



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare
Inspection Program Review
of the VA New Jersey Health
Care System

East Orange, New Jersey



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Figure 1. VA New Jersey Health Care System, East Orange, New Jersey
(Source: <https://vaww.va.gov/directory/guide/>, accessed on October 11, 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
VANJHCS	VA New Jersey Health Care System
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 New Jersey Health Care 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 August 27, 2018. The OIG conducted interviews and reviewed clinical and administrative processes related to areas of focus that affect patient care outcomes. Although the OIG reviewed a spectrum of clinical and administrative processes, the sheer complexity of VA medical centers limits the ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of Facility performance within the identified focus areas at the time of the OIG visit. Although it is difficult to quantify the risk of patient harm, the findings in this report may help facilities identify areas of vulnerability or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Results and Review Impact

Leadership and Organizational Risks

At the Facility, the leadership team consists of the Director, Chief of Staff, Associate Director for Patient Care Services (ADPCS), Associate Director–East Orange Campus, and Associate

Director–Lyons Campus. Organizational communication and accountability are carried out through a committee reporting structure, with a Quality Executive Council having oversight for groups such as the Executive Committee Medical Staff, Environment of Care Steering Council, and Compliance Committee. The leaders are members of the Quality Executive Council through which they track, trend, and monitor quality of care and patient outcomes.

The leaders have worked together as a team since February 2017, the appointment date of the Chief of Staff. The Director assumed the role in January 2017. The Associate Director–East Orange Campus and Associate Director–Lyons Campus were assigned in July 2016 and March 2013, respectively. It is noteworthy that the ADPCS has been in the position since May 1989.

In the review of selected employee satisfaction survey results regarding Facility leaders, the OIG noted employees appear generally satisfied with Facility leaders. In the review of selected patient experience survey results regarding Facility leaders, the OIG noted that patients appear generally satisfied with the leadership and care provided, and facility leaders appeared to be actively engaged with patients.

The OIG recognizes that the Strategic Analytics for Improvement and Learning (SAIL) model has limitations for identifying all areas of clinical risk but is “a way to understand the similarities and differences between the top and bottom performers” within VHA.¹ Although the leadership team was knowledgeable about selected SAIL metrics, the leaders should continue to take actions to improve performance of the Quality of Care and Efficiency metrics likely contributing to the drop from its previous “3-Star” to the current “2-Star” rating.

Additionally, the OIG reviewed accreditation agency findings, sentinel events,² disclosures of adverse patient events, and Patient Safety Indicator data and identified organizational risk factors that may contribute to future issues of noncompliance and/or lapses in patient safety unless corrective processes are implemented and continuously monitored.

The OIG noted findings in three of the eight areas of clinical operations reviewed and issued six recommendations that are attributable to the Director, Chief of Staff, and Associate Director–Lyons Campus. 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 the credentialing process. However, the OIG identified deficiencies in the Focused and Ongoing Professional Practice Evaluation processes.

Environment of Care

Privacy measures were in place at the Facility's East Orange and Lyons campuses. The OIG did not note any issues with the availability of medical equipment and supplies, and the Emergency Management program met all requirements. However, the OIG identified deficiencies with medical equipment storage and response time to panic alarms.

Medication Management: Controlled Substances Inspection Program

Generally, the Facility met requirements for Controlled Substance (CS) Coordinators and CS Inspectors, CS and Pharmacy area inspections, and staff restrictions for balance adjustments. However, the OIG found a deficiency for follow up of annual physical security survey findings.

Summary

In the review of key care processes, the OIG issued six recommendations that are attributable to the Director, Chief of Staff, and Associate Director—Lyons Campus. 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 61–62, 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.



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Purpose and Scope

Purpose

This Comprehensive Healthcare Inspection Program (CHIP) review was conducted to provide a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the VA New Jersey Health Care 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

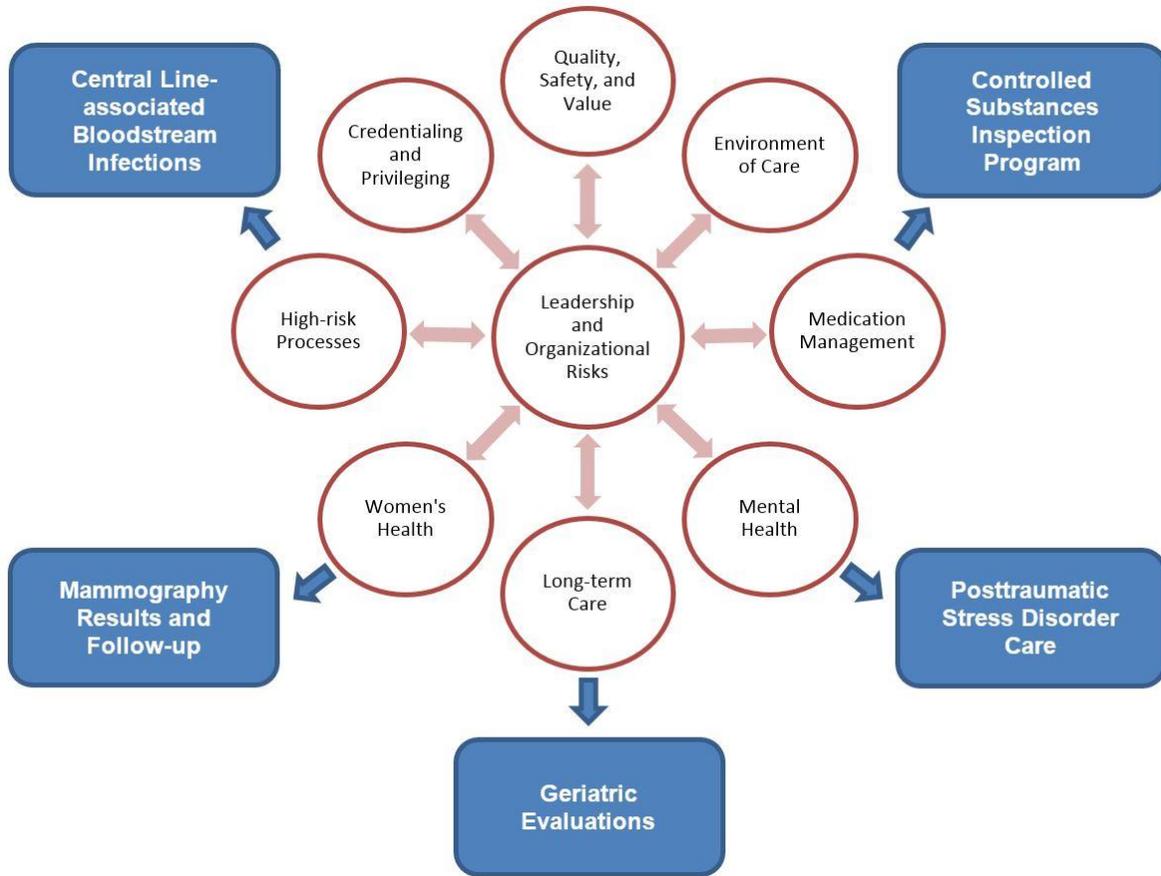
³ Carol Stephenson, “The role of leadership in managing risk,” *Ivey Business Journal*, November/December 2010. <https://iveybusinessjournal.com/publication/the-role-of-leadership-in-managing-risk/>. (Website accessed on March 1, 2018.)

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 July 20, 2015,⁸ through August 27, 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.

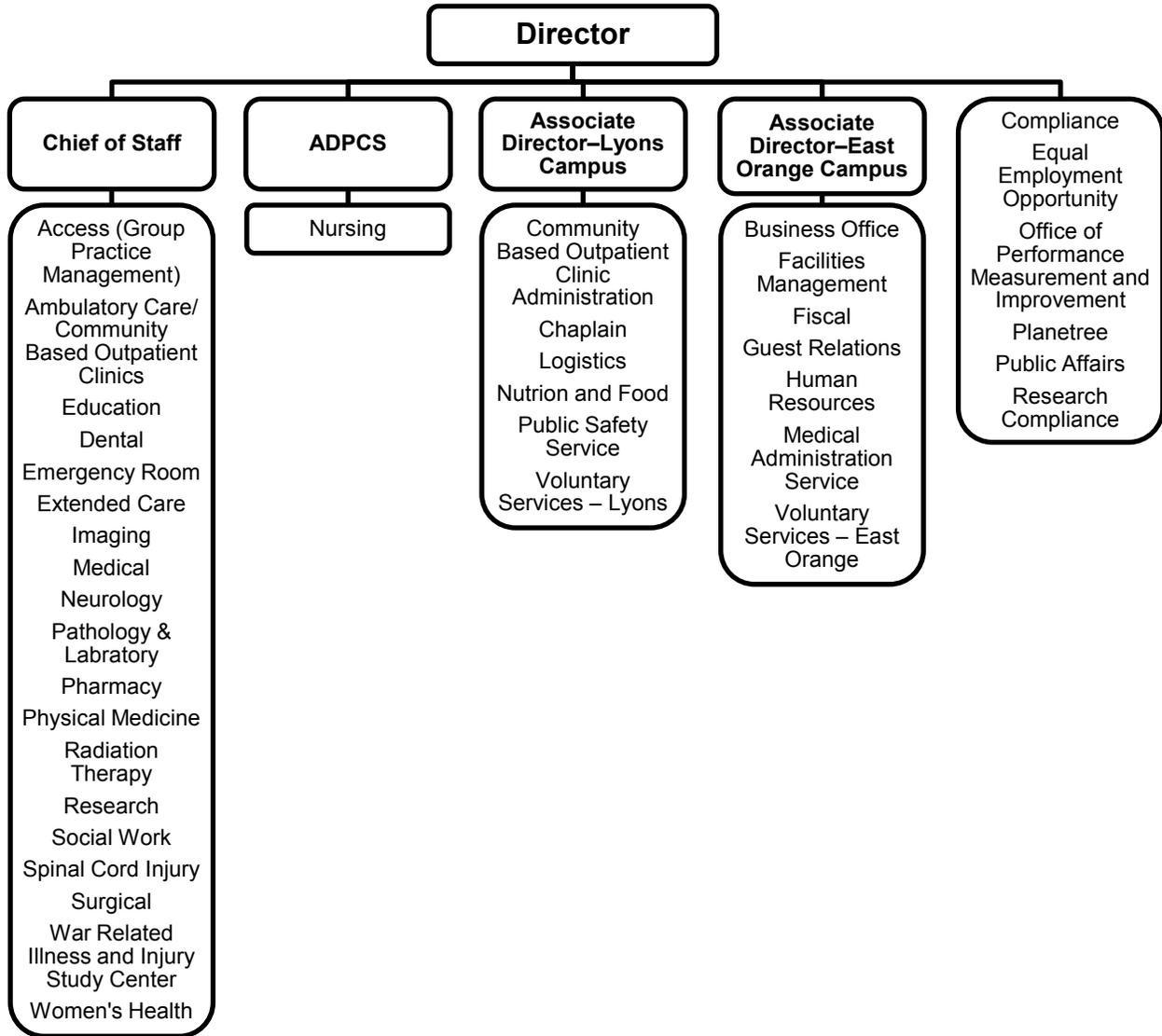
Executive Leadership Stability and Engagement

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, Chief of Staff, and Associate Director for Patient Care Services (ADPCS), Associate Director–East Orange Campus, and Associate Director–Lyons Campus. The Chief of Staff and ADPCS are responsible for overseeing patient care and service directors, as well as program and practice chiefs.

The leaders have worked together as a team since February 2017, the appointment date of the Chief of Staff. The Director assumed the role in January 2017. The Associate Director–East Orange Campus and Associate Director–Lyons Campus were assigned in July 2016 and March 2013, respectively. It is noteworthy that the ADPCS has been in the position since May 1989.

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



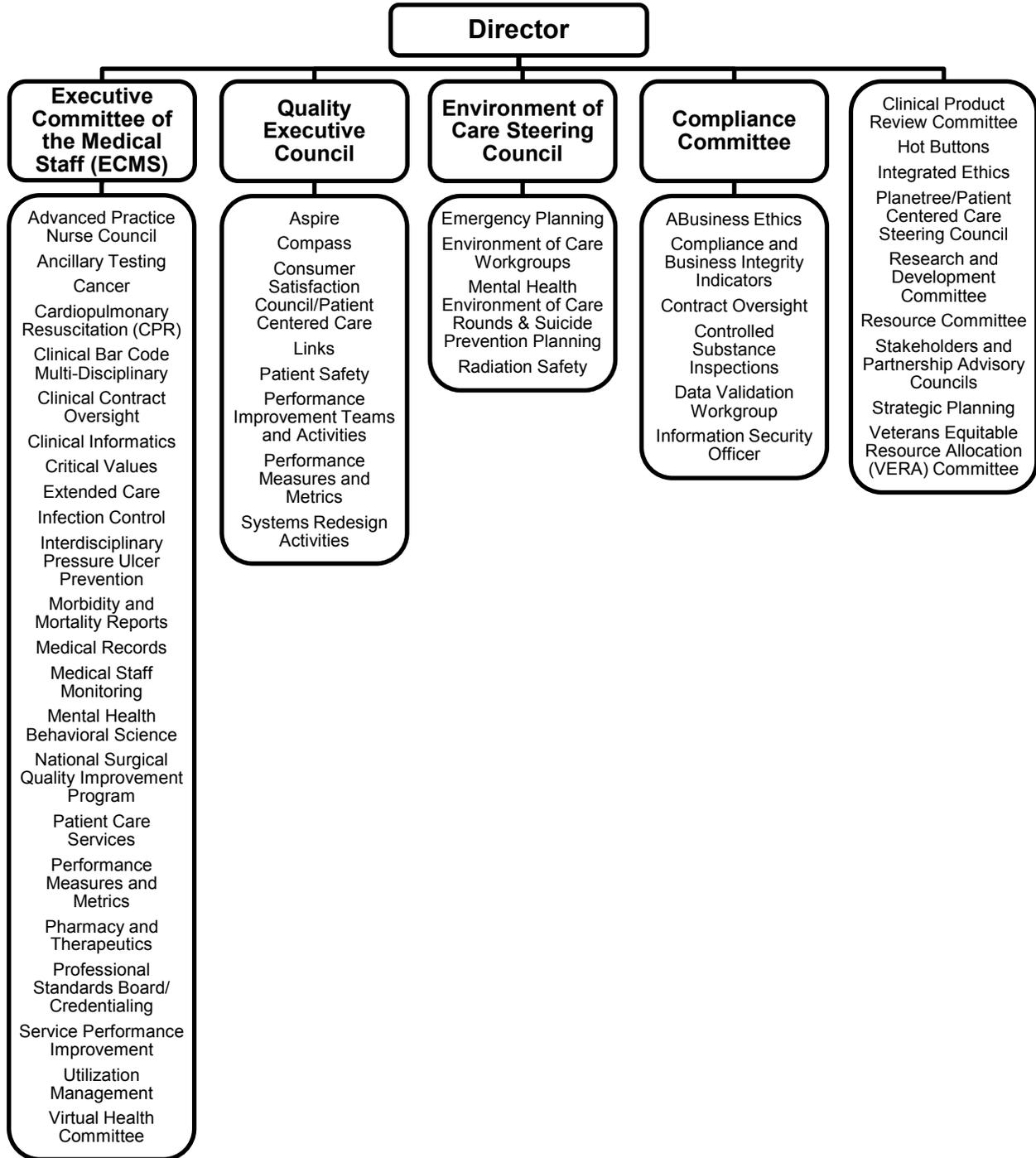
Source: VA New Jersey Health Care System (received August 27, 2018)

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

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

The leaders are also engaged in monitoring patient safety and care through formal mechanisms. They are members of the Facility's Quality Executive Council, which tracks, trends, and monitors quality of care and patient outcomes. The Director serves as the chairperson with the authority and responsibility to establish policy, maintain quality care standards, and perform organizational management and strategic planning. The Director also oversees various working groups, such as the Executive Committee of the Medical Staff (ECMS), Environment of Care Steering Council, and Compliance Committee. See Figure 4.

Figure 4. Facility Committee Reporting Structure



Source: VA New Jersey Health Care System (August 27, 2018)

Employee Satisfaction and Patient Experience

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

To assess employee 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 the VHA average.¹² The averages for the members of the executive leadership team were above 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	Chief of Staff Average	ADPCS Average	Assoc. Directors Average
All Employee Survey: <i>Servant Leader Index Composite</i>	0–100 where HIGHER scores are more favorable	67.7	66.6	80.2	78.3	83.3	86.1
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	3.4	4.3	3.9	3.7	4.0

Source: VA All Employee Survey (accessed July 27, 2018)

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

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 Facility averages for the selected survey questions were similar to the VHA average. The averages for the Facility leaders were above the VHA and Facility averages.

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

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Directors 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	3.7	4.1	4.3	4.3	4.4
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	4.2	4.6	4.3	4.4
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	3.8	4.4	4.5	4.3	4.5

Source: VA All Employee Survey (accessed July 27, 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 results that reflect patient attitudes towards facility leaders (see Table 3). For this Facility, three of four patient survey results reflected higher care ratings than the VHA average. Patients appear generally satisfied with the leadership and care provided, and facility leaders appeared to be actively engaged with patients.

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

Questions	Scoring	VHA Average	Facility Average
Survey of Healthcare Experiences of Patients (inpatient): <i>Would you recommend this hospital to your friends and family?</i>	The response average is the percent of “Definitely Yes” responses.	66.7	60.3
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	84.7
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	78.4
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	79.4

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 inspections of the Facility's Community Living Center,¹⁸ and the Paralyzed Veterans of America conducted an inspection of the Facility's spinal cord injury/disease unit and related services.¹⁹

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.

¹⁹ The Paralyzed Veterans of America inspection took place January 10, 2017. This Veteran Service Organization review does not result in accreditation status.

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 New Jersey Health Care System, East Orange, New Jersey, September 30, 2015</i>)	July 2015	16	0
OIG (<i>Review of Community Based Outpatient Clinics and Other Outpatient Clinics of VA New Jersey Health Care System, East Orange, New Jersey, October 21, 2015</i>)	August 2015	14	0
TJC	May 2018		
• Hospital Accreditation		42	0
• Behavioral Health Care Accreditation		5	0
• Home Care Accreditation		1	0

Sources: OIG and TJC (Inspection/survey results verified with the Director on August 28, 2018.)

Indicators for Possible Lapses in Care

Within the healthcare field, the primary organizational risk is the potential for patient harm. Many factors impact the risk for patient harm within a system, including unsafe environmental conditions, sterile processing deficiencies, and infection control practices. Leaders must be able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms. Table 5 summarizes key indicators of risk since the OIG’s previous July 2015 Combined Assessment Program review inspection through the week of August 27, 2018.²⁰

²⁰ It is difficult to quantify an acceptable number of occurrences because one occurrence is one too many. Efforts should focus on prevention. Sentinel events and those that lead to disclosure can occur in either inpatient or outpatient settings and should be viewed within the context of the complexity of the Facility. (Note that the VA New Jersey Health Care System is a mid-high complexity (1c) affiliated Facility as described in Appendix B.)

**Table 5. Summary of Selected Organizational Risk Factors
 (July 2015 to August 27, 2018)**

Factor	Number of Occurrences
Sentinel Events ²¹	13
Institutional Disclosures ²²	9
Large-Scale Disclosures ²³	0

*Source: VA New Jersey Health Care System’s Patient Safety Manager
 (received August 27, 2018)*

The OIG also reviewed Patient Safety Indicators developed by the Agency for Healthcare Research and Quality within the U.S. Department of Health and Human Services. These provide information on potential in-hospital complications and adverse events following surgeries and procedures.²⁴ The rates presented are specifically applicable for this Facility, and lower rates indicate lower risks. Table 6 summarizes Patient Safety Indicator data from April 1, 2016, through March 31, 2018.

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

²² Institutional disclosure of adverse events (sometimes referred to as “administrative disclosure”) is a formal process by which facility leaders together with clinicians and others, as appropriate, inform the patient or his or her personal representative that an adverse event has occurred during care that resulted in, or is reasonably expected to result in, death or serious injury, and provide specific information about the patient’s rights and recourse.

²³ Large-scale disclosure of adverse events (sometimes referred to as “notification”) is a formal process by which VHA officials assist with coordinating the notification to multiple patients (or their personal representatives) that they may have been affected by an adverse event resulting from a systems issue.

²⁴ Agency for Healthcare Research and Quality. <https://www.qualityindicators.ahrq.gov/>. (Website accessed on March 8, 2017.)

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

Measure	Reported Rate per 1,000 Hospital Discharges		
	VHA	VISN 2	Facility
Death among surgical inpatients with serious treatable conditions	113.92	115.88	150.00
Iatrogenic pneumothorax	0.17	0.25	0.00
Central venous catheter-related bloodstream infection	0.15	0.08	0.00
In-hospital fall with hip fracture	0.08	0.13	0.00
Perioperative hemorrhage or hematoma	2.62	2.85	0.00
Postoperative acute kidney injury requiring dialysis	0.65	0.88	6.78
Postoperative respiratory failure	5.11	6.04	12.66
Perioperative pulmonary embolism or deep vein thrombosis	3.09	3.45	1.73
Postoperative sepsis	3.72	3.20	3.69
Postoperative wound dehiscence	1.00	0.38	0.00
Unrecognized abdominopelvic accidental puncture/laceration	1.02	1.72	1.46

Source: VHA Support Service Center

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

Five Patient Safety Indicator measures (death among surgical inpatients with serious treatable conditions, postoperative acute kidney injury requiring dialysis, postoperative respiratory failure, postoperative sepsis, and unrecognized abdominopelvic accidental puncture/laceration) show a higher observed rate than Veterans Integrated Service Network (VISN) 2 and/or VHA. OIG noted that all the cases were reviewed.

There were three deaths among surgical inpatients with serious treatable conditions. All three cases were reviewed during Surgical Morbidity and Mortality meetings as well as through the Root Cause Analysis (RCA) process. Care was found to be appropriate, and no improvement actions were identified.

Two patients developed postoperative complications with acute kidney injury requiring dialysis. Both patients had co-morbid conditions prior to complex surgeries. After review of the patients' care, it was determined that the complications were appropriately managed, and treatments were performed in a timely fashion.

Three patients developed postoperative respiratory failure. One patient had significant preexisting chronic lung disease; and two patients had comorbid medical conditions placing them

at high risk for complications. Peer reviews found that the standards of care were met, and the postoperative complications present in all three cases were not preventable.

One patient had postoperative sepsis. The case was reviewed at the Surgical Morbidity and Mortality conference, and care was found to be appropriate.

One patient developed unrecognized abdominopelvic accidental puncture/laceration resulting from gastrointestinal surgical complications. The patient developed complications with gastrointestinal bleeding and was taken immediately back to the operating room. The bleeding was stopped, and repair was successful. Care was found to be appropriate, and no improvement actions were identified.

Veterans Health Administration Performance Data

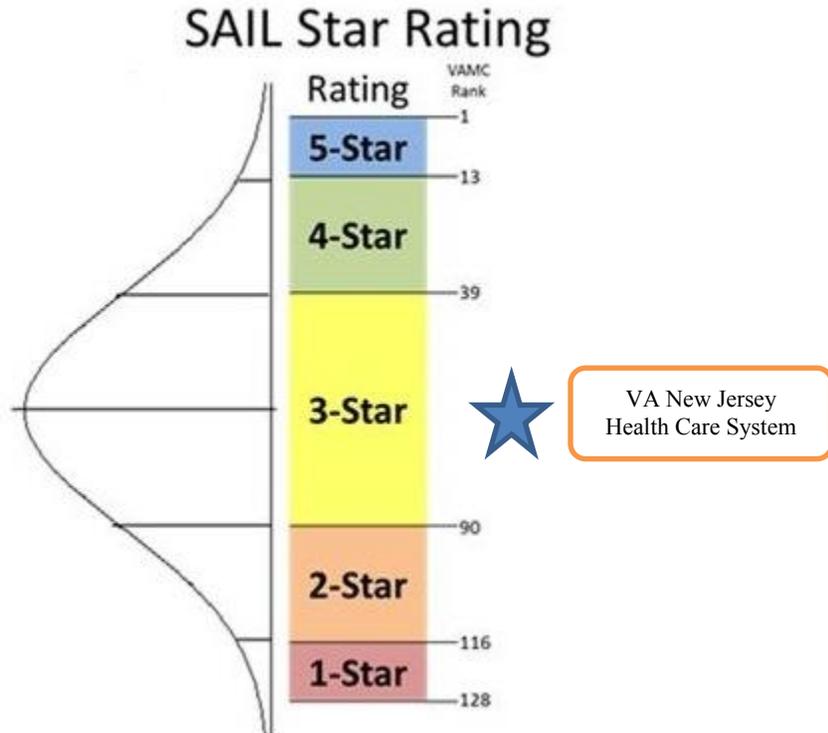
The VA Office of Operational Analytics and Reporting adapted the SAIL Value Model to help define performance expectations within VA. This model includes measures on healthcare quality, employee satisfaction, access to care, and efficiency, but has noted limitations for identifying all areas of clinical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

VA also uses a star-rating system where facilities with a “5-Star” rating are performing within the top 10 percent of facilities and “1-Star” facilities are performing within the bottom 10 percent of facilities. Figure 5 describes the distribution of facilities by star rating.²⁶ As of June 30, 2017, the Facility was rated at “3-Star” for overall quality. Updated data as of June 30, 2018, indicates that the Facility has declined to “2-Star” for overall quality.

²⁵ VHA Support Service Center (VSSC), The Strategic Analytics for Improvement and Learning (SAIL) Value Model, <http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=2146>. (Website accessed on April 16, 2017.)

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

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

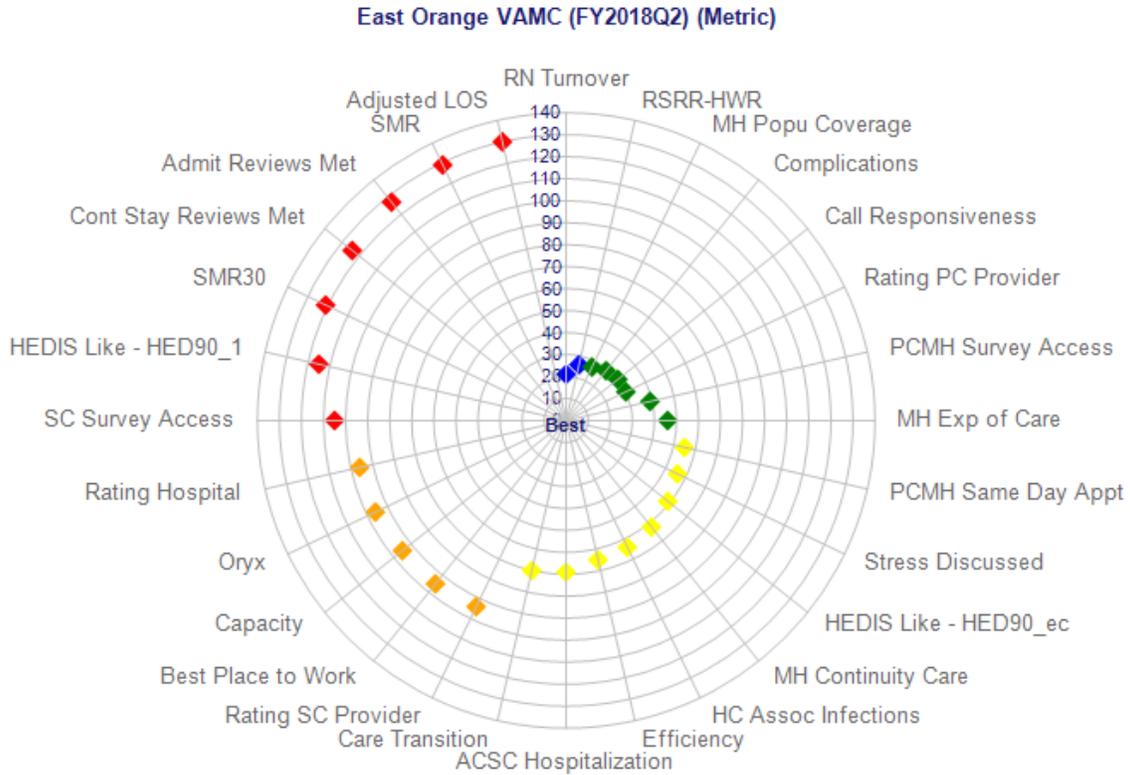


Source: VA Office of Informatics and Analytics Office of Operational Analytics and Reporting (accessed July 27, 2018)

Figure 6 illustrates the Facility’s Quality of Care and Efficiency metric rankings and performance compared with other VA facilities as of March 31, 2018. Of note, Figure 6 uses blue and green data points to indicate high performance (for example in the areas of Registered Nurse (RN) Turnover, Complications, Call Responsiveness, and Rating (of) Primary Care (PC) Provider).²⁷ Metrics that need improvement are denoted in orange and red (for example, Best Place to Work, Rating (of) Hospital, Standardized Mortality Rate (SMR), and Adjusted Length of Stay (LOS)).

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 March 31, 2018)**



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 Facility leaders have worked together as a team since February 28, 2017. The OIG noted that Facility leaders appeared 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 sentinel events, disclosures, and Patient Safety Indicator data, may contribute to future issues of noncompliance and/or lapses in patient safety unless corrective processes are implemented and continuously monitored. Although the leadership team was knowledgeable about selected SAIL metrics, the leaders should continue to take actions to improve care and performance of poorly

performing Quality of Care and Efficiency metrics that are likely contributing to the Facility's drop from its previous "3-Star" rating to the current "2-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 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 expected that all previous patient safety event reporting systems will have been 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 21 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 27, 2016, through August 27, 2018.

⁴¹ The 12-month review period was from August 28, 2017, through August 27, 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 the credentialing process. However, the OIG identified deficiencies in the Focused and Ongoing Professional Practice Evaluation processes.

Focused Professional Practice Evaluations

VHA requires that all LIPs new to the facility have FPPEs completed and documented in the practitioner's provider profile and reported to an appropriate committee of the Medical Staff. The process uses objective criteria and involves the evaluation of privilege-specific competence of the practitioner who has not had 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.⁴²

The OIG found that 9 of 10 FPPEs were initiated; however, there was no evidence of FPPE activities in the provider's profile. Further, for four of the nine initiated FPPEs reviewed, there was no evidence the FPPE included provider- or service-specific criteria to evaluate the provider's performance.⁴³ This resulted in providers delivering care without a thorough evaluation of their practice. The Chief of Staff and the Quality Manager acknowledged the lack of FPPE performance criteria and documentation in the provider profiles and reported inadequate oversight and lack of an organized process as the reasons for noncompliance.

Recommendation 1

1. The Chief of Staff ensures that clinical managers initiate and document Focused Professional Practice Evaluations that include provider- and service-specific criteria for the determination of providers' privileges and monitors compliance.

Facility concurred.

Target date for completion: June 30, 2019

Facility response: The VA New Jersey Health Care System (VANJHCS) concurs that at the time of the review several of the FPPE's initiated contained no evidence of the FPPE activity in the provider's profile and several did not include the provider / service-specific criteria to evaluate the provider's performance. VANJHCS is initiating a corrective action plan which includes the following:

VANJHCS is revising the organization policy titled "Provider Profiles Ongoing and Focused Professional Practice Evaluations" to ensure it contains all the required elements and provides clear direction to the Clinical Services.

Requiring Clinical Service Chiefs include the provider / service-specific criteria on FPPE's.

Requiring Clinical Service Chiefs to maintain FPPEs in provider profiles.

VANJHCS anticipates full implementation of the corrective actions by the end of February 2019. Adherence to the revised process will be monitored. This will be accomplished via data collection of 100% of FPPE each month for 4 months to demonstrate sustained compliance of 90% or greater; and reported at ECMS/Credentialing Committee.

⁴² VHA Handbook 1100.19.

⁴³ VHA Handbook 1100.19.

Ongoing Professional Practice Evaluations

VHA requires that at the time of reprivileging, service chiefs consider relevant service- and practitioner-specific data utilizing defined criteria when recommending the continuation of licensed independent practitioners' privileges to the Executive Committee of the Medical Staff. Such data is maintained as part of the practitioner's provider profile and may include direct observations, clinical discussions, and clinical record reviews. The OPPE process is essential to confirm the quality of care delivered and allows the facility to identify professional practice trends that impact the quality of care and patient safety.⁴⁴

For 4 of 21 LIP profiles reviewed, there was no evidence that the OPPEs were reviewed by the Facility's Executive Committee of the Medical Staff prior to reprivileging. For 5 of 17 applicable provider profiles, there was no evidence of service-specific criteria. This resulted in providers continuing to deliver care without a thorough evaluation of their practice. The Chief of Staff and the Quality Manager acknowledged the deficiencies in OPPE documentation and review and cited inadequate oversight and lack of an organized process as the reasons for noncompliance.

Recommendation 2

2. The Chief of Staff ensures that Ongoing Professional Practice Evaluations include service-specific criteria and are completed by a provider with similar training and monitors compliance.

⁴⁴ VHA Handbook 1100.19.

Facility concurred.

Target date for completion: June 30, 2019

Facility response: VANJHCS concurs that not all OPPE's included service-specific criteria or completed by a provider with similar training. VANJHCS is initiating a corrective action plan which includes the following:

VANJHCS is revising the organization policy titled "Provider Profiles Ongoing and Focused Professional Practice Evaluations" to ensure it contains all the required elements and provides clear direction to the Clinical Services.

VANJHCS ECMS/Credentialing Committee will ensure that a Provider with training that is similar to the Provider under review must complete the "Patient Care and Medical Knowledge" components of the OPPE form.

Requiring Clinical Service Chiefs to include the service-specific criteria on OPPE forms.

Requiring Clinical Service Chiefs to maintain OPPEs in provider profiles.

VANJHCS anticipates full implementation of the corrective actions by the end of February 2019. Adherence to the revised process will be monitored. This will be accomplished via data collection of 100% of OPPE each month for 4 months to demonstrate sustained compliance of 90% or greater; and reported at ECMS/Credentialing Committee.

Recommendation 3

3. The Chief of Staff ensures that the Executive Committee of the Medical Staff reviews Ongoing Professional Practice Evaluations in the consideration to grant provider privileges and monitors compliance.

Facility concurred.

Target date for completion: June 30, 2019

Facility response: VANJHCS acknowledges the importance of demonstrating that OPPEs are reviewed by the ECMS/Credentialing Committee prior to granting provider privileges or re-privileging. VANJHCS is initiating a corrective action plan which includes the following:

VANJHCS is revising the organization policy titled “Provider Profiles Ongoing and Focused Professional Practice Evaluations” to ensure it contains all the required elements and provides clear direction to the Clinical Services as well as the ECMS/Credentialing Committee membership.

VANJHCS ECMS/Credentialing Committee minutes will demonstrate that OPPEs are reviewed during the re-privileging consideration decision process.

Requiring Clinical Service Chiefs to submit a copy of the completed OPPE form prior to re-privileging consideration by the VANJHCS ECMS/Credentialing Committee.

VANJHCS anticipates full implementation of the corrective actions by the end of January 2019. Adherence to the revised process will be monitored. This will be accomplished via data collection of 100% of OPPE presented to ECMS/Credentialing Committee each month for 4 months to demonstrate sustained compliance of 90% or greater; and reported at ECMS/Credentialing Committee.

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 nine patient care areas at the East Orange and Lyons campuses. At the East Orange campus, the OIG inspected four inpatient units (5th floor Medical/Surgical, intensive care, post-anesthesia care, and locked MH), the Emergency Department, a primary care clinic, and the Women's Health Clinic. At the Lyons campus, the OIG inspected the locked MH unit, Women's Health Clinic, and Community Living Center. The team also inspected the Hamilton 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

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.

- Nursing station security
- Public area and general unit safety
- Patient room safety
- Infection prevention
- Availability of medical equipment and supplies
- Emergency Management
 - Hazard Vulnerability Analysis (HVA)
 - Emergency Operations Plan (EOP)
 - Emergency power testing and availability

Conclusion

Privacy measures were in place at the East Orange and Lyons campuses. The OIG did not note any issues with the availability of medical equipment and supplies, and the Emergency Management program met all requirements. The OIG noted that three areas had dirty ventilation grills,⁵² two areas had stained ceiling tiles,⁵³ and three areas had walls in need of repair.⁵⁴ The OIG also identified deficiencies with environmental cleanliness and general safety at both Facility campuses and the Hamilton CBOC that warranted recommendations for improvement.

Medical Equipment Storage

TJC requires hospitals to minimize the risk of transmitting infections by ensuring that dirty and used equipment are stored separately from clean equipment.⁵⁵ The OIG found dirty and clean equipment stored together in five of the 10 clean storage areas.⁵⁶ This resulted in a lack of assurance of a clean and safe patient care environment that minimizes the spread of infection. Facility managers attributed a shortage of clean storage areas as the reason for noncompliance.

Recommendation 4

4. The Associate Director–Lyons Campus ensures that managers store clean and dirty medical equipment separately and monitors compliance.

⁵² East Orange 5th floor Medical/Surgical and Lyons Community Living Center units and the Hamilton CBOC.

⁵³ East Orange intensive care and Lyons Community Living Center units.

⁵⁴ East Orange 5th floor Medical/Surgical and Lyons Community Living Center units and the Hamilton CBOC.

⁵⁵ TJC. EOC standard 02.02.01.

⁵⁶ East Orange 5th floor Medical/Surgical, post-anesthesia care, East Orange locked MH, Lyons Community Living Center units, and the East Orange primary care clinic.

Facility concurred.

Target date for completion: April 30, 2019

Facility response: VANJHCS concurs with the findings at the time of the review and acknowledges the importance of ensuring that clean and dirty equipment are stored separately.

VANJHCS will review and revise the organization policy (MCM# IC-03) titled “Infection Prevention and Control for Storing Sterile / Clean Supplies In Clinical Areas” to specifically address any patient care equipment placed in clean supply closets. The frontline staff will be in-serviced on these clarifications with sign in sheets to demonstrate completion.

VANJHCS anticipates full implementation of the corrective actions by the end of January 2019. Adherence to the revised process will be monitored. This will be accomplished via data collection by the Infection Prevention & Control Staff during their weekly unit rounding and by observations during the organization’s environment of care weekly rounding. This will be monitored for 4 months to demonstrate sustained compliance of 90% or greater and reported monthly up to the EOC Committee.

MH Unit Panic Alarm Testing

Panic alarms monitored by the VA Police are needed in locked mental health units to provide immediate support to staff in the event of a disruptive patient event. VHA requires that Police and Security Operations to periodically test appropriate physical security precautions and panic alarms in locked MH units and document response time to panic alarms.⁵⁷ The OIG found no evidence of documented police response times to panic alarms in the locked MH units at the East Orange and Lyons campuses. This resulted in a lack of assurance of a safe environment for patients, visitors, and staff. The Chief of Public Safety Service (VA Police) was unaware of the requirement.

Recommendation 5

5. The Associate Director–Lyons Campus ensures that Public Safety Service documents the response times when testing panic alarms and monitors compliance.

⁵⁷ VA National Center for Patient Safety, *Mental Health Environment of Care Checklist (MHEOCC)*, December 8, 2016.

Facility concurred.

Target date for completion: April 30, 2019

Facility response: VANJHCS concurs with the findings during the review and acknowledges the importance of ensuring that response times are documented when testing the panic alarms on the locked Mental Health Units at East Orange and Lyons Campuses.

VANJHCS is reviewing and revising the organization policy (MCM # EC-93) titled “Panic Alarm System” with Public Safety Service to ensure compliance with maintaining a safe environment for patient and staff by specifically addressing the panic alarm testing on locked Mental Health Units.

VANJHCS anticipates full implementation of the corrective actions by the end of January 2019. Adherence to the revised process will be monitored. This will be accomplished via data collection by the Public Safety Service staff who conduct the panic alarm tests. This will be monitored for 4 months to demonstrate sustained compliance of 90% or greater and reported monthly up to the EOC Committee.

Medication Management: Controlled Substances Inspection Program

The Controlled Substances (CS) Act divides controlled drugs into five categories based on whether they have a currently accepted medical treatment use in the United States, their relative abuse potential, and likelihood of causing dependence when abused.⁵⁸ Diversion by healthcare workers—the transfer of a legally-prescribed CS from the prescribed individual to another person for illicit use—remains a serious problem that can increase serious patient safety issues, causes harm to the diverter, and elevates the liability risk to healthcare organizations.⁵⁹

VHA requires that facility managers implement and maintain a CS inspection program to minimize the risk for loss and diversion and to enhance patient safety.⁶⁰ Requirements include the appointment of CS Coordinator(s) (CSC) and CS inspectors (CSI), procedures for inventory control, and the inspection of the pharmacy and clinical areas with CS.

The OIG review of these issues was conducted to determine whether the Facility complied with requirements related to CS security and inspections and to follow up on recommendations from the 2014 report.⁶¹ The OIG interviewed key managers and reviewed CS inspection reports for the prior two completed quarters;⁶² monthly summaries of findings, including discrepancies, provided to the Director for the prior 12 months.⁶³ CS inspection quarterly trend reports for the prior four quarters;⁶⁴ and other relevant documents. The OIG evaluated the following performance indicators:

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

⁵⁸ Drug Enforcement Agency Controlled Substance Schedules. <https://www.dea.gov/schedules/>. (Website accessed on August 21, 2017.)

⁵⁹ American Society of Health-System Pharmacists, “ASHP Guidelines on Preventing Diversion of Controlled Substances,” *American Journal of Health-System Pharmacists* 74, no. 5 (March 1, 2017): 325-348.

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

⁶¹ VA Office of Inspector General, *Combined Assessment Program Summary Report – Evaluation of the Controlled Substances Inspection Program at Veterans Health Administration Facilities*, Report No. 14-01785-184, June 10, 2014.

⁶² The review period was January 1, 2018, through June 30, 2018.

⁶³ The review period was July 2017 through June 2018.

⁶⁴ The four quarters were from July 2017 through June 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 destruction⁶⁵
 - Accountability for all prescription pads in pharmacy

⁶⁵ The “Destructions File Holding Report” lists all drugs awaiting local destruction or turn-over to a reverse distributor. CSIs must verify there is a corresponding sealed evidence bag containing drug(s) for each destruction holding number on the report.

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

Conclusion

Generally, the Facility met requirements for CSCs and CSIs, CS and Pharmacy area inspections, and staff restrictions for balance adjustments. However, the OIG found a deficiency for follow up of annual physical security survey findings that warranted a recommendation for improvement.

Annual Physical Security Survey

VHA requires that the Chief, VA Police, follow up with the pharmacy to ensure that identified deficiencies from the annual physical security survey have been corrected.⁶⁶ The Facility's 2018 annual physical security survey, conducted in February 2018, identified five deficiencies. The Chief of Pharmacy was unable to provide evidence that the deficiencies were corrected or that an action plan was established. Deficiencies identified during physical security surveys that are not corrected may leave the facility vulnerable to loss and theft. The Chief of Pharmacy reported the reason for noncompliance was a lack of communication among Public Safety Service (VA Police) and Pharmacy. The Chief of Public Safety Service reported sending a copy of the survey to Pharmacy Service, and the Chief of Pharmacy reported that the survey was received, but the deficiencies posed no security risk for the storage of medication or pharmacy staff. The OIG found no evidence that a work order had been generated by either the Chief of Pharmacy or the Chief of Public Safety Service.

Recommendation 6

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

⁶⁶ VHA Handbook 0730, *Security and Law Enforcement*, August 11, 2000.

Facility concurred.

Target date for completion: April 30, 2019

Facility response: VANJHCS concurs with the findings during the review and acknowledges the importance of ensuring the Chief, VANJHCS Police & Public Safety, follows up with Pharmacy for any identified deficiencies from their annual physical security survey conducted in February 2018. VANJHCS is initiating a corrective action plan which includes the following:

VANJHCS Leadership along with the Chief of Public Safety Service, and the Chief of Pharmacy Service will review the requirements in the VA Handbook 0730-4 and Homeland Security Presidential Directive (HSPD-12) to ensure a resolution of the deficiencies cited during the 2018 Annual Physical Security Survey.

VANJHCS will ensure work orders are placed specific to any unresolved deficiencies found during the annual physical security survey.

VANJHCS anticipates full implementation of the corrective actions by the end of March 2019. Adherence to the revised process will be monitored. This will be accomplished via data collection on follow up and completion of identified items noted in the February 2018 Annual Physical Security Survey. This will be monitored for 4 months to demonstrate sustained compliance of 90% or greater and reported up to the EOC Committee.

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.”⁶⁷ 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.⁶⁸

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.⁶⁹ 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.⁷⁰

To assess whether the Facility complied with the requirements related to PTSD screening, diagnostic evaluation, and referral to specialty care, the OIG reviewed relevant documents and interviewed key employees and managers. Additionally, the OIG reviewed the electronic health records (EHR) of 38 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

⁶⁷ VHA Handbook 1160.03, *Programs for Veterans with Post-Traumatic Stress Disorder (PTSD)*, March 12, 2010 (rescinded November 16, 2017).

⁶⁸ VHA Handbook 1160.03.

⁶⁹ 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.

⁷⁰ 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.⁷¹ 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.⁷² 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.⁷³

In 1999, the Veterans Millennium Benefits and Healthcare Act mandated that the veterans' standard benefits package include access to GE.⁷⁴ 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.⁷⁵ 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.⁷⁶

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

⁷¹ VHA Directive 1140.04, *Geriatric Evaluation*, November 28, 2017.

⁷² VHA Directive 1140.04.

⁷³ 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.

⁷⁴ Public Law 106-117.

⁷⁵ VHA Directive 1140.11, *Uniform Geriatrics and Extended Care Services in VA Medical Centers and Clinics*, October 11, 2016.

⁷⁶ 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

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

Women's Health: Mammography Results and Follow-up

In 2017, an estimated 252,710 new cases of invasive breast cancer and 40,610 breast cancer deaths were expected to occur among US women.⁷⁷ 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.⁷⁸ The Veterans Health Care Act of 1992 also authorized VA to provide gender-specific services including mammography services to eligible women veterans.⁷⁹

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.⁸⁰

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

⁷⁷ U.S. Breast Cancer Statistics. <http://www.BreastCancer.org>. (Website accessed on May 18, 2017.)

⁷⁸ 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).

⁷⁹ Veterans Health Care Act of 1992, Title I, Publ L. 102-585 (1992).

⁸⁰ 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 study⁸¹

Conclusion

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

⁸¹ This performance indicator did not apply to this Facility.

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.⁸² 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,”⁸³ 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.⁸⁴

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.”⁸⁵

Infections occurring on or after the third calendar day following admission to an inpatient location are considered “healthcare-associated.”⁸⁶ 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.⁸⁷

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 23 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

⁸² TJC. Infection Prevention and Control standard IC.01.03.01.

⁸³ Association for Professionals in Infection Control and Epidemiology, *Guide to Preventing Central Line-Associated Bloodstream Infections*, 2015.

⁸⁴ These are vessels that enter and leave the heart—superior and inferior vena cava, pulmonary artery, pulmonary vein, aorta.

⁸⁵ The Centers for Disease Control and Prevention, *Guidelines for the Prevention of Intravascular Catheter-Related Infections*, 2011.

⁸⁶ 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.

⁸⁷ 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 	Six OIG recommendations, ranging from documentation issues to deficiencies that can lead to patient and staff safety issues or adverse events, are attributable to the Director, Chief of Staff, and Associate Director—Lyons Campus. 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

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Credentialing and Privileging	<ul style="list-style-type: none"> • Medical licenses • Privileges • FPPEs • OPPEs 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • Clinical managers initiate and document Focused Professional Practice Evaluations that include provider- and service-specific criteria for the determination of providers' privileges. • Ongoing Professional Practice Evaluations include service-specific criteria and are completed by a provider with similar training. • The Executive Committee of the Medical Staff reviews Ongoing Professional Practice Evaluations in the consideration to grant provider privileges.
Environment of Care	<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 	<ul style="list-style-type: none"> • Managers store clean and dirty medical equipment separately. 	<ul style="list-style-type: none"> • Public Safety Service documents the response times when testing panic alarms.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
	<ul style="list-style-type: none"> • 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 		
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"> • All deficiencies identified on the Annual Physical Security Survey are corrected.
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

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
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 	<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 • Education and educational materials • Policy, procedure, and checklist for insertion and maintenance of central venous catheters 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • None

Appendix B: Facility Profile and VA Outpatient Clinic Profiles

Facility Profile

The table below provides general background information for this mid-high complexity (1c)⁸⁸ affiliated⁸⁹ Facility reporting to VISN 2.

**Table 7. Facility Profile for East Orange (561)
(October 1, 2014, through September 30, 2017)**

Profile Element	Facility Data FY 2015 ⁹⁰	Facility Data FY 2016 ⁹¹	Facility Data FY 2017 ⁹²
Total Medical Care Budget in Millions	\$506.2	\$538.0	\$552.0
Number of:			
• Unique Patients	57,129	56,470	56,482
• Outpatient Visits	724,994	744,793	718,957
• Unique Employees ⁹³	2,558	2,489	2,508
Type and Number of Operating Beds:			
• Community Living Center	300	300	300
• Domiciliary	174	174	174
• Intermediate	62	62	62
• Medicine	107	107	107
• Mental Health	152	152	152
• Neurology	8	8	8
• Residential Rehabilitation	12	12	12
• Spinal Cord	14	14	14
• Surgery	38	38	38
Average Daily Census:			

⁸⁸ The VHA medical centers are classified according to a facility complexity model; 1c designation indicates a Facility with medium-high volume, medium-risk patients, some complex clinical programs, and medium-sized research and teaching programs.

⁸⁹ Associated with a medical residency program.

⁹⁰ October 1, 2014, through September 30, 2015.

⁹¹ October 1, 2015, through September 30, 2016.

⁹² October 1, 2016, through September 30, 2017.

⁹³ Unique employees involved in direct medical care (cost center 8200).

Profile Element	Facility Data FY 2015 ⁹⁰	Facility Data FY 2016 ⁹¹	Facility Data FY 2017 ⁹²
• Community Living Center	204	209	220
• Domiciliary	132	137	146
• Medicine	31	35	34
• Mental Health	43	51	55
• Neurology	2	2	2
• Residential Rehabilitation	7	8	8
• Spinal Cord	9	10	10
• Surgery	9	7	7

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 Profiles⁹⁴

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/Encounters⁹⁵ 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 ⁹⁶ Provided	Diagnostic Services ⁹⁷ Provided	Ancillary Services ⁹⁸ Provided
Hamilton, NJ	561GA	5,476	955	Dermatology Endocrinology Rehab Physician Anesthesia	EKG	Pharmacy Social Work Weight Management Nutrition
Newark, NJ	561BY	10	n/a	n/a	n/a	n/a

⁹⁴ Includes all outpatient clinics in the community that were in operation as of February 15, 2018.

⁹⁵ An encounter is a professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient’s condition.

⁹⁶ Specialty care services refer to non-PC and non-MH services provided by a physician.

⁹⁷ Diagnostic services include EKG, EMG, laboratory, nuclear medicine, radiology, and vascular lab services.

⁹⁸ 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 ⁹⁶ Provided	Diagnostic Services ⁹⁷ Provided	Ancillary Services ⁹⁸ Provided
Brick, NJ	561BZ	21,657	12,503	Allergy Cardiology Dermatology Endocrinology Rehab Physician Spinal Cord Injury Anesthesia Eye General Surgery Otolaryngology Podiatry Urology	EKG Radiology	Pharmacy Social Work Weight Management Dental Nutrition
Elizabeth, NJ	561GB	2,980	885	Endocrinology	EKG	Social Work Weight Management Nutrition
Hackensack, NJ	561GD	14,534	7,888	Anesthesia Eye	EKG	Pharmacy Social Work Weight Management Nutrition
Jersey City, NJ	561GE	3,068	1,287	Endocrinology Anesthesia	EKG	Pharmacy Social Work Weight Management Nutrition

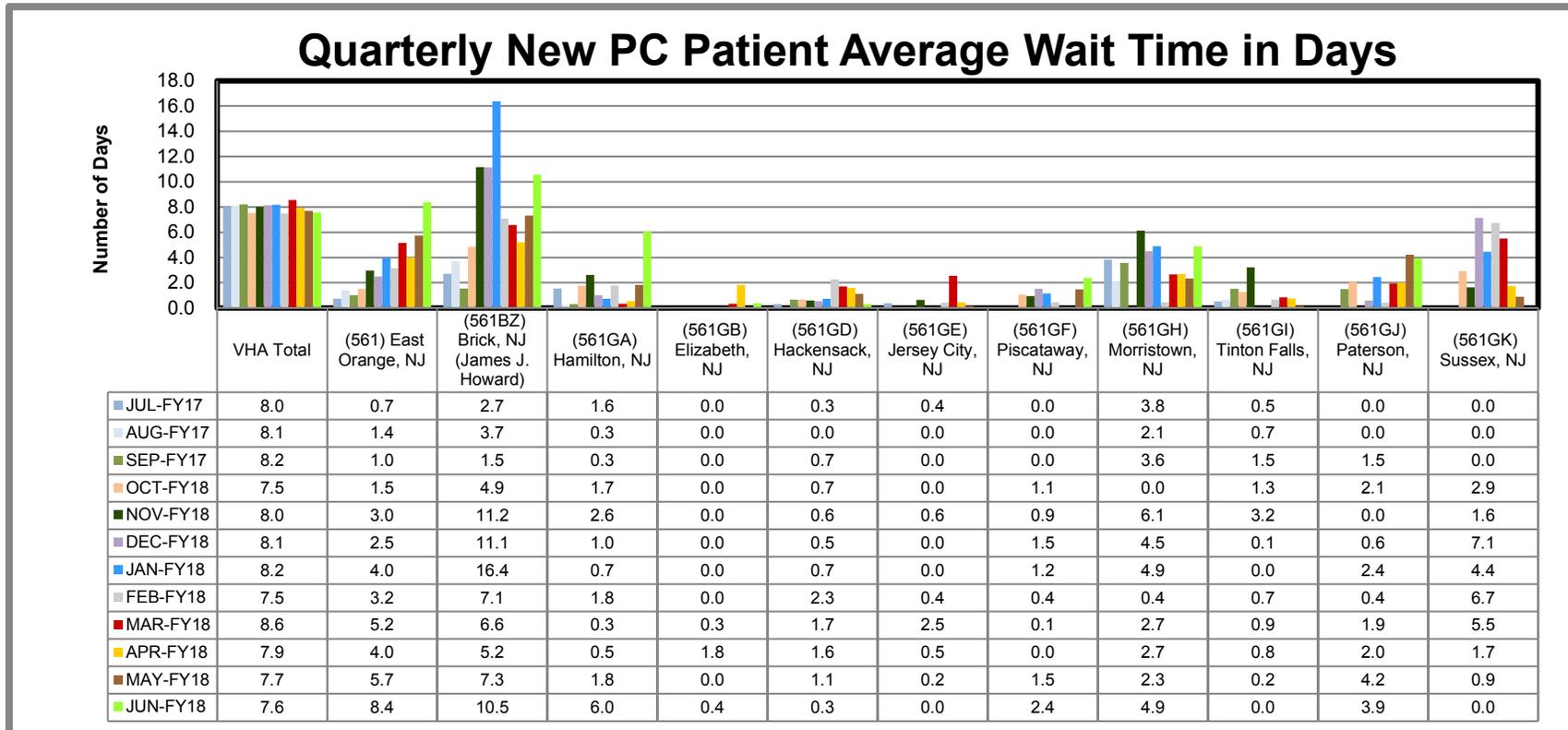
Location	Station No.	PC Workload/ Encounters	MH Workload/ Encounters	Specialty Care Services ⁹⁶ Provided	Diagnostic Services ⁹⁷ Provided	Ancillary Services ⁹⁸ Provided
Piscataway, NJ	561GF	4,822	762	Endocrinology	EKG	Social Work Weight Management Nutrition
Morristown, NJ	561GH	4,450	785	Endocrinology	EKG	Social Work Weight Management Nutrition
Tinton Falls, NJ	561GI	6,312	3,534	Endocrinology Anesthesia Eye	EKG	Social Work Weight Management Nutrition
Paterson, NJ	561GJ	3,647	1,156	Endocrinology	EKG	Social Work Weight Management Nutrition
Newton, NJ	561GK	1,265	169	n/a	EKG Laboratory & Pathology	Pharmacy Weight Management Nutrition

Source: VHA Support Service Center and VA Corporate Data Warehouse

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

n/a = not applicable

Appendix C: Patient Aligned Care Team Compass Metrics⁹⁹



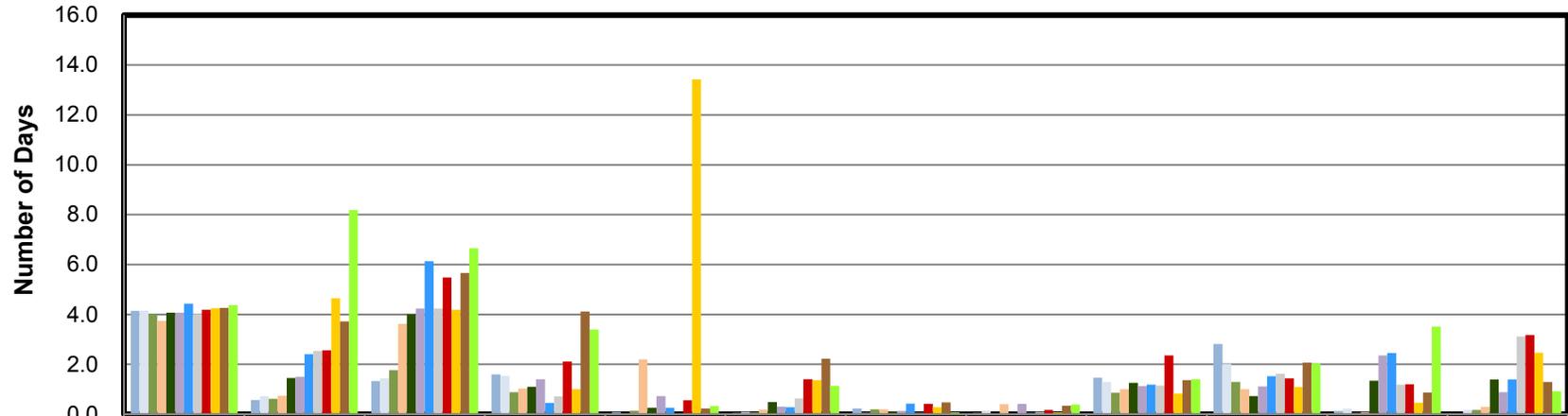
Source: VHA Support Service Center

Note: The OIG did not assess VA's data for accuracy or completeness. The OIG omitted Newark, NJ (561BY), as no data was reported.

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.

⁹⁹ Department of Veterans Affairs, Patient Aligned Care Teams Compass Data Definitions, accessed September 11, 2017.

Quarterly Established PC Patient Average Wait Time in Days

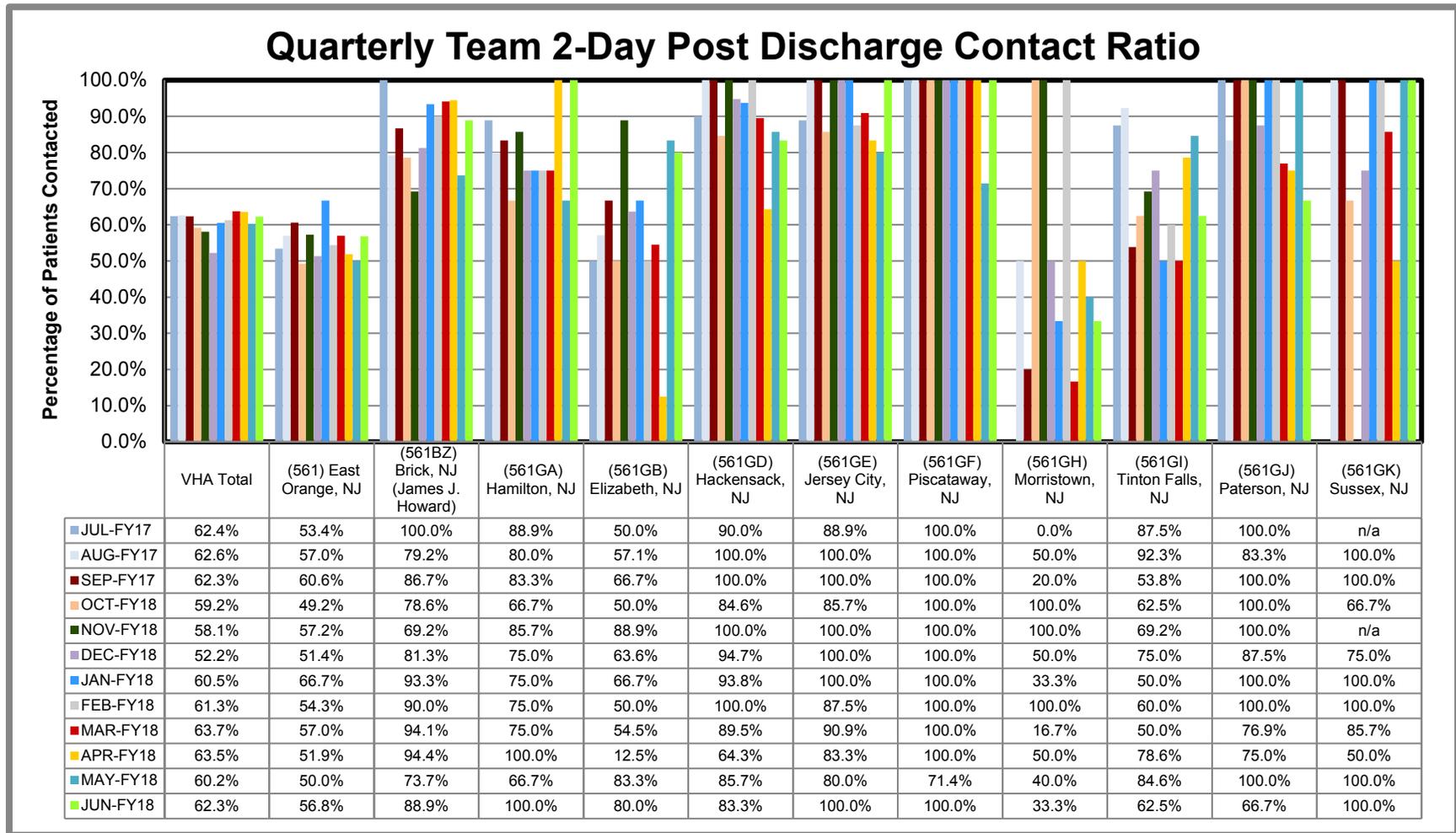


	VHA Total	(561) East Orange, NJ	(561BZ) Brick, NJ (James J. Howard)	(561GA) Hamilton, NJ	(561GB) Elizabeth, NJ	(561GD) Hackensack, NJ	(561GE) Jersey City, NJ	(561GF) Piscataway, NJ	(561GH) Morristown, NJ	(561GI) Tinton Falls, NJ	(561GJ) Paterson, NJ	(561GK) Sussex, NJ
JUL-FY17	4.1	0.6	1.3	1.6	0.1	0.1	0.2	0.1	1.5	2.8	0.1	0.0
AUG-FY17	4.2	0.7	1.4	1.5	0.0	0.1	0.0	0.1	1.3	2.0	0.2	0.2
SEP-FY17	4.0	0.6	1.8	0.9	0.1	0.1	0.2	0.0	0.9	1.3	0.0	0.2
OCT-FY18	3.7	0.7	3.6	1.0	2.2	0.2	0.2	0.4	1.0	1.0	0.1	0.3
NOV-FY18	4.1	1.5	4.0	1.1	0.3	0.5	0.1	0.0	1.3	0.7	1.3	1.4
DEC-FY18	4.1	1.5	4.2	1.4	0.7	0.3	0.1	0.4	1.1	1.1	2.3	0.9
JAN-FY18	4.4	2.4	6.1	0.4	0.2	0.3	0.4	0.0	1.2	1.5	2.5	1.4
FEB-FY18	4.0	2.5	4.2	0.7	0.0	0.6	0.0	0.1	1.1	1.6	1.2	3.1
MAR-FY18	4.2	2.6	5.5	2.1	0.6	1.4	0.4	0.2	2.4	1.4	1.2	3.2
APR-FY18	4.3	4.7	4.2	1.0	13.4	1.4	0.3	0.1	0.8	1.1	0.5	2.5
MAY-FY18	4.3	3.7	5.7	4.1	0.2	2.2	0.5	0.3	1.4	2.1	0.9	1.3
JUN-FY18	4.4	8.2	6.6	3.4	0.3	1.1	0.1	0.4	1.4	2.0	3.5	0.9

Source: VHA Support Service Center

Note: The OIG did not assess VA’s data for accuracy or completeness. The OIG omitted Newark, NJ (561BY), as no data was reported.

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.

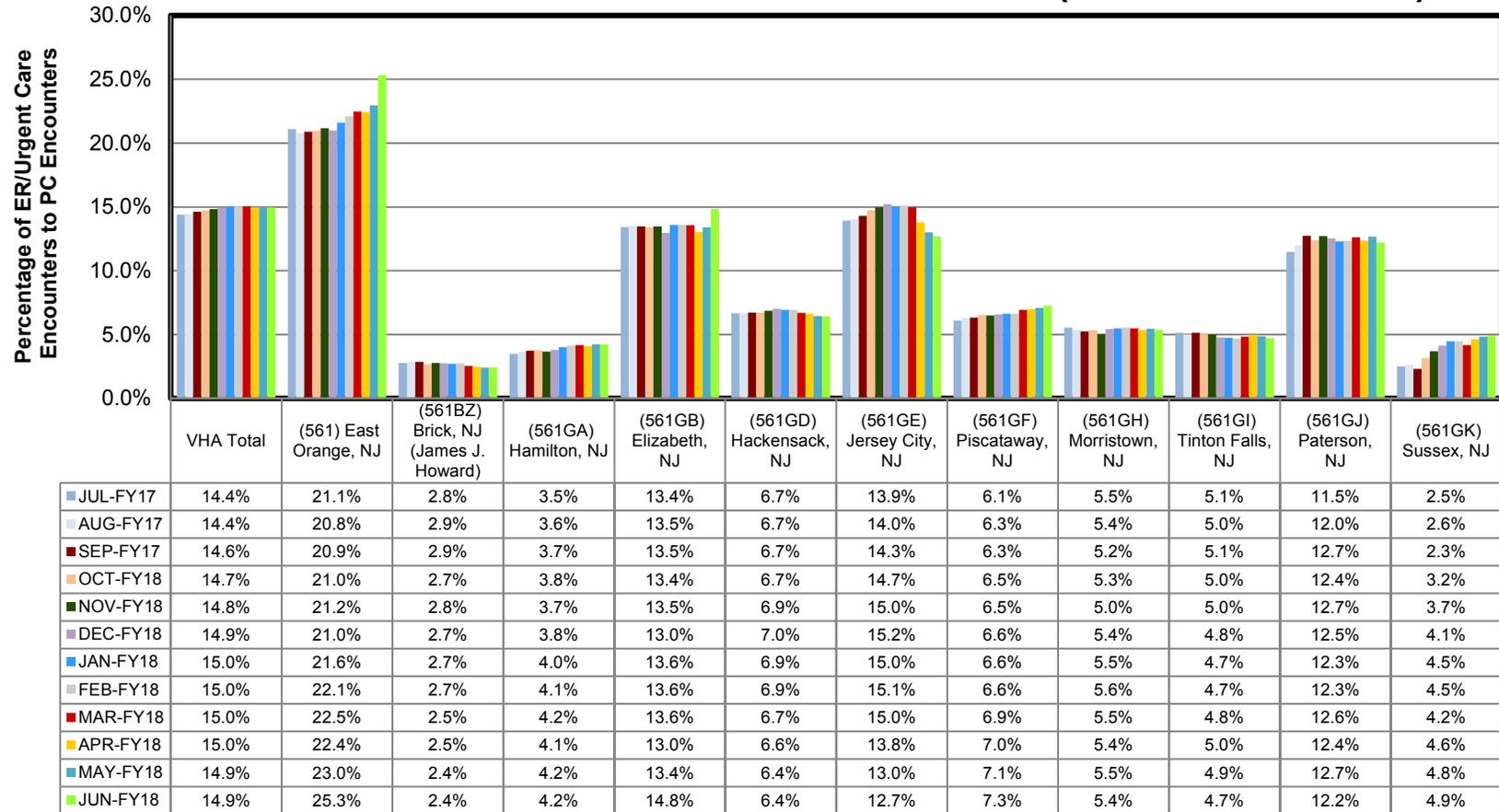


Source: VHA Support Service Center

Note: The OIG did not assess VA's data for accuracy or completeness. The OIG omitted Newark, NJ (561BY), as no data was reported.

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." The absence of reported data is indicated by "n/a."

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. The OIG omitted Newark, NJ (561BY), as no data was reported.

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 Definitions¹⁰⁰

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

¹⁰⁰ 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 29, 2018

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

Subj: CHIP Review of the VA New Jersey Health Care System, East Orange, NJ

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

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

Attached please find VISN 2 Response to the CHIP Review of the VA New Jersey Health Care System, East Orange, NJ. I concur with the findings, Recommendations 1-6 and submitted action plans.

(Original signed by:)

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

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

Appendix F: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: November 29, 2018

From: Director, VA New Jersey Health Care System (561/00)

Subj: CHIP Review of the VA New Jersey Health Care System, East Orange, NJ.

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

Thank you for the opportunity to review the draft report of the OIG CHIP (Comprehensive Healthcare Inspection Program) Review for our VA New Jersey Health Care System. I have reviewed the document and concur with the recommendations noted.

The VA New Jersey Health Care System has established corrective action plans with designated dates of completion, as detailed in the attached report. If additional information or assistance is needed, please do not hesitate to contact our Lead Accreditation Specialist/Deputy QM.

(Original signed by:)

Vincent F. Immiti, FACHE
Medical Center Director, VA New Jersey Health Care System

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

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Director, VA New Jersey Health Care System (561/00)

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