DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection Program Review of the Northport VA Medical Center

New York

CHIP REPORT | REPORT #18-01018-281 | SEPTEMBER 18, 2018

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Figure 1. *Northport VA Medical Center, New York*
(Source: https://vaww.va.gov/directory/guide/, accessed on June 20, 2018)

Abbreviations

CBOC	community based outpatient clinic
CHIP	Comprehensive Healthcare Inspection Program
CLABSI	central line-associated bloodstream infection
CS	controlled substances
CSC	controlled substances coordinator
CSI	controlled substances inspector
EHR	electronic health record
EOC	environment of care
FPPE	Focused Professional Practice Evaluation
GE	geriatric evaluation
LIP	licensed independent practitioner
MH	mental health
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
PC	primary care
PL	Performance Logic
PTSD	posttraumatic stress disorder
QSV	quality, safety, and value
RCA	root cause analysis
SAIL	Strategic Analytics for Improvement and Learning
TJC	The Joint Commission
UM	utilization management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network

Report Overview

This Comprehensive Healthcare Inspection Program (CHIP) review provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Northport 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 April 23, 2018. The OIG conducted interviews and reviewed clinical and administrative processes related to areas of focus that affect patient care outcomes. Although the OIG reviewed a spectrum of clinical and administrative processes, the sheer complexity of VA medical centers limits the ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of Facility performance within the identified focus areas at the time of the OIG visit. Although it is difficult to quantify the risk of patient harm, the findings in this report may help facilities identify areas of vulnerability or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Results and Review Impact

Leadership and Organizational Risks

At the Facility, the leadership team consists of the Director, Interim Chief of Staff, Interim Associate Director for Patient Care Services (ADPCS), and Associate Director. Organizational communication and accountability are carried out through a committee reporting structure, with the Executive Quality Council having oversight for groups such as Clinical Executive Board and Environment of Care Committee. The leaders were members of the Facility's Executive Quality Council, which tracks, trends, and monitors quality of care and patient outcomes. However, the Associate Director and Interim ADPCS attended only one of seven council meetings since April 2017.

The Director and Associate Director were permanently appointed in June 2017 and October 2017, respectively. Prior to the permanent assignment, the Associate Director had served in an interim capacity since June 2017. The Chief of Staff and ADPCS positions were both vacated on August 21, 2017. At the time of the OIG's site visit, one interim appointee was carrying out the Chief of Staff responsibilities and two interim appointees were carrying out the ADPCS responsibilities. The current executive leaders have been working together as a team since February 2018 when the most recent Interim ADPCS was assigned.

In the review of selected employee satisfaction survey results regarding Facility leaders, the OIG noted that the Director and Associate Director were in their current positions for less than three months prior to the survey, and the current Interim Chief of Staff and Interim ADPCS were not yet in their current positions at the start of the survey period. The OIG noted that employees appear generally satisfied with Facility leaders; however, opportunities appear to exist for the Director and Associate Director to provide a workplace environment where employees feel safe to bring forth issues or ethical concerns.

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

[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.)

actions to improve or sustain performance of the Quality of Care and Efficiency metrics likely contributing to the current "4-Star" rating.

Additionally, the OIG reviewed accreditation agency findings, sentinel events,[2] disclosures of adverse patient events, and Patient Safety Indicator data and identified the presence of organizational risk factors related to a lack of consistent leadership oversight of quality improvement activities. These may contribute to future issues of noncompliance and/or lapses in patient safety unless corrective processes are implemented and continuously monitored.

The OIG noted findings in five of the eight areas of clinical operations reviewed and issued 11 recommendations that are attributable to the Director, Chief of Staff, and Associate Director. These are briefly described below.

Quality, Safety, and Value

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

Credentialing and Privileging

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

Environment of Care

The OIG noted generally effective 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 or emergency management processes. However, the OIG identified the deficiencies in EOC rounds, infection prevention, Facility cleanliness and maintenance, medical equipment safety, and MH seclusion room safety.

Medication Management

The OIG found general compliance with requirements for most of the performance indicators evaluated, including Controlled Substance (CS) Coordinator reports, annual physical security surveys, ordering procedures, and the CS Coordinator and CS Inspectors having no conflicts of

[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.

interest and completing required training. However, the OIG identified a lack of restriction of staff involved in monthly reviews of inventory balance adjustments.

Long-term Care

The OIG found compliance with provision of clinical care and geriatric management. However, the OIG identified a deficiency in program oversight and evaluation.

Summary

In the review of key care processes, the OIG issued 11 recommendations that are attributable to the Director, Interim 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 64–65, for the responses within the body of the report for the full text of the Directors' comments.) The OIG considers recommendation 3 closed. The OIG will follow up on the planned actions for the open recommendations until they are completed.

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

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Purpose and Scope

Purpose

This Comprehensive Healthcare Inspection Program (CHIP) review was conducted to provide a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Northport VA Medical Center's (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: Posttraumatic 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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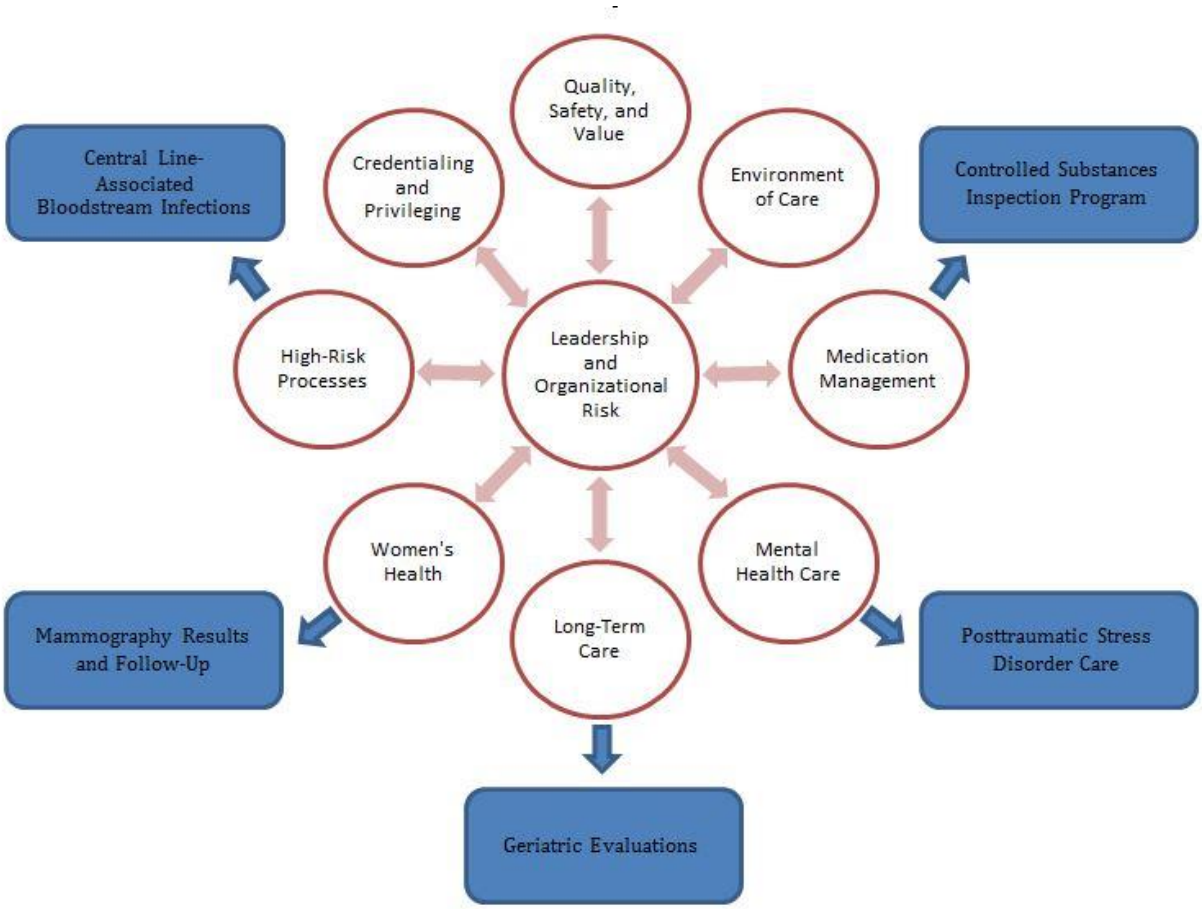
[4] Carol Stephenson, "The role of leadership in managing risk," *Ivey Business Journal*, November/December 2010. https://iveybusinessjournal.com/publication/the-role-of-leadership-in-managing-risk/. (Website accessed on March 1, 2018.)

[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 on 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

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 May 4, 2015,[9] through April 23, 2018, the date when an unannounced week-long site visit commenced.

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

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

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

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

Results and Recommendations

Leadership and Organizational Risks

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

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

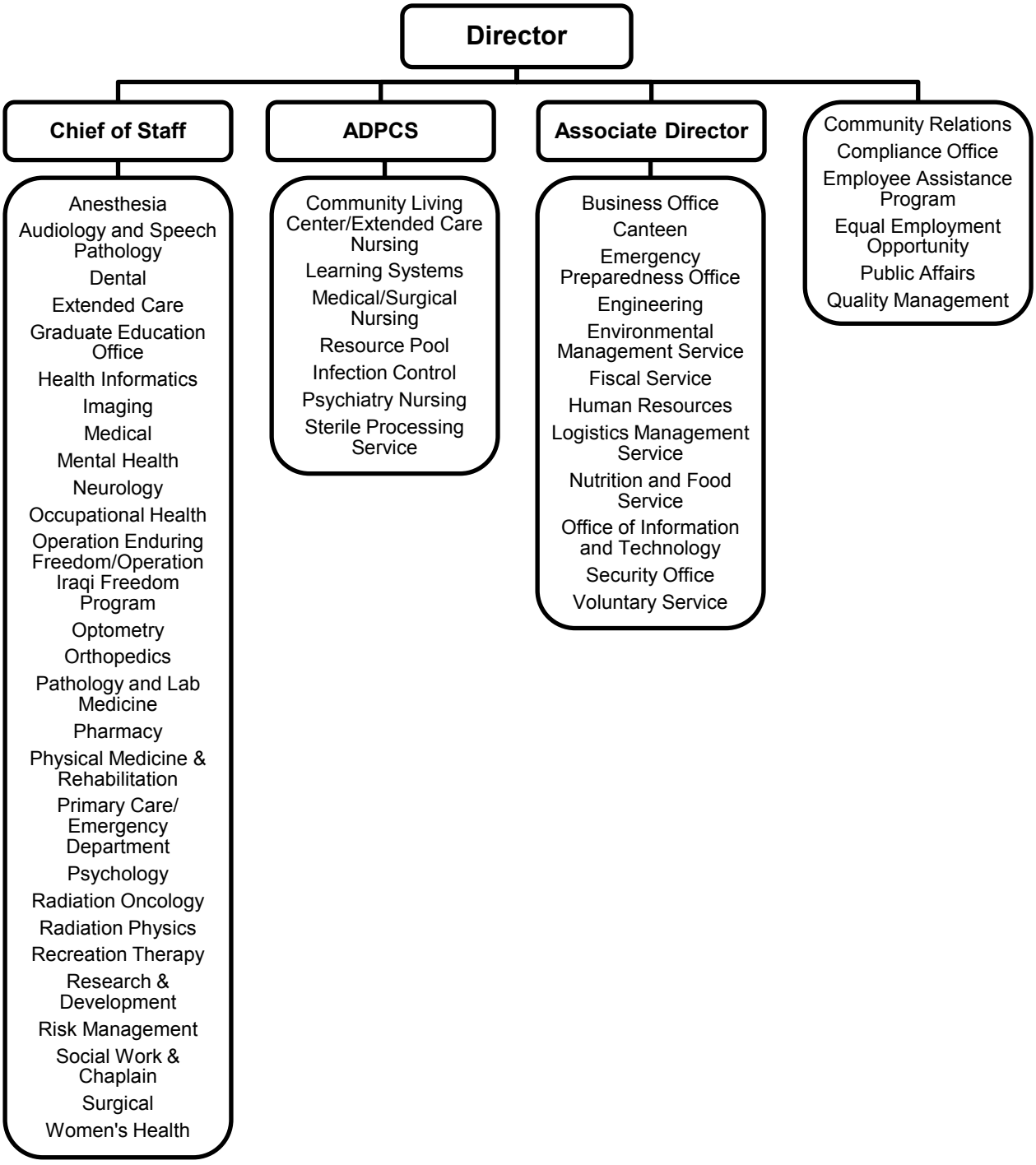
Executive Leadership Stability and Engagement

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

The Director and Associate Director were permanently appointed in June 2017 and October 2017, respectively. Prior to the permanent appointment, the Associate Director had served in an interim capacity since June 2017. The current executive leaders have been working together as a team since February 2018 when the most recent Interim ADPCS was assigned. The Chief of Staff and ADPCS positions were both vacated on August 21, 2017 when these leaders were reassigned to other positions outside the facility. At the time of the OIG's site visit, one interim appointee was carrying out the Chief of Staff responsibilities, and two interim appointees were carrying out the ADPCS responsibilities.

[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: Northport VA Medical Center (received March 23, 2018)

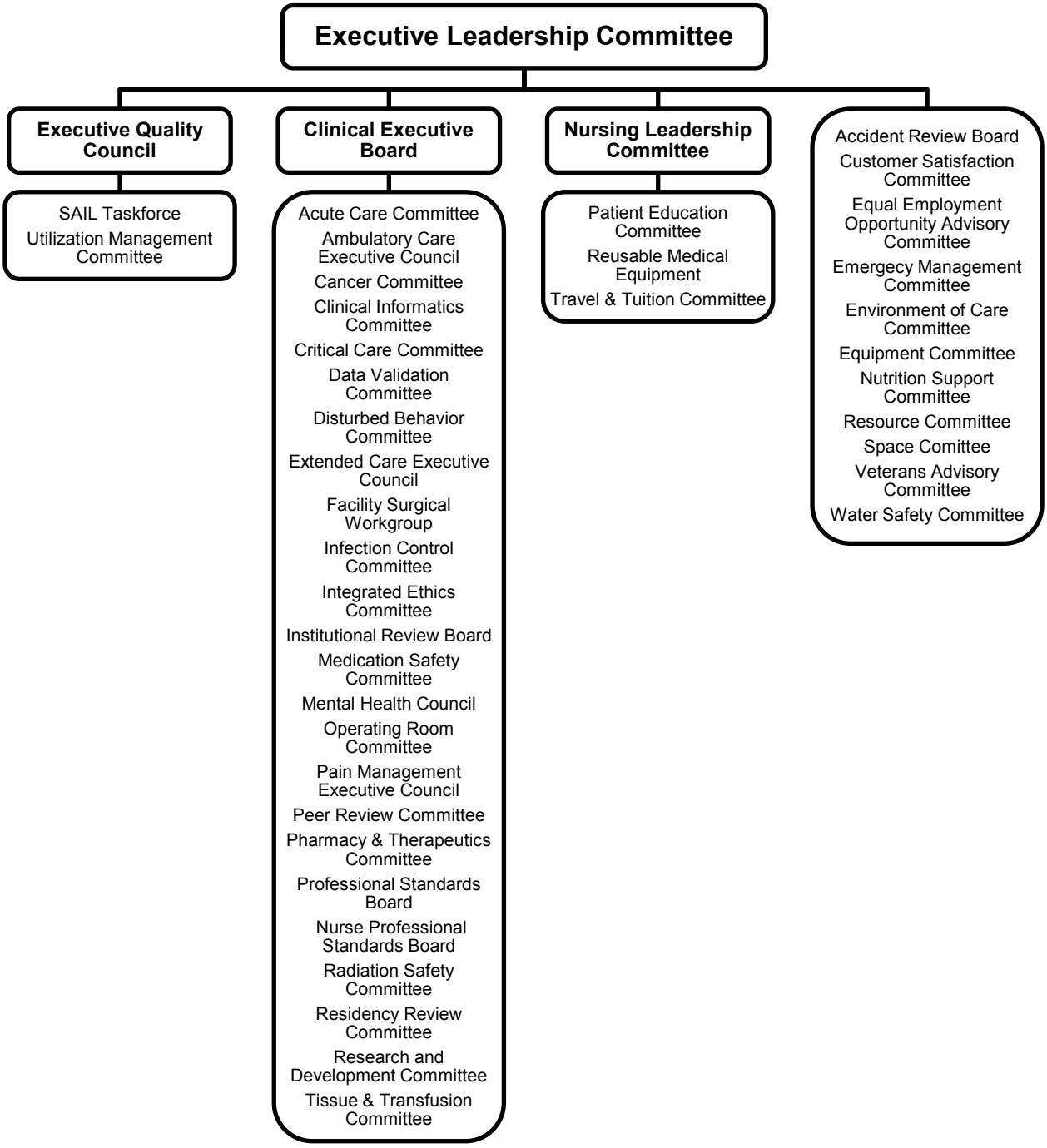
To help assess engagement of Facility executive leadership, the OIG interviewed the Director, Interim Chief of Staff, Interim ADPCS, and Associate Director regarding their knowledge of

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

In individual interviews, these executive leadership team members were able to speak about some actions taken during the previous 12 months in order to maintain or improve performance, employee and patient survey results, and selected Strategic Analytics for Improvement and Learning (SAIL) metrics.

The leaders are also engaged in monitoring patient safety and care through formal mechanisms. They are members of the Facility's Executive Quality Council, which tracks, trends, and monitors quality of care and patient outcomes; however, the Associate Director and Interim ADPCS attended only one of seven council meetings since April 2017. 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 Quality Council reports to the Executive Leadership Committee, which oversees various working committees, such as the Clinical Executive Board and Environment of Care Committee. See Figure 4.

Figure 4. Facility Committee Reporting Structure



Source: Northport VA Medical Center (received April 27, 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 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, the Facility, and selected Facility executive leaders.[11] The OIG noted that the Director and Associate Director were in their current positions for less than three months prior to the survey, and the current Interim Chief of Staff and Interim ADPCS were not yet in their positions at the start of the survey period.

Table 1 summarizes employee attitudes toward selected Facility leaders as expressed in VHA's All Employee Survey.[12] The Facility average for the selected survey questions was above or similar to the VHA average.[13] The same trend was noted for the members of the executive leadership team. In all, employees appear generally satisfied with Facility leaders.

[11] Rating is based on responses by employees who report to or aligned under the Director, Chief of Staff, ADPCS, and Associate Director.

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

[13] 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.

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 Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: *Servant Leader Index Composite*	0–100 where HIGHER scores are more favorable	67.7	71.2	63.6	70.2	77.2	64.0
All Employee Survey Q59. *How satisfied are you with the job being done by the executive leadership where you work?*	1 (Very Dissatisfied)–5 (Very Satisfied)	3.3	3.2	3.8	3.2	3.3	3.0

Source: VA All Employee Survey (accessed March 23, 2018)

Table 2 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey. The Facility averages for the selected survey questions were slightly greater than the VHA average. Results for the ADPCS and Chief of Staff were greater than or similar to VHA and Facility averages, while those for the Director and Associate Director were less than both averages. Opportunities appear to exist for the Director and Associate Director to provide a workplace environment where employees feel safe to bring forth issues or ethical concerns.

Table 2. Survey Results on Employee Attitudes toward Workplace (October 1, 2016, through September 30, 2017)

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey Q43. *My supervisor encourages people to speak up when they disagree with a decision.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.8	3.9	n/a	3.8	4.2	3.5
All Employee Survey Q44. *I feel comfortable talking to my supervisor about work-related*	1 (Strongly Disagree)–5 (Strongly Agree)	3.9	4.0	3.6	4.0	4.3	3.8

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average
problems even if I'm partially responsible.							
All Employee Survey Q75. *I can talk with my direct supervisor about ethical concerns without fear of having my comments held against me.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.9	4.0	3.6	3.9	4.3	3.7

Source: VA All Employee Survey (accessed March 23, 2017)
n/a = Not available

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

VHA collects SHEP survey data from Patient-Centered Medical Home, Specialty Care, and Inpatient Surveys. From these, the OIG selected four survey items that reflect patient attitudes towards Facility leaders (see Table 3) for the period of October 1, 2016, through September 30, 2017. For this Facility, all four patient survey results reflected higher care ratings than the VHA average, which implied that patients were generally satisfied with care provided.

Table 3. Survey Results on Patient Attitudes toward Facility Leadership (October 1, 2016, through September 30, 2017)

Questions	Scoring	VHA Average	Facility Average
Survey of Healthcare Experiences of Patients (inpatient): *Would you recommend this hospital to your friends and family?*	The response average is the percent of "Definitely Yes" responses.	66.7	68.2
Survey of Healthcare Experiences of Patients (inpatient): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	83.4	83.7

Questions	Scoring	VHA Average	Facility Average
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	83.2
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	78.4

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

Accreditation/For-Cause Surveys[14] 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 4 summarizes the relevant Facility inspections most recently performed by the OIG and The Joint Commission (TJC).[15] Indicative of effective leadership, the Facility has closed all recommendations for improvement as listed in Table 4.[16]

The OIG also noted the Facility's current accreditation status with the Commission on Accreditation of Rehabilitation Facilities[17] and College of American Pathologists,[18] which

[14] 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.

[15] 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.

[16] 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.

[17] 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.

[18] 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.

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.[19]

Table 4. 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 Northport VA Medical Center, Northport, New York, August 18, 2015)*	May 2015	27	0
OIG (*Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Northport VA Medical Center, Northport, New York, August 7, 2015)*	June 2015	8	0
TJC			
• Special Unannounced Survey[20]	May 2015	3	0
• Regular	July 2015		
○ Hospital Accreditation		22	0
○ Nursing Care Center Accreditation		2	0
○ Behavioral Health Care Accreditation		2	0
○ Home Care Accreditation		0	n/a
• Unannounced Behavioral Health Visit	October 2017	0	n/a

Sources: OIG and TJC (Inspection/survey results verified with the Risk Manager on April 25, 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 5 summarizes key indicators of risk since the OIG's previous

[19] 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.

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

May 2015 Combined Assessment Program review inspection through the week of April 23, 2018.[21]

Table 5. Summary of Selected Organizational Risk Factors (May 2015 to April 23, 2018)

Factor	Number of Occurrences
Sentinel Events[22]	2
Institutional Disclosures[23]	2
Large-Scale Disclosures[24]	1

Source: Northport VA Medical Center's Quality Manager (received April 24, 2018

The OIG found through discussions with staff that the Facility did not have consistent risk management, quality management, or patient safety processes in place to assist with identification of patient care concerns that may warrant institutional disclosures.

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 provided information on potential in-hospital complications and adverse events following surgeries and procedures.[25] The rates presented are specifically applicable for this Facility, and lower rates indicate lower risks. Table 6 summarizes Patient Safety Indicator data from October 1, 2015, through September 30, 2017.

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

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

[23] 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.

[24] 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.

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

Table 6. Patient Safety Indicator Data
(October 1, 2015, through September 30, 2017)

Measure	Reported Rate per 1,000 Hospital Discharges		
	VHA	VISN 2	Facility
Pressure ulcers	0.60	0.76	0.00
Death among surgical inpatients with serious treatable conditions	100.97	124.00	0.00
Iatrogenic pneumothorax	0.19	0.38	0.30
Central venous catheter-related bloodstream infection	0.15	0.08	0.00
In-hospital fall with hip fracture	0.08	0.08	0.36
Perioperative hemorrhage or hematoma	1.94	2.29	0.00
Postoperative acute kidney injury requiring dialysis	0.88	1.11	0.00
Postoperative respiratory failure	5.55	7.96	0.00
Perioperative pulmonary embolism or deep vein thrombosis	3.29	3.28	5.30
Postoperative sepsis	4.00	4.69	0.00
Postoperative wound dehiscence	0.52	0.00	0.00
Unrecognized abdominopelvic accidental puncture/laceration	0.53	1.14	2.42

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

The Patient Safety Indicator measure for iatrogenic pneumothorax shows a higher observed rate than VHA. Three Patient Safety Indicator measures (in-hospital fall with hip fracture, perioperative pulmonary embolism or deep vein thrombosis, and unrecognized abdominopelvic accidental puncture/laceration) show a higher observed rate than Veterans Integrated Service Network (VISN) 2 and VHA.

One patient sustained an iatrogenic pneumothorax during a procedure, which is a known potential complication. One patient sustained a hip fracture after an in-hospital fall. An RCA was completed, but no root cause was identified. Three patients experienced perioperative pulmonary embolism or deep vein thrombosis. All three cases were peer reviewed, and care was found to be appropriate. One patient had an unrecognized abdominopelvic accidental puncture/laceration. The case was referred for peer review, and opportunities for improvement were identified and discussed with the surgical provider.

Veterans Health Administration Performance Data

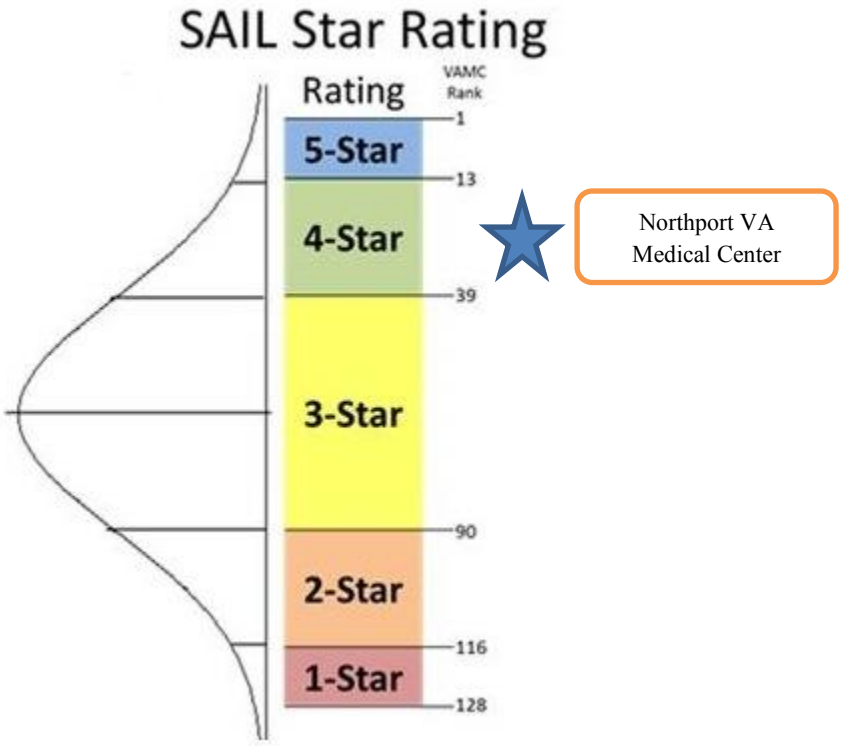
The VA Office of Operational Analytics and Reporting adapted the SAIL Value Model to help define performance expectations within VA. This model includes measures on healthcare quality, employee satisfaction, access to care, and efficiency, but has noted limitations for identifying all areas of clinical risk. The data are presented as one "way to understand the similarities and differences between the top and bottom performers" within VHA.[26]

VA also uses a star-rating system where facilities with a "5-Star" rating are performing within the top 10 percent of facilities and "1-Star" facilities are performing within the bottom 10 percent of facilities. Figure 5 describes the distribution of facilities by star rating.[27] As of June 30, 2017, the Facility was rated "4-Star" for overall quality.

[26] 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.)

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

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

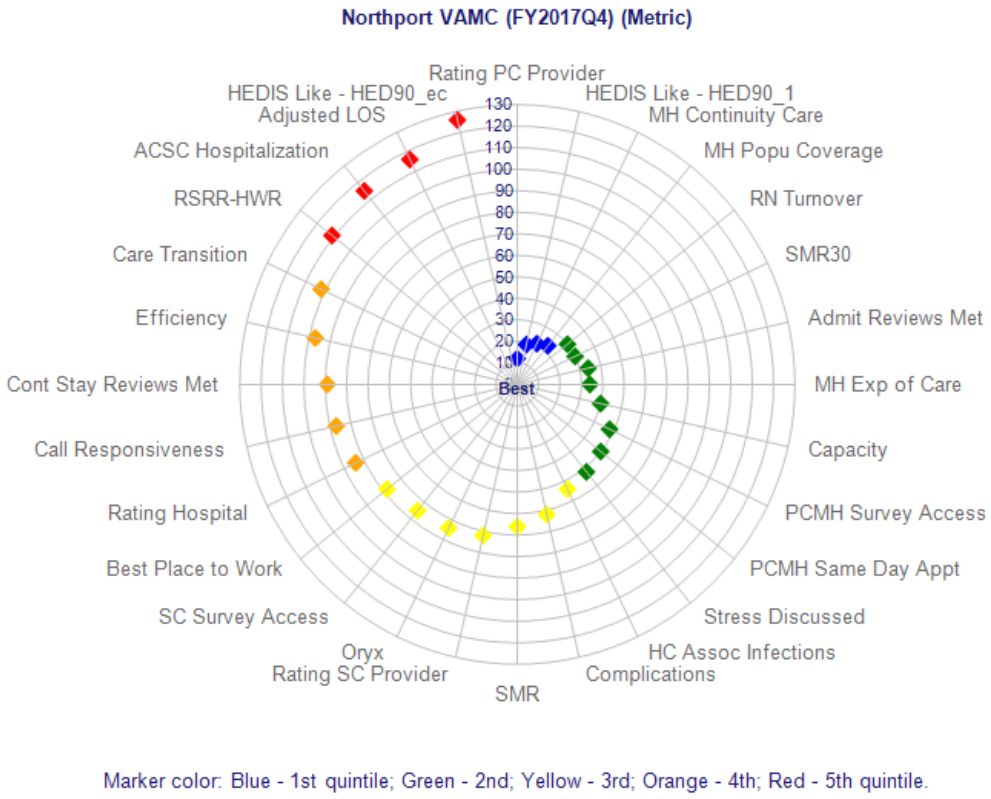


Source: VA Office of Informatics and Analytics Office of Operational Analytics and Reporting (accessed March 23, 2018)

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 in the top quintiles to indicate high performance (for example in the areas of Rating [of] Primary Care (PC) Provider, Registered Nurse (RN) Turnover, Capacity, and Stress Discussed).[28] Metrics in the bottom quintiles reflect areas that need improvement and are denoted in orange and red (for example, Rating [of] Hospital, Care Transition, Ambulatory Care Sensitive Conditions (ACSC) Hospitalization, and Adjusted Length of Stay (LOS)).

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

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



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

Conclusion

Since June 2017, there have been significant leadership changes at the Facility. The current Director and the Associate Director were permanently assigned to their positions in June 2017. The former Chief of Staff and ADPCS were assigned to positions outside the Facility in August 2017, and the positions have since been filled by interim appointees. Further, opportunities appear to exist for the Director and Associate Director to provide a workplace environment where employees feel safe to bring forth issues or ethical concerns. The OIG also noted a lack of consistent risk management, quality management, and patient safety processes (discussed later in this report) to assist with identification of patient care concerns that may warrant institutional disclosures. The presence of these organizational risk factors may contribute to future issues of noncompliance and/or lapses in patient safety unless corrective processes are implemented and continuously monitored. The leadership team was knowledgeable about selected SAIL metrics

but should continue to take actions to improve and sustain care and performance of selected Quality of Care and Efficiency metrics.

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.[29] VHA also strives to provide healthcare services that compare favorably to the best of the private sector in measured outcomes, value, and efficiency.[30]

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

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.[34]

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

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

[31] 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.)

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

[33] 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 the VHA National Center for Patient Safety, in order for VHA to learn about system vulnerabilities and how to address them as well as the requirement to implement RCAs (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.

[34] 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:[35]

- 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[36]
  - Annual completion of a minimum of eight RCAs[37]
  - Provision of feedback about RCA actions to reporting employees
  - Submission of annual patient safety report

Conclusion

The OIG found general compliance with requirements for protected peer reviews. However, the OIG found a general lack of consistent processes for identification of opportunities for improvement, implementation of recommended actions, and evaluation of effectiveness of

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

[36] 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.

[37] 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.

actions taken with UM, patient safety, and RCA processes that warranted recommendations for improvement.

Utilization Management: Data Review

VHA requires that an interdisciplinary facility group review UM data.[38] 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. This ensures that an interdisciplinary approach is taken when reviewing UM data for performance improvement. From June 2017 through March 2018, the UM Committee met quarterly; however, representation from Social Work, Mental Health, and the Chief Business Office Revenue Utilization Review did not consistently attend. This resulted in a lack of expertise in the review and analysis of UM data. The reasons given for noncompliance were that employees were on scheduled leave, had patient care responsibilities with no designated alternates, and had a lack of meeting notification.

Recommendation 1

1. The Chief of Staff ensures all required members consistently participate in the interdisciplinary group that reviews utilization management data and monitors compliance.

Facility concurred.

Target date for completion: April 1, 2019

Facility response: UM Committee Charter was re-written to include required attendance at UM Committee meetings. Attendance is measured quarterly (for 2 quarters) to reach 90 percent and reported at UM Committee and reported to Executive Quality Council quarterly.

N = number of committee members/designee present quarterly

D = Total number of Committee Service members

Patient Safety: Root Cause Analyses

VHA requires that the Patient Safety Manager provides timely feedback to staff who submit close call and adverse event reports that result in an RCA. This establishes trust in the system and ensures staff are aware that their reports were addressed. Additionally, VHA requires implementation and monitoring of RCA improvement actions.[39]

[38] VHA Directive 1117.

[39] VHA Handbook 1050.01.

In four of five RCAs conducted during FY 2017, there was a lack of evidence that the individual or department reporting the incident received feedback or education regarding actions taken. This resulted in missed opportunities to establish employee trust in the system and to positively reinforce a culture of safety. Further, RCA actions were not fully implemented in two of five reviews, resulting in missed opportunities to improve patient outcomes by preventing future occurrences of similar events. Through interviews with Quality Management Service and review of documentation, the OIG identified 24 delinquent RCA actions in FY 2017 and three in FY 2018 through April 2018. The Acting Patient Safety Manager stated that the previous staff responsible for providing documentation of feedback to the reporting individual or department did not complete this task. At the time of our visit, the current Acting Patient Safety Manager's efforts were focused on improving this process, however, actions remain open.

Recommendation 2

2. The Facility Director ensures implementation of root cause analysis actions and provides feedback of results to the reporting individuals or departments and monitors compliance.

Facility concurred.

Target date for completion: April 15, 2019

Facility response:

1. To ensure Root Cause Analyses actions are implemented:

Root Cause Analysis actions will be tracked by Patient Safety Manager and reported to leadership bi-monthly to the QUAD at morning report; RCA compliance reporting will be a standing monthly agenda item at Executive Quality Council. Will monitor for 100 percent compliance.

N = Total number of closed actions

D = 27 open actions: 24 RCA Actions outstanding from 2017 and 3 outstanding RCA Actions from 2018

Target date for completion: March 30, 2019

Facility response:

2. Ensure feedback from RCA findings and actions are provided to the individual or department that reported the incident.

Patient Safety Manager will be responsible to ensure feedback of RCA actions and findings are given to the reporter/service and will be reported as a standing monthly agenda item at Executive Quality Council. Feedback on RCA's will be recorded in the RCA tracker. Will monitor that 100 percent over the next 6 months of all completed RCA's noted in this recommendation are reported back to individuals or services that reported the incident.

N= # of reporter/services receive feedback

D= # completed RCA

Patient Safety Manager will be responsible to ensure feedback of RCA actions and findings are given to the reporter/service and will be reported as a standing monthly agenda item at Executive Quality Council. Feedback on RCA's will be recorded in the RCA tracker.

Patient Safety: Annual Report

VHA requires that the Patient Safety Manager submit an annual patient safety report at the end of each fiscal year to Facility leaders.[40] This report provides an overview of the Facility's Patient Safety Program status to ensure a safe environment. The Patient Safety Manager completed and submitted the FY2017 report to the Chief of Quality Management Service; however, there was lack of evidence that the report was submitted to Facility leaders. The Chief of Quality Management service could not provide a reason why the report was not provided to Facility leadership and demonstrated lack of oversight and accountability.

Recommendation 3

3. The Facility Director ensures that the Patient Safety Manager submits an annual patient safety report to the Facility leaders and monitors compliance.

Facility concurred.

Target date for completion: Completed

Facility response: PSM Annual report was presented at the May 17, 2018 Executive Quality Council with the facility leadership present.

The facility requests closure of this recommendation. The OIG considers this recommendation closed based on information and reports provided.

[40] VHA Handbook 1050.01.

Credentialing and Privileging

VHA has defined procedures for the credentialing and privileging of all healthcare professionals who are permitted by law and the facility to practice independently—without supervision or direction, within the scope of the individual's license, and in accordance with individually granted clinical privileges. These healthcare professionals are also referred to as licensed independent practitioners (LIP).[41]

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.[42]

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.[43]

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,[44] and 20 LIPs who were re-privileged within 12 months prior to the visit.[45] The OIG evaluated the following performance indicators:

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

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

[42] VHA Handbook 1100.19.

[43] VHA Handbook 1100.19.

[44] The 18-month period was from October 23, 2016, through April 23, 2018.

[45] The 12-month review period was from April 23, 2017, through April 23, 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 and privileging. However, the OIG identified the following deficiencies in FPPE and OPPE processes that warranted recommendations for improvement.

FPPE Processes

VHA requires that all LIPs new to the facility have FPPEs completed and documented in the practitioner's provider profile and reported to an appropriate Medical Staff committee.[46] The process involves the evaluation of privilege-specific competence of the practitioner who has not

[46] VHA Handbook 1100.19.

had previously documented evidence of competently performing the requested privileges. FPPEs may include periodic chart review, direct observation, monitoring of diagnostic and treatment techniques or discussion with other individuals involved in the care of patients.[47] For 2 of 9 applicable LIPs, the Facility's Professional Standards Board recommended continuation of initially granted privileges even though the FPPE results (primarily EHR reviews) were incomplete. This resulted in providers continuing to deliver care without a thorough evaluation of their practice. The Acting Chief of Staff reported that Service Chiefs had inconsistent methods for collecting and reporting FPPE results, and the Professional Standards Board had not required that FPPE results documentation be available for review before continuing privileges.

OPPE Processes

VHA requires that the determination to continue LIP privileges be based in part on the results of OPPE activities, such as result of EHR reviews, outcome data, and direct observation.[48] These elements allow the facility to identify professional practice trends that impact patient care, safety, and quality of care. For 8 of 20 LIPs who were re-privileged, the Facility's Professional Standards Board recommended continuation of initially granted privileges even though the OPPE results (primarily EHR reviews) were incomplete. This resulted in providers continuing to deliver care without a thorough evaluation of their practice. The Acting Chief of Staff reported that Service Chiefs had inconsistent methods of collecting and reporting OPPE results, and the Professional Standards Board had not required that OPPE results documentation be available for review before continuing privileges.

Recommendation 4

4. The Chief of Staff ensures that Service Chiefs complete and report Focused and Ongoing Professional Practice Evaluations to the Professional Standards Board for determination of provider privileges and monitors the Service Chiefs' compliance.

Facility concurred.

Target date for completion: December 31, 2018

Facility response: FPPE Service Chiefs and Service Level Credentialing staff have been advised to send the supporting patient specific data to support FPPE reports for all new hire LIPs. FPPE reports will not be accepted for presentation to the PSB by the Credentialing and Privileging Department staff without attached supporting data. Monitoring period will be six months. Will monitor until 90 percent compliance is maintained for 6 consecutive months. Monthly compliance reports will be sent to the Chief of Staff.

[47] VHA Handbook 1100.19.

[48] VHA Handbook 1100.19.

OPPE Service Chiefs and Service Level Credentialing staff have been advised to send the supporting patient specific data to support OPPE reports for all LIPs. OPPE reports will not be accepted for presentation to the PSB by the Credentialing and Privileging Department staff without attached supporting data. The requirement for data to accompany OPPE reports was first initiated in November of 2017. Monitoring period will be six months. Will monitor until 100 percent compliance is maintained for 6 consecutive months. Monthly compliance reports will be sent to the Chief of Staff.

N = # FPPE/OPPE reports submitted to the C&P/PSB committee with supporting data each month

D = Total # of FPPE/OPPE reports submitted to the C&P/PSB committee each month

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.[49]

The purpose of the OIG review was to determine whether the Facility maintained a clean and safe healthcare environment in accordance with applicable requirements. The OIG also determined whether the Facility met requirements in selected areas that are often associated with higher risks of harm to patients in the locked MH Unit and with Emergency Management processes.[50]

VHA requires managers to ensure capacity for MH services for veterans with acute and severe emotional and/or behavioral symptoms causing a safety risk to self or others, and/or resulting in severely compromised functional status. This level of care is typically provided in an inpatient setting to ensure safety and to provide the type and intensity of clinical intervention necessary to treat the patient. Such care needs to be well integrated with the full continuum of care to support safety and effective management during periods of such severe difficulty. Inpatient MH settings must also provide a healing, recovery-oriented environment.[51]

VHA requires managers to establish a comprehensive Emergency Management program to ensure continuity of patient care and hospital operations in the event of a disaster or emergency, which includes conducting a Hazard Vulnerability Analysis (HVA) and developing an Emergency Operations Plan (EOP).[52] These requirements allow the identification and minimization of impacts from potential hazards, threats, incidents, and events on health care and other essential services provided by facilities. VHA also requires managers to develop Utility Management Plans to ensure reliability and reduce failures of electrical power distribution systems in accordance with TJC,[53] Occupational Safety and Health Administration,[54] and

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

[50] 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).

[51] VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013.

[52] VHA Directive 0320.01, *Comprehensive Emergency Management Program Procedures*, April 6, 2017.

[53] TJC. Environment of Care standard EC.02.05.07.

[54] Occupational Safety and Health (OSHA) is part of the US Department of Labor. OSHA assures safe and healthful working conditions for working men and women by setting and enforcing standards and by providing training, outreach, education, and assistance.

National Fire Protection Association standards.[55] The provision of sustained electrical power during disasters or emergencies is critical to continued operations of a healthcare facility.

In all, the OIG team inspected six inpatient units (intensive care, Community Living Center 1, Medicine – Unit 34, Mental Health – Unit 21, post anesthesia care, and Surgery – Unit 33), the Emergency Department, and Outpatient Clinic 2G. The team also inspected the Riverhead CBOC. The OIG reviewed 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
- Locked MH Unit
  - Bi-annual MH EOC Rounds
  - Nursing station security
  - Public area and general unit safety

[55] National Fire Protection Association (NFPA) is a global nonprofit organization devoted to eliminating death, injury, and property and economic loss due to fire, electrical, and related hazards.

  - Patient room safety
  - Infection prevention
  - Availability of medical equipment and supplies
- Emergency Management
  - Hazard Vulnerability Analysis (HVA)
  - Emergency Operations Plan (EOP)
  - Emergency power testing and availability

Conclusion

The OIG noted generally effective 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, or emergency management processes. The OIG identified the following deficiencies in EOC rounds, infection prevention, Facility cleanliness and maintenance, medical equipment safety, and MH seclusion room safety that warranted recommendations for improvement.

Environment of Care Rounds

VHA requires facilities to conduct EOC rounds at a minimum of once per FY in non-patient care areas and twice per FY in patient care areas and document completion of such rounds using the Comprehensive EOC Assessment and Compliance Tool, Performance Logic (PL).[56] These processes ensure a safe, clean, and functional healthcare environment.

The OIG found that three of seven clinical areas at the parent Facility and the Riverhead CBOC were not inspected as required. This resulted in a lack of assurance of a clean and safe environment. The Safety Manager reported that the EOC rounds for clinical areas were overlooked and could not give a reason for noncompliance despite repeated inquiries from the OIG.

Recommendation 5

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

Facility concurred.

Target date for completion: March 29, 2019

[56] VHA Directive 1608.

Facility response: Modifications to the PL EOC Rounds database will be made to accurately reflect only those areas which are appropriate to include in EOC rounds. Environment of Care Team will conduct EOC rounds semi-annually in the patient care areas and document completion of such rounds using the Comprehensive EOC Assessment and Compliance Tool. To monitor compliance, Safety Manager will submit a report monthly to Executive Quality Council for two quarters.

Will monitor until 90 percent compliance is maintained for 6 consecutive months.

N = Total # of EOC rounds completed

D = Total # of facility EOC rounds as scheduled in a six-month period

Parent Facility: Infection Prevention

TJC requires hospitals to minimize the risk for acquiring and transmitting infections.[57] This reduces the risk of exposure of patients, visitors, and employees to infectious diseases. The OIG noted the presence of insects (ants and roaches) and insect residue in the CLC, ED and locked MH unit patient rooms. The presence of insects within the healthcare environment reflects the lack of systematic cleaning and pest control processes and could result in transmittal of diseases to patients, visitors, and staff. The Facility staff could not provide a reason why the presence of insects and insect residue had not been addressed.

Recommendation 6

6. The Associate Director ensures a proactive pest control management program is in place throughout the Facility and monitors compliance.

Facility concurred.

Target date for completion: December 31, 2018

Facility response: Environmental Management Service (EMS) will ensure patient rooms and common areas are free of insects (e.g. ants, etc.)

On site exterminator will inspect areas as scheduled by EMS and respond to concerns timely. Daily service inspection reports are sent by exterminators and are reviewed 100 percent by EMS leadership.

Will monitor until 90 percent compliance is maintained for 4 consecutive months.

N = Monthly areas inspected by exterminators

D = Monthly scheduled areas for inspection by exterminators.

[57] TJC, Infection Prevention and Control standard IC.01.03.01 EP1 and EC.04.01.05 EP1.

Facility Cleanliness and Maintenance

TJC requires hospitals to identify environmental deficiencies, hazards, and unsafe practices; keep furnishings and equipment safe and in good repair.[58,59] This ensures a clean and safe healthcare environment.

The OIG identified a serious and widespread lack of cleanliness and maintenance of general structural integrity throughout patient care areas. Specifically, the OIG found that seven patient care areas inspected had dirty, dusty, and/or rusty ventilation grills; four patient care areas had dusty fire sprinkler heads; three patient care areas had torn or partially attached privacy curtains; stained, dusty, cracked, and/or broken ceiling tiles and light fixtures. Further, the CLC rooms and hallways had water leaks, and multiple inpatient rooms throughout the Facility had holes and cracks in the walls. Facility managers stated that Environmental Management Service (EMS) housekeeping staff was not following room cleaning procedures, EMS supervisors were not spot-checking rooms after cleaning, and EOC rounds were not performed as required.

Recommendation 7

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

Facility concurred.

Target date for completion: December 31, 2018

Facility response: Areas identified in this finding/recommendation will be inspected. A monthly check list to include all items will be implemented and monitored for 4 consecutive months at 90 percent compliance.

N = # of areas completed

D = All 70 patient care areas.

Medical Equipment Inventory and Safety Inspection

VHA Center for Engineering and Occupational Safety and Health 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.[60] The facility uses stickers with the date of inspection or a statement of "no preventative maintenance required" as a visual method for equipment users to identify if

[58] TJC, Environment of Care standard EC.02.06.01 EP01 and EP20.

[59] TJC, Environment of Care standard EC.04.01.01 EP14.

[60] VHA Center for Engineering and Occupational Safety and Health (CEOSH), *Medical Equipment Management Guidebook*, October 2011.

equipment has been inspected at the required frequency. The OIG found equipment in the Community Living Center with multiple inspection stickers with different dates. As a result, clinical staff could not be confident that the pieces of equipment were safe to use for patient care. Facility staff failed to identify that they lacked attention to detail, did not remove expired inspection stickers when new ones were placed, and conducted inconsistent EOC rounds during which this issue could have been identified.

Recommendation 8

8. The Associate Director ensures that a consistent mechanism or method is in place for clinical staff to be confident that patient care equipment is safe and functional and monitors compliance.

Facility concurred.

Target date for completion: March 15, 2019

Facility response: Four out of four biomedical technicians have been re-educated, on June 7, 2018 via email, on the process to ensure all equipment have only one visible and assessible PM sticker. Biomedical Engineering has reviewed processes to include educating third party vendors. Four out of four established outside vendors will be sent registered letters by August 31, 2018 on the process of removing existing PM stickers prior to adding new ones. The New Vendor Orientation handbook was updated July 26, 2018, to include the process of sticker removal and will be distributed to all vendors. This biomedical engineering process will be implemented and monitored to reach 90 percent compliance for 4 consecutive months.

N = Total # of valid equipment inspection stickers

D = Total # of patient care equipment

Mental Health Seclusion Room Safety

VHA requires that inpatient rooms designated for seclusion be structured to prevent patient injury; this includes floors which must be made of material that provides cushioning.[61] The OIG found that the floor in the designated seclusion room on the MH unit lacked any cushioning. This could result in harm to patients in the event of a patient fall while in the seclusion room. Facility staff stated they thought they met the requirements with the flooring that was in place.

Recommendation 9

9. The Associate Director ensures the mental health seclusion room flooring provides cushioning.

[61] VHA Handbook 1106.06.

Facility concurred.

Target date for completion: February 15, 2019

Facility response: Engineering will order new flooring that will be installed in both Acute Psychiatry Units. We will ensure that we install a flooring that is outlined in the Mental Health Facilities Design Guide 5.5 Isolation, Seclusion. Flooring shall be of sheet vinyl, linoleum or rubber.

N = # floors installed

D = Installation of 2 new floors on acute psychiatry units

Monitor for 100 percent compliance

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.[62] 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.[63]

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.[64] 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.[65] The OIG team interviewed key managers and reviewed CS inspection reports for the prior two completed quarters;[66] monthly summaries of findings, including discrepancies, provided to the Director for the prior 12 months[67]; CS inspection quarterly trend reports for the prior four quarters; [68]; 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

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

[63] 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.

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

[65] 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.

[66] The review period was October 1, 2017, through March 31, 2018.

[67] The review period was April 1, 2017, through March 31, 2018.

[68] The four quarters were from April 1, 2017, through March 31, 2018.

  - 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[69]
  - Accountability for all prescription pads in pharmacy

[69] 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

The OIG found general compliance with requirements for most of the performance indicators evaluated, including CSC reports, annual physical security surveys, ordering procedures, and the CSC and CSIs having no conflicts of interest and completing required training. However, the OIG identified a lack of restriction of staff involved in monthly reviews of inventory balance adjustments that warranted a recommendation for improvement.

Restriction of Staff Involved in Monthly Review of Inventory Balance Adjustments

VHA requires the pharmacy staff assigned to monitor CS inventory balance adjustments not be the same staff that may perform and document the balance adjustments.[70] This minimizes the opportunity for CS diversions. The OIG found three pharmacy staff that monitored balance adjustments also had electronic access to perform CS balance adjustments, which increases the risk of CS diversion. The Chief of Pharmacy was unaware that the Facility was noncompliant with the requirement.

Recommendation 10

10. The Facility Director ensures that electronic access for performing or monitoring controlled substance balance adjustments is limited to appropriate staff and monitors compliance.

Facility concurred.

Target date for completion: December 31, 2018

Facility response: Pharmacy has ensured staff assigned to monitor the balance adjustments will be different than those with the ability to perform balance adjustments. Pharmacy has reviewed the keys/options held by staff members and grant balance adjustment access only to staff that cannot process/verify orders. To monitor compliance, Pharmacy ADPAC will run Pharmacy keys held for processing orders and keys for verifying orders. Service Chief will review to ensure separation of duties between monitors and adjustors.

[70] VHA Directive 1108.02(1).

N = Total # Pharmacists documenting balance adjustments

D = Total # of Pharmacists holding vista keys for entering balance adjustments

Will monitor until 100 percent compliance is maintained for 4 consecutive months.

Mental Health Care: Posttraumatic Stress Disorder Care

Posttraumatic 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."[71] 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.[72]

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.[73] 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.[74]

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 EHRs of 36 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

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

[72] VHA Handbook 1160.03.

[73] 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.

[74] 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.[75] 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.[76] 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.[77]

In 1999, the Veterans Millennium Benefits and Healthcare Act mandated that the veterans' standard benefits package include access to GE.[78] 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.[79] 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.[80]

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 49 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

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

[76] VHA Directive 1140.04.

[77] 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.

[78] Public Law 106-117.

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

[80] 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 provision of clinical care and geriatric management. However, the OIG identified a deficiency in program oversight and evaluation.

Program Oversight and Evaluation

VHA requires that GE performance improvement activities must be coordinated with quality management and reviewed by the leadership board responsible for oversight of all performance improvement activities at the Facility.[81] This ensures the leadership team reviews GE data and provides the opportunity to identify practice improvements, ensures appropriate actions were taken, and measures the effectiveness of actions on a regular basis.

The OIG did not find evidence of GE program oversight and evaluation by a Facility leadership board. Absence of reporting performance improvement activities to the leadership board may cause delay in addressing GE issues and implementing appropriate action plans. The Associate Chief Nurse for Extended Care reported that changes in leadership resulted in cessation of performance improvement activity reports to the leadership board.

Recommendation 11

11. The Chief of Staff ensures that geriatric evaluation performance improvement activities are reviewed by a Facility leadership board and monitors compliance.

Facility concurred.

Target date for completion: February 28, 2019

Facility response: LTC and HBPC are reporting on a quarterly basis, beginning May 17, 2018, to the Executive Quality Council. Reports include results from: Quarterly Satisfaction Survey, External Peer Review Process (EPRP) measure results, and Fall Data.

[81] VHA Directive 1140.04.

Compliance will be measured for 3 consecutive quarters beginning May 17, 2018 to reached 90percent compliance; reports presented at Executive Quality Council will include Performance Improvement information.

N = # quarterly reports given at EQC with Performance Improvement information

D = Total # of quarterly reports given at EQC

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.[82] Timely screening, diagnosis, notification, and treatment are essential to early detection and optimal patient outcomes.

The Veteran's Health Care Amendments of 1983 mandated VA provide veterans with preventive care, including breast cancer screening.[83] The Veterans Health Care Act of 1992 also authorized VA to provide gender-specific services including mammography services to eligible women veterans.[84]

VHA has established timeframes for clinicians to notify ordering providers and patients of mammography results. "Incomplete" and "probably benign" results must be communicated to the ordering provider within 30 days of the procedure and to the patient within 14 calendar days from the date the results are available to the ordering provider. "Suspicious" and "highly suggestive of malignancy" results must be communicated to the ordering provider within three business days of the procedure, and the recommended course of action should be communicated to the patient as soon as possible, with seven calendar days representing the outer acceptable limit. Communication with patients must be documented.[85]

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

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

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

[83] VHA Handbook 1105.03, *Mammography Program Procedures and Standards*, April 28, 2011 (Handbook rescinded and replaced with VHA Directive 1105.03, *Mammography Program Procedures and Standards*, May 21, 2018.

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

[85] VHA Directive 1330.01(2), *Health Care Services for Women Veterans*, February 15, 2017 (amended September 8, 2017), and further amended July 24, 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.[86] 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,"[87] 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.[88]

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."[89]

Infections occurring on or after the third calendar day following admission to an inpatient location are considered "healthcare-associated."[90] 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.[91]

The OIG's review of these issues examined whether the Facility established and maintained programs to reduce the incidence of healthcare-associated bloodstream infections in intensive care unit patients with indwelling central lines. In addition to conducting manager and staff interviews, the OIG team reviewed committee minutes, the Infection Prevention/Control Risk Assessment, and other relevant documents. The team also reviewed the training records of 16 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

[86] TJC. Infection Prevention and Control: IC.01.03.01.

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

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

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

[90] 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.

[91] 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	Eleven OIG recommendations, ranging from documentation issues to deficiencies that can lead to patient and staff safety issues or adverse events, are attributable to the Director, Chief of Staff, 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	• The Patient Safety Manager or designee completes root cause analysis actions and provides feedback of results to the reporting individuals or departments.	• Required members consistently participate in the interdisciplinary group that reviews UM data. • The Patient Safety Manager submits an annual patient safety report to Facility leaders.
Credentialing and Privileging	• Medical licenses • Privileges • FPPEs • OPPEs	• Service Chiefs complete and report Focused and Ongoing Professional Practice Evaluations to the Professional Standards Board for the determination of provider 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
	• Locked MH Unit
	  ○ Bi-annual MH EOC rounds
	  ○ Nursing station security
	  ○ Public area and general unit safety
	  ○ Patient room safety
	  ○ Infection prevention
	  ○ Availability of medical equipment and supplies
	• Emergency Management
	  ○ Hazard Vulnerability Analysis (HVA)
	  ○ Emergency Operations Plan (EOP)
	  ○ Emergency power testing and availability
		• Environment of care rounds are conducted in patient care areas at the required frequency.
		• A proactive pest control management program is in place throughout the Facility.
		• Facility managers maintain a safe and clean environment.
		• Mental health seclusion room flooring provides cushioning.
			• Medical equipment requiring inspection is identified as safe for patient use.

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	• Electronic access for performing or monitoring controlled substance balance adjustments is limited to appropriate staff.
Mental Health Care: Posttraumatic 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 geriatric evaluation • Program oversight and evaluation requirements • Geriatric evaluation requirements • Geriatric management requirements	• None	• Geriatric evaluation performance improvement activities are reviewed by a Facility 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)[92] affiliated[93] Facility reporting to VISN 2.

Table 7. Facility Profile for Northport (632)
(October 1, 2014, through September 30, 2017)

Profile Element	Facility Data FY 2015[94]	Facility Data FY 2016[95]	Facility Data FY 2017[96]
Total Medical Care Budget in Millions	$320.4	$321.0	$327.4
Number of:			
• Unique Patients	31,534	31,897	30,713
• Outpatient Visits	404,288	409,224	403,967
• Unique Employees[97]	1,578	1,537	1,557
Type and Number of Operating Beds:			
• Community Living Center	170	170	170
• Domiciliary	38	38	38
• Intermediate	19	19	19
• Medicine	80	80	80
• Mental Health	42	42	42
• Rehabilitation Medicine	8	8	8
• Surgery	24	24	24
Average Daily Census:			
• Community Living Center	116	110	116
• Domiciliary	33	34	34

[92] VHA medical centers are classified according to a facilities 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.

[93] Associated with a medical residency program.

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

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

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

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

Profile Element	Facility Data FY 2015[94]	Facility Data FY 2016[95]	Facility Data FY 2017[96]
• Intermediate	n/a	0	1
• Medicine	31	22	21
• Mental Health	32	30	29
• Rehabilitation Medicine	1	2	3
• Surgery	5	3	4

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[98]

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 8 provides information relative to each of the clinics.

Table 8. VA Outpatient Clinic Workload/Encounters[99] 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[100] Provided	Diagnostic Services[101] Provided	Ancillary Services[102] Provided
East Meadow, NY	632GA	9,849	3,322	Dermatology Endocrinology Gastroenterology Neurology	n/a	Pharmacy Social Work Weight Management Nutrition
Valley Stream, NY	632HA	1,998	1,366	Endocrinology Gastroenterology Neurology	n/a	Social Work Weight Management Nutrition

[98] Includes all outpatient clinics in the community that were in operation as of August 15, 2018.

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

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

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

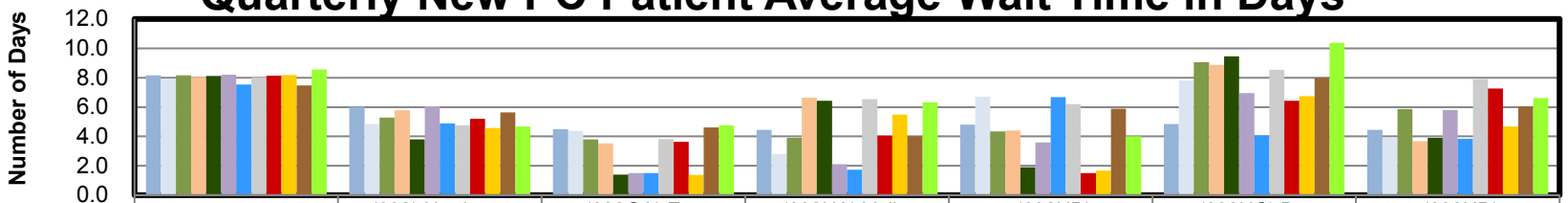
[102] Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services[100] Provided	Diagnostic Services[101] Provided	Ancillary Services[102] Provided
Riverhead, NY	632HB	4,109	1,653	Endocrinology Gastroenterology Neurology Rehab Physician Podiatry	n/a	Weight Management Nutrition
Bay Shore, NY	632HC	2,189	2,051	n/a	n/a	n/a
Patchogue, NY	632HD	6,154	2,572	Dermatology Endocrinology Gastroenterology Neurology	n/a	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.
n/a = not applicable

Appendix C: Patient Aligned Care Team Compass Metrics[103]

Quarterly New PC Patient Average Wait Time in Days



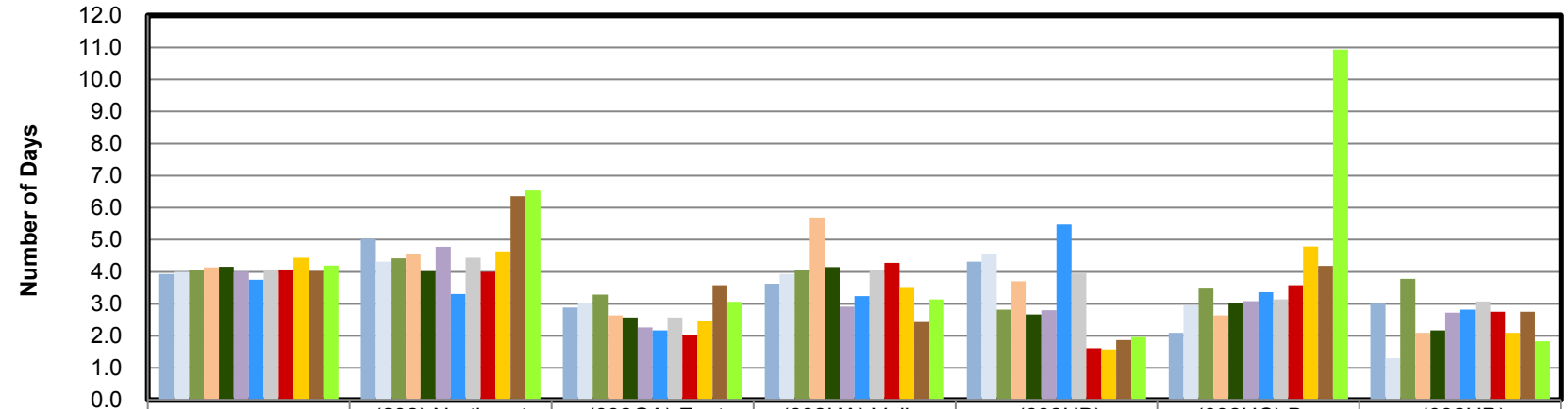
	VHA Total	(632) Northport, NY	(632GA) East Meadow, NY	(632HA) Valley Stream, NY	(632HB) Riverhead, NY	(632HC) Bay Shore, NY	(632HD) Patchogue, NY
APR-FY17	8.2	6.0	4.5	4.5	4.8	4.8	4.4
MAY-FY17	7.9	4.8	4.4	2.8	6.7	7.8	3.9
JUN-FY17	8.2	5.3	3.8	3.9	4.3	9.1	5.9
JUL-FY17	8.0	5.8	3.5	6.6	4.4	8.9	3.7
AUG-FY17	8.1	3.8	1.4	6.4	1.9	9.5	3.9
SEP-FY17	8.2	6.0	1.5	2.1	3.6	6.9	5.8
OCT-FY18	7.5	4.9	1.5	1.7	6.7	4.1	3.9
NOV-FY18	8.0	4.8	3.8	6.5	6.2	8.5	7.9
DEC-FY18	8.1	5.2	3.6	4.1	1.5	6.4	7.3
JAN-FY18	8.2	4.6	1.4	5.5	1.7	6.8	4.7
FEB-FY18	7.5	5.6	4.6	4.0	5.9	8.0	6.0
MAR-FY18	8.6	4.7	4.8	6.3	4.0	10.4	6.6

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.*

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

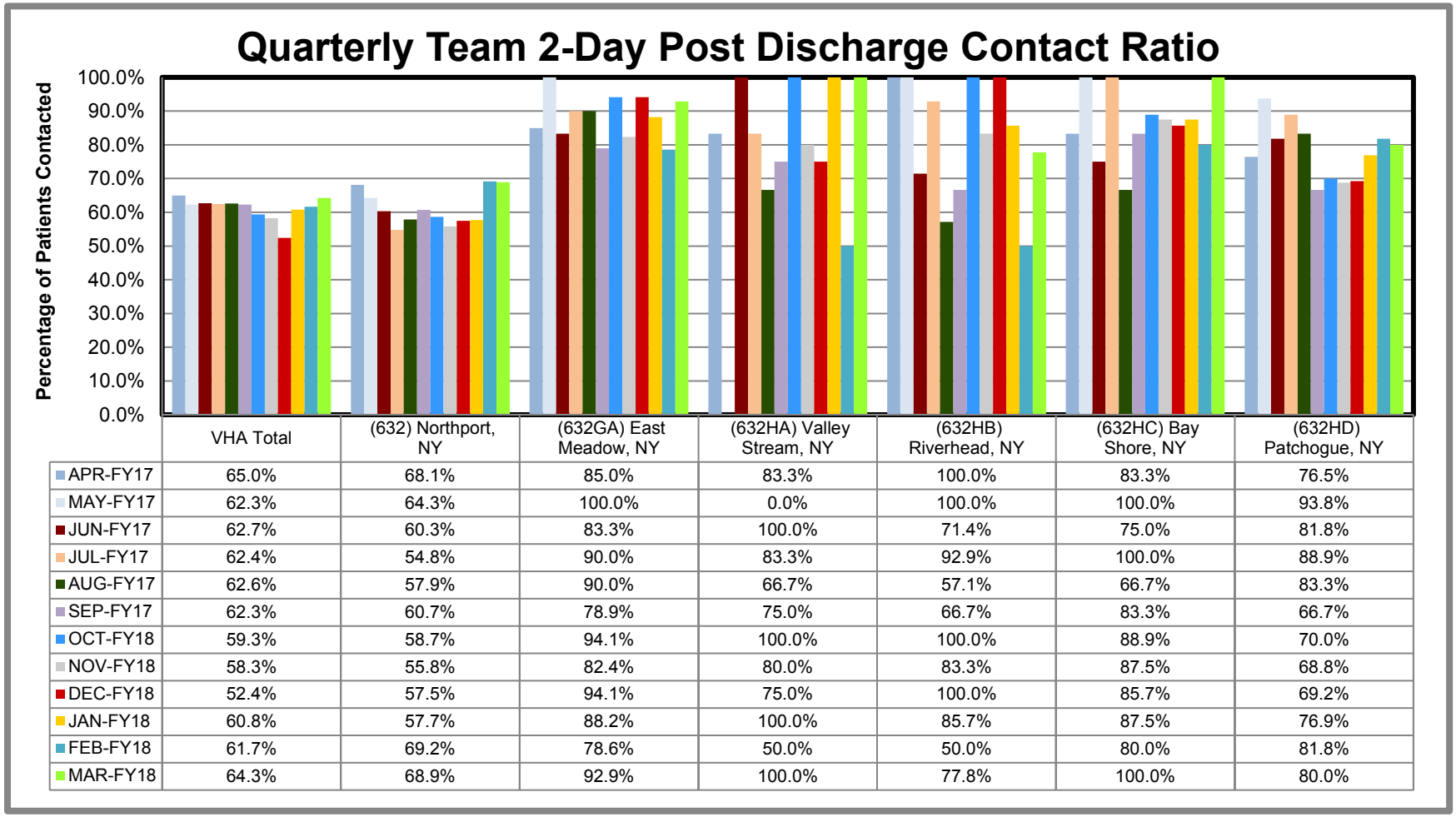


	VHA Total	(632) Northport, NY	(632GA) East Meadow, NY	(632HA) Valley Stream, NY	(632HB) Riverhead, NY	(632HC) Bay Shore, NY	(632HD) Patchogue, NY
APR-FY17	3.9	5.0	2.9	3.6	4.3	2.1	3.0
MAY-FY17	4.0	4.3	3.0	3.9	4.6	3.0	1.3
JUN-FY17	4.1	4.4	3.3	4.1	2.8	3.5	3.8
JUL-FY17	4.1	4.6	2.6	5.7	3.7	2.6	2.1
AUG-FY17	4.2	4.0	2.6	4.2	2.7	3.0	2.2
SEP-FY17	4.0	4.8	2.3	2.9	2.8	3.1	2.7
OCT-FY18	3.7	3.3	2.2	3.2	5.5	3.4	2.8
NOV-FY18	4.1	4.4	2.6	4.1	4.0	3.1	3.1
DEC-FY18	4.1	4.0	2.0	4.3	1.6	3.6	2.8
JAN-FY18	4.4	4.6	2.5	3.5	1.6	4.8	2.1
FEB-FY18	4.0	6.4	3.6	2.4	1.9	4.2	2.8
MAR-FY18	4.2	6.5	3.1	3.1	2.0	10.9	1.8

Source: VHA Support Service Center

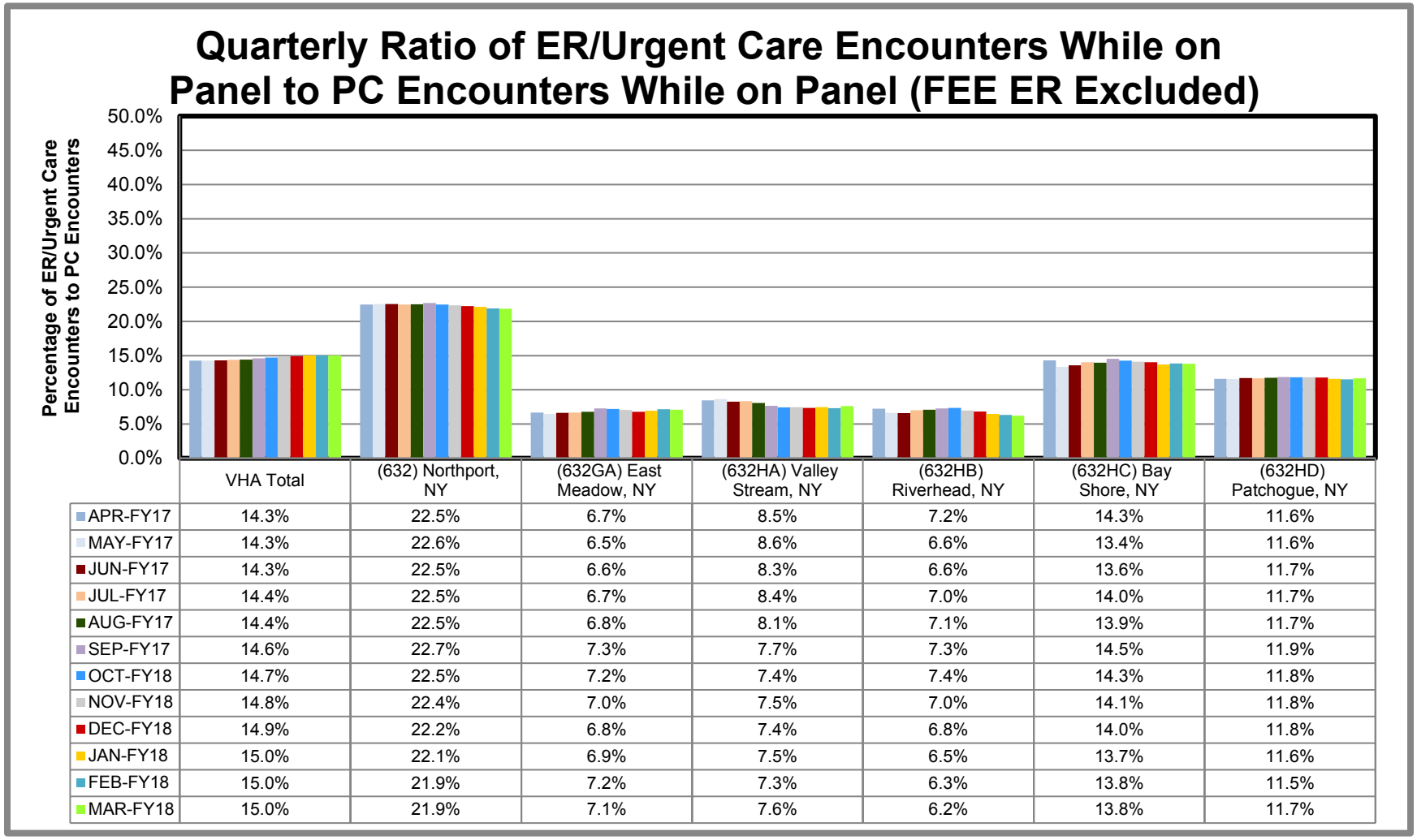
Note: The OIG did not assess VA's data for accuracy or completeness.

Data Definition: *The average number of calendar days between 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	(632) Northport, NY	(632GA) East Meadow, NY	(632HA) Valley Stream, NY	(632HB) Riverhead, NY	(632HC) Bay Shore, NY	(632HD) Patchogue, NY
APR-FY17	65.0%	68.1%	85.0%	83.3%	100.0%	83.3%	76.5%
MAY-FY17	62.3%	64.3%	100.0%	0.0%	100.0%	100.0%	93.8%
JUN-FY17	62.7%	60.3%	83.3%	100.0%	71.4%	75.0%	81.8%
JUL-FY17	62.4%	54.8%	90.0%	83.3%	92.9%	100.0%	88.9%
AUG-FY17	62.6%	57.9%	90.0%	66.7%	57.1%	66.7%	83.3%
SEP-FY17	62.3%	60.7%	78.9%	75.0%	66.7%	83.3%	66.7%
OCT-FY18	59.3%	58.7%	94.1%	100.0%	100.0%	88.9%	70.0%
NOV-FY18	58.3%	55.8%	82.4%	80.0%	83.3%	87.5%	68.8%
DEC-FY18	52.4%	57.5%	94.1%	75.0%	100.0%	85.7%	69.2%
JAN-FY18	60.8%	57.7%	88.2%	100.0%	85.7%	87.5%	76.9%
FEB-FY18	61.7%	69.2%	78.6%	50.0%	50.0%	80.0%	81.8%
MAR-FY18	64.3%	68.9%	92.9%	100.0%	77.8%	100.0%	80.0%

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	(632) Northport, NY	(632GA) East Meadow, NY	(632HA) Valley Stream, NY	(632HB) Riverhead, NY	(632HC) Bay Shore, NY	(632HD) Patchogue, NY
APR-FY17	14.3%	22.5%	6.7%	8.5%	7.2%	14.3%	11.6%
MAY-FY17	14.3%	22.6%	6.5%	8.6%	6.6%	13.4%	11.6%
JUN-FY17	14.3%	22.5%	6.6%	8.3%	6.6%	13.6%	11.7%
JUL-FY17	14.4%	22.5%	6.7%	8.4%	7.0%	14.0%	11.7%
AUG-FY17	14.4%	22.5%	6.8%	8.1%	7.1%	13.9%	11.7%
SEP-FY17	14.6%	22.7%	7.3%	7.7%	7.3%	14.5%	11.9%
OCT-FY18	14.7%	22.5%	7.2%	7.4%	7.4%	14.3%	11.8%
NOV-FY18	14.8%	22.4%	7.0%	7.5%	7.0%	14.1%	11.8%
DEC-FY18	14.9%	22.2%	6.8%	7.4%	6.8%	14.0%	11.8%
JAN-FY18	15.0%	22.1%	6.9%	7.5%	6.5%	13.7%	11.6%
FEB-FY18	15.0%	21.9%	7.2%	7.3%	6.3%	13.8%	11.5%
MAR-FY18	15.0%	21.9%	7.1%	7.6%	6.2%	13.8%	11.7%

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[104]

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

[104] 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: August 3, 2018

From: Director, New York/New Jersey VA Health Care Network (10N2)

Subj: CHIP Review of the Northport VA Medical Center, NY

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

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

I have reviewed and concur with the findings, recommendations and submitted action plans for Recommendations 1-11 for the OIG CHIP Review of the Northport VA Medical Center, Northport, NY.

(Original signed by:)

Joan E. McInerney, MD, MBA, MA, FACEP
Network Director

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

Appendix F: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: July 18, 2018

From: Director, Northport VA Medical Center (632/00)

Subj: CHIP Review of the Northport VA Medical Center, NY

To: Director, New York/New Jersey VA Health Care Network (10N2)

I have reviewed and concur with the Comprehensive Healthcare Inspection Program Review of the Northport VA Medical Center by the Office of Inspector General's findings, recommendations, responses and actions initiated by the Northport VAMC. Thank you for the opportunity to review our processes to ensure that we continue to provide exceptional care for our Veterans. If you have any questions regarding the information provided, please do not hesitate to contact my office.

(Original signed by:)

Cathy Cruise, MD

For accessibility, the original format of this appendix has been modified to comply with Section 508 of the Rehabilitation Act of 1973, as amended.

OIG Contact and Staff Acknowledgments

Contact	For more information about this report, please contact the Office of Inspector General at (202) 461-4720.
Review Team	Elizabeth Whidden, MS, ARNP, Team Leader Myra Brazell, MSW, LCSW Charles Cook, MHA Rhonda Omslaer JD, BSN Michelle Wilt, MBA, BSN Valerie Zaleski, RN, BSN
Other Contributors	Limin Clegg, PhD Justin Hanlon, BS Henry Harvey, MS LaFonda Henry, MSN, RN-BC Scott McGrath, BS Larry Ross, Jr., MS Marilyn Stones, BS April Terenzi, BS, BA Carol Torczon, MSN, ACNP Mary Toy, MSN, RN Robert Wallace, ScD, MPH

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