



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare
Inspection Program Review
of the VA Pittsburgh
Healthcare System
Pennsylvania



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. VA Pittsburgh Healthcare System, Pennsylvania
(Source: <https://vaww.va.gov/directory/guide/>, accessed on August 29, 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 VA Pittsburgh Healthcare System (Facility). The review covers key clinical and administrative processes that are associated with promoting quality care.

CHIP reviews are one element of the overall efforts of the Office of Inspector General(OIG) to ensure that our nation's veterans receive high-quality and timely VA healthcare services. The reviews are performed approximately every three years for each facility. The OIG selects and evaluates specific areas of focus on a rotating basis each year.

The OIG's current areas of focus are

1. Leadership and Organizational Risks;
2. Quality, Safety, and Value;
3. Credentialing and Privileging;
4. Environment of Care;
5. Medication Management;
6. Mental Health;
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 July 30, 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, Deputy 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 an Executive Leadership Board having oversight for groups such as the Nursing Administrative Leadership Council, Safety Committee, and Medical Executive Board. The leaders are members of the Executive Leadership Board through which they track, trend, and monitor quality of care and patient outcomes.

The leadership team have been working as a team since January 2016 when the Director was appointed to the position. The ADPCS has been in the role since 2002, the Chief of Staff and Associate Director since 2011, and the Deputy Director since 2015.

In the review of selected employee and patient experience survey results regarding Facility leaders, the OIG noted that Facility leaders appeared actively engaged with employees and 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 The leadership team was knowledgeable about selected SAIL metrics and should continue to take actions to maintain and improve care and performance of selected Quality of Care and Efficiency metrics that are likely contributing to the current “4-Star” rating.

Additionally, the OIG reviewed accreditation agency findings, RCAs, sentinel events,² disclosures of adverse patient events, and Patient Safety Indicator data and identified the presence of organizational risk factors, as evidenced by Patient Safety Indicator data and RCA processes, which 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 two of the eight areas of clinical operations reviewed and issued four recommendations that are attributable to the Deputy Director and Chief of Staff. These are briefly described below.

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.)

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.

Credentialing and Privileging

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

Environment of Care

The OIG noted privacy measures were in place at the parent Facility and the representative CBOC. The OIG did not note any issues with either emergency management processes or availability of medical equipment and supplies. The OIG identified deficiencies in infection prevention, environmental cleanliness, and mental health seclusion room safety.

Summary

In the review of key care processes, the OIG issued four recommendations that are attributable to the Deputy 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 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 CHIP review findings and recommendations and provided acceptable improvement plans. (See Appendixes E and F, pages 57–58, and the responses within the body of the report for the full text of the Directors' comments.) The OIG will follow up on the planned actions for the open recommendations until they are completed.



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

Contents

Abbreviations	ii
Report Overview	iii
Results and Review Impact	iii
Contents	vi
Purpose and Scope	1
Methodology	3
Results and Recommendations	4
Leadership and Organizational Risks	4
Quality, Safety, and Value	17
Credentialing and Privileging	19
Recommendation 1	21
Recommendation 2	22
Environment of Care	24
Recommendation 3	27
Recommendation 4	29
Medication Management: Controlled Substances Inspection Program	30
Mental Health: Posttraumatic Stress Disorder Care	33
Long-term Care: Geriatric Evaluations	35
Women’s Health: Mammography Results and Follow-up	37
High-risk Processes: Central Line-associated Bloodstream Infections	39
Appendix A: Summary Table of Comprehensive Healthcare Inspection Program Review	
Findings	41
Appendix B: Facility Profile and VA Outpatient Clinic Profiles	45
Facility Profile	45

VA Outpatient Clinic Profiles47

Appendix C: Patient Aligned Care Team Compass Metrics49

Appendix D: Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions
.....53

Appendix E: VISN Director Comments57

Appendix F: Facility Director Comments.....58

OIG Contact and Staff Acknowledgments59

Report Distribution60



Purpose and Scope

Purpose

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

Scope

Good leadership makes a difference in managing organizational risks by establishing goals, strategies, and priorities to improve care; setting the quality agenda; and promoting a quality improvement culture to sustain positive change.^{3,4} Investment in a culture of safety and quality improvement with robust communication and leadership is more likely to result in positive patient outcomes in healthcare organizations.⁵ Figure 2 shows the direct relationship leadership and organizational risks have with the processes used to deliver health care to veterans.

To examine risks to patients and the organization when these processes are not performed well, the OIG focused on the following nine areas of clinical care and administrative operations that support quality care—Leadership and Organizational Risks; Quality, Safety, and Value (QSV); Credentialing and Privileging; Environment of Care (EOC); Medication Management; Controlled Substances (CS) Inspection Program; Mental Health: 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).⁶

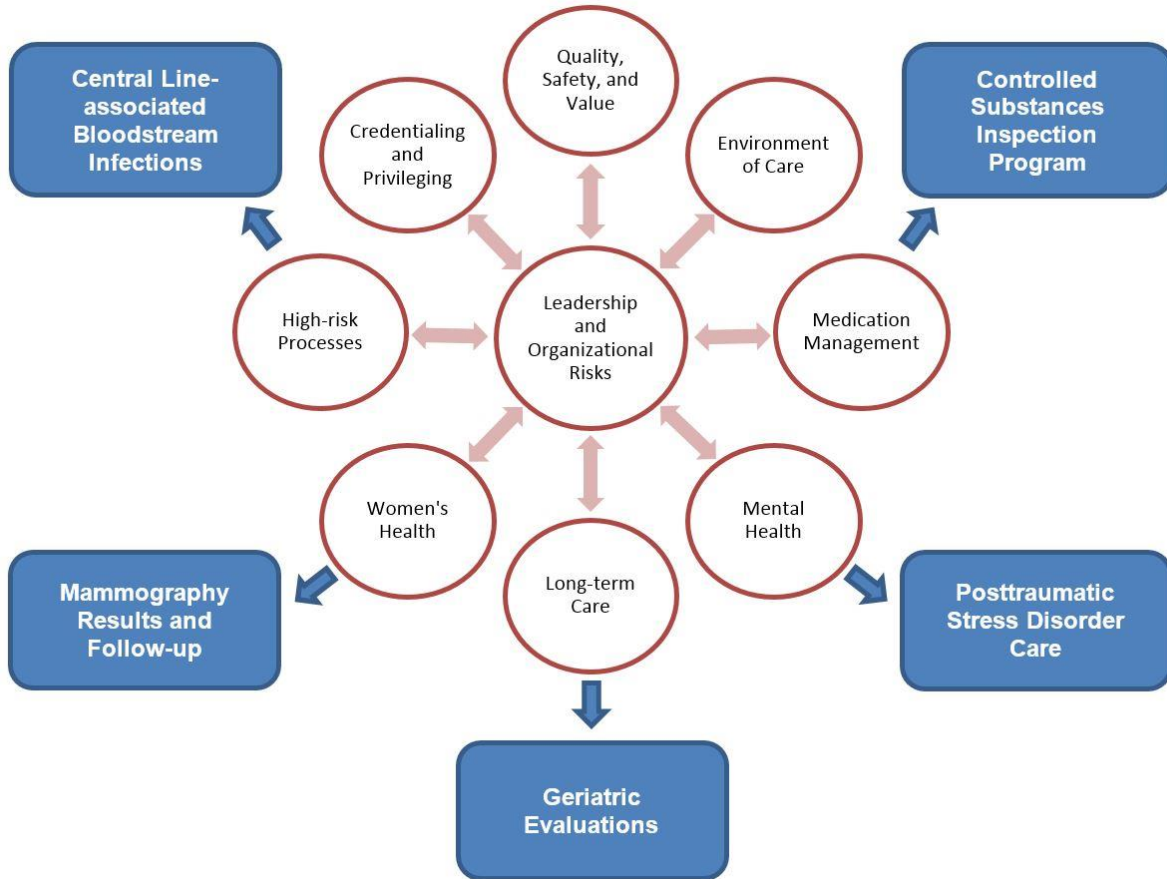
³ Carol Stephenson, “The role of leadership in managing risk,” *Ivey Business Journal*, November/December 2010. <https://iveybusinessjournal.com/publication/the-role-of-leadership-in-managing-risk/>. (Website accessed on March 1, 2018.)

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

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

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

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



Source: VA OIG

Methodology

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

The review covered operations for June 15, 2015,⁸ through July 30, 2018, the date when an unannounced week-long site visit commenced.

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

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

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

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

Results and Recommendations

Leadership and Organizational Risks

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

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

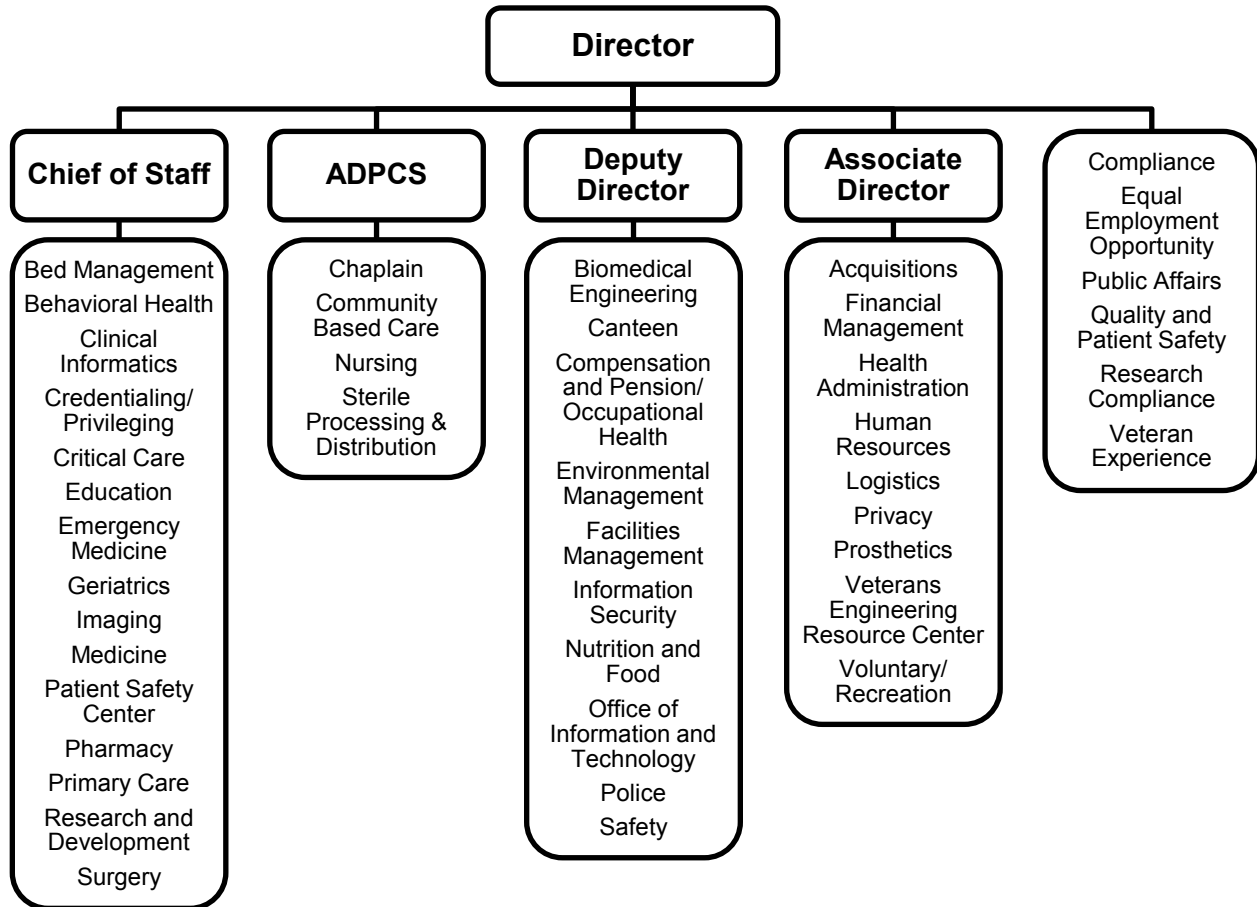
Executive Leadership Stability and Engagement

Because each VA facility organizes its leadership to address the needs and expectations of the local veteran population that it serves, organizational charts may differ among facilities. Figure 3 illustrates the Facility's reported organizational structure. The Facility has a leadership team consisting of the Director, Deputy 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 directors as well as program and practice chiefs.

The leadership team have been working as a team since January 2016 when the Director was appointed to the position. The ADPCS has been in the role since 2002, the Chief of Staff and Associate Director since 2011, and the Deputy Director since 2015.

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

Figure 3. Facility Organizational Chart



Source: VA Pittsburgh Healthcare System (received July 30, 2018)

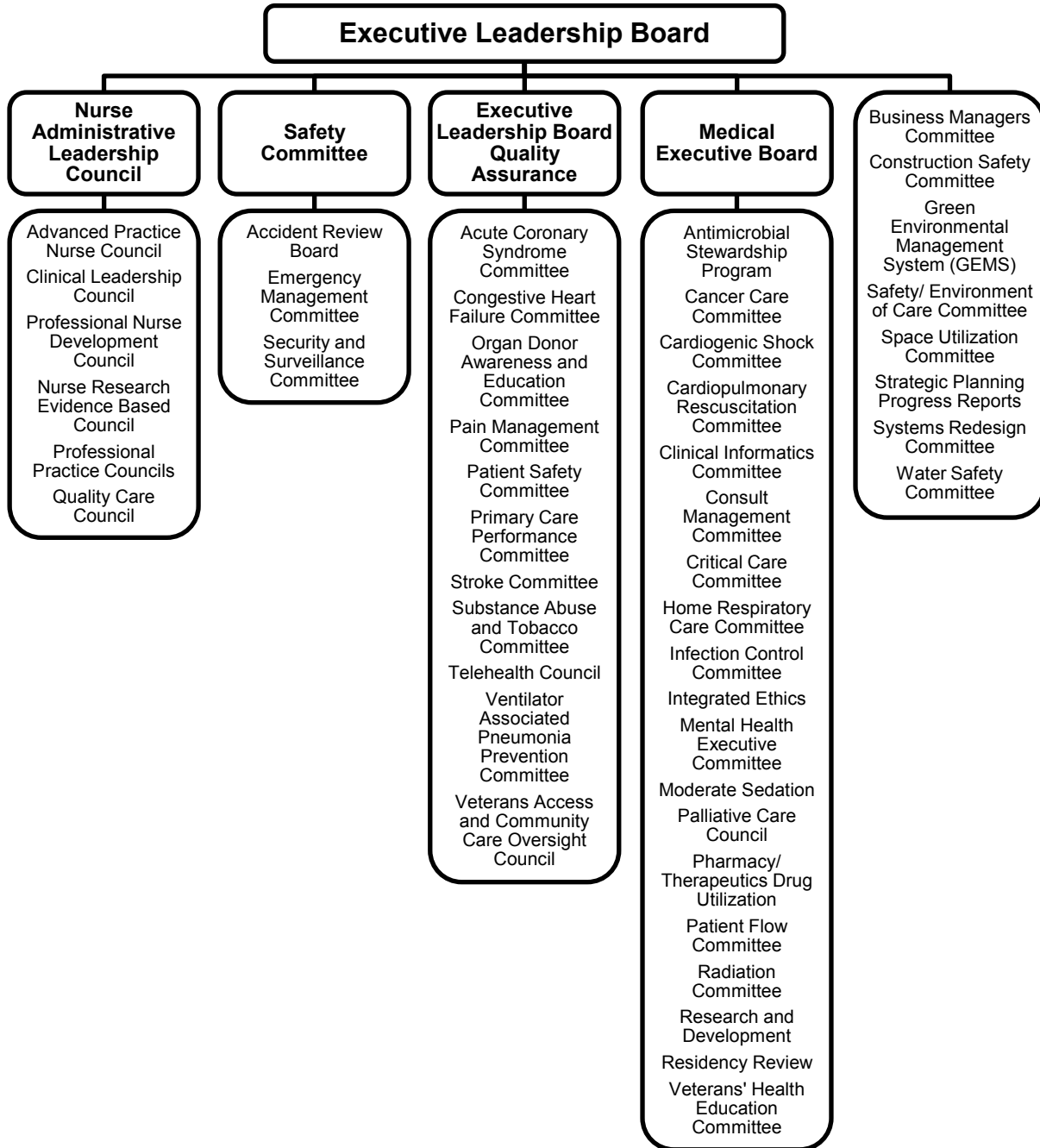
To help assess engagement of Facility executive leadership, the OIG interviewed the Director, Deputy Director, Chief of Staff, ADPCS, and Associate Director regarding their knowledge of various performance metrics and their involvement and support of actions to improve or sustain performance.

In individual interviews, these executive leadership team members could 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 Facility’s Executive Leadership Board, which tracks, trends, and monitors quality of care and patient outcomes. The Director serves as the chairperson for the Executive Leadership Board with the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. The Executive Leadership Board also oversees various working groups, such as the Nursing

Administrative Leadership Council, Safety Committee, and Medical Executive Board. See Figure 4.

Figure 4. Facility Committee Reporting Structure



Source: VA Pittsburgh Healthcare System (received July 31, 2018)

Employee Satisfaction and Patient Experience

The All Employee Survey is an annual, voluntary, census survey of VA workforce experiences. The data is 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.¹⁰

Table 1 summarizes employee attitudes toward selected Facility leaders as expressed in VHA’s All Employee Survey.¹¹ The Facility average for both selected survey questions was similar to or above the VHA average.¹² The results for the executive leadership team were higher than both the VHA and Facility 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	Deputy Director	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey: <i>Servant Leader Index Composite</i>	0–100 where HIGHER scores are more favorable	67.7	66.6	88.4	75.9	84.8	92.1	85.9
All Employee Survey Q59. <i>How satisfied are you with the job being done by the executive leadership where you work?</i>	1 (Very Dissatisfied) –5 (Very Satisfied)	3.3	3.3	4.1	3.9	4.4	4.5	4.2

Source: VA All Employee Survey (accessed June 29, 2018)

¹⁰ Rating is based on responses by employees who report to or are aligned under the Director, Deputy Director, Chief of Staff, ADPCS, and Associate Director.

¹¹ 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.

¹² The OIG makes no comment on the adequacy of the VHA average for each selected survey element. The VHA average is used for comparison purposes only.

Table 2 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey. The results for the selected survey questions were higher than the VHA and Facility averages for the entire executive team.

**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	Deputy Director	Chief of Staff Average	ADPCS Average	Assoc. Director Average
All Employee Survey Q43. <i>My supervisor encourages people to speak up when they disagree with a decision.</i>	1 (Strongly Disagree)–5 (Strongly Agree)	3.8	3.8	4.6	4.5	4.4	4.7	4.5
All Employee Survey Q44. <i>I feel comfortable talking to my supervisor about work-related problems even if I'm partially responsible.</i>	1 (Strongly Disagree)–5 (Strongly Agree)	3.9	3.9	4.7	4.7	4.4	4.7	4.6
All Employee Survey Q75. <i>I can talk with my direct supervisor about ethical concerns without fear of having my comments held against me.</i>	1 (Strongly Disagree)–5 (Strongly Agree)	3.9	3.9	4.7	4.7	4.3	4.6	4.5

Source: VA All Employee Survey (accessed June 29, 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) and reviewed results that relate to the period of October 1, 2016, through September 30, 2017. For this Facility, three of four patient survey results reflected similar or 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): <i>Would you recommend this hospital to your friends and family?</i>	The response average is the percent of “Definitely Yes” responses.	66.7	64.3
Survey of Healthcare Experiences of Patients (inpatient): <i>I felt like a valued customer.</i>	The response average is the percent of “Agree” and “Strongly Agree” responses.	83.4	82.8
Survey of Healthcare Experiences of Patients (outpatient Patient-Centered Medical Home): <i>I felt like a valued customer.</i>	The response average is the percent of “Agree” and “Strongly Agree” responses.	74.9	82.8
Survey of Healthcare Experiences of Patients (outpatient specialty care): <i>I felt like a valued customer.</i>	The response average is the percent of “Agree” and “Strongly Agree” responses.	75.2	78.9

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

Accreditation/For-Cause Surveys¹³ 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

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

recently performed by the OIG and The Joint Commission (TJC).¹⁴ Indicative of effective leadership, the Facility has closed all recommendations for improvement as listed in Table 4.¹⁵

The OIG also noted the Facility’s current accreditation status with the Commission on Accreditation of Rehabilitation Facilities¹⁶ and College of American Pathologists,¹⁷ which demonstrates the Facility leaders’ commitment to quality care and services. Additionally, the Long-Term Care Institute conducted an inspection of the Facility’s Community Living Center.¹⁸

Table 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 (<i>Combined Assessment Program Review of the VA Pittsburgh Healthcare System, Pittsburgh, Pennsylvania, August 26, 2015</i>)	June 2015	5	0
OIG (<i>Review of Community Based Outpatient Clinics and Other Outpatient Clinics of VA Pittsburgh Healthcare System, Pittsburgh, Pennsylvania, September 15, 2015</i>)	June 2015	7	0
TJC			
<ul style="list-style-type: none"> • Regular <ul style="list-style-type: none"> ○ Hospital Accreditation ○ Behavioral Health Care Accreditation ○ Home Care Accreditation • Behavioral Health Care Accreditation (Opioid Substitution Clinic) 	March 2017 September 2017	35 2 1 17	0 0 0 0

Sources: OIG and TJC (*Inspection/survey results verified with the Quality Manager on August 2, 2018*)

¹⁴ TJC is an internationally accepted external validation that an organization has systems and processes in place to provide safe and quality oriented health care. TJC has been accrediting VA medical facilities for over 35 years. Compliance with TJC standards facilitates risk reduction and performance improvement.

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

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

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

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

Indicators for Possible Lapses in Care

Within the healthcare field, the primary organizational risk is the potential for patient harm. Many factors impact the risk for patient harm within a system, including unsafe environmental conditions, sterile processing deficiencies, and infection control practices. Leaders must be able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms. Table 5 summarizes key indicators of risk since the OIG’s previous June 2015 Combined Assessment Program and Community Based Outpatient Clinic (CBOC) and Other Outpatient Clinics review inspections through the week of July 30, 2018.¹⁹

**Table 5. Summary of Selected Organizational Risk Factors
(June 2015 to July 30, 2018)**

Factor	Number of Occurrences
Sentinel Events ²⁰	7
Institutional Disclosures ²¹	5
Large-Scale Disclosures ²²	0

Source: VA Pittsburgh Healthcare System’s Quality Manager (received August 2, 2018)

The OIG also reviewed Patient Safety Indicators developed by the Agency for Healthcare Research and Quality within the U.S. Department of Health and Human Services. These provide information on potential in-hospital complications and adverse events following surgeries and procedures.²³ The rates presented are specifically applicable for this Facility, and lower rates indicate lower risks. Table 6 summarizes Patient Safety Indicator data from April 1, 2016, through March 31, 2018.

¹⁹ It is difficult to quantify an acceptable number of occurrences because one occurrence is one too many. Efforts should focus on prevention. Sentinel events and those that lead to disclosure can occur in either inpatient or outpatient settings and should be viewed within the context of the complexity of the Facility. (Note that the VA Pittsburgh Healthcare System is a highest complexity (1a) affiliated Facility as described in Appendix B.)

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

²¹ Institutional disclosure of adverse events (sometimes referred to as “administrative disclosure”) is a formal process by which facility leaders together with clinicians and others, as appropriate, inform the patient or his or her personal representative that an adverse event has occurred during care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient’s rights and recourse.

²² Large-scale disclosure of adverse events (sometimes referred to as “notification”) is a formal process by which VHA officials assist with coordinating the notification to multiple patients (or their personal representatives) that they may have been affected by an adverse event resulting from a systems issue.

²³ Agency for Healthcare Research and Quality. <https://www.qualityindicators.ahrq.gov/>. (Website accessed on March 8, 2017.)

**Table 6. Patient Safety Indicator Data
(April 1, 2016, through March 31, 2018)**

Measure	Reported Rate per 1,000 Hospital Discharges		
	VHA	VISN 4	Facility
Death among surgical inpatients with serious treatable conditions	113.92	115.15	126.13
Iatrogenic pneumothorax	0.17	0.06	0.07
Central venous catheter-related bloodstream infection	0.15	0.10	0.24
In-hospital fall with hip fracture	0.08	0.07	0.08
Perioperative hemorrhage or hematoma	2.62	2.99	4.20
Postoperative acute kidney injury requiring dialysis	0.65	0.00	0.00
Postoperative respiratory failure	5.11	3.61	5.45
Perioperative pulmonary embolism or deep vein thrombosis	3.09	2.97	3.64
Postoperative sepsis	3.72	4.34	6.91
Postoperative wound dehiscence	1.00	0.00	0.00
Unrecognized abdominopelvic accidental puncture/laceration	1.02	1.39	1.44

Source: VHA Support Service Center

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

Two Patient Safety Indicator measures (iatrogenic pneumothorax and in-hospital fall with hip fracture) show a higher observed rate than Veterans Integrated Service Network (VISN 4). Seven Patient Safety Indicator measures (death among surgical inpatients with serious treatable conditions, central venous catheter related bloodstream infection, perioperative hemorrhage or hematoma, postoperative respiratory failure, perioperative pulmonary embolism or deep vein thrombosis, postoperative sepsis, and unrecognized abdominopelvic accidental puncture/laceration) show a higher observed rate than VISN 4 and VHA. The OIG noted that not all the cases were reviewed because Facility managers and leaders relied on other data sources, such as VA Surgical Quality Improvement Program (VASQIP) and SAIL data, to trigger patient care reviews.

There were fourteen deaths among surgical inpatients with serious treatable conditions. Each case was reviewed at the Surgical Morbidity and Mortality Conference, by the Facility Surgical Workgroup, or by Quality Service.

One patient developed a pneumothorax following a lung biopsy. This was a known complication for the procedure done, and the case was not reviewed.

Two patients with central venous catheter-related bloodstream infections were reviewed by an interdisciplinary team, and care was found to be appropriate.

One patient sustained a hip fracture after a fall in the Emergency Department, and a review of the case contributed to the decision to purchase stretchers with bed alarms.

Fifteen patients experienced perioperative hemorrhage or hematoma. Fourteen of 15 cases were reviewed, and care was found to be appropriate.

Nine patients had postoperative respiratory failure. Seven of the nine cases were reviewed, and care was found to be appropriate.

Fourteen patients had perioperative pulmonary embolism or deep vein thrombosis, and based on an aggregate review that may or may not have included the same patients, education was provided to licensed independent practitioners regarding identification of those high-risk patients who may require long-term prophylaxis medication treatment.

There were 15 patients who developed postoperative sepsis. Two cases were reviewed as part of the Surgical Morbidity and Mortality Conference, and one was reviewed by the VASQIP nurse. No opportunities for improvement were identified.

Four patients had an unrecognized abdominopelvic accidental puncture/laceration. Three of the cases were reviewed, and care was found to be appropriate.

The OIG also identified an additional organizational risk related to root cause analysis (RCA) processes. During the review of RCA actions, the OIG found that in two of five RCAs, the actions were not fully implemented, even though one of the two cases had been documented as completed in WebSPOT.²⁴ Further, the OIG also noted that the outcome measures established by the Facility in those two RCAs were not measured to assess sustained improvement.

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

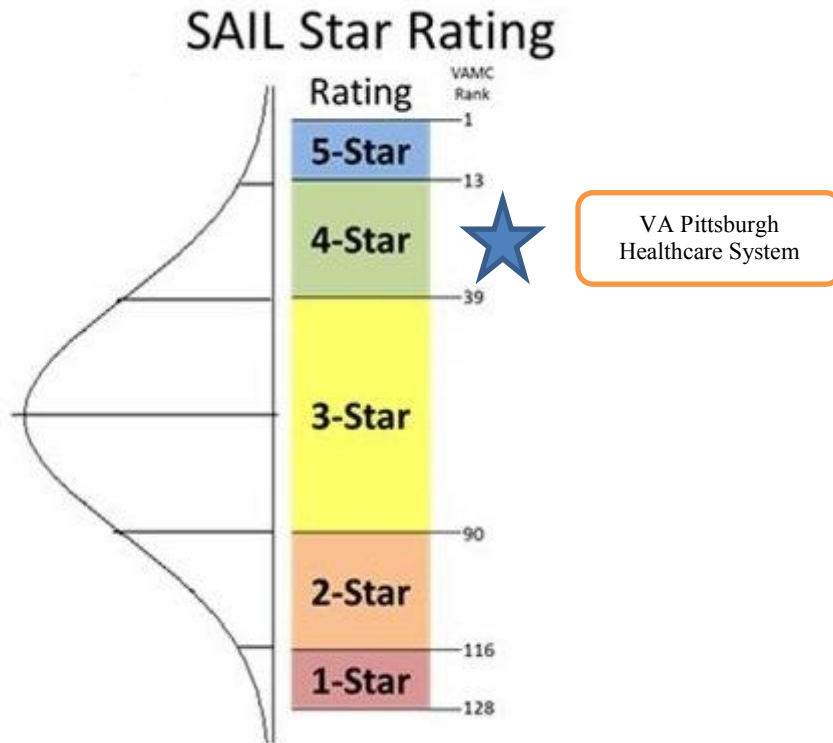
VA also uses a star-rating system where facilities with a “5-Star” rating are performing within the top 10 percent of facilities and “1-Star” facilities are performing within the bottom 10 percent

²⁴ WebSPOT is the software application used to enter and monitor RCAs in the VHA (National Center for Patient Safety) Patient Safety Information System database.

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.)

of facilities. Figure 5 describes the distribution of facilities by star rating.²⁶ As of June 30, 2017, the Facility was rated at “4-Star” for overall quality. Updated data as of June 30, 2018, indicates that the Facility rating remains at “4-Star” for overall quality.

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



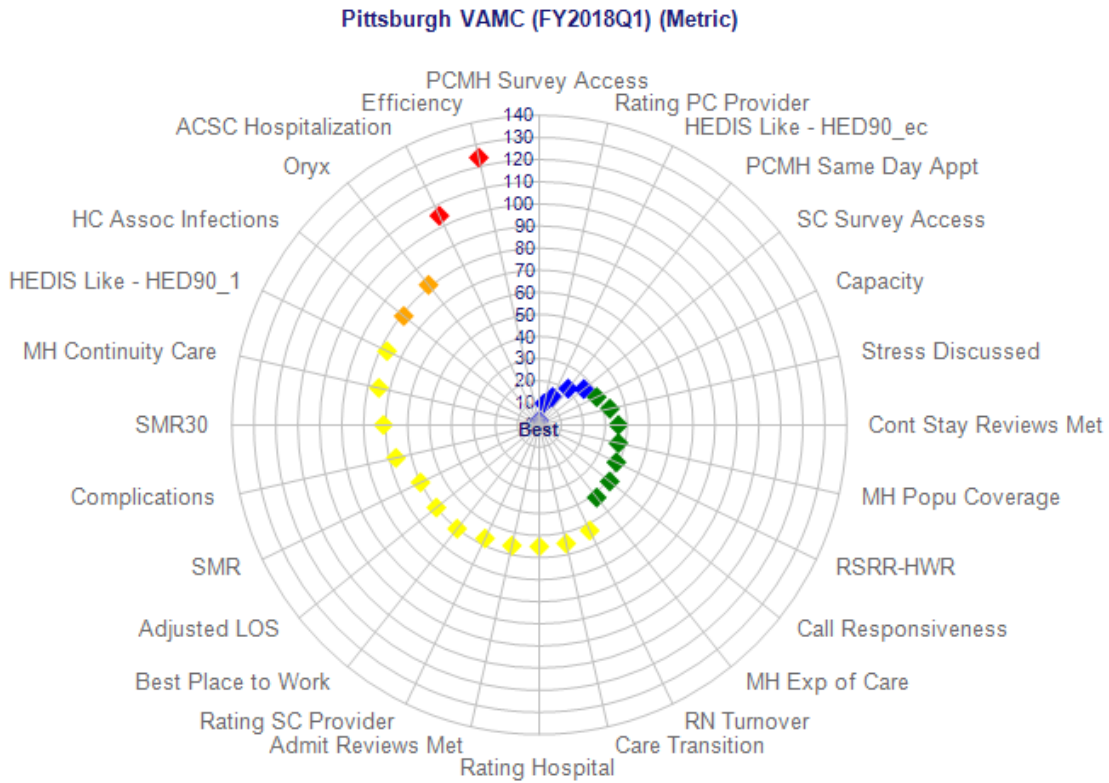
Source: VA Office of Informatics and Analytics Office of Operational Analytics and Reporting (accessed June 29, 2018)

Figure 6 illustrates the Facility’s Quality of Care and Efficiency metric rankings and performance compared with other VA facilities as of December 31, 2017. Of note, Figure 6 uses blue and green data points to indicate high performance (for example in the areas of Rating (of) Primary Care (PC) Provider, Capacity, and Call Responsiveness).²⁷ Metrics that need improvement are denoted in orange and red (for example, Healthcare (HC) Associated (Assoc) Infections and Ambulatory Care Sensitive Condition (ACSC) Hospitalization).

²⁶ Based on normal distribution ranking quality domain of 128 VA Medical Centers.

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 December 31, 2017)**



Marker color: Blue - 1st quintile; Green - 2nd; Yellow - 3rd; Orange - 4th; Red - 5th quintile.

Source: VHA Support Service Center

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

Conclusion

The leadership team consists of all permanently appointed staff who have been working as a team since January 2016. The OIG noted that Facility leaders were actively engaged with employees and patients. Organizational leaders 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). However, the presence of organizational risk factors, as evidenced by Patient Safety Indicator data and RCAs, may contribute to future issues of noncompliance and/or lapses in patient safety unless corrective processes are implemented and continuously monitored. The leadership team was knowledgeable about selected SAIL metrics and should continue to take actions to maintain and improve care

and performance of selected Quality of Care and Efficiency metrics that are likely contributing to the current “4-Star” rating.

Quality, Safety, and Value

VHA's goal is to serve as the nation's leader in delivering high-quality, safe, reliable, and veteran-centered care using a coordinated care continuum. To meet this goal, VHA must foster a culture of integrity and accountability that is vigilant and mindful, proactively risk aware, and predictable, while seeking continuous improvement.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 for 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 system³⁵
 - Annual completion of a minimum of eight RCAs³⁶
 - Provision of feedback about RCA actions to reporting employees
 - Submission of annual patient safety report

Conclusion

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

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

Credentialing and Privileging

VHA has defined procedures for the credentialing and privileging of all healthcare professionals who are permitted by law and the facility to practice independently—without supervision or direction, within the scope of the individual’s license, and in accordance with individually granted clinical privileges. These healthcare professionals are also referred to as licensed independent practitioners (LIP).³⁷

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.³⁸

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.³⁹

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,⁴⁰ and 20 LIPs who were re-privileged within 12 months prior to the visit.⁴¹ The OIG evaluated the following performance indicators:

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

³⁷ VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (Due for recertification October 31, 2017, but has not been updated.)

³⁸ VHA Handbook 1100.19.

³⁹ VHA Handbook 1100.19.

⁴⁰ The 18-month period was from February 2017 through July 2018.

⁴¹ The 12-month review period was from August 2017 through July 2018.

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

Conclusion

The OIG found general compliance with requirements for credentialing and privileging. However, the OIG identified deficiencies in the FPPE process and specialty OPPEs that warranted recommendations for improvement.

FPPE Process

VHA requires that all LIPs new to the facility have FPPEs completed and documented in the practitioner's profile and reported to an appropriate Medical Staff committee for consideration in the recommendation to continue initially granted privileges.⁴² The process involves the

⁴² VHA Handbook 1100.19.

evaluation of privilege-specific competence of the practitioner who has no previously documented evidence of competently performing the requested privileges. FPPEs may include periodic chart review, direct observation, monitoring of diagnostic and treatment techniques, or discussion with other individuals involved in the care of patients.⁴³

For 5 of 10 LIPs, FPPEs were not initiated. Of the remaining five LIPs, two FPPEs had evidence of review of data but were not presented to the Medical Executive Board. The other three FPPEs were presented to the Medical Executive Board, and continuation of privileges was approved; however, the profiles lacked evidence of review data that would support the continuation of privileges. This resulted in providers continuing to deliver care without a thorough evaluation of their practice. The Chief of Staff reported that there was no tracking mechanism or oversight to ensure the reviews were completed and submitted to the Medical Executive Board.

Recommendation 1

1. The Chief of Staff ensures that the Medical Executive Board uses the results of Focused Professional Practice Evaluations in the decision to recommend continuation of initially granted privileges and monitors compliance.

Facility concurred.

Target date for completion: April 30, 2019

Facility response:

- 1) Effective July 25, 2018, documentation in the Medical Executive Board (MEB) minutes was enhanced to appropriately capture OPPE/FPPE review by the Board in support of privilege recommendation to the Director for approval. Status: Implemented.
- 2) In the third quarter of FY18, Service Chiefs were instructed to document in VetPro completion of OPPE/FPPE review in support of privilege recommendation to the Board. Status: Implemented.
- 3) Beginning November 2018, the Executive Assistant to the Chief of Staff will randomly select for audit a sample of 5 FPPE files to review for completeness and present findings to the Chief of Staff. Audits will occur every month for 6 months compliance, at which time the need for continued monitoring will be re-evaluated by the Chief of Staff with the goal of 90% compliance for completeness.

⁴³ VHA Handbook 1100.19.

Specialty OPPEs

VHA requires OPPE criteria to be specific to the specialty and has identified minimum-required specialty criteria for gastroenterology, pathology and laboratory medicine, nuclear medicine, and radiation oncology.⁴⁴ This ensures a consistent approach to evaluating providers in these specialties and is essential to confirming the quality of care delivered.

For 2 of 6 applicable specialists' OPPEs, the OIG found no evidence of the use of minimum-required specialty criteria for competency evaluation. The Chief of Staff was temporarily assigned to another Facility when the memorandum for specialty providers was issued and did not assess if appropriate actions were taken after returning to the Facility. Additionally, the Radiology Service Chief was not aware of the minimum required specialty criteria.

Recommendation 2

2. The Chief of Staff ensures service chiefs complete all required elements, including minimum required specialty criteria for Ongoing Professional Practice Evaluations and monitors compliance.

⁴⁴ VHA Memorandum, *Requirements for Peer Review of Solo Practitioners*, August 29, 2016.

Facility concurred.

Target date for completion: April 30, 2019

Facility response:

- 1) Executive Assistant to the Chief of Staff will provide the Gastroenterology and Pathology and Laboratory Medicine Service Chiefs with the VHA-identified OPPE minimum-required specialty criteria to compare against the current OPPE criteria in use by the facility for Gastroenterology and Pathology and Laboratory Medicine. If any nationally identified criteria are missing, the facility OPPE templates will be updated and presented to the MEB for concurrence. Target date of completion: 11/30/18.
- 2) In August 2018, the Imaging Service Chief compared the facility's OPPE templates for Radiation Oncology and Nuclear Medicine with the VHA-identified OPPE minimum-required specialty criteria for both areas. Updates were made to the facility's Nuclear Medicine OPPE template to include several elements of the VHA-identified OPPE minimum-required specialty criteria. The updated Nuclear Medicine OPPE template was approved by the MEB on 8/22/18 and is currently in use. No updates were required to the facility's Radiation Oncology OPPE template. Completion date: 8/22/18.
- 3) Beginning November 2018, the Executive Assistant to the Chief of Staff will randomly select for audit a sample of 10 OPPE files to review for completeness and present findings to Chief of Staff. Audits will occur every month for 6 months, at which time the need for continued monitoring will be re-evaluated by the Chief of Staff with the goal of 90% compliance for completeness.

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.⁴⁵

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.⁴⁶

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.⁴⁷

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).⁴⁸ 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,⁴⁹ Occupational Safety and Health Administration,⁵⁰ and

⁴⁵ VHA Directive 1608, *Comprehensive Environment of Care*, February 1, 2016.

⁴⁶ 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).

⁴⁷ VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013.

⁴⁸ VHA Directive 0320.01, *Comprehensive Emergency Management Program Procedures*, April 6, 2017.

⁴⁹ TJC. EOC standard EC.02.05.07.

⁵⁰ 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.⁵¹ The provision of sustained electrical power during disasters or emergencies is critical to continued operations of a healthcare facility.

In all, the OIG team inspected six inpatient units (medical intensive care, Community Living Center (CLC)-Heinz 3B, 6W-Medicine, post-anesthesia care, 3CB-Inpatient Mental Health, and 5W-Surgical) in addition to the Emergency Department and the Oncology Outpatient Clinic. The team also inspected the Westmoreland County 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

⁵¹ 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

The OIG noted privacy measures were in place at the parent Facility and the representative CBOC. The OIG did not note any issues with either emergency management processes or availability of medical equipment and supplies. The OIG identified deficiencies in infection prevention, environmental cleanliness, and MH seclusion room safety that warranted recommendations for improvement.

Facility and CBOC Cleanliness and Maintenance

TJC requires hospitals to identify environmental deficiencies, hazards, and unsafe practices and to keep furnishings and equipment safe and in good repair.⁵² This ensures a clean and safe health care environment.

The OIG noted seven of eight patient care areas inspected at the parent Facility had dirty, dusty or rusty ventilation grills; dirty, dusty or damaged ceiling tiles; damaged or stained floor tiles; or wall damage.⁵³ Five areas had dirty or damaged light fixtures,⁵⁴ and two areas had dusty fire sprinklers.⁵⁵

Facility Management Service (FMS) and Environmental Management Service (EMS) managers stated that it became apparent while accompanying the OIG inspector on the EOC review inspections, that the reasons for noncompliance were that: (1) the FMS representative on the EOC Rounds Team lacked sufficient knowledge and training to properly identify EOC deficiencies, (2) EMS staff were not effectively communicating deficiencies identified during the

⁵² TJC. EOC standards EC.02.06.01 EP1, EP20, EP26; and EC.04.01.01 EP14.

⁵³ Medical intensive care, CLC-Heinz 3B, 3CB-MH, 6W-Medical, 5W-Surgical units; Oncology Outpatient Clinic; and the Emergency Department.

⁵⁴ Medical intensive care; CLC-Heinz 3B, 3CB-MH, 6W-Medical, and 5W-Surgical units; and the Emergency Department.

⁵⁵ Medical intensive care and 5W-Surgical units.

course of their regular duties to EMS supervisors, and (3) neither FMS nor EMS representatives for Facility EOC rounds were using Performance Logic checklists to ensure all service-level items were evaluated.

At the Westmoreland CBOC, the OIG inspected 16 rooms. The OIG found that six areas had cracked, dirty, or stained light fixture lens covers; seven areas had dirty, stained, or incorrectly sized ceiling tiles; and four rooms had dusty ventilation grills. The CBOC contracts for on-site EMS services, and FMS and EMS leaders reported that FMS and EMS representatives assigned to the facility's EOC Rounds Team were not effectively participating in the EOC Rounds Team and ensuring that patient care areas in the CBOC were clean and safe.

Recommendation 3

3. The Deputy Director ensures that a safe and clean environment is maintained throughout the Facility and Westmoreland County Community Based Outpatient Clinic and monitors compliance.

Facility concurred.

Target date for completion: July 30, 2019

Facility response:

- 1) By 8/31/18, all identified ventilation grills were cleaned, all damaged ceiling tiles were repaired, all dirty light fixtures were cleaned, and dusty fire sprinkler heads were cleaned in the parent facility.
- 2) Effective 10/29/18, the wall damage in the Emergency Department had been repaired.
- 3) The areas noted in the Oncology Clinic to be deficient are of a more complex nature and can only be corrected through a multi-phase project. It is anticipated this 6-month project will begin in January 2019.
- 4) In December 2018, plans are in the process for a vendor to present more resilient wall materials for patient rooms and corridors.
- 5) Effective 9/11/18, the facilities representative for EOC rounds is a maintenance mechanic with the appropriate knowledge to identify deficiencies.
- 6) Effective 11/2/18, the Chief of EMS, instructed the EMS staff to inform EMS supervisors of any environmental deficiencies in their assigned work areas. EMS supervisors will enforce this at staff meetings and on inspector rounds.
- 7) On 11/7/18, the EOC Specialist notified, in writing, all EOC team members to use Performance Logic checklists for all EOC rounds on campus and in CBOC's.
- 8) EOC Specialist to submit a compliance report to the Safety Committee for 4 months with the goal of 100% compliance in the use of Performance Logic checklists.
- 9) On 8/22/18, the CBOC contractor cleaned and/or replaced all cracked, dirty, or stained lens covers, replaced all dirty, stained or incorrectly sized ceiling tiles and cleaned all dirty ventilation grills.
- 10) On 11/7/18, EOC Specialist notified, in writing, EMS and FMS designees of responsibilities during EOC rounds and reinforced use of Performance Logic checklists.

Inpatient Mental Health Safety

VHA requires that inpatient rooms designated for seclusion be structured to prevent patient injury; this includes floors which must be made of material that provides cushioning.⁵⁶ The OIG found that the floors lacked any cushioning in two designated seclusion rooms on the 3CB-

⁵⁶ VA National Center for Patient Safety, *Mental Health Environment of Care Checklist (MHEOCC)*, December 8, 2016.

Inpatient Mental Health unit. This could result in harm to patients or staff in the event of a fall while in the seclusion room. The FMS Chief stated the design for the inpatient MH units was approved in early 2000 (prior to the requirement for cushioned floors in seclusion rooms), and the units were built as designed. Following the units' opening in 2012, other design issues were corrected to meet current standards, however, the seclusion room flooring was not corrected because the staff believed the installed flooring met requirements.

Recommendation 4

4. The Deputy Director ensures the flooring in the mental health seclusion rooms provides cushioning.

Facility concurred.

Target date for completion: July 1, 2019

Facility response:

- 1) On October 12, 2018 the FMS Chief, the FMS Program Management Officer and the Associate Chief Nurse for Inpatient Behavioral Health visited the university affiliate inpatient mental health hospital to discuss potential short and long-term solutions.
- 2) The FMS Chief and FMS Program Management Officer are currently developing a cost estimate and requesting funding for a project to replace seclusion room floors. Goal to award contract FY 19 Quarter 3.
- 3) Effective December 2018, monthly progress updates will be provided to Facility and VISN Leadership by FMS Leadership.
- 4) VAPHS policy is to continuously observe a Veteran placed in seclusion. If a Veteran inflicts self-harm through actions involving the floor and/or walls, the Veteran is placed into restraints for his/her safety. There have not been any reported injuries to Veterans while the seclusion rooms have been utilized.

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 team 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.dea.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 January 1, 2018, through June 30, 2018.

⁶² The review period was June 1, 2017, through May 31, 2018.

⁶³ The four quarters were from July 1, 2017, through June 30, 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 destruction⁶⁴
 - Accountability for all prescription pads in pharmacy

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.

- 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: 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 team reviewed relevant documents and interviewed key employees and managers. Additionally, the OIG reviewed the electronic health records (EHR) of 35 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, OIG staff reviewed relevant documents and interviewed key employees and managers. Additionally, the team reviewed the EHRs of 49 randomly selected patients who received a GE from July 1, 2016, through June 30, 2017. The OIG evaluated the following performance indicators:

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

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

⁷⁰ VHA Directive 1140.04.

⁷¹ Chad Boulton, Lisa B. Boulton, 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.

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

Conclusion

The OIG noted compliance with provision or access to geriatric evaluation, program oversight and evaluation, provider and social worker evaluations, patient education, development of plan of care, and implementation of interventions in plan of care when indicated. Although the OIG found inconsistent GE nurse assessments, the OIG made no recommendation due to the change in the interdisciplinary core team member requirement with the revision of VHA Handbook 1140.04.

Women's Health: Mammography Results and Follow-up

In 2017, an estimated 252,710 new cases of invasive breast cancer and 40,610 breast cancer deaths were expected to occur among US women.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 team examined whether the Facility complied with selected VHA requirements for the reporting of mammography results by reviewing relevant documents and interviewing selected employees and managers. The team also reviewed the EHRs of 47 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 Facility met requirements with the above performance indicators. The OIG made no recommendations.

High-risk Processes: Central Line-associated Bloodstream Infections

TJC requires facilities to establish systematic infection prevention and control programs to reduce the risk of acquiring and transmitting infections.⁷⁹ 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,”⁸⁰ 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.⁸¹

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.”⁸²

Infections occurring on or after the third calendar day following admission to an inpatient location are considered “healthcare-associated.”⁸³ 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.⁸⁴

The OIG’s review of these issues examined whether the Facility established and maintained programs to reduce the incidence of healthcare-associated bloodstream infections in intensive care unit patients with indwelling central lines. In addition to conducting manager and staff interviews, the OIG team reviewed committee minutes, the Infection Prevention/Control Risk Assessment, and other relevant documents. The team also reviewed the training records of 29 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

⁷⁹ TJC. Infection Prevention and Control standard IC.01.03.01.

⁸⁰ Association for Professionals in Infection Control and Epidemiology, *Guide to Preventing Central Line-Associated Bloodstream Infections*, 2015.

⁸¹ These are vessels that enter and leave the heart—superior and inferior vena cava, pulmonary artery, pulmonary vein, aorta.

⁸² The Centers for Disease Control and Prevention, *Guidelines for the Prevention of Intravascular Catheter-Related Infections*, 2011.

⁸³ 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.

⁸⁴ 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	<ul style="list-style-type: none"> • 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 	Four OIG recommendations, ranging from documentation issues to deficiencies that can lead to patient and staff safety issues or adverse events, are attributable to the Deputy Director and Chief of Staff. See details below.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	<ul style="list-style-type: none"> • Protected peer review of clinical care • UM reviews • Patient safety incident reporting and RCAs 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • None
Credentialing and Privileging	<ul style="list-style-type: none"> • Medical licenses • Privileges • FPPEs • OPPEs 	<ul style="list-style-type: none"> • The Medical Executive Board uses the results of FPPEs in the decision to recommend continuation of initially granted privileges. 	<ul style="list-style-type: none"> • OPPEs are complete and include minimum required specialty criteria.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
<p>Environment of Care</p>	<ul style="list-style-type: none"> • Parent Facility <ul style="list-style-type: none"> ○ EOC rounds and deficiency tracking ○ Infection prevention ○ General safety ○ Environmental cleanliness ○ General and exam room privacy ○ Availability of medical equipment and supplies • CBOC <ul style="list-style-type: none"> ○ General safety ○ Medication safety and security ○ Infection prevention ○ Environmental cleanliness ○ General and exam room privacy ○ Availability of medical equipment and supplies • Locked MH Unit <ul style="list-style-type: none"> ○ 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 <ul style="list-style-type: none"> ○ Hazard Vulnerability Analysis (HVA) ○ Emergency Operations Plan (EOP) ○ Emergency power testing and availability 	<ul style="list-style-type: none"> • Flooring provides cushioning in MH seclusion rooms. 	<ul style="list-style-type: none"> • A safe and clean environment is maintained throughout the Facility and Westmoreland County CBOC.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Medication Management	<ul style="list-style-type: none"> • 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 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • None
Mental Health: Posttraumatic Stress Disorder Care	<ul style="list-style-type: none"> • Suicide risk assessment • Offer of further diagnostic evaluation • Referral for diagnostic evaluation • Completion of diagnostic evaluation 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • None
Long-term Care: Geriatric Evaluations	<ul style="list-style-type: none"> • Provision of or access to geriatric evaluation • Program oversight and evaluation requirements • Geriatric evaluation requirements • Geriatric management requirements 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • None
Women's Health: Mammography Results and Follow-up	<ul style="list-style-type: none"> • Result linking • Report scanning and content • Communication of results and recommended actions • Follow-up mammograms and studies 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • None
High-risk Processes: Central Line-associated Bloodstream Infections	<ul style="list-style-type: none"> • Policy and infection prevention risk assessment • Committee discussion • Infection incidence data 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • None

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
	<ul style="list-style-type: none"> • 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 highest complexity (1a)⁸⁵ affiliated⁸⁶ Facility reporting to VISN 4.

**Table 7. Facility Profile for Pittsburgh (646)
(October 1, 2014, through September 30, 2017)**

Profile Element	Facility Data FY 2015 ⁸⁷	Facility Data FY 2016 ⁸⁸	Facility Data FY 2017 ⁸⁹
Total Medical Care Budget in Millions	\$619.1	\$655.1	\$650.4
Number of:			
• Unique Patients	70,462	72,022	73,068
• Outpatient Visits	706,270	718,953	713,019
• Unique Employees ⁹⁰	2,944	2,987	3,039
Type and Number of Operating Beds:			
• Community Living Center	225	225	225
• Domiciliary	88	88	88
• Medicine	87	87	87
• Mental Health	78	78	78
• Residential Rehabilitation	12	12	12
• Surgery	59	59	59
Average Daily Census:			
• Community Living Center	166	173	200
• Domiciliary	73	71	72
• Medicine	67	72	77

⁸⁵ The VHA medical centers are classified according to a facility complexity model; 1a designation indicates a Facility with high volume, high risk patients, most complex clinical programs, and large research and teaching programs.

⁸⁶ Associated with a medical residency program.

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

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

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

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

Profile Element	Facility Data FY 2015⁸⁷	Facility Data FY 2016⁸⁸	Facility Data FY 2017⁸⁹
• Mental Health	63	59	67
• Residential Rehabilitation	9	10	9
• Surgery	33	34	34

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 Profiles⁹¹

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/Encounters⁹² and Specialty Care, Diagnostic, and Ancillary Services Provided (October 1, 2016, through September 30, 2017)

Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services ⁹³ Provided	Diagnostic Services ⁹⁴ Provided	Ancillary Services ⁹⁵ Provided
St. Clairsville, OH	646GA	8,725	2,525	Cardiology Dermatology Endocrinology Nephrology Rheumatology Podiatry	n/a	Weight Management Nutrition

⁹¹ Includes all outpatient clinics in the community that were in operation as of February 15, 2018.

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

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

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

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

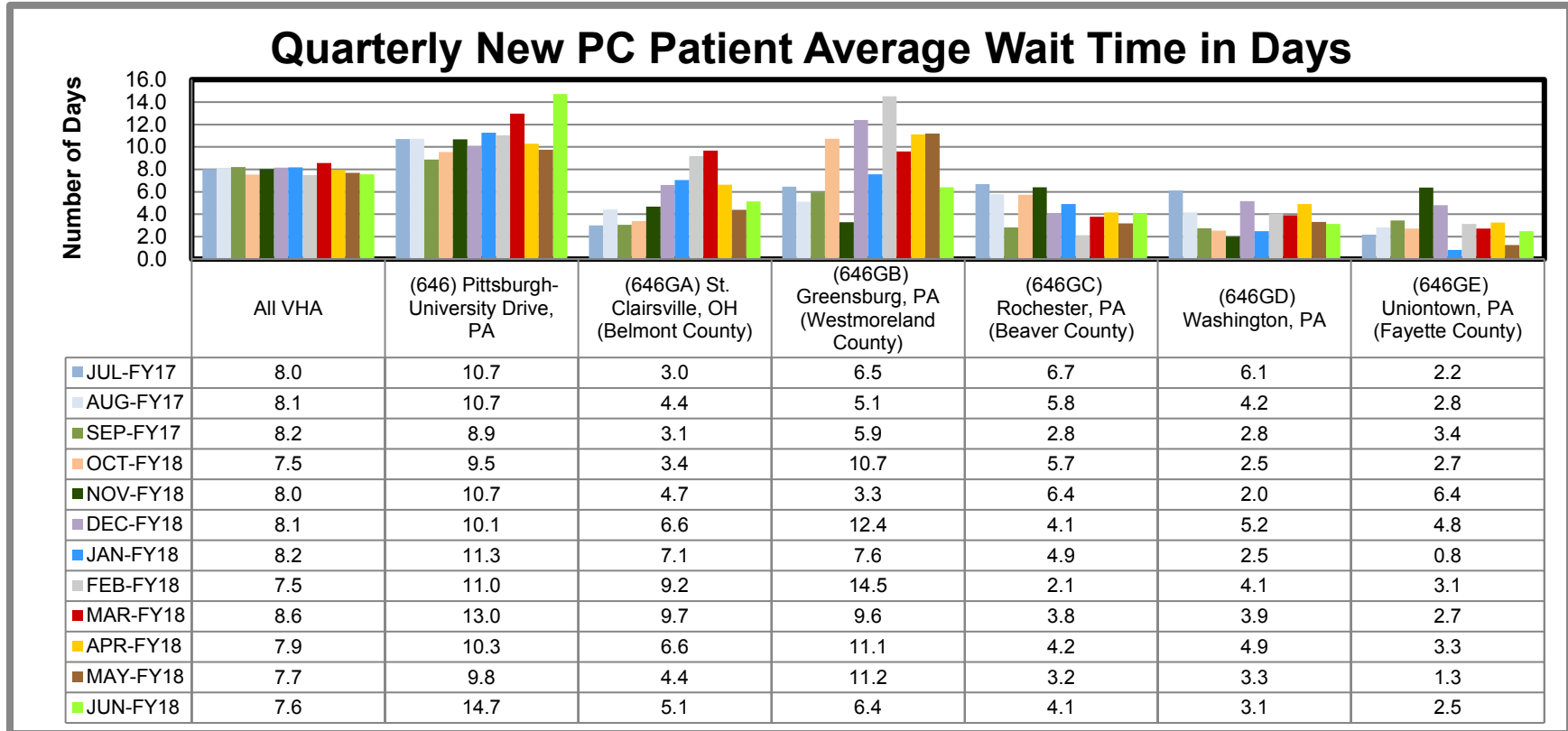
Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services ⁹³ Provided	Diagnostic Services ⁹⁴ Provided	Ancillary Services ⁹⁵ Provided
Greensburg, PA	646GB	11,558	2,092	Dermatology Endocrinology Nephrology Rheumatology Podiatry	n/a	Weight Management Nutrition
Rochester, PA	646GC	8,834	2,502	Cardiology Dermatology Endocrinology Gastroenterology Nephrology Rheumatology Podiatry	n/a	Weight Management Nutrition
Washington, PA	646GD	10,057	1,972	Dermatology Endocrinology Nephrology Podiatry	n/a	Weight Management
Uniontown, PA	646GE	8,971	1,890	Dermatology Endocrinology Nephrology Rheumatology Podiatry	n/a	Weight Management

Source: VHA Support Service Center and VA Corporate Data Warehouse

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

n/a = not applicable

Appendix C: Patient Aligned Care Team Compass Metrics⁹⁶



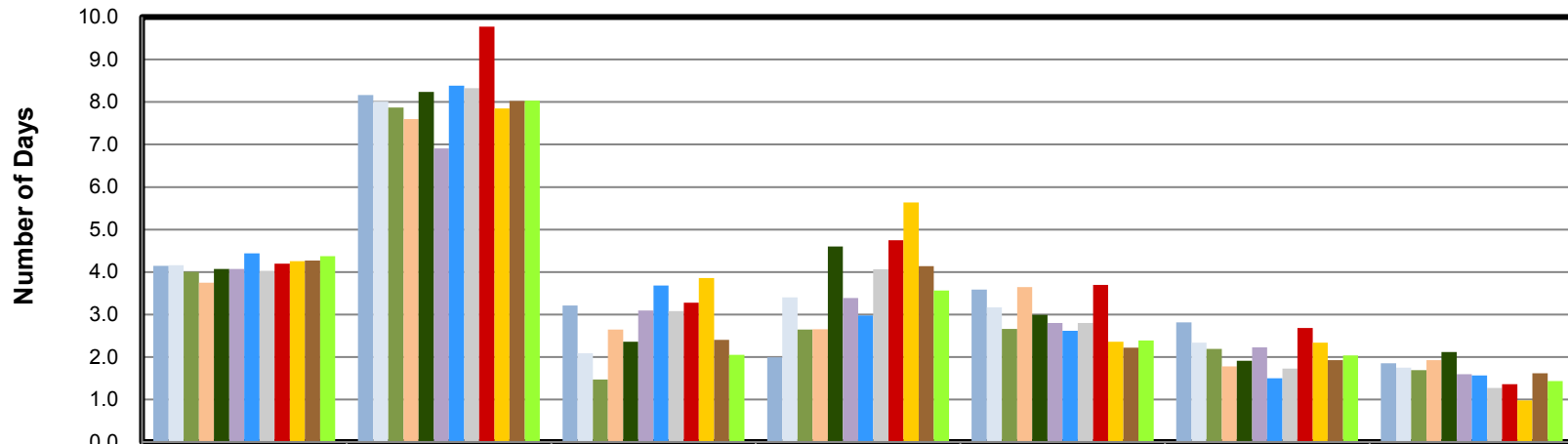
Source: VHA Support Service Center

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

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

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

Quarterly Established PC Patient Average Wait Time in Days



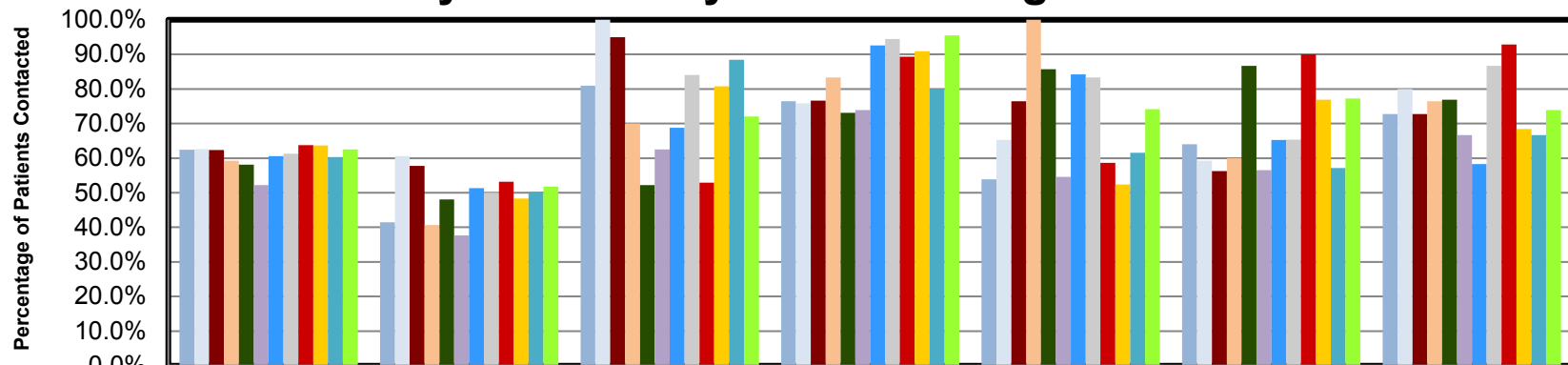
	All VHA	(646) Pittsburgh-University Drive, PA	(646GA) St. Clairsville, OH (Belmont County)	(646GB) Greensburg, PA (Westmoreland County)	(646GC) Rochester, PA (Beaver County)	(646GD) Washington, PA	(646GE) Uniontown, PA (Fayette County)
JUL-FY17	4.1	8.2	3.2	2.0	3.6	2.8	1.9
AUG-FY17	4.2	8.0	2.1	3.4	3.2	2.3	1.7
SEP-FY17	4.0	7.9	1.5	2.6	2.7	2.2	1.7
OCT-FY18	3.7	7.6	2.6	2.7	3.6	1.8	1.9
NOV-FY18	4.1	8.2	2.4	4.6	3.0	1.9	2.1
DEC-FY18	4.1	6.9	3.1	3.4	2.8	2.2	1.6
JAN-FY18	4.4	8.4	3.7	3.0	2.6	1.5	1.6
FEB-FY18	4.0	8.3	3.1	4.1	2.8	1.7	1.3
MAR-FY18	4.2	9.8	3.3	4.7	3.7	2.7	1.4
APR-FY18	4.3	7.8	3.9	5.6	2.4	2.3	1.0
MAY-FY18	4.3	8.0	2.4	4.1	2.2	1.9	1.6
JUN-FY18	4.4	8.0	2.0	3.6	2.4	2.0	1.4

Source: VHA Support Service Center

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

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

Quarterly Team 2-Day Post Discharge Contact Ratio



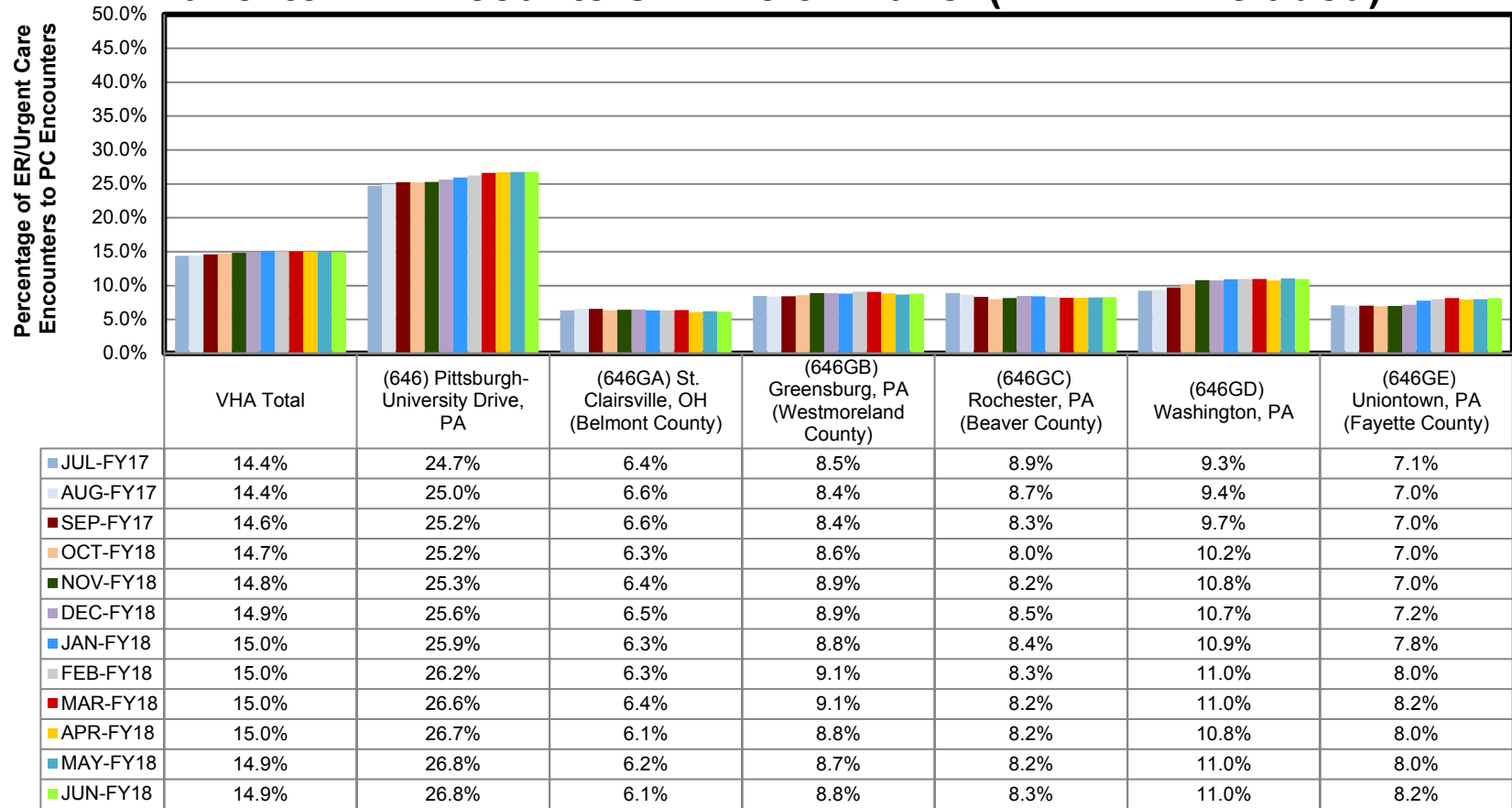
	VHA Total	(646) Pittsburgh-University Drive, PA	(646GA) St. Clairsville, OH (Belmont County)	(646GB) Greensburg, PA (Westmoreland County)	(646GC) Rochester, PA (Beaver County)	(646GD) Washington, PA	(646GE) Uniontown, PA (Fayette County)
JUL-FY17	62.4%	41.5%	81.0%	76.5%	53.8%	64.0%	72.7%
AUG-FY17	62.6%	60.6%	100.0%	75.9%	65.2%	59.3%	80.0%
SEP-FY17	62.3%	57.7%	95.0%	76.7%	76.5%	56.3%	72.7%
OCT-FY18	59.2%	40.7%	70.0%	83.3%	100.0%	60.0%	76.5%
NOV-FY18	58.1%	48.1%	52.2%	73.1%	85.7%	86.7%	76.9%
DEC-FY18	52.3%	37.7%	62.5%	73.9%	54.5%	56.5%	66.7%
JAN-FY18	60.6%	51.4%	68.8%	92.6%	84.2%	65.2%	58.3%
FEB-FY18	61.3%	50.0%	84.0%	94.4%	83.3%	65.4%	86.7%
MAR-FY18	63.8%	53.1%	52.9%	89.3%	58.6%	90.0%	92.9%
APR-FY18	63.6%	48.3%	80.8%	90.9%	52.4%	76.9%	68.4%
MAY-FY18	60.3%	50.2%	88.5%	80.0%	61.5%	57.1%	66.7%
JUN-FY18	62.5%	51.7%	72.0%	95.5%	74.2%	77.3%	73.9%

Source: VHA Support Service Center

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

Data Definition: The percent of assigned PC patients discharged from any VA facility who have been contacted by a PC team member within 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.”

Quarterly Ratio of ER/Urgent Care Encounters While on Panel to PC Encounters While on Panel (FEE ER Excluded)



Source: VHA Support Service Center

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

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

Appendix D: Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions⁹⁷

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

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

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

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

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

Source: VHA Support Service Center

Appendix E: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: November 9, 2018

From: Director, VA Healthcare – VISN 4 (10N4)

Subj: CHIP Review of the VA Pittsburgh Healthcare System, PA

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

Director, GAO/OIG Accountability Liaison (VHA 10E1D MRS Action)

I have reviewed the responses provided by the VA Pittsburgh Healthcare System, Pittsburgh, PA. I am submitting to your office as requested. I concur with their responses.

(Original signed by:)

Michael D. Adleman, M.D.

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: November 8, 2018

From: Medical Center Director, VA Pittsburgh Healthcare System (646/00)

Subj: CHIP Review of the VA Pittsburgh Healthcare System

To: Director, VA Healthcare – VISN 4 (10N4)

1. The findings from the VA Pittsburgh Healthcare System Comprehensive Healthcare Inspection Program (CHIP) reviewed by the Office of the Inspector General (OIG) conducted July 30, through August 3, 2018 have been reviewed.
2. Attached are the facility responses addressing each recommendation, including actions that are in progress and those that have already been completed.

(Original signed by:)

Barbara L. Forsha, Deputy Director, for Karin L. McGraw

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	Rhonda Omslaer JD, BSN, Team Leader Charles Cook, MHA Andrea Der, MSN, RN Elizabeth Whidden, MS, ARNP Michelle Wilt, MBA, BSN Valerie Zaleski, RN, BSN
--------------------	---

Other Contributors	Limin Clegg, PhD Justin Hanlon, BS Henry Harvey, MS LaFonda Henry, MSN, RN-BC Yoonhee Kim, PharmD Scott McGrath, BS Larry Ross, Jr., MS Marilyn Stones, BS April Terenzi, BA, BS Carol Torczon, MSN, ACNP 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, VA Healthcare – VISN 4 (10N4)
Director, VA Pittsburgh Healthcare System (646/00)

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: Sherrod Brown, Bob Casey, Joe Manchin, Shelly Moore-Capito, Rob Portman, Pat Toomey
U.S. House of Representatives: Mike Doyle, Bill Johnson, David Joyce, Mike Kelly, Conor Lamb, David McKinley, Keith Rothfus, Tim Ryan, Bill Shuster, Glenn W. Thompson

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