



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare
Inspection of the Hunter
Holmes McGuire VA Medical
Center

Richmond, Virginia



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Figure 1. Hunter Holmes McGuire VA Medical Center, Richmond, Virginia (Source: <https://vaww.va.gov/directory/guide/>, accessed on April 22, 2019)

Abbreviations

ADPCS	associate director for Patient Care Services
CHIP	Comprehensive Healthcare Inspection Program
CLC	community living center
FPPE	focused professional practice evaluation
FY	fiscal year
LIP	licensed independent practitioner
MST	military sexual trauma
OIG	Office of Inspector General
OPPE	ongoing professional practice evaluation
QSV	quality, safety, and value
SAIL	Strategic Analytics for Improvement and Learning
TJC	The Joint Commission
UCC	urgent care center
UM	utilization management
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network



Report Overview

This Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) provides a focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Hunter Holmes McGuire VA Medical Center (the facility). The inspection covers key clinical and administrative processes that are associated with promoting quality care.

CHIP inspections are one element of the OIG's overall efforts to ensure that the 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 each year.

The OIG team looks at leadership and organizational risks as well as areas affecting quality patient care. At the time of the review, the clinical areas of focus were

1. Quality, safety, and value;
2. Medical staff privileging;
3. Environment of care;
4. Medication management (specifically the controlled substances inspection program);
5. Mental health (focusing on military sexual trauma follow-up and staff training);
6. Geriatric care (spotlighting antidepressant use for elderly veterans);
7. Women's health (particularly abnormal cervical pathology result notification and follow-up); and
8. High-risk processes (specifically the emergency department and urgent care center operations and management).

This unannounced visit was conducted during the week of January 7, 2019. The OIG held interviews and reviewed clinical and administrative processes related to areas of focus that affect patient care outcomes. Although the OIG reviewed a broad spectrum of clinical and administrative processes, the sheer complexity of VA medical facilities limits inspectors' ability to assess all areas of clinical risk. The findings presented in this report are a snapshot of this facility's 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 this facility and other Veterans Health Administration (VHA) facilities to identify areas of vulnerability or conditions that, if properly addressed, could improve patient safety and healthcare quality.

Results and Inspection Impact

Leadership and Organizational Risks

At the time of the OIG's visit, the facility leadership team consisted of the director, associate director, chief of staff, associate director for Patient Care Services (ADPCS), and assistant director. Organizational communications and accountability were managed through a committee reporting structure, with the Executive Leadership Board having oversight for several working groups.

The facility's leadership team had been working together since November 2018, although several team members have been in their position for several years. The associate director, who started as the assistant director in December 2013, was permanently assigned but had been the acting facility director since November 2018. The acting associate director had been in the role for approximately two months. The chief of staff, ADPCS, and assistant director were permanently assigned January 27, 2013, August 21, 2016, and May 13, 2018, respectively. The OIG also noted long-standing nursing leadership vacancies that have had either only recent recruitment or no recruitment efforts to fill the positions.

The OIG noted that selected survey leadership results for facility leaders were similar to or lower than the VHA averages.¹ In all, opportunities appear to exist to improve employee satisfaction with facility leaders and for the leaders to provide an environment where employees feel safe bringing forth issues and concerns. Selected patient experience survey scores reflected a higher care rating than the VHA average for only one of four survey items. Opportunities also appear to exist to improve patient experiences in the inpatient and specialty care settings, and leaders reported implementing processes and plans to improve patient experiences.

Additionally, the OIG reviewed accreditation agency findings, sentinel events,² disclosures of adverse patient events, and patient safety indicator data and did not identify any substantial organizational risk factors. However, the OIG is concerned with adverse patient events related to patient identification and assessment of those cases that may need institutional disclosures. The leadership team was aware of the patient safety indicator data but should evaluate the current process of identifying improvement opportunities.

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

¹ 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.

² The definition of sentinel event can be found within VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. A sentinel event is an incident or condition that results in patient "death, permanent harm, or severe temporary harm and intervention required to sustain life."

and differences between the top and bottom performers” within VHA.³ The OIG noted opportunities for all executive leadership team members to improve their knowledge, within their scope of responsibility, about selected SAIL and CLC metrics and the actions necessary to sustain and improve performance of measures contributing to the SAIL “4-star” and CLC “1-star” quality ratings.⁴

While on site, the OIG referred an issue and concern beyond the scope of the CHIP review to our Hotline management team for further evaluation.

The OIG noted deficiencies in all eight clinical areas reviewed and issued 21 recommendations that are attributable to the director, associate director, and chief of staff. These are briefly described below.

Quality, Safety, and Value

The OIG found there was general compliance with peer reviews. It is important to note that during the review of resuscitative events from the previous 12 months, the OIG found evidence that a patient with a “do not resuscitate” order received resuscitation efforts for approximately 20 minutes before staff determined that these efforts were against the patient’s wishes. Additionally, the OIG identified concerns with documentation of physician utilization management advisors’ decisions, performance of root cause analyses that include required content, and the Code Blue Committee reviews of each resuscitation episode.⁵

³ 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=8938>. (The website was accessed on March 7, 2019, but is not accessible by the public.)

⁴ Based on fiscal year 2018, quarter 4 ratings at the time of the site visit.

⁵ The definition of utilization management can be found within VHA Directive 1117(1), *Utilization Management Program*, July 9, 2014 (amended January 18, 2018). Utilization management involves the “forward-looking evaluation of the appropriateness, medical need, and efficiency of healthcare services according to evidence-based criteria.” This directive was in effect at the time of the review but was replaced by VHA Directive 1117(2), *Utilization Management Program*, July 9, 2014 (amended April 30, 2019). This directive expired on July 31, 2019.

Medical Staff Privileging

The OIG found general compliance with requirements for privileging. However, the OIG identified deficiencies with the focused professional practice evaluations (FPPE), ongoing professional practice evaluations (OPPE), and FPPE for cause processes.⁶

Environment of Care

The facility generally complied with requirements for safety and privacy measures at the parent facility and the Fredericksburg 2 VA Clinic. The OIG did not note any issues with the availability of medical equipment and supplies. However, the OIG identified noncompliance at the parent facility with environmental cleanliness.

Medication Management

The facility complied with requirements for controlled substances coordinator reports, pharmacy operations, and requirements for controlled substances inspectors. However, the OIG identified noncompliance with monthly inspections in all non-pharmacy and pharmacy areas including completion of monthly inventories, reconciliation of dispensing from pharmacy to each dispensing area, and return of stock to pharmacy; pharmacy monthly inventory on the day initiated; verification of controlled substances on held for destruction; pharmacy prescription pad inventory count; evidence of written prescription; and pharmacy 72-hour inventory.

Mental Health

The OIG also found the facility complied with most of the military sexual trauma (MST) performance indicators, including the designation of an MST coordinator, tracking of MST-related data, and provision of clinical care. The OIG noted a concern, however, with providers completing MST mandatory training in a timely manner.

Geriatric Care

For geriatric patients, the OIG noted that providers justified the reason for medication initiation of newly prescribed medications. However, the OIG identified inadequate patient and/or

⁶ The definitions of ongoing professional practice evaluation and focused professional practice evaluations can be found within Office of Safety and Risk Awareness, Office of Quality and Performance, “*Provider Competency and Clinical Care Concerns Including: Focused Clinical Care Review and FPPE for Cause Guidance*,” July 2016 (Revision 2). An ongoing professional practice evaluation is “the ongoing monitoring of privileged providers to confirm the quality of care delivered and ensures patient safety.” A focused professional practice evaluation is “a time-limited process whereby the clinical leadership evaluates the privilege-specific competence of a provider who does not yet have documented evidence of competently performing the requested privilege(s) at the facility.” A focused professional practice evaluation for cause is “a time-limited period during which the medical staff leadership assesses the provider’s professional performance to determine if any action should be taken on the provider’s privileges.”

caregiver education related to newly prescribed medications, evaluation of patient/caregiver understanding when education was provided, and medication reconciliation processes.

Women's Health

The OIG noted compliance with most of the performance indicators, including requirements for clinical oversight of the women's health program, tracking data related to cervical cancer screenings, communicating abnormal results to patients, and follow-up care if indicated. However, the OIG identified the facility lacked a full-time women veterans program manager.

High-Risk Processes

The OIG inspection revealed that the facility generally complied with many of the above performance indicators for the operations and management of an emergency department. However, the OIG identified that the emergency department lacked a required on-site licensed independent mental health provider and directional signage.

Summary

In reviewing key healthcare processes, the OIG issued 21 recommendations for improvement directed to the facility director, chief of staff, and associate director. The number of recommendations should not be used, however, 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 acting/interim Veterans Integrated Service Network director and acting/interim facility director agreed with the CHIP inspection findings and recommendations and provided acceptable improvement plans. (See Appendixes F and G, pages 80–81, and the responses within the body of the report for the full text of the directors' comments.) The OIG considers recommendations 1 and 20 closed. The OIG will follow up on the planned actions for the open recommendations until they are completed.



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Purpose and Scope

The purpose of the Office of Inspector General (OIG) Comprehensive Healthcare Inspection Program (CHIP) is to provide oversight of healthcare services to veterans. This focused evaluation of the quality of care delivered in the inpatient and outpatient settings of the Hunter Holmes McGuire VA Medical Center (the facility) is accomplished by examining a broad overview of key clinical and administrative processes associated with quality care and positive patient outcomes. The OIG reports its findings to Veterans Integrated Service Network (VISN) and facility leaders so that informed decisions can be made on improving care.

Effective leaders manage organizational risks by establishing goals, strategies, and priorities to improve care; setting the quality agenda; and promoting a culture to sustain positive change.⁷ Investments in a culture of safety and quality improvement with robust communications and leadership significantly contribute to positive patient outcomes in healthcare organizations.⁸ Figure 2 shows the direct relationships between leadership and organizational risks and the processes used to deliver health care to veterans.

To examine risks to patients and the organization when core processes are not performed well, the OIG focused on the following nine areas of clinical and administrative operations that support quality care at the facility:

1. Leadership and organizational risks
2. Quality, safety, and value (QSV)
3. Medical staff privileging
4. Environment of care
5. Medication management (specifically the controlled substances inspection program)
6. Mental health (focusing on military sexual trauma follow-up and staff training)
7. Geriatric care (spotlighting antidepressant use for elderly veterans)
8. Women's health (particularly abnormal cervical pathology results notification and follow-up)

⁷ 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/>. (The website was accessed on January 24, 2019.)

⁸ 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>. (The website was accessed on January 24, 2019.)

9. High-risk processes (specifically the emergency department and urgent care center operations and management).⁹

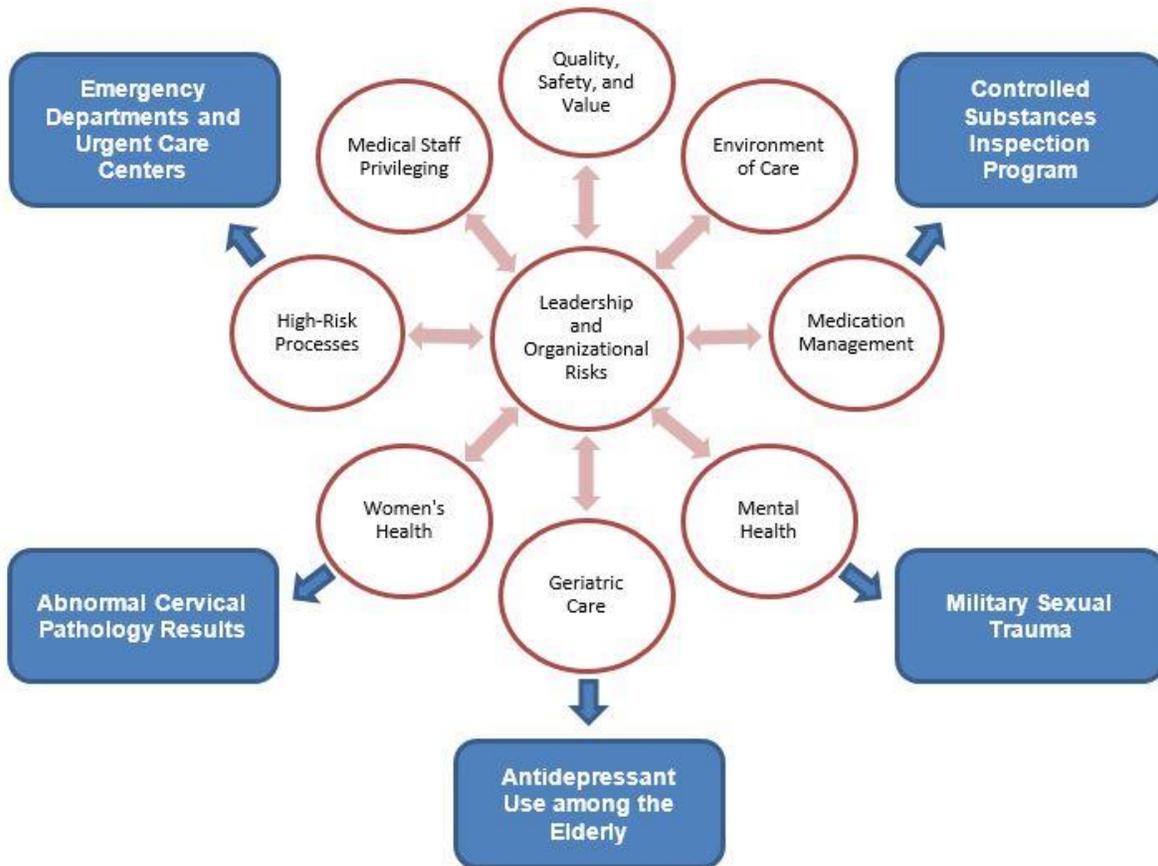


Figure 2. Fiscal Year (FY) 2019 Comprehensive Healthcare Inspection of Operations and Services
Source: VA OIG

⁹ See Figure 2. CHIP inspections address these processes during FY 2019 (October 1, 2018, through September 30, 2019); they may differ from prior years' focus areas.

Methodology

To determine compliance with the Veterans Health Administration (VHA) requirements related to patient care quality, clinical functions, and the environment of care, the inspection team reviewed OIG-selected clinical records, administrative and performance measure data, and accreditation survey reports;¹⁰ physically inspected OIG-selected areas; and discussed processes and validated findings with managers and employees. The OIG also interviewed members of the executive leadership team.

The inspection period examined operations from February 6, 2016, through January 11, 2019, the last day of the unannounced week-long site visit.¹¹ While on site, the OIG referred an issue and concern beyond the scope of the CHIP review to our Hotline management team for further evaluation.

This report's recommendations for improvement target problems that can influence 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 report recommendations appear within each topic area.

The OIG conducted the inspection in accordance with OIG standard operating procedures for CHIP reports and Quality Standards for Inspection and Evaluation published by the Council of the Inspectors General on Integrity and Efficiency.

¹⁰ The OIG did not review VHA's internal survey results, instead focusing on OIG inspections and external surveys that affect facility accreditation status.

¹¹ The range represents the time period from the last Combined Assessment Program review, which was performed prior to the comprehensive healthcare inspection, to the completion of the unannounced week-long CHIP site visit.

Results and Recommendations

Leadership and Organizational Risks

Stable and effective leadership is critical to improving care and sustaining meaningful change within a VA healthcare facility. Leadership and organizational risks can impact the facility's ability to provide care in all of the selected clinical areas of focus.¹² To assess the facility's risks, the OIG considered the following indicators:

1. Executive leadership position stability and engagement
2. Employee satisfaction
3. Patient experience
4. Accreditation and/or for-cause surveys and oversight inspections
5. Factors related to possible lapses in care
6. VHA performance data

Executive Leadership Position Stability and Engagement

Because each VA facility organizes its leadership structure to address the needs and expectations of the local veteran population it serves, organizational charts may differ across facilities. Figure 3 illustrates this facility's reported organizational structure. The facility has a leadership team consisting of the director, chief of staff, associate director for Patient Care Services (ADPCS), associate director, and assistant director. The chief of staff and ADPCS oversee patient care, which requires managing service directors and chiefs of programs and practices.

¹² L. Botwinick, M. Bisognano, and C. Haraden, "Leadership Guide to Patient Safety," *Institute for Healthcare Improvement*, Innovation Series White Paper. 2006. www.IHI.org. (The website was accessed on February 2, 2017.)

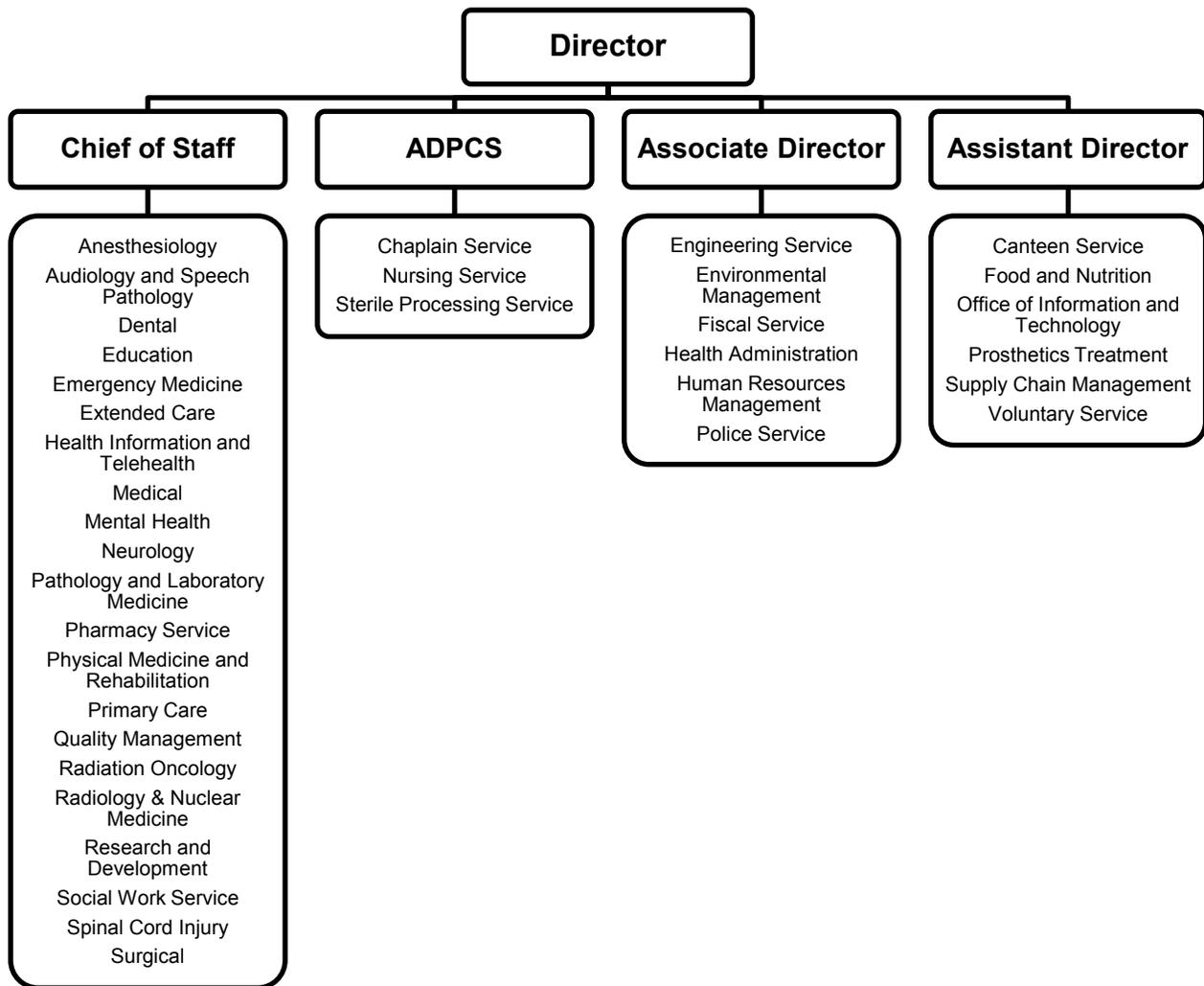


Figure 3. Facility Organizational Chart¹³

Source: Hunter Holmes McGuire VA Medical Center (received January 7, 2019)

At the time of the OIG site visit, the executive team had been working together since November 2018, although several team members have been in their position for several years. This included the chief of staff, ADPCS, and permanently-appointed associate director, who started as the assistant director in December 2013, was promoted to associate director, and had been serving as the acting facility director since November 2018 (see Table 1).

At the time of the inspection, OIG noted long-standing nursing leadership vacancies, including three section nurse chief positions for ambulatory care, surgery, and acute medicine. Specifically, the ADPCS had not initiated any recruitment efforts for the ambulatory care position since it

¹³ At this facility, the director is responsible for the Canteen Service, Food and Nutrition, Office of Information and Technology, Prosthetics Treatment, Supply Chain Management, and Voluntary Service.

became vacant in 2016 and only covered the position with the nurse manager who was also the acting nurse manager for operations and wound care, which has also had not active recruitment efforts. Additionally, the OIG noted that the surgery and acute medicine section nurse chief positions had been vacant since 2016 and 2017, respectively, but the ADPCS did initiate recruitment efforts for these vacancies immediately prior to the OIG site visit.

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Facility director	Acting since November 2018
Chief of staff	January 27, 2013
Associate director for Patient Care Services	August 21, 2016
Associate director	Acting since November 2018
Assistant director	May 13, 2018

Source: Hunter Holmes McGuire VA Medical Center human resources officer (received January 7, 2019)

To help assess facility executive leaders' engagement, the OIG interviewed the director, chief of staff, ADPCS, and associate director regarding their knowledge of various performance metrics and their involvement and support of actions to improve or sustain performance.

In individual interviews, the OIG noted opportunities for all executive leadership team members to improve their knowledge, within the scope of their responsibilities, of actions taken during the previous 12 months in order to maintain or improve performance, employee and patient survey results, and/or selected Strategic Analytics for Improvement and Learning (SAIL) metrics and community living center (CLC) measures. These are discussed in greater detail below.

The acting director identified the Executive Leadership Board as the committee responsible for tracking, identifying trends, and monitoring quality of care and patient outcomes. Executive leaders are engaged in monitoring patient safety and care through the Executive Leadership Board, for which the director is the chair. The Executive Leadership Board also oversees various working groups, such as the Medical Executive Council, Patient Service Executive Council, and Administrative Executive Council. The facility also has a Quality Executive Council (recently changed to the Quality, Safety, and Value Council), which is not chaired by the director but does report to the Executive Leadership Board. See Figure 4.

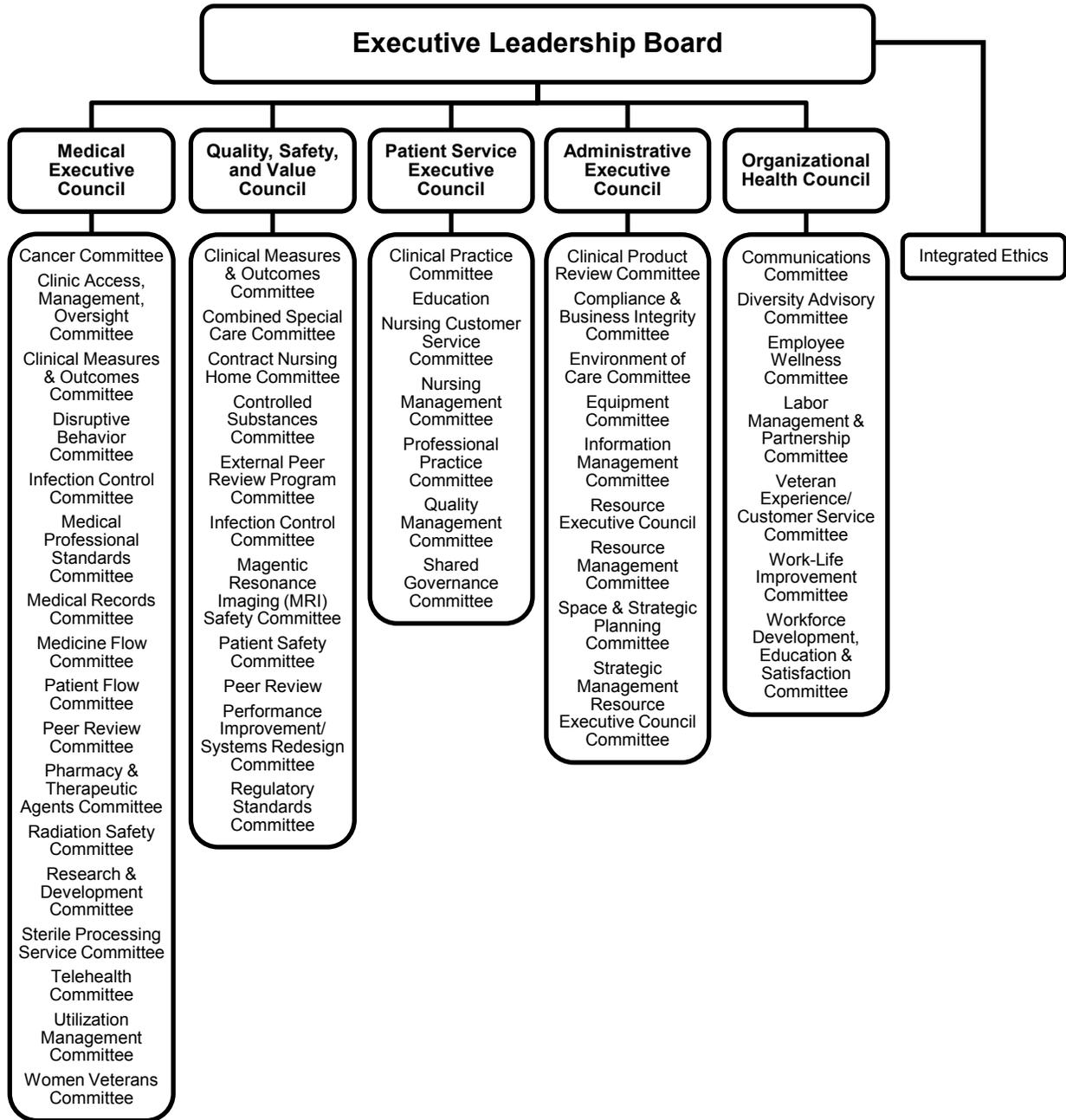


Figure 4. Facility Committee Reporting Structure¹⁴
 Source: Hunter Holmes McGuire VA Medical Center (January 8, 2019)

¹⁴ The Executive Leadership Board oversees Integrated Ethics.

Employee Satisfaction

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 several times in response to VA leaders’ inquiries on VA culture and organizational health. Although the OIG recognizes that employee satisfaction survey data are subjective, they can be a starting point for discussions, indicate areas for further inquiry, and be considered along with other information on facility leadership.

To assess employee attitudes toward facility leaders, the OIG reviewed employee satisfaction survey results that relate to the period of October 1, 2017, through September 30, 2018.¹⁵ Table 2 provides relevant survey results for VHA, the facility, and selected facility executive leaders. It summarizes employee attitudes toward these selected facility leaders as expressed in VHA’s All Employee Survey. The OIG found the facility average for several selected survey leadership questions was similar to or lower than the VHA average.¹⁶ The same trend was noted for the chief of staff, ADPCS, and associate director. The director was much higher and the assistant director was slightly higher than the facility and VHA averages. In all, opportunities appear to exist to improve employee satisfaction with the majority of the facility’s leaders.

**Table 2. Survey Results on Employee Attitudes toward Facility Leadership
(October 1, 2017, through September 30, 2018)**

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average	Asst. Director Average
All Employee Survey: <i>Servant Leader Index Composite</i> ¹⁷	0–100 where HIGHER scores are more favorable	71.7	69.8	92.3	68.7	70.1	69.0	74.4

¹⁵ Ratings are based on responses by employees who report to or are aligned under the director, chief of staff, ADPCS, and associate director.

¹⁶ 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.

¹⁷ According to the 2018 VA All Employee Survey Questions by Organizational Health Framework, Servant Leader Index “is a summary measure of the work environment being a place where organizational goals are achieved by empowering others. This includes focusing on collective goals, encouraging contribution from others, and then positively reinforcing others’ contributions. Servant Leadership occurs at all levels of the organization, where individuals (supervisors, staff) put others’ needs before their own.”

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average	Asst. Director Average
All Employee Survey: <i>In my organization, senior leaders generate high levels of motivation and commitment in the workforce.</i>	1 (Strongly Disagree) – 5 (Strongly Agree)	3.3	3.3	4.4	3.1	3.4	3.3	3.5
All Employee Survey: <i>My organization's senior leaders maintain high standards of honesty and integrity.</i>	1 (Strongly Disagree) – 5 (Strongly Agree)	3.5	3.4	4.6	3.3	3.5	3.5	3.7
All Employee Survey: <i>I have a high level of respect for my organization's senior leaders.</i>	1 (Strongly Disagree) – 5 (Strongly Agree)	3.6	3.5	4.6	3.3	3.6	3.6	3.9

Source: VA All Employee Survey (accessed December 10, 2018)

Table 3 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey. Note that the facility averages for the selected survey questions were similar to or worse than the VHA average. The same trend was noted for the chief of staff, ADPCS, and associate director. The director's and assistant director's averages were better than the facility and VHA averages. Opportunities may exist for the majority of the facility's leaders to provide an environment where employees feel safe bringing forth issues and concerns.

**Table 3. Survey Results on Employee Attitudes toward the Workplace
(October 1, 2017, through September 30, 2018)**

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average	Asst. Director Average
All Employee Survey: <i>I can disclose a suspected violation of any law, rule, or</i>	1 (Strongly Disagree) – 5 (Strongly Agree)	3.8	3.6	4.5	3.6	3.6	3.7	4.0

Questions/ Survey Items	Scoring	VHA Average	Facility Average	Director Average	Chief of Staff Average	ADPCS Average	Assoc. Director Average	Asst. Director Average
<i>regulation without fear of reprisal.</i>								
All Employee Survey: <i>Employees in my workgroup do what is right even if they feel it puts them at risk (e.g., risk to reputation or promotion, shift reassignment, peer relationships, poor performance review, or risk of termination).</i>	1 (Strongly Disagree) – 5 (Strongly Agree)	3.7	3.6	4.4	3.5	3.6	3.4	3.8
All Employee Survey: <i>In the past year, how often did you experience moral distress at work (i.e., you were unsure about the right thing to do or could not carry out what you believed to be the right thing)?</i>	0 (Never) – 6 (Every Day)	1.5	1.5	0.8	1.7	1.4	1.4	1.3

Source: VA All Employee Survey (accessed December 10, 2018)

Patient Experience

To assess patient attitudes toward facility leaders, the OIG reviewed patient experience survey results that relate to the period of October 1, 2017, through August 31, 2018. VHA’s Patient Experiences Survey Reports provide results from the Survey of Healthcare Experience of Patients (SHEP) program. VHA uses industry standard surveys from the Consumer Assessment of Healthcare Providers and Systems program to evaluate patients’ experiences with their health care and to support benchmarking its performance against the private sector. Table 4 provides relevant survey results for facility leadership and compares the results to the overall VHA averages.¹⁸

¹⁸ Ratings are based on responses by patients who received care at this facility.

VHA collects SHEP survey data from Patient-Centered Medical Home, Specialty Care, and Inpatient Surveys. The OIG reviewed responses to four relevant survey questions that reflect patients’ attitudes toward facility leaders (see Table 4). For this facility, one of four patient survey results reflected a higher care rating than the VHA average. Opportunities appear to exist to improve patient experiences in the inpatient and specialty care settings. Facility leaders appeared to be actively engaged with patients, for example, through the recent changes to preparing inpatients’ food on site, opening of a new parking deck, and moving toward mostly private rooms.

**Table 4. Survey Results on Patient Attitudes toward Facility Leadership
(October 1, 2017, through August 31, 2018)**

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.	66.9	65.0
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.	84.3	80.3
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.	76.2	82.1
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.	76.4	75.8

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed December 10, 2018)

Accreditation Surveys and Oversight Inspections

To further assess leadership and organizational risks, the OIG reviewed recommendations from previous inspections and surveys, including those conducted for cause, by oversight and accrediting agencies to gauge how well leaders respond to identified problems.¹⁹ Table 5 summarizes the relevant facility inspections most recently performed by the OIG and The Joint Commission (TJC).²⁰ The facility has closed all recommendations for improvement.²¹

At the time of the site visit, the OIG also noted the facility's current accreditation status with the Commission on Accreditation of Rehabilitation Facilities and College of American Pathologists.²² Additional results included the Long-Term Care Institute's inspections of the facility's CLC and the Paralyzed Veterans of America's inspections of the facility's spinal cord injury/disease unit and related services.²³

¹⁹ 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 other reported complaints. The outcomes of these types of activities may affect the accreditation status of an organization.

²⁰ According to VHA Directive 1100.16, *Accreditation of Medical Facility and Ambulatory Programs*, May 9, 2017, TJC provides 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."

²¹ 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.

²² According to VHA Directive 1170.01, *Accreditation of Veterans Health Administration Rehabilitation Programs*, May 9, 2017, 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; According to the College of American Pathologists, for 70 years it has "fostered excellence in laboratories and advanced the practice of pathology and laboratory science." College of American Pathologists. <https://www.cap.org/about-the-cap>. (The website was accessed on February 20, 2019.); In accordance with VHA Handbook 1106.01, *Pathology and Laboratory Medicine Service (P&LMS) Procedures*, January 29, 2016, VHA laboratories must meet the requirements of the College of American Pathologists.

²³ The Long Term Care Institute states that it has been to over 4,000 healthcare facilities conducting quality reviews and external regulatory surveys since 1999. The Long Term Care Institute is "focused on long term care quality and performance improvement, compliance program development, and review in long term care, hospice and other residential care settings." Long Term Care Institute. <http://www.ltcior.org/about-us/>. (The website was accessed on March 6, 2019.); The Paralyzed Veterans of America inspection took place March 14–15, 2017, and March 20–21, 2018. This veteran service organization review does not result in accreditation status.

Table 5. Office of Inspector General Inspections/The Joint Commission Survey

Accreditation or Inspecting Agency	Date of Visit	Number of Recommendations Issued	Number of Recommendations Remaining Open
OIG (<i>Combined Assessment Program Review of the Hunter Holmes McGuire VA Medical Center, Richmond, Virginia, Report No. 16-00107-256, April 8, 2016</i>)	February 2016	17	0
OIG (<i>Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Hunter Holmes McGuire VA Medical Center, Richmond, Virginia, Report No. 16-00016-241, April 8, 2016</i>)	February 2016	12	0
TJC Hospital Accreditation	July 2017	37	0
TJC Behavioral Health Care Accreditation		2	0
TJC Home Care Accreditation		5	0
TJC For Cause	February 2018	2	0
TJC Methadone Program	March 2018	7	0

Sources: OIG and TJC (Inspection/survey results verified with the chief of Quality Management on January 9, 2019)

Factors Related to Possible Lapses in Care

Within the healthcare field, the primary organizational risk is the potential for patient harm. Many factors affect the risk for patient harm within a system, including hazardous environmental conditions; poor infection control practices; and patient, staff, and public safety. Leaders must be able to understand and implement plans to minimize patient risk through consistent and reliable data and reporting mechanisms. Table 6 lists the reported patient safety events from February 6, 2016 (the prior comprehensive OIG inspection), through January 11, 2019.²⁴

The OIG noted that in the 12 months prior to the OIG CHIP visit, the facility has conducted three root cause analyses regarding patient identification errors, one of which was reported to the patient as an institutional disclosure.

²⁴ It is difficult to quantify an acceptable number of adverse events affecting patients because even one is too many. Efforts should focus on prevention. Events resulting in death or harm 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 Hunter Holmes McGuire VA Medical Center is a highest complexity (1a) affiliated facility as described in Appendix B.)

**Table 6. Summary of Selected Organizational Risk Factors
(February 6, 2016, through January 11, 2019)**

Factor	Number of Occurrences
Sentinel Events ²⁵	13
Institutional Disclosures ²⁶	6
Large-Scale Disclosures ²⁷	0

Source: Hunter Holmes McGuire VA Medical Center risk manager (received January 7, 2019) and chief of Quality Management (received January 8, 2019)

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.²⁸ The rates presented are specifically applicable for this facility, and lower rates indicate lower risks. Table 7 summarizes patient safety indicator data from October 1, 2016, through September 30, 2018.

²⁵ The definition of sentinel event can be found within VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. A sentinel event is an incident or condition that results in patient “death, permanent harm, or severe temporary harm and intervention required to sustain life.”

²⁶ According to VHA Directive 1004.08, *Disclosure of Adverse Events To Patients*, October 31, 2018, VHA defines an institutional disclosure of adverse events (sometimes referred to as an “administrative disclosure”) as “a formal process by which VA medical 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 the patient’s 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.”

²⁷ According to VHA Directive 1004.08, *Disclosure of Adverse Events to Patients*, October 31, 2018, VHA defines large-scale disclosures of adverse events (sometimes referred to as “notifications”) as “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.”

²⁸ Agency for Healthcare Research and Quality. <https://www.qualityindicators.ahrq.gov/>. (The website was accessed on December 11, 2017.)

**Table 7. Patient Safety Indicator Data
(October 1, 2016, through September 30, 2018)**

Indicators	Reported Rate per 1,000 Hospital Discharges		
	VHA	VISN 6	Facility
Pressure ulcer	0.74	1.14	3.21
Death among surgical inpatients with serious treatable conditions	113.42	73.94	90.91
Iatrogenic pneumothorax ²⁹	0.17	0.14	0.21
Central venous catheter-related bloodstream infection	0.16	0.39	0.94
In-hospital fall with hip fracture	0.09	0.15	0.45
Perioperative hemorrhage or hematoma	2.61	3.07	6.59
Postoperative acute kidney injury requiring dialysis	0.89	0.99	3.59
Postoperative respiratory failure	4.54	4.76	5.31
Perioperative pulmonary embolism or deep vein thrombosis	2.97	3.51	3.94
Postoperative sepsis	3.55	4.41	3.70
Postoperative wound dehiscence (rupture along incision)	0.82	2.90	9.71
Unrecognized abdominopelvic accidental puncture or laceration	1.00	1.62	2.82

Source: VHA Support Service Center

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

The patient safety indicator measures for death among surgical inpatients with a serious treatable condition shows a higher reported rate than VISN 6 and postoperative sepsis shows a higher reported rate than VHA. The remaining 10 patient safety indicator measures (pressure ulcer, iatrogenic pneumothorax, central venous catheter-related bloodstream infection, in-hospital fall with hip fracture, perioperative hemorrhage or hematoma, postoperative acute kidney injury requiring dialysis, postoperative respiratory failure, postoperative pulmonary embolism or deep vein thrombosis, postoperative wound dehiscence, and unrecognized abdominopelvic accidental puncture/laceration) show a higher reported rate than VISN 6 and VHA.

The OIG also reviewed patient safety indicator data for FY 2018, quarter 4 (the most recent data) and the previous four quarters to identify any potential trends that may impact patient safety or

²⁹ According to Northwestern Memorial Hospital, "A Pneumothorax is a type of lung injury that allows air to leak into the area between the lungs and the chest wall, which causes mild to severe chest pain and shortness of breath. An Iatrogenic Pneumothorax is one which was caused by medical treatment, often as an incidental event during a procedure such as a pacemaker insertion." Northwestern Medicine. <http://www.nmh.org/nm/quality-lung-injury-due-to-medical-care>. (The website was accessed on March 6, 2019.)

increase the risk for patient harm. It is important to note that although the data are collected and reported by quarter, each set of quarterly data represents potential complications or patient safety events over an eight-quarter or two-year period. Therefore, it is possible for a facility measure to exceed the VHA rate due to a single incident and vary above or below the VHA rate over time due to differences in the number of patients treated. Figure 5 illustrates the time frames covered by the data reviewed.

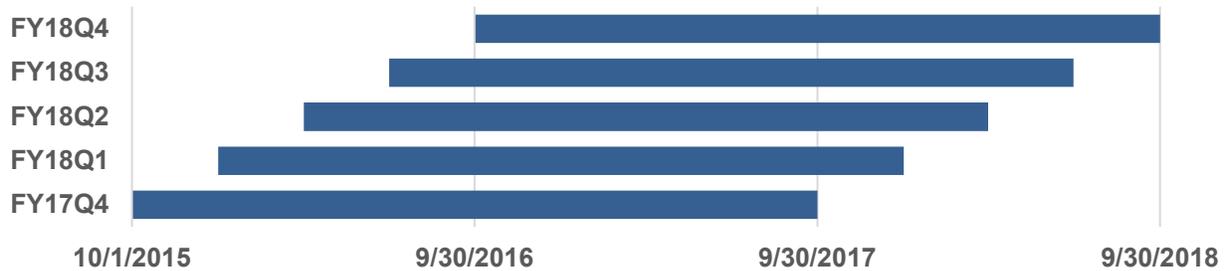


Figure 5. Associated Time Frames for Quarterly Patient Safety Indicator Data

Source: VA OIG

FY18Q4 = fiscal year 2018, quarter 4

FY18Q3 = fiscal year 2018, quarter 3

FY18Q2 = fiscal year 2018, quarter 2

FY18Q1 = fiscal year 2018, quarter 1

FY17Q4 = fiscal year 2017, quarter 4

Table 8 summarizes Patient Safety Indicator data for FY 2017, quarter 4 (FY17Q4) through FY 2018, quarter 4 (FY18Q4), which includes October 1, 2015, through September 30, 2018.

**Table 8. Patient Safety Indicator Data Trending
(October 1, 2015, through September 30, 2018)**

Indicators	Site	Reported Rate per 1,000 Hospital Discharges				
		FY17Q4	FY18Q1	FY18Q2	FY18Q3	FY18Q4
Pressure ulcer	VHA	0.60	0.88	— ³⁰	0.76	0.74
	Facility	1.58	2.89	—	2.96	3.21
Death among surgical inpatients with serious treatable conditions	VHA	100.97	118.96	113.92	114.89	113.42
	Facility	54.35	89.11	104.65	102.27	90.91
Iatrogenic pneumothorax	VHA	0.19	0.19	0.17	0.15	0.17
	Facility	0.29	0.35	0.20	0.10	0.21
Central venous catheter-related bloodstream infection	VHA	0.15	0.14	0.15	0.16	0.16
	Facility	0.67	0.60	0.71	1.10	0.94

³⁰ According to VHA’s Inpatient Evaluation Center, pressure ulcer data are not available for the time frame of April 1, 2016, through March 31, 2018.

Indicators	Site	Reported Rate per 1,000 Hospital Discharges				
		FY17Q4	FY18Q1	FY18Q2	FY18Q3	FY18Q4
In-hospital fall with hip fracture	VHA	0.08	0.09	0.08	0.09	0.09
	Facility	0.12	0.09	0.33	0.44	0.45
Perioperative hemorrhage or hematoma	VHA	1.94	2.58	2.62	2.59	2.61
	Facility	2.82	5.35	6.03	7.05	6.59
Postoperative acute kidney injury requiring dialysis	VHA	0.88	0.80	0.65	0.96	0.89
	Facility	3.22	2.85	3.16	3.14	3.59
Postoperative respiratory failure	VHA	5.55	5.34	5.11	4.88	4.54
	Facility	6.51	7.51	6.21	6.11	5.31
Perioperative pulmonary embolism or deep vein thrombosis	VHA	3.29	3.26	3.09	3.05	2.97
	Facility	5.29	5.60	5.33	4.97	3.94
Postoperative sepsis	VHA	4.00	3.96	3.72	3.70	3.55
	Facility	6.09	5.86	3.26	4.30	3.70
Postoperative wound dehiscence (rupture along incision)	VHA	0.52	1.04	1.00	0.93	0.82
	Facility	7.18	7.87	7.50	9.70	9.71
Unrecognized abdominopelvic accidental puncture or laceration	VHA	0.53	1.21	1.02	1.07	1.00
	Facility	3.13	3.76	2.43	2.83	2.82

Source: VHA Support Service Center

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

The reported rate for all measures, with the exception of death among surgical inpatients with serious treatable conditions, were generally above the VHA rates. Eight measures (pressure ulcer, central venous catheter-related bloodstream infection, perioperative hemorrhage or hematoma, postoperative acute kidney injury requiring dialysis, postoperative respiratory failure, perioperative pulmonary embolism or deep vein thrombosis, postoperative wound dehiscence, and unrecognized abdominopelvic accidental puncture or laceration) are higher than the VHA averages for all quarters reviewed, and one measure (in-hospital fall with hip fracture) is higher than the VHA average for the last three quarters. Further, five of these measures (pressure ulcer, central venous catheter-related bloodstream infection, in-hospital fall with hip fracture, perioperative hemorrhage or hematoma, and postoperative wound dehiscence) show an apparent general or recent upward trend.

For FY 2018 quarter 4, the reported rate for patients that developed pressure ulcers includes 19 patients. Each case was reviewed individually as a part of the facility pressure ulcer prevention program. The wound care nurses report pressure ulcers via the joint patient safety reporting system so that they can be evaluated, tracked, and trended. The facility recently completed an aggregate review and is piloting improvement actions. The OIG noted that the observed trend

was largely due to pressure ulcers reported during the first three quarters of FY 2018 and that there was only one additional patient identified for FY 2018 quarter 4.

Eight deaths resulted in the facility's most recently reported rate for death among surgical inpatients with a serious treatable condition to exceed the VISN 6 rate. Facility leaders provided no evidence of completing individual or aggregate reviews of the deaths prior to OIG's request for information during the on-site visit. Facility leaders reported working with Inpatient Evaluation Centers/SAIL to exclude the heart transplant patients from the facility list of events as this may be affecting the facility rates. Five of the eight events occurred in the last fiscal year with four deaths in the first and one death in the third quarters of FY 2018; there were no reported occurrences in the fourth quarter of FY 2018.

Regarding the iatrogenic pneumothorax measure, facility leaders provided no evidence of completing individual reviews of the single-patient events that occurred in the first and fourth quarters of FY 2018.

Although the OIG noted a trend for patients who developed central venous catheter-related bloodstream infections, this was mainly due to infections prior to FY 2018. There was one infection reported for FY 2018 in the third quarter, and facility leaders provided evidence to support aggregate reviews of trends. The Medical Intensive Care Unit had conducted a central line change improvement project and, based on the results, was to be rolled out facility wide.

As a result of in-hospital falls, four patients fractured their hips—three of which occurred in the second and third quarters of FY 2018. Facility leaders provided evidence to support aggregate reviews of trends through the FY 2017 falls aggregate where improvement actions were identified. The OIG was not provided with the current status of actions and outcomes.

For the surgical-related patient safety indicator measures (perioperative hemorrhage or hematoma, postoperative acute kidney injury requiring dialysis, postoperative respiratory failure, perioperative pulmonary embolism or deep vein thrombosis, postoperative sepsis, postoperative wound dehiscence, and unrecognized abdominopelvic accidental puncture or laceration), facility leaders provided no evidence of completing individual or aggregate reviews of the patients' care prior to OIG's request for information during the on-site visit. Facility staff stated that all surgical cases are reviewed through the VA Surgical Quality Improvement Program; however, the OIG was not provided information regarding the reviews or actions taken, if necessary.

Additional details regarding these measures are included below:

- For FY 2018 quarter 4, the reported rate for perioperative hemorrhage or hematoma is based on 19 patients—nine events in the first quarter, two events in the second quarter, and five events in the third quarter of FY 2018. Three of the 19 events occurred prior to FY 2018.

- Although an apparent trend was noted for patients requiring dialysis following postoperative kidney injury, the most recently reported rates were due to five injuries sustained prior to FY 2018 and single-patient injuries in the third and fourth quarters.
- Eight patients developed respiratory failure postoperatively—five of which occurred in FY 2018.
- Twelve patients experienced pulmonary embolus around the time of surgery—five of which occurred in FY 2018.
- Seven patients developed postoperative sepsis. Although there were no occurrences reported in FY 2018 quarter 4, three patients developed sepsis during the first and third quarters of FY 2018.
- Eight patients experienced postoperative wound dehiscence, with three of those in FY 2018.
- For FY 2018 quarter 4, the reported rate for unrecognized abdominopelvic accidental puncture/laceration is based on five patients, which occurred during the first three quarters of FY 2018.

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.” It does, however, have 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.³¹

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 6 describes the distribution of facilities by star rating.³² As of June 30, 2018, the facility was rated as “4-star” for overall quality.

³¹ VHA Support Service Center (VSSC), The Strategic Analytics for Improvement and Learning (SAIL) Value Model, <http://vawww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=8938>. (The website was accessed on March 7, 2019, but is not accessible by the public)

³² According to the methods established by the SAIL Model, this is based on normal distribution ranking of the quality domain for 130 VA Medical Centers.

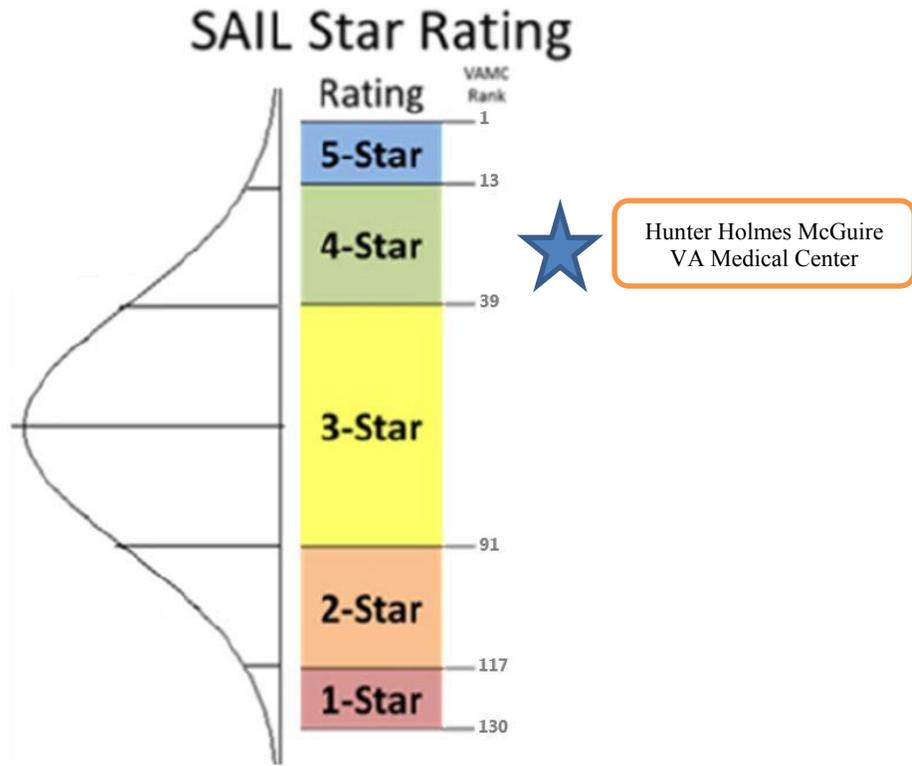
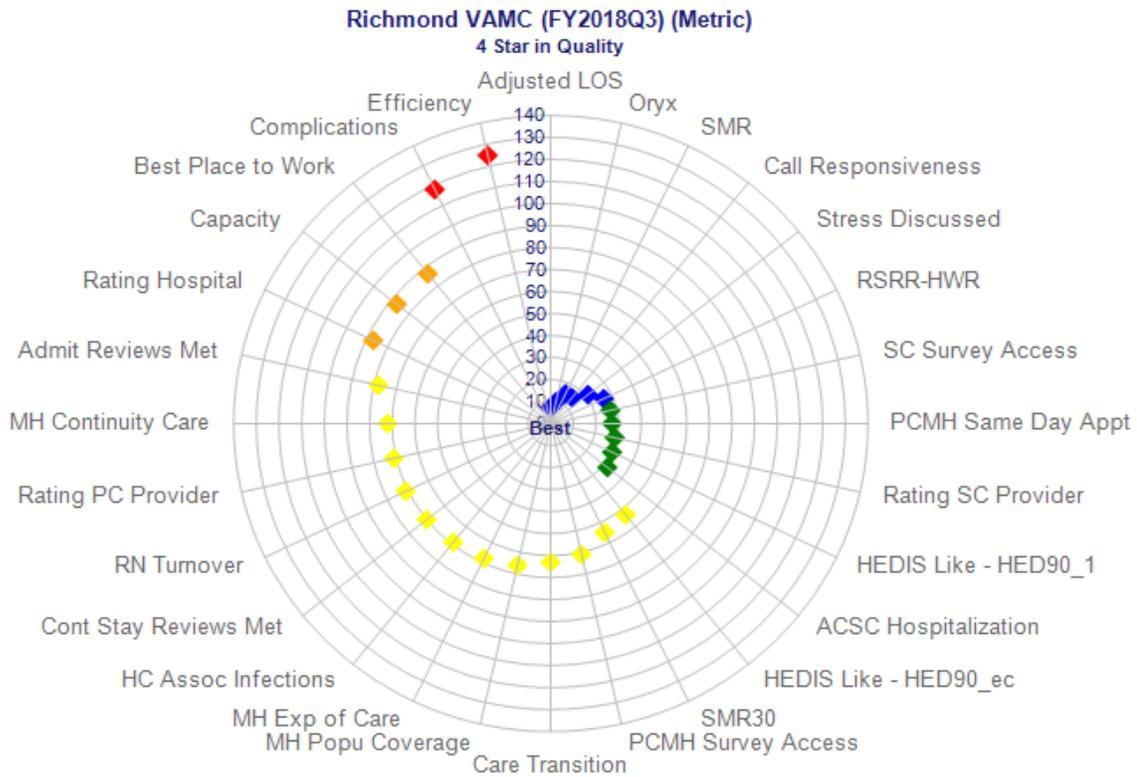


Figure 6. Strategic Analytics for Improvement and Learning Star Rating Distribution (as of June 30, 2018)
Source: VA Office of Informatics and Analytics Office of Operational Analytics and Reporting (accessed December 17, 2018)

Figure 7 illustrates the facility’s quality of care and efficiency metric rankings and performance compared with other VA facilities as of June 30, 2018. Of note, the figure uses blue and green data points to indicate high performance (for example, in the areas of adjusted length of stay (LOS), call responsiveness, hospital wide readmission (RSRR-HWR), and rating (of) specialty care (SC) provider). Metrics that need improvement are denoted in orange and red (for example, rating (of) hospital, best place to work, and complications).³³

³³ For information on the acronyms in the SAIL metrics, please see Appendix D.



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

Figure 7. Facility Quality of Care and Efficiency Metric Rankings (as of June 30, 2018)

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). Data definitions are provided in Appendix D.

The SAIL Value Model also includes “SAIL CLC,” which is a tool to summarize and compare the performance of CLCs in the VA. The SAIL model leverages much of the same data used in The Centers for Medicare & Medicaid Services’ (CMS) *Nursing Home Compare*.³⁴ The SAIL CLC provides a single resource to review quality measures and health inspection results. It

³⁴ According to the Center for Innovation and Analytics, *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, November 19, 2018, “In December 2008, The Centers for Medicare & Medicaid Services (CMS) enhanced its *Nursing Home Compare* public reporting site to include a set of quality ratings for each nursing home that participates in Medicare or Medicaid. The ratings take the form of several “star” ratings for each nursing home. The primary goal of this rating system is to provide residents and their families with an easy way to understand assessment of nursing home quality; making meaningful distinctions between high and low performing nursing homes.”

includes star ratings for an unannounced survey, staffing, quality, and overall results.³⁵ Table 9 summarizes the rating results for the facility’s CLC as of September 30, 2018. Although the facility has an overall “4-star” rating, its rating for Quality is only a “1-star.”

**Table 9. Facility CLC Star Ratings
(as of September 30, 2018)**

Domain	Star Rating
Unannounced Survey	4
Staffing	5
Quality	1
Overall	4

Source: VHA Support Service Center

In exploring the reasons for the “1-star” quality rating, the OIG considered the radar diagram showing CLC performance relative to other CLCs for all 13 quality measures. Figure 8 illustrates the facility’s CLC quality rankings and performance compared with other VA CLCs as of September 30, 2018. The figure uses blue and green data points to indicate high performance (for example, in the areas of physical restraints–long stay (LS), high risk pressure ulcers (PU) (LS), and moderate-severe pain (LS)). Metrics that need improvement and were likely the reasons why the facility had a “1-star” for quality are denoted in orange and red (for example, catheter in bladder (LS), help with activities of daily living (ADL) (LS), falls with major injury (LS), and ability to move independently worsened (LS)).³⁶

³⁵ *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, Center for Innovation & Analytics (last updated August 22, 2019).
<http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=7410>.
(The website was accessed on September 3, 2019, but is not accessible by the public.)

³⁶ For data definitions of acronyms in the SAIL CLC measures, please see Appendix E.

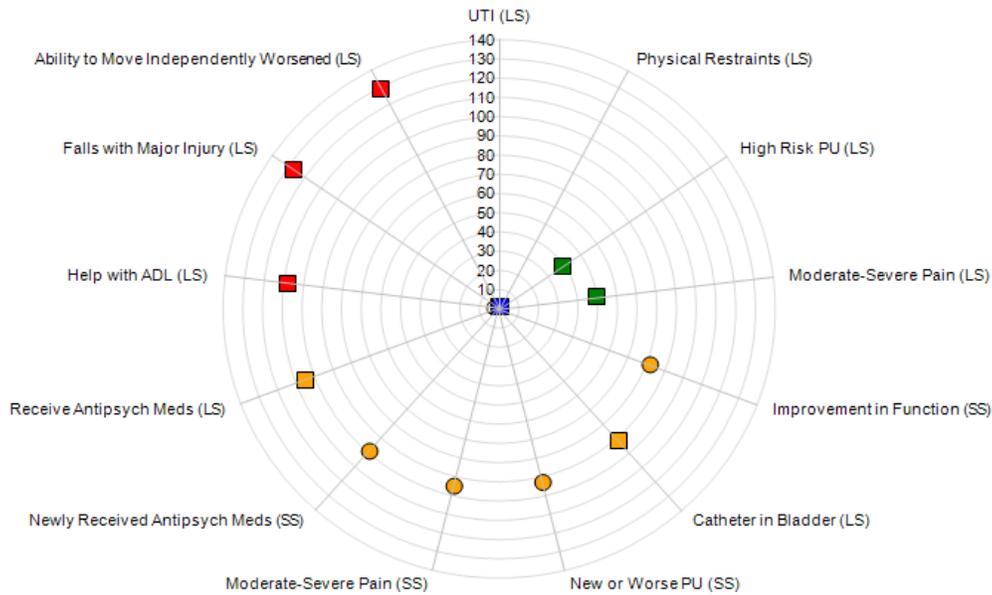


Figure 8. Facility CLC Quality Measure Rankings (as of September 30, 2018)

LS = Long-Stay Measure SS = Short-Stay Measure

Source: VHA Support Service Center

Note: The OIG did not assess VA’s data for accuracy or completeness. For data definitions, see Appendix E.

Leadership and Organizational Risks Conclusion

The facility had generally stable executive leadership, but the OIG had concerns with long-term leadership vacancies in Nursing Service that are currently filled with acting staff. These vacancies have had either only recent recruitment or no recruitment efforts. The OIG also noted opportunities appear to exist to improve employee satisfaction, to provide employees an environment where they feel safe bringing forth issues and concerns, and to improve patient experiences in the inpatient and specialty care settings. The OIG’s review of accreditation organization findings did not identify any substantial organizational risk factors. However, the OIG is concerned with events related to patient identification and assessment of those cases that may need institutional disclosures. The leadership team was aware of the patient safety indicator data but should evaluate the current process of identifying improvement opportunities. The OIG noted opportunities for all executive leadership team members to improve their knowledge, within their scope of responsibility, about selected SAIL and CLC metrics and the actions necessary to sustain and improve performance of measures contributing to the SAIL “4-star” and CLC “1-star” quality ratings.

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 that involves coordinating care among members of the healthcare team. To meet this goal, VHA must foster a culture of integrity and accountability in which personnel are vigilant and mindful, proactively risk-aware, and committed to consistently providing quality care, while seeking continuous improvement.³⁷ VHA also strives to provide healthcare services that compare favorably to the best of the private sector in measured outcomes, value, and efficiency.³⁸ VHA requires that its facilities operate a quality, safety, and value (QSV) program to monitor the quality of patient care and performance improvement activities.³⁹

In determining whether the facility implemented and incorporated several OIG-selected key functions of VHA's Enterprise Framework for QSV into local activities, the inspection team evaluated protected peer reviews of clinical care,⁴⁰ utilization management (UM) reviews,⁴¹ patient safety incident reporting with related root cause analyses,⁴² and cardiopulmonary resuscitation (CPR) episode reviews.⁴³

When conducted systematically and credibly, protected peer reviews reveal areas for improvement (involving one or more providers' practices) and can result in both immediate and long-term improvements in patient care. Peer reviews are intended to promote confidential and

³⁷ VHA Directive 1026, *VHA Enterprise Framework for Quality, Safety, and Value*, August 2, 2013. (This VHA directive was scheduled for recertification on or before the last working day of August 2018 and has not been recertified.)

³⁸ Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 2014.

³⁹ VHA Directive 1026.

⁴⁰ The definition of a peer review can be found within VHA Directive 1190, *Peer Review for Quality Management*, November 21, 2018. A peer review is a critical review of care, performed by a peer, to evaluate care provided by a clinician for a specific episode of care, to identify learning opportunities for improvement, to provide confidential communication of the results back to the clinician, and to identify potential system or process improvements.

⁴¹ According to VHA Directive 1117(1), *Utilization Management Program*, July 9, 2014 (amended January 18, 2018), UM reviews include evaluating the "appropriateness, medical need, and efficiency of health care services according to evidence-based criteria." This directive was in effect at the time of the review but was replaced by VHA Directive 1117(2), *Utilization Management Program*, July 9, 2014 (amended April 30, 2019). This directive expired on July 31, 2019.

⁴² The definition of a root cause analysis can be found within VHA Handbook 1050.01, *VHA National Patient Safety Improvement Handbook*, March 4, 2011. (This VHA Handbook was scheduled for recertification on or before the last working date of March 2016 and has not been recertified.) A root cause analysis is "a process for identifying the basic or contributing causal factors that underlie variations in performance associated with adverse events or close calls."

⁴³ VHA Directive 1177, *Cardiopulmonary Resuscitation*, August 28, 2018.

nonpunitive processes that consistently contribute to quality management efforts at the individual provider level.⁴⁴

The UM program, a key component of VHA's framework for quality, safety, and value, provides vital tools for managing the quality and the efficient use of resources. It strives to ensure that the right care occurs in the right setting, at the right time, and for the right reason using evidence-based practices and continuous measurement to guide improvements.⁴⁵

Among VHA's approaches for improving patient safety is the mandated 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 root cause analyses help to more accurately identify and rapidly communicate potential and actual causes of harm to patients throughout the facility.⁴⁶

VHA has also issued guidance to support its strategic priority of providing personalized, proactive, patient-driven care and to ensure that the provision of life-sustaining treatments, including CPR, is aligned with patients' values, goals, and preferences. VHA requires that each facility establishes a CPR Committee or equivalent that fully reviews each episode of care in which resuscitation was attempted. The ongoing review and analysis of high-risk healthcare processes is essential for ensuring patient safety and the provision of high-quality care. VHA also has established requirements for basic life support and advanced cardiac life support training and certification for clinicians responsible for administering life-sustaining treatments.⁴⁷

The OIG interviewed senior managers and key QSV employees and evaluated meeting minutes, protected peer reviews, root cause analyses, the annual patient safety report, and other relevant documents. Specifically, OIG inspectors evaluated the following performance indicators:⁴⁸

- Protected peer reviews
 - Evaluation of aspects of care (for example, choice and timely ordering of diagnostic tests, prompt treatment, and appropriate documentation)
 - Implementation of improvement actions recommended by the Peer Review Committee
 - Completion of final reviews within 120 calendar days

⁴⁴ VHA Directive 1190.

⁴⁵ VHA Directive 1117(1).

⁴⁶ VHA Handbook 1050.01.

⁴⁷ VHA Directive 1177; VHA Handbook 1004.03, *Life-Sustaining Treatment Decisions: Eliciting, Documenting and Honoring Patients' Values, Goals and Preferences*, January 11, 2017.

⁴⁸ For CHIP reviews, the OIG selects performance indicators based on VHA or regulatory requirements or accreditation standards and evaluates these for compliance.

- Quarterly review of Peer Review Committee’s summary analysis by the Medical Executive Committee
- Peer review of all applicable deaths within 24 hours of admission to the hospital
- Peer review of all completed suicides within seven days after discharge from an inpatient mental health unit⁴⁹
- UM
 - Completion of at least 75 percent of all required inpatient reviews
 - Documentation of at least 75 percent of physician UM advisors’ decisions in the National UM Integration database
 - Interdisciplinary review of UM data
- Patient safety
 - Annual completion of a minimum of eight root cause analyses⁵⁰
 - Inclusion of required content in root cause analyses (generally)
 - Submission of completed root cause analyses to the National Center for Patient Safety within 45 days
 - Provision of feedback about root cause analysis actions to reporting employees
 - Submission of annual patient safety report to facility leaders
- Resuscitation episode review
 - Evidence of a committee responsible for reviewing resuscitation episodes
 - Confirmation of actions taken during resuscitative events being consistent with patients’ wishes
 - Evidence of basic or advanced cardiac life support certification for code team responders
 - Evaluation of each resuscitation episode by the CPR Committee or equivalent

⁴⁹ VHA Directive 1190.

⁵⁰ According to VHA Handbook 1050.01, “the requirement for a total of eight [root cause analyses] and Aggregated Reviews is a minimum number, as the total number of [root cause analyses] is driven by the events that occur and the SAC [Safety Assessment Code] score assigned to them.” “At least four analysis per fiscal year must be individual [root cause analyses], with the balance being Aggregated Reviews or additional individual [root cause analyses.]”

Quality, Safety, Value Conclusion

The OIG found general compliance with peer reviews. However, during the review of 10 selected resuscitative events during the previous 12 months, the OIG found evidence that a patient with a “do not resuscitate” (DNR) order received resuscitation efforts for approximately 20 minutes before staff determined that these efforts were against the patient’s wishes. The situation was complicated by the fact that the patient was an emergent transfer from another VA facility, the facilities documented the patient’s DNR decisions differently, and there was no evidence of hand-off communication between the transferring and receiving nurses. The facility’s investigation determined that a root cause analysis was not warranted. The OIG did not identify any other patients who received inappropriate resuscitative efforts. The OIG also identified concerns with UM, patient safety processes, and committee review of resuscitation episodes that warrant recommendations for improvement.

Specific to UM, VHA requires that physician UM advisors document their decisions in the National UM Integration database regarding appropriateness of patient admissions and continued stays for 75 percent of all inpatient stays.⁵¹ From April 1, 2018, through September 30, 2018, advisors documented only 74 percent of their decisions in the database. This resulted in a lack of assurance that the appropriate level of care and treatment was provided to patients. The chief of the Clinical Command Center cited that database documentation was not maintained due to a physician UM advisor position vacancy. This is a repeat finding from the 2016 CAP inspection.

Recommendation 1

1. The chief of staff ensures physician utilization management advisors consistently document their decisions in the National Utilization Management Integration database and monitors advisors’ compliance.⁵²

Facility concurred.

Target date for completion: We request closure of this recommendation, as of August 1, 2019, based on the evidence provided.

Facility response: Eight weeks prior to the OIG CHIP an additional PUMA was hired at the facility. Compliance of greater than 75 percent has been met for January 2019 through July 2019.

VHA also requires that root cause analyses include specific content to ensure the reviews are thorough and credible. This includes “determination of the human and other factors most directly

⁵¹ VHA Directive 1117(1).

⁵² The OIG reviewed evidence sufficient to demonstrate that the facility had completed improvement actions and therefore closed the recommendation before the report’s release.

associated with the event or close call[,...]identification of system vulnerabilities or risks and their potential contributions to the adverse event or close call[,...]” and the consideration of relevant literature.⁵³ The OIG found that four of five reviews conducted did not include required content. This resulted in incomplete and unreliable reviews. To explain the noncompliance the patient safety manager reported documenting by exception⁵⁴ and not repeating the documentation that relevant literature was considered, for instance, when the root cause analysis is conducted for an issue that occurred previously.

Recommendation 2

2. The facility director confirms that the patient safety manager includes all required content in root cause analyses and monitors patient safety manager’s compliance.

Facility concurred.

Target date for completion: September 30, 2019

Facility response: Required elements have always been a part of the Root Cause Analysis (RCA) process here at the facility. We recognized the required elements were not always documented. Since January 2019 documentation now reflects the required elements.

The director will ensure compliance.

Numerator = # of Root Cause Analyses containing the required elements.

Denominator = # of Root Cause Analyses completed

Of the six RCAs completed from January 2019 through July 2019, 100% of RCAs conducted had all required elements. Audits are conducted to ensure monthly compliance at 90% or greater. These results will be reported to Quality, Safety, and Value Council.

In accordance with TJC standards, VHA requires that the facility Code Blue Committee reviews each resuscitative episode of care under the facility’s responsibility.⁵⁵ There was no evidence that the Code Blue Committee reviewed 9 of 10 OIG-selected resuscitative episodes at the facility. Furthermore, the one episode that was reviewed did not include a review of clinical/patient issues that may have contributed to the event or any delays in initiating CPR. This likely resulted in missed opportunities for the identification of errors or deficiencies in technique or procedures; availability or malfunction of equipment; and clinical or patient care issues, such as failure to

⁵³ VHA Handbook 1050.01.

⁵⁴ “Charting by exception (CBE) is a shorthand method of documenting normal findings, based on clearly defined normal, standards of practice, and predetermined criteria for assessments and interventions. Significant findings or exceptions to the predefined norms are documented in detail.”
<https://www.healthcareitoday.com/2015/05/26/documentation-by-exception-is-the-dredge-of-ehr-documentation/>. (This website was accessed on April 11, 2019.)

⁵⁵ VHA Directive 1177.

rescue, that can contribute to the occurrence of a cardiopulmonary event. The chair of the Code Blue Committee cited a position vacancy as the reason for noncompliance.

Recommendation 3

3. The facility director makes certain the Code Blue Committee reviews each resuscitative episode under the facility's responsibility and monitors Code Blue Committee's compliance.

Facility concurred.

Target date for completion: September 30, 2019

Facility response: The chief of staff will ensure that Code Blue Committee fully reviews each episode of care where resuscitation was attempted. Each cardiopulmonary resuscitation (CPR) event must be reviewed for the presence of errors or deficiencies in techniques, lack of availability or malfunction of equipment, clinical issues or patient care issues such as failure to rescue which may have contributed to the event, appropriateness of interventions performed against national standards of care, delays in initiating CPR.

Numerator = # of Code Blue episodes reviewed by the committee with 4 required elements present.

Denominator = # of Code Blue episodes

The average of the data from January 2019 through July 2019 is 100%. Audits are conducted to ensure monthly compliance of 90% or greater. These results will be reported through the Code Blue Committee.

Medical Staff Privileging

VHA has defined procedures for the clinical privileging of “all health care professionals who are permitted by law and the facility to practice independently”—“without supervision or direction, within the scope of the individual’s license, and in accordance with individually granted clinical privileges.” These healthcare professionals are also referred to as licensed independent practitioners (LIPs).⁵⁶

Clinical privileges need to be specific, based on the individual’s clinical competence. They are recommended by service chiefs and the Executive Committee of the Medical Staff 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 their expiration.⁵⁷

VHA defines the focused professional practice evaluation (FPPE) as “a time-limited period during which the medical staff leadership evaluates and determines the practitioner’s professional performance. The FPPE typically occurs at the time of initial appointment to the medical staff, or the granting of new, additional privileges.” “The on-going monitoring of privileged practitioners, Ongoing Professional Practice Evaluation[s] (OPPE), [are] essential to confirm the quality of care delivered.”⁵⁸

According to TJC, the “FPPE for Cause” should be used when a question arises regarding a privileged provider’s ability to deliver safe, high-quality patient care. The “FPPE for Cause” is limited to a particular time frame and customized to the specific provider and related clinical concerns.⁵⁹ Federal law requires VA facilities to report to the National Practitioner Data Bank when facilities take adverse clinical privileging actions, accept the surrender of clinical privileges, or restrict clinical privileges when the action is related to professional competence or professional conduct of LIPs.⁶⁰

To determine whether the facility complied with requirements for privileging, the OIG interviewed key managers and selected and reviewed the privileging folders of several medical staff members:

⁵⁶ VHA Handbook 1100.19, *Credentialing and Privileging*, October 15, 2012. (This VHA Handbook was scheduled for recertification on or before the last working date of October 2017 and has not been recertified.)

⁵⁷ VHA Handbook 1100.19.

⁵⁸ VHA Handbook 1100.19.

⁵⁹ Office of Safety and Risk Awareness, Office of Quality and Performance, “Provider Competency and Clinical Care Concerns Including: Focused Clinical Care Review and FPPE for Cause Guidance” July 2016 (Revision 2).

⁶⁰ VHA Handbook 1100.17, *National Practitioner Data Bank (NPDB) Reports*, December 28, 2009. (This VHA Handbook was scheduled for recertification on or before the last working date of December 2014 and has not been recertified.)

- No solo or few (less than two in a specialty) practitioners were hired within 18 months before the site visit or were privileged within the prior 12 months⁶¹
- Ten LIPs hired within 18 months before the site visit
- Thirteen LIPs re-privileged within 12 months before the visit
- Three providers who underwent a FPPE for cause within 12 months prior to the visit.

The OIG evaluated the following performance indicators:

- Privileging
 - Privileges requested by the provider
 - Facility-specific
 - Service-specific
 - Provider-specific⁶²
 - Approval of privileges for a period of less than, or equal to, two years
- Focused professional practice evaluations
 - Criteria defined in advance
 - Use of required criteria in FPPEs for selected specialty LIPs
 - Results and time frames clearly documented
 - Evaluation by another provider with similar training and privileges
 - Executive Committee of the Medical Staff's consideration of FPPE results in its decision to recommend continuing the initially granted privileges
- Ongoing professional practice evaluations
 - Criteria specific to the service or section
 - Use of required criteria in OPPEs for selected specialty LIPs

⁶¹ The 18-month period was from July 7, 2017, through January 7, 2019. The 12-month review period covered January 7, 2018, through January 7, 2019; VHA Memorandum, *Requirements for Peer Review of Solo Practitioners*, August 29, 2016, refers to a solo practitioner as being one provider in the facility that is privileged in a particular specialty. The OIG considers "few practitioners" as being fewer than three providers in the facility that are privileged in a particular specialty.

⁶² According to VHA Handbook 1100.19, facility-specific means that privileges are granted only for procedures and types of services performed at the facility; service-specific refers to privileges being granted in a specific clinical service, such as neurology; and provider-specific means that the privileges should be granted to the individual provider based on their clinical competence and capabilities.

- Service chief’s determination to recommend continuation of current privileges was based in part on the results of OPPE activities
- Evaluation by another provider with similar training and privileges
- Executive Committee of the Medical Staff’s decision to recommend continuing privileges based on OPPE results
- Focused professional practice evaluations for cause
 - Clearly defined expectations/outcomes
 - Time-limited
 - Provider’s ability to practice independently not limited for more than 30 days
 - Shared with the provider in advance
 - Reporting of privileging actions to National Practitioner Data Bank

Medical Staff Privileging Conclusion

The OIG found general compliance with requirements for privileging. However, the OIG identified deficiencies with FPPE, OPPE, and FPPE for cause processes that warranted recommendations for improvement.

Specifically for FPPE reviews, VHA requires the criteria be defined in advance, objective, and accepted by the practitioner.⁶³ Of the 13 applicable practitioner’s profiles reviewed, 10 lacked evidence that the evaluation criteria were defined before initiation of the FPPE. Failure to clearly define expectations can hinder the evaluation of their practice. Service chiefs reported discussion of the expectations with the provider and felt that met the requirement.

In addition, VHA requires that FPPEs are time-limited. Time limitations help to ensure an efficient process by preventing undefined or indefinite evaluation of providers.⁶⁴ The OIG found that 6 of 13 FPPEs, including one FPPE for cause, lacked documentation of the time frame for evaluation. This could have resulted in an inefficient process for evaluating these providers. The service chiefs believed that they met requirements by providing the Medical Center Bylaws and discussing the evaluation criteria with the providers.

Further, VHA requires providers with “similar training and privileges evaluate the privilege-specific competence of the practitioner and document evidence of competently performing the requested privileges of the facility.”⁶⁵ In 2 of 10 applicable provider profiles, the OIG found that

⁶³ VHA Handbook 1100.19.

⁶⁴ VHA Handbook 1100.19.

⁶⁵ VHA Deputy Under Secretary for Health Operations and Management (DUSHOM) Memorandum, *Requirements for Peer Review of Solo Practitioners*, August 29, 2016.

the evaluations were conducted by a provider who did not have similar training and privileges. This resulted in providers practicing without a comprehensive evaluation of their practice. The service chiefs reported use of data, basic elements of practice, and an interdisciplinary approach to evaluate providers.

Recommendation 4

4. The chief of staff ensures that clinical managers initiate focused professional practice evaluations that include clearly delineated criteria and time frames in advance and monitors clinical managers' compliance.

Facility concurred.

Target date for completion: November 30, 2019

Facility response: The Medical Professional Standards Committee (MPSC) has implemented new processes that were effective in April 2019. Since this implementation data reflects compliance. These data are monitored monthly to ensure compliance.

Numerator = # FPPEs reviewed with delineated criteria and time frames

Denominator = # of total FPPEs reviewed by the MPSC

The chief of staff will ensure compliance. We will continue to monitor this data until compliant for 6 months with an average of $\geq 90\%$. The average of the data from April 2019 through July 2019 is 100%. Audits are conducted to ensure monthly compliance. These results will be reported to the Medical Professional Standards Committee.

Recommendation 5

5. The chief of staff ensures that focused professional practice evaluations are completed by a provider with similar training and privileges and monitors compliance.

Facility concurred.

Target date for completion: November 30, 2019

Facility response: The Medical Professional Standards Committee (MPSC) has implemented new processes that were effective in April 2019.

Numerator = # FPPEs reviewed by providers with similar training and privileges.

Denominator = # of total FPPEs reviewed by the MPSC

The chief of staff will ensure compliance. We will continue to monitor this data until compliant for 6 months with an average of $\geq 90\%$. The average of the data from April 2019 through July 2019 is 100%. These results will be reported to the Medical Professional Standards Committee.

Despite VHA requiring that results of the professional practice evaluations be documented in the provider's profile and reported to the facility's Medical Staff Executive Committee (Medical Executive Board) "for consideration in making recommendations on privileges,"⁶⁶ the OIG found that the results of 10 of 23 professional practice evaluations (nine focused and one ongoing) were not presented to the Medical Professional Standards Committee, the Medical Executive Council subcommittee responsible for conducting the credentialing and privileging process. This resulted in the facility missing the opportunity to identify professional practice trends that could impact the quality of care and patient safety. The service chiefs reported they have multiple providers and lack a system-wide process to track when the providers are due to be presented to the Medical Professional Standards Committee.

Recommendation 6

6. The chief of staff makes certain that the Medical Professional Standards Committee reviews and evaluates licensed independent practitioners' professional practice evaluations when recommending approval of privileges through the Medical Executive Council to the director and monitors committee's compliance.

Facility concurred.

Target date for completion: November 30, 2019

Facility response: The Medical Professional Standards Committee (MPSC) has implemented new processes that were effective in April 2019.

Numerator = # professional practice evaluations presented to MPSC

Denominator = Total # of professional practice evaluation due for review

The chief of staff will ensure compliance. We will continue to monitor this data until compliant for 6 months with an average of $\geq 90\%$. The average of the data from April 2019 through July 2019 is 99%. These results will be reported to the Medical Professional Standards Committee.

In addition, VHA requires that service chiefs consider relevant service- and practitioner-specific data utilizing defined criteria when recommending the initial approval or continuation of licensed independent practitioners' privileges to the Medical Staff Executive Committee. Such data are maintained as part of the practitioner's provider profile and may include direct observations, clinical discussions, and clinical record reviews.⁶⁷

In 2 of 13 provider profiles used to support the renewal of practitioners' privileges, there was no evidence of complete service-specific data collection. This resulted in insufficient evidence to confirm the quality of care delivered by providers. The service chiefs reported this data was not

⁶⁶ VHA Handbook 1100.19.

⁶⁷ VHA Handbook 1100.19.

always maintained because it contained patient identifiable information and each service had its own process for maintaining data.

Recommendation 7

7. The chief of staff ensures that service chiefs consistently collect and review ongoing professional practice evaluation data and monitors service chiefs' compliance.

Facility concurred.

Target date for completion: November 30, 2019

Facility response: The Medical Professional Standards Committee (MPSC) has implemented new processes that were effective in April 2019.

Numerator = # OPPE for providers having required service specific elements

Denominator = # of OPPE candidates brought to the MPSC

The chief of staff will ensure compliance. We will continue to monitor this data until compliant for 6 months with an average of $\geq 90\%$. The average of the data from April 2019 through July 2019 is 100%. These results will be reported to the Medical Professional Standards Committee.

Environment of Care

Any facility, regardless of its size or location, faces vulnerabilities in the healthcare environment. VHA requires managers to conduct environment of care inspection rounds and resolve issues in a timely manner. The goal of the environment of care 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.⁶⁸

The purpose of this facet of the OIG inspection was to determine whether the facility maintained a clean and safe healthcare environment in accordance with applicable requirements. The OIG examined whether the facility met requirements in selected areas that are often associated with higher risks of harm to patients, such as in the locked inpatient mental health unit. The inspection team also looked at facility compliance with emergency management processes.⁶⁹

VHA requires its facilities to have the “capacity for [providing] mental health 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;” however, for facilities that do not have inpatient mental health services, that “capacity” could mean facilitating care at a nearby VA or non-VA facility.⁷⁰

VHA requires managers to establish a comprehensive emergency management program to ensure the continuity of patient care and hospital operations in the event of a natural disaster or other emergency. This includes conducting a hazard vulnerability analysis and developing an emergency operations plan. These requirements are meant to support facilities’ efforts to identify and minimize harm from potential hazards, threats, incidents, and events related to healthcare and other essential services.⁷¹ Managers must also develop utility management plans to increase reliability and reduce failures of electrical power distribution systems in accordance with TJC,

⁶⁸ VHA Directive 1608, *Comprehensive Environment of Care, (CEOC Program)*, February 1, 2016.

⁶⁹ Applicable requirements for high-risk areas and emergency management include those detailed in or by 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).

⁷⁰ VHA Handbook 1160.06, *Inpatient Mental Health Services*, September 16, 2013. (This VHA Handbook was scheduled for recertification on or before the last working date of September 2018 and has not been recertified.)

⁷¹ VHA Directive 0320.01, *Veterans Health Administration Comprehensive Emergency Management Program (CEMP) Procedures*, April 6, 2017.

Occupational Safety and Health Administration,⁷² and National Fire Protection Association standards.⁷³ The provision of sustained electrical power during disasters or emergencies is critical to healthcare facility operations.⁷⁴

In all, the OIG team inspected seven inpatient areas—surgical intensive care unit (2G), CLC (1N), medical unit (4D), inpatient mental health (1F), surgical unit (2F), post-anesthesia care unit, and the spinal cord injury unit (1F), due to repeated findings related to cleanliness noted in the Paralyzed Veterans of America reports from 2017 and 2018. The team also inspected the emergency department, outpatient surgical specialty clinic, and the Fredericksburg 2 VA Clinic and reviewed the emergency management program. The inspection team reviewed relevant documents and interviewed key employees and managers. The OIG evaluated the following location-specific performance indicators:

- Parent facility
 - General safety
 - Environmental cleanliness and infection prevention
 - General privacy
 - Women veterans program
 - Availability of medical equipment and supplies
- Community based outpatient clinic
 - General safety
 - Environmental cleanliness and infection prevention
 - General privacy
 - Women veterans program
 - Availability of medical equipment and supplies
- Locked inpatient mental health unit
 - Mental health environment of care rounds

⁷² The Occupational Safety and Health Administration (OSHA) is part of the US Department of Labor. OSHA’s Mission is to assure safe and healthy working conditions “by setting and enforcing standards and by providing training, outreach, education, and assistance.” <https://www.osha.gov/about.html>. (This website was accessed on June 28, 2018.)

⁷³ The National Fire Protection Association (NFPA) is a global nonprofit organization “devoted to eliminating death, injury, property, and economic loss due to fire, electrical, and related hazards.” <https://www.nfpa.org/About-NFPA>. (This website was accessed on June 28, 2018.)

⁷⁴ TJC. Environment of Care standard EC.02.05.07.

- Nursing station security
- Public area and general unit safety
- Patient room safety
- Infection prevention
- Availability of medical equipment and supplies
- Emergency management
 - Hazard vulnerability analysis (HVA)
 - Emergency operations plan (EOP)
 - Emergency power testing and availability

Environment of Care Conclusion

Generally, the facility met safety and privacy measures at the parent facility. The OIG did not note any issues with the availability of medical equipment and supplies, and the Fredericksburg 2 VA Clinic generally met the performance indicators evaluated and had no findings. However, the OIG identified deficiencies at the parent facility with environment of care cleanliness that warranted recommendations for improvement.

TJC requires hospitals to identify environmental deficiencies, hazards, and unsafe practices, and to keep furnishings and equipment safe and in good repair.⁷⁵ The OIG noted that seven patient care areas had dirty ventilation grills;⁷⁶ six had dirty, stained, and/or damaged floors;⁷⁷ and five had stained or damaged walls and ceiling tiles⁷⁸⁷⁹ and dirty or dusty light fixtures.⁸⁰ These conditions resulted in a lack of assurance of a clean and safe patient care environment. Staff did not initiate, take action, or follow-up timely to address issues.

The acting chief, Environmental Management Service, admitted to the lack of supervisory oversight for housekeeping and facility supervisory oversight for a vendor contracted for

⁷⁵ TJC, Environment of Care standard EC.02.06.01.

⁷⁶ Surgical intensive care unit (2G), CLC (1N), emergency department (1C), inpatient mental health (1F), post-anesthesia care unit (2E), spinal cord injury unit (1W), surgical unit (2F).

⁷⁷ Surgical intensive care unit (2G), CLC (1N), medical unit (4D), spinal cord injury unit (1W), surgical unit (2F), outpatient surgical specialty clinic (2D).

⁷⁸ Surgical intensive care unit (2G), CLC (1N), inpatient mental health (1F), medical unit (4D), spinal cord injury unit (1W), surgical unit (2F).

⁷⁹ Surgical intensive care Unit (2G), CLC (1N), medical unit (4D), spinal cord injury unit (1W), surgical unit (2F).

⁸⁰ Surgical intensive care unit (2G), CLC (1N), inpatient mental health (1F), spinal cord injury unit (1W), emergency department.

cleaning several of the units, including the spinal cord injury unit. The chief, engineering service, reported internal communication and accountability issues as reasons for noncompliance.

Recommendation 8

8. The associate director ensures that a safe and clean environment is maintained throughout the facility and monitors compliance.

Facility concurred.

Target date for completion: September 30, 2019

Facility response: Regarding the cleanliness of the floors, ventilation grills, and light fixtures, a new EMS Chief was hired in April 2019. New processes were implemented to address deficient areas along with a new training program to include hands on training and review of standardized operating procedures. Regarding the damaged/stained floors, ceiling tiles, and walls- Engineering service is now monitoring Performance Logic data and addressing deficiencies. Corrective action is taken within 14 days and the finding is closed out in Performance Logic software and briefed in the Environmental of Care Committee.

Numerator = # clinical areas compliant

Denominator = # of clinical areas inspected

The associate director will ensure compliance. Audits are conducted to ensure monthly compliance at 90% or greater. These results will be reported through the Environment of Care Committee.

Medication Management: Controlled Substances Inspections

The Controlled Substances Act divides controlled drugs into five categories based on whether they have an accepted medical treatment use in the United States, their relative potential for abuse, and the likelihood of causing dependence if abused.⁸¹ Diversion of controlled substances by healthcare workers—the transfer of legally prescribed controlled substances from the prescribed individual to others for illicit use—remains a serious problem that can increase patient safety issues and elevate the liability risk to healthcare facilities.⁸²

VHA requires that facility managers implement and maintain a controlled substances inspection program to minimize the risk for loss and diversion and to enhance patient safety. Requirements include the appointment of controlled substances coordinator(s) and controlled substances inspectors, implementation of procedures for inventory control, and inspections of the pharmacy and clinical areas with controlled substances.⁸³

To determine whether the facility complied with requirements related to controlled substances security and inspections, the OIG team interviewed key managers and reviewed inspection reports; monthly summaries of findings, including discrepancies, provided to the facility director; inspection quarterly trend reports for the prior two completed quarters;⁸⁴ and other relevant documents. The OIG evaluated the following performance indicators:

- Controlled substances coordinator reports
 - Monthly summary of findings to the director
 - Quarterly trend reports to the director
 - Quality Management Committee’s review of monthly and quarterly trend reports
 - Actions taken to resolve identified problems
- Pharmacy operations
 - Staff restrictions for monthly review of balance adjustments⁸⁵
- Requirements for controlled substances inspectors

⁸¹ Drug Enforcement Agency Controlled Substance Schedules. <https://www.deadiversion.usdoj.gov/schedules/>. (The website was accessed on March 7, 2019.)

⁸² 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.

⁸³ VHA Directive 1108.02(1), *Inspection of Controlled Substances*, November 28, 2016 (amended March 6, 2017).

⁸⁴ The two quarters were from April 1, 2018, through September 30, 2018.

⁸⁵ Controlled substances balance adjustment reports list transactions in which the pharmacy vault inventory balance was manually adjusted.

- No 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 annual competency assessment
- Controlled substances area inspections
 - Completion of monthly inspections
 - Rotations of controlled substances inspectors
 - Patterns of inspections
 - Completion of inspections on day initiated
 - Reconciliation of dispensing between pharmacy and each dispensing area
 - Verification of controlled substances orders
 - Performance of routine controlled substances inspections
- Pharmacy inspections
 - Monthly physical counts of the controlled substances in the pharmacy
 - Completion of inspections on day initiated
 - Security and verification of drugs held for destruction⁸⁶
 - Accountability for all prescription pads in pharmacy
 - Verification of hard copy controlled substances prescriptions
 - Verification of 72-hour inventories of the main vault
 - Quarterly inspections of emergency drugs
 - Monthly checks of locks and verification of lock numbers
- Facility review of override reports⁸⁷

⁸⁶ According to VHA Directive 1108.02(1), The Destructions File Holding Report “lists all drugs awaiting local destruction or turn-over to a reverse distributor.” Controlled substances inspectors “must verify there is a corresponding sealed evidence bag containing drug(s) for each destruction holding number on the report.”

⁸⁷ When automated dispensing cabinets are used, nursing staff can override and remove medications prior to the pharmacists’ review of medications ordered by the providers.

Medication Management Conclusion

The OIG found general compliance with requirements for some of the performance indicators evaluated, including the controlled substances coordinator reports, pharmacy operations, and requirements for controlled substances inspectors. However, the OIG identified multiple deficiencies with controlled substances area (non-pharmacy) and pharmacy area inspections.

Specifically, VHA requires controlled substances inspectors to conduct monthly physical counts of controlled substances storage areas, including the cache, and that the controlled substances coordinator retain records to include inspector worksheets and supporting documentation.⁸⁸ The controlled substance inspectors completed their inspection worksheets indicating the monthly inventories were conducted, however, all non-pharmacy and pharmacy areas and cache lacked evidence of supporting documentation for all months reviewed to show actual inventory. This impacts the ability to identify potential drug diversion activities and discrepancies with controlled substances. The controlled substances coordinator and alternate thought the electronic cover sheet was sufficient and had not maintained supporting documentation. The controlled substance coordinator, who assumed the position in May 2018, was new to the program and had started to keep supporting documentation for some pharmacy inventories but did not have the same for non-pharmacy areas and cache due to lack of awareness of the requirements.

Recommendation 9

9. The facility director makes certain that the controlled substance inspectors conduct the monthly inventories of controlled substances and the controlled substances coordinator maintains supporting documentation of the completion of the monthly inventory of controlled substances and monitors compliance.

Facility concurred.

Target date for completion: September 30, 2019

Facility response: Numerator = # of areas with supporting documentation

Denominator = # of areas for inspection

The director will ensure compliance. Printed Omnicell inventory slips are scanned and submitted with inspection forms (implemented on 1/8/2019). The average of the data from January 2019 through June 2019 is 100%. Audits are conducted to ensure monthly compliance at 90% or greater. These results will be reported to the Controlled Substances Committee.

Despite VHA requiring evidence of reconciliation of “1 day’s dispensing from the pharmacy to every ADC [dispensing area] and 1 day’s return of stock to the pharmacy,”⁸⁹ the OIG found all

⁸⁸ VHA Directive 1108.02(1).

⁸⁹ VHA Directive 1108.02(1).

10 non-pharmacy areas reviewed lacked evidence of reconciliation of 1 day dispensing from pharmacy to each dispensing area and 1 day return of stock to pharmacy for the six months period. This could result in missed opportunities to identify potential drug diversion activities and discrepancies related to controlled substances. The controlled substances coordinator started in May 2018 and had overlooked this requirement.

Recommendation 10

10. The facility director ensures that controlled substances program staff reconcile one day's dispensing from the pharmacy to each dispensing area and one day's return of stock to the pharmacy and monitors compliance.

Facility concurred.

Target date for completion: September 30, 2019

Facility response: One day dispensing and return for non-pharmacy areas is identified on the Pharmacy inspections report which was reviewed. CSC recognized omitting return to stock data and implemented review in August 2018. CSC or Alternate will complete review of one day dispensing and return (implemented 2/1/2019). The Pharmacy inspection forms have been edited to clearly specify one day dispensing and return along with other aspects of the Pharmacy inspection with scanned supporting documentation.

Numerator = # of areas reconciled

Denominator = # of areas requiring reconciliation

The director will ensure compliance. The average of the data from January 2019 through June 2019 is 100%. Audits are conducted to ensure monthly compliance at 90% or greater. These results will be reported to the Controlled Substances Committee.

For inventory counts, VHA requires that the “physical inventory of controlled substance storage area must be completed on the day initiated.”⁹⁰ The OIG also found that all pharmacy areas selected for review did not have evidence that the inventory count was completed the day initiated. This resulted in missed opportunities to identify potential drug diversion activities and any discrepancies related to controlled substances. The controlled substances inspectors document on the electronic form, record the date of inspection, and then electronically sign. However, for some pharmacy area inspections, the dates of completion were different than the date the inspection was started, and the controlled substance coordinator stated that the pharmacy area inspections are documented on one electronic form and not all areas within pharmacy may be done on the same day.

⁹⁰ VHA Directive 1108.02(1).

Recommendation 11

11. The facility director makes certain that controlled substances inspectors complete the pharmacy monthly controlled substances inspection inventory on the day initiated and monitors inspectors' compliance.

Facility concurred.

Target date for completion: September 30, 2019

Facility response: Inspection forms have been edited to specify date of inspection completion in coordination with the printed Omnicell inventory slips, verifying the date inventory was audited by the Controlled Substance Inspector (CSI).

Numerator = # of inspections completed on day of initiation

Denominator = # of inspections required

The Director will ensure compliance. The average of the data from January 2019 through June 2019 is 100%. Audits are conducted to ensure monthly compliance at 90% or greater. These results will be reported to the Controlled Substances Committee.

Specifically, VHA requires that, during controlled substances inspections, the controlled substances inspectors verify there is a corresponding sealed evidence bag containing drug(s) for each medication held for destruction as listed on the "Destructions File Holding Report."⁹¹ For all pharmacy areas, the OIG did not find evidence that controlled substances inspectors verified that drugs held for destruction were secure or that each drug had a corresponding destruction number on the report, where drugs were held for destruction. Failure to verify drugs held for destruction against the holding number on the report may leave the facility vulnerable to loss and theft. The controlled substance coordinator assumed the position in May 2018 and being new to the program, had only started to keep supporting documentation for some pharmacy inventories.

Recommendation 12

12. The facility director makes certain that during monthly inspections, controlled substances inspectors verify that each medication listed on the "Destructions File Holding Report" is contained in a corresponding sealed evidence bag and monitors compliance of controlled substance inspection staff.

⁹¹ VHA Directive 1108.02(1).

Facility concurred.

Target date for completion: September 30, 2019

Facility response: The director will ensure compliance. The facility lacked documentation of verified review for the Destruction File Holding Report. Controlled Substance Inspector (CSI)s obtain a copy of the report from Pharmacy upon random inspection for scanning and record. The Pharmacy inspection form was edited to specify detail of review. All medications identified for destruction are in one location only, the Pharmacy vault.

Numerator = # of reports verified/month

Denominator = # of reports/month

The average of the data from January 2019 through June 2019 is 100%. Audits are conducted to ensure monthly compliance at 90% or greater. These results will be reported to the Controlled Substances Committee.

Additionally, VHA requires that controlled substances inspectors “verify the inventory count of prescription pads the day of the monthly pharmacy inspection.”⁹² The OIG found that the controlled substance inspectors completed their inspection worksheets indicating the monthly inventory was conducted, however, all pharmacy areas reviewed where prescription pads were maintained lacked evidence of verification of prescription pad counts. This could result in missed opportunities to identify potential drug diversion activities and any discrepancies related to controlled substances. The controlled substance coordinator was newly assigned to the program in May 2018 and was not aware of the need to maintain documentation of prescription pad counts.

Recommendation 13

13. The facility director ensures that controlled substances inspectors and coordinator carry out all responsibilities for the verification of pharmacy prescription pad counts during monthly pharmacy inspections and monitors controlled substances inspections staff compliance.

⁹² VHA Directive 1108.02(1).

Facility concurred.

Target date for completion: September 30, 2019

Facility response: Pharmacy inspection form previously lacked specific detail of prescription pad verification completed during inspection. The Pharmacy inspection form has been edited to include identification of prescription pad control numbers with sequential verification, quantity of pads remaining in stock, identification of missing pads, proper issuance of pad/pages, quantity of boxes with prescription pad control number series in storage.

Numerator = # of inspections with all elements included

Denominator = # of inspections done

The director will ensure compliance. The average of the data from January 2019 through June 2019 is 100%. Audits are conducted to ensure monthly compliance at 90% or greater. These results will be reported to the Controlled Substances Committee.

In addition, VHA requires that during controlled substances area inspections, controlled substances inspectors verify hard copy controlled substances prescriptions for the previous month.⁹³ The OIG found that all pharmacy areas lacked evidence of verification of written prescriptions for 50 controlled substances orders where there were hard copy controlled substances prescriptions. When program oversight and process validation are not completed, opportunities to maintain an accurate count of controlled substances and minimize drug diversion activities may be missed, leading to organizational and patient risk. The controlled substance coordinator was newly assigned to the program in May 2018 and had started to keep supporting documentation of written controlled substances prescription verifications one month prior to the OIG site visit.

Recommendation 14

14. The facility director ensures the controlled substances inspectors and coordinator carry out all required responsibilities for the verification of written controlled substances prescriptions during monthly area inspections and monitors compliance.

⁹³ VHA Directive 1108.02(1).

Facility concurred.

Target date for completion: September 30, 2019

Facility response: Facility was lacking documentation of verification for controlled substance written prescriptions. A copy of the written prescription report is obtained by the Controlled Substance Inspector (CSI) and scanned for record.

Numerator = # of verified prescriptions

Denominator = # of prescriptions written

The director will ensure compliance. The average of the data from January 2019 through June 2019 is 100%. Audits are conducted to ensure monthly compliance at 90% or greater. These results will be reported to the Controlled Substances Committee.

Additionally, VHA requires that controlled substances inspectors verify and document that 72-hour pharmacy inventory checks have been completed.⁹⁴ The OIG found that all pharmacy areas inspected lacked evidence of verification of the 72-hour inventory count. Failure to verify 72-hour physical inventories could potentially delay identification of discrepancies and potential drug diversions. The controlled substance coordinator was new to the program starting May 2018 and had started to keep supporting documentation for this part of the review, but only for one month out of the six.

Recommendation 15

15. The facility director makes certain that controlled substances inspectors and coordinator carry out responsibilities for the 72-hour pharmacy inventory checks as required and monitors compliance.

⁹⁴ VHA Directive 1108.02(1). VHA Handbook 1108.01, *Controlled Substances (Pharmacy Stock)*, November 16, 2010. This handbook was in effect during the time frame for this review but was rescinded on May 1, 2019, and replaced by VHA Directive 1108.01, *Controlled Substances Management*.

Facility concurred.

Target date for completion: September 30, 2019

Facility response: The facility was lacking documentation for verified 72-hour pharmacy inventory counts indicated on the inspection form. A copy of the Pharmacy's 72-hour inventory calendar of completion is obtained by the Controlled Substance Inspector (CSI) and scanned for record. The Pharmacy inspection form was also edited to include a space for the Controlled Substance Inspector (CSI) to identify dates of the last two 72-hour pharmacy inventory reviews.

Numerator = # of verified controlled substances 72-hour checks

Denominator = # of performed controlled substances 72-hour checks

The director will ensure compliance. The average of the data from January 2019 through June 2019 is 100%. Audits are conducted to ensure monthly compliance at 90% or greater. These results will be reported to the Controlled Substances Committee.

Mental Health: Military Sexual Trauma Follow-Up and Staff Training

The Department of Veterans Affairs uses the term “military sexual trauma” (MST) to refer to a “psychological trauma, which in the judgment of a mental health professional employed by the Department [of Veterans Affairs], resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the Veteran was serving on active duty, active duty for training, or inactive duty training.”⁹⁵ “MST is an experience, not a diagnosis or a mental health condition.” Although posttraumatic stress disorder is commonly associated with MST, other frequently associated diagnoses include depression and substance use disorders.⁹⁶

VHA requires that the facility director designates an MST coordinator to support national and VISN-level policies related to MST-related care and serve as a source of information; establish and monitor MST-related staff training and informational outreach; and communicate MST-related issues, services, and initiatives with leadership.⁹⁷ Additionally, the facility director is responsible for ensuring that MST-related data are tracked and monitored.⁹⁸

VHA requires that all veterans and potentially eligible individuals seen in VHA facilities be screened for experiences of MST with the required MST clinical reminder in the computerized patient record system.⁹⁹ Those who screen positive must have access to appropriate MST-related care.¹⁰⁰ VHA also requires that evidence-based mental health care be available to all veterans with mental health conditions related to MST. Patients requesting or referred for mental health services must receive an initial evaluation within 24 hours of the referral to identify urgent care needs and a more comprehensive diagnostic evaluation within 30 days.¹⁰¹

The MST coordinator may provide clinical care to individuals experiencing MST and is thus subject to the same mandatory training requirements as mental health and primary care providers.¹⁰² All mental health and primary care providers must complete MST mandatory

⁹⁵VHA Directive 1115, *Military Sexual Trauma (MST) Program*, May 8, 2018.

⁹⁶Military Sexual Trauma. https://www.mentalhealth.va.gov/docs/mst_general_factsheet.pdf. (The website was accessed on November 17, 2017.)

⁹⁷ VHA Directive 1115.

⁹⁸ VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, September 11, 2008 (amended November 16, 2015). (This VHA Handbook was scheduled for recertification on or before the last working date of September 2013 and has not been recertified.)

⁹⁹VHA Directive 1115 states that “MST-related care is not subject to the minimum active duty service requirement set forth in 38 U.S.C. 5303A; Veterans may therefore be able to receive MST-related care even if they are not eligible for VA health care under other treatment authorities.”

¹⁰⁰VHA Directive 1115.

¹⁰¹ VHA Handbook 1160.01.

¹⁰² VHA Directive 1115.

training; for those hired after July 1, 2012, this training must be completed no later than 90 days after assuming their position.¹⁰³

To determine whether the facility complied with the requirements related to MST follow-up and training, the OIG inspection team reviewed relevant documents and staff training records and interviewed key employees. The team also reviewed the electronic health records of 50 outpatients who had a positive MST screen from July 1, 2017, through June 30, 2018. The OIG evaluated the following performance indicators:

- Designated facility MST coordinator
 - Establishes and monitors MST-related staff training
 - Establishes and monitors informational outreach
 - Communicates MST-related issues, services, and initiatives with local leaders
- Evidence of tracking MST-related data
- Provision of clinical care
 - Referral for MST-related care to patients with positive MST screens
 - Initial evaluation within 24 hours of referral for mental health services
 - Comprehensive diagnostic and treatment planning evaluation within 30 days of referral for mental health services
- Completion of MST mandatory training requirement for mental health and primary care providers

Mental Health Conclusion

Generally, the OIG found compliance with most of the performance indicators, including the designation of an MST coordinator, tracking of MST-related data, and provision of clinical care. The OIG noted a concern, however, with providers completing MST mandatory training in a timely manner that warranted a recommendation for improvement.

Specifically, VHA requires that all primary care and mental health providers complete the MST mandatory training; for those hired after July 1, 2012, this training must be completed no later than 90 days after assuming their position.¹⁰⁴ The OIG found 6 of 15 clinicians hired after July 1,

¹⁰³ VHA Directive 1115.01, *Military Sexual Trauma (MST) Mandatory Training and Reporting Requirements for VHA Mental Health and Primary Care Providers*, April 14, 2017. Acting Deputy Under Secretary for Health for Operations and Management, Compliance with Military Sexual Trauma (MST) Mandatory Training for Mental Health and Primary Care Providers, February 2, 2016.

¹⁰⁴ VHA Directive 1115.01.

2012, did not complete the required training within the 90 days of hire. At the time of the OIG site visit, four of the six still had not completed the training. For those hired prior to July 1, 2012, one of five clinicians had not completed the training. This could potentially prevent clinicians from providing appropriate counseling, care, and service to veterans who experienced MST. The MST coordinator reported that the training summary from the Talent Management System¹⁰⁵ showed 98 percent compliance, but the MST coordinator discovered during the OIG site visit that the data was incorrect.

Recommendation 16

16. The chief of staff ensures that providers complete military sexual trauma mandatory training within the required time frame and monitors providers' compliance.

Facility concurred.

Target date for completion: January 31, 2020

Facility response:

Clinical Service Chiefs or designees will ensure new staff will complete the Military Sexual Trauma (MST) training in Talent Management System (TMS) course within 90 days of hire.

Numerator = # of all new designated clinical staff hired that have completed the MST training within 90 days of hire date.

Denominator = # of all new clinical staff hired that are required to complete the MST training.

The chief of staff will ensure compliance. Audits are conducted to ensure monthly compliance at 90% or greater for 6 consecutive months. These results will be reported to Quality, Safety, and Value Council.

¹⁰⁵ “The Talent Management System (TMS) is the system of record for all Veterans Affairs (VA) training, connecting personnel with over 100,000 courses to support their professional development and improve the services they provide to the veteran community.” <https://www.valu.va.gov/SlickSheet/View/158?platform=hootsuite>. (This website was accessed on July 22, 2019.)

Geriatric Care: Antidepressant Use among the Elderly

VA's National Registry for Depression reported that "11 [percent] of veterans aged 65 years and older have a diagnosis of major depressive disorder."¹⁰⁶ The VA/DoD Clinical Practice Guideline (CPG) describes depression as "a common mental disorder that presents with depressed mood, loss of interest or pleasure in regular activities, decreased energy, feelings of guilt or low self-worth, disturbed sleep or appetite, and poor concentration." This can lead to poor quality of life, decreased productivity, and increased mortality from suicide.¹⁰⁷

According to the Centers for Disease Control and Prevention, older adults are at increased risk for experiencing depression because "80 [percent] of older adults have at least one chronic health condition and 50 [percent] have two or more." Further, "most older adults see an improvement in [their] symptoms when treated with antidepressant drugs, psychotherapy, or a combination of both."¹⁰⁸

The American Geriatrics Society revised the Beers Criteria in 2015 to include lists of potentially inappropriate medications to be avoided. Potentially inappropriate medication use in older adults continues to be associated with confusion, falls, and mortality.¹⁰⁹ The criteria provide guidelines that help to improve the safety of prescribing certain medications including antidepressants for older adults.

TJC requires clinicians to educate patients and families about the "safe and effective use of medications."¹¹⁰ In 2015, VHA outlined essential medical information "necessary for review, management, and communication of medication information" with patients, caregivers, and their healthcare teams.¹¹¹ Further, TJC requires clinicians to perform medication reconciliation by comparing the medication a patient is actually taking to the new medications that are ordered for the patient and resolving any discrepancies.¹¹² The CPG recommends that clinicians monitor patients monthly after therapy initiation or a change in treatment until the patient achieves

¹⁰⁶ Hans Peterson, "Late Life Depression," *U.S. Department of Veterans Affairs, Mental Health Featured Article*, March 1, 2011. https://www.mentalhealth.va.gov/featureArticle_Mar11LateLife.asp. (The website was accessed on March 8, 2019.)

¹⁰⁷ VA/DoD *Clinical Practice Guideline for the Management of Major Depressive Disorder*, April 2016. <https://www.healthquality.va.gov/guidelines/MH/mdd/VADoDMDDCPGFINAL82916.pdf>. (The website was accessed November 20, 2018.)

¹⁰⁸ Centers for Disease Control and Prevention, "Depression is Not a Normal Part of Growing Older," January 31, 2017. <https://www.cdc.gov/aging/mentalhealth/depression.htm>. (The website was accessed on March 8, 2019.)

¹⁰⁹ American Geriatrics Society 2015 Beers Criteria Update Expert Panel, "American Geriatrics Society 2015 Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults." http://www.sgot.org/allegato_docs/1057_Beers-Criteria.pdf. (The website was accessed on March 22, 2018.)

¹¹⁰ TJC. Provision of Care, Treatment, and Services standard PC 02.03.01.

¹¹¹ VHA Directive 1164, *Essential Medication Information Standards*, June 26, 2015.

¹¹² TJC. National Patient Safety Goal standard NPSG.03.06.01.

remission. Monitoring includes assessment of symptoms, adherence to medication and psychotherapy, and any adverse effects. The CPG also recommends that treatment planning includes patient education about treatment options, including risks and benefits.¹¹³

To determine whether the facility complied with requirements concerning use of antidepressants among the elderly, the OIG inspection team interviewed key employees and managers. The team also reviewed the electronic health records of 38 randomly selected patients, ages 65 and older, who were newly prescribed one of seven selected antidepressant medications from July 1, 2017, through June 30, 2018.¹¹⁴ The OIG evaluated the following performance indicators:

- Justification for medication initiation
- Evidence of patient and/or caregiver education specific to the medication prescribed
- Clinician evaluation of patient and/or caregiver understanding of the education provided
- Medication reconciliation

Geriatric Care Conclusion

The OIG noted that providers justified the reason for medication initiation of newly prescribed medications. However, the OIG identified inadequate patient and/or caregiver education related to newly prescribed medications, evaluation of patient/caregiver understanding when education was provided, and medication reconciliation processes that warranted recommendations for improvement.

Specifically, TJC requires that clinicians educate patients and families about safe and effective use of medications and evaluate patient/caregiver understanding of the education provided.¹¹⁵ The OIG estimated that clinicians provided this education to 45 percent of the patients at the facility, based on electronic health records reviewed.¹¹⁶ In addition, OIG estimated that clinicians assessed understanding of education provided to 65 percent of the patients at the facility, based on records reviewed.¹¹⁷ Providing medication education is important for patients to be able to manage their health at home.¹¹⁸ The chief of Primary Care and associate director of Pharmacy

¹¹³ VA/DoD Clinical Practice Guidelines for the Management of Major Depressive Disorder.

¹¹⁴ The seven selected antidepressant medications are Amitriptyline, Clomipramine, Desipramine, Doxepin (>6mg/day), Imipramine, Nortriptyline, and Paroxetine.

¹¹⁵ TJC. Provision of Care standard PC.02.03.01; Record of Care, Treatment, and Services standard RC.02.01.01.

¹¹⁶ The OIG is 95 percent confident that the true compliance rate is somewhere between 29.4 and 60.6 percent, which is statistically significantly below the 90 percent benchmark.

¹¹⁷ The OIG is 95 percent confident that the true compliance rate is somewhere between 41.2 and 87.5 percent, which is statistically significantly below the 90 percent benchmark.

¹¹⁸ TJC Provision of Care standard PC.02.03.01.

reported that providers did not document the education provided due to a lack of awareness of requirement.

Recommendation 17

17. The chief of staff makes certain that clinicians provide and document patient and/or caregiver education and assess understanding of education provided specific to newly prescribed medications and monitors compliance.

Facility concurred.

Target date for completion: April 30, 2020

Facility response: The facility implemented a process prior to the OIG CHIP placing these medications on a restricted list. This restriction requires a Pharmacist to review and discuss with the prescribing provider. Pharmacy has reeducated providers and implemented tools to assist in documentation of required elements. Pharmacy is monitoring compliance of this process.

Numerator = # of patients >65 years old initiated on a Tricyclic Antidepressants/Paroxetine after 1/1/19 with education documented correctly

Denominator = # of patients >65 years old initiated on a Tricyclic Antidepressants/Paroxetine after 1/1/19

The chief of staff will ensure compliance. Audits will be conducted to ensure monthly compliance $\geq 90\%$ average for six consecutive months. These results will be reported to Quality, Safety, and Value Council.

Regarding medication reconciliation, TJC requires that a clinician compares the medications a patient should be using (and is actually using) to the new medications that are ordered for the patient and resolves any discrepancies.¹¹⁹ TJC also requires patients' medical records contain information that reflects the patient's care, treatment, and services.¹²⁰ Furthermore, VHA requires that clinicians review and reconcile medications relevant to the episode of care.¹²¹

The OIG estimated that providers performed medication reconciliation in 66 percent of the electronic health records reviewed.¹²² Failure to reconcile medications increases the risk of duplications, omissions, and interactions in the patient's actual drug regimen.¹²³ The chief of

¹¹⁹ TJC National Patient Safety Goal standard NPSG.03.06.01.

¹²⁰ TJC. Record of Care, Treatment, and Services standard RC.02.01.01.

¹²¹ VHA Directive 1164.

¹²² The OIG estimated that 95 percent of the time, the true compliance rate is between 50 and 80.5 percent, which is statistically significantly below the 90 percent benchmark.

¹²³ TJC Rationale for NPSG.03.06.01.

Primary Care reported there was not a standard utilization of the medication reconciliation template across services.

Recommendation 18

18. The chief of staff ensures clinicians review and reconcile medications and monitors clinicians' compliance.

Facility concurred.

Target date for completion: September 30, 2019

Facility response: The facility implemented a process prior to the OIG CHIP placing these medications on a restricted list. This restriction requires a Pharmacists to review and discuss with the prescribing provider. Pharmacy has reeducated providers and implemented tools to assist in documentation of required elements. Pharmacy is monitoring compliance of this process.

Numerator = # of patients >65 years old initiated on a Tricyclic Antidepressants/Paroxetine after 1/1/19 with medication reconciliation documented correctly

Denominator = # of patients >65 years old initiated on a Tricyclic Antidepressants/Paroxetine after 1/1/19

The chief of staff will ensure compliance. The average of the data from March 2019 through June 2019 is 100%. Audits will be conducted to ensure monthly compliance $\geq 90\%$ for six consecutive months. These results will be reported to Quality, Safety, and Value Council.

Women’s Health: Abnormal Cervical Pathology Results Notification and Follow-Up

Each year, about 12,000 women in the United States are diagnosed with cervical cancer.¹²⁴ Human papillomavirus (HPV) can be transmitted during sexual contact and is the main cause of cervical cancer.¹²⁵ In addition to HPV infection, other risk factors for cervical cancer include smoking, human immunodeficiency virus (HIV) infection, use of oral contraceptives for five or more years, and having given birth to three or more children.¹²⁶ Cervical cancer is highly preventable through diligent screening and vaccination efforts. With early detection, it is very treatable and associated with optimal patient outcomes.¹²⁷

VA is authorized to provide “gender-specific services, such as Papanicolaou tests (Pap smears),” to eligible women veterans. Further, VHA requires that all eligible and enrolled women veterans have access to appropriate services and preventative care. That care would include age-appropriate screening for cervical cancer.¹²⁸

VHA requires that each facility have a “full-time Women Veterans Program Manager (WVPM) to execute comprehensive planning for women’s health care.” VHA also requires a medical director or clinical champion to be responsible for the clinical oversight of the women’s health program. Each facility must also have a “Women Veterans Health Committee comprised of appropriate facility leadership and program directors, which develops and implements a Women’s Health Program strategic plan.” The Women Veterans Health Committee must meet at least quarterly and report to the executive leaders. The facility must also have a process to ensure the collecting and tracking of data related to cervical cancer screenings.¹²⁹

VHA has established time frames for notifying patients of abnormal cervical pathology results. Abnormal cervical pathology results must be communicated to patients within seven calendar days from the date the results are available to the ordering provider. Communication of the results to patients must be documented. The facility must ensure that appropriate follow-up care is provided to patients with abnormal results.¹³⁰

¹²⁴ Centers for Disease Control and Prevention. “Cervical Cancer” *Inside Knowledge* fact sheet, December 2016. https://www.cdc.gov/cancer/cervical/pdf/cervical_facts.pdf. (The website was accessed on February 28, 2018.)

¹²⁵ Center for Disease Control and Prevention. *Basic Information About Cervical Cancer*. February 13, 2017. https://www.cdc.gov/cancer/cervical/basic_info/index.htm. (The website was accessed on March 8, 2019.)

¹²⁶ Centers for Disease Control and Prevention. *What Are the Risk Factors for Cervical Cancer?* February 13, 2017. https://www.cdc.gov/cancer/cervical/basic_info/risk_factors.htm. (The website was accessed on March 8, 2019.)

¹²⁷ Center for Disease Control and Prevention. *Basic Information About Cervical Cancer*.

¹²⁸ VHA Directive 1330.01(2), *Health Care Services for Women Veterans*, February 15, 2017 (amended July 24, 2018).

¹²⁹ VHA Directive 1330.01(2).

¹³⁰ VHA Directive 1330.01(2).

To determine whether the facility complied with selected VHA requirements for the notification and follow-up care of abnormal cervical pathology results, the OIG reviewed relevant documents and interviewed selected employees and managers. The OIG also reviewed the EHRs of 39 randomly selected women veteran patients, between ages 21 and 65, who had an abnormal pap smear or test from July 1, 2017, through June 30, 2018. The OIG evaluated the following performance indicators:

- Appointment of a women veterans program manager
- Appointment of a women’s health medical director or clinical champion
- Facility Women Veterans Health Committee
 - Core membership
 - Quarterly meetings
 - Reports to clinical executive leaders
- Collection and tracking of cervical cancer screening data
 - Notification of patients due for screening
 - Completed screenings
 - Results reporting
 - Follow-up care
- Communication of abnormal results to patients within required time frame
- Provision of follow-up care for abnormal cervical pathology results, if indicated

Women’s Health Conclusion

Generally, the OIG found compliance with most of the performance indicators, including requirements for clinical oversight of the women’s health program, tracking data related to cervical cancer screenings, communicating abnormal results to patients, and follow-up care if indicated. However, the OIG identified noncompliance regarding appointing a full-time women veterans program manager that warranted a recommendation for improvement.

Specifically, VHA requires that each facility has a full-time women veterans program manager to ensure comprehensive planning for women’s health care and to be aligned under the chief of staff or director.¹³¹ The OIG found that the women veterans program manager was not in a full-time position or aligned under the chief of staff or director. This could result in lack of adequate and timely care coordination for women veterans at the facility. The chief of staff stated there

¹³¹ VHA Directive 1330.01(2).

had been challenges in filling the position, therefore, it was combined with another role and aligned under the chief of Social Work Service.

Recommendation 19

19. The facility director makes certain that the women veterans program manager position is full time and monitors compliance.

Facility concurred.

Target date for completion: October 1, 2019

Facility response: The director will ensure compliance. Prior to the OIG CHIP, the WVPM position had collateral duties. Starting in January 2019 collateral duties were removed and is now aligned under the chief of staff. This staff member transferred to another VAMC in April 2019 and the physician provider assumed the duties until a full-time WVPM was selected. This new staff member will start in August 2019.

High-Risk Processes: Operations and Management of Emergency Departments and Urgent Care Centers

VHA defines an emergency department as a “unit in a VA medical facility that has acute care medical and/or surgical inpatient beds and whose primary responsibility is to provide resuscitative therapy and stabilization in life-threatening situations.” An urgent care center (UCC) “provides acute medical care for patients without a scheduled appointment who are in need of immediate attention for an acute medical or mental health illness and/or minor injuries.”¹³² A variety of emergency services may exist, dependent on “capability, capacity, and function of the local VA medical facility;” however, emergency care must be uniformly available in all VHA emergency departments and UCCs.¹³³

Because the emergency department or UCC is often the first point of contact for patients seeking treatment of unexpected medical issues, a care delivery system with appropriate resources and services must be available to deliver prompt, safe, and appropriate care. VHA requires that each emergency department provide “unrestricted access to appropriate and timely emergency medical and nursing care 24 hours a day, 7 days a week.” VHA UCCs are also required to provide access and timely care during established operational hours. VHA also requires that “evaluation, management, and treatment [are] provided by qualified personnel with the knowledge and skills appropriate to treat those seeking emergency care.”¹³⁴

TJC noted that patient flow problems pose a persistent risk to quality and safety and established standards for the management of the flow of patients in the emergency department and the rest of the hospital. Managing the flow of patients prevents overcrowding, which can “undermine the timeliness of care and, ultimately, patient safety.” Effective management processes that “support patient flow [in the emergency department or UCC settings] (such as admitting, assessment and treatment, patient transfer, and discharge) can minimize delays in the delivery of care.”¹³⁵

The VHA national director of Emergency Medicine developed the Emergency Medicine Improvement initiative to improve the quality of emergent and urgent care provided through VA emergency departments and UCCs. As part of this initiative, all VA emergency departments and UCCs must use the Emergency Department Integration Software (EDIS) tracking program to document and manage the flow of patients.¹³⁶

¹³² VHA Directive 1101.05(2), *Emergency Medicine*, September 2, 2016 (amended March 7, 2017).

¹³³ VHA Directive 1101.05(2).

¹³⁴ VHA Directive 1101.05(2).

¹³⁵ TJC. Leadership standard LD.04.03.11.

¹³⁶ VHA Directive 1101.05(2); The Emergency Medicine Management Tool (EMMT) uses data collected from EDIS to generate productivity metrics. The use of EDIS and EMMT are key tools in accomplishing EMI initiative goals.

VA emergency departments and UCCs must also be designed to promote a safe environment of care.¹³⁷ Managers must ensure medications are securely stored,¹³⁸ a psychiatric intervention room is available,¹³⁹ and equipment and supplies are readily accessible to provide gynecologic and resuscitation services. VHA also requires emergency departments to have communication systems available to accept requests by local emergency medical services for transporting unstable patients to VA emergency departments.¹⁴⁰

The OIG examined the clinical risks of the emergency department/UCC areas by evaluating the facility's staffing; the provision of care, including selected aspects of mental health and women's health; and the reduction of patient safety risks to optimize quality care and outcomes. In addition to conducting manager and staff interviews, the OIG reviewed emergency department staffing schedules, committee minutes, and other relevant documents. The OIG evaluated the following performance indicators:

- General
 - Presence of an emergency department or UCC
 - Availability of acute care medical and/or surgical inpatient beds in facilities with emergency departments
 - Emergency department/UCC operating hours
 - Workload capture process
- Staffing for emergency department/UCC
 - Dedicated medical director
 - At least one licensed physician privileged to staff the department at all times
 - Minimum of two registered nurses on duty during all hours of operation
 - Backup call schedules for providers
- Support services for emergency department/UCC
 - Access during regular hours, off hours, weekends, and holidays
 - On-call list for staff required to respond
 - Licensed independent mental health provider available as required for the facility's complexity level

¹³⁷ VHA Directive 1101.05(2).

¹³⁸ TJC. Medication Management standard MM.03.01.01.

¹³⁹ A psychiatric intervention room is where individuals experiencing a behavioral health crisis, including serious disturbances, agitation, or intoxication may be taken immediately on arrival.

¹⁴⁰ VHA Directive 1101.05(2).

- Telephone message system during non-operational hours
- Inpatient provider available for patients requiring admission
- Patient flow
 - EDIS tracking program
 - Emergency department patient flow evaluation
 - Diversion policy
 - Designated bed flow coordinator
- General safety
 - Directional signage to after-hours emergency care
 - Fast tracks¹⁴¹
- Medication security and labeling
- Management of patients with mental health disorders
- Emergency department participation in local/regional emergency medical services (EMS) system, if applicable
- Women veteran services
 - Capability and equipment for gynecologic examinations
- Life support equipment

High-Risk Processes Conclusion

Generally, the OIG noted compliance with many of the above performance indicators for the operations and management of emergency department. However, the OIG identified that the emergency department lacked a required on-site licensed independent mental health provider and directional signage that warranted recommendations for improvement.

Specifically, VHA requires that emergency departments must have mental health provider coverage during all hours of operation either on-site or on call and at 1a complexity facilities¹⁴² and, at a minimum, have on-site coverage from 7:00 a.m. to 11:00 p.m.¹⁴³ The OIG found that the emergency department lacked on-site mental health coverage on weekends and holidays

¹⁴¹ The emergency department fast track is a designated care area within the emergency department domain where lower acuity patients are assessed and treated.

¹⁴² The VHA medical centers are classified according to a facility complexity model; 1a designation indicates facilities with high volume, high risk patients, most complex clinical programs, and large research and teaching programs.

¹⁴³ VHA 1101.05(2).

between 4:30 p.m. and 11:00 p.m. This resulted in lack of mental health staff available to assist the emergency department with patient care during weekends and holidays. The chief of staff stated that social workers were assigned to the emergency department but did not have all hours covered, and this was an oversight.

Recommendation 20

20. The chief of staff ensures the emergency department has an independent licensed mental health provider available as required for 1a facilities and monitors compliance.¹⁴⁴

Facility concurred.

Target date for completion: Closed

Facility response: The chief of staff will ensure compliance. In February 2019 additional staff were hired for on-site mental health coverage in the ED. The goal for level 1a facilities is to have mental health coverage from 7:00 a.m. to 11:00 p.m. per VHA Directive 1101.05 (2).

Despite VHA requiring signage directing patients to the emergency department, the OIG found the facility lacked sufficient interior and exterior directional signage to assist patients and visitors in locating the emergency department.¹⁴⁵ Exterior signage specifically listing the emergency department existed only at the main entrance and at no other location enroute to the emergency department. Interior signage did not exist at key corridor intersections informing visitors where to turn to access the emergency department. This may result in patients not being able to locate the emergency department when they are in need of emergent or urgent care. The acting emergency department director was unaware of the signage deficiency.

Recommendation 21

21. The chief of staff ensures that sufficient signage assists and directs patients in locating the emergency department and monitors compliance.

Facility concurred.

Target date for completion: December 31, 2019

Facility response: The exterior signage quote has been received from vendor and order will be placed by August 6, 2019. The interior signage project has been awarded and ED directional signage will be installed throughout the first floor. The chief of staff will ensure compliance. These results will be reported to Quality, Safety, and Value Council.

¹⁴⁴ The OIG reviewed evidence sufficient to demonstrate that the facility had completed improvement actions and therefore closed the recommendation before the report's release.

¹⁴⁵ VHA 1101.05(2).

Appendix A: Summary Table of Comprehensive Healthcare Inspection Findings

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 potentially interfere with the delivery of quality health care.

Healthcare Processes	Performance Indicators	Conclusion
Leadership and Organizational Risks	<ul style="list-style-type: none"> • Executive leadership position stability and engagement • Employee satisfaction • Patient experience • Accreditation and/or for-cause surveys and oversight inspections • Factors related to possible lapses in care • VHA performance data 	Twenty-one OIG recommendations ranging from documentation concerns to noncompliance that can lead to patient and staff safety issues or adverse events are attributable to the director, associate director, and chief of staff. See details below.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	<ul style="list-style-type: none"> • Protected peer reviews • UM reviews • Patient safety • Resuscitation episode review 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • Physician UM advisors consistently document their decisions in the National UM Integration database. • The patient safety manager includes all required content in root cause analyses. • The Code Blue Committee reviews each resuscitative episode under the facility's responsibility.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Medical Staff Privileging	<ul style="list-style-type: none"> • Privileging • FPPEs • OPPEs • FPPEs for cause • Reporting of privileging actions to National Practitioner Data Bank 	<ul style="list-style-type: none"> • FPPEs are completed by a provider with similar training and privileges. 	<ul style="list-style-type: none"> • Clinical managers initiate FPPEs that include clearly delineated criteria and time frames in advance. • The Medical Professional Standards Committee reviews and evaluates licensed independent practitioners' professional practice evaluations when recommending approval of privileges through the Medical Executive Board to the director. • Service chiefs consistently collect and review OPPE data.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Environment of Care	<ul style="list-style-type: none"> • Parent facility <ul style="list-style-type: none"> ○ General safety ○ Environmental cleanliness and infection prevention ○ General privacy ○ Women veterans program ○ Availability of medical equipment and supplies • Community based outpatient clinic <ul style="list-style-type: none"> ○ General safety ○ Environmental cleanliness and infection prevention ○ General privacy ○ Women veterans program ○ Availability of medical equipment and supplies • Locked inpatient mental health Unit <ul style="list-style-type: none"> ○ Mental health environment of care rounds ○ Nursing station security ○ Public area and general unit safety ○ Patient room safety ○ Infection prevention ○ Availability of medical equipment and supplies • Emergency management <ul style="list-style-type: none"> ○ Hazard vulnerability analysis (HVA) ○ Emergency operations plan (EOP) ○ Emergency power testing and availability 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • A safe and clean environment of care is maintained throughout the facility.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
<p>Medication Management: Controlled Substances Inspections</p>	<ul style="list-style-type: none"> • Controlled substances coordinator reports • Pharmacy operations • Controlled substances inspector requirements • Controlled substances area inspections • Pharmacy inspections • Facility review of override reports 	<ul style="list-style-type: none"> • None 	<ul style="list-style-type: none"> • Controlled substances inspectors conduct the monthly inventories of controlled substances and the controlled substances coordinator maintains supporting documentation of the completion of the monthly inventory of controlled substances. • One day's dispensing from the pharmacy to each dispensing area and one day's return of stock to the pharmacy is reconciled. • Controlled substances inspectors complete the pharmacy monthly controlled substances inspection inventory on the day initiated. • During monthly inspections, controlled substances inspectors verify that each medication listed on the "Destructions File Holding Report" is contained in a corresponding sealed evidence bag. • Controlled substances inspectors and coordinator carry out all responsibilities for the verification of pharmacy prescription pad counts during monthly pharmacy inspections. • Controlled substances inspectors and coordinator carry out all required responsibilities for the

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
			<p>verification of written controlled substances prescriptions during monthly area inspections.</p> <ul style="list-style-type: none"> Controlled substances inspectors and coordinator carry out responsibilities for the 72-hour pharmacy inventory checks as required.
<p>Mental Health: Military Sexual Trauma (MST) Follow-Up and Staff Training</p>	<ul style="list-style-type: none"> Designated facility MST coordinator Evidence of tracking MST-related data Provision of clinical care Completion of MST mandatory training requirement for mental health and primary care providers 	<ul style="list-style-type: none"> Providers complete MST mandatory training within the required time frame. 	<ul style="list-style-type: none"> None
<p>Geriatric Care: Antidepressant Use among the Elderly</p>	<ul style="list-style-type: none"> Justification for medication initiation Evidence of patient and/or caregiver education specific to the medication prescribed Clinician evaluation of patient and/or caregiver understanding of the education provided Medication reconciliation 	<ul style="list-style-type: none"> None 	<ul style="list-style-type: none"> Clinicians provide and document patient and/or caregiver education and assess understanding of education provided specific to newly prescribed medications. Clinicians review and reconcile medications.
<p>Women's Health: Abnormal Cervical Pathology Results Notification and Follow-Up</p>	<ul style="list-style-type: none"> Appointment of a women veterans program manager Appointment of a women's health medical director or clinical champion Facility Women Veterans Health Committee Collection and tracking of cervical cancer screening data 	<ul style="list-style-type: none"> None 	<ul style="list-style-type: none"> The women veterans program manager position is full time.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
	<ul style="list-style-type: none"> • Communication of abnormal results to patients within required time frame • Provision of follow-up care for abnormal cervical pathology results, if indicated 		
<p>High-Risk Processes: Operations and Management of Emergency Departments and UCCs</p>	<ul style="list-style-type: none"> • General • Staffing for emergency department/UCC • Support services for emergency department/UCC • Patient flow • General safety • Medication security and labeling • Management of patients with mental health disorders • Emergency department participation in local/regional EMS system • Women veteran services • Life support equipment 	<ul style="list-style-type: none"> • The emergency department has an independent licensed mental health provider available as required for 1a facilities. 	<ul style="list-style-type: none"> • Sufficient signage assists and directs patients in locating the emergency department.

Appendix B: Facility Profile and VA Outpatient Clinic Profiles

Facility Profile

The table below provides general background information for this highest complexity (1a) affiliated¹⁴⁶ facility reporting to VISN 6.¹⁴⁷

**Table B.1. Facility Profile for Hunter Holmes McGuire VA Medical Center (652)
(October 1, 2015, through September 30, 2018)**

Profile Element	Facility Data FY 2016 ¹⁴⁸	Facility Data FY 2017 ¹⁴⁹	Facility Data FY 2018 ¹⁵⁰
Total medical care budget dollars	\$645,474,470	\$729,852,028	\$768,487,126
Number of:			
• Unique patients	59,278	59,903	62,450
• Outpatient visits	705,982	746,515	766,596
• Unique employees ¹⁵¹	3,027	3,046	3,303
Type and number of operating beds:			
• Community living center	98	98	98
• Domiciliary	16	16	16
• Medicine	80	80	80
• Mental health	22	22	22
• Rehabilitation medicine	42	42	42
• Spinal cord injury	100	100	100
• Surgery	44	44	44
Average daily census:			
• Community living center	45	40	42
• Domiciliary	10	10	10

¹⁴⁶ Associated with a medical residency program.

¹⁴⁷ The VHA medical centers are classified according to a facility complexity model; a designation of "1a" indicates facilities with high volume, high-risk patients, most complex clinical programs, and large research and teaching programs.

¹⁴⁸ October 1, 2015, through September 30, 2016.

¹⁴⁹ October 1, 2016, through September 30, 2017.

¹⁵⁰ October 1, 2017, through September 30, 2018.

¹⁵¹ Unique employees involved in direct medical care (cost center 8200).

Profile Element	Facility Data FY 2016¹⁴⁸	Facility Data FY 2017¹⁴⁹	Facility Data FY 2018¹⁵⁰
• Medicine	57	46	43
• Mental health	16	16	19
• Neurology	2	2	0
• Rehabilitation medicine	27	25	28
• Spinal cord injury	55	54	49
• Surgery	28	27	25

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 Profiles¹⁵²

The VA outpatient clinics in communities within the catchment area of the facility provide primary care integrated with women’s health, mental health, and telehealth services. Some also provide specialty care, diagnostic, and ancillary services. Table B.2. provides information relative to each of the clinics.

Table B.2. VA Outpatient Clinic Workload/Encounters and Specialty Care, Diagnostic, and Ancillary Services Provided (October 1, 2017, through September 30, 2018)¹⁵³

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services ¹⁵⁴ Provided	Diagnostic Services ¹⁵⁵ Provided	Ancillary Services ¹⁵⁶ Provided
Fredericksburg, VA	652GA	12,783	7,400	Dermatology Endocrinology Gastroenterology Anesthesia Podiatry	n/a	Nutrition Pharmacy Social work Weight management
Fredericksburg, VA	652GB	8,551	7,595	Dermatology Endocrinology Gastroenterology	Laboratory & pathology	Pharmacy Social work Weight management Nutrition

¹⁵² Includes all outpatient clinics in the community that were in operation as of August 15, 2018.

¹⁵³ The definition of an “encounter” can be found in VHA Directive 2010-049, *Encounter and Workload Capture for Therapeutic and Supported Employment Services Vocational Programs*, October 14, 2010. (This directive expired on October 31, 2015 and has not been updated.) An encounter is a “professional contact between a patient and a practitioner vested with responsibility for diagnosing, evaluating, and treating the patient’s condition.”

¹⁵⁴ Specialty care services refer to non-primary care and non-mental health services provided by a physician.

¹⁵⁵ Diagnostic services include electrocardiogram (EKG), electromyography (EMG), laboratory, nuclear medicine, radiology, and vascular lab services.

¹⁵⁶ Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

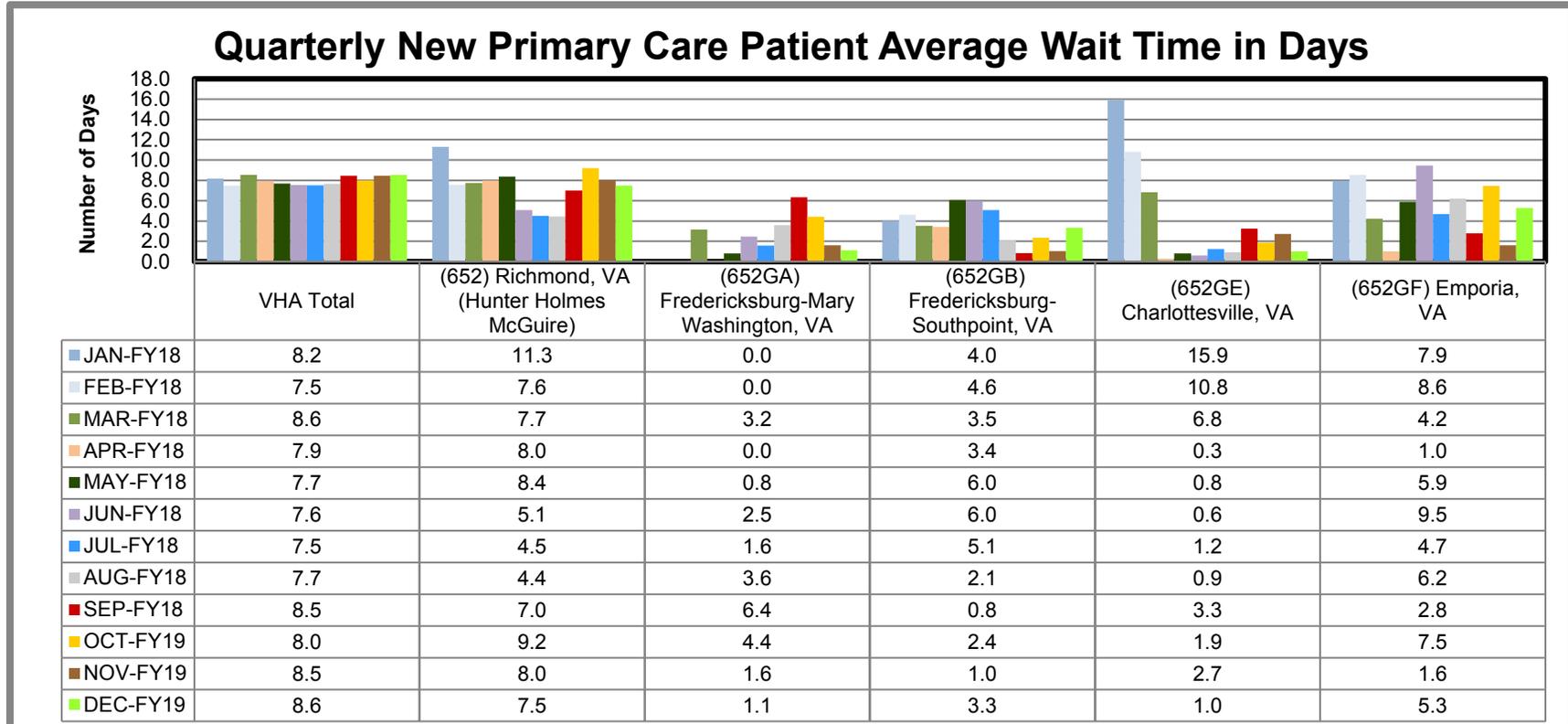
Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services ¹⁵⁴ Provided	Diagnostic Services ¹⁵⁵ Provided	Ancillary Services ¹⁵⁶ Provided
Charlottesville, VA	652GE	10,097	5,634	Dermatology Endocrinology Gastroenterology General surgery Orthopedics Podiatry	Nuclear med	Pharmacy Social work Weight management Nutrition
Emporia, VA	652GF	4,582	1,856	Dermatology Endocrinology Gastroenterology Poly-trauma Podiatry	Nuclear med	Nutrition Pharmacy Weight management

Source: VHA Support Service Center and VA Corporate Data Warehouse

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

n/a = not applicable

Appendix C: Patient Aligned Care Team Compass Metrics¹⁵⁷



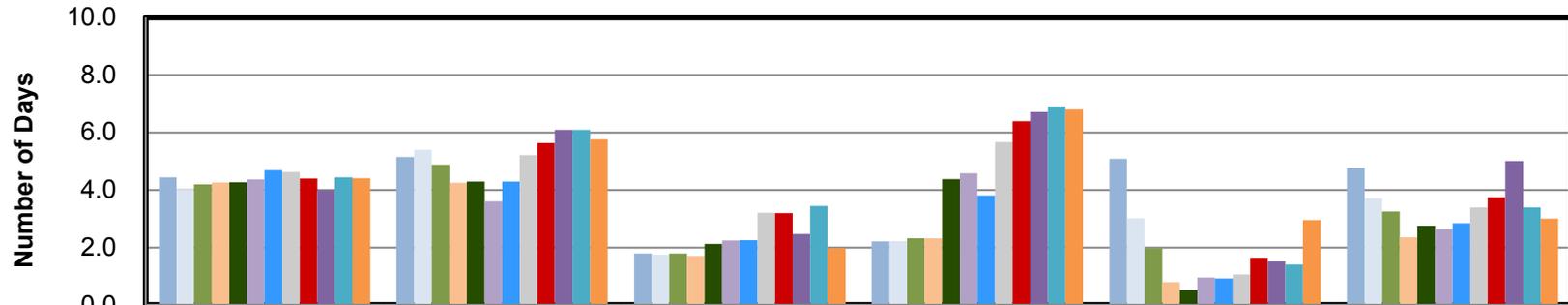
Source: VHA Support Service Center

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

Data Definition: "The average number of calendar days between a New Patient's Primary Care 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 FY15, this metric was calculated using the earliest possible create date."

¹⁵⁷ Department of Veterans Affairs, Patient Aligned Care Teams Compass Data Definitions, accessed September 13, 2018.

Quarterly Established Primary Care Patient Average Wait Time in Days



	VHA Total	(652) Richmond, VA (Hunter Holmes McGuire)	(652GA) Fredericksburg-Mary Washington, VA	(652GB) Fredericksburg-Southpoint, VA	(652GE) Charlottesville, VA	(652GF) Emporia, VA
JAN-FY18	4.4	5.2	1.8	2.2	5.1	4.8
FEB-FY18	4.0	5.4	1.7	2.2	3.0	3.7
MAR-FY18	4.2	4.9	1.8	2.3	2.0	3.2
APR-FY18	4.3	4.2	1.7	2.3	0.8	2.3
MAY-FY18	4.3	4.3	2.1	4.4	0.5	2.8
JUN-FY18	4.4	3.6	2.2	4.6	1.0	2.6
JUL-FY18	4.7	4.3	2.3	3.8	0.9	2.8
AUG-FY18	4.6	5.2	3.2	5.7	1.1	3.4
SEP-FY18	4.4	5.6	3.2	6.4	1.6	3.7
OCT-FY19	4.0	6.1	2.5	6.7	1.5	5.0
NOV-FY19	4.4	6.1	3.4	6.9	1.4	3.4
DEC-FY19	4.4	5.8	2.0	6.8	3.0	3.0

Source: VHA Support Service Center

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

Data Definition: "The average number of calendar days between an Established Patient's Primary Care 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."

Appendix D: Strategic Analytics for Improvement and Learning (SAIL) Metric Definitions¹⁵⁸

Measure	Definition	Desired Direction
ACSC hospitalization	Ambulatory care sensitive conditions hospitalizations	A lower value is better than a higher value
Adjusted LOS	Acute care risk adjusted length of stay	A lower value is better than a higher value
Admit reviews met	Percent acute admission reviews that meet interqual criteria	A higher value is better than a lower value
APP capacity	Advanced practice provider capacity	A lower value is better than a higher value
Best place to work	All employee survey best places to work score	A higher value is better than a lower value
Call responsiveness	Call center speed in picking up calls and telephone abandonment rate	A lower value is better than a higher value
Care transition	Care transition (Inpatient)	A higher value is better than a lower value
Complications	Acute care risk adjusted complication ratio (observed to expected ratio)	A lower value is better than a higher value
Comprehensiveness	Comprehensiveness (PCMH)	A higher value is better than a lower value
Cont stay reviews met	Percent acute continued stay reviews that meet interqual criteria	A higher value is better than a lower value
Efficiency	Overall efficiency measured as 1 divided by SFA (Stochastic Frontier Analysis)	A higher value is better than a lower value
Efficiency/capacity	Efficiency and physician capacity	A higher value is better than a lower value
Employee satisfaction	Overall satisfaction with job	A higher value is better than a lower value

¹⁵⁸ VHA Support Service Center (VSSC), *Strategic Analytics for Improvement and Learning (SAIL)* (last updated December 26, 2018). <http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=8938>. (The website was accessed on March 7, 2019, but is not accessible by the public.)

Measure	Definition	Desired Direction
HC assoc infections	Health care 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	Mental health 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	Mental health continuity of care (FY14Q3 and later)	A higher value is better than a lower value
MH exp of care	Mental health experience of care (FY14Q3 and later)	A higher value is better than a lower value
MH popu coverage	Mental health population coverage (FY14Q3 and later)	A higher value is better than a lower value
Oryx	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 care coordination	PCMH care coordination	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
Physician capacity	Physician capacity	A lower value is better than a higher 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

Measure	Definition	Desired Direction
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
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

Measure	Definition	Desired Direction
SC care coordination	SC (specialty care) care coordination	A higher value is better than a lower 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
SC urgent care appt	Timeliness in getting a SC urgent care appointment (specialty care)	A higher value is better than a lower value
Seconds pick up calls	Average speed of call center responded to calls in seconds	A lower value is better than a higher 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
Telephone abandonment rate	Telephone abandonment rate	A lower value is better than a higher value

Source: VHA Support Service Center

Appendix E: Strategic Analytics for Improvement and Learning (SAIL) Community Living Center (CLC) Measure Definitions¹⁵⁹

Measure	Definition
Ability to move independently worsened (LS)	Long-stay measure: percentage of residents whose ability to move independently worsened.
Catheter in bladder (LS)	Long-stay measure: percent of residents who have/had a catheter inserted and left in their bladder.
Falls with major injury (LS)	Long-stay measure: percent of residents experiencing one or more falls with major injury.
Help with ADL (LS)	Long-stay measure: percent of residents whose need for help with activities of daily living has increased.
High risk PU (LS)	Long-stay measure: percent of high-risk residents with pressure ulcers.
Improvement in function (SS)	Short-stay measure: percentage of residents whose physical function improves from admission to discharge.
Moderate-severe pain (LS)	Long-stay measure: percent of residents who self-report moderate to severe pain.
Moderate-severe pain (SS)	Short-stay measure: percent of residents who self-report moderate to severe pain.
New or worse PU (SS)	Short-stay measure: percent of residents with pressure ulcers that are new or worsened.
Newly received antipsych meds (SS)	Short-stay measure: percent of residents who newly received an antipsychotic medication.
Physical restraints (LS)	Long-stay measure: percent of residents who were physically restrained.
Receive antipsych meds (LS)	Long-stay measure: percent of residents who received an antipsychotic medication.
UTI (LS)	Long-stay measure: percent of residents with a urinary tract infection.

¹⁵⁹ *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, Center for Innovation & Analytics (last updated August 22, 2019). <http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=7410>. (The website was accessed on September 3, 2019, but is not accessible by the public.)

Appendix F: VISN Director Comments

Department of Veterans Affairs Memorandum

Date: August 5, 2019

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

Subj: Comprehensive Healthcare Inspection of the Hunter Holmes McGuire VA
Medical Center, Richmond, VA

To: Director, Bay Pines Office of Healthcare Inspections (54CH03)

Director, GAO/OIG Accountability Liaison (VHA 10EG GOAL Action)

1. The attached subject report is forwarded for your review and further action. I reviewed the response for the Office of the Inspector General Comprehensive Healthcare Inspection Program Review of the Hunter Holmes McGuire VA Medical Center, Richmond VA, and concur with the facility's recommendations.

(Original signed by:)

Deanne M. Seekins, MBA, VHA-CM

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 G: Facility Director Comments

Department of Veterans Affairs Memorandum

Date: August 5, 2019

From: Director, Hunter Holmes McGuire VA Medical Center (652/00)

Subj: Comprehensive Healthcare Inspection of the Hunter Holmes McGuire VA
Medical Center, Richmond, VA

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

1. I concur with the findings and recommendations of the Office of the Inspector General Comprehensive Healthcare Inspection Program Review of the Hunter Holmes McGuire VA Medical Center, Richmond, Virginia.
2. Please find the facility actions and progress in the reviewed areas since the time of this report and plans for continued compliance.

(Original signed by:)

J. Ronald Johnson, MHA, FACHE

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

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