DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection Program Review of the Dayton VA Medical Center

Ohio

CHIP REPORT | REPORT #18-00619-242 | AUGUST 14, 2018

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Figure 1. *Dayton VA Medical Center, Dayton, Ohio*
(Source: https://vaww.va.gov/directory/guide/, accessed on May 23, 2018)

Abbreviations

CBOC	community based outpatient clinic
CHIP	Comprehensive Healthcare Inspection Program
CLABSI	central line-associated bloodstream infection
CS	controlled substances
CSC	controlled substances coordinator
CSI	controlled substances inspector
EHR	electronic health record
EOC	environment of care
FPPE	Focused Professional Practice Evaluation
GE	geriatric evaluation
HBPC	home based primary care
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
RCA	root cause analysis
QSV	quality, safety, and value
SAIL	Strategic Analytics for Improvement and Learning
TJC	The Joint Commission
UM	utilization management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Report Overview

This Comprehensive Healthcare Inspection Program (CHIP) review provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Dayton 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 March 19, 2018. The OIG conducted interviews and reviewed clinical and administrative processes related to areas of focus that affect patient care outcomes. Although the OIG reviewed a spectrum of clinical and administrative processes, the sheer complexity of VA medical centers limits the ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of Facility performance within the identified focus areas at the time of the OIG visit. Although it is difficult to quantify the risk of patient harm, the findings in this report may help facilities identify areas of vulnerability or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Results and Review Impact

Leadership and Organizational Risks

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

The OIG noted that three of the four executive leaders were functioning in an interim status. The Chief of Staff was appointed the Interim Director in October 2017; the Acting Associate Director was appointed in April 2017, and the Acting Chief of Staff was appointed in October 2017. The ADPCS was the only permanently assigned executive leader; and the Facility was expecting a permanently assigned Director to assume the position in April 2018.

In the review of selected employee satisfaction survey results regarding Facility leaders, the OIG Facility leaders appeared actively engaged with employees as evidenced by high employee satisfaction scores. In the review of selected patient experience survey results regarding Facility leaders, the OIG noted that three of the four selected patient survey scores were above the Veterans Health Administration (VHA) averages. Patients appeared generally satisfied with leadership and care provided.

The OIG recognizes that the Strategic Analytics for Improvement and Learning (SAIL) model has limitations for identifying all areas of clinical risk but is "a way to understand the similarities and differences between the top and bottom performers" within VHA.[1] Although the leadership team was knowledgeable about selected SAIL metrics, the leaders should continue to take actions to improve patient lengths of stay, which was likely contributing to the current "4-Star" rating.

[1] VHA's Office of Operational Analytics and Reporting developed a model for understanding a facility's performance in relation to nine quality domains and one efficiency domain. The domains within SAIL are made up of multiple composite measures, and the resulting scores permit comparison of facilities within a Veterans Integrated Service Network or across VHA. The SAIL model uses a "star" rating system to designate a facility's performance in individual measures, domains, and overall quality. http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=2146. (Website accessed on April 16, 2017.)

Additionally, the OIG reviewed accreditation agency findings, sentinel events,[2] disclosures of adverse patient events, and Patient Safety Indicator data and did not identify any substantial organizational risk factors.

The OIG noted findings in four of the eight areas of clinical operations reviewed and issued 10 recommendations that are attributable to the Chief of Staff and Associate Director. These are briefly described below.

Quality, Safety, and Value

The OIG found general compliance with requirements for protected peer reviews and patient safety. However, the OIG identified deficiencies with UM required reviews, documentation, and data analysis.[3]

Credentialing and Privileging

The OIG found general compliance with requirements for credentialing, privileging, and Ongoing Professional Practice Evaluations. However, the OIG identified a deficiency in documenting the results of Focused Professional Practice Evaluations in licensed independent practitioner (LIP) profiles.

Environment of Care

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

Long-term Care

The OIG found compliance with access to and provision of geriatric evaluation (GE), assessment by a GE nurse and social worker, patient or family education, and development of plan of care based on GE. However, the OIG identified deficiencies in program oversight and evaluation, medical evaluation by a GE provider, and plan of care implementation.

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

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

Summary

In the review of key care processes, the OIG issued 10 recommendations that are attributable to the Chief of Staff and Associate Director. The number of recommendations should not be used as a gauge for the overall quality provided at this Facility. The intent is for Facility leaders to use these recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues as well as other less-critical findings that, if left unattended, may eventually interfere with the delivery of quality health care.

Comments

The Veterans Integrated Service Network Director and Facility Director agreed with the Comprehensive Healthcare Inspection Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes E and F, pages 59–60, for the full text of the Directors' comments.) The OIG considers Recommendation 7 closed, and we will follow up on the planned actions for the open recommendations until they are completed.

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General
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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 Dayton 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.[4,5] Investment in a culture of safety and quality improvement with robust communication and leadership is more likely to result in positive patient outcomes in healthcare organizations.[6] Figure 2 shows the direct relationship leadership and organizational risks have with the processes used to deliver health care to veterans.

To examine risks to patients and the organization when these processes are not performed well, the OIG focused on the following nine areas of clinical care and administrative operations that support quality care—Leadership and Organizational Risks; Quality, Safety, and Value (QSV); Credentialing and Privileging; Environment of Care (EOC); Medication Management: Controlled Substances (CS) Inspection Program; Mental Health: Post-Traumatic Stress Disorder (PTSD) Care; Long-Term Care: Geriatric Evaluations; Women's Health: Mammography Results and Follow-up; and High-Risk Processes: Central Line-Associated Bloodstream Infections (CLABSI) (see Figure 2).[7]

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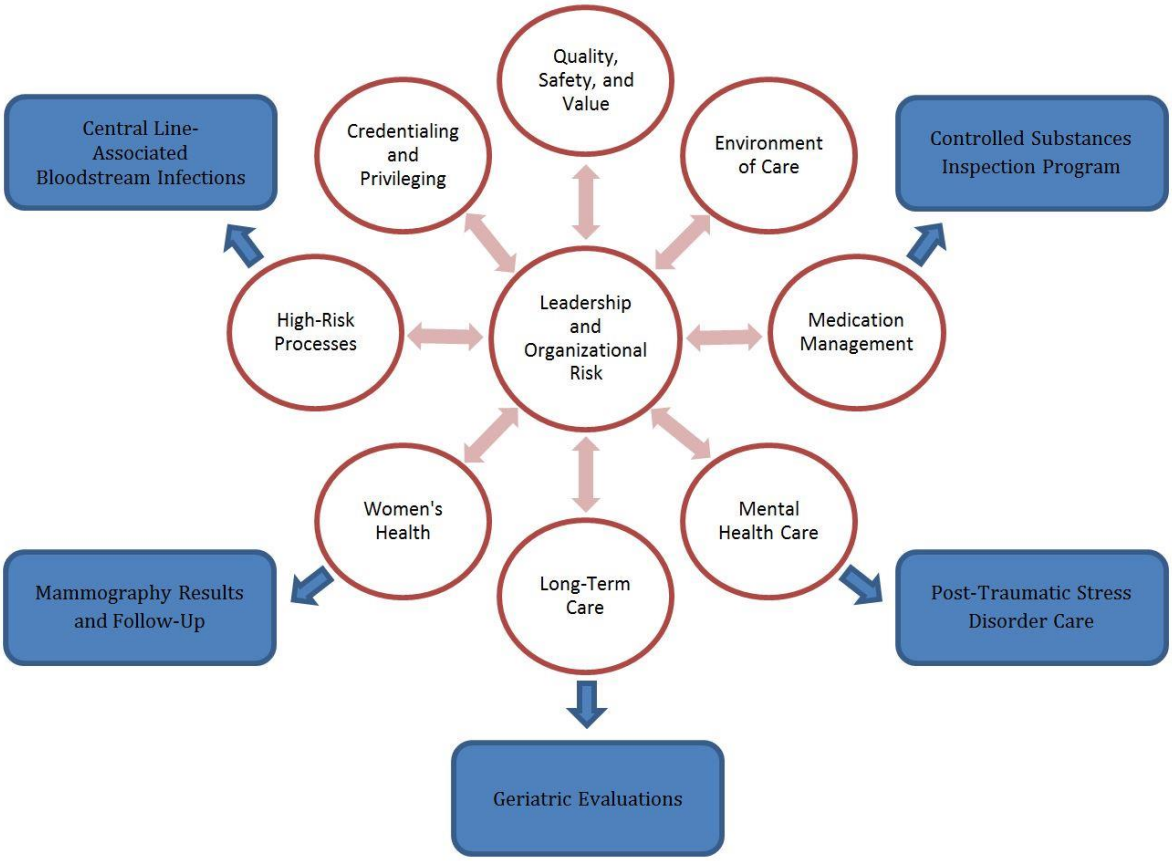
[4] Carol Stephenson, "The role of leadership in managing risk," *Ivey Business Journal*, November/December 2010. https://iveybusinessjournal.com/publication/the-role-of-leadership-in-managing-risk/. (Website accessed on March 1, 2018.)

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

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

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

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



Source: VA OIG

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

Methodology

To determine compliance with the Veterans Health Administration (VHA) requirements related to patient care quality, clinical functions, and the EOC, the OIG physically inspected selected areas; reviewed clinical records, administrative and performance measure data, and accreditation survey reports;[8] and discussed processes and validated findings with managers and employees. The OIG interviewed applicable managers and members of the executive leadership team.

The review covered operations for February 2, 2015,[9] through March 19, 2018, the date when an unannounced week-long site visit commenced. On April 2–3, 2018, the OIG presented crime awareness briefings to 86 of the Facility's 2,537 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.

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

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

Results and Recommendations

Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change. Leadership and organizational risks can impact the Facility's ability to provide care in all the selected clinical areas of focus.[10] To assess the Facility's risks, the OIG considered the following organizational elements

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

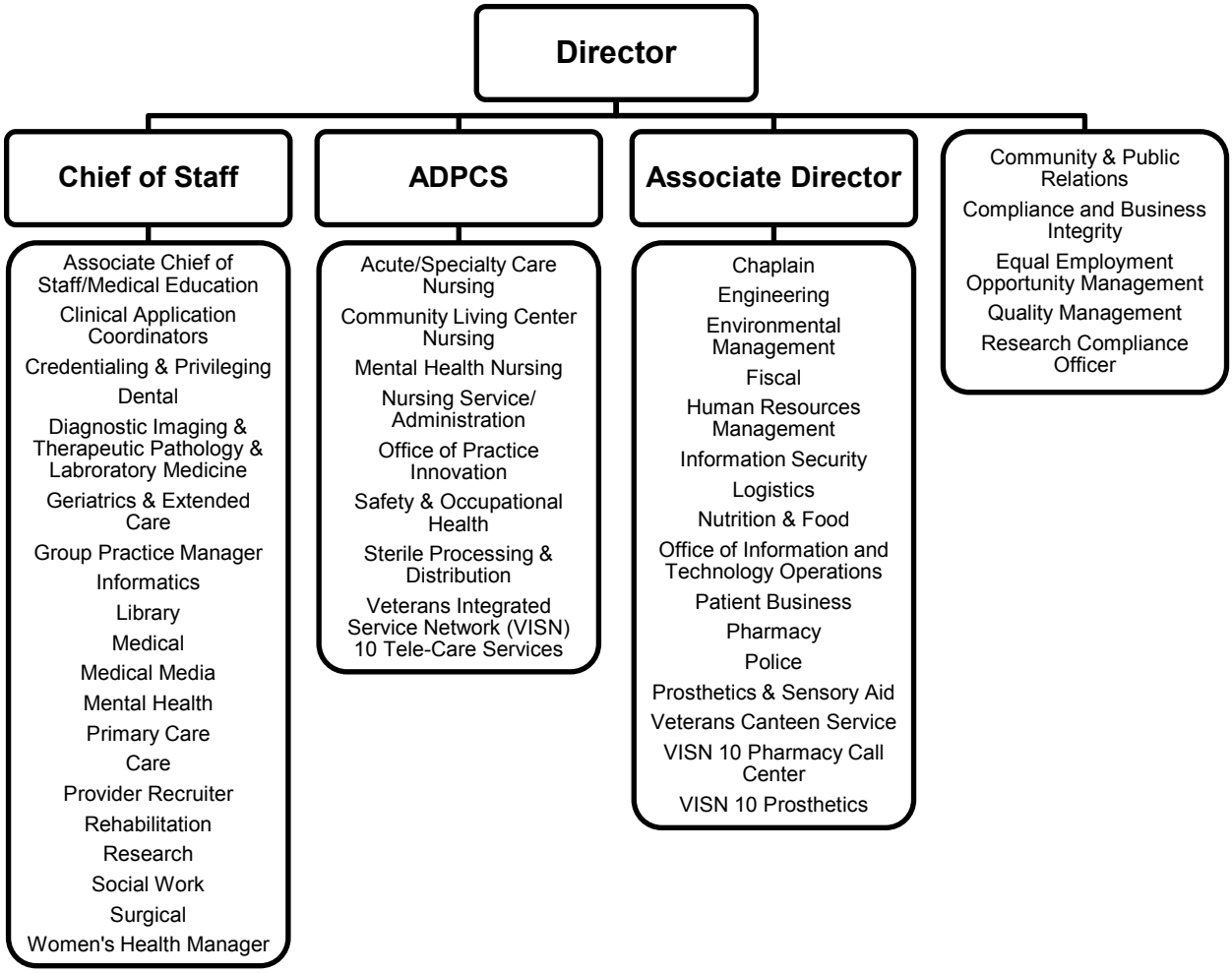
Executive Leadership Stability and Engagement

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

It is important to note that the Chief of Staff was functioning as the Interim Director, and the Chief of Medicine had been serving as the Acting Chief of Staff since October 2017. A permanently assigned Director was scheduled to assume the position in April 2018. The Acting Associate Director was appointed to the position in April 2017. The permanent Chief of Staff and ADPCS had been working together since January 2017.

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

Figure 3. Facility Organizational Chart



Source: Dayton VA Medical Center (March 19, 2018)

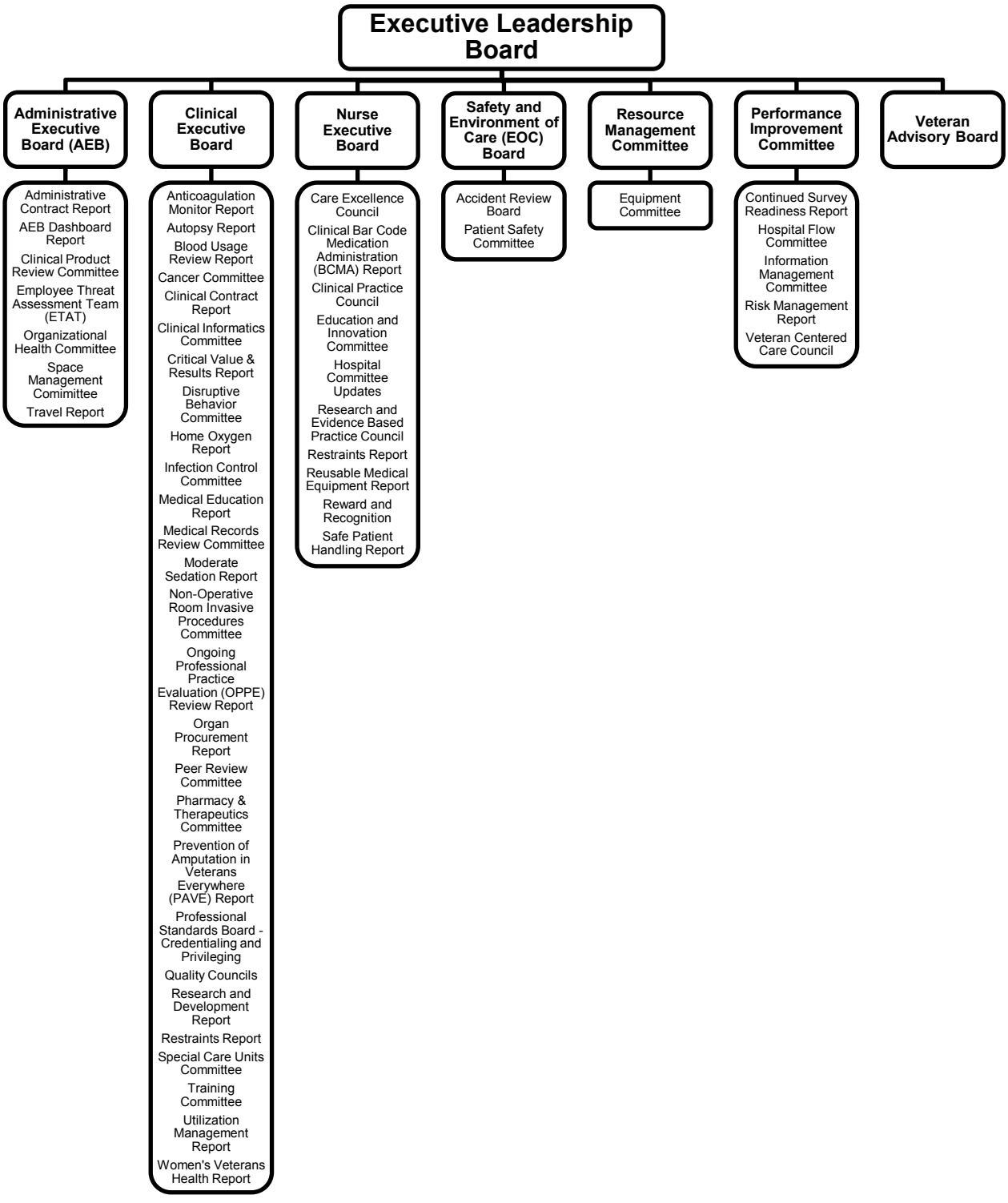
To help assess engagement of Facility executive leadership, the OIG interviewed the Interim Director, Acting Associate Director, Acting Chief of Staff, and ADPCS regarding their knowledge of various performance metrics and their involvement and support of actions to improve or sustain performance.

In individual interviews, these executive leadership team members generally could speak knowledgeably about actions taken during the previous 12 months in order to improve performance, employee and patient survey results, and selected Strategic Analytics for Improvement and Learning (SAIL) metrics. These are discussed more fully below.

The leaders are also engaged in monitoring patient safety and care through formal mechanisms. They are members of the Facility's Executive Leadership Board, which tracks, trends, and monitors quality of care and patient outcomes. The Director serves as the Chairperson with the

authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. The Executive Leadership Board also oversees various working boards and committees, including the Administrative Executive Board, Clinical Executive Board, Nurse Executive Board, Safety and EOC Board, and Performance Improvement Committee. See Figure 4.

Figure 4. Facility Committee Reporting Structure



Source: Dayton VA Medical Center (March 19, 2018)

Employee Satisfaction and Patient Experience

The All Employee Survey is an annual, voluntary, census survey of VA workforce experiences. The data are anonymous and confidential. Since 2001, the instrument has been refined at several points in response to VA leadership inquiries on VA culture and organizational health. Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on facility leadership.

To assess employee and patient attitudes toward Facility leaders, the OIG reviewed employee satisfaction survey results that relate to the period of October 1, 2016, through September 30, 2017. Tables 1 and 2 provide relevant survey results for VHA, and the Facility. As Table 1 indicates, the Facility leaders' results (Director's office average) were rated above the VHA average, and overall Facility averages were above the VHA average.[11] Employees appear generally satisfied with the leadership. Facility leaders appeared to be actively engaged with employees.

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

Questions/Survey Items	Scoring	VHA Average	Facility Average	Director's Office Average[12]
All Employee Survey Q59. *How satisfied are you with the job being done by the executive leadership where you work?*	1 (Very Dissatisfied)–5 (Very Satisfied)	3.3	3.5	4.7
All Employee Survey: *Servant Leader Index Composite*	0–100 where HIGHER scores are more favorable	67.7	68.0	92.5

Source: VA All Employee Survey (downloaded February 16, 2018)

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

VHA collects SHEP survey data from Patient-Centered Medical Home, Specialty Care, and Inpatient Surveys. From these, the OIG selected four survey items that reflect patient attitudes

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

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

towards Facility leaders for the period of October 1, 2016, through September 30, 2017. For this Facility, three of the four selected patient survey results reflected higher ratings compared to the VHA average. Patients appear generally satisfied with leadership and care provided.

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

Questions	Scoring	VHA Average	Facility Average
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	66.7	67.9
Survey of Healthcare Experiences of Patients (inpatient): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	83.4	86.6
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	74.9	78.5
Survey of Healthcare Experiences of Patients (outpatient specialty care): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	75.2	73.4

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

Accreditation/For-Cause Surveys[13] and Oversight Inspections

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

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

recently performed by the OIG and The Joint Commission (TJC).[14] Indicative of effective leadership, the Facility has closed all recommendations for improvement as listed in Table 3, except for those issued as part of a recently performed TJC inspection in March.[15]

The OIG also noted the Facility's current accreditation status with the Commission on Accreditation of Rehabilitation Facilities[16] and College of American Pathologists,[17] which demonstrates the Facility leaders' commitment to quality care and services. Additionally, the Long Term Care Institute conducted an inspection of the Facility's Community Living Center.[18]

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 Dayton VA Medical Center, Dayton, Ohio, April 9, 2015*)	February 2015	16	0
OIG (*Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Dayton VA Medical Center, Dayton, Ohio, March 30, 2015*)	February 2015	9	0
OIG (*Healthcare Inspection – Dermatology Clinic Staffing and Other Concerns (2012–2014), Dayton VA Medical Center, Dayton, Ohio, June 29, 2017*)	n/a	0	n/a
TJC	December 2015		
• Regular			
○ Hospital Accreditation		26	0
○ Behavioral Health Care Accreditation		3	0

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

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

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

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

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

Accreditation or Inspecting Agency	Date of Visit	Number of Findings	Number of Recommendations Remaining Open
○ Home Care Accreditation		2	0
• For Cause	October 2017	4	0
• Regular (Opioid Treatment Program)	March 2018	7	7

Sources: OIG and TJC (Inspection/survey results verified with Performance Improvement Nurse on March 21, 2018)

n/a – not applicable

Indicators for Possible Lapses in Care

Within the healthcare field, the primary organizational risk is the potential for patient harm. Many factors impact the risk for patient harm within a system, including unsafe environmental conditions, sterile processing deficiencies, and infection control practices. Leaders must be able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms. Table 4 summarizes key indicators of risk since the OIG's previous February 2015 Combined Assessment Program and Community Based Outpatient Clinic (CBOC) and Other Outpatient Clinics review inspections through the week of March 19, 2018.[19]

[19] 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 Dayton VA Medical Center is a mid-high complexity (1c) affiliated Facility as described in Appendix B.)

Table 4. Summary of Selected Organizational Risk Factors (February 2015 to March 19, 2018)

Factor	Number of Occurrences
Sentinel Events[20]	14
Institutional Disclosures[21]	15
Large-Scale Disclosures[22]	0

Source: Dayton VA Medical Center's Patient Safety Manager (received March 21, 2018)

The OIG also reviewed Patient Safety Indicators developed by the Agency for Healthcare Research and Quality within the U.S. Department of Health and Human Services. These provide information on potential in-hospital complications and adverse events following surgeries and procedures.[23] The rates presented are specifically applicable for this Facility, and lower rates indicate lower risks. Table 5 summarizes Patient Safety Indicator data from October 1, 2015, through September 30, 2017.

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

Measure	Reported Rate per 1,000 Hospital Discharges		
	VHA	VISN 10	Facility
Pressure ulcers	0.60	0.39	0.00
Death among surgical inpatients with serious treatable conditions	100.97	132.49	117.65
Iatrogenic pneumothorax	0.19	0.23	0.00
Central venous catheter-related bloodstream infection	0.15	0.16	0.00
In-hospital fall with hip fracture	0.08	0.07	0.00
Perioperative hemorrhage or hematoma	1.94	3.45	0.76

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

[21] 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.

[22] 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.

[23] 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 10	Facility
Postoperative acute kidney injury requiring dialysis	0.88	0.99	0.00
Postoperative respiratory failure	5.55	7.84	5.62
Perioperative pulmonary embolism or deep vein thrombosis	3.29	2.76	0.74
Postoperative sepsis	4.00	3.62	0.00
Postoperative wound dehiscence	0.52	1.39	0.00
Unrecognized abdominopelvic accidental puncture/laceration	0.53	0.27	0.00

Source: VHA Support Service Center

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

The Patient Safety Indicator for death among surgical inpatients with serious treatable conditions showed an observed rate in excess of the observed rates for VHA. Two patient deaths among surgical inpatients with serious treatable conditions were reviewed through the peer review process and by the Veterans Integrated Service Network (VISN) 10 Surgery Workgroup, and it was determined there were no opportunities for improvement.

The Patient Safety Indicator for postoperative respiratory failure showed an observed rate in excess of the observed rates for VHA. Four patients developed postoperative respiratory failure. All were screened, and the care for three patients was reviewed through the peer review process. The results of one of the three reviews required actions to ensure appropriate resident supervision.

Veterans Health Administration Performance Data

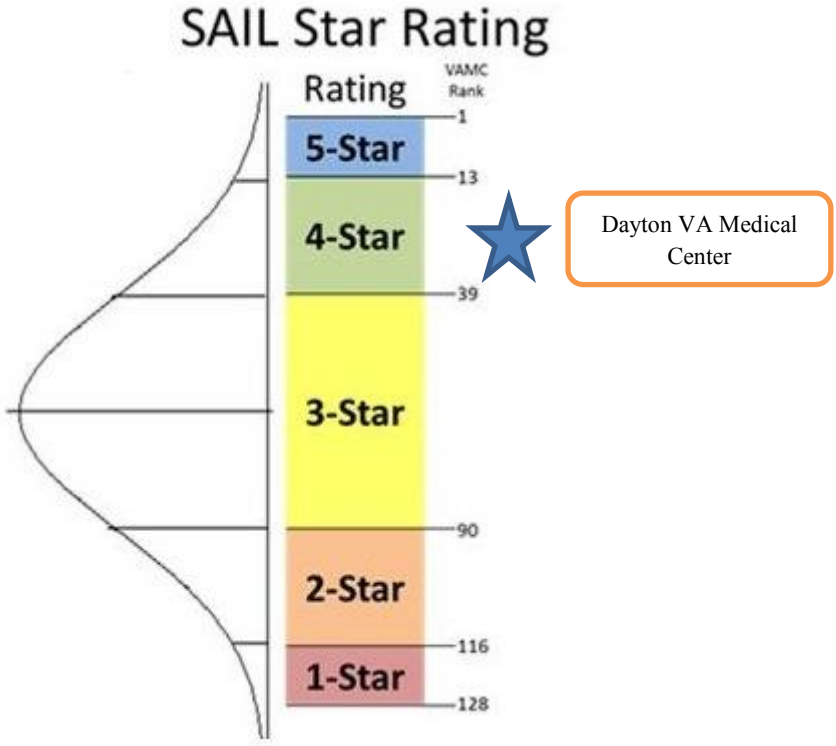
The VA Office of Operational Analytics and Reporting adapted the SAIL Value Model to help define performance expectations within VA. This model includes measures on healthcare quality, employee satisfaction, access to care, and efficiency, but has noted limitations for identifying all areas of clinical risk. The data are presented as one "way to understand the similarities and differences between the top and bottom performers" within VHA.[24]

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

[24] 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.)

of facilities. Figure 5 describes the distribution of facilities by star rating.[25] As of June 30, 2017, the Facility was rated at "4 Stars" for overall quality.

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

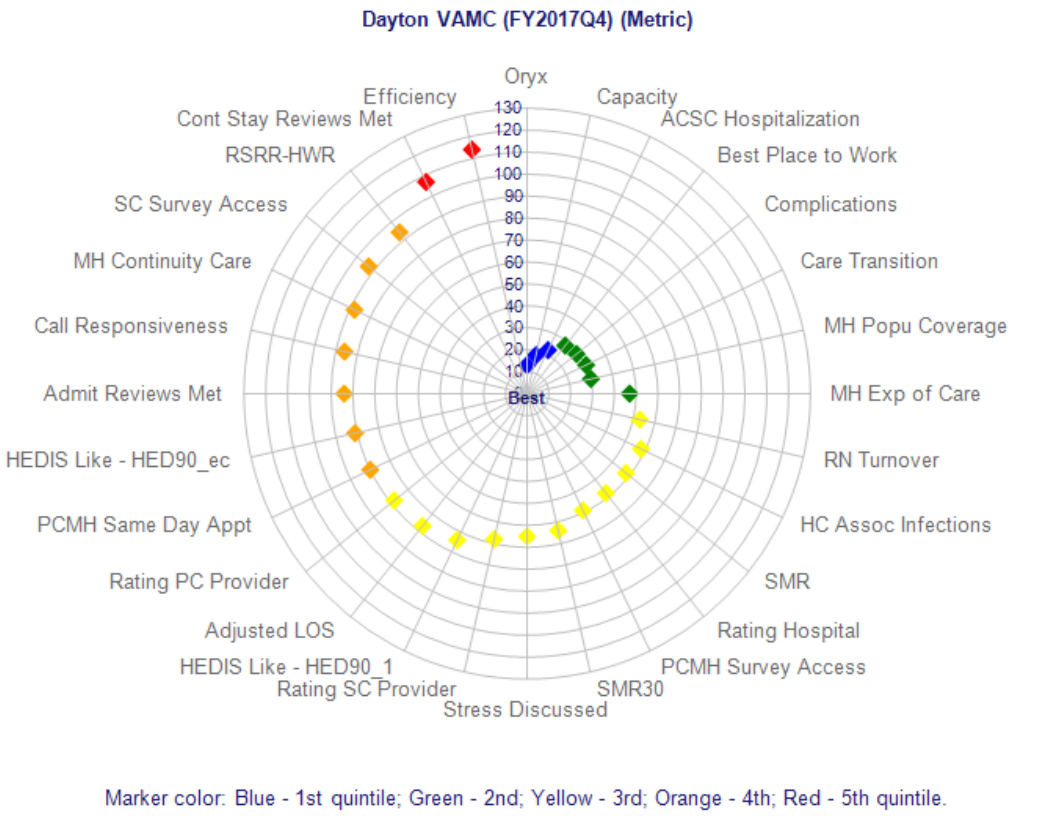


Source: VA Office of Informatics and Analytics Office of Operational Analytics and Reporting (accessed February 16, 2018)

Figure 6 illustrates the Facility's Quality of Care and Efficiency metric rankings and performance compared with other VA facilities as of September 30, 2017. Of note, Figure 6 uses blue and green data points to indicate high performance (for example, Capacity, Best Place to Work, and Mental Health (MH) Experience (Exp) of Care). Metrics that need improvement are denoted in orange and red (for example, Call Responsiveness, Mental Health (MH) Continuity (of) Care, and Continued (Cont) Stay Reviews Met).

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

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



Source: VHA Support Service Center

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

Conclusion

Three of four Facility leadership positions were filled by interim or acting staff, with long-term Facility leaders in two of the positions. The Facility had generally stable executive leadership and active engagement with employees and patients, as evidenced by high satisfaction scores. Organizational leaders supported patient safety and quality care. The OIG's review of accreditation organization findings, sentinel events, disclosures, Patient Safety Indicator data, and SAIL results did not identify any substantial organizational risk factors. The leadership team was knowledgeable about selected SAIL metrics but should continue to take actions to improve care and performance of selected Quality of Care and Efficiency metrics likely contributing to the current "4-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 VHA's patient safety reporting system[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

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

[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 has been the software application used for reporting and documenting adverse events in the VHA (National Center for Patient Safety) Patient Safety Information System database. However, it is expected that by April 1, 2018, all facilities will have implemented the new Joint Patient Safety Reporting System (JPSR), and it is anticipated that all previous patient safety event reporting systems will be discontinued by July 1, 2018.

[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.

Utilization Management: Required Reviews

VHA requires that facility UM reviewers conduct a minimum of 75 percent of acute inpatient admissions and continued stay reviews.[35] This ensures that admissions and continued days of care are appropriate for the patient's diagnosis and treatment. The Facility UM reviewers did not complete the required number of reviews over the past 12 months. This resulted in lack of evaluation of admission and continued stay appropriateness. The reason provided for noncompliance was UM reviewers were assigned other duties in the QSV Service and could not complete reviews due to competing priorities.

Recommendation 1

1. The Chief of Staff ensures that the assigned staff complete at least 75 percent of all inpatient admissions and continued stay reviews and monitors compliance.

Facility concurred.

Target date for completion: October 31, 2018

Facility response: The Utilization Management (UM) program has trained reviewers. Admission and continued stay reviews that do not meet the National Utilization Management Integration (NUMI) criteria are reported daily during the Leadership Morning Report. Monthly audits are conducted and reported at the quarterly UM Committee meetings. Two consecutive months of compliance greater than 75 percent; May 76.3 percent and June 86.9 percent, have been achieved. Sustained compliance of 75 percent or greater for a total of 6 months will be achieved for closure.

Utilization Management: Documentation of Decisions

VHA requires that Physician UM Advisors document their decisions in the National UM Integration database regarding appropriateness of patient admission and continued stays.[36] This ensures a process for communicating all UM data within the Facility and to the VISN, as a component of the Quality Management System, and facilitates the use of UM data to assist with identification of initiatives to improve efficiency. In 8 of 12 cases referred to the physician advisors from January 21, 2018, through March 21, 2018, there was no evidence that advisors documented their decisions in the database, resulting in incomplete reviews. Reasons provided for the assigned advisors not completing the reviews were competing clinical responsibilities, administrative priorities, and a lack of available alternate Physician UM Advisors.

[35] VHA Directive 1117.

[36] VHA Directive 1117.

Recommendation 2

2. The Chief of Staff ensures that Physician Utilization Management Advisors consistently document their decisions in the National Utilization Management Integration database and monitors compliance.

Facility concurred.

Target date for completion: October 31, 2018

Facility response: Physician Utilization Management Advisors (PUMA) have completed training on documentation in the NUMI data base and have access to document decisions. PUMAs with pending reviews receive email notification daily from the UM team. Monthly audits are conducted to monitor the consistency of PUMA documentation. PUMA compliance is a standard agenda item at the quarterly UM Committee meetings. Two consecutive months of compliance greater than 90 percent, May 100 percent and June 100 percent, have been achieved. Sustained compliance of 90 percent or greater for a total of 6 months will be achieved for closure.

Utilization Management: Interdisciplinary Review of Data

VHA requires that an interdisciplinary facility group review UM data. This group should include, but not be limited to, representatives from UM, medicine, nursing, social work, case management, MH, and Chief Business Office revenue utilization review.[37] This ensures that an interdisciplinary approach is taken when reviewing UM data for performance improvement. From January 1, 2017, through December 31, 2018, the UM Committee met quarterly; however, the interdisciplinary group that reviewed UM data did not consistently include representation from Social Work, Mental Health, Nursing, and Chief Business Office revenue utilization review. This resulted in a lack of expertise in the review and analysis of UM data. Facility managers cited lack of oversight from quality management as the reason for noncompliance.

Recommendation 3

3. The Chief of Staff ensures that the interdisciplinary group review UM data on an ongoing basis and monitors compliance.

[37] VHA Directive 1117.

Facility concurred.

Target date for completion: December 31, 2018

Facility response: The list of required members on the UM Committee was reconciled with current membership; Chief Business Office Revenue Utilization Reviewer was added for accuracy. The UM Committee monitors attendance and non-compliance is reported to the Chair. The fiscal year (FY) 2018 quarter two meeting was on May 14, 2018 with 93 percent required attendance rate. Sustained compliance of 90 percent or greater for the next two quarterly meetings will be achieved for closure.

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 (LIPs).[38]

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.[39]

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.[40]

The purpose of the OIG review was to determine whether the Facility complied with selected requirements for credentialing and privileging of selected members of the medical staff. The OIG team interviewed key managers and reviewed the credentialing and privileging folders of 10 LIPs who were hired within 18 months prior to the on-site visit,[41] and 20 LIPs who were re-privileged within 12 months prior to the visit.[42] The OIG evaluated the following performance indicators:

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

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

[39] VHA Handbook 1100.19.

[40] VHA Handbook 1100.19.

[41] The 18-month period was from September 19, 2016, through March 19, 2018.

[42] The 12-month review period was from March 19, 2017, through March 19, 2018.

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

Conclusion

The OIG found general compliance with requirements for credentialing, privileging, and Ongoing Professional Practice Evaluations. However, the OIG the identified a deficiency in documenting the results of Focused Professional Practice Evaluations in LIP profiles that warranted a recommendation for improvement.

Focused Professional Practice Evaluations

VHA requires that all LIPs new to the facility have Focused Professional Practice Evaluations completed and documented in the practitioner's profile, and reported to an appropriate committee of the Medical Staff. The process involves the evaluation of privilege-specific competence of the practitioner who has not had previously documented evidence of competently performing the requested privileges. Evaluation methods may include chart review, direct

observation, monitoring of diagnostic and treatment techniques or discussion with other individuals involved in the care of patients.[43]

For 3 of 10 LIPs, the Facility's Professional Standards Board recommended continuation of initially granted privileges even though the Focused Professional Practice Evaluation results, primarily the EHR reviews, were incomplete. This resulted in providers continuing to deliver care without a thorough evaluation of their practice. The Acting Chief of Staff cited Service Chiefs had inconsistent FPPE reporting processes to ensure all pertinent requirements of the FPPE plan were completed.

Recommendation 4

4. The Chief of Staff ensures that Service Chiefs complete all required elements of Focused Professional Practice Evaluations for the determination of provider's privileges and monitors compliance.

Facility concurred.

Target date for completion: October 31, 2018

Facility response: A Focused Professional Practice Evaluation (FPPE) checklist was developed and provided to the Clinical Service Chiefs as a reference to ensure FPPEs include the required elements for the determination of a provider's privileges. A monthly monitor was implemented and 10 percent of provider FPPE files are reviewed for compliance prior to submission to the Professional Standards Board. The audit process was initiated in May 2018 with 90 percent compliance and in June 2018 with 100 percent compliance. Results were reported in the June 2018 Professional Standards Board Minutes. Sustained compliance of 90 percent or greater for a total of 6 months will be achieved for monitor closure.

[43] VHA Handbook 1100.19.

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.[44]

The purpose of the OIG review was to determine whether the Facility maintained a clean and safe healthcare environment in accordance with applicable requirements.[45] 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[46] and Nutrition and Food Services processes.[47]

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.[48]

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 a hazard analysis critical control point food safety plan, food services inspections, a food service emergency operations plan, and safe food transportation and storage practices.[49]

In all, the OIG inspected six inpatient units (intensive care-3B, Community Living Center-5 South, medical/surgical-3 South and 4 North, MH-7 South, and post anesthesia care), the Emergency Department, the Dermatology Outpatient Clinic, and Nutrition and Food Services. The OIG also inspected the Springfield CBOC.[50] The OIG reviewed the most recent Infection Prevention Risk Assessment, Infection Control Committee minutes for the past six months, and

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

[45] 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).

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

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

[48] VHA Directive 7715.

[49] VHA Handbook 1109.04.

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

other relevant documents, and interviewed key employees and managers. The OIG evaluated the following location-specific performance indicators:

- Parent Facility
  - EOC rounds
  - EOC deficiency tracking
  - Infection prevention
  - General safety
  - Environmental cleanliness
  - General privacy
  - Women veterans' exam room privacy
  - Availability of medical equipment and supplies
- Community Based Outpatient Clinic
  - General safety
  - Medication safety and security
  - Infection prevention
  - Environmental cleanliness
  - General privacy
  - Exam room privacy
  - Availability of medical equipment and supplies
- Nutrition and Food Services
  - Hazard Analysis Critical Control Point Food Safety System plan
  - Food Services inspections
  - Emergency operations plan for food service
  - Safe transportation of prepared food
  - Environmental safety
  - Infection prevention
  - Storage areas

The performance indicators below did not apply to this Facility:

- 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[51]

Conclusion

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

Parent Facility's Environment of Care Rounds

VHA requires facilities to conduct EOC rounds at least once each FY in non-patient care areas and twice per FY in patient care areas and to document results using the Comprehensive EOC Assessment and Compliance Tool (Performance Logic database).[52] These practices help to ensure a safe, clean, and functional healthcare environment. From October 1, 2016, through September 30, 2017, the EOC rounds team did not complete required inspections for multiple patient care areas in Buildings 118, 119, 320, and 410. This resulted in the lack of assurance of a clean and safe patient care environment. The Facility managers did not maintain consistent oversight of processes for the required inspections.

Recommendation 5

5. The Associate Director ensures environment of care rounds are conducted in all areas of the Facility at the required frequency and monitors compliance.

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

[52] VHA Directive 1608.

Facility concurred.

Target date for completion: December 31, 2018

Facility response: Safety Service has reviewed and updated the Performance Logic computer program for optimal use including breaking out and renaming several areas for greater clarity. The Environment of Care (EOC) schedule was reviewed and rounds are scheduled in the required areas of the facility at or exceeding the required frequency. Monthly Performance Logic reports are generated for the areas inspected during that timeframe. Identified deficiencies and remediation progress are reported at the Safety and Environment Care Board (SECB). Between October 1, 2016 through September 30, 2017 bi-annual rounds were completed in buildings 320 and 410. In FY 2018, building 320 was inspected in April 2018 and is scheduled for another EOC round in September 2018. Building 410 was inspected March 2018 and is scheduled for another EOC round in September 2018. Building 118 is a chapel and was added to the EOC schedule for inspection in September 2018. Building 119 is a chapel that has been closed for 20 years, pending structural upgrades. EOC compliance with frequency of scheduled EOC rounding will be monitored monthly by the SECB Committee to sustain 90 percent compliance for 6 months to achieve closure of scheduled areas with EOC rounds completed within that month.

Facility Cleanliness and Maintenance

TJC requires hospitals to identify environmental deficiencies, hazards, and unsafe practices; keep furnishings and equipment safe and in good repair.[53] This ensures a clean and safe health care environment. The OIG noted problems with cleanliness and maintenance throughout the parent Facility. All eight patient care areas inspected had dirty ventilation grills; three areas had privacy curtains needing maintenance;[54] and four areas had stained, dusty, cracked, or broken ceiling tiles.[55] Inpatient rooms throughout the Facility had damaged walls requiring repair.[56] Additionally, the OIG inspected Nutrition and Food Service areas and found four dirty ventilation grills, dusty kitchen coolers, and a dusty fire sprinkler head. Facility managers failed to note deficiencies during EOC rounds.

Recommendation 6

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

[53] TJC. Environment of Care Standard EC.02.06.01, EP20. July 2017.

[54] Intensive care-3B and post-anesthesia care units and the Emergency Department.

[55] Intensive care 3B, medical/surgical-3 South, post-anesthesia care units, and the Emergency Department.

[56] Medical/surgical units 3 South and 4 North.

Facility concurred.

Target date for completion: December 31, 2018

Facility response: The facility took immediate action to ensure and maintain a safe and clean environment. Issues identified during this survey regarding nutrition and food area cleanliness, high vents and curtain maintenance, particularly regarding unsnapped curtains cited in the out brief, are added to our Environmental Management Service (EMS) Standard Operating Procedures (SOP) for terminal room cleaning. An interdisciplinary team, as required per VHA Directive 1608, is completing rounds in designated areas weekly to ensure sustained compliance. Deficiencies noted during EOC rounds are reported at the SECB for action with a 14-day completion turnaround or a corrective action plan is generated. Sustained compliance of greater than 90 percent of deficiencies for 6 months closed within 14 days or have a corrective action plan within 14 days will be achieved for closure.

Medical Equipment Safety Inspections

VHA Center for Engineering and Occupational Safety and Health (CEOSH) requires facilities to have a mechanism or method in place for equipment users to be confident that the equipment they are using is safe and functional.[57] The Facility uses stickers with dates of inspection or "No preventative maintenance required" as a visual method for equipment users to identify if equipment has been inspected prior to being put into use. Three examination tables at the Springfield CBOC lacked inspection stickers. This resulted in equipment in service without visual evidence that it was safe to use. Facility staff had no explanation for the missing safety inspection stickers.

Recommendation 7

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

Facility concurred.

Target date for completion: July 2018

Facility response: Engineering service visited all Community Based Outpatient Clinics (CBOCs) that are an extension of the Dayton VAMC. Medical equipment maintenance stickers were validated to ensure that the equipment was safe for patient use. The three examination tables at the Springfield CBOC now have inspection stickers attached and Biomedical Engineering validated that all of the tables had previously had incoming inspections documented by work orders in our Computerized Maintenance Management System (CMMS). Engineering Service

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

inspects all medical equipment entering the facility that is identified as “for patient use”. Compliance is tracked in SECB evaluating the number of medical equipment deployed and the number of incoming medical equipment inspected. Once the inspection is complete and the item meets the safety standards a new inspection indicator sticker is affixed to the equipment. The sticker will reflect the preventative maintenance requirement and the next date maintenance is due or if a preventative maintenance is not required. Process compliance for safety inspections and preventative maintenance is monitored during environment of care rounds and reported in SECB. During incoming inspection, the maintenance schedule and whether the item requires preventative maintenance is determined and scheduled in our CMMS. Facility has achieved compliance of greater than 95 percent for 3 three months of incoming inspections of medical equipment occurring on newly deployed equipment including 100 percent 6/6 occurring in April of 2018, 100 percent 4/4 occurring in May of 2018, and 100 percent 16/16 occurring in June of 2018. This will be noted in the July SECB minutes.

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.[58] 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.[59]

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.[60] 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.[61] The OIG team interviewed key managers and reviewed CS inspection reports for the prior two completed quarters;[62] monthly summaries of findings, including discrepancies, provided to the Director for the prior 12 months[63]; CS inspection quarterly trend reports for the prior four quarters;[64] 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

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

[59] 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.

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

[61] 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.

[62] The review period was July 2017-December 2017.

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

[64] The four quarters were from January 2017, through December 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[65]
  - Accountability for all prescription pads in pharmacy

[65] 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.

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

Conclusion

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

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."[66] 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.[67]

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.[68] 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.[69]

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 41 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

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

[67] VHA Handbook 1160.03.

[68] 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.

[69] 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.[70] 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.[71] 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.[72]

In 1999, the Veterans Millennium Benefits and Healthcare Act mandated that the veterans' standard benefits package include access to GE.[73] 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.[74] 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.[75]

In determining whether the Facility provided an effective geriatric evaluation, OIG staff reviewed relevant documents and interviewed key employees and managers. Additionally, the team reviewed the EHRs of 48 randomly selected patients who received a GE from July 1, 2016, through June 30, 2017. The OIG evaluated the following performance indicators:

- 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
  - Assessment by GE nurse

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

[71] VHA Directive 1140.04.

[72] 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.

[73] Public Law 106-117.

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

[75] VHA Directive 1140.04.

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

Conclusion

The OIG found compliance with access to and provision of GE, assessment by GE nurse and social worker, patient or family education, and development of plan of care based on GE. However, the OIG identified deficiencies in program oversight and evaluation, medical evaluation by a GE provider, and plan of care implementation that warranted recommendations for improvement.

Program Oversight and Evaluation

VHA requires facility leaders to assess the GE program and oversee performance improvement activities.[76] This provides the opportunity to identify practice improvements, ensure appropriate actions were taken, and measure the effectiveness of actions on a regular basis. There was no evidence of performance improvement activities for the GE program. As a result, Facility leaders were unable to assess GE program activities. The Home Based Primary Care (HBPC) Manager believed that the HBPC program conducted performance improvement activities; however, there was no evidence of GE program evaluation processes due to a lack of understanding of the requirements.

Recommendation 8

8. The Chief of Staff ensures that geriatric evaluation performance improvement activities are conducted, documented, and reviewed by an appropriate leadership board and monitors compliance.

[76] VHA Directive 1140.04.

Facility concurred.

Target date for completion: December 31, 2018

Facility response: Geriatric Evaluation (GE) performance improvement projects are conducted and Veteran's plan of care goals are audited. The performance improvement activities will be documented and reviewed with Primary Care leadership monthly and quarterly to Clinical Executive Board. Interdisciplinary Home Based Primary Care (HBPC) team education was completed in June 2018 on performance improvement documentation. Monitoring of documentation and performance improvement measures will be reported to CEB. These measures will be monitored for 90 percent compliance for 6 months to achieve monitor closure.

Medical Evaluation

VHA requires a GE provider or designee perform or supervise the medical evaluation and care of patients in the GE program.[77] This ensures medical needs of the geriatric patient are being considered. The OIG estimated that geriatric patients received a medical evaluation by a GE provider in 71 percent of the EHRs reviewed; and 95 percent of the time; the true compliance rate is between 58.2 and 83.2 percent, which is statistically significantly below the 90 percent benchmark. This resulted in inadequate interdisciplinary geriatric evaluation of the patient. The HBPC Manager reported misinterpreting the term "medical provider" to indicate any discipline providing care and did not realize that a physician, NP, or PA should be performing the GE medical evaluations. This resulted in failure to ensure that GE patients received medical evaluations as required.

Recommendation 9

9. The Chief of Staff ensures providers perform geriatric medical evaluations and monitors compliance.

Facility concurred.

Target date for completion: December 31, 2018

Facility response: GE will be a component of the program evaluation. Primary Care leadership and HBPC team will evaluate and ensure that geriatric medical evaluations are completed in accordance with VA regulations. HBPC will conduct chart audits for medical evaluation by an approved provider within 30 days of HBPC enrollment. Results will be reported monthly to Primary Care leadership and quarterly at Clinical Executive Board. Sustained compliance of 90 percent for 6 months will be achieved for monitor closure.

[77] VHA Directive 1140.04.

Plan of Care Implementation

VHA requires that geriatric evaluations include development and implementation of an interdisciplinary plan of care to ensure that facilities provide a comprehensive approach towards meeting collaborative care goals for patients.[78] The OIG estimated that interdisciplinary care plans were implemented in 46 percent of the EHRs reviewed; and 95 percent of the time, the true compliance rate is between 31.3 and 60.4 percent, which is statistically significantly below the 90 percent benchmark. The OIG noted the lack of medication evaluations by pharmacists in each of the noncompliant plans of care; this prevented the GE team from achieving its goal of an interdisciplinary approach to caring for their complex geriatric patients. The OIG's meeting with the Chief of Pharmacy revealed a lack of staff available to comply with the requirement.

Recommendation 10

10. The Chief of Staff ensures that clinicians accurately identify and implement geriatric evaluation plan of care interventions and monitors compliance.

Facility concurred.

Target date for completion: December 31, 2018

Facility response: Geriatric evaluation of care will include HBPC core team members to provide comprehensive and collaborative Veteran care goals. The interdisciplinary care plan will be audited to ensure HBPC core team members have documentation and participation in the plan of care. Sustained compliance of 90 percent for 6 months will be achieved for monitor closure.

[78] VHA Directive 1140.04.

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.[79] 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.[80] The Veterans Health Care Act of 1992 also authorized VA to provide gender-specific services, including mammography services to eligible women veterans.[81]

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.[82]

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

- Electronic linking of mammogram results to radiology order
- Scanning of hard copy mammography reports, if outsourced
- Inclusion of required components in mammography reports
- Communication of results and any recommended course of action to ordering provider
- Communication of results and any recommended course of action to patient

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

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

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

[82] VHA Directive 1330.01(2), *Health Care Services for Women Veterans*, February 15, 2017 (amended September 8, 2017, and further amended July 24, 2018); VHA Handbook 1105.03, *Mammography Program Procedures and Standards*, April 28, 2011, which was rescinded and replaced by VHA Directive 1105.03, *Mammography Program Procedures and Standards*, May 21, 2018.

- Performance of follow-up mammogram if indicated
- Performance of follow-up study

Conclusion

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

High-Risk Processes: Central Line-Associated Bloodstream Infections

TJC requires facilities to establish systematic infection prevention and control programs to reduce the risk of acquiring and transmitting infections.[83] 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,"[84] 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.[85]

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."[86]

Infections occurring on or after the third calendar day following admission to an inpatient location are considered "healthcare-associated."[87] 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.[88]

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 14 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

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

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

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

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

[87] 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.

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

- Performance of annual infection prevention risk assessment
- Evidence of routine discussion of CLABSI data and prevention outcome measures in committee minutes
- Provision of infection incidence data on CLABSI
- Education on reducing the risk of CLABSI for staff involved in inserting and/or managing central lines
- Educational materials about CLABSI prevention for patients and families
- Use of a checklist for central line insertion and maintenance

Conclusion

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

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

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

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	• Protected peer review of clinical care • UM reviews • Patient safety incident reporting and RCAs	• None	• At least 75 percent of all inpatient admissions and continued stay reviews are completed. • Physician UM Advisors consistently document their decisions in the National UM Integration database. • Required members attend the UM Committee meetings on an ongoing basis.
Credentialing and Privileging	• Medical licenses • Privileges • FPPEs • OPPEs	• Service Chiefs complete all required elements of FPPEs for the determination of provider's 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 ○ Hazard Analysis Critical Control Point Food Safety System plan ○ Food Services inspections ○ Safe transportation of prepared food ○ Environmental safety ○ Infection prevention ○ Storage areas	• Medical equipment is identified as safe for patient use.	• Environment of care rounds are conducted in all areas of the Facility at the required frequency. • Facility managers maintain a safe and clean environment throughout the Facility.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Medication Management	• CSC reports • Pharmacy operations • Annual physical security survey • CS ordering processes • Inventory completion during Chief of Pharmacy transition • Review of balance adjustments • CSC requirements • CSI requirements • CS area inspections • Pharmacy inspections	• None	• None
Mental Health Care: Post-Traumatic Stress Disorder Care	• Suicide risk assessment • Offer of further diagnostic evaluation • Referral for diagnostic evaluation • Completion of diagnostic evaluation	• None	• None
Long-Term Care: Geriatric Evaluations	• Provision of or access to GE • Program oversight and evaluation • Provision of clinical care • Geriatric management	• Providers perform geriatric medical evaluations. • Clinicians accurately identify and implement geriatric evaluation plan of care interventions.	• Geriatric evaluation performance improvement activities are conducted, documented, and reviewed by an appropriate leadership board.
Women's Health: Mammography Results and Follow-Up	• Result linking • Report scanning and content • Communication of results and recommended actions • Follow-up mammograms and studies	• None	• None
High-Risk Processes: Central Line-Associated Bloodstream Infections	• Policy and infection prevention risk assessment • Committee discussion • Infection incidence data	• None	• None

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
	• Education and educational materials • 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 mid-high-complexity (1c)[89] affiliated[90] Facility reporting to VISN 10.

Table 6. Facility Profile for Dayton (552)
(October 1, 2014, through September 30, 2017)

Profile Element	Facility Data FY 2015[91]	Facility Data FY 2016[92]	Facility Data FY 2017[93]
Total Medical Care Budget in Millions	$396.5	$369.3	$408.6
Number of:			
• Unique Patients	38,913	39,723	40,254
• Outpatient Visits	499,817	507,403	498,573
• Unique Employees[94]	1,847	1,959	2,057
Type and Number of Operating Beds:			
• Community Living Center	185	200	200
• Domiciliary	80	99	99
• Medicine	35	35	35
• Mental Health	25	25	25
• Surgery	31	31	31
Average Daily Census:			
• Community Living Center	124	124	124
• Domiciliary	68	65	81
• Medicine	38	35	36
• Mental Health	11	9	11

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

[90] Associated with a medical residency program.

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

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

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

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

Profile Element	Facility Data FY 2015[91]	Facility Data FY 2016[92]	Facility Data FY 2017[93]
• Rehab Medicine	n/a	1	1
• Surgery	8	8	8

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

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

n/a – not applicable

VA Outpatient Clinic Profiles[95]

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[96] 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[97] Provided	Diagnostic Services[98] Provided	Ancillary Services[99] Provided
Middletown, OH	552GA	7,242	2,482	Cardiology Dermatology Endocrinology Nephrology Cardio Thoracic Eye Podiatry	EKG	Pharmacy Weight Management Nutrition

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

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

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

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

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

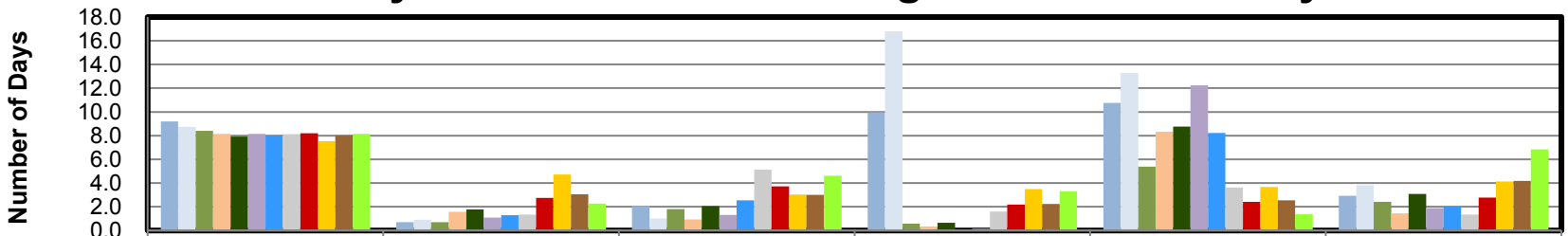
Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services[97] Provided	Diagnostic Services[98] Provided	Ancillary Services[99] Provided
Lima, OH	552GB	8,417	2,410	Cardiology Dermatology Endocrinology Nephrology Eye Podiatry	EKG	Nutrition Pharmacy Prosthetics Social Work Weight Management
Richmond, IN	552GC	7,445	2,908	Cardiology Dermatology Endocrinology Nephrology Eye General Surgery Podiatry	EKG	Pharmacy Prosthetics Social Work Weight Management Nutrition
Springfield, OH	552GD	7,047	1,764	Cardiology Dermatology Endocrinology Nephrology Eye General Surgery Podiatry	EKG	Pharmacy Social Work Weight Management Nutrition

Source: VHA Support Service Center and VA Corporate Data Warehouse

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

Appendix C: Patient Aligned Care Team Compass Metrics[100]

Quarterly New PC Patient Average Wait Time in Days



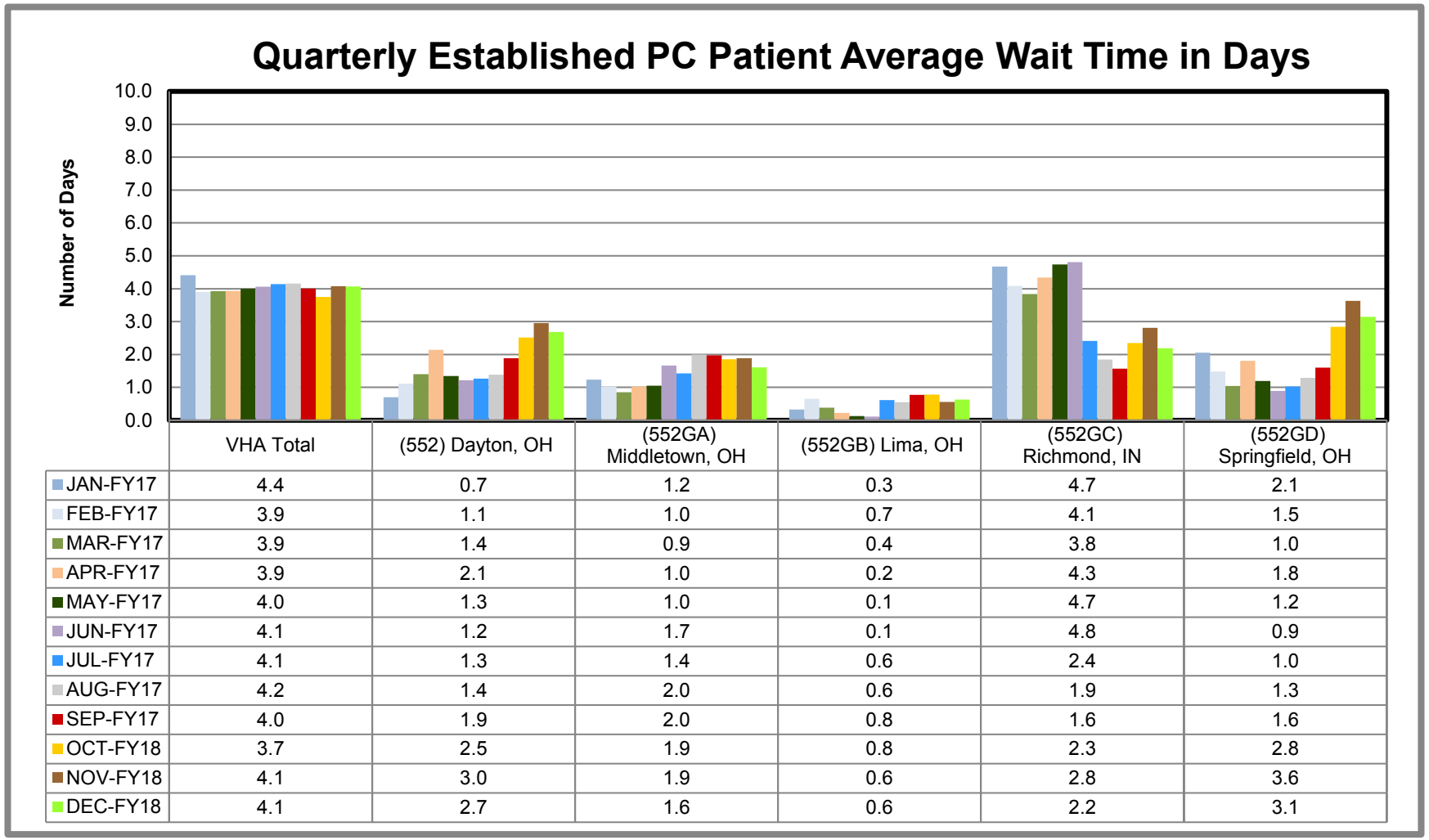
	VHA Total	(552) Dayton, OH	(552GA) Middletown, OH	(552GB) Lima, OH	(552GC) Richmond, IN	(552GD) Springfield, OH
JAN-FY17	9.2	0.7	2.1	10.0	10.8	2.9
FEB-FY17	8.7	0.9	1.0	16.8	13.3	3.8
MAR-FY17	8.4	0.7	1.8	0.6	5.4	2.4
APR-FY17	8.2	1.6	0.9	0.3	8.3	1.4
MAY-FY17	7.9	1.8	2.1	0.6	8.8	3.1
JUN-FY17	8.2	1.1	1.3	0.1	12.2	1.9
JUL-FY17	8.0	1.3	2.6	0.2	8.2	2.0
AUG-FY17	8.1	1.3	5.1	1.6	3.6	1.3
SEP-FY17	8.2	2.7	3.7	2.2	2.4	2.8
OCT-FY18	7.5	4.7	3.0	3.5	3.7	4.1
NOV-FY18	8.0	3.1	3.0	2.2	2.5	4.2
DEC-FY18	8.1	2.3	4.6	3.3	1.4	6.8

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.*

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

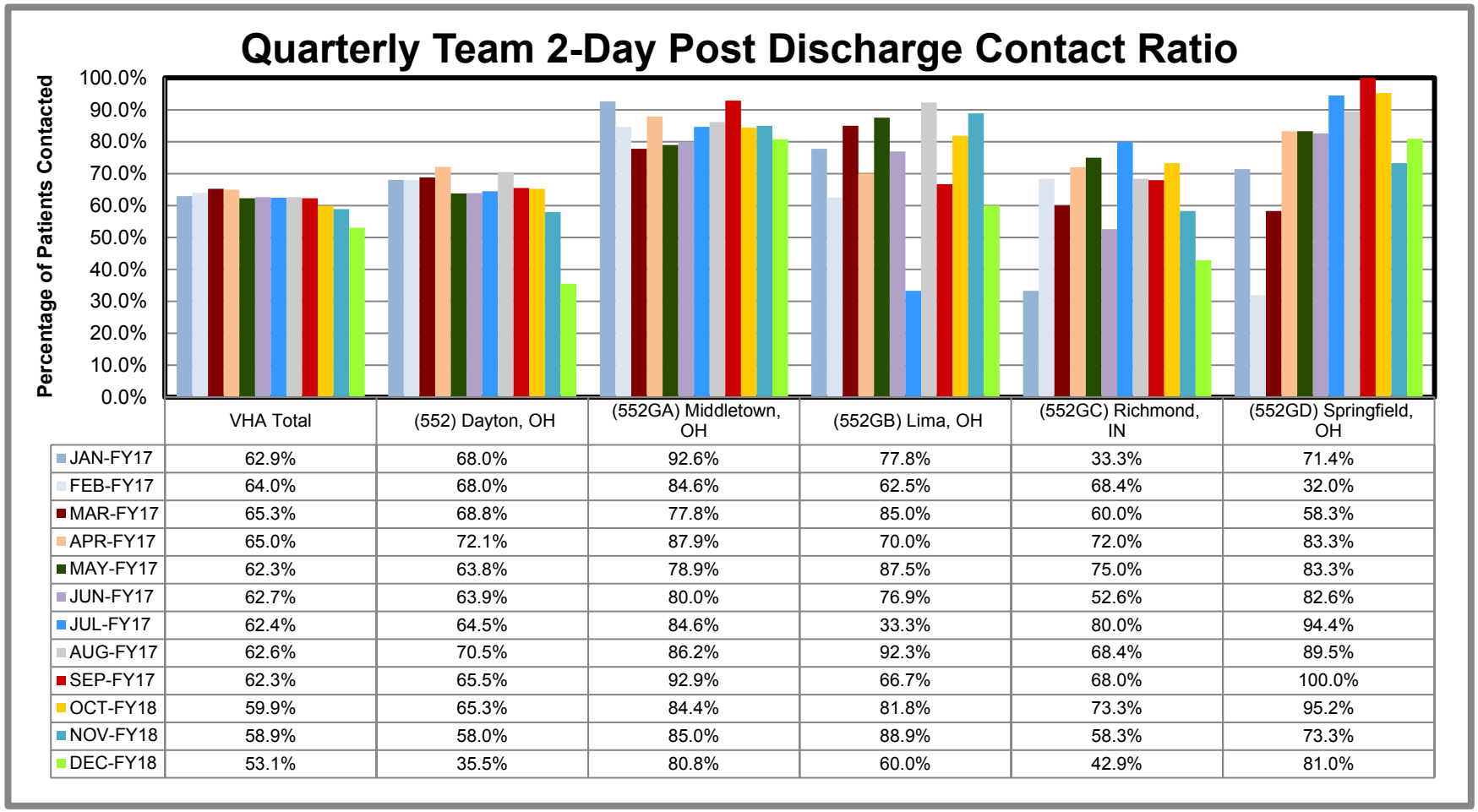


	VHA Total	(552) Dayton, OH	(552GA) Middletown, OH	(552GB) Lima, OH	(552GC) Richmond, IN	(552GD) Springfield, OH
JAN-FY17	4.4	0.7	1.2	0.3	4.7	2.1
FEB-FY17	3.9	1.1	1.0	0.7	4.1	1.5
MAR-FY17	3.9	1.4	0.9	0.4	3.8	1.0
APR-FY17	3.9	2.1	1.0	0.2	4.3	1.8
MAY-FY17	4.0	1.3	1.0	0.1	4.7	1.2
JUN-FY17	4.1	1.2	1.7	0.1	4.8	0.9
JUL-FY17	4.1	1.3	1.4	0.6	2.4	1.0
AUG-FY17	4.2	1.4	2.0	0.6	1.9	1.3
SEP-FY17	4.0	1.9	2.0	0.8	1.6	1.6
OCT-FY18	3.7	2.5	1.9	0.8	2.3	2.8
NOV-FY18	4.1	3.0	1.9	0.6	2.8	3.6
DEC-FY18	4.1	2.7	1.6	0.6	2.2	3.1

Source: VHA Support Service Center

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

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

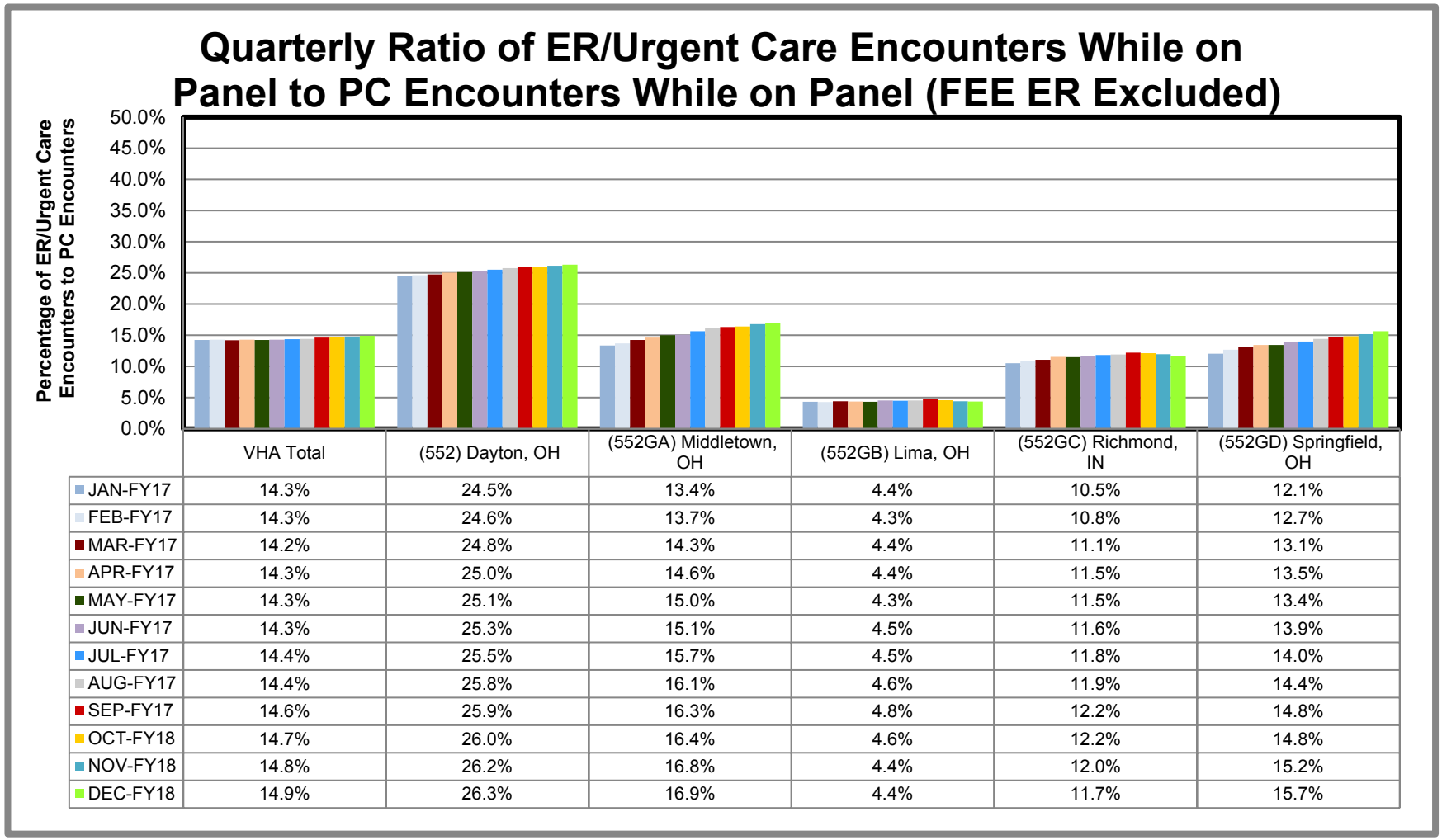


	VHA Total	(552) Dayton, OH	(552GA) Middletown, OH	(552GB) Lima, OH	(552GC) Richmond, IN	(552GD) Springfield, OH
JAN-FY17	62.9%	68.0%	92.6%	77.8%	33.3%	71.4%
FEB-FY17	64.0%	68.0%	84.6%	62.5%	68.4%	32.0%
MAR-FY17	65.3%	68.8%	77.8%	85.0%	60.0%	58.3%
APR-FY17	65.0%	72.1%	87.9%	70.0%	72.0%	83.3%
MAY-FY17	62.3%	63.8%	78.9%	87.5%	75.0%	83.3%
JUN-FY17	62.7%	63.9%	80.0%	76.9%	52.6%	82.6%
JUL-FY17	62.4%	64.5%	84.6%	33.3%	80.0%	94.4%
AUG-FY17	62.6%	70.5%	86.2%	92.3%	68.4%	89.5%
SEP-FY17	62.3%	65.5%	92.9%	66.7%	68.0%	100.0%
OCT-FY18	59.9%	65.3%	84.4%	81.8%	73.3%	95.2%
NOV-FY18	58.9%	58.0%	85.0%	88.9%	58.3%	73.3%
DEC-FY18	53.1%	35.5%	80.8%	60.0%	42.9%	81.0%

Source: VHA Support Service Center

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

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



	VHA Total	(552) Dayton, OH	(552GA) Middletown, OH	(552GB) Lima, OH	(552GC) Richmond, IN	(552GD) Springfield, OH
JAN-FY17	14.3%	24.5%	13.4%	4.4%	10.5%	12.1%
FEB-FY17	14.3%	24.6%	13.7%	4.3%	10.8%	12.7%
MAR-FY17	14.2%	24.8%	14.3%	4.4%	11.1%	13.1%
APR-FY17	14.3%	25.0%	14.6%	4.4%	11.5%	13.5%
MAY-FY17	14.3%	25.1%	15.0%	4.3%	11.5%	13.4%
JUN-FY17	14.3%	25.3%	15.1%	4.5%	11.6%	13.9%
JUL-FY17	14.4%	25.5%	15.7%	4.5%	11.8%	14.0%
AUG-FY17	14.4%	25.8%	16.1%	4.6%	11.9%	14.4%
SEP-FY17	14.6%	25.9%	16.3%	4.8%	12.2%	14.8%
OCT-FY18	14.7%	26.0%	16.4%	4.6%	12.2%	14.8%
NOV-FY18	14.8%	26.2%	16.8%	4.4%	12.0%	15.2%
DEC-FY18	14.9%	26.3%	16.9%	4.4%	11.7%	15.7%

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[101]

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	percent 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	percent 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
Employee Satisfaction	Overall satisfaction with job	A higher value is better than a lower value

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

Measure	Definition	Desired Direction
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
Rating PC Provider	Rating of PC providers (PCMH)	A higher value is better than a lower value

Measure	Definition	Desired Direction
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
SC Survey Access	Timely Appointment, care and information (Specialty Care)	A higher value is better than a lower value

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

Source: VHA Support Service Center

Appendix E: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: July 9, 2018

From: Director, VA Healthcare System (10N10)

Subj: CHIP Review of the Dayton VA Medical Center, OH

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

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

1. I have reviewed the draft report of the Comprehensive Healthcare Inspection Program Review of the Dayton VA Medical Center, March 19-22, 2018.

2. I concur with the responses and action plans submitted by the Dayton VA Medical Center.

3. Thank you for the opportunity to respond to this report.

(Original signed by:)

Robert McDivitt, FACHE

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: July 6, 2018

From: Director, Dayton VA Medical Center (552/00)

Subj: CHIP Review of the Dayton VA Medical Center, OH

To: Director, VA Healthcare System (10N10)

1. Thank you for the opportunity to review the draft report of the Office of Inspector General, Comprehensive Healthcare Inspection Program review of the Dayton VA Medical Center, conducted March 19-22, 2018.

2. I have reviewed the document and concur with the recommendations. Relevant action plans have been established as detailed in the attached report.

(Original signed by:)

Jill K. Dietrich, JD, MBA, FACHE

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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