facility's Community Living Centers,[18] and the Paralyzed Veterans of America conducted inspections of the Facility's spinal cord injury/disease unit and related services.[19]

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

Accreditation or Inspecting Agency	Date of Visit	Number of Findings	Number of Recommendations Remaining Open
OIG (*Combined Assessment Program Review of the VA Palo Alto Health Care System, Palo Alto, California, April 30, 2015*)	February 2015	14	0
OIG (*Review of Community Based Outpatient Clinics and Other Outpatient Clinics of VA Palo Alto Health Care System, Palo Alto, California, May 5, 2015*)	February 2015	7	0
OIG (*Healthcare Inspection – Alleged Dental Service Scheduling and Other Administrative Issues, VA Palo Alto Health Care System,*	September 2014	3[20]	0

[14] 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.

[15] 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 the accreditation organization or inspecting agency.

[16] 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.

[17] 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.

[18] 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.

[19] The Paralyzed Veterans of America inspections took place February 14 and 16, 2017, and February 6–7, 2018. Veteran Service Organization review does not result in accreditation status.

[20] Four recommendations were made, but one of the recommendations was directed to the Veterans Integrated Service Network Director.

Accreditation or Inspecting Agency	Date of Visit	Number of Findings	Number of Recommendations Remaining Open
Palo Alto, California, July 9, 2015)			
OIG (*Healthcare Inspection – Alleged Colorectal Cancer Screening and Other Administrative Issues, VA Palo Alto Health Care System, Palo Alto, California, July 9, 2015*)	September 2014	1	0
OIG (*Healthcare Inspection – Alleged Transcatheter Aortic Valve Replacement Program Issues, VA Palo Alto Health Care System, Palo Alto, California, September 28, 2017*)	June 2015	1	1[21]
TJC			
• Regular	February 2016		
○ Hospital Accreditation		43	0
○ Nursing Care Center Accreditation		1	0
○ Behavioral Health Care Accreditation		1	0
○ Home Care Accreditation		2	0
• For Cause Survey	April 2016	4	0
• For Cause Survey	June 2016	2	0

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

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 February 2015 Combined Assessment Program and Community Based Outpatient Clinic (CBOC) and Other Outpatient Clinics review inspections through the week of March 5, 2018.[22]

[21] One recommendation is still being monitored by the Facility for sustained compliance.

[22] It is difficult to quantify an acceptable number of occurrences because one occurrence is one too many. Efforts should focus on prevention. Sentinel events and those that lead to disclosure can occur in either inpatient or outpatient settings and should be viewed within the context of the complexity of the Facility. (Note that the VA Palo Alto Health Care System is a highest complexity (1a) affiliated Facility as described in Appendix B.)

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

Factor	Number of Occurrences
Sentinel Events[23]	8
Institutional Disclosures[24]	20
Large-Scale Disclosures[25]	0

Source: VA Palo Alto Health Care System's Patient Safety Manager (received March 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.[26] The rates presented are specifically applicable for this Facility, and lower rates indicate lower risks. Table 5 summarizes Patient Safety Indicator data from October 1, 2015, through September 30, 2017.

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

Measure	Reported Rate per 1,000 Hospital Discharges		
	VHA	VISN 21	Facility
Pressure ulcers	0.60	0.43	0.19
Death among surgical inpatients with serious treatable conditions	100.97	62.11	91.84
Iatrogenic pneumothorax	0.19	0.13	0.24
Central venous catheter-related bloodstream infection	0.15	0.04	0.00
In-hospital fall with hip fracture	0.08	0.06	0.00
Perioperative hemorrhage or hematoma	1.94	1.76	2.08

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

[24] 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 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.

[25] 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.

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

Measure	Reported Rate per 1,000 Hospital Discharges		
	VHA	VISN 21	Facility
Postoperative acute kidney injury requiring dialysis	0.88	0.98	2.48
Postoperative respiratory failure	5.55	4.11	4.99
Perioperative pulmonary embolism or deep vein thrombosis	3.29	4.96	4.99
Postoperative sepsis	4.00	3.30	6.63
Postoperative wound dehiscence	0.52	0.00	0.00
Unrecognized abdominopelvic accidental puncture/laceration	0.53	0.19	0.89

Source: VHA Support Service Center

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

Six Patient Safety Indicator measures (iatrogenic pneumothorax, perioperative hemorrhage or hematoma, postoperative acute kidney injury requiring dialysis, perioperative pulmonary embolism or deep vein thrombosis, postoperative sepsis, and unrecognized abdominopelvic accidental puncture/laceration) show higher observed rates than Veterans Integrated Service Network (VISN) 21 and VHA. Facility managers reported taking actions to review incidents for accuracy and improvement opportunities but could not provide evidence of aggregated data or reporting to leadership. Facility managers also reported coding inaccuracies as the primary reason for the higher observed rates and that Facility managers had already initiated a more comprehensive review to identify and address underlying causes.

Veterans Health Administration Performance Data

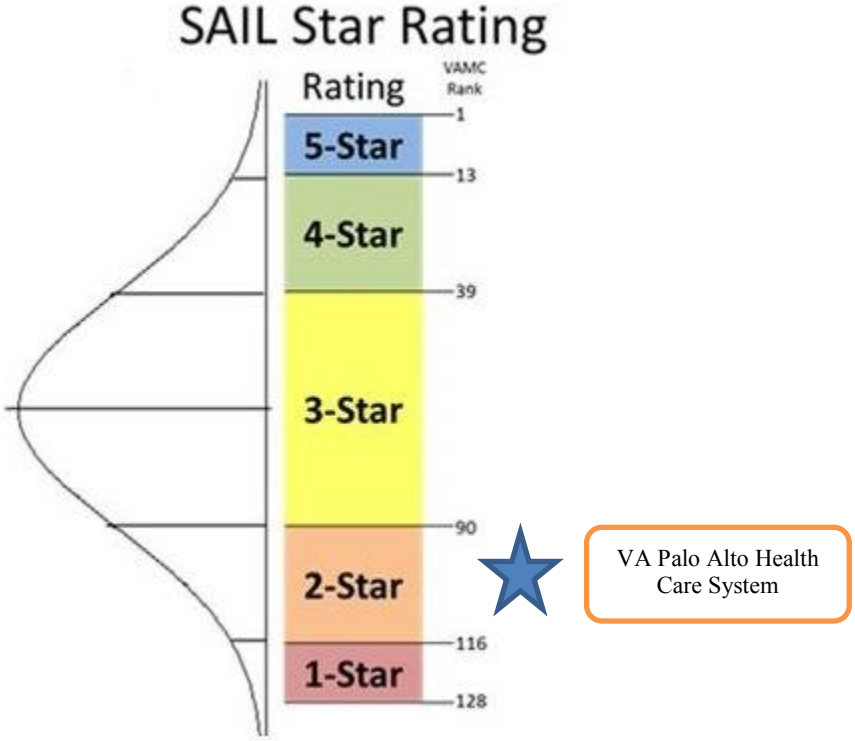
The VA Office of Operational Analytics and Reporting adapted the SAIL Value Model to help define performance expectations within VA. This model includes measures on healthcare quality, employee satisfaction, access to care, and efficiency but has noted limitations for identifying all areas of clinical risk. The data are presented as one "way to understand the similarities and differences between the top and bottom performers" within VHA.[27]

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.[28] As of June 30, 2017, the Facility was rated at "2-Star" for overall quality.

[27] VHA Support Service Center (VSSC), The Strategic Analytics for Improvement and Learning (SAIL) Value Model, http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=2146. (Website accessed on April 16, 2017.)

[28] 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)

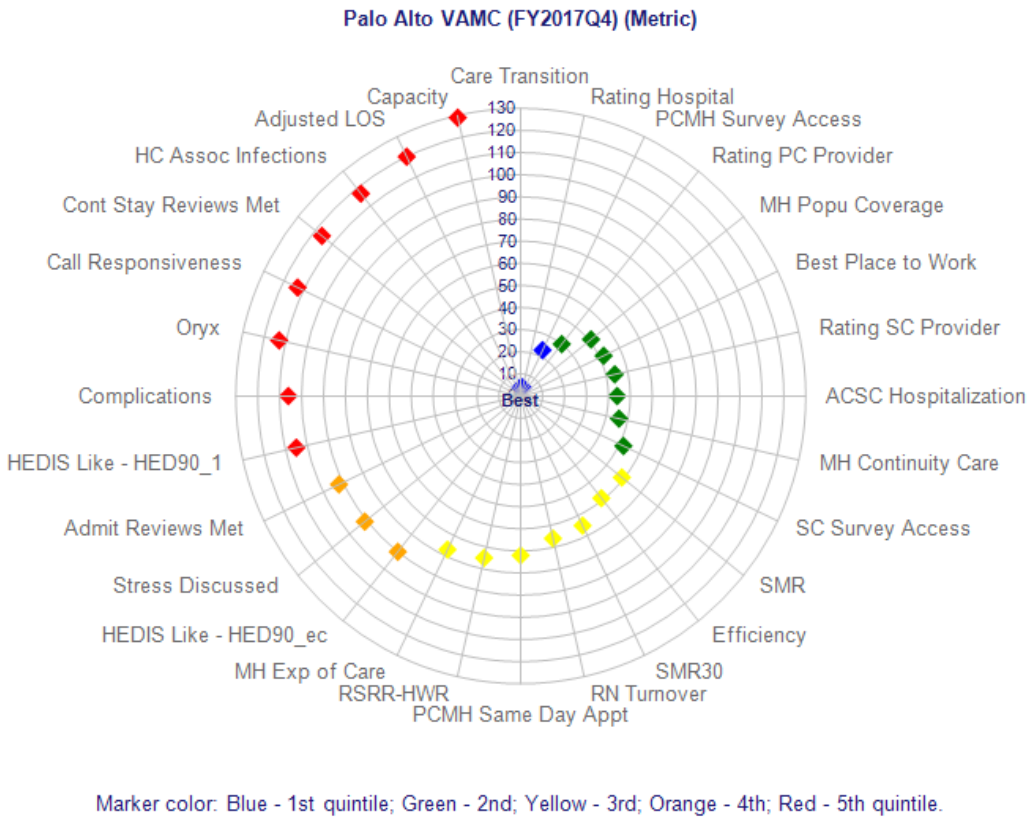


Source: VA Office of Informatics and Analytics' Office of Operational Analytics and Reporting (accessed February 9, 2018)

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 Rating (of) Hospital, Rating (of) PC (Primary Care) Provider, Best Place to Work, and Rating (of) SC (Specialty Care) Provider).[29] Metrics that need improvement are denoted in orange and red (for example, Call Responsiveness, HC (Healthcare) Assoc (Associated) Infections, and Capacity).

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

Figure 6. Facility Quality of Care and Efficiency Metric Rankings (as of September 30, 2017)



Source: VHA Support Service Center

Note: The OIG did not assess VA's data for accuracy or completeness. Also see Appendix C for sample outpatient performance measures that feed into these data points (such as wait times, discharge contacts, and where patient care is received). For data definitions, see Appendix D.

Conclusion

The Facility has generally stable executive leadership and active engagement with employees and patients as evidenced by high satisfaction scores. Organizational leaders support patient safety, quality care, and other positive outcomes (such as initiating processes and plans to maintain positive perceptions of the Facility through active stakeholder engagement). The OIG's review of accreditation organization findings, sentinel events, and disclosures did not identify any substantial organizational risk factors. However, the OIG is concerned with the lack of documented Patient Safety Indicator data review and action. The leadership team was aware of the Patient Safety Indicator data but should continue to monitor for process improvement opportunities. The senior leadership team was actively engaged and knowledgeable about selected SAIL metrics but should continue to take actions to improve care and performance of selected Quality of Care and Efficiency metrics likely contributing to the "2-Star" rating.

Quality, Safety, and Value

VHA's goal is to serve as the nation's leader in delivering high-quality, safe, reliable, and veteran-centered care using a coordinated care continuum. To meet this goal, VHA must foster a culture of integrity and accountability that is vigilant and mindful, proactively risk aware, and predictable, while seeking continuous improvement.[30] VHA also strives to provide healthcare services that compare favorably to the best of the private sector in measured outcomes, value, and efficiency.[31]

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,[32] utilization management (UM) reviews,[33] and patient safety incident reporting with related root cause analyses (RCAs).[34]

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.[35]

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

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

[32] 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.)

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

[34] 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.

[35] 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:[36]

- Protected peer reviews
  - Examination of important aspects of care (for example, appropriate and timely ordering of diagnostic tests, prompt treatment, and appropriate documentation)
  - Implementation of improvement actions recommended by the Peer Review Committee
- UM
  - Completion of at least 75 percent of all required inpatient reviews
  - Documentation of at least 75 percent of Physician UM Advisors' decisions in National UM Integration database
  - Interdisciplinary review of UM data
- Patient safety
  - Entry of all reported patient incidents into WebSPOT[37]
  - Annual completion of a minimum of eight RCAs[38]
  - Provision of feedback about RCA actions to reporting employees
  - Submission of annual patient safety report

Conclusion

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

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

[37] 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.

[38] 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 admission and continued stays.[39] This allows for national level UM data to be available for review by an interdisciplinary group to set benchmarks, identify trends and actions, and determine opportunities to improve efficiency. The OIG found no evidence that advisors documented their decisions in the database for 405 of the 585 cases (69 percent) referred to the physician advisors from January 1, 2018, through February 28, 2018. The UM program managers provided reasons for noncompliance which included position vacancies, clinical responsibilities, lack of permanently assigned Physician UM Advisors, notification process errors, and inappropriate referrals.

Recommendation 1

1. The Chief of Staff 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: Completed.

Facility response: Additional PUMAs for surgical and psychiatric services have been recruited and trained. PUMAs have set up automatic reply in NUMI so they are notified when a case has been assigned. An expectation has been set with PUMAs that assigned cased be completed within 48 hours of assignment. A Lead UM reviewer responsible for tracking case completion and reporting compliance to section leaders has been implemented. Weekly reviews are presented to the Chief of Medical Service and all PUMA reviewers to provide a snapshot of current completion for both UM and PUMA reviews. A monthly meeting including Chief and Assistant Chiefs of the Medical Service, Surgical and Psychiatry PUMAs has been implemented to review full compliance results. PUMA review completion rates are reported to the Quality, Safety and Value Council through the UM Committee on a quarterly basis.

Target: Completion of >75% of all required inpatient reviews and documentation of decisions in National UM Integration database for three consecutive months.

Corrective actions have resulted in significant improvement in overall completion rates for PUMA reviews for February through June 2018: February 84.5 percent; March 88.9 percent; April 2018 95.4 percent; May 2018 93.4 percent; and June 2018 100 percent.

We request closure based on data provided.

[39] VHA Directive 1117.

Patient Safety: Patient Incidents Data Entry

VHA requires that reported patient safety incidents be reported and documented in the VHA Patient Safety Information System using the WebSPOT software application.[40] This process provides data that is used to track and trend patient safety incidents across VHA. For FY 2017, there was a total of 2,216 electronic patient incidents reported; however, the Patient Safety Manager only entered 34 (2 percent) of the patient incidents into WebSPOT. This resulted in incomplete data for VHA to track, trend, and analyze. Facility leaders and managers were aware of the backlog but decided to wait until April 2018 to report and document data using the Joint Patient Safety Reporting (JPSR) interface,[41] the WebSPOT replacement for entering patient safety incidents.

Recommendation 2

2. The Facility Director ensures that the Patient Safety Manager reports and documents all patient safety incidents using the Joint Patient Safety Reporting System and monitors the Patient Safety Manager's compliance.

Facility concurred.

Target date for completion: September 30, 2018

Facility Response: The facility implemented the Joint Patient Safety Reporting (JPSR) system on March 28, 2018. This system requires events to be entered by persons witnessing the events. Patient safety event submission data is reported to the Quality, Safety and Value Council as part of the quarterly Quality and Safety section report.

Target: 90% of all entered events are closed out within 14 days. Monitoring will continue until compliance reached for 3 consecutive months.

Patient Safety: Annual Report Submission

VHA requires that a patient safety annual report is submitted at the end of each fiscal year to Facility leaders.[42] This report provides an overview of the Facility's Patient Safety Program status to ensure safe environment. The OIG found no evidence of an annual safety report for FY 2017. Managers were aware of this requirement but did not prepare an annual report due to staffing challenges.

[40] VHA Handbook 1050.01, *VHA Safety Improvement Handbook*, March 4, 2011.

[41] JPSR replaced WebSPOT in April 2018.

[42] VHA Handbook 1050.01.

Recommendation 3

3. The Facility Director ensures that the Patient Safety Manager submits annual reports to the leadership team for review and monitors the Patient Safety Manager's compliance.

Facility concurred.

Target date for completion: October 31, 2018

Facility Response: The 2017 Annual Patient Safety Report was signed off by the facility Director on April 25, 2018. The facility Director and the Director, Quality and Safety section (QSV) meet on a weekly basis to review quality concerns. Progress towards completion of the 2018 Patient Safety report will be reviewed at least monthly until the next annual report is submitted. Results of the annual review will be presented during the October 2018 Quality, Safety and Value Council meeting.

Target: Submission of annual report by date established by VISN Patient Safety Officer.

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

[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 September 5, 2016, through March 5, 2018.

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

    - Facility-specific
    - Service-specific
    - Provider-specific
  - Service chief recommendation of approval for requested privileges
  - Medical Staff Executive Committee decision to recommend requested privileges
  - Approval of privileges for a period of less than, or equal to, two years
- Focused Professional Practice Evaluation (FPPE)
  - Evaluation initiated
    - Timeframe clearly documented
    - Criteria developed
    - Evaluation by another provider with similar training and privileges
    - Medical Staff Executive Committee decision to recommend continuing initially granted privileges
- Ongoing Professional Practice Evaluation (OPPE)
  - Determination to continue privileges
    - Criteria specific to the service or section
    - Evaluation by another provider with similar training and privileges
    - Medical Staff Executive Committee decision to recommend continuing privileges

Conclusion

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 11 patient care areas. At the parent Facility in Palo Alto, the team inspected five inpatient units (intermediate intensive care, mental health, medical/surgical 2A and 2C, and post-anesthesia care), the Emergency Department, the pre-operative unit, a primary care clinic, Nutrition/Food Services, and three construction sites. At the Menlo Park campus, the OIG inspected the Community Living Center (CLC), Nutrition/Food Services, and two construction sites. At the Livermore campus, the OIG inspected the CLC, the podiatry clinic, and

[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.

Nutrition/Food Services. The OIG also inspected the San Jose CBOC.[54] The OIG reviewed the most recent Infection Prevention Risk Assessment, Infection Prevention and Control Committee minutes for the past six months, and other relevant documents, and interviewed key employees and managers. The OIG evaluated the following location-specific performance indicators:

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

[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.

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

Conclusion

General safety, infection prevention, and privacy measures were in place at the parent Facility in Palo Alto and at the Menlo Park and Livermore campuses. The OIG noted dirty floors at the parent Facility and the San Jose CBOC but did not identify any issues with the system-wide availability of medical equipment and supplies. Five construction projects met the construction safety requirements reviewed. The OIG identified deficiencies with EOC rounds attendance at the parent Facility and panic alarm testing at the San Jose CBOC.

Parent Facility: Environment of Care Rounds Attendance

VHA requires facilities to perform comprehensive EOC rounds with a designated team that includes specific membership to ensure a safe, clean, and high-quality care environment.[56] From October 1, 2016, through September 30, 2017, 3 of 13 required members did not attend rounds consistently, resulting in a lack of subject matter experts on EOC rounds. Facility managers were aware of the requirements but stated vacancies and competing priorities prevented compliance.

[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 4

4. 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: September 30, 2018

Facility Response: Vacant Deputy Director and Associate Director positions have been permanently filled which promotes consistent attendance from these required members and provides leadership for the each of the EOC rounds teams. Unanticipated conflicts occasionally resulted in team members not being available on the scheduled inspection days. Written standard work has been developed that provides guidance to team members and allows them to conduct rounds independently from the team. All team members were educated to the standard work between March and April 2018. Attendance at EOC rounds is presented at the monthly Environment of Care Committee meetings chaired by the Associate Director.

Target: If a member is unable to attend the scheduled EOC rounds they will complete the assigned inspection within 7 days of the scheduled inspection date for 3 consecutive months at a 90% target.

San Jose CBOC: General Safety

VHA requires Police and Security Operations to test appropriate physical security precautions and equipment, including panic alarms in high-risk outpatient areas.[57,58] Regular testing of alarm systems ensures both patient and staff safety. At the San Jose CBOC, the OIG found no evidence of panic alarm testing in the high-risk areas. The VA police were aware of requirements but did not have documented evidence due to lack of oversight.

Recommendation 5

5. The Associate Director ensures the VA Police test panic alarms at the San Jose community based outpatient clinic regularly and monitors VA Police compliance.

[57] VHA Directive 2012-026, *Sexual Assaults and other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012.

[58] VA Handbook 0730, *Security and Law Enforcement*, August 11, 2000.

Facility: concurred

Target date for completion: Completed, request closure (see below).

Facility response: There are a total of 5 panic alarms at the San Jose CBOC. When activated, these alarms alert the VA Police at the Palo Alto Division police dispatch office. The panic alarms at the San Jose CBOC are tested monthly, as are all panic alarms across the organization.

There are also two types of mutual aid/duress alarms at the CBOC. One is the Jeron nurse call system, consisting of switches and pull cords mounted on the walls of exam rooms and bathrooms. When activated these alarms annunciate at the nurse call system master consoles in the nursing stations. The second mutual aid/duress alarm at the CBOC consists of switches mounted under desks to be discrete yet accessible to staff. These switches, when activated, annunciate at the main guard desk by the front entrance and indicate the location of the alarm. During clinic hours the guard desk is manned by contract security personnel.

Panic/duress alarm testing compliance data is presented by VA Police to the Disruptive Behavior Committee (DBC) monthly and included in the DBC minutes. Mutual aid alarm testing results will be submitted to the DBC on a recurring quarterly basis, beginning the 1th quarter of FY 2019.

We request closure of this recommendation based on the information and reports provided above and during the call with the OIG inspection team on Tuesday, June 26, 2018.

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.[59] 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.[60]

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.[61] 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.[62] The OIG team interviewed key managers and reviewed CS inspection reports for the prior two completed quarters;[63] monthly summaries of findings, including discrepancies, provided to the Director for the prior 12 months;[64] CS inspection quarterly trend reports for the prior four quarters;[65] and other relevant documents. The OIG evaluated the following performance indicators:

- CSC reports
  - Monthly summary of findings to the Director
  - Quarterly trend report to the Director
  - Actions taken to resolve identified problems
- Pharmacy operations
  - Annual physical security survey of the pharmacy/pharmacies by VA Police

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

[60] American Society of Health-System Pharmacists, "ASHP Guidelines on Preventing Diversion of Controlled Substances," *American Journal of Health-System Pharmacists* 74, no. 5 (March 1, 2017): 325-348.

[61] VHA Directive 1108.02(1), *Inspection of Controlled Substances*, November 28, 2016 (Amended March 6, 2017).

[62] 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.

[63] The review period was from July through December 2017.

[64] The review period was from January through December 2017.

[65] The review period was from October 2016 through September 2017.

  - CS ordering processes
  - Inventory completion during Chief of Pharmacy transition
  - Staff restrictions for monthly review of balance adjustments
- Requirements for CSCs
  - Free from conflicts of interest
  - CSC duties included in position description or functional statement
  - Completion of required CSC orientation training course
- Requirements for CSIs
  - Free from conflicts of interest
  - Appointed in writing by the Director for a term not to exceed three years
  - Hiatus of one year between any reappointment
  - Completion of required CSI certification course
  - Completion of required annual updates and/or refresher training
- CS area inspections
  - Monthly inspections
  - Rotations of CSIs
  - Patterns of inspections
  - Completion of inspections on day initiated
  - Reconciliation of dispensing between pharmacy and each dispensing area
  - Verification of CS orders
  - CS inspections performed by CSIs
- Pharmacy inspections
  - Monthly physical counts of the CS in the pharmacy by CSIs
  - Completion of inspections on day initiated
  - Security and documentation of drugs held for destruction[66]

[66] 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.

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

Conclusion

The OIG found general compliance with requirements for most of the performance indicators evaluated, including CSC reports, annual physical security surveys, requirements for CSCs and CSIs, and pharmacy operations. However, the OIG identified deficiencies with monthly inspections and the one-day reconciliation and return of stock process 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 routine inspections.[67] In 3 of the 10 areas selected for review, the OIG noted that 8 of the 18 required monthly inspections were not completed. Failure to complete monthly inspections could potentially delay identification of discrepancies, trends, and problems related to CS usage and compromise the integrity of the CSI program. The CSCs were aware of the requirement and notified CSIs of their assigned areas; however, multiple monthly inspections were not completed due to competing priorities.

Additionally, the OIG noted that the CSCs conducted frequent monthly inspections in 5 of the 10 areas selected for review.[68] The CSCs were aware of the requirement and stated they conducted the inspections because the assigned CSIs did not complete their assignments for personal reasons or other competing priorities. When CSCs conduct frequent monthly inspections, program oversight may be compromised.

Recommendation 6

6. The Facility Director ensures that controlled substances inspectors complete monthly inspections of assigned areas and that controlled substances coordinators

[67] VHA Directive 1108.02(1).

[68] CSCs conducted monthly inspections in three out of six months in the spinal cord inpatient unit 7-F, urgent care clinic in Palo Alto, and a primary care clinic 2B at the Monterey CBOC; and two out of six months in a medical surgery unit 100-2C in Palo Alto and CC-2 at Livermore campus.

refrain from conducting routine inspections, and the Facility Director monitors program inspectors' and coordinators' compliance.

Facility concurred.

Target date for completion: November 30, 2018

Facility response: There are two issues related to this finding, 1) failure of assigned inspectors to notify the Controlled Substances Coordinator (CSC) that they would be unable to complete the inspection on time and 2) insufficient numbers of inspectors for some locations. Beginning March 1, 2018, the CSC began requiring inspections to be completed no later than the 25th of each month, rather than by the last day of the month as was previously required. This provides at least three days to assign the inspection to another inspector, rather than the CSC performing the inspection because of limited time and resources. The CSC is continuously recruiting inspectors to fill vacated positions, but the recruitment has been limited largely to requesting referrals from existing inspectors. The facility Director has become actively engaged and has engaged his administrative leaders in soliciting volunteers and encouraging employees to volunteer for this and other similar career broadening experiences. Currently, we have a full complement of trained controlled substance inspectors.

Weekly updates to the Director, Quality and Safety on inspection status with a full accounting of completed inspections is due no later than the 2nd day prior to the end of each month. Monthly Controlled substance reports are submitted to the Director, Quality and Safety (QSV) no later than the 5th business day of each month and to the facility Director, Executive Leadership Team, and pharmacy Chief no later than the 2nd Wednesday of each month. Quarterly controlled substance reports are presented to the Quality, Safety and Value Council quarterly.

Target: Monitoring will continue until 100% of monthly inspections are completed with the CSC conducting no more than two inspections in any one month for 3 consecutive months. Quarterly controlled substance reports are presented to the Quality, Safety and Value Council quarterly.

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

VHA requires CS program staff to reconcile the restocking/refilling from the pharmacy to every automated dispensing cabinet and the return of stock to pharmacy from every automated dispensing cabinet for one random day during CS area inspections.[69] The reconciliation provides the opportunity to identify potential drug diversion activities and any discrepancies with refilling or returning CS. The OIG found that reconciliation 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 CSCs

[69] VHA Directive 1108.02(1).

were not aware of the requirement until one month before the OIG on-site inspection. Missing reconciliation of returns to pharmacy stock may cause delays in identifying any potential diversion activities.

Recommendation 7

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

Facility concurred.

Target date for completion: September 30, 2018

Facility response: Controlled Substance Inspectors have been educated on expectation that reconciliation of controlled substances returned to pharmacy will be reconciled on the data of the inspection. The inpatient pharmacy supervisor has begun running the inpatient Acudose cabinet report listing returns and transfers and presents this report of the previous month's activities to the Controlled Substance Coordinator on the first work day of each month. Beginning March 2018, reconciliation of the inpatient Acudose cabinet report has been entered into the Controlled Substance monthly report. Monthly Controlled Substance reports are submitted to the Director, Quality and Safety (QSV) no later than the 5th business day of each month and the facility Director, Executive Leadership Team, and pharmacy Chief no later than the 2nd Wednesday of each month.

Target: Monitoring for compliance in reconciling returns to pharmacy on the same day as the inspection will occur monthly until there is 100% compliance for three consecutive months. Quarterly controlled substance reports are presented to the Quality, Safety and Value Council quarterly.

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."[70] 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.[71]

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.[72] 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.[73]

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

[70] 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.)

[71] VHA Handbook 1160.03.

[72] 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.

[73] VHA Handbook 1160.03.

- Completion of diagnostic evaluation within required timeframe

Conclusion

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

Long-term Care: Geriatric Evaluations

More than nine million veterans of all ages are enrolled with VA, and 46 percent of these veterans are age 65 and over.[74] 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.[75] 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.[76]

In 1999, the Veterans Millennium Benefits and Healthcare Act mandated that the veterans' standard benefits package include access to GE.[77] 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.[78] 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.[79]

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 34 randomly selected patients who received a GE from July 1, 2016, through June 30, 2017. The OIG evaluated the following performance indicators:

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

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

[75] VHA Directive 1140.04.

[76] 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.

[77] Public Law 106-117.

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

[79] VHA Directive 1140.04.

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

Conclusion

Generally, the OIG noted compliance with provision or access to GE, provider and nursing evaluations, patient education, development of plan of care, and implementation of interventions when indicated. However, the OIG identified a deficiency with program oversight that warranted a recommendation.

Program Oversight and Evaluation

VHA requires that GE performance improvement activities must be coordinated with quality management and reviewed by the leadership board responsible for oversight of all performance improvement activities at the Facility.[80] This ensures that the leadership team reviews GE data and provides the opportunity to identify practice improvements, ensures appropriate actions were taken, and measures the effectiveness of actions on a regular basis.

The OIG reviewed the Facility's Geriatric Research, Education and Clinical Center Advisory Committee meeting minutes dated January 19 and July 20, 2017, and noted evidence of monitoring, analyzing, and reporting of performance improvement activities to the committee. However, the OIG did not find evidence that GE performance improvement activities were reported to the Quality, Safety and Value Council. Program managers believed they met the requirement by conducting daily and weekly huddles and reporting urgent issues to the leadership team. Absence of reporting performance improvement activities to the leadership board may cause delay in addressing GE issues and implementing appropriate action plans.

Recommendation 8

8. The Chief of Staff ensures that the geriatric evaluation program quality improvement data are reviewed and reported to the Quality, Safety and Value Council and monitors compliance.

[80] VHA Directive 1140.04.

Facility concurred.

Target date for completion: September 30, 2018

Facility response: Geriatric Program performance improvement data was presented to the Medical Executive Committee during the April 2018 meeting. In the future, data will be presented on a recurring basis, and at least annually, to the Executive Leadership team at the Quality, Safety and Value Council.

Target: The Geriatric Program will report improvement data to the QSV no later than September 30, 2018, and then at least annually thereafter.

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.[81] 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.[82] The Veterans Health Care Act of 1992 also authorized VA to provide gender-specific services, including mammography services to eligible women veterans.[83]

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. Communication with patients must be documented.[84]

The OIG team examined whether the Facility complied with selected VHA requirements for the reporting of mammography results by reviewing relevant documents and interviewing selected employees and managers. The team also reviewed the EHRs of 44 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

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

[82] VHA Handbook 1105.03, *Mammography Program Procedures and Standards*, April 28, 2011 (updated May 21, 2018).

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

[84] VHA Directive 1330.01, *Health Care Services for Women Veterans*, February 15, 2017 (amended September 8, 2017).

- 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.[85] 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,"[86] 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.[87]

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."[88]

Infections occurring on or after the third calendar day following admission to an inpatient location are considered "healthcare-associated."[89] 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.[90]

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 15 registered nurses involved in inserting and/or managing central lines. The OIG evaluated the following performance indicators:

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

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

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

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

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

[89] 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.

[90] 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 indication. The OIG made no recommendations.

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

Healthcare Processes	Performance Indicators	Conclusion
Leadership and Organizational Risks	• Executive leadership stability and engagement • Employee satisfaction and patient experience • Accreditation/for-cause surveys and oversight inspections • Indicators for possible lapses in care • VHA performance data	Eight OIG recommendations, ranging from documentation issues to deficiencies that can lead to patient and staff safety issues or adverse events, are attributable to the Facility Director, Chief of Staff, and Associate Director. See details below.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• Protected peer review of clinical care • UM reviews • Patient safety incident reporting and RCAs	• None	• Physician UM Advisors consistently document their decisions in the National UM Integration database. • All patient safety incidents are entered into the Joint Patient Safety Reporting System. • The Patient Safety Manager submits an annual patient safety report to Facility leaders for review.
Credentialing and Privileging	• Medical licenses • Privileges • FPPEs • OPPEs	• None	• None

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Environment of Care	• Parent Facility ○ EOC rounds and deficiency tracking ○ Infection prevention ○ General Safety ○ Environmental cleanliness ○ General and exam room privacy ○ Availability of medical equipment and supplies • CBOC ○ General safety ○ Medication safety and security ○ Infection prevention ○ Environmental cleanliness ○ General and exam room privacy ○ Availability of medical equipment and supplies • Construction Safety ○ Infection control risk assessment ○ Infection Prevention/ Infection Control Committee discussions ○ Dust control ○ Safety/security ○ Selected requirements based on project type and class • Nutrition and Food Services ○ Annual Hazard Analysis Critical Control Point Food Safety System plan ○ Food Services inspections ○ Safe transportation of prepared food ○ Environmental safety ○ Infection prevention ○ Storage areas	• The panic alarms at San Jose CBOC are tested regularly.	• Required team members consistently participate on EOC rounds.

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 monthly inspections of assigned areas and CSCs refrain from conducting routine inspections. • Reconciliation of CS 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	• None	• None
Long-Term Care: Geriatric Evaluations	• Provision of or access to GE • Program oversight and evaluation • Provision of clinical care • Geriatric management	• None	• The geriatric evaluation program quality improvement data are reviewed and reported to the Strategic Planning Leadership Board.
Women's Health: Mammography Results and Follow-Up	• Result linking • Report scanning and content • Communication of results and recommended actions • Follow-up mammograms and studies	• None	• None
High-Risk Processes: Central Line-Associated Bloodstream Infections	• Policy and infection prevention risk assessment • Committee discussion • Infection incidence data • Education and educational materials	• None	• None

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
	• Policy, procedure, and checklist for insertion and maintenance of central venous catheters		

Appendix B: Facility Profile and VA Outpatient Clinic Profiles

Facility Profile

The table below provides general background information for this highest complexity (1a)[91] affiliated[92] Facility reporting to VISN 21.

Table 6. Facility Profile for Palo Alto (640)
(October 1, 2014, through September 30, 2017)

Profile Element	Facility Data FY 2015[93]	Facility Data FY 2016[94]	Facility Data FY 2017[95]
Total Medical Care Budget in Millions	$958.3	$1,000.1	$1,048.1
Number of:			
• Unique Patients	67,640	67,290	66,955
• Outpatient Visits	829,990	817,448	814,131
• Unique Employees[96]	4,253	4,355	4,345
Type and Number of Operating Beds:			
• Blind Rehab	27	27	27
• Community Living Center	360	360	360
• Domiciliary	172	172	147
• Medicine	52	67	67
• Mental Health	60	60	60
• Rehab Medicine	30	30	30
• Residential Psychiatry	10	10	10
• Spinal Cord	43	43	43
• Surgery	42	42	42
Average Daily Census:			

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

[92] Associated with a medical residency program.

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

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

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

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

Profile Element	Facility Data FY 2015[93]	Facility Data FY 2016[94]	Facility Data FY 2017[95]
• Blind Rehab	14	15	13
• Community Living Center	254	264	251
• Domiciliary	129	120	104
• Medicine	44	46	52
• Mental Health	43	45	37
• Rehab Medicine	15	17	19
• Residential Psychiatry	9	10	7
• Spinal Cord	21	21	21
• Surgery	29	32	28

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[97]

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[98] 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[99] Provided	Diagnostic Services[100] Provided	Ancillary Services[101] Provided
San Jose, CA	640BY	18,293	12,141	Cardiology Dermatology Endocrinology Gastroenterology Infectious Disease Nephrology Neurology Pulmonary/Respiratory Disease Poly-Trauma Eye Orthopedics Podiatry	Radiology	Nutrition Pharmacy Prosthetics Social Work Weight Management

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

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

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

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

[101] 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[99] Provided	Diagnostic Services[100] Provided	Ancillary Services[101] Provided
Capitola, CA	640GA	1,341	140	Endocrinology	n/a	Social Work Weight Management
Sonora, CA	640GB	6,421	2,728	Endocrinology Nephrology Spinal Cord Injury Anesthesia	n/a	Nutrition Social Work Weight Management
Fremont, CA	640GC	5,252	3,899	Endocrinology Nephrology	n/a	Nutrition Pharmacy Social Work Weight Management
French Camp, CA	640HA	15,655	7,378	Endocrinology Gastroenterology Nephrology Neurology Poly-Trauma Anesthesia	n/a	Nutrition Pharmacy Social Work Weight Management
Modesto, CA	640HB	15,932	6,399	Cardiology Endocrinology Gastroenterology Hematology/ Oncology Nephrology Rheumatology Poly-Trauma Anesthesia	Radiology	Nutrition Pharmacy Social Work Weight Management

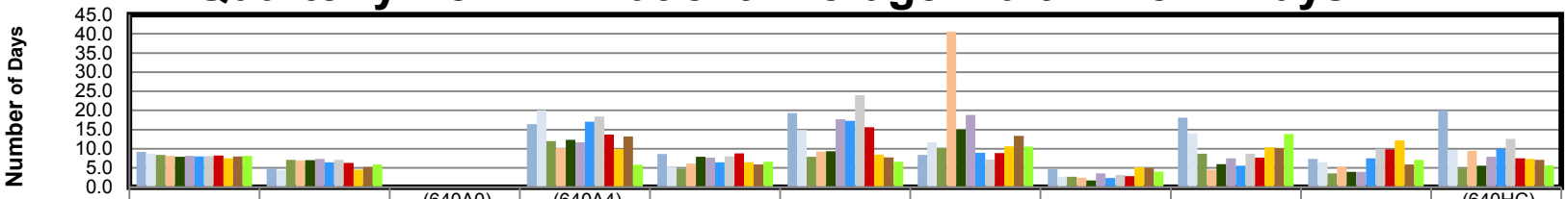
Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services[99] Provided	Diagnostic Services[100] Provided	Ancillary Services[101] Provided
Seaside, CA	640HC	19,238	8,624	Cardiology Dermatology Endocrinology Gastroenterology Hematology/Oncology Infectious Disease Nephrology Neurology Poly-Trauma Anesthesia Eye Orthopedics Podiatry Urology Vascular	EKG	Nutrition Pharmacy Social Work 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[102]



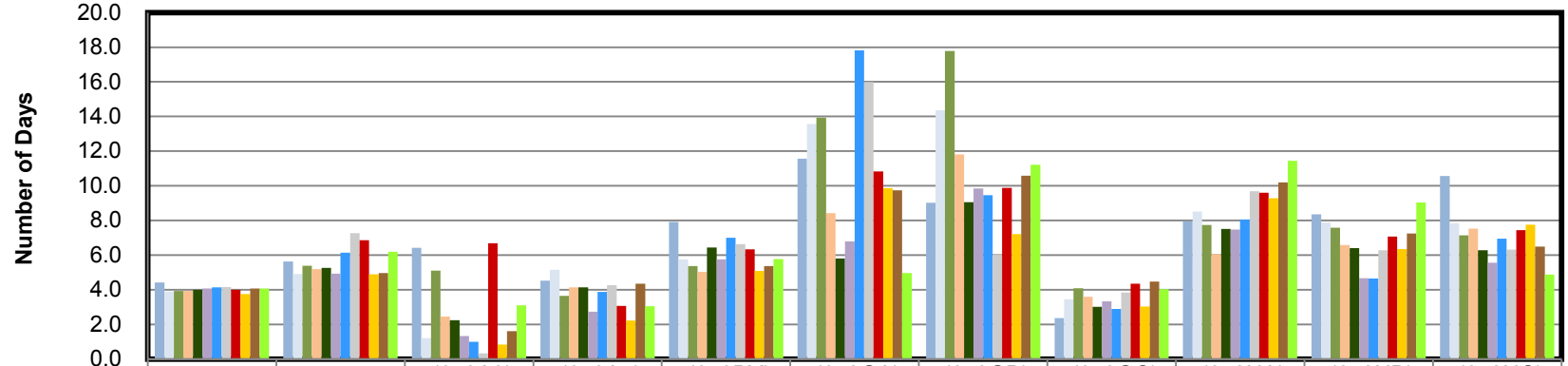
	VHA Total	(640) Palo Alto, CA	(640A0) Menlo Park, CA	(640A4) Livermore, CA	(640BY) San Jose, CA	(640GA) Capitola, CA	(640GB) Sonora, CA	(640GC) Fremont, CA	(640HA) Stockton, CA	(640HB) Modesto, CA	(640HC) Monterey, CA
JAN-FY17	9.2	4.9	0.0	16.5	8.6	19.3	8.4	4.7	18.1	7.3	20.0
FEB-FY17	8.7	4.4	0.0	20.0	5.2	14.9	11.7	2.7	14.0	6.5	9.7
MAR-FY17	8.4	7.1	n/a	12.0	4.8	7.9	10.2	2.7	8.7	3.6	4.9
APR-FY17	8.2	6.9	n/a	10.2	6.2	9.3	40.6	2.5	4.5	5.4	9.4
MAY-FY17	7.9	7.0	n/a	12.4	7.9	9.4	15.0	1.8	6.0	4.0	5.6
JUN-FY17	8.2	7.4	n/a	11.7	7.7	17.8	18.8	3.6	7.5	4.0	7.9
JUL-FY17	8.0	6.5	n/a	17.1	6.5	17.3	8.9	2.4	5.6	7.5	10.0
AUG-FY17	8.1	7.2	n/a	18.4	8.0	24.0	7.2	3.2	8.7	10.0	12.6
SEP-FY17	8.2	6.3	n/a	13.7	8.8	15.6	8.9	2.8	7.7	9.8	7.6
OCT-FY18	7.5	4.5	0.0	10.0	6.5	8.5	10.6	5.2	10.4	12.2	7.3
NOV-FY18	8.0	5.2	n/a	13.2	5.9	7.8	13.3	5.0	10.2	5.9	7.1
DEC-FY18	8.1	5.9	n/a	5.9	6.6	6.6	10.5	4.1	13.9	7.1	5.7

Source: VHA Support Service Center

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

***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."*

[102] Department of Veterans' Affairs, Patient Aligned Care Teams Compass Data Definitions, accessed September 11, 2017.

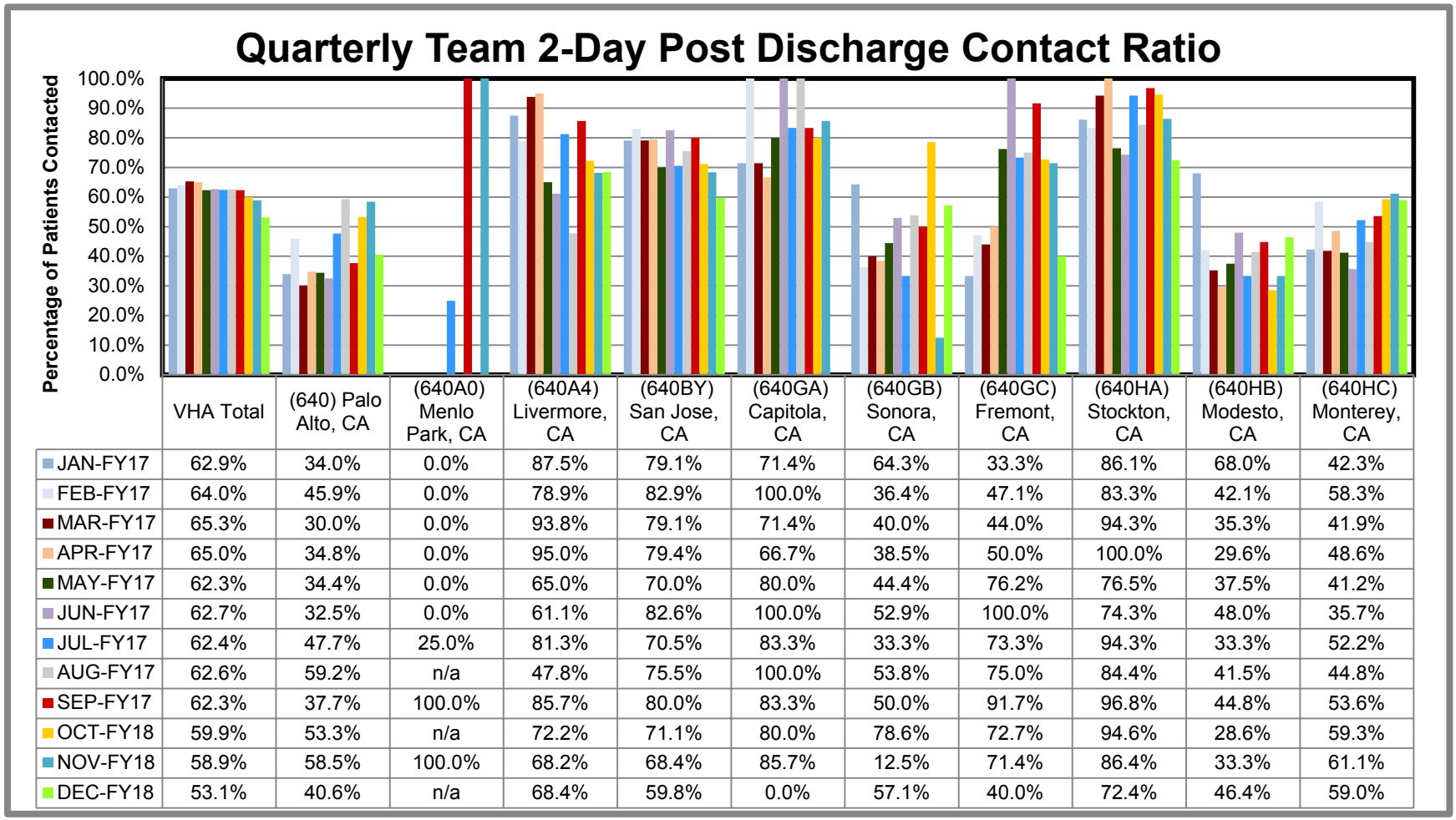


	VHA Total	(640) Palo Alto, CA	(640A0) Menlo Park, CA	(640A4) Livermore, CA	(640BY) San Jose, CA	(640GA) Capitola, CA	(640GB) Sonora, CA	(640GC) Fremont, CA	(640HA) Stockton, CA	(640HB) Modesto, CA	(640HC) Monterey, CA
JAN-FY17	4.4	5.6	6.4	4.5	7.9	11.6	9.0	2.4	7.9	8.3	10.6
FEB-FY17	3.9	4.9	1.2	5.2	5.8	13.6	14.4	3.4	8.5	7.9	7.9
MAR-FY17	3.9	5.4	5.1	3.6	5.4	13.9	17.8	4.1	7.7	7.6	7.1
APR-FY17	3.9	5.2	2.4	4.1	5.0	8.4	11.8	3.6	6.1	6.6	7.5
MAY-FY17	4.0	5.3	2.3	4.1	6.4	5.8	9.0	3.0	7.5	6.4	6.3
JUN-FY17	4.1	4.9	1.3	2.7	5.8	6.8	9.8	3.3	7.5	4.7	5.6
JUL-FY17	4.1	6.1	1.0	3.9	7.0	17.8	9.5	2.9	8.1	4.7	7.0
AUG-FY17	4.2	7.3	0.3	4.3	6.6	16.0	6.0	3.8	9.7	6.3	6.3
SEP-FY17	4.0	6.9	6.7	3.1	6.3	10.8	9.9	4.4	9.6	7.1	7.4
OCT-FY18	3.7	4.9	0.8	2.2	5.1	9.9	7.2	3.0	9.3	6.3	7.8
NOV-FY18	4.1	5.0	1.6	4.3	5.4	9.7	10.6	4.5	10.2	7.2	6.5
DEC-FY18	4.1	6.2	3.1	3.0	5.8	5.0	11.2	4.0	11.4	9.0	4.9

Source: VHA Support Service Center

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

Data Definition: *The average number of calendar days between an established patient's PC completed appointment (clinic stops 322, 323, and 350, excluding Compensation and Pension appointments) and the earliest of three possible preferred (desired) dates (Electronic Wait List(EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date.*

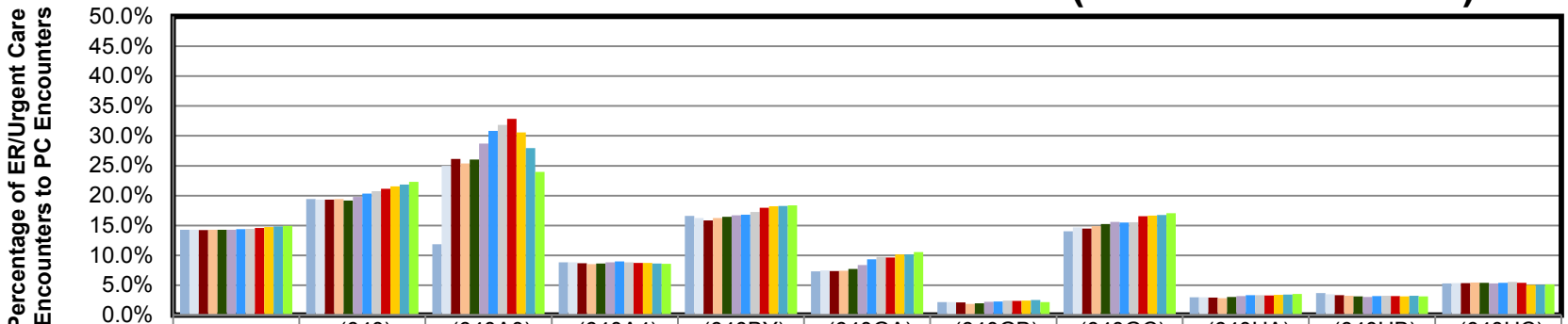


	VHA Total	(640) Palo Alto, CA	(640A0) Menlo Park, CA	(640A4) Livermore, CA	(640BY) San Jose, CA	(640GA) Capitola, CA	(640GB) Sonora, CA	(640GC) Fremont, CA	(640HA) Stockton, CA	(640HB) Modesto, CA	(640HC) Monterey, CA
JAN-FY17	62.9%	34.0%	0.0%	87.5%	79.1%	71.4%	64.3%	33.3%	86.1%	68.0%	42.3%
FEB-FY17	64.0%	45.9%	0.0%	78.9%	82.9%	100.0%	36.4%	47.1%	83.3%	42.1%	58.3%
MAR-FY17	65.3%	30.0%	0.0%	93.8%	79.1%	71.4%	40.0%	44.0%	94.3%	35.3%	41.9%
APR-FY17	65.0%	34.8%	0.0%	95.0%	79.4%	66.7%	38.5%	50.0%	100.0%	29.6%	48.6%
MAY-FY17	62.3%	34.4%	0.0%	65.0%	70.0%	80.0%	44.4%	76.2%	76.5%	37.5%	41.2%
JUN-FY17	62.7%	32.5%	0.0%	61.1%	82.6%	100.0%	52.9%	100.0%	74.3%	48.0%	35.7%
JUL-FY17	62.4%	47.7%	25.0%	81.3%	70.5%	83.3%	33.3%	73.3%	94.3%	33.3%	52.2%
AUG-FY17	62.6%	59.2%	n/a	47.8%	75.5%	100.0%	53.8%	75.0%	84.4%	41.5%	44.8%
SEP-FY17	62.3%	37.7%	100.0%	85.7%	80.0%	83.3%	50.0%	91.7%	96.8%	44.8%	53.6%
OCT-FY18	59.9%	53.3%	n/a	72.2%	71.1%	80.0%	78.6%	72.7%	94.6%	28.6%	59.3%
NOV-FY18	58.9%	58.5%	100.0%	68.2%	68.4%	85.7%	12.5%	71.4%	86.4%	33.3%	61.1%
DEC-FY18	53.1%	40.6%	n/a	68.4%	59.8%	0.0%	57.1%	40.0%	72.4%	46.4%	59.0%

Source: VHA Support Service Center

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

Data Definition: *The percent of assigned PC patients discharged from any VA facility who have been contacted by a PC team member within 2 business days during the reporting period. Patients are excluded if they are discharged from an observation specialty and/or readmitted within 2 business days to any VA facility. Team members must have been assigned to the patient's team at the time of the patient's discharge. Team member identification is based on the primary provider on the encounter. Performance measure mnemonic "PACT17." The absence of reported data is indicated by "n/a."*



	VHA Total	(640) Palo Alto, CA	(640A0) Menlo Park, CA	(640A4) Livermore, CA	(640BY) San Jose, CA	(640GA) Capitola, CA	(640GB) Sonora, CA	(640GC) Fremont, CA	(640HA) Stockton, CA	(640HB) Modesto, CA	(640HC) Monterey, CA
JAN-FY17	14.3%	19.4%	11.8%	8.8%	16.6%	7.3%	2.2%	14.0%	3.0%	3.7%	5.3%
FEB-FY17	14.3%	19.3%	25.0%	8.8%	16.2%	7.5%	2.2%	14.7%	3.0%	3.5%	5.4%
MAR-FY17	14.2%	19.3%	26.2%	8.7%	15.8%	7.4%	2.1%	14.5%	2.9%	3.3%	5.4%
APR-FY17	14.3%	19.4%	25.4%	8.5%	16.3%	7.4%	1.9%	14.9%	2.8%	3.2%	5.4%
MAY-FY17	14.3%	19.2%	26.0%	8.6%	16.4%	7.7%	2.0%	15.3%	3.1%	3.1%	5.4%
JUN-FY17	14.3%	19.8%	28.7%	8.8%	16.7%	8.4%	2.2%	15.6%	3.2%	3.0%	5.3%
JUL-FY17	14.4%	20.3%	30.8%	9.0%	16.8%	9.3%	2.3%	15.5%	3.3%	3.2%	5.4%
AUG-FY17	14.4%	20.7%	31.8%	8.8%	17.3%	9.7%	2.4%	15.5%	3.3%	3.3%	5.5%
SEP-FY17	14.6%	21.2%	32.9%	8.7%	18.0%	9.7%	2.4%	16.5%	3.3%	3.2%	5.4%
OCT-FY18	14.7%	21.6%	30.6%	8.7%	18.2%	10.2%	2.5%	16.7%	3.4%	3.1%	5.1%
NOV-FY18	14.8%	21.9%	28.0%	8.6%	18.3%	10.1%	2.5%	16.8%	3.4%	3.2%	5.0%
DEC-FY18	14.9%	22.3%	24.0%	8.6%	18.4%	10.6%	2.2%	17.1%	3.5%	3.2%	5.1%

Source: VHA Support Service Center

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

Data Definition: *This is a measure of where the patient receives his PC and by whom. A low percentage is better. The formula is the total VHA ER/Urgent Care Encounters While on Team (WOT) with a LIP divided by the number of PC Team Encounters WOT with an LIP* ***plus*** *the total number of VHA ER/Urgent Care Encounters WOT with an LIP.*

Appendix D: Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions[103]

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

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

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

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

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

Source: VHA Support Service Center

Appendix E: Acting VISN Director Comments

Department of Veterans Affairs Memorandum

Date: June 27, 2018

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

Subj: CHIP Review of the VA Palo Alto Health Care System, Palo Alto, CA

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

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

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

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

(Original signed by:)

Lisa M. Howard
Acting 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: June 22, 2018

From: Director, VA Palo Alto Health Care System (640/00)

Subj: CHIP Review of the VA Palo Alto Health Care System, Palo Alto, CA

To: Director, Sierra Pacific Network (10N21)

1. We appreciate the opportunity to review the draft report of recommendations for the OIG CHIP Review conducted at the VA Palo Alto Health Care System during March 5-9, 2018.

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

(Original signed by:)

Thomas J. Fitzgerald III
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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