DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection Program Review of the Beckley VA Medical Center

West Virginia

CHIP REPORT | REPORT #17-05401-240 | AUGUST 13, 2018

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Figure 1. *Beckley VA Medical Center, Beckley, West Virginia*
(Source: https://vaww.va.gov/directory/, accessed on May 10, 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
OIG	Office of Inspector General
LIP	licensed independent practitioner
MH	mental health
OPPE	Ongoing Professional Practice Evaluation
PC	primary care
PTSD	post-traumatic stress disorder
QSV	quality, safety, and value
RCA	root cause analysis
SAIL	Strategic Analytics for Improvement and Learning
TJC	The Joint Commission
UM	utilization management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Report Overview

This Comprehensive Healthcare Inspection Program (CHIP) review provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Beckley VA Medical Center (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 December 4, 2017. The OIG conducted interviews and reviewed clinical and administrative processes related to areas of focus that affect patient care outcomes. Although the OIG reviewed a spectrum of clinical and administrative processes, the sheer complexity of VA medical centers limits the ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of Facility performance within the identified focus areas at the time of the OIG visit. Although it is difficult to quantify the risk of patient harm, the findings in this report may help facilities identify areas of vulnerability or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Results and Review Impact

Leadership and Organizational Risks

At the Facility, the leadership team consists of the Director, Chief of Staff, Associate Director for Patient Care Services (ADPCS), and Associate Director. Organizational communication and accountability are carried out through a committee reporting structure with the Executive Committee of the Governing Body having oversight for leadership groups such as the Clinical Executive Board and Quality Leadership Council. The leaders are members of the Quality Leadership Council through which they track, trend, and monitor quality of care and patient outcomes.

The OIG found that the current leadership team had been working together for a month prior to the OIG site visit, as the Chief of Staff and Associate Director were both selected for their positions in November 2017. The Director and ADPCS were permanently assigned in September 2016 and July 2011, respectively.

In review of selected employee and patient survey results regarding Facility senior leaders, the OIG noted satisfaction scores that reflected active engagement with employees and patients. The OIG also noted that Facility leaders implemented processes and plans to maintain a committed workforce and positive patient experiences.

The OIG recognizes that the SAIL model has limitations for identifying all areas of clinical risk but is "a way to understand the similarities and differences between the top and bottom performers" within the Veterans Health Administration (VHA).[1] Although the senior leadership team was knowledgeable about selected SAIL metrics, the leaders should continue to take actions to improve performance of the Quality of Care and Efficiency metrics likely contributing to the current "3-Star" rating.

Additionally, the OIG reviewed accreditation agency findings, sentinel events,[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 could reduce potential

[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" ranking 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.)

[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.

organizational risks by establishing a more accurate and reliable system for tracking and reporting sentinel events.

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

Credentialing and Privileging

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

Environment of Care

The OIG noted a safe and clean environment of care; however, the OIG identified deficiencies with EOC rounds frequency and attendance.

Medication Management

The OIG noted general compliance with requirements for controlled substance pharmacy inspections and CSC and CSI training. However, the OIG identified deficiencies with the annual physical security survey and verification of randomly selected dispensing activities.

Women's Health

The OIG noted compliance with requirements regarding mammography report content and reporting of mammography results to providers and patients. However, the OIG identified a deficiency with mammogram results not electronically linked to the radiology orders.

High-Risk Processes

The OIG found compliance with establishing and maintaining programs to reduce the incidence of health care-associated bloodstream infections in patients with indwelling central venous catheters. However, the OIG identified a deficiency with required staff education.

Summary

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

critical findings that, if left unattended, may eventually interfere with the delivery of quality health care.

Comments

The Veterans Integrated Service Network Director and Facility Director agreed with the Comprehensive Healthcare Inspection Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes E and F, pages 55–56, for the full text of the Directors' comments.) The OIG considers recommendation 5 closed. We will follow up on the planned actions for the open recommendations until they are completed.

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Assistant Inspector General
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Purpose and Scope

Purpose

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

Scope

Good leadership makes a difference in managing organizational risks by establishing goals, strategies, and priorities to improve care; setting the quality agenda; and promoting a quality improvement culture to sustain positive change.[3,4] Investment in a culture of safety and quality improvement with robust communication and leadership is more likely to result in positive patient outcomes in healthcare organizations.[5] 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).[6]

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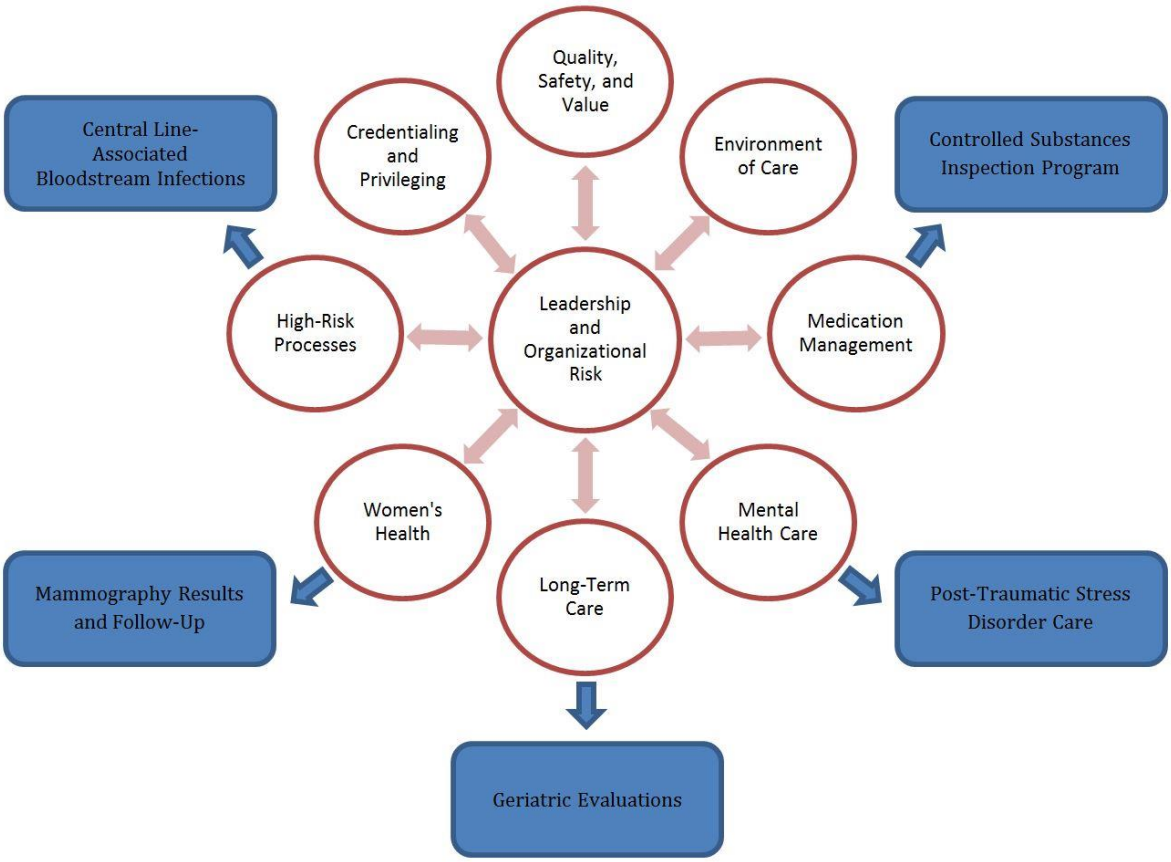
[3] Carol Stephenson, "The role of leadership in managing risk," *Ivey Business Journal*, November/December 2010. https://iveybusinessjournal.com/publication/the-role-of-leadership-in-managing-risk/. (Website accessed on March 1, 2018.)

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

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

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

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



Source: VA OIG

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

Methodology

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

The review covered operations for December 8, 2014,[8] through December 4, 2017, the date when an unannounced week-long site visit commenced. On December 13–14, 2017, the OIG presented crime awareness briefings to 75 of the Facility's 859 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 Q*uality Standards for Inspection and Evaluation* published by the Council of the Inspectors General on Integrity and Efficiency.

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

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

Results and Recommendations

Leadership and Organizational Risks

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

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

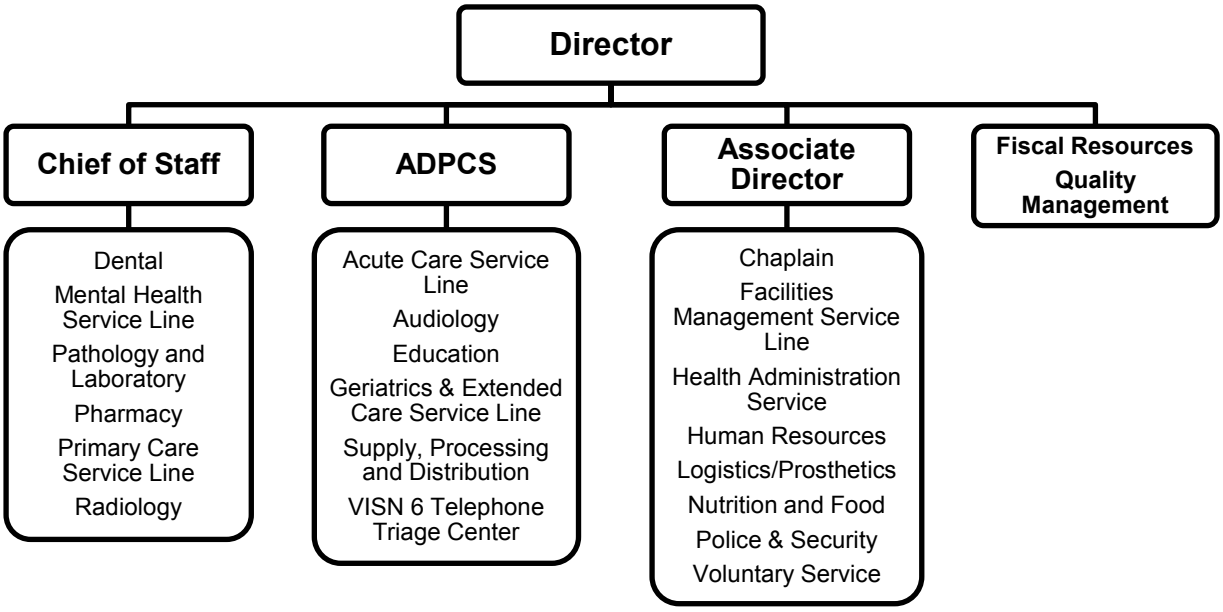
Executive Leadership Stability and Engagement

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

It is important to note that prior to hiring the Chief of Staff and Associate Director in November 2017, the Facility had four acting Chiefs of Staff from December 2016 to November 2017 and one acting Associate Director from April 2017 to November 2017. The ADPCS position has been the most stable with its incumbent in the position since 2011. The Director has been in place since September 2016. At the time of the OIG site visit, the executive leaders had been working together as a team for approximately one month.

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

Figure 3. Facility Organizational Chart



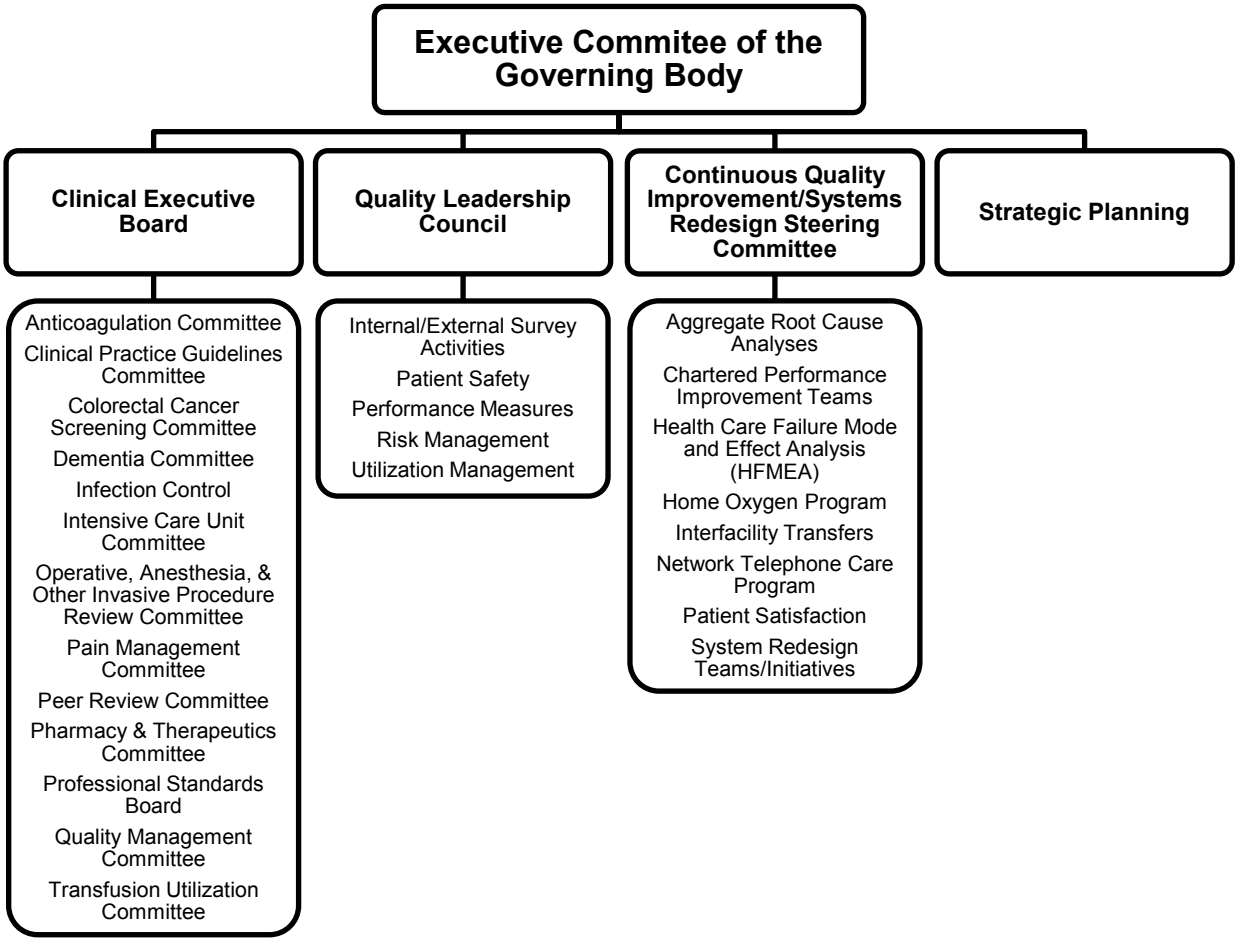
Source: Beckley VA Medical Center (received December 6, 2017)

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 metrics and their involvement and support of actions to improve or sustain performance.

Individual interviews were conducted, with the exception of the Chief of Staff and Associate Director where the previous acting staff for those positions also participated. The executive leaders generally were able to speak knowledgeably about actions taken during the previous 12 months in order to maintain or improve performance, employee and patient survey results, and selected Strategic Analytics for Improvement and Learning (SAIL) metrics. These are discussed more fully below.

The leaders are also engaged in monitoring patient safety and care through formal mechanisms. They are members of the Executive Committee of the Governing Body, which tracks, trends, and monitors quality of care and patient outcomes. The Director serves as the Chairperson with the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. The Executive Committee of the Governing Body oversees various working committees, such as the Clinical Executive Board and Quality Leadership Council. The Director also serves as chairperson of the Quality Leadership Council where clinical and administrative metrics are reported and implemented actions are followed to closure. See Figure 4.

Figure 4. Facility Committee Reporting Structure



Source: Beckley VA Medical Center (received December 6, 2017

Employee Satisfaction and Patient Experience

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

July 31, 2017. As Table 1 indicates, the Facility leaders' results (Director's Office average) were markedly higher than the Facility and VHA averages.[10] In all, employees appear generally satisfied with the leaders. The executive leaders attribute executive rounds, an open door policy, and employee moral building activities through the employee association as factors that contributed to the employee satisfaction scores.

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

Questions/Survey Items	Scoring	VHA Average	Facility Average	Director's Office Average[11]
All Employee Survey Q59. *How satisfied are you with the job being done by the executive leadership where you work?*	1 (Very Dissatisfied)–5 (Very Satisfied)	3.3	3.4	4.27
All Employee Survey: *Servant Leader Index Composite*	0–100 where HIGHER scores are more favorable	66.7	67.2	89.6

Source: VA All Employee Survey (accessed November 2, 2017)

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 towards Facility leaders (see Table 2). For this Facility, all four patient survey results reflected similar or higher care ratings compared to the VHA average. Patients appear generally satisfied with the leadership and care provided.

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

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

Table 2. Survey Results on Patient Attitudes toward Facility Leadership (October 1, 2016, through July 31, 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.	66.8	65.2
Survey of Healthcare Experiences of Patients (inpatient): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	83.4	85.1
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.	74.7	80.8
Survey of Healthcare Experiences of Patients (outpatient specialty care): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	75.0	84.4

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed November 2, 2017)

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

To further assess Leadership and Organizational Risks, the OIG reviewed recommendations from previous inspections by oversight and accrediting agencies to gauge how well leaders respond to identified problems. Table 3 summarizes the relevant Facility inspections most

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

recently performed by the OIG and The Joint Commission (TJC).[13] Indicative of effective leadership, the Facility has closed all recommendations for improvement as listed in Table 3.[14]

The OIG also noted the Facility's current accreditation status with College of American Pathologists,[15] which demonstrates the Facility leaders' commitment to quality care and services. Additionally, the Long Term Care Institute[16] conducted an inspection of the Facility's Community Living Center.

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

Accreditation or Inspecting Agency	Date of Visit	Number of Findings	Number of Recommendations Remaining Open
OIG (*Combined Assessment Program Review of the Beckley VA Medical Center, Beckley, West Virginia, February 25, 2015*)	December 2014	15	0
OIG (*Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Beckley VA Medical Center, Beckley, West Virginia, May 21, 2015*)	March 2015	10	0
OIG (*Healthcare Inspection – Alleged Patient Deaths and Management Deficiencies in Home Based Primary Care, Beckley VA Medical Center, Beckley, West Virginia, May 8, 2017*)	January 2015	0	n/a
TJC • Regular	March 2017		
○ Hospital Accreditation		25	0
○ Behavioral Health Care Accreditation		7	0

[13] 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.

[14] 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.

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

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

Accreditation or Inspecting Agency	Date of Visit	Number of Findings	Number of Recommendations Remaining Open
○ Home Care Accreditation		1	0
• Special Unannounced Event[17]	April 2015	1	0

Sources: OIG and TJC (Inspection/survey results verified with the Director on December 5, 2017)
n/a – not applicable

Indicators for Possible Lapses in Care

Within the healthcare field, the primary organizational risk is the potential for patient harm. Many factors impact the risk for patient harm within a system, including unsafe environmental conditions, sterile processing deficiencies, and infection control practices. Leaders must be able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms. Table 4 summarizes key indicators of risk since the OIG's previous December 2014 Combined Assessment Program and Community Based Outpatient Clinic (CBOC) and Other Outpatient Clinics review inspections through the week of December 4, 2017.[18]

Additionally, while reviewing Facility documents, the OIG noted two patient incidents that appeared to meet criteria for sentinel events but were not included in the list provided by the Facility. The events were reviewed through internal processes, and institutional disclosures were conducted with the patients and/or their representatives. Facility managers stated the events were not classified as sentinel events due to the interpretation of the definition, and that following the OIG site visit, the managers requested additional training related to sentinel events.

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

[18] It is difficult to quantify an acceptable number of occurrences because one occurrence is one too many. Efforts should focus on prevention. Sentinel events and those that lead to disclosure can occur in either inpatient or outpatient settings and should be viewed within the context of the complexity of the Facility. (Note that the Beckley VA Medical Center is a medium complexity (2) affiliated Facility as described in Appendix B.)

Table 4. Summary of Selected Organizational Risk Factors (December 2014 to December 4, 2017)

Factor	Number of Occurrences
Sentinel Events[19]	1
Institutional Disclosures[20]	6
Large-Scale Disclosures[21]	0

Source: Beckley VA Medical Center's Patient Safety Manager (received December 5, 2017)

The OIG also reviewed Patient Safety Indicators developed by the Agency for Healthcare Research and Quality within the U.S. Department of Health and Human Services. These provide information on potential in-hospital complications and adverse events following surgeries and procedures.[22] The rates presented are specifically applicable for this Facility, and lower rates indicate lower risks. Table 5 summarizes Patient Safety Indicator data from October 1, 2015, through June 30, 2017.

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

Measure	Reported Rate per 1,000 Hospital Discharges		
	VHA	VISN 5	Facility
Pressure ulcers	0.60	1.17	0.00
Death among surgical inpatients with serious treatable conditions	103.19	126.76	n/a
Iatrogenic pneumothorax	0.18	0.12	0.00
Central venous catheter-related bloodstream infection	0.14	0.10	0.00
In-hospital fall with hip fracture	0.08	0.04	0.00

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

[20] Institutional disclosure of adverse events (sometimes referred to as "administrative disclosure") is a formal process by which facility leaders together with clinicians and others, as appropriate, inform the patient or his or her personal representative that an adverse event has occurred during care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient's rights and recourse.

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

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

Measure	Reported Rate per 1,000 Hospital Discharges		
	VHA	VISN 5	Facility
Perioperative hemorrhage or hematoma	2.00	1.49	0.00
Postoperative acute kidney injury requiring dialysis	0.98	0.70	0.00
Postoperative respiratory failure	5.98	2.44	0.00
Perioperative pulmonary embolism or deep vein thrombosis	3.33	4.86	0.00
Postoperative sepsis	4.04	2.89	0.00
Postoperative wound dehiscence	0.50	0.00	0.00
Unrecognized abdominopelvic accidental puncture/laceration	0.53	0.00	0.00

Source: VHA Support Service Center
Note: The OIG did not assess VA's data for accuracy or completeness.
n/a – not applicable

None of the Patient Safety Indicator measures show an observed rate in excess of the observed rates for Veterans Integrated Service Network (VISN) 5 or VHA.

Veterans Health Administration Performance Data

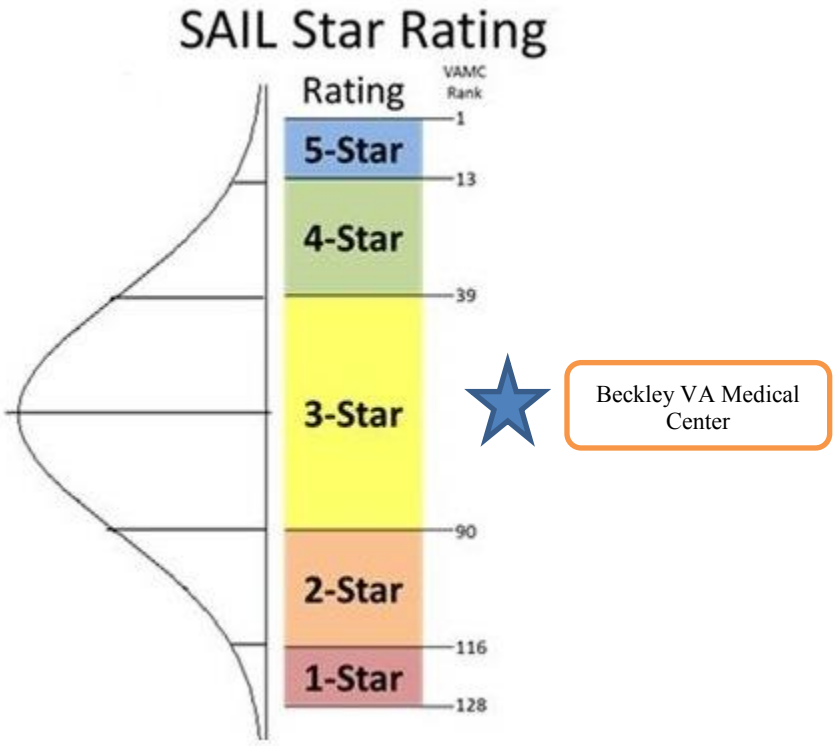
The VA Office of Operational Analytics and Reporting adapted the SAIL Value Model to help define performance expectations within VA. This model includes measures on healthcare quality, employee satisfaction, access to care, and efficiency, but has noted limitations for identifying all areas of clinical risk. The data are presented as one "way to understand the similarities and differences between the top and bottom performers" within VHA.[23]

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.[24] As of June 30, 2017, the Facility was rated at "3-Star" for overall quality.

[23] 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.)

[24] 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)

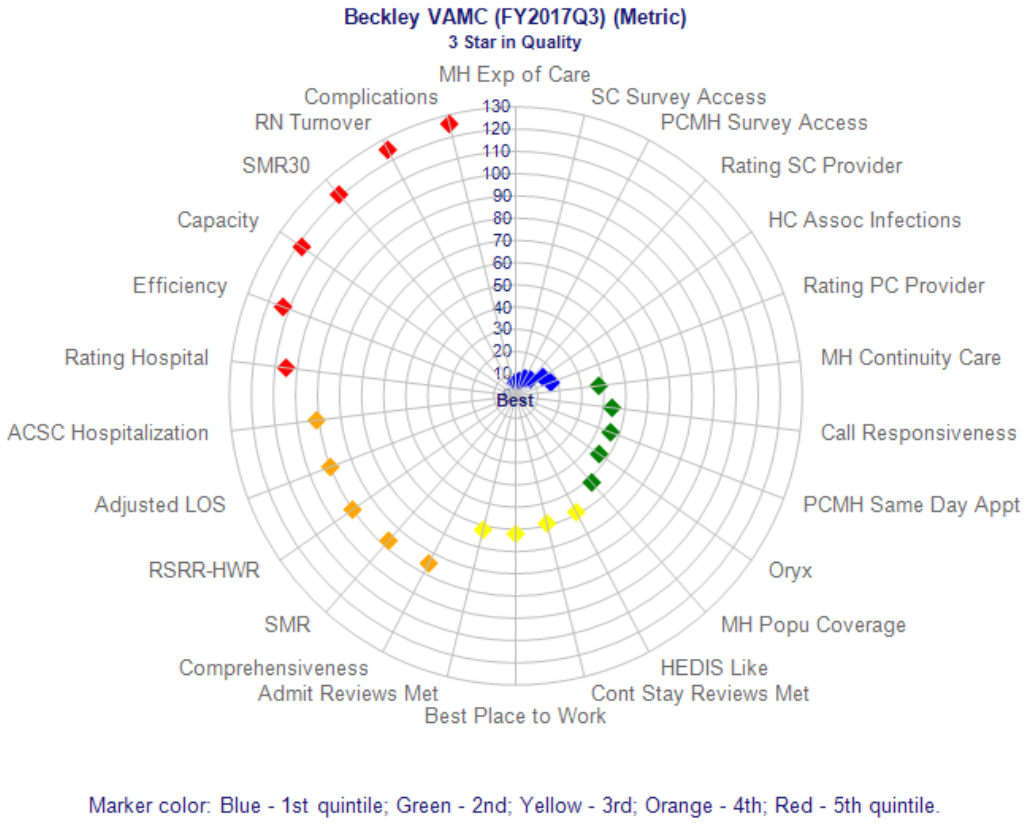


Source: VA Office of Informatics and Analytics Office of Operational Analytics and Reporting (accessed November 2, 2017)

Figure 6 illustrates the Facility's Quality of Care and Efficiency metric rankings and performance compared with other VA facilities as of June 30, 2017. Of note, Figure 6 uses blue and green data points to indicate high performance (for example in the areas of Rating of Specialty Care (SC) Provider, Healthcare (HC) Associated Infections, and Call Responsiveness).[25] Metrics that need improvement are denoted in orange and red (for example, Comprehensiveness, Capacity, Registered Nurse (RN) Turnover, and Complications).

[25] 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 June 30, 2017)



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

Conclusion

The leadership team appears stable with the hiring the Chief of Staff and Associate Director in November 2017. The leaders are committed to continuous active engagement with employees and patients to maintain high satisfaction scores. The leadership team supports 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 the organization's accreditation findings and Patient Safety Indicator data did not identify any substantial organizational risk factors. However, the OIG noted that the Facility appears to have opportunities to improve the reporting and tracking of sentinel events. Although the senior leadership team was knowledgeable about selected SAIL metrics, the leaders should continue to take actions to improve performance of selected Quality of Care and Efficiency metrics likely contributing to the most current "3-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.[26] VHA also strives to provide healthcare services that compare favorably to the best of the private sector in measured outcomes, value, and efficiency.[27]

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,[28] utilization management (UM) reviews,[29] and patient safety incident reporting with related root cause analyses (RCAs).[30]

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.[31]

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

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

[28] 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.)

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

[30] 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 RCA (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.

[31] 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:[32]

- 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[33]
  - Annual completion of a minimum of eight RCAs[34]
  - Provision of feedback about RCA actions to reporting employees
  - Submission of annual patient safety report

Conclusion

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

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

[33] 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.

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

Credentialing and Privileging

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

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

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

The purpose of the OIG review was to determine whether the Facility complied with selected requirements for credentialing and privileging of selected members of the medical staff. The OIG team interviewed key managers and reviewed the credentialing and privileging folders of 5 LIPs who were hired within 18 months prior to the on-site visit,[38] and 20 LIPs who were re-privileged within 12 months prior to the visit.[39] The OIG evaluated the following performance indicators:

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

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

[36] VHA Handbook 1100.19.

[37] VHA Handbook 1100.19.

[38] The 18-month period was from June 1, 2016, through December 1, 2017.

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

    - 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

The OIG found general compliance with requirements for credentialing, privileging, and FPPEs. However, the OIG identified the following deficiencies in the OPPE process.

Ongoing Professional Practice Evaluations

VHA requires that at the time of reprivileging, Service Chiefs consider relevant service- and practitioner-specific data utilizing defined criteria when recommending the continuation of licensed independent practitioners' privileges to the Executive Committee of the Medical Staff.[40] Such data is maintained as part of the practitioner's provider profile and may include direct observations, clinical discussions, and clinical record reviews. The OPPE process is essential to

[40] VHA Handbook 1100.19.

confirm the quality of care delivered and allows the facility to identify professional practice trends that impact the quality of care and patient safety.

For renewal of practitioners' privileges, the OIG found that 5 of 20 provider profiles examined had no evidence of complete service-specific data collection, resulting in providers continuing to deliver care without a thorough evaluation of their practice. Managers and credentialing and privileging staff provided different timeframes for completion of OPPEs. For example, some managers believed they had 60 days following the end of each six-month period to complete OPPEs for their staff; others thought they had 90 days for completion. Additionally, the credentialing and privileging coordinator reported difficulty in obtaining, in a timely manner, the required completed data from the managers. Managers stated another reason for noncompliance included lack of staffing for performing the administrative tasks related to OPPEs.

Recommendation 1

1. The Chief of Staff ensures that service line managers consistently collect and review Ongoing Professional Practice Evaluation data and monitors compliance.

Facility Concurred.

Target date for completion: December 15, 2018

Facility response: The Chief of Staff ensures the service line managers collect and review the Ongoing Professional Practice Evaluation (OPPE) data. Effective January 4, 2018, the clinical manager enters comments in the service line approval screen in VetPro with each re-credentialing cycle. A Standard Operating Procedure for the completion of Professional Practice Evaluations (focused and ongoing) was established February 1, 2018; with education of the service line chiefs on February 9, 2018. Timely completion of the ongoing professional practice evaluations is tracked by a spreadsheet maintained by the Credentialing Coordinator with monthly reporting to the Professional Standard and Clinical Executive Boards. Compliance with timely completion of OPPEs will be measured for 6 months by a review of the spreadsheet data until a target of 90% compliance is achieved and sustained with monthly reporting to the Professional Standards and Clinical Executive Boards.

Ongoing Professional Practice Evaluations by Similarly-Trained Providers

VHA requires the competency of licensed independent providers to be evaluated by another provider with similar training and privileges.[41] This requirement of the OPPE process is essential to confirm the competency of privileged providers. For 3 of 15 completed OPPEs, the OIG did

[41] VHA Handbook 1100.19.

not find evidence that a similarly-trained and privileged provider completed the evaluations. Facility managers reported that two of the three providers are solo-practitioners in respective specialties at the Facility. Facility managers also reported sending evaluations for solo-practitioners to other VHA facilities for completion by similarly trained and privileged providers. The OIG found that the OPPE for one of the two solo practitioners was completed within the Facility by a provider who was not similarly trained, and the two remaining OPPEs were not returned in a timely manner from other VHA facilities so that Facility managers could include these evaluations in their periodic six-month reviews. In one case, it took seven months for the Facility to receive the completed evaluation from the referred VHA facility. While managers did not verbalize specific reasons for noncompliance, the OIG determined that they did not have a process in place to monitor timely return of OPPEs completed by external reviewers.

Recommendation 2

2. The Chief of Staff ensures that service line managers collect Ongoing Professional Practice Evaluation data utilizing assessments by providers with similar training and privileges and monitors compliance.

Facility Concurred.

Target date for completion: June 30, 2019

Facility response: The Chief of Staff (COS) and service line managers ensure the coordination and assignment of Ongoing Professional Practice Evaluations (OPPE's) to the appropriate reviewer with similar training/privileges at offsite VHA facilities. Timely completion of ongoing professional practice evaluations for sole practitioners are tracked by a spreadsheet maintained by the Credentialing Coordinator with monthly reporting to the Professional Standard and Clinical Executive Boards. The spreadsheet verifies a reviewer of similar training and privileges completes the OPPE of the sole practitioner. The COS is notified when the offsite review has not been received 30 days from the due date to work directly with the offsite facilities' COS for completion. Compliance with timely completion of OPPE's for sole practitioners will be measured for 12 months by a review of the spreadsheet data until a target of 90% compliance is achieved and sustained with monthly reporting to the Professional Standards and Clinical Executive Boards.

Environment of Care

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

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

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

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

In all, the OIG inspected four inpatient units (3B–acute care, intensive care, 6A/B–medical/surgical, and community living center), five outpatient clinics (dental, orthopedics, PC Clinics 1 and 2, and Women's Health), the Emergency Department, and Nutrition and Food Services. The OIG also inspected the Princeton CBOC.[48] Additionally, the OIG reviewed the most recent Infection Prevention Risk Assessment, Infection Prevention/Infection Control

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

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

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

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

[46] VHA Directive 7715.

[47] VHA Handbook 1109.04.

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

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

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

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

Conclusion

General safety, infection prevention, and privacy measures were in place at the parent Facility and representative CBOC areas. The OIG did not note any issues with the availability of medical equipment and supplies. However, the OIG identified the following deficiencies in EOC rounds that warranted recommendations for improvement.

Parent Facility's Environment of Care Rounds Frequency

VHA requires EOC rounds to be conducted at a minimum of once per FY in non-patient care areas and twice per FY in patient care areas.[50] Further, the Comprehensive EOC Assessment and Compliance Tool (Performance Logic) is to be used to collect all data associated with EOC rounds within facilities. EOC rounds assist in identifying potential patient safety risks and deficiencies. The OIG reviewed Performance Logic data for October 1, 2016, through September 30, 2017, and found 22 areas were not inspected at the required frequency. Facility managers stated that although the Facility uses Performance Logic software to document EOC rounds, the EOC rounds are entered by building number and not specific areas. Managers/staff believed they were meeting the requirements and were unaware of the noncompliance.

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

[50] VHA Directive 1608.

Recommendation 3

3. The Associate Director ensures environment of care rounds are conducted at the required frequency and documented in the Comprehensive Environment of Care Assessment and Compliance Tool and monitors compliance.

Facility Concurred.

Target date for completion: September 30, 2018

Facility response: The Associate Director or his designee ensures environment of care rounds are conducted at the required frequency and documented in the Performance Logic Inspection Tool. The Occupational Safety and Health Manager, refined the locations and services within the Performance Logic Inspection Tool so the generated reports accurately reflect the areas to be inspected at the required frequency. Effective December 22, 2017, the list of locations to be inspected accurately reflects the Environment of Care rounds process to cover all patient care and nonpatient care areas twice per year. To maintain compliance, beginning January 18, 2018, a report will be generated biannually and reviewed to ensure all areas are inspected as scheduled and reported biannually to the Safety and EOC committee. Compliance will be measured monthly through review of the Performance Logic area inspection reports beginning January 2018, through September 30, 2018, until a target of 90% compliance is achieved and sustained.

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.[51] From October 1, 2016, through September 30, 2017, 11 of 13 required members did not consistently participate in EOC rounds. Lack of consistent attendance of subject matter experts increases the risk of missing deficiencies and areas of improvement, which could cause harm to patients, visitors, and staff. Facility managers informed the OIG that the Facility's Performance Logic Report was not set up to accurately record alternate member attendance and that staff needs additional training on the documentation requirements for recording attendance in Performance Logic.

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

Recommendation 4

4. The Associate Director ensures required team members participate on environment of care rounds and that attendance is recorded in the Comprehensive Environment of Care Assessment and Compliance Tool and monitors compliance.

Facility Concurred.

Target date for completion: September 30, 2018

Facility response: The Associate Director or his designee ensures attendance of all required staff for required environment of care rounds and attendance is documented in the Performance Logic Inspection Tool. To ensure attendance, the Occupational Safety and Health Manager identified core EOC members along with alternates who serves as a back-up in the event of absence of the core member. As of December 27, 2017, all core and alternate members completed training and the Performance Logic (PL) Inspection program installed on their desktop for timely entry of their findings following each inspection. To ensure compliance, as of January 2018, the EOC rounds attendance is reported monthly to the Safety and EOC Committee. Performance will be measured through monthly review of Performance Logic attendance reports beginning January 2018 through September 30, 2018 for sustained performance of 85%.

Medication Management: Controlled Substances Inspection Program

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

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

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

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

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

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

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

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

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

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

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

  - CS ordering processes
  - Inventory completion during Chief of Pharmacy transition
  - Staff restrictions for monthly review of balance adjustments
- Requirements for CSCs
  - Free from conflicts of interest
  - CSC duties included in position description or functional statement
  - Completion of required CSC orientation training course
- Requirements for CSIs
  - Free from conflicts of interest
  - Appointed in writing by the Director for a term not to exceed three years
  - Hiatus of one year between any reappointment
  - Completion of required CSI certification course
  - Completion of required annual updates and/or refresher training
- CS area inspections
  - Monthly inspections
  - Rotations of CSIs
  - Patterns of inspections
  - Completion of inspections on day initiated
  - Reconciliation of dispensing between pharmacy and each dispensing area
  - Verification of CS orders
  - CS inspections performed by CSIs
- Pharmacy inspections
  - Monthly physical counts of the CS in the pharmacy by CSIs
  - Completion of inspections on day initiated
  - Security and documentation of drugs held for destruction[59]

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

- 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 CSC monthly and quarterly reports, CSC and CSI training, and pharmacy inspections. However, the OIG identified deficiencies related to the annual physical security survey and randomly selected dispensing activities.

Annual Physical Security Survey

VHA requires the Chief, Police and Security Unit, to follow up with the pharmacy to ensure that identified deficiencies from the annual physical security survey have been corrected.[60] This ensures the security of medications stored in the pharmacy. The Police and Security Service completed the required Physical Security Survey for 2017; however, the identified deficiency had not been resolved. Facility managers provided OIG documentation that the inpatient pharmacy deficiency was a repeat finding from the 2015 and 2016 physical surveys and that a waiver from policy was in place until August 2016. Facility managers stated that lack of funding and a request for a waiver from policy as reasons the deficiencies were not corrected. In addition, Facility managers told us that work orders to correct the deficiencies were entered in June and September 2017.

Recommendation 5

5. The Facility Director ensures that deficiencies identified on the Annual Physical Security Survey are corrected and monitors compliance.

Facility Concurred.

Target date for completion: February 5, 2018

Facility response: The Facility Director or her designee ensures that deficiencies identified on the Annual Physical Security Survey are corrected and monitored for compliance. The Police Service Physical Security Specialist conducts and documents the Physical Security Surveys annually to ensure compliance with VA Handbook 0730. All deficiencies are entered onto a spreadsheet and tracked by the Physical Security Specialist. The documentation is routed through

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

the Chief of Police to Facility Leadership and the effected Service Line Chief identifying the results. Follow-up inspections are conducted within 90 days on all identified deficiencies, and the results are reported through the Chief of Police to Facility Leadership and the effected Service Line Chief.

As of February 5, 2018, to correct the deficiency cited in the 2015 and 2016, Annual Physical Security Inspections, requiring the inpatient pharmacy windows to have an expanded security mesh screening installed on the outside of the window frame, seven of seven window screens were fabricated and installed over the Pharmacy windows.

Controlled Substances Area Inspections: Verification of Orders

VHA requires that CSIs verify during CS area inspections that there is evidence of a written or electronic CS order for a prescribed number of randomly selected patients.[61] This ensures accountability for all CS. The OIG reviewed monthly documentation of eight areas for CS inspections from April through September 2017. For all eight areas, the CSIs did not consistently document verification of a written or electronic CS order. Facility managers stated the CSIs used three different forms to document results of the CS inspections and cited a lack of oversight as reasons for noncompliance.

Recommendation 6

6. The Facility Director ensures that the controlled substances inspectors consistently perform controlled substances order verification as required and monitors compliance.

Facility Concurred.

Target date for completion: August 15, 2018

Facility response: The Facility Director or her designee ensures that the controlled substances inspectors consistently perform controlled substances order verification as required and monitors inspectors' compliance. As of January, 2018, the Controlled Substance Coordinator revised Medical Center Memorandum 119-2 Inspection of Controlled Substances Attachments A1 and A3 to clearly define VHA requirements and to improve consistency of reviews by the Controlled Substance Inspectors in the following areas: completion of physical counts in areas where controlled substances are stored; verification of controlled substance orders in patient records reviewed; and documentation of verification of drugs held for destruction against the report. The Controlled Substance Coordinator educated the controlled substance inspectors on the revised forms on January 4, 2018. Compliance with these requirements will be monitored through the

[61] VHA Directive 1108.02(1).

Controlled Substance Inspection Reports from February-June 2018, for evidence of sustained performance at 100%. All reports are reviewed and concurred upon by the Medical Center Director.

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."[62] 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.[63]

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.[64] 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.[65]

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

[62] VHA Handbook 1160.03, *Programs for Veterans with Post-Traumatic Stress Disorder (PTSD)*, March 12, 2010. (rescinded November 16, 2017).

[63] VHA Handbook 1160.03.

[64] 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.

[65] Department of Veterans Affairs, Information Bulletin, *Clarification of Posttraumatic Stress Disorder Screening Requirements*, August 6, 2015.

- Referral for diagnostic evaluation
- 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.[66] As a group, veterans experience more chronic disease and disability than their non-veteran peers. VA must plan for the growing health demands by aging veterans and to have mechanisms in place for delivering those services in an appropriate and cost-effective manner.[67] Participants in geriatric evaluation (GE) programs have been shown to be significantly less likely to lose functional ability, experience health-related restrictions in their daily activities, or use home healthcare services.[68]

In 1999, the Veterans Millennium Benefits and Healthcare Act mandated that the veterans' standard benefits package include access to GE.[69] This includes a comprehensive, multidimensional assessment and the development of an interdisciplinary plan of care. The healthcare team would then manage the patient with treatment, rehabilitation, health promotion, and social service interventions necessary for fulfillment of the plan of care by key personnel.[70] Facility leaders must also evaluate the GE program through a review of program objectives, procedures for monitoring care processes and outcomes, and analyses of findings.[71]

In determining whether the Facility provided an effective geriatric evaluation, OIG staff reviewed relevant documents and interviewed key employees and managers. Additionally, the team reviewed the EHRs of 45 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

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

[67] VHA Directive 1140.04.

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

[69] Public Law 106-117.

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

[71] VHA Directive 1140.04.

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

Women's Health: Mammography Results and Follow-Up

In 2017, an estimated 252,710 new cases of invasive breast cancer and 40,610 breast cancer deaths were expected to occur among US women.[72] 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.[73] The Veterans Health Care Act of 1992 also authorized VA to provide gender-specific services, including mammography services to eligible women veterans.[74]

VHA has established timeframes for clinicians to notify ordering providers and patients of mammography results. "Incomplete" and "probably benign" results must be communicated to the ordering provider within 30 days of the procedure and to the patient within 14 calendar days from the date the results are available to the ordering provider. "Suspicious" and "highly suggestive of malignancy" results must be communicated to the ordering provider within three business days of the procedure, and the recommended course of action should be communicated to the patient as soon as possible, with seven calendar days representing the outer acceptable limit. Verbal communication with patients must be documented.[75]

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 45 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

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

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

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

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

- Performance of follow-up mammogram if indicated[76]
- Performance of follow-up study

Conclusion

The OIG found general compliance with requirements regarding the inclusion of required components in mammography reports and reporting of mammography results to providers and patients. However, the OIG identified the following deficiency that warranted a recommendation for improvement.

Electronic Linking of Results

VHA requires that mammogram results (Breast Imaging Reporting and Data System codes) are associated with the radiology order to ensure that the systems for tracking and managing mammography and breast cancer operate accurately.[77] This also ensures accurate reporting of data for use in program improvement, compliance, and oversight activities. The OIG estimated that the results of mammograms were linked to the radiology order in 60 percent of the EHRs reviewed; and 95 percent of the time, the true compliance rate is between 44.4 and 73.3 percent, which is statistically significantly below the 90 percent benchmark. This resulted in potential improper tracking and management of mammography and breast cancer results. Facility managers believed that efforts met requirements and stated that there may have been a technical issue that prevented results from electronically linking to the radiology order.

Recommendation 7

7. The Chief of Staff ensures that mammogram results are electronically linked to the radiology orders and monitors compliance.

Facility Concurred.

Target date for completion: September 30, 2018

Facility Response: The Chief of Staff or his designee ensures that mammogram results are electronically linked to the radiology orders and monitored for compliance. The Primary Care Service Line Chief ensures mammography results are linked to the radiology order in the electronic medical record. Effective January 2, 2018, the radiology Medical Support Assistant is allocated time to link the mammogram results to the radiology order. If the order has not been placed, the ordering provider is contacted to place the order for documentation. The Women's Clinic monitors compliance through chart review as part of their Quality indicators with

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

[77] VHA Directive 1330.01.

quarterly reporting to the Quality Management committee effective May 2018. Compliance will be monitored through September 30, 2018 for sustained performance at 90%.

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.[78] 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,"[79] 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.[80]

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."[81]

Infections occurring on or after the third calendar day following admission to an inpatient location are considered "healthcare-associated."[82] 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.[83]

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

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

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

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

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

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

[82] 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.

[83] 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 OIG noted that the Facility has policies on the use and care of central lines, performed an annual infection prevention risk assessment, has evidence of routine reviews of CLABSI data and prevention measures, and discussed CLABSI rates in appropriate committees and forums. In addition, the Facility has a checklist for central line insertions. However, the OIG identified the following deficiency that warranted a recommendation for improvement.

Education Requirements

The TJC requires that staff involved in managing (insertion and maintenance of) central lines receive CLABSI and infection prevention education upon hire or granting of initial privileges and periodically thereafter.[84] This ensures that involved staff are aware of what is necessary to prevent central line infections. Failure to educate staff may result in increased incidence of CLABSI. For 3 of 25 registered nurses, the OIG found no evidence of the required education. Facility managers attributed the facility's informal process of monitoring the completion of required education as the reason for noncompliance.

[84] TJC NPSG.07.04.01, EP1: Educate staff and licensed independent practitioners who are involved in managing central lines about central line–associated bloodstream infections and the importance of prevention. Education occurs upon hire or granting of initial privileges and periodically thereafter as determined by the organization.

Recommendation 8

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

Facility Concurred.

Target date for completion: September 30, 2018

Facility Response: The Associate Director for Patient Care Services ensures nursing staff receive central-line associated bloodstream infection (CLABSI) prevention education. To ensure compliance with the CLABSI education requirement, all registered nurses (RNs) are required to complete CLABSI education upon hire via the electronic course titled "Infection Prevention and Antimicrobial Stewardship" prior to completion of new employee orientation. All RNs in the Emergency Department (ED), Intensive Care Unit (ICU), Inpatient Care Team (ICT), and Community Living Center (CLC) are required to complete this course annually. Beginning January 2018, the Infection Control Coordinator monitors compliance by running an education deficiency report quarterly and tracking education completion for any nurse identified as deficient. Compliance will be monitored through September 30, 2018 for sustained compliance of 90%.

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

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

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• Protected peer review of clinical care • UM reviews • Patient safety incident reporting and RCAs	• None	• None
Credentialing and Privileging	• Medical licenses • Privileges • FPPEs • OPPEs	• OPPE data is consistently collected and reviewed. • Service line managers collect OPPE data utilizing assessments by providers with similar training and privileges.	• None

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement

Environment of Care	• Parent Facility
	  ○ EOC rounds and deficiency tracking
	  ○ Infection prevention
	  ○ General safety
	  ○ Environmental cleanliness
	  ○ General and exam room privacy
	  ○ Availability of medical equipment and supplies
	• CBOC
	  ○ General safety
	  ○ Medication safety and security
	  ○ Infection prevention
	  ○ Environmental cleanliness
	  ○ General and exam room privacy
	  ○ Availability of medical equipment and supplies
	• Construction Safety
	  ○ Infection control risk assessment
	  ○ Infection Prevention/ Infection Control Committee discussions
	  ○ Dust control
	  ○ Safety/security
	  ○ Selected requirements based on project type and class
	• Nutrition and Food Services
	  ○ Annual Hazard Analysis Critical Control Point Food Safety System plan
	  ○ Food Services inspections
	  ○ Safe transportation of prepared food
	  ○ Environmental safety
	  ○ Infection prevention
	  ○ Storage areas
		• None	• Environment of care rounds are conducted at the required frequency and documented in the Comprehensive EOC Assessment and Compliance Tool.
			• Required team members participate in EOC rounds and attendance is recorded in the Comprehensive EOC Assessment and Compliance Tool.

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	• Deficiencies identified on the Annual Physical Security Survey are corrected. • CSIs consistently perform CS order verification.	• None
Mental Health Care: Post-Traumatic Stress Disorder Care	• Suicide risk assessment • Offer of further diagnostic evaluation • Referral for diagnostic evaluation • Completion of diagnostic evaluation	• None	• None
Long-Term Care: Geriatric Evaluations	• Provision of or access to GE • Program oversight and evaluation • Provision of clinical care • Geriatric management	• None	• None
Women's Health: Mammography Results and Follow-Up	• Result linking • Report scanning and content • Communication of results and recommended actions • Follow-up mammograms and studies	• Mammogram results are electronically linked to the radiology orders.	• 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	• Nursing staff involved in managing central lines receive the required central-line bloodstream infection prevention education.

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 medium complexity (2)[85] affiliated[86] Facility reporting to VISN 5.

Table 6. Facility Profile for Beckley (517)
(October 1, 2014, through September 30, 2017)

Profile Element	Facility Data FY 2015[87]	Facility Data FY 2016[88]	Facility Data FY 2017[89]
Total Medical Care Budget in Millions	$135.4	$133.5	$140.1
Number of:			
• Unique Patients	14,385	14,428	14,271
• Outpatient Visits	187,412	189,047	195,650
• Unique Employees[90]	672	645	640
Type and Number of Operating Beds:			
• Community Living Center	50	50	50
• Medicine	28	28	28
• Surgery	2	2	2
Average Daily Census:			
• Community Living Center	32	34	37
• Medicine	17	19	17
• Surgery	0	0	0

Source: VA Office of Academic Affiliations, VHA Support Service Center, and VA Corporate Data Warehouse
Note: The OIG did not assess VA's data for accuracy or completeness.

[85] The VHA medical centers are classified according to a facility complexity model; 2 designation indicates a Facility with medium volume, low-risk patients, few complex clinical programs, and small or no research and teaching programs.

[86] Associated with a medical residency program.

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

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

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

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

VA Outpatient Clinic Profiles[91]

The VA outpatient clinics in communities within the catchment area of the Facility provide PC integrated with women's health, MH, and telehealth services. Some also provide specialty care, diagnostic, and ancillary services. Table 7 provides information relative to each of the clinics.

Table 7. VA Outpatient Clinic Workload/Encounters[92] and Specialty Care, Diagnostic, and Ancillary Services Provided (October 1, 2016, through September 30, 2017)

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services[93] Provided	Diagnostic Services[94] Provided	Ancillary Services[95] Provided
Ronceverte, WV	517GB	3,411	2,737	Dermatology Endocrinology Anesthesia Neurosurgery	Nuclear Med	Pharmacy
Princeton, WV	517QA	2,821	16	Dermatology Endocrinology Anesthesia General Surgery	Nuclear Med	Nutrition

Source: VHA Support Service Center and VA Corporate Data Warehouse
Note: The OIG did not assess VA's data for accuracy or completeness.

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

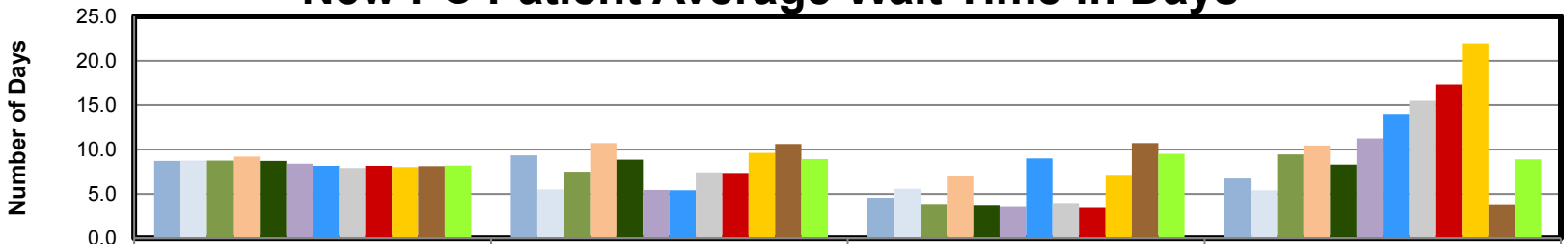
[92] An encounter is a professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient's condition.

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

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

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

Appendix C: Patient Aligned Care Team Compass Metrics[96]



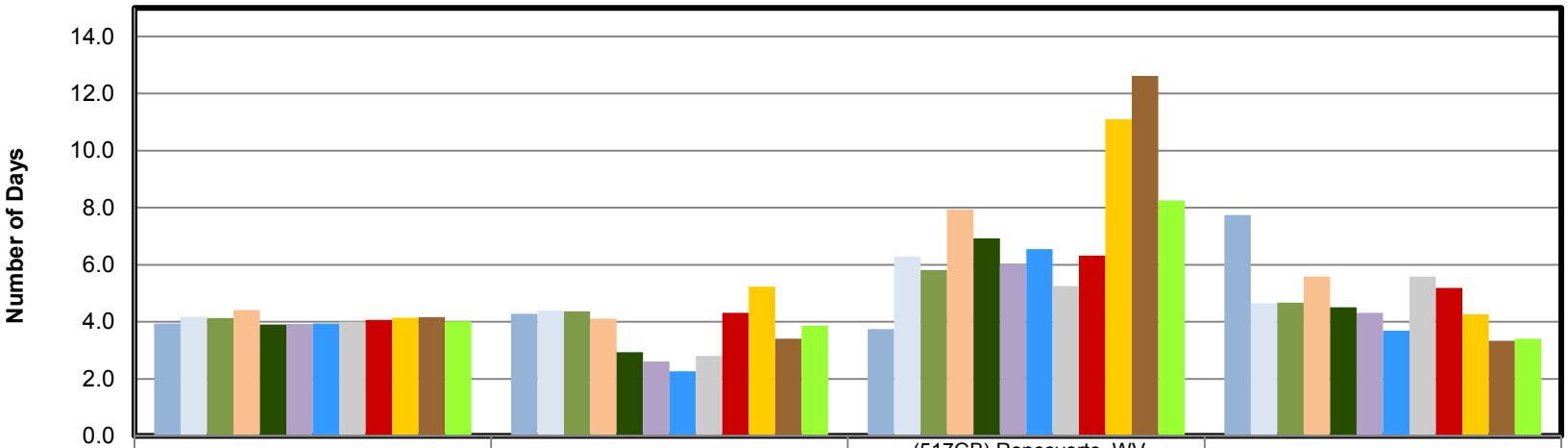
	VHA Total	(517) Beckley, WV	(517GB) Ronceverte, WV (Greenbrier County)	(517QA) Princeton, WV
OCT-FY17	8.7	9.4	4.6	6.8
NOV-FY17	8.8	5.5	5.6	5.4
DEC-FY17	8.8	7.5	3.8	9.4
JAN-FY17	9.2	10.7	7.0	10.4
FEB-FY17	8.7	8.8	3.7	8.3
MAR-FY17	8.4	5.5	3.5	11.3
APR-FY17	8.2	5.4	9.0	14.0
MAY-FY17	7.9	7.4	3.9	15.5
JUN-FY17	8.2	7.3	3.5	17.3
JUL-FY17	8.0	9.6	7.2	21.9
AUG-FY17	8.1	10.6	10.7	3.8
SEP-FY17	8.2	8.9	9.5	8.9

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 a new patient's PC completed appointment (clinic stops 322, 323, and 350, excluding Compensation and Pension appointments) and the earliest of three possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date. Note that prior to FY 2015, this metric was calculated using the earliest possible create date.

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

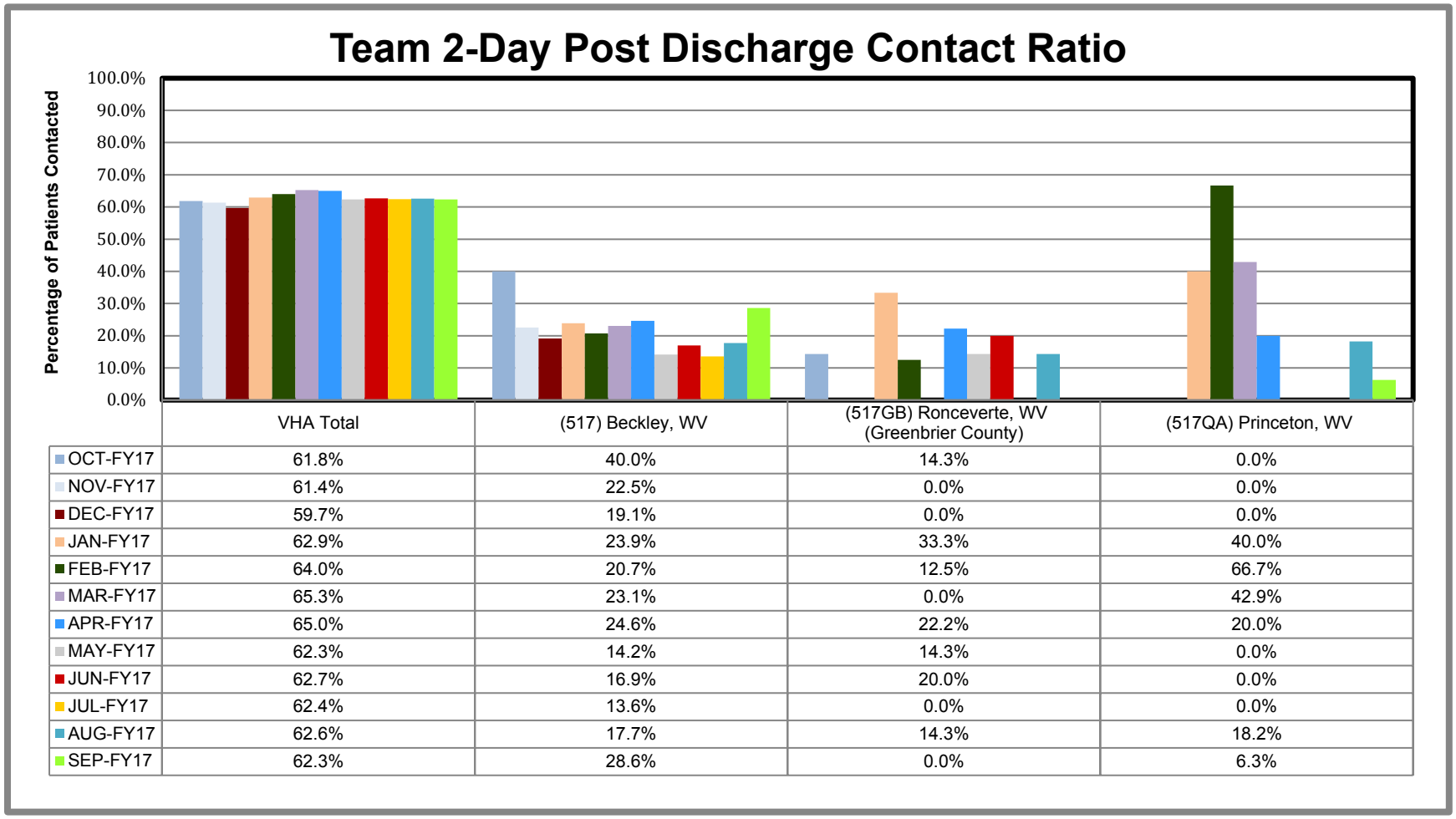


	VHA Total	(517) Beckley, WV	(517GB) Ronceverte, WV (Greenbrier County)	(517QA) Princeton, WV
OCT-FY17	3.9	4.3	3.7	7.7
NOV-FY17	4.2	4.4	6.3	4.6
DEC-FY17	4.1	4.4	5.8	4.7
JAN-FY17	4.4	4.1	7.9	5.6
FEB-FY17	3.9	2.9	6.9	4.5
MAR-FY17	3.9	2.6	6.0	4.3
APR-FY17	3.9	2.3	6.5	3.7
MAY-FY17	4.0	2.8	5.3	5.6
JUN-FY17	4.1	4.3	6.3	5.2
JUL-FY17	4.1	5.2	11.1	4.3
AUG-FY17	4.2	3.4	12.6	3.3
SEP-FY17	4.0	3.9	8.3	3.4

Source: VHA Support Service Center

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

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

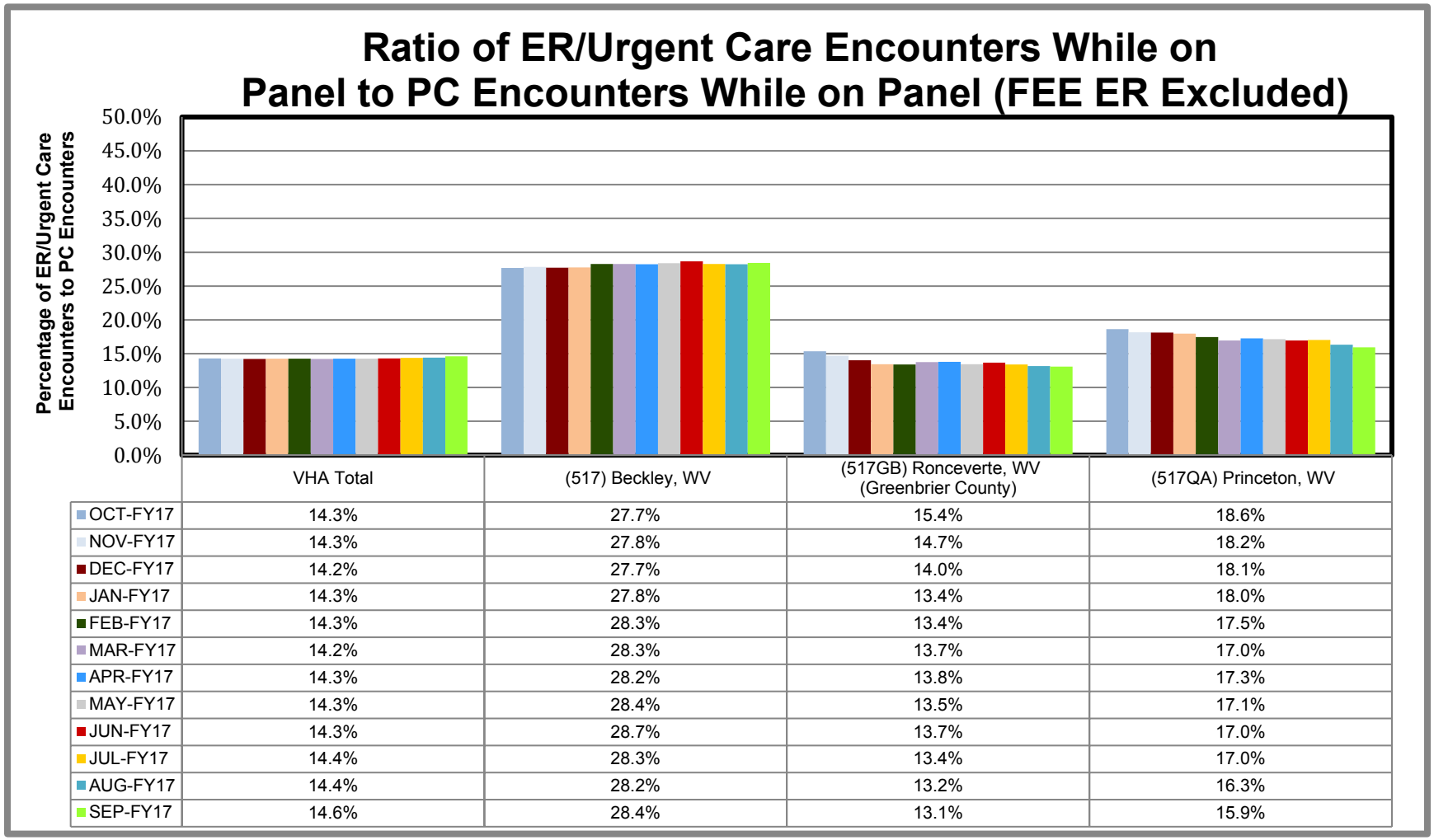


	VHA Total	(517) Beckley, WV	(517GB) Ronceverte, WV (Greenbrier County)	(517QA) Princeton, WV
OCT-FY17	61.8%	40.0%	14.3%	0.0%
NOV-FY17	61.4%	22.5%	0.0%	0.0%
DEC-FY17	59.7%	19.1%	0.0%	0.0%
JAN-FY17	62.9%	23.9%	33.3%	40.0%
FEB-FY17	64.0%	20.7%	12.5%	66.7%
MAR-FY17	65.3%	23.1%	0.0%	42.9%
APR-FY17	65.0%	24.6%	22.2%	20.0%
MAY-FY17	62.3%	14.2%	14.3%	0.0%
JUN-FY17	62.7%	16.9%	20.0%	0.0%
JUL-FY17	62.4%	13.6%	0.0%	0.0%
AUG-FY17	62.6%	17.7%	14.3%	18.2%
SEP-FY17	62.3%	28.6%	0.0%	6.3%

Source: VHA Support Service Center

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

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



	VHA Total	(517) Beckley, WV	(517GB) Ronceverte, WV (Greenbrier County)	(517QA) Princeton, WV
OCT-FY17	14.3%	27.7%	15.4%	18.6%
NOV-FY17	14.3%	27.8%	14.7%	18.2%
DEC-FY17	14.2%	27.7%	14.0%	18.1%
JAN-FY17	14.3%	27.8%	13.4%	18.0%
FEB-FY17	14.3%	28.3%	13.4%	17.5%
MAR-FY17	14.2%	28.3%	13.7%	17.0%
APR-FY17	14.3%	28.2%	13.8%	17.3%
MAY-FY17	14.3%	28.4%	13.5%	17.1%
JUN-FY17	14.3%	28.7%	13.7%	17.0%
JUL-FY17	14.4%	28.3%	13.4%	17.0%
AUG-FY17	14.4%	28.2%	13.2%	16.3%
SEP-FY17	14.6%	28.4%	13.1%	15.9%

Source: VHA Support Service Center

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

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

Appendix D: Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions[97]

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

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

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

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

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

Source: VHA Support Service Center

Appendix E: VISN Acting Director Comments

Department of Veterans Affairs Memorandum

Date: July 6, 2018

From: Acting Director, VA Capitol Heath Care Network (10N5)

Subj: Comprehensive Healthcare Inspection Program Review of the Beckley VA Medical Center

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

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

1. I have reviewed and concur with the findings and recommendations in the draft report for the VA Medical Center, Beckley, WV, and concur with the findings, recommendations, and submitted action plans.

2. Thank you for the opportunity to focus on continuous performance improvement. If you have any questions, please feel free to contact the VISN 5 Office.

(Original signed by:)

Raymond Chung, M.D.

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 21, 2018

From: Director, Beckley VA Medical Center (517/00)

Subj: CHIP Review of the Beckley VA Medical Center, WV

To: Director, VA Capitol Health Care Network, VISN 5 (10N5)

1. I would like to express my appreciation to the Office of Inspector General (OIG), Comprehensive Healthcare Inspection Program (CHIP) review team for their professional and excellent feedback provided to our employees during the CHIP review of the Beckley, WV, VAMC conducted December 4-8, 2017.

2. I have reviewed the draft report for the VA Medical Center, Beckley, WV, and concur with the findings and recommendations.

3. Please express my thanks to the Team for their professionalism and assistance to us in our continuing efforts to improve the care we provide to our veterans.

(Original signed by:)

Stacy J. Vasquez

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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