



DEPARTMENT OF VETERANS AFFAIRS
OFFICE OF INSPECTOR GENERAL

Office of Healthcare Inspections

VETERANS HEALTH ADMINISTRATION

Comprehensive Healthcare
Inspection of the Carl Vinson
VA Medical Center
Dublin, Georgia



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Figure 1. Carl Vinson VA Medical Center, Dublin, Georgia (Source: <https://vaww.va.gov/directory/guide/>, accessed on June 24, 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 Carl Vinson 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 February 11, 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 interim director, chief of staff, and associate director for Patient Care Services (ADPCS), and the permanently assigned associate director (primarily nonclinical). Organizational communications and accountability were managed through a committee reporting structure, with the Executive Leadership Team having oversight for several working groups. The director and chief of Quality Management were co-chairs of the Quality Leadership Team, which was responsible for tracking, identifying trends in, and monitoring quality of care and patient outcomes.

The director's position had been vacant since April 13, 2018, with three individuals serving in an interim capacity for this position since that time. The ADPCS was permanently assigned April 17, 2016, and was serving as the third interim director at the time of the OIG visit. The chief of surgery was also the interim chief of staff since the position became vacant September 2, 2017. The associate director, the most tenured of the facility's executive leaders, was permanently assigned June 17, 2012.

The OIG noted that selected employee satisfaction survey results indicated that facility leaders should continue to engage employees to improve employee satisfaction. However, leaders appear to be maintaining an environment where employees feel safe bringing forth issues and concerns. The selected patient experience survey scores reflected lower care ratings than the VHA average, and facility leaders had implemented processes and plans to improve the patient experience.

Additionally, the OIG reviewed accreditation agency findings, sentinel events¹ and patient safety indicator data and did not identify any substantial organizational risk factors; however, an opportunity exists to improve how institutional disclosure data are collected and used to improve care.

The OIG recognizes that the Strategic Analytics for Improvement and Learning (SAIL) model has limitations for identifying all areas of clinical risk but is "a way to understand the similarities and differences between the top and bottom performers" within VHA.² Although the leadership

¹ 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."

² 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 6, 2019, but is not accessible by the public.)

team members, with the exception of the recently-assigned interim chief of staff, were knowledgeable within their areas of responsibility about selected SAIL metrics and community living center (CLC) measures, the leaders should continue to take actions to sustain and improve performance of the quality of care metrics and measures likely contributing to the facility's SAIL "3-star" and CLC "1-star" quality ratings.³

The OIG noted deficiencies in all eight of the clinical areas reviewed and issued 22 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 requirements for protected peer review. The OIG identified noncompliance with interdisciplinary reviews of utilization management data,⁴ inclusion of required elements in root cause analyses, and committee review of resuscitation episodes.

Medical Staff Privileging

The facility generally complied with requirements for privileging. However, the OIG identified concerns with the processes for focused and ongoing professional practice evaluations and focused professional practice evaluations for cause.⁵

³ Based on fiscal year 2018, quarter 3 ratings at the time of the site visit.

⁴ 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." The January 2018 version of the directive was in effect at the time of the February 2019 review. Subsequently, the directive was replaced by VHA Directive 1117(2), *Utilization Management Program*, July 9, 2014 (amended April 30, 2019), which expired on July 31, 2019. The utilization management definition remained consistent in both versions of the directive.

⁵ 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."

Environment of Care

The facility generally complied with requirements for cleanliness and privacy measures, and the OIG did not note any issues with the availability of medical equipment and supplies. However, the OIG identified noncompliance with panic alarm testing at the Perry VA Clinic.

Medication Management

The OIG found general compliance with requirements for some of the performance indicators evaluated, including the controlled substances coordinator reports and requirements for controlled substances inspectors. The OIG noted issues with requirements for controlled substances area and pharmacy inspections and review of override reports.

Mental Health

The OIG team found that the facility complied with many of the mental health performance indicators, including the designation of a military sexual trauma (MST) coordinator and tracking of MST-related data and referrals. The OIG noted concern, however, with the MST coordinator communicating MST-related issues to local leadership and providers completing the MST mandatory training in a timely manner.

Geriatric Care

For geriatric patients, clinicians documented reasons for prescribing medications and performed medication reconciliation relative to the episode of care. However, the OIG identified inadequate patient and/or caregiver education and assessment of understanding related to newly prescribed medications.

Women's Health

The OIG also noted compliance with many of the performance indicators, including the requirement for a designated facility women veterans program manager. However, the OIG identified deficiencies with clinical oversight of the women's health program, Women Veterans Health Committee representation, tracking and monitoring of cervical cancer screening data, and patient notification of abnormal results.

High-Risk Processes

The OIG inspection revealed that the facility generally complied with many of the performance indicators for the operations and management of the urgent care center. However, the OIG identified the lack of a backup call schedule for the urgent care clinic providers.

Summary

In reviewing key healthcare processes, the OIG issued 22 recommendations for improvement directed to the facility director, chief of staff, and associate director. The number of recommendations should not however, be used as a gauge for the overall quality provided at this facility. The intent is for facility leaders to use these recommendations as a road map to help improve operations and clinical care. The recommendations address systems issues as well as other less-critical findings that, if left unattended, may eventually interfere with the delivery of quality health care.

Comments

The acting Veterans Integrated Service Network director and facility director agreed with the CHIP inspection findings and recommendations and provided acceptable improvement plans. (See Appendixes F and G, pages 82–83, and the responses within the body of the report for the full text of the directors' comments.) The OIG will follow up on the planned actions for the open recommendations until they are completed.



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Purpose and Scope

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 Carl Vinson 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.⁶ Investments in a culture of safety and quality improvement with robust communications and leadership significantly contribute to positive patient outcomes in healthcare organizations.⁷ 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)

⁶ 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.)

⁷ 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).⁸

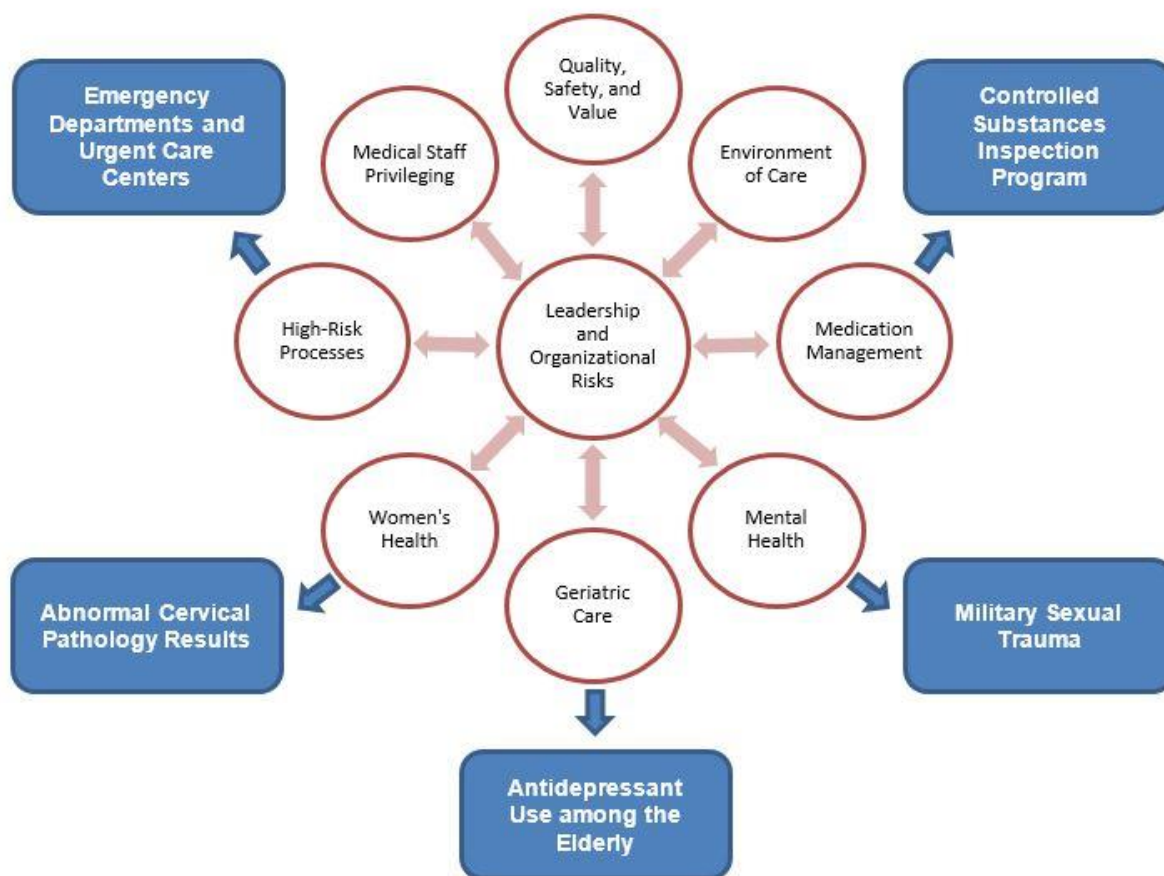


Figure 2. Fiscal Year (FY) 2019 Comprehensive Healthcare Inspection of Operations and Services
Source: VA OIG

⁸ 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;⁹ 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 27, 2016, through February 15, 2019, the last day of the unannounced week-long site visit.¹⁰ While on site, the OIG referred issues and concerns 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.

⁹ The OIG did not review VHA's internal survey results, instead focusing on OIG inspections and external surveys that affect facility accreditation status.

¹⁰ The range represents the time period from the last Clinical 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.¹¹ 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. The facility has a leadership team consisting of the director, chief of staff, associate director for Patient Care Services (ADPCS), and associate director (primarily nonclinical). The chief of staff and ADPCS oversee patient care, which requires managing service directors and chiefs of programs and practices. Figure 3 illustrates this facility's reported organizational structure at the time of the site visit.

¹¹ 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.)

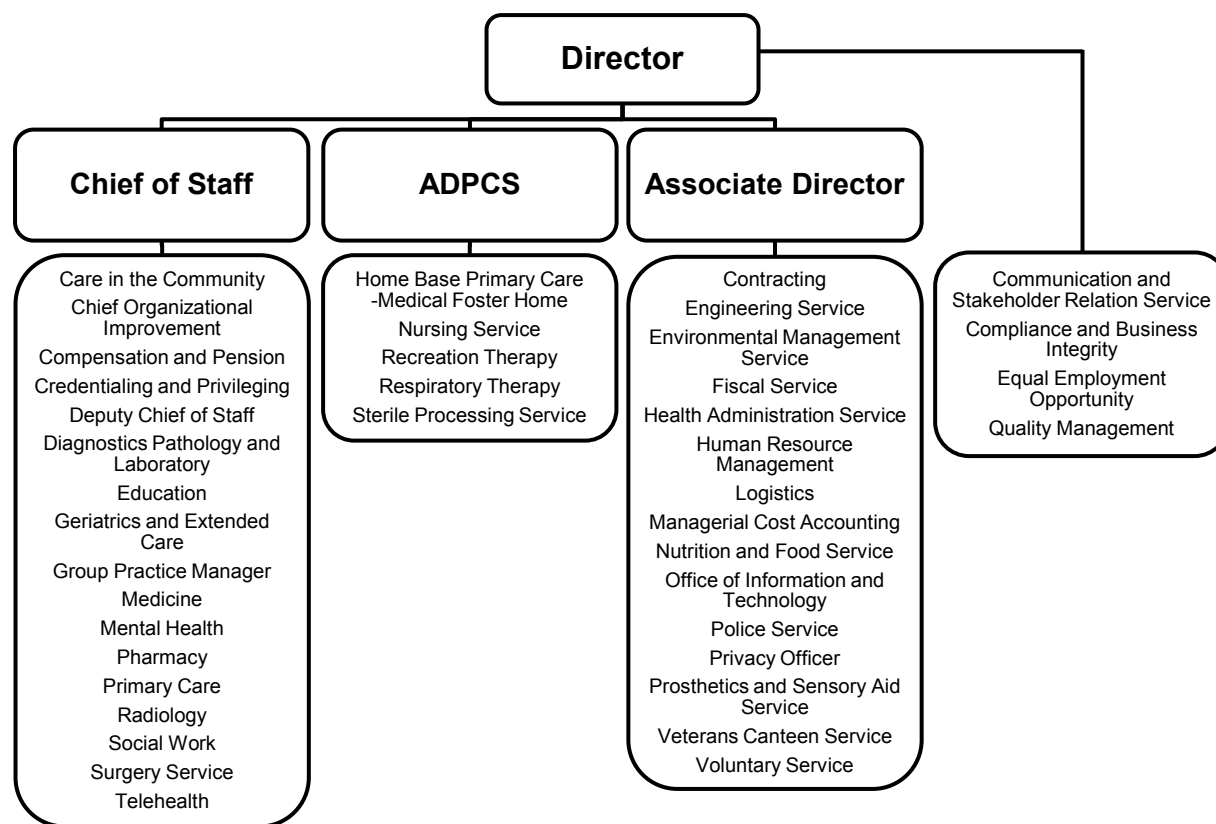


Figure 3. Facility Organizational Chart¹²

Source: Carl Vinson VA Medical Center (received February 11, 2019)

At the time of the OIG site visit, the executive team was not stable, with two (director and chief of staff) of the four positions filled with interim staff. The director position became vacant April 13, 2018, and three individuals had served as interim director since that time, including the ADPCS, who was permanently assigned April 17, 2016, and assumed the interim director position on January 23, 2019. The chief of staff position became vacant September 2, 2017, and four different individuals had served in that role in an interim capacity, including the chief of surgery who started on January 23, 2019, and was still in this role at the time of the site visit (see Table 1).

¹² At this facility, the director is responsible for the Communication and Stakeholder Relation Service, Compliance and Business Integrity, Equal Employment Opportunity, and Quality Management.

Table 1. Executive Leader Assignments

Leadership Position	Assignment Date
Facility director	January 23, 2019 (interim)
Chief of staff	January 23, 2019 (interim)
Associate director for Patient Care Services	January 23, 2019 (interim)
Associate director	June 17, 2012

Source: Carl Vinson VA Medical Center human resources officer (received February 11, 2019)

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

In individual interviews, these Executive Leadership Team members, with the exception of the recently-assigned interim chief of staff, generally were able to speak knowledgeably about actions taken during the previous 12 months in order to maintain or improve performance, as well as employee and patient survey results. In addition, the executive leaders, with the exception of the recently-assigned interim chief of staff, were generally knowledgeable within their scope of responsibilities about selected Strategic Analytics for Improvement and Learning (SAIL) metrics and SAIL community living center (CLC) measures. These are discussed in greater detail below.

The director serves as the chairperson of the Executive Leadership Team, with the authority and responsibility for establishing policy, maintaining quality of care standards, and performing organizational management and strategic planning. The Executive Leadership Team oversees various working groups, such as the Administrative Executive Board, Medical Executive Committee, and Patient Care Services Executive Committee.

The director and chief of Quality Management are also engaged in monitoring patient safety and care through their roles of co-chairs of the Quality Leadership Team. The Quality Leadership Team is responsible for tracking and identifying trends and monitoring quality of care and patient outcomes, and reports to the Executive Leadership Team. See Figure 4.

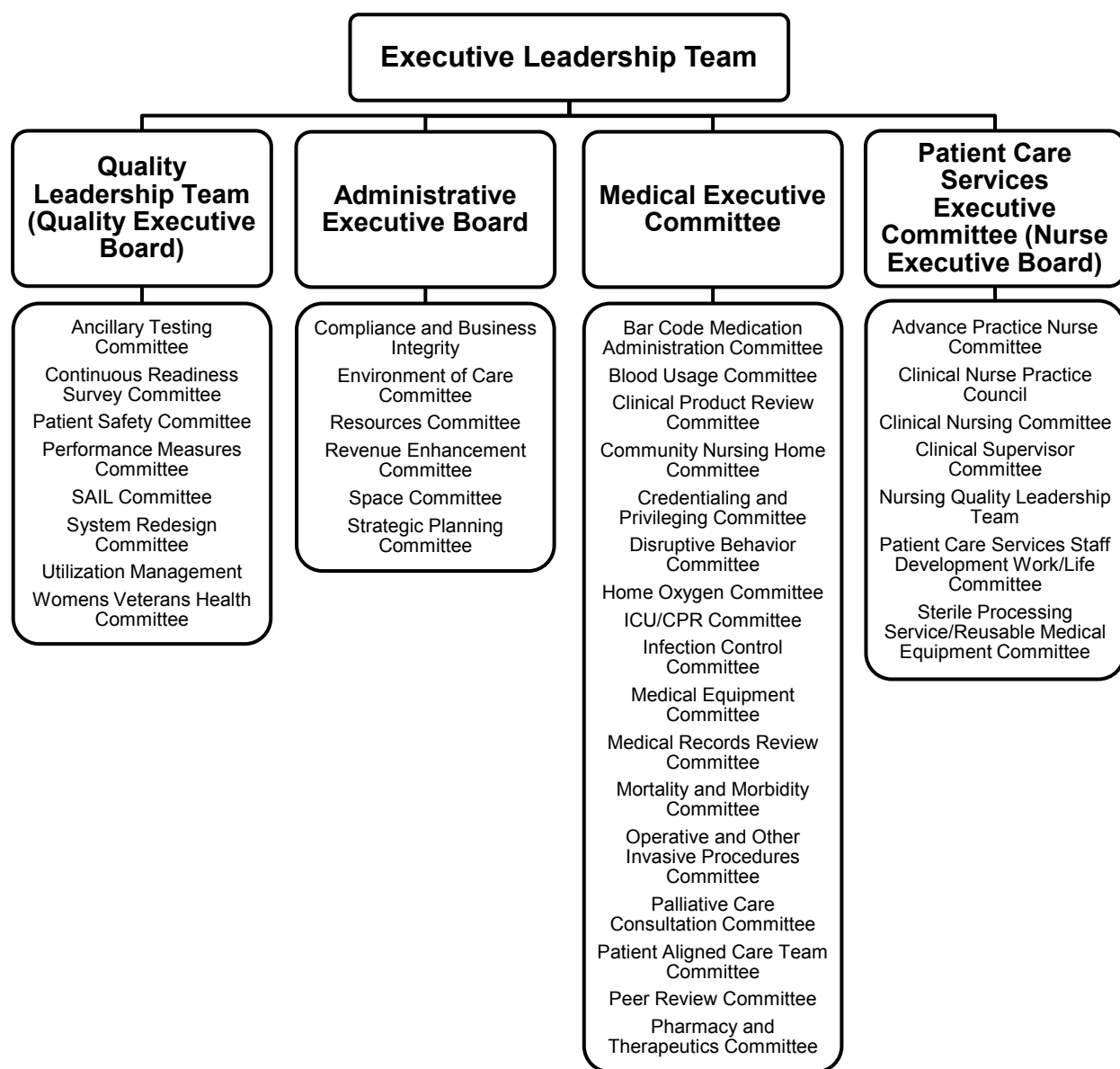


Figure 4. Facility Committee Reporting Structure

Source: Carl Vinson VA Medical Center (February 11, 2019, and updated June 3, 2019)

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 from VHA’s All Employee Survey that relate to the period of October 1, 2017, through September 30, 2018.¹³ 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 were similar to the VHA average with the exception of the servant leader index composite, which was lower.¹⁴ In addition, the associate director’s results for all four selected survey questions were worse than the VHA and facility averages. The chief of staff had two survey question averages (related to motivation and commitment in the workforce and whether senior leaders maintain high standards of honesty and integrity) that were lower than VHA and facility averages. In all, facility leaders should continue to engage employees to improve employee satisfaction.

**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
All Employee Survey: <i>Servant Leader Index Composite</i> ¹⁵	0–100 where HIGHER scores are more favorable	72.0	68.2	75.7	79.2	71.8	60.2

¹³ Ratings are based on responses by employees who report to or are aligned under the director, chief of staff, ADPCS, and associate director.

¹⁴ 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.

¹⁵ 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
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	4.0	2.9	3.5	2.8
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	4.1	3.2	3.5	3.2
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	3.6	4.4	3.6	3.8	2.9

Source: VA All Employee Survey (accessed January 11, 2019)

Table 3 summarizes employee attitudes toward the workplace as expressed in VHA's All Employee Survey. With the exception of the associate director, the facility and Executive Leadership Team averages for the selected survey questions were generally similar to the VHA averages. For the survey question related to moral distress, the associate director average was markedly worse than both the VHA and facility averages. The other facility leaders, however, appear to be maintaining 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
All Employee Survey: <i>I can disclose a suspected violation of any law, rule, or regulation without fear of reprisal.</i>	1 (Strongly Disagree) – 5 (Strongly Agree)	3.8	3.7	4.1	3.9	3.6	3.6
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	3.8	3.7	3.8	3.5
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	1.6	1.8	0.8	1.7	2.5

Source: VA All Employee Survey (accessed January 11, 2019)

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 September 30, 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.¹⁶

VHA also 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, all four patient survey results reflected lower care ratings than the VHA average. Opportunities appear to exist to engage patients and continue to improve the patient's experience when care and services are provided.

**Table 4. Survey Results on Patient Attitudes toward Facility Leadership
(October 1, 2017, through September 30, 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	54.6
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.	84.2	76.0
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.	76.3	64.1

¹⁶ Ratings are based on responses by patients who received care at this facility.

Questions	Scoring	VHA Average	Facility Average
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.	76.5	68.4

Source: VHA Office of Reporting, Analytics, Performance, Improvement and Deployment (accessed December 28, 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.¹⁷ Table 5 summarizes the relevant facility inspections most recently performed by the OIG and The Joint Commission (TJC).¹⁸ Indicative of effective leadership, the facility has closed all recommendations for improvement.¹⁹

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

¹⁷ 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.

¹⁸ 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.”

¹⁹ 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.

Pathologists.²⁰ Additional results included the Long Term Care Institute’s inspection of the facility’s CLC.²¹

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>Clinical Assessment Program Review of the Carl Vinson VA Medical Center, Dublin, Georgia, Report No. 16-00115-263, April 19, 2016</i>)	February 2016	11	0
OIG (<i>Review of Community Based Outpatient Clinics and Other Outpatient Clinics of Carl Vinson VA Medical Center, Dublin, Georgia, Report No. 16-00025-301, May 12, 2016</i>)	February 2016	7	0
OIG (<i>Alleged Violations of Nurse Practitioner Requirements, Carl Vinson VA Medical Center, Dublin, Georgia, Report No. 15-01901-160, February 16, 2017</i>)	June 2015	0	0
TJC Hospital Accreditation	September 2016	13	0
TJC Nursing Care Center Accreditation		2	0
TJC Home Care Accreditation		4	0
TJC Behavioral Health Accreditation		0	n/a

Sources: OIG and TJC (Inspection/survey results verified with the chief of Quality Management on February 11, 2019)

²⁰ 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.

²¹ The Long Term Care Institute states that it has been to over 4,000 healthcare facilities conducting quality reviews and over 1,145 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.)

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. The OIG requested a list of the facility's institutional disclosures from February 2016 through the first day of the on-site visit. The facility's risk manager provided a list of institutional disclosures; however, the list did not contain patient-specific information, and the OIG noted all nine institutional disclosures were not completed timely and the risk manager was not able to provide a reason for delay. The OIG discussed the lack of information with the chief of Quality Management, and an updated list was provided.

When data are not accurately maintained and accessible, there is potential for delay in providing leaders with timely and accurate data to implement plans for patient and organizational risk mitigation through consistent and reliable data and reporting mechanisms. Table 6 lists the reported patient safety events from February 27, 2016 (the prior comprehensive OIG inspection), through February 15, 2019.²²

²² 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 Carl Vinson VA Medical Center is a low-complexity (2) facility as described in Appendix B.)

**Table 6. Summary of Selected Organizational Risk Factors
(February 27, 2016, through February 15, 2019)**

Factor	Number of Occurrences
Sentinel Events ²³	1
Institutional Disclosures ²⁴	9
Large-Scale Disclosures ²⁵	0

Source: Carl Vinson VA Medical Center, chief of Quality Management: sentinel events and large-sale disclosure (received February 12, 2019); risk manager: institutional disclosures (received on February 11, 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.²⁶ 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.

²³ 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.”

²⁴ 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.”

²⁵ According to VHA Directive 1004.08, 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.”

²⁶ 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 7	Facility
Pressure ulcer	0.74	0.64	2.87
Death among surgical inpatients with serious treatable conditions	113.42	89.36	n/a
Iatrogenic pneumothorax ²⁷	0.17	0.13	0.00
Central venous catheter-related bloodstream infection	0.16	0.27	0.00
In-hospital fall with hip fracture	0.09	0.07	0.00
Perioperative hemorrhage or hematoma	2.61	2.58	0.00
Postoperative acute kidney injury requiring dialysis	0.89	0.64	0.00
Postoperative respiratory failure	4.54	5.43	n/a
Perioperative pulmonary embolism or deep vein thrombosis	2.97	2.46	0.00
Postoperative sepsis	3.55	2.85	0.00
Postoperative wound dehiscence (rupture along incision)	0.82	0.38	0.00
Unrecognized abdominopelvic accidental puncture or laceration	1.00	1.01	0.00

Source: VHA Support Service Center

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

n/a = Not applicable because during the review period, there were no surgical discharges meeting the criteria for the specific metrics identified.)

As noted, 2 of the 12 patient safety indicator measures (death among surgical inpatients with serious treatable conditions and postoperative respiratory failure) were not applicable to this facility. One of the ten remaining patient safety indicator measures (pressure ulcer) shows a higher reported rate than VHA and VISN 7.

A single patient developed a pressure ulcer following a surgical procedure. This case was reviewed at a meeting of the Interdisciplinary Pressure Ulcer Committee, a subcommittee of the Clinical Nursing Committee, where the certified wound care nurse serves as chairperson. In addition, the case was reviewed at the Clinical Nursing Committee and Nurse Executive Board. It was determined that interventions for treatment and prevention were in place, however, the

²⁷ 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 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.)

certified wound care nurse recommended that a higher-level pressure redistribution bed should have been used.

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 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. Further, it is possible for a facility measure to exceed the VHA rate due to a single incident and for that measure to 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.

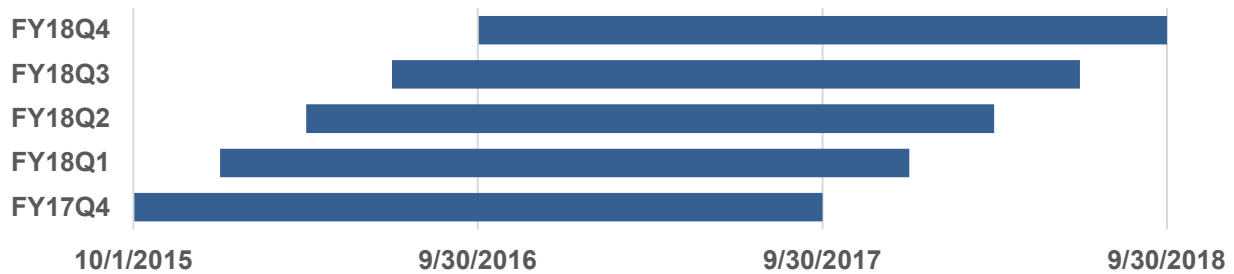


Figure 5. Associated Time Frames for Quarterly Patient Safety Indicator Data

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 potential complications from 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	— ²⁸	0.76	0.74
	Facility	0.00	0.00	—	2.65	2.87
Death among surgical inpatients with serious treatable conditions	VHA	100.97	118.96	113.92	114.89	113.42
	Facility	n/a	n/a	n/a	n/a	n/a
Iatrogenic pneumothorax	VHA	0.19	0.19	0.17	0.15	0.17
	Facility	0.00	0.00	0.00	0.00	0.00
Central venous catheter-related bloodstream infection	VHA	0.15	0.14	0.15	0.16	0.16
	Facility	0.00	0.00	0.00	0.00	0.00
In-hospital fall with hip fracture	VHA	0.08	0.09	0.08	0.09	0.09
	Facility	0.00	0.00	0.00	0.00	0.00
Perioperative hemorrhage or hematoma	VHA	1.94	2.58	2.62	2.59	2.61
	Facility	0.00	0.00	0.00	0.00	0.00
Postoperative acute kidney injury requiring dialysis	VHA	0.88	0.80	0.65	0.96	0.89
	Facility	0.00	0.00	0.00	0.00	0.00
Postoperative respiratory failure	VHA	5.55	5.34	5.11	4.88	4.54
	Facility	0.00	0.00	0.00	0.00	n/a
Perioperative pulmonary embolism or deep vein thrombosis	VHA	3.29	3.26	3.09	3.05	2.97
	Facility	0.00	0.00	0.00	0.00	0.00
Postoperative sepsis	VHA	4.00	3.96	3.72	3.70	3.55
	Facility	n/a	n/a	n/a	0.00	0.00
Postoperative wound dehiscence (rupture along incision)	VHA	0.52	1.04	1.00	0.93	0.82
	Facility	0.00	0.00	0.00	0.00	0.00
Unrecognized abdominopelvic accidental puncture or laceration	VHA	0.53	1.21	1.02	1.07	1.00
	Facility	0.00	0.00	0.00	0.00	0.00

Source: VHA Support Service Center

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

n/a = Not applicable because during the review period, there were no patients who met criteria for inclusion in the measures for the time frames noted.

²⁸ 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.

A patient in FY 2018 quarter two developed a pressure ulcer which led to the facility having a higher rate than VHA and VISN for two consecutive quarters during FY 2018. Although the facility had processes in place to aid in prevention of pressure ulcers, including the use of a specialized bed, the determination to use the equipment was not initiated until after the ulcer had developed and progressed. The facility has an opportunity to improve monitoring for at-risk patients who may develop pressure ulcers and timely implementation of prevention strategies.

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.²⁹

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.³⁰ As of June 30, 2018, the facility was rated as “3-star” for overall quality.

²⁹ VHA Support Service Center (VSSC), The Strategic Analytics for Improvement and Learning (SAIL) Value Model.

<http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=8938>. (The website was accessed on March 7, 2019, but is not accessible by the public.)

³⁰ 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.

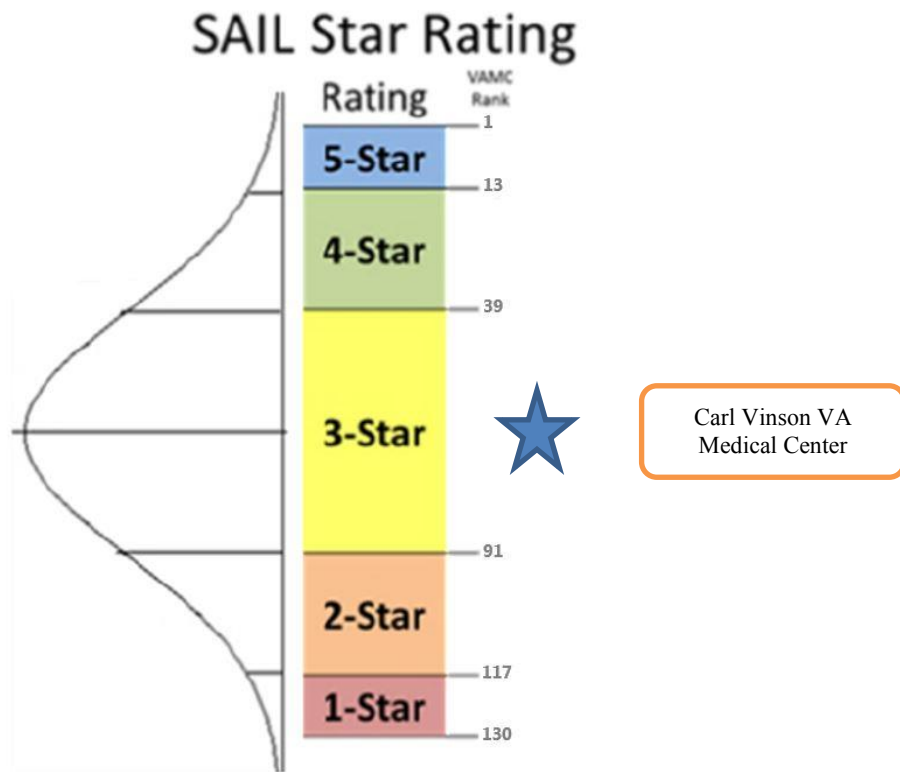


Figure 6. Strategic Analytics for Improvement and Learning Star Rating Distribution (as of June 30, 2018)
Source: VA Office of Informatics and Analytics Office of Operational Analytics and Reporting (accessed January 11, 2019)

Figure 7 illustrates the facility's quality of care and efficiency metric rankings and performance compared with other VA facilities as of September 30, 2018. Of note, the figure uses blue and green data points to indicate high performance (for example, in the areas of complications, ambulatory care sensitive condition (ACSC) hospitalization, adjusted length (of) stay (LOS), and stress discussed). Metrics that need improvement are denoted in orange and red (for example, registered nurse (RN) turnover, call responsiveness, specialty care (SC) care coordination, and care transition).³¹

³¹ For information on the acronyms in the SAIL metrics, please see Appendix D.

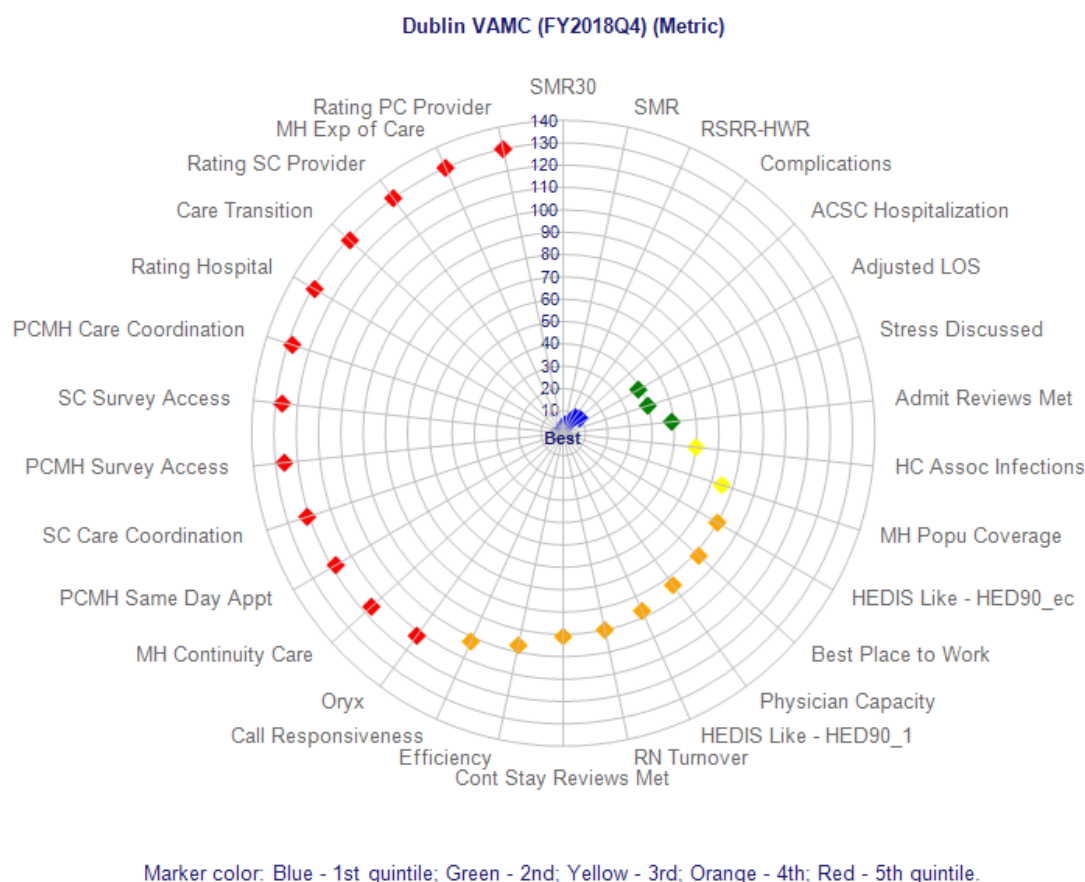


Figure 7. Facility Quality of Care and Efficiency Metric Rankings (as of September 30, 2018)

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*.³² The SAIL CLC provides a single resource to review quality measures and health inspection results. It

³² According to the Center for Innovation and Analytics, *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, August 22, 2019, “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.³³ Table 9 summarizes the rating results for the facility’s CLC as of September 30, 2018. The facility has an overall “1-star” rating and its rating for quality is also a “1-star.”

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

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

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), ability to move independently worsened (LS), and newly received antipsychotic (Antipsych) medications (Meds)—short stay (SS)). 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, moderate-severe pain (LS), catheter in bladder (LS), high risk pressure ulcer (PU) (LS), and moderate-severe pain (SS)).³⁴

³³ *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, Center for Innovation & Analytics (last updated August 22, 2019). 2018). <http://vawww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=7410>. (The website was accessed on September 3, 2019, but is not accessible by the public.)

³⁴ For data definitions of acronyms in the SAIL CLC measures, please see Appendix E.

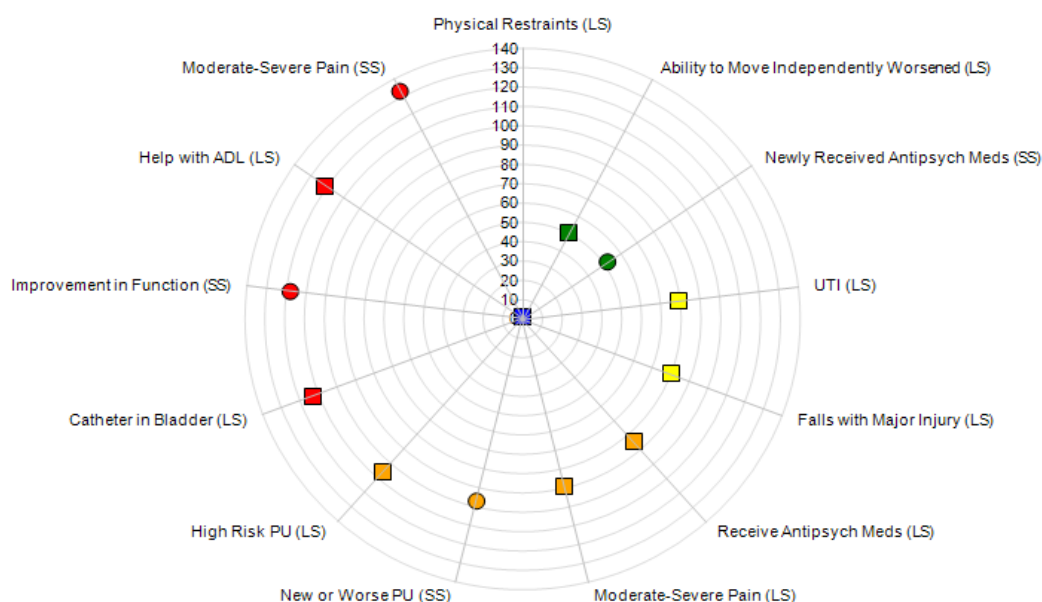


Figure 8. Facility CLC Quality Measure Rankings (as of September 30, 2018)

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

At the time of the OIG site visit, the facility's Executive Leadership Team was not stable, with both the director and chief of staff positions vacant. Selected survey scores related to employees' satisfaction with the facility executive leaders were similar to VHA average with the exception of the chief of staff and associate director, who had results that were lower than VHA and facility averages. The leaders should continue to work to sustain and further improve employee satisfaction. Patient experience survey data revealed that all four survey question scores related to satisfaction with the facility were below VHA averages, thus opportunities exist to enhance patients' experiences. The leaders appeared to support efforts to improve and maintain patient safety, quality care, and other positive outcomes. The OIG's review of the facility's accreditation findings, sentinel events, and patient safety indicator data did not identify any substantial organizational risk factors; however, review of the institutional disclosures identified an opportunity for the facility to ensure timely notification to patients and accurately maintain information and data on disclosures. The leadership team, with the exception of the recently-assigned interim chief of staff, was knowledgeable, within their scope of responsibility, about selected SAIL and CLC metrics but should continue to take action to improve performance of measures contributing to the SAIL "3-star" and SAIL 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.³⁵ VHA also strives to provide healthcare services that compare favorably to the best of the private sector in measured outcomes, value, and efficiency.³⁶ VHA requires that its facilities operate a quality, safety, and value (QSV) program to monitor the quality of patient care and performance improvement activities.³⁷

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,³⁸ utilization management (UM) reviews,³⁹ patient safety incident reporting with related root cause analyses,⁴⁰ and cardiopulmonary resuscitation (CPR) episode reviews.⁴¹

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

³⁵ 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 but was rescinded on October 24, 2019.)

³⁶ Department of Veterans Affairs, *Veterans Health Administration Blueprint for Excellence*, September 2014.

³⁷ VHA Directive 1026.

³⁸ 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.

³⁹ 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." The January 2018 version of the directive was in effect at the time of the March 2019 review. Subsequently, the directive was replaced by VHA Directive 1117(2), *Utilization Management Program*, July 9, 2014 (amended April 30, 2019), which expired on July 31, 2019. The utilization management definition remained consistent in both versions of the directive.

⁴⁰ 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."

⁴¹ VHA Directive 1177, *Cardiopulmonary Resuscitation*, August 28, 2018.

nonpunitive processes that consistently contribute to quality management efforts at the individual provider level.⁴²

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.⁴³

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.⁴⁴

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.⁴⁵

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:⁴⁶

- 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

⁴² VHA Directive 1190.

⁴³ VHA Directive 1117(1).

⁴⁴ VHA Handbook 1050.01.

⁴⁵ VHA Directive 1177; VHA Handbook 1004.03, *Life-Sustaining Treatment Decisions: Eliciting, Documenting and Honoring Patients' Values, Goals and Preferences*, January 11, 2017.

⁴⁶ 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 unit⁴⁷
- 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 analyses⁴⁸
 - 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

⁴⁷ VHA Directive 1190.

⁴⁸ 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 [Safety Assessment Code] SAC 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 requirements for protected peer reviews. The OIG identified concerns with interdisciplinary reviews of UM data, patient safety processes, and committee review of resuscitation episode reviews that warranted recommendations for improvement.

Specifically, VHA requires that an interdisciplinary facility group review UM data.⁴⁹ This group must include, but is not limited to, representatives from UM, medicine, nursing, social work, case management, mental health, and chief business office revenue-utilization review (CBO R-UR).⁵⁰ For the meetings held between February 2018 through January 2019, the Acute Care Committee reviewed UM data; however, the committee lacked representation from social work, mental health, and business office revenue-utilization review. This resulted in a lack of expertise in the review and analysis of utilization management data. The chief of Quality Management stated that the UM manager reported to the Acute Care Committee which lacked representatives from those services as there was no separate committee for UM because inpatient volume was low at the facility.

Recommendation 1

1. The facility director makes certain that all required representatives consistently participate in interdisciplinary reviews of utilization management data and monitors representatives' compliance.

⁴⁹ VHA Directive 1117(1).

⁵⁰ VHA Directive 1117(1).

Facility concurred.

Target date for completion: June 30, 2020

Facility response: The Director will ensure that there is consistent participation of all required representatives at the Acute Care Committee, which reports to the Medical Executive Committee. By November 2019, Social Work, Mental Health and CBO R-UR will be added to the Acute Care Committee. The Acute Care Committee chair will report attendance monthly to the Quality Executive Board.

Numerator: = monthly attendance of all required members

Denominator: = # of monthly meetings

The required representatives' attendance will be 90% for six consecutive months where Utilization Management data is reviewed. After six months of compliance is achieved, reporting will be changed to quarterly. If compliance falls below 90% then a new action plan will be developed, and reporting will resume monthly until the target of 90% compliance is reached.

As for root cause analyses, VHA requires inclusion of specific content to ensure reviews are thorough and credible. This includes determination of the human and other factors most directly 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.⁵¹ The OIG reviewed five root cause analyses, and none of the analyses encompassed the required content.⁵² This resulted in insufficient evaluation of patient safety events and limited the analysis of system vulnerabilities that may lead to patient harm. The patient safety manager stated a worksheet was completed for each analysis but not transcribed into WebSPOT.⁵³ The patient safety manager believed that the facility was meeting the requirements and thought the literature review was optional.

Recommendation 2

2. The facility director ensures the patient safety manager includes all required content in each root cause analysis and monitors patient safety manager's compliance.

⁵¹ VHA Handbook 1050.01.

⁵² All five root cause analyses reviewed lacked an analysis of the underlying systems through a series of "why" questions to determine where redesigns might reduce risk; four did not include literature review, and two did not have a determination of human or other factors, or outcome measures with sustained improvement. One root cause analysis did not have identification of system vulnerabilities or risks that may have contributed to the event, determination of potential improvement, or identification of at least one root cause.

⁵³ The patient safety information tool, SPOT, was developed by National Center for Patient Safety (NCPS) to guide and document the RCA process. WebSPOT is the current version.

Facility concurred.

Target date for completion: April 30, 2020

Facility response: Required elements have always been a part of the Root Cause Analysis (RCA), and the facility recognized the required elements were not always documented. Since February 2019, documentation now reflects the required elements.

From February 2019 through September 2019, all RCAs completed monthly were reviewed to ensure the required literature review and the five (5) whys were documented. All five completed RCAs were reviewed and found to have all required elements. The required elements were included in the final presentation to the Director following completion of each RCA. The Patient Safety Manager will monitor 100% of RCAs for documentation of the required elements and all discrepancies will be reported to the Director following completion of each RCA.

Numerator = # of Root Cause Analyses containing all required elements

Denominator = Total number of Root Cause Analyses completed each month

An audit is completed monthly to ensure a compliance rate of 90%. Audits are reported to Quality Executive Board.

VHA requires that the facility establish a committee for reviewing each resuscitative episode under the facility's responsibility and that each review include elements, such as identification of errors or deficiencies in technique or procedures, lack of availability or malfunction of equipment, clinical or patient care issues, and delays in initiating cardiovascular resuscitation.⁵⁴ In three of seven resuscitation episodes reviewed, the OIG found no evidence of committee review. Additionally, in the four cases that were reviewed by the committee, the OIG found no evidence of assessment of all required elements. This resulted in a lack of analysis of resuscitation episodes and trends, and missed opportunities for improvement, which may impact patient safety. The Intensive Care Unit/Cardiopulmonary Resuscitation (ICU/CPR) Committee co-chairs stated that the committee minutes did not accurately reflect the reviews conducted due to lack of oversight, and VHA requirements were not used when the code review form was created.

Recommendation 3

3. The director ensures the Intensive Care Unit/Cardiopulmonary Resuscitation Committee conducts a complete analysis of resuscitative episodes that includes all required elements and monitors committee's compliance.

⁵⁴ VHA Directive 1177.

Facility concurred.

Target date for completion: April 30, 2020

Facility response: The chief of staff will ensure that Code Blue Committee, which reports to the Medical Executive Committee, fully reviews each episode of care where resuscitation was attempted. Each cardiopulmonary resuscitation (CPR) event will 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.

In February 2019, the code critique form was revised to include all four (4) elements required and Veteran identifier. Cardiopulmonary Resuscitation critiques were added to the Cardiopulmonary Resuscitation Committee's agenda in June 2019. The facility will achieve 90% compliance for six consecutive months of monitoring. Results of the monitoring will be reported to the Quality Executive Board monthly.

Numerator: # of resuscitative episodes with all required elements documented.

Denominator: Total # of resuscitative episodes each month.

Medical Staff Privileging

VHA has defined procedures for the clinical privileging of “all healthcare professionals who are permitted by law and the facility to practice independently”—“without supervision or direction, within the scope of the individual’s license, and in accordance with individually granted clinical privileges.” These healthcare professionals are also referred to as licensed independent practitioners (LIPs).⁵⁵

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.⁵⁶

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.”⁵⁷

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.⁵⁸ 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.⁵⁹

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:

⁵⁵ 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.)

⁵⁶ VHA Handbook 1100.19.

⁵⁷ VHA Handbook 1100.19.

⁵⁸ 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).

⁵⁹ 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.)

- Three solo or few (less than two in a specialty) practitioners hired within 18 months before the site visit or were privileged within the prior 12 months⁶⁰
- Eight LIPs hired within 18 months before the site visit
- Twenty LIPs re-privileged within 12 months before the visit
- Two 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-specific⁶¹
 - 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

⁶⁰ The 18-month period was from August 11, 2017, through February 11, 2019. The 12-month review period covered February 11, 2018, through February 11, 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.

⁶¹ 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 concerns with FPPE, OPPE, and FPPE for cause processes.

Specifically, for FPPE reviews, VHA requires the criteria "to be defined in advance, using objective criteria, accepted by the practitioner." The results are also to be documented in the provider's profile.⁶² In 8 of 12 licensed independent practitioner profiles reviewed, one of which was an FPPE for cause, the OIG noted lack of evidence that the criteria for the FPPE process was defined in advance with the providers. Additionally, the OIG found that three of the FPPE provider profiles lacked evidence of results of the review. This could potentially result in unclear and ill-defined expectations for the medical staff leaders performing the evaluation as well as for the providers who are being evaluated. The credentialing coordinator reported lack of attention to detail resulting in incomplete documentation in the practitioner profiles that contributed to the service chiefs' noncompliance.

Recommendation 4

4. The chief of staff ensures that service chiefs define and communicate expectations for focused professional practice evaluations in advance and maintain appropriate documentation of the process and monitors service chiefs' compliance.

⁶² VHA Handbook 1100.19.

Facility concurred.

Target date for completion: June 30, 2020

Facility response: The Chief of Staff will communicate and define expectations in advance for focused professional practice evaluation criteria. These will then be presented to the Medical Executive Committee for approval. Starting January 2020, the focused professional practice evaluation forms will include an acknowledgement of receipt by the provider.

The Chief of Staff's office will review all providers who are on a focused professional practice evaluation to ensure the evaluation criteria was provided to the provider in advance, and that results of the evaluation criteria is documented. Target compliance rate of 90% for six consecutive months will be achieved.

Numerator = # of focused professional practice evaluation that shows the evaluation criteria was provided in advance and the provider acknowledged receipt of the criteria.

Denominator = all providers on a focused professional practice evaluation

After six months of compliance is achieved, reporting will be changed to quarterly. If compliance falls below 90% then a new action plan will be developed, and reporting will resume monthly until target of 90% compliance is reached. The Chief of Staff or designee will report monthly to the Medical Executive Committee.

Recommendation 5

5. The chief of staff makes certain that the service chiefs document the focus professional practice evaluation results in the practitioner profiles and monitors service chiefs' compliance.

Facility concurred.

Target date for completion: June 30, 2020

Facility response: The Chief of Staff will ensure that results of activities arising from the focused professional evaluation is documented in the providers profile. Starting November 2019, audits will be completed to ensure results from focused professional evaluation are documented in the provider's profile. Compliance will be monitored monthly by the Medical Staff office.

Numerator = # of provider profiles that have documented results of evaluation activity

Denominator = all providers on focused professional practice evaluations

Focused professional practice evaluations completion will be monitored until 90% compliance is reached for six consecutive months. This will be reported through the Medical Executive Committee monthly.

VHA has defined minimum-required specialty criteria for gastroenterology, pathology, nuclear medicine, and radiation oncology professional practice evaluations.⁶³ This professional practice evaluation process ensures a consistent approach to evaluating providers in these specialties and is essential to confirming the quality of care delivered.

For all four applicable specialists' professional practice evaluations, two of which were solo providers, the OIG found no evidence of the use of minimum-required specialty criteria within the professional practice evaluation. As a result, providers continued to deliver care without a thorough evaluation of their gastroenterology or nuclear medicine-specific practice. The credentialing coordinator reported a lack of attention to detail resulting in incomplete documentation in the practitioners' profiles at the service chiefs' level that contributed to the facility's noncompliance.

Recommendation 6

6. The chief of staff ensures that service chiefs include the minimum-required specialty-specific criteria for professional practice evaluations of gastroenterology and nuclear medicine practitioners and monitors service chiefs' compliance.

Facility concurred.

Target date for completion: April 30, 2020

Facility response: The Chief of Staff or designee will review provider's profiles to ensure relevant specialty-specific criteria is documented. Starting in November 2019, all specialty providers profiles will be reviewed prior to submission to the Medical Executive Committee to ensure the specialty-specific criteria is documented in the professional practice evaluations. This will be monitored by the Chief of Staff's office until 90% compliance is demonstrated for six consecutive months then quarterly for two quarters

Numerator = # of specialty providers 'professional practice evaluations with required criteria.

Denominator = # of specialty-specific professional practice evaluations

Chief of Staff office will report compliance with specialty-specific data to the Medical Executive Committee monthly.

VHA also requires that licensed independent providers' OPPEs are evaluated by providers with similar training and privileges.⁶⁴ The evaluation may include "direct observation, clinical discussions, and clinical pertinence reviews."⁶⁵ Of the 31 LIP profiles reviewed, the OIG found

⁶³ VHA Deputy Under Secretary for Health Operations and Management (DUSHOM) Memorandum, *Requirements for Peer Review of Solo Practitioners*, August 29, 2016.

⁶⁴ VHA Deputy Under Secretary for Health Operations and Management (DUSHOM) Memorandum.

⁶⁵ VHA Handbook 1100.19.

that three OPPEs lacked evidence of review by a similarly trained provider because existing documentation lacked the peer reviewer's name or signature. This resulted in licensed independent providers continuing to deliver care without a thorough evaluation of their practice. The credentialing coordinator reported reasons for noncompliance as lack of attention to detail resulting in incomplete documentation on the LIPs' profiles by the peer reviewer and at the service chief level.

Recommendation 7

7. The chief of staff ensures that ongoing professional practice evaluations are completed by providers with similar training and privileges and monitors compliance.

Facility concurred.

Target date for completion: May 31, 2020

Facility response: The Chief of Staff or designee will review service chiefs' documentation to ensure Ongoing Professional Practice Evaluations have been completed by providers with similar trainings and privileges. In the event of a solo provider, an outside reviewer will be utilized.

The Chief of Staff office will review 100% of Ongoing Professional Practice Evaluation profiles beginning November 2019.

Numerator = # of Ongoing Professional Practice Evaluations reviewed by providers with similar training and privileges

Denominator = all Ongoing Professional Practice Evaluations each month

Compliance of 90% will be demonstrated for a minimum of six consecutive months. Medical Staff office will report audit results to the Medical Executive Committee monthly.

Despite VHA requiring that results of the professional practice evaluations "be documented in the practitioner's provider profile and reported to the Executive Committee of the Medical Staff [Medical Executive Committee (MEC)] for consideration in making the recommendation on privileges,"⁶⁶ the OIG found that the results of 6 of 31 professional practice evaluations (four focused and two ongoing) were not presented to the Medical Executive Committee. This resulted in the facility missing the opportunity to identify professional practice trends that could impact the quality of care and patient safety. The credentialing coordinator reported a lack of attention to detail resulting in the incomplete documentation in LIP profiles by the peer reviewer and at the service chief level, preventing the forwarding of the profile for Medical Executive Committee review.

⁶⁶ VHA Handbook 1100.19.

Recommendation 8

8. The chief of staff makes certain that the Medical Executive Committee documents its decision to recommend privileges based on professional practice evaluation results when recommending approval of privileges to the director and monitors committee's compliance.

Facility concurred.

Target date for completion: May 31, 2020

Facility response: The Chief of Staff will ensure professional practice evaluation results and the decision to recommend privileges are documented in the Medical Executive Committee minutes. Starting, November 2019 a tracker will be utilized by the Chief of Staff office to ensure compliance.

Numerator = #Medical Executive Committee meeting minutes with documented reason for recommendations.

Denominator = total # of ongoing professional practice evaluations presented to the Medical Executive Committee

This will be monitored by the Chief of Staff's office until 90% compliance is demonstrated for a minimum of six consecutive months. Medical Staff office will report audit results to Medical Executive Committee monthly.

Regarding FPPE for cause processes, VHA requires that actions related to professional competence or conduct that adversely affect clinical privileges are reported to the National Provider Data Bank.⁶⁷ The OIG found that a single FPPE for cause resulted in a privileging action which was not reported to the National Practitioner Data Bank. Not reporting a privileging action may result in a provider continuing to deliver care and/or perform procedures that could harm a patient. The OIG found that the provider self-initiated a reduction in privileges while being evaluated through the FPPE for cause process.

Recommendation 9

9. The facility director reports privileging actions taken by the facility to the National Practitioner Data Bank and monitors compliance.

⁶⁷ 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); VHA Handbook 1100.17.

Facility concurred.

Target date for completion: May 31, 2020

Facility response: The facility director will ensure any adverse clinical privileging actions, or restriction of clinical privileges related to professional competency or professional conduct of a provider is reported to the National Practitioner Data Bank. Medical Staff office were re-educated on the policy February 2019.

The Medical Staff office will review all provider profiles who are on a current focused professional practice evaluation for cause monthly by utilizing a tracker to determine if any adverse clinical privilege actions need to be reported to the National Practice Data Bank.

Numerator: # of identified profiles with adverse clinical actions reported to the National Practitioners Data Bank.

Denominator: all focused professional practice evaluation profiles with identified privileging actions

Medical Staff office will report the results of the audit to the Medical Executive Committee monthly.

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 11 areas at the facility—blue team (primary care), green team (primary care), podiatry, specialty clinic, surgical preoperative holding area, operating room and endoscopy preoperative holding area, hospice, and CLC (8W, 8A, 17B, and 19B.) The team also reviewed the emergency management program and inspected the Perry VA Clinic. The OIG 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 unit⁷⁵
 - Mental health environment of care rounds
 - Nursing station security

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.

⁷⁵ The facility did not have an inpatient mental health unit.

- 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 and the Perry VA Clinic met cleanliness and privacy measures associated with the above performance indicators. The OIG did not note any issues with the availability of medical equipment or supplies at the Perry VA Clinic. The OIG noted a deficiency in panic alarm testing at the Perry VA Clinic.

Specifically, VHA requires facilities to implement, use, and regularly test appropriate physical security precautions and equipment including, but not limited to, panic alarm systems, in high-risk areas.⁷⁶ During the inspection of the Perry VA Clinic, facility staff were unable to provide the OIG with evidence of the required panic alarm system testing. When panic alarms are not tested as required, facility leadership may not be aware of associated risks to patients, staff, and visitors. In addition, this could potentially result in the panic alarms malfunctioning when activated during an emergent situation. The chief of Police Service and the Perry VA Clinic nurse manager stated they were unaware of the requirement to document alarm system testing.

Recommendation 10

10. The associate director ensures that the VA Police regularly test panic alarms and document results and monitors staff compliance.

⁷⁶ VHA Directive 2012-026, *Sexual Assaults and other Defined Public Safety Incidents in Veterans Health Administration (VHA) Facilities*, September 27, 2012. This directive expired on February 28, 2015

Facility concurred.

Target date for completion: April 30, 2020

Facility response: The Chief of Police or designee will ensure Perry Community Based Outpatient Clinic (CBOC) performs testing of the panic alarms on a monthly basis. November 2019 a tracker will be utilized to capture monthly panic alarm testing to ensure 90% compliance with for six (6) consecutive months.

Numerator: # of times panic alarm tested

Denominator: # of months the panic alarms were tested

The Panic Alarm test results will be shared with Quality Executive Board monthly.

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.⁷⁷ 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.⁷⁸

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.⁷⁹

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;⁸⁰ 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 adjustments⁸¹
- Requirements for controlled substances inspectors

⁷⁷ Drug Enforcement Agency Controlled Substance Schedules. <https://www.deadiversion.usdoj.gov/schedules/>. (The website was accessed on March 7, 2019.)

⁷⁸ 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.

⁷⁹ VHA Directive 1108.02(1), *Inspection of Controlled Substances*, November 28, 2016 (amended March 6, 2017).

⁸⁰ The two quarters were from July 1, 2018 through December 31, 2019.

⁸¹ 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 destruction⁸²
 - 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 reports⁸³

Medication Management Conclusion

The OIG found general compliance with requirements for some of the performance indicators evaluated, including the controlled substances coordinator reports and requirements for

⁸² 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.”

⁸³ When automated dispensing cabinets are used, nursing staff can override and remove medications prior to the pharmacists’ review of medications ordered by the providers.

controlled substances inspectors. The OIG noted issues with requirements for controlled substance area and pharmacy inspections and review of override reports that warranted recommendations for improvement.

Specifically, VHA requires that the controlled substances inspection program staff reconcile one day's stocking/refilling from the pharmacy to every automated dispensing cabinet and one day's return of stock to pharmacy from every automated dispensing unit during controlled substances area inspections.⁸⁴ The OIG found that for July 1 to December 31, 2018, 9 of the 10 non-pharmacy areas lacked reconciliation of one-day dispensing from the pharmacy to the automated dispensing cabinet; and all 10 areas lacked reconciliation of one-day's return of stock to the pharmacy from automated dispensing cabinets. Failure to reconcile dispensing and returns in all controlled substances areas may cause delays in identifying potential drug diversion activities. The controlled substances coordinator confirmed a lack of oversight and was unaware of the requirement to maintain supporting documentation.

Recommendation 11

11. The facility director makes certain that controlled substances program staff reconcile one day's stocking/refilling from the pharmacy to each dispensing area and one day's return of stock to pharmacy from every automated dispensing unit during monthly inspections and monitors coordinator's compliance.

⁸⁴ VHA Directive 1108.02(1).

Facility concurred.

Target date for completion: May 31, 2020

Facility response: Monthly inspection forms were revised April 2019 to indicate reconciliation of one days dispensing and return of stock to pharmacy from the controlled substance storage areas. Inspection forms indicate reconciliation of one days stocking/refilling from pharmacy to all controlled substance storage area. April 2019 the Controlled Substance Coordinator started reviewing one days dispensing and returns monthly from the areas reviewed. All supporting documentation and forms are scanned, and copies are filed. The facility will achieve 100% compliance monthly for six consecutive months.

Numerator = # of areas where reconciliation was completed

Denominator = # of areas requiring reconciliation

Controlled Substance Coordinator will begin November 2019 reporting to Quality Executive Board the results of the monthly reconciliation of one day's stocking/refilling from pharmacy to every automated dispensing cabinet and one day's return to pharmacy stock reviewed during the monthly inspections.

After six months of 100% compliance is achieved, reporting will be changed to quarterly. If compliance falls below 100% then a new action plan will be developed, and reporting will resume monthly until target of 100% compliance is reached.

In addition, VHA requires that during controlled substances area inspections, controlled substances inspectors verify there is evidence of a written or electronic order for a prescribed number of randomly selected patients as well as documentation of two signatures for any waste of partial doses of controlled substances.⁸⁵ The OIG found that controlled substances inspectors did not verify orders (electronic or written) for five randomly selected dispensing activities in all 10 non-pharmacy areas reviewed. For all 10 areas, the controlled substances inspectors did not assess if a partial dose was given nor verify documentation of two signatures for waste when a partial dose was administered. Failure to verify orders and wastage may result in missed opportunities to identify potential drug diversion activities and any discrepancies related to controlled substances. The OIG noted that the controlled substances inspectors used a worksheet that did not provide full instructions or spaces for the inspector to document partial dose and waste documentation. The controlled substances coordinator stated competing priorities and lack of oversight as the reasons for noncompliance.

⁸⁵ VHA Directive 1108.02(1).

Recommendation 12

12. The facility director confirms that the controlled substances coordinator ensures that written and electronic controlled substance orders have been verified and assessed for documentation of two signatures for any waste of partial doses and monitors coordinator's compliance.

Facility concurred.

Target date for completion: April 30, 2020

Facility response: Monthly inspection forms were edited October 2019 to include verification of written and electronic order, waste and two signatures documented for waste of partial doses.

Numerator = # of inspections where at least 5 controlled substance orders were reviewed, documented, assessed per the directive

Denominator = # of monthly non pharmacy inspections

Controlled Substance Coordinator will report compliance with inspection form monthly to Quality Executive Board. The facility will achieve a target compliance rate of 90%. After six consecutive months of compliance is achieved, reporting will be changed to quarterly. If compliance falls below 90% then a new action plan will be developed, and reporting will resume monthly until target of 90% compliance is reached.

VHA requires controlled substances inspectors to conduct a physical count of all controlled substances in the pharmacy during the first month of the quarter and a random physical count of 50 line items for the other two months.⁸⁶ In three of six months reviewed (August, September, December 2018) for the pharmacy area, the controlled substance inspectors verified less than the required 50 line items despite having more than 50 items available to count. This may result in the inability to account for all controlled substances. The controlled substances coordinator stated competing priorities and lack of oversight as the reasons for noncompliance.

Recommendation 13

13. The facility director makes certain that the controlled substances coordinator validates that monthly inventories of controlled substances are conducted as required in the pharmacy and monitors coordinator's compliance.

⁸⁶ VHA Directive 1108.02(1).

Facility concurred.

Target date for completion: April 30, 2020

Facility response: The Controlled Substance Coordinator is responsible for ensuring inspectors complete the monthly controlled substances inspections and physical inventory counts on the day initiated and maintaining supporting documentation.

Controlled substance forms were updated March 1, 2019 to include spaces to input the date inspection was initiated and completed on the same day.

Numerator = # of monthly inspection forms completed properly to indicate physical count completed

Denominator = # of monthly inspections

Controlled Substance Coordinator reviews all reports monthly for completeness. The review is presented to the Quality Executive Board monthly.

Target compliance rate of 90% for six consecutive months. After six months of compliance is achieved, reporting will be changed to quarterly. If compliance falls below 90% then a new action plan will be developed, and reporting will resume monthly until target of 90% compliance is reached.

TJC requires that when automatic dispensing cabinets are used, the hospital has a policy that describes the types of medication overrides that will be reviewed for appropriateness and frequency of reviews.⁸⁷ The OIG found that the pharmacy staff lacked a policy and process for reviewing medication overrides, which creates the potential for medication errors and drug diversion. The chief of Pharmacy was unaware of this requirement.

Recommendation 14

14. The facility director ensures the development and implementation of a policy for automated dispensing cabinet medication overrides and reviews of these reports and monitors compliance.

⁸⁷ TJC. Medication Management standard MM.08.01.01 EP16.

Facility concurred.

Target date for completion: April 30, 2020

Facility response: The policy was updated June 2019 to include instructions concerning medication overrides. All staff were educated July 2019 on the new process. The Chief of Pharmacy will ensure all overrides are reviewed monthly and any overrides for control substances that do not have a coinciding order will be reported to the Controlled Substance Coordinator.

Numerator = # overrides with corresponding orders

Denominator = # of total overrides

The Chief of Pharmacy will perform a monthly audit of overrides until 90% compliance is reached for 6 consecutive months to ensure sustainment. The Controlled Substance Coordinator will report results of audit to Quality Executive Board monthly beginning November 2019.

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.”⁸⁸ 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.⁸⁹

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.⁹⁰ Additionally, the facility director is responsible for ensuring that MST-related data are tracked and monitored.⁹¹

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.⁹² Those who screen positive must have access to appropriate MST-related care.⁹³ 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.⁹⁴

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.⁹⁵ All mental health and primary care providers must complete MST mandatory

⁸⁸ VHA Directive 1115, *Military Sexual Trauma (MST) Program*, May 8, 2018.

⁸⁹ Military Sexual Trauma. https://www.mentalhealth.va.gov/docs/mst_general_factsheet.pdf. (The website was accessed on November 17, 2017.)

⁹⁰ VHA Directive 1115.

⁹¹ 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.)

⁹² VHA 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.”

⁹³ VHA Directive 1115.

⁹⁴ VHA Handbook 1160.01.

⁹⁵ 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.⁹⁶

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 many of the performance indicators, including designation of an MST coordinator and tracking of MST-related data and referrals. However, the OIG identified deficiencies with the MST coordinator communicating MST-related issues to leadership and providers completing the MST mandatory training in a timely manner that warranted recommendations for improvement.

VHA requires that MST coordinators communicate MST-related issues, services, and initiatives to facility leadership.⁹⁷ The MST coordinator did not communicate MST-related issues to facility leadership. The MST coordinator's lack of communication with facility leaders about MST

⁹⁶ 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 Memorandum, *Compliance with Military Sexual Trauma (MST) Mandatory Training for Mental Health and Primary Care Providers*, February 2, 2016.

⁹⁷ VHA Directive 1115.

program actions may impact or delay the opportunity to align services and care. The chief of Mental Health Services reported that the facility efforts met requirements, as the MST coordinator attends the Mental Health Executive Council meetings. However, the OIG could not validate facility leadership awareness of MST activities because an executive member does not attend the Mental Health Executive Council meetings.

Recommendation 15

15. The chief of staff confirms that the military sexual trauma coordinator communicates the status of military sexual trauma-related issues, services, and initiatives to facility leadership and monitors coordinator's compliance.

Facility concurred.

Target date for completion: May 31, 2020

Facility response: The Chief of Staff ensures that the Military Sexual Trauma Coordinator reports to the Quality Executive Board the activities of military sexual trauma information as required.

Numerator = # of Quality Executive Board minutes with documented military sexual trauma information as required

Denominator = # of Quality Executive Board meetings

Results of the audit will be reported to the Executive Leadership Team monthly for six consecutive months until a target of 90% is achieved.

Specifically, VHA requires that all primary care and mental health providers complete the MST mandatory training requirement.⁹⁸ Providers hired after July 1, 2012, must complete the training within 90 days after entering their position.⁹⁹ The OIG found that 5 of 14 clinicians hired after July 1, 2012, did not complete the required training within 90 days of their hire date. This has the potential to impact how clinicians provide appropriate care and service to veterans who experienced MST. The chief of mental health reported lack of attention to detail and other competing priorities as reasons for noncompliance.

⁹⁸ VHA Directive 1115.01.

⁹⁹ Acting Deputy Under Secretary for Health for Operations and Management Memorandum, *Compliance with Military Sexual Trauma (MST) Mandatory Training for Mental Health and Primary Care Providers*, February 2, 2016.

Recommendation 16

16. The chief of staff confirms that primary care and mental health providers complete military sexual trauma mandatory training within the required time frame and monitors providers' compliance.

Facility concurred.

Target date for completion: April 30, 2020

Facility response: On October 17, 2019 a military sexual trauma completion report was run from the Talent Management System that shows the facility has a 98% compliance rate. A monthly military sexual trauma completion report will be generated to monitor compliance of 90% or higher for six consecutive months. Results of the military sexual training completion report will be reported monthly to the Quality Executive Board.

Clinical Service Chiefs or designees will ensure new staff will complete the military sexual trauma training in Talent Management System (TMS) course within 90 days of hire.

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

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

The Chief of Staff will ensure compliance of this recommendation.

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."¹⁰⁰ 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.¹⁰¹

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."¹⁰²

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.¹⁰³ 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."¹⁰⁴ In 2015, VHA outlined essential medical information "necessary for review, management, and communication of medication information" with patients, caregivers, and their healthcare teams.¹⁰⁵ 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.¹⁰⁶ The CPG recommends that clinicians monitor patients monthly after therapy initiation or a change in treatment until the patient achieves

¹⁰⁰ 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.)

¹⁰¹ *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.)

¹⁰² 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.)

¹⁰³ 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.)

¹⁰⁴ TJC. Provision of Care, Treatment, and Services standard PC.02.03.01.

¹⁰⁵ VHA Directive 1164, Essential Medication Information Standards, June 26, 2015.

¹⁰⁶ 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.¹⁰⁷

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 43 randomly selected patients, ages 65 and older, who were newly prescribed one of seven selected antidepressant medications from July 1, 2017, through June 30, 2018.¹⁰⁸ 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

For geriatric patients, clinicians documented reasons for prescribing medications and performing medication reconciliation relative to the episode of care. However, the OIG identified concerns with patient/caregiver education and assessment of understanding that warranted a recommendation for improvement.

In accordance with TJC requirements, clinicians must educate patients and families about safe and effective use of medications, and verify that the patient's medical record contains information that reflects the patient's care, treatment, and services.¹⁰⁹ The OIG estimated that clinicians provided education to 63 percent of the patients at the facility, based on electronic health records reviewed.¹¹⁰ In addition, the OIG estimated that clinicians assessed understanding of the education provided to 63 percent of the patients at the facility, based on electronic health records reviewed.¹¹¹ Providing medication education and ensuring it is understood is critical to ensuring that patients or their caregivers have the information they need to manage their own

¹⁰⁷ VA/DoD Clinical Practice Guidelines for the Management of Major Depressive Disorder.

¹⁰⁸ The seven selected antidepressant medications are Amitriptyline, Clomipramine, Desipramine, Doxepin (>6mg/day), Imipramine, Nortriptyline, and Paroxetine.

¹⁰⁹ TJC. Provision of Care, Treatment, and Services standard PC.02.03.01; TJC. Record of Care, Treatment, and Services standard RC.02.01.01.

¹¹⁰ The OIG is 95 percent confident that the true compliance rate is somewhere between 47.8 and 76.8 percent, which is statistically significantly below the 90 percent benchmark.

¹¹¹ The OIG is 95 percent confident that the true compliance rate is somewhere between 44.1 and 80.9 percent, which is statistically significantly below the 90 percent benchmark.

health at home.¹¹² The chief of Mental Health reported that providers lacked attention to detail when using the existing template verbiage and when documenting the complete visit.

Recommendation 17

17. The chief of staff makes certain that clinicians provide and document patient and/or caregiver education and understanding of education provided about the safe and effective use of newly prescribed medications and monitors clinicians' compliance.

Facility concurred.

Target date for completion: May 31, 2020

Facility response: The Chief of Staff or designee will review 30 random patient records monthly to confirm that documentation of patient or caregiver education for newly prescribed medications was completed.

Numerator = # of charts reviewed with patient or caregiver education

Denominator = # of charts reviewed monthly

A target of 90% compliance for education documentation will be achieved for six consecutive months. Results of the chart audits will be reported monthly to the Medical Executive Committee.

¹¹² TJC. Provision of Care, Treatment, and Services PC.02.03.01.

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.¹¹³ Human papillomavirus (HPV) can be transmitted during sexual contact and is the main cause of cervical cancer.¹¹⁴ 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.¹¹⁵ Cervical cancer is highly preventable through diligent screening and vaccination efforts. With early detection, it is very treatable and associated with optimal patient outcomes.¹¹⁶

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.¹¹⁷

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 (WVHC) 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.¹¹⁸

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

¹¹³ 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.)

¹¹⁴ Centers 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.)

¹¹⁵ 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.)

¹¹⁶ Centers 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.)

¹¹⁷ VHA Directive 1330.01(2), *Health Care Services for Women Veterans*, February 15, 2017 (amended July 24, 2018).

¹¹⁸ VHA Directive 1330.01(2).

results to patients must be documented. The facility must ensure that appropriate follow-up care is provided to patients with abnormal results.¹¹⁹

To determine whether the facility complied with selected VHA requirements for the notification and follow-up care of abnormal cervical pathology results, the OIG inspection team reviewed relevant documents and interviewed selected employees and managers. The team also reviewed the electronic health records of 16 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 some of the performance indicators, including the requirement for a designated facility women veterans program manager. Of note, during the review of the cervical screening results, OIG noted some tests are sent to Oklahoma for processing and are not returned for approximately six weeks which may impact the timeliness of follow-up care, if needed. However, the OIG identified deficiencies with clinical oversight of the women's health program, representation on the facility's Women Veterans Health Committee, tracking and monitoring of cervical cancer screening data, and communicating abnormal results to patients that warranted recommendations for improvement.

¹¹⁹ VHA Directive 1330.01(2).

Specifically, VHA requires that each “Health Care System must have a women’s health medical director or clinical champion responsible for clinical oversight of the women’s health program.”¹²⁰ The OIG found that the facility lacked a women’s health medical director or clinical champion. This resulted in a lack of clinical oversight for the women’s health program. The women veterans program manager stated after the previous women’s health medical director left the facility the role was never filled.

Recommendation 18

18. The facility director ensures the appointment of a women’s health medical director or clinical champion.

Facility concurred.

Target date for completion: April 30, 2020

Facility response: A Women’s Health Medical Director was appointed February 15, 2019 by the Acting Chief, Primary Care and approved by the Acting Chief of Staff.

Numerator = # of Women Veterans Health Committee minutes with women’s health medical director in attendance

Denominator = # of Women Veterans Health Committee minutes

This will be reported to Quality Executive Board monthly for six consecutive months to ensure sustainment.

According to VHA, each health care system must have a Women Veterans Health Committee that maintains an active charter, meets at least quarterly, and reports to executive leadership with signed minutes.¹²¹ The facility did not have a Women Veterans Health Committee, which resulted in a lack of interdisciplinary committee expertise to plan and carry out improvements for quality equitable care for women veterans. The women veterans program manager stated the former facility director dissolved the Women Veterans Health Committee due to poor attendance; and, at the time of the OIG onsite visit, this had not been addressed by interim facility directors.

Recommendation 19

19. The facility director ensures the facility has a Women Veterans Health Committee that has an active charter, meets at least quarterly, and reports to leadership with signed minutes and monitors committee’s compliance.

¹²⁰ VHA Directive 1330.01(2).

¹²¹ VHA Directive 1330.01(2).

Facility concurred.

Target date for completion: May 31, 2020

Facility response: The Chief of Staff will ensure compliance with attendance. Women Veterans Program Manager is responsible to ensure all required members are invited to all meetings.

A primary and alternate member from Primary Care, Urgent Care, and Executive Leadership Team were appointed as representatives to the Women Veterans Health Committee on November 2019. The Women Veterans Program Manager will review the Women Veterans Health Committee attendance record monthly to ensure all required members of the Women Veterans Health Committee attended at least 90% of committee meetings.

Numerator = # of Women Veterans Health Committee minutes with required members in attendance

Denominator = # of Women Veterans Health Committee minutes

Attendance compliance will be monitored monthly to ensure sustainment of attendance for six consecutive months. Attendance data from the Women Veterans Health Committee will be presented to the Medical Executive Committee quarterly by the Chief of Staff.

Additionally, VHA requires each facility must have a process in place to track data, “including notification of patients who are due for screening, tracking of completion of screening, results reporting, and follow-up care” related to cervical cancer screenings.¹²² The OIG found the facility lacked evidence of tracking patients due for screening, completion of screening, reporting of results, or follow-up care. Lack of a systematic process for collection and tracking of cervical cancer screening data may cause delays in addressing abnormal cervical screening results and implementing appropriate action plans. The women veterans program manager reported there was a lack of staff to track and monitor the required data.

Recommendation 20

20. The facility director makes certain that facility staff implement a process to track and monitor cervical cancer screenings, results reporting, and follow-up care and monitors assigned staff compliance.

¹²² VHA Directive 1330.01(2).

Facility concurred.

Target date for completion: May 31, 2020

Facility response: November 2019, the cervical tracker will be updated to include patients due for screening, completion of screening, results reporting, and follow-up care. This data will be presented to the Women Veterans Health Committee monthly.

Thirty charts a month will be audited by Nurse Navigator for Women's Health until a target of 90% compliance is achieved.

Numerator = # of charts with all required elements (patients due for screening, completion of screening, results reporting and follow-up care)

Dominator = # charts reviewed

This will be reported to the Medical Executive Committee monthly by the Women's Health Coordinator until compliance is achieved for six consecutive months.

VHA requires providers communicate abnormal results to patients within seven calendar days after the results become available.¹²³ The OIG determined that providers communicated abnormal results to patients within seven days for only 75 percent of the electronic health records reviewed.¹²⁴ Timely communication of abnormal results minimizes potential risks to patients. The women veterans program manager stated that individual delays were from several different providers and new staff assigned to track cervical pathology results which led to noncompliance.

Recommendation 21

21. The chief of staff ensures patient notification of abnormal cervical results are completed within the required time frame and monitors compliance.

¹²³ VHA Directive 1330.01(2).

¹²⁴ Confidence Intervals are not included because the data represents every patient in the study population.

Facility concurred.

Target date for completion: May 31, 2020

Facility response: Education will be provided to the Women's Clinic staff in November 2019 regarding the timely notification of abnormal cervical pathology results within seven calendar days. Assistant Chief, Quality, Safety and Value will conduct monthly audits of 30 charts to monitor timely notification to patients with abnormal cervical results until target of 90% is achieved for six consecutive months.

Numerator: # of patients notified in within seven calendar days after the results become available

Dominator: # of charts reviewed

Results of audits will be reported monthly to Medical Executive Committee by Chief of Quality, Safety and Value.

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.”¹²⁵ 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.¹²⁶

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.”¹²⁷

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.”¹²⁸

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.¹²⁹

¹²⁵ VHA Directive 1101.05(2), *Emergency Medicine*, September 2, 2016 (amended March 7, 2017).

¹²⁶ VHA Directive 1101.05(2).

¹²⁷ VHA Directive 1101.05(2).

¹²⁸ TJC. Leadership standard LD.04.03.11.

¹²⁹ 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 Emergency Medicine Improvement initiative goals.

VA emergency departments and UCCs must also be designed to promote a safe environment of care.¹³⁰ Managers must ensure medications are securely stored,¹³¹ a psychiatric intervention room is available,¹³² 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.¹³³

The OIG examined the clinical risks of the emergency department/UCC areas by evaluating the 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 those areas. In addition to conducting manager and staff interviews, the OIG team 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

¹³⁰ VHA Directive 1101.05(2).

¹³¹ TJC. Medication Management standard MM.03.01.01.

¹³² A psychiatric intervention room is where individuals experiencing a behavioral health crisis, including serious disturbances, agitation, or intoxication may be taken immediately on arrival.

¹³³ VHA Directive 1101.05(2).

- Licensed independent mental health provider available as required for the facility's complexity level
- 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 tracks¹³⁴
- 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

The facility generally complied with many of the performance indicators for the operations and management of UCC's. However, the OIG identified the lack of a backup call schedule for the UCC providers that warranted a recommendation for improvement.

Adequate staffing during all hours of operation requires an effective backup call process. VHA requires that "all emergency department and UCC facilities have written provider staffing contingency plans that includes a backup call schedule to address situations where expedient mobilization of provider resources are needed."¹³⁵ The OIG found that the UCC lacked a backup

¹³⁴ The emergency department fast track is a designated care area within the emergency department domain where lower acuity patients are assessed and treated.

¹³⁵ VHA Directive 1101.05(2).

call schedule, which could potentially impact the facility's ability to provide uninterrupted and timely patient care. The UCC lead supervisor reported personally providing sick leave coverage when needed, thought that met the requirement, and was unaware of the need for a contingency plan backup call schedule.

Recommendation 22

22. The chief of staff makes certain that a backup call schedule is maintained for urgent care center providers and monitors compliance.

Facility concurred.

Target date for completion: July 31, 2020

Facility response: By December 2019 the Supervisory Physician, Urgent Care Center will develop and implement a Standard Operating Procedure for a contingency plan to rapidly mobilize additional staff in cases where patient care demands exceeds current staffing resources during hours of operation. In January 2020, current providers will be educated on the new Standard Operating Procedure by Supervisory Physician, Urgent Care Center.

The facility will monitor for a monthly call schedule until 100% compliance is achieved for six consecutive months. The Chief of Quality, Safety, and Value will audit for the availability of the call schedule and report findings to the Executive Leadership Team.

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 engagementEmployee satisfactionPatient experienceAccreditation and/or for-cause surveys and oversight inspectionsFactors related to possible lapses in careVHA performance data	Twenty-two OIG recommendations based on topics reviewed and one incidental recommendation ranging from documentation concerns to noncompliance that can lead to patient and staff safety issues or adverse events are attributable to the director, chief of staff, and associate director. See details below.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Quality, Safety, and Value	<ul style="list-style-type: none">Protected peer reviewsUM reviewsPatient safetyResuscitation episode review	<ul style="list-style-type: none">The patient safety manager includes all required content in each root cause analysis.The ICU/CPR Committee conducts a complete analysis of resuscitative episodes that includes all required elements.	<ul style="list-style-type: none">Required representatives consistently participate in interdisciplinary reviews of UM data.

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"> • Clinical managers define and communicate expectations for FPPEs in advance and maintain appropriate documentation of the process. • Service chiefs document the FPPE results in the practitioner profiles. • Required specialty-specific criteria are included in the FPPE and OPPEs. • OPPEs are completed by providers with similar training and privileges. • The Medical Executive Committee's documentation includes discussion of the FPPE and OPPE results. • Privileging actions taken by the facility are reported to the National Practitioner Data Bank. 	<ul style="list-style-type: none"> • None

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 • 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"> • Panic alarms are regularly tested, and the results are documented.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
Medication Management: Controlled Substances Inspections	<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 program staff reconcile one day's stocking/refilling from the pharmacy to each dispensing area and one day's return of stock to pharmacy from every automated dispensing unit during monthly inspections. Written and electronic controlled substances orders are verified and assessed for documentation of two signatures for any waste of partial doses. Monthly inventories of controlled substances in the pharmacy are conducted as required. A formal process is implemented for reviewing medication override reports.
Mental Health: Military Sexual Trauma (MST) Follow-Up and Staff Training	<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"> None 	<ul style="list-style-type: none"> MST-related issues, services, and initiatives are communicated to facility leadership. Primary care and mental health providers complete MST mandatory training within the required time frame.
Geriatric Care: Antidepressant Use among the Elderly	<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 	<ul style="list-style-type: none"> None 	<ul style="list-style-type: none"> Clinicians provide and document patient/caregiver education and understanding of education provided about the safe and effective use of newly prescribed medications.

Healthcare Processes	Performance Indicators	Critical Recommendations for Improvement	Recommendations for Improvement
	<p>understanding of the education provided</p> <ul style="list-style-type: none"> Medication reconciliation 		
<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 Communication of abnormal results to patients within required time frame Provision of follow-up care for abnormal cervical pathology results, if indicated 	<ul style="list-style-type: none"> Patient notification of abnormal cervical results are completed within the required time frame. 	<ul style="list-style-type: none"> A women's health medical director or clinical champion is appointed. The Women Veterans Health Committee maintains an active charter, meets at least quarterly, and reports to leadership with signed minutes. A process is implemented to track and monitor cervical cancer screenings, results reporting, and follow-up care.
<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"> None 	<ul style="list-style-type: none"> A backup call schedule is maintained for UCC providers.

Appendix B: Facility Profile and VA Outpatient Clinic Profiles

Facility Profile

The table below provides general background information for this low medium complexity (2) facility reporting to VISN 7.¹³⁶

**Table B.1. Facility Profile for Carl Vinson VA Medical Center (557)
(October 1, 2015, through September 30, 2018)**

Profile Element	Facility Data FY 2016 ¹³⁷	Facility Data FY 2017 ¹³⁸	Facility Data FY 2018 ¹³⁹
Total medical care budget dollars	\$282,611,984	\$284,673,313	\$329,297,508
Number of:			
• Unique patients	36,532	37,318	36,991
• Outpatient visits	379,358	378,296	392,987
• Unique employees ¹⁴⁰	1,085	1,115	1,230
Type and number of operating beds:			
• Community living center	147	147	147
• Domiciliary	145	145	145
• Medicine	30	30	30
• Surgery	4	4	4
Average daily census:			
• Community living center	137	140	121
• Domiciliary	98	74	74
• Medicine	8	4	3
• Surgery	0	–	–

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.

¹³⁶ The VHA medical centers are classified according to a facility complexity model; a designation of “2” indicates a facility with “medium volume, low-risk patients, few complex clinical programs, and small or no research and teaching programs.”

¹³⁷ October 1, 2015, through September 30, 2016.

¹³⁸ October 1, 2016, through September 30, 2017.

¹³⁹ October 1, 2017, through September 30, 2018.

¹⁴⁰ Unique employees involved in direct medical care (cost center 8200).

VA Outpatient Clinic Profiles¹⁴¹

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)¹⁴²

Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services ¹⁴³ Provided	Diagnostic Services ¹⁴⁴ Provided	Ancillary Services ¹⁴⁵ Provided
Macon, GA	557GA	14,502	9,987	Dermatology Endocrinology Infectious disease Eye	n/a	Nutrition Pharmacy Social work Weight management
Albany, GA	557GB	7,777	6,847	Dermatology Podiatry	n/a	Pharmacy Social work

¹⁴¹ Includes all outpatient clinics in the community that were in operation as of August 15, 2018.

¹⁴² 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.”

¹⁴³ Specialty care services refer to non-primary care and non-mental health services provided by a physician.

¹⁴⁴ Diagnostic services include electrocardiogram (EKG), electromyography (EMG), laboratory, nuclear medicine, radiology, and vascular lab services.

¹⁴⁵ Ancillary services include chiropractic, dental, nutrition, pharmacy, prosthetic, social work, and weight management services.

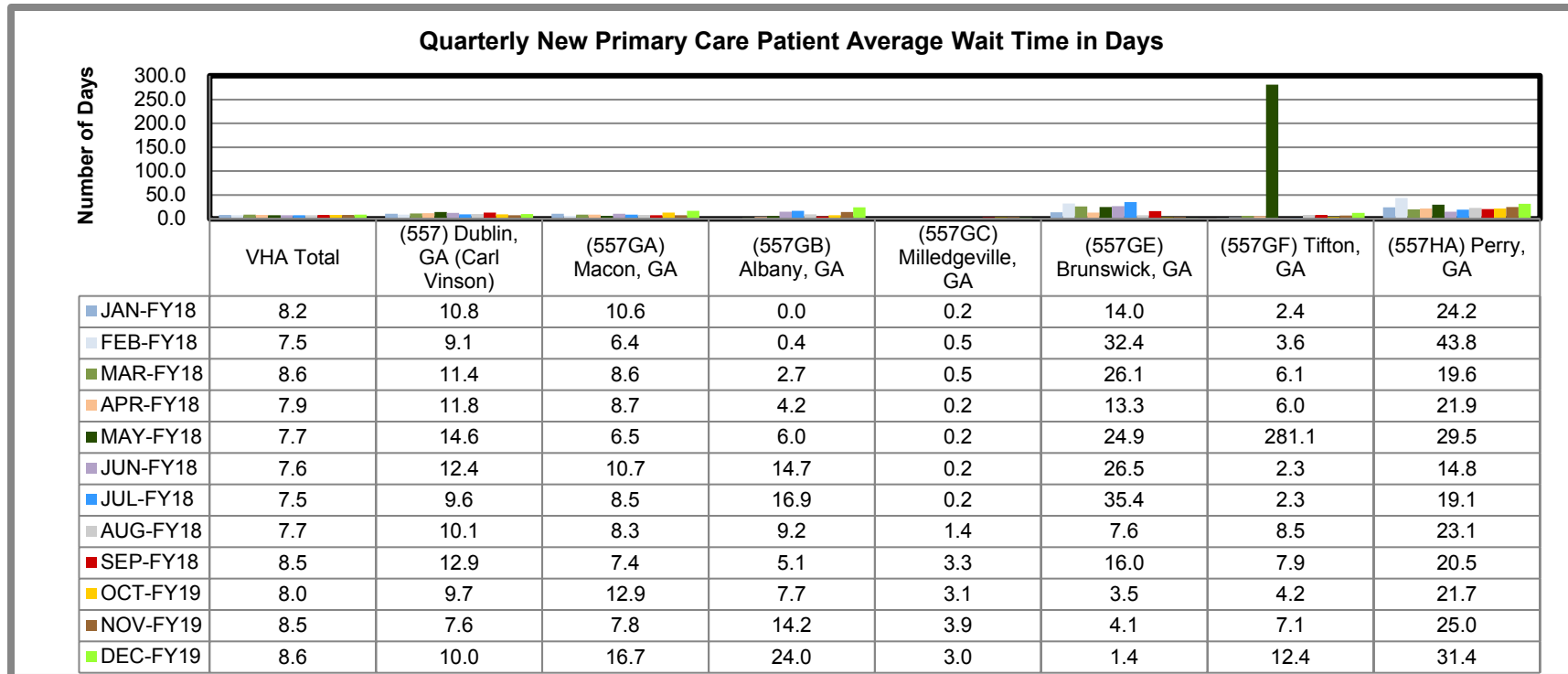
Location	Station No.	Primary Care Workload/ Encounters	Mental Health Workload/ Encounters	Specialty Care Services ¹⁴³ Provided	Diagnostic Services ¹⁴⁴ Provided	Ancillary Services ¹⁴⁵ Provided
Milledgeville, GA	557GC	3,581	1,711	Dermatology Endocrinology	n/a	Pharmacy Social work Weight management
Brunswick, GA	557GE	5,445	4,803	Dermatology Endocrinology Eye Podiatry	n/a	Pharmacy Social work Weight management
Tifton, GA	557GF	7,756	4,761	Dermatology Endocrinology	n/a	Pharmacy Social work Weight management Nutrition
Kathleen, GA	557HA	5,430	4,501	Dermatology Endocrinology Eye	n/a	Pharmacy Social work Weight management Nutrition

Source: VHA Support Service Center and VA Corporate Data Warehouse

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

n/a = not applicable

Appendix C: Patient Aligned Care Team Compass Metrics¹⁴⁶



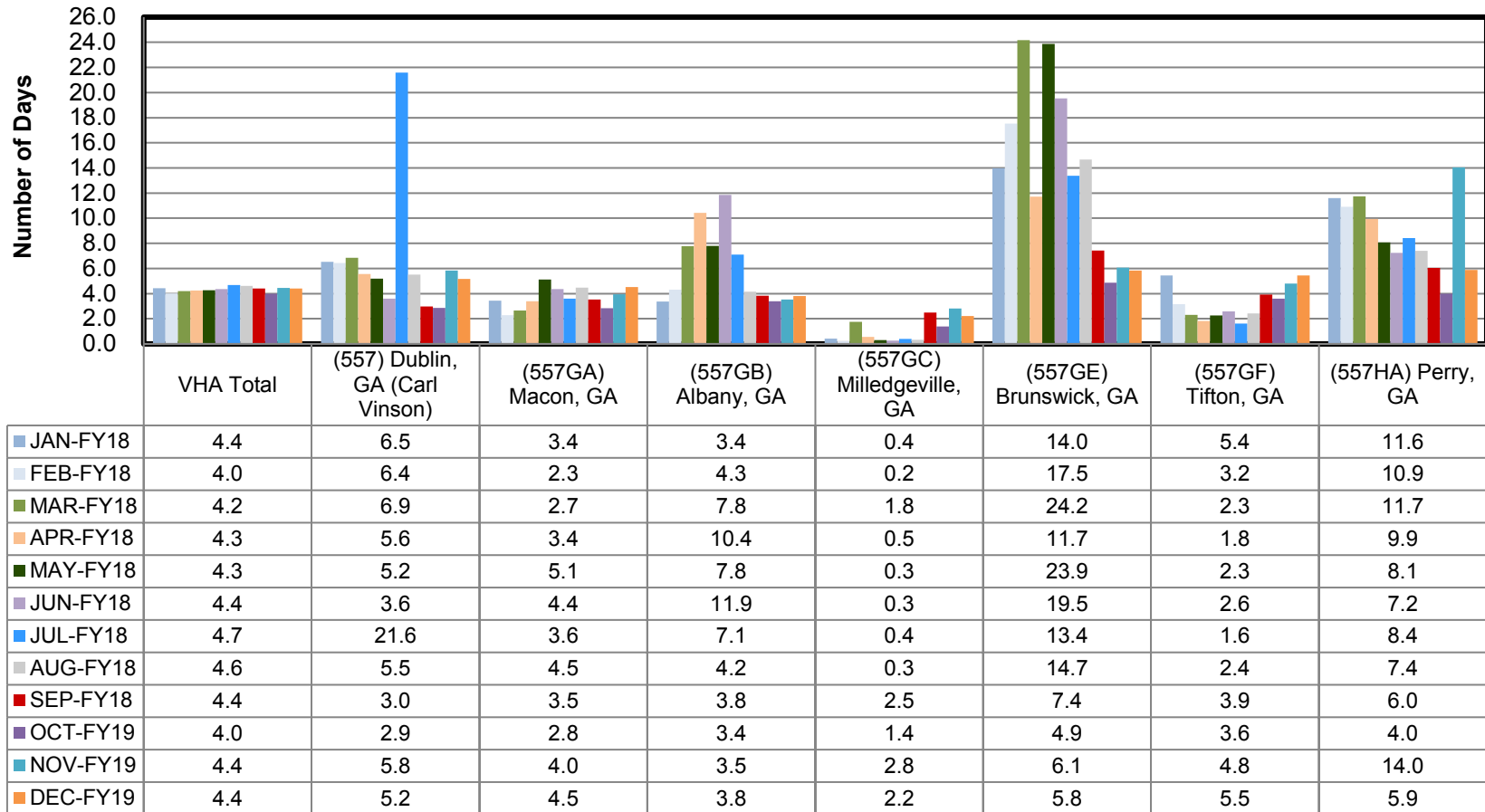
Source: VHA Support Service Center

Note: The OIG did not assess VA's data for accuracy or completeness. The OIG has on file the facility's explanation for the increased wait times for the Brunswick, GA (557GE); Tifton, GA (557GF); and Perry, GA (557HA) CBOCs.

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.

¹⁴⁶ 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



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 Definitions¹⁴⁷

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

¹⁴⁷ 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 Definitions¹⁴⁸

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.

¹⁴⁸ *Strategic Analytics for Improvement and Learning (SAIL) for Community Living Centers (CLC)*, Center for Innovation & Analytics (last updated November 19, 2018). <http://vaww.vssc.med.va.gov/VSSCEnhancedProductManagement/DisplayDocument.aspx?DocumentID=7410>. (The website was accessed on March 6, 2019, but is not accessible by the public.)

Appendix F: Acting VISN Director Comments

Department of Veterans Affairs Memorandum

Date: October 17, 2019

From: Acting Director, VA Southeast Network (10N7)

Subj: Draft Report: Comprehensive Healthcare Inspection of the Carl Vinson VA Medical Center, Dublin, GA

To: Director, Bay Pines Office of Healthcare Inspections (54CH03)
Director, GAO/OIG Accountability Liaison (VHA 10EG GOAL Action)

1. I have had the opportunity to review the Draft Report: Comprehensive Inspection of the Carl Vinson VA Medical Center, Dublin, GA.
2. VISN 7 submits concurrence to recommendations 1-22 and the attached Carl Vinson VA Medical Center submission.
3. I appreciate the opportunity for this review as part of a continuing process to improve the care of our Veterans.
4. If you have any questions or require further information, please contact the VISN 7 Quality Management Officer.

(Original signed by:)

Scott R. Isaacks

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: October 15, 2019

From: Director, Carl Vinson VA Medical Center (557/00)

Subj: Comprehensive Healthcare Inspection of the Carl Vinson VA Medical Center,
Dublin, GA

To: Acting Director, VA Southeast Network (10N7)

1. Enclosed for your review is the draft report of our Comprehensive Healthcare Inspection Program (CHIP) review of the Carl Vinson VAMC, Dublin GA.
2. I concur with the report.

(Original signed by:)

David L. Whitmer, 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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