DEPARTMENT OF VETERANS AFFAIRS

OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare Inspection Program Review of the Charles George VA Medical Center

Asheville, North Carolina

CHIP REPORT | REPORT #18-01140-312 | OCTOBER 16, 2018

The mission of the Office of Inspector General is to serve veterans and the public by conducting effective oversight of the programs and operations of the Department of Veterans Affairs through independent audits, inspections, reviews, and investigations.

In addition to general privacy laws that govern release of medical information, disclosure of certain veteran health or other private information may be prohibited by various federal statutes including, but not limited to, 38 U.S.C. §§ 5701, 5705, and 7332, absent an exemption or other specified circumstances. As mandated by law, the OIG adheres to privacy and confidentiality laws and regulations protecting veteran health or other private information in this report.

Report suspected wrongdoing in VA programs and operations to the VA OIG Hotline:

www.va.gov/oig/hotline

1-800-488-8244

Figure 1. *Charles George VA Medical Center, Asheville, North Carolina (Source: https://vaww.va.gov/directory/guide/, accessed on July 23, 2018)*

Abbreviations

CBOC	community based outpatient clinic
CHIP	Comprehensive Healthcare Inspection Program
CLABSI	central line-associated bloodstream infection
CS	controlled substances
CSC	controlled substances coordinator
CSI	controlled substances inspector
EHR	electronic health record
EOC	environment of care
FPPE	Focused Professional Practice Evaluation
GE	geriatric evaluation
LIP	licensed independent practitioner
MH	mental health
OIG	Office of Inspector General
OPPE	Ongoing Professional Practice Evaluation
PC	primary care
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 Charles George 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 June 4, 2018. The OIG conducted interviews and reviewed clinical and administrative processes related to areas of focus that affect patient care outcomes. Although the OIG reviewed a spectrum of clinical and administrative processes, the sheer complexity of VA medical centers limits the ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of Facility performance within the identified focus areas at the time of the OIG visit. Although it is difficult to quantify the risk of patient harm, the findings in this report may help facilities identify areas of vulnerability or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Results and Review Impact

Leadership and Organizational Risks

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

The Director was appointed in February 2018. The Chief of Staff was permanently assigned in July 2014 and had served as Interim Director since July 2017. The Associate Director and ADPCS were permanently assigned in January 2017 and February 2003, respectively.

In the review of selected employee survey results regarding Facility leaders, the OIG noted that employees appear generally satisfied with Facility leaders but that opportunities appear to exist for the Chief of Staff to provide a workplace environment where employees feel safe to bring forth issues or ethical concerns. The Facility leaders verbalized ongoing efforts to improve the culture of the organization, and in April 2018, the Facility was recognized as a Pathway to Excellence organization. In the review of selected patient experience survey results, the OIG patients appear generally satisfied with the leadership and care provided, and Facility leaders appeared to be actively engaged with patients.

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

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

Additionally, the OIG reviewed accreditation agency findings, sentinel events,[2] disclosures of adverse patient events, and Patient Safety Indicator data and identified the presence of organizational risk factors related to identifying and tracking sentinel events. 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 three of the eight areas of clinical operations reviewed and issued eight recommendations that are attributable to the Director and Chief of Staff. These are briefly described below.

Quality, Safety, and Value

The OIG found general compliance with requirements for completion of required utilization management[3] (UM) reviews, entry of decisions in National UM Integration database, and completion of required root cause analyses. However, the OIG identified deficiencies with UM data review, root cause analysis feedback, and implementation of identified improvement actions.

Credentialing and Privileging

The OIG found general compliance with requirements for credentialing. However, the OIG identified deficiencies in the processes for granting requested privileges and using FPPEs and OPPEs in the determination to grant continued privileges.

Women's Health

The OIG noted general compliance with requirements for many of the performance indicators reviewed, such as scanning hard copy reports if outsourced, including required components in reports, and performing follow-up mammograms and studies if indicated. However, the OIG identified deficiencies with electronic linking of mammogram results and communication of results to ordering providers and patients.

Summary

In the review of key care processes, the OIG issued eight recommendations that are attributable to the Director and Chief of Staff. 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

[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.

these recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues as well as other less-critical findings that, if left unattended, may eventually interfere with the delivery of quality health care.

Comments

The Veterans Integrated Service Network Director and Facility Director agreed with the Comprehensive Healthcare Inspection Program review findings and recommendations and provided acceptable improvement plans. (See Appendixes E and F, pages 59–60, for the full text of the Directors' comments.) We consider recommendations 1, 6, 7, and 8 closed. We will follow up on the planned actions for the open recommendations until they are completed.

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

Contents

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 Charles George VA Medical Center (Facility) through a broad overview of key clinical and administrative processes that are associated with quality care and positive patient outcomes. The purpose of the review was to provide oversight of healthcare services to veterans and to share findings with Facility leaders so that informed decisions can be made to improve care.

Scope

Good leadership makes a difference in managing organizational risks by establishing goals, strategies, and priorities to improve care; setting the quality agenda; and promoting a quality improvement culture to sustain positive change.[4,5] Investment in a culture of safety and quality improvement with robust communication and leadership is more likely to result in positive patient outcomes in healthcare organizations.[6] Figure 2 shows the direct relationship leadership and organizational risks have with the processes used to deliver health care to veterans.

To examine risks to patients and the organization when these processes are not performed well, the OIG focused on the following nine areas of clinical care and administrative operations that support quality care—Leadership and Organizational Risks; Quality, Safety, and Value (QSV); Credentialing and Privileging; Environment of Care (EOC); Medication Management: Controlled Substances (CS) Inspection Program; Mental Health: 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]

---

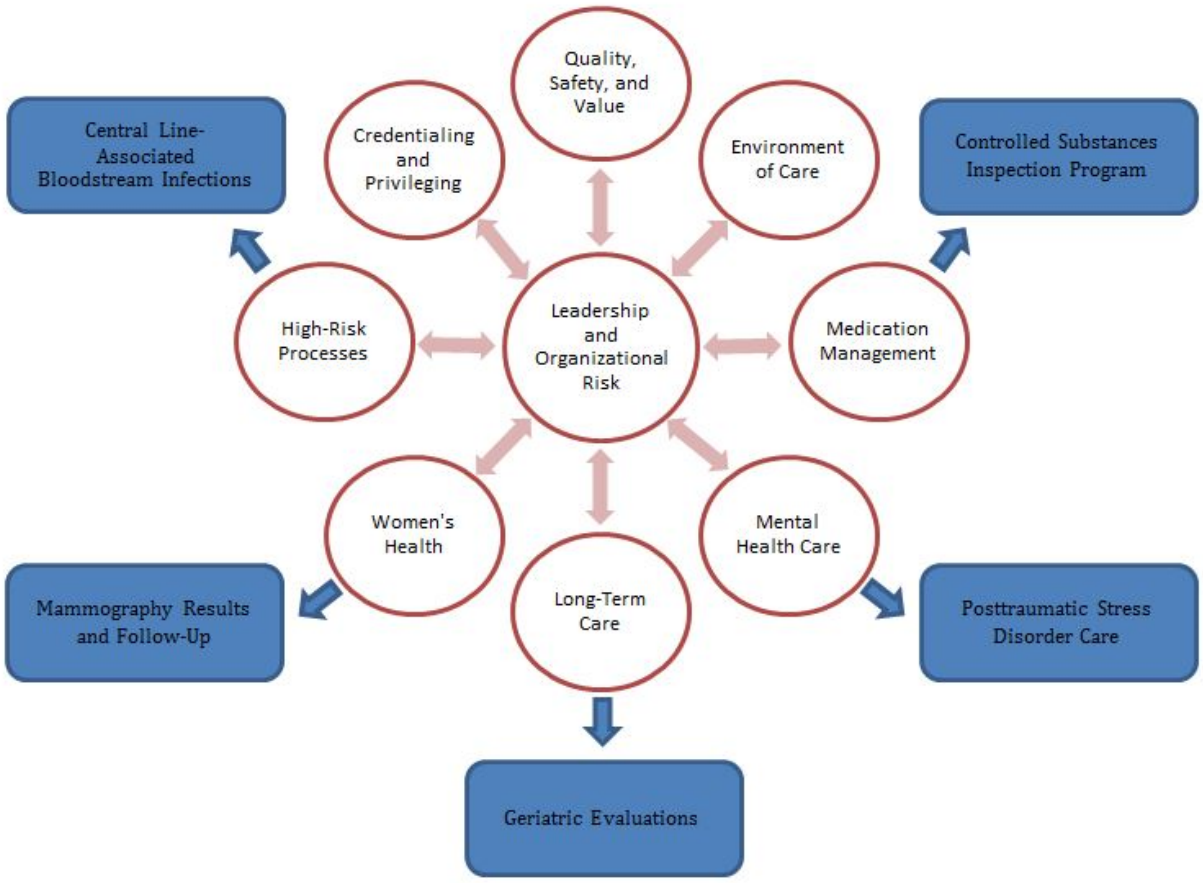
[4] Carol Stephenson, "The role of leadership in managing risk," *Ivey Business Journal*, November/December 2010. https://iveybusinessjournal.com/publication/the-role-of-leadership-in-managing-risk/. (Website accessed on March 1, 2018.)

[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 September 14, 2015,[9] through June 4, 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 referred issues and concerns beyond the scope of the CHIP review to our Hotline management team for further evaluation. 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 assess the Facility's risks, the OIG considered the following organizational elements:

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

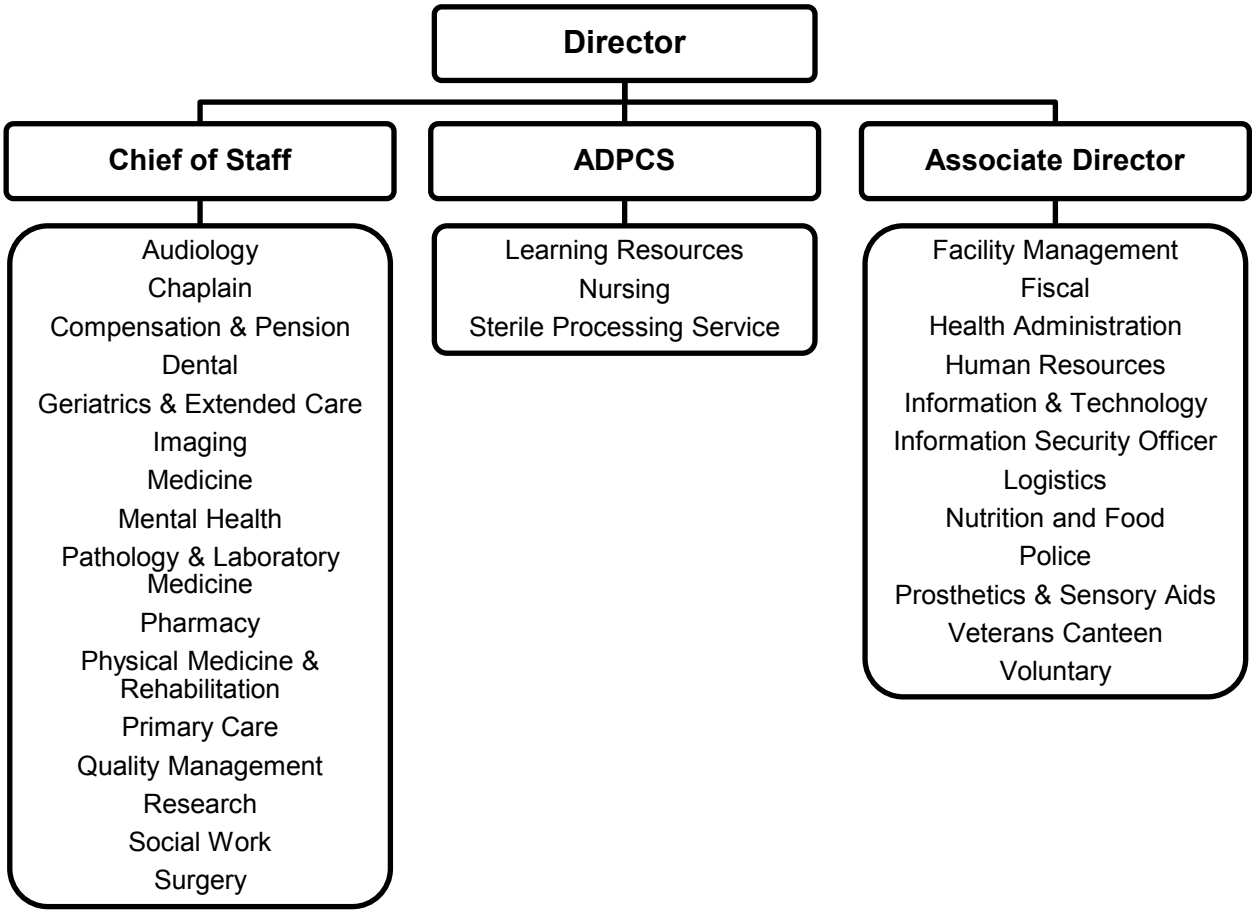
Executive Leadership Stability and Engagement

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

It is important to note that the Director was appointed in February 2018. The Chief of Staff was assigned in July 2014 and had served as Interim Director since July 2017. The Associate Director and ADPCS were permanently assigned in January 2017 and February 2003, respectively. The Chief of Staff and ADPCS have provided stable leadership since 2014. The Facility leaders had worked together for approximately four months prior to OIG's site visit.

[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: Charles George VA Medical Center (received June 4, 2018)

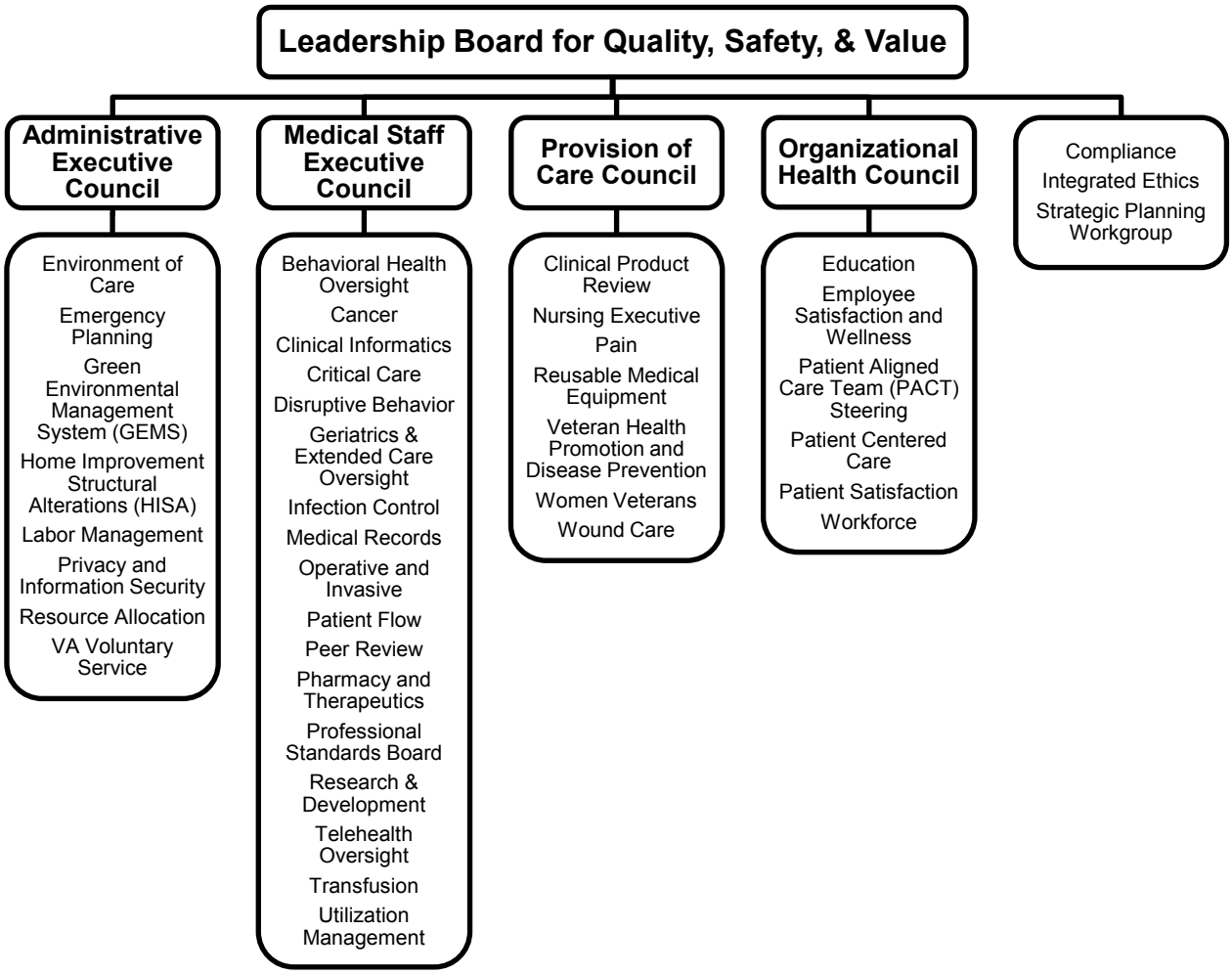
To help assess engagement of Facility executive leadership, the OIG interviewed the Director, Chief of Staff, ADPCS, and Associate Director regarding their knowledge of various performance metrics and their involvement and support of actions to improve or sustain performance.

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

The leaders are also engaged in monitoring patient safety and care through formal mechanisms. They are members of the Leadership Board for Quality, Safety, and Value (QSV), which tracks, trends, and monitors quality of care and patient outcomes. The Director serves as the chairperson with the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. The Leadership Board for QSV also

oversees various working groups that report to the Administrative Executive, Medical Staff Executive, and the Organizational Health Councils. See Figure 4.

Figure 4. Facility Committee Reporting Structure



Source: Charles George VA Medical Center (received June 5, 2018)

Employee Satisfaction and Patient Experience

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

To assess employee and patient attitudes toward Facility leaders, the OIG reviewed employee satisfaction and patient experience survey results that relate to the period of October 1, 2016,

through September 30, 2017. Tables 1–3 provide relevant survey results for VHA, the Facility, and selected Facility executive leaders.[11]

Table 1 summarizes employee attitudes toward selected Facility leaders as expressed in VHA's All Employee Survey.[12] The Facility average for both selected survey questions was above the VHA average.[13] The Director and ADPCS averages exceeded both the Facility and VHA averages; however, the Chief of Staff and Associate Director had one result lower than either the Facility and/or VHA averages. In all, employees appear generally satisfied with Facility leaders.

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

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director 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	71.9	77.4	68.0	87.9	80.2
All Employee Survey Q59. *How satisfied are you with the job being done by the executive leadership where you work?*	1 (Very Dissatisfied)–5 (Very Satisfied)	3.3	3.5	4.3	3.6	4.6	3.1

Source: VA All Employee Survey (accessed May 4, 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 similar to or higher than the VHA average, while those for the Chief of Staff were less than both averages. Opportunities appear to exist for the Chief of Staff to provide a workplace environment where employees feel safe to bring forth issues or ethical concerns. The Facility leaders verbalized ongoing efforts to improve the culture of the organization. In April 2018, the Facility was

[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.

recognized as a Pathway to Excellence organization by the American Nurses Credentialing Center for demonstrating a commitment to creating a positive work environment that empowers and engages staff and leads to staff retention through high job satisfaction.

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	4.1	3.6	4.6	4.2
All Employee Survey Q44. *I feel comfortable talking to my supervisor about work-related problems even if I'm partially responsible.*	1 (Strongly Disagree)–5 (Strongly Agree)	3.9	4.1	4.3	3.6	4.6	4.2
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	4.1	4.4	3.8	4.6	3.9

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

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

VHA collects SHEP survey data from Patient-Centered Medical Home, Specialty Care, and Inpatient Surveys. From these, the OIG selected four survey items that reflect patient attitudes towards facility leaders (see Table 3). For this Facility, all four patient survey results reflected

higher care ratings than the VHA average. Patients appear generally satisfied with the leadership and care provided, and Facility leaders appeared to be actively engaged with patients.

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	81.1
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	89.5
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): *I felt like a valued customer.*	The response average is the percent of "Agree" and "Strongly Agree" responses.	74.9	82.3
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	81.4

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

[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.

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 demonstrates the Facility leaders' commitment to quality care and services. Additionally, the Long Term Care Institute conducted inspections 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 Charles George VA Medical Center, Asheville, North Carolina, November 10, 2015*)	September 2015	14	0
OIG (*Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Charles George VA Medical Center, Asheville, North Carolina, December 7, 2015*)	September 2015	7	0
OIG (*Healthcare Inspection – Alleged Inappropriate Opioid Prescribing Practices, Rutherford County Community Based Outpatient Clinic, Rutherfordton, North Carolina, September 29, 2016*)	February 2015	6	0
OIG (*Administrative Summary – Non-VA Care Consult Program Concerns, Charles*	2016	0	n/a

[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 VA medical facilities for over 35 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.

[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.

Accreditation or Inspecting Agency	Date of Visit	Number of Findings	Number of Recommendations Remaining Open
George VA Medical Center, Asheville, North Carolina, August 3, 2017)			
TJC • Regular	February 2017		
○ Hospital Accreditation		24	0
○ Behavioral Health Care Accreditation		2	0
○ Home Care Accreditation		3	0

Sources: OIG and TJC (Inspection/survey results verified with the Quality Consultant on June 5, 2018)

Indicators for Possible Lapses in Care

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

The OIG requested a list of the Facility's sentinel events, and Facility managers responded with the fact that sentinel events are not tracked. After discussion with Facility managers, the managers conducted a review of patient incidents from September 2015 through June 4, 2018, and identified seven patient incidents that met criteria for a sentinel event. Facility leaders may miss opportunities to implement plans to minimize patient risk if managers do not establish consistent and reliable data and reporting mechanisms.

Table 5 summarizes key indicators of risk since the OIG's previous September 2015 Combined Assessment Program and Community Based Outpatient Clinic (CBOC) and Other Outpatient Clinics review inspections through the week of June 4, 2018.[20]

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

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

Factor	Number of Occurrences
Sentinel Events[21]	7
Institutional Disclosures[22]	18
Large-Scale Disclosures[23]	0

Source Charles George VA Medical Center's Patient Safety Manager (received June 6, 2018)

The OIG also reviewed Patient Safety Indicators developed by the Agency for Healthcare Research and Quality within the U.S. Department of Health and Human Services. These provide information on potential in-hospital complications and adverse events following surgeries and procedures.[24] 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 December 31, 2017.

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

[22] 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.

[23] 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.

[24] 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 December 31, 2017)**

Measure	Reported Rate per 1,000 Hospital Discharges		
	VHA	VISN 6	Facility
Pressure ulcers	0.88	1.06	0.58
Death among surgical inpatients with serious treatable conditions	118.96	84.91	74.07
Iatrogenic pneumothorax	0.19	0.21	0.14
Central venous catheter-related bloodstream infection	0.14	0.24	0.00
In-hospital fall with hip fracture	0.09	0.13	0.29
Perioperative hemorrhage or hematoma	2.58	2.88	4.22
Postoperative acute kidney injury requiring dialysis	0.80	1.08	0.75
Postoperative respiratory failure	5.34	4.36	1.04
Perioperative pulmonary embolism or deep vein thrombosis	3.26	3.54	5.06
Postoperative sepsis	3.96	4.50	4.74
Postoperative wound dehiscence	1.04	2.67	2.04
Unrecognized abdominopelvic accidental puncture/laceration	1.21	1.98	1.91

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

Four Patient Safety Indicator (PSI) measures (in-hospital fall with hip fracture, perioperative hemorrhage or hematoma, perioperative pulmonary embolism or deep vein thrombosis (DVT), and postoperative sepsis) show a higher observed rate than Veterans Integrated Service Network (VISN) 6 and VHA. Two PSI measures (postoperative wound dehiscence and unrecognized abdominopelvic accidental puncture/laceration) show a higher observed rate than VHA.

One patient accounted for two cases included in the in-hospital fall with hip fracture. The patient had elective surgery for chronic hip pain and later developed an infection in the surgical hip, resulting an additional surgical procedure. During the OIG's review, Facility managers noted the events were miscoded, resulting in inclusion for this measure.

Eight patients met inclusion criteria for perioperative hemorrhage or hematoma measure—six patients had cardiac surgery, one patient had a hip replacement, and one patient had lung surgery. The cases were individually reviewed by the surgical quality nurse. The Facility identified a potential trend related to high-risk patients having surgical procedures. As a result, the Facility implemented a multidisciplinary high-risk surgical committee whose role is to provide recommendations to the surgical team regarding the planned surgery or alternative non-surgical options and/or transfer to a higher level of care.

Ten patients were included in the perioperative pulmonary embolism or DVT measure. Seven patients had total joint replacement surgery, and three patients had general surgical procedures. The cases were reviewed individually by the quality surgical nurse, and no trends were identified; however, the Facility's surgical nursing staff received additional education related to post-operative joint care.

Six patients met criteria for inclusion in the postoperative sepsis measure. Three patients had a general surgical procedure, two patients had cardiac surgery, and one patient had a hip surgery that was not completed. Facility managers reported that cases were individually reviewed by a surgical quality nurse and that an early recognition and intervention sepsis protocol had been developed and implemented in January 2016 to reduce the incidence of postoperative sepsis.

One patient had a postoperative wound dehiscence resulting in another surgical procedure. The case was reviewed by the Facility urologist, and no quality of care issues or trends were identified.

Five patients met inclusion criteria for an unrecognized abdominopelvic accidental puncture/laceration. In three of the five cases, the injury was identified during surgery and repaired. In one case, an alternative procedure was done, and in the other case, the injury was not recognized until after surgery and appropriate treatment was provided. The cases were individually reviewed by Facility surgeons, and no issues or trends were noted.

Veterans Health Administration Performance Data

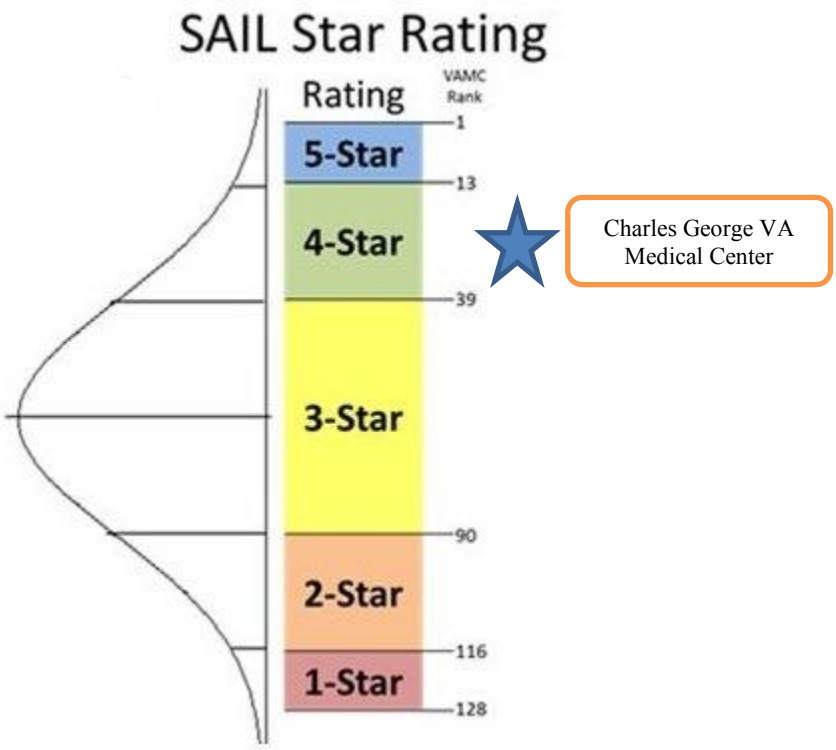
The VA Office of Operational Analytics and Reporting adapted the SAIL Value Model to help define performance expectations within VA. This model includes measures on healthcare quality, employee satisfaction, access to care, and efficiency, but has noted limitations for identifying all areas of clinical risk. The data are presented as one "way to understand the similarities and differences between the top and bottom performers" within VHA.[25]

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.[26] As of June 30, 2017, the Facility was rated "4-Star" for overall quality. Updated data as of June 30, 2018, indicates that the Facility has improved to "5-Star" for overall quality.

[25] 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.)

[26] 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)

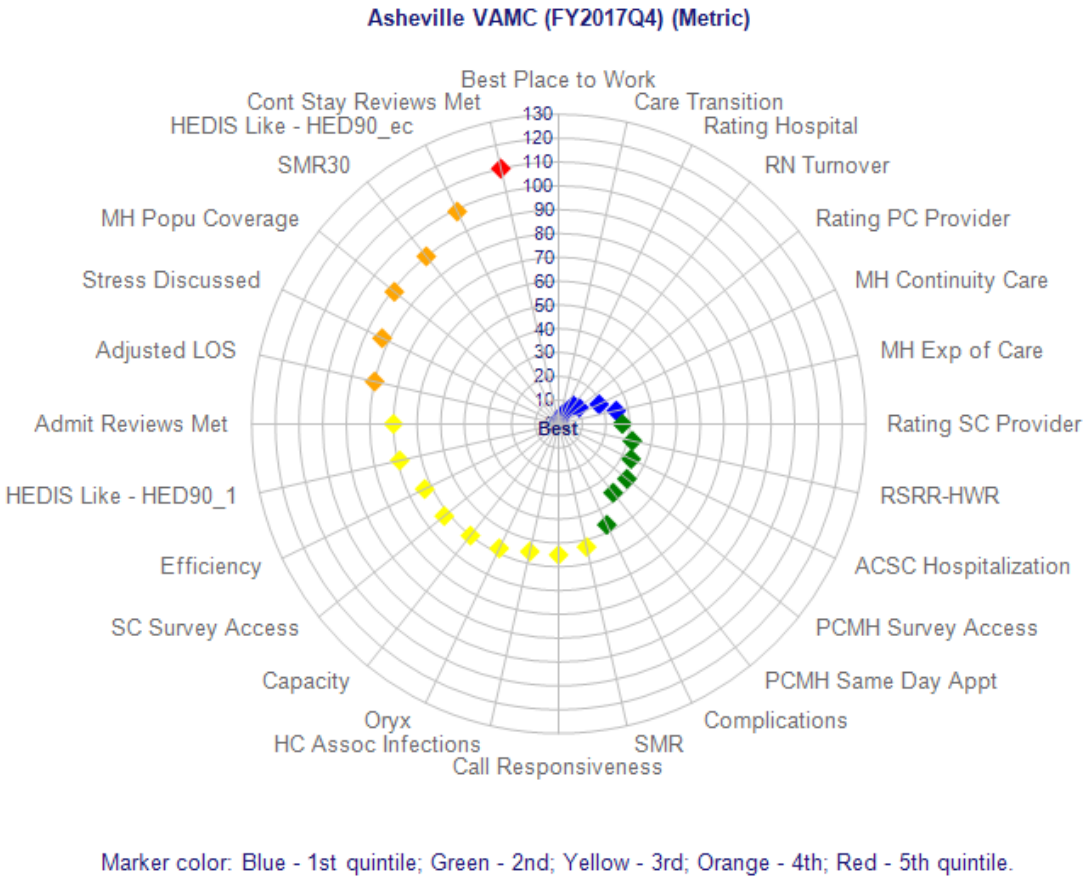


Source: VA Office of Informatics and Analytics Office of Operational Analytics and Reporting (accessed May 4, 2018)

Figure 6 illustrates the Facility's Quality of Care and Efficiency metric rankings and performance compared with other VA facilities as of June 30, 2017. Of note, Figure 6 uses blue and green data points to indicate high performance (for example, in the areas of Best Place to Work, Registered Nurse (RN) Turnover, Rating (of) Primary Care (PC) Provider, and Ambulatory Care Sensitive Conditions (ACSC) Hospitalization).[27] Metrics that need improvement are denoted in orange and red (for example, Adjusted Length of Stay (LOS), Mental Health (MH) Population (Popu) Coverage, and Continued (Cont) Stay Reviews Met).

[27] 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

One of four Facility leadership positions had been filled by interim staff prior to the OIG's on-site visit. The Director was appointed in February 2018. The Chief of Staff was assigned in July 2014 and had served as Interim Director since July 2017. The Associate Director and ADPCS were permanently assigned in January 2017 and February 2003, respectively. The Facility leaders had worked together for approximately four months prior to the OIG's site visit. Organizational leaders appeared to support efforts related to patient safety, quality care, and other positive outcomes (such as initiating processes and plans to maintain positive perceptions of the Facility through active stakeholder engagement) as seen with the achievement of the Pathway to Excellence designation. However, organizational risk factors, such as lack of

identifying, tracking, and reporting of sentinel events and higher rates of Patient Safety Indicator data may contribute to future issues of noncompliance and/or lapses in patient safety. Although the leadership team was knowledgeable about selected SAIL metrics, the leaders should continue to take actions to improve care and maintain performance of Quality of Care and Efficiency metrics that are likely contributing to the current "5-Star" rating.

Quality, Safety, and Value

VHA's goal is to serve as the nation's leader in delivering high-quality, safe, reliable, and veteran-centered care using a coordinated care continuum. To meet this goal, VHA must foster a culture of integrity and accountability that is vigilant and mindful, proactively risk aware, and predictable, while seeking continuous improvement.[28] VHA also strives to provide healthcare services that compare favorably to the best of the private sector in measured outcomes, value, and efficiency.[29]

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

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.[33]

---

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

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

[30] According to VHA Directive 2010-025, *Peer Review for Quality Management*, 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.)

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

[32] 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 RCA (a widely-used methodology for dealing with safety-related issues) to allow for more accurate and rapid communication throughout an organization of potential and actual causes of harm to patients.

[33] 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:[34]

- 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[35]
  - Annual completion of a minimum of eight RCAs[36]
  - Provision of feedback about RCA actions to reporting employees
  - Submission of annual patient safety report

Conclusion

The OIG found general compliance with requirements for completion of required UM reviews, entry of UM decisions in National UM Integration database, and completion of required RCAs. However, the OIG identified deficiencies with UM data review, RCA feedback, and

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

[35] 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.

[36] According to VHA Handbook 1050.01, 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.

implementation of identified improvement actions that warranted recommendations for improvement.

Utilization Management: Data Review

VHA requires that an interdisciplinary facility group review UM data. This group should include, but not be limited to, representatives from UM, medicine, nursing, social work, case management, MH, and Chief Business Office Revenue Utilization Review.[37] This ensures that an interdisciplinary approach is taken when reviewing UM data for performance improvement. Facility managers provided the OIG with UM Committee minutes from June 2017, August through November 2017, and January through May 2018. The interdisciplinary group that reviewed UM data did not include representation from Chief Business Office Revenue Utilization Review. This resulted in a lack of expertise in the analysis of UM data. Facility managers were unaware of the interdisciplinary requirements.

Recommendation 1

1. The Chief of Staff ensures the interdisciplinary group or committee that reviews utilization management data includes representatives from the Chief Business Office Revenue–Utilization Review and monitors compliance.

Facility concurred.

Target date for completion: September 12, 2018

Facility response: On June 13, 2018, primary and back-up Utilization Review nurses were appointed to the Utilization Management (UM) Committee by memorandum signed by the Director, Mid-Atlantic Consolidated Patient Accounts Center (MACPAC). On June 20, 2018, a UM Committee meeting was held with all required members present including the Chief Business Office Revenue – Utilization Review staff. The UM Committee charter was reviewed at the July 11, 2018 meeting to ensure all required members were listed and was approved by the Medical Staff Executive Council (MSEC) at the July 17, 2018 meeting. All required attendees were present at the UM Committee for 4/4 months (100%) at June, July, August, and September meetings in 2018.

Patient Safety: Root Cause Analyses

VHA requires that the Patient Safety Manager or designee to provide feedback about root cause analysis actions to the individuals or departments who reported the incidents.[38] This establishes

[37] VHA Directive 1117(1).
[38] VHA Handbook 1050.01.

trust in the system and ensures staff are aware that their report was taken seriously. For the four applicable RCAs reviewed, the OIG did not find evidence that the individual or department reporting the incident received feedback about actions taken. The Patient Safety Manager stated that turnover in a key patient safety position contributed to lack of compliance.

Recommendation 2

2. The Facility Director ensures that the Patient Safety Manager or designee provides feedback to employees or departments who submit patient safety incidents that result in root cause analysis and monitors compliance.

Facility concurred.

Target date for completion: December 31, 2018

Facility response: The Patient Safety Manager (PSM) will report Root Cause Analysis (RCA) feedback to the monthly Nurse Managers' meeting and Medical Staff Executive Council (MSEC) when indicated, if the RCA outcome feedback includes Medical Staff. It is the responsibility of the service chief/manager of the department where the RCA originated to relay the actions from the RCA to the front-line staff. The PSM will monitor Nurse Managers' meeting and MSEC minutes until at least 90 percent compliance is maintained for three consecutive months.

Implementation of Improvement Actions

VHA requires that improvement activities resulting from QSV reviews are completed, evaluated, and monitored for effectiveness.[39] This ensures that improvement activities are fully implemented, achieve the desired outcomes, and are efficient. Further, VHA requires that when the Peer Review Committee recommends individual improvement actions, clinical managers implement the actions. Peer review can result in both immediate and long-term improvements in patient care by revealing areas for improvement in the practice of one or multiple providers.[40] Additionally, VHA requires that corrective actions identified through RCA processes are implemented to prevent occurrences of similar events.[41] These actions can eliminate, or control, identified system vulnerabilities.

For 5 of 10 peer reviews conducted, the OIG did not find evidence that clinical managers implemented individual improvement actions. This resulted in missed opportunities to improve

[39] VHA Directive 1026.
[40] VHA Directive 2010-025.
[41] VHA Handbook 1050.01.

patient care. Facility managers stated that noncompliance was due to lack of a system for the tracking of completion of supervisors' actions.

For four of five RCAs reviewed, the OIG did not find evidence of action item implementation. This resulted in the potential for future occurrences of similar events. Facility managers reported that lack of a tracking system for RCAs and understaffing contributed to the noncompliance.

Recommendation 3

3. The Director ensures that managers consistently implement improvement actions arising from peer review and root cause analysis activities and monitors compliance.

Facility concurred.

Target date for completion: December 31, 2018

Facility response: By May 1, 2018, the Risk Manager (RM) reviewed, developed and implemented revised Peer Review Committee (PRC) minutes format to better reflect the status of peer reviews and improvement actions. A corresponding follow up action log was developed and implemented to track all follow-up actions and committee recommendations through to completion. Peer reviews, corresponding documentation, improvement actions, and signed committee minutes are maintained in a binder by assigned case numbers.

Implementation of improvement actions will be monitored until at least 90 percent compliance is maintained for three consecutive months.

At the closure of an RCA, the PSM ensures that all activities implemented from an RCA are monitored for compliance by placing all actions into the WEBSPOT database. Beginning October 1, 2017, the PSM documented all actions in the WEBSPOT database, which reflects 11 months of compliance at 100%.

Additionally, beginning October 1, 2017, all RCA actions were reviewed weekly by the PSM and reminders sent to each manager for follow up, with an expected turn-around time of one week. Beginning with July 2018, the Leadership Board was provided a listing of all activities from RCAs. Monthly minutes were monitored for July, August, and September 2018, reflecting three months of compliance at 100%.

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).[42]

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.[43]

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.[44]

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

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

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

[43] VHA Handbook 1100.19.

[44] VHA Handbook 1100.19.

[45] The 18-month period was from December 5, 2016, through June 4, 2018.

[46] The 12-month review period was from June 5, 2017, through June 4, 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. However, the OIG identified deficiencies in the processes for granting requested privileges and using documented evidence from FPPEs and OPPEs to determine continued privileges.

Recommendation to Grant Requested Privileges

VHA requires the Medical Staff Executive Council to review and evaluate LIPs' initial and re-privileging requests. Committee minutes must reflect the documents reviewed and the rationale for the stated conclusion. The committee's recommendation is then submitted to the Facility Director for approval. This process is essential to confirm the quality of care delivered and allows the Facility to identify professional practice trends that impact the quality of care and

patient safety.[47] For 4 of 30 LIP profiles, the OIG did not find evidence of the Medical Staff Executive Council's decision to recommend approval of LIP privileges. Facility managers acknowledged lack of oversight as the reason for noncompliance.

Recommendation 4

4. The Chief of Staff ensures that the Medical Staff Executive Council minutes consistently reflect the documents reviewed and the rationale to recommend approval of clinical privileges for license independent practitioners and monitors compliance.

Facility concurred.

Target date for completion: December 31, 2018

Facility response: The Chief of Staff and MSEC will assure that all practitioners presented for renewal of privileges have the results of the OPPE presented as part of the recommendation for renewal of privileges. The MSEC minutes will reflect the credentials and FPPE plans submitted for new appointments of licensed independent practitioners. The minutes format will be reviewed and revised to include specifics of the OPPE results. Compliance will be monitored by the Chief of Staff and the Director as indicated by their signatures on the MSEC minutes. A supplemental tracking log will be developed and implemented to ensure compliance of OPPE reporting. This action will be monitored until at least 90 percent compliance is maintained for three consecutive months.

Focused Professional Practice Evaluations

VHA requires that all LIPs new to the facility have FPPEs completed and documented in the practitioner's profile and reported to an appropriate committee of the medical staff. This process involves the evaluation of privilege-specific competence of the practitioner who has not had previously documented evidence of competently performing the requested privileges. Results of the FPPE must be documented in the practitioner's provider profile and reported to the Medical Staff Executive Council for consideration in making the recommendation on privileges. FPPEs may include chart review, direct observation, monitoring of diagnostic and treatment techniques or discussion with other individuals involved in the care of patients.[48]

For 5 of 10 profiles, the OIG did not find evidence of a completed FPPE. This resulted in inconsistent evaluation of the clinical competency of newly hired providers in delivering quality care. Facility managers stated a lack of administrative support, lack of a tracking mechanism to

[47] VHA Handbook 1100.19.
[48] VHA Handbook 1100.19.

ensure receipt of completed FPPEs, and turnover in key staff positions resulted in noncompliance.

Ongoing Professional Practice Evaluations

VHA requires that at the time of re-privileging, Service Chiefs consider relevant service- and practitioner-specific data utilizing defined criteria when recommending the continuation of LIPs' privileges to the Medical Staff Executive Council. Such data is maintained as part of the practitioner's provider profile and may include direct observations, clinical discussions, and clinical record reviews. The OPPE process is essential to confirm the quality of care delivered and allows the facility to identify professional practice trends that impact quality of care and patient safety.[49]

For 12 of 20 LIPs reviewed, there was no evidence that the determination to continue current privileges were based on the results of OPPE activities. This resulted in providers continuing to deliver care without a thorough evaluation of their practice. Facility managers stated lack of administrative support, lack of a tracking mechanism to ensure receipt of completed OPPEs, and turnover in key staff positions resulted in noncompliance.

Recommendation 5

5. The Chief of Staff ensures that clinical managers initiate and complete Focused and Ongoing Professional Practice Evaluations for the determination of providers' privileges and monitors compliance.

Facility concurred.

Target date for completion: December 31, 2018

Facility response: Services developed and implemented tracking logs. The service-level tracking logs will be used to ensure timely completion and presentation of the results of FPPEs and OPPEs to the Professional Standards Board (PSB) and MSEC. A master log of open and reported FPPEs and OPPEs will be developed, implemented, and maintained by the Chief of Staff's office based on the agendas for the PSB/MSEC meetings. The Chief of Staff's office schedules each service for upcoming FPPE and OPPE reviews, and services will advise the Medical Staff Office of the reports to be presented at each PSB/MSEC meeting. These actions will be monitored until at least 90 percent compliance is maintained for three consecutive months.

[49] VHA Handbook 1100.19.

Environment of Care

Any medical center, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires managers to conduct EOC inspection rounds and resolve issues in a timely manner. The goal of the EOC program is to reduce and control environmental hazards and risks; prevent accidents and injuries; and maintain safe conditions for patients, visitors, and staff. The physical environment of a healthcare organization must not only be functional but should also promote healing.[50]

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.[51]

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.[52]

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).[53] 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,[54] Occupational Safety and Health Administration,[55] and

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

[51] 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).

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

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

[54] TJC. EOC standard EC.02.05.07.

[55] 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.[56] The provision of sustained electrical power during disasters or emergencies is critical to continued operations of a healthcare facility.

In all, the OIG inspected seven inpatient units (medical intensive care, surgical intensive care, Community Living Center 1, Community Living Center 2, medical 4-West, surgical 5-West, and locked MH), post-anesthesia care unit, primary care clinic, specialty clinic, and the Emergency Department. The OIG also inspected the Hickory 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

[56] 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.

  - 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

Conclusion

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

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.[57] 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.[58]

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.[59] 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.[60] The OIG interviewed key managers and reviewed CS inspection reports for the prior two completed quarters;[61] monthly summaries of findings, including discrepancies, provided to the Director for the prior 12 months;[62] CS inspection quarterly trend reports for the prior four quarters;[63] 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

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

[58] 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.

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

[60] 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.

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

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

[63] 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[64]

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

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

Conclusion

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

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."[65] 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.[66]

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.[67] 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.[68]

To assess whether the Facility complied with the requirements related to PTSD screening, diagnostic evaluation, and referral to specialty care, the OIG reviewed relevant documents and interviewed key employees and managers. Additionally, the OIG reviewed the electronic health records (EHR) of 48 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

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

[66] VHA Handbook 1160.03.

[67] 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.

[68] 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.[69] 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.[70] 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.[71]

In 1999, the Veterans Millennium Benefits and Healthcare Act mandated that the veterans' standard benefits package include access to GE.[72] 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.[73] 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.[74]

In determining whether the Facility provided an effective geriatric evaluation, the OIG reviewed relevant documents and interviewed key employees and managers. Additionally, the OIG reviewed the EHRs of 30 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

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

[70] VHA Directive 1140.04.

[71] 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.

[72] Public Law 106-117.

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

[74] VHA Directive 1140.04.

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

Conclusion

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

Women's Health: Mammography Results and Follow-Up

In 2017, an estimated 252,710 new cases of invasive breast cancer and 40,610 breast cancer deaths were expected to occur among US women.[75] 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.[76] The Veterans Health Care Act of 1992 also authorized VA to provide gender-specific services including mammography services to eligible women veterans.[77]

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.[78]

The OIG 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 OIG also reviewed the EHRs of 45 randomly selected women veteran patients who received a mammogram from July 1, 2016, through June 30, 2017. The OIG evaluated the following performance indicators:

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

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

[76] 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).

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

[78] 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 OIG noted compliance with requirements for many of the performance indicators evaluated, such as scanning hard copy reports if outsourced, including required components in reports, and performing follow-up mammograms and studies if indicated. However, the OIG identified deficiencies with electronic linking of mammogram results and communication of results to ordering providers and patients.

Electronic Linking of Mammography Results to Radiology Orders

VHA requires that mammogram results (Breast Imaging Reporting and Data System codes) are associated with the radiology order to ensure that the systems for tracking and managing mammography and breast cancer operate accurately.[79] This also ensures accurate reporting of data for use in program improvement, compliance, and oversight activities.

The OIG estimated that the Facility electronically linked the mammogram results to the radiology orders in 2 percent of the EHRs reviewed. The OIG is 95 percent confident that the true compliance rate is somewhere between 0 and 6.7 percent, which is statistically significantly below the 90 percent benchmark. Failure to link the mammography results to the radiology order could lead to inadequate tracking and management of mammography and breast cancer results. Facility managers stated the results were available, however, the results were not visible in the required location in the EHR. Facility managers believed that efforts met requirements.

Recommendation 6

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

Facility concurred.

Target date for completion: June 18, 2018

Facility Response: On June 18, 2018, the Chief of Imaging received instruction from the Radiology Informatics Committee on how to use the administrative key to link outside mammography results to the radiology order in VistA. This was successfully done with immediate results showing linkage of the administrative reports and retrospective population of the reports into the desired location.

[79] VHA Directive 1330.01(2).

By June 27, 2018, record review monitoring by the Women Veteran Program Manager (WVPM) reflected 44 (100%) of the 44 charts previously reviewed by the OIG were now showing as compliant and linked. Since the repair, the reports populated retrospectively and in the correct location showing the appropriate BI-RADs code and are associated with the order. The WVPM reviewed a sample from 2012, which showed corrections extending back to that time. Data reflecting seven months of 100% compliance were reported to the Women Veterans Health Committee (WVHC) on August 22, 2018, and MSEC on August 21, 2018.

Communication of Results to Ordering Providers

VHA requires that mammogram results are communicated to ordering providers within established timeframes.[80] This allows the ordering provider to communicate the results to the patient and provide follow-up care as needed. The OIG estimated that results were communicated to ordering providers in 48 percent of the EHRs reviewed; and, 95 percent of the time, the true compliance rate is between 32.6 and 62.8 percent, which is statistically significantly below the 90 percent benchmark. Inconsistent or lack of test result communication to providers could lead to delays in care. Facility managers stated the reasons for noncompliance were inconsistent processes and a lack of attention to details.

Recommendation 7

7. The Chief of Staff ensures that mammogram results are communicated to ordering providers and monitors compliance.

Facility concurred.

Target date for completion: August 31, 2018

Facility Response: The additional signer status ensuring ordering providers of mammograms acknowledge the availability of scanned mammogram results in CPRS[81] was fully implemented June 18, 2018.

By July 9, 2018, the mammogram tracking spreadsheet was modified to monitor the compliance of the additional signer notification verifying that the availability of mammogram results was communicated to the ordering provider via additional signer activation. Concurrent reviews, effective June 25, 2018, resulted in the following high compliance. August 2018 reviews demonstrated 72/73 records (98%), July 2018, 40/40 (100%) and June 2018, 45/47 records (95%) were communicated to the ordering provider. This data showing three consecutive months of compliance at higher than 90 percent were reported to the WVHC and MSEC.

[80] VHA Directive 1330.01(2).

[81] The Computerized Patient Record System (CPRS) is VHA's electronic health record system.

Communication of Results to Patients

VHA requires that ordering providers or designees notify patients of mammogram results within established timeframes.[82] Timely communication of test results is essential to ensure safe and effective health care. The OIG estimated that providers communicated results to patients in 41 percent of the EHRs reviewed; and, 95 percent of the time, the true compliance rate is between 26.7and 55.6 percent, which is statistically significantly below the 90 percent benchmark. Inconsistent or lack of test result communication to patients could lead to delays in care. Facility managers stated the reasons for noncompliance were inconsistent processes and a lack of attention to details.

Recommendation 8

8. The Chief of Staff ensures providers or designees communicate mammogram results to patients and monitors compliance.

Facility concurred.

Target date for completion: August 31, 2018

Facility Response: MAMMOGRAM RESULTS LETTER and MAMMOGRAM TELEPHONE RESULT NOTE titles were created to assure documentation of timely notification of results to patients. This was fully implemented by April 30, 2018.

In April 2018, a newly funded position, the Women's Health Coordinator (WHC) began overseeing mammography program compliance. Beginning June 27, 2018, the WHC and WVPM began conducting concurrent reviews of all mammography records to validate documented communication of results to the patient. Immediate feedback and correction occurs as needed.

August data demonstrated 73 of 73 (100%) mammogram results were communicated to patients via results letters or phone calls; July 2018: 39/40 (98%), June 2018: 43/47 (91%), May 2018: 68/71 (95%), April 2018: 41/42 (97%), March 2018: 50/51 (98%). These six consecutive months of data greater than 90 percent were reported to the WVHC and MSEC.

[82] VHA Directive 1330.01(2).

High-Risk Processes: Central Line-Associated Bloodstream Infections

TJC requires facilities to establish systematic infection prevention and control programs to reduce the risk of acquiring and transmitting infections.[83] Central lines "refer to a broad category of intravascular (within blood vessels) devices used to administer fluids, medications, blood and blood products, and parenteral nutrition. Unlike the short, temporary catheters inserted into the peripheral vasculature,"[84] central lines are threaded through a vein in the arm, chest, neck, or groin and advanced so that the furthest tip terminates at or close to the heart or in one of the great vessels.[85]

The use of central lines has greatly facilitated the care provided to patients; however, they are not without their risks. The Centers for Disease Control and Prevention defines a central line-associated bloodstream infection (CLABSI) as a "primary bloodstream infection that develops in a patient with a central line in place. This type of infection occurs within the 48 hours of insertion and is not related to infection at another site."[86]

Infections occurring on or after the third calendar day following admission to an inpatient location are considered "healthcare-associated."[87] The patient's age, underlying conditions, and gender are basic risk factors, but external risk factors such as prolonged hospitalization, multi-lumen central lines, and central line duration far outnumber the basic ones. External factors are associated with a 2.27-fold increased risk for mortality and increased healthcare costs.[88]

The OIG's review of these issues examined whether the Facility established and maintained programs to reduce the incidence of healthcare-associated bloodstream infections in intensive care unit patients with indwelling central lines. In addition to conducting manager and staff interviews, the OIG reviewed committee minutes, the Infection Prevention/Control Risk Assessment, and other relevant documents. The OIG also reviewed the training records of 15 clinical employees involved in inserting and/or managing central lines. The OIG evaluated the following performance indicators:

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

[83] TJC. Infection Prevention and Control standard IC.01.03.01.

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

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

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

[87] The Centers for Disease Control and Prevention National Healthcare Safety Network, *Bloodstream Infection Event: Central Line-Associated Bloodstream Infection and non-central line-associated Bloodstream Infection*, January 2017.

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

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

Conclusion

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

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

Healthcare Processes	Performance Indicators	Conclusion
Leadership and Organizational Risks	• Executive leadership stability and engagement • Employee satisfaction and patient experience • Accreditation/for-cause surveys and oversight inspections • Indicators for possible lapses in care • VHA performance data	Eight OIG recommendations, ranging from documentation issues to deficiencies that can lead to patient and staff safety issues or adverse events, are attributable to the Director and Chief of Staff. 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	• Improvement actions arising from peer review and RCA activities are implemented.	• The interdisciplinary group or committee that reviews UM data includes representation from Chief Business Office Revenue–Utilization Review. • Feedback on RCA actions is provided to the reporting employees or departments.
Credentialing and Privileging	• Medical licenses • Privileges • FPPEs • OPPEs	• Clinical managers initiate and complete FPPEs and OPPEs for the determination of providers' privileges.	• Medical Staff Executive Council minutes consistently reflect the documents reviewed and the rationale to recommend LIPs' requested privileges.

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
		• None	• None

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Medication Management	• CSC reports • Pharmacy operations • Annual physical security survey • CS ordering processes • Inventory completion during Chief of Pharmacy transition • Review of balance adjustments • CSC requirements • CSI requirements • CS area inspections • Pharmacy inspections	• None	• None
Mental Health Care: 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	• None
Women's Health: Mammography Results and Follow-Up	• Result linking • Report scanning and content • Communication of results and recommended actions • Follow-up mammograms and studies	• Mammogram results are linked to radiology orders. • Mammogram results are communicated to ordering providers. • Mammogram results are communicated to patients.	• None
High-Risk Processes: Central Line-Associated Bloodstream	• Policy and infection prevention risk assessment • Committee discussion	• None	• None

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Infections	• Infection incidence data • Education and educational materials • Policy, procedure, and checklist for insertion and maintenance of central venous catheters		

Appendix B: Facility Profile and VA Outpatient Clinic Profiles

Facility Profile

The table below provides general background information for this mid-high complexity (1c)[89] affiliated[90] Facility reporting to VISN 6.

**Table 7. Facility Profile for Asheville (637)
(October 1, 2014, through September 30, 2017)**

Profile Element	Facility Data FY 2015[91]	Facility Data FY 2016[92]	Facility Data FY 2017[93]
Total Medical Care Budget in Millions	$325.1	$365.8	$378.5
Number of:			
• Unique Patients	38,821	46,611	46,896
• Outpatient Visits	457,988	533,965	546,340
• Unique Employees[94]	1,523	1,491	1,625
Type and Number of Operating Beds:			
• Community Living Center	73	73	73
• Domiciliary	18	18	18
• Medicine	44	44	44
• Mental Health	16	16	16
• Surgery	23	23	23
Average Daily Census:			
• Community Living Center	51	55	60
• Domiciliary	15	16	16
• Medicine	33	37	39

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

[90] Associated with a medical residency program.

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

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

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

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

Profile Element	Facility Data FY 2015[91]	Facility Data FY 2016[92]	Facility Data FY 2017[93]
• Mental Health	14	14	11
• Surgery	16	12	11

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

VA Outpatient Clinic Profiles[95]

The VA outpatient clinics in communities within the catchment area of the Facility provide PC integrated with women's health, MH, and telehealth services. Some also provide specialty care, diagnostic, and ancillary services. Table 8 provides information relative to each of the clinics.

Table 8. VA Outpatient Clinic Workload/Encounters[96] and Specialty Care, Diagnostic, and Ancillary Services Provided (October 1, 2016, through September 30, 2017)

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services[97] Provided	Diagnostic Services[98] Provided	Ancillary Services[99] Provided
Franklin, NC	637GA	6,656	3,372	Endocrinology Gastroenterology Poly-Trauma Eye	n/a	Nutrition Pharmacy Social Work Weight Management

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

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

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

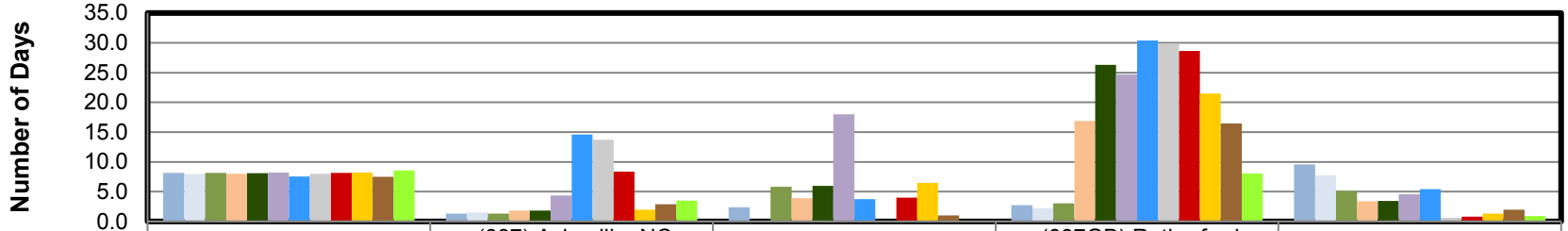
[98] Diagnostic services include EKG, EMG, laboratory, nuclear medicine, radiology, and vascular lab services.

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

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services[97] Provided	Diagnostic Services[98] Provided	Ancillary Services[99] Provided
Rutherfordton, NC	637GB	7,831	3,637	Dermatology Endocrinology Gastroenterology Poly-Trauma Eye	n/a	Nutrition Pharmacy Social Work Weight Management
Hickory, NC	637GC	17,860	7,027	Cardiology Dermatology Gastroenterology Poly-Trauma Eye General Surgery	n/a	Pharmacy 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[100]

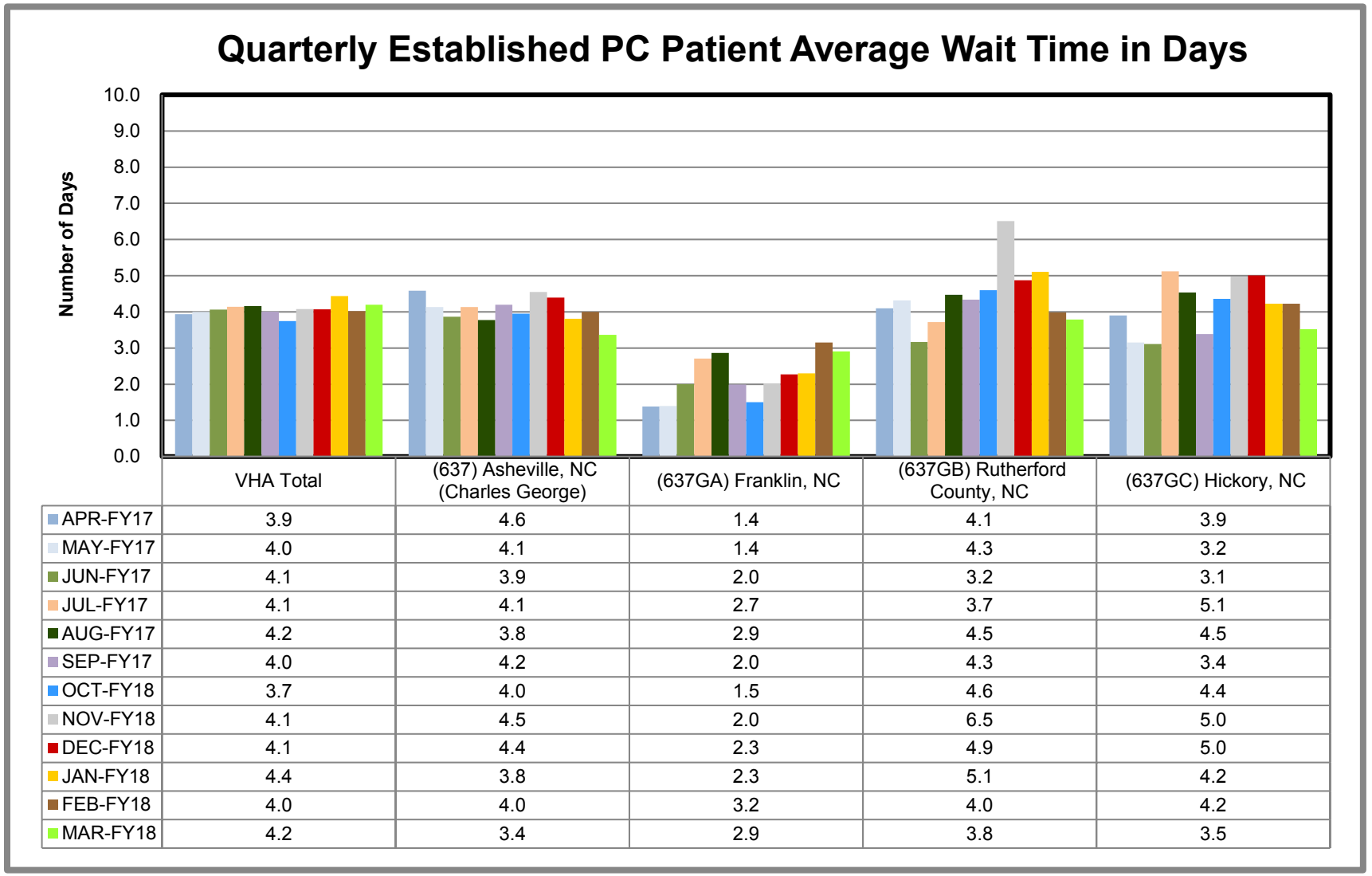


	VHA Total	(637) Asheville, NC (Charles George)	(637GA) Franklin, NC	(637GB) Rutherford County, NC	(637GC) Hickory, NC
APR-FY17	8.2	1.3	2.4	2.8	9.6
MAY-FY17	7.9	1.5	0.0	2.3	7.7
JUN-FY17	8.2	1.3	5.8	3.0	5.1
JUL-FY17	8.0	1.8	3.9	16.9	3.4
AUG-FY17	8.1	1.8	6.0	26.3	3.5
SEP-FY17	8.2	4.4	18.0	24.6	4.5
OCT-FY18	7.5	14.6	3.8	30.4	5.4
NOV-FY18	8.0	13.8	0.0	29.8	0.6
DEC-FY18	8.1	8.3	4.0	28.6	0.8
JAN-FY18	8.2	2.0	6.5	21.5	1.3
FEB-FY18	7.5	2.9	1.0	16.4	2.0
MAR-FY18	8.6	3.5	n/a	8.1	0.9

Source: VHA Support Service Center

***Data Definition**: The average number of calendar days between a new patient's PC completed appointment (clinic stops 322, 323, and 350, excluding Compensation and Pension appointments) and the earliest of three possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic Appointment, Completed Appointment) from the completed appointment date. Note that prior to FY 2015, this metric was calculated using the earliest possible create date. The absence of reported data is indicated by "n/a."*

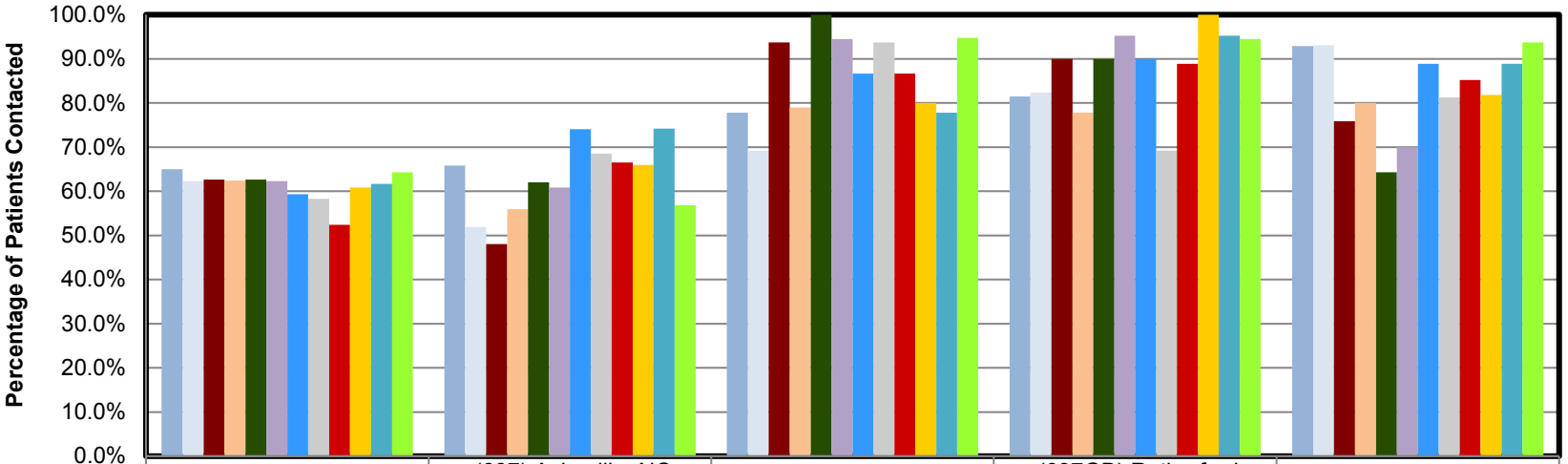
[100] Department of Veterans Affairs, Patient Aligned Care Teams Compass Data Definitions, accessed September 11, 2017.



	VHA Total	(637) Asheville, NC (Charles George)	(637GA) Franklin, NC	(637GB) Rutherford County, NC	(637GC) Hickory, NC
APR-FY17	3.9	4.6	1.4	4.1	3.9
MAY-FY17	4.0	4.1	1.4	4.3	3.2
JUN-FY17	4.1	3.9	2.0	3.2	3.1
JUL-FY17	4.1	4.1	2.7	3.7	5.1
AUG-FY17	4.2	3.8	2.9	4.5	4.5
SEP-FY17	4.0	4.2	2.0	4.3	3.4
OCT-FY18	3.7	4.0	1.5	4.6	4.4
NOV-FY18	4.1	4.5	2.0	6.5	5.0
DEC-FY18	4.1	4.4	2.3	4.9	5.0
JAN-FY18	4.4	3.8	2.3	5.1	4.2
FEB-FY18	4.0	4.0	3.2	4.0	4.2
MAR-FY18	4.2	3.4	2.9	3.8	3.5

Source: VHA Support Service Center

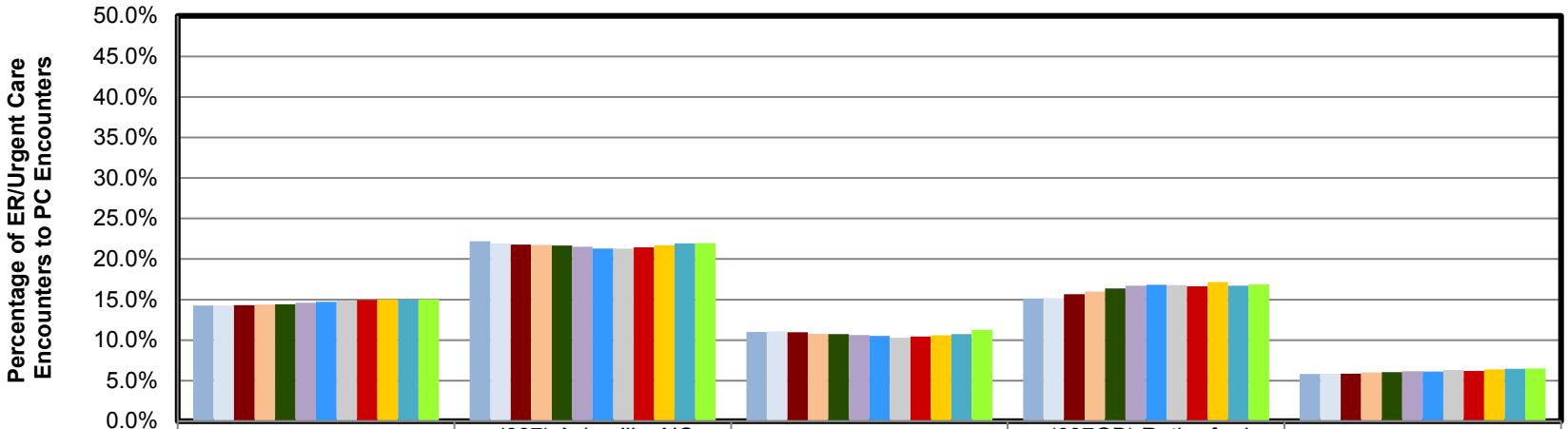
Data Definition: *The average number of calendar days between an established patient's PC completed appointment (clinic stops 322, 323, and 350, excluding Compensation and Pension appointments) and the earliest of three possible preferred (desired) dates (Electronic Wait List (EWL), Cancelled by Clinic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



	VHA Total	(637) Asheville, NC (Charles George)	(637GA) Franklin, NC	(637GB) Rutherford County, NC	(637GC) Hickory, NC
APR-FY17	65.0%	65.8%	77.8%	81.5%	92.9%
MAY-FY17	62.3%	51.9%	69.2%	82.4%	93.1%
JUN-FY17	62.7%	48.0%	93.8%	90.0%	75.9%
JUL-FY17	62.4%	55.9%	78.9%	77.8%	80.0%
AUG-FY17	62.6%	62.0%	100.0%	90.0%	64.3%
SEP-FY17	62.3%	60.8%	94.4%	95.2%	70.0%
OCT-FY18	59.3%	74.1%	86.7%	90.0%	88.9%
NOV-FY18	58.3%	68.6%	93.8%	69.2%	81.3%
DEC-FY18	52.4%	66.5%	86.7%	88.9%	85.2%
JAN-FY18	60.8%	66.0%	80.0%	100.0%	81.8%
FEB-FY18	61.7%	74.2%	77.8%	95.2%	88.9%
MAR-FY18	64.3%	56.8%	94.7%	94.4%	93.8%

Source: VHA Support Service Center

Data Definition: *The percent of assigned PC patients discharged from any VA facility who have been contacted by a PC team member within two business days during the reporting period. Patients are excluded if they are discharged from an observation specialty and/or readmitted within two 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	(637) Asheville, NC (Charles George)	(637GA) Franklin, NC	(637GB) Rutherford County, NC	(637GC) Hickory, NC
APR-FY17	14.3%	22.2%	11.0%	15.1%	5.8%
MAY-FY17	14.3%	21.9%	11.1%	15.2%	5.9%
JUN-FY17	14.3%	21.8%	11.0%	15.7%	5.9%
JUL-FY17	14.4%	21.7%	10.8%	16.0%	6.0%
AUG-FY17	14.4%	21.7%	10.7%	16.4%	6.1%
SEP-FY17	14.6%	21.5%	10.6%	16.7%	6.1%
OCT-FY18	14.7%	21.3%	10.5%	16.8%	6.1%
NOV-FY18	14.8%	21.3%	10.3%	16.8%	6.3%
DEC-FY18	14.9%	21.5%	10.4%	16.7%	6.2%
JAN-FY18	15.0%	21.7%	10.6%	17.2%	6.4%
FEB-FY18	15.0%	21.9%	10.7%	16.7%	6.5%
MAR-FY18	15.0%	22.0%	11.3%	16.9%	6.5%

Source: VHA Support Service Center

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

Appendix D: Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions[101]

Measure	Definition	Desired Direction
ACSC Hospitalization	Ambulatory Care Sensitive Conditions hospitalizations	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Admit Reviews Met	% 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

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

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

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

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

Source: VHA Support Service Center

Appendix E: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: September 14, 2018

From: Director, VA Mid-Atlantic Health Care Network (10N6)

Subj: CHIP Review of the Charles George VA Medical Center, Asheville, NC

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

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

I concur with the findings, recommendations, and submitted action plans.

(Original signed by:)

Deanne M. Seekins, MBA, VHA-CM
VA Mid-Atlantic Health Care Network Director, VISN 6

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: September 4, 2018

From: Director, Charles George VA Medical Center (637/00)

Subj: CHIP Review of the Charles George VA Medical Center, Asheville, NC

To: Director, VA Mid-Atlantic Health Care Network (10N6)

Thank you for the opportunity to review this report. The collaborative, consultative and professional approach of the review team is worth noting, as this contributed greatly to a thorough and beneficial assessment of health care system operations.

I concur with the recommendations outlined in the attached report. All findings have been reviewed and facility level action plans initiated as required.

Sincerely,

(Original signed by:)

Stephanie Young
Medical Center 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.

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	Bruce Barnes, Team Leader Patricia Calvin, MBA, RN Nancy Mikulin, MSN, RN Sandra Vassell, MBA, RN Sylvester Wallace, MSW, LCSW Sonia Whig, MS, LDN
Other Contributors	Limin Clegg, PhD Justin Hanlon, BS Henry Harvey, MS Haywood, Wachita, MSN/NED, RN LaFonda Henry, MSN, RN-BC Yoonhee Kim, PharmD Scott McGrath, BS Anita Pendleton, AAS Larry Ross, Jr., MS Marilyn Stones, BS Mary Toy, MSN, RN Robert Wallace, ScD, MPH

Report Distribution

VA Distribution

Office of the Secretary
Veterans Benefits Administration
Veterans Health Administration
National Cemetery Administration
Assistant Secretaries
Office of General Counsel
Office of Acquisition, Logistics, and Construction
Board of Veterans' Appeals
Director, VISN 6: VA Mid-Atlantic Health Care Network
Director, Charles George VA Medical Center (637/00)

Non-VA Distribution

House Committee on Veterans' Affairs
House Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
House Committee on Oversight and Government Reform
Senate Committee on Veterans' Affairs
Senate Appropriations Subcommittee on Military Construction, Veterans Affairs, and Related Agencies
Senate Committee on Homeland Security and Governmental Affairs
National Veterans Service Organizations
Government Accountability Office
Office of Management and Budget
U.S. Senate: Richard Burr, Thom Tillis
U.S. House of Representatives: Alma Adams; Ted Budd; Virginia Foxx; Richard L. Hudson Jr.; Patrick McHenry; Mark Meadows

OIG reports are available at www.va.gov/oig.